GRANT EVALUATION REPORT ON

“PADA PUSHTI KARYAKRAM”

A project implemented by APPI Partner Shikshasandhan
In Muniguda Block, Rayagada District, Odisha
(2018-2021)

Submitted to Azim Premji Philanthropic Initiatives

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1.1 *The Context*

Government of Odisha has been consistently making efforts towards improving the nutritional well-being of all women and children in the state. Integrated Child Development Services (ICDS) scheme implemented through a network on 72000 Anganwadi Centres in the state is the key platform through which nutrition services are provided to 7.2 lakhs pregnant and lactating women, 18.47 lakh children in the age group of 6 months-3 years and around 20 lakh children in pre-school category of 3-6 years. ICDS was launched in 1975 in 33 priority blocks only. In the initial years it started with limited population coverage and gradually expanded to all states and union territories. In 2006, Supreme Court of India ordered for "universalization of ICDS" in the sense that ICDS services should be extended to all children below 6 years, pregnant women, lactating mothers and adolescent girls. Government of India has declared ICDS as a programme for universal coverage and therefore, inclusion of all eligible women, children and adolescent girls is of paramount importance. The Women & Child Development and Mission Shakti Department, Government of Odisha has adopted a new strategy called Strategy for Odisha's Pathway to Accelerated Nutrition (SOPAN). It comprises of a bouquet of well-defined and focused interventions with a problem-solving approach. They key features of this strategy are:

1) Focus on nutritionally vulnerable geographies. 125 blocks in 22 Districts.
2) Well-defined pathways to change for each category of population. Ex. One Full Meal for Maternal Nutrition, Crèches for children below 3 years, PadaPustiKaryakram for hard-to-reach areas, Special package for adolescent girls
3) Issue-specific solutions. Ex. Fortification of THR.
4) Strengthen community participation
5) Use of technology to measure progress and improve efficiency.

1.2 *Malnourishment in Rayagada District*[1]

NFHS-4,2015-16 data for Rayagada District show how serious the issue of malnourishment in this district is.

Total children age 6-23 months receiving an adequate diet 10.8 %
Children under 5 years who are stunted (height-for-age) 46.5 %
Children under 5 years who are wasted (weight-for-height) 23.3%.

[1] http://rchiips.org/nfhs/FCTS/OR/OR_FactSheet_396_Rayagada.pdf

Children under 5 years who are severely wasted (weight-for-height) 5.86 %
Children under 5 years who are underweight (weight-for-age) - 44.4%

Hence it is important to accelerate and strengthen the nutrition programme, especially in the tagged villages where the AWC services have not been reaching. It should be noted that this district has a ST[2] population of 55.76%, and in Muniguda block, 33%. With the tribal communities living in hamlets situated in very difficult geographies, and extremely low access to entitlements like those provided through AWCs, the nutritional situation of tribal children can be expected to be very precarious.

Sikshasandhanis a Bhubaneswar-based non-governmental organisation (NGO), registered as a society. Sikshasandhan (SS) was established as a resource centre for education in Odisha, India in the year 1995. Sikshasandhan believes that education is a vital tool in the process of empowerment of the poor and under-privileged sections of society. It also believes that schooling in its present form excludes children of these sections of society. Education in its present form does not help children to acquire a sense of confidence in life, which is essential for enabling them to lead a life of dignity. Sikshasandhan, therefore, started working with children of tribal communities to understand educational requirements of these communities. A resource centre was set up in order to develop further the theoretical understanding of issues through practical applications. Its operational areas include Muniguda Block of Rayagada district (for the ongoing PPK project) and three blocks of Mayurbhanj district, namely Kaptipada, Moroda, Suliapada (Educational and other projects).

2. The PadaPushtiKaryakram (PPK)

2.1 *The Programme*

Pada Pusti Karyakram[3] is a special programme to provide nutrition services in remote and hard-to-reach hamlets which do not have Anganwadi Centers and/or located far away from main Anganwadi Centers. Spot Feeding of Morning Snacks and Hot Cooked Meal to children aged 3-6 years is provided in a decentralised manner through community participation. Mother Groups voluntarily cook and feed children in the hamlet itself. Growth monitoring of children is done once a month in the hamlet with active participation of mothers.

“Tagged villages” of Anganwadis are mostly geographically isolated, having natural barriers that restrict women and children from going to AWC, hard to reach with no fair-weather roads, lack of resources and

[2]NFHS data was not traceable for the ST communities of Rayagada district in general and for Muniguda Block in particular
[3]Draft guideline on PPK for WCD (APPI)

available livelihood options forced the people to live in a condition of poverty and widespread malnutrition. Most of the tagged villages are not connected either with mobile network or electricity. Most of such villages are inhabited by the tribal communities. The difficult geography and low connectivity also prevents these communities from accessing rights and entitlements for human development. The people residing in these hamlets (tagged villages), commonly known as “pada”, have been found to have a serious nutritional deficit, and hence need the SNP more than their counterparts in the village where AWC is situated.

The programme was piloted in 120 hamlets of Muniguda blocks of Rayagada district as a prototype, by a joint team of Azim Premji Philanthropic Initiatives and partner Shikshasandhan.Nutrition has been a first-time initiative for SS; together APPI and SS developed a strategy to reach out to the remote hamlets situated in difficult geographies of the tribal areas of Muniguda block.

2.2 *The historical evolution of the PPK project partnership between SS and APPI*

In 2017, team members of APPI spent two months in the remote block of Muniguda in Odisha. Over this period, the team went from village to village, to understand the state of the children in one of the most backward blocks of Odisha. While the state of the children troubled the team, they also came across little pockets of excellence. On enquiring, they found one common thread running through the well-functioning AnganWadi Centres. They were being assisted in their functioning by Volunteers employed and guided by ShikshaSandhan. The APPI team went on to meet the ShikshaSandhan team and asked them if they would be willing to work with APPI to do more of this work.

The initial discussions between APPI and ShikshaSandhan led to the evolution of the broad contours of the programme. ShikshaSandhan came in as an organisation focused on education that also worked on nutrition. Given, the clear focus of APPI on nutrition, the proposal from ShikshaSandhan was designed to have a core of 100 Nutrition Volunteers called ‘Nutrition Didis’. These women would have worked in 100 villages with focus on enhancing the functioning of the AWCs as well as being a multipurpose worker on ensuring nutrition related entitlements for children and the population in general.

The proposal was approved for a period of 15 months, with an interesting Prototype Phase of three months. The prototype phase was full of discussions within the ShikshaSandhan Team, the ShikshaSandhan Team and the APPI Team, as well as the wider stakeholders. Over this period, the project began to take a new shape that has been the approach of the

work since then. Instead of focusing on improving AWCs per se, it was decided that the project shall focus on the distant habitations under given AWCs from where children in the 3 years to 6 years age group were not able to reach the AWCs for getting the full gamut of services available for them under the ICDS. The initial focus was on the children aged 3 to 6years . But the disadvantages of being from a distant habitation also applied to children between 6 months to 3 years, pregnant and lactating women, infants below 6 months and adolescent girls.

In the year 2018, Sikshasandhan received a 15 months grant from Azim Prem ji Philanthropic Initiatives to pilot and prototype a project on improving nutritional status of children in remote villages of Muniguda Block of Rayagada district in Odisha. Duration of the grant was June 2018-Aug 2019. Thereafter, the project has received 3 successive no-cost extensions:
1st no-cost extension period: Sept 2019 to Feb 2020 (6 months)
2nd no-cost extension period: March to May 2020 (3 months)
3rd no-cost extension period: June to November 2020 (6 months).
4th no-cost extension from December 2020 to April 2021
In order to consider continuing the project beyond March 2021, a third-party evaluation/assessment was required for a fresh renewal. The current evaluation was commissioned in this context.

3. The Process of Grant Evaluation

The Grant Evaluation process was undertaken through a combination of (i) perusal of all documents pertaining to the project such as the project proposal, Results Framework, Budgets, Narrative and Financial Reports and compiled data (ii) Interviews and meetings with the APPI (local) team, the Director and Central team of SS (ii) field visits to PPK villages for interaction with the primary stakeholders – the mothers, observation of spot-feeding in some villages and (iv) Interviews and meetings with ICDS staff (AWW and LS) and senior officers such as the CDPO of Muniguda Block and the DSWO of Rayagada District. The Schedule of meetings with key government functionaries is given in Annexure - 1

The Results Framework had changed drastically during the prototype development phase. The very first objective, definitely, was to develop a prototype during the first 3-month phase and finalize the project design for the remaining project duration. This also implied that a revised RF should have been in place, with all the changed objectives, outcomes, activities, outputs and indicators documented. However this did not happen; and hence the evaluation depended heavily on reconstructing the outcomes discernible in the reports, our interactions with the team and our observations; culled out for the purpose of this evaluation. Hence this evaluation could not follow a linear process of comparing the outputs and outcomes with the RF that was provided to the Consultant.

4. Outcome-wise findings and Observations

4.1 *The Original Objectives and Outcomes of the PPK Project (Ref: Annexure 2)*

Objectives

Enhanced outreach coverage of community service providers intended for improving the nutrition quotient of people by Capacity Building of the primary stakeholders with respect to nutrition.

1. To bring in behavioural change among mothers (Pregnant, lactating, IYCF) and family members of children with respect to healthy practices that are key to improvement of nutrition level in children.
2. To improve access to sources of nutritious food available through various institutional channels.

Planned Outcomes

i. Final Design of the intervention to be ready based on the learning from the prototype
ii. Increase in human resources deployed for supporting community health nutrition.
iii. Knowledge level of a community member i.e. Nutrition Didi with respect to nutrition and its importance has increased by at least two times.
iv. Knowledge level of AWWs, supervisors and CDPO on the nutrition didi and their acceptance towards Nutrition didi has increased 50%.
v. The nutrition quotient of mothers has increased by 25%.
vi. All left out mothers of the houses that the Nutrition Didi visited are tracked and registered if not registered.
vii. 10% of the mothers have adopted the healthy nutritional practices in their daily life.
viii. Knowledge level of mothers with respect to nutrition related entitlements of people has increased 50%, increased number of THR beneficiary

4.2 *The Changed Results Framework*

The outcomes conceived in the RF of the project had changed during the prototype development phase – the first 4 months from June to September. The prototype development (although not documented) was more or less complete by October 2018; the Nutrition Didi (ND) concept was not going to be pursued; instead the project was going to be implemented by a much smaller team of supervisors reaching out to the remote hamlets in a phased manner. (This phasing is visible in the chart given in Annexure - 3)

As per the chronology of phasing we see that from June to November 2018 PPK spot-feeding is launched in 15 villages; by May 2019, 10 more villages are added, taking the total number of villages to 25. From June to November 2019, with the addition of 37 villages the number of PPK villages rises to 62. From December 2019 to May 2020, we find 46 more

villages being added to the list, with the total number now at 108. The total number of PPK villages stabilizes at the final tally of 120 by the beginning of 2021.

The interventions envisaged in the new prototype that emerged may be described as follows:

1. Awareness building and community mobilization resulting in joint cooking by mothers of children in the 3 to 6 year age group for children in that age group and the children eat together at one place in the village (spot-feeding).
2. Mothers become well-informed and capable of collecting their entitled ration from the AWC
3. Regular visits of such habitations by the Project Staff to help through monitoring and handholding.
4. An intense and positive partnership between the project team, the mothers and the individual AnganWadi Workers - Coordinated work between the Anganwadi Workers, their Supervisors and higher-level staff, the mothers, and the staff of the project;
5. Needless to say, this required many consultations with higher level Government Officials including the District Collector as well as a series of consultations with AWWs and Mothers resulting in a broad consensus and collaboration among all stakeholders

4.3 *Limited Assessment of achievement of outcomes based on the original Outcomes*

Nevertheless, an effort is made below to outline the achievements even based on the original outcomes without referring to the original indicators:

Planned outcome 1:

“Final Design of the intervention to be ready based on the learnings from the prototype”.

Although not defined explicitly in the reports, this outcome has been achieved as visible in the functioning model of PPK that is operational in 120 villages of Muniguda block. (as outlined above)

Planned outcome 2:

“Increase in human resources deployed for supporting community health nutrition”

There has been an increase in the human resources deployed – in terms of 9 supervisors and 16PustiSathis trained and capacitated through a series of capacity building programmes. (Annexure 4). (Towards the time of evaluation 9 PushtiSathis are still serving in the project). Although the initial RF aimed at 100 Nutrition Didis, in the prototype that was developed it was a team of supervisors each one implementing PPK in 7-8

villages. In addition there were the mothers' committees that ensured that the THR was collected, taken to the hamlet, stored safely and nutrition provided to the eligible children through cooking hot meals and spot-feeding them regularly.

In our interactions with the mother's committees in 10 villages, we found that at least 2-3 mothers were articulate in explaining how and why they initiated PPK in their villages, and how they are currently implementing PPK through the regular provision of hot cooked meals. All of them were fully aware of the nutritional requirements of their children. The average number of the children being served by PPK is about 6.4 per village. This would mean approximately 6 mothers per village. If we were to take these 10 villages as a sample, we could safely conclude that 30%- 50% of the mothers were perceptibly aware and articulate of the PPK and its benefits. If we were to extrapolate this to all the villages where PPK is functioning well (97 villages as per our performance scoring exercise which is presented further on in this report), the number of mothers that are anchoring this PPK could be at least {(97 x 3)} 291 mothers. Hence there definitely have been a significant increase in the human resources supporting community health nutrition.

Planned outcome 3

Knowledge level of Nutrition Didi with respect to nutrition and its importance has increased two times

Replacing the ND with Supervisors and the active mothers in the above outcome, going by the effective implementation of PPK in more than 97 out of the 120, we could safely conclude that this is possible only through enhanced knowledge of the supervisor-PushtiSaathis-active mothers' team. However in the absence of indicators that could be quantified it would be difficult to ascertain what the quantitative measure of increase of knowledge would have been achieved by them. We can only base our conclusion on our interactions in the 10 villages we visited.

Planned outcome 4

Knowledge level of AWWs, supervisors and CDPO on the nutrition didi and their acceptance towards Nutrition didi has increased 50%.

As the ND was no longer a part of the new prototype, this outcome is no longer relevant. But the acceptance of the PPK team by the AWWs, Supervisors and the CDPO, while being the most important factor in ensuring the success of PPK, it has been visible in AWW collaboration with the team and the mothers, as it emerged in the sector meetings and village visits of the evaluation team. The "support of the AWWs' has been the most highly rated by the team for most of the villages as per the performance score given in the next section below.

Planned outcome 5

Increased nutrition quotient (maternal and child health & nutrition) of mothers by 25%

There is no baseline available to assess the measure of enhancement of the said nutrition quotient. We can only safely say that all the eligible children, pregnant and lactating women in 97 out of the 120 hamlets covered are regularly obtaining the supplementary nutrition they are eligible for by ICDS standards, adequately and regularly; as borne out by the performance assessment by the team for all villages, and interactions with the mother's committees in 10 villages, and the records entered in the PPK passbooks that the mothers have for the THR they received.

Planned outcome 6

All mothers those are left out of registration of the houses that the Nutrition Didi visited are tracked

This outcome has definitely been achieved and the records are available both with the PPK team and the AWCs. Only that the supervisors along with the AWWs have done this instead of the Nutrition Didis.

Planned outcome 7

The mothers have adopted the healthy nutritional practices in their daily life

The fact that all the mothers in at least 97 out of the 120 PPK villages are implementing PPK (spot feeding of HCM) as borne out through our interactions with mothers' committees and AWWs, is adequate indication that the mothers have comprehended the need for healthy nutrition and are practising it. In addition the mothers also insist on hand-washing by the children before having food.

Planned outcome 8

Knowledge level of mothers with respect to nutrition related entitlements of people has increased 50%, increased number of THR beneficiary

The fact that at least in 97 of the 120 villages the mothers have been taking home the rations (THR) and have organized themselves to take turns to cook HCM and spot-feed the eligible children clearly indicates knowledge of nutritional entitlements. The THR beneficiaries also are almost 100% now for those (97) villages in which PPK is functioning effectively. The number of THR beneficiaries also has increased as can be seen in Annexure –8. This has to be compared with the initial (pre-PPK) context in which the mothers were just not aware of and accessing nutritional entitlements.

4.4 *The Performance Assessment Exercise based on scoring Key (Performance) Parameters (Ref Annexure 5)*

In the absence of a revised RF, benchmark data and revised output and outcome indicators to go by, the consultant proposed to undertake an exercise to assess the performance of the project through key parameters. The key parameters were developed collectively by the team based on their experience and knowledge of the programme. The PPK team, facilitated by the Consultant, undertook an exercise of scoring the performance of the project in each of the 120 hamlets that they were working in. The parameters on which the performance of PPK was scored in any village were:

(i) Support of the AWWs
(ii) Community Participation
(iii) Capacity of the mothers' group
(iv) Ownership of the mothers' group
(v) Timely allocation of ration
(vi) Adequacy of the quantity of ration
(vii) Regularity of spot-feeding

Each parameter would be assessed and assigned to one of the following performance category and assigned scores:

Excellent – 5, Good – 4, Average – 3, Fair – 2, Poor – 1

The scores for all parameters for each village were aggregated by simple addition to arrive at a composite score, and the following broad consolidated performance categories were arrived at: .

Fair and Poor (0-20), Average (21-26), Good and Excellent (28 – 35)

The team considered each village and discussed at length the performance of PPK on each of the parameters and collectively arrived at the score for each village. The score-sheet and analysis can be seen in Annexure (5)

The main outcomes of the programme that can be discerned from the performance analysis, reports and interactions are as follows:

The PPK has been established as a workable, functioning, effective model in 97 of the 120 i.e. 81% of the project villages, with all the eligible children in 120 villages being provided the nutritional entitlements prescribed by ICDS, and 148 pregnant and 166lactating women in 108 villages receiving the nutrition entitlements (THR) due to them from AWC/ICDS.

As per the performance scores that were given by the team to the 120 villages, out of the 97 villages where PPK has been established and functional, 24 villages (20%) fall in the categories good and excellent, while 73 villages (61%) fall in the 'average category'. Only 16 villages (13%) were seen to be in the 'fair' and 'poor' performance categories.

Leaving out 7 villages which are new where PPK had just started after the lockdown, we can conclude that in 97 villages the performance on all parameters was ‘average’ and ‘above’.
Analysis of the average score for each parameter across villages also corroborate these findings.

- We may consider “Timely Allocation of Ration”, “Regularity of Feeding” and “Full Quantity of Ration” as the key operational parameters that indicate whether the project is serving its purpose. In these parameters, the averages are more than satisfactory with the scores being 3.6, 3.5 and 3.7 respectively.
- Considering 5 as the highest score (Excellent), theseaverages would correspond to 71% performance in Timely Allocation of Ration, 69% performance in ensuring full quantity of ration being supplied to the beneficiaries and 73% performance in Regularity of Feeding.
- “Community Participation”, “Capacity of Mothers” and “Ownership of Mothers” can be seen as parameters the constitute the ‘soft’ interventions that influence project effectiveness which leads to “Timely Allocation of Ration”, “Regularity of Feeding” and “Full Quantity of Ration”. In these soft parameters too, the averages are quite good. In “Support of AWW” the performance score is 73.5%, in Community Participation it is 67.50%, in Capacity of Mothers it is 64.60% and in Ownership of Mothers, 66.67%.
- An analysis of the scores of the low performing (16) villages, that form 30% of the entire list of PPK villages show some interesting patterns:
  - Those villages that had the lowest composite performance scores were low on the parameters “Support of AWW” viz. “Community Participation”, “Capacity of Mothers” and “Ownership of Mothers”. 47,5% of the villages scored low on the parameter “Support from AWW”, while 62.5% of the 16 villages scored the lowest in the other 3 soft parameters.
  - These soft parameters can be considered as the causative factors for low scores for the operational parameters – “Timely Allocation of Ration”, “Quantity of Ration” and “Regularity of Ration”. In the operational parameters, we can see that for 62.5% of the 16 villages with the lowest composite score, score low on “Regularity of Rations”. While 37.5% of the villages with the lowest composite score are score low on “Timely Allocation of Ration” and the “Quantity of Ration”.
  - It is clear that in order to improve the situation in these 16 villages, attention has to be given to strengthen the parameters “Community Participation”, “Capacity of Mothers” and “Ownership of Mothers” and “Support of AWW”.

4.5 *Evidence of Achievement of Project Objectives based on Perusal of Reports and Interactions with the stakeholders and the PPK team*

The reports and interactions with the PPK stakeholders (project team and PushtiSathis, mothers and ICDS staff) has provided a grounded perspective on the development of the PPK project and its achievements.

The formal collaboration between APPI and the Government of Odisha on Nutrition certainly forms that backdrop of the PPK. (Annexure-1-ONAP)As soon as the prototype was developed, it emerged as a best practice particularly at the District level, with the District Collector accepting PPK as an effective model to be implemented across Muniguda Block. (Annexure-1) This was the most significant move towards the mainstreaming of PPK. Some of the key interventions that has contributed to the effectiveness of the PPK are delineated below:

i. The last mile delivery of AW services in distant and remote hamlets was sought to be addressed through PPK in Muniguda block. This was made possible through a series of consultations with the administration (Annexure-1)

ii. The consultation and training on PPK with 60 AWWs and 6 supervisors from 6 sectors was a significant event that helped launch the PPK. The effectiveness of this intervention has led to the successful implementation of PPK.

   The 'Support of AWW' is the parameter that shows the highest performance score in the performance assessment exercise that was undertaken. This bears testimony to the fact that the capacity building and orientation of the AWWs and the engagement with the District and Block level authorities of the ICDS were effective.

iii. The initial Design Thinking Workshop and the immersion visits and capacity building workshopfor the PPK team, AWWs and Supervisorsfacilitated the emergence of the new prototype called the PPK. Regular consultations with the mothers, PRI membres and many more training events as listed in Annexure-6 led to the enhancement ofthe competence the PPK team and the mothers' groups in each village. This level of competence was visible to the evaluators through interactions with the team, the mothers and the AWWs; as reflected in their highly grounded perspective of the community, their rapport with the mothers and the AWW. The fact that the PPK team was almost every day in the villages at work, engaging with the communities and mobilizing has been most potent educational experience for the PPK team and all the primary stakeholders.

iv. Through community interaction and consultations at the Panchayat level the team was able to reach out to over 430 mothers and 170 village heads. (Annexure – 6)

4.6 *Observations from the village visits and interactions with mothers and community leaders*

The villages to be visited by the consultant were selected to be representative of some of the best, average and low performing villages. We visited the following villages (dates):

1. Tobhapadar
2. Kujing
3. Turukupa
4. Panchubai
5. Uppar Selma
6. Solagudi
7. Kathabadi
8. Kanedipadar
9. Sunakhunti
10. Gurugaon
11. Patrani
12. Kebdatula
13. Jadigaon
14. Kutrughati

And the following AWCs also:

1. Kinam
2. Niali
3. Kalikolath
4. Ambadola
5. Tulasipadar
6. Amlabhata
7. Pediguda

The objectives of the visit were (i) to understand the difficult geography of the remote hamlets, the poverty situation and the resultant challenges faced by the community in accessing nutrition from the AWC. (ii) to interact with the mothers and community leaders regarding PPK and their understanding about it and the manner in which they implement PPK (iii) to get a sense of the effectiveness of PPK from the primary stakeholders.

Difficult geography of the remote hamlets

Most of the hamlets were quite remote and difficult to access, because of poor roads and distance from the main GP or the village where the AWC is situated. After a point some villages were accessible only by foot or two-wheelers. Many of the hamlets were forest villages and would be cut off during the monsoon with absolutely no connectivity due to overflowing streams. Moreover mobile connectivity in many villages also is extremely poor. Most of the houses were kutcha and thatched; still not electrified.

Precarious livelihood situation

The livelihood situation looked very bleak. Most people do not have much land, and engaged mostly in jhoom cultivation of ragi, cotton, corn, kandul

dal etc. All the households received their quota of rice from the PDS. Always short of cash, they also barter ragi, corn or kandul dal for other requirements. All households supplement their income by working as casual wage labourers or in MGNREGS whenever available. Non-timber forest produce is another source of meagre income. In some forest villages charcoal production was one source of income, selling the charcoal in the weekly hat. Many youth we met in the villages had migrated to other districts and states for work at many points of time, Kerala being one of the preferred destinations.

Inadequate diet and nutritional deficit

Leafy vegetables and tubers from the forest along with ragi porridge and rice from PDS seem to be the normal diet. A rare meal with chicken or pork curry (only in some villages though) seemed to be the only time they had some substantial protein content in their diet. In all the villages we visited the women narrated how their children had only the highly inadequate and limited diet as mentioned above. They were not aware of the supplementary nutrition being provided through the AWC, although many of them knew that the children from the villages nearby the AWC went there and received hot cooked meals and the THR. Before PPK commenced their children's names were not registered, , and they did not receive their THR nor did their children get HCM as they could not go to the AWC; and they never knew that there were nutritional entitlements for the children and pregnant & lactating women. Although there is no bench mark, the women did convey unambiguously in our meetings that prior to the launch of the PPK infants used to be malnourished, underweight and sickly.

Awareness and Ownership of PPK in the community

There was a common thread in what the women mentioned in all villages. The people from the organization (SS-APPI) had held many meetings in their village and explained the importance of nutrition, the kind of nutrition required for their children's physical and mental growth and development, and how the government makes it available to all the children through the AWCs, in the form of nutritious snacks, THR and HCM. They also described the process in which they implemented the PPK in their hamlet. They would go to the AWC every week and collect the THR including eggs from the AWW. They then took turns to cook and spot feed the HCM to the children of the eligible age group. When asked about the other children who would also be present during the spot feeding, the mothers did admit that even they had to be given some of it; they too were their own children. But by and large, the children of the targeted age group received their share adequately.

Asked about the difficulties they face, the mothers said that storage of THR, including eggs was a problem as they did not have adequate storage facilities, particularly to protect their stock from rodents and moisture. They also said that since they did not have adequately large cooking utensils, hence having to use more vessels to cook for all the children.

In most villages except for a few, most mothers were not aware of all the other entitlements provided through the AWC, such as the special nutrition for adolescent girls, referral services and pre-school education. But most of them were aware of the VHND as the SS team members would take them to the AWC on the VHND to get their children weighed. They knew clearly about the implication of weight and knew the meaning of being in the orange and red zones that indicated under-nutrition, also knew that yellow also was not good enough, and that children had to be in the green zone to be considered healthy.

In all the villages we visited, we found only 2-3 malnourished children, but all of them had already been identified categorized into the respective malnourishment categories by the AWW and ameliorative action in terms of special diets and referral for rehabilitation initiated. This indicated a measure of alertness regarding the nutritional status so that immediate ameliorative action could be taken.

The striking contrast

Our visit to Jharni, and remote forest hamlet in Raghuvari GP was a lesson in contrast. The PPK had been initiated only since 2 months in this village; and one could see almost all infants malnourished and sickly. All women that were present were visibly anaemic, weak and not in good health; weakened by backbreaking work collecting firewood, tubers and minor produce from the forests. No visits by the AWW or ANMs for months on end. From the 7-8 women and their children who were present in the meeting, it was clear that there were recurrent deliveries without spacing; and all were non-institutional deliveries, with no pre or post natal care or nourishment of any sort. Deliveries were being done by a traditional mid-wife with no additional training.

Our inquiry into their food stocks revealed a very worrying situation. Nobody had stocks of grain that could help them survive for more than a month or two. PDS seemed to be the only source of food security; along with what they could manage to gather from the forests around. Still most households did not receive sufficient PDS quota due to non-registration of many members of each households; and in many cases faced delay due to non-linking of their ration cards with Adhaar.

The present condition of this village was the condition of most other hamlets that have been selected under the PPK. The present situation after the launch of PPK in those hamlets indicates how PPK has

transformed the nutritional situation of the children and the women, and the general well-being in the village by linking them to the AWC. In a way PPK has been a window opened to the public entitlements for human development.

With the commencement of PPK, the malnourished children have been identified recently, categorized into the red and yellow zones as may be the case, and the process of rehabilitation has started through special diets.

Pre-school/ECCE

ECCE being the forte of Shikshasandhan, the ECCE centres established in about 25 PPK hamlets reflected their years of expertise in education. The most important contribution of SS in this project has been the rendering of the NuaArunima pre-school learning material into the local tribal language, Kui. We could see the joyful learning pedagogy in operation by the trained volunteers (the PushtiSathis themselves) using the improvised the workbooks for children, made of long-lasting card-thick pages; and many toys and material made out of locally available material.

The initial priority of PPK was rightly on ensuring that nutritional entitlements reach the children in the hamlets. As the PPK started becoming effective in the majority of the villages by 2020, Shikshasandhan initiated ECCEs in 25 hamlets. The difference it made to the children going to the ECCE (although it was just one or two days a week) as compared to the non-ECCE villages was remarkable. They were smarter, lively, showed tremendous joy in the ECCE centres and could be seen engrossed in the various joyful and fun activities that they were given.

4.7 *The Summary of outcomes*

i. The PPK project has been able to develop a prototype of enabling AWs to reach out to remote hamlets in their survey areas and ensure access of nutrition entitlements as envisaged by the ICDS – spot feeding of the eligible children with hot cooked meals.
   The PPK has been established as a functioning model in 97 of the 120 i.e. 81% of the project villages, with all the eligible children being provided the nutritional entitlements prescribed by ICDS, and pregnant and lactating women receiving the nutrition entitlements due to them from AW/ICDS.
ii. The PPK prototype comprises a 3-pronged community engagement strategy to (i) identify and include in the AW list, the children and pregnant/lactating women who still did not have access to the nutrition entitlements provided through the AW-ICDS, (ii) build awareness in the

community, especially the mothers, regarding the importance of age appropriate as well as pregnancy/lactation related nutrition and the respective ICDS entitlements, and (iii) organize and mobilize the mothers' committees to access those THR entitlements and ensure spot-feeding of hot cooked meals along with eggs exclusively to the eligible children.

iii. Mainstreaming of the PPK in Muniguda Block and as a recommended best practice in the entire district of Rayagada for similar difficult geographies where nutritional entitlements are under-accessed.

iv. This project also, beginning mid-2020, has demonstrated a workable model of ECCE using the NuaArunima in 25 of of the 120 villages over a short period of about 8 months. This has been the forte of the partner Shikshasandhan, and the rendering of the Arunima learning material into Kui (local tribal language) along with commensurate training to the Mother's group, PushtiSaathis or volunteers of the village to engage the children in a space available in the village

v. Developing Nutrigardens as a community-based solution to improve nutritional deficit, particularly of micro-nutrients has been experimented with success in many villages

4.8 *Reasons of achievement/ non-achievement of the main outcomes*

The result framework had changed based on the exigencies at the field level. The 'nutrition didis' were not recruited. This is because there was an apprehension that eventually it would make it difficult for the programme to be mainstreamed. The government would not be inclined to take on any additional liability into the AW structure. As a result the entire project was to be implemented by a team comprising of Supervisors from the local area, taking care of 10-15 hamlets and later on, PushtiSaathis that would work directly at a hamlet level. The PushtiSaathis would ideally be a person from the hamlets, from the tribal community, speaking the tribal language.

4.9 *Non-intended outcomes*

The process of community organization and the presence of facilitators from civil society (SS) has not limited the interventions to just the project deliverables in PPK. As expected of any genuine community organization process that raised critical awareness and mobilizes the community for positive collective action, in the project villages too, a number of instances of collective and individual grievance redressal have been recorded. Such demands and redress grievances have been wide ranging

such as laying roads to remote hamlets, providing solar drinking water facility, collective request to open closed schools or to sanction new schools in the villages, medical services to children in critical conditions, collective and individual applications for documents like Adhaar card, bank pass books and death certificates required for accessing entitlements and their spot issue by the respective officers, and applications for securing titles of landholdings being cultivated. (Annexure-7)

4.10 *Awareness of the implementation team regarding the Results Framework*

The revised RF not having been documented, the leadership have effectively oriented the implementation team on its mandate and plan through meetings and workshops. Hence the team has been found to be aware of what they are expected to do which drives their action in the villages – identification of the AWC-excluded children and women in the hamlets, inclusion in the list, building awareness among mothers and community leaders regarding nutritional entitlements, coordinate with the AWWs for the implementation of PPK, mobilizing the mothers to collect THR from the AWC and take turns to do the cooking and serving of HCM to the eligible children, and mobilize mothers to take their children to the VHND. The team members have been meticulously engaged in these tasks, resulting in effective implementation in the vast majority of the villages. The effectiveness of PPK establishes this fact, so also the meetings that the evaluation team had with them in the process of the grant evaluation where they articulated their perspective and their vision for the project.

They have a reporting structure, with the supervisors and PushtiSathis reporting to the Project Coordinator, with the APPI local team working shoulder to shoulder with them, providing critical inputs and managing the interface with the government. There are regular meetings to monitor their progress.

5. Implementation Strategy

5.1 *Comparison of strategies*

There were significant changes in the implementation strategy of the PPK project. The following table gives a comparison of the activities envisaged in the initial project and the actual activities undertaken after prototype development. (Ref.Annexure-2)

Activities planned in the Original Project	**Activities actually implemented after the new prototype was developed.**
Complete a Revised Results Framework as per the final design arrived through prototyping phase	The Prototype was developed but the a revised Results Framework was not developed in writing
Recruitement of Nutrition Didi	Recruitment of Supervisors – the PPK Team, and PushtiSathis, later on
Capacity Building of Nutrition Didi	Capacity Building of the PPK front line team – The supervisors and PushtiSathis, and the mothers
Orientation Programme for ICDS	Meetings with the District Collector, DSWO, CDPO, LS and AWWs Orientation of the AWWs to PPK Orientation of PRI elected representatives to PPK, and their role in monitoring it and ensuring nutritional security
Home visit and counselling of mothers by Nutrition Didi	Home visit and counselling of mothers by Supervisors and PushtiSaathis
Nutrition Mela	
Verification of eligible beneficiaries and Counselling by Nutrition Didi on their institutional entitlements during home visits	Visits and consultations with the Community and the mothers to identify all eligible children, and pregnant and lactating mothers who are not in the AWC list and ensuring that they are included. Regular community level meetings with the mothers to raise awareness regarding the nutritional entitlements for the children and mothers.
VHND session, discussion on THR supply	The supervisors and the PushtiSathis mobilize the women every month to go to the AWC every months on VHND to get themselves weighed and checked up.

The two strategies were different. At this time it would be difficult to compare the two strategies, as the first strategy that was anchored on the concept of the 'Nutrition Didi' was not really tried out. The ND strategy revolved around 100 local women who would have been trained to act as an awareness builder, an educator who would bring about a clear understanding of the importance of adequate nutrition for the children, pregnant and lactating women; and a mobilizer who would ensure that the mothers, driven by their awareness would take the children to the AWC to access their nutritional entitlements, Needless to say, this would also facilitate access to all other services offered by the AWC, especially pre-school education (ECCE). This conception was certainly modelled on Shikshasandhan's earlier ECCE project wherein a volunteer would be present in all selected villages, providing education to the children in the 3-6 age group. The ND being a local woman (most likely to be a tribal from the same villages) would have the tremendous potential of being a bridge connecting the AWC and the community (children, pregnant/lactating women and adolescent girls) from the remote hamlets.
The new approach to work also led to change in the nature of staffing. The new prototype did not envisage a strategy anchored by tribal women. The new staff need was more for people who could do a lot of logistics and handholding/monitoring work spread over many habitations; and with the ability to coordinate with the public systems and government personnel. While it would probably have been possible to recruit women for most such work, the move away from the idea of the *Nutrition Didi* led to reduced focus on recruiting female staff. This resulted in a highly male dominated team. The team has indeed been able to transcend its disadvantages to a great extent.

5.2 *The key processes in place to support successful and effective implementation of the project*

a) *Identification and Registration of all children and mothers who had not yet been included in the AWC*
   The criteria are already fixed in the ICDS. The SS-APPI local team identified tag villages of all AWs which were being under served due to the distance and inaccessibility. The team visited such hamlets, established rapport with the tribal communities, raised awareness regarding the nutritional entitlements provided through AWs and identified all children in the age group of 3-5 and also the pregnant and lactating women in each hamlet. This has been a continuous process that went on throughout the duration of the project,
b) *Constituting a competent frontline team continuously engaged with the hamlets.*

A strong local team of supervisors and pushtisaathis, continuously engaged in the hamlets selected. They have developed the competencies to mobilize the community, especially the women. They have excellent rapport with the mothers at the village level and with the respective AWWs.

c) *Engagement and Advocacy with the government*

The capability of SS and APPI to engage in dialogue and advocacy with the public (government) functionaries has definitely ensured that the PPK programme runs effectively in the project villages. The engagement of APPI at the higher levels of the government also has certainly helped in mainstreaming PPK in Muniguda block, and now even getting it incorporated into the SOPAN. This definitely has gone a long way into the success of this project, even with the modified RF.

5.3 *The process of identifying beneficiaries*

The criteria are already fixed in the ICDS. The SS-APPI local team identified tag villages of all AWs which were being under served due to the distance and inaccessibility. The team visited such hamlets, established rapport with the tribal communities; raised awareness regarding the nutritional entitlements provided through AWs and identified all children in the age group of 3-5 and also the pregnant and lactating women in each hamlet. This has been a continuous process that went on throughout the duration of the project,

5.4 *Community involvement in all relevant processes*

At this stage of the project community involvement is mainly of the mothers of the children in the age group 3-5. But this certainly assumes the support of the community as a whole in every hamlet. The women in the hamlet are able to engage in this intervention primarily because of the rapport of the local team with the community and also the awareness they have regarding nutrition issues as a result of this project. The involvement of women are in the following processes: (i) visiting the AW and securing the THR (ii) the mothers themselves cook for their own beneficiary children taking turns (iii) they prefer to do the cooking themselves and not outsource it to any other person.

The base on which the entire project rested was the highly committed mothers' groups that volunteered time and efforts to ensure that the children in the village were able to get not only a hot cooked meal, but also learn and adhere to higher standards of sanitation, hygiene and grooming. The team members of the project related to the mothers, not as individual beneficiaries receiving support from the government, but as leaders of their village who were in charge of not only the spot feeding of

their children, but for the operation of almost the entire gamut of services under the ICDS.

5.5 *Aspects of the emerging PPK 'model' that can suggest systematic learning and future scale-up/ expansion of the program*

- Large number of children who are out of AWC are getting cooked food.
- In other places, such children are not only denied cooked food, they're mostly denied dry ration as well.
- It's only during COVID that the government has started delivery of dry ration to all 3 to 6 children. Before this all those who could not come to the AWC, essentially lost their entitlement.
- The loss of entitlement was not only about the loss to the children, but also about opening up of a large arena of corruption that would impact overall performance of the System.
- Cooked Food for Children is also opening up opportunities for cooked food for Pregnant and Lactating Women
- Also opening up further opportunities for timely cooked food for children under 3, especially children between 2 to 3 years.
- Involvement of the mothers in cooking for the group of children and feeding them is enhancing their knowledge about nutrition.
- Apart from Food, the process is also enhancing timely identification of malnourished children and community pressure for referral of severely malnourished children.
- Common eating is also leading to development of discipline in terms of personal hygiene and cleanliness.
- Common eating is leading to greater interaction between children, especially benefiting the very small children in terms of life skills.
- Kui (MLE) Pre School Education

6. Systems: Organization Management, Leadership, MIS and HR

6.1 *Adequacy of management capacities to deliver the program*

The organization has a very long (25 years) experience implementing different kinds of projects, mainly education and child rights related, ranging from small to medium sized projects. SS has experienced and competent staff to implement and professionally manage such projects. Improvements are possible in the area of documentation, MIS and using digital platforms.

6.2 *Recruitment and maintenance of the team*

There was an ad published on Devnet for the various posts in this project. PC, Supervisors and the MIS coordinator. The applicants were scrutinized, shortlisted and called for written tests and interviews, and the best candidates were chosen for the job.

No conclusion could be drawn regarding the personal or professional relationships. However, the team can be rated as highly knowledgeable regarding PPK and the actions needed to ensure its success.

6.3 *Understanding of roles and responsibilities*

The HR manager takes care of recruitment of the personnel, ensures that orientation takes place and the JDs are well understood. She also visits them once in a quarter, and also consolidates the reports from the field to be submitted to the donor agency.
The HR manager interacts regularly with the team and facilitates the interpersonal issues and grievances in the team.

6.4 *Monitoring of program performance and results by the program management team*

- The Project Coordinator has been authorized and empowered with operational decision making powers to facilitate the smooth implementation of this project.
- The local team reports to the PC who monitors the project implementation through monthly planning and review meetings and written reports.
- Based on the reports submitted by the supervisors and the pushtisaathis the PC prepares the consolidated monthly, half-yearly and annual reports to be submitted to the member-secretary.
- The half-yearly and annual reports are then consolidated at the SS central office and submitted to APPI
- The PC takes all significant decisions pertaining to the project in consultation with the Member Secretary.

6.5 *Leadership, decision making and governance processes*

The member-secretary of SS, a senior and respected member of the voluntary sector, which highly acclaimed achievements in the education sector to his credit, has been constantly providing perspective and motivation to the project staff. The PPK team respects him, and without being explicit and visible, he has been influencing the functioning of the team. During our long interactions his perspective and critique of the PPK programme was articulated with great depth.

Decision-making in SS has been decentralized, with the persons in charge of each function/team having functional autonomy with accountability. In the PPK team this has been visible with the Project Coordinator empowered to make decisions pertaining to the PPK, while keeping the Member-Secretary informed.
The Member-Secretary believes in a sensitive and non-dominating approach, which brings in a democratic ethos into the organizational culture, thus encouraging autonomous decision making and innovations. The staff are provided opportunities whenever possible to participate in capacity building programmes whenever possible.

The result of a democratic and humane approach has been visible in the local team, who have learned and grown over the past years and has ensured that the PPK has been a successful model taken note of and adopted by the government (as of now in Muniguda block).

However, there have been independent views that there should be more proactive and visible hands on leadership, which takes a lot more interest in the day to day issues of the project and its management. There was a view expressed that the HR function of SS also needed to be more hands on in engaging with the team on HR issues and be more available to facilitate the emergence of a professional and accountable work culture in the PPK team.
Shiskshasandhanbelieves in developing the leadership capacities of local teams and the tribal youth (some of them are pushtisaathis in this project).
But the critique of the top leadership of SS, of way the PPK project is designed is that it does not very easily facilitate theadequate development of leadership among the women and youth in the community; which is one of the major mandates of SS.

6.6 *The Governing Board*

SS is blessed by the presence of highly qualified and experienced persons in the Board, who are active in assisting the organization as and when required. The member-secretary remains in close contact with the Chairman and Vice-chairman on a regular basis, briefing them about the on-going works, providing perspective and quality to the interventions of the organization.

7. Management Information System (MIS):

The MIS has been more done through planning and monitoring meetings at the field level, jointly by the SS and APPI teams. There has been no record of planning exercises, but the quarterly, half yearly and annual reports, the interactions with the staff at the field level and during our meetings with the team, and the abundant photographs adequately reveal that the team has been working to a plan.

But the essential data have been maintained as the annexures show – The phased expansion of villages in the PPK, the list of workshops and meetings, information compiled from theAWCs/ICDS regarding children categorized on the basis of their nutritional status (MUAC measures, Red, Yellow, Orange and Red).

The nutritional categories indicating the zone that children belong to, are definitely used, as those children are then targeted to improve their nutritional status – to move from the dangerously malnourished zones (SAM and MAM) to the green zones through special enhanced diets or by admission to NRC.

But the other data are being more for the purpose of documentation and reporting rather than informing decisions on a regular basis. The personnel at the field level have the information and data they need about their own hamlets, and operate accordingly. But the regular compilation and maintenance of data centrally, analysing it and using it for course-correction, advocacy and other pertinent actions are competencies that the organization needs to develop.

In the absence of a revised RF, and absence of a clear-cut MIS format developed for this project, the compilation of data has been more on activities and outputs. Outcome related information has not been compiled.

8. Human Resource Management – Policies, Staff Retention and Professional Growth

The basic records that the HR wing of any organization is expected to maintain were found in order. (Ref. Annexure 4). There are policies for recruitment in place. It is usually involves advertising, inviting applications and selection by a panel constituted for the purpose. There are service rules and code of conduct for the staff. The newly recruited staff are oriented to the history, culture and governance framework of the organization, and are encouraged to learn through immersion in the villages of the project area as part of the orientation to the project they are appointed in.

A perusal of the document for the PPK project shows that retention of staff has not been easy.

Three supervisors, two of whom were present from the beginning of the project left in 2020. The Project Coordinator has served throughout the duration of the project and 6 supervisors have served for fairly long – 3 of them from the early stages of the project in 2018 and of the remaining 3, one having joined in November 2019 and two in January 2019. The MIS Coordinator served only for 8 months, and there was no replacement for a period of 10 months. The HR Coordinator, Accountant and Office Assistant have been serving throughout the project duration.

9. Sustainability of the Model

9.1 *The Technical Sustainabiiity of the Programme*

Sustainability can be analysed from (i) the perspective of the sheer the monetary value of all the nutritional entitlements accessed by the children and pregnant/lactating women in the tag villages (remote hamlets) of Anganwadis who were not receiving them pre-PPK and also (ii) from the perspective of the priceless health of those children that has been protected and retrieved through the PPK.

The budget that was allocated for PPK (Rs. 11,576,682) and eventually ensured nutritional entitlements for about 1378 children from 120 hamlets worked out to Rs 2800 per child. Against that, if we were to monetize the nutritional entitlements accessed by the mothers for the children at a conservative rate of Rs. 8.00 per child (as per government norms) for 1378 children, it would work out to Rs. 2920 per child per year. (Rs. 8.00 per child x 365 days). This might look almost a 100% additional burden to enable the community to access these entitlements. But it has to be recognized that given the present situation that is the cost that needs to be invested in order to ensure this level of access of nutrition for children in remote hamlets, which otherwise wasn’t reaching them. This cost is negligible, and but a valuable investment when compared to the invaluable benefits that adequate nutrition bestows on all these children in terms of their health, normal physical and mental development and the resultant development of their capabilities for life.

While this programme focused mainly of nutritional entitlements, it has already established that it is possible to expand and deepen PPK into all the other entitlements that ICDS/AW offers. Hence making the PushtiSathis, the key community mobilizer-educators capable of ensuring that all the 6 services of ICDS reach the remote hamlets would definitely justify the mainstreaming and the investment of resources into and enhanced PPK.

But it needs to be understood that sustainability depends on building of capabilities of all the primary stakeholders - the PushtiSathis who would be the key agents of change, the mothers of the children and pregnant/lactating women eligible for THR and HCM and the community leaders as well as elected representatives in PRIs. This also means that there needs to be institutional expertise in awareness building, education and community mobilization. PPK can become sustainable only when

there is a civil society or government institution that continuously builds capabilities of these stakeholders. This is a long term commitment – at least 2 decades - that the government as well as associated civil society organizations should make.
There is no doubt that ultimately the choice to make this effort sustainable lies with the government. This certainly would involve highlighting this successful model, providing the rationale for the enabling institutional infrastructure that would ensure awareness building and community participation and mobilization. Mainstreaming of PPK in Muniguda block by the district authorities, recommended as a best practice in Rayagada district, and now being incorporated as a strategy for hamlets in difficult geographies under SOPAN - are definitely giant strides into ultimately making it sustainable through policy. The efforts by APPI-SS towards these are in themselves a model for community-centric advocacy.

9.2 *Sustainability from the perspective of the partner organization*

It is also important that the most important strength of SS – Pre-school Education or ECCE is incorporated into the project strategy. Currently SS has been able to initiate 25 ECCE centres in the PPK hamlets. This is essentially part of the strategy of making this intervention sustainable, especially as it would be addressing a service of AW which is not being provided adequately.

9.3 *Financial sustainability of Shikshasandhan*

SS has fairly good donor diversity. But with the changing policy scenario in the country many of them are likely to wind up. Hence it is important for SS to develop more local sources of fund raising. The total funding table (Ref. Annexure-9) shows that, if we were to consider only the regular programmatic funding and not the Covid Relief Funding in 20-21, there is a reduction of 42.79% over 2018-19 ; the donor diversity has gone down from 11 donors in 2018-20 to 8 donors in 2020-21. The proportion of APPI funding to total funding in 2018-19 was 15.36%, which became16.99% in 2019-20 (both based on the average of two years 2018-20);and sharply increasing further to 32.40% in 2020-21(excluding relief projects). If relief assistance is also added, then the proportion of APPI funding in 2020-21 shoots up to 41.29%. This indicates decreasing donor diversity and a trend of increasing dependence on 3-4 agencies.

10. Program Finance *(Ref. Annexures - 9 and10)*

10.1 *Inadequate description of changed budget-heads in the revised budget*

i. Initial budget was prepared on the basis of the original proposal and RF that was submitted. The initial conception of the project revolved around the recruitment of Nutrition Didis (100 Didis), their capacity building and their continuous work with the community, the mothers. The major part of the original budget was allocated for their capacity building and monitoring of their work. (The initial phase could be seen as commencing from June 2018 and continuing till late October. By end October the PPK was conceived and presented to the Rayagada District Administration, and eventually launched in Muniguda Block.)
ii. The Prototype of PPK implementation could be considered to have been developed by October 2018. Since the nutrition and training of over 100 Nutrition Didis were no longer to be pursued, the budget was revised. The allocations for remuneration of NDs were re-allocated more for the Supervisors and Shikshasandhan staff to enable the implementation of the modified project.
iii. Just as there is no adequate and clear documentation the prototype developed, there is no clear explanation of the basis of budget modification and re-allocation. Instead of a fresh budget with the correct heads emerging from a completely modified project, what we see is just a revised budget, with many of the old budget lines retained and some new lines inserted without any explanatory note or a corresponding new RF.
iv. This has resulted in a situation where the substantive disbursement made in 2018 being utilized over the whole of the year 2019.

10.2 *Alignment of activities and outcomes with the budget*

The activities and the budget were not aligned precisely, primarily because there never was a renewed RF once the PPK prototype was conceived and launched. The funds were adequate for the new phase; especially since this phase had far lesser number of personnel (only in the vicinity of 15 staff) than the 100 Nutrition Didi concept that formed the basis of the

Following the not-so-well-documented change of the RF and not-so-well-explained changes in budgetary allocation, the disbursement does not seem be on the basis of the required cash flow for a specified period of time. This is more pronounced in 2018-19, where we see that the funds that were

11. Conclusions and Recommendations

11.1 *Conclusions*

PPK has been an excellent functioning model that has been set up. Through simple, yet workable interventions, eliciting community participation through heightened awareness and action by mothers, this model has successfully addressed one of the most crucial challenges of ensuring the last mile delivery of nutrition to one of the most impoverished and under-nourished populations in the state. The fact that the state has adopted this model in principle is a testimony to the relevance and excellence of the model. The following are some of the salient features of the process that was followed:

1. The flexibility of the project design that involved the development of a prototype and dynamic changes that could be brought about based on field-based, community-based learning. This is illustrated by the substantive change that was brought about in the original conception of the 'Nutrition Didi' as an education/awareness builder; in response to the ground reality of the remoteness of the hamlets in the survey area of the AWs, difficulty of the AWW to reach out to those hamlets and the mothers and children to come to the AW Centre for spot-feeding of the hot cooked meal, the conception of the Nutrition Didi gave way to a dedicated team of Supervisors and PushtiSathis that facilitated the process of ensuring actual delivery and spot-feeding to the children in the hamlets.
2. The prototype that was developed through experimentation in 15 villages eventually was up-scaled to 64 and later 120 remote hamlets of 14 GPs through the interventions of the Shikshasandhan Team assisted by the APPI local team, within a time duration of two and a half years if we were to reduce the Covid lockdown period. The deliverable was clearly defined as the actual transportation of THR (mainly through the group of mothers from the hamlet) and cooking of hot meals every day by the mothers taking turns and spot-feeding of the children.
3. The modality of spot-feeding of children of children has been replicated to undertake spot-feeding of pregnant and lactating mothers too; although in a lesser number of villages.
4. The most significant concept that has the potential of contributing towards replicability and sustainability is that of the Supervisors and the PushtiSaathis in this project. While the Supervisors have competencies of effectively engaging with and mobilizing the community, the PushtiSathis can be seen as the future AWC extension worker who would be capacitated to become a community mobilizer-educator.

5. Although the numbers are low (9 PS), a PushtiSaathi hails from the community, speaks the local (adivasi) language Kui, and enjoys an excellent rapport with the community due to his/her ability to engage in culturally relevant communication.
6. The institutional infrastructure that has been developed through the PPK project has also now enabled the community (i) to have ECCE (ii) to increase participation of mothers in the PPK in VHND (ii) to ensure that all the children of the PPK hamlets received the AW uniforms, and (iii) to enhance the popularity of Nutri-gardens in many of the project villages and the use of the vegetables thus cultivated in the hot cooked meals prepared by the mothers for spot-feeding – all these are indications of how PPK has enabled the community to access entitlements and undertake well informed actions that benefit the children and the community.
7. A significant institutional capital that PPK has developed is the regular and intense coordination and collaboration with the AWWs and AW sector supervisors, and the district administration (DSWO and CDPO). This has been crucial in ensuring the delivery of THR through the mothers, in a timely manner.
8. The finances expended in this project should be seen as a long-term valuable investment, to facilitate the invaluable benefits that adequate nutrition bestows on all these children in terms of their health, normal physical and mental development and the resultant development of their capabilities for life. There should not be a doubt on the sustainability of such a programme, provided it is implemented efficiently.

11.2 *Recommendations for replicating and sustaining PPK in other similar, difficult geographical areas*

a) The concept of Nutrition Didi was perhaps well ahead of its time at the commencement of the PPK and as the prototype got developed. The need of the hour was to demonstrate and establish a model that functioned to address the serious nutrition deficit in the remote hamlets. But now the time seems to be ripe in reviving that concept, although not in toto, but with modifications, with much more enrichment and deepening of their roles.
b) The crux of replication of PPK is the availability of a team of competent supervisors and PushtiSaathis(PS) embedded in *an enabling institutional framework*, capable of (i) bringing about awareness in the community and the mothers regarding the importance of all services provided by the AW/ICDS to protect the health of children, mothers and adolescent girls (ii) mobilizing and organizing the community/mothers to access all the entitlements, undertake spot-feeding for the children of the respective age-group and the pregnant and lactating women.
c) The ideal PS should be a literate woman (preferably in the age-group 25-40) from the same community, from a village within 5 km radius of

the hamlets that she would offer her services under PPK. She would be, preferably, married into the village.

d) The enabling institutional framework for the PS is an important requisite; and ensuring this in the government framework is still not established. This institutional infrastructure involves comprehending the scientific basis of nutrition, development of soft skills to communicate the same in local, culturally relevant forms and modes, and building the capacity to mobilize the community/women to ensure relevant action.
e) It would be difficult to replicate PPK in a new similar and difficult geographical area without the intervention of a team similar to that which pioneered PPK in Muniguda. The role of Supervisors in this institutional framework is important; in capacitating the PS to perform their role.
f) Hence one of the crucial challenges of advocacy would be to develop an institutional infrastructure that would capacitate PushtiSaathis. This could be done by identifying a training and capacity building facility in the block where PPK has to be implemented. This should be outsourced to an institution which has the expertise for the same. To this extent it could be seen as a GO-NGO partnership.
g) This institution should be able to identify the highly effective mothers and PSs who have successfully implemented the programme in their own villages, and use their insights, experience and learning to capacitate other PSs and mothers. They would, in that sense function as trainers
h) The first preference for PS should always be literate women from the same community where PPK is sought to be replicated. In case it is difficult to find such women, a man from the same community and location could be appointed and trained.
i) But in the event of PS belonging to the community and location are difficult to identify, we could also think of fellowships being offered for 1-2 years to young (preferably female) graduates from the community or similar underprivileged communities to work in such villages, following which they would be given experience certificates that would be useful for them in future employment prospects in the social sector or even for higher studies. The enabling institution as in (d) would train these fellows to perform the role of the PS.
j) The scaling up of PPK could be by expanding to serve all difficult geographies in blocks and districts similar to Muniguda and Rayagada where underprivileged communities are unable to access nutritional entitlements for children; in which case all the above recommendations would be relevant.
k) However, there could also be a second pilot project in Muniguda itself where the role of the PS is deepened. If the PushtiSaathis were to be made viable in the long run, it is important that the PS performs not just the nutrition function but also becomes an extension worker / community liaison person for all services provided under AW/ICDS. This

is recognizing the need for a competent assistant for the AWWs working in difficult, inaccessible terrains.

l) Till such time that the government recognizes the need to appoint and support an adequate number of PushtiSathis in the remote hamlets, and accept the primacy of having an enabling institutional infrastructure, it would be worthwhile to have a decadal plan to implement PPK with existing as well as new partners; envisaging phased expansion into the remote hamlets in the neighbouring blocks and districts with similar difficult geography; as well as deepening of PPK to incorporate all the services of the ICDS. This would generate adequate data, learning and experience regarding the most efficient and effective manner in which PPK (the deepened version of it) could be implemented.

m) There should be a comprehensive benchmark survey undertaken immediately to capture the situation vis-à-vis access to all entitlements of ICDS, and also other social security/developmental entitlements too the first phase of the PPK. The next project phase should build its deliverables on the basis of this benchmark. The end line survey would then automatically highlight the changes that happened as a result of the next phase interventions.

11.3 *Recommendations to Grantee Organization*

i. SS should design a capacity building module capturing all the learnings from the current PPK phase. This module would be aimed at capacitating the PSs. The Supervisors of the first phase of PPK should be able to fulfil the role of a trainer of trainers. SS would certainly be in a position to bring in excellent trainers for this purpose.

ii. The next phase of the project could be to widen and deepen the PPK model by widening and deepening it to include all the 6 functions of ICDS-AW. Pre-school education would form an important part of this, in which the expertise of SS is highly acclaimed.

iii. SS should take the lead in the next phase of the PPK project, and APPI team should be purely a facilitating consultant team.

iv. The MIS system should be well conceived, and it would be very good for the senior personnel of SS (MIS officer and the Project Coordinator) to go through a training to learn how to develop and use MIS, including financial information for analysis, decision making and enhancing effectiveness of the project

11.4 *Recommendation to Philanthropic Initiatives*

i. The replicability and sustainability of this kind of a project is possible only when the model becomes visible and mainstreamed. In this case the government needs to recognize that the manner in which the problem of limited access to nutritional entitlements in remote/difficult geographies was addressed was through a trained, dedicated community organizer (PushtiSathi), within an enabling institutional structure. While advocacy efforts towards should continue, it is imperative that PPK be seen as a public-private partnership at best.

ii. This phase would be best handled by SS, the partner organization on its own, with the APPI team providing expertise in project management and facilitating the interface with government. In the next phase, while expanding into neighbouring blocks and districts new partnerships in addition to SS may be explored. This would bring in more insights and experience into the next phase.

iii. The functioning of two teams – the APPI local team and the SS team – despite certain perceived incompatibilities have by and large ensured that the first phase of PPK achieved the expected outcomes to a large extent. This is certainly no small achievement.

iv. But it would be good for APPI to learn from this rare collaboration between the teams from a donor agency and the partner organization. There are perceived power differentials between the two teams, which could always lead to points of conflict. It is to the credit of both teams that no such serious crisis was ever precipitated and they went on to establish the successful PPK model.

But there are differing perceptions on both ends that the evaluators could discern:

a) The team and the leadership of the partner organization felt that they did not have a say in deciding the direction the project should take. They felt that their main forte was not taken into account. For the benefit of smooth functioning they would not press matters that could lead to conflict.

b) The APPI team members had issues with the partner organization leadership having ‘abdicated’ responsibility. They felt that the senior professionals based out of Bhubaneswar were not adequately involved. There were some instances of not-upto-the-mark kind of management issues that were cited.

c) But the results / outcomes achieved by the teams definitely show that these issues never over-rode the fundamental mandate of both the teams and they never lost sight of the real stakeholders of PPK, whose interests would not be endangered.

v. In exploratory projects like the one being evaluated APPI should ensure that the partner explains the new prototype developed. The RF should be revised with the new objectives, activities, outputs and outcomes redefined accordingly.

vi. With the revised RF, the budget too needs to be prepared afresh, reflecting the new objectives and activities.