COMMUNITY BASED HEALTH PROJECT

A Manual

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FOREWORD

The Trust has initiated a number of interventions, especially in the field of community healthcare, on its own and also with the support of the European Commission. The intention is to strengthen self-reliance and the ability to implement projects, in the comparatively less fortunate segments of our society.

With this purpose in view the Trust has, and plans to, publish books to disseminate information, that is of practical help, for the benefit of the communities at the grassroots level.

This manual is designed to provide information and guidance to NGOs who intend to set up basic healthcare facilities. It contains useful information and guidance, beginning from the point when a project is thought of to the point when it is fully implemented.

Ms. Nazia Scher has done a commendable job in writing this manual that is comprehensive in its content, and simple in its presentation. I am confident that the NGOs intending to set up a health facility would find this manual of great help. It should make their job easier and more meaningful.

IQBAL JAFAR
Chief Executive Officer

Acknowledgements

In the preparation of this manual many books were consulted, out of which following were found more useful: *Primary Health Care Concepts and Challenges in a Changing World, Alma-Ata revisited by E. Tarimo and E.G Webster; Directory of Government Policies and Programmes for Citizen Sector by NGO Resource Centre (A Project of Aga Khan Foundation); National Essential Drugs List of Pakistan 2001 (Revised 3rd NEDL) by The Network for Consumer Protection in Pakistan; and Training 2000 Instruction Manual for Medical Officers, Women Medical Officers and Lady Health Visitors by* Department of Health Government of Punjab.

I am particularly grateful to Dr. Saeed Ahmad, Director TVO Board of Directors, for his valuable contribution to the "standard list of the equipment, furniture and linen", which I personally see as the most useful component of the manual. I also realize that without the technical input of Dr. Ahmad, I would have never been able to develop this list particularly on such a format that is very easy to follow even by a non-medical person.

I owe special thanks to Mr. Iqbal Jafar, Chief Executive Officer TVO, for his constant support and encouragement that I enjoyed throughout the period I spent on putting up with the manual.

I would also take this opportunity to thank all of my colleagues at TVO for their support that they have been extending in one way or the other. Mr. Zaigham Khan and Mr. Dawood Ali Khizai did the proof reading of the manual. Ms Seher Afsheenh and Ms Aqila Jabeen Qureshi assisted me in developing various worksheets and reference sheets of the manual.

Overview

This manual has been developed for the use of those planners and development professionals, who are planning or are in the process of developing a project aiming at the establishment of a health centre for the provision of community based health services. For this purpose they require technical support in terms of the following: assessing the health priorities of the communities; defining the standard requirement of equipment, furniture and linen; developing an appropriate strategy of community mobilization and involvement in the project; preparing a realistic estimate of the project budget; and developing a viable strategy regarding the long term sustainability of the project. The manual also reflects on the technical aspects of the health projects in the broader perspective of social change and community development.

The manual has broadly been divided in three parts, i.e., a) Units, b) Worksheets and c) Reference sheets. Each section contains a set of guidelines and vital information on a standard format. The section on "Units" is further divided into various sub-units. Each Unit reflects on a separate issue, containing a set of guidelines for the planners/facilitators enabling them to achieve consensus-based outcomes in every session. This part of the manual primarily addresses the issues like: how to plan for a planning workshop; how to conduct the planning workshop; and how to continue the process of project development in the post workshop period until the plan is effectively materialized. The manual, thus, includes all stages of project development from its "conceptualization' to "actual initiation"

The section on "Units" is followed by section "Worksheets". This section entails actual worksheets that have been designed exclusively for this manual aiming at structuring the process around specific issues of the health projects. These sheets have much wider application and scope as they may be used as planning and learning material by the facilitator at the workshop, as well as, provide technical solutions to the clinical and social aspects of a health project. The facilitator may develop additional worksheets by extracting data from the manual itself for which modest

creative skills will be required.

The last part of the manual mainly contains information material or specimens/formats that have been grouped as "Reference sheets". The objective is to provide additional clarity to the planners, who may then develop relevant material for their own use from the reference sheets. It is entirely the choice of the facilitators/planners whether they use reference sheets at the workshop as learning material or just use them for improving their own understanding on the subject.

Before moving on to the manual, let us also briefly look at the concept of Primary Health Care (PHC), which is the central theme of the manual. It is vital for the planners to familiarize themselves with the basic understanding of the concept of PHC as it provides parameters and a framework that is essential for the sound development of a health project.

Primary Health Care has been defined as "*essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination*".

"*It is the first level of contact of individuals, the family and community with the national health system, bringing health care as close as possible to where people live and work, and it constitutes the first element of a continuing health care process*".

(Article 6 of Alma Ata Declaration)

This definition does provide a universal conceptual understanding of PHC, yet it also poses numerous issues of practicality and application for the planners. They often require support in terms of deciding which medical service, group of medicines, and type of equipment etc. could be included/excluded from the ambit of PHC. The manual has been organized in a way that it enables the planners to decide of what may be covered in PHC and what is beyond the scope of PHC.

UNITS

COMMUNITY BASED HEALTH PROJECT

- Aims and Objectives of the Manual
- Planning for a Planning Workshop
- Planning Workshop-Day 1
- Planning Workshop-Day 2
- From Plan to a Project

Aims & Objectives of the Manual

This manual has been developed for the assistance of the civil society organizations, so as to enable them to conceptualize and plan for sustainable community health projects for the provision of Primary Health Care services (PHC). It is anticipated that the NGOs, which do not have prior experience of developing health projects, will find the manual relatively more useful.

The specific objectives of the manual are as follows:

1 Equip the planners with the methods, tools, and skill of organizing and holding a planning workshop aiming at the development of a health project

2 Address the commonly stated issues that need to be taken into consideration while developing a health project such as:

2.1 What services/facilities shall be available at the community based health centre?

2.2 What type of equipment, furniture and linen would the centre require, and in what quantity?

2.3 How can one determine as to how many people will benefit from the health centre?

2.4 How many medics and paramedics, and of what qualification and experience, should be employed at the centre? Which one of them will do what?

2.5 Are there some institutes/organizations that are offering training courses/workshops for paramedics?

2.6 What is the role and responsibilities of the NGO, community and donor in a health project?

2.7 How much does it cost to establish one health centre? What

will be the share of the NGO, community and donor?

2.8 How can NGO and community make the centre self-sustainable?

3 Provide guidelines on developing future action plan based on the deliberations of the planners at the workshop

The anticipated outcomes of the workshop are described below:

- The NGOs are able to gather the baseline data and assess the socio-economic feasibility of the health project
- The project specific objectives, comprehensive implementation strategy, realistic cost estimates and long-term sustainability methods have been worked out and agreed upon

Planning for a Planning Workshop

Project planning is often looked as a process through which needs are combined with resources (human and financial) for achieving pre defined benefits/results. The process is essentially led and participated by key stakeholders. This process may effectively be initiated by holding a planning workshop to which the primary stakeholders (NGO, Community, and potential Donors) could be invited to take part and contribute in the deliberations.

It is also suggested that those representatives of executive body, general body and the community should be invited to attend the planning workshop that are relatively more knowledgeable about the local socio-political setup, indigenous resources as well as the local development scenario. We often identify them as activists, social workers and some times even as local philanthropists.

Before the planning workshop it is important for the planners to ensure that the following tasks have been completed:

- **Selection and availability of the Resource Person(s).** A person familiar with the role and responsibilities of the facilitator, participatory workshop methodology, and having prior experience of conducting workshops would be an ideal resource person. The role of the facilitator would be to keep the discussion focused around the workshop objectives, ensure equal participation of both the NGO and community representatives, conduct sessions according to the session plan, follow the allocated time frame, analyze and record the input received from the participants in a systematic sequence, address issues and concerns raised by the participants, and ensure consensus based consultative process throughout the workshop. There can be one or more than one facilitators depending on the availability of the suitable candidates.

- **Formulation of the workshop objectives.** The workshop

Coordinator must clearly outline the purpose of holding the planning workshop. This exercise will be useful for the coordinator to structure his thoughts and present them effectively to the participants, who, in turn would be able to structure their thoughts around the workshop objectives. Worksheet-1 contains set of proposed workshop objectives.

- **Session plan**. The purpose of preparing the workshop session plan is to pre-plan and structure the activities and set a time frame for each activity to be undertaken during the workshop. The session plan should be prepared in relation to the workshop objectives. One session may cover multiple contents derived from one or more than one objective. On the basis of the objectives outlined in worksheet-1 a workshop session plan has been laid down on worksheet-2 for the assistance of the facilitator.

- **Workshop material/aids**. It is the responsibility of the workshop facilitator to develop appropriate and relevant workshop material to stimulate the thinking process of the participants leading towards productive discussion and solutions. It is also important to understand that the list of the training material and required aids should be furnished keeping in view the literacy level of the participants, and available financial resources. If most of the participants are unlettered, appropriate methods of consultation may be brainstorming exercises, group discussions, and application of drawing objects/visuals. Similarly, if the NGOs find the contents of the manual relevant to their organizational interest and priorities, they may use the worksheets as planning/learning material. The list of the workshop aids and accessories, that will be required to facilitate the workshop, is given at reference-i.

- **Workshop methodology**. The workshop methodology should be participatory, interactive and consultative in nature as well as process. It is suggested that the participants should be encouraged

to speak in local language as the borrowed expression often restricts the ability to conceive and articulate the ideas effectively and clearly. The facilitator should be neither rigid nor too flexible; he/she must handle the consultative process moderately.

- **Date, duration and workshop venue**. If the objectives, anticipated outcomes and the session plan of the manual is being followed without any major amendment then the suggested time period for the planning workshop is two-days. It is also important to inform the participants about the exact date and venue of the workshop atleast one week before hand, so as to ensure their participation. The venue for the workshop could be a communal house that may locally be known as *Baitahk/ Dera, Ottaque, Hujra*.

- **List of the resident and out stationed participants**. The list of participants should be developed with clear distinction between resident and non-resident participants. In keeping with the nature of workshop it is suggested that the participants should make their own traveling and accommodation arrangements on voluntary basis. In case this option is not feasible the NGO may spend some amount form its savings on the traveling and accommodation of the non-resident participants. This decision could only be made when the planners know about the exact number of the non-resident participants for which the list of workshop participants can be a useful reliance.

- **Logistic arrangements**. This point is very much linked with the previous point. It primarily takes into account such details: Who and how many people would be coming from outside the village/town to attend the planning workshop? Where the participants would stay? Where the workshop would take place? How many times meals and tea would be served during the workshop and at night? How many food items would be served and in what quantity? Who would be responsible for the coordination of

the logistic arrangements? How and when the participants should be informed about the arrangements? Time remains the most pertinent factor for effective coordination and logistic arrangements. All the logistic arrangements should ideally be finalized and communicated to the participants at-least one week before the workshop.

Budgeting & Financing. All the activities including preparation of workshop material, logistic arrangements, identification and involvement of workshop coordinator/facilitator, and record keeping of the whole process and event require careful and clear estimate of the expenses and possible sources of financing. The first step would be to outline a list of the required items; required quantity of each item; estimated cost of each item and the overall cost of the workshop. There are three possible ways of financing the workshop expenses, i.e., through the NGOs own saving and membership fees, indigenous donations, individual or collective financing. Another possible way of addressing the issue of financing is that the non-local participants should bear their respective travel and accommodation expenses and the local participants may divide the cost of the food/tea and other workshop material among themselves. Reference-ii contains itemized details of the workshop budget, which could be used as a sample for developing the NGO's own budget for the workshop.

PLANNING WORKSHOP

DAY 1

Sessions

I Introduction & Situation Analysis

II Structure & Functions of the Health Centre

III Essentials of Health Care

IV Budgeting

PLANNING WORKSHOP

Preamble

This part of the manual focuses on the contents, methods and exercises that will be conducted during the various sessions of the workshop. Each session will be covered as a separate Unit. The facilitators or the planners, who wish to conduct this workshop, shall first read these units along with the relevant worksheets and reference material of each Unit. This will help them to visualize as to what the workshop will be like, how the planners and facilitators will facilitate the deliberations and what will be achieved out of each session. After familiarizing themselves with the contents and format of the workshop the planners/facilitators should decide whether they will conduct the workshop as has been suggested in the manual or they will have to tailor it according to the needs/requirements of the organization. If the planners opt for the latter option, the bibliography of this manual could be a useful reference.

Let us now precede to session I and see what might happen in there.

SESSION 1 UNIT-C1

Introduction and Situation Analysis [90 minutes]

OBJECTIVES

- Establish rapport among the participants
- Familiarize the participants with the workshop objectives, methodology and anticipated outcomes
- Document the status of prevailing health, social and economic services/facilities and use it as bench mark

Facilitator's Guide

The facilitator should follow the workshop session plan. The workshop should begin with a note of welcome from the facilitator to be followed by formal round of introduction of the participants. They may be encouraged to structure their respective introductory comments following the guidelines given on worksheet-3. The assumption is that most of the participants already know each other either formally or informally, however, after the introduction every body knows each other and their collective strength.

If the introduction reveals that there is no medical or paramedical expert in the NGO or among the community the facilitator should stress on the need, significance, identification and their involvement in the decision making process through permanent membership or occasional participation in the meetings to be organized for the review, follow up, feedback and redesigning of the activities during the implementation process. In this way the NGO can have persistent technical backstopping and advice on voluntary basis.

The second part of the session should reflect on the objectives of the

workshop. The facilitator may run worksheet-1 with amendments or modifications on a slide, flip chart or plain chart. This will refresh the context, purpose and usefulness of the event in the eyes of the key stakeholders, i.e., NGO and community.

The foundation of the following sessions should be laid on the review and analysis of the current socio-economic status and facilities in the project locale or the village where the centre will be located. The guidelines given on worksheet-4 may be followed.

SESSION II UNIT-C2

Introduction and Situation Analysis [90 minutes]

OBJECTIVES

- Determine the nature & type of services to be provided at the centre
- Outline the structure and operating mechanism of the centre

Facilitator's Guide

This session builds on the assumption that in the previous session the participants have reviewed the status of current health facilities and services in the area and reached to the conclusion that the health facilities are either non-existent or insufficient. They have also jotted down the baseline data of the area. In this session the facilitator should assist the participants in the process of identification of medical services and facilities to be made available at the centre. Worksheet -5 contains the list of services and facilities that may be provided at the centre. The facilitator should ask the participants to review and identify appropriate and relevant services from the list for the centre. Prior to this, the participants should also provide justification for the inclusion or exclusion of the services. The objective is to avoid the duplication of services, resources and complement the existing facilities and services. The facilitator may explain this with the help of some examples based on hypothetical situations as given below:

a) The government Basic Health Unit (BHU) is available, but is either completely non-functional or is semi-functional. In a situation like this the planners may consider the option of taking over the administration of the BHU on lease from the relevant provincial health department, as this is very much in line with the present government's health policy. The contact details of

the government departments dealing with the issue of contracting out the BHUs on lease are given at worksheet-6. What kind of agreement could possibly take place between the NGO and the government is another relevant query that requires further clarification. This issue could easily be resolved if the planners review the contents of the Memorandum of Understanding (MOU) at worksheet-7. Incase the planners do not find the contents of the MOU completely relevant and compatible with their needs and priorities, they may modify and tailor it according to their own requirements.

b) The health facility is located at a distant place and there is no road or transport available through which the community could have access to the facility. In a situation like this the planners have a sound justification of establishing a new health facility/centre in the area.

c) If the health facility is accessible through local public transport, but is located far off from the village/area the NGO and community may ensure provision of emergency medical care, diagnosis of complicated diseases/illnesses and arrangement of timely referral to the nearest health facility through the establishment of a health outlet.

The facilitator should, then, widen the scope of the discussion and seek input from the participants on other pertinent issues like identification of the exact location and building for the centre; type and total number of the potential beneficiaries; required medical/paramedical staff strength; OPD procedures; cost recovery mechanism; referral procedure; patients record keeping, and establishment of appropriate medical facilities within the centre etc.

The facilitator should initiate the consultative process in a logical sequence. If the planners have given their consent for the establishment of a new health centre in the area the first step would be to identify a suitable

location for the centre, which means:

- The centre should be established at a central place, which is easily accessible by most of the people of the area and adjacent population;
- The centre is located on the main road or close to the main road, so is accessible through locally available transport; and
- There is no industrial noise, smoke or pollution near the proposed location of the centre.

The discussion should, then, be built on the issue of identification of an appropriate building for the centre, which is located on an easily accessible place. The discussion may lead to three possible options:

- A well constructed building is available, which has sufficient rooms/space for: seating arrangement of the medical staff; examination of the patients; attending labor (if the NGO is also planning to conduct safe deliveries); accommodating the waiting patients; installation/placement of the equipment/instruments; and storage of medicines and family planning products. The building shall also have safe drinking water and washing facilities for both the staff and patients.
- A semi-constructed building is available, which needs to be extended/renovated or partially constructed to ensure its suitability for the establishment of the centre.
- The building is *kachi* or made of mud, and comprises two to three rooms, veranda and a courtyard.

If the discussion leads the planning group to a situation that is similar to the last two situations, the consultative process should focus on the identification of a) local sources of raising finances (e.g. donations, membership contributions etc.), and b) potential donor for the construction or renovation of the building. If that is not possible, the scope

of the services should be reduced to the provision of following services: treatment of minor ailments and injuries; family planning counseling and non-surgical services; referral of serious patients and delivery cases; provision of general and life saving medicines; first aid and emergency care.

During the same session the participants should also explore the possibility of having the building of the centre transferred in the name of the NGO. This issue needs to be addressed carefully as is also linked with the issue of long-term sustainability of the project. Please also refer to session II of Day 2.

The planning group should also determine the potential clientele of the centre. The discussion should focus on the following:

- What is the total number of villages that are likely to avail the services of the proposed centre?
- What is the approximate total population of these villages?
- Who would have access to the centre? All segments of the population or just women and children would have access to the centre?
- How many patients would have access to the centre in a day/month/ year and during the total project life?

Discussion on these key issues will enable the planners to figure out the size of the population that the centre will serve and a fair idea of number of patients that will be attended at the centre on daily basis as well as quarterly and annual basis.

The facilitator should then assist the participants in ascertaining the total number of medical and paramedical staff to be deployed at the centre. During the discussion the participants should also look into the issue of availability of the health practitioners and alternative arrangement in case of non-availability of the health personals. It is suggested that the staff of

the community health centre should comprise the following members: Medical doctor, Lady Health Visitor (LHV), Trained Birth Attendant (TBA), and Dispenser/Dresser.

In case the planning group arrives at the conclusion that there is no medical doctor available within the area; the possibility of identifying the doctor from the nearest village/town/city may be explored. The non-resident doctor should visit the centre atleast twice a week or as may be feasible. In case of non-availability of a medical doctor an LHV may be made in-charge of the centre. However, in that case the skills of the LHV and TBA shall be enhanced through training courses/workshops. The contact details of the institutes/organizations that offer training courses/workshops for TBAs and LHVs are given at reference-iii. The facilitator shall share these details with the planning group, who could then identify the right contact for themselves from the given reference.

It is advisable that the staff of the centre should be local and made available for provision of medical services including emergency care round the clock. However, the facilitator may assist the participants to develop consensus on the timings of the centre for the daily consultation and management of the patients, outreach activities and emergency first aid.

The participants should also be encouraged to discuss and address the following issues through a consultative process:

Who would attend the general patients/clients, emergency cases, and delivery cases? The facilitator may use worksheet-8 to develop consensus among the participants regarding the issue of who would do what, as it contains job description of the medical and paramedical staff of the centre.

The doctor, preferably a lady doctor, shall be the in-charge of the centre and responsible for ensuring that the optimal standards of hygiene and medical services are maintained at the centre. The Doctor shall also attend the general patients including emergency cases and coordinate the referral arrangement. The LHV shall provide antenatal care, family planning

counseling/ services to expectant mothers and shall conduct safe deliveries. The TBA shall liaise between the community and the staff of the centre and assist the LHV in conducting and management of the deliveries at the centre. A dispenser shall primarily be responsible for dressing of minor injuries, maintaining ledgers/stocks, whereas the lab technician shall conduct lab tests as per the specification of the doctor.

What would be the procedure of effective and timely referral for patients suffering from serious/complicated diseases, illnesses or injuries? Where the patients would be referred? The facilitator should develop a list of the nearest accessible health facilities, including government and private hospitals and clinics, with the assistance of the participants. The same list may be utilized for the identification of " most suitable and accessible referral facility". The description of a suitable referral facility is that it is: managed by qualified and trained staff; easily accessible; affordable; and has sufficient capacity, in terms of staff's time and space, to accommodate the referred patients. The group also needs to develop clear guidelines regarding the referral of the patients requiring emergency treatment and those suffering from complicated illness/disease that cannot be treated at the centre. The facilitator should seek input from the participants on this issue. One suggestion is that round the clock referral facility shall be made available for the patients requiring emergency care. On the other hand patients requiring specialized medical care may be gathered at the centre once a week on a specified time and taken to the referral facility. Another option could be that a medical specialist of the referral centre could be requested to visit the community health centre on a specific day; examine the patients; prescribe and provide medicines to the patients; and advise the patients requiring further investigations or advanced treatment to visit him/her on a specific date and day at his hospital for follow-up and further checkup. The issue of timely referral is also linked with the availability of a vehicle for carrying patients from the centre to the referral facility. Therefore, it is pertinent for the local people that the centre has its own well-equipped ambulance. The facilitator should assist the group in the formation of a committee that should coordinate, negotiate and develop an

effective referral arrangement with the identified referral facility.

Record Keeping. It is anticipated that by this time the planning group would have worked out the structure and nature of services to be provided at the centre. It is equally pertinent that the group identifies a system that provides track record of the services/facilities that will be provided at the centre including: number of patients attended by the staff during regular working hours and through the emergency care services during the odd hours; number of deliveries conducted at the centre; number of patients referred; type and quantity of medicines purchased and provided to the patients; number of lab tests undertaken at the centre; number and type of tests referred to other laboratories etc. The facilitator should encourage the planners to form another sub-committee that would be responsible for developing the system and relevant formats for generating the required information and maintaining updated records of the centre. The same system may also facilitate the internal learning, and monitoring process of assessing the performance of the staff and overall functioning of the centre.

Essentials of Health Care [60 minutes]

OBJECTIVE

Equip and furnish the health centre as per the agreed standard

Facilitator's Guide

This session shall address the issues, such as: what type of equipment, furniture and linen the centre shall have? Defining the quantity of the required furniture/linen and equipment is another major task that the planners are often faced with. Are there any easy answers to all of these? Yes, the facilitator may certainly provide an easy answer. All that he/she will have to do is to share the list of the furniture/linen and equipment given at worksheet-9 with the participants. The salient features of the list are: it contains equipment and furniture/linen that are essential for general diagnosis/treatment, conducting safe deliveries, and establishing a lab facility within a health centre; the quantity of each item of the list has also been standardized; and the prices of each item of furniture/linen and equipment have also been included.

A centre furnished and equipped as per the worksheet-9 will have the capability of delivering the following services:

- appropriate treatment for common diseases and injuries;
- maternal and child care;
- management of safe deliveries;
- provision of family planning services;
- provision of emergency medical care ;
- facility for minor surgery, and basic lab.

It also implies that the requirement in terms of the furniture/linen and equipment for a centre shall be laid down in relation to the nature of services that will be provided at the health centre. Therefore, the facilitator shall suggest the planners to review the given list of equipment, furniture/linen in relation to the services that they had agreed to provide at the community health centre in session II of the workshop. If the group had planned to provide all the services indicated above then the same list of equipment, furniture/linen is a perfect match. If the situation is contrary to what is being assumed here, then the planners shall be assisted to develop compatibility between the services and the given list of furniture/linen and equipment. For example, if the planners are planning to provide all the services listed above except for the "facility for basic lab", the part of the list that contains equipment for lab shall be detached from the list. Similarly, if the planners do not agree to provide facility for the "management of safe deliveries", the equipment indicated in the part "Deliveries" shall be taken away from the list.

Moreover, if the planning group has also agreed to provide the referral service to the patients suffering from serious or complicated illnesses and injuries to the centre and other referral health facilities, it shall also consider the desirability of acquiring the ambulance for the centre.

The facilitator shall also bring forth the matter of ensuring the adequate stock and supply of medicines at the centre. This matter could easily be resolved through the establishment of a medical store at the centre. Assuming that the NGO will keep the level of services, to be provided at the centre, within the ambit of primary health care the facilitator may suggest a standard list of medicines that could be made available at the centre's medical store. A solution to this has been provided at worksheet-10 of the manual, which in fact is a list of essential drugs. The facilitator shall encourage the planners to review the given list and use it as a starting point. However, the same list could later on be modified on the basis of the actual requirement of the patients and centre during the implementation phase of the project.

Budgeting [120 minutes]

OBJECTIVE

Develop the overall project budget including the budget of the centre

Facilitator's Guide

This session is built on the assumption that by now the planners have a fair idea as to what will be the set up of the centre and how will it operate, e.g., will this be a basic health unit, an MCH centre, reproductive health centre, a dispensary, or just a T.B. clinic. The group will also have worked out the details regarding the required strength of the medical and paramedical staff of the centre and the equipment and furniture that the centre will be provided with. Similarly, the group will also have arrived at the decision whether the centre will have an ambulance of its own or not.

Keeping in view the key features of the health centre the facilitator shall assist the planners to develop an activity based budget for the centre and the over all budget of the project. This session will primarily be a brainstorming session that will initially focus on the development of the budget for the centre that could be developed by following the guidelines given below.

- Make a list of all the items required for the centre with the help of a checklist given at worksheet-11
- Write estimated cost next to each item of the list
- Divide the items of the list into two categories, i.e., as capital (items having life of more than one year, e.g. building, equipment, furniture) or *recurring* (items that have life of less than one year, e.g., rent of the centre, salaries, utility expenses, stationary,

maintenance cost of the equipment/furniture/building)

- Prepare an estimate reflecting the monthly as well as annual cost of each recurring item, e.g., the NGO has planned to appoint one lady doctor at the centre, whose monthly salary will be Rs 8,000/month that will further be multiplied by 12 to arrive at a figure that will indicate the annual salary of the lady doctor. This could be done by adopting the following method:

  - lady doctor's salary [1] @ Rs 8,000/month X 12 months = Rs 96,000/year

  or

  - medicines @ Rs 10,000/month X 12 months = Rs 120,000/year

  or

  - Utilities (e.g. electricity, gas charges of the centre) @ Rs 2,000/month X 12 months = 24,000

- Similarly, an estimate of the capital items shall be prepared reflecting the *absolute cost of each item* and the *total cost of all the capital items*, e.g.,

- Cost of the land of the building of the centre	Rs 300,000
- Cost of the construction of the building @ Rs 600/[2]sft X 1,570 sft covered area	Rs 942,000
- Cost of the Ambulance	Rs 500, 000
- Cost of the equipment and furniture	Rs 130,000
Total Capital Cost:	**Rs 1,872,000**

The point to remember is that the cost of capital items will not be divided into months, as the expense in terms of each capital item will be made just once during the project life.

Explanition Notes:
Symbol [1] @ indicates the rate at which the amount of salary has been fixed
Symbol [2] sft is a short form of the word square feet

- If the planners have successfully completed the tasks as have been suggested in the previous steps, they have all the details required for preparing the budget for the centre, which will look like the specimen of the budget enclosed at reference-iv. The planners shall now prepare their own budget of the centre that will tell them as to what is the total cost of the centre that they are planning to establish? They will also come to know about the capital as well as recurring expenses of the centre. This distinction between the anticipated capital and recurring expenses is essential as it is linked with the issue of long-term sustainability of the centre. The biggest challenge will be to develop an appropriate strategy of meeting the recurring expenses with minimum or no support from the Donor. This issue has been discussed at length in the session on "Sustainability".

- The next step will be the preparation of a list of other items/ and services that will be required for the successful establishment of the centre, e.g., project coordinator/accountant, stationary, office equipment etc. These expenses are often identified as overhead project cost. The planners shall try to keep the items of the overhead project cost as minimum as possible.

- Include the cost of other components of the project, e.g., training of paramedics, community meetings etc. These costs are usually looked as capacity building costs, as they bring about some kind of improvement or quality, e.g., a trained *Dai* can deliver better services than a un-trained *Dai*. Similarly meetings with the community will increase the interest and involvement of the community in the project activities that will also lead to a sense of ownership among the community members.

- Now, the items/services identified as overhead project cost and capacity building cots shall also be classified as Capital and Recurring costs.

- Include the items of the overhead project cost and capacity building cost in the budget prepared for the health centre; change the title of the budget from "Budget for Health Centre' to "Project Budget". The facilitator may congratulate the planners as they have successfully developed the first draft of the project budget.

- The planners shall review and finalize the project budget ensuring that they have included all items/services, having some cost implication, in the project budget.

- The group shall also form a Committee that should collect quotations in terms of the items to be purchased from the market, which shall then be compared with the budget prepared in the meeting. The comparison between the budget and the quotations will help the planners to ensure that they have prepared a realistic project budget based on the prevailing market rates.

- The planners shall now revisit the budget and develop consensus on the issue as to what will be the NGO, community and donor's contribution. While defining the share of each of the stakeholder, the planners shall try that the NGO/community meets the maximum recurring expenses, whereas the donor's share is primarily for the provision of capital items and capacity building component of the project. This will serve two purposes, i.e., a) build their potential donor's confidence regarding the sustainability of the project, and b) the issues of community development, involvement, empowerment will be addressed effectively, as the status of the community will not be that of a recipient, instead it will be a shareholder and a key contributor in the project.

  One key concern of the planners might be that the recurring cost of the project is too high, so it will be difficult for the poor community to make such a huge contribution. This issue could be addressed by combining two methods, i.e., a) separate the cost of those items that

are of recurring nature but will not be required after the one time financial input, e.g., training/workshop costs, development of information material, and b) then divide the remaining recurring cost, that will be the recurring cost of the centre, among the NGO and community members, e.g., the anticipated monthly recurring expenses of the centre are Rs 30,000/month and the centre will provide services to at least 1,000 households, the share of each of the benefiting household will be Rs 30/month. This could be linked with several privileges and benefits. The privileges shall exclusively be for the contributing households, whereas the benefits of services could be extended to the non-contributing members on a double price, may be at every visit. As this issue is linked with the issue of long-term sustainability of the project, the facilitator shall also refer to session on sustainability.

- The details regarding the share of NGO/community and donor shall be included in the budget.

UNIT-D

PLANNING WORKSHOP

DAY 2

Sessions

I	Sustainability-Programmatic Perspective
II	Sustainability-Financial Perspective
III	Project Funding
IV	Future Action Plan

Sustainability-Programmatic Perspective [90 minutes]

OBJECTIVE

Develop a Community Based Project Sustainability Plan

Facilitator's Guide

It is important to highlight that the long-term continuity of any initiative, and particularly of a health centre, is a lot more challenging than undertaking the initiative itself, therefore it requires special attention and shall be an integral part of any health project. The long-term sustainability of any health project needs to be assessed from two dimensions, i.e., social and financial. It is equally important to understand that both the social and financial aspects of sustainability are interdependent, as they both lead to the consolidation of a process that is usually linked to various activities and outputs. Both of these aspects are, however, dealt separately, so that a sound project sustainability strategy could be worked out that will certainly be more effective than a strategy which is based on either social or financial aspect of sustainability.

There are six key building principles that lay down the foundation of a socially/culturally sound project; therefore they shall be given due place in the sustainability plan of a project. They are:

Community Organization/Mobilization. A project plan that does not ensure the involvement of the community in the planning, implementation and post implementation phase of a project cannot be considered a feasible and effective plan. Therefore, the facilitator shall assist the planners to develop an effective community involvement strategy. One option could be that the planning group forms a Project Management Council (PMC), to be comprised equal representatives of NGO and Community. The size of the PMC shall neither be too small nor too large; it could consist of 14

members, i.e., 7 from the NGO/CBO and 7 from the community. The PMC shall be responsible for: supervision and internal monitoring of the project; developing close ties between the NGO and community; organizing PMC Forum on quarterly basis, for learning, sharing and addressing the issues of implementation and project sustainability; motivation and mobilization of the community and its resources for the project; and taking decisions, to be based on a consultative process, and ensure their implementation.

Ownership. Ownership among the community members could be created through their active involvement in the decision based consultative process, project, and by assigning them some responsibilities. The planners may ensure this by developing consensus on the following: PMC Forum shall be attended by atleast 80 % of the total community members/representatives, where they will be able to share their ideas, suggestions and concerns with the PMC; responsibilities of organizing the PMC Forum; timely referral of patients to the centre; assisting the PMC in maintaining updated records of the Centre; community and mobilizations of funds from within the community are few responsibilities that shall be assigned to community members having the interest, ability and time that they could give to complete the assigned responsibilities with desired outcomes.

It is essential for the planners to understand that the level of community involvement will determine the level of social /cultural acceptance of the project activities. Therefore, attempts shall be made to involve the community in the project from the very beginning, i.e., even from the planning stage, and their involvement shall further be increased and sustained throughout the planning, and implementation stages and even after the completion of the project activities.

Transparency. This is another key building principle, which is rarely understood completely. Most organizations think that they publish their annual progress reports and statement of audited accounts regularly; therefore they are a transparent organization. However, this is not enough,

as the community, in general, does not understand these reports due to their complex presentation and language, therefore cannot relate to them. The planners shall ensure that the community is kept well informed about the overall progress of the project, its outcomes, funding sources and utilization of donor/community funds. How would this be possible? This query could come up during the session. The solution is that the PMC may use its quarterly scheduled Forums as an opportunity to make its progress and details of funds a matter of community interest by sharing the details with the community. It may also explore the feasibility of publishing a project based News Letter, to be published in Urdu/local language, for the community.

Accountability. The facilitator may open the discussion on this key building principle by referring to the general trends of accountability. The discussion may also lead to the conclusion that the NGOs/CBOs are accountable to the donors for the successful implementation of the project. This concept is true to some extent but not completely. The NGOs are accountable to the donors as they provide principle amount/grant for meeting the project costs, e.g., funds for equipment, furniture/linen required for the centre; salary of the staff of the centre; training of the paramedics etc. However, the effective utilization of the donor/community funds, and sustainability of the project outcomes is the responsibility of the NGO, which it cannot meet without the involvement and contribution of the community, therefore is equally accountable to the community.

Particularly, in this project the community will bear the maximum recurring cost of the centre through the membership of the health benefit scheme, which shall be extended through the PMC. The contribution of the members shall also be acknowledged at the PMC Forum, which will also report to them as to where the money of the members has been utilized and for what purpose. Therefore, the NGO is also accountable to the community for protecting its interest and rights of access to services and information regarding the utilization of funds.

Standard Documentation. The participants shall look at the issue of documentation from two perspectives, i.e., they are required to ensure that they develop a system that takes into account details regarding the services that will be provided at the centre as well as it reflects on the programmatic and financial aspect of the project to the satisfaction of the donor and community. It is perhaps not possible to develop such a system in a session of few hours; therefore, the NGO shall constitute a sub-committee for visiting other similar organizations that are implementing the health projects. The committee shall study the systems of documentation of other organization and then develop a system that will be standard and meet the requirements of all the stakeholders, i.e., NGO, community and the donor, without which it will be very difficult to win the confidence of the donor as well as the community.

Consistency. It is crucial as it adds to the credibility of the organizations. The planners shall try to ensure that whatever project sustainability plan they develop they keep it consistent and if at any stage they modify their plan it shall properly be documented and shared with the key stakeholders. Similarly, the Planners shall ensure that the PMC remains active and functional throughout the project cycle and holds its Forums as per the agreed schedule and with maximum participation from the community. The planners shall also ensure that the status of the NGO and community remains that of stakeholders/partners, who pledge to work together for their collective benefit. Similarly, the planners shall also devise ways and means to ensure the integrity and impartiality of the PMC.

Sustainability-Financial Perspective [135 minutes]

OBJECTIVE

Develop a Community Based Financial Sustainability Plan

Facilitator's Guide

There are three key building principles that lay down the foundation of a sound financial sustainability plan. They are recognized as: a) Low Recurring Expenses, b) Cost Based Recovery Mechanism, and c) Standard Documentation. The facilitator shall facilitate the planners in developing a sound financial sustainability plan of the project based on these key principles. This session builds on the assumption that the planners will have worked out the details regarding the anticipated recurring cost of the health centre and the project in the session on "Budgeting".

In this session the planners shall develop a comparative statement of anticipated monthly income and expenditure. The statement of income will include all the possible sources of funds that the NGO could allocate for the project, e.g. membership fee, service charges, health benefit membership contribution, donations etc. The statement of expenditure will include the cost of such items that have been identified as recurring cost in the project budget, e.g., salary of the staff, rent of the building of the centre, stationary, utility expenses etc.

The NGO shall take out the indefinite sources of funding from its statement of possible sources of income, as those sources are not dependable, e.g., the NGO may earn reasonable income from the sale of hides and skin of sacrificed animals that it received from the community at "Baqar Eid", however, this money was not available at a time when the centre was short of funds and collapsing. So, one option may be to keep this amount intact and use it for averting the situations like the one mentioned above.

Now compare the total of the statement of anticipated income with the total of statement of expenditure, if both are same or the comparison indicates that the income is slightly higher than the expenditures the planners should be pleased with themselves as they have developed a sound cost recovery strategy that will lead to the sustainability of the project in the years to come.

If the comparison leads to a shortfall in terms of the income, which means that the anticipated income is less than the expenses, the planners shall work around the following options till they find that the total of statement of income is same or slightly higher than the statement of anticipated expenses.

- Reduce/lower the recurring expenses, e.g., motivate the relevant community member to donate the building in the name of the NGO that could be used for the health centre. Similarly, if the planners take a BHU on lease from the government they will be able to bring down a substantial portion of the project cost.

- If the previous option is not feasible then motivate the relevant community member to give the building on lease to the NGO for a period of five years. The NGO may utilize this period to win the confidence of the community by coming up to its expectations and earning credibility and stature of a credible organization. The Community member shall again be approached for having the possession of the building or make an alternative arrangement in consultation with the Community.

- Similarly reduce or exclude the cost of other recurring items from the budget that the planners may think are not pertinent till they agree that further reduction in the recurring cost will have adverse affect on the project and its output.

- Consider the option of introducing Community Based Cost Recovery Mechanism through the Project Management Council. One e services

possibility could be that the planners offer Health Benefit Scheme (HBS) to the community by dividing the recurring cost of the centre among the benefiting households, e.g., if the anticipating recurring cost of the centre is Rs 30,000/month and the anticipated number of the benefiting households is 1,000 households, each household will have to pay only Rs 30/month. In return, every member of the benefiting household will be entitled to avail the services of the health centre, whenever he/she needs them, without paying any other service charges. The person, who will buy the scheme for the household will also be entitled for participating in the forums/meetings that will be organized by PMC, as a stakeholder/shareholder. The contribution of the members will also be acknowledged at the PMC Forum, which will also report to them as to where the money of the members has been utilized and for what purpose.

- The secret of the success will be on the number of the members. The extension of the health benefit scheme will reduce the amount of membership to be paid by each member. Therefore the PMC shall be advised to extend the scheme to the adjacent villages/towns. On the contrary, the PMC should have the right to charge the non-scheme holders on commercial rates at their every visit to the centre and shall not be eligible for being associated with the PMC and its work. Their status will be of a client.

- Consider the possibility of requesting the donor for some support for meeting the operational expenses of the centre in a declining order for a specific period, e.g., if the planning group is looking at the possibility of having the donor support for three years, the donor's share for operational cost of the project should not exceed 60 % of the total operational expenditure for the first year and could be reduced to 40%, and 20%, in the second and third year respectively.

- The group shall also be sensitized on the issue of developing and

maintaining standard documentation procedures and system. This in its own entirety is a broad subject that cannot be explained/understood in a session of few hours and is also beyond the scope of this manual. Therefore, the planners shall be advised to constitute another small committee for visiting similar organizations and learning from their system of documentation, which shall eventually be able to develop a sound financial documentation system.

Project Funding [90 minutes]

OBJECTIVE

Identification of local and external sources of funding

Facilitator's Guide

A project may just remain a paper plan until an organization is able to mobilize the required financial support for the project. The question that the facilitator shall put up before the planners is what do they identify as possible financial support for the project? While doing so, the facilitator should be very careful as the discussion may begin and remain focused around just one possibility, i.e., the donor support/funding. There is no doubt about the fact that the donor's support is crucial for materializing a health plan for the benefits of the communities. Yet, it is equally important to realize that the mobilization of indigenous resources provide a sound basis for the successful implementation and sustainability of any project. Therefore, the planners shall be advised to begin their deliberations on the subject with the identification of those local resources that could be used for the financing of the project. They could broadly be classified as has been suggested below.

Monterey Resources

Those resources that are generated in the form of cash through some social/economic activity are commonly referred as monetary resources. The most commonly recognized forms of monetary resources in the development sector are: membership fee; funds generated through fundraising events, e.g., sale of products at *Meena Bazar*, exhibitions, theatrical and musical charity shows; income generation activities, e.g., sale of handicrafts at a vocational centre, computer centre, tent service, printing unit, or rent of a building; and cash donations.

The planning group shall assess which one of these monetary forms has some scope that could be materialized for the project. This shall be followed by another exercise, i.e., the development of an appropriate strategy for the mobilization of the local resources for the project. The facilitator shall also encourage the participants to develop a list of philanthropists, who could be persuaded and motivated to donate some amount for the project/fundraising events/income generation activities. The philanthropists, who have joined the planners in this meeting, should be given a lead role to play on this.

Physical Resources

These are the resources that are physically verifiable, e.g., a piece of land, building, construction material, fittings/fixtures, electrical appliances, equipment, furniture etc. During the discussion among the planners the facilitator may find out that there are few businessmen in the area, who have their own business, e.g., of construction material, electrical appliances, medical equipment/instruments, furniture etc. The group is of the opinion that they may not be comfortable with the idea of giving donations or cash contributions for the project; however, they may be willing to provide equipment/furniture for the centre or the NGO office, medicines for the centre etc. This type of contribution is also known as "contribution in Kind". Similarly, there may be few other charity donors, who may be approached and motivated to donate their personal land/building to the centre to the benefit of the humanity. The planners shall be assisted to develop an appropriate strategy of motivating these local charity donors and goodhearted businessmen to donate whatever they can for the project. Most essentially they shall be motivated to donate land, building/construction material, equipment, fittings/fixtures for the project.

At the planning stage a written MOU, stating that Mr. so and so has pledged to donate Rs 50,000 or his land/building to the NGO that will be used for establishing a health centre for the benefit of the local population,

will be sufficient. The actual support, i.e., either as cash or kind could be materialized at the initial implementation phase of the project.

Volunteerism

This is the biggest strength of the NGO sector that compels the Donors to extend their financial support to the NGOs/CBOs for projects. This has also been recognized as the key driving force that contains the magic of turning the dreams of the communities into reality. It is a feeling associated with a sense of commitment that enables a person to participate in the noble work of community development. This is the guiding spirit with which the NGOs/CBOs operate and undertake development projects.

This would perhaps not be justified to assume that the spirit of volunteerism prevails only among the NGO members. A large number of volunteers actually are the people from within the communities. The need is to capitalize on their potential and associate them with the project. Therefore, the facilitator shall suggest the planning group to identify volunteers from within the targeted community and associate and involve them in the project activities. They could be associated with the project as community representatives in the Project Management Council. They could be invited at the PMC Forum and help the PMC in achieving its given mandate. The facilitator shall draw the attention of the planners towards the issue of developing a list of potential volunteers, who could later on be approached by the members of the planning group and given the opportunity to contribute in the project activities.

Donor Funding

It is easier to identify the people, resources and funds from within the community as the planners usually belong to the same area, however the real challenge is the identification of potential donors. It is important to mention here that each donor has its own funding policy, project selection criteria, and funds disbursement policy and procedures. One thing, however, is common among all the donors that they recognize that the

funding shall be extended to the remote, neglected and underprivileged areas. The trend of developing partnership with the Community Based Organizations is also picking up. So, even if the planning group belongs to a NGO that has enjoyed little or no donor support in the past, they still have the opportunity to do so.

Action Plan [75 minutes]

OBJECTIVE

Develop a consensus based Action Plan

Facilitator's Guide

After the intensive deliberations of two days it will be the time to wrap up the key points and reflect back to see: what has been the outcome of this process; what requires follow-up; and more significantly what lies ahead; and identify one focal person who has the ability to take this process forward till the objectives of the process are fully achieved.

Assuming that during the previous sessions the facilitators have constituted various sub-committees for actions that will have to be undertaken after the conclusion of the planning meeting, the facilitator should revisit those decisions and put them once again before the planning group for developing consensus on the time frame that will be given to each committee for completing its task. The facilitator shall also get back to the members of each committee, who would have by now assessed whether they can do the task that they have been entrusted with or not, and assign the responsibilities to those who are motivated, have the ability and time to meet their assigned responsibilities.

Sequencing of the actions/activities that require follow-up in order of priority will be the next task before the planning group, which means that which action/activity will be completed first and to be followed by which activity. Similarly can two or more than two activities could be carried out simultaneously or not. As this point requires further explanation following suggestion will perhaps be useful.

The work of collection of quotations of equipment, furniture/linen should

be done on priority basis, as only then the planners will be able to prepare a realistic project budget. Similarly, if the planners are keen to win the confidence of the potential donor, they should do the work of obtaining signed pledges/undertakings from the community members first and then initiate their dialogue with the donor. In this way the planners will have a better standing and can put up their case more effectively before the potential donor.

While preparing the action plan the planners shall also bear in mind that the plan should be as such that it should keep the momentum of the process going. The suggested time frame for completing the follow-up activities, learning and devising systems and procedures of record keeping, developing contact with the donors is three months. However, the planners should develop their own action plan with the help of the suggested plan given as Reference-v. In case the planners have established systems of record keeping; they may complete the follow-up activities within a period of one month. To materialize the plan all that planners require is the will, determination, favorable circumstances and the right timing to make it happen.

From Plan to a Project

It is a stage that is full of actions and accomplishments. It should essentially be led by the focal person who was nominated to coordinate the post workshop activities between the planning group, community and potential donors. A very basic task before the focal person will be to ensure that the action plan that was mutually agreed by the members of the planning group, is fully complied.

The focal person should also ensure that the workshop facilitator compiles the workshop report that reflects on the consultative process as well as provides detailed information on the outcomes of each session. The focal person should use this report as the main reference document for developing the concept paper, which is the next major task before the focal person.

While preparing the concept paper the focal person shall ensure that it reflects on the five key aspects of the project, which are:

1 PROJECT JUSTIFICATION
Describing
Why is project needed

2 OBJECTIVES
Describing
what is the project about

3 IMPLEMENTATION STRATEGY
Describing
How will it be implemented/executed

4 PROJECT BUDGET
Describing
How much will it cost, what will be the contribution of the NGO/Community and Donor to the project

5 SUSTAINABLITY
Describing
Will the NGO/Community be able to continue the

project after the withdrawal of the Donor support

It is also important to mention here that every donor has its own formats for accepting the grant request/proposal, however the above-mentioned key points are common to the interest of the donor community. The same concept paper could also be used as a strategic tool for organizing the communities and holding their interest to the project till the support of potential donors is materialized. The contacts should be developed with the donors; the communities should be made aware of their role and contribution to the project; most significantly the plan should be followed. The most challenging question is shall we wait for this to happen or just do it.

WORKSHEETS

COMMUNITY BASED
HEALTH
PROJECT

Planning & Learning Material

Worksheet-1

to

Worksheet-11

[WORKSHEET-1]

Workshop Objectives

Assess the following through consensus based consultative process:

- Health needs of the community in relation to the prevailing socio-economic status of the community and available medical health services/facilities;
- nature and type of services to be provided at the health centre;
- number of intended beneficiaries (local & non-local);
- type and quantity of equipment, instruments and medicines to be made available at the centre;
- type and quantity of furniture required for the centre;
- referral requirements & possible arrangements;
- staff strength (project & centre);
- availability of a suitable building at a central accessible location;
- capital & recurring cost of the centre & project;
- availability of indigenous financial, human and material resources that may be mobilized for the establishment of the centre;
- external sources of funding;
- sustainability requirements and explore a local method/mechanism to ensure the sustainability of the proposed centre;
- nature, type and sequence of activities to craft and coordinate effective implementation mechanism and strategy;

- overall implementation time frame and time period required for each activity and preparation of activity calendar

- role & responsibilities of the NGO/community and donor to ensure effective monitoring of the centre, quality of the services, referral arrangements, performance of the staff, availability of medicines, appropriate utilization of the equipment, appropriate utilization of funds, and maintenance of records; and

- documentation requirements, process and procedure.

[WORKSHEET-2]

Workshop Session Plan

DAY 1	
Time	**Sessions**
09-10:30	**I** **Introduction & Situation Analysis** ▪ Welcome ▪ Mutual Introduction ▪ Workshop Objectives ▪ Situation Analysis (present socio -economic conditions and status of the inhabitants & project area)
10:30 – 11:00	Tea
11:00 – 13:00	**II** **Structure & Functions of the Health Centre** ▪ Building ▪ Staff ▪ Standard procedure for consultation, treatment, and emergency medical care ▪ Services ▪ Referral arrangement ▪ Beneficiaries ▪ Record keeping
13:00 – 14:00	Lunch/Prayers
14:00 – 15:00	**III** **Essentials of Health Care** ▪ Equipment, Instruments & other supplies ▪ Furniture and linen ▪ Medicines ▪ Ambulance
15:00 – 15:15	Tea
15:15 – 17:15	**IV** **Budgeting** ▪ Activity based budgeting ▪ Preparation of the project budget

DAY 2	
Time	**Sessions**
09-10:30	**I** **Sustainability-Programmatic Perspective** **Key Building Principles** ▪ Community Organization/Mobilization ▪ Transparency ▪ Accountability ▪ Ownership ▪ Standard Documentation ▪ Credibility & Consistency
10:30 – 10:45	Tea
10:45 – 13:00	**II** **Sustainability-Financial Perspective** **Key Building Principles** ▪ Low Recurring Expenses ▪ Cost Based Recovery Mechanism ▪ Standard Documentation
13:00 – 14:00	Lunch/Prayers
14:00 – 15:30	**III** **Project Funding** **NGO/Community/Philanthropists/Donors** ▪ Monetary ▪ Kind/Material ▪ Volunteers ▪ Any Other
15:30 – 15:45	Tea
15:45 – 17:00	**IV** **Action Plan** ▪ Who will do what? ▪ Activity Schedule/Calendar ▪ Mobilization of the local resources and donor support ▪ Developing contact and linkages with the donors and key stake holders

[WORKSHEET-3]

Participant's Introduction

- Name
- Association with the NGO (executive member, office bearer, activist, community representative, technical advisor etc.)
- Qualification
- Profession
- Main strengths

Guidelines
for Assessing the Socio-Economic profile of the area

Indicator	Status
Total population	☐
Total number of Households	☐
Main occupations ----------	
Average household income	☐
Average family size	☐
Type of houses	Kacha ☐ Packa ☐ Both ☐
Metal link road	☐
Post office	☐
Electricity	☐
Gas	☐
Telephone	☐
Number of girl's Primary schools	☐
Number of boy's primary schools	☐
Source of drinking water	
tap water ☐ hand pump ☐ tube well ☐ well ☐ pond ☐ spring/stream ☐	
Drainage system	☐
Government BHU/RHC	☐
Distance to the nearest government health facility	☐

[WORKSHEET-4]

Indicator	Status
Private clinics/practitioners	☐
Number of children borne every year	☐
Number of deaths recorded every year	☐

Most common diseases _____

Pertinent health related issues _____

(Over crowding; non availability of qualified doctors, medicines, appropriate equipment etc.)

{Please write numbers or "Yes/No" or descriptive notes as appropriate in the relevant boxes.}

Identification of Appropriate Services

Nature of Services	Required/ Not Required	Justification
❑ Treatment of minor ailments & injuries	☐	----------
❑ Emergency medical care/ first aid	☐	----------
❑ Antenatal care & safe deliveries	☐	----------
❑ Family Planning counseling & services	☐	----------
❑ Health education	☐	----------
❑ Immunization	☐	----------
❑ Blood screening	☐	----------
❑ Provision of medicines	☐	----------
❑ Laboratory facility	☐	----------
❑ Referral	☐	----------
❑ Any other	☐	----------

Please write, "Yes" or "No" as appropriate in the boxes given under the column "Required/Not Required". "Yes" would indicate the inclusion and "No" exclusion of the service(s) from the list. There are two ways of using this sheet a) the facilitator may fill the blank boxes and lines in consultation with participants in the plenary, or b) copies of this sheet may be circulated among the participants and a final sheet may be generated on the basis of the input received from the participants.

Leasing of Basic Health Units (BHUs) to NGOs

Contact Details of Relevant Government Departments

	Relevant Department	Address	Contact Person	Tel #	Fax #
1	Department of Health, Government of Punjab	Civil Secretariat,Lahore	Secretary	(042) 9210749/ 9219724	(042) 9211710
2	Department of Health, Government of Balochistan	Director General Health Office, Link Sariab Road, Quetta	Secretary	(081) 9211356	None
3	Department of Health, Government of NWFP	HRD Unit, Khyber Road, Peshawar	Secretary	(091) 9210342 / 572	(091) 9201954
4	Department of Health, Government of Sindh	Block-94, Sindh Secretariat, 4-B, Opp. Sindh Assembly Building, Karachi	Additional Secretary	(021) 9201254/ 9202603	(021) 9201254

Memorandum Of Understanding

This agreement made this 30th day of March, 2003 between the Government of ..... (hereinafter referred to as "First Party"), which expression shall include his successors-in-office and assigns of the first party and Mr..... President of ..... (hereinafter referred to as "Second Party"), which expression shall include his legal representatives and assigns of the second party.

WHEREAS THE Second Party has shown interest to administer a Basic Health Unit (hereinafter referred to as "BHU") for rendering health services to the population of the area of the BHU (hereinafter referred to as "Users").

AND WHEREAS the First Party is willing, pursuant to the interest shown by the Second Party, to transfer a BHU on lease to the Second Party for the purposes mentioned above.

1. The First Party hereby transfers on lease the BHU, described in Annexure 1 to this lease agreement, along with the fixtures, fittings, furniture and other equipment, as detailed in Annexure II, to the Second Party on the specific condition that the Second Party shall utilize the same for the sole purpose of rendering health services at the rates prevalent for comparable services in Government facilities to the Users, and as approved by the First Party.

2. Initially the lease period shall be for ten years, commencing from the date of signing of this agreement by the parties, which may, by mutual consent of the parties, be extended from time to time.

3. The Second Party shall provide such health care services, as are usually provided by BHUs, to the Users and also submit quarterly activity reports on an agreed Proforma to the First Party.

4. In consideration of this noble cause of extending essential health services in an economically depressed rural area, a token lease rent at the rate of Rs. 100.00 (Rupees one hundred only) per annum for the BHU shall be charged by the First Party which the Second Party shall pay in advance by the end of the first week every year.

5. On and from the date of taking possession of the BHU, the

employees of the First Party posted thereto shall be withdrawn or placed under the administrative control of the Second Party on such terms and conditions as may be agreed upon by the First Party and the Second Party.

6. The Second Party shall not make, other than by agreement with the First Party any changes in the aims and objectives nor shall it use the building for any purpose other than mentioned above in clause 1.

STEPS TO BE TAKEN BY THE SECOND PARTY

7. The Second Party agrees to:

(a) render health services to the Users at the rates prevalent for comparable services in Government facilities and approved by the First Party.

(b) maintain the existing preventive health programmes.

(c) make additions and alterations to the existing buildings subject to prior approval of the First Party in order to provide at least the following:

_____

_____

_____

(d) make necessary minor additions/alterations to the existing equipment installed by the First Party in the BHU in accordance with the agreed proposed activities, however, any major alterations/additions will be subject to prior approval of the First Party.

(e) Provide a pharmacy store with necessary medicines including:

_____

_____

_____

(f) Surrender, the additions made to the BHU free of cost on the expiry or termination of the lease.

(g) Not enter into any agreement with a third party regarding the

BHU or the employees of the First Party serving therein, without the prior approval of the First Party.

(h) Furnish a Bank Guarantee or surety bond, by men of means, equal to the value of apparatus/equipment detailed at Annexure II and available in the BHU at the time of the commencement of the Agreement.

8. In case of default in the performance of any of the obligations by either party, the aggrieved party may revoke the contract subject to one month notice; provided that the First Party reserves the right to revoke the contract and take over the BHU with immediate effect if the Second Party fails to deliver the health services as required by this contract.

IN WITNESS WHEREOF the parties hereto have singed this Agreement on the date first mentioned above.

Annexure I

PLAN AND LOCATION OF BUILDINGS

Annexure II

FIXTURE, FITTINGS AND EQUIPMENT

[WORKSHEET-8]

Job Description of the Medical and Paramedical staff

Staff Designation	Responsibilities
Medical Doctor	Incharge of the centre, provision of preventive services (optimal standard of sanitation and clean environment is maintained at the centre, supervises the EPI, ARI, family planning and health education activities etc.) and curative health care services (diagnosis and treatment of minor ailments, diagnosis, treatment and referral of complicated diseases/cases, emergency first aid, dressing of serious injuries etc.), ensure the deliveries conducted at the centre are managed and assisted with professional competence, liaises with community through TBA and LHV & informally through his/her contact with people for community development.
LHV	Conduct safe deliveries and provide Pre, intra, and postnatal care to the expectant mothers including TT immunization, advise on appropriate family planning methods, good breast-feeding practices, nutrition and growth monitoring, treatment of minor diseases and referrals incase of complications in the absence of the Medical Doctor. Her job extends to the care of infants and preschool children including EPI, ARI, nutrition and growth monitoring and health education. She should also supervise the TBA in performance of her duties towards mother and child.
TBA	Assist LHV in the management of normal deliveries, keep a liaison for the deliveries, between pregnant mother, her family and the community health care

centre. She should also be responsible for provision of antenatal care including arranging TT vaccination, detection and treatment of anemia in pregnancy, providing post-natal care including promotion of breast feeding, education of mothers on nipple care and new borne, advice on family planning, promoting immunization in children through education of family and coordinating with the staff of the centre in collection of data on births and deaths.

Dispenser/Dresser — Dressing of the simple injuries and assist in the dressing of serious injuries, indent linen/dressing material for dressing and maintaining the ledger /stocks, running the medical store, at the centre, preparing mixtures, lotions, suspensions, ointments, powders, liniments etc. in accordance with the prescription, updating of the stock register, inform the medical doctor about the expired/destroyed drugs and those near expiry on monthly basis.

Lab Technician — He will be responsible for conducting basic lab tests on the specification of the doctor; arrange for the referral of the sophisticated tests to the advanced and reliable lab facility; purchase, cleaning, sterilization, and maintenance of the lab equipment.

Standard List of Equipment for Delivery

S.No.	Equipment	Quantity	Unit Price	Total Price
1	Female Catheters, F 201, F 203, F 204, F 28	2	125	250
2	Foetal Stethoscope	1	30	30
3	Needle Holder Mayo 5-1/2	1	45	45
4	Catheter Female, 12 FR	4	35	140
5	Kidney Trays S.S.	1	100	100
6	Chittle Forceps	2	115	230
7	Bowls S.S with cover medium size 6"	2	80	160
8	Forceps Toothed 6"	1	25	25
9	Artery Forceps Mosquito curved	2	40	80
10	Artery Forceps Mosquito Straight	2	40	80
11	Perforator	1	550	550
12	Cranioclast & Gephelotsiel	1	1,800	1,800
13	Hager Dilator Set of 8	1	275	275
14	Double ended Curette Various sizes	12	100	1,200
15	Anterior Vaginal Wall Retractors	2	175	350
16	Bladder Sound	1	35	35
17	I.U.C.D Set	1	3,200	3,200
18	Weight Machine	1	400	400
19	Baby Weighing Scale	1	1,500	1,500
20	Wash Basin (Steel)	1	350	350
21	Sponge Holding Forceps	1	90	90
22	Breast Pump	1	55	55
23	Duck's Spoove Speculum	2	90	180
24	Volsellum Forceps	2	90	180
25	D&C Kit	1	50	50
26	Episiotomies Scissor	2	50	100
27	Cord Clamp,(Disposable)	10	3	30
28	Examination Couch	1	2,225	2,225
29	Baby Cot with Mattresses	2	1,450	2,900
30	Cusco Vaginal Speculum F 50, F 8	1	135	135

Standard List of Equipment for Delivery

S.No.	Equipment	Quantity	Unit Price	Total Price
31	Delivery table	1	6,000	6,000
32	Outlet forceps	2 sets	—	800
33	Cord Scissor	2	40	80
34	Instrument Trolley	1	1,000	1,000
35	Surgical light	1	1,000	1,000
36	Baby trolly	2	750	1,500
37	Insturment Boiler	1	1,400	1,400
38	Cocker Forceps	2	150	300
39	Suction unit Foot Opertor and Electric	1+1	—	2,000+6,000
40	Drip Stand	1	200	200
41	BP Appratus	1	500	500
42	Tooth Forceps 6"	2	25	50
43	Oxygen cyelinder	2	2,500	5,000
44	Stuns Speelum Large	1	150	150
45	Volsellum Forceps	2	110	220
46	Bladder Sound	1	75	75
47	Suction Currette	3	100	300
48	Rectangular Trays S.S size 10x12"	2	375	750
	Total			**44070**

Standard List of Equipment for General Treatment

S.No.	Equipment	Quantity	Unit Price	Total Price
1	Cylinder Oxygen 48 Cu. Ft. (With Regulator and Mask)	2	2,500	5,000
2	Scissors Dressing, Straight, Both 6"	3	35	105
3	Scissors Dressing, Straight, One Point Sharp 5-1/2	3	35	105
4	Duodenal Tube, Ryle's	3	25	75
	ii) 42" long, rubber/nylon	3	75	225
5	Tube Stomach Siphon,; with gag I.R.	2	175	350
	ii) 60" long for adults			
6	Tube Rectal (flatus)I.R.	2	80	160
	ii) Size 22" Charriers Gauge			
7	Catheter Foley's Introducer	1	125	125
8	Torches	1	85	85
9	Stethoscope	1	175	175
10	B.P Apparatus	1	250	250
11	Instrument Trolly S.S Top	1	1,550	1,550
12	Tongue Depressors	6	30	180
13	Nasal Specula (Set of 3)	6	125	750
14	Aural Specula (Set of 3)	6	75	450
15	Nasal Dressing Forceps(Tilly Forceps)	6	115	690
16	Aural Dressing Forceps(Crocodil)	2	225	450
17	Percussion Hammer	4	25	100
18	Stretcher with Trolly	2	2,800	5,600
19	Stands Curtain screw/folding	2	850	1,700
20	Dispensing table	1	3,000	3,000
21	Emergency Trolly	1	15,800	15,800
22	Wheel Chair (Non Folding)	1	2,400	2,400
23	Bag hot water	2	75	150
24	Thermometer , Clinical 35-42	6	15	90
25	Mortar &Pestle	1	125	125
26	Drip Stand	2	250	500
27	Basin Trolly Steel(Doubel Basin)	2	450	900
28	Lantern	2	150	300
29	Kerosene Oil	2	50	100
30	Spirit Lamp	1	30	30
31	Methylated Spirit (Bottle)	1	40	40
32	Kidney Trays S.S	1	200	200

Standard List of Equipment for General Treatment

S.No.	Equipment	Quantity	Unit Price	Total Price
33	Bowls S.S with cover medium size 6"	2	80	160
34	Forceps Toothed 6"	1	25	25
35	Artery Forceps Mosquito curved	4	40	160
36	Wash Basin (Steel)	1	350	350
37	Sponge Holding Forceps	1	90	90
38	Examination Couch	1	2,225	2,225
39	Insturment trolley	1	1,000	1,000
40	Drip Stand	1	200	200
41	Rectangular Trays S.S size 10x12	2	375	750
	Total			***46,720***

Standarad List of Equipment for Laboratory

S.No.	Equipment	Quantity	Unit Price	Total Price
1	Test tube racks	2	85	170
2	Test tube Holder	1	20	20
3	Slides Microscopic /Pkt of 72	1	75	75
4	Test tube 6"x3/4	1	7	7
5	Test Tubes 4" 1/2"	1	5	5
6	Improved Newbauen Chamber	1	950	950
7	E.S.R. Tubes 6"x1/4	12	40	480
8	E.S.R stand for 10 Tubes	1	225	225
9	Hemoglobinometer Sahli's Tubes	1	575	575
10	" " Pipettes	1	85	85
11	Microscope Binocular	1	18,500	18,500
12	Disposable Syringes 10 ml	1,000	5	4,500
13	" "5 ml	2,000	3	5,000
14	Dipstick for Urine Test	1	400	400
15	Centrifuge	1	5,000	5,000
16	Pregnancy Kits	100	10	1,000
17	Glucometer	1	3,500	3,500
18	Hepatetis B kit	10	20	200
19	Aids Kits	10	70	700
20	Hepatetis C kit	10	35	350
21	Blood Group kit	1	700	700
	Total			**42,442**

Standard List of Furniture & Linen

S.No.	Furniture/Linen	Quantity	Unit Price	Total Price
1	Chair Office Revolving	10	2,200	22,000.00
2	Table office with drawers	5	3,500	17,500.00
3	Revolving stools	2	700	1,400.00
3	Bed Iron	2	3,300	6,600.00
4	Shovel	1	350	350.00
5	Pick Axe	1	350	350.00
6	Bucket G.I.4 Gallons	4	350	1,400.00
7	Almirah Steel 6'x3'x1 1/2	4	5,000	20,000.00
8	Bench with back (Iron)	4	850	3,400.00
9	Towel stand	1	450	450.00
10	Waste Paper Basket	4	60	240.00
11	Soap Dish	4	15	60.00
12	Patient's Bed with Mattresses	2	1,250	2,500.00
13	Blankets	6	500	3,000.00
14	Bed Sheets	8	110	880.00
15	Draw sheets	20	100	2,000.00
16	Pillow Foam	2	80	160.00
17	Pillow Cover	4	35	140.00
18	Dusters	10	100	1,000.00
19	Overalls	6	175	1,050.00
20	Physicians Coats	2	350	700.00
21	Towels	10	125	1,250.00
22	Table Cloth	20	100	2,000.00
23	Curtain	2	350	700.00
24	Mask	6	15	90.00
25	Cap	6	15	90.00
26	Disposable Gloves (Diffrent Sizes)+C16	6	30	180.00
27	Boric Powder for Gloves (1tin)	1	100	100.00

Standard List of Furniture & Linen

S.No.	Furniture/Linen	Quantity	Unit Price	Total Price
28	Slippers (2pairs)	(2pairs)	95	190.00
29	Gauze	Sufficient Quantity	60	60.00
30	Machintosh Sheets	4	150	600.00
31	Cotton	(1/2Rolls)	23	70.00
	Total			**90,510.00**

Grand Total of the Equipment for Delivery + General Treatment + Laboratory + Furniture & Linen **Rs.223,742**

List of Essential Drugs

1. Anesthetics

1.1General Anesthetics and oxygen

Diazepam	10mg/2ml inj.
Ether, anaesthetic	liquid for inhalation

1.2 Miscellaneous

Atropine	1 mg inj. (sulfate)
Oxygen	Gas for inhalation

2. Analgesics, Anatipyretics non-steroidal anti-inflammatory drugs and drugs used to treat gout

2.1 Opioid Analgesics

Morphine	10mg & 30mg slow release tab., 10mg/ml inj. (Sulfate or hydrochloride).
Pentazocine	30mg inj. (lactate), 25mg tab. (Hydrochloride)
Pethidine	50mg/ml inj. (hydrochloride)

2.2 Non-Opioid Analgesics

Acetylsalicylic acid	300mg tab.
Ibuprofen	200, 400 & 600mg tab.
Indomethacin	25mg cap. Or tab.
Paracetamol	500mg tab., 120mg/5ml syp. /susp.

2.3 Local Analgesics

Choline salicylate	8.7 % gel for local use.

3. Antiallergics and drugs used in anaphylaxis

Adrenaline	1 mg.inj. (hydrochloride)
Chlorpheniramine	4 mg tab. (maleate), 2mg/5ml syp. (maleate),10mg/ml inj. (maleate).
Dexamethasone	0.5 mg tab., 4& 20 mg inj. (as sodium

phosphate)	
Hydrocortisone	100 mg inj. (as sodium succinate).
Prednisolone	5 mg tab, 10 & 25 mg tab. (hydrochloride)
Promethazine	10 & 25 mg tab. (hydrochloride), 5mg/5ml elixir or syp. (hydrochloride), 25 mg inj. (hydrochloride)

4. Anti-epileptics

Diazepam	10mg/2ml inj.
Phenoberbitone	30 mg tab., 200mg/ml inj.
Phenytoin	100 mg tab./ capsule (sodium)

5. Anti-infective drugs

5.1 Anthelmintics

Albendazole	200 mg tab. 100 mg/5ml susp.
Mebendazole	100mg tab., 100mg/5ml susp)
Niclosamide	500mg. Tab.
Piperazine	500 mg/5ml syp.(eq. To 750 mg hydrate)
Pyrantel	250mg tab. (pamoate), 250mg/5ml susp. (pamoate)

5.2 Antibacterials

Amoxicillin	250 & 500 mg capsule/tab.(as trihydrate). 125 & 250 mg/5ml syp. (as trihydrate)
Ampicillin	250 & 500mg tab /cap (as anhydrous/ trihydrate), 125mg/5ml syp. (As anhydrous/trihydrate), 500mg inj.(as sodium salt)
Benzylpenicillin	1.44 gm inj. (benzathine), 600mg (1 million IU) inj. (Sodium/potassium)
Chloramphenicol	250mg capsule,125mg/5ml syp.(as palmitate), 1 gm inj. (as sodium succinate)
Erythromycin	250 & 500 mg tab. (as stearate), 200 mg/5ml susp. (as ethyl succinate), 500 mg inj. (as lactobionate)

Gentamicin	40 & 80mg inj. (as sulfate)
Metronidazole	200,400mg tab., 200mg/5ml susp. (as benzoate), 500mg/100ml vial.
Nalidixic acid	500 mg tab., 300mg/5ml syp., 5000,000 IU tab., 100,000 IU /ml drops,100,000 IU pessaries
Phenoxymethylpeicillin	250 & 500 mg tab .(potassium salt), 125mg /5ml Syp.
Phthalylsulphathiazole	500mg tab.
Procaine benzylpenicillin	1&3 million IU inj.
Tetracycline	250mg capsule/tablet (as hydrochloride)

5.3 Anti-Tuberculosis drugs

Ethambutol	400mg tab (hydrochloride)
Isoniazid	50,100 & 300mg tab. Syp.
Pyrazinamide	500mg tab
Rifampicin	150,300,450 & 600mg tab/cap/syrup.
Rifampicin + isoniazid	150mg + 100mg tab./cap.+300mg+150mg tab./ Cap.+450mg+300mg tab./cap.
Streptomycin	1g inj. (as sulphate)
Thioacetazone	50mg tab.
Thioacetazone + Isoniazid	50mg + 100mg tab.+ 150mg + 300mg tab.

5.4 Anti-Fungal drugs

Nystatin	500,000 IU tab., 100,000 IU/ml oral drops, 100,000 IU pessary.

5.5 Anti-Amoebic drugs

Chloroquine	150mg tab (as sulphate or phosphate), 50 mg/5ml syp., 200mg inj.
Diloxanide	500 mg (furoate) tab.
Metronidazole	200 & 400 mg tab., 200 mg (as benzoate) /5ml Susp.

5.6 Antimalarial drugs and prophylactics

Amodiaquine	150mg tab & syp.

Chloroquine	150mg tab (as sulphate or phoshate), 50mg/5ml Syp .& 200 mg inj.
Primaquine	7.5mg tab
Pyrimethamine	25mg tab
Quinine	200mg tab. (sulphate), 300 mg tab. (bisulphate)
Ergotamine	1mg tab. (tartarate), 0.5mg inj.

6. Antimigraine drugs

Ergotamine	1mg tab. (tartarate), 0.5mg inj.

7. Antiparkinsonism drugs

Biperiden	2 & 5mg inj. (lactate)

8. Blood, drugs affecting

Anti Anemic Drugs

Ferrous salt	eq. to 60mg iron tab., eq. to 25mg iron/ml syp. (as sulfate)
Folic acid	1 & 5mg tab
Iron dextran	eq. to 50 mg iron/ml inj.

9. Blood products and plasma substitutes

Dextran 40	40% w/w for infusion.

10. Cardivascular drugs

Acetylsalicylic acid	100mg tab
Digoxin	500mcg inj.,250mcg tab., 50mcg/ml oral solution.
Isosorbide dinitrate	5mg tab (sublingual),10mg tab.
Lignocaine	1% & 2% inj. (hydrochloride)
	(lisinopril 5, 10 & 20mg tab.)
Methyldopa	250 & 500 mg tab., 250 mg inj.
Nitroglycerin	500mcg tab. (sublingual), 2.6 & 6.4mg tab., 25mg patches) (T)
Prazosin	1&2mg tab.
Propranolol	10,40,80 &160mg tab., 1mg inj.

11. Dermatological drugs (topical)

Aminobenzoic acid	5 % lotion
Benzonic acid + Salicylic acid	6 % + 3 % ointment or cream
Benzoyl benzoate	25 % lotion
Calamine powder	for 15 % calamine lotion
Clotrimazole	1 % cream/oint/solution
Coaltar liquid	for 7.5 % lotion
Gentian violets	0.5 % aq. Solution
Hydrocortisone	1 % cream/oint (acetate)
Neomycin+bacitracin	5mg neomycin sulfate + 500 IU bactitracin zinc/g
Neomycin	0.5 % oint/cream
Nystain	100,000-iu/gm oint/cream
Polymyxin + Zinc bacitracin	ointment
Salicylic acid	5 % topical solution/lotion/gel
Silver sulphadiazine	1 % cream
Sodium thiosulfate	15 % solution
Zinc oxide	25 % cream/ ointment

12. Diuretics

Bendruflumethiazide	2.5 mg tab.
Furosemide	20 & 40 mg tab

13. Gastrointiestinal drugs

Aluminium hydroxide	500mg tab., 320mg/5ml oral susp.
Aluminium hydroxide + Magenesium hydroxide	200+200mg/5ml susp.
Atropine sulphate	1mg tab.& 0.5mg inj
Bisacodyl	5mg tab
Cimetidine	200 & 400 mg tab.,200mg inj
Cyclizine	50mg tab., 12.5mg/5ml syp.,50mg inj.
Hyoscine butyldromide	10mg tab & 20mg inj.
Ispaghulla husk	for solution
Magnesium hydroxide	550mg/10ml susp., 400mg tab
Metoclopramide	10mg tab., 5mg/5ml syp., 10mg inj.
Oral rehydration salt	components to reconstitute 1 liter glucose/

	Electrolyte solution: sodium chloride 3.5g, Trisodium citrate dihydrate 2.9g, potassium Chloride 1.5g, glucose 20g.
Potassium chloride	7.4 % inj.
Promethazine	10 & 25mg tab., 1mg/ml elixir,25mg/ml inj.

14. Hormones, other endocrine drugs and contraceptives

Condoms with or without spermicide (nonoxinol)	
dexamethasone	0.5mg tab.,4 & 20mg inj.
Diaphragms with spermicide (nonoxinol)	
Glibenclamide	5mg tab.
Insulin comp. Zinc or isophane	S 100 IU/inj
Insulin regular	100 IU
Intrauterine device copper T	
Metformine	500mg tab. (hydrochloride)
Potassium iodide	60mg tab.

15. Immunologicals

15.1 Sera and immunologicals

Antiscorpian sera	inj.
Antivenom sera	inj.
Diphtheria antitoxin inj.	inj.
Tetanus antitoxin	inj.
Tetanus toxoid	inj.

15.2 Vaccine for Universal Immunization

BCG (dried) vaccine	inj.
Diptheria-Pertussis Tetanus vaccine	inj.
Diptheria-Tetanus Vaccine	inj.
Measles-mumps-rubella Vaccine	inj.

Measles vaccine	inj.
Poliomyelitis vaccine (live attenuated) P)	Oral solution
Tetanus vaccine	inj.

15.3 Vaccination for Specific Use

Rabies vaccine	inj.

16. Ophthalmological preparations

16.1 Anti-infective Agents

Chloramphenicol	1 % eye Oint., 0.5 % drops
Sulfacetamide	10 %, 20 % & 30 % eye drops,10 % eye Oint.
Tetracycline	Ointment.

16.2 Non-steroidal antiallergic/decongestants

Zinc sulphate+Boric acid	0.46% + 1.6% Eye drops

17. Oxytocics & Anti Oxytocics

Ergometrine	0.25mg tab. (hydrogen meleate), 200mg inj.

18. Psychotherapeutic drugs

Diazepam (P,2)	2,5 &10mg tab.,10mg inj.
Haloperidol	0.25,1.25 & 5mg tab., 5mg inj., 2mg/ml oral drops
Trifluperazine	1 & 5mg tab.

19. Drugs acting on the respiratory tract

Aminophylline	100 & 200mg tab., 250mg inj.
Dextromethorphan Compound	syp.
Epinephrine	1 mg inj.
Salbutamol	2 & 4mg tab., 2mg/5ml syp. 100mcg/dose aerosol

	(T), 50 mcg/5ml inj., 5mg (as sulfate)/ml respirator solution for use in nebulizers.
Theophylline	180 & 270mg tab., 350 mg Tab.(SR), 120mg/5ml syp.

20. Solutions correcting water electrolyte and acid base disturbances

Dextrose+ Saline	10%+0.9% IV solution, 5%+0.45% IV solution, 4.3%+0.18% IV solution, 3% + .03% IV solution IV solution.
Dextran 40	IV solution.
Dextrose	5%,10% & 25% IV solution.
Normal Saline	0.9 % & 0.450 % IV solution.
Potassium chloride	500mg tab., 7.4 % IV solution.
Ringer's lactate	IV solution.
Sodium bicarbonate	0.7 % IV solution.
Water for inj.	

21. Vitamins and minerals

Ascorbic acid	100mg tab.
Calcium gluconate	100mg/ml inj.
Erogocalcifcrol	1.25 mg (50,000 IU) capsule/tab., 250ug/ml (10,000 IU/ml) oral solution
Hexavitamin USP	tab. Each tab. Contains not less than: Vitamin A 5000 IU, Vitamin D 400IU, Ascorbic acid 75mg,
Thiamine Hydrochloride	2mg, Riboflavin 3mg, Nictinamide 20mg.
Nicotinamide	50mg tab.
Pyridoxine	25mg tab. (hydrochloride)
Retinol	10000 IU tab., 100,000 IU inj.

22. E.N.T. Preprations

boroglycerine	40%
ephedrine nasal drops	0.5%
gentian violet	0.5%
ichthamol glycerin BCP	

Polymyxin B Sulphate + lignocaine hydrochloride	10,000 IU + 50mg/ml Ear drops
Prochlorperazine	5mg tab.
Promethazine	10 & 25 mg tab., 1 mg/ml elixir 25mg inj.
Soda glycerine BPC	
Xylocaine	2% inj. 4% topical solution 2% topical gel
Xylometazoline	0.1% nasal drops

23. Antiseptics and dis-infectants

22.1 Antiseptics

Chlorhexidine gluconate	1.5% solution
Chloroxylenol	4.8% solution
Hydrogen peroxide BP.	solution
Providone iodine	7.5% solution
Tincture benzoin co.BP	
Tincture iodine	

24. Dispensary Items

Coal Tar
Cresol
Emulsifying wax
Formaldehyde
Gentian violet
Glucose
Glycerin
Hexylresorcinols throat paint
Hydrogen peroxide
Iodine
Kaolin
Linolic acid
Liquid paraffin
Magnesium sulphate
Methylated spirit
Paraffin, hard
Paraffin, yellow
Pectin
Peppermint oil

Potassium chloride
Potassium permanganate
Salicylic acid
Sodium acid citrate
Sodium Bicarbonate
Soft paraffin wax
Sulfer sublime
Tannic acid
Tragacanth
Trisodium citrate dehydrate
Turpentine oil
Wool fat
Zinc oxide powder
Zinc undeconate

25. Drugs for local purchase

Drugs in the following groups are required occasionally. Therefore drugs in these groups can be made available through local purchase by hospitals. Some of the illustrative drugs in these groups are mentioned below: -

25.1. Antidotes and other substances used in poisoning

Atropine	1 mg inj. (sulfate)
Charcoal, activated	powder
Flumazenil	500mcg inj. (mesylate)
Naloxone	0.04 & 0.4mg inj. (Hydrochloride)

[WORKSHEET-11]

Check List of Items Required for the Centre

Description of Items	*Required/Not Required (Tick ✓ for yes & X for No)*
Capital Items	
◇ Land/Building for the Centre	☐
◇ Construction Material for the Building	☐
◇ Equipment/Instruments	☐
◇ Furniture/Linen	☐
◇ Ambulance	☐
◇ Any Other	☐
Recurring Items	
◇ Medicines	☐
◇ Salaries: Doctor, LHV, Lab Technician, Dispenser, Patient Record Keeper, Driver/Guard, Aya/sweeper	☐
◇ POL	☐
◇ Utilities (Electricity, gas, water)	☐
◇ Stationary	☐
◇ Centre's repair & other maintenance	☐
◇ Equipment & Furniture's repair	☐
◇ Any other	☐

REFERENCE SHEETS

COMMUNITY BASED HEALTH PROJECT

Referance Material

Reference-i

to

Reference-v

List of the required Workshop Aids and Accessories

S #	Items	Quantity
1	Overhead Projector	1
2	Overhead Transparencies	1 Packet
3	Flip Charts	30
4	Plain Charts (mixed color)	15
5	Markers (multi colored)	6 (4 for Resource Person &10 for participants)
6	Tape/Glue	As required

Workshop Budget

Itemized Budget Details

S #	Item/Description	Quantity	Estimated Cost
1	Traveling 5 non-resident participants	5 participants	Rs. 200/P X 5 P = Rs. 1000
2	Accommodation 5 non-resident participants	5 participants	Rs.500/P X 5 P= Rs. 2,500
3	Food/Tea 5 non-resident + 10 resident participants	2 Lunches + 2 Dinners + 1 break fast + 4 times tea	Rs. 100/P/Day X 15P X 2 Days = Rs. 3,000
4	Workshop material/Stationary	12 OHTs + 10 Flip charts + 6 Markers + 15 Plain charts + 2 Stickies	Rs. 500
5	Incidental	Rs. 1000	
	Grand Total		Rs. 8000

P = Participant(s)
X= Multiplication sign
OHT= Overhead Transparencies

It is important to note that the details of this budget are based on the assumption that there will be 15 NGO and community representatives attending the planning workshop, out of which 5 would be coming from the adjacent villages/towns/cities. The non-resident participants would be traveling by road. The NGO, however, should outline its own itemized budget sheet following the same format and on the basis of relevant workshop expenses.

[REFERENCE-iii]

Training Facilities for TBA, LHV and Lab Assistants in Public and Private Sectors

Province	Sector	S.No.	Name of the Organization/ Institute	Address	Contact Person	Designation of the Contact Person	Tel.# of Contact Person	E-maile: addres of Contact Person
ICT/ Rawalpindi	Government	1	Maternal and Child Health Centre, Pakistan Institute of Medical Sciences, Islamabad (PIMS)	Pakistan Institute of Medical Sciences, G-7/1, Islamabad	Dr Imran Hameed	Training Coordinator	(051) 9260597	
	NGO	1	Public Health Nursing School and Social Welfare Hospital and Social Welfare Society	E/225 Chitti Hattian Rawalpindi	Mr Saleem Altaf Kashish	President	(051) 5770726	Not Available
PUNJAB	Government	1	Service Hospital, Lahore	Service Hospital, Jail Road, Lahore	Dr. Riaz Ahmed Chudhry	Medical Supreintentdent	042-7588351-59	Not Available
		2	Jinnah Hospital, Lahore	Jinnah Hospital, Mulana Shaukat Ali Road, Lahore	Dr. Hassan	Medical Supreintentdent	042-5168660, 5162339	Not Available
		3	Sir Ganga Ram Hospital	Sir Ganga Ram Hospital, Queen's Road, Lahore	Dr. Zahid Pervez	Medical Supreintentdent	042-9200572-9	Not Available
		4	Mayo Hospital	Mayo Hospital, Lahore	Dr. Rana Abdul Hameed	Medical Supreintentdent	042-9211101-9	Not Available
		5	Shaikh Zayed Hospital	Shaikh Zayed Hospital, Muslim Town, Lahore	Dr. Pervez Iqbal	Training Coordinator	042-5865731	Not Available
		6	General Hospital, Lahore	General Hospital, Ferozepur Road, Lahore	Dr. Zafar Ikram	Medical Supreintentdent	042-5810891-5	Not Available
		7	Children Hospital, Lahore	Children Hospital, Ferzepur Road Near Pathak, Lahore	Dr. Anwaar Ahmed Bughwi	Medical Supreintentdent	042-9230901-7	Not Available
		8	Public Health Nursing School	Public Health Nursing School, 24-Cooper Road, Lahore	Dr. Sabiha Akhtar	DG Health Services Lahore	042-9201140, 9200866	Not Available
		9	Population Welfare Regional Training Institute (RTI)	RTI, Civic Centre, Wasti Chowk Township, Lahore	Dr. Mumtaz	Principal	042-5118820	Not Available
		10	Institute of Public Health (For Health Technician and Lab Technicians Training)	6-Bird-Word Road, Lahore	Dr. Maqsood Ahmed	Dean	042-9200906, 9200708	iphpk@yahoo.com
	Private	1	Ace Institute of Health Sciences (LHV, TBA, Lab Technicians	6-P Model Town Extension, Lahore	Brig. Muhammad Afzal	CEO	042-5165723, 5161016	dia6p@yahoo.com
		2	Family Planning association of Pakistan, Lahore (Training of TBAs in Health Sector)	3-A, Temple Road, Lahore	Dr. Bushra Rasheed	Director Training	042-6314621-5	Not Available
		3	Fatima Memorial Hospital	Shadman Colony, Jail Road, Lahore	Dr. Col. Tanveer	Medical Director	111-555-600	Fmhhosp@brain.net.pk
		1	Public Health School, Peshawar	Phase V, Hayatabad, Peshawar	munir Akhtar	Principal	091-9217353, 9217158	Not Available
		2	Public Health School	Nishtarabad, Peshawar	Dr. Shreen Jan	Principal	091-216274	Not Available
		3	Regional Training Institute (RTI)	Phase V, Hayatabad, Peshawar	Dr. Tufail Muhammad	Principal	091-9217105	Tufailm@brain.net.pk

NWFP	Government	4	Leady Reading Hospital (LRH)	Near Khyber Bazar, Peshawar City	Ms Naik Bibi	Care Taker-Chief Nursing Supritendent	091-9211430-9	Not Available
		5	Khyber Teaching Hospital (Sherpao)	University Road Peshawar	Ms Shamshad Kadir	Chief Nursing Supritendent		Not Available
		6	Nursing School Mardan	Mardan Medical Complex, Mardan	Shameem Haq	Head Nurse	0931-9230050	Not Available
		7	Nursing School Mingora	Collage Colony, Behind Center Hospital, Saidu Road, Mingora Swat	Farhana Joseophen	Nursing Principal	0936-711023	Not Available
SINDH	Government	1	Regional Training Institute (RIT), Department of Population Welfare, Sindh	FT-21/22, Block-2, KDA, Scheme-V, Clifton Karachi	Dr. Anees Sami	Principal	021-9251005	
		2	Public Health School, Health Department, Sindh	Near Lady Different Hospital, Chand Bibi Road, Karachi	Dr. Dar-e-Shahwar	Principal	021-7732517	Not Available
		3	Population Welfare Training Institute, Department of Population Welfare, Sindh	Barrack-36/A, Sindh Secretariat, Opposite Passport Office, Karachi	Ms Shakila Zaidi	Principal	021-9203365, 9203381	Not Available
		4	Public Health School, Latifabad	Near Shah Bhati Hospital, Unit No. 5, Latifabad	Dr. Tasneem Memon	Principal	0221-9260292	Not Available
	Private	1	Department of Community Health Sciences, Aga Khan University, AKF	Aga Khan University, Stadium Road, P.o Box 2500, Karachi	Dr. Nadira Ashraf	Coordinator Education Support Unit	021-4930051, 48594839(4839)	
	NGO	1	Al-Ibrahim Eye Hospital, Isra Islamic Foundation, Int, Malir, Karachi	Old Thana, PO Memon Murad Goath, Malir Karachi	Dr. Saleh Memon	Director	021-4560708, 4560462	
		2	HANDS, Community Training Center, Health & Nutrition Society, Karachi	Jam Kanda Village, PO Memon Goath, Malir Karachi	Dr. Tanveer Shaikh	Programe Coordinator	021-4532804 Fax: 021-4527698	
Baluchistan	Government	1	Provincial Nursing School	M.A. Jinnah Road, Quetta	Dr. Sabia Babar	Principal	081-823947	Not Available
		2	Regional Training Institute	Nowa Kalli (Tareen Road), Quetta	Dr. Asia Mengal	Principal	Not Available	Not Available
		3	Multipurpose Institute	Western By Pass Brewery Road Quetta	Dr. Javed Baloch	Principal	081-854620	Not Available
	Private	1	Resource Development Institute (RDI)	New Railway Housing Society, Near Bahdar Khan T.B Hospital Quetta	Dr. Kamalan Gichki	Director	0300-9380556	
		2	School of Medical Technician	Satellite Town, Quetta	Dr. Kamalan Gichki	Director	Not Available	
	NGO	1	Family Planning Association of Pakistan (FPAP)	Satellite Town, Quetta	Dr. Syed Hassan Mehdi Zaidi	Regional Director	081-442844	Not Available

Standard Budget/BHU for Three Years

S. #	Description of Items	Total Cost in Rs
1	Renovation of the health centre's building	100,000
2	Equipment	150,000
3	Furniture & Linen	100,000
4	Medicines	100,000
5	Medical & Paramedical staff 's salary	
	- Doctor's salary @ Rs 10,000/month X 36 months	360,000
	- LHV's salary @ Rs 4000/month X 36 months	144,000
	- Lab. Technician's salary @ Rs 4000/month X 36 months	144,000
	- Accountant/Dispenser's salary @ 4000/month X 36 months	144,000
	- TBA's salary @ Rs 3000/month X 36 months	108,000
	- Sweeper/Guard's salary @ Rs 2000/month X 36 months	72,000
	- Utilities @ Rs 2000/month X 36 months	72,000
6	Incidental @ Rs 2000/month X 36 months	72,000
	Grand Total	**1,566,000**

ACTION PLAN

TIME LINE

S #	Description of Activities	Months 1	2	3	Responsible Person's Name
1	Collection of quotations for the items to be purchased from the market	✓			
2	Revision of the budget on the basis of the collected quotations	✓			
3	Mobilize the local support for the project in the form of pledges/undertaking, i.e., land transfer deed, taking over the building of BHU from the government/transfer of community building in the name of the NGO, cash donations from the community members etc.	✓			
4	contact and sign a MOU with the nearest health facility for the management of referral cases/patients	✓	✓		
5	Visit other organizations for studying their systems and procedures of record keeping at the centre	✓			
6	Design format and procedure for maintaining records at the health centre	✓	✓	✓	
7	Visit other organizations for studying their system, procedure and formats of financial record keeping and programmatic record keeping	✓			
8	Develop appropriate system of programmatic and financial record keeping		✓	✓	
9	Develop a concept paper of the project based on the deliberations of the planning group			✓	
10	Develop contact with the potential donors and introduce them with your project			✓	
11	Develop a project proposal according to the guidelines of the donor(s) that agree to fund the project			✓	

- Notes: This time sheet of the action plan has been developed with a view that all the activities stated in the action plan should complete

within a time frame of three months. The facilitator may modify this timesheet as per the consensus of the planning group.

- Column two reflects on all the activities that the planning group had agreed to undertake during the post workshop period as well as those activities that the NGO will have to undertake in order to mobilize the Donor support for the project.
- Column three indicates the timeframe that has been allowed to intiate and complete the activities indicated in column two.
- Whereas, column four shall be filled in with the names of the people, who will be responsible for undertaking the activities.

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