Chapter-VII
OTHER COMPONENTS OF RCH CARE

Health Care For Adolescents

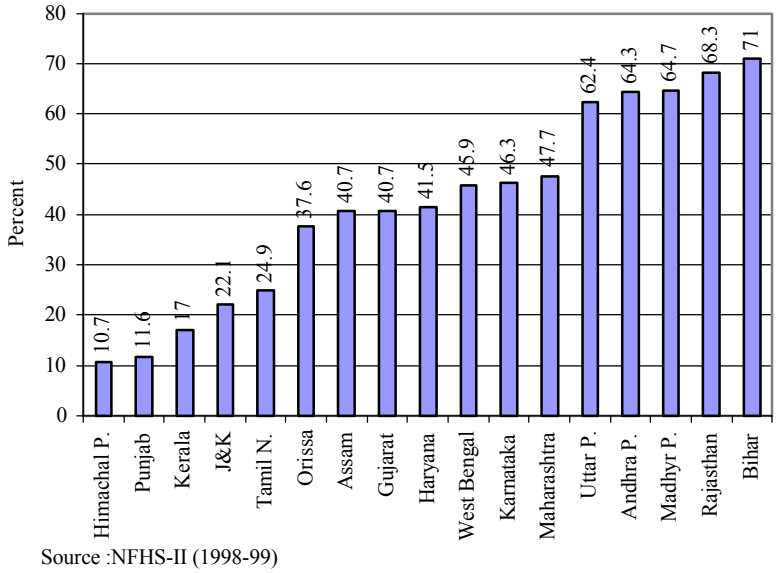
The nineties witnessed rapid increase in the adolescent population. In the next two decades there will be a rapid increase in the number of adolescents.

Ninth Plan Strategy

- Efforts to educate the girl, her parents and the community to delay marriage;
- programmes for early detection and effective management of nutritional (under-nutrition, anemia) and health (infections, menstrual disorders) problems in adolescent girls;
- Appropriate antenatal care will be provided to high risk adolescent pregnant girls
- Inter-sectoral coordination with ICDS is being strengthened in blocks where ICDS Centres have an adolescent care programme.

During the Ninth Plan Health care needs of adolescents are being addressed under the RCH Programme. The Department of Women and Child Development has initiated the Kishori Shakti Yojana in selected blocks. Proposals for the specialised counselling and IEC material to be provided through NGOs, is being sought under the NGO programme. However coverage under these programme have been very low .

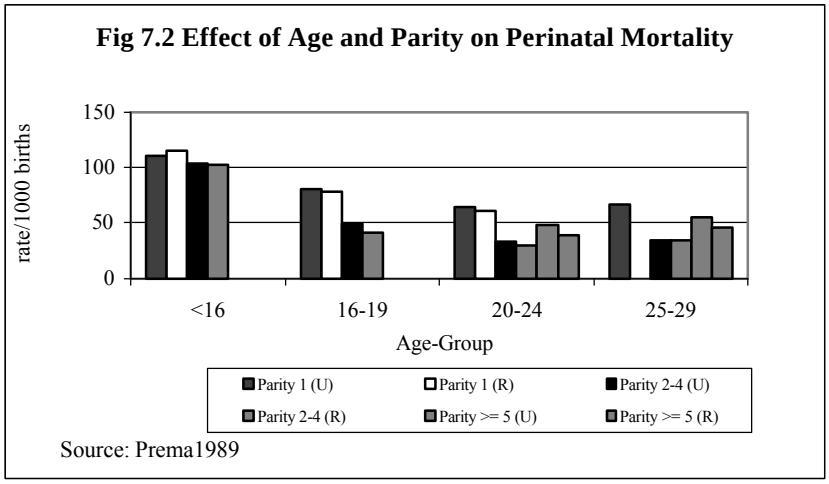
Fig 7.1 Women Aged 20-24 Years who married below age 18



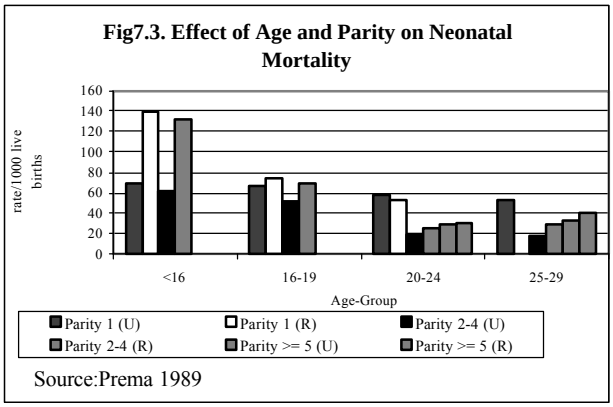
Source :NFHS-II (1998-99)

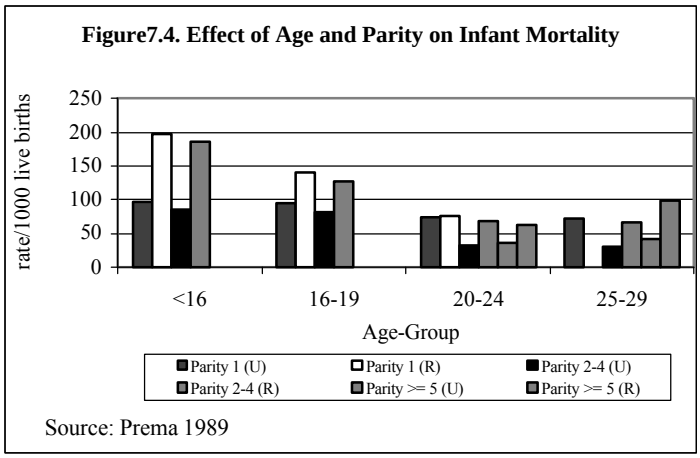
Data from NFHS –2 indicate that median age at marriage of girls in India is 16 years; The mean age at first birth is 19.2. There are substantial inter state variations in age at marriage (fig.7.1). Available data on percentage of girls marrying under 18 yrs &of women 20-24 yrs married before 18 yrs from NFHS 2 & RHS is given in Annexure 7.1 Undernutrition, anaemia and poor antenatal care inevitably lead not only to increased morbidity in the mother but also to high low birth weight and perinatal mortality. Poor

childrearing practices of these girls will add to the morbidity and under-nutrition in the infant thus perpetuating intergenerational cycle of under nutrition.



In view of the high prevalence of teenage marriages, in depth investigations have been carried out to document the adverse consequences, of teenage conception in the Indian setting. Data from Indian studies indicate that pregnancy in the early teens before 16 years is associated with an adverse effect on maternal nutrition, birth weight and survival of the offspring. The extra nutritional requirements of pregnancy coming close after the nutritional requirements for adolescent growth spurt might be the major factor responsible for the observed poor nutritional status of girls who conceived before they are 16 years of age. Lower maternal body weight, lower pregnancy weight gain, and higher prevalence of anemia and possibly pregnancy-induced hypertension among girls who conceived before they were 16 might account for the observed lower mean birth weight and higher perinatal(Fig 7.2), neonatal (Fig 7.3)and infant mortality rate(Fig 7.4) in the under sixteen group The higher low-birth weight rates obvious deficiencies in child-rearing practices of these young girls, and poor availability and utilization of health care services, especially in rural areas, account for the high infant mortality rates.





Undoubtedly, there is a very urgent need to create awareness regarding adverse consequences of early teenage conception and to mobilize social support for strict implementation of laws regarding age at marriage. As and when pregnancies are occur in early teenage, the girl should be considered as of a very high-risk group and provided with adequate nutritional and health care; her infant should also receive appropriate health care. The health personnel should be sensitized to the needs of this very vulnerable group who are unlikely to seek or utilize available health care that they urgently require. In addition to appropriate education to delay age at marriage, the Tenth Plan will take up nutrition and health interventions to promote optimum health and nutrition in adolescent girls. While adolescent health care will have to be the focus in states where the age at marriage is increasing, effective antenatal and intra-partum care will remain the focus in a majority of the states where teenage pregnancies are common. During the Tenth Plan, in addition to appropriate education, nutrition and health interventions and to promote optimum health and nutrition, efforts to delay in age at marriage in adolescent girls will be taken up through inter-sectoral coordination to break this vicious cycle. While adolescent health care will have to be the focus in the states where age at marriage is increasing, effective antenatal and intra-partum care will remain the focus in majority of the states where teen-age pregnancies are common.

Initiatives during the last five decades to improve nutritional status of the population include:

- Increasing food production- building buffer stocks
- Improving food distribution- building up of the PDS
- Improving household food security through
  - Improving purchasing power
  - Food for work programme
  - Direct or indirect food subsidy
- Food supplementation to address special needs of the vulnerable groups-ICDS,Mid day meal
- Nutrition education especially through FNB and ICDS
- Efforts of the health sector to tackle
  - Adverse health consequences of undernutrition
  - Adverse effects of infection and unwanted fertility on nutritional status
  - Micronutrient deficiency and their health consequences

Nutrition

Constitution of India (Article 47) states that “the State shall regard raising the level of nutrition and standard of living of its people and improvement in public health among its primary duties”. The importance of maternal nutrition in determining obstetric outcome and Child nutrition as a determinant of survival and health of children is well known Successive Five Year Plans laid down the policies and strategies for improving nutritional sttus of these vulnerable groups. However, several challenges remain. Inspite of huge buffer stocks, 8% of Indians do not get two meals a day and there are pockets where severe under-nutrition takes their toll even today. Every third child born is under weight. Low birth weight is associated with higher infant mortality and long-term health consequences

including increased risk of non-communicable diseases. While mortality has come down by 50% and fertility by 40%, reduction in under nutrition is only 20%. About half of the pre-school children suffer from under-nutrition. Micronutrient deficiencies are widespread; more than half of the women and children are anaemic; reduction in Vit.A deficiency and IDD are sub-optimal. Under-nutrition associated with HIV/AIDS will soon emerge as a public health problem. Alterations in the life styles and dietary intake have led to increasing prevalence of obesity and associated non-communicable diseases. In the new century, the country will have to gear itself to prevent and combat the dual burden of under and over-nutrition and associated health problems. In order to effectively combat these problems there will have to be a paradigm shift from

Major nutrition related public health problems

- Chronic energy deficiency and undernutrition
- Micro-nutrient deficiencies
  - Anaemia due to iron and folate deficiency
  - Vitamin A deficiency
  - Iodine Deficiency Disorders
- Chronic energy excess and obesity

- Household food security and freedom from hunger to *nutrition security for the family and the individual*
- Untargeted food supplementation to *screening of all the persons from vulnerable groups, identification of those with various grades of under-nutrition and appropriate management*

Interventions will have to be be initiated to achieve

Adequate availability of foodstuffs by

- Ensuring production of cereals, pulses and vegetables to meet the nutritional needs.
- Making them available at affordable cost through out the year to urban and rural population through reduction in post harvest losses and appropriate processing.
- More cost effective and efficient targeting of the PDS to address macro and micronutrient deficiencies (such as providing coarse grains, pulses and iodised/ double fortified salt to BPL families through TPDS)
- Improving purchasing power by appropriate programmes including food for work programmes

Prevention of under-nutrition through nutrition education aimed at

- Ensuring appropriate infant feeding practices (universal colostrum feeding, exclusive breast feeding upto six months, introduction of semisolids at six months)
- Promoting appropriate intra-family distribution of food based on requirements.
- Dietary diversification to meet the nutritional needs of the family

Operationalizing universal screening of all pregnant women, infants, preschool and school children for under-nutrition

Operationalization of Nutrition interventions for management of under nutrition through

- Targeted food supplementation and health care for those with under-nutrition
- Effective monitoring of these individuals and their families
- Utilisation of the PRI for effective intersectoral coordination and convergence of services, improving community participation in planning and monitoring of the ongoing interventions for prevention and management of under-nutrition.

Prevention, early detection and appropriate management of micronutrient deficiencies and associated health hazards through

- Nutrition education for prevention of micronutrient deficiencies through dietary diversification to achieve balanced intake of all micronutrients
- Universal access to iodised/double fortified salt
- Early detection of micronutrient deficiencies through screening of all
  - children with severe under-nutrition
  - pregnant women
  - school children
- Timely treatment of micronutrient deficiencies

RTI and STD

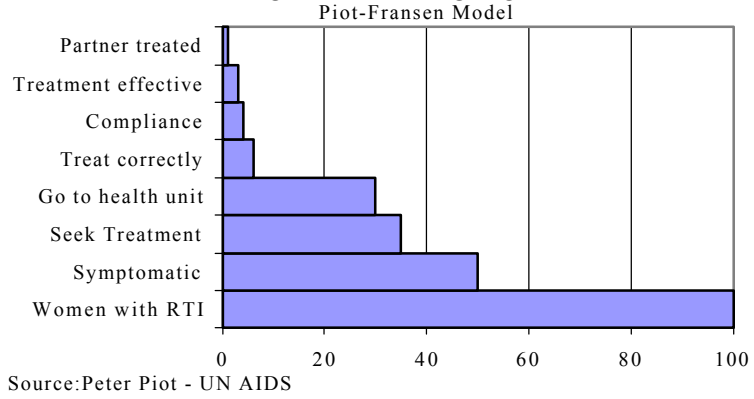
It has long been recognised that reproductive tract infections (RTI) and Sexually transmitted infections (STI) is one of the most common problems in women during reproductive age group. During the last two decades, there has been resurgence of interest in detection and management of RTI/STI. Part of this is because the clinicians to day have access to accurate diagnostic tests for aetiological diagnosis, are in a position to provide prompt, appropriate treatment for many RTI/STI and prevent long term health consequences of these infections. However part of their increasing interest and concern is because

- they are seeing larger number of patients belonging to a wider spectrum of age (adolescents, women in reproductive age group and elderly women), and socio-economic strata seeking care for RTI
- with the availability of antibiotics for treatment of STI/RTI and availability of contraceptives for prevention of pregnancy, there has been increasing prevalence of multi partner sex and inevitable increase in RTI/STI.
- in spite of increasing availability of the specific tests for diagnosis and efforts to prescribe appropriate antibiotics, there is increasing antibiotic resistance and consequent poor response to therapy and recurrences
- available data from research studies suggest that the risk of transmission of HIV infection is increased by RTI

Prevention, early detection and effective management of common lower reproductive tract infection has been included as a component of the essential RCH care through exisiting primary health care infrastructure . The Dept of Family Welfare has provided necessary drugs for treatment

and also inputs to fill the gaps in lab technician in PHC/ CHC . However the skill up gradation training of health care personnel has lagged behind in most states. Dept of Family Welfare has coordinated their efforts with the NACO so that NACO provides the input for diagnosis and management of RTI/STD at and above district level. The importance of prevention, early detection and effective treatment of RTI/STI is well recognised by the public health experts , practitioners and public themselves. Reliable easy to perform tests for accurate diagnosis of RTI/STI are readily available. Most of the infections still respond to commonly used antibiotics and chemotherapeutic agents. However it is important to recognise that there are problems in the current programmes for management of RTI. Piot and Fransen model of RTI/STI(Fig 7.5) management graphically sums up the potential effect of treatment. The model assumes that about 40% of women have RTI/STD at any given time but even under optimal conditions only 1% complete full treatment of both partners. It is therefore hardly surprising that in spite of all the current efforts to improve treatment of RTI/STI patients, gynaecologists and public health professionals feel that there has not been any substantial improvement in the situation over the last decade. However it is important to persist on health education and providing ready access to diagnostic facilities and appropriate treatment for STI/RTI so that there is steady improvement over time .

Figure 7.5. Problems in Management of RTI in Women



Source:Peter Piot - UN AIDS

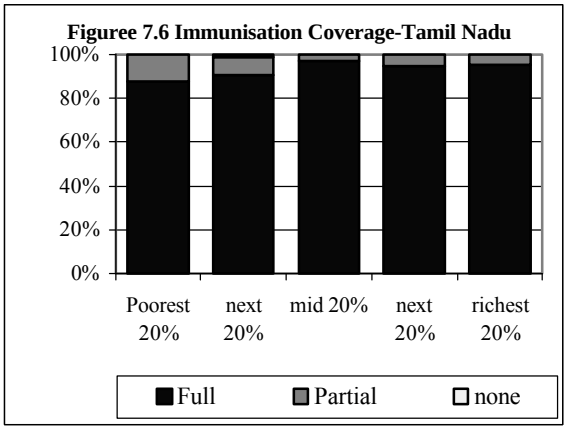
Infertility

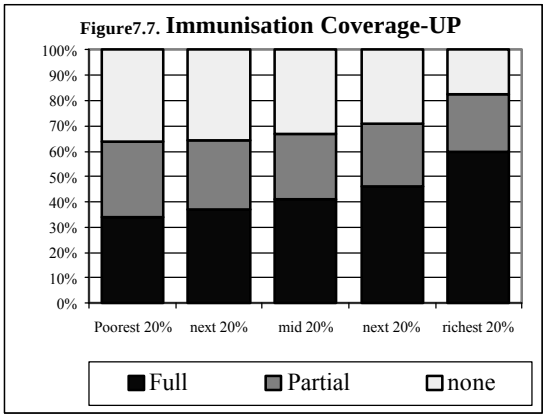
It is estimated that between 5 to 10% of couples are infertile. While provision of contraceptive advice and care to all couples in reproductive age group is important, it is equally essential that couples who do not have children have access to essential clinical examination, investigation, management and counseling. The focus at the CHC level will be to identify infertile couples and undertake clinical examination to detect the obvious causes of infertility, carry out preliminary investigations such as sperm count, diagnostic curettage and tubal patency testing. Depending upon the findings, the couples may then be referred to centres with appropriate facilities for diagnosis and management. By carrying out simple diagnostic procedures available at the primary health care institutions it is possible to reduce the number of couples requiring referral. Initial screening at primary health care level and subsequent referral is a cost-effective method for management of infertility both for the health care system and those requiring such services.

Gynaecological Disorders

Women suffer from a variety of common gynaecological problems including menstrual dysfunctions at peri-menarchal and peri-menopausal age. Facilities for diagnosis of these are at the moment available at district hospitals or tertiary care centres. During the Tenth Plan period the CHCs, with a gynaecologist, will start providing requisite diagnostic and curative services. Yet another major problem in women is prolapse uterus of varying degrees. The PHCs and CHCs will refer women requiring surgery to district hospitals or tertiary care centres. Cancer Cervix is one of the most common malignancies in India and accounts for over a third of all malignancies in women. Cancer Cervix can readily be diagnosed at the PHCs and CHCs. Early diagnosis of Stage I and Stage II and referral to places where radiotherapy is available will result in rapid decline in mortality due to Cancer Cervix in the country in the near future.

Access to RCH services





Data from research studies and clinical experience shows that social and economic deprivation are associated with poor health outcome. Poor health in turn results in deterioration of economic status partly due to loss of wages and partly due to cost of health care. Specific efforts have been made to focus on health and nutrition interventions so that these vulnerable segments have better access to health and nutrition services and the vicious circle of poverty and ill health is broken. However, in spite of efforts over the last five years better access to public health services continues to elude poorer segments of the population and those whose needs are the greatest. While this is true in all States, data from Rapid Household Survey showed that interstate comparison bring out some interesting findings poorest quintile population in Tamil Nadu (Fig 7.6) have better immunization coverage rates than the richest quintile in UP (Fig 7.7) suggesting that socioeconomic barriers can be overcome through improved awareness and access. During the Tenth Plan every effort will be made to improve access to essential primary health care; family welfare services and diseases control programmes totally free of cost. States/Centre are evolving and evaluating various options for reducing the financial burden posed by hospitalization among the poor.

Financing family welfare programme

Family Welfare Programme was considered as a single centrally sponsored scheme under which funding is provided to supplement the funds available for supporting infrastructure , manpower and providing consumables required to provide MCH and contraceptive care.. As a result, the heads of funding were functional viz. Personnel, Services, Supplies, Transport, Area Development etc. All ongoing programmes including maternal and child health and immunisation, received inputs from these functional heads. In the Ninth Plan, major projects like RCH, pulse polio immunisation and strengthening of routine immunisation were added as schemes with large outlays.

During 2001-02 the Planning Commission and the Department of Family Welfare carried out an exercise to rationalize the schemes. A revised scheme-wise listing was evolved where, schemes for strengthening of infrastructure, Area Development Project, Training, Research, programme related activities for contraception, immuninsation, maternal health, Child Health and Nutrition were identified as specific schemes. After this, a zero based budgeting effort was taken up and schemes identified for convergence, weeding out and transfer to the states. The summary of the zero based budgeting exercise is given in the Table-7.1. The scheme- wise outlays and anticipated expenditure during the Ninth Plan are given in Annexure-7.2. Yearwise outlay, R.E., and actual expenditure for the Ninth Plan is given in Table 7.2.

Table-7.1. Zero Based Budgeting 2001.

Category	No. of Schemes	Outlay for Ninth Plan (Rs. crore)	Anticipated expenditure during Ninth Plan (Rs. Crore)
Schemes to be transferred to the states	3	2,080.00	2,198.00
Schemes to be merged and retained	11/40	7,640.20	7,398.39
Schemes to be weeded out	8	185.85	31.25
Schemes to be retained	43	5,213.95	4,961.33
Total	94	15,120.00	14,588.97
Total No. of schemes to be continued in the Tenth Plan	54	12,854.15	12,359.72

Table - 7. 2 Outlays , RE and expenditure during the Ninth Plan

Year	B.E.	R.E.	Actual Expenditure
1997-98	1829.35	1829.35	1822.00
1998-99	2489.35	2253.00	2342.75
1999-2000	2920.00	3120.00	3099.76
2000-01	3520.00	3200.00	3090.11
2001-02	4210.00	3700.00	3596.63
Total	14968.70	14102.35	13951.25

Annexure 7.1

Literacy rate & % marrying before 18 yrs - Comparison between NFHS and R.H.S

Sl. No.	State/UT	% of Women Ages 20-24 Married Before Age 18 NFHS (98-99)	% of Girls Marrying Below 18 Years of Age preceeding 3 Yrs. Of survey(98/99)	Literacy Rate % Female (7 years & above) 2001 Census
	INDIA	**50.0**	**36.9**	**54.2**
I.	**MAJOR STATES**			
1	Andhra Pr	64.3	37.3	32.7
2	Assam	40.7	28.7	43.0
3	Bihar	71.0	58.2	33.6
4	Gujarat	40.7	25.2	58.6
5	Haryana	41.5	31.6	56.3
6	Karnataka	46.3	35.4	57.5
7	Kerala	17.0	9.1	87.9
8	Madhya Pr	64.7	58.6	50.3
9	Maharashtra	47.7	30.9	67.5
10	Orissa	37.6	32.2	51.0
11	Punjab	11.6	11.2	63.6
12	Rajasthan	68.3	57.1	44.3
13	Tamil Nadu	24.9	19.1	64.6
14	Uttar Pr	62.4	49.3	43.0
15	West Bengal	45.9	51.1	60.2
II.	**SMALLER STATES**			
1	Arunachal Pr	27.6	32.8	44.2
2	Chattisgarh	NA	41.9	52.4
3	Delhi	19.8	6.4	75.0
4	Goa	10.1	3.5	75.5
5	Himachal Pr	10.7	3.0	68.1
6	Jharkhand	NA	50.8	39.4
7	J & K	22.1	1.5	41.8
8	Manipur	9.9	10.2	59.7
9	Meghalaya	25.5	9.1	60.4
10	Mizoram	11.6	16.0	86.1
11	Nagaland	22.9	29.5	61.9
12	Sikkim	22.3	15.7	61.5
13	Tripura	NA	34.5	65.4
14	Uttaranchal	NA	12.4	60.3
III.	**UNION TERRITORIES**			
1	A&N Islands	NA	20.6	65.5
2	Chandigarh	NA	0.0	75.3
3	D&N Haveli	NA	50.6	43.0
4	Daman & Diu	NA	17.6	70.4
5	Lakshadweep	NA	18.2	81.6
6	Pondicherry	NA	5.0	74.1

Annexure 7.2

(Rs. in crore)

Sl. No.		Name of Scheme	Ninth Plan			
			Approved Outlay	Sum of Annual Outlay	Ant. Expdt.	Annual Plan 2002-03
	A	**INFRASTRUCTURE MAINTENANCE**	**6231.90**	**6654.85**	**7506.17**	**2303.00**
1		Rural Family Welfare Centres	1500.00	1600.00	1600.36	
2	1	Sub-Centres	2200.00	2346.00	2344.60	1809.00
3	2	Urban FW Services	250.00	307.00	305.69	122.00
4	3	Direction & Administration	671.90	541.00	465.25	200.00
5		Post Partum Centres	530.00	560.00	557.94	
6		Village Health Guides Scheme	50.00	40.00	39.70	
7	4	Logistics Improvement	80.00	51.85	4.84	10.00
	5	Contractual Services/ Consultancies	Included in RCH		Included in RCH	162.00
8		ANM (Part of Sub-Centres)				
9		Additional ANMs/PHNs/Lab. Technicians				
10		SM Consultant				
11		Aneasthetist				
12		Other Exp. (State/National level Consultants/Contingency)				
13		Arrears	950.00	1209.00	2187.79	
	B	**INFRASTRUCTURE DEVELOPMENT**	**1050.00**	**1202.35**	**915.76**	**364.20**
14	6	Area Projects (IPP Projects)	800.00	820.00	637.79	74.80
15	7	Social Marketing Area Projects		82.35	6.42	10.00
16	8	USAID Assisted Area Project	250.00	300.00	271.55	59.40
17	9	Other Externally Aided Infrastructure Development Projects				
18	10	EC Assisted SIP Project	**Includred in RCH**		**Includred in RCH**	**220.00**
	C	**TRANSPORT**	**150.00**	**250.50**	**250.65**	**113.00**
19	11	Maintainence of vehicle already available	**150.00**		**250.65**	**98.00**
20	12	Supply of Mopeds to ANMs				**15.00**
	D	**TRAINING**	**257.35**	**301.28**	**289.29**	**99.60**
21	13	Basic Training for ANM/LHVs	150.00	181.40	182.07	67.00
22	14	Maintenance & Strengthening of HFWTCs	40.00	48.06	46.94	14.00
23	15	Basic Training for MPWs Worker (Male)	35.00	37.90	35.76	10.00
24	16	Strenthening of Basic Training schools				2.00
25	17	F.W. Training and Res. Centre, Bombay	5.00	5.00	2.53	1.50
26	18	NIHFW, New Delhi	21.00	21.35	14.52	3.15
27	19	IIPS, Mumbai	5.70	6.90	6.83	1.70
28	20	Assistance to I.M.A.	0.65	0.67	0.64	0.25
	E	**RESEARCH**	**96.00**	**107.00**	**96.58**	**30.30**
29	21	Population Research Centres	35.00	33.00	22.47	8.00
30	22	CDRI, Lucknow	8.00	8.00	8.00	2.30
31	23	ICMR and IRR	53.00	66.00	66.11	20.00
32	24	Other Research Projects				0.00
	F	**CONTRACEPTION**	**1541.50**	**1578.70**	**1458.35**	**483.50**
	25	Free distribution of contraceptives	460.00	491.30	436.83	184.00
33		Conventional Contraceptives	265.00	310.00	286.20	
34		Oral Contraceptives	80.00	78.40	65.66	
35		IUD	115.00	102.90	84.97	
36		New Methods				
	26	Social marketing of contraceptives	400.00	428.70	407.40	115.00
37		Conventional Contraceptives	400.00	360.85	339.04	
38		Oral Contraceptives		67.85	68.36	
	27	Sterilization	680.20	653.80	610.26	180.50
39		Sterilization Beds	8.60	8.60	8.79	

Annexure 7.2

(Rs. in crore)

Sl. No.		Name of Scheme	Ninth Plan			Annual Plan 2002-03
			Approved Outlay	Sum of Annual Outlay	Ant. Expdt.	
40		Sterilsation and IUD insertion	600.00	575.00	534.22	
41		Supply /Procurement of Laparascopes	70.00	68.00	66.75	
42		Recanalization	1.60	2.20	0.50	
43	28	Testing Facilities	1.30	1.90	1.24	0.50
	29	Role of Men in Planned Parenthood	Included in RCH	3.00	2.62	3.50
44		No Scalpel Vasectomy		3.00	2.62	
45		Other Innovative Schemes *(Male Participation)*				
	G	**REPRODUCTIVE & CHILD HEALTH**	**5150.00**	**4423.30**	**3753.49**	**1174.20**
	30	Immunisation				226.00
46		Procurement of Vacccines for Routine Immunisation	Included in RCH		Included in RCH	
47		Cold Chain				
		(a) Cold Chain Maintenance				
		(b) Cold Chain Equipment				
48		Surveillence against VPDs				
49		Other Vaccines *(Hepatitis B)*				
50	31	Routine Immunisation Strengthening				10.00
51	32	Pulse Polio				400.00
		(a) OPV				240.00
		(b) Operating cost				160.00
	33	Child Health				1.00
52		Essential New Born care *(Home based neonatal care)*	Included in RCH		Included in RCH	
53		Diarheal Diseases - Prevention/Treatment				
54		ARI-Prevention/Treatment				
	34	NUTRITION	Included in RCH		Included in RCH	
55		Vitamin-A Programme				
56	35	Adolscent Health	Included in RCH		Included in RCH	3.00
	36	Maternal Health				254.00
57		Ante-natal care	Included in RCH		Included in RCH	
58		Nutitional Anaemia *(Anaemia Control & De-worming)*				
59		Home Delivery Care				
		(a) Community based midwives				
		(b) Dais Training				
60		Dais Kits *(Drugs, Kits & Equipments)*				
		(a) Drug Kits/FRU Drugs/PHC Drugs/RTI Drugs				
		(b) MTP/RTI/STI Equipment/Kit/IUD Kit				
		(c) Equipment for Blood Storage & Lab. Equipment				
		(d) Needles & Syringes				
		(e) Neo-Natal Equipment				
61		Promoting Institutional Deliveries				
		(a) 24 Hour Delivery				
		(b) Operationalising FRUs for Emergency Obs. & NN Care				
62	37	MTP Services (Manual Vac. Aspirator for safe abortion)	Included in RCH		Included in RCH	1.20
63	38	RTI/ STI prevention and management	Included in RCH		Included in RCH	2.00
	39	Other RCH Interventions and services				122.00
64		Referral Transport				

Annexure 7.2

(Rs. in crore)

Sl. No.		Name of Scheme	Ninth Plan			Annual Plan 2002-03
			Approved Outlay	Sum of Annual Outlay	Ant. Expdt.	
65		Out reach Services	Included in RCH		Included in RCH	
66		RCH Camps				
67		Civil Works				
68		Research (In RCH Activities)				
69		MIS				
70		Expdt. At Headquarters				
71	40	NGOs and SCOVA	Included in RCH		Included in RCH	22.00
	41	Training				53.00
72		RCH Training	Included in RCH		Included in RCH	
73		Training of ISM&H				
74		Training of AWW				
75	42	Tribal Projects	Included in RCH	Included in RCH	Included in RCH	
76	43	Urban Slums Projects	Included in RCH	Included in RCH	Included in RCH	5.00
77	44	District Projects	Included in RCH	Included in RCH	Included in RCH	75.00
78	45	Other Projects under RCH	Included in RCH	Included in RCH	Included in RCH	
	H.	**OTHER FAMILY WELFARE PROGRAMMES**	**643.25**	**450.72**	**318.68**	**355.90**
79	46	Maternity Benefit Scheme	Transferred from M/o Rural Developmen	80.00	80.00	90.00
80	47	Information, Education and Communication	170.00	184.80	160.91	84.70
		Non-RCH				
		RCH				
81	48	Travel of Experts/Conferences /Meetings etc.	16.10	15.35	2.15	1.50
82	49	International Contribution	6.30	6.99	6.33	1.70
83	50	Empowered Action Group	265.00	30.00	30.00	50.00
84	51	Community Incentive Scheme		30.00	5.00	60.00
85	52	Family Welfare Link Health Insurance Plan		0.01	0.01	50.00
86	53	Policy Seminars		3.00	3.00	3.00
87	54	Other Initiatives		0.03	0.03	15.00
88		Strengthening of Rural Family Welfare Centres under National Human Development Initiative	Included in Sub-centres (scheme 2)	20.00	Included in Sub-centres (scheme 2)	
89		Other Offices under Direction & Administration	28.10	29.60	29.02	
90		ISM Institutions	7.00	5.02	1.39	
91		Regional Institute of MCH	0.75	0.60	0.31	
92		Hindustan Latex Limited	1.90	1.72	0.13	
93		Family Welfare Counsellor Scheme	1.00	1.00	0.00	
94		School Health Scheme	147.10	42.60	0.40	
	55	Additional RCH activities in the Tenth Plan				0.30
	56	Other New Initiatives				6.00
GRAND TOTAL			**15120.00**	**14968.70**	**14588.97**	**4930.00**