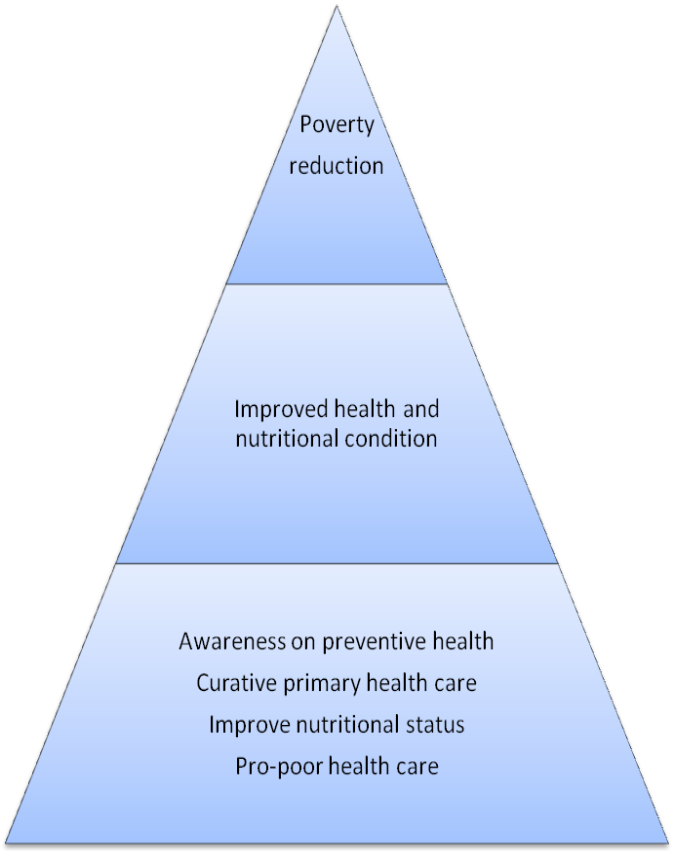
# Primary Health Care and Nutritional Support to Children and Women of Slums




## Project Proposal
**September 2010**

***36 Months***
***May 2010-April 2013***

***Required Foreign Fund:***

| Phase | Months | EURO |
|---|---|---|
| 1 | 12 | 31,864 |
| 2 | 12 | 25,537 |
| 2 | 12 | 23,666 |
| **Total** | **36** | **81,067** |

**Association for Realisation of Basic Needs - ARBAN**
House # 16 (Ground Floor), Road # 9/A,
Dhanmondi R/A, Dhaka 1209, Bangladesh
Phone: +88-02-8111321, +88-02-9111017
Mobile: 01917705600, Fax: +88-02-8122250
E-mail: arbn@agni.com, Website: www.arban.org

## Primary Health Care and Nutritional Support to Children and Women of Slums

### National Scenario:

Bangladesh is located in the South Asia region and is bordered in the North and West by India, the South by the Bay of Bengal and the East by India and Myanmar (Burma).


Bangladesh emerged as an independent and sovereign country in 1971 following a nine month war of liberation. It is located in one of the largest deltas of the world with a total area of 147,570 sq. km. Bangladesh has a population of about 150 million, making it one of the densely populated countries of the world. The majority (about 88%) of the people are Muslim. Over 98% of the people speak Bangla although English is widely spoken. The country is covered with a network of rivers and canals forming a maze of interconnecting channels.

More than 50% of the people of Bangladesh are extremely poor, 65% people are functionally landless, day labourers, workers, and marginalized professionals living in perpetual poverty, hunger and deprivation. However, they are hard working, laborious and resilient people who really keep the wheels of the Bangladesh's formal and informal economy moving forward. They live in the rural and urban areas of Bangladesh in hazardous conditions.

In Bangladesh, there are only three hospital beds and three physicians per 10000 people. Infant mortality rate per 1000 live births is 59.02. Maternal mortality ratio is 570 per 100000 live births and under 5-mortality rate are 53.84 per 1000 live births. 27% of the total population of Bangladesh is undernourished. Prevalence of Child Malnutrition (Percent Underweight under Age 5) is 39.80%. Low Birth weight Babies (Percent of Births) is 22%. The poor people cannot afford the health service of private hospitals. Water-borne diseases still account for 24% of all deaths and kill 110,000 under-five children annually. These statuses are the poorest comparatively than others countries and pars of the world mentioned in the following table.

Table: 1: Comparative data on health status

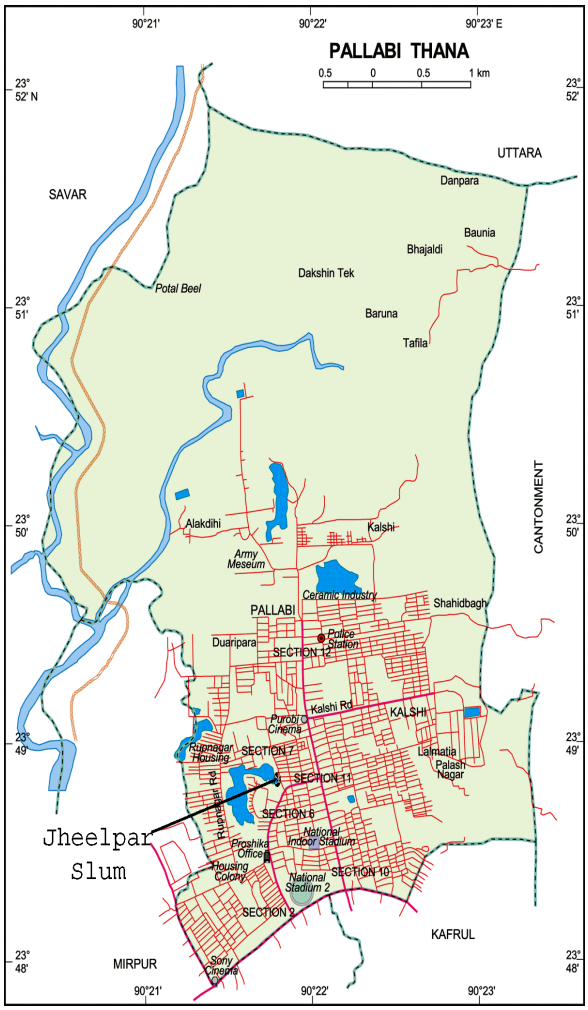
| Indicator | Bangladesh | India | Myanmar | UK | USA | Japan |
|---|---|---|---|---|---|---|
| Hospital bad per 10000 people | 3 | 7 | 6 | 39 | 31 | 140 |
| Physician per 10000 people | 3 | 6 | 4 | 23 | 26 | 21 |
| Infant mortality rate per 1000 live births | 59.02 | 30.15 | 47.61 | 4.85 | 6.26 | 2.79 |
| Maternal mortality ratio per 100000 live births | 570 | 450 | 380 | 8 | 11 | 6 |
| Population Undernourished (Percent of Total Population) | 27% | 21% | 19% | <5% | <5% | <5% |
| Prevalence of Child Malnutrition (Percent Underweight Under Age Five) | 39.80% | 43.50% | 29.60% | 0% | 1.30% | 0% |
| Low Birth weight Babies (Percent of Births) | 22% | 19% | 15% | 8% | 8% | 8% |

Bangladesh is a rapidly urbanizing country. The total urban population of Bangladesh is already over 36 million and this population is growing at a very rapid rate of nearly 4 percent per annum the capital Dhaka and the port city Chittagong is growing even faster. Such growth has been taking place mainly due to migration of the rural population to urban areas, most of these migrants being the poor.

Dhaka is the Capital city of Bangladesh. It has 9.1 million people and 3.4 million (37%) of its population living in the 3000 slums. Slums have existed in Dhaka City for a long time but their growth accelerated after the liberation of the country in 1971, mainly due to mass migration by the rural poor. Slums dwelling people have Inadequate household income; Limited asset base; Lack of access to public infrastructure and services such as piped water, sanitation, drainage, health care, schools, emergency services, etc. They also suffer from inadequate legal protection; Voicelessness, powerlessness, exploitation and discrimination. The health conditions in slums are extremely hazardous. The dense and squalid environments breed a host of communicable as well as non-communicable diseases. Children are more vulnerable than others are. The major diseases affecting particularly the urban poor population are diarrhoea, respiratory tract infections, asthma, skin diseases, helminthiasis, fevers, typhoid, whooping cough and various eye diseases. Public hospitals are not only inadequate compared to their need but also the quality of services there is equally poor. It is alleged by the urban poor that the doctors in the public hospitals often encourage them to seek treatment from the private outlets which are extremely expensive and entail heavy dependence on costly medical tests not always 'necessary' in the eyes of the urban poor.

## Situation at Project Location: Jheelpar Slum

Jheelpar is one of the slums in Dhaka city. It is located in the North West of the city under the Pallabi Thana of Dhaka City Corporation. The slum is about 5800 square metres. Half of the slum is built above polluted low lying wet areas and said to be 'a hanging slum'. About 500 families are living here in hazardous situation due to lack of basic services. Houses are made of fence and tin. In average, four people live in a house made of seven square meters area.




Total population of the slum is 2200 of which 47% are male and 53% are female. The following table showing the disaggregated population of Jheelpar slum by age and by sex:

Table: 2: Disaggregated population

| Age | Male | Female | Total | % |
|---|---|---|---|---|
| 0-<5 | 180 | 150 | 330 | 15% |
| 5-<9 | 130 | 130 | 260 | 12% |
| 9-<18 | 160 | 220 | 380 | 17% |
| 18-<45 | 530 | 600 | 1130 | 51% |
| 45> | 40 | 60 | 100 | 5% |
| Total | 1040 | 1160 | 2200 | 100% |
| % | 47% | 53% | 100% | |

Generally each household has one earning member. They are involved with laborious jobs such as day laborer (40%), garments worker (34%), small trader (10%), construction worker (6%), transport worker (4%), mechanic (4%) and others (2%). Their income sources are irregular, risky and hazardous for health. Household size is 4.4 and average monthly (30 days) household's income is BDT 5338/=. This income is less than $1 per day per capita, which does not meet minimum requirements for food (2122 kcal/per day per capita) considered in the Millennium Development Goal. Please see the following table

Table: 3: Income per day per capita

| Indicator | BDT | $ (68BDT/$) |
|---|---|---|
| Monthly (30 days) Household Income for 4.4 person | 5,338.00 | 78.50 |
| Daily Household Income for 4.4 person | 177.93 | 2.62 |
| Daily Household Income for 1 person | 40.44 | 0.59 |

Income is not increasing as the prices of commodities increased for the last three years in Bangladesh. Hardly have they had to maintain all relevant requirements like food, housing,

treatment and clothing by this income. 67% of their income has to spend for food, 14% for housing and 12% for treatment. Expenditure for others basic requirements are comparatively poor because they spend only 3% for education, 4% for clothing and 1% for entertainment.

Table: 3: Expenditure for food

| Food Expenditure | BDT | $ |
|---|---|---|
| Monthly HHs expenditure for for food | 3,567 | 52.46 |
| % of Monthly HHs expenditure for food | 67% | 67% |
| Daily HHs expenditure for for food | 119 | 1.75 |
| Per head daily average expenditure for food | 27 | 0.40 |

However, their major monthly expenditure occurred for food but they can allot only BDT 27 per day per capita. This amount is unable to provide them nutritional foods like egg, milk, butter, meat, fish, fruits etc. It is not sufficient to meet the requirements of the family members.

Table: 3: Food intake

| Days in a month when Mother and 2> y child eat | |
|---|---|
| Item | Average Days |
| FISH | 5 |
| MEAT | 5 |
| EGG | 4 |
| MILK | 2 |
| BUTTER | 0 |
| VEGETABLE | 10 |
| Average | 4.37 |

Mothers and 2> years children, can not eat nutritional foods like fish, meat, egg, milk as they required. In average 4 days in a month, they can afford these nutritional foods, which are too poor to maintain their physical and mental fitness. Please see the table 3 for details.

15% of the total population equal to 330 are child of 0-<5 years aged. 85% of the children of this age are malnourished. 270 out of 330 (73%) children of this age have been suffering from various diseases. like vision problem (9%), skin disease (9%), breathing trouble (9%), fever and cough (24%), diarrhoea /dysentery (12%) and others (9%). Besides the 0-<5 years babies a reportable portion of others ages male and female also a victim of various diseases. The following data tables show that 42% of the total populations are suffering from diseases. For details please refer the table 4 given bellow:

Table: 4: Health status

| | 0-<5 | 5-<9 | 9-<18 | 18-<45 | 45> | Total |
|---|---|---|---|---|---|---|
| Total Population | 330 | 260 | 380 | 1130 | 100 | 2200 |
| # of Disese Affected | 240 | 120 | 90 | 420 | 60 | 930 |
| % of Disese Affected | 73% | 46% | 24% | 37% | 60% | 42% |
| # of Malnurished | 280 | 60 | 0 | 100 | 0 | 440 |
| % of Malnurished | 85% | 23% | 0% | 9% | 0% | 20% |
| | | | | | | |
| Diseases | 0-<5 | 5-<9 | 9-<18 | 18-<45 | 45> | Total |
| Vision Problem | 9% | 0 | 5% | 10% | 30% | 54% |
| Skin Disease | 9% | 4% | 13% | 4% | 10% | 40% |
| Breathing Trouble | 9% | 4% | 3% | 4% | 0% | 20% |
| Others | 9% | 12% | 0% | 0% | 0% | 21% |
| Fever, cough | 24% | 15% | 3% | 1% | 0% | 43% |
| Diarrhoea/Dysentery | 12% | 11% | 0% | 2% | 0% | 25% |
| Gastric | 0% | 0% | 0% | 16% | 20% | 36% |
| % of Total Patients | 73% | 46% | 24% | 37% | 60% | 42% |

Mostly they suffer from curable and preventable diseases. But the Jheelpar dwellers can not take curative and preventative measures as there are no affordable treatment facilities in the slum like clinic, doctor, health worker, medicine etc. They are always miss guided by ignorance of health care, medicine sellers, poverty and insufficient health care services to take unscientific so-called treatment and medicine without consulting with doctors or going to hospitals, which is also increasing their life risk.

Physical fitness of the poor is essential to work in laborious jobs to survive. The more illness creates fewer work forces as well as less income. Therefore, it is expected that the dwellers of Jheelpar slum should go to doctors, hospitals and to take nutritional foods for fitness.

But truth is that they can not afford theses due to poverty, inadequate health care services, and lack of awareness. Another truth is that they actually have not enough time to go hospital or doctors chambers that are situated at medium and long distances from the slum. Being poor, they usually do not get qualitative consultations and services from the commercial doctors and private hospitals. The government hospitals cannot serve the much people for their limitation of capacity and bureaucratic mindset and systems. So the poor people of Jheelpar are deprived of health care services.

Moreover, 94% babies are born in the slum in unhygienic conditions with the care of unskilled traditional birth attendants. 20% of the newly born babies die within the 2 years of their birth in Jheelpar. The suffering babies and mothers need health care services and nutritional support, the people of Jheelpar who contribute in the development of the community and the country need basic services. But there are no health care services and no arrangements for food security for the suffering people especially the babies and mothers.

One arrangement should immediately be initiated in the slum "Jheelpar" that will provide primary health care services at the doorsteps of the poor in their convenient time with subsidized system. Moreover, food security must be ensured for the babies and mothers of the slum for meeting their requirement of physical and mental fitness.

This proposal for "Primary Health Care and Nutritional Support to Children and Women of Slums" addresses the primary concerns of access to health care and nutritional support. ARBAN has conducted a baseline survey at Jheelpar Slum in March' 2010 prior to preparation of this proposal. The project goal, objective, specific objectives, output, outcomes, approach, activities schedule budget, etc. are described bellow to assist some one who may be interested to contribute for the Primary Health Care and Nutritional Support to Children and Women of Jheelpar Slum.

## Goal:

Poverty reduction through brining the health impact in the lives of the poor slum community.

## Objective:

Improvement of health and nutritional condition of the vulnerable children, women and male of the slum

## Specific Objectives:

- To improve awareness level of the households members of the slum on preventive health measures through campaign, motivation, training and educational sessions.

- To improve curative primary health care services including reproductive, antenatal and postnatal cares for the sick male, female and children of the slum through subsidized medical support with health checkup, medicine, diagnosis and referral services.
- To improve nutritional status of malnourished mothers and children through subsidized supplementary nutritional food support.
- To enhance pro-poor health care support of NGOs, Government, Private sectors and Community people through advocacy and linkage.

## Project Location:

| SL | Country | District | Thana | Ward | Slum name | Total households | Total population |
|---|---|---|---|---|---|---|---|
| 1 | Bangladesh | Dhaka | Pallabi | 6 | Jheelpar | 500 | 2200 |
| Total | 1 | 1 | 1 | 1 | 1 | 500 | 2,200 |

## Targeted Project Beneficiaries:

The project will target the following principal beneficiaries:

- Male, female, adolescent and child of all households to raise awareness on preventive health care, hygiene and health rights.
- Sick people of the population for curative treatment and referral services
- Malnourished child and mother for providing supplementary nutritional support

## Project Targets and Outputs:

***A. 100% households of the slum will get support on preventive health care measures through campaign, motivation, training and educational sessions at the end of the project.***

***B. 42% of the people who are sick (see table 4) will get by monthly subsidized curative primary health care services with health checkup, medicine, diagnosis and referral services according to the following targets:***

| Beneficiaries | Year wise Estimated Targets | | |
|---|---|---|---|
| | 2010 | 2011 | 2012 |
| **Total Population** | 2200 | 2250 | 2300 |
| **% of sick people** | 42% | 22% | 12% |
| **# of sick people** | 924 | 495 | 276 |
| **# of health services by monthly** | 5544 | 2970 | 1656 |

***C. 20% malnourished population (see table 4) will get monthly supplementary nutritional food support according to the following targets:***

| Beneficiaries | Year wise Estimated Targets | | |
|---|---|---|---|
| | 2010 | 2011 | 2012 |
| **Total Population** | 2200 | 2250 | 2300 |
| **% of malnourished people** | 20% | 15% | 10% |
| **# of malnourished people** | 440 | 337.5 | 230 |
| **# of monthly nutritional food support** | 5280 | 4050 | 2760 |

***D. Neighboring upgraded non-slum communities, Dhaka City Corporation, Multinational Pharmaceuticals Company and concerned NGOs will extend theirs support, donations and contributions on the project initiatives through advocacy and linkages at the end of the project.***

## Outcomes:

- Peoples skills and capacity on preventive health care measures will be increased by 75%
- Poor and marginalized Peoples' access to healthcare services will be established by 100%
- Disease incidences and treatment expenditure will be reduced by 30%
- Severe Malnutrition will be reduced by 10%
- Child mortality rate will be reduced
- Households workforce, income and savings will be increased
- Poor peoples' livelihood conditions will be improved

## Implementation Approach:

- ***Preventive health care services:*** keep people apart from disease through improved hygiene practices, balanced food habit and maintaining occupational safety nets is the objective of preventive health care services. Household members' awareness and capacity on preventative measures will be increased and monitored through monthly household visits, quarterly health sessions, and half-yearly health campaigns including Patient identification, after treatment follow-up. Different types of information, education and behavioral change materials will be used. Generally, Health & Hygiene Promotion Officer will do these activities with the guidance of the physician. Besides a group of community health volunteers will be formed, developed and engaged with the above activities considering sustainability issue.

- ***Curative primary health care services:*** To provide treatment to the slum dwellers at their convenient time and places is the objective of this support. A full time appointed doctor will provide this support through a health center established by the project. A health card will be promoted among the households to records of accomplishment of treatment received. No consultation fee will be collected from the slum dwellers. However, medicines and diagnosis support will be provided at subsidized price. At emergency or in case of the most vulnerable people full free support will be provided. Earning from subsidized price will be revolving as project fund for further continuation of this support.

- ***Nutritional food support:*** To fill up the lacks of nutrition as emergency measures is the objective of nutritional food support. Enlisted malnourished children and mothers will get maximum emphasis for this support. There will be a feeding provision of free supplementary nutritional foods at health center accordingly the physician's prescription. Some cases nutritional foods can be distributed at subsidized price from the health center. Every service receiver will have a card to maintain proper information of services received. Earning from subsidized price will be revolving as project fund for further continuation of this support.

- ***Advocacy:*** Mobilizing local funds, services and donations towards the project initiatives is the objective of advocacy service. Meetings, workshops and campaigns will be doing as advocacy works.

## Risks & Undertakings

| Anticipated Risks | Risk Reduction Strategy |
|---|---|
| Community mobilization at marginalized Communities | Rapport building, Participatory methods, Focusing health emergencies will be followed. |
| Sustaining preventive measures | Development of community change agents, involving of community stakeholders, participatory monitoring, and rapid health and hygiene education will be implemented. |
| Slum eviction | Advocacy for rehabilitation of slum dwellers |
| Fund crisis | Continuous initiatives for fund raising |

## Sustainability:

The proposed project will bring positive health impact for the poor and marginalized people of Jheelpar slum. They will maintain themselves the preventative measures for their wellbeing. Their positive impact will motivate others to support them and to replicate such initiatives in other slum. Involvement of ARBAN and foreign donors will be much less after working with the disadvantaged groups for 3 years. The strategy to phase out will be made after collective decisions of the members and leaders of the community as well as beneficiaries. First priority will be given to a governing body to run the health center established by the project. Secondly, ARBAN may run the health center and thirdly the health center may run by both the community and ARBAN and fourthly be handed over to the health department of Dhaka City Corporation.

## Management Arrangements:

Under the supervision of the Chief Executive of ARBAN, the day-to-day management, implementation and monitoring of the project will be undertaken by a Project Coordinator (PC). The PC will work closely with the project implementation staff, Local Government Institutions, Service providers as well as the community to ensure the goal, objectives, outputs and outcomes of the project with a transparent, accountable, efficient and cost effective manner. Transparent procedures will be maintained in all kinds of contracting and procurements of the project. ARBAN's purchase and procurement committee will manage the purchase and procurements of the project according to ARBAN's rules and procedures**.** The project will follow ARBAN's financial guidelines, accounting procedures and systems in maintaining and preparing of account as well as Bangladesh Government's rules and procedures. The project fund will be used under the specific approval of the Bangladesh Government and the public certified Chartered Accountant would audit the books of Expenditures.

## Implementation Staff:

Two part time and three full time staff will implement the project according to the project plan and budget

| SL | Designation | Quantity | Key Responsibilities |
|---|---|---|---|
| 1 | Project Coordinator (Part) | 1 | • Manage the human and financial resources, supervise and monitoring the day-to-day functioning of the Project Team and Prepare Progress Reports of the Project. |
| 2 | Accounts Officer (Part) | 1 | • Accounts keeping, banking and accounts reporting in line of ARBAN's finance management procedures as well as Government rules and conditions. |
| 3 | Physician (Full Time) | 1 | • Provide health and nutritional services to the project beneficiaries by health checkup, consultation and prescription, refer the complex patients to GO, NGOs hospitals and maintain proper linkages. |
| 4 | Health & Hygiene Promotion Officer (Full Time) | 1 | • Assist the physician to take records of the patients, purchasing and collecting of quality medicines and health materials.<br>• Provide health motivation at household and community level to aware the people about health care and facilities. |
| 5 | Caretaker (Full Time) | 1 | • Cleaning and maintaining of office and health center's materials.<br>• Assist in the field with logistics. |
| | ***Total*** | **5** | |

## ARBAN's Capacity:

The Association for realization of Basic Needs-ARBAN, a Non Govt. Development Organization, concerned with fundamental rights and the basic needs of the people, was founded on 18th February 1984. ARBAN believes that all development projects and programmes designed and implemented by the Government, NGOs, International Organizations, UN bodies and others should be directed towards the fulfillment of the basic needs and fundamental rights of the people who live in perpetual poverty, famine, malnutrition, disease, deprivation, indebtedness, injustice and exploitations. ARBAN will dedicate its resources for the empowerment and emancipation of the disadvantaged women, men, adolescents and children by raising their critical consciousness, releasing their creative potentials and building people's organization to improve their socio-economic status-enabling establishment of genuine democracy and good governance. The broad objective of ARBAN is to arouse and advance awareness and awakening of the poor and powerless people on socio-economic, political, human, women and children's rights, health, ecology, environment, peace, democracy, governance, and consumer's issues through dialogical process leading to collective actions for their self-determination.

"Primary health care, water, sanitation, hygiene, ecology, and environmental promotion" forms the core program areas of ARBAN. Guided by the above, ARBAN has been implementing Community-led Primary health care; Child wale fare; Water, Sanitation projects both in rural and urban areas, since 1984.

ARBAN has gathered experience and successfully implemented Primary Health Care project for the poor and disadvantage people from 1999-2002 in the Chittagong and Cox's Bazar district of Bangladesh. Community empowerment for establishment of health rights, community awareness rising on preventive health measures, health checkup and consultation, providing of medicine, nursing and referral services were the major component of the projects. ARBAN has provided healthcare support to the slum dwelling Scholl children under its pre-primary education and vocational training project implemented from 2001 - 2006 in Mirpur of the Dhaka City. From 2007 this support has been expended in Tongi of Gazipur District and Fatulla of Narayangonj District through the Poverty Alleviation through Social Change project.

ARBAN has strong, rich and skilled workforce to implement the tasks outlined in this project proposal. ARBAN has work experience, project offices, training centers and necessary equipments at the proposed working area. "War On Want, U.K.", "Oxfam- America", "Water AID, U.K.", "UNESCO", "CAFOD-UK", "DISVI, Italy", One World Action-UK" and "WaterAid Bangladesh" have provided funds to implement the Primary Health Care, Water, Sanitation and Hygiene Promotion activities both in rural, coastal and urban areas. ARBAN also organizes national and international seminars, symposiums, conferences and workshop consultations covering diverse national, regional & international issues. ARBAN produces, prints, publishes & distributes Education Materials relating to development, Human Rights, Children & Women Rights, Primary Health Care, Ecology & Environment etc.

## Plan of Activities:

Name of the organization : Association for Realisation of Basic Needs - ARBAN
Name of the Project : Primary Health Care and Nutritional Support to Children and Women of Slums
Project Duration: May 2010 - April 2013

| SL | Activity Name | Total units of 3 Years | May 2010 April 2011 | May 2011 April 2012 | May 2012 April 2013 | Remarks |
|---|---|---|---|---|---|---|
| | | | Phase 1 | Phase 2 | Phase 3 | |
| | | 36 months | 12 months | 12 months | 12 months | |
| **1** | **Community Mobilization** | | | | | |
| 1.1 | Health Survey | 1 | 1 | - | - | To identify health status and benchmark |
| 1.2 | Household enrolment under health card | 500 | 500 | - | - | Households enrolment under health support |
| **2** | **Community Capacity Building** | | | | | |
| 2.1 | Health Volunteer Training | 3 | 1 | 1 | 1 | 5 volunteers per training |
| **3** | **Preventive Health Care Services** | | | | | |
| 3.1 | Half yearly health campaign | 6 | 2 | 2 | 2 | In the slum |
| 3.2 | Community group formation | 50 | 50 | - | - | 10 households per group |
| 3.3 | Quarterly health & hygiene session | 600 | 200 | 200 | 200 | 4 sessions per group annually |
| 3.4 | Monthly household visits | 3,600 | 1,200 | 1,200 | 1,200 | 100 households per month |
| **4** | **Curative Primary Health Care Services** | | | | | |
| 4.1 | Establishment of Health Care Center | 1 | 1 | - | - | Adjacent to the slum |
| 4.2 | Patient Check-up and treatment with medicine | 10,170 | 5,544 | 2,970 | 1,656 | By monthly |
| **5** | **Nutritional Food Support** | - | | | | |
| 5.1 | Nutritional food distribution | 12,090 | 5,280 | 4,050 | 2,760 | Monthly |
| **6** | **Advocacy, Learning & Sharing** | - | | | | |
| 6.1 | Yearly Assessment | 3 | 1 | 1 | 1 | To review the impact |
| 6.2 | Stakeholders' Workshop | 3 | 1 | 1 | 1 | For advocacy |

## Summary Budget - EURO

**Summery Budget -EURO**

**Name of the organization :** **Association for Realisation of Basic Needs -ARBAN**
**Name of the Project :** Primary Health Care and Nutritional Support to Children and Women of Slums

**Project Duration:** **May 2010 - April 2013**
**EURO Rate in BDT** **90.00**

| S/L | Project Components / Activities | Year | | | | |
|---|---|---|---|---|---|---|
| | | **May 2010 April 2011** | **May 2011 April 2012** | **May 2012 April 2013** | **Total Budget** | **% of Budget Allocation** |
| | | Phase 1 | Phase 2 | Phase 3 | 3 Phases | |
| | | 12 months | 12 months | 12 months | 3 YEAR | |
| | | EURO | EURO | EURO | EURO | |
| **i. Foreign Funding Budget** | | | | | | |
| A. | Project Operational Cost: | 29,793 | 23,260 | 21,161 | **74,214** | 92% |
| B. | Project Management Cost | 2,070 | 2,277 | 2,505 | **6,853** | 8% |
| | | | | | - | |
| **GRAND TOTAL (Foreign Funding Budget) - A** | | **31,864** | **25,537** | **23,666** | **81,067** | 100% |
| | | | | | | |
| **ii. Local Contribution** | | | | | | |
| A. | ARBAN Contribution | 3,189 | - | - | **3,189** | |
| B. | Community Contribution | 601 | 390 | 245 | **1,237** | |
| | | | | | | |
| | **TOTAL PROJECT BUDGET (i+ii)** | **35,654** | **25,927** | **23,912** | **85,493** | |