# APPI/SPREAD Collective Action for Nutrition Social Audit Programme Odisha, India
## Final Evaluation Report

Jessica Gordon, Jean-Pierre Tranchant, Laura Casu, Becky Mitchell & Nicholas Nisbett

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A mother with her child in a tribal district of Odisha, India. © 2014 Nikhil Utture, Courtesy of Photoshare

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# Acknowledgements

# Executive Summary

**Introduction**

This report summarises the background, design and methods, and key findings from an independent evaluation of the Collective Action for Nutrition (CAN) Social Audit programme designed and implemented by the Odisha-based non-governmental organisation (NGO) Society for Promoting Education and Rural Development (SPREAD) and supported by Azim Premji Philanthropic Initiatives (APPI). The evaluation was led by the Institute of Development Studies (IDS), UK in partnership with Development Corner Consulting (DCOR), India. Findings are intended to provide evidence on the effectiveness of the social audit model and feed into future plans for replication and scale-up.

**Background**

The first two sections of the report present the background to the intervention and the evaluation design.

Whilst India has seen steady improvements in health and nutrition services over the past decade, as reflected in some improvements in nutrition outcomes (e.g. infant mortality rates, child stunting rates), significant quality and coverage issues remain at community level, meaning that wide disparities in nutrition outcomes still exist based on inequities of socioeconomic status, caste, ethnicity, gender, and geography.

Social accountability approaches, including social audits, offer a demand-driven alternative to improving delivery of state nutrition-related services. India has a long history of innovation in social accountability approaches with social audits now institutionalised in a number of national policies and programmes including the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) and the National Food Security Act (NFSA 2013), which is the focus of the CAN programme and this evaluation. The NFSA aims to improve food and nutrition security to citizens by bringing together four existing programmes: the Targeted Public Distribution System (TPDS); the Midday Meals (MDM) programme; Integrated Child Development Services (ICDS), and the Maternity Entitlement Scheme (MAMATA).

The Odisha-based NGO SPREAD works to empower marginalised communities to access their rights. Their geographic focus is six districts (Balangir, Nuapada, Kalahandi, Malkangiri, Koraput, and Nabarangpur) of the 'KBK+' districts of Odisha.[1] The three-year CAN programme's overall goal is 'Reducing malnutrition among children and women by facilitating efficient implementation of food and nutrition programmes, ensuring transparency, downward accountability, and community participation.' The programme is running between August 2016 and July 2019. The main intervention focus is a social audit process designed to sensitise communities to their rights and entitlements under the four primary schemes covered by the NFSA. Interim outcomes expected include increased knowledge and uptake of NFSA services, improved participation in community-level governance activities (especially by women), and improved institutional delivery of nutrition services and entitlements. The longer-term outcome anticipated is reduced malnutrition amongst target communities, particularly for women and children, as a result of increased uptake and improved institutional delivery.

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[1] A number of more marginalised districts which were bounded originally by older boundaries of Koraput, Balangir, and Kalahandi.

The SPREAD programme design divides the intervention into three main phases: the pre-social audit, social audit, and post-social audit phase. All three phases involve interaction with a wider range of community and state actors, including NFSA rights holders in the community, government officials, community leaders, and service providers. During the pre-social audit phase, the social audit calendar is developed, community volunteers (Samikshya Sathis – SSs) are recruited, and social audit teams are set up. In this phase, intensive campaigns are also conducted as build-up activities for the social audit. During the intensive seven-day social audit process in each intervention Gram Panchayat (GP), a series of meetings and activities take place, including initial village meetings, focus group discussions (FGDs) with local council members (the Panchayati Raj Institution – PRI), field surveys, data collection with NFSA rights holders and verification of registers and documentation, followed by data compilation, and report writing.

The process culminates in the organisation of a public hearing taking the form of a formal village council (PRI) meeting (a Gram Sabha – GS) to share findings and grievances raised as part of the data collection. During the post-social audit phase, the social audit team are expected to follow up on NFSA grievance redressal with the relevant government officials being accountable. In the post-audit social 'follow-up' stage, the CAN programme also began work on nutrition behavioural change via a further participatory learning and action (PLA) model, but this part of the intervention is not covered or evaluated here as it fell outside of the period and scope of the evaluation.

**Evaluation design**

To assess the impact and operation of this model, the evaluation was tasked with the following two overarching objectives:

1.    To determine the short-term impact of the SPREAD model of social audits on improving the delivery of nutrition services and entitlements, as well as the uptake of these services by target groups;

2.    To understand how the social audit process leads to:
      a.    Changes in knowledge, behaviour, and practice at the household level
      b.    Community-level changes and outcomes.


The design consists of three interwoven methodological components designed to complement each other as part of a mixed methods theory-based design which draws on the programme's theory of change (Figure 1). These include:

1.    A quantitative component, based on a rigorous experimental survey design which measures the impact of the social audit on a range of outcomes;
2.    A process evaluation component, which documents critical processes, mechanisms, and outputs to assess quality of the implementation of the social audit programme;
3.    A qualitative community-based study, which explores community-level perceptions and contextual factors related to the outcomes of the social audit.

The quantitative baseline survey was conducted in December 2017–January 2018, followed by an endline survey in April–May 2018. This was shortly followed by the community-based qualitative and process fieldwork carried out in July–August 2018. Programme data used for the process evaluation were collected and analysed throughout the evaluation. Final mixed methods data analysis, synthesis, and triangulation was undertaken between September–November 2018.

The quantitative evaluation is based on an experimental design in which the timing of the social audits was randomly varied across the local administrative units (GPs), to enable a

causal estimation of the impact of the social audits. Specifically, the impact estimates are based on exogenous variations in the length of time between the social audit and the endline data collection. Treatment assignment was done at the GP level, with GPs randomly assigned into an 'Early' group (E) and 'Late' group (L). In the Early group, the gap between the social audit and endline data collection is about three months, whereas in the Late group, it is one month. As such, the focus of the design is on the more immediate outcomes of the project, rather than longer-term outcomes.

Quantitative findings draw on two sources of comparisons: (i) the experimental comparison between Early and Late GPs (based on differences in or on endline levels of the outcomes), and (ii) the before–after comparison in all GPs. Combining both sources of comparisons allows us to ascertain if there had been any impact directly as a result of the intervention; as well as whether the impact was immediate and short-lived (changes significantly higher in 'Late GPs'), or cumulative (changes significantly higher in 'Early GPs'). This model had limitations, however, as firstly, such a short duration between baseline and endline means that the evaluation focuses on the short-term impacts to communities participating in the social audit, even though we know that such processes of accountability and empowerment require a long time to filter through to improvements in service delivery (if at all). Secondly, because if desired results improved, in both Early and Late GPs, we would be unable to tell whether such improvements were the result of the communities' participation in the programme; or simply wider societal or service delivery changes that were picked up during this period of time.

Despite these limitations, this research design still enables us to rigorously assess the effects of social audits, despite the constraint of having all GPs receiving the intervention in phase 1 of the programming.

Outcomes were measured through pre- and post-social audit questionnaires administered to primary caregivers (PCs) of a child below 24 months, pregnant women, men (typically the husbands of caregivers or pregnant women), adolescent girls, Anganwadi workers (AWWs), Accredited Social Health Activist (ASHA) workers, and Sarpanchs. Specific outcomes measured include knowledge of households of NFSA entitlements; access to and uptake of health and nutrition services; the perceived quality and responsiveness of health and nutrition services; food security and Infant and Young Child Feeding (IYCF) knowledge and; participation in community-level governance and civic attitudes. For the quantitative sample, a total of 116 GPs (58 in each treatment arm) were selected. Given 20 observations (households) per GP and an intra-cluster correlation coefficient of 10 per cent, 116 GPs allowed for detection of an effect size of 0.22 standard deviations with a statistical power of 80 per cent. The number of households was later increased to 24 per GP, thus raising the statistical power to 8 per cent. For GP-level outcomes, for which there is only one observation per GP, we are able to detect an effect size of 0.5 standard deviation with a statistical power of 80 per cent.

The process evaluation component drew on a range of primary and secondary qualitative and quantitative data sources, including programme documents, and Management Information System (MIS) data, community-level in-depth interviews (IDIs), and FGDs with community members, SPREAD/SS (volunteer) staff, and others and the evaluation's quantitative data. The qualitative evaluation component methods were based on community-level IDIs and FGDs with community members, government officials, SPREAD/SS/social audit team members and NFSA service providers. Community-level data collection for both qualitative and process components was incorporated into the same tools and fieldwork process. A total of 11 villages were selected as case studies from across three districts (Balangir, Kalahandi, Koraput) based on a stratified random sample from the quantitative evaluation sample. A total of 121 IDIs and 80 FGDs were conducted.

**Figure 1 Theory of change developed for use by the evaluation**
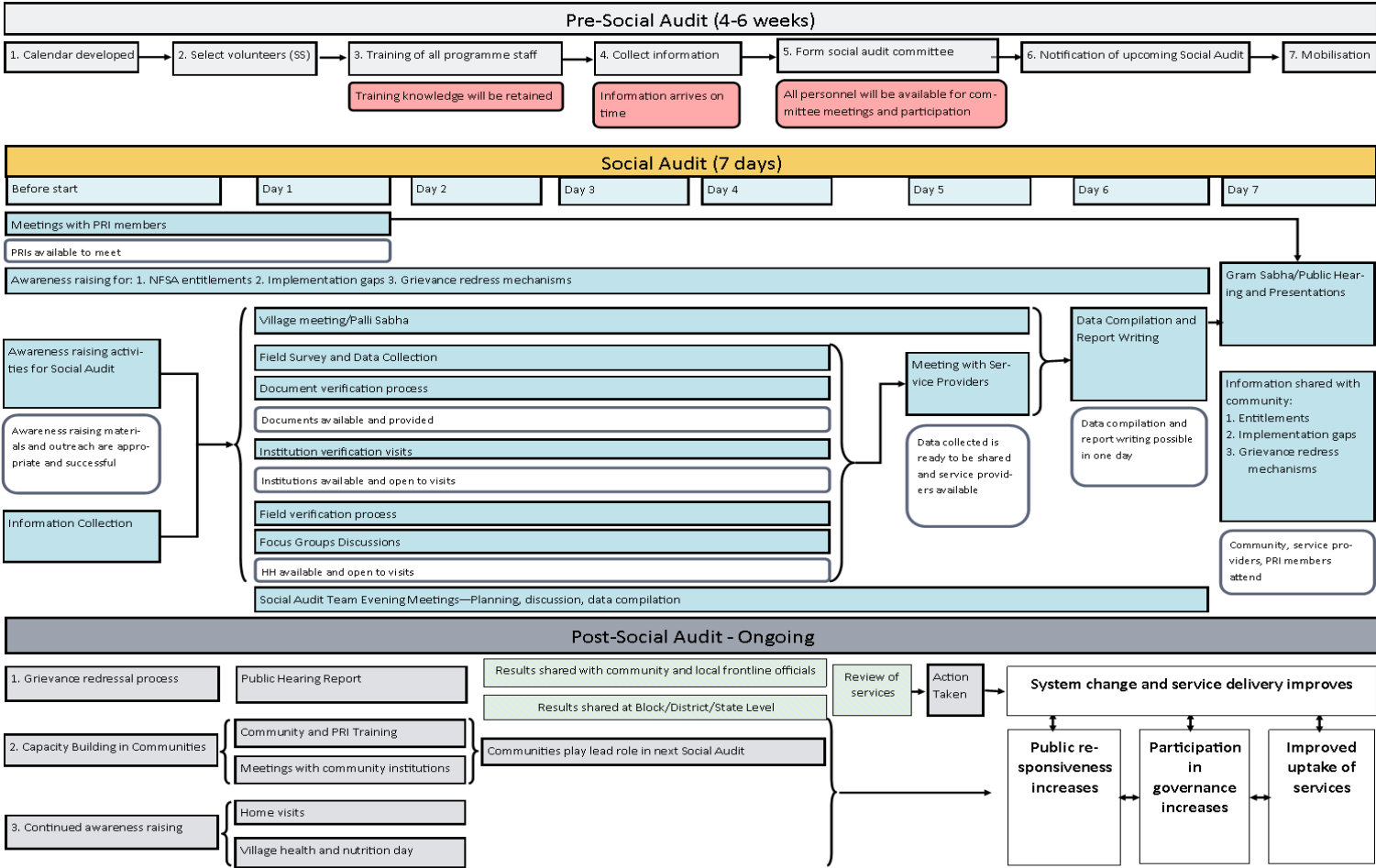


*Source*: Authors' own.

**Findings**

*Section 3 of the report contains our findings on the CAN programme's design, implementation, and processes.* These present a largely positive picture, albeit with some challenges faced and areas for further improvement. The programme model was built on existing experience and best practice, relied on the use of comprehensive guidelines (such as the Social Audit Manual), was modified through an extensive piloting process and suitably adapted to the local context to meet the programme's objectives. In terms of staffing, SPREAD recruited over 700 people at all organisational levels (state, block, district, GP) with only a few minor delays to recruitment and some staff turnover which didn't appear to affect implementation.

Extensive staff training and staff development activities were conducted at all levels and covered a range of approaches including participatory, group, and practice exercises supported by adequate induction materials and resources. Specific detailed training was conducted for the Samakhya Sathis (SS – the two volunteers recruited locally in each GP). Training was also undertaken with Gaon Kalyan Samiti and PRI members, and involved other relevant organisations. This helped develop trust and community/local governance relations. The selection of areas to work on based on nutrition vulnerability appear sensible, as was the decision to move to blanket coverage of Anganwadi Centres (AWCs) in implementation areas. However, given the model's intensity of personnel and resource requirements, a more streamlined, leaner model may be required for further scale-up.

For MIS, SPREAD relied on a new mobile-based system to collect real-/near-time data on all aspects of the social audit process. This included AWC and Fair Price Shop verifications, along with checks on midday meals in schools; as well as interviews with 20 per cent of ICDS beneficiaries from each Anganwadi centre. This data were compiled and shared with the community and relevant stakeholders at the end of the social audit in each GP. Some delays and challenges were faced in setting up and implementing the MIS approach but overall, it was deemed successful in enabling the team to better streamline data entry, cleaning, and analysis, and enable real-time monitoring, decision-making, and sharing with the community during public hearings. Some gaps in the effective monitoring of longer-term outcomes were identified.

Overall, many community members reported that their participation in the social audit process was a positive experience and was a useful tool to voice concerns, increase access to services, and involve communities directly in resolving grievance issues. Most government officials and NFSA service providers considered it to be a positive, useful, and well-managed process, although some NFSA service providers felt that issues with the TPDS couldn't be solved by an NGO and could only be addressed at a 'higher level'.

Over half (59 per cent) of primary caregivers surveyed said that they knew what a social audit was and a similar proportion (57 per cent) said that they were aware that a social audit had taken place in their GP, though there was substantial variation in awareness levels across districts (ranging from 40–80 per cent). Some village-level (Palli Sabha – PS) and wider Gram Sabha (the formal administrative unit often incorporating more than one village) meeting attendance issues were highlighted. The SPREAD team made efforts to address these issues through early and continued positive engagement with communities and officials. Difficulties were faced by the social audit team in improving immediate access to nutrition entitlements and ensuring that grievances remained focused on nutrition issues as opposed to other issues (including housing, roads, etc.).

In terms of participation rates, around one in five men (18 per cent) and women (23 per cent) from the quantitative sample attended the Palli Sabha. For women – but not for men – participation in the Gram Sabhas was much lower (10 per cent) than in the Palli Sabhas. The main reasons for lack of attendance at the GS were slightly different between men and

women: both highlighted that they were busy and lacked time (62 per cent for women and 44 per cent for men), but men were more likely to be absent from the village at the time of the meeting (38 per cent). Qualitative data suggest other possible reasons for non-participation included women's status in the household and because someone else in the household participated.

*Section 4 of the report considered the evidence we have gathered on the outcomes mapped in the theory of change* (Figure 1) relating primarily to awareness and knowledge of services, entitlements, and grievance redressal avenues; access to and satisfaction with services; use of grievance redressal and broader measures of community participation and empowerment. We also considered the broader impacts on food security and IYCF knowledge.

In terms of *knowledge of NFSA services, entitlements, and grievance mechanisms*, we see some significant changes, varying by service. Knowledge about the **ICDS** service of Take-Home Ration (THR) improved amongst caregivers and pregnant women, the latter seeing some very high changes (+25/+21 pp early/late). With no significant differences between Early and Late GPs we cannot be sure that these changes are cumulative or indeed connected to the social audit process. However, in the absence of other supply- or demand-side activities happening with regard to ICDS during this period, it is hard to rule out their connection to the CAN programme.

Awareness and knowledge of the **MAMATA** scheme and entitlements did significantly improve for the target group of pregnant women between baseline and follow-up. Such changes tend to be significantly more marked in Early GPs, indicating a cumulative positive impact of social audits.

Knowledge about the **TPDS** improved substantially or very substantially amongst all groups sampled – caregivers, pregnant women, and men. These included variables measured such as overall knowledge of entitlements and knowledge about PDS committees. The changes for men were the most marked and were also more pronounced in Early than Late GPs. This suggests that these impacts were due to cumulative exposure to the social audit process and the community-level activities it set into motion. More detailed views of those who participated in the community IDIs and FGDs lend further credence to the view that such gains in knowledge were related to attendance at social audit events and processes.

In terms of *access to, uptake of, and satisfaction with NFSA services and entitlements*, we see a more varied pattern but which includes improvement in some areas across all services. For **ICDS**, we saw an increase in the likelihood that a child was provided with special food following growth monitoring, and a small but statistically significant increase in referral to rehab centres after monitoring. Neither of these changes differed significantly between Early and Late GPs, however.

For **MAMATA**, we see significant increases (+22pp) in enrolment amongst pregnant women in the Late GPs (increases in Early GPs were not statistically significant) and a significant increase (+31 pp) in pregnant women being satisfied by MAMATA. The latter change was significantly different between early and late groups, suggesting that the change in satisfaction was based cumulatively on length of exposure to the social audit and the processes it set in motion.

For **TPDS**, we see improvements for all groups sampled, but particularly for men, including decreases (-7pp) in men reporting having to pay extra money at the ration shop in Early GPs, and a higher likelihood of having been assigned an Aadhar number (+5pp). Both these changes are significantly different between early and late groups, suggesting a cumulative effect of the social audit process. Other changes where we cannot detect a significant difference between Early and Late GPs include, amongst primary caregivers, improvements and likelihood to have an Aadhar number, likelihood that ration shops deliver food on a

monthly basis, satisfaction with the TPDS, and the quantity of the food ration. Although these changes can't be directly linked to the social audit process, the magnitude of the changes in some cases (e.g. 32pp increases in ration shops delivering food monthly in Early GPs and 46pp in Late GPs) and the absence of other major supply- or demand-side changes observed during this period are highly suggestive that these changes are related to the CAN programme. This view is supported by the information garnered from some of the individuals who participated in the community IDIs and FGDs, who reported increases in access and availability of all the services that were the target of the social audit.

However, it is also the case that other participants in IDIs and FGDs complained that there have been no changes since the social audit, or discussed the fact that expected improvements in services they thought would result from their village's participation in the CAN programme has not happened. Others still, stressed that they had difficulty accessing the services (or actively participating in services) due to their marginalisation in village life, as a result of poverty, caste, or tribal status.

Some of the most surprising results in the outcomes measured relate to *use of and confidence to use grievance redressal processes*, particularly in light of the results on the positive effects of social audits, on knowledge of these processes, and on community participation. Confidence in an ability to raise issues regarding ICDS, MAMATA, and TPDS went down, with the difference between early and late groups statistically significant. We have been unable to explain these changes as the data we gathered in community IDIs and FGDs suggest that – in some cases at least – people's confidence about the use of these processes *had* improved. The fact that the decrease in confidence is less marked in Early GPs than in Late GPs lends some support to the hypothesis that after having learnt more about service entitlements, peoples' expectations increased beyond a level that they felt could be adequately met by simply complaining to the service providers. This hypothesis is also somewhat supported by the IDIs and FGDs we undertook with the service providers themselves, who reported that complaints *had* gone up but that they were frustrated that a lot of what was being complained about was not within their power to address (as these had more to do with systemic supply-side constraints).

Our findings on *community empowerment and voice in local nutrition-related decision-making* strongly support the view that social audits led to very large positive changes in the civic life-related attitudes of caregivers and pregnant women. Both groups of women became more positive about citizens being engaged in civic life and about states being responsive to citizens' demands. Social audits also strongly enhanced the community participation of pregnant women and the political participation of caregivers (both effects are seen in Early GPs only, which is evidence of a cumulative impact of social audits in this regard). Qualitative data provide a number of further illustrations of people's growing sense of awareness of the forms of redressal and of being able to voice their problems. Qualitative data also suggested that people became increasingly motivated to take part in community life via their membership of committees as a means to solve future problems. But our qualitative research also emphasised how entrenched power structures are in villages, and how the realities of daily life may limit the participation of others.

Again, surprisingly, *the changes we see in IYCF/nutrition-related knowledge and practices are not positive*. In fact, nutrition knowledge scores amongst primary caregivers declined in Early GPs – with the only positive result being amongst those in Late GPs and relating to 'other nutrition knowledge'. Declines in knowledge are not present in Late GPs, suggesting that social audits exert a cumulative *effect* of knowledge. This could be due to the delivery of nutrition knowledge being different in Late and Early GPs (this is an area that deserves further exploration by SPREAD and which they report is being actively addressed now in follow-up activities), and/or with service providers being diverted away from nutrition counselling towards other tasks as a result of the social audits.

Our *findings on food security and dietary diversity* show very significant improvements in dietary diversity scores for women and children. However, as nutritional knowledge amongst samples had not improved during that time and in some cases had deteriorated (with nutrition knowledge actually decreasing in Early GPs), it is hard to link this change to the social audits (although neither can we formally rule out the possibility that social audits had an immediate impact). Some other plausible explanations are that income changed significantly during this period as a result of greater livelihood opportunities, or that these are seasonal variations in food availability. Some mothers interviewed as part of the community IDIs and FGDs, however, *do* link the social audit to changes in their children's diets. Further work will be needed to understand changes in this area.

Similar to above, findings on occurrence, and awareness of *village health and nutrition days* showed significant improvements in both Early and Late GPs. The quantitative data made it difficult to attribute this to the social audits, although it is plausible, particularly given the limited positive evidence from the qualitative data that the audits exerted an immediate effect, given the scale of changes seen.

**Conclusions**
*Section 5 of the report summarises earlier sections and provides broader conclusions on the suitability of the model for the purposes of the programme.*

In terms of implementation, SPREAD have clearly shown the ability to put in place a large and complex operation – including the recruitment and management of several hundred staff – and implement the social audit process in a way that was mostly welcomed by those in the communities we surveyed or interviewed; most service providers and government officials. Operating at this scale and with the political acumen to do so in a way that was well integrated into local democratic institutions and government services (the PRIs, the Palli Sabhas, the Gram Sabhas, as well as securing the participation of local officials of the concerned services) is an immense first hurdle that many organisations might fail at without proper thought and experience. This is very positive, albeit a high bar for replicability elsewhere, including at larger or less resource-intensive scales. Even bearing in mind these positive findings, participation rates were not uniformly high. Whether participation rates (at around 23 per cent for the Palli Sabha amongst women and 10 per cent for the Gram Sabha) could have been higher depends a little on one's expectations of poor communities' capacity to spend at least several hours participating in such an exercise. This may be a question of design assumptions as much as a question of implementation.

We observed positive changes in nearly all the areas in which we measured outcomes. In some areas, we cannot relate changes directly and rigorously to communities' participation in the CAN programme for reasons of the limitations explained in terms of the methodology. However, this includes some large changes in both Early and Late GPs referred to above, for which we cannot as yet offer alternative explanations. Changes in dietary diversity for both women and children, however, though substantial, similarly did not differ between early and late groups and because these changes *could* plausibly be explained by other factors of increased income and food availability, we are more cautious in linking them to the presence of the social audit.

Outcomes that we measured and which showed significant difference between Early and Late GPs (results were all higher in Early as compared to Late GPs, suggesting a cumulative impact as the result of exposure) included awareness and knowledge of, and satisfaction with, the MAMATA scheme amongst pregnant women, knowledge of entitlements and PDS committees, decreases in having to pay extra money at a ration shop, and increases in Aadhar registration amongst men; enhanced community participation amongst pregnant women; and political participation amongst primary caregivers.

Finally, there are two areas in which we see outcomes changing in the opposite way to which we would have hoped – the confidence of those surveyed to raise issues with service providers and in women's IYCF knowledge scores. Qualitative data provide some support to the hypothesis that the former is due to the immediate rise in expectations not being met. We also note that the social audit process did not prioritise IYCF knowledge and many of the service improvements were concerned with delivery of hard outputs (THR, PDS, etc.) rather than improving the 'softer' skills and delivery tasks of frontline workers such as AWWs, who have responsibility for nutrition counselling. Wider evidence from India and elsewhere shows that without a concerted, sustained, high-intensity, and well-supported effort to change IYCF knowledge, such changes in knowledge – and certainly practice – will not happen. As this was not a core part of the CAN programme, such changes are therefore not so difficult to understand.

**In summary** and in terms of the original objectives of the evaluation, we *do* see sufficient evidence that the social audit model has the potential to improve delivery and uptake of NFSA services. These service improvements and uptake were not uniformly positive for all target groups, but in some areas, the changes were significant and directly linked to communities' participation in the social audit processes. The social audit did also lead to changes in knowledge, behaviour, and practice at a household level in terms of participation in the social audit itself and increased desire to participate in aspects of civic life such as committees related to NFSA delivery. Nutrition and IYCF knowledge, however, did not change. Given that this was not an objective of the evaluation and would not have been possible given our design and methods, we cannot offer a definitive answer to the question of whether a social audit design can result in changes in maternal and child nutritional status within the context of the delivery of NFSA services in Odisha. However, some of the changes we see are of a magnitude rarely witnessed in terms of the Indian services covered by the NFSA, or local democracy strengthening, whether in terms of knowledge/awareness, participation/empowerment, and service delivery/satisfaction. There is good evidence that SPREAD is well placed to continue to implement this model effectively. As the programme is continuing into its next phase, we make some further recommendations for its ongoing implementation in the final section.

**Implications for CAN programme Phase 2 design**

- IYCF knowledge more central; AWW (and others') roles in nutrition behaviour change communication (BCC) more central;
- Further operational research and attention to differences in social audit (SA) participation rates, particularly amongst women and more marginalised groups – and to take into account other calls on time (work/household chores, migration);
- Further work to understand why confidence to raise issues declines immediately after SA;
- Further work to build on positive results in terms of knowledge, access, and satisfaction across the services – and willingness to participate in community life/committees.

**Longer-term implementation, scalability questions/research**

- Different intensities of length of exposure/rate of exposure (how many times/year)
- Different organisational structures – less resource intensive?
- Increased level of policy engagement with state-level actors through strategic partnerships /networks to address service bottlenecks at district and state-level.

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# List of Abbreviations

A4NH        Agriculture for Nutrition and Health
AAY         Antyodaya Anna Yojna
ANC         antenatal care
APL         above poverty line
APPI        Azim Premji Philanthropic Initiatives
ASHA        Accredited Social Health Activist
AWC         Anganwadi Centre
AWW         Anganwadi Worker
BC          Block Coordinator
BCC         behaviour change communication
BDO         Block Development Officer
BPL         below poverty line
CAN         Collective Action for Nutrition
CAPI        Computer Assisted Personal Interviewing
CBO         community-based organisation
CSO         Civil Society Organisation
CDPO        Child Development Project Officer
DCOR        Development Corner Consulting
DID         Difference-in-Difference
DO          District Officer
DPM         District Programme Manager
FAO         Food and Agriculture Organization
FIES        Food Insecurity Experience Scale
FGD         focus group discussion
FPS         Fair Price Shop
FRA         Forest Rights Act
GKS         Gaon Kalyan Samitis
GMP         Growth Monitoring Programme
GoO         Government of Odisha
GP          Gram Panchayat
GPC         Gram Panchayat Coordinator
GS          Gram Sabha
ICC         intra-cluster correlation coefficient
ICDS        Integrated Child Delivery Services
IDI         in-depth interview
IDS         Institute of Development Studies
IEC         Institutional Ethics Committee
IFA         iron folic acid
IFPRI       International Food Policy Research Institute
IYCF        Infant and Young Child Feeding
JC          Jaanch Committee
LPG         liquid petroleum gas
KBK         Koraput, Bolangir, and Kalahandi
MAMATA      Maternity Entitlement Scheme
MC          Mothers' Committee
MDM         Midday Meal
MGNREGA     Mahatma Gandhi National Rural Employment Guarantee Act
MI          Market Inspector
MIS         Management Information System
MOU         Memorandum of Understanding
MSP         minimum support price
MUAC        mid-upper arm circumference

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| NFSA | National Food Security Act |
| NGO | non-governmental organisation |
| NHM | National Health Mission |
| NRC | Nutrition Rehabilitation Centre |
| OBC | Other Backward Caste |
| ODK | Open Data Kit |
| OSSAAT | Odisha Society for Social Audit Accountability and Transparency |
| PC | Primary Caregiver |
| PIP | Programme Impact Pathway |
| PDS | Public Distribution System |
| PHH | Priority Household |
| PLA | participatory learning and action |
| PP | percentage point |
| PPS | probability proportional to size |
| PRI | Panchayati Raj Institutions |
| PS | Palli Sabha |
| PVTG | Particularly Vulnerable Tribal Group |
| Rs. | rupee |
| RTE | Right to Education |
| RTF | right to food |
| RTI | Right to Information |
| SA | social audit |
| SAM | severe acute malnutrition |
| SC | Scheduled Caste |
| SCN | Standing Committee on Nutrition |
| SD | standard deviation |
| SEBC | Socially and Economically Backward Communities |
| SHG | self-help group |
| SMC | School Management Committee |
| SPREAD | Society for Promoting Education and Rural Development |
| SS | Samikshya Sathi |
| ST | Scheduled Tribe |
| THR | Take-Home Ration |
| TPDS | Targeted Public Distribution System |
| TT | tetanus toxoid |
| UW | underweight |
| VHG | Village Health Guide |
| VHND | Village Health and Nutrition Day |
| VHSC | Village Health and Sanitation Committee |
| WDDS | Women's Dietary Diversity Score |
| WHO | World Health Organization |

# 1 Introduction and background

## 1.1 Context of report

Azim Premji Philanthropic Initiatives (APPI) has identified fighting malnutrition in India as one of their strategic focal areas of work. In 2015, they signed a Memorandum of Understanding (MOU) with the Government of Odisha to work collaboratively to reduce malnutrition in the state, with a particular focus on stunting reduction amongst women, adolescent girls, and children under five years. In order to achieve this goal, APPI has been working closely with a number of existing public service delivery platforms over the past three years including the Integrated Child Delivery Services (ICDS) as well as various networks of civil society organisations, private sector stakeholders, and community actors. Sixteen key areas of intervention focus were identified which included governance accountability.

As part of this strategic effort, in August 2016, APPI entered into a new partnership with the Odisha-based NGO Society for Promoting Rural Education and Development (SPREAD) to design and roll out a three-year community accountability social audit programme entitled 'Collective Action for Nutrition' (CAN). In December 2017, APPI commissioned the Institute of Development Studies (IDS) to act as the lead technical partner in the design and implementation of an evaluation of the CAN programme to assess its effectiveness.

This final report summarises the background, evaluation design and methods, main findings, and recommendations from the evaluation, incorporating primary and secondary qualitative and quantitative data collection. The main target users of the report are APPI, SPREAD, and the Government of Odisha, as well as others wanting to learn from the social accountability model. It is hoped that findings will feed into ongoing plans and preparations for the next phase of the social audit programme due to commence in December 2018.

## 1.2 Undernutrition in Odisha

Over the past decade, India's coverage of basic health and nutrition services has steadily improved, partly as a result of universalisation of the government's Integrated Child Development Services (ICDS), which provides health, nutrition, and education services to young children. Despite substantial investments in roll-out, however, significant coverage and quality issues remain at community-level (Avula *et al.* 2015; Das Gupta *et al.* 2005). Less than 55 per cent of mothers and children receive any essential health and nutrition inputs (Avula *et al.* 2015), 38.4 per cent of children under five are stunted and under 10 per cent of children aged 6–23 months receive an adequate diet (Ministry of Health and Family Welfare (2016).

Odisha has an estimated poverty rate of 32.6 per cent which masks the social and spatial variation of poverty and inequity across the state (Thomas *et al.* 2015). For example, rural poverty rates in the KBK+ districts are 68 per cent compared to the state rural average of 46.9 per cent. There have been some notable overall improvements in health and nutrition outcomes in recent years; for example, infant mortality rates have declined from 65 per cent in 2005/6 to 40 per cent in 2015/16, and rates of stunting in children under five years (height for age) have fallen from 45 per cent to 34.1 per cent in this same period (less than the national average of 38.4 per cent). However, the incidence of child wasting (weight for height) has increased from 19.6 per cent to 20.4 per cent; 34.4 per cent of children under five are underweight; and rates of women with anaemia have risen from 51 per cent to 61.1 per cent (Ministry of Health and Family Welfare 2016). In addition to this, major inequalities of nutrition outcomes still exist based on socioeconomic status, caste, ethnicity, gender, and

geography. Therefore, fighting malnutrition, particularly for children and women, remains a major concern and priority.

## 1.3 Social accountability and social audits

Much of the global focus on addressing the high burden of malnutrition has been on strengthening supply-side institutions and policies (Waldman, Reed and Hrynick 2017; Gillespie and Margetts 2013). However, recent accountability literature suggests that this approach is too technocratic and 'top down', treating individuals as passive users rather than active citizens that engage with state services in multiple ways (Fox 2015). 'Social accountability' approaches offer an alternative model that emphasises demand-side citizen participation in state processes to help shape service improvements. A plethora of initiatives have emerged under this umbrella, including social audits, community scorecards, and citizen report cards (Gaventa and McGee 2013). Whilst approaches vary, most share an interest in the power of information and assume that by publicly exposing weaknesses in services, government actors will be forced to respond and improve service delivery (Houtzager and Joshi 2008). Several recent reviews focusing on social accountability (e.g. Fox 2015; McGee and Gaventa 2011; Joshi 2013) point to the growing but mixed evidence of their impact, which they attribute in part to a lack of clear theories of change or lack of rigorous study design. A few studies have reported significant impacts, including for example, in service delivery in India (Ravindra 2004) and Uganda (Björkman and Svennson 2009). Nonetheless, there is a need for more theory-based research and evidence to understand the particular impact pathways and contextual assumptions that might explain the reasons for success and failure of this type of approach. Findings from this evaluation will be used to contribute to this evidence gap.

India has been at the forefront of innovation in social accountability initiatives across many sectors (Pande 2007) and the use of social audits to expose and address state corruption in particular has gained widespread recognition (Fox 2015; Maiorano 2014). In their Social Audit Manual of the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA), India's Ministry of Rural Development define a social audit as 'verification of implementation of a programme/scheme and its result by the community with active involvement of the primary stake holders' (GoI 2005). Emerging from informal citizen-led action alongside the Right to Food Movement, social audits have since been formally institutionalised in national policies and programmes. This includes India's National Food Security Act (NFSA) (GoI 2013) (the focus of the SPREAD CAN programme and this evaluation) which aims to ensure 'food and nutritional security by ensuring access to adequate quantity of quality food at affordable prices' (GoI 2013). The Act covers community nutrition schemes, school feeding, maternity entitlements, and food distribution (discussed more in Section 1.4). Other legal frameworks in India that refer to social audits include the Supreme Court's Direction (2002); Right to Information Act (2005); and Right to Public Services Act (passed in 2012 in Odisha).

There have been few independent studies of social audits within the context of the NFSA to date. Existing evidence on the institutionalisation of social audits in India has focused on the Government of Andhra Pradesh's decision to mandate social audits as part of the National Rural Employment Guarantee Act. An evaluation of this approach reported significant positive impacts on employment and exposure of corruption compared to other states (Afridi and Iversen 2014), but questions have been raised about the model's sustainability given the capacity and resources required (Aiyar and Samji 2009). Other questions on the nature of citizen–state interactions (Fox 2015; Joshi 2013) highlight differences between confrontational social audit approaches which are designed to expose government failures and pressurise public officials into acting, versus more collaborative community scorecard processes. The Government of Odisha has shown a strong interest in the use of social audits as a tool to improve service delivery and have recently set up the Odisha Society for Social

Audit Accountability and Transparency (OSSAAT) under the Panchayati Raj Department and housed in the State Institute of Rural Development, Bhubaneswar. The first official Governing Body meeting was held in June 2018. The main objective of OSSAAT, said Principal Secretary Sri Singh, 'is to create enabling environment for the Gram Sabha and Palli Sabha to conduct impartial and effective social audits for the development schemes and programmes in its territory.'

Whether or not their existing governance structures can effectively and sustainably manage the sensitive processes social audits entail is a key consideration alongside continued delivery of NFSA services.

# 1.4 National Food Security Act (NFSA)

The NFSA, passed in 2013, aims to provide food and nutrition security to citizens by ensuring access to adequate quality and quantity of food at affordable prices through bringing together four core existing programmes under one Act:

- The **Targeted Public Distribution System** (TPDS) – a food and essential items distribution scheme which targets food-insecure households;
- The **Midday Meals** (MDM) programme – a school-based feeding programme targeting children ages 6–14 years;
- **Integrated Child Development Services** (ICDS) – a supplementary feeding programme targeting children between six months and six years, and pregnant and lactating women;
- **Maternity entitlements –** the Odisha state programme is referred to as MAMATA.

The Act has a strong focus on nutrition support to women and children and has also mandated social audits as a process through which citizens can collectively monitor implementation of these food and nutrition entitlements to ensure adequate access to these entitlements.

## 1.4.1 Targeted Public Distribution System (TPDS)

The Targeted Public Distribution System (TPDS) is the largest social protection programme in India, in terms of both government expenditures and number of beneficiary households. The NFSA entitles 50 per cent of the urban population and 75 per cent of the rural population to receive food benefits under the TPDS.

The previously universal Public Distribution System (PDS) was converted into a targeted system in 1997. Following this shift, beneficiaries were identified and divided into two categories, as either below the poverty line (BPL) or above the poverty line (APL). People in each category were entitled to a set of food grains at differing quantities and prices. In 2000, an additional classification of Antyodaya Anna Yojna (AAY, poorest of the poor) was introduced to provide the abject poor with dedicated food grain allocations at highly subsidised prices. In 2013, the scope and mandate of the TPDS expanded significantly through its incorporation into the National Food Security Act (NFSA). Before 2013, most households had one of the three types of ration cards previously described (BPL, APL, AAY). Now there are only two categories, namely Priority Household (PHH) and Antyodaya Anna Yojna (AAY).

The distribution of subsidised cereals through the TPDS is a major instrument for ensuring the availability of affordable food grain to the public, especially the poor. The quantity and price of food grain available to households depends on the type of ration card assigned to them. Persons belonging to PHH are entitled to receive 5kg of food grains (rice, wheat, and

coarse grains) per person per month at subsidised prices of Rs.3/2/1 per kilogramme. AAY households are entitled to 35kg per month at a rate of Rs.1 per kilogramme.

The TPDS provides subsidised food grain through a large network of government-licensed fair price shops (FPSs). The government purchases food grain from farmers based on a predetermined price floor, at a minimum support price (MSP). Then it provides highly subsidised food grain to low-income and vulnerable households. State governments are responsible for identifying beneficiaries and selecting fair price shops. The district food office provides beneficiary households with a ration card that serves as identification for accessing the TPDS. Once a household receives its ration card, its members can visit their FPS (all households are assigned to a specific FPS) to buy their food grain every month. Information on eligibility and purchases made from the TPDS are recorded on the card.

Recent technological changes have been introduced in order to improve delivery of the TPDS. Beneficiaries are enrolled biometrically by the Unique Identification Authority of India, which assigns each resident a unique Aadhaar identification number. The use of Aadhaar for the distribution of TPDS rations has been controversial and critics have pointed out the large number of access and technological failures and identification errors, amongst broader issues to do with security and privacy. Both exclusion and inclusion errors were recorded, i.e. people who should be included in the TPDS as eligible cardholders but who are excluded in reality, and people who are not eligible to be covered by the TPDS but who are included by mistake or through inefficiency in implementation.

## 1.4.2 Midday Meal (MDM)

The Midday Meal programme was first established in 1995 with a view to improve school enrolment, retention, and attendance, and simultaneously improve nutritional levels among children. Under this school-based feeding programme, children attending government-run schools, aged up to 14 years, are entitled to one free hot cooked nutritious meal per day at school (excluding holidays), served according to prescribed age-appropriate nutritional standards. The scheme is either provided via a decentralised model where meals are cooked on-site by local cooks, helpers, or self-help groups (this is the most common model, particularly for rural areas) or a centralised model where meals are prepared in external kitchens through public–private partnerships and delivered to schools (more common in urban areas with high density of schools). In case of non-supply of entitled meals, the rights holders are eligible to receive a food security allowance.

## 1.4.3 Integrated Child Development Services (ICDS)

The ICDS scheme provides a package of six services to children below six years of age, pregnant women, and nursing mothers. These are supplementary nutrition, immunisation, health check-up, growth monitoring and referral services, non-formal pre-school education, and nutrition and health education.

The ICDS scheme provides specific guidance on the weighing and growth monitoring of children, and counselling for mothers/caregivers by AWWs. Each child in the age group of 0–3 years must be weighed at least once every month and assessed against the World Health Organization (WHO) New Growth Standards register. If the growth trajectory is deemed to be normal, the AWW advises the mother/caregiver to maintain the feeding and hygiene practices that she has been following. If the growth trajectory is below expected parameters, mothers/caregivers are advised on age-appropriate feeding, food preparation, and hygiene practices. Severely malnourished children are referred for further medical check-ups.

Supplementary nutrition includes Take-Home Ration (THR) and Hot Cooked Meal. THR or *chhatua* (a wheat-based preparation) and two eggs per week are given to pregnant and

lactating mothers, and children from six months to three years. A hot cooked meal is provided daily to children between three and six years of age who attend the centre. Those children between three and six years who are found to be severely malnourished are also given THR, as well as the hot cooked meal. THR packets are colour-coded (yellow/sky-blue/red[2]), to ensure that the nutritional supplements are consumed by the intended beneficiary rather than by other family members.

## 1.4.4 MAMATA

The MAMATA conditional cash transfer scheme was launched by the state of Odisha to alleviate maternal and infant undernutrition. It provides monetary support to pregnant and lactating women for the first two live births, to enable them to seek improved nutrition and promote health-seeking behaviour.

The intermediate objectives identified by the Odisha government are as follows:

- To provide partial wage compensation for pregnant and nursing mothers so that they are able to rest adequately during their pregnancy and after delivery;
- To increase utilisation of maternal and child health services, especially antenatal care (ANC), postnatal care, and immunisation;
- To improve mother and child care practices, especially exclusive breastfeeding and complementary feeding of infants.

The specific target group for this scheme are pregnant and lactating women of 19 years of age and above, except those who already avail of the maternity benefit (i.e. who are themselves employees or wives of employees of state government/central government). The payable amount is transferred directly to the account of the rights holder. This was originally allocated in four instalments. From April 2017 onwards, the money is transferred in two instalments, dependent on their meeting the desired conditions, as specified below.

Allocation rules prior to April 2017 set the total monetary support at Rs.5000/- to be allocated as follows:

- First instalment: at the end of the second trimester of pregnancy, Rs.1,500/-
- Second instalment: after completion of three months after delivery, Rs.1,500
- Third instalment: after the infant completes six months of age, Rs.1,000/-
- Fourth instalment: after the infant completes nine months of age, Rs.1,000/-

Allocation rules after April 2017 set the total monetary support at Rs.5000/- to be allocated as follows:

- First instalment: at the end of six months of pregnancy, Rs.3000/
- Second instalment: after the infant completes nine months of age, Rs.2000/-

Conditionalities for the first instalments include the registration of pregnancy within six months, the receipt of at least one antenatal check-up, iron folic acid (IFA) tablets, one tetanus (TT) vaccination, and at least one counselling session. Conditionalities for the second instalment include the registration of childbirth, child vaccination requirements, weighing of the child at least two times after birth, and at least two IYCF counselling sessions.

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[2] THR packets are yellow for pregnant and lactating mothers, sky-blue for children aged six months to three years, and red for severely malnourished children.

# 1.5 SPREAD CAN programme

## 1.5.1 Programme background, aims, and overall approach

Founded in 1989, SPREAD is an Odisha-based NGO that works to empower marginalised communities to access their rights in a number of areas including land, food, and education. The organisation works primarily in the Koraput district of Odisha and neighbouring KBK districts which have a high proportion of tribal populations and people living below the poverty line relative to the rest of Odisha.

As well as addressing the immediate needs of the communities they work with (such as provision of medical emergencies, health checks, educational supplies, etc.), SPREAD also facilitate participatory development processes that build the capacities of community-based organisations (e.g. self-help groups, village development committees) to develop long-term sustainable development with the community. This often starts with identifying the immediate needs of families and progresses to wider issues faced at the village, GP, and block level.

The goal of the three-year 'Collective Action for Nutrition'(CAN) programme (August 2016– July 2019) supported by APPI is 'Reducing malnutrition among children and women by facilitating efficient implementation of food and nutrition programmes, ensuring transparency, downward accountability, and community participation'.

SPREAD describes the following key intervention areas as the focus of their programme (SPREAD 2017a, b, c, d, e):

- Build knowledge of community on the National Food Security Act (NFSA) to improve accessibility;
- Promote participation of community and community-based organisations (CBOs) in decision-making on access and entitlements to food and nutrition programmes;
- Effective implementation of NFSA and health services (including village health and nutrition days, nutrition rehabilitation centres, village health and sanitation committees (VHSCs), etc.);
- Build capacities and strengthen community-based institutions;
- Working towards Panchayati Raj Institutions (PRIs) as nutrition champions;
- Institutionalisation of the social audit process and grievance redressal mechanisms.

The main intervention focus is a social audit process designed to sensitise communities to their rights and entitlements under the four primary schemes covered by the government's National Food Security Act (NFSA) 2013 (see Section 1.4). By raising awareness of rights and grievances through a transparent participatory process of engagement involving local community members, village leaders, government officials, and others involved in the delivery of NFSA services, culminating in a public hearing to share testimonies and findings from the process, it is hoped that NFSA services will improve.

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Box 1.1 SPREAD definition of the social audit process

Social Audit is a process of Deepening Democracy. It is a process, where the rights holders obtain information on all such schemes, programmes, systems impacting their lives; validate their truthfulness and work towards bringing a positive and reformative change. It is a participatory process which empowers citizens. Social Audit adds value to the whole idea of decentralisation and establishes the Community's capacity for Planning, Monitoring, and Course Correction.

*Source*: SPREAD Social Audit Manual (2017b).

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The overall expected outcome for the programme is reduced malnutrition among the target communities (specifically children under five years) through improved delivery of nutrition services and entitlements and increased downward accountability of the ICDS through the social audit model. However, given the nature of the intervention and relatively short time frame of the APPI grant, both organisations acknowledged that they may not see immediate changes in nutritional outcomes for children. Other interim outcomes expected include:

**Household-specific project outcomes:**

- Increased knowledge of households (especially eligible women) on NFSA entitlements (especially TPDS), and on the MAMATA scheme;
- Improved uptake of nutritional entitlements from ICDS for target groups (pregnant and lactating women; women of children under the age of three years; and adolescent girls);
- Improved uptake of antenatal and postnatal services, and knowledge of IYCF practices by eligible women (with a specific focus on pregnant and lactating women; and mothers of children under the age of five years);
- Behavioural change in adolescent girls (with respect to IFA supplementation);
- Increased immunisation coverage of children under the age of three years;
- Improved participation of households (and especially women) in community-level governance activities (with specific reference to Gram Sabhas, Palli Sabhas, and social audits);
- Improvement in intra-household decision-making for women on issues related to food security and nutrition.

**Community-specific project outcomes:**

- Emergence of empowered communities with more accountable ICDS centres;
- Improved institutional delivery of nutrition services and entitlements in Gram Panchayats;
- Increased community-level demand for improved nutrition services and entitlements; and improved community participation in decision-making related to food and nutrition programmes;
- Establishment of (mal)nutrition as a critical agenda for the Gram Sabha and making 'malnutrition-free villages' a goal for PRIs (Panchayati Raj institutions).


## 1.5.2 Overall design

There are nine objectives of the social audit, as outlined in the August 2018 version of the SPREAD Social Audit Manual (p10–11):

1. Promote transparency and accountability in the implementation of a programme.
2. Inform and educate and mobilise community and rights holders about their rights and entitlements of the programme or scheme during the course of social audit.
3. Provide a collective platform, which is inclusive and participatory, to different stakeholders to express their needs and grievances.
4. Improve capacity of the local stakeholders participating the during social audit process.
5. Democratise decision-making by providing a platform for implementing authorities to be accountable to rights holders.
6. Strengthen the scheme by deterring corruption and irregularities and improve the delivery of the programme.
7. Influencing policies with grass-roots realities and evidences.
8. Identifying systemic gaps.

9.    Establishing and exploring linkages with PRIs and community-based organisations.

According to the Social Audit Manual, a social audit is split into three phases: 1. the pre-social audit (seven days' duration), 2. the social audit (seven days' duration), and 3. the post-social audit (undefined duration – a continuing process). The whole process is split into eleven steps:

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Box 1.2 The 11 steps of the social audit

Step 1 Meet the official and Panchayat functionaries as an entry meeting
Step 2 Collect the official documents required for field verification, review the registers and documents
Step 3 Verification physically of the storage centres in schools, Anganwadi Centres, and FPS, door-to-door verification
Step 4 Conducting village meeting and FGDs with rights holders
Step 5 Filling the verification formats, seeing information gaps
Step 6 Consolidation of records that are required for social audit
Step 7 Ensuring government official participation in the Gram Sabha on the specified date as well as participation of all rights holders
Step 8 Report preparation
Step 9 Presenting the social audit report with evidence in the Gram Sabha
Step 10 Noting the minutes carefully
Step 11 Follow-up of the social audit Gram Sabha with action taken report from the concerned department

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## Pre-social audit phase design

The first part of the process is to develop a calendar that includes details of important dates within the areas the social audit will be carried out. This is so that the audit can be conducted at an appropriate time for these other events, or ideally in conjunction with an existing planned Gram Sabha meeting. Next, volunteers who will conduct the social audit are identified and recruited, giving priority to local people who are from marginalised groups. Thirdly, the Social Audit Committee should be set up, and formed at least seven days in advance. The committee should comprise 10–15 people including PRI members, SHG members, Gaon Kalyan Samitis (GKS) members, disabled people, and respected people from the GP. The social audit team should also interact with the Community Committees formed for the NFSA programmes.

## Social audit phase design

The social audit itself is expected to take seven days in total as outlined in the calendar presented in Table 1.1.

**Table 1.1 Model calendar for social audit process**

| Days | Activity | Discussion with | Points of discussion |
|---|---|---|---|
| Day 1 | Village meeting, Focus Group Discussion (FGD) and meeting with PRI members | Community and PRI members | Village profile, schemes and services, exclusion and inclusion errors, hunger and malnutrition, roles and responsibilities of PRI members |
| Day 2 | Field survey and data collection | Beneficiaries, AWW, ASHA, teachers, *jogan sahayak*, members of SMC, JC, MC, PDS advisory committee | Demographic profile of the village, infrastructure of AWC, school, number of beneficiaries, register verification, cross-check of secondary data with primary data |
| Day 3 | Field survey and data collection | Beneficiaries, AWW, ASHA, teachers, *jogan sahayak*, members of SMC, JC, MC, PDS advisory committee | Demographic profile of the village, infrastructure of AWC, school, number of beneficiaries, register verification, cross-check of secondary data with primary data |
| Day 4 | Field survey and data collection | Beneficiaries, AWW, ASHA, teachers, *jogan sahayak*, members of SMC, JC, MC, PDS advisory committee | Demographic profile of the village, infrastructure of AWC, school, number of beneficiaries, register verification, cross-check of secondary data with primary data |
| Day 5 | Meeting with service providers | AWW, ASHA, teachers, *jogan sahayak*, members of SMC, JC, MC, PDS advisory committee | Based on the data collection from the field, the findings will be shared with service providers |
| Day 6 | Data compilation and report writing | Team members | |
| Day 7 | Public hearing and presentations | | |

*Note*: *jogan sahayak* = supply assistant; SMC = School Management Committee; JC = Jaanch Committee. *Source*: Authors' own based on SPREAD Social Audit Manual.

The Social Audit Manual lists the principles that should be adhered to during the implementation of social audits (p10):

- Social auditors responsible for facilitating social audit need to have access to the complete information prior to social audit, to assimilate and verify the information provided to them by the administration.
- A social audit Gram Sabha and public hearing should mandatorily have officials and PRI members to be present, and answer the queries raised there.
- Outcomes of a social audit must have legal sanction and the state governments should enact specific rules for this.
- Social audit must be conducted in every Gram Panchayat once in every six months.
- Social audit Gram Sabha must be presided by an authority other than from the implementing agency.
- During the social audit process make sure that a person, related directly, or indirectly to any of the stakeholders of the schemes or services, should not be a part of it, as there is chances of getting false/biased information.
- The quorum of a Gram Sabha as defined in the Odisha Panchayati Raj Act will apply to the social audit Gram Sabha too.

- The social audit Gram Sabha and social audit public hearing should be open for all the members of the public to participate. This includes people from the press, civil society organisations and members, SHG members, etc.
- The social audit team should present all recorded information to the Gram Sabha orally.
- Social audit must include the exercise of the officials (independent observers) taking and announcing a decision on each deviation presented which is also recorded in the social audit public forum resolution.
- A social audit is a joint exercise of the government and citizens. It is the responsibility of the Gram Sabha to conduct a social audit with the help of the social audit facilitators. But acting on the grievances identified during a social audit within a fixed time period is the sole responsibility of the state government.
- Civil society organisations should be an important part of the social audit. They should participate in the social audit Gram Sabha and social audit public hearings.

**Post-social audit phase design**

After the social audit has finished, the social audit team is expected to complete a number of tasks, including writing up and sharing the report from the public hearing (in the local language), ensuring the grievance redressal process is followed for every issue raised about the NFSA, and following up grievances, within a specific time frame. The team is expected to hold the relevant officials accountable to resolve grievances.

## 1.5.3 SPREAD CAN implementation plan

According to the SPREAD implementation plan (see SPREAD 2016a, Implementation PLAN Final 4.8.16) a total of 240 social audits were planned to take place under the CAN programme. This included 24 pilots within the first year of the project, and the remaining 216 social audits in a corresponding number of GPs (within 24 blocks, 6 districts, and including 2,923 villages) were planned for year 2. The whole programme was planned to take three years, starting August 2016 and ending July 2019.

**Year 1 August 2016–July 2017** The 24 pilot social audits were planned to take place between February 2017 and July 2017.

**Year 2 August 2017–July 2018** The remaining 216 social audits were planned to take place during the second year of the programme, 108 between August 2017 and January 2018, and the final 108 between February 2018 and July 2018.

**Year 3 August 2018–July 2019** Further social audits carried out in the same locations by the SS volunteers that were trained by SPREAD.

## 1.6 Baseline characteristics of target groups

In this section, we summarise the demographic characteristics of households and particular target groups included in the baseline quantitative sample of 116 GPs. The survey is representative of households in the SPREAD programme area but the SPREAD programme area itself is not necessarily representative of the population living in the KBK districts. In fact, SPREAD targets the most food-insecure regions within the KBK area for its CAN programme so that we should expect some systematic differences between the characteristics of study participants and those of the general population. Table 1.2 summarises the mean of some key socioeconomic and food security indicators by districts based on our household survey and contrasts them with the district-level means provided by

the **POSHAN** programme, which collates data from the NFHS4. The following subsection will refer to this table when describing survey respondents.

## 1.6.1 Household characteristics

**Religion and caste:** 97.7 per cent of respondents belong to Hindu households (defined as the religion of the head), 2.2 per cent to Christian households and 0.1 per cent to Muslim households. This religion breakdown very closely mirrors the figures from the census in Odisha in 2011 for each single district in the sample. 51 per cent of respondents are Scheduled Tribes (STs), 25 per cent belong to Other Backward Castes (OBCs), 22 per cent are Scheduled Castes (SCs), and just 3 per cent are in the 'general' category. This caste composition is quite different from that of the census for most districts. Our survey tends to

**Table 1.2 Baseline characteristics in selected districts – existing data and evaluation data**

| Characteristic/district | Balangir (%) | | Kalahandi (%) | | Koraput (%) | | Malkangiri (%) | | Nabarangpur (%) | | Nuapada (%) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Source | POSHAN (NFHS4) | SPREAD evaluation survey | POSHAN (NFHS4) | SPREAD evaluation survey | POSHAN (NFHS4) | SPREAD evaluation survey | POSHAN (NFHS4) | SPREAD evaluation survey | POSHAN (NFHS4) | SPREAD evaluation survey | POSHAN (NFHS4) | SPREAD evaluation survey |
| Exclusive breastfeeding | 53.4 | 82.5 | 67.4 | 81.4 | 70.2 | 79.4 | 66.2 | 80.3 | 71.7 | 68.4 | 49.2 | 80.4 |
| Adequate diet | 7.3 | 32.5 | 4.5 | 11.2 | 3.4 | 10.3 | 16.8 | 21.9 | 11.5 | 17.7 | 2.6 | 18.8 |
| Mother and Child Protection Card | 100 | 96 | 96.7 | 88 | 98.2 | 89 | 95.4 | 92 | 92 | 86 | 99.1 | 85 |
| Women who are literate | 61.9 | 61 | 46.1 | 38 | 39.7 | 27 | 34.8 | 32 | 41.8 | 23 | 49.9 | 40 |
| Women with ≥10 years of education | 21.6 | 21 | 18.7 | 11 | 14.5 | 7 | 11.8 | 6 | 10.7 | 3 | 19.9 | 10 |
| HH has an improved water source | 94 | 96 | 93.6 | 93 | 84.7 | 90 | 89.3 | 93 | 98.4 | 99 | 95 | 94 |
| HH has an improved sanitation facility | 14.1 | 21 | 14.9 | 19 | 18.2 | 11 | 16.7 | 12 | 16.1 | 9 | 20.2 | 27 |
| Open defecation | 83.6 | 79 | 87.5 | 80 | 81.3 | 87 | 89.3 | 87 | 89 | 90 | 84.6 | 73 |

*Source*: Authors' own and POSHAN (2018).

over-sample the SC (except in Malkangiri where it is the opposite) and ST categories of the population. This is to be excepted as the social audits are implemented in the most remote parts of each district, where the SC/ST share of the population is the highest.

**Access to drinking water:** 77 per cent of households obtain their drinking water from tube wells, 11 per cent from a public tap/sandpipe, 2.5 per cent from an unprotected well. 2.2 per cent of respondents receive their water directly through a pipe to their house/yard. Overall, 94 per cent of respondents get their drinking water from an improved source, a figure in line with POSHAN's NFHS4 statistics.

**Access to toilet facilities**: 84 per cent of respondents do not have any access to a toilet and defecate in the open. This is in line with information provided by POSHAN (2018) for the sample districts (see Table 2.1). The remaining 15 per cent of respondents use some variations of pit latrines (almost 10 per cent of respondents use a flush-to-pit latrine, 3.2 per cent have access to a pit latrine with slab and 2.2 per cent use a flush to sceptic tank). The rate of open defecation ranges from 73 per cent in Nuapada to 90 per cent in Nabarangpur.

**Household assets**: The average respondent reports that their household owns 2.7 assets out of a list of 9 assets. There is a wide geographic disparity in the assets index as its mean in the sample ranges from two in Koraput to four in Balangir District. 82 per cent of respondents have access to electricity and 12 per cent have access to solar electricity. The most commonly owned assets are: mobile telephone (66 per cent), electric fan (38 per cent), television (33 per cent), and wardrobe (26 per cent). Generators, air conditioners, laptops/computers, and DVD players are all owned by less (and sometimes considerably less) than 5 per cent of respondents.

**Cooking facilities**: Just over half of respondents have a separate room for cooking. 93 per cent of respondents use wood as cooking fuel and 6 per cent use LPG/natural gas. Close to three-quarters (72 per cent) of respondents have an earth floor and the remaining quarter have a cement floor.

**Construction of home dwelling**: Materials for the roof and external walls are relatively varied in the sample. Almost 50 per cent have tiles, 29 per cent have asbestos, 11 per cent have thatch/palm leaf, and 8 per cent have cement for the roof. External walls are made of dirt for 46 per cent of respondents, of cement for 26 per cent of respondents, of bricks for 20 per cent of respondents, of bamboo, or stone with mud for 5.5 per cent of respondents, and of stone for 2.2 per cent of respondents.

**Food security:** to measure food security, we implemented the Food Insecurity Experience Scale (FIES) proposed by Ballard et al. (2013) for the FAO. The scale is made up of eight questions with dichotomous yes/no responses. We have used a 12-month reference period and we applied the scale at the level of the respondent (individual scale). The questions are not meant to be analysed separately. The mean FIES score is 3.02 (out of a maximum of 8). The FIES does not vary much across districts as it ranges from 2.7 in Kalahandi to 3.1 in Koraput and Malkangiri. However, Nabarangpur stands out as the most food-insecure district as the mean FIES there is 3.6. The extent of food insecurity is higher for the SC and ST population (3.2) than for OBCs (2.6).

## 1.6.2 Primary caregivers

The baseline survey included answers from 1,884 primary caregivers. The number of interviewed caregivers per GP ranged from 11 to 23, with a mean of 16.6.

**Age, gender, and household size**: Primary caregivers are 25 years old on average (three-quarters of caregivers are below 29, and the oldest respondent is 60), and are

overwhelmingly female (only 1.3 per cent of primary caregivers are male). 80 per cent of primary caregivers are the spouse of the household head, 16 per cent are the daughter/daughter-in-law of the household head, and less than 3 per cent (2.6 per cent) are household heads themselves. 98 per cent of primary caregivers have just one child below 24 months. Households have 3.8 members on average, with 25 per cent of them having more than five members.

**Literacy rates**: 37 per cent of the caregivers are literate, which is far below the Odisha-wide literacy rate for women which is 64 per cent. Rates of female literacy are noticeably lower in the SPREAD sample than in the whole district for Kalahandi (38 per cent against 46 per cent), Koraput (27 per cent against 40 per cent), Nabarangpur (23 per cent against 42 per cent) and Nuapada (40 per cent against 50 per cent). Overall, these figures suggest that the SPREAD programme targets the most disadvantaged districts, and within these districts, that it targets the most disadvantaged areas.

**Employment:** 84 per cent of PC respondents are housewives, 8 per cent are self-employed, 5 per cent are employees, and just under 3 per cent work without pay (as an apprentice or in a family business). 86 per cent of PC respondents who reported a work activity did so in agriculture (57 per cent in their own farm and 35 per cent as an agricultural labourer).

**Women's dietary diversity**: we also implemented the Women's Dietary Diversity Score (WDDS) proposed by Arimond *et al.* (2010). The WDDS is simply the sum of all the food groups consumed by the respondent on the day prior to the survey (if this was a typical day; otherwise, we used the last typical day). The WDDS is based on 21 food groups, using the most disaggregated food groups' indicators (the base version of WDDS uses nine food groups). The mean score of WDDS is 6.7 (out of a maximum of 21). The mean WDDS is around 7.2 in Nabarangpur, 7.3 in Nuapada, and 7.6 in Balangir. Districts with lower values of WDDS are Koraput (5.9), Kalahandi (6.2), and Malkangiri (6.3). The mean WDDS is lower among SC/ST populations (around 6.5) than among OBCs (7.2).

**Nutrition knowledge**: we implemented a small questionnaire to test nutrition knowledge as in Hoddinott *et al.* (2016). This entails four questions on breastfeeding, three questions on supplementary feeding, and seven questions on health and nutrition. Respondents on average correctly answered 8.8 questions out of 14. In detail, they correctly answered 2.2 questions on breastfeeding (out of 4), 1.9 questions on supplementary feeding (out of 3), and 4.7 questions on health and nutrition (out of 7).

**Committee membership**: we asked about the existence of 14 possible groups or committees at the local level. Overall, respondents know about the existence of 4.3 groups/committees, with the mean ranging from 3.8 in Nuapada to 4.6 in Nabarangpur. Caregivers are members of 0.6 groups/committees on average, while 34 per cent of caregivers belong to at least one group/committee.

## 1.6.3 Pregnant women

The baseline survey included answers from 510 pregnant women (who were not also primary caregivers). The number of interviewed caregivers per GP ranged from 1 to 11, with a mean of 5.6.

**Age, gender, and household size**: Pregnant women are 24.5 years old on average (three-quarters of pregnant women are below 27, and the oldest respondent is 42). 77 per cent of pregnant women are the spouse of the household head, 20 per cent are the daughter/daughter-in-law of the household head and less than 2 per cent (1.8 per cent) are household heads themselves.

**Food security:** The mean FIES score among pregnant women is 2.6 (out of a maximum of 8), which is noticeably lower than among primary caregivers (3.2). Similarly, the mean WDDS score is 7 for pregnant women against 6.7 for primary caregivers. Both results indicate a lower extent of food insecurity among pregnant women than among primary caregivers.

**Nutrition knowledge:** respondents on average correctly answered 8.2 questions out of 14. In detail, they correctly answered 1.9 questions on breastfeeding (out of 4), 1.8 questions on supplementary feeding (out of 3), and 4.5 questions on health and nutrition (out of 7). Knowledge of nutrition practices is therefore slightly lower among pregnant women than among primary caregivers.

Other than that, there is very little difference in terms of socioeconomic characteristics between pregnant women and primary caregivers.

## 1.6.4 Children below two years of age

**Exclusive breastfeeding**: We find that 78 per cent of children below six months of age are exclusively breastfed, which is noticeably more than figures reported by POSHAN. The gaps are especially wide for Balangir (83 per cent of exclusive breastfeeding in the SPREAD sample against 53 per cent for the entire district), Nuapada (80 per cent against 49 per cent), Malkangiri (80 per cent against 66 per cent), and Kalahandi (81 per cent against 67 per cent). In Nabarangpur, the rate of exclusive breastfeeding is slightly lower in the SPREAD sample (68 per cent) than in the whole district (72 per cent).

**Adequate diet:** the proportion of children eating four food groups is also noticeably higher in the SPREAD sample than in the district sample obtained in NFHS4, as evidenced by Table 1.2. The gaps are especially marked for Balangir (33 per cent against 7 per cent), Nuapada (19 per cent against 3 per cent), Kalahandi (11 per cent against 5 per cent) and Koraput (10 per cent against 3 per cent).

# 2 Evaluation design and methods

## 2.1 Evaluation aims and objectives

The original Terms of Reference APPI shared with IDS in June 2017 describes the following two main objectives for the evaluation:

1. Determine the impact of the SPREAD model of social audits on improving the delivery of nutrition services and entitlements as well as the uptake of these services by target groups;
2. Understand how the social audit process leads to:
   a. Changes in knowledge, behaviour, and practice at the household level
   b. Community-level changes and outcomes.

A number of different evaluation design options were presented and discussed with the APPI and SPREAD teams over the course of a few months in late 2017 which took into account the SPREAD programme timings and anticipated outcomes, as well as evaluation budget and methodological limitations. The final design chosen (described more in the sections below) determined the extent to which the evaluation team are able to address and make evidence-based conclusions on the above original objectives. In particular, the final design did not incorporate any survey-based methods for measuring nutritional outcomes/ anthropometry such as stunting and wasting. We discussed whether or not this would be an appropriate evaluation objective but decided against, given the limited time and implementation period of both project and the evaluation. Therefore, we are unable to make a comprehensive assessment of the extent to which uptake of NFSA services as a result of the SPREAD programme has led to improved nutritional outcomes based on primary data collection. We do, however, draw on other evidence gathered from further back along the Programme Impact Pathway which might suggest possible changes in these longer-term outcomes.

## 2.2 Programme Impact Pathway for mixed methods approach

The evaluation design combines both quantitative and qualitative methodologies within a strong mixed methods theory-based design. The three main methodological components (summarised below in Box 2.1) were designed to complement and build on each other at every stage of the evaluation process including planning, tool design, data analysis, and synthesis. Evaluation questions, protocols, and the data collection instruments component drew heavily on the social audit model's hypothesised theory of change as well as evidence from recent literature published on other similar downward accountability programme models in India and globally.

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**Box 2.1 The three evaluation components**

**Component A: Quantitative survey component**: this used an experimental baseline and endline household survey design to rigorously assess the effects of the social audit on immediate and longer-term outcomes relating to health and nutrition entitlements and NFSA government services, as well as community empowerment and participation.

**Component B: Process evaluation component:** this documented critical implementation processes, mechanisms, and outputs to assess the coverage and quality of the social audit intervention compared with its design. This component draws on analysis of programme documentation and internal MIS data, qualitative interviews and focus groups with programme stakeholders and others, and quantitative data collected via the quantitative endline survey.

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> **Component C: Qualitative evaluation component:** this explores the community-level perceptions and contextual factors which might explain intended/unintended and positive/negative outcomes resulting from the programme (as captured via the quantitative component). These include levels of community empowerment and participation as well as wider interactions between societal, community, and intra-household structures which might influence behaviour change. This component draws primarily on findings from in-depth interviews and focus group discussions with different sub-groups of target communities and government stakeholders.

*Source*: Authors' own.

Figure 2.1 summarises the key stages of the evaluation which combined sequential and concurrent data collection components followed by a final phase of mixed methods analysis. See also the mixed methods table in Annex 2 which maps the steps along the impact pathway with the evaluation methods of data collection and sources of analysis.

**Figure 2.1 Key stages of evaluation mixed methods process**
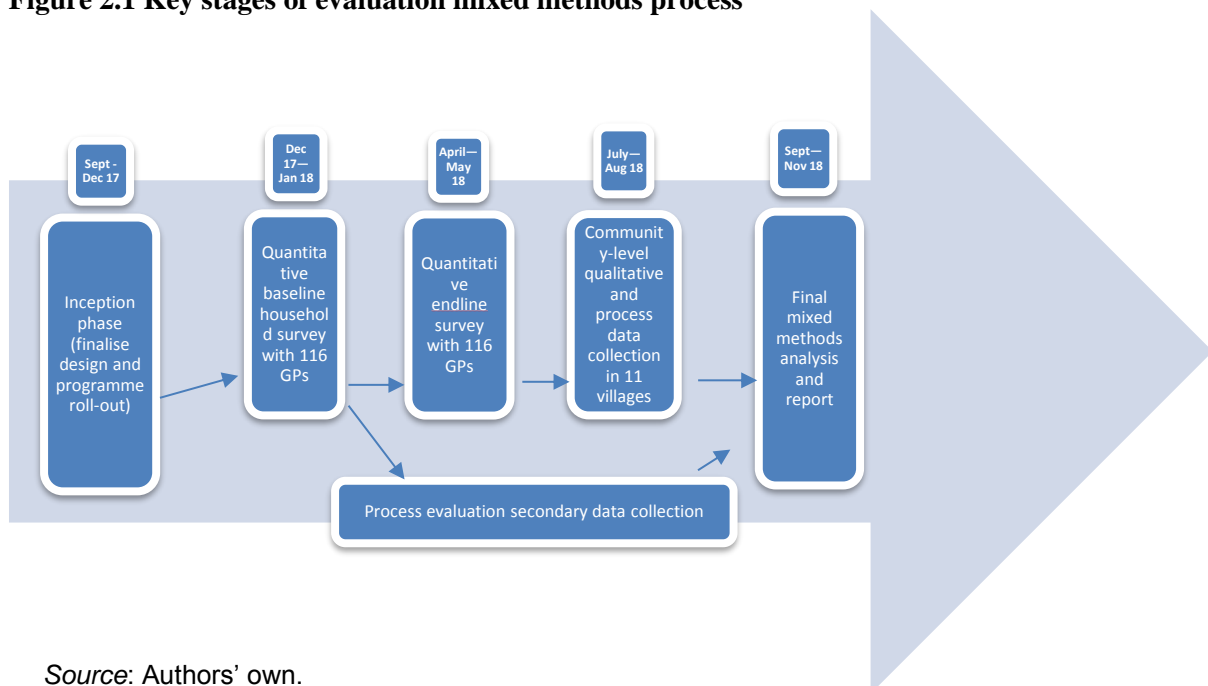


*Source*: Authors' own.

**Figure 2.2 Programme Impact Pathway**
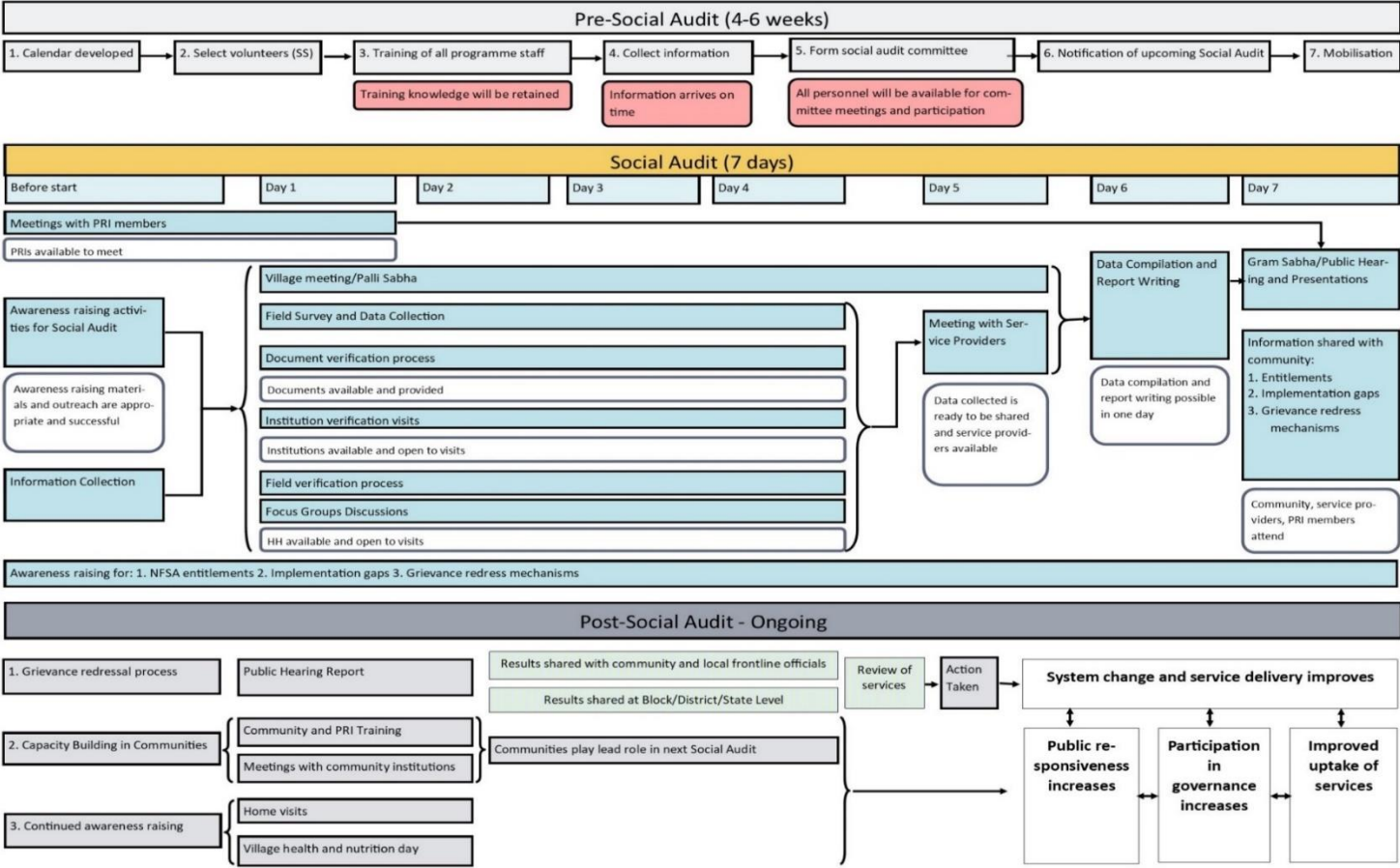


Source: Authors' own.

The Programme Impact Pathway (PIP) diagram is the final product of an iterative production process. The starting point was the plan described in the original Social Audit Manual (prior to the publication of the August 2018 version). This first version was then discussed and altered directly with SPREAD team members during workshops and meetings with IDS researchers to better reflect the reality of what they were planning and carrying out in the field. That version was reduced to the most basic components and shared during focus group discussions with social audit team members, in the fieldwork stage of this evaluation. Focus groups were asked if they thought the diagram was an accurate representation of the process, what obstructions they faced, and what worked well during the implementation phase. Information gained from these focus groups, along with further discussions and interviews with SPREAD, was integrated to produce this most recent version.

The PIP is designed to build on the SPREAD model's theory of change to provide a comprehensive overview of the different stages of the social audit process and how these relate to longer-term programme outcomes. It has acted as a key reference point in the design of quantitative, qualitative, and process-related fieldwork tools, for discussions with the SPREAD team and the evaluation team's analysis focused on implementation-level findings (as presented in Section 3 of this report) and outcomes (as presented in Section 4).

## 2.3 Quantitative component design and approach

### 2.3.1 Quantitative evaluation design

The objective of the quantitative evaluation component is to measure the impact of the social audits on a range of outcomes of interest, and to assess if this impact is statistically different from zero.

The quantitative evaluation is based on an ***experimental design in which the timing of the social audits is randomly varied across Gram Panchayats (GPs)***. Randomly assigning the timing of social audits generates exogenous differences in the length of time between endline data collection and social audit among otherwise similar GPs which enables us to estimate the impact of the social audit.

This differs from the classic 'phased-in' experimental design in which communities in the control group would not receive social audits in phase 1, enabling a comparison with treatment communities. This design was not deemed feasible in the SPREAD social audits evaluation as all 216 GPs were required to receive the social audits in phase 1.

Treatment assignment was done at the Gram Panchayat level. The unit of intervention of the social audit is the ICDS centre, but SPREAD aims to cover all ICDS centres within treated GPs, so that we could not assign the intervention at this level.

We randomly assigned Gram Panchayats into an 'Early' group (E) and a 'Late' group (L). GPs in the E group had their social audits occur between 4 January and 8 February 2018, whereas GPs in the L group had their social audits occur between 13 March and 6 April 2018. The baseline data collection was undertaken in December 2017–January 2018, just before the social audits were scheduled to be implemented, whereas the endline data collection took place in April–May 2018, within two weeks since the GPs in the L group had their social audits organised.

**Figure 2.3 Flowchart of the quantitative evaluation**

Figure 2.3 represents the flowchart of the evaluation. It is worth emphasising that although the dates for baseline data collection and early social audits overlap (as well as for late social audits and endline data collection), the baseline data was always collected prior to the social audit in any given GP. Likewise, the endline data was always collected after the social audit in any given GP.

We opted for creating two experimental groups. Based on existing evidence, we believed that the strongest design was to implement all the social audits in the treatment GPs within a short period of time at the beginning of the implementation window and, similarly, to implement all the social audits in the control group within a short period of time as late as possible. This maximises the difference in exposure between treatment and control group and minimises internal heterogeneity within each group, thus increasing statistical power.

There was an average of 107 days between the social audit and the endline data collection among GPs of the Early group and an average of 36 days between the social and the data collection among GPs of the Late group. The data collection was organised in such a way as to minimise variation within each of these groups. Figure 2.4 shows the distribution of the number of days between social audit and endline data collection in both Early and Late GPs. It is apparent that within-group variations have been kept small, especially for the Early GPs.

**Figure 2.4 Number of days between social audit and endline data collection among Early and Late GPs**
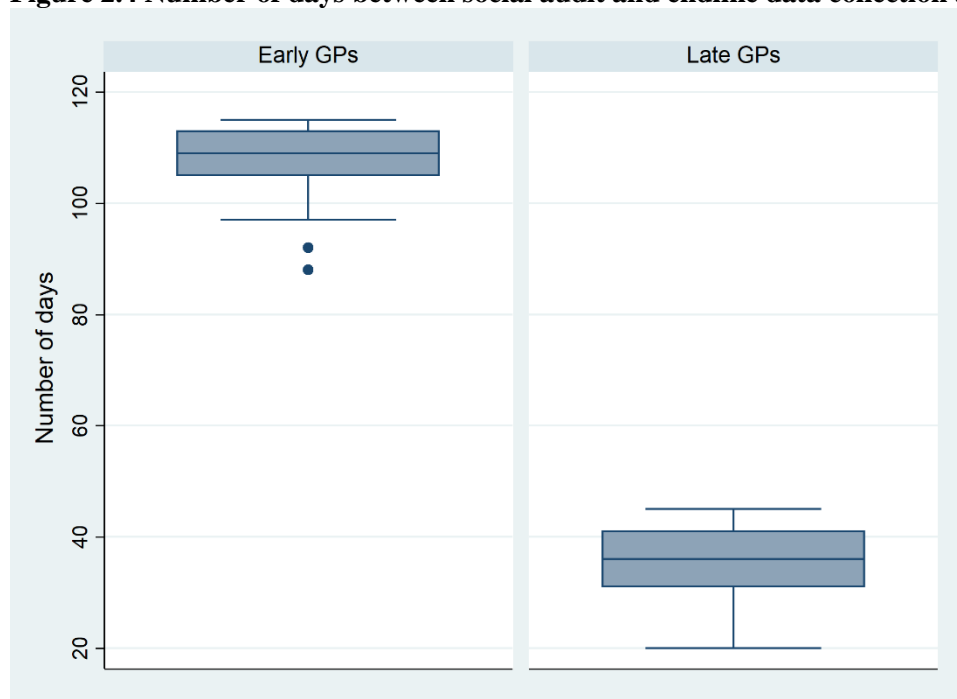


*Source*: Authors' calculations.

The evaluation design proposes to exploit relatively small differences in exposure to the social audits to measure impact. As a result, we expect these small differences in exposure to exert an effect on short-term outcomes, but not necessarily on longer-term outcomes. **The focus of the evaluation design is therefore on the more immediate outcomes of the projects**.

### Interpretation of the findings

The quantitative evaluation draws on two sources of comparisons: (i) the experimental comparison between Early and Late GPs (based on differences or on endline levels of the outcomes) which will be used to assess impact, and (ii) the before–after comparison in all GPs, which will be used to contextualise the impact estimates.

The rationale for relying on the Early–Late comparison is based on the assumption that full effects of the social audits will need a period of time to manifest themselves after the social audits take place. In other words, we expect the bulk of the impact to derive from post-audit activities and not from the 6–7 days in which the social audit itself takes place. This means that we expect to see more effects of the social audits among the E group than the L group. It is possible, however, that the effects of social audits would in fact only be immediate and disappear quickly. If that were the case, then the impact of social audits would be larger in the L group than in the E group.

Solely reporting on the differences between Early and Late GPs would not give any indication as to the trajectory of outcomes since baseline. Imagine that we find no statistical difference in terms of the evolution of across Early and Late GPs for a given outcome. This could be because: a) the outcome did not change at all between baseline and endline, b) the outcome improved similarly in both groups between baseline and endline, or c) the outcome deteriorated similarly in both groups between baseline and endline. For the sake of the interpretation of the impact estimates, it is thus key to display the before–after comparison.

Combining the before–after and the Early–Late comparisons, we can classify the impact of social audits (SAs) into the following five categories:

- SAs have an **immediate and constant** effect: levels of outcomes change over time, but there is no difference between E and L GPs.

- SAs have a **cumulative** effect: levels of outcomes change over time, but the changes are more pronounced in the Early GPs.

- SAs have a **transient** effect: levels of outcomes only change over time for a short while. The changes will be concentrated in the L GPs.

- SAs have a **non-linear** effect: levels of outcomes first increase (or decrease) after the audit before decreasing (or increasing) past their baseline values as time passes.

- SAs have **no effect**: no discernible changes in the levels of outcomes for either E or L GPs.

Another useful feature of the evaluation design is that the 'before and after' comparisons of outcomes of interest would be meaningful in its own right. Given that the timespan is so short between the baseline and endline data, substantial changes in the outcomes of interest are suggestive of an effect of social audits, although only the experimental comparison between E and L groups will have a causal interpretation.

Impact is measured through pre- and post- social audits questionnaires administered to primary caregivers of a child below 24 months, pregnant women, men (typically the husbands of caregivers or pregnant women), adolescent girls, Angawandi workers (AWWs), ASHA workers, and council leaders (Sarpanches).

**Outcomes that have been measured through the quantitative approach include:**

- Knowledge of households of NFSA entitlements;
- Access to and uptake of health and nutrition services;
- Perceived quality and responsiveness of health and nutrition services;
- Food security and IYCF knowledge;
- Participation in community-level governance;
- Civic attitudes.


### Sample size and sampling design

We first randomly selected the 116 GPs to take part in the evaluation out of the 216 GPs in which SPREAD operate and which did not receive the pilot social audit programme. We then randomly assigned these GPs into Early or Late groups using implicit stratification. Specifically, we ordered observations by district and by block prior to the randomisation to minimise sampling variability across the two treatment arms.

We then randomly chose one village with probability proportional to size (PPS) in each GP to include in the survey. In a number of cases, the selected villages were small, and the field team was not able to find the required number of eligible households to interview. In this case, the team was instructed to add the closest village to the sampling frame, and to conduct a household listing in the additional village. If the target number of 25 was still not achieved, the team would add a third village and so on. The map of sample villages is in Annex 2.

In the selected villages, the field team conducted a household listing of A: households with a primary caregiver of a child below two years of age, and B: households with a pregnant woman. The team then randomly selected households from these lists for the interviews. The team also selected one AWW and one ASHA worker per GP for interview (based on the presence of health workers in

the village during survey time). The team also aimed to interview the Sarpanch in each of the 116 GPs.

We set the total number of GPs for the evaluation at 116 (58 in each of the Early and Late groups). Given 20 observations per GP and an intra-cluster correlation coefficient[3] of 10 per cent, 116 GPs allows us to detect an effect size of 0.22 standard deviations with a statistical power of 80 per cent. We eventually increased the number of households to 24 per GP, thus raising the statistical power of the quantitative evaluation to 82 per cent. For GP-level outcomes, for which we will only have one observation per GP, we were able to detect an effect size of 0.5 standard deviation with a statistical power of 80 per cent.

The target groups for the quantitative evaluation are women with a child below 24 months (caregivers) and pregnant women (who may or may not already have a child). Caregivers were given the highest priority in the selection of respondents, and pregnant women were added to the survey if the field team could not find 24 eligible caregivers at the time of survey. The mean number of caregivers in each GP was just below 17 (and the mean number of pregnant women in each GP was about 7).

As most outcomes are the same for caregivers and pregnant women (excluding the fact that the latter are not asked about child-related questions), we could pool both groups in the estimations. However, we decided to run the estimations on both sub-samples separately to ascertain potential heterogeneity of the social audits' impact. Estimations associated with caregivers are powered to detect an effect size of 0.20 SD. Estimations associated with pregnant women are powered to detect an effect size of 0.25 SD.

Table 2.1 presents the breakdown of the sample size by target group and by district.

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[3] In a cluster randomised trial, the intra-cluster correlation coefficient (ICC) measures the degree of similarity of observations within each cluster (i.e. GP). The higher this coefficient, the less each additional household interview brings in new information (as households tend to be the same) and so the lower the effective sample size. With an ICC of 15 per cent instead of 10 per cent, the statistical power of the valuation would fall to 70 per cent (i.e. we would face a 30 per cent risk of wrongly declaring the intervention to have no impact when it does have one).

**Table 2.1 Number of interviews per target group and district**

| District | Balangir | Kalahandi | Koraput | Malkangiri | Nabarangpur | Nuapada | All |
|---|---|---|---|---|---|---|---|
| Target group | | | | | | | |
| Primary caregivers | 380 | 415 | 386 | 221 | 340 | 143 | 1885 |
| Pregnant women | 120 | 109 | 94 | 68 | 81 | 38 | 510 |
| Men | 382 | 350 | 377 | 195 | 260 | 81 | 1645 |
| Adolescent girls | 37 | 55 | 36 | 30 | 44 | 8 | 210 |
| AWW | 23 | 24 | 24 | 14 | 21 | 9 | 115 |
| ASHA workers | 24 | 25 | 24 | 14 | 18 | 9 | 114 |
| Sarpanches | 23 | 25 | 23 | 14 | 19 | 9 | 113 |

*Source*: Authors' own.

## 2.3.2 Estimations of treatment effect

We estimate the effect of the social audit through the following model:

$$\Delta Y_{ij} = \alpha + \beta \cdot Early\ SA^j + \varepsilon_{ij}$$

where α denotes the change in the outcome of interest Y between baseline and endline, β is the difference-in-difference parameter associated with the effect of being assigned to the early social audit group, and $\varepsilon_{ij}$ is the error term.

The estimations account for the clustering of observations within GPs in the computation of standard errors.

For a number of outcomes, the baseline variable does not exist (or was measured differently than at endline) so that the double-difference framework above cannot be used. Instead, we will use a single-difference framework in which the endline value of the outcome is explained by the treatment status and an error term.

The model of equation (1) is based on a panel framework where the same individuals are present at baseline and endline. Unfortunately, we faced a very high – and unexpected – level of attrition at endline. More than one-third (38 per cent) of primary caregivers interviewed at baseline could not be re-interviewed at endline, mostly because people were momentarily unavailable due to work. We systematically replaced attrited households by new households drawn from the updated listing of eligible households. This opens the possibility to conduct estimations based on a repeated cross-section framework. However, we preferred keeping the panel estimations as our preferred specification as the new households were quite different from the original ones in terms of the endline value of key outcomes of interest, and because the panel specification allows us to measure change in a more robust fashion (as change is based on answers from the same respondents).

Attrition poses two challenges for the panel estimations of treatment effect. First, when the determinants of attrition are systematically related to the intervention, then the internal validity of the estimates is threatened. Second, if the characteristics of remaining participants differ from those lost at follow-up, the nature of the sample changes and the generalisability of results to the initial population of interest cannot be guaranteed (external validity problem). Table 2.2 shows the baseline characteristics of primary caregivers across Early and Late groups for the initial sample, the sample lost to follow-up, and the sample of remaining participants. It suggests that neither problems manifest themselves. The characteristics of participants lost to follow-up are mostly the same to those who remain in the sample. The only meaningful difference concerns participation in the labour market as active women tended to drop from the sample at a higher rate. Importantly, the differences between women of the Early and Late groups were no greater among remaining participants than they were at baseline, suggesting no problem of internal validity.

**Table 2.2 Attrition rates for quantitative sample**

| | All participants | | | | Loss to follow-up | | | | Remaining participants | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Group | Early | | Late | | Early | | Late | | Early | | Late | |
| | Mean | (SD) | Mean | (SD) | Mean | (SD) | Mean | (SD) | Mean | (SD) | Mean | (SD) |
| Household size | 4.73 | (1.50) | 4.93 | (1.52) | 4.73 | (1.58) | 4.86 | (1.65) | 4.73 | (1.45) | 4.97 | (1.44) |
| SC | 0.22 | (0.41) | 0.22 | (0.41) | 0.22 | (0.41) | 0.20 | (0.40) | 0.22 | (0.41) | 0.23 | (0.42) |
| ST | 0.53 | (0.50) | 0.47 | (0.50) | 0.53 | (0.50) | 0.46 | (0.50) | 0.53 | (0.50) | 0.48 | (0.50) |
| OBC | 0.22 | (0.42) | 0.28 | (0.45) | 0.22 | (0.41) | 0.31 | (0.46) | 0.23 | (0.42) | 0.26 | (0.44) |
| General caste | 0.03 | (0.17) | 0.03 | (0.17) | 0.03 | (0.18) | 0.03 | (0.17) | 0.03 | (0.17) | 0.03 | (0.18) |
| Spouse of household head | 0.78 | (0.41) | 0.82 | (0.38) | 0.75 | (0.44) | 0.82 | (0.39) | 0.81 | (0.39) | 0.82 | (0.38) |
| Illiterate | 0.44 | (0.50) | 0.40 | (0.49) | 0.40 | (0.49) | 0.41 | (0.49) | 0.47 | (0.50) | 0.40 | (0.49) |
| Literate | 0.34 | (0.48) | 0.40 | (0.49) | 0.37 | (0.48) | 0.38 | (0.49) | 0.32 | (0.47) | 0.40 | (0.49) |
| Can read but not write | 0.22 | (0.41) | 0.20 | (0.40) | 0.23 | (0.42) | 0.21 | (0.41) | 0.21 | (0.41) | 0.19 | (0.40) |
| Illness | 0.16 | (0.37) | 0.14 | (0.34) | 0.16 | (0.37) | 0.15 | (0.36) | 0.16 | (0.36) | 0.13 | (0.34) |
| Housewife | 0.81 | (0.39) | 0.85 | (0.35) | 0.78 | (0.41) | 0.81 | (0.39) | 0.84 | (0.37) | 0.88 | (0.33) |
| Active in labour market | 0.18 | (0.39) | 0.14 | (0.35) | 0.21 | (0.41) | 0.19 | (0.39) | 0.16 | (0.37) | 0.12 | (0.32) |
| Improved water source | 0.95 | (0.22) | 0.93 | (0.26) | 0.94 | (0.23) | 0.93 | (0.26) | 0.96 | (0.21) | 0.93 | (0.26) |
| Improved sanitation source | 0.14 | (0.35) | 0.17 | (0.38) | 0.13 | (0.34) | 0.16 | (0.37) | 0.14 | (0.35) | 0.18 | (0.38) |
| Separate kitchen | 0.50 | (0.50) | 0.50 | (0.50) | 0.51 | (0.50) | 0.51 | (0.50) | 0.49 | (0.50) | 0.50 | (0.50) |
| Assets index | 2.69 | (1.79) | 2.71 | (1.91) | 2.73 | (1.86) | 2.67 | (1.84) | 2.66 | (1.74) | 2.74 | (1.94) |
| FIES | 3.09 | (2.60) | 2.96 | (2.56) | 2.99 | (2.57) | 3.10 | (2.52) | 3.15 | (2.62) | 2.88 | (2.59) |
| WDDS | 6.67 | (2.12) | 6.78 | (2.02) | 6.67 | (2.02) | 6.85 | (1.99) | 6.68 | (2.19) | 6.74 | (2.04) |

*Source:* Authors' own.

## 2.3.3 Quantitative data collection process

For both the baseline and endline data collection, DCOR engaged a survey team consisting of 104 people. For the endline survey, DCOR could only bring back around 80 per cent of the field

supervisors and 40 per cent of the field investigators who were involved in the baseline survey. Many of the field investigators were already engaged in other studies conducted by other agencies but DCOR ensured that the core team (team leader, survey coordinators, and IT expert), which was involved in the baseline, was available for the endline survey.

During the classroom training of the survey team, all the questions in the tools were clearly explained to the survey team including the additional questions included for the endline survey. The survey team members were also provided tablets to do mock-practice during the classroom training, which helped them to become well versed with the Open Data Kit (ODK) tools loaded in the tablet. For both baseline and endline data collection, two days of field practice were organised in which Computer Assisted Personal Interviewing (CAPI) application of all the tools were tested to check the functionality, logical linkage, and skip patterns, and also to suggest changes in the tools.

A household listing was carried out before both the baseline and endline survey. For the household survey, this allowed us to assess the number of eligible households for interviews in each sampled village. In case the number of eligible households was below the target, we included the closest neighbouring village into the sample and carried out a household listing and the required number of interviews there to reach the initial target. Overall, the field team added 72 villages/hamlets to the 116 sampled villages.

For the endline survey, the household listing was necessary to replace mothers of children below 24 months, pregnant women, or adolescent girls interviewed at the baseline who were not eligible under the same category or who were absent when the endline survey was conducted.

During the baseline, the field team identified 4,196 eligible households, out of which 2,394 were interviewed (1,884 households with a primary caregiver and 510 with a pregnant woman). The field team also interviewed 1,645 male respondents, 210 adolescent girls, 115 AWWs, 114 ASHA workers, and 113 Sarpanches.

During the endline survey, the household listing was carried out in all the 188 villages/hamlets (116 sample villages and 72 additional villages/hamlets where the baseline survey was carried out to obtain the required sample size) from the 116 sample Gram Panchayats. But due to the non-availability of the required eligible sample households, another four neighbouring villages/hamlets from the same sample Gram Panchayats were covered in the household listing during the endline. In total, the household listing in the endline survey was carried out in 192 villages/hamlets from 116 sampled Gram Panchayats. The household listing exercise enumerated a total of 19,221 households, of which 3,500 households (i.e. 18 per cent) had eligible respondents for the interview (2,695 households had primary caregivers only, 787 households had pregnant woman only, and 18 households had both the respondents).

After the training of the survey team was complete, endline data collection started on 28 April 2018 and continued until 23 May 2018. A total of 2,379 households were interviewed, of which 1,984 were primary caregivers (mothers of a child below 24 months) and 385 were pregnant woman. As with the baseline, the sample households where both primary caregivers and pregnant women were found, the interview of the primary caregiver was conducted. The spouse of the primary caregiver or pregnant woman could be interviewed in 1,738 households (i.e. 73 per cent) out of the 2,379 households covered in the survey. Similarly, the survey team could interview 167 (i.e. 7 per cent) adolescent girls in 2,379 households covered in the endline survey. In addition to these respondents, the survey team could interview 115 AWWs, 115 ASHAs, 115 Sarpanchs, and 114 village leaders in the 116 sample villages covered in the survey.

In all the interviews conducted at the endline, a photograph of the respective Gram Sabha was shown to all the respondents to help them to recall the social audit conducted in their Gram Panchayat. Prior to the start of the survey in every sample village, the interviewers were provided with the photograph of the respective Gram Sabha to show to the respondent at the time of interview.

## 2.4 Process component design and approach

The process component of the evaluation was designed to gather and document information relating to programme design and inputs, implementation mechanisms, and immediate outputs to determine whether the programme was successfully implemented according to its intended design and any associated challenges faced. It was also used to help shed light on why the social audit model may have achieved or failed to achieve its desired outcomes due to issues earlier on in the Programme Impact Pathway. Findings from this component are covered in Section 3 of this report.

**Primary objectives**

1. **Assessment of quality of implementation:**
   a. Identify and map out the critical processes and mechanisms involved in the implementation of the social audit model;
   b. Assess to what extent these processes were implemented as planned and resulted in achievement of planned outputs;
   c. Examine possible reasons for success and/or failure in implementation (e.g. logistical, budget, personnel, PRI/community/individual resistance, etc.) and how these might have affected the achievement of outputs.

2. **Community participation in audit process:**
   a. Explore the project's approach to inclusivity (e.g. village listing exercises, selection process for community leaders, etc., proportion of village/GP members participating in audit events, gender considerations, geographical distribution of contributing individuals/households);
   b. Examine transparency of process and information sharing: documentation and distribution of information captured from meetings, decisions, etc., fora used for sensitisation and dissemination, etc., awareness of audit process amongst wider community);
   c. Assess governance mechanisms built into programme: leadership and decision-making around pre-audit, audit, and post-audit phases, role of PRIs, AWWs and others in decision-making at different stages of process.

**Methods**

The process evaluation applied a range of approaches to gather qualitative and quantitative data to address the above questions, including:

- Programme document review (M&E framework, implementation work plans and tools, presentations, progress reports, promotional material, budgets, contracts, etc.);
- In-depth interviews and focus group discussions with community members, SPREAD programme stakeholders, and others which included participatory process mapping (combined with the community-level qualitative tools and data collection);
- Data obtained from endline quantitative household survey at output level;
- Analysis of SPREAD monitoring data including MIS data from the social audit process.

## 2.5 Qualitative component design and approach

The qualitative component sought to explore and unpack some of the important explanatory social contextual factors existing at community-level which may have influenced the uptake and impacts of the social audits (as captured through the quantitative evaluation component).

**Primary research questions**

1.  How does the social audit affect or facilitate community empowerment and participation in government service delivery and decision-making?
2.  How does the social audit impact differently on different sub-groups of the target population (including ST, SC, and OBC groups, adolescent girls, children <2 years, the elderly, etc.?)
3.  What are the interactions between societal, community, and household-level structures and how might these influence participation in the social audit process and nutrition-related behaviour change?
4.  What are the local contextual factors that might enhance or hinder the uptake of the social audit model as part of the government's mandate under the NSFA?

**Methods**

The qualitative component applied a multi-site case study approach to gather detailed descriptive community-level data from a sample of 11 villages where the social audits had been implemented. The primary tools for data collection were semi-structured In-Depth Interviews (IDIs) and Focus Group Discussions (FGDs) with a range of different target groups including male and female community members, government officials, social audit team members, and NFSA service providers.

## 2.6 Sampling strategy and process for community-level qualitative and process data collection and analysis

APPI and IDS partnered with DCOR to conduct the community-level data collection for the qualitative and process components. DCOR were already familiar with the local context and communities, had experience of working with APPI on other similar nutrition surveys as well as having led on the quantitative survey data collection process for the evaluation, so could apply their learning and experience from this process to the qualitative and process fieldwork.

IDS were responsible for the development of the research tools and initial data collection plan in May–June 2018, with input from the APPI, SPREAD, and DCOR teams as needed to ensure they met APPI's expectations, were contextually appropriate, and feasible to implement. The tools were also cross-checked against the quantitative baseline survey tools and baseline data/report to ensure that they complemented the approach and findings from the quantitative component. The six main research tools developed were:

1.  Community member IDI guide
2.  Community member FGD guide
3.  Social audit team/SPREAD/Samikshya Sathi IDI guide
4.  Social audit team/SPREAD/Samikshya Sathi FGD guide
5.  NFSA service provider IDI guide
6.  Government officials IDI guide.

These are available for public inspection and sharing by contacting the authors. The sampling strategy for the selection of villages for data collection incorporated the following steps:

## Sampling at district level

A total of three out of the six KBK+ districts (50 per cent) that SPREAD had selected for implementation of the programme were sampled according to different levels of vulnerability based on a vulnerability index[4] constructed from the quantitative baseline data.

**Figure 2.5 Mean of vulnerability index across six target districts**
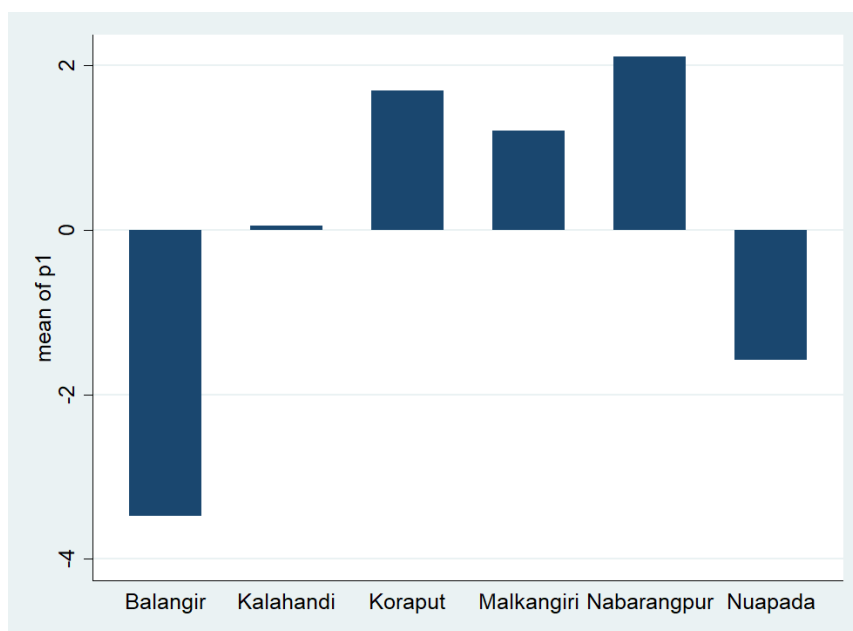


*Source*: Authors' own.

By construction, the index was normalised to 1. Kalahandi District was found to be a typical district, with Balangir and Nuapada as the least vulnerable districts and Koraput, Malkangiri, and Nabarangpur as the most vulnerable districts. A random sampling procedure run by IDS selected Kalahandi, Balangir, and Koraput as the three chosen districts from across these three levels of vulnerability.

## Sampling at village level

Three villages were sampled from each of the three selected districts where social audits had taken place. These were selected as a sub-sample of the quantitative survey sample in order to be able to triangulate, draw on, and expand on the quantitative data. A stratified random sample of nine villages was taken based on distance from the district capital, whereby one village per district was selected from across the three distance categories (close to capital, medium distance to capital, far from capital).[5] The final list of villages comprised:[6]

## Balangir District

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[4] The index of vulnerability at district level (p1) was constructed based on (i) proportion of SC, (ii) proportion of ST, (iii) proportion of primary caregivers who are illiterate, (iv) assets ownership index, (v) index of nutrition knowledge, (vi) index of knowledge of MAMATA entitlements, (vii) household food insecurity index, (viii) primary caregivers' dietary diversity index and (ix) density of groups/committee. The higher the index, the lower the vulnerability.

[5] 'Close' villages are about 30km from the district capital, 'medium' villages 62km, and 'far' villages 83km.

[6] Village names have been removed to ensure they remain anonymous.

1. 1 'Close' village (Late) in Sihini GP
2. 1 'Medium' village (Early) in Luhasinga GP
3. 1 'Far' village (Late) in Haldi GP

**Kalahandi District**

1. 1'Close' village (Late) in Duarsuni GP
2. 1'Medium village (Early) in Baradanga GP
3. 1'Far' village (Late) in Thuamul GP

**Koraput District**

1. 1'Close' village (Late) in Raniguda GP
2. 1'Medium' village (Late) in Bagderi GP
3. 1'Far village' (Early) in Ballel GP

The original design proposed selecting two additional villages that hadn't been exposed to the social audit process to act as a comparison, but it was later decided that it would be more useful to select a few 'positive deviance' villages where the social audits had been taken up extremely well by the community, and participation and engagement rates had been high, as this would provide insights into what characteristics may have led to their success. The two 'positive deviance' villages were selected from two of the three districts according to the highest social audit participation rates based on the quantitative baseline data. These villages were:

1. 1 Late village in Boipariguda GP, Koraput District
2. 1 Late village in Golamunda GP, Kalahandi District

The total of eleven villages sampled were not intended to be statistically representative of the wider population but rather provide rich contextual insights that could complement and enhance the quantitative survey data.

### Piloting of tools and research team training

Internal training of the field research coordinator, supervisors, and researchers was conducted by DCOR for six days from 20–25 June 2018, which included three days of classroom training and mock practices for two days so that the team could get used to using the tools and pick up on any issues or challenges faced. The IDS team then joined the DCOR team for three days from 26–28 June for further orientation and discussion of the tools and pilot testing of the tools. Suggestions and inputs were provided by the DCOR research team to adapt the tools to the local context. Representatives from the SPREAD team also provided valuable inputs to the study team about the social audit intervention being implemented.

Pilot testing of the topic guides was done over the next two days from 27–28 June. One of the non-sampled intervention villages, Kumbhari in Saintala Block was visited for the pilot testing. The IDS and DCOR teams jointly conducted this pilot-testing exercise with field support from the SPREAD team, which included FGDs with different categories of community members, and IDIs with NFSA providers and community members. De-briefing on the findings of the pilot testing was conducted after completion of each day of fieldwork. The research team shared their experience of pilot testing with the IDS team who recorded any suggested changes and incorporated them into the final versions of tools that were finalised shortly afterwards.

During the pilot testing, it became clear that the DCOR research team would benefit from additional field practice before starting data collection. Therefore, a week-long field practice was done after the piloting was conducted which helped them become more familiar with the tools.

**Data collection**

After the topic guides were finalised, data collection was started on 9 July 2018 and continued until 23 May 2018. In all three districts, data collection was carried out simultaneously. The team consisted of 17 people (a team leader, field research coordinator, three field research supervisors, and 12 field researchers). Five team members (1 field supervisor and four field researchers) were engaged in data collection in each of the three districts. The four field researchers engaged in each district were into two sub-teams to conduct the FGDs or IDIs paired (one researcher conducted the interview and the other researcher acted as the note-taker). In total, six pairs of field researchers were engaged across the three districts for conducting the FGDs and IDIs planned for the study.

**Table 2.3 IDIs conducted per district and target group**

| District | Koraput | Bolangir | Kalahandi | Total |
|---|---|---|---|---|
| **A. Community member** | | | | |
| Community member | 36 | 20 | 26 | 82 |
| Sub-total | 36 | 20 | 26 | 82 |
| **B. NFSA service providers** | | | | |
| AWW | 2 | 2 | 1 | 5 |
| School teacher | 1 | 1 | 1 | 3 |
| Jogana Sahayaka | 1 | 1 | 1 | 3 |
| Sub-total | 4 | 4 | 3 | 11 |
| **C. Government officials** | | | | |
| ABEO | | 1 | | 1 |
| ICDS/lady supervisor | 1 | 1 | 1 | 3 |
| Sarpanch | 1 | 2 | 2 | 5 |
| CRCC | 1 | | 1 | 2 |
| Ward member | 1 | | 1 | 2 |
| Sub-total | 4 | 4 | 5 | 13 |
| **D. Social audit team** | | | | |
| Samikshya Sathi | 3 | 3 | 3 | 9 |
| Block coordinator | 1 | 1 | 1 | 3 |
| District coordinator | 1 | 1 | 1 | 3 |
| Sub-total | 5 | 5 | 5 | 15 |
| **Total IDIs** | **49** | **33** | **39** | **121** |

*Source*: Authors' own.

A total of 121 IDIs were conducted in the three districts. Of these, 82 IDIs were conducted with the community members, 11 with the NFSA service providers, 13 with the government officials and the remaining 15 were conducted with the social audit team members.

The number of FGDs conducted is presented below in Table 2.4.

**Table 2.4 FGDs conducted by district and target group**

| District | Koraput | Bolangir | Kalahandi | Total |
|---|---|---|---|---|
| **A. FGD with community member** | | | | |
| SC Younger women | 2 | 2 | 4 | 8 |
| ST Younger women | 5 | 3 | 4 | 12 |
| OBC Younger women | | 1 | | 1 |
| SC Older women | 3 | 3 | 4 | 10 |
| ST Older women | 4 | 2 | 4 | 10 |
| OBC Older women | | 1 | | 1 |
| ST Men | 5 | 3 | 4 | 12 |
| SC Men | 1 | 3 | 4 | 8 |
| OBC Men | 1 | | | 1 |
| Village leader | 4 | 3 | 4 | 11 |
| Sub-total | 25 | 21 | 28 | 74 |
| **B. FGD with implementation team** | | | | |
| SPREAD district and block coordinator | 1 | 1 | 1 | 3 |
| SPREAD Samikshya Sathis | 1 | 1 | 1 | 3 |
| Sub-total | 2 | 2 | 2 | 6 |
| **Total FGDs** | **27** | **23** | **30** | **80** |

*Source*: Authors' own.

The DCOR study team conducted a total of 80 FGDs across all three districts together, of which 74 FGDs were conducted with the community members and 6 FGDs were conducted with the implementation team. The 80 FGDs were attended by a total of 624 persons (200 in Koraput, 184 in Bolangir, and 240 in Kalahandi districts). On average, each FGD included around eight individuals.

**Data handling and analysis**

*Audio recording of the FGDs and IDI*

After informed consent[7] was given, IDIs and FGDs were digitally recorded using a portable digital recorder. Audio recordings were downloaded after coming back from the field on a daily basis. The recorded files were renamed using an anonymised coding system developed in an encrypted Excel sheet.

*English translation of the FGDs and IDIs*

Recorded files were then transcribed as verbatim in English by a team of 30 translators. The quality of the English transcriptions was assured by matching audio recordings with the transcriptions by the DCOR quality assurance team. The translation team were provided training on the social audit intervention and research tools before conducting the translation. After the transcriptions were completed, all the transcription data files were given new names and codes to ensure data and informant confidentiality.

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[7] The purpose and objectives, risks, benefits, and confidentiality of the information collected in the study were clearly explained to the participants prior to taking informed consent.

*Data coding and analysis*

The translated FGDs and IDIs were coded using qualitative data analysis software (NVivo 12) through a two-stage primary and secondary coding process. First, the IDS team developed a primary-level coding scheme for each research tool/target group based on the main research questions, tools, and key themes to be explored, based on their initial review of the transcripts. This was shared with DCOR who conducted the primary-level coding exercise. During the coding process, DCOR raised queries and provided feedback to IDS on the coding and some of the themes which led to some sections being revised and new nodes added or changed.

Once DCOR completed the primary-level coding in NVivo, the IDS team developed a secondary coding scheme which built on the primary-level coding. The IDS team used this to carry out a higher level of qualitative data analysis of key emerging themes, patterns, and crosscutting issues important for assessing and exploring the programme's implementation processes and outcomes, in accordance with the Programme Impact Pathway and evaluation objectives. These themes were also triangulated with the quantitative and SPREAD MIS data.

# 2.7 Ethical considerations

Ethical approval was granted by the Institutional Ethics Committee (IEC) in Odisha. The IEC meeting took place in Bhubaneswar and was chaired by Justice Hruday Ballav Das. The applicant organisations included IDS, APPI, and DCOR Consulting. Relevant documentation had been submitted to the board prior to the meeting. Following a discussion of ethical implications of the evaluation design by the ethics panel with IDS, DCOR, and SPREAD representatives, the IEC granted ethical clearance on 11 December 2017. IDS' Institutional Ethics Committee also approved the study design in November 2017.

Data collection did not involve any collection of biological samples or use of biometric testing or anthropometric measurements so the overall risk of possible harm or discomfort caused to participants was considered low. Specific measures taken to minimise risk and to ensure the safety of the participants included the following:

- Informed consent was obtained from each individual prior to interview and respondents were told that participation was completely voluntary and that they could stop at any time.
- So as to minimise taking up people's time, data collection tools were tested and piloted so as to ensure that they did not include unnecessary details and did not exceed 1–1.5 hours.
- In order to minimise participant burden, particularly given that the same communities were sampled for both quantitative and qualitative data collection, participants received a small gift as compensation for their time.
- Care was taken to protect data privacy and confidentiality. All files containing interviews and focus groups that were digitally recorded were stored with password protection and according to an anonymised code system. All the transcription and translation files were de-identified and kept anonymous for data coding and analysis. The back-up of all the files was kept on a separate hard disk in order to avoid data loss.

# 3 Findings at implementation level (design, inputs, outputs)

Section 3 presents the evaluation's main findings related to the design and implementation of the SPREAD CAN programme, including the appropriateness of the overall design, staff recruitment, and training, selection of areas and target groups, programme management and monitoring, implementation roll-out, and knowledge and participation of the communities in the social audit process. Evidence is drawn from a range of primary and secondary data sources including SPREAD programme documentation, meetings, and MIS data, community-level IDIs, and FDGs with different stakeholder groups, as well as other external literature.

## 3.1 Design

In this section, we review the appropriateness of the design for the intended outcomes, including evidence that it draws on 'best practice', any wider evidence on effectiveness or implementation considerations; and evidence of any effort that went into improving the intended design, including through field tests and pilots.

Overall, programme documentation, discussions with the SPREAD and APPI teams and the evaluation team's prior knowledge of the field of social accountability practice suggest that a substantial amount of effort went into the design of the social audit process. The strongest piece of evidence for this is the production of the Social Audit Manual itself and the associated training attached to it. The Social Audit Manual was produced following a pilot of the social audit methodology in 24 locations in six 'KBK +' districts. This followed a review of earlier social audit guides and consultation with organisations who had been involved in auditing the government's MNREGA programme.

The SPREAD Social Audit Manual is comprehensive and covers a number of important areas which are helpful in ensuring that SPREAD team members are sufficiently oriented to the history and objectives of both the NFSA and related programmes, and the social audit approach itself. This is an important observation because, as we will go on to describe below, raising awareness of the NFSA context and the objective of the social audits within this was an important part of the intervention.

As well as providing essential background on the NFSA and each of the services covered, the manual also lays out clear steps and considerations for every step of the audit process. This includes: overall objectives, principles, and procedures; specific activities in the pre-, during, and post-social audit stage; social audit team; Samikshya Sathi (SS) and social audit recruitment and criteria; documents to be consulted for each scheme covered; information and communication activities, field verification; laying the ground for and conducting the public meeting; and follow-up, including grievance redressal, and onward referral to state officials.

Social audits have a long history in India and are a popular form of social accountability and advocacy. They have been used in multiple contexts related to NFSA programmes, primarily relating to the Public Distribution System (PDS), but also in programmes such as the ICDS. Although widespread, there is limited rigorous quantitative evidence on their effectiveness in terms of food security and nutrition outcomes, reflecting a wider and global gap in the literature in terms of social accountability and nutrition.

The substantial experience of using social audits in the Indian context combined with the requirement that state governments carry out some form of social audit as per their NFSA responsibilities suggests that the design was appropriate in this case – albeit one requiring further development and evaluation in the context of nutrition (something to which this evaluation report

contributes). The further development of the training manual, the way in which the SPREAD team was able to draw on practice and guidelines from broader allied sectors including NREGA and the right to food campaign (RTF), and the attempt to pilot and further alter the design are all exemplary in terms of thought going into the design, once a decision had been made to pursue a social audit model.

# 3.2 Staff/volunteer recruitment, training, and characteristics

This section reports on evidence we have gathered on the process followed to recruit and train staff and volunteers associated with the CAN programme – including core and district-level staff and Samikhya Sathis. Evidence is largely drawn from a review of SPREAD programme documentation including training manuals and reports, and discussions with SPREAD staff.

## Recruitment

Recruitment needs for the programme were extensive, as the design required recruitment of a substantial number of people at all organisational levels:

- 10 state-level staff
- 48 block coordinators
- 6 district coordinators
- 240 Gram Panchayat coordinators
- 480 Samikshya Sathis.

This task appears to have been carried out successfully – some delays in timing are reported in programme documents, but not so much to delay implementation. There is evidence of a suitable and formal recruitment process having been in place according to programme documents. Positions were advertised via the development portal *devnetjobs*, or locally in the case of Gram Panchayat coordinators and SSs. A decentralised process of recruitment (presumably under the management of district coordinators) to select local personnel was reported as working well. There is evidence of a clear interview process (scored written test and interview) and clear criteria for recruitment via job descriptions. Attention was also paid to diversity, though there were some reported early challenges in finding female candidates for state and district-level positions. Out of the total 185 sanctioned positions for phase 1, 176 were reported to be in place by February 2017. Of this, 26 per cent were female and 74 per cent male. In terms of caste composition, 39 per cent of project staff were 'Scheduled Tribe' (ST), 15 per cent Scheduled Caste (SC), 28 per cent 'Other Backward Caste' (OBC), 2 per cent 'Socially and Economically Backward Communities' (SEBC), and 17 per cent from the general communities. Efforts were made to appoint local persons for the GP and block coordinators.

SSs were recruited separately – some via the GPC recruitment process, others recruited directly by a process led by the district coordinator (DC). Here, local contextual knowledge, and aptitude to mobilise people and facilitate meetings were prioritised as desired knowledge and skills.

## Training

The programme carried out extensive training and staff development activities at all levels. There is evidence that this extended beyond basic induction, to further training, and refresher training at later stages in the programme. There is also evidence that training employed a suitably wide array of pedagogical approaches, including participatory, group, and practical exercises.

Basic induction materials were reported as prepared in Odisha on the NFSA, ICDS, and malnutrition. Further resources were provided as primers by the RTF campaign (on social audit,

know your rights, ICDS, MDM, NFSA, Right to Information (RTI), Right to Education (RTE), Forest Rights Act (FRA)). A two-day induction workshop was held for district and block coordinators. Noteworthy is the attention to basic understanding of the objectives and motivations of the project, rather than a focus on isolated tasks. Further training on GKS and PRIs was undertaken in all six districts to ensure understanding of the three-tier Panchayat Raj system and the roles and responsibilities of different PRI members. The GKS training focused on the overall context of the National Health Mission (NHM) and the role of the GKS in relation to health and nutrition, including in the preparation of village health and nutrition plans. Other relevant organisations were involved in the training process (District Programme Manager (DPM)-NHM, District GKS Coordinator, etc.), which SPREAD reported helped develop relationships in this area. Training also extended to senior management (state team and DC), who underwent a 'Management Development Programme' facilitated by an external expert, focusing on individual, team, and organisational functioning. Similar exercises took place for each of the district teams in October–November 2017. Refresher training took place in December 2017.

Training documents reviewed by this evaluation include a 'Report of the Social Audit Training Year One (August 2016 to July 2017)'; 'Report of the Samikshya Sathi Induction Training' and 'Collect Training, Testing of Forms, and Field Piloting 30th June to 4th July 2017'.

The document on Social Audit Training describes how training of the entire 224 staff members took place in two waves of six days in Koraput in May 2017. SPREAD's senior staff and district coordinators formed a resource team for the training and took responsibility for communication and participation, while a separate administrative team took care of logistics. Emphasis is placed in the report and in the training plan on ensuring participation; ensuring learning through regular group recaps; and ice-breaking and social events. Training took place in Odisha. Pedagogical methods appearing in the agenda are an appropriate mix of didactic teaching combined with role-play, practical demonstrations, group discussion, quizzes, group presentations, and in-field practice. Some evaluative reflection is included in the report itself, including comments by participants that would improve future training. It is also reported that the training team met every evening to adapt the training according to the evolving needs of the participants.

Training of the initial (pilot) 54 Samikshya Sathis took place separately at two locations: Bhawanipatana and Koraput in March 2016. A similar mix of pedagogical methods were employed over the three days of each training session. Encouraging signs of broader pedagogical methods employed by the course which are documented in the report are the sharing of the expectations of the training by the participants; participatory games used to encourage understanding of community mobilisation; and reports of feedback from trainee SSs being taken into account during the training itself. A further training for the 426 intervention SSs took place in December 2017 according to a similar methodology.

## 3.3 Targeting and selection of regions and participants

This section focuses on the evidence available on the SPREAD team's rationale and process for selecting the geographic and participant focus of the CAN programme. Evidence is drawn from review of SPREAD programme documentation, discussions with the SPREAD team and some external literature.

### 3.3.1 Selection of target areas (state, block, GP, village level)

**State-level selection**

At state level, the CAN programme's geographic focus is on the state of Odisha. This reflects APPI's strategic focus on supporting and influencing the Government of Odisha's efforts to mainstream social audits within the state as a tool to improve nutrition outcomes which remain poor

relative to most other states in India. By trialling the programme at scale within the state, if proven to be successful, it is hoped that this will influence the Government of Odisha, as well as other states, to adopt this type of model in ensuring community accountability for delivery of nutrition-related services. SPREAD has been working in Odisha State since 1989 and Odisha remains the geographic focus of their programme operations and existing networks.

**Figure 3.1 Areas covered by SPREAD CAN programme**
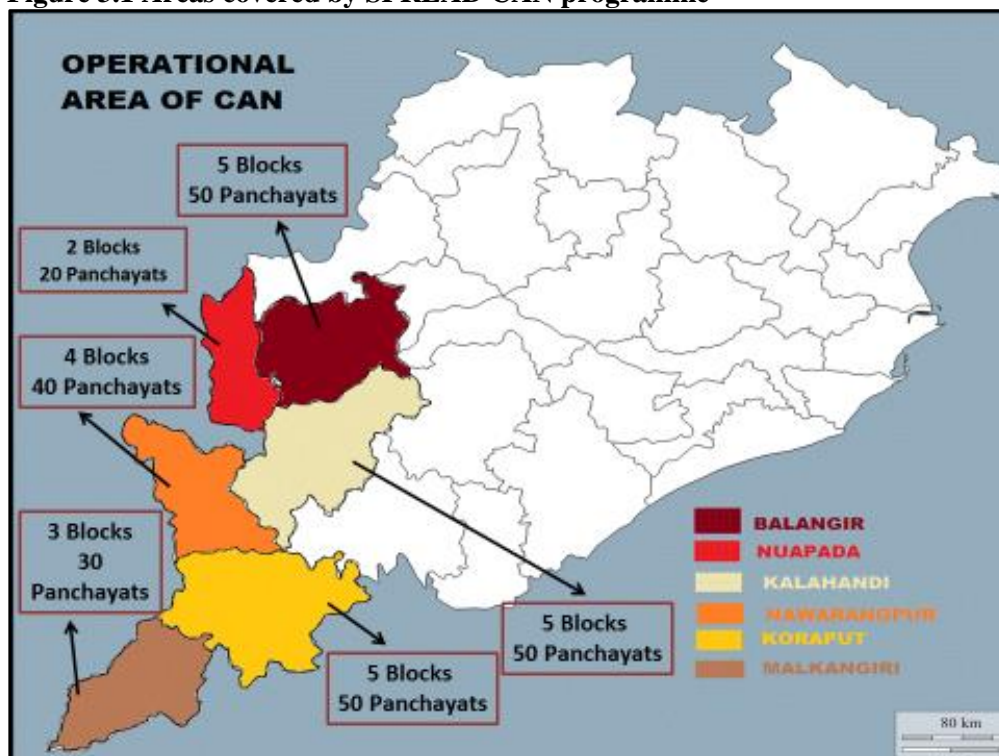


*Source*: SPREAD (2017a).

## District-level selection

For its first three years of implementation (2016–19) the CAN programme is focusing on six of the thirty districts in Odisha located in the south and western areas of the state, namely: Koraput, Malkangiri, Nabarangpur, Kalahandi, Nuapada, and Balangir (see Figure 3.1). These six districts, along with two others (Rayagada and Sonepur) form the 'KBK+' (Kalahandi-Balangir-Koraput+ ) districts, which are collectively recognised by the following characteristics (see Thomas *et al.* 2015):

- High proportion of Scheduled Tribe and Scheduled Caste populations (56 per cent compared to 35 per cent in the rest of the state);
- High rates of poverty, with average rural poverty rates close to 68 per cent compared to the state average of 46.9 per cent (in Nabarangpur District it is as high as 80.6 per cent);
- Poor health and nutrition indicators and severe food insecurity compared to non-KBK+ districts;
- Geographically marginalised, with poor road connectivity and dense hill terrain which inhibits access to public services including health.

These characteristics made them an ideal target area for the CAN social audit programme and formed the basis for them purposively selecting six of the KBK+ districts. The latest NFHS4 government data available on nutrition vulnerability was used to inform this selection.

**Block and GP-level selection**

At sub-district level, SPREAD selected a total of 24 administrative blocks based on a target to reach 40 per cent of the total blocks per district. Within each block, approximately 50 per cent of the GPs were selected for inclusion in the programme, which was subsequently standardised to 10 GPs per block. This resulted in a total of 240 GPs being selected. Of the total 240 GPs, 24 GPs (1 per block) were selected for inclusion in the pilot implementation phase carried out between May and June 2017, with the remaining 216 GPs included as part of the scaled up implementation between January and May 2018. As was the case with the selection of districts, blocks were purposively selected based on existing secondary data from NFHS4. GP-level selection was influenced by discussions with Child Development Project Officers (CDPOs) and District Officers (DOs) responsible for nutrition, based on their assessment of need and which GPs were lagging behind nutritionally.

SPREAD and APPI agreed to the above programme coverage for the following reasons (SPREAD 2016a):

- It covered most of the KBK+ districts and would provide enough evidence to mainstream the social audit tool within the state government (one of the programme's primary overarching objectives);
- A 40 per cent block coverage was considered substantial enough to influence and ensure that the district collectors would take forward decisions for improvement of ICDS in their district;
- It would enable adequate assessment of SPREAD's capacity to scale up implementation of social audits and their presence in Odisha State.

As this sampling approach appeared to work well, there are no plans to change the approach for the next cycle of audits. The GP was considered the main *unit of intervention* for implementation of social audits and for delivery of improved nutrition services and entitlements. The SPREAD Social Audit Manual (2018) highlights that the selection of the appropriate programme target area is critical and the Panchayat is the ideal unit for conducting social audits.

**Village-level selection**

The original sampling design was to select 50 per cent of the Anganwadi Centres within each GP to conduct social audits. Following the pilot, this was increased to 100 per cent based on feedback from PRIs and discussions with communities who felt it was important to capture the full picture of the performance of every AWC in each GP; otherwise, there was a risk that some poorly performing ones might be missed out. It was also felt to be more effective for gaining community and political support at GP and higher levels. The introduction of the MIS system for the full-scale implementation phase meant that this process could be done quicker so the expanded sampling approach did not affect overall timings for the process.

## 3.3.2 Targeting of participant groups

A number of different factors influenced the targeting and inclusion of particular groups and sub-groups in the social audit process, which included:

**Individuals entitled to NFSA services**

Given that the CAN programme focuses specifically on improving demand and uptake of the four government schemes covered under the NFSA (2013) – namely ICDS, TPDS, MAMATA, and Midday Meals – individuals eligible for these schemes were considered the main target for inclusion in the social audit (SA) process. SPREAD specifically focused on individuals eligible for ICDS as it

was thought to cover the vast majority of target beneficiaries (pregnant and lactating women, and children under six years).

The SPREAD SA manual highlights that, before initiating the village-level field verification process, the social audit teams need to decide whether to apply a *census* approach (whereby all rights holders under each of the NFSA schemes are approached for household-level interview and focus groups), or a *sample* approach (whereby the team agrees on a target percentage of eligible individuals to target). SPREAD estimated that all NFSA schemes combined would cover more than 90 per cent of households across the KBK+ districts.

For the CAN programme audits conducted in 2017/2018, SPREAD chose to adopt a sample approach, targeting 20 per cent of rights holders for ICDS for field verification as this would reach the vast majority of NFSA-eligible households, with the exception of the Midday Meals scheme which was covered separately via FGDs with children in schools. Selection for field verification household surveys was done through a lottery-based system of randomly selecting individuals from a list of rights holders based on secondary data available from the AWC. SPREAD estimate that on this basis they were able to reach their target of 20 per cent of ICDS, PDS, and MAMATA beneficiaries. For a few AWCs, SPREAD reported some issues with accessing rights holders' details from AWWs but this was minimised through prior and consistent engagement and capacity building with communities prior to the start of the social audit process. For focus group discussions, the main focus was on sampling individuals whose household members were entitled to ICDS services. There is a risk that, by relying on secondary data from AWCs to select households for field verification, they may have potentially missed sampling newly eligible households, or else those who were particularly marginalised in terms of awareness of, and access to, AWC facilities.

## Government officials and community leaders

Many of SPREAD's internal programme documents and published reports highlight the critical importance of gaining support and involvement from village leaders, state officials at different levels of administration, ASHAs and AWWs, and existing committee structures such as Mothers' Committees throughout the social audit process (including pre-, during and post-audit phases). This ensured that responsibility and ownership of the process was taken on by the communities themselves, with the support and involvement of the SPREAD social audit team. The social audit teams therefore made a consistent strategic effort to identify and involve the appropriate individuals from across these different groups, particularly PRI members. This was primarily achieved through close engagement with the Sarpanches of the respective GPs who themselves coordinated the introduction and involvement of other PRI members and state officials involved in implementation of the NFSA (e.g. the Block Development Officer (BDOs), CDPO, Market Inspector (MI), and Block Education Officer).

As part of this effort, SPREAD's programme design incorporated a series of structured training sessions for PRI and GKS members prior to the initiation of the actual audit process to raise awareness on areas including the Nutrition Manifesto, NFSA, roles and responsibilities of the PRIs, and social audit, with a view to helping to motivate the PRIs to take a lead role in the social audit process. The programme also incorporated block-level sharing meetings after the social audit meetings involving PRI members, BDOs, CDPOs, Mis, and other block-level officials to present and follow up on actions highlighted during the GS hearing (SPREAD 2018c). This ensured the active participation of government officials in the post-audit phase of addressing concerns and grievances raised during the audit.

## Marginalised or disadvantaged groups

Central to SPREAD's downward accountability model and social audit approach was a specific effort to improve NFSA service delivery for particularly marginalised and disadvantaged groups across the six KBK+ target districts. This includes SC, ST, and other backward caste members,

women, and individuals with disabilities. Whilst the overall population in these districts is considered poorer and more vulnerable relative to populations in other districts, these groups were considered particularly vulnerable and susceptible to poor access to NFSA services and entitlements, and would therefore be more likely to directly benefit from inclusion in the social audit process.

At GP and village level, this meant that the SPREAD social audit teams were trained and instructed to take special care to identify and mobilise rights holders from SC, ST, and other backward communities and disabled households to ensure their active participation in focus group discussions, the Palli Sabha village meeting, and Gram Sabha public hearing.

# 3.4 Programme management and monitoring

This section focuses on assessing SPREAD's overall approach to managing and monitoring the CAN social audit programme, including personnel structures, and monitoring tools and systems set up. Evidence is largely drawn from review of SPREAD programme documentation and MIS data. Findings on how the various steps of the social audit processes were implemented by SPREAD are included in Section 3.5.

## 3.4.1 SPREAD management approach and structures

SPREAD's approach to managing the CAN programme was able to draw on ten years of learning and experience accumulated from their work facilitating community mobilisation and monitoring of food entitlements, and implementing other social audit approaches within the same regional contexts.

Piloting their SA approach with 24 GPs in 2017 meant that earlier lessons and experience (which were systematically documented in individual social audit reports) and challenges faced during implementation were able to help shape the design and management structures for scaled up implementation across the remaining 216 GPs in 2018. The development and use of a detailed Social Audit Manual and SS training manual acted as important management tools for providing detailed and standardised guidance for SPREAD staff on the background /context/aims as well as steps involved and sensitivities required to undertake the social audit process (for more details on staff recruitment and training see Section 3.2).

SPREAD designed a complex multi-tier management structure in order to oversee and implement the programme (see Figure 3.2). This included a number of core State team members (including State Programme Manager, Community Governance Coordinator, Social Audit Expert, Accounts Officer, and M&E Coordinator) based in the main Koraput office, six District Coordinators, 48 Block Coordinators (BCs), 240 GP Coordinators, and 480 Samikshya Sathis. Whilst not considered formal SPREAD employees, the Samikshya Sathi volunteers recruited from the 240 individual GP communities were considered a central pillar to the functioning of the whole programme and were closely supervised by the Gram Panchayat Coordinators (GPCs). The SSs were appointed and trained to facilitate the social audit process and acted as a critical connection between the SPREAD team and community members (more details on recruitment and training of SSs is included in Section 3.2).

**Figure 3.2 SPREAD management structure**
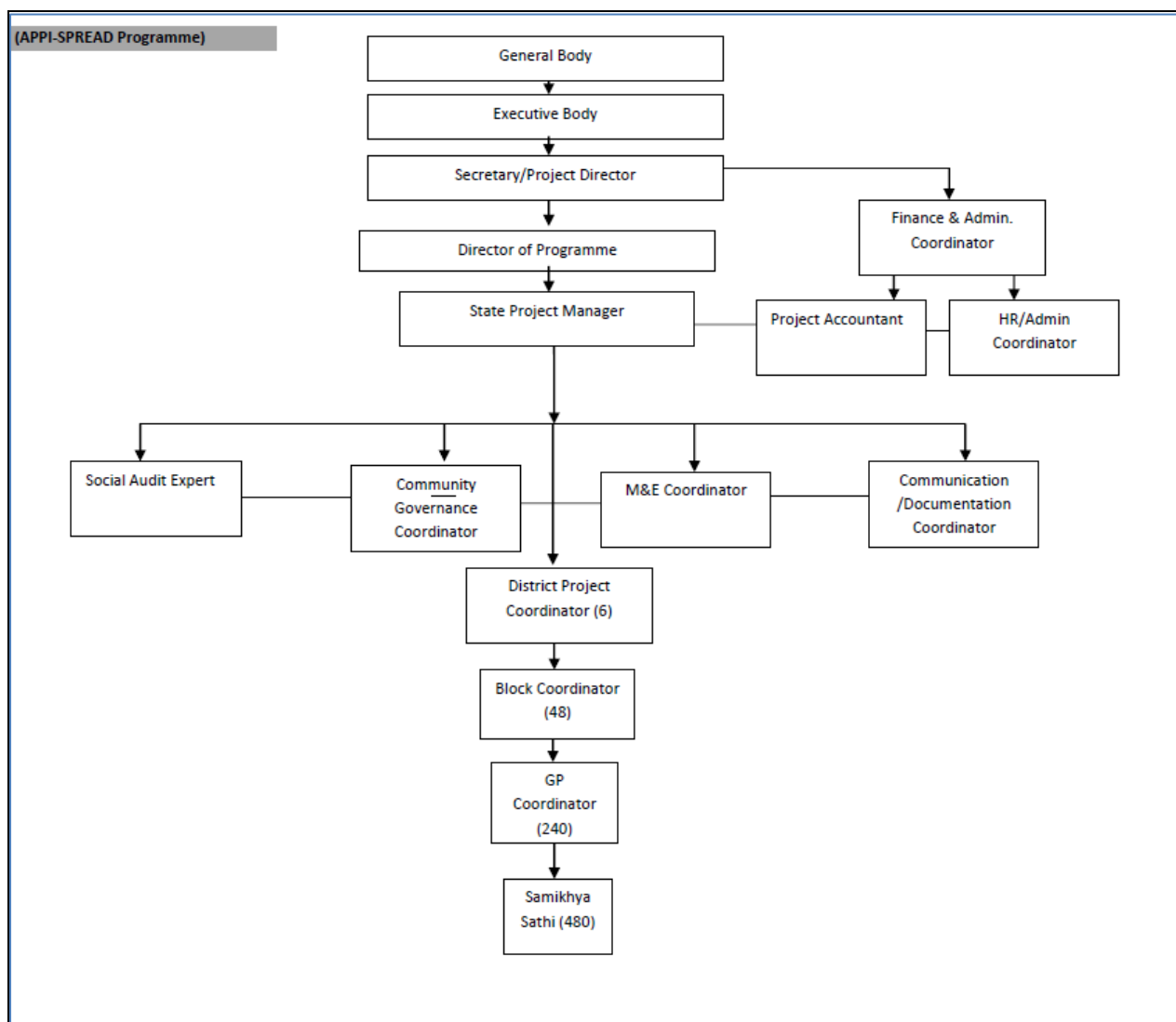
This multi-layered management model combined staff working at GP/village level alongside more strategic political engagement with government officials and service providers at higher levels of administration (state, district, block). Evidence from programme documentation and interviews with SPREAD staff suggest that this model helped increase state involvement in, and responsiveness to, the programme. More details on participation rates in the social audit process are included in Section 3.6.

Whilst proven to be an effective management model, there remains a question around its intensity in terms of personnel and resource requirements, particularly when considering wider scale-up of the programme and replication elsewhere. Indeed, the core SPREAD team indicated during discussions with the evaluation team in February 2018 that, in the longer term, they were looking at options for a leaner management model. It will be important for SPREAD to consider this as part of their planning for the next phase of social audits due to commence in December 2018.

Some staff turnover issues were reported during the course of the programme, particularly at block and SS level, although this doesn't appear to have had any major impacts on the delivery of the SA programme and vacant positions (at least at block level) were filled up immediately.

By using the SSs recruited from within their local community (rather than SPREAD employees) to act as the main facilitators of the social audit process, through collaboration with the Sarpanch and local officials, it is perhaps unsurprising that qualitative interviews with community members revealed a widespread low level of awareness of NGO SPREAD as the main implementing agency responsible for overseeing the audits. Many community members either said they didn't know who managed the social audits or else named the Sarpanch or other Panchayat officers as the lead responsible.

Whilst a lack of community awareness of who led the process could be seen as a sign of poor communications about the programme and process, this also stems from a deliberate intention on behalf of SPREAD to integrate the social audit process into existing community structures with a limited profile, particularly given the longer-term plan for communities to manage social audit processes themselves without external support.

An external advisory committee was set up by SPREAD to provide strategic guidance on the overall direction and management of the programme. This structure was formally in place by December 2016 and the first official meeting was held in July 2017 (originally planned for March 2017 but delayed to due to member availability issues and other processes). The committee included individuals with expertise in food, nutrition, governance, water, sanitation, and journalism. Feedback and advice was sought from the committee on resource material and ongoing activities and challenges faced, who were able to provide constructive suggestions for improvements (for example, on strengthening relationships with PRIs and framing the advocacy agenda for social audit and nutrition). Specific ToRs with some members were agreed to fulfil specific activities for example one member agreed to facilitate a training workshop to the project team on nutrition (SPREAD 2018c).

## 3.4.2 Monitoring frameworks and tools

SPREAD's internal programme documentation includes two key documents central to the planning and monitoring of programme activities, outputs, and outcomes: 1) a grant monitoring plan (SPREAD 2016b) and 2) an implementation plan (SPREAD 2016a).

The monitoring plan, prepared before the start of the project in August 2016, summarises the project's main anticipated outputs and outcomes alongside their associated indicators, means of verification/data sources, frequency of data collection, and risks/assumptions. The monitoring plan has not been reviewed or updated within the course of the project. The plan provides a useful overview of the areas to be monitored and sources of verification (e.g. annual reports). The plan doesn't include details on the specific monitoring tools and data collection approaches intended to capture the information needed to meaningfully assess ongoing progress at output level or assess longer-term programme outcomes anticipated, such as community empowerment/ownership, women's empowerment, food consumption, and other nutrition outcome indicators. Discussions with SPREAD confirmed that they consider the MIS social audit templates (discussed more below) as their primary monitoring tool for measuring achievement of outputs (e.g. number of GS meetings held, participation rates, etc.). Community-based monitoring during the post-social audit phase (also discussed more below) was used as the primary tool for assessing some outcomes (such as community empowerment) but not others (such as improved NFSA service delivery, increased uptake, etc.). For some of these longer-term outcomes, SPREAD will be looking to the independent evaluation results to determine the extent to which these have been achieved. For the next round of social audits, SPREAD will be able to compare their MIS findings e.g. on service access from the previous round in order to determine changes in these outcomes over this period.

The implementation plan developed at the start of the programme in 2016 maps out key steps involved in the four phases of the programme's implementation between August 2016 and August 2019. Monitoring of progress against this plan was recorded via monthly progress reports and via the six-monthly Programme Reports submitted to APPI (with the latest being August 2018). These

reports also document key opportunities, achievements, what worked well, challenges, modifications to the initial plan, utilisation of resources, partnerships, spend patterns, future plans, and significant change stories experienced by participants in the process.

A process documentation of the social audit was conducted during the fourth phase by an external consultant commissioned by SPREAD who produced a summary that was shared with government officials as part of post-audit follow-up. Efforts were also made to discuss and document the experience of the blocks teams while organising the social audits.

## MIS approach, process, and tools

APPI appointed an external Copstech platform agency, SocialCops, to work closely with APPI and SPREAD in the development and roll-out of a mobile phone-based Management Information System (MIS) approach for collecting and analysing data as part of the social audits. Detailed survey templates were developed according to the different sources of field verification. This included the main sites for NFSA services such as the AWC, Fair Price Shop and School, PDS, ICDS, and MAMATA beneficiary households. Templates were also developed to monitor participation in the social audit processes including Palli Sabha and Gram Sabha meetings, PRI training, and post-audit PLA and VHND monitoring. The survey templates were programmed into a software tool ('Collect') that could be accessed by the social audit team via an android-based application. Once data was uploaded to the central online database ('dashboard') it could be viewed and analysed by the SPREAD team.

Given the central importance the social audit model places on documenting information about individuals' entitlements to specific services to use as an accountability tool to hold service providers to account to bring about improvements, having a reliable and efficient tool and process to collect and quickly analyse this data was critical to the success of the SPREAD programme. Programme documents including the Social Audit Manual and programme progress reports highlight the importance of this use of technology for increasing efficiency, enabling quick data compilation, and quick analysis compared to traditional paper-based methods.

> From the programme perspective, it has saved time for data collection by SS and GPC and also the cumbersome and time-consuming process of data entry, cleaning, and compilation has been minimised and avoided to great extent. Digitising the social audit process can be a model for future social audits across the country.
>
> (SPREAD 2018c)

Staff training, form testing, and field piloting of the Collect MIS tool across four of the pilot GPs were facilitated by SocialCorps in June–July 2017 (see SPREAD 2017e). This included training on the various steps involved in MIS data collection in the field and on the management of data via the dashboard.

Aside from its core function to store and analyse data about NFSA services and the social audit process, the MIS also acted as an important management tool for SPREAD BCs and GPCs to be able to monitor the social audit team's precise locations, progress in conducting verification processes, and quality of data and documentation (e.g. photos of AWC registers) collected.

The MIS was in place and used for data collection across all the 216 social audits conducted in 2018. The SPREAD team was also able to use the dashboard to display data during block-level sharing meetings as part of the post-social audit follow-up phase and also planned to use them in district and state-level meetings with officials.

Some of the challenges posed by the introduction of this mobile-based MIS approach included the following:

- Some delays were experienced in selecting the appropriate IT agency which meant the development and testing took place later than SPREAD had originally planned, although this didn't affect their ability to roll out the system in time for the cycle of 216 audits started in January 2018.

- Some auditors were initially apprehensive as this was the first time they had used mobile phones and the internet. With ongoing guidance and support from SocialCops and other SPREAD staff, plus hands-on experience in piloting the mobile application, their confidence and competence improved, although there remains a question around data reliability and input error rates if staff were so unaccustomed to use of this technology. A WhatsApp support group was formed with SocialCops to discuss and resolve MIS-related difficulties.

- Areas with poor internet connectivity were found to cause problems with uploading data in real time. To overcome this issue, auditors were instructed to ensure they saved responses in offline mode and move to an area with better internet connectivity every three days.

- Cleaning of data, especially cleaning of data of the names of Anganwadis took longer than expected. MIS data sets reviewed by the evaluation team showed many incidents of block and GP names being recorded with multiple spelling variations which may have affected the accuracy of data analysis via the dashboard.

- The initial dashboard set up in 2017 didn't fully meet expectations and required improvements to its functionality.

SPREAD also used their MIS system to monitor community-level follow-up during the post-social audit follow-up phase. This included ten cycles of participatory learning and action (PLA) meetings developed and conducted with the support of the organisation Ekjut as a tool for community monitoring of governance and transparency. The main target group for these meetings were women and adolescents. These meetings were designed to cover NFSA schemes and behavioural aspects. VHND participation rates were also captured as part of the MIS. MIS findings on participation rates for these post-audit follow-up activities will help feed into the design of the next round of social audits starting in December 2018.

## 3.5 Social audit implementation

This section first examines the CAN programme's overall success in meeting its implementation targets in terms of timings for the calendar of social audits planned and final geographic coverage achieved. Evidence for this is taken from SPREAD programme documentation. We then go on to examine some of the key implementation findings related to each of the three main phases of the audit process (pre-audit, social audit, and post-audit). Evidence for these findings are drawn largely from community-level IDI and FGDs with different target groups and to a lesser extent from SPREAD programme documentation and MIS data.

SPREAD successfully carried out 240 social audits across 240 GPs as per their original design and plan (described in Section 1). The 24 pilots were completed during May, June, and July of 2017. The remaining 216 were not carried out strictly according to the planned timetable, with the majority taking place during the final six months of year 2 (58 between August 2017 and January 2018, and 158 between February 2018 and July 2018). However, they did meet their overall deadline of 216 before August 2018. (SPREAD 2018c). The timings of the audits shifted slightly to accommodate the evaluation research plan of IDS, in particular to fit the design of the quantitative component which required the GPs randomly sampled for 'early' and 'late' phases of the programme cycle to be implemented accordingly by SPREAD.

The final count of villages covered by the Social Audit programme was higher than planned, with 3116 villages included (193 more than planned).

**Pre-social audit findings**

During discussions with SPREAD and in interviews and focus groups with the social audit teams, it became clear that to interpret the timeframe as set out in the manual as a rigid one was not realistic or the intention of the programme team. The social audit teams started the 'pre-social audit phase' months before the beginning of the social audit, as they realised it was necessary to build relationships with key people, in particular PRIs, over a longer period in order to gain the trust of communities and raise awareness about the process. Forming the Social Audit Committee in accordance with the recommendations in the Social Audit Manual also proved problematic in the reality of the field. The Social Audit Committee inevitably became the same group of people as the social audit team. This is a flaw in the process that has been recognised by SPREAD, and is something they are aiming to improve in the next round of social audits.

The majority of the social audit teams reported that gaining the initial trust of the community, healthcare providers, and government officials was challenging.[8] This created issues when trying to persuade them to engage in the social audit process. This was due to a number of factors, including, firstly a history of other NGOs working in these communities, who were reported to have made promises of change that resulted in nothing. Secondly, the community had no previous contact with SPREAD, ('no one knew us'), which was exacerbated by some members of the social audit team being relatively young and female, who therefore struggled to communicate effectively with community members who were older, more senior, or men. A lack of understanding about the process also meant that community members had very low initial expectations of its effectiveness, and this also created fear and resistance from health-care providers and schools that the process was confrontational and was about finding problems with them.

Prior to the social audit week, several community members did report being contacted or visited by SPREAD to inform them of the upcoming meetings and verifications. Many people reported that their first contact with the social audit team was during the social audit itself. This finding supports the original Social Audit Manual plan for proceedings.

According to the Social Audit Manual, government officials should be included in the planning process for the social audit. A few of the government officials interviewed reported that the SPREAD team did not contact them prior to the social audit starting. However, a couple did report being contacted by SPREAD, and that they were subsequently involved in the social audit process from the outset.

Several NFSA service providers reported being contacted during the pre-social audit phase. They reported that they were given information about the social audit, that it would take seven days, and that they would be carrying out research that would verify information regarding NFSA services.

> *One madam and sir had come, they said they will reside in the Panchayat and conduct investigations of the Anganwadi Centres, conduct meetings, etc. They stayed here for 7–8 days.*

> (Male, OBC, 32, Kalahandi, TPDS distributor)

However, an equal number of NFSA service providers reported that they had not been contacted and that the commencement of the social audit was a surprise to them.

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[8] Five out of six FGDs and four out of fifteen IDIs.

*They arrived suddenly and revealed that 'We are from the SPREAD team and will inspect about the midday meal'?*

(Male, OBC, Bolangir, teacher – MDM provider)


## Social audit findings

The social audits were generally carried out as planned within the seven-day period. However, the activities that were divided into day 1, and then days 2–4, were reported to be carried out simultaneously throughout days 1–4.

Logistical and practical issues created several problems with keeping to the seven-day schedule, however. Social audit teams experienced problems with their tablets, with accessing the internet and electricity, and with transportation between and within communities.[9] Team members reported a particularly heavy workload during Gram Sabha times, and timing issues created by external factors, such as fitting around schedules of government officials, left them carrying out more than one Gram Sabha on the same day.[10] Further time pressures were created by seasonal migration of target community members and school and Anganwadi centre closures during the social audit week, making the strict seven-day schedule problematic.[11] Long days and an extremely heavy workload during the social audit period were also reported to be a problem; compiling the reports from the data, as well as having daily team meetings in the evening, were reported as problematic. Some social audit team members suggested extending the seven-day period to reflect the need to be flexible within communities, perhaps to nine or ten days.

Reflecting the challenge of establishing trust within the communities during the pre-social audit phase, social audit teams also experienced resistance from some health-care providers, government officials, and schools during the social audit phase. This created difficulties in collecting the necessary data.[12] In some communities, health-care providers (and their families) were reported to have been deliberately intimidating during Gram Sabha meetings in order to prevent people from reporting grievances,[13] or creating deliberate disturbances during the meeting.[14] A lack of attendance of community members, health-care providers and government officials at village meetings and Gram Sabhas was also reported in some cases.[15] SPREAD have tried to overcome this challenge through early positive engagement and continued communication, as well as providing further training and support for social audit team members and communities.

Social audit teams reported feeling disheartened when the social audit process did not meet the expectations of the communities. This was caused by two distinct issues. Firstly, when social audit team members were unable to enhance access to nutrition schemes for community members who were entitled.[16] Secondly, in areas where there has not been a functional grievance redressal system prior to the social audit, the process has been appropriated in order for people to voice concerns over issues such as housing, drinking water, roads, etc.[17] This has created issues for the social audit teams, as they try to ensure that the discussion focuses on nutrition.

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[9] Five FGDs, three IDIs.

[10] Four FGDs.

[11] Two FGDs, one IDI.

[12] Reported in official reporting documents for Feb 2017, August 2017, and Feb 2018, four out of six FGDs.

[13] Five FGDs.

[14] Four FGDs, three IDIs.

[15] Reported in official reporting documents for Aug 2017 and Feb 2018, four FGDs, two IDIs.

[16] Reported in official reporting documents for Feb 2018 and August 2018, five out of six FGDs.

[17] Reported in official reporting document for Feb 2018 and August 2018.

A consistent theme that emerged during interviews and focus groups with community members, social audit team members, and NFSA providers was around a lack of trust in the process due to previous inaction, or the problem being at such a high level that they did not know how to resolve it. One community focus group participant explained that she did not engage with the social audit process 'because [no matter] how much you complain, the government will never listen to it' (female community FGD participant).

Despite the challenges identified, many people within the communities reported that the social audit process was a positive experience.

> Interviewer: *Was the experience of the Gram Sabha meeting good?*
>
> Response: *Yes it was good…they asked all people about their problem.*
>
> (Male, ST, 28, Bolangir)

> Response: *It was a good experience. I felt good.*
>
> Interviewer: *Why did it felt good?*
>
> Response: *There was an awareness among the people. People who were unaware of it came to know about it.*
>
> (Male, OBC, 45, Kalahandi)

Aspects of the process that were found to be particularly pleasing to the community were the ability for everyone to voice concerns (even if this option was not used), the possibility that access to schemes would increase, the feeling of being included in something, and in particular, when the process was successful in resolving grievances.

> *Yes the meeting happened so that they can solve our problems. They did that meeting, so that the things will change and anything good will happen in [future].*
>
> (Female, SC, Koraput)

> *The point of going to every house and creating awareness to the people made me happy, from that we came to know that a meeting is going to be held so that we could go and join.*
>
> (Male FGD participant (average age of FGD, 53), Balangir)

Criticism of the social audit process from community members centred around the same issues raised by social audit team members. A few people were upset when Gram Sabha meetings were disrupted by other community members, when they did not feel listened to, when the process did not meet their expectations regarding increased access to NFSA services, when senior officials failed to attend, or when they did not understand what was happening.

The majority of government officials interviewed for this evaluation found the social audit process to be a positive one. Most appreciated the mechanisms of public accountability for NFSA service providers and PRI members, that allowed them to understand the gaps in services and requirements for improvement. Further, many reported that they valued the awareness-raising aspects of the process, and the inclusiveness of all community members.

Very few challenges were identified by government officials. One person reported that the Gram Sabha meeting did not provide necessary refreshment, and was too long for mothers with small children to attend. Another reported disappointment at not being able to resolve all the problems raised. The final complaint was that there was not enough time for everyone to speak in the Gram Sabha.

The majority of NFSA service providers interviewed considered the social audit process to be useful, positive, and well managed. This group includes those who were not contacted prior to the start of the social audit, suggesting that even though they were not warned of the upcoming events, they have still witnessed the merits of the process.

> *Almost all the work was done neatly and properly. They checked all our records and documents of Anganwadi and MS records as well and took a photo of everything.*

> (Female, OBC, 50, Balangir, AWW Provider)

A few of the NFSA service providers reported that the grievance redressal processes that were started by the social audit were useful and positive and that the process itself was conducted well.

There were two criticisms of the process from NFSA providers. Firstly, that, in their opinion, it is not possible for an NGO to solve the problems within the TPDS programme because the issues are at 'the upper level'. Secondly, that during a Gram Sabha, there were some unruly participants. There was no direct criticism of the way that the process was conducted, or of the SPREAD team itself. One suggested improvement for future social audits was a need to include more people, but also to ensure that the required changes had been made to NFSA services in order to ensure people's trust in the process.

## Post-social audit findings

The social audit teams stated that they have gone beyond the expectations of the audit manual during the post-audit stage. They have remained in contact with communities, and encouraged the reinvigoration of NFSA-related community committees, as well as providing training in the form of ten PLA meetings with community-level institutions.

MIS data reported the following from PLA meeting participation rates until 24 November 2018:

**Table 3.1 SPREAD MIS data on PLA meeting participation**

| | |
|---|---|
| Total meetings conducted | 9,666 |
| Total participants | 224,184 |
| Average participation per meeting | 23 |
| Total female participants | 208,983 (93% of total participants) |
| Adolescent girls participants | 27,034 |
| Pregnant women participants | 21,341 |
| Lactating women participants | 30,003 |
| Mother of child aged 6 months to 6 years participants | 64,452 |

*Source*: Authors' own based on data provided by SPREAD MIS.

Awareness-raising events have also been organised at village level, increasing knowledge about (i) good breastfeeding practice, (ii) handwashing and (iii) nutrition. The social audit team also visits the homes of the most vulnerable households, to ask about the status of their services and utilisation.

VHND tracking has been developed and results have been shared with officials. SPREAD also reported organising a state-level meeting to share the findings of the 216 social audits (SPREAD 2018c).

The social audit teams that were included in this evaluation did not report experiencing difficulties with writing up and sharing reports from the public hearing. Some problems were reported regarding monitoring and following up on grievances that were raised, where GPs did not have a pre-existing functioning grievance redressal process.

The social audit team are not expected to maintain direct contact with the individuals who participated in the social audit process. However, they have stated that they hope to deliver awareness-raising events and training within social audit communities. Amongst the community members who are members of committees, the majority reported that there has been no contact with the social audit team, and that there has been no change in their committees. However, when discussing change within committees the majority of respondents stated that they had always been functioning well, and so there was no need to improve. One person did report positive contact, when there was a further visit to check AWW improvements.

There was a mixed experience amongst government officials around communication with the social audit team after the submission of the report from the Gram Sabha. A few providers reported repeated positive contact, during which they were asked further about grievance redressal procedures.

> *They had met me and had also contacted me through telephone and had asked about the wellbeing of village…and whether anyone is having any problem and you put a board in the village displaying about the number of people to have availed benefits by the different schemes.*
>
> (Female, ST, 40, Koraput, Sarpanch)

Several, however, reported that once the team had submitted the report, they did not hear from them again.

> *No, they came to submit the report and took signature. After that they haven't contacted me yet or haven't done any follow-up actions.*
>
> (Female, ST, 44, Kalahandi, MAMATA Area Headquarter Supervisor)

It was generally agreed, however, that the submission of the Gram Sabha report was carried out in a timely manner.

NFSA service providers also reported a mixed experience regarding contact from the social audit or SPREAD team after the social audit had ended. Half of respondents reported continued support and contact, whereas the other half had no contact at all.

> *They came and attended the Inspection committee meeting and the Mothers' committee meeting and gave valuable suggestions.*
>
> (Female, OBC, 50, Balangir, AWW Provider)

> Interviewer: *Did they help you anyway to solve the problems regarding the complaints or did they give any information? Whatever complaints were lodged in the Gram Sabha…*

Response: *No. Nothing.*

(Female, Brahmin, 45, Balangir, AWW Provider)

**Gender challenges**

SPREAD expressed a desire to ensure that the social audit programme was inclusive of women, and would encourage their involvement with all aspects of the process. However, several obstacles were encountered in operationalising this wish.

In February 2017, they reported that recruiting suitable female candidates for district and block coordinator roles was challenging. Female participants were reported to be less active during training events, as male block coordinators dominated discussions. This was recognised by SPREAD who planned to ensure that special attention is given to those who participate less in the training. In February 2018, it was reported that female Sarpanchs are dominated by their husbands when it comes to decision-making and that attending the CAN Gram Sabha was, for many of them, their first large gathering as Sarpanch. It was recognised that these women required extra support from the social audit team. Separate training has been organised for female PRIs in order to enhance the participation of women in activities at Panchayat level and to also increase their knowledge around poverty and malnutrition (SPREAD 2018b). Social audit team members reported finding it difficult to persuade women and girls to participate in meetings, but thanks to SPREAD training, they now find it easier to engage with women and girls in communities. Further, female social audit team members experienced difficulties engaging with men in the community. SPREAD have also organised training to combat this issue.

# 3.6 Community knowledge of and participation in the social audit process

This section focuses on findings related to community knowledge of and participation in the CAN programme social audit process, drawing on evidence from SPREAD programme documentation (in particular the Social Audit Manual and training manual), data from the quantitative evaluation component, as well as community-level IDIs and FGDs with different target groups.

Ensuring that community members have knowledge of the social audit process, and subsequently participate in that process is explicitly part of the social audit teams' responsibilities. The Social Audit Manual goes so far as to say that active participation in the process is 'mandatory' for ensuring the success of a social audit (p30). This is in order to build ownership of the process within the community, enhance effectiveness, and ensure transparency (p30).

Both the Social Audit Manual and the Social Audit Training Manual emphasise the requirement of the social audit team to communicate effectively with communities regarding the social audit process, but also, crucially, to ensure that the community engage with and participate in all aspects of the process. Further, the necessity to include marginalised groups (such as ST, SC, OBC, women, and disabled people) is stressed. However, despite this emphasis on marginalised people within the manuals and training sessions, and other anecdotal evidence that the team took this issue seriously, there are no specific systematic reporting requirements or reporting templates, and so it is not possible to see evidence of whether what happened in the communities reflected the training within the SPREAD documentation.

## 3.6.1 Knowledge of the social audit process

Despite the emphasis on including the community within the social audit process, detailed instructions regarding how to raise awareness and knowledge about the process are lacking within the SPREAD social audit manuals, particularly the training manual. Rather, there is a strong

emphasis on increasing the knowledge of the community about their rights and NFSA entitlements. Parts of the social audit process itself do require a certain amount of awareness from within the community, particularly regarding the purpose of the Gram Sabha, and at least some understanding of grievance redressal processes.

The Social Audit Manual ascribes responsibility for ensuring that communities are aware of the process to the social audit team (p30). It suggests that when preparing the ground for the forthcoming social audit, the social audit team should organise a public awareness meeting at village level, in order to ensure that the community understand the aim and benefits of the social audit. This information can also be shared during door-to-door visits and in small videos filmed during previous social audits (SPREAD 2018d: 13, 34). Once a social audit has been completed, one of the follow-up actions that should be undertaken by the social audit team is to train and support community members and service providers to undertake further social audits (*ibid*.: 15).

The manual contains detailed information regarding the training process for social audit team members. However, it has very few instructions regarding awareness raising for the **social audit process** rather than the NFSA entitlements and rights. It does emphasise the need to mobilise people, but does not give explicit instructions about how and when to do this (again, there are instructions regarding awareness-raising activities for NFSA entitlements). However, SPREAD felt that the process of conducting the village meetings, as well as door-to-door verification visits, should provide opportunities for awareness raising about the social audit process itself – with the NFSA awareness raising taking precedence.

The SPREAD team indicated in discussions with the evaluation team that the 480 community-based SSs who facilitated the social audits had gained valuable knowledge about the social audit process through extensive training, capacity building, and hands-on experience. Given that SSs were recruited from within their home communities, it was anticipated that knowledge about the process would be retained and shared with other community members for this and future rounds of social audits.

### Quantitative findings on knowledge of the social audit process

According to the evaluation's quantitative survey data, when asked whether they knew what a social audit is, 59 per cent of caregivers and 56 per cent of men responded yes. 57 per cent of caregivers and 56 per cent of men stated that they were aware that a social audit took place in their GP. Regional disparities were sizeable, with the proportion of female respondents aware of social audits ranging from a high of 80 per cent in Nabarangpur to a low of 40 per cent in Koraput, and male respondents ranged between 48 per cent in Malkangiri and 66 per cent in Nabarangpur.[18] Of those who knew what the social audit was, 56 per cent of caregivers knew that a social audit covered ICDS, 55 per cent knew that it covers TPDS, and 29 per cent knew that it included MAMATA. Just over half of men (who were aware of the audit) knew that SAs covered PDS (51 per cent) and just below half knew that SAs covered ICDS (47 per cent). About a quarter of men knew that MAMATA was part of the process (24 per cent). Overall, 36 per cent of men and 31 per cent of caregivers could not cite a single scheme covered by the SA process.

Overall, between a fifth and a quarter of caregivers (23 per cent), and 18 per cent of men attended a village meeting (Palli Sabha) as part of the social audit. However, only 14 per cent of the attendees reported that they were told that the social audit process is ongoing and there is a Gram Sabha meeting.

A lack of knowledge about the process was given as a reason for caregivers not attending the Palli Sabha (14 per cent of respondents) and the Gram Sabha (10 per cent of respondents).

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[18] A chi-squared test rejects that the mean awareness levels are the same across districts.

Comparatively, 13 per cent of men did not know about the Gram Sabha and 11 per cent did not know about the Palli Sabha meeting. The main modes through which caregivers had knowledge about the social audit were through relatives/friends/neighbours (38 per cent and through a visit from the SA team (37 per cent). The main modes through which men knew about social audits were 'from relatives/friends/neighbours' (41 per cent), because someone from the SA team came to their house (30 per cent), because they were invited to a village meeting in their (or a neighbouring) village (23 per cent) and through a ward member (15 per cent).

There was some confusion as to who is in charge of the social audit process as 55 per cent of caregivers did not know who was responsible, 13 per cent thought it was conducted by the local elected officials, and 4 per cent by government people from outside the village. Only 28 per cent of caregiver respondents correctly answered that an NGO was in charge of the audits. 40 per cent of men did not know who was responsible, 16 per cent thought it was conducted by the local elected officials, and 6 per cent by government people from outside the village. Only 38 per cent of male respondents correctly answered that an NGO was in charge of the audits.

**Broader community findings on knowledge of the social audit process (IDIs and FGDs)**

The majority of people included in community interviews and focus groups knew about the social audit in some way. However, knowing it is happening is not the same as having an understanding of the process. Of the people who participated in the social audit, the majority were able to discuss the process in more depth during interviews and focus groups, including discussing the management, organisation, and purpose of the process. Just under half the interview participants thought the management process was good, and several stated firmly that they understood the process. Many people who did not participate in the social audit still considered that it was managed well, and explained that other people had reported this to them.

> Interviewer: *OK, do you think it was organised well?*
>
> Response: *Yes, it was well organised.*
>
> Interviewer: *How well was it organised? You didn't go, how do you know it was well organised?*
>
> Response: *People said so.*
>
> (Male, ST, 61, Kalahandi)

Of those people who participated in the social audit in some way (attending the Gram Sabha, village meeting, or being included in the field verification processes), several said that they would have participated further but they did not know about the rest of the process. Amongst the 44 people interviewed who did not participate in the social audit in any way, the majority stated that this was because they did not know about it.

Awareness-raising events that took place (as reported by the majority of NFSA providers interviewed, as well as many community members), concentrated on discussion of entitlements and services, and inviting people to participate in the social audit, rather than information about the social audit process itself. Very few people were able to accurately explain who decided the place and time of the Gram Sabha.

One government official reported that as a result of participating in the social audit he was able to learn how useful a social audit can be for society.

> *Through this, the public was able to directly get involved and communicate with the government authorities.*

(Male, Brahmin, 42, Balangir, Sarpanch)

As outlined above (pre-social audit section), half of the NFSA service providers interviewed were contacted prior to the process in order to inform them about what was going to happen. Several people reported an increased understanding of the process that occurred during the social audit itself.

## 3.6.2 Community participation in the social audit process

Without community participation, the social audit process would not function. Carrying out the village meeting, door-to-door visits, public events (such as plays), and displaying posters throughout the community act as methods through which participation is encouraged.

According to SPREAD's internal monitoring data, a total of 64,789 people participated in the 216 social audits, and so an average of 300 people participated in each audit. A total of 8,577 people attended because their role within the community required it in some way (from ward member to NFSA service provider, to district and block officials, this number also includes social audit team members). This meant that a total of 56,212 community members participated, making an average of 260 community members per social audit. A total of 14,152 testimonies and 20,568 grievances were collected. The total population of the GPs where Gram Sabhas took place is just over 1.1 million people; of those 670,645 are eligible to vote (and therefore over the age of 18). This means that an average of 5 per cent of the total population and just over 8 per cent of the adult population participated.

*Marginalised groups*

Including marginalised groups is imperative, and there are specific instructions issued by SPREAD around this issue. It is stated that the Social Audit is specifically designed to empower and facilitate certain marginalised groups (SC, ST, Particularly Vulnerable Tribal Groups (PVTGs), OBCs, women, disabled, and others) to access information (SPREAD 2018d: 22).

The Social Audit Manual requires that the recruitment of Samikshya Sathis (SS) volunteers come from within the community where the social audit will be undertaken, and that 'priority should be given to women and mostly from SC, ST and Backward Classes' (*ibid.*: 29). When carrying out field verification exercises, including focus group discussions with rights holders, 'special care should be taken to include rights holders from SC, ST and other backward communities and disabled households' (*ibid.*: 35). When organising the village meeting, it is suggested that the participation of women, SC, and ST should be 'in good number' (*ibid.*: 44); however, there are no specific instructions regarding how to ensure that this occurs.

The Social Audit Training Manual requires that during the training of the social audit team they are educated about the issues of multidimensional poverty in India. It is emphasised that those from SC or ST households, as well as those households that include someone who is disabled, illiterate, landless, and with no adult male present, are classed as deprived by the Indian government. The training goes on to explain that by classifying groups of people as poor, the government is then able to target specific interventions towards them, including the NFSA entitlements. Social audit team members are trained on each NFSA programme, and the specific entitlements of marginalised people. Social audit team members are encouraged to focus their efforts on those who are entitled to access NFSA schemes, which automatically includes marginalised groups. When organising the Gram Sabha social audit, team members are encouraged to place special emphasis on remote and unreached hamlets and households, particularly the weak and marginalised – in order to ensure that their concerns can be reported and heard.

## Quantitative findings on community participation

According to the evaluation's quantitative findings, overall, 18 per cent of men attended a village meeting (Palli Sabha) as part of the social audit, a smaller proportion than women (23 per cent). 10 per cent of women and 17 per cent of men sampled attended the Gram Sabha meeting. 11 per cent of men reported that they attended both meetings, compared to 6 per cent of caregivers.[19]

Of those who attended the meetings, 40 per cent of women and 59 per cent of men raised a concern. 69 per cent of women and 72 per cent of men reported that their concerns were raised by others. Local elected officials were reported to be present at the meeting by 70 per cent of women and 72 per cent of men; people reported being allowed to speak to them directly in 90 per cent of cases for women and 98 per cent of cases for men. Of the men who attended the Gram Sabha, 91 per cent reported that they were asked to share grievances/issues with the PDS, pension card, etc. and 81 per cent that they were asked about Angawandi centres and/or the MAMATA scheme in the meeting.

Just one-third of caregiver respondents (33 per cent) reported that the social audit team visited their house. This proportion ranges from between 23 per cent (in Kalahandi and Koraput) and 35 per cent in Nuapada, while Nabarangpur was a clear outlier with 52 per cent of respondents having been visited. The purpose of the home visit was to ask questions about the schemes in 59 per cent of the cases, and to invite people to a village meeting in 37 per cent of the cases. Men were markedly less likely to report that the social audit team visited the house, with just 22 per cent reporting a visit – though this is likely to reflect the programme's focus on women for the verification process for most services.

By far the biggest reason for women not to attend the Gram Sabha was that they were busy at the time (62 per cent). Other reasons were absence from the village (13 per cent), the respondent lived too far from the location of the Gram Sabha (12 per cent), lack of information on the meeting (10 per cent), and family members speaking against the respondent to attend (8 per cent). The two biggest reasons for men not to attend the Gram Sabha were lack of time (44 per cent) and absence from the village at the time of the meeting (38 per cent).

We estimated the likelihood for primary caregivers to attend the Palli Sabha and Gram Sabha, based on characteristics of the household and the women themselves (see Table 3.2 below). Few variables predict participation. Surprisingly, caste affiliation, the assets index, and food insecurity are unrelated to the odds of attending either meeting. Illiterate women and women who can read but not write tend to participate less than literate women, but the difference is not statistically significant. Factors explaining participation are sanitation and status of the women in the household. Women who have access to improved water sources are two and a half times more likely to attend the Palli Sabha and almost three times more likely to attend the Gram Sabha than other women. Moreover, women who are the wives of the household head – as opposed to their daughter – are about one-third less likely to participate in either meeting. Finally, women who are active in the labour force are 50 per cent more likely to attend Palli Sabhas than other women (although the difference is only significant at 10 per cent and is not significant at all for Gram Sabhas).

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[19] It is not possible to directly compare participation figures from the MIS and from the quantitative evaluation survey. The MIS indicates that about 8 per cent of the adult population participated. The quantitative survey shows that 10 per cent of adult women and 17 per cent of adult men participated. The difference may be attributable – in part at least – to the fact that the target groups for the quantitative surveys were those most concerned by the social audit (i.e. caregivers and pregnant women and their husbands).

**Table 3.2 Determinants of women's participation in Palli and Gram Sabha – logistic regression estimates**

| | Participated in Palli Sabha | Participated in Gram Sabha |
|---|---|---|
| SC | 0.77 | 0.62 |
| | (0.37) | (0.39) |
| ST | 1.59 | 1.34 |
| | (0.71) | (0.79) |
| OBC | 0.88 | 0.53 |
| | (0.42) | (0.33) |
| Household size | 1.02 | 1.01 |
| | (0.058) | (0.068) |
| Respondent is the spouse of HH head | 0.67$^*$ | 0.65$^*$ |
| | (0.14) | (0.17) |
| Respondent is illiterate | 0.93 | 0.79 |
| | (0.24) | (0.21) |
| Respondent can read but not write | 0.82 | 0.60 |
| | (0.24) | (0.21) |
| Respondent was ill in last 12 months | 1.31 | 0.68 |
| | (0.36) | (0.23) |
| Respondent is in the labour force | 1.53$^*$ | 1.55 |
| | (0.39) | (0.44) |
| Access to improved water source | 2.49$^{**}$ | 2.93$^*$ |
| | (1.06) | (1.59) |
| Access to improved sanitation | 1.07 | 1.12 |
| | (0.27) | (0.36) |
| House has a separate kitchen | 1.07 | 0.89 |
| | (0.21) | (0.17) |
| HH assets index | 1.09 | 1.13 |
| | (0.070) | (0.094) |
| Food Insecurity Experience Scale | 1.03 | 1.07 |
| | (0.036) | (0.043) |
| Woman Dietary Diversity Score | 0.96 | 0.94 |
| | (0.050) | (0.046) |
| Observations | 1150 | 1150 |

*Notes:* Exponentiated coefficients; standard errors in parentheses. $^*$ $p < 0.1$, $^{**}$ $p < 0.05$, $^{***}$ $p < 0.01$. *Source*: Authors' own.

**Impact of participation on perceptions of social audit success**

**Table 3.3 Perceptions on impact of social audit**

|  | Caregivers | | Men | |
| Proportion of respondents who agree with the following statements: | Did not participate in Palli Sabha or Gram Sabha | Participated in Palli Sabha or Gram Sabha | Did not participate in Palli Sabha or Gram Sabha | Participated in Palli Sabha or Gram Sabha |
|---|---|---|---|---|
| Village community is more confident about raising their concerns/issues in a public forum? | 38.1 | 70.5 | 49.6 | 79.6 |
| There has been a change in behaviour of people such as AWW, helper, headmaster, ration shop owner after the social audit process? | 24.4 | 51.9 | 30.6 | 43.2 |
| There was a change in how the monitoring committees function after the social audit process? | 12.3 | 34.4 | 19.8 | 28.4 |

*Source*: Authors' own.

The next chapter considers outcomes that relate to the social audit process. By mapping participation in the Palli Sabha and Gram Sabha to perceptions about the impact of the social audit, we can see the extent of satisfaction with the process and the changes it has brought about more generally.

For all variables, there is a sharp difference between women who attended the Palli Sabha and/or the Gram Sabha and men who attended neither. The former are systematically more positive about the impact of social audits. It may be due to these women being more aware of the change brought by SA thanks to their involvement but it could also reflect a selection bias whereby women who have the time and who decided to attend the meetings are more likely to be well integrated into the community and to report positive changes. Women were most positive about the effect of SA on boosting the confidence of the community to raise concerns/issues and community members being more aware of their rights and entitlements. Typically, two-thirds of women who participated in the process and one-third of the women who did not participate agreed that SA had a positive impact on these outcomes. A quarter of women who were not involved report that the behaviour of AWW/ASHA workers changed. This proportion doubles for women who attend the meetings. Women were most sceptical about the effect of SA on the behaviour of local elected officials (with 37 per cent of women who were involved agreeing that the behaviour of officials changed).

Men were most positive about the effect of SA on boosting the confidence of the community to raise concerns/issues and community members being more aware of their rights and entitlements. Typically, about three-quarters of men who participated in the process and almost half of men who did not participate agreed that SAs had a positive impact on these outcomes. 31 per cent of men who were not involved report that the behaviour of AWW/ASHA workers changed. This proportion reaches 43 per cent for men who attended the meetings. Men were most sceptical about the effect of SA on how monitoring committees function (with 28 per cent of men who were involved agreeing that there was a change).

**Broader community findings (IDIs and FGDs) on community participation**

Of the 82 community members interviewed as part of the qualitative/process data collection process, just under half participated in the social audit in some way (38 people – 16 men and 22 women). Participation includes attending a meeting, being visited by the social audit team in their home, or being involved in other field verification exercises. People did not choose whether or not

they were visited at home and so were not self-selecting into the process. Of those people who attended the Gram Sabha, a few of them spoke, and the majority of those who did speak felt listened to. Those people who attended wanted to speak, but did not feel able, chose not to for a variety of reasons, including others voicing similar issues which were resolved satisfactorily, feeling that there was no point in speaking because it would make no difference, and one person stated there was not enough time in the meeting to speak as they had to leave early.

Of those who did not participate in the social audit, nearly half stated that they were unable to participate due to work commitments, many stated that they had no information about the social audit, did not participate because someone else from their household participated instead or because they were not present in the village at the time. Of those who did not participate because someone else from their household participated instead, it is possible that it was not their choice to remain at home – but they were prevented from going due to their status in the household. All were women, and the majority were under 30 years old, with children.

All government officials interviewed participated in the social audit process in some way, the majority were present at the Gram Sabha meeting. Others met with the social audit team during the process, and participated in awareness-raising events. All of the NFSA service providers interviewed participated in the social audit process. Most witnessed assessments and verification activities, and attended the Gram Sabha. According to SPREAD reports, there were NFSA service providers present at all Gram Sabha meetings.

Community members reported that some Gram Sabhas did not have the required government officials present to make the meeting worthwhile. According to SPREAD reports, despite the attendance of 341 block-level officials and 416 district-level officials in total, there were 35 Gram Sabhas with no block-level official in attendance, 32 Gram Sabhas with no district-level official in attendance, and 8 Gram Sabhas where no officials from any level attended. If government officials do not participate in social audits, it has a detrimental effect on the validity of the process, particularly from the viewpoint of community members, discouraging them from participating themselves.

## 3.7 Summary

In summary, findings in this section on the SPREAD programme's design, implementation, and processes present a largely positive picture, albeit with some challenges faced and areas for further improvement. The programme model was built on existing experience and best practice, relied on the use of comprehensive guidelines (such as the Social Audit Manual), was modified through an extensive piloting process and suitably adapted to the local context to meet the programme's objectives. In terms of staffing, SPREAD recruited over 700 people at all organisational levels (state, block, district, GP) with only a few minor delays to recruitment and some staff turnover, which didn't appear to affect implementation. Extensive staff training and staff development activities were conducted at all levels and covered a range of approaches including participatory, group, and practice exercises supported by adequate induction materials and resources. Specific detailed training was conducted for the SSs. Training was also undertaken with GKS and PRI members and involved other relevant organisations which helped develop trust and relations.

Purposive selection of the specific areas (districts, blocks, and GPs) for inclusion in the programme was based on an assessment of nutrition vulnerability and need (rather than via a randomised selection process). This was informed by both government data (NFHS-4) and consultation with government officials. A target sample percentage of geographic coverage was agreed and implemented at block level (40 per cent), GP level (50 per cent), and village level (50 per cent of AWCs during the pilot phase, later increased to 100 per cent). This was felt to provide adequate coverage to be able to influence district and state-level changes to address grievances raised from the audit process, and to provide a model for scaled up implementation of social audits which the government or others could replicate. Specific groups targeted for the programme included

individuals eligible for the four NFSA services; government officials/community leaders; and marginalised groups. SPREAD put in place a complex management structure which enabled activities to take place concurrently at multiple levels (GP/village, district, block, and state) and provided an effective structure for staff supervision, training, and support. This was further supported by establishment of an external advisory committee who provided expert input and strategic guidance on the management of the programme. Given the model's intensity of personnel and resource requirements, a more streamlined, leaner model may be required for further scale-up.

In terms of monitoring systems, SPREAD have relied predominantly on a new mobile-based MIS-based system to verify community entitlements as part of the social audit process, as well as to manage and monitor timings and progress for implementation of programme activities undertaken at community-level (including the PS and GS meetings, PLA meetings, and VHNDs). Some delays and challenges were faced in setting up and implementing the MIS approach but overall, it was deemed successful in enabling the team to better streamline data entry, cleaning, and analysis, and enable real-time monitoring and decision-making. Some gaps in the effective monitoring of longer-term outcomes were identified. Implementation of the social audits as per the plan was deemed successful, with a total of 240 audits undertaken across the 240 selected GPs including 24 during the pilot phase in mid-2017 and the remaining 216 in late 2017/18. 3,116 villages were included which exceeded their original target by 193 villages. Some delays to the process occurred but they were still able to complete the final audits within the original timeframes agreed (by July 2018).

Regarding the three key phases of the audit process (pre-social audit, social audit, post-social audit), there were some challenges faced during the pre-audit phase including gaining trust of the community, health-care providers, and government officials, and addressing communities' doubts and scepticism about the effectiveness of the programme in bringing about change. For the seven-day audit phase, activities weren't implemented as rigidly as suggested in the Social Audit Manual with many activities taking place simultaneously. Logistical and practical issues made it difficult to keep the seven-day schedule and the social audit teams had to manage heavy workloads during this intensive period, particularly around the Gram Sabha meeting. Some PS and GS meeting attendance issues were highlighted, which the SPREAD team made efforts to address through early and continued positive engagement with communities and officials. Difficulties were faced by the social audit team in improving immediate access to nutrition entitlements and ensuring that grievances remained focused on nutrition issues as opposed to other issues (including housing, roads, etc.). Overall, however, many community members reported that the process was a positive experience and was a useful tool to voice concerns, increase access to services, and involve communities directly in resolving grievance issues. Most government officials and NFSA service providers considered it to be a positive, useful, and well-managed process, although some NFSA service providers felt that issues with TPDS couldn't be solved by an NGO and could only be addressed at a 'higher level'. Both officials and SPREAD staff felt that Gram Sabhas could be disrupted by some unruly participants. In terms of post-audit follow-up, the SPREAD teams exceeded expectations, conducting a range of follow-up activities at community-level (e.g. PLA meetings, home visits) and organising sharing meetings with government officials at district, block, and state level to follow up on grievances and issues raised during the audit phase.

In terms of community knowledge of and participation in the social audit process, there was a deliberate effort to focus more on rights and NFSA entitlements rather than awareness of the social audit process itself. However, over half (59 per cent) of primary caregivers surveyed said that they knew what a social audit was and a similar proportion (57 per cent) said that they were aware that a social audit had taken place in their GP, though there was substantial variation in awareness levels across districts (ranging from 40–80 per cent). Quantitative and qualitative findings confirmed that a lack of knowledge about the process was the main reason for not attending and there was some confusion around who was responsible for leading the process (over half of caregivers – 55 per cent – weren't aware). Qualitative findings showed that for those who did participate in the audit, the majority were able to discuss the process including the management and purpose of the process. In terms of participation rates, around one in five men (18 per cent) and women (23 per cent) from the

quantitative sample attended the PS. For women – but not for men – participation in the Gram Sabhas was much lower (10 per cent) than in Palli Sabha. The main reasons for lack of attendance at the GS were slightly different between men and women: both highlighted that they were busy and lacked time (62 per cent for women – and 44 per cent for men) but men were more likely to be absent from the village at the time of the meeting (38 per cent). Qualitative data suggests other possible reasons for non-participation included women's status in the household and because someone else in the household participated. SPREAD's own data reports a total of 64,789 people having participated in the social audits, with an average of 300 participants per audit (of which 260 were community members and the remaining being officials or others involved in NFSA service delivery). An impressive 14,152 testimonies and 29,569 grievances were collected in total from across the GPs.

# 4 Findings at outcome level

## 4.1 Knowledge of NFSA services, entitlements, and grievance mechanisms

One of the nine primary objectives of the social audit is to 'inform and educate and mobilise community and rights holders about their rights and entitlements of the programme or scheme during the course of the social audit' (SPREAD 2018d: 10). Social audits are also designed to generate awareness, share information about services and entitlements of the NFSA, and facilitate grievance redressal (SPREAD 2018d: 12).

In this section, we first report data on knowledge and awareness of ICDS, Mamata, and TPDS services from the household services separately, before looking at broader opinions on knowledge and awareness that we explored in the community IDIs and FGDs.

### ICDS

Table 4.1 shows results for ICDS-related outcomes that were measured at baseline and follow-up for caregivers. Caregivers are more likely to feel very well informed about THR (by about 11 percentage points), Women in Early GPs are less likely to report having been informed on the preparation of THR (by eight percentage points).

**Table 4.1 DID Estimates of the impact of social audits on THR and GMP functioning – awareness/knowledge (primary caregivers sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| Very well informed about THR | 0.11*** | 0.12*** | -0.01 | 1088 |
| Very well informed on GMP | 0.07** | 0.02 | 0.05 | 1152 |

*Note*: *** p<0.01, ** p<0.05, * p<0.1. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to $\alpha+\beta$ in equation (1). 'Change in Late GPs' corresponds to $\alpha$ in equation (1). The DID parameter corresponds to $\beta$ in equation (1). *Source*: Authors' own.

Pregnant women – Table 4.2 also reported large increases in how knowledgeable they are about THR (+25pp in Early GPs and +21pp in Late GPs).

**Table 4.2 DID Estimates of the impact of social audits on THR functioning – awareness/knowledge (pregnant women sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| Very well informed about THR | 0.25*** | 0.21** | 0.04 | 119 |

*Note*: *** p<0.01, ** p<0.05, * p<0.1. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to $\alpha+\beta$ in equation (1). 'Change in Late GPs' corresponds to $\alpha$ in equation (1). The DID parameter corresponds to $\beta$ in equation (1). *Source*: Authors' own.

**Table 4.3 DID Estimates of the impact of social audits on AWC functioning – awareness (adolescent girls sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| AWC awareness | 0.94*** | 0.91*** | 0.03 | 134 |

*Note*: *** p<0.01, ** p<0.05, * p<0.1. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to α+β in equation (1). 'Change in Late GPs' corresponds to α in equation (1). The DID parameter corresponds to β in equation (1). *Source*: Authors' own.

All the positive evolutions have been equally felt in Early and Late GPs, as evidenced by the DID estimates of the effect of the social audit being indistinguishable from zero in all cases.

## MAMATA

Pregnant women are the targets of the MAMATA scheme, so we first report impacts on awareness for this group. The effect of social audits is unsurprisingly much larger than for caregivers. The proportion of pregnant women feeling very well informed on MAMATA is 34 percentage points higher at follow-up than at baseline in Early GPs. In Late GPs, the knowledge score has tended to decrease but the change is not statistically different from zero. As a result, the DID estimate of the impact of social audit on feelings of being very well informed is a very large 50 percentage points, and is statistically significant at 1 per cent.

**Table 4.4 DID Estimates of the impact of social audits on MAMATA functioning – awareness/knowledge (pregnant women sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| Aware of MAMATA | 0.3*** | 0.07 | 0.22*** | 124 |
| Very well informed on MAMATA | 0.34*** | -0.15 | 0.49*** | 63 |
| MAMATA knowledge score | 1.75*** | 0.63** | 1.13*** | 124 |

*Note*: *** p<0.01, ** p<0.05, * p<0.1. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to α+β in equation (1). 'Change in Late GPs' corresponds to α in equation (1). The DID parameter corresponds to β in equation (1). *Source*: Authors' own.

Amongst caregivers, we can see that awareness of the scheme increased by nine percentage points in Early GPs (from 85 per cent) and six percentage points in Late GPs (from 91 per cent). Both these increases are strongly significant statistically. However, the difference between the change in Early GPs and the change in Late GPs is not itself statistically significant. This suggests that the change in awareness arose very quickly after the social audit.

**Table 4.5 DID Estimates of the impact of social audits on MAMATA functioning – awareness/knowledge (primary caregivers sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| Aware of MAMATA | 0.09*** | 0.06*** | 0.03 | 1152 |
| Very well informed on MAMATA | 0.07* | -0.01 | 0.08 | 877 |
| MAMATA knowledge score | 1.02*** | 0.57*** | 0.45*** | 1152 |

*Note*: *** p<0.01, ** p<0.05, * p<0.1. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to α+β in equation (1). 'Change in Late GPs' corresponds to α in equation (1). The DID parameter corresponds to β in equation (1). *Source*: Authors' own.

Caregivers from the Early GPs were also more likely (by seven percentage points) to feel very well informed with MAMATA at follow-up than at baseline. The effect is only significant at the 10 per cent level, and the difference-in-difference estimate (0.08) is not statistically significant.

Consistent with the idea that social audits improved information, the mean score of the MAMATA knowledge variable increased significantly for pregnant women (+1.75 for Early GPs and +0.6 in Late GPs) and the DID estimate of the impact of early social audit is large (+1.1), suggesting that the changes to knowledge on the MAMATA scheme were cumulative. These changes are very large as they correspond to an increase of 0.9 and 0.3 standard deviation of the baseline value of the variable, respectively. Results for caregivers are similar, though of lower magnitude (mean score increases of one point in the Early GPs and by 0.6 points in the Late GPs among caregivers – both effects are significant at the 1 per cent level; and there is a 0.45 difference-in-difference estimate between early and late groups).

**TPDS**

Knowledge about the TPDS improved substantially or very substantially across all groups (primary caregivers, pregnant women, and men) surveyed about the TPDS. For primary caregivers, this was the case for knowledge of TPDS entitlements, likelihood that ration shops provide the equivalent of entitlements, knowledge of PDS committees, and information on TPDS. The most substantial changes amongst this group were the likelihood that caregivers report feeling very well informed about TPDS, which increased by 12 percentage points in both early and late groups. For pregnant women, this is the case for feelings of being well informed, knowledge of the PDS committee and for information on TPDS.

**Table 4.6 DID Estimates of the impact of social audits on TPDS functioning – knowledge/awareness (primary caregivers sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| Knows PHH entitlement | 0.04** | 0.02** | 0.02 | 765 |
| Knows AAY entitlement | 0.2* | 0.22 | -0.02 | 24 |
| Knows there is a PDS committee in GP | 0.13*** | 0.14*** | -0.02 | 871 |
| Very well informed about TPDS | 0.12*** | 0.12*** | 0 | 871 |

*Note*: *** p<0.01, ** p<0.05, * p<0.1. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to α+β in equation (1). 'Change in Late GPs' corresponds to α in equation (1). The DID parameter corresponds to β in equation (1). *Source*: Authors' own.

**Table 4.7 DID Estimates of the impact of social audits on TPDS functioning – knowledge/awareness (pregnant women sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| Knows there is a PDS committee in GP | 0.02 | 0.15 | -0.12 | 97 |
| Very well informed about TPDS | 0.29** | 0.11 | 0.18 | 97 |

*Note*: *** p<0.01, ** p<0.05, * p<0.1. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to α+β in equation (1). 'Change in Late GPs' corresponds to α in equation (1). The DID parameter corresponds to β in equation (1). *Source*: Authors' own.

The biggest changes were amongst men, reflecting the fact that this was the service of most interest to men or that men were the more likely to hold ration cards and collect entitlements.

**Table 4.8 DID Estimates of the impact of social audits on TPDS functioning – awareness/knowledge (male respondents sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| Knows PHH entitlement | -0.02 | -0.02 | 0 | 549 |
| Knows there is a PDS committee in GP | 0.52*** | 0.24*** | 0.28*** | 619 |
| Very well informed about TPDS | 0.16*** | 0.06 | 0.09 | 619 |

*Note*: *** p<0.01, ** p<0.05, * p<0.1. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to α+β in equation (1). 'Change in Late GPs' corresponds to α in equation (1). The DID parameter corresponds to β in equation (1). *Source*: Authors' own.

The likelihood that men know that there is a PDS committee in the GP increased by 52 percentage points in Early GPs and 24 percentage points in Late GPs, and the likelihood that men know about the PDS committee increased by an extra 28pp in the Early GPs (p<0.01). These more substantial changes in early GPs suggest that these impacts were due to cumulative exposure to the social audit process and its effects.

The above provides information about the perceptions of the community's awareness. Further to this, just over 60 per cent of caregivers who attended a meeting declared that their understanding of ICDS, MAMATA, and PDS improved after the meeting. 63 per cent of men who attended Gram Sabha meetings stated that their understanding of PDS had improved, 50 per cent stated that their understanding of ICDS had improved, 33 per cent had better knowledge of MAMATA, and 16 per cent had improved understanding of MDM.

**Broader community findings (IDIs and FGDs)**

The community IDIs and FGDs support the findings that appear across the NFSA services of increased knowledge and awareness of entitlements – many of the community members who participated in the social audit reported that their individual knowledge of NFSA services and entitlements had increased directly as a result of the social audit. A resulting increase in knowledge throughout the wider community was also observed. Increased knowledge in the community centred on understanding better what the Anganwadi Centre should be providing, entitlements to TPDS rations cards, and the expected quality of rations, with many people stating that their understanding of these services had improved. Some women (and one man) also reported an increase in knowledge of MAMATA entitlements.

> *Earlier fewer members knew about this…now the ladies are more aware. Now they go to receive the rice grain.*
>
> (Male SC FGD participant (average age of FGD 42), Balangir)
>
> *I could know about this much egg is coming, this much* chhatua *is coming…and what Anganwadi is doing.*
>
> (Female, OBC, 50, Kalahandi)
>
> Interviewer: *Do you now know more about these schemes after this meeting?*
>
> Response: *Yes, I got to know some things that I didn't know earlier…in the MAMATA Yojana, we will get 5,000 rupees…also, some more things about the Anganwadi Scheme.*
>
> (Male, OBC, 45, Kalahandi)

This increase in knowledge was widely reported to have been gained through attendance at social audit events (particularly through the Gram Sabha), or direct contact with the social audit team during verification processes at their homes.

> *Since the day what you conducted…. The Gram Sabha; from that day everyone was able to know. As we complained, everything happened well.*
>
> (Male Village Leader FGD participant (average age of FGD: 55), Mixed Caste, Kalahandi)
>
> *The sisters… they came to our house to explain to us these things. We were able to understand things.*
>
> (Elderly Women Scheduled Caste FGD participant (average age of FGD: 53), Kalahandi)

Of those people who reported that their knowledge levels did not increase as a result of the social audit, some stated that this was because they already knew about these things prior to the social audit process.

> *We only know what we knew before...nothing more.*
>
> (Female, OBC, 22, Balangir)

In addition to overall knowledge and awareness of services reported so far, many respondents also reported an increase in knowledge of grievance redressal mechanisms.

> Interviewer: *They have make you understand how to complain? How did you feel it?*
>
> Response: *I felt good there, what they made me understand.*
>
> (Male, ST, 56, Koraput)

> Interviewer: *Well, if you get any problem in future, you can complain.*
>
> Response: *Yes.*
>
> Interviewer: *Do you think that Sarpanch and other authorities also should take these services?*
>
> Response: *Yes, Sir.*
>
> (Male, OBC, 38, Balangir)

The majority of NFSA service providers and government officials also reported that their own knowledge of NFSA services and grievance redressal mechanisms was improved as a direct result of the social audit process.

> *I have learnt two to three things regarding Anganwadi. In midday meals, which day they will give the egg, which day will give rice and dal (Gram). These things I got to learn from it.*
>
> (Male, SC, ward member, Koraput)

> *A lot of awareness has come from this. There has a lot of awareness relating the children...There is no more negligence in availing the money under the Mother's Protection act, the money that a pregnant lady should get.*
>
> (Male, Brahmin, Sarpanch, Balangir)

> *It was beneficial because the awareness reached a large number of mass. So that they were able to meet us and discuss their grievances with us, people who could not get out services were also present. CDPO madam was also present to address all the problems of the mass....I learnt regarding the PDS system and the midday meal. I got to know how to file a complaint in case you have any grievances.*
>
> (Female, OBC, AWW service provider, Balangir)

## 4.2 Access to, uptake of, and satisfaction with NFSA services and entitlements

The social audit is designed to measure the community's satisfaction with NFSA services (SPREAD 2018d). There may be a mixed short-term effect on satisfaction levels regarding NFSA services; satisfaction may go down as knowledge levels increase, and so people become aware that they are not receiving the services they should, or satisfaction may increase as grievance redressal mechanisms lead to improved services and increased access. However, in the long term, it is hoped that satisfaction levels will increase, as levels of access gradually increase, and grievance redressal mechanisms allow for services to improve.

SPREAD report that their teams have been able to ensure that changes have been made where dissatisfaction with services were identified. For example, as a result of the social audit process, the SPREAD teams have ensured that AWC hygiene kits are available in 479 out of 665 centres where they were missing, and AWC weighing machines have been made available in 181 out of 619 centres where they were missing. They also ensured increased access to services (as detailed above) for many community members. It is hoped that these improvements will lead to improved services and therefore increased satisfaction.[20]

In this section, as above, we report first on the results of the household surveys, before expanding the discussion to the results of the IDIs and FGDs with community members and others.

### ICDS[21]

Results for ICDS are mixed – there is no evidence of social audits having a cumulative effect on the overall operation of the actual Anganwadi Centres. However, there were notable changes observed in terms of improvements in the specific services of growth monitoring and take-home rations.

AWC operation was measured in terms of outcomes such as opening hours and contact with AWWs, as viewed from the caregivers' perspective. AWWs are not reported to come more often or in a timelier manner to the centres in the Early GPs with respect to the Late GPs, and the likelihood that women were in contact with AWWs was also not statistically different in the Late and Early GPs. In fact, the likelihood of contact with AWWs did go down over the period by 3pp, but this likely reflects the change in the period of reference over which contact is recorded (from the last three months at baseline to the last month at follow-up, thereby limiting scope for interactions with AWWs), and the decrease was uniform across the two groups. There was no change in the satisfaction rate of women regarding AWCs in either the Early or Late GPs. Overall, very little change occurred between baseline and follow-up. Reported opening times of AWCs have gone down by eight minutes (0.14*60 minutes) but the decline is only statistically significant in Late GPs, so that such a development might be transitory.

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[20] SPREAD (2018c). Other successes reported by SPREAD during the first two years of the project include the following:
• 306 children with severe acute malnutrition (SAM) have been referred to nutrition rehabilitation centres. The social audit team's role in this was to identify, counsel, collaborate, and follow up with the SAM children, along with the Anganwadi Worker and ASHA.
• 3,443 households have now received ration cards, and SPREAD have submitted applications for many more.
• 1,621 women now receive cash benefits under the MAMATA scheme, thanks to the SPREAD team's identification of gaps during the social audit process.
• 5,737 applications for social security pensions have also been submitted, and 1,994 people have so far been successful in receiving a pension.
[21] Some of the key outcomes in this section have not been measured in the exact same way at baseline and follow-up because the reference period has changed (last three months at baseline, last month at follow-up).

**Table 4.9 DID Estimates of the impact of social audits on AWC functioning – access/satisfaction (primary caregivers sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (D) | N |
|---|---|---|---|---|
| Had contact with the AWW | -0.02 | -0.06*** | 0.04 | 1126 |
| Received services from AWC or AWW | 0.07*** | 0.03** | 0.04* | 840 |
| AWC opened on time | -0.01 | 0.01 | -0.03 | 918 |
| Hours open per day | -0.11 | 0.17** | -0.28** | 716 |
| AWW comes to the centre daily | 0.01 | 0 | 0.01 | 861 |
| Very satisfied with AWC | 0.02 | 0 | 0.02 | 1046 |

*Note*: *** $p<0.01$, ** $p<0.05$, * $p<0.1$. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to $\alpha+\beta$ in equation (1). 'Change in Late GPs' corresponds to $\alpha$ in equation (1). The DID parameter corresponds to $\beta$ in equation (1). *Source*: Authors' own.

**Table 4.10 DID Estimates of the impact of social audits on AWC functioning – access/satisfaction (pregnant women sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| Had contact with the AWW | 0.13* | 0.09 | 0.04 | 120 |
| Received services from AWC or AWW | 0.11** | 0.1 | 0.01 | 85 |
| AWC opened on time | -0.02 | 0 | -0.02 | 93 |
| Hours open per day | -0.06 | 0.33* | -0.39 | 66 |
| AWW comes to the centre daily | -0.03 | 0.04 | -0.07 | 87 |
| Very satisfied with AWC | 0.06 | -0.14 | 0.2 | 106 |

*Note*: *** $p<0.01$, ** $p<0.05$, * $p<0.1$. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to $\alpha+\beta$ in equation (1). 'Change in Late GPs' corresponds to $\alpha$ in equation (1). The DID parameter corresponds to $\beta$ in equation (1). *Source*: Authors' own.

**Table 4.11 DID Estimates of the impact of social audits on AWC functioning – access (adolescent girls sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| AWC opened on time | 0.78*** | 0.92*** | -0.14* | 85 |
| AWW comes to the centre daily | 0.75*** | 0.85*** | -0.1 | 85 |

**Table 4.12 Single-Difference Estimates of the impact of social audits on AWC functioning (adolescent girls sample)**

| Outcomes (endline) | Treatment | Outcome (baseline) | Constant | N |
|---|---|---|---|---|
| Received services from AWC | -0.01 | 0.65*** | 0.03 | 65 |

*Note*: *** p<0.01, ** p<0.05, * p<0.1. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to α+β in equation (1). 'Change in Late GPs' corresponds to α in equation (1). The DID parameter corresponds to β in equation (1). *Source*: Authors' own.

When considering specific ICDS services (we focused on growth monitoring and take-home rations), we observe that the likelihood to receive a service from the AWC did increase by 4pp more in Early compared to Late GPs (p<0.1). Caregivers are also more likely to report being provided with special food after the child was measured (+ 23 percentage points) and are more likely to report that the child was referred to a nutrition rehabilitation centre after measurement (+3.5 percentage points) over the Early and Late GPs).

**Table 4.13 DID Estimates of the impact of social audits on THR and GMP functioning – access/uptake/satisfaction (primary caregivers sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| Informed about the preparation of THR at least once | -0.08** | 0 | -0.08 | 860 |
| Very satisfied about THR | -0.04 | 0 | -0.04 | 1088 |
| Child's weight has been measured | -0.11*** | -0.05 | -0.06 | 1152 |
| Was provided with special food after child measurement | 0.23*** | 0.23*** | -0.01 | 1701 |
| Child was referred to rehab centre after measurement | 0.03*** | 0.04*** | -0.01 | 1701 |
| Very satisfied with GMP | 0.02 | 0 | 0.03 | 1041 |

*Note*: *** p<0.01, ** p<0.05, * p<0.1. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to α+β in equation (1). 'Change in Late GPs' corresponds to α in equation (1). The DID parameter corresponds to β in equation (1). *Source*: Authors' own.

**Table 4.14 DID Estimates of the impact of social audits on THR functioning – access/satisfaction (pregnant women sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| Informed about the preparation of THR at least once | 0.08 | 0 | 0.08 | 47 |
| Very satisfied about THR | 0.14 | 0.05 | 0.1 | 119 |

*Note*: *** $p<0.01$, ** $p<0.05$, * $p<0.1$. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to $\alpha+\beta$ in equation (1). 'Change in Late GPs' corresponds to $\alpha$ in equation (1). The DID parameter corresponds to $\beta$ in equation (1). *Source*: Authors' own.

Table 4.15 and Table 4.16 show results on ICDS-related outcomes from the viewpoint of AWWs. We do observe a modest but statistically significant increase in the use of infantometers in the Early GPs (by four percentage points). The difference-in-difference parameter is not itself statistically significant but this result suggests that social audits may have triggered a positive change in that regard. This is further supported by the fact that the difference-in-difference parameter is positive and statistically significant for the use of a wall meter. Indeed, use of wall meters has gone up in the Early GPs (by 16 percentage points) and gone down among the Late GPs (by ten percentage points). Apart from these, we do not observe any significant change over the study period except that AWWs have become less likely to report that there was no problem regarding ICDS in the last month in the Early group (6pp, $p<0.1$). This effect is not statistically significant among AWWs in the Late group and thus points to the cumulative effect of social audits. This could signal a deterioration of the service and/or a greater tendency for problems to be noticed and reported following social audits.

**Table 4.15 DID Estimates of the impact of social audits on AWC functioning (Angawandi Workers sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| Cooking of supplementary food is done inside AWC | 0.047 | 0.197* | -0.15 | 221 |
| Hand-washing | 0.019 | 0.197 | 0.058 | 221 |
| AWC has no toilet facility | 0.176** | 0.197 | -0.167 | 221 |
| AWC has no operational toilet facility | -0.054 | 0.197 | 0.037 | 221 |
| Drinking water within 200m of AWC | 0.051 | 0.197 | -0.004 | 221 |
| A weighing scale is available and functional at the centre to weigh women | -0.007 | 0.197 | -0.005 | 221 |
| AWC has electricity eight hours a day | -0.022 | 0.197 | 0.042 | 221 |
| Time spent by AWW on her duties in a week | 1.691 | 0.197 | 1.131 | 221 |
| Days worked as an AWW | -0.268 | 0.197 | -0.597 | 218 |
| The AWC remained closed for a week or more in the last month | 0 | 0.197 | -0.059 | 221 |

*Note*: *** $p<0.01$, ** $p<0.05$, * $p<0.1$. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to $\alpha+\beta$ in equation (1). 'Change in Late GPs' corresponds to $\alpha$ in equation (1). The DID parameter corresponds to $\beta$ in equation (1). *Source*: Authors' own.

**Table 4.16 DID Estimates of the impact of social audits on GMP functioning (Anganwadi Workers sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| Days worked as an AWW | -0.268 | 0.329 | -0.597 | 218 |
| Distribution of THR to pregnant women | -0.04 | -0.029 | -0.011 | 221 |
| Children are weighed every month at the centre | 0.042 | -0.206** | 0.249 | 221 |
| Growth status of children displayed at the AWC | 0.116 | 0.087 | 0.029 | 221 |
| Maintenance of child growth cards for children below six years | 0.019 | 0.096 | -0.077 | 221 |
| These cards are produced before visiting medical and paramedical personnel | 0.057 | 0.159* | -0.102 | 221 |
| How many home visits in which you weighed children did you make last calendar month? | 0.541 | -0.857 | 1.398 | 221 |
| Are you provided with cash by the GKS for referral of SAM children? | -0.034 | -0.142 | 0.107 | 221 |
| Use of electronic bathroom scale (adult) | 0.017 | -0.068 | 0.085 | 217 |
| Use of stadiometer | 0.032 | -0.029 | 0.062 | 221 |
| Use of infantometer | 0.040* | 0.004 | 0.036 | 221 |
| Use of wall meter | 0.162 | -0.103 | 0.266* | 221 |
| Do you usually also measure the mid-upper arm circumference (MUAC) of children? | -0.044 | 0.04 | -0.083 | 221 |

| | | | | |
|---|---|---|---|---|
| How many underweight (UW) children did you refer to NRC in the last one month? | -0.151 | -0.083 | -0.068 | 221 |
| AWW did not encounter any problem with ICDS in the last month | -0.062* | 0.053 | -0.116 | 221 |

*Note*: *** p<0.01, ** p<0.05, * p<0.1. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to α+β in equation (1). 'Change in Late GPs' corresponds to α in equation (1). The DID parameter corresponds to β in equation (1). *Source*: Authors' own.

## MAMATA

For the MAMATA scheme, we see a significant increase in the enrolment amongst that scheme's target group of pregnant women – an increase of 22 percentage points (p<0.05) in Late GPs. A 15 percentage point increase in Early GPs, however, was not statistically significant (likely to be a result of the small sample size).

**Table 4.17 DID Estimates of the impact of social audits on MAMATA functioning – access/satisfaction (pregnant women sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| Registered with MAMATA | 0.15 | 0.22** | -0.07 | 67 |
| Very satisfied with MAMATA | 0.31** | -0.09 | 0.4** | 63 |

*Note*: *** p<0.01, ** p<0.05, * p<0.1. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to α+β in equation (1). 'Change in Late GPs' corresponds to α in equation (1). The DID parameter corresponds to β in equation (1). *Source*: Authors' own.

The proportion of pregnant women reporting being very satisfied with MAMATA jumped by 31 percentage points in Early GPs and the DID estimate of the impact of early social audit is 40 percentage points (p<0.01). This suggests that while we were only able to detect a statistically significant change in enrolment in the late GPs, overall changes in satisfaction levels *were* cumulative.

**Table 4.18 DID Estimates of the impact of social audits on MAMATA functioning – access/satisfaction (primary caregivers sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| Registered with MAMATA | 0 | 0.02 | -0.02 | 855 |
| Very satisfied with MAMATA | 0.1*** | 0.04 | 0.06 | 877 |

*Note*: *** p<0.01, ** p<0.05, * p<0.1. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to α+β in equation (1). 'Change in Late GPs' corresponds to α in equation (1). The DID parameter corresponds to β in equation (1). *Source*: Authors' own.

**TPDS**

Our data on the TPDS scheme reveal some substantial positive changes, particularly for men, where the changes are also more marked between Early and Late GPS (with better results for early GPs, suggesting a cumulative effect linked to exposure to the social audit process).

For primary caregivers, we see significant improvements and likelihood of having an Aadhar number and the likelihood that their ration shop delivers food on a monthly basis. For pregnant women, this is the case for satisfaction levels with TPDS of the TDPS ration, monthly delivery of the TPDS, assignment of an Aadhar number, and confidence in ability to raise an issue.

Some of these changes are very substantial. For instance, among caregivers, the likelihood that ration shops deliver food monthly increased by 32 percentage points in Early GPs and 46 percentage points in Late GPs.

For caregivers, most of the changes are of a similar magnitude between Early and Late GPs. In fact, there are only two outcomes for which the DID estimate of early social audit is significantly different from zero: whether the ration shop delivers food monthly (-14 percentage points) and confidence in capacity to raise issues with TPDS (+11 percentage points). There is thus little evidence in Table 4.19 in favour of social audits exerting a cumulative positive impact on TDPS-related outcomes for this group. But the high number of outcomes displaying improvements in both Early and Late GPs is suggestive that social audits may exert a positive, immediate impact in favour of social audits exerting a cumulative positive impact on TDPS-related outcomes.

**Table 4.19 DID Estimates of the impact of social audits on TPDS functioning – access/uptake/satisfaction (primary caregivers sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| Received help with TPDS | -0.13*** | -0.08*** | -0.05 | 1152 |
| Household has a valid ration card | -0.02* | 0 | -0.03 | 1152 |
| Household has received info on ration card application | 0.2 | 0.14 | 0.06 | 55 |
| Ration shop always provides entitlement | 0.03* | 0.01 | 0.02 | 871 |
| Ration shop never provides entitlement | 0 | 0 | 0 | 871 |
| Was delivered PHH entitlement | -0.03* | -0.02* | 0 | 744 |
| Was delivered AAY entitlement | 0.13 | 0.22 | -0.09 | 24 |
| Had to pay extra money at ration shop | -0.04** | 0 | -0.04 | 871 |
| Household usually consumes TPDS food | 0.01 | 0 | 0.01 | 871 |
| Ration shop delivers food monthly | 0.32*** | 0.46*** | -0.14** | 871 |
| Has been assigned an Aadhar number | 0.04** | 0.03*** | 0.01 | 871 |
| Delivery of TPDS was hampered by Aadhar issue | 0.03 | 0 | 0.03 | 871 |
| Rice is weighed with electronic scale | -0.05 | -0.06 | 0.02 | 861 |
| Very satisfied with TPDS quantity | 0.03 | 0.1*** | -0.07 | 871 |

*Note*: *** $p<0.01$, ** $p<0.05$, * $p<0.1$. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to $\alpha+\beta$ in equation (1). 'Change in Late GPs' corresponds to $\alpha$ in equation (1). The DID parameter corresponds to $\beta$ in equation (1). *Source*: Authors' own.

For pregnant women, satisfaction and confidence only significantly increased in Early GPs, suggesting that the impact of social audits may have been cumulative. But the DID estimate is not statistically significant, presumably due to small sample size.

**Table 4.20 DID Estimates of the impact of social audits on TPDS functioning access/uptake/satisfaction – (pregnant women sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| Received help with TPDS | -0.16** | -0.15** | -0.01 | 124 |
| Household has a valid ration card | -0.05 | -0.04 | -0.01 | 124 |
| Ration shop always provides entitlement | 0.1** | 0 | 0.1* | 97 |
| Was delivered PHH entitlement | 0 | -0.04 | 0.04 | 83 |
| Had to pay extra money at ration shop | -0.1* | -0.02 | -0.08 | 97 |
| Household usually consumes TPDS food | -0.02 | -0.02 | -0.01 | 97 |
| Ration shop delivers food monthly | 0.43*** | 0.51*** | -0.08 | 97 |
| Has been assigned an Aadhar number | 0.19*** | -0.05 | 0.25*** | 97 |
| Delivery of TPDS was hampered by Aadhar issue | 0.12 | 0.05 | 0.06 | 97 |
| Rice is weighed with electronic scale | -0.12 | -0.09 | -0.03 | 96 |
| Very satisfied with TPDS quantity | 0.17** | 0.02 | 0.15 | 97 |

*Note*: *** p<0.01, ** p<0.05, * p<0.1. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to α+β in equation (1). 'Change in Late GPs' corresponds to α in equation (1). The DID parameter corresponds to β in equation (1). *Source*: Authors' own.

For men, many outcomes improved over the study period. In addition, there is strong evidence of a positive and cumulative effect of social audits. The proportion of men having to pay extra money at the ration shop decreased by 7pp more among men assigned to the Early group than among men assigned to the Late group. This difference is statistically significant at 5 per cent. Similarly, the likelihood that the TPDS ration is consumed by the household increased by 5pp more in the Early GPs (p<0.05). Furthermore, men in the Early group reported a significantly higher likelihood (5pp) of having been assigned an Aadhar number at follow-up than at baseline, although the DID estimate is not itself statistically significant. Similarly men in the Early group reported an increased satisfaction with their information on TPDS (+ 16pp, p<0.01) but the DID estimate is not statistically significant.

**Table 4.21 DID Estimates of the impact of social audits on TPDS functioning –
    access/uptake/satisfaction (male respondents sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| Household has a valid ration card | -0.02 | 0.01 | -0.03 | 778 |
| Household has received info on ration card application | 0 | 0.06 | -0.06 | 35 |
| Ration shop always provides entitlement | 0.01 | 0 | 0.02 | 619 |
| Ration shop never provides entitlement | 0 | 0 | 0 | 619 |
| Was delivered PHH entitlement | -0.01 | 0 | -0.01 | 545 |
| Had to pay extra money at ration shop | -0.06** | 0.01 | -0.07** | 619 |
| Household usually consumes TPDS food | 0.05*** | 0 | 0.05** | 619 |
| Ration shop delivers food monthly | 0.34*** | 0.4*** | -0.06 | 619 |
| Has been assigned an Aadhar number | 0.05** | 0.01 | 0.05 | 619 |
| Delivery of TPDS was hampered by Aadhar issue | 0.02 | -0.01 | 0.03 | 619 |
| Rice is weighed with electronic scale | -0.08* | -0.06 | -0.01 | 615 |
| Very satisfied with TPDS quantity | 0.07* | -0.02 | 0.09 | 619 |

*Note*: *** p<0.01, ** p<0.05, * p<0.1. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to α+β in equation (1). 'Change in Late GPs' corresponds to α in equation (1). The DID parameter corresponds to β in equation (1). *Source*: Authors' own.

## Broader community findings (IDIs and FGDs)

As expected, community members reported a mixed response to questions about satisfaction levels with NFSA services.

Many people do report that they have started receiving services they had previously been unable to access, or that the services themselves have improved and now provide more. More community members reported being satisfied with NFSA services than not satisfied.

> *Now it is good… People are getting all the benefits from the Panchayat.*

(Female, ST, 45, Balangir)

> *There is a change in the MAMATA Card, and there is a change in midday meal also.*

(Male, ST, 33, Balangir female, 30, Labourer)

> *Earlier, there were few people with ration cards in lower village area but now the card holders have increased, even increased by double.*

(Male, ST, 31, Balangir Farmer)

*The changes have come in the Anganwadi Centres and the school. The food (MDM) provided here now is very good. My granddaughter is even getting good food what the kid was saying. Earlier the kid didn't used to speak, maybe due to fear but I have seen that good food is being provided now.*

(Male SC FGD participant (average age of FGD: 42), Balangir)

Several people reported that their satisfaction has increased as a direct result of the social audit process.

Interviewer: *Are you satisfied with the midday meal or the other services your children are getting in the school?*

Response: *Yes, I am happy.*

Interviewer: *Why are you thinking that you are happy?*

Response: *Because earlier nothing is happening. Problem may happen but from my view, in that situation, I am doing my duty of looking into the school matters. The headmaster is also checking the quality of the food. Food is getting tastier. I even know how much does a child require food or the food they are getting in the midday-meal scheme. I see in that way.*

(Community member, Male, ST, 31, Balangir)

*Before the conduction of the Gram Sabha they were not getting the money by MAMATA Scheme on time, they were facing a lot of problems. But after the Gram Sabha on 20 January, they are getting their money immediately without any late.*

(Male village leader mixed caste FGD (average age of FGD: 53), Balangir)

However, some community members who participated in the FGDs and IDIDs have experienced disappointment resulting from the social audit process, as their expectations have been raised, but they have not seen a corresponding increase in access to services.

Interviewer: *Have there been any changes in the Anganwadi services or the MAMATA services or the ration services or the school food? Has there been any change after this meeting?*

Response: *No it is same as before. What changes have come? Nothing.*

(Male, SC, 30, Kalahandi)

*The problem of pension card and ration card has not been resolved. Many old people who are blind are also not getting pension and ration… Sarpanch has talked about this problem with them but still nothing has been done.*

(Female ST FGD participant (average age of FGD: 27), Balangir)

*We are not getting rice grains anymore and the card we had for rice grains was returned when he said, so how do we notice anything, sir. And the midday meal that is given to children at school is steady without any improvement, rather it's downgrading than to improve.*

(Male village leader FGD participant (average age of FGD: 47), Balangir)

Notably, however, the majority of those respondents who state that there had been no change since the social audit did not attend the Gram Sabha meeting, and a small majority did not participate in the social audit in any way.

The vast majority of NFSA officials, and some of the government officials interviewed did report an increased uptake in services as a result of the social audit, which is in line with the SPREAD reports of increased access.

> Interviewer: *Have you observed any increase in the intake of services provided by Aanganbadi, Mamta yojna, public distribution system, or midday meal?*
>
> Response: *Yes.*
>
> Interviewer: *Why can they [access these services after the social audit]?*
>
> Response: *Awareness has been created. They were able to know that how much they should get. They were able to know. There were people who were in doubt or didn't know anything.*
>
> (Male, OBC, teacher, Kalahandi)

*Barriers and enablers to accessing NFSA services*

In the community FGDs and IDIs, the people who are responsible for delivering (and therefore able to gate-keep) NFSA services in communities are cited as both enablers and barriers to accessing NFSA services. Community members who are receiving services view the deliverers of those services as enablers, whereas those community members who are not receiving these services view the service providers as the barrier. However, several community members were also able to identify that problems may also stem from other sources 'higher up' within local and national government. Similarly, village leaders are also cited as both enablers and barriers to accessing NFSA services. This suggests that the willingness and ability of individuals within each community is intrinsic to enabling access. If an individual lives in a village with a leader who is both willing and able to respond to NFSA grievances, then they are helped to access services. However, if an individual lives in a village where their leaders are either willing but not able, or not willing or able to enable access, then individuals will continue to be frustrated and unable to use these services. Therefore, providing village leaders and NFSA services providers with support and education about NFSA processes and entitlements (as SPREAD are doing) will be central to resolving problems.

Characteristics such as poverty, caste, or tribal status, or other marginalisation issues are reported to influence access to NFSA services. Some community members report that all people within the village receive services equally, regardless of these issues, but a significant number disagree. For example, many community members report that 'backward' people are not able to access services.

> *These people are not getting equal benefits because they are not able to go to the Sarpanch or to the party because of their low intelligence or illiteracy.*
>
> (Male, ST, 31, Balangir)

> Interviewer: *You told that the people who are backward and deprived, do they get the all the facilities of government like other people or they don't get it?*
>
> Response: *No, they get only the rice…they don't get [midday meals or Anganwadi services].*
>
> (Male, ST, 33, Balangir)

Further, families who move away from the village in order to work are also reported to struggle with accessing services.

> Interviewer: *Do the unprivileged and deprived people in your village avail these services like other people or not?*
>
> Response: *They are not availing these services…*
>
> Interviewer: *They're not availing… why are they not availing?*
>
> Response: *They have gone away… they get rice grain for a month… or two… and they don't get the rations for two months at once…*
>
> (Female, OBC, 25, Balangir)

> Interviewer: *Why don't they get such privileges? What is the problem?*
>
> Response: *The people who don't have enough job opportunities back at their home move to different places in search of a job.*
>
> (Female, OBC, 26, Kalahandi)

The most common issues named by many community members as a barrier to accessing NFSA services were administrative issues with TPDS ration cards, obstruction by village leaders, and AWWs not providing services or obstructing access. Other frequently discussed barriers include marginalisation of individuals or families, poverty, and administrative issues with the MAMATA scheme.

> Response: *Anganwadi Didi.*
>
> Interviewer: *Except her, who else is creating problem?*
>
> Response: *No one else. But, there are supervisor and some higher ups come but they don't listen even if we complain.*
>
> (Female, ST, 23, Kalahandi)

> *The Sarpanch and others… and the ward members…. they have obstructed us getting these facilities.*
>
> (Female, SC, 19, Koraput)

> Response: *They said that they will provide but still didn't.*
>
> Interviewer: *Who said that?*
>
> Response: *The Sarpanch and the ward members… I have submitted the Adhaar card and all the necessary requirements but they don't seem to take heed of the problem.*
>
> (Female, ST, 60, Koraput)

> *We haven't got MAMATA money ever from that… I did the paper works also. The children were growing and I was doing the paper works to get the money... But we didn't get it.*

(Male, ST, 37, Kalahandi)

The majority of community members stated that nothing helped them access NFSA services. However, of those people who did state that they received help, many people stated that this came from Anganwadi workers and ASHAs, and village leaders. Other reasons cited by several community members were that the government helped them by providing the services and that community committees also enabled access to NFSA services.

> *They didn't cause any problem; rather, that helped us, especially the Anganwadi Workers, and ASHA workers and the teacher. They helped me.*

(Male, SC, 43, Balangir)

## 4.3 Use of and confidence to use grievance redressal processes

One crucial aspect of the stated desire of the social audit to improve access to and uptake of NFSA schemes is increased awareness of, as well as monitoring and improvement of, grievance redressal processes. Four of the nine objectives of the social audit (referred to in more detail in Section 1 of this report) refer in some way to grievance redressal procedures. From the side of the rights holder, these objectives were aimed at increasing their ability to make complaints, and from the side of service providers, this was to ensure complaints are upheld, and services are held accountable.

In many districts, SPREAD reported that the grievance redressal systems for any government services had not been functioning for some time. This meant that by organising the social audits, they were providing some communities with access to grievance redressal for the first time. While this means that levels of access will certainly have increased as a direct result of the social audit programme, it also created issues. These included other issues such as roads, pensions, or access to water, hijacking the Gram Sabha and side-lining nutrition issues, and raised expectations of community members, where new understandings of entitlements and rights are not matched with provision from NFSA services (SPREAD 2018c).

SPREAD reports and case studies provide some evidence of improvements within grievance redressal processes (not only people accessing them, but also changes being made). They also reported that the new block-level meetings provided officials with greater insights into and access to the grievance redressal process. This allows officials to ensure that grievances are suitably addressed (SPREAD 2018c).

There is information on the impacts of the social audit process on grievance redressal from both the household surveys and the community IDIs and FGDs. Again, we first report results from the survey data before exploring further what we learnt from the community-based work.

### ICDS

Somewhat surprisingly, women's confidence in their ability to raise an issue regarding AWCs went down by 2pp in Late GPs and by 8pp in Early GPs, and the difference between Early and Late GPs is statistically significant ($p<0.05$). This negative result may be interpreted as a sign that the information regarding grievance redressal procedures conveyed in the SAs confused women, or was a sign that the SAs laid bare the grievances that women had and that, in turn, women started to actively question whether they did indeed have appropriate avenues to express their grievances. In the second interpretation, the loss in confidence would not be a negative result but instead is a first necessary step in a pathway towards empowerment. We see a similar result when caregivers reflected directly on THR and growth monitoring – here caregivers also felt less confident in their

ability to raise issues (by nine percentage points in Early GPs and 18 percentage points in Late GPs).

**Table 4.22 DID Estimates of the impact of social audits on AWC functioning – confidence (primary caregivers sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| Very confident, can raise issue on AWC | -0.08** | -0.2*** | 0.12** | 1132 |

*Note*: *** p<0.01, ** p<0.05, * p<0.1. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to α+β in equation (1). 'Change in Late GPs' corresponds to α in equation (1). The DID parameter corresponds to β in equation (1). *Source*: Authors' own.

**Table 4.23 DID Estimates of the impact of social audits on AWC functioning – confidence (pregnant women sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| Very confident can raise issue on AWC | -0.07 | -0.23*** | 0.15 | 120 |

Note: *** p<0.01, ** p<0.05, * p<0.1. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to α+β in equation (1). 'Change in Late GPs' corresponds to α in equation (1). The DID parameter corresponds to β in equation (1). *Source*: Authors' own.

**Table 4.24 DID Estimates of the impact of social audits on THR and GMP functioning – confidence (primary caregivers sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| Very confident, can raise issues on GMP | -0.09** | -0.18*** | 0.09* | 1152 |

Note: *** p<0.01, ** p<0.05, * p<0.1. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to α+β in equation (1). 'Change in Late GPs' corresponds to α in equation (1). The DID parameter corresponds to β in equation (1). *Source*: Authors' own.

## MAMATA

For MAMATA, there is no evidence that social audits improved responsiveness of providers and/or improved grievance redressal mechanisms. In fact, similar to the findings with ICDS, caregivers became significantly less confident in their ability to raise any issue with MAMATA between the two waves of data collection (-6 percentage points in Early GPs and -15 percentage points in Late GPs). The fact that this negative evolution is less marked among Early GPs could indicate that it is a transient one. It could also reflect the hypothesis we outline above that after the social audit raised expectations, the caregivers started to question whether they indeed have sufficient avenues for addressing or expressing their grievances, thus causing the drop in confidence.

**Table 4.25 DID Estimates of the impact of social audits on MAMATA functioning – confidence (primary caregivers sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| Very confident can raise issue on MAMATA | -0.06 | -0.15*** | 0.09 | 877 |

*Note*: *** p<0.01, ** p<0.05, * p<0.1. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to α+β in equation (1). 'Change in Late GPs' corresponds to α in equation (1). The DID parameter corresponds to β in equation (1). *Source*: Authors' own.

**Table 4.26 DID Estimates of the impact of social audits on MAMATA functioning – confidence (pregnant women sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (D) | N |
|---|---|---|---|---|
| Very confident can raise issue on MAMATA | -0.03 | -0.12 | 0.08 | 63 |

*Note*: *** p<0.01, ** p<0.05, * p<0.1. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to α+β in equation (1). 'Change in Late GPs' corresponds to α in equation (1). The DID parameter corresponds to β in equation (1). *Source*: Authors' own.

## TPDS

For TPDS, caregivers in the Late group report a 1pp deterioration of their confidence in their ability to raise an issue, though this was not the case in the Early group. Similarly for men, those in the Late group report an 11pp drop in confidence to raise an issue – with the 16pp DID highly significant (p<0.01). This could mean that the drop in confidence was only transient, with those experiencing the change over a longer period reporting no overall change (rather mitigating this somewhat surprising result).

**Table 4.27 DID Estimates of the impact of social audits on TPDS functioning -confidence (primary caregivers sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| Very confident to raise an issue on TPDS | -0.03 | -0.13*** | 0.11* | 871 |

*Note*: *** p<0.01, ** p<0.05, * p<0.1. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to α+β in equation (1). 'Change in Late GPs' corresponds to α in equation (1). The DID parameter corresponds to β in equation (1). *Source*: Authors' own.

**Table 4.28 DID Estimates of the impact of social audits on TPDS functioning – confidence (pregnant women sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| Very confident to raise an issue on TPDS | 0.07 | -0.09 | 0.16 | 97 |

**Table 4.29 DID Estimates of the impact of social audits on TPDS functioning – confidence (male respondents sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| Very confident to raise an issue on TPDS | 0.05 | -0.11*** | 0.16*** | 619 |

## Broader community findings (IDIs and FGDs)

In contrast to the data reported from the household surveys, community members reported that the social audit process had taught them about NFSA grievance redressal processes, and that this meant they now felt able to make a complaint.

> Interviewer: *Could you complain before?*
>
> Response: *No I couldn't.*
>
> Interviewer: *Now why can you do that?*
>
> Response: *Due to the meeting, after listening their talks. By going to the meeting we are understanding something right? Earlier there were no meetings. The Anganwadi were kicking us, the Sarpanch was kicking us. Now there are meetings.*
>
> (Female, OBC, 50, Kalahandi)

All NFSA service providers found that there was an increase in complaints about their services because of the social audit, meaning that more people were able to access and use the grievance redressal system. Despite the grievances raised during the social audit process being directed at NFSA service providers, the majority of those that were interviewed reported that they responded positively to the process, and had acted as a result of the social audit. However, they also reported frustration at not being able to meet the expectations of the community, many of which had been raised by the social audit process itself.

> Interviewer: *Why do you feel it a negative thing when you're questioned?*
>
> Response: *Because we have no role in the ration card distribution and it requires the attention of the higher authorities, it comes from the collector's office. So that's why it's a negative experience because we don't interfere in the matter.*
>
> (Male, Brahmin, 34, TPDS service provider, Balangir)
>
> *I did have a bad experience. It was when the people who did not have a ration card tried to create a raucous and tumultuous atmosphere. We are trying to solve their problems but it cannot be done overnight. But, those people fail to understand that and are always creating chaos.*
>
> (Male, OBC, TPDS service provider, Koraput)

Many government officials also reported that the Gram Sabha meetings in particular provided community members with renewed opportunities to engage with grievance redressal mechanisms. They reported that they responded positively to the complaints that were raised at the Gram Sabha meeting(s) they attended.

> Interviewer: *Have you taken any step after social auditees complaint eradication programme?*
>
> Response: *Sir, once we got a complaint, a worker does not distribute eggs and mixed grain powder properly. I reached that place and shut out the problem.*
>
> (Female, ST, 47, Ladies Supervisor ICDS, Balangir)

They also reported that they considered that the process for grievance redressal had been strengthened as a result of the social audit.

> Interviewer: *The process of solving the complaint, do you think there will be any improvement?*
>
> Response: *Yes. Sure. If you give any complaint then the responsible departments are made aware of how to solve the problem then sure it will improve. There will be an improvement.*
>
> (Male, OBC, 55, ABEO, Balangir)

## 4.4 Community empowerment and voice in local nutrition-related decision-making

One of the key goals of social audits is to enhance participation in civic life and community-level governance. We computed a number of indices capturing various aspects of community participation based on respondents' answers. Annex 1 gives a detailed description of each variable, which are also briefly described in Box 4.1.

Table 4.30 shows how some of these outcomes changed among caregivers between baseline and follow-up. One can see that indices of 'political participation', 'engaged citizen attitudes', and 'responsive state attitudes' substantially increased more in the Early than in the Late GPs. Table 4.31 and Table 4.32 present results for pregnant women and men, respectively. These are similar to those for caregivers. The DID estimate of early social audits is positive and statistically significant for the indices of 'community participation', 'political participation', 'engaged citizen attitudes', and 'responsive state attitudes' among pregnant women and men, and the GP effectiveness index also substantially rose for men.

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Box 4.1 Basic description of the community and political engagement indices

The community participation index increases with the number of groups/committees a respondent is part of, the number of groups/committees a respondent feels empowered to speak at during meetings, and whether the respondent knows the Sarpanch and local officials.

The community engagement index increases with attendance in group/committee meetings, contribution to group/committee actions, speaking out and/or taking part in monitoring actions by the GP, and with attendance in Gram Sabha and Palli Sabha.

The political participation index increases when respondents report voting independently, and when they intend to vote in the next local and national elections.

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The engaged citizen attitude index increases with the number of domains in which the respondents consider that citizens should take responsibility.

The responsive state attitude index increases with the number of domains in which respondents consider that states should be accountable for.

*Source*: Authors' own.

These results would suggest that social audits have triggered a cumulative positive change on these outcomes. However, Table 4.30 shows that the indices of 'political participation', 'engaged citizen attitude', and 'responsive state attitude' have significantly *decreased* among primary caregivers in the Late GPs. The same is true for pregnant women and male respondents for the latter two indices. This negative evolution partly explains the positive sign of the DID estimate of early social audit on these outcomes, and suggests that we need to nuance the interpretation of these findings. Indeed, is the decrease of the outcomes in the Late group which illustrates that social audits cause respondents to question their civic attitudes as well as their attitudes towards what they expect from the state. Such a process leads to a sharp decrease in their likelihood to display positive civic life attitudes. But this is a short-lived effect, which has completely dissipated after two and a half months, so that the evolution of these outcomes is either null or positive in the Early GPs. In summary, while there is evidence that social audits leads to a positive cumulative change in terms of political participation, the same is not true for the indices of engaged citizen and responsive states, for which the positive DID parameter stems from the negative transient impact of social audits in the Late GPs.

We observe a decrease in trust towards AWWs among Early GPs (significant at the 10 per cent level) with the proportion of caregivers who completely trust AWWs being reduced by six percentage points. This is suggestive that the process of social audits may undermine the authority or standing of AWWs over time. However, the estimated impact of early social audit on trust towards AWWs is negative but not statistically significant, suggesting that such an effect is not precisely estimated.

**Table 4.30 DID Estimates of the impact of social audits on civic life (primary caregivers sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| Community participation index (standardised) | 0.07 | 0.02 | 0.05 | 1057 |
| Community engagement index (standardised) | 0 | 0.01 | -0.02 | 1149 |
| Political participation index (standardised) | 0.16** | -0.15** | 0.31*** | 1151 |
| Engaged citizen index (standardised) | 0.05 | -0.17** | 0.22** | 1152 |
| Responsive state index (standardised) | 0.05 | -0.15** | 0.2* | 1152 |
| GP effectiveness index (standardised) | -0.08 | -0.05 | -0.03 | 1152 |
| Highly trust teachers | -0.06* | -0.05 | -0.01 | 1086 |
| Highly trust farmers' association | 0.09 | 0.09** | -0.01 | 524 |
| Highly trust GP officials | -0.03 | -0.01 | -0.02 | 1047 |
| Highly trust AWW | -0.06* | -0.04 | -0.03 | 1135 |

**Table 4.31 DID Estimates of the impact of social audits on civic life (pregnant women sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| Community participation index (standardised) | 0.34** | -0.2 | 0.54*** | 103 |
| Community engagement index (standardised) | 0.06 | -0.02 | 0.08 | 124 |
| Political participation index (standardised) | -0.12 | -0.12 | 0 | 124 |
| Good citizen index (standardised) | 0.11 | -0.36** | 0.47* | 124 |
| Good state index (standardised) | 0.13 | -0.54** | 0.67** | 124 |
| GP effectiveness index (standardised) | -0.12 | 0.13 | -0.25 | 124 |
| Highly trust teachers | -0.12 | -0.06 | -0.05 | 116 |
| Highly trust farmers' association | 0.3* | 0.3** | -0.01 | 50 |
| Highly trust GP officials | 0 | -0.07 | 0.07 | 111 |
| Highly trust AWW | 0.04 | -0.2** | 0.23* | 121 |

*Note*: *** p<0.01, ** p<0.05, * p<0.1. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to α+β in equation (1). 'Change in Late GPs' corresponds to α in equation (1). The DID parameter corresponds to β in equation (1). *Source*: Authors' own.

**Table 4.32 DID Estimates of the impact of social audits on civic life (male respondents sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| Community participation index (standardised) | 0.25*** | -0.13* | 0.38*** | 752 |
| Community engagement index (standardised) | -0.06 | 0.05 | -0.1 | 778 |
| Political participation index (standardised) | 0.16** | -0.1 | 0.27** | 778 |
| Good citizen index (standardised) | 0.06 | -0.16** | 0.21* | 778 |
| Good state index (standardised) | 0.11 | -0.13 | 0.24* | 778 |
| GP effectiveness index (standardised) | 0.12* | -0.11 | 0.23** | 778 |
| Highly trust teachers | -0.08* | -0.04 | -0.04 | 759 |
| Highly trust farmers' association | 0.04 | 0.11 | -0.07 | 395 |
| Highly trust GP officials | -0.03 | -0.05 | 0.02 | 749 |
| Highly trust AWW | 0.01 | 0.02 | -0.01 | 768 |

*Note*: *** $p<0.01$, ** $p<0.05$, * $p<0.1$. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to $\alpha+\beta$ in equation (1). 'Change in Late GPs' corresponds to $\alpha$ in equation (1). The DID parameter corresponds to $\beta$ in equation (1). *Source*: Authors' own.

Qualitative data expand upon these findings via several themes we have analysed. Empowerment and participation were difficult topics to discuss directly with participants so we looked for evidence of positive reflection on the social audit process as having consciously changed participants' own view of their power over personal or community decision-making, or a sense that they had new powers or voice in redressal for inadequate services. We also looked for evidence of positive feelings about other avenues for participation in community processes (including PRI institutions and committees) following the social audit process.

Several community IDI and FGD participants referred to better knowledge of the avenues to complain about existing or future problems. This included specific reference to the Sarpanch, Ward Members, particular named individuals including the AWW and even, in the following case, more senior officials such as the Block Development Officer (BDO):

> *After all these happened, a little courage in us just increased. Then we were not able to talk with you, but now we do and then can ask to Sarapanch, in case he refuses, we are able to talk with BDO. Then again when we had money we would give it to our husband to deposit in account, but now we can do it ourselves, be it five or ten rupees, Indira Awas money, or our hard work earned money, by this we are able to save some.*

> (Female SC FGD Participant (average age of FGD: 46), Balangir)

> *Anganwadi did not give eggs and multi-grain cereal powder properly. It kept selling half of the multi-grain cereal powders and rice. After these meetings, this stopped happening. People are getting their share. We also learnt our rights and questioned the Anganwadi workers and voiced our grievances in the meeting. With the help of the officials this happened.*

(Female ST FGD Participant (average age of FGD: 47), Koraput)

A small number of the views expressed in the IDIs also give a sense of a growing confidence of participants about their rights and the possibility for redress, which support the survey findings, both on citizen engagement and on state responsiveness. One participant [bio] talks of having 'gained courage' – 'I hope I can get what I am not given…I can go to the concerned person' (Female, OBC, 22, Kalahandi) – while another references the power of collective action in noting that in future they would be able to 'gather and complain' (Female, SC, 28, Koraput) in response to non-delivery of the NFSA services.

Although the survey results are not clear with regard to membership of committees, there is some indication of increased willingness to join committees; or to see their benefits, within the community IDIs and FGDs. Some mentioned that they now wanted to be part of groups in future, in order to improve the general welfare of the village and there was also mention of benefiting children or education… Others mention specifically their keenness to contribute to the awareness and learning of others: 'by taking part in the committee, I will share whatever good I know. I will try to create awareness among people' (Female, SC, 30, Koraput), while one person mentions wanting to increase opportunities for their own learning by being part of a group (Female, SC, 45, Kalahandi).

Despite these positive reports of growing awareness, participation, and empowerment, there were many people who did not report such changes in the community IDIs or FGDs and people who talked negatively about the process in terms of empowerment and/or the structural constraints to their empowerment. A couple mentioned the fact that they had to work and so didn't have time for things like joining committees. In one case, a participant reflected wryly on their position: 'would I be in this state if anything had changed' (Male, OBC, 20, Balangir) whilst a few others reflected on the pointlessness of committee membership in the face of entrenched village power structures, as the following excerpts illustrate:

> These are all useful things and I can't listen to the useless talks of people. We also say that AWW is eating away everything. We are telling that the teachers are misutilising their power. Why get involved in such chaos, that's why we are not participating.

(Male, SC, 54, Kalahandi)

> Rich men supress those things. Some things happen in meeting, but they do things in their own way behind the meeting.

(Female ST FGD participant (average age of FGD: 24), Balangir)

> Sir we are tired objecting and raising our problems in the Panchayat but there is no result. Whatever they are doing meeting or what nothing else is being solved only problems.

(Male SC FGD participant (average age of FGD: 35), Kalahandi)

In one case, a participant raised the fact that their marginalisation could itself be a cause of conflict, which prevented them from participating – as 'many people blame us' (Male, OBC, 35, Balangir).

## 4.5 IYCF/nutrition-related knowledge

Table 4.33 and Table 4.34 show the estimated impact of social audits on nutrition knowledge. Surprisingly, we can see that the impact of early social audit is negative and statistically significant for overall nutrition knowledge and child-feeding knowledge. In contrast, other nutrition knowledge

increased in Late GPs but the effect was not sustained and is not seen in Early GPs. These findings reveal that social audits exerted a cumulative and negative impact of nutrition knowledge.

When looking at the individual questions used to build the knowledge scores, we see that the proportion of correct answers dropped the most for questions on whether infants below six months should be given water when the weather is very hot (from 62 per cent of correct answers to 52 per cent), on the correct age to introduce solids in infants' diets (from 58 per cent to 51 per cent), on the correct age to introduce liquids in infants' diets (from 72 per cent to 67 per cent), and on the correct use of colostrum (from 27 per cent to 22 per cent).

The decrease in the proportion of correct answers to the first question may well be linked with the beginning of the summer season in Odisha at the time of the endline data collection. Summer typically starts in March and is very hot in the sampled districts, with temperatures well above 40 degrees. This could lead respondents to increased acceptance of the practice of giving water to infants.

Such an explanation is not plausible for the other three questions which have seen a marked drop in the proportion of correct answers. For these questions, we believe that the explanation lies in inadequate nutrition messages being disseminated during and following the social audits. Our survey of ASHA workers indicates that while 98 per cent of them believed a pregnant woman should eat a quarter more than normal at baseline, this proportion fell to 63 per cent at endline, with a sharp rise in the proportion of ASHA workers believing pregnant women should eat an extra meal. Furthermore, there is some confusion regarding the correct age to introduce complementary food in addition to breast milk. At baseline, 79 per cent of ASHA workers indicated that complementary food should be introduced for children aged six months and more, and 21 per cent of ASHA workers indicated that complementary food should be introduced for children aged seven months and more. At endline, these proportions changed to 57 per cent and 43 per cent respectively. There was thus obviously a confusion amongst ASHA workers on whether the introduction of semi-solids should be done for children in their sixth month of life or after the sixth month has been completed. Furthermore, such confusion increased between the two waves.[22]

Another reason for the decrease in nutrition knowledge may be the reduced contact time between AWWs/ASHA workers and beneficiaries during home visits. Home visits are the key moment for dissemination of knowledge on good nutrition practices; however, ASHA workers indicated a sharp drop in the time they spent on home visits between the two waves (from almost 6 hours per week at baseline to 3.6 hours per week at endline). The same is true for AWWs whose average time spent per week administering home visits went down from three to two hours over the two waves. However, there is no noticeable difference between Early and Late groups in terms of the time spent on time activities, so there is no evidence that social audits exert a cumulative adverse effect on nutrition knowledge through that mechanism.

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[22] This could be the result of the social audits, but it can also be because the ASHA workers being interviewed were not necessarily the same for both surveys. When we restrict the sample to the panel of workers who answered both rounds of the surveys, the change is even more dramatic: whereas 78 per cent of workers indicated that semi-solid foods should be introduced for children aged six months and more, and 28 per cent that the correct age was seven months, at endline the proportions were 38 per cent and 62 per cent respectively.

**Table 4.33 DID Estimates of the impact of social audits on nutrition knowledge (primary caregivers sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| Nutrition knowledge score | -0.28* | 0.13 | -0.41* | 1152 |
| Breastfeeding knowledge score | -0.04 | 0.06 | -0.1 | 1152 |
| Child-feeding knowledge score | -0.35*** | -0.1 | -0.25** | 1152 |
| Other nutrition knowledge score | 0.11 | 0.17** | -0.06 | 1152 |

*Note*: *** p<0.01, ** p<0.05, * p<0.1. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to α+β in equation (1). 'Change in Late GPs' corresponds to α in equation (1). The DID parameter corresponds to β in equation (1). *Source*: Authors' own.

**Table 4.34 DID Estimates of the impact of social audits on nutrition knowledge (pregnant women sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| Nutrition knowledge score | -0.3 | -0.25 | -0.04 | 124 |
| Breastfeeding knowledge score | -0.16 | 0.24 | -0.4 | 124 |
| Child-feeding knowledge score | -0.21 | -0.43** | 0.22 | 124 |
| Other nutrition knowledge score | 0.07 | -0.06 | 0.13 | 124 |

*Note*: *** p<0.01, ** p<0.05, * p<0.1. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to α+β in equation (1). 'Change in Late GPs' corresponds to α in equation (1). The DID parameter corresponds to β in equation (1). *Source*: Authors' own.

## Broader community findings (IDIs and FGDs)

There is no evidence available from the evaluation's qualitative IDIs and FGDs with community members, government officials, service providers, and the SPREAD team to suggest that the social audit process may have directly affected nutrition and IYCF knowledge of pregnant women and primary caregivers of children under five years or that of the wider community. The Programme Impact Pathway suggests a number of potential avenues for change, the main one being via AWW nutrition counselling to pregnant women and mothers as part of antenatal visits and postnatal/child check-ups. It is also a conditionality of women receiving some of their MAMATA payments that they attend IYCF counselling sessions. One possible explanation suggested by the qualitative data for the negative change observed by the quantitative data could be that the social audit process may have diverted AWW's attention more towards improved delivery of 'hard' outputs (such as provision of THR) and away from their responsibility to provide one-to-one nutrition counselling to mothers of children, and pregnant and lactating women. This theory is supported by the significant number of community IDIs where receipt of these 'hard' inputs was mentioned, either where there had been a positive change or no change. A review of SPREAD's internal programme documentation and monitoring indicators shows a similar pattern. There is only one ICDS component mentioned under the MIS entitlement list for verification by the social audit team which relates to this: 'home visit by the AWW', but the focus here is on maintenance of the home visit register rather than any measure of quality or topics covered as part of these home visits.

# 4.6 Village Health and Nutrition Days (VHNDs)

The organisation of monthly VHNDs for pregnant and lactating women, mothers, and adolescent girls is a core ICDS service that is meant to be offered by AWWs at AWCs in order to support maternal and child health. Activities covered should include: antenatal care (ANC) check-ups; counselling on ANC, delivery and postnatal care, and nutrition; menstrual hygiene; breastfeeding; supplementary feeding; child immunisations; family planning and referral of severely malnourished children.

Table 4.35, Table 4.36, and Table 4.37 show the impacts of social audits on whether or not a VHND was conducted.

The first two tables show that the likelihood that one VHND was conducted in the last month was much higher at endline than it was at baseline. Furthermore, VHND awareness also rose by 40pp among adolescent girls. It is not possible to formally attribute this effect to social audits as the DID estimate is indistinguishable from 0, but it remains plausible than audits exerted an immediate effect (and thus, not detectable by the quantitative evaluation) this outcome given the scale of the change.

**Table 4.35 DID Estimates of the impact of social audits on VHND (primary caregivers sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| VHND was conducted once | 0.52*** | 0.52*** | 0 | 1000 |

*Note*: *** p<0.01, ** p<0.05, * p<0.1. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to α+β in equation (1). 'Change in Late GPs' corresponds to α in equation (1). The DID parameter corresponds to β in equation (1). *Source*: Authors' own.

**Table 4.36 DID Estimates of the impact of social audits on VHND (pregnant women sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| VHND was conducted once | 0.64*** | 0.47*** | 0.17 | 110 |

*Note*: *** p<0.01, ** p<0.05, * p<0.1. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to α+β in equation (1). 'Change in Late GPs' corresponds to α in equation (1). The DID parameter corresponds to β in equation (1). *Source*: Authors' own.

**Table 4.37 DID Estimates of the impact of social audits on VHND awareness (adolescent girls sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| VHND awareness | 0.41*** | 0.36*** | 0.05 | 134 |

*Note*: *** p<0.01, ** p<0.05, * p<0.1. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to α+β in equation (1). 'Change in Late GPs' corresponds to α in equation (1). The DID parameter corresponds to β in equation (1). *Source*: Authors' own.

**Broader community findings (IDIs and FGDs)**

None of the community members interviewed highlighted any specific changes to the incidence of VHNDs in their communities or any increased level of awareness as a result of the audit. However, a few participants from FGDs conducted with SSs and SPREAD Social Audit Committee Coordinators did mention that they felt that the audits had either improved the AWW's organisation of the VHNDs or increased awareness about them. One FGD member suggested that this was a direct result of additional pressure put on the AWW by the audit process to fulfil all their job responsibilities, with the VHND being one of many activities they were required to do:

> *During the Social Audit, they were sure that legal actions might be taken against them; they were insecure about their job, they thought that they might end up losing their jobs so in the duration of those eight days I saw they were regular in their jobs… Irrespective of whether earlier they were doing their job sincerely or not but in those eight days, regularly they opened the Anganwadi Centre, provided Hmm... The hot cooked meal, conducted pre-school... Their VHND was proper and the Anganwadi Didi (AWW) were regular.*

(SPREAD Social Audit Committee Coordinator FDG participant, Kalahandi)

As two SSs explained in one FGD conducted in Balangir, they felt that increased community awareness about the ICDS services provided meant that people were now more likely to use them, including attending VHNDs:

> Respondent 8: *They can understand about the things they were entitled to, but couldn't get. They can get their entitlement. They can understand it now.*

> Respondent 6: *They didn't use to go to VHND but now they go to VHND.*

> Respondent 8: *The Anganwadi didn't come to the Anganwadi Centre. Now they are also coming. They didn't give food. Now they are giving food as well. They are teaching the children in Anganwadi.*

(SS FGD participants, Balangir)

## 4.7 Food security and dietary diversity

Impacting food security and nutrition outcomes were amongst the primary objectives of the CAN programme. Although it would be difficult for any programme to impact these types of outcomes in the period assessed leading to the decision not to take anthropometric measurements, we still measured changes in a limited number of relevant food and nutrition outcomes between baseline and endline. All four NFSA schemes are designed to contribute in various ways towards improvements in household food security and dietary diversity, with ICDS and MAMATA targeted at children and pregnant women in particular.

Table 4.38 displays results of the estimations of the effect of social audits on food security and dietary diversity for primary caregivers. We observe that both the Women's Dietary Diversity Score (WDDS) and the child dietary diversity score (for children between 6 and 24 months) have increased over the study period. Women have eaten almost one extra food type (0.88) and children 0.5 extra food type at follow-up compared to the baseline. The increase in dietary diversity has been driven by consumption of fruits (which doubled), legumes, and rice. However, women and children assigned to the Early group have not increased their dietary diversity more than those assigned to

the Late group. We thus have no evidence that this increase in dietary diversity is caused by the social audits.[23]

The Food Insecurity Experience Scale (FIES), which measures food insecurity at the household level, has not changed over the study period, for neither of the Early and Late groups.

Insufficient dietary diversity is typically a result of an income gap (not enough resources to acquire diverse type of food) and/or of a knowledge gap (not enough knowledge as to what a good diet is). The increase in dietary diversity could thus be linked with either one or two of these gaps narrowing down between baseline and follow-up. Results for nutrition knowledge among caregivers discussed in the earlier subsection suggests that knowledge has not improved so that the positive change in diets is most likely linked with the income situation (and thus, independent of the social audits).

**Table 4.38 DID Estimates of the impact of social audits on food security and dietary diversity (primary caregivers sample)**

| Outcomes | Change in Early GPs | Change in Late GPs | Difference-in-Difference (DID) | N |
|---|---|---|---|---|
| Child dietary diversity score (7 food groups) | 0.53*** | 0.51*** | 0.02 | 1151 |
| Woman Dietary Diversity Score | 0.77*** | 0.99*** | -0.22 | 1152 |
| Food Insecurity Experience Scale | -0.19 | 0.01 | -0.2 | 1152 |

*Note*: *** p<0.01, ** p<0.05, * p<0.1. Standard errors are clustered at the Gram Panchayat level. 'Change in Early GPs' corresponds to α+β in equation (1). 'Change in Late GPs' corresponds to α in equation (1). The DID parameter corresponds to β in equation (1). *Source*: Authors' own.

## Broader community findings (IDIs and FGDs)

The qualitative data from IDIs and FGDs with community members support the quantitative findings that women and children's dietary diversity improved over the period when the social audit was carried out, although the frequency that this topic was explicitly mentioned was low. Whilst the quantitative data was unable to confirm any causal relationship with the social audits, qualitative findings showed that many community members perceived there to be a direct link. Positive changes reported in children's diets were most commonly highlighted within the context of improved NFSA delivery of food entitlements. This included improved quality and quantity of take-home rations provided by the AWC (for example, more frequent distribution of rice, pulses, and eggs) as well as improved MDM provisions for children in school. A few mothers reported a marked increase in their child's consumption of a wider range of foods following the audit process, including eggs and other grains (for example, rice in addition to corn). Whilst very few specific references were made to improvements in women's diets, this might be explained by a greater community awareness of the importance placed on child nutrition and wellbeing relative to other household members, rather than an indication that women's diets hadn't also shown improvements as a result of increased access to foods (e.g. via TPDS and THR).

Although access to a greater and more nutrient-rich diversity of foods may have improved, one male FGD member in Kalahandi District had observed a trade-off in terms of *quantity* of food provided:

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[23] In particular, there is no evidence of increased availability of eggs in children's diets.

*Government is helping us. Here we have heard that before government only supplying us 'daal' (pulses), but now they are providing us rice, 'dalma' (different vegetable mixed daal), eggs, and vegetables but in less amount.*

(Male village leaders/elders FGD participant (mixed caste; average age of FGD participant: 40), Kalahandi)

Several community members commented on positive changes in the *quality* of food provided, for example as THR from the AWCs. A few individuals connected this directly with their child's health status, for example:

*See how it happened... they didn't give my son proper food... they weren't giving proper water... due to which he suffered from dysentery and diarrhoea... that's why we complained. After that, they kept a check on the person serving the food... and if the food was being served on time or not.*

(IDI with female, ST, 27, Koraput)

Interestingly, there was no evidence from the qualitative data that changes had occurred in decision-making on intra-household food allocation or food purchasing decisions that would impact on dietary diversity, which in theory might be associated with increased nutrition knowledge, gained for example from nutrition education sessions provided by AWW visits or VHSDs, or increased income from access to increased MAMATA payments.

## 4.8 Summary

This section considered the evidence we have gathered on the outcomes mapped in the theory of change (Figure 1) relating primarily to awareness and knowledge of services, entitlements, and grievance redressal avenues; access to and satisfaction with services; use of grievance redressal and broader measures of community participation and empowerment. We also considered broader impacts on food security and IYCF knowledge.

In terms of *knowledge of NFSA services, entitlements, and grievance mechanisms,* we see some significant changes, varying by service. Knowledge about the **ICDS** service of THR improved amongst caregivers and pregnant women, the latter seeing some very high changes (+25/+21pp Early/Late). With no significant differences between Early and Late GPs, we cannot be sure that these changes are cumulative or indeed connected to the social audit process. However, in the absence of other supply- or demand-side activities happening with regard to ICDS during this period, it is hard to rule out their connection to the CAN programme. Awareness and knowledge of the **MAMATA** scheme and entitlements did significantly improve for the target group of pregnant women between baseline and follow-up. Such changes tend to be significantly more marked in Early GPs, indicating a cumulative positive impact of social audits. Knowledge about the **TPDS** improved substantially or very substantially amongst all groups sampled – caregivers, pregnant women, and men. These included variables measured such as overall knowledge of entitlements and knowledge about PDS committees. The changes for men were the most marked and were also more pronounced in Early than Late GPs. This suggests that these impacts were due to cumulative exposure to the social audit process and the community-level activities it set into motion. More detailed views of those who participated in the community IDIs and FGDs lend further credence to the view that such gains in knowledge were related to attendance at social audit events and processes.

In terms of *access to, uptake of, and satisfaction with NFSA services and entitlements,* we see a more varied pattern but which includes improvement in some areas across all services. For **ICDS**, we saw an increase in the likelihood that a child was provided with special food following growth monitoring, and a small but statistically significant increase in referral to rehab centres after

monitoring. Neither of these changes differed significantly between Early and Late GPs, however. For **MAMATA**, we see significant increases (+22pp) in enrolment amongst pregnant women in the Late GPs, (increases in Early GPs were not statistically significant) – and a significant increase (+31pp) in pregnant women being satisfied by MAMATA. The latter change was significantly different between Early and Late groups suggesting that the change in satisfaction was based cumulatively on length of exposure to the social audit and the processes it set in motion. For **TPDS** we see improvements for all groups sampled, but particularly for men, including decreases (-7pp) in men reporting having to pay extra money at the ration shop in Early GPs, and higher likelihood of having been assigned an Aadhar number (+5pp). Both these changes are significantly different between early and late groups, suggesting a cumulative effect of the social audit process.

Other changes where we cannot detect a significant difference between Early and Late GPs include, amongst primary caregivers, improvements, and likelihood to have an Aadhar number, likelihood that ration shops deliver food on a monthly basis, satisfaction with the TPDS, and the quantity of the food ration. Although these changes can't be directly linked to the social audit process, the magnitude of the changes in some cases (e.g. 32pp increase in ration shops delivering food monthly in Early GPs and 46pp in Late GPs) and the absence of other major supply- or demand-side changes observed during this period are highly suggestive that these changes are related to the CAN programme. This view is supported by the information garnered from some of the individuals who participated in the community IDIs and FGDs, who reported increases in access and availability of all the services that were the target of the social audit. However, it is also the case that other participants in IDIs and FGDs complained that there have been no changes since the social audit, or discussed the fact that expected improvements in services they thought would result from their village's participation in the CAN programme has not happened. Others still, stressed that they had difficulty accessing the services (or actively participating in services) due to their marginalisation in village life, as a result of poverty, caste, or tribal status.

Findings on occurrence and awareness of *village health and nutrition days* showed significant improvements in both Early and Late GPs. The quantitative data made it difficult to attribute this to the social audits although it is plausible, particularly given the limited positive evidence from the qualitative data, that the audits exerted an immediate effect, given the scale of changes seen.

Some of the most surprising results in this chapter relate to *use of and confidence to use grievance redressal processes*, particularly in light of the results on the positive effects of social audits on knowledge of these processes and on community participation. Confidence in ability to raise issues regarding ICDS, MAMATA, and TPDS went down, with the difference between early and late groups statistically significant. We have been unable to explain these changes as the data we gathered in community IDIs and FGDs suggest that – in some cases at least – people's confidence about use of these processes *had* improved. The fact that the decrease in confidence is less marked in Early GPs than in Late GPs lends some support to the hypothesis that after having learnt more about service entitlements, people's expectations increased beyond a level that they felt could be adequately met by simply complaining to the service providers. This hypothesis is also somewhat supported by the IDIs and FGDs we undertook with the service providers themselves, who reported that complaints *had* gone up but that they were frustrated that a lot of what was being complained about was not within their power to address (as these had more to do with systemic supply-side constraints).

Our findings on *community empowerment and voice in local nutrition-related decision-making* strongly support the view that social audits led to very large positive changes in civic life-related attitudes of caregivers and pregnant women. Both groups of women became more positive about citizens being engaged in civic life and about states being responsive to citizen's demands. Social audits also strongly enhanced the community participation of pregnant women and political participation of caregivers (both effects are seen in Early GPs only, which is evidence of a cumulative impact of social audits in this regard). Qualitative data provide a number of further illustrations of people's growing sense of awareness of the forms of redressal and of being able to

voice their problems. Qualitative data also suggested that people became increasingly motivated to take part in community life via their membership of committees as a means to solve future problems. However, our qualitative research also emphasised how entrenched power structures are in villages, and how the realities of daily life may limit the participation of others.

Again, surprisingly, the changes we see in IYCF/nutrition-related knowledge and practices are not positive. In fact, nutrition knowledge scores amongst primary caregivers declined in Early GPs – with the only positive result being amongst those in Late GPs and relating to 'other nutrition knowledge'. Declines in knowledge are not present in Late GPs, suggesting that social audits exert a cumulative *effect* of knowledge. This could be due to the delivery of nutrition knowledge being different in Late and Early GPs (this is an area deserving of further exploration by SPREAD) and/or with service providers being diverted away from nutrition counselling towards other tasks as a result of the social audits.

Our *findings on food security and dietary diversity* show very significant improvements in dietary diversity scores for women and children. However, as nutritional knowledge amongst samples had not improved during that time and in some cases had deteriorated (with nutrition knowledge actually decreasing in Early GPs), it is hard to link this change to the social audits (although neither can we formally rule out the possibility that social audits had an immediate impact). Some other plausible explanations are that income changed significantly during this period as a result of greater livelihood opportunities, or that these are seasonal variations in food availability. Some mothers interviewed as part of the community IDIs and FGDs, however, *do* link the social audit to changes in their children's diets. Further work will be needed to understand changes in this area.

# 5 Conclusions and recommendations

## 5.1 Institutional accountability for NFSA services delivery improvements

Following a rigorous, independently executed evaluation, this report has considered the impact of the CAN programme along the theory of change identified in Figure 1. We have used a theory-based mixed methods evaluation to consider whether the programme conformed to its expected design when in operation, whether it delivered outputs and processes as expected and uniformly across the evaluation communities (*process* evaluation); and whether assumptions linking those outputs to intended outcomes for a wide range of relevant variables have been met (*impact* evaluation). Where possible, we have tried to explain these impacts, or lack thereof, in relation to wider contextual knowledge relating to the study communities gained from background research; programmatic knowledge, the process evaluation, or our qualitative exploratory work at community level.

Evaluation and design considerations described in Section 2 mean that there are limitations to the design of this evaluation that must be taken into account when interpreting the findings we have reported here. Because we were not able to select communities outside of the intervention communities against which we could compare intervention impacts, we opted for a phased design, which compared randomly allocated and thus similar communities who had been surveyed at baseline and then received the intervention either three to four months ahead of the endline, or just over a month ahead of the endline. Comparing average differences in differences in outcomes between the communities allowed us to see whether there had been any impact directly as a result of the intervention; as well as consider whether the impact was immediate and short-lived (results significantly higher in 'Late GPs') or cumulative (results significantly higher in 'Early GPs').

This model had drawbacks, however, as firstly, such a short duration between baseline and endline means that the evaluation focused on the short-term impacts to communities participating in the social audit, even though we know that such processes of accountability and empowerment require a long time to filter through to improvements in service delivery (if at all) and secondly, because if desired results improved, in both Early and Late GPs, we were unable to tell whether such improvements were the result of the communities' participation in the programme; or were simply the results of wider societal or service delivery changes during this period of time.

Still, the design we followed was the best available option given operational limitations, and it provides rigorous quantitative estimates of impact. Furthermore, the services we were interested in are generally known to be improving in Odisha (Kohli *et al.* 2017), but they are not known to be improving at a dramatic rate. Moreover, there were not any other significant supply- or demand-side measures being implemented by government or other agencies in the evaluation area between the baseline and endline. Significant changes experienced in *both* Early and Late GPs with no significant difference between them could then *plausibly* be linked to their participation in the CAN programme, although we cannot formally establish any causal claim through the quantitative evaluation.

With these limitations and caveats in mind, this concluding section brings together the results of Sections 3 and 4 of the report which report, respectively, on the design, outputs/implementation of the programme (Section 3) and our findings on the outcomes we were able to measure (Section 4).

Our findings on the design and implementation are largely positive. SPREAD have clearly shown the ability to put in place a large and complex operation – including the recruitment and management of several hundred staff, and implement the social audit process in a way that was mostly welcomed by those in the communities we surveyed or interviewed: most service providers

and government officials. Operating at this scale and with the political acumen to do so in a way that was well integrated into local democratic institutions and government services (the PRIs, the Palli Sabhas, the Gram Sabhas, as well as securing the participation of local officials of the concerned services) was an immense hurdle that many organisations would have failed to clear without proper thought and experience. This is very positive, albeit a high bar for replicability elsewhere, including at larger or less resource-intensive scales. Even bearing in mind these positive findings, participation rates were not uniformly high. Whether participation rates (at around 23 per cent for the Palli Sabha amongst women and 10 per cent for the Gram Sabha) could have been higher depends a little on one's expectations of poor communities' capacity to spend at least several hours participating in such an exercise. This may be a design question as much as an implementation question. Findings from the evaluation reveal that being busy with work (both women and men), with household chores (women), and being away from the village (men), were reasons cited for non-participation, as well as broader issues of the marginalisation of women.

Taking into account the design limitations and caveats above, our findings on the outcomes we measured are also largely positive. We structured Section 4 along the various parts of the impact pathway and its assumptions that we could measure in terms of the outcomes that were targeted by the CAN programme. We looked firstly at increased knowledge and awareness about NFSA services; then at whether services or satisfaction with those services improved; and then at whether there was evidence of wider empowerment and participation improving via improved use of attempts to raise grievances; participation in village committees; and other aspects of civic life. We also considered changes in IYCF knowledge and practice, and dietary diversity amongst women and children; and food insecurity.

We see positive changes in nearly all these areas, except for IYCF knowledge and practice, and confidence to raise issues with service providers, where we see some negative changes. In some cases, the observed changes were very substantial over the study period but these changes were of the same magnitude in the Early and Late GPs. In these cases, we cannot relate the observed changes to communities' participation in the CAN programme for reasons explained above on the limitations of the evaluation design. However, this includes some examples of very large changes for which we cannot as yet offer alternative explanations. This is true for changes in caregivers' and pregnant women's knowledge of take-home rations; likelihood of children being offered special food after growth monitoring, referral to rehabilitation centres (a relatively small change), and a number of changes in terms of TPDS service provision for primary caregivers and pregnant women.

Areas that we measured and which showed significant difference between Early and Late GPs (results were all higher in Early as compared to Late GPs, suggesting a cumulative impact as the result of exposure) included awareness and knowledge of, and satisfaction with the MAMATA scheme amongst pregnant women, knowledge of entitlements and PDS committees, decreases in having to pay extra money at a ration shop, and increases in Aadhar registration amongst men; enhanced participation in community participation amongst pregnant women, and political participation amongst primary caregivers.

In two areas – increased dietary diversity of both children and women, and VHND awareness and occurrence – we see positive changes in both early and late groups. For dietary diversity, such change is probably primarily related to increased livelihood and income opportunities or changes in food availability over the study period. Yet, we cannot rule out that social audits contributed to this positive change (such a contribution could not be picked out by the quantitative evaluation design).

Finally, there are two areas in which we see outcomes changing in the opposite way to which we would have hoped – the confidence of those surveyed to raise issues with service providers, and in women's IYCF knowledge scores. Our qualitative data help set the first of these findings in perspective – there is some support for the hypothesis that confidence went down (more markedly in late than in early communities) because the social audit had an immediate effect on raising expectations beyond a level that could be met by service providers faced with broader supply-side

or systemic issues. This is a finding which is supported by service provider interviews. Our process data and review of the design sets the second finding in perspective – the social audit process did not prioritise IYCF knowledge, and many of the service improvements were concerned with delivery of hard outputs (THR, PDS, etc.) rather than improving the 'softer' skills and delivery tasks of frontline workers such as AWWs, who have responsibility for nutrition counselling. Wider evidence from India and elsewhere shows that without a concerted, sustained, high-intensity, and well-supported effort to change IYCF knowledge, such changes in knowledge – and certainly practice – will not happen. As this was not a core part of the CAN programme, such changes are therefore not so difficult to understand. There is the possibility, however, that with attention diverted elsewhere, the cumulative greater decrease in knowledge in Early GPs (which we don't see in Late GPs) is something to be avoided and this therefore feeds into one of our primary recommendations, below.

**In summary** and in terms of the original objectives of the evaluation, we *do* see sufficient evidence that the social audit model has the potential to improve delivery and uptake of NFSA services. These service improvements and uptake were not uniformly positive for all target groups, but in some areas, the changes were significant and directly linked to communities' participation in the social audit processes. The social audit did also lead to changes in knowledge, behaviour, and practice at a household level, in terms of participation in the social audit itself and increased desire to participate in aspects of civic life, such as committees related to NFSA delivery. Nutrition and IYCF knowledge, however, did not change. Given that this was not an objective of the evaluation, and would not have been possible given our design and methods, we cannot offer a definitive answer to the question of whether a social audit design can result in changes in maternal and child nutritional status within the context of the delivery of NFSA services in Odisha. However, some of the changes we see are of a magnitude rarely witnessed in terms of the Indian services covered by the NFSA, or local democracy strengthening, whether in terms of knowledge/awareness, participation/empowerment, and service delivery/satisfaction. There is good evidence that SPREAD is well placed to have been implementing this model effectively. As the programme is continuing into its next phase, we make some further recommendations for its ongoing implementation in the final section.

## 5.2 Implications for CAN programme Phase 2 design

- IYCF knowledge more central; AWW (and others') roles in nutrition behaviour change communication (BCC) more central;
- Further operational research and attention to differences in participation rates, particularly amongst women, and more marginalised groups – and to take into account other calls on time (work/household chores, migration);
- Further work to understand why confidence to raise issues declines immediately after SA;
- Further work to build on positive results in terms of knowledge, access, and satisfaction across the services – and willingness to participate in community life/committees.

## 5.3 Longer-term implementation, scalability questions/research

- Different intensities of length of exposure/rate of exposure (how many times/year);
- Different organisational structures – less resource intensive?;
- Increased level of policy engagement with state-level actors through strategic partnerships/networks to address service bottlenecks at district and state level.

# Annex 1 Definitions of variables for quantitative data

| Variables | Definition | Type |
|---|---|---|
| Very satisfied with AWC | Index of satisfaction with the AWC:<br>1= very satisfied<br>0= somewhat satisfied, somewhat dissatisfied, very dissatisfied | (1=yes, 0=no) |
| Very confident, can raise issue on AWC | Index of confidence with the AWC:<br>1= very confident<br>0= somewhat confident, somewhat not confident, not confident | (1=yes, 0=no) |
| Had contact with the AWW | At least one member of the household had contact with the AWW in the last 3 months (endline survey: last month) | (1=yes, 0=no) |
| Received services from AWC or AWW | AWC or AWW provided services or gave assistance to any member of the household in the last 3 months (endline survey: last month) | (1=yes, 0=no) |
| AWC opened on time | The AWC generally opens on time | (1=yes, 0=no) |
| Hours open per day | Average amount of hours that AWC is open daily | continuous |
| AWW comes to the centre daily | The AWWs generally come to the centre daily | (1=yes, 0=no) |
| AWC awareness | Respondent is aware of AWC existence | (1=yes, 0=no) |

| | | |
|---|---|---|
| Has been visited at home by a health worker | Has been visited at home by a health worker in last 3 months (endline survey: within the last month) | (1=yes, 0=no) |
| Aware of MAMATA | Respondent is aware of the MAMATA scheme | (1=yes, 0=no) |
| Registered with MAMATA | Registered with the AWC as part of the MAMATA scheme | (1=yes, 0=no) |
| Very well informed on MAMATA | Respondent feels very well informed about MAMATA:<br>1= very well informed<br>0= quite well informed, not so well informed, not well informed at all | (1=yes, 0=no) |
| Very satisfied with MAMATA | Index of satisfaction with MAMATA:<br>1= very satisfied<br>0= somewhat satisfied, somewhat dissatisfied, very dissatisfied | (1=yes, 0=no) |
| Very confident can raise issue on MAMATA | Index of confidence with MAMATA:<br>1= very confident<br>0= somewhat confident, somewhat not confident, not confident | (1=yes, 0=no) |
| MAMATA knowledge score | Score constructed by the sum of correct answers on knowledge about the MAMATA scheme – respondents are given seven true/false statements about who is entitled to receive benefits of the scheme | score (min=0, max=7) |
| Household has a valid ration card | Household has a valid ration card | (1=yes, 0=no) |
| Household has received info on ration card application | Household has received information in writing about the status of the ration card application | (1=yes, 0=no) |
| Ration shop always provides entitlement | Ration shop always provides with the amount of food that the respondent is entitled to | (1=yes, 0=no) |

| | | |
|---|---|---|
| Ration shop never provides entitlement | Ration shop never provides with the amount of food that the respondent is entitled to | (1=yes, 0=no) |
| Knows PHH entitlement | Respondent knows the correct amount of rice they are entitled to (only for PHH cardholders) | (1=yes, 0=no) |
| Knows AAY entitlement | Respondent knows the correct amount of rice they are entitled to (only for AAY and AY cardholders) | (1=yes, 0=no) |
| Was delivered PHH entitlement | Respondent received the correct amount of rice they are entitled to (only for PHH cardholders) | (1=yes, 0=no) |
| Was delivered AAY entitlement | Respondent received the correct amount of rice they are entitled to (only for AAY and AY cardholders) | (1=yes, 0=no) |
| Had to pay extra money at ration shop | Respondent paid extra money for the grains they were entitled to | (1=yes, 0=no) |
| Household usually consumes TPDS food | Household usually consumes the grains they received | (1=yes, 0=no) |
| Ration shop delivers food monthly | Household receives food once a month | (1=yes, 0=no) |
| Knows there is a PDS committee in GP | Respondent knows that there is a PDS advisory committee in their GP | (1=yes, 0=no) |
| Has been assigned an Aadhar number | Respondent has been assigned and Aadhar number (12-digit unique identity number) | (1=yes, 0=no) |

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|---|---|---|
| Delivery of TPDS was hampered by Aadhar issue | Food grain delivery was withheld because of issues with Aadhar | (1=yes, 0=no) |
| Rice is weighed with electronic scale | Rice was weighed with electronic scale | (1=yes, 0=no) |
| Very well informed about TPDS | Respondent feels very well informed about TPDS:<br>1= very well informed<br>0= quite well informed, not so well informed, not well informed at all | (1=yes, 0=no) |
| Very satisfied with TPDS quantity | Index of satisfaction with the quantity of TPDS:<br>1= very satisfied<br>0= somewhat satisfied, somewhat dissatisfied, very dissatisfied | (1=yes, 0=no) |
| Very confident to raise an issue on TPDS | Index of confidence with TPDS:<br>1= very confident<br>0= somewhat confident, somewhat not confident, not confident | (1=yes, 0=no) |
| Received help with TPDS | Respondent sought/advice regarding access to TPDS | (1=yes, 0=no) |
| Informed about the preparation of THR at least once | Respondent was explained how to prepare THR contents at least once (either during pregnancy, after pregnancy while breastfeeding, while raising a child of 6–12 months old or a child of 12–24 months old) | (1=yes, 0=no) |
| Very well informed about THR | Respondent feels very well informed about THR service:<br>1= very well informed<br>0= quite well informed, not so well informed, not well informed at all | (1=yes, 0=no) |
| Very satisfied about THR | Index of satisfaction with the THR service:<br>1= very satisfied<br>0= somewhat satisfied, somewhat dissatisfied, very dissatisfied | (1=yes, 0=no) |
| Was provided with special food after child measurement | Child was given special food after measurement | (1=yes, 0=no) |

| | | |
|---|---|---|
| Child was referred to rehab centre after measurement | Child was referred to a hospital or a rehabilitation centre after being measured | (1=yes, 0=no) |
| Very well informed on GMP | Respondent feels very well informed about GMP: 1= very well informed 0= quite well informed, not so well informed, not well informed at all | (1=yes, 0=no) |
| Very satisfied with GMP | Index of satisfaction with GMP: 1= very satisfied 0= somewhat satisfied, somewhat dissatisfied, very dissatisfied | (1=yes, 0=no) |
| Very confident, can raise issues on GMP | Index of confidence with GMP: 1= very confident 0= somewhat confident, somewhat not confident, not confident | (1=yes, 0=no) |
| Child's weight has been measured | Child's weight has been measured by the AWW or ASHA either at home or the AWC in the last 3 months (endline survey: in the last month) | (1=yes, 0=no) |
| Community participation index (standardised) | Index on community participation constructed with principal component analysis using the following variables:<br><br>Number of groups/organisations the respondent belongs to, percentage of groups/organisations the respondent belongs to, number of groups/organisations the respondent feels empowered to speak, percentage of groups/organisations the respondent feels empowered to speak, knowledge of the name of the Sarpanch and knowledge of the names of elected officials. | standardised index (mean=0, standard deviation=1) |
| Community engagement index (standardised) | Index on engagement with the community constructed with principal component analysis using the following variables:<br><br>Attending at least one group meeting to discuss nutrition, contribution to group decisions on community monitoring of health and nutrition services, speaking out against problems associated with health and nutrition services and entitlements, taking part in monitoring implementation of health and nutrition services, attendance at Gram Sabha and attendance at Palli Sabha (all of these refer to the last 4 months for the baseline survey and the last month for the endline survey). | standardised index (mean=0, standard deviation=1) |

| | | |
|---|---|---|
| Political participation index (standardised) | Index on political participation constructed with principal component analysis using the following variables:<br><br>independent decision on who to vote for in local elections, willingness to vote in the next local elections and willingness to vote in the next national elections. | standardised index (mean=0, standard deviation=1) |
| Good citizen index (standardised) | Index on the importance of responsibilities of citizens regarding their GP according to the respondents' opinion.<br><br>The index is constructed as a sum of yes (1) or no (0) answers on which of the following are the most important responsibilities: vote in elections, complain when things don't go as they should, make suggestions to government officials, attend meetings, respect the law, pay taxes, and contribute otherwise to public projects. | standardised index (mean=0, standard deviation=1) |
| Good state index (standardised) | Index on the importance of responsibilities of the state with respect to the citizens according to the respondents' opinion.<br><br>The index is constructed as a sum of yes (1) or no (0) answers on which of the following are the most important responsibilities: accept elections outcomes, respond to citizen's complaints, respond to citizen's suggestions, explain the GP's actions to the population, avoid corruption, consult people when taking decisions, and help services run well. | standardised index (mean=0, standard deviation=1) |
| GP effectiveness index (standardised) | Index on the effectiveness of the GP according to the respondents' opinion.<br><br>The index is constructed as a sum of agree (1) or disagree (0) answers on whether the GP responds to citizen's complaints, consults the population, helps services run well, avoids corruption, and explains its actions to the people. | standardised index (mean=0, standard deviation=1) |
| Highly trust teachers | Index of respondents' trust in teachers:<br>1= trust a lot<br>0= somewhat trust, somewhat distrust, distrust a lot | (1=yes, 0=no) |
| Highly trust farmers' association | Index of respondents' trust in farmers' association:<br>1= trust a lot<br>0= somewhat trust, somewhat distrust, distrust a lot | (1=yes, 0=no) |

| Highly trust GP officials | Index of respondents' trust in GP members:<br>1= trust a lot<br>0= somewhat trust, somewhat distrust, distrust a lot | (1=yes, 0=no) |
|---|---|---|
| Highly trust AWW | Index of respondents' trust in AWWs:<br>1= trust a lot<br>0= somewhat trust, somewhat distrust, distrust a lot | (1=yes, 0=no) |
| Child dietary diversity score (7 food groups) | Score of dietary diversity among children constructed as a sum of the following foods consumed the day before the interview: grain, roots, or tubers, beans, legumes, or nuts, dairy products, meat, organ meat, fish, eggs, vitamin A-rich fruits or vegetables, and other fruits or vegetables. | score (min=0, max=7) |
| Child dietary diversity standardised index | Standardised Index of dietary diversity among children constructed as a sum of the following foods consumed the day before the interview: grain, roots, or tubers, beans, legumes, or nuts, dairy products, meat, organ meat, fish, eggs, vitamin A-rich fruits or vegetables, and other fruits or vegetables. | standardised index (mean=0, standard deviation=1) |
| Woman Dietary Diversity Score | Score of dietary diversity among women constructed as a sum of the following foods consumed the day before the interview: foods made from grains, white roots, and tubers, pulses (beans, peas, and lentils), nuts, and seeds, milk and milk products, organ meat, meat, and poultry, fish, and seafood, eggs, dark green leafy vegetables, vitamin A-rich vegetables, roots and tubers, vitamin A-rich fruits, other vegetables, other fruits, condiments and seasonings, insects, and other small protein foods, oils, and fats, savoury, and fried snacks, sweets, sugar-sweetened beverages, other beverages, and foods. | score (min=0, max=15) |
| Woman Dietary Diversity Score (standardised) | Standardised index of dietary diversity among women constructed as a sum of the following foods consumed the day before the interview: foods made from grains, white roots, and tubers, pulses (beans, peas, and lentils), nuts, and seeds, milk and milk products, organ meat, meat, and poultry, fish, and seafood, eggs, dark green leafy vegetables, vitamin A-rich vegetables, roots and tubers, vitamin A-rich fruits, other vegetables, other fruits, condiments and seasonings, insects, and other small protein foods, oils, and fats, savoury, and fried snacks, sweets, sugar-sweetened beverages, other beverages, and foods. | standardised index (mean=0, standard deviation=1) |

| | | |
|---|---|---|
| Food Insecurity Experience Scale | Score of food insecurity experience among the respondents. The score is constructed as the sum of occasions in the last 12 months when, because of lack of money or other resources, the respondent: was worried they would not have enough food to eat, was unable to eat healthy and nutritious food, ate only a few kinds of foods, had to skip a meal, ate less than they thought they should, their household ran out of food, was hungry but did not eat, went without eating for a whole day (endline survey: in the last month). | score (min=0, max=8) |
| Food Insecurity Experience Scale (standardised) | Standardised index of food insecurity experience among the respondents. The score is constructed as the sum of occasions in the last 12 months when, because of lack of money or other resources, the respondent: was worried they would not have enough food to eat, was unable to eat healthy and nutritious food, ate only a few kinds of foods, had to skip a meal, ate less than they thought they should, their household ran out of food, was hungry but did not eat, went without eating for a whole day (endline survey: in the last month). | standardised index (mean=0, standard deviation=1) |
| Nutrition knowledge score | Score on knowledge about nutrition. The score is constructed as the total of correct answers on 14 general questions regarding nutrition. | score (min=0, max=14) |
| Breastfeeding knowledge score | Score on knowledge about breastfeeding. The score is constructed as the total of correct answers on four specific questions regarding breastfeeding knowledge. | score (min=0, max=4) |
| Child-feeding knowledge score | Score on knowledge about child-feeding. The score is constructed as the total of correct answers on three specific questions regarding child feeding knowledge. | score (min=0, max=3) |
| Other nutrition knowledge score | Score on knowledge about other nutrition facts. The score is constructed as the total of correct answers on seven questions regarding general knowledge on nutrition. | score (min=0, max=7) |
| VHND was conducted once | VHND was conducted once in the past 3 months (endline survey: in the last month) | (1=yes, 0=no) |
| VHND awareness | Respondent is aware of VHND | (1=yes, 0=no) |

# Annex 2 Mixed methods analysis approach

| Point along Programme Impact Pathway | Design | Inputs | Outputs | Outcomes | Impacts |
|---|---|---|---|---|---|
| Focus of evaluation assessment | Appropriateness of overall design and approach against original aims/objectives as tool to reduce malnutrition in Odisha | Staff and SS volunteer recruitment, characteristics, and training<br><br>Other resources/ investments required to set up programme<br><br>Targeting and selection individuals/sub-groups<br><br>Targeting of villages/GPs/blocks etc. | Critical SA components /mechanisms<br><br>Quality, coverage, and timings of programme activities undertaken<br><br>Community knowledge of and participation in SA processes (pre, during, and post-audit follow-up)<br><br>Management, governance, monitoring, and transparency of SA process | Knowledge of NFSA entitlements, grievances, etc.<br><br>Access to and uptake of NFSA entitlements for different sub-groups<br><br>Community empowerment and demand for nutrition services and entitlements<br><br>Community/ CBO participation in local governance activities/ decision-making related to food and nutrition, esp. for women<br><br>IYCF/nutrition-related knowledge and practices<br><br>VHND occurrence and awareness<br><br>HH food security/dietary diversity | Behavioural change of adolescent girls<br><br>Institutional accountability for NFSA services<br><br>Nutrition outcomes (e.g. stunting, wasting) particularly for women and young children (not measured directly via evaluation)<br><br>GoO validates social audit as tool to improve nutrition Increased immunisation coverage of <3 yrs |

| Data sources | SA manual SPREAD programme background documents Academic literature | SA manual SS induction training report Other programme documents, monitoring plans etc. Qual IDIs/FGDs | Programme operational documents, monitoring/ MIS data, annual reviews, reports etc. SPREAD MIS data Qual IDIs/ FGDs Quant. survey modules | Quant HH survey modules SPREAD MIS data IDIs/ FGDs with community members | Not measured directly via evaluation given short time frame for impacts to be shown but some hypotheses/assumptions can be drawn based on impact pathway |
|---|---|---|---|---|---|
| Evaluation component | Process evaluation | Process evaluation Qualitative evaluation Quant survey | Process evaluation Qualitative evaluation Quant. survey | Quant. survey Qualitative evaluation | |
| Final report section | Section 3.1 | Section 3.2–3.4 | Section 3.4–3.6 | Section 4 | n/a |

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