Operational strategy for implementation of FNHW interventions in Tripura

Tripura State Rural Livelihood Mission

Glossary

- ***New-born*:** Any person below the age of 28 days.
- ***Infant*:** Any person below the age of 1 year.
- ***Child*:** Any person below the age of 18 years.
- ***Adolescent*:** Any person between the ages of 10–19 years
- ***IMR:*** No. of children died per 1000 children before the completion of 1 year.
- ***MMR:*** it is the annual number of female deaths per 100,000 live births from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes).
- ***ANC*:** It is a type of preventive healthcare, with the goal of providing regular check-ups that allow doctors or midwives to treat and prevent potential health problems throughout the course of the pregnancy while promoting healthy lifestyles that benefit both mother and child. Govt. offers 4 free ANCs in regular intervals during the pregnancy period.
- ***PNC:*** Postnatal care (PNC) is the care given to the mother and her newborn baby immediately after the birth and for the first 6-8 weeks of life. There are provisions of three PNC visits with in the 6-8 weeks of birth. Presently ASHA has the mandate of 6 visits to the lactating mother and new born with in first 42 days i.e. 3rd, 7th, 14th 21st, 28th and 42nd day
- ***EBF:*** "Exclusive breastfeeding" is defined as no other food or drink, not even water, except breast milk (including milk expressed or from a wet nurse) for 6 months of life, but allows the infant to receive ORS, drops and syrups (vitamins, minerals and medicines).
- ***Complete Immunisation:*** Complete immunisation defined as receipt of BCG, three doses of OPV, three doses of DPT, three doses of hepatitis B vaccine, and a dose each of measles and yellow fever vaccines respectively before the completion of one year.
- ***Institutional Delivery:*** the delivery of the pregnant women at any type of institution (Govt. Health Centres, Hospitals, Nursing Homes, etc.) with the support of trained and skilled birth attendants or medical professional
- ***Growth Monitoring:*** It is a process of measuring the growth of the child mainly the age, height, and weight to calculate the measure of underweight, stunted and wasted. At the AWC level growth monitoring is done on the scale of underweight measuring the weight for age.
- **AWC**- a pre-schooling education centre for cognitive development, SNP, growth monitoring, health nutrition education awareness, counselling
- **Health Sub-centre**: a last point of providing primary health care and immunisation of children and women, counselling
- **Stunted**: low height against age
- **Wasted**: low weight against height
- **Underweight**: – low weight against age

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Introduction and Background

2023-24 is the 10th year of implementation of NRLM in Tripura. In 2014-15 TRLM started its journey with 6 (six) Resource Blocks under 3 (three) districts i.e. Dhalai, Gomati and South Tripura districts and till 2019-20, TRLM has entered in all 24 (twenty four) blocks of 3 (three) districts. Till 7 Feb. 2020, total 3735 SHGs have been formed/revived covering 31,788 households. During 2019-20, after closure of NERLP, TRLM had entered into 20 (twenty) blocks new under 5 (five) districts i.e., North Tripura, Unakoti, Khowai, West Tripura and Sepahijala districts and thus had covered total 44 (forty-four) blocks in 8 districts. Presently, TRLM has total 51,136 SHGs covering 4.65 lakh household in all eight districts. In Tripura, overall, 90% household in the rural areas are covered under the networkof TRLM. In Annual Action Plan 2023-24, it was planned that TRLM will work in all the 58 (fifty-eight) blocksunder 8 (eight) districts in the State. But due to the pandemic situation by COVID-19, pace of the project and its different activities in the field were affected very badly.

Since the inception major focus was given on institution building and capacity development, accordingly all SHGs registered under TRLM have been following the rules of 5 financial intermediates known as ***'Pancha Sutra'*** strategy (regular meetings, regular savings, regular inter-loaning, regular repayment, regular book-keeping).In 2016-17, as per the NRLM guidelines TRLM has adopted the ***'Dasha Sutra'*** strategy by incorporating health, nutrition and WASH, education, PRI coordination, access to entitlements and sustainable livelihoods along with existing ***'Pancha Sutra'*** norms. Along with the financial and livelihood activities it is imperative to create awareness and encourage behaviour change to adopt the recommended good practices for healthy lifestyle, and increasing their access to rights and entitlements from concerned line departments. In 2019-20, according to the directories TRLM SHGs have participated in *'POSHAN Abhiyaan'* profoundly through organizing rallies, awareness camps, health camps, VHND, etc with the ICDS and Health staff. The *'Poshan Maah'* and *'Poshan fortnight'* activities in the entire project areas has created a positive environment among the leaders and members at SHGs, VOs and CLF level. The VOs formed the Social Action Committee (SAC) to adhere the responsibilities of different issues on health, nutrition, education, rights and entitlements, etc.

In the VO Annual Action Plan of 2019-20, issues related to health, nutrition, education, etc. were prioritized by all the VOs. Hence during last two years their active involvement and participation in celebration of *'Poshan Abhiyaan',* VHND across the project areas was observed which has created good awareness among the members and established a good convergence platform with ICDS and Health. The PRI CBO convergence initiatives by the TRLM with the respective Panchayats and Village Committee with the dedicated LRG gives them the opportunity to address the issues of rights and entitlements and also the water and sanitation related areas. Under the Livelihood sector various on-firm activities and livestock development, viz. rice, vegetables, fisheries and other ARDD activities given a sustained effort to ensure their food security. At this juncture of the project as the awareness generation is already there, introducing the composite package of FNHW interventions is creating a positive vibe in the target areas and giving an effective push to address the issues of mother and children by the SHG members. The SHGs under TRLM are gradually establishing and

strengthening the organic link in their activities and performance, which starts from thrift and credits, then to agriculture and subsequently to food & nutrition and many more. Despite of many challenges and odds, women in Tripura get involved in the SHGs and day-by-day they are emerging as the most effective community warriors on the issues related to their livelihoods, children, rights and entitlements.

Situation Analysis

Services for primary health care, nutrition program through SNP at AWC and Mid-day meal in Schools, food security entitlements through PDS for the poorest and deprived families (Antyodaya Families), Water and Sanitation related activities under Atal Jaldhara Mission and Swachh Bharat Mission are universal and provided free of cost or low-cost by the Government as public services. But yet many of the outcome indicators and overall progress are not been satisfactory at the desired level. These services require not only efficient delivery of services, but also demand driven push needed through mobilization and participation of targeted beneficiaries for maximum and quality coverage.The SHGs representing the poor and marginalized households from the community collectively can plan an important role in reaching all these services to everyone mainly the deprived and actual needy. During the journey of last 7 years TRLM has realized that while the women in SHGs are involved in different on-farm livelihood activities as a strong institution, they have the potentiality toperform in other important functions in the social sector provided they are empowered and enabled to do so by appropriate capacity building measures, awareness creation and taking certain collateral steps by the State Government.

As per the Census 2011, total population of Tripura is 36.74 lakh of which 73.8% are residing in rural areas. The total population of the State has increased with a decadal growth rate of 14.8%. The literacy rate in the state was 87.22% (male 91.53%, female 82.73%). The Human Development Report (HDR) of Tripura (2018) pitched its HDI at 0.65 and ranked 16th position among all the states of India[1]. Tripura has rapidly caught up in HDI value and is performing well among many including big states. The index which follows the UNDP method is an average of sub-national values of 3 dimensions i.e., health – life expectancy, education – literacy rate, and standard of living – per capita income. Demystifying many constraints of connectivity, infrastructure, productivity and marketing Tripura has been experiencing significant progress in social, economic and political indicators of human development.

From the following table of 22 outcome indicators from NFHS-4 on health and nutrition status of women and children, a comparison of Tripura with the national average and district wise performance is captured. At Under Five Mortality Rate, the state is ranked 43 in comparison to the National Average 42 which is concerning. Dhalai and North Tripura performed as high burdened districts as compared with the State average followed by South Tripura and West Tripura as low burdened districts in the State. The Neonatal Mortality Rate, Infant Mortality Rate (IMR) and Under 5 mortality rate of the state is 22.9, 37.6 and 43.3 against national average of 24.9, 35.2 and 41.9, respectively. The anaemia prevalence among the women including the pregnant is high at 61.5% against the national average. This situation is worrisome as more than half of the women are anaemic.

Around 64.3% of the children are also anemic. The complete immunization coverage of children below 1 year at 69.5% against the national coverage of 76.4%. Importantly the BCG coverage is 82.4% and 18% of the children are left out from any type of immunization and more than 45% are not fully immunized. The Maternal Mortality Ratio (MMR) of Tripura was recorded at 85[2] in the SRS special Bulletin on MMR 2011-13, compare to the national average of 113. (SRS 2014-16). Regarding ANC, 66.4% pregnant women get registered in the 1st trimester and about 64.3% pregnant had received at least 4 ANC. But when we discuss the full ANC[3] the situation is very grim at only 7.6%. Regarding the consumption of IFA for 100 days or more, only 26.7% pregnant women had consumed as per NFHS 5. There are some myths, misconception and strong resistance at the household level regarding consumption of IFA. Supply is there during the ANC visits, but due to lack of tracking and proper counselling IFA consumption is very less, though the anemia prevalence is high among the women. Presently the school health program is also not continuing where IFA are distributed for the adolescent girls and boys. An exponential growth in Institutional deliveryis reported 89.2% in Tripura in NFHS 5 with significant improvement from 79.9% during NFHS 4. The prevalence of Stunting (height for age) and Wasted (weight for height) in NFHS 5 among under 5 yearschildren are 32.3% and 18.2% respectively which is more in comparison to the NFHS 4 data and around 25.6% of the children under 5 years are Underweight (weight for age).

Indicators	**India**	**Tripura**	**Dhalai****	**North Tripura**	**South Tripura**	**West Tripura**	**Gomati**	**Khowai**	**Sepahijala**	**Unakoti**
Infant mortality rate (IMR)	35.2	37.6	No District wise data available							
Under Five Mortality Rate (U5MR)	41.9	43.3								
Maternal Mortality Ratio (MMR)	97 NFHS 5	85 NHM								
Nutritional Status										
Non-pregnant women 15-49 years who are anaemic (<12 g/dl)	57.2	67.4	69.7	69.6	66.8	67.6	62.6	63.7	69.8	67.4
Pregnant women 15-49 yearswho are anaemic (<11 g/dl)	52.2	61.5	75.4	55.3	57.1	56.2	52.8	63.7	55.8	76.7
Children under age 6 months exclusively breastfed	63.7	62.1	61.1	58.1	*	*	46.6	*	*	*
Children under 5 years who are stunted	35.5	32.3	45.7	26.2	25.5	30.3	22.7	47	34.5	31.8
Children under 5 years who are wasted	19.3	18.2	15.9	30.0	15.3	11.7	27.6	16.6	14.9	19.3
Children under 5 years who are severely wasted	7.7	7.3	15.9	18.1	5.2	2.1	11.2	6.2	6.7	4.0

Children under 5 years who areunderweight	32.1	25.6	27.6	32.2	21.6	21.2	29	24.7	21	32
Consumption of micronutrient / supplements										
Households using iodized salt	94.3	99.5	98.7	99.2	99.3	99.8	99	100	99.7	99.3
Mother who consumed IFA for100 days or more when they were pregnant	44.1	26.7	26	17.3	29.5	31.8	22	38	18.8	31.6
Access to health services										
Mother who has ANC check-up infirst trimester	70.0	63.2	58.1	75.5	54.2	78.7	54	57.2	61.9	41
Mother who had at least 4 ANCvisit	58.1	52.7	52.0	67.1	58.4	61.2	40.6	41.5	52.8	24.6
Mothers who were protectedagainst neonatal tetanus	92	94.9	97.8	95.0	89.4	99.3	91.7	96.8	90.2	95.6
Mothers who received PNC fromhealth personal within 2 days of delivery	78	71.9	72.4	76.6	68.0	87.7	66.3	59.7	72.1	44.5
Institutional delivery	88.6	89.2	87.3	85.4	89.7	95.3	93.2	95.7	87.7	72.5
Women age 15-24 years who usehygienic methods of protection during their menstrual period	77.3	68.8	63.2	74.2	49.6	81.5	71.5	69.2	68.3	56.8
Access to safe drinking waterand sanitation commodities										
Households with an improveddrinking water source	95.9	88.0	70.3	75.6	90.5	98.5	87.7	83.2	97.4	78.6
Households using improvedsanitation facility	70.2	73.6	67.6	74.1	68.6	80.2	77.4	67.8	75.4	61.8
Prevent early, poorly spaced or unwanted pregnancy										
Women with 10 or more years of schooling	41	23.2	13.9	23.7	21.6	30.9	22.8	18.9	21.7	18.7
Women age 20-24 years marriedbefore age 18 years	23.3	40.1	38.9	34.2	46.2	37.1	42.8	28.3	51.9	38

Women age 15-19 years who arealready mothers	6.8	21.9	26.9	11.9	23.1	20.2	24.4	24.3	26.6	21.2

**: Dhalai is the NHM priority and Aspirational district

[1] The data has been incorporated from NHM Health Dossier 2021

[2] Full ANC is at least 4 ANC visits, at least 1 TT injection and 100+ days IFA consumption

Sources: NFHS 5 (2019-20)

From the above analysis of various data on mother and children, it could be depicted about some gap areas, lacking of scientific approach and follow-up to deal with human behaviour among the service providers, as well as mobilisers. On the other hand, poor health seeking behaviour, lacking ofawareness, negligence at the beneficiaries level are main reasons for poor outcome. If we further narrow down the analysis of poor performing outcomes, we find majorly the lacking of recommended good behavioural practices at the community/HH level.

After the bifurcation 4 districts into 8, on the basis of HMIS Tripura under NHM, 16 numbers of dashboard monitoring indicators on pregnancy care, child birth, post-natal care, immunization, reproductive age-related indicators interestingly South Tripura and Khowai are considered as good performing district among eight in the State. Gomati, Dhalai and West Tripura are considered as promising districts while North Tripura, Unokoti and Shepahijala as low performing districts. (NHSRC, 2016-17)

Another important concern of the situation is FNHW interventions in the hilly districts mainly Dhalai and North Tripura. Due to the hilly terrain and undulating topography some of the in habitants areas are very remote, poor communication, even inaccessible in some season. Among the tribal population in those areas many household still practice ***jhum*** cultivation in the land where they got the ***Patta*** under RoFR Act, 2006. During the ***jhum*** farming season mainly from March/April to September/October many household stay in their jhum lands which are at far flung from the main locality.

Goals and Objectives

Goal:

Improvement in the status of key Food, Nutrition, Health and WASH (FNHW) behaviours among SHG women and in turn contribute to poverty reduction by decreasing out of pocket expenditure due to poor health and by increasing income through establishment of FNHW enterprises.

Objectives:

1. Improve awareness among the SHG members on good behaviours and practices on FNHW with special focus on first 1000 days (i.e., Antenatal Care, Postnatal Care, Infant and Young Child Feeding, Maternal and child Nutrition and IFA consumption).
2. Improve knowledge of target beneficiaries through community institutions (SHG, VO and CLF) on government services, schemes and entitlements related to FNHW.
3. Establish and strengthen functional convergence platforms with related SRLM verticals and other government/non-government stakeholders for improving access of SHG households to FNHW services.
4. Improve livelihoods of women under the women collectives (VOs and CLFs) through FNHW enterprises while also improving the FNHW outcomes of households associated with TRLM SHGs.

Target Group

All SHG members and their family, particularly:

a) Pregnant women in SHG families
b) Lactating mothers in the SHG family
c) Children under 2 years

d) Adolescent Girls in SHG families

Area of Operation

The FNHW interventions in TRLM will be implemented in 61 CLFs under 6 resource blocks of three districts viz. Dhalai, Gomati and South Tripura in phase manner. In first year i.e., 2020-21 FNHW interventions was initiated in 5 CLF in Dumburnagar, Dhalai; Killa and Matabari in Gomati districts. This year the implementation is expanded into all 8 districts covering 32 blocks. The number of VOs, SHGs in CLF is shown in the following table.

Sl. No.	District	Block	Name of CLF	No. of VOs	No. of SHGs	VO/CLF Level Community Cadre
1.	Dhalai	Ambassa	Sarbajaya	15	269	15
2.	Dhalai	Ambassa	Swapner Siri	13	261	13
3.	Dhalai	Ambassa	Swargar Yakhili	14	283	14
4.	Dhalai	Durgachowmuhani	Anuradha	9	140	9
5.	Dhalai	Durgachowmuhani	Tejaswini	12	240	12
6.	Dhalai	Durgachowmuhani	Natun Disha	7	143	7
7.	Dhalai	Salema	Mamata	10	168	10
8.	Dhalai	Salema	Alor Disha	12	236	12
9.	Dhalai	Manu	Sonar Tari CLF	13	214	13
10.	Dhalai	Manu	Tripureswari CLF	11	243	11
11.	Dhalai	Chawmanu	Chati CLF	9	190	9
12.	Dhalai	Chawmanu	Roshni CLF	8	159	8
13.	Dhalai	Dumburnagar	Ujjal CLF	14	248	14
14.	Gomati	Amarpur	Birganj Kartabya CLF	17	357	17
15.	Gomati	Silachari	Silachari CLF	12	230	12
16.	Gomati	Tepania	Natun Disha CLF	16	298	16
17.	Gomati	Tepania	Bijoyee CLF	14	220	14
18.	Gomati	Ompi	Changang CLF	17	377	17
19.	Gomati	Ompi	Twidu CLF	16	374	16
20.	Gomati	Karbook	Karbook CLF	20	361	20
21.	Gomati	Karbook	Tirthamukh CLF	15	251	15
22.	Gomati	Kakraban	Kakraban CLF	8	450	8
23.	Gomati	Kakraban	Mirza CLF	10	223	10
24.	Gomati	Matabari	Dataram CLF	12	179	12
25.	Gomati	Matabari	Maharani CLF	11	194	11
26.	Gomati	Matabari	Matabari CLF	15	290	15
27.	South	Jolaibari	Kalsi CLF	17	333	17

	Tripura					
28.	South Tripura	Jolaibari	Debdaru CLF	14	280	14
29.	South Tripura	Jolaibari	Jolaibari CLF	13	254	13
30.	South Tripura	Jolaibari	Muhuripur CLF	17	308	17
31.	South Tripura	Satchand	Kalachara CLF	13	421	13
32.	South Tripura	Satchand	Manubazar CLF	15	362	15
33.	South Tripura	Satchand	Sabroom CLF	16	483	16
34.	South Tripura	Rajnagar	Mangaldeep CLF	15	298	15
35.	South Tripura	Rajnagar	Natunalo CLF	12	242	12
36.	South Tripura	Hrishyamukh	Ujjwalayan CLF	14	261	14
37.	South Tripura	Hrishyamukh	Ujjwayani CLF	24	388	24
38.	South Tripura	Bokafa	Alor Disha CLF	12	260	12
39.	South Tripura	Bokafa	Joyee CLF	14	256	14
40.	South Tripura	Bokafa	Ujjal Yapri CLF	12	220	12
41.	South Tripura	B.C. Nagar	Deepshikha CLF	6	113	6
42.	South Tripura	Poangbari	Poangbari CLF	16	293	16
43.	South Tripura	Rupaichari	Rupaichari CLF	14	198	14
44.	West Tripura	Lefunga	Holong CLF	7	215	7
45.	West Tripura	Old Agartala	Alo Jyoti CLF	12	220	12
46.	Khowai	Khowai	Naba Diganta CLF	9	209	9
47.	Khowai	Padmabil	Kuchuk Yakhwrai	7	156	7
48.	Sepahijala	Bishalgarh	Gokulnagar CLF	11	240	11
49.	Sepahijala	Charilam	Charilam CLF	8	240	8
50.	North Tripura	Jubarajnagar	Alor Dishari CLF	13	235	13
51.	North Tripura	Panisagar	Sarbajoyi CLF	8	190	8
52.	Unakoti	Gournagar	Abahan CLF	18	292	18
53.	Unakoti	Kumarghat	Bijoyee CLF	14	235	14
8 districts		**32 blocks**	**53 CLFs**	**VOs**	**SHGs**	**CRPs**

Strategies and activities under FNHW interventions

For introducing the FNHW (Food, Nutrition, Health and WASH) interventions a multi-dimensional approach will be adopted to establish the 4 strategic pillars as per the national guidelines, which are as follows:

i. System Strengthening
ii. Social and Behavioural Change Communication
iii. Convergence
iv. Promotion of FNHW Enterprise

In the initial phase of introducing FNHW interventions, TRLM will adopts first three strategies and then gradually introduce the 4th pillar on Promotion of FNHW enterprise.

1. **Systems strengthening:** For system strengthening TRLM will take up various initiatives to recognize FNHW as an integral component of development to reduce poverty. Following measures will be taken up under system strengthening:
   - **Selection of Community Resource persons (CRPs):** State Resource Persons (SRPs) will be identified from existing mission staffs trained on FNHW. Swasthya Sakhi will be identified from the existing community cadre in the intervention geography and will also be trained on FNHW by the trained MRPs. As per the strategy there will be 1 Swasthya Sakhi for every VO.

   - **Capacity building of SRLM staff and cadres:** SRLM staff and cadres will be oriented on different sessions under FNHW and operational aspects of FNHW integration, which will be rolled out in the SHG. This will be done with support from NRO and other technical partners. The trained staff and cadres will further extend their support in facilitating the MRPs in the blocks at CLF level. Further, SRPs will train the swasthya sakhis to rollout the FNHW sessions in the SHGs.
   - **Establishing periodic reporting process:** Reporting of monthly progress at the project and field level will be done. The measurable indicators will be majorly the process indicators to understand the coverage of capacity building of cadre, SHGs and their federation. In addition to that, if any community events are organized then it will also be included in the reporting process.
   - **Establishing review mechanism at all level:** The agenda of FNHW will be added in the review mechanism at the level of VO, CLF, block, district and at the state. The respective point person at each level will take the lead in organiszng and reviewing the progress, identifying gaps and providing needful suggestions for further improvements in the FNHW interventions and integration.
   - **Exposure visit of staff/YPs and Cadres:** For cross learning and capacity building some exposures will be planned for the staff/YPs and the cadres. The cross-learning exposures will be focused on new initiatives for example exploring new ideas for developing FNHW enterprises at the VO and SHG level.

2. **Social behaviour change communication**

Within the life cycle Approach (LCA) during the stages of pregnancy and development of a new born; there are two important factors of behaviour – Supply and Demand.

One is by the service providers viz. ANM, ASHA, AWW, Medical practitioners, etc. and the others at the family/household/community level by mothers, caregivers at home, relatives or decision makers

and elders in the family. Early registration, ANC check-up, IFA distribution, immunization of mother and children, institutional delivery, JSY, spot feeding of children under SNP, growth monitoring, etc. are some of the activities provided by the service providers. On the other hand, adequate rest during day time (at least 2 hrs.), extra diet, infant feeding process (position) and frequency, IFA consumption, new born care, exclusive breast feeding, health seeking manners, etc. are some examples of household level behaviours. And maximum of the infringement happens in this part at household/ community level. The behavioural practices in some of the household in the project areas on pregnant, lactating and new born particularly on less diet during pregnancy, early bathing of infant, poor and late initiation of breast feeding, early introduction of complementary feeding or top feeding practices before six months, multiple handling and exposes in many hands during neo-natal period, etc. coupled with high rated of infections, diseases and threats. Thus, it is very much necessary to ensure that mothers, care givers and family members are provided with appropriate knowledge, capacity and guidance on recommended household level good practices on regular basis with proper follow-up mechanism. To strengthen the BCC component in FNHW interventions some reference materials, handbooks, banners, posters, hoardings, some sort of checklist or tool on assessing the behavioural practices to be developed. The thumb rules, do's & don't, technical know-how, frequently asked questions (FAQ), etc. covering the FNHW interventions will be prepared and widely distributed and displayed up to the district, block, CLF, VO, SHG level.

Adolescent girls in SHG families:

Hygiene during menstruation is an inevitable part of woman's life. Various aspects such as physiology, pathology and psychology of menstruation have been found to be associated with health and well-being of women. It is during this period a woman is regarded most vulnerable for developing any kind of reproductive tract infections, urinary tract infections, and various sexually transmitted diseases. Menstrual hygiene deals with special healthcare needs and requirements of women during monthly menstruation or menstrual cycle. Therefore, increased knowledge about menstruation right from childhood may escalate safe practices and may help in mitigating the suffering of millions of women. Menstrual hygiene management should be an imperative part of healthcare. Sensitization programme on menstrual hygiene for adolescent girls can be organized in convergence with NHM.

3. Convergence

The FNHW interventions are a composite package of cross cutting issues on Health, Social Welfare, DWS, Local Governance and livelihood. Accordingly, the Ministry of Health and Family Welfare (MoHFW) and the Ministry of Women and Child Development (MoWCD) are the most relevant ministry for FNHW convergence. Further the schemes have been identified on the basis of core required areas of basic interventions like, the First 1000 days, the Complementary Nutrition at HH level, etc, which improve the FNHW key indicators. It is very imperative to leverage and develop a synergy of programs and schemes viz. NHM, ICDS, SBM, DWS and GPDP with TRLM. Consequently, the focus is given on such schemes, which are directly beneficial for the SHG HHs as well meet the defined FNHW objectives and are linked with the livelihood mandates of TRLM.

Six services provided by the AWC are – NFE, SNP, Immunization of Pregnant and Children, Health Check-up and Growth Monitoring, Health Nutrition Education Counselling, and Referral. Beside their daily activities of NFE and SNP they also organized some monthly IEC events at the AWC level where the meaningful synergy could be carried out

1) Birthday celebration or Suprasan Day: In every month, birthday of any children falls in that month will be celebrated at the AWC level.
2) Annaprasan Day: On the completion of 180 days of every child rice feeding ceremony celebrated at the AWC level.
3) Kanya Santan Divas: On the occasion of birth of a girl child, will be celebrated.
4) Swaad Bhakhhan: During the pregnancy, Swaad Bhhakhhan ceremony celebrated in case of every pregnant woman.
5) Celebration of these 4 special days at the AWC level, are budgeted by ICDS @Rs.250/- per event per month. These events are organized to deliver some important messages, counselling and providing the due services to them. SHG/VO with the collaboration of AWC, could add some value, mobilize more people on these days more meaningfully.

Participation of SHGs/VOs/CLFs in the POSHAN Abhiyaan and POSHAN Pakhwada (fortnight) during last two years has paved this path and established a good relationship among SHG/VO/CLF, and the AWC. Health Sub-Centre is the last point of health services by the government providing primary health care and immunization services to children and women through ANC, organizing immunization day, VHND, out-reach camps, home visits, counselling, etc. on which VOs can leverage to take the maximum benefits.

Every Tuesday '***Matri Mangal'*** is celebrated to ensure quality ANC including blood test, pressure check and medicine distribution. To strengthen this convergence among the SHGs/VOs/CLFs and the concerned line departments viz. Health, ICDS (Social Welfare), DWS and PRIs some collateral measures could be taken. The following initiatives are proposed to be institutionalized and practicedon regular basis.

1. Frontline workers like ANM, ASHA, AWC, Swachhata Doot, etc. and PRI members would be participating as an invitee in the VO & SHG meeting to aware the members on different issues (at least once in a month
2. VO representatives, SHG members, Swasthya Sakhi to attend any events at AWC and Sub-Centre level.
3. VOs under TRLM could be a nominated member in each of the standing committee of line department programs at the grass root level, i.e., Village Health and Nutrition Committee, Village Water and Sanitation Committee, AWC Management Committee, Sub-Centre Management Committee, etc.
4. VOs with the support of VC/GP should convene a monthly meeting with all the frontline workers related o FNHW interventions at the GP/VC office chaired by the GP/VC President. This is to create a supportive and responsive environment towards addressing the issues of pregnant, lactating and children in the village, mainly from the deprived, vulnerable and resistant households.

Integration of FNHW intervention with other thematic interventions:

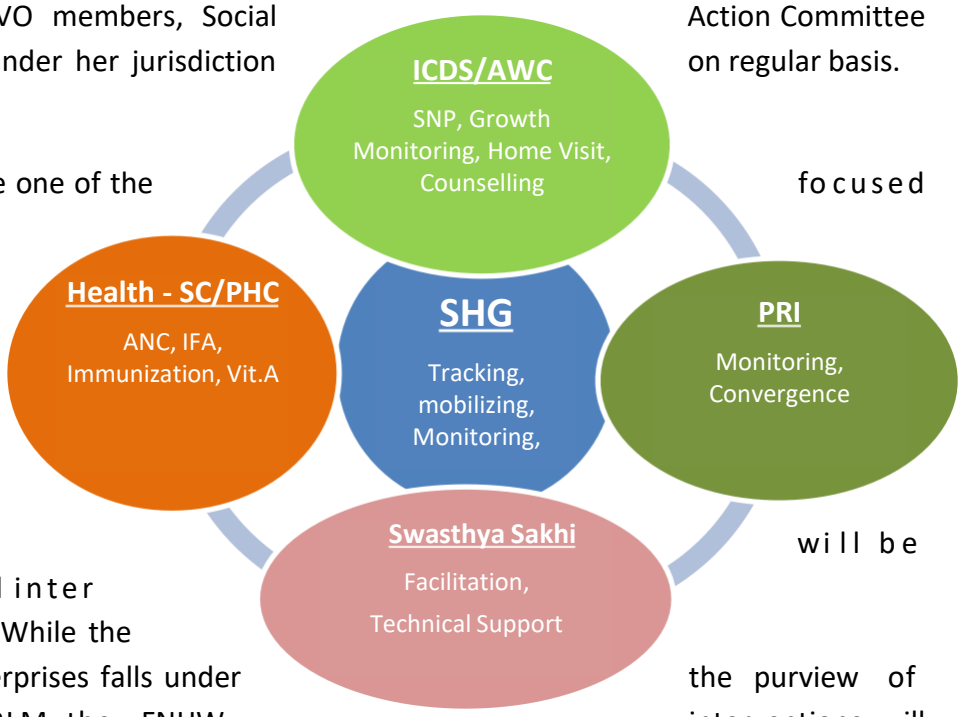
The integration within TRLM with other livelihoods intervention is identified as one of

the key convergence strategies. On the pathway of development of livelihoods-based institutions, the individuals/ beneficiaries start with thrift & credit activities, then strengthens the agriculture and its allied based livelihoods activities to full fill the food requirements of the household, there is a gradual organic link with the nutrition and food security. Similarly, there is an organic link in activities of SHG, which starts from thrift and credits, gradually start agriculture activities under on farm livelihood activities and now focusing on food security, dietary diversity, primary health & nutrition issues. The purpose of FNHW integration is to support SHG households in accessing and consuming minimum expected food groups from the available HH food baskets. The project has majorly established the linkages and integration with kitchen/nutria-garden, poultry, dairy, small enterprises, creation of vulnerability reduction fund, food security fund and Health and Sanitation Fund, etc. Similarly, the FNHW agenda is being incorporated in CBOs' meetings for inculcating the practice of integration within the community institution. The *'Dasa Sutra'* approach further to be revisited in the project areas and strengthened. Promotion of FNHW cadre as *Swasthya Sakhi* as the resource person at the community level for every VO who will be engaged dedicatedly to integrate the FNHW interventions, establish the strategy and provide support in capacity building,

training program for the VO members, Social Action Committee (SAC) and SHGs members under her jurisdiction on regular basis.

4. FNHW Enterprise:

The FNHW enterprise will be one of the focused interventions. This would be a combination of activities for generating demand, income and building awareness for improving the health and nutrition outcomes among the SHG households. This will be done through intra and inter departmental convergence. While the establishment of social enterprises falls under the purview of Non-Farm vertical of TRLM, the FNHW interventions will focus on promoting usage of FNHW related products being manufactured at the enterprises and on improved awareness about the products among SHG households.



- In order to promote FNHW enterprises in a more structured manner, it is planned that during the first six months, the mission will focus on learning about enterprises through exposure visits to successfully running enterprises located in other districts or states. In coordination with Non-Farm team, capacity of the SHG/VO members will be built on establishing and managing enterprises.
- Support will be extended to existing FNHW enterprises that promote improvement in nutritional intake, health and WASH behaviour through affordable products/services, such as production of soaps, sanitary napkins etc.

Project Level Implementation Arrangement

TRLM has developed the below system for smooth functioning of FNHW interventions. The organogram reveals that there is a three-tier structure in the organization. At the State, there is a State Mission Management Unit (SMMU), at the middle, there is a District Mission Management Unit (DMMU) & at the bottom, there is a Block Mission Management Unit (BMMU).

Identify state nodal person:

The State Mission Manager (IBCB)/ Programme Manager (IB &SI) is identified at the state level as the State Nodal Person for anchoring the FNHW activities in the state. The state nodal person will coordinate with the NMMU, SMMU, DMMU, BMMU, community institutions, line departments and agencies for planning, implementation of activities, monitoring and reporting.

Constitute a core committee:

A core committee will be formed under the Chairmanship of the CEO-TRLM, with the membership of ACEO/AMD of TRLM, different thematic SMMs from the SMMU, Staff and selected Cadres from districts and blocks (selected for implementation of FNHW interventions), Resource person from the State or NMMU. Details regarding the composition and TOR of the committee is given below.

Composition of State Core Committee:

The state core committee for FNHW will be established under Chairpersonship of the CEO, TRLM. The core committee will mandatorily hold quarterly meetings and may also additionally meet as and when required. The minutes of the meeting will be recorded and Action Taken Report will be discussed in the following meeting. The proposed core committee will have the following members:

1. CEO, TRLM **- Chairperson**
2. ACEO/AMD/COO - Member
3. SMM (IBCB) FNHW - Convenor
4. PM (IB-SI) -Member
5. SMM (Livelihood) - Member
6. SMMs (M&E) - Member
7. SMMs (FI) -Member
8. State Level YP (FNHW) -Member
9. DMMs of selected districts - Member
10. BMMs of selected blocks -Member
11. Leaders from VO/Cadre - Member
12. Resource Person (NRP/SRP) - Member
13. Any other, nominated by the Chairperson

TOR of State FNHW Core Committee

The core committee would be a managerial and coordination body with responsibilities to:

I. Appoint a nodal officer to coordinate with the NMMU, NRO and other stakeholders as required.
II. Establish protocol for convergence between SRLM, State Health Mission, ICDS and other relevant departments, agencies, institutions and conduct regular convergence meetings.
III. Coordinate development of the state operational strategy for FNHW integration and ensure adherence to the strategy/guidelines.
IV. Guide development of state Annual Action Plan (AAP) and incorporate FNHW related activities.
V. Regularly review the progress of FNHW interventions in the state against the work plan set in the AAP.
VI. Develop State specific IEC strategies, various tools / checklist, reference reading materials for training, posters, banner, hoardings etc.
VII. Undertake problem solving for roll-out of FNHW implementation plan.
VIII. Coordinate with internal M&E team, NRP/SRP, development partners to undertake evaluations/research studies/documentation of best practices/case studies etc.
IX. Identify FNHW indicators and ensure their inclusion in SRLM MIS.
X. Coordinate efforts to contribute to the state and national knowledge management system.
XI. Guide internal linkages with FNHW of related activities within other verticals ofTRLM

At SMMU Level:

At the state, the CEO-TRLM/TRLM is supported by the different thematic SMMs, who play the central role in managing the project and provides the guidance as well support to the district and block team of the Mission. The SMMs are responsible to provide the required information to the CEO in time as well to participate in the planning, monitoring, review and preparing the program strategies. To assist the SMM there is also a thematic PM under SMM, who plays the crucial role in the organization. Further, APMs are being placed at the state under different thematic areas to assist the program and to provide support to the SMMs. The FNHW is one of the dedicated vertical at TRLM, which has been mentioned in the above organogram separately for the greater visibility. In introducing the FNHW interventions, the SMM – IB&CB would lead the entire FNHW program and activities as per the directions and guidance of FNHW core committee formed at the state. The empaneled resource pool on FNHW will support the SMM- FNHW in rolling out and up scaling in the project areas.

At DMMU Level:

At the DMMU level, the District Coordinator under the vertical of the IB&CB and SI&SD will be the point person and would be responsible to initiate the FNHW related interventions in the entire district. He / She will work under guidance and supervision of SMM-FNHW. All the Block Mission Coordinators in the district will work as per the directions and guidance of District Coordinator.

At BMMU Level:

The BMMU is the core unit for implementation of all the FNHW interventions. Therefore, all Cluster Coordinators and the BMM would be responsible to roll out the FNHW interventions in all the CLFs and VOs. In every block there are 3-5 Cluster Coordinators depending upon the number of GP. The entire BMMU staff will be trained on FNHW interventions. They will be the main driver to lead the FNHW interventions in the field. There are many thematic cadres at the village level under the Cluster Coordinator at the VO level. These Community Cadres will support eh Cluster Coordinator, who will be responsible to provide the handholding support to CBOs on planning, execution and review the FNHW activities, conduct in capacity building and trainings and follow-up.

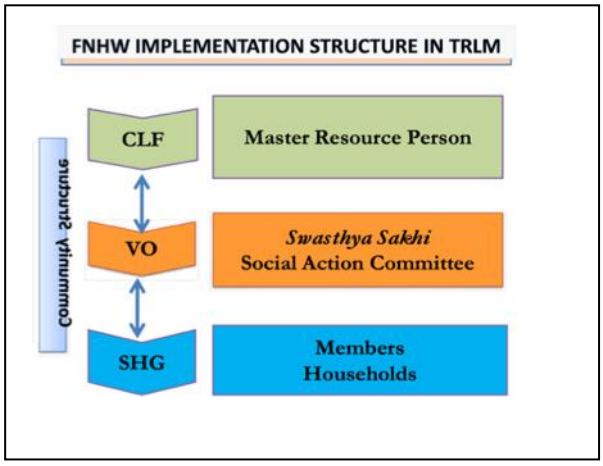
Community Level Implementation Arrangement

For effective implementation of various project activities at the grass-root level under any vertical of the TRLM, the three-tier community-based structure of SHG-VO-CLF are been applied in arrangement to roll out, implement, capacity building, monitoring and review, handholding, etc. under TRLM. Under the FNHW vertical the Social Action Committee (SAC) at VO as well as at CLF would be the responsible core committee at the community level. At the CLF level, there would be a MRP (Master Resource Person) mainly for CB, technical guidance to CLFs and VOs, review and monitoring, maintaining of MIS and reporting. At the VO or Panchayat level, there would be a

Swasthya Sakhi, who will be providing the services to the SHGs under that VO. At the SHG level, every individual member would be the mobiliser & motivator and ensure the recommended best practices within her family members, relatives mainly on the pregnant, lactating and the children up to 2 years. The purpose of this arrangement is to bring the behaviour change at the household level, increase the accessibility as well creation of demand for health and nutrition services and behaviours among all the households of SHGs' members.

State Resource Person (MRP):

The State Resource Person (MRP) on FNHW to be selected and placed with CLF to support FNHW related activities in all the VOs under the CLF in the areas of CB, review and monitoring, planning, handholding, etc. Her key responsibilities would be:



a) Be the part of the District Resource Pool on FNHW
b) Trained the *Swasthya Sakhi* and VO – SAC on FNHW and BCC modules.
c) Provide handholding support to the *Swasthya Sakhis* in rolling out different modules at the VO level with the support of SAC.
d) Support in MIS data entry related to FNHW
e) Maintain FNHW database: grading formats of VO performance, training plan, training reports, etc.

Swasthya Sakhi

Swasthya Sakhis to be selected from the existing pool of Cadres at the VO level. LRG who had the prior experiences on line department activities and preparation of VRP and VPRP under the PRI-CBO convergence initiatives in the project would be promoted as Swasthya Sakhi and should provide 50% of her time in FNHW interventions in her VO areas. The *Swasthya Sakhi* is expected to perform the assigned responsibilities -

a) To provide handholding support to SAC members to have a clear understanding on issues and activities of FNHW interventions.
b) Support to VOs for conducting community awareness activities and campaigns on FNHW issues.
c) Attend the VO meetings and roll-out of FNHW SBCC modules.
d) Ensure participation of Frontline Workers (ASHA/AWW) in the meetings. (At least once in a month)
e) Participate in Annaprashan Diwas, Suprashan Diwas(Birthday), Kanya Santan Diwas and Saad Bhakhhan Diwas
f) Participate in VHND and mobilise the community through the VO/SHG network..

g) Participate in SHG meeting and provide need based support to the SHGs.
h) Support the VO-SAC in conducting meeting on FNHW to review, monitor and plan
i) Handholding support to the SAC in each VO to maintain data base of VO
j) Maintenance of MIS and reporting

Sub- committee of Village Organisation- Social Action Committee:

At VO level, a Social Action committee (SAC) is formed with 3-5 members all across during the preparation of VO annual action plan, who would be main anchor of FNHW interventions at each GP level for coordinating with Frontline Workers (FLWs) and ensuring the participation of all the eligible beneficiaries from her respective SHGs in VHND, immunisation camps and other events at the AWC level. Given below are the key roles and responsibilities assigned to the SAC:

a. Women, who are in the third trimester of pregnancy to ensure institutional delivery and initiation of breastfeeding within one hour of delivery
b. Recently delivered women to ensure exclusive breast feeding and early and prescribes immunisation of children.
c. Children aged of 6-8 months to ensure timely initiation of complementary feeding
d. Regular interface with FLWs and mobilise the beneficiaries to access services provided by FLWs.

Being the representative of VO, SAC voluntarily performs the above tasks.

Log Frame

Objectives	Outcome	Output	Activities	Indicators (Suggestive)
Objective 1: Improve awareness among the SHG members on good behaviours and practices on FNHW with special focus on first 1000 days (i.e., Antenatal Care, Postnatal Care, Infant and Young Child Feeding, Maternal Nutrition and IFA consumption)	Improved Health and Nutritional status of pregnant and lactating women and children	Improved diet diversity among pregnant and lactating mothers Improved status of early initiation of breastfeeding, exclusive breastfeeding, timely complementary feeding with minimum recommended diet diversity	Capacity building and awareness generation of TRLM Staff, cadres, EC & SAC members of VO and CLF on promotion of good behaviours and practices on FNHW, on SBCC modules and importance of first 1000 days SHG level rollout of FNHW SBCC modules (importance of 1000 days) Mobilising SHG members to converge with the AWC promoting access to FNHW services Promotion of food processing units and other FN HW enterprises aimed at producing nutritious food through locally available raw materials (Complementary/ supplementary food)	% SHG members whose awareness has improved on: - Good infant and young child feeding practices - Importance of ANC - Maternal diet - PNC
Objective 2: Improve knowledge among community institutions (SHG, VO and CLF) on government services, schemes and entitlements related to FNHW	Access of services and entitlements to beneficiaries, leading to poverty reduction	Improved demand accessing ICDS and VHSND services Increase in number of beneficiaries linked with ICDS Centres Improved demand for PDS services & new PDS cards by left-out beneficiaries Improved demand for entitlements such as pension schemes and insurance schemes for widows, elderly and PWD etc.	Awareness generation in a cascade manner for SHG members on Govt services and schemes available for women, children, elderly and PWD (such as PDS, THR etc.) Campaigns to support SHG and their families to enrol for PMJAY, PMMVY, Insurance and other applicable Insurance schemes.	% increase in SHG women accessing PDS, THR, VHSND services % increase in SHG families enrolled for government schemes like PMJAY, pension, insurance and others.

Objectives	Outcome	Output	Activities	Indicators (Suggestive)
Objective 3: Establish and strengthen functional convergence platforms with related SRLM verticals and other government/non-government stakeholders for improving SHG's access to FNHW services	Improved access to regular and quality FNHW services for the beneficiaries	Regular meeting / interaction among intra and inter verticals for improving access to quality services	Identify convergence partners at VO, CLF, Block district and state level Link SHG/VOs with other verticals like farm and non-farm livelihoods to integrate FNHW with livelihood and promote income generating activities Conduct intra and inter departmental convergence meetings/ interactions at VO, CLF, block district and state level for quality services	No. of convergence partners identified at different level No. of convergence meetings planned and held at different level Activities planned or decisions taken in the meetings for FNHW integration No. of VO/SHG member benefitted by services through convergence
Objective 4: Improve livelihoods of women under the women collectives (VOs and CLFs) through nutrition based enterprises while also improving the nutritional outcomes of households associated with TRLM SHGs.	Sustainable enterprises are established generating sustained revenue and profits Improved FNHW outcomes of beneficiaries availing these products and services from such FNHW enterprises	Establishment of profitable enterprises by community institutions/ members	Identification of willing and eligible community members/ institutions for starting FNHW enterprises Needs Assessment to identify FNHW enterprise opportunities Training and orientation of community institutions Inter and Intradepartmental convergence Funding and Setting up of the enterprises	Number of community institutions involved in FNHW Enterprises Number of FNHW enterprises running in the state Number of SHG women involved in FNHW enterprises Number of SHG women for whom SHGs Total revenue from FNHW enterprises Average annual Income of SHG women from FNHW enterprises Annual Sales figures

Monitoring Learning and Evaluation:

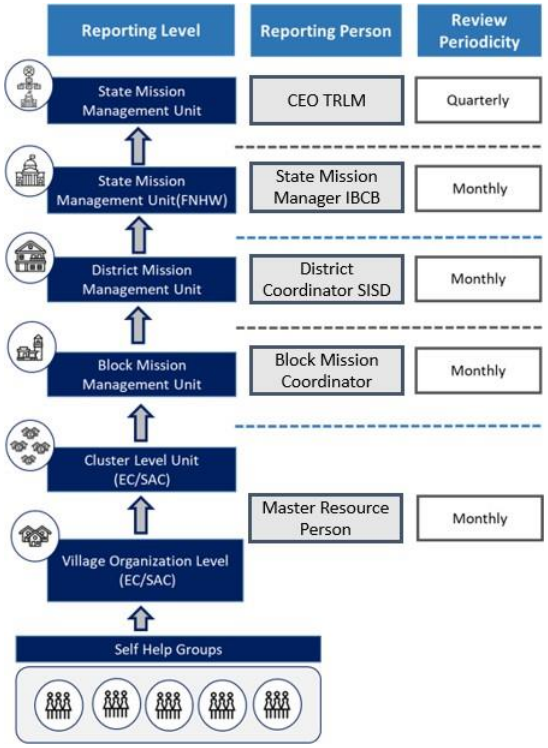
The primary objective of Monitoring Learning & Evaluation (MLE) framework is to institute a comprehensive system of evidence-based decision making. The MLE framework should enable SRLM to constantly monitor, review and support the implementing bodies at various levels. The MLE components also facilitate assessment of role of SRLM towards penetration of FNHW awareness, rural poverty reduction, livelihoods promotion, empowerment, quality of life and wellbeing of the poor. Given the scale and diversity of the Mission, which is geographically dispersed and institutionally decentralised, a comprehensive MEL has been provided with the following mechanisms:

Program evaluation:

- Baseline, Midline and End-line assessment – The assessments will be done internally through CRPs. Survey formats and questionnaires will be developed at state taking into account FNHW target indicators as captured in NFHS-5 as well as the interventions planned under the strategy. CRPs will be trained on conducting the surveys using the formats. Their capacity will also be built on compiling all the formats and submit in form of a report at VO. In order to maintain more transparency and accuracy, the area of survey will be different from their duty village. This exercise will be conducted for all the assessments including baseline, midline and end-line. Rapid Baseline of existing SHG members in the intervention blocks using a multi stage cluster sampling will be undertaken by SRLM in 2021. The baseline study will analyse and report on qualitative and quantitative indicators (to be finalised in consultation with NRLM).
- Mid of the second year of implementation (around December 2022) a midline assessment will be undertaken to assess the progress made and to undertake any course correction measures (if required). At the end of 3 years i.e., in January 2024, an end line will be conducted to assess the impact of the interventions

Some of the key indicators for evaluation will be:

S.No.	Indicators
Food	
1	% of eligible SHG HHs enrolled in PDS
2	% of pregnant and lactating women receiving THR
3	% of children between 6 months and 3 years receiving THR
4	% of children studying in classes 1 to 8 receiving mid day meal
5	% of identified SHG HHs developed Nutri garden
Nutrition	
6	% children aged 0–11 months were breastfed within one hour of birth
7	% children fed colustrum
8	% of children under age 6 months exclusively breastfed
9	% of children 6-11 months whose complementary feeding was initiated timely
10	% of children 6-11 months who were fed the minimum number of times per day for their age (minimum meal frequency)
11	% of children 6-11 months who are fed an adequately diverse diet (who received 4 or more food groups out of 7 the previous day)
12	% of children 6-11 months whose received minimum acceptable diet



13	% of lactating women who are fed an adequately diverse diet (who received 5 or more food groups out of 10 the previous day)
14	% of women consumed IFA for 100 days or more when they were pregnant
Health	
15	% of institutional births
16	% of mothers who had at least 4 ANC care visits
17	% of mothers who had full ANC care
18	% of children received dry cord care
19	% of children fully immunized (Age appropriate)
WASH	
20	% women who use hygienic methods of protection during their menstrual period
21	% HHs who have access to toilet/Households using improved sanitation facility
22	% women who practice appropriate handwashing practices (before eating, after defecating, before feeding child, after washing child feces, may be customized based on COVID 19 prevention protocols, etc.)

MIS

Management Information System (MIS) based input-output monitoring includes Results framework-based MIS; web-based MIS; real time input-output monitoring at various levels The relevant indicators will be decided and incorporated in the main MIS of SRLM that will be monthly updated by PFT/BMMU coordinators. The validation of data/ supervision will be done at the district by the DM/ FNHW nodal person. They shall ensure timely submission for monthly progress/assessment at state. A dashboard will be developed to show the progress, gaps and required support. State Level – YP FNHW MIS will be in charge of the management and monitoring of the MIS. The MIS apart from including all FNHW indicators from NRLM MPR will also have a few additional indicators based on its requirement.

Some of the Key indicators are:

- **No. of CRPs trained on FNHW**
- **No. of CLFs SAC trained on FNHW**
- **No. of VO SAC trained on FNHW**
- **No. of SHGs where FNHW session has been rolled out (Module wise monthly)**
- **Number of review meetings organized at VO**
- **Number of review meetings organized at CLF**
- **Number of review meetings organized at Block**
- **Number of blocks reviewed at district**
- **No. of SHG members having a nutri-garden**

Process/output indicators will be collected and reported by the Social Action Committee at the VO level
Data will be entered by the Block Mission Management Unit, onto the designated MIS. State Mission Management Units will analyse the data on a monthly basis, and, with the assistance of State Resource Persons and Young Professionals at state and district level, support the Block Mission Units in implementing the Interventions

Review Mechanism:

A multi-tier mechanism for the review of progress of FNHW interventions is proposed. SAC of VOs shall monitor SHGs and review the progress across the key FNHW indicators through a VO level reporting format. The VO SACs shall report to CLF SAC through Master Resource Person (MRPs). Monthly review meetings will be organized by CLF SAC to review the progress of VOs. CLF SAC shall report to Block Mission Coordinator. At the block level, Block Mission Coordinator shall organize monthly review meetings to assess the performance of CLFs. Young Professional FNHW/ will support Block Mission Coordinator in monitoring of the interventions and reporting to the district level unit.

At district level, District Coordinator (SISD) (In-charge FNHW) will be reporting person for Block Managers. Monthly review meeting will be organized at the district by DC with Block Mission Coordinators (BMC)to review the work at the block level. At the state, State Mission Manager, IBCB, will organize monthly review meetings with District Coordinators to assess the status on achievement of deliverables (qualitative and quantitative) and to appraise the CEO. Review templates to be used at every level, will be designed, and shared by SRLM along with the calendar for organizing review meetings. Supportive supervision will be provided at each level to equip the reporting officers to review the performance of their reporter efficiently and objectively on set indicators. The performance review indicators and the outcome indicators will be finalized based on baseline reports and shared with the respective levels.

Gant Chart/Activity Plan

Activity	(Oct' 23- Nov' 24)			
	Q1	Q2	Q3	Q4
Identifications ofgeography				
Situational Analysis/Baseline				
Identification of State,district and block resource persons				
Development of intra departmental (thematic) convergence plan				
Plan strategies for convergence with other FNHW stakeholder departments (WCD/NHM,etc.)				
Development of SBCC materials and BCC plan				
Develop training modules				
Issuing state advisories/orders				
Development and Integration of MIS for review mechanism				
Distribution of SBCC materials to SHGs under selected geographies				
Training rollout in cascade model				
Promotion FNHW enterprises				
Exposure visits on FNHWenterprise models of other states				
Training on MIS/ Reporting/ Evaluation mechanism				
Training on reporting mechanism				

Activity	(Oct ’23- Nov ‘24)			
	Q1	Q2	Q3	Q4
Periodic review meetings at VO, CLF, block and district level				
Impact evaluation of key interventions				
Learning documentations				