POLICY & DEVELOPMENT ADVISORY GROUP
Facilitating people-centric public policy

HDFC
WITH YOU, RIGHT THROUGH

Impact Assessment Report
Delhi Mobile Creches

HEALTHCARE: NUTRITION

For Working Mother's Children

April 2022

LIST OF ABBREVIATIONS	
CATI	Computer Assisted Telephonic Interviews
CSO	Civil Society Organization
ECCD	Early Childhood Care & Development
FGD	Focus Group Discussion
FI	Field Investigator
HTPF	HT Parekh Foundation
MC	Mobile Creches for Working Mother's Children
MIS	Management Information System
NCR	National Capital Region
NGO	Non-Governmental Organization
PDAG	Policy & Development Advisory Group
TFGD	Telephonic Focus Group Discussion
TPI	Telephonic Personal Interview

TABLE OF CONTENTS

1. EXECUTIVE SUMMARY 4
2. ABOUT THE PROGRAM 6
3. OBJECTIVES OF THE STUDY 6
4. METHODOLOGY 7
   - 4.1. Tools for Data Collection 7
   - 4.2. Sampling Strategy and Data Collection 8
   - 4.3. Method of Analysis 10
5. KEY FINDINGS 11
   - 5.1. Quantitative 11
   - 5.1.1. Socio Economic Characteristics 11
   - 5.1.2. Uptake of the Program 12
   - 5.1.3. Supplementary Nutrition and Immunisation 13
   - 5.1.4. Other Services provided by MC 13
   - 5.1.5. Children's Nutritional Outcomes 16
   - 5.2. Qualitative 20
   - 5.2.1 Description of Analysis 20
   - 5.2.2. Summary of Findings 23
6. CONCLUSION 26
7. ANNEXURE A: Figures 28
8. ANNEXURE B: Tools for Data Collection 64
9. ANNEXURE C: Textual Analysis Rubric 79

CSR Project	Program
Healthcare-Nutrition: Access to nutritious food supplements for children and women addressing SDG 2 and 3 	Food and nutrition for underprivileged children undergoing treatment for cancer at government hospitals

1. EXECUTIVE SUMMARY

The evaluation study of the services provided by Mobile Creches for Working Mother's Children (MC) was conducted by Policy and Development Advisory Group (PDAG), on behalf of the HT Parekh Foundation (HTPF), to understand and evaluate the efficacy of the nutritional services and nutritional counselling services provided by the centres.

MC is a pioneering organisation working for the rights of marginalised children for early childhood development. It provides health, nutrition and childcare services to children at construction sites and urban slums to the most vulnerable children in need of urgent interventions. Their work spans from grassroot level interventions to policy advocacy at the national level. MC follows a multi-pronged approach from bottom to top in order to achieve the goals identified under their Early Childhood Care & Development Programme (ECCD). The interventions at various levels include.

a. Providing/ensuring childcare services at the construction sites and in the slums

b. Building awareness in the community on importance of ECCD, the need for enhanced childcare practices at home, access and entitlement to state services, and enlisting their participation to monitor and oversee quality of government child care services

c. Training other NGOs, staff of state-run facilities and community women, in skills, knowledge and management of ECD centres/crèches

d. Sensitizing builders/contractors to children's issues and persuading them to take greater ownership and walk the talk with us and bring changes in their policies for employee welfare

e. Advocating with the government on issues of policy/law making, program design, and planning and implementation for young children.

HTPF is a progressive, impact-driven, philanthropic foundation guided by the principles of inclusion, long-term commitment, integrity and respect. Its philanthropic activities are aimed at enhancing the quality of life of people from marginalised and vulnerable communities that shall eventually help in creating a stronger and inclusive India. The HTPF has been funding MC for the last seven years and the evaluation was carried out for the period between April 2018 and March 2021. For the year 2018-19, besides taking care of dietary needs of 1000 children across 13 centres, MC employed the funding to focus upon maternal health, improvised nutrition, immunisation, and basic healthcare. For the year 2020-21, HTPF is funding MCD to support their work vis-à-vis maternal health, improvised nutrition, immunisation, and basic healthcare. Additionally, supporting the dietary needs of 1450 children.

PDAG is a policy advisory, research and strategic communications firm headquartered in New Delhi. Founded in 2018, PDAG partners with governments, non-profits, impact investment and multilateral organizations, academic institutions and global digital platforms to analyse and execute robust policy, research and communication solutions. Its vision is to drive a people-centric public policy framework in South Asia, especially India.

HTPF partnered with PDAG for the evaluation focusing on two objectives:

1. To understand the knowledge, attitude and practice level of key officials, mothers and community members
2. Evaluate changes in children's nutritional outcomes

The evaluation study was conducted by a group of qualified researchers from PDAG, through direct engagements with the beneficiaries and grounded research methodologies using a mixed methods approach.

The quantitative study through a statistical analysis of anthropometric data (weight and height) reflects the positive impact of the ECCD program on children's nutritional outcomes. The analysis using z-scores calculated for incidences of underweight and wasting suggests a change in nutritional status of children coming to the centres for a minimum of two months. However, minimal change is observed in cases of stunting in children. It can be inferred that the meals and supplementary nutrition plays a significant role in positively impacting adequate levels of nutrition in children. Supplementary nutrition along with regular health check-ups further plays a complementary role in generating a safety net for these children who belong to economically underprivileged communities.

Through the evaluation of these objectives, the study has arrived at conclusions that reflect the effectiveness of the program and the implementing agency's capability to sufficiently implement the project. The qualitative aspect of this study evaluated the knowledge, attitude and practice level of key officials, mothers and community members through textual analysis of narratives along with inputs from participant observation of researchers during the field visits. Inferences were drawn from this analysis, through a structured rubric of the collated data.

The program's aim is to provide nutritional and medical support that has been well received by the communities. At the heart of this reception lies the centres' ability to provide a safe environment for the children, to then benefit them from the services provided through the project. The nutritional outcomes of children that have been captured by the study, showcase that the services provided through the centres play a significant role in positively impacting adequate levels of nutrition. The regularity in children attending the centres and consuming all three meals testifies for the well-designed framework of the program. The knowledge and awareness of mothers on better caregiving practices is important, and a centre's ability to effectively generate this awareness depends heavily on the centre in charge/ staff's ability to do so. The program's general framework has showcased plausible success and can be improved further by employing standardized operations performed by the project functionaries across all the centers to conduct activities and counselling with the parents.

2. ABOUT THE PROGRAM

MC is a pioneering organisation working for the right of marginalised children to early childhood development. It provides health, nutrition and childcare services to children at construction sites and urban slums to the most vulnerable children in need of urgent interventions. Their work spans from grassroot level interventions to policy advocacy at the national level. MC follows a multi-pronged approach from bottom to top in order to achieve the goals identified under their ECCD program. The interventions at various levels include a) providing/ensuring childcare services at construction sites and in the slums b) building awareness in the community on importance of ECCD, the need for enhanced childcare practices at home, access and entitlement to state services, and enlisting their participation to monitor and oversee quality of government child care services c) training other NGOs, staff of state-run facilities and community women, in skills, knowledge and management of ECCD centres/crèches d) sensitizing builders/contractors to children's issues and persuading them to take greater ownership and walk the talk with us and bring changes in their policies for employee welfare and e) advocating with the government on issues of policy/law making, program design, and planning and implementation for young children.

MC partners with several Non-Governmental Organizations (NGOs) across different cities for the implementation of their program. They are working with Sampark and Sparsha in Bangalore who are responsible for service delivery across different construction sites. Currently, the creches supported by HTPF are operational across 9 centres in Bangalore and 4 centres in Delhi.

MC ensures child care – health, nutrition, early learning, and care – for infants-12-year-old children living at the construction sites of Delhi (NCR). MC operates from the day care centres that are located within the labour camps near the construction sites. These day care centres also function as schools or Aanganwadi centres conducting classes for younger children alongside providing meals. The need for nutrition is fulfilled by providing three balanced and nutritious meals for children that are prepared by well-trained caregivers at the day care centres. These meals are carefully designed with the help of nutritionists and medical practitioners to take into account the nutritional needs of children. Health check-ups are conducted at the centre by a certified medical practitioner to scan for seasonal ailments and provide medical guidance to children with serious illnesses. The centres also monitor the nutritional status of children by maintaining records of height (cm) and weight (kg) using a MIS.

3. OBJECTIVES OF THE STUDY

The evaluation focuses on two main objectives:

1. Evaluate changes in children's nutritional outcomes ; This objective evaluates the changes in child's nutritional outcomes through anthropometric measurements and assessing the delivery of various components of the programs that facilitate holistic growth and development of children.
2. To understand the knowledge, attitude and practice level of mothers and community members; This objective primarily focuses on understanding the perceptions of mothers on the facilities and services provided by the centres. It also assesses the effectiveness of the counselling activities conducted by the centres on generating awareness around best nutritional and caregiving practices.

4. METHODOLOGY

The twofold objectives of the evaluation were carried out using a mixed methods approach in order to provide a holistic evaluation of the project. Using qualitative and quantitative research methods of data collection and analysis, the two methods were employed to act as complementary to each other. Thereby allowing for a comprehensive evaluation, wherein inferences are drawn after observations from both methods are compared and reflected upon.

4.1. Tools for Data Collection

The twofold objectives of the evaluation were assessed using mixed methods approach in order to provide a holistic understanding. Using qualitative and quantitative methods of data collection and analysis, the two methods were employed to act as complementary to each other. Thereby allowing, for a comprehensive evaluation, wherein inferences are drawn after observations from both methods are compared and reflected upon.

4.1.1. Quantitative

The quantitative method of data collection focused on the first objective to evaluate the nutritional outcomes of children who are also the direct beneficiaries of the programme. A structured questionnaire was used to collect data on different indicators assessing the nutritional outcomes. All the quantitative interviews were conducted using this structured schedule that was translated into Hindi for the centres in Delhi and in Kannada for the centres in Bangalore and digitised using the SurveyCTO application. The consent form was integrated within the schedule and no interview could be initiated without the consent of the respondent.

4.1.2. Qualitative

The qualitative aspect of the study has largely addressed the questions of knowledge, attitude and practice level of mothers, community members, and officials associated with the project.

The methods included:

a. Telephonic Personal Interviews (TPI) with the officials (addressed as key respondents) such as assistant manager, assistant coordinators, centre in charge: They informed the researchers about the functioning of the project, how the organisation managed the project and how they went on about achieving their goals.

b. Telephonic Focus Group Discussions (TFGD) with community respondents were conducted which allowed community members to speak about their interactions, practices and engagement with the centre. Community respondents, especially parents (mothers of the children) informed us about their perspective of the project, how they receive its services (safety and security of their children, nutrition, medical and health support, nutritional counselling and support during the pandemic induced lockdowns), their degree of satisfaction with the staffs at the centre, whether they manage to learn essential skills (such as nutritional cooking, identifying a nutritious menu for their family, etc), gather knowledge on nutritional requirements and ways of achieving them without the support of the organisation and continue to establish the desirable practices as a part of their daily lives.

c. Day care centre audits were also part of the research data collection exercise where researchers physically visited the centres after they reopened in February, 2022. The centres and the labour camps were observed and the researchers made an attempt to experience the material conditions of the centres and the labour camps located at the construction site and collated their observations as a reflection to the interactions that they had with the officials as well as the beneficiaries i.e., the children and their parents.

4.2. Sampling Strategy and Data Collection

4.2.1. Quantitative

The sample size for primary data collection was determined using Cochran's sample size calculation at 95 percent confidence level and 5 percent level of precision to achieve robust estimates. The calculation further assumed 50 percent of maximum variability to take care of potential dropouts among the sampled units. Using this method, the data collection exercise aimed at conducting a total of 245 interviews. The total number of beneficiaries at the centres in December 2021 constituted the sample frame and the sample was divided proportionally across the centres. The target sample size was calculated as 172 for Bangalore and 73 for Delhi out of which we achieved 161 and 69 in Bangalore and Delhi respectively. Table 1 represents the sample size of each centre in both the cities (target and achieved).

Table 1: Sample size across all centers

S. No.	Centre	Total beneficiaries	Target sample	Achieved sample
		Bangalore		
1	CLPD	127	47	65
2	Homebale	37	12	8
3	Mahaveer turquoise	51	19	8
4	Mahaveer Ranches	71	26	22
5	NR Greenwood	35	12	8
6	Prestige Fern galaxy	54	19	8
7	Prestige Falcon city	23	10	9
8	Purva Palm Beach	45	17	18
9	Suncity Ibbaluru	32	10	14
		NCR		
10	ATS Le Grandiose	66	24	23
11	ATS Nobility	48	17	17
12	Care Village Samriddhi	56	21	16
13	Sushma Sites	31	11	13
	Total	**676**	**245**	**229**

Owing to the third wave of Covid-19 pandemic, we conducted Computer Assisted Telephonic Interviews (CATI) to collect data instead of visits to the centres. The list of mobile numbers of the beneficiaries were provided by the NGO partners for each of the centres. Beneficiaries from this list were sampled randomly to conduct telephonic interviews.

Primary data collection was conducted across all 9 centres in Bangalore and 4 centres in Delhi. The telephonic interviews were conducted by a team of local Field Investigators (FIs) in Bangalore and by the PDAG team for Delhi. Both the teams had prior experience in collecting data using digital forms via the SurveyCTO application were identified for the Bangalore team. The FIs in Bangalore were fluent in Kannada, Hindi and English to ensure robust communication. A one-day training was conducted online for both the teams. The mock sessions conducted with the FIs also helped in refining the schedules with appropriate language and tested for any technical errors. Both the teams were supervised on a daily basis by the Field Manager from PDAG and data collected was monitored at the back end to ensure quality check.

To collect data on anthropometric measures (height and weight), the teams relied on the registers maintained at each centre for each child in the sample.

4.2.2. Qualitative

The qualitative research gives a snapshot of the entire implementation mechanism of the project, the practice level of the community stakeholders and the officials associated with ECCD through a representative sample. The sample satiates all possible variability of data/information. In qualitative work, one way of assessing representation is thematic saturation or redundancy of additional information. Ideally, new data are collected within each group of interest (here officials and beneficiary groups) until saturation (i.e., to arrive at a juncture in data collection at which little to no new information is being gained in each additional interview1). The saturation principle2 was deployed and the researchers considered ten telephonic personal interviews with officials and eleven telephonic FGDs with parents which were put through textual analysis. To supplement TPIs and TFGDs, day care centre audits were also conducted after the lockdowns were lifted and they resumed their work in Bangalore and Delhi NCR in mid-February 2022. The TPIs, TFGDs and centre audits were planned and scheduled in collaboration with MC leadership and their local CSO partners and were done in person by trained researchers of PDAG. A reference questionnaire was prepared in advance for qualitative data collection as well as for the centre audits. A detailed review of the annual reports, project proposals and grant letters shared by MC on their ECCD project helped us to compile the data collection tools. The tools were referential and researchers only used it to loosely structure the interviews, FGDs and interactions during the audit. The verbal data was recorded on a Dictaphone and each of the interactions were transcribed into text for textual analysis; observations were systematically entered by researchers on a rubric. Names and other personal or professional details have been kept confidential or transcribed under an anonymous alias, to maintain the ethical integrity of the research.

---

[1]Lincoln, Y. S., & Guba, E. G. (1986). But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. New directions for program evaluation, 1986(30), 73-84

[2] Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. Field methods, 18(1), 59-82. This study presents evidence that informational "saturation" typically occurs within the first 12 interviews conducted, with basic themes beginning to emerge as early as the sixth interview. We used this as a guide for estimating the number of interviews required per subgroup of interest.

4.3. Method of Analysis

4.3.1. Quantitative

There are two components with respect to analysis of quantitative data for the evaluation. The first component includes analysis of raw data collected through personal interviews conducted telephonically with the parents (229 interviews). The second component includes analysing the anthropometric measures recorded by MC for their own monitoring purposes. R programming language and Stata were used to efficiently analyse the data for both the components.

For the first component of analysis, post protocol cleaning of raw data statistical analysis was carried out using the indicators captured through the questionnaire to assess a holistic service delivery of the program.

For the second component of the analysis, MC provided the anthropometric measures of each child enrolled at the centres between April 2018 and March 2021. Data is available from August 2018 to February 2020 for the centres in Delhi, and from April 2019 to February 2020 for the centres under Sparsha in Bangalore. Only data from November and December 2021 was available for the centres under Sampark in Bangalore.

Limitations

Although the data shared between April 2018 to March 2021 covers 4465 children enrolled at the centre, the anthropometric measures are recorded only for 2279 children. Due to unavailability of anthropometric measures, the second component of the analysis is performed only for children between 0-59 months amongst these 2279 children. Additionally, anthropometric measures for children aren't reported in the month of March 2019. Apart from March 2019, anthropometric measures are not reported for months in between. This could be attributed to the nature of movement of the families as the children might be associated with the centres whenever the parent(s) have work at the construction site. Additionally, COVID-19 severely affected the operations of the centers including the monitoring of anthropometric measures which explains the breaks in data.

4.3.2. Qualitative

For this study we have employed an evaluative approach to analyse our collected data against a set of monitoring indicators which have been determined with reference to the thematic objectives of the ECCD project.

1. Evaluating the objectives of the project mentioned in the project proposal with reference to the processes and the impact of the process which we have collected in the form of narratives from two distinct groups of respondent stakeholders i.e. the project functionaries and the community. The text, in this case, are notes and transcripts of TPI, TFGDs and observations from the centre audits. The objectives and the monitoring indicators and the planned process of the project are then juxtaposed against the narratives in a textual analysis rubric (Annexure C). Inferences have been drawn on the basis of triangulation of

the narratives of the officials along with those of the beneficiary community and finally in relation to the observations made by the researchers during their field visits, i.e., centre audits.

2. The inferences drawn are further theorised to form a more abstract theory which can inform other similar contexts. The approach was developed by sociologists (Glaser and Strauss 1967; Strauss and Corbin 1990) and is widely used to analyse interview data.
3. Key findings are presented by using examples, that is, quotes from interviews and the observations that illuminate the theory or the inferences.

The mechanics of grounded theory are:

a. After production of transcripts of TPIs and TFGDs, the transcripts are juxtaposed against the notes made during the interviews and observations which are made during audits. Then the transcripts are thematically analysed as per the determined indicators and significant parts are highlighted using a colour scheme associated with each thematic indicator.

b. As the significant narratives emerge, they are mapped in relation to the objectives of the project and their monitoring indicators on a rubric. Here, we have developed the rubric which collates the objectives of the ECCD project, followed by the corresponding programmes, their critical monitoring indicators, the vignettes from the transcripts and the observation notes. The relevant sections of the transcripts and the rubric are in turn highlighted in accordance with the colour scheme associated with each thematic objective, which in turn correspond with the inferences which have been drawn.

5. KEY FINDINGS

5.1. Quantitative

5.1.1. Socio-economic characteristics

The quantitative aspect of the study also focused on understanding the socio-economic characteristics of the families in order to gain a comprehensive insight on the effectiveness of the program. Research indicates that there is a strong linkage between maternal education and children's health and mother's education persists as a strong predictor of child's nutritional status (Abuya et al, 2012; Negash et al, 2015). More than 50 percent of mothers in the sample are illiterate that could subsequently result in poor food choices and caregiving practices (Figure 1). Further, the average monthly family income is less than 15,000 for approximately 63 percent of the respondents (Figure 2). On food choices, it is also corroborated from the qualitative data that the mothers prepare food from the resources available to them wherein they might not be able to include healthy food items for their children.

Figure 1: Attained education level of respondents

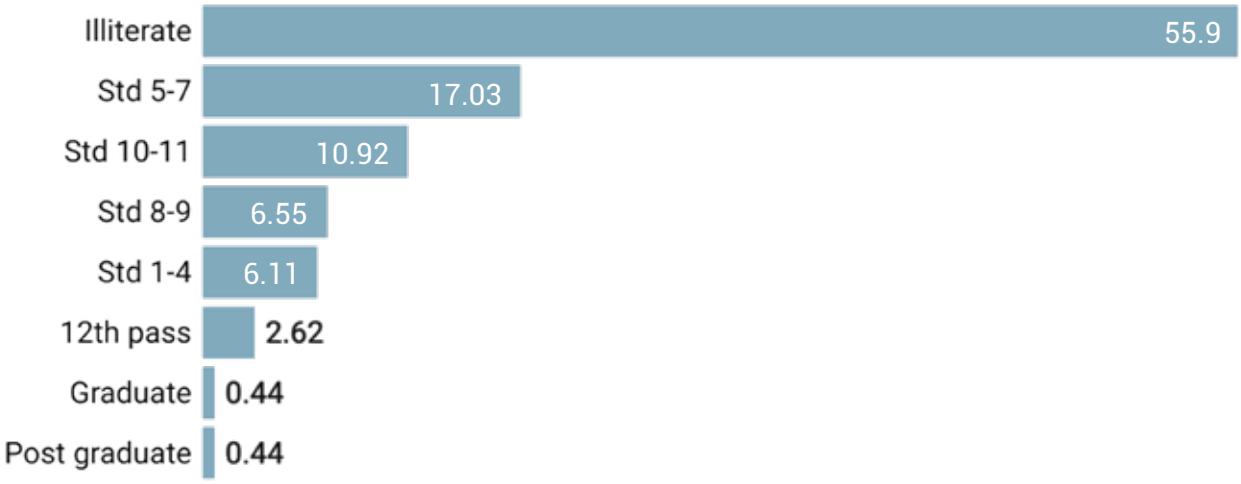
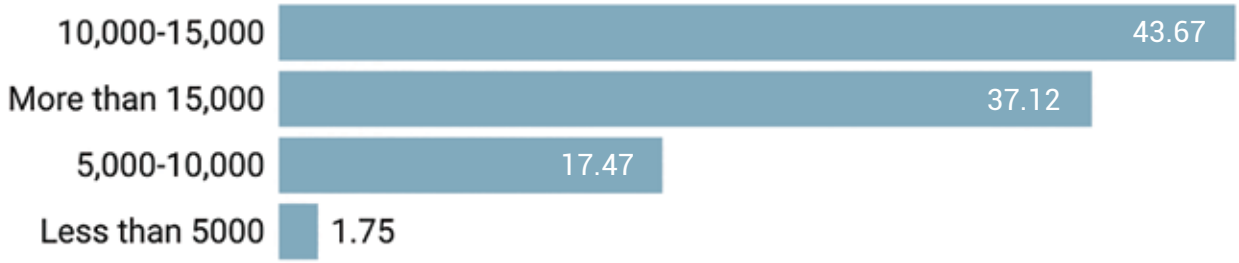


Figure 2: Average monthly family income of respondents



5.1.2. Uptake of the program

95.2 percent of children reported going to the centres all days in a week except for holidays (Figure 3). This is also inferred by qualitative interviews wherein the mothers reported that the children like to go to the centres which also adds to a day to day safe upkeep of the child. Approximately 86 percent of the respondents reported that the child gets three meals in a day at the centres while 13 percent reported receiving two meals in a day (Figure 4). These cases are mostly exceptions wherein the older children are enrolled in nearby schools and hence are not present at the centers throughout the day. Mothers reported that their children usually receive milk in the morning, a preparation made of rice for lunch and halwa/chikki or other nutritional food items as evening snacks. When asked about the provision of bananas and eggs, approximately 70 percent of them reported receiving bananas and eggs daily at the centre.

Figure 3: No. of days in a week the children visit centres

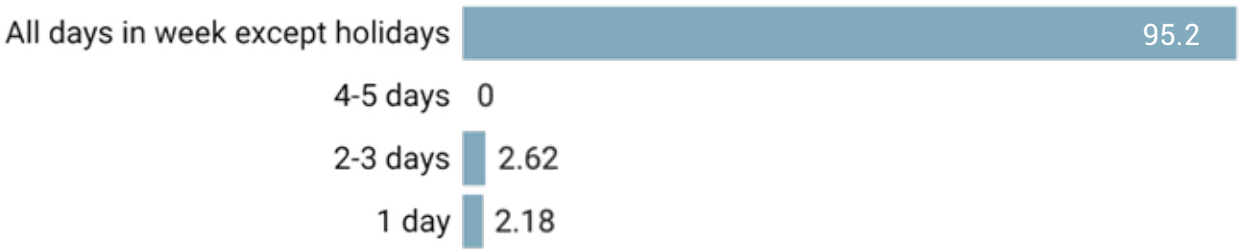


Figure 4: No. of meals children receive at the centres

5.1.3. Supplementary nutrition and immunisation

Apart from the meals provided at the centres, the program also mandates to provide nutritional supplements to children in the form of iron supplements and deworming tablets. The frequency of these are pre-decided with the help of nutritionists and medical practitioners associated with the program. More than 50 percent of mothers reported about their child receiving iron supplements on a daily basis. Children are also provided deworming tablets at the centres that are provided once in six months. 90 percent of mothers reported their child receiving deworming tablets from the centre. However, 26 percent and 5 percent of mothers are not aware of iron supplements and deworming tablets respectively captured by the category "others". Regular counselling sessions with all parents becomes an important part of the program that should also cater to imparting complete information on the day-to-day functioning of the centre with respect to caregiving practices.

Figure 5: Frequency of children receiving deworming tablets

5.1.4. Other services provided by MC

A certified doctor visits the centres at regular pre-decided intervals to conduct health screening and assess the nutritional status of children. The doctor also addresses concerns relating to any seasonal or chronic ailments that the children might be suffering from 87.16 percent mothers reported regular

health check-ups of their children at the centres (Figure 6). However, a small proportion (approximately 9 percent) are unaware about the doctor visits.

Figure 6: Frequency of doctor visits at the centres

The centre along with the help of a medical practitioner also refers the parents to local hospitals in case of severe illnesses and malnourishment. In such cases, supplementary food is provided by the centre along with take home ration (Figure 7). The centre also supports the children with procuring medicines in case of seasonal illnesses whenever required (Figure 8).

Figure 7: Additional support received for malnourished children

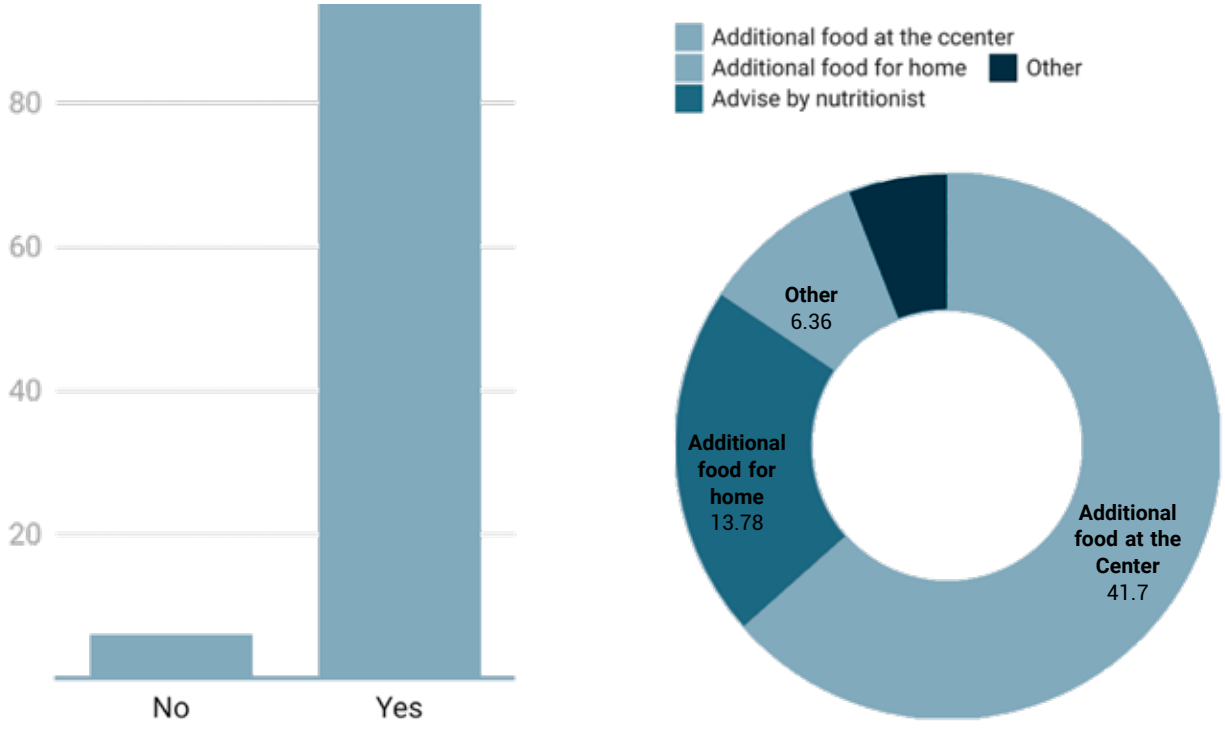
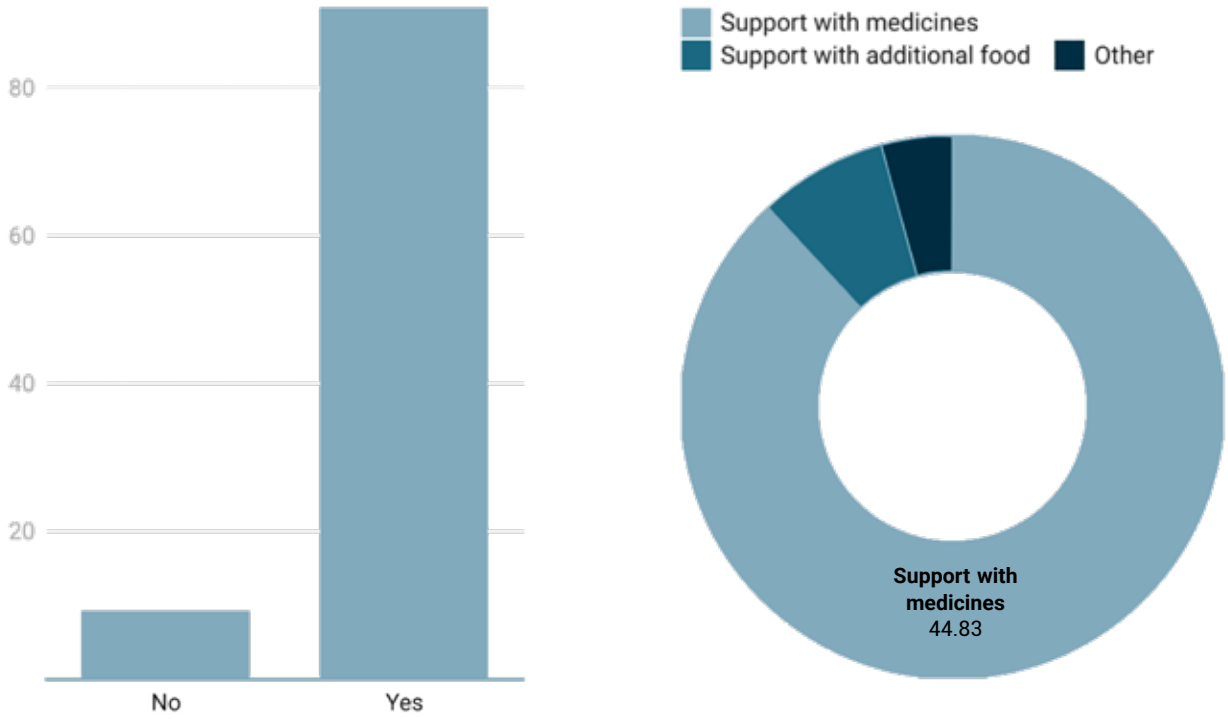
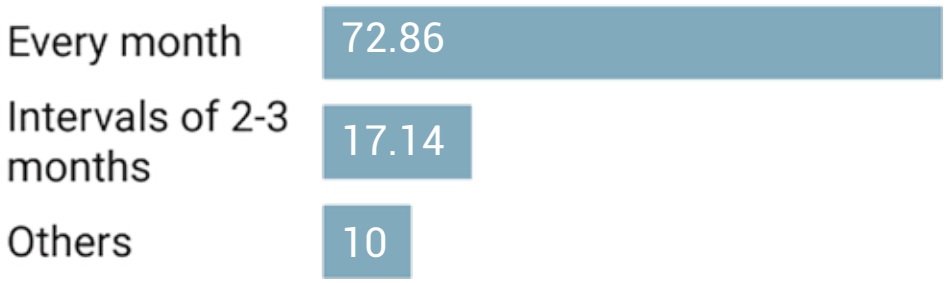


Figure 8: Additional support for children who are sick



In addition to actively tracking the nutritional status of children with the help of medical practitioners, one of the primary objectives of the centre is to provide counselling to parents and caregivers on nutrition related matters and other healthy practices such as maintaining hygiene and healthy cooking practices. With respect to this, the centres conduct regular meetings with the parents in the form of counselling sessions and/or specific activities to generate awareness and to make the centres more accessible to parents in discussing child's health. Approximately, 73 percent of mothers reported attending such sessions every month where they received information on an array of aspects involving nutrition and caregiving practices (Figure 12). The effectiveness of these sessions is analysed using qualitative data and the findings are presented in section 5.2.2.

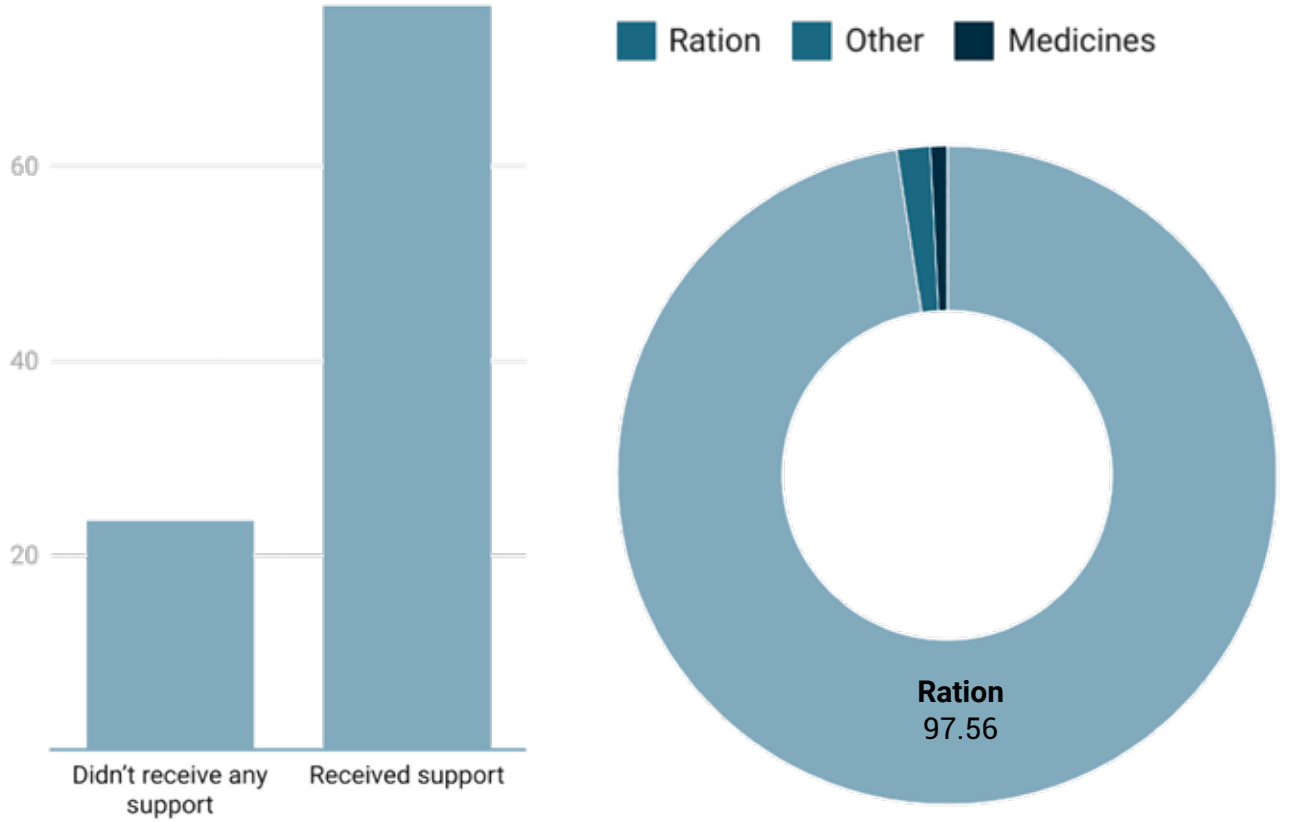
Figure 9: Frequency of meetings held with parents on nutritional counselling



The Covid-19 induced lockdown posed severe challenges to the service delivery of these centres. The closure of centres affected the delivery of meals and the monthly meetings with the parents. In such cases, centres adapted to providing ration kits to the families residing in labour camps with the help

of local volunteers (Figure (13). The ration kits included items such as rice, pulses, sooji, ghee, dalia, oil, gram, peanuts, etc.

Figure 10: Support provided during lockdown



5.1.5. Children's nutritional outcomes

The height and weight of children captured through the quantitative questionnaire has been used to assess the nutritional outcomes of children coming to the centres. A total of 138 children out of 229 children were included in the analysis. Out of these 33 children belonged to 0-23 months category and 105 children are between 24-59 months.

The anthropometric measures are used to calculate weight for age z-score representing incidence of underweight, height for age z-score representing incidence of stunting and weight for height z-score representing incidence of wasting in children. These are the core set of indicators for the Global Nutrition Monitoring Framework and are also included in WHO's Global reference list of 100 core health indicators. A value below -3 represents severe malnourishment, -3 to -2 represents moderate malnourishment and -2 to 2 represents normal status of nourishment.

Table below presents the findings wherein the findings suggest that the majority of children fall under the normal category in case of underweight and wasting measures calculated using z-scores. The data collection that ensured only those children are included in the sample who have been associated with the program for at least two months might explain these findings. However, in case of stunting, a majority of children report severe or moderate levels. Existing research suggests that stunting is inseparably connected to reproductive and maternal nutrition and is often determined in the mother's

womb by a mother's social status and level of education and cannot be immediately rectified using short term interventions with children themselves[3].

Table 2: Anthropometric indicators for children according to z-score (0-23 months)

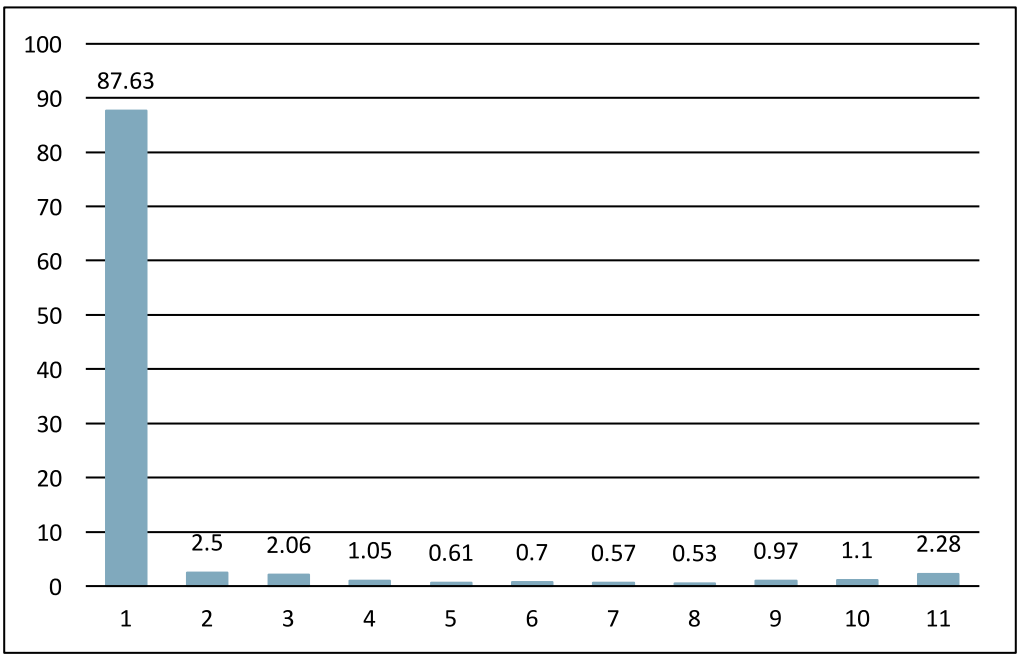
Indicators	Severe	Moderate	Normal	Total
Underweight	12.1	6.06	66.66	33
Stunting	51.51	9.09	21.21	33
Wasting	3.03	0	72.72	33

Table 3: Anthropometric indicators for children according to z-score (24-59 months)

Indicators	Severe	Moderate	Normal	Total
Underweight	12.38	28.57	55.23	105
Stunting	39.04	14.28	37.14	105
Wasting	5.71	13.33	67.62	105

The second component of quantitative data analysis reveals that a small proportion (2.28 percent) of children stayed at the centre for 11 months (Figure 14). On an average, a child stays at the centre for 1.6 months however, the highest proportion (87.63 percent) of children stay for one month or less. The duration that a child is associated with the center is useful to further understand the change in nutritional status brought about by MC's program.

Figure 11: Month wise distribution of children at the centres



[3]https://www.unicef.org/india/what-we-do/stop-stunting

The graphs below represent the z-scores for underweight of children coming to the centres depending on sex and the age of children (Figures 15-17). Each child is represented on a horizontal line along with any change in z-scores over the months. Among the three indicators, weight for age and weight for height representing underweight respectively report significant change in z-scores while wasting reports smaller change. Children who are severely underweight and wasted during the first months of their stay report a change in status improving to moderate or normal levels of underweight and wasting. However, height for age representing stunting presents minimal change. Unlike height, weight fluctuates over time and therefore reflects current as well as acute chronic malnutrition and can show change even during a shorter duration. Stunting on the other hand is associated with long term factors and indicates past growth failures.

Figure 12

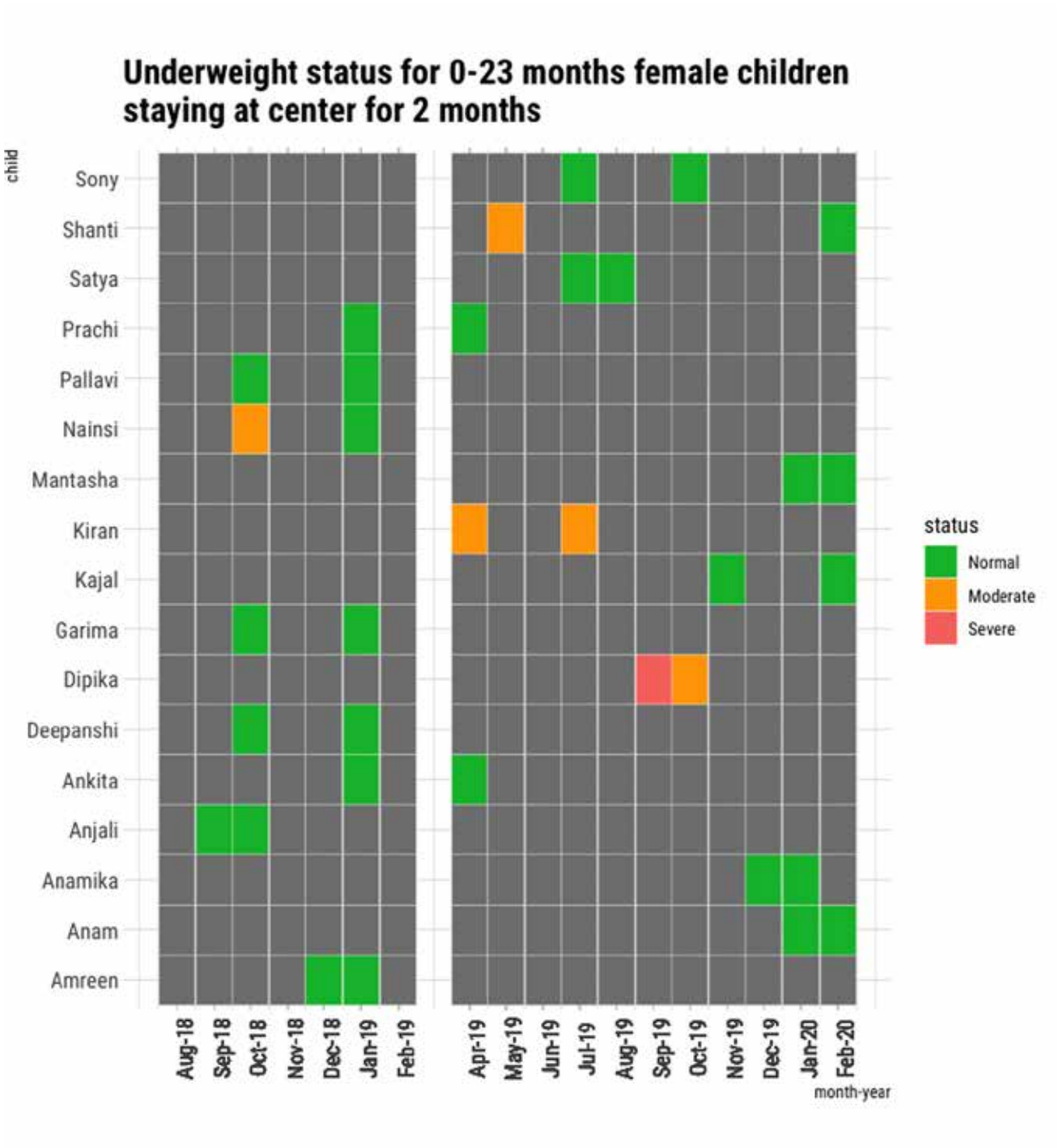


Figure 13

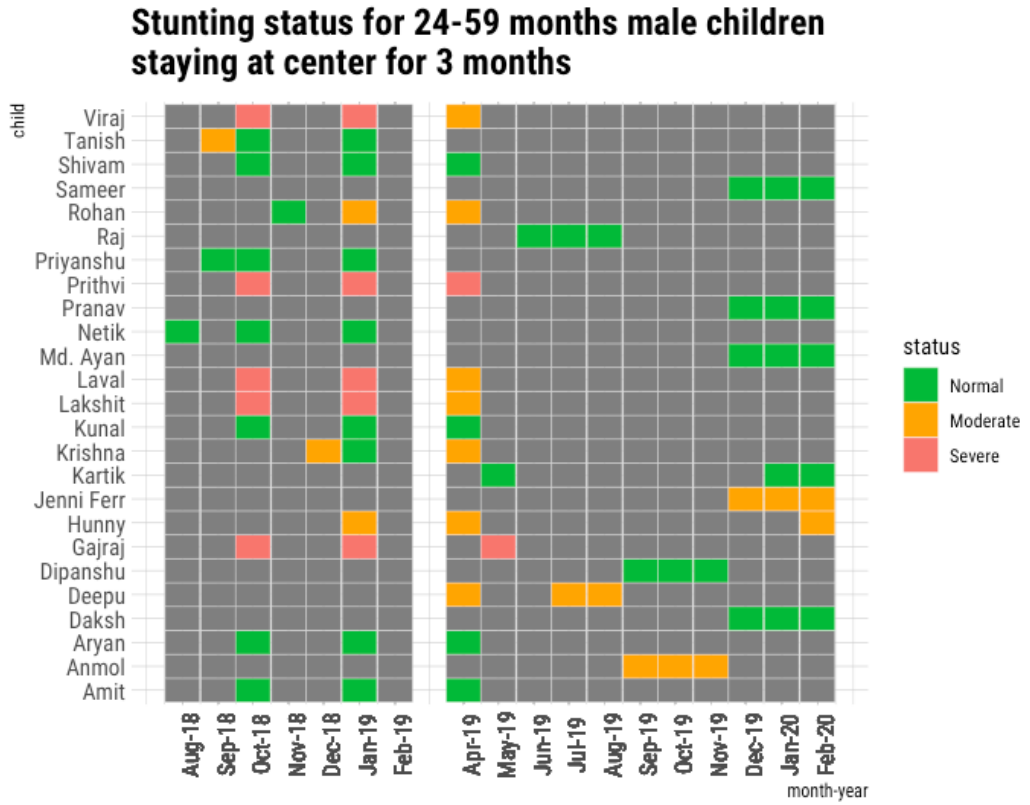
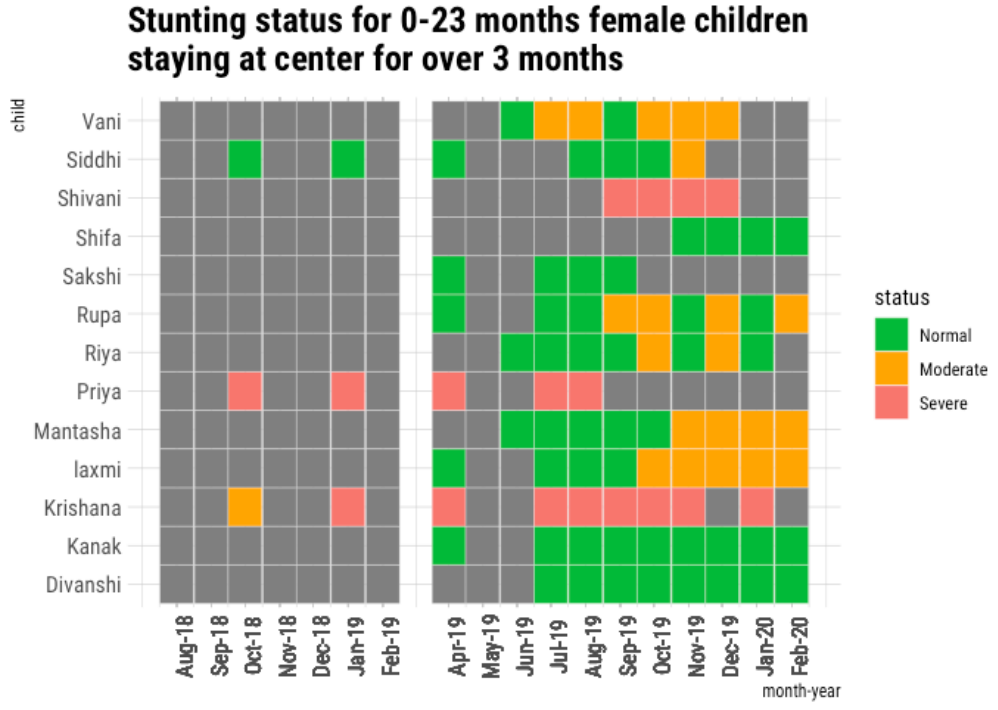


Figure 14



5.2. Qualitative

5.2.1. Description of the Analysis

The analysis rubric juxtaposes the deliverables alongside the programmes undertaken by MC and the significant monitoring indicators that help us to evaluate procedural narrations from the officials, responses from the community, and observations of the researchers have been triangulated systematically to draw inferences of the impact of the interventions. The thematic objectives/ deliverables were extrapolated from a review of the project proposal and the project report of MC with HTPF.

The deliverables were classified into:

1. Safety (safe space for children)
2. Nutrition
3. Nutritional counselling
4. Management of centres and programmes
5. Medical support for children
6. Support during lockdowns
7. Education

The short descriptions will help us understand the analysis. We recommend reading the analysis while referring to the rubric attached in the annexure. The following have been the broad aggregate observations across all the day care centres which were part of the study.

1. Safety (safe space for children) is one of the fundamental deliverables of the ECCD programme, it addresses this basic requirement through housing the enrolled children within their day care centre which are constructed at a safe distance from the site of construction. However, the day care centres which were part of the evaluation were also not far from the labour colony, some were placed beside or within the colony or within a short distance from the site of construction. The location of the day care centres is placed optimally to ensure convenience and safety. Apart from the location, all the centres offer an enclosed space and the staff of the centre provides security. The presence of the safety features of the day care centre such as gates, security personnel, movement registers of students, enclosed spaces for activities, separate space for Creche (0-3 years), Balwadi (3-5 years) and Bridge Course (informal education for 5-14 years) were present across all centres and its maintenance has been verified physically by the researchers. The procedural functions of the facilities have been triangulated with responses from the community as well as with the empirical observations of the researchers. The vignettes from the field have been presented in a schematic manner to draw inferences. Refer to the annexure for the schematic presentation of this analysis.
2. Nutrition: Meals are provided to all children at the centre according to their age and nutritional requirements. Meals are cooked in a kitchen at the centre. Proper hygiene is maintained in the kitchen. Nutritional charts specifying servings and nutritional requirements are present in

all kitchens. Across all centres there was a general homogeneity of the meal timings and the food served to different categories of children.

Breakfast menu and timings: The timings for breakfast at all centres were 9 AM to 10 AM. *Suji halw*a or *Suji kheer* is provided at the centres in Delhi, depending on the age group. The children in the Bangalore centres are provided with *chikki* and milk in some centres, while some centres also provide *halw*a. The timings between the creche age group and the rest are also staggered in some centres.

Lunch menu and timings: The timings for lunch are fixed at 12 PM to 1 PM across all centres. *Khichdi* or *Dalia* is provided on alternate days. Different vegetables or soya chunks are added on different days. *Anaj* mix or multigrain mix is also provided during lunch in some centres. Eggs are provided in some centres for lunch. The timings between the creche age group and the rest are also staggered in some centres.

S. No.	Meal	Items	Timings	Comments
1	Breakfast	Delhi: *Suji halwa* or *Suji kheer* Bangalore: *Chikki, Milk, Halwa*	9 am -10 am	The timings between the creche age group and the rest are also staggered in some centres
2	Lunch	All Centres: *Khichdi* or *dalia*. *Anaj* mix or multigrain mix. Eggs are provided in some centres during lunch	12 pm - 1 pm	The timings between the creche age group and the rest are also staggered in some centres. Different vegetables or soya chunks are added on different days
3	Snacks	Boiled *chana dal* or boiled *moong dal*. Fruits are provided on one day of the week.	3:30 pm - 5 pm	A fruit is provided once a week to all the children, while in some Bangalore centres they are provided every day.
4	Special food supplements provided to malnourished children: Eggs, bananas, extra *anaj* mix and an extra spoon of refined oil, are all provided every day, as a special diet to malnourished kids.			
5	Lactating mothers are called to the centre at regular intervals to breastfeed the infants.			

Snacks menu and timings: The timings for snacks are fixed at 3:30 PM across all centres. *Boiled Chana dal* or *boiled moong dal* is provided as snacks. Fruits are provided on one day of the week, while in some Bangalore centres they are provided every day.

Special food supplements provided to malnourished children: Eggs, bananas, extra *anaj* mix and an extra spoon of refined oil, are all provided every day, as a special diet to malnourished kids.

Lactating mothers are called to the centre at regular intervals to breastfeed the infants.

Nutrition is also provided for lactating and pregnant mothers. The quality of the meals, the menu of food has been verified by researchers and triangulated through comparing narratives of the officials against the responses from the community. The variety of food served is very limited and some of our observations did highlight that it did not always help as young children prefer tasting a slightly wider variety of meals.

3. Nutritional Counselling is provided to mothers as part of the Parent Development Programme (PDP) to ensure that they continue to cook nutritional meals when they are at home with their children and choose a nutritious menu within their budget. The nutritional counselling contributes towards building capacities of the community to sustain the effort towards fulfilling the nutritional requirements of growing children in their crucial ages of development. Nutritional counselling is conducted through cooking demonstrations, community meetings and FGDs with parents of children with special needs or malnutrition. The frequency and the efficacy of the programme has been evaluated through comparing procedural narrations of the officials and facilitators along with the responses of the community and the observation of the researchers.

The general observation that we had across the centres at Bangalore and Delhi NCR suggests that the PDP is generally not received with seriousness. There were multiple reasons in support of such an attitude. Primarily, working mothers had limited time after their day's work. Post which, the kitchen space in their makeshift camp homes is very small, making it difficult to maintain hygienic conditions as the same space accommodates 3-4 individuals from a family. Additionally, it was observed in some of the centres in Bangalore that communication with the migrant labour community is a barrier, while the staff is local, a significant portion of the workers migrate from other states like West Bengal, Bihar, Jharkhand and Uttar Pradesh. Consequently, language does become a hindrance in communication of essential practices.

4. Medical support, support during COVID-19 induced lockdowns and education are also important functions of the project. Medical support is provided through a monthly programme where medical practitioners visit the day care centre. In addition to that, medical practitioners also visit in case there is any emergency.

   Dry ration support was provided during lockdown to the entire community. Ration kit provided at the time of the lockdown was supported by government agencies, donors and the builders themselves. The details of the ration kit were verified through a comparison of narrations from officials and beneficiary responses.

   Education is provided by teachers in every centre. They follow a well-designed curriculum designed through categorising students into appropriate age groups.

   The guide book called Khel Pitari published by Mobile Creches, is used for educating creche children of 0 to 3 years; children of 3 to 5 years are part of the Balwadi programme, and ages 5 and above follow a module of non-formal education popularly called Bridge Course within the MC, Delhi system. When a child is staying at the day care centre for more than 6 months

the child is admitted to the local government school depending on the age and the appropriate standard of education he/she is supposed to receive. The entire rehabilitation of such children is managed through the bridge course facilitated at the day care centre by designated teachers. The efficacy of the educational programme has also been evaluated through comparison of narratives as researchers had a limitation of time to observe educational outcomes over a longer period of time.

Limitations

The qualitative study of the effectiveness of the nutritional counselling process, the effectiveness of the PDP as well as the educational modules cannot be evaluated within a limited time frame. We studied the impact that it has made on the community through their responses, however, a deeper understanding can be arrived at only when the processes that are conducted by the officials and the facilitators can be observed and experienced over a considerable period of time. Additionally, in-person interactions were limited due to the COVID-19 induced pandemic situation and the Omicron wave that swept the nation during the initial fieldwork phase. However, as soon as things opened up in February, we paid visits to the centres and conducted field visits.

5.2.2. Summary of findings

The understanding of 'Practice Level' of stakeholders i.e., mothers and officials are further classified into:

1. Nutritional support: corresponds to services of nutrition provided by the centre to the children and its reception by the parent community.
2. Nutritional counselling and demonstrated nutritional knowledge of the parents: corresponds to the nutritional counselling programme and its efficacy to inform parents on the overall nutritional requirements and various ways of achieving them through a practice of cooking hygienic, palatable and nutritious food.
3. Understanding of medical and health issues of the child: corresponds to the realisation of the parents and the officials of the importance of medical support and nutritional supplementation for the children and its performance.
4. Understanding and performance of safety and safe space for children: corresponds to keeping the centre safe for children from both physical hazards and abuse as well as making it into a safe space which contributes to the overall well-being of the children. It also attributes to the level of trust imbued by the parents in the centre's capacity to provide such a space for their children.
5. Finally, the importance of continuing with nutritional and medical services for the children even during unprecedented circumstances such as the COVID-19 induced lockdowns.

Based on these five broad objectives the practice level of the community and the key officials associated with the programme has been assessed. The summary of the assessment is provided in Table 2.

Table 4: Summary of assessment (Refer to Annexure B for a detailed description)

S. No:	Objective	Inference
1.	Safety/Safe Space for Children	1. General observation of researchers and narrations from community as well as officials demonstrate that the centres are safe spaces for children. The infrastructure such as tall gates, enclosed areas, movement registers and security personnel helps to ensure this. 2. The distance and location of the centre seems to be at a distance from the construction site, even if it is in certain cases away from the labour colony. Some centre staff attest to picking the children up from the labour camps, which enhances the children's safety. 3. Parents feel that their children are safe and are taken care of at the centre by the staff of DMC. The parents expressed their trust in the centre's facilities to ensure that their children do not wander, which was especially appreciated by the working mothers. 4. Safety of children seems to be incorporated as part of the basic functioning and processes of the centre. The features of the centres themselves allow for the children to be present within the confines of a space allocated for them, and thus remain safe. 5. Movement registers, attendance registers help monitor children's location. 6. The functional relationship between the centre and the construction site officials helps ensure the safety and protection of the children at the centre. 7. Certain systematic measures such as child protection forms, visitor screenings and security cameras were present, although their sustained use was questionable.
2.	Nutrition	1. There is a general consistency in all narratives about the items provided as food. 2. There is a general consistency that the food is nutritious and the quantity of food served per helping is more than adequate for the children. 3. Narratives suggest that both children and parents find the food nutritious and healthy but also monotonous as it is either Khichdi or Daliya. 4. Some significant nutritional improvements mentioned by both community and officials, such as using different types of vegetables. It was appreciated by the community. 5. Fruits, vegetables, nuts and millets further add to the nutritional spectrum. 6. There are certain inconsistencies when it comes to the provision of milk, eggs and nutritional mixes, in terms of the recipient children group. 7. While the menu is nutritious, observations in the field showcase children might be dissatisfied with the repetitive menu, especially for lunch. 8. There is a lack of a change in the nutritional structure to accommodate for the effects of a pandemic on children. Immunity boosting foods do not seem to be a component of the ascribed food plan.

S. No:	Objective	Inference
3.	Nutritional Counselling	1. Activities related to nutritional counselling are held regularly as per mandate. 2. Community testifies to attending and benefiting from it. 3. As per officials, the mothers are pressed for time to cook and also lack access to a kitchen in the labour colony which leads to lack of quality food. 4. While the mothers testify to having cooked the meals as advised, the responses seem narrated across centres and pose concerns of authenticity. 5. Given the unique socio-economic and environmental characteristics of the parents and children, they continue to look up to the food served at the centre. 6. The children's liking of the centre food is an important factor in terms of the mothers responding to the centre's nutrition advice through their home cooking. Mothers are more inclined to cook food similar to the one fed at the centre when their children ask them to. 7. The nutrition specific mixes are not home cooking friendly, even though they seem to be an integral part of the nutritional programme. While kits are provided during lockdown, there is a lack of alternatives otherwise. 8. PDP methods, flashcards and other meeting structures do not seem to take the living conditions of the labourers into consideration. The inhumane living conditions make adhering to any of the narrative counselling components almost impossible. Additionally, in some centres of Bangalore, communication with the migrant labour community was limited due to language barriers. The labourers were from West Bengal, Uttar Pradesh, Bihar and Jharkhand and the staff were from Karnataka and hence, they had some limitations in communication. 9. Although centre staff have noted that mothers do not cater to their children enough, there needs to be more sensitivity training in terms of understanding the different communities, and their situations, that comprise these labour camps.
4.	Medical Support for Children	1. Although supplements are given as part of the general nutritional plan, there doesn't seem to be an allocation for malnourished children. 2. Awareness of these supplements seem to not be prominent among the mothers. Educating the parents in this regard may prove useful. 3. The health cards used at the centres are very extensive in terms of the medical details it can enclose, and it also suggests to be useful in cases of relocation of children to other DMC supported construction sites. The older cards recorded only weight for determining the status of nutrition. The new cards being issued to children who are registering anew have both weight and height for determining the status of nutrition. Systematically, these cards can prove to be immensely beneficial in monitoring and assisting the growth of the children, but its effective usage in practice could not be observed to a satisfactory level.

S. No:	Objective	Inference
4.	Medical Support for Children	4. Multiple registers are maintained, allowing for a solid framework for growth monitoring and medical data collection. 5. Immunisation, and regular counselling efforts for the same, seem to be well in place. COVID vaccination of the children and their parents has been taken up as a priority in terms of medical support by the centres. 6. The medical programme does not have a COVID oriented consultancy/medication component, which might be needed to safely transition into and out of a pandemic-imposed lockdown. Although post lockdown vaccinations are provided, medical support during the lockdown does not have enough clarity.
5.	Support During Lockdowns	1. Provision of dry ration kits for every month is a part of the deliverables mentioned in the grant. According to the testimonies these rations were provided for the children in regular intervals, although the interval time frame could not be completely verified. 2. The ration kits seem to have assisted the families in sustaining nutritional meals for their children, and was appreciated by the community. 3. Hygiene practices have a high focus in light of the pandemic, but these also need to take the living conditions of the labour camps into consideration. The hygiene counselling needs more situational cognizance. 4. The centres were observed to be well organised and well maintained, within the infrastructure provided to them. Basic sanitary protocols appear to be followed.

6.Conclusion

6.1.1. Quantitative

The change in the z- scores of underweight and wasted children coming to the centres regularly for two months or more suggests positive impact from MCD's ECCD program. The change can be more significantly observed if a child stays at the centre for a longer duration (in this case up to 11 months). This findings is also corroborated with the first component of primary survey data analysis that suggests a low proportion of children being malnourished. This can be attributed to the duration of stay at the centre as only those parents were interviewed whose children came to the centres for a minimum of two months.

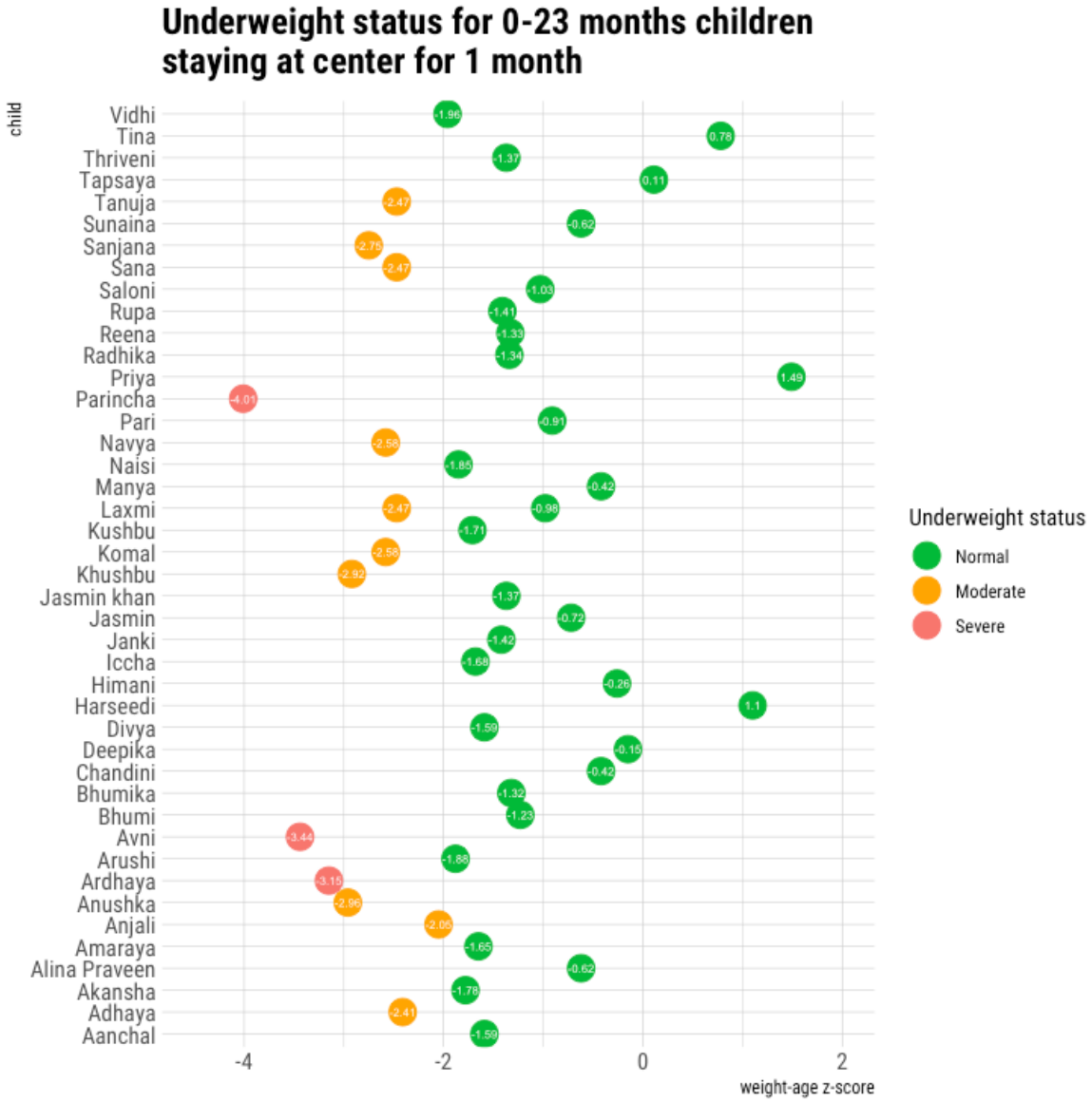
Further, it can be inferred that the meals and supplementary nutrition provided through the program plays a significant role in positively impacting adequate levels of nutrition. Supplementary nutrition along with regular health check-ups further plays a complementary role as creating safety nets for these children who belong to economically underprivileged communities. The regularity in children attending the centres and consuming all three meals testifies for the well-designed framework of the program. However, the knowledge and awareness of mothers with respect to the better caregiving practices, hygiene habits and healthy cooking remains an area to be worked upon that is reflected by their limited awareness on the kind and frequency of supplementary nutrition being given to the

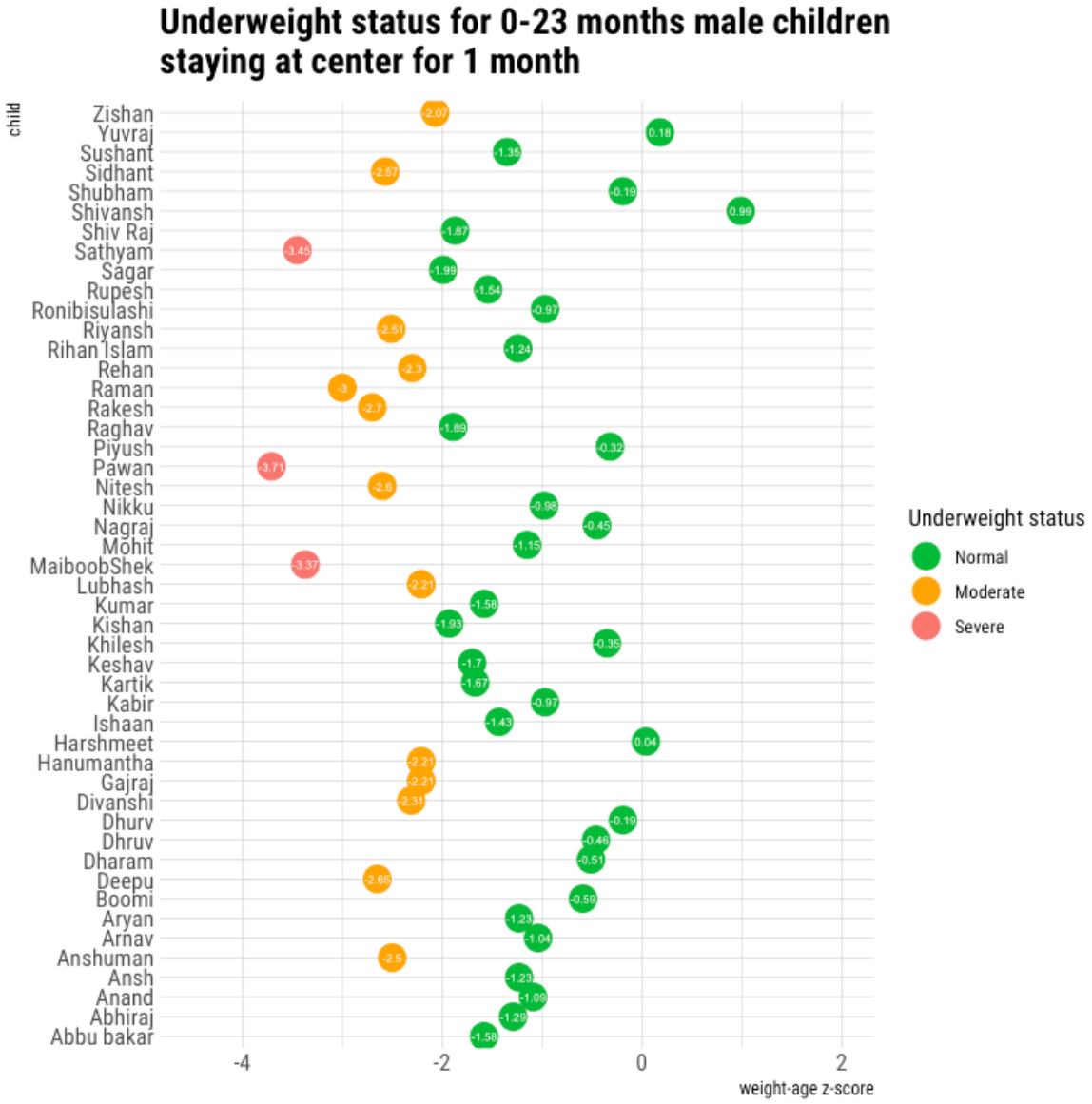
children in the form of iron supplements, bananas, eggs, etc. The need to generate awareness and inculcate better caregiving practices by the mothers is imperative as these families belong to the informal sector migrating population in India wherein their nature of work and living conditions change frequently. In absence of the nutritious meals provided by Project Poshan, the awareness, attitude and practice level of parents supported by their economic conditions would secure and sustain better nutritional outcomes in children.

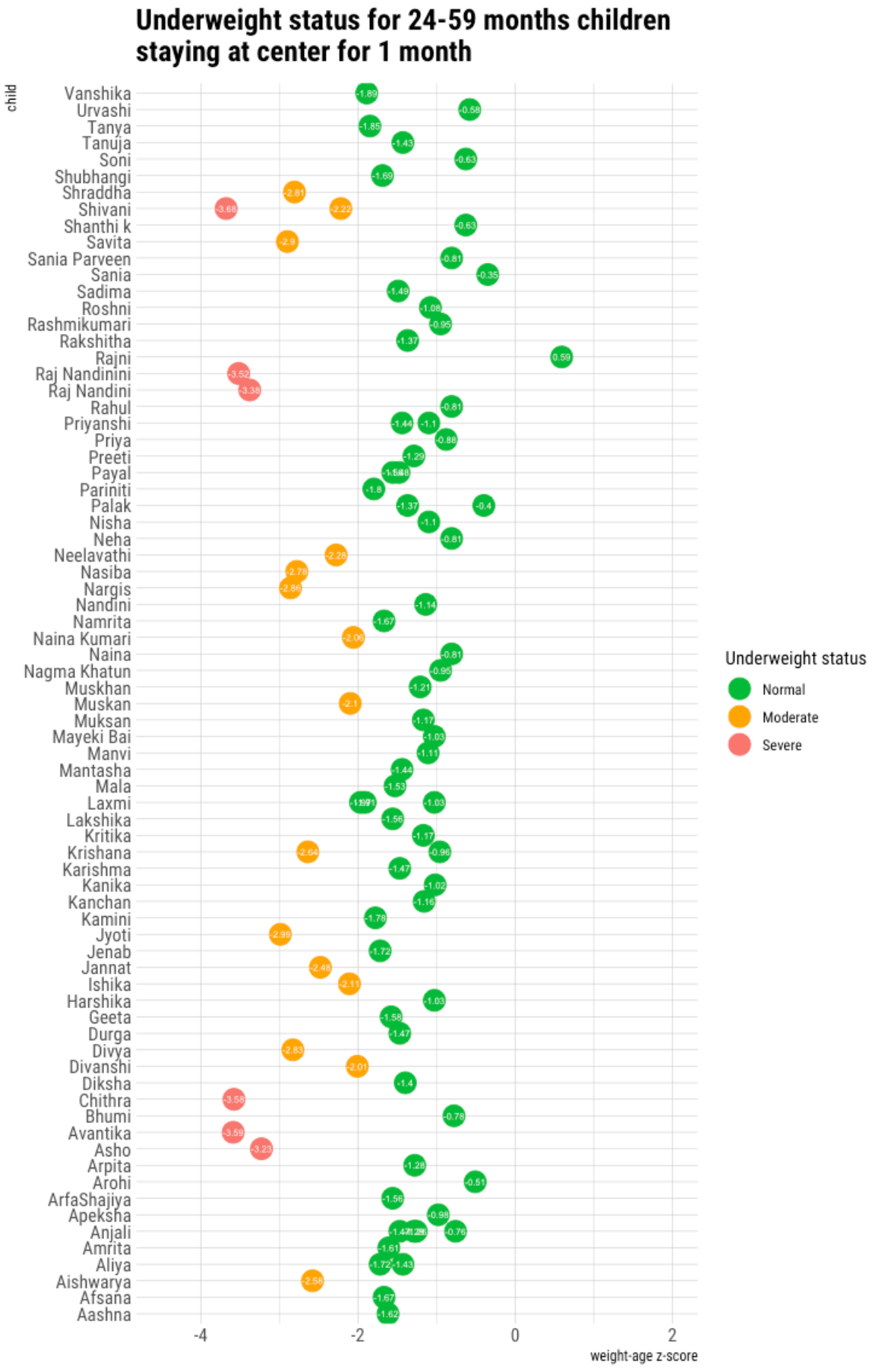
6.2.2. Conclusions on the practice level of the officials and knowledge, attitude and practice level of mothers from the labour community:

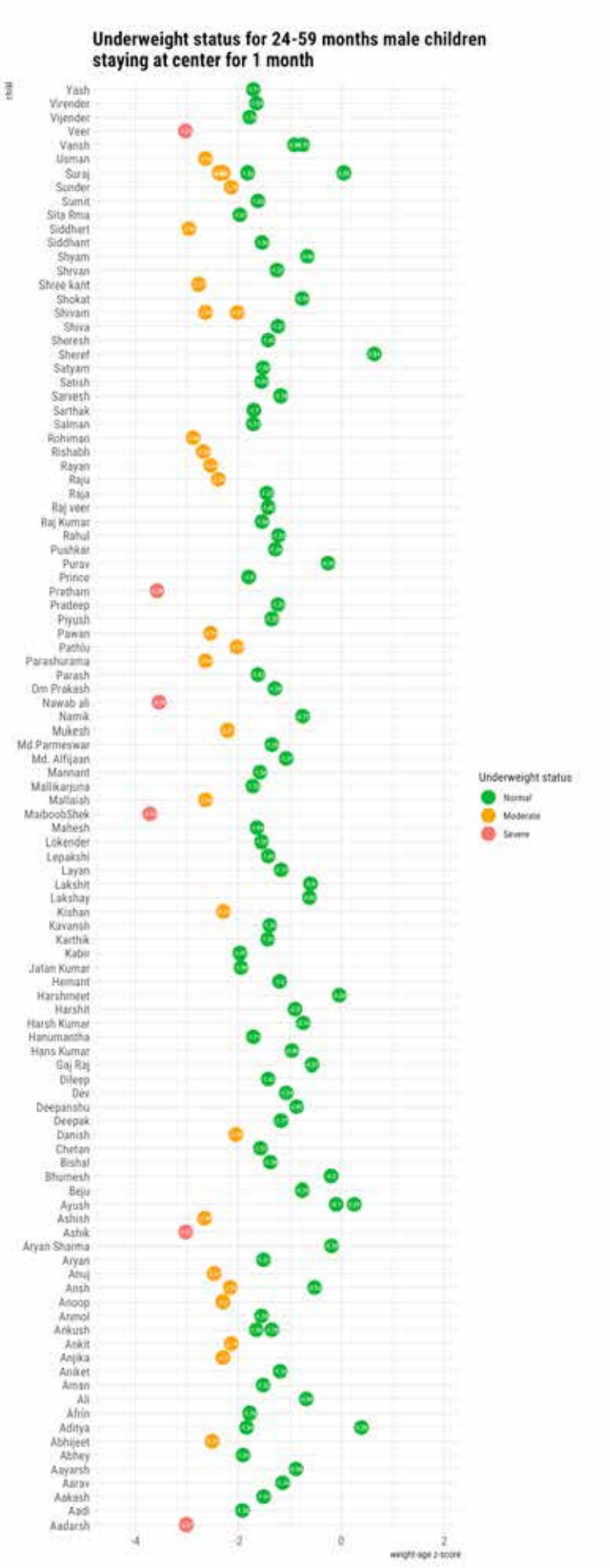
1. The centres have systems in place to provide a safe and secure environment for the children of labourers engaged with construction work in the vicinity of the construction site. The centre is at a convenient distance from the labour colony and far enough from the hazardous construction site. The staff at the centres are responsible and look after the safety of children.
2. The centre staff are organised with their nutritional services and serve hygienic and nutritious food in a timely fashion to the beneficiaries.
3. The centres provide basic medical support to identify incidences of malnourishment and other medical issues of the children, as well as provide vaccination services for the children. In cases of serious medical issues staff support parents to access comprehensive medical care at the hospitals.
4. The officials of the centre worked hard to continue with the delivery of services even during the lockdown.
5. The centre staff organises training and discussions on nutrition regularly but the efficacy of such activities does not always translate into a practice amongst mothers or parents in general. Parents continue to remain dependent on the nutritious food supplied at the centre. Inability of the parents to practice cooking healthy and nutritious food can also be associated with lack of time and space to cook at the labour colony as the amenities in the colony are limited and the parents are pressed for time after engaging in hard physical labour. One can safely conclude that the community is yet to take strong nutritional decisions although the responsible officials continue to put in their efforts.

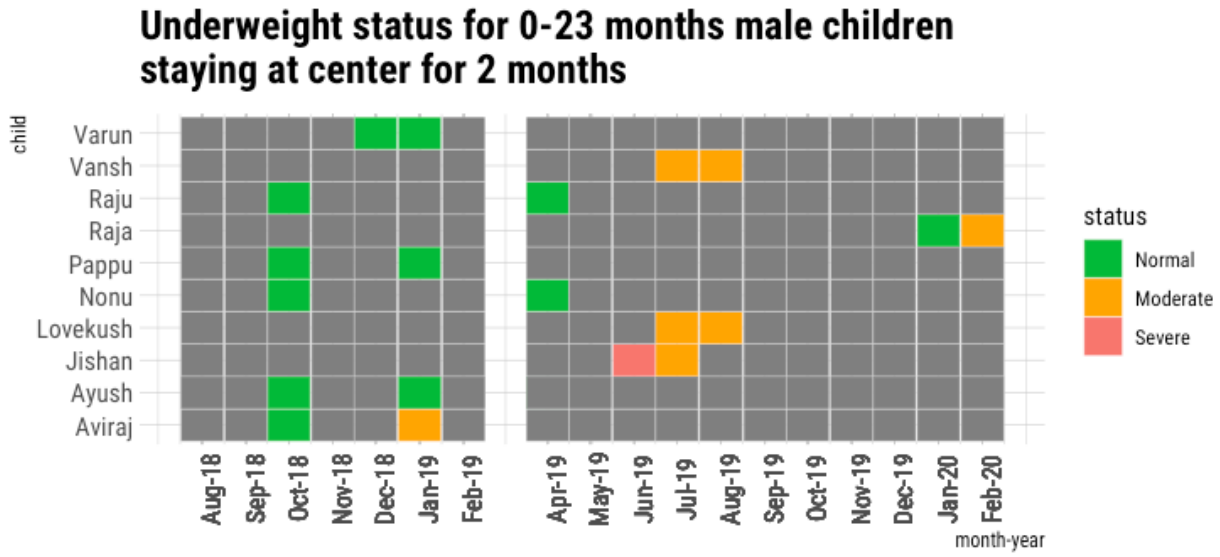
ANNEXURE A

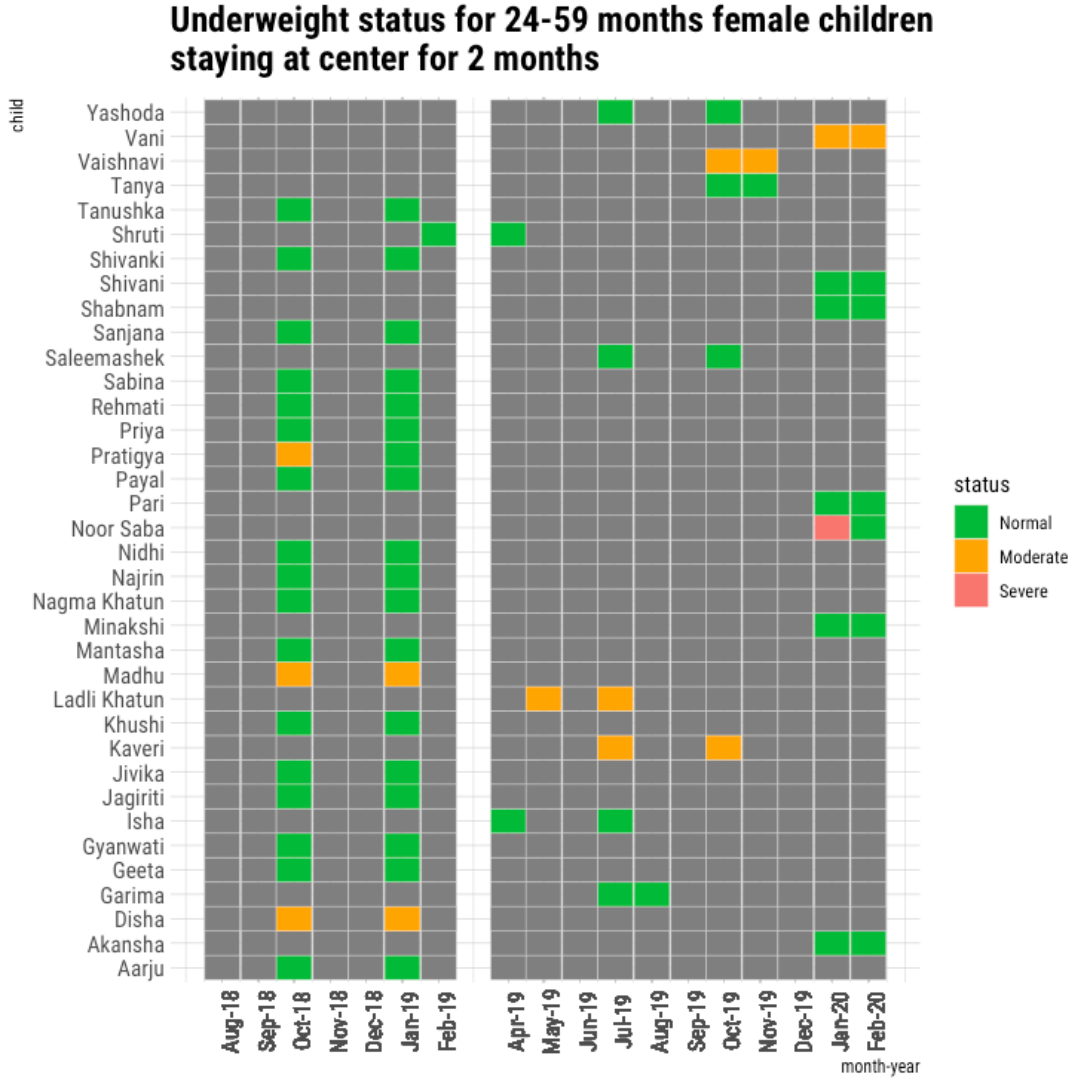

Underweight status for 0-23 months children staying at center for 1 month
child
Vidhi
Tina
Thriveni
Tapsaya
Tanuja
Sunaina
Sanjana
Sana
Saloni
Rupa
Reena
Radhika
Priya
Parincha
Pari
Navya
Naisi
Manya
Laxmi
Kushbu
Komal
Khushbu
Jasmin khan
Jasmin
Janki
Iccha
Himani
Harseedi
Divya
Deepika
Chandini
Bhumika
Bhumi
Avni
Arushi
Ardhaya
Anushka
Anjali
Amaraya
Alina Praveen
Akansha
Adhaya
Aanchal
-1.96
0.78
-1.37
0.11
-2.47
-0.62
-2.75
-2.47
-1.03
-1.41
-1.33
-1.34
1.49
-4.01
-0.91
-2.58
-1.88
-0.42
-2.47
-0.98
-1.71
-2.58
-2.92
-1.37
-0.72
-1.42
-1.68
-0.26
1.1
-1.59
-0.16
-0.42
-1.32
-1.23
-3.44
-1.88
-3.15
-2.96
-2.05
-1.65
-0.62
-1.78
-2.41
-1.59
-4
-2
0
2
weight-age z-score
Underweight status
Normal
Moderate
Severe

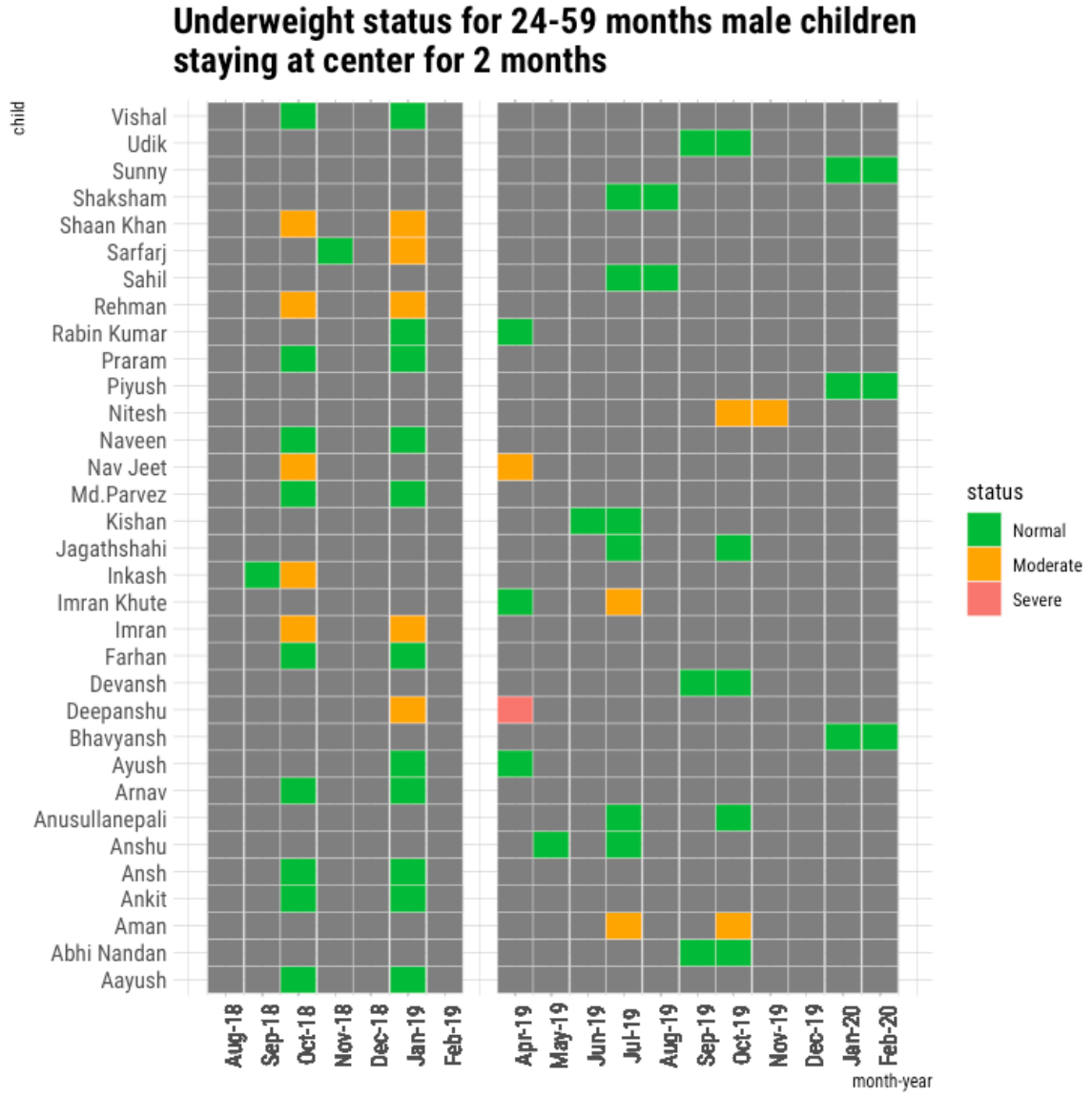

Underweight status for 0-23 months male children staying at center for 1 month
child
Zishan
Yuvraj
Sushant
Sidhant
Shubham
Shivansh
Shiv Raj
Sathyam
Sagar
Rupesh
Ronibisulashi
Riyansh
Rihan Islam
Rehan
Raman
Rakesh
Raghav
Piyush
Pawan
Nitesh
Nikku
Nagraj
Mohit
MaiboobShek
Lubhash
Kumar
Kishan
Khilesh
Keshav
Kartik
Kabir
Ishaan
Harshmeet
Hanumantha
Gajraj
Divanshi
Dhurv
Dhruv
Dharam
Deepu
Boomi
Aryan
Arnav
Anshuman
Ansh
Anand
Abhiraj
Abbu bakar
-2.07
0.18
-1.38
-2.57
-0.19
0.99
-1.87
-3.45
-1.99
-1.54
-0.97
-2.51
-1.24
-2.3
-3
-2.7
-1.89
-0.32
-3.71
-2.6
-0.98
-0.45
-1.15
-3.37
-2.21
-1.58
-1.93
-0.35
-1.7
-1.67
-0.97
-1.43
0.04
-2.21
-2.21
-2.31
-0.19
-0.46
-0.51
-2.65
-0.59
-1.23
-1.04
-2.5
-1.23
-1.09
-1.29
-1.58
-4
-2
0
2
weight-age z-score
Underweight status
Normal
Moderate
Severe

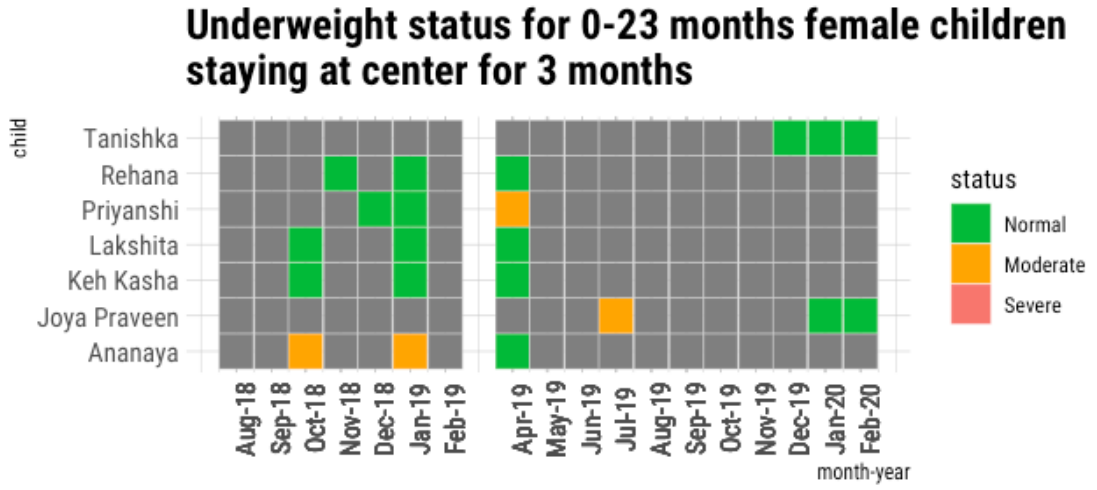

Underweight status for 24-59 months children staying at center for 1 month
child
Vanshika
Urvashi
Tanya
Tanuja
Soni
Shubhangi
Shraddha
Shivani
Shanthi k
Savita
Sania Parveen
Sania
Sadima
Roshni
Rashmikumari
Rakshitha
Rajni
Raj Nandinini
Raj Nandini
Rahul
Priyanshi
Priya
Preeti
Payal
Pariniti
Palak
Nisha
Neha
Neelavathi
Nasiba
Nargis
Nandini
Namrita
Naina Kumari
Naina
Nagma Khatun
Muskhan
Muskan
Muksan
Mayeki Bai
Manvi
Mantasha
Mala
Laxmi
Lakshika
Kritika
Krishana
Karishma
Kanika
Kanchan
Kamini
Jyoti
Jenab
Jannat
Ishika
Harshika
Geeta
Durga
Divya
Divanshi
Diksha
Chithra
Bhumi
Avantika
Asho
Arpita
Arohi
ArfaShajiya
Apeksha
Anjali
Amrita
Aliya
Aishwarya
Afsana
Aashna
-4
-2
0
2
weight-age z-score
Underweight status
Normal
Moderate
Severe

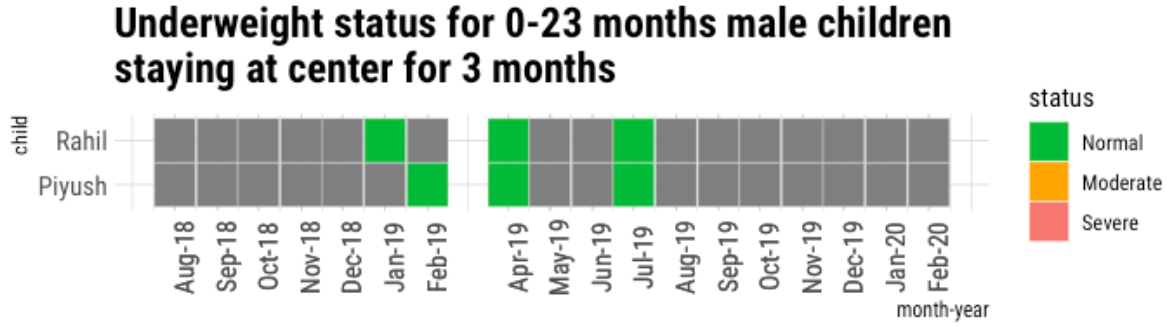

Underweight status for 24-59 months male children staying at center for 1 month
child
Yash
Virender
Vijender
Veer
Vansh
Usman
Suraj
Sunder
Sumit
Sita Rma
Siddhart
Siddhant
Shyam
Shrvan
Shree kant
Shokat
Shivam
Shiva
Sheresh
Sheref
Satyam
Satish
Sarvesh
Sarthak
Salman
Rohiman
Rishabh
Rayan
Raju
Raja
Raj veer
Raj Kumar
Rahul
Pushkar
Purav
Prince
Pratham
Pradeep
Piyush
Pawan
Pathlu
Parashurama
Parash
Om Prakash
Nawab ali
Namik
Mukesh
Md Parmeswar
Md. Alfijaan
Mannant
Mallikarjuna
Mallaish
MaiboobShek
Mahesh
Lokender
Lepakshi
Layan
Lakshit
Lakshay
Kishan
Kavansh
Karthik
Kabir
Jatan Kumar
Hemant
Harshmeet
Harshit
Harsh Kumar
Hanumantha
Hans Kumar
Gaj Raj
Dileep
Dev
Deepanshu
Deepak
Danish
Chetan
Bishal
Bhumesh
Beju
Ayush
Ashish
Ashik
Aryan Sharma
Aryan
Anuj
Ansh
Anoop
Anmol
Ankush
Ankit
Anjika
Aniket
Aman
Ali
Afrin
Aditya
Abhijeet
Abhey
Aayarsh
Aarav
Aakash
Aadi
Aadarsh
-4
-2
0
2
weight-age z-score
Underweight status
Normal
Moderate
Severe


Underweight status for 0-23 months male children staying at center for 2 months
child
Varun
Vansh
Raju
Raja
Pappu
Nonu
Lovekush
Jishan
Ayush
Aviraj
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
month-year
status
Normal
Moderate
Severe

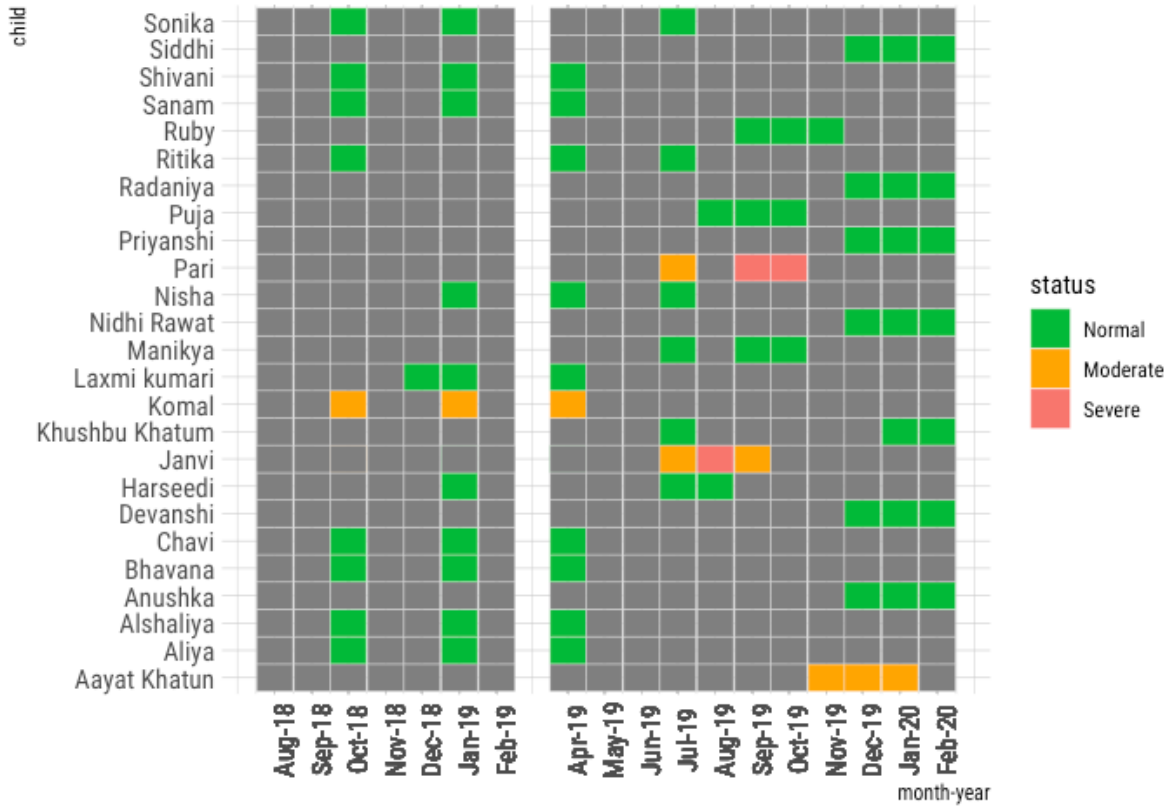

Underweight status for 24-59 months female children staying at center for 2 months
child
Yashoda
Vani
Vaishnavi
Tanya
Tanushka
Shruti
Shivanki
Shivani
Shabnam
Sanjana
Saleemashek
Sabina
Rehmati
Priya
Pratigya
Payal
Pari
Noor Saba
Nidhi
Najrin
Nagma Khatun
Minakshi
Mantasha
Madhu
Ladli Khatun
Khushi
Kaveri
Jivika
Jagiriti
Isha
Gyanwati
Geeta
Garima
Disha
Akansha
Aarju
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
month-year
status
Normal
Moderate
Severe

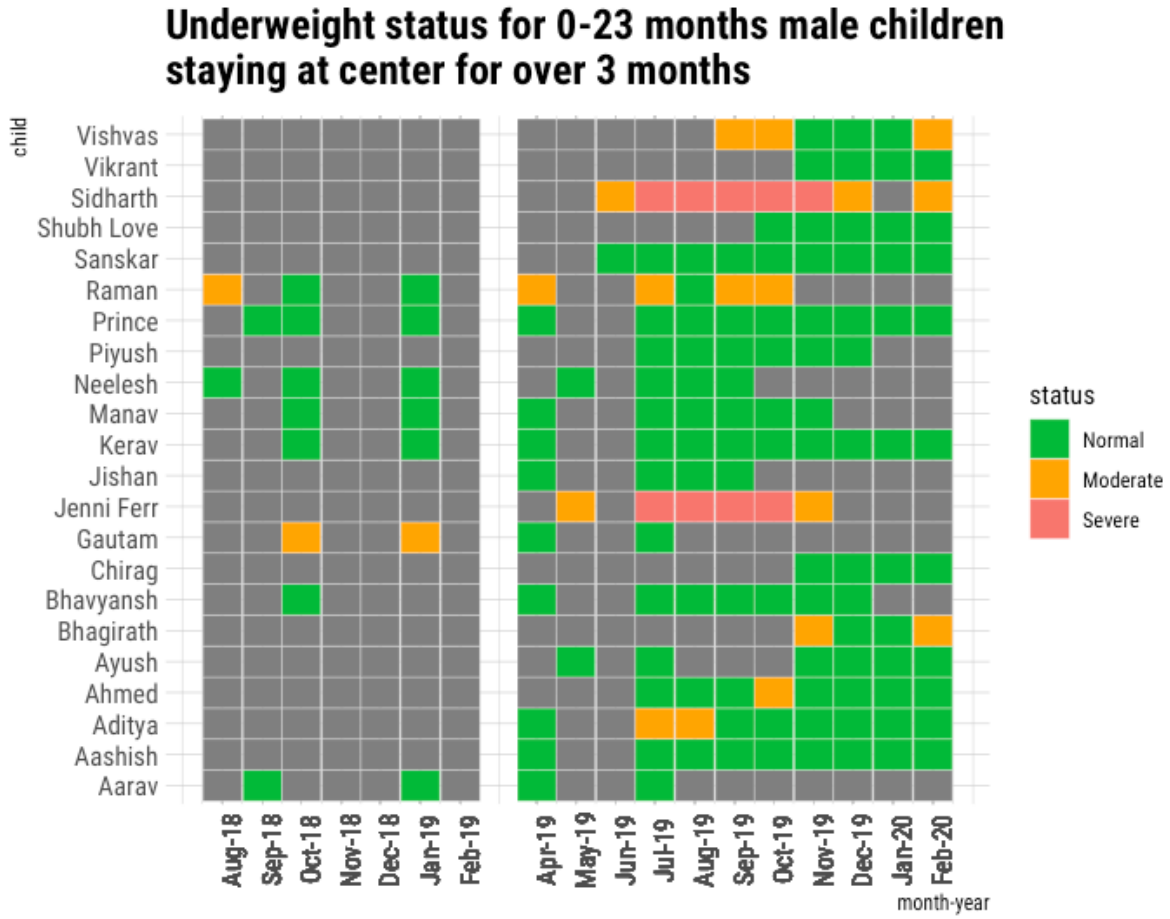

Underweight status for 24-59 months male children staying at center for 2 months
child
Vishal
Udik
Sunny
Shaksham
Shaan Khan
Sarfarj
Sahil
Rehman
Rabin Kumar
Praram
Piyush
Nitesh
Naveen
Nav Jeet
Md.Parvez
Kishan
Jagathshahi
Inkash
Imran Khute
Imran
Farhan
Devansh
Deepanshu
Bhavyansh
Ayush
Arnav
Anusullanepali
Anshu
Ansh
Ankit
Aman
Abhi Nandan
Aayush
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
month-year
status
Normal
Moderate
Severe


Underweight status for 0-23 months female children staying at center for 3 months
child
Tanishka
Rehana
Priyanshi
Lakshita
Keh Kasha
Joya Praveen
Ananaya
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
month-year
status
Normal
Moderate
Severe

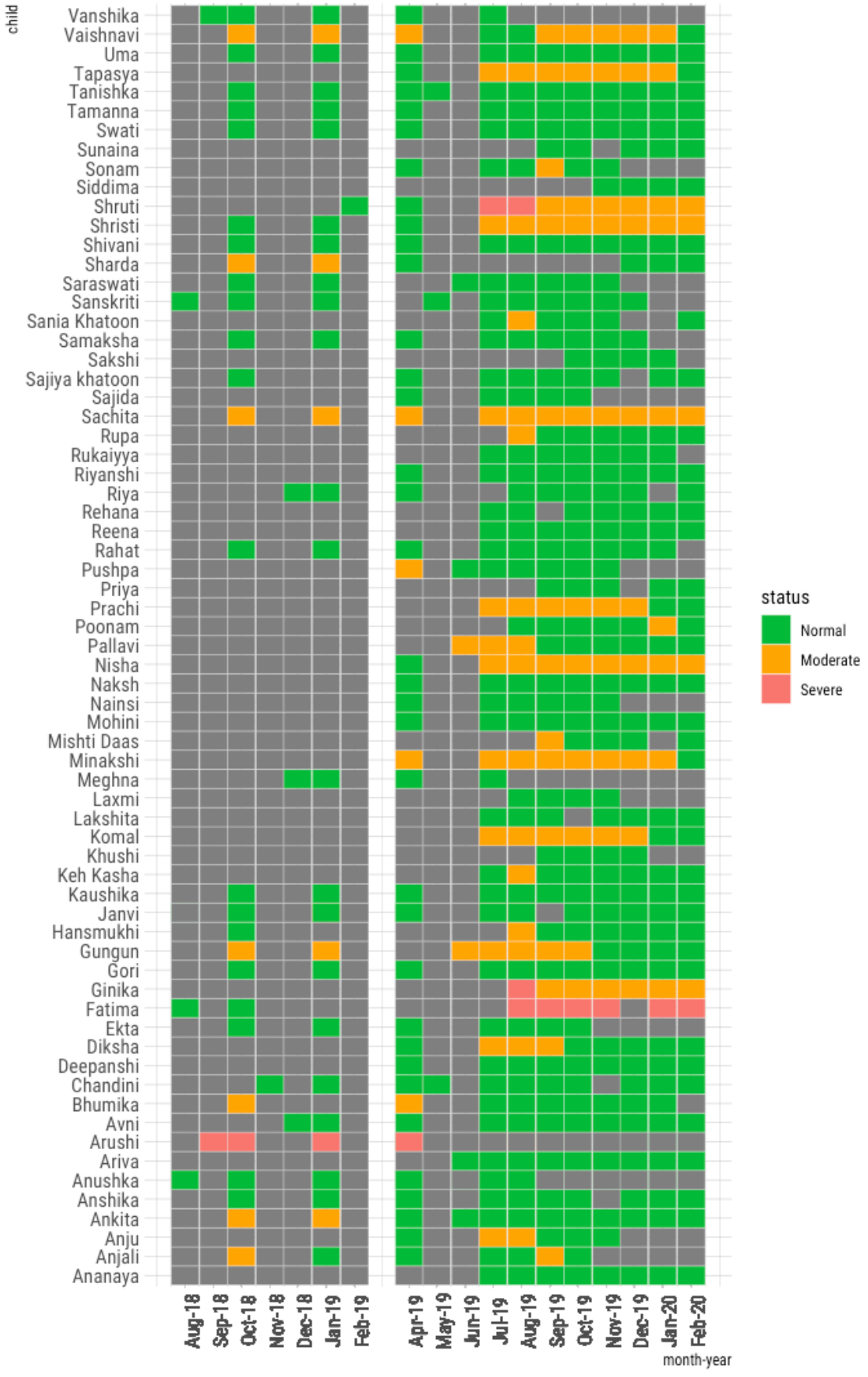

Underweight status for 0-23 months male children staying at center for 3 months
child
Rahil
Piyush
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
month-year
status
Normal
Moderate
Severe

Underweight status for 24-59 months female children staying at center for 3 months

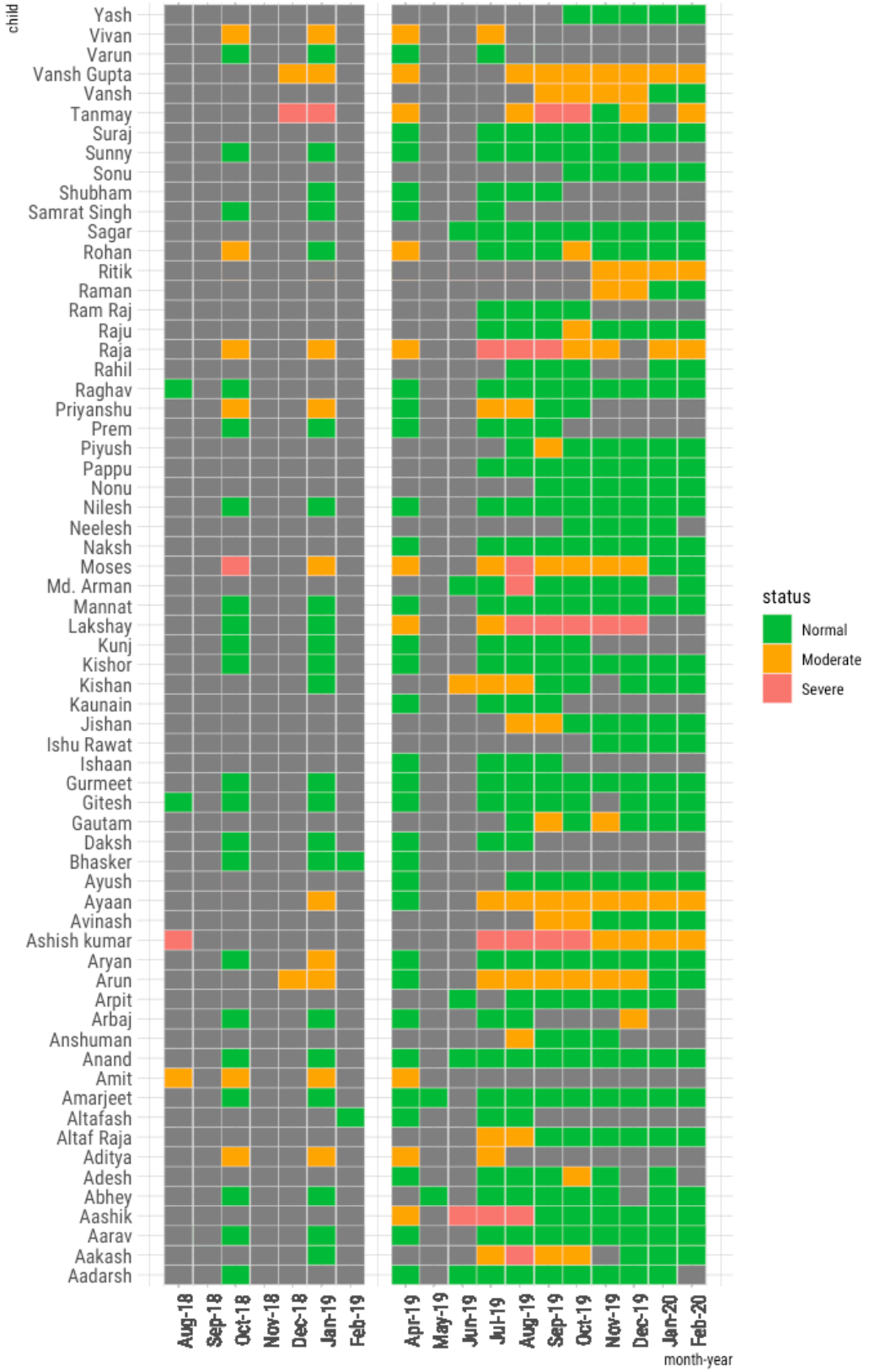


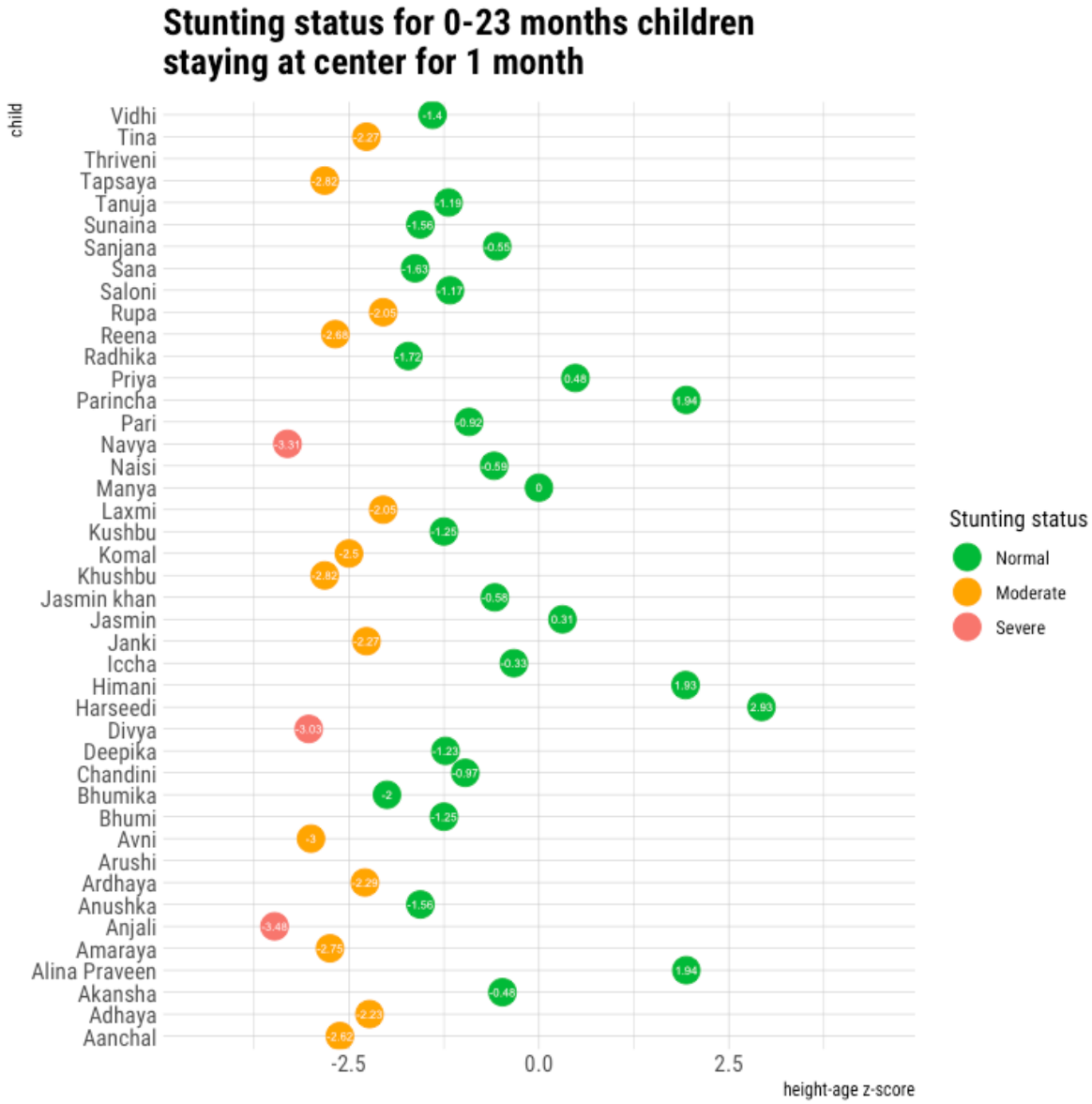

Underweight status for 0-23 months male children staying at center for over 3 months
child
Vishvas
Vikrant
Sidharth
Shubh Love
Sanskar
Raman
Prince
Piyush
Neelesh
Manav
Kerav
Jishan
Jenni Ferr
Gautam
Chirag
Bhavyansh
Bhagirath
Ayush
Ahmed
Aditya
Aashish
Aarav
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
month-year
status
Normal
Moderate
Severe

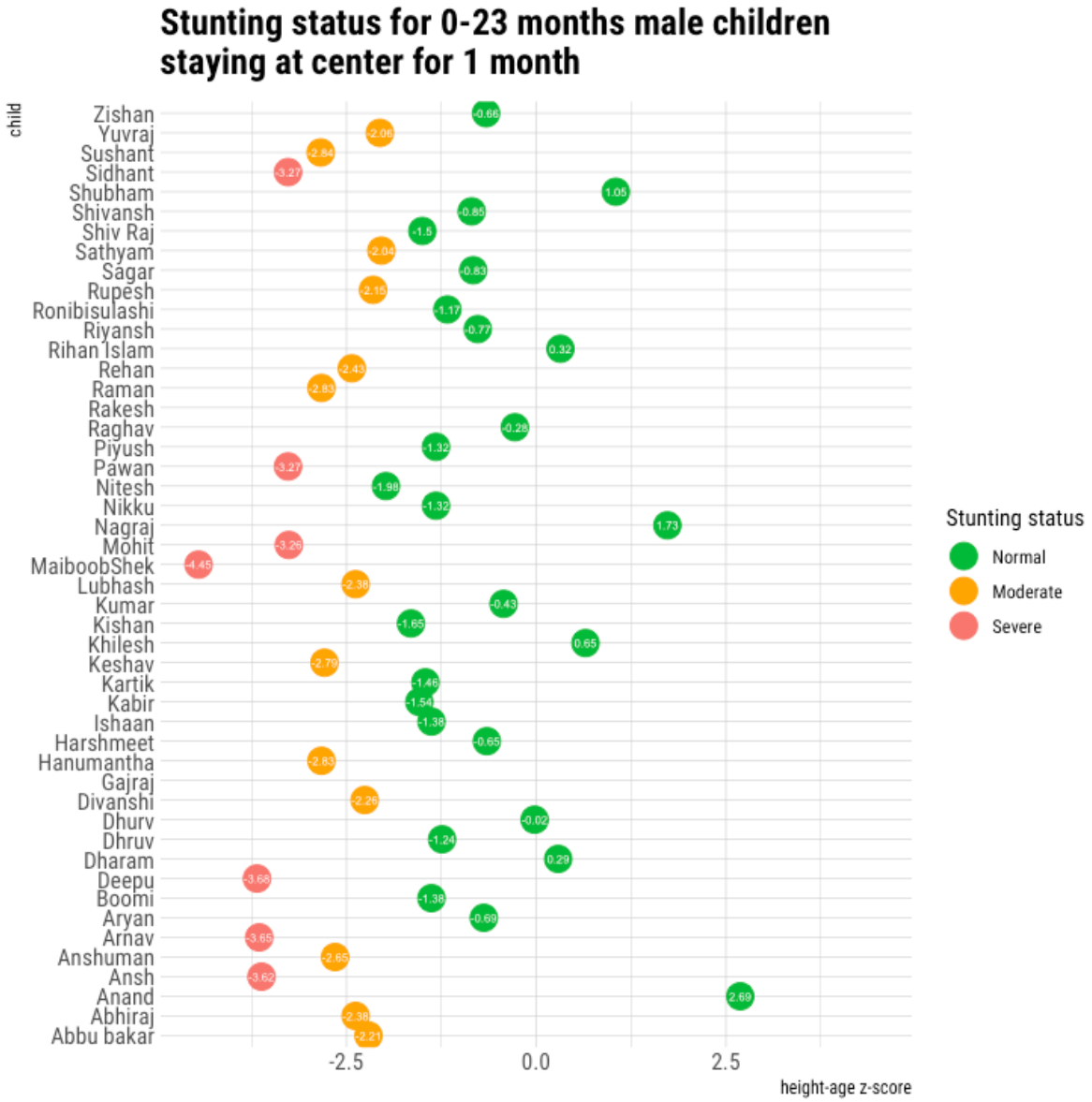
Underweight status for 24-59 months female children staying at center for over 3 months

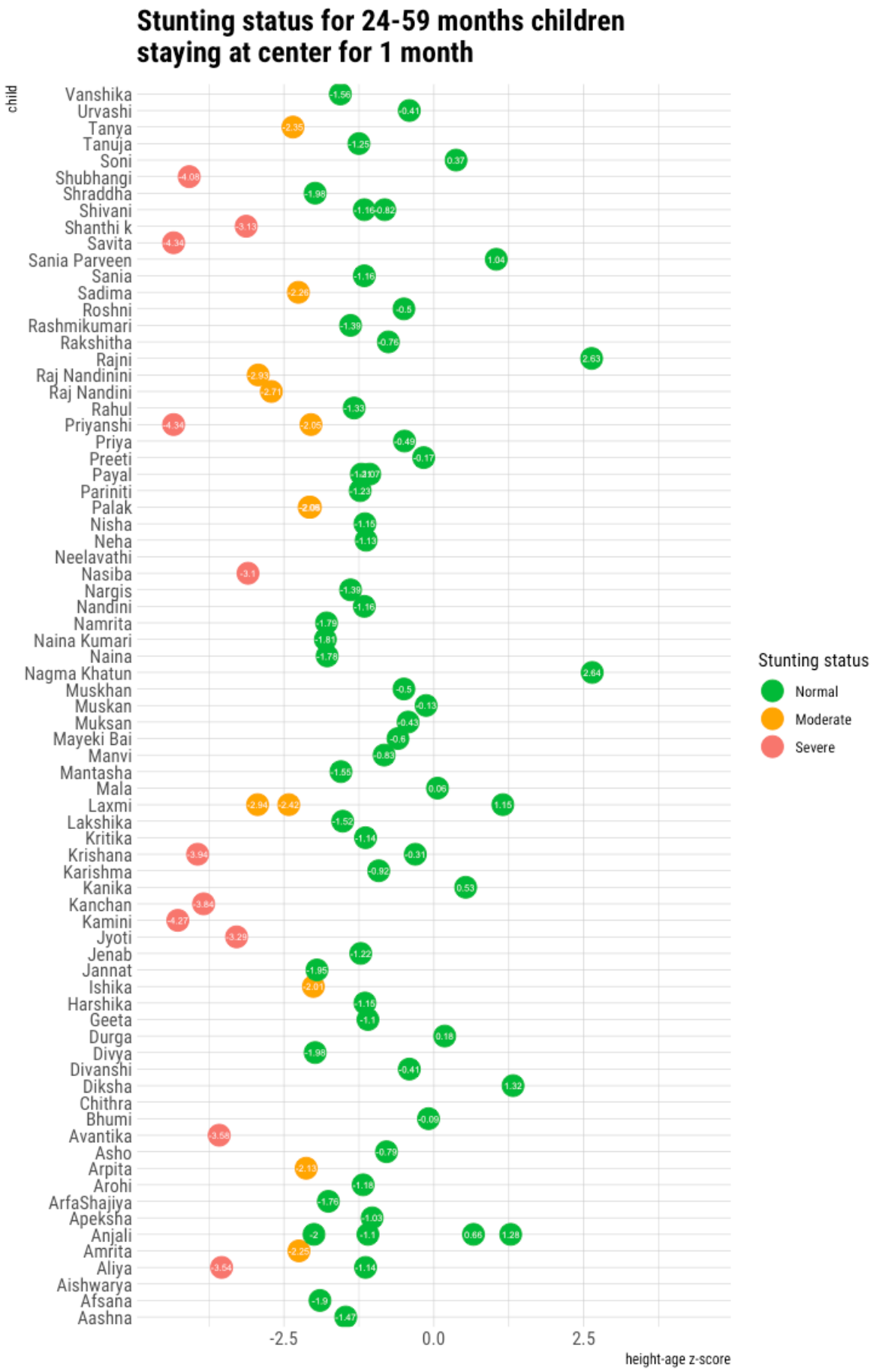


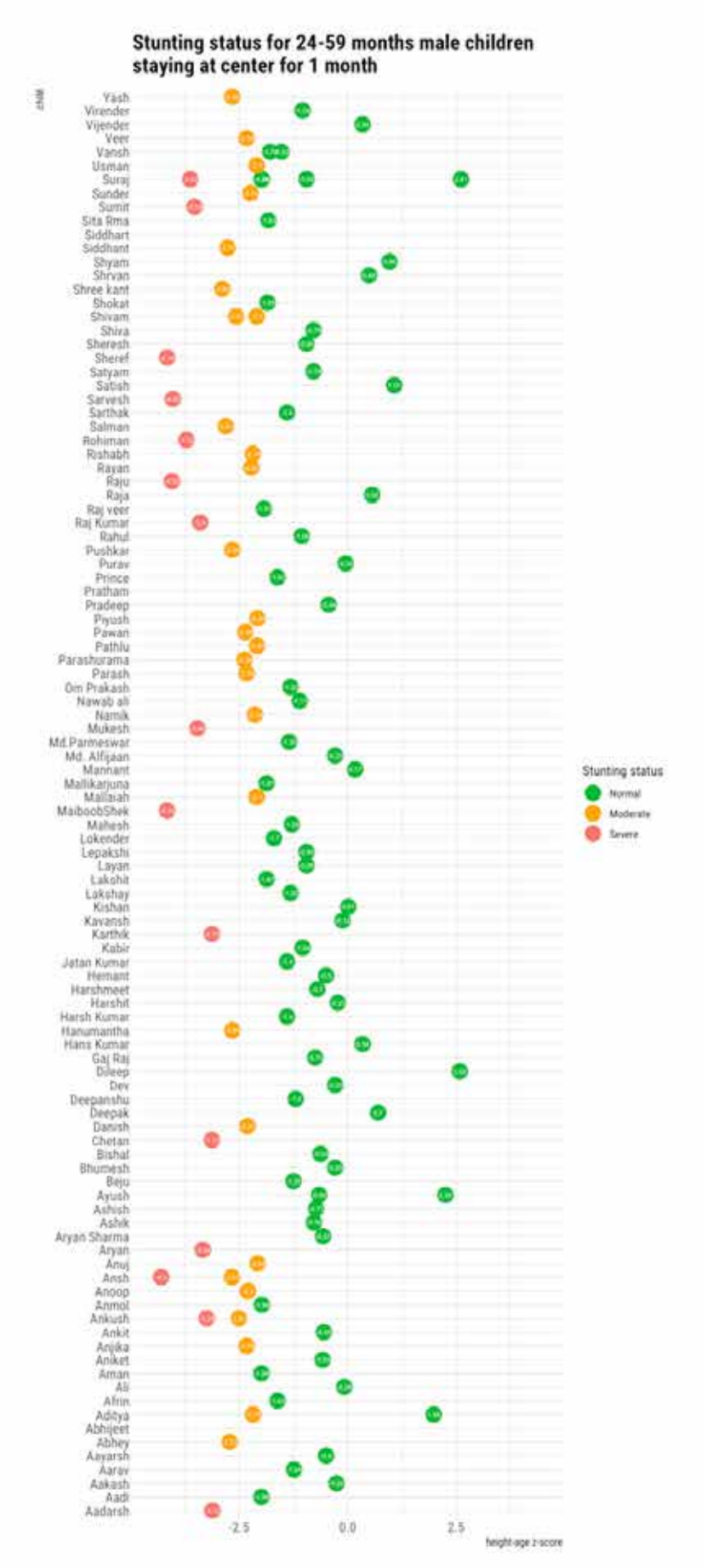
Underweight status for 24-59 months male children staying at center for over 3 months



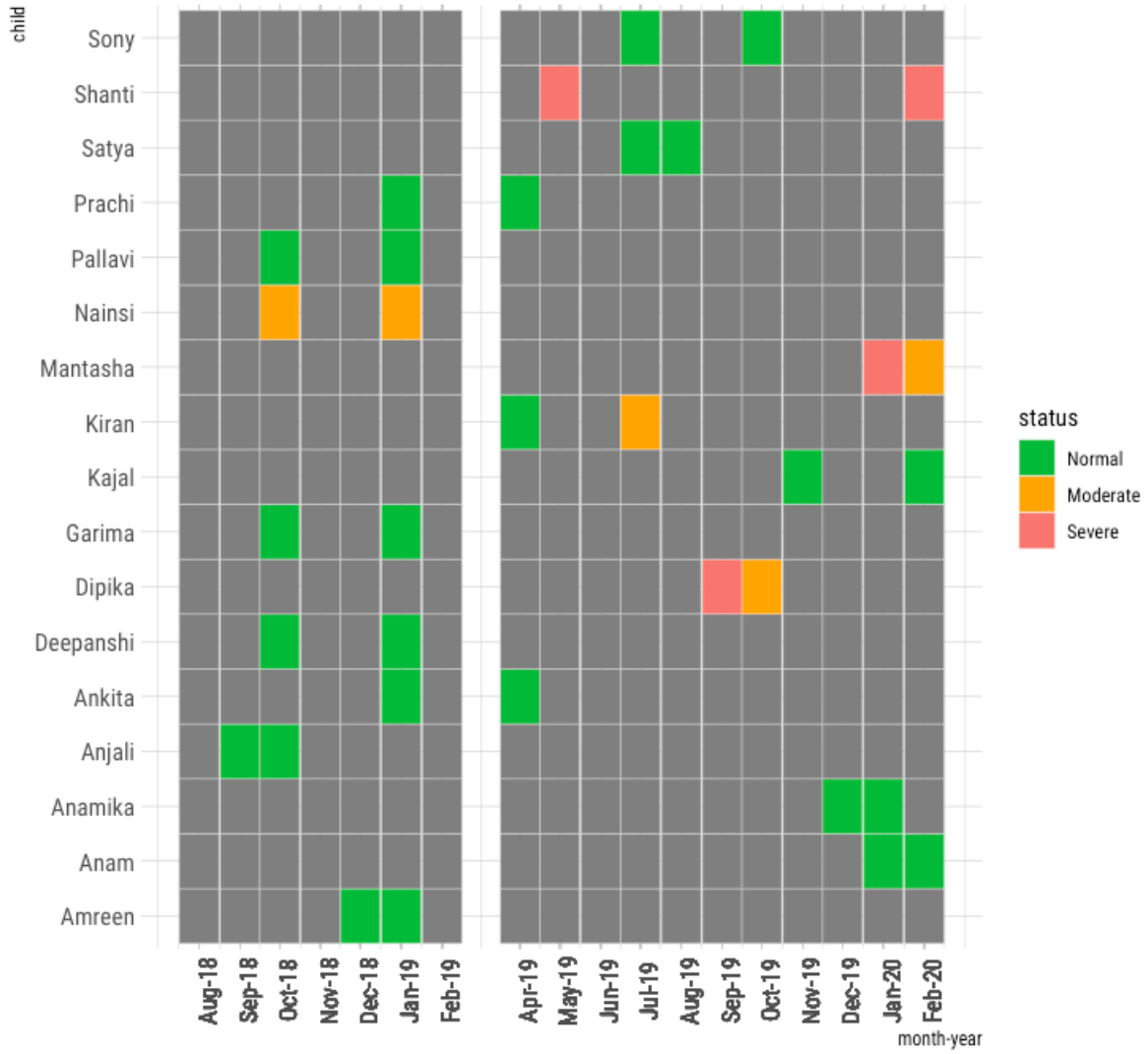

Stunting status for 0-23 months children staying at center for 1 month
child
Vidhi
Tina
Thriveni
Tapsaya
Tanuja
Sunaina
Sanjana
Sana
Saloni
Rupa
Reena
Radhika
Priya
Parincha
Pari
Navya
Naisi
Manya
Laxmi
Kushbu
Komal
Khushbu
Jasmin khan
Jasmin
Janki
Iccha
Himani
Harseedi
Divya
Deepika
Chandini
Bhumika
Bhumi
Avni
Arushi
Ardhaya
Anushka
Anjali
Amaraya
Alina Praveen
Akansha
Adhaya
Aanchal
-1.4
-2.27
-2.82
-1.19
-1.56
-0.56
-1.63
-1.17
-2.05
-2.68
-1.72
0.48
1.94
-0.92
-3.31
-0.59
0
-2.05
-1.25
-2.5
-2.82
-0.58
0.31
-2.27
-0.33
1.93
2.93
-3.03
-1.23
-0.97
-2
-1.25
-3
-2.29
-1.56
-3.48
-2.75
1.94
-0.48
-2.23
-2.62
-2.5
0.0
2.5
height-age z-score
Stunting status
Normal
Moderate
Severe


Stunting status for 0-23 months male children staying at center for 1 month
child
Zishan
Yuvraj
Sushant
Sidhant
Shubham
Shivansh
Shiv Raj
Sathyam
Sagar
Rupesh
Ronibisulashi
Riyansh
Rihan Islam
Rehan
Raman
Rakesh
Raghav
Piyush
Pawan
Nitesh
Nikku
Nagraj
Mohit
MaiboobShek
Lubhash
Kumar
Kishan
Khilesh
Keshav
Kartik
Kabir
Ishaan
Harshmeet
Hanumantha
Gajraj
Divanshi
Dhurv
Dhruv
Dharam
Deepu
Boomi
Aryan
Arnav
Anshuman
Ansh
Anand
Abhiraj
Abbu bakar
-0.66
-2.06
-2.84
-3.27
1.05
-0.85
-1.5
-2.04
-0.83
-2.15
-1.17
-0.77
0.32
-2.43
-2.83
-0.28
-1.32
-3.27
1.98
-1.32
1.73
-3.26
-4.45
-2.38
-0.43
-1.65
0.65
-2.79
-1.46
-1.54
-1.38
-0.65
-2.83
-2.26
-0.02
-1.24
0.29
-3.68
-1.38
-0.69
-3.65
-2.65
-3.62
2.69
-2.38
-2.21
-2.5
0.0
2.5
height-age z-score
Stunting status
Normal
Moderate
Severe

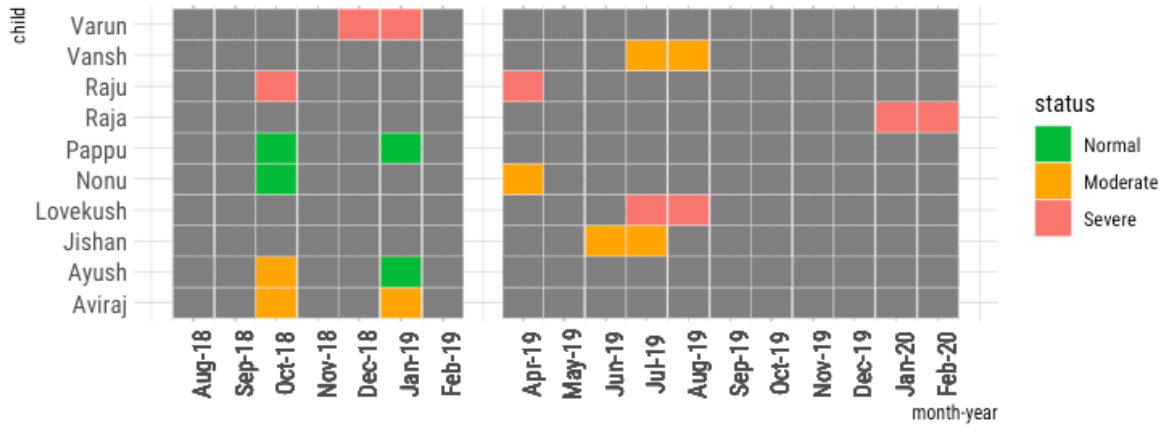

Stunting status for 24-59 months children staying at center for 1 month
child
Vanshika
Urvashi
Tanya
Tanuja
Soni
Shubhangi
Shraddha
Shivani
Shanthi k
Savita
Sania Parveen
Sania
Sadima
Roshni
Rashmikumari
Rakshitha
Rajni
Raj Nandinini
Raj Nandini
Rahul
Priyanshi
Priya
Preeti
Payal
Pariniti
Palak
Nisha
Neha
Neelavathi
Nasiba
Nargis
Nandini
Namrita
Naina Kumari
Naina
Nagma Khatun
Muskhan
Muskan
Muksan
Mayeki Bai
Manvi
Mantasha
Mala
Laxmi
Lakshika
Kritika
Krishana
Karishma
Kanika
Kanchan
Kamini
Jyoti
Jenab
Jannat
Ishika
Harshika
Geeta
Durga
Divya
Divanshi
Diksha
Chithra
Bhumi
Avantika
Asho
Arpita
Arohi
ArfaShajiya
Apeksha
Anjali
Amrita
Aliya
Aishwarya
Afsana
Aashna
-2.5
0.0
2.5
height-age z-score
Stunting status
Normal
Moderate
Severe

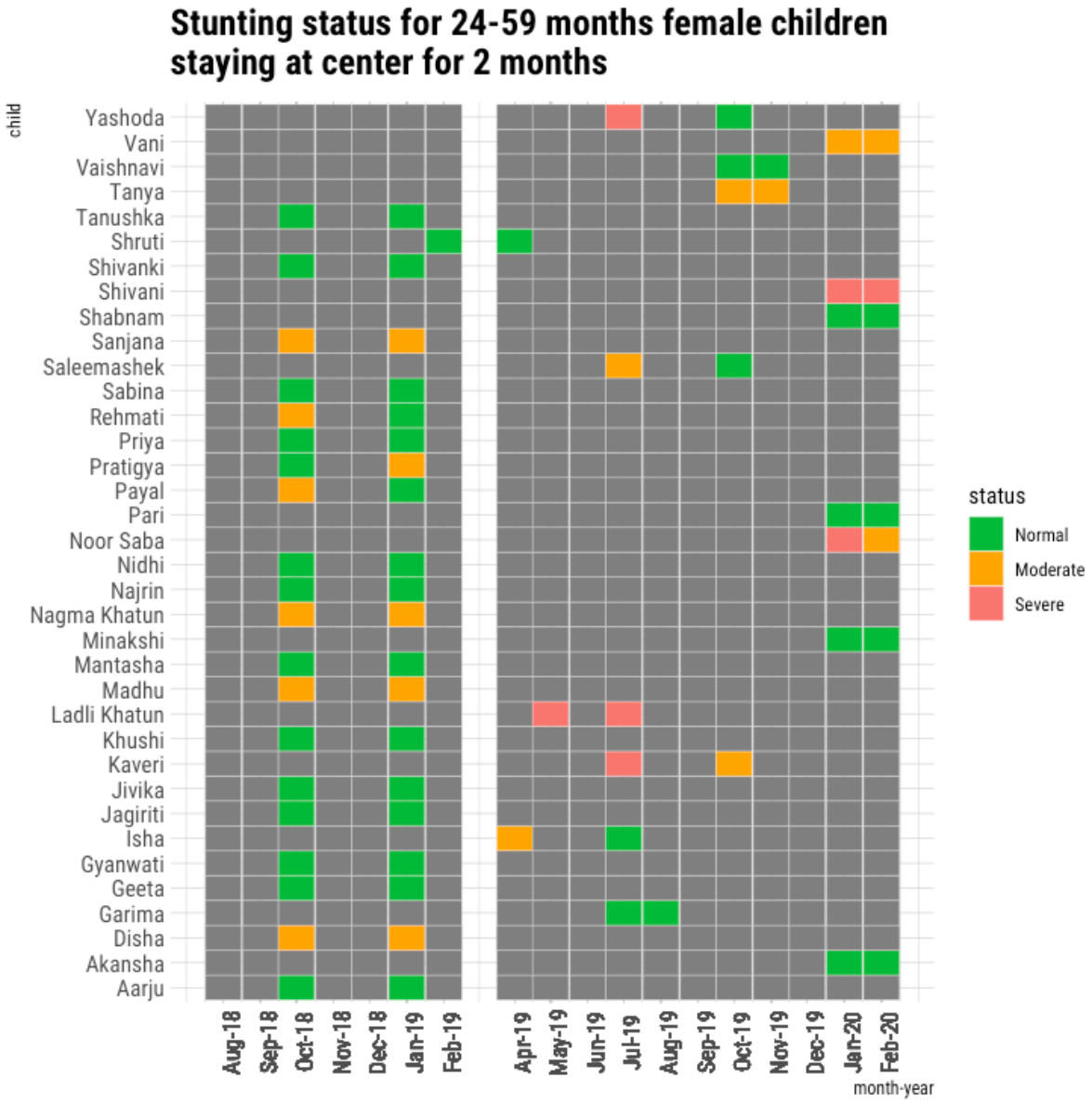

Stunting status for 24-59 months male children staying at center for 1 month
child
Yash
Virender
Vijender
Veer
Vansh
Usman
Suraj
Sunder
Sumit
Sita Rma
Siddhart
Siddhant
Shyam
Shrvan
Shree kant
Shokat
Shivam
Shiva
Sheresh
Sheref
Satyam
Satish
Sarvesh
Sarthak
Salman
Rohiman
Rishabh
Rayan
Raju
Raja
Raj veer
Raj Kumar
Rahul
Pushkar
Purav
Prince
Pratham
Pradeep
Piyush
Pawan
Pathlu
Parashurama
Parash
Om Prakash
Nawab ali
Namik
Mukesh
Md.Parmeswar
Md. Alfijaan
Mannant
Mallikarjuna
Mallaiah
MaiboobShek
Mahesh
Lokender
Lepakshi
Layan
Lakshit
Lakshay
Kishan
Kavansh
Karthik
Kabir
Jatan Kumar
Hemant
Harshmeet
Harshit
Harsh Kumar
Hanumantha
Hans Kumar
Gaj Raj
Dileep
Dev
Deepanshu
Deepak
Danish
Chetan
Bishal
Bhumesh
Beju
Ayush
Ashish
Ashik
Aryan Sharma
Aryan
Anuj
Ansh
Anoop
Anmol
Ankush
Ankit
Anjika
Aniket
Aman
Ali
Afrin
Aditya
Abhijeet
Abhey
Aayarsh
Aarav
Aakash
Aadi
Aadarsh
-2.5
0.0
2.5
height-age z-score
Stunting status
Normal
Moderate
Severe

Stunting status for 0-23 months female children staying at center for 2 months



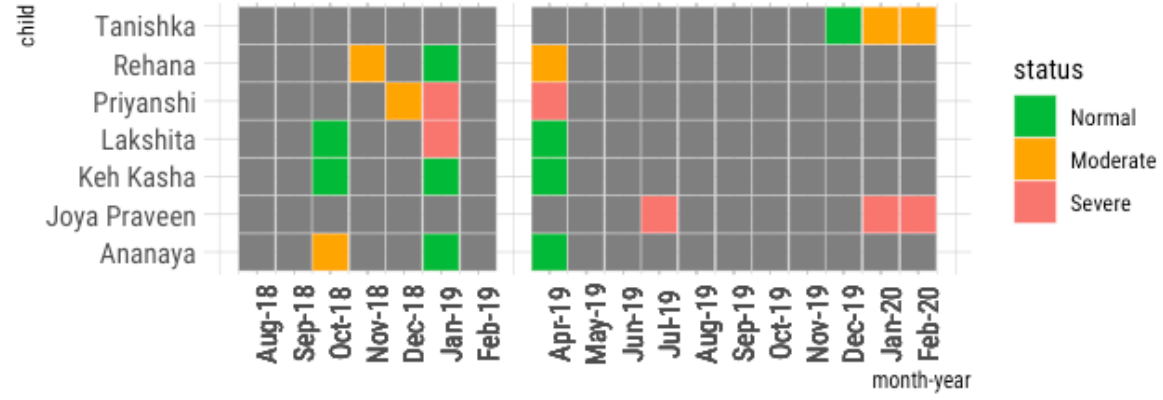
Stunting status for 0-23 months male children staying at center for 2 months

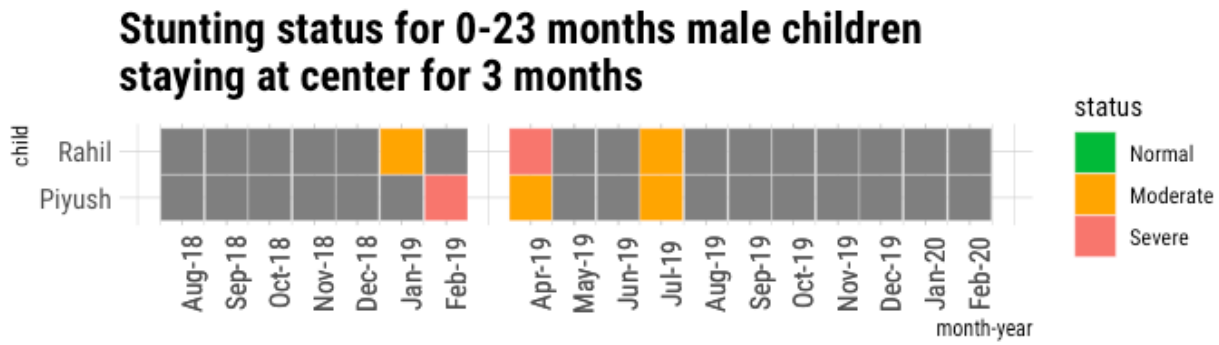


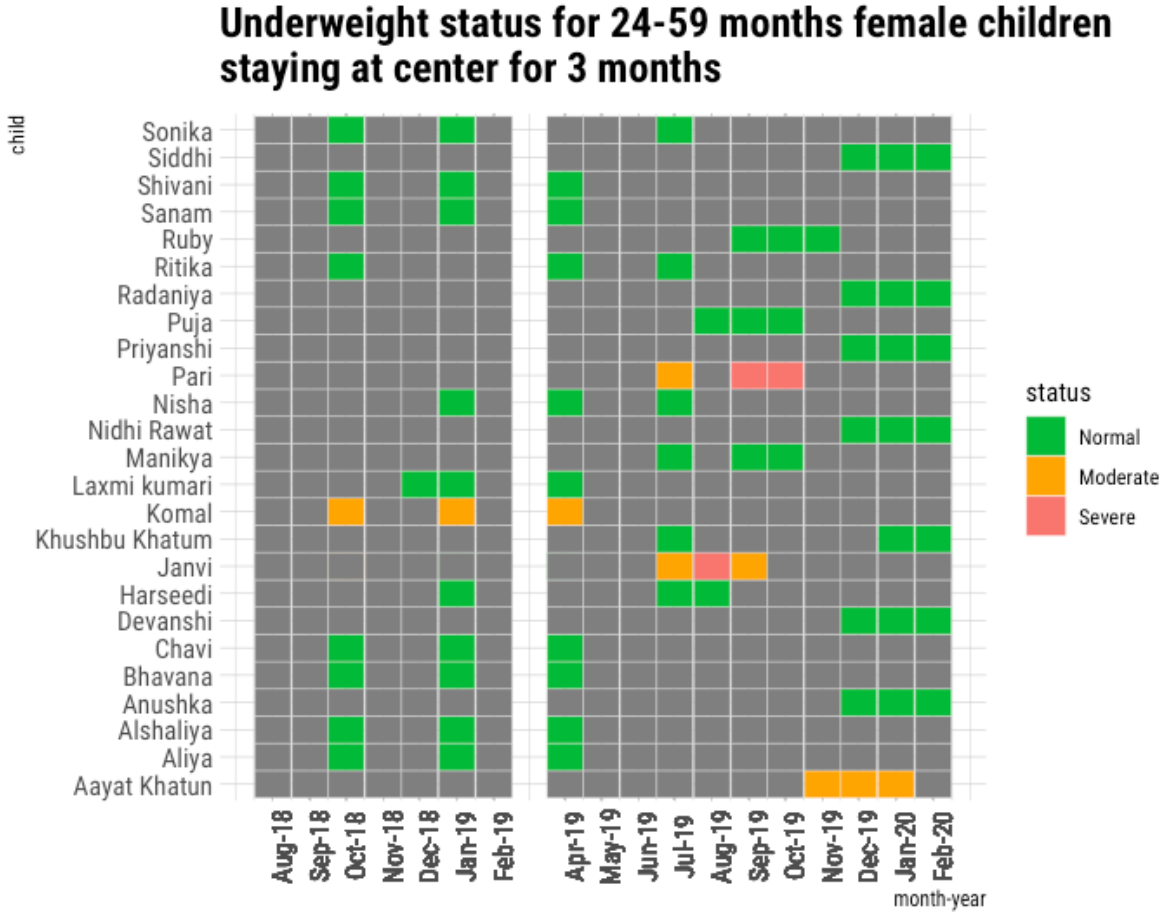

Stunting status for 24-59 months female children staying at center for 2 months
child
Yashoda
Vani
Vaishnavi
Tanya
Tanushka
Shruti
Shivanki
Shivani
Shabnam
Sanjana
Saleemashek
Sabina
Rehmati
Priya
Pratigya
Payal
Pari
Noor Saba
Nidhi
Najrin
Nagma Khatun
Minakshi
Mantasha
Madhu
Ladli Khatun
Khushi
Kaveri
Jivika
Jagiriti
Isha
Gyanwati
Geeta
Garima
Disha
Akansha
Aarju
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
month-year
status
Normal
Moderate
Severe

Stunting status for 24-59 months male children staying at center for 2 months

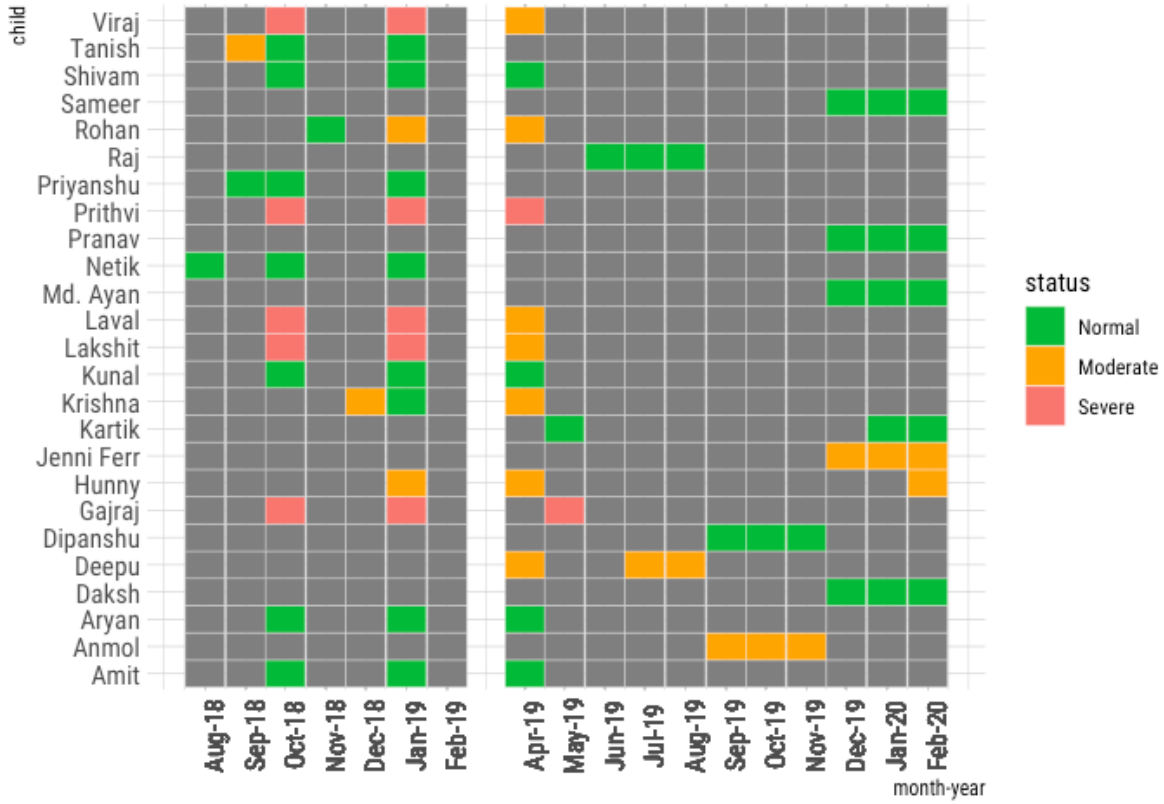
Stunting status for 0-23 months female children staying at center for 3 months



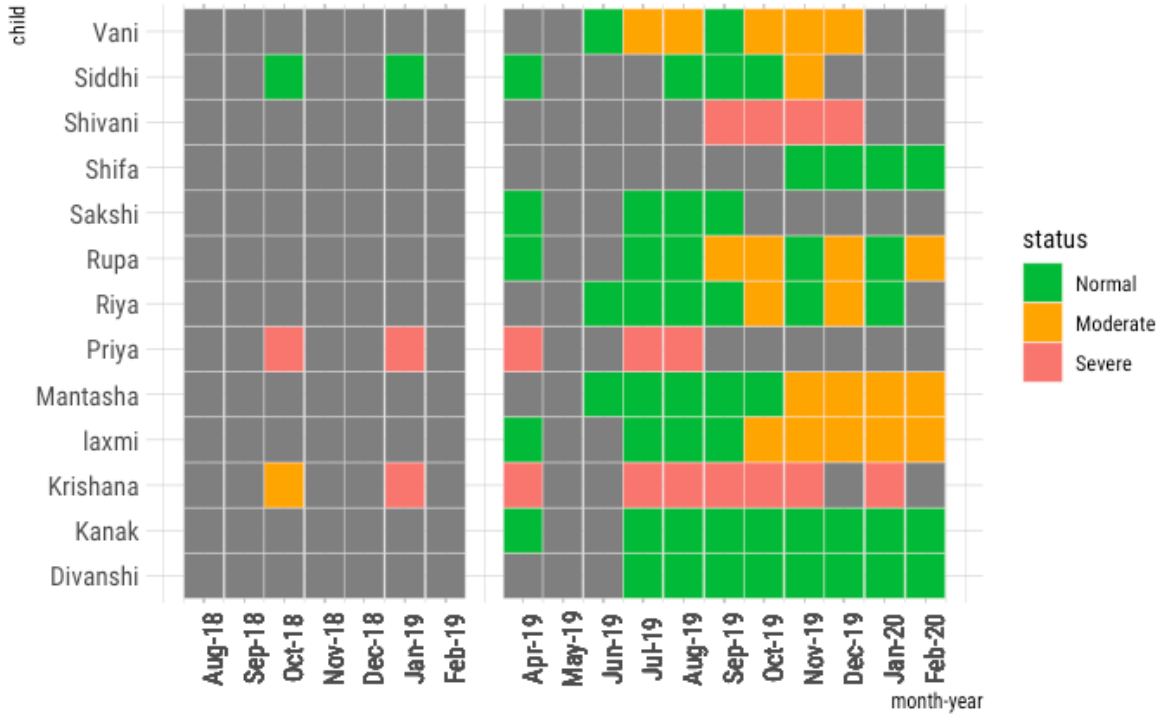

Stunting status for 0-23 months male children staying at center for 3 months
child
Rahil
Piyush
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
month-year
status
Normal
Moderate
Severe

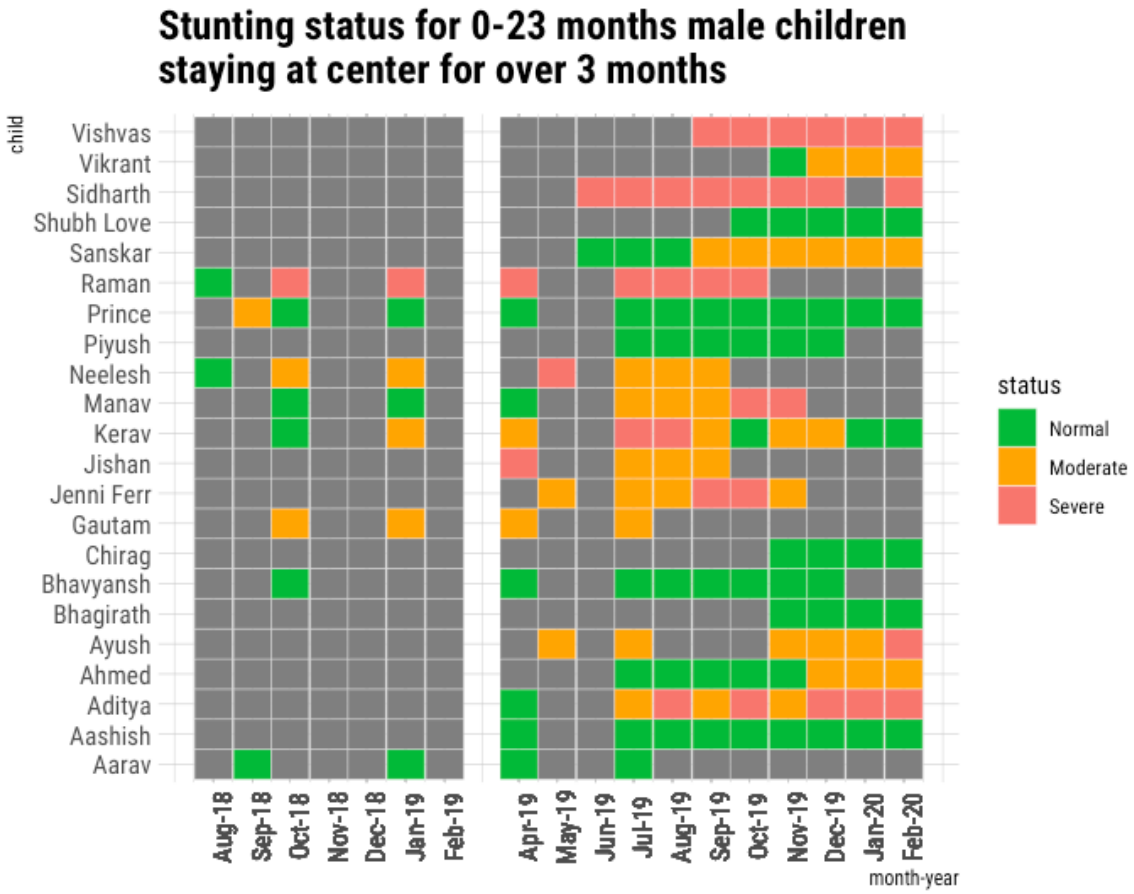

Underweight status for 24-59 months female children staying at center for 3 months
child
Sonika
Siddhi
Shivani
Sanam
Ruby
Ritika
Radaniya
Puja
Priyanshi
Pari
Nisha
Nidhi Rawat
Manikya
Laxmi kumari
Komal
Khushbu Khatum
Janvi
Harseedi
Devanshi
Chavi
Bhavana
Anushka
Alshaliya
Aliya
Aayat Khatun
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
month-year
status
Normal
Moderate
Severe

Stunting status for 24-59 months male children staying at center for 3 months

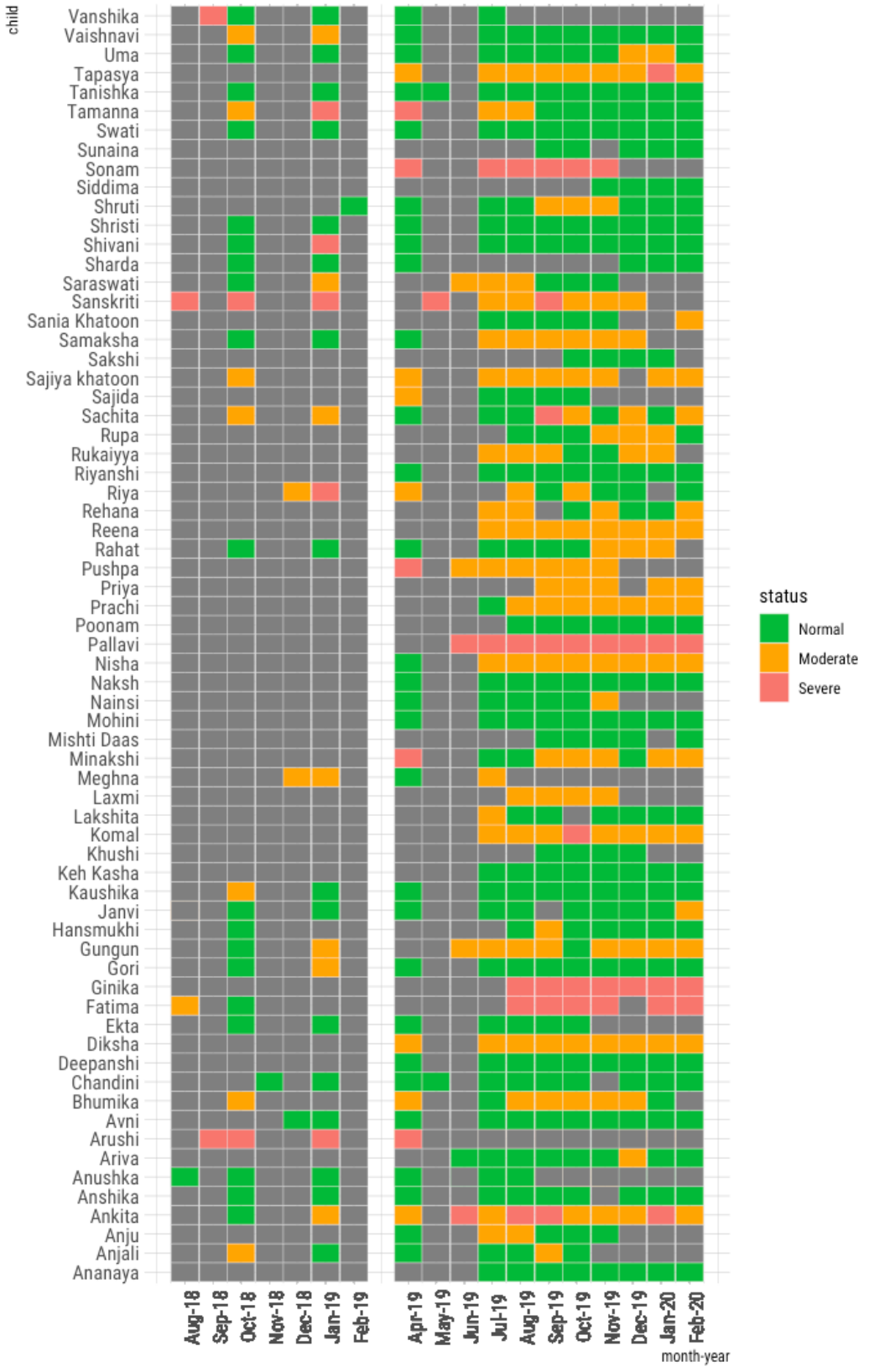


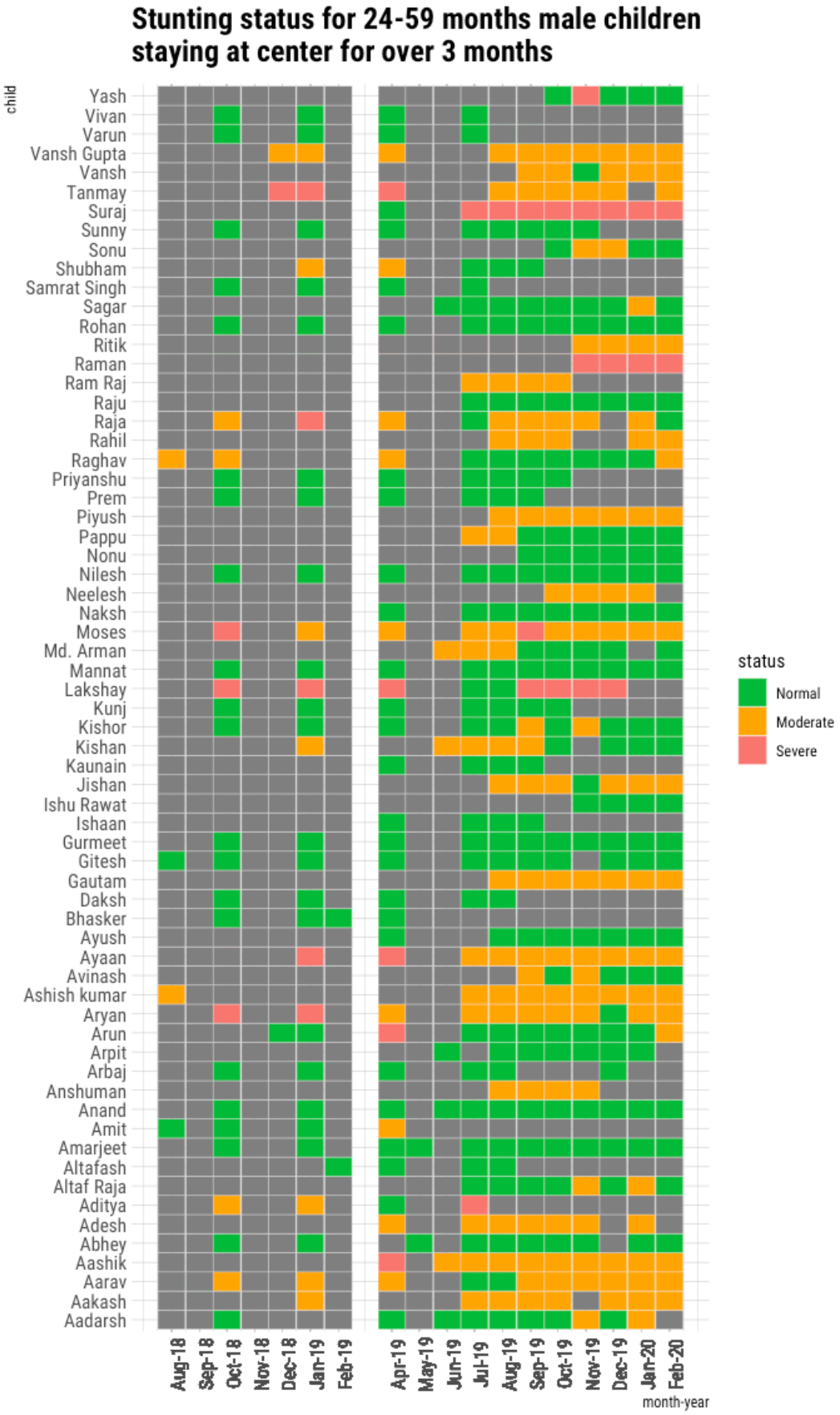
Stunting status for 0-23 months female children staying at center for over 3 months

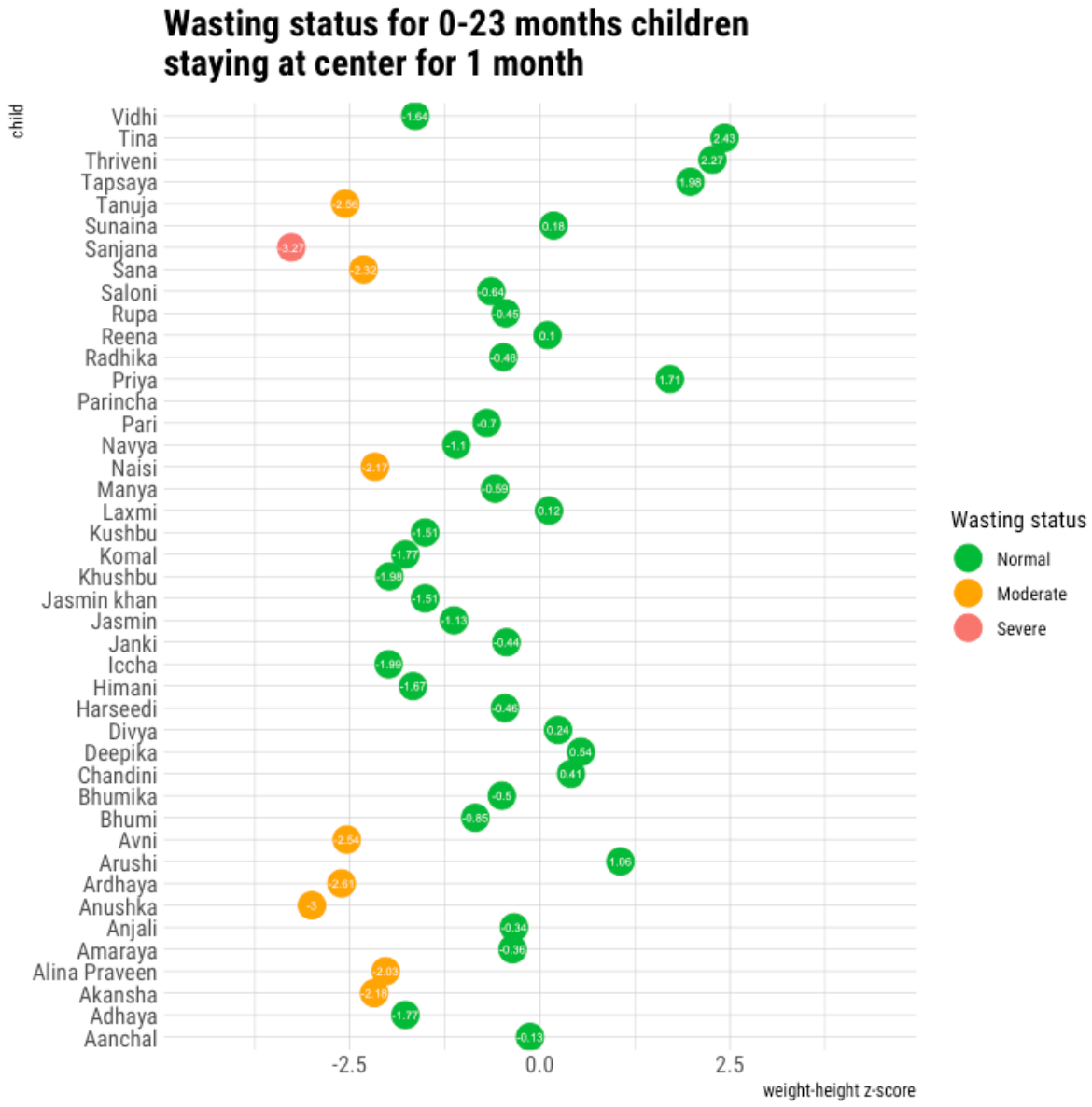


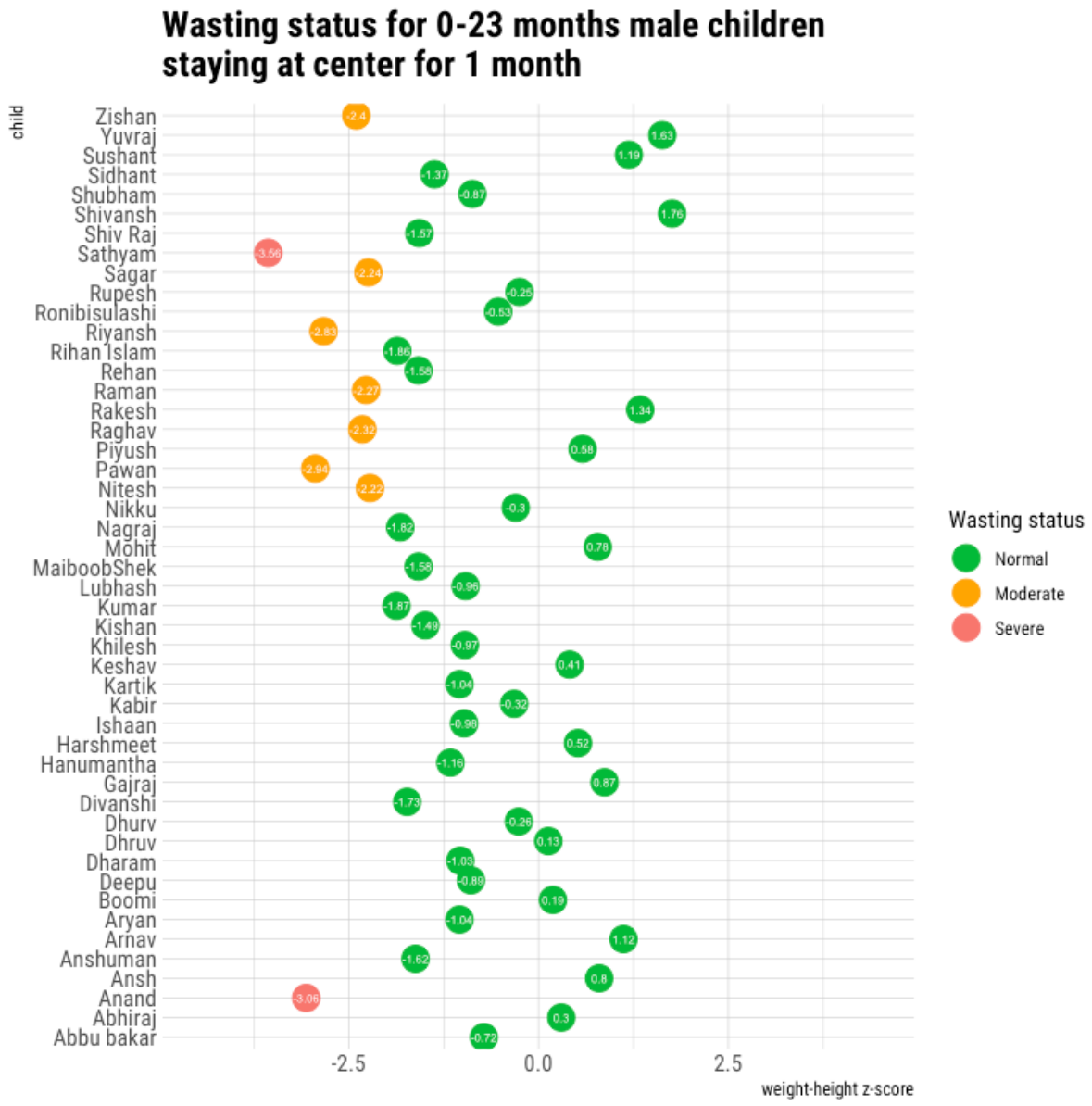

Stunting status for 0-23 months male children staying at center for over 3 months
child
Vishvas
Vikrant
Sidharth
Shubh Love
Sanskar
Raman
Prince
Piyush
Neelesh
Manav
Kerav
Jishan
Jenni Ferr
Gautam
Chirag
Bhavyansh
Bhagirath
Ayush
Ahmed
Aditya
Aashish
Aarav
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
month-year
status
Normal
Moderate
Severe

Stunting status for 24-59 months female children staying at center for over 3 months

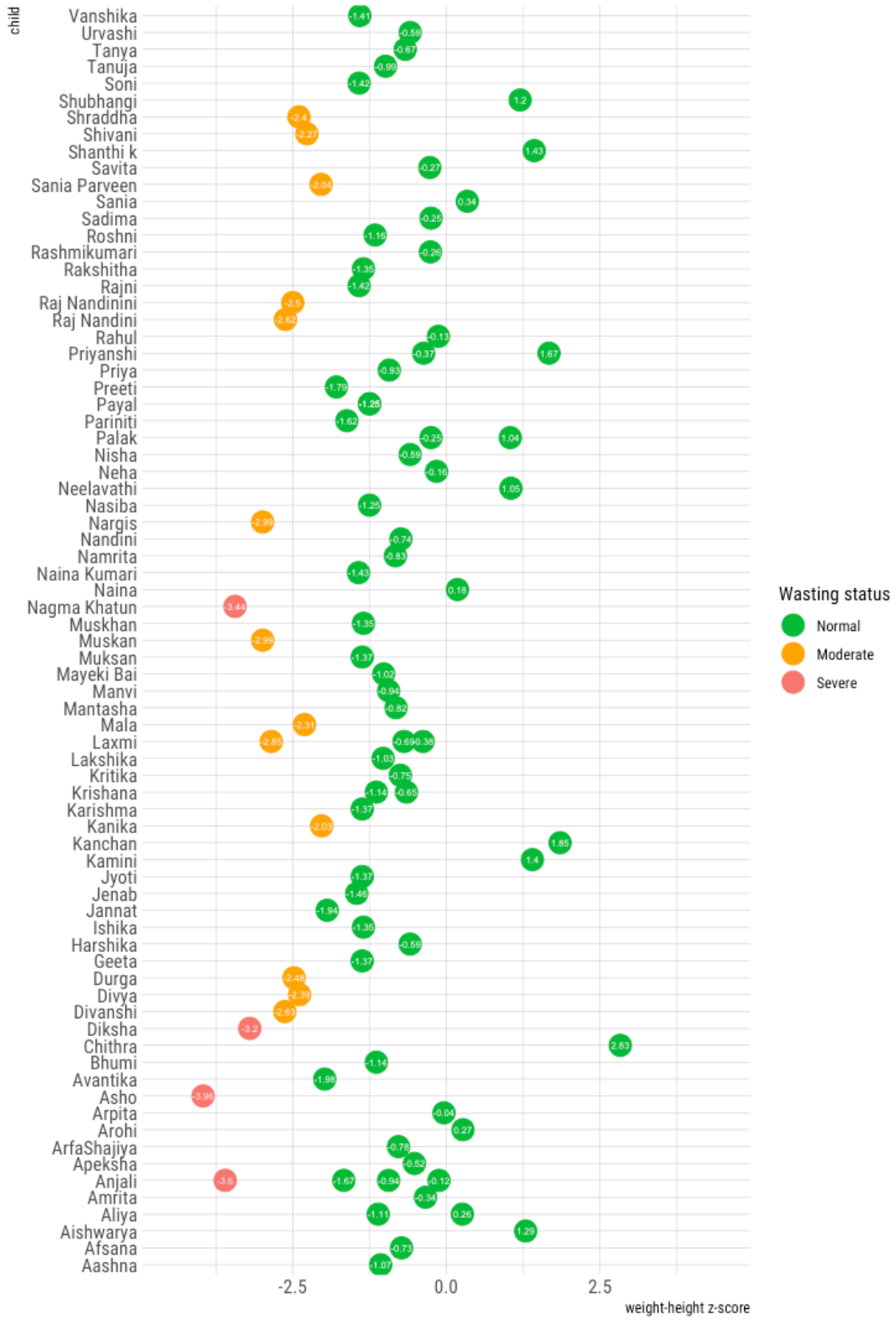


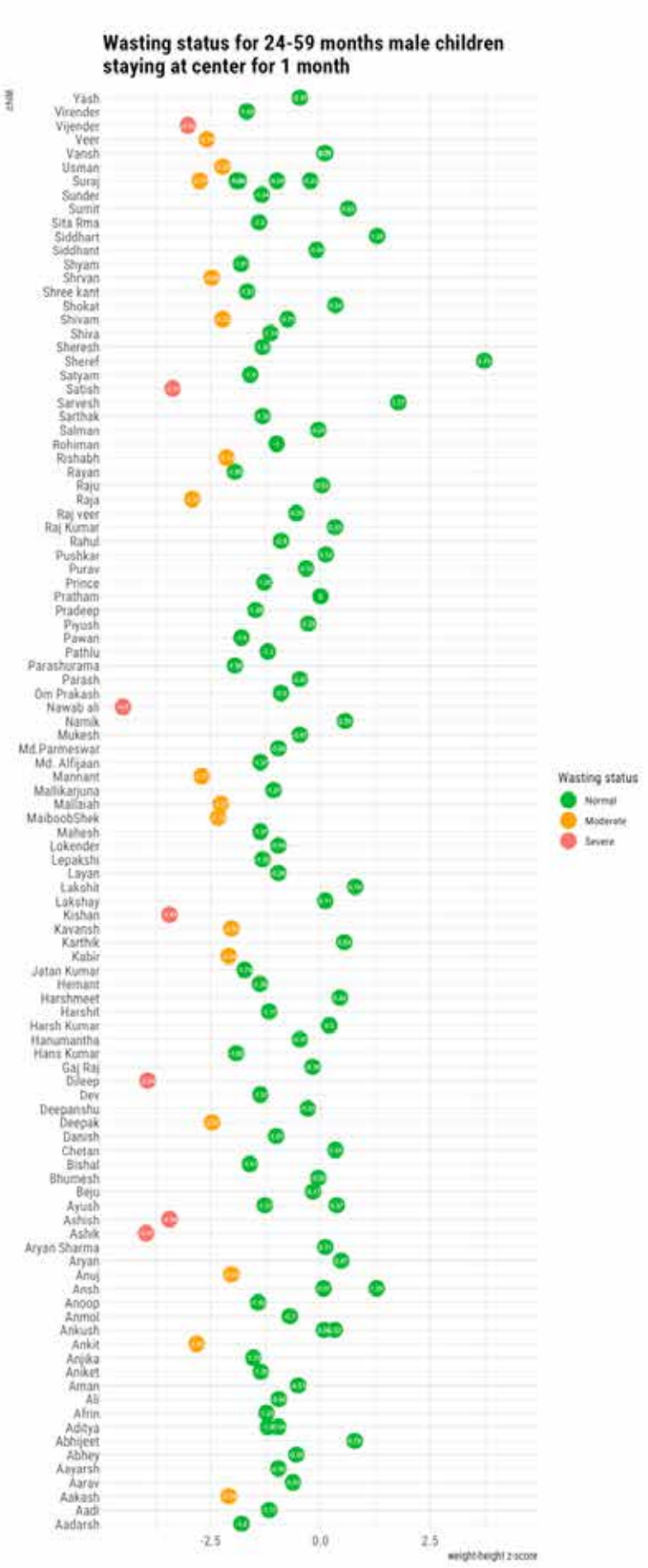

Stunting status for 24-59 months male children staying at center for over 3 months
child
Yash
Vivan
Varun
Vansh Gupta
Vansh
Tanmay
Suraj
Sunny
Sonu
Shubham
Samrat Singh
Sagar
Rohan
Ritik
Raman
Ram Raj
Raju
Raja
Rahil
Raghav
Priyanshu
Prem
Piyush
Pappu
Nonu
Nilesh
Neelesh
Naksh
Moses
Md. Arman
Mannat
Lakshay
Kunj
Kishor
Kishan
Kaunain
Jishan
Ishu Rawat
Ishaan
Gurmeet
Gitesh
Gautam
Daksh
Bhasker
Ayush
Ayaan
Avinash
Ashish kumar
Aryan
Arun
Arpit
Arbaj
Anshuman
Anand
Amit
Amarjeet
Altafash
Altaf Raja
Aditya
Adesh
Abhey
Aashik
Aarav
Aakash
Aadarsh
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
month-year
status
Normal
Moderate
Severe


Wasting status for 0-23 months children staying at center for 1 month
child
Vidhi
Tina
Thriveni
Tapsaya
Tanuja
Sunaina
Sanjana
Sana
Saloni
Rupa
Reena
Radhika
Priya
Parincha
Pari
Navya
Naisi
Manya
Laxmi
Kushbu
Komal
Khushbu
Jasmin khan
Jasmin
Janki
Iccha
Himani
Harseedi
Divya
Deepika
Chandini
Bhumika
Bhumi
Avni
Arushi
Ardhaya
Anushka
Anjali
Amaraya
Alina Praveen
Akansha
Adhaya
Aanchal
-1.64
2.43
2.27
1.98
-2.56
0.18
-3.27
-2.32
-0.64
-0.45
0.1
-0.48
1.71
-0.7
-1.1
-2.17
-0.59
0.12
-1.51
-1.77
-1.98
-1.51
-1.13
-0.44
-1.99
-1.67
-0.46
0.24
0.84
0.41
-0.5
-0.85
-2.54
1.06
-2.61
-3
-0.34
-0.36
-2.03
-2.18
-1.77
-0.13
-2.5
0.0
2.5
weight-height z-score
Wasting status
Normal
Moderate
Severe

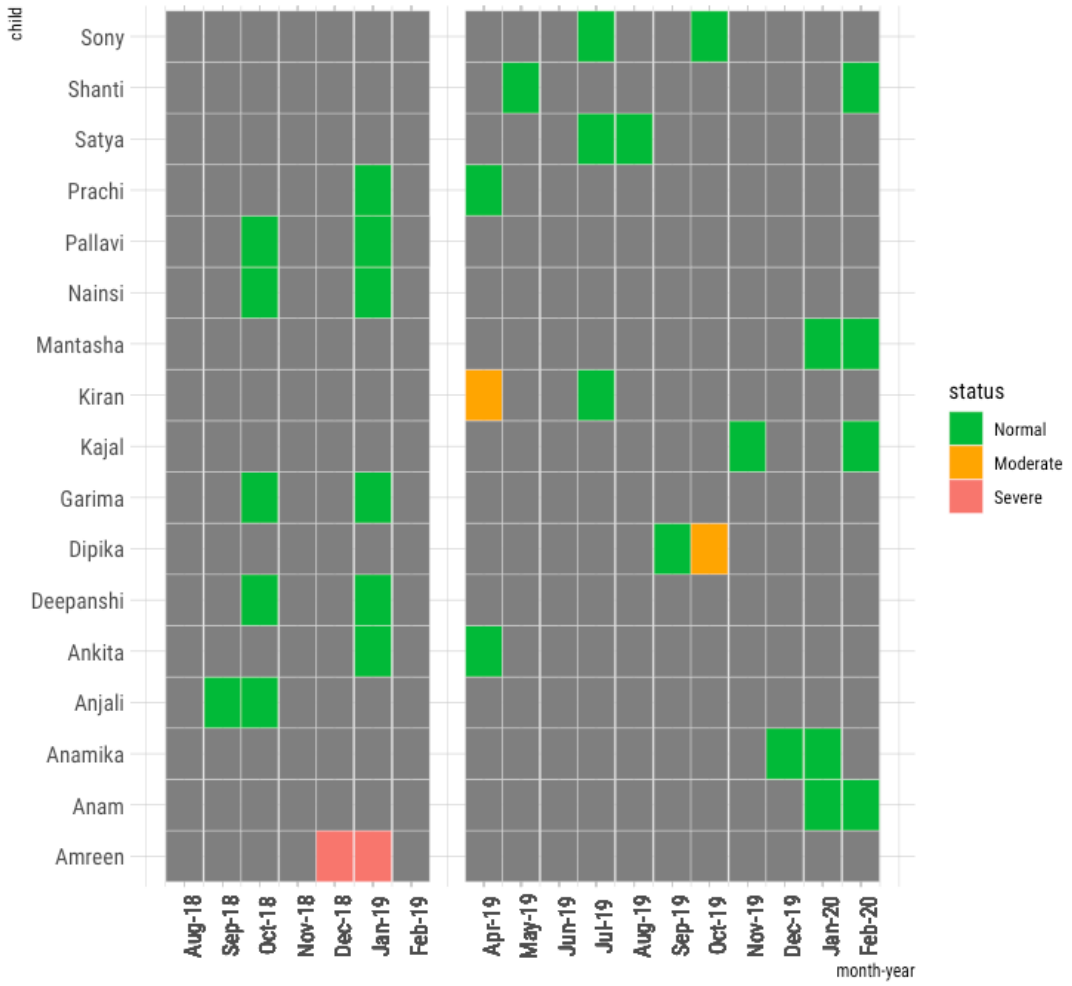

Wasting status for 0-23 months male children staying at center for 1 month
child
Zishan
Yuvraj
Sushant
Sidhant
Shubham
Shivansh
Shiv Raj
Sathyam
Sagar
Rupesh
Ronibisulashi
Riyansh
Rihan Islam
Rehan
Raman
Rakesh
Raghav
Piyush
Pawan
Nitesh
Nikku
Nagraj
Mohit
MaiboobShek
Lubhash
Kumar
Kishan
Khilesh
Keshav
Kartik
Kabir
Ishaan
Harshmeet
Hanumantha
Gajraj
Divanshi
Dhurv
Dhruv
Dharam
Deepu
Boomi
Aryan
Arnav
Anshuman
Ansh
Anand
Abhiraj
Abbu bakar
-2.4
1.63
1.19
-1.37
-0.87
1.76
-1.57
-3.56
-2.24
-0.25
-0.53
-2.83
-1.86
-1.58
-2.27
1.34
-2.32
0.58
-2.94
-2.22
-0.3
-1.82
0.78
-1.58
-0.96
-1.87
-1.49
-0.97
0.41
-1.04
-0.32
-0.98
0.52
-1.16
0.87
-1.73
-0.26
0.13
-1.03
-0.80
0.19
-1.04
1.12
-1.62
0.8
-3.06
0.3
-0.72
-2.5
0.0
2.5
weight-height z-score
Wasting status
Normal
Moderate
Severe

Wasting status for 23-59 months female children staying at center for 1 month

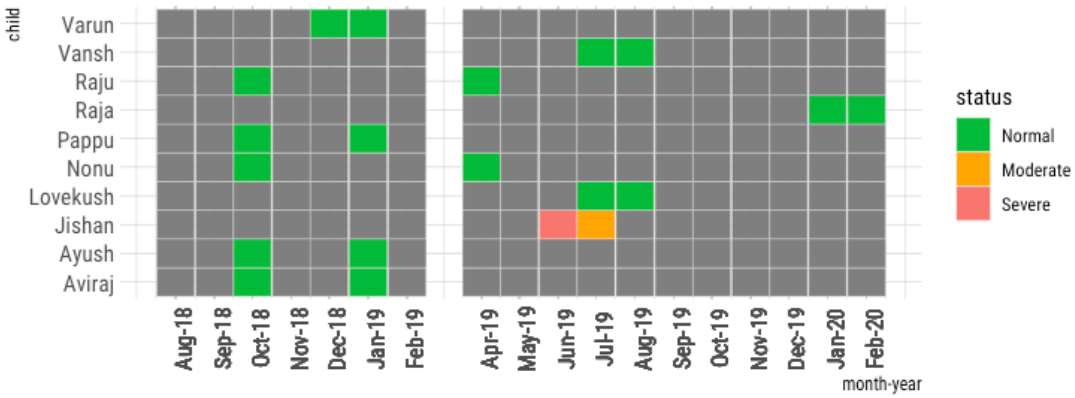


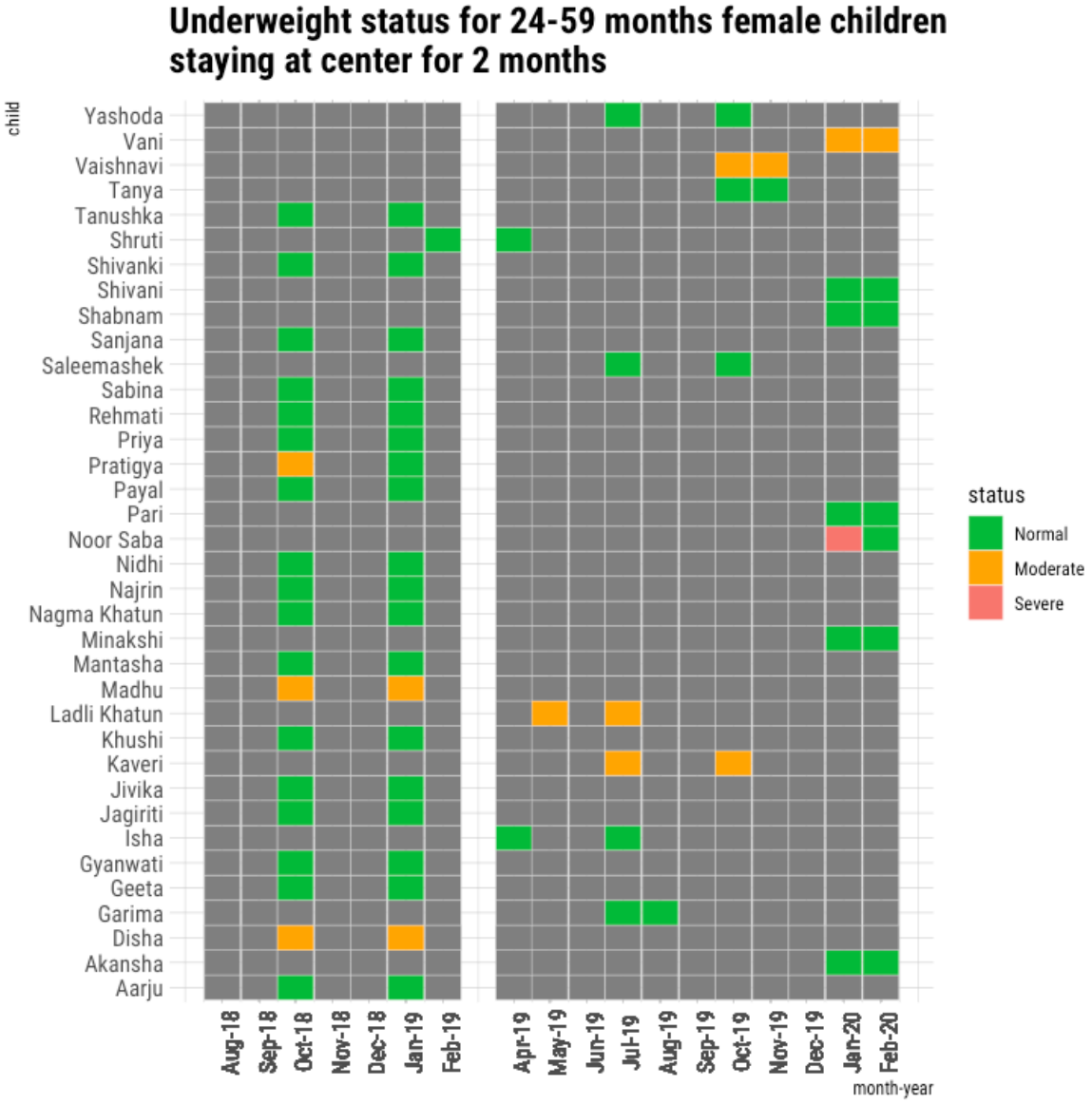

Wasting status for 24-59 months male children staying at center for 1 month
Name
Yash
Virender
Vijender
Veer
Vansh
Usman
Suraj
Sunder
Sumit
Sita Rma
Siddhart
Siddhant
Shyam
Shrvan
Shree kant
Shokat
Shivam
Shiva
Sheresh
Sheref
Satyam
Satish
Sarvesh
Sarthak
Salman
Rohiman
Rishabh
Rayan
Raju
Raja
Raj veer
Raj Kumar
Rahul
Pushkar
Purav
Prince
Pratham
Pradeep
Piyush
Pawan
Pathlu
Parashurama
Parash
Om Prakash
Nawab ali
Namik
Mukesh
Md.Parmeswar
Md. Alfijaan
Mannant
Mallikarjuna
Mallaiah
MaiboobShek
Mahesh
Lokender
Lepakshi
Layan
Lakshit
Lakshay
Kishan
Kavansh
Karthik
Kabir
Jatan Kumar
Hemant
Harshmeet
Harshit
Harsh Kumar
Hanumantha
Hans Kumar
Gaj Raj
Dileep
Dev
Deepanshu
Deepak
Danish
Chetan
Bishal
Bhumesh
Beju
Ayush
Ashish
Ashik
Aryan Sharma
Aryan
Anuj
Ansh
Anoop
Anmol
Ankush
Ankit
Anjika
Aniket
Aman
Ali
Afrin
Aditya
Abhijeet
Abhey
Aayarsh
Aarav
Aakash
Aadi
Aadarsh
-2.5
0.0
2.5
weight-height z-score
Wasting status
Normal
Moderate
Severe

Wasting status for 0-23 months female children staying at center for 2 months



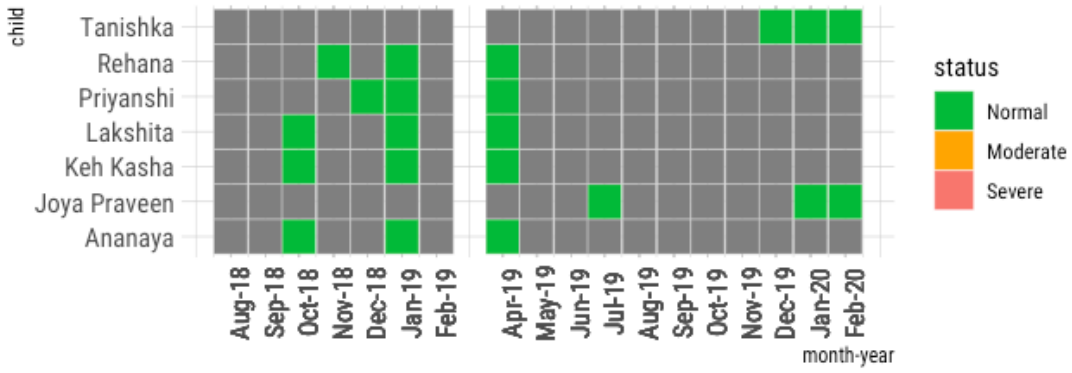
Wasting status for 0-23 months male children staying at center for 2 months

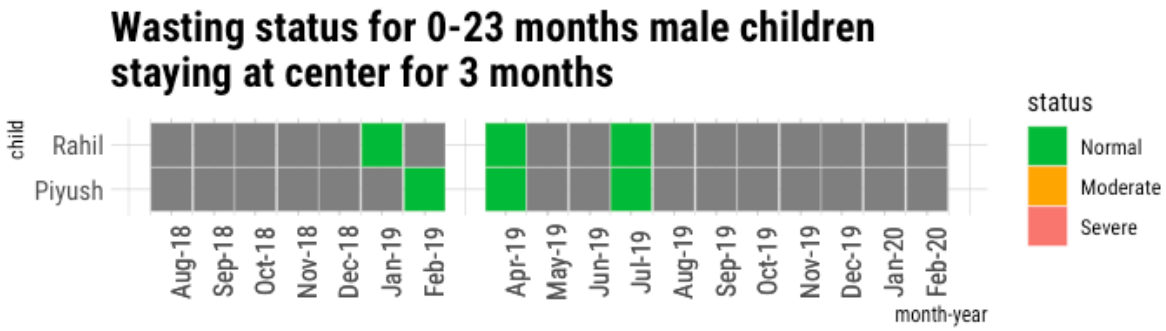


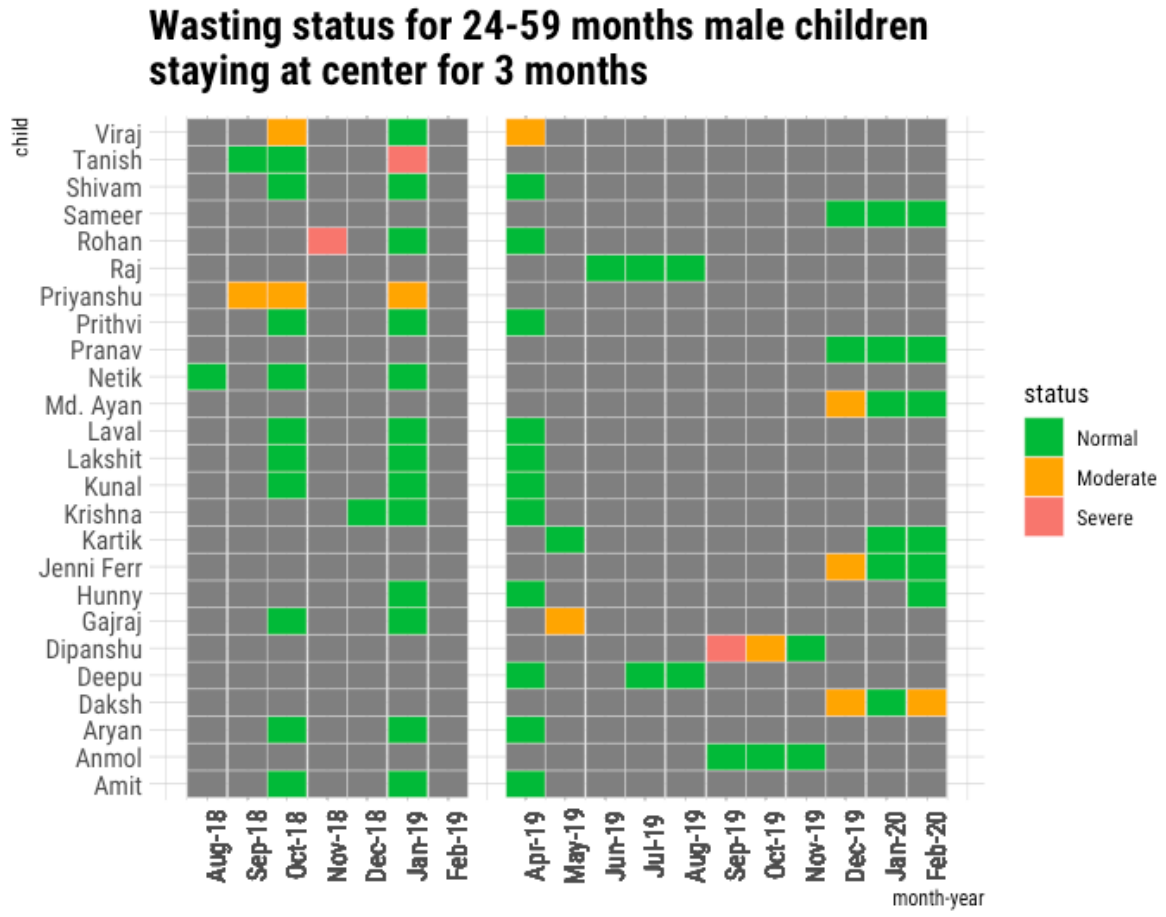

Underweight status for 24-59 months female children staying at center for 2 months
child
Yashoda
Vani
Vaishnavi
Tanya
Tanushka
Shruti
Shivanki
Shivani
Shabnam
Sanjana
Saleemashek
Sabina
Rehmati
Priya
Pratigya
Payal
Pari
Noor Saba
Nidhi
Najrin
Nagma Khatun
Minakshi
Mantasha
Madhu
Ladli Khatun
Khushi
Kaveri
Jivika
Jagiriti
Isha
Gyanwati
Geeta
Garima
Disha
Akansha
Aarju
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
month-year
status
Normal
Moderate
Severe

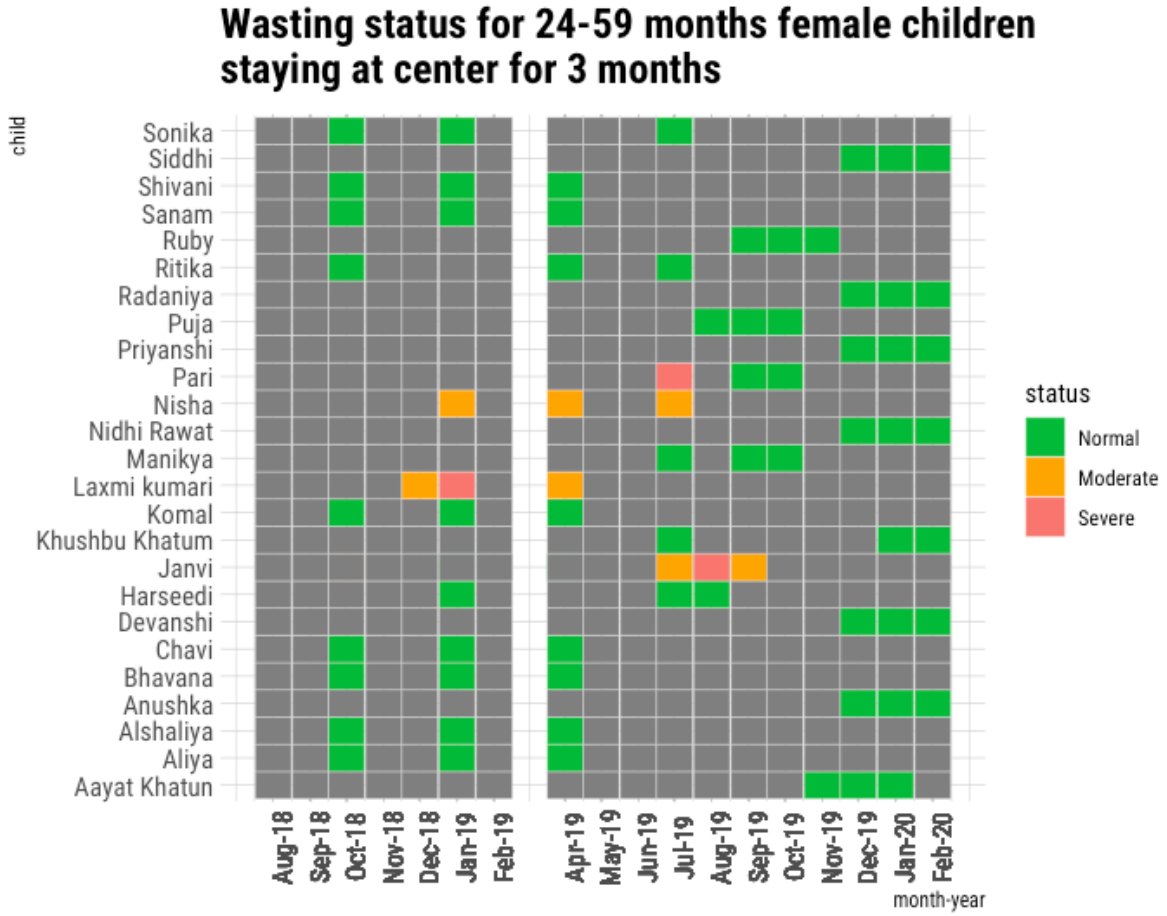
Wasting status for 24-59 months female children staying at center for 2 months

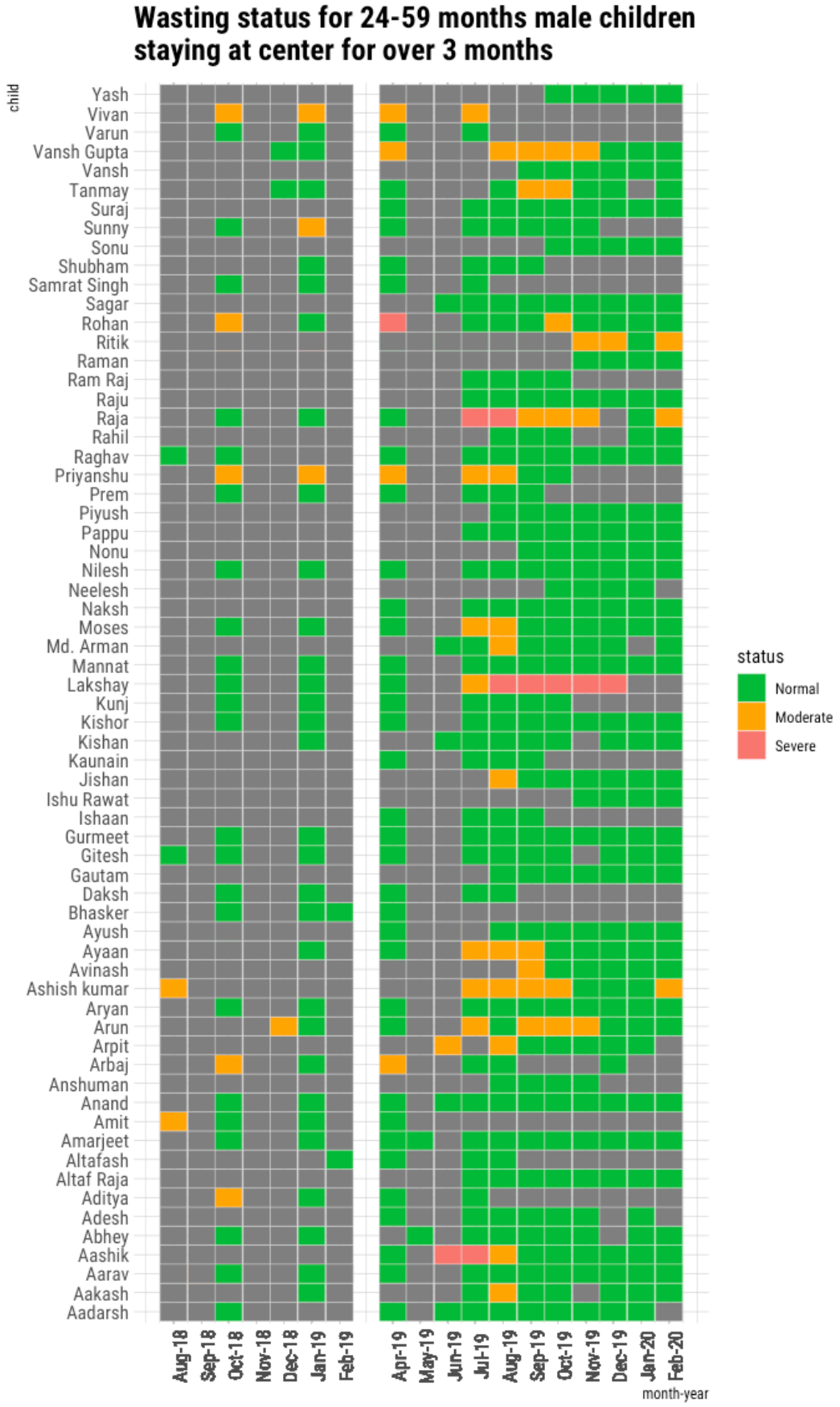
Wasting status for 0-23 months female children staying at center for 3 months

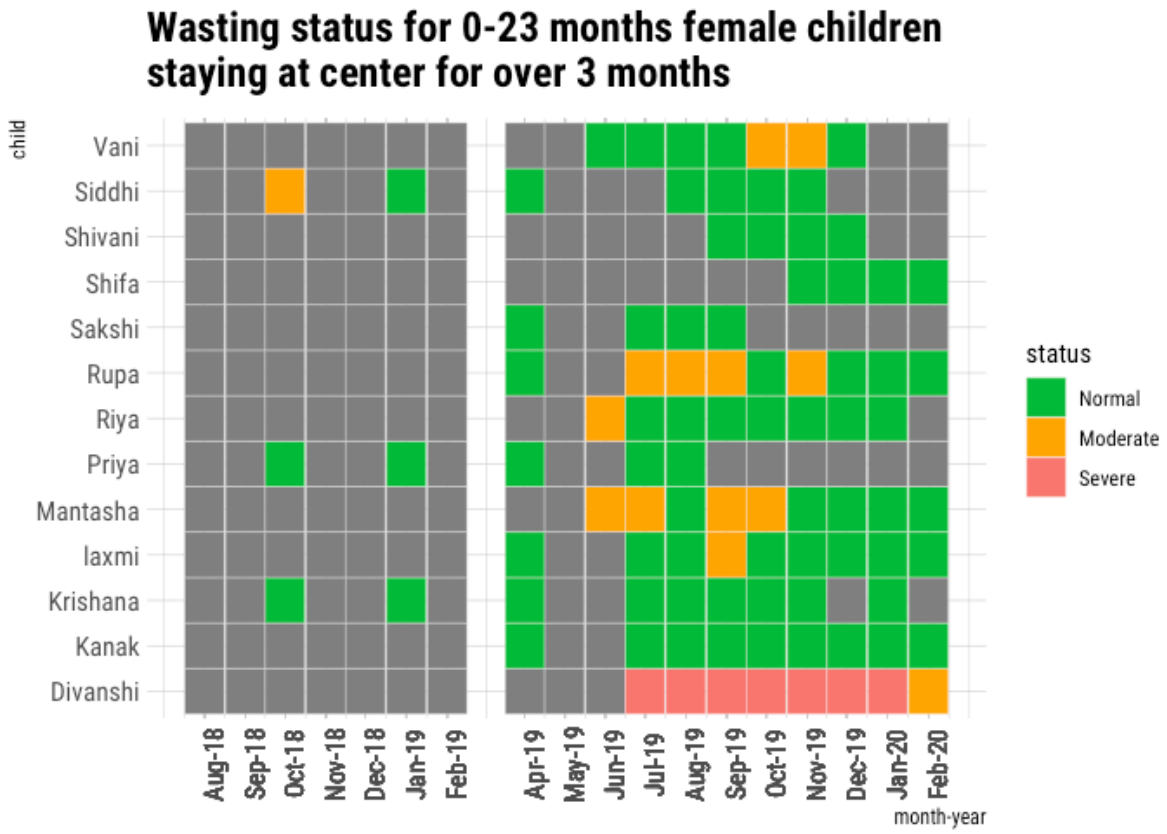


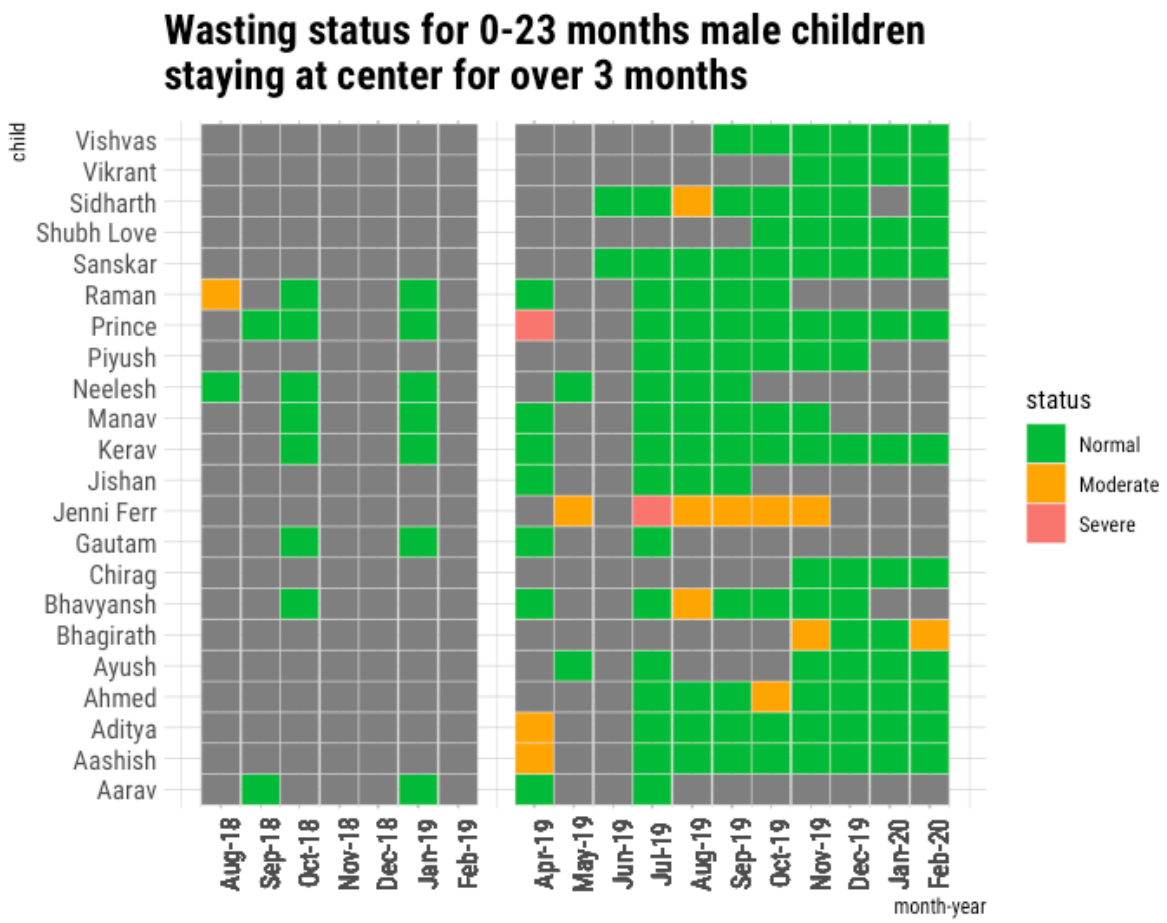

Wasting status for 0-23 months male children staying at center for 3 months
child
Rahil
Piyush
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
month-year
status
Normal
Moderate
Severe


Wasting status for 24-59 months male children staying at center for 3 months
child
Viraj
Tanish
Shivam
Sameer
Rohan
Raj
Priyanshu
Prithvi
Pranav
Netik
Md. Ayan
Laval
Lakshit
Kunal
Krishna
Kartik
Jenni Ferr
Hunny
Gajraj
Dipanshu
Deepu
Daksh
Aryan
Anmol
Amit
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
month-year
status
Normal
Moderate
Severe

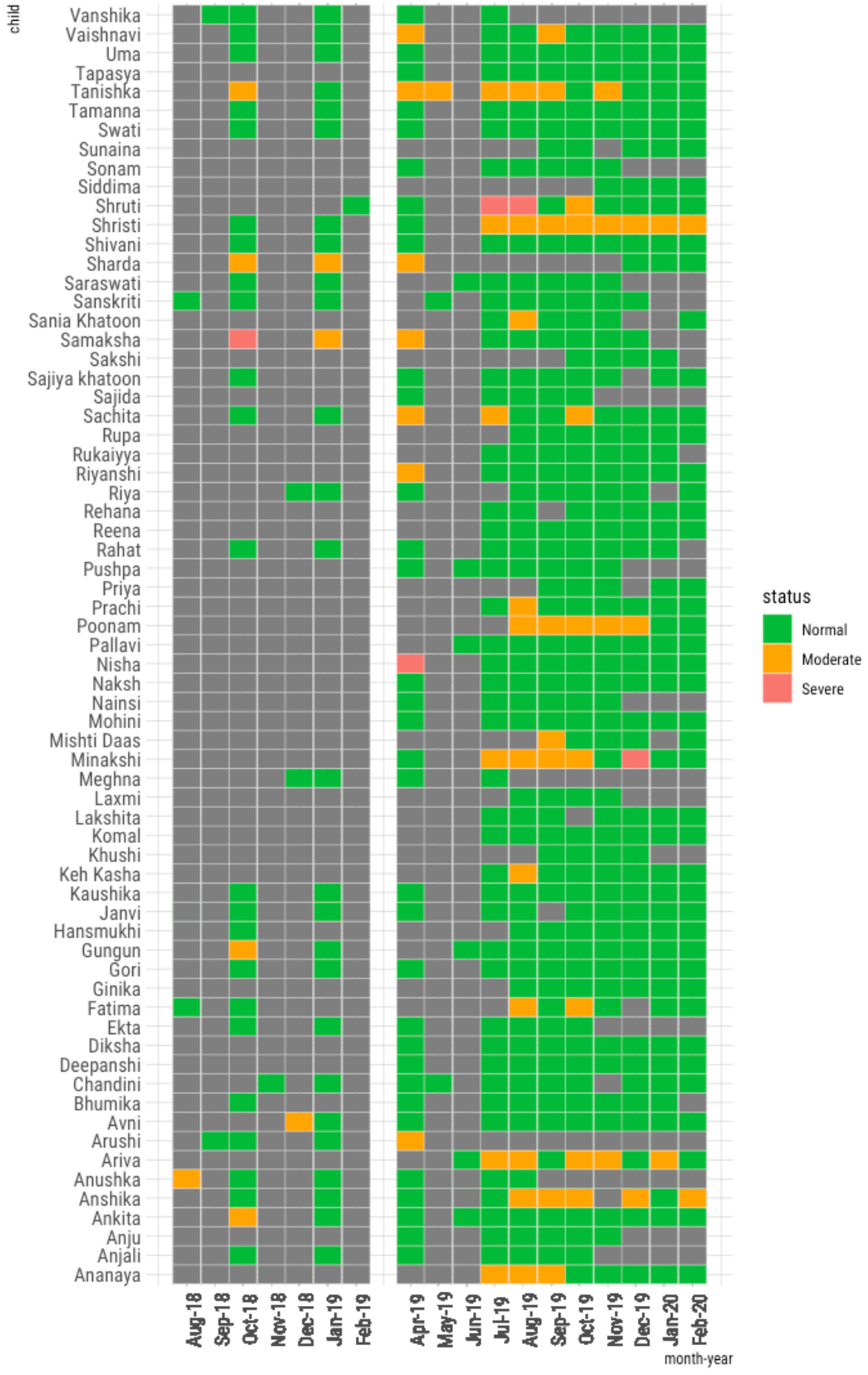

Wasting status for 24-59 months female children staying at center for 3 months
child
Sonika
Siddhi
Shivani
Sanam
Ruby
Ritika
Radaniya
Puja
Priyanshi
Pari
Nisha
Nidhi Rawat
Manikya
Laxmi kumari
Komal
Khushbu Khatum
Janvi
Harseedi
Devanshi
Chavi
Bhavana
Anushka
Alshaliya
Aliya
Aayat Khatun
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
month-year
status
Normal
Moderate
Severe


Wasting status for 24-59 months male children staying at center for over 3 months
child
Yash
Vivan
Varun
Vansh Gupta
Vansh
Tanmay
Suraj
Sunny
Sonu
Shubham
Samrat Singh
Sagar
Rohan
Ritik
Raman
Ram Raj
Raju
Raja
Rahil
Raghav
Priyanshu
Prem
Piyush
Pappu
Nonu
Nilesh
Neelesh
Naksh
Moses
Md. Arman
Mannat
Lakshay
Kunj
Kishor
Kishan
Kaunain
Jishan
Ishu Rawat
Ishaan
Gurmeet
Gitesh
Gautam
Daksh
Bhasker
Ayush
Ayaan
Avinash
Ashish kumar
Aryan
Arun
Arpit
Arbaj
Anshuman
Anand
Amit
Amarjeet
Altafash
Altaf Raja
Aditya
Adesh
Abhey
Aashik
Aarav
Aakash
Aadarsh
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
month-year
status
Normal
Moderate
Severe


Wasting status for 0-23 months female children staying at center for over 3 months
child
Vani
Siddhi
Shivani
Shifa
Sakshi
Rupa
Riya
Priya
Mantasha
laxmi
Krishana
Kanak
Divanshi
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
month-year
status
Normal
Moderate
Severe


Wasting status for 0-23 months male children staying at center for over 3 months
child
Vishvas
Vikrant
Sidharth
Shubh Love
Sanskar
Raman
Prince
Piyush
Neelesh
Manav
Kerav
Jishan
Jenni Ferr
Gautam
Chirag
Bhavyansh
Bhagirath
Ayush
Ahmed
Aditya
Aashish
Aarav
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
month-year
status
Normal
Moderate
Severe

Wasting status for 24-59 months female children staying at center for over 3 months



ANNEXURE B

Questionnaire for Community Informant- (Informal sector laborer / Mothers)

A. GENERIC- OPEN ENDED QUESTIONS:

1. Sir/ Madam, what is your name?
2. Where do you come from and where do you live?
3. Where do you work/where does your spouse work? (If not in construction)
4. Are you able to access the creche facility being provided by the Delhi Mobile Creche Programme? (Probe with: Does it help to keep your child in the creche while you go to work? Do you feel that the centre will keep your child safe?)
5. Does your child get any Nutritional Supplement at the centre? (move to more detailed questions)
6. Do you participate in the Nutritional Counselling Programme/ discussions? (Brief overview) (ask after whether nutrition counselling is provided)

B. ASSESSMENT OF PROGRAMME IMPACT:

1. Could you tell us a little bit whether your child likes to be at the centre?
2. How many meals does your child get at the centre? What sort of food items are served?
3. Does your child like how the food tastes? Do you talk about it at home?
4. When your child is at home what sort of food do you feed your child? Can you recall the last four meals that you have provided your child?
5. Do you participate in the discussions that are held at the centre? When was the last time you participated in a discussion? Can you recall what was discussed?
6. Do you think that the discussions that you have participated at the centre helped you to make better food choices for your child? Can you describe a food choice that you have recently made?
7. What sort of care do you receive if your child has been assessed as under nourished or has any special dietary needs?
8. What according to you would be a balanced meal; what sort of items would you choose within a budget of 20-25 rupees for a meal?
9. What are the hygienic practices of food preparation and eating would you and your family practice in general?
10. When you are unable to access the centre; since we all need to migrate to different work sites what sort of nutritional choices will you make in future to ensure that your family gets the right kind of nutrition?
11. Does your child/ children have access to basic education facilities apart from the centre? (Such as Aanganwadi centre, Primary school etc.)

12. Does the centre organize any sports and recreational activities for the children and the mothers?

13. If your child gets unwell, do you get to access any health care support from the centre?

14. How did the COVID-19 Pandemic affect the services being provided? What were the most notable challenges? (Probe: what are the experiences during the lockdown period)

C. COUNTER QUESTIONS:

Do you have any questions for us?

D. OBSERVATION/ REFLECTIONS OF THE INTERVIEWERS:

Questionnaire for Key Informant- (Nutritionist/ Officials)

A. GENERIC- OPEN ENDED QUESTIONS:

1. Sir/ Madam, what is your name? What is your designation / In which institutional capacity are you working?

2. Could you please tell us in brief about the Delhi Mobile Creche Programme in Delhi? (Probe with: Geographical extent, communities covered, Larger Focus areas, what sort of support does HT Parekh provide)

3. Could you please briefly discuss the Nutritional Supplement and Counselling Programme? (Brief overview)

4. What are the roles and responsibilities of the Nutritionist / Facilitator of the Day care centre/ creche?

B. INSTITUTIONAL ISSUES:

1. Could you tell us briefly about the organizational structure of the Centres?

2. Could you tell us a little bit about the relationship between MCD and the construction site owners? (Probe with whether the construction site owners are in any way aware of the programme; are there any norms, rules etc concerning the safety of the child in a hazardous space such as a construction site.)

3. How does MCD make the workers aware of the support services that they are providing?

4. Are there any challenges that the MCD officials or the community face at the construction site / or from the site owners?

C. OPERATIONAL/ PROCEDURAL ISSUES:

1. Tell us a little bit about the Nutritional Counselling Programme with Mothers of the Children? (How do you go about discussing the issues, how do you keep track of the reception of the knowledge on nutrition by the mothers of the children, if records are maintained how are they managed so that the impact of the discussions can be charted)

2. How is the dietary programme / action decided upon? Do MCD officials discuss the issues

and challenges with the mothers? (Food habits, preferences, cultural issues such as vegetarian / non- vegetarian diet etc)

3. What are the Standard Operational Procedures for providing Nutrition and Nutritional Counselling? Does MCD use any Application Software to streamline the procedures? How is it done?
4. What is a basic outline of the Community Awareness/ outreach programme? What are the themes which are covered and how?
5. How do you take care of children with special needs or mothers with special needs such as Anaemic children, undernourished children, pregnant or lactating mothers etc?
6. Does the programme involve any health care professional to assist them in designing the programme and assessing the progress towards their goal?
7. How does MCD plan to run the programme with or without the financial support from HT Parekh? What is a long-term sustenance strategy that MCD is working towards? (Probe with: partnerships with the other CSOs, State services such as the Aanganwadi or Primary Schools etc specially to ensure protein rich and nutrition dense food reaches the child.)
8. How did the COVID-19 Pandemic affect the services being provided? What were the most notable challenges?

D. KEY INFORMANTS' ASSESSMENT OF THE PROGRAMME:

1. Do you think that the programme is successful? If you think it is, then what are the reasons that convince you?
2. Can you give us some case study or anecdotes from your experience where mothers have held onto the discussions on nutrition or the nutritional status of the child/ children have improved after participating in the programme?)
3. If you are using the APP then do you find the App useful? Any feedback about the APP which needs to be discussed.

E. COUNTER QUESTIONS:

Do you have any questions for us?

F. OBSERVATION/ REFLECTIONS OF THE INTERVIEWERS:

Schedule for Quantitative Interviews with Mothers (Delhi)

Consent	मेरा नाम ———————————— है और मैं दिल्ली की एक संस्था पॉलिसी डिवेलप्मेंट एंड अड्वाइज़री ग्रूप (च्क।ळ) से आया/आयी हूँ। हम दिल्ली मोबाइल क्रेष द्वारा बच्चों के लिए चलाए जा रहे कार्यक्रम का मूल्यांकन करने आए हैं। यह मूल्यांकन एच.टी. पारेख फाउंडेषन द्वारा आयोजित किया जा रहा एक स्वतंत्र अध्ययन है। इस मूल्यांकन के दौरान आप जो भी जानकारी हमें देंगे वह किसी को बताई नहीं जाएगी और आपकी पहचान गुप्त रखी जाएगी। अगर इस बातचीत के दौरान आपको लगता है कि आप इसमें आगे और भाग नहीं लेना चाहते हैं तो आप रुक सकते हैं। हमें उम्मीद है की आप इस मूल्यांकन में भाग ले कर इस अध्ययन को सफल बनाने में हमारी मदद करेंगे। इस बातचीत में 10–15 मिनट लगेंगे, कृपया कुछ समय देकर इस मूल्यांकन को पूरा करने में हमारी मदद करें। क्या आप इस बातचीत के लिए तैयार हैं? 1. हाँ 2. नहीं
Survey id	अपना टैब आईडी दर्ज करें
Introductory questions	
A1	कृपया सेंटर चुनें. (Select one from the list of centres) 1. Care Village Samriddhi 2. ATS Le Grand 3. Sushma Sites 4. ATS Nobility
A2	प्रोजेक्ट में काम करने वाले सेंटर कोऑर्डिनेटर की संख्या?
A3	सेंटर पर खाना बनाने और बच्चों की देखभाल करने के लिए कितने लोग जिम्मेदार हैं?
A4	अन्य स्टाफ की संख्या?
A5	आप कहाँ तक पढ़े/पढ़ी हैं? (Select one) 1. कक्षा 1–4 2. कक्षा 5–7 3. कक्षा 8–9 4. कक्षा 10–11 5. 12जी पास 6.आईटीआई/डिप्लोमा 7. स्नातक/ग्रेजुएट 8. पीजी डिग्री (एमए/एमटेक) 9. पढ़ाई नहीं की
A6	आपकी जाति? (Select one) 1. दलित/SC 2. आदिवासी/ST 3. अन्य पिछड़ा वग/OBC 4. General
A7	आपका धर्म? 1. हिंदू 2. इस्लाम 3. सिख 4. ईसाई 5. बौद्ध 6. Others (Please specify)

A8	आपके परिवार की मासिक आय? (Select one) 1. Less than Rs 5000 2. Rs 5000- Rs 10000 3. Rs 10000 – Rs 15000 4. 15000 and above
A9	आपका बच्चा इस सेंटर पर कब से आ रहा है? (महीनों में)
CHILD*S NUTRITION	
C1	बच्चे का लिंग? 1. पुरुश 2. स्त्री
C2	बच्चे की उम्र? 1. 6 महीने – 3 साल 2. 3 साल – 6 साल 3. 6 साल – 12 साल
C3	बच्चे का वजन? (किलो में)
C4	बच्चे की लम्बाई? (सेंटीमीटर में)
C6	आपका बच्चा हफ्ते में कितने दिन सेंटर जाता है? 1. सप्ताह के सभी दिन (छुट्टी के दिन छोड़ कर) 2. सप्ताह के 4–5 दिन 3. सप्ताह के 2–3 दिन 4. हफ्ते में एक दिन
C7	आपके बच्चे को सेंटर पर प्रतिदिन कितनी बार खाना मिलता है? 1. एक बार 2. दो बार 3. तीन बार 4. तीन बार से ज़्यादा
C8	आपके बच्चे को केला हफ्ते में कितने दिन मिलता है? 1. सप्ताह के सभी दिन (छुट्टी के दिन छोड़ कर) 2. सप्ताह के 4–5 दिन 3. सप्ताह के 2–3 दिन 4. हफ्ते में एक दिन 5. नहीं मिलता है
C9	आपके बच्चे को अंडा हफ्ते में कितने दिन मिलता है? 1. सप्ताह के सभी दिन (छुट्टी के दिन छोड़ कर) 2. सप्ताह के 4–5 दिन 3. सप्ताह के 2–3 दिन 4. हफ्ते में एक दिन 5. नहीं मिलता है
C10	बच्चे को खाने में और क्या–क्या चीजें मिलती हैं? (नोट करें)
C11	क्या आपको सेंटर की तरफ से सरकारी स्वास्थ्य सुविधाओं का लाभ लेने में किसी तरह की सहायता मिलती है? 1. हाँ 2. नहीं

C12	सेंटर पर आने वाले बच्चों की लम्बाई और वजन का माप कितने अंतराल पर लिया जाता है? 1. एक हफ्ते 2. हर दो हफ़्ते 3. दो हफ्ते से ज़्यादा 4. एक महीने से ज़्यादा
C13	आपके बच्चे को आयरन की गोली कितने अंतराल पर मिलती है? 1. हर दिन 2. हफ्ते में तीन बार 3. हफ्ते में 2 बार 4. हफ्ते में एक बार 5. अन्य (नोट करें)
C14	आपके बच्चे को आखिरी बार कृमिनाषक गोली कब दी गयी थी? 1. पिछले 6 महीने में 2. 6 महीने से ज़्यादा 3. एक साल से ज़्यादा 4. कह नहीं सकते/पता नहीं
C15	आपके बच्चे का टीकाकरण आखिरी बार कब हुआ था? 1. पिछले 6 महीने में 2. 6 महीने से ज़्यादा 3. एक साल से ज़्यादा 4. कह नहीं सकते/पता नहीं
C16	पिछली बार सेंटर पर मौजूद बच्चों की स्वास्थ्य जांच कब हुई थी? 1. पिछले 6 महीने में 2. 6 महीने से ज़्यादा 3. एक साल से ज़्यादा 4. कह नहीं सकते/पता नहीं
C17	इनमें से सेंटर द्वारा संचालित कौन कौन से जागरूकता अभियान के बारे में आपको जानकारी है? 1. परिवार नियोजन 2. एचआइवी/AIDS 3. बाल उत्पीड़न 4. महिला अधिकार 5. घरेलू हिंसा 6. मासिक धर्म 7. बाल विवाह 8. स्त्री–पुरुश समानता 9. बच्चों की परवरिष से संबंधित 10. गर्भवती महिलाओं के पोशण सम्बंधित 11. अंधविश्वास
C18	यदि बच्चा कुपोशित हो तो क्या उस स्थिति में बच्चे के पोशण के ऊपर अतिरिक्त/ज्यादा ध्यान दिया जाता है? 1. हाँ 2. नहीं

C19	बच्चे के कुपोशित होने पर सेंटर से कौन कौन सी अतिरिक्त मदद /सुविधा मिलती है ? 1. डॉक्टर /NRC को रेफर करना 2. nutritionist से सलाह 3. घर पर खिलाने के लिए अतिरिक्त भोजन 4. सेंटर पर अतिरिक्त भोजन 5. अन्य (नोट करें)
C20	क्या बच्चे के बीमार होने पर सेंटर से मदद मिलती है? 1. हाँ 2. नहीं
C21	बच्चे के बीमार होने पर सेंटर से किस किस तरह की मदद मिलती है? 1. डॉक्टर द्वारा चेकअप 2. दवाइयों की सहायता 3. भोजन की सहायता 4. अन्य (नोट करें)
C22	क्या सेंटर आपको पोशण से संबंधित बातों के बारे में परामर्ष/सलाह देता है? 1. हाँ 2. नहीं
C23	सेंटर द्वारा बच्चे के पोषण से संबंधित मीटिंग आखिरी बार कब हुई थी? 1. हर महीने 2. 2–3 महीने के अंतराल में 3. 6 महीने के अंतराल में 4. अन्य (नोट करें)
C24	क्या आपको lockdown के दौरान सेंटर से कोई मदद मिली? 1. हाँ 2. नहीं
C25	lockdown के दौरान सेंटर से कौन कौन सी मदद मिली? 1. राशन 2. डॉक्टर से सलाह 3. दवाइयां 4. अन्य (नोट करें)
इस बातचीत के लिए समय देने के लिए धन्यवाद, आपका दिन शुभ हो।	

Schedule for Quantitative Interviews with Mothers (Bangalore)

Consent	ನನ್ನ ಹೆಸರು _____ ಮತ್ತು ನಾನು ಪಾಲಿಸಿ ಅಂಡ್ ಡೆವಲಪ್ಮೆಂಟ್ ಅಡ್ವೈಸರಿ ಗ್ರೂಪ್ (PDAG) ಪ್ರತಿನಿಧಿಸುತ್ತೇನೆ. ಮೊಬೈಲ್ ಕ್ರೆಚೆ (Mobile Creche) ನಡೆಸುತ್ತಿರುವ ಪೌಷ್ಟಿಕಾಂಶ ಕಾರ್ಯಕ್ರಮದ ಕುರಿತು ನಾವು ಅಧ್ಯಯನ ನಡೆಸುತ್ತಿದ್ದೇವೆ ಮತ್ತು ನಿಮ್ಮ ಸಹಕಾರವನ್ನು ಕೋರುತ್ತೇವೆ. ಈ ಅಧ್ಯಯನಕ್ಕೂ ಯಾವುದೇ ಸರ್ಕಾರ ಅಥವಾ ರಾಜಕೀಯ ಪಕ್ಷಕ್ಕೂ ಸಂಬಂಧವಿಲ್ಲ. ಈ ಅಧ್ಯಯನದ ಸಮಯದಲ್ಲಿ ನೀವು ನಮಗೆ ಒದಗಿಸುವ ಯಾವುದೇ ವೈಯಕ್ತಿಕ ಮಾಹಿತಿಯನ್ನು ಯಾರಿಗೂ ಬಹಿರಂಗಪಡಿಸಲಾಗುವುದಿಲ್ಲ ಮತ್ತು ನಿಮ್ಮ ಗುರುತನ್ನು ಕಟ್ಟುನಿಟ್ಟಾಗಿ ಗೌಪ್ಯವಾಗಿ ಇರಿಸಲಾಗುತ್ತದೆ. ಈ ಅಧ್ಯಯನದ ಸಮಯದಲ್ಲಿ ನೀವು ಇನ್ನು ಮುಂದೆ ಭಾಗವಹಿಸಲು ಬಯಸುವುದಿಲ್ಲ ಎಂದು ಭಾವಿಸಿದರೆ, ನೀವು ನಿಲ್ಲಿಸಬಹುದು. ಈ ಸಂಭಾಷಣೆಯು 15-20 ನಿಮಿಷಗಳನ್ನು ತೆಗೆದುಕೊಳ್ಳುತ್ತದೆ ಮತ್ತು ಭಾಗವಹಿಸುವ ಮೂಲಕ ಈ ಅಧ್ಯಯನವನ್ನು ಯಶಸ್ವಿಗೊಳಿಸಲು ನೀವು ನಮಗೆ ಸಹಾಯ ಮಾಡುತ್ತೀರಿ ಎಂದು ನಾವು ಭಾವಿಸುತ್ತೇವೆ. ನೀವು ಭಾಗವಹಿಸಲು ಬಯಸುವಿರಾ? 1. ಹೌದು 2. ಇಲ್ಲ
ಹೌದು ಎಂದಾದರೆ, ಮುಂದುವರಿಯಿರಿ. ಇಲ್ಲದಿದ್ದರೆ, ಇನ್ನೊಬ್ಬ ಸದಸ್ಯರನ್ನು ಹುಡುಕಿ	
Survey id	ಮುಂದುವರಿಯಲು ದಯವಿಟ್ಟು ನಿಮ್ಮ ಸರ್ವೇಯರ್ ಐಡಿಯನ್ನು ನಮೂದಿಸಿ
	ನಿಮ್ಮ ನಗರವನ್ನು ಆರಿಸಿ 1. ದೆಹಲಿ

	2. ಬೆಂಗಳೂರು
Introductory questions	
A1	ಸ್ಥಳದ ಹೆಸರು.(ದೆಹಲಿಯ ಸಂದರ್ಭದಲ್ಲಿ ಒಂದನ್ನು ಆಯ್ಕೆಮಾಡಿ) 1. ಕೇರ್ ವಿಲೇಜ್ ಸಮೃದ್ಧಿ 1 2. ಎಟಿಎಸ್ ದಿ ಗ್ರ್ಯಾಂಡಿಯೋಸ್ 3. ಎಟಿಎಸ್ Nobility 4. ಸುಪ್ರಾ -ಸೈಟ್
A1	ಸ್ಥಳದ ಹೆಸರು (ಬೆಂಗಳೂರಿನಲ್ಲಿ ಒಂದನ್ನು ಆಯ್ಕೆಮಾಡಿ) 1. CLPD 2. ಮಹಾವೀರ್ Turquoise 3. ಮಹಾವೀರ್ ರಾಂಚಸ್ 4. ಪ್ರೆಸ್ಟೀಜ್ ಫರ್ನ್ ಗ್ಯಾಲಕ್ಸಿ 5. ಪ್ರೆಸ್ಟೀಜ್ ಫಾಲ್ಕನ್ ಸಿಟಿ 6. ಸೂರ್ಯನಗರ ಇಬ್ಬಲೂರು 7. ಪೂರ್ವ ಪಾಮ್ ಬೀಚ್ 8. ಹೊಂಬಾಳೆ 9. ಎನ್ಆರ್ ಗ್ರೀನ್ವುಡ್
A2	ಯೋಜನೆಯಲ್ಲಿ ಕಾರ್ಯನಿರ್ವಹಿಸುತ್ತಿರುವ ಕೇಂದ್ರ ಸಂಯೋಜಕರ ಸಂಖ್ಯೆ ಎಷ್ಟು?
A3	ಕೇಂದ್ರದಲ್ಲಿ ಅಡುಗೆ ಮತ್ತು ಆರೈಕೆ ಚಟುವಟಿಕೆಗಳಿಗೆ ಜವಾಬ್ದರಿಯುತರಾಗಿರುವ ಸಿಬ್ಬಂದಿಗಳ ಸಂಖ್ಯೆ ಎಷ್ಟು?
A4	ಇತರ ಸಿಬ್ಬಂದಿಗಳ ಸಂಖ್ಯೆ ಎಷ್ಟು? - . ಉಲ್ಲೇಖಿಸಿ

A5	ನೀವು ಎಲ್ಲಿಯವರೆಗೆ ಓದಿದ್ದೀರಿ? (ಒಂದನ್ನು ಆರಿಸಿ) 1. ತರಗತಿ 1-4 (1st - 4th std) 2. ತರಗತಿ 5-7 (5th - 7th std) 3. ತರಗತಿ 8-9 (8th - 9th std) 4. ತರಗತಿ 10-11 (10th - 11th std) 5. 12ನೇ ತೇರ್ಗಡೆ 6. ಐಟಿಐ/ಡಿಪ್ಲೊಮಾ 7. ಪದವಿಧರ 8. ಸ್ನಾತಕೋತ್ತರ ಪದವಿ 9. ಅನಕ್ಷರಸ್ಥ
A6	ನೀವು ಯಾವ ಸಮುದಾಯಕ್ಕೆ ಸೇರಿದವರು? (ಒಂದನ್ನು ಆರಿಸಿ) 1. SC 2. ST 3. OBC 4. General/ಸಾಮಾನ್ಯ
A7	ನೀವು ಯಾವ ಧರ್ಮವನ್ನು ಅನುಸರಿಸುತ್ತೀರಿ? 1. ಹಿಂದೂ 2. ಇಸ್ಲಾಂ 3. ಸಿಖ್ 4. ಕ್ರಿಶ್ಚಿಯನ್ 5. ಬೌದ್ಧಧರ್ಮ 6. ಇತರೆ (ದಯವಿಟ್ಟು ನಿರ್ದಿಷ್ಟಪಡಿಸಿ)

A8	ನಿಮ್ಮ ಸರಾಸರಿ ಮಾಸಿಕ ಕುಟುಂಬದ ಆದಾಯ ಎಷ್ಟು? (ಒಂದನ್ನು ಆರಿಸಿ) 1. 5000 ರೂ.ಗಿಂತ ಕಡಿಮೆ 2. ರೂ 5000- ರೂ 10000 3. ರೂ 10000 - ರೂ 15000 4. 15000 ಮತ್ತು ಹೆಚ್ಚಿನದು
A9	ನಿಮ್ಮ ಮಗು ಯಾವಾಗಿನಿಂದ ಡೇ ಕೇರ್ ಸೆಂಟರ್‌ಗೆ ಬರುತ್ತಿದೆ? (ತಿಂಗಳಲ್ಲಿ)
CHILD'S NUTRITION	
C1	ಮಗುವಿನ ಲಿಂಗ ಯಾವುದು? 1. ಗಂಡು 2. ಹೆಣ್ಣು
C2	ಮಗುವಿನ ವಯಸ್ಸು ಎಷ್ಟು? (ತಿಂಗಳಲ್ಲಿ) 1. 6 ತಿಂಗಳು - 3 ವರ್ಷಗಳು 2. 3 ವರ್ಷಗಳು - 6 ವರ್ಷಗಳು 3. 6 ವರ್ಷಗಳು - 12 ವರ್ಷಗಳು
C3	ಮಗುವಿನ ತೂಕ ಎಷ್ಟು? (ಕೆಜಿಗಳಲ್ಲಿ)
C4	ಮಗುವಿನ ಎತ್ತರ ಎಷ್ಟು? (ಸೆಂ.ಗಳಲ್ಲಿ)
C5	ಮಗು ವಾರದಲ್ಲಿ ಎಷ್ಟು ದಿನ ಕೇಂದ್ರಕ್ಕೆ ಹೋಗುತ್ತದೆ? 1. ಪ್ರತಿದಿನ (ಆಫ್-ಡೇಸ್ ಹೊರತುಪಡಿಸಿ) 2. ವಾರದಲ್ಲಿ 4-5 ದಿನಗಳು 3. ವಾರದಲ್ಲಿ 2-3 ದಿನಗಳು 4. ವಾರಕ್ಕೆ ಒಂದು ಸಲ

C6	ಕೇಂದ್ರದಲ್ಲಿ ಮಗುವಿಗೆ ಪ್ರತಿದಿನ ಎಷ್ಟು ಸಲ ಊಟ ಸಿಗುತ್ತದೆ? 1. ಒಂದು 2. ಎರಡು 3. ಮೂರು 4. ಮೂರಕ್ಕಿಂತ ಹೆಚ್ಚು
C7	ವಾರದಲ್ಲಿ ಎಷ್ಟು ದಿನ ಮಗುವಿಗೆ ಕೇಂದ್ರದಲ್ಲಿ ಬಾಳೆಹಣ್ಣು ಸಿಗುತ್ತದೆ? 1. ಪ್ರತಿದಿನ (ಆಫ್-ಡೇಸ್ ಹೊರತುಪಡಿಸಿ) 2. ವಾರದಲ್ಲಿ 4-5 ದಿನಗಳು 3. ವಾರದಲ್ಲಿ 2-3 ದಿನಗಳು 4. ವಾರಕ್ಕೆ ಒಂದು ಸಲ 5. ಸ್ವೀಕರಿಸುವುದಿಲ್ಲ
C8	ಒಂದು ವಾರದಲ್ಲಿ ಎಷ್ಟು ದಿನ ಮಗು ಕೇಂದ್ರದಲ್ಲಿ ಮೊಟ್ಟೆಗಳನ್ನು ಪಡೆಯುತ್ತದೆ? 1. ಪ್ರತಿದಿನ (ಆಫ್-ಡೇಸ್ ಹೊರತುಪಡಿಸಿ) 2. ವಾರದಲ್ಲಿ 4-5 ದಿನಗಳು 3. ವಾರದಲ್ಲಿ 2-3 ದಿನಗಳು 4. ವಾರಕ್ಕೆ ಒಂದು ಸಲ 5. ಸ್ವೀಕರಿಸುವುದಿಲ್ಲ
C9	ಮಗುವಿನ ಊಟದಲ್ಲಿ ಬೇರೆ ಯಾವ ಪದಾರ್ಥಗಳಿವೆ? (ವಿಸ್ತರಿಸಿ)
C10	ಸರ್ಕಾರಿ ಆರೋಗ್ಯ ವ್ಯವಸ್ಥೆಯನ್ನು ಪ್ರವೇಶಿಸಲು ನಿಮಗೆ DMC ಯಿಂದ ಸಹಾಯ/ಸಹಾಯ ದೊರೆಯುತಿದೆಯಾ? 1. ಹೌದು 2. ಸಂ
C11	ಮಗುವಿಗೆ ಕೇಂದ್ರದಲ್ಲಿ ಆಂಥ್ರೊಪೊಮೆಟ್ರಿಕ್ ಕ್ರಮಗಳನ್ನು ಎಷ್ಟು ಬಾರಿ ತೆಗೆದುಕೊಳ್ಳಲಾಗುತ್ತದೆ? 1. ಪ್ರತಿ ವಾರ 2. ಪ್ರತಿ 2 ವಾರಗಳಿಗೊಮ್ಮೆ 3. 2 ವಾರಗಳಿಗಿಂತ ಹೆಚ್ಚು 4. ಒಂದು ತಿಂಗಳಿಗಿಂತ ಹೆಚ್ಚು
C12	ಕೇಂದ್ರದಲ್ಲಿ ನಿಮ್ಮ ಮಗು ಎಷ್ಟು ಬಾರಿ ಕಬ್ಬಿಣದ ಪೂರಕಗಳನ್ನು ಪಡೆಯುತ್ತದೆ? 1. ಪ್ರತಿ ದಿನ

	2. ವಾರಕ್ಕೆ ಮೂರು ಬಾರಿ 3. ವಾರಕ್ಕೆ ಎರಡು ಬಾರಿ 4. ವಾರಕ್ಕೆ ಒಂದು ಸಲ 5. ಇತರೆ
C13	ಮಗುವಿಗೆ ಜಂತುಹುಳು ನಿವಾರಣಾ ಮಾತ್ರೆಗಳನ್ನು ಕೊನೆಯ ಬಾರಿಗೆ ನೀಡಿದ್ದು ಯಾವಾಗ? 1. ಕಳೆದ 6 ತಿಂಗಳಲ್ಲಿ 2. 6 ತಿಂಗಳಿಗಿಂತ ಹೆಚ್ಚು ಹಿಂದೆ 3. ಒಂದು ವರ್ಷದ ಹಿಂದೆ 4. ಗೊತ್ತಿಲ್ಲ/ಹೇಳಲಾರೆ
C14	ಮಗು ಕೊನೆಯ ಬಾರಿಗೆ ಲಸಿಕೆಯನ್ನು ಪಡೆದದ್ದು ಯಾವಾಗ? 1. ಕಳೆದ 6 ತಿಂಗಳಲ್ಲಿ 2. 6 ತಿಂಗಳಿಗಿಂತ ಹೆಚ್ಚು ಹಿಂದೆ 3. ಒಂದು ವರ್ಷದ ಹಿಂದೆ 4. ಗೊತ್ತಿಲ್ಲ/ ಹೇಳಲಾರೆ
C15	ಕೇಂದ್ರದಲ್ಲಿ ಕೊನೆಯ ಬಾರಿಗೆ ಆರೋಗ್ಯ ತಪಾಸಣೆ ಯಾವಾಗ ನಡೆಯಿತು ? 1. ಕಳೆದ 6 ತಿಂಗಳಲ್ಲಿ 2. 6 ತಿಂಗಳಿಗಿಂತ ಹೆಚ್ಚು ಹಿಂದೆ 3. ಒಂದು ವರ್ಷದ ಹಿಂದೆ 4. ಗೊತ್ತಿಲ್ಲ/ ಹೇಳಲಾರೆ
C16	ಕೇಂದ್ರದಿಂದ ನಡೆಸುತ್ತಿರುವ ಜಾಗೃತಿ ಕಾರ್ಯಕ್ರಮಗಳ ಬಗ್ಗೆ ನಿಮಗೆ ಅರಿವಿದೆಯಾ ? 1. ಕುಟುಂಬ ಯೋಜನೆ 2. ಎಚ್‌ಐವಿ/ಏಡ್ಸ್ 3. ಶಿಶು ದೌರ್ಜನ್ಯ 4. ಮಹಿಳಾ ಹಕ್ಕುಗಳು 5. ಕೌಟುಂಬಿಕ ಹಿಂಸೆ 6. ಮುಟ್ಟು 7. ಬಾಲ್ಯ ವಿವಾಹ 8. ಲಿಂಗ ಸಮಾನತೆ 9. ಪೋಷಕತ್ವ 10. ಗರ್ಭಿಣಿಯರಿಗೆ ಪೋಷಣೆ 11. ಮೂಢನಂಬಿಕೆಗಳು

C17	ಮಗುವು ಅಪೌಷ್ಟಿಕತೆಯಿಂದ ಬಳಲುತ್ತಿರುವ ಸಂದರ್ಭಗಳಲ್ಲಿ ಮಗುವಿಗೆ ವಿಶೇಷ ಪೋಷಣೆ ಸಿಗುತ್ತದೆಯೇ? 1. ಹೌದು 2. ಸಂ
C18	ಮಗುವಿಗೆ ಅಪೌಷ್ಟಿಕತೆ ಇದ್ದಲ್ಲಿ ಕೇಂದ್ರವು ಯಾವ ರೀತಿಯ ಹೆಚ್ಚುವರಿ ಬೆಂಬಲವನ್ನು ಒದಗಿಸುತ್ತದೆ? 1. ವೈದ್ಯರು/ಆರೋಗ್ಯ ಕೇಂದ್ರಕ್ಕೆ ಶಿಫಾರಸುಗಳು 2. ಪೌಷ್ಟಿಕತಜ್ಞರಿಂದ ಸಲಹೆ 3. ಮನೆಯಲ್ಲಿ ನೀಡಬೇಕಾದ ಹೆಚ್ಚುವರಿ/ಪೂರಕ ಆಹಾರ 4. ಕೇಂದ್ರದಲ್ಲಿ ಹೆಚ್ಚುವರಿ/ಪೂರಕ ಆಹಾರ 5. ಇತರೆ (ದಯವಿಟ್ಟು ನಿರ್ದಿಷ್ಟಪಡಿಸಿ)
C19	ಮಗುವು ಅನಾರೋಗ್ಯಕ್ಕೆ ಒಳಗಾದಾಗ ಮಗುವಿಗೆ ಯಾವುದೇ ಬೆಂಬಲ ಸಿಗುತ್ತದೆಯೇ? 1. ಹೌದು 2. ಇಲ್ಲ
C20	ಮಗುವು ಅನಾರೋಗ್ಯಕ್ಕೆ ಒಳಗಾದಾಗ ಕೇಂದ್ರವು ಯಾವ ರೀತಿಯ ಹೆಚ್ಚುವರಿ ಬೆಂಬಲವನ್ನು ನೀಡುತ್ತದೆ? 1. ವೈದ್ಯರಿಂದ ಪರೀಕ್ಷಿಸಿ 2. ಔಷಧಿಗಳ ರೂಪದಲ್ಲಿ ಬೆಂಬಲ 3. ಹೆಚ್ಚುವರಿ ಆಹಾರದ ರೂಪದಲ್ಲಿ ಬೆಂಬಲ 4. ಇತರೆ (ದಯವಿಟ್ಟು ನಿರ್ದಿಷ್ಟಪಡಿಸಿ)
C21	ಮಗುವಿನ ಪೋಷಣೆಗೆ ಸಂಬಂಧಿಸಿದ ವಿಷಯಗಳ ಕುರಿತು ಕೇಂದ್ರವು ಸಲಹೆ/ಸಲಹೆ ನೀಡುತ್ತದೆಯೇ? 1. ಹೌದು 2. ಇಲ್ಲ
C22	ಮಗುವಿನ ಪೋಷಣೆಯ ವಿಷಯಗಳನ್ನು ಚರ್ಚಿಸಲು ಕೇಂದ್ರವು ಯಾವಾಗ ಸಭೆಗಳನ್ನು ನಡೆಸುತ್ತದೆ? 1. ಪ್ರತಿ ತಿಂಗಳು 2. ಪ್ರತಿ 2-3 ತಿಂಗಳಿಗೊಮ್ಮೆ 3. ಪ್ರತಿ 6 ತಿಂಗಳಿಗೊಮ್ಮೆ

	4. ಇತರೆ (ದಯವಿಟ್ಟು ನಿರ್ದಿಷ್ಟಪಡಿಸಿ)
C23	ಲಾಕ್‌ಡೌನ್ ಸಮಯದಲ್ಲಿ ನೀವು ಕೇಂದ್ರದಿಂದ ಯಾವುದೇ ಬೆಂಬಲವನ್ನು ಪಡೆದಿದ್ದೀರಾ? 1. ಹೌದು 2. ಇಲ್ಲ
C24	ಲಾಕ್‌ಡೌನ್ ಸಮಯದಲ್ಲಿ ನೀವು ಕೇಂದ್ರದಿಂದ ಯಾವ ರೀತಿಯ ಬೆಂಬಲವನ್ನು ಪಡೆದಿದ್ದೀರಿ? 1. ಪಡಿತರ ಕಿಟ್‌ಗಳು 2. ವೈದ್ಯರಿಂದ ವೈದ್ಯಕೀಯ ಸಲಹೆ 3. ಔಷಧಿಗಳು 4. ಇತರೆ (ದಯವಿಟ್ಟು ನಿರ್ದಿಷ್ಟಪಡಿಸಿ)
ಸಂದರ್ಶನದ ಅಂತ್ಯವಾಗಿದೆ . ನಿಮ್ಮ ಸಮಯಕ್ಕಾಗಿ ಧನ್ಯವಾದಗಳು.	

ANNEXURE C

Deliverables (for DMC) / Objectives (for evaluation)	Beneficiary	Stakeholders	Programmes (Responds to the deliverables, and works with stakeholders)	Monitoring Indicators	Excerpts/vignettes from the field- Community Respondents (Referred as Cases)	Excerpts from Officials	Observations of Interviewer and Researcher	Inferences (drawn from the linking of vignettes and observations with indicators)
1) Safety/Safe space for children Highlight colour: Light Blue 2	Children	Parents, Centre incharge, Security incharge	Safety of children from any kind of abuse and danger. Safekeeping in a space, from wandering (perspective of parents) Activities on children protection	Location of centre and distance from construction site Features of the centre (gate,etc.) Feedback/ perspective of parents Indicators of children satisfaction, agency of the child Narration of centre incharge or equivalent stakeholder	Case 1 Homebale: Interviewer: how far is the centre from where you stay? Respondents: 2 km. Takes 10 minutes to come here. Interviewer: Do you feel that this is a safe space for your children? Respondents: yes Case 2 Mahavir Ranches: Interviewer: Do you all feel that your child is safe at the centre after you drop them there to go for work? Respondents: We do feel they are safe. Interviewer: Are they told about the hazard of taking the children at the construction site and why they should be kept at the centre? Respondents: The teacher at the centre tells us to not take children to construction site for safety reasons. . . Respondents: Even when us parents come to drop children, then also, safety measures and other advice is given. Respondents: The location of the centre is little far and there is no proper road to access the centre. There is issue with water and toilet facility. The centre is small so there is little space for playing. Interviewer: Can they elaborate more about the problem? Respondents: There is no water facility and space to play outside the centre is less and the kids play at the centre. Case 3 Mahavir Turq: Interviewer: Do they like to spend their day at the centre? Like to learn and play? Respondents: They stay there comfortably, and we do not have to worry about them. . . Interviewer: So, do you find it beneficial to leave them at the centre and not take them with you to the construction site due to pollution, hygiene, and safety issues? Respondents: We are tense about their safety at the construction site, what if something falls on their head. They are safer at the centre, and we cannot take them to the new building. Case 4 NR: It's very nice here. They take good care of the children and they give them food on time. We can't feed them on time when we go to work, and they take care of that here. They are very safe here, there is no fear of them wandering around. Since the centre has been closed for the past few days it's been very difficult without them now because we have to work with the children around. But the centre is very safe and it feels very nice that they are at the centre. Case 6 Purva: Q: Do you feel that the centre will keep your child safe? A: The construction site is dangerous for children. The managers do not allow children at the work site. Our children remain safe there. The centre has space for them to play; they meet other children and the teachers keep them engaged.	Narrative 1 Security: How do you ensure the security of children in the centre? Respondent: We ensure that the school is near the labour shed, so that it is easier to get to the school for children. We provide security at the pathway to the school. The pathway has been made even throughout. And as far as the NGO's work is considered it is quite appreciated. We keep the children away from the site, they are not allowed there. Children are only supposed to be either at the school or the shed. Other than that wherever they have to go, they go with their parents. Narrative 2: Interviewer: How accessible is the centre from the construction site? Nalanda: The centre is around 300 metres from the colony. The parents leave the children at the centre and in case the parents go for work, then teachers even go and bring the children to the centre on their own. Narrative 3: Interviewer: So, do you also speak about the safety and hazards at the construction site? Respondent: Yes, earlier they used to take them along but now we told them about safety and hazards and now they leave children at our centre. Interviewer: So, you also have individual interaction with them as well apart from the FGD? Nalanda: Yes. We have separate interactions when we meet in our free time. In case of a new family, the old family tells them about the centre and brings them along.	The centre was found to have been constructed and was well maintained. Cleanliness was also maintained within the centre premises. The centre was in a good condition, it had ventilation, and was kept clean. Besides security guards there were CCTV cameras installed in the centre. However, they seemed to be not functional. Movement registers, attendance registers to monitor children's location. The gates and the general infrastructure in the centres are capable of preventing children from exiting the centres without supervision. The behaviour of the teachers and staff was found to be appropriate, and they seemed very friendly with the kids. The mothers emphasise on the centre's ability to keep their children both safe and engaged in activities. Beyond nutrition, safety and activeness of the child is very highly valued.	1. General observation of researchers and narrations from community as well as officials demonstrate that the centres are safe spaces for children.The infrastructure such as gates, enclosed areas, and security personnels help to ensure this. 2. The distance and location of the centre seem to be further from the construction site, even if it is in certain cases away from the labour colony. Some centre staff attest to picking the children up from the camps, which enhances the children's safety. 3. Parents feel that their children are safe and are taken care of at the centre by the staff of DMC. The parents expressed trust in the centre's facilities to ensure that their children do not wander, which were especially appreciated by the working mothers. 4. Safety of children seems to be incorporated as part of the basic functioning and processes of the centre. The features of a centre themselves allow for the children to be present within the confines of a space allocated for them, and thus remain safe. 5. The functional relationship between the centre and the construction site officials helps ensure the safety and protection of the children at the centre. 6. Certain systematic measures such as security cameras were present, although their sustained use was questionable.

Deliverables (for DMC) / Objectives (for evaluation)	Beneficiary	Stakeholders	Programmes (Responds to the deliverables, and works with stakeholders)	Monitoring Indicators	Excerpts/vignettes from the field- Community Respondents (Referred as Cases)	Excerpts from Officials	Observations of Interviewer and Researcher	Inferences (drawn from the linking of vignettes and observations with indicators)
2) Nutrition Highlight colour: Yellow	Children, lactating/ pregnant mothers, mothers	Parents, Centre incharge, Coordinators	Meals provided in centre according to plan Special foods provided to malnourished children Nutrition for lactating and pregnant mothers Nutritional supplements	Awareness of incharges of program initiatives and plan Awareness of parents about nutritional plan Accomodations in plan for malnourished children Testimonies of mothers of malnourished children	Case 1 Homebale: Interviewer: what do the children do once you leave them at the centre? Respondents: At 10 AM they have halwa. At 12: 30 they get to eat khichdi. At 4 pm, they get a banana or chikki. Everyday they get one. Milk and eggs are given to younger children who are around 3 years of age. The weak ones also get it. Case 2 Mahavir Ranches: Interviewer: According to the parents, how does the centre take care of food and nutrition needs of the children? Respondents: We got to know after enrolling their children about what kind of food is to be given and now, they serve vegetables, soup and eggs to children. Case 3 Mahavir Turq: Interviewer: So, what nutritious food is given? Can you name some? Respondent: Medicine is given first and after that chikki is given in the morning. Rice and lentil khichdi is given with soybean and boiled chana. Boiled eggs are given daily with the banana. . . Interviewer: When you feed the children as per the instructions and suggestions given at the centre and if the children still turn out to be malnourished/ weak by the doctor, then what is suggested by them? Respondent: In such cases, additional supplement of banana and eggs is given along with supplements such as iron. They also tell us to maintain hygiene and sanitation. Case 4 NR: P: In terms of the food they give at the centre, what do you think about it? A1: In the morning they give chikki, and they give them khichdi for lunch, and when we come to pick them up in the evening, they feed the children milk and snacks. They give them barfi to eat also. . . P: Do your children like coming to the centre? What do they do at the centre? A2: They go to the centre everyday. First they go there and they get some sweets, then for lunch they have khichdi, then in the evening they get eggs, barfi, channa. Case 5 Falcon: P: What kind of food is given at the centre? A: From the start, they have been giving eggs, bananas, milk, biscuits, chikki, khichdi and boiled dal such as moong dal. There is also a kit with a multigrain atta mix that has been given in the evening time. P: How is this atta mix given to the children? A: They add a little sugar and boil it with water. P: Do you think your children like the food there? What do you think about its helpfulness for your children's health? A: We think that our children benefit from the food given there, it's nutritious for them. They also like the taste . . P: What do you mean by the variety? What are the changes seen after the centre came into the picture? A: Whatever the adults used to eat, we used to give the same to our children but with less masala and salt. The food given in the centre, and the timings they follow here is better. P: What is better here? A: The timing here is good, sometimes the children weren't given food in time when we were in our hometown, but now it's good and healthy. P: Have you seen any other changes in your children's health since coming to the centre? A: Ever since we came, our children's weight and height are getting better, and they are healthy also. The children are also more active, they play and talk to others. Case 6 Purva: Q. Does your child get any Nutritional Supplement at the center? A. Yes they get hot cooked meals: They get a meal after prayer and for lunch they get Khichdi and Eggs and in the evening they get chikki. Sometimes chana is also given. Q.What sort of food items are served? A. In school our children get Khichdi, Kela, Chana, Badam Chikki, Anda, Ragi Soup	Narrative 2: Respondent: The children at the creche course are fed at the centre and given mashed food. The older children are able to eat on their own. Interviewer: Did you face any kind of severe malnourishment in your centre with any children? Respondent: There are 3 such children. Interviewer: How were their problems addressed? Respondent: They were given additional foods such as eggs and were told to consult with doctors. Narrative 3: Interviewer: How many malnourished children are there in your centre? Respondent: Three are in the yellow band and one is in the red band. Interviewer: Is there some separate treatment for such children? Respondent: We give them extra eggs and a little more food and bananas. Narrative 4: We feed the children Chikki and milk in the morning, then we give them lunch at 1 pm for the children. We give them khichdi, which has a different vegetable in it each day, and we also give them eggs with it. There is tea time from 2-3 pm, where they go home and come back. Then in the evening we give them boiled chana or moong dal for the children on alternating days. Narrative 6 Suncity: Once every month we check the height and weight of the children. We also have special care for the malnourished or underweight children, where we check their weight and we give them more oil, eggs, and also more of the multigrain anaj powder. Narrative 7 Project coordinator: How is the dietary programme / action decided upon? Do DMC officials discuss the issues and challenges with the mothers? (Food habits, preferences, cultural issues such as vegetarian / non vegetarian diet etc) While a dietician decides on the essential nutrients we ensure that locally available food is cooked at the centre; also we teach mothers to cook locally available foods which can be easily prepared in a small kitchen. Since we have a good community connection we ensure that food preferences are considered while preparing the menu.	There isn't any specific nutritional accomodation for the COVID pandemic situation, such as immunity boosting foods. Eggs are not provided to all the children, and milk does not seem to be part of a regular diet for all the children. Lack of clarity if the Anaj mix is actually provided regularly. There is a lack of correlation between telephonic interviews, field visits and centre location, in this aspect. Lack of variety in the lunch menu can pose an issue. The three meals are filling in nature, and have approval from the parents. Extra quantity served to children severely and moderately malnourished.	1. There is a general consistency in all narratives about the items provided as food. 2. There is a general consistency that the food is nutritious and the quantity of food served per helping is more than adequate for the children. 3. Narratives suggests that both children and parents like the taste of the food and look forward to it. Mothers seem to specifically appreciate the timing with which the food is regularly provided to the children at the centre. 4. Some significant nutritional improvements mentioned by both community and officials, such as using different types of vegetables. It was appreciated by the community. 5. Fruits, vegetables, nuts and millets further add to the nutritional spectrum. 6. There are certain inconsistencies when it comes to the provision of milk, eggs and nutritional mixes, in terms of the recipient children group. 7. While the menu is nutritious, observations in the field showcase children might be dissatisfied with the repetitive menu, especially for lunch. 8. There is a lack of change in the nutritional structure to accommodate for the effects of the pandemic on children.

Deliverables (for DMC) / Objectives (for evaluation)	Beneficiary	Stakeholders	Programmes (Responds to the deliverables, and works with stakeholders)	Monitoring Indicators	Excerpts/vignettes from the field- Community Respondents (Referred as Cases)	Excerpts from Officials	Observations of Interviewer and Researcher	Inferences (drawn from the linking of vignettes and observations with indicators)
3) Nutritional counselling Highlight colour: Light Green 1	Parents	Parents, Centre incharge, Coordinators	Regular meetings with parents with the intention of counselling on nutritional awareness Counselling focusing on teaching mothers how to replicate/ attempt to replicate centre's nutritional practices Specialists' involvement: through nutritionists, through awareness programmes Community involvement programmes focused on nutrition	Awareness of meetings by mothers Different types of meetings Mothers' nutritional knowledge/ awareness of process of nutritional food preparation Testimonies of reciprocation by mother Awareness of programme initiative in centre incharges	Case 1 Homebale: Interviewer: Do you have a meeting with the teacher at the centre? Respondents: We do it every month once. We talk about nutrition for children, about sending them to school. Children are also taken for a health check up. Interviewer: Do you talk about nutrition in these meetings? Like how could ragi soup be made? Respondents: Yes, we feed them halwa. We make rotis and rice. I give milk with bournvita, desi ghee made at home. Yesterday, I made roti with aloo kalia. Case 2 Mahavir Ranches: Interviewer: Do parents participate at the centre in discussion around what kind of food should be given to the children and how should they be taken care of? Respondent: The teachers give instructions not to feed junk food and oily food to children. Parents are told to feed the children fruits, vegetables. The parents participate in the meeting. Interviewer: How do the parents plan to provide proper attention and care in overall development of the children if the centre is not there? Have they been given any special training or counselling for the same? Respondent: Feeding the children was not a problem but earlier they were unaware about what to feed them. We used to feed them the same kind of food such as junk items and bakery items that were consumed by them. Because of this school, now children are better and there are some changes. Now, they compare what kind of food is to be given. Case 3 Mahavir Turq: Interviewer: Ok. Do they ask what your children want to eat? Respondent: Yes. They do. The madam comes and tells us about the importance of healthy eating for stronger immunity. She tells us to give soup to the children. Interviewer: What we mean to ask is, have they given you any training about what kind of food to cook, what kind of food is nutritious? Respondents: Yes. They taught us about vegetables and leafy vegetables. They have also cooked and fed us. . . Interviewer: So, some of you have young children and some of you have older children. So how do you give them food differently? Respondents: Yes. We have been told to pound the ingredients in a mixture and then serve the food to younger children. . . Interviewer: Can you elaborate how you will take care if you are unable to avail the facilities currently provided by the centre? Respondents: Initially, we used to feed them lollipops, Kurkure and other such snacks. After we were informed at the centre to not feed kids junk food, we no longer feed them these. Case 4 NR: P: The khichdi that they give at the centre, are you able to make it at home? A1: No, unfortunately we can't make it at home. Sometimes, during the lockdown when they gave us rations, we were able to try it, but otherwise we weren't able to make it at home. They even told us during the meetings to feed our children these foods as it is very healthy for them. We try to give them whatever is possible for us, with the effort that we can put in. P: What is the difficulty you're facing in not making it? A1: The rate of the ingredients we have to buy is a little high. We try to make do with what we can afford. They buy such good quality oil and items, we can't afford all that can we. We try to do it a few times, maybe once a month, but otherwise we can't afford that much. . . P: What do they talk about in the meetings? A1: They tell us to add different types of vegetables, and other healthy food items we can make for our children for their nutrition. They ask us to give them eggs and other nutritious items for our meals at home. . . P: Were you able to make khichdi with the rations they gave then? A1: Just like how they told us that we could make khichdi in the meetings, we tried it at home itself. We would make it at home like once a week. P: You said that it is very difficult to make such food at home, how do you think that can be helped? A1: It's not that we can't make any good food at home, but with the lockdown it's very difficult. We can't give them eggs and bananas everyday, that much we simply cannot afford to. Case 4 NR: P: Have you gotten any training or program on how to make cheap but nutritious food	Narrative 2 Incharge: Respondent: We inform about the nutrition for children and about family planning, both individually and even through focused group discussions. Interviewer: Please elaborate more about the nutritional counselling given to the mother? Respondent: The mothers and parents are told during the FGD and during home visits about what should be eaten, what kind of food is to be consumed such as vegetables and fruits. Narrrative 3: Interviewer: Do you also interact with the parents of the children and also tell them about what kind of food to eat and how to cook it? Respondent: We do talk to them. We tell them not to feed junk food and we also tell them to make the children eat more vegetables such as leafy ones like spinach, and roti, sprouts. We tell them about vitamins and proteins. Narrative 4: P: Where does this camp take place? A: It takes place at the centre. We inform the parents about the timings and they come. But if in any case the parents have some problems and can't come to the centre, we go to the communities and hold the meetings there, the FGDs, nutrition camps, etc. . . . P: Why do you think some children are underweight? And what difficulties do you face in giving them this supplementary nutrition? A: The children barely eat any vegetables in their homes, so we smash and give vegetables to the children so they all eat it. Since the parents are busy with work, they neglect giving them this kind of food. In the centre, we make sure they are fed these vegetables, and they like it. P: These vegetables are given with the khichdi? What kinds of vegetables do you give? A: Sometimes palak, sometimes carrot or beetroot. Each day we use a different vegetable. Along with this we give eggs during lunch. P: Do you make any other changes for the children who are underweight? A: No specific changes, we add an extra spoon of oil for them that's all.	Language came out to be a major barrier in communication as many migrant workers belonging to Uttar Pradesh, West Bengal, Bihar and Jharkhand failed to understand Kannada, and the teacher as well as centre incharge understood limited Hindi. At the expense of providing high quality nutritious foods to the children, sometimes the mothers might not be able to financially cope with attempting to continue an equivalent meal structure at home. The living conditions of the labour families need to be taken into consideration when it comes to nutritional counselling methods. The labour camps are extremely cramped, devoid of basic facilities, and does not provide any space for the residents to maintain basic hygiene. Training is done for the staff to effectively implement the different modules and meeting forms, when approaching the counselling of parents.	1. Activities related to nutritional counselling are held regularly as per mandate. 2. Community testify attending and benefiting from it. 3. As per officials, the mothers are pressed for time to cook and also lack access to a kitchen in the labour colony which leads to lack of quality food. 4. While the mothers testify to having cooked the meals as advised, the responses seem narrated across centres and poses concerns of authenticity. 5. Given the unique socio-economic and environmental characteristics of the parents and children, they continue to look up to the food served at the centre. 6. The children's liking of the centre food is an important factor in terms of the mothers responding to the centre's nutrition advice through their home cooking. Mothers are more inclined to cook food similar to the one fed at the centre when their children ask them to. 7. The nutrition specific mixes are not home cooking friendly, even though they seem to be an integral part of the nutritional program. While kits are provided during lockdown, there is a lack of alternatives otherwise. 8. According to the narratives, the kits provided during lockdown, accompanied with training or counselling on how to provide nutritious food using these kits, seem to have inadvertently helped the mothers learn how to make nutritious food as it is made in the centre. 8. PDP methods, flashcards and other meeting structures do not seem to take the living conditions of the labourers into consideration. The inhumane living conditions makes adhering to any of the narrative counselling components almost impossible. 9. Although centre staff have noted that mothers do not cater to their children enough, there needs to be more sensitivity training in terms of understanding the different communities, and their situations, that comprise these labour camps.

Deliverables (for DMC) / Objectives (for evaluation)	Beneficiary	Stakeholders	Programmes (Responds to the deliverables, and works with stakeholders)	Monitoring Indicators	Excerpts/vignettes from the field- Community Respondents (Referred as Cases)	Excerpts from Officials	Observations of Interviewer and Researcher	Inferences (drawn from the linking of vignettes and observations with indicators)
					from the centre? A2: No, we haven't. P: Have the centre approached you to inform you on how to make nutritious food, or on why nutritious food needs to be fed to your children? Has there been any discussions regarding this? A2: Yes sometimes. How to make food, how to care. Case 5 Falcon: P: Did you get to know about the food plan from the centre or from talking to your children? A: Initially the centre had informed us about all of this. Our children also come home and tell us what food they ate at the centre. P: How does the centre inform the mothers of all of this? Are there meetings of some sort? A: They let us know in meetings, where they also tell us to make those types of food at home also, for our children. P: What is talked about with regards to food and nutrition in these meetings? A: They tell us to give the same type of chana dal/moong dal for the children, and they advised us not to get the children too much junk food/outside food. They ask us to make food as they make it in the centre, whenever the children ask them to make it. P: Are you able to make the centre food in their homes? Have you faced any difficulties in it? A: In the meetings they tell them what kind of food is made at the centre and ask us to make, and since we're all from Karnataka, the food is pretty much the same. In case we don't know how to make some things, we come and ask them during these meetings. Apart from this, we also make the children food that they like. . . A: Except for the atta mix, everything else we already make at home. We don't know how to make that atta mix at home. . . . P: During the lockdown, did you think your children got the same nutrition they got when they went to the centre? Were you able to provide that nutrition for them on your own? A: We didn't see any difference without the centre food, or face any problems. We were able to make it ourselves and feed our children, the same way they give in the centre. The same way the centre planned breakfast and then khichdi and then snacks, we also gave at home . . . P: During the lockdown, did you think your children got the same nutrition they got when they went to the centre? Were you able to provide that nutrition for them on your own? A: We didn't see any difference without the centre food, or face any problems. We were able to make it ourselves and feed our children, the same way they give in the centre. The same way the centre planned breakfast and then khichdi and then snacks, we also gave at home Case 6 Purva: Q. Do you think that the discussions that you have participated at the centre helped you to make better food choices for your child? A. Yes we have spoken about many things, Nutrition, Family Planning and vaccination for children after birth and education of our children. Yes it has made us change the food we give our children; bakery items and junk food are not good.	Narrative 7 Program coordinator: What is a basic outline of the Community Awareness/ outreach programme? What are the themes which are covered and how ? Through the cooking demo and community discussions we talk of nutritional choices, best cooking and Hygiene Practises etc Through FGDs specific malnourishment, malnutrition cases and specific health care related issues are discussed in small groups with the community. Case 8 Suncity: P: You said that the food that you make is slightly different from the centre food, since you're from Bengal. Can you expand from that? Have the centre people talked to you about it? A: So we don't eat as much roti and other things. We prefer boiled rice over raw rice, and we have it with dal and different types of vegetables. We have fish, chicken, mutton, we also eat all types of food. When we have meetings, they tell us how it's made in the school and how we can make it in our homes even though we make different foods.		

Deliverables (for DMC) / Objectives (for evaluation)	Beneficiary	Stakeholders	Programmes (Responds to the deliverables, and works with stakeholders)	Monitoring Indicators	Excerpts/vignettes from the field- Community Respondents (Referred as Cases)	Excerpts from Officials	Observations of Interviewer and Researcher	Inferences (drawn from the linking of vignettes and observations with indicators)
4) Medical support for children Highlight colour: Light Magenta	Children, mothers	Parents, incharge/ centre representative	Regular weight checks of children and correspondence with parents regarding their health. Growth monitoring of Severe Acute Malnutrition (SAM), Moderately Acute Malnutrition (MAM) in children Nutritional supplements Addressal of contingent and chronic medical issues and support to parents to access medical care Growth monitoring	Awareness of parents Testimonies of cases of malnourishment Testimonies of mothers describing services provided to their own children Centre in charge narratives on medical support	Case 1 Homebale: Interviewer: if you or your children fall ill, does the doctor come visit? Respondents: the centre is visited by a doctor every month, we also go visit the doctor if the need be. It takes 10 minutes to get there. Case 2 Mahavir Ranches: Respondent: One of the children here was malnourished and he was given special attention and care by the centre. Interviewer: How does the centre provide medical health in case of necessity or takes care of the malnourished/ weak children? Respondent: There is a visit by a doctor every once a month and in case of sickness or emergency, the children are given medicines and in case of serious situation, the doctor is gold. Interviewer: Are they also given medicines along with food? Respondents: Yes. Vitamin syrup and iron supplements are given. Case 3 Mahavir Turq: Interviewer: So, in case of illness, do the children receive immediate attention or after some gap of a week or so? Respondent: No. They are given immediate medical attention. Interviewer: Is there one doctor or caretaker to look after all the kids or do they take shifts alternatively? Respondent: There is one doctor who is attached to the centre and comes to the centre whenever there is need of any medical help. Case 4 NR: P: If your children are ill, does a doctor come to treat them? A2: Doctor comes once or twice every month. They give them medicines and leave. P: Have your children been vaccinated and immunised? A2: Yes they have got all the vaccines. Case 5 Falcon: P: Have your children ever fallen ill or had any health-related difficulties in your time here? A: Since we came, due to climate change initially all our children had some fever and cold. But since then no illness. P: At that time, did you get any help from the centre? A: Yes the doctor came for a check-up, and they prescribed some medicines that the centre had. When we were busy with work, they were able to feed the medicines to the children in the centre itself. Whenever we had too much work, the teachers took care of our children well, by tying their hair, etc. P: When you do get time from work, do they give you the medicines to give your children at home? A: The doctor, through the centre, does give us the medicines to give at home. If our children aren't getting better, the doctor gives us the prescription for the medicines we need to give our children for it. Case 8 Suncity: P: What is this syrup? A: It is a vitamin syrup they give the younger children everyday, and once every 3 days for the older children. . . . P: When the doctor comes, do they call you? A: Yes they let us know when it happens, and they even ask us if we want to get checkedup. P: During the checkup, have they ever diagnosed any of your children with any illness? A: Whenever the children get a cold or something, they give the syrup and medicines at the centre itself. They also provide the medicines for us too if we need it.	Narrative 2 Incharge: The children with poor health/weak are given extra food along with supplements such as iron tablets or iron syrup. Interviewer: What kind of regular medical check-up is done? Respondent: There is a monthly visit by the doctor and in case the children are sick, medicines or syrup is given after following up with the doctor. . . . Narrative 3: We highlight cases of malnourishment before the doctor as well. Interviewer: Do you take these children to the doctor? Respondent: Yes. At times, we do when parents do not know how to talk to doctors. In such cases we go. . . Interviewer: How often does the doctor come, daily or in case of serious sickness? Respondent: We do 2 times height-weight checkup and once in a month health check-up. Doctor comes 2 times a month, in which a height-weight checkup happens and next week a malnutrition test happens. The medicinal instruction about syrup and medicine is given to the teacher and they in turn tell doctors. Some medicines are to be given at night, how much of it to be given after food is also told. . . Interviewer: During COVID the doctor used to come? Respondent: No. . . Interviewer: What was the biggest problem during the COVID and lockdown for the teachers at the centre? Respondent: No problem as such. All parents' numbers were taken and formed into one online group and there we used to give assignments. Narrative 4: P: Could you tell me more about any supplementary nutrition that's given? A: In the morning we give children a multivitamin tonic, along with a nutritious chikki. We also give them an Anar mix to the children who are underweight. Narrative 6 Suncity: P: Apart from the anaj powder, what other nutritional supplements do you provide? A: We give them multivitamin syrup, and a neofylin syrup. The smaller children get it everyday, while the older ones get it on alternative days. During the doctor's checkup, if they notice that some child is weak, then we give that child double the amount based on the doctor's suggestion.	There doesn't seem to be a failsafe preparation in case of a COVID outbreak Nutritional supplements were heavily showcased by the the staff, even in the video calls Weighing scale and inch tape were available at the centre. However, the method adopted to take the height measurement (child made to stand against the wall, the height marked on the wall with chalk, the child removed and the inch tape used to measure the length from the floor until the mark) was not appropriate. A stadiometer (used at Anganwadi centres) could be used instead of an inch tape. The health report cards of children which had all the basic details of the child and nourishment status were of two kinds. The older version recorded only weight to ascertain the nourishment status of the child. The new version recorded both height and weight. Most of the health cards were the older version. The centre's regular use of these cards was questionable.	1. Although supplements are given as part of the general nutritional plan, there doesn't seem to be an allocation for malnourished children. 2. Awareness of these supplements seem to not be as prominent among the mothers. Educating the parents in this regards may prove useful. 3. The health cards used at the centres are very extensive in terms of the medical details it can capture, and is also suggested to be useful in cases of relocation of children to other DMC supported construction sites. Systematically, these cards can prove to be immensely beneficial in monitoring and assisting the growth of the children, but its effective usage in practice could not be observed to a satisfactory level. 4. Multiple registers are maintained, allowing for a solid framework for growth monitoring and medical data collection. 5. Immunization, and regular counselling efforts for the same, seem to be well in place. COVID vaccination of the children and their parents, has been taken up as a priority in terms of medical support by the centres. 6. The medical programme does not have a COVID oriented consultancy/ medication component, which might be needed to safely transition into and out of a pandemic imposed lockdown. Medical support during the lockdown does not have enough clarity.

Deliverables (for DMC) / Objectives (for evaluation)	Beneficiary	Stakeholders	Programmes (Responds to the deliverables, and works with stakeholders)	Monitoring Indicators	Excerpts/vignettes from the field- Community Respondents (Referred as Cases)	Excerpts from Officials	Observations of Interviewer and Researcher	Inferences (drawn from the linking of vignettes and observations with indicators)
5) Support during lockdowns Highlight colour: Cyan	Children, mothers	Centre incharge, co-ordinators Construction site owners Other associated government and CSO stakeholders	Rations and kits provided during lockdown Nutritional snacks provided during lockdown Hygiene counselling	Testimonies from parents of support during lockdown Structural plans for lockdown described by centre representatives	Case 2 Mahavir Ranches: Interviewer: how was your experience during the lockdown and how did you take care of children when the centre was closed? Respondents: During lockdown, there was no food and no work. The centre provided some ration for the children. Case 4 NR: P: You said that the lockdown has been very difficult, what kind of difficulties did you face in the previous lockdowns? A1: In the last lockdowns they gave us rations to use, they also gave us brush, paste, soap and other items along with it at the centre itself. It was extremely helpful during that time. They gave us rice and other things also. . . . P: During the pandemic lockdowns, did you face any difficulties? Was the centre helpful? A2: Yes, during the lockdown our work stopped. The centre gave us rations of rice, oil, dal, etc. P: Assuming someone got ill during the lockdown, did the doctor come to treat that? A2: Yes, the doctor came once every month and prescribed medicines. Case 5 Falcon: P: So even though everything was closed during the lockdown, you had work and the centre was open? A: Yes, we still had work to go to, that didn't stop. But while the centre was open, the school in the centre was closed. They still provided us with rations and support. P: What kind of rations were provided ? A: Rice, sugar, suji, masala powders, chikki, eggs and bananas. P: How often were these rations given? A: Each month a certain quantity was given once. Case 6 Purva: Q.If your child gets unwell do you get to access any health care support from the centre? A. Doctor comes once a month. To check on our children. Q. How did the COVID-19 Pandemic affect the services being provided? What were the most notable challenges? A. There were no problems due to the lockdown. We got rations from the centre; 10Kg Rice; 1 Kg Badam; 1 Kg Sugar; 1 Kg Dal; 2 Kg Chana; 1 ltr Oil; and Spice powder.	Narrative 1 Security: Respondent: We used to conduct a meeting with the labourers which is called Tool Box Talk in which we talked about safety during work with them. That has also stopped due to instructions from the head office to not conduct them anymore due to COVID. But before COVID these meetings used to happen regularly. Interviewer: When a child or a parent falls ill, what is the safety, security and support system you provide? Respondent: We have tied up with a hospital for anybody that falls ill. There is a hospital named East point Hospital which is 2 km from the site. If a child falls ill, the teacher takes them to the hospital. If it is something serious, then we get involved. Narrative 2 : Interviewer: What kind of problems did you both faced during the COVID in running the centre and providing services to the children? Respondent: During COVID, the labour families found it difficult to earn and at that time rations kits were provided to the families. Narrative 3: Interviewer: What was biggest problem during the COVID and lockdown for the teachers at the centre? Respondent: No problem as such. All parents' numbers were taken and formed into one online group and there we used to give assignments. Narrative 4: P: Since the COVID 19 pandemic, has there been any changes in the pan to accommodate it? A: No changes at all. The plan is just as it has been since before. Narrative 6 : P: Have there been any changes in the plan because of COVID? A: No, it's been the same before and after lockdown. During the lockdown the children lost a lot of weight since they were just roaming around and not fed at the right time. Since they joined the centre after the lockdown, their weights have trended back to normal. P: Was the centre closed during the lockdowns? A: Yes we were closed, but we provided rations for the children to the families in the camp.	To ensure that the child was the one eating meals cooked with the provided dry ration, photographs were asked for from the parents Dry rations seem to have been provided for the children at the labour camp, to compensate for the lack of cooked meals that the centre could have provided without the lockdown in place. The community received the dry ration with pleasure Heavy focus on hygiene counselling conducted by the centre staff Centre was shut down during the lockdown, even while the construction work took place. Rations were provided in these times	1. Provision of dry ration kits for every month is a part of the deliverables mentioned in the grant. According to the testimonies these rations were provided for the children in regular intervals, although the interval time frame could not be completely verified. 2. The ration kits seem to have assisted the families in sustaining nutritional meals for their children, and was appreciated by the community. 3. Hygiene practices have a high focus in light of the pandemic, but these also need to take the living conditions of the labour camps into consideration. The hygiene counselling needs more situational cognizant. 4. The centres were observed to be well organised and well maintained, within the infrastructure provided to them

Deliverables (for DMC) / Objectives (for evaluation)	Beneficiary	Stakeholders	Programmes (Responds to the deliverables, and works with stakeholders)	Monitoring Indicators	Excerpts/vignettes from the field- Community Respondents (Referred as Cases)	Excerpts from Officials	Observations of Interviewer and Researcher	Inferences (drawn from the linking of vignettes and observations with indicators)
6) Education Highlight colour: Dark Blue	Children	Parents, Centre incharge, Coordinators	Noticeable curriculum Categorisation of children into age groups. Classroom activities	- Existence of curriculum - Classification of children as per age groups - Bridge programmes for children who spend more than 6 months at the centre and linking them with the local schooling system. - Presence of teachers in each centre	Case 4 NR: P: What kind of education do your children get at the centre? A2: Children come here, they read, write and play. They eat food. P: Do they learn languages here? Do they learn maths? A2: They learn Kannada, some Hindi. They also learn maths.	Narrative 3: We teach them as per their physical and mental development Interviewer: How do you manage the learning of each category of the students according to different age groups. Respondent: We teach them small tables, alphabets using some things we have here. Interviewer: What all routine activities do you undertake? Respondent: We do social, language development as per timeline. Narrative 7 Project coordinator: Education: A thematic curriculum engages children from birth to 3 years (Creche); 3 to 5 years (Balwadi); 6 years and above (non-formal bridge course). Learning takes place in a play-based environment, with age appropriate activities, to develop the following aspects: cognitive development– puzzles, blocks, beads, colouring books; Socio-emotional learning– group games, doll's house, sand box .	There is a separate curriculum for the kids going to creche, balwadi and bridge courses. There are dedicated teachers for each of the three sections. Classrooms for different age groups are allocated separate rooms or spaces within the available infrastructure. The centre starts at 9:30 and goes on until 5 pm. Curriculum for each of the sections is stuck on the walls of the classes.	1) The children are divided into three age groups: 0-3 - Creche, 3-5 - Balwadi, 6 & above - Bridge. Lessons and activities are split accordingly. This structure is based on the distinct requirements of each of these age groups. One teacher was allocated to each age group, but this was dependant on staff availability. 2) Parents were content with the centres providing basic education, and appreciated the activities that kept the children active and engaged.

Deliverables (for DMC) / Objectives (for evaluation)	Beneficiary	Stakeholders	ECCD (Early Childhood Care and Development) programme features	Monitoring Indicators	Excerpts / vignettes from the field- Community Respondents (Referred as Cases)	Excerpts from the field- Officials	Observations of Interviewer and Researcher	Inferences (drawn from the linking of vignettes and observations with indicators)
1) Safety/Safe space for children Highlight colour: Light Blue 2	Children	Parents, Centre incharge, Security incharge	Safety of children from any kind of abuse and danger. Safekeeping in a space, from wandering (perspective of parents) Activities on children protection	Location of centre, and distance from construction site Features of the centre (gate,etc.) Feedback/ perspective of parents Indicators of children satisfaction, agency of the child Narration of centre incharge or equivalent stakeholder	Case 7 Sushma: Interviewer: How do you feel about leaving your children here? What is the time when you leave them here? Respondents: I like the centre, it is clean, they make them clean their hands. The kids are safe here. Since I work, it is good that my child is here. They get to play around and they are fed regularly. Respondents: It is good to know that my children are safe and sound at the centre while we work. They eat, play and learn here. Had they been at home it would have been doing nothing. I have no tension that they might be unsafe. Case 11 CV: Interviewer: How do you all as parents feel after you leave your children at the centre and go to work. Respondents: We feel good as they are looked after properly and we feel they are safe. We do not face any problem as they are looked after, educated and also fed.	Narrative 10: Incharge: We went to the camps and told them about the school, how their children will be safe at the centre, that they will be given food on time, etc.. We tell them about all the care that their children will receive at the centre.	Movement registers, attendance registers to monitor children's location. The gates and the general infrastructure in the centres are capable of preventing children from exiting the centres without supervision. The mothers emphasise on the centre's ability to keep their children both safe and engaged in activities. Beyond nutrition, safety and activeness of the child is very highly valued. Structured organisation and positive relationship with the construction site representatives, such as the camp supervisor, helps prioritise the children and their safety. Child protection forms were provided to visitors, although their sustained use was questionable based on the signatures on the forms. Yet these forms conformed to the required mandates.	1. General observation of researchers and narrations from community as well as officials demonstrate that the centres are safe spaces for children.The infrastructure such as gates, enclosed areas, and security personnels helps to ensure this. 2. The distance and location of the centre seems to be further from the construction site, even if it is in certain cases away from the labour colony. 3. Parents feel that their children are safe and are taken care of at the centre by the staff of DMC. The parents expressed trust in the centre's facilities to ensure that their children do not wander, which were especially appreciated by the working mothers. 4. Safety of children seems to be incorporated as part of the basic functioning and processes of the centre. The features of a centre themselves allow for the children to be present within the confines of a space allocated for them, and thus remain safe. Movement registers, attendance registers help monitor children's location. 5. The functional relationship between the centre and the construction site officials helps ensure the safety and protection of the children at the centre. 6. Certain systematic measures such as child protection forms and visitor screenings were present, although their sustained use was questionable.

Deliverables (for DMC) / Objectives (for evaluation)	Beneficiary	Stakeholders	ECCD (Early Childhood Care and Development) programme features	Monitoring Indicators	Excerpts / vignettes from the field- Community Respondents (Referred as Cases)	Excerpts from the field- Officials	Observations of Interviewer and Researcher	Inferences (drawn from the linking of vignettes and observations with indicators)
2) Nutrition Highlight colour: Yellow	Children, lactating/ Pregnant mothers, Mothers	Parents, Centre incharge, Coordinators	Meals provided in centre according to plan Special foods provided to malnourished children Nutrition for lactating and pregnant mothers Nutritional supplements	Awareness of incharges of program initiatives and plan Awareness of parents about nutritional plan Accomodations in plan for malnourished children Testimonies of mothers of malnourished children	Case 7 Shushma: Interviewer: did you get supplementary ration once your child weighed lesser than they were supposed to? Respondents: they give eggs, milk and bananas to increase their weight. . . . Respondent: The child eats a little bit. My child likes the cooked food given at the centre. I like the facilities at this centre. Case 9 LeGrand: Interviewer: What do your kids do at school? Respondent: The bigger boys get halwa in the morning. Small kids get kheer mixed with milk. During lunch all the kids get khichdi. The small kids get milk at 3 PM. The bigger kids get snacks made of jaggery. They also get badam, chana, and bananas as snacks. The snacks are served differently on different days. Interviewer: If a kid is underweight or malnourished then do these kids get special cooked food in such cases? Respondent: Yes sir, in such cases the kids get boiled eggs. Weak kids get boiled eggs. Case 11 CV: Interviewer: Please tell me what you feel about the food provided to the children at the centre. Respondents: They give dalia, khichdi, sooji and also give snacks in the evening such as milk to small children and eggs and bananas. They give khichdi and dalia in the lunch and peanuts, gudpatti, grams and at times banana in the evening.	Narrative 5 Shushma: Q. What kind of food is given to the children at the centre and when? A. For breakfast, the elder children are given halwa, and the younger ones (creche children) get rava kheer. For afternoon lunch, dalia and khichdi are made on alternative days with veggies and soya chunks. Different items are given for evening snacks every day. Mon- Fried chana, Tuesday- chikki, Wednesday- groundnut, Thursday- Fried chana, and Friday bananas are given. The creche children also get milk around 3PM in the afternoon. Children suffering from malnutrition are given eggs, bananas, and an extra spoon (5 gm) of refined oil in their khichdi. Narrative 8 Centre incharge: A: I give the kids breakfast in the morning. The small kids get kheer mixed with milk. They get khichdi mixed with green vegetables and oats as lunch on alternate days. At 3 pm the small kids get milk and during the evening snacks they get sweets made of jaggery, bananas, chana and mungfali on alternate days.	There isn't any specific nutritional accomodation for the COVID pandemic situation, such as immunity boosting foods Eggs are not provided to all the children, and milk does not seem to be part of a regular diet for all the children. Lack of clarity if the anaj mix is actually provided regularly. There is a lack of correlation between telephonic interviews, field visits and centre location, in this aspect. Lack of variety in the lunch menu can pose an issue. The three meals are filling in nature, and have an overwhelming approval from the parents	1. There is a general consistency in all narratives about the items provided as food. 2. There is a general consistency that the food is nutritious and the quantity of food served per helping is more than adequate for the children. 3. Narratives suggests that both children and parents like the taste of the food and look forward to it. Mothers seem to specifically appreciate the timing with which the food is regularly provided to the children at the centre. 4. Some significant nutritional improvements mentioned by both community and officials, such as using different types of vegetables. Fruits, nuts and millets further add to the nutritional spectrum.It was well received by the community. 5. There are nutritional diet plans allocated for malnourished children, which the community seem to recognise. 6. There are certain inconsistencies when it comes to the provision of milk, eggs and nutritional mixes, in terms of the recipient children group. 7. While the menu is nutritious, observations in the field showcase children might be dissatisfied with the repetitive menu, especially for lunch. 8. There is a lack of a change in the nutritional structure to accommodate for the effects of a pandemic on children.

Deliverables (for DMC) / Objectives (for evaluation)	Beneficiary	Stakeholders	ECCD (Early Childhood Care and Development) programme features	Monitoring Indicators	Excerpts / vignettes from the field- Community Respondents (Referred as Cases)	Excerpts from the field- Officials	Observations of Interviewer and Researcher	Inferences (drawn from the linking of vignettes and observations with indicators)
3) Nutritional Counselling Highlight colour: Light Green 1	Mothers	Parents, Centre incharge, Coordinators	Regular meetings with parents with the intention of counselling on nutritional awareness Counselling focusing on teaching mothers how to replicate/attempt to replicate centre food Specialists' involvement: Through nutritionists, through awareness programs Community involvement programs focused on nutrition	Awareness of meetings by mothers Different types of meetings Mothers' nutritional knowledge/ awareness of process of nutritional food preparation Testimonies of reciprocation by mother Awareness of program initiative in centre incharges Different methods of approach, and array of topics covered in meetings	Case 7 Shushma: Interviewer: Do you give the same food at home to your children which they get here? Respondents: yes, roti, daal and rice, tea- this is all we give at home. The teacher here tells about feeding the children. She tells us to send the children here neat and clean, with combed hair. If we miss out sometime, they comb their hair here. We cook the ration we receive. We received refined oil, sooji, dalia, rice , salt, and turmeric. We also cook khichdi, dalia at home. At night I cook potatoes, roti, rice and daal. Last night I cooked vegetables and roti.	Narrative 5 Shushma-Centre incharge: Q. To make food from the given ration, did you teach them how to cook? A. While distributing the ration every month, we used to tell the parents to prepare food similarly as we did at the centre. During the visit to the centre, parents had seen the preparation, and we asked them to do the same. Q. Before the lockdown, when the centre was running, did you arrange a cooking demonstration session for mothers, or did you tell them what and how food should be given to children for mothers? A. No, we never actually demonstrated any cooking preparation. Still, we used to keep the parents informed about the kind of food we were serving to the children and the ingredients we put in the food during the monthly meeting with the mothers. Even when the parents drop off children at the centre, they look around the kitchen, but there was no specific session. It mainly was a one-to-one conversation. We never actually thought anything like a lockdown would be in place. Q: What do you discuss in your monthly meetings? A. In case the child is underweight, or the parents tell us that they don't want to eat, then we tell them how a healthy diet is essential for the child's growth. They should be given food five times a day. We also tell them they should be given chai biscuits including breakfast, even in evening chai biscuits apart from regular meals including lunch and dinner. If the child doesn't eat at night, they will not receive the complete nutrition needed for their growth. Dinner is an essential part of the meal. Food like khichdi, daliya is nutrition-rich and should include vegetables. Variation in meals is vital for children; milk and banana can also be given.	At the expense of providing high quality nutritious foods to the children, sometimes the mothers might not be able to financially cope with attempting to continue an equivalent meal structure at home The living conditions of the labour families needs to be taken into consideration when it comes to nutritional counselling methods. The labour camps are extremely cramped, devoid of basic facilities, and does not provide any space for the residents to maintain basic hygiene. Segregation of labour camps by the community and other stakeholders, has been observed. "Malda Labour", composed of Bangla speaking labourers from the Malda region of West Bengal, are considered to be temporary workers and are prone to constant relocation. This community seems to be visibly segregated from the other labourers. They also have their own mess which provides food for the community due to what they claim to be different staple food preferences, which might also include the dinner meals of the children within the community. While the living conditions seem to be similar to the other labourers, they are othered due to their eating habits, and their supposed lack of hygiene. Training is done for the staff to effectively implement the different modules and meeting forms, when approaching the counselling of parents.	1. Activities related to nutritional counselling are held regularly as per mandate. 2. Community testify attending and benefiting from it. 3. As per officials, the mothers are pressed for time to cook and also lack access to a kitchen in the labour colony which leads to lack of quality food. 4. While the mothers testify to having cooked the meals as advised, the responses seem narrated across centres and poses concerns of authenticity. 5. Given the unique socio-economic and environmental characteristics of the parents and children, they continue to look up to the food served at the centre. 6. The children's liking of the centre food is an important factor in terms of the mothers responding to the centre's nutrition advice through their home cooking. Mothers are more inclined to cook food similar to the one fed at the centre when their children ask them to. 7. The nutrition specific mixes are not home cooking friendly, even though they seem to be an integral part of the nutritional programme. While kits are provided during lockdown, there is a lack of alternatives otherwise. 8. According to the narratives, the kits provided during lockdown, accompanied with training or counselling on how to provide nutritious food using these kits, seem to have inadvertently helped the mothers learn how to make nutritious food as it is made in the centre. 8. PDP methods, flashcards and other meeting structures do not seem to take the living conditions of the labourers into consideration. The inhumane living conditions makes adhering to any of the narrative counselling components almost impossible. 9. Although centre staff have noted that mothers do not cater to their children enough, there needs to be more sensitivity training in terms of understanding the different communities, and their situations, that comprise these labour camps.

Deliverables (for DMC) / Objectives (for evaluation)	Beneficiary	Stakeholders	ECCD (Early Childhood Care and Development) programme features	Monitoring Indicators	Excerpts / vignettes from the field- Community Respondents (Referred as Cases)	Excerpts from the field- Officials	Observations of Interviewer and Researcher	Inferences (drawn from the linking of vignettes and observations with indicators)
					Case 9 LeGrand: Interviewer: Are you aware of the nutritious food that comes cheap? Do they tell you about such edibles in the center? Do they keep training sessions of such sort? Respondent: Yes Sir, they tell us about that, and they keep training sessions as well. Interviewer: How frequently do they conduct such training sessions? Respondent: Once a month. Case 11 CV: Interviewer: Apart from the food given at the centre, do they also tell you about how to prepare food at your home? How do you follow that? Respondents: Yes. We give children what we make for ourselves. We give them eggs and no spicy food. Interviewer: So, the children ask you to make any particular kind of food? Respondents: They ask us to make halwa, poori and milk and whatever they ask for. We make khichdi and egg and also milk at home and try to feed all the kids. Interviewer: What else do you cook apart from this? Respondents: They ask for banana and daliya. Interviewer: Do you feel any discomfort in cooking it? Respondents: No. Interviewer: So, you visit the centre for a meeting? Respondents: Yes, but they also come to our homes for inviting.	Narrative 8-Centre incharge: Interviewer: What do you teach the parents on nutritional aspects? Do you keep discussion sessions or group discussions? Mamta: I keep Focused Group Discussions with the parents. Interviewer: On what matters do you conduct FGD and in what interval? Mamta: The FGD is kept on nutrition, cleanliness and safety. Narrative 9-Coordinator: Interviewer: In your organisational structure do you have any sessions on nutritional counselling? Who designs the contents of the sessions? CC: We conduct parents teachers' meetings with everyone. If there is a need then we form Focused Group Discussions with parents and monitor them. Apart from that we have community meetings whenever required like discussions around corona vaccinations. Narrative 11 CV incharge: Q. Explain briefly how the meetings work. Are there separate agenda for each meeting or several topics are covered in each meeting? A. There is a set agenda for each meeting, for instance if the meeting's agenda is about cleanliness: we discuss it with parents. Similarly last week we arranged a meeting on Omicron for parents. We also keep meeting on news years with parents when the child's measurements are taken. Q. Are there separate meetings for providing the right kind of nutrients for children? If yes, what do you tell the parents in such meetings? A. Yes, we do keep meeting on providing nutritional food for children. In case the child is malnourished. We tell the parents that the child should be given food 4-5 times a day, also to maintain hygiene around them. In some cases we realise that the parents are not very careful of the fact, we reiterate to maintain a healthy environment around the child. We have seen benefits from the meeting, the children who did not come clean to the centre have started to come all neat and clean. If we feel that there is a need to put certain pointers in the agenda for the meeting, we keep them. Q: Do you hold FGDs? How do they work? A: We call the parents as per need, there are 4 to 5 children malnourished in our centre. So, we call those parts and tell them out the right kind of food given to them, or in case the child is not coming to the centre neat and clean, we call those particular parents and ask them to maintain hygiene around children. Q. When you keep meeting with the mothers, Do you teach them anything like how to cook daal, khichadi? A: A. During the lockdown we came across one of the families from Bengal who did not understand our language and communicated that they didn't know how to cook from the provided ration. Puja, one of the teachers from the centre went to their house and demonstrated how to make khichdi. The next time we provided them with ration we asked her if she used the ration, and she then made khichdi in front of us.		

Deliverables (for DMC) / Objectives (for evaluation)	Beneficiary	Stakeholders	ECCD (Early Childhood Care and Development) programme features	Monitoring Indicators	Excerpts / vignettes from the field- Community Respondents (Referred as Cases)	Excerpts from the field- Officials	Observations of Interviewer and Researcher	Inferences (drawn from the linking of vignettes and observations with indicators)
4) Medical Support for Children Highlight colour: Light Magenta	Children, Mothers	Parents, Centre incharge, Coordinators	Regular weight checks of children and correspondence with parents regarding their health. Growth monitoring of Severe Acute Malnutrition (SAM), Moderately Acute Malnutrition (MAM) in children Nutritional supplements Addressal of contingent and chronic medical issues and support to parents to access medical care Growth monitoring	Awareness of parents Testimonies of cases of malnourishment Testimonies of mothers describing services provided to their own children Centre in charge narratives on medical support	Case 9 LeGrand: Interviewer: Do doctors come if any kids fall ill? Respondent: Yes sir, there is a site doctor who comes otherwise the madams from the centre call the doctors. Case 11 CV: Interviewer: Has there been any improvement in the health or weight of the children? Respondents: Yes. There is an increase in weight. In the last assessment, my child weighed 5 kgs 700 gm and in the latest assessment, his weight improved to 7 kgs 300 g.	Narrative 8 Centre incharge: Interviewer: Do you have a dispensary? CI: No, we do not have a dispensary, but we do have a site doctor. In case of emergency, we are sent outside. We get our regular checkups done by the doctor that visits our site. Interviewer: Do you have any immunisation programs like vaccination of small children or vaccination of adults? CI: Sir we have a Primary Health Centre for that. Interviewer: How far is the PHC? CI: It is a bit far around 10 kms. Interviewer: Do the children get routine immunisation facilities at the centre? CI: Yes, the children receive that. Medical practitioners from the PHC come for that. Narrative 10: P: How often do you visit the labour camp to talk to the mothers? A: Two times a month we measure weight, we go and inform them about it. Some mothers who have younger children and who stay at home with their children, we ask them to come with their child to measure their weight and height. Monthly twice the doctor comes to conduct checkups Narrative 11 CV incharge: Q. How many times does the doctor make visits to the centre? A. The doctor in our centre visits every month for the children. In case we find the need to call the doctor for our parents, we arrange for it. As doctors are really busy.	Nutritional supplements are promoted by the centre staff as being provided to all the children. Field observations show an extremely detailed health card, that also depicts the malnourishment level of the children as part of either green, yellow or red (representing healthy, moderately maklnourished and Severely malnourished respectively), to be part of the organisation's procedure of growth monitoring. The health cards showcase a Weight-Age graph which can be filled to determine which nourishment band they fall in. According to the officials, these medical cards can help if the child's family moves to a different construction site with facilities supported by DMC, and the parents wish to continue use of DMC's services. Different registers are maintained. Growth monitoring register which is maintained by the respective class teacher. Rest are maintained by the centre incharge. Different avenues and local support seem to be leveraged to ensure immunization efforts are continued.	1. Although supplements are given as part of the general nutritional plan, there doesn't seem to be an allocation for malnourished children. 2. Awareness of these supplements seem to not be as prominent among the mothers. Educating the parents in this regard may prove useful. 3. The health cards used at the centres are very extensive in terms of the medical details it can capture, and is also suggested to be useful in cases of relocation of children to other DMC supported construction sites. Systematically, these cards can prove to be immensely beneficial in monitoring and assisting the growth of the children, but its effective usage in practice could not be observed to a satisfactory level. 4. Multiple registers are maintained, allowing for a solid framework for growth monitoring and medical data collection. 5. Immunization, and regular counselling efforts for the same, seem to be well in place. COVID vaccination, of the children and their parents, has been taken up as a priority in terms of medical support by the centres. 6. The medical program does not have a COVID oriented consultancy/medication component, which might be needed to safely transition into and out of a pandemic imposed lockdown. Medical support during the lockdown does not have enough clarity.

Deliverables (for DMC) / Objectives (for evaluation)	Beneficiary	Stakeholders	ECCD (Early Childhood Care and Development) programme features	Monitoring Indicators	Excerpts / vignettes from the field- Community Respondents (Referred as Cases)	Excerpts from the field- Officials	Observations of Interviewer and Researcher	Inferences (drawn from the linking of vignettes and observations with indicators)
5) Support During lockdowns Highlight colour: Cyan	Children, Mothers	Centre incharge, coordinators Construction site owners Other associated government and CSO stakeholders	Rations and kits provided during lockdown Nutritional snacks provided during lockdown Hygiene counselling	Testimonies from parents of support during lockdown Structural plans for lockdown described by centre representatives	Case 7 Shushma: Interviewer: didi, you were here during the lockdown, but the centre was closed. Did you get any help from the centre otherwise? A: during the lockdown, we received ration from here such as dalia, refined, rice, sooji, chana every month. I cooked halwa, kheer, dalia from the ration. Case 11 CV: Interviewer: During the COVID lockdown in the first and second wave, did you get any help from the centre and how did you manage to give proper food to your children? Respondents: We got masks, sanitizer and rations. We got wheat flour and rice. Interviewer: How many times did you get this ration? Respondents: We got it 3-4 times. Interviewer: Did it help you in feeding your children? Respondents: Sir, we got monthly rations for the children as well. During the lockdown, we got rations for ourselves and dry rations for children to feed them as they were fed at the centre. They told us how to mix rice, wheat and dal and prepare the food. There was also a pregnant woman who got Corona. She was also helped by the sisters from the centre.	Narrative 5 Shushma: Q. What steps were taken during the COVID time for the labour camps? Was ration given to the children? If yes, what ration was provided? A. We used to do activities with children in the labour camp. Yes, ration was given to the children. Mostly all dry ration was given instead of the cooked food from the centre. Like dal, daliya, fried gram, black gram, groundnut, along with tamarind and salt. Narrative 9 Coordinator: Q: Are there any changes in the food menu or food plan pre lockdown and post lockdown? CC: During the normal days when the kids come to school, we give them cooked meals and during the lockdown we give them dry rations or dry nutrition for 15 days and we take feedback from the parents. Q: Has your diet plan changed after the lockdown? CC: No, the plan has not changed but we have only adopted more safety measures. Narrative 11 CV: Q. During lockdown how did the centres manage to help the families? A. During lockdown, when we distributed the dry ration, there were similar responses from parents that they don't eat daliya and they don't know how to cook it. So we taught them how to cook daliya and the parents made it as well. 2 months ago, a girl named Sofia joined our centre. Initially she was not ready to come to dawalwadi but during the lockdown period, when we distributed dry ration she wanted to eat daliya we made at the centre.	Dry rations seem to have been provided for the children at the labour camp, to compensate for the lack of cooked meals that the centre could have provided without the lockdown in place. Heavy focus on hygiene counselling conducted by the centre staff. Centre was shut down during the lockdown, even while the construction work took place. Rations were provided in these times.	1. Provision of dry ration kits for every month is a part of the deliverables mentioned in the grant. According to the testimonies these rations were provided for the children in regular intervals, although the interval time frame could not be completely verified. 2. The ration kits seem to have assisted the families in sustaining nutritional meals for their children, and was appreciated by the community. 3. Hygiene practices have a high focus in light of the pandemic, but these also need to take the living conditions of the labour camps into consideration. The hygiene counselling needs more situational cognizance. 4. The centres were observed to be well organised and well maintained, within the infrastructure provided to them. Basic sanitary protocols appear to be followed.

Deliverables (for DMC) / Objectives (for evaluation)	Beneficiary	Stakeholders	ECCD (Early Childhood Care and Development) programme features	Monitoring Indicators	Excerpts / vignettes from the field- Community Respondents (Referred as Cases)	Excerpts from the field- Officials	Observations of Interviewer and Researcher	Inferences (drawn from the linking of vignettes and observations with indicators)
6) Education Highlight colour: Dark Blue	Children	Parents, Centre incharge, Coordinators	Noticeable curriculum Categorisation of children into age groups. Classroom activities	Existence of curriculum Classification of children as per age groups Bridge programmes for children who spend more than 6 months at the centre and linking them with the local schooling system. Presence of teachers in each centre	Case 9 LeGrand: Interviewer: What do they teach the kids at the centre? Respondent: They teach the kids counting numbers. Case 11 CV: Interviewer: Have you seen any improvement in his overall activity such as learning or playing? Respondents: He is more participative, talkative and plays and laughs more than before.	Narrative 8 Centre incharge: A: We impart education to the kids in a playful manner. Interviewer: How do you do that? A: We have a curriculum for that. Interviewer: What are the things that your curriculum covers? If you could elaborate on this. Do you teach the kids different ABCD or counting or different languages like Haryanvi? A: We mostly teach Hindi according to our curriculum as Hindi is the mother tongue of most of the kids here. Narrative 10: P: What do you all teach? A: We have a syllabus, a book which has what all we have to teach each day. I teach from that.	Classrooms for different age groups are allocated separate rooms or spaces within the available infrastructure. Books published by DMC are used to provide basic education to the children at the centre. Syllabus and content was encapsulated within the books, with one book per age group. The books covered basic education, activities, moral instructions and manners to be followed. The syllabus lasted 6 months each. Different activities and interactive sessions seem to take place.	1) The children are divided into three age groups: 0-3 - Creche, 3-5 - Balwadi, 6 & above - Bridge. Lessons and activities are split accordingly. This structure is based on the distinct requirements of each of these age groups. One teacher was allocated to each age group, but this was dependant on staff availability. 2) The syllabus books, made for each age group, covered an array of topics that can provide basic education at the centre. 3) Parents were content with the centres providing basic education, and appreciated the activities that kept the children active and engaged. 4) The bridge course focused on transitioning students towards getting admissions to government schools, with centre staff involved in advising and assisting the parents in this process.


A B C D
F G H
J M
P Q R S
V W X
Z


हल्का - भारी


बालवाड़ी
प्रकल्प
खेल पिटारा
आओ सीखें और सीखें

DISCLAIMER

Policy & Development Advisory Group (PDAG) does not assume any responsibility and disclaims any liability, however occasioned to HDFC and H T Parekh Foundation or any other party, as a result of the circulation, publication or reproduction of this report. PDAG has not performed an audit and does not express an opinion or any other form of assurance. Further, comments in our report are not intended, nor should they be interpreted to be legal advice or opinion. In accordance with its policy, PDAG advises that neither it nor any partner, director or employee undertakes any responsibility arising in any way whatsoever, to any person other than HDFC and H T Parekh Foundation in respect of the matters dealt with in this report, including any errors or omissions therein, arising through negligence or otherwise, howsoever caused.

In connection with the report or any part thereof, PDAG does not owe duty of care (whether in contract or in tort or under statute or otherwise) to any person or party or entity to whom the report is circulated and PDAG shall not be liable to any person or party or entity who uses or relies on this report. PDAG thus disclaims all responsibility or liability for any costs, damages, losses, liabilities, expenses incurred by such third party arising out of or in connection with the report or any part thereof.