Population
And
Reproductive Health

India will soon be the world's most populous country, if it's population is not kept within limits. No doubt India's population control programme have made some impact, but the small family concept has yet to become popular and effective to the required extent. There is some ongoing counter propaganda by some sections of the society who make the under privileged believe that their strength lies in their number. This can be countered effectively by educating the people which will greatly help in developing the necessary consciousness and behaviour pattern.

A sample project proposal for ***"Population and Reproductive Health"*** *is given in detail under the heading of* ***Awareness and Prevention of Maternal Mortality****.*

PROJECT PROPOSAL

on

"Awareness and Prevention of Maternal Mortality"

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"Awareness and Prevention of Maternal Mortality"

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The Project - An Overview

1.1 The project

This project is envisaged to organize awareness programme for prevention of maternal mortality for an initial period of 1 year from the date of conception with an estimated investment of Rs. 7 lakhs. While "Awareness on maternal mortality and contraceptive services forms basis for formulating the project, a plethora of schemes under "Reproductive care" have been discussed herein this report.

1.2 Project Objectives

- Prevention of maternal mortality through awareness on maternity care.
- Prevention of teenage and un-wanted pregnancy
- Contraceptive and family planning services
- Timely emergency obstetric care
- Having skilled attendance
- Sensitisation of health workers, doctors and other social partners.

1.3 Project interventions

- Identification of targeted area
- Base line survey
- Awareness programmes on family planning
- Sensitisation programmes on prevention of maternal mortality
- Free distribution of contraceptive and IUDs.
- Networking of beneficiaries, social partners, NGOs
- Referral services for emergency obstetric care

1.4 Target group

Women belonging to slum areas in reproductive age group.

1.5 Scope of the project

World over, every minute, a women dies needlessly in the agony of childbirth. She may leave behind a devastated family and young children who will fail to thrive. And for every women who dies, 30 out of 100 pregnant women, injured or disabled. The tragedy is that all of these deaths - over, 5,00,000 a year in our country alone- are preventive. Yet, while most of other health services have improved in the developing nations over the last decade, maternal mortality and morbidity continue to take their high tail.

This can be prevented to a maximum extent by

- Timely emergency obstetric care
- Having skilled attendance
- Meeting the unmet need for contraceptive services - this can reduce maternal mortality by 20% or more.
- Awareness on family planning
- Avoiding teenage pregnancies and unlawful abortions.

Reducing maternal mortality is a priority area of the Ministry of Health and Family Welfare, which supports safe motherhood interventions undertaken by various voluntary organizations, as a part of it's commitment to reproductive health.

Contraceptive services to prevent un-wanted and un-timely pregnancies is one of the priority area of the policy makers. Differing patterns of contraceptive use may not reflect women's personal preferences as much as political and economic decisions made by the Government to emphasis certain methods, the attitudes of medical professionals, cost, the limited availability of contraceptive supplies.

In fact, high quality family planning services are often not available in our country. Many family planning programmes are either.,

- Fail to offer a wide selection of methods
- Lacks high standards of medical practice
- Are insensitive to cultural conditions
- Fail to provide sufficient information about proper use or possible side effects or neglects women's other reproductive health needs.

In many developing countries, at least one third of women need contraceptive services. However,

- Some women do not know about modern methods, or unable to obtain or afford them or distrust or dislike the methods that are available.
- Single women and teenagers are often barred from obtaining contraceptive services
- Other women are ambivalent about whether they want child or are unsure about their ability to become pregnant.
- Still others live with a partner who does not approve of contraception or who wants them to become pregnant against their will.

This complicated mix of contraceptive option prevalent in most of the slum areas in our country where the impoverished women are abstained from the services owing to their acute poverty and awareness about the probable usage of these devices.

The abstinence of the impoverished women from availing the family planning methods and contraceptive services is resulting into increased maternal mortality besides contributing to the unchecked increase in population. India will soon be the world's most popular country, if its population is not kept within limits. No doubt, India's family planning programmes have made some progress, but the small family concept has yet to become popular especially amongst the impoverished population. There is some ongoing counter propaganda by some sections of the society, who make the underprivileged to believe that their strength lies in numbers.

This can be countered effectively through awareness and education. But this mission cannot be accomplished unless concerted efforts are made to co-ordinate the health sector with related activities of all other sectors of development.

Awareness and health education, nutritional feeding of mother, training midwives, setting-up emergency obstetric care, contraceptive services and maternity care, complement each other.

Ministry of Health and Family Welfare, Nutrition Foundation of India, Ministry of Social Welfare, Department of Urban Development are a few National agencies supporting various voluntary intervention in this direction.

Since, central to all these agencies to reduce maternal death and disability is a new emphasis on making contraceptive services available to all women who need it, there is a scope for tenacious intervention by any voluntary organization in this direction.

1.6 Project planning

This project is an approach intended to undertake the following activities

a) identification of targeted beneficiaries
b) organizing awareness camps
c) organizing family planning camps
d) distribution of oral contraceptives and intra-uterus devices.
e) Organizing sensitisation programmes on reduction of maternal mortality.

1.7 Project cost and means of funding

The project "Awareness programme and contraceptive services" is proposed with an initial capital investment of Rs. 7 lakhs. The project is expected to last for a duration of one year from the date of conception. The project is expected to be funded out of 100% grant-in-aid assistance from some National/International developmental agency

1.8 Organisation and man-power

The Executive Secretary of the implementing agency will assume the overall superintendence of the project and he will be the project director. He will be assisted by "Health volunteers" in his day-to-day pursuits. The administrative part of the project will be taken care by a part-time "computer operator cum project executive".

The services of external medical/health professional will be obtained on contract basis wherever required.

1.9 Impact analysis

The basic objective of the implementing agency is to reduce the maternal mortality through indirect method of preventing unwanted and untimely pregnancies through family planning and contraceptive services.

The task of the implementing agency to evaluate the impact of the programme is two fold.

1) to establish a framework for concurrent monitoring and evaluation to assess programme implementation, performance and sustainability.

2) define a list of indicators and variables for process monitoring which are consistent with the programme objectives and reflect the different stages of project implementation.

A project advisory committee consisting of project leader as member secretary and other resource persons as members will be formed to oversee the implementation and monitoring of the project.

This committee will also review the accounts and audited statements of the implementing agency.

The programme will be reviewed periodically by the Executive Committee of the implementing agency and all necessary modifications to achieve the desired objectives would be incorporated as per the directives issued by the Project Advisory Committee.

1.10 Schedule of implementation

The project duration will be initially for a period of 12 months. The break-up of various activities interconnected with the implementation of the project is given at chapter - 9 of this proposal.

2

Maternal Mortality in India - Critical areas of Concern

As enumerated in earlier chapter, every minute, a women dies needlessly in the agony of childbirth. A devastated family and young children with none to take care off is the general scene and common in any such casualty in India. This is particularly prevalent amongst the poor and marginalized families living in slums. As per the survey conducted by the World Health Organisation, for every woman who dies, 30 out of 100 pregnant women are injured and disabled during the delivery. The tragedy is that all most all of these deaths - over a 5,00,000 a year can be prevented. Yet while most of other health indicators, have improved in India the maternal mortality and morbidity continue to take their high tail.

But these deaths can be prevented or at least reduced to a great extent provided.

a) timely emergency obstetric care

b) having skilled attendance

c) meeting the unmet need for contraceptive services which can reduce the maternal mortality by 20% or more., are induced in a tenacious manner.

The government of India is emphasising more on making emergency obstetric care available to all in order to reduce the maternal mortality. Even, central to WHO efforts to reduce maternal death and disability is a new emphasis on making emergency obstetric care available to all women who need it.

This does not mean that all births should take place in a well equipped health facility. It does not mean that all pregnant women should have access to functioning facilities that offer essential obstetric care if they develop complications during delivery. This in turn has other implications for a country's health care system. Since, complications cannot be prevented or reliably predicted, it requires that facilities capable of delivering essential obstetric care are well equipped and staffed 24 hours a day and 7 days in a week and that women who need them have a way of getting them in time to prevent death or disability.

The Ministry of Health and Family Welfare is supporting various programmes right from advocating health reform policies and upgrading health facilities to mobilising communities to prepare for and respond to obstetric emergencies.

The basic emergency care, provided in health centres and small maternity homes, includes the capabilities for

- administration of antibiotics, oxytocics or anti-convulsants
- manual removal of placenta
- removal of retained products following miscarriage or abortion
- assisted vaginal delivery with forceps or vacuum extractor

Comprehensive emergency obstetric care, typically delivered in district hospitals in our country includes all the above basic functions, plus caesarean section and safe blood transfusion.

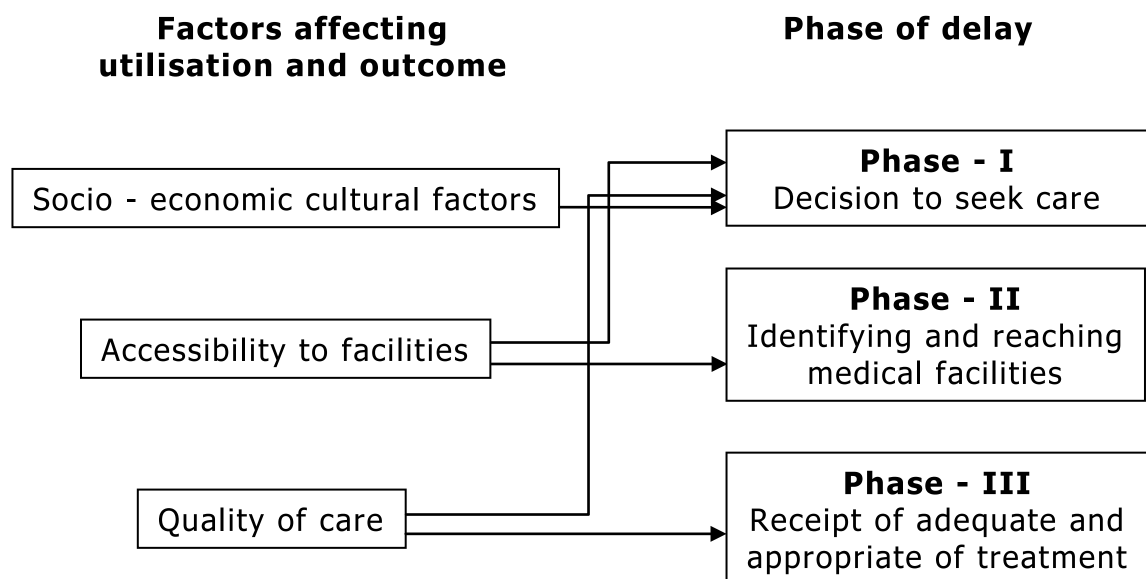
But unfortunately most of these hospitals are not at an easy reach to the needy women in emergencies.

In guidelines jointly issued by WHO, UNICEF and United Nations population fund, it is recommended that for every 5 lakh people there should be four facilities offering basic services and one facility offering comprehensive, essential obstetric care.

But in our country, this is yet to be implemented in various parts.

To manage obstetric complications, the life saving component of maternity care should have a facility of trained staff, functional operation theatre and must be able to administer blood transfusions and anaesthesia. But unfortunately most of the maternity care centres in India, particularly in rural areas are lacking these facilities.

Most of the deaths and disabilities during the child delivery could be prevented by reducing life-threatening delays. Timing proves to be critical in preventing maternal death and disability. Although, post partum haemorrhage can kill a woman in less than two hours, for most other complications, a woman has 12 hours or more to get life saving emergency care. The three delays model given hereunder has proved to be a useful tool to identify the points at which delays can occur in the management of obstetric complications, and to design programmes to address these delays.



The first two delays (delay in deciding to seek care and delay in reaching appropriate care) relate directly to the issue of access to care encompassing factors in the family and the community including transportation. The third delay (delay in receiving care at health facility) related to factors in the health facility. Unless, the three delays are addressed, no safe mother hood programmes can succeed in India.

Further, this requires many sequential procedures and functions - from antenatal care and preparation to attend births with referral capabilities.

India is in the midst of health transition wherein new threats are being added to the already burdened morbidity due to malnutrition and lack of control over sexually transmitted diseases. Multiple factors have been involved in India's health transition including urbanisation, migration, teenage pregnancy, child marriages etc. Health care for the poor and impoverished in general and the living population in slums in particular is not up to the mark and need a review. Health, among the urban poor has received much less attention from policy planners despite the fact that the living conditions in some of India's slums are most staggering.

However, several NGOs have evolved several models to address the health needs of urban slums and several initiatives in the areas of reproductive health, and childcare have been taken to bridge the gap. But, still, a lot more has to be done in order to mitigate the maternity mortality.

3

Obstetric care and Contraceptive Services - An Approach

An essential part of the health policy in India involves in promoting the integration and improving the quality of a constellation of reproductive health services, including family planning, maternal and infant care and prevention and treatment of sexually transmitted diseases.

Expanding access to client - centred family planning information services, where a range of effective contraceptive methods is offered and responsive counselling provided, reduces the number of un-planned pregnancies, which often lead to sub-optimal pregnancy care and unsafe abortion procedures. Currently, as many as 50 % of pregnancies in India are unplanned and 25 % are unwanted.

At the same time strengthening maternal health services can also bring benefits to the overall health system and enhance the impact of a country's broader reproductive health programme.

The use of modern contraceptive methods including voluntary sterilisation, has increased rapidly over the last 2 decades. All most all the possible methods of contraception prevailing in this country are mostly used by women, rather than their sexual partners. Fewer than 5% of the couples in our country rely on male methods (the condom, withdrawal during ejaculation or vasectomy).

Still, an estimated 12 million women, who want to delay or cease child bearing - roughly one in sex women in reproductive age, are in need of effective contraceptive methods.

More than 50 percent in our country say that their last pregnancy was unwanted or mistimed. More than 12 million of the 60 million pregnancies each year end in abortions, many of the procedures, which are clandestine and performed under most unsafe conditions.

Differing patterns of contraceptive use may not reflect women's personnel preferences as much of political and economic decisions made by Government to emphasise only certain methods, the attitudes of medical professionals, cost, the limited availability of contraceptive supplies.

In fact, high quality family planning services are often not available to the common people in this country. Many family programmes are either

- Fail to offer a wide selection of methods
- Lack high standards of medical practices
- Are insensitive to cultural conditions
- Fail to provide sufficient information about proper or possible side effects or severely neglect woman's other reproductive health needs.

In our country, at least one third of women need contraceptive services. However,

- Some women do not know about modern methods, are unable to obtain or afford them or distrust or dislike the methods that are available.
- Single women and teenagers are often discouraged and barred from obtaining contraceptive services.
- Other women are ambivalent about whether they want child or are unsure about their ability to become pregnant.
- Still others live with a partner who does not approve of contraception or who wants them to become pregnant against their will.

The lack of general conscience is posing severe impediment to the implementation of various programmes on family planning. Unless, the woman are properly educated on this account, nothing much can be achieved in this direction.

Basic approach

The basic approach for addressing this problem is to sensitise the woman about contraception and increasing their access to various contraceptive services.

Organising campaigns, family planning sibhirs, distribution of oral pills and intra-uterus devises free of cost initially, will motivate the women towards usage of these methods.

Sensitising the health professionals and health workers on teenage pregnancy, safe abortions, timely maternal care and nutritional supplement to pregnant women will certainly help the overall atmosphere to be congenial.

Propagating small family concept, removing the myths about vasectomy to males and educating the women on their rights and access to health care, are a few tenacious approaches, which help in prevention of maternal mortality.

4
Voluntary Interventions in Reproductive Health care - Institutional Support

4.1 Voluntary Interventions

The following are a few interventions under the reproductive health care, which can be effectively implemented by voluntary organisation.

a) Maternity care centres
b) Infant care centres
c) Field publicity campaigns on population control and family welfare
d) Awareness programme on prevention of maternal mortality
e) Preventive care and publicity on genetic disorders in children
f) Basic maternity care and referral services
g) Nutritional care
h) Contraceptive services
i) Family planning camps
j) Maternity care and paediatric clinics in rural areas
k) Ambulance services for maternity care
l) Training programmes for midwives and auxiliary medical professionals.
m) Distribution of sterile delivery kits and trained mid wife services in rural areas.

4.2 Institutional support

The following National and International Agencies support the voluntary interventions.

a) Ministry of Health and Family Welfare
b) Nutrition foundation of India
c) Central Social Welfare Board
d) Ministry of Urban Development
e) Church's auxillary for social action
f) Indo-German social service society
g) Norweign Agency for International Development
h) Save the children alliance
i) Bernard Van Lean Foundation
j) ARCA Foundation, USA
k) International Foundation, USA

5
Planning of Infrastructure

5.1 Infrastructure

The following parameters may be adopted while determining the infrastructure requirements of the project. They serve merely as guidelines for formulating the project and purely indicative in nature. They may vary from project to project in accordance with their individual requirements.

a) Location

This project should be located in a close and proximate place to the targeted area, preferably near a slum in same urban area.

b) Requirement of land

The project does not require any land, as it is not advisable for the project to have permanent structures

c) Requirement of building

The project will be requiring around 1000 sft. of Built-up area for administrative office, stocking of supplies and material etc. This building can be a hired premises with all basic infrastructure like water, power and telephone connection. The building should have good access to the intending public.

d) Requirement of power, water

The project does not require much power and water. Domestic supplies of water and power to meet the daily chores of administrative staff is only the requirement.

e) Requirement of furniture

The project will be requiring some basic furniture's for the administrative office.

The following is the requirement of the furniture:

i) Office tables - 4
ii) Chairs - 12
iii) Almirah - 1
iv) Cup boards - 2

f) Requirement of equipment

The following is the requirement of equipment

i) Typewriter
ii) Public address system
iii) First aid kit

6
Organisation and Man-power

6.1 Organisation

The Organisation will have the constituents

a) Project Advisory Committee
b) Project functionary

The Project Advisory Committee will be constituted out of the following resource persons.

a) Project Advisory Committee

1.	President of the Implementing Agency	-	Chairman
2.	Secretary of the Implementing Agency	-	Member secretary/ Convenor
3.	Nominee from the Funding Agency	-	Member
4.	Nominee from the local health unit	-	Member
5.	Reputed Doctor/Social worker	-	Member
6.	Reputed woman social worker	-	Member

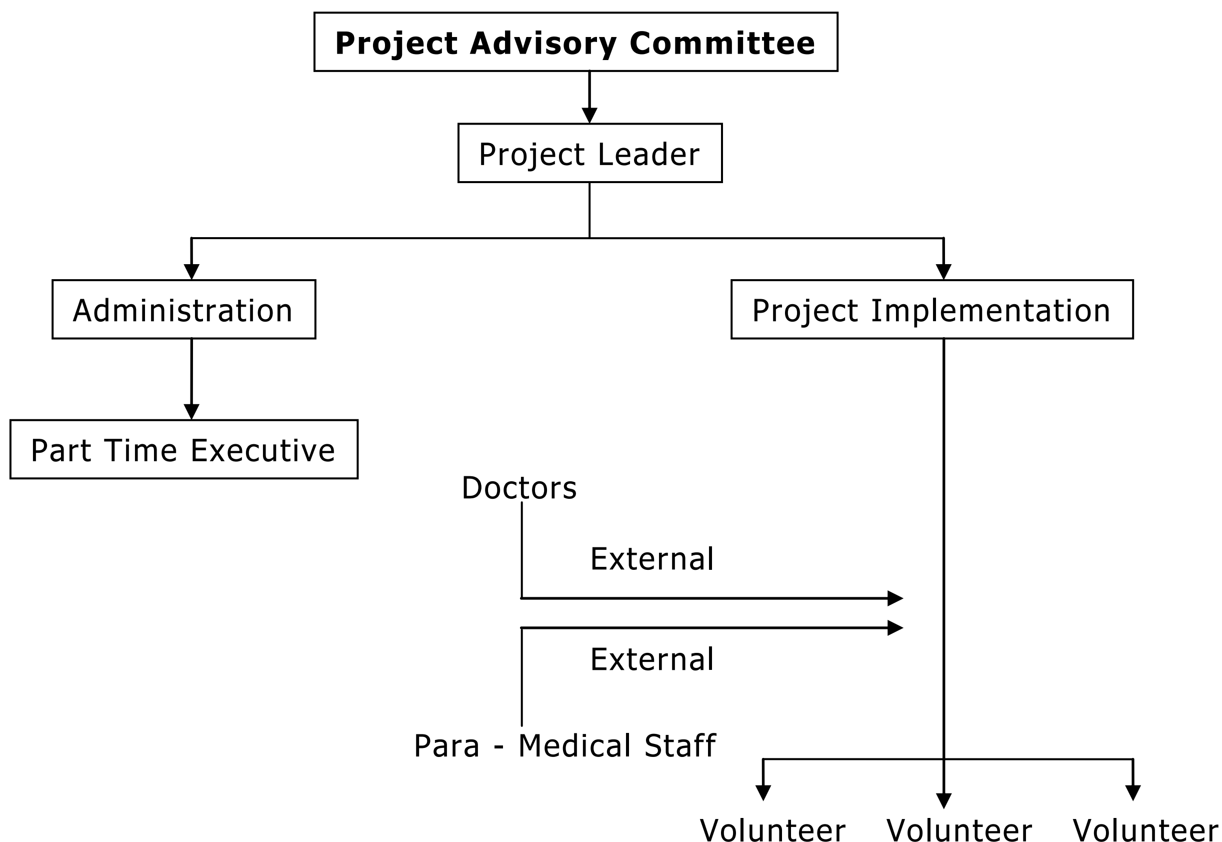
This committee would meet periodically once in three months and would advise the implementing agency on all aspects concerning the project implementation, evaluation, monitoring and funding.

b) Project Functionary

The project will be headed by the Executive Secretary of the implementing agency and he will assume the overall superintendence of the project. He will be the project director.

He will be assisted by Health Volunteers at the field level to implement the project.

In the administrative matters, he will be assisted by a part time "computer operator cum project executive. The following diagram represents the organisational structure of the project.



In all, the project will be requiring the following staff :

1.	Project Leader	-	1
2.	Part-time clerk/computer operator	-	1
3.	Health volunteers	-	3
			5

The services of the doctors and auxiliary health professional, wherever needed will be obtained externally on contract basis.

6.2 Remuneration

Sl.	Category	Nos.	Wage per month (in Rs.)	Wage per project period (in Rs.)
1.	Project leader	1	5,000/-	60,000/-
2.	Part-time project executive	1	3,000/-	36,000/-
3.	Health volunteers	3	2,500/-	90,000/-
		5	10,500/-	1,86,000/-

7
Project Cost and Means of Funding

7.1 The Project Cost

The total cost of the project including fixed components and variables, works out to Rs. 7 lakhs. The break-up of the project includes.

a) Fixed components

I) Lease rental deposit for the project office Rs. 25,000.00

II) Furniture

Sl.	Description	Nos	Rate per item	Total Rs.
1.	Office tables	4	1,250.00	5,000.00
2.	Chairs	12	250.00	3,000.00
3.	Almirah	1	2,500.00	2,500.00
4.	Cup boards	2	1,500.00	3,000.00
				13,500.00

III) Equipment

Sl.	Description	Nos.	Rate per item	Total Rs.
1.	Type writer	1	10,000.00	10,000.00
2.	Public address	1	5,000.00	5,000.00
3.	First-aid kit	1	750.00	750.00
4.	Misc. fixed assets, electricals etc.	LS	5,000.00	5,000.00
				20,750.00

b) Variable components

i) Awareness camps

Sl.	Item of expenditure	No. of camps	Cost per camp (in Rs.)	Total expenditure (in Rs.)
1.	Hiring of shamiyana and furniture	4	1,000.00	4,000.00
2.	Hiring of audio-visuals	4	2,500.00	10,000.00
3.	Conveyance	4	5,000.00	20,000.00
4.	TA, DA to resource persons	4	10,000.00	40,000.00
5.	Hand outs & publicity material	4	2,000.00	8,000.00
6.	Refreshments	4	2,500.00	10,000.00
				92,000.00

ii) Family planning camps

Sl.	Item of expenditure	No. of camps	Cost per camp (in Rs.)	Total expenditure (in Rs.)
1.	Hiring of furniture & Shamiyana	4	1,000.00	4,000.00
2.	Medicines & surgicals	4	10,000.00	40,000.00
3.	Conveyance	4	2,000.00	8,000.00
4.	Incentives	4	5,000.00	20,000.00
5.	Honorarium	4	5,000.00	20,000.00
6.	Lunch & refreshments	4	2,500.00	10,000.00
				1,02,000.00

iii) Sensitisation programmes

Sl.	Item of expenditure	No. of camps	Cost per camp (in Rs.)	Total expenditure (in Rs.)
1.	Hiring of auditorium	1	1,000.00	1,000.00
2.	Hiring of furniture	1	1,000.00	1,000.00
3.	Hiring of audio-visuals	1	2,000.00	2,000.00
4.	Stationery & publicity material	1	2,500.00	2,500.00
5.	Conveyance	1	2,500.00	2,500.00
6.	TA, DA to the resource persons	1	5,000.00	5,000.00
7.	Refreshments	1	2,500.00	2,500.00
				16,500.00

iv) Contraceptive distribution programmes

Sl.	Item of expenditure	Cost per programme	Total expenditure (in Rs.)
1.	Oral contraceptive	-	60,000.00
2.	IUD	-	50,000.00
3.	Honorarium to medical professionals	-	24,000.00
4.	Conveyance	-	6,000.00
			1,40,000.00

v) Miscellaneous overheads

Sl.	Item of expenditure	Cost per month	Cost per total project period (in Rs.)
1.	Power	500.00	6,000.00
2.	Conveyance	500.00	6,000.00
3.	Telephones	500.00	6,000.00
4.	Postage & Stationery	500.00	6,000.00
5.	Publicity	1,000.00	12,000.00
6.	Stores material	1,000.00	12,000.00
7.	Rentals	2,000.00	24,000.00
8.	Miscellaneous overheads	500.00	6,000.00
			78,000.00

Total cost of the variable component

a)	Awareness camps	92,000.00
b)	Family planning camps	1,02,000.00
c)	Sensitisation programmes	16,500.00
d)	Contraceptive distribution programme	1,40,000.00
e)	Overheads (administrative)	78,000.00
		4,28,500.00

Total cost of the scheme

a)	Fixed component	59,250.00
b)	Variable components	4,28,500.00
c)	Salaries to staff	1,86,000.00
		6,73,750.00
	Add 5% to meet contingencies and escalation in project cost	33,687.00
		7,07,437.00
		Say Rs. 7 lakhs

7.2 Means of funding

The total cost of the scheme viz. Rs. 7 lakhs is expected to bridged out of 100% grant-in-aid assistance from some National or International Agency.

8
Project Evaluation

8.1 Project duration : 12 months

8.2 Project goals : To provide contraceptive services to nearly 1000 women during the project plan period.

8.3 Success indicators

The success indicators include the number of women covered under the programme, the number of covered beneficiaries adopted permanent family planning methods, the number of new entrants and the potential of furthering the programmes.

Further, a few other visible indicators which may be taken as basis for evaluation of the programme are:

- Increase in the awareness levels of the women about reproductive health, family planning and birth control.
- Increased number of women adopting birth control methods and contraceptives.
- Positive change in sexual partners to avert unwanted pregnancies
- Greater access to the maternity care
- Increased participation of women in the programme
- Response of the social partners and stake holders
- Reduction in maternal mortality

The project would be monitored basing on the above cited logical framework, through a project advisory committee constituted out of resource persons as indicated under chapter - 6 of this proposal.

The World Health Organisation prescribed that for every 5 lakh people, there should be 4 basic facilities for maternal care and one comprehensive care unit. It further suggested that 15% of all births should be in the emergency care.

The overall success indicators of the programme implemented all over the country by various voluntary agencies includes the number of facilities offering emergency obstetric care, their geographic distribution, the percentage of women with complications treated in emergency, the caesarean section rate, the case fatality rate and the rate of birth control.

Maternal death audits, undertaken with families, communities and health providers, are also a powerful way of improving the delivery of services.

9
Implementation Schedule

9.1 Project Duration : 12 months

9.2 Suggestive Project Plan

Month 1- 3

a) Formation of Project Advisory Committee
b) Selection of Targeted area
c) Awareness programme
d) Family planning camp
e) Distribution of contraceptive

Month 4 - 6

a) Awareness programmes
b) Field publicity
c) Sensitisation programme
d) Family planning camp
e) Distribution of contraceptive
f) Project Advisory Committee

Month 7 - 9

a) Household survey
b) Awareness programme
c) Family Planning group
d) Distribution of contraceptive
e) Project Advisory Committee

Month 10 - 12

a) Interaction with social partners
b) Awareness programme
c) Family Planning Camp
d) Distribution of contraceptives
e) Final Survey
f) Project Advisory Committee
g) Reporting and termination