 **OPTIMAL HEALTH**

**For**

**Mother and Child**

**Of**

**PROJECT LOCATIONS in MUZAFFARPUR DISTRICT**



Submitted to

**GLOBAL GIVING**

Submitted by:

**NARI NIDHI**

Plot No- 11, Laxmi Niwas, Panchvati Colony, Majhoulia Khetal, Muzaffarpur 843146

**Mob: 9430013517, 8651183313**

**E-mail:** **narinidhi.muz@gmail.com****, narinidhi\_mzp@rediffmail.com**

To,

The Global Giving Team

**Subject**: Submission of Project Proposal for Optimal Health for Mother and Child

**(AAROGYA PROJECT)**

Dear Sir,

We, on behalf of the Nari Nidhi, would like to submit the enclosed project proposal for entitled as above for your kind consideration and necessary action.

Ours is a non-political, non-profitable & secular voluntary organization working in the field of awareness, health, education, training and skill development, women and child welfare activities etc. in Bihar for SC/ST/OBC Women and Child, other backward and under privileged people for their upliftment above the poverty line and to ameliorate their standard of social, health and economic lives.

It will be highly appreciated if the concerned authorities be kind enough to provide suitable arrangements for implementing this project by our N.G.O. so that we can cover more and more population.

Hope you would be kind enough to give due consideration of above facts and do the needful at your earliest for implementing the project.

Thanking you

Yours Faithfully

Rajesh Choudhary

Program Manager

Nari Nidhi

Mob: 91 8651183313

## About the applicant:

|  |  |
| --- | --- |
| Name of Proposed Project  | OPTIMAL HEALTH for Mother & Child of PROJECT in Muzaffarpur district, Bihar |
| State | Bihar |
| District | Muzaffarppur |
| Project Location | 05 Urban Slums and 05 Rural peripheries of Muzaffarpur district |
| Project Duration | 36 months |
| Grant Amount Requested | 4526000.00 (Forty Five Lakh Twenty Six Thousand Rupees) (INR) |

NARI NIDHI is a National, Humanitarian Women Centered Development Organization without Religious, Political or Governmental Affiliations presently working in 32 villages and 06 urban project locations under 2 blocks of 2 districts (Jehanabad and Muzaffarpur) of Bihar State through 2 branch offices with integration of different.. Social, Educational, Economical and Community development are the basic foundation of the Organization.

The organizations have worked previously in five district of Bihar states on Health, Education, child protection, female feticide, and women empowerment sectors. Organization has all ready completed the previous project “DISHA” and “Optimal Health for Mother and Child” supported By The Hans Foundation, RCH project supported by Geneva Global, USA, women empowerment supported by Women Power connect. Sex and sexuality supported by CREA Delhi.

**ORGANIZATIONAL PROFILE NARI NIDHI**

|  |  |
| --- | --- |
| **Registered Office Address** | NARI NIDHI |
| AT | Ram Pratap Bhawan |
| Village | North of Kathpool, Mandiri |
| PO | GPO Patna |
| District | Patna |
| State | Bihar |
| PIN Code | 800001 |
| Email | Narinidhi\_mzp@rediffmail.com narinidhi.muz@gmail.com  |
| **Administrative Office Address** | Village | Plot No- 11, Laxmi Niwas, Panchvati Colony, Majhoulia Khetal |
| P.O. | Khabra |
| District | Muzaffarpur |
| PIN Code | 843146 |
| State | Bihar |
| Mobile No. | 91- 9430013517, 8651183313 |
| Email | Narinidhi\_mzp@rediffmail.com narinidhi.muz@gmail.com  |
| **SECRETARY** | Mrs. Asha ChoudharySecretaryContact Mobile No. 91- 9430013517Email- narinidhi\_mzp@rediffmail.com narinidhi.muz@gmail.com |

**Legal Status**

|  |  |  |  |
| --- | --- | --- | --- |
| S.No. | Particulars | Registration No. | Date |
| 1 | Registered under Societies Registration Act XXI,1860 | 826 | 30.03.1993 |
| 2 | Registration under Foreign Contribution(Regulation) Act, 1976 | 031170200  | 15.05.2001 |
| 3 | Income Tax & Other Registration |  |  |
| Under Section 12A | 84/2007-08,2100-03 | 14.12.2007 |
| Under Section 80G | 804/07-08,2104-07 | 14.12.2007 |
| Permanent Account No. (PAN) | AAATN6641A  |  |
| Tax Deduction Account No. (TAN)  | PTNN01178C |  |
| 4 | Registration No. of NITI AAYOG NGOPortal Unique ID | BR/2016/0097008 |  |
| **Goal** | All our efforts will enhance the capabilities of vulnerable people, especially women and children, to better control their lives. |
| **Vision** | We see a world where vulnerable people live a better life in a better community. NARI NIDHI commits to this by being an innovator in development, valued by all. |
| **Mission** | Nari Nidhi’s mission is to serve “Vulnerable individuals and families to achieve sustainable improvements in their livelihood, education, health and sanitation status”. We pursue our mission with both excellence and compassion because the people whom we serve deserve nothing less. |

**Composition of Governing Body:**

|  |  |  |  |
| --- | --- | --- | --- |
| S.N. | NAME | DESIGNATION | ADDRESS |
| 1 | Anupama Kumari | President | D/o Sri Lalan panday, Vill- Manganpur, post- Goroul, Dist - Vaishali, Mob:9304332605 |
| 2 | Asha Choudhary | Secretary | D/o Late D.P Sharma, Vill- Aropur,post- Rupouli, Dist -Muzaffarpur, Mob:9430013517 |
| 3 | Ganesh Prasad Singh  | Treasurer | S/O Late Sia Prasad Singh. Executive secretary, Adithi, Bailey Road Patna – 800014  |
| 4 | Manorama devi | Member | W/o Ripusudhan Sahi, Vill- Hariharpur, Dist- Muzaffarppur |
| 5 | Maya devi | Member | W/o Late Munshi Prasad, Vill- Hariharpur, Dist- Muzaffarppur |
| 6 | Panvati devi | Member | W/o Lalan Ram, Vill- Raghunathpur, Dist-Muzaffarpur. |
| 7 | Chandravati Devi | Member | W/o Bindeshwari patwa, Vill – Sahebganj, Dist – Muzaffarpur. |

**A Brief Introduction of Nari Nidhi**

NARI NIDHI, which literally means “women wealth/fund”, is a National, Humanitarian Women Centered Development Organization without Religious, Political or Governmental Affiliations. Social, Educational, Economical and Community development are the basic foundation of the Organization mostly in Bihar.

Nari Nidhi has stemmed from a pilot project launched by its mother organization-ADITHI in 1990, with assistance from FORD FOUNDATION, started a group link fund for giving small production loans to needy rural women of Bihar. The result was encouraging with 100% recovery and soon demand from other areas started coming. Strategic Review in the same year i.e. 1990, recommended expansion of the programme considering its potentiality vis-à-vis improving credit access of rural women. With the support from FES (Freidrich Ebert Stiftung) a separate fund of Rs.8.44 lakhs was created, which was named Nari Nidhi meaning “women’s fund”. The programme was gradually expanded to more and more districts of Bihar as Sitamarhi, Madhubani, and Muzaffarpur. In this phase the element of saving was compulsory. Financial support also came from NABARD in the term of Rs. 10 lakhs carrying an interest of 9% per annum and from SIDBI- Rs. 5 lakh carrying an interest of 9% per annum. RMK (Rastriya Mahila Kosh), department of Rural Development, Govt. of India and SIDBI provided support for administrative expenses and FES provided training fund. Nari Nidhi organizes training and exposure trips for the women vendors, vegetable and fish sellers and other hawker groups in other parts of the country. The experience of loan- repayment is very remarkable and for most of the phases the average return is more than 90%.

In 1993 this beautiful experiment benefiting, by the time, thousand of rural resource-poor women, was registered as a separate organization as NARI NIDHI.

Since establishment, it is working with the marginalized, the destitute and the deprived communities mainstreaming them with development, upbringing their survival, growth, health status, education, leadership skill, entrepreneurship and sustainable livelihood options.

**OBJECTIVES:**

* To organize, develop capabilities and train rural women through their own organization;
* To set up new type of women and community based organization of women, for women;
* To provide support to all rural women in economical, social, health and educational sectors at the grassroots level;
* Supporting the implementation of their programmes;
* To enable rural women to have self confidence and status in their communities;
* To improve their position in society through economic activities;
* To support rural women to get assets and development resources;
* To improve rural women’s individual and group leadership and decision-making

## Honor: Awards and recognition

* Nari Nidhi is member of AIDS Care Watch Campaign.
* Nari Nidhi is member of NASVI, New Delhi (National level)
* Nari Nidhi is member if NASVI, Patna, Bihar(State level)
* Nari Nidhi is accredited member of Bihar Forces
* Nari Nidhi is listed on Sir Dorabji Tata Trust
* Nari Nidhi is listed on Planning Commission of India
* Nari Nidhi is listed on AISF, Australia

***Our Resources-***

* Own Office set up at all places
* Mobile Health UNIT FORCE Traveler AC III Vehicle
* Oxygen cylinder
* BP Instruments
* Stethoscope
* Gluco meter
* ECG Machine
* Hemoglobin Meter
* Weight Machine
* LED TV
* Computers
* Scanner, Printer
* Xerox machine
* Vehicles- Four wheelers, two wheelers
* Furniture’s
* Generator
* Training hall
* LCD, OHP, Slide projector
* Digital camera etc.

## Annual Income in last three years

|  |  |  |
| --- | --- | --- |
| **2012-2013** | **2013-2014** | **2014-2015** |
| 3402810.00 | 2178980.00 | 8711050.00 |

**Project undertaken by Nari Nidhi in last five years with quantum of funding and name of donors.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of project** | **Quantum of funding** | **Name of donors** | **Results** |
| Polio eradication initiative and routine immunization | 1200000 | Project concern international, USA | More than 100000 children vaccinated with oral polio drop and fully immunized with routine immunization |
| Polio eradication awareness generation program. | 1800000 | Unicef, Patna, Bihar | More than 300000 children vaccinated with oral polio drop  |
| Swayamsiddha  | 2400000 | WDC Patna | 120 SHG formed and functional and involved in income generating activities |
| DEEP project | 650000 | WDC Patna | 120 SHG formed and functional and involved in income generating activities |
| Female feticide (KOPAL) | 365000 | Plan International through Adithi | Raised knowledge of community members in project area and vicinity on the harmful effects of female feticide and infanticide.Raise awareness of communities on benefits of birth registrations.Raise birth registration coverage in the project area and its Reliability. To set up a proper institutional mechanism for proper enforcement of PCPNDT. Decrease in the cases of female infanticide and feticide |
| RCH program | 435000 | State health society | Strengthened the public health service delivery system through consistent availability and improved quality of care in FP & RCH services throughout the district.  |
| SGSY Project | 540000 | DRDA Muzaffarpur | 120 SHG formed and functional and involved in income generating activities |
| SGSY | 1000000 | DRDA Siwan | 120 SHG formed and functional and involved in income generating activities |
| Basic Health initiative | 1838579 | Geneva Global, USA | Direct access to health care services and their health status improvedChange in attitude and behavior of the girls for well being of self, family and communityChange in attitude and behavior of the girls for well being of self, family and communityASHA, Traditional Birth attendants and RMPs educated about the reproductive and child health issues to enable them to influence their clients on safe delivery, immunization, contraception, child care and social issues which affect health of women and children and give quality services to clients |
| Elimination of Female feticide | 270000 | Women Power Connect | Raised knowledge of community members in project area and vicinity on the harmful effects of female foeticide and infanticide.Raise awareness of communities on benefits of birth registrations.Raise birth registration coverage in the project area and its replicability. To set up a proper institutional mechanism for proper enforcement of PCPNDT. Decrease in the cases of female infanticide and feticide |
| Ongoing micro finance program | 1281000 | NABARD, RMK and own fund | More than 500 hundred SHGs benefited by thrift & credit. SHG federation established and functional |
| Adolescent reproductive and sexual health right project | 800000 | CREA, New Delhi | 50 group of adolescent girls formed and practicing safe and hygienic behavior  |
| Remedial education program | 672000 | The Hans Foundation, New Delhi | 165 Children enrolled in primary schools159 children are advancing from lower to upper grades500 children participated in exposure visit |
| Ongoing Remedial education Project | 1948 | Rural India Supporting Trust, USA  | 180 Children get enrolled back in mainstream schools35 children got disability assistive devices42 disable children participating in disability rehabilitation prog |
| Optimal Health for Mother & Child | 5701050 | The Hans Foundation, New Delhi | Formation of Mahila Arogya Samiti (MAS) Review meeting of CHWs and MAS volunteerHome visit/Individual Counseling and follow up are ongoing continuously Staff Training has completed organizing 160 health check up camps in all the 10 project area for community women and children with the help of health official Undertaking orientation program of eligible couples & also adolescents for familiarizing the availability & use of different family planning methodExtending support to local health govt. facilities for conduction of regular immunization camp, supporting some cost to undertake immunization camp in the most in accessible areas. Demonstration of complementary food at field level |
| Quality basic education for children of special needs (Disha Project) | 1707500 | The Hans Foundation, New Delhi | 245 Children enrolled in primary schools259 children are advancing from lower to upper grades500 children participated in exposure visit180 Children get enrolled back in mainstream schools35 children got disability assistive devices42 disable children participating in disability rehabilitation prog |
| Advancing Sexual and Reproductive health and Rights of Adolescent Girls Through Sports. | 379125.00 | CREA, New Delhi | Nari Nidhi has formed 15 Kishor/Kishori mandal (Adolescent/Youths club) as a peer educator to spread awareness and knowledge of community people and out of school youths regarding health and hygiene and best practices of health care and life skill education. |

**Nari Nidhi’s best practices and experiences in the field of health interventions.**

In Bihar Nari Nidhi has given visibility to the invisible illegal women’s livelihood in large numbers by promoting alternatives in the following constituencies: sharecroppers, traditional craftswomen fisherwomen, women, adolescent girls and girl’s children and women engaged in saving and credit and street vendors and home based workers.

* + We were first to work with adolescent girls. We have developed programmes in “healthy communities”, reproductive and child health, Adolescent reproductive and sexual health and doorstep education for adolescent girls, barefoot marketers and highlighted issues like female feticide/infanticide.
	+ We were first to start the concept of Balika Kishori Chetna Kendra (BKCK) to provide life skill education to adolescent girls and boys, which has in several cases resulted in raising the age of marriage, weddings without dowry etc.
	+ We have developed modules on reproductive and child health and adolescent reproductive and sexual health and for rural adolescents, which has been proved very useful for the social activists working at grassroots.
	+ Nari Nidhi has been recognized by ministry of health and family welfare, Govt. of India and has been given support for the reproductive and child health (RCH) programme.
	+ Nari Nidhi has done massive campaign on polio eradication initiative in three district of Bihar with the support of UNICEF, WHO, DISTRICT HEALTH DEPARTMENT, project concern international.
	+ Nari Nidhi has done a study on “situational analysis of Universal birth registration and Child labor.
	+ We are working with 500 adolescent girls and boys on family life education and prevention of HIV/AIDS.
	+ Nari Nidhi has implemented RCH programme in one district namely Jehanabad.
	+ We are also implementing RCH and prevention of HIV/AIDS activities through our SHGs members and our well skilled project staffs in five district of Bihar namely Patna, Jehanabad, Siwan, Muzaffarpur and Samastipur.
	+ We have also recognized and supported by various foreign donors like Project concern international, plan international and Geneva global and The Hans Foundation in the field of health domain like RCH, ARSH, PERSONAL HYGIENE, RUITINE IMMUNIZATION, POLIO ERADICATION, CSSM and HIV/AIDS etc.
	+ Nari Nidhi staffs has participated in various seminars Meetings, Workshops and training programme organized by national and international development institutions.
	+ Nari Nidhi has formed 15 Kishor/Kishori mandal (Adolescent/Youths club) as a peer educator to spread awareness and knowledge of community people and out of school youths regarding health and hygiene and best practices of health care and life skill education.

**Organogram**

**GOVERNING COUNSIL**

 **MANAGING COMMITTEE**

 **SECRETARY**

**CORE COMMITTEE MEMBER/RESOURCE PERSONS**

**PROJECT IN CHARGE /**Manager **CHIEF ACCOUNTANT**

**PROGRAMME CO-ORDINATORs ACCOUNTANTS**

**ASSITANT PROGRAMME CO-ORDINATORs**

Supervisors Sahayak/Sahayikas

 Other Field Staff & Volunteers

## Project proposal:

## Organization’s capacity to implement health/education/livelihood etc. based projects:

## NARI NIDHI has well experienced health expert team in the field of RCH/MCH/HIV/Aids. Organization has worked in Health sectors with joint collaboration of Project Concern International, UNICEF, Geneva Global, The Hans Foundation and WHO for routine immunization, polio eradication and RCH Issues.

## Rationale:

**Major Findings of Targeted Project Communities:**

|  |
| --- |
| **Project location Indicators, Muzaffarpur** |
| **Indicators**  | **Finding project location** |
| Population (in thousands)  | **32500** |
| Decadal Growth Rate  | **26.7** |
| Sex Ratio\*  | **928** |
| Percent Urban population  | **45** |
| Percent SC population  | **60** |
| Percent ST population  | **0.0** |
| Percent Muslim population | **17** |
| Female Literacy Rate (7 years and above)  | **29.0** |
| Male Literacy Rate (7 years and above)  | **50.0** |
| **Sample outcome**  |  |
| **Category** |  |
| Households  | 1500 |
| Ever Married Women (15-49 years)  | 2731 |
| Adolescent girls (11-19 years)  | 533 |
| Men surveyed | 375 |
| Sub Centers (SC)  | 04 |
| Primary Health Centers (P H C)  | 01 |
| Community Health Centers (C H C)  | 00 |
| District Hospital (D H)  | 01 |
| **Population and Household Characteristics** |  |
| **Background Characteristics**  |  |
| Percent total literate Population (Age 7 +)  | 45 |
| Percent literate Male Population (Age 7 +)  | 50.0 |
| Percent literate Female Population (Age 7 +)  | 29.0 |
| Percent girls (age 6-11) attending Schools  | 61.0 |
| Percent boys (age 6-11) attending Schools  | 72.0 |
| Have Electricity connection (%)  | 20.0 |
| Have Access to toilet facility (%)  | 15.0 |
| Use piped drinking water (%)  | 8.7 |
| Use LPG for cooking (%)  | 5.0 |
| Live in a Pucca house (%)  | 15 |
| Own a house (%)  | 55.0 |
| Have a BPL card (%)  | 60.0 |
| Own Agriculture Land (%)  | 10.0 |
| Have a television (%)  | 55.0 |
| Have a mobile phone (%)  | 60.03 |
| Have a Motorized Vehicle (%)  | 2.5 |
| **Standard of Living Index**  |  |
| Low (%)  | 85.0 |
| Medium (%)  | 10.0 |
| High (%)  | 5.0 |
| **Marriage and Fertility**  |  |
| Percentage of girl's marrying before completing 18 years  | 41.7 |
| Percentage of Births of Order 3 and above  | 50.5 |
| Sex Ratio at birth  | 94.0 |
| Percentage of women age 20-24 reporting birth of order 2 & above  | 56.4 |
| Percentage of births to women during age 15-19 out of total births  | 19.6 |
| **Family planning (Married women, age 15-49)**  |  |
| Any Method (%)  | 15.0 |
| Any Modern method (%)  | 15.0 |
| Female Sterilization (%)  | 21.5 |
| Male Sterilization (%)  | 1.0 |
| IUD (%)  | 1.0 |
| Pill (%)  | 0.0 |
| Condom (%)  | 23.0 |
| Total unmet need (%)  | 25.0 |
| For spacing (%)  | 5.5 |
| For limiting (%)  | 14.2 |
| **Maternal Health:**  |  |
| Mothers registered in the first trimester when they were pregnant with last live birth/still birth (%)  | 18.0 |
| Mothers who had at least 3 Ante-Natal care visits during the last pregnancy (%)  | 17.5 |
| Mothers who got at least one TT injection when they were pregnant with their last live birth / still birth (%)# | 44.9 |
| Institutional births (%)  | 19.0 |
| Delivery at home assisted by a doctor/nurse /LHV/ANM (%)  | 3.0 |
| Mothers who received post natal care within 48 hours of delivery of their last child (%)  | 20.0 |
| **Child Immunization and Vitamin A supplementation**  |  |
| Children (12-23 months) fully immunized (BCG, 3 doses each of DPT, and Polio and Measles) (%)  | 44.0 |
| Children (12-23 months) who have received BCG (%)  | 58.0 |
| Children (12-23 months) who have received 3 doses of Polio Vaccine (%)  | 65.8 |
| Children (12-23 months) who have received 3 doses of DPT Vaccine (%)  | 44.9 |
| Children (12-23 months) who have received Measles Vaccine (%)  | 37.6 |
| Children (9-35 months) who have received at least one dose of Vitamin A (%)  | 50.8 |
| Children (above 21 months) who have received three doses of Vitamin A (%)  | 1.7 |
| **Treatment of childhood diseases**  |  |
| Children with Diarrhoea in the last two weeks who received ORS (%)  | 17.8 |
| Children with Diarrhoea in the last two weeks who were given treatment (%)  | 71.2 |
| Children with acute respiratory infection/fever in the last two weeks who were given treatment (%)  | 55.4 |
| Children had check-up within 24 hours after delivery (based on last live birth) (%)  | 28.1 |
| Children had check-up within 10 days after delivery (based on last live birth) (%)  | 28.1 |
| **Child feeding practices (Children under 3 years)**  |  |
| Children breastfed within one hour of birth (%)  | 15.5 |
| Children (age 6 months above) exclusively breastfed (%)  | 4.2 |
| Children (6-24 months) who received solid or semisolid food and still being breastfed (%).  | 81.2 |
| **Knowledge of HIV/AIDS and RTI/STI among Ever married Women (age 15-49)**  |  |
| Women heard of HIV/AIDS (%)  | 25.3 |
| Women who knew that consistent condom use can reduce the chances of getting HIV/AIDS (%)  | 25.3 |
| Women having correct knowledge of HIV/ AIDS (%)  | 20.5 |
| Women underwent test for detecting HIV/ AIDS (%)  | 1.6 |
| Women heard of RTI/STI (%)  | 31.0 |
| **Knowledge of HIV/AIDS among Adolescent girls(age 11-19)**  |  |
| Adolescent heard of HIV/AIDS (%)  | 46.2 |
| Adolescent who knew that consistent condom use can reduce the chances of getting HIV/AIDS (%)  | 29.5 |
| Women having correct knowledge of HIV/ AIDS (%)  | 20.0 |
| Women underwent test for detecting HIV/ AIDS (%)  | 0.0 |
| Women heard of RTI/STI (%)  | 25.0 |
| **Women facilitated/motivated by ASHA for**  |  |
| Ante-natal Care (%)  | 1.5 |
| Delivery at Health Facility (%)  | 4.3 |
| Use of Family Planning Methods (%)  | 3.5 |
| Villages that have implemented Janani Suraksha Yojana (JSY)  | 00 |
| Villages with Health & Sanitation Committee  | 00 |
| Villages with Rogi Kalyan Samiti (RKS)  | 00 |
| Villages where PRI aware of untied fund by Government  | 00 |
| Health facility within village-ICDS (Anganwadi)  | 06 |
| If health facility is not in the village, whether accessible to the nearest health facility throughout the year-ICDS (Anganwadi)  | 00 |
| Health facility within village- Sub-Centre  | 03 |
| If health facility is not in the village, whether accessible to the nearest health facility throughout the year-Sub-Centre  | 00 |
| Health facility within village- PHC  | 00 |
| If health facility is not in the village, whether accessible to the nearest health facility throughout the year-PHC  | 01 |
| Health facility within village- Block PHC  | 00 |
| If health facility is not in the village, whether accessible to the nearest health facility throughout the year-Block PHC  | 01 |
| Health facility within village- Govt. Dispensary  | 00 |
| If health facility is not in the village, whether accessible to the nearest health facility throughout the year-Government. Dispensary  | 01 |
| Health facility within village- Private Clinic  | 00 |
| If health facility is not in the village, whether accessible to the nearest health facility throughout the year-Private Clinic  | 03 |
| Health facility within village- AYUSH Health Facility  | 00 |
| If health facility is not in the village, whether accessible to the nearest health facility throughout the year-AYUSH Health Facility  | 01 |

## Summary of the project:

The comprehensive community health program for mother and child will provide primary health care services to a population of 10 project locations of Muzaffarpur district. The project includes traditional Birth Attendant (Dai), ASHA, TBA, MAMTA, PRI, ANM, RMP, CHW and Community Organizer at the village level, Public Health supervisor and Nutritionist-cum-Health Educator at Middle level and supervisory technical staff providing support to field staff. The focus of the project is on health service, family planning, mother and child Health, Immunization, low cost nutrition, food preparation and Oral Re-hydration. This project will develop an innovation system of Training, Reporting and Monitoring. Reporting system will be formulated by the CHW/community organizer and supervisory staff, which indicate the projects consistent emphasis on participative training and development.

**Profile of the project area:**

We want to start this intervention in 10 project locations of Muzaffarpur district where illiteracy is rampant, superstition is supreme and poverty in the accepted fact of their daily livelihood. As per census about 37585 people live in these project locations out of which 22551 are scheduled casts, 12926 are backward cast and 2108 are Muslim minority. They depend only on one 16 bedded primary Health center. In a total of 10 project locations 95% of the people depend on daily wage laborer. It has been seen that most of the community do not have Supply water and which are sunk previously are not working since long back. Naturally most of the community dwellers depend on Tube well water, which is highly polluted. In Project locations where we are working all peoples prefer open field or Maidan excretion. There is a great need of low cost sanitary latrine to reduce the case of health hazards like malnutrition and dehydration etc. Due to inadequate communicative have to depend on quack. One or two TBAs to look after one community. As per our diagnosis through in depth interview, observation and group discussions it has been seen that the Health Delivery system is not at all adequate enough and due to various socio-economic reasons 80% people cannot migrate from the community. So for any chronic or severe disease they have to depend solely on quack and untrained TBAs, naturally the maternal mortality, child mortality and morbidity, dehydration and malnutrition rate is increasing day after day. The family size is 5-8 on an average in our adopted project locations. The people are ignorant about family welfare. The percentage of literacy among women and girls of lower middle classes is having education of primary standard. So any intervention with mobile health delivery system and with referral services in case of high-risk pregnancies and children will help those community peoples to equip themselves for the betterment of their standard of health and hygienic condition.

**Size of the problems:**

Due to lack of knowledge, information and orientation in health and hygiene the grass root level peoples cannot understand the need of immunization, importance of growth monitoring, technique of low cost nutritious food preparation, different methods of birth control, spacing between two children, importance using sanitary or pit type latrine, preparation of safe drinking water, maintenance of personal hygiene and disposal of waste products from the home and practices to maintain good health. In fact sound health deteriorates herewith the increase of superstition and wrong method of treatment. So the incidence of maternal mortality, child mortality, morbidity, dehydration and malnutrition rate and other infectious diseases are quite high as per our community diagnosis. The existing TBAs/ASHAs are not qualified so they cannot diagnosis in the case of high-risk pregnancies properly. The quacks are not trained. They depend on limited indigenous knowledge. The diversity and multiplicity of the problem can be decreased with some comprehensive program in this matter. At the time of feeling pain, they have to take to distant primary Health center but on the way the pregnant women face great problem. Sometime the pregnant women are compelled to give birth their children under the open sky. A child has been born on the road and that is why the child has been named as ‘Pathik’ (in English it is called 'street'). A child has been born in the cornfield and the child has been named as ‘Banamali’ (in English it is called ‘Bush’). When they come to the health center of Government, there is no adequate arrangement for delivery and treatment. So most of the severe patients have to go to district hospital and Patna but some of them die in the street.

**Project-design/strategy:**

At the grass root level: At this level we have to formed Community Organizations as cluster of project locations/Mahila Samiti/Adolescent group in 10 project locations of Muzaffarpur district. The community organizer will preliminarily detect the high-risk mother and children through home visit and person-to-person communication method and she will also conduct group discussion to identify the rural need of the community people. This grass root level organization will help us to form an institutional base and for better participation in any program implementation. The community organizer will also help the community level TBAs/ASHAs and people to make them conscious about the importance of birth control through different methods, immunization, regular health check up for pregnant mother and children up to 0-6 years of age, to diagnosis the high risk pregnant mothers and children prevention of epidemic diseases, oral re-hydration therapy. They will arouse general health consciousness amongst housewives, school students and youth clubs members. We will also arrange for mothers meeting, baby show, immunization camp and mother and child health on a regular basis. We can ensure for strengthening our existing resources to work with TBAs/ASHAs and community organizer for successful implementation of the program of the grass root level.

**Intermediate Level:**

At this level Health post will be conducted by Health supervisor, ANMs and physician (M.B.B.S) through Mobile Clinic basis at our adopted 10 project locations. The community people including women, adolescent and children will assemble at the health post at community level. They will consult with the doctor. The doctor will make them aware through treatment, advice, lecture, showing, chart poster, health seminar etc. The high risk mother and children will be attended to by the Mobile unit and referral service will be rendered to relevant mother and children at PHC/District/State level Hospital and on the basis of the severity of the patients they will be referred central or private level hospital. At this stage we will follow a scientific management information system for quick decision-making and to take up appropriate treatment for the poorest of the poor mother and children. At this stage all information will come to the physician through community organizer(s) for quick action and referral services to reduce maternal mortality, child mortality and morbidity malnutrition and re-hydration rate. This system will be followed from the inception of the program. The Mobile unit will also arrange camp from time to time for better coverage and will monitor the activities of TBAs and community organizers.

 **Central Level/Referral services:**

At this level under the leadership of a Doctor, ANM and Health supervisor all the activities of the project will be monitored and corrective measure will be taken from time to time for effectiveness of the program and for better outcome to achieve our ultimate goal Health and education for all and economic self reliance amongst women folk in our target group in project locations. The high-risk mothers and children will be treated in district/state Hospital Campus for safe delivery and good health for children and mothers. At this stage referral services will be given to mother and children during emergency. To ensure whether we are proceeding as per plan and scheduled we will form an impact Evaluation Team. It will look into outcome of the program and its effectiveness and suggest corrective measures.

## PROJECT TITLE:

## “OPTIMAL HEALTH FOR MOTHER AND CHILD” (AAROGYA)

**TARGET GROUP(S) OF THE PROJECT**:

1. Women of reproductive period
2. Lactating Mothers (15-49 Age groups)
3. Adolescents (12-19 Age groups)
4. Children (0-6 years)

**GEOGRAPHICAL AREA FOR EXECUTION OF PROJECT:**

## PROJECT LOCATION: 05 urban slums and 05 Rural Peripheries of Muzaffarpur district.

|  |  |  |  |
| --- | --- | --- | --- |
| **S. No** | **Name of Location** | **Total Population** | **KM Calculation** |
| 1 | Dumari Village  | 2763 | 24 |
| 2 | Jheel Nagar(Akharaghat) slum | 3370 | 48 |
| 3 | Sikandarpur slum (East& West) | 2120 | 40 |
| 4 | Jogiya math slum | 3574 | 40 |
| 5 | Barmatpur khabra village | 2250 | 40 |
| 6 | Gandhi Kustha Aashram Motipur  | 758 | 100 |
| 7 | Sherpur village | 6509 | 48 |
| 8 | Majhaulia village/slum | 5821 | 15 |
| 9 | Chakbaso village | 5032 | 40 |
| 10 | Susta village | 5388 | 60 |
|  | **Total** | **37585** | **455km** |

 **TARGET GROUP (DIRECT AND INDIRECT BENEFICIARIES)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Direct:** | **Number** | **Indirect** | **Number** |
| Women | 10585 | Community member | 21160 |
| Adolescent girl | 2500 | TBAs and Rural Medical Practitioners Accredited Social Health Activists (ASHA) | 175 |
| Children between (0-5) | 3500 | Panchayati Raj Institution (PRIs) members  | 250 |
| **TOTAL** | **16000** |  | **21585** |

**Goal:**

Enhancement of Mother and Child health though promoting better health services, training to traditional birth attendants and building capacity of community based health workers in 10 project locations communities of Mushari Block under Muzaffarpur District of Bihar State in India.

The Hans Foundation grant will enable Nari Nidhi (English translation: Women’s wealth) to increase immunization coverage for children under 6 and pregnant mothers, Adolescents and Women of reproductive period (15-44 years)improve their nutrition status; create access to safe drinking water; capacitate traditional birth attendants; strengthen community self help groups and their cluster, including their collaboration and assist them interface with local government health, education and social welfare personnel.

**OBJECTIVES OF THIS PROJECT**:

* The programme seeks to improve the health status of women and children through improved access and quality Reproductive and Child Health services with focused attention to the most vulnerable sections of the society.
* To promote the Positive health seeking behaviour among community particularly in the age group of 15-49 yrs.
* To improve the status of Ante Natal Check-ups , Post Natal Check-ups and promote institutional deliveries amongst target group
* To treat 16000 patients in 10 Project locations of Muzaffarpur district who have limited access to health services
* To form and educate 15 Adolescent girls/boys groups
* To educate approx 2500 adolescent girls and boys through Family Life education in Middle and secondary schools in project areas

**The process objectives are:**

1. To improve maternal health by enabling women to access knowledge and quality health service
2. To increase access to information and capacity building to exhibit responsive health seeking behavior and system strengthen mechanism for sexual and reproductive health.
3. To provide affordable, high quality health care through effective partnerships at the village level
4. To generate awareness about disastrous demographic and social consequences of pre birth elimination of females.
5. To know the community's perception responsible for IMR/MMR.
6. Birth and death registration
7. Making pregnancy a safe and happy event in the life of a mother in project locations

**The impact objectives are:**

* 1. Improve maternal health by enabling women to access knowledge and quality health services.
	2. Children, families and communities can exercise their right to attain and maintain an optimal health status, based on appropriate Knowledge and services.
	3. To reduce maternal mortality and morbidity
	4. To reduce child mortality and morbidity in children under 5 years

**Milestone/Outcomes/Results indicators:**

1. 9585 women experience better health and access healthcare services as evidenced by:

* 70% of pregnant women get tetanus injections and iron folic acid tablets
* 65% of the target women deliver in a hospital settings
* 17% decrease in mother mortality rate

2. 2500 adolescent girls gain knowledge about adolescent and reproductive and sexual health and life skills as evidence by:

* 45% decrease in cases of anemic adolescence
* 100 girls start earnings money and become economically independent
* 45% decrease in early marriage
* 20% newly married girls are able to postponed the birth of their first child

3. 4500 children, ages 0-6 receive full immunization and proper nutrition resulting in enhanced health and decrease infant mortality rates as evidence by record shoeing

* 95% increase in total immunization
* 40% decrease in IMR
* 45% DECREASE IN respiratory infectious disease and diarrhea
* 35% decrease in the cases of pneumonia

4. 21160 community people learn about health hygiene, birth spacing and family well being as evidence by:

* 1000 Community people promoting 10 slum development committees for development advocacy and planning
* 20000 community people learn about RCH and cooperate with their partners and other females
* 56% increased by in institutional health services
* Behavioral changes that reflect and understanding of RCH
* Commitment to safe sex and behaviors
* Interfacing with government agencies to create access to safe drinking water and proper sanitation
* Mortality rate reduced to 60 percent of the present level.

5. 175 traditional birth attendants learn safe delivery method and receive safe birth kit that are used to educate women and the community about reproductive and child health issues as evidence by:

* 50%crease in deliveries attended by TBAs
* Influence exerted on institutions for increased pre and post natal care for mothers
* 95% of children younger than 5 receive full immunizations
* 100% newborns breastfed within one hour of birth
* 100% infants exclusively breastfed up to 6 months

6. 240 local government employees learn about public health and reproductive health issues and commit to promoting hospital deliveries that will decrease infant and mother mortality rate as evidence by:

* 65% of professional health care workers participate in the programme
* 80% of Nari Nidhi beneficiaries participating in government health programs
* 85% children up to 5 yrs of completed age who are given 9 doses of Vitamin A.
* 80 % children with diarrhea who are treated with ORS.
* 90% women who know key danger signs during (i) pregnancy, (ii) labor and (iii) post partum

7. 10 local govt. units clearly understand their roles and responsibilities regarding health programs as evidence by:

* 80% of local officials participate at the meetings
* (80 %) children with ARI provided treatment.
* All the 10 project communities were covered by the Mobile clinic regularly for treating the patients.

**1. EXECUTION / IMPLEMENTATION PLAN (WITH SPECIFIC TIME FRAME)**

**1.1 Project period: Continuation for another 3 year w.e.f 1st april 2016 – March 2019** Duration of the programme will be three years. A period of three years is essential for systematic work on capacity building of staff, approach, rapport building & meetings in the villages, treatment of ailments & its follow –up, observations, documentation & recommendations etc.

**1.2 Better accessibility through health services in Dist. Muzaffarpur. A** team of 20 people comprising with 2 Doctors, Project Manager, account/MIS, 1 ANM, 10 community health workers, health supervisor, lab technician & a pharmacist will move together to the identified and 10 selected project locations of Muzaffarpur district. Muzaffarpur, in order to provide services of healthcare to the women and children of rural areas/project locations where such facilities are inaccessible. These teams will move from NARI NIDHI Project office to the respective Project area / villages/project locations as per the plan.

**1.3 Clinic Rotation: 10** such clinics will be organized every month covering 10 slums/villages, thus entire project location will be reached in twice in a months. Each project slum/village will have a rotation period of 2 in months. It will be equipped with medicines and other necessary equipments required for conducting tests of women, pregnant women and adolescents.

**1.4 Counselling:** After the check-ups the patients will be provided with medicines as per their diagnosis. Counselling will be done by the CHWs for the anaemic cases (women & adolescents) identified through blood tests, counselling of parents of those children found under nourished and non- immunized and counselling of pregnant women and its family members to promote institutional delivery & counselling of women on personal hygiene & sanitation .The people usually do not have the knowledge of medicines/ antibiotics to be taken in precise timings and in full course. Counselling will also be done for taking the full dose of the medicines as per the prescription. In which he /she will inform patients about the side effects if they do not take full dose of medicines. Counselling will be provided to the patient and their caretakers/ family members on individual basis for diagnosis made the treatment they are getting and what they need to do for being cured.

**1.5 Clinic timings and target:** Clinic will be operational for 4 hrs where 2 doctors, 1 ANMs will diagnose and make prescriptions. 20 clinics will be organized in a month thus 240 such clinics will be organized in one year. Since there will be 2 Doctors, 1 ANMs with 4 hours of operation assuming that one doctor will spend 10 minutes with the patient, considering this fact 1 Doctor will be able to treat 24 patients’ maximum 50 patients in a visit thus treating 50 patients by team of 2 Doctors in a visit. The target will be to treat 12000 (Count in frequency) patients in a year, 36000 patients in 3 years. Since clinics will be organized on the routine immunization day, it will be conducted at Aanganwadi centre or at village Choupal in order to ensure maximum coverage.

**1.6 Health Service Package**

Primary health checks ups of women and children. Diagnosis & Treatment of focused beneficiaries group of women [15 to 49] and children under the age of 6 years.

* Ante natal checkups/care
* Post natal care of mother and new born baby
* Treatment of RTI’s/ STI’s
* Counselling services on RCH/MCH, Anaemia, and Nutrition &Hygiene and Importance of taking full course of medicines.
* Routine Immunization

**Following laboratory test may be done by the lab technician under the supervision & prescription of the Doctor.**

* Haemoglobin test
* Blood group test
* Pregnancy test
* Blood sugar test
* Blood pressure
* Weighing

**1.7 Family Life Education**

**1.7.1 Promoting Girl child and imparting Family Life Education among adolescents through School health sessions.** The project team will coordinate with middle and senior secondary school authorities in the project implementation area and conduct regular health sessions at schools on FLE and reproductive health aspects for Adolescent groups [girls & boys] in the age group of 12 to 19 yrs. Total 2500 adolescents will be oriented & educated on FLE and reproductive health aspects in the entire intervention area in the given period covering 10 schools of Project areas.

**1.7.2 Promoting Girl Child /Educating Adolescents on Reproductive health aspects and Family Life education [FLE] through School Health Sessions:** Health sessions will be conducted at community/ district level by Project team for adolescent’s girls for promoting gender sensitivity and reproductive health knowledge among them. We have already 15 number of Adolescent girls group (each group consist 20-25 members) will be done, a roaster of session will be developed and sessions will be designed and planned accordingly.

**1.8 Involvement of various stakeholders in the programme (Govt functionaries like health , ICDS , Education Deptt , Community like Panchayati Raj Institutions & NGO’s)**

**1.8.1 Linkages & Network:** Better planning and coordination with the local stakeholders can make future programmes more successful which will ultimately contribute to the better health, economic empowerment, peace and harmony among the people. The Health clinic services will be organized in close coordination and planning with concern PHCs in order to increase the engagement of government health system and for the convergence. The Health clinics would be organized with Health department’s routine Immunization [RI] schedule in order to ensure the maximum coverage of the village and target groups. The health and ICDS departments would be actively involved in rendering the Health services. Efforts will be to implement the program in close collaboration and involvement of Distt Health Officials Referral system has to be strengthened & established by the project. Diagnosed critical cases [women, children etc] would be referred to the government hospitals. Malnourished children would be referred to the ICDS department. List of referral institutions will be developed by the program with details mentioning names of the organization/institute /contact details in order to refer patients from where they can get proper treatments. Involvement of Aanganwadi workers, Accredited Social Health Activist (ASHA) and Auxiliary Nursing Midwife (ANM’s) for constant follow-up and community mobilization at the grass root level. Involvement of Panchayati Raj Institutions and other influential persons for greater involvement of the community.

**1.9 Awareness sessions/ IEC exhibition:** Awareness sessions will be organized by the community health worker during each visit, he/ she will conduct 10 such awareness sessions in a month .Topics for group sessions will be developed by the Project on rotation basis to cover all the thematic areas related to Community health and Mother & Child Health. IEC materials procured from Govt Health Departments will be exhibited during these clinics .There will be a separate counter on which various health messages, pamphlets, banners & posters will be displayed & distributed. Pre-publicity of the clinic will be done one day prior to the clinic through local stakeholders and through grass root level health workers like ASHA’s or Aanganwadi workers.

**1.10 Orientation & Capacity Building of the staff:** 2 training programs will be conducted in a year for all the staff members involved in the Project

**1.11 Setting up of Project office at Project Area:** A Project office already established at the location where the project areas can be easily accessed in order to ensure smooth execution of project/field activities. The project team [Project Manager and MIS cum Account Associates] will be placed at project office; therefore it is not viable to operationalise the project from NARI NIDHI main office. The team from NARI NIDHI will regularly visit the field area and monitor the project activities/progress.

**Management & Supervision supports**

NARI NIDHI will provide support to technical, financial and management aspects of the project to ensure meeting its objectives, is of the highest quality and is in compliance with Hans Foundation’s requirements. As project lead, Nari Nidhi will be responsible for overall planning, management, technical oversight and accountability of the project. Nari Nidhi will develop monitoring and evaluation systems and Protocols jointly with the partners. Nari Nidhi will provide directional and technical support through programme personnel such as the Project Manager (1), Accounts cum MIS assistant (1), Health supervisor (1) ANM (1) Community health workers (10). The roles and responsibilities of team members are:

1. Project Director: (25% time) Overall head of the project, Provide planning and implementation assistance to the team, Over see technical & financial aspects of the project.
2. Project Manager: (100% time) Provides day-to-day management and technical oversight of the project area; reviews monitoring data and provides technical and financial reports.
3. Accountant: (100% time) Manages project finances, logistics and administration.
4. MIS Assistant: (100% time) Collates data from the field and prepare reports.
5. Supervisor: (100% time) Train and provide supportive supervision to CHWs, facilitate coordination between government frontline workers and CHWs, build capacity building of CHWs in project interventions.
6. CHW (community Health Worker): (100% time) Anchor & facilitate all field level activities as per project plan. Deliver BCC, organize health camps, and organize group meetings and home visits.

**Monitoring and evaluation plan:**

The project will track activities, output indicators and the three purpose level indicators through routine monitoring. An initial workshop will be held for all implementing partners (IPs) to develop a monitoring protocol (formats, frequency of reporting, data analysis tools, feedback channels to data generator etc.). A part time M&E Advisor will be hired to provide technical expertise and support to the implementing partners in designing the protocols and feedback mechanisms. The records maintained by the CHWs on their activities and behaviors of mothers and other caregivers will form the basis of the monitoring data. The importance of compiling honest and clean data in recordkeeping, and understanding the link between activities, outputs and outcomes, as presented in the log frame, will be part of formal training for CHWs. CHWs’ records will be checked by health supervisor for consistency and accuracy, with post-training mentoring provided. Health supervisor will be required to back-check five percent of data as quality control. Health supervisor will be responsible for collecting data from the community and facility level health providers on the mentoring they are receiving from the CHWs. Nari Nidhi and the IPs will record advocacy data when such achievements as a government order on health issues is released or a workshop / CME by health professional associations is organized. Project will have an MIS assistant who will enter all the data into a data analysis programme designed centrally by Nari Nidhi. The project manager will review this data collate and analyze to generate monthly reports. Feedback on progress will be shared in quarterly meetings for cross-learning among IPs.

Note: Monitoring data on behaviors of women and caregivers on health practices will be a “self assessment” of the CHWs, and therefore has an inherent bias. Also, the source of the data will be only those women that CHWs has reached out to. Thus women, who have not yet been reached out to by the CHWs, will not be part of the denominator. Thus, monitoring data trends, while good for programme management purposes will not give the “real picture”. Coverage rates reflected in the monitoring data will need to be validated by an independent survey.

**Documents:**

* Monthly progress report
* Quarterly Progress report
* Quarterly Expenditure report
* Health camp report
* Group session report
* Counselling report
* Monthly HMIS ( Health Management Information System)
* Documentation of best practices
* Documentation of case studies / success stories
* Patient records

Monthly Report prepared by program person and responsible to send it to head quarter of organization and donor agencies also. Organization have ensure to quality documentation and signed hard copy of all monthly, quarterly and annual report with utilization certificate on time to donor agencies

**MANPOWER INVOLVED:**

Following staff is proposed for Project activities

1) Project Director

2) Project Manager

3) Doctors- 2

6) Pharmacist 1

7) Lab Technician 1

 7) Accountant cum MIS assistant 1

8) Community Health Worker -10

9) Driver 1

10) Supervisor 1

11) Nurse- 1

**Staff selection and general ethics of the organization:**

Nari Nidhi has a code of ethic that is an integral part of the Staff Handbook, which every Employee is required to read and adhere to. In order to minimize the risk of fraudulent activity,

Nari Nidhi adheres to the following practices:

* Conducts pre-employment background checks
* Contract/ Agreement procedures - uses approved vendors and consultants
* Financial and internal control:
* Procurement policies and guidelines
* Security level access for all IT system
* Dual cheque signing by senior officials
* Bank reconciliation controls
* Management detail review of expenditures
* Review and approval process for employee claims
* Finance sub-committee oversight

**VISIBILITY TO THE DONOR:**

Visibility to the donor on this project will be provided through following means:

* All the IEC materials, like, pamphlets, posters, banners etc. will prominently carry the name of the donor in them, acknowledging the contribution of the donor.
* Any banner put-up by at public meetings in villages, or in trainings that it conducts or any gathering anywhere related to the project will carry the name of the donor.
* A small documentary of program will be made

**Indicators of Program Progress:**

* No. of clinics/camps conducted
* Hours of clinic operation
* No. of patients treated
* No of targeted group reached out during clinic/camp
* No. of RTI/STI cases identified & treated
* No. cases counselled for STI’s
* No. of pregnant women received services
* No. of women treated ( 15-49 years )
* No. of children treated ( 0-6 years )
* No. of pregnant women counselled for institutional delivery
* No. of anaemic cases identified and counselled
* No. of adolescents counselled
* No of group meetings conducted with the target group
* No. of target group exposed through these group meetings
* No. of cases referred to health deptt.
* No. of cases referred to ICDS department
* No of cases referred to NGOs for sponsorship
* No. of meetings organized with different stakeholders (Govt,(Health & education),PRI, AWW, ASHA etc.
* No of FLE sessions conducted in the schools
* No. of adolescents provided with FLE ( Boys and girls )

**Impact Indicators:**

**Mother’s Health**

* % pregnant women registered within 12 weeks of pregnancy.
* % Pregnant women with complete ANC (3 ANCs + 2 TTS + 100 IFA)
* % Pregnant women who had institutional delivery
* % women who received post-natal care
* % women counselled on Health ,Nutrition & hygiene

**Child health**

* % mothers having knowledge of the 6 diseases that can be prevented by primary immunization.
* % Children aged 12-23 months received all primary immunization.
* % Children exclusively breast fed
* % Children fed on colostrums
* % Women aware about 3 major danger signs of ARI and diarrhoea.
* % Children malnourished.
* % children received health check ups
* % of mother/Parents counseled on Child health care.

**Qualitative**

* Access to MCH services provided as per needs of the community.
* Increased demand for and utilization of Quality of Care in health services
* Increased engagement of government health system in providing health (esp.MCH services in the area.
* Community empowerment and ownership for the programme increased.
* Increased immunization coverage
* Improved status of ANC, PNC and Institutional deliveries
* Improved immunization status of children aged 0-1 year

**Project Risk and Mitigation:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Explanation of Risk** | **Potential impact High/Medium/Low** | **Probability****High/Medium/Low** | **Mitigation measures** |
| **External Factors:** |
| Change ingovernance at stateor district level | Low | State: LowDistrict: Medium | Engage with officials at various levels; re-orient new officials with Support of existing officials. |
| Floods and other disasters, eg. Epidemics | Medium | Low | Retain contingency plans; eg; Communication in relief camps &/or adapt messages to the epidemic. |
| **Internal factors** |
| Difficulty identifyingand/or retaining good PE/CC candidates  | High  | Low | Selection criteria may be revised & provide more intensive training afterSelection. Short-list more PE/CCs per area for back-up candidates. |
| Community / facility based providers unwilling to work with CHWs | Medium | Medium | Advocate to district supervisors to motivate the providers |
| Drop out by a partner | Low | Low | Change existing organizational coverage or identify other partners. |
| District / StateGovernment unwilling to scale up | Medium | Medium | Develop strong MIS to capture success data and cultivate district / state level champions for advocacy |

## Sustainability:

The project will promote a range of strategies to ensure that basic health services and nutrition counseling remains a focus in the target areas. Through earning recognition as specialist health counselors in their communities, the CHWs will be motivated to sustain their services beyond the end of the project. While incentivized through the project with a small honorarium, Nari Nidhi will encourage the state government to take on and fund these trained hands, similarly to the recommendation from the recent Planning Commission retreat on how to tackle India’s malnutrition problem, where recruitment of stand-alone nutrition counselors at the village level was strongly proposed. Another recommendation from the retreat was for the government to take on a second AWW, whose main focus would be on home visits to counsel mothers and young women about dietary recommendations during pregnancy, lactation, infancy, childhood and adolescence.

Alternatively, the National Rural Health Mission (NRHM) mandates the recruitment of “ASHA facilitators” to provide mentoring support to the ASHAs. However, no recruitment has yet been made against these positions in Bihar. As one of the main tasks of the CHWs is to mentor field level functionaries, including ASHAs, they could be paid from the budget set aside for the ASHA facilitators. A third option is to advocate with the Panchayati Raj Institutions, and specifically the Village Health and Sanitation Committees, to use their untied funds to continue to pay the honorarium of these workers beyond the life of the project. The focus of the project is to create sustainable capacity among the respective audiences. For example, if the ASHAs learn and practice the skills of group and interpersonal counseling, it is likely that they will retain these skills beyond the project period. Also VHNDs are a government priority and group counseling sessions by front line workers form an integral part of the VHND guidelines. Sustainability also refers to retention of behavior change in the target populations. Once the women in the community feel the benefits of mother support groups and peer learning, it is likely that knowledge sharing and mutual problem solving through these processes will continue even without external support. The project will work at a level of critical mass in 10 project locations. The project will coordinate closely with other major health programmes currently rolling out in Bihar, such as the Gates-supported programmes and DFID’s bilateral support to NRHM, so as to scale up the successful elements of the project model through the state. The project will similarly coordinate with the district administration. The project will create a body of demonstrated evidence and data by the mid-term to support the case to the government’s district health societies for project components to be built into the annual district action plans (DAPs) and become eligible for public budget allocation. This will help scale up the activity across the district and sustain funding after project support ends.

**Declaration:**

Nari Nidhi does not work on projects that directly focus on Child Protection. However, where projects target children, Nari Nidhi ensures that children rights are protected on the basis of the individual country’s laws or acts on Child Protection as well the United Nations Conventions on the Rights of the Child.

**Action - Plan**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| S.l.  | Month | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
|  | Activity |
| 1  | Covering 1 villages per day  | \* | \* | \* | \* | \* | \* | \* | \* | \* | \* | \* | \* |
| 2  | Addressing Curative health care  | \* | \* | \* | \* | \* | \* | \* | \* | \* | \* | \* | \* |
| 3  | Health Awareness Education  | \* | \* | \* | \* | \* | \* | \* | \* | \* | \* | \* | \* |
| 4  | Referral services  | \* | \* | \* | \* | \* | \* | \* | \* | \* | \* | \* | \* |
| 5  | Audio visual programmes  | \* | \* | \* | \* | \* | \* | \* | \* | \* | \* | \* | \* |
| 6  | Distribution of medicines  | \* | \* | \* | \* | \* | \* | \* | \* | \* | \* | \* | \* |
| 7  | Networking with community  | \* | \* | \* | \* | \* | \* | \* | \* | \* | \* | \* | \* |
| 8 | Awareness on Human Rights, IGP Mother & Child Health, HIV/AIDS  | \* | \* | \* | \* | \* | \* | \* | \* | \* | \* | \* |  |
| 9  | Education and Communication  | \* | \* | \* | \* | \* | \* | \* | \* | \* | \* | \* | \* |
| 10  | Project Monitoring & Reporting  | \* | \* | \* | \* | \* | \* | \* | \* | \* | \* | \* | \* |
|  | Project Evaluation |  |  |  |  |  |  |  |  |  |  |  | \* |

**BUDGET FOR ONE YEAR:**

|  |
| --- |
| **NARI NIDHI** |
| **BUDGET FOR OPTIMAL HEALTH FOR MOTHER & CHILD PROJECT IN 10 PROJECT LOCATION AT MUZAFFARPUR DISTRICT**  |
| **S. No** | **Particular** | **Unit** | **Month** | **Unit cost** | **Request from Global Giving** | **Notes**  |
| **A** | **A Human Resource** |
| A1 | Project Director (15 % time) | 1 | 12 | 6500 | 78000 | Secretary will pay their 15% time for project supervision and interact with govt. health official and project personal  |
| A2 | Project Manager | 1 | 12 | 30000 | 360000 | 1 senior staff full time for day to day project interventions |
| A3 | Part time Accountant | 1 | 12 | 7500 | 90000 | Preparing of vouchers and accounting in TALLY Software. |
| A4 | Doctors(2), 2000 per clinic (20 clinic in a month) | 2 | 12 | 40000 | 960000 | One general physician and one gynecologist will be hired on daily fee basis  |
| A5 | Field Supervisor (@Rs.12000/-month | 1 | 12 | 12000 | 144000 | One field supervisor for day to day project interventions (also to help in supervising CHWs) and to work with community influencers including community/opinion leaders, religious and local leaders and liasonig with Govt. health system and service providers. |
| A6 | 1 ANM @ 15000/month | 1 | 12 | 15000 | 180000 |   |
| A7 | Lab technician[1] 500 per clinic (for collection of blood sample and other sample | 1 | 12 | 10000 | 120000 |   |
| A8 | Cost of laboratory services @ 15,000 month \*12  | 1 | 12 | 12500 | 150000 | 15 samples tested every day @50 each for 15 sample X 20 days a month |
| A9 | Community Health Worker [10] 6500 per month | 10 | 12 | 6500 | 780000 | 10 Community health workers (CHW) who are community based. HH visits by the CHWs will be undertaken 10 HH on regular basis for one-to-one interaction on MCH. This will also serve as means to keep in surveillance of health and hygiene behavior of the family with reference to project’s input.  |
| A10 | Driver @ 12,000 | 1 | 12 | 12000 | 144000 | A full time driver of MHU. He shall keep MHU well maintained and get ready for work.  |
|  | **Sub-Total A** |  |  |  | **3006000** |   |
| **B** | **B Transportation Cost** |
| B1 | Fuel of Ambulance Cost (5497.50 per month) | 1 | 12 | 6000 | 72000 | The minimum distance of project location is 15 km and maximum distance of project location is 100 km (To & Fro in two time visits in one project location). After every 2000 KM MHU will move to Patna for routine servicing and oil change. So average calculation of distance is 550 km in a month. Fuel consumption rate of MHU with AC is 6 KM per liter. MHU will consume 92 liter diesel @ Rs.55= 5060. MHU will consume oil 15 liter in three time (at the time of routine servicing) @ Rs.350= Rs.5250. So average running cost of MHU will be Rs. 5497.50 per month. |
| B2 | Recurring expenditure of MHU | 1 | 12 | 4000 | 48000 | General Servicing/Insurance/Maintenance of Ambulance |
|  | **Sub-total B** |  |  |  | **120000** |   |
| **C** | **Operating Cost (service Delivery**) |
| C1 | Medicine & equipment required for health clinic (Rs.3000/- per camp). | 1 | 12 | 60000 | 720000 | Medicine will be purchased as per prescription and instruction of doctors by suitable vendors |
|   |   |
|  | **Sub Total C** |  |  |  | **720000** |   |
| **D** | **Information Education & Communications** |
| D1 | Wall writings/paintings @ 6000\*10 villages. (10 Iron board and 10 wall writing/painting@ Rs. 3000 each) | 20 | 1 | 3000 | 60000 | Health related services and benefits will be displayed in bold letters with pictures at public places and main entrance of villages. Wall writing/painting would also serve the purpose of disseminating important messages pertaining to MCH/ARSH/Water &sanitation. Good slogans already in use by different MCH programmes would also be used.  |
|   | **Subtotal (D)** |  |  |  | **60000** |   |
| **E** | **Capacity building**  |
| E1 | 4 day residential Training on Mother & Child health and Family Life Education to all staff 1 unit trainings (Rs.800\*25participants\*4days) cost includes Resource person fee, Hiring charge of venue, tent materials, tea, breakfast, Lunch and dinner, Banner and stationeries etc | 1 | 1 | 80000 | 80000 | This focuses on building a clear & uniform understanding on project design and responsibilities attached with each functionary among the team members. The exercise would also target training of project staff on MCH issues |
| E2 | residential Training on Sexual Reproductive Health and Family Life Education to 15 adolescent girls group in 5 unit trainings (5trg\*4quart\*Rs.8000) cost includes Resource person fee, Hiring charge of venue, tent materials, tea, Banner, breakfast, Lunch and dinner, and stationeries etc | 5 | 4 | 8000 | 160000 | Adolescents will be oriented on ARSH, sanitation and hygiene issues of the local area school students by sharing of facts & figure. They will also be sensitized on the role that they need to play for generating awareness among the community people, school going students for their accountabilities for effective maintenance and management of sanitation infrastructure.  |
| E3 | School level Training on Sexual Reproductive Health and Family Life Education to 500 adolescent girls and boys in 5 middle and upper middle school (Rs.100\*500 Adolescent in 2times) cost includes Resource person fee, tent materials, Sound system, Banner, Refreshment, prizes and stationeries etc | 500 | 2 | 100 | 100000 | Adolescents will be oriented on ARSH, sanitation and hygiene issues of the local area school students by sharing of facts & figure. They will also be sensitized on the role that they need to play for generating awareness among the community people, school going students for their accountabilities for effective maintenance and management of sanitation infrastructure.  |
|  | **Sub Total (E)**  |  |  |  | **340000** |   |
| **F** | **F Community Involvement** |  |  |  |  |   |
| **F1** | **Community meeting 3000 X 10 X 4Quarter (**cost includs tent materials, Refreshment and stationaries etc) | **10** | **4** | **3000** | **120000** | Project personal will tag themselves into the meeting schedules of VWSC/VHSC, CBOs/ SHGs/ ASHA/ ANMs/AWWs and regular facilitate discussion on MCH/ARSH/Sanitation and hygiene issues. They would be sensitized on the role that they can play in improving Health, family planning, sanitation and hygiene habits among target people. The meetings along with other project input will lead to achievement of project’s target.  |
| **G** | **Administrative cost** |   |   |   |   |   |
| G1 | Stationary | 1 | 12 | 3000 | 36000 |   |
| G2 | Communication | 1 | 12 | 1500 | 18000 | Telephone, postage and internet charges etc. |
| G3 | Bank Charge/TDS Consultant fee and missl. | 1 | 12 | 2000 | 24000 |   |
| G4 | Travelling and Conveyances | 1 | 12 | 5000 | 60000 | Cost of field visits and out of project area and monitoring for project purposes |
| G5 | Audit (0.5% of total budget) | 1 | 1 | 30724 | 22000 | Preparing of final project financial reports by CA |
|  | G Total |  |  |  | **160000** |   |
| **H** | **Grand Total** |  |  |  | **4526000** |   |
|  | **Total Rupees Forty Five lakh Twenty Six Thousand Required From**  |

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***