SWABHIMAAN
(2016-2020)

Multi-sector integrated programme through women collectives (promoted by Aajeevika) to improve girls and women's nutrition

Swabhimaan tests the delivery of an integrated package of essential nutrition (specific and sensitive) interventions through Aajeevika promoted women collectives to improve nutrition status of adolescent girls' and women in Bihar, Chhattisgarh and Odisha

1 March 2017

Summary

Swabhimaan evaluates the delivery of an package of 18 essential nutrition (specific and sensitive) interventions via Aajeevika (National Rural Livelihood Mission) promoted village organizations (federation of women groups) to improve girls' and women's nutrition before conception, during pregnancy and after birth in three Indian states: Bihar, Chhattisgarh and Odisha.

The geographical sites of Swabhimaan are 356 revenue villages of five schedule caste/tribe of dominated administrative blocks under NRLM resource block strategy. These blocks are in 4 districts and together house 125,097 households and 6, 28,622 population.

The swabhimaan programme design was informed by a scoping study and consultations with multi-sector partners, experts and community meetings and validations, leading to National agreement to integrate nutrition-specific and sensitive interventions into their Poverty Alleviation Livelihood programme (Aajeevika) portfolio and testing this approach in swabhimaan blocks.

The Swabhimaan evaluation design is a prospective, non-randomised controlled evaluation in which, within across three States, five areas (intervention arm) have been purposively allocated to start community-level activities via village organizations in 2017, and five remaining other areas (control arm) will be allocated to starting these activities 36 months later, in 2020.

The **intervention arm** will receive a package of community-based activities, including: 1. The 231 women's village organizations (and 4175 SHGs) designing and implementing integrated village health, nutrition and Water and Sanitation Hygiene (WASH) plans through community cash grants received by the State Rural Livelihood Missions via the Vulnerability Reduction Fund/other such options, 2. Trained community cadres of village organizations (Community Resource Persons/Poshan Sakhis) facilitating women-issues specific (Maitri Bethak) monthly meetings with women's self-help groups using participatory learning and action cycle methodology, 3. Trained cadres (Community Resource Persons/adolescent Sakhis) of Village Organizations form and facilitate weekly/fortnightly adolescent girls' clubs (Kishori Samooh) for discussions using a participatory learning and action cycle and link girls for village organizations for receiving grants for secondary education, 4. Quarterly trainings of community farming cadre (Krishi Resource persons) of Village Organizations to in turn monthly engage with women farmer/producer groups of State Rural Livelihood Missions on nutrition-sensitive agriculture methodologies for creation of community nutrition-sensitive agriculture demonstration sites (farmer field school at cluster level) and promotion of backward micronutrient-rich kitchen gardens at homes, 5. Trained community cadres of village organizations (Community Resource Persons/Poshan Sakhis) identify, track and follow-up at nutritional risk adult women[1] through fortnightly group/home visits and linkage with (a) village organizations for provision of seed grants for agriculture and poultry-rearing activities and (b) free one noon hot cooked meal under social welfare department, 6. Village organizations conduct special newly-wed couples meetings and rallies and 7. Village organizations conduct a biannual process audit of their progress against plan.

1. MUAC <23 cms for women, Height <145 cms, First/Adolescent pregnancy, Previous foetal/child death, Late pregnancy (>35 years), Poor weight gain in pregnancy (less than 1 kg per month in second and third trimester) in pregnancy (if data is available), Haemoglobin level less than 11 g/dl (if Hb. is available)

Both intervention and control arms will receive systems strengthening activities to improve the coverage of food security entitlements, health, nutrition, water and sanitation services. These include: 1. Strengthening Village Health, Sanitation and Nutrition Days (VHSND) to improve access to antenatal care, family planning and micronutrient supplementation. Strengthening will involve quarterly trainings of health service providers, monthly review of nutrition indicators and the identification women at risk of undernutrition for special supplementary food/ counselling, 2. Strengthening adolescent health day to improve access to adolescent health, nutrition services via quarterly trainings of health and ICDS service providers. 3. An extended Village Health, Sanitation and Nutrition Day once every six months for newly-wed and women, including individual counselling and information about entitlement camps. 4. Annual training and follow-up meetings with service providers from allied departments (PHED, civil supplies) to help them improve the delivery of entitlements and services and 5. Regularizing block nutrition convergence review mechanism

The evaluation's hypothesis is that such village organization-led activities will lead to – (a) a 15% reduction in the proportion of adolescent girls with a BMI<18.5, (b) a 15% reduction in the proportion of mothers of children under two with a BMI<18.5, and a 0.4cm improvement in mean MUAC among pregnant women, over the intervention period of three years and (c) improvements of between 5% and 20% in the coverage of 18 key nutrition specific and sensitive interventions over three years.

The State Livelihood Missions are anchoring and implementing the Swabhimaan programme, in coordination with Departments of Health, Civil Supplies, Social Welfare, Agriculture and Public Health Engineering, with UNICEF technical and financial support. UNICEF in turn is partnering with relevant non-government partners (and resource persons) for development of capacity building tools and methodologies and with relevant academia for impact and process evaluation. The impact evaluation is led by the All India Institute of Medical Sciences (AIIMS) in Bihar, Chhattisgarh and Odisha, with technical support from International Institute of Population Sciences and University College London. The process evaluation and concurrent monitoring of quality of implementation strategy is led by Clinical Development Services Agency, a unit of Department of Biotechnology, Government of India. The programme is reviewed at national level biyearly and is guided by a national technical advisory group.

1. Background

Nutrition-specific and nutrition-sensitive interventions for improving nutritional status of women – before, during and after pregnancy are well known and can be broadly classified into five thematic areas – (1) Improve the food and nutrient intake of girls and women, (2) Prevent micronutrient deficiencies and nutritional anaemia, (3) Increase access to prenatal and postnatal health services, (4) Increase access to education and WASH commodities/services and (5) Prevent early, poorly spaced and repeated pregnancies.

The primary accountability for delivery of these interventions lies with the government although many development partners, non-governmental organizations (NGOs), faith-based agencies and private sector stakeholders are also involved supporting the improved reach and utilization of these services in high burden/dispersed/poverty pockets. The Ministry of Health and Family Welfare, through the National Health Mission, and the Ministry of Women and Child Development, through the Integrated Child Development Services, have been central to delivery of most of the listed interventions. Under the National Food Security Act, the Ministry of Food and Civil Supplies, through the Public Distribution System, is critical for provision of subsidized rations to 75 per cent of rural households countrywide. The Ministry of Drinking Water and Sanitation is responsible for providing all households with drinking water and access to toilets. Through its newly launched Swachh Bharat Abhiyaan, the Ministry has heavily subsidized and incentivized toilet construction at household and community level. Initiatives for economic empowerment of women and families to break the intergenerational transmission of poverty are made possible through the National Rural Livelihood Mission – Aajeevika, Deendayal Upadhyaya Grameen Kaushalya Yojana and the Mahatma Gandhi National Rural Employment Guarantee Act implemented through the Ministry of Rural Development.

Activating and regularizing convergence mechanisms of all these five ministries (Women and Child, Civil supplies, Rural development, Public Health Engineering and Health) has been a persistent challenge. There is also no mechanism to identify newlyweds and women at nutrition risk and providing them a special package of feeding and care. Those nutrition interventions that are present also need quality strengthening to address operational challenges in service delivery owing to capacity building, monitoring and huge vacancy load.

One delivery platform untapped to reach out to adolescents, newlywed women and pregnant women with special package of reproductive, health and nutrition messages as well as services is the women Self- help Groups (SHGs) and their federated units often called Village Organizations (VO). Evidence from randomized controlled trials within and outside India suggests that using women's groups as platforms for promoting health interventions is a feasible approach in low resource settings. This is provided the necessary requisites, such as high quality facilitators for establishing and maintaining the group, high coverage of intervention, sufficient time for implementation of the intervention, concomitant supply strengthening interventions and appropriate safeguards against harm such as conflict with service providers and domestic violence, are met.

In view of the undisputed role of income poverty in the aetiology of undernutrition, need to integrate poverty alleviation in nutrition programmes and vice-versa are necessary. The government's increased interest in promoting women groups involved in thrift and credit and village organizations through the

National Rural Livelihood Mission (Aajeevika) remains an untapped platform for improving reach and use of essential nutrition interventions, particularly for women residing in resource-constraint settings.

The main Aajeevika is poverty reduction through collectivization of women residing in poverty into self-help groups and federate them further. In this process, Aajeevika engages with them over a long period of time in building their capacity to save, access credit and promote livelihoods and participate in promotion of community development activities in a systematic manner. The federated structure promoted through Aajeevika involves SHG at tier 1, Village Organisations comprising 10 to 20 SHGs at tier 2 and Cluster/ Gram Panchayat Level Federations at tier 3. In some states, high tier federations at block and district level are also being formed. All Mission compliant SHGs are required to adhere to Panchsutras or five canons of democratic functioning, that is, (i) regular conduct of weekly meetings, (ii) member attendance at meetings, (iii) regular subscription of savings by members, (iv) inter-lending of SHG funds and (v) up-to-date bookkeeping. The management units at state, district and block level provide supervisory and capacity building support to SHGs and their federations.

Aajeevika recent observations that members of Self-Help Groups spend a lot of their savings/ Credit for meeting health expenses and their recurrent illness also reduce their productive work days – creating dual substantial economic loss, triggered the integration of a nutrition, health, WASH and social development strategy in their framework in areas/ pockets where village organizations are mature. The criteria for 'maturity' assessment varies with the tier, including duration of operations and regularity of savings and loan disbursement as well as support to lower tiers by higher tier collectives. The activities envisaged by Aajeevika for the VOs include – (a) **Mobilize and build capacity of Women and demand generation** (Village Health and Nutrition Days, Services of the ICDS are accessed, Sanitary Toilets are constructed and Access to healthy food that are available in the villages), (b) **Promote Behavior Change** (Discussions on Mother and Child Health and Nutrition issues during SHG Meetings), (c) **Promote Health and Nutrition Livelihoods** (Manufacture and sale of Sanitary Napkins, NutriMix Units and Vegetable Cultivation under MKSP) and (d) **Prevent poverty due to medical care costs** (Mobilize women to enroll into Insurance Schemes and The Use of the Vulnerability Reduction Fund).

Thus, in context to India where previously engagement of self help groups for improving the last mile delivery of health services and undertaking a range of activities like community mobilisation, counselling, record keeping, to name a few, have largely been considered honorary workers, NRLM provides an opportunity to shift strengthening the last mile delivery of women's nutrition services and women's nutrition promotion at community level into an invested service that can be implemented through VOs and higher federated institutions as grantees rather than as volunteers. **This mechanism by which organised units of self help groups, with active bank accounts, such as village organizations of NRLM directly receive and manage money to deliver services as per community needs-based plans approved by the funding agency is often called community cash grant/transfer mechanism.**

Notable global examples where women collectives have been partnered with, in equal capacity as a grantee and fund manager for delivering services and promoting health and nutrition behaviours in underserved communities include Community Conditional Transfer programme in Indonesia, livelihood and food security programmes in Bangladesh (Shouhardo, Jibaon-o-Jibika) and Nepal (Suaahara). Indian experiences include Kudumbashree (Kerala), Society for Elimination of Rural Poverty Project (Andhra Pradesh and Telangana), Self Employed Women's Association - rural (various states), Community Health Care Management Initiative (West Bengal), Jamkhed model (Maharashtra) and urban health models by Urban Health Resource Centre and Mahila Abhivrudhi

Society, Andhra Pradesh. All these experiences build on bank linkages of women collectives and government or non-government organisation (NGO) as their promoting agency. Women's groups are trained on promotion of the health and nutrition interventions, the scope and duration of training varying with the type of programme. The promoting agency or federated structure provides capacity building and supervisory support. Most programmes strengthen the health services delivery system in addition to intervening with community groups.

UNICEF 2016 scoping study suggests that that NRLM village organisations have the potential to manage grants for improving last mile delivery of essential nutrition services for women, provided they are enabled, supervised and provided protection against violence and exploitation.

Given this background swabhimaan demonstration programme was designed with the aim of engaging with village organization promoted by Aajevika as equal and accountable partners for improving nutrition of adolescent girls and women in resource blocks of NRLM in states of Bihar, Chhattisgarh and Odisha.

2. Objectives

1. Improve the nutritional status of adolescent girls and women before pregnancy (newlyweds), during pregnancy and after birth by improving the coverage of five essential nutrition interventions (Improving their food and nutrient intake, Preventing micronutrient deficiencies and anaemia, Increasing access to VHND services and provide special care to nutritionally 'at risk' women, Increasing access to education about water and sanitation and access to WASH commodities and Preventing early, poorly spaced and too many pregnancies).

2. To demonstrate a methodology of Aajeevika promoted VOs preparing village-wise integrated plans and receiving and implementing community cash grants to implement these plans.

3. To strengthen Village Health, Sanitation and Nutrition Day (VHSND)-linked package of health, family planning, water, sanitation and hygiene and nutrition services for women and serve as a platform to identify at nutritional risk women and provide a special care package in collaboration with AAJEVIKA.

4. To demonstrate a menu of options for culturally appropriate nutrition-sensitive agriculture (at home and at farm) for use by the agriculture wing of State Livelihood Missions.

5. To form adolescent groups via and linked to village organization platform.

3. Target Groups

- Adolescent girls
- Newlywed women
- Pregnant women
- Mothers of children under two (lactating women).

4. Package Of Essential Nutrition Interventions

	Interventions	Required During Preconception	Pregnancy	Lactation
I.	**Improve food and nutrient intake**			
1	Access to generalized household rations of PDS	✓	✓	✓
2	Balanced energy protein supplementation through access to supplementary food rations (THR/Hot cooked meal)	✓	✓	✓
3	Access to knowledge and choices about how to increase maternal dietary diversity *	✓	✓	✓
4	Access to knowledge and support for nutrition-sensitive agriculture at home (kitchen gardens) and community-based food insecurity coping strategies	✓	✓	✓
II	**Prevent micronutrient deficiencies and anemia**			
5	Iron and folic acid supplementation	✓	✓	✓
6	Universal use of iodized salt	✓	✓	✓
7	Calcium and deworming	✗	✓	✓
8	Access to information/commodities to prevent malaria (including but not limited to insecticide treated nets)	✓	✓	✓
9	Access to information preventing tobacco and alcohol use in pregnancy	✗	✓	✗
III	**Increase access to health services and provide special care to nutritionally 'at risk' women**			
10	Early registration in outreach health services	✓	✓	✗
11	Recording and monitoring of nutritional status and special community-based at-nutritional risk package	✗	✓	✗
12	Quality reproductive health, antenatal and postnatal care	✓	✓	✓
13	Access to knowledge and entitlements for promotion of institutional delivery and maternity benefit	✗	✓	✓
IV	**Increase access to education about water and sanitation as well as WASH commodities**			
14	Sanitation and hygiene (incl. menstrual hygiene) education	✓	✓	✓
15	Access to safe drinking water and sanitation commodities	✓	✓	✓
V	**Prevent early, poorly spaced or unwanted pregnancies**			
16	Promotion of secondary education and education for delaying the age at marriage to legal age	✓	✗	✗
17	Access to information and family planning commodities for delaying age at first pregnancy and prevention of repeated pregnancies	✓	✓	✓
18	Women's collective voice and empowerment for decision making for preventing child marriage, violence against women, child spacing and other gender-related issues	✓	✓	✓

* Through nutrition-sensitive agriculture and preventing food adulteration

5. Geographic Locations

States	Bihar	Chhattisgarh	Odisha
Districts	Purnea	Bastar	Angul, Koraput
Blocks	Kasba, Jalalgarh	Bastar	Pallahara, Koraput Sadar
Households	40, 000	34, 212	50, 885
Population	2, 70, 000	1, 53, 949	2, 04, 673

Source: Census 2011

6. Implementation Strategy

Both intervention and control arms will receive strategy 1 i.e., systems strengthening activities to improve the coverage of food security entitlements, health, nutrition, water and sanitation services. Only intervention arms will in addition to strategy 1 also receive strategy 2 i.e., receive community-based activities led by village-organizations of NRLM.

Strategy 1: Service provider system strengthening throughout the block (100% villages)

Building an enabling environment	1. UNICEF to set up nutrition cells at district level for technical assistance to address issues of supplies, training manpower and monitoring
Capacity building	1. Quarterly trainings of ICDS and Health workers on Village Health, Nutrition Day (VHNSD), Adolescent Health Day and identification and care for women at nutritional risk 2. Annual training and follow-up meetings with service providers from civil supplies and PHED departments to help them improve the delivery of entitlements and services 3. Biannual sensitization during farmers chaupals via KVK/ATMA on entitlements and behaviours
Monitoring of coverage and quality services and entitlements	1. Activation and improving coverage of quarterly adolescent health day 2. Universal and quality coverage of VHND 3. Ensuring opening of PDS shops and receipt of generalized food ration 4. Provision of maternity entitlements and ICDS Ration
Special initiatives	1. Special Biannual women service and entitlement camps by Health department 2. Inclusion of identification and package for at-risk of women and newly-wed package as part of VHND
Fostering convergence and partnerships	1. Formation/Activation and periodic meetings of state, district and block coordination committee anchored via Aajeevika for monthly review of nutrition indicators 2. Endorsement of integrated village micro plans by district administrations

Service providers to be reached via strategy 1

	Bihar	Chhattisgarh	Odisha	Total
ASHA	252	471	212	935
AWW	261	358	304	923
ANMs	49	58	33	140
Lady Supervisors	9	7	12	28
Fair Price Shop owners	109	78	46	233

Strategy 2: Community-system strengthening only in resource blocks via CRP-VO led strategy

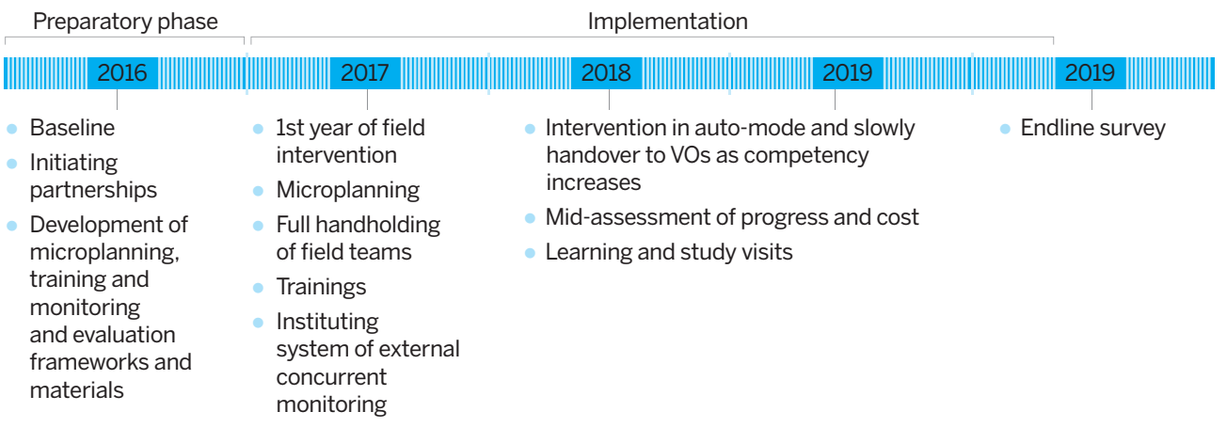
Building an enabling environment	1. VO develop integrated village health, nutrition and Water and Sanitation Hygiene (WASH) plans 2. VO implement integrated plans through cash grants received by the State Rural Livelihood Missions via the Vulnerability Reduction Fund 3. Trained CRP/Poshan Sakhi conduct monthly Maitri Bethak as part of monthly SHG meeting 4. Fortnightly meetings/home visits for women with MUAC <23cm, with provision of seed grants for agriculture and poultry-rearing activities 5. Biannual Newly-wed couples meetings 6. Rallies and mobilize for VHND, AHD services and other social issues
Interventions for adolescent girls	1. Form adolescent girls' clubs/activation of Sabla clubs 2. CRP/Kishori Sakhi engage with adolescents weekly/fortnightly over weekend meetings using sports/play activities as bases 3. VO to give loans for secondary education 4. Rallies and mobilize for AHD/Kishori Divas services 5. Adolescent groups make efforts to reduce child marriage and active citizenship in their villages
Interventions for farmer clubs	1. Quarterly trainings of VRP in nutrition-sensitive agriculture for farmer's groups 2. VRPs to engage with farms producer groups through monthly meetings 3. VO/GPLF form farmer field school sites/nutrition-sensitive agriculture demonstration sites 4. Promote backyard micronutrient-rich kitchen garden

Geographic reach and target groups of swabhimaan via strategy 2: Vo-led interventions

	Bihar	Chhattisgarh	Odisha	Total
Revenue villages	77	111	168	356
GPLF and related (Tier -3)	5	4	12	21
VOs (Tier 2)	72	80	79	231
Poshan Sakhis or CRPs	72	100	79	251
Kishori Sakhis	72	-	-	72
SHGs (Tier-1)	1985	1488	702	4175
VRPs/Krushi Mitra	115	80	39	234
Farmer Groups	44	10	31	85

*Odisha has GP led federations-GPLF (1 per GP) and Community Resource Persons (CRPs) instead of VOs

7. Timelines



8. Financial Incentives To Community Resource Persons And Village Based Organizations

Financial incentives to CRPs/ Poshan Sakhis and VOs are decided by State Rural Livelihood Missions (SRLMs). In Bihar CRPs/ Poshan Sakhis receive INR 1500 against submission of completed monthly reporting formats. However, in Chhattisgarh and Odisha, CRPs receive a performance based incentive against completed activities.

Activity linked financial incentives to CRPs, VOs and federations

Activity	Frequency	Incentive amount (INR)
CRPs		
Making of PMP (women's/ kishori's)	One time	450 per day @150 per day for 3 days
Monthly Maitri Baithak	Monthly	50 per meeting
Food demonstration session for undernourished women/ kishoris	Fortnightly	100 per session
Newlywed couples meeting	Quarterly	100 per quarter
Adolescent group SHG meetings	Monthly	100 per meeting
Mobilizing women for VHSND	Monthly	100 per VHSND
Mobilizing women for women's camp	Biannual	500 per camp
Tracking and monitoring each "at nutrition risk", pregnant and lactating women for a maximum of 50 HH	Monthly	1000 for 50 HH
VO/ CLF/GPLF		
Programme review meeting by federation(GPLF/ CLF) for VO	Quarterly	2500 per quarter
PMP formation by GPLF/VO members	Once	1500 per PMP
Quarterly newly-wed couple meeting	Quarterly	500 per meeting
Monthly Maitri Baithak	Monthly	100 per meeting
Data entry incentive for baithak	Monthly	200 per month
Untied fund welcome Suitcase for newlywed (estimated 150 per year) • Soap • Iodized salt packet • Folic acid tablet strip • Condom • Pregnancy testing kit • Calcium tablet • Sanitary napkin • A pictorial aid	Once	2500 per newly-wed
Women Biannual camps (two per year)	Per VOs	1000 per camp
Three Issue-based drives alcohol, dowry, tobacco	3 per year	2000 per drive
Organizing recreational activities for adolescent girls	Biannual	1000 per event
Nutri-farm demonstration site	2 sites	1000 establishment cost and 5000 annual recurring cost

9. Inter-Departmental Coordination

Swabhimaan cuts across atleast five departments in order to achieve co-location of 18 interventions.

Departments and their respective roles in implementation of Swabhimaan programme

S.No.	Departments/ Missions	Role
1	**Department of Rural Development (State Rural Livelihood Mission)**	1. Anchor for Swabhimaan interventions providing the administrative and field structure and financial support to the project
2	**Department of Social Welfare (ICDS)**	Improve women's dietary intake through: 1. Ongoing food supplementation for pregnant women and lactating mothers 2. Double ration for at nutrition risk women 3. Counselling and/food supplementation for adolescent girls 4. Fortification of THR
3	**Department of Health and Family Welfare (National Health Mission)**	1. Quarterly orientation of service providers on VHSND guidelines 2. Biannual health camps for newlyweds and reproductive health camps for women, adolescent girls' health camps 3. Engagement with Poshan Sakhis (or equivalent carders) in VHSNDs and camps for mobilisation support
4	**Department of Rural Development (Water and Sanitation Mission)**	1. Access to Open Defecation Free areas funds 2. Engaging VOs in needs assessment and toilet construction
5	**Department of Food Supply**	1. Provision of entitlement cards 2. Timely operations of Fair Price Shops

10. Partnerships Established for Project Implementation

The State Livelihood Missions are anchoring and implementing the Swabhimaan programme, with the entire implementation strategy based on their available adminsitrative and human resource structure in coordination with UNICEF technical and financial support. Through SRLM coordination committees they are engaging with Departments of Health, Civil Supplies, Social Welfare, Agriculture and Public Health Engineering, The roles and responsibilites at each level of the SRLM structure is provided below

SPMU

- Project oversight
- Convergence with departments

DPCU

- Project facilitation and convergence with departments to ensure services and entitlements reach comunities
- Data managment

BPIU

- Project monitoring/ handholding support to community cadres
- Data management

CLF

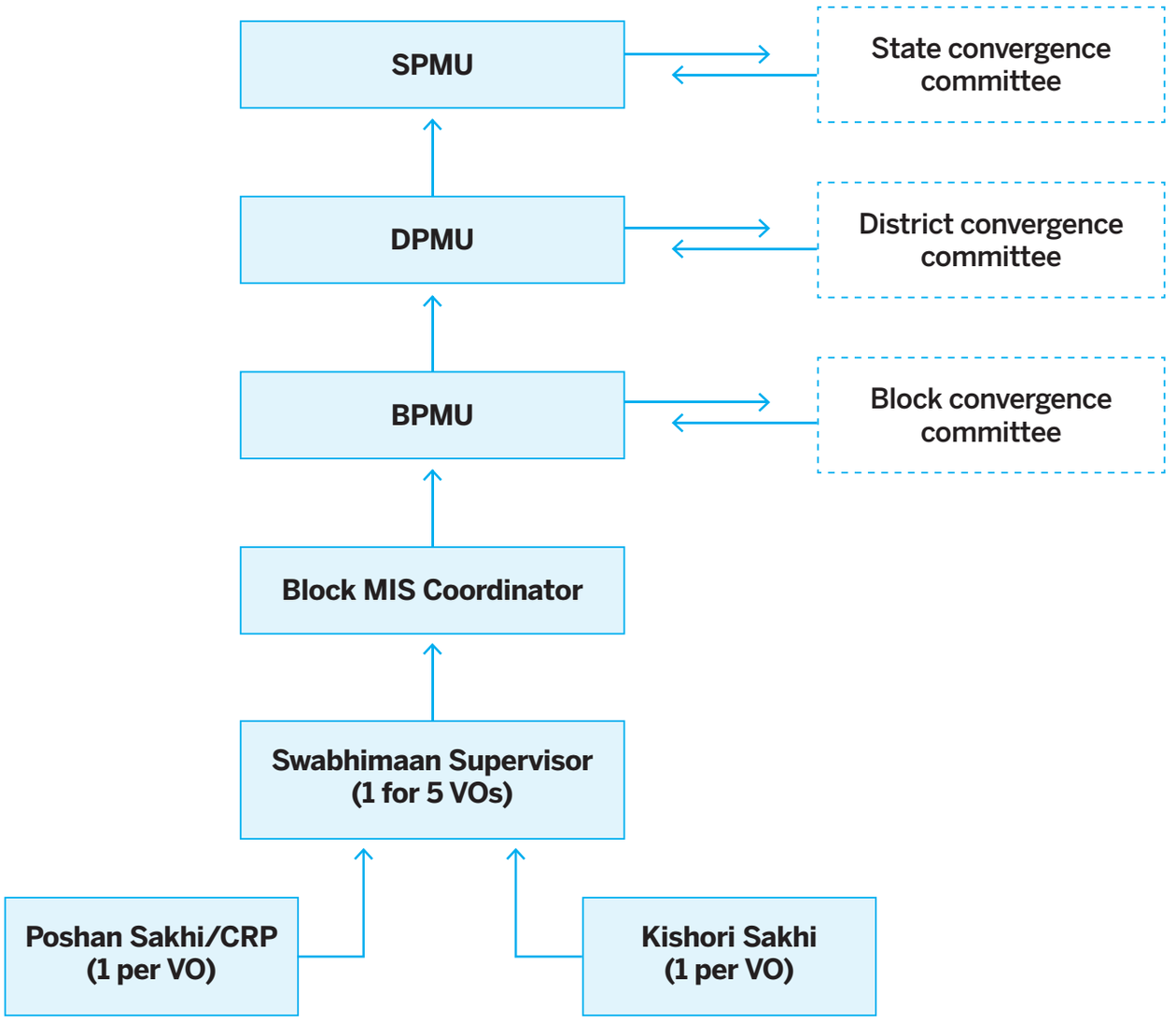
- Compilation of PMPs
- Collaboration with JEEViKA
- Handling of the untied fund / community cash grant

VO

- PMP and appointment of Poshan sakhis and Kishori Sakhis
- Special new-wed couple meetings, rallies and women health and entitlement camps
- Agriculture: Meeting of the farmer groups and demonstration of Nutri Farm
- Quarterly review of progress

SHG

- Monthly PLA Maitri Baithak by Poshan Sakhi/Kishori Sakhi
- Mobilization for ANC and Kishori Divas
- Identification and fortnightly meetings of at risk women and adolescent girls



UNICEF

UNICEF is the lead technical assistance agency and provides financial support for capacity building and evaluation components in addition to staff time of experts at National and State levels. All technical aspects of the project design, implementation and evaluation are led by UNICEF. UNICEF is partnering with relevant non-government partners (and resource persons) for development of capacity building tools and methodologies and with relevant academia for impact and process evaluation. The impact evaluation is led by the All India Institute of Medical Sciences (AIIMS) in Bihar, Chhattisgarh and Odisha, with technical support from International Institute of Population Sciences and University College London. The process evaluation and concurrent monitoring of quality of implementation strategy is led by Clinical Development Services Agency, a unit of Department of Biotechnology, Government of India. The programme is reviewed at national level biyearly and is guided by a national technical advisory group.

11. Reporting Mechanisms

At VO level : Monthly reporting is done by Poshan Sakhi/CRPs and Kishori Sakhi on coverage and performance indicators.

Target groups (denominators)

- Newly-wed
- Pregnant women
- Mothers' of under two
- At-risk women

Activities conducted as per plan

- VHSND held (Y/N)
- Maitri baithak held (Y/N)
- Forth nightly food demonstration and counselling session held for at-risk (Y/N)
- Home visits conducted for at-risk (Y/N)
- Village drives conducted as per plan (%)
- Newly-wed couple meetings conducted as per plan (Y/N)
- Special VRF/other services for at-risk by VO:_____
- Special women only camps held as per plan: Y/N

Performance indicators

- Target women who attended the VHSND (%)
- Target women who attended the Maitri baithak (%)
- At-risk women visited fortnightly in their home visits (%)
- At-risk women attended fortnightly food demonstration and counselling session (%)
- Target newly-wed who attended the couple meeting
- Target groups who attended the women only camps

At block level:

All VO level reports are consolidated at the BPMU and entered into the SRLM dashboard. Data is made available for district and state level review.

12. Review Mechanism

A biannual review is planned by VOs under supervision of block coordinator to assess implementation gaps (using bindis-red, yellow, green as markers of not optimal to good performance against reporting indicators) and address bottlenecks.

The convergence committees at block, district and state level review performance on reported indicators every quarter mainly to identify areas requiring interventions from their respective departments.

A quarterly update is shared with the respective Mission Directors at state level and once in six months an update/review is held at NRLM level.

13. Concurrent Monitoring and Quality Control

Presently, UNICEF state consultant (1 per state) was providing the monitoring support. However, to strengthen this component, Clinical development services agency (CDSA) is setting up concurrent monitoring mechanisms to independently monitor the programme and provide feedback to respective SRLMs.

14. Impact Evaluation

The impact evaluation design is Prospective, non-randomised controlled. **The evaluation seeks to answer two main research questions:**

1. Did the Swabhimaan programme improve the nutritional status of adolescent girls aged 10-19 years, pregnant women, and mothers of children under two?

2. Did the Swabhimaan programme increase the coverage of 18 key nutrition specific and sensitive interventions for girls, pregnant women, newlywed women, and mothers of children under two?

The Hypotheses the evaluation is testing is:

1. We hypothesise that the Swabhimaan programme will lead to a 15% reduction in the proportion of adolescent girls with a BMI<18.5, a 15% reduction in the proportion of mothers of children under two with a BMI<18.5, and a 0.4cm improvement in mean MUAC among pregnant women, over the intervention period of three years.

2. We hypothesize that the Swabhimaan programme will lead to improvements of between 5% and 20% in the coverage of 18 key nutrition specific and sensitive interventions over three years.

Impact evaluation is planned via cross-sectional baseline and endline surveys. These surveys are being implemented by the respective state AIIMS in the three states, with support of IIPS Mumbai and with technical support of UCL-C. The impact evaluation has been registered in RIDIE and CTRI. For baseline, villages in intervention and control areas were selected to take part in baseline and endline surveys. In Bihar, a full household listing was conducted to identify adolescent girls aged 10-19 years, pregnant women and mothers of children under two in all programme areas. Simple random sampling was then used to select respondents in each of these three groups. In Chhattisgarh, 224 villages in two blocks (administrative areas of around 100,000 population) were paired on the basis of population size and whether they had held a monthly Village Health and Nutrition Day for the last three months. Forty such pairs (a total of 80 villages) were then randomly selected for data collection, and all eligible respondents in each of the three target groups in these 80 villages were approached for interview. In Odisha, a set of 12 Gram Panchayats (administrative units of around 5000 population in two blocks have been purposively identified as the intervention areas, and all remaining Gram Panchayats in the two blocks serve as control areas. All eligible respondents in each of the three target groups will be approached for interview. It was not possible to blind participants to allocation, but data collection teams and analysts will be blind to allocation.

For analysis, it will be carried out at an individual level, adjusting for clustering at the level of the village and Village Organisation using linear and logistic random effects models in STATA 14. In each State, we will assess the comparability of intervention and control areas at baseline by examining area-level and individual level characteristics, including: the number of self-help groups and village organisations in each area, the socio-demographic profile of respondents and their households (caste, literacy and assets) and key evaluation outcomes at baseline. We will use the difference-in-difference method to compare primary and secondary outcomes between intervention and control at endline, adjusting for their baseline values and for other characteristics that differed significantly between the two areas at baseline. We will present analyses both a State level, and conducted a pooled analysis with data from all States.

Outcomes of interest to this evaluation include:

PRIMARY OUTCOMES

1. % adolescent girls with BMI <18.5 kg/m2
2. Mean MUAC among pregnant women
3. % mothers of children under 2 with <18.5 kg/m2

SECONDARY OUTCOMES

Adolescent Girls (Girls aged 10-19) - unmarried, not pregnant and not the mother of a child under two	DENOMINATOR
1. Mean dietary diversity score	All adolescent girls aged 10-19
2. % receiving minimum dietary diversity score (MDD) (5 of10 food groups)	As above
3. % consuming four or more IFA tablets in the month preceding the survey	As above
4. % living in a household with iodized salt	As above
5. % living in food secure households	As above
6. % living in households with a kitchen garden	As above
7. % living in households with a toilet or covered pit latrine	As above
8. % using safe pads or sanitary pads	As above
9. % accessing adolescent health services (Kishori Divas) in six months preceding the survey	As above
10. % who attended at least three Kishori meetings in six months	As above
11. % who attended at least three Kishori meetings in in six months	Adolescent girls from underprivileged groups *

Pregnant Women (if she is pregnant, a girl or woman will join this category whether she is an adolescent, newlywed or the mother of any child under two)	
1. % of pregnant women in the 2nd and 3rd trimester consuming at least 25 IFA tablets in the month preceding the survey	Pregnant women in 2nd or 3rd trimester
2. Mean dietary diversity score	All pregnant women
3. % receiving minimum dietary diversity (5 out of 10 food groups)	All pregnant women
4. % living in a household with iodized salt	All pregnant women
5. % living in food secure households	All pregnant women
6. % living in households with a kitchen garden	All pregnant women
7. % living in households with a toilet or covered pit latrine	All pregnant women
8. % receiving ICDS entitlement for supplementary food in month preceding the survey	Pregnant women entitled to ICDS rations
9. % who had one antenatal check-up in the first trimester	All pregnant women
10. % weighed at least once in first trimester	All pregnant women
11. % who received one dose of albendazole in second trimester	Pregnant women in 2nd or 3rd trimester
12. % who took two calcium tablets in 2nd trimester	Pregnant women in 2nd or 3rd trimester
13. % below the age of eighteen	All pregnant women
14. % who attended at least three Maitri Baithak meetings in six months	All pregnant women
15. % who attended at least three Maitri Baithak meetings in six months	Pregnant women from underprivileged groups
16. % who attended at least three VHNDs in six months	All pregnant women
17. % who attended at least three VHNDs in six months	Pregnant women from underprivileged groups
18. % using a modern family planning method (in previous delivery); before the current pregnancy	All pregnant women
19. % who are members of women's Ag-producer groups and have adopted at least 1 mix micronutrient-rich cropping methods, against previous practice	Pregnant women who are a part of women's Ag-producer groups
20. % who are members of women's Ag-producer groups and have adopted at least 1 pesticide-free agri-methods, against previous practice	Pregnant women who are a part of women's Ag-producer groups

Figure 8 (Continued)

Figure 8 (Continued)

Mothers Of Children Under Two	
1. Mean dietary diversity score	All mothers of children under two
2. % receiving minimum dietary diversity (5 out of 10 food groups)	All mothers of children under two
3. % living in a household with iodized salt	All mothers of children under two
4. % living in food secure households	All mothers of children under two
5. % living in households with a kitchen garden	All mothers of children under two
6. % living in households with a toilet or covered pit latrine	All mothers of children under two
7. % receiving their minimum PDS entitlement in month preceding survey	All mothers of children under two entitled to PDS
8. % receiving ICDS entitlement for supplementary food in month preceding survey	All mothers of children under two entitled to rations
9. % who received at least four ANC overall in last pregnancy	All mothers of children under two
10. % consuming 100 or more IFA tablets during last pregnancy	All mothers of children under two
11. % weighed at least four times in last pregnancy	All mothers of children under two
12. % using a modern family planning method	All mothers of children under two
13. % who accessed at least one of three social protection schemes (JSY, Adarsh Dampati Yojana)	All mothers of children under two
14. % who delivered in a health facility in last pregnancy	All mothers of children under two
15. % who attended at least three Maitri Baithak meetings and three VHNDs in last year	All mothers of children under two
16. % who attended at least three Maitri Baithak meetings and three VHNDs in last year	As above, from underprivileged groups
17. % who are members of women's Ag-producer groups and have adopted at least 1 mix micronutrient-rich cropping methods, against previous practice	Mothers of children under two, who are members of farmer producer groups
18. % who are members of women's Ag-producer groups and have adopted at least 1 pesticide-free agri-methods, against previous practice	All mothers of children under two who are members of farmer producer groups

Annex. 1: Select women's nutrition indicators for study districts (NFHS-4, 2015-16)

Indicators	Purnea	Bastar	Angul	Koraput
Nutritional status and anemia				
Women with BMI <18.5 kg/m2	38.8	31.3	22.1	34.5
Women who are overweight >=25 kg/m2	8.7	6.3	17.6	10.2
Non-pregnant women 15-49 years who are anemic (<12 g/dl)	68.4	59.4	43.5	63.4
Pregnant women 15-49 years who are anemic (<11 g/dl)	72.2	68.2	58	60.5
Consumption of micronutrient rich foods/supplements				
Households using iodized salt	95.9	98.5	89.5	90
Mothers who consumed iron folic acid for 100 days or more when they were pregnant	9.6	29.1	38	31.9
Access to health services				
Mothers who has antenatal check-up in first trimester	35.5	59.1	73.3	55.8
Mothers who had atleast 4 antenatal care visits	12.2	55.8	68.4	58.4
Mothers who were protected against neonatal tetanus	91.7	97.2	98.8	94.7
Mothers who received postnatal care from health personnel within 2 days of delivery	86.7	53	85.2	49.1
Mothers who received financial assistance under JSY for institutional delivery	46.8	78.4	70.2	73.5
Institutional delivery	61.5	66.4	90.3	68.4
Access to safe drinking water and sanitation commodities				
Households with an improved drinking water source	99.7	94.5	77.2	84.7
Households using improved sanitation facility	14.4	17.6	35.6	18.2
Prevent early, poorly spaced or unwanted pregnancies				
Women with 10 or more years of schooling	15.1	17.1	27.6	14.5
Women age 20-24 years married before age 18 years	36.8	20.1	22	34.7
Women age 15-19 years who are already mothers	12.3	4.8	9.9	12.6
Married women of reproductive age group using any modern method of family planning	30.3	42.9	48.6	10
Health worker ever talked to female non-users about family planning	22.8	34.6	27.7	23.7

(Figures in %)

BIHAR

Swabhimaan project is implemented in blocks Kasba and Jalalgarh of district Purnea, in alignment with JEEViKA's cluster based approach. The region is divided into three clusters, all (108 revenue villages) receiving system strengthening interventions. Clusters 1 and 2 (77 revenue villages) in 2017 and 2018 respectively receive VO led interventions while Cluster 3 (31 revenue villages) serves as control with no VO led interventions.

Table 1: VO led intervention coverage in blocks Kasba and Jalalgarh (Bihar)

	Jalalgarh	Kasba	Total
Revenue villages			
Total Village	47	57	104
Intervention village	34	42	76
CLF	2	3	5
VOs	72	60	132
SHGs	970	1014	1984
PS (for CL-2)	39	33	72
KS	39	33	72
VRP	58	57	115
Farmer groups	17	27	44

Table 2: Service providers mapped in blocks Kasba and Jalalgarh (Bihar)

	Jalalgarh	Kasba	Total
ASHA	111	141	252
AWW	96	165	261
ANMs	18	31	49
LS	3	6	9
PDS dealers	38	71	109

Table 3: Infrastructure mapped in blocks Kasba and Jalalgarh (Bihar)

	Jalalgarh	Kasba	Total
CHC	Nil	1	1
PHC/APHC	3	2	5
Sub-centre	18	26	44
AWC	99	167	266
PDS shops	38	71	109

CHHATTISGARH

All four SRLM identified clusters in block Bastar of district Bastar will receive system strengthening and VO led interventions. Another block Bakawand is the control arm.

Table 1: Coverage of Swabhimaan VO led interventions

By SRLM clusters

	Cluster 1 (Ghotiya)	Cluster 2 (Chamiya)	Cluster 3 (Kesarpal)	Cluster 4 (Parchanpal)	Total
Revenue villages	25	27	23	36	111
VOs	18	21	17	24	80
SHGs	307	421	332	428	1488
KS	—	—	—	—	—
VRP	—	—	—	—	—
Farmer groups	—	—	—	—	—

Table 2: Service providers mapped for Swabhimaan interventions in block Bastar

By SRLM clusters

	Cluster 1 (Ghotiya)	Cluster 2 (Chamiya)	Cluster 3 (Kesarpal)	Cluster 4 (Parchanpal)	Total
ASHA					471
AWW					358
ANMs		Currently compiling, will be updated by September			58
Lady Surpervisors					7
Fair Price Shop owners					

Table 2: Service providers mapped for Swabhimaan interventions in block Bastar

By SRLM clusters

	Cluster 1 (Ghotiya)	Cluster 2 (Chamiya)	Cluster 3 (Kesarpal)	Cluster 4 (Parchanpal)	Total
CHC					1
PHC					9
Sub-Centre		Currently compiling, will be updated by September			52
AWC					359
PDS Shop					78

In Chhattisgarh, an additional feature of the implementation strategy is replication of the Swabhimaan model in four other blocks namely – Narharpur (District Kanker), Balrampur (District Balrampur), Chhura (District Gariyabandh) and Rajnandgaon (District Rajnandgaon).

ODISHA

In Odisha Gram Panchayats (GPs) in block Pallahara (district Angul) and block Koraput Sadar (district Koraput) are the intervention arms for Swabhimaan project. Six GPs each will be covered of 26 GPs in Pallahara and 14 GPs in Koraput Sadar.

Table 1: Coverage of Swabhimaan VO led interventions in blocks Pallahara (Angul) and Koraput Sadar (Koraput)

	Pallahara	Koraput Sadar	Total
Intervention GPs	6	6	12
Revenue villages	61	40	101
GPLF	6	6	12
CRPs	32	50	82
Self Help Groups	285	318	603
Producer groups	28	3	31
Livelihood CRP(Farm)		Data to be collected	

Table 2: Service providers mapped for Swabhimaan interventions in blocks Pallahara (Angul) and Koraput Sadar (Koraput)

	Pallahara	Koraput Sadar	Total
ASHA	65	147	212
AWW	89	215	304
ANMs	13	20	33
Lady Surpervisors	5	7	12
Fair Price Shop owners	33	13	46

Table 3: Infrastructure mapped for Swabhimaan interventions in blocks Pallahara (Angul) and Koraput Sadar (Koraput)

	Pallahara	Koraput Sadar	Total
CHC	1*	1	2
PHC	5	3	8
Sub-centre	13	19	32
AWC	89	236	325
Fair Price Shops/PDS shops	33	13	46

*(Sub divisional Hospital)

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