ARNEC CONNECTIONS

Working Together for Early Childhood

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Special Edition:
Noteworthy Early Childhood Care and
Development (ECCD) Practices 2010

ARNEC
Asia-Pacific Regional Network
for Early Childhood

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About the Special Edition and Initiative:

ARNEC covers a large geographical area, totaling 47 countries in the Asia-Pacific region. ARNEC Connections is one of the many ways that our organisation has sought to disseminate information pertaining to early childhood care and development (ECCD).

This year, ARNEC is publishing a Special Edition of ARNEC Connections due to the immense popularity and request for more frequent issues.

In keeping with its mission to expand the knowledge base on innovative practice in early childhood in the Asia-Pacific region, ARNEC has launched a new initiative to document noteworthy practices in ECCD. This initiative highlights promising and noteworthy ECCD practices that are not yet widely known and can serve as an inspiration to others. Four sites were selected for documentation in 2010, under the 2010 ARNEC theme *Inclusive Foundations: Working together to reach the unreached*.

This Special Edition features the reports written by the Research Fellows who documented four programmes in the Asia-Pacific region in 2010 as part of the ARNEC Noteworthy ECCD Practices initiative.

What is a Noteworthy Practice?

A noteworthy practice is a programme, initiative or project that has shown initial promise and effectiveness in responding to a particular need of young children (conception to 8 years), and that can serve as an inspiring model for other actors.

Specific characteristics of noteworthy practices include the following:

- Noteworthy practices are useful and practical; they answer a specific need;
- Noteworthy practices show initial effectiveness in addressing the need;
- Noteworthy practices promote holistic responses and empower disadvantaged and excluded groups of children;
- Noteworthy practices mobilise parents and communities to support children's care and development;
- Noteworthy practices are cost effective and are sustainable over time; they have a clear and realistic sustainability plan.

Site Selection

The ARNEC Secretariat issued a call for applications to their network of ECCD stakeholders, introducing the initiative and specifying priorities for documentation in 2010. Government ministries, local and international NGOs and private sector organisations that implement ECCD programmes were encouraged to apply.

ARNEC received 24 applications from a wide range of ECCD programmes in South Asia, Southeast Asia, East Asia, Central Asia and Oceania/the Pacific. Applications were evaluated through a two-phased review by an expert panel composed of ARNEC Steering Committee members, the ARNEC Secretariat, and external ECCD Advisors.

Field Documentation

The research fellows used qualitative methods to document the noteworthy practices as they were implemented and experienced in practice. Data were collected through semi-structured interviews, focus group discussions, and reviewing existing documentation. The research fellows also observed programme implementation, meetings, and training activities, shadowing partners as they engaged in their daily tasks.

Fellows worked with a wide variety of stakeholders, including local partner organisations, international and regional NGOs, state officials, local academics, and local community members, with the aim of providing a comprehensive and multi-level perspective of the ECCD programs.

Dissemination

As an international network of ECCD practitioners, ARNEC will use its wide reach to promote and share these noteworthy practices. They will be featured on the ARNEC website, published in a special edition of ARNEC Connections, and highlighted by ARNEC at upcoming regional and glocal ECCD events.

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Introduction

By Sheldon Shaeffer, Former Director - UNESCO Bangkok

The four "noteworthy practices" presented here, selected from 24 applications from throughout Asia and the Pacific, in many ways are among the best examples of early childhood care and development (ECCD) programmes in the region. Taken together, they avoid the characteristics of many current ECCD programmes – mono-sectoral, centralized, overly academic and formal – and are based on the increasingly global understanding that good quality ECCD programmes not only cover children in the age range of 0-8 but also are multi-sectoral and integrated, comprehensive, community-based, and child- and family-focused. They also demonstrate how these kinds of programmes are most likely to have both immediate and lasting impact on a child's health, behavior, and learning. They are therefore essential reading for ECCD policymakers, programmers, and practitioners.

These programmes share some common characteristics:

- They target children (and, in some cases, their families) during the most sensitive period of their development; i.e., from birth (or before) to 3-6 years of age and even into primary school.
- They emphasise participatory training processes, both of parents and other family/community caregivers and of more formal ECCD programme facilitators, and extensive and intensive capacity-building of actors from the bottom of the implementation system to the top.
- They take a holistic, comprehensive approach to the multitude of family, community, and social influences which have an impact on child development, attempting to adapt the approach as much as possible to local contexts and needs, especially of the most vulnerable and marginalised populations.
- They make a special effort to involve a wide range of stakeholders in the programme, from the immediate families, to community members and leaders, and to local governments and relevant national programmes, in every aspect of its implementation, both to promote local ownership and, where possible, local support.

Each programme also has a unique strength.

- **A New Day for Kids** in Cambodia places special emphasis on adult and child Reflect Circles, to promote caregiver/parent development and empowerment, even going beyond good principles and practices of ECCD to cover health, agriculture, and financial management.
- **Hands to Hearts International**, in this case through one of its partners, Viswa Yuda Kendra, stresses the adaptation and cultural relevance of its work to high-poverty, rural communities in Orissa, India, and thus focuses on appropriate curricula and participatory pedagogy rather than material resources.
- The **Early Childhood Development Support Program - Bangladesh** uses a cascade model of implementation by supporting three ECD models developed by local NGOs (in this case, that of the Friends in Village Development, Bangladesh) and then, with intensive technical capacity-building and organisational development, replicated by nine smaller NGOs active in hard-to-reach areas (in this case, Prochesta).
- **Healthy Start** in the Philippines focuses particularly on pregnant women and families with newborns to not only increase positive parenting behaviours and decrease environmental risks but also strengthen relationships within families and increase access to local social, medical, and employment services, with formal monitoring of child development through a comprehensive assessment tool.

The programmes also have common challenges: their immediate sustainability;

the ability and viability of taking them to scale; and the need for more comprehensive assessment – both qualitative and quantitative – of their processes, structures, and outcomes.

In terms of **sustainability**, at the moment most of the programmes are limited in scope and implemented by rather labour-intensive processes of staff and family recruitment, initial training, community sensitization, and ongoing family/child monitoring and facilitator mentoring. Thus, A New Day for Kids covers just over 5000 men, women, and children; Hands to Hearts International, over 2000 child development workers, crèche workers, and mothers (and, of course, the children they care for); the Early Childhood Development Support Program-Bangladesh, 20 parenting and pre-school programmes managed by Prochesta and a total of 165 managed by the entire Support Program; and Healthy Start, 444 families.

The immediate problem is ensuring the short-term continuation of these current services after the initial support from international and national NGOs and/or development donors stops. This is why the programmes' emphasis on ensuring strong ownership by local communities, strong collaboration with local governments, and/or strong linkages with national government programmes (especially in India) becomes so important.

The longer-term challenge, of course, is **going to scale** beyond the current limited coverage. The children, parents, and communities being reached by these programmes represent only a fraction of those who could benefit from them. But adapting and replicating complex, labour-intensive, and sometimes costly projects across districts, states/provinces, and even countries with very different needs, resources, and contexts are not easy tasks. Here it is essential to identify among the various and varied components of the innovation (a variety often made possible by the fact that the early pilot stage of an innovation is well-resourced and well-staffed, with the luxury of more experimentation) those which are core and critical to the innovation's success – in other words, those

Mom practices "Play-by-Play" - one of the many parenting methods promoted by the Healthy Start programme in the Philippines.

components without which the innovation could not stand. These core components thus become those which *must* be found in all replications while others become supplementary and elective depending on the particular context.

Ensuring the sustainability of existing programmes and their eventual adaptation and replication requires a rigorous process of systematic, comprehensive **monitoring and evaluation**. This must go beyond what are often now more anecdotal observations and informal reports to longer-term, in-depth, and comparative studies, both ethnographic/qualitative and quantitative in nature, which describe and assess the implementation structures and processes and rigorously analyse both immediate results and longer-term outcomes. Such an assessment can provide useful recommendations for mid-course corrections, provide evidence to potential supporters of replication about what works and why, and help isolate those components of the programmes that are essential to their success – thus guaranteeing that these "noteworthy practices" both remain noteworthy in their own contexts and become the inspiration for similar efforts through the vast and diverse region of Asia and the Pacific.

Philippines: Partnerships for a Healthy Start

By Jessica Malkin, Research Fellow

Abstract

Healthy Start is an intensive, community-based, home-visiting programme that enrols pregnant women and families with newborns and provides support for healthy family and child development during the first three years of the child's life. The programme focuses on increasing positive parenting behaviours and decreasing environmental risks through: (1) increased parental knowledge of child development, (2) the provision of games and activities to support healthy development and learning, (3) strengthened relationships among family members, and (4) increased access to social, medical, and employment services. The Consuelo Foundation partners with local non-government organisations to implement the programme in highly diverse settings and with families who are vulnerable across a great variety of domains. Healthy Start currently serves 444 families across 14 sites throughout the Philippines.

Formal programme evaluations demonstrate that Healthy Start has had positive effects on parent knowledge of child development, parenting practices, and child health and well-being (among others outcomes), and the documentation process reveals similarly positive anecdotal effects. This impact may be at least in part explained by six programme characteristics that can be considered noteworthy practices:

- **Providing good quality, comprehensive services for the prenatal to the three-year old age group** is uncommon. The fact that Healthy Start addresses health, nutrition, and early stimulation; starts prenatally; and also focuses on the young child and her family is particularly noteworthy.
- Healthy Start stands apart for its **attention to the most vulnerable marginalised populations**: tribal groups, religious minorities, pregnant teenagers, the rurally isolated, and urban slum dwellers. These groups are particularly difficult to reach and yet typically have the most to gain from quality support services such as Healthy Start.
- Partner families benefit from remarkably **strong, trusting, and empathetic relationships with Family Support Workers (FSWs)** who respect the families and their choices and see themselves as guides and support, not teachers or traditional service providers. This distinction is critical as the quality of the relationship is closely related to the impact of the programme.
- Healthy Start incorporates developmental assessment for the **formal monitoring of child development** and can tailor programming to each individual partner family. In the assessment tool, FSWs have both a formal measure which can identify any developmental concerns and the resources to refer families to specialist services and from which they can make decisions about planning and curriculum.
- The **adaptation of the programme to the local context**, which takes place at site-level, is noteworthy because it increases the quality and effectiveness of programming by ensuring it is aligned with the partner families' daily reality and more closely meets their needs.
- Grounding Healthy Start in **strong partnerships** enhances the programme's offerings, leverages resources more effectively, and lays an important basis for an operationally independent programme in the mid- to long-term future.

Introduction

The Philippines has a long history of investing in early childhood development (ECD) programmes and services, having first begun programming for ECD in the 1960's and having built a number of strong policy frameworks over the following decades. The most recent legislation, the Early Childhood Care and Development Act (Republic Act 8980), which was passed in 2000, formally recognises the importance of comprehensive, integrated early childhood development services for children from birth through the age of six. The act establishes a framework for the provision of early childhood development services in health, nutrition, education, and social protection through centre-based and home-based delivery mechanisms. Due in large part to this advance in the policy arena, the country has recently benefited from increased attention to ECD and witnessed an expansion of ECD services.

However, despite the government's notable achievements in laying a strong foundation for ECD policies and beginning the implementation of these policies, there are still many young Filipino children who would benefit markedly from ECD programming but do not yet have access to it. The World Health Organisation reports that 34% of children under the age of five are stunted, 32 in every 1000 children die before they reach the age of five, and 23% of Filipinos live on less than a dollar a day (Global Health Observatory, n.d.). There is no global measure of child development to which one can refer for a snapshot of children's cognitive and socio-emotional development, but it is clear that both early stimulation is critical

The Healthy Start babies

for children's learning and development and that a significant number of Filipino children do not receive sufficient and appropriate stimulation during this sensitive period of development (Consuelo Foundation, 2010).

Non-government organisations (NGOs) and community-based organisations (CBOs) play an important role in increasing access to services and increasing the quality of ECD programmes in the Philippines. One such organisation, the Consuelo Foundation, has made great strides in both these aspects with its home-visiting programme, Healthy Start. Run by the foundation and implemented by partner organisations throughout the archipelago, Healthy Start works with highly vulnerable children and their families to lay a strong developmental foundation in the first three years of life. For these reasons, it is considered a high-quality and relatively successful programme by many in the Filipino ECD community.

Background

The Consuelo Foundation was established in 1988 by Consuelo Zobel Alger "to improve the quality of life of disadvantaged children, women and families in the Philippines and Hawaii" (Consuelo, n.d.). A Filipina living at the time in Hawaii, Consuelo was impressed by the nascent work of an organisation called Child and Family Services, operating in both Hawaii and the Philippines, and

sought to support its work through the establishment of a foundation bearing her name. Since its inception, the Foundation has been an operational foundation, directly managing programmes or collaborating with implementing partners to do so. With offices in both the Philippines and Hawaii, today the Consuelo Foundation's Filipino operations have a programme budget of US $2 million (FY2010) and work with more than 60 active implementing partners to prevent the abuse, neglect, and exploitation of children, women, and their families.

Based largely on the Hawaiian programme of the same name designed to prevent abuse and neglect, the Consuelo Foundation's Healthy Start programme was established in the Philippines in 1995. The programme was envisioned as a response to the great number of Filipino children living in conditions that threatened their optimal development and learning, including severe poverty, malnutrition, domestic violence, parental substance abuse, and social isolation. At the time of Healthy Start's inception, there were limited programmes and services, government or otherwise, targeting vulnerable mothers and children, and this was particularly true for the prenatal through three-year old age range. A limited number of programmes covered maternal and child health, but they did not extend beyond health and, at times, nutrition. Thus, Healthy Start represented a departure from

the sector-based programming common at the time.

The Healthy Start programme in the Philippines follows a similar model to Healthy Start in Hawaii, consisting of a screening process to identify environmental risks and a subsequent home-visiting programme for the most at-risk infants and their families. The programme currently operates at fourteen sites throughout the country . Five of the sites are operated by the Consuelo Foundation and its implementing partners, two are operated by local government units, and six are operated by Save the Children and Plan International. This case study predominantly documents the five programmes directly supported by the Consuelo Foundation and its implementing partners since the additional Healthy Start programmes are each financially independent and as such do not fall under the direct auspices of the Consuelo Foundation.

The five directly-affiliated Healthy Start programme sites are each managed by one of the Consuelo Foundation's implementing partners:

- Community and Family Services International (CFSI)
- Child and Family Services Philippines Incorporated (CFSPI)
- Notre Dame Business Resource Center (NDBRC)
- Tribal Leaders Development Foundation Incorporated (TLDFI)
- Families and Children for Empowerment and Development (FCED).

The programme sites are located in four provinces and the National Capital Region, five municipalities, and 42 *barangays* (neighbourhoods).

They span the northern cordillera and lowland areas in and around Baguio city, metro Manila, and the rural areas of Maguindanao and Saranggani in the south. The children and families served include the urban poor and slum dwellers, rural communities, isolated tribal groups, and a religious minority group in a conflict area. Healthy Start currently serves 444 families with either a female member who is currently pregnant or with a child from zero to three years of age. The families enrolled in the programme are characterised by poverty,

teenage pregnancy and motherhood, domestic abuse (physical and/or sexual), social isolation, substance abuse, and low use of social services. (It is worth noting that the population served does not have universally low literacy levels; in fact, at some programme sites, mothers' educational attainment reaches the high-school level. This is particularly the case in the urban areas and for teenage mothers who have often been enrolled in high school up to and even during their pregnancy, especially in Baguio.)

Programme Description

Healthy Start is a home-visiting programme that enrols pregnant women and new mothers and provides support for healthy family and child development during the first three years of the child's life. The programme focuses on increasing positive parenting behaviours and decreasing environmental risks through: (1) increased parental knowledge of child development, (2) the provision of games and activities to support healthy development and learning, (3) strengthened relationships among family members, and (4) increased access to social, medical, and employment services for the target family.

Families, called partner families in Healthy Start, are enrolled in batches so that all the enrolled children in a given batch are approximately the same age (generally within a three-month age bracket). During pregnancy and in the first two years of the child's life, Family Support Workers (FSWs) conduct home visits two or three times per month; in the third year of the child's life, the visit frequency is reduced to one or two times per month. There is, however, some variation in the number of home visits which reflects the programmatic approach of Healthy Start: matching the programme services with each family's individual needs. In practice, home visits may occur as frequently as once a week if a Partner Family's situation requires it. Home visits are complemented by regular group sessions which may occur as frequently as weekly or as infrequently as once a quarter.

Programme Implementation

Implementation of the Healthy Start programme varies across the five


A Family Support Worker talks to the parent during a home visit.

implementing partners, but there are some structural elements that cut across the entire programme, particularly with regards to staffing and training, curriculum, and developmental screening.

Each Consuelo Foundation implementing partner designates a Healthy Start Program Manager, Healthy Start Supervisor(s), and the necessary number of FSWs to oversee the implementation of the programme. There is generally one Supervisor for every eight FSWs, and each FSW carries a caseload of up to 15 partner families. FSWs conduct both the home visits and group sessions and liaise with other programme staff, local governments, local health workers, and other community actors to advocate for the partner families and obtain the provision of any additional necessary services.

FSWs are generally female and between 35 and 60 years old, have completed secondary school, have their own children, and come from the communities they serve. In some cases they themselves were partner mothers
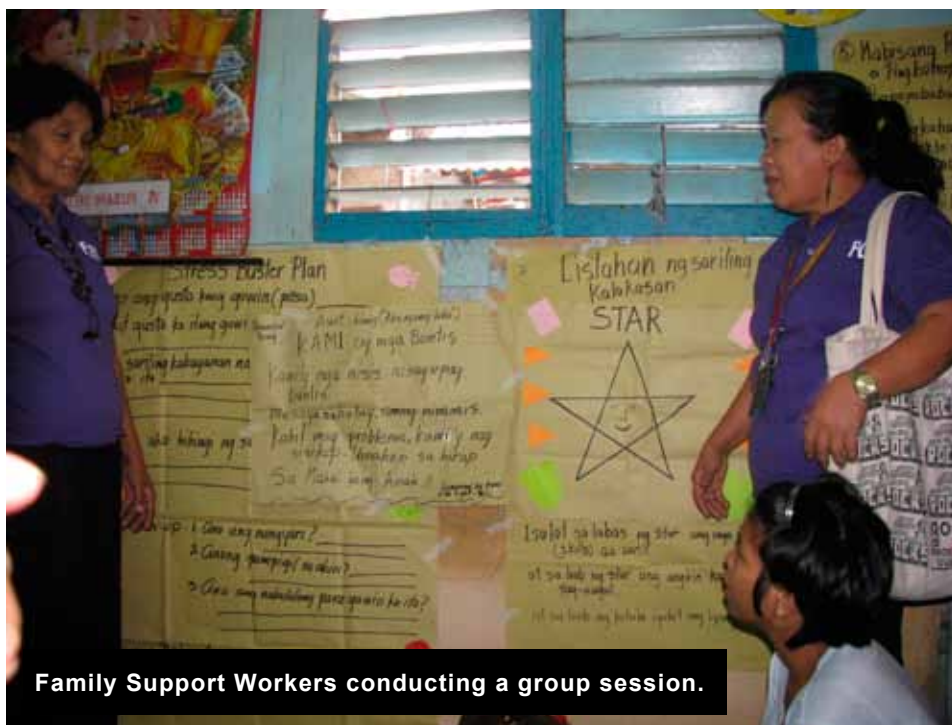
Family Support Workers conducting a group session.

in previous batches of the Healthy Start programme. A small number of FSWs also are employed as Barangay Health Workers (a local government position); this means that they have additional training in health, increased knowledge of local services and institutions, but also a significantly larger caseload. FSWs are hired directly by the implementing partner, and while they are paid – they receive an honorarium for their work (less than the minimum wage) – they are technically referred to as volunteers by the Foundation and the implementing partners. The honorarium varies across the five partners, ranging anywhere from 3,000-6000 pesos (US $66 - $132) per month. Healthy Start Supervisors share many of the same characteristics as the FSWs and, in some cases, were a FSW prior to becoming a Supervisor.

Both the Supervisors and FSWs receive similar training comprised of "wrap-around" and "core" training, both of which are completed prior to formal work with the programme and delivered by trainers certified in the Healthy Start model by Great Kids, Inc. in the United States. Each of the training programmes are ten days in duration and are structured such that participants spend four days in classroom training, followed by a week of practice in the field, followed by another four days in the classroom, another week in the field, and a concluding two days in the classroom. Wrap-around training consists of building a foundation of knowledge related to child and family development while also touching on topics related to the Supervisors' and FSWs' personal development. Units include prenatal development, child health and nutrition, family values, culture, the Filipino context, child abuse, family violence, substance abuse, first aid, stress management, and professional boundaries and ethics. Core training succeeds wrap-around training and covers two curricula focusing on children and families' needs respectively, the developmental screening tool, planning and documentation, and the Individualised Family Service Plan (each of which are detailed below). In addition to wrap-around and core training, Supervisors receive supplementary training which focuses on coaching.

One of the core foundations of the Healthy Start model is its use of a scripted core curriculum for both the home visits and the group sessions. Healthy Start closely follows the content and activities prescribed in the two curricular models, Growing Great Kids (GGK) and Growing Great Families (GGF), developed by Great Kids, Inc. and used in Healthy Start's namesake programme in Hawaii. Early in the programme's development, the Consuelo Foundation contracted a Filipino consultant to undertake localisation of the curricula which was subsequently translated into Filipino. It is this version that is used by the Healthy Start partner organisations with the families they serve. GGK includes 72 modules separated into four age-based units and covering topics directly related to healthy child development, and GGF contains 16 modules that focus on strengthening families.

The development of the **partner babies** is monitored using the Ages and Stages Questionnaire (ASQ). This developmental screening tool is administered by the FSWs when the babies are four months of age and then again every two months until the child is two years old, after which it is administered quarterly. The tool has been translated into Filipino but has not been validated in the Philippines. The results of each screening are analysed by the FSWs and form the basis of decisions regarding referrals for additional services, particularly medical and/ or remedial developmental services. The information is also used by the FSWs to help the partner families better understand their children's development and, in theory, is used to individualise the content of the home visits to the developmental needs of each partner infant.

Additionally, the Healthy Start model places a strong emphasis on the use of Individual Family Service Plans (IFSPs). On a yearly basis, FSWs work with the **partner families** to elicit important objectives related to the partner infant's or family's development that they would like to achieve in the coming year. Examples include purchasing a large washing bucket in order to take in the neighbours' laundry and earn additional income for the family, fixing a leaking roof, and creating storage for the baby's toys. Working from the identified objectives, FSWs and partner families elaborate a plan for how the family will achieve their objectives, including the concrete steps necessary to do so. When formalised, the plan becomes the IFSP. FSWs and partner families refer to it throughout the year during the home visits, continually assessing their progress towards the desired outcomes.

In addition to engaging the partner family around child and family development, FSWs also use the home visits to address any

A Family Support Worker uses a developmental screening tool with a four month old baby in an urban poor neighborhood in Baguio, Philippines, while the baby's great-grandfather and brother look on.

additional needs that the family may have related to health, employment, and general welfare. FSWs provide information to pregnant partner mothers about the available facilities and resources for the delivery of her baby, immunisations, well-child care, and sick visits. The programme partners with local doctors and health centres to be able to provide referrals for specialists and, in some cases, arrange for free paediatric care and access to a medical assistance fund to cover the costs of treatment and prescriptions. Referrals to employment and livelihood resources, as well as to actual jobs within the community, are also made available for partner families, as are some small-scale feeding programmes. Depending on the operational methods of the partner organisation, in some cases these referrals and services may be provided in conjunction with local governments or another NGO such as the local Rotary Club.

The Healthy Start programme is funded by the Consuelo Foundation and its implementing partners, and the Foundation's own calculations indicate that the programme costs 50,000 pesos (US $1087) per family over the course of the programme's four-year duration, the equivalent of approximately US $250 per year. Analysis of the programme's budget indicates that the great majority of these costs stems from training and staff support.

Impact

The most recent impact evaluation of the Healthy Start programme was conducted in 2003, and for the annual evaluation of accomplishments, data is collected from each of the five implementing partners' sites. The 2003 evaluation found that the Healthy Start programme at the two original sites (Bacolod and Manila) met its objectives in the following four categories: capable family support workers, the number of infants who passed the ASQ, zero incidence of abuse and neglect, and low incidence of malnutrition. Outcome objectives were not met in the following three categories: zero incidence of preventable illness, zero incidence of child mortality, and families able to fulfil their IFSPs (Consuelo Foundation, 2010).

Programme materials also present generalised evaluation data from 2002 which reports that compared to available community data, effects were found in the following areas (Consuelo Foundation, 2010):

- improved general health and welfare of children (e.g.. completion or near completion of the immunisation schedule, decreased malnutrition and child mortality)
- improved child care practices (e.g., increased breastfeeding, increased use of regular daily routines with babies, increased time dedicated to stimulation and play)
- increased use of non-violent disciplinary methods

"The programme was really important for us."

Karly and his family live in an urban poor squatter community in Manila. The community, full of temporary and semi-permanent temporary residences, is where Karly grew up. Family Support Workers (FSW) recruited Karly and his family for the Healthy Start programme when he was seven months old. At the time, Karly was malnourished, had two fathers, and was the youngest of eight children, and his parents were renters in the squatter community – each of which were factors that contributed to the FSWs' conviction that Karly's was at-risk for non-optimal development and would benefit from the Healthy Start programme.

When they enrolled, Karly's mother had her hands full with her other seven children and, as she says, she "didn't think much about healthy foods or how to really care for the children". In the Healthy Start programme, she developed a very strong relationship with the Family Support Worker and learned things about which she had little idea when raising her other seven children: "I learned how to care for Karly when he was sick [malnourished], and I learned about feeding and started going to the supermarket for nutritious food. I bought picture books and colouring books for the first time, and I started to read to Karly when he was young. The other thing, I wasn't as overprotective as I was with the other children. Before when they were young, my children didn't go out and didn't meet other children, but the FSW taught me that it was important for Karly to go outside and play with other children." Karly's mother recounts that a few months after starting Healthy Start, she noticed he was more active than her other children were at that age and that he learned to speak much earlier.

Today, Karly is twelve years old. He is an honours student and salutatorian in his class, is the school representative in interschool mathematics competitions, and is devoted to his studies. While admitting that some of the extra attention paid him may have stemmed from the fact that he was the only boy among many girls, Karly's mother believes that Healthy Start changed the way she and her husband parented and made a real difference for Karly's development: "He's smarter than his other siblings and gets more honours. We're very proud of him… the programme was really important for us". With a small smile that belies the large influence she seems to have had on this family's life, the FSW (who has stayed in touch with the family over the years) says, "Karly is healthy and is a good child; that's what matters".

- improved safety in the home and community
- increased utilisation of health care services
- increased sharing of child-rearing responsibilities between parents
- improved conflict management and problem-solving
- stronger parental support systems for infants (e.g., decreased maternal depression)
- deeper parental understanding of brain development
- improved parental understanding of the importance of the first three years of life
- increased community support for positive child development

Anecdotal evidence collected from programme staff, local governments, and partner families echoes the findings of the impact evaluation. FSWs from FCED and CFSPI report that families enrolled in Healthy Start are more functional than at the time of enrolment and also in comparison to other families in the surrounding area, demonstrating less infidelity, less family violence, and stronger marriages.

"We've seen changes in families, not just the children" said one FSW. "In so many cases we see more functional families and more responsible parents in terms of their children and their family affairs". Also, FSWs indicate that the programme had generated "new knowledge and changing belief structures", noting that they had "seen important changes in the way [the partner families] discipline the partner babies, and they breastfeed much more than other families in the community". FSWs also note that Healthy Start parents are increasingly attentive and responsive to their young children and engaged them in stimulation and play activities more frequently, no longer "treating the children as they were treated, but breaking the parenting cycle in at-risk families" and engaging them in more positive interactions. One partner mother in Manila happily shared the ways she had been incorporating the information from home visits into her daily routine with her son, explaining to the FSW: "I talk more with Jonathan [her son], and when I dress him, I tell him about the things he's wearing, tell him colours and other things. We play more, too".

Partner families who were enrolled in the pilot programme in the early years of the current decade note that their children, now school-age, enjoy school more and excel relative to their peers. Similarly they perceive the Healthy Start children as more confident and more intelligent than their older siblings who did not participate in Healthy Start.

Noteworthy Practices

Beyond the data from the evaluations and the anecdotal impacts, the project is distinct because of particularly noteworthy elements of its approach, structure, and implementation. This report outlines six elements that merit particular mention, each of which is detailed below using case studies where appropriate. These include:

- the age-group served – prenatal to three years of age
- highly vulnerable, marginalised, and difficult-to-reach populations
- the programme approach – "empathy not sympathy"
- the use of developmental assessment
- localisation at the site level
- strong partnerships

Healthy Start parents are increasingly more attentive and responsive to their young children.

Teen mothers share a lesson on mother-infant interaction, led by Family Support Workers as part of the Healthy Start program.

PHILIPPINES

Age-group served – prenatal to three years of age

Research in the biological, behavioural, and social sciences has confirmed the importance of early experience on later life outcomes and, in particular, that experiences before birth and during the first few years of life lay the foundation for subsequent development, learning, health, and welfare (Shonkoff & Phillips, 2000). In the Philippines, attention to early childhood development has historically been largely focused on early health and nutrition, particularly for the zero through three-year old age group. Further, very little attention has been paid to the prenatal period. Government early childhood education programmes are predominantly targeted at children in the year or two before school entry, and many NGO-run programmes have traditionally served a similar age group.

While the national government does operate some programmes that address the birth to three-year old age group (including the government's long-standing Parental Effectiveness Service's home-visiting programme), they have limited coverage and are unable to reach all vulnerable children and families. In addition, programmes for this age group are also notably more costly than programmes for preschool age children (and significantly more costly than programmes for school-age children), a fact which discourages additional investment. In this context, high quality programmes that address the needs of parents and their children during this period are critically important for the optimal development of vulnerable Filipino children, families, and communities and for the nation at large.

The Healthy Start programme enrols pregnant mothers early in their pregnancy (when possible, before the birth of the baby), in order to begin developing a strong and trusting relationship between the FSW and the partner mother, and generally intervenes as early as possible to have the greatest effect on the partner child's development. The relationship continues after the birth of the child as the partner mother and FSW work together to create a positive developmental environment for the child and prioritise her healthy development. Access to this relationship - and the support, knowledge, and resources it provides - is highly

An infant is shown an animal cut-out.

important for vulnerable families and their children, most particularly at this early stage of development. Thus the developmental imperative, the lack of coverage of existing services, and the high cost of programmes for this age group render Healthy Start's focus on the period prenatal to three years of age particularly noteworthy.

Highly vulnerable, marginalised, and difficult-to-reach populations

In its founding principle - seeking to serve populations at risk of abuse, neglect, and exploitation - the Consuelo Foundation has made a clear commitment to working with the most vulnerable Filipino children and their families. As a result, the Healthy Start programme is notably inclusive, seeking out children and families whose development is jeopardised by multiple risk factors. Some of the largest and most well-established early childhood programmes in the world rely solely on measures of poverty to determine their target population, but the Healthy Start programme seeks sites and partner families on the basis of risk factors beyond simply poverty. They use a family stress checklist to determine eligibility for the programme, reviewing a large number of factors ranging from the number of previous pregnancies and live births, to the number of family members living in the household, access to services, exposure to substance abuse, and exposure to physical abuse. Thus,

the populations served: (1) are vulnerable across multiple domains (due to the evidence that risk has a cumulative effect), (2) may have historically been marginalised, (3) are often difficult to reach, and (4) do not have access to other programmes and services that promote optimal early childhood and family development.

As an example, Community and Family Services International (CFSI) operates Healthy Start in the southern province of Maguindanao, home to the Filipino Muslim minority. Prone to natural disaster and recently beset by violent conflict, the province consists largely of a rural and isolated population. Poverty is certainly one of the challenges that the partner families face, but they grapple also with their religious minority status, rurality, and isolation that result in a lack of services. Some cultural beliefs and practices also do not promote healthy child development. Each of these factors (and others specific to each family) contributes to increasing these families' vulnerability to non-optimal outcomes.

Similarly, the partner families enrolled in the Tribal Leaders Development Foundation, Inc.'s (TLDFI) Healthy Start programme are also vulnerable due to factors that extend beyond poverty. TLDFI serves the T'boli tribe in rural areas predominantly characterised by mining and farming. The tribe has only recently been exposed to modern civilisation

and does not have recourse to many services to support this transition and/or assist children, families, and the community more generally. Some of the T'boli traditional child-rearing practices jeopardise young children's healthy development with child-rearing perceived as the only the responsibility of the mother and illness and death attributed to spirits. The Healthy Start programme thus recognises the multiple facets of marginalisation and vulnerability present in the partner families' lives and, in response, seeks to reduce their impact on the partner children's development.

The Child and Family Services Philippines Incorporated (CFSPI) programme in the northern city of Baguio provides a third example of the extent to which the Healthy Start programme reaches highly vulnerable, marginalised, and difficult-to-reach populations. Baguio is known as a student city because of its many universities, literacy rates are higher than in the rest of the country, and poverty is also not as deep-rooted as elsewhere. However, in recent years the city has seen an increase in teenage pregnancies, particularly among the poorest of Baguio's residents. An example of one of the many difficulties faced by these young women as a result of pregnancy is the sudden social isolation that arises from having to drop out of school while pregnant. The paradox of their situation is that this

happens during adolescence when peer relationships and networks are critical, most particularly during times of distress. It is alarming that some of the mothers have themselves been victims of abuse, and in at least one documented case, the child was the result of sexual abuse by a relative. Additionally, some of the pregnant teens already have young children.

In response to the increase in teenage pregnancies and in order to support these highly vulnerable young women, CFSPI works with the city social welfare office to review a list of the depressed areas in Baguio and cross-check it with lists of reported child abuse and teenage pregnancy. The resulting compilation of names allows CFSPI to conduct outreach with these particularly vulnerable families and attempt to enrol them in the programme during the pregnancy. A number of the infants enrolled in the current CFSPI batch have severe health problems including hydrocephalus, pneumonia, cerebral palsy, and congenital heart disease. Of interest (and perhaps little surprise), these infants were not selected because of their health conditions; it was their mothers who were enrolled before the birth of the baby based on the risk factors in their own lives. In the great majority of the partner families in the CFSPI Baguio Healthy Start programme (and, in fact, in each of the Healthy Start programmes), both

the mother and baby are highly vulnerable, marginalised, and not reached by traditional services. There is little doubt that they benefit from programmes such as Healthy Start which take into account their unique situation.

Approach – "empathy not sympathy"

The Healthy Start programme emphasises relationships between the FSW and the partner families, stressing the importance of an intimate, trusting friendship between them. While employing an approach that relies heavily on the relationship of the service provider to the client is not innovative in and of itself (particularly in the context of home-visiting programmes), the depth and nature of the relationship in the Healthy Start model make it a noteworthy characteristic of the programme.

The FSWs from CFSPI articulate well the basic approach and attitude toward partner families. When asked to explain what made the Healthy Start programme different from other community services that they were familiar with, one FSW stated, "we do it with empathy, they do it with sympathy". The distinction between the two approaches is what makes Healthy Start so noteworthy. The FSW drew a comparison with the local Health Care Workers who run a health-specific home-visiting programme in the areas in which CFSPI works. She said, "the health centre workers are didactic; they give orders and make diagnoses without knowing [for example] if the families can afford the medications they are prescribing". Another FSW mentioned that the health centre workers don't tailor their suggestions; "they give sermons and are scolding" the partner families. One of the FSWs who has the unique perspective of also being a local health centre worker described the comparison this way: "[As health centre workers] we focus directly on the welfare of the children themselves, [using] more scripted, direct lessons, with less dialogue, but its different as a FSW; we take a different approach".

There are a number of possible explanations for this distinction between programmes, but two stand out. First, the FSWs are heavily emotionally invested in their role and find Healthy Start rewarding on a personal level; for most of them, it's not just a job. One

A Partner Mother is massaging her baby.

FSW remarked that, "the programme has developed my personality and my lifestyle. I'm a better person because of it, and I have an increased desire to help the poor". Second, the formalised training and curriculum appear to provide the FSWs with concrete, practical knowledge and approaches that increase the quality of the interactions between the FSW and the partner family. In turn, the FSW is able to provide information that is useful to the partner families and can help them understand how to meaningfully apply the lessons to their lives.

There is other evidence which indicates that the Healthy Start FSWs build a different kind of relationship with the partner families. Perhaps not surprisingly, they interact with them first and foremost as partners. The FSWs dedicate a large amount of time during enrolment and intake to getting to know the family, and they continue to focus on the relationship throughout the 3-4 years of the programme, paying specific attention to each family's own resources and taking that into account when discussing content or helping the family solve problems. The FSWs take a dialogic approach throughout each visit (and the relationship more generally), observing and responding, and make the distinction of working *with* families, not *for* them.

Even though the CFSPI FSWs do not live in the same communities as their partner families (due to the geographical distance between the families served), the relationship between the FSW and the partner family extends beyond the formal boundaries of the Healthy Start programme. FSWs have received text messages in the middle of the night from the partner families, and the FSWs visit the families on the basis of need, not necessarily adhering to the home visit schedule. This appears to be an indication of the fact that the families feel comfortable and supported by the relationship. This sentiment is also echoed by the FCED FSWs in Manila in statements such as: "it's my responsibility to take care of the family and guide them through problems" and "as a FSW you are impacting their life and your life. You're a friend who understands their reality and that they trust". The great majority of the home visits reflects this closeness, mutual support, and trust underlying the FSW-partner family relationships, a characteristic that very clearly increases the quality of the

Healthy Start programme.

The Use of Developmental Assessment

As mentioned previously in the programme description, the Ages and Stages Questionnaire is a central component of the Healthy Start model. (The tool is published by Brookes Publishing Company in the United States, and while it has been translated into a number of languages other than English, it has not been validated in studies in developing countries. For more information, see: http://www.agesandstages.com/)

The programme uses a Filipino translation of the English-language tool which is used to monitor the partner child's development over time. The assessment also affords the FSWs an accurate and complete snapshot of the child's development at a given point so that the FSW can meet each child's individual needs. The use of developmental assessment is rare in global ECD programmes. yet it has been a core component of the Healthy Start programme since its inception. It permits three important contributions to the quality of the intervention:

• as a screening tool, it allows service providers to regularly and consistently monitor children's growth and development, identify any concerns, and make referrals to additional services. FSWs routinely use this information for this purpose
• with appropriate training, FSW's can link the assessment with the curriculum, assisting with the planning process and allowing them to individualise the content and activities they share with the babies. Program Managers and Healthy Start Supervisors at CFSPI note that in some cases the more experienced FSWs are able to incorporate information from a young child's latest instance of developmental assessment to individualise the home visits.
• the FSWs use the information to assist in planning which content to deliver, when to

deliver it, and also how to deliver this content most appropriately for the child's developmental stage. This practice is, however, nascent among the FSWs (particularly the less experienced), but with training about how to link assessment and curriculum, it can become an increasingly strong element of the programme. Nevertheless, successfully integrating developmental assessment into programming and using the information it provides to tailor an approach to individual needs is fraught with complexity, and Healthy Start's initial success in this area is noteworthy.

Adaptation to the Local Context

Despite the consistency across sites in the core components of the programme - training, curriculum, monitoring of development, and the use of Individual Family Service Plans - contextual differences impact the sites' operations in notably different ways. Implementing partners have skilfully adapted the programme to the local context and the needs of the particular families they serve, ensuring that Healthy Start does not become a 'one size fits all' model.

Comparing and contrasting the urban Healthy Start programme run by Families and

A Family Support Worker showing the toys she created for the home visits.

Led by Family Support Workers from the Healthy Start program in Manila, teen mothers engage their infants with home-made toys.

Children for Empowerment and Development (FCED) with the rural programme in Maguindanao run by Community and Family Services International (CFSI) provides a useful example of some of the differences in implementation. The FCED programme operates among the urban slums in Manila. FSWs have relatively high literacy rates in both Pilipino and English and can link partner families to an existing network of additional services located within close proximity because of the urban setting. However, at the CFSI site in Maguindanao, the FSWs have low literacy (in both Filipino and English), and this has an impact on their ability to complete documentation, IFSPs, and the developmental screening tool. There are very few additional community services available, particularly in the realm of health, due to rural isolation, the prevalence of natural disasters, and also the ongoing conflict in the region. Further, CFSI's programme works with the Muslim minority (the Maguindanaoan tribe), which, according to programme leadership at CFSI, presents certain religious and cultural challenges (for example, the belief that immunisation is a method of Christianisation).

As a result, CFSI has had to adapt its Healthy Start programme to account for these contextual differences and has been relatively successful in doing so. They provide functional literacy training for FSWs that entails three months of training and support in reading, writing, and numeracy so that FSWs are better able to fulfil the planning, monitoring, and documenting requirements of the Healthy Start programme. CFSI has also built a strong, collaborative relationship with the closest health unit so that health personnel now make regular visits to the community and partner families (and in fact, all families in the community) so that they no longer have to travel the bad road and difficult distances to obtain basic health care. Additionally, to overcome the cultural challenges and the difficulty of establishing trusting relationships in conflict areas, CFSI requires that each FSW must come from the village that she serves. To further mitigate the negative effects of the conflict on the programme and its operations, in periods of disaster and displacement the FSWs participate in rapid response, conduct situational assessments, and then continue to serve families regardless of whether they have been displaced to evacuation camps or elsewhere. Further, when working with partner families in the camps, they extend the activities and services to all interested displaced families, not simply those who were enrolled in the programme prior to the emergency incident. Thus, it is evident that while CFSI uses the training, curricula, monitoring, and planning processes common to the Consuelo Foundation's Healthy Start model, they have made adaptations to address the needs of the distinct constituency they serve.

It should be noted that the impact of the implementing partners' adaptations on child and family outcomes has not been evaluated. But it does seem clear that the Healthy Start model is grounded in certain core elements that are common to all implementation sites but is also potentially enhanced by the flexibility that implementing partners have in certain aspects of programme operations and service delivery.

Strong Partnerships

In the face of complex social problems and when resources are limited, partnerships are very important to a programme's operations and sustainability. Partnerships have the potential to allow programmes to reach a greater number of people more effectively, more efficiently, and over a longer time horizon. The Consuelo Foundation and the Healthy Start implementing partners know this well; they are aware of their own limitations and have woven partnerships through almost every aspect of the Healthy Start programme.

The Consuelo Foundation's use of partner organisations lays a strong foundation for partnerships at each level of the Healthy Start programme. Consuelo provides a leadership, strategic, and monitoring role while organisations with established relationships in the local community and a track record of effective service provision work directly with partner families. First, by being open to partnerships outside its traditional implementing partner approach, the Consuelo Foundation has allowed organisations such as Plan International and Save the Children to adopt the Healthy Start model to complement their existing programmes for three- to five-year old children. The Consuelo Foundation provides training for the FSWs and other resources that ensure that the programme maintains its core components and meets certain quality standards, but Save the Children and Plan operate their Healthy Start programmes independently (including the hiring of FSWs). As a result of these partnerships, the model will reach an additional 590 children, more than doubling the reach of the Consuelo

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Foundation's Healthy Start programme. Second, the Consuelo Foundation has built strong partnerships with implementing partner organisations, allowing each contributor to leverage its strengths and resulting in mutual benefit. This operational model simultaneously allows Consuelo to build capacity in the implementing partners which, in some cases, have gone on to deliver Healthy Start independently.

At the local level, the Consuelo Foundation insists on similarly strong partnership models. The Foundation requires that all partner organisations collaborate with local governments and service organisations about Healthy Start, conducting significant outreach before the programme is introduced. Local government units, including the Barangay council, Health Center Workers, and the Local Council for the Protection of Children, are asked to participate in outreach to the community, the selection of FSWs, and the identification of partner families. In the case of the last, collaboration with local organisations allows the implementing partner to reach some of the most marginalised families in the community since the organisations have an intimate knowledge of the community and its members.

During the implementation of the programme, the Program Manager, the Healthy Start Supervisor, and the FSWs continue to build and develop partnerships with complementary organisations, jointly hosting group sessions and partnering to provide additional services. As an example, in Baguio CFSPI has partnered with a paediatrician in private practice who accepts a reduced fee from partner families for consultations which CFSPI then subsidises in full. For previous batches of Healthy Start, this partnership with the paediatrician also resulted in lectures/training on developmental milestones for the FSWs and clinical consultations at the CFSPI facility for partner families. Throughout the implementation process, the partner liaises with decision-makers in the local government, essentially marketing the programme by reporting on its successes with the intent to secure public funds for subsequent batches of Healthy Start.

While such strong partnerships do present some challenges (for example, when there have been changes in local government), the benefits conferred are valuable. Healthy Start programmes have strong operational partnerships and strong support from local organisations, are able to provide an increased breadth of services to the partner families, and are able to serve a greater number of families.

Concluding Thoughts

In the 15 years since the Healthy Start model was first introduced to the Philippines, the Consuelo Foundation and its implementing partners have built and refined a valuable intervention programme to strengthen child and family development. Implementing a programme of this scope is not without its challenges, however, but as a learning organisation, the Consuelo Foundation is the first to point this out and look for ways to address them. Three of the greatest challenges are building capacity in less experienced FSWs, evaluating programme outcomes, and guaranteeing sustainability. Each is described briefly in the following paragraphs.

Capacity-Building in Family Support Workers

FSWs are the core of the Healthy Start programme, and their capacity to deliver tailored, developmentally appropriate, and meaningful experiences to partner families is critical to the programme's success. The more experienced FSWs are adept at this, building strong relationships with the partner families; engaging in fluid, dynamic interactions with the parents and the partner baby; and individualising content based on their own observations of the family and information gathered from the developmental assessment. Some of the less experienced FSW find this more challenging; they have weaker content knowledge and rely heavily on the scripted curriculum guide during home visits, they are less able to engage in meaningful observations of the partner family, and they are less responsive to cues from the mother and child. As a result, they are less able to individualise their home visits and tailor them to the needs of each partner family. With targeted support from the Healthy Start Supervisors to increase the FSWs' content knowledge, improve their observation skills, and build their understanding of how to use observations and assessments to guide their work, the

less experienced FSWs can overcome some of these challenges – and is well worth the financial and human resources such mentoring implies. This could be enhanced even further by Supervisor training in coaching and mentoring, as well as a master FSW programme where more experienced FSWs would model the desired types of behaviours and interactions with partner families.

Programme Evaluation

The Consuelo Foundation conducts annual monitoring and evaluation of the Healthy Start programme. There are some data collection and analysis mechanisms in place, but the programme has never been evaluated using a methodologically rigorous approach.

A toddler getting to know different colors

The Foundation has made a considerable investment in the Healthy Start programme based on its American evidence base, and while there are many indications that the programme has produced similarly positive effects in the Philippines, little research has been conducted that addresses causality or which attempts to understand differential effects across the population served, across sites, or across implementing partners. A full-scale evaluation of the programme's impact would benefit not only the Foundation and the implementing partners but also the larger ECD community in the Philippines and the Asia-Pacific region. Such an evaluation might also promote the programme's sustainability by producing an evidence base that can be used to encourage partial financing of the programme from local governments and/or other actors.

Sustainability

Despite the lack of methodologically rigorous research in support of the Filipino Healthy Start programme, the Consuelo Foundation and its implementing partners have had some success in convincing local governments to take over the Healthy Start programme in two cities. However, the majority of Healthy Start sites do not receive financial support from their local government. The Foundation and its implementing partners' funds are not limitless, and without some kind of additional financial contribution to the programme's operating costs, Healthy Start will not be sustainable in the mid- to long-term. This is particularly true because the programme is somewhat expensive relative to alternate investments in early childhood due to high staff and training costs. Healthy Start trainers must receive initial certification and recertification from Great Kids, Inc. in the United States, and the Consuelo Foundation conducts centralised annual training (both of which incur significant travel-related expenses). If the Consuelo Foundation could reduce the programme's travel costs by exploring alternative (i.e., not United States-based) certification options and establishing a network of trainers who deliver on-site training and technical assistance, it may succeed in improving the cost-effectiveness of the programme and securing outside funding in the mid- to long-term.

Despite these challenges, the Healthy Start programme merits the attention of ECD scholars, policy-makers, and practitioners alike. There is strong anecdotal evidence of positive programme impacts for partner children and their families. Partner families freely express their satisfaction with the programme and note the many ways they believe that it benefits themselves and their children. FSWs, too, are gratified by the relationships they build with the families and value the contribution that they feel they are making to these families' lives and to the community at large. As the Philippines government takes further steps to implement the Early Childhood Care and Development Act, it should look to learn from Healthy Start's experience and consider incorporating its innovative practices into its programmes and services. Doing so would be to learn from and draw on the strengths of local experience and enhance child and family development for the nation as a whole.

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Cambodia: A New Day for Kids

By Jessica Malkin, Research Fellow

Abstract

A New Day for Kids (ANDK) is a comprehensive programme that takes an ecological approach to early childhood and community development, addressing both the root causes of developmental risks in children's home environments and villages and more indirect cultural and institutional influences. Working directly with children, their parents and caregivers, village members and village leaders, commune chiefs, and district governments, ANDK is grounded in strong partnerships and deeply embedded in the communities in which it operates. ANDK employs the "Reflect" approach for caregiver empowerment and child learning, engaging the community in guided discussion around topics including child development and parenting (with a particular emphasis on the period of prenatal through school-entry), health, agriculture, and financial management. Simultaneously, children up to six years of age participate in "Children's Circles", a facilitated, informal preschool experience. The programme currently serves 1,310 men, 2,095 women, and 1,952 children in two of Cambodia's most rural and remote provinces.

ANDK is an indigenous project that grew out of community needs and has become a treasured part of village life in the communities in which it operates. Enthusiasm for the programme runs high, and among participants it seems to have stimulated a thirst for new knowledge that is unparalleled in many other development or social service programmes. Anecdotally, adult behavioural change and advances are said to follow the acquisition of knowledge in these communities, and children's developmental contexts are believed to have improved. There are surely many factors that contribute to the programme's success, but four in particular stand out as noteworthy:

- ANDK targets children during a sensitive period in their development (from conception to six years), when their experiences have a marked impact on their later learning, behaviour, and health.
- ANDK recognises the multiple spheres of influence in young children's lives and seeks to create change in children, their parents, and the community in order to maximise the impact on children's outcomes. Intervening across these contexts, ANDK is strengthening the multiple facets of children's development.
- ANDK is driven by the community it serves, with the involvement of villagers and their leaders at each step in the programme's implementation, from the selection of facilitators to the topics of discussion in Reflect Circles. ANDK is thus well aligned with community interests and tailored to community needs.
- ADRA has built strong partnerships with local governments, broadening its (non-financial) resource base. In doing so, ADRA has strengthened the capacity of its technical staff and widened the scope of knowledge, skills, and referrals from which the facilitators and communities can draw.

Introduction

Cambodia's recent history poses a great challenge to political, economic, and social development. In both urban and rural areas, constant reminders of the extreme hardships faced by the Cambodian people between 1975 and the peace agreement in 1991 are woven throughout the fabric of society. The United Nations Development Programme's Human Development Index currently ranks Cambodia 137 out of 182, Gross National Income per capita was US $610 in 2009, and the national poverty rate is just over 30% (UNDP, n.d.). Life expectancy is low, malnutrition rates are the worst in Asia, and 40% of children in Cambodia are chronically malnourished (World Food Programme, n.d.). Further, the under-five mortality rate is 90 for every 1000, and the infant mortality rate, 85 for every 1000.

Nevertheless, over the past two decades since the peace agreement, Cambodia has made important progress towards creating a more peaceful and stable society with notable prospects for development. The international community continues to play a large role in supporting development and providing funding, technical assistance, and. in many cases, direct service provision across a number of different sectors, and the government has developed and implemented a number of policies that aim to provide a formalised framework for social programming.

Most recently, the national government has paid increasing attention to child, family, and community development and has taken a number of important steps towards building a stronger network of support and services for the Cambodian people. Commendably, early childhood development has been formally recognised by the national government as a key component of the nation's development. Yet while a national early childhood care and development policy has been in place since 2002 and a new policy was enacted early this year, a relatively small percentage of Cambodian

children have access to early childhood programmes, particularly in rural areas. As with other service areas, NGOs such as the Adventist Development and Relief Agency (ADRA) have played an important role in extending and/or supplementing the provision of early childhood development services across health, nutrition, education, and social welfare. ADRA's programme, A New Day for Kids (ANDK), is an example of one such programme which works across sectors to improve the developmental context of young children in isolated, rural areas.

Background

The Adventist Development and Relief Agency (ADRA) is an international non-government organisation that was founded by the Seventh Day Adventist Church in 1956. With global operations in 124 countries, ADRA conducts humanitarian and development work across six areas of focus: "protecting the vulnerable, supporting families, promoting health, providing food and water, establishing livelihoods, and responding to emergencies" (ADRA, n.d.). ADRA Cambodia was established in 1988 and currently operates development projects in four of Cambodia's largest provinces as well as in the capital, Phnom Penh. Most of its projects have been established in rural areas, and their work covers health, education, agriculture, food security, water and sanitation, and disaster relief. A New Day for Kids, ADRA's first early childhood development project, began in 2008 and has since grown to become one of ADRA's core projects.

In response to low literacy rates and a poor understanding of health and nutrition among rural women in Cambodia, in 2004 ADRA began a new development project, Literacy for Women's Health and Empowerment (LWHE). Originally funded by ADRA Norway, LWHE's main focus was empowering women through women's groups. Under the leadership of a facilitator, village women gathered regularly to discuss community development, increase their literacy skills, and improve their knowledge of health, nutrition, and hygiene. While the project was generally considered successful, ADRA technical staff observed that women's active participation in LWHE was hindered by their care-giving duties: young children

accompanied their mothers to the group meetings, and their needs posed a challenge to fluid discussion and learning.

During the same period, ADRA technical staff were also becoming increasingly aware that in order to engender significant change in the communities they served, their work needed to improve the lives of the communities' very youngest members. They observed that adults did not often engage children in conversation or activities, that interactions were often negative, and that parents believed their children's learning

Women's Reflect Circle working on a "graphic" for discussion.

to be the sole responsibility of formal schooling. To respond to these identified needs, ADRA proposed an offshoot project, A New Day for Kids (ANDK). This new project would continue the women's groups but also establish groups for young children. Both would be strongly anchored in child development and would have the objective of building the strongest possible developmental foundation for the youngest members of each participating community.

Through ADRA Cambodia's affiliate, ADRA Australia, ANDK received project funding from AusAID to begin operations in 2008 and subsequently received additional funding from ADRA Norway when LWHE was phased out soon thereafter. The funding

received was for a three-year project cycle, and it is unclear whether the project will receive renewed funding commitments in 2011-2012. During the initial stages of the project's implementation, men from the villages where ANDK was being rolled out also asked to be included in the programme. As a result, men's groups were developed, and the project now serves any interested community member, regardless of age or gender. ANDK has subsequently become a major project in ADRA's portfolio and the central focus of ADRA development work in Pursat Province.

Located in the western half of Cambodia, Pursat Province is predominantly rural with a high rate of poverty; 34% of the population lives below the consumption poverty line, the amount considered necessary to meet basic needs (World Food Programme, n.d.). 2004 data showed that of all Cambodian provinces, Pursat had the highest rates of stunting and wasting for children less than five years of age and very high child mortality. ANDK operates in two of the province's six districts, Phnom Kravanh and Veal Veng, and in provincial surveys, communes in Phnom Kravanh were found to have the highest percentage of stunted and underweight children (World Food Programme, n.d.).

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While there was no information available for Veal Veng at the time of the provincial survey, it is generally thought that the district faces a similarly grave situation with regards to the health and nutrition of its youngest inhabitants. In the face of similar sobering statistics and in the absence of strong provincial and local infrastructure, some parts of Cambodia have been fortunate to benefit from the active involvement of a strong NGO community. However, in Phnom Kravanh and Veal Veng there are very few active NGOs due to the difficulty of accessing the villages in which the majority of the districts' population resides. Those that do operate tend to be smaller, local organisations providing limited services to a very small percentage of the population.

ANDK operates in 35 villages in Phnom Kravanh and nine villages in Veal Veng, each of which is characterised by high levels of poverty and extremely limited access to services, government or otherwise. Additionally, some tribal groups live in ANDK villages and participate in the programme. In an attempt to ensure that the project reaches the most vulnerable and marginalised communities, ANDK is located only in villages that do not already have access to government preschools or non-government early childhood programming. The project serves 1,310 men, 2,095 women, and 1,952 children (see Table 1). All adults in each participating community may take part in ANDK, and children are eligible for the programme from birth and can formally be involved until they reach six years of age and enter formal schooling.

Programme Description

ANDK is a comprehensive programme that takes an ecological approach to early childhood and community development, addressing both the root causes of developmental risks in children's home environments and villages and more indirect cultural and institutional influences. It does so by working directly with children, their parents and caregivers, village members and leaders, commune chiefs, and the Phnom Kravanh and Veal Veng district governments.

The core component of the project, the women's, men's, and children's groups, are called Reflect Circles and take their name from the pedagogical approach upon which the concept was originally based. Grounded in the pedagogy of Paulo Freire, in its traditional form, the Reflect approach uses adult literacy as a conduit to the empowerment of disenfranchised populations. The Reflect approach relies on the creation of a "democratic space" in which participants raise and discuss the issues that are most pressing in their lives. In this way, participants are organised and mobilised in order to better advocate for themselves and their community. (For more information, see http://www.reflect-action.org.)

The ANDK theory of change relies heavily on adult Reflect Circles because it presupposes that changes in parents' behaviour, particularly in their parenting style and approach, will change children's developmental contexts and have the strongest effect on their children's development. The women's and men's Reflect Circles generally convene parents, grandparents, and caregivers, although other

Table 1			
	Phnom Kravanh	Veal Veng	Total
Communes	5	2	7
Villages	35	9	44
Men's Circles	93	34	127
Women's Circles	142	36	178
Children's Circles	144	36	180
Men	907	403	1,310
Women	1,632	463	2,095
Chilldren	1,572	380	1,952

Mothers with young children and life skills reading materials.

community members are also encouraged to participate. The Circles gather at the home of one of the members and are led in discussion by a local facilitator . The topics of discussion focus on child development and parenting, health, agriculture, and financial management. However, discussion of other issues identified by the community plays a very important role in the Reflect Circles in keeping with the Reflect methodology which emphasises empowering participants through discussion to generate community change.

In the ANDK programme, the Reflect Circles rely on a mix of content-focused, pre-planned activities and open-ended discussion. Adult literacy (and, to a lesser extent, numeracy) is incorporated in each Reflect Circle since literacy levels in the villages served are typically very low, and it is a central component of the Reflect methodology. ANDK has plans to incorporate a phased model to the curriculum which would alter the number of times a group meets and the content presented as it progresses through the phases of the model. Under the proposed phases, a Reflect Circle would initially meet multiple times per week and would have a heavy focus on adult literacy and less on community development. In the intermediate phase ("post-literacy"), the group would meet weekly and adjust its focus so that more time is spent on community development. In the final phase, the great majority of time at a monthly meeting would be spent on community development with very little time dedicated to the review of literacy skills. It is anticipated that child health and development information and skills would be consistently present throughout the three phases. While the session content and approach vary across communities, the strongest constant is that all facilitators are encouraged to place a strong emphasis on child development and weave elements of child health, nutrition, and stimulation throughout each of the adult Reflect Circle meetings.

Children's Reflect Circles aim to provide a developmentally enriched environment in which children have an opportunity to begin learning before school-entry. They bring together toddlers to school-age children in one large group for an informal preschool-like experience once a week for approximately two hours. Trained facilitators lead children

Young children engage in counting and sorting using locally-sourced painted shells, bottle caps, and stones in Pursat Province, Cambodia.

in a variety of activities including songs, counting games, picture recognition, and storytelling. Each week, one of the children's mothers attends the children's Reflect Circle to help the facilitator, and a number of older children are also often present. Nevertheless, the broad age-range included in the Circles poses notable challenges for the facilitator, and the needs of infants and toddlers are often inadequately met as facilitators find it easier to engage the preschool-age children. ADRA provides children's Reflect Circle facilitators with paper, pens, markers, paint, and one or two storybooks. Outside, children engage in activities such as collecting flowers and leaves and playing on the playground. Snacks or meals are not a routine part of the children's Reflect Circle although once a month children are provided a meal prepared by the members of the

A Children Reflect Circle shelter and supplies.

women's Reflect Circle.

The core component of ANDK, the Reflect Circles, is complemented by two additional programme elements, both of which are designed to generate increased awareness and behaviour change in areas that directly impact child, family, and community development. First, ANDK includes a water and sanitation component. In the Reflect Circles, adults learn about the importance of clean water and sanitation facilities, and individual families with high Reflect Circle attendance may request the construction of a latrine from ADRA. ADRA can only finance a limited number of facilities in each village, and if the demand exceeds ADRA's capacity, Reflect Circle members must resolve the imbalance as a group. Prior to construction, recipient families must make a commitment to use and maintain the facilities, and they also must make a contribution to the cost of construction which is subsidised up to 70% by ADRA. The contributions raised through this process are held in a fund administered by ANDK to support community development projects such as village road rehabilitation and the purchase of household water filters. Communities can access the funds by submitting a proposal which is generally led by local leaders and facilitated by ANDK staff.

Second, ANDK supports the organisation of campaigns that aim to increase community awareness and knowledge about key topics selected in the Reflect Circles. Multiple villages come together for a campaign and are led in discussion by the commune leader, the village leaders, other NGOs, and ADRA staff. The meeting takes place in a village temple or commune office and is followed by a community procession through the host village, with young children, school-age children, parents, and elders all participating and carrying posters and banners. Topics thus far have included, among others, domestic violence, child trafficking, and malaria and dengue fever.

Programme Implementation

Since the programme expanded upon the pre-existing LWHE project, most ANDK sites were chosen because they were already participating in LWHE. However, as ANDK expanded beyond the original footprint of LWHE, additional villages were selected.

To make this selection, ADRA convenes multiple village leaders from within a commune, provides an explanation of the ANDK project, and then asks the leaders to decide amongst themselves which villages should be selected as ANDK sites. According to ADRA project staff, the district leaders make their selections cooperatively and largely on the basis of perceived need. Once a site is chosen, ADRA requests that the leaders nominate village members for the role of facilitator for each of the women's, men's, and children's Reflect Circles.

Reflect Circles

In theory, each village should have 12 Reflect Circles, four of each for women, men, and children with eight to ten members per adult Circle. With this level of penetration, the project can reach over half (and in many cases three-quarters) of the population in each village. In practice, however, not all villages reach this total.

Men's participation is lower than that of women and children due to their work schedules, and, in addition, it has been difficult to find and retain enough male facilitators due to the transient nature of some common male occupations. As a result, there is typically one or two male Reflect Circles in each village, compared with three to four women's and children's Circles. The

number of children in each Circle varies and depends largely on the number of children of women attending women's Reflect Circles since both occur concurrently. In practice, the Circles typically involve between 12 and 20 children.

Children's Reflect Circles generally meet in a purpose-built children's shelter constructed by village members with limited material support from ADRA (generally the provision of nails and paint). A playground is constructed next to the shelter, using local materials such as wood, rope, tires (for swings), and coconut shells (for climbing). The shelters are spacious enough to fit a large group of seated children (approximately 16-20) but cannot easily accommodate small group activity. The shelter and playground are generally built close to the adult Reflect Circle location, but since ANDK provides resources for only a single children's shelter and playground per village, proximity to these facilities is not always possible in geographically spread out villages. (Not needing specific facilities, adult Reflect Circles have a great deal of freedom as to where they meet and tend to meet close to the members' houses.) In these instances the children's Reflect Circle may meet in a makeshift area (e.g., under a house in close proximity to the adult Reflect Circle) or, alternatively, the children may travel the distance to the shelter and playground.

Young children play an organized game with their teacher outside the Children's Reflect Circle shelter and playground.

Facilitators

Not surprisingly, the facilitators are the central component of the programme, and they play a significant role with regards to the quality of the Reflect Circles. Facilitators generally have a primary school education and in some cases may have completed some years of secondary school. Each Reflect Circle facilitator is the same sex as the Reflect Circle they lead, and in the case of Children's Circles, facilitators are women. Additionally, facilitators must be literate and numerate and must demonstrate their level of skill through a written test. As mentioned above, they are nominated by the village leaders and then elected by popular vote. Notably, over 50% of village members must participate in the facilitator elections for the result to be valid. The facilitator role is considered part-time, typically involving eight hours per week (four two-hour Reflect sessions at a maximum), and they receive a monthly stipend of US $28, which is funded by ADRA. On top of the stipend, they receive additional funds to cover transport costs for meetings and training.

Upon election, the facilitator receives ten days of training provided by a technical team composed of ADRA project staff. The training covers use of the Reflect approach, child development, health, and agriculture. In addition to the initial training, facilitators meet monthly as a group (by district) to receive additional training on new topics, address challenges or concerns, and complete administrative functions (which include monitoring women's, men's, children's, and facilitators' attendance). Facilitators also receive one full day of on-site technical assistance per month; half a day is provided by ADRA technical staff and another half day is provided by the district supervisors or partner representatives (see below).

District Supervisors and the ADRA Project Team

District supervisors monitor the day-to-day aspects of ANDK, working with the facilitators and Reflect Circle members to provide support for Reflect Circle activities, address any questions of issues that the facilitators have, and monitor programme implementation. They receive initial training in child development at the outset of the

Children learning motor and hand eye coordination.

project from an external, independent consultant as part of a train-the trainer-model. The supervisor role is a part-time position, estimated to have a full-time equivalency of 50%.

In turn, the supervisors are supported by the ADRA project team. Based out of ADRA Cambodia's provincial office in Pursat, the team manages the on-the-ground implementation of ANDK. A project manager is supported by an overall Reflect Circle/community mobilisation coordinator who is one of three technical specialists who oversee the Reflect Circles. An additional technical assistant supports the men's Circles, and two staff members support the water and sanitation component. The technical specialists spend the majority of their time in the field visiting the project sites and providing project support in each village. They provide technical assistance for both the supervisors and facilitators, helping to introduce new material, modelling facilitation approaches, and providing an additional one-on-one opportunity to address any issues that the facilitator or the community is facing. When Reflect Circle members wish to add a new programme element to their Circle, such as a micro-lending programme recently requested by a number of villages, the technical specialists act as consultants for the facilitators, and supervisors consult with the technical specialists about how to design and implement the new programme elements and about what kind of support ADRA can provide.

Partnerships

ADRA also works very closely with local and provincial governments to strengthen ANDK project implementation. In addition to keeping government officials abreast of programme developments, government representatives also attend ADRA's train-the-trainer sessions held at the beginning of the project. Representatives from the district offices of the Ministries of Women's Affairs and of Education provide monthly, direct technical assistance to the facilitators to broaden the scope of their training and technical assistance. Their role is very similar to that of the District Supervisors, and ADRA supplements the ministry representatives' government salary (with the same monthly stipend amount as provided to the District Supervisors) to ensure their ongoing participation and commitment. Additionally, the two ministries help ANDK staff access additional resources and work across the different government offices. This is particularly helpful when ADRA staffs are working on integrated initiatives that require multi-sector participation.

Impact

As of May 2010, ANDK was supporting 178 women's Circles, 127 men's Circles, and 180 children's Circles and reaching a total of 5,357 women, men, and children (see Table 1). Baseline data was gathered in 2008 using a cluster sampling method. The data focused specifically on children's

Fathers attending the Men's Reflect Circle with a child looking on.

environments and cognitive development, and end-line surveys will be conducted at the project's conclusion in 2011-2012. Quarterly progress reports measure the project's outputs and also provide case studies on Reflect Circle participants to demonstrate the programme's impact.

Evidence from site visits suggests that the project is having a positive effect on child, family, and community development. Without a formal evaluation, however, it is difficult to assess the impact of the project or to determine the extent to which the anecdotal evidence presented in ADRA's quarterly progress reports is reflective of overall project outcomes. Nevertheless, there are two main areas of impact in ANDK villages: (1) child development and skills and (2) family functioning, particularly with relation to fathers' participation in the household.

When parents and caregivers have been asked whether they had observed any changes in their children since enrolment in the children's Reflect Circle, the response was overwhelmingly positive. One grandmother whose grandchild had been in the children's Reflect Circle for a few months remarked that she liked the Circle because, "the children are learning colours, the names of things, know their numbers and are braver. I think they're more knowledgeable than the other children who were their age [before the Reflect Circles began], and they're better

behaved. When they're not in class, now they draw in a book and try to name shapes by themselves." The adults most often cite **changes in their children's behaviours and skills**, noting that the children can now count, sing songs learned at Reflect Circle, are more likely to play with one another, and are more likely to greet adults in the formal, polite Cambodian manner. This notion of knowledge of greetings is mentioned with particular frequency. Another common comment is that children are now more "brave".

One mother said she was very happy with the programme because her child was less shy, now liked to go to the Reflect Circle, was more active at play and at home, and would be more confident when starting school because he already had friends. Many facilitators and other parents also cite children as better prepared for formal schooling because of their counting skills, greetings, and familiarity with the other children. It should also be noted that children were highly enthusiastic about the children's Reflect Circles, arriving early (sometimes up to an hour in advance) and were highly engaged in the lessons and activities.

Women and men have also been asked to share any examples of changes in their household and family life that had occurred since the inception of the Women's and Men's Reflect Circles. Positive change in family

functioning as a result of **changes in fathers' behaviours** is frequently mentioned. In one village on the rare occasion of a joint meeting of both the Women's and Men's Reflect Circles, when asked about the changes they had observed, the participants encouraged one particular man, Kwong Pao, a 47-year old father of six, to speak of changes in his household. With only the slightest hesitation, Pao recounted his story and how, in his words, his "personal life" had changed: "Before, I didn't care about my family and didn't help with household tasks and was not involved in the care of the children". He also drank to excess regularly and beat his wife and children. A short while after joining the Reflect Circles, Pao recounted, "I decided to spend less time drinking with friends after working in the fields and wanted to spend more time at home and be more involved in household things". His wife said that as a result, "he drinks less and is less violent with the family" and added that they also had increased their savings and had a closer, more intimate relationship. When pressed as to why he had made these changes, Pao said. "the Reflect Circles made me stop and think about life and my family. I realised I made mistakes and wasn't happy". He said that as he had become more involved with his family, he had also become happier. Tuy, his wife, concurred, saying that not only was he happier, but things were better at home for everyone.

Additional behavioural changes range from **change in the domain of health**, such as boiling water in the home, maintaining cleaner houses, and clearing mosquito breeding grounds, to **change which has an impact on a child's cognitive and socio-emotional development**, including the use of more positive language with children, parents' increased patience with children, and less physical punishment.

As mentioned previously, without a formal evaluation it is difficult to assess the full impact of such changes and, indeed, of the programme itself, but noteworthy changes in adult behaviour could lead to meaningful change in children's developmental contexts; the direct impacts on children also said to be promising.

Noteworthy Practices

ANDK's practices are noteworthy for their

impact on child, family, and community development among very impoverished, rural populations. They are particularly meaningful in the context of a population so recently ravaged by conflict, violence, and trauma. It seems as if some of these communities accept the project as an opportunity to start again with a clean slate and have seized the chance to work together to improve their lives. Beyond its direct outcomes, the programme is noteworthy for elements of its approach, structure, and implementation. Four merit particular mention:

- *The age-group served – prenatal through school-entry:* For children, the project emphasises the importance of early development and targets the full age-range in early childhood: prenatal through six years of age.
- *An ecological approach:* The project takes an ecological approach to child development, targeting not only the young child but also her/his parents and the communities in which they live.
- *Community involvement:* The project is both anchored in, and driven by, the community with significant community involvement from before site selection through to the content and direction of Reflect Circles.
- *Local partnerships:* There are strong partnerships with district and local governments including the direct, formalised, and consistent involvement of local government representatives in the project implementation.

Each of the four highlighted elements is detailed below, using case studies where appropriate.

The age-group served

Early experiences can have a lasting effect on children's health, development, and learning with consequences that can extend into their adult life (Shonkoff & Phillips, 2000). Early experiences that are stimulating and relationships that are warm and responsive promote healthy development, while early adversity can hinder it. Research has demonstrated that high quality interventions which target health, nutrition, and stimulation in the first years of a child's life can mitigate the impact of early adversity and build a strong foundation for educational

achievement, health, and economic success (Engle et al., 2007). Acknowledging the vast developmental potential in the first few years of life, ADRA designed ANDK to focus on the optimal development during early childhood, beginning before birth and extending to school-entry at six years of age. In Cambodia, children's learning and development are generally thought to be the responsibility of formal schooling, and parents are not usually aware of the ways in which their action (or inaction) in the early years affects their young child's development. ADRA staff report that many young children, particularly in isolated rural areas, receive very little stimulation from their parents and are exposed to very little spoken language as parents speak to their young children infrequently and push children away from conversations with other adults.

The emphasis on the first years of life has thus been critical in helping parents understand the role they play in their children's development and the actions that promote it. The child development topics covered in the women's and men's Reflect Circles are concerned explicitly with early development, focusing almost exclusively on early health, nutrition, and stimulation. Furthermore, ADRA's decision to ground the discussion in the Convention on the Rights of the Child (with which parents are previously unfamiliar) helps parents understand that all children, including the very youngest babies, have rights that are important for their health, development, and well-being and for which parents have a certain measure of responsibility. In this cultural context, and given the absence of formalised early childhood development services for at-risk children in the first three years of life, ANDK's focus on the prenatal through school-entry age range is particularly important.

An ecological approach

The underlying principles of ANDK and its programmatic approach recognise and affirm the ecological context of early childhood development. As such, ANDK's programme's theory espouses the notion that multiple actors and contexts influence children's development and that programme elements must therefore address not only the direct developmental needs of the individual child but also the needs of adults

and the wider community.

Direct services for young children, the children's Reflect Circles, are complemented by direct services for adults, the adult Reflect Circles, which cover not only topics directly related to child development but also adult and community development and livelihoods. In this way, the programme aims to improve both the development and learning of young children and the well-being of the adults around them. The story of Kwong Pao (introduced in the preceding section) is a useful example. While his children attended a children's Reflect Circle and learned stories and played games, he and his wife participated in their respective Circles, learning about child development and a variety of other topics. His participation in the men's Reflect Circle caused him to reconsider certain choices he made in his life and, in particular, the way he interacted with his family. He subsequently made changes in his life that improved his family's functioning and created a more positive environment for his children's development. The increased savings meant that his children had more to eat, and his increased time at home (sober) meant he had more frequent, positive interactions with them. Additionally, these changes were apparent at the community level and were felt strongly enough that he has become somewhat of a role model for other men in the village and in doing so has contributed directly to building a more positive community environment for the village's children.

The fact that ANDK programming stems from community members' interests means that there is a number of different interventions which target a multitude of influences on young children's development. The road refurbishment activities (which draw funds from the latrine initiative) are a good example of another way in which ANDK is improving children's environment outside the home. Village members want better roads for a number of reasons, and small improvements can have notable impacts on a number of children's outcomes. Better roads can increase access to health centres, make it easier for children to get to school, and help parents get their produce to market and purchase goods and services that may not be available in the village. Additionally, community campaigns, which stem from the community's concerns about specific

threats to children's development, are direct attempts by village leaders and ADRA to create widespread change that reduces the incidence of behaviours and practices in the community that threaten healthy development.

Another example demonstrates how Reflect Circle members are improving their financial stability to better provide for their children and improve their community. In Opreal village, Reflect Circle members heard about microfinance and thought it sounded promising. While the villagers do learn about financial management in the Reflect Circles, very few villagers in Opreal had savings, and they were interested in the notion of saving as a community and multiplying their resources so that individual families could afford more significant investments in their children's health, their crops, their housing, and other areas of interest. The Reflect Circle members appealed to ADRA for information on how to structure and implement microfinance and also for help finding a secure location to store the money collected. In response, ADRA technical staff helped the women's and men's facilitators access relevant information, provided technical assistance as necessary, and then provided secure storage for the funds. With a significant contribution from each Reflect Circle member (approximately US $2.50), the Reflect Circles established a fund from which members can take loans for expenses as diverse as a child's visit to the health clinic or home improvements. One Opreal Reflect Circle member noted that ANDK provided the community with an unprecedented opportunity to "get to know each other" and that now, as a result of the microfinance programme, they can pool their resources and "help each other when there is trouble", thereby improving the well-being of the community as a whole.

Community Involvement

Local communities are heavily involved in ANDK at each stage of the organisation and implementation of the project, contributing to programme effectiveness by ensuring that there is local ownership and support and that the programme is closely aligned with the needs of the community. Site selection for ANDK involves village and commune leaders who participate in a roundtable discussion with ADRA staff about each village's needs,

interest in the programme, and capacity to contribute to its implementation. When there is a greater number of interested villages than there are available funds, villages are encouraged to work with commune leaders to agree on which village should be selected. Once a site has been chosen, ANDK relies upon a nomination and voting process for facilitator selection rather than standard employment procedures. The village leaders nominate candidates who, after an initial orientation to the programme and screening for basic literacy and numeracy, are put to community vote. This process appears to have significant advantages: increasing community exposure to ANDK, leveraging villagers' knowledge of candidates and their suitability for the role, establishing early support and buy-in for ANDK, and encouraging active participation and self-determination in a country whose recent history has been characterised by repression and violence. Similarly, while ADRA funds the salaries of the facilitators and provides some materials for the Reflect Circles, the community must contribute materials and labour to the construction of the shelter and playground for the children's Reflect Circle and provide an appropriate space for the women's and men's Reflect Circles.

Perhaps most notably, as mentioned previously, a large portion of the content addressed in the adult Reflect Circles is community-driven and focuses on topics that can directly have an impact on children's

health, nutrition, and the quality of their early experiences. While facilitators have action plans for the topic areas and content they wish to cover during a given time period, they are responsive to community interests and needs as observed by the facilitator or brought to their attention by Reflect Circle members. For example, when communities are interested in increasing the effectiveness of agricultural production methods to strengthen food security or to reduce the incidence of a specific malady afflicting children in the village, they work with the facilitator and the ADRA technical staff to locate relevant content and materials to be presented and discussed in the Reflect Circles. Additionally, facilitators observe that the participants are most interested in the discussions of child development and that as a result, they spend a large amount of the time in Reflect Circles talking about strategies to improve outcomes for children.

Adult members of the Reflect Circles are remarkably committed to and enthusiastic about the ANDK programme; this can be at least partially attributed to the high level of the villagers' involvement in the direction and functioning of the programme. Across sites, members are notably engaged in the sessions and the material presented. Through their questions to facilitators and ADRA technical staff, they display a noteworthy thirst for new knowledge and skills, particularly as related to child development and parenting. Furthermore, the women's and men's

A Children Reflect Circle engaged in group activity.

Reflect Circles have high enrolment rates (anecdotally reaching up to 90% in some villages), high attendance rates (tempered only by seasonal agricultural demands), and very low dropout rates. This is probably attributable to the fact that participants believe they are learning practical and useful information and can see a positive impact. One mother reported that "it's important because [the facilitators] leads us and gives us knowledge. It benefits me, my family, and my community. We see improvement in lots of things and our community is developing". It is clear that the Reflect Circle members' interest, engagement, and commitment contribute significantly to the programme's effectiveness and will play an important role in the programme's longer-term sustainability.

Local Partnerships

ANDK has prioritised strong partnerships with local institutions since the project's inception. It is of particular note that local governments were not simply involved in the planning stages but continue to play an important role in the project's implementation. Local officials from the Ministry of Women's Affairs serve as district supervisors alongside the ADRA appointed supervisors. The Ministry representatives participate in the initial ANDK training and provide technical assistance to the facilitators, just as the district supervisors do, but they also contribute their own knowledge of women's affairs and their understanding of local government. For this work, which is additional to their formal Ministry role, they receive an honorarium from ADRA in order to encourage their participation. This partnership appears to affect the project in four valuable ways: (a) it increases the supervisory capacity within ANDK, thereby providing a greater amount of technical assistance to facilitators and the Reflect Circles; (b) it increases the knowledge base from which Facilitators may draw to design and construct activities; (c) it permits extended referrals and linkages between various government services and the Reflect Circle members; and (d) it ensures a level of government familiarity with and involvement in ANDK which is conducive to longer-term sustainability.

In June, 2010, ADRA staff convened meetings in Phnom Kravanh and Veal

Veng provinces in order to establish a committee to oversee ANDK. In these first meetings, district leaders, commune chiefs, and representatives from Women's Affairs, Non-formal Education, and the community Health Centres were assigned the task of establishing a charter for the committee and outlining the roles and responsibilities that the committee would have towards the villages and the ANDK project. It was proposed that the committee meet regularly (approximately every three months) and that the committee would help sustain community support for ANDK and, by involving the facilitators in the monthly meetings between each commune chief and his respective village chiefs, the committee could serve to monitor the facilitators and Reflect Circles.

In the view of both the meeting participants and the ADRA staff, these actions would help ensure that ANDK became more strongly rooted in commune- and village-level institutions, contributing to its sustainability and longevity. During the meeting, the ANDK Project Manager reminded the participants that the project and its impacts "don't belong to ADRA, but to each of the communities", a refrain and approach that permeated not only the committee meetings but also general project activities.

Concluding Thoughts

In its first two years of existence, ANDK has done a remarkable job of reaching out to vulnerable communities and supporting them in a community-based, collaborative way. There is little doubt that their work has brought child development to the forefront in communities where it was previously afforded little thought and consideration. Any undertaking such as this is not, however, without its challenges. There are three challenges, which if addressed, could increase the quality of the programme and its impact in the long-term. Each is described briefly in the paragraphs that follow.

Programming quality

As with any early childhood programme, in ANDK the quality of the service providers is remarkably important. One of the facilitators, who had been with the programme for six months, demonstrates excellent skills. Her children are fully engaged and thoroughly enjoying themselves. She has created a puppet show by building a small garden bed in a shallow washing bucket and making small paper butterflies tied to pieces of string. With children gathered around her, holding the strings and making the butterflies dance, she tells the children (and

Children and parents watch intently as the Children's Reflect Circle Facilitator tells a story about butterflies using hand-made puppets and props.

their gathered siblings and parents) a story about the butterflies and the seasons.

After the story, the usually timid children clamour to be the one to retell it to their classmates, and they continue, rapt, as the butterflies recommence their dance and one of the young girls recounts the teacher's story. But examples of this sort of creativity, resourcefulness, and engaging manner are not common among the facilitators.

In many children's Reflect Circles, activities are much more focused on rote learning (common in the Cambodian education system) and free outdoor play. It seems, however, that with focused training and technical assistance, ADRA could significantly strengthen the capacity of the facilitators by increasing their understanding of how children learn and their knowledge of engaging, child-centred activities. With this sort of attention to high-quality, facilitator-child interaction and experiential learning, many more children would benefit from the promising practice described above.

Serving infants, toddlers, preschoolers, and beyond

Children seem to love the Reflect Circles; they arrive early, stay late, and leave with smiles on their faces and songs to sing for their parents. However, the Circle's popularity has translated into burgeoning attendance, particularly among school-age children. This phenomenon varies across sites; in some cases the older children start off just outside the shelter and then only get involved when the younger children go outside to play, but in others, the older children are inside the shelter and involved right from the beginning. While it's encouraging that the older children (who are as old as 12) enjoy the Reflect Circle activities, their presence has a direct impact on the experiences of the younger children. The facilitators, who are generally quite new to working with toddlers and preschool-age children, find it much easier to engage the older children and gravitate towards doing so in their activities. The youngest children, lost in activities that are beyond their developmental reach, tend to get easily distracted and fussy and sometimes wander away. The outcome is that the target recipients of the programme are not being served as effectively as the project would hope.

The solution in this instance is far from simple. To add separate sessions for the older children would divert the project's resources from its main objective (improving the community environment for children in early childhood), yet discouraging their enthusiasm is not ideal either. However, project staff do need to find a way to limit the participation of older children during the Reflect Circles so that the focus remains on the younger children. One way to address this might be to create a mentoring programme. This would continue the older children's involvement in a structured way and allow them to take on responsibility, while ensuring that the facilitators' attention is primarily directed towards the children up to the age of six.

Sustainability

As is the case in any grant-funded programme, the question of sustainability poses some challenges for ANDK. Despite significant community involvement and strong partnerships with local- and district-level organisations, the project's reliance on ADRA for funding means that the programme does not have a clear succession plan. While the communities, organisations, and government-units associated with ANDK value the project, it remains to be seen whether they will make a financial commitment to its continued operations after 2011-2012. This issue has been raised with government representatives and local leaders at the recent meetings to establish ANDK oversight committees, so they are aware of the funding limitations, but to date none of the actors involved has expressed concrete interest in taking over the financial responsibilities.

The ADRA Cambodia leadership and project staff are keenly aware of the difficulty of this situation and recognise that the project may not continue beyond 2011-2012. However, community commitment to ANDK (and particularly the Reflect Circles) is remarkably strong. ADRA can leverage this community ownership and explore whether some communities may be willing to gather funds to pay the facilitators' salaries. While the salary is relatively low, some facilitators have indicated that they would be interested in continuing the Circles even without pay (presumably in the absence of alternative income-generating activity). Additionally,

ADRA should continue to pursue the possibility of local government contributions to the facilitator costs and to demonstrate the value of the project to decision-makers in local government units. These options should be explored if those involved decide that they would like to see the project continue.

As Cambodia emerges from its tumultuous past, the country faces many significant challenges. Helping its citizens raise themselves out of poverty and into greater opportunities for development is a fiercely difficult undertaking. Investing in early childhood development is an important part of this process. Recent endorsement of a multi-sector national early childhood development policy and the current process of developing a plan of action for implementation certainly mark critical first steps towards strengthening children's developmental contexts. It is the programmes and services on the ground, however, which have the potential to turn the goals and objectives of the policies into reality. While the country should not fall into the trap of relying disproportionately on development assistance or programmes without a strong evidence base, it may do well to remember that there are noteworthy indigenous projects such as ANDK which offer valuable lessons for strengthening children, their families, and the communities in which they live.

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India: Making Our Children Alert

By Miriam Thangaraj, Research Fellow

Abstract

Hands to Hearts International (HHI) organises a variety of training interventions for primary and secondary caregivers in Central Orissa, delivered by their local implementing partner, Visa Yuma Kendra (VYK). In a socio-economic context marked by poor child development outcomes (high rates of malnutrition, mortality and disease, and low levels of awareness about child development practices) and an institutional context where the state's 'anganwadi' centres are growing in importance, the Programme holds great potential by directly targeting mothers and anganwadi workers. Initial impacts on child development practices at home and within anganwadis are promising: new practices of nutrition and hygiene, new attitudes towards child development, and improvements in cognitive and linguistic abilities. As mothers (and fathers) often say, these new practices make their young children more "alert."

Particularly noteworthy elements of the Programme include the following:

- the modality of the training sessions that emphasises a participatory pedagogy
- the content of the curriculum that emphasises caregiver interactions with young children over the role of learning resources
- the purposive scope for contextualisation and cultural relevancy in the curriculum,
- the distributed implementation model that reaches a larger number of poor and rural communities directly through the participation of local, grassroots organisations
- the cost-effectiveness of the training interventions
- the localisation of the training intervention to the context
- the impact of the programme in terms of observed and reported increase in the awareness of the significance of ECD for the life chances of young children

Introduction

Hands to Hearts International (HHI) was founded in 2004 by Laura Peterson, its current Executive Director, who leads a small international team of trainers and curriculum designers working with local organisations and communities in countries such as India and Uganda on early childhood development issues. HHI's training interventions in India can best be seen through the lens of its partnership with Viswa Yuva Kendra (VYK), a non-government organisation (NGO) working since 1986 with rural communities in the central districts of Orissa, one of India's less-developed states.

Programme Description

The clear notes of Hema's Oriya lullaby that carry across the afternoon hush at the Chadeimara Panchayat Office no longer evoke any surprise among the panchayat functionaries at work or the men chatting over their afternoon cups of tea. The office building has played host to a two-day

workshop on mother and child health for the government's Integrated Child Development Services (ICDS) staff, also known as anganwadi (childcare centre) workers. ICDS is an integrated early childhood programme in India, with over 40,000 centres nationwide. The programme offers health, nutrition and hygiene education to mothers, non-formal preschool education to children aged three to six, supplementary feeding for all children and pregnant and nursing mothers, growth monitoring and promotion, and links to primary healthcare services such as immunization and vitamin A supplements.

The sessions have been punctuated by song – Bharati Nayak, the lead trainer, loves to sing. In fact, she carries a diary full of Oriya songs that have been painstakingly collected over the years; they range from rhymes a few lines long to complex mnemonic devices and rousing nationalistic anthems. One song, of epic length, lays out, almost month-by-month, the important child development milestones that an anganwadi

The state of Orissa has a culture rich in tradition, though it lacks many basic resources.

worker or a new mother should watch for. Today, however, it is the trainees' turn, and Hema, whose sprightliness belies her 17 years as an anganwadi didi, steps forward to demonstrate an 'action-song' that she has often used to quiet her charges at the ICDS

centre she manages. As a few of the other 13 participants hesitantly join in – some of them were appointed less than a year earlier and are still finding their feet, while others are still not entirely sure about this more participatory style of training – the bare, cement-floored room with its unfinished walls is suddenly transformed into a riot of colour. Their gaiety and laughter keeps the sweltering heat of the afternoon at bay, even in a yet-to-be-electrified room without a fan.

Such action-songs bring in much-needed local colour and encourage participation among the workshop attendees; they also serve as critical teaching moments. Bharati repeatedly points out how the training workshops are themselves designed to demonstrate how young children at ICDS centres may be usefully engaged; they are "a valuable opportunity to reinforce for the [participants] the connection between their playful interactions with the children in their care and the optimal development of those children" (Chaille and Mahler, 2007). In other words, training methods can be easily transferred and translated into ICDS classrooms and are closely linked to the physical and cognitive development in young children.

The ICDS training workshops must deliver content that covers the entire gamut of early childhood development domains, including hygiene and appropriate nutrition. Thus, Day 1, in addition to introductory activities, is focused on physical and cognitive (brain) development while Day 2 is split between linguistic and affective development, with a session on health and hygiene added on. Each training workshop is marked by pre- and post- testing that checks for participants' knowledge as a means of assessing the effectiveness of the training.

The HHI Curriculum

HHI's publication – *A Curriculum for the Study of Early Childhood Development: Trainer's Manual* – is the bedrock on which the entire programme is built. Over a hundred pages long, it is purposively broad in scope and application and aims to be culturally neutral, affording it the flexibility to be used in a cross-cultural context and for a number of target groups with an emphasis on deliberately including local ways of doing things. The Manual serves as the

ICDS workers with over 20 years experience say they learn new and very valuable information from HHI.

primary reference for all three types of HHI's training interventions: a four-day residential training for secondary caregivers (crèche, daycare, and orphanage workers), a two-day workshop for ICDS workers, and a four-hour session for mothers. The case for the curriculum is laid out more comprehensively in *Best Practices in ECD: A Review of the Literature for the Work of HHI*, available on the HHI website, http://www.handstohearts. org/home.htm.

> [The curriculum]…seeks to equip resource-poor communities to use easily available, inexpensive, local materials for nutrition and play; equally important, it seeks to reassure these communities that their poverty does not put ECD activities out of their reach.

Since HHI's first training workshop in February 2006 in the southern Indian state of Tamilnadu, the curriculum has been enriched and localised on an ongoing basis, shaped to meet the needs of a variety of caregivers and their particular social and cultural contexts. The principal focus of the curriculum is the caregiver – be it the mother; the crèche, day care, or orphanage worker; or the *anganwadi didi* – and its purpose is to help them gain a deep understanding of how

important they are to the lives of children. Indeed, HHI Founder Laura Peterson's message to training workshop participants starts by saying that, "caregivers are the most important person in the world to the child that they care for. In this role, you have the power to teach love, peace, and compassion" (Viswa Yuva Kendra & Hands to Hearts International, 2010). At the level of awareness, the curriculum seeks to make participants conscious of the complex process of child development in the first five years of life and the impact of these years on future life trajectories. In a social context where schooling is increasingly perceived as the key to future employment and the good life, appropriate linguistic and cognitive development in children is highly valued, creating a demand for HHI training.

In terms of knowledge, the curriculum seeks to familiarise caregivers both with child development milestones, across each development domain, and the relationships among these development domains. Health and hygiene information is shared; sometimes, vaccination schedules or state sponsored nutrition programmes may also be introduced. More importantly, the curriculum emphasises what caregivers can *do* to support children's development. Thus, each session offers specific activities through which caregivers can engage their charges and a list of "*what you can do*" to encourage child development; for example,

Levels of Training	Desired Participant Outcomes
Awareness	Recognise the significant of ECD Recognise the role of the caregiver
Knowledge	Recognise age-appropriate child development
Behaviour	Learn specific activities to encourage appropriate child development
Perception	Understand the importance of affective development
Empowerment	Valdiate the (female) caregiver
Material resources	Develop the ability to use available resources for ECD, despite great poverty

> The workshop is not merely an intellectual exercise; trainers are not just a delivery mechanism for information, but they must also model how a caregiver may actively interact with the children in her charge, respectfully listen to them, and incorporate them fully in the learning process.

a new born baby responds to eye contact, so caregivers can hold the baby, making eye contact as they talk and sing to her, while for a one-year old caregivers can encourage the baby to clap in time with music, perhaps to encourage good coordination and muscle control. This intertwining of knowledge of age-appropriate child development with very specific caregiver actions is a particularly powerful instructional strategy. Also, at the behavioural level, the inclusion of activities and games in the curriculum allows for new behaviours to be modelled and practiced in the training room itself. Massage demonstrations, for example, are particularly effective, with mothers showing a great deal of enthusiasm for them.

From an interventionist point of view – a desire to change existing perceptions – the curriculum stresses *holistic* child development with a particular emphasis on social and emotional development through bonding and attachment. The need which young children have for *attachment* and *trust*, easily ignored as a luxury in a context where caregivers face many demands on their time just concerned with daily subsistence, is repeatedly emphasised across all sessions. It is also separately dealt with in the training session on Affective Development. From an empowerment perspective, the curriculum aims to underline the importance of the role of (women) caregivers for young children, typically overlooked in most societies. It also seeks to equip resource-poor communities to use easily available, inexpensive, local materials for nutrition and play.

Equally important, it seeks to reassure these communities that their poverty does not put ECD activities out of their reach. Such an approach also encourages a great deal of contextualisation, creating a space for trainers to employ as much local colour – the stories and songs of their communities , their languages, their diets, their agricultural expertise – as they need to speak to local practices and contexts.

Thus, when Bharati and Sangeeta deliver training workshops in Orissa, they use local Oriya translations, adapted from the original by VYK, HHI's local partner organisation, to underline its cultural relevance and better meet local needs. For instance, based on initial participant feedback, Bharati added pictures to the Oriya booklet that each workshop participant receives, making it more accessible and interesting to participants. Training materials are also available in Tamil and Malayalam, the state languages of Tamilnadu and Kerala respectively, where HHI-funded programmes also exist.

Trainers and Training

Bharati's role as trainer is vital to the success of the training workshop. Not only does she need to have enough curricular knowledge to command the respect of *anganwadi* workers, but she must relate with them in a manner that keeps them engaged and eager to participate. The design of the curriculum stresses effective delivery in a way that will be useful, meaningful, and memorable to the participants and which foregrounds the trainer's role in delivering relevant and powerful workshops. The trainer also competes with other demands on participants' time; ICDS workers must attend HHI workshops in addition to their daily duties at ICDS centres while mothers must fit sessions in alongside their work in the fields and at home. A further challenge for the trainer is the diversity of participants'

Developing bonding and attachment is a core message in HHI's training.

Bharati, an HHI Master Trainer, draws on 20 years of community health experience.

Love is the underlying message in all of HHI's lessons.

Creche teachers in Angul learn to use drama to support language development.

experiences and needs; many ICDS workers have only about a year of experience in the system while others are as old as the Project itself, having worked in it for more than 20 years.

Even more important, the trainer's engagement with participants must demonstrate how ICDS workers and other caregivers may go about building relationships with the children in their charge. Having two trainers co-facilitate training sessions affords greater opportunity to model behaviours, be it demonstrating specific techniques of child care such as massages or co-constructing a supporting learning environment. The workshop is not merely an intellectual exercise. Trainers are not only a delivery mechanism for information; they must also model how a caregiver may actively interact with the children in her charge, respectfully listen to them, and incorporate them fully in the learning process.

Modelling such a respectful relationship is difficult when the social and cultural distance between trainer and participants is significant. *Anganwadi* workers are poorly paid and enjoy little status in society (although their social standing – and salary – is much higher than it was when they started out). In training sessions for mothers, for instance, participants have little or no schooling and are invariably from poor households. In some

districts, a large proportion of the participants are from historically marginalised scheduled castes or tribes. The space of the training workshop is far removed from the daily lives of such participants in which their gender

> … trainers walk a thin line – educating participants and encouraging new practices while also empowering them to recognise and employ the (social, cultural and material) resources they already have at hand.

and social position may often leave them disempowered and voiceless. As a result, the modality of the training workshop – where active and vocal participation is expected; where participants are encouraged to be reflective and evaluative about their everyday routines; and where child care, typically taken for granted in daily life, is discussed as a particular set of activities and attitudes. This can very quickly work to alienate or silence participants because of its sheer unfamiliarity.

Trainers must also appreciate local ways of knowing; for instance, when communities still reckon time by planting and harvesting seasons, marking child development milestones in months and years is an

alien system for most mothers. Trainers must therefore ensure that their instruction does not invalidate or disparage the local practices and contexts in which participants are embedded.

It is not an easy task to recognise the social, intellectual, and cultural resources that participants bring, often when participants themselves are unaware of them or quick to devalue them. As a result, trainers walk a thin line – educating participants and encouraging new practices while also empowering them to recognise and employ the social, cultural, and material resources they already have at hand. This is a task often made harder by a socio-cultural context in which the foreign origins of the programme – its American connections via HHI – may represent an exotic appeal in contrast with local efforts.

Thus, the training workshop encounter is easily fraught with power differences between trainers and participants. To ensure that training programmes become positive interventions rather than outside impositions is perhaps the trainers' greatest challenge. Some training is residential; those for crèche workers, for example, are housed in VYK's training premises for the length of the programme. The intimate settings allow for greater, freer interaction between participants and trainers, creating a more supportive learning dynamic.

That the trainers are indigenous also goes some way towards redressing the unequal power dynamic in the training room. Thus, trainers speak the language of their workshop participants, literally and figuratively. They are typically associated with non-profit, community-based organisations, often working with women's self-help groups, community health initiatives, or livelihood programmes. Hence, they are also more aware of the particular and peculiar needs of the communities they work with, drawing on this knowledge to deliver content that is best suited to their contexts. It is easy to overlook the fact that trainers such as Bharati are committed grassroots workers, with years of experience working on women's issues. That, and the resultant trust they have built with local communities, are key inputs that keep the programme going despite its small size and limited resources. In essence, the influence that non-government organisations

such as VYK enjoy in the village communities they work in is unmatched by the state despite its much greater resources.

> Trainers also have to cope with more pragmatic concerns – how can mothers or ICDS workers afford to take part in training sessions given their hectic daily routines and duties?

Trainers also have to cope with more pragmatic concerns; e.g., how can mothers or ICDS workers afford to take part in training sessions given their hectic daily routines and duties? Thus, workshops are purposively structured to accommodate participants' schedules – training for ICDS workers begins after they have shut their anganwadi centres for the day. Since ICDS workers have to make their own way to the training venue, training sessions must finish at an early hour. Participants must also be provided lunch for the two-day duration of the workshop and paid a small amount to cover travelling costs.

For mothers, on the other hand, attending training sessions may represent a very real opportunity cost since most of them are economically active. To minimise disruptions to their workday, training is spread over two days, with shortened sessions (about two hours each day) scheduled in the afternoons (women typically spend the mornings working in the field, while evenings are reserved for household chores). Sessions may still eat into the time that mothers might otherwise spend earning money.

At the present time, beyond serving the mothers some light refreshments, the HHI programme does not have the resources to offer compensation for attendance. Moreover, HHI's programme designers have consciously chosen not to offer mothers any compensation as the modalities of determining who deserves such assistance are complicated. However, as a consequence, the poorest households where women cannot afford to take any time off from work may end up not being reached. That a large number of women participate in HHI training despite the opportunity costs may be seen as a reflection of the

value mothers place on the workshops and the credibility the workshops – and the HHI partner organisations – enjoy in local communities.

All in all, the trainer – and thus, training the trainer – is perhaps the most critical element for achieving positive outcomes from the delivery of the HHI programme. This is all the more important since trainers do not have formal, educational qualifications in ECD or a related field. Bharathi and Sangeeta are both 'HHI certified' trainers; they were trained by an HHI master and by HHI Executive Director, Laura Peterson, during a residential, eight-day workshop in July 2008, held at the VYK premises. With nine trainees, it was a small and intimate group, allowing for a great deal of participation and collaboration. Moreover, since language and cultural differences are central to the curriculum design process, the workshop opened up a bigger space for trainees to contribute their local knowledge and experience with local language, games, songs, dance, and stories and to shape

> All in all, the trainer ... is perhaps the most critical element for achieving positive outcomes from the delivery of the HHI programme.

HHI's curriculum in Orissa.

Programme Implementation

At present, HHI has two implementing partners in India – Shishu Bhawan in Kerala, which focuses on ECD activities in orphanages, and Viswa Yuva Kendra (VYK), a non-governmental organisation working for the sustainable development of communities in western and central districts of Orissa. Ongoing training support for the two organisations is provided on a needs-basis by HHI's master trainer for India who also delivers the programme in the state of Tamilnadu.

VYK was established in 1986, primarily to work with local youth. Over the years, as other community needs have emerged, the organisation has responded by expanding its activities. Despite its range of activities, VYK remains a small committed band of community organisers led by its Director, Manoj K. Mohapatra. Most of its core staff, less than a dozen in number, have significant and diverse experience working in development. They are supported by part-time/project-based staff, as well as by an Executive Committee and an Advisory Board comprising members drawn from a variety of fields (education, business, medicine, and social work). The fact that VYK is able to sustain a number of projects despite its size and limited resources reflects

Songs and dance keep mothers engaged and teach how they can support their child's development.

the commitment of its staff (yearly funding raised by the organisation is typically in the range of 30 lakh rupees, or US $65,000, though some years it has gone as high as US $100,000).

Since VYK's partnership with HHI began in 2007, over 60 training workshops have been held for mothers, another 60 plus for ICDS workers, and 25 for caregivers in crèches and orphanages. Thus, over 750 *anganwadi didis*, about 1,000 mothers, and nearly 300 crèche and orphanage workers across the five central Orissa districts of Angul, Boudh, Deogarh, Dhenkanal and Sonepur, have been trained to better care for their communities' young children.

The HHI-VYK partnership is a close one; the modalities of the partnership require it, while the relatively small size of both organisations enables it.. While HHI is the primary funding partner, providing a per participant sum for training workshops, VYK must supplement these funds by mobilising for other training costs, including providing for the venue and organising for participation and publicity. While HHI trains those who deliver the workshops, the trainers are identified and recruited by VYK. And while HHI funds the wage costs for two trainers, VYK must do its part to make other trainers' involvement worthwhile for them.

Despite the geographical distance that separates the two organisations, respect and accountability are sustained through direct phone or email contact between the directors of the two organisations. This is supplemented by VYK's monthly reports on workshop delivery - the numbers and kinds of training imparted, the number of participants trained, as well as the participants' pre- and post- test scores – which are the primary means of oversight by the funding partner. Since funding is tied to the number of participants/workshops, this also serves to regulate the amount of funds transferred to VYK.

Thus, the funding partner-implementing partner relationship is intertwined to a large extent, with the implementing partner enjoying a significant amount of independence. VYK plans the workshops' schedules, depending on local needs/demand. Where required, it brings in local partners to better reach communities and

defray costs; it also taps into its substantial network of relationships with other NGOs and state officials, built over long years of interactions, to mobilise support for the HHI

> [Since July 2007] over 750 *anganwadi didis*, about 1,000 mothers, and nearly 300 crèche and orphanage workers across the five central Orissa districts of Angul, Boudh, Deogarh, Dhenkanal and Sonepur were trained to better care for their communities' young children.

Creche teachers from Angul graduate from an HHI training.

training workshops. The Child Development Project Officer (CDPO), who are part of the *anganwadi* system, for instance, evangelises for the HHI workshops, despite their own internally developed training sessions for ICDS workers; the CDPO's official sanction ensures full participation of *anganwadi* workers, and in some cases it subsidises training venues.

By involving *panchayat* office-bearers, typically invited to open the training workshop or to distribute graduation certificates at their completion, VYK also creates greater local recognition and demand for the HHI programme – credibility that helps cut

coordination costs.

By employing a distributed implementation model, the HHI-VYK partnership ensures that training is delivered *in situ* and reaches communities that other efforts might be unable to reach. Such a model is efficient; the relationships that these local partners have in their immediate communities translate into lower programme costs. For instance, they can often account for the costs of mobilising participants or the costs of training venues. The local partners also benefit. The HHI training sessions offer an opportunity to learn new skills, develop a stronger project portfolio, and participate in an established and credible network of NGOs: a resource for organisations that are

very small, local, and with limited funds. The distributed implementation model thus leads to a greater embedding of the knowledge/skills/curricula/pedagogy of HHI training within local networks while simultaneously localising the HHI programme.

Thus, the partnership allows both HHI and VYK to play to their respective strengths. HHI capitalises on its location with respect to research and funding networks in the United States to access the latest research as well as effectively raise funds; VYK capitalises on its position in terms of local knowledge and relationships to effectively customise the programme and widely deliver it. HHI brings

to the table its training expertise; VYK, its implementation skills. Their complementary roles and skill-sets represent smart programming and help stretch every dollar spent on the programme.

It is because of VYK's strong relationships with NGOs in neighbouring districts that "training comes here;" the programme's distributed implementation model reaches communities that other efforts might be unable to reach.

Relevance of the Programme

Orissa is one of the major states of the Indian Union but is also the poorest one: the Modified Expert Group of the Planning Commission has estimated that 47.15% of the state lives below the poverty line (Center for Environmental Studies, 2007). Of even more concern is the much greater incidence of the 'calorie poor'; an analysis in 2004-05 estimated that 79% of rural Orissa had a calorie intake that is even lower than that represented by the poverty line, a "nutritional crisis" in the making (Mishra, S. 2009).

Predominant contributing factors are Orissa's Infant Mortality Rate (IMR) which continues to be the highest in the country, even higher among scheduled caste and tribal communities, and an equally high under-five mortality rate. Among the causes of high infant and under-five mortality are low birth weight and preventable diseases including diarrhoea, gastroenteritis, anaemia, and jaundice, which in turn may be linked to inadequate care, poor sanitation, and inadequate nutrition.

Given this context, working on women and child health issues is easily justified. While large-scale sectoral interventions are clearly called for, the data also suggests that a lack of information about state services and of awareness of good child and maternal care practices significantly contributes to the high mortality rates among young children. At Child and Mothers' Health workshops discussions among representatives of community-based organisations, women's self-help groups, NGOs, district-level

There are very few services for mothers in Orissa.

government officers, ASHA (Accredited Social Health Activist) workers, and ICDS supervisors and worker, repeatedly and consistently bring up the lack of awareness in rural Orissa about reproductive and child health as the most critical issue requiring attention.

To sum up the ECD context in Orissa: it is marked by high and wide-spread levels of poverty and malnourishment, inadequate health infrastructure, and low levels of "awareness" at the household level. A large proportion of rural mothers are undernourished, illiterate, and under-resourced, characteristics that are more likely and more intense if they belong to scheduled caste and tribal communities. While the state has responded to these conditions by expanding infrastructure – a sorely needed investment – a lack of awareness about how, why, and when to access these services has also stymied these efforts. Moreover, with state efforts primarily focused on improving health, nutrition, and sanitation for children – certainly a priority - the government's approach also means that child development is restrictively understood as physical development, overlooking the other child development domains.

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The one exception perhaps, is the *anganwadi* centre which has been implemented under the ICDS project and attempts to address the cognitive development of 3 to 6 year-olds by means of preschool activity. The ICDS Project in Orissa was substantially expanded in 2008-09, adding almost 20,000 new centres to the existing 40,000 *anganwadis*. According to a state government release in January 2009, enrolment in these preschools increased from 980,000 in 2001-02 to 1.44 million in 2008-09, with attendance

also increasing in the same period from 840,000 to 1.28 million (Women and Child Development Department, Govt. of Orissa, n.d.). However, as of July 2010, there were a mere 26 Anganwadi Workers' Training Centres operational in the state, with the training of new recruits further adding to the backlog in meeting the refresher training requirements of older *anganwadi* workers.

Much recent training, in fact, has shortened the length of both pre-service and in-service courses. This means that more experienced

One in every three malnourished children in the world lives in India.

Programmes catchment area characteristics	
Rural population	90% or more (4 of 5 districts)
Agricultural labour	60% or more (4 of 5 districts)
Per capital income	Below Rs. 6000 per annum
Literacy rates	58 to 69%

Orissa is a very rural state, and one of the poorest in India.

colleagues have attended several state-sponsored training while newer recruits have had far less training and fewer training materials for ICDS workers to carry back to their centres and use.

It is in this context that the HHI-VYK partnership targets mothers, ICDS workers, and crèche teachers with its low-cost, holistic child development programme. The catchment area of the programme – the five central Orissa districts of Angul, Boudh, Deogarh, Dhenkanal and Sonepur – is predominantly rural and agrarian; in fact, in four of the five districts, over 90% of the population lives in rural areas, with at least 60% engaged in agriculture, as labour or cultivators. The annual per capital income in 1998-99 in four of these districts was below Rs. 6000 (US $130), with three officially classified as 'industrially backward tribal districts'. In one of the districts, tribal communities comprise over a third of the population. Literacy rates in the districts range from 58 to 69%, with literacy rates among women and lower caste and tribal communities significantly lower.

Intervening in such a context can be transformative for the lives of young children and their communities. These children and communities are vulnerable on multiple dimensions; state interventions are often ineffective because they cannot address all sources of vulnerability. Thanks to a distributed implementation model and VYK's extensive network of relationships, HHI's programme has unprecedented and *direct* access to these communities. The programme is well placed, therefore, to address the need for increased ECD awareness among communities in the region. Also, by targeting communities such as those described above, the programme is purposively inclusive.

Cost-effectiveness of the Programme

The HHI-VYK funding model is starkly simple and straightforward; what's more, it underscores the central focus of the partnership - the delivery of the training/capacity-building programme. Given the small size of both organisations, resources need to be maximally routed towards programme implementation. Thus, the funding model is directly linked to programme outputs – the number of training courses delivered or the number of participants trained. For ICDS worker training, HHI's funding is tied to the number of workers participating in training workshops, at the rate of Rs. 150 (US $3) per participant. Mothers' training courses are funded by

HHI at a flat rate of Rs. 1000 (US $21) for both days. For four-day residential training, the expenditure per crèche teacher is Rs. 125 (US $2.50) per day which covers three meals a day, stationery, and transportation.

In each case, the cost of organising training venues and lodging arrangements, coordinating the smooth running of the training sessions, managing state officials and community leaders, and mobilising participation are borne by the implementing partner. These costs are defrayed to a large extent through the strong relationships VYK has with local communities, other grassroots organisations, and government officers. While VYK typically provides the trainers for workshops and bears participant expenses as detailed above, local partners in the distributed implementation model contribute their time and draw on their local contacts to lower the cost of training workshops. The extensive and dense network of NGO relations that implementing partners are embedded in also lowers the costs of disseminating information about the workshops and mobilising participants. For instance, VYK and its local partners identify and invite mothers of young children to their training programmes by tapping into their links with women's self help groups. HHI also funds the wage costs for two trainer-facilitators in Orissa.

In terms of cost-effectiveness, a very small outlay of Rs. 14,400 – or under US $350 – per month reaches about two dozen *anganwadi* workers, a dozen crèche workers, and 75 mothers each month. To underline the impact of the programme, consider that each *anganwadi didi* delivers preschooling activities to 20 children in the 3 to 6 age-group each year; consider also that she conducts home visits to all households with children in the 0 to 3 age-group to deliver nutrition and health information. By reaching the *anganwadi* worker at a cost of a little over US $3, the HHI training programme can potentially transform the early childhood care and education landscape of an entire village. Crèche workers care for 20 to 25 children in the 0 to 3 age-group per crèche centre; with two caregivers to a crèche and 12 caregivers trained each month, at a cost of Rs. 1000 (about US $21), the HHI programme is a significant intervention in building nurturing and protective relationships for children at their most vulnerable age.

Mothers and grandmothers at an HHI training in Dhenkanal.

Even more cost-effective – and significant – are mothers' training programmes. At an average cost of under US $1.50 per participant, they *directly* intervene at the household level. With a fertility rate of 2.4 in Orissa, one HHI mothers' workshop potentially has an impact on the daily lives – and future trajectories – of 180 young children. In close-knit village communities such as the ones the programme serves, the ripple effect of the trainings is also significant, if more difficult to estimate. In all, across *anganwadis*, crèches, and households, the programme potentially reaches over 800 children in the 0 to 6 age-range each month at a staggeringly small expenditure of less than 45 cents per child.

> ...mothers' training... at an average cost of under US $1.50 per participant, represents one of few, direct training interventions at the household level.

Of course, the low programme costs reflect a design that is also rather starkly simple and pragmatic. The training venues used, for instance, are very basic. Training materials for participants are few and inexpensive, with printed booklets provided to ICDS workers and crèche teachers but not to mothers. Except for residential training, other workshops make no use of any training equipment – as a result, child massage videos, for example, cannot be shared at mothers' training courses. The trainers' salaries cannot afford candidates with degrees in ECD or an allied field. However, this bare-bones, stripped-down approach is appropriate given the socio-economic context of the programme's target groups. With low female literacy rates, text-based training materials would be irrelevant. Investing in training equipment is impractical, given that most training venues are not electrified. And while trainer salaries cannot afford ECD specialists, they are nevertheless attractive in a context where a crèche teacher is paid Rs. 1000 a month (US $21).

Most importantly, the training's low cost approach is consistent with a central tenet of the programme. To quote from the curriculum, it seeks to "empower people to act, regardless of specific toys or resources." Thus, the training seeks to demonstrate that elaborate materials, expensive toys, and special rooms or structures are not essential to child development - but supportive and responsive interactions are. This message, as demonstrated and reinforced in the training workshops, is vital if the programme is to have any credibility among participants. Especially in areas of high poverty such as Orissa, the training workshops seek to reassure mothers and caregivers that their lack of material resources need not

> … the training's low cost approach is consistent with a central tenet of the programme; to quote from the curriculum, it seeks to "empower people to act, regardless of specific toys or resources."

inevitably preclude the healthy development of their children.

Impact

How has the HHI-VYK programme had an impact on training workshop participants? Perhaps more importantly, how has it been translated into the daily lives of young children in Angul, Boudh, Deogarh, Dhenkanal and Sonepur?

The training, as previously detailed, seeks both to deliver key child development information and model appropriate child-friendly behaviours. To understand the impact of the programme, therefore, it is necessary to: (1) estimate their effectiveness within training room spaces, in terms of knowledge transfer and the adoption of new behaviours; (2) map the translation of newly learned knowledge and behaviours into household/work spaces and their incorporation into everyday routines and interactions with young children; and (3) to trace their effect on children's daily lives and development trajectories.

As mentioned before, each training workshop uses a fairly basic pre- and post-test instrument consisting of ten items – statements that participants mark as true or false – that attempt to evaluate caregivers' knowledge of hygiene and awareness of children's physical, social, emotional, and cognitive development. An "effectiveness evaluation" conducted in March 2009 by interns at HHI who studied data from 19 training courses for mothers and 24 for secondary caregivers (N= 641) that were delivered between May and December 2008 found that "both mothers and secondary caregivers had gains in knowledge as measured by pre- and post-tests." The evaluation also concluded that **trainees gained knowledge across child development domains** and that the impact

of the training was highest for mothers; since many secondary caregivers would have already been exposed to some of these ideas, this is perhaps to be expected.

Pre- and post- test data for training courses delivered by VYK and its local partners between March and May 2010 echoed those of the evaluation exercise from a year earlier; large knowledge gains were found. Clearly the gains are large and significant. The scores also make a strong case for the emphasis on affective development in the HHI curricula; it appears that primary caregivers coming into the training either tended to devalue the emotional development domain or took it for granted. Of course, a single instrument, in question-answer format, is not the best means to capture knowledge gains; nevertheless, the consistently higher post-test scores are a definite cause for optimism. Based on the scores, the training certainly achieved the two curricular objectives of making caregivers aware of the importance of early childhood development and improving their understanding of it.

Is there any evidence to suggest that this impact lasts beyond the time and space of the training workshop? Over a three-month follow up period, HHI's internal evaluation exercise also found that "mothers trained

by HHI reported **a greater awareness of child health and development**, more frequent and meaningful interactions with their children, and a better understanding of child's needs; were finding children easier to handle; had greatly improved hygiene, sanitation and nutrition practices."

While most mothers remembered that the training had clearly spelt out the things they could do daily to support their child's age appropriate development, only a few could list specific behaviours they had learnt.

Knowledge gains from HHI training courses among mothers and primary caregivers* (based on pre- and post- test scores) N=214	
The importance of trusting relationships for appropriate child development	54%
The impact of cognitive development from 0-5 years on future development trajectories	53%
Babies' unique development trajectories	51%
Brain development from 0 to 1 year	51%
The impact of hygiene on health	48%
Recognising babies' means of communication	47%
The use of play to support linguistic, physical, cognitive, and social/emotional development	46%
*expressed as the average number of participants across training sessions who moved from a wrong to a right answer from pre- to post- test. Sample questions: Babies think before the age of one. Babies have emotions. Babies only communicate by speaking. All babies develop at the exact same time.	

These were typically better-off, stay-at-home mothers – more common closer to town centres – who had fully taken on board the content of the training. Some of them claimed to spend as much as three hours every day exclusively focused on implementing the child development activities they recalled from the training. They closely observed the behaviour and reactions of their young children, they massaged them, sang to them, made up stories with them (often based on TV soaps!), and encouraged

> That more mothers have fewer misconceptions about child development is in itself a powerful intervention.

play and exploration. On the other hand, poorer mothers who worked as agricultural labourers – who predominated in most villages – and could afford relatively less time with their children had not been able to implement many of the requisite behaviours and often could not recall them with much specificity.

Irrespective of whether they worked or not, mothers across the board report one significant change – they all made an effort to curb their language and gentle their tone in the presence of their young children. Nearly every mother also reports **a positive change in their attitude and response to their children's playfulness** and fledgling attempts to be helpful – where they might have disciplined them, ignored them, or rebuffed them earlier, they now view these efforts as integral to their children's development and try to encourage and share in the activity with them as far as possible.

> Nearly every mother reports a change in their attitude and response to their children's playfulness and fledgling attempts to be helpful – where they might have disciplined them, ignored them or rebuffed them earlier, they now view these efforts as integral to their children's development, and try to encourage and share in the activity with them as far as possible.

The most easily recalled aspect of the training – mothers invariably listed it first and spoke animatedly of it – was the "baby massage." This is designed to promote bonding, develop trust between child and parent, and improve child health by strengthening immune systems, improving digestion, building muscle tone, and heightening body awareness.

What piqued the interest of mothers in the HHI training is the massage technique which is radically different from the one they are familiar with. The HHI Baby Massage

emphasises a touch that is slow, smooth, and gentle, in sharp contrast to the traditional massage in which strokes are applied with pressure and involve a lot of squeezing and pulling of the baby's limbs.

Perhaps the most obvious changes that mothers make in their routines, post-training, relate to **nutrition, safety, and hygiene**; e.g. the greater use of 'chudagundo', a highly nutritious, locally prepared baby food that trainers emphasise, but with cheaper alternatives for some of chudagundo ingredients so that mothers can afford to prepare it fairly regularly. Much of the evidence concerning the impact of the HHI programme on nutrition is anecdotal. But there is some evidence suggesting that HHI training has a positive effect on children's weight gain and general health. This is clearly a fruitful line of enquiry for a systematic longitudinal study.

Hygiene, too, has shown improvement. For instance, mothers wash their babies' clothes "in dettol," an anti-septic, because that was what the HHI trainers advised them to do. Those who can't afford to buy it nevertheless make sure that diapers are hung out to dry in the sun. HHI-trained mothers also religiously wash their young children's clothes separately from those of the rest of the household, unlike the usual practice. Many mothers also report that HHI training on hygiene convinced them to go against

HHI teaches a gentle style of baby massage, enjoyed by mother and child.

another established practice – that of not changing/washing babies in the evenings (linked to superstition, often justified as keeping children from catching a chill), a practice that ironically often leads to more disease.

Thus, it does appear that **changes in child rearing practices have been introduced into households and have persisted beyond the training programmes,** some held nearly ten months earlier. The

Village mothers report making significant changes in nutrition, hygiene and sanitation after HHI's training.

increasing advent of the television (even among remote villages in India), and the impetus it provides for being "modern," also leads to greater acceptability of practices such as those endorsed by HHI.

How have *anganwadi* workers been changed by the HHI training? Barring the newest set of recruits, other *anganwadi* workers participated in several training programmes on early child development organised through the state's Anganwadi Workers' Training Centres. Irrespective of length of service, however, what stood out for *anganwadi* workers across the sites is how much they enjoyed the HHI training (perhaps in contrast with state-developed training). Much of their **enjoyment of the training** appears to derive from its participatory nature which encourages *anganwadi* workers to speak up, share their work experiences, and contribute their input. The frequent use of songs and games by HHI trainers also helps to sustain their interest across the two days of the HHI training.

Another aspect of the training that draws praise from ICDS workers is that the HHI training also demonstrates or outlines *how* child development can be appropriately supported. While ICDS centres come with a few basic teaching aids (blackboards, picture charts, etc.), and the ICDS workers have a preschool curriculum to follow, very few *anganwadi* centres, in fact, function as preschools. Since *anganwadi* workers find classroom management a huge challenge, the centres have largely been run as spaces where young children can spend a couple of hours off the village roads while their mothers are away and receive some nutrition in the bargain.

Since the HHI training, however, *anganwadi didis* **spend more time on child development-oriented teaching activities than did they in the past**. They have a larger repertoire of activities to choose from, which keep children interested and which in turn makes classroom management less taxing, therefore resulting in more time spent on teaching activities – a very positive, reinforcing loop. As an *anganwadi didi* puts it, before the HHI training, she was a child-minder; but now she is a teacher -- perhaps the most significant impact of the training on ICDS workers and consequently on children's cognitive, emotional, and linguistic

Because HHI does not rely on materials, trainings can and are given anywhere. An HHI Mother's training in the remote tribal village of Jogiepathar.

development. This is even more important given the low primary school retention rates in Orissa – about a third of the student population (over half, among tribal children) drops out at the primary level.

A list of **new teaching behaviours that** *anganwadi didis* **credit HHI training** for include using participatory story-telling; incorporating linguistic elements into children's games and exercises; seeing free play as an opportunity for impromptu teaching moments; and encouraging children to speak about their routines at home, including those of cleanliness.

ICDS workers are also **more attentive to the emotions of the children in their care** – they are better able to "read" them, thanks to the exercises with 'baby cues cards' as part of the HHI workshop, and are more sensitive to their charges'. The greater focus on attachment and bonding in the HHI curriculum and its emphasis on engaging

Using games and demonstrations imparts new information and gives caregivers new ideas in how to support children.

with the centre's children through games, alphabet routines, story-telling, or in simple conversation has a very positive impact on the relationship between the didi and the children at her centre.

A less direct but no less important outcome associated with the HHI training relates to *anganwadi* workers' involvement with local *Mahila Mandals* and *Mahila Samitis* as part of their official duties. These state-organised women's meetings are platforms aiming to generate awareness among rural and tribal women regarding safe motherhood, child care, personal hygiene, etc.; in January 2009, nearly 650,000 women in Orissa were members of these groups. *Anganwadi didis* are expected to address these groups each month; *didis* who are HHI-trained often share the HHI training content with the village women. As a result, HHI's sphere of influence had widened, at no extra effort or cost.

Having made a case for the impact of HHI training on the knowledge and attitudes of caregivers towards child development, and having observed changes in the behaviours and routines of *anganwadi* workers and mothers, a key question remains: the subsequent impact of the new knowledge gained and the new behaviours adopted on the children themselves. In one crèche whose teachers received HHI training, **children have developed new hygiene routines**: every child brushes his/her teeth in the morning, and they bathe in the afternoon when their mothers return from the fields. They also insist that they wash their hands with soap before and after meals and after using the toilet. Some of them even remind their mothers to clean their hands before cooking or serving them food.

As further evidence, in comparing across children within selected households, mothers, fathers, and immediate relatives all appear unanimous in claiming that their **younger children, who had received the benefit of their mother's participation in HHI training, develop more quickly**. Even when rates of physical development are not very different across their children, cognitive and linguistic development appears to be markedly faster/better in their younger children – they speak sooner and more clearly and are more inquisitive. While closer investigation is required to separate

the developmental effects of being younger children and thus benefiting from their older siblings, parents appear convinced that it is their implementation of the HHI training that is responsible for the difference. A word frequently used to describe their older children is "shy," while their younger children, who have experienced the impact of the HHI training, are often described in contrast as "alert" or "smart" The latter are **more confident, more outgoing, more interested in their surroundings, and more vocal.** Important – and researchable – issues, of course, would be to see if there is any impact of the HHI training on the physical development and health of children, whether these differences persist into primary school, and whether they have an impact on retention rates and performance in school.

An easily overlooked outcome of the training relates to the dominant socio-cultural context of Orissa: for many women, just **being invited to participate in a training programme is novel and confidence-boosting, validating and giving recognition to "women's work"**. With *anganwadi* workers as well, participating in a workshop where their voices are heard and incorporated, does much for their self-confidence. They also appreciate the opportunity to receive the training completion certificate from the hands of important local officials or supervisors at the close of the HHI workshop.

Noteworthy Practices

In conclusion then, the HHI training intervention has many noteworthy elements. These include the following:

- the *modality of the training sessions* that emphasises a participatory pedagogy, models/demonstrates *how* caregivers can engage young children, and is organised around the routines and schedules of the participants, thus minimising disruptions to their daily lives
- the *content of the curriculum* that emphasises caregiver interactions with young children over the role of learning resources (toys, aids, or literacy levels of care givers), focuses on very specific age-appropriate activities that caregivers can *perform* which emphasise holistic development,

> ... a very positive impact on the relationship between the didi and the children at her centre. Where they used to ignore their anganwadi didi or hide in fear from her, they now ran to welcome her when she arrived in the village!

Grandmothers often play a key role in caregiving in India.

and seeks to comprehensively target participants, intervening at multiple levels simultaneously (awareness, knowledge, behaviour, material resources, etc.)

- the purposive *scope for contextualisation* and cultural relevance in the curriculum, requiring the participation of local trainers and allowing for the incorporation of local games, songs, and stories
- the *distributed implementation model* that reaches a larger number of communities directly, through the participation of local grassroots organisations, increases the credibility of the programme among local communities, and embeds training delivery skills and ECD practices within local NGO networks
- the *cost-effectiveness of the training interventions*, partly as a result of the distributed implementation model and partly because of the commitment of the organisations involved
- the *fit of the training intervention* to

the context, meeting both a 'real' need in rural Orissa where lack of ECD awareness is a significant contributing factor to high infant mortality and malnutrition rates and the needs of the state's expanding ICDS project, which is marked by an insufficient number of Anganwadi Workers Training Centres, a lack of written training materials, and the reduced training offered for new *anganwadi* workers and that targets high-poverty, rural communities with a significant proportion of lower caste and tribal populations

• the **impact of the programme** in terms of observed and reported increases in the awareness of the significance of ECD for the life chances of young children; changes in nutritional practices and personal hygiene routines at the household level; increases in bonding between anganwadi didis and their charges; and attitudinal and behavioural changes among primary and secondary caregivers towards children's cognitive and linguistic development, reflected in children typically described as "alert" or "smart" rather than "shy"

Concluding Thoughts

It will always be difficult to know whether these positive changes are attributable to HHI training or a more widespread modernisation through state and media efforts. Direct observation and anecdotal information suggest that children of mothers with HHI training are more likely to wear clean clothes, exhibit daily hygiene routines, and have food that was better planned in terms of nutrition than children of mothers of similar socio-economic background who have not undergone HHI training.

Longer-term, in-depth studies would certainly be useful along these lines. For instance, ethnographic approaches can help to observe and describe changes in child development practices in the daily lives of communities; comparative studies (at the household, village, or even country level) can provide insights into what configurations of interventions are most effective with respect to socio-economic, cultural, and political contexts; and quantitative longitudinal studies can attempt to correlate training interventions with specific, quantifiable child development outcomes (such as weight gains).

Several points are clear. The effectiveness of HHI's mothers' training is mediated by socio-economic status; greater impacts are likely for children in households that are comparatively less poverty-stricken – not only as a result of material differences, but primarily as a result of fewer demands on mothers' time. These mothers do not face the same pressure to work long hours outside the home as compared to those in poorer households and thus have more time to invest in early child development. In less resourced households, while mothers' awareness of appropriate childhood development has increased, the dire lack of resources and mothers' need to work often preclude significant child-oriented changes in the household.

Moreover, in such households the care of young children is the responsibility of the older women in the house – children spend more time with their grandmothers and great-aunts than with their mothers. Since the prime target audience for HHI training consists of mothers with children below age three, households where grandmothers are responsible for childcare may end up being excluded. A more flexible definition of the 'primary caregiver' would go some way towards addressing these households and ensuring that the training does not inadvertently reproduce economic disparities.

If socio-economic status is the limiting factor when it comes to mothers implementing HHI training, for *anganwadi* workers, it is their personal commitment and the extent of the "extra" duties (such as implementing state censuses and data collection efforts) that often fall on them. While it is true that the HHI workshop may itself have a positive impact on personal commitment by reminding *didis* of the important role they play in the lives of their charges, for more sustainable impact, salary structures and work duties may need to be reconsidered. A more directed intervention to motivate them may also be called for.

HHI training is clearly a positive intervention, equipping mothers and secondary caregivers to play more proactive and positive roles with respect to child development. The participatory mode of the training and the modelling of appropriate behaviours by trainers are central to the effectiveness of the workshops. That the workshops target different types of caregivers and reach so many participants despite limited resources is a testament to the commitment of the participating organisations as well as a reflection of the distributed implementation model employed.

Maintaining such commitment – both of these organisations and of the trained caregivers – and thus sustaining and expanding the HHI programme are not easy tasks, especially given the limited financial and human resources available. But the need for improved childcare practices in Orissa is indubitably large, and HHI's intervention shows great promise in meeting this need. The challenge will be to find the necessary support to ensure that this promise can be fulfilled and the work of HHI therefore sustained and replicated.

Children enjoy being a part of trainings.

Bangladesh: The Cascale Model

By Miriam Thangaraj, Research Fellow

Abstract

The Early Childhood Development Support Program-Bangladesh (ECDSP-B) has developed a "cascade model" of implementation through which it seeks to transform the nature and size of the early childhood development sub-sector in Bangladesh. While Bangladesh has recently committed to universalising pre-primary education, local ECD expertise is concentrated in a very small number of non-government organizations (NGOs) largely dependent on international resources. The ECDSP-B aims to strengthen Bangladeshi ECD programming capacity by investing in ECD models developed by three Bangladeshi NGOs and supporting them in replicating their model through nine smaller NGOs that are active in hard-to-reach areas. ECDSP-B support includes extensive technical capacity building, a comprehensive monitoring and evaluation system, and resources for organisational development. In the process, not only are hard-to-reach communities served, but local ECD models and specialists are developed within a network of local NGOs.

One example of this model - the case of Friends in Village Development, Bangladesh (FIVDB) in partnership with Prochesta – is particularly noteworthy in terms of what it has achieved for the participating organisations and the beneficiary target groups.   These noteworthy elements include the following:

- **a two-layered implementation structure** that purposively builds a network of organisations that can collaboratively replicate locally developed ECD models
- **extensive technical capacity building** with support from the Institute of Educational Development (IED) and **organisational development** with external service providers' support
- **the participatory modality** of the cascade model, essential for maximising the learning provided to organisations at all levels
- **simultaneous investment at the individual, organisational and sectoral levels**

Introduction

Given its scope and *raison d'être*, it is perhaps no surprise that the Early Childhood Development Support Program-Bangladesh (ECDSP-B) was two years in planning. The "cascade model" at its core is not only designed as a multiple-level, capacity-building exercise; the diversity of its partner organisations, geography, target groups, and ECD models only adds to its complexity. Set in a context marked by high levels of poverty and relatively low levels of ECD expertise, a state weakened by recent political instability, and a non-governmental space often described as "competitive" rather than cooperative, the ECDSP-B, supported by the Aga Khan Foundation, has a radical – and much needed – agenda.

With a five-year operational plan (2008-2013), a rather spare programme staff, and a budget of about US $9.5 million, the Programme aims to strengthen institutional capacity in ECD programming by investing in locally proven ECD models and in a network of local NGOs. As a relatively new programme, several aspects of it are still very much work in progress; highlighted here, therefore, is its cascade model which helps to demonstrate its effectiveness in developing local ECD capacity and its consequent impact on the vulnerable communities targeted through the lens of one of the Programme's three major partners, Friends in Village Development, Bangladesh (FIVDB).

Background

A new national policy framework for preschool education in Bangladesh stipulates that it must be universal in provision. This is significant in the Bangladeshi context for three reasons: (a) the country's rapid progress in lowering under-five mortality resulting in more young children requiring more developmental support; (b) continuing challenges in increasing the initial enrolment, retention, and achievement of children in primary school pointing towards need for expanded ECCD services to help improve the internal efficiency of the education sector, and (c) a level of economic development with more than 80% of the population living below US $2 dollar a day showing the need for free/subsidised services and support to young children and their families.

To arrive at an understanding of the present-day ECD context in Bangladesh, one must keep in mind that the past decade and a half of programming has been driven primarily by non-government organisations with the Bangladeshi state arriving fairly late on the scene. The dependence on international funding and expertise has meant that local NGO participation has been restricted to a few implementation partners; it has also meant that most ECD efforts have been small-scale and scattered, with a view to developing preschooling models, rather than large-scale, sector-wide, and state-directed. The sector's origins in preschooling programmes, as a response to Education

BANGLADESH

> While the start of the current century saw a gradual increase in resources for ECD in Bangladesh, ECD continued to be largely driven by international organisations... and continued to primarily focus on pre-schooling.

for All (EFA) goals, also means in practice that ECD is often conflated with ECE (early childhood education).

At the start of the 1990's, with the focus on basic education post-Jomtien, ECD in Bangladesh was not an attractive issue and did not garner much interest or funding from international or national development agencies. What ECD programming took place was either small, idiosyncratic, or led by international NGOs which targeted young mothers in the form of parenting sessions. By the mid-1990's, home-based early learning centres were being opened in rural areas, also funded by international NGOs; most of these did not have any formal curriculum but were based on free play. However, with concerns increasingly raised about high primary school drop-out rates, the case for preschool education gained ground. In response, a few international development agencies started up ECD programmes in Bangladesh; Save the Children USA (SC-USA) and Plan, for instance, mobilised international resources for school preparatory programmes that were implemented through partnerships with national NGOs. However, as the national EFA monitoring report of 2000 noted, neither the concept nor the need for Early Childhood Care and Education (ECCE) was "well established" in Bangladesh; indeed, the Report declared that "as far as EFA goals and targets are concerned, ECCE is one of the weakest areas." (UNESCO, 2000)

While the start of the current century saw a gradual increase in resources for ECD in Bangladesh, it continued to be largely driven by international organisations (UNICEF, SC-USA, PLAN, UNESCO) and continued to focus primarily on preschooling. The role of the Bangladeshi state was negligible and there was little in the nature of formal support for ECE. Indeed, in several cases, schools resisted the integration of NGOs'

early learning programmes into the formal school system so that there was very little change in preschool enrolment from 2002-2005.

In 2005, however, the state began to play a more active role with respect to ECD. With more international resources mobilised for ECD and a growing presence of ECD service providers within the country, the Bangladesh government developed the 2005 National Plan of Action (NPA) III for children which identified preschool educational activities as a major area of intervention. A key government commitment in the NPA was to phase in pre-primary education into all its primary schools by 2012; given that current coverage is well below 30%, such a commitment would require about 90,000 pre-primary centres across the country. Clearly, a huge investment in ECD services is essential.

Despite increased state interest and greater public demand, it is clear that ECD continues to be a relatively new concept in Bangladesh. In many ways, constraints reported by the EFA Assessment Report in 2000 – the lack of awareness, experience, data, institutions, learning materials, and trained teachers – continue to mark the Bangladesh ECD context. The national government also admits to a severe lack of resources for pre-primary education and for teachers in particular. Indeed, apart from a handful of preschool programmes developed by international organisations

and implemented by a small pool of national NGOs, the capacity and infrastructure to support the state's ECE expansion plans are decidedly limited.

Aggregate data on the pre-primary education sector in Bangladesh is hard to come by. As estimated by NGO personnel in Bangladesh, currently less than a fifth of government supported 'registered' and 'non-registered' primary schools are associated with a preschool. An estimated 18,000 preschools are also open, operated by private providers and typically aimed at the urban middle and upper classes. In response, ECE programmes run by international organisations have sought to extend coverage to less privileged groups.

Typically, their primary focus has been to develop successful preschooling models for replication rather than significantly expand early childhood education per se. On the other hand, national NGOs such as Grameen Shikkha and the BRAC Education Programme, relatively recent entrants, have engaged in rapid expansion, currently operating over 20,000 non-formal learning centres. The Islamic Foundation is also a major – if less talked about – player, running as many as an estimated 25,000 or more religious education centres for preschool-age children. However, these centres are not linked to the formal education stream and have been relatively isolated from the national ECD policy discourse; with a curriculum more religious in content and

Figure 1:
The Cascade Model
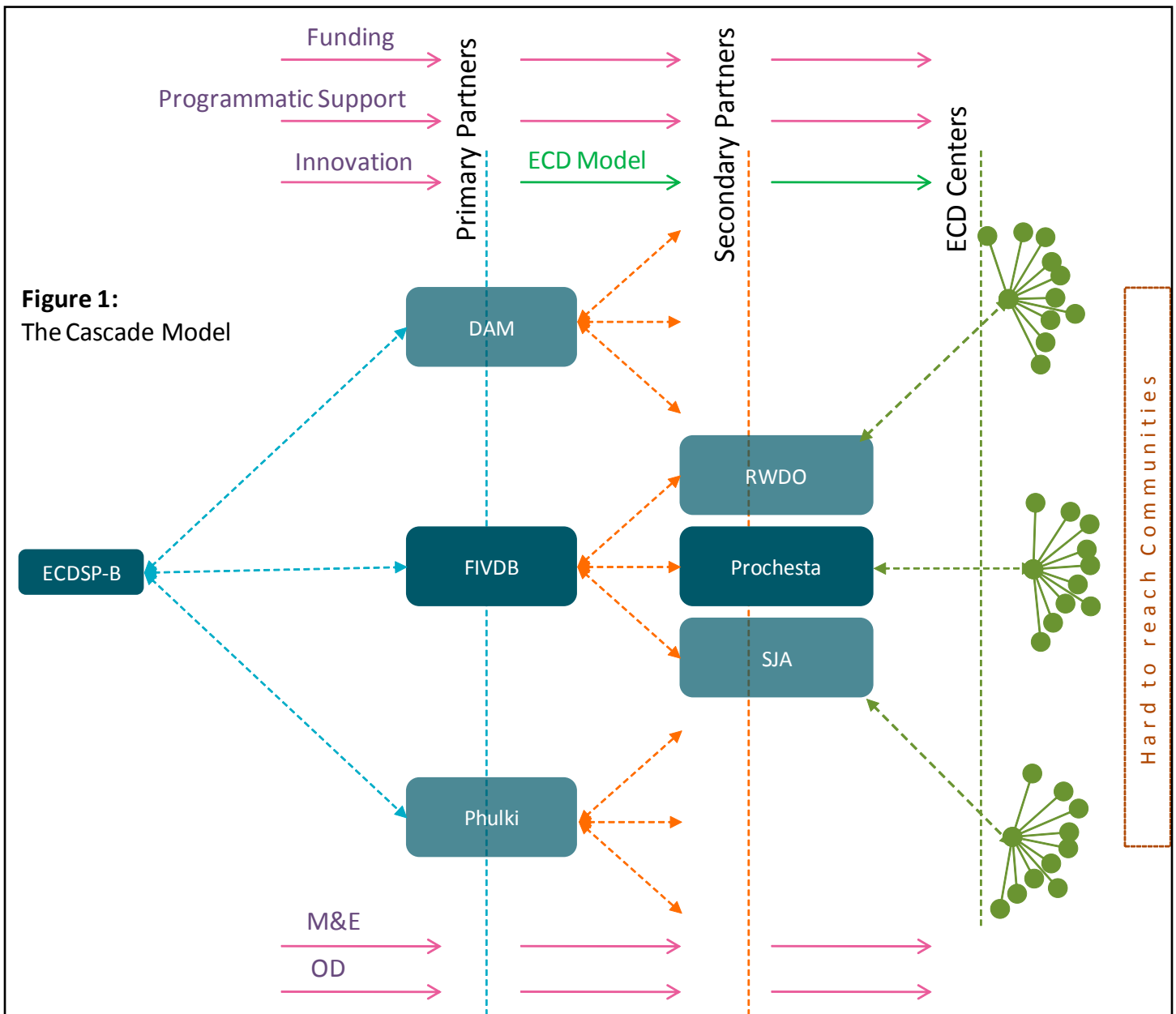
less ECD-specific, it remains to be seen how they are integrated under the National Policy Framework for Pre-primary Education.

ECD programming and implementation expertise is concentrated in a relatively closed network of development agencies; a mere 16 NGOs account for 95% of NGO-run pre-primary education centres in the country. With the state committed to pre-primary education for all 3-6 year-olds, the very large and significant challenge of building adequate local capacity remains.

But local NGOs in development have tended towards dependent relations with northern NGOs. And while the number and size of NGOs are perhaps greater in Bangladesh

than in any other country of comparable size, over 85% of foreign funding is consumed by a very small group of ten NGOs. In the evocative words of Ahmad, the Bangladeshi NGO context continues to be marked by "'donorship' rather than 'partnership'" (Ahmad, 2000). Thus, building local ECD capacity becomes a priority.

> ... in the evocative words of Ahmad, the Bangladeshi NGO context continues to be marked by "'donorship' rather than 'partnership'".

It is this reality that AKF's ECDSP-B Programme seeks to address. The Programme intervenes by developing and investing in a network of local organisations that can participate in expanding pre-primary education in Bangladesh and, in the longer-term, be less dependent on INGOs. As a self-labelled "Support Programme", the resulting cascade model of implementation is careful to adhere to "the principles of local ownership [and] partnerships for effective development;" at the top of its list of targeted outcomes is "sustained improvements in organisational capacity" of its local partner organisations (Aga Khan Foundation Canada, 2008). By investing in the ECD capacity of its local partners, the Programme sets them up to capitalise on

the Bangladeshi government's commitment to universal pre-primary education as well as keep pace with larger-scale development funding shifts. Simultaneously, it builds a set of relationships within the ECD sector that can continue to disseminate knowledge even after the Programme ceases to operate. That these relationships cut across multiple levels, bringing together research universities in Dhaka and elsewhere, civil society organisations of varying sizes and spheres of influence, and the pre-primary classrooms on tea gardens or the day care centres on garment factory-floors, augurs well for the Bangladesh ECD sector.

Programme Description and Implementation

The Early Childhood Development Support Program-Bangladesh, ECDSP-B, is a five year (2008-2013) effort with a budget of about US $9.5 million funded by CIDA (the Canadian International Development Agency) and Aga Khan Foundation Canada. It aims to strengthen Bangladeshi ECD programming capacity by establishing partnerships with three medium-sized civil society organisations (CSOs) (referred to as Primary CSOs or PCSOs) to build and mentor the technical capacity, and finance the activities, of nine smaller CSOs (referred to as Secondary CSOs or SCSOs). The secondary CSOs are relatively new to the ECD subsector but by virtue of their local presence, can readily access hard-to-reach communities. (See Figure 1)

Secondary partners are provided technical support and financial resources to implement the primary partner's ECD model in the local communities they serve, thereby promoting transfer of ECD skills and knowledge from primary to secondary partner and ultimately to the community– the "replication" component of the Programme. Currently, secondary partners have replicated the ECD model of its primary partner in ten sites each. ECDSP-B supports the replication component with ongoing **monitoring and evaluation (M&E)** activities. It also invests in its primary and secondary partners in terms of both **programmatic support** (the "capacity building" component) and the provision of resources for **organisational development** (the "OD" component). In addition, the Programme offers its primary partners resources to experiment with and

further develop their ECD models (the **"innovation"** component). Finally, the Programme seeks to build research and advocacy links among partners, educational institutions (primarily the ECD Resource Centre at BRAC University), and other ECD service providers (through Bangladesh ECD Network).

The Programme is clearly complex and ambitious in its scope and design. How it works in practice, in the specific case of FIVDB, one of the Programme's three primary partners, demonstrates why the cascade model, despite its complexity, is already having an impact on participating organisations and beneficiary communities.

The Primary Partner

FIVDB's primary area of operation is the north-eastern Division of Sylhet, where it has a large and long-standing presence (with over 1,200 staff, it is the largest NGO in the region). The organisation grew out of the work of International Voluntary Services in 1981. FIVDB has a diverse portfolio of activities, at its core are non-formal adult education and life-long learning while later additions include livelihood enhancement, primary education, ECCD, and community health and sanitation, among others. Thanks to its established track record, the organisation enjoys tremendous credibility with both the community and the state administration. Indeed, FIVDB was an easy choice for ECDSP-B as a primary partner and is one of a relatively few Bangladeshi organisations involved in ECD service provision.

While size and ECD involvement were the primary criteria for the selection of primary partners, the choice of FIVDB also allowed for targeting hard-to-reach communities – such as those on Sylhet's famous tea gardens or in its flood-prone areas. FIVDB therefore facilitates the Programme's objectives of reaching socially and economically vulnerable groups. Moreover, with Sylhet having the lowest enrolment rates for primary and pre-primary education among the seven Bangladesh Divisions as well as the lowest concentration of NGOs, partnering with FIVDB strengthens ECD delivery in a context of greatest need.

FIVDB's participation in basic education

began in the eighties. Today, the organisation operates a network of about 330 primary schools. In 1985, "*shishu shreni*" – 'baby classes' for children below six years – were also established within FIVDB's primary schools. These baby classes developed into the year-long early childhood education model for 5 to 6 year olds which was selected by ECDSP-B as one of its replication models.

The ECD Model

The model has a three-pronged curriculum of reading, mathematics, and environmental science. The reading activity uses beautifully illustrated picture books to facilitate interactive story-telling with 19 sets of stories organised into two levels of language difficulty. The stories have recurring characters that students can easily identify. Woven into these stories are lessons on the relationships that young children navigate in their daily lives, and pictorial writing exercises at the end of each lesson offer students the space to describe and reflect on the relationships in their own lives. The mathematics and environmental science curricula are also based on active learning through games; these often involve the learning corner at the ECD centre or the surrounding area immediately outside. Environmental science also includes a hygiene component with a focus on cleanliness at home.

FIVDB's *shishu shreni* was put through a quality audit by the ECDSP-B. Not only did this contribute to refining the ECD model that was replicated, but its findings continue to serve as the baseline for ongoing technical evaluation and development of the model. Thus, the replication model is constantly worked on even as it is being implemented. This focus on finding and filling in the gaps found in FIVDB's ECD model is part of the Programme's innovation component.

For instance, the initial Quality Audit determined that the FIVDB's model had a rather academic school preparedness focus; hence, FIVDB's in-house ECD specialists, with support from the ECDSP-B, widened its focus to include physical and emotional development components for more a holistic ECD model. In fact, it is the partnership with the ECDSP-B that has seen the FIVDB ECE model evolving into an ECD model. From

Figure 2:
The Programme's "Innovation" component results in a constantly evolving ECD Model for replication
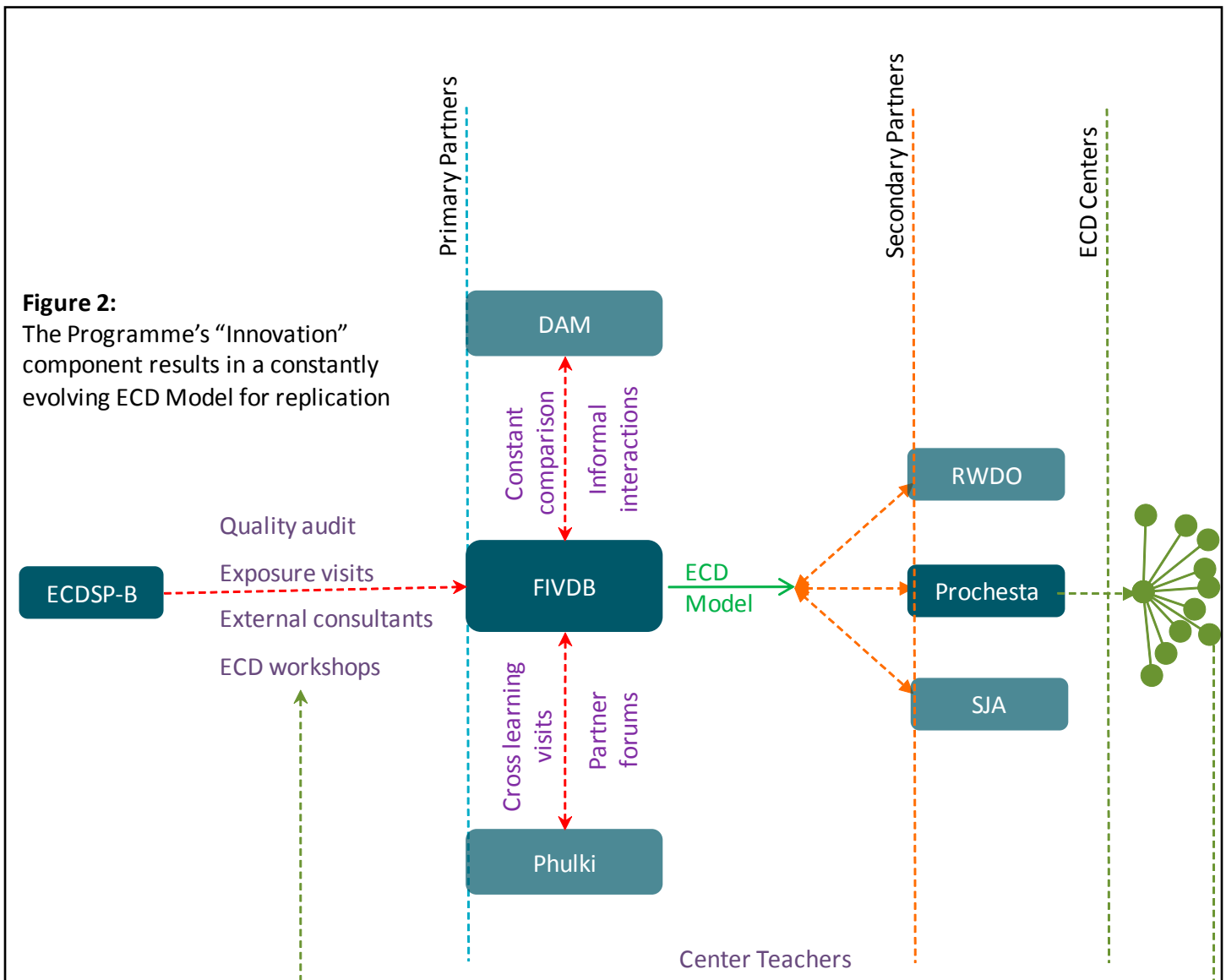
the nearly 100% focus on school readiness that characterised the initial ECE model, FIVDB team members estimate that today over 40% of students' time is spent on free play, physical activity, and interactive story-telling.

The refinements to the model are often facilitated by external consultants that primary partners are able to access via the Programme. While large organisations such as FIVDB may be in a position to procure one or two consultants, having a wider pool of expertise to draw upon as well as the ECD expertise in AKF's international network has enabled greater innovation to occur. The present curriculum and pedagogy have a more explicit focus on health and hygiene issues as well; thus, checking the classroom's general cleanliness as well as students' nails, teeth, and personal hygiene

has been institutionalised as daily class routines. A recent innovation has been the inclusion of a bimonthly cultural programme; every other Thursday, students have the opportunity to perform local songs, plays, and dances.

Parenting sessions have also been added to the FIVDB ECD model, distinct from its shishu shreni model; these sessions target mothers and fathers, aiming to achieve greater alignment between the home and the classroom for sustained child development. Parenting sessions also serve as an opportunity to address the care of younger children in the 0-3 age range who are not otherwise directly covered by the FIVDB ECD model and purposively seek to encourage fathers' participation in bringing up their children. Other additions and changes to the FIVDB model are ongoing –

a five minute physical exercise routine, for instance, is in the process of being adopted in consultation with the ECDSP-B. Thus, the ECD model is constantly evolving to better meet the needs of the communities served.

Such flexibility is in sharp contrast to most ECD projects where not only are programme indicators and goals statements provided by the (typically international) lead agency to local implementing partners, but also there is far less room to experiment with the ECD model once a project is underway. Indeed, such flexibility and experimentation are often discouraged, with the role of the local NGO typically limited to implementation, and success of the project is measured in terms of its ability to adhere to comprehensively laid out guidelines. In contrast, the ECDSP-B has not only invested in the ECD models of Bangladeshi organisations such as FIVDB,

but has actively supported experimentation with their ECD models; the Programme's resources and monitoring and evaluation modalities allow partners room to redesign and innovate as appropriate. This flexibility not only contributes to the strengthening of the organisations' in-house ECD capacity but also permits a greater awareness of the contexts and the communities that are being served.

Many of the additions to the FIVDB model are a direct result of periodic ECD workshops and exposure visits organised by ECDSP-B for its partners which involve a purposive effort to encourage the building of cross-cutting, knowledge-sharing networks. Such workshops connect personnel from across the ECD spectrum in Bangladesh, offering a platform for mutual learning and enabling greater participation across levels. In one instance, centre teachers contributed popular local games – *phul tuka* or *bouchi* for example – that were subsequently used as part of the FIVDB model. Moreover, the constant comparison and reflection on practice with other models that is made possible by such opportunities has pushed

project staff to focus on all four child development domains, achieving a more appropriate balance in their ECD model. (See Figure 2)

Improvements to individual models from constant comparison with others is also aided by quarterly Partners' Forum meetings where representatives from all primary partners share with each other and the ECDSP-B team their progress on the different programme components of replication, innovation, capacity building, and OD. Also present are staff from IED to provide technical input and better coordinate professional development and capacity-building activities. These periodic meetings are supplemented by cross-learning visits where partners have an opportunity to learn first-hand how other partners are faring with implementation. Events such as these also help initiate other, less formal interactions among partner organisations.

The Three Programmatic Pillars

In addition to investing in the innovation of the ECD model that is replicated, the

ECDSP-B supports replication through the three programme components of capacity building (support for organisational and individual level technical capacitation in ECD), monitoring and evaluation (tracking the Programme's outcomes and outputs), and organisational development (strengthening policies and processes at the organisational level). Such encompassing investment is unprecedented and makes the Programme unique in Bangladesh.

The three programmatic components were also designed to strictly cascade down from primary to secondary partners; the role of the primary partner as mentor is purposively emphasised in Programme implementation. (See Figure 3)

Of the three programmatic pillars, ECD capacity building is at the heart of the Programme. While FIVDB has in-house ECD specialists and years of experience implementing preschools, given the paucity of ECD personnel in Sylhet, the project team that works with the ECDSP-B is very young and relatively new to ECD. Since the project team members are responsible for training secondary partners to replicate and implement their ECD model, the ECDSP-B must invest in their professional development if the replication process is to stay on track. In addition to capacity building activities, the Programme supports a plethora of initiatives as part of its technical capacity building initiatives at the individual level, from specific training sessions and workshops to a master's level ECD course offered by IED. The Consolidated Training Calendar put together by the ECD Specialist at ECDSP-B derives from a formal training needs analysis and also intervenes at the individual level. While FIVDB's distance from Dhaka, where IED is based, precludes its team members from taking advantage of some of these learning opportunities, the Programme has attempted to organise short-term, intensive training sessions for them.

Equally, team members feel motivated by the scope they have to employ their own ideas; despite being relatively young and inexperienced, they see themselves as not just carrying out activities, as with other projects, but being fully and personally engaged by the Programme. Participation in the Programme has given the FIVDB team

Figure 3:
The three primary programmatic components
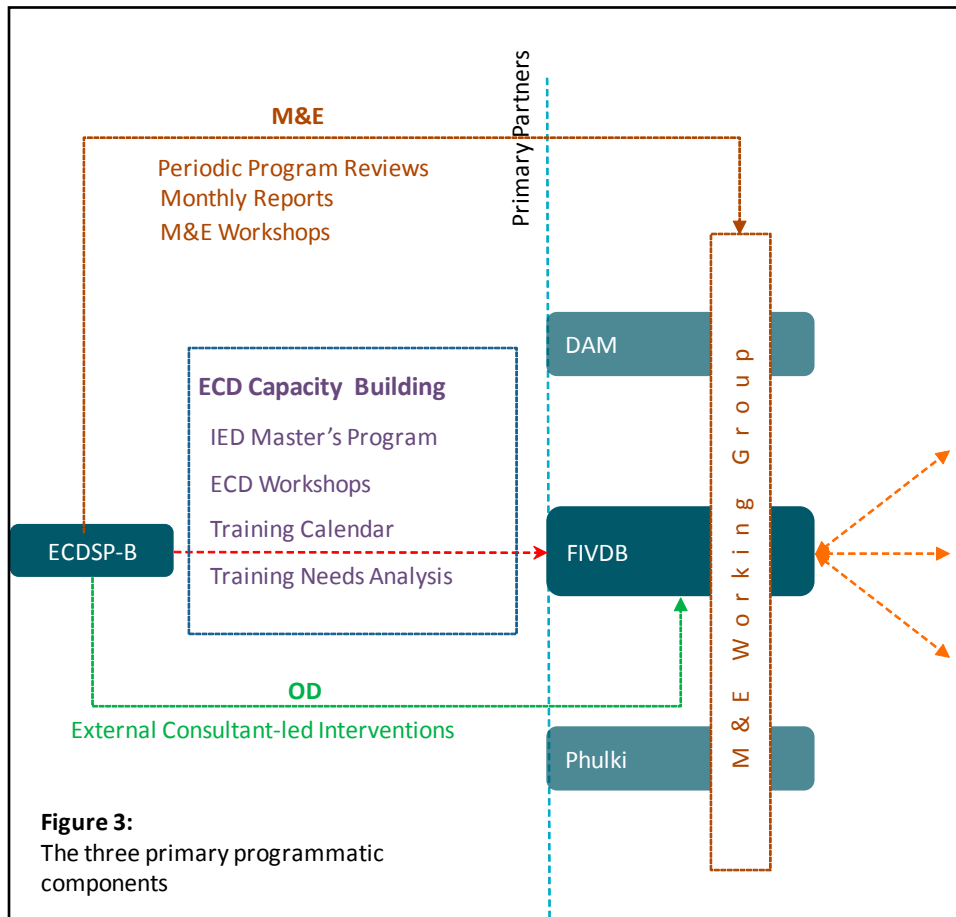
a huge amount of confidence in addition to technical capacity.

Given the size and complexity of the programme, M&E is one of the key components of the Programme, a de facto backbone that holds together its various individual elements. It not only ensures that the implementation of the Programme is on track but also builds M&E into partners' ECD and organisational models. The alignment between the M&E and ECD pieces of the Programme is one of its strengths even if it is too early to tell whether its results-based management (RBM) approach is proving more effective than other models.

As the M&E specialist put it, the RBM approach seeks to move partners from a focus on activities to a focus on outcomes and outputs and, in the process, helps align activities with outcomes. These are measured in terms of impact on target groups – indicators such as enrolment and transition rates for pre-primary education, for example – while outputs are intermediary achievements leading to positive outcomes in the longer-term (e.g., technical and organisational capacity building measured in terms of quality audits, self-assessment scores, and training programmes). While the RBM model was a relatively top-down decision mandate by CIDA, it continues to be developed, with new/different indicators, competencies, and data collection emphases added on an ongoing basis.

As with much of the Programme, the mode of M&E activities emphasises a team-based participatory approach that is crystallised in the M&E Working Group, which consists of the M&E personnel from across partner organisations. While partner personnel may not always have the requisite technical capacity to be full participants at the M&E table, they are nevertheless purposively involved in M&E activities as a means of "learning by doing" – the M&E component is as much a learning exercise for partners as it is a monitoring process. This presents an opportunity for FIVDB's M&E Officer to be part of the entire M&E process, from identifying competencies to rolling out the framework in secondary partner organisations. In addition, the Programme provides M&E personnel formal learning opportunities based on self-assessment of training needs.

The M&E component is also implemented as a cooperative effort; for instance, the 30 FIVDB-supported ECD centres were reviewed by an M&E team that was constituted from M&E personnel from across partner organisations as well as the ECDSP-B team. Such joint programme quality monitoring efforts reflect the trust among organisations built over frequent and ongoing interactions among M&E personnel. These interactions are enabled by monthly, quarterly and annual reviews organised at various levels of the Programme and make the relationship between primary and secondary organisations more open to joint scrutiny. Moreover, these M&E forums also connect partner personnel with each other; younger M&E professionals, for example, are mentored by more experienced personnel of the Working Group.

In addition to technical capacitation and M&E, which directly feed into the replication process, the ECDSP-B has also invested in the organisational capacity of its primary partners. This approach is a move away from the event-based culture that often characterises capacity building and towards institutionalising it within organisational systems.

OD interventions are determined on the basis of partners' self-assessments and driven by their priorities; indeed, the partners also decide which measurement tools would be best suited to their organisational context. In fact, the interventions are delivered by a third-party consultant to prevent OD interactions from becoming de facto assessments or a form of surveillance by the ECDSP-B. This is important to note; given the competitive NGO landscape where a few local organisations are competing for funding from a handful of bilateral and multilateral funding agencies, the OD component may easily intimidate primary partners.

As FIVDB has pointed out, similar fears about surveillance must be allayed at the employee level as well, who may see outside intervention as destabilising. For OD to be effective, it is important that neither the personnel nor the primary organisation itself feels threatened by having to (self) assess their performance. Organisations are assessed in areas such as human resources systems, succession planning, project management, financial systems, training,

and gender development, among others. Based on these self-assessments, FIVDB has developed a two-year work plan, to be implemented with support from external consultants and the ECDSP-B team. A key OD achievement at FIVDB has been the development of a comprehensive gender policy for the organisation.

OD interventions offer greater returns for secondary as compared to primary organisations. The latter are well-established and well-capacitated organisations; for them OD is more an opportunity to fine tune existing systems and align practice and policy rather than an organisational priority. For instance, FIVDB's baseline self-assessment scores on most organisational capacity areas fall in the "acceptable" or "above acceptable" range. Of course, be it secondary or primary organisations, OD must support rather than supplant the ECD replication component.

The Two-tiered Structure

Central to the achievement of the stated objectives of the Programme is the two-tiered partnership structure; it is also perhaps the most unique element of the Programme. Instead of working with the primary partner, FIVDB, to directly implement ECD centres in Sylhet – arguably a more efficient approach, at least in the short-term – the Programme has chosen to recruit three smaller local NGOs as secondary partners with which the FIVDB works. While the ECDSP-B does have a large and oftentimes leading role, it is the joint responsibility of secondary and primary partners for programme implementation that the cascade model emphasises. To reiterate, the key programme objective is the creation of a network of local organisations that can take on the challenge of universalising ECD provision in the country, rather than to merely establish ECD centres.

To bypass the two-tiered cascade process in the name of efficiency would dilute the ownership and responsibility of primary partners and be inimical to the development of a strong, locally-led network of ECD organisations. This sentiment is reflected in the Programme's structure in which it is the primary partner – and not the ECDSP-B team – that enters into contractual relations with the secondary partner organisations. After all, it is the FIVDB model that is replicated by

its secondary partners, and it is the FIVDB project team that plays the leading role with respect to its secondary partners in the implementation of their *shishu shreni* model. Thus, while the partnerships are built under the aegis of the ECDSP-B, the success of the cascade model hinges on the involvement and commitment of the primary partner to its secondary partner organisations.

FIVDB personnel often reiterate that ECDSP-B does not impose its directives on them and compare the Programme's flexibility favourably in comparison with other projects. This flexibility also attests to the management style of the individuals on the ECDSP-B team – without respectful and mentoring relationships at the personal level, primary partners may feel marginalised in decision-making.

As one of FIVDB's management personnel has put it, if the ECDSP-B team were to bypass them, choosing to work directly with secondary partners, it would be a "shocking breach of trust." Thus, FIVDB is typically involved in all activities involving its secondary partners; all resources for the latter are channelled through the former, and while in practice the cascade model may be occasionally overlooked, it is strictly adhered to in terms of funding.

The Secondary Partner

Once primary partners and replication models were lined up, the critical next step was the identification of secondary partners. FIVDB was an integral part of this selection process, recommending organisations they could potentially work with; the ECDSP-B team, however, made the final decision after a round of due-diligence processes. Selection criteria were not very demanding (justifiably so in the Bangladeshi ECD context): secondary partners were to be small organisations, with a degree of involvement in education provision of some kind, an expressed interest in ECD, and a significant presence in relatively less accessible, remote areas. Thus, FIVDB's three secondary partners – Prochesta, RWDO, and SJA – are not only part of a fairly sparse NGO landscape in Sylhet; they also each work with communities that are hard-to-reach. Prochesta and RWDO, for instance, work with communities settled on some of the tea estates in the area while SJA works with conservative fishing communities.

The partnership between FIVDB and Prochesta showcases well the second layer of the cascade model. Prochesta was established in 1994 in Sylhet as an independent NGO implementing a range of projects in education, health, and gender, with a special focus on young children and adolescents in areas of very high poverty. The organisation runs a number of centres that reach out-of-school children or offer non-formal primary education. The organisation's work in tea gardens began as an effort to address gender violence among the ethnic minority populations who work as tea leaf pickers on these gardens. To quote Prochesta's Chairman, its interest in ECD stems from its desire to transform the future of communities that are linguistic, ethnic, and religious minorities, such as those settled in the tea gardens. Between October and December 2009, the organisation partnered with the ECDSP-B Programme to pilot FIVDB's ECD model. Currently, Prochesta operates ten ECD centres, five each in tea gardens and flood-prone areas. Two hundred learners and their families are served by ten teachers, ten co-facilitators, two programme officers, a financial officer, and a team leader. The beneficiaries are expected to triple in the next phase of the

Figure 4: Cascading capacity building activities
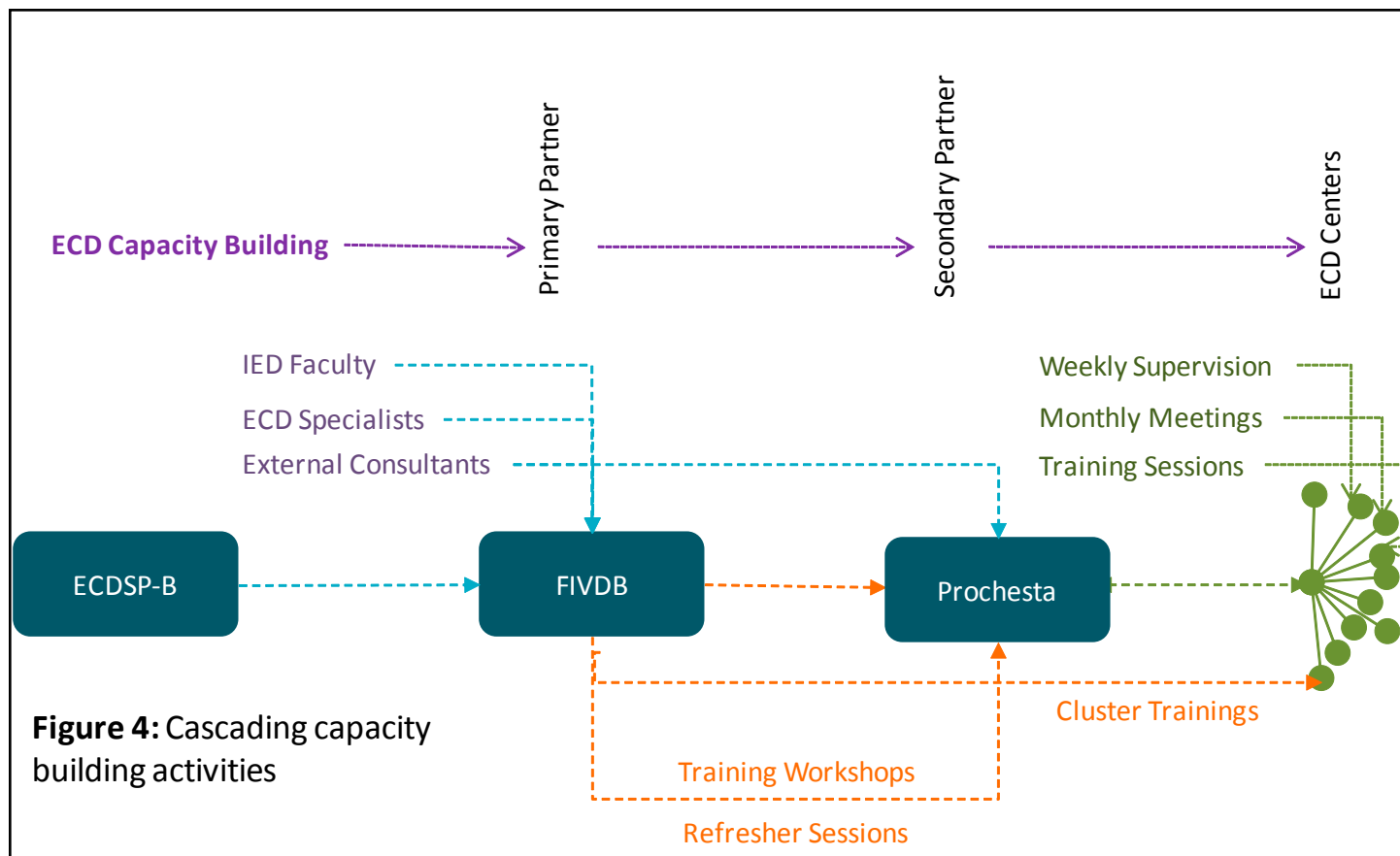
replication process when 20 new ECD centres are to be opened.

ECD Capacity-Building

ECD capacity building activities are at the heart of the relationship between primary and secondary partners. One example are workshops where team members from Prochesta and other secondary partners associated with FIVDB are trained in child development by the trainers on the FIVDB team. Since July 2009, the Prochesta team has participated in several training programmes covering a wide range of themes, from basic ECD knowledge and the FIVDB curriculum to specialised sessions on brain development and parenting. For members of the Prochesta team with no prior exposure to ECD, this extensive professional development was a unique opportunity and enabled a career shift from micro-finance to the ECD sub-sector within a year. (See Figure 4)

Much of this capacity building cascades down to the Prochesta team via FIVDB trainers. To illustrate, FIVDB team members are supported by the ECDSP-B to participate in a ten-day, three-credit course on brain development offered by IED faculty. Subsequently, FIVDB trainers delivered a brain development workshop for their secondary partner teams. While the cascade model remains the typical capacity building route, it has been relaxed in some cases, as a pragmatic response to the lack of local expertise. Gender training, for instance, was directly delivered to all secondary and primary partners by the ECDSP-B's centralised resources.

Training teachers for the ECD centres has been one of the most significant investments of the Programme as well as one of the most challenging. Again, the training follows the cascade model, with Prochesta's programme officers being trained by FIVDB trainers and, in turn, training centre teachers. At the end of a long process of knowledge transfer, teachers were identified by primary and secondary partners as the lynchpin of the Programme; the success of the replication process rests on how well teachers are trained. As a result, the cascade model's layered structure has been relaxed to accommodate more direct training interventions for centre teachers who are

Local teachers/ECD center facilitators trained by RWDO, a local NGO active in some of the tea estates of Sylhet Division. Like the communities they serve, these teachers have grown up on the tea-garden, and have familial roots in India.

not only trained by Prochesta personnel but often directly by FIVDB trainers as well. The initial set of frontline training – on child development for three days, on the preschool curriculum for ten days, and on parenting sessions for four days – is supplemented by ongoing refresher sessions delivered by Prochesta's programme officers as well as cluster training sessions that are conducted by trainers from FIVDB.

Programme officers also visit each centre every week to help teachers with any curricular or pedagogical issues and often support the delivery of parenting sessions. If a teacher finds it difficult to organise learners during group work, programme officers step in to demonstrate how it might be done. They also are more effective at responding to parents who are sceptical about new ECD practices.

In addition, all centre teachers have monthly meetings together to share experiences and frustrations with each other and the Prochesta team. Teachers, for instance, are happy that their "new way of teaching with love" brings them the respect of learners' guardians. On the other hand, teachers admit to difficulty in implementing curricular elements such as "shared writing."

While capacity building interventions such as training work primarily at the individual level, OD efforts intervene explicitly at the organisational level. As the Programme's lead designer has pointed out, the desire that small organisations such as Prochesta have for new knowledge and practices makes the Programme's investment go a long way. Organisations such as Prochesta are better described as project-based organisations; their resource-dependency means that their priorities are driven by implementation contracts rather than organisational structures. By funding and supporting the institutionalisation of organisational policies and management systems, the OD component helps transform them into full-fledged NGOs.

From offering Prochesta a means of scientifically assessing their organisational capacity, to prioritising areas of intervention, to systematically training personnel and supporting the implementation of new systems or even organising grant-writing and proposal development workshops, OD covers the gamut of activities: developing a participatory appraisal system; training workshops on performance appraisal systems and on financial management, communication, reporting and documentation systems; changes to existing personnel policies; adoption of the Programme's M&E systems and Project Implementation Plans, etc.

Given the small size and capacity of secondary organisations and their

dependence on the primary partner for ECD technical expertise, and given also that funding is routed through the primary partner, the secondary partner organisation may justifiably feel overwhelmed. Thus, without mutual respect between primary and secondary partners, ownership issues may become complicated. While the presence of the ECDSP-B team has a balancing effect , the quality of the relationship between FIVDB and Prochesta is primarily negotiated by the partner organisations.

This negotiation is grounded in programmatic outcomes. While FIVDB contributes the ECD model, it must rely on the more situated knowledge that secondary partners have if the ECD model is to be successfully replicated. Thus, the replication plan was developed by FIVDB sitting together with its secondary partners, taking into consideration the values and community contexts of these secondary partners. The frequent contact between organisations necessitated by the cascade model – in the form of training sessions, review meetings, quarterly forums, fortnightly field visits, etc. – enables strong personal connections across organisations. In addition to communicating through monthly reports, work plans, and activity reports, the Prochesta team also interacts with the FIVDB team on a daily basis by email, phone, or in person.

Good working relations between primary and secondary organisations at the implementation level also derive from interaction and trust built at the top management level; a direct and open line of communication has been established between the executive directors at Prochesta and FIVDB. FIVDB's reputation as a credible and transparent organisation plays a part as well. Any differences of opinion with FIVDB are seen in the light of feedback and learning rather than surveillance or imposition.

The two-tiered model and all the formal and informal exchanges between partners it requires support strong inter-organisational relations and facilitates the growth of an NGO network within the ECD sector in Bangladesh. There is a very good chance that such a network will outlast the five-year implementation period of the Programme, contributing to a sustained ECD presence in the country.

Children at an ECD centre run by partner organizations of ECDSP-B in the tea plantations of Bangladesh.

Reaching the Target Group: the Tea Gardens of Sylhet

In addition to seeding a network, the cascade model also aims to better serve target groups by partnering with local organisations. The Programme relies on Prochesta's access to the community, its good relations with tea garden managements, and its knowledge of the target group. These resources that secondary partners bring to the table are not readily available or easily replicable elsewhere in Bangladesh.

Secondary partners' longstanding relationships with local communities enable the enthusiastic participation of the community; they also support a greater degree of localisation. For instance, the Prochesta team leader grew up on a tea estate and is thus able to draw on his knowledge of the local community to strengthen programme implementation; the RWDO programme officer worked for over five years in one of the tea estates as part of a youth development project and has excellent connections with the trade unions and *panchayats* as a result. Their participation has come about because of the Programme's unique implementation approach.

Tea has been grown in the Sylhet Division since the middle of the 19th century, when tea plantations were established under the control of colonial Britain. Most of the workers across the 160 plus tea gardens in the region are descendants of workers who were settled in Sylhet by the British from various parts of India. Despite a century and half in Sylhet, these communities continue to be perceived as non-Bangladeshi, and despite their diversity in terms of language, ethnicity or religion – there is a significant tribal population as well – they are often spoken of as a single 'outsider' category in Bangladesh.

As a result, these communities have been historically marginalised, socially as well as politically, and despite being granted voting rights, they are far removed from the state's protection. With communities primarily dependent on the garden management for wages, housing, hospitals, sanitation, and education, the tea garden can be seen as a "a state within a state" with the garden management enjoying sweeping powers over the lives of the workers.

The wage rate, for instance, at about 48 *taka* (US $.70) per day is very low, usually insufficient to meet household expenses even when mother and father both work on the tea estate. Low incomes are compensated to an extent by a perpetual lien on land, free housing for workers, and subsidised food grain; workers also have access to the free health care centres, crèches, and primary schools that the

5 to 6 year olds at an ECD centre in Sylhet. The centre functions on one of the many tea gardens in the region.

garden management runs. These benefits are conditional on work status – they are strictly restricted to permanent workers – and on the management's goodwill and capacity with many garden managements providing poor or inconsistent benefits provision. Living conditions on tea gardens therefore are characterised by poor housing, lack of sanitation and clean water, inadequate health care, and low quality schooling.

Economic vulnerability is often exacerbated by relative social and political isolation. For instance, the entry of NGOs may be restricted on many tea gardens. The restricted access to these communities throws into further relief the activity of a handful of NGOs such as Prochesta and RWDO that have managed to find a foothold on the tea estates. Their

presence in these communities is the result of careful relationship-building with garden management, worker unions, and the community *panchayat*.

In a context where being proscriptive about workers' rights may result in NGOs losing access, Prochesta's is a pragmatic approach. The organisation ensures that its activities are not framed in direct opposition to the interests of the tea industry, instead focusing on the link between education and improved health and productivity. Their vision is for a new generation that is equipped to better their lives and living conditions without feeling compelled by their circumstances to leave tea gardens. Their strategy of working with the *panchayat* to demonstrate the community's demand for ECD services

also strengthens their case with tea garden management. This nuanced approach derives from Prochesta's understanding of the circumstances and contexts in which tea garden workers live; it reads very differently from the generic INGO rights-based approach, which typically alienates the management and is counter-productive in the context of garden management-worker relations.

In the last decade and half, a number of families from some tea gardens have managed to support their children's education beyond primary school; one of them has gone on to become a cardiologist – the first doctor from the tea garden community. His story has fuelled a desire among tea garden workers to see their children educated; it has made real for families the possibility of a life trajectory for their children that does not involve working as a leaf picker from 12 years of age. Thus, there is great demand to increase the coverage of the Programme seen in an unshakeable faith in education as a guarantor of a better future and the hope that schooling will enable children to leave the garden economy, moving into the formal economy on the outside.

Each of the five ECD centres operated by Prochesta in tea gardens accommodates 20 learners in the 5-6 age range. The location of the centres as well as the selection of learners was based on surveys carried out by Prochesta personnel. This data was then used by the community – represented by local elders and members from the *panchayat* and union parishad – to ensure that the most vulnerable children in the community were identified on a preferential basis.

Girls from the poorest families were purposively targeted; as a result, girls outnumber boys (60%) at the centres. According to ECDSP-B data, over 75% of the learners covered by the Programme in Sylhet fall into the 'very poor' category with an annual household income below 25,000 taka (Aga Khan Foundation Canada, 2010). Most of these children are also from the lower castes. This is a significant achievement, given that lower caste families are often perceived by the parents and community elders as not being interested in education.

Centres are rented from the community with

the permission of the garden management; several communities have pitched in with fans, additional building materials, or free labour to show their enthusiasm for these centres. A centre typically consists of a room, a potable water supply, and a toilet, but most centres are also well provided with rugs on the mud or cement floors, ceiling fans, blackboards, a learning corner with wooden blocks and locally-made stuffed toys, and a variety of charts and teaching aids. Learners are also provided two sets of uniforms each, but no nutritional support is as yet provided. Each centre is managed by a centre teacher and a co-facilitator. Most centres run for about two hours between 9:30 and noon. Attendance has remained strong, and barring illness, learners don't usually miss their mornings at the ECD centre.

Attendance has been less regular in the case of Parenting Sessions, a set of 16 bi-monthly, two-hour interventions directed at the parents of learners at the ECD centres. Led by centre teachers and supported by Prochesta personnel, the sessions aim to equip parents to effectively support child development and place a special emphasis on appropriate nutrition. The sessions also have a gender agenda as well; they promote the role of women in decision-making with respect to child development issues and encourage fathers to play a bigger role in caring for their young children. But it has proven difficult to ensure sustained parental participation; the sessions compete unsuccessfully with the many demands on parents' time on their one day off. Consequently, the FIVDB-Prochesta partnership is working with the ECDSP-B to develop a new parental outreach model that is centred on home-visits. The flexibility offered by the Programme enables such changes to be implemented on an ongoing basis.

Impact

Mothers of learners show that they are very proud of their children and of their **discipline** in particular; the children develop a daily routine (for example, preparing for class every evening and waking up early in the morning to reach the Centre on time) which is favourably contrasted with "those other children loafing about" on the tea estate. Mothers are also grateful that their children are looked after in the morning when the adults in the household are at work. In most

Women on the Center Management Committees (CMC) of three ECD centres that are being run on tea-estates in Sylhet. For most of these women, their CMC roles are the first they have held any kind of public position; for some of them, it was the first they had stepped outside the space of the household, and the first time they had interacted with men outside the home. Their Indian origins and their minority religious status are reflected by the dots - bindis - on their foreheads.

families, all adults are required to work to supplement income; with little time to care for the young children, they are mostly left to their own devices until they turn six and start primary school. As a result, the transition to formal schooling is often a difficult process. Guardians, who are often anxious about whether their children will adjust to primary school, are now relieved that Prochesta's ECD centres will make **the transition to school significantly easier.**

Frequently mentioned also is how impressed mothers are with their children's **creativity** – that their children can "tell so many stories" or play with marbles, using them to create alphabet shapes, or draw pictures on every scrap of paper around. Children also learn hand-washing and personal hygiene routines from their centre facilitators.

The presence of the ECD centres has also created a **demand for pre-primary and primary education** in the community. For instance, centres operated by RWDO have established formal links with the nearest primary school to ensure that learners continue on with their education.

In communities where only the higher castes are perceived to take an interest in schooling, a wider demand for education that increasingly draws lower caste families into formal school-spaces, is potentially transformative. The Centres also serve as an intervention in the caste- and ethnicity-based social structure of the community by creating a space where all children are treated the same.

The **Centre Management Committees** (CMCs) that have been created by Prochesta to oversee centre operations are also a purposive space that brings together community members from across ethnic and religious lines. As the CMCs require the participation of mothers, they are also the site of a key gender intervention. For most of these women, their participation in the CMC is their first public role. Both men and women on the CMC see these meetings as highly participative where everyone talks and has a voice. CMC members are selected for five-year terms by the community. In addition to guardians, they comprise representatives from the *panchayat* and the union *parishad* or labour unions. Among other duties, the

CMC arrange for community sponsorship of ECD centre infrastructure (ceiling fans or latrines), organise teacher replacements, review attendance records and follow up on habitual absentees, and arrange for children's visits to local schools.

CMCs are also at the heart of the one of the Programme's strategic emphases: cross-sectoral linkages which attempt to empower communities to access government or NGO-provided social services. Prochesta, for instance, has successfully organised regular physical check-ups at its centres by linking up with an NGO, while sanitary latrines for five of its centres have been sponsored by another NGO. Efforts are also underway to identify linkages for providing food at the centre, one of the issues that parents identified as missing from the current ECD model.

Teachers and co-facilitators are women, recruited from the local tea garden community; their participation further promotes **localisation of the ECD model.** They speak, quite literally, the language(s) of their charges. Of course, given the focus on school preparedness, Bangla, the medium of instruction in the national education system, continues to predominate in the Centres. However, a tentative effort is being made to acknowledge the languages of the community by means of the recently introduced bimonthly cultural programme hour when students are encouraged to perform songs, dances, and stories in their mother tongue. Some teachers, at RWDO-run centres for instance, are also highly conscientised, bringing to their work an active understanding of the social structures and ethnic and religious divides that keep tea garden communities poor and marginalised.

Employing local women as centre teachers and co-facilitators is also a move towards **the empowerment of women in the community.** To work at an ECD centre is not only a means of employment, but also a means of gaining self-respect. Most teachers are young matriculates and are often among the first few cohorts in their communities to study up to the matriculation-level. They cannot work on the tea gardens nor are they ready to look for work off the tea estate. For them, employment at the Centres represents a rare opportunity available on the tea estate itself – the options being unemployment or occasional work on the tea estate.

The recruitment of teachers who fit the programme requirements is not easy, especially from among vulnerable communities. Many teachers had been, self-admittedly, timid and afraid to speak in front of others with little experience outside of the tea estate. In poorer estates, qualifications have been relaxed; instead of matriculates, young women who have studied up to grade 8 have been recruited. Hence, supportive relations with their supervisors at Prochesta are key to building their confidence and teaching skills. While the centre teacher-supervisor relationship is also fraught with the gender dynamic of two male programme officers supervising female centre teachers and co-facilitators, relatively open relationships have been established, enabled by the significant amount of time supervisors spend working with and coaching teachers at the centres.

But the greatest impact of the Programme relates to its core objective of **the institutionalisation of ECD programming capacity in Bangladesh**. Listed below are assessments from Programme participants concerning what they believe will outlast the Programme's five-year project:

- the centres themselves and the ECD materials created that will continue to serve as resources for children, communities, and NGOs
- the "soft infrastructure" of the Programme – the cross-sectoral linkages that deliver health, ECD services, education, sanitation, and nutrition to communities
- the increased knowledge of ECD practices that will continue to inform the daily lives of mothers, centre teachers, CMC members, and primary and secondary partners' personnel and their families and be disseminated via their social and work-based networks
- the demand generated among marginalised communities for educational services that could potentially transform the social structures that have marginalised them
- the increase in the number of ECD practitioners who are expected to "self-perpetuate" as their career prospects continue to improve
- the embedding of ECD knowledge in NGO networks as those people newly skilled by the Programme and their specialist knowledge will remain in Bangladesh
- the relationships among partner organisations that can extend to other potential partnership areas
- the professionalisation of the secondary partner organisations as a result of the Programme 's investment in their capacity, policies, and systems that has moved them away from being a one-man show to more sustainable modes of operation
- an activated network of NGOs for the delivery of ECD services that can transform the ECD sub-sector by taking advantage of the window of opportunity in the government's commitment to universal pre-primary education
- the mainstreaming of community-based organisations focused on the most marginalised population groups that brightens their prospects of sustainability

Noteworthy Practices

Several things are noteworthy about the cascade model:

- It derives its power **from a two-layered implementation structure** that purposively builds a network of organisations that can collaboratively replicate locally developed ECD models. In the Bangladeshi context, where the ECD sector is characterised by government commitment to universal coverage but with few local resources or ECD expertise, the cascade model equips primary and secondary partners to participate in expanding ECD – in the process, indigenising interventions in the ECD sector and reducing dependence on international development agencies. The cascade model appears to be an effective means of embedding ECD expertise within a network of Bangladeshi NGOs.
- The embedding of ECD expertise is achieved through **extensive technical capacity building** with IED support and **organisational development** with external service providers' support. For primary partners, capacity building has resulted in strengthening their ECD models (in the case of FIVDB,

transforming a primarily academic preschool programme to a more holistic ECD intervention), while for secondary partners, OD has transformed them from project-based organisations to full-fledged NGOs. A comprehensive M&E backbone keeps the Programme on track and itself works as a learning exercise.

- The **participatory modality** of the cascade model is not only noteworthy; it is essential for maximising the learning afforded to organisations at all levels. Primary partners, through constant comparison with the others' models, adopt and adapt each other's strengths, continuously innovating with their own models; primary and secondary partners learn from each other by interacting frequently and working with each other. A network of intense relationships between organisations is achieved as a result of the flexibility to explore and innovate around characterises the ECDSP-B primary partner relationship and the mutual respect that characterises the primary partner–secondary partner relationship. Flexibility allows primary organisations the opportunity to learn by taking the lead on fine-tuning their models to best suit implementation contexts; mutual respect empowers secondary organisations to fully contribute their local knowledge. Together, the approach works to make the ECD models more responsive to the needs of the communities being targeted.

- The cascade model enables **the targeting of hard-to-reach communities** by bringing together the primary partner's ECD model with the secondary partner's local knowledge and on-the-ground access to communities.

- At each layer of the cascade model, interventions achieve maximum impact through the **simultaneous investment at the individual, organisational, and sectoral levels**. Thus, primary partners have better trained ECD personnel, an evolving ECD model, increasing capacity to mentor and monitor replication, and increased participation in a network of NGOs in the ECD sub-sector. Secondary partners also have better trained personnel, organisational capacity to implement ECD projects, and

the resources to provide ECD services to communities that are less accessible to the state or other agencies. The result is that children and their families receive quality ECD services, community members feel more empowered to take decisions about their children's futures through the CMC, and there is a surge in demand for primary and pre-primary education among them.

Concluding Thoughts

One challenge resulting from the two-tiered modality of partnership is "system loss." As secondary organisations have little or no ECD experience and capacity, primary partners such as FIVDB sometimes admit to feeling held back by them. For instance, the Programme's replication component started small with a pilot of ten ECD centres per secondary partner; if FIVDB were to directly implement the ECD centres, a more ambitious implementation schedule might have been used. The two-tiered route, as the FIVDB project team has admitted, also exposed their relative inexperience in coordinating with and monitoring an external team/organisation. Perhaps the most challenging aspect of the cascade model is when it comes to capacity building through training; to train a set of people relatively new to the ECD sector (at FIVDB) to then train another group of people with no experience of ECD at all (at secondary partner organisations) cannot have a short turn-around time. With both primary and secondary partners in the learning mode, there is an inevitable system loss.

Hence, it is easy to see why the cascade model might appear inefficient; it certainly is more time consuming when compared with other implementation models. In reality, the ECDSP-B has established a relatively small number of ECD centres despite the time and resources invested by the Programme. In the short-term, this appears to be inefficient; however, replication of ECD models is *not* the *raison d'être* of the Programme. The primary goal is the strengthening of institutional capacity for ECD programming in Bangladesh. By putting in place a structure that requires the participation of the primary partners, the Programme aims to establish in them the skills, experience, and technical ability to take a leadership role in the expansion of ECD in Bangladesh. In other words, the system loss that might accompany the cascade process is compensated by the greater learning opportunity it presents, with both primary and secondary partners pushing each other to do better.

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ARNEC CONNECTIONS

Working together for Early Childhood

UNDERSTANDING OUR NETWORK

The Asia-Pacific Regional Network for Early Childhood (ARNEC) is a network established to build strong partnerships across sectors and different disciplines, organizations, agencies and institutions in the Asia-Pacific region to advance the agenda on and investment in early childhood.

ARNEC works to ensure the Rights of every Child to optimal holistic development through:

1. Advocacy for Policy Change
2. Knowledge Generation:
3. Information Management and Dissemination
4. Capacity Building
5. Partnership Building

ARNEC was established in February 2008 and acts as a platform for all individuals concerned with young children to voice, learn and share their knowledge and experiences in Early Childhood Development (ECD) with others.

Essentially, ARNEC's aim is to become a node linking all early childhood professionals, national networks, institutions and organizations together to increase inter-sectoral collaboration that enhances the region's early childhood capacities

In February 2010, the ARNEC Secretariat moved from the UNICEF East Asia and Pacific Regional Office in Bangkok to SEED Institute in Singapore.

ARNEC is guided by 15 Steering Committee members made up of ECD experts from the Asia-Pacific region who provide direction for the planning and development of the Network and its activities.

Six core team members have agreed to support ARNEC. They are:

• UNESCO
• UNICEF
• Plan International
• Open Society Foundation
• Save the Children
• SEED Institute

WHO ARE OUR MEMBERS?

Our members are individuals in the field of early childhood who is concerned with young children and families of Asia and the Pacific. The Network's strengths draws upon the support of our members who are experts in health, education, nutrition, social welfare, human development, social research or policy, sociology, or anthropology. Becoming an active ARNEC member means you are able to contribute your knowledge and share with others your experiences. It is free to become a member, please visit our website to sign-up.

ARNEC Advocacy Messages

Message 1:
The Early Years: Ensuring a Child's Right from the Start

Message 2:
ECCD Begins at Home: Caring for Children in a Nurturing and Stimulating Environment

Message 3:
Quality Early Childhood Matters: Making a Critical Investment for a Country's Future

Message 4:
Inclusive ECCD for All: Valuing and Respecting the Unique Needs of Every Child

Message 5:
Integrated ECCD: Working Towards a Seamless Early Childhood System

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