Health Care & Sanitation

The health of the under privileged is gaining attention of the world community and there is a call for ending poverty and health for all in developing countries by the end of 2000. But this mission of development could not be accomplished, as there was lack of commitment to ensure coordinated efforts of health sectors with related activities of other development sectors and their multi level convergence over the space.

Nutritional feeding, health education, functional literacy and primary health care complement each other and they should be run concurrently to achieve the desired end result. National Institute of public cooperation and child care development (NIPCCD), Nutrition Foundation of India, Ministry of Health and Family Welfare, Ministry of Social Welfare, Ministry of Urban Development are a few National Institutions besides umpteen number of International Agencies which have put forth various schemes of assistance to supplement the efforts of NGOs in this direction.

A sample project proposal on ***"Mobile Clinic for Slum Care"*** *is given in detail under the heading of* ***"Health Care & Sanitation"****.*

PROJECT PROPOSAL
ON
MOBILE CLINIC FOR SLUM CARE

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MOBILE CLINIC FOR SLUM CARE

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1
The Project - An Overview

1.1 The Project

This project is proposed to establish a mobile clinic facility for attending the health needs of slums with an estimated project cost of 17.50 lakhs. Besides attending to the primary health care of the slum people, this project is intended to organise regular health camps for family planning and vaccination camps for slum children.

1.2 Objectives

The basic objective of this scheme is to ;

- Develop and implement a community based, low cost primary health care programme for mothers and children supported by referral services.
- Organise effective action oriented health workers who will initiate and manage mother and child health programme.
- Train the health workers for the community.

1.3 Scope

The health of the under privileged is gaining attention of the world community and there is a call for ending poverty and health for all in developing countries by end of 2000. But this mission of development could not be achieved as there was lack of commitment to ensure coordinated efforts of health sector with related activities of all other sectors of development and their multi-level convergence over the space.

Nutritional feeding, health education and training, functional literacy and primary health care compliment each other.

National institute of public cooperation and child development (NIPCCD), Nutritional Foundation of India, Ministry of Health and Family Welfare, Ministry of Social Welfare, Ministry of Urban Development etc. are a few national agencies which are actively supporting the initiatives of various non-governmental and governmental organisations in this direction.

1.4 Possible interventions

Several non-governmental organisations are operating in this field with various interventions in the areas of sanitation and health care. Different modalities like

a) National programme on mother and child care and immunisation.

b) Primary health care and prevention of communicable diseases.

c) Mobile clinics for slum care.

d) Low cost sanitation, construction and maintenance of community lavatories in urban slums.

e) Mobile first aid and trauma care

f) Field publicity campaign on family planning, health and hygiene.

g) Centre for paramedical training

h) Rehabilitation center cum leper homes.

i) Training centres for nurses and para medical health workers.

j) Preventive care and care homes for cerebral palsy.

k) Neuro psychiatric centres cum mental asylums

l) Counseling cum post treatment care centres for drug and psychotropic substance abuse.

m) Care homes for infirm and terminally ill, etc., are being initiated by various non-governmental and voluntary agencies as collaborative approach with different developmental ministries/agencies.

1.5 Project planning & Methodology

This project is proposed to set up a mobile clinic for attending the health care of slum dwellers and it will have the following elements of approach

a) weekly clinics

b) home visits by health workers

c) primary health care and pre-natal and post-natal mother and child care

d) growth monitoring of children through parent retained cards

e) Treatment to common childhood illness, preventive measures and immunisation

f) Referral services

Further, strong emphasis will be laid on preventive care.

Safe drinking water, proper disposal of human waste, personal hygiene and oral rehydration are given due propaganda to prevent communicable diseases.

1.6 Standards

Minimum standards in terms of services, superintendence, training and infrastructure have been laid down by the Ministry of Health and Family Welfare. Due care have been taken to formulate the project in accordance with the standards put forth by the said Ministry.

1.7 Project cost and means of finance

The project "Mobile clinic for slum care" is proposed with an initial capital investment of 17.50 lakhs, out of which the implementing agency is expected to bring-in a minimum contribution of Rs. 1.50 lakhs and the rest of the gap would be bridged out of grant-in-aid from some National/International Funding Agency.

The detailed capital cost of the project along with a break-up of components is given at Chapter - 7 of this proposal.

1.8 Organisation and Man-power

The Executive Secretary/President of the Implementing Agency will handle overall supervision and control of the project and he will act as the project director. He will be assisted by well-trained, sympathetic and committed health workers. The service of the Doctors and other Medical Specialists will be taken by the implementing agency on contract basis. Voluntary services of the doctors and medical professionals will be encouraged in the project.

1.9 Implementing schedule

The project is proposed to take off within a period of 6 months from the date of conception. The project duration will be

initially for a period of 3 years and the likelihood of its continuance will be based on the impact of the project.

1.10 Impact analysis

The programme will be monitored at regular intervals by constituting at Project Advisory Committee with the officials/members drawn from the following agencies.

i)	President of the implementing agency	-	Chairman
ii)	Secretary of the IA	-	Convener/ Member Secretary
iii)	Official nominee from Directorate of health services	-	Member
iv)	Nominee from the Funding Agency	-	Member
v)	Local NGO	-	Member
vi)	Reputed social worker	-	Member
vii)	Nominee from local media	-	Member

This committee would meet periodically once in the three months and advise the implementing agency on various issues concerning formulation and implementation of programmes.

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

This programme will be reviewed periodically by the Executive Committee through an effective management information system and appropriate modifications to achieve the desired objectives would be incorporated as and when necessary.

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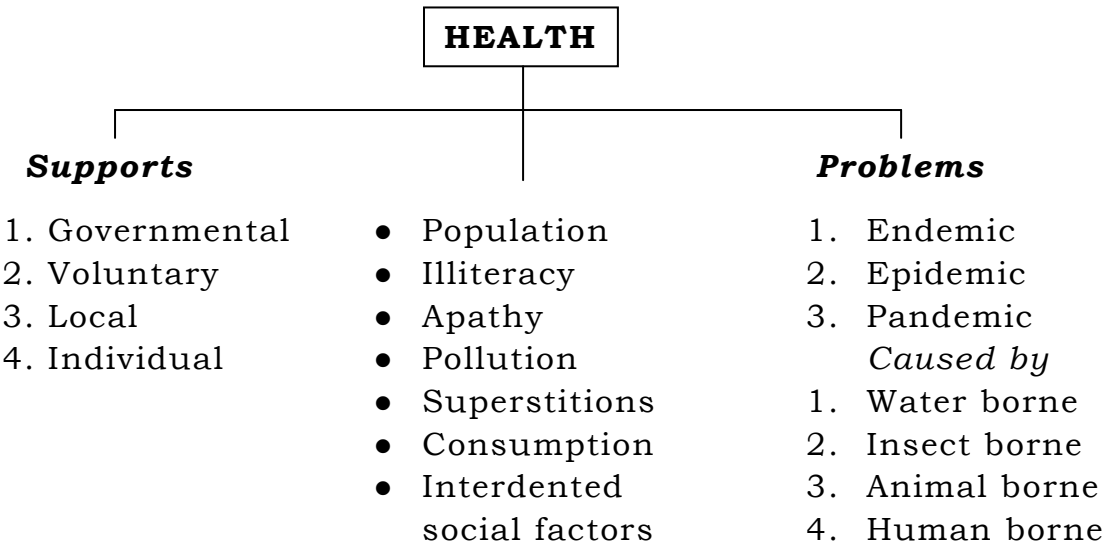
2

Health Situation in India and Scope for Voluntary Action

2.1 Health situation

The following diagram represents the health situation in India.



After independence from colonial rule, a process of planned development was embarked upon. During the early five-year plans, it was expected that the benefits of planned development will reach the rural poor on the premise of trickledown theory. However, the gap between the rich and poor widened further during this period, prompting the policy makers to look for alternative models and means for encompassing the rural poor and under privileged in urban areas in the ambit of socio-economic development. Thus commencing from the 4th five-year plan, the concept of direct attack on various issues of poverty, health, education etc was espoused and elaborated in the succeeding plan periods. Many new developmental programmes and schemes were derived directly to assist various vulnerable sections of the population.

However, India is in the midst of an epidemiological and health transition wherein diseases of affluence and new environmental and behavioural threats are being added to the already burdened morbidity due to spread of communicable diseases, poor sanitation, poverty and malnutrition. Multiple factors have been involved in India's health transition including

ageing of population, urbanisation, migration, challenging life styles and the impact of health problems that will require different strategies from those that have been used to implement health care and sanitation for under privileged. Health, among the urban poor has received much less attention from policy planners than rural health despite the fact that the living conditions in some of India's slums are among the worst in the world. However, several NGOs have developed models for urban health and sanitary care that could provide useful lessons for planning programmes. The frontiers of voluntary action are likely to change with emerging health needs and will unfold new dimensions of voluntarism. The emergence of explosive AIDS epidemic and the rising incidence of communicable diseases are posing new challenges in health care. In India, NGOs are at forefront trying to address the multiple medical, social, legal, ethical and policy dimension of this problem. New strategies, innovative approaches, and different service delivery packages will have to be evolved to address the needs of various high risk groups including women, children, migrant workers, drug abusers and slum dwellers. There will be growing demands on non-governmental organisations to respond to these new challenges.

2.2 Scope for voluntary interventions

Though the policy thrust is in favour of targeting the welfare programmes directly to the desired and vulnerable sections, the implementation posed great many problems. The developmental programmes in India have to be administered by bureaucracy which was accustomed to mostly dealing with and catering to the needs of etite section of the society. The poor themselves were almost always unorganised and plagued with illiteracy and ignorance making it difficult for them to appreciate the significance of new programmes and to utilise them effectively. The factual needs of rural poor and the inflexible development schemes and programmes could not be matched leading to wastage of scarce resources. It was realised that close involvement of people in the planning and implementation of basic needs and anti-poverty programmes was essential for success. People's participation was sought to be brought out through the involvement of local self government. Besides, voluntary agencies and NGOs working with the poor found roles for themselves in helping the target groups to avail of the various programmes implemented by the Government. The inevitable need for greater involvement of people's organisation in the development process was further stressed in the 7th, 8th and subsequent plan periods, thus opening new vistas for NGOs in the areas of socio-economic development.

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3

Project Planning and Methodology

3.1 Project objectives

a) Develop and implement a community based primary health care programmes for mother and children in urban slums supported by referral services.

b) Organise effective, action oriented, trained health workers who will initiate and manage mother and child health programmes.

c) Train the health workers from the community.

3.2 Project components

a) identification and training of health workers

b) setting-up mobile health clinic with basic facilities, emergecy care

c) organising weekly health camps

d) home visits by health workers

e) ante-natal, and post-natal services.

f) family planning and free distribution of contraceptive pills.

g) treatment to common childhood illnesses, preventive measures

h) immunisation camps

i) awareness programmes on sanitation and health care.

3.3 Salient features

a) Child care through distribution of parent retained cards to each mother and monitoring the growth of the child periodically

b) Regular home visits by trained health workers

c) Special emphasis on prevention of communicable diseases through awareness on safe drinking water, proper disposal of human waste, personal hygiene and oral rehydration.

d) Free distribution of contraceptive pills for women, in reproductive ages.

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4

Institutional Support for Health and Sanitary Care in India

4.1 Problems and areas of intervention

As enumerated in earlier chapters the following are a few areas where the non-governmental agencies can intervene and supplement the efforts of the government in the context of developing health and sanitation.

1. National programme on mother, child care, immunisation.
2. Primary health care and prevention of communicable diseases.
3. Mobile clinics for slum care
4. Low cost sanitation, construction and maintenance of community lavatories in urban slums.
5. Mobile first aid and trauma care
6. Field publicity campaigns on family planning, health and hygiene
7. Center for paramedical training
8. Handling and disposal of hospital waste
9. Rehabilitaiton centres cum leper homes
10. Training centres for nurses and paramedical staff
11. Preventive cure and care homes for cerebral palsy.
12. Neuro psychiatric centres cum mental asylums
13. Counseling cum post treatment care centres for drug and psychotrophic substance abuse.
14. Care homes for infirm and terminally ill
15. Emergency ward and nutrition rehabilitation centres.

4.2 Supporting agencies

The following are a few National and International Agencies extending funding/technical support to NGOs in the areas of Health care and sanitation.

a) NIPCCD
b) Ministry of Health and Family Welfare
c) Indian council for social work
d) Central social welfare board
e) HUDCO
f) Ministry of Rural Development
g) Ministry of Urban Development
h) Nutrition foundation of India
i) Child care foundation
j) UNICEF
k) Global fund for fighting TB, Malaria and AIDS
l) Department of women development

5

Mobile Clinic for Slum Care - Infrastructure Planning

5.1 Infrastructure requirement

i) Built-up area

The unit will be requiring around 250 sft of built-up area for accommodating the administrative building cum counselling centre. The project will make all necessary arrangements to procure the desired premises on lease rental basis.

The building should be located close to the service/targeted area.

It should contains necessary provisions like running water, electricity, telephone etc.

It should have basic facilities to treat medical emergencies.

ii) Furniture and equipment

1) Administrative office cum counselling center

a) Tables
b) Chairs
c) Examination table/couch
d) PC with printer
e) Almirah
f) Cup boards
g) Telephone
h) Refrigerator
i) Misc. electrical fittings and fixtures

2) Mobile clinic

1. DCM closed body vehicle 1
2. Examination table cum couch (Retractable)
3. Transfusion equipment
4. Oxygen equipment
5. Sterilisation tools
6. Clinical tools
7. Medical Chest
8. Freezer box/ice box
9. Public address system
10. Auxiliary power supply

The complete description, quantity and cost data of equipment are given at chapter - 7 of the report. The list of equipment and furniture indicated in this report is only illustrative and was given only for the purpose of guidance to the NGO. The NGO may inturn refer "Term of reference" laid down by the funding agencies and may add/delete certain facilities accordingly.

6
Organisation and Man-power

6.1 Organisation

The project will be headed by the Executive Secretary/President of the implementing agency and he will assume the overall superintendence of the project. He will receive all sorts of advisory and directional support from the "Project Advisory Committee" constituted of the following members.

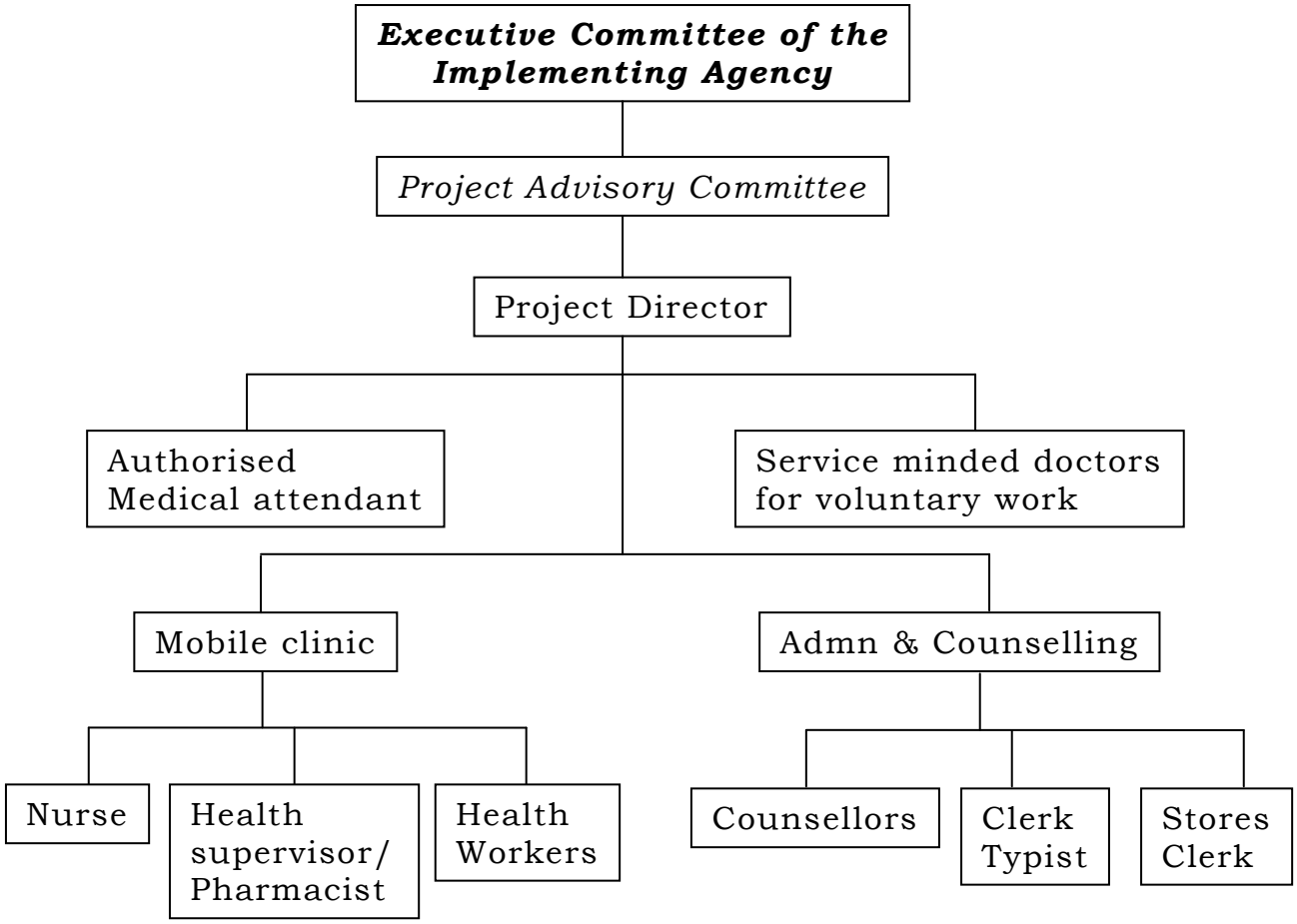
Constitution of Project Advisory Committee

a)	President of the implementing agency	- Chairman
b)	Secretary of the implementing agency	- Member secretary/convenor
c)	Official nominee from District Medical and Health Office	- Member
d)	Official nominee from NMEP	- Member
e)	Official nominee from the Funding Agency	- Member
f)	Official nominee from the local municipal health unit	- Member
g)	Prominent social worker	- Member
h)	Prominent doctor	- Member
i)	Nominee from the local media	- Member

The duration of the committee will be for an initial period of 3 years and it will meet periodically once in 3 months and will advise the implementing agency on various issues concerning formulation of the project, allocation of funds, impact analysis and implementation.

The project director will be assisted in his day-to-day pursuits by the field level staff consisting of health supervisors, health seviks and counsellors. The service of a part-time doctor will be employed wherever necessary. The mobile clinic will be staffed by qualified nurse/midwife and other para-medical staff. The services of philanthropic/service minded doctors will be used for organising regular health camps.

6.2 Organisation chart



6.3 Personnel requirement

a) Administration

1.	Project Director	1
2.	Clerk/Typist	1
3.	Stores keeper	1
4.	Peon/Attendant	1
		4

b) Health care

1.	Nurse/Midwife	1
2.	Pharmacist	1
3.	Health supervisor	1
4.	Health workers	3
5.	Driver	1
		7

Total no. of persons required for the project.

1.	Administration	4
2.	Health care	7
		11

6.4 Schedule of salaries and wages

Sl.	*Category*	*Nos.*	*salary per head*	*Total (in Rs.)*
1.	Project Director	1	7000.00	7000.00
2.	Pharmacist	1	5000.00	5000.00
3.	Nurse/Midwife	1	5000.00	5000.00
4.	Health supervisor	1	4000.00	4000.00
5.	Health workers	3	2500.00	7500.00
6.	Typist/clerk	1	3500.00	3500.00
7.	Stores keeper	1	3500.00	3500.00
8.	Peon/Attendant	1	2000.00	2000.00
9.	Driver	1	3500.00	3500.00
		11		41,000.00

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7
Project Cost and Means of Finance

7.1 Project Cost

The total cost of the project including recurring funds for an initial period of 6 months works out of Rs. 17,37,000 the capital out lay of which includes;

a) Cost of fixed assets :

Sl	Description	Nos.	Cost per unit (in Rs.)	Total (in Rs.)
1.	*Mobile clinic*			
	a) DCM Closed van	1	6,00,000	6,00,000
	b) Medical equipment	LS	2,00,000	2,00,000
	c) Auxiliary power supply	1	35,000	35,000
	d) Public address system	1	5,000	5,000
				8,40,000
2.	*Administrative office cum counseling center*			
	a) Tables	3	1,000.00	3,000.00
	b) Chairs	25	100.00	2,500.00
	c) Examination Table/couch	1	1500.00	1,500.00
	d) PC with printer	1	45,000.00	45,000.00
	e) Almirah	2	2,500.00	5,000.00
	f) Cup boards	3	1,500.00	4500.00
	g) Refrigerator	1	12,000.00	12,000.00
	h) Telephone	1	2,000.00	2,000.00
	i) Miscellaneous assets including electricals	LS	5,000.00	5,000.00
				80,500.00

b) Variable costs

Sl.	Description	Nos.	Cost per unit (in Rs.)	Total (in Rs.)
A)	*Programme costs*			
1.	Health camps	9	5,000.00	45,000.00
2.	Immunisation camps	9	5,000.00	45,000.00
3.	Training camps	2	15,000.00	30,000.00
4.	Awareness programmes	3	10,000.00	30,000.00
5.	Family planning	3	25,000.00	75,000.00
6.	Nutrition programme	3	25,000.00	75,000.00
				3,00,000.00
B)	*Stores materials*			
1.	Medicines	LS		75,000.00
2.	Vaccines	LS		75,000.00
3.	Contraceptives	LS		30,000.00
4.	Surgicals	LS		20,000.00
				2,00,000.00
C)	*Salaries & Wages*			
	As per chapter - 6 of the proposal for 6 months @ Rs. 41,000/-month			2,46,000.00
D)	*Administrative overheads*			
1.	Power			3,000.00
2.	Fuel			15,000.00
3.	Postage & Stationery			1,500.00
4.	Telephones			3,000.00
5.	Honororium			30,000.00
6.	Publicity material			6,000.00
7.	Staff welfare			3,000.00
8.	Consumable stores			3,000.00
9.	Miscellaneous			6,000.00
				70,500.00

Total cost of the scheme

a)	Fixed assets	9,20,500.00
b)	Variable costs (Recurring costs)	8,16,500.00
		17,37,000.00

7.2 Means of finance

a)	Contribution from the NGO @ 10% of the project cost	1,73,700.00
b)	Grant-in-aid assistance @ 90%	15,63,300.00
		17,37,000.00

The implementing agency is expected to make arrangements to tie-up with same other funding agencies to met the recurring costs from the 7th month onwards.

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8

Project Evaluation and Impact

8.1 Project evaluation

The project will be evaluated periodically by the project advisory committee basing on the logical framework cited hereunder.

a) Overall objectives
b) Project purpose
c) Expected results
d) Activities

The objectively verifiable indicators of achievement like number of awareness programmes/health camps/immunization programmes organized and the no. of beneficiaries assisted will be scrutinized.

The following checklist to review performance of the implementing agency on quarterly basis will be adopted.

a) no. of programmes organized
b) no. of beneficiaries
c) no. of invitees
d) response of beneficiaries
e) response of people towards collective action
f) understanding of beneficiaries about hygiene, health and sanitation
g) potential of community action
h) advise of secondary players/developmental partners

8.2 Indicators of achievement

The following objectively verifiable indicators marks the achievement of the project.

a) Comparision of pre-development and post-development scenario.
b) Increased level of awareness amongst the beneficiaries about the programme
c) Increased participation
d) Increased community action
e) Marked improvement in health and hygiene of the target group.

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9

Project Implementation Schedule

9.1 Schedule of activities

a) basic survey
b) project preparation
c) funding dossiers
d) formation of project advisory committee
e) procurement of assets
f) periodical health camps
g) awareness programmes
h) periodical immunization camps
i) family planning activities
j) Sensitisation programmes
k) Review, reporting and termination

9.2 Project period

The project duration will initially be for a period of 36 months from the date of conception.

9.3 Suggestive project time plan

Month 1-3

a) baseline survey
b) project preparation
c) Funding dossiers

Month 4-6

a) Formation of project advisory committee
b) Approval of project plan
c) Procurement of assets

Month 7-9

a) Project advisory committee
b) Appointment of personal
c) Sponsoring to training programmes
d) Pre-launch survey

Month 13-15

a) health camp
b) sanitation programme

c) family planning camp
d) PAC

Month 16-18

a) health camp
b) immunization programme
c) PAC

Month 19-21

a) health camp
b) awareness programmes
c) project advisory committee

Month 22-24

a) sanitation drive
b) immunization camp
c) project advisory committee

Month 25-27

a) health camp
b) HIV/AIDS awareness programme
c) Family planning
d) Project advisory committee

Month 28-30

a) health camp
b) immunization programme
c) sanitation drive
d) project advisory committee

Month 31-33

a) health camp
b) nutrition programmes
c) family planning
d) project advisory committee

Month 34-36

a) health camp & referrals
b) review
c) reporting
d) termination of the project