PROJECT PROPOSAL: SELF-SUSTAINING PRIMARY HEALTH CARE IN CHANDIGARH

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DEVELOPING INDIGENOUS RESOURCES-INDIA

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DEVELOPING INDIGENOUS RESOURCES - INDIA

Developing Indigenous Resources - India (DIR-I) was founded as a response to the limitations of typical development projects in Public Health. Too often, the solution has been to improve conditions by providing more and more money for development. Temporary relief has sometimes been witnessed, but quickly dies when the funds run out, as inexorably they must. By design, DIR-I positions the community members not as beneficiaries of assistance, but as implementers of change.

Activities of DIR-I aim to increase knowledge to change specific behaviours that have a lasting effect on the health and wellbeing of the individual, household, community and society as a whole. Community members, especially women, not only are the primary actors in organizing and implementing the program, but they are also the ones who will instigate change by adopting appropriate behavioural practices based on the skills they learn. The project is therefore positioned as a catalyst for change, “ dosing” people with a potent mixture of information and support, which provides the motivation and structure for individual and collective change.

In the project areas, DIR-I’ s main goal is not to train professionals or semi-professionals, but to equip local, uneducated women who l ive in urban areas characterized by substandard housing and poverty, to solve their own problems. Experience indicates that the most pressing issues in many areas of the developing world are preventable and the local people, with proper initial assistance, can solve their own problems without outside aid.

LETTER FROM THE CEO, DR. ASHA KATOCH

I have always been inclined towards a social cause. The advice that was given by my father the day he admitted me in medical school was: “serve the poor, don’t convert your profession into a business, and offer free treatment to the underprivileged,” so I have been following that policy ever since.

I graduated from Jammu Medical College in 1978 with MBBS, MD (Anesthesiology). In 2006 I surrendered my anesthesiology profession and started giving my services to the underprivileged. I met the founder of DIR-I, Dr. Fredrick Shaw, who offered that I work here at this organization.

When we first started working in Janta Colony, it was a forest land that was forcefully occupied by migrants. January 2006, we started the survey of Janta Colony. The government didn’t have any statistics yet of the community, so we did everything from scratch, going door to door in a population of 10,000 people to get stats on how many men, women and children lived in this slum. Our main agenda was to decrease the infant mortality rate and maternal mortality rate, and ensure a 100 per cent immunization rate in this community of 10,000 people.

Our organization has proved successful because of our close monitoring and accountability, and the ability of staff from every level of our organization to go into the field to do the work and not just sit in an office. I put in the work to gain the respect and win the hearts of the people in Janta Colony.

This project is a beautiful model for development because it employs local women from the slum, so it encourages women empowerment, as they gain a respectable employment, an income to support their families, and an education. By educating one woman, you educate a community, so we prefer female employees. This project combines women empowerment, community building, and income generation, all while serving the health needs of the most vulnerable populations of this community.

"By educating one woman, you educate a community"

the essence of the project

IMPROVING LIVES IN THE DHANAS

Who will implement the project?
The non- governmental organization, Developing Indigenous Resources-India (DIR- I) , which is a public, charitable, non- profit trust, registered in Chandigarh.

What are the chief goals?
Minimizing preventable illnesses and deaths in the general population, and focusing on maternal and infant healthcare. Implemented with a model in which local people are taught to solve their own healthcare issues with minimal or no outside assistance, a model which has been proven effective in Janta Colony, and is appropriate and replicable throughout India.

Why should it be done?
In certain rural and urban areas it is evident that there are many preventable deaths and illness which are not presently being adequately addressed. As the population increases, these preventable diseases will become an even more urgent matter to attend to as more people will be at risk. Our model is effective and replicable in all of India for a low cost, and could impact many other communities on a global scale.

How will it be implemented?
By employing local women who reside in the slums to be health promoters (HPs) who are trained and educated and initially supervised in their tasks. The HPs ensure that at least 90 per cent of all target residents in a chosen area have a full series of all necessary immunizations. Target residents include children under five years old and pregnant women. The HPs will train at least 80 per cent of all parents to make their own Oral Rehydration Solution (ORS) and administer it properly. Women who give birth will have appropriate antenatal and postpartum examinations and care, with the practices of midwives and birth attendants improved as specifically needed. Residents of the chosen area are enabled to purify or provide for themselves clean drinking water. Iodine deficiency and other nutritional deficiencies will be reduced by training mothers in proper infant nutrition and by giving multivitamins to pregnant and lactating mothers and Vitamin A supplements and deworming medicine to children under five years of age. Effective interventions to curtail the spread of contagious diseases will be implemented, such as holding committee meetings to educate the community on health risks during monsoon season.

How will results be measured?
Data collected during routine monthly monitoring and evaluations of the target population will be compared with baseline data which is established when each community is initially included in the project.

NEEDS ANALYSIS

India has pockets of neglected communities scattered throughout urban rural areas. Preventable deaths and illnesses are commonplace in these communities. Typically, such communities are located in economically disadvantaged areas, with residents living on, or below, the poverty line. High rates of unemployment, underemployment, illiteracy, and lack of education are often the norm, and the state's highest percentage of preventable deaths and illnesses are found in these communities. It is in areas such as these that nations experience their greatest losses.

54%

of children's illnesses stem from malnutrition

90%

of children in neglected communities are malnurished

These losses are expressed in:

- Loss of the life of children and pregnant women to preventable diseases.
- Loss of productivity due to preventable diseases and due to masses of people not reaching their potential.
- Loss of health status of the national population because such communities serve as reservoirs of human diseases which eventually reach all segments of the population.

Beyond the humanitarian motivation, it is in the interests of regional and national authorities, as well as everyone capable of understanding the severity and immensity of this problem, to seek to eliminate, or at least minimize, these losses.

As India's population increases, and more and more people are affected, it becomes an urgent matter that this problem is solved before it becomes impossibly large to handle. The principal reasons this project is important are:

- It will immediately reduce suffering amongst those living in substandard housing and poverty.
- It will immediately reduce government health expenditure, as illness will be prevented.
- It will provide a low-cost model of how to solve major health care problems which can be readily replicated throughout India

In India, 54 per cent of all children's illnesses stems from malnutrition. This is an average figure and it is generally understood that there is almost no malnutrition in middle and upper classes. Thus, the rate of children's malnutrition in neglected communities often reaches 90 per cent. DIR-I's research in Janta Colony, SAS Nagar, Punjab confirms this.

The slum dwellers in Janta Colony live below the poverty line, often in deplorable conditions. Many of their homes consist of just one room of approximately 12 square feet, with all family members often sharing the space with livestock. The water supply, whether in the home, or a communal tap, is not clean and water must be boiled or purified in another manner before it can be considered safe for consumption or hygienic use. Access to education beyond the most basic level is limited.

RATIONALE

The principle reasons to believe that the approach proposed here will be successful are:

- Since January 2006, DIR-I has been active in Janta Colony, a slum area with over 14 ,000 residents in an unincorporated area very close to Chandigarh. The results so far indicate success in that 100 per cent immunization rate has been achieved and an 86 per cent decrease in the percentage of underweight children.
- The project will address the specific needs of the children and women in each community. This is accomplished through a system in which the most severe health problems in each community will be identified and solved on an individual priority basis.
- The model is scientifically sound and accurate as baseline health statistics are recorded at the start of the project in each individual community and the changes brought about by interventions are recorded monthly, thereby facilitating precise evaluation and analysis.
- A main focus of the project is preventive medicine as over 80 per cent of the illness occurring in the sample areas are categorized as preventable.
- The local people, especially the women, will become enabled to provide the bulk of their health promotion and primary health care needs and eventually take over the program.
- India' s rapidly increasing population is widely attributed to parents having large families in order to compensate for expected childhood deaths and to provide more family wage-earners. With this being the case accepted cause of overpopulation, any program which effectively addresses one or more of these causes as well as basic health issues, as the project here does, may be expected to have a significant beneficial impact.

DETAILED IMPLEMENTATION PLAN

Project Period

1 → 2 → 3

Prepatory
2 months

Initial community sites are surveyed and their needs confirmed, administration needs fulfilled, equipment purchased, local staff recruited, procedures established, and initial staff training started.

Implementation
3 years

Project conducted as outlined in proposal.

Evaluation
2 months

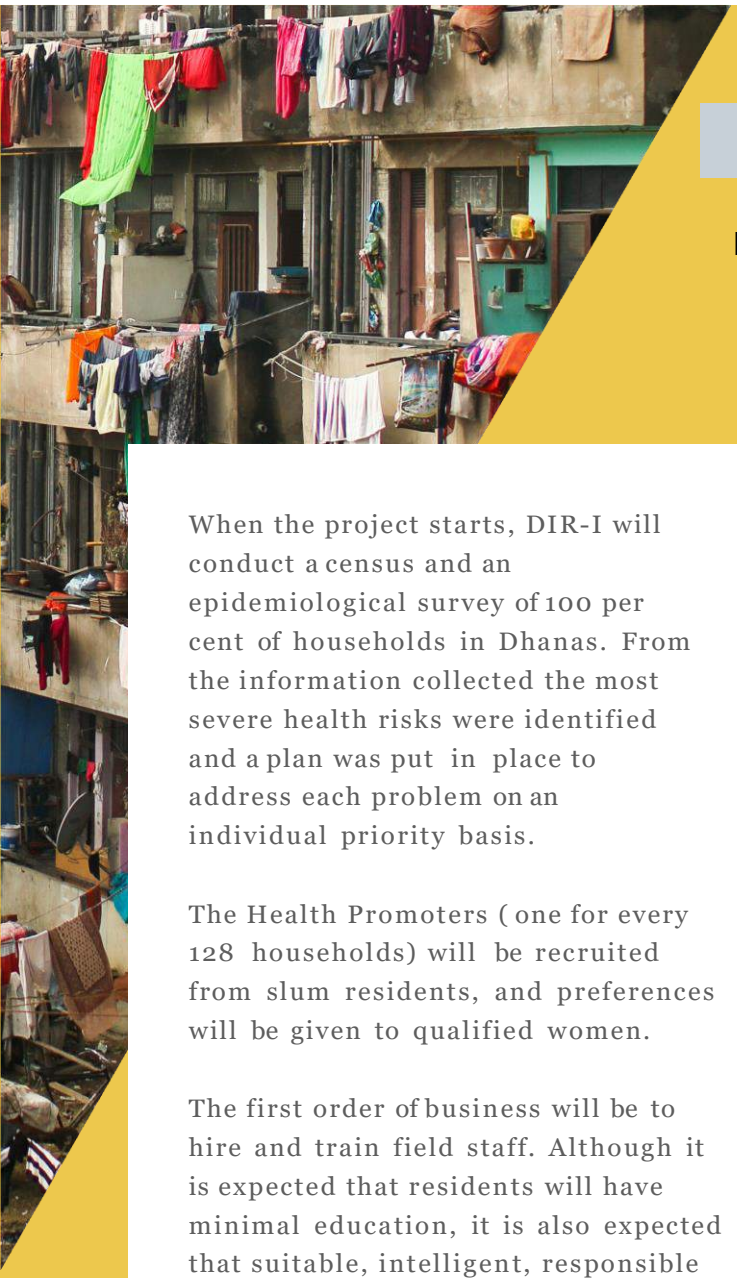
A full-scale impartial evaluation will be conducted, findings written-up and reports disseminated.

Goals

1. To reduce morbidity and mortality in communities where this is most needed.
2. To facilitate the local people to improve their own health and their children's health with low cost and minimal external assistance.
3. To demonstrate that this model of low cost, high impact, sustainable development is replicable throughout India.

Objectives

1. At least 90 per cent of women aged 15-45 have a full series of tetanus toxoid (TT) shots.
2. At least 90 per cent of children below five years old are fully immunized against all six serious childhood diseases: chickenpox, measles, mumps, rubella, tetanus, diphtheria.
3. At least 90 per cent of all parents can demonstrate that they can make and administer their own home-made oral rehydration solution.
4. At least 90 per cent of women who give birth during and up to one year after the start of the project will have at least two antenatal and two postpartum examinations.
5. Households know how to purify or provide for themselves clean water for consumption and hygienic use.
6. Households improve on their disposal of waste.
7. Personal hygiene and related behavior is improved.
8. The birthing practices of birth attendants and midwives are improved.
9. All health problems discovered within each community are appropriately addressed.



Modus of Operandi

DIR-I's central aim is to facilitate the development of local capacity to deal with the problems of those areas in such a way that the quality of life of local residents is significantly improved.

When the project starts, DIR-I will conduct a census and an epidemiological survey of 100 per cent of households in Dhanas. From the information collected the most severe health risks were identified and a plan was put in place to address each problem on an individual priority basis.

The Health Promoters (one for every 128 households) will be recruited from slum residents, and preferences will be given to qualified women.

The first order of business will be to hire and train field staff. Although it is expected that residents will have minimal education, it is also expected that suitable, intelligent, responsible people can be found.

The first two hours of each day they will attend seminar type classes which will supplement on- the-job-training. Planned classes include: communication, elementary physiology and anatomy, elementary nutrition, malaria eradication, hygiene, body systems, home-made ORS preparations, disease spread and health promotion.

After class time each day the health promoters will spend five and a half hours working with community residents. Their duties include:

- Holding regular meetings to pass on information learned to their individual committees (each staff member will have a committee of at least eleven other residents) in her particular block.
- Weighing every child under five years of age each month, and classifying them in one of the four weight categories: red-zone, yellow- zone, green- zone and high-priority- zone. If a child is severely underweight (more than four kg. below the ideal weight) they will be seen by a physician and given treatment. Parents of children in all other weight categories will be advised on how to take corrective actions, and all chronic cases will be followed up by a professional.
- Immunizing all children under five years of age with their childhood disease immunizations, utilizing whenever possible local government immunization services.
- Organizing local teams to clean up the physical environment, such as removing trash, pools of standing water and other health hazards.
- Making a roster of all pregnant women, recognizing high- risk pregnancies as well as nutritional deficiencies which affect both mother and child.
- Addressing specific problems such as narcotic addiction and AIDS as necessary.

Beneficiaries and Scope

Direct beneficiaries:
The total populations of communities included in the project constitute the direct beneficiaries, however, children under five years of age and pregnant women will receive priority attention as this segment of the population is at greatest risk of contracting serious diseases and premature death. The number of babies who die before reaching their first birthday and the proportion of women who die in childbirth (or a cause related to childbearing) are both exceptionally high and merit attention.

Indirect beneficiaries:
With such projects in the past, it has been observed that some residents of neighboring communities learn of, and copy, some of the newly adopted behaviors in the project areas. Cases have been documented in which residents of nearby areas have made beneficial changes including increasing the numbers of people immunized and using home-made oral rehydration solutions.

Addressing Addiction

Because of the growing prevalence of addiction to alcohol, narcotics and other substances in India, special attention will be given to correcting the harm addiction causes. The main aim of any anti-addiction activities we would undertake would be preventative in orientation - activities which would prevent potential addicts from ever experimenting with these harmful substances. Our policy would be to train our staff to be able to communicate to adolescents in understandable ways.

Emphasis on Women

Many health problems experienced in the slums depend directly upon the behavior of women more than any other group. Because of the multiple roles women play in their household and the health impact of these roles, much emphasis will be upon women's activities. High priority will be given to increasing their knowledge and developing their decision-making skills as they participate in educational experiences. Information will be disseminated and discussion will be encouraged in a risk-free environment. Each woman will be given autonomy to decide her own course of action. Healthcare education provided to the women will focus on choices, learning to differentiate between which choices lead to advantageous outcomes, and which lead to disadvantageous outcomes.

Administration, Management, and Technical Oversight

The Chief Executive Officer (CEO) of DIR-I, Dr. Asha Katoch, will provide overall supervision of the project. Dr. Asha has expertise in project design, project management, establishing monitoring and evaluation systems, health survey research, and the development of indigenous resources to solve health problems.

The CEO reports to the Board of Trustees of DIR-I, and functions within the authority, responsibility and limitations as described in various DIR-I documents, including the DIR-I Bylaws and the DIR-I Standard Operational Procedures (SOP). The Board of Trustees has wide discretionary powers, described in DIR-I Bylaws, including: making policy, collecting and disbursing funds, providing supervision, and hiring and firing senior staff.

MONITORING

A system of project monitoring which has already proven itself to be effective in our project in Janta Colony will be used.

Monthly Reports:

A series of reports are submitted monthly from each health promoter to her senior health promoter regarding their assigned community. Such reports include: accomplishment of immunizations, details of births, deaths, and pregnancies, details of illnesses, results of antenatal exams, the weight of every child under five years of age, and other progress reports.

These monthly reports are looked over and signed off by the senior health promoters and given to the field coordinators who compile the information into a single document who then submit it to the senior staff (the medical officer and dieticians).

The senior staff submit monthly reports to the CEO. These reports consist of: compiled data from the senior health promoters reports, the quantification of the achievements of the month' s objectives for the region, and a written discursive report of the month's activities.

The accountant submits monthly financial report of expenditures and vehicle reports to the CEO as well.

The CEO then compiles this data together and sends it to the Board of Trustees, all donors and contributors and publishes it online.

Quarterly Reports:

At the end of each quarter, a quarterly report takes the place of the monthly report from the Senior Staff to the CEO, who will forward it to the Board of Directors, with her evaluative remarks. The President of the Board of DIR-I sends copies, or shortened versions of Quarterly and Annual Progress Reports to major donors.

EVALUATION

Ongoing Evaluation:
Constant evaluation activities go on at each supervisory level and are conducted with three main purposes in mind: to ensure that objectives are being achieved on-schedule, to detect and correct any difficulties, to ensure that staff at all levels have adequate support and training and are producing optimal results.

Periodic Evaluations:
Periodic evaluations will be written at the project's middle and end, this evaluation will be organized by the CEO. It will be her duty to assemble and coordinate an impartial team of health or development specialists who will donate their time to evaluate the project. This team will be given free rein to use whatever methods they choose to assess the achievement of objectives. It is the responsibility of the CEO to compile and summarize their findings to the satisfaction of the team and to ensure appropriate distribution of the reports to major donors, Trust Members, etc.

SUSTAINABILITY

"Is this activity likely to lead to a gain which is permanent or self sustaining?"

At every planning stage, the criterion question will be asked: "Is this activity likely to lead to a gain which is permanent or self sustaining?" If we judge that, under normal conditions, the answer is "No" the activity will be excluded from plans. The project staff will consistently choose to take action which will produce permanent results, even if this action will be slower to implement, rather than action which will produce quick, unsustainable changes. Although every effort will be made to adhere to the project schedule, this sustainability rationale will be considered adequate reason to create a revised schedule. A change in schedule needs to be approved by the Project Director in writing and ratified by the CEO and any involved major donor.

When addressing the question of sustainability, it may be necessary to remind ourselves of what this project is and what this project is not. In the first place, this is not a project in which a clinic is set-up, put into operation, staffed, equipped, and supplied for three years, and then left with the expectation that it will continue to function without outside help. With establishing a clinic their concern is with the continuation of provision of the necessary goods and services it takes to run the clinic after the end of the project. With this DIR-I project, the principal product to be sustained is not the goods and services provided by a clinic, but the improvement in the health behavior of local residents. Our principal sustainability question then is not "who or what will furnish the recurring cost?" instead, "what reason do we have to believe that the improved behavior will continue, or that the gains made will not be lost after the project ends?"

Any discussion of sustainability here would be remiss if it were to omit mention of the committees in each unit. These committees are the means by which information is disseminated and discussed, and it is in them that the bulk of meaningful health education takes place. Decisions concerning health activities are also made in the committees, usually after discussion of the associated pros and cons. Past experience leads us to anticipate that most of these committees will take on a life of their own; these lives will extend outside health to other problem areas which may benefit from the group's actions. It is also anticipated that the committees will continue to function long after the end of any input from outside the community.

ACCOUNTABILITY

It is DIR-I policy to operate with complete transparency. That is to say, all work and all transactions are to be conducted in an open manner, and are open to the scrutiny of all appropriate individuals and organizations. It is also DIR-I policy to invite major donors to send a representative (not at DIR-I expense) to participate as a member in our team's annual project evaluation. In such evaluations, participants are free to examine any aspect of DIR-I's field operations and make recommendations as they see f it. Systems have been designed to ensure there are high levels of accountability in all components of the project.

Financial Accountability

The financial system for the proper handling of funds has built-in accountability at each level. Money never moves from the hand of one individual to the hand of another without there being made a record of the transaction bearing the signature of the receiving party. Each Regional Director supervises and verifies the appropriateness and accuracy of all financial transactions within his or her region, reporting on the distribution of funds each month. Regional Directors submit his or her reports to the Project Director. The Project Director compiles these reports and submits them to the CEO. The accuracy of calculations and the appropriateness of expenditure in all monthly reports are checked upon at each receiving level. The accountant of DIR-I ensures that records and reports of all financial transactions are audited annually, and may conduct an audit at any time, at his or her discretion. At the most senior level, the CEO is responsible and must account for all funds received by DIR-I and for their proper utilization. It is her responsibility to ensure that any and all financial reports required under the provision of any grants are supplied to donors on schedule.

Program Accountability

The DIR-I system ensures that all employees know their responsibilities and each are held accountable for accomplishing her assigned work each month. The monitoring system requires employees to quantify the accomplishment of objectives set for each month.

APPENDIX

During the month of April 2009, selected faculty and graduate students of the School of Public Health at Panjab University and the Home Science College, conducted an impartial evaluation of the collected activities of Developing Indigenous Resources- India. Both institutes are located in Chandigarh.

The activities evaluated took place in Janta Colony, a slum of approximately 14,000 residents where DIR-I strives to improvethe quality of life for those in greatest need. While Janta Colonyis very close to the Post Graduate Institute of Medical Science and Research in Sector 12, Chandigarh. It is in SAS Nagar District of the Punjab.

DIR-I has organized a low cost, sustainable development project in which the residents of the slums implement improvements in their living conditions after having been giventhe necessary knowledge, skills, and supervision by DIR-I trainers. Leading the implementation is a team of Health Promoters (HPs). They are slum residents and full-time paid employees of DIR-I. Each HP provides daily services and adviceto a “Unit” of 200 households. HPs are trained and supervised by a team of DIR-I professionals, made up of two doctors and two nutritionists.

Panjab University's Evaluation

FINDINGS

Janta Colony Stats

Infant Mortality Rate 2006 — 44%

Infant Mortality Rate 2019 — 5%

TABLE A

Item Evaluated	India's % Average	DIR's Aim	DIR Achieved
Children immunized against Tuberculosis	91.9	100	100
Children immunized against Diphtheria, Pertussis and Typhoid (DPT)	78.4	100	100
Children Immunized against Measles	81.1	100	100
Children Immunized against Polio	72.8	100	100

Source: National Family Health Survey (NFHS-4) 2015-16

TABLE B

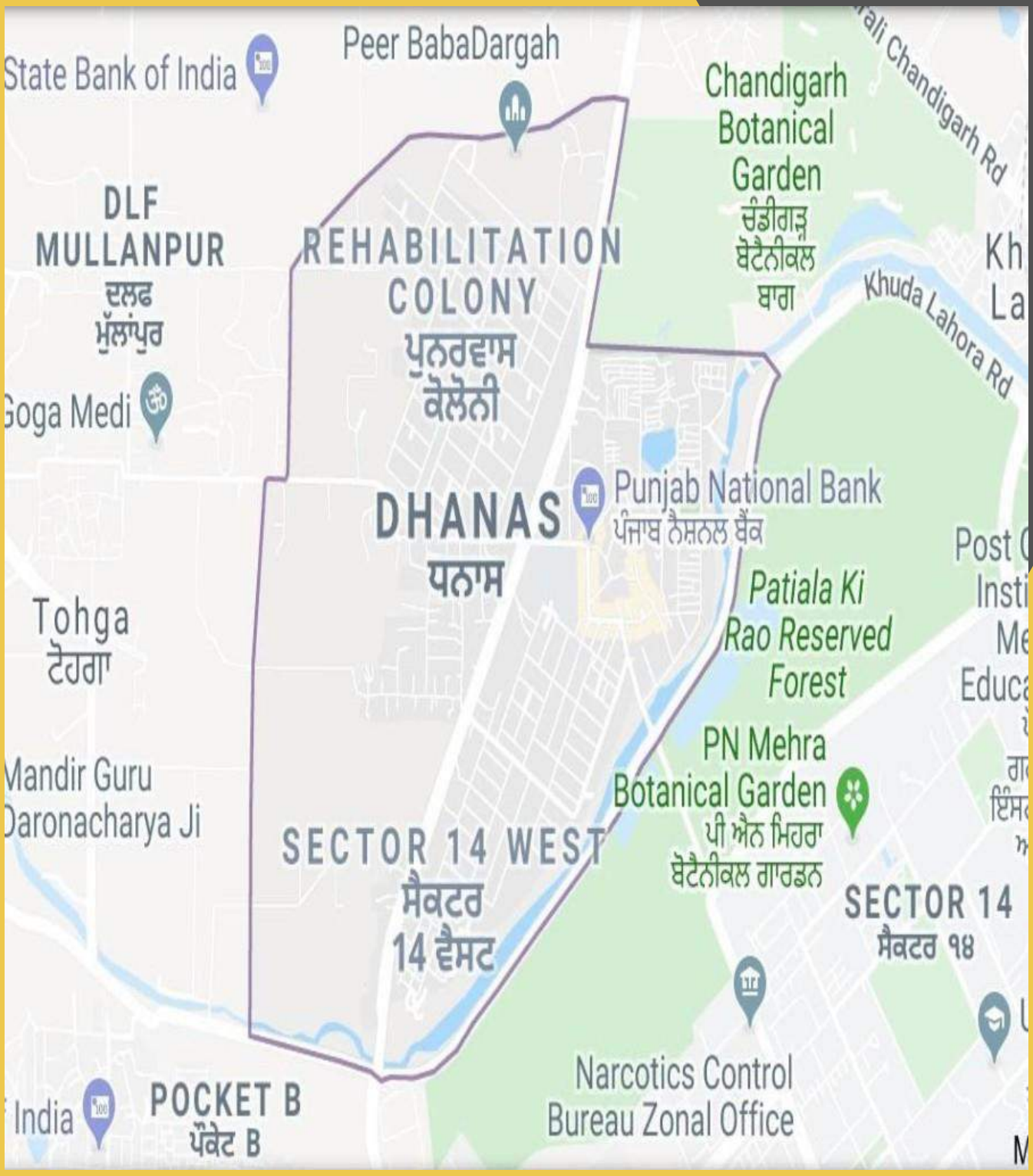
On the Women who delivered within the last 12 months:	India's % Average	DIR's Aim	DIR Achieved
Had Tetanus shots prior to giving birth	68 Source: NFHS 2005-06	100	100
Had professionally trained person assisted delivery	81.4 **Source: Unicef data 2013-2018**	100	100
Had at least 2 ante-natal exams	86.8	100	100
Had post-partum exams within 2 days of Delivery.	73.4	100	100

Source: National Family Health Survey (NFHS-4) 2015-16

TABLE C

Item Evaluated	India's Average	DIR's Aim	DIR Achieved
Average number of visits each Health Promoter makes to each home each month	N/a	1	4.2
Parents Knowledge of making ORS: Use only Pure water	N/a	100	25
Parents Knowledge of making ORS: Other ingredients exactly accurate	N/a	100	70

MAP OF DHANAS



SAMPLE SURVEY FORM

DIR INDIA IMPROVING LIVES- HEALTH SURVEY

DATE | || INTERVIEWER | || VILLAGE - DHANAS | Head of Households | Subject #

A - PEOPLE WHO HAVE NOT REACHED THEIR 15TH BIRTHDAY

	Name- List the oldest first and the youngest last	Relationship to head of household	Age in years	Is this a male ?	SHOTS RECEIVED				illness in last 30 days.						his person was bi	Nutritional Status				Dental Status	Migrated?	School	
					BCG	DPT	Polio	Measles	No. days ill	Diarrhea	Upper resp.	Other	Helped By	GET O.R.S ?		Wt.	Ht.	Arm Circu.	Head Circu.				
1																							
2																							
3																							
4																							
5																							
6																							
7																							
8																							
9																							
10																							
11																							
12																							

B- WOMEN BETWEEN THE AGES OF 15 TO 45

	Name- List the oldest first and the youngest last	Relationship to head of household	Age in years	Children		Now Pregnant ?	No. of last T.T	Spacing			O.R.S				Growth Chart		Lives with Husband	JOB	Illness in last year	Within last 12 months		Dental Status	Migrated?
				Now Living	Now Dead			Knows about	Method used	Gets supply from	Uses O.R.S	Can make it	Knows dose	knows when to give	Has seen	Knows Value of it				Age child died	Cause of death		
1																							
2																							
3																							
4																							
5																							
6																							

C- ALL OTHERS

	Name- List the oldest first and the youngest last	Relationship to head of household	Age in years	Is this a male ?	Spacing			O.R.S				Growth Chart		Lives with Husband/wife	JOB	Illness in last year	Dental Status	Migrated?
					Knows about	Method used	Gets supply from	Uses O.R.S	Can make it	Knows dose	knows when to give	Has seen	Knows Value of it					
1																		
2																		
3																		
4																		
5																		
6																		
7																		

E- DATA ON RESIDENCE

#ROOMS	
WATER SOURCE	
ELECTRICITY?	
LATRINE TYPE	
SEWER CONNECTED	

D-PREGNANCY OUTCOMES WITHIN LAST 12 MONTHS

PREGNANCY	OUTCOME	DELIVERY DATE	BOY?	DELIVERY LOCATE	WHO HELPED	GOT CARE		BREAST FED NOW ?	MONTHS FED	AGE SOLID FOOD
						ANTE	POST			
FIRST										
SECOND										
THIRD										
FOURTH										
FIFTH										

F-FATALITIES OTHER THAN THOSE MENTIONED EARLIER

NAME	SEX	AGE	DEATH CAUSE

G- ILLNESS NOW

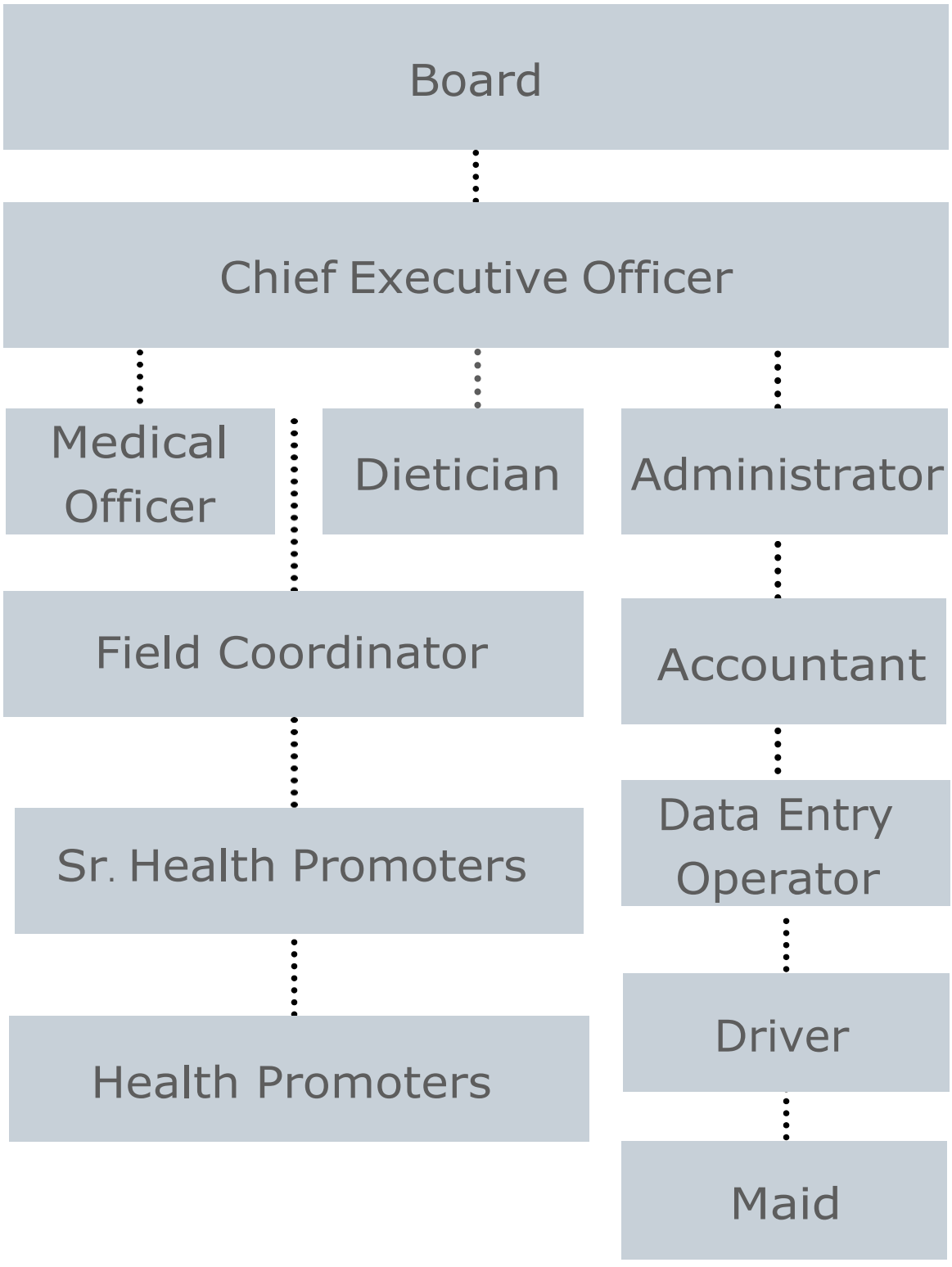
#WITH GOITER	
#PHYSIC DISABLED	
#MENTAL DISABLED	
#OTHER	

PRG.OUTCOMES
0= Miscarriage or spont. Abortion
1= Induced Abortion
2= Stillborn
8= Live Birth

WATER SOURCES
0=carry>15 minutes
1=Own Pump/Pipe
2= Own Well or Own Protected Spring
3= Public Pump
4= Public Well
5= Pub. Prot. Spring
6=Pub. Unprotected Spring
7= River
8= rain

LATRINES
1= Own Dry Pit.
2=Own Water Trap
3= Dry Pit Shared
4=W.C.Shared

DIR'S ORGANIZATIONAL STRUCTURE



REFERENCES

International Institute for Population Sciences (IIPS). *"National Family Health Survey (NFHS-4), 2015-16"* Government Of India; Ministry of Health and Family Welfare, Dec. 2017.

International Institute for Population Sciences (IIPS). "National Family Health Survey (NFHS-3), 2005-06" Government Of India; Ministry of Health and Family Welfare, Sept. 2007.

UNICEF. "India (IND) - Demographics, Health & Infant Mortality." UNICEF DATA, https://data.unicef.org/country/ind/?fbclid=IwAR1phseRBtgO9raCm1wAmrecEGmBVS_voljkmnkJj hslanmGO-bhzHqTjBc.