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CONTROL OF DIARRHOEAL DISEASES, WATER AND SANITATION INTEGRATION

DRAFT PLAN OF ACTION
1997

ALWAR DISTRICT
RAJASTHAN

UNICEF, Jaipur

CONTENTS

CONTROL OF DIARRHOEAL DISEASES - WATER AND SANITATION INTEGRATION

I. INTRODUCTION

A large proportion of sickness in the developing countries is attributed to unsafe drinking water and poor sanitation facilities. World Health Organization has estimated that 80% of sicknesses can be prevented by ensuring availability of safe water and adequate sanitation facilities. The water borne diseases are a major concern in under five children. Diarrhoeal diseases along with acute respiratory infections and vaccine preventable diseases are the three major killers. The diarrhoeal diseases also contribute significantly to malnutrition in children which has a very high prevalence and predisposes children in India to many other sicknesses. Diarrhoea cases account for as much as 40% of pediatric beds and a third or more of pediatric outpatient visits in peak seasons. This represents an enormous cost to the health care system and probably much more to the individual families.

1. Magnitude of the Problem:

With the gradual improvement in the reporting system in the health infrastructure at different levels, it is now possible to know the magnitude of the health problems, as data related to disease focussing on children are available. It may not be adequately updated or reported. But as compared to earlier data availability, now the information & data is available even at ANM or Sub-centre levels.

1.1 Routine Reports: The information available at district level for 1996 was reviewed and the situation of CDD is as follows:

Cases of diarrhoea & deaths reported during 1996
in Alwar district (Source : CM&HO Office, Jan. 1997)

Month	No. of cases reported	Deaths
Jan	1463	1
Feb	1282	0
March	3278	0
April	4419	0
May	4587	0
June	3698	0
July	883	0
August	5572	0
Sept	2610	0
Oct	1341	0
Nov	1383	0
Dec.	Data not yet received at Distt. but as per information available nearly 1150 cases were reported during Dec.	

☞ Seasonal Peaks : The information available for PHCs for 1994 and 1995 calender years shows that peak occurs from April to August.

☞ Epidemics: Epidemics are often reported from different parts of the district.

Information Gaps: On review of the information available at the district level (Health office) the following information gaps were identified:

✱ Irregular/weak reporting from Sub-centres to PHCs and other Health Institutions

✱ Information available at PHC/Institutions does not reach the District Level on monthly basis.

The following information from special studies is available from Alwar District:

☞ From Background Document circulated by ICO:

Diarrhoeal Point Prevalence	5.5%	(Percentage of under five children having diarrhoea at a point of time)
30 Day Diarrhoea Incidence	18.1%	(Percentage of under five children having diarrhoea in 30 days)
Annual Diarrhoea Incidence	2.2%	Episodes/Child/Year

☞ Modes of Treatment:
Diarrhoea Management - ORT

2. Existing Interventions::

2.1 Water Supply:

The GOR has relaxed the norms for water quantity and quality and distance so as to make available at least some quantity of potable water at a reasonable distance.

37,183 villages in the State of Rajasthan, representing nearly 97% of the total 37,889 villages, have been fully or partially covered by Dec. 1995. Active efforts are in progress to cover the remaining villages by end of 1997. In the State Plan of Action for Children document '*Promises to Keep*', it has been stated on page 71 that Alwar, being a CDD WATSAN project district, the goal is to provide to urban population with safe drinking water supply of 90 LPCD in Municipal, 70 LPCD in town areas and rural population with one water source for every 150 persons.

The present status of water availability in the rural areas of Alwar is as follows:

Status of water availability in Rural Alwar - As of Dec. 1996
Villages covered under various water schemes

Sl. No.	Number of villages	Scheme
1.	1588	Handpumps❶
2.	151	Piped water supply
3.	94	Local Schemes
4.	105	Janta Jal Yojana
Total	1938	

- Total villages 1947
- Villages covered with one source of water 1938
- Villages yet to be covered 8

❶In Alwar as of Dec. 1996, 7817 Handpumps, both India Mark II and III, were installed and out of it, 5800 (74%) are reported working. The duration of the H.Ps which are out of order is as follows:

1 month	250	13%
2 months	262	14%
3 months	1405	73%
Total H.Ps out of order	1917	

(Source: Zila Parishad, Alwar 2 January 1997)

There are at present 136 mistries and each mistry is expected to be responsible for 58 hand pumps in his area. There is a need to review the system so that no H.P. should remain idle for more than 2-3 days, otherwise the benefits which the community gets by using water from the hand pump will have a bad effect on the health of the community.

Maintenance of handpumps is being conducted now by Mistries available at Panchayat Samiti level as their staff. In addition, PHED conducts hand pump repair drive twice a year. Keeping in view the problems faced by the PHED and the Panchayat Samitis in maintaining these hand pumps, both the Departments are actively thinking to evolve a system by which the community could be involved in the maintenance of H.P. particularly women users. Zilla Parishads have been directed to take active steps to establish "Pani Panchayats" at village levels. Once these are established, it is hoped that the situation will gradually improve.

2.2 Rural Sanitation Programme (RSP)

The Rural Sanitation Programme at present is in operation in 14 districts including all the blocks of Alwar. The Rural Development and Panchayati Raj Department and Zila Parishads are responsible for implementation of this programme. UNICEF provides part of the cost of construction of sanitary facilities and supports in training and health education activities. The programme provides a sanitation package which includes:

- Sanitary latrines
- Garbage Pits
- Soakage Pits
- Washing/Bathing Platform

For implementation of this programme, the following guiding principles are followed:

★ Health Education and awareness raising activities go hand in hand with construction and provision of sanitary facilities

★ Coordination with other ongoing programmes like ICDS, DWCRA and WDP is encouraged and their village functionaries are involved.

★ Priority to be given to the villages where development programmes like ICDS, DWCRA and WDP have convergence

★ NGOs are involved in health education and awareness raising activities

In Alwar, initially five blocks were taken up but keeping in view the trend of progress and the positive attitude of the community, two more blocks were added in 1989. The implementation of the programme during the first four years has shown positive improvement in the overall environment sanitation situation. Though it is difficult to say about the exact decline in the water borne diseases, it is presumed and observed by the health workers and residents of the project area that there is a decline in the number of reported cases of diarrhoea, jaundice, malaria etc. The other significant change which is visible in the project area is the greater participation and involvement of the community in general and of women in particular. This has resulted in a demand for more support not only in the existing areas but in other parts of the district. Both GOR and UNICEF extended the project area and from 1991, all blocks and 413 villages have been covered as of December 1996.

2.3 Control of Diarrhoeal Diseases Programme (CDD)

A programme for Control of Diarrhoeal Diseases was started in the country in the VI Five Year Plan by modifying the National Cholera Control Programme. The main stress of the Programme has been on supporting ORS production and health education. This programme mainly stressed on preventing deaths from diarrhoeal diseases rather than prevention of diarrhoeal diseases.

WHO, UNICEF, Ministry of Health and Family Welfare, Government of India and various non governmental organizations have attempted to improve diarrhoea case management mainly, through oral rehydration therapy during the last two decades. Despite this, ORT still gets low status in diarrhoea management by practitioners in government system and outside.

The Directorate of Medical, Health and Family Welfare Services, Government of Rajasthan every year launches an Intensive Communication Drive for Diarrhoeal Diseases Control since 1990, i.e., before and during the peak season of diarrhoeal diseases in the State. All workers were trained in key communication messages for the community by a 3-tier training starting with a state level followed by district level and block level training. ICDS functionaries were also trained.

Government of India has launched Child Survival and Safe Motherhood Programme. Diarrhoeal Disease Control among children is one of the major components of this programme. All the districts will be covered in a phased manner. Alwar district was included in this programme in 1992.

II. RATIONALE AND OBJECTIVES:

The main objective of the above programmes is to bring down the morbidity and mortality due to diarrhoeal and other water borne diseases. CDD is operational with the joint cooperation and involvement of Health Department and Zila Parishad through the Panchayat Samiti's in all the 271 villages covered so far of Rajgarh and Kishangarh blocks. PHED has also installed 278 Hand Pumps in all these villages during this period. To have a better and effective participation of these Departments, it is proposed to form a joint consultation sub-committee consisting of the following officers:

1.	SE-PHE	Chairperson
2.	Dy. CM&HO (Health), Rural Alwar	Member Secretary
3.	XEN PHE, Alwar	Member
4.	Project Officer, CDD, Zila Parishad	Member
5.	Project Officer, RSP, Zila Parishad	Member

This group will ensure that priority is accorded to all the 1,900 villages of the 14 blocks.

The impact of the departments would be synergistic if they work together. With this objective in mind the present integrated approach has been planned. The main task is to provide water and sanitation facilities to the people and take the message of ORT to every home and make it a basis of each medical practice in the area. For this, two programmes have to play a complementary role and work together.

The purpose of this project is two folds:

- To develop operational model for achieving the goals to reduce cases due to diarrhoea by 25% through universal access to safe drinking water and improved coverage of sanitary facilities and hygiene behaviour at household and community levels by 1999.
- To develop ways to foster intersectoral collaboration laying great stress on community based and convergent services.

1. GOALS:

- Reduce the incidence of diarrhoeal diseases in under five children by 25 percent in project areas, in a period of three years say by 1999.
- Facilitate to make available 100% universal access to safe drinking water and improved sanitation coverage to 20% rural families by 1998 with major activities related to hygiene education completed by 1998, in project areas of the selected blocks.

2. Specific Objectives:

A. Improving Access to Services in the Project villages:

These will create conditions for adoption of various practices.

- To provide one source of drinking water in the project areas not covered so far.
- To ensure availability of 40 litres per capita per day of clean drinking water to all households

- Once all villages covered with one safe source of water and further one safe source of water is available for 250 persons in the project area, efforts will be initiated to install one source of drinking water per 150 persons within half a kilometer of every household.
- Every Gram Panchayat with handpumps to have at least one team of handpump mechanics, preferably female, trained jointly by PHED/RD&PRD.
- To have at least one information source in every village/urban slum for:

  . low-cost sanitation facilities, knowhow, liaison with agencies for construction; and
  . proper case management for diarrhoeal disease

- To have one sanitation mart (a place where all hardware items of RSP are available) in every block and community in the block be aware of its location so that they can buy required items from there when needed.
- To determine the optimum number of trained masons required per block to provide guidance to households constructing sanitation facilities
- To have at least one source with ORS packets available 24 hours in every village/urban slum.
- To have ORT corners in every primary health centre, community health centre and hospital in the district.
- To have clean water and facilities for sanitary disposal of excreta in every school, anganwadi centre, hospital, community health centre, primary health centre and sub-centre. These should be maintained properly to serve as a model for the community.
- To ensure near universal coverage of all children under one with measles vaccine (along with other vaccines being given in the immunization programme).
- To have one Diarrhoea Treatment Training Unit at the District Hospital.

B. <u>Promoting key practices for Prevention of Diarrhoea:</u>

These will contribute to prevention of diarrhoeal morbidity

- To increase availability and use of safe water for drinking among target families
- To promote use of adequate quantity of water for personal and domestic hygiene
- To promote safe disposal of excreta, especially that of infants and young children
- To promote hand washing with soap before eating, before feeding/breast-feeding and cooking food and after defecation/disposal of child's stools.
- To promote exclusive breast-feeding in infants up to 4-6 months of age.
- To improve infant feeding practices, especially breast-feeding and hygienic weaning
- To promote use of sanitary facilities

- To promote hygienic handling and storage of drinking water and food

C. Promoting key practices for Management of Diarrhoea:

These will contribute to prevention of mortality and bring down morbidity:

- To promote timely administration of ORT using correctly prepared fluids in increased volume in children 0-5 years having diarrhoea
- To enhance ORT usage rate to 80% level from the present level of 64%.
- To promote continued feeding in adequate quantity with appropriate foods in children 0-5 years having diarrhoea
- To further promote seeking of timely and correct referral outside the home when the condition of child with diarrhoea deteriorates. This involves:
  - recognition by mother/caretaker of signs of dehydration;
  - recognition by mother/caretaker of other danger signs (fever, blood vomiting, etc)
  - knowledge of where to seek correct referral.

D. Approach:

The CDD-WATSAN initiative is not a programme but a strategy and will have the following approach to planning and implementation so as to achieve the desired goals and objectives.

III. Programme Strategy:

The implementation process adopted since 1992 in CDD-WATSAN has successfully demonstrated the strategy and approach adopted as per the plan of action has proved relevant and needs to be reiterated with minor modifications in the approach adopted for intersectoral coordination and involvement. The basic strategy of the project will be one of promoting and motivating the community to have and use sanitation facilities available health services in their households to improve their own health status and general well-being.

The overall goal of the project is to reduce the incidence of diarrhoeal diseases by 25% by 1999.

In order to achieve the goals and objectives of the project, the following activities/interventions will continue to be operationalized in the newly selected four blocks.

I. Situational Analysis :

I.I Baseline survey

An in-depth assessment and benchmark data of present prevalence of diarrhoeal diseases and factors influencing it. This will be conducted to include the following points :

i) Prevalence of diarrhoeal diseases, seasonal variation, epidemics from secondary data and community survey.
ii) KAP of health, ICDS, DWCRA, RSP and other functionaries. Training needs of these functionaries.

iii) KAP of community on diarrhoeal diseases with special emphasis on under-five children.
iv) Water availability, quality, storage and handling practices.
v) Sanitation facilities available, their use and its impact on the health of the family and on the environment of the community.

1.2 Planning :

The strategies and physical outputs given in the POA represent the tentative projections and requirements based on suggested norms. The actual requirements will be determined by local needs and situations; and will be undertaken as part of a micro planning process. The elements to be covered as part of this exercise include :

i) Infrastructure of related departments and their role in the programme.
ii) Identify possible outlets (at least one in every village) for ORS packets.
iii) Identify possible channels of communication in the selected areas.
iv) Suggest indicators for monitoring of the programme.
v) Identify NGOs, active in the area and the role they can play.

Initially a detailed inventory of existing programmes, personnel and services has been attempted for both villages and blocks in the project area using secondary sources of data. Soon a phased approach to villages based participatory planning will be attempted whereby resources both institutions and services and personnel (AWW, existing mistries, school teachers residing in the village etc.) has mapped for villages, hamlets and urban slum units. The process of micro planning will also involve selection of motivators/depot holders in new areas, handpump and additional sites required in the 14 blocks will be communicated by the Executive Engineer, PHED, Alwar division. Techniques of participatory learning involving the communities themselves will be attempted in Panchayat villages to start with. Details of project outcomes will emerge from the process.

Objectives and Interventions for achieving these objectives

Sl. No.	Objective	Intervention
I.	IMPROVE ACCESS TO SERVICES	
1.	To ensure availability of 40 litres per capita per day of clean drinking water to all households.	. Provide one hand pump @ per 250 persons by 1998 . Ensure Maintenance of hand pumps . Involve community in Handpump site identification (PLA Workshop etc)
2.	To cover areas with one source of safe water not covered so far.	. Provide 500 hand pumps to PHED . Reorient the HP Mistries and facilitate in the establishment of 'CBHPM' system in at least one block.
3.	Every Gram Panchayat with handpumps to have at least one team of handpump mechanics, preferably female, trained by PHED/RD&PR	. Identification, training, supervision & monitoring support of mechanics at Gram Panchayat Level
4.	To have at least one information source in every village/urban slum for: a) low-cost sanitation facilities, knowhow, liaison with agencies for construction; and b) to have one sanitation mart (a place where all hardware items of RSP are available) in every block and community in the block be aware of its location so that they can buy required items from there when needed.	. Identify, train, supervise, reorient, monitor and support ORS Depot Holder cum Sanitation Motivators - Facilitate the Department of Rural Development in establishing a RSM in each project block.
5.	Proper case management for diarrhoeal diseases	. Ensure availability of ORS in every village. To start with the villages above 1000 population . Establish linkages with ANM and other health functionaries and supervisors . Proper Home Management through social mobilization and communication and Hospital management through training and strengthening health institutions through CSSM
6.	To determine the optimum number of trained masons required per block to provide guidance to households constructing sanitation facilities	. Identify and train Masons.
7.	To have at least one source with ORS packets available 24 hours in every village/urban slum.	. Identify and train sanitation motivators/depot holders
8.	To have ORT corners in every primary health centre, community health centre and hospital in the district	. Establish ORT corners as part of CSSM project
9.	To have clean water and facilities for sanitary disposal of excreta in every school, anganwadi centre, hospital, community health centre, primary health centre and sub-centre. These should be maintained properly to serve as a model for the community.	. Provide and maintain institutional sanitation facilities
10.	To ensure near universal coverage of all children under one with measles vaccine (along with other vaccines being given in the immunization programe)	. Through existing UIP
11.	To have one Diarrhoea Treatment Training Unit at the District Hospital	. Establish DTTU as part of CSSM project.

II.	PROMOTING KEY PRACTICES FOR PREVENTION OF DIARRHOEA	
1.	To increase use of safe water for drinking among target families.	. Providing Hand Pumps . Communication activities for improving safe water practices
2.	To promote use of adequate quantity of water for personal and domestic hygiene	. Providing Hand Pumps . Communication activities for improving safe water practices
3.	To promote safe disposal of excreta, especially that of infants and young children	. Providing sanitation facility with subsidy to 20% Households and through motivation to the remaining
4.	To promote hand washing with soap before eating, before feeding/breast-feeding and cooking and food and after defecation/disposal of child's stools.	. Social mobilization & communication activities involving NGOs, other Government agencies, through interpersonal communication, drives, media etc.
5.	To promote exclusive breast-feeding in infants up to 4-6 months of age	. Social mobilization and communication activities involving NGOs, other Government agencies through interpersonal communication, drives, media, etc.
6.	To improve infant feeding practices, especially breast-feeding and hygienic weaning	Social mobilization and communication activities involving NGOs, other Government agencies through interpersonal communication, drives, media, etc.
7.	To promote use of sanitary latrines	Social mobilization and communication activities involving NGOs, other Government agencies through interpersonal communication, drives, media, etc.
8.	To promote hygienic handling and storage of drinking water and food	Social mobilization and communication activities involving NGOs, other Government agencies through interpersonal communication, drives, media, etc.
III.	PROMOTING KEY PRACTICES FOR MANAGEMENT OF DIARRHOEA	
1.	To promote timely administration of ORT using correctly prepared fluids in increased volume in children 0-5 years having diarrhoea	. Interpersonal communication by Health, ICDS, DWCRA and other functionaries . Communication and social mobilization activities . Making ORS available through sanitation motivator cum ORS Depot Holder
2.	To promote ORT usage rate to 80% level	. Interpersonal communication by Health, ICDS, DWCRA and other functionaries . Communication and social mobilization activities . Making ORS available through sanitation motivator cum ORS Depot Holder
3.	To promote continued feeding in adequate quantity with appropriate foods in children 0-5 years having diarrhoea	. Interpersonal communication by Health, ICDS, DWCRA and other functionaries . Communication and social mobilization activities . Making ORS available through sanitation motivator cum ORS Depot Holder

III.	PROMOTING KEY PRACTICES FOR MANAGEMENT OF DIARRHOEA	
4.	To promote seeking of timely and correct referral outside the home when the condition of child with diarrhoea deteriorates. This involves: - recognition by mother/caretaker of signs of dehydration; - recognition by mother/caretaker of other danger signs (fever, blood, vomiting, etc); - knowledge of where to seek correct referral.	. Interpersonal communication by Health, ICDS, DWCRA and other funtionaries . Communication and social mobilization activities . Making ORS available through sanitation motivator cum ORS Depot Holder . Mothers Meetings

A. Interventions for preventing diarrhoea

1. Health interventions

The district is already having a strong health infrastructure which could be made use for the proposed health interventions to be taken up under the integrated strategy.

The major thrust in health interventions pertaining to the CDD-WATSAN strategy will be to shift the focus on the control of diarrhoeal diseases from sub-centre to the village and empower the mothers with regard to (i) home management of diarrhoea (ii) recognition of the danger signs during diarrhoea and (iii) knowledge of where to seek the correct care when the child has any of the danger signs. This would call for a changed approach in the strategy and undertaking a host of activities for both improving access to services and promoting key practices for prevention and management of diarrhoea. As regards the former, the following interventions are proposed:

1. The Diarrhoea Training and Treatment Unit already established in the district hospital, Alwar, should be effectively used for further training of functionaries at various levels.

2. The pediatrician specialists and the nursing staff of PHC's and the community health centres' of the district will be trained at the DTTU in correct case management of children with diarrhoeal diseases.

3. Two health workers and one medical officer from each one of the primary health centres/units in the selected four blocks and the community health centre will be given training on establishment of an ORT corner. These PHC/Cs, PHUs, CHCs and ANMs will be provided with adequate quantities of ORS packets to enable them to run the ORT corners at least during the months of peak incidence of diarrhoeal diseases.

4. The health department will identify at least one information source in every project village for proper case management of diarrhoeal diseases. In this regard, the anganwadi workers/helpers could be very useful. Of the 4 blocks, the number of anganwadi centres existing at present comes to 860 and there are these many workers and helpers. However, only those workers/helpers

who are active and stay in the village should be involved; otherwise any of the following functionaries could be identified as an information source.

- A health functionary - a female health worker, a male health worker, pharmacist; (the district has 501 ANMs and 264 nurses (male/female).
- MPW or traditional birth attendant.
- Primary school teacher.
- Voluntary workers and willing functionaries in the village (especially in those villages where none of the above functionaries are available) who can be trained and be motivated to stock and distribute ORS packets as well;
- Functionaries who may be identified as information source for low-cost sanitation facilities or as handpump maintenance workers in the village.

One the functionary is identified, the following will be expected from him or her:

- To promote various personal hygiene/sanitation measures to prevent occurrence of diarrhoeal disease.
- Once diarrhoea occurs, promote:
  - increased fluid intake to the child; home available fluids, continuation of breast-milk
  - continued feeding during diarrhoea and increased food intake for 2 weeks following recovery from diarrhoea
  - early recognition of dehydration through simple signs such as increased thirst and skin pinch - and if dehydration is detected, immediate therapy with ORS solution
- To a dehydrated child:
  - In addition to the above, distribute ORS packets and orient/guide mothers and care-givers to prepare ORS solution correctly and administer the same to their children.
  - Motivate mothers to continue ORS solution and if the diarrhoea worsens or additional signs such as fever, blood in stools, increased number of stools even after beginning therapy with ORS solution, vomiting, then referral to a health institution with intravenous fluid therapy facilities.

5. The person acting as information source will also be encouraged to act as ORS depot holders. When the functionary is a health functionary, they will be expected to distribute ORS packets of the government supply free to those children with diarrhoea.

   If the functionary is a voluntary worker, they will be provided with ORS packet and will be allowed to charge a nominal amount from the community.

UNICEF will support procurement of initial supply of ORS packets which will be distinct from the ORS packets distributed through the government system free. The functionaries stocking and distributing such ORS packets will be authorised to charge 50 Paisa more for these ORS packets. This (50 Paisa per packet) will be retained by the ORS depot holder. The remaining part will be returned to the health department which will be used for procuring additional supplies. UNICEF will progressively decrease the amount of ORS packets procured from its funds.

6. The ongoing immunization programme in district will be sustained and coverage of infants for measles immunization will be increased to 80%. This will be done by improving on the fixed day strategy for immunization in every village of the area. The information sources for correct case management of children with diarrhoea will act as additional motivators for ensuring high coverage and sustaining coverage. The implementors at the PHC will accord attention to :

   - whether the planned fixed day sessions in their area will adequately cover all infants in their area, and
   - whether the number of fixed day sessions held in their area is actually the number planned.

The following activities will be carried out to `promote key practices for prevention of diarrhoea' as well as to' promote key practices for management of diarrhoea' :

1. A mass media campaign will be organized by using the radio, television and other media which have a reasonable reach in the district. These will be given special priority in the months before the onset of a diarrhoea season, i.e., in March and April every year. Such messages will continue to be disseminated through the media through the months of increased diarrhoeal episodes as well as when special outbreaks occur.

2. The message used in the mass media campaign will also be used through the field publicity units, in the cinema halls of the district and various campaigns organized in the schools, fairs, important places through the coordinated efforts of IEC Bureau and block extension educator.

3. Interpersonal communication will be accorded priority. All functionaries of the health, ICDS, RSP, DWCRA systems will be given special orientation on various key messages related prevention of diarrhoea. They will be supported with appropriate communication material such as flip charts, flash cards etc. and trained to use them in mothers' meetings and group meetings.

4. Under the programme, a three-day training programme will be organized initially to develop a core team of trainers in all the 14 project blocks. These trainers in turn will train, in phases, interpersonal communicators from different systems such as health workers (male and female), ICDS

functionaries, Primary school teachers', Women's groups, RSP motivators and NYK members).

5. A two-day workshop will be conducted by the State/Central programme managers for the senior doctors, specialists, ANM training school faculty, matrons/staff nurses of hospitals, pharmacists and medical officers-in-charge of the block PHCs. Considering the total number of such functionaries in the district, four such workshops will have to be organized.

6. Training/orientation of AWWs and Helpers will be done at the block and sector levels along with the health workers of the area in batches of 30 each.

7. A separate workshop for the 9 CDPOs and the ICDS/DWCRA supervisors will be conducted. At the State level, the health and ICDS departments will coordinate to ensure that additional ORS packets are purchased for the AWWs medicine kits as well as for the PHCs and other health institutions.

8. All health workers will be oriented in the revised strategy for reporting diarrhoea cases as a part of the CDD-WATSAN report.

9. A special team will be constituted in the district and in the project block PHC to prepare specific action plan for response when there are outbreaks of gastroenteritis in their areas. All medical officers in the area will be oriented in the action plan for their relevant areas.

10. Monitoring at the district and PHC levels will include monitoring of training activities, training material, communication activities and communication material.

<u>Key messages which will receive emphasis include:</u>

* Improve infant feeding practices, i.e., breast-feeding, appropriate weaning at the correct age
* Continued feeding including increased feeding for 1 week after diarrhoea stops
* When diarrhoea occurs:

  - increase fluid intake with home available fluids
  - continue feeding
  - recognize key signs of dehydration early (increased thirst and delayed return of skin pinch)
  - seek help if key sign present
  - give ORS solution when there is dehydration
  - recognize a danger sign early (fever, vomiting, blood in stools, increased number of stools etc.)
  - where to seek help

2. Sanitation interventions

2.1 The present situation

It will not be out of place to say that Alwar has been one of the first district where a comprehensive Rural Sanitation Scheme was initiated during the later part of 1986-87 by the Department of Rural Development & Panchayati Raj, Government of Rajasthan. The project received a good response from the people. Nearly 14,800 of household latrines have been completed. This activity has been linked with providing smokeless chullah as a part of the sanitation package. As regards development of human resources, trainings have been completed for all block and village level functionaries. Besides, at least one mason per village has been trained for construction of low-cost sanitary facilities such as latrines, soakpit, garbage pit, batching cubicle and smokeless chullah.

2.2 Thrust areas

The Rural Sanitation Project will be further intensified to cover sanitation as package, encompassing the following seven components:

- Personal hygiene
- Handling of drinking water
- Disposal of waste water
- Disposal of human excreta and construction of sanitary latrines
- Garbage disposal
- Food hygiene and home sanitation
- Sanitation in the community

The components mentioned above will have two parts viz., provision of facilities/services and awareness creation and mobilization. The section below analyses the requirements of facilities/services from the point of view of improving their accessibility through an improved sanitation coverage. Awareness building and motivation will form a part of the action on IEC.

Disposal of waste water:

The three levels at which this activity could be taken up are: household drinking water source and community. Construction of domestic soak pit for draining out water to the garden or to a natural drainage could be promoted through motivational process. Households adopting sanitation will be persuaded to take up disposal of waste water at domestic level. As regards disposal of waste water/drainage improvement around drinking water sources, the situation deserves priority attention. It has been observed and reported by Block and Gram Panchayat officials that many handpump sites have the following problems:

- In many of the handpumps, the condition of a platform is reported to be bad

creating drainage problem.
- In many cases, the platform did not have any drainage at all.
- Nearly half of the handpumps show some water accumulation around them.
- Very often people wash utensils on the platform while washing of clothes seems to be common practice.

Keeping these factors in view, it appears that half of the handpumps in the project villages will need some treatment pertaining to drainage improvement. However, under the present Plan of Action, it is proposed to cover 25% of handpumps (where condition of the platform is bad or there is no drainage at all) for drainage improvement. In all, the number of water points needing such treatment will be around 300. An amount (average) of Rs.1,500 has been kept for this support which will also include providing bathing/washing platform and cattle trough on selective basis. Since each water point may need a different treatment, it necessary to initiate a comprehensive survey to identify the points needing drainage improvement, type of treatment needed and the cost.

As regards drainage improvement at village level, lining the village roads with a built-in drainage on either side could be taken up. It is expected that this would be handled by the Gram Panchayats out of the funds available from Jawahar Rozgar Yojna and any other special scheme permitting such activities.

The disposal of waste water in a village should ultimately lead to a water-logged-free environment. For this purpose, all the three above-mentioned activities viz., waste water disposal at domestic, water source and village level are taken together. For further convergence with other components villages covered under construction of household latrines may be given priority.

Disposal of human excreta and sanitary latrines :

Construction of sanitary facilities can be taken after intensive health education awareness has been built up at two levels.

- at household level
- at school level

So far as household sanitation facilities are concerned, attempts will be made to avail financial cost benefits of CRSP. Required financial provision has already been made and released for this purpose for 1996-97. The subsidy amount will be discontinued from 1998. Government will keep a provision for this purpose for 1998-99.

The Government has taken a decision to construct Janta houses for BPL families under Janta Avas Scheme. The unit cost of these houses is estimated at Rs.12,000. Under this scheme, both Government of Rajasthan and Government of India contribute along with the beneficiary. Since no provision has been made for construction of sanitation under this scheme, sanitary facilities could be provided under the present Plan of Action. Subsidy will be Rs.700 per unit to be provided by UNICEF during

1997 to further strengthen the process of adoption of sanitary facilities in the "unreached areas and to BPL families not covered so far".

With regard to institutional sanitation, a selective approach will be adopted. So far as school sanitation facilities are concerned preference will be given to Primary schools and girls Middle school if Primary school is already having sanitation facility. While selecting an institution for providing this facility, the following factors will be kept in mind:

- a 50% matching contribution is available either from the concerned department or from the institution or from the Panchayat.
- there is a water source nearby.
- the institution will be in a position to maintain the facility.

In addition to the above-mentioned interventions, which may cover only a small proportion of villages/population, attempts will be made to develop alternate delivery system by establishing `Rural Sanitary Mart' (RSM) at least one in each project block. An initial revolving fund of Rs.50,000 will be provided for this purpose in addition to managerial and support for social mobilization. Suitable institutions will be identified for this purpose. This scheme is now fully supported by both the Government of India and Government of Rajasthan and bank loans are available for establishing `RSM'.

Food Hygiene and Home Sanitation:

This component will be undertaken mostly through awareness creation, motivation and social mobilization. However, the proposed sanitary marts can keep stock of certain items like foodsafe, fuel-efficient chullah, cattle's trough etc., as a part of promoting home sanitation. The smokeless chullah programme implemented by the Department of Rural Development & Panchayati Raj will be dovetailed into the present strategy.

Personal Hygiene

While the concept of personal hygiene has many ramifications, the proposed strategy will concentrate on two vital interventions viz., hand washing and nail cutting. A mass campaign would be organized in the district on hand washing with soap or ash before food and after defecation. Schools, Anganwadi Centres and DWCRA group members will be involved in this activity. As a part of promotion, each Anganwadi Centre will initially be given two nail cutters and popular soap for hand washing. In case of schools, each class should have a nail cutter which will be with the class monitor. The children will be exposed to hand washing before taking the food. Replenishment of nail cutters and soaps at Anganwadi and school should be done with contribution from the Gram Panchayat. All the schools and Anganwadis will be covered under this activity. If feasible, selected DWCRA groups could be encouraged to manufacture popular soap for distribution.

Village Sanitation:

The aspect of sanitation relates to those activities which will promote the `cleanliness' concept in the village. Beside drainage improvement at the water sources and in the lanes and community garbage disposal points, the other activities under this will include filling up the water pools, renovation of public wells, cleaning up of ponds etc. All these activities would be taken up under the Jawahar Rojgar Yojna and other relieve schemes.

3. Training :

Attempts will be made to arrange joint training programme involving concerned agencies for personal belonging to a particular category. This will ensure establishment of rapport among the functionaries at a particular level and create better understanding of the activities promoted under the proposed strategy. Joint training modules involving a different category of personnel are being developed for this purpose. The following statement presents the level of training, type of training, duration of the training and nature of participants for the various training programme contemplated.

Technical

- Orientation of trainers (AEN, JEN)
- Training of local masons (3 days duration)
- Village women mechanics (5 days duration)

Non-technical

- Combined trainers' training* (3 days duration)
- Block level extension officers** (2 days duration)
- Village level motivators/ORS depot holders (2 days duration)
- NGO functionaries (2 days duration)
- NGO networking workshop

* Shall also include MO (PHC), CDPO and ICDS/Health Supervisors.
** Includes Anganwadi Worker and Members of village WATSAN committees.

The training modules developed by UNICEF will be the basis of organizing the above-mentioned training programmes.

3. Information, Education and Communication (IEC) and Social Mobilization :

The CDD-WATSAN project has already created a base for promoting rural sanitation through selected block and village level functionaries. This will be further intensified and strengthened and will include other functionaries of the govt. departments such as Health, ICDS, DWCRA, Education etc., & NGOs.

Alwar district has the unique advantage of being covered under the IEC project. It is expected that a number of volunteers will be mobilized. These volunteers could also be used for awareness building, motivation and social mobilization.

The thrust will be in the following areas:

- Demand generation for water/sanitary/health facilities and hygienic practices.
- Use of facilities created/service delivery pertaining to health, water and sanitation.
- Adoption of key practices for prevention of diarrhoea.
- Adoption of key practices for management of diarrhoea.

It is essential that the contents of communication and the key messages will be closely linked to specific objectives of the CDD-WATSAN strategy outlined earlier. The possibility of translating some of the existing literature in Hindi will be explored to ensure greater adaptability. New communication materials will be developed to suit the local situations.

Since the district is characterized by a large number of small villages, efforts will be made to identify a person to the common information source for both sanitation and diarrhoea prevention and management practices as well as for stocking the ORS packets and ensuring their availability in the village for 24 hours. The criteria for selection of such a person will be:

1. Be able to spare 2-3 hours a day for the above-mentioned tasks.
2. Preferably a female.
3. Between 25-45 years of age.
4. Able to read, write and explain clearly.
5. Should be acceptable to the community.
6. Should be a local resident.

In villages where an Anganwadi Centre exists, the worker or the helper could be the person. In the absence of such a centre, the DWCRA group organizer, school teacher, health guide, active member of WATSAN Committee etc., could be identified for this purpose.

Anganwadi Centre

These centres could serve as the focal point for orienting mothers on the CDD-WATSAN strategy and empowering women on prevention and management of diarrhoea. The Anganwadi worker will be trained to explain various components of CDD-WATSAN strategy as it relates to prevention and management of diarrhoea. The worker will identify a group of mothers (who are also good communicators) to serve as change agents in their hamlets/areas.

School

The district has 1,520 primary schools. In addition, there are more than 700 non-informal centres run by the State Government NGOs. These institutions can be used as a part of the awareness creation and social mobilization process. Suitable communication kits will be developed for this purpose.

Mothers' meeting

In every village mothers' meetings will be held at least twice every quarter. The focus of such meetings will be to promote key practices related to prevention and management of diarrhoea through adoption of simple measures related to personal hygiene, food hygiene, village sanitation as well as by giving home available fluids to children when they have diarrhoea. These meetings will be held in collaboration with the Anganwadi workers, DWCRA organizers. NGO groups and other ongoing programmes.

Nehru Yuvak Kendra

The district has many NYK units. These units will be used for both communication and social mobilization activities related to the CDD-WATSAN strategy. Specifically, the village adoption approach by the NYK units will be followed. The NYK units of the village will be encouraged to adopt a cluster of 400 villages and the NYK workers will visit these villages for one day a month. Annual camps will be organized in some of these villages to promote activities related to safe water, sanitary practices and diarrhoea prevention. During the village visits and camps, the NYK workers will promote various themes which will include:

- handling of drinking water and disposal of waste water
- disposal of human excreta and garbage
- home sanitation (including food hygiene) and personal hygiene
- promotion of continued feeding, increased fluid intake during diarrhoea
- oral rehydration therapy and facilitating services during outbreaks.

The financial support will include transportation, refreshment to workers, training/orientation for NYK workers and their leaders and other charges of organizing camps.

NGOs will be encouraged to work on various aspects of the strategy depending on their strength. The activities in which NGOs collaboration will be specifically sought include the following:

IEC and social mobilization
Motivation and promotion of key practices
Conducting various trainings

Planning and conducting awareness campaigns

PLA techniques

The Participatory Rural Learning Technique will be used as a part of the participatory process in planning through village community. To start with, it will be taken up in relatively bigger villages or Gram Panchayats (say those with a population between 500-1000). Based on the experience, it could be extended to others. For this purpose, NGOs will be involved.

Wall Paintings & Slogans

These will be used in spreading health education messages. The wall paintings will be done at ORS depots, prominent public places, schools and health institutions.

Media Campaign

The Health Department's district-based EPO's support and involvement will be fully ensured in launching the media campaign. He will be the nodal officer for the CDD Media Campaign and IEC related activities. The block-based Extension Officer will also be a part of the team.

Phasing

It may not be feasible to take up all activities such as provision of sanitation facilities and activities related to it in all the 1,900 villages of the 14 blocks in 1997 for obvious logistic and other reasons. However, it is proposed that certain activities can be initiated in all the 1,900 villages which will create conditions for a speedier implementation of the Plan of Action in the subsequent year. The statement below indicates the activities which can be initiated in all the 14 blocks in 1997. For subsequent years, phasing will be done after reviewing the pace of progress at the end of the year.

IV. Project areas activities :

S.N.	ACTIVITY	AREA TO BE COVERED DURING 1997	RESPONSIBLE AGENCY	NO. OF PARTICIPANTS EXPECTED	EXPECTED OUTCOME
A.	TRAINING :				
01.	Orientation of AEN/JEN	All 14 blocks of the district	ZP in collaboration with the State Sanitation Cell	20	Enhance technical & enriched skills leading to improvement in quality of the construction.
02.	Local masons	1 each from all the 1,900 villages	BDO	1,900	Enrichment of appropriate skills for the construction of low cost sanitary facilities.
03.	Women mechanic	From selected villages	ZP (Engg.division)	50	Will lead to help in the process of community management of HPs.
04.	Combined trainers' training	Entire district	ZP in association with the State Sanitation Cell	60	Will strengthen the training facilities at District & Block levels and develop capabilities to conduct trainings.
05.	Block level Extension Officers	Entire district	Chief Executive Officer	15	Will enhance the effective implementation of social mobilization process.
06.	Village level motivators	1 per panchayat village	BDO	400	Help at grassroots for follow up and development of MIS at village level.
07.	NGO functionaries (including Bharat Scouts & Guides & Nehru Yuvak Kendra volunteers)	Entire district	Chief Executive Officer	2000	Create better understanding of the project goals and activities.
08.	NGO networking workshop	Entire district	Chief Executive Officer - Zila Parishad	50	Establishment of effective rapport and working relations between NGOs and Govt., functionaries.
B.	IEC/SOCIAL MOBILIZATION				
01.	Identification of Motivators-cum-ORS Depot holders	In all the ANM centres.	EPO in consultation with ICDS and Dy.CM&HO (H)	712	Ensure availability of ORS at different sources and depots.

S.N.	ACTIVITY	AREA TO BE COVERED DURING 1997	RESPONSIBLE AGENCY	NO. OF PARTICIPANTS EXPECTED	EXPECTED OUTCOME
02.	Mothers' meeting	Entire range of villages	Anganwadi workers/Sanitation/Motivation/ORS Depot holders	10 mothers from each village (1900 x 10 = 19,000)	Will lead in the reduction and control of diarrhoea cases.
03.	Social mobilization through EPO	All 1,900 villages	EPO	1,900 x 200 = 3,80,000	Effective social mobilization campaign in the project area.
04.	Social Mobilization through NYK	All villages allocated to NYK	EPO	500 x 200 = 1,00,000	Will enhance the communication skills of NYK workers.
05.	Social Mobilization through NGOs (Bharat Scouts & Guides organization)	1,000 villages	EPO	1,000 x 200 = 2,00,000	Will enhance the communication skills of NGO workers.
06.	PLA technique	For 14 blocks	EPO	42	Will help in establishing a system of planning at the grassroots levels by the community.
07.	Wall paintings/slogans	In all 400 Panchayats villages	Zila Parishad	In 4 selected places of 400 Panchayats	Will help in the spread and adoption of messages on CDD.
08.	Use of Block Extension /Field Publicity	In all 400 Panchayats villages	State Sanitation/IEC Cell	400 Panchayat villages	Appropriate and timely use of IEC material.
09.	Awareness drive through non-formal education workers	14 selected blocks	District Coordinator (ZP)	-	Ensuring the effective involvement of the education workers.
C.	HEALTH				
01.	Establishment of DTU	For district	CMHO/Dy.CMHO (H)	1	Will ensure the availability of ORS & advise on the treatment of diarrhoeal cases.
02.	Training at DTU district hospital	For district	Dy.CMHO (H)	1	Will help in developing the training skills of workers from different villages in the control of diarrhoeal diseases.
03.	Distribution of ORS packets	In entire 1,900 project villages	BMO	-	Timely availability of the ORS will help in reduction of IMR and prevention of childhood disability.

S.N.	ACTIVITY	AREA TO BE COVERED DURING 1997	RESPONSIBLE AGENCY	NO. OF PARTICIPANTS EXPECTED	EXPECTED OUTCOME
04.	Immunization	In entire 1,900 project villages	District Immunization Officer	-	Timely availability of the ORS will help in reduction of IMR and prevention of childhood disability.
D.	WATER SUPPLY				
01.	Identification of villages for installation of India Mark III handpumps to attain the goal of `1 safe source of drinking water for 150 persons'.	From 14 blocks	SE (PHED), Alwar	-	Will facilitate in achieving the goals as per the SPAC. Ensure in the establishment of uniformity in the maintenance.
02.	Identification of pumps needing rejuvenation	1,900 villages	SE (PHED), Alwar	-	Will ensure availability of safe drinking water supply.
03.	Installation of handpumps	Villages not yet covered	SE (PHED), Alwar	-	Will ensure availability of safe drinking water supply.
04.	Formation of CDD-WATSAN Committees	In all 1,900 villages	ZP	-	Will lead to the process of community-based maintenance system.
05.	Community-based Handpump Maintenance System	In 400 Panchayat villages	Zila Parishad	-	Will reduce dependability on outside agency for the maintenance and enhance the `community ownership process'.
E.	SANITATION				
01.	Identification of water points needing drainage improvement	14 blocks	Zila Parishad	-	Will improve the environment around HP sites.
02.	Drainage improvement around handpumps/water points	14 blocks	Zila Parishad	-	Will reduce chances of water contamination.
03.	Construction of household sanitary facilities	In 14 blocks for `BPL' families	Zila Parishad	-	Will improve the quality of construction and durability of the unit.
04.	Construction of Institutional sanitation	Schools not yet covered	Zila Parishad	-	Will lead to the adoption of better hygienic practices at the school age among the children.

PROGRAMME MANAGEMENT, COORDINATION, MONITORING AND EVALUATION

State level:

The Public Health Engineering Department (PHED), Government of Rajasthan, will be the nodal agency responsible for the implementation of the project. The Principal Secretary of the PHED will be the Chairman and the Chief Engineer (Rural), PHED will be the Project Coordinator. The Department will ensure the full cooperation of the concerned officials and implementing agencies at the district, block and village levels. In addition, it will ensure the cooperation and participation of the other departments/directorates concerned such as Rural Development & Panchayati Raj Department (RD&PRD), Department of Women & Child Development (DWCD), Medical & Health Services , IEC Bureau and Education etc. The IEC Cell, under the overall supervision of the Coordinator, will provide support to the programme. Under the supervision of the Coordinator, the IEC Cell will undertake the following functions and responsibilities.

i) Redevelop and modify the existing guidelines for project implementation in view of integrated development with CDD programme and provide guidance and assistance to village, block and district level agencies in the detailed planning and implementation of all activities envisaged in the project.
ii) Monitor project progress, initiate corrective action wherever necessary and collect, compile and submit quarterly progress reports and utilization certificates to UNICEF.
iii) Coordinate with the agencies identified for training and health education, plan and organize details of the activities with them, ensure timely completion of activities and act as a resource in the conduct of training programme.
iv) Ensure timely accounting and release of funds to the district level.
v) Be responsible for identification of individuals and agencies, in consultation with UNICEF, for implementation at block and district levels.
vi) To provide overall supervision and guidance through frequent and regular visits to the village, block and district level.

State Review Committee:

A State Review Committee will meet initially every three months to review the progress of the project with the participation of the following members:

1) Principal Secretary, Public Health Engineering Department, Government of Rajasthan
2) Special Secretary & Director, Rural Development & Panchayati Raj Department, Government of Rajasthan
3) Chief Engineer (Rural), Public Health Engineering Department , Government of Rajasthan

4) Director, Department of Women & Child Development, Government of Rajasthan
5) Director, IEC, Directorate of Medical & Health Services, Government of Rajasthan
6) Director, Health & Family Welfare, Directorate of Medical & Health Services, Government of Rajasthan
7) Director, HRD & IEC, Public Health Engineering Department, Government of Rajasthan
8) Additional Chief Engineer, Public Health Engineering Department, Jaipur division
9) Representative from UNICEF
10) Representative from the voluntary organization

The HRD & IEC Cell, PHED would review the progress in every three months and would provide a copy of the review report to UNICEF for its perusal and share with all the concerned departments.

The Executive Engineer, PHED, Alwar will send a consolidated monthly progress report to Chief Engineer (Rural), PHED, Jaipur.

A joint review of the accomplishments would be done on a six monthly basis jointly by PHED and UNICEF. This would form the basis for making suitable modifications in the plan in order to achieve the desired objectives.

Additional Chief Engineer, PHED Jaipur Division will monitor the progress of handpumps installation and issue guidelines. PHED officers will undertake periodic field visits and assess continuously and evaluate the programme and suggest corrective action.

The following will be the members of the District Coordination Committee for CDD-WATSAN programme in Alwar district.

District level :

1. Collector, Alwar, Chairman of the District Coordination Committee
2. Chief Executive Officer, Zila Parishad, Alwar, Vice-Chairman of the Committee
3. Chief Medical & Health Officer, Convenor of the committee.
4. Zila Pramukh will be a special invitee
5. Executive Engineer, PHED, Alwar
6. Executive Engineer (Drilling) PHED Alwar Division, Alwar
7. Education Officer, Zila Parishad, Alwar
8. Assistant Engineer, Zila Parishad, Alwar
9. Assistant Director, Women & Child Development, Alwar
10. Child Development Project Officer, Alwar
11. Superintending Engineer, PHED, Sub-division, Alwar, Member Secretary
12. Deputy Chief Medical & Health Officer (Heath Rural), Alwar

13. EPO (Officer responsible for media related support in the Health Deptt., at the district level)
14. District Immunization Officer, Alwar
15. Project Officer, CDD, Zila Parishad, Alwar
16. Project Officer, RSP, Zila Parishad, Alwar
17. Representative of active voluntary organizations
18. Project Director, DRDA, Alwar
19. Assistant Project Officer, DWCRA
20. District Information and Publicity Officer
21. Project Officer, District Womens' Development Agency
22. Project Officer, UNICEF

The functionaries of this Committee will:

a) review and guide the implementation of the CDD-WATSAN activities at block and village levels on monthly basis, undertake some joint field visits to review and observe the field situations.

b) review the proposals and advise on the allotment of funds.

c) meet every month.

Block level

The Block level Committee for CDD-WATSAN will have :

1. Block Development Officer as Chairman
2. Extension Officer as Convenor

and following as members:

3. Block Medical Officer
4. Child Development Project Officer (ICDS block)
5. PHC Medical Officer
6. Assistant Engineer, PHED
7. Junior Engineer (at Block level)
8. Adult Education Project Officer
9. Representative of NGO

Role of UNICEF :

Subject to availability of funds, satisfactory progress and periodic review, UNICEF will make suitable financial assistance as summarized in budget section.

The release of UNICEF assistance will be governed by the following:

i) UNICEF assistance will be subject to actual project progress and utilization

of funds dispersed for the approved activities as per the POA. No transfer of allocation and expenditure from one calender year to subsequent one will be possible.

ii) Annual work plan and estimates will further be developed by the Zila Parishad and Public Health Engineering Department and submitted by October of each year.

The government of Rajasthan will undertake a review of the programme with participation of UNICEF. This review will be a part of the annual review of UNICEF cooperation with the Government of Rajasthan and other coordinating and participating departments.

Based on the recommendations of the review meetings, the guidelines for an implementation and financial pattern will be revised, where necessary, in consultation with UNICEF and in concurrence of the PHED, Department of Rural Development and Health & Family Welfare Department.

PHED and Rural Development & Panchayati Raj Department will ensure timely release of their share to the district and ensure the continuity of the CDD activities beyond UNICEF assistance is phased out.

UNICEF will release its share in advance on quarterly basis. The next instalment will only be released on the receipt of a statement of accounts duly endorsed by the concerned department.

Budget :

A summary of physical targets and financial outlay (provisional) pertaining to UNICEF share is presented below. The outlay is for a budgetary purpose and is linked with the expected commitment on cost sharing by the State Government and hence subject to change.

CDD-WATSAN STRATEGY IN ALWAR DISTRICT OF RAJASTHAN
PHYSICAL TARGETS AND FINANCIAL OUTLAY FOR 1997-98

S.N.	Activity	Physical target	Financial outlay (Rs.)
(A)	Training		
1.	Orientation of Supervisors/AEN & JENs	2 courses	25,000.00
2.	Local masons (1,000)	50 courses	7,00,000.00
3.	Women mechanic (50)	4 courses	80,000.00
4.	Trainers' training (40)	1 course	50,000.00
5.	Block level extension officers (15)	1 course	15,000.00
6.	Village level motivators (400)	10 courses	3,00,000.00
7.	NGO functionaries (1,000)	12 courses	1,20,000.00
8.	NGO networking workshop	1	50,000.00
	Sub total	80 courses	13,40,000.00
(B)	IEC/SOCIAL MOBILIZATION		
1.	Village contact drive through volunteers of NYK & NGO	900 drives	90,000.00
2.	Monthly visits through NYK/NGO volunteers	-	-
3.	Camps through NGO	500 camps	5,00,000.00
4.	Camps through motivators	500 camps	5,00,000.00
5.	PLA camps	One per block in 14 blocks	1,40,000.00
6.	Wall paintings/slogans	400 Gram Panchayats (Rs.500 per Gram Panchayat)	2,00,000.00
7.	Material development/replication		2,00,000.00
	Sub total		16,30,000.00
(C)	HEALTH		
1.	Training at DTU		50,000.00
2.	ORS packets	2,00,000 packets	Through Health Deptt.
	Sub total		50,000.00

S.N.	Activity	Physical target	Financial outlay (Rs.)
(D)	WATER SUPPLY		
1.	Installation of India Mark III handpumps	480 Pumps and 22,600 meters GI pipe	41,61,000.00
	Sub total		41,61,000.00
(E)	SANITATION		
1.	Household sanitation facilities	1400 units	9,80,000.00
2.	Sanitary Mart	12 marts	9,60,000.00
3.	Institutional latrines	100 Nos.	2,50,000.00
4.	Other support (public stand posts)	100 Nos.	1,50,000.00
	Sub total		23,40,000.00
(F)	PROJECT SUPPORT		
1.	Staff support (1 PO CDD at Zila Parishad)		84,000.00
2.	Support to NGO		6,00,000.00
	Sub total		6,84,000.00
	Contingency unforeseen (5%)		50,000.00
	GRAND TOTAL		1,02,55,000.00

SUMMARY OF BUDGET ESTIMATES 1997-98 (till 31 March 1998)

(Figures in Indian Rupees)

S.No.	Major activity	Govt. Of Rajasthan	UNICEF	Total
1.(a)	Construction of latrines in households and institutions and provision of sanitation facilities at PSPs, institution and households	20,00,000.00	13,80,000.00	33,80,000.00
(b)	Rural Sanitary Mart	-	9,60,000.00	9,60,000.00
2.	Trainings/workshops**	-	13,40,000.00	13,40,000.00
3.	Communication & Social Mobilization	-	16,30,000.00	16,30,000.00
4.	Health	-	50,000.00	50,000.00
5.	Water supply	***1,44,00,000.00	41,61,000.00#	1,85,61,000.00
6.	Manpower support to Zila Parishad - PO (CDD)	-	84,000.00	84,000.00
7.	Project support to NGOs for infrastructure	-	6,00,000.00	6,00,000.00
8.	Contingency Unforeseen (5%)	-	50,000.00	50,000.00
	TOTAL	1,64,00,000.00	1,02,55,000.00	2,66,55,000.00

** Government of Rajasthan's support will be in the form of paying TA/DA to the staff nominated for the trainings/workshops

*** This is the estimated cost of drilling for 480 boreholes in the Alwar project villages. Normally drilling cost without handpumps and GI pipes varies from Rs.30 to 35,000 depending upon the site and the location of the borehole.

This is the cost of 480 handpumps and 22,600 meters GI pipe.

PROJECT AREA:

1. Alwar District at a Glance:

	Alwar	Rajasthan
Population (1991) (5.21% of State Population	2,286,701	43,880,640
Decennial Growth Rate (1981-91)	23.56%	22.14%
Area (Sq. Km)	8,380	3,42,239
Population Density	274	128
Percentage of SC (1991) ST	17.64 8.12	1.7 12.21
Sex Ratio	880	910
Literacy: Persons Male Female	 33.65 47.97 17.53	 38.81 55.07 20.84
Infant Mortality Rate (1994 SRS) Total Urban Rural	 - - -	 89 60 88

Alwar district is situated in the North Eastern Plains of Rajasthan. With 5.21% of the population, it is the fourth biggest district in the State.

3.2 Project Area: The district will be the unit of planning and implementation for this programme. Keeping in view the experience gained during the last 3 years in the 2 blocks, the project will be taken up in all the 14 blocks of the Alwar district. All 1,900 villages and the towns in these blocks will be covered. At present, 413 villages are covered by WATSAN programme.

The essential information from all the blocks of Alwar district is given in Table I. A health infrastructure in Table II.

3. CDD WATSAN in Alwar at a Glance

Total No. of blocks	14
No. of Project Blocks proposed under CDD	4
No. of project villages proposed under CDD (100% villages)	1,900
No. of Household (H.H) units covered so far (December 1996)	14,080
No. of Primary Schools covered Dec.'96	359
No. of H.H. units to be covered during 1997	1,400
Washing/bathing platform	1,400
Soak Pit	1,400
Population of the Project Villages (estimated)	19,30,000
No. of PSP to be covered	All in the 14 blocks
No. of institutions to be covered	All in the 14 blocks
No. of village-based motivators available	65

Table - I Checklist of Blocks

Sub-division	Block	PHC	Town (Population)	Pop. of the Block	No. of villages	Watsan villages in present	NYK clubs	AW centres	DWCRA groups
RAJGARH	Rajgarh	Tahla	Rajgarh (18000)	1,04,000	136	136	33	110	50
	Reni	Reni		1,37,000	139	13	46	-	32
	Khatoomar	Khatoomar	Kherli (10,000)	1,67,000	141	9	-	178	46
	Laxman garh	Govindgarh		1,79,000	178	14	34	176	45
ALWAR*	Thanagazi	Narayanpur		1,09,000	99	13	16	-	52
	Umrain	Malakhera		1,50,000	151	11	47	160	44
	Ramgarh	Nauganwa		1,49,000	160	16	36	-	40
BEHROR	Behror	Gandala	Behror (12,000)	1,34,000	106	12	05	-	52
	Bansur	Rampur		1,52,000	123	14	87	-	47
	Neemrana	Majri Kalan	Alwar (1,80,000)	1,19,000	83	14	19	-	20
KISHAN GARH	Tijara	Tijara	Tikara (15,000)	1,45,000	197	14	64	-	40
	Kishangarh	BK Nagar	Khairtal (19000)	1,29,000	130	130	38	136	38
	Kot Kasim	Kot Kasim		95,000	115	10	0	-	40
	Mundawar	Mundawar		1,61,000	134	7	-	-	40
Total				19,30,000	1,892	413	425	760	586

* There are 100 AWWs in Alwar town.

1. ANM 1 x 408 = 408
2. AID post 1 x 63 = 63
3. Mini PHC 57
   Strength:

1 Doctor	1 x 57 =	57
1 Male Nurse	1 x 57 =	57
1 ANM	1 x 57 =	57
1 LHV	1 x 57 =	57
1 S.I.	1 x 57 =	57
1 Lab Asst.	1 x 57 =	57
1 Male Nurse	1 x 63 =	63

4. Block PHC 14
   Strength:

1 Doctor	1 x 14 =	14
2 Male Nurses	2 x 14 =	28
1 Block Health Supervisor (Female)	1 x 14 =	14
1 LHV	1 x 14 =	14
1 S.I.	1 x 14 =	14
1 Food Inspector	1 x 14 =	14
1 Lab Asst.	1 x 14 =	14

5. Community Health Centre 17
   Strength :

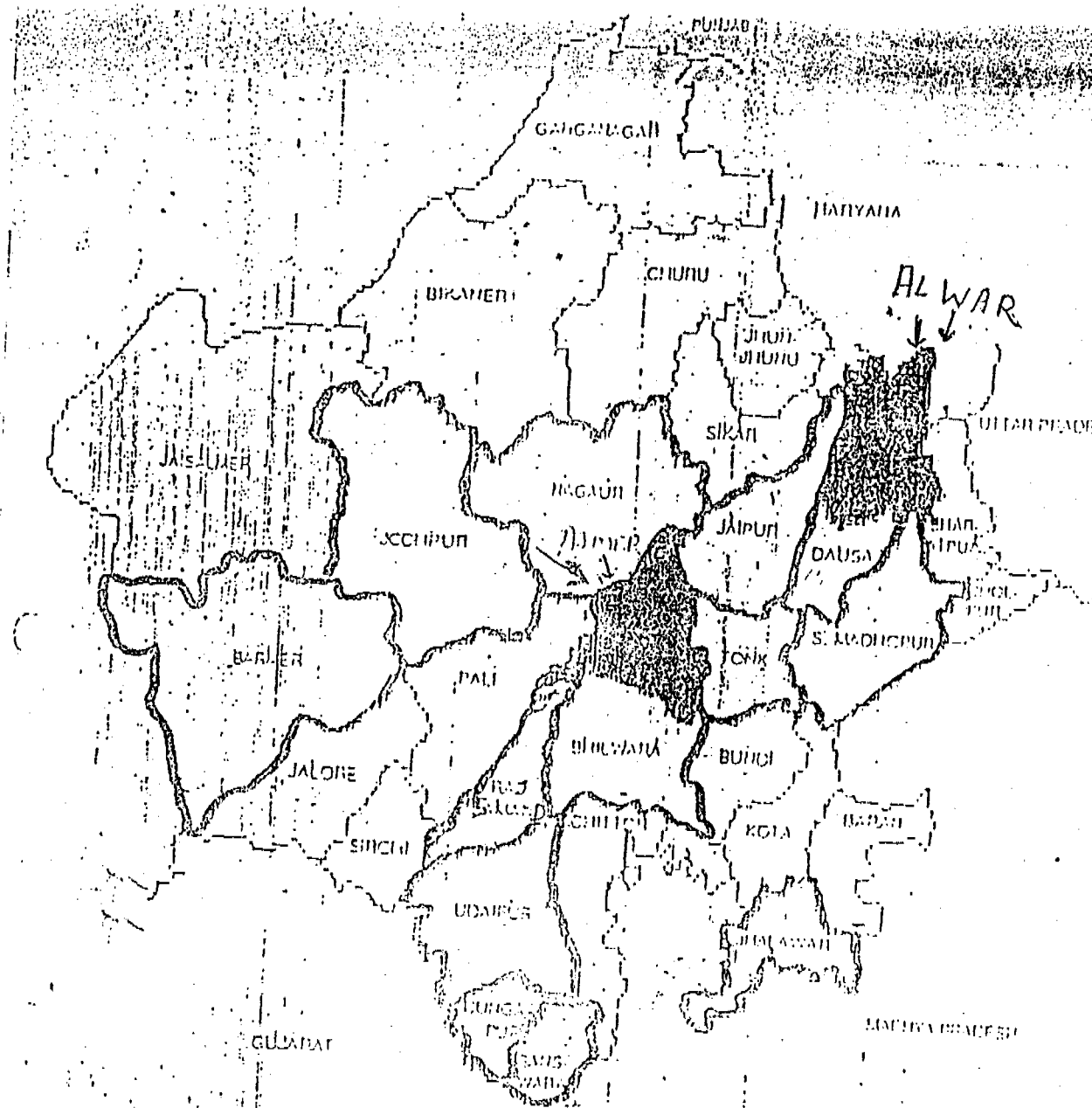
Doctor	1 x 17 =	17
Male or female nurse	1 x 17 =	17
Grade I & II	1 x 17 =	17
Nurse (F)	1 x 17 =	17
Nurse (M)	1 x 17 =	17
ANM	1 x 17 =	17
Lab.Asstt.	1 x 17 =	17
S.I.	1 x 17 =	17

Medical manpower available in Rural Based Health Institutions , Alwar
December '96
(Source : Dy. CM&HO (FW) 3.1.97)

SR.NO.	DESIGNATION	NOS.
1.	Doctors (Both Male & Female)	197
2.	Nurse Grade I & II	264
3.	ANM	501
4.	LHV	49
5.	Block Health Supervisor (Male & Female)	45
6.	Sanitary Inspector	45
7.	Sector Supervisor	61
8.	Laboratory Assistant	97
9.	MPW (Male only)	211

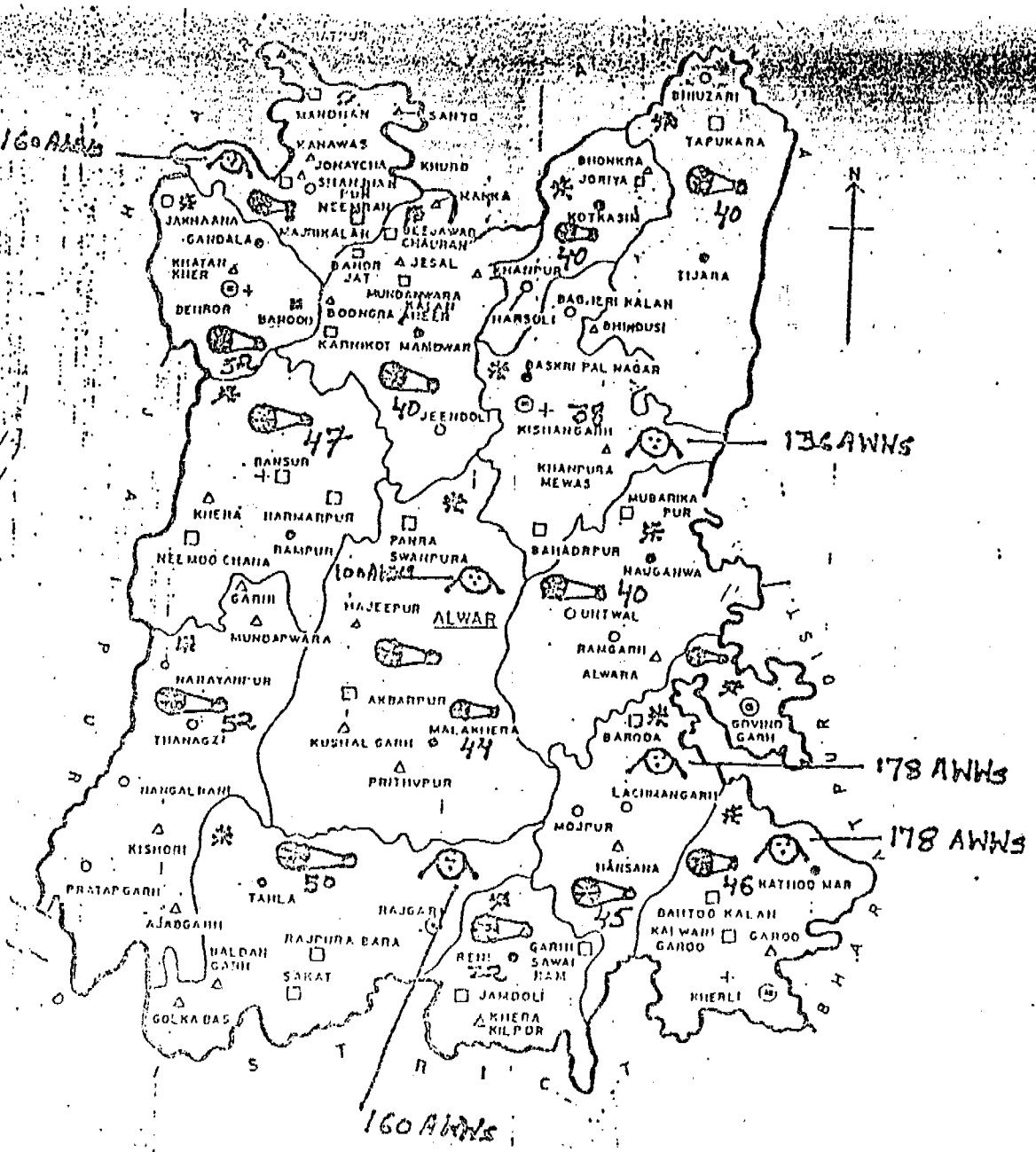
Table II - District Alwar
Blockwise List of Health Institutions

Block	Kishangarh	Tijara	Mundawar	Kotkasim	Rajgarh	Reni	Laxmangarh
B.PHC	B.K. Nagar	Tijara	Mundawar	Kotkasim	Tehala	Raini	Govindgarh
PHC	Bhagorikala Bahadurpur	Bhiwari Tapookada Jheevana	Jindroli Chandpur Karnikot Siradikala Jatbehror Beejwad Chauhan	Harsoli Jaadia	Kohdariba Baldevgarh Rajpurbada	Jaamrodi Peenan Gathisawariam	Kojpur Barodamer Ideda
CHC	Kishangarh	Tijara Bhiwadi			Rajgarh		Govindgarh Lacchmangarh
P.P. Scheme		Tijara			Rajgarh		Govindgarh
MCW Centre	Khairthal Kishangarh						
RFWC	Ismailpur		Tatarpur	Pur			
Dispensary	Khairtal		Mundawar				
SHC							
Aid Post	Bhidoosi Khanpur Mewan	Bagore Guwalda	Bhungada Ahir Jasai Khaanpur Ahir Maanka	Bhonkar	Golakabas Talab	Gathisawiran Kilpur Kheda Naachadi	Harsana Khudiyana Maalawali
No. of Sub-centres (ANM)	36	36	35	36	36	35	36
Block	Kathoomar	Behrod	Neemrana	Bansur	Ramgarh		
B.PHC	Kathoomar	Gandala	Kaajari	Raaspur	Nauganvan	Kalakheda	Naarayanpura
PHC	Behtookala Kaalwadi	Jakharana	Kaajra Shaahjahan Naathan	Hameerpur Neebchana Baansoor	Raamgarh Utwad Koobarikpur	Dehra Shapur Akbarpur	Pratapgarh
CHC	Kherli	Behrod			Raamgarh	Kalakheda	Thaanagazi
P.P. Scheme		Behrod				Alwar	
MCW Centre	Kherli	Behrod		Baansoor		City.Disp.	Naarayanpur
RFWC				Harsora			Guda Chaurani
Dispensary							
SHC							
Aid Post	Gaaru Jatwada Raagal Rupa	Dehni	Jonayacha Khurd Kaanawas Pratap Pur Santi	Kheda Shyampur Haaripur	Alwada Bhaagith	Haazipurudikar Kushalgarh Prithvipura Burza Haldina	Ajabgarh Kishori Nundawara Suratgarh Jheeri
No. of Sub-centres (ANM)	35	36	32	38	38	33	37



RURAL SANITATION PROGRAMME DISTRICTS

Note : Alwar and Ajmer districts have all the blocks fully covered under the Rural Sanitation Programme


160 AWWs
136 AWWs
178 AWWs
178 AWWs
160 AWWs
ALWAR
ALWAR DISTRICT
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PRIMARY HEALTH CENTRE
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