



Tele-Swabhimaan Programme Telangana

Baseline Survey (2022) Results

Sangareddy and Zaheerabad Block, Sangareddy District

1. Background

Telangana being India's youngest state, is improving on several health indicators. When we look at the maternal and child health indicators, according to the latest SRS report (Ministry of Health and Family welfare), Telangana has shown the highest decline of 17% in Maternal Mortality Rate from 81 MMR per lakh births in 2014 to 63 in 2018. The recent NFHS 5 survey also states that Telangana has shown a 3.2% decline in Neonatal Mortality and roughly 1% decline in Infant and under 5 mortality rates

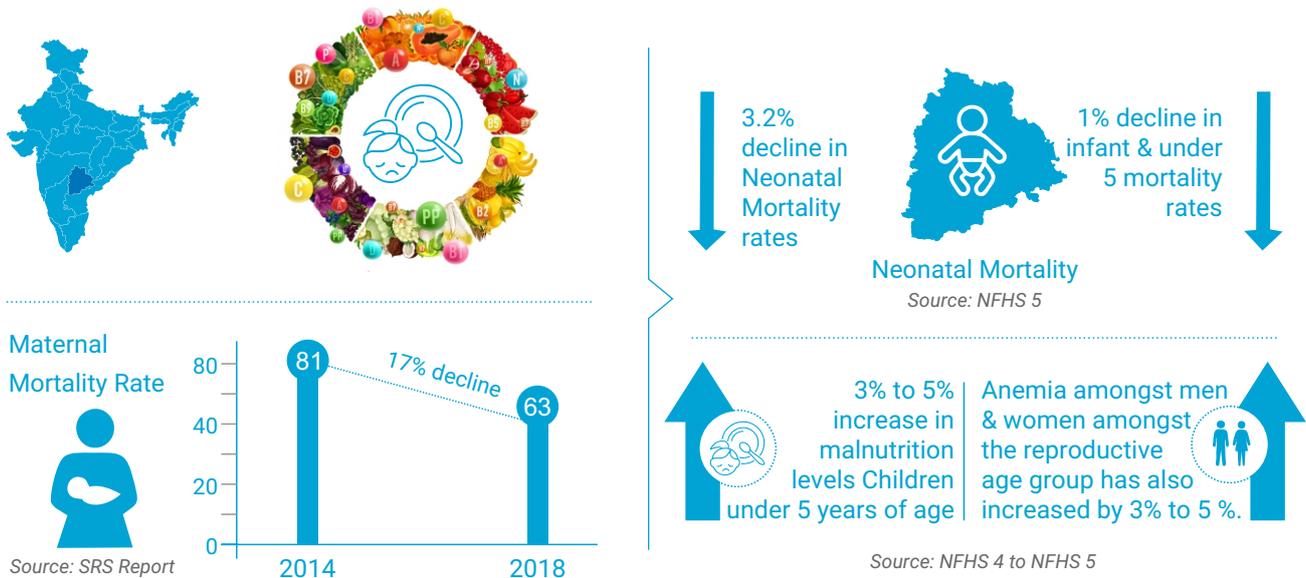


Figure 1. Maternal and child health facts, Telangana

However, the nutrition indicators are contrary to the maternal and child health indicators, showing an incline in the level of malnutrition amongst the pregnant, lactating women and under 5 children in both urban and rural areas. There is a 3-5% increase in malnutrition levels from NFHS 4 to NFHS 5 in children under 5 years of age, anemia amongst men and women amongst the reproductive age group has also increased by 3% to 5%. The urban areas have the same share as their rural counterparts in the overall indicators. The prevalence of severe wasting in urban areas (9.2%) is slightly higher than the state average. Urban areas are also predisposed to higher overweight and obesity, especially among children (4.2%) and pregnant women (42%), and increased prevalence of diabetes and hypertension, even among young adults (adolescents).

Components of Antenatal check-ups and institutional deliveries have significantly improved in most urban areas. However, the gap in the continuum of care from early pregnancy registration, complete ANC's with gestational weight monitoring anemia screening does not demonstrate the same level of improvement. Only 37% of pregnant women have reported having received 180 IFA tablets, and 7% of women post-pregnancy have reported an unmet need for family planning (NFHS-5). Women residing in urban areas are 40% more unlikely to breastfeed their children exclusively, and 25% are less likely to receive full immunization (Coverage less than the state average in urban areas).

There are some apparent advantages of people residing in urban areas. The literacy rates are higher among men as well as women. 89% of women have reported participating in household-level decision-making. More than half of the women own their own house, 3 in 4 own mobile phones, and 4 in 5 women have their bank accounts. While on the one hand, it paints a great picture of women's empowerment for urban Telangana; a quarter of women have also reported spousal violence, 2% of this was during the pregnancy period.

Innovative education and social protection programmes for adolescents with special focus on girls are improving the lives of adolescents in Telangana. While Child Marriages are decreasing in Telangana from 26.2% during NFHS-4 to 23.5% in NFHS-5, there are 13 districts out of 33 which have high number of child marriages.

Maternal and Child Health Welfare Schemes, Telangana

The Government of Telangana has several active welfare schemes for maternal and child health under the Health and Family Welfare (HFW) and Women Development and Child Welfare (WDCW) ministries. Some of the initiatives which focus on maternal and child health are KCR kit, Amma Vodi, routine immunization under Health and family welfare department. The schemes focusing on Maternal and child nutrition are Arogya lakshmi, Supplementary feeding program, NRCs under the Women development and child welfare department.

KCR kit scheme was launched in 2017 for pregnant women and the newborn baby. Pregnant women can utilize this scheme for maximum 2 deliveries. The pregnant women are given financial assistance of Rs. 12,000 in three phases. In case the pregnant women birth a baby girl Rs. 1000 is given additionally. The idea is to encourage more and more deliveries in the government hospitals, reduce the infant mortality rate and female feticide. After the delivery for the wellbeing of the mother and newborn the government gives KCR Kit with 16 items. The kit contains essentials for the mother and the baby like clothes, baby soaps, baby oil, baby powder, mosquito net, toys, napkins, towel, diapers, baby bed etc., which will be sufficient for three months.

Another welfare scheme, Amma Odi was launched in 2018, Under the scheme, a pregnant woman can use free 102 service van to visit the hospital and dropped off at no cost. It can be used any number of times as necessary. After the delivery, the mother along with the newborn are dropped at home after discharge from that hospital. The call centre to avail the service is based in Hyderabad and works 8 AM to 8 PM every day, 365 days.

In 2013, Arogya Lakshmi Scheme was launched to prevent malnutrition among pregnant and lactating. Through this scheme, one full meal along with iron folic acid supplement at the Anganwadi Centre is provided to pregnant and lactating women to fulfil their nutritional needs. The meal consists of rice, dal with leafy vegetable/sambhar, vegetables for a minimum of 25 days, boiled egg, and 200 ml milk for 30 days in a month. This scheme aims to eliminates anaemia among women, control incidence of low birth babies and child malnutrition, provide facilities for health check-ups and immunization to pregnant and lactating women. Through this scheme, the incidence of infant mortality and maternal mortality is expected be reduced.

Under ICDS, Balamrutham was introduced, it is a supplementary food to provide improved supplementary nutrition to children between 7 months to 3 years. The supplementary food is a preparation of wheat, chana dal, milk powder, oil and sugar. It is fortified and thus provides 50% of iron, calcium, vitamins, and other RDA that children require per day. Balamrutham is distributed in packets of 2.5 kg per child per month. It is distributed on first day of every month on Nutrition Health Day to mothers of 7 months - 3 years children as Take-Home Ration. Along with Balamrutham packet, these children also receive 2 eggs a week at the AWC. It is expected that Balamrutham will serve as an effective supplementary nutrition during the child's crucial period of 7 months to 3 years and along with counselling to mother on IYCF practices will help to prevent incidence of chronic malnutrition.



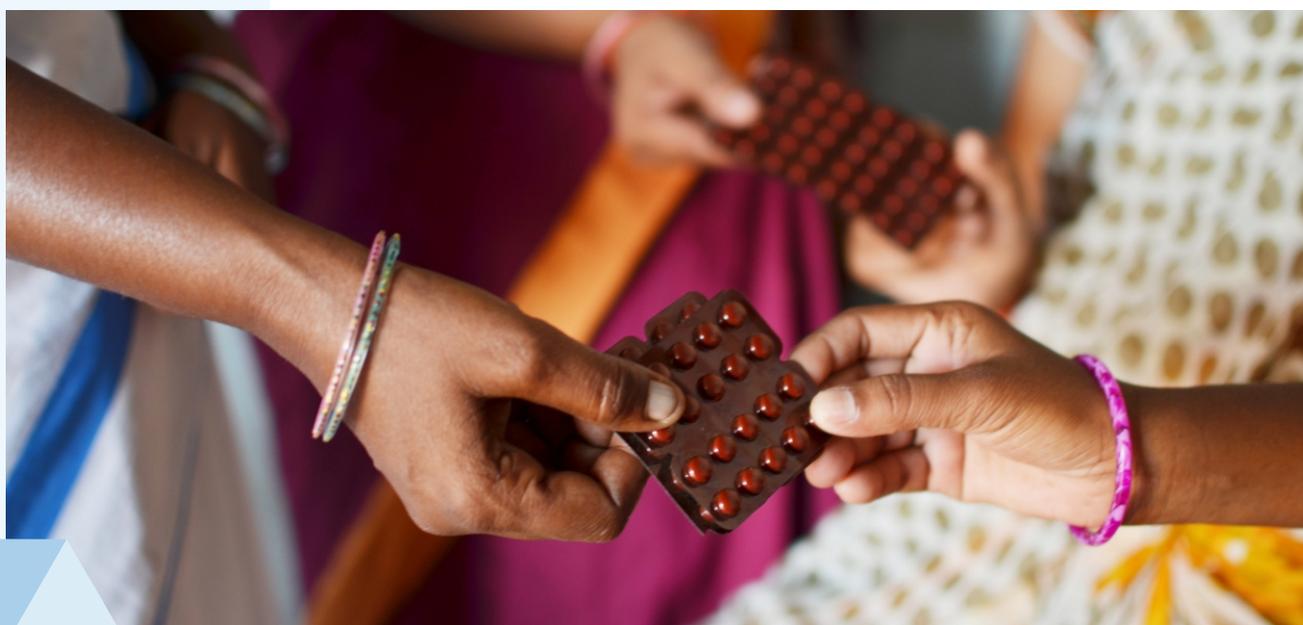
2. Need for Tele-Swabhimaan (Tele Mahila Mitra)

While National Urban Health Mission (NUHM) has been operational in Telangana since 2015, most service delivery on the ground is carried out through Urban Primary Health Centres (U-PHCs), Basti Davakhana (Subcentres at the population of 5000-10000), and ASHA (USHA) workers at the community level. Although Anganwadi Centres exist in urban areas, there is a gap in penetration of ICDS services, and a large section of migratory and non-notified populations remains unserved, predominantly living in the slums. MEPMA, the state nodal agency for Poverty elimination in municipal areas, through a network of Resource People, is working on creating MAS (Mahila Arogya Samitis) from the existing Self-Help Groups. In the past, they have also supported at the community level to mobilize urban slum dwellers to avail services from public health systems.

2020 onwards COVID-19 pandemic has further disrupted the delivery of Health and Nutrition of essential interventions. The counselling services led by women's groups and awareness interactions were also disrupted. In rapid assessment carried out by UNICEF in 2020-21, it has been identified that the service gap is very high for growth monitoring and antenatal services, with some disruptions in the supply of IFA and Vitamin A supplements. Counselling continues to remain an unmet need for population groups across life cycles.

Tele Swabhimaan in Telangana has been formulated to establish a continuum of care on essential health and nutrition elements layered with mental health and gender transformation components, crucial for urban communities, particularly the slum dwellers, through a blend of technology and physical modes of delivery. The Tele Swabhimaan program will target pregnant women and mothers and children (under 2) dyad and adolescents in phases. In each of these, husbands and fathers will be educated on gender-transformative components.

This program will use a two-pronged strategy to build demand through customized digital communication and reinforce physical counselling on the ground. Also, to improve the supply side by a system strengthening approach by bolstering service provision related to growth monitoring for women and children, ANC and Immunization, and micro-nutrient supplementation. Tele Mahila Mitra brings in innovative strategies for delivering health and nutrition solutions for women from/through women.



3. Aims of Tele-Swabhimaan

- Develop programmatic know-how and assess the “added value” and challenges of engaging community-based CRPs for a COVID-19 sensitive package - to facilitate demand generation and access to nutrition services, obstetric advice and mental health advice - that addresses gender disadvantage.
- Improve nutritional status of adolescent girls, pregnant women, mothers and children under-age of two, reduce gender disadvantage, improve mental health and wellbeing.
- Support adaptation of ongoing community-led nutrition programmes for tele-mode, with the integration of interventions for mental health, and addressing gender disadvantage among pregnant women (including pregnant adolescents), mothers of children under 2, and adolescent girls.
- Through simple and culturally acceptable screening methods, enable frontline workers and Resource Persons (RPs) to recognise and report gender-based discriminatory practices, violence, abuse, and signs of psychological distress among target groups.
- Capacitate frontline workers and RPs to provide mental health interventions, including referrals to existing programs in the state like the District Mental Health Programme and WCD One-Stop Centres.



4. Objectives of Tele-Swabhimaan

- The main objectives of tele-Swabhimaan are:
- To improve the women's nutrition led by federation of women agencies promoted by MEPMA in Telangana.
- To understand existing gaps and enhancing knowledge of women on health, nutrition, and mental health.
- To transform gender norms and provide psychosocial support to the target group.



5. Outcomes of Tele-Swabhimaan

As primary outcome of the tele-Swabhimaan, we hypothesize that the interventions will lead to:

- A 5% reduction in the proportion of mothers of children under age two years with BMI < 18.5 kg/m²
- A 5% reduction in the proportion of mothers of children under age two years with BMI > 25.0 kg/m²

As secondary outcome of the programme, an improvement of 5-10% is expected in the coverage and utilization of various nutrition-specific and nutrition-sensitive services.

6. Intervention Components

- Tele Mahila Mitra program is a package of interventions addressing multiple deprivations amongst the communities. This will include support for access to food safety nets, nutrition services, obstetric advice and entitlements, and mental health and child protection support for adolescents, pregnant women (including pregnant adolescents), and mothers of children under 2 years.
- The intervention will be layered with a gender transformative approach. Interventions will focus on understanding gaps and enhancing knowledge of women and men on health, nutrition, mental health, and psychosocial support.
- There will be awareness building for protection services, addressing discriminatory gender norms and behaviors by encouraging male involvement in shared workload, enhancing perceived familial support by women, challenging normalization of gender-based violence', and women's self-efficacy, empowerment, and decision-making power.



7. Key Strategies

The TMM intervention will use outbound calls technology (OBD) for communicating health, nutrition, mental health, women safety, and child protection related messages to the target group and couple it with community level discussion and physical support on the same topics through the resource person network from MEPMA and SHG groups. There will be a provision of a dedicated helpline that will connect the beneficiaries to an expert from relevant medical fields to help them with their queries related to their or their families' health problems.

The Flow of the TMM intervention



Outbound calls (OBDs)- Audio information about nutrition, physical and mental health, and gender transformation will be sent via OUTBOUND DIALING CALLS to the 5 target groups in the intervention



Every group will receive thematic calls once every week on topics related to their health, nutrition, mental health, gender etc.



On field assistance by the MEPMA field functionaries (MEPMA, in convergence with ASHA, ANM and AWTs) to the beneficiaries, including family and community members, to create an enabling environment.



Talk to the expert - A dedicated helpline number available to all the beneficiaries receiving OBD calls to talk to a gynecologist, pediatrician, or mental health professional regarding their problems.

Role of MEPMA Resource persons

Data collection of beneficiaries, their enrolment in the program and follow up



On ground support to the beneficiaries by focused group discussions and connecting them to appropriate service delivery channels like PHC, AWC etc.



The MEPMA 'RP's will be capacitated through continuous capacity building training on the technical aspects of the intervention



Strengthen linkages with Departments of ICDS, HFW and Food & Civil Supplies for providing better services to women and children.



Figure 2. Flow of TMM intervention and role of MEPMA Resource Persons



8. Role of IIPS

The International Institute for Population Sciences (IIPS) serves as a regional Institute for Training and Research in Population Studies for the ESCAP region. The functions of the IIPS can be classified into four categories: teaching, research, consultative services, and documentation. IIPS has the expertise and vast experience of carrying out various large-scale population-based research projects.

Previously, IIPS provided technical support for the Swabhimaan baseline survey. Later, during 2018-19, the midline process evaluation of the Swabhimaan intervention program in Bihar, Chhattisgarh, and Odisha was carried out by IIPS. The institute has also completed the endline impact evaluation of the Swabhimaan Programme in the three states during 2021-22. IIPS has been an integral consortium member of the Swabhimaan Programme. Recently, UNICEF entrusted IIPS to conduct the baseline survey of Tele-Swabhimaan Programme in Telangana.

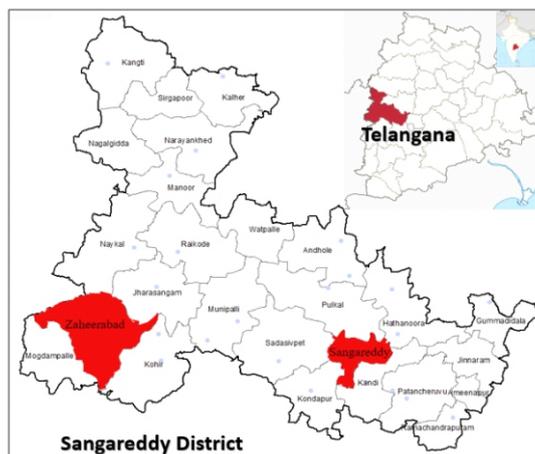
9. Purpose of Baseline Survey (2022)

The purpose of the quantitative survey of Tele-Swabhimaan was to assess the current situation of health and nutrition, gender equality and gender-based disadvantage and mental wellbeing of mothers of children under age two years in the Zaheerabad and Sangareddy blocks of Sangareddy district, Telangana.

The objective of the stakeholders' IDIs was to understand their roles and knowledge, health and nutrition issues in the community, challenges in service delivery, support required and acceptance towards Tele-Swabhimaan programme. The aim of FGDs understand the discriminative gender norms in context with the dietary practices, health seeking behavior, household work and other responsibilities especially during the perinatal period.

10. Baseline Survey (2022), Tele-Swabhimaan

Quantitative data collection for the baseline survey in Sangareddy district was conducted between June and September 2022. In Zaheerabad block, 32 slums served as the intervention area and in Sangareddy block, 35 slums were treated as comparison area. First, a house-to-house census was conducted to enlist each house and its members in the two blocks during June-July 2022. This list identified 5,695 mothers with children under age two years (15-49 years) and their children under age two years. This group was envisaged as the target groups for the system strengthening component of the intervention (as it covered the entire block).



Mothers who consented to participate in the survey were interviewed. Finally, 4,152 mothers were interviewed - 2,099 from Zaheerabad block (intervention) and 2,053 from Sangareddy (control). The baseline survey protocol, methodology and tools were approved by the Institutional Review Board of the IIPS. Computer-Assisted Personal Interviewing (CAPI) based bilingual interview schedules were used for data collection by 24 investigators who were supervised by two Junior Project Managers. Quality control checks were conducted for 10% of the interviewed population. Verbal and written consent was taken from all participants before conducting the interviews.

Household and mother schedules were prepared and pre-tested before data collection. Information obtained included socio-demographic and household characteristics, educational attainment, diet diversity, food security and coping mechanism, access to health and ICDS services, WASH practices, women empowerment, decision making practices, gender-based disadvantage and violence, mental health, infant and young child feeding practices and anthropometry. Nutritional status was assessed using anthropometry (weight, height, MUAC, waist and hip circumference).

Additionally, qualitative data collection was done in Zaheerabad and Sangareddy blocks in July 2022. Under the qualitative approach, in-depth interviews (IDIs) of stakeholders like Resource Person (RP), Auxiliary Nurse Midwife (ANM), Accredited Social Health Activist (ASHA), Anganwadi Teacher (AWT), and Medical Officer (MO) were done. Also, UNICEF conducted the focus group discussions (FGDs) with pregnant women, mothers of children under age two years, men and community women in both the blocks.

The detailed findings from quantitative and qualitative surveys are presented in the sections ahead.

Training of the Investigators



MOTHERS OF CHILDREN UNDER AGE TWO YEARS (15-49 YEARS)



MOTHERS OF CHILDREN UNDER AGE TWO YEARS (15-49 YEARS)

	KEY INDICATORS	Intervention Area (Zaheerabad) n=2099	Control Area (Sangareddy) n=2053	Total N = 4152
HOUSEHOLD CHARACTERISTICS				
Religion of the head of household				
1.1	Hindu (%)	46.4	69.3	57.0
1.2	Muslim (%)	43.0	28.2	36.2
1.3	Christian (%)	10.3	2.2	6.6
1.4	Others ¹ (%)	0.3	0.3	0.3
Caste/Tribe of the head of household				
2.1	Scheduled Caste (SC) or Scheduled Tribe (ST) (%)	18.0	23.4	20.5
2.2	Other Backward Classes (OBCs) (%)	65.0	59.5	62.5
2.3	Others ² (%)	17.0	17.1	17.0
3.	Households that reported migration of family member(s)	17.2	4.0	11.1
4.	for at least two months ³ (%)			
	Households that reported at least one member is part of Self-help groups (SHGs) (%)	32.4	16.4	25.1
Public Distribution System (PDS)				
5.1	Mothers living in the households having ration card (%)	92.9	70.3	82.4
5.2	Mothers living in households with access to PDS in the month preceding the survey ⁴ (%)	99.8	99.1	99.5
6.	Mothers living in households using clean fuel for cooking ⁵ (%)	99.1	99.9	99.5
7.	Mothers living in households owning agricultural land (%)	66.2	75.4	70.4
8.	Mothers living in households using iodized salt (%)	99.0	98.7	98.9
Accessibility and Affordability to fresh produce				
9.1	Households having access to fresh vegetables and fruits throughout the year (%)	88.4	80.8	84.9
9.1.1	Notified slums (%)	84.7	81.1	82.3
9.1.2	Non-notified slums (%)	90.6	75.7	89.6
9.2	Households that can afford fresh and green vegetables (%)	95.6	80.4	88.6
9.2.1	Notified slums (%)	94.8	80.6	85.1
9.2.2	Non-notified slums (%)	96.0	77.7	94.8
Water, Sanitation and Hygiene				
10.	Mothers living in households having access to drinking water from:	88.8	55.7	73.5
10.1	Piped water (%)	8.8	42.8	24.5
10.2	Packaged/ bottled water/ community RO plant (%)	2.4	1.5	2.0
10.3	Others ⁶ (%)			

¹ Others include Buddhists/ Neo-Buddhist, Sikh, Jains and others.

² Others include those who have reported others, can't say or don't know.

³ Head of households who reported that family member(s) migrated out of the household for at least two months during the last one year preceding the survey.

⁴ Includes only those households which possessed a ration card (Total = 3399; Intervention Area = 1948; Control Area = 1451).

⁵ Clean fuel includes LPG and electricity.

⁶ Others include those households which have other source of drinking water (tube well, borewell, protected dug well, other).

MOTHERS OF CHILDREN UNDER AGE TWO YEARS (15-49 YEARS)

	KEY INDICATORS	Intervention Area (Zaheerabad) n=2099	Control Area (Sangareddy) n=2053	Total N = 4152
11.	Mothers living in households having an improved toilet facility ⁷ (%)	97.1	99.9	98.4
12.	Mothers living in households in which members use soap for handwashing after defecation (%)	96.5	98.3	97.5
13.	Mothers living in households using insecticide-treated mosquito nets/ mosquito repellent ointment/ liquid (%)	97.3	51.9	74.4
COVID-19 indicators				
14.	Members of 18 years and above who got vaccinated for COVID-19 with ⁸			
14.1	No dose (%)	6.9	10.1	8.5
14.2	One dose (%)	13.0	9.9	11.5
14.3	Two doses (%)	79.0	76.0	77.6
14.4	More than two doses (%)	1.1	4.0	2.5
15.	Households in which any member got infected with COVID-19 (%)	0.9	4.4	2.5

SOCIO-DEMOGRAPHIC INDICATORS				
	Number of Mothers interviewed ⁹	2099	2053	4152
Distribution of mothers by age groups (years)				
16.1	15-19 (%)	1.7	1.4	1.6
16.2	20-29 (%)	81.0	78.4	79.8
16.3	30-39 (%)	17.1	20.0	18.4
16.4	40-49 (%)	0.2	0.2	0.2
16.5	Mothers mean age (years)	25.7	26.1	25.9
Age at marriage of mothers (years)				
17.1	< 18 years (%)	19.6	12.6	16.4
17.2	<21 years (%)	58.8	53.2	56.2
17.3	Mothers mean age at marriage (years)	20.1	20.8	20.5
18.	Mothers mean age at first birth (years)	20.6	22.4	21.5
19.	Mean number of children ever born ¹⁰	1.8	1.7	1.8
19.1	Primigravida (%)	63.5	53.7	59.0
Educational status of mothers				
20.1	Never attended school (%)	6.3	6.7	6.5
20.2	≤ 5 years (%)	6.7	5.6	6.2
20.3	6-9 years (%)	16.2	10.7	13.7
20.4	10-12 years (%)	37.2	36.7	37.0
20.5	> 12 years (%)	33.6	40.3	36.7
SHG membership status				
21.1	Mothers who have ever been a member of self-help group (SHG) (%)	25.4	12.4	19.4

⁷ Improved toilet facility includes a flush toilet, a pour-flush toilet, pit latrine with slab.

⁸ Includes household members who were of age 18 years and above (Total = 10705; Intervention Area = 5267; Control Area = 5438).

⁹ Mothers refer to women who have children under two years of age.

¹⁰ Mean children ever born is based on the study sample.

MOTHERS OF CHILDREN UNDER AGE TWO YEARS (15-49 YEARS)

	KEY INDICATORS	Intervention Area (Zaheerabad) n=2099	Control Area (Sangareddy) n=2053	Total N = 4152
21.2	Mothers who are currently member of self-help groups (SHGs) (%)	17.1	12.1	14.8
NUTRITIONAL STATUS¹¹				
22.	Mothers' mean weight (kg) [Standard Deviation, SD]	51.2 [8.7]	55.4 [12.0]	53.3 [10.7]
23.	Mothers' mean height (cm) [SD]	152.6 [4.3]	153.3 [5.8]	153.0[5.1]
24.	Mothers with height<145 cm (%)	4.3	7.1	5.6
25.	Mothers' mean Body Mass Index (BMI) ¹² [SD]	21.9 [3.5]	23.5 [4.8]	22.7 [4.3]
26.1	Mothers who are underweight (BMI<18.5) (%)	14.2	14.6	14.4
26.2	Mothers who are normal weight (BMI between 18.5-24.9) (%)	69.2	48.9	59.9
26.3	Mothers who are overweight (BMI between 25.0-29.9) (%)	14.2	27.2	20.2
26.4	Mothers who are obese (BMI >29.9) (%)	2.4	9.4	5.6
27.1	Mothers' mean MUAC (cm) [SD]	25.0 [2.7]	26.4 [3.9]	25.7 [3.4]
27.2	Mothers with MUAC <19 cm (%)	0.4	0.5	0.5
27.3	Mothers with MUAC between 19-20.9 cm (%)	3.1	6.0	4.4
27.4	Mothers with MUAC between 21-22.9 cm (%)	14.1	12.0	13.1
27.5	Mothers with MUAC 23 cm and above (%)	82.4	81.6	82.0
28.	Mothers experiencing both severe stunting and wasting ¹³ (%)	1.9	2.3	2.1
FOOD INSECURITY¹⁴				
29.	Mothers who experienced food insecurity in the 12 months preceding the survey			
29.1	Worried about insufficient food (%)	27.0	6.9	17.7
29.2	Unable to eat healthy and nutritious food (%)	35.3	7.2	22.4
29.3	Had to eat limited variety of food (%)	24.7	7.0	16.5
29.4	Had to skip a meal (%)	20.5	3.9	12.8
29.5	Had to eat less meals (%)	19.0	4.6	12.4
29.6	Household ran out of food (%)	17.1	2.4	10.3
29.7	Had no food to eat at any time (%)	5.5	0.8	3.4
29.8	Had to go an entire day without food (%)	2.8	0.6	1.8
Food Insecurity Experience Scale (FIES)				
30.1	Mothers living in food secure households (%)	56.4	89.5	71.7
30.2	Mothers living in mildly food insecure households (%)	15.2	4.1	10.1
30.3	Mothers living in moderately food insecure households (%)	22.0	5.4	14.3
30.4	Mothers living in severely food insecure households (%)	6.4	1.0	3.9

¹¹ Includes mothers who consented to have their anthropometric measurements taken (Total=4149; Intervention Area =2098; Control Area=2051)

¹² The World Health Organisation (2004) defines Body Mass Index (BMI) as a simple index of weight for height and is used to categories adults as either underweight, normal weight, overweight or obese. It is calculated as weight (kilograms) divided by the square of height (metres).

¹³ Double burden of stunting and wasting is defined as mothers whose height is <145 cm and MUAC<23cm

¹⁴ There are eight items indicating different levels of food insecurity severities. The first three indicate mild level of insecurity, items four to six indicate moderate food insecurity, and last two being items for severe food insecurity. FIES is then divided into four categories: 'food secure', if households have not reported affirmatively to any of the eight items; 'mildly insecure', if only any one of the first three are affirmatively reported; 'moderately insecure', if either of items four, five or six are affirmatively reported; 'severely insecure', if all items are affirmatively reported or either of items seven and eight are affirmatively reported.

MOTHERS OF CHILDREN UNDER AGE TWO YEARS (15-49 YEARS)

	KEY INDICATORS	Intervention Area (Zaheerabad) n=2099	Control Area (Sangareddy) n=2053	Total N = 4152
Coping mechanism to manage shortfall of food¹⁵				
31.	Coping strategies of the households as reported by mothers			
31.1	Household head now spends extra hours at work to earn more money (overtime) (%)	63.3	20.6	56.0
31.2	Unlike earlier, now female(s) of household start working outside home (%)	23.3	11.3	21.3
31.3	Unlike earlier, now children of household start working outside home (%)	16.7	0.4	13.9
31.4	Migration of a family member to earn money and send it back to the family (%)	28.3	3.4	24.1
31.5	Borrowing money to meet household expenses (%)	25.5	27.8	25.9
31.6	Resort to low-cost food grains/items available (%)	64.5	42.7	60.8
31.7	Borrowing grains to meet food requirements (%)	23.5	15.2	22.1
31.8	Sold household articles or possessions (%)	5.7	3.6	5.3
DIETARY DIVERSITY¹⁶				
32.	Mothers' mean Dietary Diversity Score (DDS) ¹⁷ [SD]	7.4 [1.8]	5.7 [2.3]	6.5 [2.2]
Dietary Diversity in Moderately Food Insecure Households¹⁸				
32.1	Mean Dietary Diversity Score (DDS) ¹⁷ of mothers in moderately food insecure households [SD]	7.7 [1.7]	5.6 [2.6]	7.3 [2.1]
Dietary Diversity in Severely Food Insecure Households¹⁹				
32.2	Mean Dietary Diversity Score (DDS) ¹⁷ of mothers in severely food insecure households [SD]	8.6 [2.1]	5.3 [2.3]	8.3 [2.4]
Dietary Diversity by Household's Wealth Quintile				
32.3	Mean Dietary Diversity Score (DDS) ¹⁷ of mothers by household wealth status [SD]			
	Poor	6.7	5.1	6.1
	Poorest	7.3	6.0	6.9
	Middle	7.5	5.9	6.7
	Rich	7.7	5.5	6.0
	Richest	8.0	6.0	7.0
10 food groups consumed by mothers in the last 24 hours preceding the survey				

¹⁵ Considered only those mothers who reported any kind of food insecurity (Total = 1121; Intervention Area = 912; Control Area = 209)

¹⁶ Excludes those mothers who ate less or more than usual on the day prior to the date of the interview or a day before that, as in the case of a fast or a celebration. (Available for Total = 3886; Intervention Area = 1952; Control Area = 1934)

¹⁷ Dietary Diversity Score (DDS) is computed based on consumption of food items, from the ten food groups, on the day prior to the date of the interview. Based on Food and Agricultural Organisation (FAO) 2016 methodology, 14 major food items were clubbed together to form 10 food groups. A ten-point DDS scale was thus created (1 being the lowest value, 10 being the highest).

¹⁸ Includes households have Moderately Food Insecurity (Total = 550; Intervention Area = 451; Control Area = 99)

¹⁹ Includes households have Severely Food Insecurity (Total = 136; Intervention Area = 121; Control Area = 15)

MOTHERS OF CHILDREN UNDER AGE TWO YEARS (15-49 YEARS)

	KEY INDICATORS	Intervention Area (Zaheerabad) n=2099	Control Area (Sangareddy) n=2053	Total N = 4152
33.1	Grains, white roots and tubers and plantains (%)	97.6	96.6	97.1
33.2	Pulses (beans, peas and lentils) (%)	78.2	43.9	62.3
33.3	Nuts or seeds (%)	52.4	26.6	40.5
33.4	Dairy (%)	86.8	83.9	85.4
33.5	Meat, poultry and fish (%)	77.2	34.3	57.4
33.6	Egg (%)	59.5	36.9	49.0
33.7	Dark green leafy vegetables (%)	60.2	55.2	57.9
33.8	Other vitamin A-rich fruits and vegetables (%)	81.9	71.4	77.0
33.9	Other vegetables (%)	80.1	72.9	76.7
33.10	Other fruits (%)	65.3	43.0	56.0
33.11	Any sugar-sweetened beverages (%)	64.2	34.4	50.4
33.12	Any savoury and fried snacks (%)	55.9	27.5	42.8
Mothers consuming food from specific food groups				
34.1	Animal-source food (meat, poultry, fish and egg) (%)	87.2	49.5	69.7
34.2	Pulses (beans, peas and lentils) and nuts or seeds (%)	84.8	49.5	68.5
34.3	Dark green leafy vegetables and other vitamin A-rich fruits and vegetables (%)	83.0	66.3	75.2
34.4	Mothers with minimum dietary diversity score (5 or more out of 10) (%)	94.6	63.6	80.2
34.5	Mothers with minimum dietary diversity score (6 or more out of 10) (%)	84.4	50.9	68.9
35.	Mother who usually ate at least three meals (%)	97.7	88.1	93.3
Mothers consuming aerated drinks and junk/fast food				
36.	Aerated beverages			
36.1	Often (%)	25.1	10.3	18.2
36.2	Sometimes (%)	62.8	74.2	68.0
36.3	Never (%)	12.2	15.6	13.8
37.	Junk/fast food			
37.1	Often (%)	12.9	17.6	15.1
37.2	Sometimes (%)	81.8	69.1	76.0
37.3	Never (%)	5.4	13.3	9.0

ACCESS TO HEALTH SERVICES				
Registration in Antenatal Care (ANC) services during last pregnancy				
38.	Mothers who have registered their last pregnancy (%)	96.9	91.9	94.6
39.	Mothers who have registered in the first trimester (%)	94.6	88.7	91.9
40.	Mothers who have received a Mother and Child Protection (MCP) card or any other card from private doctor ²⁰ (%)	86.2	81.3	83.9
ANC services received during last pregnancy				
41.	Mothers who sought ANC services (%)	98.2	97.0	97.6
42.	Mothers who received ANC services from			

²⁰ Mother and Child Protection (MCP) card is a joint initiative of ICDS and the National Urban Health Mission (NUHM). It is a comprehensive multipurpose card which provides information to the parents/guardians on various types of services delivered through ICDS and NUHM in case MCP card was not available mothers were asked to show any prescription or reports available from a private doctor.

MOTHERS OF CHILDREN UNDER AGE TWO YEARS (15-49 YEARS)

	KEY INDICATORS	Intervention Area (Zaheerabad) n=2099	Control Area (Sangareddy) n=2053	Total N = 4152
42.1	Government health facilities (%)	98.1	85.6	92.4
42.2	Private health facilities (%)	62.4	66.3	64.2
43.3	Other (%)	11.4	1.1	6.6
44.	Mothers who had ANC check-up in the first trimester (%)	91.3	83.3	87.6
45.	Mothers who had at least four ANC check-ups (%)	47.1	60.3	53.2
46.	Mothers who have received Tetanus Toxoid (TT) injection (%)	98.1	97.0	97.6
47.	Mothers whose blood pressure was measured (%)	96.6	95.5	96.1
48.	Mothers whose blood (haemoglobin) test was performed at least four times (%)	12.8	31.4	21.3
49.	Mothers whose urine test was done (%)	99.3	99.4	99.4
50.	Mothers who had received counselling on birth preparedness by a frontline health worker ²¹ (%)	90.4	49.4	71.5
51.1	Mothers who had high blood pressure during the last pregnancy (%)	21.2	6.7	14.5
51.2	Mothers who had high blood sugar during the last pregnancy (%)	11.2	0.9	6.4
52.	Mothers who reported that their last pregnancy was high-risk (%)	9.1	13.8	11.3
Reasons for high-risk pregnancy				
52.1	Primigravida under 15 years (%)	7.7	2.0	4.5
52.2	Primigravida above 35 years (%)	6.3	2.8	4.3
52.3	Pregnancy after prolonged infertility (10 years) (%)	5.7	2.5	3.9
52.4	Height less than 145 cm (%)	4.0	1.2	2.4
52.5	Systemic diseases (%)	5.0	1.0	2.7
Monitoring of nutritional status during pregnancy				
53.	Mothers whose weight was monitored (%)	98.6	96.9	97.8
54.	Mothers who were weighed at least four times (%)	51.5	57.5	54.3
55.	Mothers whose height was recorded (%)	81.2	67.5	74.9
56.	Mothers whose Mid-Upper Arm Circumference (MUAC) was measured (%)	58.8	32.0	46.4
Micronutrient supplementation and deworming				
57.	Mother who ever received Iron and Folic Acid (IFA) tablet during the last pregnancy (%)	98.6	96.2	97.5
58.	Mother who received 180 Iron and Folic Acid (IFA) tablet during the last pregnancy ²² (%)	8.7	42.0	23.9
59.	Mothers who consumed at least 100 IFA tablets during the last pregnancy ²² (%)	11.9	63.0	35.1
60.	Mothers who ever received calcium tablet during the last pregnancy (%)	98.4	96.3	97.4
61.	Mothers who consumed at least 100 calcium tablets during the last pregnancy ²³ (%)	11.5	60.1	33.6

²¹ Frontline health workers include Auxiliary Nurse Midwives (ANMs), Accredited Social Health Activists (ASHAs) and Anganwadi Teachers (AWTs).

²² Includes those mothers who received IFA tablets during the last pregnancy. (Total = 4046; Intervention Area = 2069; Control Area = 1977).

²³ Includes those mothers who received calcium tablets during the last pregnancy. (Total = 4042; Intervention Area = 2064; Control Area = 1978).

MOTHERS OF CHILDREN UNDER AGE TWO YEARS (15-49 YEARS)

	KEY INDICATORS	Intervention Area (Zaheerabad) n=2099	Control Area (Sangareddy) n=2053	Total N = 4152
62.	Mothers who have consumed tablet for deworming during the last pregnancy (%)	59.2	45.6	52.9
63.	Mothers who had an institutional delivery ²⁴ (%)	95.9	98.3	97.1
64.	Place of last delivery of mothers			
64.1	Government health facility (%)	68.8	52.7	61.3
64.2	Private health facility (%)	27.2	45.6	35.7
64.3	Others (%)	4.0	1.7	3.0
65.	Mothers who had a caesarean section delivery (%)	43.9	56.6	49.8
66.	Mean out-of-pocket expenditure of mothers on delivery during the last pregnancy ²⁵ (INR)	16121	33172	24497
67.	Mothers who received 180 IFA tablets after delivery ²⁶ (%)	3.7	1.0	2.5
68.	Mothers who received calcium tablets after delivery (%)	99.5	99.2	99.4
69.	Mothers who received maternity entitlement payment from government during the last pregnancy ²⁷ (%)	32.1	9.9	21.9
70.	Mothers who received KCR kit during the last pregnancy ²⁷ (%)	54.6	41.0	48.3
71.	Postpartum check-up			
71.1	Mothers who did not receive postpartum check-up within 14 days (%)	12.2	67.2	37.6
71.2	Mothers who received postpartum check-up within 48 hours (%)	17.8	7.8	13.2
71.3	Mothers who received postpartum check-up within 3-7 days (%)	42.6	11.3	28.2
71.4	Mothers who received postpartum check-up within 8-14 days (%)	27.4	13.7	21.0
INFANT AND YOUNG CHILDREN				
72.	Mothers whose last child was weighed at birth (%)	99.8	99.7	99.8
73.	Mothers who reported that their last child had low birthweight (< 2.5 kgs) ²⁸ (%)	7.5	8.7	8.1
74.	Mothers who reported their last child was breastfed within one hour of birth ²⁹ (%)	92.5	74.6	84.0

²⁴ Institutional delivery refers to last birth(s), which took place in a health facility/institution.

²⁵ Includes out-of-pocket expenditure on last birth like transportation, hospital stay, tests, medicines, and other costs. (Total = 4126; Intervention Area = 2099; Control Area = 2027).

²⁶ Considered only mothers who received IFA tablets after the last delivery (Total = 3980; Intervention Area = 2085; Control Area = 1895).

²⁷ The pregnant women are entitled to Rs. 12,000 financial assistances in three phases. In case the pregnant women give birth to a baby girl Rs. 1000 is given additionally. After the delivery for the wellbeing of the mother and new-born the government gives KCR Kit with 16 items. The Kit has clothes, quality baby soaps, baby oil, baby powder, mosquito net, toys, napkins, diapers etc., which will be sufficient for three months. KCR is given for maximum two deliveries, however, in our study it is based on the last pregnancy.

²⁸ Includes children who were weighed at the time of birth (Total = 4142; Intervention Area = 2095; Control Area = 1047).

²⁹ Includes children who were ever breastfed (Total = 3909; Intervention Area = 1914; Control Area = 1995).

MOTHERS OF CHILDREN UNDER AGE TWO YEARS (15-49 YEARS)

	KEY INDICATORS	Intervention Area (Zaheerabad) n=2099	Control Area (Sangareddy) n=2053	Total N = 4152
INTEGRATED CHILD DEVELOPMENT SERVICES³⁰(ICDS)				
75.	Mothers receiving ICDS entitlement for supplementary food (%)	96.8	66.6	82.9
76.	Type of ICDS entitlements received by mothers			
76.1	Take-home ration (THR) (%)	92.5	59.7	77.4
76.2	Eggs (%)	96.2	66.0	82.3
76.3	Full meal (%)	81.5	45.5	64.9
URBAN HEALTH, SANITATION AND NUTRITION DAY³¹(UHSND)				
77.1	Mothers who attended UHSND meeting(s) in the last one year preceding the survey (%)	38.5	7.4	24.2
77.2	Mothers who attended at least three UHSND meetings in the last one year preceding the survey (%)	11.1	1.0	6.4
78.	Mothers using sanitary napkins (%)	99.5	99.3	97.3
CURRENT USE OF FAMILY PLANNING METHODS AS REPORTED BY MOTHERS				
79.	Currently using any family planning method ³² (%)	25.5	19.6	22.8
80.	Currently using any modern contraceptive ³² (%)	25.2	18.6	22.1
80.1	Female sterilization (%)	16.0	15.7	15.9
80.2	Male sterilization (%)	1.6	0.2	0.9
80.3	IUD/ PPIUD (%)	6.7	0.6	3.9
80.4	Injectable (%)	0.3	0.5	0.4
80.5	Pills (%)	0.9	0.6	0.8
80.6	Condom (%)	0.2	1.0	0.6
81.	Mothers who received joint counselling session for the couple on family planning after childbirth (%)	64.7	42.5	54.4

LIFESTYLE HABITS				
82. Mothers who reported exercising				
82.1	Regularly (%)	2.4	2.1	2.3
82.2	Sometimes (%)	39.3	13.1	27.2
82.3	Never (%)	58.3	84.8	70.5
83. Mothers who reported spending time on sedentary activities like watching TV or using mobile phone				
83.1	Regularly (%)	3.1	14.4	8.3
83.2	Sometimes (%)	84.0	64.4	75.0
83.3	Never (%)	12.9	21.2	16.7
84. Mothers who had at least 6 hours of sleep (%)				
		81.7	85.8	83.5

³⁰ Supplementary Nutrition is provided to mothers and lactating mothers under ICDS (Mothers who received THR, egg and cooked meal).

³¹ The Urban Health, Sanitation and Nutrition Day (UHSND), a component of ICDS, is held at Anganwadi Centres once every month. On this day, mothers and lactating mothers are provided with integrated health solutions as per their needs.

³² Includes mother who were not pregnant at the time of the survey. Modern contraceptives include female and male sterilizations, Intra-Uterine Devices (IUDs), injectable, pills, condoms, and diaphragms (Total = 3865; Intervention Area = 1950; Control Area = 1915).

MOTHERS OF CHILDREN UNDER AGE TWO YEARS (15-49 YEARS)

	KEY INDICATORS	Intervention Area (Zaheerabad) n=2099	Control Area (Sangareddy) n=2053	Total N = 4152
EMPOWERMENT AND DECISION-MAKING				
85.	Mothers who worked in the last 12 months preceding the survey ³³ (%)	25.2	8.0	17.3
86.	Mothers who were paid in cash for their work ³⁴ (%)	90.1	98.8	92.6
87.	Mothers who have bank or savings account (%)	98.0	92.9	95.6
88.	Mothers who own any house alone or jointly (%)	69.1	58.5	64.2
89.	Mothers who own any land alone or jointly (%)	47.0	39.5	43.6
90.	Mothers deciding how the money earned by them will be used (%)	34.9	71.6	43.3
91.	Mothers taking decisions about their own health care ³⁵ (%)	19.9	62.4	39.5
92.	Mothers taking decisions about making major purchases for the household ³⁵ (%)	25.7	62.8	42.8
93.	Mothers taking decisions about visits to family members or relatives ³⁵ (%)	25.9	57.4	40.4
COMMUNICATION AND INTERNET CONNECTIVITY				
94.	Mothers who own a mobile phone (%)	88.9	90.2	89.5
95.	Mothers who have access to a family phone (%)	94.7	89.7	92.6
96.	Mothers who have access to			
96.1	Feature phone (%)	29.9	24.3	27.3
96.2	Smart phone (%)	70.1	75.7	72.7
97.	Mother living in households with internet (%)	81.3	88.9	84.8
98.	Mothers who would be interested to receive health and nutrition related calls (%)	87.7	63.8	76.7
PERCEPTIONS ON PARTNER VIOLENCE				
99.	Mothers who think that a husband is justified in hitting or beating his wife if:			
99.1	She goes out without telling him (%)	3.7	9.6	6.4
99.2	She neglects the house or children (%)	15.5	23.9	19.4
99.3	She argues with him (%)	17.7	16.5	17.1
99.4	She refuses to have sex with him (%)	9.5	4.0	7.0
99.5	She does not cook food properly (%)	9.1	5.0	7.2
99.6	He suspects her of being unfaithful (%)	15.0	25.6	19.9
99.7	She shows disrespect towards in-laws (%)	9.5	20.6	14.6

LIFESTYLE HABITS				
100.	Mothers who reported depression³⁶			
100.1	None/ Minimal (0-4) (%)	45.2	82.8	62.5
100.2	Mild (5-9) (%)	20.3	10.1	15.6
100.3	Moderate (10-14) (%)	17.5	4.4	11.4
100.4	Moderately severe (15-19) (%)	14.7	2.6	9.1

³³ Considered mothers who worked in the last 12 months preceding the survey (Total = 694; Intervention Area = 534; Control Area = 160).

³⁴ Considered mothers who worked in the last 12 months preceding the survey and were paid in cash for their work (Total = 643; Intervention Area = 485; Control Area = 158).

³⁵ Mothers who reported that they either took decisions on their own or did so along with their partner were considered as being able to take decision themselves.

³⁶ Depression was screened using Patient Health Questionnaire – 9 (PHQ-9). The PHQ-9 is the 9-item depression module. Mothers who scored ≥ 10 on this module were diagnosed to have depression.

MOTHERS OF CHILDREN UNDER AGE TWO YEARS (15-49 YEARS)

	KEY INDICATORS	Intervention Area (Zaheerabad) n=2099	Control Area (Sangareddy) n=2053	Total N = 4152
100.5	Severe (20 – 17) (%)	2.3	0.2	1.3
101.	Mothers who reported having anxiety³⁷			
101.1	Minimal (0 – 4) (%)	53.5	86.7	68.8
101.2	Mild (5 – 9) (%)	15.6	9.5	12.8
101.3	Moderate (10 – 14) (%)	22.6	3.3	13.7
101.4	Severe (≥ 15) (%)	8.3	0.6	4.7
102.	Mothers' ability to recover from stress³⁸			
102.1	Low resilience (1.00 – 2.99) (%)	42.6	21.9	33.1
102.2	Normal resilience (3.00 – 4.30) (%)	57.4	78.1	66.9
102.3	High resilience (4.31 – 5.00) (%)	0.0	0.0	0.0
103.	Mothers who experienced gender-based disadvantage³⁹			
103.1	Gender-related barriers (%)	65.1	10.9	40.1
103.2	Gender discrimination (%)	68.6	18.4	45.5
103.3	Violence/sexual harassment (%)	48.7	7.6	29.8
103.4	Emotional distress (%)	65.4	9.5	39.6
103.5	Total gender disadvantage (%)	74.6	22.2	50.4
104.	Maternity social support available to mothers⁴⁰			
104.1	Low support (≤ 18) (%)	28.7	18.8	24.2
104.2	Medium support (19–24) (%)	45.5	61.1	52.7
104.3	Adequate support (>24) (%)	25.8	20.1	23.1
GENDER EQUALITY AND VIOLENCE				
105.	Mothers who were given priority to eat first and how much they waited during the last pregnancy (%)	95.4	95.4	95.4
106.	Mothers who received equal opportunities as husband for nutrition, study, work, health (%)	95.5	96.1	95.8
107.	Mothers who reported feeling pressured to have a male child (%)	35.5	46.8	40.7
108.	Mothers who could express their views openly at home (%)	78.7	95.0	86.2
109.	Mothers whose husband was asked to accompany her to ANC check-up visit by a front-line health worker (%)	84.2	79.4	82.0
110.	Mothers whose husbands accompanied them to ANC check-up during the last pregnancy (%)	87.8	95.2	91.2
111.	Mothers who felt supported by the husband in household decision-making (%)	88.3	95.9	91.8
112.	Mothers who reported their husband supported them in shared domestic work (%)	76.4	94.6	84.8
113.	Mothers who reported feeling safe at home/ neighbourhood (%)	88.5	96.9	92.4
114.	Mothers who often faced domestic violence during the last pregnancy (%)	9.2	0.3	5.1

³⁷ Generalized anxiety disorder (GAD-7) was used to screen anxiety disorder which is a 7-item anxiety scale. Mothers who scored ≥ 10 on this were characterised as having anxiety disorder.

³⁸ Resilience was measured using Brief Resilience Scale (BRS). Mothers who scored <3 on this scale were said to have low resilience.

³⁹ Gender disadvantage was measured using CAGED. Women who scored ≥ 1 on this scale were said to have experienced gender-based disadvantage.

⁴⁰ Maternity social support scale was used to assess support available to mothers. Mothers who scored 18 or less were said to have low social support.

MOTHERS OF CHILDREN UNDER AGE TWO YEARS (15-49 YEARS)

	KEY INDICATORS	Intervention Area (Zaheerabad) n=2099	Control Area (Sangareddy) n=2053	Total N = 4152
COMMUNITY CHARACTERISTICS				
115.	Number of slums	32	35	67
116.	Number of notified slums	14	31	45
117.	Number of non-notified slums	18	4	22
118.	Health facilities in slums			
118.1	Number of slums having a government health facility	3	4	7
118.2	Number of slums having a private health facility	27	21	48
118.3	Number of health facilities in notified slums	29	55	84
118.4	Number of health facilities in non-notified slums	42	1	42
120.	Number of health facilities (Government/Private) in the slum			
120.1	≤ 2 kms	5	21	26
120.2	3-4 kms	19	13	32
120.3	≥ 5 kms	8	1	9
121.	Number of slums having a PDS shop	30	30	60

**FINDINGS FROM
THE QUALITATIVE SURVEY,
TELE-SWABHIMAAN, TELANGANA**



1. Introduction

The Tele-Swabhimaan programme or locally known as the Tele Mahila Mitra (TMM) Programme was initiated with an aim to improve nutritional status, reduce gender disadvantage, improve mental health and wellbeing of adolescent girls, pregnant women (including pregnant adolescents), mothers of children under age two years. UNICEF has entrusted IIPS for conducting the Baseline Survey (2022) of Tele-Swabhimaan in Telangana. However, along with the behavioral changes associated with health, nutrition and empowerment, service delivery is an integral part of the approach. Resilience of health systems is a key to withstand shocks and emergencies, and maintain steady routine service delivery without disruptions. Community workers such as Auxiliary Nurse Midwife (ANM), Accredited Social Health Activist (ASHA), Anganwadi Teacher (AWT), and Resource Person (RP) play a critical role as intermediaries between communities and Government systems, for delivering key health and nutrition interventions. Therefore, it was deemed necessary to conduct a qualitative study including these stakeholders to understand their knowledge, challenges, preparedness, capacities with respect to service delivery and their readiness to support health and nutrition interventions.

2. Objectives

The major objectives of the in-depth interviews are given the figure below.

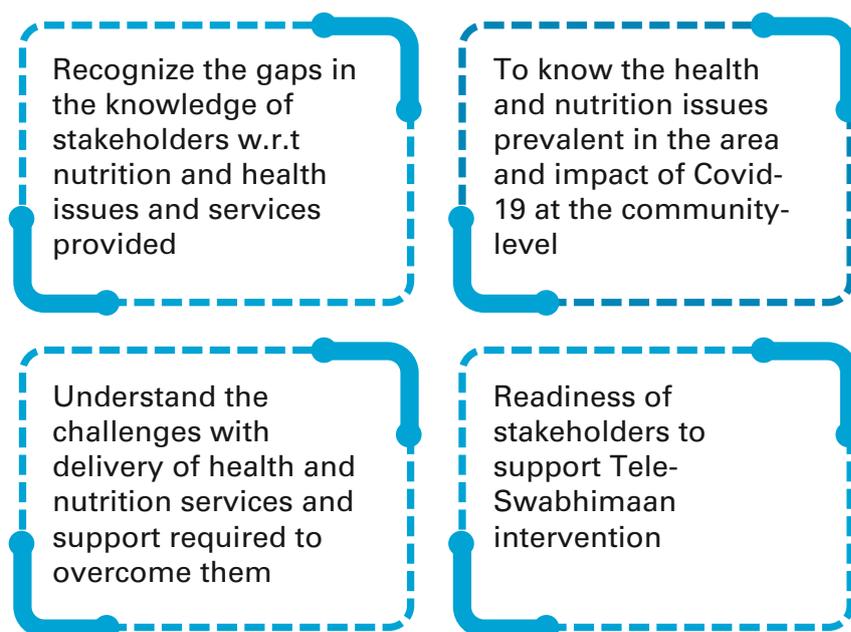


Figure 1: Objectives of the stakeholders' in-depth interviews

3. Methodology

Approach

As part of the qualitative approach, IIPS conducted in-depth of interviews of stakeholders in the intervention area (Zaheerabad block) and control area (Sangareddy block) during the baseline survey in July 2022. Forty-two in-depth interviews covering ANMs (n=3), ASHA (n=4), AWT (n=13), RPs (n=19) and Medical Officers (n=3) were done. Later on, MEPMA conducted FGDs with the pregnant women, mothers of children under age two years, men and community women to get information on food and dietary practices, work and information on TMM. The number of participants is sufficient to draw relevant inferences as it is well above the minimum suggested number to justify data

saturation. The participants were selected purposively. Respondents who voluntarily consented to the participate were interviewed. The interviews were audio-recorded after written consent from the participants.

Analysis

The field notes supplemented the audio-recorded in-depth interviews to finalize the transcriptions. ATLAS.ti 22 was used for organizing and coding data. Thematic analysis was used to evaluate data. Based on the essential indicators, major themes were identified, codes were generated and the transcripts were coded. Each theme captured some critical information from the data and helped identify, analyse, and report patterns within the responses, thus facilitating the interpretation of various aspects. The relationship among various themes, categories and codes was studied using memos and various visualization techniques. Additionally, anonymous direct quotes were used to validate the findings wherever appropriate.

Profile of participants

Mean age of participants was 38 years. Among the respondents, 21 had 12+ years, 8 had 11-12 years, and 11 had 6-10 years of schooling. Twenty-six respondents were SHG members. Average, work experience of respondents was 10 years.

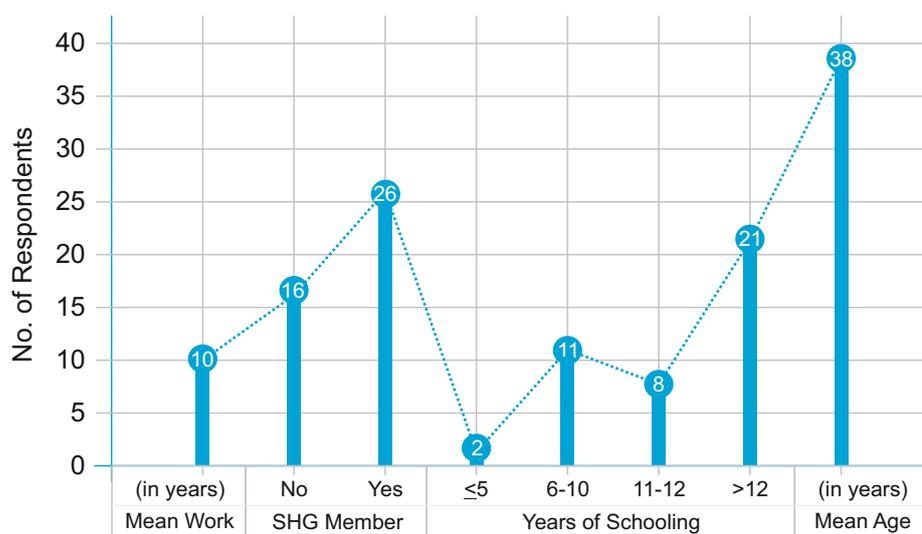


Figure 2: Profile of interviewed respondents

4. Results

This section describes the major findings from the qualitative data. The segment has been divided into two parts. The first part describes the major findings from the in-depth interviews and these findings have been discussed in the form of the major themes and the narratives supporting them. The second, section comprises of major issues emerged from the FGDs. The results of the FGDs have been discussed in three parts: food and dietary practices and behaviour, work and participation in TMM and awareness about it.

4.1. Findings from the In-depth Interviews

Five major themes that emerged to explain the health and nutrition services and issues from the stakeholders' perspective were (1) Knowledge on importance of nutrition, (2) Health and nutrition issues in the area, impact of COVID-19 at community-level, sensitizing people on nutrition and maternal health and support required from authorities, (3) Problems faced in delivery of services in the community, and (4) Acceptance towards Tele-Swabhimaan programme.

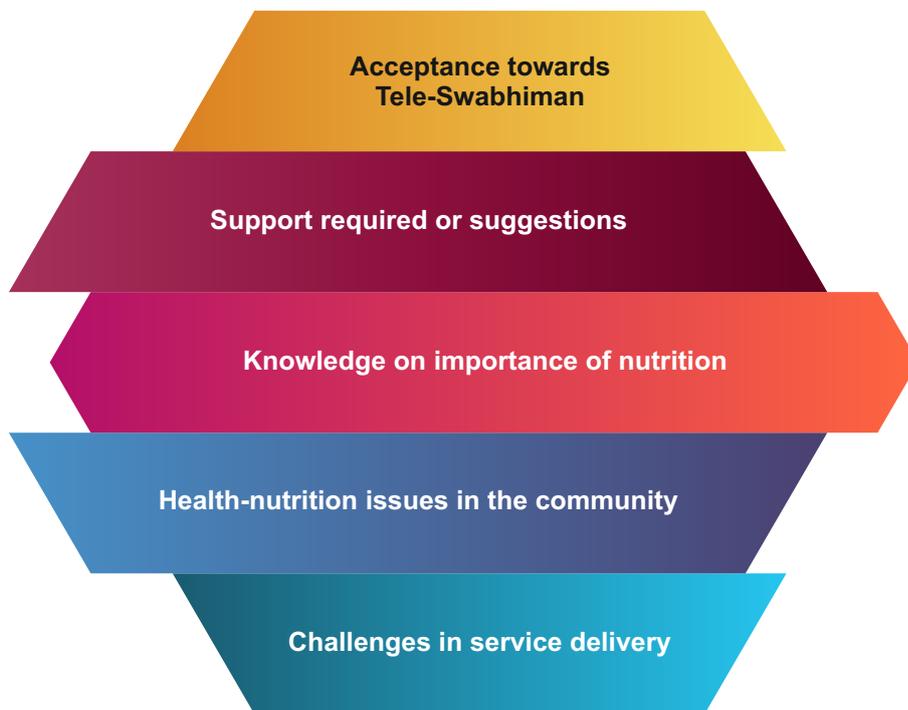


Figure 3: Major themes emerged from the in-depth interviews

Knowledge of health and nutrition services

Respondents were well aware about the ongoing health and nutrition and social support programmes in the community. It was mentioned that most of the health and nutrition-related programmes are delivered through or held in the Anganwadi Centre (AWC) such as Aarogya Lakshmi, Balamrutam, Health and Nutrition Day. The proper nutrition helps maintain a good immunity and avoid diseases. It was mentioned that intake of balanced and nutritious food is very important, particularly for pregnant women and lactating mothers, such practice will also be beneficial for the health of young children. Also, nutritious food helps avoid malnutrition among children and ensures that children have proper growth and development and lead a healthy life. Good nutrition practices can also help avoid health issues at the later stages of life.

Nutrition is very important for every human being for full development. Nutritious food keeps us away from sickness and diseases. Among children, if they have nutritious and healthy food they will be away from malnutrition. Having proper nutrition can also help avoid diseases in the old age. (ASHA)

Every program about health in the area is held at AWC. We explain importance of proper nutrition to pregnant women and lactating mothers, if they do not take nutritious food, then they will be anaemic and might develop other health issues which will affect growth of their babies. (RP)

The community health workers mobilised pregnant women and lactating mothers to maintain a healthy and nutritious diet. They suggested them to have plenty of vegetables and fruits in their diets. Green leafy vegetables, fruits, eggs, meat, milk were some foods suggested by these workers to pregnant women, and lactating mothers. They suggested to avoid processed or packaged food. Additionally, they recommended regular intake of folic acid, IFA and calcium supplements as guided. These stakeholders also suggested mothers to breastfeed children and its significance.

We ask them to eat green vegetables, green peas, ber and others fruits, jaggery, to have small and frequent meals for healthy mother and child. We suggest them to eat leafy green vegetables to maintain appropriate Hb levels. There is no specific food to avoid during pregnancy, I think all are vegetables and fruits are good in my point of view. (AWT)

Pregnant women should properly intake micronutrients, IFA, calcium tablets prescribed to them. After delivery, women should have IFA and calcium tablets for six months. If delivery was normal then women can eat normal food but if delivery was caesarean then they should pick their food carefully or have limited healthier food items. (ANM)

Health and nutrition issues in the community

Respondents reported that seasonal diseases like malaria, dengue and viral fevers are the most common issues in the community. Diarrhoea and typhoid are also quite prevalent in the area. It was reported that TB cases in the area are increasing and COVID-19 cases are often reported. Anaemia among women and C-section deliveries is also an issue in the area. Other health problems reported by the community were blood pressure and other non-communicable diseases. The major health issues in the community can be seen in the figure below.

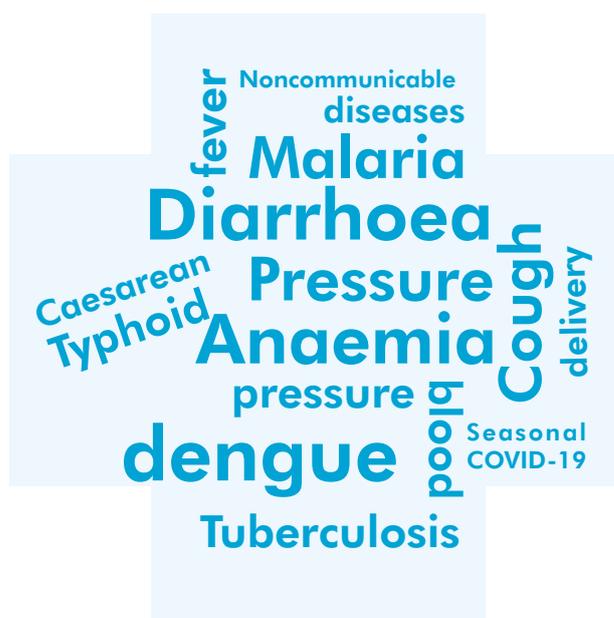


Figure 4: Major health issues in the community

COVID-19 cases keep coming in and lately, incidences of TB are on rise in the area. Two dengue cases were reported three weeks back, we are working with Municipal Corporation to keep the environment and surroundings clean and follow health principle. (MO)

Seasonal diseases are common. Dengue, malaria, diarrhoea and fevers are common. To prevent these health problems, we conduct survey and set-up health camps to provide treatment for them. (ANM)

In my area, dengue and diarrhoea are common. To avert this, myself and ASHA conduct door-to-door survey to inform people not to store water for too many days and keep the water containers covered and use mosquito repellent as precaution. (AWT)

Anganwadis have. Lately, keeping the records has been very tedious and time consuming since record has to be updated online and then there are so many registers that are needed to be maintained on regular-basis.

RPs	AWT	ASHA/ANM
<ul style="list-style-type: none"> • No ID card issued: hinders rapport with the community members • Highly irregular salary • No ASHA in the ward for service delivery support • High workload 	<ul style="list-style-type: none"> • Congested AWCs, limited space for children and other activities • Poor compliance of beneficiaries with eating cooked meal at AWC • Irregular supply of THR • Out-of-pocket expenditure on kitchen budget • Maintenance of records is very-time consuming 	<ul style="list-style-type: none"> • Poor staff strength • No ASHA in several wards • Low salary • High workload • Problem in follow-up due to different place of delivery

Figure 6: Challenges in service delivery reported by various stakeholders

At present, irregular salary the biggest problem. Salary should be increased as per our workload; we are working hard consistently. People behavior and community support are encouraging and change related to health awareness and economically empowerment among women can be observed. (RP)

We don't have ID cards. Some people don't believe us and thus, behave rudely. (RP)

Not getting regular training and salary are very discouraging for my work. We are working hard and getting less salary. Sometimes we spent our pocket money to send patient to the hospital also. (AWT)

The THR distribution is irregular. Some people don't bring their children for height and weight checkup. (AWT)

Our AWC is very congested, small and not enough space for the children. Lack of space hinders service delivery. Due to small AWC we are getting disturb during UHSND and THR distribution. It very difficult to manage and update so many registers and doing online. It's making burden on me. (AWT)

The work pressure is too much, I have to cover wards and some of the wards do not have ASHA to support and share the work load. This reduces the quality of services because you cannot pay your complete attention to a specific area. (ANM)

Support required to improve service delivery

The major support required is in terms of alleviating the work load on the RPs and frontline health workers. The area needs more ASHAs, each ward should have atleast one ASHA. The AWCs are also pressurised and there is need for more AWC. There is also need to increase the kitchen budget of AWCs to overcome out-of-pocket expenditure on kitchen commodities. There should be a more efficient and time saving way to update records instead of having to fill data in registers and online. There is scope to improve facilities in the government hospitals and inform community about the incentives provided for availing treatment in government health facilities, support from health staff is also requested to motivate community members for health check-ups.

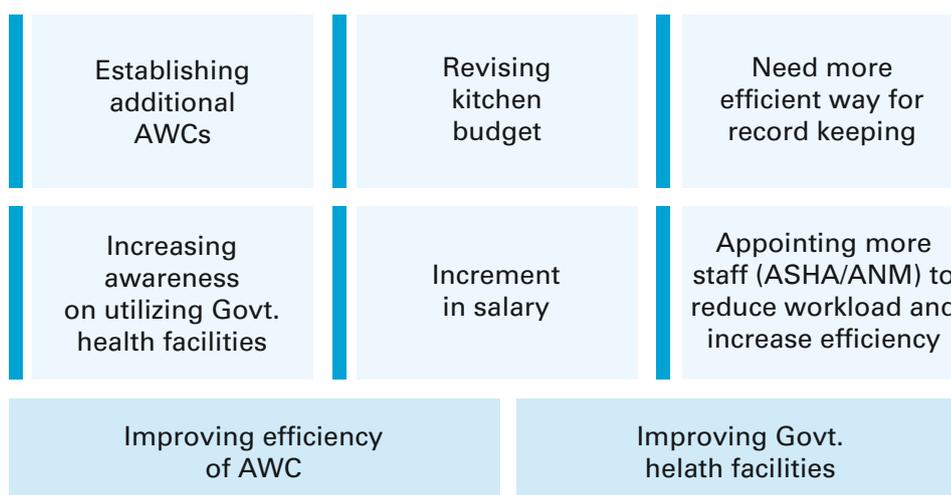


Figure 7: Support required by stakeholders to improve service delivery

We hope that by improving the facilities in the government hospitals and by informing everyone about the incentives provided by the government, there will be a change in this current situation and more people will be ready to avail health services from the government health facilities. (ASHA)

I hope that the government acknowledges the hard work of RPs and ensure that our salary is regular and it compensates for the amount of hard work we put in. (RP)

There is no ASHA in my ward and the ANM available is responsible for two other wards as well. This increases the work load on me and compromises the smooth and efficient delivery of services. (RP)

I am over-burdened with work, actually all the ANMs are and the salary very low. We request the authorities to revise our salaries and appoint more staff for ease the workload and improve quality of facilities. (ANM)

The Anganwadi is very congested and it meddles with the smooth functioning of other ongoing activities in the Anganwadi. There is need of more anganwadi centres in the area. I would like to request the government to increase the kitchen budget since the current budget does not cover many miscellaneous kitchen items like condiments. (AWT)

I wish a new system is established for the maintenance of records because currently, there are so many registers to be maintained and information needs to be updated online as well; this consumes so much time that can be put to use in improving quality of services and their delivery.

Acceptance towards Tele-Swabhimaan Programme and suggestions

The majority of participants showed acceptance towards Tele-Swabhimaan programme. Since, programme aims to improve the health and nutrition of women in the community and promote women empowerment and gender equality, majority of respondents were ready to support the programme in any way that they could.

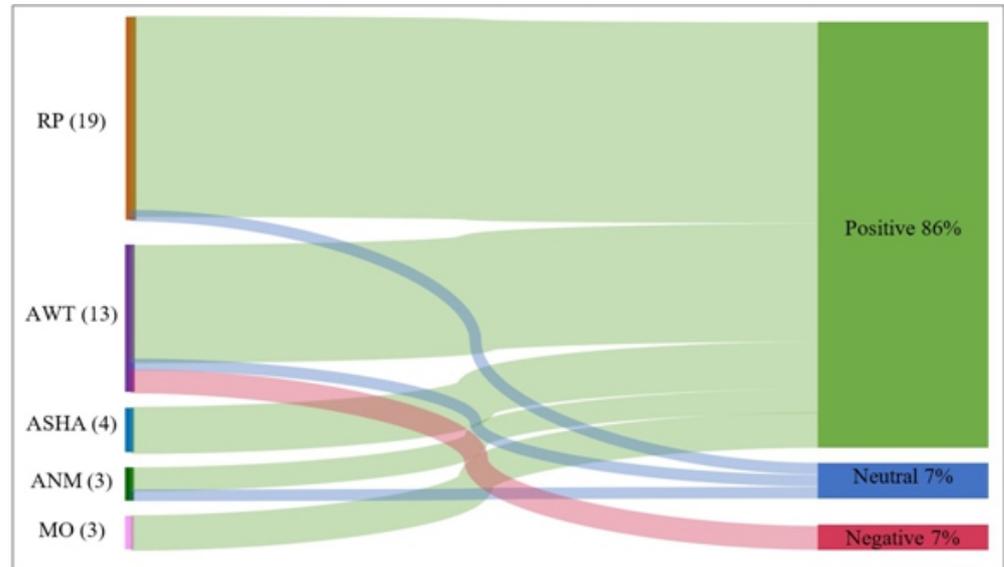


Figure 8: Sentiment analysis showing acceptance towards Tele-Swabhimaan Programme

If they [women] know some more things related to health it will be very helpful to them. If you people provide any tollfree number for getting more awareness on health from their mobile only it will be convenient and better. (RP)

I will be happy to support the programme if it means to improve the health conditions of women and children in our area. (AWT)

We will be happy to support the intervention programme in all aspects of health for children and women. (MO)

Apart from ladies, provision of some kind of health education programme for old age people will also be appreciated by the community. (RP)

It would be good if this [programme] could also provide information on educational opportunities and scholarship available for girls. (RP)

4.2 Findings from the FGDs

This section presents the findings from the FGDs of men and women in the community, giving an insight in the discriminative gender norms in context with the dietary practices, health seeking behavior, household work and other responsibilities especially during the perinatal period. A detailed account of findings is given below.

Food and dietary practices

This section presents the gender norms in context with dietary practices in both the blocks.



Staple Food

- Rice, Jowar, Wheat

Meal Frequency

- Average 3 meals per day
- 2-3 snacks/fruits in between the meals



Dietary Practices

- PW are given little extra food only after 1st trimester, and mostly after 4 or 5 months pregnancy.
- Lot of apprehensions during 1st trimester about eating food with a fear of abortion.
- Later, during 8th & 9th months again food intake is restricted with a fear of overweight baby leading to minimised chances for normal delivery.
- New mothers are given less food for almost 3 – 4 weeks after delivery. NMs expressed that even if they are hungry, they are not allowed to eat extra – quantity & periodicity.



Discriminative Practices

- Women solely responsible for cooking and serving food
- Food is made to the liking of men in the family
- Food is first served to husbands and in-laws
- Leftovers are only consumed by women in the family
- Unlike women, husbands get to eat eggs almost daily
- Best of the food prepared at home is served to men, next best to the elders (MIL) and the remaining goes to DIL, even when she is pregnant.
- DIL cannot even ask for better or more food. This reflects the deep-rooted patriarchal norms and power relations.



Dietary Beliefs

- PW should not eat papaya, pineapple, guava, banana
- PW should limit consumption of food that produce heat in the body like chicken
- New mothers should avoid citrus fruits.
- Dietary beliefs and food restrictions are more for mothers after delivery.
- Mothers shared that they are not given sufficient food with the belief that the body will be sore and has to be dried after delivery, then only it comes back to the normal stage. It is noting related to availability of food but the issue of accessibility to healthy food after delivery.
- Belief is that eating egg produces bodily heat and hence it is prohibited to avoid any unforeseen instances like abortion.

Figure 9: Food and dietary practices of PW and mothers, and related beliefs and discriminative practices

Family members eat at least one meal together, usually dinner. If men couldn't make it on time, they inform family to eat without them, yet women generally wait for the men to come, till late in the night. What food is to be prepared is decided by the mothers-in-law in the joint families and by the woman in consultation with husband in the nuclear families, however, food is usually prepared to the liking of male family members. Food is set and served by women even in their last trimester. Pregnant women and mothers take rest for one or two hours every day during day time.

In Sangareddy, the majority of pregnant women started eating healthy food and avoided junk after becoming pregnant. Participants in Zaheerabad mentioned that they sometimes eat sweets, snacks like samosa, mirchi bajji, etc and prefer to have aerated drinks thinking that it helps for digestion and gastric discomfort. PW & NM eat two or three biscuits with tea first in the morning. As a practice, lactating mothers (in the early months after delivery) are encouraged to eat bun or bread for better production of breast milk. However, the PW & NM are still eating leftover food, despite the belief that they should not eat stale food.

"We can only ask to prepare or get food of our choice when we are at parental home. We cannot ask for food of our choice or even for little more food to eat at our in-laws' home."- PW

"I am eating well and sufficient to my satisfaction now after coming to my parents' house. I am drinking milk, eating fruits, fish, chicken, what not... I eat almost 7 times a day. In my marital home there is no choice to eat food that I like"- PW

A few beliefs regarding dietary practices of pregnant women and new mothers are prevalent in the area and these are being passed over generations. Restrictions on eating banana has a strong patriarchal norm which is related to ability to give birth to many children. The belief is that if the PW should not eat banana as the tree produce crop only once and the tree is cut down after harvesting the fruits.

Work and division of household chores

Out of all the pregnant women and mothers, only two were working, one as tailor and another as a teacher, remaining women were homemakers. Another PW who was working as nurse had to give up the job due to risk pregnancy. She still feels bad for giving up the job and strongly wanting to resume the job after delivery, but not sure when she can actually go back to work. The burden of the household chores was shared solely by the women in the family. The new mothers are given complete rest for 40 days in general; even if they start working, they are not allowed to work for longer time or chores using water like washing clothes.

Husbands are not of much help in taking care of children either. In the control area (Sangareddy) most of the participants of the FGD come from nuclear families and hence husbands help them in household chores only when it is required, during pregnancy and after delivery. They do not take part in the household chores in normal times, shared by the group. Mothers get little rest during the day since they have to cater to children and their needs. If seldom, men in the family work women consider it as "help", not their responsibility. Men who knew their way around the household work, only helped if asked or they comfort the babies if they cry a lot.

"There are MILs and husbands who do not work at all even if the DIL is pregnant or new mother. My daughter who delivered recently does all the household work while taking care of the infant. Her MIL doesn't even help her in simple works. How can a new mother manage all the works without support??" – (one community member)

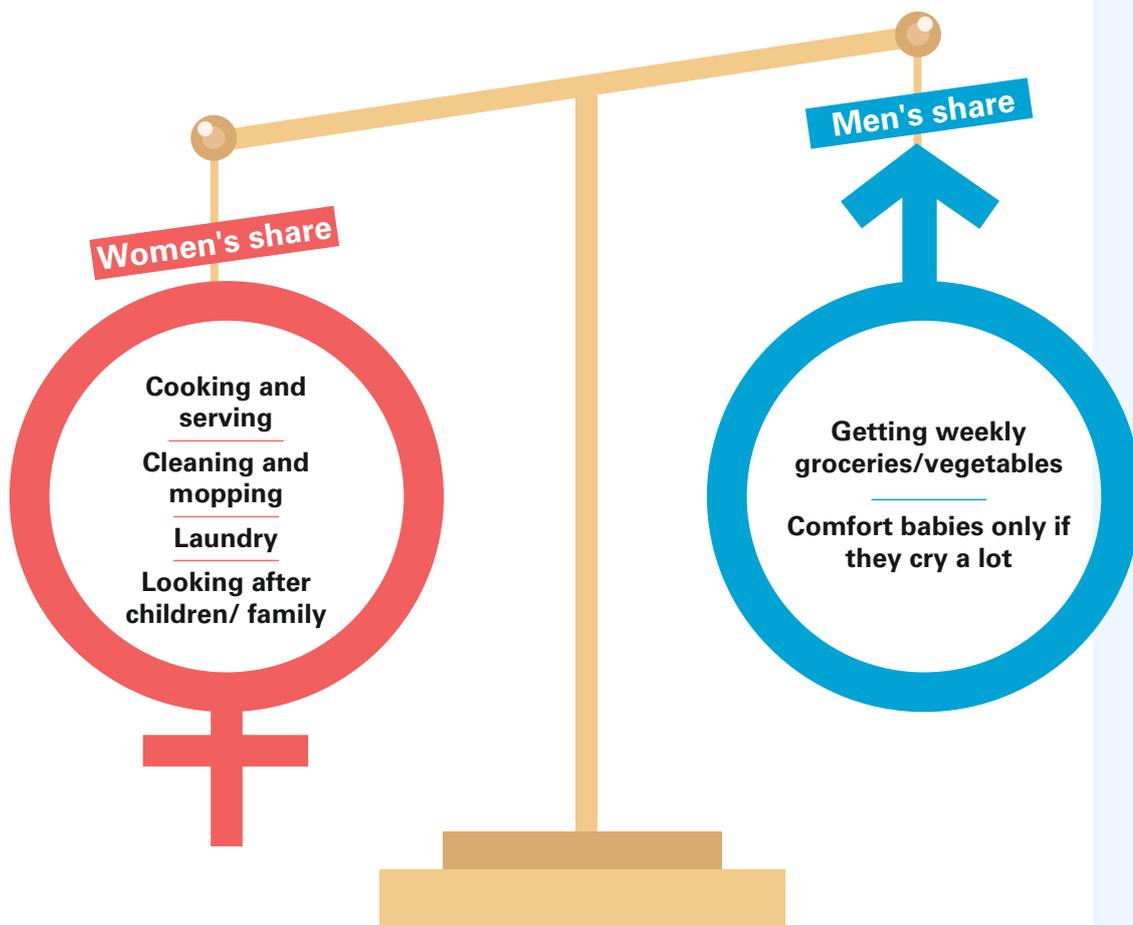


Figure 10: Share of household work among men and women

Husbands' participation in Antenatal Care

Most of the times MILs or SILs or mothers accompany PW to the hospitals, reported 65% of the pregnant women from Zaheerabad. Husbands accompanied wives only for few visits. 25% of the men (husbands of the PW) reported that they never accompanied their wives to the hospital. However, it is only the husbands who take the PW to the Anganwadi centres to register for services. The reason men mentioned was that their wives would not know all the details required to register. But women don't seem to be of that opinion. They just oblige following the gender norms. They say that all the required documents are in the custody of their husbands only and hence they follow them. Similarly, in the case of immunisation to the child, it is the MILs or SILs to accompany new mothers to the hospital for immunisation or health care. About 30% of the fathers would accompany their wives to the hospital. In Sangareddy, in the nuclear families, husbands have to go with their wives to the hospital, whenever necessary. In joint families MILs or SILs accompany the mother.

Views on TMM Messages

From the FGDs it is evident that only one PW from intervention area is not having mobile while all others have possessed one for them. One mother is having phone for herself but the remaining are having access to family phone as they don't have one for themselves. In most of the cases their husband's phones are registered for TMM, though they have access to family phone or owning one. There could be cultural reasons for this. This is also one gender disparity and norm. but they are unable to listen to it as their husbands are at work when the call comes. However, sometimes husbands share with their wives about the call. Women who do have a mobile phone could not listen to the messages since they cannot understand Telugu. Most of the men and community women have not heard about TMM messages.

“There are MILs and husbands who do not work at all even if the DIL is pregnant or new mother. My daughter who delivered recently does all the household work while taking care of the infant. Her MIL doesn’t even help her in simple works. How can a new mother manage all the works without support??” – (one community member)

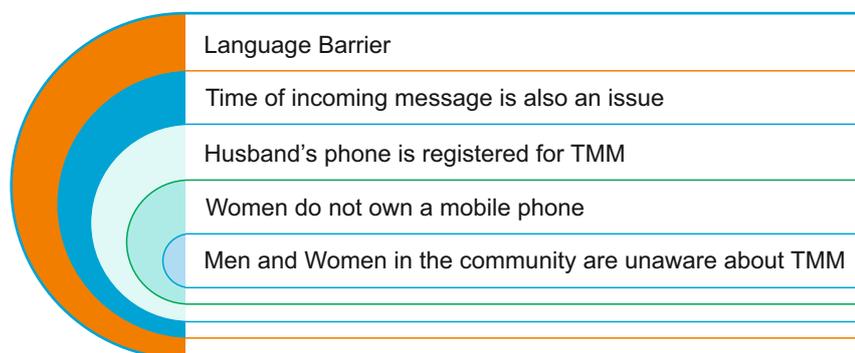


Figure 11: Issues related to TMM messages

5. Conclusion

The in-depth interviews of stakeholders revealed that they are very well aware about their roles and responsibilities. Participants were aware about the ICDS services; however, they did not know the term “health and nutrition day (UHSND)” and needed some explanation to make them understand the term. MAS meetings were not taking place since the outbreak of COVID-19. The seasonal diseases like cold, cough, viral fever, typhoid, dengue were the most common issues the area. A surge in TB cases was reported. Besides, COVID-19 cases keep coming in from time-to-time. Community was deeply impacted by the pandemic, with people being stripped off their jobs, livelihoods and even lives. Community and health workers worked their hardest to render support by distributing packets of ration/food, medicinal supply, masks, essential information on the COVID-19 disease.

The major challenges in service delivery were irregular and under-payment, excessive workload, shortage of frontline health workers, congested AWCs, extensive register and record maintenance. Stakeholders requested to improvise their salaries, pointed towards the need to have more and spacious AWCs, more staff among frontline health workers. Despite all issues, a positive change has been noticed in the health and nutrition behaviour of the women. Stakeholders suggested to improve government health facilities.

Rice and Jowar was the staple food in the households. Majority of pregnant women and mothers eat 3 meals a day and had fruit and snacks in between the meals. It was evident from FGDs that, women were responsible for preparing food and serving while husbands were responsible for bringing groceries, vegetables from the market. It was believed that pregnant women should not eat papaya, guava, banana, and pineapple. Citrus fruits are not given to lactating mothers.

In most of the cases, husband’s number was registered for TMM messages and some could not understand Telugu. Therefore, in order to achieve the desired outcomes of TMM messages it is critical that women have their own mobile phone or they are given some sort of recharge services. Also, it is important that messages are delivered in a language understandable to beneficiaries.



Project Coordinators

- Prof. Sayeed Unisa
- Prof. LaxmiKant Dwivedi
- Dr. Reshmi R.S.
- Dr. Sarang Pedgaonkar
- Dr. Preeti Dhillon

Email: iipsswabhimaan@iipsindia.ac.in

Webpage: <https://www.iipsindia.ac.in/content/swabhimaan-project>

I AM GEETAMMA
I STRIVE FOR AROGYA TELANGANA



For more information, please contact:
UNICEF Child Development & Nutrition Section
UNICEF Office for Andhra Pradesh, Telangana & Karnataka
Hyderabad 500034 (INDIA)