

**Community Processes
for Mobilising Women and Communities
for improved Health, Nutrition and WASH**



Odisha Health and Nutrition Sector Programme (OHNSP)

Community Processes for Health, Nutrition, Water, Sanitation and Hygiene (HNWASH)

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Contents

1. COMMUNITY PROCESSES FOR IMPROVED HNWASH: AN OVERVIEW.....	7
1.1 Introduction	7
1.2 The Odisha Health and Nutrition Sector Plan: the starting point.....	7
1.3 Why focus on community processes?	7
1.4 What do we aim to achieve by supporting community processes?	8
1.5 How will we support community processes to be synergistic and convergent?.....	8
1.6 What will we do and where?	9
1.7 Summary matrix of CP	13
2 Shakti Varta: Participatory Learning and Action (PLA) cycle with SHGs	14
2.1 Community mobilisation through women’s groups: the evidence	14
2.2 SHGs in Odisha	15
2.3 The SHG PLA approach for HNWASH in Odisha: Shakti Varta	16
2.3.1 Process	16
2.3.2 The 20 meeting PLA cycle	17
2.3.3 Delivery of the Shakti Varta meetings	18
2.3.4 Selection of SHGs for Shakti Varta sites.....	19
2.3.5 Quality assurance.....	19
2.3.6 Information kiosks.....	20
2.3.7 Linkages with Gaon Kalyan Samitis.....	20
2.3.8 Coverage and timeline	20
2.3.9 Management and implementation structure	22
2.3.10 Human Resources	23
2.3.11 Capacity building.....	24
2.3.12 Budget	25
2.3.13 Limitations and Risks.....	25
3 Community Led Total Sanitation (CLTS).....	27
3.1 Introduction	27
3.2 CLTS plan	27
3.2.1 The implementation approach	28
3.2.2 Geographical coverage, criteria of selection and community process.....	29
3.2.3 Mobilization of Government resources	29
3.2.4 Broad strategies for Block level NGOs	29
3.2.5 Timeline for Programme Implementation	30

3.2.6	Documentation and Dissemination	31
3.2.7	Budget Estimates	32
4	Community based Management of Acute Malnutrition (CMAM)	33
4.1	Background:	33
4.2	Objectives.....	34
4.3	CMAM process.....	34
4.4	CMAM pilot.....	36
4.5	Budget:.....	36
5	Strengthening the capacity of Gaon Kalyan Samiti (GKS).....	37
5.1	Introduction	37
5.2	Key activities planned under NRHM	37
5.3	Integrated capacity building of GKS to address determinants of health.....	37
5.4	Management and implementation structure	38
5.5	Coverage	39
5.6	Implementation timeline	39
6	Linkages with existing Communication campaigns.....	39
6.1	Suno Bhouni Campaign	39
6.2	Swasthya Kantha Campaign	39
6.3	IEC activities for ten key health, nutrition and WASH messages in conjunction with other community process work.....	39
6.4	Timeline and budget	40
7	Strengthening capacity of Frontline Workers through IPC skill building	40
8	Strengthening the capacity of Jaanch and Mother’s Committees.....	40
8.1	Objective	40
8.2	Coverage	41
	Annexes.....	42

Acronyms

ADPHCO	Assistant District Public Health Communication Officer
ASHA	Accredited Social Health Activist
ANM	Auxiliary Nurse Midwife
AWW	Angawadi Worker
CLTS	Community led total sanitation
CMAM	Community management of acute malnutrition
COE	Centre of Excellence
CPRC	Community Process Resource Centre
CRSP	Central Rural Sanitation Programme
DHFW	Department of Health and Family Welfare
DPHCO	District Public Health Communication Officer
DWCD	Department of Women and Child Development
FA	Financial assistance
FLW	Frontline worker
GKS	Gaon Kalyan Samiti
GOI	Government of India
GoO	Government of Odisha
GP	Gram Panchayat
HBD	High burden district
HNWASH	health, nutrition, water, sanitation and hygiene
ICDS	Integrated Child Development Scheme
IEC	Information, education and communication
INR	Indian rupees
JC	Jaanch Committee
MC	Mother's Committee
MD	Mission Director of NRHM

MNH	Maternal and Newborn Health
MUAC	Middle upper arm circumference
NFHS	National family health survey
NGO	Non-governmental organisation
NOP	Nutrition operational plan
NRC	Nutrition Rehabilitation Centre
NRHM	National Rural Health Mission
OHNSP	Odisha Health Nutrition Sector Programme
OR	Operations research
PHEO	Public Health Extension Officer
PRI	Panchayati raj institutions
RD	Rural Development Department
SAM	Severe acute malnutrition
SIHFW	State Institute of Health and Family Welfare
TA	Technical assistance
THR	take home ration
TMST	Technical, management support team
TOT	Training of trainers
TSC	Total Sanitation Campaign
VHSNC	Village health, sanitation, nutrition committee
VLI	Village level institutions

1. COMMUNITY PROCESSES FOR IMPROVED HNWASH: AN OVERVIEW

1.1 Introduction

This paper presents how the Odisha Health and Nutrition Sector Programme working with the three government departments of Health and Family Welfare, Women and Child Development, and Rural Development, and with Mission Shakti and DFID will mobilise communities for improved HNWASH outcomes. The paper begins by setting out the rationale, scope and scale of OHNSP's community process interventions. It then unpacks the community process package, and provides a detailed description of the three new and innovative areas of action that OHNSP will bring to the state:

- Shakti Varta: community mobilisation using a participatory and learning action (PLA) cycle with women's Self Help Groups (SHGs).
- Community led total sanitation (CLTS) to mobilise communities to strive for open defecation free (ODF) living.
- Community management of acutely malnourished children (CMAM).

These three new interventions will receive the major share of technical and financial aid for CP under OHNSP. The paper then presents a shorter description of how existing government programmes will be augmented to support the community process objectives and the powerful blending of interventions needed to stimulate community action.

A separate and complementary paper on the monitoring and evaluation of community processes has been prepared, and should be read in conjunction with this document.

1.2 The Odisha Health and Nutrition Sector Plan: the starting point

The Odisha Health and Nutrition Sector Plan¹ (2007-15) is the Government of Odisha's plan of action for implementing the Government's Health Sector Strategy. The expected outcome is increased use of quality health, nutrition and sanitation services by the poor.

OHNSP has 4 outputs:

1. Improved access to priority health, nutrition and water and sanitation services in underserved areas
2. Public health management systems strengthening
3. Positive health, nutrition practices and health seeking behaviour of communities improved
4. Improved use of evidence in planning and delivery of equitable health, nutrition, and water and sanitation services

1.3 Why focus on community processes?

Odisha's health, nutrition, water and sanitation (HNWASH) outcomes have improved over the past ten years. Infant, child and maternal mortality are declining, under-nutrition too; though the journey is far from over. The systems that support HNWASH service delivery are stronger and service coverage is now better than it ever was. Targeted efforts to reach the poor, Scheduled Tribes,

¹ Previously known as the Odisha Health Sector Plan.

Scheduled Castes, and remote areas have helped reduce the gap in the use of services by these vulnerable groups compared to others. However, health practices and behaviours fundamental to improving nutrition and health status, such as diet during pregnancy, infant and young child feeding, care of sick children, handwashing, and sanitation, are poor. Against the backdrop of improving service coverage and many years of health systems strengthening in the state, it is now recognised that family practices and the underlying social determinants of poor HNWASH outcomes are key to further improving outcomes.

Communities in Odisha are diverse and complex but catalysed into action are a powerful driving force for the social and behavioural change that underpin improved health and nutrition. A major focus of OHNSP is therefore to work at the community level, to support community processes that inform, mobilise, and create the capacity, solidarity and leadership for better HNWASH outcomes. This means working across the HNWASH spectrum on convergent actions, building on existing social capital and local resources, and working in partnership with multiple agencies, programmes and stakeholders. In essence, OHNSP will seek to leverage existing community resources, augment existing programmes, bring innovation, and forge a more powerful blend of interventions to stimulate community action.

1.4 What do we aim to achieve by supporting community processes?

By mobilising communities, informing families of better health seeking behaviours, and empowering women with the skills and know-how to bring about change, the programme aims to improve HNWASH practices at the home and in the community, and increase the demand, responsiveness and use of HNWASH services.

Specifically, through support to community processes and continuing improvements in service delivery, we expect to see improvements in such intermediary outcomes as: antenatal care, safe deliveries, post natal care, early and exclusive breastfeeding, introduction of complementary feeding, complete immunisation, care of sick children, early diagnosis and complete treatment of malaria, sleeping under nets, hand washing, and sanitation.

1.5 How will we support community processes to be synergistic and convergent?

Many existing programmes and initiatives are working at the community level. To avoid duplication, and to maximise impact, OHNSP recognises the importance of working synergistically and convergently, of local ownership, and strong coordination. To support this, the programme will:

Build on existing community resources and structures: Women's Self Help Groups (SHGs), Mother's Committees, Jaanch Committees, Gaon Kalyan Samities (GKS) are important development platforms in Odisha that are already working for improved HNWASH. OHNSP will support these key platforms to become more effective vehicles for change.

Augment existing community initiatives: Suno Bhouni and Swasthya Kantha Campaign are state initiatives to raise community awareness of key HNWASH issues, and mobilise support to address them through women's groups and GKS. OHNSP will aim to build on these communication entry points and reinforce the messages and mobilisation they generate.

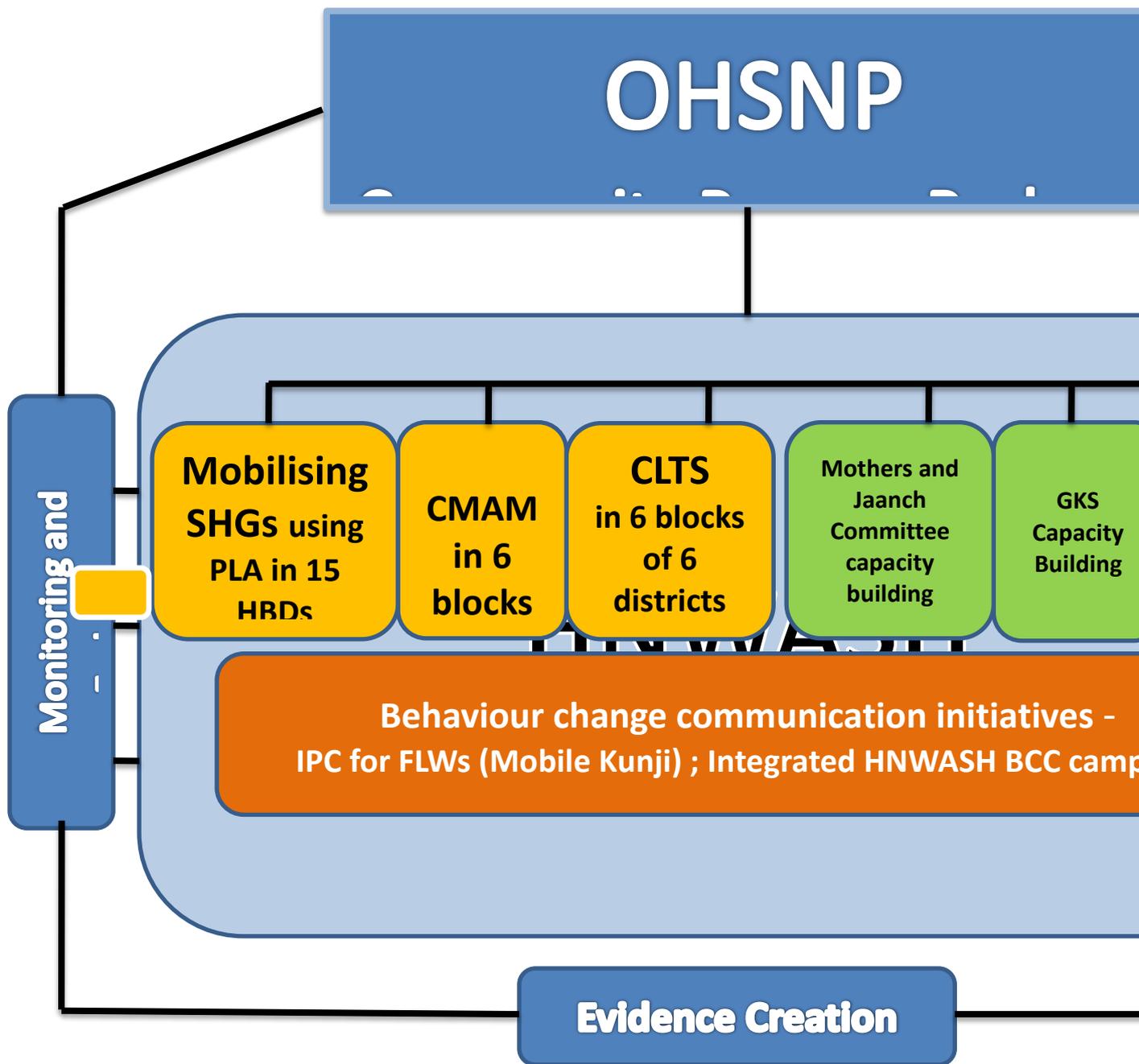
Complement government efforts to strengthen the capacity of frontline workers to deliver responsibly: Government plans to strengthen the technical and communication capacity of

frontline workers (FLWs), including the interpersonal communication skills of FLWs which are critical to mobilising communities and influencing behaviour change. GKS and Jaanch Committees already have a mandate to monitor and provide feedback to service providers to improve the responsiveness of services. OHNSP will build on these platforms to increase the interaction between women and frontline providers and provide constructive feedback on how services can be delivered to be more accessible, and respond to the needs of the local community.

Maximise linkages and coordination between interventions to strengthen the pathway of change: Coordination across departments and with the local administration will aim to foster convergence at all levels of service delivery, link and reinforce interventions. Community mobilisation activities will involve frontline workers and governance committees. Common themes, messages and logos will be used across communication material to reinforce messaging and linkages.

1.6 What will we do and where?

OHNSP will support a package of interventions to strengthen community processes; this includes the introduction of three innovative interventions and the strengthening of four existing government programmes; see later sections for detailed description. The three new interventions include:



TMST technical and implementation support for new interventions



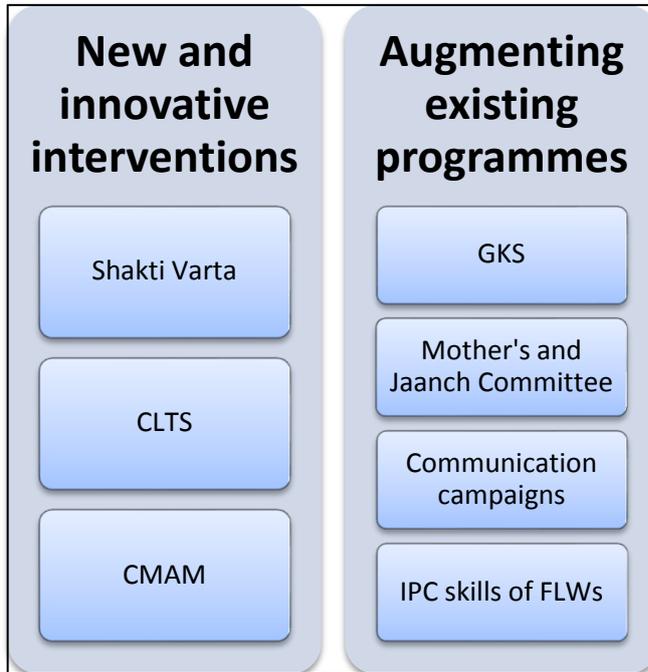
BBC Media Action support for communication interventions



Ongoing Govt. led interventions (NRHM and ICDS) including technical support provided by TMST

- Shakti Varta: community mobilisation using a participatory and learning action (PLA) cycle with women’s Self Help Groups (SHGs).
- Community led total sanitation (CLTS) to mobilise communities to strive for open defecation free (ODF) living.

- Community management of acutely malnourished children (CMAM).



Government's existing and synergistic programmes that will be strengthened and supported include the:

- Capacity building of Gaon Kalyan Samitis (GKS)
- Capacity building of Mother's and Jaanch Committees
- Suno Bhouni and Swasthya Kantha Campaigns
- Capacity building of frontline workers interpersonal communication (IPC) skills

The three innovative interventions will receive the bulk of OHNSP technical and financial support earmarked for CP.

Technical support to the existing government programmes from TMST will leverage government funding from the state and NRHM, and coordinate with other technical agencies involved in capacity building, such as BBC Media Action that is leading on the design of FLW IPC skills building.

The theory of change underpinning the community process programme rests on the three pillars of demand, supply, and governance and accountability.

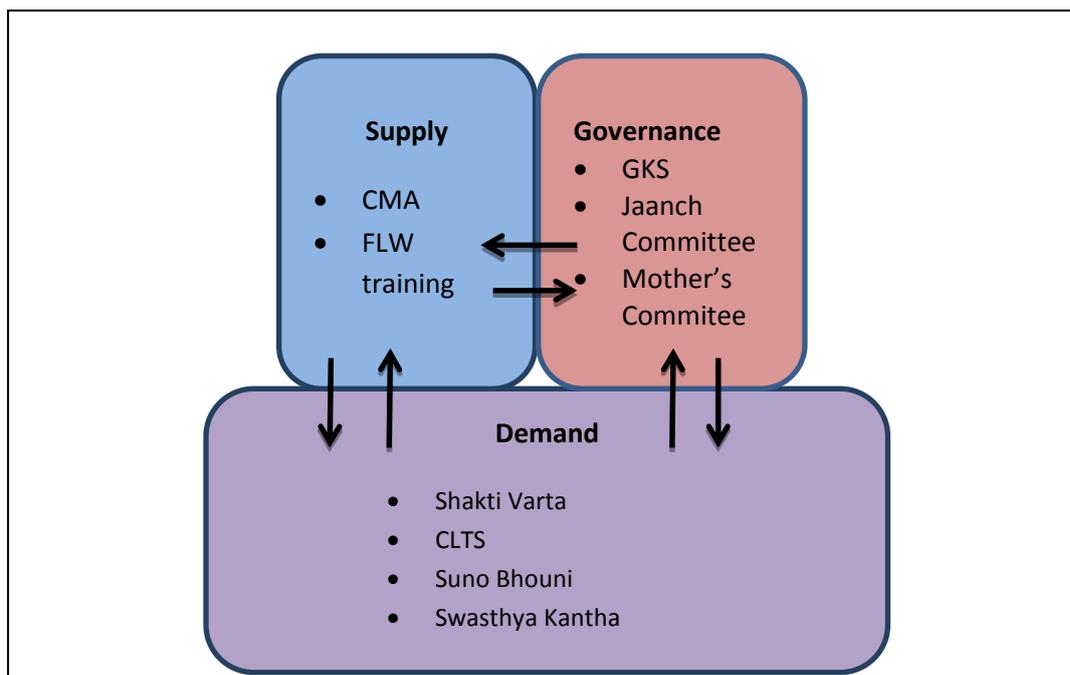
From the demand side it asserts that demand for HNWASH services and improved HNWASH behaviours can be triggered by empowering women and communities and providing them with information on their entitlements and positive HNWASH practices.

From the supply side it recognises that to both increase demand and to better respond to demand, HNWASH services themselves need strengthening to be an agent of change, and a quality service provider.

From the governance and accountability side the theory is that building the capacity of local leaders, communities and citizens to participate in local governance mechanisms will increase the responsiveness of local service provision and the quality of services.

The package of CP interventions supported is rooted across the three pillars to create and support a positive cycle of community led change.

Figure 1: Three pillars of change and CP interventions



The interventions will have differing coverage, with the new interventions tending to start in pilot or selected geographical areas before being taken to scale while government’s existing programmes have state coverage.

Figure 2: CP Interventions and coverage

Intervention areas	State wide	Across 15 High Burden Districts	Selected blocks and panchayats
A. New and innovative			
Shakti Varta: Participatory and learning action cycle through women’s SHGs		x	
Community led total sanitation to achieve open defecation free living			x
Community management of malnourished children			x
B. Augmenting existing government programmes and plans			
GKS capacity building	x		
Capacity building of Mother’s and Jaanch Committees	x		
Augmenting communication campaigns and materials	x		
Strengthening the interpersonal skills of frontline workers		x	

1.7 Summary matrix of CP

Figure 3: Summary table of community process package of OHNSP

ACTIVITIES	START OFF	SCALE UP	TA BUDGET	FA BUDGET
Empowering women through Mission Shakti and other groups:				
<ul style="list-style-type: none"> a) Structured Participatory Learning and Action (PLA) – Mission Shakti and other community groups b) Community Incentives – SHGs conditional on HNWASH outcomes 	Start implementation in 3 districts from March 2013; and expand to cover over 7 lakh women across the 15 high burden districts	Provide Support to Government to scale up in the remaining 15 districts (total 30 districts)	158597697	2871940925
Community Led Total Sanitation (CLTS)	Start in 6 blocks and expand to cover 6 pilot districts	Government departments to take a decision on scale up based on evidence from the 6 pilot districts	35000000	
Pilot on Community Management of Acute Malnutrition (CMAM)	Pilot in 4 blocks of Kandhamal	Scale up to high prevalence areas based on results and lessons from pilot	16000000	20000000
GKS capacity building to improve their financial and programme management skills and enhance spending on HNWASH outcomes	Covering more than 40,000 GKS			75000000
Capacity building of Mother’s Committees on their (MC) roles and responsibilities to strengthen accountability of the service providers	Covering around 60714 MCs			10655359
Capacity building of Jaanch Committees (JC) for clarity in roles and responsibilities and to strengthen accountability of the service providers	Covering around 65621 JCs			10655359
Communication campaigns and materials	Covering entire population			110000000
Inter Personal Communication (IPC) skill building of frontline workers (FLW)	Start in 7 districts by BBC; expand to cover more than 25000 FLWs across the 15 high burden districts	Government to scale up		50000000 (IPC)

2 Shakti Varta: Participatory Learning and Action (PLA) cycle with SHGs

2.1 Community mobilisation through women's groups: the evidence

Randomised controlled trials in India and several other South Asian countries have shown that community mobilisation through women's groups can reduce neonatal mortality and improve maternal health. Through a participatory planning process with women's groups – a community action cycle – community mobilisation reduced neonatal mortality in Jharkhand and Odisha in India², and likewise in Nepal³.

In Jharkhand and Odisha, Ekjut implemented a cluster randomised trial to demonstrate the impact of a PLA cycle on neonatal mortality. Women's groups met on a monthly basis for 20 meetings⁴. These meetings were facilitated by a local woman who had been identified by the community and trained by Ekjut. Facilitators used participatory learning and action methods such as picture-cards, games, role play and story-telling to guide meetings and to encourage discussions about the problems faced by mothers and infants, and develop strategies for prevention, home care, and seeking treatment. Selection of the women's groups and the meeting place to hold the PLA cycle sought to maximise access to the meeting, with non-members including men and local stakeholders, encouraged to join in. The meetings were not exclusive to the members of the specific women's group, and over time opened up to reach a wider community audience and stimulate community commitment to improve health practices. Linkages with village level health committees were also important in channelizing voice, and seeking responsiveness of health services.

Evidence from reproductive and maternal health care programmes show that community mobilisation empowers women, and often particularly disadvantaged women, to overcome socio-cultural, information and financial barriers to seek reproductive and maternal health care and change health practices⁵. Women become advocates for change, leverage local resources for health and speak out for improved quality of services.

Community mobilisation by encouraging community consciousness, and solidarity to act on particular issues, has the potential to address the social determinants of health, and the social norms and power dynamics that influence care practices and health care access. Moreover, by targeting excluded and vulnerable groups, community mobilisation through women's groups has shown to “get below” to include and empower groups that are at risk of exclusion from development. The transformational potential of community mobilisation is particularly important in considering how to address the social determinants of malnutrition and the gendered social norms that underpin food distribution and child feeding practices.

²Tripathy P., et al., “Effect of a participatory intervention with women's groups on birth outcomes and maternal depression in Jharkhand and Odisha, India: a cluster-randomised controlled trial”, *Lancet* 2010; published online on March 8, 2010.

³Manandhar DS., Osrin D, Shrestha BP., et al., « Effect of a participatory intervention with women's groups on birth outcomes in Nepal: cluster randomised controlled trial”, *Lancet* 2004; 364: 970-79.

⁴ Rath S., et al explaining the impact of a women's group led community mobilization intervention on maternal and new born health outcomes: the Ekjut trial process evaluation.

⁵Hulton L., Murray S, Thomas D., 2009, “The Evidence Towards MDG5: A Working Paper”, Options: London.

Community mobilisation can be a vehicle for empowering women, families and influential stakeholders to redefine the social norms that influence health and nutrition and hygiene behaviours and create the enabling environment for individual and social change.

Participatory learning and action aims to be transformational in contrast to information giving forms of communication which involve much less, if any, scope for interaction, reflection, and questioning. For many populations where there is an existing demand for services, and a readiness for improved health seeking practices, raising awareness through information giving may be sufficient to trigger behaviour change: PLA may not be necessary or represent good value for money. However, where informational gaps interact with social and cultural inhibitors to change, and affecting the social norms that underpin HNWASH behaviours are pivotal to raising poor demand for services and improved practices, then PLA is a valid response. PLA is most effective when targeted to underserved areas.

The Jharkhand and Odisha experience of Ekjut, and the Makwanpur project in Nepal⁶ shows how the participatory and learning approach fosters the confidence of participants to promote change among their families and peers, resulting in health gains being amplified across hamlets and communities. The non-incentivised participation of women and men in the meetings upholds the principles of community led sustainable development and acts to reinforce the inclusive nature of the process. Non-incentivised participation promotes individual responsibility and community solidarity and reflects good development practice.

2.2 SHGs in Odisha

In 2011 there were an estimated 4,68,900 SHGs in Odisha, with around 56,26,800 members. Other key community institutions that provide platforms for CP include Mother's Committees, Jaanch Committees, and Gaon Kalyan Samitis. Evidence collected by TMST (Assessment of community institutions in Odisha, 2012) show that a significant percentage of SHGs have been involved in community actions. These involved: improving community services including water supply, education, health care, veterinary care, village road; trying to stop alcohol sale and consumption; contributing finance and labour for new infrastructure; protecting natural resources; and acts of charity (to non-members). Such actions by SHG women reflect their agency, in terms of decision-making, and contributing to community development in a way that goes beyond traditional gender roles.

Mission Shakti is the nodal agency for forming women's groups in Odisha. The challenges of sustaining and functionalising women's groups should not be under-estimated, and as in other states, the majority of women's groups in Odisha focus primarily on savings and credit, and the promotion of income generation. Reliable evidence of the percentage of functioning SHGs is not available, but estimates from the field suggest this is in the order of 50-60% of those registered.

⁶Morrison J., et al., "Understanding how women's groups improve maternal and newborn health in Makwanpur, Nepal: a qualitative study"

2.3 The SHG PLA approach for HNWASH in Odisha: Shakti Varta

Given the social and cultural context of the high burden districts of Odisha, and mixed success in achieving HNWASH outcomes to date, community mobilisation through SHGs using a participatory learning and action cycle makes sense.

A new PLA cycle integrating health, nutrition and WASH has been developed for Odisha which:

- Builds on Odisha, Indian, and international evidence of proven effectiveness of PLA for health and nutrition, and its limitations.
- Draws on Ekjut's experience and expertise of what works in the community in Odisha, Bihar, MP, and other states.
- Focuses on improving family and community practices to reduce malnutrition, and improve newborn and maternal health, including hygiene practices.

Well documented PLA experiments through women's groups have tended to focus on maternal and newborn health, and there is less evidence of the effectiveness of PLA via women's groups to impact on nutrition and WASH outcomes. However, the participatory and reflective nature of PLA leaves this open to subject matter, and growing experience in India suggests that an integrated PLA cycle which covers a range of HNWASH practices can affect change. As PLA encourages the participation of men, adolescents and non-SHG members in the learning and action process, it will be a platform on which to engage communities on issues of sanitation. Efforts will be made to mobilise the community to take a resolution for toilet construction and usage. It is also expected that the focal SHGs will set an example to others in the community by demonstrating toilet construction and use. Scope to link improved HNWASH behaviours in the community with incentives for the participating SHGs/Federations is also being explored.

2.3.1 Process

PLA is not IEC. While IEC tries to impart information, PLA seeks to build people's capacities to identify their problems, develop strategies to tackle them, build solidarity to work together as a group and community, and put plans for behaviour change into ACTION. Shakti Varta will retain the essence of PLA as a community driven approach to stimulate action.

The PLA cycle will be facilitated by trained local women in selected SHGs in a village. The cycle will involve 20 facilitated meetings which will work through the four standard PLA phases of:

- Identify, discuss and prioritise problems
- Identify and prioritise strategies
- Implement strategies
- Evaluate progress

Included in the cycle will be meetings aimed at building group identity and belief in their capacity to foster change, and illustration of the linkages between maternal, infant and child health and nutrition and WASH. The links between early conception, low birth weight, child under nutrition and poor growth and development, and unsafe WASH practices will be brought out. The emphasis will be on using stories, games and pictures to illustrate the causes and consequences of HNWASH

problems and facilitate group discussion, problem-solving and decision-making. Key HNWASH information and simple health promoting messages will be woven into the group's discussion.

2.3.2 The 20 meeting PLA cycle

The content of the Shakti Varta meetings will be developed so that it is flexible to the local HNWASH needs and context, but standardised so that core practices are covered through the process.

Shakti Vaarta will include two interlinking problem identification exercises. These will be framed around a set of known problems linked to:

- a. Newborn and maternal health
- b. Malnutrition

The set of problem cards developed for Shakti Varta will build on those already trialled for newborn and maternal health in Odisha, and which have proven very effective, as well as learning from Bihar, and include some new cards identified as problem areas in the context of Odisha.

The problem identification process will first address maternal and newborn survival and then lead into malnutrition and child development. Issues around hygiene and sanitation are woven into both areas as critical social determinants.

Using the cards, participants will identify and prioritise their problems, and develop strategies for action around MNH. By working through the problem solving process for MNH, group participants will become familiar with this process and will have built confidence to identify the causes and solutions. Building on this base, malnutrition which is often an unrecognised problem among mothers can be more effectively introduced and actions promoted.

While maintaining the spirit of PLA, and responsiveness to community priorities, rolling out PLA at scale requires a certain level of standardisation if the intervention is to be manageable. There will be some flexibility in the sequencing of meetings, for example to reflect seasonality and context related problems, but generally the meetings will follow the same sequence.

Some actions that have proven effective in previous PLA cycles will be repeated in Shakti Varta meetings, this includes:

- a. Practicing wrapping of newborns using dolls
- b. Handwashing
- c. Positioning of the baby for breastfeeding
- d. Preparation of oral rehydration salts

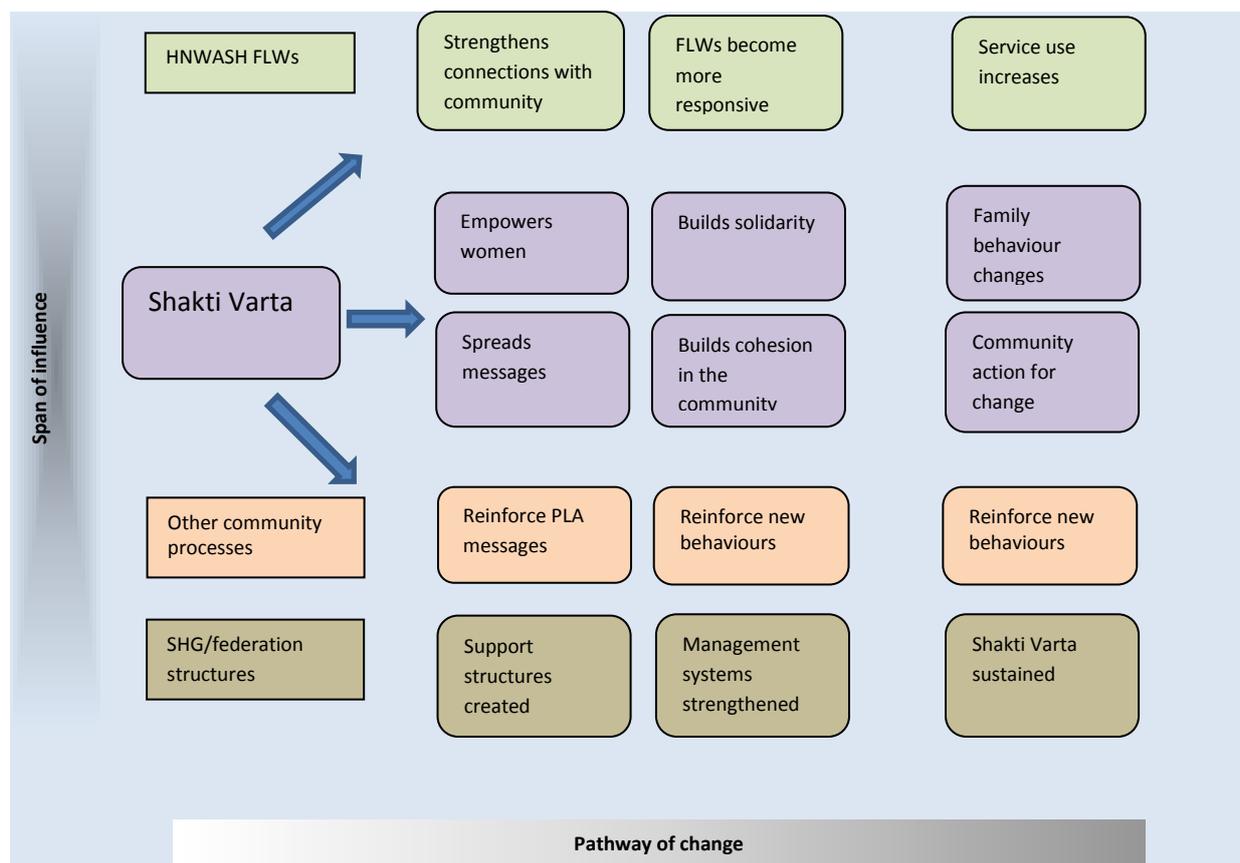
Others, such as Annaprasanna (weaning ceremony) will be tested.

Some topics and information key to improved childhood nutrition and maternal health will be woven into discussions, and covered in all groups regardless of their prioritised strategies:

- a. Birth preparedness and newborn survival practices
- b. Mapping of locally available food, and dietary diversity during pregnancy, lactation and for children
- c. Weaning and complementary feeding
- d. Diarrhoea, worms, faecal-oral transmission, sanitation including toilets

Service Providers will be invited to some of the 20 meetings during which SHG members will get a chance to interact with them and identify ways for improving quality and coverage of services being offered. This will also serve as a good platform to agree on complementary roles for effective community outreach.

Figure 4: Shakti Varta's span of influence



2.3.3 Delivery of the Shakti Varta meetings

The PLA meetings will be delivered by trained facilitators, local women identified by the Block or Panchayat Federations and partner district NGOs. Two facilitators will be engaged per Gram Panchayat and they will each cover a maximum of 10 SHGs. It will take approximately 15 months to cover the entire 20 meetings including two community meetings. Each month they will facilitate two meetings per SHG. The Facilitators will be trained in intervals during the PLA process so that new information can be shared, skills developed over time, and training sessions used to discuss and solve issues coming up from the community. The training of Facilitators will be provided in five phases throughout the full PLA cycle.

At the Block level, four Block Coordinators cum Master Trainers will coordinate implementation of the PLA cycle, provide training to facilitators, undertake community based supportive supervision and quality assurance. The four coordinators will include two full-time NGO staff, the block ICDS Supervisor, and one representative from the block federation. This will support the capacity building

of the latter two officers, prepare the ground work for future institutionalisation, and foster linkages between the SHGs and ICDS, and with the block federation.

The fortnightly Shakti Varta meetings will be between 1.5 to 2 hours in length. SHG members and other women and men in the community, particularly pregnant and lactating women, women with children below 2 years and adolescent girls will be informed about the time and venue of the meeting one day prior to the meeting by the Facilitator. Block Coordinators cum Master Trainers will support the entry of the programme in the community by engaging and orientating the Sarpanch, and by supporting the Facilitator during the initial meetings. Each SHG meeting will be documented, attendance of participants in each meeting will be tracked to ensure continuity, follow up visits will be made, and the Facilitators will reach out to the most marginalized groups to encourage their participation. Data from these meetings will be compiled at the Block level and progress tracked over time.

2.3.4 Selection of SHGs for Shakti Varta sites

The logic of the Shakti Varta meetings is that through the participatory process, participants become change agents, and that the meeting attracts non-SHG participants as well as members. Participation in the meeting is therefore not limited to the 10-12 members of the specific SHG that hosts the intervention. Field research by TMST suggests that on average a village has between 4-6 SHGs. While it is not necessary to hold PLA cycles at all SHGs in a village, it is essential that vulnerable sections of the community are reached, that the geographically isolated or distant are covered, as well as the main hub of the community. Evidence suggests that a ratio of 1 PLA SHG per 500 population is the optimal dosage, and underpins our planning.

Block federations will support the programme in identifying the pool of functional SHGs in each Gram Panchayat. Using this information, a PRA exercise such as social mapping will be undertaken by the Facilitator to identify focal SHGs to receive the PLA intervention. Facilitators will be trained to prioritise the excluded, to take into consideration caste divisions in selection of SHGs so as to ensure inclusion of the most vulnerable, and both social and physical barriers faced by non-group members in attending meetings. A tool will be developed to guide the Facilitator in selecting SHGs. In each community, she will also discuss SHG selection with PRIs and other key stakeholders such as ASHA and AWW. Through this process, SHGs will be selected that cover vulnerable segments, as well as those that have the potential to cover a large share of the community. So for example, in a village with 6 SHGs, the PLA cycle may only be implemented in say 2 or 3 groups, although the mobilisation process will include members from all 6 groups and the larger community. Where there is no functioning SHGs, Facilitators will identify existing women's groups, or form Suno Bhouni groups, that can be the platform for the PLA. If newly formed groups are not already nominated as Suno Bhouni the Facilitator can link them to ASHA/AWW for their inclusion.

2.3.5 Quality assurance

Supportive supervision and quality assurance of the PLA process will be provided by the four Block Coordinators through community based monthly review meetings with clusters of Facilitators, as well as through their attendance and support to Facilitators at PLA meetings. Such visits will help in reviewing progress, identifying and resolving issues, and reinforce skills and content being covered. Block Coordinators will also facilitate linkages with PRIs, GKS and frontline workers. The district TMST CP field staff including the District Program Coordinator from the local NGO partner will also

monitor implementation and undertake field visits to assess and promote quality. Periodic visits will also be made by the TMST State Team. In addition to this, formal inter-sectoral committee meetings will be held at the Block and District level to share experience in each quarter, review progress, and agree on plans for effective implementation. The strong focus on monitoring throughout the programme is intended to create a quality oriented and learning work culture. The externally contracted evaluation and documentation agencies will assist in build local monitoring capacity and further promote quality of effort and output.

2.3.6 Information kiosks

As part of the Shakti Varta process information kiosks will be introduced to all participating SHGs. While PLA encourages inter-personal group discussions, SHG members will be linked using mobile technology. A call centre will manage a database of all mobile users among the SHG members. A two way communication will be established with the database, and message download will promote services and entitlements for every member enrolled. The information kiosk will complement the Shakti Varta community process by bridging the gap between demand and supply.

2.3.7 Linkages with Gaon Kalyan Samitis

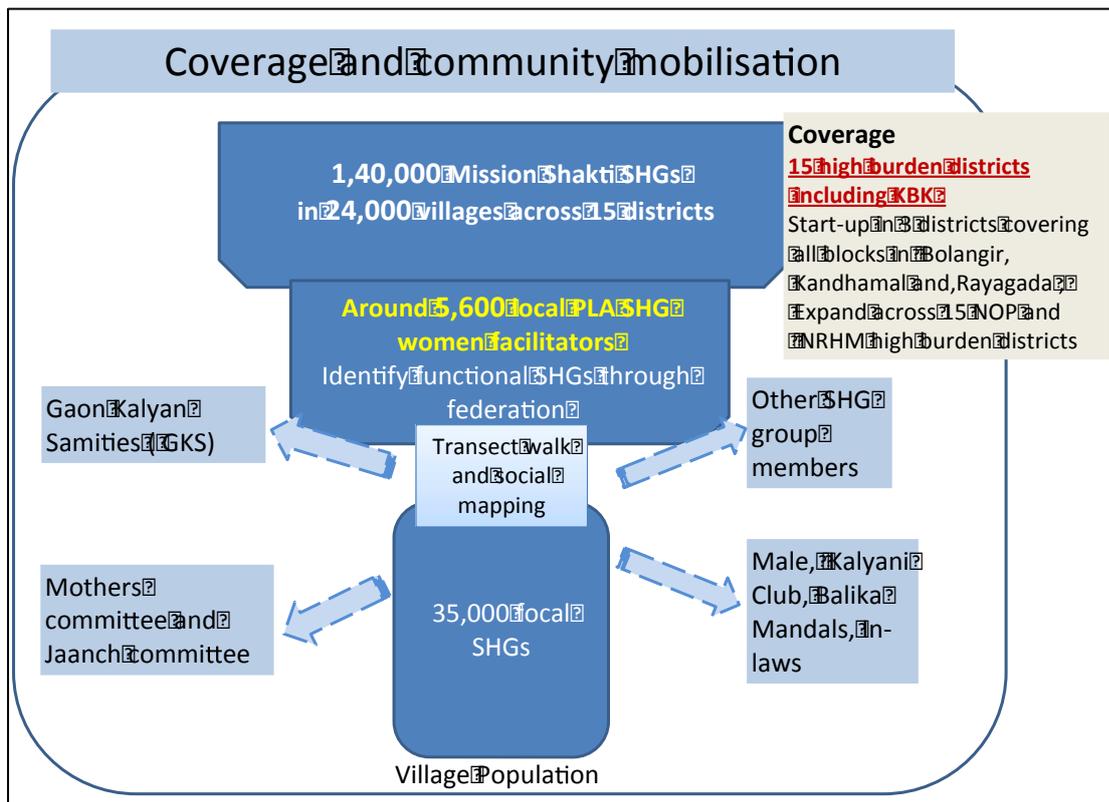
Evidence from Jharkhand, Odisha and Nepal, shows the importance of linking mobilised groups in a sustained manner with local bodies that oversee health services. This provides a channel through which communities can voice community demands and provide feedback on the quality of services, and seek responsiveness. In the India context, as GKS also includes frontline workers, it is a channel for both feeding demands to ASHAs and AWWs, and for influencing PRI monitoring and oversight of service provision, and their use of local PRI budgets and untied funds. Block Coordinators cum Master Trainers will play a key role in orienting PRI members as the programme enters into a Gram Panchayat, and supporting Facilitators and SHGs engage with GKS over the course of the PLA cycle. Monitoring the leveraging of GKS achieved by SHGs, and the participation of women in Gram and Palli Sabhas, and the extent to which decisions made promote HNWASH, are ways in which to measure the effect of the PLA process on women's agency and community governance.

2.3.8 Coverage and timeline

Shakti Varta will be implemented across all blocks of the 15 high burden districts; see Annex 1.

- The first wave will cover all blocks in the three districts of Kandhamal, Bolangir and Rayagada
- The second wave of implementation will cover the remaining 12 High Burden Districts of Angul, Bhadrak, Gajapati, Jharsuguda, Koraput, Malkanagiri, Nawarangpur, Nuapada and Sambalpur.
- In total Shakti Varta will cover 152 Blocks, 2799 Gram Panchayats, 24000 villages and around 1,40,000 SHGs.

Figure 5: Coverage of Shakti Varta

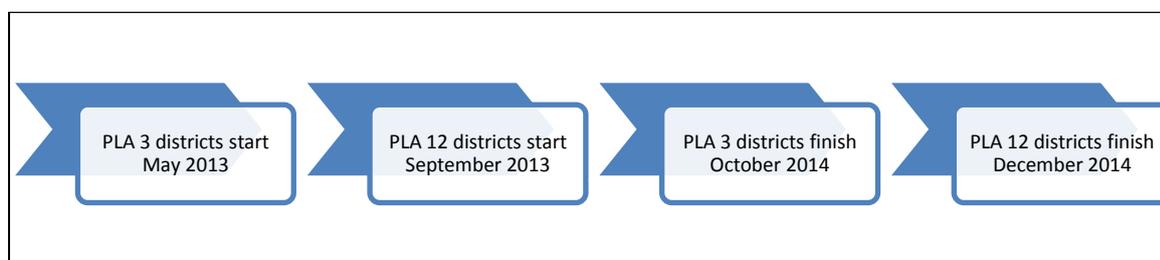


Implementation is divided into three phases:

- Preparatory phase: September to February 2013
- Implementation in 3 districts: May 2013 to October 2014
- Implementation of second wave in 12 districts: September 2013 to December 2014.

Scale up to the remaining districts will be contingent on results and the decision will rest with the Steering Committee. Opportunity to further scale up through the National Rural Livelihoods Mission will be one option.

Figure 6: Timeline of Shakti Varta Implementation



The goal is to cover a large proportion of the women members of functioning SHGs through direct participation in PLA meetings and through the amplifier effect as participants become change agents, and the social acceptability and awareness of improved HNWASH practices spreads. For

planning purposes we estimate that one to two SHGs per village will receive the PLA package and that this will cover the members from an additional 2-4 SHGs. The benefits will of course be broader than the number of SHG members covered, and as set out in the separate CP monitoring and evaluation document, the results of the PLA intervention will be measured through changes in practice and outcome indicators for the village or geographical cluster covered.

2.3.9 Management and implementation structure

Oversight and leadership of the community process programme, and Shakti Varta as a component of it, rests with the State Inter-Sector Committee chaired by the Development Commissioner and including the three nodal sectors.

State level: At the state level implementation will be led by Department of Women and Child Development in collaboration with Department of Health and Family Welfare and Rural Development, in partnership with Mission Shakti and supported by TMST. TMST has set up a State level expert group and will contract in expertise to support the development of PLA tools, PLA kits, training materials, and the delivery of training of trainers (TOT) to develop a pool of around 20-30 Resource Persons across fifteen districts and Block level Master Trainers. TMST will also hire District personnel, independent technical agencies to support evaluation, and documentation respectively.

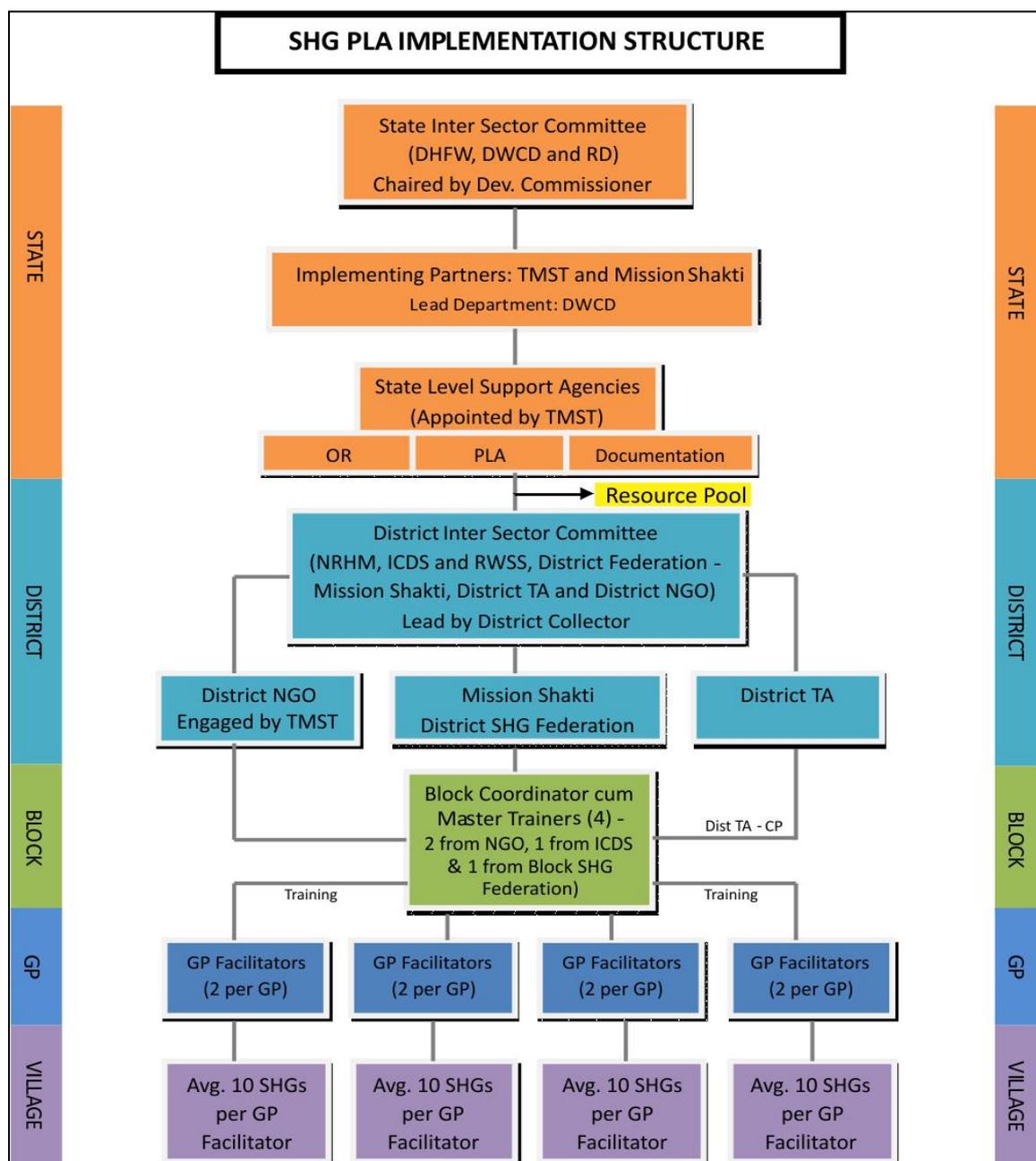
District Level: At the district level, Shakti Varta will be overseen and led by the District Inter-Sector Committee as part of the broader CP package. Implementation of the intervention will be supported by Mission Shakti's District Federation, TMST's District TA, and a District NGO that will provide coordination, training, supervision and quality assurance inputs.

Additional support from District TMST:

- 1 District Programme Officer in each of 15 identified districts will provide management and supervision support to the District Federation;
- Dedicated team of 9 SHG PLA Co-ordinators at district level will support implementation and monitoring;
- 6 Finance and Operations Consultants will oversee all 15 districts, to build capacity of District/Block Federations, and to manage and disburse programme funds.

Block and Village Level: At the block level, four Coordinator cum Master Trainers (two from NGO, one representative from the Block Federation, and one ICDS Supervisor) will form a resource pool to coordinate, train, supervise and quality assure implementation. At the village level, two Gram Panchayat facilitators from SHG members will be trained to facilitate PLA meetings covering approximately ten SHGs each per month.

Figure 7: Shakti Varta management and implementation structure



2.3.10 Human Resources

For rolling out the PLA intervention in 3 Districts there will be a need for three NGO appointed District Programme Coordinators (DPC), 148 Block Coordinators cum Master Trainers and 1218 Facilitators. For the second wave of 12 Districts, there will be an additional need for 12 DPCs, 460 Block Coordinators cum Master Trainers and 5763 Facilitators. See Annex 2 for details.

Each District NGO will be responsible for hiring the following personnel:

- 1 Programme Coordinator for each District
- 2 Block Coordinators cum Master Trainers per Block

- 2 Facilitators per Gram Panchayat

2.3.11 Capacity building

Training and capacity building is at the heart of the PLA approach. The Technical Expert Agency will lead this process but it will be necessary to develop a resource pool of around 20-30 master trainers between state and district level to assist with the rapid roll out of the approach.

- **Resource Pool:** A resource pool of around 20-30 Trainers will be created at state level by the technical agency, comprising of members from TMST district TA, District NOP, ICDS staff and members from the state technical agency itself. They will be provided training on PLA cycle in five phases of four days each. The resource pool will be mobilized and assigned to conduct trainings in five phases of three days each for block level trainers in the first three districts and similarly in the second 12 districts.
- **Block Coordinators cum Master Trainers:** Four master trainers will be selected depending on the population size of the block. They will be trained in five phases of 3 days each at the district level. Their role will be to train the facilitators and to provide supportive supervision and hand holding support. Two of the master trainers will be salaried personnel recruited by the district NGO and the rest will be identified from staff of the federation and ICDS; they will provide a crucial training and supervision resource at the block level. They will also organise the block inter-sectoral committee meeting each quarter to review progress and plan further.
- **Facilitators:** The women identified as facilitators will be imparted training on the PLA cycle in 5 training phases of 3 days each, in batches of 30. These trainings will be organised at the block level.

In addition to intervention specific training, capacity building of block and district federation staffs will be supported through their participation in the programme. By strengthening the human and material resources of block federations it is expected that the block federations will be better able to support the SHGs post the Shakti Varta intervention, and more broadly to develop community based institutions, and foster future women leaders.

2.3.12 Budget

Figure 8: Shakti Varta budget

PLA Specific Budget Allocations						
Sl. No.	Components	District Budget (first 3 Districts) INR		District Budget (following 12 Districts) INR		District Budget (for rest 15 Districts)
		TA Fund under OHSNP	FA Fund under OHSNP	TA Fund under OHSNP	FA Fund under OHSNP	
1	SHG PLA State Resource Agency, M&E Agency, Documentation Agency, Mission Shakti Capacity Building, Information KIOSK, 2 staff - SHG PLA Operations, Launching Ceremony	79000000	0		0	79000000
2	NGO Cost					0
	Program Mgmt Cost	14040000		39300000		53340000
	Training & Review	2176930		6978400		9155330
	Mobility	3524000		9788000		13312000
	NGO overhead Cost	987047		2803320	0	3790367
	Total NGO Cost	20727977		58869720	0	
3	Federation Cost					0
	Program management and Resource Person Fee to GP level Facilitators (SHG members)		48720000		148920000	197640000
	Training & Review		9959450		45989934	55949384
	Mobility		2960000		7820000	10780000
	Materials		2605300		6543500	9148800
	Federation overhead cost		3212237.5		10463672	13675909
	Total Federation Cost		67456987.5		219737105	
	Sub Total	99727977	67456987.5	58869720	219737105	
	Total	88,184,964.00		278,606,825.44		445,791,789.44

2.3.13 Limitations and Risks

Impact: The scope and scale of the intervention are ambitious within the given time frame, and impact level changes may not be measured.

Frequency and breadth of meetings: The timeframe means the PLA cycle will need to be accelerated with fortnightly meetings, compared with the prior practice in the Ekjut trial of monthly meetings. There is a risk women will not be able or interested to attend such frequent meetings. Further if they do attend, there is enough time to trigger change around each thematic area. The cycle now also includes modules on nutrition and WASH, so greater breadth with less depth also risks less opportunity for learning and change.

Time for scale-up: From 37 blocks in 3 districts, the intervention will need to be expanded to the next 12 districts after 4 months to allow enough time for the second wave districts to complete all the cycles. This gives limited leeway for Phase 1 learning and high pressure to keep all the stakeholders on board.

FA commitment: Commitment from DWCD for use of FA is now agreed. Given the intensive and rapid 15 month implementation, two facilitators per Gram Panchayat will be needed to complete the 20 meeting cycle (Ekjut model had one). This increases costs, which may not be acceptable to Government.

Operational risks:

- NGOs may lack the capacity to implement the intervention with only PLA centred training. More systemic capacity building will be costly and time consuming.
- Distances between villages may mean that Facilitators are unable to cover the estimated 10 SHGs each.
- Low educational levels among women in HBDs may mean that training takes longer and facilitation needs greater handholding by block coordinators than planned.
- The time taken to recruit partner agencies may extend beyond the planned preparation phase and delay implementation.
- SHGs may not be functional in the most vulnerable areas, this would jeopardise reaching the target audience given the very short timeframe available to implement the intervention, and therefore to initiate group formation.
- The actual number of existent, functional SHGs and federation needs to be assessed.

Wider risks:

- Upcoming state election in year 2014 may lead to a less favourable political environment for empowerment approaches.
- Many of the districts are affected by left wing extremism and PLA may not be acceptable in communities affected by conflict as the approach depends on trust within the group.

3 Community Led Total Sanitation (CLTS)

3.1 Introduction

Individual health and hygiene is largely dependent on the availability of adequate drinking water and proper sanitation. There is, therefore, a direct relationship between water, sanitation and health. Consumption of unsafe drinking water, improper disposal of human excreta, improper environmental sanitation and lack of personal and food hygiene have been found to be major causes of many diseases in rural India. The prevailing high infant mortality rate is also largely attributed to poor sanitation. It was in this context that the Central Rural Sanitation Programme (CRSP) was launched in 1986 primarily with the objective of improving not only the quality of life of rural people but also to provide privacy and dignity to women. Unfortunately, studies indicate that the programme has by and large failed to achieve its objective due to its subsidy and governmental mode of implementation.

Further, several evidence-based research programmes conducted by various governmental and non-governmental agencies have found that benefits accruing from the sanitation programme cannot be sustainable unless programme actions are **demand driven and community-led including technological choices**. To ensure a community-led approach, the “Total Sanitation Campaign (TSC)” was initiated emphasizing information, education and communication (IEC), human resource development, capacity building to increase awareness among the rural people, and generation of demand for sanitary facilities.

Notably, the TSC does not focus on building infrastructure, but on preventing open defecation through exerting peer pressure and invoking the element of shame. The Total Sanitation Campaign is supposed to concentrate on promoting behavioural change among the community, as against a toilet construction focused approach of previous programmes. However, in spite of all the above laid down principles, the Odisha government continued to implement TSC as a top down target-driven toilet construction programme. Several studies including the recent rapid assessment study commissioned by DFID (implemented by SUTRA) indicate that over the years, community participation has substantially reduced although the number of toilets constructed has increased significantly from 13,332 in 2001 to 37,81,943 in 2012 (DDWS online monitoring data). Nevertheless, **there are large numbers of missing toilets as well as increased number of unused toilets**. To address these issues, the assessment study strongly recommended innovative **demand-led approaches to increase access to and uptake of sanitation services**. Community-led Total Sanitation (CLTS) is found to be one of the most successful approaches across the world that has worked for meeting the twin objectives of demand generation and uptake of sanitation services.

3.2 CLTS plan

TMST and Government of Odisha have agreed to adopt CLTS⁷ approaches in 6 blocks of 6 selected districts for strengthening the governmental sanitation programme. For this, village level institutions, namely GKS and Gram Panchayats, and self help groups (SHGs) will be strengthened

⁷ Please see Annex 3 for concept of Community-led Total Sanitation Approach.

through IEC and capacity building activities to improve their institutional performance and programme sustenance.

3.2.1 The implementation approach

The aim of the government is to cover all 30 districts in the state including the 15 high burden nutrition districts which are the initial focus areas of the planned approach. The approach includes:

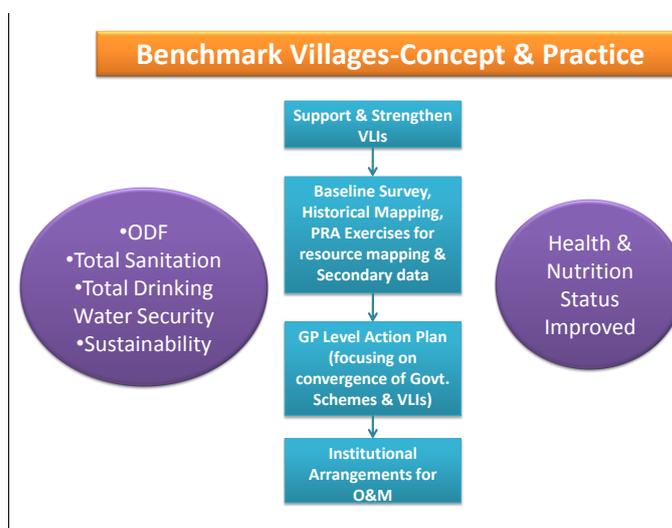
1. **CLTS in 6 blocks of 6 selected districts:** To begin with, the CLTS approach will be implemented in 6 blocks of 6 selected districts out of the 15 HBDs through local NGOs. Making the village or Gram Panchayat Open Defecation Free (ODF) is the primary focus of the approach. NGOs, preferably one NGO per district, will be selected through standard procurement process. A national or state level agency, again to be recruited through standard procurement procedures, will provide technical and handholding support to the entire programme, including components such as capacity building, IEC support, policy advocacy, coordination with government bureaucracy and departments, resource material, documentation and workshops for dissemination.

It may be mentioned here that CLTS Foundation is a network partner for the OHNSP, and hence it is decided that one block out of the 6 blocks will be awarded to CLTS Foundation through the Single Source route.

For the remaining 5 blocks, the standard procurement procedures will be followed for selecting a technical and management support agency.

2. **Benchmark Village Concept and Practice:** This concept envisages using any of the community approaches to improving sanitation services, including, but not limiting to, Open Defecation Free as per the CLTS approach. This is earmarked for one Gram Panchayat each in Gopi and Puri districts which are outside of the 15 HBDs.

Figure 9: Benchmark village concept



For the above (1) and (2) actions, DFID will meet all the programme expenses including providing technical and management support through TMST. In addition, existing government schemes and projects will be dovetailed with DFID programme implementation to achieve value for money.

- 3. Scaling up from 6 districts to 15 districts:** Based on the learnings from implementation of the above two approaches, TMST will analyse the impact of the approaches, document learnings and case studies, to extend/modify/improve the above two approaches for expansion from 6 districts to 15 districts. While TMST will provide technical support during this scaling up, the programmatic support will come from government schemes such as the Nirmal Bharat Abhiyan.
- 4. Scaling from 15 districts to 30 districts:** This will be undertaken by government post DFID support which is due to finish in 2015.

3.2.2 Geographical coverage, criteria of selection and community process

The 6 selected districts are Bolangir, Kalahandi, Keonjhar, Kandhamal, Rayagada, Sundergarh.

For CLTS, 6 blocks will be selected from among the 6 districts based on the following criteria in consultation with the government and respective district collectors:

1. The block should have acute ODF problem
2. Low performing blocks as per Nirmal Bharat Abhiyan
3. Favorable conditions for implementing CLTS
4. Proactive PRI members
5. Good NGO presence

In the selected blocks other CP processes will be operational, including Shakti Varta, that CLTS will learn from and work in synergy with. Further, as per the suggestion of RD secretary, one Gram Panchayat from one block each of Puri and Ganjam districts are shortlisted for implementation of Village Benchmarking Concept and Practice described above. These blocks are Bhanjanagar of Ganjam and Gop of Puri.

3.2.3 Mobilization of Government resources

It is proposed that the creation of ODF and Bench Mark villages is supported by DFID TMST Project on a shared cost basis with Government of Odisha. Hardware will be funded through existing GoI and GoO programmes via the PRI in each ODF & Model Village and software (planning, survey, design, capacity building, community mobilisation and training) will be funded through TMST TA. However to avoid delay some minimum hardware components may be paid from TA money where innovations will be piloted, but support for others will be mobilized from on-going programmes.

3.2.4 Broad strategies for Block level NGOs

- A. Focusing first on one area like a Panchayat. Building up and out from success.
- B. Starting wherever conditions are favourable and with favourable communities

- C. Mounting a general campaign and using CLTS selectively for those communities which lag behind.
- D. In all campaigns, mobilizing many actors and doing many different things which reinforce each other.

The actions that follow are almost all based on experience in other parts of India, and outside the country. However NGOs will be encouraged to take innovative strategic choices as per the socio-cultural context. Headline guidance for CLTS is:

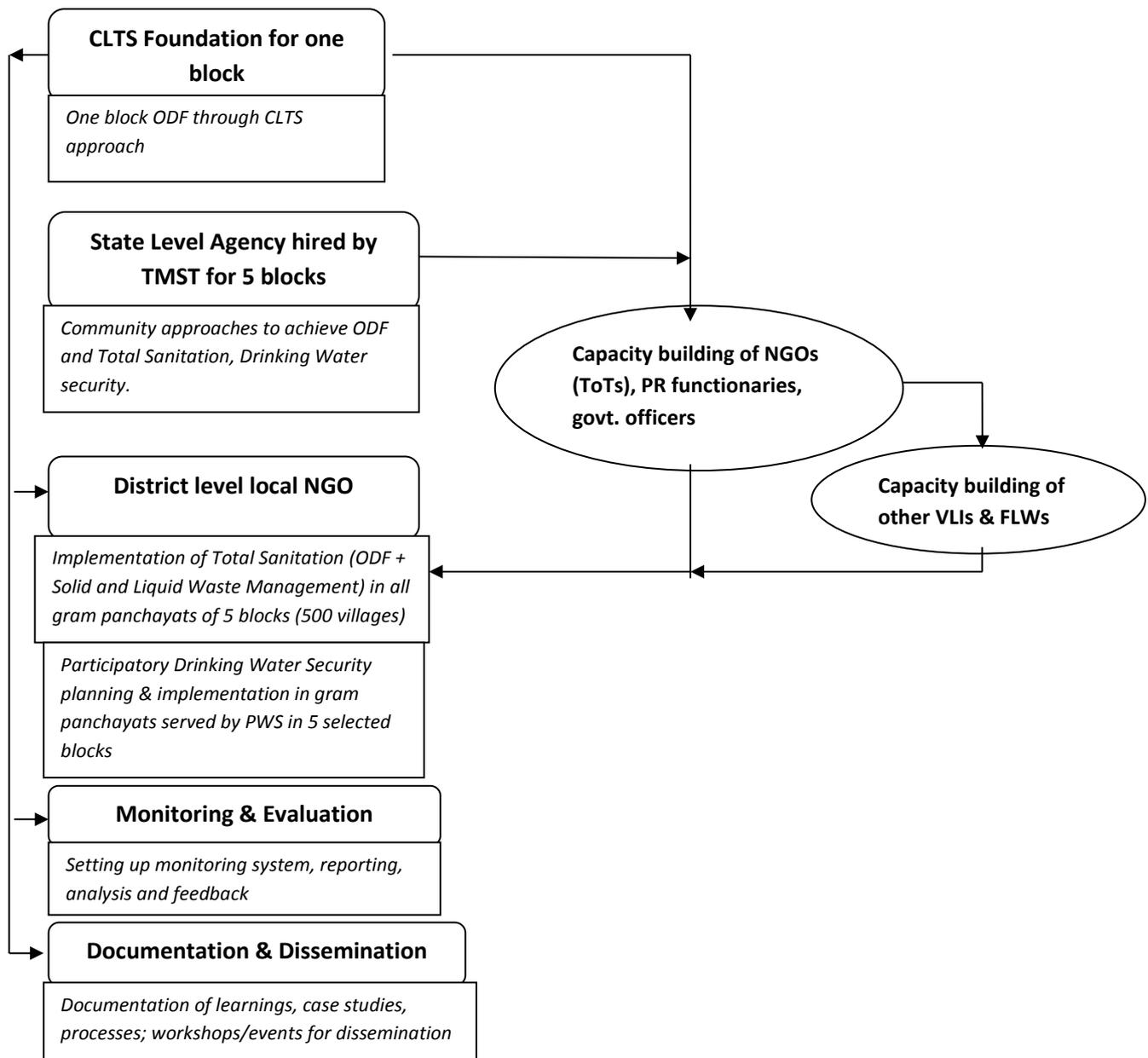
- Getting started with training, triggering and follow-up
- Use road shows, competition and consciously create situations for queuing by different communities
- Foster, find, encourage and support champions
- Organise occasions for celebration and publicity
- Adopt an inclusive team approach
- Use many media at the same time
- Involve active VLI, children, teachers and schools,
- Be concerned about those less able
- Monitor, reflect, innovate
- Cautionary endnotes: rewards, penalties and realism to be institutionalized by Gram Panchayats

3.2.5 Timeline for Programme Implementation

Figure 10: Timeline of CLTS implementation

	Key activities	FY 2012				FY 2013				FY 2014			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1	Procurement of services of (i) 2 State Level agencies and (ii) District Level agencies												
2	Inception Report by 2 State Level Agencies												
3	Inception Reports by District Level Agencies (including Baseline study plan)												
4	Capacity building of NGOs, PR functionaries and govt. officers												
4	Capacity building of VLIs & FLWs												
5	Field Action based on micro plans prepared by NGOs)												
6	Hand holding support provided by State Level Agency to all Block level NGOs (programme implementation support, addressing conflicts, facilitating policy instruments, policy advocacy)												
7	End line survey												
8	Dissemination workshops/events for promoting findings/ successful approaches from the completed programme												
9	Monitoring & Evaluation												
10	Documentation and Dissemination												
11	End of Project Report												

Schematic Representation of Programme Approach



Note: The State Level Agencies will work in close coordination with state and district missions.

3.2.6 Documentation and Dissemination

Documentation and dissemination will form an important activity which will help not only the ongoing implementation but also for scaling up from 6 districts to 15 districts and finally to 30 districts of the State. Documentation will include capturing key lessons learned, successful approaches, impact of ODF and safe water security on health and nutrition. Dissemination will be done through periodic events in a variety of ways that includes published material, organizing workshops for various stakeholders and for the government.

TMST will coordinate all documentation and dissemination work included in the terms of reference of the State Level and District Level agencies.

See the separate paper on CP monitoring and evaluation for a full discussion of the monitoring and evaluation of CLTS and the Village Benchmark Concept.

3.2.7 Budget Estimates

The budget for CLTS implementation in six blocks is below:

Total Budget for CLTS implementation in six blocks	INR 3.5 crores
Fee for technical support for six blocks	INR 1.0 crore
Implementation (including Agency overheads) for six blocks	INR 2.5 crores

A State level agency will be hired for a period of 24 months, the budget is below:

Broad heads	Unit cost	Numbers	Period	Total Cost
Consultancy fee	15000	4 person	120 days	7200000
Travel and Accommodation				1000000
Stationary and communication				1000000
Capacity building				1000000
Total cost				10200000

The budget for block level NGOs for a period of 24 months per block is presented below:

Broad Heads	Unit cost	Numbers	Period	Total cost
Master facilitator (Block level)	12000	1 person	24	288000
Panchayat facilitator (1per 3 panchayat)	7000	6 person	24	1008000
Village motivator (1 per 2 to 3 village)	500	30 person	24	360000
Mobility	8000	month	24	192000
Capacity building				1000000
Campaigns				1500000
Administrative charges				200000
Total				4548000
For 6 blocks				27288000
Grand total				37,488,000

4 Community based Management of Acute Malnutrition (CMAM)

4.1 Background:

Odisha has reduced child under-nutrition by 10.8 % between NFHS II (1998-9) and NFHS III (2005-6). However despite this progress, close to 40% of children under the age of 3 are still underweight and not growing to their full potential.

Close to 50% of deaths in children less than 5 years can be attributed to under-nutrition. Within the overall burden of under nutrition, severe acute malnutrition (SAM), which is defined by a very low MUAC of less than 11.5cm or nutritional oedema, is a serious problem in both India and specifically in Odisha. The risk of death for children with SAM is 5-20 times more than that of normal weight children (WHO). SAM occurs very early in life, mostly during the first two years of life (56%) and 70% happens within the first three years (based on NFHS-III data). NFHS III data for Odisha found 5.2% of children below 60 months of age were suffering from severe acute malnutrition, of which only 2.2% had access to care.

The Nutrition Baseline Survey for Odisha Nutrition Operational Plan (2011) reports 5.9% children have a Middle Upper Arm Circumference of below 11.5cm. Extrapolating the proportion of children with visible severe wasting in Odisha (from NFHS 3 data), we can estimate that 2, 530, 00 (2.53 Lakh) children are acutely malnourished and have limited access to treatment. In order to have a comprehensive understanding of the above mentioned progress and challenges, DWCD decided to undertake a systematic study to develop an integrated evidence-based nutrition operational plan (NOP). The NOP aims to address the poor nutrition condition of the children in Odisha, particularly of those belonging to the most vulnerable sections of the society with higher under-nutrition rates.

The state has focused on addressing under nutrition through improvement of underlying causes of under nutrition (e.g. providing iron folic tablets and syrup to children, adolescents and mothers, improving feeding and hygiene practices through information and counselling, and prevention/treatment of diseases such as measles, malaria, worm and gastro-intestinal infections).

In order to address severe acute malnutrition there are already 5 nutritional rehabilitation centres (NRC) that are currently functional and a further 6 were planned to be operational by March 2012 and are in the process of being established. The plan through NRHM is to scale up to a total of 77 NRCs by end of March 2013. In order to increase coverage of treatment for children with SAM the state would like to implement a community based management of acute malnutrition programme (CMAM). This decentralises the treatment of SAM out to the level of anganwadi centre and ensures more children can be treated. It is based on the mobilisation of communities to create awareness and ownership of the programme, using simple methods to find the cases of SAM and the development of local capacity to produce an energy dense nutrient rich food that meets the needs of a child with SAM. Finally a joint approach by DWCD and DHFW ensure that these children are adequately treated for SAM.

The Integrated Child development Service (ICDS) under the responsibility of the Department of Women and Child Development (DWCD) already provides several nutritional interventions from the Anganwadi centres using existing local foods e.g. the provision of hot cooked meals to pre School

aged children and also a take home ration of a blended food as part of a supplementary feeding programme.

After several rounds of discussion and detailed deliberation among multiple stakeholders at policy level, it was agreed that a CMAM program for SAM child would be first piloted in two districts and it would be limited to three blocks of the chosen districts. The districts that were chosen earlier were Kalahandi and Sundergarh. However, on 31st May, 2012, DWCD, while reviewing the recommendation of the members of the clinical and food committee, experts, opinion and field visits reports and keeping in mind the feasibility of the pilot to be successful decided that, the CMAM project should be piloted in one District of Odisha and the district that was finalised is **Kandhamal**. Further it was decided that a total of four blocks would be piloted for this purpose. Furthermore, the Energy Dense Nutrient Rich Food model would be piloted in two blocks and the existing hot cooked meals and THR adapted in the context of SAM requirement would be piloted in one block each. To maintain the quality of SAM nutritional product and to ensure rigorous quality control requires a food testing lab with access to credible laboratory facilities and rigorous batch sampling of product and ideally of ingredients.

4.2 Objectives

The **objectives** of the programme will be:

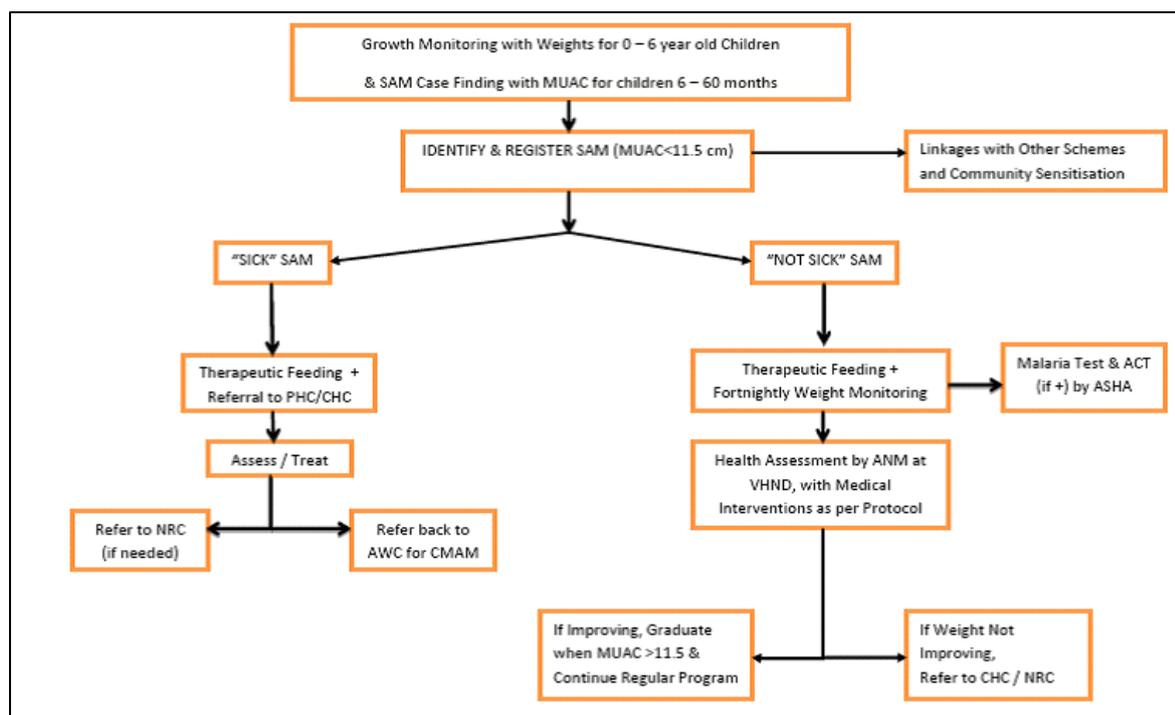
- Ensure that over 50% of children with severe acute malnutrition are effectively treated and are no longer severely wasted thus increasing their chances of adequate growth.
- Learn from implementation of CMAM in the piloted district and adapt the community based model accordingly based on the results of initial programme.

4.3 CMAM process

The CMAM **process** includes the following:

- Identification of cases of children with SAM using a middle upper arm (MUAC) tape. Those with a MUAC of below 11.5cm are considered to be severely wasted i.e.; Severe Acute Malnutrition (SAM)
- Management of SAM cases with absence of complications (including a good appetite) at the Anganwadi centre level by Anganwadi Workers (AWW) but closely linked with Auxiliary Nurse Midwife (ANM) and Pustikar Divas system. (“NON SICK SAM”)
- Management of SAM cases with complications, medical complications and/or poor appetite at existing NRCs. (“SICK SAM”)

Figure 11 (CMAM Flow Chart) outlines the process.



Several nutritional foods specifically formulated to meet the needs of a child with SAM will be piloted:

- Provide **daily hot cooked meals** at Anganwadi Centres (existing hot cooked meal approach at AWC formulated to meet the nutritional needs of children identified with SAM)
- Provide a **blended food** as a 2 weekly take home ration from the Anganwadi Centres (adapt the existing blended food, THR - 'chatua') that is given to all children under 3 years as a take home ration every 2 weeks to meet the needs of those children identified with SAM)
- Provide a **milk based energy dense nutrient rich food made of groundnut, milk powder, sugar, oil and vitamin mineral mix** as a 2 weekly ration (formulated to meet needs of a child with SAM). This product would be produced by a self-help group of women already involved in producing *chatua* at block level. As discussed above, the programme will be piloted in 4 blocks in the 1 district of **Kandhamal** -see figure below (CMAM Pilot Programme Districts, Blocks and Nutritional Interventions).

Figure 12 :CMAM Pilot Programme Districts, Blocks and Nutritional Interventions

District	Block 1. <i>Hot Cooked Meals</i>	Block 2 <i>Blended Food(Take Home Ration)</i>	Block 3 <i>Energy Dense Nutrient Rich Food</i>	Block 4 <i>Energy Dense Nutrient Rich Food</i>
Kandhamal	Tikabali	Phiringia	Phulbani Sadar	K.Nuagaon

4.4 CMAM pilot

CMAM is a new programme in the state of Odisha which is why it is starting as a pilot programme in 4 blocks with the plan to scale up adapted according to the outcomes from the initial programme. In order to monitor the progress and outcome of this new programme in the pilot district, there is a need to gather information in order to analyse effectively the impact of this intervention and also to inform scale up. Thus community assessment, baseline, mid-term and final surveys measuring coverage (what proportion of children with SAM are being treated) of the programme over 1 year are planned. The DFID supported TMST, Valid International and other stakeholders can provide technical cum facilitating support (community assessment, baseline, mid-term and final survey, support in trainings etc.) in implementation of CMAM in Odisha. The CMAM programme will be implemented by DWCD with required support from other departments especially Health and Family Welfare, and NRHM.

Figure 13: Proposed Timeline for CMAM Implementation Activities in Odisha

CMAM Programme Implementation	2012		2013				
	July - Sep	Oct - Dec	Jan - Mar	April - Jun	July - Sep	Oct - Dec	Jan - Mar
Finalisation and translation of guidelines/protocols							
Development of training materials							
Development of production of nutritional foods for SAM							
Community Assessments							
Community Orientations							
Baseline coverage/prevalence surveys							
Master training (District/Block/AWS)							
Training of AWW/ANM							
Case Finding Training (ASHAS)							
Training of PHC/NRC staff							
Community based treatment of SAM							
Mid term follow up survey and review							
Final surveys							
Final programme review, analysis and write up							

At present around 2% of children with SAM have access to treatment. Decentralising the approach to treat SAM at community level with a programme of community based management of acute malnutrition will contribute to increasing the amount of children that will have access to treatment. This new programme will be piloted over 1 year in 4 blocks in 1 district and then scaled up in those other areas in the state of Odisha where there is a high prevalence of severe acute malnutrition.

4.5 Budget:

Most of the programme activities for CMAM pilot are part of the Financial Assistance (FA) component of DWCD and is about 1.93 Crores. This includes the cost of equipment required for setting up an energy dense nutrient rich production unit and incentives to be paid to AWWs in the selected four blocks of Kalahandi. The CMAM budget has received in principle approval of Secretary, DWCD subject to approval of Chief Minister.

5 Strengthening the capacity of Gaon Kalyan Samiti (GKS)

5.1 Introduction

Village Health, Sanitation and Nutrition Committee (VHSNC) are known as Gaon Kalyan Samiti (GKS) in the state of Odisha. GKS are functional at the revenue village level as a community level platform to address local health issues through participatory community action. Meetings of the GKS are facilitated by ANM with support from AWW. Members in GKS include ASHA, Ward Member, 3 members from SHG, representative from NGO or Yuvak Sangha.

Concerted, coordinated effort will be put by NRHM, GoO in 2012-13 to achieve the objective of **“Effective and vibrant Gaon Kalyan Samiti (GKS) for better health and wellbeing”**. Intensive activities will be conducted throughout the state focusing on 18 high focus districts that overlap with 15 high burden districts. Field TMST with the support of a nodal agency and field level partners will demonstrate the results of effective GKS activity during the year 2012-13. Some of the activities include: IEC, advocacy and community mobilization, capacity building of newly elected members, strengthened regular review and monitoring forums, strengthening of inter-sectoral convergence. NRHM also plans for GKS to be a forum for experience sharing and cross learning and play a role in Gaon Swasthya Samiksha (community monitoring). Handholding and capacity building support will be provided to GKS in achieving these objectives.

The capacitated and more vibrant GKS will be an active forum through which key messages on health, nutrition, water and sanitation, hygiene will be disseminated to the community in alignment with the 52 week Swasthya Kantha campaign being implemented in the state. Group discussions will be held at the GKS level on the designated topics of the week, month and quarter. Radio and television programmes will be organized on the thematic health issues on a specific date and time as per the calendar given to the GKS. The trained SHGs would also work closely with the GKS and seek their active support in utilising their untied funds for promotion of positive health, nutrition, water and sanitation, hygiene practices through wide dissemination of BCC materials and messages in the villages. The vision is that GKS will gradually develop as a community resource centre and will offer support in generating demand and promoting positive health, nutrition, water and sanitation, and hygiene practices in the communities.

5.2 Key activities planned under NRHM

1. VHSC (GKS) empowerment
2. Capacity building of President of GKS
3. Strengthened regular review and monitoring forums
4. Strengthen inter-sectoral convergence
5. Forum for experience sharing and cross learning exercise in 12 NHF districts
6. Strengthening initiative for low performing GKS - Activity performance by GKS, assessment, monitoring, mapping and provision of need based support.

5.3 Integrated capacity building of GKS to address determinants of health

- Formation of state core group including the members from four departments (Health, WCD, RD and PR), SIHFW and TMST.
- Meeting of core group under the chairmanship of MD, NRHM – share the plan, budget of all four departments.

- Preparation of the action plan for integrated capacity building of GKS - convergence of resources, budget, responsibility.
- State level external support agency for implementation support.
- State Resource Group and District Resource Group formation involving resource persons from all four departments.
- Module preparation for the capacity building, training plan preparation and responsibility sharing.
- State and District TOT.
- Field level training of GKS members.

5.4 Management and implementation structure

At the state level implementation of the GKS capacity building intervention will be led by the Community Process Resource Centre of NRHM in partnership with CARE and Action AID and supported by TMST. At the state level, TMST will support CPRC in the development of capacity building tools, kits, training materials, and training of TOT to develop a pool of State and District level Resource Persons across thirty districts. TMST will also provide technical guidance on evaluation, and documentation respectively.

At the district level, GKS capacity building will be led by the District Inter-Sector Committee as part of Community Process. Implementation of the intervention will be supported by DPMU-NRHM, TMST's District TA, and a District NGO that will provide coordination, training, supervision and quality assurance inputs.

At the block level, four Master Trainers will form a resource pool to coordinate, train, supervise and quality assure implementation.

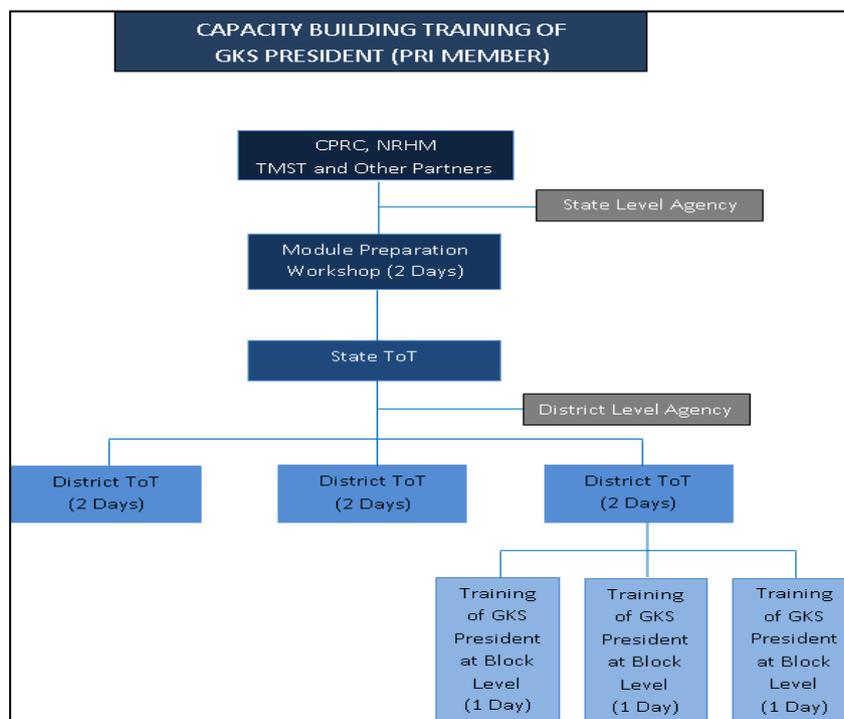


Figure 14: Implementation structure for GKS capacity building

5.5 Coverage

The GKS capacity building work will cover around 45,000 GKS in all 30 districts. The task plan includes a capacity building plan of around 45,000 PRI members.

5.6 Implementation timeline (see Annex 4)

6 Linkages with existing Communication campaigns

6.1 Suno Bhouni Campaign

Suno Bhouni is a campaign to empower Self Help Groups in all 47000 villages across the State of Odisha on health and nutrition related messages. The broad objectives of the 'Suno Bhouni' Campaign are to provide health and nutrition messages for improved health and nutrition seeking behaviour, and to establish SHGs as a reliable health and nutrition communication resource. The Campaign will use the existing platform of Swasthya Kantha Campaign. 'SUNO BHOUNI' uses an interpersonal communication kit comprising of leaflets, flashcards etc. along with existing radio and television programmes and posters available from the existing Swasthya Kantha campaign.

6.2 Swasthya Kantha Campaign

The '**SWASTHYA KANTHA**' Campaign is a mega communication campaign that covers more than 40,000 Gaon Kalyan Samitis across the length and breadth of Odisha, especially in the rural hinterland, over a period of 12 months. Each of the 52 weeks in a year will see events at the local, state and district level under each thematic area of health, nutrition and hygiene related messages. Local mobilization through posters and IPC using the health wall 'Swasthya Kantha' as the backdrop and brand 'Kantha kahe Kahani' in mass media (wall speaks stories) to generate a massive people's participation in the campaign across villages, blocks and districts.

6.3 IEC activities for ten key health, nutrition and WASH messages in conjunction with other community process work

Swasthya Kantha campaign will continue to spearhead convergent IEC messages across HNWASH. Key activities planned are:

- Key findings from information need assessment (i.e., Nutrition BCC, etc.) disseminated to identify and promote priority nutrition and health behaviour.
- Message development and creative workshop initiated by CoE, SIHFW to build message and materials in continuation of Swasthya Kantha Campaign.
- All communication materials uploaded in web IEC warehouse, training repository and COM MIS and support training of users.
- Support in developing guidelines for implementation.
- Coordinate development of communication materials on Swasthya Kantha Campaign and Suno Bhouni and support through District TA in implementation.
- Facilitate training of communication service providers (DPHCO, ADPHCO, PHEO) on supportive supervision.

6.4 Timeline and budget (see Annex 5)

7 Strengthening capacity of Frontline Workers through IPC skill building

The “Study to Assess the functioning of Community Health Workers in KBK+ districts of Odisha and their Potential for Improved Coordination and Convergence” (2012) identified gaps in the IPC skills of all three frontline workers, (ANM, AWW and ASHA) which both departments accepted and plan to address. BBC will lead the training of FLWs in 7 Districts of the State and will support DHFW and DWCD in scaling up the same to other districts. TMST will provide strategic support in building the FLW IPC capacity building plan, implementation support in 15 high burden districts and periodic monitoring as well as quality assurance of the initiative, and will link the initiative with other community level interventions. Improved IPC skills of the FLWs will result in better counselling during VHSNDs as well as during their discussions with members of Gaon Kalyan Samitis. Participation of FLWs in Shakti Varta will contribute to strengthening their IPC skills, and encourage FLW led IPC sessions during SHG meetings, Gaon Swasthya Diwas and household visits.

NRHM and NOP PIP has earmarked 5 crores of FA towards this activity.

8 Strengthening the capacity of Jaanch and Mother’s Committees

8.1 Objective

Community participation is a key for effective implementation of DWCD’s new and innovative initiatives. Though various programs have been planned to ensure the full participation of Mother’s and Jaanch Committees, their present level of understanding on their roles and responsibilities is not satisfactory. The primary responsibility of the Jaanch Committee (JC) is to ensure that all feeding programmes maintain their prescribed standards of quality and quantity. The Mother’s Committee (MC) is responsible for ensuring quality at the AWC level and to be present when take home rations (THR) is received and distributed. The Government expects that bringing the full potential of communities into the programme will result in major changes in programme outcomes. In this regard, communities require capacity building to help them to understand their role in improving the quality of services through improved transparency and community monitoring.

DWCD proposes a series of training programmes for Mother’s Committee and Jaanch Committee on health and nutrition in Odisha with the help of an external agency. A state level consulting agency will provide facilitation support and expertise to all these trainings. The total training cost will be borne by the NOP funds and the agency selection and field level trainings (logistics for resource persons, training materials with handouts) will be borne by TMST.

The objective of the training is:

- To enhance the social inclusion and promote full participation of all beneficiaries

- To monitor, supervise and support Anganwadi centre level activities in a village
- To ensure transparent transactions within government

8.2 Coverage

All Mother's Committees and Jaanch Committees of 30 districts of Odisha are to be covered, this comes to a total of 65,000 MC's and 60,000 JC's. It is planned that 2 members from MCs and 2 members from JCs and one key member of the village will be given training at cluster level (4/5 villages).

Annexes

Annex 1: Coverage of Shakti Varta

Annex 2: Shakti Varta human resource needs

Annex 3: The concept of CLTS

Annex 4: GKS Implementation Plan - Activity Matrix with timeline

Annex 5: Swasthya Kantha Task Plan with timeline and Budget

Annex 1: Coverage of Shakti Varta

COVERAGE-First wave of 3 districts													
District	Population-2011 (Census provisional)			C.D. Block	G.P.	Block Coordinators (2+2)	G.P. facilitators @2 per GP	No. of Villages	Total No. of SHGs	No of PLA groups planned @1:500 population	Average groups per facilitator	Meeting load per facilitator within 1 month	Average groups for supervision per Block coordinator
	Male	Female	Total										
Bolangir	8,31,349	8,17,225	16,48,574	14	285	56	570	1794	10642	3,297	6	12	59
Kandhamal	3,59,401	3,72,551	7,31,952	12	153	48	306	2515	6143	1,464	5	10	30
Rayagada	4,69,672	4,92,287	9,61,959	11	171	44	342	2667	7098	1,924	6	11	44
TOTAL	16,60,422	16,82,063	33,42,485	37	609	148	1218	6976	23883	6,685	5	11	45
COVERAGE- First wave of 12 districts													
District	Population-2011 (Census Provisional)			C.D. Block	G.P.	Block Coordinators (2+2)	G.P. facilitators 2 per GP	No. of Villages	Total No. of SHGs	No of PLA groups planned @1:500 population	Average groups per facilitator	Meeting load per facilitator within 1 month	Average groups for supervision per Block coordinator
	Male	Female	Total										
Anugul	6,54,898	6,16,805	12,71,703	8	209	32	418	1922	14872	2,543	6	12	79
Kalahandi	7,85,179	7,87,875	15,73,054	13	273	52	546	2205	11126	3,146	6	12	61
Keonjhar	9,07,135	8,95,642	18,02,777	13	286	52	572	2127	11881	3,606	6	13	69
Sundargarh	10,55,723	10,24,941	20,80,664	17	262	68	524	1744	17602	4,161	8	16	61
Bhadrak	7,60,591	7,45,931	15,06,522	7	193	28	386	1307	9512	3,013	8	16	108
Gajapati	2,82,041	2,93,839	5,75,880	7	129	28	258	1576	5209	1,152	4	9	41
Jharsuguda	2,97,014	2,82,485	5,79,499	5	78	20	156	356	4324	1,159	7	15	58
Koraput	6,77,864	6,99,070	13,76,934	14	226	56	452	1997	17370	2,754	6	12	49
Malkangiri	3,03,913	3,08,814	6,12,727	7	108	28	216	928	7676	1,225	6	11	44
Nawarangpur	6,04,046	6,14,716	12,18,762	10	169	40	338	897	9204	2,438	7	14	61
Nuapada	3,00,307	3,06,183	6,06,490	5	109	20	218	659	6475	1,213	6	11	61
Sambalpur	5,29,424	5,14,986	10,44,410	9	148	36	296	1325	8841	2,089	7	14	58
TOTAL	71,58,135	70,91,287	1,42,49,422	115	2190	345	4380	17043	124092	28,499	7	13	83
Grand Total	88,18,557	87,73,350	1,75,91,907	152	2799	608	5598	24019	147975	35,184	6	13	58

Annex 2: Shakti Varta human resource needs

SN	District	No of Blocks	NGO		TMST		
			BCs	DPCs	F&O	DPO-HNWASH	SHG PLA Coordinators
1	Koraput	14	56	1	1	1	1
2	Malkangiri	7	28	1		1	
3	Kalahandi	13	52	1	1	1	1
4	Nawarangpur	10	40	1		1	
5	Rayagada	11	44	1	1	1	1
6	Kandhamal	12	48	1		1	1
7	Gajapati	7	28	1		1	
8	Bolangir	14	56	1	1	1	1
9	Nuapada	5	20	1		1	
10	Sambalpur	9	36	1	1	1	1
11	Jharsuguda	5	28	1		1	
12	Sundargarh	17	68	1		1	1
13	Keonjhar	13	52	1	1	1	1
14	Bhadrak	7	32	1		1	1
15	Angul	8	32	1		1	
	Total	152	620	15	6	15	9

Annex 3: The concept of CLTS

CLTS is an approach in which people in rural communities are facilitated to do their own appraisal and analysis, come to their own conclusions, and take their own action. They are not instructed or taught. With CLTS in its classical form, a small team of facilitators conduct a triggering. The PRA (Participatory Rural Appraisal) principle that 'they can do it' is fundamental and PRA methods are used. These include participatory mapping on the ground to show where people live and where they defecate, transect walks to visit and stand in those places, calculations of quantities of shit (the crude local word is used) produced by each household and the community, and identifying pathways to the mouth leading to the shocking recognition that 'we are eating one another's shit'. This triggering is designed to lead to a moment of ignition and a collective decision to end OD followed by action to become ODF. When triggering is successful, Natural Leaders emerge. People dig holes and build latrines. There are no standard models and construction is by self-help with or without purchase of hardware from the market. Principles can be induced from successful practice. From an early stage the basic principles of CLTS were:

1. No external individual household hardware subsidy (IHHS). Communities install their own latrines or toilets with their own resources. Those who are better off help those who are too weak or poor to help themselves.
2. No standardised top-down designs. People decide for themselves.
3. Facilitation, not teaching or preaching. Appraisal and analysis are facilitated. But after triggering information and encouragement can be provided.

More recently, two further principles that can be inferred from effective practice are:

1. Creativity and innovation in approach.
2. Review, reflection, learning and change through operation research

Annex 4: GKS Implementation Plan - Activity Matrix with timeline

Budget head	Unit of measure	Rate (Rs./unit)	Target for the quarter					Amount (Rs. Lakhs)	Remarks
			Q-I	Q-II	Q-III	Q-IV	Total Target		
VHSC (GKS) Empowerment									
IEC / Advocacy									
Campaign for completing formalities of newly elected ward members as GKS President	Per GKS	50	45470				45470		Budget under NRHM Advocacy
Advocacy activity - sensitisation of GKS President and GP Sarapanch at block level	Per person	100	51704				51704	51.70	Budget under NRHM Advocacy
Printing of materials (Register, SOE Format, IEC materials)	Per GKS	100	45470				45470		Budget under NRHM Advocacy
Health awareness through Swasthya Kantha (District, Block and GP level)									Met out of concerned CPRC Untied fund under NRHM PIP
IEC, advocacy campaign and community mobilization activity with the involvement of GKS									Included in IEC / Advocacy campaign
Operational guideline on the role of GKS in disaster situation management									Budget under Printing-NRHM PIP
Sub Total								51.70	
Capacity building of President of GKS									
Two days Module preparation workshop for one day training of newly elected GKS President (including components of Health, Nutrition, water and sanitation etc.)	Per batch	90000	1				1	.9	
Two days State TOT for training of newly elected GKS President	Per batch	130000	1				1	1.30	
Two days District TOT for training of GKS President (4 persons from each block)	Per batch	50600	42				42	21.25	
One day training of newly elected Ward Members (GKS President) in coordination with PR Deptt.	Per person	300		22735	22735		45470	136.41	
One day district ToT for training of ICDS personnel on record keeping of GKS	Per person	500		1064	1064		2128	10.64	
Orientation on record keeping of GKS to GKS Conveners (Training of District Trainers, materials etc.)	Per block	1000		314			314	3.14	
Sub Total			44	24113	23799	0	47956	173.64	
Strengthened regular review and monitoring forums									

Budget head	Unit of measure	Rate (Rs./unit)	Target for the quarter					Amount (Rs. Lakhs)	Remarks
			Q-I	Q-II	Q-III	Q-IV	Total Target		
Bi - Monthly meeting at the 6234 GP level (headed by GP Sarapanch with the participation of GKS President, ANM & others) - mobility-cum-facilitation cost for MPHS M/F	Per meeting per GP	200		12468	12468	12468	37404	74.81	
Bi - Monthly meeting at the Block level (Headed by BDO / CP, PS with the participation of GP Sarapanch, Block Resource Person and functionaries)	Per meeting per block	500		628	628	628	1884	9.42	
Sub Total		700	-	13,096	13,096	13,096	39,288	84.23	
Strengthen Inter sectoral Convergence									
Strengthen forum for intersectoral convergence at state, district, block level									Met out meeting cost at various level
Joint Health & ICDS review meeting (State & district)	per meeting per quarter								
Sustha Gaon Puraskar to Best performing GKS	Per GKS	10000				455	455	45.50	
Sub Total								45.50	
Forum for experience sharing and cross learning exercise in 12 NHF district									
Platform for experience sharing and interface with Govt.- GKS Convention at the Block level	Per block	10000			314		314	31.4	
Platform for experience sharing and Interface with the Govt .system - GKS Convention at the District level	Per dist	80000			30		30	24	
Sub Total								55.4	
Strengthening initiative for low performing GKS - Activity performance by GKS, assessment, monitoring, mapping and provision of need based support									
Mapping of GKS based on the level of functional effectiveness (Outsourced)	Per GKS	50		45470			45470	22.74	
Facilitation and handholding support to 40% low performing GKS (4 days per GKS @150/- per day) based on assessment	Per GKS	600			18188		18188	109.13	
Demonstration of Model Community process initiatives in health (25 blocks on a pilot basis)	Per block	100000		8	8	9	25	25	
Thematic training of members of selected (10%) GKS (Flood, epidemic, malaria, seasonal diseases etc.)	Per GKS	275			4547		4547	12.5	
Management and facilitation cost to Nodal Agency and implementing partners for activity implementation (10% of the activity cost)							0	49.56	
Sub Total								197.04	

GRAND TOTAL	607.51
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Annex 5: Swasthya Kantha Task Plan with timeline and Budget

Budget head	Unit of measure	Rate (Rs./unit)	Target for the quarter					Total Target	Amount (Rs. Lakhs)	Remarks
			Q-I	Q-II	Q-III	Q-IV				
Mass media campaign through AIR and Doordarshan	Per Quarter	1,500,000						45		
Group discussion at GKS on 10 key behaviors at Gaon Swasthya Divas									Integrate d in Gaon Swasthya Divas	
Swasthya Kantha Update at every week									Met out of GKS untied fund	
Inter Personnel Communication and sensitisation on 10 Key behaviours at VHND by AWW & HW(F)	Per sector p.m						0	-	Integrate d in VHND session	
Painting of swasthya kantha at GKS	Per kantha	1,000						-	Met out of GKS untied fund	
Sensitisation of FLW at Sector level meeting on Swasthya Kantha- 10 key behaviours									Intigrated in Sector level meeting	
Suna Bhauni Folder	Per quarter	5	500000	500000	500000	500000	2000000	100		
Poster & calendar for Swasthya Kantha Campaign	Per GKS	150		45660			45660	25	Budget under Printing	
TOTAL								170		