

Digital Green Pathway to Achieving RMNCH+A Nutrition Objectives

Digital Green worked with Dalberg Global Development Partners to assess and refine Digital Green's strategy and operational framework for applying its innovative video-based extension approach to meet reproductive, maternal, newborn, child, and adolescent health (RMNCH+A) nutrition goals under the four-year, USAID-funded *Digital Integration to Scale Gender-Sensitive Nutrition Social and Behavior Change Communication (SBCC)* project, which launched in October 2015. Under this project, Digital Green will reach 200,000 women in 2,000 villages and indirectly engage over 1,000,000 people by rapidly scaling its approach to gender-sensitive SBCC in existing public, private, and civil society extension systems. Dalberg's findings and recommendations are summarized below and chart Digital Green's path forward toward creating lasting, beneficial changes in nutritional behavior.

Service Approach

Based on existing capabilities and experience, Digital Green is well-positioned to quickly launch and grow programs in RMNCH+A nutrition in India. However, to drive sustained behavior change, Dalberg believes that Digital Green will need to adapt and refine its service approach to:

- Invest more in *localized, formative research and knowledge generation* to identify underlying causes of behaviors and locally-feasible solutions that can drive the adoption of new behaviors.
- *Leverage other SBCC methodologies* over time, including interpersonal counselling and mobile-based content, to reinforce and further propagate nutrition and health messages.
- *Expand and intensify training* on nutrition-tailored video production and dissemination, and increase frontline health workers' access to training resources through ICT-enabled platforms.
- Provide *measurable, meaningful definitions and indicators* for nutrition adoptions.

Geographies

Bihar, Chhattisgarh, Gujarat, Jharkhand, Madhya Pradesh, Maharashtra, Odisha, Rajasthan, Uttar Pradesh, and West Bengal emerged as long-term priorities based on their malnutrition burdens. Bihar, Jharkhand, and Odisha were selected as near-term priority states based on the estimated time to implement, potential to scale, and strength of existing capabilities and partner networks.

Partnerships

Dalberg explored potential partners across Digital Green's core knowledge, SBCC, dissemination, and data functions. Among knowledge stakeholders, Alive and Thrive (FHI 360) and Poshan (IFPRI) offer substantial, nutrition-specific intellectual property for India. BBC Media Action is a high-potential, cross-cutting SBCC partner based on their approach and experience in priority states. The National Rural Livelihoods Mission (NRLM), National Health Mission (Ministry of Health and Family Welfare), and Integrated Child Development Services (ICDS; Ministry of Women and Children) are influential dissemination stakeholders, offering large networks of frontline health workers. DIMAGI is well-positioned to enhance Digital Green's data collection process and provide ICT-enabled platforms for frontline health workers to access training and resources. In addition, several large-scale and multi-state initiatives offer opportunities to leverage funding and access influential nutrition stakeholders.

Implementation

In Bihar, Jharkhand, and Odisha, Digital Green's near-term implementation road map will consist of 1/ establishing the quickest "route-to-market;" 2/ expanding program reach and impact by incorporating new partners and aligning SBCC approaches with the potential to boost adoption and behavior change; and 3/ demonstrating capabilities and scale. Dalberg's overall findings suggest that Bihar is likely to implement and scale the fastest thanks to Digital Green's existing partnerships, and that Jharkhand may have higher overall impact and adoption rates due to potential cross-cutting partnerships.

■ Nutrition for RMNCH-A and SBCC Strategy Study for Digital Green

Final Report

12 March 2016



Dalberg

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Context

- Digital Green (DG) uses an **ICT-enabled social and behavior change communication (SBCC) approach**, based on low-cost, peer-to-peer videos to disseminate messages and practices on agriculture practices to villages in India
- Now, with USAID's funding, DG seeks to adapt and apply its approach to nutrition for reproductive, maternal, newborn, child and adolescent health (RMNHC+A), including messaging on **family planning**
- The program's objectives are to reach at least 200,000 women directly, and over 1 million people indirectly in **2,000 villages in four states** with nutrition-specific, mediated video disseminations
- Success for DG will mean that target women in rural areas are well-aware of the concept of the first 1000 days and undertake their responsibilities with respect to nutrition-related behaviors (for themselves and their children)
- To do this, DG needs to strengthen its organizational capacity and refine its agriculture extension model by **identifying the right nutrition BCC interventions in the right areas through right partners**

Digital Green approach



Initiate



Produce



Diffuse

- Research
- Identify and study target communities
- Select and train partners on video production, facilitation and data collection

- Storyboard, cast, shoot and edit videos
- Check and control audio-visual quality and technical content in the videos

- Show and mediate videos within small groups through front line workers (FLWs)
- Collect feedback and source new ideas
- Monitor propagation and adoption
- Collect and evaluate data

Objectives and guiding principles

Study objectives

- Understand DG's current operations and priorities for RMNCH+A nutrition program, and assess how the program would fit in with DG's wider operations
- Develop service approach for DG's RMNCH+A nutrition program in India
- Select target states for the program for the short and the long term
- Map the nutrition stakeholder landscape; identify and assess potential partnerships opportunities and partner organizations, including the ability for partners to share costs

Guiding principles

- **Aspire:** program targets are only a baseline; strong appetite and potential to achieve more
- **Learn, leverage, demonstrate:** establish a rapid "route-to-market", by seeking to maximize existing penetration and capabilities; provide proof-of-concept
- **Partner to scale:** identify, explore and initiate partnerships to drive scale, and importantly, adoption and impact

Main questions

Main questions	Sub- questions
Service approach	<ul style="list-style-type: none">• What existing capabilities of DG may be leveraged? What will need to be refined for the RMNCH+A nutrition program?
Geographies	<ul style="list-style-type: none">• In the long term, which states should be explored for nutrition interventions?• Which of these states should be prioritized for work in the short term?
Partnerships	<ul style="list-style-type: none">• What is the high-level landscape of influential nutrition stakeholders in India and in the priority states?• Which stakeholders are best-suited for partnerships with DG?
Implementation	<ul style="list-style-type: none">• How can DG's nutrition programs be implemented and scaled in the short-term priority states (over the next 30-36 months)• What is a high-level, long-term roadmap for DG's nutrition programs?

Scope of the study

In-depth analysis,
coverage of RMNCH+A
outcomes and goals

- RMNCH+A nutrition is the primary focus of DG's expansion plans (from ag-related activities)
- Bulk of DG's indicators of success relate to behavior change¹ are focused on RMNCH+A and nutrition

Lighter-touch coverage of
Family Planning

- FP indicators are not the focus of this study, but some critical FP indicators especially around increasing awareness and knowledge of practices and techniques may be integrated easily into RMNCH+A programs, using the same partners
- The study points out and discusses these opportunities

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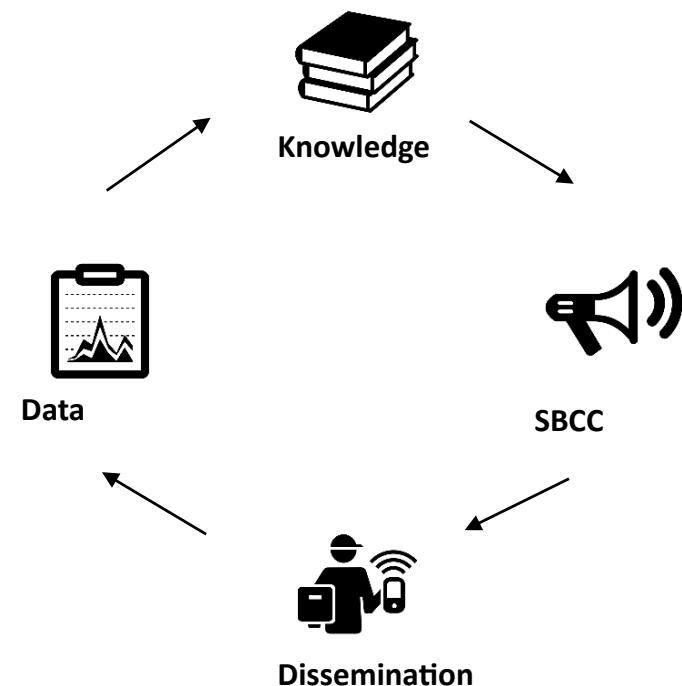
Summary findings and recommendations (1/4)



Service approach

- Based on existing capabilities and experience, DG is well-positioned to quickly launch and grow programs in RMNCH+A and nutrition in several states in India. But, pilots raised important challenges related to the capacity of the approach to drive sustained behavior change. Importantly, nutrition topics are more complex/abstract and sensitive than those address in agriculture, and, many topline behaviors are not tangible or easily quantifiable, which limits DG's ability to influence change.
- The standard DG service approach will require important adaptations and refinements. Importantly:
 - *Knowledge*: Invest more on localized, formative research, e.g. on identifying local underlying causes of behaviors and locally feasible solutions (e.g. sourcing for home gardens that enable diverse diets) that could drive adoption of new behaviors
 - *SBCC approach*: Over time, leverage other SBCC methodologies, to reinforce and further propagate messages. In particular, (1) incorporating a greater focus on interpersonal counselling, and (2) mobile-based content and reminders
 - *Dissemination*: Expand/intensify training on nutrition-tailored video production and dissemination; Increase access to ongoing training and resources through ICT-enabled platforms for FLWs
 - *Data*: Provide measurable and operationally meaningful definitions and indicators for “adoption” for FLWs, and; establish/define metrics to improve tracking/reporting of nutrition-specific information and analytics on COCO

Evaluation framework for service approach



Summary findings and recommendations (2/4)



Geographies

- A long-list of 10 states was prioritized based on an assessment of the malnutrition burden. Long-term priority states (3-6) may be selected from this long list. The prioritized states are Bihar, Chhattisgarh, Gujarat, Jharkhand, Madhya Pradesh, Maharashtra, Odisha, Rajasthan, Uttar Pradesh and West Bengal.
- Other factors that could drive the choice of geographies, such as “states with fewer development actors”, were not considered in this study.
- Of the prioritized long-list, Bihar and Jharkhand are selected for short-term implementation based on a high-level assessment of (1) estimated time to implement and, (2) time/potential to scale, and most importantly, (3) existing capabilities/ networks of DG.
- In addition, Odisha shows potential to contribute in the short term as a learning laboratory, feeding insights and course corrections into programming in other states. This is based on current activities in the state involving a randomized control trial (RCT) with partners on RMNCH+A nutrition and BCC.
- Programs in Bihar are expected to launch first, with the highest potential to scale, based on (1) existing operations and capabilities in Bihar, and (2) strong relationships with the Bihar Rural Livelihoods Mission (JEEVIKA) – a dissemination partner with significant penetration and mission convergence.

DG's current operations – Agriculture + Nutrition



Summary findings and recommendations (3/4)

Partnerships

- Potential partners were explored across DG's core functional areas: knowledge, SBCC, dissemination and data. Our main findings were:
 - Knowledge:** Several influential "knowledge" stakeholders are operating in the priority states and have existing relationships with DG. **Alive and Thrive (FHI 360)** and **Poshan (IFPRI)** appear to have the best nutrition-specific intellectual property for India.
 - SBCC:** **BBC Media Action** emerged as a high-potential cross-cutting SBCC partner, based on their complementary approach and experience in priority states. BBC has scaled rapidly in Bihar (potential for integration), and is initiating programs in Jharkhand.
 - Dissemination:** Expectedly, three national ministries/missions – National Rural Livelihoods Mission (**NRLM**), **National Health Mission** (Ministry of Health and Family Welfare) and the **ICDS** (Ministry of Women and Children) – are the most influential dissemination stakeholders for nutrition with access to large front line worker (FLW) networks. State-level presence and capacities vary substantially for these ministries.
 - Data: **DIMAGI**'s experience with video-based content delivery, and working in nutrition in India position it well to enhance DG's data collection process, and provide an ICT-enabled platform for FLWs to access ongoing training and refreshers.
- In addition, **large-scale programs and multi-state initiatives** such as (1) National Nutrition Mission, (2) ICDS Systems Strengthening & Nutrition Improvement Program (ISSNIP), and (3) USAID's RMNCH+A Nutrition program in 6 states **offer opportunities to leverage funding and a single point of access to multiple influential nutrition stakeholders.**

Prioritized partners



Summary findings and recommendations (4/4)

Implementation

- Our suggested implementation road map across the three short term priority states is broadly the same: (1) **establish the quickest “route-to-market”** i.e. launch quickly, leverage existing capabilities/networks), (2) **expand program**, both reach and impact, by incorporating new partners and aligned SBCC approaches that have the potential to boost adoption and behavior change, and (3) **demonstrate** capabilities, scale and incorporate cross state learnings.
- Overall, findings suggest that **Bihar is likely to implement and scale fastest through DG’s partnership with BRLPS**. The program in **Jharkhand shows potential for crucial cross-cutting partnerships with JSLPS, SNM and BBC Media Action (which is specifically seeking partnership opportunities in JH)**. However, in **Odisha**, while the reach is currently limited in the absence of a local dissemination partner with potential to scale, the current RCT **offers significant opportunities to gather and incorporate lessons and best practices** regarding optimal behaviors and processes for BCC in RMNCH+A nutrition.

Priority states for short-term implementation

- Quickest to launch
 - Launch rapidly with existing partner Bihar Rural Livelihoods Mission (JEEVIKA); potential to scale to 11 priority districts
- 
- Capacity to launch in 2016 in at least 2 districts with existing partner Jharkhand State Livelihood Promotion Society
 - Potential to expand to 7 districts if procurement of picos materializes
- Launching in 45 villages with MSSRF and MKSP in 1 district
 - Expected to launch in 100 villages by end 2016 for an RCT with VARRAT/LSH/EkJut
 - Potential to expand unclear

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DG brings to bear important capabilities through its work in agriculture



Knowledge

Main capabilities and organizational assets

- Partnerships with prominent technical and research bodies on behaviors/messages to target/promote



SBCC

- Structured and innovative production and dissemination process that leverages local talent and focuses on local issues – found to be 10X more cost effective than conventional BCC
- High quality of videos and accompanying consultations and counselling



Dissemination

- Leveraged model focused on transferring skills to partners via high-quality training modules
- Mature relationships and networks with AJEEVIKA in key states like Bihar and Jharkhand
- High-touch engagement/interface with communities to enhance behavior change



Data

- Simple but intensive data collection process with a short feedback loop between diagnosis and action
- Open source data platform that tracks key metrics that are then inputs to monitor the program and partner performance

Views from internal and external consultations¹

[DG] works best when it channels best knowledge practices to communities, by ideally getting them involved in video production, dissemination and data management. This is responsible for success and ensures sustainability since people are motivated to do something for their community.

- Internal stakeholder

The quality of videos has been appreciated by community members. They like that they can see local villagers in the videos talking about issues that are also very local. They ask a lot of questions.

- Community mediator

[DG] already has good coverage with the government. It is doing great work in Bihar, working with the government frontline workers there. Working with the government is difficult since it depends so much on the officials' individual motivations, but they are probably necessary to reach any kind of scale.

- External stakeholder

(1) N=~20 consultations across internal and external interviews.

Source: Internal and external consultations; Review of Digital Green materials and documents; Dalberg analysis

It has begun to explore the RMNCH+A nutrition space in India through pilots

Overview of DG's pilots in health and nutrition and associated outcomes

Uttar Pradesh (2012)

- Implemented in 84 villages
- Partnered with Gram Vikas Sangathan, Nehru Yuva Sangathan Tisi, PATH, Univ. of Washington (USA)
- Focus on using ASHA workers to screen videos to mother's groups and VHND
- 38 videos produced and ~4.5k group disseminations occurred over 24 months

Odisha (2012-13)

- Implemented in 30 villages, across two districts
- Partnered with VARRAT and USAID SPRING
- Tested efficacy of using NRLM VRPs screening to SHGs
- 10 videos developed and disseminated to 40+ SHGs

Bihar (2013)

- Implemented in 40+ villages across 3 districts
- Partnered with WBG and JEEVIKA
- Tested efficacy of using NRLM VRPs screening to SHGs
- 15 videos were produced on 10 topics, and screened for 104 SHGs (~1.5k-2k individuals)

Madhya Pradesh (2013)

- Implemented in 100 villages in Khandwa district
- Partnered with Real Medicine Foundation using their own 'community nutrition educators' as VRPs/CRPs



- ~250-300 total villages reached across four states through past nutrition programs



- ~8-10k women reached¹ through SHGs



- 50-65 nutrition specific videos developed
- 5k+ video disseminations



- High-level dissemination partnerships with JEEVIKA in Bihar, JSLPS in Jharkhand
- Partnerships/relationships with key technical players like IFPRI (POSHAN), PCI, and London School of Hygiene
- Different scenarios of partners to test effectiveness (NRLM VRPs vs ASHAs) of nutrition messaging

(1) Reach is defined as the number of individuals who have watched at least 1 DG video and attended at least 1 mediated dissemination session. This is an estimated number.
Source: Materials from Digital Green; Internal consultations; Dalberg research and analysis

The pilots raised important challenges and considerations...

Nutrition-specific challenges



Knowledge

- Nutrition **topics are more complex/ abstract** and sensitive than those in agriculture
- Behaviors are reinforced by **deep-rooted socio-cultural factors** that are hard to change



SBCC

- Understanding the drivers of behaviors to target and customization of associated **messaging is complicated** in nutrition
- **Selection of target audience is tricky** given a diverse set of invested stakeholders, multiplicity of decision makers
- Target audience (pregnant, lactating women) is **difficult to access** outside the home
- **Lack of visible, short-term outcomes** limits credibility and diffusion of messages



Dissemination

- Video Resource teams require **in-depth technical knowledge/training** to produce quality videos
- Overall, **FLWs with backgrounds in nutrition and health performed better than others without** (e.g. ASHA workers performed better than NRLM FLWs)
- Amongst FLWs with limited contextual knowledge (e.g. NRLM), **performance of fluctuated** more widely, and depended more on individual skill, capacity than in agriculture
- **Ready platforms exist that offer access to target populations in rural areas** such as Village Health and Nutrition Days (VHNDs) through the NRHM's ASHA workers



Data

- Uncertainty on an **appropriate measure/ indicator of "adoption"** of behavior change
- Challenges in **ensuring and tracking compliance**
- **Results occur in the long term and are rarely visible**, making them difficult to observe, track and report
- Several **important and impact behavioral changes do not require significant supply-side interventions and linkages** (e.g. breastfeeding practices) – with positive implications for driving cost-effective BC

..that have implications for the service approach

Recommendations for refining DG's current service approach



Knowledge

- ➲ Enhance in-house **domain knowledge of RMNCH-A and family planning issues**
 - ➲ Provide **greater emphasis and explore different models for improved formative research** at the local level to
 - Identify a comprehensive set of behaviors to target to reduce malnutrition
 - Understand underlying local causes/drivers of nutritional behaviors and incorporate these into videos
-



SBCC

- ➲ DG approach positions it well to scale nutrition programs quickly, but **sustainable impact (i.e. adoption) is likely to require layering in other SBCC methodologies over time**, to reinforce and further propagate messages
 - In particular, (1) incorporating a greater focus on **interpersonal counselling**, including **targeting local opinion leaders¹** and influencers (2) **mobile-based content, reminders** to reinforce and complement DG's messaging
-



Dissemination

- ➲ **Expand/intensify training** on nutrition-tailored video production and dissemination
 - Include **greater emphasis on nutrition topics** and behaviors for ongoing training/refreshers
 - Support FLWs with **ICT-enabled (mobile) access to technical content, training and toolkits** as detailed in Digital Public Health paper by PATH
 - Work with on-the-ground dissemination partners to (1) **explore existing platforms, e.g. VHNDs²** to access and organize target populations (2) **cultivate Village Nutrition Committees or Advisory Boards²** to provide inputs into video topics, support and coordinate activities at the village level and help monitor adoption
-



Data

- ➲ Provide **measurable and operationally meaningful definitions and indicators for "adoption"** for FLWs
 - ➲ Enable **full decentralization and digitization of data collection** by investing in **mobile and ICT-based platforms** (through strategic partnerships)
 - ➲ Develop/improve **capacity to report nutrition-specific information and conduct in-depth analytics** (on COCO), with potential to coordinate data from multiple data sources (other partners), which feeds into ongoing course corrections, refinements in the program (e.g. aggregating demand, optimizing FLW follow-ups, etc.)
-

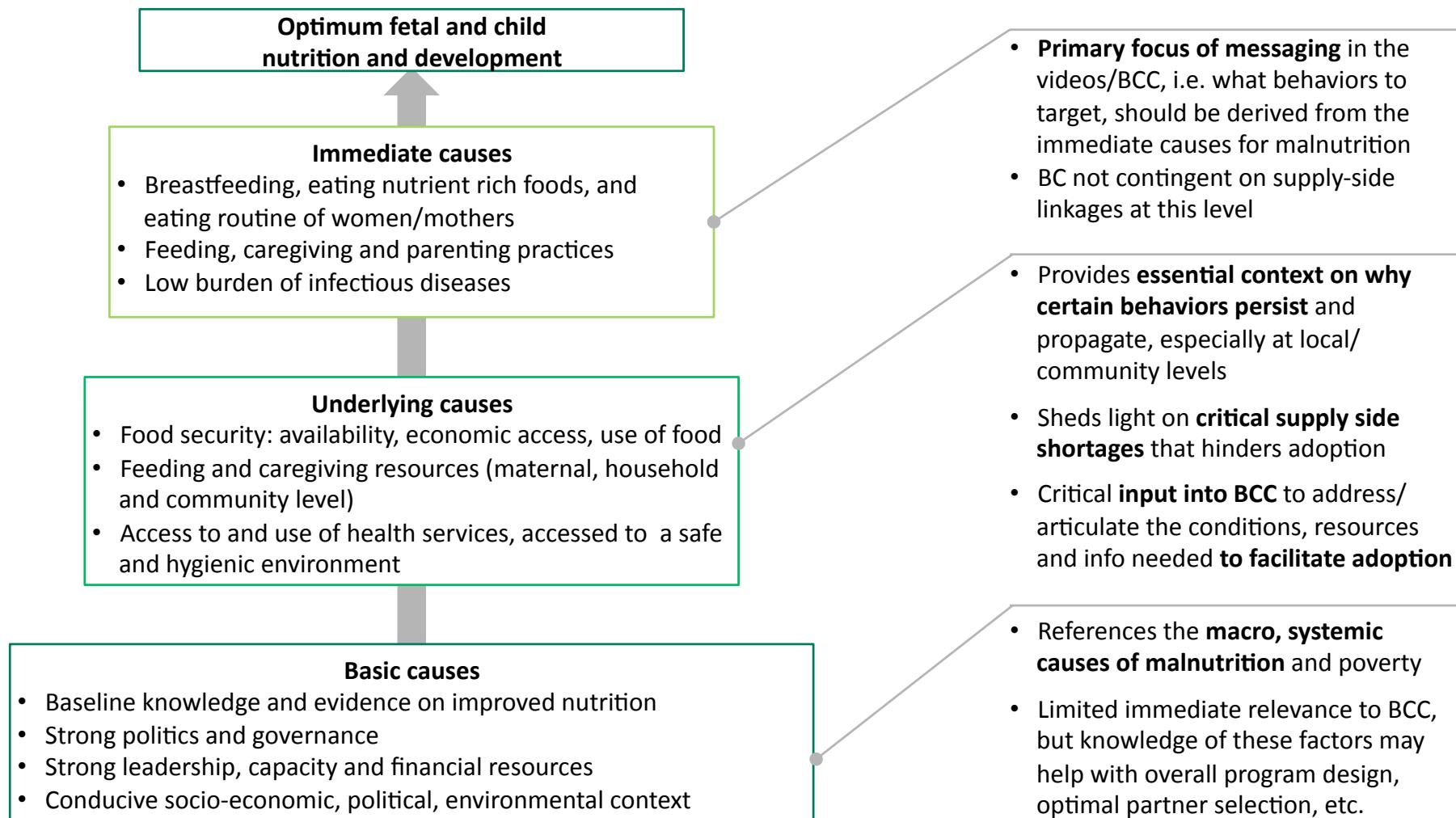
(1) Consultations with DG staff on lessons from pilot in Odisha

(2) "Projecting Health: Community-led Video Education for Maternal Health", Digital Green, University of Washington and PATH (2015): Concerning lessons from DG's pilot in UP.
Source: Initial external consultations; Dalberg research and analysis



Better understanding the local nutrition context and underlying causes of behaviors is crucial to develop actionable messages

Causes of RMNCH+A malnutrition and implications for messages and behaviors to target¹



(1) Framework for Causes of RMNCH+A malnutrition adapted from "A Review of Evidence-Based Interventions in Indian Nutrition Programs", POSHAN (IFPRI, 2013); "What Works? Interventions for MCH Undernutrition and Survival", Bhutta, Z.A. et al (The Lancet 371, 2008), and POSHAN District-level Nutrition Profiles (IFPRI, 2013)
Source: POSHAN (IFPRI) and UNICEF; Dalberg research and analysis



Evidence from nutrition pilots suggests that DG has prioritized several important behaviors for RMNCHA+A nutrition

Critical behaviors/inputs to target for improved RMNCH+A nutrition

#	Critical messages and inputs for nutrition outcomes	DG coverage?	Key considerations
1	Timely initiation of breastfeeding within 1 hour of birth	Yes	<ul style="list-style-type: none"> Supply linkages not needed for reach, impact Non-specialist partners (e.g. AJEEVIKA, NGOs) sufficient to drive impact
2	Exclusive breastfeeding during the first 6 months of life	Yes	
3	Safe/hygienic handling of complementary foods/practices	Yes	
4	Timely introduction of complementary foods at 6 months	Yes	<ul style="list-style-type: none"> Strong supply-side linkages needed for impact Messages on locally feasible/sourced solutions (e.g. home gardens) critical for impact Partnerships with other agencies, e.g. WCD, MoHFW will help drive greater impact
5	Age-appropriate complementary feeding for children 6-24 mths.	Yes	
6	Improved food/nutrition for adolescent girls, to prevent anemia	Yes	
7	Improved food/nutrition for women (when pregnant or lactating)	Yes	
8	Prevention of anemia	Partial	<ul style="list-style-type: none"> Strong supply linkages needed for impact Partnership with ICDS crucial
9	Reducing vitamin A deficiency	Partial	
10	Reducing burden of intestinal parasites	Partial	<ul style="list-style-type: none"> Strong supply linkages needed for impact Partnership with MoHFW crucial Current coverage could be intensified through inclusion/focus on WASH messaging
11	Prevention and treatment of diarrhea	Partial	
12	Prevention and treatment of malaria	No	
13	Full immunization	No	<ul style="list-style-type: none"> Strong supply linkages needed for impact Partnership with WCD/MoHFW needed
14	Quality feeding/care for children with severe acute malnutrition	No	

In addition, BCC aimed at increasing awareness and acceptance of suitable family planning practices will be implemented

DG's priority indicators for Family Planning

#	DG's priority indicators for Family Planning	Considerations
1	Proportion of women in the reproductive age group who recall seeing / hearing a message on family planning	<ul style="list-style-type: none">• Indicators seek to increase awareness and knowledge of FP methods• Limited supply-side linkages needed for awareness building• Facilitation/propagation will require specialized training on modern FP methods and practices such as safe birth spacing• Good opportunity to scale through partners such as AJEEVIKA
2	Proportion of women in the reproductive age group who know of at least three Family Planning methods	<ul style="list-style-type: none">• Supply-side linkages needed• Significant interpersonal and HH level interactions/ credibility likely required• Likely to require support from ASHA and Anganwadi Workers for effective propagation
3	Proportion of women in the reproductive age group have a favorable attitude towards family planning	<ul style="list-style-type: none">• Significant interpersonal and HH level interactions likely required• Likely to require specialized training on interpersonal, communication skills, given socio-cultural sensitivities• Likely to require support from ASHA and Anganwadi Workers for effective propagation
4	Proportion of women in the reproductive age group who can seek health care for themselves and their children without seeking permission	
5	Proportion of women in the reproductive age group who have participated in the decision about how many children they wish to have	



SBCC

In the long term, a layered service approach is likely to drive sustained behavior change by “bombarding” target communities with messages

SBCC inputs received by target group



Video broadcast for knowledge dissemination

- Mediated video disseminations to women's groups
- Incorporated refinements to current ag-based approach, including content/messaging tailored to nutrition, research on underlying causes, etc.



Mobile-based reminders and content for community

- Interactive, professionally-curated, voice-based content on a mobile platform
- Customized to local languages/context to overcome literacy/cultural barriers, and drive adoption
- Strong link to DG videos, to reinforce same messages
- Provided by a partner (e.g. BBC Media Action)



One-on-one or group counselling for communities

- Counselling at the HH level provided by FLWs to address specific/sensitive queries, and to reinforce changes in behavior

Why?

- Standard DG service approach has demonstrated strong potential in driving nutrition outcomes
- Refinements including targeting key opinion leaders, and, utilizing existing platforms to target and organize local individuals to become champions e.g. leveraging Village Nutrition Committees
- Multiple mediums of communication and reinforced messaging targeting influencers and decision makers likely to drive increased adoption
- Ability to scale program quickly, including reaching influential stakeholders outside the target group
- Behavior change in nutrition likely to require intensive and sustained hand-holding by FLWs

Not all three inputs are needed at once to achieve scale. However, an integrated “bombardment” approach is recommended to drive impact and adoption of right nutritional behaviors These may be incorporated gradually, over time.



SBCC

Evidence from globally prominent SBCC initiatives in health and nutrition also highlight multiple channels of demand creation

Case studies	Description	Results	Main lessons
Government of India Polio Vaccination Program	<ul style="list-style-type: none"> Focused on social mobilization by creating demand and segmenting population to ensure supply of polio vaccines 	<ul style="list-style-type: none"> At its peak, 150 million children / year were vaccinated WHO declared India free of wild polio virus in 2014 	<ul style="list-style-type: none"> Multiple channels of demand creation are an effective driver of behavior change e.g. TV and radio ads by celebrities, mobilization by religious leaders and local health workers
EHG Indonesia Healthy Gossip Movement	<ul style="list-style-type: none"> Tested the efficacy of message broadcast and message broadcast and personal engagement on maternal health behavior 	<ul style="list-style-type: none"> Dietary diversity increased for all Increase was ~25% more for the treatment groups 	<ul style="list-style-type: none"> Reinforcement of emotional drivers is an important factor in behavior change. E.g. the messages used drivers such as affiliation, and disgust, which were reinforced through personal visits
FHI360 Nigeria breastfeeding	<ul style="list-style-type: none"> Tested effectiveness of group activities + mobile messages for exclusive breastfeeding (EBF) 	<ul style="list-style-type: none"> % of women who had intentions to practice EBF and those who did increased from 42% to 64%. 	<ul style="list-style-type: none"> Mobile-based SBCC mechanisms show potential in driving behavior change, especially when reinforced by peer groups Group ownership of mobile phones may overcome of access at the individual level¹

(1) Although ownership of mobile phones in India is rising fast, rural penetration hovers at around 75-80%. Most households have access to a single phone, which is usually kept in the possession of a male member of the household. This was also confirmed in consultations with FLWs from VARRAT (DG's implementation partner in Odisha) during a field visit.

Source: Internet research including program websites and reports; External consultations; Dalberg research and analysis



The content of training provided by DG, as well as the medium of delivery should be streamlined to the RMNCH+A context

	Existing coverage	What should change	Why?
Technical content (RMNCH+A nutrition)	<ul style="list-style-type: none"> Some coverage in 2-day dissemination training (only for FLWs not engaged in health / nutrition disseminations) Ongoing refreshers during FLW coordination meetings 	<ul style="list-style-type: none"> Develop independent module on technical content on nutrition, WASH, FP and on techniques, best practices for facilitating/persuading SHGs Leverage sufficient existing resources and partners for content/practices Use video-based platform (offline/online) to provide FLWs access core content/research e.g. DIMAGI 	<ul style="list-style-type: none"> Nutrition topics are complex, sensitive, require more expertise than agriculture topics ICT-enabled platforms provide ongoing support, training; greater leverage for technical partners (like DG, BBC, etc.) Increase capacity/quality of mediators to promote BC
Video production	<ul style="list-style-type: none"> Comprehensive training provided over 5-day module Significant on-the-job learning 	<ul style="list-style-type: none"> Enable VRPs to undergo training on content/ dissemination modules so that video production techniques and storylines are more nutrition-sensitive 	<ul style="list-style-type: none"> Not uncommon for VRPs to get asked questions on behavioral issues, best practices Enable VRPs to create better, data-backed, contextual and actionable videos
Dissemination	<ul style="list-style-type: none"> 2-day module focusing on (1) content, (2) behaviors to propagate, (3) facilitation Ongoing Q&A during FLW coordination meetings 	<ul style="list-style-type: none"> Deeper focus on “learning-by-doing” – including mock disseminations for FLWs Sharper focus on interpersonal persuasion skills using BCC, e.g. drivers like affiliation, disgust, praise, etc. Enable ICT-accessible training content (including video formats) 	<ul style="list-style-type: none"> Nutrition topics are complex, sensitive, require more expertise than agriculture topics Increase capacity/quality of mediators to promote BC

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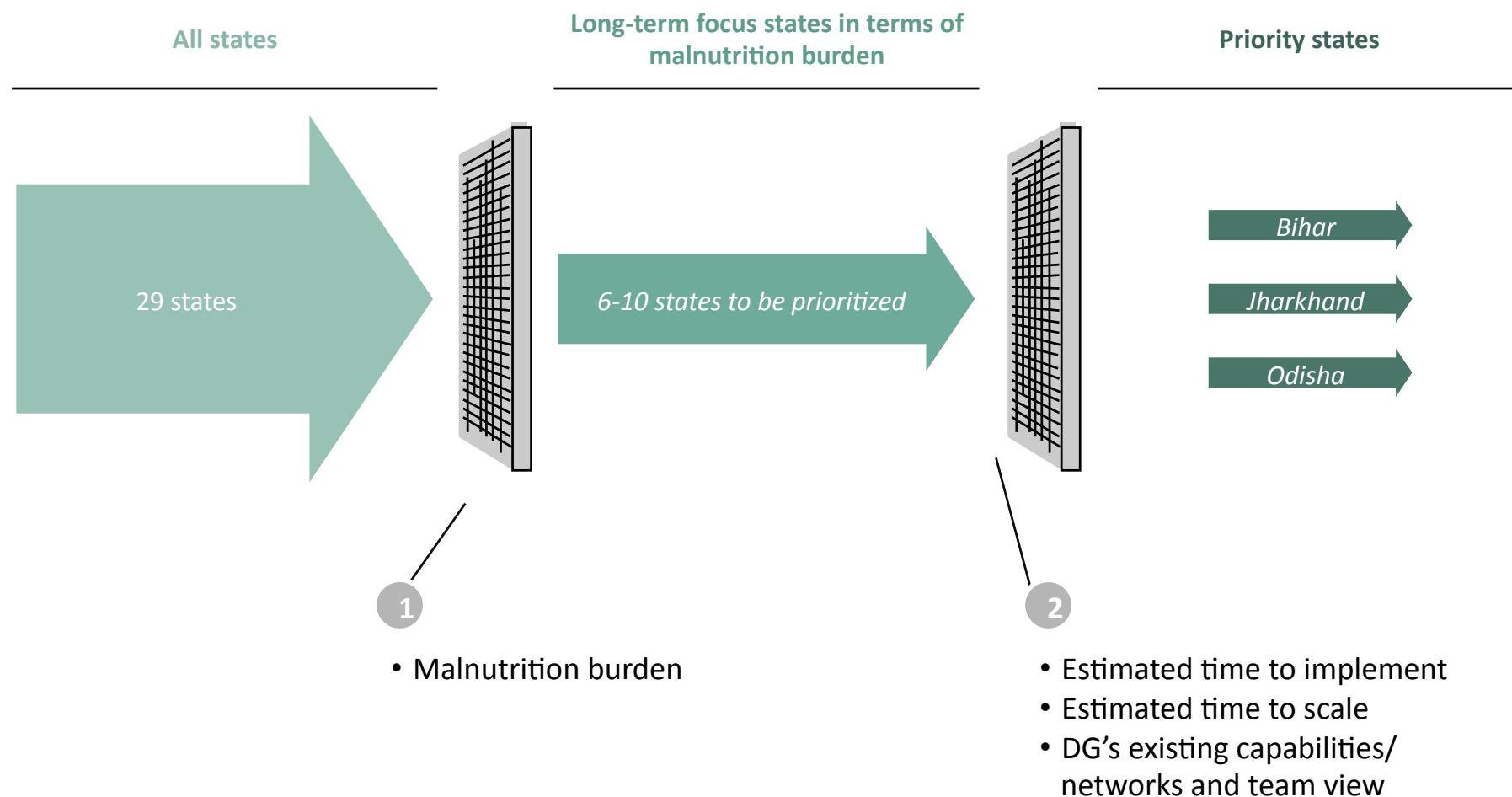


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We adopted a two-stage process to identify long term and priority states

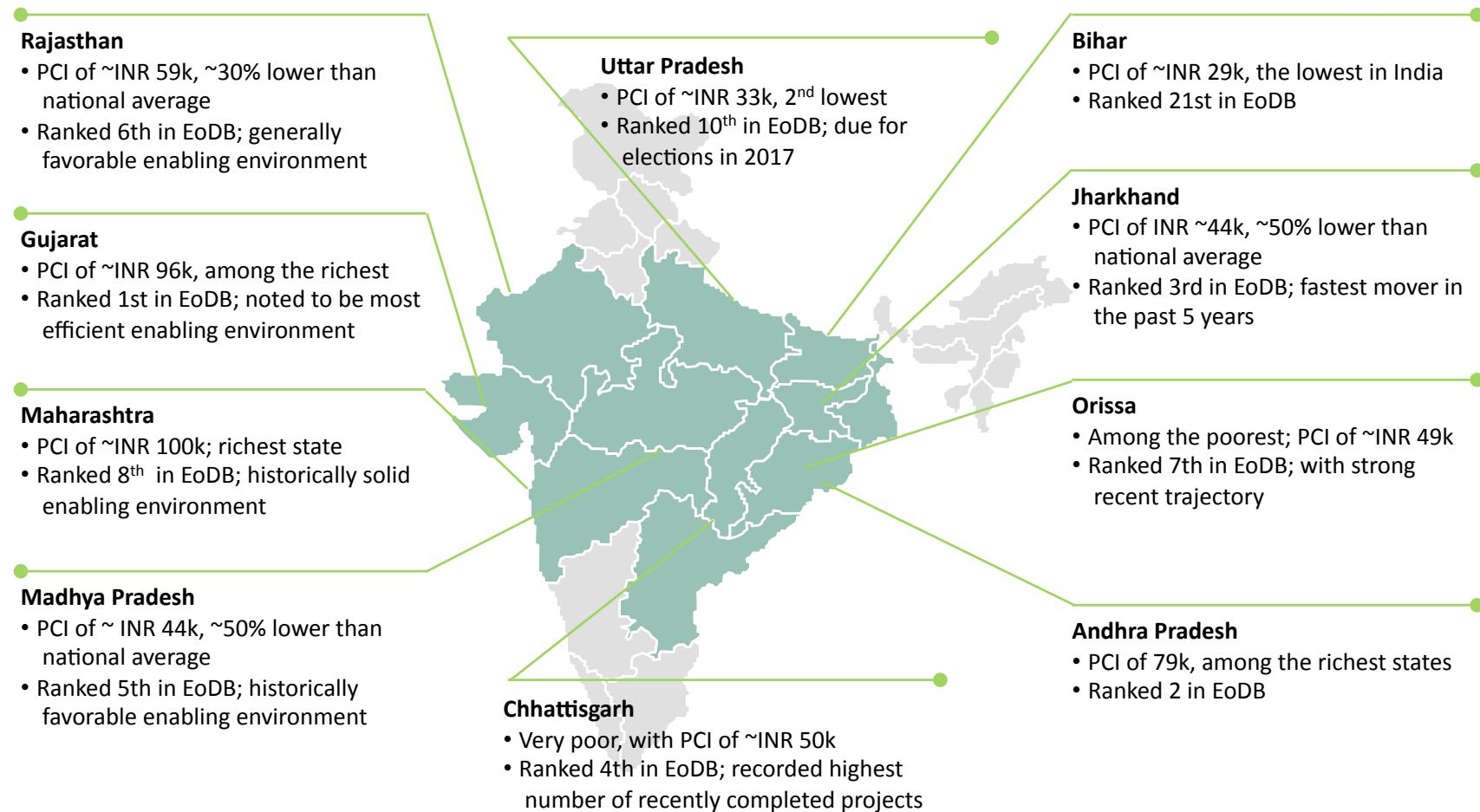
Process to select priority states



① Based on malnutrition burden, 10 states emerged as potential targets for long term programming

Overview of potential priority states based on malnutrition burden¹

Rankings from National Nutrition Mission and World Bank ISSNIP; Per capita Income (PCI) in INR/year; Ease of Doing Business (EoDB) rankings²



(1) The prioritization of these ten states was based on the following methodology: We took a weighted average of the proportion of high-burden districts in Indian states, based on (i) The classification by GOI's National Nutrition Mission, and (ii) The classification of states by the World Bank for its ISSNIP program to address malnutrition in India. This enabled us to develop a fairly robust perspective on the highest burden states in India. It should be noted that, expectedly, there was a lot of overlap across the GOI and the WBG lists. (2) In December 2014, States agreed to a 98-point action plan for reforms that should be undertaken to improve the regulatory framework for business. These are rankings based on assessments till June 30, 2015. EoDB is taken as a proxy for rankings derived from this study.

Source: Economic Survey – Government of India (2012-13) (<http://www.mapsofindia.com/maps/india/percapitaincome.htm>); DIPP report; Dalberg analysis

Bihar, Jharkhand emerged as priority states for rapid implementation

Overview of priority states

- 
- The map shows the state of Bihar in light green and the state of Jharkhand in dark green, both highlighted against the background of other Indian states.
- DG operating in 22 districts, with a total reach of ~300k in villages in agriculture
 - Nutrition pilots conducted in 40+ villages in three districts, reaching ~100 SHGs and ~2k women in 10 months
 - Access to trained FLW network through BRLPS with strongest potential to scale
 - DG operating for 1.5 years in 2 districts (~100 villages), reaching ~5-10k individuals through SHGs
 - 80+ videos produced/screened

Time to implement
How quickly can DG launch operations in the state based on existing presence, networks?



Ability to launch quickly with BRLPS

Time to scale
What are the capabilities of existing partners/channels to scale rapidly in nutrition?



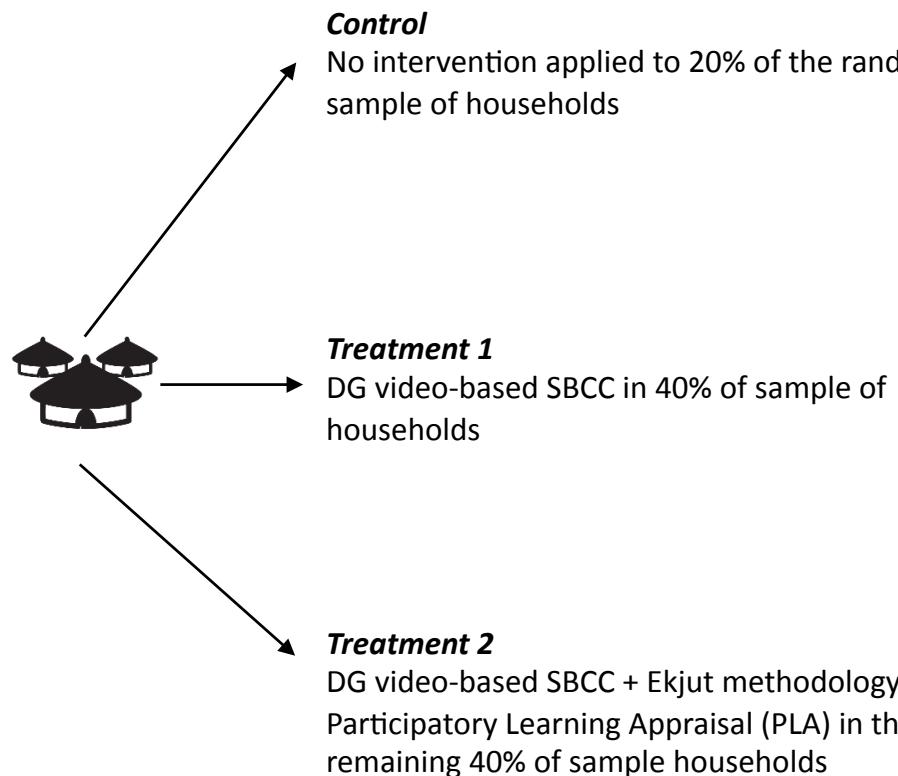
Strong potential to scale to 11 districts in Bihar with BRLPS

 Ability to launch with JSLPs; interest in pilot from SNM



Potential to scale along with JSLPS to 700+ villages in 12 months

② While Odisha emerged as a priority state with a unique short term opportunity as a learning laboratory



Expected lessons

- Rigorous processes for combining video enabled SBCC and PLA methodology
- Insights into disaggregated impact of video enabled SBCC methods and combined method of PLA + video
- Rapid implementation of DG+ models (through detailed human mediation) for nutrition intervention based on early learnings
- Possible partnership with Ekjut to implement combined approaches in other areas of Ekjut's operations

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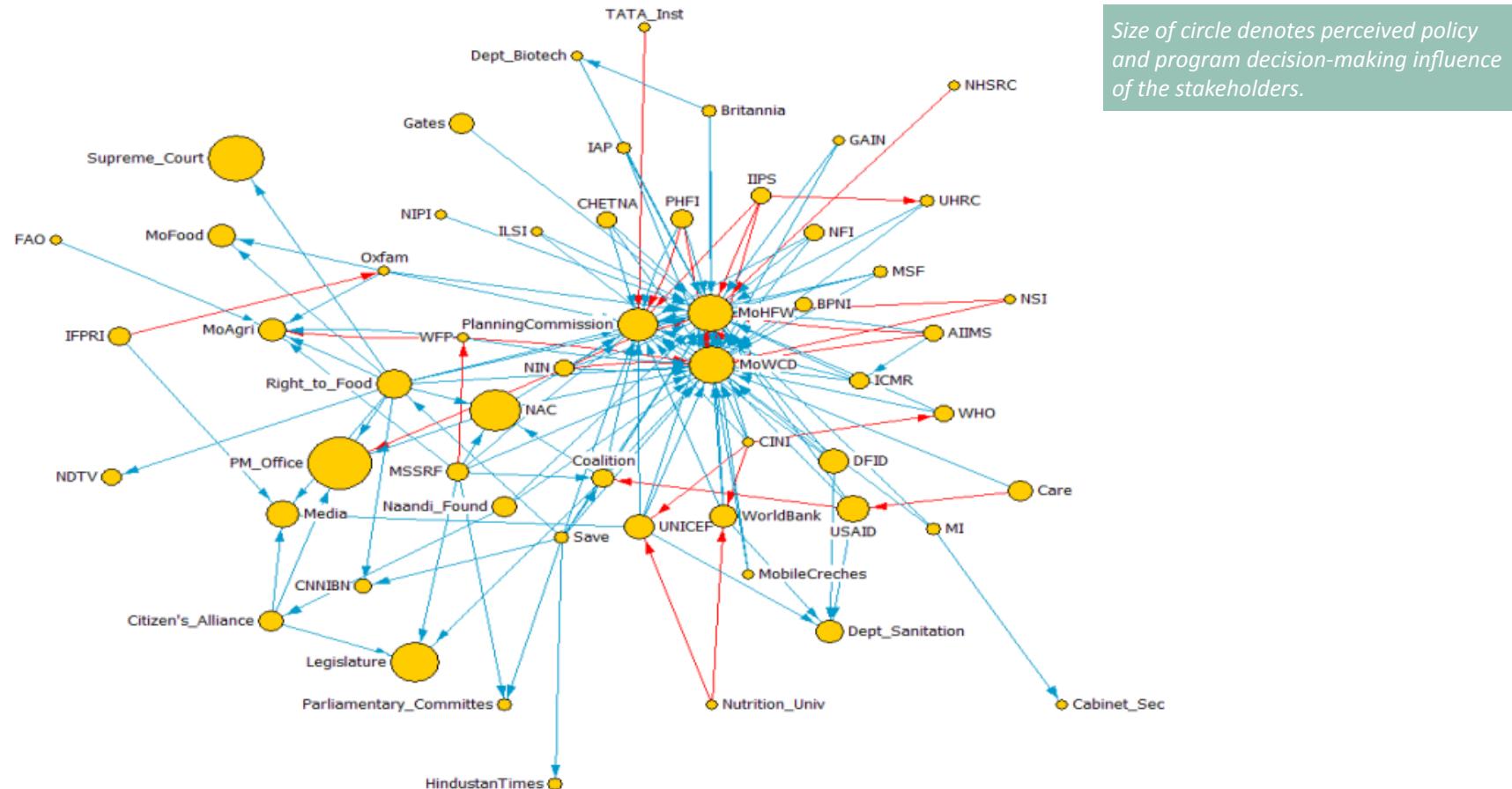
Annex

*Digital Green background and context
Case studies
Key messages from interviews*

The actors in the national nutrition landscape are cross-sectoral and operate at multiple levels of influence

Not exhaustive

A view of the national nutrition stakeholder network in India



Partnerships will be implemented at the state or district level. In the next few slides we identify stakeholders that have important nutrition-specific capabilities and mission convergence with DG in India. We also provide a state-level view of potential influential partners in the priority states of Bihar, Jharkhand and Odisha.

Note: Size of circle denotes perceived influence of the stakeholders on the map in relation to influencing policy and programs decisions related to maternal and child nutrition

Source: Transform nutrition analysis through the Net-Map method which is a participatory interview technique, in this case of major stakeholders in India that combined social network analysis, stakeholder mapping, and power mapping. Supported by IFPRI and Save the children; Dalberg research and analysis

Potential partners have been identified across DG's four core functional areas

Type of partners	Main responsibilities	Organizations
 Knowledge	<ul style="list-style-type: none"> Undertake detailed research on local conditions to support appropriate program design Identify gaps in RMNCH+A and recommend messages to be communicated to the communities Collaborate with SBCC and data partners to provide inputs into messaging, training, etc. 	 POSHAN <small>Led by IFPRI</small>
 SBCC	<ul style="list-style-type: none"> Partner with DG to provide other ICT based platforms to reinforce DG's messaging on nutrition Augment DG's capabilities through additional ICT capabilities such as IVR, sms and/or app based offerings to facilitate behavior change 	 BBC MEDIA ACTION <small>TRANSFORMING LIVES THROUGH MEDIA AROUND THE WORLD</small>
 Dissemination	<ul style="list-style-type: none"> Provide access to target populations Provide access to network of frontline agents (staff) for video production, dissemination and data management 	
 Data	<ul style="list-style-type: none"> Assist in data collection methods and processes Evaluate DG's interventions and assess impact Drive increased coordination between partners to reinforce and refine each others messages 	 



Several of the influential “knowledge” stakeholders are operating in priority states and have existing relationships with DG

	Strengths and assets	Main convergence opportunities
“Alive and Thrive” (FHI 360)	<ul style="list-style-type: none">Existing presence in 2 states in India, including Bihar (through Project Ananya)In-depth expertise conducting rural research, especially on nutrition/WASH/FP topicsStrong IP/technical content on nutrition topics, including how to use BCC to influence outcomes e.g. report on complementary feeding practicesRelationships with prominent nutrition stakeholders in India, including FHI 360, BMGF	<ul style="list-style-type: none">Strong mission convergence: focus on MCH nutrition, health and also family planningOpportunity to integrate research and knowledge from A&T into existing DG programsPotential to immediately leverage A&T relationships to integrate with Project Ananya in BiharExpressed strong interest in collaboration, although ability to cost share will likely be fairly low
“POSHAN” (IFPRI)	<ul style="list-style-type: none">Existing focus on 6 heavy burden states including Bihar, Jharkhand and Odisha e.g. district level nutrition profilesExpertise in MIYCN with knowledge of global standards and best practicesNetworks with prominent nutrition stakeholders in India through their efforts for policy advocacy	<ul style="list-style-type: none">Opportunity to utilize district level nutrition profiles for three priority statesPotential to engage independently for formative research on behaviors of target populationUnlikely to cost share for formative research, hence need to mobilize additional funds from the networks of donors, multilaterals and foundations
Public Health Resource Network	<ul style="list-style-type: none">Existing presence in heavy burden states such as - Jharkhand, Bihar, Odisha, ChhattisgarhExpertise in research, provision of technical support on social mobilization and behaviors of target communities around RMNCH+A	<ul style="list-style-type: none">Strong mission convergence : focus on child malnutrition in the project <i>Action against Malnutrition (AAM)</i> projects with partners like Ekjut, PRADAN in Jharkhand, Odisha, Bihar and ChhattisgarhOpportunity to leverage the funding by Jamsetji Tata Trust and partner as the projects scale up (with PRADAN)



SBCC

BBC Media Action is a high-potential partner, due to complementary approach, experience in priority states, and cost share potential

	Strengths and assets	Main convergence opportunities
BBC Media Action	<ul style="list-style-type: none">• Well developed theory of change on behavior change through a 360° approach of mobile apps, radio groups, personal contact and professional videos (<i>initial stages</i>)• Scalable mobile apps - Mobile academy –training of community workers, Mobile Kunji –deck of cards for dissemination, and, Kilkari – reminders for target women;• Potential point-of-entry into MRHM, MoWCD through BBC (especially in JH)	<ul style="list-style-type: none">• Potential to cost share in common areas of operations and through platforms of convergence (JEEViKA, ICDS)• Expressed interest in collaborating with DG• Opportunity to collaborate by loading DG's videos to FLWs using Mobile Kunjis,
HealthPhone	<ul style="list-style-type: none">• Initiative of the Mother and Child Health Nutrition Trust with the videos content based on best practices and knowledge developed by UNICEF, WHO, UNESCO, UNFPA, UNDP, UNAIDS, WFP and World Bank• Current reach ~20,000 villages in Maharashtra and U.P.• Simple and effective video solution involving giving videos loaded memory cards to village communities to view on demand• Partner on a large scale nutrition project – Poshan, in collaboration with IAP, MoWCD, UNICEF, Aamir Khan and Vodafone, aiming to reach 6 million women by 2018	<ul style="list-style-type: none">• Strong mission convergence: focus on MIYCHN• Opportunity to utilize platform / Project Poshan to load DG videos for broader dissemination• Opportunity to share curated knowledge on best practices of video messaging developed by major multilateral agencies• Ability to cost share unclear



SBCC

Digital Green can also explore partnerships with other complimentary SBCC players in geographies of operations in the longer term

	Strengths and assets	Main convergence opportunities
Gramvaani	<ul style="list-style-type: none">• Existing presence 12 states including Jharkhand, Bihar and Odisha with ~800,000 listeners / contributors• Expertise in offering community radio solutions with features such as personalized counseling, leaving and listening to messages and conducting polls• Large exposure to agriculture issues with experience in conducting related campaigns	<ul style="list-style-type: none">• Limited ability to cost share, since no current projects are a natural fit for DG• Expressed interest in collaborating with DG by creating a co-branded curated series focused on RMNCH+A practices, especially breastfeeding, targeted at the existing user base
Awaaz.De	<ul style="list-style-type: none">• Expertise in offering voice based social platform applicable for data collection, reminders, interactive sessions• Project dependent application of the tool, no particular focus on RMNCH+A	<ul style="list-style-type: none">• Low potential to cost share since no current projects that are a natural fit for DG have been identified• Opportunity to utilize platform to create reminders, host interactive sessions after information dissemination to drive deeper behavior change



Three national ministries are the most influential stakeholders to collaborate with for long term program sustainability

	Strengths and assets	Main convergence opportunities
AJEEVIKA National and State Rural Livelihoods Missions	<ul style="list-style-type: none"> Apex government body for enhancing rural livelihoods Designated GOI partner for “demand-side” interventions¹ Provides access to village communities through SHGs and Village Orgs; present in 1000 (out of about 6,500) blocks 	<ul style="list-style-type: none"> Extensive and growing presence in priority states, especially Bihar and Jharkhand Seeking to explore/expand programs in nutrition and FP (JEEViKA) because of strong linkages to livelihoods
ICDS Ministry of Women and Child Development	<ul style="list-style-type: none"> Apex government body for women and children in India Implements/monitors ICDS for RMNCH+A nutrition Provides access to village communities (especially women) through ~1.3M Aanganwadi workers 	<ul style="list-style-type: none"> Demarcated funds for SBCC (through ICDS) for RMNCH+A nutrition in rural areas Existing program and funds to strengthen ICDS, including BCC component from WBG (ISSNIP)
NRHM Ministry of Health and Family Welfare	<ul style="list-style-type: none"> Apex body for all health interventions including nutrition and family planning Provides critical access to communities through ASHA workers (850k)— who have presence and credibility with the community on health/nutrition issues 	<ul style="list-style-type: none"> RMNCHA+ nutrition is a major pillar of NRHM Strong focus on BCC to build awareness/demand for RMNCHA nutrition Opportunity to incorporate DG approach/videos into training curriculum of ASHA workers

State-level presence and capacities vary substantially for these ministries, and will require assessment. Partnerships will also require DG to develop state-level relationships.



Data

DIMAGI's experience with video-based content delivery, of working in nutrition in India, and ability to cost share position it well as a partner

DIMAGI

Strengths and assets

- **Extensive experience in m-Health globally** through customized mobile apps
- **Partner with MoWCD** to roll out an open source app which is a job aid, in 8 states under ISSNIP funding, to 100,000 FLWs

Awaaz.De

- Expertise in offering voice based social platform applicable for data collection, reminders, interactive sessions
- Project dependent application of the tool, no particular focus on RMNCH+A

Main convergence opportunities

- Strong mission convergence: app geared towards maternal and child nutrition focused FLWs
- Existing partner in Ethiopia; also, currently uses DG videos to train AWW in MP to use Dimagi's mobile-based data collection app in a pilot with MOWCD
- **Likely potential to cost share due to ISSNIP's funding**
- **Expressed interest in exploring avenues of collaboration** such as - loading DG videos at the app backend; and; partnering to access real time data to gather in-depth information
- **Low potential to cost share** since no current projects that are a natural fit for DG have been identified
- Opportunity to utilize *Voice survey* feature to collect rich data through audio / numeric methods from DG's target audience

In Bihar, DG is in partnership with BRLPS, with strong potential for scaling; other institutional partners may also explored for rapid implementation

	Strengths and assets	Main convergence opportunities
BRLPS Bihar Livelihoods Mission	<ul style="list-style-type: none"> Existing DG partner for RMNCH+A programs in 11 priority districts (malnutrition) in Bihar Wide reach through penetration in all 38 districts in Bihar with access to thousands of Sevaks (FLWs) and VOs Experience in conducting several programs related to nutrition 	<ul style="list-style-type: none"> Strong opportunity to scale nutrition programs to 11 priority districts as per BRLPS plans Potential to scale to the full state (38 districts) by integrating with sanitation and WASH-related programs implemented by BRLPS High cost share as an existing DG partner already procured 4k picos, with tenders for 2k more
PCI	<ul style="list-style-type: none"> Multiple year ground-level experience in Bihar through Project Ananya, with a reach of ~425k Relationships with most influential actors, including JEEVIKA, BMGF, UNICEF, etc. Strong skills in training and capacity building for BC Technical expertise/knowledge on MCH nutrition and health including indigenous research in Bihar 	<ul style="list-style-type: none"> Strong mission convergence with relationships with influential nutrition stakeholders like JEEVIKA and Project Ananya (BMGF) Potential to explore linking JEEVIKA VRPs/CRPs to AWWs through PCI Expressed strong interest in partnering with DG to develop focused training curriculum on nutrition and health modules for FLWs Potential to utilize/channel some current funding toward BCC for RMNCHA nutrition
UNICEF	<ul style="list-style-type: none"> Relationships with most influential actors, including JEEVIKA, State Welfare Department, Health Society and Education Department Technical expertise/knowledge on MCH nutrition and health which is used for capacity building of various departments at the state level 	<ul style="list-style-type: none"> Strong mission convergence with a focus on RMNCH+A and related SBCC Expressed strong interest to tie with DG to partner on a nutrition / kitchen garden and nutrition and FP focused pilots in Purnia – Project Ankuran and Swabhiman Opportunity to leverage tie up with Department of Education for Ankuran (delivered through '<i>champions of nutrition</i>' among school staff) and with Ekjut for Swabhiman (delivered through PLA exercises in JEEViKA SHGs)

In Bihar, DG could also partner with corporate partners and the large donor driven grant for implementation of RMNCH+A intervention

	Strengths and assets	Main convergence opportunities
Bhavishya Alliance	<ul style="list-style-type: none">Coalition of UNICEF, UNILEVER and Synergos; with current reach of 500k children with a projected reach of ~9 million children by 2018Access to network of skilled staff who conduct BCC activities and training in schools by visiting them 4 times in a 21 day period	<ul style="list-style-type: none">Opportunity for DG to reach adolescent girls in schools through alliance's FLW network to disseminate DG's videos on WASH and hygienePotential for cost sharing is unclear
Project Ananya	<ul style="list-style-type: none">Coalition of PCI, CARE, A&T, DIMAGI, BBC Media ActionWide reach across all districts in Bihar – CARE's support to ICS in 8 districts, PCI's support to JEEViKA in 11 districts, BBC Media Action roll out in 8 districts and DIMAGI pilot in 1 district	<ul style="list-style-type: none">Opportunity for DG to utilize the network of partners separately to focus on RMNCH+A intervention through various channels – access to PCI trained SHGs, utilize DIMAGI's app to screen DG videos, collaborate with BBC Media Action's messaging platforms

In Jharkhand, JSLPS offers the quickest route to market; the State Nutrition Mission offers access to ASHA workers and has expressed interest in a pilot

	Strengths and assets	Main convergence opportunities
JSLPS State Livelihoods Mission	<ul style="list-style-type: none"> Currently working in several districts in JH, with plans to grow to all 22 quickly Existing experience/knowledge in executing MCH nutrition programs through strong network of FLWs Mandate includes agriculture primarily, but also nutrition, WASH and FP¹ 	<ul style="list-style-type: none"> Slated to implement nutrition programs in 2 districts/100 villages; expected to scale to about 700+ villages by year-end Opportunity to incorporate approach in the <i>Mahila Kisan Sashaktikaran Pariyojana</i> (MKSP) that works with women farmers on nutrition/sanitation
State Nutrition Mission	<ul style="list-style-type: none"> Started in July 2015, with limited activities till-date; partnered UNICEF Coordinates/improves nutrition, WASH, FP outcomes by coordinating ICDS/HFW functions Access to Asha/ Aanganwadis and core technical content/resources 	<ul style="list-style-type: none"> Expressed strong interest in partnering with DG to explore a pilot in the Garwah district in JH; opportunity to expand into 6 districts prioritized on the basis of malnutrition burden Focuses on the formation of Village Nutrition Committees – which is vehicle that may be used by DG/partners to spread messages, and drive adoption
PHRN / PRADAN	<ul style="list-style-type: none"> Started in May 2014 in JH; brought together CINI, Ekjut and IDEA, with funding from TATA Trust Working in Bihar, Odisha, Jharkhand in India with prominent NGOs including PRADAN; current all-India reach of 15k HH 	<ul style="list-style-type: none"> Working in 2 blocks in JH, with potential to include DG approach/messages Access to content and key local data on nutrition behaviors/underlying causes that DG may leverage
CSR Council of Jharkhand	<ul style="list-style-type: none"> Established to access CSR funds from 8 companies for priority initiatives Annual budget of about INR 900 CR for social initiatives 	<ul style="list-style-type: none"> No special focus on RMNCH+A nutrition, but no restrictions on how funds may be utilized DG of the SNM in JH also sits on the board of the CSR Council and may be able to influence funding

(1) AJEEVIKA has been identified by the GOI to be the main delivery channel for demand side interventions across different sectors including health and nutrition (External consultations). Current capabilities/skills in areas other than livelihoods promotion/agriculture remain low but are expected to ramp up, offering convergence opportunities.
Source: External consultations; Dalberg research and analysis

Identifying and engaging a long-term dissemination partner in Odisha that works at scale is of priority

	Strengths and assets	Main convergence opportunities
Odisha Livelihoods Mission	<ul style="list-style-type: none">Penetration in all 30 districts of Odisha with access to a large FLW networkExisting experience in executing maternal nutrition programs through strong network of FLWs	<ul style="list-style-type: none">High ability to cost share with a separate funding stream for MKSP projectOpportunity to expand upon the partnership with MKSP to deliver RMNCH+A intervention
State Health Mission and ICDS	<ul style="list-style-type: none">Deep penetration in all 30 districts through a network of AWWs and ASHAsMain point of access to all MCH nutrition/health knowledge and BCC for rural communitiesStrong reputation and credibility in villagesStrong linkages to critical supply-side interventions that will likely be needed to drive adoption	<ul style="list-style-type: none">Unlikely to cost share in the short term due to the long process involvedOpportunity for DG to utilize on the convergence platforms in partnership with OLM to disseminate videos on RMNCH+A
PHRN/Pradaan	<ul style="list-style-type: none">Penetration in Odisha through the Facilitated Action Again Malnutrition (<i>FAAM</i>) Initiative; additional penetration in 6k villages through OLMPradaan that has received training on nutrition topics and BCCAll India reach that is ~15k HH	<ul style="list-style-type: none">Potential to integrate DG approach into current programming in OdishaOpportunity to integrate DG approach into potential scale up in Odisha (planned for this year)Likely to be some cost share ability
VARRAT	<ul style="list-style-type: none">Among the oldest partners with ~5 years of experience in delivering DG's modelCritical partner in helping DG generate insights on effectiveness of the video dissemination and video dissemination + PLA approach by giving access to SHGs for the RCT	<ul style="list-style-type: none">Limited opportunity to scale further through VARRAT due to 1) limited geographical reach and 2) strict framework of the RCT

Further, the following multi-state initiatives offer a single access point to influential actors, and opportunities to leverage nutrition-specific funding

	Overview	Funding details
State Nutrition Missions	<ul style="list-style-type: none">Started in 2013 in Bihar and July 2015 in Jharkhand, with limited activities till-date; partnered with UNICEF; no such mission in OdishaAims to improve RMNCHA nutrition outcomes, strengthen ICDS by providing technical leadershipPotential for access to govt FLWs and core contentMissions are in initial stages of planning, ideal time for DG to initiate conversations at the state level	<ul style="list-style-type: none">Existing plan allocation of INR ~50,000 crores is marked under Mission's supervision in BiharDetails of funding allocation unclear in Jharkhand, however, the state aims to appoint ~30,000 trainers to support ICDS centers to improve nutrition outcomes
ISSNIP Program	<ul style="list-style-type: none">Started in 2012; partnership between WBG/ICDSAims to comprehensively strengthen ICDS, including BCC in 8 states across 162 districtsImplementation has been challenging, but program has been refined and re-started recentlyThe World Bank and state-level missions are best points-of-contact and entry	<ul style="list-style-type: none">Total funding allocation from WBG is INR 2,000 crores million across 7 years of which INR ~680 crores was earmarked for phase 1 till 2015 (INR ~50 crore disbursed)30% of the budget has been specifically earmarked for SBCC
RMNCH+A Health Scale-up (USAID)	<ul style="list-style-type: none">Started in May 2014, by NRHM, USAID, UNICEF and IPE GlobalAims to reduce preventable RMNCH deaths in 6 states and 30 districts; provides technical support and training to govt, civil and private bodies to scale up their nutrition programsPotential to integrate DG approach to NHM, NRHM programs through IPE Global and UNICEF (which advises state on BCC)	<ul style="list-style-type: none">Total funding allocation of INR 175 crores till 2018

Finally, DG can explore opportunistic plays in the longer term across states with a diverse set of partners (1/3)

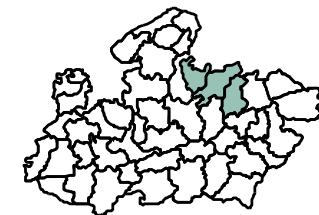
Major state-level platforms for health and nutrition interventions in Madhya Pradesh



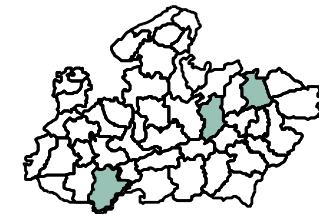
Overview

- Grant by Cargill to implement MPNP with CARE, WFP and State ICDS, focused on reducing malnutrition burden among children by raising awareness about WASH and nutrition and increasing incomes
- Implemented in 766 villages of Chattarpur, Panna and Tikamgarh districts
- Opportunity to work with CARE in incorporating DG's video enabled SBCC methodology for target FLWs

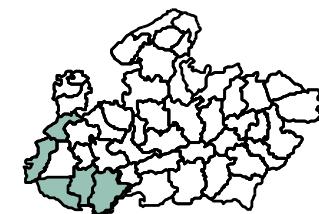
District-level coverage



- Using internal resources to reach ~3,000 FLWs and undertake capacity building and raise awareness on health and nutrition. Also coordinating street plays and screening health films in communities to raise awareness
- Present in Damoh, Khandwa and Satna districts, reaching ~700,000 people
- Opportunity to work with EFICOR in creating community driven videos and reach out to target FLWs



- Using internal resources to implement child malnutrition reduction through community nutrition educators who raise awareness and help in treatment
- Present in 600 villages of 5 districts – Jhabua, Alirajpur, Khandwa, Khargone and Barwani
- Opportunity to plug video enabled SBCC approach through the network of 60 women who serve as community nutrition educators



Finally, DG can explore opportunistic plays in the longer term across states with a diverse set of partners (2/3)

Major state-level platforms for health and nutrition interventions in Rajasthan



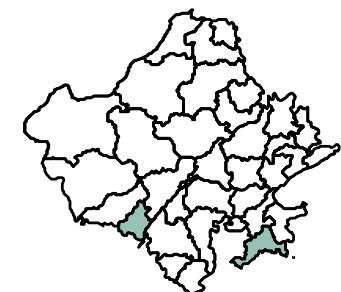
Overview

- Partnership between UNICEF, GAIN and Government of Rajasthan to target 10,000 children suffering from acute malnutrition through fortified foods and raising awareness
- Implemented in 13 high priority districts of Rajasthan before being scaled up
- Opportunity to work with UNICEF to supplement behavior change effort through plugging in the video enabled SBCC methodology

District-level coverage

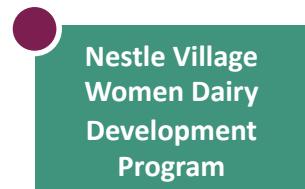


- Grant by Tata Foundation in partnership with government of Rajasthan and Antara Foundation to target RMNCH
- Implemented in Jhalawar and Sirohi districts before being scaled up across the state
- Opportunity to leverage Antara Foundation's networks with FLWs to load DG videos on to mobile phones / tablets to be screened to the target audience



Finally, DG can explore opportunistic plays in the longer term across states with a diverse set of partners (3/3)

Major state-level platforms for health and nutrition interventions in other states



Overview

- Undertaken by Nestle as a CSR activity to serve as an education program for women dairy farmers targeting best practices in dairy, sustainable agriculture and personal health and hygiene
- Reaching ~60,000 women across the states of Punjab, Haryana and Rajasthan.
- Opportunity to leverage Nestle's network and funding to disseminate videos on agriculture best practices and hygiene, driving deeper behavior change

Coverage¹



- Conducted a pilot with 10 FLWs in Takalghat, Maharashtra to test the effectiveness of a CommCare based mobile app, co-developed with DIMAG. The app serves as a multimedia tool for behavior change and a job aid
- Planning to scale the intervention to all health centers in Takalghat panchayat in Maharashtra
- Opportunity to leverage LMRF's networks with trained government FLWs with mobile job aids to load DG's videos to drive behavior change. Additional opportunity to synthesize data collection methods through tie ups with the foundation and government departments



Note: (1) – Operational districts unclear for Nestle. LMRF operates at a block level in Nagpur district

Source: CARE document, EFICOR Annual Report and RMF website. Dalberg research

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We have provided perspectives on the short-term, in particular in the priority states, as well as long-term implementation

Priority states road map

Bihar, Jharkhand and Odisha

- High-level landscape of influential nutrition stakeholders in the state
- Road map to scale up nutrition activities

Long term road map

- High-level long term road map
- Illustrative long term stakeholder map

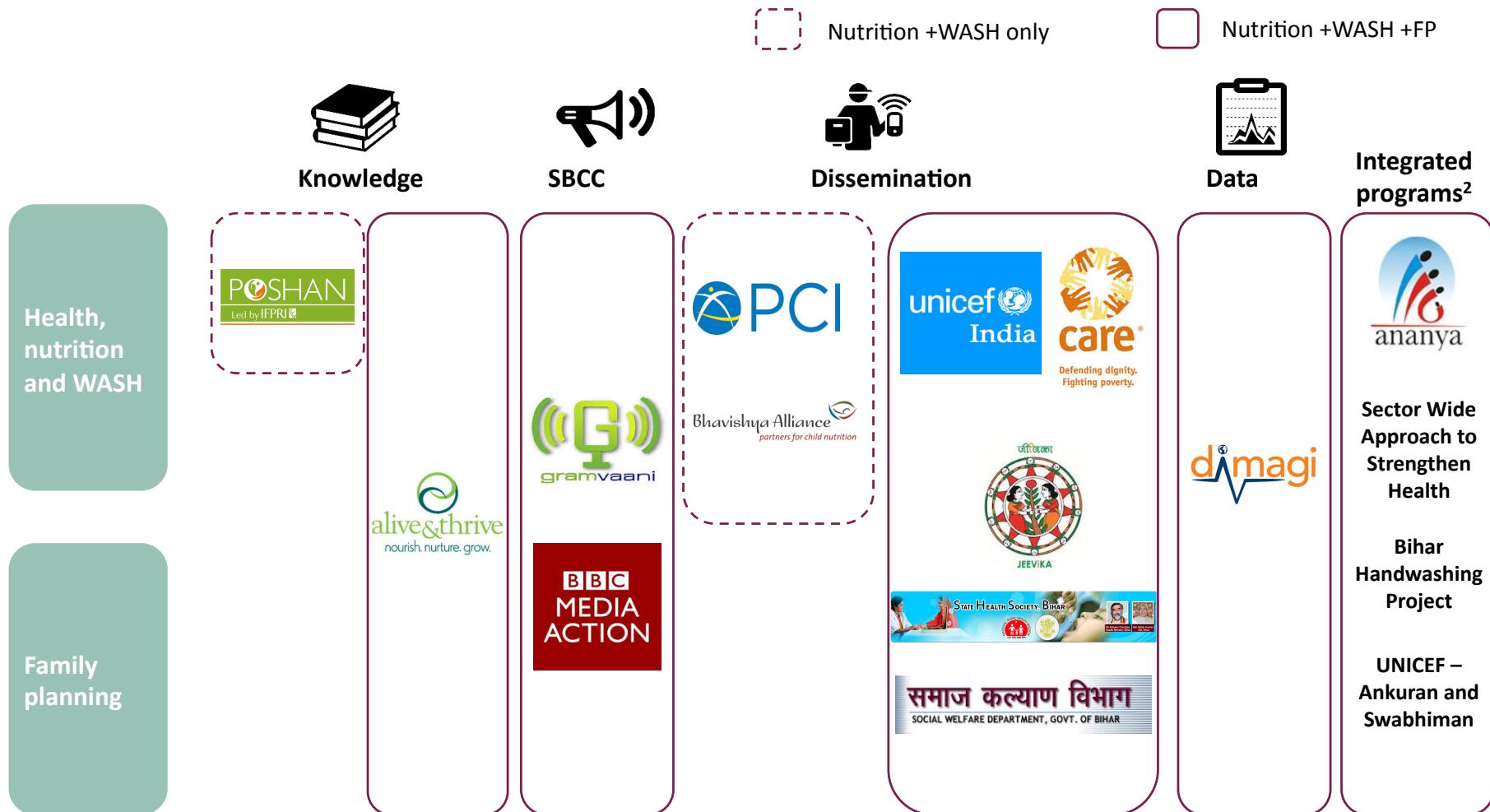


Bihar

The relevant nutrition stakeholder map in Bihar

Not exhaustive

Overview of partner landscape by functional areas¹



Note: (1)The landscape of partners have been taken from Alive and Thrive's nutrition stakeholder map, DG interviews, external interviews and desk research by Dalberg. (2) The programs consist of multiple organizations that are already listed in the partner landscape under the categories of Knowledge, SBCC, Delivery and Data
Source: Dalberg analysis and interviews



DG has the opportunity to scale its RMNCH+A nutrition program rapidly in Bihar in the next twelve months

6-12 month road map for Bihar

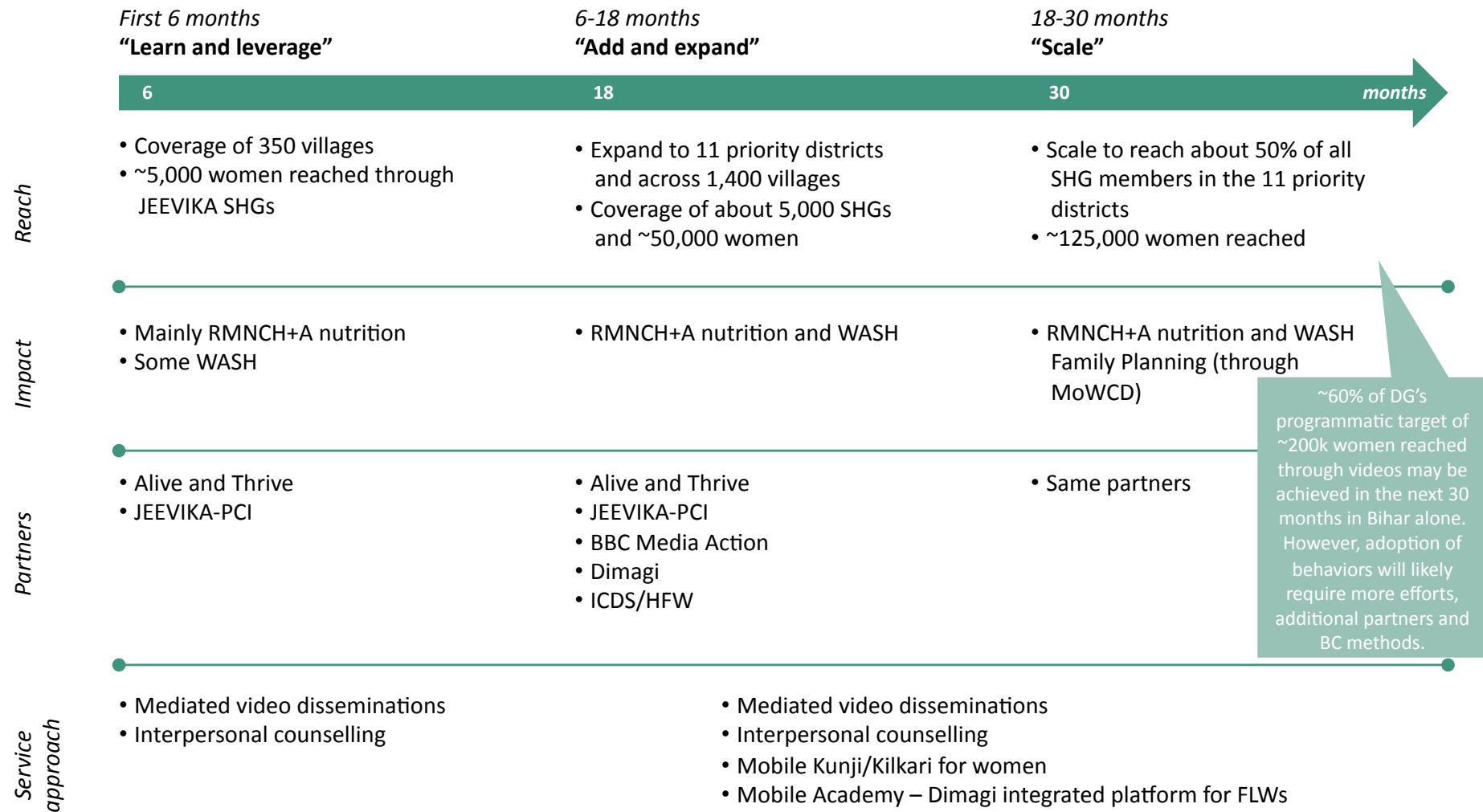
	Reach	Impact		
Results	<ul style="list-style-type: none">Potential to reach (through JEEVIKA) 11 priority districts (800 villages), ~2.5k SHGs, and ~25,000 women in Bihar with videos on WASH and RMNCH+A practices, in a phased manner	<ul style="list-style-type: none">Enhanced institutional capacity of program partners (including DG, JEEVIKA, Knowledge partner)Improved knowledge and practice of behaviors particular to WASH and Nutrition for women and childrenImpact on Family Planning behaviors likely to be limited since JEEVIKA's mandate focuses primarily on livelihoods and nutritionIncreased women empowerment through engagement of SHGs		
Main outputs	<ul style="list-style-type: none">Increased investment (cost share) in formative research by partnerImproved understanding of local nutrition/WASH practices in BiharImproved info on locally feasible solutions to nutrition problems	<ul style="list-style-type: none">Improved/enhanced nutrition training materials for VRPs/CRPsVideo dissemination approach streamlined and adapted to the local nutrition/WASH context	<ul style="list-style-type: none">6-7 additional videos produced~2,500 SHGs and ~25,000 women reachedAdditional resources mobilized (cost share) for screenings	<ul style="list-style-type: none">Comprehensive monitoring system set up consisting of continuous tracking through COCO by CRPs and articulation of current baselines
Near term activities	<ul style="list-style-type: none">Engage relevant knowledge partner (e.g. Alive and Thrive)Conduct additional in-depth research (e.g. WASH practices, factors underlying/preventing BC)	<ul style="list-style-type: none">Develop additional training materials that are nutrition-specific for VRPs and CRPsIdentify additional messages	<ul style="list-style-type: none">Additional training for CRPs/VRPs on nutrition-specific contentPhased roll out of videos using existing content/CRPs in 11 districtsProcure (JEEVIKA) addition pico-projectors as neededProduce additional videos as neededExplore long-term partnerships	<ul style="list-style-type: none">Execution of baseline study to allow for measurement of impact of SBCC intervention
Existing assets and capabilities	<ul style="list-style-type: none">KnowledgeCore behaviors to target and aligned messagingBasic understanding of underlying behaviors and barriers to BC	<ul style="list-style-type: none">SBCCScalable service approach of mediated video showingsExisting video content, lessons and best practices from Bihar and Odisha pilots	<ul style="list-style-type: none">DeliveryExisting base of trained VRPs (27) and CRPs (100)Existing base of 20 Bihar-specific nutrition videos4,000 pico-projectors (from JEEVIKA)Access to SHGs within 11 priority districts for nutrition	<ul style="list-style-type: none">DataDecentralized data collection process that leverages JEEVIKA's network of FLWsICT platform to consolidate and report data from the villages



DG has the potential to reach up to half of its program target of 200k women in Bihar alone

Indicative

High-level long term road map for Bihar

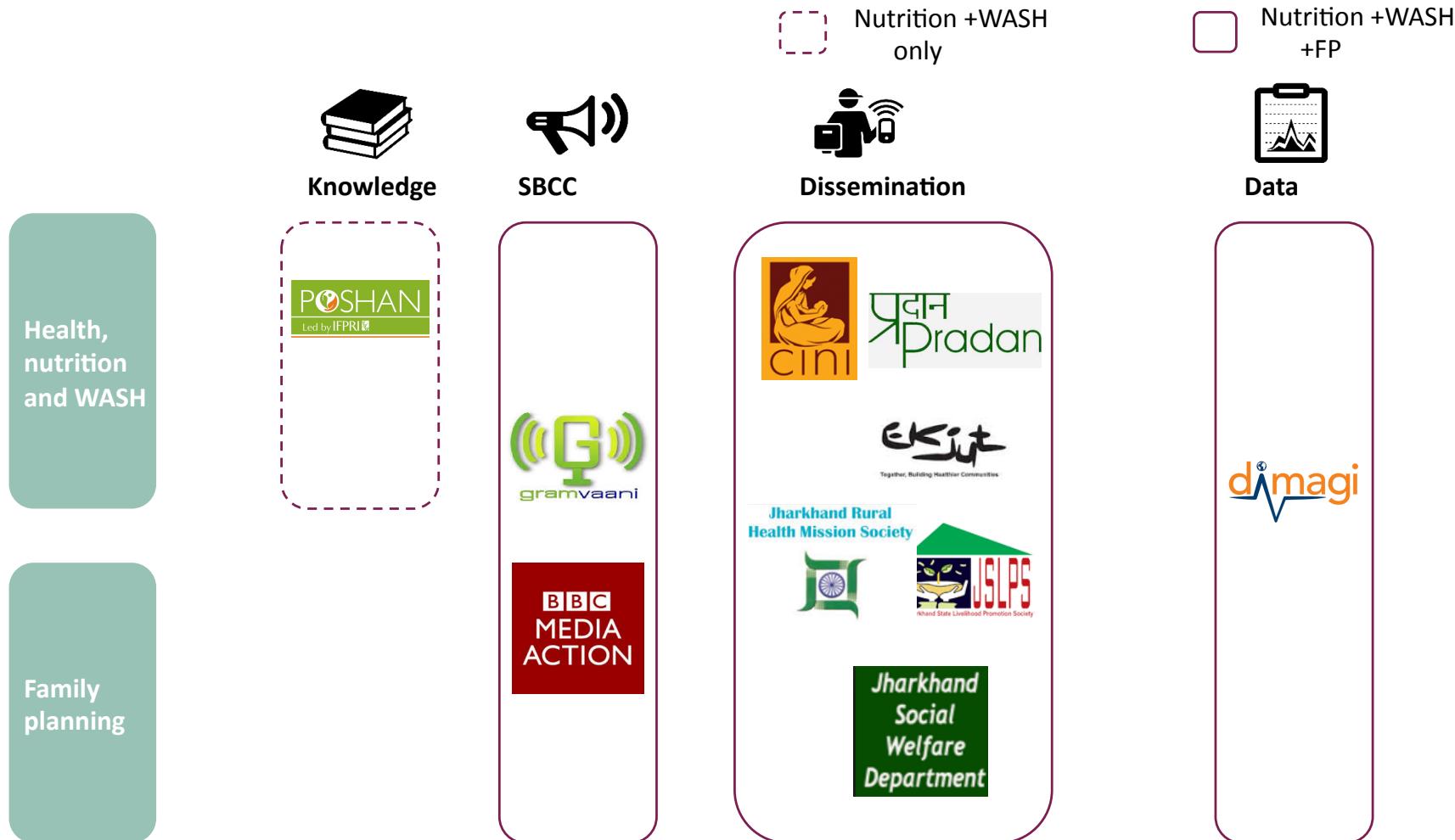




The relevant nutrition stakeholder map in Jharkhand

Not exhaustive

Overview of partner landscape by functional areas¹



Note: (1)The landscape of partners have been taken from Alive and Thrive's nutrition stakeholder map, DG interviews, external interviews and desk research by Dalberg.
Source: Internal and external consultations; Dalberg analysis and interviews



Scale in the short term will depend on the capacity of JSLPS; the SNM offers an interesting opportunity as well

6-12 month road map for Jharkhand

	Reach	Impact		
Results	<ul style="list-style-type: none"> Potential to reach 3 districts through JSLPS and SNM, ~50-80 villages, ~300 SHGs and ~5,000 - 10,000 women in Jharkhand with videos on WASH and RMNCH+A practices, in the next 6-10 months¹ 	<ul style="list-style-type: none"> Enhanced institutional capacity of program partners (including DG, JSLPS, Knowledge partner) Improved knowledge and practice of behaviors particular to WASH and Nutrition for women and children Impact on Family Planning behaviors likely to be limited since JSLPS; mandate focuses only on livelihoods and nutrition Increased women empowerment through engagement of SHGs 		
Main outputs	<ul style="list-style-type: none"> Understanding of local nutrition/WASH in Jharkhand Increased investment (cost share) in formative research by partner Improved info on locally feasible solutions to nutrition problems 	<ul style="list-style-type: none"> Improved/enhanced nutrition training materials for VRPs/CRPs Video dissemination approach streamlined and adapted to the local nutrition/WASH context 	<ul style="list-style-type: none"> Nutrition-specific training for 2 VRP teams and 75 CRPs 10 new videos produced for ~300 SHGs and ~5,000-10,000 women Additional resources mobilized (cost share) for screenings 	
Near term activities	<ul style="list-style-type: none"> Conduct research to understand underlying behaviors and barriers to BC (e.g. WASH practices, factors underlying/preventing BC) Sharpen initial list of target messages to align with generated knowledge Engage relevant knowledge partner (e.g. Alive and Thrive) 	<ul style="list-style-type: none"> Develop additional training materials that are nutrition-specific for VRPs and CRPs Explore partnerships with other BCC players like BBC Media Action, Gram Vaani and DIMAGI 	<ul style="list-style-type: none"> Nutrition training for CRPs/VRPs Roll out in 2 districts with JSLPS, and pilot in 1 district with SNM Procure (JSLPS) additional pico-projectors (~700-800) as needed Produce nutrition focused videos Conduct pilot with SNM in Garhwa district (25-50 villages) 	
Existing assets and capabilities	<p>Knowledge</p> <ul style="list-style-type: none"> Basic understanding of behaviors and an initial target list with aligned messaging 	<p>SBCC</p> <ul style="list-style-type: none"> Scalable service approach of mediated video showings Existing lessons and best practices from Bihar and Odisha pilots 	<p>Delivery</p> <ul style="list-style-type: none"> Existing base of trained VRPs (2 districts) and CRPs (100) 100+ pico-projectors (from JSLPS) Access to 100 SHGs within 2 districts for nutrition 	<p>Data</p> <ul style="list-style-type: none"> Decentralized data collection process that leverages network of FLWs ICT platform to consolidate and report data from the villages

(1) Estimates based on current operations and scale of DG in JH, and on internal consultations on numbers: 1 village has 8-10 SHGs with about 10 women per SHG (rough estimates).

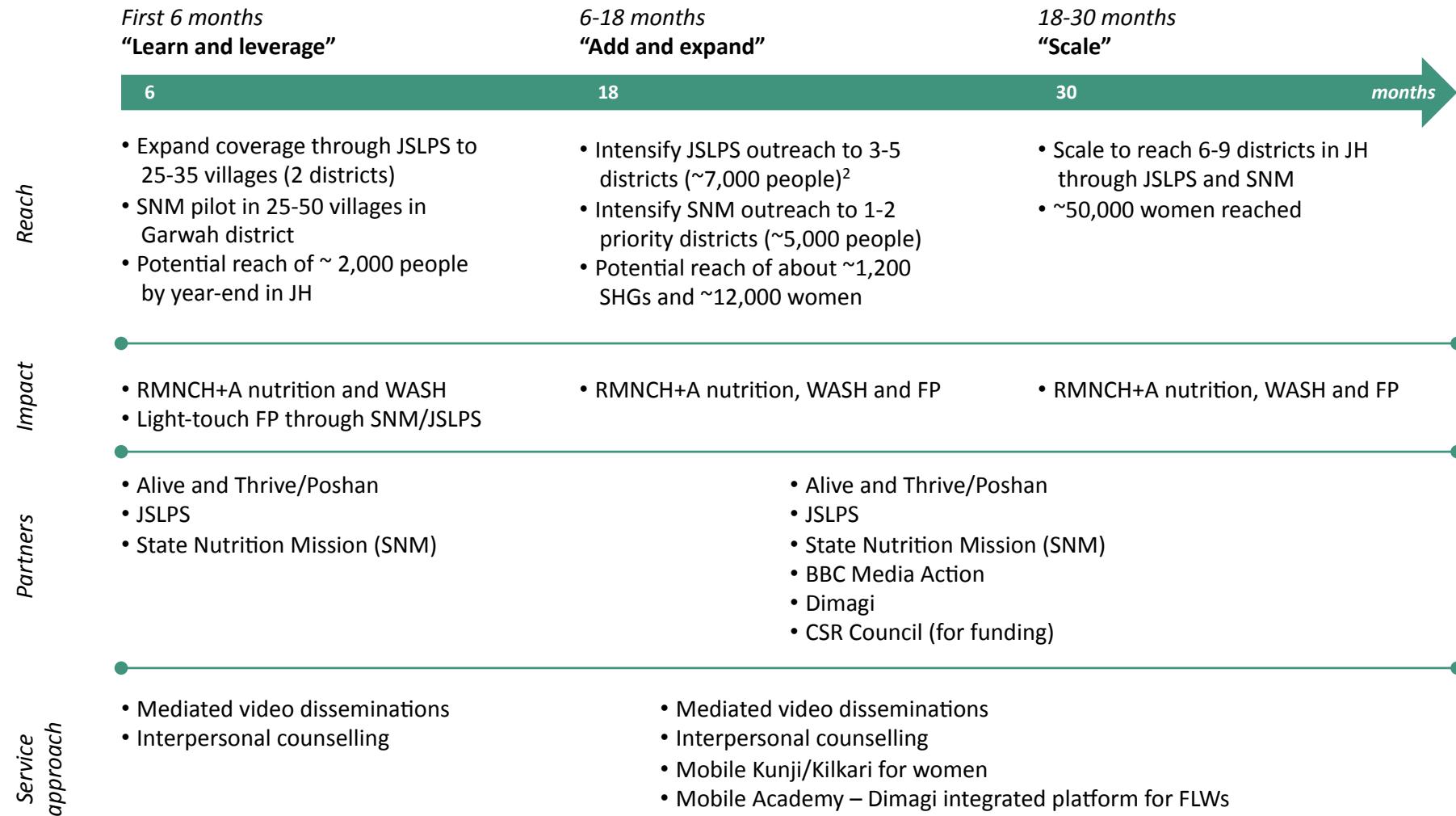
Source: Materials from Digital Green; Consultations with Digital Green staff; Dalberg research and analysis



DG's program in Jharkhand could potentially reach up to 50k women in the long term

Indicative

High-level long term road map for Jharkhand

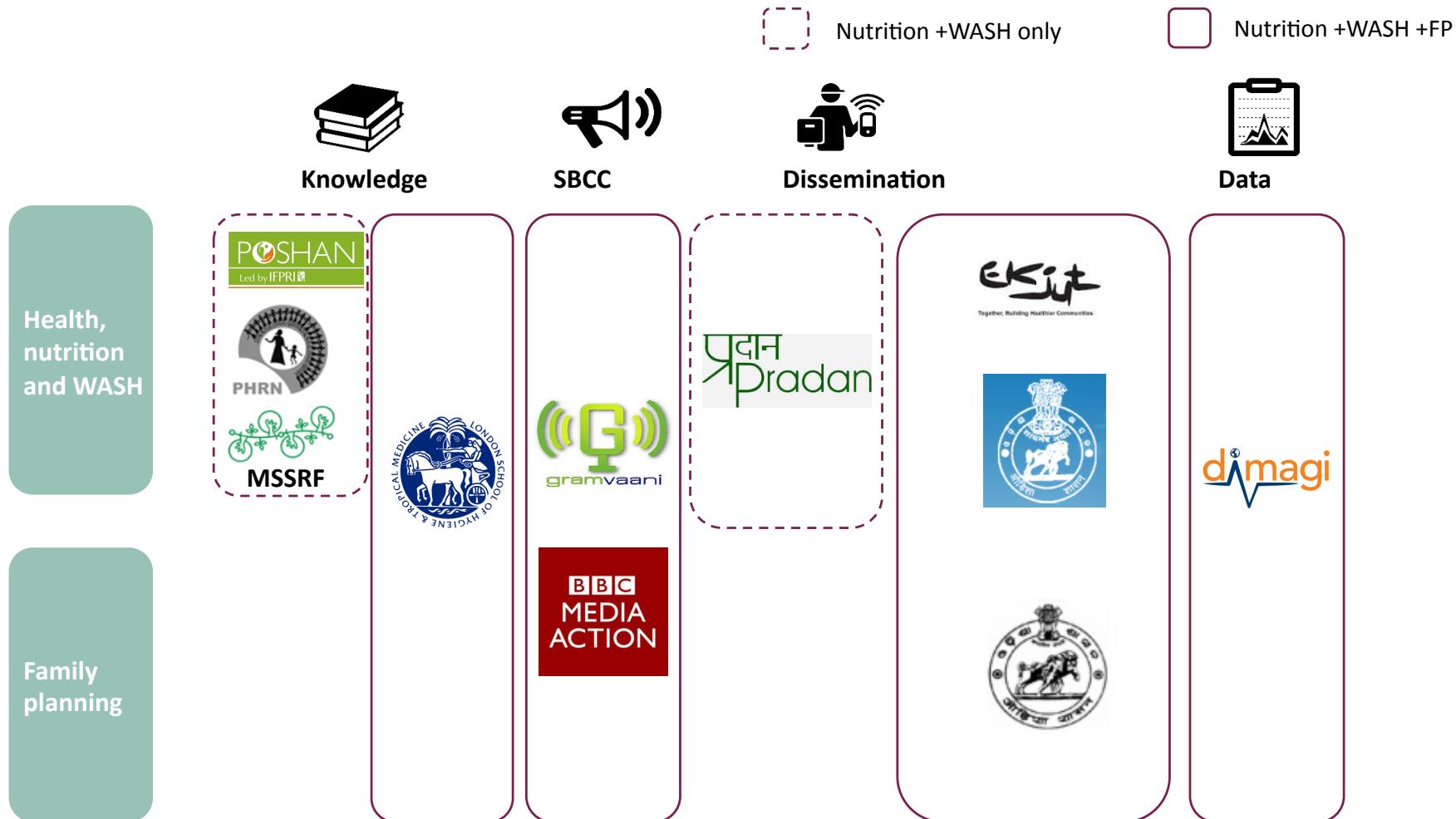




The relevant nutrition stakeholder map in Odisha

Not exhaustive

Overview of partner landscape by functional areas¹

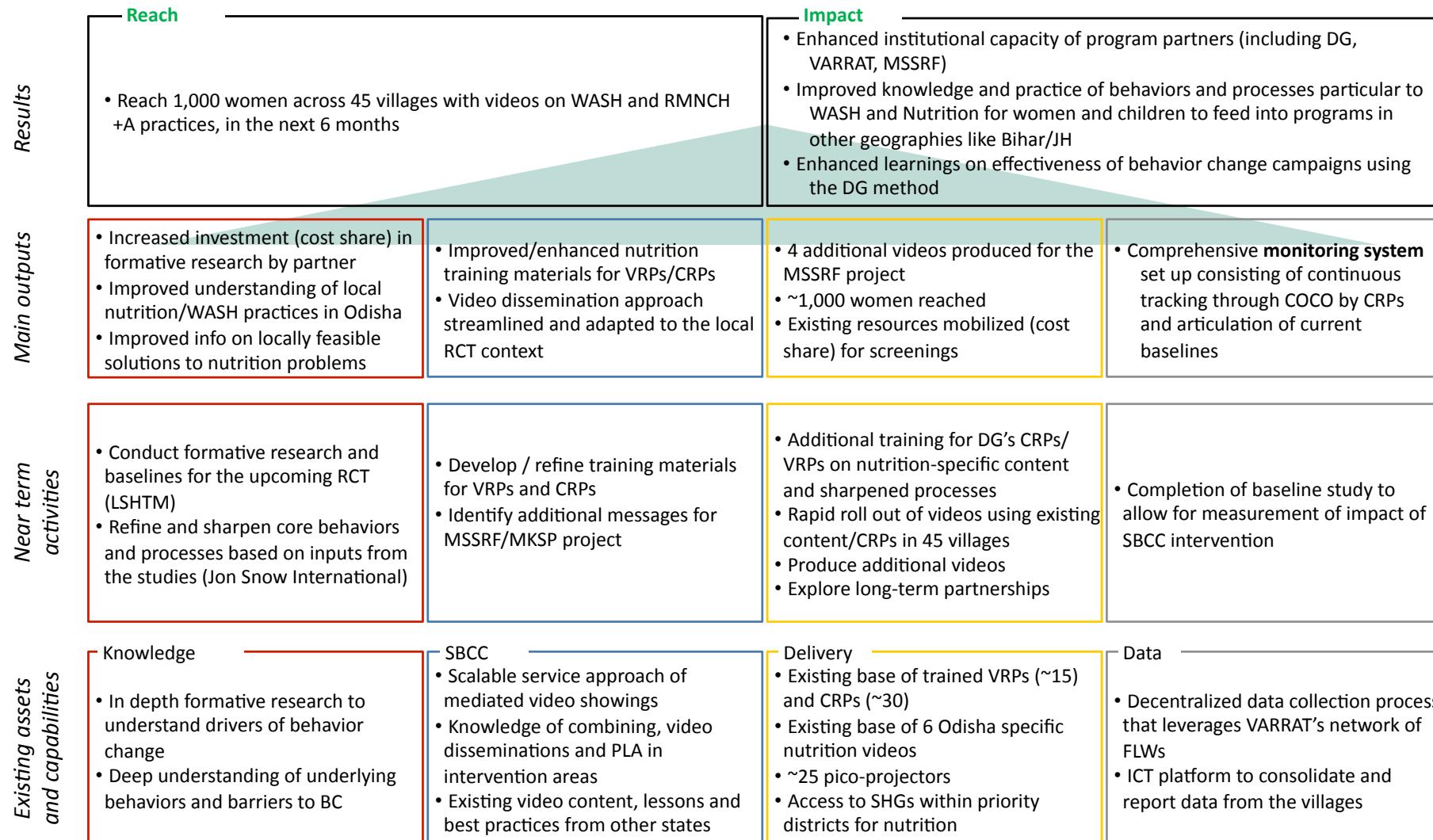


Note: (1)The landscape of partners have been taken from Alive and Thrive's nutrition stakeholder map, DG interviews, external interviews and desk research by Dalberg. (2) The programs consist of multiple organizations that are already listed in the partner landscape under the categories of Knowledge, SBCC, Delivery and Data
Source: Dalberg analysis and interviews



Lessons from Odisha will feed into changes and refinements in the overall service approach implemented in other geographies

6-12 month road map for Odisha

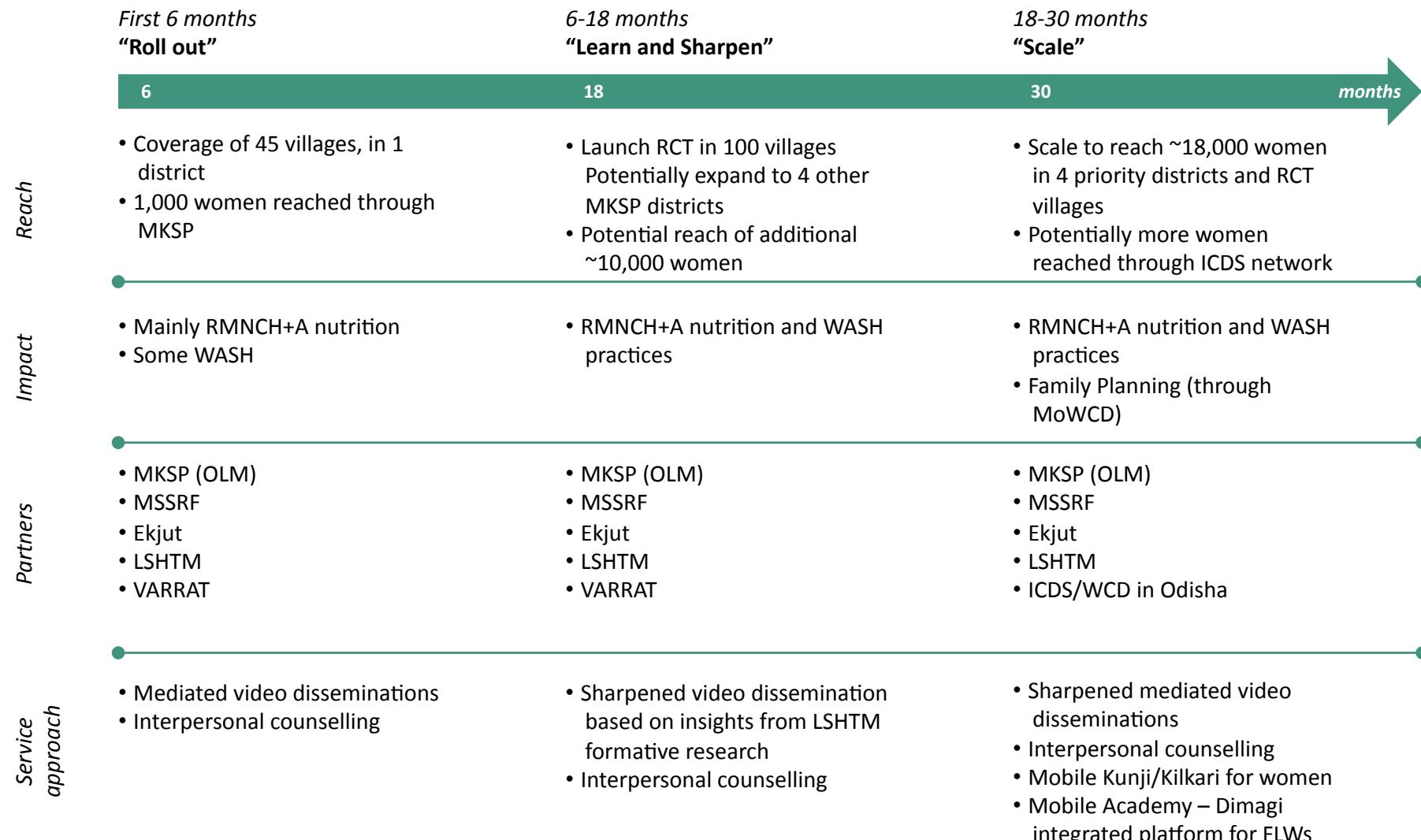




Even in Odisha, there is potential for scale in the long term

Indicative

High-level long term road map for Odisha



● Overall, Bihar is likely to scale fastest through JEEVIKA; potential partnership with SNM likely to boost adoption in JH

Cross-cutting considerations



Bihar

Reach

- Partnership with AJEEVIKA has the highest potential to scale
- Collaboration with BBC Media Action will drive reach even further even in the short term (based on their existing reach in Bihar)
- Opportunity to boost long-term scale by investing in partnership with SHM

Impact

- Based on JEEVIKA's experience and mandate, **most impact expected with agri-nut linked messaging, messaging on simple WASH practices; limited FP impact expected**
- Leveraging BBC's content in DG messaging and **spreading DG messaging into BBC's existing activities/platforms could improve adoption** in the short term
- Comprehensive technical content/resources already exists in the state (A&T, PCI), with opportunities for DG to incorporate into its approach and boost impact



Jharkhand

- **JSLPS nascent in Jharkhand** with growing scale / capacities; strong relationship with DG means DG has potential to expand with JSLPS
- **Linking to JH's SNM could expand reach** in the short term (SNM expressed interest in pilots)
- BBC Media Action's imminent entry into JH offers avenue for widespread dissemination using ICT-enabled platforms, but over time

- **Access to Asha/Aangan workers** through potential partnership with SNM promises critical supply linkages and boosts adoption rates for nutrition and WASH
- Working with BBC to **refine training curriculum** for Asha/Aangan workers, including using ICT-enabled platforms offers a chance to **boost adoption in the state**
- **Investment in local, on-the-ground research** on mapping behaviors and causes will be **needed to boost impact**



Odisha

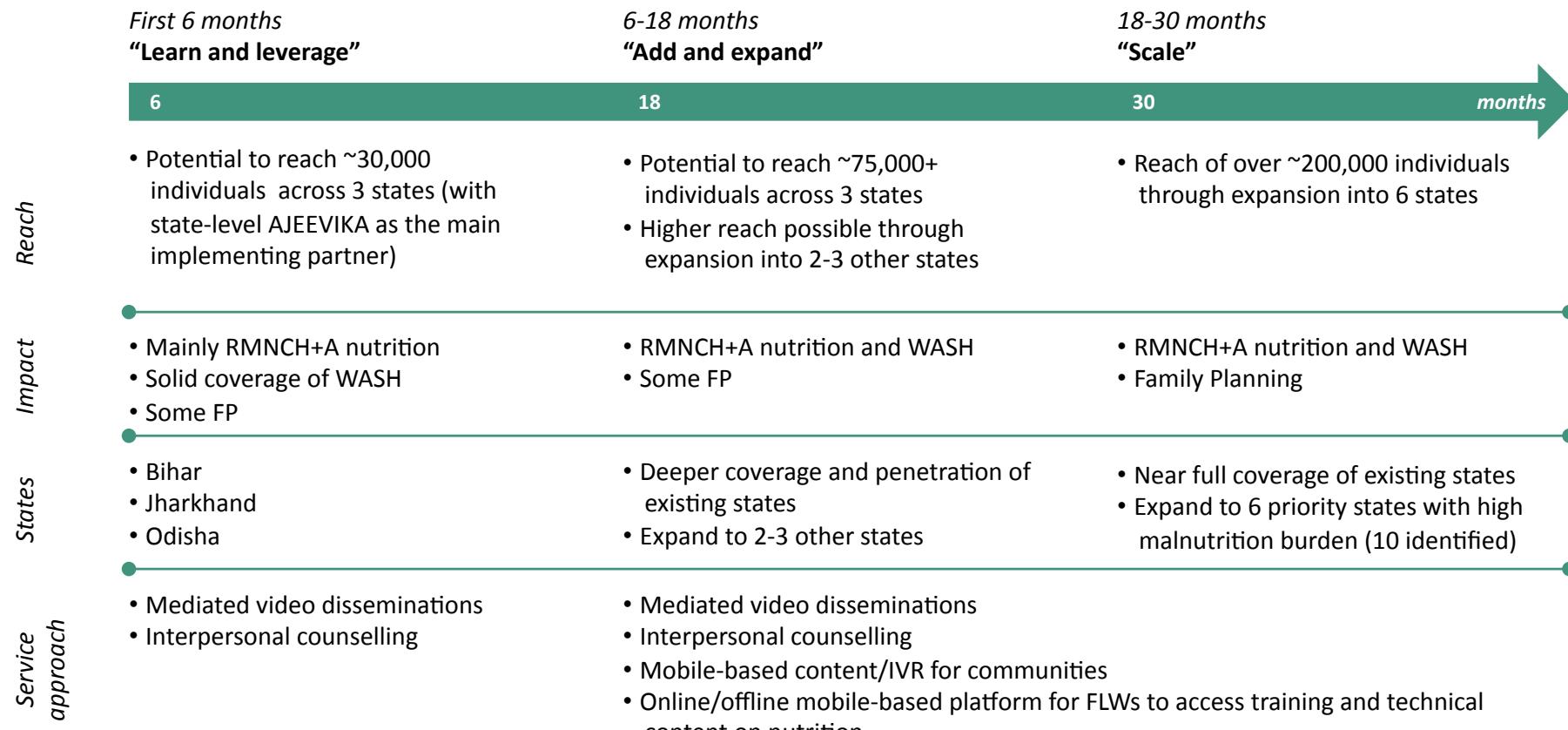
- Pace of program **reach/scale likely to be incremental** in Odisha – lack of a large-scale, GOI partner for DG (e.g. AJEEVIKA) in the state

- Opportunity to use **Odisha programs as a learning laboratory to inform and feed into work in other locations** on key elements of the service approach including (1) what behaviors to target, (2) what processes to use to enhance community participation, (3) BCC methods etc.

● DG's operations in the priority states will gradually build required capabilities/networks for greater reach and impact

Indicative

High-level long term road map for DG in RMNCH+A nutrition in India



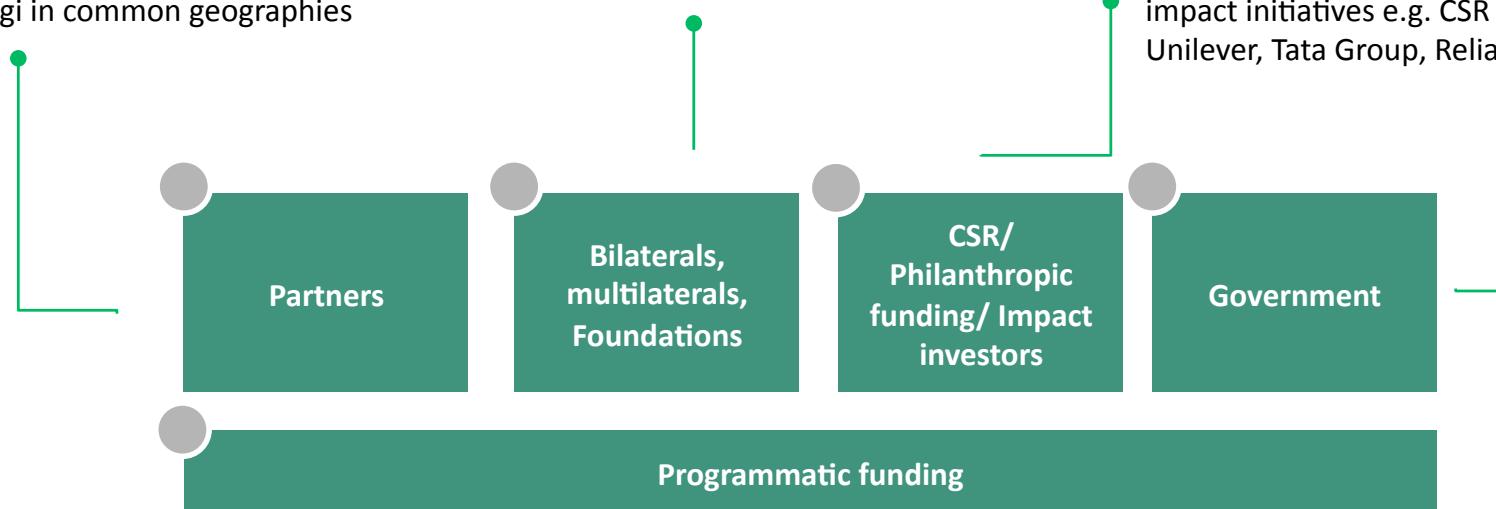
There are five main funding models that DG seeks to leverage

Funding models

Cost-sharing including, in-kind (staff, materials and resources) and/or direct funding from **potential partner** organizations like BBC Media Action, Dimagi in common geographies

Direct funding support from **donors** (e.g. USAID, BMGF, World Bank) for specific DG initiatives such as SBCC in RMNCH+A nutrition

Funding from **independent private actors, or private platforms, or impact investors** seeking to channel CSR, philanthropic and other funding for social impact initiatives e.g. CSR Council, Unilever, Tata Group, Reliance



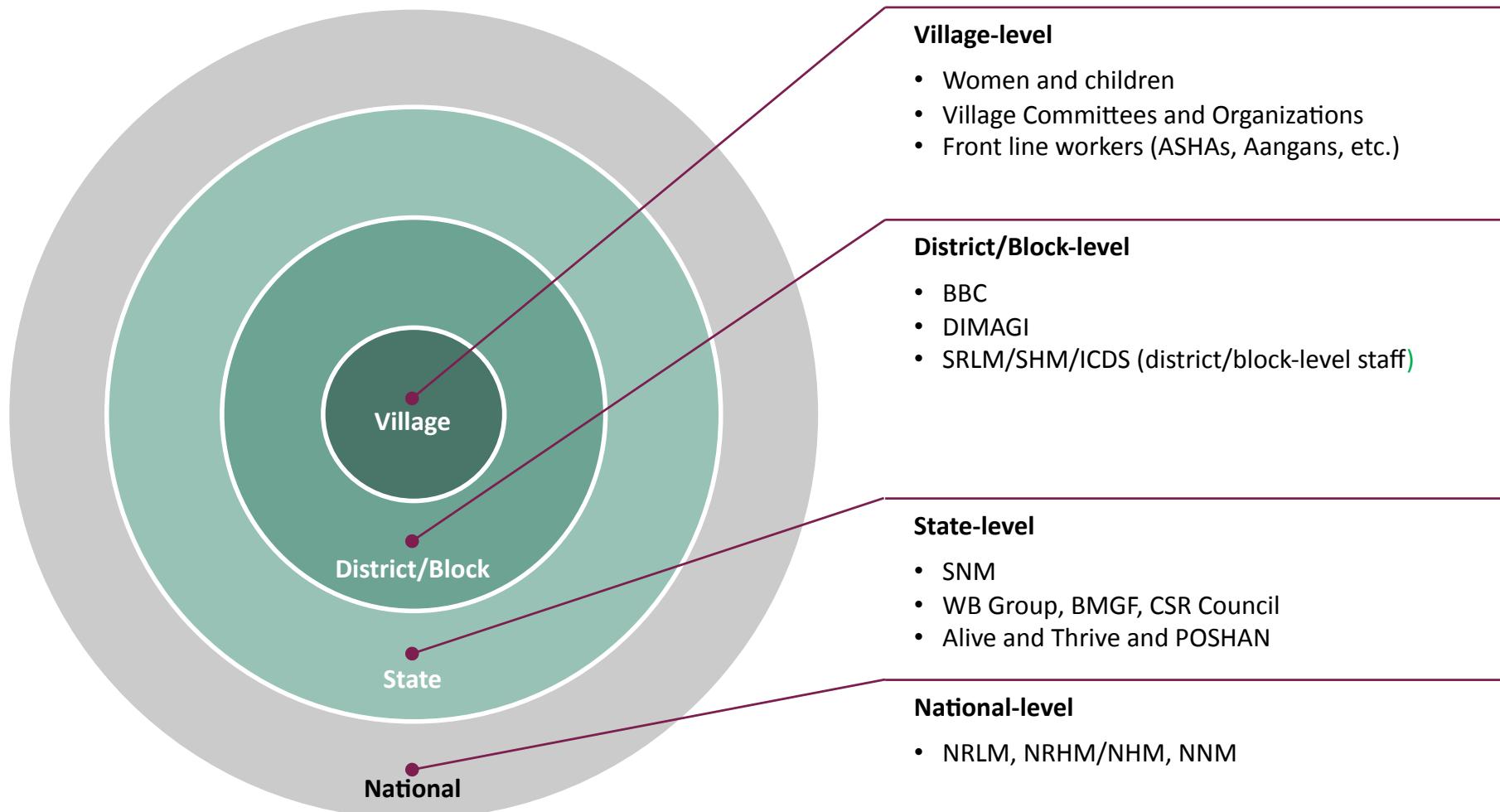
Funding from existing multi-stakeholder initiatives, programs focused on RMNCH +A Nutrition and/or family planning e.g. ISSNIP

Primarily in-kind support in the form of infrastructure, procurement of pico-projectors, etc. from relevant **government agencies** such as MOH, MOWCD, NRLM

Long term program stakeholders – “steady state”

Indicative

Illustrative long term stakeholder map for DG's RMNCH+A nutrition program in India¹

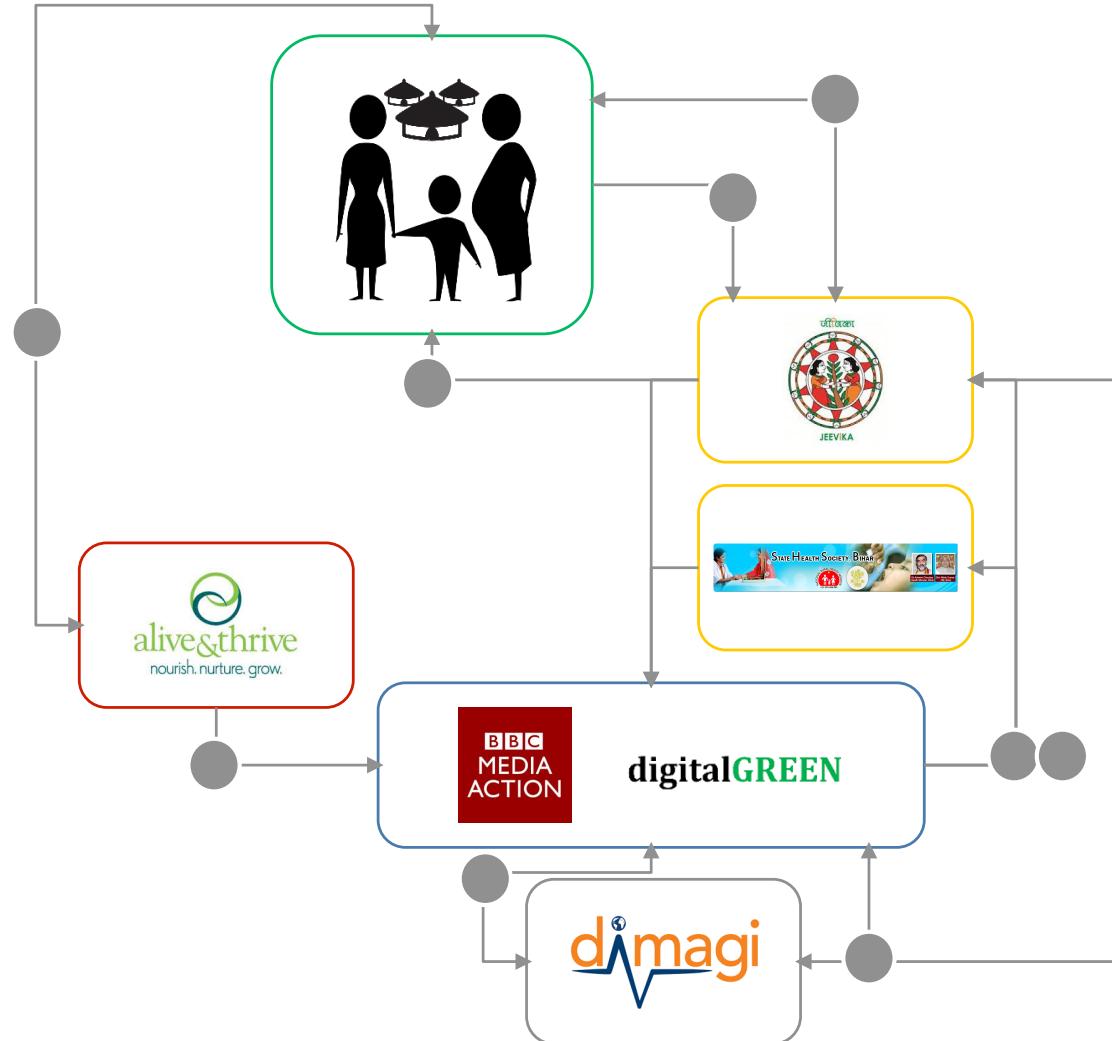


(1) Stakeholders have been defined here according to their “lowest” level of operation. Front line workers have been called out independent of their association with government missions and ministries.

Source: Materials from Digital Green; Consultations with Digital Green staff; Dalberg research and analysis

Long term program stakeholders – roles and responsibilities

Illustrative



Main roles and responsibilities

- 1) Formative and ongoing research to identify and baseline local needs and gaps and locally feasible solutions
- 2) Research inputs to design of SBCC methods/platforms, associated training modules, and messaging for BC
- 3) Co-creation/refinement of training materials/platforms for FLWs
- 4) Supply of FLWs from local communities including VRPs, and mediators
- 5) Training and capacity building of FLWs
 - E.g. *Mobile Academy* and Dimagi platform to train FLWs on content, mediation
 - Potential to integrated *Mobile Kunji* into mediation process), and data collection
- 6) Ongoing support and quality control for DG video-production, enrollment for *Kilkari*, etc. *Mobile Kunji*, *Mobile Academy*
- 7) Dissemination/facilitation of videos using mixed methods (e.g. integration of *Kunji* and *Kilkari* to reinforce/promote adoption)
- 8) Informal, ongoing feedback from community
- 9) Formal data collection, M&E

Areas for DG's further analysis and work

Partnerships

- Detailed due diligence of potential partners, with emphasis on understanding (1) specific areas of collaboration, especially in priority states, and (2) ability to share costs

Funding

- Deeper engagement with funders to understand scope for funding, especially in the priority states

Strategy, planning and organization management

- Budgeting, costing and planning operations in RMNCH+A nutrition, and further detailing of the high-level implementation road map, including development of pilot plans with potential partners
- Linking DG's nutrition work to shaping its overall strategy and business plan, as well as changes in its organization structure

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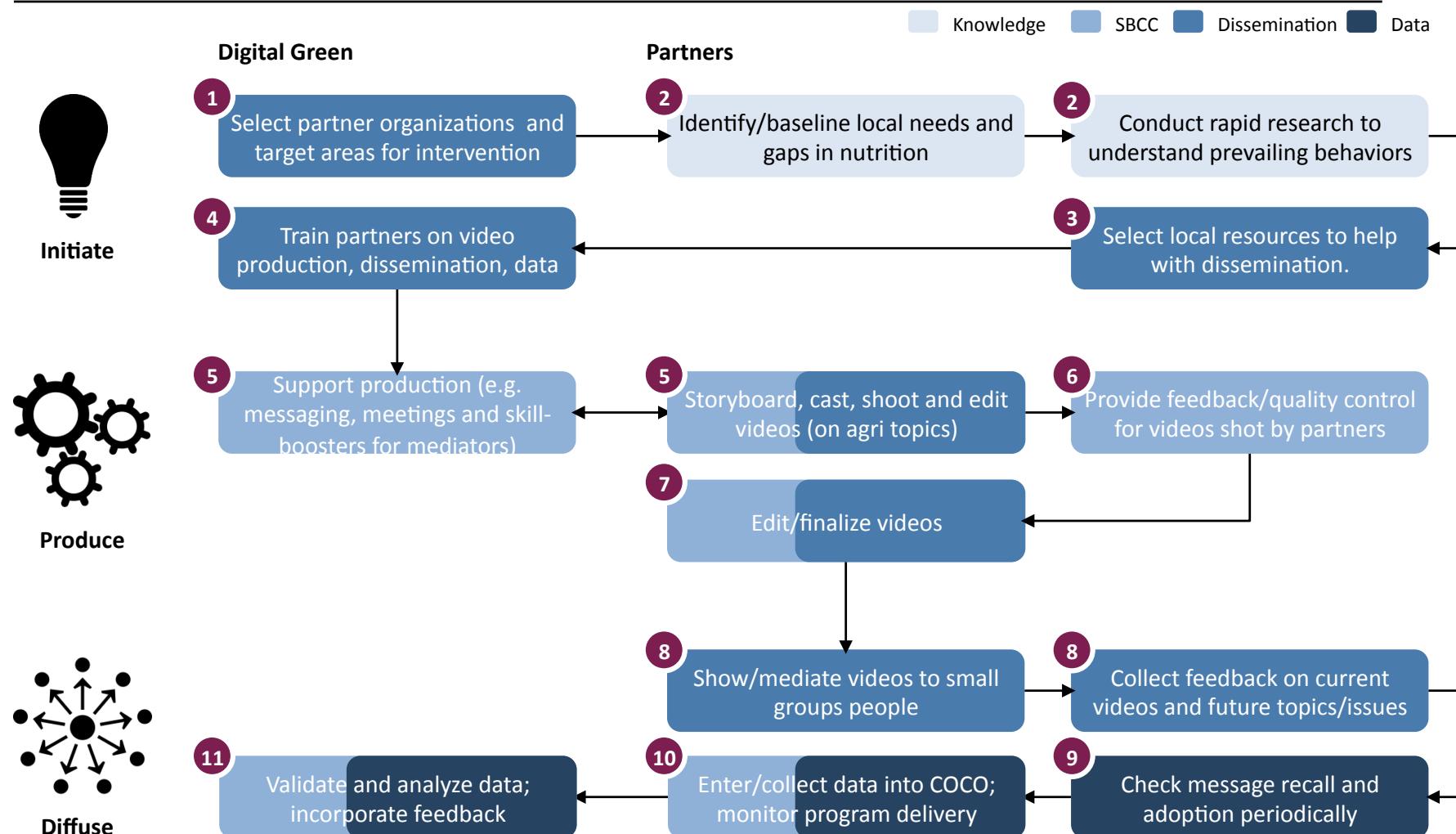


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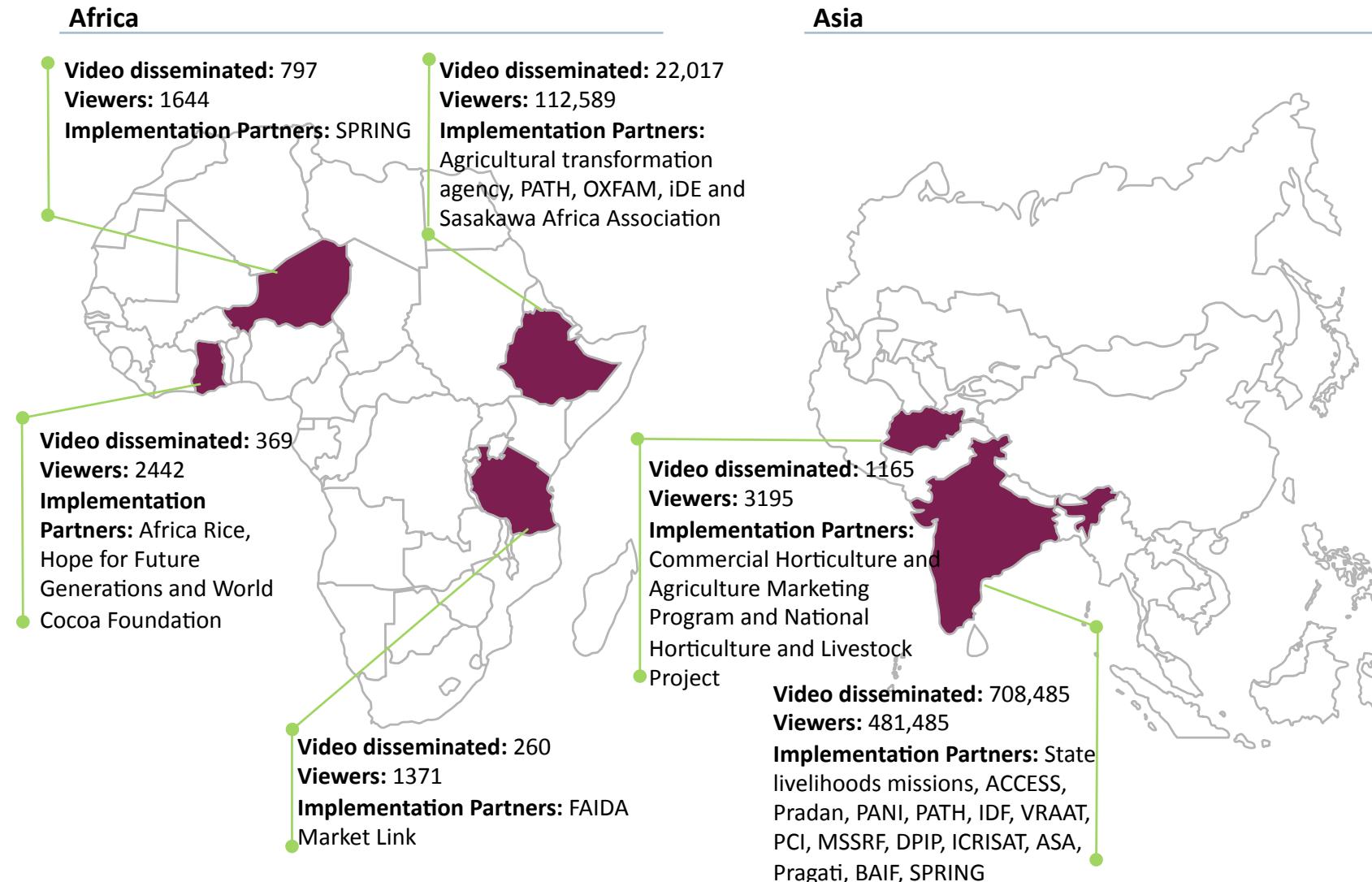
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DG's current service approach in agriculture and nutrition brings together four main functional areas

Core responsibilities for DG and its partners in the existing ag-focused model



DG has expanded rapidly in the last 3-5 years



In India, DG's work has focused on improving agriculture, food security and health outcomes in rural areas

	Program	Description	Partners	Location
Agriculture	District Poverty Initiatives Project	Improving the efficacy of Department of Panchayat and Rural Development's agricultural extension work geared to small holder farmers.	District Poverty Initiatives Project logo	100 villages in Rajgarh and Raisen districts, M. P.
	Leveraging ICT based extension to Augment Productivity (LEAP)	Demonstrating new practices in farming through the Farm Field School program. Also, organizing SHGs to promote saving and credit and helping develop pulses and vegetable clusters through Farm Producer organizations.	ACCESS Development Services in collaboration with ATMA, NABARD and SFAC logo	430 villages in Rajgarh, Guna and Ashoknagar districts, M.P.
	Jeevan Jyoti	Working on the scheme through MNREGA to diversify the livelihood of smallholder farmers through training in agricultural topics to improve plantation on wastelands.	People's Action for National Integration (PANI) and Bharat Renewable Energy Limited (BREL) logo	38 villages, Rae Bareli, Amethi and Sultanpur districts, Uttar Pradesh
	ICT in Improving Access to Crop Production Technologies	Working on a pilot project to strengthen the existing government extension system to increase access to improved crop production technologies.	Krishi Vigyan Kendra and Department of Agriculture - Government of Odisha, Cereal Systems Initiative in South Asia (CSISA) logo	20 villages, Puri district, Odisha
Health	Digital Public Health (DPH)	Helping extend PATH's health interventions initiated under a project called Sure Start through the provision of training on video production and dissemination to over a 100 government appointed Accredited Social Health Activists (ASHAs).	PATH, Gramin Vikas Sansthan (GVS) and Nehru Yuwa Sangathan-Tisi (NYST) logo	84 villages, Rae Bareli district, Uttar Pradesh

Nutrition is a nascent area of work for DG

Program	Description	Partners	Location
Making Innovative Linkages between Agriculture and Nutrition (MILAN)	Using the video-enabled approach to test the feasibility of integrating agriculture-nutrition linkages focused towards maternal, infant, and young child nutrition to an existing agriculture model that was successfully being implemented with VARRAT.	SPRIGN and VRAAT logo	80 villages, Keonjhar and Kendrapara districts, Odisha
Advancing Nutrition through Community Engagement (ADVANCE)	Utilizing video-enabled model to address the gap between available resources and knowledge on addressing malnutrition and the people who need this vital information through RMF's existing cadre of Community Nutrition Advisors.	Real Medicine Foundation logo	100 villages, Khandwa district, Madhya Pradesh
Digital Approach to Rural Sanitation, Health and Nutrition (DARSHAN)	Aiming to accelerate behavior change related to maternal newborn and child health and sanitation (MNCHS) by promoting local practical solutions around these issues.	PCI logo	40 villages, Saharsa district, Bihar

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Annex 1: Detailed case studies

1

India. Pulse Polio Campaign. Government of India

2

Bangladesh. WASH Toilet Campaign. BRAC and IRC

3

Indonesia. Maternal Nutrition. GAIN and EHG

4

Nigeria. Breastfeeding Campaign. FHI360

5

India. Mobile radio on various topics including health and nutrition. Gram Vaani

6

India. Maternal Health. BBC Media Action

7

India. CCS Pilot. DIMAGI

1 India's pulse polio campaign worked through social mobilization and ensuring supply

Context

- In 1995, India launched a polio vaccination campaign by setting up booths across the country on specified dates, which led to significant reduction in number of cases registered. However, 5.3 million a year were still dropping out of the cycle by 1998-99

Intervention

- Government of India introduced a house-to-house (HTH) approach experimentally to reach the unreach in polio endemic states. The positive outcome led complimenting of existing approach with another two to three day outreach to bring vaccination closer to home.

Results

- Within two years, the number of reported cases dropped by a further ~85% from ~2,000 in 1998-99 to ~270 in 2000-01 and WHO declared India free from Wild Polio Virus in 2014

Details

Knowledge

- The thrust was two fold – on social mobilization and supply to ensure easy access.
- Social mobilization through celebrities, localized messaging worked to create demand for vaccines
- Supply was aimed to capture all groups including hard to reach and migrant population

SBCC

- 3 fold approach was used –
1) T.V. , and radio ads, 2)
messaging by local and
religious leaders and, 3)
Home visits by health
workers.
- The broadcast focused on
upcoming immunization
dates, local leaders won
credibility for the drive and
health workers were last
mile delivery mechanisms
in hard to reach areas

Delivery

- Partnerships were formed
with celebrities to spread
message and with
telecoms to replace
ringtones with reminders.
- Volunteers were paid a
small fee to motivate them.
Demand for vaccination
was made the thrust
broadcasting only the
importance of going to the
booth instead of home
visits.

Data

- A disease surveillance
system facilitated case
reporting and enabled
swift responses.
- Volunteers regularly
examined babies and
collected stool samples for
testing.
- Health centers, doctors and
spiritual healers were
trained to report
symptoms that might
indicate polio.

2 BRAC and IRC partnered to undertake large scale behavior change in Bangladesh in sanitation

Context

- In 2006, only 1 in 3 people had access to sanitation of which ~80 million were in rural Bangladesh, leading to sub-optimal health and nutrition outcomes.

Intervention

- Formative research was undertaken to understand perceptions, group exercises were carried out to raise awareness about sanitation and WASH committees of 50-300 households were formed in 250 sub-districts. The committees ensured that the messages were reinforced. Capacity of local sanitation entrepreneurs was built through trainings and micro finance.

Results

- 37 million people got access to sanitation in Bangladesh in a decade. The resultant momentum has changed the landscape of sanitation in Bangladesh with the OD rate now at 3%.

Knowledge

- Core communication package was targeted to focus on 7 key WASH behaviors, from the earlier 19.
- Communication training also focused on ensuring that social marketing was about, 'selling not telling'; on dialogue, rather than on repeating and recalling key messages.

SBCC

- Participatory rural appraisal* was used which emphasizes local knowledge and enables people to make their own plans based on analysis.
- Advocacy workshops were conducted for local leaders and influencers, health volunteers, schools and local media to foster demand.

Delivery

- A three step process - awareness, reinforcement and supply, was used.
- Awareness was created through initiation workshops by BRAC staff. Reinforcement was through peer pressure by WASH committees. And, provision of training and funds to sanitation entrepreneurs ensured supply

Data

- QIS (Quality Information system) was used to monitor behavior change.
- Monitoring team of 2 would visit households and rank households on a pre-agreed scale.
- This data was entered in an app and sent to BRAC office where it would be further analyzed and disseminated.

Details

Gerakan Rumpi Sehat (The Healthy Gossip Movement) by the Environment Health Group, aims to reach 50 MN mothers in Indonesia

Context

- Indonesia has among the highest rates of stunting in the world (35% of the population). It has also long been a test-case for nutritional interventions, but substantial, long-lasting change has yet to be realized.

Intervention

- GAIN and EHG partnered to design Gerakan Rumpi Sehat – The Healthy Gossip Movement. The focus of the 3 month pilot was on targeting 4 behavioral areas: EBF, complementary feeding, healthy snacking and maternal nutrition. Emotional drivers were employed for broadcast ads and certain households received personal visits from partners to reinforce messages.

Results

- The campaign was successful in improving dietary diversity of children under two and increasing the provision of fruit as a healthy snack. The change was more significant for the group which received ad broadcasts + personal visits

Details	Knowledge	SBCC	Delivery	Data
	<ul style="list-style-type: none"> Emotional drivers of behavior change, such as affiliation, nurture and disgust were employed through multiple channels. A five step process of Behavior Centered Design was used which consisted of: A: Assess, B: Build, C: Create, D: Deliver and E: Evaluate. 	<ul style="list-style-type: none"> The aim was to test the effectiveness of emotional drivers of behavior change, such as affiliation, nurture and disgust. The campaign had 'Mrs Gossip', who would judge the feeding practices of others before realizing, to her embarrassment, that she had actually been doing the wrong thing. 	<ul style="list-style-type: none"> The campaign was run through television commercials and supported by community activations and house-to-house visits. Interactive community activations through games were used which targeted specific barriers by using emotions and story telling. 	<ul style="list-style-type: none"> A 2-arm cluster RCT was employed. Each cluster had 1,300 households. 1st arm received TV only, 2nd arm received TV + community activations. A score sheet was filled by surveyors who conducted visits after a specified amount of time.

4 FHI360 partnered with micro-credit groups in rural Nigeria and used technology to test behavior change effects in infant feeding

Context

- Only 7% of Nigerian infants are exclusively breastfed (EBF). Water is commonly given during the first days of life and throughout breastfeeding. Complementary foods are introduced early – 20% at 0-1 months of age.

Intervention

- FHI360 partnered with 4 micro-credit organizations for an RCT targeting pregnant women. The objective was to test the effect of an breastfeeding promotion through group activities and mobile messages on EBF. Breastfeeding initiation within one hour of delivery was the other indicator being tested.

Results

- Percentage of women who intentioned to practice EBF and those who ended up practicing it increased from 42% to 64%. Similar percentage for breastfeeding within 1 hour of delivery increased from 51% to 70%.

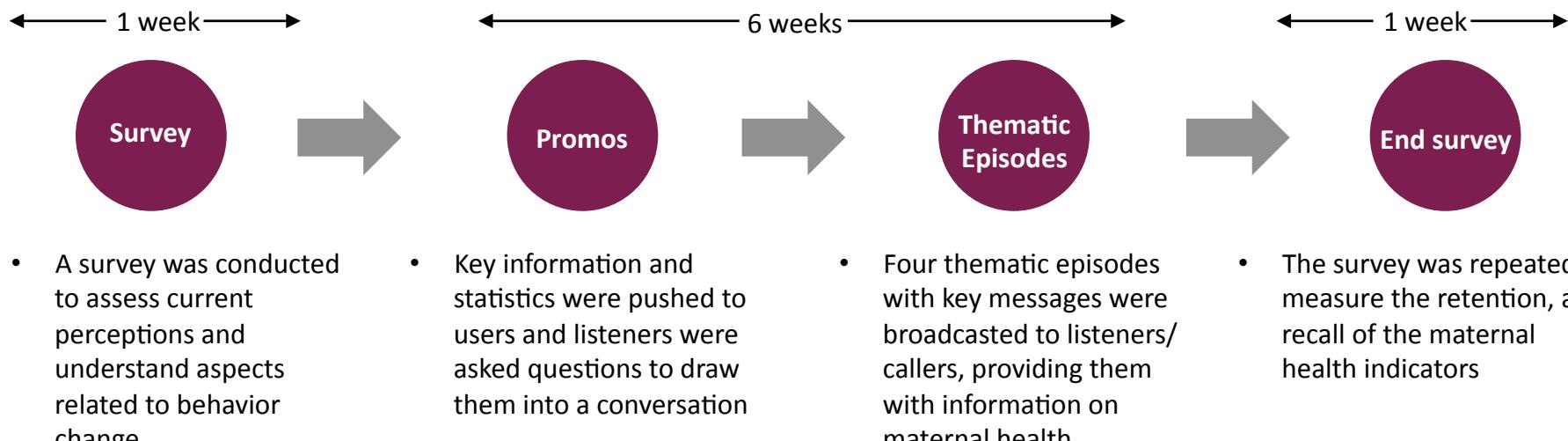
Details	Knowledge	SBCC	Delivery	Data
	<ul style="list-style-type: none">The framework used was 6 fold – social norms, knowledge, beliefs about outcomes, skills and self-efficacy, and enabling environment.The intervention targeted building knowledge, reinforcement, reminders and creating social acceptance for new feeding practices.	<ul style="list-style-type: none">7 monthly BF learning session was launched during microcredit meetings.Cell phone voice and text messages were sent twice a week to reinforce key BF messages.There were monthly presentation of song or drama around messages by the groups to build social norm around the practice.	<ul style="list-style-type: none">A phone was given groups of 5-7 women to which messages were sent.Partners broadcasted messages during meetings, and encouraged these groups to perform monthly songs and dramas to a larger group to build social norm around the practice.	<ul style="list-style-type: none">Baseline and final survey interviews were conducted by trained data collectors. Paper questionnaire were used and data was then recorded in an electronic database.At baseline, groups were asked about their infant feeding beliefs. The final survey tested their infant feeding practices.

Gramvaani Oxfam campaign on maternal health using community radios

Context

- Oxfam India wanted to engage rural communities in raising awareness and initiate discussions about maternal health practices. They also wanted to understand their perspectives and beliefs on the topic.
- The campaign was conducted in Jharkhand, Bihar, M.P., Odisha, Uttarakhand and U.P. through Mobile Vaani network of three Community Radio Stations and four Mobile Vaani numbers.

Process of intervention



Results

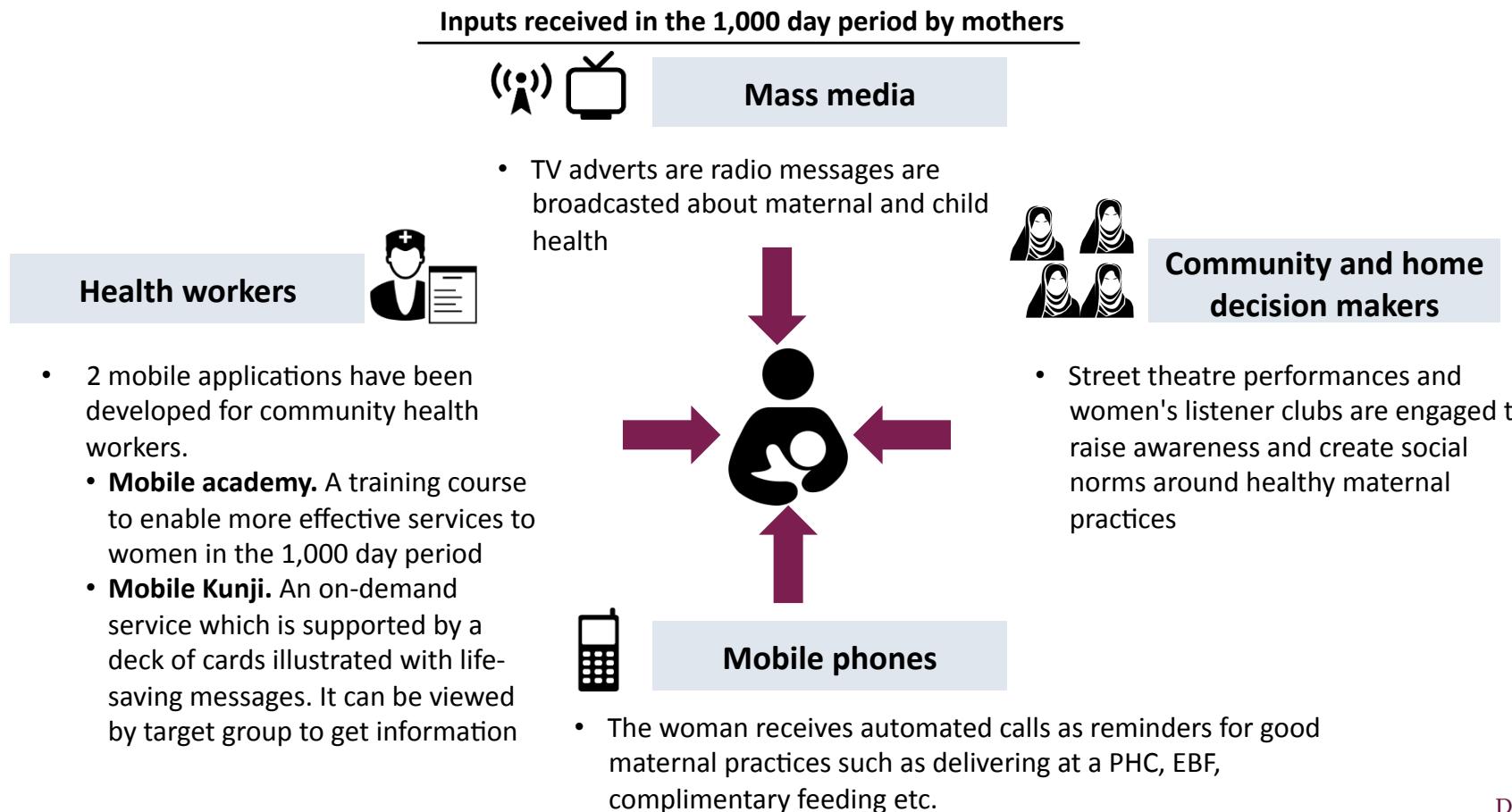
- User perceptions of major issues afflicting maternal health were identified. 49% believed that child marriage led to low maternal health, 14% believed that maternal health government schemes were inadequate and 37% believed that maternal health quality care needed improvement.
- The campaign was successful in mobilizing responses from both males and females with an almost equal split of contributors (56% men to 44% women).

BBC Media Action is working on a BMGF funded program in Bihar—Ananya, to improve maternal health

Context

- Bihar has among the worst indicators in maternal health in India. Among a population of 104 million, only 27% of young mothers have access to any traditional media (TV, radio, newspapers or cinema). However, adding cell phone into the mix takes the, increases the access to 90%.
- BBC Media Action is working through multiple channels to change maternal health behavior among target women.

Process of intervention



Note: End lines are yet to be conducted which would measure the impact generated by BBC Media Action approach Source: BBC Media Action website, Dalberg research

DIMAGI's Continuum of Care Services (CCS) pilot in Bihar under project Ananya demonstrated an effective ICT based approach for MCHN

Context

- Bihar's 42% children are underweight, maternal mortality rates are high and only 1 out of 3 pregnant women receive appropriate care at a clinic
- To address the challenges, CARE under project Ananya tested innovative solutions for improving family health interventions. CCS, piloted in Saharsa district, was one such solution, designed in collaboration with DIMAGI and Grameen Foundation
- The goal was to improve number of visits and quality of service to improve MCHN care through the use of mobile technology

Process of intervention



- CCS was deployed across 35 health sub-centers, with 550 FLWs (ASHAs, AWWs), 58 supervisors, 12 managers to deliver services to a population of 400,000
- The following apps were created:
 - ASHA application** – Specific app to track pregnancies and children up to 2 years of age used by AWWs as well
 - AWW application** – Additional app to track specific tasks such as, daily attendance, ration delivery, monitoring growth charts, and registration and tracking of children from 0 to 6
 - Supervisor application** – Tracked FLWs performance via custom reports viewable through the cell phone
 - Manager application** – Tracked overall sub health center performance for the block level officials
- The control group had 35 health sub centers with FLWs, supervisors and mangers using paper based tools
- The results of the RCT were measured after 2 years in 2014 through a comprehensive end line

Results



Pre natal visits



Post natal visits (1 week of delivery)



Complimentary feeding related visits



Quality of service

Mixed. Treatment group received more advice on certain topics while in others, there was no difference

Dalberg 74

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Major takeaways from external interviews

Interviewee details	Key messages
Aditeshwar Seth – Gramvaani	<ul style="list-style-type: none">Creating localized content important. Created this for multiple campaigns in agriculture and maternal healthExisting user base in Jharkhand and Bihar can be leveraged by DG. Good opportunity to provide frequent reminders after broadcasting information to target audience
Sara Chamberlain – BBC Media Action	<ul style="list-style-type: none">Adopting a 360⁰ approach through street plays, IVR systems, tools for front line workers and creation of social normsScaling operations thorough partnership with MoWCD, Government of Odisha, Bihar, Jharkhand and U.P.Good opportunity to partner with DG in places like Jharkhand where currently rolling out intervention for the USAID project. Are also exploring professional video based materials
Kenda Cunningham – LSHTM	<ul style="list-style-type: none">Need to focus on limited set of messages and segment videos according to relevant populationsBombardment of messaging and creating social norms in communities is an effective technique to ensure lasting behavior changeMajor issue with ICT based BCC are 1) Low penetration of cell phones among women and, 2) Divergence between target of messaging (women) and decision makers (men)
Rishabh Rath – DIMAGI	<ul style="list-style-type: none">Developing a mobile app that would be used by 100,000 Aanganwadi workers across 8 statesThe app would serve as a job aid by helping measure specifics such as growth, weight etc. It would be used at all levels starting from Aanganwadi to block, district, state and nationalConducted initial conversations to produce the 1st draft of videos. Plenty of opportunities for collaboration, since there exists a plug and play model where the videos can be loaded onto the back end of the app ecosystem and can be accessed by FLWs

Major takeaways from external interviews

Interviewee details	Key messages
Prakash Kotecha – Nutrition expert	<ul style="list-style-type: none">• There is low awareness among the FLWs on nutrition• No integrated view of supply is taken till date. Logistics of delivery of supplements such as IFA tablets need to be a lot more rigorously thought out• Malnourishment of child under 2 needs to be on high priority. This includes EBF and initiation of complimentary feeding after 6 months. This needs to be targeted through localized content
Laura Birx - BMGF	<ul style="list-style-type: none">• Reinforcement and reminders are important mechanisms for SBCC. While ICT tools are important, human actions and touch is a critical component which can drive BC• Another great method is the positive deviance model and building a social network around the technology is important as well• Real opening and enthusiasm to partner by the governments, however, it needs to be grounded in solid formative research
Vishnu Vasudev – Antara Foundation	<ul style="list-style-type: none">• Considering a tablet based solution in Rajasthan where videos are shown to the target group by AWWs and ASHAs. State government has a budget for ~12,000 tablets• While there are a multitude of partners working in this space, it is the content which has to be unique to drive home behavior change• While localization is good, it can not be too granular since that means that the model can not be scaled
Nagendra Varada – Alive and Thrive	<ul style="list-style-type: none">• Technical partners for JEEViKA digital support program to help build capacity through PCI. Providing support to mainstream MICN in the health system of Bihar and also supporting ground level activities and mobilization events• About to release a formative research report on complimentary feeding in Bihar based on which we will draw up a nutrition strategy• 2nd phase of Ananya is starting and interested in getting DG involved to incorporating their model in the SBCC methods

Major takeaways from external interviews

Interviewee details	Key messages
Tarun Vij - GAIN	<ul style="list-style-type: none">GAIN's work in India has been fortification that lends itself to population wide coverage and reachCorrect feeding practices, WASH issues are important since that increases the absorption of nutrientsThe health workers are untrained, so if they could be trained, that would be very helpful. It is important to simplify that training process since many of them over 60 and are not very literate
Hari Menon - BMGF	<ul style="list-style-type: none">Tata trust has been investing in livelihood intervention to work with marginalized farmers and wateraid usually conduct WASH pilots that might be interestingOdisha is a good state to scale in. There is demand and the government is receptive to partnerships. However, their SRLM is only a year old. Telenganga is another interesting state with demand. Chhattisgarh has a strong grass route community due to the right to food work and might be an interesting opportunity to explore
Vijay – USAID	<ul style="list-style-type: none">In FP, we are trying to position it as an intervention in preventive maternal health. Focus is on expanding the choice and shift the method mix to increase the share of other methodsDG would be ideal to generate demand through their disseminationsOther indicators that we want to target are stunting and underweight issues in children

List of internal stakeholders and on-field organizations interviewed

Internal DG interviewee details

Delhi

- Rikin Gandhi
- Vinay Kumar
- Charu Chopra
- Anchita Patil
- S Kaushik
- Aditya Sethi
- Namita Singh

Bihar

- Pawan Ojha
- Abhinav Kumar

Jharkhand

- Praveen Sriramshetty

Odisha

- Ronali Pradhan

Interviewed on-field organization details

Delhi

- MoRD

Bihar

- JEEViKA
- CARE
- State Health Society
- Alive and Thrive (ex DFID SWASTH)
- UNICEF

Jharkhand

- State Nutrition Mission
- CSR Council
- IPE Global

Odisha

- VARRAT

Summary findings and recommendations (1/2)



Service approach

- **Based on existing capabilities and experience, DG is well-positioned to quickly launch and grow programs in RMNCH+A nutrition in several states in India.** But, pilots raised important challenges related to the capacity of the approach to drive sustained behavior change. Importantly, nutrition topics are more complex/abstract and sensitive than those address in agriculture, and, many topline behaviors are not tangible or easily quantifiable, which limits DG's ability to influence change.
- **Thus, the standard DG service approach will require important adaptations and refinements.** Importantly:
 - **Knowledge:** Invest more on localized, formative research, e.g. on identifying local underlying causes of behaviors and locally feasible solutions (e.g. sourcing for home gardens that enable diverse diets) that could drive adoption of new behaviors
 - **SBCC approach:** Over time, leverage other SBCC methodologies, to reinforce and further propagate messages. In particular, (1) incorporating a greater focus on interpersonal counselling, and (2) mobile-based content and reminders
 - **Dissemination:** Expand/intensify training on nutrition-tailored video production and dissemination; Increase access to ongoing training and resources through ICT-enabled platforms for FLWs
 - **Data:** Provide measurable and operationally meaningful definitions and indicators for “adoption” for FLWs, and; establish/define metrics to improve tracking/reporting of nutrition-specific information and analytics on COCO



Geographies

- **A long-list of 10 states was prioritized based on an assessment of the malnutrition burden. Long-term priority states (3-6) may be selected from this long list.** The prioritized states are Bihar, Chhattisgarh, Gujarat, Jharkhand, Madhya Pradesh, Maharashtra, Odisha, Rajasthan, Uttar Pradesh and West Bengal.
- Other factors that could drive the choice of states for long-term implementation, such as “states with fewer development actors”, were not considered in this study.
- **Of the prioritized long-list. Bihar, Jharkhand were selected for short-term implementation** based on a high-level assessment of (1) estimated time to implement and, (2) time/potential to scale, and most importantly, (3) existing capabilities/ networks of DG.
- In addition, **Odisha shows potential** to contribute in the short term **as a learning laboratory**, feeding insights and course corrections into programming in other states. This is based on current activities in the state involving a randomized control trial (RCT) with partners on RMNCH+A nutrition and BCC.
- **Programs in Bihar are expected to launch first, with the highest potential to scale** based on (1) existing operations and capabilities in Bihar, and (2) strong relationships with the Bihar Rural Livelihoods Mission (JEEVIKA) – a dissemination partner with significant penetration and mission convergence.

Summary findings and recommendations (2/2)

Partnerships

- Potential partners were explored across DG's 4 core functional areas: knowledge, SBCC, dissemination and data. Our main findings were:
 - **Knowledge:** Several influential “knowledge” stakeholders are operating in the 3 priority states and have existing relationships with DG. **Alive and Thrive (FHI 360) and Poshan (IFPRI)** appear to have the best nutrition-specific intellectual property for India.
 - **SBCC:** **BBC Media Action** emerged as a high-potential cross-cutting SBCC partner, based on their complementary approach and experience in priority states. BBC has scaled rapidly in Bihar (potential for integration), and is initiating programs in Jharkhand.
 - **Dissemination:** Expectedly, three national ministries/missions – National Rural Livelihoods Mission (**NRLM**), **National Health Mission** (Ministry of Health and Family Welfare) and the **ICDS** (Ministry of Women and Children) – are the most influential dissemination stakeholders for nutrition with access to large front line worker (FLW) networks. State-level presence and capacities vary substantially for these ministries.
 - **Data:** **DIMAGI**’s experience with video-based content delivery, and working in nutrition in India position it well to enhance DG’s data collection process, and provide an ICT-enabled platform for FLWs to access ongoing training and refreshers.
- In addition, **large-scale programs and multi-state initiatives** such as (1) National Nutrition Mission, (2) ICDS Systems Strengthening & Nutrition Improvement Program (ISSNIP), and (3) USAID’s RMNCH+A Nutrition program in 6 states **offer opportunities to leverage funding and a single point of access to multiple influential nutrition stakeholders.**

Implementation

- Our suggested implementation road map across the three short-term priority states is broadly the same: (1) **establish the quickest “route-to-market”** i.e. launch quickly, leverage existing capabilities/networks), (2) **expand program**, both reach and impact, by incorporating new partners and aligned SBCC approaches that have the potential to boost adoption and behavior change, and (3) **demonstrate capabilities and scale**.
- Overall, findings suggest that **Bihar is likely to implement and scale fastest through DG’s partnership with BRLPS**. The program in **Jharkhand shows potential for crucial cross-cutting partnerships with JSLPS, SNM and BBC Media Action (which is specifically seeking partnership opportunities in JH)**. And, in **Odisha**, while the reach is currently limited in the absence of a local dissemination partner with potential to scale, the current RCT **offers significant opportunities to gather and incorporate lessons and best practices** regarding optimal behaviors and processes for BCC in RMNCH+A nutrition.

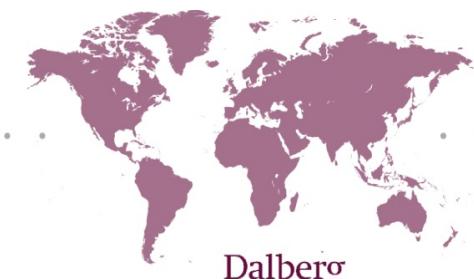
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