

# **Report on the Evaluation of SEWA's Early Childhood Development Interventions in Remote and Tribal Regions in the Context of the COVID–19 Pandemic**

**March 2024 | Study Report**



### About IWWAGE

Institute for What Works to Advance Gender Equality (IWWAGE) aims to build on existing research and generate new evidence to inform and facilitate women's economic empowerment agenda. IWWAGE is an initiative of LEAD, an action-oriented research centre of IFMR Society (a not-for-profit society registered under the Societies Act). LEAD has strategic oversight and brand support from Krea University (sponsored by IFMR Society) to enable synergies between academia and the research centre.

### About LSST

This study is being supported by Lok Swasthya SEWA Trust (SEWA). SEWA focuses on ensuring that informal women workers obtain social protection such as healthcare and childcare to enable their economic empowerment and self-reliance, both financially and in terms of decision-making and control. It helps them obtain full employment at the household level to achieve self-reliance and better health status. It has been working towards providing holistic and comprehensive primary health care to informal workers with a multi-pronged approach, focusing on health information and awareness, referrals, promotion of rational therapeutics, livelihoods and social security, including healthcare, childcare, insurance, pension and housing with basic amenities.

### About this report

This report has been prepared by Divya Singh Kohli, Sruthi Kutty and Trisha Chandra. It has been reviewed by Dr. Sona Mitra, Principal Economist, IWWAGE, an initiative of LEAD at Krea University. This document is not a priced publication.

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## Table of Contents

|  |    |
|--|----|
| Context  | 7  |
| Summary of the Needs Assessment Report   | 9  |
| Introduction to the SEWA-ECD Interventions in the Context of Covid-19 Pandemic     | 12 |
| Details of the Interventions by SEWA and Partner Organisations                     | 14 |
| Introduction to the SEWA-ECD Interventions Evaluation Study                        | 17 |
| Findings of Evaluation Study (Care-giving)   | 20 |
| Intervention-specific Findings (State-wise)  | 24 |
| Discussion   | 34 |
| Triangulation of the Needs Assessment Study and ECD Interventions Evaluation Study | 37 |
| Conclusions  | 40 |
| Appendices   | 42 |



## List of **Tables**

|  |    |
|--|----|
| <b>Table 1:</b> Details of the FGDs held                     | 18 |
| <b>Table 2:</b> District-wise findings about care-giving     | 22 |
| <b>Table 3:</b> District-wise findings about care facilities | 23 |

## Abbreviations

|      |   |                                       |
|------|---|---------------------------------------|
| AWC  | : | Anganwadi Centre                      |
| AWW  | : | Anganwadi Worker                      |
| ECD  | : | Early Childhood Development           |
| ECE  | : | Early Childhood Education             |
| FGD  | : | Focused Group Discussion              |
| ICDS | : | Integrated Child Development Services |
| NRC  | : | Nutrition Rehabilitation Centre       |
| PDS  | : | Public Distribution System            |
| SEWA | : | Self-Employed Women's Association     |
| ST   | : | Scheduled Tribe                       |







The lack of proper childcare services is a significant issue for women who work in the informal sector of India, especially those living in remote tribal communities. These women reside in challenging geographies such as rugged hilly terrains where the reach of even the Integrated Child Development Services (ICDS) programme is limited. Due to scarce resources, mothers from these communities frequently work outside their homes while also taking care of their children. This adds to the burden of unpaid care work that mostly falls on women, limiting their ability to enter, remain and succeed in the workforce. During the COVID-19 pandemic the situation deteriorated with the closure of Anganwadi Centres (AWCs), depriving mothers of the childcare facilities they could have otherwise availed of. As a result, the education, health and nutrition of their children were adversely affected. To enhance the socio-economic prospects of women and children in these communities, it is essential to offer community-based childcare services that are tailored to the unique requirements of informal female workers who belong to vulnerable tribal or indigenous communities.

It is crucial to understand their unmet needs and demand for quality childcare services if the challenges faced by indigenous or tribal communities are to be addressed. Additionally, it is essential to improve the situation of pandemic-stricken tribal and indigenous communities and enable them to ensure their own and their children's continued well-being. To achieve this objective, IWWAGE and SEWA are collaborating on a study that will take place from 2021 to 2024, divided into three phases.

The first phase, a needs assessment study, has already been conducted in all four states (Gujarat, Odisha, Kerala and Meghalaya) and will serve as a baseline for Gujarat. In the second phase, a evaluation study has been conducted to measure the short-term impacts of the Self-Employed Women's Association (SEWA)- Early Childhood Development (ECD) interventions introduced during the COVID-19 pandemic. This study has been conducted in all four states and will also serve as a midline for Gujarat. The final phase, the Endline, will assess the full impact of SEWA ECD interventions but will only be conducted in Gujarat. The needs assessment study and short-term evaluation have already been completed. The former was a quantitative study conducted between November 2021 and May 2022, while the latter was a qualitative study between November 2022 and June 2023. The Endline is scheduled for 2024.

This report presents the results of a evaluation of SEWA's ECD interventions in the context of the COVID-19 pandemic. The study aimed to evaluate the effectiveness of the interventions, participants' satisfaction, and short-term impact on the targeted population. The report is structured as follows: Section 2 gives a summary of the needs assessment report; Section 3 discusses the SEWA-ECD interventions in the context of the COVID-19 Pandemic; Section 4 explains the research design of the evaluation study; Section 5 presents the findings of the study; Section 6 includes a discussion on the common themes emerging from the study; and Section 7 presents a triangulation of the needs assessment study and evaluation study.





A group of children of various ethnicities are gathered in what appears to be a classroom. In the foreground, a young girl with dark hair, wearing a camouflage-patterned jacket with a yellow collar and a red anchor emblem, is smiling broadly. To her right, a boy in a dark blue sweater with a green and white striped collar is looking down. Behind them, several other children are visible, some looking towards the camera and others looking away. A girl in a yellow shirt is smiling in the background. The setting includes a chalkboard with some writing and a grid pattern in the background.

# SUMMARY OF THE NEEDS ASSESSMENT REPORT

02

Image Credit: Atul Loke @ODI



The needs assessment study's purpose was to better understand the status of childcare in remote tribal areas, both before and after the COVID-19 lockdown when (AWCs were closed). The study aimed to evaluate the demand for full-day, high-quality childcare services in remote areas and tribal communities, and to assess how childcare responsibilities affect a mother's employment. Additionally, it aimed to identify their preferences for an ideal childcare arrangement and evaluate how the availability or lack of childcare facilities affects their ability to participate in the labour force.

The study investigated how women balance their paid work with caring for their household and performing unpaid care work, types of activities women engage in, both paid and unpaid, and amount of time they spend on unpaid care work. Additionally, it explored mothers' preferences and perceptions of childcare services and their knowledge of available facilities. The quality of existing childcare centres was also assessed, including their proximity to beneficiaries, staffing capacity and quality, nutrition and health services offered, and availability of ECD materials. Finally, the study briefly assessed the impact of COVID-19, the lockdown of ICDS centres on childcare needs and unpaid care work of mothers.

The needs assessment study employed a non-experimental approach using a quantitative study tool in five districts across four states: Tapi and Sabarkantha in Gujarat, Kandhamal in Odisha, Trivandrum in Kerala, and East Khasi Hills in Meghalaya. Since the study aimed to examine the burden of childcare on women in remote tribal areas and better understand their childcare needs, the respondents were women (mothers) in the five remote tribal districts, aged between 18 and 45 years, with at least one child aged between zero to six years. Among the respondents, 65 per cent were 25-34-year-olds; these women were the most active in the labour force and thus had more significant childcare needs than others. Of the women studied, 85 per cent belonged to the Scheduled Tribes (ST) community. According to the study, around 80 per cent of the women were educated. Around 50 per cent belonged to families with household size of five to eight members and 40 per cent to household size of one to four members.

Around 75 per cent of the respondents had a monthly household income of less than INR 10,000. Among them, 23 per cent had an income between INR 5,000 and INR 10,000, 40 per cent had a

monthly household income below INR 2,000, and 11 per cent between INR 2,000 and 5,000. These incomes were reported during the pandemic period (November 2021-May 2022), when people faced significant job and income losses. It was observed that households with a monthly income below INR 2,000 had only one source of income while households earning more had multiple sources of income.

Out of the total number of women studied, 535 had worked in paid jobs during the past year. Among these women, 29 per cent had only worked for a short duration of one to three months, while about 20 per cent had worked for four to six months. About 25 per cent of these women had worked for seven to nine months and 10 to 12 months each. The women who were employed had worked as small and marginal farmers (66.54 per cent), domestic workers (4 per cent), agricultural labourers (11.78 per cent), teachers (2 per cent), clerical workers (2 per cent), construction workers (1 per cent), and as Anganwadi Workers (AWWs) (3 per cent). The remaining women were involved in self-owned businesses/self-employment, shopkeeping and street vending, and forest work.

Mothers who worked for pay or profit spent an average of 15.15 hours on economic and non-economic activities, while mothers who did not work for pay or profit spent an average of 11.23 hours, mostly on non-economic activities. This suggests that employed mothers have longer days than those who do not work for pay.

Nearly 67 per cent of working mothers relied on "informal/personal" resources for childcare. More than 30 per cent reported that they regularly took their child along while going to work, while 27 per cent said that another female family member who stayed at home looked after their children. Only 15 per cent of women reported that their husbands looked after the children in their absence, while 14 per cent left their children under the supervision of their older siblings. Less than 1 per cent of the children attended schools or AWCs.

At least 41 per cent of women involved in paid work had to skip work due to childcare responsibilities. About 25 per cent of the respondents reported having a crèche at their workplaces while almost 75 per cent reported the unavailability of such facilities. All states reported low availability of crèches: 7 per cent in Trivandrum, 6 per cent in Tapi, 4 per cent in Kandhamal and 1 per cent in East Khasi Hills. Given



the high demand for childcare facilities, women were asked about their willingness to send their children to the free-of-cost childcare facility near their homes. A majority (84 per cent) of respondents expressed willingness to send children to free full-day care centres while 16 per cent refused. The study revealed a clear need to establish affordable and adequate childcare arrangements close to mothers' worksites or homes. Many women have reported being absent from work due to childcare responsibilities. By having access to childcare services, women, whether employed or not, can benefit greatly by easing their unpaid care burden. This high demand emphasises the need for improved public infrastructure and government-run facilities.

A very small number (0.75 per cent) of the respondents sent their children to AWCs. This might be because the children below three years of sample size outnumber the four to six-year-olds. Given their greater vulnerability, women trusted family members more than the AWCs to look after their infants and toddlers. There was a trust deficit and uncertainty about the quality of childcare the child would receive at an AWC or childcare facility. The trust perception was further reduced due to the outbreak of the pandemic.

It was clear from the needs assessment study results that a six-hour operational time of AWCs will be most suitable for working women though the preferred time window would be different for different women depending on the nature of employment. For example, 50 per cent of the women engaged in construction work, 50 per cent of those in forest work and 36 per cent of casual workers preferred to drop off their children at the care facilities as early as 8 am, while 81 per cent of domestic workers and 44 per cent of teachers chose the 9 am slot. The rest of the respondents preferred 10 am, while self-employed women entrepreneurs or home-based workers were indifferent to the opening time of the childcare facilities. A majority (89 per cent) of women engaged in clerical work said they preferred to pick up their children at 3 pm while others preferred 4 pm. Very few preferred 6 pm as the picking-up time. Overall, amongst working women, 65 per cent wanted to drop their children at the AWCs before 10 am and 56 per cent preferred to pick them up in the 4-5 pm window. It is, therefore, very important to note that to cater to the childcare requirements of informal women workers, an extension of the working hours of the AWCs is necessary. This might also open opportunities of alternative forms of productive employment for women which they might not have considered yet due to time poverty.



# INTRODUCTION TO THE SEWA-ECD INTERVENTIONS IN THE CONTEXT OF COVID-19 PANDEMIC

03



Image Credit: Atul Loke @ODI



The second wave of COVID-19 cases in India highlighted the importance of understanding its impact on ECD, children's health, and the well-being of caregivers and parents in the tribal and vulnerable regions of the country. During the pandemic, AWCs had closed down, and the assistance they provided in childcare to these communities had stopped. To enable parents and caregivers in the tribal areas to cope with the pandemic and continue their children's learning and overall well-being, SEWA and its partner organisations implemented a holistic set of interventions in select districts. These interventions took place across 44 AWCs located in five districts across four states: Sabarkantha and Tapi (Gujarat), Kandhamal (Odisha), Trivandrum (Kerala), and East Khasi Hills (Meghalaya).

The interventions were implemented to promote cognitive development in children, provide maternal and child health information to mothers, and educate them on neo-natal and ante-natal care, nutrition, food security and hygiene practices, to improve health outcomes. The SEWA grassroots leaders were trained to facilitate these interventions.



# 4 DETAILS OF THE INTERVENTIONS BY SEWA AND PARTNER ORGANISATIONS



Image Credit: Atul Loke @ODI



The implemented interventions consisted of three main components: (i) engagement of parents and children in Early Childhood Education (ECE); (ii) building awareness on health and nutrition; and (iii) delivering psychosocial support to promote the mental well-being of parents and caregivers – all of which were conducted in the context of the COVID-19 pandemic.

SEWA took the lead and worked with all the technical and implementation partners such as Pratham (for ECE) and Saarthak (for mental health). The details of the interventions are:

### **a. Engagement of Parents and Children in ECE**

Mothers were provided with guidance on how to encourage their children's emotional and social development by engaging them in games, rhymes, stories, puzzles and playtime. Children between the ages of one and three make significant strides in their cognitive abilities, imagination, and motor skills. Therefore, SEWA distributed ECE material that is designed to foster and strengthen these critical growth areas. The cultural beliefs and practices of specific indigenous communities served as inspiration for this material. Mothers were given access to the content through group meetings and their phones, which provided them with information about the activities they could conduct with their children and how to help build their children's skills. As women are usually their children's primary caregivers, it is important to involve them in setting up a conducive learning environment at home. ECE material was distributed to develop and strengthen children's cognitive, language, physical, social-emotional, and creative outcomes. This was during lockdown and when only online access was possible. AWCs were closed, and children were at home. SEWA trainers provided online training to the grassroots leaders and sent the learning materials through WhatsApp.

#### **Activity Process**

- Formation of mothers' groups by SEWA grassroots leaders (as per their children registered in AWCs and Faliyu-wise/hamlet-wise);
- Formation of WhatsApp groups of mothers to send out information on digital activities to mothers; mothers with simple phones were sent information in SMS form;

- Grassroots leaders visited these mothers/children every day for activities; and
- Activities were demonstrated to mothers so that they could ensure developmental activities with their children at home.

### **b. Building Awareness on Health and Nutrition**

SEWA developed a training module to serve as reference material for their grassroots leaders on various topics concerning health and nutrition. The module covered maternal and child health, providing information on pregnancy care, delivery, and neonatal care. It also included information on nutrition and food security, the importance of a nutritious diet, and government schemes such as AWC, Nutrition Rehabilitation Centre (NRC), and Public Distribution System (PDS). The third topic covered in the module was health and hygiene, aimed at creating awareness among women about hygiene and cleanliness of their bodies and surroundings. Additionally, recipe demonstrations were held to train mothers on cooking nutritious meals using locally available, affordable, and traditionally acceptable ingredients.

#### **Activity Process**

- SEWA provided training to all district supervisors and the training module was given as reference material, which supervisors then translated into the local language;
- Each district supervisor then provided training to their grassroots leaders;
- The grassroots leaders trained their respective groups of mothers; and
- The grassroots leaders along with district supervisors shortlisted recipes to be demonstrated. During each activity, mothers were explained the nutritional benefits of ingredients and method to cook the recipe.

### **C. Psychosocial Support and Mental well-being of Parents and Caregivers**

The purpose of the intervention was to provide support in developing and delivering early childhood mental health interventions through parenting programmes. To achieve this, meetings were held between the expert partner organisation and grassroots researchers to understand the lifestyle and needs of local people in each geographic region selected for the study. Based on these

interactions, training material was developed that covered the following topics: brain development, domains of development, developmental milestones, "good enough" parenting, effects of neglect/maltreatment on a child, types of accidents, and creating a safe environment (both physical and

social-emotional) for the child. This intervention was conducted with SEWA grassroots leaders and is a unique programme that deserves recognition for addressing mental health issues during the pandemic. The programme is still in its nascent stages.





# INTRODUCTION TO THE SEWA-ECD INTERVENTIONS EVALUATION STUDY

05



The evaluation study aimed to gain insight into the effectiveness of ECD interventions in targeted districts and their impact on the lives of mothers and children. The objectives of the assessment can be summarised as:

1. To understand how interventions were delivered to mothers as primary caregivers. This includes information on the training frequency, delivery process, and expected benefits of changing practices; and
2. To estimate the benefits of the interventions regarding ECD, health and nutrition outcomes. This involved analysing the child's ability to retain the knowledge taught, whether they continue to use the newly acquired skills, and examining any significant effects on their height and weight.

The evaluation study involved Focused Group Discussions (FGDs) with eight to 12 beneficiaries from five AWCs in each state. This report presents the findings from the FGDs, which were recorded and analysed to determine how well the interventions were implemented, the level of participant satisfaction, and the short-term impact on the targeted population.

## a. Research Design

### Methodology<sup>1</sup>

The evaluation study was a qualitative assessment of interventions carried out through FGDs conducted across five districts in four states. A total of 203 participants attended the 25 FGDs across Tapi, Sabarkantha, Kandhamal, Trivandrum and East Khasi Hills. Each session lasted for 60 to 80 minutes. The number of participants and the dates the FGDs were conducted are shown in Table 1.

**Table 1:** Details of the FGDs held

| State     | District         | AWC                           | FGD Dates | Number of Participants |
|-----------|------------------|-------------------------------|-----------|------------------------|
| Gujarat   | Tapi             | Zankhari (Dungri Faliyu)      | 5.11.22   | 10                     |
|           |                  | Zankhari (Get Faliyu)         | 5.11.22   | 8                      |
|           |                  | Lakhali (Charch Faliyu)       | 6.11.22   | 10                     |
|           |                  | Lakhali (Parshi Faliyu)       | 6.11.22   | 12                     |
|           |                  | Lakhali                       | 7.11.22   | 9                      |
|           |                  | <b>TAPI Total</b>             |           | <b>49</b>              |
|           | Sabarkantha      | Dantaral (Kharakundala)       | 10.11.22  | 12                     |
|           |                  | Dantaral (Sangaram Faliyu)    | 10.11.22  | 10                     |
|           |                  | Kajavas (Bijol Faliyu)        | 11.11.22  | 8                      |
|           |                  | Amba Mahuda                   | 11.11.22  | 8                      |
|           |                  | Ganva (Udot Faliyu)           | 12.11.22  | 8                      |
|           |                  | <b>SABARKANTHA Total</b>      |           | <b>46</b>              |
| Odisha    | Kandhamal        | Kalinga                       | 2.11.22   | 13                     |
|           |                  | Kiramaha                      | 4.11.22   | 8                      |
|           |                  | Jakamaha                      | 4.11.22   | 17                     |
|           |                  | Ratinga                       | 5.11.22   | 8                      |
|           |                  | Kandhamal                     | 5.11.22   | 10                     |
|           |                  | <b>KANDHAMAL Total</b>        |           | <b>56</b>              |
| Kerala    | Trivandrum       | Pachamala                     | 29.10.22  | 6                      |
|           |                  | Elanjiyam                     | 06.11.22  | 4                      |
|           |                  | Alamkuzhi                     | 12.11.22  | 2                      |
|           |                  | AgriFarm                      | 13.11.22  | 3                      |
|           |                  | Edavam                        | 14.11.22  | 3                      |
|           |                  | <b>TRIVANDRUM Total</b>       |           | <b>18</b>              |
| Meghalaya | East Khasi Hills | Mawshibuit                    | 20.06.23  | 25                     |
|           |                  | Thansning                     | 22.06.23  | 9                      |
|           |                  | <b>EAST KHASI HILLS Total</b> |           | <b>34</b>              |

<sup>1</sup> xxxxxxxxxxxxxxxxxxxxxx

The IWWAGE-created English FGD guide covered topics such as ECE, health and nutrition, and psychosocial support and mental well-being of parents and care givers, in addition to general information about interventions and availability of childcare facilities. Since the FGDs took place in local languages, the handbook was translated into Gujarati, Oriya, Malayalam, and Khasi. To facilitate these FGDs, IFMR-Lead assigned a field supervisor fluent in the target language. The goal was to collect as much information as possible; the facilitators were told to ask follow-up questions based on the participants' answers. Each facilitator led a maximum of two FGDs per day. SEWA and the Anganwadi facilities had access to information about the mothers who benefited from the intervention. Initial phone calls were made to potential participants to determine their interest. The FGDs were held in a comfortable setting already known to the participants. Most FGDs occurred between the last week of October and middle of November 2022. The FGDs in East Khasi Hills in Meghalaya were held in July 2023.

## **b. Limitations**

The evaluation study has limitations, discussed in this section, due to challenges faced during data collection.

### **Limitations of the Study**

- Contacting the participants proved challenging due to the delayed evaluation study. Additionally, the gap between the interventions and FGDs resulted in limited interest from some participants while support from grassroots researchers was lacking as they had already left for other activities;
- The interventions took place in remote tribal areas. In some cases, such as Trivandrum, fewer respondents were present for the FGDs<sup>2</sup>; and
- Women were reluctant to answer specific health and hygiene questions, especially those on menstrual hygiene, resulting in limited data on menstrual hygiene practices post-interventions in the evaluation. The probing method would be intensified at the endline.

<sup>2</sup> Most of the respondents in Trivandrum were occupied in MGNREGS or some form of daily wage work, which made it difficult for them to attend the FGDs, given a lack of time. It is possible that individual interviews might have been a better choice for data collection in these locations.



A photograph of three children of different ethnicities smiling and hugging. The child on the right is a girl with dark hair, a nose ring, and a red beaded necklace, wearing a dark red polka-dot dress. The child in the middle is a boy with short dark hair, wearing a grey shirt. The child on the left is a younger girl with dark hair, wearing a dark blue shirt. They are all smiling and hugging each other. The background is a rustic, weathered wall.

# FINDINGS OF THE EVALUATION STUDY (CARE-GIVING)



### a. Care-giving

The study revealed that, in all the sampled districts across four states, mothers were the primary caregivers for their children. When both parents worked, mothers-in-law were the most trusted caregivers, followed by other family members such as parents-in-law, husbands, elder siblings, uncles, and aunts. Most women preferred mothers-in-law because of their experience, understanding of children's needs and routines, and the fact that they stay at home. Some mothers said they took their children to work if they had no family member to take care of them, while others voluntarily refrained from engaging in paid work due to childcare responsibilities. They sometimes dropped their children at AWCs if they trusted the AWWs but avoided sending very young children to AWCs due to vulnerability and lack of trust. Mothers preferred home-based childcare for their children due to safety and familiarity reasons and trusted family members more than community members to care for their children. Since mothers are the primary caregivers, it is important that SEWA chose them to deliver the ECD interventions.

In **Sabarkantha, Gujarat**, the primary caregiver for children is typically the mother. If the mother is absent, the mother-in-law, sometimes assisted by the father-in-law, takes care of the children at home. Occasionally, the older children may look after the younger ones, but this is not common. Families trust their elders, such as fathers-in-law, sisters-in-law and uncles, to care for their children. If the elders are unavailable, the mothers take their children to work with them. Sometimes, children are also dropped at AWCs.

In **Tapi, Gujarat**, the mother is usually the primary caregiver for the children. However, when she is working in the field, the responsibility of taking care of the children falls on the woman's mother or mother-in-law. At times, the child's father or grandfather also helps. The women mentioned that their mothers-in-law were experienced, stayed at home, understood the children's needs and routines and hence, were capable of taking better care of them than anyone else. In some cases, if

the grandmother-in-law is present at home, she is also entrusted with taking care of the children if the woman, her husband and in-laws, all go to work. The mothers believe that they can trust their family members to take care of their children in their absence since they have a deep emotional connection with the kids and are aware of their needs. The children also feel more comfortable staying with family members as compared to strangers in the community.

In **Kandhamal, Odisha**, when mothers have to go to work, they often entrust the care of their children to their parents-in-law, typically the mother-in-law. If the mother-in-law is unavailable, the father-in-law or another relative, often the sister-in-law, may provide care. The mothers believe that their parents-in-law are the most reliable caretakers because they are family members who will ensure the children are properly fed and well taken care of. If the AWCs are open, children may also be dropped there during their operating hours. However, if the AWCs are closed, and no family members or relatives are available, the children may be looked after by trustworthy neighbours. Only one out of 56 surveyed mothers reported having to take her child with her to work.

In **Trivandrum, Kerala**, mothers often entrust the care of their children to their parents-in-law, especially their mother-in-law, in their absence. Other female relatives or females from the community also extend their support. Occasionally, husbands, siblings, and brothers also care for the children. However, if no family member is available, AWCs are preferred.

In **East Khasi Hills, Meghalaya**, mothers depend on family members, especially the child's grandmother or elder sibling, to care for their children. Mothers take their children to work when no caregiver is available. However, during the monsoon season, caring for children at work becomes challenging. In such instances, older siblings must assist with childcare responsibilities at home. Many families face financial constraints and cannot afford to send their children to school. As a result, they have to stay at home and help with childcare duties.

**Table 2:** District-wise findings about care-giving

| District         | Findings  |
|------------------|---|
| SabarKantha      | <ul style="list-style-type: none"> <li>• The primary caregiver is the mother.</li> <li>• Children are mostly looked after by mother-in-law in the absence of the mother</li> <li>• Parents-in-Law most trusted</li> <li>• Mothers take children to the field if no alternative is available</li> <li>• Mothers sometimes drop their children at AWCs if AWCs are operating</li> </ul>   |
| Tapi             | <ul style="list-style-type: none"> <li>• Primary caregivers are mother.</li> <li>• Mother-in-law are the most aware of children's needs and trusted in the absence of the mother</li> <li>• Grandmother-in-law takes care of child if respondent, her husband as well as in-laws are working</li> <li>• Family members are the most trusted</li> <li>• Children most comfortable with a family member</li> <li>• Women didn't trust neighbours</li> </ul>   |
| Kandhamal        | <ul style="list-style-type: none"> <li>• Respondent and their parents-in-law take care of children</li> <li>• Other relatives (sister-in-law, parents) also take care</li> <li>• Parents-in-law are mostly trusted</li> <li>• Children left at neighbour's home if no relative is available at AWC is closed</li> </ul>   |
| Trivandrum       | <ul style="list-style-type: none"> <li>• Mother-in-law, aided by father-in-law, takes care of the child in mother's absence</li> <li>• Respondent's husband and siblings also care for the child</li> <li>• Home was the safest place for children, according to mothers</li> <li>• AWCs preferred if no family member is available</li> </ul>  |
| East Khasi Hills | <ul style="list-style-type: none"> <li>• In East Khasi Hills, mothers depend on family members, especially the child's grandmother or elder siblings, to care for their children.</li> <li>• Mothers take their children to work when no caregivers is available. However, during the monsoon season, taking care of children at work.</li> <li>• In such instances, older siblings must assist with childcare responsibilities at home. Many families face financial constraints and cannot afford to send their children to school. As a result, they have to stay at home and help with childcare duties.</li> </ul> |

## b. Care Facilities

Most study respondents reported that paying for a childcare facility was challenging due to their economic background. As a result, they preferred free childcare facilities. However, the safety and treatment of children were also major concerns for mothers.

Most people surveyed in **Sabarkantha** were poor agricultural labourers who couldn't afford to spend much on childcare. The study found that most earn a maximum of INR 200 per day, which leaves them with very little money for additional care services. They also have other expenses to cover and would prefer to save money instead of spending it on paid childcare facilities. However, they mentioned that they would be willing to pay a maximum of INR 50-100 per month for paid childcare facilities if necessary. It was observed that some parents in Sabarkantha were afraid that their children might be expelled from the centre if they failed to pay the monthly fee.

In **Tapi**, families also reported their inability to sustain a monthly payment arrangement due to financial difficulties. They would also prefer to use the money they can spare for other household expenses. In a hypothetical scenario, the parents would give INR 50 to 100 per month on average for a paid care facility.

**Mothers in Kandhamal** demand quality care and education for their children at the crèche facility they pay for. Due to financial difficulties, many women opt for unpaid care facilities, which raises concerns about the safety and education of their children. The study showed that some women were willing to pay up from INR 50 to 500 per month for such services, but the affordability of these services remains a concern. Additionally, mothers were worried about the safety of their children if they could pay the monthly fee.



*"Because there we have to pay fees monthly and sometimes we don't get monthly wages so we cannot afford a paid child care centre."*

In **Trivandrum**, parents are willing to enrol their children in a paid care facility, provided that their child's safety and learning opportunities are guaranteed. They are willing to pay a monthly fee of INR 300-500 for such services.

Mothers in **East Khasi Hills** are keen on having a childcare facility or crèche, provided they can trust the caregiver. They suggested setting up a childcare centre, such as a crèche, to cater to this need. They are willing to pay up to INR 500 rupees per month for these services.

*"Despite being capable of work, my in-laws are bound to stay with my children. If the care centre is open, we can send our children there and they can do any work at home or outside as well."*

*"It's not just about money. We will also look whether they are safe there. Some will harm kids by beating them. Some will not care for the kids. We can't send kids to such places. Whether it's a paid or unpaid service, I will send my kid only if I feel the child is safe there."*

The study emphasises the significance of trust in care-giving and the need for safe, affordable and quality childcare facilities. These facilities are necessary to enable women to work without worrying about their children. The respondents pointed out that AWCs would help them manage childcare alongside work if their operating hours aligned with their work schedules. The AWCs provide free nutrition, safety and protection to children, as well as some health and educational services. The respondents reported that it was challenging to bear the expenses of both nutritional as well as educational requirements of the children simultaneously. The AWCs would provide a solution to their problem but their operational hours need to be extended and aligned with the parents' work schedules.

**Table 3:** District-wise findings about care facilities

| District         | Findings   |
|------------------|--|
| SabarKantha      | <ul style="list-style-type: none"> <li>Strictly prefer unpaid care facilities</li> <li>Would pay Rs. 50-100 if they had to pay</li> <li>Feared children might be expelled in case of failure to pay fee in a month</li> <li>AWCs could help if the timings matched the work schedules of the respondents</li> </ul>  |
| Tapi             | <ul style="list-style-type: none"> <li>Free-of-cost services preferred</li> <li>Families reported the inability to sustain a monthly payment arrangement due to financial difficulties.</li> <li>They would also prefer to use the money they can spare, for other household expenses.</li> <li>Women said they did not earn enough</li> </ul>                                     |
| Kandhamal        | <ul style="list-style-type: none"> <li>Preferred unpaid facilities</li> <li>Willingness to pay-Kalinga: Rs. 100-500, Ratingia: Rs. 30, Jakamaha: Rs. 50-300</li> <li>Feared about children's safety if they failed to pay monthly fees</li> <li>AWCs could be useful if the operating hours of the centres align with the work schedules of the individuals using them.</li> </ul> |
| Trivandrum       | <ul style="list-style-type: none"> <li>Preference for Government- run facilities such as the AWC</li> <li>Willing to pay Rs. 300-500 if paid care facilities provides better educational opportunities.</li> </ul>   |
| East Khasi Hills | <ul style="list-style-type: none"> <li>Mothers expressed their interest in a childcare facility or creche, provided they could rely on the caregiver.</li> <li>The suggested establishing a child care centre in urban areas, such as a create, to fulfil this need. They mentioned a willingness to pay to 500 rupees for such services.</li> </ul>                               |

# INTERVENTION-SPECIFIC FINDINGS (STATE-WISE)

07



Image Credit: Suchit Nanda\_Majority World



## A. Early Childhood Education

### A.1 Sabarkantha, Gujarat

#### A.1.1 Delivery of Interventions, Method and Content

The SEWA grassroots leaders personally visited women's homes to inform them about the meetings. Among the interventions, those aimed at ECE were the most popular among children. The SEWA grassroots leaders taught the mothers and children various skills such as drawing, colouring, identifying fruits and vegetables, recognizing shapes, making paper cutouts, and sorting grains—most of which was new and unknown to them before the training. According to the mothers, their children showed a keen interest in these activities. To further assist the learning process, SEWA grassroots leaders shared WhatsApp videos of other children doing these activities, which helped them learn faster and fostered a sense of community, helping them develop a peer group. Since the children were too young to work independently, the mothers spent time practising these exercises with them regularly. The mothers of the children were also given worksheets to practice the skills with their children at home. The mothers regularly took time out to teach the activities to the children, despite their hectic schedule and daily chores.

While most children remembered and practised these activities long after the training, some would do it only at their mothers' insistence. The mothers especially took time to teach them the activities and helped them fill out the practice papers provided by the SEWA grassroots leaders.

*"It's essential that children engage in various activities and maintain good manners while at home."*

*"SEWA didi came home and informed me about the meeting."*

#### A.1.2 Observed Change

Based on the feedback received, the respondents were highly impressed with the programme's unique content. They were confident that most things taught would benefit their children's future development. The programme's content was new to them, and they were excited about the prospect of their children learning something new. According to the feedback from the mothers, most children

retained what they were taught during the training sessions. However, younger children could only remember a portion of the content. The mothers expressed satisfaction with the interventions and believed their children's cognitive abilities had improved.

*"No, kids only learned after being taught."*

#### A.1.3 Digital Access

One major challenge in providing interventions in Sabarkantha was the women's limited access to mobile smartphones and their lack of proficiency in using WhatsApp. The programme relied heavily on instructional videos sent through WhatsApp. In many instances, male members owned mobile phones and received the program information, and women received instructions from the only phone available. However, women preferred one-on-one meetings with SEWA grassroots leaders, as they found personal sessions more effective in understanding the content. To address this issue, SEWA leaders conducted group meetings with women.

*"Some of our husbands give us their phones while others do not allow us to use them. Sometimes, the balance may not be available on the mobile phone."*

### A.2 Tapi, Gujarat

#### A.2.1 Delivery of Interventions, Method and Content

SEWA grassroots leaders went to women's homes to inform them about meetings, but the women could not remember the exact time of the interventions. ECE-related training was held thrice a week. In Tapi, SEWA's grassroots leaders provided valuable education to mothers and children on various subjects, including colours, shapes, stories, nursery rhymes, birds and their sounds, and songs. In addition, they taught children the Gujarati and English alphabets, basic arithmetic, colouring techniques, and how to make shapes like squares and triangles using rice. They also taught the children the classification of grains, cereal grains and green vegetables. They also taught the children how to make paper boats and paper fans. The children could even create photo frames and toys from dough. The mothers were given worksheets to practice skills with their children at home.

*"They explained to us about the colouring and vocalisations of animals and birds, taught the children about different shapes, including triangles and squares, and singing songs. They taught us the Gujarati alphabets, ABCD, and basic arithmetic."*

*"Some children are shy to participate in activities, while others engage freely with both parents."*

### A.2.2 Observed Changes

These activities were designed to improve the cognitive development of children. The children were taught new activities and showed great interest in them. They remembered most of the activities and could do them independently at home. When asked if it was easy or challenging to participate in these activities with their children, most mothers said they found it easy, although some found it challenging. When asked if they had noticed any improvements in their children, most mothers reported that their children had become quicker, sharper and more intelligent. They added that the children could easily recognise colours, and their writing skills had improved as well as their language skills. Many respondents also noted that the training and interventions had improved their children's memory. In all respects, the training and interventions were well received by the respondents, who found them practical and valuable for their children's cognitive development.

*"Children under three years were unfamiliar with those activities, whereas those above three years had some knowledge about them."*

*"They seem more interested in studying now."*

### A.2.3 Digital Access

Interventions were carried out using face-to-face meetings and digital means; Most women preferred the former which allowed them to clarify any doubts instantly. Access to mobile phones was limited and using them was an issue for many women as they were unaware of the application WhatsApp and how to operate it. Additionally, poor network connectivity made it difficult to access mobile phone-based training. As a result, women generally

preferred one-on-one personalised training. To overcome the challenges posed by mobile phones, SEWA leaders conducted group training sessions to teach women various skills.

## A.3 Kandhamal, Odisha

### A.3.1 Delivery of Interventions, Method and Content

In Kandhamal, SEWA grassroots leaders provided the interventions with the assistance of AWWs. In each district, approximately four meetings were conducted weekly until June 2022. SEWA grassroots leaders frequently visited the children's homes to monitor their progress and ensure they were practising the activities and completing the worksheets.

SEWA leaders engaged the children in various activities, including art and craft, using materials such as mud, clay, and wheat flour dough. They also taught painting, drawing pictures by connecting dots, and creating rail bogies with different shapes, such as squares and rectangles. Additionally, children were taught to sing, dance, recite poems, and differentiate between various fruits and vegetables. During the interventions conducted in person, the mothers reported learning many new things. They found the activities to be easy, and none of them mentioned any difficulty in conducting these activities at home with their children.

*"When a child learns, there are numerous things we can learn as well."*

*"They had colouring classes, identified pictures, and participated in various activities such as frog jumping. They also learned how to introduce themselves and share their parents' names."*

### A.3.2 Observed Changes

Mothers reported that their children greatly benefited from the interventions as they learned new things. They saw a significant improvement in the children's cognitive abilities, motor skills and imagination. Even after the interventions were completed, the children continued to practice what they had learned at home. However, due to their young age, they only partially retained the knowledge. The mothers found the activities easy to conduct at home. They noted that their children listened attentively to the SEWA grassroots leaders when they gave instructions.

*"Our child is in good hands and learning a lot at the centre. We have peace of mind while at work. Additionally, when children gather in one place, their brain development increases."*

### A.3.3 Digital Access

The mothers preferred in-person meetings over online ones since they had restricted or no access to digital media such as smartphones or WhatsApp and felt that their children took better instructions from SEWA grassroots leaders than their mothers. Male members of the family mainly owned the smartphones, and most mothers did not know how to use WhatsApp even if they had access to smartphones. Naturally, they found the in-person meetings more effective.

*"How did I obtain information about the worksheet without knowing how to use WhatsApp? Didi used to visit our home to make us understand everything. They also invited us to a training session."*

## A.4 Trivandrum, Kerala

### A.4.1 Delivery of Services, Method and Content

In Trivandrum, the training sessions with SEWA grassroots leaders were mostly scheduled when mothers came to pick up their children from the AWCs. However, the Trivandrum centres faced the challenge of low attendance. A mother disclosed that only one or two mothers would attend the SEWA training sessions since they struggled to find time due to work or other reasons.

SEWA grassroots leaders conducted activities with mothers and children to promote brain development. These activities included colouring and identifying shapes, lessons on self-introduction, nutrition (what to eat and what to avoid), and hygiene. The SEWA grassroots leaders provided worksheets for the mothers to do with their children, and they were also trained on how to use them effectively. Additionally, informative videos were shared online, which some mothers found helpful in keeping their children engaged while they tended to other tasks.

### A.4.2 Observed Changes

Mothers generally had a positive perception of the training offered by SEWA leaders. They were happy with the techniques used by the trainers to

teach new skills and activities to their children. The interventions effectively enhanced the children's cognitive abilities, including language skills, and recognition of shapes, colours, animals, birds, and sounds. Additionally, the trainers guided mothers on how to support their children's learning and development at home.

*"We tried to guide them according to our ways. But when they started to get these from more innovative and interesting ways, they felt more comfortable. It was an encouragement to us as well. Because it was COVID time, and they were not going to school. But with these activities they developed an interest in learning. We were interested too."*

### A.4.3 Digital Access

Regarding digital content, some mothers faced challenges in accessing it through their smartphones. While some had their phones and utilised WhatsApp, others relied on their husbands' phones or had to go to the AWC to use someone else's phone. Unfortunately, there were also cases where mothers reported having no smartphone access, which prevented them from sharing online materials or participating in activities with their children. However, most content was shared in person.

Respondents also discussed the issue of time availability. They proposed that a better system be implemented to coordinate and schedule sessions at a convenient time for most mothers. This would significantly increase the number of mothers who could participate in the programme's interventions.

*"They had online programmes via the Anganwadi. It helped us a lot. The kids will do their work alone when we are busy with the chores. They imitated the works that the kids in the videos did. They found their happiness through that. They were encouraged with the work that other kids do."*

## A.5 East Khasi Hills, Meghalaya

### A. 5.1 Delivery of Services, Method and Content

SEWA grassroots leaders taught mothers various techniques to support their children's learning, including how to guide them in writing by holding their hands. They used picture charts and shape

sorter toys to make learning and recognition easier for the children. In addition, they gave lectures highlighting the importance of education, health and cleanliness. Rhymes with moral lessons and stories were read aloud to the children, and videos shown to enhance their understanding. The activities proved to be highly beneficial as they facilitated the children's learning process. Although the activities were unfamiliar to the children, they could recall most of them. The respondents were previously unfamiliar with these methods.

### **A.5.2 Observed Changes**

Although the activities were intended to be practiced at home, the women often had to go out for work and therefore did them infrequently. According to most respondents, the activities taught to the children were beneficial as they facilitated their learning. The respondents noticed some changes in the children's behaviour as they started learning to read and write. Their ability to retain rhymes, poems and stories, and solve puzzles improved, making them more active and attentive listeners. They are now reciting verses, singing songs, and colouring images more easily and confidently.

### **A.5.3 Digital Access**

In East Khasi Hills, in Mawshubuit, all the respondents had smartphones and knew how to use WhatsApp. Although some women preferred in-person training and sessions, others were open to digital modes of communication for updates on activities. Some expressed concern about understanding everything sent on their phone, while others found messages related to activities on their phones convenient. The benefit of this was receiving information quickly and being able to access it easily. Many women prefer educational activities in person though they prefer health and nutrition information or activities over the phone. In Thansning, on the other hand, only a small number of women had access to smartphones and were somewhat familiar with WhatsApp. The individual with the phone was given the necessary information, and they would then pass it on to others. The unanimous choice was in-person training and sessions since not all had access to phones, particularly smartphones. They found it easier to comprehend all the information and activities when they were sitting opposite the person providing the information or leading the activities. The digital mode was perplexing and challenging for them. SEWA leaders addressed the issue by holding offline meetings with the respondents.

## **B. Recipe Demonstration**

### **B.1 Sabarkantha, Gujarat**

#### **B.1.1 Service Delivery, Method and Content**

The second intervention was to teach women how to cook tasty and healthy recipes for their families. These recipes were selected basis local people's eating habits and geography. The intervention taught women 15-20 new recipes, including khichdi, sheera, moong and chana dal, and corns and tomato cucumber salad and poha including new recipes and old recipes in new ways. The children overwhelmingly loved the latest recipes and insisted on preparing them. There were cases when women would not have time to prepare the new recipes but, whenever they had time, they would prepare them for their children and other family members. The mothers acknowledged that the recipes were more nutritious than their traditional ways of cooking food. However, there were occasions when the mothers did not have enough time to cook nutritious recipes for their children but they tried to make them as often as their children requested. Their children, many women suggested, did not want them to return to their old, traditional ways of cooking and recipes.

#### **B.1.2 Observed Changes**

The children were enthusiastic about the new recipes and insisted on preparing them. The mothers recognised that these recipes were more nutritious than their traditional cooking methods and saw improvements in their children's health and weight. They did mention that some ingredients required were not always available. They also pointed out that making the new recipes took longer than usual, and it was difficult to cook the new ones regularly.

### **B.2.Tapi, Gujarat**

#### **B.2.1 Service Delivery, Method and Content**

The training sessions provided several new recipes to the mothers. These recipes were more nutritious and included dishes such as besan chila, dhokla, sukhdhi, chila, patra, chana chatpati, rice ogli, khoda laddu, rava laddu, and muthiya. After learning about the nutritional value in the training sessions, the mothers started giving their children more boiled than fried food. They also learnt the importance of meat, fish and eggs in increasing the protein content of their children's diet. Vegetarians could substitute them with gram flour, til, and rava daily. The children enjoyed the new recipes and often



asked their mothers to prepare them. However, the mothers found it difficult to cook these new dishes regularly as they also had other responsibilities. One of the mothers mentioned that, before the training sessions, she used to cook rice without washing it but no longer. Some mothers also pointed out that they didn't always have the ingredients required for the new recipes. Despite that, all mothers agreed that the new recipes were quite popular with their children and had improved their health.

*"During the training, we gained knowledge about things that we were previously unaware of. Prior to the training, we had no knowledge about them."*

*"In villages, the most common food available is dal-rice, which lacks the necessary nutrition and protein for children. Since all the women have work to do, cooking new, healthy recipes becomes challenging. However, we have observed that children enjoy the new boiled recipes we have introduced, which are more nutritious and beneficial for their health. We have learned that, by introducing new recipes, we can provide children with the necessary nutrition and protein they need to grow and maintain good health."*

### B.2.2 Observed Changes

The level of knowledge retention regarding nutritional information varied among women across different Anganwadis, with some being more aware than others. However, the new recipes introduced during training sessions were well-received by mothers, who reported that their children enjoyed them and often requested them. As a result, many mothers have opted to serve more boiled food over fried food, resulting in some children gaining weight and experiencing improved digestion and increased appetite. Unfortunately, not all necessary ingredients for these recipes are available to the women.

*"He is now eating more and has no stomach pain,"*

## B.3 Kandhamal, Odisha

### B.3.1 Service Delivery, Method and Content

During the recipe demonstration held in Kandhamal, women were taught around 20 new recipes using

common kitchen ingredients such as soya beans, rice, jaggery, ground nuts, gram flour, coconuts, and lentils. They learned how to prepare dishes such as vegetable and chicken in mustard paste, papaya curry, moringa leaf fry, mixed vegetable khichdi, kheer, biriyani, poda pitha, millet khichdi, pulao with vegetables, paneer dishes, jackfruit curry, and more. The grassroots leaders from SEWA taught them recipes that required less oil and were more nutritious as well as seasonal recipes; they also told the women about types of food could keep them cool during summers and prevent them from falling sick. The SEWA leaders cleared up some misconceptions regarding using some products. For instance, one mother thought that children could catch a cold or have stomach problems if they ate millet but the recipes demonstrated that this was a misconception.

*"Earlier, we made tasteless boiled millet. Now, we make millet kheer and dosa which taste delicious."*

*"Due to the COVID pandemic, the Anganwadi Kendra had to closed down. However, Didis from SEWA visited every house and educated the residents about preparing various types of nutritious food items. They also provided information on which foods are best for children's health."*

### B.3.2 Observed Changes

The women reported gaining knowledge about new, healthier recipes from SEWA grassroots leaders as they require less oil and provide more nutrition. They also learned about seasonal recipes and food items that keep them cool during summer and prevent illnesses. Mothers have reported that the recipes they learned positively impacted the overall health of their families, not just their children. The mothers could use the same ingredients as before but now prepare more nutritious meals. However, some ingredients were not readily available, making it challenging for them. The children really enjoyed the new recipes. However, they were more time-consuming, making it difficult for the mothers to find the time to cook them. Despite this, the mothers persisted with the new techniques even after the interventions were long over, as they personally and their families benefited from them. They noticed visible improvements in their children's digestive systems and eating habits. The recipes that were demonstrated to the mothers

by SEWA grassroots leaders differed from state to state and were designed keeping in mind the availability of products in each region as well as the seasonal requirements. The recipes were the most popular among the interventions that were conducted as well as those that were best retained by the mothers.

*"Their digestive power has improved and the amount of food children consume has increased."*

*"After consuming leftover food, our stomachs may become upset for a few days. However, eating fresh food can improve our overall health and fitness."*

*"Yes, we tried to follow the instructions while cooking. Also, our children got interested in eating food."*

## B.4 Trivandrum, Kerala

### B.4.1 Service Delivery, Method and Content

The women were given recipe demonstrations to enable them to cook more nutritious recipes. They were taught to make ragi, dosa and idli using peas, rasam with hibiscus, and snacks with amrutham powder. This intervention was aimed at improving the health of their children in particular and family in general. The mothers were taught new recipes and new ways to cook traditional food to make the food more palatable to children. The mothers had not heard of some of the recipes. The challenge was accessibility and affordability of the ingredients for most low-income families, which the training should have considered. In the recipe interventions, the women weren't aware of the number of training sessions held but remembered that they were held and also the content.

### B.4.2 Observed Changes

The respondents shared that SEWA leaders had taught them about nutritious food with recipe demonstrations. Some of the food items introduced by the SEWA team were completely new to the respondents but they found them tasty. The inclusion of nutritious item like amrutham powder into everyday recipes was a new addition post the training. Most respondents said they had started using this item after learning about it. However, in Agrifarm, a respondent mentioned that availability

of amrutham powder was an issue and she would replace it with maida or rice powder. They also learnt new ways of cooking traditional recipes, which were enjoyed by the children. For example, making puttu (rice cakes) by mixing it with vegetables. After having learnt new recipes from the classes, mothers also tried out other ideas from YouTube which they wouldn't earlier. The children really enjoyed food made from the new recipes, except for ragi dosa which the children found a little sour. The children enjoyed the new recipes, which were colourful and more interesting.

*"We didn't know about other dishes right? Now we prepare these dishes once in a while. You will get amrutham powder from anganwadi upto a certain year. After that you have to buy it from someone else. There are children at my sister's home, and I take amrutham powder from there. I will make snacks out of it and they like it. Before we just knew how to make kurukku (porridge) out of amrutham powder. But they won't eat. But now as we are making it in different forms of snacks, they like it and they eat it. We will provide this intermittently along with the traditional food we serve."*

## B.5 East Khasi Hills, Meghalaya

SEWA leaders made an effort to enhance women's nutrition in East Khasi Hills by teaching them how to prepare 15-20 nutritious and delicious meals that can be easily made at home. Unfortunately, due to financial and time constraints, the respondents were unable to use these techniques and ingredients regularly.

## C. Health and Hygiene Interventions

### C.1 Sabarkantha, Gujarat

#### C.1.1 Health-related Interventions

SEWA grassroots leaders advised pregnant women to take iron and folic acid tablets, and informed them about the importance of institutional delivery for the safety of both mother and child. The women were also educated about the significance of breastfeeding, normal blood pressure and urine tests during pregnancy, and timely vaccinations for their children. Additionally, they were informed about the free services available at government hospitals and trained to recognise the symptoms of anaemia and how to prevent it. The training sessions



also covered Mamta Divas, a day for vaccinating children at AWCs, and Mamta cards that can track their health.

Regarding health and nutrition interventions, the women interviewed agreed that the AWCs were performing quite effectively. The centres conduct regular health check-ups, administer vaccines, and provide information on pregnant women and lactating mothers. They even provide tablets such as calcium and iron if they detect any deficiencies among women. On Mamta Divas, the mother's and child's weight, baby's height, and mother's blood pressure are measured, and appropriate medication and health advice are offered to the mothers. The mothers are provided food packets and educated about the importance of consuming green vegetables. The women are also informed about institutional deliveries in civil hospitals.

### C.1.2 Hygiene-related Interventions

The SEWA leaders also disseminated information on maintaining personal, general and menstrual hygiene. The women were advised to clean their houses daily, wash their clothes and wear clean clothes, wash their hands before eating, cut their nails, bathe their children regularly, and make them wear clean clothes. Mothers were advised to use sanitary or cloth pads and change them at regular intervals. If they use clothes, they are asked to wash and dry them before using them again. The women interviewed admitted that taboos surrounding menstruation still exist, and they must follow them. They are not allowed to cook food, enter places of worship, touch grains going for grinding, and sometimes not even touch drinking water. The women agree that maintaining personal hygiene was essential to stay fit and avoid falling ill. They felt that the information shared on health and hygiene by the SEWA leaders was very beneficial in many ways as well as novel to them.

*"We dust and dispose of trash, clean dishes, then proceed to the field."*

## C.2 Tapi, Gujarat

### C. 2. 1 Health-related Interventions

The SEWA leaders educated the women on various health and hygiene practices in their daily lives, particularly during menstrual cycles, pre-natal and post-natal stages. The women attended eight to 12 training sessions over a period of six months, during which they were instructed to consume iron

and folic acid tablets during pregnancy, educated on the importance of institutional delivery for the safety of both mother and child, and taught about the benefits of breastfeeding, regular blood pressure and urine tests during pregnancy, and timely vaccinations for children. They were also informed about the free services available at government hospitals and introduced to several cleanliness and hygiene practices.

During the training sessions, the women were taught that new-borns should be breastfed until they are six months old and that children above six months of age can be fed foods other than mother's milk. They were educated on the importance of the first thick yellow milk for a child as it helps build immunity, and told that the children should be fed every two hours until six months. The women also learned about the schedule for regular check-ups of children and their vaccinations.

They were also taught to recognize the symptoms of anaemia and how to avoid it. The training sessions included information on healthy food consumption, monthly sonography, timely tetanus injections, Mamta Divas for child vaccination at the AWCs and Mamta card to track the child's health. However, not all women were equally aware of this information, and retention levels varied among women across different AWCs.

### C.2.2 Hygiene-related Interventions

The women were educated on hygiene practices, including keeping a clean home, brushing their teeth twice daily, washing their hair at least twice weekly, changing their sanitary pads three times daily, washing clothes used during menstruation, and ensuring they are adequately dried before reuse. While there were some differences in how well the women in our study retained information, most of them remembered the recipes and hygiene practices the best. They reported that they continued to follow those practices consciously, and many also noted that their children had started adopting good hygiene habits such as washing their hands without needing to be prompted.

## C.3 Kandhamal, Odisha

### C.3.1 Health-related Interventions

The SEWA grassroots leaders educated mothers about the significance of maintaining a gap in age between two children, benefits of breastfeeding for infants, importance of regular health check-ups for

expectant mothers, and of consuming prescribed iron and folic acid tablets. Furthermore, they provided information about immunising children and monitoring their growth by regularly tracking their height and weight. The mothers also learnt that new-borns must be kept in a warm towel after birth, their clothes should be washed in an antiseptic liquid, and adults should wash their hands properly before holding new-borns. The mothers were also informed about the importance of institutional delivery for the safety of both mother and child. The mothers had received some information on health and hygiene from the AWCs and accredited health workers before the intervention. So, the information provided to them as a part of the intervention designed by SEWA was not entirely new to them. However, they said they learnt quite a few new things and continued practising them.

### **C.3.2 Hygiene-related Interventions**

Mothers received information on essential hygiene practices, including washing hands before and after meals, cutting nails, brushing twice daily, and maintaining proper sanitation during menstrual cycles and before/after childbirth.

## **C.4 Trivandrum, Kerala**

### **C.4.1 Health-related Interventions**

As per the feedback from the participants, the grassroots leaders from SEWA offered valuable advice on taking care of new-borns, covering essential topics such as hygiene, nutrition and overall well-being. The trainers also stressed the importance of getting proper medical care during delivery and ensuring that the infants receive necessary vaccinations.

### **C.4.2 Hygiene-related Interventions**

The children received education on basic hygiene practices, including brushing their teeth and bathing. The mothers were also taught about maintaining their health during pregnancy and the significance of nutrition and hygiene. Additionally, menstrual hygiene was addressed during the sessions. While cloth pads and sanitary napkins are commonly used, menstrual cups remain uncommon. The SEWA training sessions emphasised hygiene, cloth pad usage, and proper pad replacement. Most information given to women was new and hitherto not known to them. On the issue of menstrual health, they were taught to use cloth pads instead of pads and how to dispose of them

effectively. This information was actively taken up by the women who started using cloth pads and disposing of them as they were taught. This was new and vital information that was given to the women. Newer products such as menstrual cups were also introduced, though the women did not take them up.

## **C.5 East Khasi Hills, Meghalaya**

### **C.5.1 Health-related Interventions**

In Mawshibuit, women were provided information regarding the necessity of regular check-ups during pregnancy, including vaccinations, medication, and blood tests by the SEWA leaders. They were also advised about the significance of delivering babies in a hospital and vaccinating newborns. Above all, the mothers were educated on the crucial importance of breastfeeding and the associated issues that may arise if it is not done. They were instructed to breastfeed exclusively and not give their infants any other food items. Women were educated on the significance of a nutritious diet, including fruits and green leafy vegetables, to maintain their fitness. The women were previously well-informed about the necessary health practices for pregnant and lactating mothers, as many visited local dispensaries where they received detailed information. In Thansning, SEWA grassroots leaders advised pregnant women to attend regular check-ups, undergo blood tests and vaccinations, follow the physician's prescribed medication, attend at least four check-ups throughout pregnancy, and take iron and calcium tablets for at least 90 days. According to the respondents, the information provided was mostly new as they were unaware of the recommended health practices for pregnant and lactating mothers. Further information was been made available about how to care for infants properly. Women were advised to receive vaccinations during pregnancy, and feed newborns with only breast milk. It was also important to bring children in for vaccinations when requested, they were informed.

### **C.5.2 Hygiene-related Interventions**

In Mawshibuit, women were instructed on the importance of maintaining cleanliness in their homes and surroundings and washing their hands before and after using the toilet. The information provided was exceptionally helpful. It was confirmed that the ladies are actively practicing cleanliness as they believe it is crucial for maintaining good health. They ensure their surroundings are clean and use lime



powder to eliminate germs. In Thansning, SEWA grassroots leaders provided helpful information on personal, general and menstrual hygiene during their interventions. Mothers were advised to utilise sanitary or cloth pads and to change them regularly. Valuable advice on hygiene and cleanliness

practices was shared, which proved highly useful. The ladies diligently follow these practices, as they understand the importance of keeping themselves and their surroundings clean to maintain good health. They even sprinkle lime powder to eliminate germs from their immediate environment.



Image Credit: Atul Loke @ ODI







## Gendered Care-giving in the Household

The study suggests that women are predominantly responsible for household childcare duties, with men occasionally taking on a secondary role. When parents are absent, the primary caregiver is usually the mother-in-law, followed by the father-in-law, husband, older siblings, or other family members like the child's great-grandmother, maternal grandparents or aunts. These results highlight the continued existence of gender-based divisions of labour in households across the studied districts, which is consistent with existing literature on the topic.

## Affordable and Safe Childcare Facilities

Based on the study, we can conclude that parents prioritise affordability, safety and quality of services when choosing childcare facilities for their children. Additionally, the working hours of the childcare facility must align with the parents' work schedules. Many respondents admitted that they couldn't afford paid facilities and would opt for unpaid ones. This highlights the need for the government to expand the public provisioning of childcare services while also enhancing the quality of services provided to meet the growing demand. AWCs could provide a solution but it is essential to extend their work hours and align the duration of their operations with the work schedules of the respondents.

## Quality of Training

The participants were provided high-quality training on innovative methods of educating children, maternal health and hygiene, and children's health and nutrition. The training was conducted both in-person and online, with online sessions used as a supplement to the offline ones. The majority of women were content with the dissemination of information, although some were unsure of the exact number of training sessions they had attended. Nonetheless, most of them found the training helpful. The efficacy of the training was evident as women were able to recall mostly everything that was taught to them and their children.

## ECE Training

Most women perceived a positive outcome of the interventions on their children's cognitive abilities. Mothers reported their children enjoyed the regular training sessions. Activities were explained well, enabling easy participation. In-person sessions and WhatsApp videos helped children learn better and

make friends. The programme reinforced concepts innovatively, was age-appropriate, and improved children's confidence and learning abilities. Rhymes and songs improved creativity and language skills. The respondents stressed the novelty of the programme and expressed confidence that the skills taught would benefit their children's cognitive development. Most mothers reported that the children had become quicker and sharper than they used to be when asked about noticeable improvements they have observed after the intervention.

## Health- and Hygiene-related Training

Mothers were provided extensive training on maternal and child health, covering various topics such as regular check-ups, maintaining healthy dietary habits, getting vaccinated, practising good hygiene, and menstrual health. They were also introduced to new practices, such as using sanitary napkins or cloth pads for menstrual hygiene. The training proved effective, as the mothers acquired valuable knowledge on the subjects that were highlighted. Although some of the information was already known to the mothers through the AWCs, the training gave them a deeper understanding of these topics. The mothers continued to practice what they had learned. While most of the content was found to be valuable by the mothers, they did not respond positively to the use of menstrual cups. It was observed that the women had started practicing the new habits helping us to conclude that these interventions had helped in behavioural changes amongst women.

## Recipe Demonstration

As part of an effort to improve the health of their children and families, the women received recipe demonstrations to teach them how to prepare more nutritious meals. They were taught new recipes and innovative ways to cook traditional dishes to make them more appealing to children. However, there were challenges in terms of the accessibility and affordability of the required ingredients for low-income families, which should have been taken into consideration during the training. The women were unsure about the number of training sessions they received but were able to recall the content and found it helpful. The children enjoyed the new recipes due to their colourful and interesting nature. In all respects, the training and interventions were well received by the respondents, who found them practical and valuable for their children's development. In some cases, though, the women

thought that the new recipes were more time-consuming than the traditional recipes.

### Access to Technology

The interventions were conducted face-to-face and through digital media (smartphones via WhatsApp). Responses from women indicated that they preferred in-person meetings more than online meetings or the digital transmission of educational materials since many of them did not own smartphones or did not know how to operate the phone or use WhatsApp even if they did. The mobile network was usually bad, hindering access to mobile phone-based training. Women, in general, therefore, preferred one-on-one personal training. The women also reported that the SEWA grassroots leaders met women in groups to address the issue.

This hints at the need to improve women's access to digital means of communication.

### Role of AWCs

During the intervention, it was observed that AWCs are highly effective in disseminating information related to maternal and child health, immunisation, institutional deliveries, pre- and post-natal care, child health and nutrition, regular health check-ups, and other relevant information to pregnant women and lactating mothers. The women who received this information could recall it and followed the measures more strictly after the SEWA intervention. This highlights the crucial role played by state-run childcare programmes and emphasises the need to improve AWCs by enhancing their capacity, infrastructure, and budgetary allocations.





# TRIANGULATION OF NEEDS ASSESSMENT STUDY AND ECD INTERVENTIONS EVALUATION STUDY

99



Image Credit: Sara @ Flickrm



The needs assessment study aimed to understand the existing conditions of childcare in remote tribal regions. It assessed how the availability or lack of care facilities affects a mother's chances of being engaged in the labour force. The study also explored the preferences and perceptions of mothers regarding these facilities and their awareness of the services they can avail of from the ICDS centres. Additionally, it includes a brief assessment of the impact of COVID-19 and the pandemic-induced lockdown of the ICDS centres on childcare needs and the mothers' unpaid care work responsibilities.

The evaluation study was conducted to evaluate the short-term impacts of interventions related to ECE, health, hygiene, nutrition, psychosocial support, and mental well-being of parents and caregivers during the COVID-19 pandemic. SEWA and its partner organisations carried out the interventions. The findings of the evaluation study mostly confirm the results of the needs assessment study.

### Work Life of Mothers

The needs assessment study found that most employed women were small and marginal farmers (66.54 per cent). Other sectors of employment included domestic work (4 per cent), agricultural labour (11.78 per cent), teaching (2 per cent), clerical work (2 per cent), construction labour (1 per cent), and AWC work (3 per cent). The evaluation study confirmed these findings as it revealed that most mothers were engaged in agricultural labour in some capacity. In Gujarat Odisha and Meghalaya, most mothers were small and marginal farmers while, in Kerala, some women were involved in clerical activities or shopkeeping, in addition to work as agricultural labourers as indicated by the needs assessment survey data. Additionally, regardless of employment status, women spent a significant amount of time on unpaid household chores.

### Monthly Income of the Respondents and Willingness to Pay for Childcare Facilities

The needs assessment study revealed that around 75 per cent of the respondents had a monthly household income of less than INR 10,000. Out of these, 23 per cent had an income between INR 5,000 and INR 10,000, 40 per cent earned below INR 2,000, and 11 per cent made between INR 2,000 and INR 5,000. It's worth noting that these incomes were reported during the pandemic period when many people faced significant job and income losses. The

study also showed that households with a monthly income below INR 2,000 had only one source of income, whereas those earning more had multiple sources. The evaluation study further supported this finding, which revealed that most families had only one or two earners. Additionally, respondents from Gujarat, Odisha, Kerala and Meghalaya reported low monthly household incomes.

Based on the needs assessment survey results, it was discovered that most mothers were only willing to send their children to care facilities free of charge. The data collected revealed that 84 per cent of the respondents were willing to opt for free care centres. During FGDs, it became apparent that mothers preferred unpaid facilities over paid ones. They explained that they did not have enough income to spend on care centres and would rather rely on family members to care for their children.

As per the needs assessment data, if the respondents had to pay for the care facility, only a small percentage was willing to spend money. Around 8 per cent were willing to spend between INR 1 to INR 50, 29 per cent were willing to spend between INR 51 to INR 100, while 35 per cent were willing to pay between INR 101 to INR 200. A proportion of 23 per cent were also willing to pay between INR 201 to INR 500. The respondents of the needs assessment study strictly preferred unpaid to paid care facilities. However, they were willing to pay between INR 50 to INR 500 under hypothetical circumstances. This finding is consistent with the results of the evaluation study.

### Lack of Childcare Facilities

As per the needs assessment study, around 80 per cent of the respondents reported missing work days to take care of sick children, while over 30 per cent stated that they often had to bring their children along to work. At least 27 per cent of women reported that another female family member who stays at home takes care of the children, while 15 per cent said that their husbands were responsible for childcare. Meanwhile, 14 per cent of respondents said the older siblings supervised their children. Similarly, the evaluation study revealed that mothers face a significant lack of proper childcare facilities. Most rely on informal and personal solutions, such as leaving children with their mother-in-law or bringing them to work. Many miss work days to care for sick children or voluntarily refrain from paid work due to childcare responsibilities. This is an alarming observation



since none of the respondents belonged to high income households where they would voluntarily choose to be unemployed by choice.

### Usage of Childcare Facilities

According to the needs assessment study, 65 per cent of women working for pay or profit preferred to drop their children at the AWCs before 10 am, and 56 per cent preferred to pick their children up between 4-5 pm. This highlights the need for AWCs to be operational for at least six hours a day to cater to the requirements of informal women workers. By extending the operating hours of the AWCs, women may be empowered to explore alternative forms of employment which they may not have considered before due to their time constraints.

Mothers expressed their desire to send their children to affordable and quality childcare centres, but only if the centres' operating hours were in line with their work schedules, which typically lasted six hours or more. It is essential to extend the operating hours of the AWCs to address this concern, ensuring that they align with the work schedules of the individuals who use them and enable women to become employed without worrying about childcare responsibilities.

### Preferences for Services

The needs assessment survey showed that the respondents consider learning opportunities at childcare centres as essential. Approximately 75 per cent of the women preferred learning services while 64 per cent preferred playing facilities. A evaluation study further supported these findings, revealing that mothers highly preferred care centres that provided learning and playing opportunities for their children. The mothers valued education as a crucial factor for the future of their children and therefore preferred ECE interventions delivered by SEWA. This finding was consistent in both studies.

### Facilities Provided by AWCs

As per the needs assessment study, the usual functions of AWCs were in place. They offered facilities such as take-home rations, supplementary food, immunisation, health check-ups, learning materials, and different types of food. At times, they also provide uniforms and winter clothes. The evaluation study confirmed these findings. These came to a halt during the COVID-19 pandemic.



# 10 CONCLUSION



Image Credit: Atul Loke @ODI



The study is set to end in 2024 when an analysis will be conducted to determine the project's impact. Currently, a pilot project, already completing two years, is being carried out in two districts of Gujarat, namely, Sabarkantha and Tapi. This project is being implemented in 10 ICDS centres, four of which are in Tapi and six in Sabarkantha. The project's objective is to enhance full-day care service provision through a participatory and community-centred approach. The programme aims to extend the operating hours of ICDS centres, providing additional hours, nutrition, and AWWs. By comparing the needs assessment (baseline) and endline, we can assess the impact of the pilot intervention and estimate the long-term implementation costs of a similar programme. The evaluation will be limited to the state of Gujarat.



# 10 APPENDICES



Image Credit: Suchit Nanda | Majority World



## APPENDIX 1: FOCUSED GROUP DISCUSSION GUIDE

Session duration: 80 mins (excluding last section)

### Section to be filled by facilitator

|                        |                       |
|------------------------|-----------------------|
| Facilitator Name       |                       |
| Note Taker Name        |                       |
| AWC, District, State   |                       |
| Date                   |                       |
| Start and End Time     |                       |
| Number of Participants |                       |
| Age of Participants    | (Write down all ages) |

### Introduction: (5 mins)

Hello, my name is \_\_\_\_\_ and this is my colleague \_\_\_\_\_, we are conducting this discussion as part of a study for SEWA. Pratham and SEWA had conducted some activities and information sessions with you on topics of education of children and health, nutrition and hygiene. We have some questions for you about those sessions.

There are no right or wrong answers to the questions. We are just interested in your opinion, based on your direct experience of attending those meetings. Your responses are voluntary. If we come to a question you do not wish to answer, please tell me and we will move on. Your answers will help to shed light on how helpful those activities and the information was for you, so please answer as truthfully as you can.

The questionnaire will ask you about your access to own financial resources and about how financial decisions in your household are made, and what your role and your husband's role is in this process. Some of our questions might ask for some private information and about some challenges you were facing. Please remember that you can decline to answer any question that you do not feel comfortable answering.

This is a group discussion session and we will follow the principle of confidentiality. By doing this we are creating a safe and trusting space for everyone present here today. You all have the freedom to express yourself freely without hesitation. We would request you all to listen to the person talking with patience and when you have something to add please slightly raise your hand and start when the person before you has stopped. Lastly, we would also like to ask you to treat each other with respect

and not to judge or laugh or make faces at anyone when they are sharing their experiences.

If you have any questions, we are happy to answer them now.

### General information: (10 mins)

1. Who helps in childcare when you are doing other work (paid work outside the home or are busy with household chores)? (3 mins)
2. At such a time, if a childcare facility was available, would you send your child to: (4 mins)
  - a. An unpaid care facility? Why/why not?
  - b. A paid care facility? Why/why not? How much would you be willing to pay for the service per day?
3. For *employed/working* mothers, who takes care of the child for the most part of the day? And why is that the most suitable person? (3 mins)
4. Who conducted the intervention activities of education of children and health, nutrition and hygiene? And when were they conducted? (4 mins)
  - a. How many sessions were conducted under each heading?

*Probe: use this question as an ice breaker so participants start interacting*

### Engagement of parents and children in ECE: (30 mins)

1. What activity was done to improve the child's learning at these training sessions/meetings? Can you explain how these activities were conducted (format of the session)? (4 mins)

2. Have you done these activities and worksheets with the children at home? (4 mins)
  - a. Was it easy or difficult – very easy, moderately easy/slightly difficult, not easy at all/very difficult?
  - b. How useful were these activities/worksheets – very useful, moderately useful, not useful at all?
3. Did you all have access to a smartphone? (2 mins)
  - a. If yes, did you know how to use WhatsApp on the phone?
  - b. If you did not have access to WhatsApp, how were you informed about teaching and learning activities?
4. Which did you prefer more: in-person training sessions/meetings or the digital mode to tell you about activities (WhatsApp and SMS)? And why? (3 mins)
  - a. What part of the training (in percentage or proportion terms) was face-to-face, and what part (percentage or proportion terms) was digital?
5. Did the child already know these things earlier or was this new to them? (1 min)
6. Does the child still remember these activities? (1 min)
7. What did the child learn? Does the child continue to do the activities? By her/himself or with your help? (3 mins)
8. Has there been any change in the child's behaviour and abilities, in terms of being able to retain the rhymes, poems, stories, and solve the puzzles, etc.? If yes, what change have you observed (Probe for- better memory, more active, able to concentrate better, colouring has improved, writing has improved, etc.)? (4 mins)
9. Do you feel that the training sessions/meetings where you were informed of various teaching methods helped you? Were these methods new to you, or were they already familiar to you? (4 mins)
10. Were you satisfied with this training? (4 mins)
  - a. If yes, why – what were some advantages/ key features?
  - b. If no, why – what were some challenges or issues?

## Building awareness on health and nutrition: (35 mins)

1. Can you remember and list some of the things you were told about (ask women to elaborate on each of these): (6 mins)
  - a. Mother and child's health (Probe for: (i) Among pregnant women and lactating/new mothers – ante-natal checkup, iron and calcium tablet, blood, blood pressure and urine test, consuming nutritious food, safe delivery in medical centre, breastfeeding, (ii) child's vaccination, weight and height measurement).
  - b. Nutrition and food (Probe for: importance of nutritious diet, eating nutritious food in right amounts, anaemia among women, services at an AWC and PDS shop).
  - c. Hygiene and sanitary practices (Probe for: practices of cleaning their body, home and surroundings and menstrual hygiene).
2. Were you previously aware of what health practices pregnant women or new/lactating mothers should follow? (3 mins).
  - a. If yes, who told you and when? Did you used to follow the practices?
  - b. If partly yes/no, what were the new information?
3. Were you informed of any hygiene and cleanliness practices in these sessions? Were they useful? Are you practicing those? If no, why? (4 mins).
4. How many recipe demonstrations were held? Were all the ingredients and methods already familiar to you? What were the few new things you learnt from these session (Probe for – new ingredients, method of cooking, using hygienic practices, etc.)? (3 mins).
5. Has the new awareness changed anything in your usual dietary practice at home – the food you serve, how you cook it, etc., post the training? Do you continue to do practice what you were taught or have you gone back to old methods? (4 mins).
  - a. If they don't practice new methods and have gone back to old ways, why is it so, what were the challenges you faced (Probe for - ingredients not available, time consuming, etc.)?
6. Was the child attracted to the new food, did the child like it and ask for more if it, or did



they want to go back to eating the old food? Does the child ask you to cook more food with these new recipes? (2 mins)

7. Have you observed any change in the child's physical health because of the new dietary practice you have been following since the training and/or recipe demonstration activities? Has there been any change in the child's stomach or digestive health? (5 mins)

8. Have you realised the importance of nutritious meals every day? Why do you feel that is it important to eat nutritious food in the right amount? (3 mins)

9. Did you find the information on health of women and nutritious food, and recipe demonstration sessions helpful? What did you like the most at these sessions? Was there anything you would like to be done differently? (5 mins)

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***Psychosocial support and mental well-being of parents and caregivers (section to be administered to grassroot researchers by research team over phone call; in case of language barrier take support from field team): (15 mins).***

1. Did you have a meeting/session on mental health? What did you think of the meetings you had with the trainers from Saarthak? Who conducted them, how often, and when were they conducted? (3 mins)
2. What were the issues that were discussed at the meeting? (3 mins)
3. Do you think that these insights useful in dealing with mothers who need psychosocial support? If yes, please explain how? What were some learnings? (4 mins)
4. Is this the first time you heard about various aspects of mental health? (2 mins)
5. Would you like to receive more training on mental health and wellbeing? If yes, what would you like to discuss at the session? How can we help you support mothers better? (3 mins)

## Appendix 2: Training Manual for Field Investigators

### I. Context of the Project

The second COVID wave in India shed light on the need to study how the pandemic has impacted ECD outcomes, children's health and nutrition, and the overall health and well-being of parents and caregivers in vulnerable and marginalised communities. Towards this, SEWA, in collaboration with partner organisations, implemented a holistic set of interventions to help parents and caregivers to cope with the pandemic and to continue their children's learning and overall well-being. The services delivered included: (i) ECE for parents and caregivers; (ii) health and nutrition; and (iii) psychosocial support and mental well-being of parents and caregivers, all in the context of the COVID-19 pandemic.

These interventions were implemented in 44 AWCs across five districts/four states - Sabarkantha, Tapi, Kandhamal, Trivandrum and East Khasi Hills.

Under this study, IWWAGE will be conducting FGDs with beneficiaries of interventions across all districts to assess the interventions. The beneficiaries are all mothers of children in the age group of zero to six years.

### II. About the Interventions Conducted

#### A. Engagement of parents and children in ECE

ECE material was disseminated to develop and strengthen children's cognitive, language, physical, social-emotional and creative outcomes. Mothers were delivered content at group meetings and on their phones to tell them which activities they can conduct with their children and how to help build children's skills.

- Between October 2021 and May 2022, about 12 meetings were scheduled to be held with mothers of children in the age group of zero to six years.
- The meetings were held in a community-driven model with five to six mothers coming together as a group in each meeting. Children could or could not accompany mothers. The meeting and intervention were targeted at mothers.
- The trainer/SEWA helper/grassroot researcher visited each group of mothers once in 15 days for 30-45 minutes. They held two or three activities with mothers at each meeting. The

SEWA helper was not supposed to interact with the child.

- The activities were such that mothers could go home and try them with the children at their homes. Mothers were given a feel of the activity at these meetings as the SEWA helper demonstrated it, and mothers were also explained the objective of the activity.
- Example of activities demonstrated and conducted at meetings:
  - ◆ How to neatly/properly tear a piece of paper: to improve motor skills
  - ◆ How to put beads together in a string: to improve eye and hand coordination
  - ◆ How to throw a paper ball in a basket: to improve motor and sensory skills
  - ◆ Other activities taught: drawing shapes, making patterns, clapping, sorting, sequencing, picture identification, pasting, craftwork, memory game using cards
- Women were also given different worksheets at meetings, which they first completed at the meeting together and then also took home to do with the child. These worksheets included activities like:
  - ◆ Joining numbers to make a drawing
  - ◆ Colouring
  - ◆ Matching
  - ◆ Classification and identifying the odd one out
- At some meetings, mothers were sometimes also shown videos which had a story with a message, and the mothers would go home and narrate it to their children at home. These videos were targeted at how mothers can help children and were meant for mothers' capacity building (not for children to see).
- Apart from these training sessions/meetings, messages were sent on mothers' phone regularly (thrice a week). These were video messages for the overall development of child that showed:
  - ◆ Mother and child doing calculations together
  - ◆ Videos showing how to do the classification activity
  - ◆ Stories and rhymes the mother could watch and narrate to the child (not for the child to see)



- While children aged three to six years understood these activities and could try them themselves, the activities for children aged zero to three years were slightly different and targeted at stimulation of their cognitive abilities.
- If a mother did not have a smartphone with WhatsApp, an SMS was sent to her phone with instructions of how to do an activity with the child.
- At each next training/meeting with mothers, the SEWA helper checked with mothers if they tried the activities with their children – for activities taught at previous meetings, and for messages sent over the phone.
- This intervention did not target the child's learning level or school readiness. Rather, the overall development of children was tracked.

## B. Building awareness on health and nutrition

A training module was developed as a reference material for grassroots leaders on topics of: (i) maternal and child health to provide information about care during pregnancy, delivery and neonatal care, and lactation; (ii) nutrition and food security to educate women about anaemia, importance of nutritious diet encourage them to eat nutritious food to lead a health life, and to provide information about government schemes (AWC, NRC and PDS); (iii) health and hygiene to create awareness among women on the importance of hygiene and cleanliness in their bodies and surroundings.

Recipe demonstrations were also held to train mothers on cooking nutritious meals using locally available, affordable and traditionally acceptable ingredients.

Group meetings were held where mothers were given information on issues. Issues discussed under each topic are listed below:

### 1. Maternal and Child Health

- a. Proper prenatal and antenatal care requirements for both the mother and the child
- b. Duration and schedule of antenatal checkup: testing and monitoring weight, haemoglobin, blood, protein, urine and blood pressure during pregnancy; completing iron and calcium tablet course; taking nutritious food
- c. Pregnancy detection ways

- d. Family planning, correct age for first pregnancy, the importance of conception at the right age for the health of both mother and child, as well as the importance of keeping at least a three-year age gap between the first and second child
- e. Availability of affordable and safe contraceptives
- f. Certain symptoms which need attention: jaundice, anaemia, swelling of body parts, especially among women who had given birth at a very young age (<19) or old age (>40), among those who had given multiple births or faced complications in previous pregnancies or were overweight or underweight
- g. Institutional delivery
- h. Lactation and first milk of the mother to enhance children's immunity
- i. Keeping newborn babies warm and safe, bathing, feeding and caring for them, their regular vaccinations during Village Health Nutrition Day at AWCs
- j. Regular weight and height monitoring of the child at the nearest AWC, and that they should be hospitalised if they shows any signs of danger (sluggish look, doesn't drink milk properly, has fever, difficulty in breathing, etc.)

### 2. Nutrition

- a. Anaemia and its symptoms (discoloration of eye, nails, tongue, exhaustion, dizziness, etc.) and prescribed diets to avoid it (these diets include green vegetables, beans, dry fruits, pulses, milk, meat, fish, eggs)
- b. Nutritious diets and proper food portions
- c. Lack of nutrition could lead to diseases
- d. Consumption of iron and folic acid pills every day for three months, with lemon water as well as iron-rich food
- e. Regular blood tests
- f. Recipe demonstration: recipe demonstrations were held at sessions to show women how to cook healthy and nutritious recipes for children and for themselves, using locally available, affordable and traditionally acceptable ingredients

### 3. Food Security

- a. Government schemes to ensure food security and services available through the AWCs for children and women across various age groups
- b. Services available for children at AWCs:
  - i. Midday meal for children in classes 1-8
  - ii. Vaccination
  - iii. Nutrition under ICDS scheme for children between zero to six years
- c. Services available for Adolescent girls (12-18 years):
  - iv. Nutrition
  - v. Iron and folic acid tablets
- d. Services available for pregnant and lactating mothers:
  - i. Nutrition
  - ii. Janani Suraksha Yojana
  - iii. Pradhan Mantri Matru Vandana Yojana
  - iv. Facilities available through ration shops:
  - v. Ration for BPL, APL, Antyodaya card holders
- e. Facilities available through NRC:
  - i. Nutritious meals for severely malnourished children
  - ii. Nutritious food for mothers and children. Mothers counselled on nutritious diets that can be given to children
  - iii. Children's growth monitored
- f. AWWs give special attention to malnourished children to help them recover and prevent them from getting malnourished again

### 4. Health and Hygiene

- a. Women were informed about waste generation from inside or outside to ensure everyone is free of diseases.
- b. Women were encouraged to maintain cleanliness and hygiene.
- c. Cleaning one's own body
  - i. Shower regularly (thoroughly wash your whole body with soap, especially the genitals and genital hair), wash and clean hair, wash eyes

- ii. Brush teeth twice a day

- iii. Cut and clean your nails regularly

#### d. Cleaning your home

- i. Keeping house clean helps in preventing diseases
- ii. Keep the kitchen clean and cover food
- iii. Keep drinking water covered
- iv. Put the household waste in the dustbin

#### e. Cleaning your surroundings

- i. Do not leave garbage in open
- ii. Do not allow water to collect around you
- iii. Do not defecate in the open, wash hands thoroughly with soap after defecation and before eating food

#### f. Menstrual hygiene

- i. Maintaining cleanliness during menstruation (clean, soft, cotton pads, clean water, disinfected cloth which cannot be reused after three months, warm water to avoid pain, nutritious food)
- ii. Superstitions need not be followed during menstruation (such as not worshiping or touching pickle or abstaining from certain types of food). They were encouraged to lead normal lives during menstruation.

### C. Psychosocial support and mental well-being of parents and caregivers

The intervention was intended to provide support in the form of development and delivery of early childhood mental health interventions through parenting programmes. Meetings were held between the expert-partner organisation and grassroot researchers to understand local people's lifestyle and needs in each geographic region picked for the study. Based on these interactions, training material was developed with the following content: brain development, domains of development, development milestones, "good enough" parenting, effects of neglect/maltreatment on child, types of accidents, and creating a safe environment (physical and social-emotional) for the child.

- The mothers were educated on what a "good enough" parenting should look like: A "good enough" parenting should be one where the child feels cared for and



protected, where the child develops a sense of attachment with the parent, there should be early intervention at the proper time and there should be a predictable routine for the child. A “good enough” parenting is important since it determines the child’s ability to develop subsequent relationships in the future, determines the confidence level, independence or interdependence of the children as well as their overall developmental outcomes.

- The needs of the children were divided into the following categories:
  - ◆ Physical needs (including food and nutrition, health services, water and sanitation, safety, shelter, cleanliness, good sleeping patterns)
  - ◆ Emotional and social needs (to make a child feel cared for and loved so that they develop a sense of attachment)
- The impact of neglect or maltreatment on children was conveyed to the mothers. They were informed that maltreatment could lead to irreversible damages to children’s development and affect their emotional, social and cognitive abilities.
- Parents were also informed about the various types of accidents that they should be careful about since these accidents could affect children’s growth. These accidents included not only physical injuries but other incidents that could have profoundly adverse impacts on the children such as being abandoned by a parent, lack of caregiving, abuse (physical or sexual or under substance or alcohol), absence of a structured routine in their regular lives and the use of inappropriate language.
- It was explained to mothers how a safe environment could be created for the children physically, socially and emotionally.
- Mothers were also cautioned to keep an eye out for red alerts such as late speech or motor abilities, lack of reciprocity from the children or a lack of eye contact, inability to express emotions clearly in language or through actions, signs of abuse and neglect as well as their vulnerability.

### III. Research Objectives

The study proposes to qualitatively assess the interventions implemented across four states to help communities ameliorate the impact of COVID

on the above-mentioned aspects. The FGDs will aim to:

1. Procedurally understand the delivery of interventions to mothers as primary caregivers (beneficiaries) – how the intervention was delivered, how often the trainings were held, what they were told about the expected benefit from changing practices, etc.
2. Determine the extent to which the intervention has benefitted children on ECD and health and nutrition outcomes – how many activities the child has been able to retain, whether the child continues to use the skills taught, any significant effect on child’s height and weight, etc.
3. Understand the issues that grassroots researchers discussed about parents’ and primary caregivers’ mental health at their meetings and enquire how the intervention on the subject can be delivered to parents effectively.

### IV. Some Points to Remember

- The assessment of interventions will be done through FGDs conducted across all five districts. IWWAGE proposes to conduct five FGDs in each of the five districts with mothers/primary caregivers who received the intervention.
- A separate telephonic interview will be conducted with grassroots researchers who attended meeting on the psychosocial support and mental well-being component using the last five questions listed in the FGD guide in the section titled ‘Psychosocial support and mental well-being of parents and caregivers’. PLEASE IGNORE THE LAST SECTION FOR THE PURPOSE OF THE FGD.
- Each FGD session is expected to have eight to 12 (no more) participants in attendance.
- Excluding the last section (five questions on mental health) the FGD should be expected to last for about 80 minutes. Please try and stick to the time duration provided against each question and section.
- Five FGDs are scheduled to take place in each district, with one investigator per district who knows the local language (two in Gujarat for the two districts). It is suggested that no more than one or two FGDs are conducted in a day. Even conducting one FGD per day should take up to one week per district.

- A pilot of two to three FGDs will be conducted in the districts picked by supervisors. Once the data from these two-three FGDs is analysed by the research team, the supervisors will instruct investigators to proceed with the remaining FGDs.
- For dates, timings and venue of FGDs, please contact the supervisor.
- For details of participants (name, phone, address), please consult your supervisor.
- At the end of each FGD, a small token of appreciation will be given out to respondents. Please do not convey to them about this before/during the FGD. Simply ensure that the gift items are calmly distributed to all respondents who came for the FGD.
- Before beginning the discussion:
  - ◆ The FGD guide has a table at the beginning. Please fill that at the begin and share the information with your supervisor.
  - ◆ Read out the 'Introduction' to respondents as a way of seeking their consent for participation in the session.
- The questions in the FGD guide are not intended to study the impact or outcome of the intervention. We cannot determine if the intervention made a difference in this little time.
- Rather, the FGD will be conducted to find out:
  - ◆ When, how and by whom the interventions under each heading were conducted
  - ◆ What activities took place
  - ◆ Did the beneficiaries find the information and tips shared at the meetings useful
  - ◆ Do they continue to remember or use the information shared
  - ◆ Whether they are satisfied with the intervention, and what they would like to change about it
- AWCs were shut at the time when the interventions were administered in 2021-22.
- Probing of responses: Encourage all women to speak up, especially try to interact with women who seem shy or are silent. If you observe any particular outliers (women whose responses are significantly and consistently different from the group), please specifically note those instances in your observations, so they can be cited or highlighted as distinct

anecdotes, and a diverse set of responses can be captured for women whose experiences are different from other respondents.

## V. Timeline and Expected Outcome

- The FGDs are proposed to be conducted between 19 September 2022 and 7 October 2022 across all five districts.
- The data collected will be transcribed in English, compiled and analysed by the research team.
- A final report in English will be delivered based on the findings from the FGDs.

## VI. General Field Dos and Don'ts

### Dos

- Report any peculiar/odd/different observation to the field supervisor.
- Exhibit appropriate behaviour at the time of conducting the FGD. This includes:
  - ◆ Being friendly with the respondent – first cooperate then expect cooperation.
  - ◆ Being patient and listening to what the respondents are saying.
  - ◆ Maintaining the data and respondent confidentiality.
  - ◆ Clarifying all the doubts of the respondents before, during and after the FGD, i.e., at all times.
- Probe *but do not exhibit* bias for any answer and do not prompt the respondents with response (unless stated in the question/comment).
  - ◆ Remain neutral about the subject of the FGD and responses.
  - ◆ Have a few different ways of asking/clarifying the question.
  - ◆ If the respondents take more time to answer or are not able to answer the question, try putting the question in more simple language. Do not reveal the options before the respondents attempt answering the question, unless where stated explicitly.

### Don'ts

- Answer other calls or browse phones during the FGD.
- Force/persuade the respondents to reveal any information if they are hesitant to do so.



- Interrupt the respondent when he/she is expressing a view/opinion different from the rest of the group.
- Note the observation if you find the answer unrealistic/different. In this event, repeat the question and seek clarity without showing to the respondent that you are surprised by the answer.
- Create biases by sharing your opinion or view about the information being gathered.
- Take any gifts from respondents.
- Visit or call respondents outside of the project purpose or share their phone numbers.
- Behave (sexually) inappropriately.





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