



Using social audits to improve delivery of state nutrition-related services: Lessons from the CAN Program

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Photo Credit: SPREAD (spread@spread.org.in)

In India, social accountability approaches, including social audits, offer demand-driven alternatives to improve delivery of state nutrition-related services, with potential to improve local governance, delivery, and uptake of national policies such as the National Food Security Act (NFSA). While India has seen steady improvement in health and nutrition services, reflected in reduced infant mortality and child stunting rates, significant quality and coverage issues remain at community level. To improve food and nutrition security, the NFSA brings together four existing programs:

- Targeted Public Distribution System (TPDS)
- Midday Meals (MDM)
- Integrated Child Development Services (ICDS)
- Maternity entitlements (Mamata)

The Collective Action for Nutrition (CAN) social audit program was trialled and evaluated at scale in six districts in Odisha. The program was designed and implemented by the local NGO Society for Promoting Education and Rural Development (SPREAD) and supported by Azim Premji Philanthropic Initiatives (APPI). The Institute of Development Studies (IDS) at the University of Sussex led the independent evaluation of the program in partnership with Development Corner Consulting (DCOR), and with support from the CGIAR Research Program on Agriculture for Nutrition and Health (A4NH).

Background

The overall goal of the three-year CAN program (2016–2019) was “Reducing malnutrition among children and women by facilitating efficient implementation of food and nutrition programmes, ensuring transparency, downward accountability and community participation.” The main intervention was a social audit process designed to sensitize communities to their rights and entitlements under the four primary schemes under the NFSA. The program aimed to increase knowledge and uptake of NFSA services, improve participation in community-level governance activities, especially by women, and improve institutional delivery of nutrition services and entitlements, as well as to reduce malnutrition, especially among women and children.

Combining quantitative, qualitative, and process methodologies, the IDS-led evaluation looked at immediate impacts on strengthening local governance and improving service in the ICDS, Mamata, and TPDS programs, and explored contextual, design, and implementation-related factors that may have affected the effectiveness of the social audits. Communities (GPs) selected by the SPREAD program were randomly split into an Early and a Late group, which went through the audit process at different times. The quantitative analysis used differences in outcomes between groups to try to understand how change happened, how it accumulated, and whether it might be short-lived—important considerations for complex village-level governance.

Findings

CAN program’s design, implementation and processes: The model was built on existing experience and best practice, relied on use of comprehensive guidelines, and was modified through an extensive piloting process and adapted to the local context.

Many community members reported that participating in the audit process was a positive experience and a useful way to voice concerns, increase access to services, and involve communities directly in resolving grievance issues. Most government officials and NFSA service providers considered the process positive, useful, and well managed, although some providers felt that issues with TPDS could only be addressed at a “higher level” than an NGO.

Fifty-nine percent of primary caregivers surveyed said they knew what a social audit was, while 57 percent were aware a social audit had taken place in their GP, though awareness levels ranged from 40 to 80 percent across districts.

Knowledge and awareness of services, entitlements, and grievance mechanisms: Knowledge about the ICDS service of Take Home Rations (THR) improved among caregivers and pregnant women, the latter seeing very high increases of 25 and 21 percentage points in the Early and Late samples, respectively. While the evaluation cannot definitively connect this to the social audit process, no other ICDS supply- or demand-side activities were taking place during this time.

Awareness and knowledge of the **Mamata** scheme and entitlements significantly improved 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.

Overall knowledge about the **TPDS** entitlements as well as about TPDS committees improved substantially among all groups sampled—caregivers, pregnant women, and men. Changes for men were the most marked and more pronounced in Early than Late GPs, suggesting impacts were due to cumulative exposure to the social audit process and the community-level activities it set in motion.

Access to, uptake of, and satisfaction with NFSA services and entitlements:

- **ICDS:** Increased likelihood a child was provided with special food following growth monitoring, and a small but statistically significant increase in referral to rehab centers after monitoring. Neither change differed significantly between Early and Late GPs. Occurrence and awareness of village health and nutrition days showed significant improvements in both groups.
- **Mamata:** Significant increases of 22 percent in enrolment among pregnant women in the Late GPs and 31 percent in pregnant women satisfied with Mamata. The latter increase was significantly different between Early and Late groups, suggesting the change was based on the cumulative exposure to the social audit and the processes it set in motion.
- **TPDS:** Improvements for all groups sampled, but particularly for men, including a seven-point decrease in those reporting having to pay extra at ration shops in Early GPs, and a 5 percent higher likelihood of having been assigned an Aadhar number (a unique ID number issued by the government, required to be able to register to receive benefits). Both changes differed significantly between Early and Late groups, suggesting a cumulative effect of the social audit process. No significant difference was detected between Early and Late GPs among primary caregivers for improvements and likelihood of having an Aadhar number, likelihood ration shops delivered food on a monthly basis, satisfaction with the TPDS, or food ration quantity. Although the changes cannot be directly linked to the social audit process, the magnitude of change in some, such as increase in ration shops delivering food monthly absent other major supply- or demand-side changes observed during this period, are highly suggestive that these changes relate to the CAN program. This view is supported by some participants in the community IDIs and FGDs who reported increases in access and availability of all services targeted by the social audit.

Community empowerment and voice in local nutrition-related decision-making: Social audits aim to enhance participation in civic life and community-level governance. Pregnant women and

men reported large positive changes in community engagement, and primary caregivers and men reported substantial increases in political participation. Both effects were markedly stronger in Early than Late GPs, suggesting cumulative change. Social audits appeared to negatively affect civic life-related attitudes of caregivers, pregnant women, and men in the immediate aftermath. In GPs with longer exposure to audits, however, such negative effects were fully offset and it is possible that, with more time, attitudes would improve as the result of social audit. A sign of such cumulative change among men and pregnant women was observed, but the effects were not statistically significant. Qualitative data provided further evidence of the growing sense of awareness about forms of redress and ability to voice problems, and suggested people became increasingly motivated to take part in community life via committee membership to solve future problems.

Dietary diversity: Very significant improvements in dietary diversity scores for women and children were observed. The link to social audits can neither be made nor ruled out, as findings may relate to greater seasonable availability of fruits and vegetables.

Lessons for future implementation and scale-up

Putting community-level self-governance structures and existing health and nutrition committees at the center of the social audit process was seen as critical to the model's success. The drive and leadership of an NGO with substantial experience and expertise in social audits proved to be critical to the successful planning, implementation, and follow-up of the audit processes. Participation and awareness rates in village institutions were high, but less so for women. This is not surprising given their difficulties in finding time to travel to GS meetings not in their own village and/or time away from work, and notable marginalization of Scheduled Tribe communities. Greater effort could be made in future to reach the most marginalized groups. A further focus on awareness-raising meetings (Palli Sabhas) in conjunction with the more formal public hearing (Gram Sabha) process also seems important.

A stronger focus on the knowledge of frontline workers (in particular Anganwadi Workers—AWWs) is also recommended, given some less positive results in infant and young child feeding (IYCF) knowledge. Wider evidence from India and elsewhere shows that without a concerted, sustained, intensive, and well-supported effort to change IYCF knowledge, such changes in knowledge—and certainly practice—will not happen. The main focus of service improvements monitored by the program was on delivery of hard outputs, such as subsidized food rations, rather than softer skills and delivery tasks, such as nutrition counselling, that are the responsibility of frontline workers including AWWs. SPREAD's subsequent implementation of a series of Participatory Learning and Appraisal meetings with mothers to focus on nutrition knowledge likely benefited this area but, as part of the second phase of the program, did not form part of this evaluation.

To read the full report, visit <http://bit.ly/2RJ90f8>.

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