Shakti Varta Women's Groups using a Participatory Learning and Action Cycle in Odisha

Evaluation Immediately Post Intervention

Executive Summary

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This brief summarises the evaluation immediately post-intervention of Shakti Varta, a large scale participatory learning and action (PLA) cycle with women's groups in Odisha State, India. The intervention took place from 2014 to 2016. The intervention and its evaluation were supported by the Government of Odisha and the UK's Department for International Development. The UK Government provided financial and technical support through a Technical and Management Support Team (TMST), managed by Options Consultancy Services and IPE Global, with inputs from CARE India.

Introduction

Shakti Varta is a convergent programme of the Government of Odisha involving the Department of Women and Child Development (DWCD), Department of Health and Family Welfare (DHFW), the Department of Rural Development (RD) and Mission Shakti, the Government department supporting women's self-help groups.

Shakti Varta was designed to build on the evidence that participation in women's groups using a facilitated PLA process in a low-resource setting reduces maternal and newborn mortality. A systematic review and meta-analysis of seven randomised controlled trials found that exposure to women's groups resulted in a 37% reduction in maternal mortality, a 23% reduction in neonatal mortality, and a 9% non-significant reduction in stillbirths[1]. In 2014, WHO officially recommended the use of facilitated PLA with women's groups to improve maternal and newborn health in rural areas with low access to health services[2].

While the evidence of PLA impact is linked to maternal and newborn health outcomes, Odisha used the methodology to address a wider set of determinants. It adapted the PLA cycle to embrace a broader health, nutrition, water and sanitation and hygiene (HNWASH) focus. Like earlier trials in the region, Shakti Varta uses women's Self-Help Groups (SHGs) as a platform to engage with targeted women and to empower them and broader community members to address HNWASH issues. It seeks to improve maternal, newborn, child health and nutrition, and improve WASH practices to support these objectives.

The theory of change

The theory of change underpinning Shakti Varta is that through participation in a cycle of PLA meetings, women's knowledge about HNWASH will increase and that women's enhanced confidence and solidarity resulting from their participation in meetings will, together with improved knowledge, support changes in family health practices. Moreover, information will be shared and discussed by participants outside of meetings so as to diffuse messages and build up community support for behaviour change and community action. Frontline health and nutrition workers (FLWs), namely

[1] Prost et al. Women's groups practicing participatory learning and action to improve maternal and newborn health in low-resource settings: a systematic review and meta-analysis. Lancet. 2013;381(9879):1736-46.
[2] WHO. WHO recommendation on community mobilization through facilitated participatory learning and action cycles with women's groups for maternal and newborn health. 2014. World Health Organization, Geneva.

ASHAs and AWWs, play an important role in supporting the mobilisation process and promoting better linkages between communities and basic health services, and responding to the expected increased demand for services. Similarly community leaders and institutions are important agents of change for Shakti Varta to work with to support change processes. SHG Federations provide the platform for the programme through their SHGs and support implementation and future sustainability of the initiative. Shakti Varta is expected to strengthen SHGs and block federations through their involvement in the programme.

The Shakti Varta intervention

The Government of Odisha launched Shakti Varta in 2013, identifying 15 High Burden Districts where infant mortality and child undernutrition were high. The first wave of implementation covers the three districts of Bolangir, Kandhamal and Rayagada, which were Shakti Varta's learning site for scaling up to the remaining 12 Wave II districts. Shakti Varta has the potential to benefit nearly 3 million people in these first three districts.

Shakti Varta engages group participants in a reflective process, known as a PLA cycle, to identify and prioritise their local HNWASH problems, develop local strategies to address priority problems, take action, and review their achievements. The PLA cycle consists of 20 group meetings that are facilitated by a local SHG member who is trained as a facilitator for her Gram Panchayat (GP). Known as a GP Facilitator, she uses engaging interactive tools such as story-telling, picture cards and games, to lead the PLA meetings.

Unlike the PLA trials that typically included monthly PLA meetings, Shakti Varta planned on two weekly meetings and for the entire PLA cycle to be completed in approximately 12-20 months. The PLA cycle also includes two community meetings to mobilise community leaders, men and the broader community in the change process. These take place around the middle and end of the twenty meeting cycle.

Each group (known as a 'Shakti Varta point') covers a population of about 500 people with this ratio dropping to 300 in remote areas with scattered populations. A total of 6633 Shakti Varta points were established and functioning in the three Wave I districts, covering a population of 2,933,392. This resulted in an average population coverage of one Shakti Varta point per 442 members of the population therefore surpassing the target coverage. A total of 119,892 meetings were conducted across the three districts throughout the implementation of the programme and by the end of February 2016 (project end), 94% of meetings were completed out of the expected 20 meeting cycle in Bolangir, 86% in Kandhamal and 88% in Rayagada.

Evaluation purpose and methodology

As the evidence base for the PLA approach mainly comes from controlled trials, the overall aim of this evaluation was to assess the feasibility of implementing Shakti Varta through government and community structures at scale, and its effect on key secondary HNWASH indicators immediately post-intervention. The evaluation covers the three Wave I districts.

The evaluation employed a mixed methods approach and draws on the following data sources:

- Cross-sectional household survey data collected at baseline (2014) and towards the end of the 20 meeting PLA cycle (2016).
- Qualitative research undertaken at two intervals, the first early into implementation after meeting three had been completed (Grounding study) and the second, towards the end of the meeting cycle.
- Shakti Varta's Monitoring Information System which tracked implementation progress of PLA village meetings, meeting participation and changes reported.
- Process monitoring data and documentation collected during implementation by Shakti Varta's State Technical Agency.

Data on key secondary outcome indicators were collected in population representative cross-sectional household surveys conducted in 2014 and 2016 in all 37 blocks of the three Wave I Shakti Varta districts. The surveys focused on rural areas (covering remote to peri-urban areas), excluding urban centres. The method ensures proportionate representation of remote and vulnerable HHs which may be missed in other surveys. A list of villages to be visited was sampled from the Odisha Primary Census Abstract 2011 (excluding uninhabited villages). At selected villages, all HHs were invited to participate according to the eligibility of residents, and all people from all subgroups were invited to complete the relevant questionnaire. The total number of unique key respondent interviews was 34,364 in 2014 and 34,857 in 2016[3].

Given that this evaluation is being conducted immediately post-intervention, its focus is on evaluating the implementation process, assessing the robustness of the pathway of change, and the effect of the intervention on a reduced number of secondary HNWASH knowledge and practice indicators, community action and women empowerment. The evaluation does not include a control site and therefore the evidence presented does not show causality rather indicates the contribution that Shakti Varta has made to reported changes. A later evaluation is recommended to measure change in the primary outcome of neonatal mortality, a broader number of secondary outcome indicators than possible in the current assessment, as well as to evaluate performance of Wave II districts.

Evaluation findings on the scope and quality of implementation

This evaluation has identified a variety of design and implementation factors that have affected the quality of implementation and the potential of the programme to achieve results.

Timeline

WHO recommends PLA interventions with women's groups are applied for a minimum of three years, although depending on the context and other factors, improvements in key outcomes may be observed sooner than this. PLA meetings were held for 20 months in Bolangir and Rayagada and only 18 months in Kandhamal, due to implementation challenges and a fixed end of project closure date. Delays in fund disbursement meant that meetings were squeezed into very short 7-12 day periods in the latter half of the PLA cycle (from around meeting 14 onwards) in order to complete before the end of DFID financial and technical support. The short span between meetings is likely to have some impact on the quality of meetings and attendance, and affected the ability of participants to understand, absorb and translate messages into action.

[3] For further information on survey methodology, please see Shakti Varta main report (http://options.co.uk/publications/evaluation-report-shakti-varta-odisha-june-2016) or CCMII survey report (Odisha Technical and Management Support Team. (2015). *Concurrent Monitoring II: Odisha state survey 2014-15*. Options Consultancy Services LTD, IPE Global, CARE India).

Coverage

The large scale nature of the intervention in poor, geographically remote, Left Wing Effected and hilly locations presented major implementation challenges. The target coverage was a ratio of one GP Facilitator for 500 population, however effective use of process monitoring information and qualitative studies found that this ratio was too high for people living in hilly areas who would face difficulty in attending meetings in distant Shakti Varta points. The programme therefore reduced the ratio to 1:300 in remote areas with scattered populations. Additionally, plans were also revised so that the number of GP facilitators per GP was based on population size rather than being fixed for all GPs which helped to improve coverage. The inclusion of all blocks in the focal districts, as agreed with the government and DFID, meant that both areas with better and poorer health outcomes and access to services were included, though the evidence base for PLA is from populations with very low access to services and high mortality.

Scope

The division of a 20 meeting PLA cycle into two mini-cycles was an innovative response to meeting a broad HNWASH agenda but carried the risk of making the PLA process too shallow for the breadth of behaviour change being promoted. Coupled with the very tight timeline exacerbated by fund related bottlenecks, feedback from the community suggests that insufficient time was available to explore difficult subjects at a reasonable pace for poorly educated rural women. This will most likely have affected understanding of messages and the readiness for women and their families to translate them into changed behaviours. Despite this, the qualitative endline found widespread approval and support from participants, facilitators and FLWs for the interactive and participatory methods adopted.

Motivation and retention of GP Facilitators

Mobilising women for meetings was difficult, time consuming and required considerable persuasion of GP Facilitators and the FLWs that supported them. Low remuneration of Rs 100 per meeting with no extra compensation for mobilising participants or undertaking the taxing journeys that they had to make to reach Shakti Varta points explains the relatively high dropout rate of about 25% of facilitators. In some cases, this impacted the quality of meeting facilitation and broader community mobilisation especially in the absence of funds to train new facilitators on training they had missed. As a response to this, 'back up or reserve' facilitators were identified and trained at review meetings although the quality of their facilitation may have been reduced.

Low education standards

The capability of GP Facilitators varied and in remote areas it was particularly difficult to find candidates with the minimum criteria of eight years of education. Less educated GP facilitators required considerable handholding and mentoring. In future, a more systematic approach is needed to adapt the standard training packages and materials, supervision and support frameworks to the capability levels of lower educated facilitators.

Training and support

Good training and support of facilitators is an essential pillar of effective PLA. The cascade and interval training system was well designed and a pragmatic response to the scale related challenges of the programme. Partnership with local NGOs to fill human resource gaps in the government structure and the involvement of SHG Federations to provide block level personnel for supervision and training were creative solutions to creating decentralised, block level training and supervision capacity. However, funding bottlenecks experienced at the beginning of the cycle resulted in large

gaps in cascading the training down, and significant delays in disbursing funds from the centre to the district in the second half of the cycle meant that one phase of residential training could not take place. These bottlenecks had a negative effect on training quality, the quality of facilitating meetings and mobilising communities, and the motivation of facilitators. The quality of training of GP facilitators did however improve as block coordinators improved their own training skills, and the participatory style of training was well received. Block and district stakeholders reported high levels of participation by GP facilitators in their training.

PLA games and picture cards

The quality, audience appeal and impact of the games and picture cards were reported by all stakeholders to be extremely high. The games and picture cards were particularly felt to help village people in visualising problems and to be more effective than plain discussion in the meetings. These materials and the handbooks, training manuals and job aides are an important resource for the state and for communities, and there is high demand for the picture cards from ASHA and AWW to support their own work.

Monitoring and MIS

The intelligent use of online and offline MIS sought to overcome the challenges of monitoring a large scale community programme in remote areas with poor infrastructure and communication networks. Delays in data entry were however commonplace and the lack of a dedicated computer and office space at block level were significant barriers to an efficient MIS able to inform management in real time. The additional layer of field monitoring provided by Quality Managers positioned in each district raised implementation and reporting standards and highlights again the importance of field based supervision and support.

Funding and fund management

The complex funding arrangement of Shakti Varta where funds were channelled through different state level government entities for block level activities implemented by teams of government and non-government staff who were themselves funded via different channels, was ambitious. The level of synchronisation of fund flows needed for a programme of Shakti Varta's scale and complex operational arrangements was highly challenging with the multiple funding flows and delay in transferring funds through the government system.

SHG Federations

Shakti Varta offered multiple benefits to Block level SHG Federations, helping to revive fledging organisations, building their capacity and in turn credibility with communities. SHG Federations now have greater capacity to contribute to the sustainability of Shakti Varta than pre-intervention, but this is a medium to long term goal that will require continued technical and financial support to achieve.

Evaluation findings for participation in Shakti Varta meetings, the effect on HNWASH outcomes, community action and women empowerment

Despite implementation challenges, the evaluation indicates that Shakti Varta has likely contributed to some improvements in HNWASH indicators, enhanced community action and women's empowerment.

Level of participation

The 2016 household survey data found 20% of pregnant women and women with a child under five respectively, have participated in a Shakti Varta meeting, although the frequency of attendance was generally low at 1-3 meetings. A further 15.0% (95% CI 13.5-16.5) of pregnant women and 22.3% (95% CI 20.5-24.3) of women with a child under five had ever heard of Shakti Varta meetings but had not attended. Qualitative research also found that women reported low attendance at meetings.

Despite the larger scale of the intervention, these levels of participation are comparable with much smaller trials, where participation by pregnant women ranged from 2-51%[4]. The barriers to participation documented through qualitative data and process documentation help to explain the participation levels. Firstly, the livelihood demands on women and men make them unavailable for meetings during the day; in fact very few men attended any meetings due to their daily labour. Women reported household chores as the second reason why they could not attend meetings. Unsuitable timing of the meeting was stated as an important barrier to participation with women stating a preference for evening meetings; timing also impeded participation by adolescent girls who were at school during the day. Women from far-flung hamlets were often not able to attend due to distance and the difficulty and time required to travel to Shakti Varta points. The added frequency of meetings in the latter half of the cycle further hindered participation with meetings requiring more of women's time.

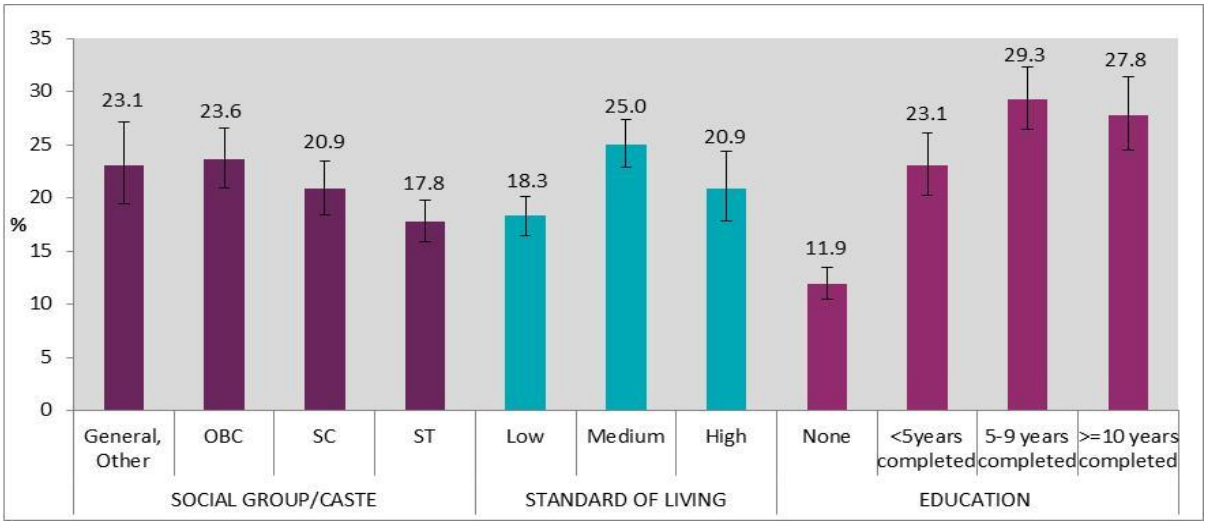
The relatively low attendance and frequency of attendance has implications for the extent to which the meetings can influence behaviours and build solidarity and support among women to empower them to support behaviour change. However, reductions in key outcome indicators have still been observed with similar attendance[5]. To some extent low attendance may be offset by the diffusion of messages. However, increasing participation, continuity of attendance and the potential for holding meetings later in the day and evening needs attention by programme managers.

Who participates in meetings?

The household survey found that out of the sample of pregnant women and women with a child under five interviewed, the proportion of Scheduled Tribe and Scheduled Caste women who reported to have attended Shakti Varta meetings was slightly lower than for other caste groups (Figure 1). However as women from Scheduled Tribes and Scheduled Castes represented around two thirds of the women interviewed the actual numbers of women who reported attending were highest from these groups. The MIS shows that 72% of participants are from Scheduled Tribe and Schedule Castes. The local recording by the GP Facilitator of participants at the meeting itself and the lack of incentive to encourage false reporting of participant's caste or tribal status suggest that the MIS data is reliable on this point.

[4] Prost et al. Women's groups practicing participatory learning and action to improve maternal and newborn health in low-resource settings: a systematic review and meta-analysis. Lancet. 2013;381(9879):1736-46.
[5] Ibid.

Figure 1. % Pregnant women and women with a child under five who have ever attended a Shakti Varta meeting disaggregated by social group, standard of living and education level (error bars indicate 95% confidence intervals)



The FLW survey and the MIS both show high levels of AWW and ASHA participation in Shakti Varta meetings. Qualitative data also shows that FLWs played a critical role in supporting GP Facilitators, mobilising women to attend meetings, explaining messages during meetings, and working with the facilitator to track target groups, including high risk pregnancy cases and advocate for their well-being with family members. Shakti Varta encouraged collaborative working of the three field based agents which helped AWWs and ASHAs in achieving their own work targets.

Diffusion

The qualitative study's quantitative tracking of the diffusion of Shakti Varta messages found that the meeting participant frequently shared information with others. Information was most often shared within the home and in the evening, and the most common persons participants shared information with were family members (59%), neighbours (31%) and then friends (10%).

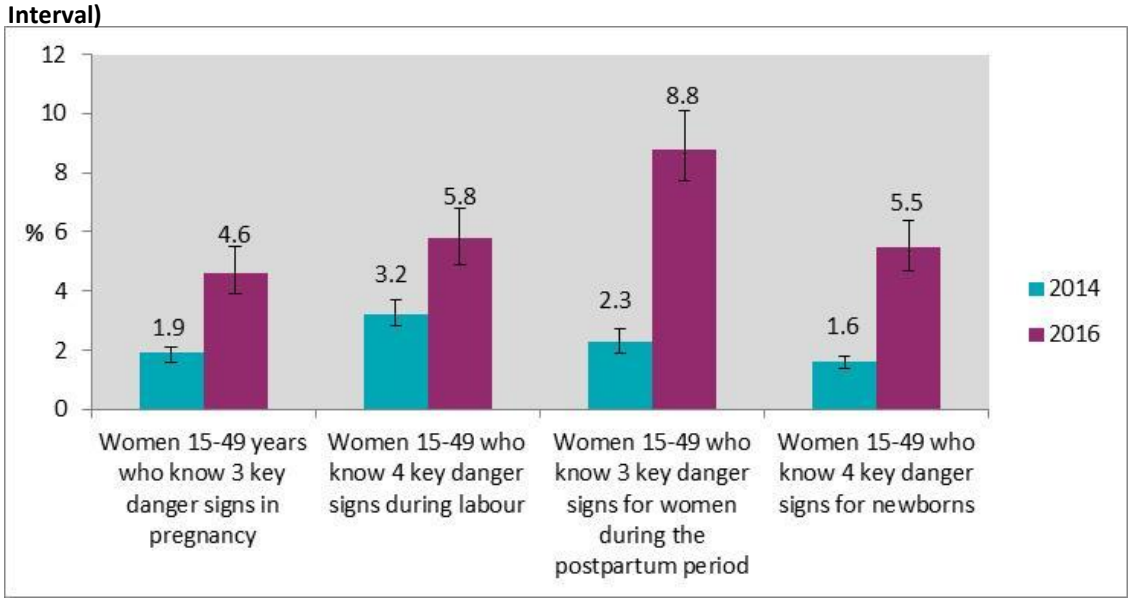
The findings on diffusion suggest that women who attend meetings are diffusing information as per the theory of change, but this is primarily remaining within the family home. Increasing the attendance of women from households not currently participating in Shakti Varta will therefore be important to spread the information to a larger share of households in the community.

Knowledge and awareness related to pregnancy and infant and young child feeding

The household surveys from 2014 and 2016 show modest increases in knowledge and awareness related to pregnancy and infant and young child feeding. Although knowledge of key danger signs during pregnancy, labour, postpartum and in newborns by married women 15-49 years of age appeared to increase, they remained low (although more women may have known about some of the danger signs but not all) (Figure 2). More women knew the recommended number of antenatal checks during pregnancy in 2016 compared to 2014 at 25.8% (95% CI 24.3-27.4) and 17.3% (95% CI 16.5-18.2) respectively. Knowledge of timely initiation of breastfeeding was already high prior to the intervention at 94.3% (95% CI 93.8-94.8) of women who knew that babies should be put to breast within 10 minutes of birth and remained similarly high in 2016. Data from Stories of Most Significant Change show how Shakti Varta has created space for women to share information on pregnancy and infant and child feeding, when previously such discussion was mostly confined to the home. Women

reported to welcome the opening up of space for discussion, the new opportunity to share experiences, seek inputs from one another, clarify doubts and access to 'expert opinion'.

Figure 2. Knowledge of danger signs during pregnancy, labour, postpartum period and in newborns of married or cohabiting women aged 15-49 (LCU=Lower Confidence Interval; UCI=Upper Confidence Interval)



Maternal and child health and nutrition practices

Among all pregnant women interviewed in the household surveys in 2014 and 2016 there was a small improvement in registration of pregnancies at AWCs, pregnant women receiving a take home ration from AWCs and pregnant women taking rest. In 2014, 81.4% (95% CI 79.9-82.8) of pregnant women had their current pregnancy registered at the AWC compared to 88.5% (95% CI 87.3-89.6) in 2016, 63.2% (95% CI 61.3-65.2) of pregnant women had received a take home ration from the AWC the previous month compared to 72.2% (95% CI 70.3-74.0) in 2016. Breastfeeding women with a child under two receiving a THR the previous month was unchanged but was high in both 2014 and 2016 at 92-93%.

The most common practices reported by pregnant women who attended Shakti Varta meetings after learning from attending was taking more rest (80%), sleeping under a bed net (68%), and improving handwashing (47%). Pregnant women who had only heard of Shakti Varta meetings but not attended reported similarly high levels of improved practices in the same areas. Out of all pregnant women (i.e. who attended, heard of or never heard of Shakti Varta), 47.6% (95% CI 45.2-49.9) reported to have taken extra rest during their current pregnancy than before they were pregnant in 2016 compared to 28.9% (95% CI 27.2-30.7) in 2014. These findings suggest that attendance at Shakti Varta meetings and diffusion of messages from those meetings is contributing to improved behaviours among pregnant women.

Women with children under five who attended Shakti Varta meetings reported adopting improved newborn care practices with over 50% stating they put the baby to the breast within an hour of birth, and wiping, wrapping and delayed bathing of the newborn. Women with children under five who had ever heard of Shakti Varta meetings but not attended also reported improved practices such as feeding their baby colostrum (49%).

Qualitative data illustrate the process through which participation in meetings is raising awareness and how Shakti Varta group participants, facilitators and FLWs are actively tracking target women to

improve maternal health practices and advocate for them with family members. Although data is from a small number of examples, the case story material illustrate how the Shakti Varta platform is nurturing bonds between women, and the active role that facilitators and FLWs are taking to promote better pregnancy outcomes.

Knowledge and practices in hygiene and sanitation

Mothers of children under five reported increased hand washing at critical moments; 8.7% (95% CI 7.9-9.6) reported this in 2014 compared to 21.0% (95% CI 19.2-22.8) in 2016. There was a small increase in the prevalence of mothers of children under five reporting safe disposal of their own and their children's faeces, although both remained low at 12.0% and 8.6% in 2016 respectively. There was no similar improvement in adolescent girls' handwashing and sanitation practices. This coincides with similar findings in the CLS evaluation, and the very low attendance of adolescents in Shakti Varta meetings. One out of 37 blocks receiving the Shakti Varta intervention also received the CLS intervention (K.Nuagan in Khandhamal district), however any contribution of CLS is likely to be small as 97% of Shakti Varta blocks did not receive this intervention.

The household surveys show a considerable improvement in FLWs knowledge of the five critical moments for handwashing, rising five-fold between 2014 and 2016 from 5.5% to 28.4% respectively. FLW use of an appropriate cleansing agent during handwashing improved from 80% in 2014 to 99% in 2016. However other sanitation practices were unimproved for example, the prevalence of FLWs who reported safe disposal of their own faces remained similarly low in 2014 and 2016 at 35.8% and 39.8% respectively.

Qualitative data from Shakti Varta participants strongly asserts that Shakti Varta has increased awareness of the harm of open defecation, changed community understanding about the benefits of using toilets, stimulated many people to start building toilets and for those who had toilets, to start using them. The 2016 survey of FLWs also found that close to a third of FLWs reported that Shakti Varta raised awareness of building toilets.

The combined data suggests that Shakti Varta is contributing to the increasing awareness of better handwashing and safer sanitation, however further efforts are needed to improve practice.

Community action

The 2016 household survey found that among those women that had attended a Shakti Varta meeting, some 48% had been involved in some form of community activity after attending a meeting. This high level of community activity corresponds to the findings from qualitative and process documentation that shows how participation in meetings is building women's confidence to ignite and participate in mobilising communities behind social and HNWASH agendas.

Women's empowerment

Household survey data found little change in indicators related to women's decision-making authority in the home with around two thirds of women reporting involvement in minor/major purchases or spending of their husbands earnings in both 2014 and 2016. There was some improvement in women's decision making over personal issues and in the perception that women like them can change things in their community where in 2014, only 19.2% (95% CI 18.0-20.3) of women reported that they could fairly or very easily change things in the community compared to 49.2% (95% CI 47.0-51.3%) in 2016.

Qualitative data shows the process through which Shakti Varta is building women's confidence to express their opinions, take part in family discussions and village meetings. Case stories also show

how GP Facilitators have gained confidence and status through their work, increased their influence in their homes and communities and are taking on leadership roles. Empowering rural women from Odisha is a long term process being addressed through many development programmes including Mission Shakti and improving human development outcomes in the State. Shakti Varta appears to be contributing to this process of change not least through building the capacity and influence of 5800 community based facilitators trained to promote HNWASH messages and mobilise women and the community to support behaviour change.

Value for money

Shakti Varta is an economical and a cost-efficient behaviour change communication intervention in comparison to Government of India norms. Assuming a person who attends a Shakti Varta meeting disseminates messages to four or more other persons, the cost per person of raising awareness is INR 5 (£0.05). In comparison, the Government of India norm for BCC activities under the National Rural Health Mission/National Health Mission is INR 10 (£0.10) per person. Evidence of effectiveness and sustainability are not feasible at this early stage of evaluation. Procurement of NGO implementing partners for Shakti Varta in each of the Wave I districts was through a competitive process which kept prices low. The unit cost of person days for the three local NGOs was INR 315 (£3). The human resource and travel costs are highly economical in view of market rates and average costs of travel in the geographical areas.

Conclusion

The results from this evaluation immediately post-intervention reflect the challenges of implementing a large scale community mobilisation programme embedded into government systems and structures and the creative solutions that were implemented to fill related gaps and capacities. Despite challenges, the evaluation has shown that this kind of intervention can be implemented through government systems at scale, and at reasonable cost. Participation by 20% of pregnant women and women with a child in these three blocks, measured through a household survey on a wide-range of health nutrition and WASH indicators, is a reasonable achievement for an intervention implemented on a large scale through government-civil society organisation partnership. Local NGOs played an important role as contracted partners to introduce and support the approach, but with certain adjustments, once embedded, it is feasible to institutionalise.

Delays in funding flow were a critical bottleneck that undermined implementation progress and quality. It frequently resulted in implementation delays, and demotivation of field teams, and reduced quality of community interactions. Going forward, as the government plans to complete the PLA cycle in Wave II districts and sustain the gains from Shakti Varta, streamlining the flow of funds through the government system needs priority attention.

Two important and possibly interrelated lessons have been that the time span between meetings was too short during the second half of the PLA cycle, and that the number of target women attending meetings needs increasing to expand reach. Monthly meetings as common in the PLA trials seems to be a more realistic time period given the livelihood and daily pressures on women's time and better corresponds to the WHO recommendation of a minimum three year implementation window. This would be facilitated by allowing a sufficient 'run-in' period prior to implementation / scale up to allow for inevitable challenges and for meetings to be completed comfortably within project funding periods. Changing the timing of meetings and in some areas the locations will likely be necessary to increase attendance especially of women living in far-flung areas. This will however add additional challenges for facilitators and further underlines the need for a

review of the compensation they receive. Tailored approaches for challenging operational contexts such as Left Wing Effected areas and remote pockets also need to be considered.

Despite implementation challenges, the early findings of this intervention are promising. As per the theory of change we find that pregnant women and women with children under five that participated in meetings report improvements in pregnancy and newborn care practices, and improved handwashing, and this is also reported from women in the target group who had heard about meetings but not participated. Evidence suggests that Shakti Varta is contributing to improved awareness of and practice of safer sanitation. There is also evidence that participation contributes to community action and the building of women's agency and self-confidence. Shakti Varta has actively engaged AWWs and ASHAs in the community mobilisation process and fostered collaborative working between them and GP Facilitators. It has also strengthened the capacity of Block level SHG Federations. These are indications that at this early stage of evaluation, the theory of change is robust. Later evaluation to capture the results of Wave II and changes in the primary outcome of neonatal mortality is recommended.

The evaluation documents the challenges and feasibility of taking PLA to scale through government and community systems and structures. The findings contribute to debate on the trade-off between a narrow versus broader focused PLA cycle and on the benefits of highly targeted versus wider population reach of this intervention. Government of Odisha has committed to completing the cycle of meetings in Wave II after DFID financial and technical support has closed. This will require commitment to sustain the core supporting systems of cascade and interval training, regular field supervision and support at the block level, field monitoring and the MIS. Reduced investment in any of these core areas will reduce the quality of implementation and the potential outcomes.

Disclaimer:
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For the full report, please visit http://options.co.uk/publications/evaluation-report-shakti-varta-odisha-june-2016

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