

# Programme Evaluation of *Swabhimaan* across three Indian States

(Bihar, Chhattisgarh and Odisha)

**FINAL EVALUATION REPORT**

3<sup>rd</sup> January 2024

Name of the Evaluation Project	Programme Evaluation of SWABHIMAAN Across Three Indian States (Bihar, Chhattisgarh, and Odisha)
Timeframe of the evaluation	2016-2021
Duration of the Evaluation Assignment	March 2022- March 2023
Location of the evaluated object	Bihar, Chhattisgarh, and Odisha
Names and/or organisation(s) of the evaluator(s)	Athena Infonomics
Name of organisation commissioning the evaluation	UNICEF India

# Table of Contents

Table of Contents .....	iii
List of Boxes, Figures, Tables & Annexures.....	vi
Acknowledgement.....	viii
List of Acronyms .....	x
Executive Summary.....	xiii
Background .....	xiii
Purpose of the Evaluation and Intended Audience.....	xiii
Evaluation Methodology .....	xiii
Evaluation Findings.....	xiv
Conclusion .....	xv
Lessons Learned .....	xv
Recommendations.....	xvi
1. Introduction, Context and Objectives.....	1
1.1 Introduction .....	1
1.2 Context.....	1
1.3 Overview: The <i>Swabhimaan</i> Programme.....	4
1.4 Evaluation Rationale and Objectives.....	9
1.5 Evaluation Scope .....	10
1.6 Evaluation Criteria and Questions.....	10
1.6.1 Departure from the ToR.....	11
1.7 Intended Users .....	12
2. Evaluation Methodology.....	14
2.1 Evaluation Implementation .....	14
2.2.1 Programme ToC.....	15
2.2.2 Contribution Analysis .....	15
2.2.3 Most Significant Change.....	15
2.3 Data Collection Methods and Sampling .....	15
2.3.1 Desk Review and Secondary Data Analysis .....	15
2.3.2 Primary Data Collection .....	15
2.4 Data Analysis.....	16
2.5 Ethical Considerations .....	16
2.6 Evaluation Management.....	17
2.7 Limitations of the Study.....	18
3. Findings .....	21
3.1 Profile of Respondents .....	21
3.2 Relevance.....	22

3.2.1 To what extent is the <i>Swabhimaan</i> Programme relevant to the needs of various target population groups (adolescent girls, newlywed women, pregnant women, mothers of children below two yrs.) and recipients (VO, CLF, service providers) of the Programme in Bihar, Chhattisgarh, and Odisha?.....	22
3.2.2 To what extent is the <i>Swabhimaan</i> Programme relevant to the priorities and policies of DAY-NRLM and global goals and priorities? .....	23
3.2.3 How did the ToC change during and after COVID-19? Did the intervention stop at any point during the implementation phase? Currently, what activities are being continued? .....	27
3.3 Effectiveness .....	28
3.3.1 Where did the Programme perform as expected and where are the major gaps and can the changes or lack of changes in pregnant women, children below 2 yrs. and adolescent girls' outcomes be linked to the actions of the Programme? How has the Programme capacitated the VOs to design, implement and manage integrated, context-responsive, needs-based plans for multi-sector nutrition programmes for women and girls? .....	29
3.3.2 What were the key challenges faced in implementation of activities under the strategy? .....	41
3.4 Efficiency.....	43
3.4.1 To what extent was the Programme implemented in a timely manner? What were the key factors that affected delays in implementation? How did pandemic affect overall timelines? .....	43
3.4.2 Were funds sufficiently allocated for Programme implementation? What was the fund transfer mechanism? Were they disbursed on time at every level based on the plans? What were the inefficiencies and bottlenecks? .....	44
3.4.3 Was the utilisation of available human resources efficient? Were sufficient human resources allocated and utilized from UNICEF and SRLM in each year of the implementation period? (Factors like responsibilities, workload, knowledge, skill, capacity, leadership, stability, commitment, attrition etc.).....	46
3.4.4 How was review and reporting done to identify and address inefficiencies or leakages in the Programme interventions? Was it timely and useful? What were the challenges? Can this process be integrated and continued without external support? How can it be made more efficient from the present manner? .....	47
3.5 Sustainability.....	49
3.5.1 To what extent is there government ownership to continue the interventions and integrating and scaling up the Programme (Financing and Programme activity, spillover of activities, Staff leveraged, Investment in PIP, support to SRLM, scale-up)?.....	49
3.5.2 What are those components that may require additional human resources or budget to sustain the intervention? What level of advocacy/effort with respective government departments be required from UNICEF to ensure inclusion of additional components in government planning process?.....	52
3.6 Impact .....	54
3.6.1 Did the <i>Swabhimaan</i> Programme demonstrate a statistically significant difference in the primary and secondary outcomes? To what extent were the impact and outcome indicators changes predicted by the Programme's ToC and RBM achieved? .....	54
3.7 Coherence .....	60
3.7.1 (EXTERNAL COHERENCE) How does various activities of <i>Swabhimaan</i> Programme fit with the work of external partners (government, partner agencies in states, other partner Programmes, global partners, regional partners, research agencies like IFPRI, Population Council etc.)? Does <i>Swabhimaan</i> Programme activities part of a coherent approach that is likely to have positive results, or are there critical gaps? .....	60
3.7.2 (INTERNAL COHERENCE) How does various activities of <i>Swabhimaan</i> Programme align with/fit with other interventions being carried out by UNICEF (Nutrition, Health, C4D, Communication and other key sections)?...61	
3.8 Fidelity.....	63

3.8.1 To what extent was the <i>Swabhimaan</i> Programme being implemented according to plan and were there any divergence from the protocol for systems and community actions? (Factors like timely implementation, intensity, frequency, administrative mechanisms) Were the systems strengthening strategy implemented as envisaged in the ToC? What factors were critical for implementing actions with the Health, ICDS, PDS department and their frontline service providers? What were the bottlenecks in this strategy? (Themes: microplanning, training, guidelines, supply, and service strengthening, convergence, etc.).....	63
3.8.2 Did the design of the impact evaluation maintain its fidelity and integrity? For example, was there any evidence of spill-over or contamination from the intervention areas to the control areas? Were there issues of attrition that might affect the reliability of the findings? Are there confounding factors affecting the comparison of results? .....	65
3.9 Gender and Equity.....	67
3.9.1 How have the <i>Swabhimaan</i> Programme activities ensured to widen the reach of intervention to vulnerable communities? Leveraged partnerships to improve the demand and supply of services for vulnerable communities? Developed and implemented alternate work plans/strategies with special focus on vulnerable communities?.....	67
4. Conclusions and Lessons Learned.....	70
4.1 Conclusions .....	70
4.2 Lessons Learned.....	71
5. Recommendations .....	74
References.....	77

# List of Boxes, Figures, Tables & Annexures

Box 1: Lalita's journey - a story of health transformation .....	57
Box 2: Battling COVID-19: a story on the efforts of PS in minimizing its effects.....	58
Box 3: Increased knowledge leading to change in gendered norms and practices .....	58
Box 4: Tacking gender-based violence through CRPs.....	59
Figure 1: Implementation areas .....	4
Figure 2: Ecosystem Map.....	5
Figure 3: Implementation Modalities and Stakeholders.....	7
Figure 4: Timeline of Swabhimaan Programme .....	8
Figure 5: Evaluation Implementation Plan .....	14
Figure 6: Steps Involved in Contribution Analysis .....	15
Figure 7: Gender profile of respondents (%).....	21
Figure 8: Age profile (in years) of respondents (%) .....	21
Figure 9: Education profile of respondents (%) .....	21
Figure 10: SDG Goals, Targets and Alignment with the Swabhimaan Programme.....	26
Figure 11: Theory of Change for Assessing Claim 1 .....	28
Figure 12: WASH practices.....	37
Figure 13: Target groups living in households with kitchen gardens.....	38
Figure 14: State-wise UNICEF-budgeted contribution for the Swabhimaan Programme .....	45
Figure 15: Participation rates in activities across years .....	65
Table 1: Comparison of health and nutrition indicators among women and adolescent girls in Bihar, Chhattisgarh, and Odisha (NFHS 4 to NFHS 5).....	2
Table 2: Programme coverage in intervention areas (5 blocks, 3 States).....	5
Table 3: Roles and responsibilities .....	5
Table 4: Examples of Programme Activities .....	7
Table 5: Evaluation Criteria .....	10
Table 6: Limitations of the evaluation.....	18
Table 7: Basic statistics from Bihar, Chhattisgarh, and Odisha .....	22
Table 8: FHNW Strategies under NRLM and Corresponding Activities under Swabhimaan .....	24
Table 9: Schemes and Protocols for National level nutrition related program for women incorporated in Swabhimaan strategies and activities.....	24
Table 10: Swabhimaan's Alignment with UNICEF's Global Strategic Plan .....	25
Table 11: Swabhimaan's Alignment with CEDAW's provisions .....	26
Table 12: Reported increase in knowledge .....	31
Table 13: Summary of findings on training for service providers .....	32
Table 14: Capacity change of service providers.....	34
Table 15: Increased knowledge amongst target groups on health and nutrition services .....	34
Table 16: Associated knowledge increase for WASH practices and services .....	36
Table 17: Associated capacity change for VOs and CLFs .....	39
Table 18: Progress of VO and CLF-led activities – Progress update 2019.....	39
Table 19: Hindering and Accelerating Factors .....	41
Table 20: Total Programme Cost (in USD Million) .....	45
Table 21: Swabhimaan Implementation human resources structure .....	47
Table 22: Benefits of Swabhimaan reported by DoHFW and WCD .....	50
Table 23: Scaling up of the Swabhimaan programme in the three states .....	51
Table 24: Scale up of Swabhimaan across states.....	53
Table 25: Changes in nutritional and health service indicators between baseline and endline survey (%).....	54
Table 26: Nutritional Status of Target Groups at Endline Survey .....	55

Table 27: Findings from baseline, midline and endline factsheets of Swabhimaan .....	55
Table 28: Interventions to address gender vulnerabilities and mental health .....	62
Table 29: Planned Activities and Frequency.....	63
Table 30: Implementation Fidelity.....	64
Table 31: Percentage of women and adolescent girls living in SC/ST household across states .....	68

Annexure 1: List of Swabhimaan Programme Documents and Data

Annexure 2: Year-wise Budget of Swabhimaan Programme- Implementation

Annexure 3: Evaluation Matrix

Annexure 4: Contribution Analysis

4.1 COM-B Approach

4.2 Output-Specific ToC for Contribution Analysis

Annexure 5: Data Collection Tools

5.1 State-Level Tools

5.1.1 SRLM Staff

5.1.2 State Departments- Department of Health and Family Welfare (DHFV) and Integrated Child Development Services Schemes (ICDS)

5.2 District-Level Tools

5.2.1 SRLM Staff

5.2.2 District Departments- Health and ICDS

5.3 Block and Community-Level Tools

5.3.1 Block Departments- Health and ICDS

5.3.2 Service Providers

5.4 Tools for UNICEF Programme Staff

5.5 Focus Group Discussions

5.5.1 Pregnant Women

5.5.2 Mothers with children under two years

5.5.3 Adolescent Girls

5.5.4 Newly married couples

5.6. Questionnaire for Most Significant Change

Annexure 6: Workplan

Annexure 7: IRB Certificate

Annexure 8: List of Stakeholders Interviewed

Annexure 9: Programme Theory of Change

Annexure 10: Selected Findings from Swabhimaan Factsheets across the three states

Annexure 11: Terms of Reference

# Acknowledgement

This report documents findings from an independent evaluation of the *Swabhimaan* Programme across three Indian states – Bihar, Odisha, and Chhattisgarh between 2016 and 2021. The evaluation was commissioned by UNICEF ICO and is based on interviews with relevant stakeholder groups at state, district, and community levels, in addition to a documentary review.

The evaluation team wishes to acknowledge the contribution and support of all those who have been involved in this project. The team specially wishes to acknowledge the following individuals at UNICEF ICO whose time and inputs have helped us through this process: Vani Sethi (Regional Nutrition Specialist, UNICEF ROSA and former Nutrition Specialist, UNICEF India), Lopamudra Tripathy (C4D Specialist, UNICEF India), Maaikje Bijker (Chief of Evidence, UNICEF India), Vishal Shastri (Research and Evaluation Specialist, UNICEF India). We would also like to thank colleagues, especially Ms. Monica Shrivastava, at ROSHNI-CWSA who explained the Programme to us in great detail and provided valuable information during the inception phase of this evaluation.

We would also like to express our gratitude to focal points at the state level who provided detailed insights and inputs into the implementation of the *Swabhimaan* Programme and spent much time in coordinating field work in their respective states – Sandip Ghosh (Nutrition Officer, UNICEF Bihar), Sourav Bhattacharjee (Nutrition Specialist, UNICEF Odisha), Mahendra Prajapati (Nutrition Officer, Chhattisgarh), Debashish Ghosh (Divisional Nutrition Coordinator, UNICEF Bihar), Shrobana Hazra (Consultant, UNICEF Odisha) and Bharati Sahu (State Consultant, UNICEF Chhattisgarh).

We would also like to express our sincere gratitude to the members of the Evaluation Reference Group for providing the evaluation team with feedback, information, and support throughout the evaluation period.

This evaluation has greatly benefitted from the interviews and discussions with stakeholders at all levels. The evaluation team give their most sincere thanks to all those who participated in the present evaluation for their valuable inputs and time.

The evaluation was undertaken by Athena Infonomics under the guidance of Dr. Rajesh Khanna (Project Director), Dr. Francis Xavier Rathinam (Evaluation Specialist) and Dr. V J Naidu (Advisor) with support from Ms. Aikantika Das (Qualitative Researcher and Gender Specialist), Ms. Aparna Stephen (Consultant/ Project Manager), Ms. Trisha Pande (Associate Consultant) and Dr Mamta Mehar (Senior Consultant).

**Authors:**

1. Dr. Francis Xavier Rathinam
2. Dr. Rajesh Khanna
3. Ms. Aikantika Das
4. Ms. Aparna Stephen
5. Ms. Trisha Pande
6. Dr. Mamta Mehar

**Evaluation Manager:** Maaïke Bijker, Chief of Evidence, UNICEF India

**Evaluation Consultant:** Dr. Vishal Dev Shastri, Research and Evaluation Consultant, UNICEF India

**Programme Team:**

Dr. Vani Sethi, Former Nutrition Specialist, UNICEF India

Ms. Lopamudra Tripathy, C4D Specialist, UNICEF India

**Evaluation Reference Group (ERG) Members:**

Dr. Vani Sethi, Former Nutrition Specialist, UNICEF India

Dr. Sheila Vir, Director, Public Health, Nutrition and Development Centre

# List of Acronyms

AHD	Adolescent Health Day
AHSND	Adolescent Health Sanitation and Nutrition Day
AIIMS	All India Institute of Medical Sciences
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwives
APR	Annual Progress Report
ASHA	Accredited Social Health Activists
AV	Audio-visual
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BDO	Block Development Officer
BH	Bihar
BIMARU	Bihar, Madhya Pradesh, Rajasthan, Uttar Pradesh
BMI	Body Mass Index
BPL	Below Poverty Line
C4D	Communication For Development
CA	Contribution Analysis
CAP	Communication, Advocacy and Partnerships
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CG	Chhattisgarh
CLF	Cluster-level Federation
COM-B	Capability, Opportunity, Motivation- Behavioural Change
CPAP	Country Programme Action Plan
CRP	Community Resource Person
CSR	Corporate Social Responsibility
CWSA	Centre of Women Collectives Led Social Action
DAC	Development Assistance Committee
DAY-NRLM	Deendayal Antyodaya Yojana-National Rural Livelihoods Mission
DDS	Dietary Diversity Score
DPM	District Project Manager
ENI-W	Essential Nutrition Interventions for Women
ERG	Evaluation Reference Group
FGD	Focus Group Discussion
FLW	Front Line Workers
FNHW	Food, Nutrition, Health, and WASH interventions
FP	Family Planning
FSA	Food Security Act
FTM	Follow-The-Money
GEROS	Global Evaluation Reports Oversight System
GEROS	Global Evaluation Report Oversight System
Goi	Government of India
GP	Gram Panchayat
GPLF	Gram Panchayat Level Federation
H&N	Health and Nutrition
IBCB	Institutional Building and Capacity Building
ICDS	Integrated Child Development Scheme
ICO	India Country Office
IDDCP	Iodine Deficiency Disorders Control Programme
IDI	In-depth Interview
IEC	Information, Education and Communication
IEG	Institute of Economic Growth

IFA	Iron Folic Acid
IFPRI	International Food Policy Research Institute
IIPS	International Institute for Population Sciences
IMP	Integrated Micro Plans
IMR	Infant Mortality Rate
IRB	Institutional Review Board
KEQ	Key Evaluation Questions
KII	Key Informant interview
KS	Kishori Sakhi
KVK	Krishi Vigyan Kendra
LMIC	Low and Middle-Income Countries
LNOB	Leave No One Behind
MIS	Management Information System
MKSP	Mahila Kisan Sashaktikaran Pariyojana
MM	Mangun Mit
MoHFW	Ministry of Health and Family Welfare
MSC	Most Significant Change
MSPP	Micro Social Poshan Plan
MUAC	Mid-Upper Arm Circumference
NFHS	National Family Health Survey
NHM	National Health Mission
NIMHANS	National Institute of Mental Health and Neurosciences
NRC	Nutrition Rehabilitation Centre
NRLM	National Rural Livelihood Mission
NSIFS	Nutrition Sensitive Integrated Farming Systems
OD	Odisha
ODF	Open Defecation Free
OECD	Organisation for Economic Co-operation and Development
OHRP	Office for Human Research Protections
PDS	Public Distribution System
PHC	Primary Health Centre
PIP	Programme Implementation Plan
PLA	Participatory Learning and Action
PM	Project Manager
PMP	Poshan Microplan
PMU	Project Management Unit
PRI	Panchayati Raj Institution
PS	Poshan Sakhi
QA	Quality Assurance
RBM	Results-Based Matrix
RH	Reproductive Health
SAM	Severe Acute Malnutrition
SC/ ST	Scheduled Caste/ Scheduled Tribe
SDG	Sustainable Development Goal
SEQ	Suitability Evaluation Question
SHG	Self-Help Group
SISD	Social Inclusion and Social Development
SPM	State Project Manager
SRLM	State Rural Livelihood Mission
THR	Take-Home Ration
ToC	Theory of Change
ToR	Terms of Reference
U.S.A.	United States of America
UFE	Utilisation Focused Evaluation

UNEG	United Nations Evaluation Group
UNICEF	United Nation Children’s Fund
VHSND	Village Health, Sanitation and Nutrition Day
VO	Village Organisation
VRF	Vulnerability Reduction Fund
VRP	Village Resource Person
WASH	Water, Sanitation and Hygiene
WHO	World Health Organisation
WRA	Women of Reproductive Age

# Executive Summary

This is an evaluation report of the *Swabhimaan* Programme (2016-2021). The evaluation was conducted between March 2022 – March 2023.

## Background

The *Swabhimaan* Programme aimed to deliver a package of 18 essential nutrition interventions (through community groups and existing systems) in Bihar, Chhattisgarh, and Odisha across five blocks of four districts (Figure 1 and Table 2) to improve the health and nutrition outcomes of women and adolescent girls in these states between 2016 and 2021. More specifically, it aimed to improve the food and nutrient intake of women and girls, prevent micronutrient deficiencies and nutritional anaemia, increase access to services during fixed-day, Village Health Sanitation and Nutrition Days (VHSNDs), increase access to education about water, sanitation, and hygiene (WASH), and prevent early, poorly-spaced, and repeated pregnancies. The Programme also focused on creating an enabling environment for women's health and nutrition by working with local government agencies and service providers to improve access to quality health services and nutrition support.

The Programme focused on four primary target groups: adolescent girls; newlywed women; pregnant women; and mothers of children under two years of age, with secondary target groups including husbands, fathers, and mothers-in-law. Anchored by the State Rural Livelihoods Missions (SRLMs) in the three states, the Programme leveraged existing structures to deliver the interventions. UNICEF provided technical and financial support for the development of the Programme, including the development of training modules, monitoring and evaluation systems and community mobilisation strategies.

Some significant aspects of the Programme include inclusion of newlywed women as a target group, recognising health and nutrition services as an invested service rather than volunteer work through payments to community resource persons, application of multiple touch-point participatory learning and action (PLA) methods to engage beneficiaries and encouraging the promotion of more scientific tools such as MUAC tapes to screen and categorise beneficiaries.

## Purpose of the Evaluation and Intended Audience

The purpose of the evaluation report is to assess the quality of implementation and evaluate the relevance, effectiveness, efficiency, and sustainability of the *Swabhimaan* Programme. The evaluation period is from 2016-21, after which the Programme was scaled up within the states and is being implemented across other states as *Swabhimaan* 2.0. The evaluation covered all five blocks of four districts of three states, i.e., Bihar, Chhattisgarh, and Odisha. While the *Swabhimaan* Programme provides convergent activities with multiple departments, this evaluation focused on its health, nutrition, and WASH components.

The findings of the evaluation will primarily be used by UNICEF involved in the Programme, with recommendations likely to feed into adaptations of *Swabhimaan* 2.0. Further, the report will also be shared with external stakeholders including the National Rural Livelihood Mission and counterparts, other relevant government stakeholders and other implementing partners.

## Evaluation Methodology

Evaluation evidence was assessed using the Organization for Economic Co-operation and Development's Development Assistance Committee (OECD/DAC) criteria of relevance, effectiveness, efficiency, coherence, and sustainability. Questions related to gender and equity were also assessed separately.

The evaluation used a theory-based evaluation method that combined Contribution Analysis (CA) with Most Significant Change (MSC) to arrive at credible causal claims about Programme's contribution to outcomes of interest, taking into consideration other factors that may have influenced such outcomes. The evaluation team, in consultation with the ROSHNI Centre, developed five contribution claims corresponding to each of the five output areas of the Programme and developed output-specific ToCs using the COM-B (Capacity, Opportunity, Motivation- Behavioural Change) approach. *Swabhimaan*'s contribution to change was assessed by mapping evidence of change against the behaviour changes, links, and assumptions (causal pathways) in the ToC.

## Evaluation Findings

The main findings are described for each evaluation criterion and structured around the key evaluation questions that guided the evaluation.

- **Relevance:** The evaluation found that the package of interventions provided by the *Swabhimaan* Programme addressed the relevant needs of the target population in the study areas, such as low consumption of IFA tablets. Beneficiaries and community-level service providers also attested to this relevance, and Programme implementers added that interventions were also informed by data collected from baseline and other national surveys. Further, processes such as validation of integrated micro plans (IMPs) with key community members and selection of community cadres from local areas with contextual familiarity added to the relevance of the Programme. However, state implementers also stated that FNHW interventions are still considered a ‘top up’ activity in large-scale welfare programmes rather than one of the key focus areas and highlighted the need for increased advocacy and awareness across all levels to change this perception. The Programme was found to directly align with and contribute to the DAY-NRLM’s stated goals and other priorities within national schemes, such as Poshan Abhiyaan. The evaluation found that there was overall relevance with UNICEF’s global and national priorities, such as alignment with the Global Strategic Plan, Sustainable Development Goals and Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). No modifications were made to the Programme ToC as a result of adaptation to the pandemic but Programme delivery was modified to ensure it was running with the use of technology, with the least possible disruption to services offered.
- **Effectiveness:** The evaluation found evidence to confirm the Programme’s contribution to most key change activities across the five output areas. However, evidence on activities such as convergence of community cadres with service providers such as PDS dealers and ASHAs/ANMs to increase access to convergent services; integration of WASH-related issues in micro plans and increasing household access to WASH services; adoption of specific cropping methods specified within nutri-sensitive agricultural practices; and capacity building for VOs and CLFs to conduct Programme activities presented mixed evidence and also varied between the states. Some activities for which strong evidence was found include training for community cadres on identifying those at nutritional risk; increased knowledge of food security services and food and nutrition habits; increased knowledge of nutri-sensitive agricultural practices; and demand generation for services through community awareness and mobilisation. Stakeholders also reported various hindering factors that affected the delivery of the Programme such as poor supply chains for distribution of medicines and supplements, limited land and water availability for kitchen gardens, income constraints of respondents to keep up improved dietary practices, dissolution of benefits intended for beneficiaries, poor participation and irregular attendance of women and adolescent girls in monthly meetings and long timeframes for establishment and practice of implementation and reporting protocols.
- **Efficiency:** The evaluation found the *Swabhimaan* Programme to be implemented overall in a timely manner, and the funding for the activities was found to be adequate – and scaled-up through the SRLM budget. Impact of the COVID-19 pandemic led to alteration in the execution of the Programme, and the adoption of technology to mitigate challenges. The role of UNICEF resources was integral for technical and programmatic support.
- **Sustainability:** Regular monitoring and reporting through the *Swabhimaan* Programme led to the identification of interventions in *Swabhimaan* 1.0 which were sustainable and scalable. These FNHW interventions were implemented across new Programme states in *Swabhimaan* 2.0, and activities were also bundled for best-practices to continue in the scale-up across Bihar, Chhattisgarh, and Odisha – *poshan* microplanning was found to be an easily replicable and sustainable intervention which promotes community ownership of health and nutrition. Systems were put in place for convergence meetings – which were sustainable at the district and block levels, but weaker at the state levels due to scheduling issues and disruption due to COVID-19. There was strong government ownership, which led to *Swabhimaan* interventions being adopted by state actors through the SRLM structures.
- **Impact:** The evaluation found statistically significant improvement for the coverage of secondary outcomes (health and nutrition) – which observed a 10-15% improvement in the coverage of the interventions in the *Swabhimaan* Programme. However, the primary outcome indicators did not have a significant improvement – although qualitative data from primary interviews shows evidence to support that there was improvement in accessing health and nutritional services, as well as overall improved nutritional status of target groups. Most

Significant Change stores are presented pertaining to 5 domains – improvement in health status, increased self-confidence and self-efficacy, changes in influencing social norms, and women empowerment.

- **Coherence:** *Swabhimaan* is coherent with the state government priorities under SRLM, and with the overall NRLM strategy of improving women’s outcomes through participation in SHGs – the evaluation found that the *Swabhimaan* Programme is executed in close collaboration with different state government departments across hierarchies. It was also found to be internally coherent with UNICEF’s other areas of work and priorities, such as WASH programmes, C4D, and CAP.
- **Fidelity:** There is mixed evidence of implementation fidelity – there was evidence of intervention platforms (AWCs, service providers) to be operational, however the evaluation questions on intensity and coverage of interventions faced recall bias from respondents (particularly PDS dealers and ASHAs). Secondary resources were analysed to confirm the key community-level activities, stakeholders, and frequency and duration of interventions. Another source of evidence was data from previous rounds of evaluation which indicate the extent of coverage – which show that participation has increased, but regular attendance rates continued to be low (especially for adolescent girls). Evidence of spill-over effects was observed, as well as scale-up to control areas, and migration of beneficiaries – which pose as limitations.
- **Gender and Equity:** The evaluation found *Swabhimaan* Programme to have high evidence for integrating gender and equity, since by design it focuses on areas which are hard to reach and includes socioeconomically excluded groups (concerning factors such as caste and tribal status). There is a renewed focus on adolescent girls as a category, and the evaluation found the interventions to be beneficial for this target group. However, there is scope to increase the scale of interventions which involve men and boys across Bihar and Odisha – which is implemented in Chhattisgarh and in adherence to SDG’s principle of Leave No One Behind (LNOB).

## Conclusion

- An extremely capable and motivated cadre of CRPs (Poshan Sakis and Kishori Sakhis) have significantly contributed to the achievements of the Programme.
- The evaluation found that the *Swabhimaan* Programme was relevant to the needs of the target population groups as well as with DAY-NRLM’s priorities. In addition to the DAY-NRLM priorities, *Swabhimaan* was also found to be closely aligned with other national schemes related to health and nutrition.
- Most Programme activities were implemented within the stipulated timeframe, with some delays arising due to COVID-19 related restrictions.
- The evaluation found that the Programme was successful in increasing coverage of health and nutritional services.
- The evaluation revealed that deviations from implementation fidelity, particularly coverage and convergence, hinder the efficacy of the program and result in low participation rates, particularly among newlyweds and adolescent girls.
- Discrimination and social norms that inhibit participation also pose a challenge and indicate a greater need to integrate interventions into existing socio-cultural norms and targeted behaviour change messaging.
- Challenges such as supply chain issues and the need for a coherent approach to FNHW interventions require a renewed focus on the utilisation of VRF funds.
- Sustained advocacy on FNHW activities and strengthened MIS systems can document the successes of program activities, and there is a need for increased capacity building for monitoring and reporting activities among community cadres.
- The Programme was found to be gender-inclusive but can increase coverage of men and adolescent boys as target groups.
- The evaluation found that learnings from *Swabhimaan* 1.0 were being utilised for scaling-up the Programme as *Swabhimaan* 2.0.
- The scale-up of interventions may require greater government support and planning, and the CRP cadre can be utilized to implement activities across states through refresher trainings and incentives.

## Lessons Learned

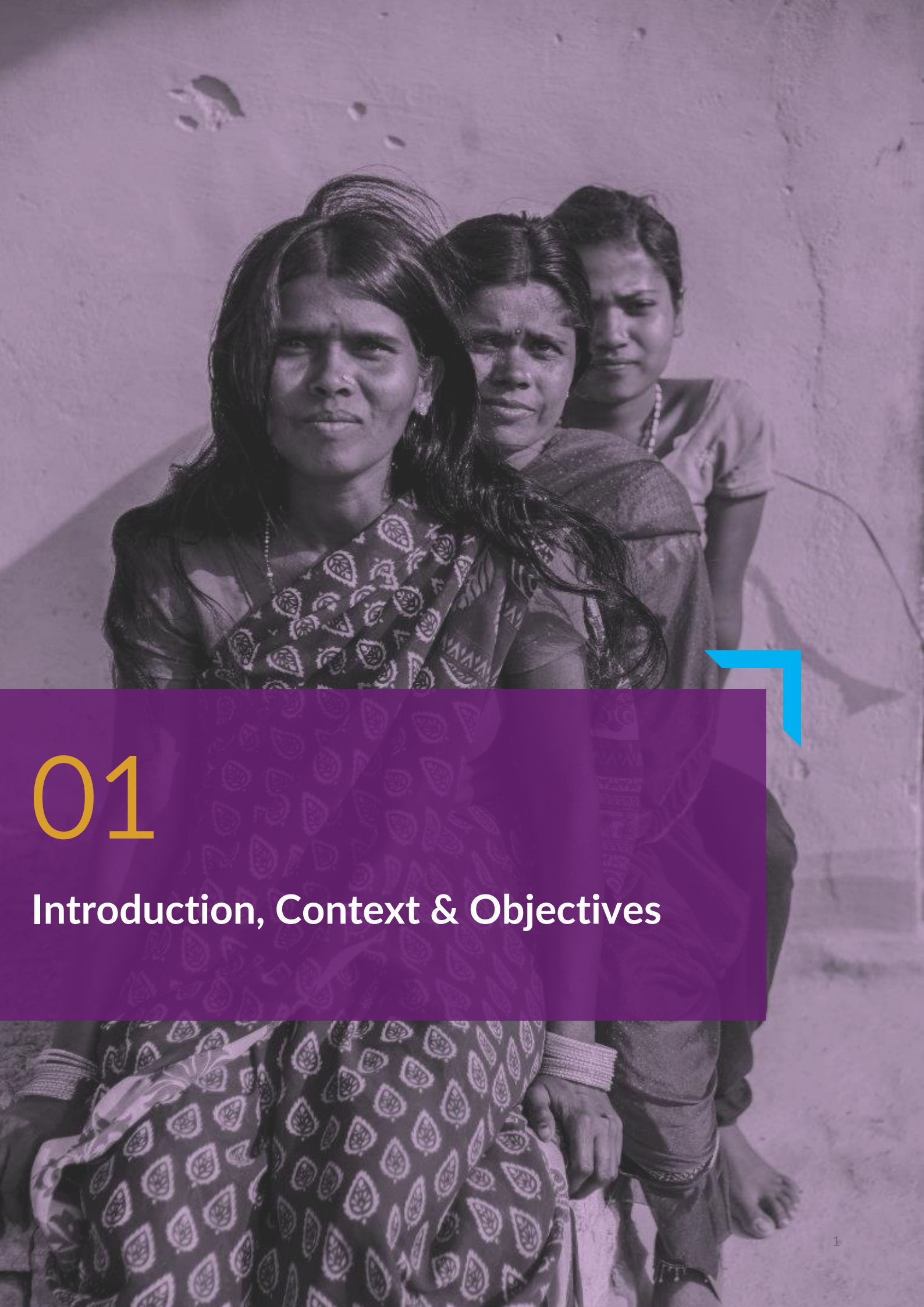
- In the scale-up phase, ensuring that the intensity of the selected interventions (i.e., frequency, duration, coverage, etc.) remains high will be essential to ensure that the success of *Swabhimaan* can be successfully replicated.

- Ensuring that the community cadre remains motivated through monetary and/or non-monetary incentives is key to the Programme's success.
- Reducing misinformation amongst FLWs about the roles and responsibilities of CRPs, regarding duplication of efforts, is essential in ensuring effective convergence.
- Supply-side challenges and resource constraints need to be addressed to ensure adequate and effective utilisation of services.
- Effective strategies that promote utilisation of community funds like VRF by beneficiaries and mapping the utilisation patterns are instrumental in ensuring that the Programme achieves its outcomes.
- Socio-cultural norms around FNHW and gender need to be addressed at the larger community level (involving men, boys, and mothers-in-law) for holistic behaviour change.

## Recommendations

Recommendation	Corresponding evaluation criteria	Priority	Responsible Agency
1. Evidence from the evaluation found that in the scale-up phase, all 18 interventions in the Swabhimaan package will not be taken up and a customised, 'light-touch' model will be developed by each state, keeping their programme priorities in focus. UNICEF can support SRLMs in developing customised packages of interventions to ensure that the impact of the Programme is successfully replicated.	Relevance, Effectiveness, Sustainability	High	UNICEF ICO, UNICEF state offices, DAY-NRLM, SRLMs, ROSHNI-CWSA
2. To strengthen convergence in Programme design and implementation, UNICEF can support DAY-NRLM in aligning/integrating Swabhimaan activities with existing government programmes like POSHAN 2.0 that have similar objectives. They can also support DAY-NRLM in facilitating conversations with line departments to address the demand-supply gap and increase convergence.	Effectiveness, Efficiency, Sustainability	High	UNICEF state offices, DAY-NRLM, SRLMs, ROSHNI-CWSA, other line departments
3. To address monitoring and reporting-related challenges, DAY-NRLM can focus on strengthening the capacities of staff at all levels. Additionally, capacity building of CLFs may be considered to ensure they can anchor monitoring and reporting of inputs, activities, outputs and outcomes. Further, DAY-NRLM can explore the integration of <i>Swabhimaan</i> indicators into existing, national-level monitoring systems like POSHAN 2.0's MIS to avoid building a parallel MIS and overburdening the data system.	Effectiveness, Efficiency, Sustainability	High	UNICEF state offices, DAY-NRLM, SRLMs
4. Given the pivotal role played by the community cadres in the success of the Programme, training mechanisms can be strengthened with a focus on retention of the cadre. DAY-NRLM can focus on increasing the frequency of refresher training sessions, creating a pool of trainers, revamping training material to include more audio-visual (AV) content and developing CLFs as training centres. Additionally, to keep the cadre motivated, SRLMs can consider providing monetary and/or non-monetary incentives (like honours, awards, etc.).	Effectiveness	High	UNICEF state offices, DAY-NRLM, SRLMs, ROSHNI-CWSA
5. To efficiently manage human resources, DAY-NRLM and SRLMs can develop allocation plans based on human resource requirements and hiring qualified, trained, local personnel, especially at the block-level.	Efficiency	High	UNICEF Field Offices, SRLM in different states

<p>6. To strengthen efforts to address gender and equity concerns, DAY-NRLM can consider including mothers-in-law as a secondary target group in PLA meetings and social influencers like religious leaders and traditional healers for targeted messaging and campaigns. Additionally, DAY-NRLM should continue its focus on men and adolescent boys as participants in PLA meetings.</p>	<p>Gender and Equity</p>	<p>High</p>	<p>UNICEF state offices, DAY-NRLM, SRLMs, ROSHNI-CWSA</p>
<p>7. To promote ownership of the Programme within DAY-NRLM and SRLMs, UNICEF can support DAY-NRLM in generating evidence and disseminating learnings, especially for the scale-up phase.</p>	<p>Sustainability</p>	<p>High</p>	<p>UNICEF ICO, UNICEF state offices, DAY-NRLM, SRLMs, ROSHNI-CWSA</p>



# 01

## Introduction, Context & Objectives

# 1. Introduction, Context and Objectives

## 1.1 Introduction

This report documents the findings and recommendations from the Programme Evaluation of *Swabhimaan* (hereafter referred to as the *Swabhimaan* Programme or the Programme) implemented in three states of India – Bihar, Chhattisgarh, and Odisha between 2016 and 2021. The evaluation was commissioned by the UNICEF India Country office and was conducted between March- December 2022.

The five-year Programme (2016-21) aims to improve girls' and women's nutrition through a combination of system approaches and community approaches (led by federation of women agencies promoted by the SRLM, also known as *Aajeevika*) in the three Programme states. *Swabhimaan's* stated goals, design and modalities of implementation contribute to the operationalisation of four of the ten SDGs (refer to Section 3.2.2., Figure 10). The final evaluation report is presented in four sections – Section 1 provides the background to and a broad overview of the *Swabhimaan* Programme and describes the objectives, scope, and intended users of the evaluation findings. Section 2 presents the evaluation methodology, including data collection and sampling strategies and limitations of the evaluation as well as the evaluation management process, and ethical considerations. The findings of the evaluation are detailed in Section 3 and are organised according to the evaluation criteria. Section 4 presents the conclusions and lessons learned from the evaluation and recommendations are documented in Section 5. In addition, the annexures provide supplementary information and are referenced within the text of this report.

## 1.2 Context

### *A. Gendered Health and Nutrition: A Prevailing Issue*

At the national level in India, figures depicting the health status of women and children remain alarming. Thus, the need to focus on women's nutrition, especially prior to, during, and post pregnancy – for the health and well-being of mother and child is compelling. Several national and global programmes are working in different capacities across regions to improve food and nutrient intake and thus reduce nutrient deficiencies, including micronutrient deficiencies, among adolescent girls and women in India.

Certain states in India require targeted interventions to improve access to healthcare services and improved nutrition for women, across all social and economic groups. Bihar and Chhattisgarh were part of the BIMARU list of states, first developed in 1980s, and revised later to include Odisha. The list comprises of states that displayed high fertility, infant mortality, and maternal mortality rates besides lower literacy rates compared to the rest of India (Som & Mishra, 2014). Differential economic and educational conditions have always been attributed to the inaccessibility of health and nutrition services among the disadvantaged communities across India. Social inequalities result in aggravating the extent of inequalities in health and nutritional status in the states of Bihar, Chhattisgarh and Odisha, especially among the women and adolescent girls belonging to different caste/tribal categories (Roy et al., 2004).

While policies like 'health for all' increase individual capacity for the utilisation of health and nutrition delivery services, socio-economic constraints such as illiteracy, casteism and culture impede decision-making, skill development and cultural and economic empowerment of women (Upadhyay, 2018). Caste system and tribe determine the living standards and dietary habits, obligations, privileges, and social choices of individuals. This, in turn, affects their perceptions and expectations about education, health, nutritional demands and accessibility to healthcare resources and facilities (Singh, 2018). It has a strong influence on the antenatal and postnatal care, and professional assistance during delivery as well.

In Bihar, the intersectionality of caste and gender discrimination leave Scheduled Caste women exposed to inequitable accessibility, affordability, acceptability, information, and quality regarding health-related services. This results in malnutrition in adolescent girls (Rani, 2019), and poor maternal health among women in Bihar (Patel et al., 2018). They are also found to have lower BMI and higher prevalence of anaemia (P. Kumar et al., 2021).

Gender inequalities deepen the gap in health and nutritional outcomes. However, strengthened health system, non-discriminant accessibility of health resources and entitlement schemes, and mobilised political will has enabled health equity in Odisha up to a certain extent. The gap between maternal and child health and nutrition outcomes of STs, SCs and the southern districts have narrowed. There has been a rise in antenatal and postnatal care, immunisation, and reduction in the prevalence of undernutrition and anaemia among the women in Odisha (Thomas et al., 2015).

Women have lower autonomy over decision-making in households and society at large due to lower levels of education and income, and higher levels of gender and caste disparity, especially in the rural areas. This, along with geography, is tightly intertwined with the level of awareness and accessibility to health and nutrition services in Chhattisgarh (Verma, 2020). Around three-fourth of the women living in the difficult terrain are found nutritionally at-risk due to lack of special nutrition care during and post-pregnancy. Additionally, the level of BMI and malnutrition among women with lower literacy rate was also found to be higher in Chhattisgarh (Mishra, 2016).

The NFHS 4 (2015-16) data highlights some key cultural, social, and political differences between Bihar, Chhattisgarh, and Odisha. These differences can have significant implications for the implementation of policies and programs aimed at improving the health and well-being of the population in these states.

### Social, Cultural and Political Comparisons between Bihar, Chhattisgarh, and Odisha

- **Education:** The literacy rate is lowest in Bihar (63%) compared to Chhattisgarh (71%) and Odisha (73%). The percentage of women who are literate is also lower in Bihar (53%) compared to Chhattisgarh (62%) and Odisha (65%)
- **Women's empowerment:** The percentage of women who participate in decision-making regarding their own health care is highest in Odisha (71%) compared to Bihar (57%) and Chhattisgarh (64%)
- **Governance:** The percentage of households that have access to basic amenities such as electricity, water, and sanitation is highest in Odisha (87%) compared to Bihar (70%) and Chhattisgarh (72%). The percentage of households that have a bank account is also highest in Odisha (63%) compared to Bihar (42%) and Chhattisgarh (47%)
- **Women's political participation:** The percentage of women who have participated in a village meeting in the last 12 months is highest in Odisha (59%) compared to Bihar (48%) and Chhattisgarh (51%).
- **Caste:** The NFHS 4 data shows that the prevalence of caste-based discrimination is higher in Bihar (43%) and Chhattisgarh (40%) compared to Odisha (26%)

NFHS-4 (2015-16) data reveals that the health and nutrition status of women and adolescent girls in Bihar, Chhattisgarh, and Odisha needed improvement. The high prevalence of anaemia among women and children, as well as the low proportion of women who receive full ANC, were major concerns to be addressed. Furthermore, the prevalence of malnutrition among women and adolescent girls was also a significant cause for concern. Thus, there was a pressing need to strengthen health systems and increase access to healthcare services for these groups.

Comparing health and nutrition indicators for adolescent girls and women in Bihar, Chhattisgarh, and Odisha in NFHS 5 (2019-2020) to NFHS 4 (2015-2016), the following changes are observed:

Table 1: Comparison of health and nutrition indicators among women and adolescent girls in Bihar, Chhattisgarh, and Odisha (NFHS 4 to NFHS 5)

<b>Adolescent Girls</b>	<ul style="list-style-type: none"> <li>• In Bihar, the percentage of underweight adolescent girls decreased from 29.3% in NFHS 4 to 25.6% in NFHS 5</li> <li>• In Chhattisgarh, there was a slight increase in the mean BMI of adolescent girls from 17.5 in NFHS 4 to 17.8 in NFHS 5</li> <li>• In Odisha, there was a significant increase in the mean diet diversity score of adolescent girls from 3.4 in NFHS 4 to 5.4 in NFHS 5</li> </ul>
<b>Women</b>	<ul style="list-style-type: none"> <li>• In Bihar, there was a decrease in the percentage of women who were underweight from 33.5% in NFHS 4 to 29.7% in NFHS 5</li> <li>• In Chhattisgarh, there was a slight increase in the mean BMI of women from 21.7 in NFHS 4 to 22.2 in NFHS 5</li> <li>• In Odisha, there was a significant increase in the percentage of women who received full antenatal care, from 21.5% in NFHS 4 to 31.7% in NFHS 5. Additionally, the percentage of women who received iron and folic acid supplements during pregnancy increased from 37.2% in NFHS 4 to 58.2% in NFHS 5</li> </ul>

Source: NFHS-4, NFHS-5

Overall, there have been improvements in some indicators, such as decrease in proportion of underweight adolescent girls and women in Bihar and an increase in dietary diversity and antenatal care in Odisha. However, there are still

significant challenges to be addressed, as a substantial proportion of women and adolescent girls continue to be underweight, and indicators such as anaemia prevalence remain high in these three states.

**Progress across Health and Nutrition Outcomes:** The *Swabhimaan* Programme has shown some positive effects on health and nutrition indicators for women and adolescent girls in Bihar, Chhattisgarh, and Odisha. The program's baseline, midline, and endline data suggest that the mean BMI, diet diversity score, and MUAC of adolescent girls and mothers of children under two have improved over time. The Programme has also increased the percentage of pregnant women receiving ICDS entitlement for supplementary food, which can improve their nutritional status. However, the Programme's impact on visitation to AWCs has been mixed, with some areas seeing increased visits and others seeing decreased visits. Overall, the *Swabhimaan* Programme has had some positive effects on health and nutrition indicators for women and adolescent girls. For a detailed table of the changes discussed below, please refer to Impact (Section 3.6) and Annexure 10.

### *B. Gendered Health and Nutrition: Addressing the Issue through Community Institutions*

Studies show that Women's Self-Help Groups (SHGs) in South Asia are increasingly becoming a popular medium to deliver health and nutrition interventions to women. Evidence points towards the fact that outcomes for new-born mortality improve when health and nutrition information is delivered to women through SHGs and can promote behavioural change in the face of pervasive cultural norms through community action (N. Kumar et al., 2018). The National Rural Livelihoods Mission (NRLM) facilitates the formation of SHGs to help them access credit and build savings, whilst the Ministry of Rural Development issued an advisory in 2017 to promote information-sharing about health, sanitation, and nutrition within SHGs for better health outcomes. This approach is known as 'layering' and can help with increased coverage of government services, provide structure to intervention delivery, and address underlying determinants of health outcomes (for example, political participation, social security etc) (Hazra et al., 2022). A recent study by the University of Washington reported the effectiveness of such group interventions to deliver enhanced health and nutrition benefits in South Asia (Gugerty et al., 2019). According to the study, SHGs have been successful in changing attitudes about and knowledge of reproductive health issues, which include contraceptive use and risky sexual behaviour.

NRLM – a government poverty alleviation programme in India - uses SHGs as a service delivery system for nutrition-sensitive programmes. Launched in 2011, the Government of India's flagship programme for poverty alleviation, **Deendayal Antyodaya Yojana-National Rural Livelihoods Mission (DAY-NRLM)** aims at breaking the intergenerational cycle of poverty through the economic empowerment of vulnerable women and families. A scoping study by (Sethi et al., 2017) suggests that SHGs, with capacity building and support, can develop plans and manage grants and can be used as a platform to improve the essential nutrition intervention services provided by DAY-NRLM. NRLM has focused on and catalysed the spread of SHGs to deliver nutrition services across rural India with about 60 million women across six million SHGs by 2019 (*Can Covid-19 Provide Opportunities to Strengthen the SHG Movement?*, 2020).

However, programme evaluation of layered nutritional and health interventions delivered through SHGs indicates that the implementation intensity must be significant and sustained, since the SHGs have other objectives apart from health and nutrition. Another problem that evaluation of programmes with SHGs for layering health interventions suggests is that data from pilot studies show greater benefits than when the programme is implemented on a wider scale - and those benefits might be lower due to the lower intensity of interventions. To address these problems, UNICEF India partnered with DAY-NRLM on a five-year initiative (2015-2020) to improve the nutritional status of adolescent girls and women across three Indian states (Bihar, Chhattisgarh, and Odisha) using SHGs as a service delivery system. In India, gender-based discriminatory norms, social norms and wider structural and contextual factors continue to neglect and violates the rights of girls and women throughout their lives and is manifested through inadequate health services and nutrition, inadequate access to safe sanitation, etc. *Swabhimaan* was designed with the central idea that gender equality is a fundamental human right that needs to be promoted and protected. The Programme's contributes to four of the ten SDGs and its change strategy is focused addressing the discriminatory practices that leave particular groups of people behind (UNSDG's Universal Values Principle Two: Leave No One Behind). These have been detailed in the Section 3.2.

### 1.3 Overview: The Swabhimaan Programme

*Swabhimaan* was a five-year initiative. While two of the five years focused on baseline and endline data collection, the interventions were implemented over a period of three years. *Swabhimaan* aimed to improve the nutritional status of adolescent girls and women across Bihar, Chhattisgarh, and Odisha and strengthen the systems of other existing mechanisms such as the Integrated Child Development Services (ICDS), PDS (Public Distribution System) and the Village Health Sanitation and Nutrition Days (VHSND) to tackle the health and nutrition question/gap on multiple counts. The specific objectives of the Programme, target groups, and implementation modalities are described below.

- **Goals:** The *Swabhimaan* Programme contributes to national nutritional priorities in addition to global priorities such as the Sustainable Development Goals (SDGs). More information regarding the Programme’s alignment with other plans and policies is outlined in Section 3.2 (Relevance). However, the five specific goals of the Programme are as outlined below.
  - Improve the food and nutrient intake of adolescent girls and women
  - Prevent micronutrient deficiencies and nutritional anaemia
  - Increase access to services during fixed day, VHSNDs and provide special care to nutritionally ‘at nutritional risk’ women, defined as those with mid-upper arm circumference (MUAC) <23 cm or Body Mass Index (BMI) <18.5 kg/m<sup>2</sup>
  - Increase access to education about water, sanitation, and hygiene (WASH) and access to WASH commodities
  - Prevent early, poorly spaced, and repeated pregnancies
- **Target Group:** The Programme primarily targets adolescent girls (10-19 years), newly-wed couples, pregnant women, and mother of children under two years of age. However, secondary target groups include family members such as husbands and mothers-in law and farmer producer groups.
- **Geographic Coverage:** The Programme covered 356 villages across five blocks of four districts in the three states. In Bihar, it was implemented in the Jalalgarh and Kasba blocks of Purnia district; in Chhattisgarh, the Programme focused on the Bastar block of Bastar district; and in Odisha it was implemented in Pallahara (Angul district) and Koraput (Koraput Sadar district). Figure 1 below provides a representation of these areas on a map. Table 2 presents the coverage of the Programme by state.

Figure 1: Implementation areas

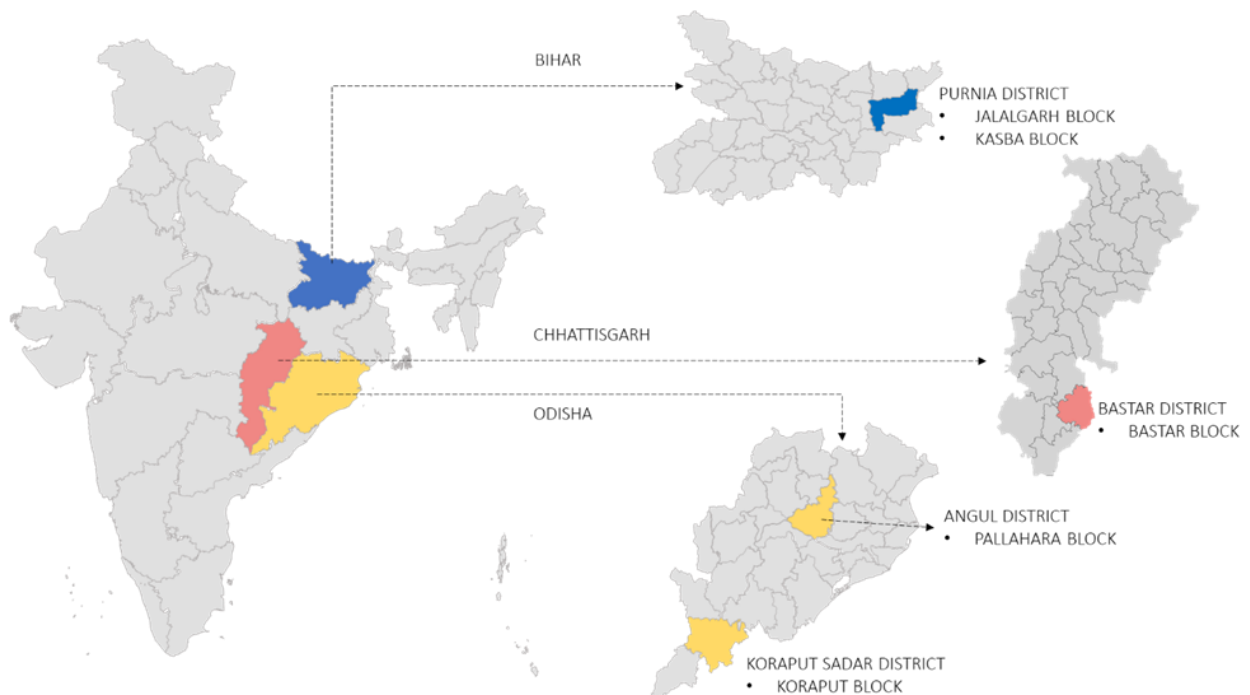


Table 2: Programme coverage in intervention areas (5 blocks, 3 States)

State Blocks	Bihar		Chhattisgarh	Odisha		Pooled
	Jalalgarh	Kasba	Bastar	Koraput Sadar	Pallahara	
Revenue villages	17	22	111	36	37	223
Gram Panchayat	8	8	78	7	6	107
CLFs (Tier-3)	2	2	4	6	6	20
VOs (Tier-2)	76	74	104	41	41	336
Poshan Sakhis (CRPs at Tier-2)	39	33	104	41	41	258
Kishori Sakhis (at Tier-2)	39	33	-	-	-	72
SHGs (Tier-1)	957	979	2118	463	485	5002
Adolescent girls' groups	172		771	61	72	1076
VRPs/Krishi Mitra	49	49	80	-	12	190

Source: UNICEF Swabhimaan Terms of Reference

- Stakeholders Involved:** Government departments and technical agencies involved in the development, implementation and monitoring of the Programme are summarised in Figure 2 below. Further, the roles and responsibilities of the stakeholders are described in Table 2 below.

Figure 2: Ecosystem Map

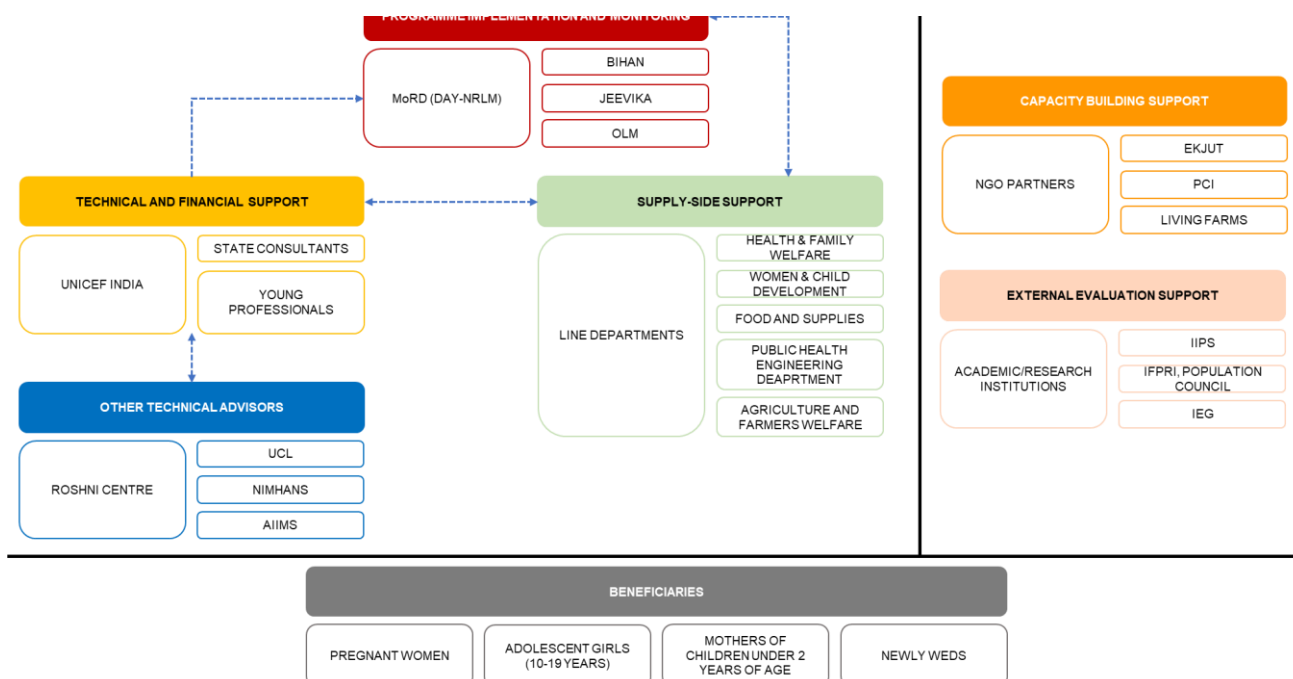


Table 3: Roles and responsibilities

Stakeholder	Responsibilities
DAY-NRLM	<ul style="list-style-type: none"> <li>Anchor for the Programme; provides financial, administrative, and monitoring support as well as platforms for delivery of interventions</li> </ul>

Women and Child Development Department (ICDS)	<ul style="list-style-type: none"> <li>• Food supplementation for pregnant women and lactating mothers</li> <li>• Double ration for at nutrition risk women</li> <li>• Counselling and food supplementation for adolescent girls</li> <li>• Fortification of THR</li> </ul>
Department of Health and Family Welfare	<ul style="list-style-type: none"> <li>• Quarterly orientation of service providers on VHSND guidelines</li> <li>• Biannual health camps for newlyweds and reproductive health camps for women, adolescent girls' health camps</li> <li>• Engagement with <i>Poshan Sakhis</i> in VHSNDs and camps for mobilisation support</li> </ul>
Department of Food and Supplies	<ul style="list-style-type: none"> <li>• Provisioning of ration cards</li> <li>• Timely operation of ration (fair price) shops</li> </ul>
Public Health Engineering Department	<ul style="list-style-type: none"> <li>• Provisioning of piped drinking water supply</li> </ul>
Agriculture and Farmers Welfare Department	<ul style="list-style-type: none"> <li>• Responsible for anchoring MKSP for women farmers</li> </ul>
UNICEF India	<ul style="list-style-type: none"> <li>• Technical and financial support for capacity building</li> <li>• Financial support for evaluations</li> <li>• Staff expertise at national and state levels</li> </ul>
ROSHNI Centre	<ul style="list-style-type: none"> <li>• Knowledge management partner</li> <li>• Houses a repository of materials (job aids, PLA tools) used in <i>Swabhimaan</i> sites for dissemination with state governments</li> <li>• Supports external process monitoring and documentation of lessons from the Programme (especially during COVID-19)</li> <li>• Conducts workshops and events around gender transformative interventions, community-led interventions</li> <li>• Conducts research on gender disadvantage, psychosocial distress, and resilience of adolescent girls mobilised in groups</li> </ul>
Ekjut, PCI, Living Farms	<ul style="list-style-type: none"> <li>• External capacity building support for community mobilisation, PLA, SBCC and establishment of kitchen gardens</li> </ul>
IFPRI, IEG, IIPS, Population Council	<ul style="list-style-type: none"> <li>• External evaluation partners for conducting baseline, midline, endline assessments as well as research studies on fidelity and cost-effectiveness</li> </ul>
UCL, AIIMS, NIMHANS	<ul style="list-style-type: none"> <li>• Technical/advisory support for evaluations</li> <li>• Implementers for baseline survey - AIIMS</li> </ul>

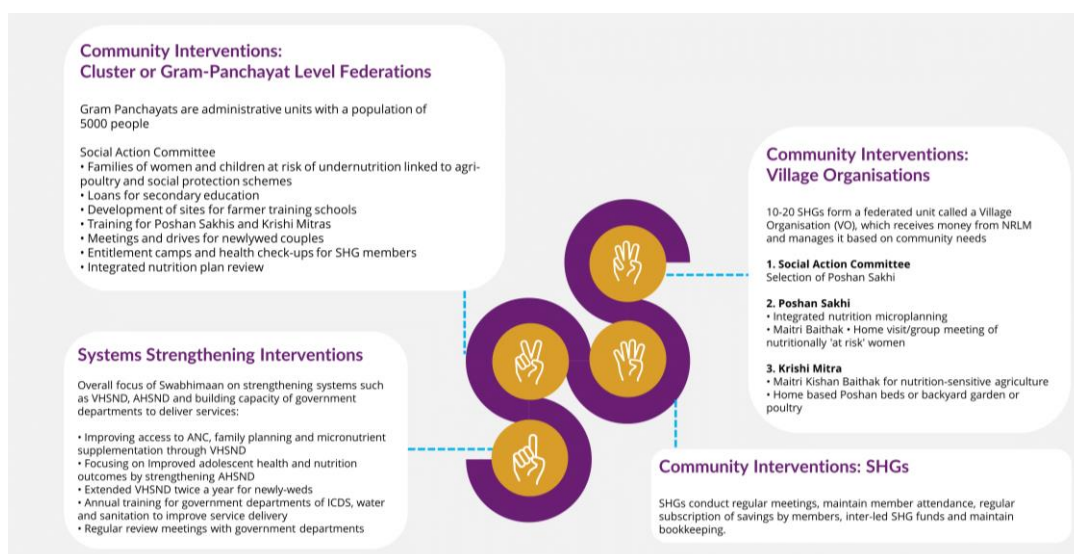
Source: (Overview of *Swabhimaan*, 2017); prepared by authors

- **Programme Implementation:** The interventions are delivered through a combination of community-led and systems-strengthening actions in the intervention areas. Community-led interventions are delivered through trained community cadres who are part of the DAY-NRLM and State Rural Livelihoods Mission (SRLM) implementation structure. These are members of village organisations, which is the primary unit, and comprises 8-10 villages on average. The members are associated with different programmes. First, in each village under the livelihood mission, there is one *Poshan Sakhis* (lit. 'Nutrition sister/friend'), known as Community Resource Persons (CRPs) in Odisha and *Mangun Mitra* in Chhattisgarh. These PS/CRP/MM are cadre for all SHGS (on average 10-12 SHG in a village and 15 women above 18 years in each SHG) in a village. In Bihar, a separate cadre of *Kishori Sakhis* (lit. 'Adolescent sister/friend') for reaching out to and serving adolescent girls has been created. Second, among the above VOs there is Cluster Level Federation, known as Gram Panchayat federation in Odisha, which comprises 8-10 villages on average and has a master bookkeeper facilitated by UNICEF. Under health and WCD, ASHA and Anganwadi respectively are connected. At GP or CLF level, *Krishi Mitras* (lit. *farmer friends*) or Village Resource Persons are selected and trained who provide guidance for nutrition-sensitive gardening. Additionally, on average 2-3 PDS in a block are connected. SRLMs are inter-connected with hierarchical reporting structures from block to district to state. UNICEF staff acts as technical support to all these stakeholders. This mechanism is illustrated in Figure 3 under the three tiers of SHGs, VOs, and CLFs.

In the system-strengthening component of the interventions, ASHAs and ANMs are given training to improve access to the VHSND, ANC, micronutrition, weight monitoring and family planning for the target populations, government departments of Women and Child Development, ICDS, Department of Health and Family Welfare are

empowered to build capacity and increase access to services for the beneficiary population, the Department of Food and Civil Supplies is able to expand coverage of PDS ration.

Figure 3: Implementation Modalities and Stakeholders



Source: prepared by authors based on Programme documents from Bihar, Chhattisgarh, and Odisha; and (Sethi et al., 2019)

- **Programme Interventions:** The Programme provides a comprehensive package (called Essential Nutrition Interventions for Women or ENI-W) of 18 essential nutrition-specific and -sensitive interventions. The interventions include providing access to household rations, hot cooked meals, access to information on improving dietary diversity, distribution of iron and folic acid supplementation, calcium and deworming tablets, support to increase access to healthcare services including promotion of institutional delivery, early registration for antenatal care services, and recording and monitoring of nutritional status.
- **Programme Activities:** The Programme activities are designed for the 18 interventions and customised for each of the responsible stakeholders. A snapshot of this is provided in below in Table 3.

Table 4: Examples of Programme Activities

Activity	Odisha	Bihar	Chhattisgarh
<b>CRPs</b>			
Making of PMP (women/ <i>kishoris</i> )	One-time	One-time	One-time
Maitri Baithak	Monthly	Monthly	Monthly
Kishori Baithak	Monthly	N/A	Monthly
Food demonstration session for undernourished women/ <i>kishoris</i>	Quarterly	Fortnightly	Fortnightly
Adolescent girls group formation	No data	N/A	Monthly
Newlywed couples meeting	Quarterly	Quarterly	N/A
Adolescent group SHG meetings	Monthly	Monthly	N/A
Mobilising women for VHSND	Monthly	Monthly	Monthly
Mobilising girls for VHSND	N/A	N/A	Monthly
Mobilising women for health camp	Biannual	Biannual	Biannual
Mobilising girls for health camp	No data	N/A	Biannual
Mobilising girls for Kishori Diwas	Weekly	N/A	N/A
Tracking and monitoring each "at nutrition risk" pregnant and lactating women	Monthly (for a maximum of 50 HH)	Monthly (for a maximum of 50 HH)	Monthly
Tracking and monitoring each "at nutrition risk" adolescent girls	No data	N/A	Monthly

AHD	No data	No data	Biannual
<b>Federations</b>	<b>GPLF</b>	<b>VO/CLF</b>	<b>VO/CLF</b>
PMP formation by GPLF/VO members	Annual	Annual	Annual
Programme review meeting by federation (GPLF/ CLF) for VO	No data	Quarterly	Monthly
Food demonstration and counselling session for target groups	No data	No data	Monthly ( <i>Amcho Basul</i> )
Newly-wed couple meeting	No data	Quarterly	N/A
Maitri Baithak	No data	Monthly	Monthly
Welcome suitcase for newlyweds	Once (estimated 50 per CLF per year)	Once (estimated 150 per year)	Once (estimated 800 per year)
Women Biannual camps	No data	Per VOs	Per VOs
Issue-based drives alcohol, dowry, tobacco	1 per year per GPLF	3 per year	4 per year
Organizing recreational activities for adolescent girls	Biannual	Biannual	No data
Nutri-farm demonstration site	Annual (30 GP 1st year & 58 GP 2nd year)	2 sites	N/A
Kishori Baithak	No data	N/A	Monthly

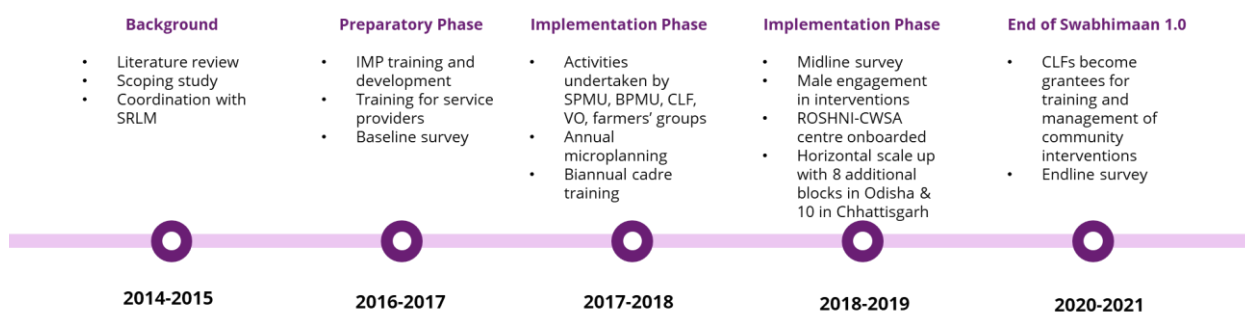
Source: (ROSHNI, 2020c, 2020a, 2020b)

- Funding:** Since its implementation in 2016, *Swabhimaan* has received financial support from state governments (through the SRLMs) and UNICEF state offices of the 3 states for community actions and systems strengthening. UNICEF India funds the Programme in Bihar as it is a demonstration and learning site, where the activities and human resources budget is funded by UNICEF with some contribution of the SRLM towards infrastructure and remaining human resources activities.

Since 2018, there has been a horizontal scale-up within Chhattisgarh and Odisha, with 8 and 10 additional blocks being added to the Programme, respectively. This led to an increase in the budget contribution by SRLM and UNICEF. The total funds for the implementation of the Programme expended by UNICEF were approximately Rs. 3,06,54,000 (~USD 386,000) in Bihar, Rs. 2,53,30,000 (~USD 319,000) in Chhattisgarh and Rs. 3,91,47,000 in Odisha (~USD 493,000). The total funds for *Swabhimaan* activities integrated in and expended by SRLM were approximately Rs. 7,14,66,000 (~USD 900,000) in Chhattisgarh and Rs. 6,42,40,950 (~USD 809,000) in Odisha.

- Timeline:** The phases of the Programme and corresponding timelines are provided in Figure 4. In addition, the Programme has undertaken extensive baseline, midline, and endline surveys that are cross-sectional, between 2016-21 across the three states.

Figure 4: Timeline of Swabhimaan Programme



Source: Prepared by Authors, based on Swabhimaan Progress Update 2018, Bihar and Annual Progress Reports of Bihar, Chhattisgarh, and Odisha

## Significance of the Programme

The distinctive features of the Programme in comparison to other nutrition programmes delivered by the government are highlighted below:

- **Delivery Platform:** The Swabhimaan Programme leverages a previously untapped platform of community groups to deliver essential nutrition services. Layering such interventions on the work of pre-existing platforms such as SHGs and their networks help to address multiple deprivations efficiently.
- **Invested Service:** The Programme recognizes and promotes delivery of nutrition services as an invested service rather than volunteer work. The community cadres are remunerated for this additional work, lending credibility, and validating their work.
- **Implementation Modality:** The PLA model adopted by the *Swabhimaan* Programme aimed at promoting community ownership through multiple touch points and interactive sessions as compared to single-point, ToT based PLA models employed by the NRLM.
- **Target Groups:** The Programme is one of the early examples from the country to consider newlywed women as a key target group to address preconception care and health issues.
- **Nutrition Interventions:** As part of the packages of its essential nutrition services, Swabhimaan undertakes nutritional screening of women using MUAC tapes and provides related packages to those found 'at nutritional risk'. The use of MUAC tapes is an important value add of the Programme to similar services provided by the ICDS, which previously used weighing machines to screen women in the three states.

## 1.4 Evaluation Rationale and Objectives

This Programme evaluation is an essential addition to the impact evaluation executed by IIPS (International Institute for Population Sciences). The impact evaluation by IIPS aims to explore the changes in the well-being of women and girls across the Programme years (2016-21) quantitatively, but this Programme evaluation attempts to establish reasons behind impact findings and elaborate on the achievement/non-achievement of outcomes and explain unintended outcomes. The Programme evaluation was planned to focus on assessing aspects related to the design and delivery of interventions, with the primary respondents being Programme implementers. Additionally, the timing of the evaluation helps to generate learnings on the sustainability and scalability of such a systems approach for the government before their plan of strategizing on scaling up in other districts.

The specific objectives of the evaluation are as follows:

- Evaluate the relevance of the Programme for target groups, i.e., adolescent girls, newly-wed women, pregnant women, and mothers of children under-two years
- Critically assess the quality and the process of implementation of interventions including adherence to the plan, quality of Programme delivery and coverage of the intervention
- Assess the integrity of the impact evaluation, and independently validate the impact of the Programme on the primary and secondary outcome indicators as specified at the start of the impact evaluation
- Examine expected and unexpected changes in women and adolescent girl's outcome indicators in the intervention areas, including any changes in gender norms and traditional power dynamics (Are some changes unexplained? What needs programmatic and evaluation attention for scaling up across the states?)
- Evaluate the efficiency of the Programme's convergent programming of services (Is it managed in a coordinated and comprehensive manner?)
- Assess the sustainability of the Programme in terms of ownership of the government, project implementation units, and community organisations
- Capture the drivers/triggers for the success of the Programme
- Gauge extent to which VOs (village organisations) and other federations are capacitated to design, implement, and manage integrated, context-responsive, multi-sector nutrition Programmes, and how this can be replicated across diverse contexts

## 1.5 Evaluation Scope

The scope of the evaluation, as defined by the overarching criteria and aspects of the Programme is detailed below.

- **Evaluation Criteria:** The evaluation seeks to assess the Programme using the Organisation for Cooperation and Economic Development (OECD)/Development Assistance Committee (DAC) criteria of relevance, effectiveness, efficiency, sustainability, impact, fidelity, internal and external coherence. Using the Most Significant Change method, the evaluation will also attempt to capture the unexpected or unintended changes and process outcomes which are not captured in the theory-based Contribution Analysis method.
- **Programmatic Scope:** The evaluation focused on assessing the interventions of *Swabhimaan* Programme in all three stages, from inception to the end.
- **Period Examined:** The evaluation has covered the Programme duration between July 2016 and March 2021. The evaluation will utilise information available in other documents and evaluation studies conducted till date as well as information provided by UNICEF.
- **Geographical Coverage:** The evaluation has covered all the activities that are being implemented in the five blocks of four districts of three states, i.e., Bihar, Chhattisgarh, and Odisha. Data was collected from two villages per block in Bihar and Odisha and four villages in a single block in Chhattisgarh, for a total of 12 villages. Additional state-wise information on geographical coverage of data collection is presented in Annexure 8.
- **Sectors:** While the Programme covered multiple sectors – health and nutrition, WASH, education and awareness, and antenatal care check-ups (ANCs), this evaluation focused on health and nutrition as well as WASH components of the Programme.

## 1.6 Evaluation Criteria and Questions

This evaluation is guided by the Quality Standards for Evaluation of the DAC of the OECD (*Evaluation Criteria - OECD*, n.d.). The ToR (Terms of Reference) (Annexure 11) provides 25 evaluation questions nested under the six OECD-DAC criteria (Table 4). In addition, the evaluation has questions around gender and equity, and fidelity in accordance with UNICEF evaluation policy. The full set of evaluation questions, relevant indicators and analysis methods are identified and presented in Annexure 3.

Table 5: Evaluation Criteria

Criteria	Description	
OECD-DAC Criteria	<b>Relevance</b>	To examine the extent to which the objectives of the Programme correspond to the expectations of the target groups, the needs of the region, the global priorities (UNICEF global strategic plan, SDGs, and core commitments of <i>Swabhimaan</i> Programme to nutrition status of adolescent girls and women) and the policies of the partners and funders.
	<b>Effectiveness</b>	To assess the achievement of intended results, unintended outcomes, contributing/ hindering factors, and lessons learned.
	<b>Efficiency</b>	To assess the timeliness, utilisation, and optimal use of resources during Programme implementation.
	<b>Impact</b>	To estimate the significant impacts in terms of food security, adolescent health, nutrition, and health services, focus on reproductive health, access to WASH services, knowledge about nutrition-sensitive agriculture practices and empowered VOs in the targeted group in the intervention areas
	<b>Coherence</b>	To assess compatibility or fit of the intervention with other activities by government partners and other development actors in delivering nutrition and health services.
	<b>Sustainability</b>	To examine whether the benefits resulting from the Programme would continue beyond the intervention period and if there has been sufficient buy-in from all the stakeholders. Challenges to achieving sustainability will also be explored.
Other Criteria	<b>Fidelity</b>	To understand whether the Programme was implemented according to the plan, and key changes in intervention design or delivery and the reasons for these changes.
	<b>Gender</b>	To examine whether the Programme has been influential in changing gender norms and perceptions of women in the society.

Criteria	Description
Equity	To examine the extent to which UNICEF's Programme addressed the needs of the vulnerable groups of women and adolescent girls, such as tribal communities in the targeted districts.

### 1.6.1 Departure from the ToR

The ToR provided 25 evaluation questions under the criteria described above. During the inception stage, the evaluation team conducted an "evaluability" assessment of the evaluation questions to check whether each question was essential or desirable and the extent to which the question can be answered based on the scope of information available and other parameters such as bias or repetition of themes. As a result, several modifications were made to the original evaluation questions outlined in the ToR and Annexure 3 summarises the changes made to the evaluation questions.

Further, the evaluation team combined some evaluation questions when presenting the findings to avoid duplication of information and maintain the brevity of the overall report. These changes are summarised below and are not reflected in the evaluation matrix.

- Under Efficiency, the following were merged to form a coherent narrative since similar responses were elicited during the interviews.
  - What mechanisms were in place to identify and address inefficiencies or leakages in the receipt of benefits? How well did the convergence committees at the state, district, and block levels and coordination within SRLM verticals function? What were key inefficiencies/bottlenecks at each level (e.g., District, Block, or VO)?
  - How was review and reporting done to identify and address inefficiencies or leakages in the Programme interventions? Was it timely and useful? What were the challenges? Can this process be integrated and continued without external support? How can it be made more efficient from the present manner?
- Under Sustainability, the following modifications have been made
  - The evaluation question "What results are likely to be sustained, based on the available data? What results are not likely to be sustained? Why?" has been merged a part of another evaluation question, "What are those components that may require additional human resources or budget to sustain the intervention?"
  - The evaluation questions, "To what extent is the intervention scalable to other blocks and districts in the same states? What are those components of *Swabhimaan* Programme that may be scaled up to other blocks and districts with certain system strengthening alignments in the current manpower and financial resources available or budgeted in PIP?" and "To what extent is the intervention scalable to other states in the country? What are those components of *Swabhimaan* Programme that may be scaled up to other states with certain system strengthening alignments in the current human resources and financial resources available or budgeted in PIP?" have been merged
- The following questions under Impact and Effectiveness have been merged
  - What are the intended and unintended outcomes of community led and system strengthening strategies of the Programme -Integration of FNHW interventions into gender strategies, linkage with line departments to create nutrition-based livelihoods, child nutrition outcomes etc.?
  - Are there any unexpected findings in the treatment areas? What may be the reason for these? How did certain national level new interventions/externalities viz. rollout of *Poshan Abhiyaan*, and key interventions influence the results of *Swabhimaan* Programme?
- Under Coherence, the following questions have been merged
  - How does various activities of *Swabhimaan* Programme fit with the work of external partners (government, partner agencies in states, other partner Programmes, global partners, regional partners, research agencies like IFPRI, Population Council etc.?)
  - Does *Swabhimaan* Programme activities part of a coherent approach that is likely to have positive results, or are there critical gaps?

The evaluation has also departed from the inception report with regard to the proposed sample for data collection. The evaluation team was unable to achieve the proposed sample at the state and district level due to various challenges, which are outlined in Section 2.7 (Limitations of the Study).

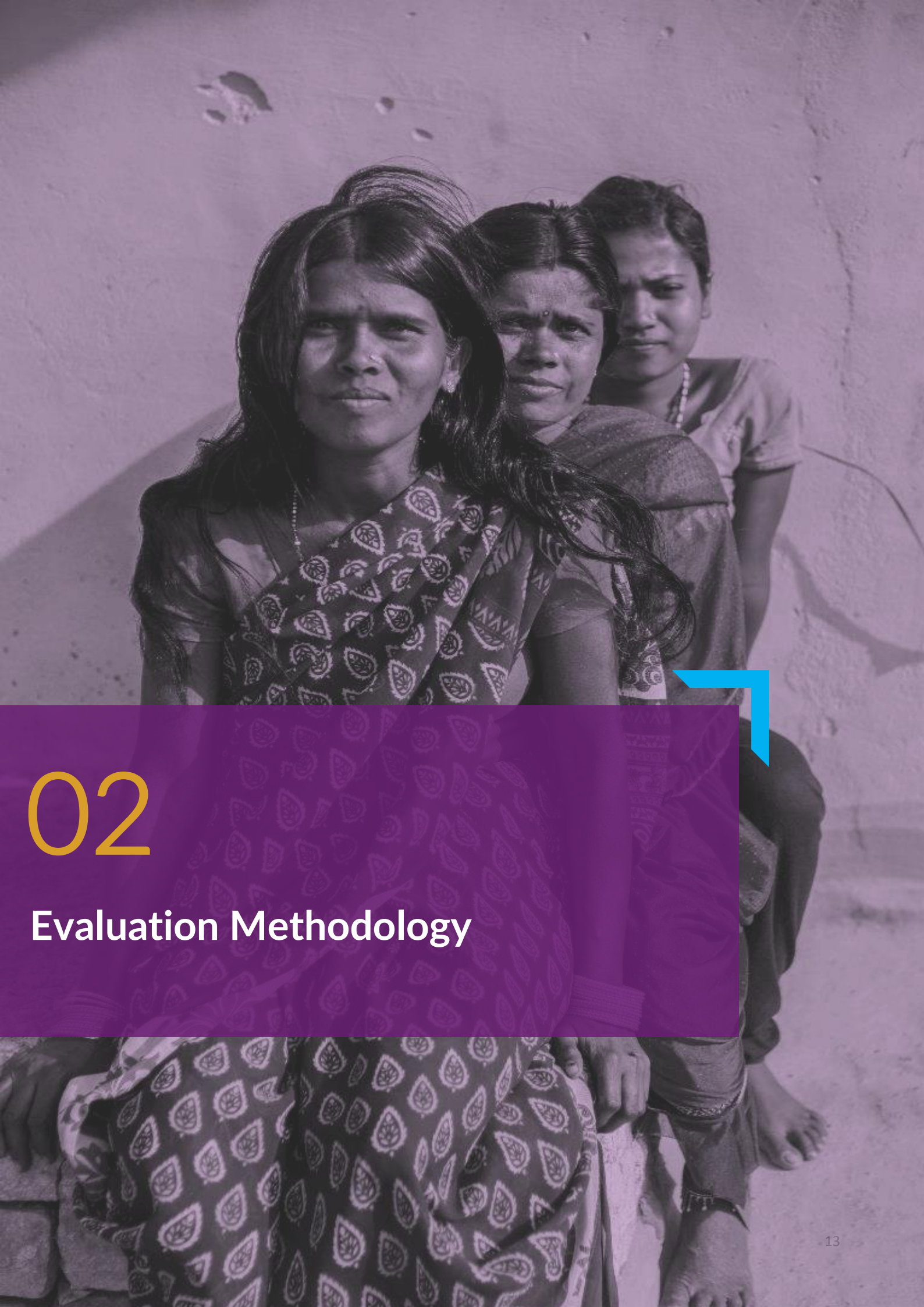
Given the complexity and scale of the evaluation, the report exceeds the suggested length as per the Global Evaluation Report Oversight System (GEROS) format and as recommended in the ToR. Condensing the information in the report or executive summary may have led to the loss of pivotal findings and has been agreed on with the UNICEF ICO.

## 1.7 Intended Users

The findings from this evaluation will primarily be used by UNICEF staff involved in the development and implementation of the *Swabhimaan* Programme to understand its contributions towards achievement of the outcomes. Conclusions and recommendations based on the findings and learnings from the challenges identified may also be adapted into the design of *Swabhimaan 2.0*.

Further, the evaluation findings will be shared with external stakeholders, including government departments and agencies such as the DAY-NRLM at the national level, relevant SRLMs and supporting departments such as the Department of Health and Family Welfare, Women and Child Development, Agriculture and Food/Civil Supplies. The findings and recommendations will also be useful to institutional partners of the Programme such as ROSHNI-CWSA and other partner NGOs, who have previously supported or are currently supporting *Swabhimaan*, to make decisions regarding implementation modalities or design of interventions or scale-up of the Programme.

More broadly, the findings will also be eventually converted into a working paper to feed into the existing body of literature covering community-led interventions and delivery of health and nutrition services through large-scale national programmes.



# 02

## Evaluation Methodology

# 2. Evaluation Methodology

## 2.1 Evaluation Implementation

The evaluation implementation was organised into three sequential phases of work. The distinct activities that will be undertaken in each phase is briefly outlined below. Each phase included activities contributing directly and/or indirectly to evaluation deliverables, as seen in Figure 5.

Figure 5: Evaluation Implementation Plan

Phases	Activities	Deliverable
Inception Phase	<ul style="list-style-type: none"> <li>Initial virtual kick-off meeting, initial desk review to understand context and Programme</li> <li>Virtual meeting with UNICEF staff to understand Programme and stakeholders involved</li> <li>Evaluation design: evaluability matrix, finalisation of methodology, sampling and drafting data collection instruments</li> </ul>	Inception Report
Data collection phase	<ul style="list-style-type: none"> <li>Development of contribution claims for all five outputs</li> <li>IRB approval, piloting the research tools, enumerator training and final data collection</li> <li>Transcription of interviews</li> </ul>	Field Completion Report
Data Analysis and Report Writing	<ul style="list-style-type: none"> <li>Analysis</li> <li>Triangulation of data to address the evaluation question under each 8 evaluation criteria</li> <li>Final evaluation report preparation incorporating feedback from ERG presentation</li> </ul>	Final Evaluation Report

The technical approach for this evaluation was guided by [OECD DAC Criteria](#), [United Nations Group for Evaluation \(UNEG\) Norms and Standards](#) (UNEG, n.d.-a), [The Ethical Guidelines for the Evaluation](#) of UNEG (UNEG, n.d.-b) and [the Code of Conduct for UNEG](#) (UNEG, n.d.-a) for evaluation in the United Nations System will be adhered to. A theory-based evaluation method that combines Contribution Analysis and Most Significant Change were adopted to arrive at credible causal claims about Programme’s contribution to outcomes of interest, taking into consideration other factors that may have influenced such outcomes. Contribution Analysis will explore the extent to which *Swabhimaan* has contributed to the outcomes identified in the Theory of Change (ToC), while the Most Significant Change will explore the unintended changes. The primary evaluation methods were qualitative, including extensive analysis of the documents, and primary information collected using key informant interviews (with the UNICEF staff and government stakeholders at the state and district levels), in-depth interviews (with implementers at the state and sub-state levels) and focus group discussions (collected information from the beneficiaries).

The evaluation was gender-sensitive in its design and methods. The evaluation is utilisation-focused which is compatible with gender-sensitive approaches in its key focus being generating evidence from multiple stakeholders for their use. The evaluation selection criteria were open, transparent, and impartial and reflected the diversity of stakeholder communities (women and men, key stakeholders). Additionally, the evaluation questions were focused on understanding outcomes while accounting for cultural and gender-specific results. The use of the OECD DAC evaluation criteria ensured that gender and equity were included as evaluation questions. In terms of the competencies and expertise of the evaluation team, the team members were all experienced in gender as well as methodological and evaluation skills and cultural competencies related to the gender issues being examined. The data collection team was comprised of female researchers who had a deep knowledge of cultural norms, values, and socialisation processes.

The evaluation was also gender-responsive in its design as it was focused on assessing the extent to which the Programme resulted in progress (or the lack thereof) towards intended and/or unintended results regarding gender equality. It also included understanding of changes in cultural values, norms, attitudes, social behaviours and power relations, the participation of women and men in community meetings, access to resources, etc.

### 2.2.1 Programme ToC

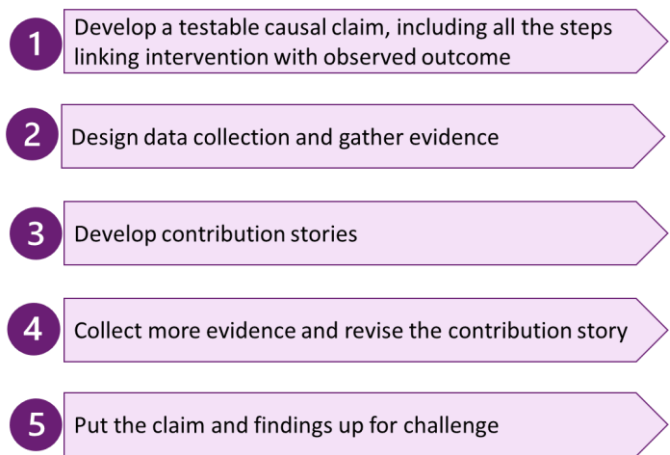
The *Swabhimaan* Programme ToC maps the challenges facing the nutritional status of adolescent girls and target groups of women in defined poverty pockets of three states (Bihar, Chhattisgarh, and Odisha) and potential areas of improvement through targeted activities and strategies. The ToC elucidates the change pathways originating from these intervention-based activities to the five output areas and five outcomes. The ToC provides detailed inputs and processes for each of the output and outcome areas (Annexure 9).

### 2.2.2 Contribution Analysis

The Contribution Analysis method was adopted to develop evidence showing the steps between the activities of programme intervention and intended changes (capacity and behavioural) to link cause and effect. As mentioned previously Contribution Analysis focuses on the five output areas in the ToC. Using the COM-B (Capacity, Opportunity, Motivation - Behavioural Change) approach (refer to Annexure 4.1), the evaluation team developed output-specific ToC (refer to Annexure 4.2) and detailed contribution claims for each output.

The Contribution Analysis approach involves five steps as in Figure 6 (based on (Mayne, 2012)) including developing a Logic Model or ToC for intervention and gathering evidence in order to explore the intervention's contribution to observed outcomes. By verifying that the intervention is based on and taking into consideration other influencing factors, Contribution Analysis can provide evidence that the intervention did or did not make a difference. Contribution Analysis provides a helpful and intuitive framework, but not a prescribed set of methods and processes for assessing a ToC. The contribution claims, reach, assumptions, and behaviour changes underpinning the ToC of each output area are provided in Annexure 4.2. The claims and corresponding ToC were first developed based on document reviews and programmatic understanding. These were further refined based on discussions with the ROSHNI-CWSA team. These were further adapted based on field realities as discovered during the data collection and analysis phase.

Figure 6: Steps Involved in Contribution Analysis



Source: Mayne (2012)

### 2.2.3 Most Significant Change

The Most Significant Change (MSC) technique, a participatory approach developed by (Davies, 2005), was used to capture the unexpected changes as well as indirect and process outcome that are often not recorded by indicator-based evaluations. This approach seeks feedback or “stories” from all stakeholders—from implementers to *Swabhimaan* Programme beneficiaries—to capture these changes. The steps executed to identify MSC stories include defining domains of change, story collection, story selection, and verification of the stories.

## 2.3 Data Collection Methods and Sampling

### 2.3.1 Desk Review and Secondary Data Analysis

The evaluation team reviewed Programme materials shared by the UNICEF team, annual reports, and other documents available on the ROSHNI-CWSA website and peer-reviewed articles based on the Programme. Annual reports, other progress reports and findings from the baseline, midline and endline evaluations were studied state-wise while peer-reviewed papers and other documents presented the design and implementation of the Programme at an aggregate level. Data from the three rounds of evaluation was also analysed to substantiate the findings from this Programme evaluation. The full list of documents reviewed is provided in the References section. The full list of Programme documents reviewed can be found in Annexure 1.

### 2.3.2 Primary Data Collection

Primary data collection included KIIs and FGDs, as described below. The full set of tools used can be found in Annexure 5.

- **Key Informant Interviews:** In-depth interviews were conducted with a range of stakeholders (including UNICEF staff, government official from different departments, service providers at community level such as *Kishori Sakhi/Poshan Sakhi/Mangun Mit*, ASHA/ANM, *Krishi* Village Resource Person etc.) at the national, state and district levels. The list of the participants is available in Annexure 8.
- **Focus Group Discussion:** The FGDs for all the four categories of beneficiaries (adolescence girls, pregnant women, mother with children under age two, and newlywed couples) were conducted at the community level. Since considerable time has elapsed between the course of the Programme (2016-2021) and this evaluation, it is essential to attach a temporal definition to the community-level stakeholders who will be interviewed as part of FGDs. For this evaluation, respondents will be defined and sampled depending on their status at the time of the Programme. For example, 'pregnant women' would be women who were pregnant during the Programme and received benefits specific to this stakeholder group. Likewise, 'mothers' would be women who were mothers of children under two years during the Programme and received specific interventions.
- **Most Significant Change Stories:** The MSC stories were collected from Programme implementors during in-depth interviews. Each state team has existing stories repositories, which compile stories collected and validated during the Programme implementation and covering of all themes of the Programme. The stories with maximum impact on the direct beneficiaries (and community in many cases) in context of the Programme objectives have been showcased. The stories were further validated by the data collection team over phone.

### 2.3.2.1 Sampling Strategy

Data collection included two broad categories of stakeholders: a) internal stakeholders such as UNICEF staff at the state level who were involved in the conceptualisation, implementation, and monitoring of the Programme; and b) external stakeholders such as relevant government organisations and departments, implementers part of community institutions and beneficiaries of the Programme. The data collection was conducted over a period of one month from November 14 to December 14. To ensure the content and face validity of the tools, a pilot was conducted in October 2022 in the state of Odisha. All IDIs at state and district level were conducted remotely via telephone or video conferencing platforms such as Zoom/ Microsoft Teams or Google Meet based on the respondent's convenience. Data collection processes and mitigation strategies are discussed in the Field Implementation Report submitted to UNICEF team.

The villages for data collection were purposively selected on the basis of levels of literacy. A high-level and low-level literacy village were selected in each district. Further, for KIIs, a full list of potential stakeholders was compiled during the stakeholder mapping process with the help of state implementation teams. The sampled list of respondents was finalised in consultations with the UNICEF team at the national and state level. A total of 97 KIIs were conducted across the three study areas, at state and sub-state levels. For FGDs, the respondents were approached directly by enumerators using 'purposive sampling' following pre-stated guidelines during training. Twenty FGDs were conducted in each state with adolescent girls, mother of children under two years, pregnant women, and newlywed women for a total of 60 FGDs. This is detailed in **Annexure 8**.

## 2.4 Data Analysis

The evaluation team used MAXQDA qualitative analysis software to help systematically extract qualitative data from the wealth of documentation produced by the UNICEF over the evaluation period and the interviews/ discussions conducted by the team. The process involved transcribing and coding qualitative data collected through interviews and FGDs followed by collating and summarising into categories and themes to answer the evaluation questions and sub-questions. An iterative process was followed for coding and categorisation to identify emerging patterns.

The quantitative information of the three surveys (baseline, midline, endline) was done using STATA v.17 software. Finally, triangulation of qualitative interview data and other secondary information was conducted to synthesise the evaluation findings and draw conclusions.

## 2.5 Ethical Considerations

The evaluation approach was guided by relevant UNICEF's Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis (UNICEF, n.d.), UNICEF-Adapted UNEG Evaluation Reports Standards (*UNICEF-Adapted UNEG Evaluation Reports Standards*, 2017), UNEG Norms and Standards for Evaluation (UNEG, n.d.-a), UNICEF's guidelines for Ethical Research Involving Children (Graham et al., n.d.) and UNEG Ethical Guidelines for Evaluation (UNEG, n.d.-b). The research design, data collection and informed consent document was reviewed and approved by

Sigma Institutional Review Board (IRB). The ethical certificate provided by Sigma IRB can be found in Annexure 7. This ensured proper protocols were in place for informed consent, data protection and safeguards to protect the rights of participants, among other standard protocols for data collection. Some steps taken by the evaluation team with respect to ethical data collection are summarised below.

- **Respect for dignity:** The study was designed to ensure respect for the respondent's autonomy i.e. their right to make their own choices and take their own actions free from coercion. The following methods were used to ensure the same:
  - **Confidentiality:** All participants were assured of the confidentiality of any information they share, and care was taken to protect the participants' anonymity through the use of anonymised interviewee codes for each respondent.
  - **Preventing disclosure of identity:** Appropriate measures were put in place to prevent any individual data from being published or otherwise released in a form that would allow any subject's identity to be disclosed or inferred.
  - **Informed consent:** We obtained oral-informed consent from all participants and ensured that participants have the contact details of the evaluation team to withdraw or change their consent at any time.
  - **Data security:** Raw data such as interview transcripts were transferred to Athena's server through secure means using an encrypted shared drive. Only team members and the field coordinator had access to the folders for the project's duration.
- **Respect for diversity:** Topic-based guides were developed for different respondent groups to ensure that the diversity of each respondent category is respected. Additionally, efforts were made to ensure that questions that are of personal/sensitive nature were not included in the guides.
- **Impartiality:** To reduce the subjectivity or positive bias, similar questions were posed to multiple stakeholders across various cohorts and levels and validated through secondary sources (wherever possible).
- **Credibility:** The findings presented in the evaluation have been obtained through primary and secondary data. In Section 3.3, relating to the effectiveness of the Programme, the evaluation team has also included a clear rating scale based on validation measure to note the strength of the evidence in supporting claims related to the Programme.
- **Independence:** The evaluation was separately managed by the Research and Evidence unit at the UNICEF ICO, separate from the Programme unit responsible for Swabhimaan. Further, the evaluation team had full and free access to all available information and geographies for data collection.
- **Do no harm:** The research instruments were designed and executed in line with the context of the study areas and with appropriate respect to cultural sensitivities while engaging with the target groups. This included introductions/facilitations by persons familiar with the family, such as ASHAs or village heads and deployment of surveys by female enumerators who speak the local language and understand local customs.
- **Research with children:** Data collection with adolescent girls were conducted in accordance with the protection and priority principles outlined in the Convention on Rights of the Child and UNICEF's Guidelines for Ethical Research Involving Children (Graham et al., n.d.). Oral consent was obtained from parents/ guardians, followed by oral assent from adolescent girls, before planned discussions. The group discussions were held at convenient times (such as before or after classes or during weekends) and in a central, accessible but safe and private location such as schools, primary health centres or village halls.

Additionally, all the core evaluation team members have completed the UNICEF's Ethics in Evidence Generation. Furthermore, all the researchers involved in the data collection underwent training on ethics as part of the enumerator training.

## 2.6 Evaluation Management

The following mechanisms were implemented to assure the quality of all deliverables and processes throughout the evaluation cycle:

- **Aligning deliverables with the Global Evaluation Report Oversight System (GEROS):** The evaluation team used the checklist and guidelines provided in GEROS to ensure that the deliverables cover all relevant, required and expected information. The GEROS template was also used to guide the structure of key deliverables (including the Inception report and Draft Evaluation report).
- **Quality assurance during data collection:** A series of steps, as outlined below, ensured that data collection and analysis are transparent, verifiable, and meet appropriate ethical standards:

- Explicit consent was sought from respondents to record the interviews. Recordings were carefully transcribed in English by qualitative researchers.
- During the first week of data collection, the core team held regular debriefs with the qualitative researchers to address potential challenges and discuss mitigation strategies.
- During the data collection cycle, necessary updates were provided to the evaluation management team at UNICEF.
- **Meetings with the UNICEF evaluation management team:** The Athena team coordinated with the evaluation management team and the *Swabhimaan* Programme team at UNICEF India country office to review key milestones, track changes or updates in timelines and to gather client feedback throughout the evaluation cycle.

The workplan for the evaluation can be found in Annexure 6.

## 2.7 Limitations of the Study

A few key limitations of the evaluation are noted below.

Table 6: Limitations of the evaluation

Area of Limitation	Description
<b>Methodological Limitation</b>	
Sampling design	Since the evaluation was aimed at understanding the ecosystem in which the Programme operates, the focus was on gathering evidence from Programme beneficiaries and key stakeholders to understanding perspectives and contributions respectively. Therefore, no special efforts were made to further stratify the sample by caste or disability. However, the sample was inclusive of vulnerable groups i.e. pregnant women, mothers of children under 2 and adolescent girls in line with the Programme strategy.
Recall bias	Since considerable time has elapsed between the end of the Programme and the evaluation, the respondents' answers were subject to recall bias to some extent. This risk was higher when determining the extent to which services and interventions were delivered to beneficiaries through focus group discussions since respondents did not accurately remember whether they had received them or not. Documentary evidence and factsheets from baseline, midline and endline evaluations were used to triangulate the information from interviews and mitigate this risk to some extent.
Subjectivity of qualitative data	It is likely that implementers and beneficiaries adopted positive bias towards the Programme and its continuation in the interviews due to social desirability and the hesitancy to speak against government priorities. Wherever possible, the information has been verified through interviews with multiple stakeholder cohorts across various levels. Additionally, secondary information has been used to confirm the findings to the best extent possible.
Availability and limitations of secondary data and reports	Other studies envisioned as part of the Programme design were either made available to the evaluation team during the latter part of the evaluation or are still being conducted. This has resulted in some gaps in triangulation and verification of primary research information. Additionally, this has also resulted in information gaps in findings under criteria such as Fidelity and Efficiency, which were accorded lower priority in this evaluation during the inception phase on the assumption that these would be comprehensively covered under other ongoing studies.  Limited data was also available to understand and judge the financial efficiency of the Programme. For example, the breakup of expenditures incurred for the capacity building partner and activities related to implementation were not available.
Spillover effects	Several other similar projects and activities were implemented and funded by other donors in the same area during the course of the Programme. The evaluation has not considered this aspect.
<b>Data Collection Limitations</b>	
Timelines and compressed data collection phase	Both the pilot and final data collection survey coincided with festivals in different states. The pilot survey, planned in Odisha was delayed due to Rath Yatra and

Area of Limitation	Description
	Navaratri/Durga Puja/Dussehra. The final survey was planned after Diwali and Chhath Puja (in Bihar) due to the challenges in obtaining appointments with respondents across all levels. Consequently, the evaluation team had limited timeframe to follow up with relevant stakeholders and some of the key stakeholders were unresponsive or could not be reached.
Inability to achieve proposed sample	Due to the logistical challenges mentioned above, the evaluation team was unable to achieve the proposed sample, especially at the state and district levels. Although multiple attempts were made to conduct these interviews according to the timelines, some respondents refused to participate or provided only short appointments for the interviews.
Limited information from interviews	In some instances, respondents at the state and district levels only provided short appointments for interviews or provided limited information despite repeated probing. While the evaluation team tried to pose questions which were more relevant to the stakeholder cohort and attempted to condense the tool, this has resulted in some information gaps and limited the ability to triangulate and verify all findings.
Turnover	In a few instances, respondents either refused to participate or were unable to provide comprehensive responses due to their limited duration of engagement with the Programme. The evaluation team was unable to speak to their previous counterparts who had deeper knowledge of <i>Swabhimaan</i> over the years.
Duration of internal stakeholder interviews	Interviews with internal stakeholders were longer than anticipated due to the expansiveness of information to be collected. In some instances, these interviews took up to two hours.



# 03

## Findings

# 3. Findings

## 3.1 Profile of Respondents

This section provides a snapshot of the profile of the respondents in terms of their gender, age and level of education. We have considered data for community-level interviews with service providers (i.e., ASHA/ANM, AWW, PS, KS, CLF, VO, Supervisors and PDS dealers) for this analysis since there were data collection challenges for state, district, and block-level staff (refer to Section 2.7).

- Gender:** While most of the respondents were female, we found that a small percentage of respondents (i.e. PDS dealers and some CLF/VO staff) were male (Figure 7) across the three states. In Bihar, 33% of the total respondents were males, while in Chhattisgarh and Odisha, 12% and 15% of the respondents were male respectively.
- Age:** Almost 70% of the respondents across all three states were in the age groups of 20-29 and 30-39 years (Figure 8). In Bihar and Odisha, 46% and 42% of the respondents were in the age group of 20-29 years. In Chhattisgarh, 57% of the respondents were in the age group of 30-39 years.
- Level of education:** In terms of level of education attained, 27% of the respondents had passed class 12 (intermediate) and 18% had passed class 10 (Figure 9) across the three states. In Bihar, 63% of the respondents had passed class 12 or were graduates or postgraduates. In Chhattisgarh, 38% of the respondents had passed class 12 but none had a graduate or postgraduate degree. In Odisha, 25% of the respondents had passed class 10 and 8% were postgraduates.

Figure 7: Gender profile of respondents (%)

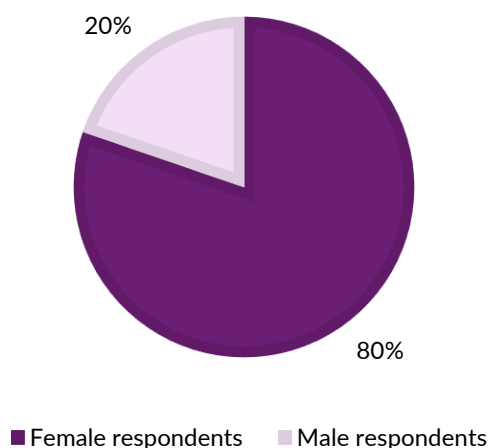


Figure 8: Age profile (in years) of respondents (%)

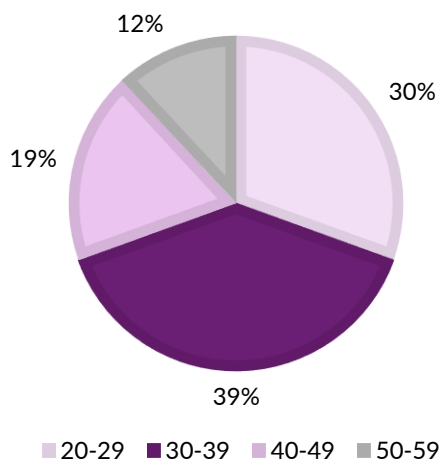
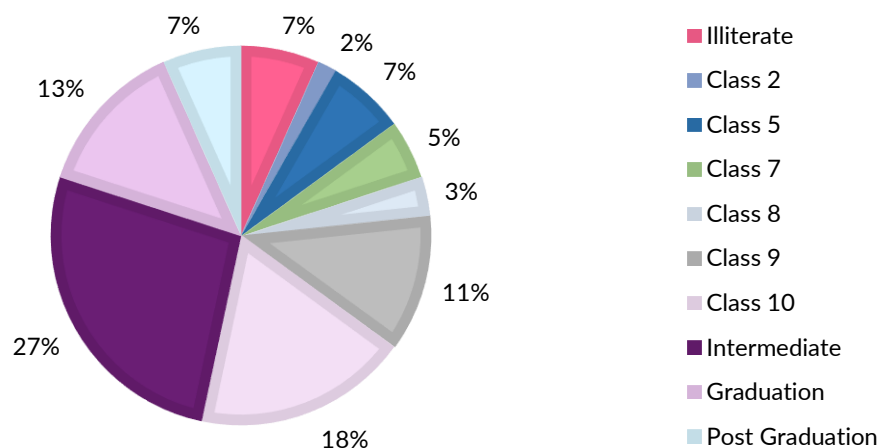


Figure 9: Education profile of respondents (%)



## 3.2 Relevance

This section discusses the relevance and alignment of the *Swabhimaan* Programme: 1) with the SDGs, CEDAW, UNICEF global strategic plan and UNICEF India country programme goals, objectives, and strategies, 2) with national level health and nutrition priorities & policies, and 3) with the needs and context of the target groups of the *Swabhimaan* Programme.

**Evaluation Finding:** The *Swabhimaan* Programme addresses relevant nutritional and health challenges of the target groups, as evidenced by data from national surveys and baseline statistics and confirmed by stakeholder interviews. The goals and activities of the Programme align with the overarching objectives of the National Rural Livelihood Mission (NRLM), UNICEF's strategic global and national priorities as well as the SDGs and rights-based international treaties such as CEDAW. While the evaluation did not note a change in the Programme ToC in response to the pandemic, documentary review and stakeholder interviews show that implementation modalities were adapted, and reporting and monitoring continued with the use of technology. However, key community activities such as face-to-face monthly meetings were adversely affected in most areas of the three states due to restrictions in movement imposed by the government.

### 3.2.1 To what extent is the *Swabhimaan* Programme relevant to the needs of various target population groups (adolescent girls, newlywed women, pregnant women, mothers of children below two yrs.) and recipients (VO, CLF, service providers) of the Programme in Bihar, Chhattisgarh, and Odisha?

**The evaluation found that the *Swabhimaan* Programme was relevant to the needs of the target population groups.**

As evidenced from data presented in Table 6 from NFHS-4 and NFHS-5, over half of the women aged 15-49 years were found to be anaemic. Health-related indicators such as the percentage of institutional births provide a

*“Before Swabhimaan Programme started, there was a baseline survey that took place in Paswa and Jalalgarh and in this survey, about 44% were found to be malnourished and 54% of the newborn babies were found to be malnourished. And that is why this Programme was introduced here. And the main goal of this Programme was to end malnourishment for everyone who is suffering. And there were five strategies that were taken up to achieve this goal, first, to check the usefulness and right quantity of the food we are consuming. Second was to overcome anaemia. Third was family planning. Fourth was “Health Day” and its importance. And fifth was to maintain cleanliness and using of toilets, and how to purify water for drinking purpose.”*

- Supervisor, KII Respondent

more promising picture but also presents scope for improvement. Poor health and nutritional status in the three study states is also confirmed from baseline data (Chattopadhyay et al., 2019; Sethi et al., 2019; Unisa et al., 202; Baseline Fact Sheets)) - the mean BMI of adolescent girls across the three states was below 18.5 (considered underweight), about one-third of the girls surveyed were found to be stunted and only about 10% of adolescent girls were consuming the prescribed course of IFA tablets.

Table 7: Basic statistics from Bihar, Chhattisgarh, and Odisha

District	% of women (15-49 years of age) with Anaemia		% of women (15-49 years of age) with low BMI		% of institutional births		% of women (15-19) who were already mothers/pregnant		% of unmet need for family planning for women (15-49)	
	NFHS-4	NFHS-5	NFHS-4	NFHS-5	NFHS-4	NFHS-5	NFHS-4	NFHS-5	NFHS-4	NFHS-5
Purnia	66	68.8	31.4	38.8	68.9	61.5	12.3	21.4	20.2	22.8
Bastar	67.6	77.2	37.1	34.9	66.4	63.5	4.8	6	12.8	12.1
Angul	44	75.8	21.7	20.6	90.3	85.7	9.9	12.2	10.2	2.9
Koraput	63.3	58.2	34.5	27.2	68.4	82.1	12.6	8.4	10	6.6

Source: (National Family Health Survey (NFHS-4), 2017); (National Family Health Survey (NFHS-5), 2019)

The package of interventions was designed to address the most pressing issues and their associated factors evident through national and baseline survey statistics. As such, the Programme focused on improving food intake and dietary

practices, providing access to information regarding safe sanitation practices and building capabilities to establish and maintain own kitchen gardens. A majority of service providers and state level implementers interviewed attested to this focus being informed by baseline surveys and considered it relevant in addressing health and nutritional challenges, in addition to income generation. However, state implementers also stated that FNHW interventions are still considered a 'top up' activity in large-scale welfare programmes rather than one of the key focus areas and highlighted the need for increased advocacy and awareness across all levels to change this perception.

Relevance of the Programme to local needs and contexts were also highlighted in discussions with beneficiaries, service providers and CRPs. Respondents reported that the information disseminated through monthly meetings on nutritional, WASH and hygiene practices were useful

*"This Programme should keep on going with frequent meetings because instead of staying at home these meetings and information will help us."*

- Pregnant Woman, FGD Respondent\*<sup>1</sup>

to them on multiple counts and provided anecdotal evidence on how access to information and services has resulted in behavioural and capacity changes. These are summarised in Section 3.3 (Effectiveness). The relevance of the interventions is also evidenced through the extent of community reception of the Programme; beneficiaries interviewed expressed interest in the continuation of the Programme, including the monthly group meetings. Further, service providers and community cadres interviewed highlighted that the Programme ensured relevance of issues addressed through the process of creation of IMPs, which focuses on validation of the plans with key community groups to prioritise nutrition and related problems. CRPs and VRPs also belong to local communities and are familiar with the key issues related to health, nutrition, and sanitation in their respective areas.

**The Swabhimaan programme in Bihar implemented an additional component known as the Kishori Sakhi.** The Kishori Sakhis were CRPs responsible for the formation of Adolescent Girl groups, facilitating weekly games cum counselling sessions, and organizing Adolescent Health and Nutrition Day. The component was aimed at empowering adolescent girls and improving their overall health and well-being. However, recent data suggests that during the scale-up phase, JEEViKA (the implementing agency of Swabhimaan in Bihar) will not be engaging with the Adolescent Girl groups. Instead, the focus will be on the Nutrition Sensitive Integrated Farming Systems (NSIFS) and its convergence with other programmes. The NSIFS programme aims to promote sustainable agriculture practices, increase income and nutrition security, and reduce the vulnerability of smallholder farmers in Bihar. While the Kishori Sakhi programme may not continue during the scale-up phase, JEEVIKA's efforts to improve the livelihoods and well-being of rural communities in Bihar will continue through various interventions, including the NSIFS programme.

### 3.2.2 To what extent is the Swabhimaan Programme relevant to the priorities and policies of DAY-NRLM and global goals and priorities?

#### *Relevance to DAY-NRLM Priorities*

The DAY-NRLM was established to bring rural poor households out of the vicious cycle of malnutrition and related illness through a savings and enterprise approach, implemented through a network of women's groups and their federations (*MoU Signed between Lady Irwin College & MoRD for Roshni*, n.d.). The Mission also serves as the principal point of delivery of the convergent action plan under Gol's *Poshan Abhiyaan* Programme, which works to reduce stunting, under nutrition, anaemia, and other nutrition-related issues in the country. The *Swabhimaan* Programme was developed in complete alignment with these national strategies to demonstrate the layering of FNHW interventions with DAY-NRLM platforms and to institutionalise the delivery of FNHW activities as an invested service rather than a voluntary responsibility. More specifically, *Swabhimaan* aims to achieve one of the four stated goals of the Mission- "social inclusion, social development and access to entitlements through convergence."

The *Swabhimaan* Programme is implemented through structures created under respective SRLMs in the three states. Community actions under the Programme are led by Tiers 2 (VOs) and 3 (CLFs) under the SRLM structure. Table 7 maps the FNHW strategies envisioned by NRLM for VOs and CRPs, and some corresponding activities under the *Swabhimaan* Programme. The close degree of alignment was also stated by state-level stakeholders, who reported that while SRLM and other government-led initiatives were aware of nutritional and health needs of the community,

<sup>1</sup> \*Please note that the quotes from beneficiaries used in this report reflect their opinion and experiences of the benefits received from the Swabhimaan programme. At times, the beneficiaries might conflate other services provided through the SRLM and other programmes with Swabhimaan – however, the report quotes them verbatim.

they were limited by resource constraints. Having a resource-intensive programme such as *Swabhimaan* to pilot effective solutions before their integration into SRLM activities was appreciated by the stakeholders.

Table 8: FHNW Strategies under NRLM and Corresponding Activities under *Swabhimaan*

Strategies envisioned by NRLM	Activities under <i>Swabhimaan</i>
Mobilise and build capacity of women and enable demand generation	<ul style="list-style-type: none"> <li>Ensuring opening of PDS shops and receipt of generalised food ration</li> <li>Provision of maternity entitlements and ICDS Ration</li> </ul>
Promote behaviour change	<ul style="list-style-type: none"> <li>VO develop integrated village health, nutrition and Water and Sanitation Hygiene (WASH) plans</li> <li>VO implement integrated plans through cash grants received by the SRLM</li> <li>Trained CRP/<i>Poshan Sakhi</i> conduct monthly <i>Maitri Baithak</i> as part of monthly SHG meeting</li> <li>Rally and mobilise for VHSND, AHD services and other social issues</li> </ul>
Promote health and nutrition livelihoods	<ul style="list-style-type: none"> <li>Fortnightly meetings/home visits for women with MUAC &lt;23cm, with provision of seed grants for agriculture and poultry-rearing activities</li> <li>Support for nutrition-sensitive agriculture at home (kitchen gardens) and community-based food insecurity coping strategies</li> <li>Access to information and commodities to prevent malaria</li> </ul>
Prevent poverty due to medical care costs	<ul style="list-style-type: none"> <li>Special biannual women service and entitlement camps by Health department</li> <li>Inclusion of identification and package for at-risk of women and newly-wed package as part of VHSND</li> <li>Linkages to Vulnerability Reduction Fund</li> </ul>

Source: Developed by authors based on Report on the *Swabhimaan Bihar Baseline Survey Results* (IIPS, 2016) and *Swabhimaan Programme Document* (UNICEF, 2017)

In addition to the DAY-NRLM priorities, *Swabhimaan* is also closely aligned with other national schemes related to health and nutrition. A few such schemes, their provisions and corresponding activities under the Programme is provided in Table 8 below.

Table 9: Schemes and Protocols for National level nutrition related program for women incorporated in *Swabhimaan* strategies and activities

FHNW Theme	Scheme/Department	Provisions under Scheme	Activity under <i>Swabhimaan</i>
<b>Food Quantity</b>	Food Security Act (FSA), Food Supply Department	Per head 5 kg rice according to Food Security Act (FSA) 2013	Food grains are distributed as per PDS scheme
<b>Micronutrient Supplement</b>	VHND (Mamata Diwas) (Ministry of Health and Family Welfare (MoHFW)/ Ministry of Women and Child Development (ICDS)	All pregnant women need to consume IFA tablet (100mg Iron and 500mg folic acid) every day; from 4th month of pregnancy. For other women weekly once IFA	Iron and folic acid (IFA) supplement
		Calcium tablet (500mg Calcium and 250 IU Vitamin-D3)	Calcium supplement
	ICDS	Distribution of hot-cooked meals and THR to maintain the calorie and protein intake of women. Counselling by <i>anganwadi</i> worker monthly to educate women about nutrition benefits and the importance of small family	Nutrition-loaded food supplement and counselling
	IDDCP (MoHFW)	<i>Anganwadi</i> workers will advise to take proper amount of iodine salt for proper nutrients (15 PPM or more)	Iodine salt supplement

FHNW Theme	Scheme/Department	Provisions under Scheme	Activity under Swabhimaan
Identification and Treatment for Health issues	VHND (Mamata Diwas), (MoHFW)	Provide Albendazole 400mg to pregnant women for consumption between 4 and 6 months of pregnancy and if more than 40% worm is found later, then albendazole is given once more.	Anthelmintic drug
	VHND (Mamata Diwas), (MoHFW)	Check height, weight, and haemoglobin level to determine whether the woman/adolescent girl is malnourished	Identifying anaemia and its treatment
	Malaria eradication program (MoHFW)	Distribution of insecticide treated mosquito nets to pregnant women in malaria-affected area	Safety from Malaria

#### Relevance to UNICEF's Global and National Priorities

The *Swabhimaan* Programme is aligned with UNICEF's other global and national goals and initiatives. UNICEF's Global Strategic Plan (2022-2025) lists "Every child, including adolescents, survives and thrives, with access to nutritious diets, quality primary health care, nurturing practices and essential supplies" as one of its key goals, with focus on nutrition of adolescents and women under this goal. Further, the *Swabhimaan* Programme hinges on using gender transformative approaches to address health and nutritional issues of women and adolescent girls in three study states, which is recognised as a key change strategy in the Global Strategic Plan (*UNICEF Strategic Plan (2021-2025)*, 2021). Table 9 below maps the other key change strategies envisioned by the Global Strategic Plan and its alignment with *Swabhimaan* activities.

Table 10: *Swabhimaan's* Alignment with UNICEF's Global Strategic Plan

Global Strategic Plan	Swabhimaan Activities
<b>CHANGE STRATEGY 2: Community engagement, social and behaviour change</b>	<i>Swabhimaan</i> employs a series of community-based interventions aimed at improving access to information on FHNW practices to bring about social and behaviour change. It also engages community cadres to implement this change due to their familiarity and proximity to local needs, ultimately resulting in increased demand generation for health, nutrition, and WASH services.
<b>CHANGE STRATEGY 9: Systems strengthening to leave no one behind</b>	<i>Swabhimaan</i> delivers a set of its interventions through its systems strengthening components. These activities, including training for ICDS and Health workers, are designed to strengthen the capacity of institutions to deliver health and nutrition services and other prescribed entitlements.
<b>CHANGE STRATEGY 3: Data, research, evaluation, and knowledge management</b>	Activities aimed at evidence generation are nested within <i>Swabhimaan's</i> programme design. Monthly reporting on coverage and performance indicators is done by the community cadres. The Programme design also included multiple rounds of evaluations to study its progress (baseline, midline and endline) in addition to a final impact evaluation.

Source: Developed by authors, based on UNICEF Global Strategic Plan

At the national level, the Programme also aligns closely with the UNICEF India Country Programme Action Plan (CPAP, 2018-2022). It contributes directly to three (reduction of child and maternal mortality, reduction of undernutrition in adolescent girls, and inclusive social policy) outcomes and indirectly (safe and sustainable WASH services, all boys and girls learn, public and private sector engagement for child rights) to three other outcomes areas listed in the CPAP (*Country Programme Action Plan 2018-2022*, n.d.). Additionally, the Programme contributes to the promotion of gender equity and emergency preparedness and response identified as cross-cutting priorities in the document.

## Relevance to Sustainable Development Goals (SDGs)

Swabhimaan's stated goals, Programme design and modalities of implementation contribute to the operationalisation of four of the ten SDGs. Figure 10 below maps the SDG goals and sub-goals to various interventions delivered under the Programme.

Figure 10: SDG Goals, Targets and Alignment with the Swabhimaan Programme



## Relevance to CEDAW

Swabhimaan's overall objective and Programme design are aligned with multiple provisions of CEDAW, as mentioned below:

Table 11: Swabhimaan's Alignment with CEDAW's provisions

CEDAW provisions	Swabhimaan Activities
<ul style="list-style-type: none"> <li>Article 5                             <ol style="list-style-type: none"> <li>To modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women</li> </ol> </li> </ul>	Swabhimaan's 18 interventions are deeply influenced by gender norms, and men's behaviour and gendered social norms. The Programme seeks to engage men to address factors rooted in gendered social norms that are a hindrance to improvement of women and girls' health and well-being.
<ul style="list-style-type: none"> <li>Article 12                             <ol style="list-style-type: none"> <li>States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning</li> <li>Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.</li> </ol> </li> </ul>	Swabhimaan is focused of increasing access to health services and special care to nutritionally 'at risk' women through (a) early registration (in first trimester) in outreach services; (b) quality reproductive health, antenatal and postnatal care; and (c) access to knowledge and entitlements for promotion of institutional deliveries and maternity benefits.
<ul style="list-style-type: none"> <li>Article 14                             <ol style="list-style-type: none"> <li>States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they</li> </ol> </li> </ul>	Activities aimed at prevention of early, poorly spaced or unwanted pregnancies through (a) promotion of secondary education and education for delaying the

participate in and benefit from rural development and, in particular, shall ensure to such women the right: (a) To have access to adequate health care facilities, including information, counselling and services in family planning;	age at marriage to legal age; and (b) access to information and family planning commodities for delaying age at first pregnancy and prevention of repeated pregnancies
<ul style="list-style-type: none"> <li>• Article 16</li> <li>1. States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women: <ul style="list-style-type: none"> <li>(e) The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights;</li> </ul> </li> </ul>	Activities focused on prevention of early, poorly spaced or unwanted pregnancies through (a) promotion of secondary education and education for delaying the age at marriage to legal age; (b) access to information and family planning commodities for delaying age at first pregnancy and prevention of repeated pregnancies; and (c) women's collective voice and empowerment for decision-making to prevent child marriage, violence against women, child spacing and other gender-related issues.

### 3.2.3 How did the ToC change during and after COVID-19? Did the intervention stop at any point during the implementation phase? Currently, what activities are being continued?

**The evaluation did not find evidence of adaptations to the Programme ToC as a result of the pandemic but noted changes in implementation modalities.** Institutionalised mechanisms for monitoring of and reporting by CRPs were adapted to be conducted over telephone during the pandemic under *Tele-Swabhimaan*. Additionally, guidance notes, ICE material and counselling tools for CRPs on how and which activities were to be continued, modes of adaptation and guidelines for protection against the COVID-19 virus were developed and disseminated over WhatsApp. Stakeholder interviews also attest to these changes in implementation.

Evidence from a monitoring exercise conducted in May 2020 (found that community actions were more adversely affected by movement restrictions imposed by the GoI, in comparison with systems strengthening actions. Within systems strengthening actions, interventions related to distribution of weekly iron folic acid supplementation to adolescent girls and school dropouts were discontinued in most places across the three states. However, other activities such as distribution of ration through PDS, distribution of THR through *anganwadi* centres and home visits by ASHAs were found to be continued. The status of activities related to distribution of IFA and calcium supplementation for pregnant women varied across the states- while these were continued in most villages in Odisha, Bihar, and Chhattisgarh saw higher levels of disruption.

Most community actions including monthly *maitri* and *kishori baithaks*, food demonstration and counselling sessions and newlywed couples' meetings were largely discontinued in Bihar and Chhattisgarh but were less affected in Odisha. However, most CRPs were found to be involved in undertaking home visits, either independently or jointly with *anganwadi* workers or ASHAs during this period. The pandemic also witnessed higher utilisation of VRF funds (or equivalent in the state) to provide food grains and medicines to vulnerable girls and women and increased linkages to agri-poultry and social protection schemes. Interventions led by CLFs such as the organisation of entitlement camps and health check-ups did not take place during this period. Additionally, CRPs were involved in other COVID-related activities such as handwashing demonstration sessions, production and distribution of masks, soaps and sanitisers and identification and surveillance of COVID-19 cases in their respective communities.

### 3.3 Effectiveness

This section discusses the extent to which the Programme has achieved or is likely to achieve its intended results and evaluates the contribution of UNICEF towards achievement of results. The description of the results is organised according to the five contribution claims, each one of which refers to the five outcome areas as described in the Programme ToC. For each contribution claim, we have developed individual ToCs which are representative of each output area of the Programme ToC. The claim ToCs retain the inputs and processes, outputs, outcomes and impacts as described in the Programme ToC. To evaluate effectiveness, each claim ToC has two additional sections: (a) activities and associated capacity change, and (b) behaviour change. The claim ToCs also account for assumptions, enablers/barriers, and context (initial conditions) (Annexure 4.2). For purposes of clarity, the process followed for the development of the ToC for Outcome 1 i.e. 'By 2020, there is equitable reach of food security and safety-nets and services for adolescent girls and women with focus on at-nutritional risk', and the method of evaluation, is explained below:

Figure 11: Theory of Change for Assessing Claim 1

**Claim 1: How and to what extent has the Swabhimaan Programme contributed to increasing the reach of food security safety nets and services for adolescent girls and women with focus on those at nutritional risk?**



The claim that was developed and tested for Outcome 1 was “How and to what extent has the *Swabhimaan* Programme contributed to increasing the reach of food security safety nets and services for adolescent girls and women with focus on those at nutritional risk?”. As mentioned above, for the inputs and processed highlighted in the Programme ToC for Outcome 1 (refer to Annexure 9), the evaluation team developed detailed activities, associated capacity changes and associated behaviour changes to generate a better understanding of the causal pathways leading to the attainment/non-attainment of the outcome. Further, enablers/barriers, assumptions and external factors were also developed. Subsequently, using Contribution Analysis (refer to Section 2.2.2), evidence for every activity and the associated capacity and behaviour change was triangulated from primary and secondary data sources and analysed to arrive at the strength of each activity that contributed/did not contribute to the attainment/non-attainment of the outcome. The same method was followed to develop the ToCs for the other outcome areas and to evaluate the strength of the causal pathways contributing towards the achievement/non-achievement of those outcomes.

The evidence under each claim was classified according to three different levels of strength and should be read accordingly. These are as follows:

- **Strong:** Strong has been used in instances where data triangulation was done from various stakeholder cohorts across levels and from different states and from existing documents/reports.
- **Mixed:** Mixed has been used in instances where data triangulation was done from relatively fewer sources (primary/secondary) and/or the information was relevant for one/two states.
- **Weak:** Weak has been used in instances where data triangulation primarily relies on a single/limited source of evidence.

**NOTE:** The claim ToCs have been modified to the extent of reorganising the content under activities, capacity change and behaviour change to improve comprehensibility. The purpose of this reorganisation was to enhance the overall coherence of the ToCs and make them easier to understand. The content was reorganized after thorough and meticulous data analysis exercise. The modified claim ToCs are aligned with *Swabhimaan's* original programme ToC.

**3.3.1 Where did the Programme perform as expected and where are the major gaps and can the changes or lack of changes in pregnant women, children below 2 yrs. and adolescent girls' outcomes be linked to the actions of the Programme? How has the Programme capacitated the VOs to design, implement and manage integrated, context-responsive, needs-based plans for multi-sector nutrition programmes for women and girls?**

*Establishment of UNICEF's Contribution Across the Five Output Areas*

*Claim 1: How and to what extent has the Swabhimaan Programme contributed to increasing the reach of food security safety nets and services for adolescent girls and women with a focus on those at nutritional risk?*

**Summary of Contribution:** The evaluation noted strong evidence in UNICEF's support towards building and strengthening capacities of community-based cadres (CRPs) for increasing awareness and access to food security safety nets and services for beneficiaries. The trainings provided to CRPs has resulted in effective identification of women and girls at nutritional risk, discerning the key demand and supply-side challenges and developing relevant, context-based approaches to mitigate such challenges. Evidence also suggests that there is an increased knowledge of food security safety nets and services amongst service providers across departments. However, the evidence on the degree of convergence of CRPs with service providers (specifically, PDS) to increase access to services (like ration cards) for beneficiaries is low and varied across states.

*A. Activities and associated capacity change*

**Desk review of existing documents and stakeholder interviews present strong evidence of UNICEF's technical support for developing locally relevant food safety nets and services across states.** The key activities and associated capacity change under this output area include (i) training of CRPs on IMP development, nutrition counselling, food demonstrations, nutri-sensitive agriculture; (ii) identification of 'at-risk' women and adolescent girls; (iii) fostering linkages with PDS and AWC services for ration and hot-cooked meals/THR; and (iv) facilitating monthly

meetings with groups of women and adolescent girls to disseminate messages on nutri-sensitive practices and services and conducting monthly home-visits with 'at-risk' women and adolescent girls.

Evidence of UNICEF support for training of CRPs on IMP development, nutrition counselling, food demonstrations and nutri-sensitive agriculture was strong across the three states. Findings from interviews with CRPs across all states show that CRPs received multiple rounds of training on development of IMPs which helped them to develop MSPPs. Primary data collected from CRPs provide evidence on multiple rounds of training for nutrition counselling and food demonstrations on topics such as *tiranga bhojan*, supplemental diet, adequate and timely food intake etc. They also received training on organising food demonstrations which focused on different recipes to cook nutritious food, especially THR, to make them more suitable and palatable to the requirements of the target beneficiaries. Secondary documents also provide strong evidence on training for nutrition counselling on topics such as the need to consume fruits and green, leafy vegetables, timely and adequate food consumption and micronutrient supplementation (Monica Shrivastav & Sethi, 2021). Additionally, CRPs also received multiple training sessions on low-cost, organic, nutri-sensitive agriculture through development of kitchen gardens focused on increasing diet diversity, chemical pesticide-free agriculture and reducing out-of-pocket expenditure on food. They also received trainings on using and maintaining registers for record-keeping on meetings, issues and tracking of target groups. Existing documents on *Swabhimaan* also mention that the majority of the CRPs received trainings on development of IMPs (N. Kumar et al., n.d.).

*"R: I received microplan training which was going on for 3 days in Koraput. I got trained by Sir. We were trained to eradicate our own problems and how to be disease-free from malnutrition it was also regarding cleanliness."*

- Poshan Sakhi, KII Respondent

Evidence from interviews and secondary data sources also support the claim that UNICEF's training support to CRPs aided in the identification of nutrition 'at-risk' women and adolescent girls across the three states. Interviews with *Poshan Sakhis* show that they received training on the use of MUAC tapes to assess the nutritional status of women and adolescent girls and identifying those at risk. Evidence from primary data and secondary documents show that CRPs had knowledge on how MUAC tapes could help identify at-risk individuals. They also added identifying at-risk by looking at physical appearance - 'slim', tired walk, swollen legs, paleness in face, lips, and nails. Some also added that BMI <18.5 is considered at risk (N. Kumar et al., n.d.). Data from different secondary sources also shows that PSs had received training on the use of MUAC tapes to identify at-risk individuals.

*"M: What facilities did you receive from these trainings?"*

*R: Tape to measure arm.*

*M: What did you learn from the training?"*

*R: If the length of the arm of pregnant women is more than 23 cm then she is healthy."*

- Poshan Sakhi, KII Respondent

We found strong evidence on monthly meetings with target groups facilitated by the PS from primary data as well as existing *Swabhimaan* documents. Interviews with PSs and discussions with target groups across all three states show that regular monthly PLA meetings were conducted with pregnant women, mothers of children under 2 years of age, newlywed women and adolescent girls on topics such as nutrition-related illnesses like anaemia, healthy eating habits, balanced diet, kitchen gardens, eating first and adequately, etc. Additionally,

*"M: Did Poshan Sakhi didi ever help you in getting ration cards?"*

*R: Yes, she did inform us about it whenever the process starts in block or nearby. Most ration cards are approved but few of them are not yet because of a name issue or ration cards still being linked to parents' ration cards."*

- Pregnant woman, FGD Respondent\*<sup>2</sup>

there is evidence to show that PSs conducted regular home visits for adolescent girls, who were anaemic, and for pregnant women who could not attend meetings to provide home-based nutrition counselling. Existing documents also provide evidence of PLA meetings being conducted monthly with all target groups across all three states on topics such as background information about the Programme and malnutrition, methods to identify malnutrition, issues

<sup>2</sup> \*Please note that the quotes from beneficiaries used in this report reflect their opinion and experiences of the benefits received from the *Swabhimaan* programme. At times, the beneficiaries might conflate other services provided through the SRLM and other programmes with *Swabhimaan* - however, the report quotes them verbatim.

related to it and solution/prevention which are counselling on kitchen garden, nutrition thali, *tiranga bhojan*, food demonstration, inclusion of green leafy vegetables in the diet, measurement using MUAC, etc. (N. Kumar et al., n.d.; Monica Shrivastav & Sethi, 2021; Sethi, n.d.).

**Increased knowledge on healthy food and nutrition practices:** Interviews with different respondent groups provided evidence of an increase in knowledge of identification of ‘at-risk’ individuals and consuming a balanced diet. Table 10 provides a summary of issues/areas where respondent groups reported an increase in knowledge.

Table 12: Reported increase in knowledge

Respondent group	Reported areas with increased knowledge
Poshan Sakhi	<i>Tiranga bhojan</i> , identification of ‘at-risk’
AWC worker	<i>Tiranga bhojan</i>
ASHA/ANM	<i>Tiranga bhojan</i> , identification of ‘at-risk’
Pregnant women	<i>Tiranga bhojan</i> , malnourishment – identification, eating hot food
Adolescent girls	<i>Tiranga bhojan</i> , kitchen garden – use and benefits
Newly married	<i>Tiranga bhojan</i> , eating hot food/ drinking warm water
Mothers of children under 2 years of age	<i>Tiranga bhojan</i> , malnourishment – identification

**Convergence with PDS dealers for IMP development:** There is weak evidence of Poshan Sakhis facilitating meetings with PDS dealers for IMP development to increase access to fair-price shops. While primary data shows that one PS in Chhattisgarh facilitated meetings between households and PDS dealers to get ration cards generated for those who did not have them and to ensure that all eligible households are receiving ration regularly, there is no evidence to substantiate the claim that PS engaged with PDS dealers to develop IMPs to increase access to ration cards and fair-price shops. Existing *Swabhimaan* documents show some evidence of PDS dealers participating in gap assessment exercises but no evidence of their participation in convergence meetings (N. Kumar et al., n.d.; ROSHNI, 2019a).

**PS-AWW convergence for increasing access to THR/hot-cooked meals:** There is mixed evidence on convergence between PS and AWWs for increasing access THR/hot-cooked meals at AWCs for target groups. While primary data shows some evidence of PS providing information on hot-cooked meals at AWCs and recipes for cooking THR through food demonstrations, there is limited evidence on what strategies were adopted by PSs to increase access to these services. However, secondary data shows that there is continued advocacy with ICDS to improve the uptake of THR/hot-cooked meals by target groups at AWCs across all three states (ROSHNI, 2019c).

### B. Behaviour change

**The evaluation found evidence of behaviour change related to consumption of nutritious food and supplementary ration, cultivation of nutri-sensitive produce in kitchen gardens and consumption of hot cooked meals at AWCs amongst target groups as well as behaviour change in food and nutrition habits of Poshan Sakhis.** Primary data shows that beneficiaries\*<sup>3</sup>, who attended PLA meetings and food demonstrations, changed existing food habits, adopted diet diversity (*tiranga bhojan*) and supplementary nutrition from THR and other healthy food and nutrition practices such as consumption of hot food, lukewarm water, keeping food covered, eating frequently, etc. Findings also show that pregnant women accessed AWCs for hot-cooked meals and were able to get timely information on getting ration cards made. Additionally, most target groups are engaged in nutri-garden related activities for self-consumption vis-à-vis the erstwhile practice of exclusively selling the produce in the market. We

“R3: Before *Swabhimaan* meetings, we would only eat rice and mandia. After attending these meetings, we are eating different types of food. We are eating rice, dal, curry, fried vegetables, etc.

R4: We use vegetables from our kitchen garden.”

- Adolescent Girl (10-14 years), FGD respondent

<sup>3</sup> \*Please note that the quotes from beneficiaries used in this report reflect their opinion and experiences of the benefits received from the *Swabhimaan* programme. At times, the beneficiaries might conflate other services provided through the SRLM and other programmes with *Swabhimaan* – however, the report quotes them verbatim.

also find some evidence that Poshan Sakhis, after receiving the training, changed food habits to include a more balanced diet.

These findings are also substantiated by existing documents where improvements were observed in consumption of *tiranga bhojan* and hot cooked meals amongst target groups. Additionally, some PSs also shared that they were not aware of their nutritional status and that they were underweight. After the trainings, they made changes to their diet and became healthy (N. Kumar et al., n.d.).

*Claim 2: How and to what extent has the Swabhimaan Programme had an impact on making health and nutrition (including reproductive health and family planning) services consistently and concomitantly available for adolescent girls and women?*

**Summary of Contribution:** The evaluation noted strong evidence on UNICEF's support efforts for increasing awareness on health and nutrition services amongst CRPs, FLWs and target groups for systems strengthening. While training provided to the service providers has resulted in effective identification of women and girls at nutritional risk, low convergence between the CRPs and service providers continues to pose a challenge in bridging the demand-supply gap. While evidence suggests that there is an understanding of individual roles and responsibilities amongst service providers, the uptake of activities requiring shared responsibilities such as participation in PLA meetings and community mobilisation for health camps and VHSND remains a challenge. The evaluation also finds strong evidence of increased knowledge of, and behaviour change for certain health and nutrition services such as IFA and calcium supplementation, balanced diet, and some reproductive health (RH) and family planning (FP) services such as early registration of pregnancies, use of condoms, birth spacing, and ANC check-ups.

#### A. Activities and associated capacity change

##### **Desk review of existing documents and stakeholder interviews present strong evidence of UNICEF's technical support for facilitating access to health and nutrition services across states.**

The key activities and associated capacity change under this output area include (i) training of service providers (ASHA, ANM, Supervisors and AWW) on PMP development, revised VHSND guidelines and MUAC tape usage; (ii) fostering linkages with ASHA, ANM and AWC services for IFA supplementation and registration for reproductive health and FP services through convergence meetings; and (iii) ensuring participation of target groups in VHND and other health camps.

*"R: They also provide training about health issue at the starting phase of pregnancy, what type of food and medicines we need to take to fulfil our bodily requirements like vitamin, calcium, minerals, pulses and green vegetables etc. for women and girls whose age is about 12-18 years."*

- ASHA worker, KII Respondent

Evidence on UNICEF support for training of service providers (ASHA, ANM, Supervisors and AWW) on gap assessments for PMP development and use of anthropometric tools, especially MUAC tape usage was strong across the three states. However, the evaluation found mixed evidence on training for revised VHSND guidelines. Findings from interviews with service providers across all states show that they received multiple rounds of trainings on food and nutrition requirements for different target groups (discussed in claim 1) as well as reproductive and family planning services such as vaccinations, use of condoms, birth spacing, ANC services, etc. The 3-year progress reports for *Swabhimaan* across the three states also mention that majority of the service providers received multiple rounds of trainings as a part of *Swabhimaan*. (Refer to Table 11 below).

Table 13: Summary of findings on training for service providers

Themes	Findings from primary data	Relevant findings from secondary data	Strength of evidence
<b>Training on MUAC tape for mothers</b>	Data shows that PS, ASHA, AWW, Supervisor, VO, CLF reported that they received training on	The use of MUAC tape as a tool to identify at-risk pregnant women was integrated into an ICDS programme in Chhattisgarh,	Strong

Themes	Findings from primary data	Relevant findings from secondary data	Strength of evidence
	MUAC tape usage to identify at-risk mothers	known as the <i>Mahatari Jatan</i> programme (N. Kumar et al., n.d.).	
<b>Training on revised VHSND guidelines</b>	Data does not provide any evidence of trainings being provided on revised VHSND guidelines	As per the State Annual Progress Update Reports of 2018, 100% of all 507 supervisory staff (including 79 ANMs and 8 LHVs) at the block-level, and frontline workers (FLWs) (includes 420 ASHAs) were oriented on the revised VHSND guidelines in Chhattisgarh. In Odisha, 100% of all 252 supervisory staff (ANM, LHV, MO/IC) and FLWs (ASHA) received orientation on revised guidelines. In Bihar, 66% of supervisory staff (ANM, LS) and 96% (256/265) of FLWs (AWW) were oriented on the revised guidelines (N. Kumar et al., n.d.).	Mixed
<b>Training of service providers (ASHA/ANM, Supervisors, AWW)</b>	Data shows that ASHA and AWW received training on identification of issues through gap assessments	The service providers of health and ICDS departments are being oriented at-least once each year (ROSHNI, 2020b).	Strong

### **Swabhimaan training sessions for service providers**

**Chhattisgarh:** In 2017, quarterly training of ANM and other service providers was not planned in the SRLM AAP for 2017-18. As per the AAP of 2018-19 to conducted training of health service providers, AWW were given one round of training. ANM training was not organized due to the strike of nurses. From 2019, the training for health service providers would be conducted biannually instead of quarterly plan. Two rounds of training of ANM and AWW were completed in 2019.

**Bihar:** In 2019, the health service providers (ANMs) were provided four rounds of training at PHC level during their scheduled monthly meeting to discuss guidelines on conducting sessions on *Arogya Diwas/VHSND* sessions and gaps identified from the microplanning and VO/CLF meetings. In 2018, the training for service providers was conducted during the scheduled monthly meetings of ANMs. Whereas in 2017, four rounds of training were conducted as planned for the service providers.

**Odisha:** In 2017, four rounds of training for health service providers were completed in both blocks. Whereas, in 2018, the trainings were conducted monthly during routine departmental meetings covering 100% ANM, ASHA, AWW. In 2019, no quarterly training sessions were planned for the health service providers under the annual action plan. The training sessions were conducted as an annual activity. Training for Pallahara block was completed in 2019, while training in Koraput Sadar training is pending, which is planned to be conducted in 2020.

*Source: 3-year Annual Progress Comparative Reports (2017-19)*

Findings provide mixed evidence on increased capacity amongst service providers to conduct different activities after they received training from *Swabhimaan*. While there is strong evidence to show increased access to and use of anthropometric tools to identify malnutrition, increased access to IFA supplementation and RH and FP services, there is mixed evidence to show that convergence between PS and FLWs for mobilising target groups for VHSND, health camps etc. is low. Table 12 provides a summary of the nature of capacity change amongst service providers.

Table 14: Capacity change of service providers

Themes	Findings from primary data	Relevant findings from secondary data	Strength of evidence
Increased access to and knowledge of the use of advanced anthropometric tools	Data from interviews with ASHA, AWW, Supervisors show that they received access to and training on different anthropometric tools such as MUAC tapes, weighing scales, temperature check watches, malaria kits, etc. to identify malnutrition and other illnesses	Refresher training for ANM, ASHA, AWW, and supervisors at their monthly meetings on the roles and responsibilities of service providers as per the revised VHSND guidelines was given. Training included the identification of women at-risk, weight gain monitoring, and micronutrient supplementation (IFA, deworming, and calcium supplementation) (ROSHNI, 2019a).	Strong
Increased access to IFA supplementation, RH and FP services	While there is limited evidence on increased access to IFA supplementation and RH services from service provider interviews, data from interviews with all target groups provides evidence on availability of iron folic, calcium, and deworming tablets at AWCs, registration of pregnancies at AWCs, provisioning of ambulance services during pregnancies, and family planning services	Action taken post gap assessment exercise with ANMs and supervisors in Bihar (July 2017 – June 2018) (ROSHNI, 2019a): <ul style="list-style-type: none"> <li>• Procurement of IFA red has been made and procurement of IFA blue is in progress</li> <li>• Calcium and albendazole have been made available</li> </ul> Privacy is maintained during antenatal check-ups	Strong
Mobilising target groups to participate in VHSND, health camps, etc.	There is limited evidence from supervisor interviews to show that ASHA and PS work together to mobilise target groups to attend VHSND for vaccinations and health check-ups	Secondary data shows that there is low convergence between PS and community health workers for mobilising target groups for VHSND, community health camps, etc. (Sethi, n.d.).	Mixed

The evaluation also found strong evidence on increased knowledge amongst target groups on different health and nutrition services. Table 13 provides a summary of issues/areas where respondent groups reported an increase in knowledge.

Table 15: Increased knowledge amongst target groups on health and nutrition services

Respondent group	Reported areas with increased knowledge
Pregnant women	IFA and calcium supplementation, ANC services, institutional delivery, use of condoms, balanced diet
Adolescent girls	IFA and calcium, anaemia, use of condoms, balanced diet
Newly married	IFA and calcium supplementation, birth spacing, use of condoms, balanced diet
Mothers of children under 2 years of age	IFA and calcium supplementation, use of condoms and copper T, vaccination, balanced diet

## B. Behaviour change

**The evaluation found strong evidence of behaviour change related to consumption of IFA and calcium tablets, iron rich foods, prevention of repeated pregnancies and improved birth spacing, delayed age at first pregnancy and access of ANC services and nutrition counselling amongst target groups.** Primary data shows that beneficiaries<sup>\*4</sup>, who attended PLA meetings, changed existing food habits and adopted diet diversity (*tiranga bhojan*) and micronutrient supplementation from IFA and calcium tablets. Additionally, amongst pregnant women, there is positive behavior change in terms of early registration of pregnancies at AWCs, ANC check-ups and institutional deliveries. For mothers of children under 2 years of age, evidence shows behaviour change in terms of provisioning of condoms and copper T to prevent unwanted pregnancies. For newlyweds, there is some evidence of delayed age at first pregnancy once they are identified by CRPs through home-visits. Lastly, for adolescent girls, there is behaviour change in terms of increased consumption of IFA tablets to prevent anaemia.

*"M: Why were you asked to consume iron tablets?"*

*R3: So that there is no shortage of blood in our body.*

*M: Did you consume or throw them?"*

*Rs: We consumed them."*

- Adolescent Girls (10-14 years), FGD Respondent

These findings are substantiated from existing documents where increased participation in PLA meetings resulted in higher chances of consumption of micronutrients across all the groups. For instance, consumption of IFA was 47% higher among adolescent girls and 78% among mothers. The chances of consumption of calcium were two times higher among pregnant women and more than 50% among mothers. The chances of utilization of health services were higher among pregnant woman and mother of children under 2 years who participated in program activities. For pregnant women, there was a 2-fold higher chance of check-up in first trimester and receipt of ANC. Apart from utilization of services, improvements in intake of diversified diet among pregnant and mothers was observed (Sethi, n.d.).

*Claim 3: How and to extent has the Swabhimaan Programme resulted in increased household access to drinking water and sanitation products/services and improved personal hygiene behaviours amongst adolescent girls and women?*

**Summary of Contribution:** The evaluation noted mixed evidence in UNICEF's support towards increasing household access to clean drinking water and sanitation products and services and strong evidence for improved personal hygiene behaviours amongst adolescent girls and women. While the training provided to CRPs and theme-based PLAs conducted by them have resulted in increase of knowledge of WASH practices and services amongst service providers and target groups, there is little evidence to understand how WASH-related issues are identified and incorporated into micro plans. Additionally, there is no evidence of linkages with VRF/other special funds for WASH. However, there is strong evidence to show improvements in certain WASH practices such as handwashing, reduction in open defecation and use of sanitary napkins (only for adolescent girls) across all states.

## A. Activities and associated capacity change

**Desk review of existing documents and stakeholder interviews present mixed evidence of UNICEF's technical support for facilitating access WASH services across states.** The key activities under this output area include (i) training of CRPs on IMP development; (ii) conducting PLA meetings for target groups; and (iii) promotion of use of loans from SHGs to construct WASH-related infrastructures.

The evaluation found some evidence from primary data on WASH-themed PLA meetings with target groups. Issues such as handwashing, maintaining cleanliness within the household as well as the surroundings, washing and drying clothes in the sun, boiling water before drinking, using sanitary napkins, methods to prevent malaria, etc. were discussed in these meetings. However, the evaluation could not find evidence from existing documents to support this activity.

<sup>4</sup> \*Please note that the quotes from beneficiaries used in this report reflect their opinion and experiences of the benefits received from the Swabhimaan programme. At times, the beneficiaries might conflate other services provided through the SRLM and other programmes with Swabhimaan – however, the report quotes them verbatim.

We found low evidence from primary data on training of CRPs to include WASH-related issues in IMP and promotion of loans from SHGs like VRF for constructed WASH-specific infrastructure across the three states. Secondary data sources show that WASH-specific issues identified under *Swabhimaan* through microplanning were provisioning of safe drinking water, waste disposal management, improved sanitation facility, access to sanitary napkins and open defecation. Additionally, the evaluation could not find substantial evidence from secondary data on CRPs receiving WASH-specific training for IMP development and VRF/other SHG loans being made available for WASH-related activities.

We found evidence from primary data on capacity change in terms of increased knowledge of WASH practices and services amongst CRPs, service providers and respondent groups. These have been summarised in Table 14 below.

Table 16: Associated knowledge increase for WASH practices and services

Respondent group	Increased knowledge of WASH practices/services	Increased access to WASH-linked products/services
CRPs	Handwashing, menstrual hygiene practices (appropriate usage and disposal of sanitary napkins), status of toilet construction and usage	Mapping of WASH services through village mapping
Service providers	Menstrual hygiene practices, personal hygiene practices (like washing clothes), status of toilet construction and usage	Linkage to Nutrition Rehabilitation Centres (NRC) for children with SAM, distribution of sanitary napkins to AGs
Target groups	Handwashing practices, menstrual hygiene practices, personal hygiene practices (like washing clothes, changing clothes, clipping nails, taking bath daily), boiling water before drinking, malaria prevention (reducing open spaces with stagnant water, sleeping under mosquito bed nets), keeping surroundings clean	Access to sanitary napkins, malaria prevention kits

### B. Behaviour change

#### The evaluation found strong evidence for improvement in certain personal hygiene practices amongst adolescent girls and women.

Primary data<sup>5</sup> shows positive changes were observed in handwashing practices, use of sanitary napkins during menstrual cycles, consumption of clean (boiled) drinking water, maintaining cleanliness of surroundings as well as other personal hygiene practices such as bathing regularly, wearing washed clothes, clipping nails, etc. From existing *Swabhimaan* data, the evidence shows improvements in some key WASH practices (like use of sanitary napkins, open defecation, and handwashing) for adolescent girls, pregnant women, and mothers of children under 2 years across the three states between the 2016 and 2021 in the intervention areas. The data shows (i) an increase in the percentage of adolescent girls using sanitary napkins during periods, (ii) an increase in percentage of all target groups living in households with members practicing handwashing after defecation, and (iii) a decrease in the percentage of all target groups living in households with members practicing open defecation across the three states (Refer to Figure 12).

*M: How many types of hand washing techniques do you know?*

*R1: S.U.M.A.N method.*

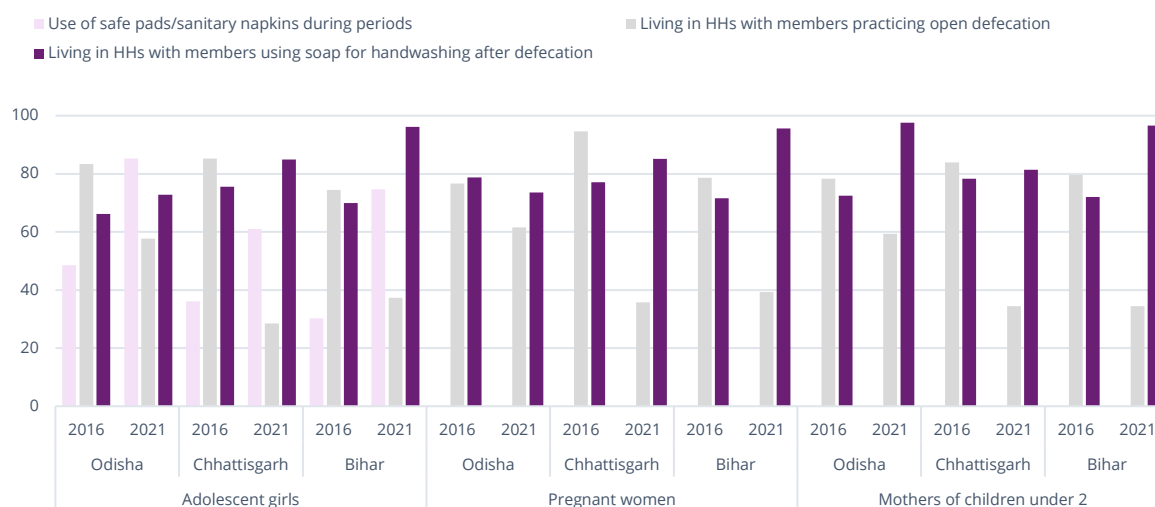
*M: What have you been told regarding toilets?*

*R1: To wash hands with soap after using toilet and dry with a clean cloth.*

- Adolescent Girls (15-19 years), FGD Respondent

<sup>5</sup> \*Please note that the quotes from beneficiaries used in this report reflect their opinion and experiences of the benefits received from the *Swabhimaan* programme. At times, the beneficiaries might conflate other services provided through the SRLM and other programmes with *Swabhimaan* – however, the report quotes them verbatim.

Figure 12: WASH practices



Source: IIPS Swabhimaan online factsheets

*Claim 4: How and to what extent has the Swabhimaan Programme contributed to increased know-how on nutri-sensitive agricultural practices at district and sub-district levels and their application at village-level?*

**Summary of Contribution:** The evaluation noted mixed evidence of UNICEF's support towards increasing know-how on nutrition sensitive agricultural practices and their adoption at the village-level. While training support to VRPs has resulted in an increase in awareness and knowledge of nutri-sensitive agricultural practices amongst target groups, evidence shows that certain activities such as convergence with KVKs, creation of nutri-gardens as demonstration sites at CLFs and development of farmer groups were planned but either not initiated or not implemented as per timelines. In terms of adoption, findings provide strong evidence on adoption of kitchen gardens and organic farming at the household-level and improvements in behaviours/practices around production for self-consumption versus selling the entire produce. However, the evaluation found no conclusive evidence on adoption of specific micronutrient cropping and pesticide-free cropping methods.

#### A. Activities and associated capacity change

**Desk review of existing documents and stakeholder interviews present mixed evidence of Swabhimaan's technical support in increasing know-how on nutrition-sensitive agricultural practices and their application at the household-level across states.** The key activities under this output area include (i) training of VRPs (*Krishi Mitras*) on nutri-sensitive agricultural practices (in convergence with KVKs); (ii) conducting PLA meetings to discuss nutri-sensitive agricultural practices; and (iii) setting-up nutri-gardens at household-level; and (iv) creation of nutri-gardens at CLFs as demonstration sites.

*M: Have you ever received training for nutri-gardens?*

*R: Yes, I received training.*

*M: What training you have received for nutri-gardens?*

*R: To grow vegetables like Palak, Methi in small boxes."*

- Kishori Sakhi, KII Respondent

Evidence from primary and secondary data sources found mixed evidence on training of VRPs on nutri-sensitive agricultural practices in convergence with KVKs. While data from primary data was limited, secondary data shows that VRPs were identified and trained during 2017-19 across the three states (ROSHNI, 2019c, 2019a, 2019b). However, we found limited evidence on convergence with KVKs from primary or secondary data.

The evaluation found evidence of VRPs conducting PLA meetings with target groups/farmers groups on nutri-sensitive agricultural practices from both primary and secondary data. Evidence shows that VRPs provided information to target groups on organic farming methods and techniques on developing nutri-gardens.

Findings from the evaluation also provide strong evidence of VRPs providing support to target groups/famer groups for setting up nutri-gardens. Primary data shows that VRPs developed demo fields/gardens to help target groups understand how to develop nutri-gardens in their households. They also provide assistance on backyard poultry such as provisioning of hens for rearing and consumption for at-risk households. This is supported by secondary data where VRPs were trained to support home-based *Poshan* beds/backyard poultry in all three states between 2017-19 (ROSHNI, 2020b, 2020c, 2020a). However, the evaluation found no evidence of nutri-gardens set-up at CLFs as demonstration sites.

The evaluation also provides mixed evidence on increase in awareness and knowledge of organic manure, multi-cropping, and locally relevant food groups amongst VRPs and target groups. Primary data shows that VRPs and target groups across the three states were aware about organic fertilisers and how to use them. They were also aware about how to best utilise small plots of land to grow multiple types of crops. Additionally, they were also aware about the locally available items in the different food groups namely animal-source foods (meat, poultry, fish, and egg), pulses (beans, peas, and lentils) and nuts or seeds, and dark green leafy vegetables and other vitamin A-rich fruits and vegetables. Secondary data (i.e., PLA modules for farmers across the three states) also provide information on the above-mentioned topics.

*"If we take 20 by 20 feet of a small field, we will make a drainage system in between and we will make 5 small fields and we sow varied kinds of vegetables and crops in those small fields. And we plant mustard and broad beans all around the field to attract worms and insects that may otherwise have attacked the crops."*

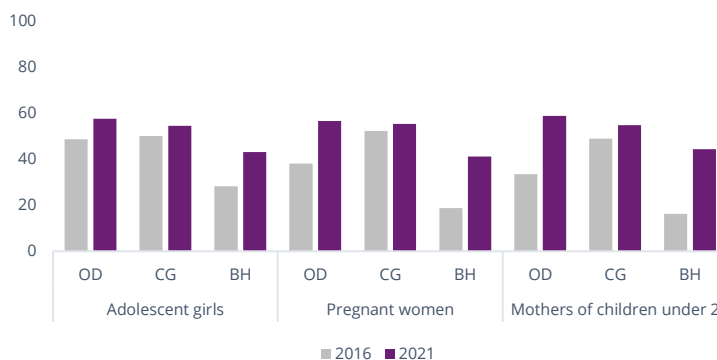
- VO President, KII Respondent

### B. Behaviour change

#### **The evaluation found strong evidence for increase in the number of households with kitchen gardens and improvements in self-consumption of produce from kitchen gardens.**

Primary data shows that target groups that received information on and support for development of kitchen gardens and had land available in their backyard, developed kitchen gardens (as detailed in claim 1). Findings also show an increase in self-consumption of produce from kitchen gardens which is a departure from the erstwhile practice of selling the entire produce. Existing *Swabhimaan* data also shows improvements in in the percentage of target groups living in households with kitchen gardens from 2016 to 2021 across the three states (Refer to Figure 13). However, the evaluation could not find any conclusive evidence on target groups becoming members of producer groups, adopting at least one mixed micronutrient cropping method and at least one pesticide free agricultural method from primary or secondary data.

Figure 13: Target groups living in households with kitchen gardens



Source: IIPS *Swabhimaan* endline factsheets

#### *Claim 5: How and to what extent has the Swabhimaan Programme contributed to the capacity building of VOs and CLFs?*

**Summary of Contribution:** The evaluation noted weak evidence in UNICEF's contributions towards building capacities of VOs and CLFs to conduct programme activities across the three states. While primary data was limited for this claim, secondary data provides some evidence to show increased capacities amongst VOs and CLFs to generate demand for services through (i) identification of local FNHW issues and challenges through PLA meetings, (ii) development of IMPs with target groups, and (iii) mobilisation of target groups for community events like VHND and health camps. However, the evaluation finds limited evidence to present increased capacities within VOs and CLFs to address supply-side issues through convergence with other stakeholders/line departments.

A. Activities and associated capacity change

**Desk review of existing documents and stakeholder interviews present weak evidence of Swabhimaan's contribution in building capacities of VOs and CLFs across the three states.** The key activities under this output area include (i) consolidation and annual review of micro plans from all levels; (ii) monthly/quarterly review of VOs and *Poshan Sakhi* and *Kishori Sakhi* on their monthly progress; (iii) conducting annual entitlement camps; (iv) meeting for newlyweds by CLF; (v) setting-up of demonstration sites/farmer field schools; (vi) organizing quarterly/biannual/annual recreational activities for adolescent girls; and (vii) mobilising target groups for VHSND/AHD through SHGs.

While evidence from primary data on the above-mentioned activities is limited, secondary data sources provide strong evidence on the status of completion of each activity. Data shows that activities such as the development and review of IMPs, training of cadres, monthly PLA meetings with target groups and monthly home-visits for at-risk households were conducted regularly. Table 16 provides the state-wise progress of VO and CLF-led activities.

*"Through Swabhimaan, we can organize meetings. We review the work done by Poshan Sakhi and Kishori Sakhi every month. We can now check what has improved in our area."*

- CLF president, Bihar

Further, primary, and secondary data sources present some evidence of increased capacities of VOs and CLFs to conduct the activities mentioned above. Some of the key areas where capacity change was observed from primary data are presented in Table 15.

Table 17: Associated capacity change for VOs and CLFs

Respondent group	Increased capacities to conduct Programme activities
<b>VO</b>	<ul style="list-style-type: none"> <li>• Ability to identify issues related to FNHW</li> <li>• Ability to organize PLA meeting on FNHW issues</li> <li>• Ability to anchor activities</li> <li>• Mobilisation for VHSND</li> <li>• Mobilisation for health services (including RH services)</li> <li>• Capability to link target groups with nutri-sensitive interventions</li> </ul>
<b>CLF</b>	<ul style="list-style-type: none"> <li>• Ability to review Programme activities</li> <li>• Ability to anchor Programme activities with limited support</li> <li>• Ability to converge with FLWs, Gram Sabha and PRI</li> </ul>

Table 18: Progress of VO and CLF-led activities – Progress update 2019

Activity	Chhattisgarh Bastar	Odisha Koraput Sadar	Pallahara	Bihar Jalalgarh and Kasba
<b>VO-led activities</b>				
Annual review of IMP (N=1 per VO)	Done	Done	Done	Done
Monthly PLA meetings at VO (N= 12*No. of VOs)	44% <i>Maitri baithaks</i> 43% <i>Kishori baithaks</i> 25% <i>Parivar choupals</i>	94% <i>Maitri baithaks</i> 54% <i>Kishori baithaks</i>	98% <i>Maitri baithaks</i> 69% <i>Kishori baithaks</i>	64% <i>Maitri baithaks</i> 82% <i>Kishori baithaks</i>
Monthly home visits to at-nutrition risk women and adolescent girls (N=No. of at-risk identified)	100%	100%	100%	91%

Activity	Chhattisgarh Bastar	Odisha Koraput Sadar	Pallahara	Bihar Jalalgarh and Kasba
Fortnightly/monthly food demonstration or group counselling sessions for at-nutrition risk women (N=No. of VO) ^/ (N=No. of at-risk attending food demonstrations) #	100%^ (completed as one-time activity)	98%# (Revised frequency to quarterly)	100%# (Revised frequency to quarterly)	100%#
Regular village drives (N= No. of drives planned*No. of VOs)	100%	100%	100%	64%
Monthly Farmers' PLA meeting (N= 12*No. of VOs)	67%	VRP-led interventions not planned	VRP-led interventions not planned	29%
Monthly support to home-based nutrition gardens/backyard poultry (N=No. of HHs of at-risk target group)	100%	VRP-led interventions not planned	VRP-led interventions not planned	86%
SHG members to mobilise family members for VHND services (N= No. of target women who attended VHSND; N=Total no. of target groups)	62%	Data not available	Data not available	93%
SHG members to mobilise adolescent girls for AHD (N= No. of target AG who attended AHD; N=Total no. of target AG)	< 30%	Data not available	Data not available	34%
<b>CLF-led activities</b>				
Linking of at-risk target groups to agri-poultry and social protection schemes (monthly) (N=No. of HHs of at-risk target group)	11%	53%	74%	100%
Development of farmer field school sites or community KVKs (monthly) (Y/N)	Not planned	Not initiated (However, nutri-farms developed at GPLF-level)	Not completed (However, nutri-farms developed at GPLF-level)	Y (N=2)
Training of cadres on PLA (quarterly) (N=4)	100% <ul style="list-style-type: none"> <li>PLA women phase 2 and 3</li> <li>PLA adolescent girls' phase 2</li> <li>PLA farmers phase 3</li> </ul>	100% (Training is conducted annually and is completed. No VRPs trained as training of VRPs not in plan)	100% (Training is conducted annually and is completed. No VRPs trained as training of VRPs not in plan)	100%
Organize health and entitlement camps (biannual) (N=2 per VO or CLF)	100%	0% (as per OLM AAP)	100% (as per OLM AAP)	Not completed (2 each completed)
Organize meeting for newlyweds (biannual)	Not planned	53%	89%	100% (organized annually)

Activity	Chhattisgarh Bastar	Odisha Koraput Sadar	Pallahara	Bihar Jalalgarh and Kasba
(N=No. of meetings planned)				
Review IMPs of each VO (annual) (N=No. of VOs)	90%	Not done	Not done	100%

Source: 3-year Annual Progress Comparative Reports (2017-19)

### B. Behaviour change

**The evaluation found some evidence of adoption of food, nutrition and WASH practices and increase in perceptions of self-confidence amongst CLF and VO members.** Primary data shows that CLFs and VOs that were trained adopted balanced diets and handwashing practices. There is also an increase in their perceptions of self-confidence in terms of being able to engage with larger groups and negotiating within their households. The evaluation was not able to find similar evidence from secondary data sources for these behaviour changes with respect to CLFs and VOs.

*“My confidence has increased when I used to go from one village to another and talk amidst everyone. Even in my own home, I can explain to everyone what is right, what should be done and what should not be done.”*

- VO President, KII Respondent

### 3.3.2 What were the key challenges faced in implementation of activities under the strategy?

Respondents interviewed at the state and district levels reported a few challenges that hindered the implementation of the Programme, whereas community cadres and beneficiaries relayed challenges in conducting activities and following advice and practices learned from *baithaks*. Hindering factors reported by implementers include delays and limitations in conducting field activities due to COVID-19, which are explained in Section 3.3 (Effectiveness) and Section 3.4 (Efficiency). Supply-side challenges were also reported- medicines and supplements such as IFA tablets were in short supply and held up in different areas due to the poor distribution network and other logistical issues. This resulted in delayed provision of the same to *Kishori* groups and erratic consumption by adolescent girls since there was not enough time to strongly establish the behaviour change by the end of the Programme.

State-level staff involved in Programme implementation and monitoring also highlighted issues related to the time taken to establish processes and systems. For example, facilitators needed time to understand manuals and guidelines and understand the process of developing IMPs and prioritising interventions. Similarly, the process of escalation of issues from VOs to CLFs was reported to take some time to establish. Implementers also reported that convergence meetings were conducted as mandated but coordination to deliver such services were not as efficient or self-motivated.

Community cadres noted that in some instances, there was dissolution of benefits intended for target group. One respondent recalled that in a meeting to provide financial aid to at-risk women, women who were not part of the identified group demanded that they also be given financial assistance. Although the CRPs tried to explain the scheme protocols to the group, some of the women still had to be given the money. They also noted that establishment of kitchen gardens were difficult in some cases since women did not have enough land to do or due to issues around water logging and water supply, especially in summers. CRPs highlighted that they faced much resistance in convincing beneficiaries of information that were against traditional practices such as abstaining from consumption of certain food items during pregnancy. Low frequency of participation in *baithaks* were reported in some areas, especially for adolescent girls. The impact evaluation provides further confirmation of lower participation and hypothesises that this could also be because of recall bias.

Challenges relating to establishment of kitchen gardens reported by CRPs were also confirmed by beneficiaries. In addition, beneficiaries reported that although their knowledge and importance of appropriate food and WASH behaviours had increased, they were often unable to practice these due to income constraints. The hindering factors discussed above are summarised in Table 17 below.

Table 19: Hindering and Accelerating Factors

Thematic category	Hindering Factors	Accelerating Factors
Contextual Factors	Poor supply chain for distribution of medicines and supplements	Other programmes focusing on nutritional and health behaviours
	Limited land availability and issues related to water supply/ water logging for kitchen gardens	
	Resistance to acceptance of information against traditional social norms	
	Financial constraints	
Implementation factors	Dissolution of benefits	Convergence approach
	Poor participation/ irregular attendance of women in <i>baithaks</i> , especially in those for adolescent girls	Selection of community cadres from local communities extended relevance and acceptance of the Programme
	Longer timeframes for establishment and practice of implementation and reporting protocols	

Source: Developed by authors based on primary data

Respondents at various levels also reported some accelerating factors that contributed to achievement of Programme results. Other schemes and policies focusing on improved nutritional and behaviour changes were noted to be in progress in the study areas during the time of implementation of *Swabhimaan* which helped to reinforce positive messaging around related behaviour changes. Stakeholders and beneficiaries highlighted the benefits of the convergence approach in some cases with the presence of ASHAs or ANMs in *baithaks* improving the credibility of the information shared. The selected cadre of local resources persons were highlighted to be the most important catalyst by stakeholders at the state level. These CRPs were aware of pressing challenges in their communities and had easier access to women in their areas.

## 3.4 Efficiency

The section discusses the efficiency using Follow-the Money (FTM) approach. The FTM method comprises tracking expenditures allocated to the project and assigning them to the corresponding outputs. This section discusses the timelines of the Programme and its cost-efficient implementation across three dimensions: a) allocation of resources, b) utilisation of resources, and c) timeliness of interventions and its adequacy

**Evaluation Finding:** The Programme activities for *Swabhimaan* were implemented in a timely manner, apart from the delays arising due to COVID-19. In-person meetings were stopped, however the delivery of dry ration and door-to-door counselling for at-risk populations was continued. New methods of monitoring progress and providing service delivery were used, such as tele counselling, WhatsApp groups and telemonitoring. The funding for the activities was found to be adequate, and SRLM funds continued the scale-up of *Swabhimaan*. UNICEF technical resource persons played a major role in successful implementation of *Swabhimaan* and trained the SRLM staff. For monitoring, a combination of approaches such as MIS, field visits and telemonitoring during COVID-19 was used.

### 3.4.1 To what extent was the Programme implemented in a timely manner? What were the key factors that affected delays in implementation? How did pandemic affect overall timelines?

**Stakeholder interviews show that most activities were implemented within the stipulated timeframe, with delays arising due to COVID-19 related restrictions.** However, anecdotal evidence suggests that the process indicators were largely not affected by the pandemic. These claims are further reinforced by the improvement observed in coverage of nutrition service indicators at endline. These changes are summarised under Section 3.6 (Impact). However, reporting in the form of block reports was delayed in Odisha due to coordination issues. The Master Bookkeepers have to collate reports from individual *Poshan Sakhis* from the villages. Since this process is often delayed at the village (*Poshan Sakhi*) level, the reporting at the block and gram panchayat level is also affected. *Swabhimaan* is trying to solve this challenge by providing documentation support to *Poshan Sakhis* through the Village Organisation, and by providing tablets to the Master Bookkeepers to help digitise the reporting process.

Some areas of implementation faced external difficulties in achieving timeliness, which were highlighted by stakeholders. For instance, the delivery of IFA tablets in Bihar to certain remote areas and in Koraput, Odisha was affected by supply chain management issues. In the instance of Koraput, primary interviews evidenced that initially there was a supply shortage of IFA tablets. Following the resolution of this issue, the drug houses store the IFA tablets, and approvals took time to clear the IFA tablets from the District Drug House. After that, the clearance from the CDPO office took time, so the IFA tablets were stuck there. These issues were systemic – IFA supplements initially faced a supply shortage, and later lacked clearance from various government offices, leading to an overall delay in their distribution. Due to the non-availability, the target beneficiaries would disperse, and stakeholders highlighted that the *Balika Mandal* groups needed to be reformed – which was a time-intensive activity.

Mixed views were shared regarding timely implementation of planning during the pandemic. Even during the pandemic, the states have continued their support and efforts for them to ensure continuity of interventions as per plan as mentioned by Programme implementors. Majority of the Programme implementers interviewed were of the opinion that the activities related to supply of health products (such as IFA tablets, calcium tablets, deworming tablets etc.) were never stopped, as health products comes under essential services. Align to this, beneficiaries also confirmed they have received the tablets as well as vaccination during the pandemic. The major affected activities, as reported by beneficiaries during interview were monthly meetings for women and girls and access to hot cooked food. In Odisha, stakeholders testified that recruiting community cadres was a challenge at the block level in the areas where *Swabhimaan* was being scaled up, and a backlog of recruitment was created. AWWs reported that female beneficiaries developed misconceptions around the COVID-19 vaccine, believing that it would interfere with their ability to reproduce. AWWs countered these beliefs by vaccinating their own children, to increase trust among the community. Despite the constraints, they mentioned receiving dry ration during the pandemic. The implementor and beneficiaries mentioned that check-ups were done by visiting door-to-door. This was challenging for the service providers since they were met with resistance from the beneficiaries during the initial days of the pandemic.

Certain activities such as convergence meetings were disrupted at the state level. Stakeholders reported a bureaucratic lag due to conflicting priorities in the schedules of government officials across departments. The difficulty in scheduling convergence meetings at the state level was observed before COVID-19, but the pandemic led to deprioritisation of meetings due to other state responsibilities to be carried out by government officials. The challenges related to funding are discussed in the section below.

*"We were not able to organise meetings and faced problem in calling women for meetings. When we visited their house, they showed us sticks to beat us. Iron tablets were not available at that time."*  
-ASHA worker, KII Respondent

*"The family members warned us not to go out or meet anyone. But I stitched some masks myself and bought soap with my own money and went with health workers and distributed it. We maintained contact with the beneficiaries over phone during the pandemic."*  
-Supervisor, KII Respondent

### 3.4.2 Were funds sufficiently allocated for Programme implementation? What was the fund transfer mechanism? Were they disbursed on time at every level based on the plans? What were the inefficiencies and bottlenecks?

**The evaluation found that the funds for Programme implementation were sufficient and timely, especially in the pilot stages. Fund disbursement faced some setbacks during the COVID-19 pandemic.** Stakeholders across all levels confirmed that project expenditure had been on track during implementation and reported adequateness of funds to carry out planned activities. Stakeholders at state-level involved in programming mentioned that the fund was sufficient as it was for limited areas (intervention and control), implying limited panchayats and beneficiaries within a state. They also opined that the Programme aimed to strengthen the existing system and activities so planning of financial and human resources were done accordingly within budget limits. They further mentioned that the convergence meetings and involvement of different departments in the initial planning/inception phase of Programme and budget allocation helped them to plan to avoid duplications. UNICEF primarily worked as a technical partner and has more contribution to Programme design (building technical and knowledge content for the Programme delivery), implementation and evaluation. *Swabhimaan* has leveraged financial support from state governments and UNICEF state offices for implementation since 2016. The Programme was funded by UNICEF in Bihar, which acted as the learning and demonstration site for *Swabhimaan*. In Odisha and Chhattisgarh, the Programme was mostly funded by the respective SRLM (*Bihan* in Chhattisgarh and Odisha Livelihood Mission (OLM) in Odisha). The ratio of UNICEF's financial contribution to that of SRLM in Chhattisgarh and Bihar (JEEViKA in Bihar) was estimated to be 1:5. During the evaluation, stakeholders reported that *Swabhimaan's* model of leveraging public funds was highly effective.

**The evaluation found that the SRLM funds were adequate for planning and implementation of the scaled-up Programme, and UNICEF supported SRLM in case of delays.** Stakeholders described that the SRLM funds were used to provide the *Poshan Sakhis* with kits which contained tools for participatory discussions during the monthly meetings. Beneficiaries received a specific apron for the *Swabhimaan* Programme, as well as modules regarding microplanning printed through the SRLM funds. The kit took some time to procure, hence UNICEF provided the funding for kits to be distributed to master trainers, so that the training could be accelerated in the scaled-up areas.

**The evaluation noted that the funds allocated for FNHW work faced external challenges at the national level.** FNHW funds flow from the national to the state level and are then allocated directly to CLFs on the action plans they submit. Action planning at the CLF level halted due to the COVID-19 pandemic, therefore releasing funds became an issue for the areas in which *Swabhimaan* was being scaled up. The pandemic also brought about challenges related to achievement – for instance, the DPMS were overburdened with conflicting priorities and could not solely focus on *Swabhimaan*. The shortfall of funds at the state level required activities to be clubbed together and required greater national support for FNHW activities to be reprioritised.

Stakeholders testified that the VRF community cash grant was important in addressing the needs of vulnerable communities. Angul and Koraput performed better in leveraging the VRF community cash grants, however the funds in other scale-up areas had to be reduced due to the COVID-19 pandemic.

The Programme costs USD 5.75 million (Table 18) from 2015 to 2021, with USD 0.03 million spent on preparatory and conceptualisation phase (2015-16). This cost includes the scaled-up blocks in the three states. The Programme has

been scaled-up within the states to 22 additional resource blocks in nine districts through 142 women’s groups federations across the three states. Additionally, to provide institutional support to the Programme for knowledge management, process monitoring and documentation to inform scale-up through national and state governments, a budget of USD 0.45 million is allocated to ROSHNI Centre. Annexure 2 provides year-wise budget for the *Swabhimaan* Programme by UNICEF and SRLM.

Table 20: Total Programme Cost (in USD Million)

State	SRLM	UNICEF	Consolidated
Bihar		0.43	0.43
Chhattisgarh	0.94	0.33	1.27
Odisha	3.54	0.51	4.05
<b>Total</b>	<b>4.48</b>	<b>1.27</b>	<b>5.75</b>

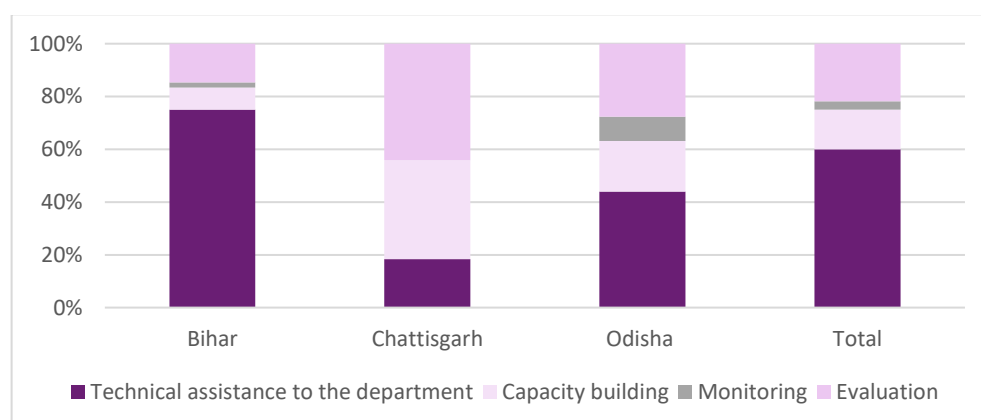
Source: Internal Programme documents

Overall, the financial resources were used for three major activity-related expenditure as follows:

- **Implementation-related expenditure:** This includes personnel cost (such as salaries of officials at state/district/block levels, stipends to officials from other department especially during convergence and review meetings, cash incentives to CRP/VO/SHG/ KS/PS/MM etc.), cost of preparing IMPs, cash/loan allowances to beneficiaries etc. The financial incentives paid to CRPs, VO/CLF varied across states and are decided by the SRLMs (State progress reports).
- **Training and capacity building-related expenditure:** This includes expenditure incurred on trainings to community cadre (such as CRP, KS/PS/MM, ASHA/ANM) on developing the *Poshan* micro plan (grants to CRPs only), understanding of IMP, about identification of ‘at nutritional risk’, conducting food and kitchen garden demonstration session, establishing kitchen garden for demonstration at VO level, teaching use of MUAC tapes for identification of at-nutrition risk beneficiaries, preparing ‘welcome kit’ to be given to newlywed couples (with essential items such as IFA, contraceptives, sanitary napkins etc.), developing farmer training school sites (only in Bihar) and on participatory learning action. This component also includes expenditure made on providing weight measurement tools, MUAC tapes, newlywed kit, seed for kitchen gardening, cost of training venues, printing IEC materials etc.
- **Research-related expenditure:** This includes the scoping study, fidelity study, progress reports, evaluation (baseline, midline, endline) of the Programme etc. The overall budget for baseline survey of *Swabhimaan* was USD 0.23 million and for midline evaluation USD 0.19 million and for endline USD 0.19 million.

As per the direction of expenditure flow, the last two parts were explicitly covered from UNICEF fund. On average, 75% of UNICEF fund was spent on implementation activities (technical assistance and capacity building). Further break-up of expenditure incurred was not available. However, based on the information in progress reports, we found that a large amount is spent for

Figure 14: State-wise UNICEF-budgeted contribution for the *Swabhimaan* Programme



Source: Progress reports

incentives to consultants/CRPs followed by expenditures made on capacity building, organising convergence meetings and expenditure on IEC material (Figure 14). As Bihar was the learning and demonstration site for *Swabhimaan*, it has the highest expenditure on technical assistance (75%).

Due to different components in cost and variations in activity per cost across states, the calculation of unit cost expenditure for beneficiary in total or by category (pregnant, women, adolescent girls, newlywed) was difficult to measure. At community level, most cost intensive and complex grant management activities are led by CLFs in all states. State-wise variations are observed in the grants provided for different activities, as documented in annual state progress reports. Addition to all these activities, the cadre are trained about government schemes, which they explain to beneficiaries. Some of these are vulnerability reduction fund, widow pension scheme, scheme related to livestock rearing, kisan credit card, scheme for girls' marriage allowance, scheme for providing money on childbirth as shared by a KII respondent. This is also confirmed from the group discussion interviews with beneficiaries, a few testimonies from FGD are presented below as evidence.

*"PS Didi helped us to get card [Mother Child Card]. I receive 6000 INR on birth of my first child in two instalments"*  
Newly Married, FGD respondent\*<sup>6</sup>

*"The economically weaker section received 500 rupees on Jandhan".*  
Village Officer, KII respondent

*"I received 35000 INR loan for my operation (medical expenses), some of this I spent on house. I was delaying operation due to money, but KS didi [sister] informed me about the loan scheme [vulnerability reduction fund]"*

Mother of children age under two years, FGD Respondent\*<sup>7</sup>

### 3.4.3 Was the utilisation of available human resources efficient? Were sufficient human resources allocated and utilized from UNICEF and SRLM in each year of the implementation period? (Factors like responsibilities, workload, knowledge, skill, capacity, leadership, stability, commitment, attrition etc.)

**The evaluation found that UNICEF's nodal persons across the Programme districts played a major role in ensuring effective implementation of the activities.** Government partners reported that the UNICEF nodal persons working with the SRLM would be aligned with the needs of the Programme on various areas such as agriculture, nutrition, health etc. The SRLM staff, young professionals, and UNICEF's nodal staff, worked together as a team. Their progress was monitored through the SRLM. Government stakeholders also reported that the timeliness of Programme activities was dependent on the role played by UNICEF consultants in ensuring regular review takes place. Their reporting assisted overburdened government employees, through the compilation of timely reports highlighting areas that needed focus and greater support. This allowed the government staff to be compliant and improvise in executing *Swabhimaan's* activities.

**SRLM human resources allocated for the pilot programme of *Swabhimaan* were found to be adequate.** Stakeholders reported that with regular training and support of the community cadres and service providers, the *Swabhimaan* Programme's implementation was implemented effectively. However, some stakeholders expressed that as the Programme was scaled up, there was a need for more resource persons to be added to support the increased number of Gram Panchayats covered under the Programme.

However, certain stakeholders noted that areas such as Institutional Building and Capacity Building (IBCB) have greater numbers of Young Professionals embedded in their programmes, which they can leverage through the UNICEF structure. It would be useful for *Swabhimaan* to have an increased number of Young Professionals in the structure, who could be

*"In the reporting structure, the nodal persons from UNICEF in the districts played a major role in making sure that the Programme was on-track and being reviewed regularly."*

- Government Stakeholder, KII Respondent

<sup>6</sup> \*Please note that the quotes from beneficiaries used in this report reflect their opinion and experiences of the benefits received from the *Swabhimaan* programme. At times, the beneficiaries might conflate other services provided through the SRLM and other programmes with *Swabhimaan* – however, the report quotes them verbatim.

<sup>7</sup> \*Please note that the quotes from beneficiaries used in this report reflect their opinion and experiences of the benefits received from the *Swabhimaan* programme. At times, the beneficiaries might conflate other services provided through the SRLM and other programmes with *Swabhimaan* – however, the report quotes them verbatim.

trained at the state level through UNICEF. Another suggestion was to have at least one nodal point at the district level focusing on FNHW. This is discussed in greater detail in Section 3.5 (Sustainability).

UNICEF India supports human resource at state and block levels (Table 19), but none at the VO level in all states with aim to gradually lessen its support or hand over to the mission. UNICEF India's support on human resource will gradually lessen. The supporting human resources structured for providing technical assistance and field supervision.

Table 21: *Swabhimaan Implementation human resources structure*

Level	Designated personnel for <i>Swabhimaan</i> implementation by SRLM	Designated personnel for <i>Swabhimaan</i> implementation through UNICEF		
		Bihar	Chhattisgarh	Odisha
<b>State project management unit (SPMU)</b>	State Programme manager: health and nutrition	One consultant	State <i>Swabhimaan</i> consultant State scale-up manager and State level documentation	State Programme coordinator and State MIS coordinator for <i>Swabhimaan</i> through UNICEF
<b>District project management unit (DPMU)</b>	District Programme manager,	Five consultants	None	None
<b>Block project management unit (BPMU)</b>	Two block Programme managers	<i>Swabhimaan</i> supervisor (one for 5–7 VOs)	2 pilot and 2 scale up Block Level Coordinators (total 4)	Four block coordinators for <i>Swabhimaan</i>
<b>Cluster-level federation (CLF)</b>	Office bearer of cluster-level federations	<i>Poshan sakhis</i> (one for each VO) <i>Kishori sakhi</i> (one for each VO)	16 Cluster level Mits	None
<b>Village organisation (VO)</b>	Office bearer of village organisations	None	None	None
<b>Self-help group (SHG)</b>	Office bearer of self-help groups	None	None	None
<b>Farmer's groups</b>	VRP or <i>Krishi Mitras</i>	2 resource farmers	None	None

Source: Drawn from Progress report of programme of each state

**3.4.4 How was review and reporting done to identify and address inefficiencies or leakages in the Programme interventions? Was it timely and useful? What were the challenges? Can this process be integrated and continued without external support? How can it be made more efficient from the present manner?**

**Various mechanisms such as MIS, monthly progress reports, micro plans, monitoring visits, WhatsApp groups, VO meetings and telemonitoring were used to track the efficiency of the Programme.** The MIS used to capture insights if *Swabhimaan* related activities is standardised across states, as it is designed at the national level. However, stakeholders feel that to capture granular field-level data, it is important to have a parallel MIS system which can incorporate relevant FNHW indicators. For instance, Odisha is currently designing a phone-based MIS to capture these specific insights. The MIS data helps inform the convergence meetings – which stakeholders feel lacks structure presently.

**The evaluation found that convergence meetings function as planned at the district and block levels but can be improved at the state level.** Stakeholders reported that the design of the Programme intended the community cadres to generate field-level insights, which were then aggregated at the block level. The gaps were then escalated

in the convergence committee meetings at the state, district, and block levels. For instance, at the block level, the BDO and block officers preside over the meeting. If a village is lacking certain equipment during the VHSND then the ANM would escalate it to the medical officer who would add it as an agenda item under unavailability of infrastructure. The BDO would then assist in procuring the required items or escalate it to the district level. However, stakeholders reported that the convergence meetings were more routinely held at the district and block levels, as compared to the state level. One of the major reasons was identified as the conflicting schedules of different government officials. This has been discussed in the evaluation question above.

**Monitoring visits by BMUs and coordinators at the field level are beneficial to monitor and support *Poshan Sakhis*.** Due to the nature of PMP and PLA trainings and orientations, BMUs and coordinators were frequently in touch with the *Poshan Sakhis*. The increased number of monitoring visits allowed them to help the *Poshan Sakhis* in creating reports and handholding them through the process. However, this process was stalled during the COVID-19 pandemic, and telephonic reports had to be collected. The Programme did not come to a complete halt due to its systematic implementation in the past.

## 3.5 Sustainability

This section explores the extent to which the Programme intervention can be (or already has been) scaled up, and the advocacy/effort with respective government departments be required from UNICEF to ensure inclusion of additional components in government planning process. The section has two aspects: a) the information available from documents, and b) perspectives of IDI and FGD participants.

**Evaluation Finding:** Systems put in place through *Swabhimaan* such as convergence meetings, sustained government advocacy, focus on FNHW interventions, empowerment of VOs and CLFs, fostering community partnerships and Poshan microplanning have proven to be sustainable, and best practices are being scaled up across the Programme states (as well as new states through *Swabhimaan 2.0*). Certain areas of the Programme are dependent upon UNICEF's continued support, such as technical assistance and financial/procurement assistance during supply shortages. The ROSHNI Centre provides technical support to the *Swabhimaan* programme and assists the SRLM in documenting best practices, conducting trainings, and supports scale-ups.

### 3.5.1 To what extent is there government ownership to continue the interventions and integrating and scaling up the Programme (Financing and Programme activity, spillover of activities, Staff leveraged, Investment in PIP, support to SRLM, scale-up)?

**Secondary documents analysed during the evaluation illustrate the scale-up of *Swabhimaan's* learnings through *Swabhimaan 2.0*.** The *Swabhimaan* Programme demonstrates the operationalisation of DAY-NRLM's FNHW strategy objectives, aligned with its mandate under the joint convergent action plan for POSHAN Abhiyaan or the National Nutrition Mission, in the poorest areas of three states – Bihar, Chhattisgarh, and Odisha. Lessons from the Programme (*Swabhimaan 1.0*) simultaneously inform the scaling-up of interventions across these states. *Swabhimaan's* evaluation was thus nested within the implementation since its inception on request of national and state governments to provide evidence-based inputs for their strategies. Evidence generated from the evaluation was planned to inform DAY-NRLM's multi-sectoral FNHW strategy and scaling-up of interventions in the states, as per their mandate in *Swabhimaan 2.0*.

**The evaluation found that convergence meetings benefitted government departments at the state, district, and block level to create system level sustainable practices.** Stakeholders in Odisha testified that government functionaries have been keen to see evidence of *Swabhimaan's* successes. There have been innovative methods to share information such as field findings and case studies. The use of common WhatsApp groups is a quick method of dissemination, as well as the findings published on the ROSHNI website, which are easily accessible for government stakeholders – including state level officials such as the State Mission Director. Another strategy used by UNICEF to increase government ownership is through publishing human interest stories and clearly explaining them as government achievements. Similarly, government stakeholders in Bihar testified that the convergence meetings were useful for diverse departments to come together and plan strategies to improve the health and welfare delivery mechanisms for target groups. The convergence meetings also proved useful in understanding the supply chain issues of supplementary material which was distributed to beneficiaries during the *Swabhimaan* Programme. Lastly, it served as a platform for block and district level government officials to escalate their concerns.

**In Odisha, stakeholders felt that *Swabhimaan's* activities had strong support at the state and district level which led to its success at the block and community level.** Primary interviews evidenced the role of sustained government engagement through real-time monitoring and report generation. *Swabhimaan's* success was documented through the block reports collected periodically. Whilst UNICEF provides technical support at the district level, stakeholders testified that there was strong ownership of Programme activities from the District Collector. This support has translated into garnering CSR resources for continuing *Swabhimaan's* piloted FNHW activities at a scaled-up level and leveraging master trainers from Programme blocks to train Poshan Sakhis or implement activities in the scale-up blocks to reduce financial and technical dependence on UNICEF. Stakeholders expressed that NRLM, and state funds are limited, so it is necessary to club activities together to ensure sustainable results.

A state-wise compilation of inputs received from representatives from DoHFW and WCD are discussed in **Table 20** below, based on the primary data collected.

Table 22: Benefits of Swabhimaan reported by DoHFW and WCD

State	Government Department	Benefits Reported
Bihar	DoHFW	<ul style="list-style-type: none"> <li>a. Support received from UNICEF for Human Resources. 2 consultants provided (1 block, 1 district), who helped with project coordination. The consultant position was later scrapped, and support received from UNICEF nutrition consultant.</li> <li>b. Convergence committee meetings conducted bi-annually, which helped in problem identification and solution discussion with FLWs and CRPs</li> <li>c. Awareness of villagers increased, as they came to know about Aarogya Diwas and health camps; vaccination; received iron tablets</li> <li>d. Swabhimaan contributed to – (i) increasing water quality; (ii) increasing adoption of nutri-sensitive agriculture</li> <li>e. UNICEF did not provide cash grants/issue-specific funds</li> </ul>
	WCD	<ul style="list-style-type: none"> <li>a. Mobilisation for VHSND</li> <li>b. Increase in awareness of birth spacing and vaccination among target groups</li> <li>c. Counselling by CRPs essential for anaemia reduction</li> <li>d. Supported in distribution of ration to target groups</li> <li>e. Outreach and mobilisation through Poshan Sakhis, especially in heavily populated areas to assist AWWs who might not be able to reach every area – access to remote regions (since PS are community members)</li> <li>f. Support in monitoring of supply-side essential services like vaccination, availability of medicines</li> <li>g. UNICEF organised trainings which were useful for AWWs</li> </ul>
Chhattisgarh	DoHFW	<ul style="list-style-type: none"> <li>a. Health camps organised and attended by FLWs and CRPs</li> <li>b. Attendance increased – health camps</li> <li>c. Mobilisation of community and line department workers for health camps</li> <li>d. Health check-ups organised where lab technicians were made available</li> <li>e. Awareness of NRC to rehabilitate malnourished children</li> <li>f. Augmented existing health and nutrition initiatives by the Department of Health and Family Welfare</li> <li>g. UNICEF's partnerships with local NGOs assisted DoHFW during COVID-19 for outreach and awareness</li> <li>h. Swabhimaan played a part in health education and mainstreaming of ostracized populations</li> </ul>
	WCD	<ul style="list-style-type: none"> <li>a. CRPs disseminated information of key health and nutrition messages through community-level events like <i>nukkad natak</i></li> <li>b. Information dissemination during COVID-19 for target groups and assisted in ration distribution to their homes</li> <li>c. Community-based group discussions on benefits of immunization and vaccination</li> <li>d. Monitoring support provided by UNICEF through inspection</li> <li>e. Increased knowledge on existing and new health and nutrition related government initiatives for target population</li> </ul>
Odisha	DoHFW	<ul style="list-style-type: none"> <li>a. Increased participation of target groups in community meetings</li> <li>b. CRPs helped establish regular home visits, where earlier DoHFW used to do broader supervision</li> <li>c. Revised VHSND guidelines initiated by Swabhimaan increased participation and uptake of services, as well as changes in behaviours like institutional delivery, colostrum, complementary diet and feeding practices</li> <li>d. CRPs connecting link between community and service providers</li> <li>e. Swabhimaan contributed to capacity building of FLWs</li> <li>f. Conducting and regularising VHSNDs</li> </ul>

		<p>g. Increased awareness of sanitation has led to increased demand for sanitary napkins from target groups – increased pressure on supply side</p> <p>h. During COVID-19, physical monitoring, counselling, and communication was hampered, as well as the supply chain. Beneficiaries could not reach out and access services. CRPs were able to help beneficiaries access services during this time</p>
	<b>WCD</b>	<p>a. Poshan Sakhis role was important in informing parents about malnourishment and helping AWWs</p> <p>b. Increased individual home visits and promotion of handwashing during COVID-19</p> <p>c. Assistance in referral services to NRC</p> <p>d. Assistance in community mobilisation for VHSND, especially in hard-to-reach areas where AWWs are unable to access target groups</p> <p>e. PS and FLWs worked together for identification of most-vulnerable groups in the population</p>

Source: Primary data

At the national level, the guidelines for maternal calcium supplementation and deworming are integrated into 'Kuposhan Mukh Bharat Abhiyaan', 2020-25 (i.e., free from malnutrition). The MUAC tool and guidelines prepared by Swabhimaan are integrated into *Mahahtari Jatan Yojna* (Scheme/Programme to improve health of pregnant women) of ICDS in Chhattisgarh. Further, state-level stakeholders reported that the Programme was hailed as a "best practice" across all three states and is being scaled up as FNHW interventions within SRLM activities. This is also evidence in the master circular for FNHW within NRLM which calls for FNHW immersion blocks within states with improved access to PDS systems, take-home rations, and access to services during VHSND listed as key intervention areas to be delivered through convergent efforts with the ICDS, Department of Education and other initiatives such as the National Health Mission and Swachh Bharat Mission. The scale up of the Programme is evidenced in Table 21.

Table 23: Scaling up of the Swabhimaan programme in the three states

State	Impact evaluation (2016-21)					Scale-up (2019 onwards)				
	District	Block	CLF	VO	SHG	District	Block	CLF	VO	SHG
Bihar	1	2	3	150	1936	1	2	2	79	1011
Chhattisgarh	1	1	4	104	2118	6	8	32	716	9026
Odisha	2	2	12	82	948	3	16	123	904	9514
<b>Total</b>	<b>4</b>	<b>5</b>	<b>19</b>	<b>336</b>	<b>5002</b>	<b>10</b>	<b>26</b>	<b>157</b>	<b>1699</b>	<b>19551</b>

Additionally, *Swabhimaan 2.0* was initiated in Telangana and Chhattisgarh in 2021. The expansion involved adding new dimensions for strategies on the formative research reports carried out for the respective dimension, contractual agreement with external partners (ARMMAN for implementation and support for developing tele-*Swabhimaan* contents, NIMHANS for implementation and technical support). The new dimensions include:

- Use of tele-methods for continued interaction with target groups
- Integrating activities for secondary beneficiaries (husbands of pregnant women, husbands of mothers of children under 2, mothers-in-law, fathers of adolescent girls, adolescent boys) based on formative research on engaging men and boys-gender formative research, and
- Integrating strategy for adolescent skills based on formative research on mental health.

## The Role of ROSHNI Centre in Scaling *Swabhimaan's* Achievements

The ROSHNI Centre is a technical support unit of the National Rural Livelihood Mission (NRLM), established by the Department of Development Communication and Extension at Lady Irwin College. The Centre is financially and technically supported by UNICEF India and has entered an MoU with the Ministry of Rural Development, Government of India.

Strategies from the Programme being scaled-up country-wide in a phased manner as National Rural Livelihood Mission Contribution to *POSHAN Abhiyaan*. For this, a national centre of women's collectives has been established in Lady Irwin College. The establishment of the institutional mechanism ROSHNI played a significant role in supporting the mainstreaming and scale-up of the *Swabhimaan* program. ROSHNI's mandate is to provide knowledge management, policy guidance, and convening support for various interventions, including food, nutrition, health, WASH, and gender-transformative measures, under *POSHAN Abhiyaan* for supporting SRLMs in implementing *Swabhimaan*.

Consultants from ROSHNI Centre have been placed at DAY-NRLM to support annual action planning for FNHW interventions through evidence-based inputs. A mechanism for learnings from *Swabhimaan* sites to be fed back to national and state governments is thus in place. These consultants have also supported SRLMs to draft their state operational strategies based on lessons from the midline evaluation, and this process will be continued and strengthened based on endline findings. .

### Government stakeholders testified that *Swabhimaan* was beneficial in empowering VOs and CLFs to focus on FNHW activities.

Previously, they did not see the significance of implementing FNHW interventions which would run for a long time – they intuitively understood medication or

healthcare as curative. The significance of nutrition and long-term improvement was a positive and sustainable change that came about through *Swabhimaan's* interventions. During the field visits, state level government staff could see that communities were benefiting from the improved knowledge which the CLFs and VOs were disseminating in the community. These positive changes in nutrition were visible in terms of the different recipes that women would make from locally sourced foods, which were nutrient-dense, as well as their increased adoption of sanitary napkins. During the evaluation, VOs also responded that through *Swabhimaan* and *JEEViKA* they particularly became informed of the importance of and how to set up kitchen gardens to achieve improved nutritional outcomes.

*"I would like to say that Swabhimaan and JEEViKA taught us a lot. We did not know about border crop or inter-crop. We did not know how to do farming or multiple cropping. We also did not know the model form of farming where a small pond can be transformed into a multi-layered farming model, with fish on the bottom and hens on the upper side. We never heard or saw this type of model or could have never even imagined about it."*

- VO, KII respondent

### 3.5.2 What are those components that may require additional human resources or budget to sustain the intervention? What level of advocacy/effort with respective government departments be required from UNICEF to ensure inclusion of additional components in government planning process?

**The evaluation found that FNHW interventions integrated into NRLM are likely to be sustained.** Stakeholders across the three states expressed that FNHW activities under *Swabhimaan* have been adopted as best practices and are being scaled up. In Bihar, the government administration appreciated the improvement in diet diversity scores at the household level through the nutritional benefits availed by women and adolescent girls through the *Swabhimaan* Programme – leading to a scale-up of these activities in additional districts. Moreover, the change brought about in social norms – especially around sanitation and hygiene regarding menstrual health are regarded positively by all stakeholders, including the beneficiaries. Before *Swabhimaan*, women and girls were found to use cloth rags during menstruation and were also excluded from consuming various food groups which led to nutritional deficiencies. Similarly, during pregnancies, women from certain tribal areas could not previously access healthcare centres for delivery – as they were traditionally required to deliver children in a closed room with lack of ventilation. This process often led to complications or death during delivery. However, through the sustained counselling provided through *Swabhimaan*, there is a community level change which has emerged.

**Community partnerships built through *Swabhimaan* were found to be sustainable.** Through primary interviews, the evaluation found that there is increased coordination between GPLF, CLFs and the community – whereby they have come together in their awareness of FNHW practices. Since the community partnerships rely on pre-existing and

positions, these are likely to be scaled up across states. However, stakeholders pointed out that there needs to be increased trust-building between the community cadre and the livelihood cells so that there is greater convergence.

**The evaluation found *Poshan* microplanning to be a sustainable intervention.** In implementing *Swabhimaan*, *poshan* microplanning was regarded by all stakeholders as a sustainable activity which managed to involve target groups in a manner that they took ownership of planning. Responses gathered during the focus group discussions across the three states with beneficiaries of *Swabhimaan* also testified that microplanning was useful for them and led to an increase in their knowledge of which items to consume. This is discussed in detail under Section 3.3 (Effectiveness). **Information from primary interviews also evidenced that *Poshan* microplanning will be scaled up across the states.**

**Certain results such as procurement of supplements/medicines, technical and financial assistance are dependent on UNICEF's continued support during the VHSND.** Government stakeholders expressed mixed views about the sustainability of interventions provided through the VHSND – they specifically referred to the supplement and medicine distribution, vaccination, as well as the financial support extended by UNICEF to execute the Programme. Although *Swabhimaan* activities are designed to be funded through the NRLM primarily with technical support from UNICEF, there are instances of resource constraints regarding supply chain issues or printing of resources – which require aid from UNICEF.

**UNICEF's technical support continues to be a requirement for capacity building of government employees at all levels and for establishing a streamlined MIS.**

Through primary interviews, the evaluation found that UNICEF's support is required to create standard tools for providing training on the importance of PMP and PLA and building greater understanding of these

*"We need more convergence with livelihood cells to understand how health and nutrition interacts with livelihood programmes. This is ultimately a contribution to FNHW, the health and nutrition indicators of the household – hence we need capacity building of all the staff members. Staff members should not think that their focus has to be narrow and only one dimensional (for example, only on livelihoods)."*

- Government stakeholder, KII respondent

issues beyond the community level and training departments involved in the livelihood mission – since a number of staff members are often transferred – creating a challenge for effective implementation of the Programme. Further, the current system of knowledge transfer and management was reported to be weak and stakeholders expressed continued support to establish and improve a state-level monitoring system.

The SRLMs of Bihar, Chhattisgarh and Odisha have adopted best-practices of *Swabhimaan* and initiated scale-up in the states as follows, in Table 22.

Table 24: Scale up of *Swabhimaan* across states

<b>Bihar</b>	<ul style="list-style-type: none"> <li>• Replication of NSIFS (Nutrition Sensitive Integrated Farming Systems) in scale-up area</li> <li>• Currently trained cadres employed as community resource persons in scale-up areas</li> <li>• Increase in behavioural and community interventions which seek to change social behaviour and norms</li> </ul>
<b>Chhattisgarh</b>	<ul style="list-style-type: none"> <li>• SRLM sanctioned scale-up to 16 blocks across 12 districts</li> <li>• Currently trained cadres employed as community resource persons in scale-up areas</li> </ul>
<b>Odisha</b>	<ul style="list-style-type: none"> <li>• 12 blocks from both intervention districts used as incubation blocks for learning</li> <li>• 700 CRPs to be trained to support scale-up across 14 blocks</li> </ul>

Source: Prepared by authors based on Monica Shrivastav & Sethi, (2021)

## 3.6 Impact

The section discusses the impact of the Programme on two aspects: a) evidence (primarily statistical) for improvement in key indicators related to Programme outcome, and b) most significant change stories reflecting capacity development and unexpected changes.

**3.6.1 Did the Swabhimaan Programme demonstrate a statistically significant difference in the primary and secondary outcomes? To what extent were the impact and outcome indicators changes predicted by the Programme's ToC and RBM achieved?**

**Evaluation Finding:** As hypothesised, the impact evaluation found a net improvement of 10-15% in secondary outcomes related to the coverage of the 18-nutrition sensitive and nutrition specific interventions. However, primary outcomes related to the nutritional status of pregnant women, lactating mothers and adolescent girls have witnessed little to no change.

**Findings from the impact evaluation indicate that while statistically significant differences can be observed for coverage of nutritional and health services (secondary outcomes), similar results were not found for nutritional status of pregnant or lactating women (primary outcomes).** A net improvement of 5-10% in secondary outcomes was found in intervention areas, with indicators related to health services increasing by almost 15%. For example, in the intervention areas, there was a 17-percentage point difference between participants (who had attended at least six VHSNDs) and non-participants in the consumption of IFA tablets. Similarly, 34.7% of lactating women in intervention areas who had attended VHSND and *baithaks* had consumed hundred or more calcium tablets during their last pregnancy as compared to 21.6% in control areas. Further, the percentage of nutritionally at-risk women accessing ANC in the first trimester increased by 26 and 10 percentage points in the intervention and control areas respectively, between the baseline and endline survey. The difference between the two areas over time was statistically significant at the 1% significance level. These statistics are summarised in Table 23 below.

Table 25: Changes in nutritional and health service indicators between baseline and endline survey (%)

Key Indicators	Intervention Area		Control Area	
	Baseline (2016)	Endline (2021)	Baseline (2016)	Endline (2021)
<b>Pregnant Women</b>				
Minimum dietary diversity	20.6	44.3	21.4	38.9
Received ICDS entitlement for supplementary food in month preceding survey	27.8	65	32.6	55.2
Consumed 25 or more IFA tablets in second and third trimester	23.6	64.4	24.8	62.7
Two calcium tablets in second trimester	17	62.1	22.8	54.4
First antenatal check-up in first trimester	41.1	67.5	47.8	58.1
<b>Mothers of Children Under Two Years</b>				
Minimum dietary diversity	19.4	44.1	18.2	40.2
Received ICDS entitlement for supplementary food in month preceding survey	44.5	78.6	49.7	76.4
Consumed 100 or more IFA tablets during last pregnancy	22.4	38.8	32.7	38.6
Consumed 100 or more calcium tablets during last pregnancy	0.1	28.7	0.1	26.5
Received at least 4 antenatal care in last pregnancy	18.2	43.3	20.8	39
<b>Adolescent Girls (10-19 years)</b>				
Minimum dietary diversity	17.8	38.8	17.5	36.8
Visited AWC for any service	22.2	41.5	28.5	32.4
Consumed 4 or more IFA tablets	8.9	17.6	11.8	17.6
Consumed deworming tablets	47.9	75.3	48.4	70.3

Source: (Sethi, n.d.)

However, primary outcome indicators related to nutritional status remained the same or witnessed minimal changes between participants and non-participants in the intervention areas. 34.7% of pregnant women who had attended VHSND and *baithaks* were considered underweight compared to 36.3% of non-participants. Similarly, the difference between mothers of children under two years of age who had participated in the Programme and non-participants was only 0.8 percentage points. The difference was slightly higher for adolescent girls at 1.3 percentage points. These indicators are summarised in Table 24 below.

Table 26: Nutritional Status of Target Groups at Endline Survey

Key Indicators	Intervention Area		Control Area	
	Attended AHD/VHSND + Baithak	No participation	Attended AHD/VHSND	No participation
<b>Pregnant Women</b>				
MUAC < 23 cm	34.7	36.3	31.7	36.6
<b>Mothers of Children Under Two Years</b>				
BMI < 18.5 cm	37.9	38.7	39	38.3
<b>Adolescent Girls (10-19 years)</b>				
BMI < 18.5 cm	10.5	14.8	10.3	12.6
Short and thin (Double burden)	2.8	4.1	1.7	3.9

Source: (Sethi, n.d.)

Table 27: Findings from baseline, midline and endline factsheets of Swabhimaan

Stakeholder Group	State	Changes
Adolescent Girls	Odisha	<ul style="list-style-type: none"> <li>• Mean BMI increased from baseline to midline and remained stable from midline to endline in both intervention and control groups. However, the mean BMI at endline was higher in the intervention group than in the control group.</li> <li>• Visits to AWC for any reason decreased from baseline to midline in both intervention and control groups but increased in the intervention group at endline.</li> <li>• Mean diet diversity score decreased slightly from baseline to midline but increased again at endline in both intervention and control groups. The mean score at endline was higher in the intervention group than in the control group.</li> <li>• Mean weight, MUAC, and height increased from baseline to endline in both intervention and control groups, with slightly higher values in the intervention group at endline.</li> </ul>
	Bihar	<ul style="list-style-type: none"> <li>• Mean BMI increased across all groups, with the intervention groups showing greater improvement than the control groups.</li> <li>• Visits to AWC for any reason increased significantly in the intervention groups, while the control groups saw little change.</li> <li>• Mean diet diversity score increased in all groups, with the intervention groups showing greater improvement than the control groups.</li> <li>• Mean weight and MUAC increased across all groups, with the intervention groups showing greater improvement than the control groups.</li> </ul>
	Chhattisgarh	<ul style="list-style-type: none"> <li>• Mean BMI increased slightly from baseline to midline and remained stable until endline, in both intervention and control groups.</li> <li>• Visiting Anganwadi Centres (AWC) for any reason decreased at midline but increased again at endline, in the intervention group only. The control group showed a steady increase across all time points.</li> </ul>

		<ul style="list-style-type: none"> <li>• Mean Diet Diversity Score increased from baseline to endline in both intervention and control groups, but the intervention group showed a larger increase.</li> <li>• Mean weight and MUAC increased steadily across all time points in both groups.</li> </ul>
<b>Pregnant Women</b>	<b>Odisha</b>	<ul style="list-style-type: none"> <li>• The proportion of pregnant women receiving ICDS entitlement for supplementary food increased substantially from baseline to endline in both intervention and control groups, with higher values in the intervention group at all three time points.</li> <li>• Mean diet diversity score decreased slightly from baseline to midline but increased again at endline in both intervention and control groups. The mean score at endline was higher in the intervention group than in the control group.</li> <li>• Mean height remained relatively stable across all three time points in both intervention and control groups.</li> <li>• Mean MUAC increased from baseline to endline in both intervention and control groups, with slightly higher values in the intervention group at all three time points.</li> </ul>
	<b>Bihar</b>	<ul style="list-style-type: none"> <li>• The proportion of pregnant women receiving ICDS entitlement for supplementary food increased across all groups, with the intervention groups showing greater improvement than the control groups.</li> <li>• Mean diet diversity score increased in all groups, with the intervention groups showing greater improvement than the control groups.</li> <li>• Mean MUAC increased across all groups, with the intervention groups showing greater improvement than the control groups.</li> </ul>
	<b>Chhattisgarh</b>	<ul style="list-style-type: none"> <li>• Mean height increased slightly from baseline to endline, in both intervention and control groups.</li> <li>• The percentage of women receiving ICDS entitlement for supplementary food increased across all time points in both groups, but the intervention group showed a higher percentage at each time point.</li> <li>• Mean Diet Diversity Score increased from baseline to endline in both groups, but the intervention group showed a larger increase.</li> </ul>
<b>Mothers of children under 2 years</b>	<b>Odisha</b>	<ul style="list-style-type: none"> <li>• The proportion of mothers receiving ICDS entitlement for supplementary food increased substantially from baseline to endline in both intervention and control groups, with higher values in the intervention group at all three time points.</li> <li>• Mean diet diversity score remained relatively stable across all three time points in both intervention and control groups, with slightly higher values in the intervention group at endline.</li> <li>• Mean BMI increased from baseline to endline in both intervention and control groups, with slightly higher values in the intervention group at all three time points.</li> <li>• Mean height and MUAC increased from baseline to endline in both intervention and control groups, with slightly higher values in the intervention group at endline.</li> </ul>
	<b>Bihar</b>	<ul style="list-style-type: none"> <li>• The proportion of mothers receiving ICDS entitlement for supplementary food increased across all groups, with the intervention groups showing greater improvement than the control groups.</li> <li>• Mean diet diversity score increased in all groups, with the intervention groups showing greater improvement than the control groups.</li> </ul>

		<ul style="list-style-type: none"> <li>• Mean BMI and height increased across all groups, with the intervention groups showing greater improvement than the control groups.</li> <li>• Mean MUAC increased across all groups, with the intervention groups showing greater improvement than the control groups</li> </ul>
	<b>Chhattisgarh</b>	<ul style="list-style-type: none"> <li>• Mean height remained stable across all time points in both groups.</li> <li>• Mean MUAC increased slightly from baseline to midline and remained stable until endline, in both intervention and control groups.</li> <li>• The percentage of women receiving ICDS entitlement for supplementary food increased slightly from baseline to endline, in both intervention and control groups, with the intervention group showing a higher percentage at each time point.</li> <li>• Mean Diet Diversity Score increased from baseline to midline in both groups but decreased at endline, in both intervention and control groups. The intervention group showed a larger increase from baseline to midline but a larger decrease from midline to endline.</li> <li>• Mean BMI increased slightly from baseline to endline, in both intervention and control groups.</li> </ul>

Source: Baseline, Midline and Endline factsheets (ROSHNI website)

While statistical evidence to show improvements in access to health and nutritional services and nutritional status of target groups is discussed above, qualitative data on the extent of change in primary and secondary outcomes and impact of the Programme is captured in the form of Most Significant Change stories. Four key stories each relating to a thematic area or domain of the Programme is presented below. It may be noted here that the evaluation found no unintended outcomes for the Programme.

#### Domain 1: Improved health and nutritional status

Indian women experience multiple nutritional deficiencies (such as low BMI and anaemia) especially during pregnancy. One important aspect of the Programme was to identify “at nutritional-risk” women and adolescent girls using simple measurement tools like MUAC tapes and weighing machines. Anecdotal evidence collected from beneficiaries show that the change in the nutritional and health status of at-risk women was possible through the cumulative effort of various community cadres and service providers. This includes support in establishment of kitchen gardens, regular home visits by community cadres to check health status and provide supplements, and provision of entitlements by Anganwadi workers. An example of a change in the nutritional status of pregnant women due to the convergent efforts community cadres and service providers is presented below.

#### Box 1: Lalita's journey - a story of health transformation

**Scenario:** Lalita (name changed), a homemaker and a mother of two girls (aged eight and three years) suffered from poor health when she pregnant with her second child in 2020. Her MUAC measurement was 21 cm and haemoglobin levels were 8.6 mg/dl during this period, considered to be both underweight and anaemic by WHO classifications for pregnant women. Although she had experienced pregnancy and childbirth before, her last pregnancy was harder due to her poor health.

**Process Change:** After Lalita's poor health was identified by the *Poshan Sakhi* during her pregnancy, the *Poshan Sakhi* guided her in multiple ways to improve her nutritional status. A package of interventions was prepared and shared with Lalita and her family by the PS *didi*, as described below:

- Consumption of *tiranga food* and establishment of kitchen garden: Through the monthly meetings with the PS, Lalita was aware that consumption of a balanced diet (*tiranga bhojan*) would help better her overall health condition. However, owing to her poor financial condition, buying food items from multiple food groups from the market was not feasible for her. The PS *didi*, aware of Lalita's poor financial condition, advised her to set up a *Prushti Bagicha* (nutri-garden) in her backyard. The *Poshan Sakhi* demonstrated to Lalita how to set up a nutri-garden in her backyard, thus making for daily availability of nutritious vegetables to be incorporated in regular diet.
- Regular home visits and access to other health and nutrition-related services: The *Poshan Sakhi*, through regular home visits and PLA meetings, motivated Lalita to attend the VHSND events at her local Anganwadi Centre.

Lalita started attending the VHSND where she received regular health check-ups and advisory services from the ANM and ASHA. At the AWC, she also received supplementary nutrition in the form of nutritionally rich dry food, eggs and *chhattua*, in addition to IFA and calcium tablets from the ASHA and ANM, who also followed up on her status through regular home visits.

**Outcome:** After a few months of regularly following dietary instructions and availing various services at the AWC and VHSND, Lalita's MUAC and haemoglobin levels increased to 24.5 cm and 10.2 mg/dl respectively. In April 2021, she gave birth to a healthy child weighing 2.7 kg. Being witness to the merit of the efforts put in by the *Poshan Sakhi* in improving her health status and ensuring that she has a safe and healthy pregnancy, Lalita has recently started working as a *Krishi Mitra* in her village with the aim to help other target group members establish nutri-gardens in their backyards.

### *Domain 2: Convergence as a key enabler*

Given their local presence and acceptance within the community, *Poshan Sakhis* played an essential role as conduits between the community and service providers in bridging the demand-supply gap. They engaged with communities to gauge their demands and worked alongside FLWs to enhance service delivery. The story below is an example of the nature of convergence between CRPs and service providers and its impact on reducing the effects of COVID-19.

#### *Box 2: Battling COVID-19: a story on the efforts of PS in minimizing its effects*

**Scenario:** Suchita (name changed) had been working as a *Poshan Sakhi* in her village when the COVID-19 pandemic started in 2020. A year later, given the sharp rise in the number of cases and fatalities, the State Government issued an order to the FLWs to conduct door-to-door surveys to understand the status of COVID-19 in the villages. The survey was to be conducted from 24<sup>th</sup> May to 31<sup>st</sup> August 2021.

**Process Change:** Suchita was informed about this survey when she went to her SHG meeting. While the order did not require her to participate in conducting the survey, she knew that this was a rather laborious task and not one that could easily be accomplished by the ASHA and AWW. She was always an active member of her SHG, and she decided to join the FLWs in helping them conduct the survey. She was also aware that given how easily the infection spread, many village folk in her area would not allow the FLWs to conduct the surveys at their homes. However, since she was from the village, known and accepted by the residents, she would be able to convince them to let the FLWs conduct the surveys. Subsequently, Suchita accompanied the ASHA and AWW to every household and mapped out the prevalent COVID-19 symptoms and co-morbidities.

**Outcome:** As a result of her efforts, not only was the survey completed in time for all the 1,010 residents of the village, but provisions were made to access funds from the *Gaon Kalyan Samiti* to procure and distribute 900 masks to them. Suchita also played an active role in disseminating messages and information on COVID-19 appropriate behaviour in her village. This resulted in minimising the spread of the infection and saving lives. The joint efforts were appreciated at various levels within the government as well as the community. While the COVID-19 infection eventually reduced, the community continues to practice the healthy habits they learnt from Suchita and the FLWs during the time.

### *Domain 3: Changes in influencing Social Norms*

The Programme goals have indirectly aimed to influence the embedded roles of gender and social norms which are key drivers of appropriate food and WASH practices. The stories collected highlighted changes in superstitious beliefs related to accessing nutrition and health services, traditional practices of women eating after men and men being unaware of women's food and health status. The story below reflects increased knowledge and change in practices as a result of attending *Parivar Chaupals*.

#### *Box 3: Increased knowledge leading to change in gendered norms and practices*

**Scenario:** Satyendar (name changed) worked as an agricultural labourer and was the only earning member in the family. He was married and lived with his wife. He, like most other men in his village, subscribed to gendered notions of contraception being used only by women, only women engaging in household chores, etc. He believed that using contraception would affect his health and work. He also reported that he would engage in household chores when his wife visited her natal home as he feared embarrassment from his friends in the village who would make fun of him if he helped his wife.

**Process Change:** Satyender had heard his neighbours talking about family meetings being organized in the village where important family-related issues were being discussed. Curious, he went with his wife to attend a *Parivar Chaupal*. In the meeting, information related to the use and benefits of contraception by both men and women, the benefits of having a small family, the importance of helping women in their household work and ensure their good health were being disseminated. He learnt that it was acceptable to help his wife with household chores and that men could also use contraceptives without any health risk. He also learnt about the importance of women using sanitary napkins during menstruation and birth spacing in these meetings.

**Outcome:** After attending a few *Parivar Chaupals*, Satyendar now keeps money aside for purchasing sanitary napkins and condoms. He not only encourages his wife to use sanitary napkins but does not hesitate to buy them for her. He uses condoms and also mentioned that other men in his village have also started using contraception.

#### *Domain 4: Promoting gender and equity*

An important goal of the programme was to promote equity and inclusiveness. An important part of such a gender responsive programming was to empower women to recognise different forms of violence and tackle them. The story below presents an instance of a woman reaching out to CRPs and other institutions to address violence.

#### *Box 4: Tackling gender-based violence through CRPs*

**Scenario:** Anshika (name changed), married, lives with her husband, 4 children and her in-laws. While her relationship with her husband was happy and peaceful initially, a few months back, her husband resorted to drinking alcohol regularly. He would get intoxicated and then beat Anshika up. When Anshika's in-laws would try to intervene, her husband would end up beating them up as well. Tired from the daily physical violence, Anshika decided to leave her marital home and stay with her parents in her natal home.

**Process Change:** A few days after she moved to her natal home, Anshika's parents decided that this could not continue, and some action needed to be taken. They discussed with Anshika and explained to her that she is an SHG member and can seek their help in resolving the violence. They also told her that the Cluster *Mit* lives close to her marital home and that she could speak to her and seek her help. Anshika, along with her parents, approached the Cluster *Mit* and explained the issue to her. The Cluster *Mit* took the issue up at Anshika's SHG meeting. They, along with the VO representatives, approached the *Sarpanch* and *Mukhiya*. They all got together and went to Anshika's marital home to confront her husband. On reaching there, they found him to be in an inebriated state. The *Mukhiya* spoke to her husband and told him that he and the others there were aware that he abuses Anshika physically and verbally when he is inebriated and that they were issuing a complaint letter against him stating the same. They also told him that if he continued with such behaviour, he could also be jailed. A copy of the complaint letter was shared with the *Sarpanch* and with Anshika's father. Afraid of any legal action, Anshika's husband admitted to indulging in violent behaviour and promised that he would stop drinking and beating up his wife.

**Outcome:** Anshika's husband gave up drinking and started going back to work. Both Anshika and her husband are now working and earning to pay off the SHG loan Anshika had taken before. They are taking good care of their four children and are cohabiting peacefully.

**Note:** While some of the MSC stories reflect improvements in health outcomes, the overall Programme does not reflect similar results (Table 24). MSC, as a technique, cannot be used to understand impact at the population-level and hence, the results cannot be generalised. However, MSC provides a detailed understanding of the processes required to achieve the desired change. Additionally, the Programme was for a 5-year period and health outcomes take a longer time period to reflect positive changes. However, the evaluation notes positive changes in health and nutrition-related behaviours like dietary diversity which could result in changes in health outcomes in the long run.

## 3.7 Coherence

The section investigates the policy coherence<sup>8</sup> between *Swabhimaan* Programme and its complementarity or alignment with the work of national level external partners as well as with other interventions carried out by UNICEF in India. The dimensions of policy coherence in this section are divided into external coherence (which focuses on multiple policies/domains, here the evaluation focuses on coherences with the work on similar agenda by external partners at national and state level), and b) internal coherence (which focuses on single domain, here the evaluation focuses on coherences within UNICEF interventions in India).

**Evaluation Finding:** The evaluation found the *Swabhimaan* Programme to be coherent with state government's priorities in executing NRLM, and therefore works in close collaboration with state departments of health, nutrition, rural development, social welfare, food supply, and sanitation. It is also coherent with the work of the government at the district and block levels since one of the areas of intervention is system strengthening, improving public service delivery mechanisms.

**3.7.1 (EXTERNAL COHERENCE) How does various activities of *Swabhimaan* Programme fit with the work of external partners (government, partner agencies in states, other partner Programmes, global partners, regional partners, research agencies like IFPRI, Population Council etc.)? Does *Swabhimaan* Programme activities part of a coherent approach that is likely to have positive results, or are there critical gaps?**

Across all the three states and at the national level, UNICEF engaged with the relevant ministries/ department with a strong degree of coordination and ownership, at aggregate level. The external coherence evaluation regarding complementarity and synergies between is a rather complex task. Thus, the coherence is assessed with three broad aspects- partnership and relationship types (i.e., hierarchical (vertical/horizontal), networked, distributed, dormant), funding and co-design (i.e., identify, define, develop and delivery training/services/products) the Programme framework.

### *External partners and relationship types*

The State Livelihood Missions (SRLMs) (known as *JEEVIKA/BRLPS* in Bihar, *Bihan* in Chhattisgarh, and *OLM* in Odisha) partnered with the UNICEF to initiate the *Swabhimaan*<sup>9</sup> Programme. The state SRLMs were planned to be anchoring and implementing the *Swabhimaan* Programme, in coordination with the Departments of Health, Civil Supplies, Social Welfare, Agriculture and Public Health Engineering, with UNICEF technical and financial support (Table 24). UNICEF in turn planned to be partnering with relevant non-government partners (and resource persons) for development of capacity building tools and methodologies and with academia for impact and process evaluation.

The organisations collaborate to organise and setup the Programme to support existing programs and system to improve health and nutrition status of beneficiaries. NRLM structure covers engagement of different government departments mentioned in Table 11. Operationally, SRLM creates multi-tier structure of women involving SHGs at tier-1, Village Organisations (VOs) comprising 10 to 20 SHGs at tier-2 and Cluster Level Federations (CLFs) at tier-3. For the Programme a supervisor position has been embedded in the organisation structure. The Programme at community level has also engaged with service providers (involved in governmental program delivery).

**Swabhimaan's goals are achieved through the collaboration of several external partners.** The International Institute of Population Studies serves as the lead national level technical agency. AIIMS Patna, Raipur, and Bhubaneswar are the baseline survey implementers. University College London provides international advisory services. EKJUT and Living Farms NGOs aid in capacity building. The Evidence Consortium on Women's Groups is funded by the Bill & Melinda Gates Foundation and is co-led by the American Institutes for Research and the Population Council. The World Bank funds the National Rural Livelihoods Project (NRLP), created as a complementary sub-project under NRLM as a proof of concept for DAY-NRLM, and supports JEEVIKA. All of these external partners

<sup>8</sup> Policy Coherence is defined by the OECD as the systematic promotion of mutually reinforcing policy actions across government departments and agencies creating synergies towards achieving the agreed objectives. (Information retrieved from <https://globalnaps.org/issue/policy-coherence/>, Accessed on Dec. 29, 2022)

<sup>9</sup> In Chhattisgarh, the program is named as 'Macho Mangun' in the state, which means self-esteem in Halbi.

work together to support Swabhimaan's goals and improve the lives of women in rural communities. ROSHNI-CWSA is SRLM's institutional partner for Swabhimaan.

The role of external partners is detailed in **Section 1.3 (Overview of the Swabhimaan Programme)**.

#### *Funding*

Broadly, UNICEF provides funding support for technical component and evaluation work, with occasional support for Programme related activities such as resources (supplements, printing of training programmes) in case of funding delays through the SRLM. This is discussed in detail in Section 3.4 (Efficiency).

#### *Co-design and execute programme framework*

This is reflected in interviews with state-level officials from different departments of government and UNICEF. Some of the officials mentioned they were engaged since conceptualisation phase (2015) of the Programme. They shared that each department representative ensures reflection of policies in designing activities considering no duplication of work or fund are added. They confirm the regular convergence meeting in initial years before it was disrupted by COVID-19 or due to scheduling conflicts. This is discussed in detail in Section 3.4 (Efficiency).

Consultants from ROSHNI Centre, which is also the Programme's knowledge management partner, have been placed at DAY-NRLM to support annual action planning for FNHW interventions through evidence-based inputs.

*"We did many meetings during the conceptualization of this program. The discussions were around the questions: what is the intervention that should be there? Which are the groups be included? Who would be the nodal stakeholders? Who would be considered? Which are the departments that we link up with? What would be the role of OLM? How do we leverage the woman collectives? Who would be the woman who would be taking lead? What would be the nomenclature of CRP? How do we mark them from the rest of the front-line functionaries that are there? What would be the roles and responsibility? What would be the capacity building modules?"*

-Internal stakeholder, KII respondent

*"The convergence meetings are not regular now. Different departments' schedule timings and plannings don't match. Accountability for meetings isn't there that usually happens in departments"*

-Internal stakeholder, KII respondent

### **3.7.2 (INTERNAL COHERENCE) How does various activities of Swabhimaan Programme align with/fit with other interventions being carried out by UNICEF (Nutrition, Health, C4D, Communication and other key sections)?**

**The evaluation found Swabhimaan to be aligned with other activities being carried out by UNICEF**, such as WASH programmes including personal hygiene and sanitation, prevention of child marriage, empowerment of adolescents and with Communication for Development (C4D) and Communication, Advocacy and Partnerships (CAP). Primary information from UNICEF stakeholders testified that the FNHW strategy of *Swabhimaan* was designed and supported by all sectors of UNICEF – such as health, WASH, child protection, C4D and CAP. There was close collaboration with other initiatives such as Advika (in Odisha), which is a state government initiative for empowerment of adolescent girls, and with the vaccination initiatives across the three states. The internal convergence with CAP was witnessed through media publications, and increased government advocacy support.

**Secondary information confirming internal coherence was collected through Programme documents from UNICEF's other areas of work.** Updates on UNICEF India's intersectoral programming approach and reach are summarized in UNICEF Situation report (UNICEF 2022). The evaluation of coherences of various activities of *Swabhimaan* with other interventions carried out by UNICEF is done by UNICEF thematic areas. To ensure efficient programming, sub-departments (Nutrition, Health, C4D, Communication and other key sections) at different levels (state, district) were created and staff for Programme duration were employed.

### Health and Nutrition

UNICEF, working in close collaboration with the GoI supported the continuity of essential maternal and newborn care services and for capacity building (UNICEF 2022). UNICEF continues to prioritize support to the MoHFW and the Ministry of Women and Child Development at state and national levels to ensure continued access to quality essential nutrition services for children, adolescents, and women during the COVID-19 pandemic and other emergencies. UNICEF has also supported the Ministry of Health and Family Welfare in conceptualizing and convening for the development of *Anaemia Mukht Bharat (Anaemia Free India)* operational guidelines and related materials such as the reporting dashboard and communication materials. The Initiative received national award and now is being scaled-up country-wide in a phased manner as National Rural Livelihood Mission Contribution to POSHAN Abhiyaan. For this, a national centre of women collectives (<http://nceard.roshni-cwca.co.in/>) has been established in Lady Irwin College.

Capitalising on the NRLM platform, the *Swabhimaan* Programme initiative aims to improve adolescent girls' and women's nutrition with a comprehensive package of community-led interventions. This can be realized from activities conducted at community level as well improvement in health and nutrition status of beneficiaries from discussion in findings for fidelity, effectiveness, and impact criteria.

### Child Protection

FGD with adolescent girl for this evaluation found increasing awareness about early child marriage among adolescent girls as well as other members of women groups. In *Swabhimaan* 2.0, life skills education for girls is added in activities.

*"It was informed to us that we should not marry early. Now the legal age for marriage has been shifted to 21 years from 18 years. And we also are informed about maintaining good health".*

-Adolescent Girl (15-19 years), FGD respondent

### Education

*Swabhimaan* programme's activities were not directly linked to education. However, qualitative interviews revealed its contribution to increasing literacy and aspiration to studies among adolescent girls. This aspect is discussed with testimonies under effectiveness criteria.

### Water, Sanitation and Hygiene (WASH)

UNICEF interventions includes the provision of WASH supplies which include hygiene kits, masks, personal protective equipment and cleaning materials to vulnerable communities, frontline workers, children, women, and other beneficiaries at schools, Anganwadi and healthcare facilities. UNICEF also supported the construction/ rehabilitation of toilets, washbasins, water pipelines, fixed and portable handwashing stations. In coherence to this *Swabhimaan* programme has one explicit outcome in its strategy *"by 2020 household access to drinking water and sanitation products/services and practice of personal hygiene behaviours of beneficiaries"*. The activity, outreach and changes are discussed in Section 3.3.

### Communication Advocacy and Partnerships

UNICEF generates and communicates data/information with digital connections. The content on COVID-19 aspect had generated over 3.7 million engagements and the videos garnered almost 130 million views (UNICEF India). In 2021, *Tele-Swabhimaan* Programme was approved under *Swabhimaan* 1.0<sup>10</sup> by integrating interventions to address gender disadvantage and mental health risks. Inferences from qualitative interviews for Chhattisgarh providing supportive assertions. One strategy of *Tele-Swabhimaan* include monthly link to a professional counsellor via *"Doctor se Baatchee"* to give advice to *"at nutritional risk"* mothers, girls, and children (Table 26).

Table 28: Interventions to address gender vulnerabilities and mental health

Beneficiary category	Community Intervention
Interventions for Adolescent girls and boys	Linkage to professional counsellors (mental health professional) telephonically – at least one a month
Interventions for Pregnant women (including pregnant adolescents), Mothers of children under 2 years	Linkage to professional counsellors (gynaecologists, pediatricians, and mental health professionals) telephonically – at least one a month
Interventions for Newlywed couples, Husbands of pregnant women and husbands of mothers of children under 2 years	Linkage to professional counsellors (gynaecologists, pediatricians, and mental health professionals) telephonically – at least one a month

<sup>10</sup> This evaluation is for *Swabhimaan* programme 1.0 conducted in three states of India.

## 3.8 Fidelity

The section discusses the implementation fidelity<sup>11</sup> of the Programme on two aspects: a) frequency and c) coverage.

**Evaluation Finding:** The evaluation found mixed evidence of implementation fidelity. Some community activities such as PLA meetings were conducted as planned but fell short of the targeted frequency. Other systems strengthening activities such as AHD days were delayed or could not be conducted in some areas due to various challenges. Coverage, as measured by participation rates, increased over the years whereas coverage of other interventions such as distribution of THR varied widely between the states.

**3.8.1 To what extent was the *Swabhimaan* Programme being implemented according to plan and were there any divergence from the protocol for systems and community actions? (Factors like timely implementation, intensity, frequency, administrative mechanisms) Were the systems strengthening strategy implemented as envisaged in the ToC? What factors were critical for implementing actions with the Health, ICDS, PDS department and their frontline service providers? What were the bottlenecks in this strategy? (Themes: microplanning, training, guidelines, supply, and service strengthening, convergence, etc.)**

**The evaluation found mixed evidence on the delivery of the intensity and coverage of interventions as planned and could not ascertain the content of monthly meetings due to significant recall bias.** While intervention platforms such as *anganwadi* centres and service providers such as ASHAs and *anganwadi* workers were found operational in most areas, a majority of PDS dealers and ASHAs in some places were not aware of the *Swabhimaan* Programme. The ASHA workers who were unaware of the Programme reported that they had only recently taken up the post but the evaluation team could not ascertain the cause of inactivity of PDS dealers.

The *Swabhimaan* protocol paper details key community-level activities, associated stakeholders as well as the frequency and duration of implementation of interventions. While more resource intensive and complex interventions were delivered by village organisations and CLFs, community cadres co-facilitate the development of an integrated microplan with the block coordinators and are then responsible for implementing the planned activities in their respective villages. Table 27 summarises the key community activities of the Programme and their planned intensity.

Table 29: Planned Activities and Frequency

Community level Cadre	Activity	Frequency Planned
<b>Community Resource Persons (CRPs)</b>	Preparing Poshan Micro Plan (women/ <i>Kishoris</i> )	Once
	Monthly meetings (women/ <i>Kishoris</i> )	Monthly
	Food demonstration session for undernourished (women/ <i>Kishoris</i> )	Fortnightly
	Mobilising women for VHSND	Monthly
	Tracking and monitoring each “at nutrition risk”, pregnant and lactating women for a maximum of 50 HH	Monthly
<b>Vos/CLF/GPLF</b>	Programme review meeting by federation (GPLF/ CLF) for VO	Quarterly
	Newlywed couples meeting & distribution of kit	Quarterly
	Theme-based (e.g., alcohol, dowry, tobacco, early marriage) rallies held in villages	At least 3 per year
	Conduct community audit (data entry)	Biannual
	Organising recreational activities for adolescent girls and <i>Kishori Diwas</i>	Quarterly
<b>Krishi Mitras (lit. farmer friends) or Village Resource Persons</b>	Nutri-farm demonstration site	Minimum 2 sites
	Home visits to “at nutritional risk” beneficiaries to establish nutri-garden/ <i>kitchen garden</i> <sup>12</sup> at their home	As needed

<sup>11</sup> Implementation Fidelity refers to the degree and extent to which an intervention is delivered as intended/planned.

<sup>12</sup> Kitchen gardens are small plots of land cultivated by households. They provide the latter with easy access to fresh and nutritious vegetables and fruits, often daily. They include homestead land, vacant plots, and roadsides, edges of a field or even containers.

The Fidelity study conducted as part of the Programme and interviews with service providers and beneficiaries show that the frequency was as planned for some activities but deviated for other activities. For activities such as *baithaks*, the numbers of meetings conducted was difficult to ascertain at this point in time due to challenges in recalling information. Table 28 below provides a comparison of the implementation fidelity from the above-mentioned sources.

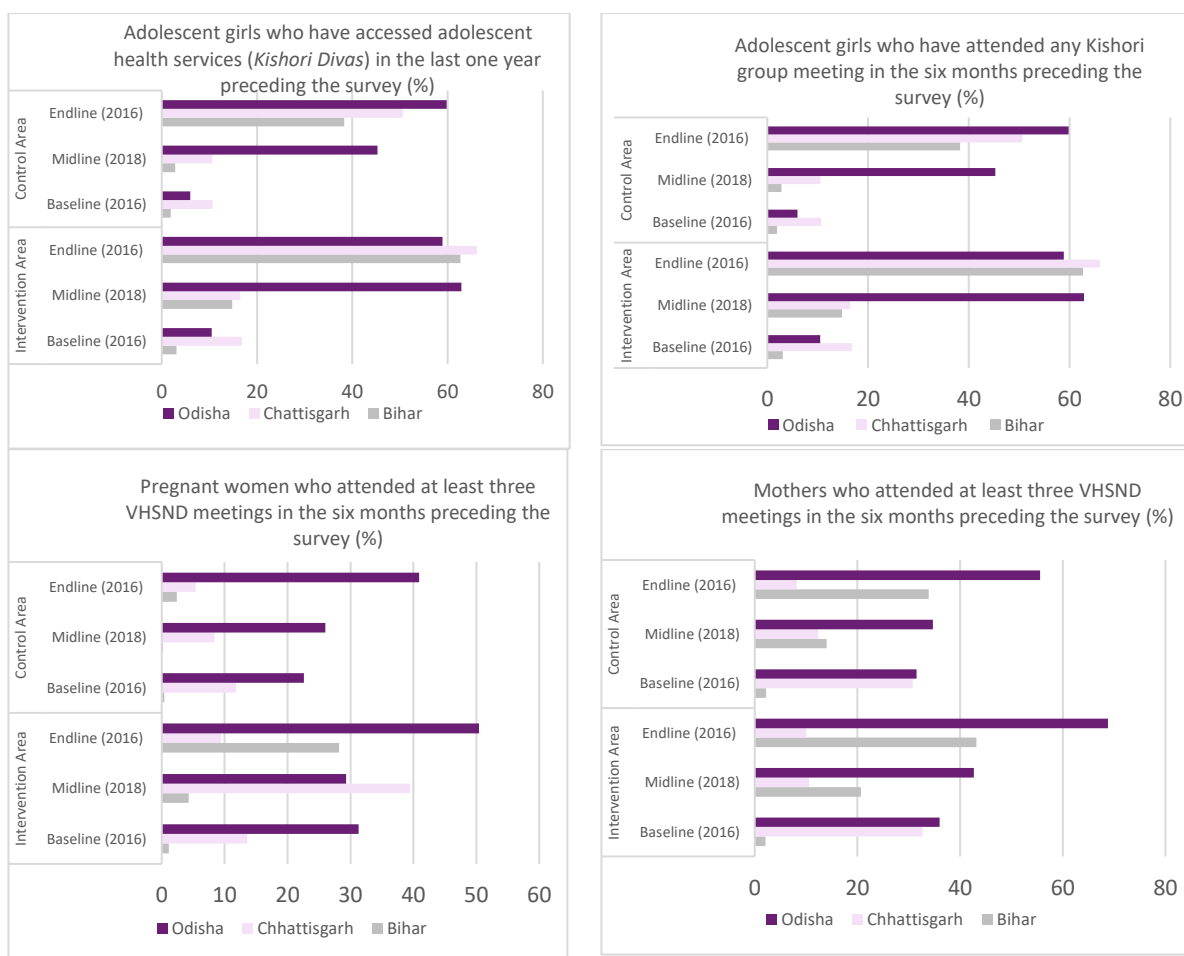
Table 30: Implementation Fidelity

Training/Activity	Findings from Poshan Sakhi interviews	Evidence from secondary data (Fidelity Report)
Poshan Micro Plan (PMP)	<i>Poshan Sakhis</i> , across all the three states, reported receiving training and preparing PMPs	Across all the three states, all reported receiving training and preparing them
PLA modules and meetings	Frequency of PLA meetings is not clear from data but all <i>Poshan Sakhis</i> report having received training on PLA modules and have organised theme-based PLA meetings with target groups	A total of 2-6 out of 8 rounds of meetings in Chhattisgarh and all the planned 15 meetings in Bihar were conducted. While in Odisha, the <i>Poshan Sakhis</i> mentioned they have organised meetings but did not specify the number of rounds of meetings organised.
Identification of at-risk individuals	All reported that they received training in identifying at-risk pregnant women, adolescent girls, lactating women, and children using weighing scales, MUAC tapes, etc. All mentioned conducting at least one home visit per month for at-risk individuals and for all during COVID-19.	All reported identifying at-risk pregnant women, adolescent girls, lactating women, and children. All mentioned conducting at least one home visit per month.
Food demonstrations	At least once a month	At least once a month
<i>Maitri baithaks/Kishori baithaks</i>	Frequency not clear but all reported conducting <i>maitri baithaks and kishori baithaks</i> at least once a month	Responses varied across the three states but most reported conducting these <i>baithaks</i> once a month.

Further, the Fidelity study also reports the extent to which some of these activities have been conducted- for example, although *maitri baithaks* were reported to be conducted, only 75% (Chhattisgarh), 53% (Odisha) and 86% (Bihar) of the target number of meetings were conducted in the three states. Similarly, while food demonstrations were reported to be conducted at least once a month, only about 717 of 960 such planned demonstrations and counselling sessions were held in Chhattisgarh. State-level stakeholders reported that some interventions received lesser focus due to the extent of activities that are to be carried out by community cadres.

Data from various rounds of evaluation show that the coverage, as measured by beneficiaries reached, have increased over the years, as evidenced in the graphs below. While participation rates increased over the years, regular attendance rates have continued to be low especially for adolescent girls. Some possible causes for low attendance could be challenges in arranging for alternate childcare, caste-based preferences and behaviours in meetings, distance to meeting centres or mobility restrictions at home. The coverage of other activities under the Programme, such as the percentage of women receiving take home rations varied widely across the states, from 30% in Bihar to 99% in Chhattisgarh.

Figure 15: Participation rates in activities across years



### Systems Strengthening Activities

As with community activities, mixed evidence was also noted on the implementation fidelity of systems strengthening activities. Progress reports from 2018 show that biannual health camps were not conducted in some areas due to various reasons such as unavailability of medicines and lab services, doctors and strikes by ANM workers. Similarly, quarterly AHDs were reported to be uninitiated as of 2018 in Bihar. VHSNDs had a higher rate of implementation – in Odisha, 98% of the planned number of VHSNDs were held in the blocks of Koraput and Pallahara. In the focus blocks of Kasba and Jalalgarh in Bihar, these numbers stood at 97% and 100 % respectively. The extent of implementation was slightly lower at 94% in the Bastar block of Chhattisgarh.

Trainings for service providers show better results in terms of adherence to the protocol. In Jalalgarh and Kasba blocks of Bihar, 100% of supervisors and on average, 88% of anganwadi workers received training on nutritional issues. Similar figures were also reported in Odisha with 100% of ANMs and ASHAs being trained.

However, the Fidelity report states that convergence meetings to ensure joint delivery of services were not initiated in all the three states as of 2018. Interviews with state and district level stakeholders also reported issues related to convergence, citing it was often undertaken as a mandated function but without little collaboration and coordination in actual implementation. Convergence was reported to be better at the block and district levels due to the on-ground nature of activities, as compared to the state-level. Other issues related to coherence are detailed in Section 3.7.

### 3.8.2 Did the design of the impact evaluation maintain its fidelity and integrity? For example, was there any evidence of spill-over or contamination from the intervention areas to the control areas? Were there issues of attrition that might affect the reliability of the findings? Are there confounding factors affecting the comparison of results?

The evaluation found evidence of spillover effects and other issues that might affect the reliability findings, as noted in the impact evaluation. The impact evaluation notes that scale-up of the Programme to different blocks and

introduction of community actions to initially designated “control” areas might invalidate the strict comparison of results between the control and intervention areas to extract its impact. Additionally, some migration of beneficiaries, especially due to marriage and COVID-19 is possible, and it is not necessary that those who were surveyed during the endline were exposed to the interventions from the start of the Programme.

## 3.9 Gender and Equity

The Programme's activities and effect on capacity and behaviours of women regarding accepting and adopting improving health and nutrition practices is already discussed in detail with focus on several aspect in above criteria. This section discusses the vulnerability aspect of women and adolescent girls in two dimensions: a) nutritional vulnerability, b) adapting equity framework for gender and social inclusiveness.

**Evaluation Finding:** The *Swabhimaan* Programme integrates equity and gender into its design, by focusing on areas which are harder to reach for service delivery. It has focused on adolescent girls as a target group, and also engages men and boys to tackle gender norms. Members from disadvantaged social groups such as caste and tribe are focused on by the *Swabhimaan* Programme. The inclusion of the most vulnerable and marginalized populations within the Programme aligns with UNSDG's principle of LNOB.

### 3.9.1 How have the *Swabhimaan* Programme activities ensured to widen the reach of intervention to vulnerable communities? Leveraged partnerships to improve the demand and supply of services for vulnerable communities? Developed and implemented alternate work plans/strategies with special focus on vulnerable communities?

**The *Swabhimaan* Programme was designed focusing on gender and equity concerns, as it was implemented in areas which are socially deprived and do not have high uptake rates of public services. Interventions benefitted members who were disadvantaged by caste and tribal status.** Stakeholders interviewed during the evaluation discussed the challenge of the pilot areas chosen for *Swabhimaan* – wherein the ASHA and AWWs required greater support to facilitate government initiatives for the target groups. The CRPs were especially useful in building rapport with women and girls and played a key role in changing pervasive social norms through regular meetings and counselling. Government staff at the state, district, and block levels also came to be more sensitised through *Swabhimaan* as service providers escalated issues related to adolescent girls and women to them regularly. Efforts by the community cadre to make beneficiaries aware about vulnerability reduction fund (VRF) and use it has addressed vulnerabilities like health and food security.

Through the interviews, government stakeholders discussed the challenge of equity during the meetings – upper caste women often did not attend meetings since they did not wish to sit with lower caste women. This proves to be a challenge in implementing Programme activities in certain villages and areas. The *Swabhimaan* interventions focus on benefitting members from marginalised groups disadvantaged by their caste status, thereby fulfilling the fundamental principle of LNOB. Another issue faced in service delivery was seeking permission from tribal and community leaders. Since men are usually the decision-makers in the areas *Swabhimaan* was piloted and implemented in, explaining the Programme, and bringing them into the planning process was integral to the Programme before conducting demonstrations.

**An important focus of *Swabhimaan* was on providing services for adolescent girls and offering the VHSND to them.** Government stakeholders discussed the importance of focusing on adolescent girls, which was previously de-prioritised in the VHSND design by the state. According to government stakeholders, it was through initiatives like *Swabhimaan* which re-focused the adolescent girls as a target population under the NRLM. The programme '*Advika*' also focuses on adolescent boys and sensitises them on issues concerning gender. Moreover, there are WhatsApp groups created for information dissemination to adolescent boys and girls. Stakeholders mentioned the need to counsel boys, in order to create a positive environment to discuss gender-related concerns. **The evaluation found that there is a focus on programming interventions for men in Chhattisgarh, by increasing male engagement through *Parivar Chaupals* (family meetings) which engage men and mother-in-law to counter gender norms which affect women's nutritional and pregnancy related outcomes.** Stakeholders from Bihar and Odisha testified that due to COVID-19, they were unable to implement the 'engaging men' component, however it is a component they are looking to replicate – with learnings adopted from Chhattisgarh.

*"VHSND programs helps the vulnerable people like adolescent girls, children, and pregnant women. Swabhimaan has helped in the counselling part as well as social mobilisation and cooperation with the AWW and ASHA. They also identified the needy [“at nutritional risk”] who will come to the camp.”*

-Government stakeholder, KII Respondent

*"I would like to say, Swabhimaan has primarily included vulnerable groups who are far from main block"*

-Government stakeholder, KII Respondent

Increased nutrient requirements for menstruation, pregnancy and lactation make women of reproductive age (WRA) (15–49 years) and adolescent girls physiologically vulnerable to undernutrition and micronutrient deficiencies (Philip T. James & Mates, 2022). The Programme drawing on the ‘women-centred approaches’ has explicit goals and interventions to improve WRA and adolescent girls’ health and intake of nutritious food. The Programme beneficiaries (WRA and adolescent girls) have strategically identified vulnerable areas (mostly remote and tribal areas) and vulnerable people (by emphasizing on identifying “at nutritional risk” WRA and adolescent girls).

Studies have established that dietary intake has a great influence on the vulnerability of individuals to ailments and those unique diets and/or combinations of nutrients can influence the immune system (Valdés-Ramos et al., 2010). Results from *Swabhimaan* Programme suggest that being a member of SHG or having a BPL card, having a kitchen garden, low number of pregnancies, and who attended school have low risk to food insecurity (Monica Shrivastav & Sethi, 2021).

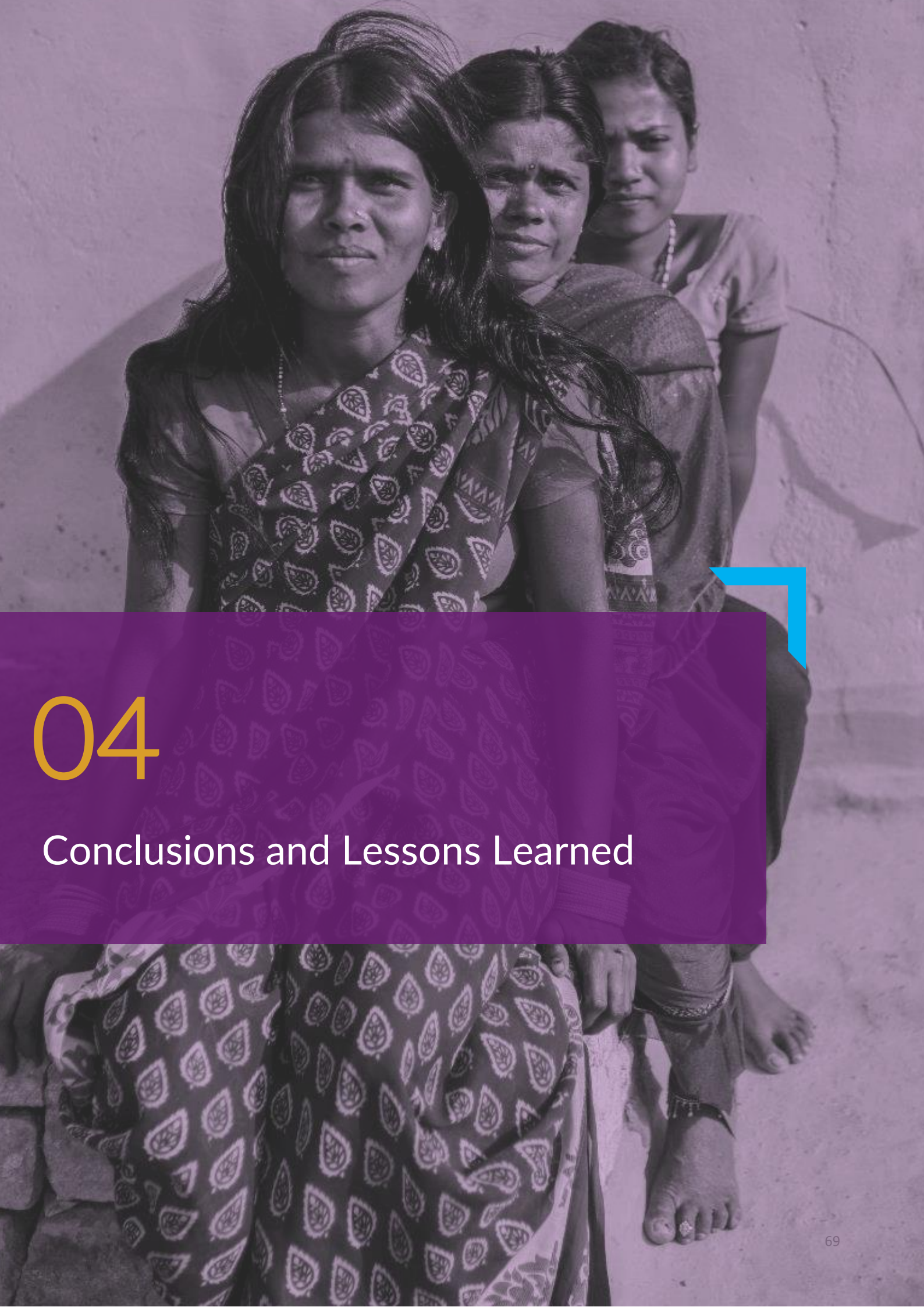
One distinguished aspect of the Programme is interaction and engagement with the newlyweds who are going to be mothers. The Programme has covered all the stages of women’s life cycle i.e., adolescence, pre-pregnancy (newlyweds), pregnancy, lactation (mothers of children under two) period to break the vicious circle of *kuposhan* (malnutrition). The evaluation found several evidence of WRA and adolescent girls understanding, practicing, and getting benefits from the Programme intervention package, as mentioned in several parts of the report. Data from three rounds of evaluation shows that majority of women in all states belongs to schedule caste, schedule tribe or backward caste (Table 29) which is aligned to UNSDG’s LNOB principle. In some places, the area selected for interventions are on basis of vulnerability due to geographical location, such as Purnia is frequently affected by flood. The Programme strategy of home visits by community cadre has helped in uplifting the restrictions on mobility as well as superstitious beliefs associated with food habits.

Table 31: Percentage of women and adolescent girls living in SC/ST household across states

Group	State	Intervention Area	Control Area
Adolescent girls (10-19 Years)	Bihar	35.6	30.4
	Chhattisgarh	71.4	73.8
	Odisha	76.2	67.9
Pregnant women (15-49 years)	Bihar	38.5	26.9
	Chhattisgarh	71.9	70.1
	Odisha	77.2	73.2
Mothers of Children under age two years	Bihar	34.6	29.4
	Chhattisgarh	73.7	73.3
	Odisha	79.9	75.9

Source: Endline Survey

However, a women-centric approach alone may not be enough to address the FNHW issues as these issues have multi-layered complexities mediated by intersectional factors (such as class/caste, wealth, activities involvement, poverty level, religion, power relations between men and women, social norms etc.). While the Programme seeks to engage men and mothers-in-law in its efforts to address social norms and barriers that lead to inequalities and unequal power relations resulting in discrimination, sustained efforts would be necessary to address these issues. A more comprehensive approach (aligned with the principles of LNOB) which includes use of disaggregated data in order to determine who is experiencing various and intersecting types of discrimination and inequality, as well as how and why they are being excluded or subjected to discrimination, would be essential. In order to achieve both formal and substantive equality for all groups in society, it would also be necessary to address the patterns of exclusion, structural limitations, and unequal power relations that create and perpetuate inequities throughout generations. Further, more active engagement of all stakeholders—especially the most marginalised—would ensure that the Programme is able to address issues of gender and equity effectively.



# 04

## Conclusions and Lessons Learned

# 4. Conclusions and Lessons Learned

## 4.1 Conclusions

### *Effectiveness, Fidelity and Coherence*

**The efficacy of the Programme is affected by deviations from its implementation fidelity, especially in terms of coverage and convergence.** Findings from previous studies and this evaluation show that attendance and participation rates remain low, especially for adolescent girls and newlyweds. This can be partly explained by incumbent traditions, such as newlyweds not being allowed to step out of their homes for one or two months after their marriage. Caste-based behaviours and discrimination were highlighted to be other barriers to achieving the intended coverage through monthly *baithaks*.

The Programme protocol clearly identifies points of convergence and has established guidelines for the same at the state and sub-state levels. However, evidence from the fidelity study and this evaluation shows several challenges to convergence as a mandated function. At the state level, convergence meetings were not conducted in some areas due to challenges in finding a convenient time where all relevant duty bearers were available. Stakeholders also reported that even while the meetings happened, they were often conducted in an ad-hoc manner with no real actionable decisions linked to proper feedback mechanisms. At the sub-state level, weak convergence with certain actors such as ASHAs and ANMs were noted while convergence with other actors such as PDS dealers was more or less non-existent. While activities such as gap assessment and co-creation of PMPs with service providers were reported in some areas, this was not consistent across the states and deviated from the Programme protocols. The lack of a coherent approach and challenges identified to this approach reflect the lower priority accorded to FNHW interventions in the larger scheme of NRLM/SRLM functions, which primarily targets credit and thrift availability. Related to convergence is the poor utilisation of resources available as part of the VRF and other special funds. The VRF was established as a corpus to be distributed to SHG members through the VOs, within the NRLM structure. Documentary review and stakeholder interviews confirmed the community cadres' support in linking beneficiaries with these funds (especially during COVID-19), but no evidence was found on the utilisation of these loans.

**An extremely capable and motivated cadre of CRPs (Poshan Sakis and Kishori Sakhis) have significantly contributed to the achievements of the Programme thus far.** Stakeholders interviewed at the state level attested to the capabilities of the community cadres and highlighted further scope for leveraging their skills and local relevance while beneficiaries provided anecdotal evidence on how community cadres have helped them in addressing various health and nutritional issues.

### *Efficiency*

**Most activities were implemented within the stipulated timeframe, with delays arising due to COVID-19 related restrictions.** However, anecdotal evidence suggests that the process indicators were largely unaffected by the pandemic. These claims are further reinforced by the improvement observed in coverage of nutrition service indicators at endline.

**Barriers in the enabling environment, such as poor supply chains, also affected the implementation of the Programme.** Documentary evidence and interviews with stakeholders at the state level indicate that planned activities, such as AHDs or distribution of IFA and other supplementation, did not occur in some areas due to the unavailability of medicines or were conducted much later than planned leading to challenges in establishing behavioural changes.

**Advocacy on the importance of FNHW interventions could be strengthened by better monitoring, reporting and dissemination of evidence generated.** FNHW interventions were reported to be considered a 'top-up' activity by implementers at the state and sub-state levels implying that activities were often dropped or inefficiently conducted due to its lower priority. Stakeholders also reported the need for more capacity building for monitoring and reporting by community cadres to address delays in sending monthly reports to CLFs and VOs and consequent deviation from stipulated reporting guidelines.

### Relevance

**The evaluation found that the *Swabhimaan* Programme was relevant to the needs of the target population groups as well as with DAY-NRLM's priorities.** In addition to the DAY-NRLM priorities, *Swabhimaan* was also found to be closely aligned with other national schemes related to health and nutrition.

### Impact

**The evaluation found that the Programme was successful in increasing coverage of health and nutritional services. However, entrenched socio-cultural norms and the timeframe for behavioural initiation to be converted to behavioural maintenance at the community-level remain challenges to observing intended impact.** The primary outcomes as measured by nutritional status of beneficiaries have either remained the same or shown minimal changes. Behaviours related with frequency and types of food consumed could still be limited by social norms and income of the target groups and requires closer inspection. Further, the gap could also be partly explained by the timeframe required to convert an initiated behaviour (such as increased dietary diversity at a particular point in time) to a consistent habit that could eventually lead to an improvement in nutritional status, as measured by BMI and MUAC.

### Sustainability

**The evaluation found that learnings from *Swabhimaan 1.0* were being utilised for scaling-up the Programme as *Swabhimaan 2.0*. However, scaling up these interventions could possibly require more than a "light-touch" model by the government.** Evaluation findings point to the need for more financial and human resources to efficiently train the community cadres and continuously engage and monitor field-level activities. Further, the provision of FNHW interventions as an invested service rather than a volunteer activity requires the payment of salaries to a larger cadre of CRPs.

### Gender and Equity

**While the Programme is gender-sensitive by virtue of its design and target groups, there is limited engagement with men and boys.** The *Swabhimaan* Programme includes men and boys as part of its secondary target group, but research shows that programmes with gender transformative approaches that actively engage with actors in the ecosystems that women operate within (i.e., family, household, community) are more likely to be effective in changing social norms and behaviours related to sexual and reproductive health and maternal, newborn and child health.

## 4.2 Lessons Learned

*Scalability and sustainability of the Programme will depend on the intensity of the interventions:* Evidence from the evaluation found that in the scale-up phase, all 18 interventions in the *Swabhimaan* package will not be taken up and a customised, 'light-touch' model will be developed by each state, keeping their programme priorities in focus. This might result in dilution of the success of the Programme in the pilot areas. Therefore, ensuring that the intensity of the selected interventions (i.e., frequency, duration, coverage, etc.) remains high will be essential to ensure that the success of *Swabhimaan* can be successfully replicated.

*Ensuring that the community cadre remains motivated is key to the Programme's success:* Interviews with the UNICEF and SRLM staff found that the success of the Programme was largely owed to the community cadres who were trained and incentivised to carry on the Programme activities. However, evidence from some KIIs found that during the scale-up phase, monetary incentivisation of such a large cadre of CRPs may not be feasible and activities will have to be carried out on volunteer-basis. This could lead to attrition within the cadres, which will affect the efficiency and effectiveness of the Programme.

*Reducing misinformation amongst FLWs about the roles and responsibilities of CRPs is essential in ensuring convergence:* While the mechanisms for inter-departmental convergence are clearly designed as a part of the Programme, findings from primary data showed that there was a lack of clarity amongst FLWs on the roles and responsibilities of CRPs, often leading to conflicts. Many FLWs felt that CRPs were performing the same activities as them and felt demotivated and would therefore, not participate in CRP-led community activities/initiatives. Disseminating information within FLWs and CRPs that clearly delineate their roles and responsibilities could be considered.

*Supply-side challenges and resource constraints need to be addressed to ensure adequate and effective utilisation of services:* Evidence from the evaluation show that there were weak supply chains and other logistical issues that led to delays

in availability of medicines and other nutritional supplements. Such delays affected availability and resulted in erratic consumption, thereby restricting habit-forming and behaviour change. Additionally, resource constraints such as lack of adequate land and water for the development of nutri-gardens are other barriers to uptake of positive behaviour change activities.

*Effective strategies that promote utilisation of community funds by beneficiaries are instrumental in ensuring Programme success:* The evaluation found very limited evidence on utilisation of community funds such as VRF and other special funds by beneficiaries. While the Programme ToC envisages access to and utilisation of such funds to be crucial in promoting behaviour change at the community-level, evidence shows that a very limited number of beneficiaries have utilised these funds. Specific strategies that promote usage of such funds and document their utilisation through MIS and research could result in better targeting and higher utilisation.

*Socio-cultural norms around FNHW and gender need to be addressed for holistic behaviour change:* While the Programme seeks to address social and cultural norms, evidence from the evaluation found that many of these norms are deeply entrenched and require the participation of the larger community for effective behaviour change. Given the complexities in the social fabric (like caste, class, power, poverty, patriarchy, etc.), addressing regressive norms requires the participation of the primary target groups as well as boys, men, and mothers-in-law.



05

Recommendations

# 5. Recommendations

The following recommendations have been developed based on findings from interactions with key stakeholders and beneficiaries, actionable conclusions and lessons learned from the evaluation, as presented above. To ensure their utility and encourage ownership, these recommendations have been validated by a small group of relevant stakeholders, including the ERG members, through a recommendations' workshop. Feedback from the ERG and the recommendations workshop have been incorporated to refine the recommendations.

**Recommendation 1:** Develop package of interventions based on priorities, results and cost-effectiveness for 'light-touch' model

<b>Priority:</b> High	<b>Corresponding Evaluation Criteria:</b> Relevance, Effectiveness, Sustainability	<b>Responsible Organisations:</b> UNICEF ICO, UNICEF state offices, DAY-NRLM, SRLMs, ROSHNI-CWSA
--------------------------	---	--

Evidence from the evaluation found that in the scale-up phase, all 18 interventions in the Swabhimaan package will not be taken up and a customised, 'light-touch' model will be developed by each state, keeping their programme priorities in focus. The evaluation found that Programme activities focused on increasing knowledge and awareness around FHNW behaviours showed positive capacity and behaviour changes. However, programme activities that focused on increasing access to services provisioned by other line departments (like PDS ration, iodised salt, IFA tablets, etc.) showed mixed results primarily due to supply-side issues arising from a lack of inter-departmental convergence. In terms of cost, it was found that the unit cost to improve the intake of food and nutrients and micronutrient supplementation was \$89 and \$83 respectively per additional woman reached through the Programme activities.

Some action points to develop the approach are outlined below:

- **Mapping priorities of SRLMs to Swabhimaan interventions for scale-up phase:** ROSHNI-CWSA can support SRLMs in mapping FNHW priorities to Swabhimaan interventions. This will ensure that the FNHW activity can replicate the positive impacts of Swabhimaan.
- **Developing customised package of interventions:** UNICEF can support DAY-NRLM in developing a customised package of interventions ('light-touch' model) based on the findings from the mapping of priorities (mentioned above) and the cost-effectiveness study (refer to Recommendation 7)

**Recommendation 2:** Strengthen convergence in programme design and implementation

<b>Priority:</b> High	<b>Corresponding Evaluation Criteria:</b> Effectiveness, Efficiency, Sustainability	<b>Responsible Organisations:</b> UNICEF state offices, DAY-NRLM, SRLMs, ROSHNI-CWSA, other line departments
-----------------------	--	--

The evaluation found that some Swabhimaan interventions are aligned with existing national-level nutrition schemes and programmes (like FNHW, POSHAN 2.0) and the Programme had clear guidelines for convergence. However, it was found that convergence meetings functioned as planned at the district and block levels but did not take place at the state-level, as planned. The failure to adhere to convergence protocols was partly attributable to the fact that FNHW interventions are considered as a 'top-up' activity. Findings also showed that there was a lack of clarity amongst FLWS on the roles and responsibilities of CRPs, often leading to conflicts and a subsequent lack of convergence between them. Going forward, the Programme can consider:

- **Integrating activities with POSHAN 2.0:** Swabhimaan's activities to be aligned/integrated with government programmes like POSHAN 2.0 that is focused on addressing malnutrition, promoting nutrition awareness and habits, capacity building, etc. through mapping on linkages and points of convergence.
- **Increasing intra-vertical convergence within DAY-NRLM/SRLMs:** It is essential that financial inclusion and livelihoods verticals work closely with IBCB for effective implementation of FNHW programme activities like promotion of VRF and other community funds and nutri-based livelihoods.
- **Increasing liasoning with line departments to address supply side constraints:** DAY-NRLM, with support from UNICEF can organise regular convergence meetings with line departments to address the demand-supply gap.
- **Developing guidance for line departments managing FLWs:** DAY-NRLM can consider developing a convergence manual/guidance clearly delineating roles and responsibilities of FLWs and CRPs.

### Recommendation 3: Strengthen existing MIS and streamline monitoring and reporting processes

<b>Priority:</b> High	<b>Corresponding Evaluation Criteria:</b> Effectiveness, Efficiency, Sustainability	<b>Responsible Organisations:</b> UNICEF state offices, DAY-NRLM, SRLMs
-----------------------	---	---

Evaluation noted challenges in monitoring and reporting such as delays in development of monthly reports by CRPs and consequent deviations from stipulated reporting guidelines. Issues such as frequent transfers of personnel and weak knowledge transfer mechanisms were identified as barriers for creating a streamlined MIS. To address these issues, specific action points could include:

- **Exploring integration of Swabhimaan KPIs into existing MIS:** There is an opportunity to align inputs, outputs and process monitoring indicators of *Swabhimaan* into existing national-level MIS like POSHAN 2.0 MIS to avoid setting up a parallel MIS and overburdening the data system.
- **Conducting state-level scoping studies on various programme components:** SRLMs can commission multiple scoping studies on components such as HR, funding, training, MIS, etc. to identify gaps for targeted resolution.
- **Strengthening capacities of staff:** (a) CLFs can be provided with additional capacity building support to anchor monitoring and reporting of inputs, activities, outputs and outcomes, (b) Staff at all levels can be provided with capacity building support on monitoring and reporting activities.

### Recommendation 4: Strengthen training mechanisms with focus on retention

<b>Priority:</b> High	<b>Corresponding Evaluation Criteria:</b> Effectiveness	<b>Responsible Organisations:</b> UNICEF state offices, DAY-NRLM, SRLMs, ROSHNI-CWSA
-----------------------	---	--

Interviews with the UNICEF and SRLM staff revealed that the success of the Programme was largely owed to the community cadres who were trained and incentivised to carry out the Programme activities. However, CRPs expressed the need for refresher trainings and improved training tools for themselves and for providing messages to beneficiaries. Additionally, evidence from some KIIs found that during the scale-up phase, monetary incentivisation of such a large cadre of CRPs may not be feasible and activities will have to be carried out on volunteer-basis. This could lead to attrition within the cadres, which could affect the efficiency and effectiveness of the Programme. To tackle these challenges, some actions points could be:

- **Increasing frequency of refresher trainings:** DAY-NRLM and SRLMs can consider incorporating quarterly refresher trainings and develop protocols for the same.
- **Increasing touch points for trainings:** DAY-NRLM and SRLMs can consider techniques like online training sessions, WhatsApp groups of community cadres and master trainings for sharing reflections and feedback, etc. to increase participation in trainings.
- **Creating pool of trainers:** DAY-NRLM and SRLMs can consider identifying and creating a resource pool of master trainers at the national, state, district, block and village level who will focus on building capacities of CLFs and VOs.
- **Revamping existing training resources to include interactive IEC material:** UNICEF can support ROSHNI-CWSA and DAY-NRLM/SRLMs to develop AV-based training material to aid retention of knowledge from trainings.
- **Developing CLFs as training centres:** To increase reach, SRLMs can consider developing CLFs as training centres by channelling funds from community funds to support this activity.
- **Ensuring monetary incentives are paid timely:** SRLMs must ensure that monetary incentives to CRPs are paid regularly and on-time, wherever applicable.
- **Developing non-monetary incentive models for CRPs:** SRLMs that cannot provide monetary benefits to CRPs can consider incentivisation through non-monetary means such as:
  - Honours (CRP of the month/year; nominating them for honours outside the DAY-NRLM ecosystem)
  - Awards and prizes (like plaques, pins, certificates)
  - Advanced training courses
  - Public recognition (in the form of an article about the achievements of CRP on their website/newsletter; uniforms and identity cards with designation)

**Recommendation 5:** Re-examine human resource model at state and sub-state levels

<b>Priority:</b> High	<b>Corresponding Evaluation Criteria:</b> Efficiency	<b>Responsible Organisations:</b> UNICEF Field Offices, SRLM in different states
-----------------------	--	--

Interviews with UNICEF and SRLM representatives found that there was a need to hire more professionals with sector expertise and contextual knowledge who could support monitoring of the Programme at the state, district and block-levels. Some action points could be:

- **Developing plans to ensure effective HR allocation:** SRLMs can assess human resource requirements and develop allocation plans to implement FHNW activities, especially at the block-level.
- **Hiring qualified, local personnel:** Hiring protocols can focus on candidates with prior knowledge or experience in FHNW-related work, knowledge of local context, relevant educational qualifications, and proficiency in regional language.

**Recommendation 6:** Strengthen efforts to address gender and equity concerns

<b>Priority:</b> High	<b>Corresponding Evaluation Criteria:</b> Gender and Equity	<b>Responsible Organisations:</b> UNICEF state offices, DAY-NRLM, SRLMs, ROSHNI-CWSA
-----------------------	---	--

The evaluation noted that the Programme is gender-sensitive and inclusive by virtue of its design and target groups but the engagement with men and boys is limited. Additionally, it was found that social norms are deeply entrenched and complex (like caste, class, power, poverty, patriarchy, etc.), and require the participation of the larger community for effective behaviour change. To address these issues, some action points could include:

- **Continued focus on men and adolescent boys:** DAY-NRLM and ROSHNI-CWSA can develop customised training material for men and boys with messaging around sexual and reproductive health, maternal, infant and newborn health and dietary practices to be discussed in PLA meetings.
- **Including mothers-in-law as a secondary target group to increase participation of newly married women in PLA meetings:** DAY-NRLM can consider addition of mothers-in-law in separate PLA meetings to address socio-cultural barriers around mobility restrictions, food habits etc. to help newly married women navigate challenges within the household.
- **Including social influencers for messaging/campaigns:** DAY-NRLM can consider inclusion of individuals like religious leaders, tribal healers, etc. (who have social acceptance within the community) for targeted messaging, campaigns, and rallies .

**Recommendation 7:** Generate evidence and disseminate learnings to promote programme ownership and sustainability

<b>Priority:</b> High	<b>Corresponding Evaluation Criteria:</b> Sustainability	<b>Responsible Organisations:</b> UNICEF ICO, UNICEF state offices, DAY-NRLM, SRLMs, ROSHNI-CWSA
-----------------------	--	--

While secondary data (i.e., evaluation reports, studies, etc.) was available as resource material for the evaluation, there was limited evidence for certain components like some Programme activities being conducted, the nature of convergence, the specific interventions that were being considered by SRLMs for the 'light-touch' scale-up model etc. Some action points to address the evidence gap could be:

- **Conducting state-level scoping studies on various programme components:** SRLMs can commission multiple scoping studies on components such as HR, funding, training, MIS, etc. to identify gaps and develop targeted approaches to address them.
- **Assessing cost-effectiveness of different programme elements:** DAY-NRLM can utilise findings from cost-effectiveness study (being undertaken jointly by UNICEF and DAY-NRLM) to develop an understanding of which programme components to budget for/invest in during scale-up.
- **Advocating for robust evidence generation:** UNICEF to promote robust evidence generation during scale-up phase through process monitoring studies, evaluations, etc. with DAY-NRLM to ensure adaptability and responsiveness to local contexts.

**Disseminating results with key stakeholders:** UNICEF to advocate results of *Swabhimaan* through regular dissemination workshops with government and other key partners to ensure ownership and sustainability of the Programme.

# References

*Can Covid-19 provide opportunities to strengthen the SHG movement? – Iwwage.* (2020, May 14). <https://iwwage.org/covid-19-provide-opportunities-to-strengthen-the-shg-movement/>

Chattopadhyay, A., Sethi, V., Nagargoje, V. P., Saraswat, A., Surani, N., Agarwal, N., Bhatia, V., Ruikar, M., Bhattacharjee, S., Parhi, R. N., Dar, S., Daniel, A., Sachdev, H. P. S., Singh, C. M., Gope, R., Nath, V., Sareen, N., De Wagt, A., & Unisa, S. (2019). WASH practices and its association with nutritional status of adolescent girls in poverty pockets of eastern India. *BMC Women's Health*, 19(1), 89. <https://doi.org/10.1186/s12905-019-0787-1>

*Country Programme Action Plan 2018-2022.* (n.d.). UNICEF, Government of India.

Davies, R. (2005). *The 'Most Significant Change' (MSC) Technique: A Guide to Its Use*. <https://doi.org/10.13140/RG.2.1.4305.3606>

*Evaluation Criteria—OECD.* (n.d.). Retrieved December 9, 2022, from <https://www.oecd.org/dac/evaluation/dacriteriaforevaluatingdevelopmentassistance.htm>

Graham, A., Powell, M., Taylor, N., Anderson, D., & Fitzgerald, R. (n.d.). *Ethical Research Involving Children*. UNICEF Office of Research - Innocenti. Retrieved May 2, 2023, from <https://www.unicef-irc.org/publications/pdf/eric-compendium-approved-digital-web.pdf>

Gugerty, M. K., Biscaye, P., & Leigh Anderson, C. (2019). Delivering development? Evidence on self-help groups as development intermediaries in South Asia and Africa. *Development Policy Review*, 37(1), 129–151. <https://doi.org/10.1111/dpr.12381>

Hazra, A., Das, A., Ahmad, J., Singh, S., Chaudhuri, I., Purty, A., Prost, A., & Desai, S. (2022). Matching Intent With Intensity: Implementation Research on the Intensity of Health and Nutrition Programs With Women's Self-Help Groups in India. *Global Health: Science and Practice*, 10(2), e2100383. <https://doi.org/10.9745/GHSP-D-21-00383>

Kumar, N., Kaur, H., Sivaram, S., & Desai, S. (n.d.). *Delivering a multisectoral intervention to improve girls' and women's nutrition before conception, during pregnancy and after birth in India: A fidelity assessment*.

Kumar, N., Scott, S., Menon, P., Kannan, S., Cunningham, K., Tyagi, P., Wable, G., Raghunathan, K., & Quisumbing, A. (2018). Pathways from women's group-based programs to nutrition change in South Asia: A conceptual framework and literature review. *Global Food Security*, 17, 172–185. <https://doi.org/10.1016/j.gfs.2017.11.002>

Kumar, P., Srivastava, S., Chauhan, S., Patel, R., Marbaniang, S. P., & Dhillon, P. (2021). Associated factors and socio-economic inequality in the prevalence of thinness and stunting among adolescent boys and girls in Uttar Pradesh and Bihar, India. *PLoS One*. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7904204/>

Mayne, J. (2012). Contribution analysis: Coming of age? *Evaluation*, 18(3), 270–280. <https://doi.org/10.1177/1356389012451663>

Mishra, R. (2016). Nutrition and Health Status of Women and Children of Pahari Korwa Tribe in Chhattisgarh. *Madhya Pradesh Journal of Social Sciences*. <https://go.gale.com/ps/i.do?id=GALE%7CA558368331&sid=googleScholar&v=2.1&it=r&linkaccess=abs&issn=0973855X&p=AONE&sw=w&userGroupName=anon%7Eafae7bf8>

Monica Shrivastav, B. M., Abhishek Saraswat, Neha Abraham, R. S. Reshmi, Sarita Anand, Apolenarius Purty, Rika Shalima Xaxa, Jagjit Minj, & Sethi, V. (2021). *Early lessons from Swabhimaan, a multi-sector integrated health and nutrition programme for women and girls in India*. 65, 103.

*MoU signed between Lady Irwin College & MoRD for Roshni.* (n.d.). Retrieved February 15, 2023, from <https://pib.gov.in/pib.gov.in/Pressreleaseshare.aspx?PRID=1549866>

*National Family Health Survey (NFHS-5).* (2019). IIPS and ICF. [http://rchiips.org/nfhs/NFHS-5\\_FCTS/India.pdf](http://rchiips.org/nfhs/NFHS-5_FCTS/India.pdf)

- National Family Health Survey (NFHS-4). (2017). IIPS and ICF. <http://rchiips.org/nfhs/NFHS-4Reports/India.pdf>
- Overview of Swabhimaan. (2017). UNICEF India. <http://www.roshni-cwca.co.in/UploadDocument/UnicefSwabhimOverviewReport.pdf>
- Patel, P., Das, M., & Das, U. (2018). The perceptions, health-seeking behaviours and access of Scheduled Caste women to maternal health services in Bihar, India. *Reproductive Health Matters*, 114–125.
- Philip T. James, R. M., Stephanie V. Wrottesley, Natasha Lelijveld, Eilise Brennan, Bridget Fenn, & Mates, E. (2022). *Women's nutrition: A summary of evidence, policy and practice including adolescent and maternal life stages*. 0, 0.
- Rani, N. (2019). Effect of Malnutrition on Schedule Caste School Going Children in Rural Area of Darbhanga District in Bihar. *International Journal of Engineering Development and Research*. <https://www.ijedr.org/papers/IJEDR1901007.pdf>
- ROSHNI, C. (2019a). *Swabhimaan Progress Update July 2018 Bihar*.
- ROSHNI, C. (2019b). *Swabhimaan Progress Update July 2018 Chhattisgarh*.
- ROSHNI, C. (2019c). *Swabhimaan Progress Update July 2018 Odisha*.
- ROSHNI, C. (2020a). *3-year Annual Progress Comparative Report (2017-2019)—Bihar*.
- ROSHNI, C. (2020b). *3-year Annual Progress Comparative Report (2017-2019)—Chhattisgarh*.
- ROSHNI, C. (2020c). *3-year Annual Progress Comparative Report (2017-2019)—Odisha*.
- Roy, T. K., Kulkarni, S., & Vaidehi, Y. (2004). Social Inequalities in Health and Nutrition in Selected States. *Economic and Political Weekly*, 39(7), 677–683.
- Sethi, V. (n.d.). *Evaluation of impact of engaging federations of women groups to improve update of women's nutrition interventions—Before, during and after pregnancy in social and economically backward geographies: Evidence from three eastern Indian states*.
- Sethi, V., Bhanot, A., Bhalla, S., Bhattacharjee, S., Daniel, A., Sharma, D. M., Gope, R., & Mebrahtu, S. (2017). Partnering with women collectives for delivering essential women's nutrition interventions in tribal areas of eastern India: A scoping study. *Journal of Health, Population and Nutrition*, 36(1), 20. <https://doi.org/10.1186/s41043-017-0099-8>
- Sethi, V., Bhanot, A., Bhattacharjee, S., Gope, R., Sarangi, D., Nath, V., Nair, N., Singh, U., Daniel, A., Parhi, R. N., Sinha, S., Loomba, A., S, S., Purty, A., Ali, N., Mohapatra, B., Agarwal, N., Bhatia, V., Ruikar, M., ... Unisa, S. (2019). Integrated multisectoral strategy to improve girls' and women's nutrition before conception, during pregnancy and after birth in India (Swabhimaan): Protocol for a prospective, non-randomised controlled evaluation. *BMJ Open*, 9(11), e031632. <https://doi.org/10.1136/bmjopen-2019-031632>
- Singh, R., & Alok. (2018). Recent Changes in Health Status of Women in Bihar through National Family Health Survey Window. *Journal of Clinical and Diagnostic Research*. [https://www.jcdr.net/articles/PDF/11413/33975\\_CE%5bRa%5d\\_F\(P\)\\_PF1\(MLS\\_SHU\)\\_PFA\(MLS\\_AnG\)\\_PB\(MLS\\_AnG\)\\_PN\(SL\).pdf](https://www.jcdr.net/articles/PDF/11413/33975_CE%5bRa%5d_F(P)_PF1(MLS_SHU)_PFA(MLS_AnG)_PB(MLS_AnG)_PN(SL).pdf)
- Som, & Mishra. (2014). BIMARU States: Need a Rethinking. *IOSR Journal of Humanities and Social Science*, 19(7), 34–41. <https://doi.org/10.9790/0837-19713441>
- Thomas, D., Sarangi, B. L., Garg, A., & Ahuja, A. (2015). Closing the health and nutrition gap in Odisha, India: A case study of how transforming the health system is achieving greater equity. *Social Science and Medicine*. <https://www.sciencedirect.com/science/article/pii/S0277953615003421>
- UNEG. (n.d.-a). *UNEG Code of Conduct for Evaluation in the UN System*. United Nations Evaluation Group. Retrieved February 11, 2022, from [https://procurement-notices.undp.org/view\\_file.cfm?doc\\_id=245190](https://procurement-notices.undp.org/view_file.cfm?doc_id=245190)
- UNEG. (n.d.-b). *UNEG Ethical Guidelines for Evaluation*. Retrieved April 13, 2022, from <http://www.unevaluation.org/document/detail/2866>

UNICEF. (n.d.). *UNICEF Procedure on Ethical Standards in Research, Evaluation, Data Collection and Analysis*. UNICEF Global Development Commons. Retrieved February 11, 2022, from <https://gdc.unicef.org/resource/unicef-procedure-ethical-standards-research-evaluation-data-collection-and-analysis>

*UNICEF Strategic Plan (2021-2025)*. (2021). UNICEF. <https://www.unicef.org/sites/default/files/2022-02/UNICEF-strategic-plan-2022-2025-publication-EN.pdf>

*UNICEF-Adapted UNEG Evaluation Reports Standards*. (2017). UNICEF. <https://www.unicef.org/evaluation/media/816/file/UNICEF-Adapted-UNEG-Evaluation-Report-Standards.pdf>

Unisa, S., Saraswat, A., Bhanot, A., Jaleel, A., Parhi, R. N., Bhattacharjee, S., Purty, A., Rath, S., Mohapatra, B., Lumba, A., Sinha, S., Kejrewal, N., Agrawal, N., Bhatia, V., Ruikar, M., & Sethi, V. (2021). Predictors of the diets consumed by adolescent girls, pregnant women and mothers with children under age two years in rural eastern India. *Journal of Biosocial Science*, 53(5), 663–682. <https://doi.org/10.1017/S0021932020000462>

Upadhyay, R. K. (2018). Major Issues Related to Women Health, Social, Cultural and Economic Development. *Interventions in Gynaecology and Women's Healthcare*. <https://lupinepublishers.com/gynecology-women-health-journal/fulltext/major-issues-related-to-women-health-social-cultural-and-economic-development.ID.000150.php>

Valdés-Ramos, R., Martínez-Carrillo, B. E., Aranda-González, I. I., Guadarrama, A. L., Pardo-Morales, R. V., Tlatempa, P., & Jarillo-Luna, R. A. (2010). Diet, exercise and gut mucosal immunity. *Proceedings of the Nutrition Society*, 69(4), 644–650. <https://doi.org/10.1017/S0029665110002533>

Verma, D. K. (2020). Anthropometric Assessment of Nutritional Status in Relation to Socio-Economic Determinants among Bhatra Women of Bastar, Chhattisgarh, India. *International Journal of Humanities Social Sciences and Education*. <https://www.arcjournals.org/pdfs/ijhsse/v7-i1/6.pdf>