

Public Disclosure Authorized

WHAT DO WE KNOW ABOUT INTERVENTIONS TO INCREASE WOMEN'S ECONOMIC PARTICIPATION AND EMPOWERMENT IN SOUTH ASIA? CARE POLICIES AND CARE SERVICES

Najaf Zahra[†], Amna Javed[†], and Ana Maria Munoz Boudet[†]

The World Bank's South Asia Region Gender Innovation Lab is conducting a systematic review and meta-analysis of interventions with direct or indirect effects on measures of women's economic empowerment. The review focuses on changes in labor force participation, employment, income, and empowerment outcomes. The goal is to document what has and has not worked for women in the region (covering all countries: Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka), the types of interventions implemented, and identifiable gaps in knowledge and action. The review organizes interventions in five broad categories: Skills trainings, Asset transfers and property laws, Financial products, Care policies and Care services, and Empowerment (self-help groups)¹. This brief summarizes key findings from the **Care** category.

WHAT IS INCLUDED?

The review includes experimental and quasi-experimental evidence for policies and programs that have either directly or indirectly changed women's economic outcomes regarding labor force participation, employment, income, and empowerment. The Care category covers interventions and mandates that reduce the care burden on women and, consequently, enable them to participate as active economic agents.

For the review, care responsibilities are defined as activities that keep women engaged in looking after members of their household. Particularly, the review explores care activities that prevent women of working age from entering the labor force, both at the extensive and intensive margins. Household care activities include childcare, elder care, and care for the sick and disabled. The research for this review accounts for interventions that reduce this burden of care on women and enable them to enter or re-enter the work force. First, this includes childcare services—those provided by the government, non-governmental organizations (NGOs), private and employer-provided, or supported on-site childcare. Second, it accounts for policies or mandates that provide women with care services and childcare mandates. It also includes additional mandates that provide families with tax breaks, vouchers, and subsidy benefits to help with care responsibilities, and it accounts for labor market regulations, such as leave, family-friendly policies, and arrangements. Lastly, the review excludes policies or programs that provide education to school-age children beyond the pre-school level.

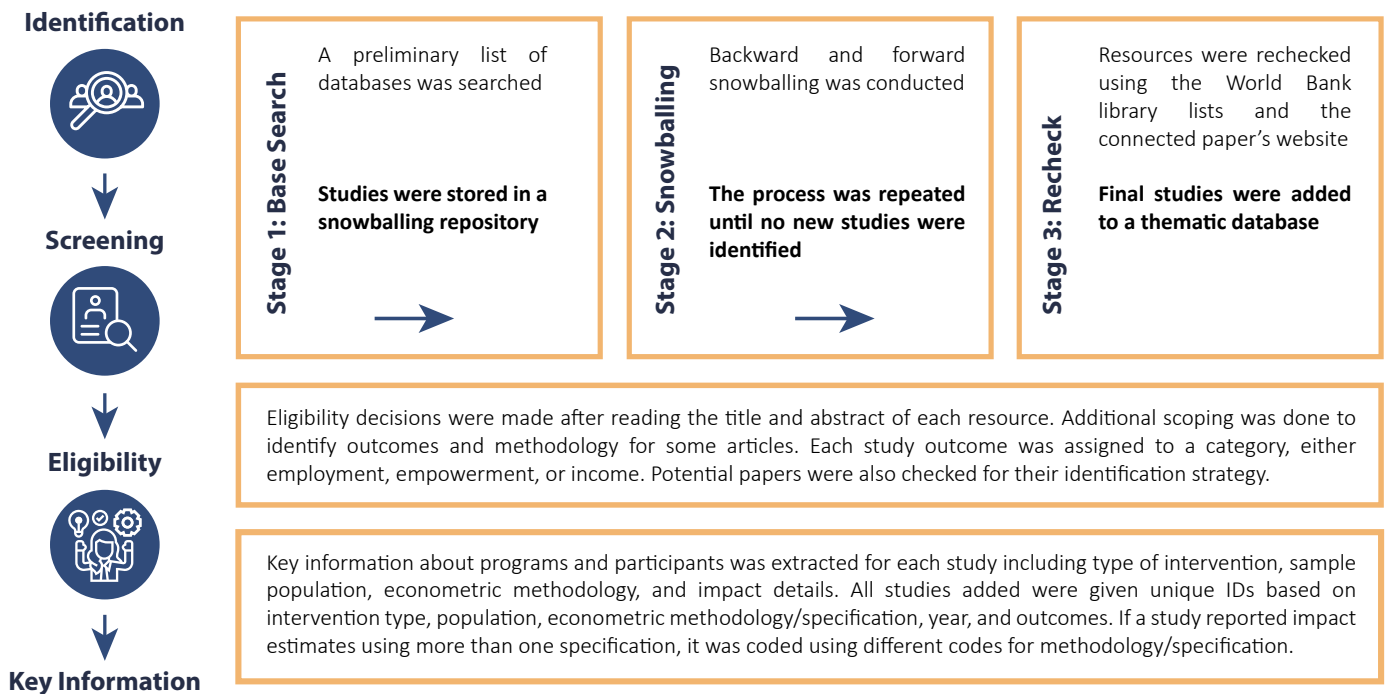
The review includes English-language studies published between January 1990 and July 2022 across white and gray literature (peer-reviewed journals, working papers, program or agency reports, and academic thesis, among others) identified via an extensive search of multiple databases². Intervention inclusion was not limited by time, duration, frequency, or method of exposure. Figure 1

[†]World Bank

¹Previously, the interventions were divided into six categories. However, the Credit and Entrepreneurship categories have been pooled into the Financial products theme. The Labor markets theme has been replaced with a Care category (i.e., this brief). This replacement was made due to a lack of studies uniquely associated with the Labor markets theme.

²The search spanned databases that included Econlit, Web of Science, Science Direct, National Bureau of Economic Research (NBER), Google Scholar, World Bank e-Library, UNU-WIDER, Abdul Latif Jameel Poverty Action Lab (J-PAL), Institute of Labor Economics (IZA), Center for Global Development (CGD), International Growth Center (IGC), American Economic Association (AEA), AEA Registry, International Initiative for Impact Evaluation (3iE), RePEc Research Papers in Economics IDEAS database, and JSTOR.

Figure 1: Search Methodology



summarizes the three-stage identification process. The first stage filtered papers that were relevant to the region and programs that targeted interventions that reduced the burden of care. The second stage filtered for intervention type, and the third stage for methodology. Two reviewers independently searched for and extracted data on impact effects, design, and intervention components from the list of finalized articles. Additional outcome-specific data, such as units of reporting, coefficient significance, and standard errors, were also extracted. If a study reported impact estimates using more than one specification, all were recorded; however, only the researchers' preferred specification is used in this brief.

Eligible studies met at least one of the following conditions:

- Evaluated a program that provided women with childcare services. This includes home-based care, center-provided care programs and improvised and unremunerated family and community arrangements. Home-based care includes registered or unregistered home-based providers or childminders, who take care of a group of babies, toddlers, and/or older children at the caregiver's home. Home-based care also includes nannies and au pairs employed to care for

the child in their own homes. Center-provided care includes employer-provided care (both on-site and off-site), government-run childcare centers (including community-based models implemented in support with an NGO or government agencies) and private childcare provision (including informal for-profit centers). Faith-based providers of care and parents' cooperatives are included too.

- Evaluated an Early Childhood Development (ECD) program that freed up the time that women spent on care activities for children. These include public and private nurseries and pre-school programs.
- Evaluated mandates that provided employers, childcare centers, and/or parents with incentives and/or subsidies for childcare provision. This includes financial support arrangements (for example, subsidies and vouchers) for parents and providers. Also included are preferential tax regimes, such as childcare tax credits.
- Evaluated a legislation that provided women or men with access to flexible work arrangements or certain benefits to attend to care responsibilities. This includes maternity leave, parental leave, and paternity leave.

- Evaluated any program designed to relieve the care burden of the elderly or the sick.

In addition, the studies were required to have:

- Used experimental or quasi-experimental evaluation methods.
- Reported outcomes for women, either because they were the direct target population or as a subpopulation.
- Reported required outcomes for employment (including labor market outcomes, income, earnings, self-employment) and empowerment (including agency, well-being, and happiness).

The database search process identified **247,538** potential studies after using key words for all filter types. After skimming the title and abstract, researchers saved **36** studies for further review. After briefly reviewing the titles and abstracts, researchers shortlisted **7** of the 36 studies for an in-depth review. They obtained a core list of **5** studies to scope in-depth for eligibility. The final database has **5 impact evaluations—all studies evaluate the impact of childcare interventions on selected women empowerment outcomes**. The final details on the papers included in this review are in table A.1. All studies cover India, as the search identified no evaluated programs in other countries in the region.

INTERVENTIONS AND POLICIES TO REDUCE THE BURDEN OF CARE ON WOMEN

Caring for family members is a responsibility that is disproportionately borne by women. Time use surveys conducted in Pakistan and India show that men’s share of unpaid care work is less than 10 percent (8.9 and 9.5 percent), which is far less than the global average of 27.5 percent (Charmes 2019). This unequal division of responsibility is evident in many South Asian countries, where entrenched sociocultural norms and patriarchal traditions view women as the primary caretakers of children and other family members.

This translates into less time spent on education, self-care, and employment. Providing care support to women frees up time spent disproportionately on care responsibilities at home. Women can use this time to pursue economically productive activities.

Our systematic review documents three childcare models: Home-based care, center-provided care programs, and improvised and unremunerated family and community arrangements. In South Asia, the childcare landscape is constrained by issues related to accessibility, affordability, and quality (Women, Business and the Law 2022). Bangladesh is the only country in the region that has regulations in place for both public and private provision of childcare services, including mechanisms for licensing, accreditation, and penalties for non-compliance. However, the fee structures and financial support mechanisms are not regulated by law in any country in the region. Nepal only regulates private childcare services, with the law requiring inspections to ensure compliance to laws and quality standards. While employer-provided childcare exists in Nepal, it is mandated only in some instances. Bangladesh, India, Pakistan, and Sri Lanka mandate employers to provide childcare services³, with only India and Bangladesh providing tax benefits to employers. No country has laws regulating hours of operation or offering flexible hours of service. Table 1 shows the landscape of childcare in South Asia.

Even in areas where legislation exists, there is limited capacity to monitor and enforce childcare laws. In cases where employer-provided childcare is available, many women opt-out of these services fearing unsafe practices, unpredictable work hours, and long commutes to work-offices (Devercelli and Beaton-Day 2020). In some countries, such as Bangladesh and India, childcare services are also provided by international and national NGOs.

In addition to childcare, other family policies are designed to provide support to those who have care responsibilities toward newborns and children. These include maternity and paternity leave policies, child benefits such as grants/government subsidies, tax rebates, vouchers, and other monetary incentives provided to caregivers of children, and breastfeeding policies. Maternity leave policies specifically support new mothers and their newborns by providing

³These laws are also constrained by a minimum threshold of employees for the enforcement to be legally binding

Table 1: Landscape of Childcare Mandates in South Asia

Country	Law regulating public provision of childcare services	Law regulating private provision of childcare services	Law mandates employers to provide or support childcare services	Paid leave of at least 14 weeks available to mothers	Paid leave available to fathers	Length of paid maternity leave (days)	Length of paid paternity leave (days)
Bangladesh	✓	✓	✓	✓	✗	112	0
Bhutan	✗	✗	✗	✗	✓	60	14
India	✗	✗	✓	✓	✗	182	0
Nepal	✗	✓	✗	✓	✓	98	21
Pakistan	✗	✗	✓	✓	✗	112	0
Sri Lanka	✗	✗	✓	✗	✗	84	0
Afghanistan	-	-	-	✗	✓	90	14
Maldives	-	-	-	✗	✓	60	3

Note: Mandates are reported at the national level.
Source: Women, Business, and Law, 2023

mothers with paid time off from work to recuperate from childbirth and to attend to the needs of the newborn. It also provides mothers with job security and ensures sustained income and wages. Paternity leave policies encourage fathers to play a greater role in caring for children and aim to shift the gendered attitude toward childcare. Encouraging men to take an equal responsibility for child-caring enables women to enter/re-enter the labor force with minimal breaks in their career trajectories. Further, these policies may reduce discrimination against women in the workplace, particularly in hiring. Table 1 shows the state of family friendly policies in South Asia, in line with the benchmarks mandated by the International Labour Organization (ILO). Most countries mandate maternal leave for women workers; however, only four countries provide the ILO mandated minimum of 14 weeks. Most countries in South Asia have no legal provision for paternity leave at the national level⁴.

This review found no studies that evaluated the impact of leave policies on the economic empowerment dimensions for women.

This paucity of research on economic outcomes for women is also evident in the early childhood intervention landscape. ECD interventions, when carefully designed, have shown impacts on children’s physical, cognitive, and socioemotional development. However, their indirect effects on mothers and other household members are not

well-researched. A study by Evans, et al. (2021) highlights the paucity of evidence on studies that measure the impact of ECD interventions on women’s labor market and empowerment outcomes. Of the 478 studies, globally, that evaluated an ECD-related intervention, only 4 percent (19 studies) account for maternal labor market outcomes, and 1 percent (6 studies) report outcomes for women empowerment.

PROGRAM DESIGN

The review of care interventions maps five studies, all of which evaluate childcare interventions. The five evaluations explore cases of subsidized childcare services and preschool programs provided through a government provider, an NGO, and a private provider. Of the five programs, two evaluate the effectiveness of childcare provided through the Integrated Child Development Scheme (ICDS) (Jain 2016, Friedman, et al. 2017). Richardson, et al (2018) and Nandi, et al. (2020) evaluate a community-based daycare program with an NGO called Seva Mandir. Lastly, Ranganathan and Pedulla (2021) look at a case of employer-provided daycare on site by a garment factory in India.

All five childcare programs targeted women that belonged to rural and marginalized backgrounds. Most women had never attended school and reported unfavorably on

⁴In Pakistan, the revised leave rules provide paternity leave for a maximum of seven days only in the province of Punjab only.

empowerment outcomes and emotional and physical abuse by their partners. The interventions also targeted women in low-skilled occupations.

In addition to childcare services, programs also provided complementary services to children at the daycare centers. The ICDS program provided additional services, such as supplementary nutrition support, immunization, health checkups, referral services, pre-school education and nutrition and health education. Ranganathan and Pedulla (2021) also reported additional food and health services that included breakfast, lunch and afternoon snacks from the factory canteen and health checks with a nurse on site.

While basic modalities of childcare provision are similar across programs, this review reports differences in both structure and operational activities.

Launched in 1975, the ICDS program caters through centers across India. A caretaker and helper run each center, with both receiving three months of institutional training and four months of community-based training. The community-run daycare centers run by Seva Mandir are operated by local women called *sanchalikas* who are hired and trained by Seva Mandir. The centers are open for five days a week, six hours a day. The childcare center at the garment factory is run by two women who are trained to take care of children and infants. The on-site center provides children with health and sanitation facilities, educational learning activities, and meal services. However, due to capacity constraints, the center can only accommodate 100 children at a time. To qualify, mothers are put on a waitlist that is managed by the company's human resources department.

The utilization of childcare services varies across programs. The three-year evaluation of the ICDS program by Friedman, et al. (2017) showed an 8-percentage point increase in the utilization of the daycare services. This increase could be attributed to complementary interventions such as provision of cooking gas and construction of latrines during the same period. On average, each center catered to 10 children, and this increased over time. However, daily attendance was not consistent and was affected by seasonal changes, migration, and festivities. When comparing utilization between different services of the ICDS program, Jain (2016) picked up discrepancies. For instance,

the evaluation reports lower participation of children in preschool, despite the same children being enrolled for other ICDS services including daily supplementary feeding, vaccination, and health checkups. Jain (2016) shows that children from scheduled caste households are less likely to participate in preschool services and attributes this discrepancy to discrimination against marginalized castes. The primary reason for parents not using the daycare services is distance and difficulty in dropping off and picking up the child. The ICDS daycare centers also have operational issues. Parents report inconsistent functioning and poor quality as reasons for not sending their child to the ICDS daycare. Friedman, et al. (2017) highlight quality concerns at the centers. These include limited availability of clean drinking water, inadequate hygiene protocols, and limited nutrition and cleanliness support for food. An additional process evaluation reveals shortages of play material, water, and sanitation facilities at the centers. Lastly, many care providers are inadequately trained to manage and run the centers.

There is a similar pattern of service utilization for NGO-provided daycare centers. Richardson, et al (2018) and Nandi, et al. (2020) show an uptake of 41 percent to 43 percent for the Seva Mandir daycare centers in India. This modest uptake is attributed to other structural barriers beyond the lack of affordable daycare. However, in contrast to the ICDS program, qualitative interviews with parents regarding service provision show satisfactory opinions of the service and security provided, including the nutrition and education components. For employer-provided childcare, Ranganathan and Pedulla (2021) report full utilization of on-site daycare.

PROGRAM IMPACTS

Program impacts are categorized into two groups: 1) Labor market and 2) Broader empowerment.

A. LABOR MARKET OUTCOMES

All five studies report labor market outcomes for women. Jain (2016) reports a 6-percentage point increase in the maternal labor supply in rural India⁵. These results are

⁵This increases to 13.9*** percentage point if combined with daily supplementary feeding, which includes foods other than breast milk.

mostly driven by impacts from central rural India, where the provision of preschool has resulted in a 10-percentage point increase in women's labor force supply. Similar findings are reported by Friedman, et al. (2017) and Ranganathan and Pedulla (2021) who report that access to daycare improves the likelihood of work⁶ among caregivers by 0.637 days and leads to a 5.5 percentage point increase in women's attendance at work⁷, respectively. Richardson, et al. (2018) and Nandi, et al. (2020) report a reduction in women's time spent performing care work. However, while Richardson, et al. (2018) do not find any effect on women's paid work, Nandi, et al. (2020) find an increase of 2.3 percentage points in the proportion of women working for cash paid jobs in the last 12 months and, a 2.6 percentage point increase in the proportion of women who engaged in any paid work in the last 24 hours.

B. BROADER EMPOWERMENT OUTCOMES

Only one study reports other empowerment outcomes for women. Richardson, et al. (2018) report the impact of childcare services on mother's agency, mental health, and incidence of violence. Access to affordable daycare has resulted in a 11 percent reduction in mental distress among women, in comparison to women in the control group. While intervention impacts on measures of agency are not significant, the study reports a 3-percentage point reduction in Intimate Partner Violence among women exposed to the treatment, which is primarily mediated by a reduction in controlling partner behavior (5 percentage points) and psychological abuse (4 percentage point decrease).

DISCUSSION AND CONCLUSION

Our review of the childcare landscape highlights several insights. First, the studies in this review include only childcare interventions delivered either by an NGO or government program. Researchers found no evaluations of laws, mandates, and care benefits. Second, uptake of childcare provision is mixed, even for large scale

programs such as ICDS in India⁸. Studies report an uptake between 40-52 percent. Uptake and attendance of children varies geographically across India and is impacted by migration and seasonal activities. It is also impacted by the nature of jobs. The target women in the reviewed studies are young, from low-income backgrounds, and tend to be engaged in low-skill occupations. Most low-skill jobs don't offer consistent contracts, and the work is either seasonal or irregular and offers compensation in daily wages.

Third, the reviewed studies show encouraging results for labor market outcomes for women. Four of the five studies show improved maternal labor supply, both at the extensive and intensive margins, and most significantly for women from marginalized backgrounds. Results also illustrate a reduction in time women spend on housework and care activities for family members. Access to childcare services also improved women's attendance at work. Interestingly, Ranganathan and Pedulla (2021) explore benefits from employer-provided childcare for women with and without non-work social networks. They find that women who have less support from non-work networks for childcare support, specifically women with daughters, are more likely to benefit from employer-provided childcare. This may be because, in societies where sons are preferred, women with daughters have only limited support from their social networks in providing informal childcare. Only one study from India shows no impact on women's labor market outcomes, which the authors attribute to structural barriers that go beyond the childcare landscape. Last, only one study evaluates the impact of childcare interventions on women's general empowerment, with positive impacts on several outcomes.

While the labor market results seem promising, the pool of studies is small and limited only to India. This lack of rigorous impact evaluations can be partly attributed to the nascent institutional childcare landscape in South Asia. While all countries for which data are available, except for Bhutan, regulate at least one of the three types of formal childcare providers—public, private and employers, only one country, Bangladesh, regulates all three.

⁶Probability of work in last week.

⁷Additional calculations indicate that the attendance of women with daughters went up by 7.5 percentage points in response to receiving access to childcare, whereas the attendance of women with sons went up by 2.5 percentage points

⁸The program targets children between the ages of 3 and 6. The ICDS program has faced several operational challenges, the key one being its inability to reach children below the age of three. Ages 0-3 is most critical for early childhood development.

Even though we have a small pool of studies, we have many useful insights that shed light on the relationship between childcare and women's economic empowerment:

In the presence of other constraints, the impact of childcare on women's economic empowerment may be muted.

The positive link between childcare provision and women's economic empowerment, while evident to some degree from the studies included in this review, may be muted by factors outside the childcare landscape. The burden and unequal distribution of domestic responsibilities and broader social norms in general may add constraints to where and how women can work. Hence, even in the presence of childcare services, many women may not engage in paid work outside the family home.

Aggregate effects hide heterogeneity.

The utilization of childcare depends on a wide variety of factors that relate to economic status, social norms about the societal role of women, and household structure. Women who are intrinsically motivated to stay in the labor force will have a higher demand for childcare and will expect to gain more from the service. Existing job opportunities, the availability of flexible work arrangements, and social norms about women's mobility will also add to a woman's decision to access childcare. Socioeconomic status adds another layer of complexity. If women's work outside the family home is stigmatized, women from high-income backgrounds may choose to not enter or return to the labor force. In contrast, women from marginalized backgrounds might not have a choice, and could benefit from low-cost childcare options. Household

structure and social hierarchies may also determine demand for childcare. Women living in bigger families may have an increased responsibility to care for extended family members and perform household chores but may also have more childcare support from other family members. Similarly, the number of children a woman has may also be a determining factor for childcare demand. Women with multiple children may want to enroll their older children in daycare centers to leave them free to attend to the needs of the younger ones. Hence, having access to childcare may free up time for women, but not necessarily translate into increased labor market participation.

Quality of care is underregulated and understudied but likely an important factor.

Quality of childcare services can significantly influence parental decision-making to utilize childcare services, and consequently determine women's decision to re-enter/enter the labor market. While the relationship between the quality of childcare and women's decision to work is not widely researched, a few studies done in high-income countries indicate that quality is important (Baker, Gruber and Milligan 2008; Haeck, Lefebvre and Merrigan 2015). In South Asia, only Bangladesh mandates some quality standards for public and private childcare provision (while Nepal has similar regulations in place for private centers); however, implementation of standards is still weak. Quality measures include structural quality such as teacher-to-student ratios, professional development of caregivers, and infrastructure facilities. The hours of operation and flexibility in service hours are also crucial aspects. Lastly, lack of parental trust and concerns with safety may impact the demand for childcare services and, consequently, women's decision to work.

STAY CONNECTED

SARGENDERLAB@WORLDBANK.ORG
WORLDBANK.ORG/SARGENDERLAB

We gratefully acknowledge funding from the South Asia Trade Facilitation Program (SARTFP) and the Umbrella Facility for Gender Equality (UFGE). SARTFP is a trust fund administered by the World Bank with financial contribution from the Government of Australia's Department of Foreign Affairs and Trade. UFGE is a multi-donor trust fund administered by the World Bank to advance gender equality and women's empowerment through experimentation and knowledge creation to help governments and the private sector focus policy and programs on scalable solutions with sustainable outcomes. The UFGE is supported with generous contributions from Australia, Canada, Denmark, Finland, Germany, Iceland, Ireland, Latvia, the Netherlands, Norway, Spain, Sweden, Switzerland, United Kingdom, United States, the Bill and Melinda Gates Foundation, and the Wellspring Philanthropic Fund.



APPENDIX

Table A.1: Included Studies and Program Details

ID	Title and Author(s)	Methodology	Region	Implementing Partner	Intervention Type	Intervention	Population Sample
1	The effect of affordable daycare on women's mental health: evidence from a cluster randomized trial in rural India. <i>Robin A. Richardson, Sam Harper, Norbert Schmitz, Arijit Nandi, 2019</i>	Cluster Randomized Control Trial (RCT)	India, Rajasthan	Seva Mandir (NGO)	Community based childcare centers	Community members were offered full-time, community-run affordable daycare services, called "balwadis." Each <i>balwadi</i> provided childcare, nutritious meals, preschool education, and linkage to health services (e.g., immunizations) to children between one and six years of age. The centers were run by local women, called "sanchalikas," who were trained by the implementing NGO. Members using the services were charged a fee of Rs. 150 per child, which was used to purchase the needed items for the center. The centers were open 5 days a week, for 6 hours every day.	Women were, on average, 30 years of age; majority were from scheduled tribes and had many had never attended school. These women also reported experiencing some form of intimate partner violence.
2	Access to affordable daycare and women's economic opportunities: evidence from a cluster-randomized intervention in India <i>Arijit Nandi, Parul Agarwal, Anoushaka Chandrashekar & Sam Harper, 2020</i>	Cluster Randomized Control Trial (RCT)	India, Rajasthan	Seva Mandir (NGO)	Community-based childcare centers	Community members were offered full-time, community-run affordable daycare services, called "balwadis." Each <i>balwadi</i> provided childcare, nutritious meals, preschool education, and linkage to health services (e.g., immunizations) to children between one and six years of age. The centers were run by local women, called "sanchalikas," who were trained by the implementing NGO.	Women from low-income backgrounds and had never attended school.
3	Public Preschooling and Maternal Labor Force Participation in Rural India. <i>Monica Jain, 2016</i>	Randomized Control Trial (RCT)	India, rural areas in the central and south	Integrated Child Development Scheme (ICDS)	Public pre-school centers	The ICDS program has a long history of providing numerous services to underprivileged women in India. These services include supplementary nutrition, health check-ups, immunization, and preschool services. Pre-schooling is provided in childcare centers or "anganwadis," located in villages. Each center is run by an <i>anganwadi</i> worker and one helper— they undergo three months of institutional training and four months of community-based training.	Women between ages 15-49 years of age from rural regions. Most women had at least one child.
4	Evaluating Integration in the ICDS: Impact Evaluation of an AWC-cum-creche pilot in Madhya Pradesh. <i>Jed Friedman, Harold Alderman, Mohini Kak, and Ramesh Govindaraj, 2017</i>	Randomized Control Trial (RCT)	India, Madhya Pradesh	Integrated Child Development Scheme (ICDS)	Public pre-school centers	The ICDS program has a long history of providing numerous services to underprivileged women in India. These services include supplementary nutrition, health check-ups, immunization, and preschool services. Pre-school is provided in childcare centers or "anganwadis," located in villages. Each center is run by an <i>anganwadi</i> worker and one helper, who undergo three months of institutional training and four months of community-based training.	Women between ages 15-49 years of age from rural regions. Most women had at least one child.
5	Work-Family Programs and Non-Work Networks: Within-Group Inequality, Network Activation, and Labor Market Attachment. <i>Aruna Ranganathan and David S. Pedulla, 2021</i>	Randomized Control Trial (RCT)	India, Bengaluru	Private garment factory	Employer provided on-site childcare center	A large garment factory in India employs 1,800 women and specializes in producing menswear. The factory provides on-site childcare to women workers. Run by two women trained in the care of children and infants, the center provides educational learning, meals, and health services free of charge.	Low-skilled female garment factory workers. Many of the women in the sample use informal, neighborhood-based childcare centers before gaining access to the employer-provided childcare center.

Table A.2: Reported Outcomes

Outcome Category	Reporting Units	Outcome Measurement	Effect (reported)	Effect (change from mean of control)
------------------	-----------------	---------------------	-------------------	--------------------------------------

(Richardson et al. 2018) The effect of affordable daycare on women's mental health: evidence from a cluster randomized trial in rural India.

Labor market	Time, hours	Total work hours	-0.12	-7.20 min
		Farm work	0.09	05.40 min
		Paid work	-0.02	-01.20 min
		Housework	-0.01	-00.60 min
		Caring for children, elderly, disabled	-0.16	-09.60 min
Women's empowerment, mental health	Average of 12 sub-indicators from the General Health Questionnaire (GHQ-12)	Mental distress	-0.21	-10.61 perc
Women's empowerment, agency	Average of all agency types across 23 sub-indicators	Overall agency	0.02	-15.38 perc
	Average of 9 sub-indicators	Household decision making	0.02	-66.67 perc
	Average of 5 sub-indicators	Freedom of movement	0.02	-11.76 perc
	Average of 6 sub-indicators	Participation in the community	0.01	-33.33 perc
	Average of 3 sub-indicators	Attitudes and perceptions	0.02	-28.57 perc
Women's empowerment, violence, and abuse	Average of 6 sub-indicators from the Demographic and Health Survey's Domestic Violence Module	Intimate partner violence	-0.03	-03.85 perc
		Physical abuse	-0.01	-03.70 perc
		Psychological abuse	-0.04	-12.50 perc
		Controlling behavior	-0.05	-06.94 perc

(Nandi et al. 2020) Access to affordable daycare and women's economic opportunities: evidence from a cluster-randomised intervention in India

Labor Market	Worked in the past 7-day, percentage point	Employment	-0.40	-00.65 perc
	Self-employed, percentage point	Employment	-0.50	-01.44 perc
	Works year-round, percentage point	Employment	2.00	22.47 perc
	Paid in cash for work in the last 12 months, percentage point	Employment	2.30	24.21 perc
	Any time on paid work in the last 24 hours, percentage point	Employment	2.60	48.15 perc
Income	Money, rupees	Total household income	-770.1	-01.41 perc

(Jain 2016) Public Preschooling and Maternal Labor Force Participation in Rural India.

Labor market, employment	Working in the last 7 days, percentage points	Rural India	6.00***	17.65 perc
		Rural South and West	5.00*	11.63 perc
		Rural North	1.00	3.85 perc
		Rural East	5.00*	19.23 perc
		Rural Northeast	5.00	21.74 perc
		Rural Central	10.00*	20.83 perc

(Friedman et al. 2017) Evaluating Integration in the ICDS: Impact Evaluation of an AWC-cum-creche pilot in Madhya Pradesh

Labor market	Worked at all in the past week, percentage points	Employment	-0.40*	-
	Number of days worked in the last week, days	Employment	-0.50	-
	Care provided, percentage points	Household care responsibilities	2.00*	-

(Ranganathan and Pedulla 2021) Work-Family Programs and Non-Work Networks: Within-Group Inequality, Network Activation, and Labor Market Attachment

Labor Market	Present at work, log	Attendance	0.536*	70.91 Perc
--------------	----------------------	------------	--------	------------

Note: Richardson, et al. (2018) and Nandi, et al. (2020) do not report significance values, only 95% confidence intervals.

BIBLIOGRAPHY

- Baker, Michael, Jonathan Gruber, and Kevin Milligan. 2008. "Universal Child Care, Maternal Labor Supply, and Family Well-Being." *Journal of Political Economy* 116 (04): 709-745. doi:<https://doi.org/10.1086/591908>.
- Charmes, Jacques. 2019. *The Unpaid Care Work and the Labour Market. An analysis of time use data based on the latest World Compilation of Time-Use Surveys*. International Labour Organization .
- Devercelli, Amanda E. , and Frances Beaton-Day. 2020. *Better Jobs and Brighter Futures: Investing in Childcare to Build Human Capital*. Washington, DC.: World Bank. <https://openknowledge.worldbank.org/entities/publication/385821d3-bce3-5640-b140-48e27b58296b> License: CC BY 3.0 IGO.
- Evans, David K., Pamela Jakiela, and Heather A. Knauer. 2021. "The impact of early childhood interventions on mothers." *Science* 372: 794-796. doi:10.1126/science.abg0132.
- Friedman, Jed, Harold Alderman, Mohini Kak, and Ramesh Govindaraj. 2017. "Evaluating Integration in the ICDS: Impact Evaluation of an AWC-cum-creche pilot in Madhya Pradesh." <https://documents1.worldbank.org/curated/en/49395153776051558/pdf/Impact-Evaluation-of-an-AWC-cum-creche-pilot-in-Madhya-Pradesh.pdf>.
- Haeck, Catherine, Pierre Lefebvre, and Philip Merrigan. 2015. "Canadian evidence on ten years of universal preschool policies: The good and the bad." *Labour Economics* 36 (C): 137-157. doi:10.1016/j.labeco.2015.05.002.
- Jain, Monica. 2016. "Public pre-schooling and maternal labour force participation in rural India." *Oxford Development Studies* 44 (2): 246-263. doi:<https://doi.org/10.1080/13600818.2015.1082998>.
- Nandi , Arijit , Parul Agarwal, Anoushaka Chandrashekar, and Sam Harper. 2020. "Access to affordable daycare and women's economic opportunities: evidence from a cluster-randomised intervention in India." *Journal of Development Effectiveness* 12 (3): 219-239. doi:<https://doi.org/10.1080/19439342.2020.1773898>.
- Ranganathan, Aruna, and David S. Pedulla. 2021. "Work-Family Programs and Nonwork Networks: Within-Group Inequality, Network Activation, and Labor Market Attachment." *Organization Science* 32 (2): 257-525. doi:<https://doi.org/10.1287/orsc.2020.1391>.
- Richardson , Robin A. , Sam Harper, Norbert Schmitz, and Arijit Nandi. 2018 . "The effect of affordable daycare on women's mental health: Evidence from a cluster randomized trial in rural India." *Social Science & Medicine* 217: 32-41. doi:<https://doi.org/10.1016/j.socscimed.2018.09.061>.
- Women, Business and the Law. 2022. *Towards Available, Affordable, and Quality Childcare in South Asia*. The World Bank Group. <https://wbl.worldbank.org/en/wbl>.