

UPAVAN: Upscaling participatory action and videos for agriculture and nutrition

Submission date 28/10/2016	Recruitment status No longer recruiting	<input type="checkbox"/> Prospectively registered <input checked="" type="checkbox"/> Protocol
Registration date 21/12/2016	Overall study status Completed	<input type="checkbox"/> Statistical analysis plan <input checked="" type="checkbox"/> Results
Last Edited 13/02/2025	Condition category Nutritional, Metabolic, Endocrine	<input type="checkbox"/> Individual participant data

Plain English summary of protocol

Background and study aims

Maternal and child undernutrition (the outcome of insufficient food intake and repeated infectious diseases) is one of the world's most serious health, economic and human development challenges. Child undernutrition causes an estimated 3.1 million child deaths annually, and one third of women in South Asia are underweight. There is an increasing scientific consensus that interventions to address immediate determinants of undernutrition ('nutrition-specific' interventions) are necessary but not sufficient: acceleration of progress in maternal and child nutrition will entail coupling these interventions with nutrition-sensitive programs that tackle the underlying causes of undernutrition. 'Making agriculture work for nutrition' is now a top policy priority but the evidence-base is weak, largely due to poorly designed studies that are unable to discern causal effects. In this study, three variants of a participatory agricultural intervention that use low-cost participatory videos and facilitated discussions with women's groups on maternal nutrition (body mass index) and child dietary diversity will be tested.

Who can participate?

Children aged between 0-23 months and their mothers.

What does the study involve?

The study is recruiting 148 village clusters (villages and adjoining hamlets) in rural Keonjhar district in Odisha, India. These clusters are randomly allocated to receive one of the three variants of the intervention or to a control group (no intervention). The first variant involves the circulation of locally made nutrition-sensitive agriculture videos to women's self-help groups (SHGs), with follow-up home visits to group members who are in the '1000 golden days' period, i. e. women who are pregnant or are the mother of a child under 2 years old. Frontline workers circulate two nutrition-sensitive agriculture videos each month, to 10-12 self-help groups (SHGs) per 1000 population, with each group comprising approximately 20 to 25 members. For the home visits, frontline workers visit all women in the 1000 golden day period to reinforce messages and verify the adoption of agricultural practices. The second variant is similar to the first but also contains nutrition-specific videos that focus directly on maternal and child nutrition, and related social and behaviour change. Each SHG (10-12 self-help groups (SHGs) per 1000 population) also receive two video dissemination meetings per month, with an approximately 50:50 allocation of nutrition-sensitive and nutrition-specific videos over the 36-

month intervention period. Frontline workers also conduct home visits to women in the 1000 golden day period for message reinforcement and verification of the adoption of any agricultural practices, and for knowledge recall of recommended nutrition practices. The third variant uses both nutrition-sensitive and nutrition-specific videos disseminated to SHGs (10-12 self-help groups (SHGs) per 1000 population) in a similar way to first program. In addition, an enhanced participatory approach of 'Participatory Learning and Action' (PLA) women's groups focussing on maternal and child nutrition (one PLA group per cluster) is implemented, which feeds into the nutrition-specific video development and circulation by using the discussions in the PLA group meetings to inform the prioritisation and development of video content. Home visits for women in the golden 1000 days are conducted in a similar way to the first group.

What are the possible benefits and risks of participating?

The purpose of the study is to find out if the interventions will improve agricultural practices and nutrition of children and mothers, so it is possible that these outcomes will improve, but we cannot be certain of these outcomes. In the interviews at the start and end of the study, severely undernourished women and children will be referred to the nearest health facility, so this will be some small benefit for all study groups. The participation of this village may lead to future benefits for families in Keonjhar. If the interventions prove to be successful, the trialists will try to secure additional funding to deliver one of the interventions after the 32-month study period. In this case, priority would be given to the villages that did not receive any additional intervention during the study. However, the trialists cannot be certain if this will happen or not. There are no known risks involved with participating in this study.

Where is the study run from?

The study is run by London School of Hygiene and Tropical Medicine (UK) and takes place in 148 village clusters (villages and adjoining hamlets) in rural Keonjhar district in Odisha (India)

When is the study starting and how long is it expected to run for?

December 2015 to May 2020

Who is funding the study?

Bill and Melinda Gates Foundation (USA)

Who is the main contact?

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Contact information

Type(s)

Scientific

Contact name

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Additional identifiers

Protocol serial number

QA896

Study information

Scientific Title

Community-driven and digital technology-enabled agriculture intervention for nutrition: a cluster randomized controlled trial in Odisha, India

Acronym

UPAVAN

Study objectives

1. An agricultural intervention in rural India, involving the facilitated dissemination of locally made agricultural videos through women's groups, will improve maternal nutritional status (body mass index) and child dietary diversity, compared to the control group, through improvements in household income, agricultural development (especially the availability and accessibility of nutrient-rich foods), and women's empowerment
2. The two variants of this agricultural intervention, that embed nutrition-specific messaging and also use enhanced participatory approaches, will further enhance the impact of the intervention, compared to the control group, on maternal nutritional status and child dietary diversity

Ethics approval required

Old ethics approval format

Ethics approval(s)

1. Odisha government's Institutional Review Board, Research and Ethics Committee, Department of Health and Family Welfare, Government of Odisha, 03/09/2016, ref: 141 / SHRMU
2. London School of Hygiene and Tropical Medicine (LSHTM) Interventions Research Ethics Committee, 10/10/2016, ref: 11357

Study design

Interventional cluster randomised trial

Primary study design

Interventional

Study type(s)

Quality of life

Health condition(s) or problem(s) studied

Maternal and child undernutrition

Interventions

Three variants of a participatory, video-based, agricultural intervention will be tested. 148 village clusters will be randomly allocated to four trial arms (37 clusters per trial arm), stratified by distance to nearest town (<10 km or ≥10 km) and low, medium or high proportion of Scheduled Tribe or Scheduled Caste households in the cluster.

'AGRI' intervention

This involves the facilitated dissemination of locally made nutrition-sensitive agriculture videos to women's self-help groups (SHGs), with follow-up home visits to group members who are in the '1000 golden days' period, i.e. women who are pregnant or have a child under 2 years old. Frontline workers will disseminate two nutrition-sensitive agriculture videos each month, to 10-12 self-help groups (SHGs) per 1000 population, with each group comprising approximately 20 to 25 members. For the home visits, frontline workers will visit all women in the 1000 day period to reinforce messages and verify the adoption of agricultural practices.

'AGRI-NUT' intervention

This intervention is similar to the 'AGRI' intervention, but SHGs will also view and discuss nutrition-specific videos that focus on maternal and child nutrition, and related social and behaviour change. Each SHG (10-12 self-help groups (SHGs) per 1000 population) will receive two video dissemination meetings per month, with an approximate 50:50 allocation of nutrition-sensitive and nutrition-specific videos over the 32 (updated 06/08/2019, previously: 36) month intervention period. Frontline workers will also conduct home visits to women in the 1000 day period for message reinforcement and verification of the adoption of any agricultural practices, and to check participants' knowledge of recommended nutrition practices.

'AGRI-NUT+PLA' intervention

Nutrition-sensitive and nutrition-specific videos will be disseminated to SHGs (10-12 self-help groups (SHGs) per 1000 population) in a similar way to the AGRI-NUT intervention. In addition, an enhanced participatory approach of 'Participatory Learning and Action' (PLA) women's groups focussing on maternal and child nutrition (one PLA group per cluster) will be implemented. Using the PLA approach, groups discuss and prioritise problems relating to maternal and child nutrition, implement strategies at the community and/ or household level to address these problems, and informally review their strategies. The PLA component will feed into the nutrition-specific video development and dissemination by using the discussions in the PLA group meetings to inform the prioritisation and development of video content. Home visits for women in the 1000 day period will be conducted in a similar way to the AGRI-NUT intervention.

Control group

The effect of each of the three intervention variants will be compared to a control group that will only receive any existing programs from Government or other non-governmental organisations.

The total duration of all three variants of the intervention will be 32 months. Repeat cross sectional surveys at baseline and endline (32 months after the intervention starts) will assess nutritional outcomes of index children aged 0 to 23 months, and the mothers or primary caregivers of the index children.

Intervention Type

Behavioural

Primary outcome(s)

1. Percentage of children (aged 6 to 23 months) that consume four or more food groups per day, based on a 24-hour dietary recall, is assessed by a team of trained local data collectors, using a cross-sectional survey designed for the purpose of this study at baseline (before the interventions begin) and endline (32 months after baseline)
2. Mean maternal Body Mass Index (kg/m sq) for non-pregnant, non-postpartum women is measured by a team of trained anthropometrists, using stadiometers (Seca 213) to measure height and weighing scales to measure weight, in cross-sectional anthropometric surveys conducted at baseline and endline (32 months after baseline).

All outcomes will be measured using repeat cross-sectional surveys conducted at baseline (October to December 2016) and endline (October to December 2019).

Key secondary outcome(s)

Current secondary outcome measures as of 06/08/2019:

Secondary outcomes:

1. Percentage of mothers consuming >5 out of 10 food groups per day, based on a 24-hour dietary recall is assessed by a team of trained local data collectors, using a cross-sectional survey designed for the purpose of this study at baseline (before the interventions begins) and endline (32 months after baseline)
2. Percentage of children with a weight-for-height z-score <2SD is measured by a team of trained anthropometrists, using infantometers (Seca 417) to measure child length and weighing scales to measure weight (and z-scores calculated by comparing weight-for-height against WHO standards), in cross-sectional anthropometric surveys at baseline (before the interventions begin) and endline (32 months after baseline)

Other outcomes of interest:

1. Percentage of mothers with MUAC < 23 cm is measured by a team of trained anthropometrists, using circumference tapes, in cross-sectional anthropometric surveys at baseline (before the interventions begin) and 32 months after baseline.
2. Mean haemoglobin (Hb) concentrations of mothers (g/dl) is measured by a team of trained lab technicians, using haemocue machines(model Hemocue Hb 301), in cross-sectional anthropometric surveys at baseline and 32 months after baseline
3. Mean haemoglobin (Hb) concentrations of children 6 to 23 months (g/dl) is measured by a team of trained lab technicians, using haemocue machines, in cross-sectional anthropometric surveys at baseline and 32 months after baseline
4. Percentage of children (age 6-23 months) meeting WHO recommended Minimum Acceptable Diet is measured by a team of trained data collectors, using a cross-sectional survey designed for the purpose of this study, at baseline and 32 months after baseline
5. Percentage of women 'empowered' in women's decision-making in productive and health-related domains, aggregated, measured using the Women's Empowerment in Agriculture Index.
6. Percentage of women 'empowered' in the women's time use domain of the Women's Empowerment in Agriculture Index.
7. Percentage of women achieving gender parity between themselves and a male household member, defined using the Women's Empowerment in Agriculture Index
8. Mean per capita household share of food expenditures
9. Mean per capita total household expenditures
10. Mean production diversity (count of the number of crops or livestock produced)
11. Total value of agricultural production
12. Net value of agricultural production (= value of agricultural production – costs)

Previous secondary outcome measures:

Secondary outcomes:

1. Percentage of mothers consuming >5 out of 10 food groups per day, based on a 24-hour dietary recall is assessed by a team of trained local data collectors, using a cross-sectional survey designed for the purpose of this study at baseline (before the interventions begins) and endline (32 months after baseline)
2. Percentage of children with a weight-for-height z-score <2SD is measured by a team of trained anthropometrists, using infantometers (Seca 417) to measure child length and weighing scales to measure weight (and z-scores calculated by comparing weight-for-height against WHO standards), in cross-sectional anthropometric surveys at baseline (before the interventions begin) and endline (32 months after baseline)
3. Percentage of children with MUAC < 125 mm is measured by a team of trained anthropometrists, using MUAC tapes in cross-sectional anthropometric surveys, at baseline (before the interventions begin) and endline (32 months after baseline).

Other outcomes of interest:

1. Percentage of mothers with MUAC < 23 cm is measured by a team of trained anthropometrists, using head circumference tapes, in cross-sectional anthropometric surveys at baseline (before the interventions begin) and 32 months after baseline.
2. Mean haemoglobin (Hb) concentrations of mothers (g/dl) is measured by a team of trained lab technicians, using haemocue machines(model Hemocue Hb 301), in cross-sectional anthropometric surveys at baseline and 32 months after baseline
3. Mean haemoglobin (Hb) concentrations of children 6 to 23 months (g/dl) is measured by a team of trained lab technicians, using haemocue machines, in cross-sectional anthropometric surveys at baseline and 32 months after baseline
4. Percentage of children (age 6-23 months) meeting WHO recommended Minimum Acceptable Diet is measured by a team of trained data collectors, using a cross-sectional survey designed for the purpose of this study, at baseline and 32 months after baseline
5. Percentage of mothers receiving > 3 antenatal care visits by a qualified provider is measured by a team of trained data collectors, using a cross-sectional survey designed for the purpose of this study, at baseline and 32 months after baseline
6. Percentage of mothers receiving minimum iron and folic acid supplements during pregnancy is measured by a team of trained data collectors, using a cross-sectional survey designed for the purpose of this study, at baseline and 32 months after baseline
7. Percentage of mothers receiving tetanus injections is measured by a team of trained data collectors, using a cross-sectional survey designed for the purpose of this study, at baseline and 32 months after baseline
8. Percentage of children (0-23 months) receiving appropriate care during illness episodes is measured by a team of trained data collectors, using a cross-sectional survey designed for the purpose of this study, at baseline and 32 months after baseline
9. Percentage of households using WHO-recommended handwashing practices is measured by a team of trained data collectors, using a cross-sectional survey designed for the purpose of this study, at baseline and 32 months after baseline
10. Mean Women's Empowerment in Agriculture Index (WEAI, measured using a modified score) (and the 5 domains of empowerment) is measured by a team of trained data collectors, using a cross-sectional survey designed for the purpose of this study, at baseline and 32 months after baseline
11. Mean gender parity in agriculture (also using WEAI) is measured by a team of trained data collectors, using a cross-sectional survey designed for the purpose of this study, at baseline and 32 months after baseline
12. Mean per capita expenditures in total, and on food, and non-food expenditures is measured by a team of trained data collectors, using a cross-sectional survey designed for the purpose of this study, at baseline and 32 months after baseline
13. Mean household asset ownership score is measured by a team of trained data collectors,

using a cross-sectional survey designed for the purpose of this study, at baseline and 32 months after baseline

14. Percentage of households with number months of inadequate household food provisioning is measured by a team of trained data collectors, using a cross-sectional survey designed for the purpose of this study, at baseline and 32 months after baseline

15. Mean production diversity (includes produced crops, dairy, livestock and foraged non-timber forest products) is measured by a team of trained data collectors, using a cross-sectional survey designed for the purpose of this study, at baseline and 32 months after baseline

16. Mean total yield per crop is measured by a team of trained data collectors, using a cross-sectional survey designed for the purpose of this study, at baseline and 32 months after baseline

17. Mean total income and net profit from agricultural production is measured by a team of trained data collectors, using a cross-sectional survey designed for the purpose of this study, at baseline and 32 months after baseline

18. Percentage of households with access to credit and agricultural entitlements is measured by a team of trained data collectors, using a cross-sectional survey designed for the purpose of this study, at baseline and 32 months after baseline

19. Cost-effectiveness ratios for the primary and secondary outcomes listed above is measured using programme-related cost data provided by the implementing organisations' accounting systems and through annual structured interviews with staff, and using data on the cost-burden on participants using household expenditure data and time use surveys conducted at endline (32 months after baseline)

20. Net cost per disability-adjusted life year (DALY) averted is measured using a cross-sectional survey designed for the purpose of this study, 32 months after baseline

All outcomes will be measured using repeat cross-sectional surveys conducted at baseline (October to December 2016) and endline (October to December 2019).

Completion date

31/05/2020

Eligibility

Key inclusion criteria

For intervention eligibility, all women in the cluster are eligible to receive the group-based interventions and video dissemination, with intended coverage of at least one woman per household attending the SHGs. Mothers in the 1000-day period (pregnant or with a child aged up to 23 months) are eligible to receive home visits. For the trial impact evaluation eligibility, children aged 0 to 23 months (and the mothers or primary caregivers of children aged 0 to 23 months) will be interviewed measured, so the trial effects are only generalisable to this sub-population.

For participation in interventions:

1. Village clusters from four blocks (Patna, Keonjhar, Harichandanpur and Ghatgaon blocks) in Keonjhar district, Odisha, India are eligible to be randomly allocated to any of the four trial arms
2. In the intervention arms, all women are eligible to participate in the study and attend the women's SHGs
3. All pregnant women and primary caregivers of children aged 0 to 23 months are eligible to receive home visits

For primary outcomes:

1. Children (male and female) aged 6 to 23 months

2. Non-pregnant, non-postpartum (added 06/08/2019) mothers or primary caregivers of children aged 0 to 23 months

For secondary outcomes:

1. Children (male and female) aged 0 to 23 months
2. Mothers or primary caregivers of children aged 0 to 23 months

Healthy volunteers allowed

No

Age group

Mixed

Sex

All

Key exclusion criteria

For participation in interventions:

1. Any of the 8 clusters selected for formative research
2. Any clusters with prior exposure to programmatic work by any of the implementing partners

For primary, secondary and other outcomes:

1. Any discernible disability of children or primary caregivers that prevents them from responding to the survey, or impairs their recumbent length or standing height
2. Any primary caregiver who is not defined as a 'household member'. That is, primary caregivers who have not resided in the household regularly at least half of the time during the past 12 months (e.g. 3-4 days of each week for 12 months, or 6 full months of past 12 months), unless she joined the household through marriage less than 12 months ago. Residing means living in the households and eating from the same pot. A married mother who is temporarily visiting her parental home, and so has not lived at the parental home for the past 12 months, will not be included. Household members do include servants, lodgers, and agricultural labourers currently in the household who will be staying in the household for a longer period, even if they arrived less than 12 months ago.
3. Any primary caregiver not of reproductive age (that is, not aged 15 to 49 completed years)

Date of first enrolment

19/12/2016

Date of final enrolment

19/01/2020

Locations

Countries of recruitment

India

Study participating centre

VARRAT (Voluntary Association for Rural Reconstruction and Appropriate Technology)
Boulakani Baradang

Mahakalpara
Kendrapada
Odisha
India
754224

Study participating centre
Digital Green Foundation and Trust
Plot No N3/18, Ranjita Apartment
Flat No 401, IRC Village
Bhubaneswar
Odisha
India
751015

Study participating centre
Ekjut
Amyhata
New Colony
Near Teli Samaj
Keonjhar
Odisha
India
758001

Sponsor information

Organisation
London School of Hygiene and Tropical Medicine

ROR
<https://ror.org/00a0jsq62>

Funder(s)

Funder type
Charity

Funder Name
Bill and Melinda Gates Foundation

Alternative Name(s)

Bill & Melinda Gates Foundation, Gates Foundation, Gates Learning Foundation, William H. Gates Foundation, BMGF, B&MGF, GF

Funding Body Type

Government organisation

Funding Body Subtype

Trusts, charities, foundations (both public and private)

Location

United States of America

Funder Name

UK aid Department for International Development from UK government

Results and Publications

Individual participant data (IPD) sharing plan

The study team will make the full datasets available in anonymized form within 2 to 3 years of project completion. This embargo period is requested to allow time for additional analysis and further publication of research findings to be performed. Prior to deposit into the data repository, data outputs will be anonymized to protect participant confidentiality and converted into a file format suitable for long-term access, based on the recommendations of the UK Data Service (<http://ukdataservice.ac.uk/manage-data/format/recommended-formats.aspx>). Data will be submitted to LSHTM Data Compass - an institutional research data repository built upon the ePrints platform to be launched in early 2015 – for long-term curation, preservation and sharing. A metadata record will be created for each output, outlining pertinent information such as when, where and how it was created. All metadata records will be exposed via RSS, ATOM, and OAI-PMH for harvesting by 3rd party services, such as research data catalogues. A Digital Object Identifier (DOI) will also be assigned to the metadata records, enabling citation in academic papers. Access to each output will be provided through request access. It is envisaged that a request access system will be used to provide data access. An interested researcher will complete a web-based data access form in the LSHTM Research Data Repository and submit it to the primary contact for approval. If the intended use complies with consent agreement and ethical approval has been obtained, they will be asked to sign a Data Transfer Agreement indicating, among other requirements, that they will not attempt to re-identify participants.

IPD sharing plan summary

Study outputs

Output type	Details	Date created	Date added	Peer reviewed?	Patient-facing?
Results article		01/05/2021	06/04/2021	Yes	No
Results article	Economic evaluation	10/06/2022	13/06/2022	Yes	No

Results article		20/03 /2020	13/02 /2025	Yes	No
Results article	Intrahousehold power inequalities and cooperation	20/03 /2023	13/02 /2025	Yes	No
Protocol article	protocol	09/03 /2018		Yes	No
Protocol article	Protocol for the cost-consequence and equity impact analyses	27/05 /2019	13/02 /2025	Yes	No