when without loss of wage the population can access it. This timing alone must be excluding most working women labour from these clinics. Currently the sub-center is regrettably a token of primary care that cannot even provide a minimum professional quality of antenatal care– much more symbolic than substance. There is a case for making it substantial with little additional costs but much more seriousness on ensuring access and quality of care.

Data collection and use:

Displays of the key data should be available ward wise- and disaggregated by gender and for the three categories of population served as well as for specific sub-groups of beneficiary and vulnerable subgroups.

To facilitate data entry and analysis - A rugged,almost unbreakable, 7000 rupees simputer suitable for this purpose is now available. It could have software designed for the specific purpose. This could be made availbale for each sub-center along with a smart card for each HHW. Thus the HHW could enter the data in within minutes and such data analysis could become readily available. If one wants to save on costs one could keep one such simputer at the HAU level with a weekly visit by the HHW to the HAU for data entry. This gets fed into the muncipal level computer with an instant display of the data as required.

Data entry time may be reduced to two hours per week – at all levels. The extraordinary amount of time HHWs and especially FTS currently attribute register and report writing is not merited by the data that is available for inspection or in use at the level of KMDA and health planning.

The utility and design of the family health card already in use in 6 ULBs needs to be studied further. There are three possible outcomes from such a card-

a. Family has a better understanding of their healh situation and better access of services; the family health card design has far too much data requirements that are not relevant to this purpose. And does not have essential data which is relevant to this purpose.

b. The HHW is able to consolidate this to understand each familys health needs and gaps and use this for health planning at the block level and to reach out to families better. But there is no attempt at health planning at the block level and there is data that is not relevant to this purpose as also not having data relevant to it.

c. The health system and ULB gets a good quality data on health status , utilisation of various health services and their determinants. : Comment – This requires high quality consolidation and monitoring and interpretation. Even is this becomes available it is not useful for epidemiological profiling. As a project adminstration tool it is far too much work in data gathering and analysis which would tell on its quality. Such data needs are best served by good sample surveyh and Participatory assessments. The workload increase would be out of proportion to the benefits.

This is not to reject the family health card. The suggestion is to keep only such data as is useful to the family with the family in the form of a family card. A much less data item register/ smart card would be able to store the more relevant information relevant to the HHW for focussing more attention on more vulnerable families.

The HHW training Programme:

Training for HHWs must be a continuing process. About 12 days per year in a training camp environment. The one day meetings which are used for training purposes do not count against these 12days. The 12 day training is in addition to all in-service training measures.

The regular 12 day training is to see that the competencies needed to carry out her work definition are built up in the HHW and her supervisors.

Session by session curriculum development, training material that covers all training information needs, and an in built training evaluation are key steps necessary for more effective training.

The training programme should be based on printed training modules developed for the same. These materials get systematically transacted during the training session – ensuring minimum quality and commonality in the training programme. Lectures /presentations by medical officers untrained as trainers are welcome but as additionalities to the core training process.

Training may be for the first year outsourced to agencies who have the ability to provide training using participatory training approach. In parallel the skills of trainers – FTS and STS is built up through training of trainers programmes.

Failure to use regular HHW training linked with a distance education opportunity – national open school system or IGNOU or a state level system to get those HHWs who opt for it formally qualified over these ten years is a missed opportunity. Even now, if HHW's who are eligible and interested could get qualified/certified as a community health worker under the NIOS or get a diploma in women and child care etc. such an option should be open and subsidised by the programme

Other possibilities of training – allowed optionally- to enhance their skills and seek better career prospects should be encouraged. Also a part of the workforce absorbed into ICDS schemes would give further space to restructure the force. There are many areas where HHW is not needed and other areas that it is needed. The reluctance to abruptly drop women who have worked well for over ten years is understandable. But alternatives could and should have been worked out by now.

The Referral Centers:

Quality of care in referral centers:

The quality of care in referral services is in most dimensions admirable:

There is however urgent need to examine the need for more guidelines in some dimensions . The high C-section rates is one important example of the failure to develop quality standards. Again the way forward is through standard treatment guidelines and protocols along with an internal monitroing structure for ensuring adherence to it.

In addition with a hospital consultancy agency one could develop minimum standards for all key activites that constitute the hospital or service. We note that in the development of the RDC such quality control procedues have been built in. They are equally useful for other services. The lack of standard hospital waste management practices is an example of the urgency of such a measure.

Once the quality standards are developed the hospital adminstrator and staff need to be trained /oriented on it and a system of review built in.

Increased access of the poor to ULB run referral centers.

The most urgent dimension of reform in the ULB run referral services – is to increase access to the poor. This is not adequately happenning now though we note that there are ULBs where this is happenning also.

As a first step the health officers of the ULBs should with professional facilitation conduct a workshop to study the factors that have made some MHs function at higher levels of pro efficiency and higher degrees of access to the poor as compared to others. This may be much more instructive than recommendations from external teams. In such a workshop the following possible explanations may be examined:

a. ease of availability of exemption: more poor even paying poor attend a MH where more get complete exemption.

b. Over all efficienty and image: a MH which has full bed occupancy and higher turn out and a better image and therefore attracts the poor also more. (There is some doubt on this since in a few MHs we visited this was not so- but it is a hypothesis worth examining).

c. Perception of the HHW and how actively she promotes the MH is a major determinant.

d. Perception of the objectives by workforce in the MH- how friendly they are and how far they see themselves as providing care to the poor as compared to an implicit objective of demonstrating they are running a good quality hospital that recovers costs and satisfies the middle class.

e. Community variables like migrant nature,or level of poverty or language barriers are the main determinants of the poor using these services.

The study team has formed its opinion on these five possibilites but it is not adequately substantitated by evidence as our sample was too small. Hence this recommendation.

However undeniably cost of care is an issue and we also need to make some suggestions over and above the possibilites mentioned earlier

We recommend:

a. The ULB changes the current process of collecting Rs 1 per beneficiairy family per fortnight. (this has been difficult to implement and is resented by population and HHW, the funds get pooled at ULB level with little transperency /feedback information about how much is collected and what it is spent on, there are no matchning contributions being received, and finally it seems too insubstantial to make any differnce.). Instead the HHW collects the funds of Rs 1 or even more and deposits it in an account of their own. This is matched by the ULB or by a bank- in a one to three ratio. The saved amount is lent to a family for health needs during an emergency. Easy quick access to it needs community mechanisms. We note that even then poor families would only be able to afford the free state governemtn health systems care- but this loan would meet their invisible needs – like food for attenders, and transport cost etc. In other words each HHW may organise one or more self help groups in each poor community. The self help groups may have a bank account which is operated by the HHW as one signatory and by another elected member of the community as another signatory.(there is a very good large scale model with 2000 groups known as the Malar model that is immediately useful.(innumerable grass roots details like what to do when one woman migrates to another area, wants to leave, wants tojoin etc have been worked out. But there may be many other equally useful such work to learn from.

b. Once the above step is organised – a social insurance package is then used to cover these groups. The above step of first organising a self help group is needed , at least desirable, for organising the social insurance package. This package would cover all in patient costs at designated centers- largely the ULBs referral centers but may also include private accredited centers who agree to abide by such a cost package as is given at the ULB's referral centers. All diagnostic tests in RDCs may also be similarly covered. The package must include all in pateint costs- and not only institutioanl delivery and CS. However since many ULBs do not provide these services, planning with communities may lead to other ULBs Referral Centers/RDCs being so designated. Additionally

c. Taken together there would be substantial progress towards the goals of investment in health as poverty alleviatation. Both components synergise and each reinforces the other. It would be difficult and much less useful to operate one component without the other- but it is not impossible. The cost of one component is readily picked by banks

and the second requires an insurance company to administer with help from the HHW workforce.The premium can be raised from ULBs by a cess or from Donors etc. The HHW role gets transformed and there may be even some part of costs of her employment that is met. Community mobilisation and organisation occurs. The referral centers can serve beneficiaries better with no loss to themselves. But yes – it would be a lot of work and re-orientation.!!

Increasing availability of referral centers for the poor:

"Quality access" to state hospitals:

The state run hsopitals are playing a major role. There is a need to see them as part of the package and to understand better how to structure the ease of access and quality of services these provide too.

There is also a need to de-pressurise the tertiary care centers so that secondary and primary care centers do not flood it and higher order problems get the attention they deserve. What can be done for these two goals has to be finalised in discussion with the state health system. However certain suggestions are immediately possible:

a. designate a weekly once afternnon special clinic- or a thrice a week evening clinic (or some such variation)in these hospitals for attending to RCH referrals from KMDA. Only those with referral slips will attend. All those with referral slips would receive a feed back note to the sub-center so that the follow up would be done there. Referrals would be for only well defined agreed upon indications: eg RTIs that have not responded to primary treatment, safe abortion services, sterilisation services, cases needing elective cesarean section etc. This is more relevant where there are no ULB run maternity homes but given the fact of user fees and how it is currently excluding the poor and also the fact that HHWs are in fact referring more to such hospitals then to ULB run hospitals – such a referral arrangement should not be resisted on turf considerations alone. If an incentive package is offerred to the doctor in the state hospital, resistance to this can be overcome and more motivation obtained. This would be essential if it is an evening clinic- as it would cut into private practice time.

b. Strenghthen the credit self help group arrangments so that the invisible costs of such care can be met. A lower-rate insurance replayment made out to the self help group n to meet drug costs may also de required in the vulnerable groups in special circumstances when drugs are not available in the hospital. A special credit mechanism in addition to the self help group may also be needed.

Private Sector partners: see section on sterilisation services below

Sterilisation Services:

The single most important challenge and current barrier to improving performance in fertility control is ease of access to sterilisation services.

The second most important challenge in this is to increase males seeking these services. (see section on gender sensitivity in the ULB).

The minimum process indicator for meeting this challenge is to have in every ULB at least one if not three health care facilites where on a fixed day of the week – the HHW can refer any person who needs the service to a family planning clinic. And in the same week on another day the operation should be completed and the HHW should receive the necessary feedback form attesting to its completion This may be the maternity home ULB, or it may be a special clinic in an ULB, or it may be a private clinic who agrees to provide these services at a fixed rate of reimbursement. (the government of India would pay the reimbursement cost readily). If a private clinic is recruited to play this role – it would need the entire processes of advertisement, inspection, accreditation and MOU so as to take care of quality standards, price fixation and legal issues. But if this process indicator cannot be met within existing ULB maternity home and state health department hospital then what ever the difficulty the private sector partner has also to be recruited. (Model systems and plans for such public private partnership are readily available).

Safe abortion services: the same as was discussed for sterilisation services applies to safe abortion services too. Exemption from payment for all beneficiaries for this service is essential to avoid resort to illegal and unsafe abortions or expensive options in the private clinics.

Referral linkages:

The current referral system may be replaced by a system that has inbuilt feedback. A simple three part perforated form would suffice. One part is retained by the referring HHW or FTS /STS or PTMO. The second part , filled up is retained by the referral center – to be collected later by the system. The third part is filled up and sent as feedback to the person who referred initially. This has an educational- skill building dimension for the referring first contact health care provider. This provided a better follow up for the patient and reduces unnecessary visits to the secondary systems. A separate queue structure at the referral center or the elimination of say a registration fee etc. could greatly enhance the desire to use this referral card by the patient.

The importance of two way referral linkages not only with ULB referral centers with the state government hospitals, with medical college hospitals and designated private nursing homes cannot be over emphasised. It also makes for much more accountable and ethical health care provision.

The acccess to the ambulance systems needs to be improved upon. Again volume of usage should be a process indicator. Easy access on the telephone for callig the ambulance in, easy access to exemption of all fees where needed are both measures that would increase utilisation.

Improving community participation:

Community participation in planning, and implementation needs to be enhanced considerably.

Possible ways to do so are:

a. Form a women's health committee – especially or only in those habitations where performance is low by criteria like how many are unable to utilise the maternity home because of costs, nor visit sub-center for ante natal care etc or any group that constitutes a vulnerable beneficiary. This could be a health and devlopment committee. This could be any pre- existing non- party forum that is acceptable.It could be a self help group.The womens health committee should have a secretary or coordinator in whom we need to invest some capability building through training and support processes. This would help her keep the group together, reinforce messages to the group and organise self help groups etc. The womens health committee would help the HWW in needs assessment and disease surveillance and vital events registration. Measurable process indicator should be number of meetings in a month which discussed issues in the context of the KMDA programme

b. Ward level committees that identify the most –poor based on objective criteria and help to plan interventions that are intersectoral – especially improving living conditions, working together with the muncipality, also need to be reinforced and where necessary initiated.

Organisation of occasional community level mobilisational event is desirable– a public show, a drama programme, a meeting where the key messages are reiterated, the particpatory structures are strengthened and the services offered by the KMDA are informed of. Such an event is almost madatory if the community has to get actively engaged with the particpatopry institution being ~~created~~ created and the HHW plays the role of organisation and empowerment. The major part of the funding for this is with community contribution. That is part of the process.

Increasing gender sensitivity.

There are six components of this:

1. **Increased male participation in child care and womens health :**

   a. this should be reflected in the training material and IEC material

   b. In the programme design, the HHW visits should call upon discussions at times when the husband is also present.

   c. Interactions with key messages is essential .

2. Increased male participation in fertility control.

    a. male vasectomy operations should be easier to access and more widely available.

    b. there should be an attempt to increase the male acceptance rate from 3% of all sterilisations to about 25% of all sterilisations.

3. **Going beyond the reproductive fix.**

a. the focus on addressing a narrow range of reproductive issues so as to effect fertility control(so clearly expressed in the foreword to the training module) should give way to a mor eholistic level of womens health. This should be seen in the standard treamtment protocols of the HHW and her supervisors and the STPs made for the sub-center too. It should also mean a general transition from maternity homes to women and child hospitals. It should also be seen in more thea very tokenish nature of programmes being undertaken in areas like anemia and malnutriton in women, adloescent health programmes etc giving way to more serious substantive programme designs.

4. **Addressing women and violence issues**: The HHW is uniquely placed to address women and violence as a healh issue. Their background in womens associations, their own age and maturity, and their good connections with authority are all useful for addressing this problem. Few programmes have realised it due to a lack of a viable programme design. The book "where women have no doctor" by the Hesperian foundation is a particularly good example of how the women and violence issue can be analysed as a health issue. This is a good place to start and build on.

5. **Training and community mobilisation as empowerment**. Understanding the close links between patriarchy and women health issues, there is the scope for developing health education and awareness building as part of a process of empowerment of women.

6. **The woman health care provider and her rights**: the HHW continnues the tradition of low paid women on whom the burden of health care is palced without any thought to them as individuals. Over ten years there has been no arrer plan, no creation of alternative spaces , no increase in her skills – not even the skill to give immunisation that she so eagerly seeks. One suspects that gender has combined with medical professionalism to keep the HHW at such a modest skill level after ten years.There is a need to expand her work profile and her skills so that ther e is a greater sense of satisfaction and a greater number of opportunites that open up. Scale of near angnawadi level along with a work profile change would be the right direction. Discreet but effecitve greivance redressal mechanisms for assisstance in the case of any harrasment on the job are needed for such jobs. This

study shows a small but significant number of women who would have foound such support useful.

Reaching out to adolescents:

The HHW progamme may aim for a major thrust at adolescent health. This is an untapped area of work and must start with the recognition that are few clear ideas about the objectives and operational elements of an adolescent health programme.

As a preliminary proposal the HHW may focus on the following five:

a. malnutrion and anemia in adolescents and young women

b. Awareness about ones body and ovecoming anxiety and stress in its normal functions.

c. Easy access to quality information about sexuality and the ability to exercise control over ones own body(with reference to patriarchy) which includes the the ability to protect oneself from unwanted and unsafe sexual relationships and unwanted pregnancies.

d. Easy access to quality care for common adolescent health problems.

e. Awareness of the problems of violecne, drugs , smoking and alcoholism as health issues.

We note that adolescent should not get reduced to adolescent women alone. The problems of the adolescent male are different but they are equally if not much more worrying. (And of course they would become the problems of the adolescent female).

There are three proposed strategies of doing so:

a) HHW organised adolescent health camps that screen for anemia and malnutrition – and of course other health problems- about once a year. These are more forms of awareness building about these two issues rather than comprehensive care in themselves. These can be one or two day camps held in the same block in four or five place with an attempt to get all adolescents to attend. Weighing the adolescent with BMI calculation as well as hemoglobin estimation , the use of charts and small hall meeting are four elements that would go a long way to creating awareness of this issue. This also becomes an opportunity to flag the need for a dialogue on the issues relating to sexuality and violecne and to introduce the peer educators.

b) Create adolescent or young women peer educators in each and every community – perhaps at the frequency of one in hundred families or even less.

The selection of these peer educators needs careful techniques. Familiarity with and subjective impressions of the HHW would be a poor guide.

c) A weekly or even monthly once adolescent clinic held at the sub-center or at a adolescent frequented area in the locality with clinical examination and counselling facilites. The package of services that go into this is critical. To make it attractive – some elements- perhaps sports or more likely career or job or vocational counselling .

The HHW would be involved in all three aspects but there would be much to gain if partnered with womens organisations or civil socity groups which has worked on such issues.

Programme Management-

A. The ULB Health Committee. These must be more active space in both planning and execution of the ULB health services. Currently its inability to change even the beneficiaries let alone the content of the package shows that decentralisation has largely meant only a certain deconcentration of funtions. Though health officer capability building is the key – some degree of sensitisation to the issues involved would have played a major role in making better use of the tremendous resource that most ULB chairpersons could be . In terms of understanding their current programme and some of its problems and in adminstering these facilites the ULB has been very effective. It is just that issues like the differnce between providing RCH services and health services or to give another example the mechanisms of data gathering and the need for independent surveys to validate system gathered data etc are not understood adequately. Ideally this committee also needs to look after closely related areas like the ICDS scheme implementation and safe water supply and sanitation.

B. **Reports and statements exclusively on health and its determinants**: Regular annual reports and monthly or quarterly statements with more verifiable process indicators would also make the ULB health committees more useful. All the data collected along with information from the disease surveillance system should be reflected in this.

C. Public health trg and career plan for Health officers

One of the key problems of the targetted slective approach is that health planning and even most elements of public health managemen has become redundant. Yet as we have seen most of the problems remain – and often remain outside the erception of health officers. AllHealth officers we met are very sincere , committed people but with very little training on public health and not even aware of such a necessaity. This in Kolkata which has one of the pioneering and premiere institutes in India for this purpose- is unfortunate.

There are three month short duration distance education programmes available – but eventually by distant education along with adequate contact classes and inservice training

every health officer must obtain at least a two year degree. That would of course mean better remuneration- which should be twice if not thrice the current pathetically low rates. Of course along with professionalisation and increased salaries the option for private practice would go. Promotion to KMDA health sector management and a cross channel to the state governemnts adminstrative cadre where eventually all will have compulsory public health qualifications is the direction in which change would occur and this would provide an attractive career plan for health officers.

One useful immediate addition is for HHWs, FTS and the health officers to bec ome conversant with participatpry health assessment methodology – and invaluable semi-quantitative and excellent qualitiative tool to assisst in ULB level health planning.

D. Disease surveillance:

This is essential for meaningful public health both for epidemic response and to understand key disease patterns. There is no system in place. No ULB visited was even able to state the number of patients of specific communicable disease like tuberculosis or malaria had been treated in the public hospitals.

Disease surveillance data can be generated from three sources :

a) through HHW with assitance from the community - outbreaks (meaning over 5 to 10 cases occuring within a week)of diarrhoea or jaundice (indicating water supply problems); outbreaks of measles (more than three children with fever and rash, acute flaccid paralysis, deaths of any person with acute(less than two weeks) high fever, under 5 deaths and deaths in pregnancy can be got.

b) Through the ESOPDS and state hosopitals and RDCs and regular report of key notificable illness is generated every month – other than immediate response. The state hospital visited did not keep place of residence , much less it corelation with positve communicable disease data from laboratory, in patient and out patient. On the other hand if when registering patients they could record address and on discharging patients they could record the disease diagnosis, this data could be analysed to give a monthly report on the ULB wise incidence of key diseases. The main diseases that may be short listed are : cholera, acute flaccid paralysis and measles or any other vaccine preventable disease, malaria, filaria, HIV and tuberculosis. Also under 5 child deaths and maternal deaths.

c) A number of private practioners with good levels of practice could be recurited to provide iformation through printed psotacards if needed. Not all private providers need to be distributed. If a few are ready with good distribution of these few we would have an effective sentinel surveillance system in place.

A nodal center in the ULB with a person for this task using a customised software would be able to enter this data and provde ready information to the ULB on disease patterns.

Epidemic response protocols are the next steo. They should be specifying what needs to be done by the HHW, by the health officer , by the ULB admisntration if a pre defined criteria for epidemic is obtained from the reporting system.

E. Role for civil soceity organisations: Finally, the ULBs should consider the inclusion of civil socity groups in these committees . Careful choice of civil soceity groups who have a track record of pro-poor health activism and have health system understanding would make a big difference. There is a large trandition of this in India , even to some extent in West Bengal. The question to be aksed in this context is not of their legitimacy to speak for the poor. The ULBs are soverigen and representative and civil soceity groups cannot be more representative. Rather the issue we are flagging is of the need to institutionalise a space for "external" view points into the decision making or at least into a consultative apparatus. The problems appears to be that the system carrys through its perspective and rationale so efficiently to all the personneel at all the rungs that when the feedback is derived from the same system it tends to reiterate the same approach without being able to provide alternative perspectives- much less action points. This conflation of RCH with Health, this feeling that the materniaty homes are catering to the poor or at least that this is all that can be done, the policies regarding exemption of user fees, this overhwleming sense of a completely successful programme based on the three indicators of TFR, IMR and MMR and many other aspects are all shared so completley at all levels of the adminstration chain that even questioning them would be unacceptable. Yet these perspectives vary quite widely with community perceptions and civil soceity organisation perceptions.

F. Choice of Indicators for planning and monitoring : Regular annual reports using a much larger number of process indicators other than output indicators would be crucial for improvement of the programme. Thus all reports acclaim service delivery at the door step as one of the major innovations and achievement of the programme but in the absence of an objectively measurable process indicator for this- these claims can mislead the ULBs own planning efforts.

The indicators should also relates to related services- esp ICDS and safe water and sanitation situtation.

The outcome indicators used like IMR and MMR are impossible to verify – indeed almost impossible to measure in the first place- and they play little use in local planning. Even in out come indicators there is a need to look at indicators like disaggregated mortality indices or child malnutrition rates etc to get a better picture of the health status and set goals that can be addressed.

Financial Implications and Financing Options:

1. The single biggest expenditure item is the HHW honararium and the most important perceived request is an increase in this. Given the fact that some public health sytstem outreach for basic preventive activites is essential the HHW becomes essential. The question that the study has therefor e addressed is how to restructure her work so

that there is maximum effectiveness. This can be done with a small increment in pay and accepting some of the work additions suggested. Or there can be a decision to bring her on par with the ICDS anganwadi worker and bring about a major alternations in the work profile. One way if by integration with the ICDS programme whose outreach is thus extended.(there is already a supreme court ruling to universalise ICDS. If that becomes inevitable the move to integrate with ICDS would be far sighted. Of course we would need substantial changes in the ICDS programmes to reach these sections – more flexibilkity in timings, more community participation and mobilisation etc – but they are in line with the current suggestions made for the HHW.) This is one policy decision.

2. Training costs should be non –negotiable. Investing in honararium and salaries without investing in training makes little sense. Traning is not only for HHW,, but even more so for FTS, STS, PTMO and health officers.This can be stated as about 15 percent of the salary plus honorarium costs if there are no major programme content changes. But is there are major chages on the lines proposed than at least in the first year because of a back log of training and because of new dimensions that need training these costs may rise to about 25% of the costs.

3. On sub-center there is an existing demand to improve infrastructre- but without clearly spelling out the level of service provision and consumables cost that would rise in tandem. The suggestion is that the sub-center be strengthen with infrastructure to provide quality outpatient care along with a small laboratory and retraining of the FTS and PTMO to play this role. No laboratory technician is needed. Existing staff can be trained to play this role with appropriate training inputs- the level of testing is kept that basic. This would be a package of costs. Alternatively tests can be done at minimal rates through a Private sector partner. If the decision to upgrade the sub-center thus is taken – infrastructure and equipment and skills-set norms should be declared and the gaps closed. This would be a significant expenditure. Since the HAU almost always has a sub-center embedded in it – it would also automatically and easier reach these levels. Confiniing such improvements to the HAU alone would not be as useful. At a rough estimate this would have a non recurrent cost of about Rs 50,000 per subcenter excluding infrastrructre costs. Recurring costs would be only modestly higher than what it is today.

4. The other major additional costs would be of the social insurance premiums if this decision is made.

5. IEC and community mobilisation would have a small expenditure tag- again it is small but it would be essential.

6. Expenditure on drugs would go up.

7. Other suggestions- standard treamtenet protocols and quality of care meassures, adolecscent healthc are , STI/RTI services, improving access to the poor to referral service, linakge with self help gorups, increased community participation, identifying vulnerable groups, change of indicators, regular presentation of reports, etc – do not have a price tag on it but are equally essential to the overall outcomes.

How are the considerable funds for these suggestion to be obtained?

Once the critical programmatic decisions are taken the the budgetary implications of these would be come evident . If these are no salary increases and the sub-center definition is maintained at what it provides now the increase in costs would be largely the cost of training and IEC and drugs – a modest increase back to the 1999 levels of funding for these items which would be about 25% of the salary costs. If on the other hand there is then training costs would be higher and the costs of equipping the subcenters and the social insurance arrangements would all add to costs.

We have already discussed that savings groups linked to bank credit could be used to cover the invisible out-of pokcet costs in illness.(invisible only to planners). There are limits to how much this would contribute, but even with its limitations this could be welcome.

In the main financing has the following options:

1. More user fees from the secondary referral centers.(the referral fee at the primary level is a non- starter):

The only way this can be gained is by increasing volumes of patients seen. Even the current rates which are modest by commercial stndards are too high for the poor and have largely led to their exclusion. Also non beneficiary turnover increases at the cost of being able to cover the beneficiary defeat the purpose. Cost recovery is not the criteria of success of the maternity home- access to the poor is. If Cost recovery can be affected without compromsing access then it would be most welcome. The referral centers should not become an avenue to subsidise the HHW compoents. Rather it should be having a minimum criteris for exemptions to increase access to the poor.

2. More revenue mobilisation by the ULB from other sources and its deployment into reaching health to the poor. This could be an earmarked fund or a non earmarked mobilisation.

This would be part of the study on financing in general. We just flag one such possibility here . That is raising funds from commercial private sector hospitals- funds that are earmarked for serving the poor through these programmes. Medical tourism dependent corpoarate hospitals could attract even more cess and this may be presented as part of corporate social responsibility. While hihger end patient mobility is being planned for to tap the overseas patient market, the larger migrant population already here largely from within the country could also access their basic human rights. Other possibilites for earmarked fund transfer are for financing social insurance- if properly positioned a number of donors as well as some innovative cess collections could be proposed for this. The fact that the funds go directly to providing access for the poor at services provided by the ULBs at very reasonbale rates- is an attractive marketting proposition for fund raisers.

3. More fund transfers from the central or state governemnt with or without external donor support.

This is inescapble. As long as budgets have not reached the levels mandated by the national health policy, this should be the first avenue of exploring of funds for programme that is so sharply targetted to the poor. It is unrealisitc, even unfair toexpect full cost recovery from poorer sections. This is now an acceptable principle and the sums involved would not be beyond the possible.

In this context one would need to re- examine the concept of sustainability. Maximising financing options and cost recovery options without affecting the access to the poor is an acceptable premise. But to prioritiese sustainability – understood as being able to run the health system targetted for the poor, purely on funds generated within it- is a problematic proposition. Such a proposition contradicts another fundamenatal proposition that investment in health sector is a form of poverty allevation , a form of transfer of reosurces to the poor .

Measures like self help groups and social insurance are more addressing problems of management , of access , of conveninence, of flow of funds. But eventually health care for the poorest, especially the most vulnerable of these sections requires a net transfer of resources. The question that this study has addressed is how best to do it. Not whether it needs to be done.

This was a fundamental premise of this study.

KOLKATA URBAN SERVICES FOR THE POOR

CHANGE MANAGEMENT UNIT

Date :June 16, 2004

Letter No : CMU-25/2002/61

16 JUN 2004

From
Subrata Biswas, IAS
Project Director
Change Management Unit, KUSP

To

1) The Mayor, Chandannagar Municipal Corporation
2) The Chairman, Kalyani Municipality
3) The Chairman, Bhadreshwar Municipality
4) The Chairman, New Barrackpore Municipality

Dear Sir

Sub: Invitation for participation in the Presentation for KUSP Action Plan.

You must be aware that the Interim Support Consultants (ISC) and the Organisational Development (OD) Consultants have been working in association with the CMU towards achieving the desired overall objective of the KUSP program. These consultants have already submitted their Inception Reports with the CMU. It becomes imperative now that a feasible action plan is being chalked out based on your valuable views and comments.

In this connection the CMU is organising a Presentation on KUSP-Action Plan on 23.06.2004 to be held at SUDA building within ILGUS Bhavan premises, Bidhannagar at 3.00 p.m. The Secretary, MAD will chair the meeting. You are hereby requested to make it convenient to please attend the above said presentation.

Looking forward for your presence.

Yours Sincerely,

Sd/-

SUBRATA BISWAS
Project Director
CMU, KUSP

ILGUS BHAVAN, HC BLOCK, SECTOR 3, BIDHANNAGAR, KOLKATA 700106
Ph : 033-2334 2660, 2337 7315, 2358 6403/5767
Fax : 033-2337 7318/2358 5800
email: kuspcmu@vsnl.net

Copy to:

1) The Secretary, MAD
2) The Director, Local Bodies
3) The Chief Engineer, MED
4) The Director, SUDA
5) The Superintending Engineer, MED
6) Project Officer, Health, SUDA
7) Ken Robson, ISC
8) Srinibas Kowligi, ISC
9) Paul Thornton, ODC
10) Project Manager, CMU

They are requested to please attend the said presentation.

Project Director
CMU, KUSP

পূজালী পৌরসভা

পূজালী, বজবজ, দঃ ২৪ পরগণা

স্বাস্থ্য মেলা - ২০০৫

২৬শে মার্চ, শনিবার ২০০৫

সকাল ১১টা হইতে বিকাল ৫ টা

SUDA

STATE URBAN DEVELOPMENT AGENCY

HEALTH WING
"ILGUS BHAVAN"
H-C BLOCK, SECTOR-III, BIDHANNAGAR, CALCUTTA-700 091
West Bengal

Ref No. .....**SUDA-Health/DFID/04/616** *Date* **11.08.2005**

From : Dr. Shibani Goswami
Project Officer
Health Wing, SUDA

To : Mr. Anirban Kundu
Infrastructure Professionals Enterprise (P) Limited
IPE Towers, IB-78, Salt Lake City, Sector - III
Kolkata - 700 091.

Sub. : Invitation to attend the launching ceremony of Health Systems Development Initiative Programme of our department on Tuesday, August 16, 2005.

Sir,

Thanks for invitation.

This is to confirm that Dr. N.G. Gangopadhyay, Adviser, Health, SUDA and myself will be participating at the launching ceremony of HSDI on August 16, 2005.

Thanking you.

Yours faithfully,

Project Officer

C:\Dr. Goswami\DFID\DFID - MISC.doc

KOLKATA URBAN SERVICES FOR THE POOR
CHANGE MANAGEMENT UNIT

Arnab Roy, *IAS*
Project Director

Memo No.CMU- 133/2 004/16-8(9) Date: 26-05-2005

From: Arnab Roy
Project Director, CMU, KUSP

To:

(1) Project Manager, CMU, KUSP
(2) Technical Adviser, CMU, KUSP
(3) Engineering Expert, CMU, KUSP
(4) Municipal Finance Expert, CMU, KUSP
(5) OD Expert, CMU, KUSP
(6) Economist, CMU, KUSP
(7) Financial Adviser, CMU, KUSP
(8) Health Expert, CMU, KUSP
(9) Communication Agency, CMU, KUSP

Discussion will be held regarding design and contents of KUSP Website on 27th May 2005 at 12-00 Noon. You are requested to attend.

(Arnab Roy)
Project Director, CMU, KUSP

Ltr(PD) akd. (4)/p-V

ILGUS BHAVAN, HC BLOCK, SECTOR 3, BIDHANNAGAR, KOLKATA-700 106
PH : 033-2334 2660, 2337 7315, 2358 6403/5767, FAX : 033-2337 7318/2358 5800
E-mail : kuspcmu@vsnl.net, Website : www.changekolkata.org

KOLKATA URBAN SERVICES FOR THE POOR
CHANGE MANAGEMENT UNIT

Arnab Roy, *IAS*
Project Director

Memo No.CMU-31/2002(Pt-III)/463(40). **Date: 19-07-2005**

From: Arnab Roy
Project Director, CMU, KUSP

To: (1) Mayor/Chairperson

..... Municipal Corpn./Municipality

(2) Commissioner/Chief Executive Officer/Executive Officer

..... Municipal Corpn./Municipality

Sub: Preparation of Draft Development Plan (DDP)

Ref: Our Memo No.CMU-31/2002(Pt-III)/375(40) dt.4-7-05

Sir/Madam,

Kindly refer to the above-mentioned letter regarding preparation of Draft Development Plan (DDP). I am happy to enclose fifty copies of Book-1: Guidelines for Launching DDP (in Bengali).

You are requested to kindly initiate steps for launching the process for DDP preparation in your ULB preferably within 15th August 2005. The date of holding the initial DDP launching workshop may kindly be informed to us so that we may arrange for sending resource persons to facilitate holding of the launching workshop for DDP in your Urban Local Body.

The booklets may be distributed to all concerned persons at the DDP Launch Workshops.

Yours faithfully,

(Arnab Roy)
Project Director, CMU, KUSP

Encl: As stated above

Ltr(PD) akd.(4)p-100

ILGUS BHAVAN, HC BLOCK, SECTOR 3, BIDHANNAGAR, KOLKATA-700 106
PH : 033-2334 2660, 2337 7315, 2358 6403/5767, FAX : 033-2337 7318/2358 5800
E-mail : kuspcmu@vsnl.net, Website : www.changekolkata.org

Memo No.CMU-31/2002(Pt-III)/463(40)/1(10). **Date: 19-07-2005**

Copy along with copy of the guidelines for launching DDP for kind information:

1. Secretary, M.A. Dept.
2. PS to Minister-in-Charge, MA & UD Dept.
3. CEO, KMDA
4. Secretary, KMDA and Secretary, KMPC
5. Director of Local Bodies
6. Director, SUDA
7. Chief Engineer, MED
8. Jt. Director, ILGUS
9. Director General (Planning & Development), KMDA
10. Director (A&SP), KMDA

Project Director, CMU, KUSP

Memo No.CMU-31/2002(Pt-III)/463(40)/2(8). **Date: 19-07-2005**

Copy forwarded to:

1. Project Manager, CMU
2. Urban Planner, CMU
3. Financial Adviser, CMU
4. Engineering Expert, CMU
5. Municipal Finance Expert, CMU
6. OD Expert, CMU
7. Economist, CMU
8. Health Expert, CMU

Project Director, CMU, KUSP

Sub. : Utilisation Certificate in respect of training of Health Officer & Asstt. Health Officer in Public Health

C/P-(1)

Placed below is the communication bearing memo no. 21/G-06 dt. 18.04.2005 from the Chairman, Halisahar Municipality addressed to the Project Manager, CMU with an endorsement to the undersigned. The said communication pertains to the submission of Utilisation Certificate in respect of training of Health Officer & Asstt. Health Officer of Halisahar Municipality in Public Health at New Delhi during 14 – 18 March, 2005, under Health Component of KUSP. This office communications bearing memo no. CMU-94/2003(Pt. II)/704 dt. 24.02.2005 and 777 dt. 11.03.2005 are enclosed.

C/P-(2)
C/P-(3)

The instruction was given to book the expenditure incurred for the training purpose under the A/C head "Health Component – Training of HOs & AHOs". Regarding submission of Statement of Expenditure (SOE) and Utilisation Certificate (UC), no clear procedure was communicated to the ULBs.

Hence, the ULBs whose HO / AHO attended such training programmes may be instructed clearly to submit SOE and UC through the Accounting support Agency.

The Health Officer and Asstt. Health Officer of the following ULBs participated in the 1st training programme held at New Delhi during 14 – 18 March, 2005.
Barrackpore, Baranagar, Barasat, Dum Dum, Halisahar, Kanchrapara, Kamarhati, Khardah, Madhyamgram, Naihati, New Barrackpore, North Barrackpore, North Dum Dum, Panihati, South Dum Dum & Bhatpara.

The Health Officer and Asstt. Health Officer of the following ULBs participated in the 2nd training programme held at Jaipur during 18 – 22 April, 2005.
Bidhannagar, Garulia, Budge Budge, Maheshtala, Pujali, Rajpur Sonarpur, Bally, Howrah, Uluberia, Kalyani, Bansberia, Bhadreswar, Rishra and Uttarpara Kotrung.

Necessary action may kindly be taken from your end.

A, SUDA
& KUSP.

Sd/-
DE, CMU
25.5.05

Dt. .. 19.05.2005

To : Jayanta Kumar chakraborty
OD & Poverty Expert, CMU

Sub. : Health related Activities, OVIs & MOVs as envisaged for inclusion in MOU with West Bengal Municipal Association.

Activities	OVIs	MOVs
All the Councillors should be oriented and motivated to health programmes	No. of orientation session held with the Councillors.	Report of WBMA. Agenda of ward level committee meeting ~~will include health issue.~~
Male vasectomy.	10 % of total sterilization will be vasectomy cases.	Report of WBMA and HMIS.
Collection of community contribution @ Rs. 2/- per family per month.	100% collection.	Report of WBMA. ULB report.
At least 3 antenatal check ups.	100% antenatal care coverage.	Report of WBMA and HMIS.
Complete immunization of infant (including measles vaccine).	100% immunization.	Report of WBMA and HMIS.

Goswami
19.5.05

PHONE : 2241-2035

WEST BENGAL MUNICIPAL ASSOCIATION

(RECOGNISED UNDER THE BENGAL LOCAL SELF-GOVERNMENT ASSOCIATIONS (RECOGNITION) ACT, 1936)
Established-1936
C-55, COLLEGE STREET MARKET, KOLKATA - 700 007

From,
Govinda Ganguly
General Secretary
West Bengal Municipal Association
C- 55, College Street Market
Kolkata- 7000 07.

To,
Shri Arnab Roy
Project Director
Change Management Unit
Kolkata Urban Services for the Poor
ILGUS Bhavan, HC Block, Sector-3
Kolkata- 7001 06.

Sir, **Date:**

Sub: Capacity Building

We are happy to learn that the Govt. of West Bengal has agreed t implement multi sector programme viz. KUSP with the assistance o DFID for the 40 ULBs within KMA. It is also learnt that th implementation of KUSP has already been started within the 4 ULBs and will get momentum very soon.

As you know, our association is one of the pioneer organizations t deal with the problems of ULBs in our state and it won't be out o place to mention that no other state in the country can claim havin such an association, which have been recognized under the Benga Local Self Govt. Association (Recognition) Act, 1936. Being so, w are the only association of all the ULBs in our state which is tryin to playa key role in combating the challenges of ULBs throug negotiating with the appropriate authorities so that these issues ar properly addressed.

In this context, we are to convey that our association can play major role as Coordinator or Change Agent to bring reforms with the municipalities utilising the spirit and philosophy of participator management approaches to facilitate the implementation process KUSP. You will also appreciate that involvement of our associatio will make all the 40 ULBs to act in unison to achieve the comm goal as envisaged under your programme.

PHONE : 2241-2035

WEST BENGAL MUNICIPAL ASSOCIATION

(RECOGNISED UNDER THE BENGAL LOCAL SELF-GOVERNMENT ASSOCIATIONS (RECOGNITION) ACT, 1936)
Established-1936
C-55, COLLEGE STREET MARKET, KOLKATA - 700 007

Our association has identified the following areas where it can provide effective support to municipalities in bringing changes as envisaged.

1) Awareness building programme on preventive and promotive health care services.

2) Strengthening functional roles involving ward committees and Community Development Society in Management of Municipal Services and Resource Generation at ward level.

3) To promote and propagate successful/innovative implementation of any municipal service to other municipalities.

When we express our determination, we never forget to assess our shortcomings. Main difficulties are lack of our infrastructure to render such services to ULBs. Our office should be equipped with some essential equipments and also provision of support with technical person.

We understand that KUSP is a programme which intends to build capacities of the ULBs as well as supporting organizations. You will agree that our association can be considered as one of the supporting organizations who can render assistance to CMU in building some of the capacities of municipalities as indicated above and we believe that our association has the capability in rendering such services But unfortunately due to paucity of fund we could not build our infrastructure facilities at our office levels through which we can render this service. We will be happy if you kindly arrange to provide the following infrastructure facilities in our two Offices situated at Salt Lake and College Street respectively.

CAPACITY BUILDING OF OFFICE

I. Computer with Printer (2 Nos.)	-	1 No. for Salt Lake Office & 1 No. for College Street Office
2. Fax Machine (2 Nos.)	-	-Same-
3. Almirah (2 Nos.)		
4. Table and 20 Chairs.		

PHONE : 2241-2035

WEST BENGAL MUNICIPAL ASSOCIATION

(RECOGNISED UNDER THE BENGAL LOCAL SELF-GOVERNMENT ASSOCIATIONS (RECOGNITION) ACT, 1936)
Established-1936
C-55, COLLEGE STREET MARKET, KOLKATA - 700 007

For organizing day-to-day work we also hope that remuneration for one computer operator for our association may kindly be provided from your end for a reasonable period besides some nominal expenditure towards contingency.

Thanking you,

Yours faithfully,

Govinda Ganguly
General Secretary
(West Bengal Municipal Assocission)

KOLKATA URBAN SERVICES FOR THE POOR

CHANGE MANAGEMENT UNIT

Memo no:- CMU-28/2002(Pt-II)/519(10) **Order** Date:- 08.11.2004

A Health Steering Committee consisting of the following members has been formed to finalize the design of the health component of KUSP programme :

1.	Secretary, KMDA	Member
2.	Project Manager, CMU	Member
3.	Health Expert, CMU	Member Secretary
4.	Chairman, New Barrackpore Municipality	Member
5.	Mayor, Chandannagar Municipal Corporation	Member
6.	Health Officer, South Dum Dum Municipality	Member
7.	Health Officer, Bhadreswar Municipality	Member
8.	Health Officer, Rajpur, Sonarpur Municipality	Member
9.	A representative of Health Department, Govt. of W.B	Member
10.	Dr. N. G. Gangopadhyay	Chairman
11.	Project Director, CMU	

Till Health Expert joins, Project Manager, CMU may function as Member Secretary.
This has the approval of Secretary, Municipal Affairs Department.

Arnab Roy, IAS
Project Director, CMU

Copy forwarded to :

1. Principal Secretary, Health Department, Govt. of W. B. for kind information and request to nominate a representative from Health Department. The representative may kindly be asked to attend the first meeting on 10.11.2004.
2. Secretary, KMDA
3. Project Manager, CMU
4. Health Expert, CMU
5. Chairman, New Barrackpore Municipality
6. Mayor, Chandannagar Municipal Corporation
7. Health Officer, South Dum Dum Municipality
8. Health Officer, Bhadreswar Municipality
9. Health Officer, Rajpur, Sonarpur Municipality
10. Dr. N. G. Gangopadhyay

Dr. S. Goswami
She may please attend the meeting on 10.11.2004.

The first meeting of the Health Steering Committee will be held on 10.11.2004 at 11.00 AM in the Conference hall of SUDA Building . ILGUS Bhavan . HC Block Sector 3, Bidhannagar, Kolkata – 106. The members are requested to please make it convenient to attend the meeting.

Project Director, CMU

Copy for kind information to :

1. Secretary, Municipal Affairs Department
2. P.S. to MIC, M.A & U.D.

Project Director, CMU

ILGUS BHAVAN, HC BLOCK, SECTOR 3, BIDHANNAGAR, KOLKATA 700 106
PH : 033-2334 2660, 2337 7315, 2358 6403 / 5767, FAX : 033-2337 7318 / 2358 5800
email : kuspcmu@vsnl.net, website : www.changekolkata.org

CHANGE MANAGEMENT UNIT (CMU)

17-05-2005

NOTE

Enclosed please find the ISC fresh contract given by DFID and the Terms of Reference for your information. Please determine the first month's milestones, if concerning your area of work, to be covered as per the Terms of Reference and discuss the same with me at your convenience.

(Arnab Roy)
Project Director, CMU

Encl: As stated above.

Project Manager, CMU
Technical Adviser, CMU
Engineering Expert, CMU
Economist, CMU
Municipal Finance Expert, CMU
OD Expert, CMU
Financial Adviser, CMU
Health Expert, CMU

19.5.05

Section 2 - GENERAL CONDITIONS

CONTENTS

DEFINITIONS AND INTERPRETATION

1. Definitions

"the Consultant" means the person(s), partnership(s) or company(ies) with whom this Contract is placed.

"the Consultant's Personnel" means any person instructed pursuant to this Contract to undertake any of the Consultant's obligations under this Contract, including the Consultant's employees, agents and sub-contractors.

"the Equipment" means any equipment, computer hardware or software, materials, goods and vehicles and associated services necessarily required for the implementation of the Services, which the Consultant cannot reasonably be expected to provide, which are financed or provided by DFID for use by the Consultant.

"the Financial Limit" means the amount specified in Section 1 and is the maximum amount payable by DFID under this Contract.

"the Services" means the services set out in the Terms of Reference (Section 3).

"the Project Officer" means the person named in Section 4 who is responsible for issuing instructions and dealing with all correspondence in connection with the technical aspects of the Contract.

"the Contract Officer" means the person named in Section 4 who is responsible for all contractual aspects of the Contract.

"the Administration Officer" means the person named in Section 4 to whom invoices should be sent.

2. Interpretation

2.1 In the event of any inconsistency between the Form of Contract (Section 1), these General Conditions (Section 2) and the Special Conditions (Section 4), the Special Conditions shall prevail.

2.2 Except as expressly provided in Clause 14 the Consultant is not the agent of DFID and has no authority to represent and shall not purport to represent or enter into any commitments on behalf of DFID in any respect.

2.3 Nothing in this Contract is intended to make nor shall it make DFID the employer of the Consultant or any of the Consultant's Personnel.

2.4 All communications by the Consultant relating to notifications or applications for consents or instructions must be addressed to the DFID Contract Officer whose name and address are given in Section 4.

OBLIGATIONS OF THE CONSULTANT

3. Obligations

3.1 The Consultant shall perform all its obligations under this Contract (including the provision of the Services) with all necessary skill, diligence, efficiency and economy to satisfy generally accepted professional standards expected from experts.

3.2 If the Consultant is a joint venture then each of the joint venture parties shall have joint and several liability in respect of the Consultant's obligations under this Contract.

4. Personnel

4.1 All members of the Consultant's Personnel shall be appropriately qualified, experienced and in a suitable physical condition so as to ensure that the Consultant complies with all the Consultant's obligations under this Contract.

4.2 No changes or substitutions may be made to members of the Consultant's Personnel identified as key personnel in Section 4 of this Contract without DFID's prior written consent.

4.3 If DFID considers any member of the Consultant's Personnel unsuitable, the Consultant shall substitute such member as quickly as reasonably possible without direct or indirect charge to DFID with a replacement acceptable to DFID.

4.4 The Consultant is responsible for all acts and omissions of the Consultant's Personnel and for the health, safety and security of such persons and their property.

5. Sub contractors

5.1 The Consultant shall not sub-contract any of its obligations under this Contract without the prior written consent of DFID.

5.2 If, having obtained DFID's consent, the Consultant sub-contracts any of its obligations, the sub-contract shall:-

(a) provide that payments due to the sub-contractor shall be made not more than 30 days after provision to the Consultant of a valid invoice; and

(b) include rights for the Consultant and obligations on the sub-contractor to ensure that DFID's rights to require replacement of personnel (as set out in Clause 4.3) and DFID's rights and the Consultant's obligations as set out in Clauses 6 to 11 (inclusive) can be enforced against the sub-contractor.

6. Disclosure of Information

6.1 The Consultant and the Consultant's Personnel shall not, without the prior written consent of DFID, disclose to any third party any confidential information obtained during or arising from this Contract (other than in the proper performance of this Contract or as may be required by authority of competent jurisdiction). In addition, no publicity is to be given to this contract without the prior written consent of DFID.

7. Intellectual Property Rights

7.1 All intellectual property rights in all material (including but not limited to reports, data, designs whether or not electronically stored) produced by the Consultant or the Consultant's Personnel pursuant to the performance of the Services ("the Material") shall be the property of the Consultant.

7.2 The Consultant hereby grants to DFID a world-wide, non-exclusive, irrevocable, royalty-free licence to use all the Material.

7.3 For the purpose of Clause 7.2, "use" shall mean, without limitation, the reproduction, publication and sub-licence of all the Material and the intellectual property rights therein, including the reproduction and sale of the Material and products incorporating the same for use by any person or for sale or other dealing anywhere in the world.

8. Official Secrets Acts

8.1 The Consultant shall ensure that all members of the Consultant's Personnel are aware that the Official Secrets Acts 1911 to 1989 apply to them.

9. Access and Audit

9.1 The Consultant shall keep accurate and systematic accounts, files and records ("the Records"). The Records shall clearly identify, among other things, the basis upon which invoices have been calculated and the Consultant shall keep the Records throughout the duration of this Contract and for six years following its termination.

9.2 The Consultant shall upon request provide DFID or its representatives including the National Audit Office, unrestricted access to the Records in order that the Records may be inspected and copied. The Consultant shall co-operate fully in providing to DFID or its representatives answers to such enquiries as may be made about the Records.

9.3 Where it is found by DFID that any overpayment has been made to the Consultant the Consultant shall reimburse DFID such amount within 28 days of the date of DFID's written demand.

10. Corruption, Commission and Discounts

10.1 The Consultant warrants and represents to DFID that neither the Consultant nor any of the Consultant's Personnel:

(a) has given, offered or agreed to give or accepted, any gift or consideration of any kind as an inducement or reward for doing or forbearing to do or for having done or forborne to do any act in relation to the obtaining or execution of any contract or for showing or forbearing to show favour or disfavour to any person or entity in relation to any contract; or

(b) has entered into any contract in connection with which commission has been paid or agreed to be paid by or to the Consultant or Consultant's Personnel or on their behalf or to their knowledge unless, before such contract was made, particulars of any such commission and of the terms of any agreement for the payment of such commission were disclosed in writing to DFID, whose written consent was subsequently given to such payment.

10.2 Neither the Consultant nor any of the Consultant's Personnel shall accept for or on their own benefit any trade commission, discount or similar payment or benefit in connection with this Contract.

11. Conflict of Interest

11.1 Neither the Consultant nor any of the Consultant's Personnel shall engage in any personal, business or professional activity which conflicts or could conflict with any of their obligations in relation to this Contract.

11.2 The Consultant and the Consultant's Personnel shall notify DFID immediately of any actual or potential conflict together with recommendations as to how the conflict can be avoided.

12. Insurances

12.1 The Consultant shall maintain professional indemnity insurance cover of an amount not less than the Financial Limit.

12.2 At the request of DFID, or its representatives, the Consultant shall provide evidence showing that such insurance has been taken out and maintained and that current premiums have been paid.

13. Indemnity

13.1 Except where arising from the negligence of DFID or DFID's employees, the Consultant shall indemnify DFID in respect of any costs or damages howsoever arising out of or related to breach of warranty or representation, contract or statutory duty, or tortious acts or omissions by the Consultant or the Consultant's Personnel or any claims made against DFID by third parties in respect thereof.

PROCUREMENT AND EQUIPMENT

14. Procurement

14.1 Subject to Clause 14.4 all Equipment to be procured pursuant to this Contract and paid for by DFID shall be procured by a DFID registered procurement agent, acting as agent of DFID ("the Procurement Agent").

14.2 For the purpose of the appointment of a Procurement Agent and for this purpose only, the Consultant shall act as an agent of DFID.

14.3 The Consultant shall provide the Procurement Agent with sufficient details for the satisfactory procurement and delivery of Equipment and shall manage the Procurement Agent on DFID's behalf.

14.4 Where the total value of the Equipment is less than 50% of the Financial Limit or £100,000, whichever is less the Consultant may, subject to DFID's prior written consent, procure such Equipment.

14.5 All procurement of Equipment shall

(a) be undertaken in accordance with DFID Guidance on Procurement of Goods or such other procedures as may be agreed in writing by DFID;

(b) achieve "Value for Money" and be conducted in a fully transparent manner;

(c) be on the basis that the ownership in Equipment shall vest in DFID, and shall be so marked.

14.6 "Value for Money" shall mean procuring at the optimum combination of whole-life cost and quality to meet requirements.

15. Use of and Responsibility for Equipment

15.1 Equipment may only be used in providing the Services and shall be safely kept and maintained. Personal use of Equipment by the Consultant is not permitted unless DFID gives prior written consent.

15.2 The Consultant shall keep an up to date inventory of the Equipment its condition and location and make such inventory available to DFID immediately on request.

15.3 Subject to Clause 15.4 the Consultant shall be responsible for all loss or damage to Equipment other than that caused by fair wear and tear. The Consultant shall notify DFID immediately the Consultant becomes aware of any loss of or damage to Equipment.

15.4 Except as required by law, the Consultant shall not insure Equipment. DFID shall bear the risk in respect of loss or damage provided such loss or damage was not due to the Consultant's negligence and provided the Consultant obtains and pays to DFID such proper compensation as may be due from others.

15.5 The Consultant shall obtain DFID's instructions on the disposal of Equipment and comply with such instructions.

PRICE AND PAYMENT

16. Applicable Provisions and Financial Limit

16.1 Unless different provisions are substituted in Section 4, Clauses 16 to 20 inclusive shall apply in relation to price and payment.

16.2 The components which comprise the Financial Limit are set out in the Schedule of Prices, Section 5. No expenditure may be incurred in excess of the Financial Limit and no virements between components shown in the schedule of prices in Section 5 are permitted without the prior written authority of the Contract Officer.

17. Fees

17.1 Any fees payable are deemed to cover the cost of salary, overseas inducements, leave allowances, bonuses, profit, taxes, insurances, superannuation, non-working days and all other costs including, but not limited to, clothing, passports, visas and vaccinations, overheads and expenses of whatsoever nature that may be incurred except those otherwise specifically provided for in this Contract.

18. Expenses

18.1 Whenever travel and living expenses for Consultant's personnel are incurred they will be paid at a rate consistent with that payable to DFID staff in comparable situations.

19. Invoicing Instructions

19.1 Unless otherwise expressly provided in Section 4 or Section 5, invoices should be submitted monthly in arrears in duplicate and in accordance with the remainder of clause 19.

19.2 DFID shall unless otherwise expressly provided in Section 4 make payments due by direct credit through the UK Bank Clearing Systems (BACS). All invoices must contain details of the UK bank account to which payments are to be made.

19.3 Invoices should include a form of letterhead, the contract reference number and bear an original signature. They should be numbered sequentially and dated, and marked "For the attention of the Administration Officer" named in Section 4. Each invoice should state the period the services were provided using "from" and "to" dates. The final invoice presented in connection with this Contract should be endorsed "Final Invoice".

19.4 Unless this Contract is on a milestone payment basis, all invoices should contain details of expenditure in accordance with Section 5 of this Contract.

19.5 DFID may request proof of payment in respect of any item and shall be entitled to refuse to meet a claim if this cannot be provided.

19.6 Any invoice not presented in accordance with the above may be rejected and in any event shall be liable to query and delay in payment. DFID reserves the right not to pay any amount due in respect of an invoice received by DFID more than 90 days after the day of the Consultant becoming entitled to invoice for the payment to which it relates.

20. Payments

20.1 Subject to DFID being satisfied that the Consultant is or has been carrying out their duties, obligations and responsibilities under this Contract, sums duly approved shall be paid within 30 days of receipt of a valid invoice.

20.2 Payment shall be made in sterling in the UK. Expenses (if any) arising in foreign currency shall be reimbursed at the exchange rate stated in the London Financial Times "Guide to World Currencies" on the Friday immediately preceding the date on which the purchase was made or services acquired by the Consultant or, if this took place on a Friday, at the rate so stated on that day.

20.3 If for any reason DFID is dissatisfied with performance of this Contract, an appropriate sum may be withheld from any payment otherwise due. In such event DFID shall identify the particular Services with which it is dissatisfied together with the reasons for such dissatisfaction, and payment of the amount outstanding will be made upon remedy of any unsatisfactory work or resolution of outstanding queries.

20.4 Should DFID determine after paying for a particular service that the service has not been completed satisfactorily, DFID may recover, or withhold from further payments, an amount not exceeding that previously charged for that service until the unsatisfactory service is remedied to its satisfaction.

FORCE MAJEURE AND TERMINATION

21. Force Majeure

21.1 Where the performance by the Consultant of their obligations under this Contract is delayed, hindered or prevented by an event or events beyond the reasonable control of the Consultant and against which an experienced consultant could not reasonably have been expected to take precautions, the Consultant shall promptly notify DFID in writing, specifying the nature of the force majeure event and stating the anticipated delay in the performance of this Contract.

21.2 From the date of receipt of notice given in accordance with Clause 21.1, DFID may, at its sole discretion, either suspend this Contract for up to a period of 6 months ("the Suspension Period") or terminate this Contract forthwith.

21.3 If by the end of the Suspension Period the parties have not agreed a further period of suspension or re-instatment of the Contract, this Contract shall terminate automatically.

22. Suspension or Termination without Default of the Consultant

22.1 DFID may, at its sole discretion, suspend or terminate this Contract at any time by so notifying the Consultant and giving the reason(s) for such suspension or termination.

22.2 Where this Contract has been suspended or terminated pursuant to Clause 22.1, the Consultant shall:

(a) take such steps as are necessary to terminate the provision of the Services, (including suspending or terminating any Sub-Contracts) in a cost-effective, timely and orderly manner; and

(b) provide to DFID, not more than 60 days after DFID notifies the Consultant of the suspension or termination of this Contract an account in writing, stating:

(i) any costs, if any, due before the date of suspension or termination;

(ii) any costs to be expended after the date of suspension or termination which the Consultant necessarily incurred in the proper performance of this Contract and which it cannot reasonably be expected to avoid or recover.

22.3 Subject to DFID's approval DFID shall pay such amount to the Consultant within 30 days after receipt from the Consultant of an Invoice in respect of the amount due.

23. Suspension or Termination with Default of the Consultant

23.1 DFID may notify the Consultant of the suspension or termination of this Contract where the Services or any part of them are not provided to the satisfaction of DFID, giving the reasons for such dissatisfaction and, in the case of suspension, the action required by the Consultant to remedy that dissatisfaction and the time within which it must be completed.

23.2 Where this Contract is suspended under Clause 23.1 and the Consultant subsequently fails to remedy the dissatisfaction DFID may terminate this Contract forthwith.

23.3 DFID may, without prejudice to its other rights, including but not limited to the right to claim for costs and losses incurred, terminate this Contract forthwith where:

(a) the Consultant or any member of the Consultant's Personnel, either directly or through their servants or agents, breaches any of their obligations under this Contract; or

(b) the Consultant or any member of the Consultant's Personnel has committed an offence under the Prevention of Corruption Acts 1889 to 1916 or the Anti-Terrorism Crime and Security Act 2001 or in breach of Clause 10 of this Contract; or

(c) the Consultant is an individual or a partnership and at any time:

(i) becomes bankrupt; or
(ii) is the subject of a receiving order or administration order; or
(iii) makes any composition or arrangement with or for the benefit of the Consultant's creditors; or
(iv) makes any conveyance or assignment for the benefit of the Consultant's creditors; or

(d) the Consultant is a company and:

(i) an order is made or a resolution is passed for the winding up of the Consultant; or
(ii) a receiver or administrator is appointed in respect of the whole or any part of the undertaking of the Consultant.

(e) the Consultant is a partnership or a company and there is a Change in Control. "Change in Control" means that the person(s) (including corporate bodies) directly or indirectly in Control of the Consultant at the time this Contract is entered into cease to be in Control. "Control" means the power of a person to secure that the affairs of the Consultant are conducted in accordance with the wishes of that person.

23.4 Where this Contract is terminated in accordance with this Clause, the Consultant shall without prejudice to DFID's other remedies, take any steps necessary to terminate the provision of the Services in a timely and orderly manner but shall not be entitled to any further payment in relation to this Contract.

23.5 Where this Contract is terminated pursuant to Clause 23.3(b) the Consultant shall pay DFID within 10 days of notification such amount as DFID shall have determined as the amount of any loss to DFID resulting from such termination together with the amount or value of any gift, consideration or commission concerned.

GENERAL PROVISIONS

24. Variations

24.1 No variation in the terms or scope of this Contract shall be effective without DFID's prior written consent and recorded in writing [in the form of a letter entitled "Contract Amendment No. "]. DFID shall have no liability in respect of work performed outside the Services set out in Section 3 .

25. Assignment

25.1 The Consultant shall not, without the prior written consent of DFID, assign or transfer or cause to be assigned or transferred, whether actually or as the result of takeover, merger or other change of identity or character of the Consultant, any of its rights or obligations under this Contract or any part, share or interest therein.

26. Limit of Liability

Except where there has been misconduct, gross negligence, dishonesty or fraud on behalf of the Consultant or the Consultant's Personnel the Consultant's liability under this Contract shall be limited to the amount of the Financial Limit.

27. Retention of Rights

27.1 Clauses 6, 7, 8, 9, 13, 28 and 29 of this Section 2 and any relevant clauses listed under Section 4 shall continue in force following the termination of this Contract.

28. Law and Jurisdiction

28.1 This Contract shall be governed by the laws of England and Wales.

29. Amicable Settlement

29.1 The parties will attempt in good faith to negotiate a settlement to any claim or dispute between them arising out of or in connection with this Contract. If the matter is not resolved by negotiation the parties will refer the dispute to mediation in accordance with CEDR (Centre for Effective Dispute Resolution in London, UK) procedures. If the parties fail to agree terms of settlement within 90 days of the initiation of the procedure the dispute may be referred to an arbitrator as agreed between the parties or failing such agreement as may be nominated by the President of the Law Society of England and Wales upon application of any party. The initiation of the procedure is defined as the written request to CEDR by any party for a mediation provided that such request is copied to the other party (ies).

29.2 The decision of the arbitrator shall be final and binding on both parties.

29.3 The place of arbitration shall be London.

Section 3

(Appendix A)

Terms of Reference

1. **Support to CMU in DDP Rollout and Training (including FLIP)**

   - Prepare Training Material for ULBs (DPG & DTG) for FLIP and DDPs
   - Prepare Training Material for CMU/KMDA Support Teams for FLIP and DDPs
   - Deliver Training to CMU/KMDA Support Teams
   - Deliver Orientation Training to about 10 ULBs - to assist with CMU leading the training process. The Support teams will then carry out the required training in balance ULBs
   - Prepare presentation material for DDP launch
   - Assist CMU in DDP Launch workshops in 10 ULBs - CMU to lead the launch process. Support teams will then facilitate launch process in balance ULBs
   - Preparation of Formats, Checklists, Templates to be used by ULBs in preparation DDP
   - Prepare Guidelines for ADP Preparation & budgeting process
   - Preparation of guidelines for appraisal and approval of DDP for KMPC
   - Capture the above in the form of 'Process Guideline for Preparation of DDPs - Version 2'
   - FLIP Preparation Tool (simple application based on MS Excel/VB)
   - Defining Development Objectives for C1, C2 & C3 components of DDP as guidance to ULBs, and submit a Supplementary to the Guideline on 'Development Objectives in Municipal Planning'
   - Preparation of a compendium of relevant extracts of laws and rules required for the preparation of DDP and implementation of the components included in the DDP.

2. **Support in the Accounting Reforms module**

   - Prepare a updated Accounting Manual dovetailing with recommendations of the NMAM
   - Prepare Draft Amendment to the West Bengal Municipal (Finance and Accounting) Rules, 1999 in line with the Accounting Manual
   - Recommend draft amendments to the Municipal Acts, if required to enable these changes
   - Provide support to the CMU Accounting Expert in supervising and supporting ULBs in the process of preparation of Opening Balance Sheets

3. **Challenge Fund – Interim Fund Management**

   - Preparation of Appraisal Criteria for Concept Papers and Proposals
   - Assistance to CMU in appraising Concept Papers
   - Assistance to CMU in appraising Proposals
   - Develop detailed Operations Manual for Challenge Fund including formats, appraisal criteria, selection, communication plan, contracts, formats etc.
   - Develop Systems and Procedures for Management, Budgeting, Accounting and Audit of Fund Recipients
   - Preparation of Monitoring & Evaluation Framework for ICF funded Projects

- Prepare material for outreach workshops and seminars
- Assist CMU in Outreach Workshops
- Revise TOR for Fund Manager & Assistance to CMU in engaging a Fund Manager for ICF

4. **Public Private Participation (PPP) Pilot Project, Training & Capacity Building**

- Identify Municipal Services for PPP - prioritize 4 areas
- Organise visits of key stakeholders to leading ULBs in India to examine successful PPP in Municipal Services
- Develop Sample Contracts for PPP for identified Municipal Services (max 4)
- Develop Sample Bid Documents for PPP for identified Municipal Services (max 4)
- Develop Training Material for managing PPPs for key ULB and Support Agency Staff
- Deliver training to key staff of ULBs on PSP opportunities, mechanisms and model contracts
- Deliver training to key staff from Support Agencies
- Piloting a PPP project - one project in one ULB (involving the following activities):
  - Identification of project
  - Discussions on project structure
  - Preparation of contract & bid documents
  - Assistance in managing the bid
  - Assistance in bid evaluation and negotiations

5. **Performance Management System for ULBs**

- Define Performance Management objectives and needs (Managing Incentive Fund, KUSP & allocation of other programme funds, Monitoring DDP implementation, etc.)
- Define Financial & Non-financial parameters
- Identify data needs for financial & non financial parameters
- Define methods for data collection
- Design Performance Management System
- Define linkages & methods to use the new system
- Implement Performance Management System (single location at DLB)
- Prepare User Manual
- Design & deliver training programme for DLB officers

6. **Technical Assistance in formulation of KMA level Economic Development Vision**

- Develop detailed methodology for visioning exercise
- Collection and analysis of existing economic data from secondary sources
- Facilitate workshops with Chambers of Commerce
- Facilitate workshops with stakeholders from Government
- Facilitate workshops with civil society organizations
- Integrating stakeholder visions into KMA level economic vision
- Formulate implementation structure (ie linkage to KMA DDP and ULB level DDPs) and suggest allocation of institutional responsibilities at KMA level
- Prepare Economic Vision Document

URBAN MANAGEMENT CENTRE

ADMINISTRATIVE TRAINING INSTITUTE
GOVT. OF WEST BENGAL

ORIENTATION PROGRAMME FOR NEWLY APPOINTED EXECUTIVE OFFICERS IN KMA MUNICIPALITIES
2-13 May 2005 (9 days)

6th May, Friday

10.30-12.00 pm	Health Programmes in Municipalities	Dr S Goswami, Project Officer, SUDA & Health Expert, CMU
12 – 12.15pm	**TEA BREAK**	
12.15-1.45 pm	Assessment & Valuation	Sri Syamales Datta, Ex Chief Valuer, HIT
1.45-2.45 pm	**LUNCH BREAK**	
2.45-4.00 pm	Site Visit: Practical Orientation to Municipal work	ATI - CMU representation

10th May, Tuesday

10.30-12.00 pm	Overview of Municipal Services	Sri. B.K. Sengupta, Ex-Advisor, KMDA
12 – 12.15pm	**TEA BREAK**	
12.15-1.45 pm	Municipal Services: Water Supply, Solid Waste Management, Sanitary Services	Sri. B.K. Sengupta, Ex-Advisor, KMDA
1.45-2.45 pm	**LUNCH BREAK**	
2.45-4.00 pm	KUSP: Organization Development	Sri. Jayanta Kr Chakrabarti, OD Expert, CMU
4.00-4.15 pm	**TEA BREAK**	
4.15-5.30 pm	KUSP: E-Governance	Shri Tapas Ghatak, KMDA

11th May, Wednesday

10.00-10.45 am	Special session	Meeting with DFID - India Representative
10.45-12.00 pm	Interface with other support agencies	Sri Swapan Chakraborty, DLB, WB
12 – 12.15pm	**TEA BREAK**	
12.15-1.45 pm	Economic Development of KUSP	Sri. Saikat Sengupta, Economist CMU
1.45-2.45 pm	**LUNCH BREAK**	
2.45-4.00 pm	Citizens' Interface: Ward Committee & CDS	IBRAD
4.00-4.15 pm	**TEA BREAK**	
4.15-5.30 pm	Sarba Siksha Abhijan	Smt. Chhanda Sarkar, Jt. Director, ILGUS

12th May, Thursday

10.30-12.00 pm	KUSP: Slum Improvement Programme	Sri G Sarkar, Expert Engineering, CMU
12 – 12.15pm	**TEA BREAK**	
12.15-1.45 pm	Interface with Elected Representatives	Smt. Chhanda Sarkar, Jt. Director, ILGUS
1.45-2.45 pm	**LUNCH BREAK**	
2.45-4.00 pm	KUSP: Accounting Reforms	Sri Atanusason Mukhopadhyay, MFE, CMU
4.00-4.15 pm	**TEA BREAK**	
4.15- onwards	Meeting with MIC, Urban Development GOWB	

13th May, Friday

10.30-12.00 pm	Personal Effectiveness	Sri Anjan Chakraborty, Chief Manager SBI
12 – 12.15pm	**TEA BREAK**	
12.15-1.45 pm	Personal Effectiveness	Sri Anjan Chakraborty, Chief Manager SBI
1.45-2.45 pm	**LUNCH BREAK**	
2.45-4.00 pm	Citizens' Charter	
4.00-4.15 pm	**TEA BREAK**	
4.15-5.30 pm	Evaluation and Feed back Valedictory	Sri. Uttam Kumar Roy

Note: Programmes on 12th May is tentative

Uttam Kumar Roy
Course Director

UM/2005/KUSP2

KOLKATA URBAN SERVICES FOR THE POOR
CHANGE MANAGEMENT UNIT

Arnab Roy, *IAS*
Project Director

Memo No. CMU - 25/2002/67(3) **Dated: 26.04.05**

From: Arnab Roy
Project Director, CMU

To : 1. Project Manager, CMU
2. Director, SUDA
3. Technical Advisor, CMU
4. Health Expert, CMU
5. Municipal Finance Expert, CMU
6. Financial Advisor, CMU
7. OD & Poverty Expert, CMU
8. Urban Planner, CMU
9. Economist, CMU

Sir,

Dr. Sangeeta Purushottoma of Best Practices Foundation, a DFID assisted venture, will be coming to CMU on 27th April 2005 at 3.30 p.m.. She will give a presentation followed by a discussion on Best Practices in various areas of Urban Governance and Urban Development.

You are requested to remain present for the presentation and discussions.

Thanking you,

Yours faithfully,

(Arnab Roy)
Project Director, CMU

ILGUS BHAVAN, HC BLOCK, SECTOR 3, BIDHANNAGAR, KOLKATA-700 106
PH : 033-2334 2660, 2337 7315, 2358 6403/5767, FAX : 033-2337 7318/2358 5800
E-mail : kuspcmu@vsnl.net, **Website** : www.changekolkata.org

Change Management Unit
KUSP Project – The Way Forward
February 22, 2005

*connectedthinking

PRICEWATERHOUSECOOPERS

Agenda

- Objective of the Presentation
- Approach
- KUSP Task Analysis
  - 'As – Is' Scenario
  - Way Forward
- CMU Structural Implications
  - Key Principles
  - Test Questionnaire – Illustration
  - Test Results - Illustration
- Organization Structure Report – Table of Contents
- Your Comments

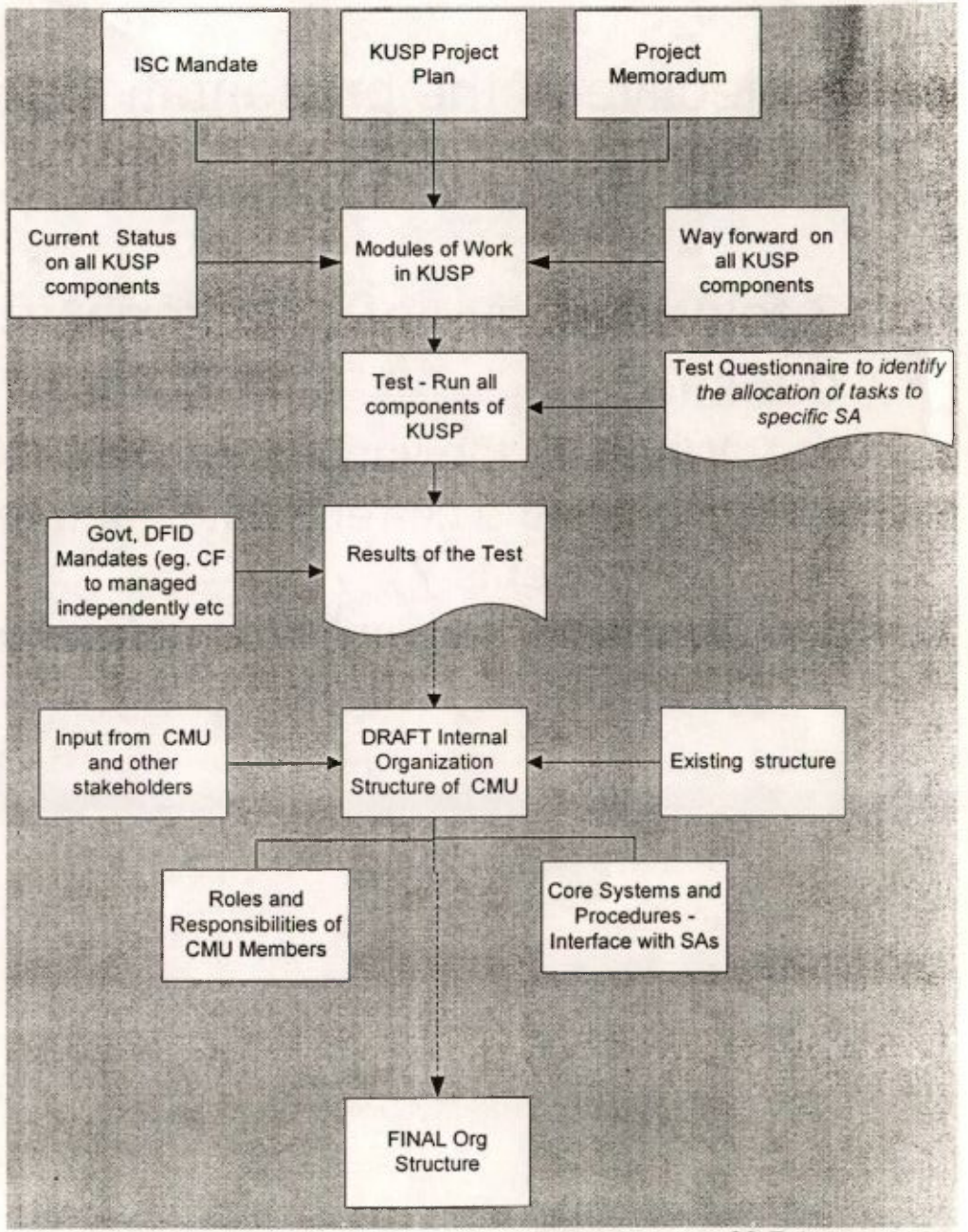
Objective of the presentation

3 fold objective of our presentation is to address the following questions:

- What are the various components of the KUSP Project?
- What is the current status and the way forward on the various components ?
- What are the implications for the Organization Structure of CMU?

Organization Structure of CMU - Approach

- Inputs from various sources to derive the **key components** of KUSP Project
- **Status analysis** and **way forward** for each component of the KUSP Project
  - Use a test questionnaire and take inputs from the CMU Team
- Arrive at the **draft organization structure** comprising
  - **Roles** & **Responsibilities** of CMU **core team** and **support staff**
  - Systems and Procedures in CMU
- Inputs from CMU and steering committee
- Final Organization Structure for CMU



Task Analysis of KUSP Project

Task No.	Task Name	Status*	Way forward
A	**Strategy Planning**		
1	Preparation of DDP & ADP	The guidelines have been prepared and field tested by ISC	• Actual preparation of DDPs by the ULBs by FY2007 -Ensuring that the ULBs are equipped to prepare the DDPs -Ensure that all the inputs to the DDP are available
2	Howrah Rejuvenation & Development Plan	ToR under preparation	• Preparation of the ToR and engaging the consultants for preparing the plan -Ensuring that the ToR addresses the requirements of a city strategy involving Infrastructure as well as Economic Rejuvenation Plan • Monitor the deliverable of the module and facilitate the implementation of the plan by SAs/ULBs
3.	West Bengal Urban Strategy	-TORs to be prepared.	
B	**Fund Management / Programme Management**		
3	Managing Technical Expertise (Consultancy)	Maintaining oversight and control of all services procured through KUSP Funds is being done piece by piece.	• Manage various levels of procurement in terms of preparation of ToRs, issuing tenders, contracting and overlooking the task. The various levels of oversight may be – Level 1) Oversight of all procurement through KUSP fund Level 2) Managing all procurement initiated by CMU Level 3) Managing and administering all contracts signed by CMU (excludes subject matter supervision)
4	Allocation criteria for projects	Allocation criteria for project funds has been prepared	• Administration of the Allocation Criteria. -Ensure that data is available about various ULBs to determine the allocation funds on various criteria which may be need based or simply based on project requirements

Task Analysis of KUSP Project

Task No.	Task Name	Status	Way forward
5	Monitoring and Evaluation	Monitoring and Evaluation Framework is under preparation	• Progress of each KUSP module as per logframe have to be evaluated as per this framework • Issuing ToR for appointing a third party for Monitoring and Evaluation of the KUSP Project
6	Change Management Unit (CMU) office management and administration, Managing KUSP Funds, Communication, Event Management	-	• Recruitment/Appointments, IT Needs, Office Space need to be taken care to ensure smooth day to day operations of CMU. Such needs will evolve/change over a period of time.
7	Design and Managing of Challenge Fund	The Design of Challenge Fund has been prepared	• Prepare the operational manual / formats for the challenge fund. Appointment of the Challenge Fund Manager . • Develop mechanism to have oversight of the fund manager.
8	Managing Incentive Fund	Incentive Fund Guideline has been prepared	• Administer the Incentive fund • Evolve the various criteria for the Incentive Fund management • Train the evaluators in various criteria for evaluating ULBs • Communication about evaluation criteria to ULBs • Feedback from ULBs on the Incentive Fund
9	Design and Management of West Bengal Municipal Development Fund	- Malyan Ray KMDA	The Design and Management details of the fund needs to be prepared and implemented.
C	**Surveys**		
10.1	Participatory poverty assessment	ToR has been prepared	• Tenders need to be invited and the agencies need to be selected. • Deploy and Manage Agency • Translation of guidelines for the understanding of the target population
10.2	Infrastructure Situation Assessment	ToR has been prepared	• CURRENTLY SHELVED

Task Analysis of KUSP Project

Task No.	Task Name	Status	Way forward
10.3	Quick Slum Needs Assessment Survey	ToR has been prepared	• Tenders need to be invited and the agencies need to be selected. • Deploy and Manage Agency
10.4	Socio-Economic Base Line Survey	ToR has been prepared	• Tenders need to be invited and the agencies need to be selected. • Deploy and Manage Agency
D	**Institutional Strengthening**		
11.1	Preparation of Digital Base Map	ToR has been prepared .	• Necessary action be taken to deploy means and method for preparation of Digital Base Maps
11.2	Preparation of GIS	ToR has been prepared for GIS	• Necessary action be taken to deploy means and method for implementing. • Take action on the ToR and appoint suitable agency
12	Design and Implementation of Municipal Information System	-	• Design Road – Map for the MIS • Pilot implementation in few ULBs • Full roll-out in all ULBs
13	Implementation of Accounting Reforms	• The draft manual has been prepared and field tested • ToR issued for the implementation of the IT system	• Implementation of the double entry accrual accounting method -Ensuring that the ULBs are equipped to implement the same. • Appointment of the IT H/w and S/w vendor for the implementation of the Accounting system

Task Analysis of KUSP Project

Task No.	Task Name	Status	Way forward
14	Preparation/Implementation FLIP	• The Fiscal Analysis of ULBs has been done • Guideline have been prepared for FLIP	• Actual preparation of FLIP by ULBS -Ensuring that the ULBs are equipped to prepare the FLIP – Traing the ULBs for preparation of FLIP • Prepare the tools for FLIP • Determining the way ahead after the preparation of FLIP to ensure its implementation -Design action plans to revenue mobilization and cost reduction
15.1	Placements and Appointments in ULBs	-	• Ensuring that people with the right set of competencies are appointed in the ULBs within a specific timeframe -This is to ensure that the ULBs have sufficient capacity to successfully attain the KUSP project objectives
15.2	Co-ordinating Training Delivery in ULBs staff	-	• Training Needs Assessment to understand the training gaps • Identify the right agency to impart training • Identify people who require training • Ensure that training is delivered, as recommended • Training evaluation
15.3	Competitions and Awareness Campaigns	KMDA organized the SWM competition amongst ULBs	• Organize awareness campaigns on issues of concern • Set criteria for competitions • Communicate the criteria to various ULBs • Design the evaluation process
16	Capacity Building for Support Agencies		• Based on the OD review done by the OD Consultants, take necessary steps to enhance the capacity of the SAs -Restructuring of some Support Agencies -Staffing/Manpower planning and Job Descriptions -Performance Monitoring System -Training

Task Analysis of KUSP Project *Contd.*

Task No.	Task Name	Status	Way forward
17.1	Implementation of OD Action Plans in ULBs	OD Action Plans have been prepared	• Implementation of OD Action Plan by the ULBs has to be done -Support the ULBs technically and financially to build capacity for implementing the OD action plan
17.2	**Preparation of OD Plan for DDP**	-	• Guiding the planning for OD component in the DDP
E	**Infrastructure / Environment Dev.**		
18	Trans-municipal infrastructure		Engineering design of trans-municipal infrastructure works needs to be prepared and implemented – Linked to design & implementation of WB Municipal Fund
19	Intra-Municipal Infrastructure	ToR has been prepared for the EDC	• Roll out the intra-municipal engineering ToR (Engg. Design Consultancy) • Hire and manage the agency for the Intra-municipal infrastructure
20	Preparation of State of Environment Assessment Report	ToR has been prepared	• The ToR needs to issued • Co-ordination with the Pollution Control Board • Evaluation and selection of the agency • Manage the agency
21.1	Slum level infrastructure with necessary augmentation in city system	The manual/guidelines have been prepared for Community Participation in Slum Level Infrastructure	• Appointment of the Quality Support Agency • Prioritization of slums based on Quick Slum Survey • Anchor for the implementation of Slum Level Infrastructure

Task Analysis of KUSP Project *Contd.*

Task No.	Task Name	Status	Way forward
21.2	Appointment and Management of Community Support Agency (CSA)	ToR has been prepared	-Appointment of the Community Support Agency to mobilize slum dwellers for the community participation in infrastructure development -Oversight on the performance of the CSA
F	**Social and Livelihood Development**		
23	Economic Visioning	Concept Note and ToR for visioning has been submitted	• Issuing of ToR • Selection and management of the agency
24	Local Economic Development Intervention - model projects	The model for LED interventions has been prepared	• Facilitate ULBs identify and implement LED interventions
25	Entrepreneurship Development and Wage Employment Activities	-	• Implement the employment interventions -Entrepreneurship based -Wage employment based • Ensure that a proper needs survey is conducted to ensure that the right sets of skills are developed in a particular locality • Engage a skills development / training agency and placement agency
26	Strengthening the working of SJSRY	Review of SJSRY has been done and recommendation have been made	• Decisions on recommendations need to be taken • Ensure that the program be implemented with improvements
27	Health Sector Interventions	Review of the current HHW Programmes has been done	• The HHW members need to be trained, • ToRs for engaging trainers need to be done in a timely manner. Decisions to be taken on the recommendations made as per the review • Implementation of the decisions related to Social Insurance, ...

Key Principles

- The role of the SA agency with respect to the work component of CMU will be determined by the *test questionnaire* run for various components of the KUSP Project
  - The possible roles that may arise as a result of test run for various components are –
    - The work component should be **incubated in Support Agency from initial stages itself**
    - The work component should be **incubated in CMU to be transposed to the suitable Support Agency** after the capacity has been built in the SA to take over the work
    - The work component should be **incubated in CMU till its completion**

Facts	Implications
•CMU is a dynamic entity	•CMU organization structure will be fluid
•CMUs priorities will evolve over a period of time	•Positions/roles & responsibilities will change/evolve
•Each component of the KUSP will meet milestones	•Respective positions will either cease to exist or be transposed to Support Agency
•Components of KUSP project will be transposed to SA	•The CMU technical expert will interface with the Support Agency to build capacity

Test Questionnaire - Illustration

- The test will assess all SAs on certain parameters *viz.*
  - Does the work component fit in the existing portfolio of the SA?
  - What is the life of the work component?
  - Does the current capacity of SA permit it to take over the work component?
  - What kind of capacity (Technical/Financial) are needed to carry out the work component? Can such capacity be built in 6 months or less?

Task Name		
S.No.	**Questions**	**Response**
1	Nature of Task – Lifecycle of the Work Component	Temporary / Ongoing
2	Possible SAs that can take over the task	
3	Is the SA the right body to undertake/lead the task in the long run? *Does it fall in line with its current scheme of activities*	Yes/No
4	Does SA currently have the capacity to undertake/lead the task?	Yes/No
5	If the answer to 2 is No then; Can capacity be built in the short term (6 months)? *viz.*	Yes/No
5.1	Training	-
5.2	Domain Expert	-
5.3	IT Systems	-
5.4	Devolution of Powers	-
5.5	*Others*	-
6	What is the available timeframe for the task under consideration? *(Is the task input to another task?)*	months or years
7	Key Capital/other Requirements -	
7.1	Finance	-
7.2	Infrastructure	-
7.3	People/Human Resources	-
7.4	Expert Agency/Consultants for outsourcing work	-
7.5	*Other*	-
Decision		
1	Task to be undertaken by Support Agency _____	-
2	Incubate in CMU and transpose to Support Agency____	-
3	Incubate in CMU till completion	-

Illustrative

DLB:
HBVB
SUDA
ILGUS
KMDA
MED

Test Results – Incubate in CMU and then transpose to SA

Task Name	Implementation of Accounting Reforms	
S.No.	**Questions**	**Response**
1	Nature of Task – Lifecycle of the Work Component	Ongoing . Preparation of the Manual for shifting from Single entry to double entry accounting system. Implementation of the Accounting method and system (IT software)
2	Possible SAs that can take over the task	DLB
3	Is the SA the right body to undertake/lead the task in the long run? *Does it fall in line with its current scheme of activities*	Yes, even though it does not falls in the current scheme of activities of DLB
4	Does SA currently have the capacity to undertake/lead the task?	None of the SAs have the capacity to implement the task
5	If the answer to 2 is No then; Can capacity be built in the short term (6 months)? *viz.*	No
5.1	Training	✓
5.2	Domain Expert	✓
5.3	IT Systems	✓
5.4	Devolution of Powers	-
5.5	*Others*	-
6	What is the available timeframe for the task under consideration? *(Is the task input to another task?)*	Ongoing for another 3 years
7	Key Capital/other Requirements -	
7.1	Finance	-
7.2	Infrastructure	IT Hardware/Software
7.3	People/Human Resources	Trained Finance & Account Professionals
7.4	Expert Agency/Consultants for outsourcing work	CA Firm associated with each ULB for the First Year ONLY
7.5	*Other*	-
Decision		
1	Task to be undertaken by Support Agency _____	
2	Incubate in CMU and transpose to Support Agency____	DLB
3	Incubate in CMU till completion	-

Illustrative

Test Results – Incubate in SA

Task Name	Co-ordinating Training Delivery for ULBs staff	
S.No.	**Questions**	**Response**
1	Nature of Task – Lifecycle of the Work Component	Ongoing task. Identifying training needs and the trainers. Ensuring the delivery of training. Training evaluation.
2	Possible SAs that can take over the task	ILGUS
3	Is the SA the right body to undertake/lead the task in the long run? *Does it fall in line with its current scheme of activities*	ILGUS
4	Does SA currently have the capacity to undertake/lead the task?	Yes
5	If the answer to 2 is No then; Can capacity be built in the short term (6 months)? *viz.*	-
5.1	Training	-
5.2	Domain Expert	✓
5.3	IT Systems	-
5.4	Devolution of Powers	-
5.5	*Others*	Process map of the interface between ILGUS and the ULBs for the training purposes
6	What is the available timeframe for the task under consideration? *(Is the task input to another task?)*	-
7	Key Capital/other Requirements -	Yes
7.1	Finance	Depending the type of training/Agency hired
7.2	Infrastructure	Areas / tools for providing training
7.3	People/Human Resources	Trainers and other resources for Needs Assessments and providing training
7.4	Expert Agency/Consultants for outsourcing work	Yes - Depends on the type of training
7.5	*Other*	-
Decision		
1	**Task to be undertaken by Support Agency** _____	ILGUS
2	Incubate in CMU and transpose to Support Agency____	
3	Incubate in CMU till completion	

Test Results – Incubate in CMU till completion

Task Name	Change Management Unit (CMU) office management and administration	
S.No.	**Questions**	**Response**
1	Nature of Task – Lifecycle of the Work Component	Ongoing as long as CMU exists
2	Possible SAs that can take over the task	None. Since this is a temporary task limited till the time CMU would exist
3	Is the SA the right body to undertake/lead the task in the long run? *Does it fall in line with its current scheme of activities*	NA
4	Does SA currently have the capacity to undertake/lead the task?	NA
5	If the answer to 2 is No then; Can capacity be built in the short term (6 months)? *viz.*	NA
5.1	Training	-
5.2	Domain Expert	-
5.3	IT Systems	-
5.4	Devolution of Powers	-
5.5	*Others*	-
6	What is the available timeframe for the task under consideration? *(Is the task input to another task?)*	Till 2008
7	Key Capital/other Requirements -	NA
7.1	Finance	-
7.2	Infrastructure	-
7.3	People/Human Resources	-
7.4	Expert Agency/Consultants for outsourcing work	-
7.5	*Other*	-
Decision		
1	Task to be undertaken by Support Agency _____	
2	Incubate in CMU and transpose to Support Agency____	
3	Incubate in CMU till completion	**Yes**

Illustrative

Table of Contents - Illustration

February 22, 2005

Dear CMU Member:

Sub: Organization Structuring of CMU

To take forward the various components of KUSP, the Interim Support Consultants (ISC) have developed an approach to examine the way forward on each project sub-component of KUSP and analyzing the role that CMU and each Support Agency can play in implementing the same. Please find enclosed a presentation outlining their approach. The highlights of the presentation comprise:

1. Identification of work components of KUSP projects under five heads - Strategy Planning, Fund Management / Programme Management, Surveys, Institutional Strengthening and Infrastructure / Environment Development
2. Status analysis of the work components and their way forward
3. Mechanism to identify the Support Agency responsible for individual work components.
4. Implications on Organization Structure of CMU

To contribute to the analysis so far, I request each member of CMU to interact with Ms. Jasmit of the ISC, who will get in touch with you to take your inputs.

Yours faithfully,

Anup M. Matilal

Anup Matilal

Project Manager, KUSP
Change Management Unit

Dr. Shibani Goswami
Health Expert, CMU.

CHANGE MANAGEMENT UNIT (CMU)

03.02.05

NOTE

The Interim Support Consultant (ISC) of the Change Management Unit (CMU) will make a presentation of their study on the "DLB managing the ULBs" on 4th February '05 at 2 p.m. in the Conference Hall of SUDA.

DLB, West Bengal is requested to kindly make it convenient to remain present during the presentation along with all the officers of DLB. The officers of CMU are also requested to please attend the presentation.

Anup K. Matilal

(Anup K. Matilal)
Project Manager, CMU

Copy to:

1. DLB
   (With a request to be present during the presentation with all officers)
2. Director, SUDA / Joint Director, ILGUS
3. Technical Advisor, CMU
4. Engineering Expert, CMU
5. Procurement Expert, CMU
6. Health Expert, CMU
7. Municipal Finance Expert, CMU
8. Financial Advisor, CMU
9. OD & Poverty Expert, CMU
10. Urban Planner, CMU
11. Economist, CMU

Anup K. Matilal

Project Manager, CMU

U.O. NO. CMU-44/2003(Pt-II)/182
dt. 3.2.05

Attended

Department of Municipal Affairs &
Urban Development Department.

01.02.2005.

Hon'ble Minister-in-Charge, Municipal Affairs & Urban Development Deptt., desires to **hold a review meeting with the Mayors / Chairpersons of the Municipalities of Howrah, Hooghly and South 24 Parganas districts, on the following developmental programmes** on **7th February, 2005** at **3 p.m.** at the **Conference Hall of SUDA, Salt Lake.**

1) **Antodaya Anna Yojana (AAY):**
   Progress reg. identification of beneficiaries and supply of food grains would be reviewed;
2) **Mid-day Meal Progm. in primary schools and SSKs of Municipal areas;**
   In view of the order of the Hon'ble Supreme Court that all the primary schools & SSKs are to be covered under Mid-day Meal Progm. by 31.03.2005, present status will be reviewed;
3) **National Slum Development Programme (NSDP);**
4) **Utilisation of 11th Finance Commission;**
5) **Progress of KUSP work;**
6) **Integrated Development of Small & Medium Towns (IDSMT);**
7) **VAMBAY;**
8) **Progress of SJSRY;**
9) **Collection of revenue of ULBs;**
10) **Sishu Shiksha Kendra;**
11) **Utilisation of Urban Reforms Incentive Fund**

Hon'ble Minister has desired that Mayors / Chairpersons of Corporations / Municipalities of South 24 Parganas; Howrah and Hooghly Districts may kindly make it convenient to remain present at the above meeting.

Hon'ble Minister has further desired that Secretary, Municipal Affairs Deptt.; CEO, KMDA; Project Director, KUSP; Director of Local Bodies, West Bengal; District Magistrates of South 24 Parganas, Hooghly and Howrah; Director, SUDA; Chief Engineer, Municipal Engineering Directorate and Health Expert, KUSP may also kindly make it convenient to remain present at the above meeting.

1/2/05

PS to MIC, MA & UD Deptt.
Private Secretary to
Minister-in-Charge
Municipal Affairs and Urban
Development Deptts.
Govt. of West Bengal

Health Expert, KUSP.

PS / 45 - D / 2005
01.02.2005.

Attended meeting.
1.2.05

Project Director

From: "Subhronil Ganguly" <subhronilganguly@rediffmail.com>
To: <contact@changekolkata.org>; <kuspcmu@vsnl.net>
Sent: Saturday, January 29, 2005 11:16 AM
Attach: Copy_of_subhronil_new_bio.doc
Subject: Application for the post of social worker

Respected Sir/madam,

Learning from a reliable source I came to know that you are going to recruit some social worker for your esteemed organisation. I beg to offer my candidature for one of the same.

In 2001, I completed my Master Degree in Social Work form Vidyasagar University. While in university, I developed strong organizational and people centered skills. As a coordinator, I organized events, led meetings, and lead team members. As a counselor I developed inter personal communications skills. I maintained budgets and presented reports. My course based in job training also required extensive interaction with the public. I believe these experiences have prepared me for fulfilling of your vacancies. I feel that the job advertised is well suited to the career route I aim to take. .

From the MSW course I have acquired lot of practical knowledge by working in the field of health related field. Regarding theoretical knowledge, I do read extensively and keep myself informed on the latest development in the route.

Please find attached a copy of my Bio Data, which you will notice states I have spent 2 years and 6 months in different reputed NGOs, which enabled me to gain the confidence and application needed to grass root level to managerial level. I hope that I might be considered for this position and look forward to hearing from you soon.

Yours sincerely,

Subhronil Ganguly

Health Expert
May pl. keep in file.
2/2/05

BIO-DATA

SUBHRONIL GANGULY
228, Prafullanagar, Belgharia,
Kolkata – 700056,
West Bengal.
Ph. 033-2564-0677®, 033-2544-0679(PP), 9830595085 (mob)
E-mail – subhronilganguly@yahoo.com, subhronil_ganguly@yahoo.com.
Date of Birth – 21/12/1976
Languages known – Read: English, Bengali, Hindi, Assamia.
Write: English, Bengali, and Hindi.
Speak: English, Hindi, and Bengali.

Career objective:
To obtain a position as a manager of ngo where I can utilize my extensive experience to develop an efficient department and ensure clients' rights.
To secure administrative position involving program planning in an ngo.

Personal profile
Well-organized, reliable administrator and self-starter with experience of managing a project efficiently whilst adapting to the benefits of new technologies. Able to remain calms under pressure and retain a sense of humor and proportion with a sporting ability.
Key Skills
Skilled in team building, team planning, and the development of strategic work plans for short- and long-term teams planning. Has contributed to development and delivery of various project proposals for work in social development, and scores of short-term project proposals.

- Ability to manage and motivate my team of staff
- Awareness of confidentiality and data protection issues
- Competence in Word, Excel, Access, and PowerPoint, internet
- Competence in Microsoft Outlook for managing company email and shared diaries
- Typing 40 wpm

Career History
15.07.04- 31.12.2004
Cancer Foundation of India as a
Field Coordinator - of Collaborative research project on cervical cancer prevention.
Funded by WHO
Responsible for the day-to-day management of a group of dedicated field worker.

- Build up linkages and networking with different VO, NGO and funding agencies.
- Training and supervising 16 members team.
- Documentation of reports, presentations, conducting social research, conduct research and data analysis/tracking of clinic client population.
- Writing agendas, minutes and reports dealing with queries from members of the public, proposal writting
- Fund raising activity, Financial Management, database registration, field level and indoor management.
- Improving BCC materials, advocate cancer prevention and treatment facility, Educate on secondary prevention
- Monitoring and evaluation.
- Ensure appropriate care for Cancer patients is being met through thorough review of records; create maintain statistical database to track patient medical care.

- Establish and foster partnerships with other city and districts Health service agencies; facilitate off-site referrals.
- Oversee grants, including developing, implementing, and evaluating continuous Quality improvement projects
- Facilitate communications with care providers' recruit community members to participate in the fight against cervical cancer.
- Provide psychosocial screening, counseling, and testing and patient education on cancer care.
- Target acute/crisis management needs for newly diagnosed cancer patients.
- Oversee daily operations, including directing participants to available community resources.

1.07.03-14.07.04

Narayantala Mass Communication Society as a
Counsellor - Brick Kiln Migrants Labors TI project on HIV/AIDS/STDs Prevention and Awareness

- Responsible for the day-to-day management of a 22 person department
- Training and supervising junior staff
- Compiling monthly statistical returns, documentation of reports, presentations, conducting social research
- Writing agendas, minutes and reports
- Dealing with queries from members of the public
- Incharge of condom social marketing
- Providing support to members of the Social Work team
- Coordination, Planning, Monitoring, evaluation, advocacy, BCC planning and implementation
- Designed and implemented treatment strategies that included group and individual counseling.
- Oversaw medication disbursement; liaised with client network resources; assisted clients in daily living

1st May 2002 to 30th -April 2003
CINI ASHA (An urban unit of CINI Child In Need Institute) as a
Program Associate and assignment staff

- Administration (Coordination, Supervision, Monitoring, Evaluation, Planning, Policy design) of Rehabilitation of children at risk station & Street children) Program, Project planning and management,
- Helping to Child line (1098), Intervention of child health project
- STD, HIV, AIDS Hotline telephone counseling as a telecounsellor, Involvement of sexual health project,
- Community mobilization, on urban slums for education and mainstreaming the children in need through bridge course (Supervision, Monitoring & Evaluation of non-formal education.),
- Organize & prepare different social research and study reports of CINI ASHA, Documentation o,
- Financial and budget management, Networking with different govt. and non govt. setup and different system of local bodies, Staff and human resource management
- Group and individual counseling, case management, group work, community participation, proposal preparing and management,

- Intervention on adolescent behavior management, Rehabilitation of deprived girls
- Coordinate a cultural professional group of street children

April to August 2001
Loomtex Engg. Private Ltd. (Titaghur Jute Mill)
(Fieldwork exp. As a personnel officer's assistant.)
Negotiation, Research, Settlement, Recruitment, Performance evaluation, Lobar and human resource management, Social security, Trade union handling, Works committee, Disciplinary action, Placement, Welfare measures utilization, counseling, employee training,

Feb to July 2000
National Institute for the Orthopaedically Handicapped
(Fieldwork exp. As a Social Workers assistant)
Survey, Training to disable and ICDS team member, Case management, Group work, Community sensitization, Intervention in Community Based Rehabilitation Project, AGPs, Research, Aids and limbs distribution programs, workshops on disabilities, micro finances and SHG involvement, monitoring and evaluation, counseling, IGP.

Last Salary: 6000/- (consolidated)
Expected Salary: Negotiable
Educational Qualification

2001	Master of Social Work from Vidyasagar University with II Class Specialization with Labor Welfare, Industrial Relations, Personnel Management Human Resource Development. Subjects History & Philosophy of SW, Methods of SW (Case work, Group Work, Community Organization), Sociology, Economics, Psychiatry, Psychology, Statistics, Social research, Social Problems, Law and legislation, Health and Hygiene, Urban community development, Rural community development, Criminology, Social welfare administration, Labor welfare, Industrial relations, Personnel Management, HRM. Research Experience: Conducted dissertation on OCCUPATIONAL HEALTH HAZARDS AND PREVENTIVE HEALTH PROVISIONS INTERVENTION- A CASE STUDIY ON HINDUSTHAN COTTON MILLS LTD.
1998	B.Com (Hons.) from Calcutta university with II class Subjects Accountancy, Higher A/c, Costing, Taxation, Economics, Statistics, Mathematics, Secretarial Practice, Business Management, Mgt.A/c, Audit, Law, Business organization, Geography
1995	Higher Secondary from W.B.C.H.S.E. with II Division Subjects Accountancy, Economics, Business organization, Geography, Mathematics, Bengali, English
1993	Madhyamik from W.B.B.S.E. with I Division Subjects Bengali, English, History, Geography, Mathematics, L.Sc, P.Sc. Chemistry

Seminar, Workshops, Training Programme Attended:

- Two Trainings on STD/HIV/AIDS Awareness and prevention (West Bengal State AIDS Prevention and Control Society)
- Workshop on Widows Rehabilitation (J.P. Institute for Social Change)
- Monitoring and Evaluation Programme a seminar organized by NIPCCD
- Workshop on Legal Literacy of Women (J.P. Institute for Social Change)
- HIV/STD/AIDS Counseling Training Programme for VCTC and Telephone Counselors in different centers (Vivekananda Education Society & W.B.State AIDS Prevention and Control Society)
- Training on Community Mobilisation (CINI ASHA)
- Training on Counselling (CINI ASHA)
- Training on implementation of Bridge course in urban slum children for non formal education (CINI ASHA)
- Pedagogy training by (CINI ASHA)
- Training on Bridge Course Monitoring and Evaluation (CINI ASHA)
- Training on Behavioural Psychology (ANNEAGRAM) by SERVE
- Training on Adolesescence Sexual Health by CINI CHETNA RESOURCE CENTRE
- Training on Base Course and Staff development (CINI ASHA)
- Trainings and Workshops on Behaviour modification therapy through cultural process (CINI ASHA)
- Targeted intervention counselors training By SMA and SACS
- Internal training of NMCS on BCC, Enabling Environment,
- International Training Programme on Planning For Care & support of PLWHA by IIHMR & BRCHBT from2-6 Feb, Kolkata
- I-Star training programmes on capacity assessment by PCI from 22 to 24 March, 04
- Training on communication materials designing and participatory communication by CFI .
- Training on research and data collection by ACN-ORG-MARG

Reference:
Mr. Joydeb Majumdar 2529-6912
Deputy Director of J.P. Inst. For Social Change
Mr. Malay Das 9830032365
Secretary, Narayantala Mass Communication Society
Dr. P Sen.,
Principal Vidyasagar School of social work,
Ph. 2337-6695

SUBHRONIL GANGULY

In order to facilitate the CMU take the programme implementation forward, we (ISC) will need to foresee the activities in the forthcoming one year, competencies required for the same, specific staff / personnel required for the same within CMU.

Workstreams	Workplan for workstream (over next 1 month, 6 months, 12 months)	Competencies required	Specific staff / personnel (within CMU, within SOs, outsourcing – through contractual staff / consultants)	Team working arrangements (working arrangements between the specific responsible staff / SOs / external resources)
• ...	• ... • ... • ... • ...	• ... • ... • ... • ...	• ... 1 nutritionist • ... Monitoring & • ... supervision cell • ...	• ... • ... • ...
For e.g. Challenge Fund	• *Fund management system to be in place* *- first yr – Dec 04* *- Second yr onwards -- Mar 04* • *Civil society inputs in project selection – Jan 04* • *Communication & dissemination amongst civil society – Dec 04*	• *Project appraisal* • *Technical support to NGOs / CBOs* • *Capacity assessment of CBOs / NGOs / CDSs* • *Communication & dissemination skills*	• *CMU – staff assigned* • *SUDA – specific actions* • *Fund Manager –* • *Others ??*	• *Fund Manager will report* *- periodically to Project Selection Committee* *- daily basis to CMU* • *Fund Manager debrief & meet CMU experts on fortnightly basis to ...* • *Fund Manager will monitor communication dissemination impact with C&PR agency*

PLEASE BE DETAILED, SPECIFIC & BRIEF. INCLUDE ONLY MAJOR / SIGNIFICANT POINTS. NOT TO EXCEED ONE PAGE FOR EACH WORKSTREAM.

Statement showing population covered under CUDP-III and IPP-VIII in different Municipalities

Sl. No.	Name of the Municipality	CUDP-III		IPP-VIII	
		No. of HAUs/ Subcentres	Population covered	No. of HAUs/ Subcentres	Population covered
1.	Baidyabati	1/6	31,067	2/11	47,099
2.	Bally	1/6	29,393	3/21	1,03,857
3.	Bansberia	1/6	29,064	2/14	70,797
4.	Baranagar	1/6	30,620	1/7	35,720
5.	Barasat	1/6	23,862	7/42	2,07,462
6.	Barrackpore	1/6	31,086	2/11	52,949
7.	Baruipur	1/5	22,695	-	-
8.	Bhadreswar	2/12	61,070	2/11	57,290
9.	Bhatpara	-	-	6/38	1,94,848
10.	Bidhannagar	-	-	1/6	37,157
11.	Budge Budge	1/6	30,376	2/11	50,426
12.	Champdani	1/6	30,287	2/13	61,044
13.	Chandannagar	2/12	57,886	1/6	32,962
14.	Dum Dum	1/4	21,530	1/6	29,422
15.	Garulia	2/12	61,280	1/7	35,203
16.	Gayeshpur	1/6	29,430	1/7	35,239
17.	Halisahar	1/6	30,868	2/14	73,974
18.	Hooghly Chinsurah	2/12	59,163	3/6	89,536
19.	Howrah	2/16	87,410	11/44	3,20,300
20.	Kalyani	-	-	1/7	35,478
21.	Kamarhati	-	-	4/28	1,27,309
22.	Kanchrapara	1/6	30,988	2/13	61,378
23.	Khardah	1/6	27,823	3/21	1,05,025
24.	Kolkata	12/90	4,35,892	1/7	31,195
25.	Konnagar	1/6	30,205	1/7	35,050
26.	Madhyamgram	-	-	3/19	95,523
27.	Maheshtala	-	-	6/41	1,99,148
28.	Naihati	1/6	28,875	2/14	69,089
29.	New Barrackpore	1/4	19,470	2/11	55,973
30.	North Barrackpore	2/12	53,192	2/12	51,552
31.	North Dum Dum	1/6	30,472	3/13	89,069
32.	Panihati	2/12	59,060	4/28	1,46,534
33.	Pujali	-	-	1/7	35,931
34.	Rajarhat Gopalpur	-	-	6/26	1,95,672
35.	Rajpur Sonarpur	1/6	26,897	4/28	1,41,312
36.	Rishra	1/6	31,661	3/14	89,353
37.	Serampore	1/6	29,740	4/21	1,23,530
38.	South Dum Dum	-	-	6/41	1,97,669
39.	Titagarh	-	-	3/14	1,04,888
40.	Uluberia	1/6	33,396	3/14	1,32,105
41.	Uttarpara Kotrung	2/12	48,868	2/14	67,590

Total No. of HAUs under CUDP-III & IPP-VIII	-	166
Total No. of Subcentres under CUDP-III & IPP-VIII	-	992
Total Population covered under the projects – CUDP-III & IPP-VIII	-	52,79,284

(Statement showing Contraceptive prevalence in IPP.doc)

Performance in Immunisation Programme in CUDP-III & IPP-VIII areas in different municipalities, 2002–2003.

Sl. No.	CUDP-III & IPP-VIII areas in municipalities	Live Births	Immunisation status (% Coverage)				Remarks
			BCG	DPT	OPV	Measles	
1.	Baidyabati	654	96.8	97.1	98.2	92.0	
2.	Bally	1332	96.6	96.2	96.8	89.2	
3.	Bansberia	1204	98.3	98.3	98.9	90.2	
4.	Baranagar	302	96.4	97.4	98.3	89.7	
5.	Barasat	3454	98.4	98.0	98.7	94.1	
6.	Barrackpore	743	97.7	96.9	97.4	91.4	
7.	Baruipur	206	93.7	95.1	97.6	89.3	
8.	Bhadreswar	1288	98.7	98.1	98.8	90.2	
9.	Bhatpara	1316	98.0	97.2	97.9	88.1	
10.	Bidhannagar	462	96.1	96.0	96.3	88.3	
11.	Budge Budge	739	96.9	97.6	98.2	90.8	
12.	Champdani	704	93.0	96.9	98.0	89.8	
13.	Chandannagar	588	98.0	98.3	98.8	91.7	
14.	Dum Dum	367	96.5	96.5	97.5	89.6	
15.	Garulia	716	90.0	97.6	97.8	93.2	
16.	Gayeshpur	641	95.8	96.3	98.0	90.3	
17.	Halisahar	1140	97.5	96.8	98.0	84.3	
18.	Hooghly Chinsurah	1499	98.3	97.2	98.7	92.8	
19.	Howrah	4033	96.6	96.6	97.4	87.6	
20.	Kalyani	504	96.7	95.3	96.9	85.4	
21.	Kamarhati	799	98.2	97.1	98.1	87.9	
22.	Kanchrapara	779	97.0	96.7	97.6	80.6	
23.	Khardah	987	87.4	97.0	98.3	89.9	
24.	Kolkata	3501	99.4	99.1	99.6	95.9	
25.	Konnagar	584	97.9	97.1	98.5	91.4	
26.	Madhyamgram	976	98.4	98.2	98.7	90.6	
27.	Maheshtala	1907	95.6	95.1	98.5	86.7	
28.	Naihati	781	98.3	97.9	98.7	90.4	
29.	New Barrackpore	631	98.9	98.3	98.9	90.7	
30.	North Barrackpore	862	98.6	98.1	98.8	90.6	
31.	North Dum Dum	1109	97.8	97.5	98.6	90.2	
32.	Panihati	2353	98.0	98.1	98.5	91.8	
33.	Pujali	450	96.7	95.8	96.2	86.5	
34.	Rajarhat Gopalpur	2101	98.1	96.1	96.4	88.0	
35.	Rajpur Sonarpur	1475	97.8	97.2	98.2	89.9	
36.	Rishra	881	97.4	96.3	97.9	88.6	
37.	Serampore	1319	97.7	97.2	97.8	91.8	
38.	South Dum Dum	2168	98.7	98.0	98.7	91.0	
39.	Titagarh	1058	97.9	96.7	98.2	88.3	
40.	Uluberia	1772	96.9	95.8	97.6	89.0	
41.	Uttarpara Kotrung	1159	97.4	97.3	98.3	91.8	

(Statement showing Contraceptive prevalence in IPP.doc)

Consolidated Monthly Report Under IPP-VIII, Kolkata

Sl. No.	Name of the Municipality	Total Population	No. of HAU	Eligible Couple	No. of Infants (under 1 year)	No. of Children (1-2 year)	No. of Children (2-5 yerrs)	ANC Registered	ANC- have received 3 Check-ups	How many received TT2	Inst Delive
1.	Bally	97891	3	14884	958	6908	1725	237	53	140	148
2.	Baidyabati	48225	2	8284	744	3254	881	137	112	88	88
3.	Baranagar	35740	1	4760	203	2086	549	70	51	42	55
4.	Bansberia	69414	2	10960	689	4389	1210	256	128	148	124
5.	Bhatpara	190174	6	26586	1616	10980	3254	338	130	176	198
6.	Barrackpore	53333	2	8035	389	3471	1037	179	110	116	56
7.	Bidhannagar	38356	1	7177	582	3822	786	128	85	88	78
8.	Budge Budge	51079	2	7584	610	3358	765	132	74	85	99
9.	Barasat	204868	7	32921	2549	17847	17133	550	292	302	314
10.	Chandannagar MC	32997	1	5500	212	1580	475	59	20	29	31
11.	Champdani	61649	2	9249	404	4467	657	151	113	126	70
12.	Dum Dum	27847	1	4480	351	2415	695	62	34	23	31
13.	Gayeshpur	32938	1	5830	385	2495	725	103	48	77	63
14.	Garulia	35081	1	4930	258	2024	286	64	10	55	53
15.	Hooghly Chinsurah	88976	3	13227	937	7097	1607	200	137	144	100
16.	Howrah M.C.	322694	11	47764	6981	29646	8480	718	371	317	606
17.	Halisahar	75545	2	11131	867	5969	1850	213	51	109	113
18.	Konnagar	34512	1	5374	330	2781	648	75	61	66	52
19.	Kalyani	35892	1	6114	538	3169	902	105	15	50	62
20.	Kanchrapara	59658	2	9305	703	4016	1021	120	26	105	93
21.	Khardah	93342	3	15679	1019	7339	2034	227	198	211	134
22.	Kamarhati	125721	4	19786	1037	8025	10537	192	139	120	160
23.	Kolkata MC	31463	1	3555	299	1801	382	67	9	28	33
24.	Maheshtala	195910	6	31612	2107	18795	5499	390	72	242	274
25.	North Dum Dum	96384	3	15245	914	5337	1004	475	369	320	173
26.	Panihati	144645	4	22098	1564	10987	2729	522	383	348	298
27.	Pujali	34547	1	5400	509	2793	520	182	132	129	61
28.	Rishra	84475	3	13057	985	6144	1789	166	110	92	95
29.	Rajpur Sonarpur	87902	4	15444	1723	9755	2361	270	114	125	141
30.	Rajarhat Gopalpur	186647	6	29058	2519	14091	4469	548	328	298	347
31.	Serampore	128243	4	18924	1322	7829	2132	297	169	209	204
32.	Titagarh	104887	3	15833	2377	9288	2173	322	172	223	198
33.	Uttarpara Kotrung	64124	2	10408	2406	4505	1098	198	94	153	92
34.	Uluberia	106841	3	16517	1562	11713	1615	412	379	386	335
35.	Bhadreswar	57290									
36.	Madhyamgram	95523									
37.	New Barrackpore	56093									
38.	North Barrackpore	51521									
39.	Naihati	69089									
40.	South Dum Dum	195997									
	Total	**3607513**									

EC

MAHESHTALA MUNICIPALITY
Maheshtala, South 24 Parganas

ORDER 16 DEC 2004

Smt. Kalyani Halder, C/o Shri K.Halder residing at "Jeevan Vihar", of 249 N.S.C Bose Road, P.O. Naktala,Kolkata-700047, was engaged to act as Urban Health Improvement Organiser under IPP-VIII of this Municipality on contract basis for a period of one year with effect from 15.11.2003, in persuant to Government order No.95/MA/P/C-10/- 26.2.2003, dated 14.01.03 of the jount Secretary to the Government of West Bengal Municipal Affairs Department, Writers' Buildings Kolkata.

The tenure of Service of Smt. Kalyani Halder U.H.I.O is hereby extended from a further period of one year with effect from 16.11.2004, on the existing terms and conditions.

Sd/-
Executive Officer
Maheshtala Municipality

Memo No : 3635(12)/14/MM/395. Dated : 2.12.04

Copy forwarded for information and necessary action to :-

1. Joind Secretary to the Govt. of West Bengal, Municipal Affairs Department, Writers' Building, Kolkata-1.
2. Chief Executive Officer, K.M.D.A.,
3. Adviser (Health) S.U.D.A.
4. Chief of Health, IPP-VIII, KMDA,
5. Vice-Chairman, Maheshtala Municipality.
6. C.I.C. Health. "
7. Finance Officer. "
8. Health Officer. "
9. Smt. Kalyani Halder,"Jeevan Vihar",249,N.S.C Bose Road, Naktala, Kolkata - 700047.
10. Superintendent, Matrisadan, Maheshtala Municipality.
11. Head Clerk. "
12. Office Copy.

02.12.04

Executive Officer
Maheshtala Municipality

MAP DEPICTING PROJECT AREA UNDER KUSP

PHONE : 2477-9245

RAJPUR - SONARPUR MUNICIPALITY

P. O. HARINAVI, SOUTH 24-PARGANAS

Ref. No.....

Date 11.1.2005.

To

The Project Director
CMU, KVSP

Sub:- Timing of Health Steering Committee meeting KVSP

Sir,

I like to inform you that it will be convenient for me if you kindly arrange the Health Steering Committee KVSP meeting at about 2 PM instead of early or late hrs of the day in future.

Thanking you

Yours faithfully

I agree the same.
Sd/ H.O. Bhadreswar.
11/1/05.

Sd/
H.O.
S.D.O.M.

S.D.O.
Rajpur - Sonarpur
Municipality
Member KVSP Health Steering Committee

OFFICE OF THE BOARD OF COUNCILLORS
KANCHRAPARA MUNICIPALITY
42, Lenin Sarani (east), Kanchrapara, North 24 Parganas.
Phone No. 2585 4354, Fax – 25858247

U.O.NO. CMU-94/2003
dt. 14.12.04

No. 2303

Dated, Kanchrapara, the 4th Dec., 04.

From: Shri Sankar Lal Basak,
Chairman, Kanchrapara Municipality.

To : Sri Arnab Roy
Project Director
Changed Management Unit, KUSP

Sub : K.U.S.P. fund for better Health Service initiative.

Ref : Your memo no. CMU-185/2004/282.
Dated 25.10.2004.

Dear Sir,

Health services given by the 111 nos. of lady Health Workers at very low amount of honorarium of Rs. 700/- per month under C.U.D.P. – III & I.P.P.- VIII health programmes in which they have to go from door to door with medical kits or move around for implementation of Immunisation programmes (e.g., leprosy, D.T.P., Health awareness etc.). They need mobility, identity and protection from adverse weather for better performances.

Hence the Board of Councillors propose that each one of them be provided with the following articles essential for their service rendering ;

1. Bicycle
2. Badge
3. Bag
4. Umbrella

The cost involvement in this matter is estimated as follows :

1. Bicycle	@ Rs. 1200/- each,	Rs. 1200 X 111	=	Rs. 1,33,200 .00
Badge	@ Rs. 25/- each,	Rs. 25 X 111	=	Rs. 2,775.00
2. Bag	@ Rs. 125/- each,	Rs. 125 X 111	=	Rs. 13,875.00
3. Umbrella	@ Rs. 100/- each,	Rs. 100 X 111	=	Rs. 11,100.00
			Total	Rs. 1,60,950.00

An allotment of fund from K.U.S.P. will enable the Municipality to carry out the resolution .Otherwise it would put an additional burden on the Municipal fund which we are trying to augment by tapping various sources of revenue and observing thrift.

Awaiting favourable response from your end.

Yours faithfully,

Basak 2.12.04

(Sankar Lal basak)
Chairman
Kanchrapara Municipality.

925
16.11.04

2589-8579
Fax & Phone : 2589-9614
2589-9615
Unit Office at Gayeshpur : 2589-9630

OFFICE OF THE
GAYESHPUR MUNICIPALITY
P. O. KATAGANJ, DIST. NADIA.

From :
Chairman / Executive Officer
Gayeshpur Municipality

Ref. No. GM\64.2602/2004. Date 10/11/04

To
The Project Director, CMU,
KUSP,
ILGUS Bhavan,
H.C.Block, Sector-3,
Bidhannagar,
Kolkata- 700106.

Sub:- Suggestion regarding components of K.U.S.P. Programme.

Ref:- Your memo No. CMU-185/2004/282 Dt.25/10/2004.

S i r,

As desired vide memo under above reference I beg to submit suggestion on the following three components of KUSP Programme.

1) Health.
2) Innovative/Challenge Fund.
3) Economic Development.

1. Health

H.H.W.based health system should be sustained and augmented. The people under BPL should be provided with the facility of medical treatment at free of cost. Diagnostic charges i.e. X-Ray, Scan, ECG etc. should be free to them. Medical officers in the Maternity are inadequate. This problem should be removed.

The Health Units in the Municipality should be equipped with Doctors. This problem is acute in most of the ULBs. Full-time Doctors should be arranged in the Maternity Homes.

2. Innovative/Challenge Fund.

The CDS, NGO, Academic Institutions, and other benevolents organisation should be made well aware of the developmental Schemes for rendering service to the poorest of the poor. A broad publicity should be under taken by the Municipality to encourage the local institution to prepare theme for the poor. The provision of fund will be made by the K.U.S.P. depending upon the objective of the schemes. The ward Committees are requested to enthuse the local interested bodies to chalk-out the beneficial programme for long-term welfare service to the poor.

Contd.....p|2.

Phone No : 26610274
Fax No. : 26611395

ULUBERIA MUNICIPALITY

ULUBERIA ★ HOWRAH

REF. NO..... DATE.....

To
The Officer-on-Special Duty,
Health,UHIPU, K.M.D.A.,
Unnayan Bhaban,Bidhannagar,
G Block, K o l k a t a-700 091.

Sir,

With reference to your letter bearing Memo No.976(40)/1-1/ KMDA/UHIPU/04, Dt.24.11.2004 furnishing herewith the names, address and contract numbers of Trainees for the 'Trainers' Training (Refresher Training) at the KMDA Headquarter.

Sl.No.	N a m e.	Designation.	Address with Telephone No.
1.	Dr.Swapan Kumer Mondal.	Health Officer.	Vill.& P.O.-Khalisani, Dt.-How. 26610274 (Office) Contract No.2691-0349.
2.	Dr.Kallyan Kumer Sarkar.	P.T.M.O.	Vill.& P.O.-Burikhali, Dist.-Howrah. Tel.Ph.No. 2661-8205. Mobile No.9831027997.
3.	Dr.Seikh Kalu Mollah Mahammad Zakaria.	P.T.M.O.	Vill.-Balarampota, P.S.-Panchla,Dt.-Howrah Tel.Ph.No.-2661-9253, 2661-0967. Mobile No.9831288539.

For necessary action please.

Yours faithfully,

Sd/-
Chairman,
Uluberia Municipality.

Memo No. um/3568/1 Dated 15.12.04

Copy forwarded for information and necessary action to : The Project Director,Change Management Unit,Kolkata Urban Services for the poor,ILGUS Bhaban,Sector-III,Bidhannagar, Kolkata- 700 106.

13.12.04
Chairman,
Uluberia Municipality.
13.12.04

BARRACKPORE MUNICIPALITY

B.T. Road, P.O. : Talpukur, North 24 Parganas

Dr. Goswami
21/12

Memo No. 1153/Health/BM

Dated 20.12.2004

From :

MAHADEB GHOSH
Chairman

To : Project Director,
C.M.U./KUSP.

Ref : Memo No. CMU - 94/2003/405 (40) dt. 14.12.04.

Sub : Presentation on Key observations and recommendations with regard to Health Care delivery in ULBS by Interim Support Consultants under KUSP.

Sir,

With reference to above , I am sending herewith Dr. Pabitra Kumar Biswas , M.B.B.S. , a Part-time Medical Officer, under IPP VIII to remain present in the presentation session on 21.12.04 at Ilgus Bhavan from 2.00 p.m. to 4.00 p.m. for participation and sharing of views.

Dr. Ashutosh Chowdhury, Health Officer, is on leave in connection with his mother's sad demise and the post of AHO is lying vacant for a pretty long time.

With thanks.

Yours faithfully,

20/12/04
Chairman,
BARRACKPORE MUNICIPALITY.

29/12/04

Phone : 2592 - 0221/5565/ 1067(O), 2592 - 2679(Fax), 2592 - 0948(R)

KOLKATA URBAN SERVICES FOR THE POOR

CHANGE MANAGEMENT UNIT

Memo No.CMU-94/2003/479 **Date..03.01.2005**

05

The 2nd meeting of the **Health Steering Committee**, KUSP will be held at **SUDA Conference Hall**, ILGUS Bhavan, HC Block, Sector - III, Bidhannagar, Kolkata - 700 106 on **11.01.2005 at 04.00 P.M.** to discuss the design of the health activities under KUSP in the 1st year.

All the members of the Health Steering Committee and Technical Adviser, CMU are requested kindly to make it convenient to attend the said meeting.

A brief note on proposed health activities under KUSP in 1st year is enclosed.

Arnab Roy, IAS
Project Director, CMU

Copy forwarded to :

1. Secretary, KMDA
2. Dr. A.K. Ghosh, Chief Technical Officer, SPSRC, DHFW
3. Project Manager, CMU
4. Technical Adviser, CMU
5. Mayor, Chandannagore Municipal Corporation
6. Chairman, New Barrackpore Municipality
7. Dr. N.G. Gangopadhyay
8. Health Officer, South Dum Dum Municipality
9. Health Officer, Bhadreswar Municipality
10. Health Officer, Rajpur-Sonarpur Municipality
11. Health Expert, CMU.

Project Director, CMU

Copy for kind information to :

1. Secretary, Municipal Affairs Dept.
2. PS to MIC, MA & UD Dept.
3. Project Director, CMU

Project Director, CMU

ILGUS BHAVAN, HC BLOCK, SECTOR 3, BIDHANNAGAR, KOLKATA /00106
Ph : 033-2334 2660, 2337 7315, 2358 6403/5767
Fax : 033-2337 7318/2358 5800
email kuspcmu@vsnl.net

Brief notes for designing health activities under KUSP in the 1st year

DFID during their last review meeting held during 1 - 3 December, 2004 discussed on health components. The following decisions were arrived at :

I. KUSP health component in the 1st year can comprise of support to HHWs across 61 ULBs (40 KMA and 21 Non-KMA) for uniforms, kits and re-training.

II. CMU will arrange for piloting the use of private sector health insurance for poor citizens in 2 ULBs.

III. CMU will put forward a considered proposal for either improve mobility or contingency in the form of a "Referral Fund".

IV. ISC, as part of their review, will examine the ULB position with respect to Refurbication of Sub-Centre (cost effectiveness, levels of utilisation etc.).

Pursuant to those decisions, the following activities along with process details have been designed and are placed before the Health Steering Committee for consideration and approval.

1. Re : Uniform

Grass root level health functionaries are HHWs and FTSs. Though DFID has approved uniform for HHWs, it is strongly felt that FTSs are also to be provided with the uniform, the colour of which will be different from that of HHWs'.

a) Initial discussion with cross section of the HHWs regarding their views on texture and colour of the uniform which includes Saree, Blouse and petticoat.

One discussion session with HHWs & FTSs each for East Bank ULBs, West Bank ULBs and ULBs of Southern part.

(2 HHWs and 1 FTS per ULB will participate in the discussion session. The venue will be at a ULB which is more or less centrally located.)

b) Consensus on texture & colour of Uniform will be ascertained through these discussion sessions.

c) Mode of procurement

(i) CMU will procure Sarees, cloth for blouse and petticoat, 70 nos. each for providing samples to 61 ULBs and 9 set of samples to be kept with CMU.

(ii) Procurement at ULB level will be done by the respective ULBs through their Purchase Committee maintaining norms set forth by CMU.

d) Estimated Cost :

1 Saree - Rs.200/-

1 Petticoat - Rs.70/-

Cloth for 1 Blouse and stitching charge - Rs.80/-

Total estimated cost for 1 set of Uniform - Rs 350/-

e) Double set of uniforms are required to be provided per HHW and FTS.

f) **Cost involvement for double set of uniforms for HHWs and FTSs is Rs. 54,73,300/- including cost for samples.**

g) A communication from CMU is required to be made to the ULBs to ascertain the actual no. of HHWs and FTSs now working.

h) Fund for procurement of uniform (actual no. of HHWs & FTSs per ULB x cost for 2 sets of uniform) may be released to the ULBs by CMU.

i) SOE and U.C. will be submitted by the respective ULBs to CMU in due course.

2. Re : HHW Kit

DFID assisted Honorary Health Worker Scheme has been launched in 10 ULBs of Non-KMA with effect from 01.02.2004, where HHW Kit with contents had already been procured by Central Co-ordinating Cell, SUDA and provided to the ULBs concerned.

It is proposed that the same type of Kit Bag with contents may also be provided to the HHWs of the remaining 51 ULBs (40 ULBs in KMA and 11 ULBs in Non-KMA).

Mode of procurement

1. Like uniform, CMU may procure 62 HHW Kit Bag with contents to provide to the ULBs as approved sample. ULBs will procure the same through their respective Purchase Committee maintaining the norms set forth by CMU.

- **Estimated unit cost of Kit Bag with contents - Rs. 300/-**
- **Estimated cost involvement in KMA ULBs 4,751 HHWs x Rs. 300/- = Rs. 14,25,300/-**
- **Estimated cost involvement in Non-KMA ULBs 1,477 HHWs x Rs. 300/- = Rs. 4,43,100/-**
- **Estimated Grand Total Cost involvement - Rs. 18,87,000/- including cost for samples.**

3. Re : Re-training

Re-training at different level of health care providers i.e. HHW, FTS, STS / ANM, PTMO, HO, AHO and UHIO are essentially required for updating of technical knowledge & skill and strengthening of Primary Health Care services at door step.

For this purpose, the following are proposed :

a) Training of HOs and AHOs in public health and management / supervision outside the state of West Bengal. Proposal for the purpose will be mooted by CMU to DFID for approval and identification of suitable institutes.

- Total no. of HOs and AHOs both in KMA and Non-KMA ULBs are around 100. Hence, at least 3 batches will be made for training.
- Duration of training for each batch will be of 7 days.
- Target date of completion by March, 2005.

b) Trainers' training for imparting training to HHWs and FTSs.

- Identification of trainers (HO, AHO and PTMO), 3 to 4 from each ULB by the Chairperson and forwarding the list to CMU.
- Trainers are to be nominated by the CMOH for imparting training on National Health Programmes. The Chairperson of the ULB will liase with the respective CMOH.
- Training venue - at CMU, SUDA.
- Duration - 2 days.
- For KMA ULBs - 160 trainees - 4 batches, each batch comprising of 40.
- For Non-KMA ULBs - 44 trainees - 2 batches.
- Training to trainer will be imparted by CMU.
- Target date of completion - March to April, 2005.

c) Training of HHWs.

- For KMA ULBs total no. of HHWs as per record is 4750 and for Non-KMA ULBs is 1470 (excepting 260 no. of HHWs under DFID assisted Honorary Health Worker Scheme in 11 Non-KMA ULBs).
- No. of batches will be decided per ULB depending upon the no. of HHWs.
- On an average 180 training batches for HHWs in KMA ULBs and 36 training batches in Non-KMA ULBs.
- Training module will be developed by the Outsource institute / agency i.e. All India Institute of Hygiene & Public Health, WBVHA and the like.
- Duration of training including practical - 12 days for each batch.
- Training venue - at respective ULBs.
- Co-ordinator of the training - Health Officer (AHO where there is no HO) of the respective ULBs.
- Monitoring and evaluation by CMU at ULB level by a group of professionals having expertise in community based health programme.
- Tentative date of initiation / completion - Mid April, 2005 - January, 2006 respectively.
- Estimated total cost involvement for re-training is Rs 58.77 lakhs for KMA ULBs and 20.29 lakhs for Non-KMA ULBs.

d) Training of FTSs.

- For KMA ULBs total no. of FTSs as per record is 910 and for Non-KMA ULBs is 345.
- Suitable nos. in a batch will be 20 to 25. The ULBs having less than 20 FTSs will be clubbed with adjacent municipality to form the required batch.
- Training module will be developed by the Outsource institute / agency i.e. All India Institute of Hygiene & Public Health, WBVHA and the like. The module include comprehensive HHWs training curriculum and monitoring / supervisory capacity building.
- Duration of training including practical - 5 days for each batch.
- The training venue will be either at the municipality where no. of FTSs are within 20 to 25 or in other cases at conveniently located ULBs.
- Co-ordinator of the training - Health Officer (AHO where there is no HO) of the respective ULBs.
- Monitoring and evaluation by CMU at ULB level by a group of professionals having expertise in community based health programme.
- Tentative date of initiation - completion - May, 2005 - December, 2005 respectively.

e) Training of STSs.

- Tentative load for KMA and Non-KMA ULBs is 130 & 96 nos. respectively.
- Each batch comprising of 30 to 35 STSs.
- Duration - 3 days
- Training venue - at CMU.
- Training by the professionals of CMU.
- Preparation of training curriculum - by the same process as described for HHWs and FTSs above.
- Tentative date of initiation / completion - July, 2005 - August, 2005 respectively.

f) Training of UHIOs.

- Will be done at CMU level.
- Duration - 2 days.
- Tentative date of initiation / completion - August, 2005 - September, 2005 respectively.

g) Training of PTMOs.

- Will be done at CMU level.
- Duration - 2 - 3 days.
- Tentative date of initiation / completion - May, 2005 - July, 2005 respectively.

- Estimated cost involvement for re-training of all category is Rs 150.00 lakhs approximately.

- DFID assisted Honorary Health Worker Scheme has been launched in 11 Non-KMA ULBs with effect from 01.02.2004. The training to HHWs has been completed recently. During drawing of action plan for one year, re-training for the manpower under these ULBs have not been taken into consideration. However, re-orientation training will be required in future and reflected in the 2nd year action plan.

4. **Re : Improved mobility or contingency in the form of a "Referral Fund"**

- Provision for maximum limit of Rs. 100/- per HHW per month, based on visit in all the families allotted to her twice in a month, inclusion of data entry in the Family Schedules after each visit and certified by the respective FTS.
- Provision for maximum limit of Rs. 100/- per FTS per month, based on checking of data entry in the Family Schedule regularly, field verification as and when required and certified by the respective STS.
- Estimated cost for one year for KMA and Non-KMA ULBs is Rs. 67.93 lakhs and Rs. 25.67 lakhs respectively, the totaling Rs. 93.60 lakhs.

5. **Re : Refurbication of Sub-Centres**

- Apropos instruction of DFID, ISC has already been requested to examine the ULB position with respect to Sub-Centres (Cost effectiveness, levels of utilisation etc.).
- On receipt of report from ISC, the issue will be reviewed further.

6. **Re : Piloting the use of private sector Health Insurance in 2 ULBs**

- Detailed plan is to be obtained from ISC.
- Identification of 2 ULBs by the Health Steering Committee where private sector Health Insurance can be piloted.

7. **Re : I.E.C.**

- Group discussion at block level quarterly with female and male members of the community.
- Installation of hoarding / repair and re-painting of existing message boards.
- Baby show (60 nos. for KMA ULBs and 21 nos. for Non-KMA ULBs).
- Pada Yatra (5 yatras per ULB per year).
- Deployment of folk media (2 programmes per HAU per year).
- Role play by the community (2 per ULB).
- Estimated cost both for KMA and Non-KMA ULBs for one year Rs. 100.97 lakhs.

To be circulated to all the members of the Health Steering Committee & Tech. Advisor, CMU by 7.11.05

Annexure: IV

Towards a social insurance approach in the KUSP context:

4.1 Identification of Beneficiaries –

4.1.1 The HHWs are assigned the work of house-to-house surveys to compile the information on BPL population, which includes the vulnerable section. The entire population has been classified into three groups as follows –

- Category I – General – those with an annual salary of 1 lakh or more.
- Category II – Poor – APL but annual salary less than 1 lakh.
- Category III – Vulnerable – as identified by the HHWs. (BPL, this category would include rag pickers, street children, CSWs, slum dwellers, etc.)

This is being illustrated by the following table:

Category	**Number of households**	**Total beneficiaries**
Category I (@ 65% of the total population)	13000	65000
Category II (@ 25% of the total population)	5000	25000
Category III (@ 10% of the total population)	2000	10000
Total	20000	100000

4.2 Benefits: -

4.2.1 The insured is eligible only for hospitalization expenses under the following two categories:

Category	Benefits covered	Upper limit in Rs.
Major procedures/surgeries	Shall include Caesarean Section	4000/-
Minor procedures	Shall include Normal deliveries	1000/-

4.3 Contributions: -

4.3.1 The following table details out the level of contributions to be made.

Category		Contribution in Rs.		Total
		From the beneficiaries	From the government	
Category I	Per family	600	0	
	Total	7800000	0	7800000
Category II	Per family	300	300	
	Total	1500000	1500000	3000000
Category III	Per family	0	600	
	Total	0	1200000	1200000
Total		9300000	2700000	12000000

4.3.2 The contributions to be collected from Category I & Category II can be deducted at source i.e. in the form of health tax of Rs. 600 and Rs. 300 per family, respectively; thereby ensuring the collection of the premium from every household. The government contribution accounts for only 22.5% of the total contribution.

4.3.3 Definition of family – A family covers four members viz. the proposer his/her spouse and two unmarried children. To extend the benefits of the scheme to other members a premium of Rs. 150 (for all the Categories) needs to be paid by the proposer for an annual cover.

4.4 Viability of the scheme:

4.4.1The viability of the scheme can be explained in the following way: CBR being 15/1000, it can be expected 1500 births in a population of one lakh. Only 10% of these are expected to undergo Caesarean Section. Therefore, total expenditure on

1. Normal Deliveries– (1500-150) X1000 = Rs. 1350000/-

2. Caesarean Section – 150 X 4000 = Rs. 600000/-

4.4.2 Of the total population 1% require any surgical intervention out of which only 15% would require any major surgical intervention. Therefore the expenditure on

1. Minor Surgical interventions – (1000-150) X1000 = Rs. 850000/-

2. Major Surgical interventions – 150X4000 = Rs. 600000/-

4.4.3 Thus the total claims expected in one year are Rs. 34 lakhs.

- Administrative costs @ 20% - Rs. 680000/-
- Total Expenditure = Rs. 4080000/-
- Net Profit = Rs. 7920000/-

4.4.4 The following points must be kept in mind:

1. A health card (photo I card) must be issued to each family with all the other details. They become eligible for it only if a member of a local self help group.

2. Payments are made only as third party payments to the hospital. – which in this case is the ULB MH. Payment ceiling is Rs 20,000 per year per family.

3. Category I families pay Rs 50 per month, category II families pay Rs 25 per month and category III families pay nil amount- though they too contribute to a local self help group fund.

4.4.5 Complementing this scheme to meet the indirect costs which are also estimated to be high a deposit linked scheme functional through SHGs could be devised. A monthly contribution of Rs. 10 per family earmarked for the purpose of meeting the indirect costs, viz. the transport charges, food charges, wages lost by the patient and the relative accompanying the patient to the hospital, etc. this is mandatory for Category III but optional for Category I & II. An upper limit is fixed for the wages lost, food and conveyance per hospitalization event.

To be circulated to all the members of the Health Steering Committee & Tech. Adviser, CMU by 7.11.05

Annexure: IV

Towards a social insurance approach in the KUSP context:

4.1 Identification of Beneficiaries –

4.1.1 The HHWs are assigned the work of house-to-house surveys to compile the information on BPL population, which includes the vulnerable section. The entire population has been classified into three groups as follows –

- Category I – General – those with an annual salary of 1 lakh or more.
- Category II – Poor – APL but annual salary less than 1 lakh.
- Category III – Vulnerable – as identified by the HHWs. (BPL, this category would include rag pickers, street children, CSWs, slum dwellers, etc.)

This is being illustrated by the following table:

Category	**Number of households**	**Total beneficiaries**
Category I (@ 65% of the total population)	13000	65000
Category II (@ 25% of the total population)	5000	25000
Category III (@ 10% of the total population)	2000	10000
Total	20000	100000

4.2 Benefits: -

4.2.1 The insured is eligible only for hospitalization expenses under the following two categories:

Category	Benefits covered	Upper limit in Rs.
Major procedures/surgeries	Shall include Caesarean Section	4000/-
Minor procedures	Shall include Normal deliveries	1000/-

4.3 Contributions: -

4.3.1 The following table details out the level of contributions to be made.

Category		Contribution in Rs.		Total
		From the beneficiaries	From the government	
Category I	Per family	600	0	
	Total	7800000	0	7800000
Category II	Per family	300	300	
	Total	1500000	1500000	3000000
Category III	Per family	0	600	
	Total	0	1200000	1200000
Total		9300000	2700000	12000000

4.3.2 The contributions to be collected from Category I & Category II can be deducted at source i.e. in the form of health tax of Rs. 600 and Rs. 300 per family, respectively; thereby ensuring the collection of the premium from every household. The government contribution accounts for only 22.5% of the total contribution.

4.3.3 Definition of family – A family covers four members viz. the proposer his/her spouse and two unmarried children. To extend the benefits of the scheme to other members a premium of Rs. 150 (for all the Categories) needs to be paid by the proposer for an annual cover.

4.4 Viability of the scheme:

4.4.1 The viability of the scheme can be explained in the following way: CBR being 15/1000, it can be expected 1500 births in a population of one lakh. Only 10% of these are expected to undergo Caesarean Section. Therefore, total expenditure on

1. Normal Deliveries– (1500-150) X1000 = Rs. 1350000/-
2. Caesarean Section – 150 X 4000 = Rs. 600000/-

4.4.2 Of the total population 1% require any surgical intervention out of which only 15% would require any major surgical intervention. Therefore the expenditure on

1. Minor Surgical interventions – (1000-150) X1000 = Rs. 850000/-
2. Major Surgical interventions – 150X4000 = Rs. 600000/-

4.4.3 Thus the total claims expected in one year are Rs. 34 lakhs.

- Administrative costs @ 20% - Rs. 680000/-
- Total Expenditure = Rs. 4080000/-
- Net Profit = Rs. 7920000/-

4.4.4 The following points must be kept in mind:

1. A health card (photo I card) must be issued to each family with all the other details. They become eligible for it only if a member of a local self help group.
2. Payments are made only as third party payments to the hospital. – which in this case is the ULB MH. Payment ceiling is Rs 20,000 per year per family.

3. Category I families pay Rs 50 per month, category II families pay Rs 25 per month and category III families pay nil amount- though they too contribute to a local self help group fund.

4.4.5 Complementing this scheme to meet the indirect costs which are also estimated to be high a deposit linked scheme functional through SHGs could be devised. A monthly contribution of Rs. 10 per family earmarked for the purpose of meeting the indirect costs, viz. the transport charges, food charges, wages lost by the patient and the relative accompanying the patient to the hospital, etc. this is mandatory for Category III but optional for Category I & II. An upper limit is fixed for the wages lost, food and conveyance per hospitalization event.

ALLOCATION OF DUTIES AND RESPONSIBILITIES

After joining of some Officers, it has become necessary to redefine the roles and responsibilities of the functioning officers in KUSP. The following will be the present duties and responsibilities. Additional responsibilities may be assigned as necessary.

1. **Shri G. Sarkar Engineering Expert):**

Will be responsible for implementation of the following components of the KUSP programme:

1) Slum level infrastructure with necessary augmentation in the city system.
2) Incentive Fund for intra-municipal infrastructure community need.
3) All Construction Works/Engineering matters.

Formulation of guidelines for infrastructure and allocation criteria will be driven by him. Coordination of Engineering design and estimating work for intra-municipal infrastructure.

Will coordinate with KMDA regarding development of the West Bengal Municipal Development Fund and identification of Trans Municipal Infrastructure.

(Leave substitute: Shri Samir Mukherjee)

2. **Shri Samir Mukherjee (Procurement Expert):**

Will be responsible for all procurement matters relating to the KUSP programme in ULBs, Support Agencies and Change Management Unit.

Will act as 'Contract Officer' for CMU. Formulation of Procurement Manual will be driven by him

Will coordinate with West Bengal Valuation Board regarding 'Property Tax' reforms under KUSP, Internal Office accommodation of CMU, I.T. needs and Resource Centre will also be looked after by him.

(Leave substitute: Shri G Sarkar)

3. **Shri Saikat Sengupta (Economist):**

Will be responsible for implementation of the following components of the KUSP program:

1) Economic Development
2) Innovative/Challenge Fund

Will coordinate with KMDA regarding 'Economic Visioning' of KMPC.

(Leave substitute: Shri Shubha Brata Roy).

4. **Shri Subha Brata Roy (Urban Planner):**

Will be responsible for implementation of following components of KUSP programme:

1) DDP/ADP preparation.
2) Poverty Surveys and impact studies.
3) Howrah rejuvenation and development plan.
4) Urban strategy for West Bengal.
5) Ward Office/Citizen Service Centre selection and design matters.

(Leave substitute: Shri Saikat Sengupta)

5. **Shri Atanusasson Mukhopadhyay (Municipal Finance Expert)**

Will be responsible for implementation of accrual based double entry accounting system in the ULBs.

Will also be responsible for design and implementation of Fiscal Leveraging and Improvement Plan in ULBs.

(Leave substitute: Shri Subir Bhattacharya)

6. **Shri Subir Bhattacharya (Financial Adviser):**

Responsible for supervising CMU's Accounts & Audit, entire accounting and audit of KUSP.

(Leave substitute: Shri Atanusasson Mukhopadhyay)

7. **Shri Jayanta Chakraborti (OD Expert):**

Will be responsible for Implementation of Organisational Development Plans in ULBs.

Will be responsible for Organisational Development of Support Organisations.

Will provide inputs on Poverty Surveys and community development.

(Leave substitute: Sri D K Roy)

8. **Dr. S Goswami (Health Expert):**

Will be responsible for design and implementation of Health Component of the Program.

(Leave substitute: Shri Jayanta Chakraborti)

9. **Shri Utpal Chakraborti (Accounts Officer)**:

Will be responsible for all Accounts and Audit Work of CMU under the guidance of Financial Advisor.

Will also function as Drawing and Disbursing Officer.

(Leave substitute: Shri Subir Bhattacharya)

10. **Shri Puspendu Chakrabarti (Computer Programmer):**

Will be responsible for maintenance of CMU Website.

Will be responsible for all hardware and software support in CMU

(Leave substitute: Shri Subha Brata Roy)

11. **Shri D K Roy (Technical Advisor):**

Will provide inputs and advice on all aspects of the program.

Will also specifically look after the following components:

1. GIS, MIS and other computerization needs in ULBS.
2. Training needs and coordination with ILGUS/ATI
3. Environmental matters relating to the Project
4. Design agreement/MOUs with ULBs and other formats/guidelines from the Project.

(Leave substitute: Shri A Matilal)

12. **Shri A Matilal, WBCS(Exe), Project Manager:**

Will oversee implementation of all aspects of the program.

Will supervise office functioning of CMU.

Will coordinate organisation of meetings and seminars.

Will be responsible for internal training arrangements and exposure visits of CMU.

Will look after communication work of the programme.

(Leave substitute: Shri D K Roy)

The officers will work in coordination with the Interim Support Consultancy. They are expected to clarify the outputs required from ISC and seek all technical help as needed. They are also encouraged to discuss and brainstorm design and policy matters with colleagues. They should seek advice of Technical Advisor who will provide inputs during drafting stage of designs/ToRs/guidelines/policy decisions.

Each Officer will be functioning independently in their field of work. All major decisions and policy directives will have to be discussed and cleared from Project Manager and Project Director.

Project Director will be the deciding authority.

(Arnab Roy)
Project Director, KUSP

Copy to:

1. Shri Arnab Roy, Project Director
2. Shri Anup Matilal, Project Manager
3. Shri D K Roy, Technical Adviser
4. Shri G Sarkar, Engineering Expert
5. Shri Samir Mukherjee, Procurement Expert
6. Shri Saikat Sengupta, Economist
7. Shri Subha Brata Roy, Urban Planner
8. Shri Subir Bhattacharya, Financial Adviser
9. Shri Atanusasson Mukhopadhyay, Municipal Finance Expert
10. Shri Jayanta Chakraborti, OD Expert
11. Dr. S Goswami, Health Expert
12. Shri Utpal Chakraborti, Accounts Officer
13. Shri Puspendu Chakrabarti, Computer Programmer
14. Mr Shrinivas, Team Leader, Interim Support Consultant
15. Office

Project Director, KUSP

Copy for kind information:

1. The Secretary, MA Dept.
2. PS to MIC, MA Dept.
3. Shri Sudipto Mukherjee, DFID

Project Director, KUSP

KUSP
FOOTFALLS OF FUTURE

Sub. : Study on ULB position with respect to Sub-Centre in terms of management, cost effectiveness, levels of utilisation.

In the Aide memoire of the last review meeting held by Govt. of West Bengal and DFID during 1 – 3 December, 2004, DFID expressed that ISC as part of the review to examine the ULB position with respect to Sub-Centre (Cost effectiveness, levels of utilisation etc.) following to that ISC was requested to do the needful which had not been materialised.

While preparing work plan for FY 2005 – 2006 for health component it was felt that unless proper facilities at Sub-Centres are provided in terms of replacement of some of the important equipment i.e. weighing machine, weighing jacket, BP instrument, Haemoglobinometer etc.; furniture e.g. patient examination table, screen partition for maintaining privacy during examination etc. and some minor repair / renovation like white wash, window repairing, provision of toilet and water sources etc. are taken in to care of, functioning of Sub-Centre could not be strengthened.

As preventive public health has been decentralized at the block level by HHW, Sub-Centre is the nerve centre for providing service delivery to the urban population focusing reproductive and child health.

It was suggested that a short study of 10 nos. of Sub-Centres of 5 ULBs may be conducted by an Expert to get an overview on the functioning status of Sub-Centre. For the purpose, it was decided that Dr. N.G. Gangopadhyay may be contacted. Dr. Gangopadhyay has got vast experience in the community based health programme namely CUDP III, CSIP, IPP-VIII & IPP-VIII (Extn.) and RCH Sub-Project, Asansol as Director and Advisor. Dr. Gangopadhyay with his team may be entrusted with the task as per TOR (enclosed).

Total 14 (fourteen) man days will be required to complete the task. The undersigned discussed with Dr. Gangopadhyay regarding cost involvement of the entire work which has been estimated to an amount of Rs. 25,500/-. However, the matter has been negotiated with Dr. Gangopadhyay at a lump sum rate of Rs. 20,000/- provided vehicle support for 5 days field visit be provided by CMU. The rate per man day has been calculated Rs. 1,429/- (approx) which may be accepted.

PD CMU

Submitted for favour of kind approval. If approved, Dr. Gangopadhyay and his team may be asked to take up the job immediately since the available time is very short.

12.4.05

Study on ULB position with respect to Sub-Centre in terms of management, cost effectiveness, levels of utilisation.

TOR

Objective

- To understand functioning status of Sub-Centres both in municipal owned and non-municipal premises.
- To understand management & supervision network.
- To know utilisation pattern of services provided from the Sub-Centres.
- To study adequacy of logistic support in terms of important equipment, furniture & others require for effective delivery of services.
- To study existing physical condition of Sub-Centres.

Methodology

- To study 2 Sub-Centres per municipality, 1 in municipal owned premises and the other one in non-municipal premises – total 10 Sub-Centre of 5 ULBs out of 40 KMA ULBs.
- 5 ULBs to be selected on random basis.
- 2 Sub-Centres to be selected ULB-wise on random sampling.

Study Instrument

- To get list of Sub-Centres (both municipal & non-municipal accommodation) of sampled 5 ULBs.
- Selection of 2 Sub-Centres (1 municipal & 1 non-Municipal accommodation) through sampling.
- Visit to Sub-Centre.
- To examine records, registers, cards etc.
- To discuss with grass root level functionaries i.e. HHW, FTS, HO / AHO & PTMO.
- To discuss with the community staying around the Sub-Centre location.
- To examine the essential furniture & equipment.
- To examine the physical condition of the Sub-Centre.

Data Analysis

- Data will be entered, tabulated & analyse by using computer.

Time Frame

- 18.04.2005 to 04.05.2005
  - 18.04.2005 – Finalization of study design with PD, CMU.
  - 19.04.2005 – Visit & study at Madhyamgram (1st ULB).
  - 20.04.2005 – Visit & study at Panihati (2nd ULB).
  - 21.04.2005 - Analysis of findings of 1st ULB.
  - 23.04.2005 - Analysis of findings of 2nd ULB.
  - 25.04.2005 – Visit to Konnagar (3rd ULB).
  - 26.04.2005 – Analysis of findings of 3rd ULB.
  - 27.04.2005 – Visit & study at Serampore (4th ULB).
  - 28.04.2005 - Analysis of findings of 4th ULB.
  - 29.04.2005 - Visit & study at Budge Budge (5th ULB)
  - 30.04.2005 to 02.05.2005 – Analysis of finds of 5t ULB, consolidation and draft report writing & sharing with PD, PM & Health Expert.
  - 03.05.2005 – Preparation of Final Report.
  - 04.05.2005 – Submission of report to Project Director, CMU, KUSP.

Cost Involvement

- On the days of field visits (total 5 days) mobility support to be provided by CMU.
- Entire cost including submission of final report – not exceeding Rs. 20,000/- (Rupees twenty thousand) only.

Terms of Payment

- To negotiate with Dr. N.G. Gangopadhyay.

KOLKATA URBAN SERVICES FOR THE POOR

CHANGE MANAGEMENT UNIT

Circular No.CMU- 28/2002(Pt-II)/850(10) **Date: 22-03-2005**

CIRCULAR

To attend to year-end activities, the Office of the CMU will remain open on 26th and 27th of March 2005.

This issues with the concurrence of PD, CMU.

Anup K. Matilal

(Anup K Matilal)
Project Manager, CMU, KUSP

Distribution:

1) Project Director, CMU
2) Technical Adviser, CMU
3) Engineering Expert, CMU
4) OD Expert, CMU
5) Health Expert, CMU
6) Urban Planner, CMU
7) Economist, CMU
8) Financial Adviser, CMU
9) Municipal Finance Expert, CMU
10) Accounts Officer, CMU

ILGUS BHAVAN, HC BLOCK, SECTOR 3, BIDHANNAGAR, KOLKATA 700106
Ph : 033-2334 2660, 2337 7315, 2358 6403/5767
Fax : 033-2337 7318/2358 5800
email: kuspcmu@vsnl.net

KOLKATA URBAN SERVICES FOR THE POOR
CHANGE MANAGEMENT UNIT

Arnab Roy, IAS
Project Director

Memo No.CMU- 44/2003 (Pt-II) 190(12) **Date: 28-04-2005**

From: Arnab Roy
Project Director, CMU, KUSP

To: Dr S Goswami
Project Officer, Health Wing, SUDA &
Health Expert, CMU, KUSP

Madam,

The Municipal Affairs Department, Govt. of West Bengal and the Administrative Training Institute, Govt. of West Bengal, are going to conduct an orientation programme for the newly appointed in-service Executive Officers in KMA Municipalities covered under KUSP. The programme is scheduled to be held in Administrative Training Institute, Salt Lake, Kolkata on and from 2nd May 2005 to 13th May 2005 (9 days).

May I request you to please manage a few hours out of your busy schedule to be with the participants and share your valued experience with them on the subjects as per the programme enclosed. The date and time schedule of your deliberations is also attached along with the programme for your convenience.

A line in confirmation shall be highly appreciated.

Yours faithfully,

(Arnab Roy)
Project Director, CMU, KUSP

Encl: Programme Schedule

Ltr(PD).akd/p-92

ILGUS BHAVAN, HC BLOCK, SECTOR 3, BIDHANNAGAR, KOLKATA-700 106
PH : 033-2334 2660, 2337 7315, 2358 6403/5767, FAX : 033-2337 7318/2358 5800
E-mail : kuspcmu@vsnl.net, Website : www.changekolkata.org

URBAN MANAGEMENT CENTRE

ADMINISTRATIVE TRAINING INSTITUTE
GOVT. OF WEST BENGAL

ORIENTATION PROGRAMME FOR NEWLY APPOINTED EXECUTIVE OFFICERS IN KMA MUNICIPALITIES
2-13 May 2005 (9 days)

2nd May, Monday

10.00-10.30am	Reporting and Registration	At Reception
10.30-12.00 pm	Inauguration and Key note address	Sri. D. Mukhopadhyay, Secretary, M Affairs Deptt, Govt of West Bengal
12 – 12.15pm	**TEA BREAK**	
12.15-1.45 pm	Introduction to Urbanization and Decentralization of Urban Governance	Sri. Uttam Kumar Roy, Associate Professor, Urban Management Centre, ATI
1.45-2.45 pm	**LUNCH BREAK**	
2.45-4.00 pm	Evolution and Growth of KMA: A Historical Background	Sri. A. K. Matilal, Project Manager, CMU
4.00-4.15 pm	**TEA BREAK**	
4.15-5.30 pm	Municipal Administration	Smt. Chhanda Sarkar, Jt. Director, ILGUS

3rd May, Tuesday

10.30-12.00 pm	Municipal Act	Smt. Chhanda Sarkar, Jt. Director, ILGUS
12 – 12.15pm	**TEA BREAK**	
12.15-1.45 pm	Municipal Act	Smt. Chhanda Sarkar, Jt. Director, ILGUS
1.45-2.45 pm	**LUNCH BREAK**	
2.45-4.00 pm	Municipal Building Rules and Regulations	Sri. Gautam Das, Chief Engineer, MED
4.00-4.15 pm	**TEA BREAK**	
4.15-5.30 pm	Municipal Accounts Rules	Sri. Subir Bhattacharjee, FA, SUDA & CMU

4th May, Wednesday

10.30-12.00 pm	Overview of KUSP	Sri. Arnab Roy, IAS, Project Director, CMU
12 – 12.15pm	**TEA BREAK**	
12.15-1.45 pm	Financial Resource Base of Municipality	Sri. Atanu S. Mukherjee, MFE, CMU
1.45-2.45 pm	**LUNCH BREAK**	
2.45-4.00 pm	Urban Planning and Development Plans	Sri D. Kumer. Sr. Town Planner, WBHIDCO
4.00-4.15 pm	**TEA BREAK**	
4.15-5.30 pm	Planning and Development Plans with reference to DDP to be prepared by ULBs	Sri. Srinivas Kowligi, Consultant, PWC

5th May, Thursday

10.30-12.00 pm	Economic Development & Poverty Alleviation Programmes	Sri. D. K. Roy, Technical Advisor, CMU
12 – 12.15pm	**TEA BREAK**	
12.15-1.45 pm	KUSP: Procurement Procedure	Sri. D. K. Roy, Technical Advisor, CMU
1.45-2.45 pm	**LUNCH BREAK**	
2.45-4.00 pm	5th Economic Census	Sri. A. K. Matilal, Project Manager, CMU / Director, Bureau of Economics and Statistics
4.00-4.15 pm	**TEA BREAK**	
4.15-5.30 pm	5th Economic Census	Sri. A. K. Matilal, Project Manager, CMU / Director, Bureau of Economics and Statistics

-Continued-

URBAN MANAGEMENT CENTRE

ADMINISTRATIVE TRAINING INSTITUTE
GOVT. OF WEST BENGAL

ORIENTATION PROGRAMME FOR NEWLY APPOINTED EXECUTIVE OFFICERS IN KMA MUNICIPALITIES
2-13 May 2005 (9 days)

6th May, Friday

10.30-12.00 pm	Health Programmes in Municipalities	Dr. S. Goswami, Project Officer, SUDA & Health Expert, CMU
12 – 12.15pm	**TEA BREAK**	
12.15-1.45 pm	Assessment & Valuation	Sri Syamales Datta, Ex Chief Valuer, HIT
1.45-2.45 pm	**LUNCH BREAK**	
2.45-4.00 pm	Site Visit: Practical Orientation to Municipal work	ATI - CMU representation

10th May, Tuesday

10.30-12.00 pm	Overview of Municipal Services	Sri. B.K. Sengupta, Ex-Advisor, KMDA
12 – 12.15pm	**TEA BREAK**	
12.15-1.45 pm	Municipal Services: Water Supply, Solid Waste Management, Sanitary Services	Sri. B.K. Sengupta, Ex-Advisor, KMDA
1.45-2.45 pm	**LUNCH BREAK**	
2.45-4.00 pm	KUSP: Organization Development	Sri. Jayanta Kr Chakrabarti, OD Expert, CMU
4.00-4.15 pm	**TEA BREAK**	
4.15-5.30 pm	KUSP: E-Governance	Shri Tapas Ghatak, KMDA

11th May, Wednesday

10.00-10.45 am	Special session	Meeting with DFID - India Representative
10.45-12.00 pm	KUSP: Slum Improvement Programme	Sri Swapan Chakraborty, DLB, WB
12 – 12.15pm	**TEA BREAK**	
12.15-1.45 pm	Economic Development of KUSP	Sri. Saikat Sengupta, Economist CMU
1.45-2.45 pm	**LUNCH BREAK**	
2.45-4.00 pm	KUSP: Accounting Reforms	IBRAD
4.00-4.15 pm	**TEA BREAK**	
4.15-5.30 pm	Sarba Siksha Abhijan	Smt. Chhanda Sarkar, Jt. Director, ILGUS

12th May, Thursday

10.30-12.00 pm	Interface with other support agencies	Sri G Sarkar, Expert Engineering, CMU
12 – 12.15pm	**TEA BREAK**	
12.15-1.45 pm	Interface with Elected Representatives	Smt. Chhanda Sarkar, Jt. Director, ILGUS
1.45-2.45 pm	**LUNCH BREAK**	
2.45-4.00 pm	Citizens' Interface: Ward Committee & CDS	Sri Atanusason Mukhopadhyay, MFE, CMU
4.00-4.15 pm	**TEA BREAK**	
4.15- onwards	Meeting with MIC, Urban Development GOWB	

13th May, Friday

10.30-12.00 pm	Personal Effectiveness	Sri Anjan Chakraborty, Chief Manager SBI
12 – 12.15pm	**TEA BREAK**	
12.15-1.45 pm	Personal Effectiveness	Sri Anjan Chakraborty, Chief Manager SBI
1.45-2.45 pm	**LUNCH BREAK**	
2.45-4.00 pm	Citizens' Charter	
4.00-4.15 pm	**TEA BREAK**	
4.15-5.30 pm	Evaluation and Feed back Valedictory	Sri. Uttam Kumar Roy

Note: Programmes on 12th May is tentative

Uttam Kumar Roy
Course Director

UM/2005/KUSP2

CHANGE MANAGEMENT UNIT (CMU)

NOTE

24-03-2005

A meeting will be held today at 3-00 P.M. in my chamber regarding the following:

1) Work Plan for 2005-06
2) Design of Incentive Fund for 2006-07
3) Preparation of Annual Administrative Report for 2003-04

Please attend positively.

(Arnab Roy)
Project Director, CMU

Project Manager, CMU
Technical Adviser, CMU
Engineering Expert, CMU
Urban Planner, CMU
Economist, CMU
OD Expert, CMU
Municipal Finance Expert, CMU
Health Expert, CMU

attended.

Phone : 2660 3211-3
Fax : 91-33-2660 3214

HOWRAH MUNICIPAL CORPORATION

HEALTH DEPARTMENT

4, MAHATMA GANDHI ROAD, HOWRAH - 711 101

Ref. No. 69(14)

Date 01.04.05

To
Dr. Shibani Goswami,
Health Expert, CMU.

Dear Madam,

In view of your letter No.CMU-94/2003(Pt.II)/755(16) dt. 4.3.05 I am informing you that this Corporation is interested to accepting your proposal of a) Provision of Uniform to HHWs, FTs and STs, b) Provision of Kit Bag alongwith contents of HHWs.

Please let us inform the procedure for procurement.

Thanking you,

Yours sincerly

Manika Biswas
31.03.05
(Manika Biswas)
Deputy Mayor,
Howrah Municipal Corporation

Dated: _____

Memo No._____

Copy forwarded for information :
1) [illegible] Mayor, Howrah Municipal Corporation,
2) Mrs. Mamata Jaiswal, Chairperson, Ward nT.
3) Dr. Subhasis Sarkar, Asst. Health Officer, H.M.C - to co-ordinate the matter.

(Manika Biswas)
Deputy Mayor,
Howrah Municipal Corporation

Received 4/1/2005 4:23 PM

Phone : 2477-9245

RAJPUR-SONARPUR MUNICIPALITY

P. O.--HARINAVI, SOUTH 24-PARGANAS

REF. NO. HAU/367/RSM

DATE 28. 03. 2005

Health Expert re

We've already written. Possibly!
4/4/05

To
The Project Director
CMU,KUSP
ILGUS BHAWAN
Salt Lake, Kol- 106

Sub: Proposal for allotment of fund of Rs.127162=00(Rupees One Lakh twenty seven thousand one hundred and sixty two only) towards purchase of UNIFORM and Kit-Bags with Contents for Health workers.

Your ref no: CMU/94/2003 (PtII/755(16) dt 17.3.05

Sir,

As per above mentioned ref from your Office we have make necessary arrangement for procurement of above mentioned items afyer observing office formalities.

Pl. make necessary arragement for above mentioned fund. Adjustment will be submitted after completion of the procurement.

28/3/05

Chairman.
Rajpur-Sonarpur Municipality.

Special attention of Dr. Shibani Goswami, Health Expert, CMU

Received 3/28/2005 3:06 PM

PM

Pl. ask them to procure at KUSP advance. If advance is insufficient they may procure & claim reimbursement

4/4

Sub. : Printing of final report on HHW programme review by Interim Support Consultation under KUSP.

One copy of the final report and a CD containing the matter on HHW programme review by Interim Support Consultation to Change Management Unit (CMU) has been received. As per instruction the copy of the said report is to be distributed to the members of the Health Steering Committee, KUSP and other officials concerned. Thus, 50 (Fifty) nos. of the copy of the report are required for distribution.

For the purpose, different firms have been contacted and received quotations. The comparative statement are as under :

Sl. No.	Name of the firm and address	Offered Unit Rate inclusive of all charges and taxes (In. Rs.)
1.	M/S Graphic Offset 96/4A, Acharya Prafullo Chandra Road, Kolkata - 700 009.	264.00
2.	M/S Fine Graphics 18B, Keyatala Road, Kolkata - 700 029.	250.00
3.	M/S Contre Jour 6/1, Dehi Entally Road, Kolkata - 700 014.	239.00
4.	M/S Eastern Enterprise 85E Raja Dinendra St. Kolkata - 700 006	450.00

From the CS, it may be seen that M/S Contre Jour has submitted the lowest quotation.

Hence, the said firm may be entrusted with the job of Xerox printing and binding of 50 nos. of the report containing ~~275~~ 175 (one seventy five) pages, A4 size, with colour digital printing cover and spiral binding - clear and opaque plastic cover.

The total financial involvement will be Rs. 11,950/- (50 nos. x Rs. 239/-) (Rupees Eleven thousand nine hundred fifty) only.

The expenditure for the purpose may be booked under the A/C head of "~~Health~~ Support to Health Sector - ~~component~~ - printing of booklet" of KUSP fund.

Submitted for favour of kind perusal and clearance.

PM, CMU

The lowest rate quoted may be approved. If approved, M/S Contre Jour may be asked to print/xerox print 50 copies.

17.3.05

17.3.05. Approved 18/3

P.P

EASTERN ENTERPRISE

(Specialist in Printing and Stationary Suppliers)
85E, RAJA DINENDRA STREET KOLKATA – 700 006
Ph:23546231, Mobile: 9831251960, Fax: 25545758

Dated: March 7, 2005

To
The Procurement Specialist,
CMU
State Urban Development Agency
Ilgus Bhawan, Salt lake city,
Kolkata

Sub :QUOTATION for Printing of 175 Pages Book Book – 50 Copies with spiral binding and Plastic Cover.

Madam,
I do hereby quoting my lowest possible rate for the above mentioned Book as per verbal discussion at your office which you had so kindly been asked for.

Sl.	Item Description	Unit Rate
1.	Printing of Book (175 Pages) with spiral binding and Plastic cover. (As per your sample)	Rs.450.00 per book

Time Required for printing and binding and delivery 10 Working days maximum.
The above rates are inclusive of all taxes and free delivery at your above mentioned office. I hope you will find our rates quite reasonable.

Thanking you,
Yours faithfully,
For: EASTERN ENTERPRISE

(Authorised signatory)

EASTERN ENTERPRISE Kolkata

(3)

[redacted]

To,
The Health Expert
Change Management Unit,
Bidhannagar,
Kolkata - 700 106.

11.03.05

Attention. **Dr. Shibani Goswami**

Sub: **Printing of "Interim Support Consultation to the C.M.U"**
Final Report on HHW Programme Review

Respected Madam,

In response to your verbal enquary for the above items, we furnish our offer which are as follows :-

Specification :

No. of Books	:	50pcs
No. of pages	:	175
Size	:	A4
Printing	:	Xerox inside
Printing Cover	:	Colour Digital
Paper	:	Maplitho
Binding	:	Spiral
Cover	:	Clear & Opaque Plastic

Cost including B&W digital output from CD, Xerox printing, colour digital cover printing, spiral binding with plastic cover complete including delivery to your office.

Rs. 11,950.00 (Rupees Eleven thousand nine hundred fifty Only)

Thanking you,

For **CONTRE JOUR**

Contre jour

6/1, Debi Entally Road, Calcutta - 700 014

Phone 22451234

FINE GRAPHICS

18B, Keyatala Road , Kolkata - 700 029 ■ Phone : 2274 0403

To,
The Health Expert
Change Management Unit,
Bidhannagar,
Kolkata - 700 106.

11.03.05

Attention. Dr. Shibani Goswami

Ref: Printing of "Interim Support Consultation to the C.M.U" Final Report on HHW Programme Review

Respected Madam,

With reference to your verbal enquiry dated 09.03.2005 asking rates for printing of 50 pcs of books containing 175 A4 pages in xerox and cover in colour with spiral binding and using acrylic sheel on front and back, please find our offer which is as follows :-

@ 250.00 for 50 pcs. Total Rs. 12,500.00 (Rupees Twelve thousand five hundred only)

The above charges are quoted for preparation, binding etc. and free delivery to you.

Thanking you,

For Fine Graphics

(Partner)

GRAPHIC OFFSET

To,
The Health Expert
Change Management Unit,
Bidhannagar,
Kolkata - 700 106.

10.03.05

Attention. Dr. Shibani Goswami

Ref : Your Verbal Enquary

Respected Madam,

Thanks you for your enquiry requesting us to quote for Printing of 50 pcs. books containing 175 (A4) pages in Black and white, cover page in colour in photocopy method with plastic sprial binding and plastic cover on ***Interim Support Consultation to the C.M.U, Final Report on HHW Programme Review.*** In reply to your quiry our quotation will be Rs. 13,200 (Rupees Thirteen thousand two hundred Only) all inclusive.

We presume that you will find our rates reasonable and favoured us with your valued order.

Thanking you,

Sincerely yours,
Samar Dutta

96/4A, Acharya Prafullo Chandra Road, Calcutta - 700 009 Ph: 2350 5692

wbvha
West Bengal Voluntary Health Association
WORKING TOGETHER FOR HEALTH & DEVELOPMENT

Sri.Arnab Roy I.A.S.
Project Director, KUSP
State Urban Development Agency
ILGUS Bhavan, HC Block, Sec-III,
Salt Lake, Kolkata-700 106

sch/wbvha.05
2nd March, 2005

Dr. Goswami

Sub: Training on HIV/AIDS and STDs for HHWs and other Health Functionaries

Dear Sir,

We have submitted a Project Proposal on Training on above mentioned topics for HHWs and other health functionaries to conduct in 40 Municipalities under ULB of KSUP. We are ready to take up the assignment and wish to launch the project work soon.

You are well aware that WBVHA prints wide range of project support materials round the year for the health workers and others of different categories of end-users involved in health and development projects in order to inform and educate about he subject as well as enhance the skills so that the work delivered becomes accurate and technically sound. These reading materials are simple, easily accessible and usable. Hesperian Foundation is a leader in health publications worldwide. Their latest book is

HIV HEALTH & YOUR COMMUNITY

-A GUIDE FOR ACTION

This is translated in Bengali by WBVHA(copy was enclosed with the project proposal).As a tool to educate and motivate general people and risk group this is excellent and highly useful as it deals with what to know, how to communicate, hat t communicate, understanding peoples behaviour, developing attitude, home care, counseling, common illness and STDs and host of other essential information that an individual needs to know and deliver services. We literally urge the trainee participants to carry one such material for better and effective services in addition to taking back experience and skills after the training. Cost is highly subsidized for the number to print Rs.35/-(Rupees Thirty Five only).

Trust, you will favor the points and call us. With kind regards.

Sincerely yours,

Aminul Ahsan
Project Director 02/03/05

KOLKATA URBAN SERVICES FOR THE POOR

CHANGE MANAGEMENT UNIT

Memo No. CMU-28/2002(Pt. II)/840 014 **Dt.. 18.03.2005**

From : Dr. Shibani Goswami
Health Expert, CMU

To : M/S Contre Jour
6/1, Dehi Entally Road
Kolkata 700 014.

Sub. : Work order for Xerox printing, binding and supply of 50 (fifty) nos. of final report on HHWs programme review by ISC under Health component of KUSP.

Sirs,

I am directed to state that your quotation submitted under your letter dt. 11.03.2005 has been accepted by the appropriate Authority.

You are now requested to take up the job as described below :

Specification :

No. of Books	:	50 Pcs
No. of pages	:	175
Size	:	A4
Printing	:	Xerox inside
Printing Cover	:	Colour Digital
Paper	:	Maplitho
Binding	:	Spiral
Cover	:	Clear & Opaque Plastic

Terms and Conditions :

1) Delivery : Within a period of 10 (Ten) days from the date of this order
2) Payment : After delivery and submission of the bill.
3) Taxes /Charges : The above rate is inclusive of all taxes / charges
4) Delivery : Free
5) I.T. Deduction at Source : As per rules.

The total value of the order is Rs. 11,950/- (Rupees Eleven thousand nine hundred fifty) only inclusive of all charges, taxes and delivery charges.

After the supply is complete, the claim may be preferred through bill (in triplicate) raised in favour of Project Director, Change Management Unit, along with receipted copy of Challan. The payment will be made through account payee cheque.

This order issues with the approval of Project Director, CMU.

Yours faithfully,

Health Expert

UJGUS BHAVAN, HC BLOCK, SECTOR 3, BIDHANNAGAR, KOLKATA 700 106
PH : 033-2337 8723, 2337 7315, 2358 6403 / 5767, FAX : 033-2337 7318 / 2358 5800

Memo No. CMU-28/2002(Pt. II)/840/1(4) Dt. 18.03.2005

Copy forwarded for information and necessary action to :

1. Project Director, CMU
2. Project Manager, CMU
3. Financial Adviser, CMU
4. Accounts Officer, CMU

Health Expert

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Yours faithfully,

Health Expert

JIGUS BHAVAN, HC BLOCK, SECTOR 3, BIDHANNAGAR, KOLKATA 700 106
PH : 033-2337 8723 / 2337 7315 / 2358 6403 / 5767 FAX : 033-2337 7318 / 2358 5800

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Health Expert

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3. Financial Adviser, CMU
4. Accounts Officer, CMU

Health Expert

STD Code 033
Phone : Office : 633 5283
Resi : 633 5264

OFFICE OF THE MUNICIPAL COUNCILLORS

BHADRESWAR, DIST. HOOGHLY.

From : S. Nandy Majumder, Health Officer
Chairman/Vice-Chairman/Councillors, Bhadreswar Municipality

Memo No. Health. 178 Dated, Bhadreswar the 23th Feb. 2005

To
Sri Arnab Roy, IAS
Project Director Change Management Unit
Kolkata Urban Services for the poor (KUSP)
ILGUS Bhavan, HC Block, Kolkata - 700106

Sub:- Implementation of Health Camp under KUSP.

Sir,

We have completed "Baby Show" within our Municipality as per letter of KMDA dated 10/11/04 (Xerox Copy is given for necessary action) We have done it in phased manner from Block till Municipal level. All the papers regarding awareness is also given along with. Hereby I am sending all the bills of expenditure made for early release of fund. Total amount is Rs. 12243.00 (Twelve thousand two hundred and forty three) only.

Thanking your,

Faithfully yours

Health Officer
Bhadreswar Municipality.

Memo No. Health. 178/1(2) Dated, 23th Feb. 05.

Copy to the Chairman, Bhadreswar Municipality for information.
Copy to the O.S.D (H) UHIP KMDA for information.

Health Officer
Bhadreswar Municipality.

STD Code : 033
Phone : 83-5283

Office of the Municipal Councillors

BHADRESWAR, DIST. HOOGHLY

From : [redacted], Dr. Suchita Nandy Majumder Health Officer, ~~Chairman/Vice-Chairman/Councillor~~ Bhadreswar Municipality

Health. 869

Dated, Bhadreswar the 16th December '04.

To
The Health Officer,
The Asstt. Health Officer,
The Paedeatrician,
ESOPD/CUDP-III/IPP-~~III~~ III
The Supdt, Ankur.

Sub : 'Baby Show'.

As per KMDA, norms, we have done 'Baby Show' and prelimenery selection is complete at Block Level. Now, there will selection at Health Administrative Unit.

I am glad to inform you that you are selected as 'Judges' for the said Baby Show.

1) 18/12/2004 - 12 Noon at IPP-VIII HAU-I N.S.Road.
2) 20/12/2004 - 12 Noon at CUDP-II Subhas Maidan
3) 21/12/2004 - 12 Noon at Segun Bagan
4) 24/12/2004 - 12 Noon at Digra HAU.
5) 08/01/2005 - 12 Noon at Sampriti Mela.

Hope your co-operation.

Thanking you,

Yours faithfully,

Health Officer,
Bhadreswar Municipality.

Health Officer
BHADRESWAR MUNICIPALITY

Kolkata Metropolitan Development Authority

URBAN HEALTH IMPROVEMENT PROGRAMME UNIT

Unnayan Bhavan, Bidhannagar, 'G' Block, 1st, 2nd & 3rd floor, Kolkata – 700 091.
☎ : 2334-5257/2337-0697/2358-6771/2337-4103. FAX Nos. : 2358-3931 & 2358-7368 E-mail : cmdaipp8@vsnl.net

No 926(7) / I-1/KMDA/UHIPU/04 Dated: 10.11.2004

From: The Officer On Special Duty
UHIP Unit, KMDA.

To: The Chairman
New Barrackpore/South Dum Dum/Bhadreswar/Budge Budge/
Khardah/Uluberia & Madhyamgram Municipality.

Re: Implementation of health component under KUSP.

Sir,

This is to inform you that KMDA has been requested by KUSP to undertake the following health components during the current financial year :

1. **Refresher training course for HHWs for updating their skill.**
2. **Household survey to update the family schedules.**
3. **IEC activities and health awareness campaign.**

The course content and other details of the above health components have been developed by KMDA in consonance with the changing health scenario in the KMA.

A meeting at the IEC Conference Room at Unnayan Bhavan, 2nd floor, 'G' Block will be held to discuss the draft design and course content of the health components.

You are requested to kindly attend the said meeting on 17th November,2004 at 2-00 P.M. at the IEC Room along with your Health Officers to examine the draft and render your valued suggestions in this regard.

Yours faithfully,

10/11/2004
OSD,UHIPU,KMDA

No / I-1/KMDA/UHIPU/04 Dated: 10.11.2004

Copy forarded for information and necessary action to :-

1. Dr. K.L. Mukherjee, DCOH,UHIPU,KMDA
2. Dr. P.K. Chatterjee,ACOH,UHIPU,KMDA
3. Dr. Chaitali Mukherjee, ACOH,UHIPU,KMDA
4. Shri H.P. Mondal,WBCS(Ex),Project Coordinator,UHIPU,KMDA
5. Shri P. Aich Bhowmick,IEC,UHIPU,KMDA
6. Dr. B.B. Biswas, MIES,UHIPU,KMDA

OSD,UHIPU,KMDA

AHO for na please

23/11/04

Please refer to the number with file mark and date of the letter in future reference

Phone : { STD Code 033
Office : 633 5283
Resi : 633 5264

OFFICE OF THE MUNICIPAL COUNCILLORS

BHADRESWAR

No. 8008-27(20).

From : SRI DEBAGOPAL CHAKRABARTI,
Chairman, Bhadreswar Municipality

To All Councillors
Bhadreswar Municipality.

Dated, Bhadreswar, the 16th December, 2004.

Sir/Madam,

I am glad to inform you that HAU Level Baby Show will be held as per schedule given below. Please make it convenient to attend the same.

Sl.No.	Venue	Date & Time
1.	IPP-VIII, N.S. Road	18/12/2004 at 12 Noon.
2.	CUDP-III -II Subhas Maidan	20/12/2004 at 12 Noon.
3.	CUDP-III -I Segun Bagan	21/12/2004 at 12 Noon.
4.	IPP-VIII - II Digra	24/12/2004 at 12 Noon.
5.	Municipal Level at Subhas Maidan	08/01/2005 at 12 Noon.

Thanking you,

Yours faithfully,
Dgchakrabarti.
16.12.2004.
Chairman.

ভদ্রেশ্বর পৌরসভা
স্বাস্থ্য বিভাগ
বিজ্ঞপ্তি

স্মারক সংখ্যা:

আগামী ৩রা ডিসেম্বর,০৪, শুক্রবার, বেলা ১২টার সময়, অঙ্কুর প্রশিক্ষণ হলে কাস্প্ কর্মসূচী নিয়ে একটি আলোচনার আয়োজন করা হয়েছে। এই আলোচনায় আপনাকে অবশ্যই যোগদান করতে হবে।

আলোচ্যসূচী

১। কাস্প্ এর আই.ই.সি. কর্মসূচীর শিশুপ্রদর্শনী এবং মায়েদের কুইজ ও তাৎক্ষণিক বক্তৃতার উপস্বাস্থ্যকেন্দ্র এইচ.এ.ইউ.স্তরে অনুষ্ঠানের তারিখ স্থির করা।

২। ঐ অনুষ্ঠানগুলির আর্থিক ব্যয় অনুমোদন।

৩। ঐ অনুষ্ঠানগুলির বিচারকমন্ডলী স্থির করা।

৩। লোকরঞ্জক অনুষ্ঠান।

৪। প্রশিক্ষণ।

৫। স্বাস্থ্যমেলায় অংশগ্রহণ।

এই সঙ্গে প্রদত্ত সারকুলারটি পড়ে আপনাদের আগামী সাপ্তাহিক মিটিং(২৯।১১,৩০।১১।১।১২) আলোচনা করে, তারিখগুলি সম্বন্ধে সিদ্ধান্ত নিয়ে এই আলোচনাসভায় মতামত দেবেন।

৩১১১০৪

২৯/১১/০৪

ডাঃ শুচিতা নন্দী মজুমদার,
স্বাস্থ্য-আধিকারিক,
ভদ্রেশ্বর পৌরসভা।

অনুলিপি:

১/ পৌরপ্রধান,ভ.পৌ.স.।২/ উপ-পৌরপ্রধান,ভ.পৌ.স.। ৩/পৌরপ্রধান পারিষদ- স্বাস্থ্য, ভ.পৌ.স.।
৪/সহ-স্বাস্থ্য-আধিকা ,ভ.পৌ.স.।৫/ইউ.এইচ.আই.ও., ভ.পৌ.স.। ৬/স্টাফ নার্স, ভ.পৌ.স.।
৭/প্রশাসনিক ম্যানেজার, অঙ্কুর। ৮/শ্রী শুভময় চ্যাটার্জী।
৯/-৩৭/ ভ.পৌ.সভার সকল এইচ.এ.ইউ.র সকল ১ম ও ২য় স্তরের পরিদর্শক (এফ.টি.এস./এস.টি.এস.)।

২৯/১১/০৪

ডাঃ শুচিতা নন্দী মজুমদার,
স্বাস্থ্য-আধিকারিক,
ভদ্রেশ্বর পৌরসভা।

ভদ্রেশ্বর পৌরসভা

প্রজ্ঞাপন

তাং ২৩।১১।০৪

স্মারক সংখ্যা:

কলকাতা আর্বান সার্ভিসেস ফর দি পুওর (কাসপা) এর আই.ই.সি. কর্মসূচীর অন্তর্গত জনস্বাস্থ্যমূলক নিম্নবর্ণিত শনী ও প্রতিযোগিতার আয়োজন করা হবে:-

১/ শিশু-প্রদর্শনী।

২/ কিশোরী ও মায়েদের জন্য কুইজ প্রতিযোগিতা। বিষয়: যৌনরোগ ও এইচ.আই.ভি।

৩/কিশোরী ও মায়েদের জন্য তাৎক্ষণিক বক্তৃতা প্রতিযোগিতা।
বিষয়: শিশুর যত্ন, মায়ের যত্ন, ভন্যপান, পরিবার পরিকল্পনা, নিরাপদ পানীয় জল।

৪ ৩য় থেকে ৮ম শ্রেণী পর্যন্ত ব্যক্তিগত স্বাস্থ্য সম্বন্ধে কুইজ প্রতিযোগিতা।

৫ স্বাস্থ্য-প্রদর্শনী। বিষয়: প্রজনন ও শিশু স্বাস্থ্য ও পুষ্টি।

সাংগঠনিক পরিকল্পনা

প্রধান সংগঠক: স্বাস্থ্য-আধিকারিক, ভদ্রেশ্বর পৌরসভা।

সহকারী সংগঠক: সহ-স্বাস্থ্য-আধিকারিক, ভদ্রেশ্বর পৌরসভা।

আর্থিক সংগঠক: প্রসাশনিক ম্যানেজার, অঙ্কুর।ইউ.এইচ.আই.ও., ভদ্রেশ্বর পৌরসভা।

ব্যবস্থাপনা সংগঠনে: স্টাফ নার্স, ভদ্রেশ্বর পৌরসভা। ইউ.এইচ.আই.ও., ভদ্রেশ্বর পৌরসভা।

সহকারী: রেজি. নার্স, আই.পি.পি. ৮।

করণিক ও কম্পিউটার অপরেটর: শ্রী শুভময় চ্যাটার্জী।

দায়িত্ব:

প্রধান সংগঠক: পরিকল্পনা ও রূপায়ন।

আর্থিক সংগঠক: প্রয়োজনীয় সামগ্রী ও অর্থের ব্যবস্থা ও U/C প্রস্তুতি।

ব্যবস্থাপনা সংগঠক: বিভিন্ন স্তরে প্রদর্শনী ও প্রতিযোগিতার আয়োজন করা। বিজ্ঞানকমন্ডলীর সঙ্গে যোগাযোগ।

পরিকল্পনা:

১। শিশু প্রদর্শনী:

৩টি বিভাগ: ক) অনূর্ধ্ব ৬ মাস। খ) ৬মাস-১৮ মাস। গ) ১৮মাসের বেশি- ৩বছর।

প্রাথমিক ভাবে উপ-স্বাস্থ্যকেন্দ্রে বাছাইপর্ব অনুষ্ঠিত হবে। উপ-স্বাস্থ্যকেন্দ্রগুলি থেকে প্রতি বিভাগে ৫জন করে পরবর্তী পর্যায়ে এইচ.এ.ইউ. স্তরে (অর্থাৎ সেগুনবাগান ও সুভাষ ময়দানের ২টি এইচ.এ.ইউ.তে প্রতি বিভাগে ৫*৬=৩০, মোট ৩০*৩=৯০, এবং দিগড়াতে প্রতি বিভাগে ৫*৫=২৫ ও মোট ২৫*৩=৭৫জন) প্রতিযোগিতা হবে। প্রতি এইচ.এ.ইউ. থেকে প্রতি বিভাগে ৫জন করে পরবর্তী ও চূড়ান্ত পর্যায়ে পৌরসভা স্তরে (অর্থাৎ প্রতি বিভাগে ৫*৪=২০, মোট ২০*৩=৬০) প্রতিযোগিতা অনুষ্ঠিত হবে। চূড়ান্ত পর্যায়ের প্রতিযোগিতার সম্ভাব্য সময় জানুয়ারী মাসে মেলার সময় (৮/১/২০০৫,শনিবার, বেলা ১১টা)।

উপস্বাস্থ্যকেন্দ্রে শিশুপ্রদর্শনীর আয়োজনের মূল দায়িত্বে থাকবেন সেই উপস্বাস্থ্যকেন্দ্রের এফ.টি.এস.।

এইচ.এ.ইউ. স্তরে আয়োজনের ও ইউটিলাইজেসন সার্টিফিকেট প্রস্তুতির দায়িত্ব নেবেন: এস.টি.এস.।

বাছাই পর্বে যে সব বিষয়ে গুরুত্ব দেওয়া হবে

মায়ের সচেতনতা-- কত বছর বয়সে বিবাহ, বিবাহের কতদিন পরে প্রথম সন্তানধারণ, মোট কতবার গর্ভবতী ও কতগুলি সন্তান, সন্তানের জন্মের ব্যবধান, নবজাতক ও শিশুর যত্ন বিষয়ে ধারণা, পরিবার পরিকল্পনা, নিজের

রক্তের গ্রুপ জানেন কিনা।

শিশুর স্বাস্থ্য-- জন্মের ক্রম, গর্ভবতী মা ১২সপ্তাহের মধ্যে নাম নথিভুক্ত করিয়েছিলেন কিনা, কতবার প্রাক-প্রসব ও প্রসবোত্তর পরীক্ষা, গর্ভবতী অবস্থায় রক্তপরীক্ষা হয়েছিল কিনা, টিটেনাসের প্রতিষেধক টীকা দেওয়া হয়েছিল কিনা, কোথায় প্রসব হয়েছিল।

শিশুর জন্মকালীন ওজন, স্বাভাবিক প্রসব না হলে মা তার কারণ জানেন কিনা, জন্মের কতক্ষণ পর প্রথম স্তন্যপান করেছিল, কোলোস্ট্রাম খেয়েছিল কিনা, কতদিন কেবল স্তন্যপান করেছে, বছর বয়সে অন্য খাবার খাওয়া শুরু করেছে, নিয়মিত টীকাকরণ হয়েছে কিনা, নিয়মিত ওজন পরীক্ষা হয়েছে কিনা, কোনো বড় অসুখ হয়েছিল কিনা, শিশুর বৃদ্ধি ও বিকাশের কোনো সম[illegible] আছে কিনা।

এই প্রদর্শনীতে যোগদানের জন্য শিশুর জন্মের প্রমাণপত্র, টীকার নথি, কোনো অসুখ হয়ে থাকলে তার কাগজ অবশ্য করে আনতে হবে। বাছাই পর্বে সব অংশগ্রহণকারী শিশুকে শংসাপত্র দেওয়া হবে। পরবর্তী পর্যায়ে যারা নির্বাচিত হবে, তাদের পুরস্কৃত করা হবে, এবং পরবর্তী পর্যায়ে অংশগ্রহণকালে উপহার দেওয়া হবে।

শিশুদের অবশ্যই সেই উপস্বাস্থ্যকেন্দ্র এলাকার বাসিন্দা হতে হবে।

উপস্বাস্থ্যকেন্দ্রগুলির শিশুপ্রদর্শনী ৮ই-১৬ই ডিসেম্বরের মধ্যে শেষ করতে হবে।

এইচ.এ.ইউ. স্তরে এই অনুষ্ঠান ২০শে থেকে ৩০শে ডিসেম্বরের মধ্যে করতে হবে।

উপস্বাস্থ্যকেন্দ্রে বিচারক হিসাবে থাকবেন: এস.টি.এস. রেজি: নার্স (আই.পি.পি.-৮ ও ইউ.এইচ.আই.পি.), পি.টি.এম.ও.।

এইচ.এ.ইউ. ও পৌরসভা পর্যায়ে বিচারকমন্ডলীর প্যানেল:

স্বাস্থ্য-আধিকারিক, সহ-স্বাস্থ্য-আধিকারিক, পি.টি.এম.ও., অঙ্কুরের আর.এম.ও., শিশুরোগবিশেষজ্ঞ, গাইনি, পৌরসভার সঙ্গে যুক্ত অন্যান্য চিকিৎসক।

২। কিশোরী ও মায়েদের কুইজ ও তাৎক্ষণিক বক্তৃতা প্রতিযোগিতা:

এই প্রতিযোগিতাগুলিতে যাতে সকলে উৎসাহের সঙ্গে অংশ নেন, তার জন্য প্রত্যেক উপস্বাস্থ্যকেন্দ্রে, প্রয়োজনে ব্লকে কিশোরী ও মহিলাদের নিয়ে নির্দিষ্ট বিষয়গুলি নিয়ে আলোচনাচক্রের আয়োজন করতে হবে। এই সমস্ত আলোচনাচক্রগুলি অবশ্যই ১৫ই ডিসেম্বরের মধ্যে শেষ করতে হবে। উপস্বাস্থ্যকেন্দ্রে আলোচনাচক্রের আয়োজনের মূল দায়িত্বে থাকবেন সেই উপস্বাস্থ্যকেন্দ্রের এফ.টি.এস.। তিনি এইচ.এ.ইউ.র এস.টি.এস. এবং ব্যবস্থাপকের সহায়তা পাবেন।

মূল প্রতিযোগিতা এইচ.এ.ইউ. গুলিতে অনুষ্ঠিত হবে; প্রয়োজনে পৌরসভাস্তরে একটি চূড়ান্ত প্রতিযোগিতার আয়োজন করা যেতে পারে, যা মেলার সময়ে অনুষ্ঠিত হবে। তাই এইচ.এ.ইউ. স্তরে প্রতিযোগিতা [illegible] ডিসেম্বরের মধ্যে করে ফেলা বাঞ্ছনীয়। (যদি চূড়ান্ত প্রতিযোগিতা না হয়, তবে এইচ.এ.ইউ. স্তরে প্রতিযোগিতা ফেব্রুয়ারি ২০০৫এ করা যেতে পারে। সেক্ষেত্রে উপস্বাস্থ্যকেন্দ্রে আলোচনাচক্রগুলি স্বাস্থ্যকর্মী প্রশিক্ষণের পর করা হবে।)

প্রতিযোগীদের অবশ্য [illegible] সেই উপস্বাস্থ্যকে[illegible] লাকার বাসিন্দা হতে হবে। একজন প্রতিযোগী প্রতিযোগিতাতেই নাম দিতে পারবেন। প্রত্যেক প্রতিযোগীকে উপহার দেওয়া হবে।

আলোচনাচক্রের জন্য প্রয়োজনীয় বই, ও অন্যান্য শিক্ষণবস্তুর তালিকা সহকারী ব্যবস্থাপক প্রস্তুত করে উচ্চপর্যায়ের আধিকারিকদের অনুমোদন নেবেন। (ভলান্টারি হেলথ এ্যাসোশিয়েশনের প্রকাশনাগুলির সহায়তা নিতে পারেন।)

প্রতিযোগিতার ভাষা: বাংলা, হিন্দি। তাৎক্ষণিক বক্তৃতা প্রতিযোগিতার সময়: [illegible]ত প্রতিযোগী ২+১ মিনিট।

প্রতি এইচ.এ.ইউ.তে পরপর ২দিন ধরে অয়োজন করা যেতে পারে। ১ম দিন শিশুপ্রদর্শনী ও ২য় দিন আলাদা আলাদা সময়ে অথবা একই সময়ে ঐ স্থানে আলাদা জায়গায় ২টি প্রতিযোগিতার আয়োজন করা যেতে পারে।

ব্যক্তিগত স্বাস্থ্য বিষয়ে কুইজ:

২টি বিভাগ: ক) ৩য়-৪র্থ শ্রেণি। খ) ৫ম-৭ম শ্রেণি।

মেলার সময়ে অনুষ্ঠিত হবে। বিদ্যালয়ের শিক্ষক-শিক্ষিকা ও অবিভাবক-অভিভাবিকাদের এই বিষয়ে অবহিত করতে হবে। বিস্তারিত নিয়মাবলী পরে বিদ্যালয়ে পাঠানো হবে।

লোকরঞ্জক অনুষ্ঠান /ফোক প্রোগ্রাম:

প্রতি এইচ.এ.ইউ.তে ১টি করে। প্রত্যেক এইচ.এ.ইউ.র এস.টি.এস ঐখানে অনুষ্ঠিতব্য প্রোগ্রামটির সম্ভাব্য তারিখ ২০শে জানুয়ারি ২০০৫এর মধ্যে স্বাস্থ্য-আধিকারিকের কাছে জমা দেবেন।
এছাড়াও অঙ্কুরে ১টি ও স্বাস্থ্যমেলায় ৩টি অনুষ্ঠিত হবে।

এইচ.এ.ইউ. স্তরে ৩১শে জানুয়ারি ২০০৫, ও পৌরসভা স্তরে ২৮শে ফেব্রুয়ারি ২০০৫এর মধ্যে সব ইউটিলাইজেসন সার্টিফিকেট সম্পর্ণ করতে হবে।

ডাঃ শুচিতা নন্দী মজুমদার,
স্বাস্থ্য-আধিকারিক,
ভদ্রেশ্বর পৌরসভা।

SUB-VOUCHER NO.

BHADRESWAR MUNICIPALITY

The Municipal Councillors Bhadreswar Dr.

To The Chairman Bhadreswar Municipality

of

APPROVAL SLIP 633 5857

SONALI

STATIONER & ORDER SUPPLIERS

65, G. T. Road, Bhadreswar Hooghly.

M/s Chairman, Bhadreswar Municipality

PARTICULARS	VALUE
72 Pcs Stainless Thala (Big) @ 20/-	1440.00
72 " Do (Med) @ 16/-	1152.00
72 " Do (Sm) @ 12/-	864.00
144 Pcs " Bati - @ 8/-	1152.00
3 Pcs. Thermo Flask @ 125/-	375.00
TOTAL	4783.00

Sir, Said this [illegible] ... for baby show ... the payment ... the bond

Pay [illegible]

Date— 19.07.05

Signature

পয়সা

Dated 200

CHAIRMAN BHADRESWAR MUNICIPALITY

Signature of the actual payee

SUB-VOUCHER NO.

BHADRESWAR MUNICIPALITY

The M[illegible]cipal Councillors Bhadreswar Dr.

To The Chairman

of Bhadreswar Municipality

APPROVAL SLIP 633-5857

SONALI

STATIONER & ORDER SUPPLIERS

65, G. T. Road, Bhadreswar, Hooghly.

M/s Chairman, Bhadreswar Municipality

PARTICULARS	VALUE
2018 Pcs. Stainless Steel Spoon @ 2/-	4036.00
3 Pcs. Jug type flask - @ 95/-	285.00
3 " flask - @ 80/-	240.00
6 Pcs. Water Bottle @ 35/-	210.00
500 gm Eraser	95.00
TOTAL	4866.00

Sir, Said [illegible] for baby show ... this payment may be paid

Pay this [illegible] (Rupees Four thousand ...)

Date— 19.07.05

Signature

পয়সা

payee

SUB-VOUCHER NO.

BHADRESWAR MUNICIPALITY

The Municipal Councillors Bhadreswar ______ Dr.

To the Chairman

of Bhadreswar Municipality

DATE	PARTICULARS	AMOUNT Rs.	P.
	In connection of baby show		
	final Round held on 8 Dec. 04		
	Tea and snack @ 2.00 X 100 heads	200	00
	Tea @ 1.00 X 100	100	00
		300	00

Pay Rs. (300.00) [illegible]) উল্লিখিত হিসাবের টাকা পয়সা পাইয়া অত্র রসিদ দিলাম।

Accountant ______ Chairman

Dated ______ 2005 ______ Signature of the actual payee

SUB-VOUCHER NO.

BHADRESWAR MUNICIPALITY

The Municipal Councillors Bhadreswar ______ Dr.

To the chairman Bhadreswar Municipality

TRIPTI
Prop.— SANKAR ROY
Stationers & General Order Suppliers
20, G. T. Road
Bhadreswar, Hooghly.

PARTICULARS	AMOUNT Rs.	P.
Colour Ribbon [illegible]	125	00
Balloon big 5 Packet	100	00
[illegible]		
Plastic flower	82	00
Total Rs	407	00

পয়সা ... দিলাম।

/ payee

SUB-VOUCHER NO.

BHADRESWAR MUNICIPALITY

The Municipal Councillors Bhadreswar Dr.

To The Chairman

of Bhadreswar Municipality

DATE	PARTICULARS	AMOUNT Rs.	P.

Sagarika
Chandannagore

Folder @ Rs. 12 x 25 Pices 300.00

300.00

Pay Rs. (Three hundred) উল্লিখিত হিসাবের টাকা পয়সা

পাইয়া অত্র রসিদ দিলাম।

Accountant Chairman

Dated 11/12 200

Signature of the actual payee

SUB-VOUCHER NO.

BHADRESWAR MUNICIPALITY

The Municipal Councillors Bhadreswar Dr.

To The Chairman

of Bhadreswar Municipality

DATE	PARTICULARS	AMOUNT Rs.	P.
	For Donation of baby show 1st Name held on 6, 9, 11, 13, 16 Dec 04		
	Tea & snacks @ 3.00		
	3.00 x 5 days x 15 heads	225	00

Pay Rs. (Two hundred twenty five) উল্লিখিত হিসাবের টাকা পয়সা

পাইয়া অত্র রসিদ দিলাম।

Accountant Chairman

Dated 11/12 2004

Signature of the actual payee

SUB-VOUCHER NO.

BHADRESWAR MUNICIPALITY

The Municipal Councillors Bhadreswar Dr.

To the chairman

of Bhadreswar Municipality

DATE	PARTICULARS	AMOUNT Rs.	P.
	Manasha Sweet **Bhadreswar**		
	5 pac kits x @ Rs 10.00 = 50.00		
	Manasha Patra 50.00		

Pay Rs. (50 ...) উল্লিখিত হিসাবের টাকা পয়সা পাইয়া অত্র রসিদ দিলাম।

Accountant Chairman

Dated 2005

Manasha Patra

Signature of the actual payee

SUB-VOUCHER NO.

BHADRESWAR MUNICIPALITY

The Municipal Councillors Bhadreswar Dr.

To the chairman

of Bhadreswar Municipality

DATE	PARTICULARS	AMOUNT Rs.	P.
	Colour Xerox Center Bagbazar, Chandannagore		
	Colour Xerox @ 9 x 25 copes = 225.00		
	225.00		

Pay Rs. (225.00) উল্লিখিত হিসাবের টাকা পয়সা পাইয়া অত্র রসিদ দিলাম।

Accountant Chairman

Dated 2005

D. Tirkuluh

Signature of the actual payee

SUB-VOUCHER NO.

BHADRESWAR MUNICIPALITY

The Municipal Councillors Bhadreswar Dr.

To The Chairman

of Bhadreswar Municipality

DATE	PARTICULARS	AMOUNT Rs.	P.
	GOURANGA STORES		
	CHAMPI NI		
	3 Pices Towal x Rs. 130.00 =	390.00	
		390.00	

Gouranga Agarwal

Pay Rs. (Three Hundred Ninety) ডাঃ/লিখিত হিসাবের টাকা পয়সা পাইয়া অত্র রসিদ দিলাম।

Accountant Chairman

Dated 11/12 200

Gouranga Agarwal
Signature of the actual payee

SUB-VOUCHER NO.

BHADRESWAR MUNICIPALITY

The Municipal Councillors Bhadreswar Dr.

To The Chairman

of Bhadreswar Municipality

DATE	PARTICULARS	AMOUNT Rs.	P.
	Satya Varity Stores Sasthitala, Bhadreswar		
	৫ পিস তোয়ালে × @ ৳ 32.00 =	60.00	
	১ পিস লুঙ্গি =	32.00	
		92.00	

Satya Dey

Pay Rs. (Ninety Two) ডাঃ/লিখিত হিসাবের টাকা পয়সা পাইয়া অত্র রসিদ দিলাম

Accountant Chairman

Dated 11/12 200

Satya Dey
Signature of the actual payee

SUB-VOUCHER NO.

BHADRESWAR MUNICIPALITY

The Municipal Councillors Bhadreswar Municipality Dr.

To The Chairman

of Bhadreswar Municipality

DATE		AMOUNT Rs.	P.

Pay Rs. (Eighty five only) উপরিলিখিত হিসাবের টাকা পয়সা পাইয়া অত্র রসিদ দিলাম।

Accountant Chairman

Dated 14.4.2005

Signature of the actual payee

wbvha
West Bengal Voluntary Health Association
WORKING TOGETHER FOR HEALTH & DEVELOPMENT

Dr. Goswami
26/3

Sri.Arnab Roy I.A.S.
Project Director, KUSP
State Urban Development Agency
ILGUS Bhavan, HC Block, Sec-III, Salt Lake
Kolkata-700 106

sch/wbvha.14
16th March, 2005

Sub: Training on HIV/AIDS & STDs for HHWs, FTS in HAUs

Respected Sir,

Upon invitation from Col.G.Gangopadhya, Health Adviser and Dr.Shibani Goswami, Project Officer, Health Unit, KUSP for submission of project proposal on "Training on HIV/AIDS and STDs for the Health Staff of HUs" for 2 days, we have submitted the PP along with all necessary credentials on demand. We are explained in detail by Col.Gongopadhya and Dr.Goswami about the thrust areas in the course outline as depicted in the guidelines and surely this has been our specialized area we are covering last one decade in various program for Adolescents Reproductive and Sexual Health, HIV/AIDS Prevention and Control program and Tender Minds Counseling center in the city.

We had similar opportunity to serve CMDA in 1993 given with responsibility to train municipal commissioners, medical officers, councilors, supervisors and several others in large numbers for 37 municipalities in the state. It was an exciting experience that we often fondly remember. Still we have the same craving and sprit coupled with decadal experience and expertise on various areas and developed an ability to integrate uniquely in every of the delivery.

Trust, this time too we would be given opportunity to make our branded quality available for the targeted invention areas KUSP intending to. Waiting to receive your call at an early date.

With kind regards,

Sincerely yours,

Aminul Ahsan
Project Director
Health Promotion and IEC
Development

KOLKATA URBAN SERVICES FOR THE POOR

CHANGE MANAGEMENT UNIT

Memo No. CMU-28/2002(Pt. II)/840 Dt.. 18.03.2005

From : Dr. Shibani Goswami
Health Expert, CMU

O/C

To : M/S Contre Jour
6/1, Dehi Entally Road
Kolkata 700 014.

Sub. : Work order for Xerox printing, binding and supply of 50 (fifty) nos. of final report on HHWs programme review by ISC under Health component of KUSP.

Sirs,

I am directed to state that your quotation submitted under your letter dt. 11.03.2005 has been accepted by the appropriate Authority.

You are now requested to take up the job as described below :

Specification :

No. of Books	:	50 Pcs
No. of pages	:	275
Size	:	A4
Printing	:	Xerox inside
Printing Cover	:	Colour Digital
Paper	:	Maplitho
Binding	:	Spiral
Cover	:	Clear & Opaque Plastic

Terms and Conditions :

1) Delivery : Within a period of 10 (Ten) days from the date of this order
2) Payment : After delivery and submission of the bill.
3) Taxes /Charges : The above rate is inclusive of all taxes / charges
4) Delivery : Free
5) I.T. Deduction at Source : As per rules.

The total value of the order is Rs. 11,950/- (Rupees Eleven thousand nine hundred fifty) only inclusive of all charges, taxes and delivery charges.

After the supply is complete, the claim may be preferred through bill (in triplicate) raised in favour of Project Director, Change Management Unit, along with receipted copy of Challan. The payment will be made through account payee cheque.

This order issues with the approval of Project Director, CMU.

Yours faithfully,

Health Expert

ILGUS BHAVAN, HC BLOCK, SECTOR 3, BIDHANNAGAR, KOLKATA 700 106
PH : 033-2337 8723, 2337 7315, 2358 6403 / 5787 FAX : 033-2337 7318 / 2358 5800

Memo No. CMU-28/2002(Pt. II)/840/1(4) Dt.. 18.03.2005

Copy forwarded for information and necessary action to :

1. Project Director, CMU
2. Project Manager, CMU
3. Financial Adviser, CMU
4. Accounts Officer, CMU

Health Expert

Project Director

From: "Athar Haq" <haque@ehealth-care.net>
To: <kuspcmu@vsnl.net>
Sent: Sunday, March 13, 2005 2:18 PM
Subject: National Award for eHealth-Care

eHealth-Care Foundation, a NGO based in New Delhi an “Internet based {eHealth-Care / Card} project for benefiting Rural / Urban Poor Population” has received the National Award for Year 2004 Exemplary Implementation for eGovernance Initiatives (Silver Icon) under ‘Innovative Operations and Best Practices’ – Professional Category.

The award was presented by the Union Minister for Information Technology Mr. Dayanidhi Maran at the 8th National Conference on eGovernance held on 3rd – 5th February 2005 at Bhubaneshwar, Orissa. The award and conference was jointly organised by the Department of Information Technology (Government of India) and Department of Administrative Reforms & PG (Government of India) and Department of Information Technology (Government of Orissa).

Project eHealth-Care is designed for all the districts of India where the villagers can get benefit through services on Rural Health Care, Insurance, eBlackBoard, eGovernance and eCommerce. It is to give the have not, tools that can empower them to take decisions, build themselves and demand what they deserve.

They have implemented project at General & Civil Hospital, Sirsa district of Haryana State of India in association of District Administration and District Red Cross Society. Also implemented Birth / Death Registration & Certificate software. Wireless on Local Loop (WLL) Telephone & ISP connection is used for Data Transfer. Polio affected handicapped personnel has been hired for issuance of Health Cards. Around 46000 rural & urban people has benefited by the project. Here, they have bagged order from the Deputy Commissioner, Sirsa to implement at all 178 PHC’s / CHC’s / Hospitals.
‘eHealth-Care’ project is finalists of the “Stockholm Challenge Award 2003/2004” Nearly 900 projects from 107 countries entered the Stockholm Challenge Award.
Around 46000 health cards have been distributed to the people of Sirsa. Out of which 10000 cards distributed to the Below Poverty Line (BPL) people Free of Cost. Rest 36000 cards made for general population. Which has generated revenue of Rs. 1,80,000/- (Rupees, One Lakh and Eighty thousand Only). [@ Rs.5/- per card]. The District Red Cross Society is keeping the entire Transaction amount for sustenance of project. Simultaneously, the medical data of the patient are being stored and upgraded on regular basis which can be accessed from any where in the world by authorised user.

e-Swasthya: A Health Card & Online Medical Advice Software provided to network 26 health centres for benefiting unprivileged mass of the

Madhubani district, Bihar using Information Technology. It enables the patients to walk into any health centre and with the patient ID their health history would be extracted from the network, which can also be updated by the authorized user. The MPLAD Fund of Ex-M.P-Rajya Sabha is used to develop the infrastructure.
Digital Partners Global, a USA based Non Profit organisation in presence of Confederation of Indian Industries (CII) awards the project for the ‘Best Innovation in Information Technology for upliftment of poor’ for the year 2002-03.

Athar Haque

President: eHealth-Care Foundation
(A registered NGO under Society Registration Act(XXI) of 1860)
Director: eHealth-Care
(An Information Technology Company)

Mobile: +91-9811257571
Tele: +91-9313063198
Fax: +91-11-51644688
Email: haque@ehealth-care.net
Address: D-81, Ground Floor, (Bliss), Kalkaji, New Delhi-110019, India

Branches: Patna, Deoria, Muzaffarpur, Gurgaon, Sarguja, Bhopal, Noida

Please visit us at www.ehealth-care.net / www.eswasthya.net for more information.

"No success or achievement in material terms is worthwhile unless it serv es the needs or interests of the country and its people and is achieved by fair and honest means." ..... J R D Tata

wbvha
West Bengal Voluntary Health Association
WORKING TOGETHER FOR HEALTH & DEVELOPMENT

1885

Dr. Goswami

Sri.Arnab Roy I.A.S.
Project Director
Change Management Unit, KUSP
State Urban Development Agency
ILGUS Bhavan, HC Block, Sec-III, Salt Lake
Kolkata-700 106

sch/wbvha.05
23rd February, 2005

Sub: Proposal for training of HHWs, FTS and Mid-level health functionaries on HIV/AIDS and STDs in ULBS under KUSP Health Programme

Dear Sir,

Thank you for your invitation to hold series of training workshop on HIV/AIDS for Honorary Health Workers, First Tier Supervisors and others in ULBS under 40 municipalities in the state.

It had been our exciting experience and opportunity in 1993 to sensitize large number of Municipal (37 Municipalities) commissioners, councilors, chairman, medical officers, Health workers in Unnayan Bhavan,Salt Lake. CMDA Senior officers, Health Wing took active part in facilitating all those workshops. Col. Dr. G. Gangopadhya Health Adviser, was the main source of inspiration and guide too. We solemnly remember the days. Since then WBVHA has crossed a long way with its enlargement of network, expertise and personnel, extending full fledged collaboration with Govt. NGOs, Municipalities, Academic and Medical institutions, corporate bodies, professional groups and many other key stakeholders. Over the time, HIV/AIDS has paved sound footing in the social map of our country affecting 4.5 million of people. Full blown cases of HIV/AIDS in West Bengal itself is near about 5000.

Decision to sensitise and orient Honorary Health Workers, FTS and others health functionaries has been splendid in the light of present situation and context. In fact, HHWs are the key link workers to maintain close linkages and deliver services at the door steps what the decision-makers are unable to execute. So HHWs have a dynamic role bring change in he pattern of human behaviour in the locality. However, we have detailed the training plan for your doing the needful. We are ready to take up the assignments with pleasure and assure our best quality of services in terms of selecting training design, course contents, faculty, reading materials etc. WBVHA is unique in organizing training for grass root workers since1974 through our Community Health and Development training (40 days). WBVHA possesses considerable amount of IEC materials of wide range issues available for all categories of workers and people. We wish to share our expertise and ground level experiences for the benefit of the trainee participants in the proposed training workshop on HIV/AIDS.

Enclosed please find the proposed plan of work along with budget. Best regards.

Sincerely yours,

24/02/05

Aminul Ahsan
Project Director
Health and IEC promotion
Enclosures as stated above

C:\Dr. Goswami\KUSP\KUSP\Letter Head.doc

O/C

URGENT / CONFIDENTIAL

KOLKATA URBAN SERVICES FOR THE POOR

CHANGE MANAGEMENT UNIT

Memo No.CMU-94/2003(Pt-II)/567. **31.01.2005**

From : Arnab Roy
Project Director, CMU

To : The Secretary, KMDA
Proshasan Bhavan,
Salt Lake City
Kolkata

Sub : Forwarding ULB-wise information on Health facilities created under CUDP III and IPP-VIII Health Programmes.

Sir,

To facilitate final designing of Health component under KUSP, you are requested kindly to forward ULB-wise information (40 KMA ULBs except KMC) on Health facilities created under CUDP III and IPP-VIII as per the proforma given below :

Sl. No	Name of ULBs	Population covered		No. of Blocks		No. of Sub-Centres		No. of HAUs		No. of ESOPD		No. of MH	No. of RDC
		CUDP III	IPP-VIII	CUDP III	IPP-VIII	CUDP III	IPP-VIII	CUDP III	IPP-VIII	CUDP III	IPP-VIII	IPP-VIII	IPP-VIII

It will be highly appreciated if the required information is forwarded by 4th February, 2005.

Yours faithfully

ILGUS BHAVAN, HC BLOCK, SECTOR 3, BIDHANNAGAR, KOLKATA 700106
Ph : 033-2334 2660, 2337 7315, 2358 6403/5767
Fax : 033-2337 7318/2358 5800
email: kuspcmu@vsnl.net

Project Director

Kolkata Metropolitan Development Authority

URBAN HEALTH IMPROVEMENT PROGRAMME UNIT

Unnayan Bhavan, Bidhannagar, 'G' Block, 1st, 2nd & 3rd floor, Kolkata – 700 091.

2334-5257/2337-0697/2358-6771/2337-4103. FAX No. : 2358-3931 & 2358-7368 E-mail : cmdalpo8@vsnl.net

1682
3.2.05

No.: 1239/I-1/KMDA/UHIPU/04(Pt-II) Date: February 2, 2005

From: The Officer on Special Duty, Health,
UHIP Unit, KMDA

To: Sri Arnab Roy, IAS
Project Director/Change Management Unit
Kolkata Urban Services for the Poor (KUSP)
ILGUS Bhavan, HC Block, Kolkata – 700 106

Health Expert &
Am 4/2/05
7.2.05

Sub: Implementation of Health Components under KUSP.

Ref.: Your letter no. CMU-94/2003/283 dated 26.10.2004

Sir,

In continuation to this office letter No.1216/1(40)/I-1/KMDA/UHIPU/04(Pt.II) dated 27.01.2005, I enclose 2 (two) letters in connection with above subject received from the following UBLs for doing the needful from your end:

1. Bhadreswar Municipality
2. Khardah Municipality.

Encl: As stated.

Yours faithfully,

Officer on Special Duty, 03/02/05
Health, UHIP Unit, KMDA

No.: _____/I-1/KMDA/UHIPU/04(Pt-II) Date: February 2, 2005

Copy forwarded for information and necessary action to:

1. Bhadreswar Municipality
2. Khardah Municipality.

Officer on Special Duty,
Health, UHIP Unit, KMDA

STD Code : 033
Phone : 633-5283
633-5264

Office of the Municipal Councillors

BHADRESWAR, DIST. HOOGHLY

From : Sri Debagopal Chakrabarti
Chairman/Vice-Chairman/Councillor, Bhadreswar Municipality

Memo No. Health . 855 Dated, Bhadreswar the 15th December 2004

To
The Officer-on-Special Duty, Health.
UHIP Unit, K.M.D.A. "Unnayan Bhavan"
Salt Lake City, C Kalcata - 91

P.A to OSD 21/12

Sub:- Implementation of health Component under KUSP.

Sir,

With Ref.to letter dt. 10/11/04 no.926(7)/1-1/KMDA/UHIP/04. I am to inform you of the following points for taking necessary action from your end with the provision of release of necessary fund:-

1. Refresher training course for HHW's for updating their skill.
The training is suggested to be for 10 days instead of 7 days as stated.

2. Household survey to update the family schedules.
House hold survey is already done and family schedule had been updated in july,02 So if may kindly be accepted.

3. IEC activities and health awareness campaign.
We have fixed a few programmes and I am to submit the same below

4. School Routine card with health Messages waiting for getting supply from the Head Quarter.

@ Mass Communication Media.

a) Baby show. HAU level.

I.P.P-VIII	H.A.U - I	18/12/04 at 12 Noon
"	H.A.U - II	24/12/04
C.U.D.P-III	H.A.U - I	21/12/04 (12 Noon)
"	H.A.U -II	20/12/04 12 Noon

Baby Show at Municipal level = on 8/1/05

b) Quiz Competition :-

I.P.P-VIII -	H.A.U-I	Date 27th January to 5th Feb. 05
" -	H.A.U-II	
C.U.D.P-III	H.A.U-I	
	H.A.U-II	

Municipal level on 10th Feb. 2005.

Contd.to page 2

STD Code : 033
Phone : 633-5283
633-5264

Office of the Municipal Councillors

BHADRESWAR, DIST. HOOGHLY

From :

Chairman/Vice-Chairman/Councillor, Bhadreswar Municipality

Dated, Bhadreswar the.....200

c) Competition on Extempo lecture among beneficiary mothers.

I.P.P-VIII - H.A.U - I
" - H.A.U -II
C.U.D.P-III- H.A.U - I
" H.A.U-II

from the 27th January to 5th Feb. 05

Municipal level on 10th Feb. 05.

d) Quiz competition among school students on personal Hygiene practice:-

Class III.IV 12/1/05 2 p.m at town Hall
Class V-VIII - " 3 p.m " " "

e) Health Exhibition :-
1/1/05 to 10/1/05 Sampriti Mela at Subhash Maidan.

f) Repairing and Repainting of existing hoarding boards size 20X10'each
Waiting taking delivery from the Head Quarters.

3) Folk Programme :-
Waiting for clearance by the Head Quarters :-

This is to inform you that, we have planned the programme from block level. After selection at Block the programme will be observe at H.A.U. than ~~that~~ we wil do same at Municipal level also. So, the estimated cost will be more than the proposed are in all programmes,

Hope for your early action please.
Thanking you,

Faithfully yours,
Agch Mukherjee
Chairman. 15.12.2004
Bhadreswar Municipality.

Project I: Roll out at 4 more Muni: 87,500 per muni: 20 Th + 15 Talk Doll + 2 Ws

Barasat, Panihati, Rajpur Sonarpur and ?? – ***proposal submitted on Jan 11, 2005***

What we did at 4 muni before

i) Awareness on Health & Hygiene	Theatre Shows/ Talking Doll
ii) Awareness on Solid Waste Management	Theatre Shows/ Talking Doll
iii) Awareness on Immunization and Disease Prevention	Theatre Shows
iv) Community Participation in Asset Maintenance & Ownership	Workshop / Talking Doll

We propose i + ii + iv to be taken up in message plan (to be fixed up as per KUSP guidelines).
Timeframe: Feb – Mar 2005= cost 3,50,000

Project II: Health Training + Awareness at all 40 ULBs

1 ULB – 1 communication workshop with health workers for 2 days +
15 theatre shows in 3 days on HIV/AIDS , Malaria, TB, Immunization +
3 days of talking doll shows on Routine Immunization/ Polio
= 49,500

40 ULB – 19,80,000

Timeframe: In sync with ULB level Health Training

Content: to be decided after reading their material

Or,

1 ULB –	2-3 days of HIV/AIDS 1 day of Malaria 2 days of TB 2 days on Immunization	5-6 days of Campaign, 20-25 shows, 40-50K per ULB 40 ULB – 2 months – Feb – Mar' 05 40 ULB – Rs. 20 Lakhs

We will do a study and speak to KUSP and Muni health people and decide the ratio of content and also dates of the campaign along with spots. We will do pre-publicity and also distribute any other IEC material if muni/ KUSP has (like leaflets etc)

Project III: Sanitation & Health & Hygiene+ Awareness at 105 slums

1 slum - 1 four-five days workshop (addressing both community ownership and communication skill improvement for the peer group) +
2 theatre shows on sanitation +
5 talking doll shows on sanitation & health hygiene issues = 26,500

105 slums = 27,82,500

Mar	4
Apr	4
May	6
Jun	6
Jul	2
Aug	3
Sep	10
Oct	10
Nov	15
Dec	15
Jan	15
Feb	15

Suggested Campaign Schedule and Manpower Deployment Plan

Project: Awareness Campaign and Community Mobilization

Organised by : Kolkata Urban Services for the Poor (KUSP, CMU)

Agency : banglanatak.com (i-land informatics Limited)

	Municipality	A	B	C	D
Sl.No.	Activities	Time Frame			
1	Initial Visit	7-Feb	8-Feb	9-Feb	10-Feb
		Niloy, Sovon, Sreosi, Madhura, Ananya			
2	Research & Study	Feb 14-15	Feb 14-15	Feb 16-17	Feb 16-17
		Ananya, Sreosi, Samik	Niloy, Madhura, Malay	Ananya, Sreosi, Samik	Niloy, Madhura, Malay
3A	Community Workshop 1 (to be attended by 25-30 participants)	Feb 21-25	Feb 21-25	Feb 28- Mar 4	Feb 28- Mar 4
		Ananya, Avijit	Niloy, Bhaswati	Ananya, Avijit	Niloy, Bhaswati
	Workshop Venue 1				
3B	Community Workshop 2 (to be attended by 25-30 participants)	Feb 21-25	Feb 21-25	Feb 28- Mar 4	Feb 28- Mar 4
		Sreosi, Siddhartha	Susanto, Sovan	Sreosi, Siddhartha	Susanto, Sovan
	Workshop Venue 2				
4	Script Finalisation	Feb 18	Feb 19	Feb 22	Feb 24
		Sreosi, Samik	Niloy, Samik	Madhura, Samik	Madhura, Samik
5	Pre-publicity	Feb 22	Feb 23	Mar 1	Mar 2
		AvijitS	Malay	Samik	Malay
6	20 Street Theatre Shows	Feb 24-28	Feb 24-28	Mar 3-7	Mar 3-7
		AvijitS	Malay	Samik	Malay
7	15 Talking Doll Shows	Mar 1-3	Mar 4-6	Mar 8-10	Mar 11-13
		AvijitS	AvijitS	AvijitS	AvijitS
8	Post Campaign Survey	Mar 9	Mar 10	Mar 14	Mar 17
		Sreosi, Malay	Niloy, Malay	Sreosi, Malay	Niloy, Malay
9	Report Submission	Mar 22			

Team profile	
Madhura	MA in Sociology
Ananya	Engg with 14 yrs of workexp + Commonwealth Scholar in Sustainable Dev
Sreosi	MA in Sociology
Niloy	Over 7 yrs of hands-on Project Management exp
Bhaswati	Theatre Workshop Specilaist with 5 yrs of hands-on exp
Sushanto	Theatre Workshop Specilaist with 11 yrs of hands-on exp
Siddhartha	NSD, Theatre Workshop Specilaist with 11 yrs of hands-on exp
Avijit	Theatre Workshop Specilaist with 8 yrs of hands-on exp
Avijit S	Field Coordinator, 4 yrs of exp
Malay	Field Coordinator, 4 yrs of exp
Samik	MSW, 5 yrs of hands-on field exp
Sovan	Journalist with over 3 years of hands-on field management exp

ISC comments on the proposed training schedule: -

This training content requires to be re-examined thoroughly. By being comprehensive, it loses considerable focus. It may also fail to cover gaps while it would be repetitive of well-known ones- as it is not based on a systematic training needs assessment. Above all it has to be contextualised. We list below some of the major issues which have been left out:

1. What is the right to health care?
2. How appropriate is beneficiary choice? How do we represent such issues?
3. What are the different social groups? How do we assess this in our area? What is the difference between them in access to care and why?
4. Define these groups that can be called marginalized. How are health rights seen in this context?
5. What are the different approaches to community mobilization and organization? What is happening in our area? How can it be built on?
6. Making a home-visit for child health- questions to ask, things to do, messages to give
7. What are special problems of poor in child-malnutrition? Using case-examples and field visits to explain how these are to be done.
8. How do living conditions impact on health? What can be done to improve housing/ environmental sanitation? What are the schemes available?
9. National programmes- need more time and clear guidelines
10. Gender issues: how gender issues impact on women's access to health care and reproductive health services.

Response of Interim Support Consultants: -

We express our gratitude for the frank and very considered and detailed responses to the draft report of the HHW Programme Review by the Interim Support Consultation submitted to the Change Management Unit.

We had initially received comments during the presentation and discussion of the report with the Steering Committee and through the process of a special consultation held with a group of health officers. Subsequently we also got written submissions from the Health Officers on the Steering Committee as well as from senior KMDA official. We respect all the comments sent in and appreciate the various different viewpoints expressed and information provided. We are happy that many who participated have welcomed the report as such or many aspects of it and we note that there are important dissenting views on many key issues.

External reviews can never supplant the insights and experiences of a programme's own management and we understand this well. However external reviews – precisely because they are external- can bring different perceptions, insights and data into the discussion so that decision- makers can use these inputs to reflect on their own programme and improve on it. Eventually the acceptance of main recommendations is a policy decision – even where technically the analysis and recommendation are accepted as sound.

This note is not meant to respond, much less rebut, each and every comment made. This is more so because we agree with many of the comments that have been made – especially those by the health officers. We suggest that along with the HHW Review Report, some of these comments and our response are circulated so that the reader can make their own decision. Our response is in the nature of clarifications and for better understanding of some of the persisting differences so that the steering committee (and other concerned authorities) is enabled to make a more informed choice about accepting or not accepting these recommendations. Some of the recommendations we have made are small and easy to implement while some require major changes in policy and increase in levels of financial and policy commitment. There is a clear apprehension that these latter suggestions are not feasible in the current economic and administrative context and in this background even the desirability of such suggestions is scrutinized more rigorously. This is understandable. However, decisions like introducing insurance or transforming the sub-centre require changed policy directions-they do not admit of merely administrative solutions. We also note that though CMU made efforts to make all previous studies available to us, there have still been other recent evaluation reports and studies that were unavailable to us and this has been pointed out in the comments. Though we would have no doubt benefited by reading their views, ours was anyway constructed as an "independent review" and we would not have been led by their conclusions. However we are happy to note and to emphasize that end-users of these studies would have more reviews to compare and learn from in addition to ours.

Clarifications:

1. We have considered CUDP-III and IPP-VIII together because we felt that operationally they are very similar and the goals and outcomes have been all along assessed together. The sample of HHWs and sub-centers is taken from all of them together. If the IPP-VIII has been over represented in the sample, it was because we had not stratified the sample for adequate representation from each of the two programmes separately as we did not perceive it as materially affecting the outcome. Most of those concerned about the omission of CUDP are referring to the population of beneficiaries being different if CUDP-III had been taken into account and some have expressed that we have used this to come to our conclusion of exclusion. We clarify that all our statistics of beneficiaries come from the ULB's own data as made available to us by the KMDA and this compared very well with the figures we were given during ULB visits. We think that these figures are inclusive of both CUDP and IPP-VIII beneficiaries. But the moot point is that what statistic has been used does not matter at all –as the arguments advanced for exclusion *are not at all* based on the statistic of numbers or percentage of BPL families. We would concur with the view expressed by one of the comments that in at least many of the ULBs there may be some over estimation of the BPL population- but that too is immaterial to the discussion on exclusion. Our understanding of exclusion is based on HHWs' and health officers and at least one chairperson's own reports and also largely drawn from community level interactions. As regards the computations for estimating BPL utilisation of maternity homes (annexure x)- we note that if we increase the number of BPL by adding the CUDP beneficiary population to the already stated population then the utilisation percentage which is already very low would worsen further and by a significant degree as this total beneficiary population figure is used to estimate the denominator in the percentage calculation. The numerator is drawn from the actual number of deliveries attended to in a year from all the maternity homes – again as supplied by KMDA and verified by us in one or two places and this would remain fixed.
2. There has been some discussion on the validity of the Participatory Health Assessment as a method, and on the choice of areas for PHA as many of our conclusions on exclusion and impact on poverty have been drawn from this. Participatory Health Assessment is a well-known rapid qualitative method which can be used in a semi quantitative manner to assess programme impacts in a more holistic way. This approach began as Participatory Rural Appraisal or Rapid Rural Appraisal and was subsequently adapted for use in other areas and sectors. Of course such methods have serious limitations too and one has to keep this in mind – as we have done- while drawing inferences from them. We note that one of our important recommendations are that the health officers be trained on this technique and that it is mandated that they use this for periodic internal evaluation of the programme. We reinforce this suggestion again and state that many of the gaps in internal perceptions of the performance- would be overcome if this technique is used. As for the choice of areas for PHA –the choice is always

purposive- not random depending on what we looking for. We made the choice by asking the ULB health officer/STS/FTS/Chairman-in-Council to lead us to a place within their municipal area where the people are poorest- and they did so and thus we arrived at the areas of exclusion amongst beneficiaries. The health officer was just not aware that such programme gaps were there and indeed the techniques he or she was using would not have allowed them an opportunity to perceive such issues either. As for those not even covered nominally even these areas were just pointed out to us in response to simple direct queries to health officers or HHWs. No complex techniques were needed. If such "exclusion" is eventually accepted then the system could usefully reflect on how this has remained invisible not only to authorities but also to prior evaluation processes. If on the other hand such exclusion is denied then the problem disappears and there is no need to mull over newer techniques of assessment and monitoring.

3. The selection of beneficiaries has been commented upon differently – perhaps representing the different experiences across ULBs. We recognise, respect and agree that the formal process is the recommendation by the ULB councillor and its acceptance by the ULB committee. We only note that in practice there are a lot of snags that tend to lead to less than optimal choices and to exclusions. The processes for selection we are suggesting- adding in a criteria of vulnerability, demarcating the whole area into blocks so as to ensure that any changes are registered, using participatory processes which ensure stakeholder participation – in addition to the survey -are all suggestions to provide inputs to the ULB councillor and the ULB committee to make for more informed decisions- not to replace their role. We note that most comments have recognized that categories like the homeless, the migrant, the street child etc do tend to get left out – though they differ in what can be done about it within the programme context. These revised processes would make these poor more visible. The problem of the invisibility of these sections of the poor is now a well-accepted fact of all urban development literature.
4. Nutritional programmes: Whereas the desirability of this is largely accepted – funding seems to be one major problem and the generation of the will to do it is another. We suggest that as a first step measurement and public display of malnutrition figures block wise and ULB wise are stepped up along with HHW household visits and counseling (what is known as the knowledge-centred approach). Then as the next step -in more severe areas- perhaps the last 25% of blocks in this ranking introduce the ICDS programmes and strengthen school midday meals. Then depending on fund availability, there should be a move to cover more blocks. If the moves at the national level for universalization of ICDS come through this would be helped. But even otherwise day care centers, crèches and anganwadis have always been part of ULB mandate. The point is in generating the will to secure the funds and get the programme going. Currently even growth monitoring and nutrition counselling is far from adequate and on principle – as a child rights issue – the need to prioritise child nutrition in the programme is inescapable. Comparisons to the all India figures may show better achievements in malnutrition in Kolkata. But as in other indicators like IMR and

MMR where KMDA figures rival the best states – we think that with some determination in child malnutrition too, KUSP can create a success story.

5. There have been reservations expressed on the adequacy of the sample size and cross-verifications. We feel that the size was adequate to support the inferences drawn. Had we been verifying IMR, and MMR etc-we would have needed a larger sample and a different approach but we were not set such objectives. Moreover, we have made little use of statistical inference, relying more on process evaluation and qualitative methods, for such observations as quality of care in a sub-centre or the type of services provided by a HHW, or community perceptions. We also note that there was, at the HHW and sub-centre level a very great uniformity in observations and responses right across the project areas-and therefore a larger sample size would have been tedious and added little. On the other hand when it comes to the Maternity Homes, the variation is very large and that is why we have refrained from studying or recommending any measures to improve the functioning of the Homes, except for the issue of access.
6. There are many suggestions into improved running of the maternity homes- for e.g. regarding biomedical waste management, regarding funding, regarding expanding its scope to include emergency services and other common problems. These are very valid and very well made suggestions. We had taken a decision not to go into hospital management details. We had noted the wide variation in performance between maternity homes and suggested that is the health officers were only to sit together in a facilitated workshop mode and share experiences many of the solutions for improvement would be forthcoming.(see 10.2.5.2) We again reiterate this and add that it may help to have a hospital management consultancy agency to look at these issues in greater depth – if it is needed before such a workshop so that like for the HHW scheme the internal discussion is enriched by some external perspectives.
7. We note with favour one comment on the supply side problem of providing sterilisation services and we think this needs to be followed up further- not only with more training and laparoscopes as suggested, but with all the steps needed to realise a clear goal of providing sterilisation services on demand – one fixed day every week in every maternity home.
8. The suggestions in secondary care also discuss expanding MHs and ESOPDs to cover all ULBs and increasing the scope of these institutions. These are important suggestions that we endorse. We note that the suggestion to accredit private sector players who are willing to provide services at the same rates and quality as the ULBs for filling these gaps has not been followed up – and we readily sympathize with the will to develop these within the ULB/public sector. The general experience with the private sector has been poor as regards both cost and quality and in contrast the ULB run Maternity Home experience is so positive that most opinion asks for only an expansion of what exists. In principle the study team endorses this call for expansion. However if public investment is limited then *without at any point of time transferring any public investment to private hands* if private sector players can be roped in then we increase the net investment in health care that the poor can access. (The Janani and Jyothi clinic models have shown this to be viable and there seems to be enough not – for- profit hospitals

who may rise to accept this role. If social insurance is added in then it becomes financially feasible and equitable too.

Policy Issues:

There are however some suggestions that in themselves seem small but they are so interlinked that they require a policy formulation at a larger level.
We will discuss three such issues – the role of the sub-center, the focus on vulnerability, and the social insurance proposal.

Let us consider the sub-center first.
The system can choose-
A. To make the sub-centre (and HHW taken together) provide care equivalent to the norms of what is needed for a primary health center because provision of (as different from provisions of select aspects of RCH) comprehensive primary health care as different from some aspects of RCH – provided close to their homes --is a basic health need and right of the poor.

Or it can decide that

B. The sub-center would provide only such care as can be provided in the space currently available, with the staff currently available at the timings currently possible and with the supplies currently available.

If the first choice is made – at the level of policy formulation – then it follows that five aspects of what have been questioned as impractical – door step delivery to the vulnerable, more space, facilities and comprehensive care in the sub-center, increased pay and salaries for PTMOs and HHWs, changed timings so as to suit the vulnerable and over coming motivation issues (expressed as security will be poor for HHWs to work in the evenings…) would all have to follow. Without it we just will not be able to achieve an adequate quality and access of health care. The objections raised to issues like the laboratory support at the sub-center are for the most part (except for the issue of space) really minor obstacles that admit of easy answers.

But if we see these current sub-center parameters as fixed a priori- then of course almost all that can be done is being done. Though little is happening it is likely to have good cost benefit ratios and be quite cost effective. However if we expand the sub-center mandate then we can argue that as most of the investment is already made, the increased investment – though definitely called for – would not be as high as starting to set up a sub-center from zero levels and would make the programme even more cost –effective then it is now. We do not think that it would be possible for getting more work allocation on PTMO and HHW without a significant salary increase. But if the salary increase is to be conceded anyway (as it has been over the years) it is possibly *the* opportunity for restructuring their work allocation for a more rewarding set of objectives. Given the choice, most HHWs interviewed were clear

that a significant salary rise along with major re-skilling and redefinition of tasks and jobs and timings would be welcome. Indeed there is a thirst to acquire more skills and meaningful (of course a salary rise without a redefinition of tasks may be equally welcome – but that is natural). The choice is " Do we want to make the sub-center a location of good quality comprehensive primary health care – paramedical based with medical back up- or is it to be limited to a site of immunisation, incomplete Ante-natal care and trivial illness management as a mere token of curative care -with very low utilisation. " If this choice is the former then

a. Even within the current finances available with small increases that a donor can provide significant improvements can be made and
b. We can create the case for getting more funds for this programme for major improvements that would make for a more effective programme.

{We have enclosed one standard treatment guideline for a paramedical run sub-center and another for a medical officer run primary health care center (prepared for another state government) to illustrate the wide nature of care that the sub-centre can provide. Kolkata with its higher quality of medical and paramedical education should be able to do more – not less than what is illustrated.}

Issue of the vulnerable:

One is happy to note that almost all have readily accepted that the disabled, the street-child, the sex worker, the migrant labourer, the rag picker have all a right to health care. What is not as well recognised is that they have an extra special claim to health care – over and above what others in the municipality have. This is the first requirement of equity. To treat the unequal equally is discriminatory. They need to be treated unequally. If this is accepted as a policy priority then all the other consequences follow- extra programmes over and above HHW like peer educator programmes, disability management, insurance cover, complete exemption at MHs, special efforts to reach them at the door step and perceiving their under-utilisation of services with more understanding. If on the other hand the vulnerable are not seen as the ULB's primary responsibility, or if it is to be left to someone else, or that merely because they do not fit the definition of a family a migrant street child or a sex worker cannot get HHW services- then of course the problem just disappears.

(We note that almost all the poorest live in service lands within the municipal geographically. The state health system has no outreach system to reach them other than what is available through the ULB health system.)

The point is that the commitment to reach out to them must be primary and the means secondary. Once the policy commitement is made then we are sure that the health officers would be able to come up with enough ideas of how to meet these needs. Again the health officer and the PTMO are not likely to opt for a greater burden of work unless they are convinced that their work is being valued appropriately, and this would mean higher salaries as well. One value based policy decision would call for a number of corollaries. In some of these finances are pointed as the limiting factor – but some simple calculations tell us that the sums involved for some of these component are not large – it is merely that the policy recognition of this issue and the

corresponding policy decision has to be made. (For example, our suggestions for tripling the Health Officers' salaries, along with public health training and banning of private practice seem financially impossible. But in actual financial terms it is a mere Rs.76 lakhs per year which must come from regular budgets.)

The third issue is of insurance.

Again the question is that does the ULB want to undertake a goal of investing in health care as a poverty reducing strategy, or is it sufficient to bring down the stated indices through a targeted selective set of RCH intervention, irrespective of the impacts on poverty of the rest of health care needs. Or to put it another way " does it set itself the task of reducing poverty through health investments while simultaneously accepting the special responsibility of the state for meeting the health needs of the poor? Is state policy concerned that the poorest have a disproportionate share of out-of pocket expenditure and that health needs are a major cause of indebtedness at usurious rates?"
Yes opening up insurance is difficult- and even more so because the study team has not proposed contracting out to an insurance agency but managing it within a special cell created in the ULB. Yes, using economic impacts as an indicator is difficult – even if we understand that it is not the HHW that is expected to collect this data but professional sample surveys (very high cost, very high reliability) and Participatory health assessments (very low cost and high reliability). Yes public investment in health care will not decrease- though we would argue that cost –effectiveness of current health expenditure in terms of reaching the poorest would improve. And yes we would have to train the administration and HHWs to understand this new insurance dimension- even if we were contracting it out. It is lot of work – difficult to succeed in, easy to fail. Why not just let it pass?

Again the contention is that we need to start with a policy directive. If the opinion is that if IMR and fertility rate are reduced the goals of state intervention are adequately met- then the entire discussion on insurance becomes redundant. If on the other hand the commitment is to provide accessible and affordable health care- then we need to look for alternatives- recognising that RCH needs account for only about 20% of all health needs. It is not the issue now whether in 1993 it was acceptable to have a limited goal- after all IMR and TFR were high then – though better than all India averages even then. The question is whether the programme is willing to move on to newer frontiers or would rather rest on its laurels. If it accepts the challenge and will go for further dimensions of health care while improving on RCH also – then it would have to find the higher investment needed – from within state, central and donor budgets. And showing the cost effectiveness of interventions and that increased interventions are effectively reaching the poor are the pre-conditions of being able to attract these investments. We readily welcome the suggestion of beginning with a five ULB pilot programme and not the entire 40 ULBs – and once the tremendous increase in outreach, especially to the poor is demonstrated, then to seek expansion to the other areas. But even before that is attempted- policymaking has to affirm or re-affirm its goals.

One final point- though we are not insistent on it – is that this insurance be undertaken by the ULB itself-this may be done in collaboration with an insurance firm – if needed. The important point we make here is that every aspect of the " supplementary insurance approach" has to be thought out afresh as it does not fall within the existing insurance paradigms. Also if all the administration – promoting insurance usage, collecting premiums, ensuring claim payments etc have to be done by the insurance company the overheads are huge and unaffordable (almost 25%). If on the other hand the HHW workforce is used to collect premiums – not for the poorest but the others -and to help with receipt of claims etc then though the overheads remain the same they are now seen as additional incomes – not as a waste to the ULB system. Also unlike in most insurance programmes every single family is likely to have claims equal to the at least 50% if not 100% of its maximal claim amount – for deliveries, for emergencies etc. which would be very unattractive for an insurance company. However if this is seen as generating adequate incomes for the maternity homes and the doctors serving there (who no longer need to forgo fees for seeing beneficiary payments) then it becomes a sort of deferred payments for each family to access quality care at subsidised rates and for the government it means that its efforts and its subsidies are reaching the more vulnerable and its larger goals of poverty reduction are better addressed.

The study team is highly appreciative – despite the contrary interpretation by one or two comments – about the achievements of the ULB's health system. Indeed we recommend this set of suggestions precisely because we value the high quality of human resource and structures developed and the high value secondary center chain that has been built up. We would be the most disappointed if the West Bengal government and the ULB health system did not respond to these three key policy issues – rethinking the sub-center as a site of comprehensive primary health care, bringing in the vulnerable into health system visibility and expanding to include all health needs (from RCH needs alone) with focus on poverty reduction -with strong affirmations that would lead to more equitable and more universal health care for its urban citizens. On the other hand if the limitations are such that in all these three areas policies decisions are deferred, we still hope that there is much in our recommendations that the ULB system finds implementable.

8. The selection of agency for Study of Organisational Development is under process in DFID office and it is expected that the same will be on the field within a month.

9. CMU has to procure one Organisational Development Expert as consultant immediately.

10. DFID fund will be available for support to Secretariat of West Bengal Municipal Association. The OD Specialist will examine and suggest.

11. DFID pointed out that there is provision in the Project Memorandum to appoint catalytic agents (consultant) for each ULB who will be acting as extended arms of CMU and will facilitate implementation of KUSP in respective ULBs. The procurement of these consultants may be done immediately.

12. The terms of reference for CMU activities is to be prepared. Municipal Affairs Department and DFID would jointly developed a Terms of Reference for the CMU.

13. CMU pleaded that as KMDA is at present managing the continued health programme started during IPP-VIII & CUDP-II projects, they may be entrusted with the responsibility of implementing the KUSP health component.

But, DFID opined :

The health component in KUSP is to strengthen the HHW and the agreement was that we will review the current scheme to agree on areas of support. Just adding resources to this stand-alone programme wont add any value. The purpose is to get ULBs to take on health as one of municipal function. The DDP process should capture this and KUSP resources should be contributing to their plan. This component may be developed incorporating other ongoing programmes like the one supported by EC. The Health Expert should take lead on this agenda.

14. It was agreed that CMU and DFID will work jointly to develop a frame work/guideline for Innovative / Challenge Fund.

CHANGE MANAGEMENT UNIT (CMU)

17.01.05

Sub: Redesign of the existing website of CMU.

Project Director, CMU desired that the existing website of CMU should be suitably redesigned with a revised Menu System to make it more effective and purposeful to viewers and also to achieve the desired objective in Communication and Public Relations of CMU.

A revised Menu System has been prepared referring to websites of organizations with identical function. The draft revised menu is enclosed here with. CMU officials may kindly see the draft revised menu and offer their comments preferably by the 28th January '05 so that we may discuss the matter with Project Director subsequently thereafter and finalised the same.

Enclosed as above.

S.K. Mukherjee

(S.K. Mukherjee)
Procurement Expert, CMU

17.1.05

1. Project Manager, CMU
2. Technical Advisor, CMU
3. Expert Engineering, CMU
4. Municipal Finance Expert, CMU
5. Economist, CMU
6. Urban Planner, CMU
7. OD Expert, CMU
8. Health Expert, CMU
9. FA, CMU

Copy forwarded to Project Director for information.

S.K. Mukherjee

Procurement Expert, CMU

17.1.05

SCOPE OF WORK

Client Requirements

1. **Redesign** of Existing Website www.changekolkata.org
2. **CMS** (content Management System)
3. **Admin Section** for News, **Jobs, Tender, Event and Guideline Section**
4. **Personal Email.**

Remove from current site:

1. Flash Intro.
2. Dropdown Menu.
3. Some HTML Pages.

Menu Details:

1) About KUSP

- Brief History
- Objectives
- Projects Components
- ULB's Under KUSP
- Project Memorandum
- Project Budget

2) ~~Under~~ W.B.

- At a Glance
- Back Drop
- Urbanization
- Urban Poor (to be rewritten)

3) **Urban Governance**

?

4) Latest News and Events

- Clean City Campaign
- Chief Minister gives away Prizes
- Orientation Workshop at Raichok
- New BKP launches Website
- Kharda inter ward Prize

5) Tenders, Quotations, EOI, Job, etc.

- Tender
- Quotations
- EOI
- Job
- Result

6) Success stories of KUSP

7) Evaluation

8) Activities and Reports

- OD
- LED
- Slum level infrastructure
- Procurement
- Accounting Reforms
- Urban Planning

9) Guide line / Forms / Proforma

(Download will be in Acrobat Reader mode) or Excel File.

10) Consultants

11) Project Download

12)Maps

13) People at KUSP

14) Modernizing Municipal Management Model

15) Photo gallery

16)

17)

18)

19)