PROJECT PROPOSAL

Maternal, Neonatal and Child Health (MNCH)

Promoting Mother and Child Health by Preventing Malnutrition

1. About the Organization

Network for Human and Social Development (NHSD) is a registered charity with the Islamabad Charity Commission, Pakistan Software Export Board, and the Economic Affairs Division, Government of Pakistan. It serves as a collaboration partner for Air University and Capital University of Sciences and Technology (CUST). NHSD is an implementation partner for more than 60 international and national organizations, including King Baudouin Foundation (Belgium), Myriad USA, GlobalGiving USA, Benevity, NextGenU Canada, Akhuwat Cloth Bank, USAID/SGAFP, Malteser International, and GIZ.

Thematic focus areas include Public Health Education, Water and Sanitation, Disaster Risk Reduction and Management, Youth and Women Empowerment through Skill Development, Technical Trainings for Poverty Reduction, Advocacy, and Maternal, Neonatal and Child Health. NHSD has been nationally recognized for its work since 2012.

2. Background

Maternal, newborn and child health (MNCH) outcomes in Pakistan remain among the weakest in South Asia, with the burden falling disproportionately on rural households. According to the National Nutrition Survey 2018 — still the country's most recent nationally representative data — roughly two in five children under five are stunted nationally, affecting an estimated 12 million children. Rural prevalence (43 percent) runs well above urban (35 percent).

Maternal mortality has fallen from 276 to 186 deaths per 100,000 live births between 2007 and 2019, yet the decline has been slow, and rural infant mortality remains meaningfully higher than urban rates. These outcomes are driven by a well-documented set of causes:

- Inadequate maternal and infant nutrition during the critical first 1,000 days of life;
- Low exclusive breastfeeding rates and poor complementary feeding practices;
- Weak antenatal and postnatal care coverage;
- Poor water and sanitation access (linked in national data to higher odds of stunting);
- A thin rural health workforce — Pakistan has roughly one physician and half a nurse or midwife per 1,000 people; and
- Low maternal health literacy, compounded by poverty and household food insecurity.

This project directly addresses these gaps through a dual-track approach: immediate nutritional support combined with sustained behaviour-change training and household food-production capacity, implemented in selected rural villages of Rawalpindi and Chakwal districts.

3. Project Objectives

1. Provide structured nutritional supplements to 5,000 mothers and young children over a 12-month period.
2. Deliver recurring community-based technical training for mothers covering antenatal and postnatal self-care, breastfeeding and complementary feeding, hygiene, sanitation, clean drinking water, and recognition of danger signs requiring referral.
3. Facilitate vaccination services in collaboration with the Expanded Programme on Immunization (EPI) and provide family-planning counselling and services.
4. Conduct kitchen-gardening workshops and distribute seasonal seeds so that households can produce their own nutritious food, thereby sustaining gains after the project ends.

4. Methodology

Duration and Geography. The project will run for 12 months across selected rural areas of Rawalpindi Division (Punjab), specifically the villages of Dhoke Chowdrian, Maskeenabad, Rawat (Murree), Chakri (Rawalpindi Division), and Choa Saidan Shah (Chakwal District). Because the sites span two districts, implementation will coordinate with two separate district health authorities; this is reflected in staffing and supply schedules.

Core Intervention Tracks

- **Nutritional Supplementation:** Monthly distribution of age- and pregnancy-appropriate micronutrient supplements and supplementary food packages to enrolled mothers and children under five, reaching a cumulative 5,000 beneficiaries.

- **Recurring Community Workshops:** Monthly or bi-monthly sessions (rather than one-off events) covering antenatal/postnatal care, exclusive breastfeeding, complementary feeding, hygiene, sanitation, clean water practices, and danger-sign recognition. Practice-level change requires repeated contact; therefore sessions are deliberately iterative.
- **Vaccination & Family Planning Linkages:** On-site or nearby EPI vaccination days coordinated with district health teams; family-planning counselling and commodity provision linked to existing government and partner services.
- **Kitchen Gardening:** Practical workshops on small-scale vegetable production plus distribution of seasonal seed kits, enabling households to grow nutrient-dense food and reduce dependence on external supply once the project ends.

Dual-Track Logic. Supplementation addresses the immediate nutritional deficit; training and kitchen gardening build the household-level knowledge, behaviour change, and food-production capacity needed to sustain gains after supplements cease. The design treats the 12-month period as the first phase of a longer-term MNCH intervention rather than claiming measurable stunting reduction within the project window itself (stunting is a cumulative, slow-moving indicator).

Staffing & Coordination. A lean field team (Project Coordinator, two Community Health Facilitators, one Nutrition/Logistics Officer, and part-time M&E support) will work under NHSD's existing management structure, maintaining close liaison with District Health Officers of Rawalpindi and Chakwal, Lady Health Workers, and EPI focal points.

5. Sustainability Plan

Sustainability is structured around a self-replicating model rather than continued dependence on donor or NGO funding alone:

- **Trained Mother Champions:** A cohort of mothers who complete the full training cycle will be positioned as community resource persons, extending correct practices (breastfeeding counseling, complementary feeding, hygiene, kitchen gardening) within their own villages after project close.
- **Kitchen Gardening Continuity:** Seed kits and practical skills enable households to produce nutrient-rich vegetables seasonally; seed-saving techniques will be taught so that production can continue without external input.
- **Industry & Local Stakeholder Engagement:** Relevant local stakeholders (agricultural extension services, private-sector nutrition suppliers, district health authorities) will be engaged during the project to explore longer-term supplement supply chains and mentorship support once formal funding ends.
- **Government Linkages:** Close coordination with EPI, Lady Health Worker programmes, and district health offices ensures that vaccination and family-planning components are absorbed into routine public systems rather than remaining project-dependent.

6. Monitoring and Evaluation

A practical, monthly M&E system will track both delivery and early outcome indicators, allowing course correction during implementation rather than only at closeout.

Key Indicators

- **Output:** Number of mothers and children receiving supplements each month; workshop attendance rates; number of seed kits distributed; number of EPI vaccination sessions facilitated; family-planning counseling contacts.
- **Outcome (knowledge & practice):** Pre- and post-training knowledge scores on breastfeeding, complementary feeding, hygiene and danger signs; proportion of households establishing and maintaining kitchen gardens; self-reported exclusive breastfeeding and complementary feeding practices among enrolled mothers.
- **Process:** Timeliness of supplement procurement and distribution; coordination meetings held with district health authorities; stock-out incidents.

Data Collection & Reporting. Field facilitators will maintain simple paper/digital registers. Monthly summary reports will be compiled by the Project Coordinator and reviewed by NHSD management. A baseline knowledge-and-practice survey will be conducted in Month 1; a comparable end-line survey in Month 12. Quarterly narrative and financial reports will be submitted to the donor. An independent or internal end-of-project review will document lessons and recommendations for scale-up.

Because stunting is cumulative and slow-moving, the project does not claim measurable reduction in stunting prevalence within 12 months. Instead it positions itself as building the delivery infrastructure, trained cohort, and monitoring baseline required for longer-term nutritional impact.

7. Project Budget (12 Months)

All figures are in United States Dollars (USD). The budget is divided into Capital Cost and Operational Cost only.

7.1 Capital Cost

Item Description	Unit Cost (USD)	Total (USD)
Weighing scales, height boards & MUAC tapes (community kits)	450	450
Training materials, flip charts, demonstration kits & IEC materials	1,200	1,200
Kitchen-gardening tools & demonstration plot starter kits (5 sites)	800	800
Basic IT equipment (tablets for field data, portable printer)	950	950
Storage cupboards / secure boxes for supplements at field points	600	600
Total Capital Cost		**4,000**

Capital Cost – explanatory notes:

- Anthropometric equipment enables growth monitoring and identification of children needing referral.
- Training and IEC materials support the recurring workshop model and household behaviour-change messages.
- Gardening tools and seed demonstration kits establish practical household food-production capacity.
- Field tablets and a portable printer support real-time data collection and monthly reporting.
- Secure storage protects supplement stocks at village-level distribution points.

7.2 Operational Cost

Item Description	Unit Cost (USD)	Total (USD)
Nutritional supplements & supplementary food packages (5,000 beneficiaries × 12 months, averaged)	—	48,000
Seasonal seed kits for kitchen gardens (approx. 1,200 households)	—	3,600
Project Coordinator (full-time, 12 months)	650/mo	7,800
Community Health Facilitators × 2 (full-time, 12 months)	400/mo each	9,600
Nutrition / Logistics Officer (full-time, 12 months)	450/mo	5,400
Part-time M&E / Data support	250/mo	3,000
Workshop costs (venue, refreshments, facilitator transport – recurring sessions)	—	4,800
Field transport, fuel & vehicle hire (multi-site coverage)	—	6,000
Baseline & end-line surveys, data entry, reporting & communication	—	2,400
Office / administrative support, bank charges, contingency (approx. 5 %)	—	4,400
Total Operational Cost		**95,000**

Operational Cost – explanatory notes:

- Supplements form the largest line item and cover micronutrient and supplementary food needs for 5,000 mothers and children across 12 months.
- Seed kits enable the kitchen-gardening component that underpins post-project food security.
- Staffing is lean and field-heavy to maximise direct contact with communities while keeping overhead low.
- Workshop and transport costs reflect the multi-site, recurring-session design required for behaviour change.
- M&E and contingency ensure adaptive management and absorption of minor price or logistical variations.

8. Expected Contribution to Outcomes

By the end of the 12-month period the project will have:

- Reached 5,000 mothers and young children with consistent nutritional supplementation;
- Built practical knowledge and improved practices among participating mothers through recurring workshops;
- Linked families to EPI vaccination and family-planning services;
- Established kitchen gardens in approximately 1,200 households, creating a sustainable source of nutrient-dense food; and
- Trained a cohort of Mother Champions who can continue peer support after formal project activities end.

Implementation Schedule – Maternal, Neonatal and Child Health Project

Activity / Month	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Notes
1. Project start-up & staff orientation	■	■											Contracts, orientation
2. Baseline knowledge & practice survey	■	■											All 5 sites
3. Community mobilisation & enrolment	■	■	■										Target 5,000
4. Supplement procurement & logistics set-up	■	■	■										Quarterly re-order
5. Monthly nutritional supplement distribution		■	■	■	■	■	■	■	■	■	■	■	Ongoing M2–M12
6. Recurring MNCH & nutrition workshops		■	■	■	■	■	■	■	■	■	■	■	Monthly / bi-monthly
7. EPI vaccination linkage days		■	■	■	■	■	■	■	■	■	■	■	With district EPI
8. Family-planning counselling & services		■	■	■	■	■	■	■	■	■	■	■	Integrated sessions
9. Kitchen-gardening workshops & seed distribution			■	■	■	■	■	■	■	■			Seasonal windows
10. Mother Champion selection & advanced training					■	■	■	■	■				Sustainability cohort
11. District health authority coordination meetings	■	■	■	■	■	■	■	■	■	■	■	■	Monthly
12. Monthly monitoring, data review & reporting	■	■	■	■	■	■	■	■	■	■	■	■	Continuous
13. End-line survey & final evaluation											■	■	Compare to baseline
14. Project close-out, handover & lesson documentation											■	■	Final report

Notes: M1–M12 = Project months 1 through 12. Blue cells indicate periods of active implementation. Supplement distribution, workshops, vaccination linkages and family-planning services run continuously from Month 2 onward once enrolment and logistics are complete. Kitchen-gardening activities follow seasonal planting windows. Mother Champions are developed from Month 5 to create a post-project community resource base.