3 DISTRICT MASTER PLAN

This master plan is for Damoh and Tikamgarh districts, and was developed within the frameworks of state population policy and state health strategies. It is recommended that the plan should be integrated into a comprehensive district health plan, and implemented in coordination with other state health activities.

The district master plan consists of overall goal, objectives, strategies and priority projects. The priority project is explained in the next Chapter of this report (Chapter 4).

3.1 PLANNING FRAMEWORK AND GOAL FOR DISTRICT MASTER PLAN

3.1.1 Policy Framework

As already described in Chapter 4 and 10, the1994 International Conference on Population and Development (ICPD) in Cairo marked a turning point in the approach that the Government of India (GOI) enunciated for its population and health programmes. In line with the Programme of Action adapted at the ICPD in Cairo and the Government of India (GOI) espousal of a policy supporting provision of quality services to meet the full range of reproductive health needs of women and couples, it adopted integrated RCH approach and the "target-free reproductive health approach." Method-specific targets were discouraged nationwide in April 1996.

The Reproductive and Child Health (RCH) Programme was begun in 1997 combining several Programmes that had previously been vertical in line with the Action Programme adopted in ICPD Cairo. The target free approach was adopted, which changed its name in 1998 to the Community Needs Assessment Approach (CNAA) to emphasize the positive side of the new orientation.

Under these circumstances, GOI issued its National Population Policy in 2000. The Government of Madhya Pradesh also establish the State Population Policy in 2000. These are the major policy frameworks for RCH programme and the district planning to improve RCH in the target districts, Tikamgarh and Damoh District.

The mission of State Population Policy is ***"improving the quality of life of people in the state by achieving a balance between population, resources and environment."*** This mission is to be accomplished by achieving the main objective: reaching a TFR of 2.1 by 2011. Sub-objectives including increasing contraceptive prevalence through women's and couple's informed and voluntary choice, reducing infant mortality rate (IMR), reducing maternal morality ratio (MMR) and reducing morbidity of RTIs/STIs through integrated approach with emphasis on women's empowerment. Specific objectives are set up for more than 20 items in these four fields as shown in the Table below.

Draft National Health Policy 2001 affirms close relationship between population stabilization and achieving better health standards, and addresses to reduce the unmet needs for basic and reproductive health services. It also says "The synchronized implementation of these two policies will be the very cornerstone of any national structural plan to improve the health standards."

Table 10 Specific Objectives of Madhya Pradesh Population Policy

	Current	2005	By 2011
Reduction in Fertility (TFR)			**2.1**
Increase the use of modern contraceptives	42%	55%	65%
Reduce unmet need for contraception		By half	By 90%
Increase in male sterilization acceptors	2%	7%	20%
Increase the use of spacing method among young married couples	---	---	At least 50%
Increase in the average age of marriage	15 years		18 years
Increase in the age of the mother at the birth of her first child	16 years	20 years	21 years
Increase in the gap between the first and the second child		3 or more years	
Motivate couples with two or more children for terminal contraceptive methods			
Adjusting service delivery to regional variations			
Reduction in Maternal Mortality (MMR)	**498**	**330**	**220**
Increased registration of first-trimester pregnant women and provide a full range of ANC services to all pregnant women		70%	90%
Increased proportion of institutional deliveries	15% in 1995	25%	50%
Increased participation of trained TBAs in assisting delivery		75%	90%
Creation of sub-centre pregnancy testing facilities		by 2003	
Creation of block-level EmOC and MTP, and prevention and treatment of RTI facilities		50%	100%
Reduction in Infant Mortality (IMR)	**97 in 1997**	**75**	**62**
Reduction in Child Mortality (U5MR)	**120 in 1997**	**90**	**65**
Total immunization coverage		70%	90% by 2009
Increase ORS use	40%	80%	90% by 2009
Reduce incidence rate of ARI		50% reduction	75% ↓ by 2009
Introduction of ARI treatment		In all block level institutions	
Creation of appropriate facilities for treatment of diarrhea		All SCs	
Ensure children's receipt of Vit.A		50%	90% by 2009
Provision of Other Services			
Prevention of transmission of STIs			
Provision of quality services to infertile couples at the district level		By 2005	
Universal primary education		By 2005	
Completion of elementary education (girls)		30% of girls	50% of girls

Source: Madhya Pradesh Population Policy 2000, Government of Madhya Pradesh

3.1.2 State Health Strategies

As mentioned in Chapter 2

, the DOHFW has contracted a consultants group for developing the mid-term state health strategy, and it is undergoing at present. However, the DOHFW has already developed a basic state health strategy as described below to push implementation of population policy on forward, since it is critical issues which needs immediate action for the development of the state of Madhya Pradesh.

In the above mentioned state health strategy, "Convergence", "Implementation", "Micro-planning" and "Monitoring" are raised as the Key Word of the strategic approach with "40 points activities."

Key Word

(1) Convergence: This means the optimum utilization of existing resources (both human and financial) and avoiding the duplication of activities of various agencies. It also means uniformity of content and effort in training of health workers, and public-private-NGO partnership.

(2) Micro-planning: In rural areas, 20% villages will be covered in the first year, 40% in the second year, and the remaining 40% in the third year. Similarly, in urban areas the slums will be covered. The forth and fifth year would be used for consolidation.

(3) Implementation: To ensure effective implementation of the programmes/projects, it should be ensured that ANMs are in the position and sessions are carried out regularly. The detailed district plan will be developed based incorporating the outcomes of micro planning. Health insurance will be experimented.

(4) Monitoring: A detailed HMIS will be developed including incorporation of GIS package into HMIS, simplification of input format, and carrying out concurrent surveillance.

The following are the family welfare activities to reduce TFR (40 points activities):

1) Assessment of service need for primary health care.
2) Eligible couple survey complete.
3) 100 % vital registration of marriage, pregnancy, births, and deaths.
4) 3 ANC check-up to all pregnant mothers along with two does TT, 100 IFA and complete check-up.
5) Nutritional supplement to all pregnant mothers in AWW.
6) 100 % delivery by trained personal ANM.
7) Weighing of all new born and referral to hospital of LBW babies.
8) Referral of all complicated deliveries to CHC and their follow-up.
9) DDK to all pregnant mothers in last trimester.
10) 100% full immunization of infants and children no drop out.
11) 100% vitamin A distribution to children 9 months to 3 years.
12) IFA small distribution to under five children.
13) Growth monitoring of all children under 6 in AWW.
14) Registration and treatment by ORS of all diarrhea cases under 5 years.
15) Registration and treatment by Co-trimoxazole of all ARI/common cold cases under 5 years and

appropriate referral and follow-up of ARI cases.

16) Provision of referral system by community for high delivery cases.
17) Clint segmentation of all eligible couple in a separate diary and work out CPR of the area. Ensure that 70 % couples are covered by some or the other contraceptive.
18) All PNC to be followed up till first year regularly every months. And provided with contraceptive.
19) All newly wed couples must receive Condom/OP.
20) All PNC cases screened for RTI and counseled for IUD and insertation according to their wish.
21) Cover all PNC with some or the other contraceptive till 3 years of age.
22) Maintain CC/OP/IUD insertation register separately and regular record keeping.
23) All cases have been two and more children must be counseled for NSVT/CTT/LTT. If they are resistant proper counseling by peers/PRI/MSS/Religious and opinion leaders.
24) MSS must be formed and meeting are held regularly.
25) Group meeting with all the SHG regularly every month.
26) RTI/STD treatment.
27) Group meeting regularly with eligible couples in each mohalla.
28) Slogan and wall writing.
29) TB and leprosy cases to be given regular treatment.
30) All fever cases blood slide to be taken and pre-presumptive treatment of malaria given.
31) Campaign for environmental sanitation.
32) All wells must be disinfected regularly every week.
33) All Infant deaths, Maternal deaths must be notified and investigated.
34) Any epidemic of VPD must be reported within 24 hrs. and containment majors taken.
35) Surveillance of Polio, VPD and diarrhoeal disease.
36) Regular weekly ANC/PNC clinics at SHC.
37) Regular visit of health supervisor alternate week for supportive supervision and IEC.
38) School health of all school in area once in a year.
39) Meeting with community once in a month and presentation of statistics.
40) Health Mela for mothers and babies every three months.
41) Gender issues.
42) Adolescent Health.
43) Gender based violence.

Swasth Jeevan Sewa Guarantee Yojana (Rajiv Ghandi Mission for Community Health)

The state scheme of Swasth Jeevan Sewa Guarantee Yojana (Rajiv Ghandi Mission for Community Health) was launched in 2001 in MP. This mission programme also emphasises decentralised planning and management in health sector and revitalisation of the village health committee as a core mechanism for community participation in their own health care.

3.1.3 Overall Goal and Targets of District Master Plan for Improvement of Reproductive Health

The National and State Population Policy suggest that plan for implementation of the policy should be developed at district level taking consideration of local needs. The district master plan will cover reproductive and child health areas which are included in the current RCH Programme, but not other less priority areas in India such as women's cancer, menopause, etc.

Performance of the RCH programme currently implemented nationwide is moderate in Madhya Pradesh, and limited in Tikamgarh and Damoh District. One of the issues at district level is that the reproductive health approach is not well understood by district officers, politicians, health staff and general population.

Based on the policy frameworks and the situation at district level, the overall goal for the district master plan for improvement of reproductive and child health is proposed as ***to improve health status of all women and children through a Reproductive and Child Health (RCH) approach contributing to population stabilization in the target districts.***

As indicated in Table 11-1, the Government of Madhya Pradesh set quantitative goals in the State Population Policy. In the District Master Plan, quantitative goals for TFR and IMR are set according to the State Population and Policy. However, to set quantitative goal for MMR is difficult since district level data is available only at one point (1991) and quality is questionable. Since the period of the Tenth National Five-Year Plan will be 2003 – 2007, the goal in 2007 are also set.

Table 11 Quantitative Goal for District Master Plan

	MP *			Tikamgarh			Damoh		
	Current	2005	by 2011	Current	2007	by 2011	Current	2007	by 2011
Fertility (TFR)			2.1			2.1			2.1
Maternal Mortality (MMR)	498	330	220	1,178	---	---	856	---	---
Infant Mortality (IMR)	97 in 1997	75 (71 in 2007)	62	132 in 1991	80	70	123 in 1991	75	65

Source: * Population Policy of Madhya Pradesh, MP, 2000

3.1.4 Socio-economic Frameworks in 2007 and 2010

(1) Population

Based on the population projection of Case 2 where the assumption of decreasing in TFR to 2.1 in 2011 is adopted, population framework is set shown below. In Tikamgarh population will increase 12% in 2007 and 18% in 2011. In Damoh, it will be 11% in 2007 and 17% in 2011.

Table 12 Population Projection in 2007 and 2011

	Sagar div.	Tikamgarh	Chhatarpur	Panna	Sagar	Damoh
Population ('000)						
2001*	6,636	1,203	1,475	854	2,022	1,082
2006	7,314	1,334	1,628	940	2,227	1,184
2007	7,416	1,353	1,653	953	2,258	1,199
2011	7,823	1,427	1,750	1,004	2,380	1,261
Annual Growth Rate (%)						
2001-2006	1.97	2.09	2.00	1.94	1.95	1.82
2006-2011	1.35	1.35	1.45	1.32	1.34	1.28
Annual Live Births ('000)						
2001-2006	105	20	22	14	32	16
2006-2011	95	16	19	13	31	16

Note: *Actual
Source: Census of India 2001

(2) Literacy Rate

Literacy, one of indicators of development in a society, forms an important input in the overall development of individuals enabling them to comprehend their social environment and respond to it appropriately. The literacy rates are projected based on the current trend in India from 1991 to 2001 as shown below.

Table 13 Literacy Rate * in 2007 and 2010

(Unit: %)

		Sagar div.	Tikamgarh	Chhatarpur	Panna	Sagar	Damoh
1991**	Male	55.4	47.5	46.9	46.3	67.0	60.5
	Female	27.5	20.0	21.3	19.4	37.8	30.5
	Total	42.4	34.8	35.2	33.7	53.4	46.3
2001**	Male	73.2	68.8	65.5	74.0	80.0	75.0
	Female	46.7	41.0	39.4	47.8	54.5	47.5
	Total	60.8	55.8	53.4	61.6	68.1	62.1
2007	Male	79.8	77.0	75.0	80.3	84.3	81.0
	Female	56.1	51.6	50.4	56.9	62.3	56.7
	Total	68.7	65.1	63.5	69.2	74.0	69.5
2010	Male	83.3	81.2	79.8	83.6	86.6	84.1
	Female	61.5	57.6	56.6	62.1	66.8	61.9
	Total	73.0	70.1	69.0	73.3	77.3	73.6

Note: *The population of seven years and above only is classified as literate and illiterate.
** Actual
Source: Census of India, 2001

(3) Economic Growth

The Ninth Five Year Plan 1997-2002 of India set its main objective as 'Growth with Social Justice and Equity'. According to the Ninth Plan, one of the specific objectives is to accelerate

the growth rate of the economy with stable prices and the GDP growth target of 6.5% per annum is established after detailed examination. In addition, the growth rate of the GDP after the period of the Ninth Plan is estimated at 7.7%. The growth rates of the GDP of the state of Madhya Pradesh were lower than that of India during the period of 1993-99. Taking into consideration these conditions, the GDP of the State is estimated as shown below.

Table 14 GDP at Constant Price of 1998-99

	1993-94*	1998-99*	2006-07	2007-08	2011-12
GDP (billion Rs.)	731	907	1,319	1,386	1,690
Annual Growth Rate (%)	-	4.43	4.79	5.08	5.08

Note: *Actual

Source: Estimate of State Domestic Product of Madhya Pradesh 1993-94 – 1998-99, Dir. of Economics & Statistics, MP

3.2 OBJECTIVES AND STRATEGIES OF THE DISTRICT MASTER PLAN

3.2.1 Objectives and Strategies

Based on the current problems and issues in RCH and the RCH Programme in Tikamgarh and Damoh, which are described in Chapter 10, the District Master Plan address three objectives and several strategies to achieve them.

Overall Goal

To improve health status of all women and children through a Reproductive and Child Health (RCH) approach contributing to population stabilization in the target districts.

<Quantitative goals>

Reduction of TFR: 2.1 by 2011 in both Tikamgarh and Damoh District
Reduction of MMR: 50% reduction in 2010 in both Tikamgarh and Damoh District
Reduction of IMR: 80 in 2007, and 70 in 2010 in Tikamgarh District
75 in 2007, and 65 in 2010 in Damoh District

Objectives

(A) To improve the access to high quality RCH services

(B) To promote effective and efficient RCH service delivery through improved management

(C) To encourage women's empowerment and improvement of women's quality **of life**

Vision in 2010: In 2010, the followings are achieved according to the objectives.

(a) Management capacity at block level and district level is strengthened:

- District and block health office (CMHO and BMO offices) develop their plan for improvement of RCH for implementation of effective services with participation of all stakeholders including other departments, PRIs, NGOs and the community.
- BMO offices implement the plan efficiently, and supervise and monitor the activities for better implementation and planning based on the analysis of performance, health information data and field visits. CMHO office supervises and monitors BMO offices.
- To support these CMHO and BMO office tasks, improved health management information system becomes functioning by introduction of computers in each BMO office and CMHO office.
- BMO office works as a focal point of all service and political levels and partners within the block to coordinate and provide support to health and health related activities. BMO office works as a link to CMHO/District for the lower level in the block.
- Close coordination mechanism between health administrative structure and health committees within the political structure (Panchayat and Urban Local Body) is established and become functioning.

(b) First referral unit (FRU) and referral system become functioning in all blocks:

- CHC is established in all block with adequate building/facilities, equipment and human resources.
- CHC fully functions for the entire block as a core health institute. About a half of CHCs provides full range of essential and emergency obstetric care including blood transfusion.
- Referral system, particularly for emergency obstetric care, functions in all block. Referral system between CHC and District Hospital also fully functions.

(c) High quality RCH service delivery system is established in all block, then in the district:

- All SCs have basic building/facilities and equipment and all basic RCH services are available, and 85% of population is accessible to SCs within 4km distance.
- All existing PHCs have adequate building/facilities and a medical doctor posted provides integrated RCH services including EOC and non-surgical EmOC, and MTP.
- In remote areas, out-reach services are available regularly.

(d) Increased demand for and utilization of RCH services:

- Access to high quality RCH services is enhanced by community participation
- Village health committee is established in all village
- Operation and management committee for SC is established by the representatives of village health committee members for all SCs.

Strategies

Objective (A) To improve the access to high quality RCH services

<Increase of coverage of RCH services>

A1. Improve infrastructure (health facilities and equipment) to facilitate availability of high quality of health services and emergency obstetric care.

A2. Increase adequate (quality) coverage by field staff (Enhance field activities in villages)

A3. Fill the vacancy posts at PHC, CHC and District Hospital.

A4. Implement functioning and adequate referral systems

A5. To provide basic infrastructure in order to improve communication and accessibility

<Improve quality of RCH services>

A6. Increase knowledge and skills of health service providers

A7. Increase number and proximity of EOC and EmOC services and MTP service provision

A8. Improve availability of drugs and medical supplies

A9. Build up user- fee structures for proper utilization of services

<Increase knowledge and awareness and behaviour change of population on RCH>

A10. Strengthening of IEC and Introduction of BCC

A11. Encourage voluntary health activities at community level (Social and community mobilization and involvement)

Objective (B) To promote effective and efficient RCH service delivery through improved management

B1. Improve management capabilities of health administrative organization and Panchayat

B2. Increase linkages between and within governments, programmes, NGOs and private sectors (to enhance linkage between different levels and to encourage collaboration between different sectors)

Objective (C) To encourage women's empowerment and improvement of women's quality of life

C1. Promote and encourage women's empowerment

C2. Improve women's quality of life

3.3 INTERVENTIONS BY OBJECTIVES AND STRATEGIES

3.3.1 Improvement of Access to High Quality RCH Services

(1) Increase of Coverage of RCH Services

Lack of emergency obstetric care is notable in the health system. The most important issue here is to change the state policy focusing on Dai training to ensuring skilled attendance during childbirth.

(A1) Improve infrastructure (health facilities and equipment) to facilitate availability of high quality of health services and emergency obstetric care.

<Necessary Interventions>

- Review SC catchment areas and reallocation of catchment areas.
- Construction and upgrading of SC building adequate to provide RCH services.
- CHC upgrading to provide necessary services as FRU.

(A2) Increase adequate (quality) coverage by field staff (Enhance field activities in villages)

<Necessary Interventions>

- Develop a supervisory system of the health services provided by the ANMs and LHVs at the SCs and villages.
- Create / develop sustainable linkages among field health workers to ensure that the Health Professionals (doctors and nursing staff) are always informed correctly and in a timely fashion.
- Create mechanisms to ensure that the field nursing staff and supervising doctors have means of transportation to visit all the villages under their responsibility.
- Train doctors and nurses in EOC: in service competency-based and learner-centred training with special emphasis on referral protocols and use of the partograph of Friedman.
- Improve the planning capabilities of the local authorities and physicians-in-charge in order to:
  - Improve the better distribution of workload among field staff
  - Design of training, development of human resources and reward mechanisms
  - Ensure the availability of supplies

(A3) Fill the vacancy posts at PHC, CHC and District Hospital

Redesigning of standards of human resource allocation to each service level of facility. Posting doctors with training in some specific area and aesthetician but not specialist to CHC and PHC should be considered.

(A4) Implement functioning and adequate referral systems

<Necessary Interventions>

- System Development

- Design a EmOC delivery system
- Health facility at no more than 1 hour from every settlement (usually PHC)
- Equipped and staffed to attend to most cases of EmOC
- Upgrade hospital to receive and treat most severe cases (intensive care, equipment, supplies including blood)
- Assess the impact of "Maternity Houses" for villages very distant from any well-equipped and staffed PHC or where transportation is not available.

- Training
  - Train of doctors and nurses in EOC and EmOC
  - In-service competency-based and learner-cantered training with special emphasis on abnormal ANC and delivery, including use of suction device and surgical and anaesthetics procedures according to basic qualifications
- Transport system (see A5)
- Communication system (see A5)
- Motivate institutional delivery

(A5) To provide basic infrastructure in order to improve communication and accessibility

<Necessary Interventions>

- Transport system
  - Vehicles should be available at the all health facilities
  - Work with the community to implement a fund for transportation of emergency cases
  - Improve and maintain trunk roads
  - Construct and improve access roads to health facilities
- Communication system
  - Implement telecommunication devices in every community and health facilities. these devices.
  - ANMs should also be provided with communication devices.
  - Involve Gram Panchayat and health committees to equip communication devices at AWCs

(2) Improvement of Quality of RCH Services

(A6) Increase knowledge and skills of health service providers

<Necessary Interventions>

- Training
- Clarify and re-design a standard of services provided by each health service providers (health professional and field workers) including health providers under the ISM (Indian System of Medicine).
- Reorient Community Needs Assessment Approach (CNAA)
- Establish policy that all medical officers should manage EOC and basic EmOC.
- Assess expansion of availability of safe abortion by adopting simple technologies, e.g. manual vacuum extraction.

- Implement policy of non-discrimination (by caste) in work of health system.
- Modify medical school curricula or create a competency residency required for DoPHFW medical officers
- Modify ANM and Nursing school curricula
- Provide reorientation seminars / workshops on CNAA and RCH to all health officers, health professionals and health workers, and provide training on IPC and counselling skills
- Provide refresher training to LHVs, ANMs and AWWs.
- Improve ANM and AWW skills in educating & counselling on temporary methods (Family Planning)
- Train doctors and nurses in all PHCs on EOC and EmOC
- ANMs to stabilize patients prior to referral and to know and teach danger signs
- Train health professionals and health workers on diagnosis and treatment of RTIs/STIs
- Equip training centres

(A7) Increase number and proximity of EOC and EmOC services and MTP service provision

<Necessary Interventions>

- Re-design service delivery system according to the design of the training and the viability of staff, transportation, etc. in order to implement the delivery of services in an effective and efficient manner.
- Review and assess adaptation of simple technologies, e.g. manual vacuum extraction by nurses and LHVs.
- Assess the catchment's area of SHC (not population based norm but based on actual accessibility by community)

(A8) Improve availability of drugs and medical supplies

<Necessary Interventions>

- Implement State Drug and Medical Supply Management Policy
- Establish district logistics system
- Improve health officers and storekeepers capability in logistics management
- Train storekeepers and health workers on drug and medical supplies management

(A9) Build up user- fee structures for proper utilization of services

<Necessary Interventions>

- Establish uniform fee structure, allowing for no payment by the poorest.
- Strengthen RKS at hospital and block level.
- Eliminate extra-charging in hospital, specifically individual caretakers' soliciting fees.
- Establish emergency transport system at community level not dependent on individual's ability to pay.

(3) To Increase knowledge and awareness of population on RCH

Low utilization of services is big problem in MP and in Tikamgarh and Damoh. This is mainly because of lack of knowledge and awareness of population on RCH or lack of behaviour changes in health care seeking behaviours.

Extensive efforts of IEC activities and introduction of BCC is needed to increase use of services.

(A10) Strengthen EIC (education, information and communication) and introduce BCC (behaviour change communication)

<Necessary Interventions>

- Training of communication skill
  - Train health professionals and health workers on IPC (interpersonal communication) skills, counselling and providing of health education
  - Strengthen IEC Bureau and district IEC activities review and reform the bureau / target local needs and family / provide skill training / strengthen district level IEC planning and activities
  - Integrate some IEC activities with DWCD IEC activities, particularly the topics regarding the gender issues and women empowerment
- RCH mass media campaign
  - RCH mass media information on danger signs in pregnancy, benefits of safe delivery, institutional delivery (safe motherhood)
  - Include basics of child nutrition, immunizations, key disease symptoms and care in RCH mass media campaign (child health)
  - RCH mass media campaign on temporary methods, age at marriage (family planning)
- Awareness of symptoms of disease, modes of transmission, and possibility and source of treatment (RTI/STI)
- Organize Panchayat, health committee, SHGs to increase community people awareness, to enhance health promotion activities and to monitor health status of the community, women and children.
- Introduce social marketing for basic drugs and contraceptives
- Provide family health education through school and peer education
- Provide family health education to adolescent groups in collaboration with WCD programme.
- Sensitise people on symptoms of disease, modes of transmission, and possibility and source of treatment

(A11) Encourage voluntary health activities at community level (social and community mobilization and involvement)

<Necessary Interventions>

- Strengthen capacity of VHC
- Establish health committees for SHG

- Organize and strengthen SHGs and women's groups for community health activities and voluntary works.
- Design and implement interventions with NGOs and SHGs.

3.3.2 Improvement of Management Capabilities of Health Administrative Organization and Panchayat

(B1) Improve management capabilities of health administrative organization and Panchayat

The RCH programme already exists and being implemented since 1997, however, the performance is moderate in MP and limited in Tikamgarh and Damoh District. There are many problems found in the implementation: insufficient planning, no proper records on budget and expenditure, poor quality of training, no planed and coordinated building construction and provision of equipment, lack of supervision, lack of quality data available, no data sharing, etc. All these are related to lack of management capacity.

In the framework of decentralization policy, the district and block level need capacity building for effective service delivery and efficient programme/project implementation.

The first thing to be done is to re-orient RCH programme, since most of health personnel including district officers do not fully understand the concept of RCH. Reorientation of RHC programme and CNAA is the must for improving RCH status through the programme.

The other important role of block is described in the next section.

<Necessary Interventions>

- RCH programme management
  - Provide reorientation seminars / workshops on CNAA and RCH to all health officers and implementation of policies.
- Capacity building (Training)
  - Train officers in the district and block level on management capacity
  - Improve planning capacity of district and block level officers and improve linkage between planning and budgeting
- Supervision and monitoring
  - Development of monitoring and evaluation systems towards increased supervision and program management at each level: Standardization, Development of supervision protocols, and Training on them.
  - Provision of supervisory transportation
- Development of supporting systems for better management
  - Development of communication system between health care levels
  - Systems improvement/development in finance, personnel, inventory of equipment , and drug supply logistics (partly covered in HMIS)
  - Improve HMIS at state, district, block level and PHC/SHC level
  - Feedback of data and information from field to district and block level

officers and planning committee for better planning and monitoring
    - Promote data and information sharing through HMIS
- Health administrative structure, Panchayat structure and health committees (see *Figure* 2)
    - Clarify role/function and demarcation of health administrative structure and Panchayat structure on delivery of health services
    - Strengthen Panchayat and health committees' capability to identify their health problems, conduct micro planning and organize health activities
    - Organize Panchayat, health committee, SHGs to monitor pregnant women and advise on delivery
- GIS cell development at the state head quarters.

(B2) Increase linkages between and within governments, programmes, NGOs and private sectors

<Necessary Interventions>

- To enhance linkage between different levels and to encourage collaboration between different sectors,
- Strengthen interdepartmental committee and information sharing mechanism at the district and block level.
- Integrate child health services in collaboration with AWWs including child growth and nutrition
- Support to small local NGOs with material and orientation programmes on RCH policy and implementation.
- Explore and test strategies for private sector care for EmOC and health education (Operation Research)

3.3.3 Encouragement of Women's Empowerment and Improvement of Women's Quality of Life

The low status of women is one of the reasons for low health status of women and children. The imbalance of sex ratio clearly shows the discrimination of women in health care. Poor accessibility to information on health and health care, depending on decision making on their own health to others (husband and mother-in-low), and care for women always comes last after the other family members' dare. Women's empowerment activities should be incorporated with RCH programme/projects together with gender awareness campaign.

(C1) Promote and encourage women's empowerment

<Necessary Interventions>

- Increase gender awareness at all levels
- Support economic employment of women's groups and SHGs (Self Help Groups)
- Enforce legal age of marriage and elimination of Dowry discrimination and harassment

- Increase girls' and women's access to education (formal and informal) and achievement of education.
- Provide vocational trainings to girls
- Strengthen legal enforcement on minimum wages

(C2) Improve women's quality of life

<Necessary Interventions>

- Reduce women's workload, particularly the disadvantaged women's overwork
- Introduction of new/alternative technology: new cooking fuel and improved oven, introduction of flourmill
- Increase the number of common water supply system in the community, etc.

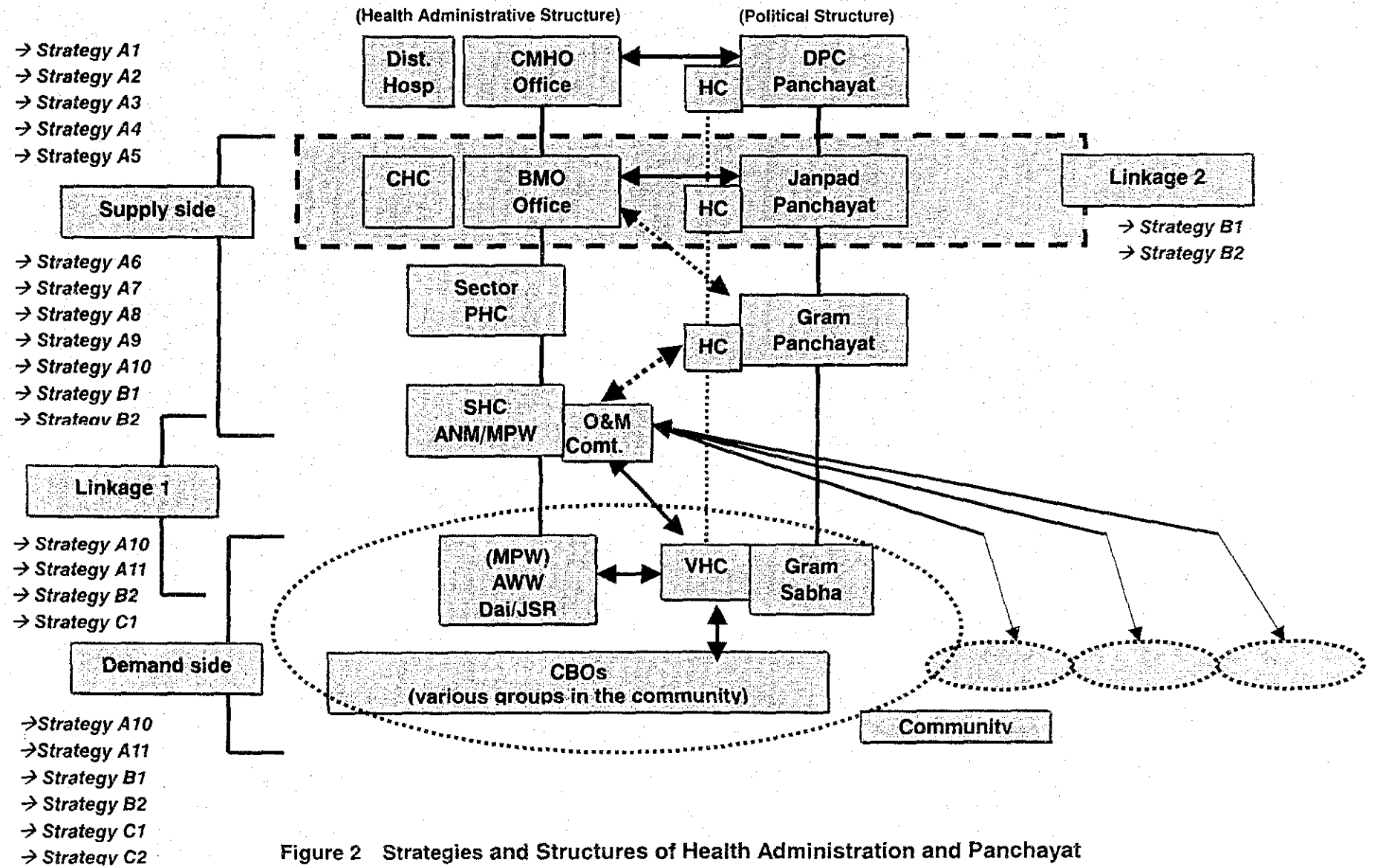

Figure 2 Strategies and Structures of Health Administration and Panchayat

(HC: health committee, CAB: community advisory boar)

3.4 STRATEGIES FOR IMPLEMENTATION

The implementation of these projects, the team also develop the strategies for implementation, which provide the methodology of effective implementation of the projects in compliance with decentralization and democracies.

(A) Establishment of block level as a nodal spot, aims at linkage of all level organizations to attain sustainability of RCH service delivery with effectiveness and efficiency (See Figure 2)

Community participation contributing to people's ownership of programmes is essential for sustainable field activities and encouragement of own decision on RCH. Furthermore, people's involvement may bring reduction of cost and enhancement of effectiveness on programmes. Amount of budgets of community level organizations, however, is deemed to be inevitably limited even in the near future and is not enough for employment of sufficient permanent staff for overall arrangement and implementation of RCH programmes because these organizations, which are the basis of community participation, have rather small population.

In short, community is crucially important, but has not enough resources and capability for implementation of RCH programme. This situation shows that intensive support to community level organizations is indispensable.

On the other hand, neither the Madhya Pradesh State government in Bhopal nor the district government is far from community geographically and mentally. Furthermore, decentralization proceeded in recent years requires the state government to delegate the authority and responsibilities to local governments.

Therefore, intermediate function linking between community and upper-stream such as state and district is required for the sake of effective and efficient implementation of RCH programme.

As shown above, one of crucial issues for implementation is linkage of all level organizations concerned because of long distance between the state and community, and complicated administrative structure including PRIs. As for implementation of RCH programme, block level among these is to be emphasized on account of close to community where programmes are implemented, as well as provision of administrative function and health facility to some extent

in comparison with community level.

(B) Stepwise extension of implementation area and activities of RCH programmes, aims at focusing on the first success in the initial stage of implementation, and inspiring people concerned by exhibiting initial successful precedent in the consecutive extended stage.

This strategy is applied in such a manner that efforts will be concentrated in a selected pilot area in order to examine designed systems and projects how they function, then to improve them, and to attain the first success in the initial implementation stage. In the following stage for the extended area, lessons learned in the initial stage are applied for the redesign of the project plan.

The community leaders and groups in the initial stage target areas should be involved in the extension stage for motivate and guide communities in new areas.

In the state strategy, it recommends a phased manner implementation in which 20% villages of a selected district is coveted in the first year, 40% in the second year, and another 40% in the third year. The study team also recommends a phased manner implementation, however, the target area(s) covered in each year is different.

Since project implementation for system strengthening and development needs to select one consolidated administrative area (cluster) in which a target health system exists and all the level of services from the village to CHC (or B-PHC) are available so as to developed system can be evaluated in the health system. In this regards, administrative "block" under district is the most proper unit to implement projects, and one health administrative block is covered in the first year, other two to three more blocks in the second year, and the all blocks in the third year.

This does not mean to put huge amount of resources in a small area, but emphasize implementation of well-designed projects and systems with practical operation and management plans also considering necessary resources based on the pilot project implementation. The pilot project should be replicable to the entire district.

Proposed Blocks for the pilot implementation

As a demonstration block for the first step, Hatta block in Damoh and Bardevgarh block are selected according to the following criteria.

- The block has CHC
- The block has willingness to improve RHC services by themselves
- In the block, women's group activities and SHGs activities are more active than other blocks
- The CHC in the block is near to the district head quarter for close supervision and monitoring of the project, and for referring patients to the district hospital for blood transfusion if necessary.

4 PRIORITY PROJECTS

According to the strategies which developed based on the current situation and problems and needs assessment to achieve the set objectives, the team proposes the several projects for the implementation by the government and donors/NGOs.

4.1 PROJECT FOR IMPROVEMENT OF ACCESS AND QUALITY OF RCH SERVICES

4.1.1 Project Purpose

The project purpose is to improve the RCH coverage and quality of services through management capacity building, health and communication skill development, referral service establishment, provision of equipment and upgrading/construction of health facilities.

4.1.2 Project Location

(1) Year 1

- Damoh District – Recommended pilot area: Hatta Block
- Tikamgarh District – Recommended pilot area: Baldevgarh Block

(2) Year 2 ~ 8

After an evaluation of the activities and results in the first year, area for implementation will be extended to two to three blocks in the second year. If results of evaluation on the project for two years are positive, the project area will be extended to cover all blocks of the entire two districts.

- Damoh District – all blocks
- Tikamgarh District – all blocks

4.1.3 Target Beneficiaries

(1) Year 1

- **Direct beneficiaries**: the women of reproductive age who reside in Damoh and Tikamgarh district, and their children, particularly neonates.
- **Indirect beneficiaries**: the families and communities of the direct beneficiaries.

(2) Year 2 ~ 8

- **Direct beneficiaries**: the women of reproductive age and their children in Damon and Tikamgarh Districts.
- **Indirect beneficiaries**: the families and communities of the direct beneficiaries.

4.1.4 Project Duration

Eight (5) years in total;

(1) Preparation and pilot phase in one demonstration block per district: the first year
(2) Expansion phase 1 in two to three blocks per district: the second years
(3) Expansion phase 2 in the remaining blocks: the third years
(4) Continuous phase of full implementation in the entire district: the forth and fifth years
(5) Adding project sub-components under the project to achieve the master plan objectives in the sixth and eight years

4.1.5 Implementation Agency / Body

District level: District Department of Public Health & Family Welfare (DOHFW)

State level: Department of Public Health & Family Welfare (DOHFW)

4.1.6 Project Components and Activities

The Project Activities fall under four major sub-components.

(1) Project preparation

The first step in project activities is to establish a coordinating committee in each district, composed of donor, district, state, and block stakeholders, to oversee and support the project.

This committee will be responsible for assuring smooth implementation of the project and will monitor the quality of its implementation on an on-going basis. Next a reassessment must be conducted to ascertain the status of the target health facilities and infrastructure, equipment, skills and recent training, communication and management. This reassessment is necessary because of the time elapsed between the original project design and its implementation.

(2) Strengthening of Management Capacity

1) Training in management
2) Establishment of supervision system and training in supervision
3) Referral system establishment and operation
4) Improvement of HMIS and training in HMIS
5) Improvement of drug supply logistics
6) Establishment of collaboration and coordination mechanism with health committees and Panchayat and set MCH day (instead of immunization day)
7) Strengthening of RKS
8) Improvement of blood supply system

(3) Improvement of competency of health staff and health related field workers

1) Training of trainers (District Hospital doctors/nurses, district training officers/district health officers, BEE)
2) Training of health staff (skill development) – Doctors and LHVs/ANMs/MPWs
   - Training in ANC, postnatal care, EOC and EmOC, danger signs in pregnant women
   - Training in family planning and counselling and interpersonal communication skill
   - Training in nutrition and micro-nutrients
   - Training in child health, including danger signs in newborn, ARI, diarrhoea
3) Training of Dai (skill development)
   - Training in safe delivery, breast feeding, danger signs in pregnant women and newborn
4) Training of other health related workers – Anganwadi workers and JSRs
   - Training in family planning and counselling and interpersonal communication skill
   - Training in danger signs in pregnant women and new born, and nutrition

(4) Improvement of RCH Service Delivery System

1) Review of roles and functions of each service level
2) Improvement of health facilities
   - SC improvement
     - Assessment of location of SCs, reassignment where needed and catchment area particularly of SCs without a building
     - Redesign of SCs to improve privacy in exam room, construction of new SCs, & renovation of old SCs

- Renovation of CHC, PHC and District Hospital

3) Improvement of mobility of field workers
   - Testing of different types of transport for MPWs to learn what works

4) Referral system improvement
   - Establishment of referral management system
   - Establishment of transport system and provision of an ambulance at CHC
   - Establishment of communication system and provision radio/cell phone to all CHCs. PHCs and SCs

5) Provision of equipment and supplies
   - Provision of equipment: each level of health facilities and training centre
   - Provision of medicines and medical supplies: each level of health facilities

Component and Activities	District level	Block level*	Year							
			1	2	3	4	5	6	7	8
(1) Project management										
1) Establishment and operation of Coordinating Committee	X	X	X	x	x	x	x	x	x	x
2) Reassessment of the situation	x	X	X		X			X		
(2) Strengthening of health administrative management capacity										
1) OJT on management skills	X	X	X	X	X	X	X	X	X	X
2) Establishment of supervision system / training	X	X	X	X	X					
3) Establishment of referral system and its operation	x	X	X	X	X	X	X	x	x	x
4) Improvement of HMIS	X	X	x	x	x	X	X	X	X	X
5) Improvement of drug supply logistics	X	x	x	x	x	X	X	X	x	x
6) Coordination with Health Committee & Panchayat and setting MCH day	X	X	X	X	X	X	X	x	x	x
7) Strengthening of RKS (Community participation and user fee system)	X	X				x	x	X	X	X
8) Establishment of blood supply system	X	X				x	x	X	X	X
(3) Improvement of competency of health staff										
1) Improvement of syllabus/training module *	X	x	X	X				X	x	
2) Training of trainers	X	x	X	X		X	x	X	x	
3)~5) Skill development training	x	X	X	X	X	x	x	X	x	x
(4) Improvement of RCH service delivery system										
1) Review of roles and functions of each service level	X	x	X			X				
2) Renovation of health facilities										
SC		X		X	X	X	X	X	X	X
CHC		X			X		X		X	
S-PHC and District Hospital		X					X	X	X	X
3) Improvement of mobility of field workers		X	X	X	X				X	
4) Referral system improvement		X	X	X	X	X	X	x	x	x
5) Provision of equipment	X		X		X		X		X	
6) Provision of medicines and medical supplies	X		X	X	X	X	X	X	X	X

4.1.7 Project Outputs / Inputs

(1) Expected Outputs

- Improved RCH service system in which functioning FRU is the core of the system and service delivery
- More efficient and effective RCH service delivery through better management
- Improved staff reproductive and child health skills that are critical for a fully functioning FRU
- Improved coverage and functioning of the SCs
- Improved coverage and functioning of the sector-level PHCs

(2) Project Inputs

- Training and education for improved management and skill development
- Technical assistance for development of training modules and materials
- Technical assistance for system development
- Provision of medical equipment and furniture
- Provision of drugs and medical supplies
- Construction and renovation of health facilities

4.1.8 Project Management Issues

Linkages of several kinds are crucial to the success of this project:

- With the district hospital
- With dais
- With community institutions and individuals who are gatekeepers between pregnant women and the CHC/PHC/SC.
- In Tikamgarh with the Community Health Boards and Block Advisory Committee supported by UNICEF
- In Tikamgarh with World Bank Project to strengthen women's development groups.

4.2 PROJECT FOR RCH IMPROVEMENT THROUGH STRENGTHENING BCC/IEC LINKED WITH GENDER AWARENESS CAMPAIGN PROGRAMME

4.2.1 Project Purpose

The purpose of the project is to create the context for positive behaviour change in several identified problem RCH areas including social gender issues through a series of linked BCC interventions in the project area.

4.2.2 Project Location

- State level: IEC Bureau
- District level: Damoh District
  Tikamgarh District

4.2.3 Target Beneficiaries

- The families and communities in Damoh and Tikamgarh districts.

4.2.4 Project Duration

Eight (5) years in total;

4.2.5 Implementation Agency / Body

- State level: IEC Bureau, Department of Public Health & Family Welfare
- District level: District Department of Public Health & Family Welfare

4.2.6 Project Components and Activities

The three major components of the BCC Strategy implementation for this project are: 1) BCC Campaign Preparation including Gender Awareness Campaign, 2) Mass Media/Materials' Development and 3) Social Mobilisation and Community Based Campaign.

All three components will involve the long-term project co-ordinator, based in Damoh District and state IEC staff. Counterparts for the Government of India (GOI) will be assigned from the State IEC Bureau and the District IEC Bureau. State IEC Bureau participation will focus primarily on the second component which District IEC Bureau participation will focus on the first and third components. Short-term technical assistance for the first and the third components will be provided to the project as indicated in the timeline. The second component will be managed primarily by the long-term project co-ordinator and the implementation of this component will be sub-contracted to one or more advertising agencies.

(1) BCC Campaign Preparation

1) Training in RH Competency, RH BCC and IEC and advocacy (State, District and Block level)
2) Refining of problems and conducting assessment
3) Development of BCC/IEC strategies
4) Development of Media/Social Mobilisation work plan
5) Development of Advocacy work plan
6) Development of Gender Awareness Tools and Materials For Training and Campaign
7) Establishment of monitoring and evaluation system

(2) Mass Media/Materials' Development

1) Assess, identify and contract local design and advertising resources
2) Conducting field assessment
3) Development of BCC/IEC materials
4) Launch of district mass media campaign

(3) Social Mobilisation

1) *Conducting baseline studies/Behavioural surveillance survey*
2) Identification and contracting resource to conduct social mobilisation training
3) *Selection and training of social mobilizer in blocks*
4) Launch of block social mobilization
5) *Community Based Awareness Camps organized by local officers with full participation* of all concerned CBOs and Panchayats

<Problem Area Prioritisation>

Problem areas below are prioritised in terms of the importance of the intervention for overall RH *improvement and in terms of the problem area can be effectively addressed through BCC* in the study areas.

- Family Planning Spacing Options' Promotion
- RTI/STI Awareness Raising
- PHC Perinatal Campaign and ANM Role Enhancement
- Postponement of Marriage
- De-emphasis of Dowry and Reduction of post-marital Harassment
- Reduction of Boy Child Preferences
- Enhancing Women's Equality from Birth to Death
- Increasing Girls' School Enrolment and Retention
- Postpartum Care Promotion and Awareness Raising
- Health Facility Promotion and Increased Service Demand
- Women's and Children's Nutrition

4.2.7 Project Outputs / Inputs

(1) Expected Outputs

- Increased use of temporary family planning methods

- Improved ability of clients to recognise symptoms of some RTIs/STIs
- Higher level of registrations by women for postpartum care
- Greater BCC skills among IEC specialists at district level and below
- Increased contacts between ANMs and their clients
- Women's later marriage age
- Higher school enrolment and retention of girls
- Increased number of perinatal visits
- Higher levels of contact among members of Village Health Committees
- Increased number participation of Gender Awareness Camps

(2) Project inputs

- Long-term experts
- IEC equipment
- Contract out for developing IEC materials
- Technical inputs for trainings
- Fund for holding workshops and meetings

4.2.8 Project Management Issues

Linkages of several kinds are crucial to the success of this project:

- With GOI IEC actors especially at the state, district and village levels.
- With frontline service providers
- With ANMs
- With Village Health Committees
- With community stakeholders and gatekeepers
- With donors and NGOs which have been active in social mobilisation, such as UNICEF, Samarthan and CARE
- With the proposed project of "Project for RCH Improvement through Community Based Activities"
- With PRIs for Gender Awareness Camps
- With the Educational Committee and Institutions

4.3 PROJECT FOR RCH IMPROVEMENT THROUGH COMMUNITY BASED ACTIVITIES

4.3.1 Project Purpose

The purpose of the project is to improve RHC status of population by increase of access and

community participate in RCH services through revitalization of village health committee.

4.3.2 Project Location

- Damoh District
- Tikamgarh District

4.3.3 Target Beneficiaries

- Direct beneficiaries: village health committee members and the women of reproductive age who reside in Damoh and Tikamgarh districts.
- **Indirect beneficiaries**: the families and communities of the direct beneficiaries.

4.3.4 Project Duration

Three (5) years

4.3.5 Implementation Agency / Body

- Offices of Block Medical Officer of Tikamgarh District
- Offices of Block Medical Officer of District Damoh
- with support from District Department of Public Health & Family Welfare (DOHFW)

4.3.6 Project Components and Activities

The Project Activities fall under four major sub-components.

(1) Establishment or Revitalization of Village Health Committee

1) Defining roles and function of village health committee
2) Selection of village health committee members
3) *Mobilization of community group for collaboration with village health committee* activities
4) Training of Panchayat member, village health committee member, and community group leaders in RCH, RCH programme and micro-planning

(2) *Establishment of Coordination Mechanism for Health Workers, Other Health* Related Field Workers and Village Health Committee

1) Establishment of village heath worker team and conducting joint training

2) Establishment of SC management team consisting of representatives of village health committee and health workers
3) Establishment of MCH day per month in every village

(3) Raising Awareness of RCH and RCH services and Demand Creation

1) Conducting regular village health meeting

4.3.7 Project Outputs / Inputs

(1) Expected Outputs

- Functioning village health committee
- Increased participation of community in operation and management of SC
- Operation of MCH day by community with support of health workers
- Increased participation of community in micro-planning and assessment of their RCH status and RCH programme

(2) Inputs

- Technical assistant for training and education of Panchayat members and community group leaders
- Technical assistant for joint training of field health workers
- Provision of IEC materials
- Fund for holding workshops and meetings in the villages

4.3.8 Project Management Issues

Linkages of several kinds are crucial to the success of this project:

- Close coordination with the proposed project of "RCH Improvement through Strengthening BCC/IEC linked With Gender Awareness Campaign"
- Close coordination with the Community Health Boards and Block Advisory Committee supported by UNICEF In Tikamgarh
- With World Bank Project to strengthen women's development groups in Tikamgarh

4.4 PROJECT OF SOCIAL MARKETING AND FAMILY LIFE EDUCATION FOR ADOLESCENT

4.4.1 Project Purpose

The objective of the project is to improve the level of sexual and reproductive health services and family planning acceptance with particular emphasis on younger acceptors through behaviour change communication, social marketing, and advocacy.

A secondary objective of the project will be to enable adolescents and youth to make positive behaviour changes to deal effectively with the demands and challenges of their everyday life.

4.4.2 Project Location

Hatta block, Damoh District

4.4.3 Target Beneficiaries

- **Direct beneficiaries**: the women and adolescents of reproductive age who reside in Damoh District.
- **Indirect beneficiaries**: the families and communities of the direct beneficiaries.

4.4.4 Project Duration

Three (3) years

4.4.5 Implementation Agency / Body

NGO (FPAI (Family Planning Association of India) has interest in implementation of the project, if the fund will be supported.)

4.4.6 Project Components and Activities

(1) Project preparation

1) Conducting a formative research
2) Obtaining of consensus of key stake holders
3) Development communication design

(2) Family Life Education and BCC

1) Development of training aides
2) Orientation of Master Trainers in Family Life Education and BCC
3) Formation of peer groups and orientation
4) Establishment of adolescent and youth counselling centres
5) Capacity building of service providers

(3) Social Marketing

1) Identification and orientation of Link Persons
2) Awareness programme for the Community
3) Develop teams of Community Based Distributors (CBDs)
4) Programme for service providers for attitudinal change
5) Procurement of contraceptives and health items

(4) Sensitisation and Coordination for Village Health Committees (VHCs)

1) Conducting sensitisation orientation and workshops for VHCs
2) Coordination programmes of VHCs

** Monitoring and evaluation of the project will be conducted through the project.

4.4.7 Project Outputs / Inputs

(1) Expected Outputs

- Capacity building of service providers for functional competence in Behaviour Change Communication in reproductive health and FP.
- Adolescents and youth will be covered through peer groups of boys & girls and equip them with knowledge and skills in Family Life Education, both in terms of practice as well as in performing the role of peer groups.
- Creating consistent acceptors of family planning services by providing FP services including awareness generation, counselling and FP products.
- Capacity building of village health committees towards their roles in bringing about behavioural change outcomes through community mobilisation.

(2) Inputs

Fund for NGO

4.4.8 Project Management Issues

- Linkage with Panchayat and Health Committees at higher level (Gram and Block level)
- Close coordination with the proposed project of "RCH Improvement through Strengthening BCC/IEC"

4.5 LIFE ENVIRONMENT DEVELOPMENT PROJECT FOR RURAL WOMEN

4.5.1 Project Purpose

Project purpose is to improve women's quality of life through;

- Reducing women's workload by introduction of ecological friendly bio-gas technology
- Increasing intake of nutritious food by introduction of kitchen garden

4.5.2 Project Location

- Damoh District
- Tikamgarh District

4.5.3 Target Beneficiaries

- Direct beneficiaries: the women of reproductive age who reside in Damoh and Tikamgarh districts and their children.
- **Indirect beneficiaries**: the families and communities of the direct beneficiaries.

4.5.4 Project Duration

Eight (5) years in total

4.5.5 Implementation Agency / Body

- State level: Department of Agriculture (DA)
- District level: District Department of Agriculture (DDA)

4.5.6 Project Components and Activities

The Project Activities fall under four major sub-components.

- Introductory workshop of life environment development programme for officers
- Bio gas (Cow dang gas) plant will be introduced to the households that required
- Smokeless energy efficient oven will be introduced to the households that required
- Kitchen garden programme for each household will be guided and implemented
- Other life Improvement skill will be guided through agricultural extension worker

4.5.7 Project Outputs / Inputs

(1) Expected Outputs

- Introduction of alternative eco-friendly fuel (bio-gas, cow dang-gas) and use of smokeless stove..
- Introduction of kitchen garden by utilizing enriched organic fertilizer generated by bio-gas (Cow dang gas) plant.
- Increase of knowledge on nutrition and improvement of food intake in family
- Cow or other cattle compost will be utilized for generating organic fertilizer

(2) Project inputs

- Technical assistance for introduction of bio-gas plant and mobilization of community
- Training and education
- Fund for subsidy of bio-gas plant
- Fund for provision of seeds for kitchen garden

4.5.8 Project Management Issues

Linkages of several kinds are crucial to the success of this project:

- With on-going bio-gas plant introduction programme by Agriculture Department. Programme should be demand-oriented project.
- With MP Agro Industry Development Corporation and Energy Development Corporation
- With agriculture extension workers and health workers
- With ICPD nutrition programme by Department of Women and Child Development