

Report No. 59

South Asia Human Development Sector

Improving Early Childhood Development through Community Mobilization and Integrated Planning for Children

Results from the evaluation of Bachpan program, Ratlam District, Madhya Pradesh, India

March 2013



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Glossary and Abbreviations

ANM	Auxiliary Nurse Midwife
ANM	Auxiliary Nurse Midwife
AWC	Anganwadi Centre
AWW	Aanganwadi Worker
Bachpan	Means “childhood” in Hindi
Bal kosh	Children’s Fund
Bal Melas	Children’s fair
Bal Mitra	A teacher who is a children’s friend
Bal Panchayat	Children’s Panchayat (local self-governance by children)
BCG	Bacillus Calmette-Guérin (vaccine against tuberculosis)
BEO	Block Education Officer
CDPO	Chief District Programme Officer
CHC	Community Health Centre
CSS	Centrally Sponsored Scheme
Dai	Midwife
DM	District Magistrate
DPEP	District Primary Education Programme
DPT	Diphtheria, Pertussis (whooping cough) and Tetanus vaccine
ES	<i>Ekta Samuh</i> , or unity groups/a collective
HDR	Human Development Report
ICDS	Integrated Child Development Services
IEC	Information, Education, and Communication
IFA	Iron and Folic Acid
Jan Mitra	literally, “friends of the community” in Hindi
JM	Jan Mitra
Kishori Manch	Adolescent girls’ group
Mahila Manch	Women’s group
Mahotsav	Celebration
MDM	Mid-Day Meal
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
MP	Madhya Pradesh
NCERT	National Council of Educational Research and Training
NGO	Non-Governmental Organization
NREGS	National Employment Guarantee Scheme
NRHM	National Rural Health Mission
PA	Project Associate
PRI	Panchayati raj Institutions
PTR	Pupil Teacher Ratio
RCH	Reproductive and Child Health
Sarpanch	Village head
SNP	Supplementary Nutrition Programme

SSA	<i>Sarva Shiksha Abhiyan</i> (elementary education for all)
TBA	Traditional Birth Attendant
TLM	Teaching Learning Material
VPC	Village Plans for Children
VRG	Village Resource Group
Yuvak Mangal Dal	Youth group

Executive Summary

Introduction

This study reports the results of an impact evaluation of a pilot project implemented in 220 villages in *Bajna* block, *Ratlam* district, Madhya Pradesh (MP), India. The 30-month pilot was designed to improve early childhood development outcomes through: (a) creating awareness on child development issues among households and the community; (b) strengthening linkages between different service providers; (c) intensifying the connection between the community, *Panchayat* (local governments), and service providers; (d) facilitating the formation of Village Resource Groups (VRGs) with representatives of the community, *Panchayat* and service providers to ensure better convergence and coordination of service delivery; (e) developing integrated village-level action plans around the needs of the child; and (f) advocating and lobbying with local, district, and state administration for flexible allocation of resources.

Background

The pilot project was inspired by the World Bank report, *Reaching out to the Child: An Integrated Approach to Child Development* (2004), which analyzed the reasons for the far from satisfactory status of children in India, in spite of several significant policy and programmatic provisions. The report had recommended the development of Village Plans for Children (VPC)—community-led, decentralized, and cross-sectoral planning for children that would inform sectoral interventions and implementation.

Enthused by the VPC model for child development, in 2005 the Government of Madhya Pradesh (GoMP) opted to pilot the concept in one of its blocks, and sought World Bank assistance to implement it. The World Bank supported the pilot by: (i) engaging *Naandi* Foundation, an NGO, to work with the community as catalysts; and (ii) designing and implementing a meticulous evaluation of the program. Through a consultative process, *Bajna*, a remote backward tribal block with 220 villages, was identified as the pilot site because: no other NGOs or private groups were active in the block; all the child development programs—Reproductive and Child Health (RCH), Integrated Child Development Scheme (ICDS), and *Sarva Shiksha Abhiyan* (SSA)—were being implemented in the area; and the Government of MP felt that if the project could demonstrate success in this block, they could replicate it elsewhere in the state.

The initial community meetings decided to call the project ‘*Bachpan*’ (childhood), with a vision to ensure that every child enjoys a “happy, healthy, and learning childhood.”

Project implementation comprised the following components: (a) Participatory resource/service delivery mapping; (b) Provision of information and educating the community on child development issues, as well as managing service delivery; (c) Community mobilization aimed at bringing parents and service providers on common platforms to discuss child development and service delivery issues; (d) Formation of Village Resource Groups (VRGs) called *Ekta Samuhs* (unity groups), to discuss child advancement issues, identify gaps and requirements, and formalize it in the form of village plans; (e) Facilitation of the interactions between VRGs and block- and district-level health, nutrition and education officials, and feeding the village plans into district plans for RCH, ICDS and SSA; (f) Enable specific service provisions like the fixed day health checkup (a particular day in a month agreed between the health worker and the community on which the health worker visits schools and the community brings the children for regular checkup); and, (g) Provide training to frontline service providers (health workers, *anganwadi* workers, and teachers) to manage service delivery records, deliver effective services, and sensitize them to ensure enhanced accountability.

The project was implemented in *Bajna* from 2006 till 2009. The groundwork for resource mapping, information, education and communication (IEC), and community mobilization took a year to take shape,

all the Village Resource Groups (VRGs) were formed by the end of the second year, followed by the planning process and convergent service delivery in the third year.

Impact Evaluation Study

The evaluation assessed the impact of the project on health, education, and nutrition milestones or outcomes/outputs identified for each stage of child development. The World Bank's evaluation of the pilot followed a quasi-experimental design. While the project interventions were administered in 220 villages in Bajna, an adjacent tribal block, Sailana, was identified as the control block. In both the control and project blocks, a baseline survey was conducted in 2005-06, while an end-line survey was conducted in 2009. The baseline and end-line surveys interviewed both households and providers.

Baseline Survey Findings

The baseline survey found low outcomes/developmental milestones in early childhood (education, health and nutrition) in both Bajna and Sailana, though in general the situation was somewhat better in Sailana. For example:

- Very few pregnant women had availed of full antenatal care (9 percent in Bajna and 24 percent in Sailana), and
- Only a small minority of pregnant women underwent institutional delivery or deliveries attended to by trained professionals (one-third in Bajna and one-quarter in Sailana).
- The rate of child immunization was less than 10 percent in both communities, and malnourishment was very high (about one-third of children in each block).
- While 67 percent of children aged 3-5 years in Bajna and 59 percent in Sailana were enrolled in *anganwadis*, daily participation in preschool activities were low (61 percent in Bajna and 71% in Sailana attended *anganwadis* for less than an hour) and 5-year-olds fared inadequately in school readiness competencies (mean score of only 50 percent in Bajna and 60 percent in Sailana; for example, only 30 percent in Bajna and 50 percent children in Sailana could comprehend a simple sentence; and 24% in Bajna and 37% in Sailana could do visual discrimination).
- Though out of school children numbers were low and school attendance was surprisingly not bad (84 percent in Bajna and 72 percent in Sailana, children's learning achievements were low, with a mean overall score in mathematics and Hindi of 54.56 percent in Bajna and 65.10 percent in Sailana.

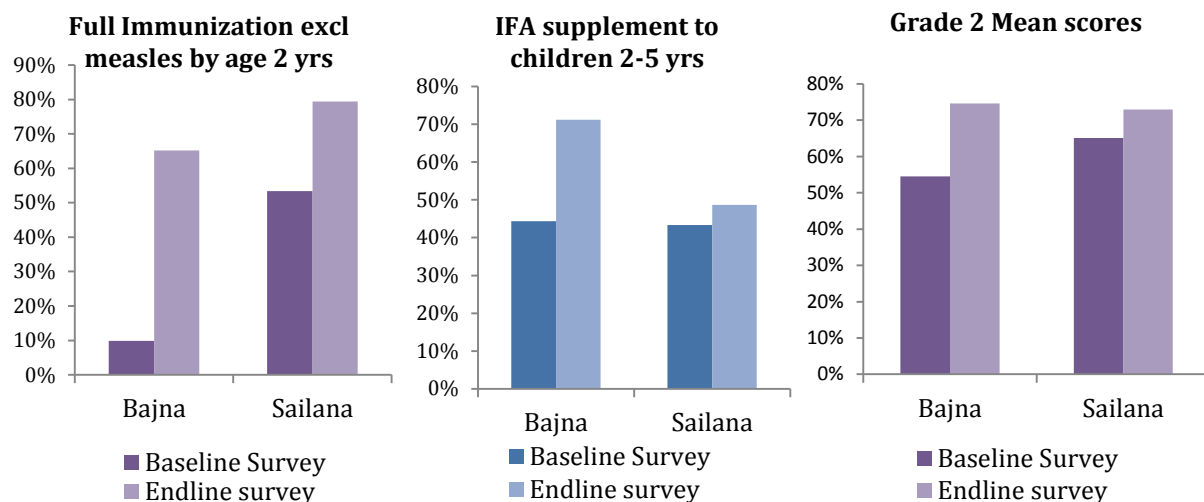
End-line Survey Findings

The end-line survey shows that the *Bachpan* program significantly improved outcomes for children, as well as enhanced the community's knowledge, awareness levels, and practices. These improvements occurred across a very wide range of outcomes (see Table). These improvements meant that Bajna block was able to catch up and, in some cases, surpass the developments outcomes found in the neighboring Sailana block. The experience of the Sailana block shows that some progress is possible with different programs targeted on specific issues. However, there is greater impact of these programs where, as was the case in Bajna, there is a concerted effort at the local level to contextualize and coordinate these programs.

Table: Summary of Outcomes: "Difference in difference" between treatment and comparison blocks		
Indicators on Outcome for various stages		Progress better in Bajna or Sailana
Stage 1	Percentage of pregnant women who received full ante-natal check-up	Bajna
	First ANC within first trimester	Bajna
	Percentage pregnant women regularly received Supplementary food	Bajna
	Percentage of deliveries assisted by institutionally trained	Bajna
	Decline in the percentage of children underweight	Sailana
Stage 2	Percentage of children fully immunized by year 1	Bajna
	Percentage of children who have completed all prophylaxis Vit A	Bajna
	Percentage of children with normal weight for age	Bajna
Stages 3 & 4	Percentage of children entering in Grade 1 who have an adequate vocabulary in the school language	Bajna
	Percentage of Grade I children who have attended pre-school program	Bajna
	Percentage of children in school clean and neat	Bajna
	Percentage of children who wash hands before eating	Bajna
	Achievement levels in language and Mathematics in Grade II	Bajna

Improvements were seen in particular in the following dimensions (see charts):

- The proportion of pregnant women who had availed of full antenatal care tripled in Bajna to 23.8 percent.
- The rate of home delivery where births were not attended to by trained professionals halved in Bajna while barely shifting at all in Sailana.
- The rate of child immunization in Bajna was 56.9 percent, up from just 5.2 percent at the baseline and malnourishment dropped to 21.6 percent from 33.6 percent (while remaining at around 30 percent in Sailana).
- The enrolment of 3-5 years in *anganwadis* improved (in Bajna from 67 percent at baseline to 91 percent by end-line survey compared to Sailana where it improved from 59 percent to 83 percent), of which those attending anganwadi early childhood education program for five days or more improved significantly (in Bajna, from 48 percent at baseline to 71 percent by end-line while in Sailana the improvement was from 31 percent to 60 percent), and “school readiness” scores improved significantly (in Bajna, from 50 percent mean score at baseline to 67 percent by end-line while in Sailana, the improvement was from 60 percent to 65 percent).
- Children’s learning achievements improved significantly, with mean scores in Bajna now marginal above those in Sailana (up from 54.56 to 74.60 percent); as importantly, the distribution of Bajna mean scores has decreased so that many more children are closer to the mean (standard deviation gone down from 10.50 to 8.08).



Lessons from the Impact Evaluation of the Pilot

The impact evaluation and process documentation together provide an insight into what works better or what does not, in geographical areas with many socio-cultural challenges for improving the quality of children's lives. The evaluation demonstrates that the interventions under the pilot led to significant improvements in childcare-related behavior and delivery of services for children, which in turn lead to child-related outcomes. The inferences from the results are as follows:

- Dramatic improvements are possible even in the most disadvantaged communities, with the right approach.
- Greater progress is made through invigorating the local community and service providers by informing communities and enabling them to make their voices heard, than through vertical projects implemented in a top-down fashion.
- Participatory planning, rather than a top-down approach, enables contextualization of interventions and convergence and coordination in planning and implementation; both are important because child development requires a slew of complementary interventions no single solutions.
- Community participation is ensured when there is enough awareness and empowerment. This requires change agents or catalysts, and this necessitates involving civil society organizations.
- Interventions in the development sector can take time to show results. So the final assessment of their success should take place after the initial enthusiasm of a pilot dies down and actual results are visible.
- An effective and informative evaluation was possible because the process was documented meticulously. This can also enable any mid-course corrections that may be required.
- The costs of this intervention were modest (the real investment was 20 youth ("Jan mitras", the change agents selected from within the community) who were paid Rs. 3000 per month, and the training and material charges), as the focus was on improving the effectiveness of existing programs, which themselves are large, rather than creating new ones. Hence, there are clear opportunities for scaling up this approach to other blocks across Madhya Pradesh.

Introduction

Making services for the poor work and result in desired outcomes has been a major challenge to social development, as pointed out by the *World Development Report* (2004). When services meant for early child development fail to reach children, the fallout is irreparable damage to building subsequent human capital.

Every child deserves a “happy, healthy and learning” childhood, which facilitates her/his physical, social, emotional, intellectual and educational growth. For any nation, developing human capability and hence, human capital, is vital for economic growth and social development, and every *rupee* spent on a child is an investment in the future. However, as the World Bank’s *Reaching Out to the Child* (2004) report corroborated, despite several policy endorsements and substantial investments for nearly six decades since independence, the child development outcomes are very poor. Further, the benefits accrued thus far have not penetrated equitably, thus leaving out a large section of children, especially those from marginalized groups and remote backward regions. The report also identified some factors responsible for the limited impact of existing provisions. These include: (a) a fragmented, sectoral approach in implementing schemes that do not capture the synergies across sectors; (b) over centralized and standardized program designs that do not address contextual diversities; (c) inadequate financial resources and incompetent implementation; (d) insufficient monitoring capacity; and (e) low accountability resulting in service delivery issues. The absence of converging nodes close to service delivery points, and the lack of stakeholder or community involvement (especially in the context of local settings), are major challenges for effective service delivery.

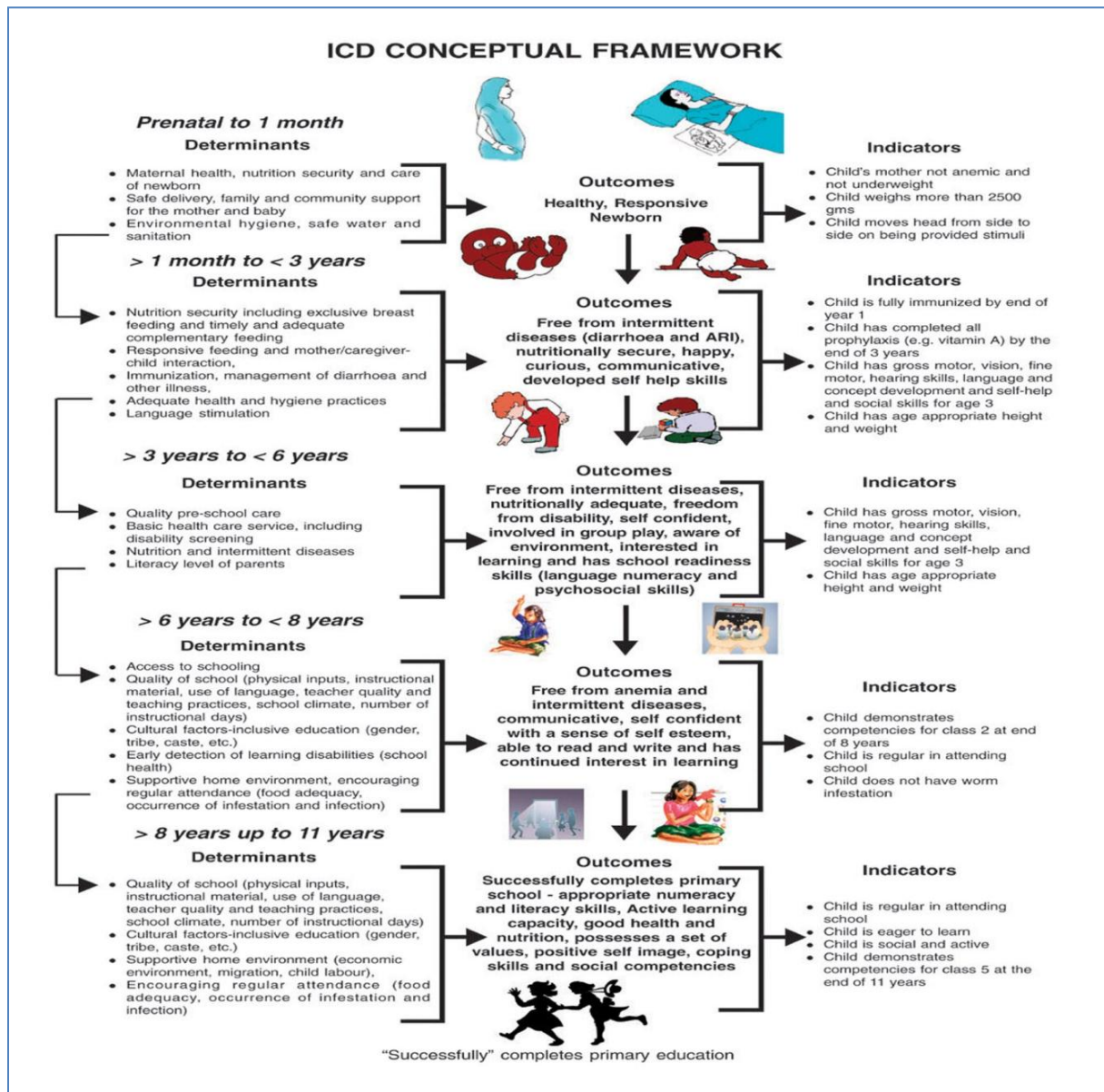
Over and above its emphasis on the requirement for an integrated and life cycle approach to child development, including basic education, the study also highlighted the need for locating planning and monitoring within a comprehensive and holistic child development framework. Thus, one of the major recommendations of the research was to move toward a decentralized and cross-sectoral approach to program planning and monitoring, and improved coordination in implementation. It suggested that informed communities come together around child development issues for planning in a convergent manner. This concept deviates from the existing approach in two ways: (i) it is a bottom-up approach involving participatory planning by each village community for its children and has the potential to be more context specific and need based, and (ii) it is in accordance with a multi-sectoral convergence approach that addresses the needs of the “whole child” and not on different aspects (health, nutrition, education) in isolation from each other.

This report presents the results of one such innovative experiment aimed at improving early child development (ECD) outcomes through energizing communities and enabling convergence of child-related services at the village-level in 220 tribal villages in backward and remote Bajna block, in Ratlam district, Madhya Pradesh. The report organization follows the logical framework of the program (Chart 3). While Section 1 provides a background to the pilot and the project activities and interventions, Section 2 details the evaluation design. Section 3 analyses the results of the evaluation of the pilot project in terms of “outputs” and the results of the “impact” on ECD milestones/outcomes. Section 4 summarizes the findings of the pilot project.

Chapter 1: Background

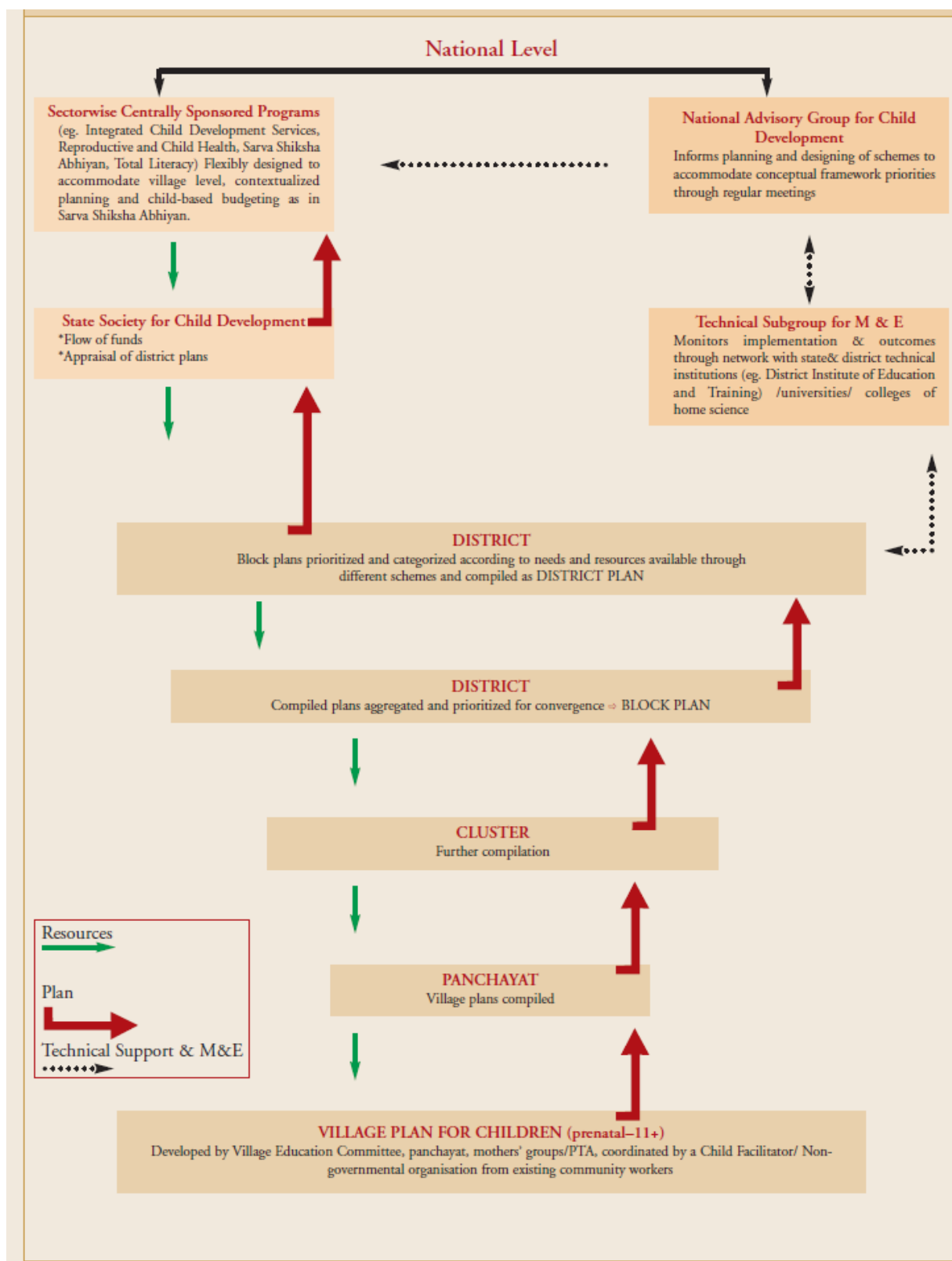
The World Bank (2004) Report *Reaching Out to the Child* proposed an integrated child development conceptual framework, which detailed the health, education, nutrition, and child protection related outcomes for each stage of early childhood (pre-natal to 1 month, 1 month-3 years, 3-6 years, 6-8 years and 8-11+ years), and the indicators that manifest these outcomes. The framework also listed the possible determinants of these outcomes. The framework is presented below (Chart 1). The report also proposed a possible structure for developing village plans for children (Chart 2).

Chart 1 ICDS Conceptual Framework



Source: *Reaching Out to the Child*, World Bank, 2004

Chart 2 Village Plans for Children: A Possible Structure Advocated by World Bank (2004)



Source: *Reaching Out to the Child*, World Bank, 2004

Bachpan: From Concept to Pilot

The attempt to translate into reality the concept of an integrated approach to child development was not a new one. In 1999, the Philippine Government launched an ECD project, adopting an integrated, multi-sectoral approach to delivering a combination of services that included center-based and home-based interventions. To link the two sets of interventions, a new service provider, the Child Development Worker (CDW), was placed in all program areas (see the Process Documentation Report in Annex 1). In India, the Integrated Child Development Scheme (ICDS) was aimed as an integrated approach to child development, though, in practice, it remained at the level of yet another ring-fenced approach.

The Government of Madhya Pradesh (GoMP), bought into the report’s concept of decentralized and cross-sectoral planning, coupled with coordinated implementation of child development programs (and the village plans envisaged therein). They recognized it as a feasible route to address the state’s child development issues, especially that of service delivery, and community awareness and mobilization at grassroots levels. The GoMP suggested piloting the concept through Village-level Child Development Plans, which would form the contextual plan document. At their invitation, the World Bank agreed to facilitate the process in the state through a pilot, to be evaluated rigorously for impact.

Bajna, a tribal Community Development Block in Ratlam district with around 220 villages, was selected as the administrative unit within which to implement the pilot (for details, see the Baseline reports and Process Documentation by Education Resource Unit [ERU] in the Annex) selection method). Naandi Foundation, a leading Non-Governmental Organization (NGO), was assigned the responsibility of facilitating the interventions related to convergent and decentralized village-level planning. The intervention under the pilot was titled *Bachpan* (see Process Documentation Report by ERU for details), and was implemented from 2006 to 2009. The process documentation responsibilities were given to the Education Resource Unit (ERU).

The Pilot Project

The first year of the project was devoted to conducting a needs and gaps assessment, and in mobilizing the community. The major task of the implementing agency (Naandi Foundation) was to identify local people who would work with the community in implementing the project. At this inception stage, the project was only an idea, with no clear intervention plans or processes. Thus, the first step was to develop a logical framework for implementing the pilot project (Chart 3).

Chart 3 Logical framework for the Pilot



The pilot was designed to address the inputs and process arms of the logical framework, keeping in mind the outcomes and impact to follow. Thus, while one of the expected outcomes of the project was the preparation of “village plans for children” that would feed into different centrally sponsored schemes’

(CSS)/state schemes' district plans, the major measurable outputs were in the nature of community awareness, better childcare practices and behavior, and improved service delivery.

In the preparatory stage, the NGO identified around 20 young men and women (tribal and non-tribal, both) who had recently completed high school, to work in the villages, so as to mobilize community, educate them about the schemes and preparation of village plans. Educational levels (minimum education of Class X for non-tribal) and some understanding of the area were the basic criteria for selection. Tribal youths were accorded priority irrespective of their academic qualifications, as they belonged to the villages/areas of the pilot. This band of young people, the *Jana Mitras* (friends of people/community), and were given intensive training in village resource mapping (see Annex 2 for an example of village resource mapping) and participatory planning. They were also informed about the various existing child-related schemes and their set result targets: these included *Sarva Shiksha Abhiyan* (SSA), Integrated Child Development Scheme (ICDS), Reproductive and Child Health (RCH), National Rural Health Mission (NRHM), and others.

As part of their resource mapping exercise, the Jan Mitras conducted a rapid appraisal of service delivery gaps in health, education, and nutrition. The Jan Mitras also carried out house-to-house visits to assess the current child development outcomes and care practices, and to educate the community on child development needs. To aid management and monitoring, the block was divided into three widely scattered clusters—Bajna, Raoti and Kundanpur—each with specific geographical or service delivery features. While Bajna is hilly and dry, the Raoti area is a fairly fertile river basin (of the river Mahi), and Kundanpur is an area of sparsely scattered settlements with a poor communication network.

As a next step, the Jan Mitras brought together community and service providers of health, education, and nutrition on common platforms to discuss individual and common concerns. This led to the formation of Village Resource Groups (VRGs) or *Ekta Samuhs* (united communities/ solidarity groups). VRGs facilitated the convergence points for various service providers, and many interventions/processes common to different schemes were carried out in a coordinated way (for example, a census of children who should be enrolled in ICDS and primary schooling, or the information, education and communication (IEC) activities).

The communities came up with the project name (*Bachpan*), meaning childhood. The communities (during VRG meetings, facilitated by the Jan Mitras), also formulated the vision and mission for the project, including a list of objectives and the type of interventions required under the project. The community also felt the need to address the life cycle continuum and, realizing the importance of child development, the *Ekta Samuhs* came up with a vision for the pilot project—realizing a “happy, healthy and learning childhood” for their wards (See Box 1).

The preparation of village-level plans for child development (see Annex 3 for a village child plan structure), and feeding the plans into district level plans for SSA, RCH and ICDS was considered as the next step forward in the process. By the end of the second year, more than half the villages had prepared village-level plans and submitted it to the district authorities for further action (see Box 2 and 3). The details of the *Bachpan* program, its administrative arrangement, project interventions, bottlenecks faced in the process, etc., are detailed in the Process Documentation Reports (a total of 8 reports; see Annex 5 for the consolidated report).

Box 1 Vision, Mission, Objectives and Activities of the Pilot Project “Bachpan”

<i>Vision</i>	Happy, healthy, learning child
<i>Mission</i>	Facilitate integrated child development by (a) helping improved service delivery through coordinated and convergent approach and (b) promoting better child care and development practices by educating community and providing information about child care practices, outcomes and availability of services and schemes.
<i>Objectives</i>	<ul style="list-style-type: none"> ▪ Create awareness on child development with a focus on the girl child ▪ Strengthen linkages between different service providers ▪ Strengthen linkages between the community, <i>panchayat</i> and service Providers ▪ Facilitate formation of <i>Ekta Samuhs</i> at village level (Village Resource Group) with representatives of the community, <i>panchayat</i> and service providers ▪ Develop integrated village level action plans around the needs of the child ▪ Advocate and lobby with local, district and state administration for flexible allocation of resources
<i>Key features</i>	<ul style="list-style-type: none"> • Address the life cycle continuum. • Establish convergence of provisions for children across health, nutrition and education sectors. • Engender bottom-up planning through community participation.
<i>Interventions</i>	<ul style="list-style-type: none"> • Selection and training of village level facilitators (<i>Jan Mitras</i>) and orientation of Block level functionaries • Participatory survey and resource mapping of the project area (in all 220 villages); Collation of resource mapping data in all villages • Orientation of both service providers and community on the concept of integrated child development, capacity building • Community mobilization through the formation Village Resource Groups (VRGs) named by communities as “<i>Ekta Samuhs</i>”; Orientation of the VRGs on (a) Government Schemes; (b) Specific outcomes desired for each sub stage of childhood with regard to health, education and nutrition and related determinants; and (c) Their own role in planning and monitoring at the village level; <i>Sandesh Vahini Dals</i> (Communicators forums) were constituted from among local talent available for this purpose to make the strategy folk theatre based. • Continuous interventions for building and sustaining community as well as service providers’ awareness around nutrition, health and education issues; orientation and training of service providers (AWW, health workers/ ANM and teachers); setting up contextualized models (fixed day services in AWC/HC, setting up <i>Maje ki Pathshala</i> models; melas, teacher motivation activities etc); • Workshop organized for block level functionaries of the three government departments of Education, Health and Women and Child Development. • Development of Village plans (3 year plans from pre natal to 11 + years in each village) and feeding the plans into sector specific plans each year.

Box 2 Evolving Village-level Plans for Children: Evidences from Process Documentation I: In Keriapada village, the first tentative village plan was discussed amongst the members of the Ekta Samuh, facilitated by a Jan Mitra.

- The group focused attention on the problem of student dropouts, prenatal care for women, the poor health status of children, heavy migration of families (50%) for economic sustainability, alcoholism and smoking among men, and the issue of dowry.
- They discovered that many children were in school but the parents were unaware of which grade they were in. The irregularity of the schoolteacher was another problem discussed.
- Ekta Samuh was fairly active in the village and had already taken a decision to work on certain issues in the second meeting, in the presence of the team and the larger community.
- They wanted to identify children of migrant families and motivate them to stay back in a residential center when their parents migrated. The parents present had consented to this proposal.
- The Ekta Samuh wanted to organize a health check-up camp for village children during the monsoon (rainy) season for preventive remedies. Subsequently, the community also wanted to ensure that all children aged 3-6 year were in the anganwadi centre, and all children under six were immunized.
- The Ekta Samuh members, in the process of discouraging alcohol intake across the village, also vowed to become teetotalers themselves.
- The members considered setting up a Bal Kosh (Funds for children) in the village for the children, by putting in fifty paisa per person per month, as a saving. This was to take care of the health or educational needs of children.

Box 3. Evolving picture of village level plans for children:

Ekta Samuhs to take the initiative in respective villages: Planning at *Panchayat* level, *Kundanpur* cluster
– *Chikni* and *Binti Panchayats*
(Evidences from Process Documentation II)

Actions to be taken			
Children < 5yrs	Month 1	Month 2	Month 3
<ul style="list-style-type: none"> • Immunization of children whose parents migrate • SNP irregular & nutrition & sanitation weak • AW children not regular • Children have poor nutrition 	<ul style="list-style-type: none"> • Make mothers aware about immunization. Door to door visits of ANM. Set fixed place for immunization in village • Training on importance of SNP • Discuss and motivate mothers and ensure AWC functioning is regular • Get ANM and AWW to speak about nutrition from local foods 	<ul style="list-style-type: none"> • Awareness about pre-school education to parents • Move for fixed day services • Follow up with AWC and <i>panchayat</i> on SNP • Discussions with mothers and follow up activities • See that nutrition is served in AWCs and ask mothers whether children eat at home 	<ul style="list-style-type: none"> • Inform parents about meetings to follow up on issues. • ES to follow up motivation of parents and track children. • Ensure fixed day services become regular. • ES tracks AWC, AWW ANM
Children in school			
<ul style="list-style-type: none"> • Children from some hamlets absent from school even though enrolled • Schools do not open regularly 	<ul style="list-style-type: none"> • Talk to parents about shifting of children from sibling care • Community to track children who are absent frequently and speak to parents • Mobilize parents for enrolling children and making them regular 	<ul style="list-style-type: none"> • Motivation of parents hamlet wise • Discussions with parents through meetings and discussions • PTA to track children in the schools and ensure that incentives are available for them 	<ul style="list-style-type: none"> • ES to monitor use of funds in schools through PTA • PTA and ES to monitor school regularity and quality and report to Education Department • PTA to convene timely and follow up activities – hamlet level meetings and sharing of experiences
Other village issues			
<ul style="list-style-type: none"> • Regular visits of ANMs to AWC • Visits of pregnant women to health centre • School boundary and beautification • Drinking water facility dysfunctional 	<ul style="list-style-type: none"> • Speak to ANMs telling them of their problems – at meetings • Identify and motivate women through AWW and ANM – in the hamlets • PTA to become active – speak to the teacher • Mobilise people for action 	<ul style="list-style-type: none"> • Set a day for examination of women by the ANM • Inform them about services at the health centre • Children and parents get involved in school improvement • ES speaks to <i>Sarpanch</i> 	<ul style="list-style-type: none"> • Track the women and ensure their records are maintained • Ask <i>Mahila Manch</i> (Women’s group / forum) to track them in the different hamlets • Function to showcase school • Move to higher level if <i>Sarpanch</i> does not take action

Chapter 2: Evaluation of the Results of the Pilot Project

A rigorous evaluation of the results along with a detailed process documentation of the project was planned at the conceptualization stage of the pilot itself, so that the efficacy of the pilot could be measured and lessons learned could be replicated or emulated elsewhere in the state. Following the logical framework of the project, it was expected that the inputs from the pilot, or the activities undertaken under the project, could lead to the mobilization of the village community, including those employed as frontline service providers in health, education, and the ICDS. This, in turn would result in better interaction within the community and between the providers and beneficiaries, and improve awareness about child development issues. Enhanced service delivery and child development practices, and better use of services would lead to improved child development related outcomes. Hence, the impact evaluation of the study needed to look at the improvements in child development related outputs and outcomes, or the envisaged milestones of the project interventions.

Evaluation Study Objectives

The overall objectives of the study are:

- To assess the changes in child development outcomes (specific milestones in each stage of child development, related to health, education, and nutritional parameters) resulting from the project interventions (informing and educating the community, community mobilization around child development issues, and facilitating interface with frontline service providers), and the integrated approach toward interventions.
- To understand the changes in service delivery and community awareness arising from project interventions.
- To examine the changes in service delivery, community behavior, and child development outcomes in the context of the interventions, in direct contrast to the absence of any convergence of planning or coordination in sectoral implementation.

Methodology

This evaluation uses a quasi-experimental design. The concept note of the evaluation plan was reviewed and agreed upon. The identification of the counterfactual is important for such studies. The impact of the interventions is assessed as the net effects, or the difference-in-difference, whereby the changes in outcome/output indicators between the pre-intervention and post-intervention periods are compared—an intervention group against that of the non-intervention (counterfactual) group. The conceptualization of the net effects is in terms of the comparable differences in the changes before and after the project between the treatment group and the control group.

A detailed note on the design and methodology of the impact evaluation, sampling framework, and questionnaires are provided in Annex 6.

Comparison of Bajna and Sailana

While identifying a perfect counterfactual area was difficult, Bajna and Sailana are a close enough match. Both are tribal blocks in Ratlam district of Madhya Pradesh state, have around 220 villages each, and display similar geographic, socio-economic, and ethnic profiles. The selection of these blocks by the GoMP for the study was purposive—they believed that if the pilot interventions in one of these blocks worked, then it could be similarly implemented anywhere else in the state with equal success. A

comparison of the situations and interventions in the two tribal blocks is provided in Box 4. A detailed description of the socio-economic milieu of the two blocks is presented in Annex 2.

Box 4 Comparison of interventions in Bajna and Sailana

Child development interventions	BAJNA	SAILANA
Education related projects:	<ul style="list-style-type: none"> • <i>Sarva Shiksha Abhiyan (SSA)</i> • Mid Day Meal Scheme (MDM) • State interventions 	<ul style="list-style-type: none"> • <i>Sarva Shiksha Abhiyan (SSA)</i> • Mid Day Meal Scheme (MDM) • State interventions
Health related interventions	<ul style="list-style-type: none"> • Reproductive & Child Health (RCH) • National Rural Health Mission (NRHM) • State interventions 	<ul style="list-style-type: none"> • Reproductive & Child Health (RCH) • National Rural Health Mission (NRHM) • State interventions
Nutrition related interventions	<ul style="list-style-type: none"> • Integrated Child Development Scheme (ICDS) 	<ul style="list-style-type: none"> • Integrated Child Development Scheme (ICDS)
<i>Nature of services/ activities</i>	BAJNA (with Bachpan)	SAILANA (without Bachpan)
Planning	Village level Child centered planning, converging health, education and nutrition interventions, village plans feeding into district plans for SSA/MDM, RCH/NRHM, ICDS; expansion of services by starting new ICDS centers, engaging more teachers etc.	No consolidated village plans for child development whatever is planned at district level for the block separately for health, education and nutrition projects
Convergence in service provision	Facilitated by VRG; specific fix day services	Work in silos
Community Mobilization	Through Village Resource Groups (VRG); integrating Village Education Committees (VEC), Village Health Committees and ICDS related groups with <i>Panchayati Raj</i> institutions and providers.	Separate Committees like VECs, Health Committees etc; extent of their involvement is not known
Community awareness programs	Bachpan, through the <i>Sandesh Vahinis</i> and <i>Kala Jathas</i> ; engagement of <i>Jan Mitras</i>	Standard government IEC programs through wall writing etc.; limited in nature
Training of frontline providers	<i>Anganwadi</i> workers, ANMs and teachers trained for context specific issues	Training of providers as by the CSS plans

Child Development Outcomes/Milestones to be monitored

While the pilot was aimed at changing household behavior and practices, planning for children at the grassroots level, and the convergence of service delivery modalities, the impact of the pilot is measured on the changes in outcomes related to health, education and nutrition for various stages of child development. The pilot monitored a variety of indicators for each milestone of development for the child (Table 1).

Table 1 Indicators on Outcome for Various Stages

<p>Stage 1: Improved monitoring of growth and development of children and health of pregnant women</p>	<ul style="list-style-type: none"> • Percentage of pregnant women who received full antenatal check-up • Percentage of pregnant women who regularly received supplementary food • Percentage of deliveries assisted by the institutionally trained • Percentage of children not underweight
<p>Stage 2: Improved rates of immunization by end of year 1; completion of all prophylaxis of Vitamin A; average daily time spent on adult-child interaction in families</p>	<ul style="list-style-type: none"> • Percentage of mothers of children under one year who have provided six months exclusive breast-feeding • Percentage of children fully immunized by year 1 • Percentage of children who have completed all prophylaxis of Vitamin A • Percentage of children with appropriate weight-for-age • Average daily time spend on adult-child interaction in the family
<p>Stages 3/4 Quality of early childhood education; teacher and student attendance; rates of dropouts and transition; achievement levels in Grade 2</p>	<ul style="list-style-type: none"> • Percentage of children entering Grade 1 who have an adequate vocabulary in the school language • Percentage of Grade I children who have attended preschool program • Percentage of teacher and student attendance • Rate of dropout and transition to next stage • Achievement levels in language and Mathematics in Grade 2 • Percentage of 6-11 year olds completing primary education

Chapter 3: Progress in Processes and Identified Outcomes/Milestones

The objectives of the interventions facilitated by the NGO in the treatment block (220 villages in Bajna) included: (a) creating awareness on child development issues and needs; (b) strengthening linkages between different service providers; (c) strengthening linkages between service providers and the community; (d) formation of village resource groups that brought convergence of concerns, ideas and plans regarding child development needs and service delivery modalities; (e) development of integrated village plans around the needs of children; and (f) advocate and lobby with local, block and district administration for provision and facilitation.

The changes expected could thus be perceived in: (i) the way communities participate and work together in child development related activities; (ii) the processes of service delivery; (iii) knowledge and practices of community/households regarding child care; and (iv) outputs and outcomes. In this section, the changes in outputs and outcomes are taken up for detailed analysis.

3.1 Changes in Community Mobilization

Since the project interventions pay a great deal of attention to community energizing and mobilizing, it is important to look at whether the interventions actually altered the way communities think and work on child development issues and related service delivery improvements. During the baseline survey, what emerged strongly was a lack of awareness/understanding on the part of households and the community of what best methods to employ for child care and development. Additionally, there was a general apathy and indifference toward the health/education/AWC providers. The focus group discussions and process documentation in Bajna during the end-line survey show improvements in community awareness, child care practices, and demand for better services. Focus group discussions in Sailana indicate the awareness of people about the interventions taking place in the neighboring villages in Bajna, and a desire to emulate some of the interventions, for which there were demands for a facilitating agency (like the NGO-supported facilitators in Bajna).

One of the first measures used to understand the impact of the community-based interventions was to ask people directly about the changes in service delivery. Using the “citizens’ report cards” type of questions, during the end-line survey households were asked whether the provision of services had changed over the last three years. In both control (Sailana) and treatment (Bajna) blocks, households reported improvements, but those who reported improvements in service delivery, especially significant improvements, were at least 5 times more in percentage terms in Bajna, when compared to Sailana. For example, 36% of people in Bajna felt AWC services had improved significantly during the last three years, while only 7% in Sailana reported the same. Regarding health care services, 91% of people surveyed in Bajna mentioned improvements in service delivery, while only 51% felt the same in Sailana. Only 13% people in Bajna reported that nothing had changed in schools during the three years of intervention, as against 57% in Sailana. Improved community mobilization and activities were reported in Bajna by 47% of respondents, whereas only 15% experienced the same in Sailana (Table 2).

Table 2 Changes in Service Provision Over the Last 3 Years

	AWC		Health care		Schooling		Community mobilization	
	Bajna	Sailana	Bajna	Sailana	Bajna	Sailana	Bajna	Sailana
IMPROVED	88.9%	80.4%	90.55%	51.0%	87.3%	43.8%	47.0%	15.12%
	(0.63)	(0.85)	(0.58)	(1.1)	(0.66)	(1.05)	(0.99)	(0.76)
<i>Improved significantly</i>	35.5%	7.2%	18.3%	2.5%	25.6%	2.6%	5.3%	0.9%
	(0.95)	(0.5)	(0.77)	(0.33)	(0.87)	(0.33)	(0.44)	(0.2)
<i>Improved somewhat</i>	53.4%	73.2%	72.25%	48.5%	61.7%	41.2%	41.7%	14.12%
	(0.99)	(0.94)	(0.89)	(1.06)	(0.97)	(1.04)	(0.98)	(0.74)
No change/ worsened	11.1%	19.6%	9.45%	49.0%	12.7%	56.17%	53.02%	64.93%
	(0.6)	(0.84)	(0.58)	(1.1)	(0.65)	(1.04)	(0.9)	(0.7)

Figures in parentheses show standard errors
Source: Household Survey, 2005-06 and 2009

The evaluation attempted to understand community awareness about activities that the main intervention in the trial region strove to improve: household knowledge/awareness of child related census and planning, and the nature of their involvement in the process in the preceding one year. The analysis of community/household awareness of child census/planning show that the percentage of households that were aware of the child census and planning had improved from 51% to 85% between baseline and end-line in Bajna (an increase by 35 percentage points), as compared to an increase by only 16 percentage points in Sailana. In Bajna, the percentage of households with knowledge about who conducts survey/census/planning and for what purpose the survey/planning was carried out, jumped from a mere 10% to 86%. This improvement is more significant than that reported in Sailana (Table 3).

Table 3 Awareness and Participation in health/education/AWC related activities

	Baseline		End-line	
	Bajna	Sailana	Bajna	Sailana
Is the HH aware of any child census/planning	51.2%	46%	85.8%	62.0%
Who conducts the survey	10.3%	30.9%	85.6%	62.5%
Have you participated in any school/AWC/health committee activities	2.87%	2.8%	52.9%	22.56%
Participated in school committee	0.5%	1.8%	24.19%	15.98%
Participated in AWC committee	0.2%	0.9%	43.9%	11.8%
Participated in Health Center committee	0%	0.9%	10.36%	1.24%
Participated in committees as a user/parent			51.54%	21.9%
Participated in committees as a member of the community	0.04%	1.5%	4.5%	0.64%
Have a role in decision making	0.64%	1.33%	7.6%	2.45%
Attended most of the meetings	1.04%	2.22%	44.8%	18.6%
Having a committee good for community			73.9%	63.5%

Source: Household Survey, 2005-06 and 2009

While households who reported participation in school/AWC/health center related committee activities was around 2.8% during baseline survey in both blocks, the end-line survey shows that in Bajna, more than 50% households now involve themselves in service delivery related discussions and activities, while in Sailana, only a little more than one-fifth of the households participated in school/AWC/health center related activities at the time of end-line survey. In Bajna, 52% households attended health/education/nutrition related meetings as parents/users, compared to 21% in Sailana. Only 2.5% of the Sailana

households reported having ever been part of a decision making forum in any of the committees, while in Bajna 7.6% households (14% of all households interviewed) reported being part of decision making regarding health/education/nutrition related service delivery.

3.2: Stage 1: Improved monitoring of growth and development of children and health of pregnant women

In this stage, the main concerns revolve around the health of pregnant women and the initial growth of infants.

1. Did pregnant women and their households prepare themselves enough to embrace a healthy, responsive newborn?

How a pregnant woman and her family are taken care of during pregnancy has a bearing on the newborn's health. Health care during pregnancy (antenatal care, or ANC) is vital for the baby's development in the first few months. ANC is a complex mix of services ranging from advice on recommended diets, monitoring and recording bodily changes, to counseling on precautions to be taken during pregnancy. The aim is to identify, prevent and treat conditions that can endanger the life of the mother and the fetus. Usually, the doctor or health worker provides ANC. Timely and adequate number of checkups is essential for proper monitoring of a pregnancy. A basic (but complete) ANC schedule includes a minimum of three antenatal care visits, consumption of the prescribed dosage of iron and folic acid, and vaccination against tetanus.

(a) Anganwadi Centre checkups

Information on antenatal care was collected from mothers of children in the 0-12 months age group. The following indicators were examined: (i) whether the pregnant woman availed of any (or at least one) Anganwadi Centre (ANC); (ii) whether she went in for the full ANC; (iii) whether she availed of ANC during the first trimester itself; (iv) whether she received various components of ANC checkups; (v) average number of ANC visits by pregnant women; and (vi) whether mothers-to-be received post-ANC feedback and support.

- ***Any ANC:*** The indicator is a minimal measure, as it considers pregnant women who had made at least one antenatal visit. The baseline survey results shows that in 2005-06, around 25% of the mothers in Bajna and 80% of mothers in Sailana had at least one ANC during their pregnancy. The figures for in these two blocks are comparable to the MP state average figures (77% in rural MP in 2005-06) available from NFHS-3 (National Family Health Survey). The end line survey results show that by 2009, almost 98% of all mothers reported having at least one ANC checkup during their pregnancy.¹
- ***Full ANC:*** A full ANC includes a minimum of three ANC visits. In 2005-06, only 8% of mothers had received full ANC in Bajna when compared to 23% in Sailana. As per the NFHS-3 survey of 2005-06, in rural MP, more than 34.6% of mothers made at least three antenatal visits during their most recent pregnancy. An analysis of the end-line shows that 24% of mothers in Bajna and 32% mothers in Sailana received full ANC treatment. Bajna's improvements were significantly better than those of Sailana.
- ***First ANC:*** As per the baseline survey of 2005-06, in Bajna, 12% of pregnant women had their first ANC during the first trimester, while in Sailana, 21% of women availed of ANC during the first trimester itself. Around 49% of women in Bajna and 56% of women in Sailana had their first ANC

¹ An analysis using the difference-in-difference approach shows that the improvements in ANC were more prominent in Bajna, though the improvements were not significant enough to be statistically better than the changes in Sailana.

checkup during the second trimester. Thus, in 2005-06, 61% of women in Bajna and 77% of women in Sailana made their first ANC visit during the first two trimesters. The end-line survey shows tremendous improvements in the first ANC visits during the first trimester itself (57% in Bajna and 87% Sailana). A comparative analysis of the indicator “time of first ANC visit by pregnant women” of the two blocks shows that the improvements were significantly better in Sailana, but the proportion of pregnant women who made the first ANC visit within the first six months was more or less the same in both blocks.

- ***Provision of different components of ANC:*** Pregnant women availing of ANC is a demand side indicator, while the supply side indicator (or service delivery indicator) measures how many of those who approached the health center/AWC received the various components of ANC. Of those who received “any ANC,” the most common components provided were weight and height measurements, blood pressure, and blood chemistry. It is interesting to note that the changes in the many components of ANC provided were more prominent in Sailana than in Bajna. This is especially true for the three most-commonly offered components. In Sailana, the baseline figures were lower than that in Bajna, but the end-line demonstrates better indicators for Sailana. However, we found that for the abdomen examination (the most important component of ANC), Bajna recorded a giant leap from less than 10% during baseline, to more than 60% by end-line. In Sailana, on the other hand, this declined from a little less than 60% to around 11% by end-line. This poses an interesting issue. Was this result due to Bajna health workers/AWCs/doctors relying on abdominal examinations, compared with Sailana, where service providers prescribed a number of examinations without taking into account the basic, abdominal examination? This study, given its quantitative data analysis focus, is not equipped to decipher these differences.
- ***Mean number of ANC visits:*** On average, pregnant women in Bajna had less than two ANC checkups in 2005-06, which has now increased to at least two checkups (end-line survey, 2009). In Sailana, the number of ANC checkups has improved slightly from 1.7 times to 2.2 times between baseline and end-line surveys.
- ***Feedback and follow up action post ANC:*** One of the key milestones that the project hoped to achieve was an improvement in antenatal care. Availing of ANC services coupled with the doctors/ANMs providing the right feedback for corrective action was intrinsic to the success of the pilot. The baseline survey indicated that only 33% of pregnant women in Bajna and 36% in Sailana received any feedback after their ANC. However, the end-line survey shows tremendous improvement, with 85% of pregnant women in Bajna and 71% in Sailana reporting having received feedback post ANC. The improvements in Bajna were significantly more than the advancements made in Sailana. Any follow-up action post ANC was also improved significantly upon in Bajna, when compared to Sailana during the period 2005/06-2009.

(b) Iron and Folic Acid Intake (IFA)

Since most of the women in the area are generally undernourished, it is important that they have sufficient nutritional intakes, generally in the form of iron and folic acid (IFA) tablets. The baseline survey shows that around 72% of the women in Bajna and 79% of women in Sailana had received IFA tablets during their pregnancy. Our end-line survey revealed that the intake of IFA by pregnant women had improved, and 97% of women in Bajna and 88% in Sailana took IFA tablets. The analysis shows that the improvement in Bajna was significantly better than that in Sailana. It also revealed that the intake of IFA was also significantly higher among mothers with full ANC. All mothers who had followed the full ANC cycle received supplementary nutritional intake during their pregnancy, compared with only 70% (baseline survey) and 77% (end-line survey) of those who had not. This meant that a majority of mothers (75%) who had no ANC checkups did not receive supplementary nutrition intake during their pregnancy.

Clearly, the role of ANC checkups for identifying nutritional deficiencies and taking remedial measures on the part of mothers is evident from these results.²

(c) Vaccination against tetanus

Neonatal tetanus is a very common cause of death among neonates, and is common among children who are delivered in unhygienic environments, or when unsterilized instruments are used to cut the umbilical cord. Hence, it is vital that in regions where there is a dearth of adequate health care, the mother is vaccinated against tetanus to prevent the likelihood of neonatal tetanus. An analysis of the baseline and end-line survey results show that in the block where Bachpan was implemented, the improvements were significant when compared to the control block. Mothers who went in for a full ANC were also given the Tetanus Toxoid vaccination during their ANC visits, whereas those with no ANC were mostly left out.

Table 4: Indicators Related to ANC (Sub-Stage 1 of Child Development)							
	Baseline Survey		End-line Survey		Regression coefficients		Diff-in-difference
	Bajna	Sailana	Bajna	Sailana	Bajna	Sailana	coefficients
Percent of pregnant women who:							
Did not receive/avail of any ANC	24.9% (0.015)	19.8% (0.017)	1.3% (0.006)	0.4% (0.003)	-0.22 (0.019)	-0.194 (0.018)	-0.033 (0.027)
Availed of at least one ANC	75.1% (0.015)	80.2% (0.017)	98.7% (0.006)	99.5% (0.003)	0.226 (0.019)	0.193 (0.018)	0.033 (0.027)
Availed of the full ANC	8.9% (0.009)	23.8% (0.018)	24.4% (0.018)	32.5% (0.021)	0.148 (0.019)	0.087 (0.027)	0.061* (0.032)
Mean number of ANC	1.4 (0.035)	1.7 (0.057)	2.05 (0.03)	2.26 (0.031)	0.627 (0.052)	0.578 (0.067)	0.04817 (0.084)
Of those who received some ANC, those who							
Had their first ANC within the first two trimesters	48.8% (0.017)	55.3% (0.021)	89.01% (0.014)	98.1% (0.006)	0.402 (0.024)	0.428 (0.016)	-0.026** (0.034)
Had their first ANC during the 1st trimester itself	11.8% (0.011)	21.2% (0.017)	56.3% (0.022)	88.2% (0.015)	0.444 (0.022)	0.670 (0.023)	0.225*** (0.032)
Those who received different components of ANC							
Had their weight measured during ANC	64.9% (0.016)	59.2% (0.021)	85.2% (0.016)	83.9% (0.017)	0.202 (0.024)	0.248 (0.027)	-0.045 (0.036)
Had their height taken during ANC	46.5% (0.017)	19.4% (0.017)	56.7% (0.022)	83.1% (0.017)	0.092 (0.028)	0.637 (0.023)	-0.545*** (0.038)
Had their BP checked during ANC	42.0% (0.017)	20.5% (0.017)	63.7% (0.021)	76.8% (0.019)	0.212 (0.027)	0.563 (0.025)	-0.351*** (0.038)
Had their blood tested during ANC	23.6% (0.015)	23.2% (0.018)	53.6% (0.022)	59.8% (0.022)	0.300 (0.025)	0.365 (0.028)	-0.065* (0.038)
Had their urine tested during ANC	16.9% (0.012)	12.3% (0.014)	38.5% (0.021)	38.6% (0.022)	0.213 (0.023)	0.263 (0.025)	-0.050 (0.035)
Had their abdomen examined during ANC	9.9% (0.010)	58.6% (0.021)	60.2% (0.022)	10.5% (0.014)	0.498 (0.021)	-0.481 (0.026)	0.978*** (0.033)
Had an internal examination	16.9%	22.9%	11.3%	5.3%	-0.057	-0.176	0.119***

² However, it was not easy to ascertain whether they consumed these for 90 days or more when they were pregnant, as most of the mothers lacked recall on this.

Table 4: Indicators Related to ANC (Sub-Stage 1 of Child Development)							
	Baseline Survey		End-line Survey		Regression coefficients		Diff-in-difference
	Bajna	Sailana	Bajna	Sailana	Bajna	Sailana	coefficients
during ANC	(0.013)	(0.018)	(0.014)	(0.01)	(0.019)	(0.021)	(0.029)
Had their X-Ray done during ANC	0.2% (0.001)	0.7% (0.003)	6.2% (0.01)	6.7% (0.011)	0.059 (0.008)	0.060 (0.011)	0.001 (0.01)
Other aspects							
Intake of IFA	71.7% (0.016)	78.6% (0.017)	96.5% (0.008)	87.8% (0.015)	0.240 (0.020)	0.092 (0.023)	0.147*** (0.0312)
Vaccination of TT	77.1% (0.015)	83.5% (0.016)	95.0% (0.009)	88.0% (0.015)	0.178 (0.019)	0.045 (0.022)	0.133*** (0.029)
*Indicates significance at 0.01 confidence level (statistically significant at least at 90% level. ** Indicates significance at 0.05 level (statistically significant at least at 95% level. *** Indicates significance at 0.001 level (statistically significant at 99% level). <i>Figures in parenthesis are standard errors.</i>							

2. How many of these pregnant women ensured a safe delivery?

Deliveries in a health facility under medical supervision, or at home but conducted by a health professional (doctor/nurse/traditional birth attendant), are considered as safe deliveries. Even though childbirth is a natural process, the presence of a trained assistant is important to handle any emergencies that might arise, as quick and informed action can save the life of both the mother and the child. Using this definition of safe delivery, according to an RCH survey (2005) the percentage of safe deliveries in MP in 2004 was around 35.5%. This is lower than the national average of 48%. In Ratlam, however, the corresponding figures were a little over 50%.

Table 5: Results related to improvements in Safe Delivery practices							
	BASELINE SURVEY		END-LINE SURVEY		Regression coefficients		Diff in difference
	Bajna	Sailana	Bajna	Sailana	Bajna	Sailana	Coefficients
Place of Delivery							
Home	67.5% (0.016)	74.9% (0.018)	31.3% (0.0203)	71.3% (0.0204)	-0.365 (0.026)	-0.036 (0.027)	-0.329*** (0.038)
Government Health Facility	29.8% (0.0158)	16.5% (0.0158)	67.7% (0.021)	28.7% (0.020)	0.372 (0.025)	0.121 (0.025)	0.251*** (0.036)
Institutional delivery	31.7% (0.016)	24.5% (0.018)	68.0% (0.02)	28.6% (0.020)	0.363 (0.026)	0.0415 (0.0273)	0.321*** (0.038)
Assistance during Delivery							
Health Professional	34.5% (0.016)	29.0% (0.019)	76.7% (0.019)	34.9% (0.022)	0.415 (0.025)	0.059 (0.028)	0.358*** (0.038)
Traditional Birth Attendant	49.6% (0.017)	61.2% (0.021)	15.9% (0.016)	32.1% (0.021)	-0.334 (0.025)	-0.29 (0.029)	-0.0436 (0.038)
Delivery not in govt. b'se it's far off	50.1%	51.7%	21.4%	27.3%			
Orientation about child care and	14.8%	33.6%	64.2%	18.3%	0.49	-0.15	0.65***

	BASELINE SURVEY		END-LINE SURVEY		Regression coefficients		Diff in difference
	Bajna	Sailana	Bajna	Sailana	Bajna	Sailana	Coefficients
post-delivery care after delivery	(0.012)	(0.021)	(0.021)	(0.017)	(0.022)	(0.03)	(0.034)
*indicates significance at 0.01 confidence level (statistically significant at least at 90% level); ** indicates significance at 0.05 level (statistically significant at least at 95% level); *** indicates significance at 0.001 level (statistically significant at 99% level) Figures in parentheses show standard errors in estimation							

The baseline survey showed that in Bajna, home births constituted 68% of all deliveries, and in Sailana, it stood at 75%. In keeping with this finding, it was noted that health professionals' attendance at deliveries was less than 35% in Bajna, and less than 30% in Sailana. The majority of deliveries (especially those at home) were attended to by a traditional birth attendant (TBA), the most accessible option. Interestingly, by the time of the end-line survey, there were some changes: in Bajna, only 31% of the deliveries were at home, whereas in Sailana, a large number (71%) continued to have home births. In Bajna, 77% of births were attended to by a health professional, compared with only 35% in Sailana. Only 7% of deliveries in Bajna were conducted without the presence of either a health professional or a trained/traditional birth attendant, as against 33% in Sailana. The block-wise regression analysis of institutional deliveries shows that the improvements from 2005-06 to 2009 were of the magnitude of 36% in Bajna, and only 4% in Sailana, and a difference between the changes was to the extent of 32%, which is highly significant. Similarly, deliveries attended to by a trained health professional improved by 41% in Bajna and by around 6% in Sailana, a difference of 36% in improvements. See Table 5 for details.

3. Orientation post-delivery about subsequent health care and childcare

Since most of the deliveries, especially during the baseline survey, were not institutional (they took place at home), any orientation regarding childcare from health workers/*anganwadi* workers/birth attendants or even elders in the family, is crucial for the mother of the newborn. In keeping with the high rate of births taking place at home and attended to by TBAs, the results show that very few mothers received some orientation post delivery (15% in Bajna, and 30% in Sailana) at baseline. However, the end-line survey results show that around 35% of mothers received orientation post delivery in both Bajna and Sailana. The improvements in Bajna are significant not only because of their low levels in baseline indicators but also because of the number of women catered to (the higher number of institutional deliveries in Bajna is described in detail in the section that studies project outcomes/milestones).

4. Were the newborns taken care of properly?

It is important that wherever the child is born—at home or in an institutionalized set up—it is born healthy and given the care that it deserves. Appropriate antenatal care has a considerable influence on the health of the fetus and the newborn. Additionally, with adequate postnatal care, those born 'not so healthy' display higher recovery rates.

Newborns whose weights were recorded at birth: As a consequence of non-institutional deliveries, most children's weights were not taken at birth, even in the case of TBA-assisted births. The frequent fallout of this negligence is that underweight babies are not identified at the appropriate time, and corrective measures are overlooked. The baseline survey shows that weight was recorded at birth for only 34% newborns in Bajna and 24% in Sailana. But the end-line shows that this has shot up to 79% in Bajna, and gone up marginally to 29% in Sailana.

Breastfeeding and complementary feeding practices: Exclusive breastfeeding facilitates an infant's initial growth, but subsequently, the child should be provided with timely and appropriate complementary feeding. It must be noted that the concept of exclusive breastfeeding, especially at birth, did not exist in the communities under study (both Bajna and Sailana). Along with mother's milk, infants were generally fed goat milk and water, right from the first day itself. On the other hand, the custom in the area is that often breast milk is not given to newborns immediately after birth. It was observed that breastfeeding was started only after a few days after birth; this practice was rooted in tradition that believed mother's milk to be harmful for the newborn. In both villages, a large proportion of mothers (on average, about 41%) squeezed out the milk rather than let their baby drink it. The end-line survey shows that in Bajna, 38% of mothers did this in comparison to 75% mothers in Sailana. In such a context, the relevant question is whether mother's milk was given apart from other fluids within the first few hours of birth. In Bajna, 62% of the newborns were breastfed at birth, while this was as low as 46% in Sailana. This percentage is, in fact, much higher than MP state figures (overall 15%; in rural areas, only 13%).³ By the time of the end-line survey, more than 77% of mothers in Bajna and 76% in Sailana had breastfed their newborns at birth.

Were children getting enough nutrition to ensure appropriate weight-for-age/height? In keeping with the U.S. National Center for Health Statistics (NCHS) standard, in this report we follow three indices of physical growth that describe the nutritional status of children: (a) height-for-age (stunting); (b) weight-for-height (wasting); and (c) weight-for-age (underweight).⁴

In Bajna, the two indices of stunting and underweight improved faster than that in Sailana, whereas in the case of wasting, there was no great improvement over Sailana. The baseline survey showed that only around one-fifth of children in their early months had proper weight-for-age in both Bajna (21%) and Sailana (22%). Another 15-20% infants in these blocks were mildly undernourished (weight-for-age is < -1 SD). However, an alarming majority of children in their first year were found to be severely malnourished (65% in Bajna, and 58% in Sailana). Worse, 34% in Bajna and 31% in Sailana were acutely malnourished. Three years down the line, there is definite improvement in both blocks, but not to the extent expected, especially in view of the focus given to this issue in Bajna during the project interventions. The proportion of "normal" children improved from 21% in baseline to 27% at end-line in Bajna and from 22% at baseline to 29% in the end-line survey in Sailana. However, it is heartening that there is a reduction (in both blocks) in the proportion of children who were severely and acutely malnourished, with significantly more reduction in Bajna. The decline in the proportion of underweight children in households in Bajna was 22% and 12% respectively for severe (proportion of children with < -2SD weight-for-age) and acute malnourishment cases (proportion of children with weight-for-age is < -3SD). The same was in the order of 8% and 1% in Sailana, and the overall differences between the changes in both blocks were of the magnitude of 13% for severe and 11% for acutely malnourished children.

³ Data from NFHS-3, 2005-06.

⁴ This study was designed before the World Health Organisation (WHO) prescribed the new growth standards in 2006⁴ that were adopted by the Government of India. Therefore, during the baseline analysis the only measure used for understanding the nutritional status of children was to look at age-related weight of children, as derived from the U.S. National Center for Health Statistics (NCHS) standard, and which was recommended at that time by the WHO. According to the NFHS-3, 2005-06 report, "The new WHO growth standard adopts a prescriptive approach, describing how healthy children should grow. The new standard is based on children around the world (Brazil, Ghana, India, Norway, Oman, and the United States) who are raised in healthy environments, whose mothers do not smoke, and who are fed with recommended feeding practices (exclusive breastfeeding for the first 6 months and appropriate complementary feeding from 6 to 23 months). The WHO growth standard identifies the breastfed child as the normative model for growth and development standards, depicts normal early childhood growth under optimal environmental conditions, and can be used to assess children everywhere, regardless of ethnicity, socioeconomic status, and type of feeding." (NFHS-3, 2005-06, India Report Volume I, page 268).

Table 6. Improvements in reducing proportion of children underweight							
	BASELINE SURVEY		END-LINE SURVEY		Regression coefficients		Diff in difference
	Bajna	Sailana	Bajna	Sailana	Bajna	Sailana	coefficients
New born babies' weight measured	33.6% (0.016)	24.5% (0.018)	78.6% (0.018)	28.6% (0.020)	0.450 (0.033)	0.041 (0.027)	0.408*** (0.037)
Measures of physical growth that describe the nutritional status of children:							
<i>Proportion of children with :</i>							
Height-for-age (stunting) =<-2SD	89.1% (0.01)	62.3% (0.02)	63.3% (0.02)	62.2% (0.02)	-0.0005 (0.030)	-0.256 (0.02)	-0.255*** (0.013)
Weight-for-height (wasting) =<-2SD	34.2% (0.016)	50.8% (0.02)	31.02% (0.02)	41.66% (0.02)	-0.0915 (0.030)	-0.0318 (0.026)	0.059 (0.04)
Weight-for-age (underweight) =<-2SD	64.8% (0.016)	57.9% (0.021)	43.3% (0.022)	49.4% (0.023)	-0.215 (0.027)	-0.085 (0.031)	-0.129** (0.041)
No complementary food even at 12+ months	30.0% (0.018)	17.0% (0.018)	3.9% (0.008)	1.8% (0.005)	-0.26 (2.0)	-0.16 (2.2)	-1.012*** (3.03)
Mean height- in cm for boys	53.2 (0.005)	59.6 (0.006)	57.3 (0.005)	58 (0.007)	3.99 (0.75)	-1.59 (0.9)	5.59*** (1.16)
Mean height – in for girls	52.8 (0.006)	57.4 (0.006)	56.9 (0.005)	57.8 (0.007)	4.11 (0.79)	0.27 (0.90)	3.83*** (1.19)
*indicates significance at 0.01 confidence level (statistically significant at least at 90% level); ** indicates significance at 0.05 level (statistically significant at least at 95% level); *** indicates significance at 0.001 level (statistically significant at 99% level) Figures in parentheses show standard errors in estimation							

Who takes care of the child? In these regions, habitations primarily consist of close and distant relatives, or those belonging to the same community. Hence, there is a strong bonding between members in a household and also with the community. Traditionally, the newborn is either taken care of by the mother herself, or by family members, including older siblings or grandparents. At baseline, the involvement of the father in childcare was reported only in 20% in the 0-12 months age bracket in Bajna, in contrast to 61% of the households in Sailana reporting father's role in infant care. However, in both blocks, the involvement of fathers is largely limited to a short time period per day, and mainly involved "taking child for a walk." Very few households reported that the father was took his child for immunization and/or to health centers.

In the end-line survey, 88% of households in Bajna (a four-fold increase over the baseline) and 83% households in Sailana (up 20 percentage points) reported that fathers are now more involved in infant care in one way or another. Moreover, 27% of households in Bajna and around 40% households in Sailana reported that fathers take care of infants for a sizeable amount of time.

Summary of Results: Stage 1

The analysis of antenatal care practices of pregnant women, and the modalities of delivery and post-delivery practices and care for the newborn child shows mixed results in terms of the impact of the Bachpan project. While some of the antenatal care related practices improved much more in the non-project block, changes related to delivery and postnatal care practices were better in the project block than in the control block.

Overall, the analysis demonstrates that practices related to antenatal care had improved in both Bajna and Sailana, though the magnitude of change was of different scales for different components of ANC, and

hence have different meaning for the two blocks. Sailana showed equal or better changes than Bajna on many counts, almost to the level of dismissing the role of interventions under the Bachpan project. However, when the qualitative changes in practices are considered, the project's value addition is borne out. For example, while the numbers of women opting for ANC had gone up in Sailana, Bajna reflected significantly more improvements in women going in for the full ANC checkup, crucial for improving the gains from ANC (3.4% better than the gains in Sailana). Similarly, the gains in Bajna between baseline and end-line with respect to IFA intake and TT vaccine of mothers were 9.8% and 10% better than the gains in Sailana.

The interventions by ANMs and Anganwadi workers in both Bajna and Sailana seem to be generating enhanced awareness among communities about the need for consultations with doctors, as is evident from the increased demand for ANC checkups. The quality of service delivery is also improving, evident from the fact that more pregnant women report feedback and follow up actions. These changes, indicative of deep qualitative behavioral change (or change in practices), are further evident from the indicators related to IFA intake and TT vaccination. While services provided and availed of improved in the control block, the treatment block displayed more qualitative improvements.

3.3 Stage 2: Take off period? Children aged between 1-2 years

The foundation for a child's development is ensured through appropriate antenatal care, safe delivery, and the type of childcare provided to the infant. The first two years of a toddler's life is critical for brain development and for building cognitive and physical capabilities. Moreover, this period is important as the child is now extremely susceptible to environmental influences. This is also the stage when corrective measures should be acted upon to compensate for any nutritional inadequacies accumulated during the later months of the first year. If the second year also passes by without correction, the deprivation may in fact result in deficits that might be irreversible. During this period, immunization of the child against various communicable diseases and other childhood illnesses becomes vital, as does the child's nutritional needs.

The indicators to gauge their development during this sub-stage are: (a) children in the 12-23 month (1-2 years) age groups received vaccinations against the 6 serious but preventable diseases (which are essential for child survival); and (b) children who are not underweight for their age.

During the household survey, mothers were asked whether their children were immunized against tuberculosis (BCG), diphtheria and tetanus (DPT), poliomyelitis, and measles. Full immunization of a child includes BCG, Measles, three booster shots of DPT, and three polio shots excluding the Polio 0. The NFHS-2 (1999) reported that 17% of the children aged 12-23 months in rural MP received all immunization, and by 2005-06 (NFHS-3) this had improved to 32%. For Ratlam district, the number of children fully immunized by the time they were 2-years-old was only 5.7% (NFHS-2). These rates of immunization at baseline are low even when compared to the M.P state average (as available from NFHS-2 and 3).

Immunization: During the baseline survey, in Bajna, only 5.2% of the children in the age group of 12-23 months had received full immunization, while Sailana stood at a marginally better 6.5%. Three years later, these figures improved several-fold in both blocks.

A disaggregated analysis of the proportion of children receiving different doses of Polio and DPT vaccines during the baseline survey highlights a major problem that existed with the immunization scenario in these blocks, especially in Bajna. The baseline survey data show that the proportion of children who received the successive three booster doses of Polio and DPT vaccines was low, particularly in Bajna. In Bajna, while 77% of the children took the DPT 1 shot, only 16% availed of the DPT 3 vaccination, indicating that 61% children dropped out between DPT 1 and DPT 3. On the other hand, in

Sailana, 67% children took the DPT 1 vaccination, and 56% took the DPT 3 shot, a drop of only 11%. Similarly, 89% of children in Bajna received the Polio 1 vaccine while only 20% received the Polio 3 vaccine, compared to Sailana, where 95% children were given Polio 1 and 88%, Polio 3. As a result, in Bajna, while many children took one dose of these vaccines, those who received the complete stipulated inoculation were far fewer. Only those with full immunization were actually protected from these diseases.

Table 7: Details of immunization of children between 1- 2 years of age							
	BASELINE SURVEY		END-LINE SURVEY		Regression coefficients		Diff in difference
	Bajna	Sailana	Bajna	Sailana	Bajna	Sailana	coefficients
BCG	82.7% (0.015)	77.2% (0.0202)	96.3% (0.008)	94.9% (0.011)	0.136 (0.018)	0.177 (0.023)	-0.04089 (0.03)
DPT 1	77.4% (0.017)	66.9% (0.0227)	95.6% (0.009)	94.3% (0.01.2)	0.182 (0.02)	0.274 (0.03)	-0.0924** (0.033)
DPT 2	47.6% (0.019)	62.5% (0.023)	83.1% (0.017)	91.2% (0.01.4)	0.355 (0.03)	0.288 (0.03)	0.0672* (0.04)
DPT 3	16.4% (0.015)	55.7% (0.024)	68.3% (0.021)	84.8% (0.018)	0.519 (0.025)	0.291 (0.031)	0.228*** (0.039)
All 3 DPT	15.8% (0.014)	54.8% (0.024)	66.9% (0.022)	83.8% (0.019)	0.511 (0.025)	0.290 (0.031)	0.221*** (0.039)
Polio 0	70.5% (0.018)	91.8% (0.0132)	94.6% (0.0103)	94.3% (0.012)	0.241 (0.022)	0.025 (0.018)	0.216*** (0.031)
Polio 1	89.3% (0.012)	94.6% (0.011)	91.9% (0.012)	94.3% (0.012)	0.026 (0.018)	-0.003 (0.016)	0.029 (0.025)
Polio 2	65.9% (0.019)	92.8% (0.013)	81.7% (0.018)	90.9% (0.015)	0.157 (0.026)	-0.018 (0.019)	0.175*** (0.035)
Polio 3	20.2% (0.016)	87.9% (0.0158)	69.8% (0.021)	81.9% (0.0195)	0.496 (0.026)	-0.059 (0.025)	0.555*** (0.037)
ALL 3 POLIO	19.4% (0.0157)	87.9% (0.0158)	68.3% (0.0213)	81.2% (0.02)	0.489 (0.026)	-0.067 (0.025)	0.556*** (0.037)
Measles	26.3% (0.018)	8.2% (0.013)	72.1% (0.020)	70.9% (0.023)	0.457 (0.027)	0.627 (0.026)	-0.169*** (0.038)
Hepatitis B	2.4% (0.006)	0.5% (0.003)	28.3% (0.021)	36.6% (0.024)	0.260 (0.019)	0.361 (0.024)	-0.101** (0.03)
Full imm. Excl measles	9.9% (0.011)	53.4% (0.024)	65.2% (0.022)	79.4% (0.021)	0.553 (0.023)	0.260 (0.032)	0.292*** (0.039)
Full Immunization	5.2% (0.008)	6.5% (0.012)	56.9% (0.023)	66.8% (0.024)	0.517 (0.022)	0.602 (0.026)	-0.086** (0.034)

*indicates significance at 0.01 confidence level (statistically significant at least at 90% level); ** indicates significance at 0.05 level (statistically significant at least at 95% level); *** indicates significance at 0.001 level (statistically significant at 99% level)
 Figures in parenthesis are standard errors of estimation

The emerging lesson for health providers in Bajna was that while people were aware of the various vaccines for babies, they were not cognizant with the components of the vaccines and the requirement to provide all the different dozes within the stipulated timeframe. While this was an indication of the lack of

awareness among the community and parents, it also pointed to the inadequate IEC (information, education and communication) efforts on the part of the schemes. The baseline survey results also brought out the fatigue factor in campaigners, who lost the initial momentum and were not able to mobilize the community to get the booster vaccines. Also, parental lethargy set in with successive doses. This problem was more acute in Bajna than in Sailana. The interventions under Bachpan were aimed at improving community awareness about the vaccination requirements and in motivating service providers to enable synergies between supply and demand.

As is evident from the table, the percentage of children who took the required vaccines improved from baseline to end-line in both Bajna and Sailana. While Sailana had better indicators overall, especially with respect to the booster shots of DPT and Polio, the improvements in Bajna were much better, especially given their low baseline indicators. However, in three years' time, Bajna was able to accelerate its vaccination related practices. There were significant improvements in the immunization of both boys and girls, with better indicators in Sailana, but better improvements in Bajna. For a closer scrutiny, see Table 8.

Table 8: Details of immunization of children between 1- 2 years of age: by gender										
	BOYS					GIRLS				
	Baseline Survey		End line survey		DID	Baseline Survey		End line survey		DID
Vaccination	Bajna	Sailana	Bajna	Sailana	Coef	Bajna	Sailana	Bajna	Sailana	Coef
BCG	81.9%	76.7%	96.5%	94.6%	-0.033	83.6%	77.8%	95.9%	95.2%	-0.049
All 3 DPT	15.3%	53.4%	68.9%	83.2%	0.238***	16.4%	56.8%	64.6%	84.4%	0.205***
Polio 0	68.9%	92.5%	96.5%	95.1%	0.250***	72.5%	90.9%	92.4%	93.6%	0.172***
ALL 3 POLIO	17.2%	87.8%	69.3%	80.7%	0.591***	22.1%	88.1%	67.3%	81.7%	0.515***
Measles	26.8%	8.7%	72.4%	68.8%	-0.145***	25.7%	7.4%	71.8%	73.1%	-0.196**
Hepatitis B	3.4%	0.4%	32.7%	38.6%	-0.089	1.1%	0.6%	23.3%	34.4%	-0.115**
Full Immu.zn	4.8%	6.7%	57.6%	65.8%	-0.063	5.7%	6.3%	56.1%	67.7%	-0.111*
Full imm. Excl	9.3%	51.4%	66.5%	79.2%	0.293***	10.7%	56.3%	63.7%	79.6%	0.296***

*indicates significance at 0.01 confidence level (statistically significant at least at 90% level); ** indicates significance at 0.05 level (statistically significant at least at 95% level); *** indicates significance at 0.001 level (statistically significant at 99% level)

Nutrition Status: Are Bajna and Sailana children growing up healthy and well nourished in their first and second years? Are they compensated for the undernourishment accumulated in their first year? A comparison of growth and malnutrition status (using the three growth indicators of height-for-age, weight-for-height, and weight-for-age) of children aged 12-24 months with that of infants (0-12 months), is carried out here.

Baseline survey data shows that the health status of children had not improved after they turned one; rather, they further deteriorated in their second year. If in their first twelve months only 41% of children were severely malnourished in Bajna and 33% in Sailana, by the time they completed their second year, their share went up to 66% in Bajna and 51% in Sailana. This is quite similar to the figures for rural MP (62.6% in 2005-06) as reported by NFHS-3. On the other hand, the proportion of children who had desirable weight-for-age (>-2SD) reduced from 34% in Bajna and 53% in Sailana in the 0-12 months age group to less than 16% in Bajna and 22% Sailana.

However, the situation improved significantly between baseline and three years later. A comparison of the weight-for-age status of children aged 12-24 months in both blocks showed marginal improvements overall, but a comparison of the indicator between the baseline survey and end-line survey reveals that the proportion of children with severe malnutrition (proportion of children with less than 2SD weight-for-

age) declined significantly in the intervention block, when compared to the control block (improvements are 7 percentage points better in Bajna than in Sailana). However, the improvements in reducing moderate malnourishment were better in Sailana.

	BASELINE SURVEY		END-LINE SURVEY		Regression coefficients		Diff in difference
	Bajna	Sailana	Bajna	Sailana	Bajna	Sailana	coefficients
Height-for-age (stunting) = <-2SD	85.66% (0.009)	74.77% (0.02)	76.8% (0.011)	68.79% (0.02)	-0.115 (0.031)	-0.059 (0.023)	-0.013 (0.037)
Weight-for-height (wasting) = <-2SD	24.04% (0.017)	51.53% (0.024)	47.48% (0.022)	41.49% (0.025)	0.23 (0.028)	-0.100 (0.035)	0.334*** (0.044)
Weight-for-age (underweight)=<-2SD	85.65% (0.014)	78.32% (0.02)	82.08% (0.02)	67.01% (0.023)	-0.036 (0.022)	-0.113 (0.031)	0.077* (0.037)
Mean height – in cm for boys	68.2cm (0.43)	72.1cm (0.4)	70.33cm (0.45)	70.4cm (0.98)	2.13 (0.63)	-1.69 (0.96)	3.820*** (1.11)
Mean height – in cm for girls	66.5cm (0.46)	70.4cm (0.4)	68.8cm (0.46)	70.4cm (1.01)	2.28 (0.66)	0.32 (1.1)	1.970 (1.21)

indicates significance at 0.01 confidence level (statistically significant at least at 90% level) ; ** indicates significance at 0.05 level (statistically significant at least at 95% level); * indicates significance at 0.001 level (statistically significant at 99% level)*
 Figures in parenthesis are standard errors of estimation

We examine here the various possible factors for this decline in children’s health status. In both Bajna and Sailana, less than 7% of the parents thought that their ward was underweight. Since more than 80% of the parents in these blocks are illiterate, their only source of learning about their children’s weight-for-age appropriateness was through the *anganwadis* or health workers. The statistics from the household survey shows that among this group of children (12-23 months), only 42% children in Bajna and 57% children in Sailana had their height and weight measured regularly at *anganwadi* centers (AWCs). More literate parents than illiterate parents ensured that their children’s growth monitoring was regularly taken at AWCs.

Parental knowledge about child malnutrition: Parents learned about their children’s weight-for-age status from AWCs when the children were measured as part of the regular growth monitoring exercise managed by the AWC. However, during the baseline survey, it was found that around 9% households in Bajna and 2% in Sailana were unaware of such services delivered by AWCs. About half of the respondents (54% in Bajna, and 44% in Sailana) reported that regular growth monitoring was not taking place at AWCs, and hence their ward’s growth was not screened.

For the small proportion of children whose growth was monitored on a regular basis, an even smaller proportion of parents (12% in Bajna, and 26% in Sailana) kept a record of their children’s growth. In Sailana, the figures stand at 23% among illiterates and 40% among literates.

	BASELINE SURVEY		END-LINE SURVEY		Regression coefficients		Diff in difference
	Bajna	Sailana	Bajna	Sailana	Bajna	Sailana	coefficients
Regular measure of height & weight	41.96% (0.02)	56.64% (0.023)	65.21% (0.021)	73.45% (0.022)	0.232 (0.029)	0.17 (0.033)	0.064 (0.044)

Table 10: Regular monitoring of Child health related indicators							
	BASELINE SURVEY		END-LINE SURVEY		Regression coefficients		Diff in difference
Regular growth monitoring	37.54%	53.85%	52.29%	69.07%	0.147	0.152	-0.004
	(0.019)	(0.024)	(0.023)	(0.024)	(0.029)	(0.033)	(0.045)
Figures in parenthesis are standard errors of estimation							

The practice of regular measuring of height and weight of children at AWCs improved between baseline and end-line survey periods, and more evidently in the intervention block (5 percentage points better than that in the control block).

In a scenario where the majority of children are underweight, and not identified, for the most part, remedial action becomes a challenge. Counter measures include providing adequate supplementary nutrition, either through additional food supplements at home, or from micro-nutrients at AWCs. The baseline survey shows that at home, around 34% of the households in Bajna and 53% in Sailana gave their children watered-down goat's milk in addition to breast milk. Around 33% households in Bajna and 35% in Sailana reported that they fed their children the usual cereals and pulses everyone else took at home—rice, *roti* (unleavened flat bread), *dals* (pulses), etc. In addition to this, 4% households in Bajna and 5% in Sailana reported that the children were also given some vegetables in addition to cereals. However, 29% households in Bajna and 8% in Sailana reported no supplementary food for the children in this age group, which is quite alarming.

The end-line survey shows tremendous improvements in the supplementary food provided. As many as 92% households in Bajna and 97% in Sailana reported feeding rice/*roti* and *dal* to children in this age group. Similarly, 77% of households in Bajna and 75% of the households in Sailana reported that breast milk was supplemented with fruits and vegetables for children in this age bracket. Interestingly, the tendency to feed baby food like Cerelac and Lactogen is increasing in these communities—around 39% of households (27% in Bajna, and 54% in Sailana) reported topping up their children's diet with either one of these.

Households who fed the child cereals, pulses, and vegetables fell proportionately more among the high asset group than in the lower income groups, a clear indication that feeding habits are very much a reflection of a household's prosperity level. The differences were also obvious with respect to the social groups—more non-tribals than tribals (the majority population in this area) tended to feed their children supplementary food. However, there was no significant difference (between parents who supplemented their child's food as against those who didn't) in terms of literacy of the parents. Also, there were no gender differences in terms of what was fed to the children.

Summary of Outcomes: Stage 2

The analysis of net gains (in improving immunization practices and children's weight-for-age outcomes) shows that in Bajna, the improvements were better than in Sailana. This is especially notable with respect to the indicators related to complete doses of DPT and Polio, as well as in reducing the severe underweight among children. It appears that the interventions under Bachpan have served to accelerate the pace of child development at this stage in the trial villages.

Use of Services

For the children in the age group of 12-23 months, immunization and care are important services provided at *anganwadis*. During the baseline survey, only 36% of the households in Bajna and 41% percent in Sailana availed of these services. Accessing AWCs seems to have been a major issue, especially in

Bajna, where parents were reluctant to take their toddlers to a distant center. In Sailana, half of those who did not use AWCs for this age group stated that since there were no activities in AWCs for their children, they saw no reason to send them there. By the time of the end-line survey, 59% in Bajna and 56% in Sailana reported availing of AWC childcare services, and another 20% in Bajna and 16% in Sailana reported using the health sub-center services instead.

At end-line, parents stated they had started taking measures to ensure that the child stays clean and healthy. These included: keeping the home clean and neat; regular bathing of children and washing of their clothes; providing timely and healthy diet; and regular checkups with doctors around the toddler's health. These measures were reportedly more prevalent in Bajna than in Sailana: the most notable differences were in the proportion of parents who reported that they took these measures; as well as in scheduled checkups with doctors.

Measures	BAJNA			SAILANA		
	To a great extent	To some extent	Not done	To a great extent	To some extent	Not done
Keep home clean and relatively germ free	41.04%	51.46%	7.5%	14.95%	67.8%	17.3%
Proper care of sanitation of the child	23.96%	59.2%	16.9%	6.44%	67.5%	26.03%
Regular bath	52.92%	39.8%	7.29%	17.8%	54.9%	27.3%
Regular wash of child's clothes and other materials used by the child (such as bottles, utensils etc.)	19.4%	46.3%	34.4%	13.7%	57.99%	28.4%
Regular wash of clothes/other materials used by the person taking care of the child	23.75%	48.13%	28.13%	7.7%	57.99%	34.3%
Keeping the child away from people having any infection	10.2%	60%	29.8%	5.9%	57.99%	36.08%
Healthy diet	38.13%	51.04%	10.83%	17.53%	67.3%	15.21%
Timely diet	23.96%	52.1%	23.96%	16.24%	63.92%	19.9%
Scheduled check-up of the child by qualified doctor/person	10.6%	63.96%	25.42%	3.4%	34.5%	62.11%

3.4: Stage 3: Children Aged Between 2-5 Years—Time to go to an Anganwadi?

The early years of a child's life determine its physical growth and health, with nutrition playing a significant role in child development. This is also the time to inculcate social skills in children, and prepare them for school. The evidence presented so far shows that there was significant improvement in the child development indicators in the first two years of children's lives in Bajna, though there remain significant challenges for a minority of children. Did the accumulated deficits of the first two years affect the subsequent growth years of a child? Or, were these deficits compensated by corrective actions and care during this stage? Did improvements in early childcare outcomes benefit the later child years? This section of the report chronicles a child's development during this stage (2-5 years). Here, we look at five key child development indicators: (a) growth monitoring and weight-for-age of children, (b) supplementary nutrition provision, (c) attendance at anganwadi centers, (d) participation in preschool education, and (e) school readiness of children.

(a) Growth monitoring and weight-for-age of children: Regular monitoring of weight and height, both by parents and at the anganwadi center, improved tremendously between the baseline and end-line surveys in both Bajna and Sailana, but the greater rate of improvement in Bajna meant that it was able to catch up with Sailana on this indicator.

However, the proportion of children who were severely underweight for their age remained more or less stagnant between baseline and end-line in Bajna, as against a slight decline in Sailana. This finding demands attention—it shows that regular monitoring of weight-for-age did not lead to improved nutritional status. Another matter of concern was also the higher proportion of severely underweight children among girls, which indicates lingering gender discrimination .

During the baseline survey, 46% of the parents in Bajna and 61% of the parents in Sailana reported that their ward’s height and weight were measured regularly at the anganwadi center. By the time of the end-line survey, the percentage of parents reporting regular monitoring of height and weight of children increased to 84% and 86%, respectively, in Bajna and Sailana. The growth monitoring practices were better for this age group when compared to Sub-Stage 2 (1-2 years of age) in both blocks for a variety of reasons, chief among them being the increase in AWC attendance by children, both for supplementary nutrition as well as for preschool education. During the baseline survey, it was observed that growth monitoring by AWC on a regular basis happened for 51% of children as reported in Bajna, and around 59% children in Sailana. In the three-year period that followed, this improved to 71% and 74% in Bajna and Sailana, though the magnitude of improvements was more in the former.

(b) Supplementary nutrition provision: The findings, pointing to the worsening of severe malnutrition among children at this stage compared to earlier in life (as indicated by the high proportion of children with less than median weight-for-age), suggest that there is a need to compensate the deficits by supplementary nutrition and food. At the baseline survey, parents of 43% children in this age group in Bajna, and 44% in Sailana reported that their children were administered Vitamin A drops from AWCs. Similarly, 44% children in Bajna and 43% in Sailana reportedly received IFA supplements. However, given the high proportion of children who were severely and mildly underweight, the percentage of children receiving these supplements should have been higher. The need and supply/demand gap could be the result of low utilization of AWCs in Bajna and Sailana.

The end line survey results indicate large improvements in the proportion of children who received Vitamin A and IFA supplements. Parents of more than 82% children in Bajna and 76% children in Sailana reported receiving Vitamin A supplements, while 71% in Bajna and 49% in Sailana reported that their wards were provided with IFA supplements. The increase in the provision of Vitamin A supplements and IFA were significantly more in Bajna, indicating improved proactive efforts to compensate for poor nutrition of children.

	BASELINE SURVEY		END-LINE SURVEY		Regression coefficients		Diff in difference coefficients
	Bajna	Sailana	Bajna	Sailana	Bajna	Sailana	
Height-for-age (stunting) =<-2SD	83.86% (0.009)	74.54% (0.011)	76.8% (0.011)	68.79% (0.012)	-0.070 (0.014)	-0.057 (0.017)	-0.0128 (0.022)
Weight for age <-2SD	82.71% (0.109)	79.64% (0.11)	81.18% (0.10)	75.4% (0.012)	0.064 (0.015)	-0.042 (0.016)	-0.042*** (0.016)
Weight-for-height (wasting) =<-2SD	19.8% (0.010)	47.44% (0.013)	42.66% (0.012)	38.57% (0.013)			
Measure height and weight	45.68% (0.012)	61.29% (0.0132)	84.04% (0.009)	85.57% (0.009)	0.384 (0.016)	0.243 (0.016)	0.141*** (0.023)
AWC growth monitoring	48.79% (0.0126)	58.85% (0.013)	71.47% (0.012)	73.73% (0.012)	0.227 (0.017)	0.149 (0.018)	0.078*** (0.025)

Table 12: Regular monitoring of Child health related indicators (2+-5 years)

	BASELINE SURVEY		END-LINE SURVEY		Regression coefficients		Diff in difference
Vitamin A Supplement	42.57%	43.82%	82.61%	76.46%	0.400	0.326	0.074***
	(0.012)	(0.0135)	(0.009)	(0.012)	(0.016)	(0.018)	(0.024)
IFA supplement	44.35%	43.3%	71.2%	48.67%	0.269	0.054	0.215***
	(0.013)	(0.013)	(0.011)	(0.014)	(0.017)	(0.02)	(0.026)
Attending AWC	48.34%	41.7%	90.35%	83.45%	0.42	0.418	0.002
	(0.013)	(0.013)	(0.007)	(0.010)	(0.015)	(0.017)	(0.022)
Mean days children attending AWC	3.39	2.15	4.74	4.2	1.35	2.05	-0.69***
	(0.067)	(0.073)	(0.047)	(0.01)	(0.083)	(0.09)	(0.126)

indicates significance at 0.01 confidence level (statistically significant at least at 90% level) ; ** indicates significance at 0.05 level (statistically significant at least at 95% level); * indicates significance at 0.001 level (statistically significant at 99% level)*
 Figures in parenthesis are standard errors of estimation

(c) Attendance at anganwadi centers: The baseline survey showed that 51% of children in Bajna and 58% of children in Sailana had not visited any AWC for regular monitoring of health / nutrition. Specifically among the 5-year-olds, only 73% in Bajna and 48% in Sailana were going to anganwadi centers during the baseline survey, which improved to 89% and 85%, respectively, at end-line three years later. Reportedly, of the children in both blocks (in both baseline and end-line surveys) who attended AWCs, they did so a minimum of five days a week.

(d) Participation in preschool education: Preschools play a leading role in facilitating the psychosocial development of children in this age group. Additionally, preschool education is complementary to primary education. Anecdotal evidences show that preschool attendance reduces underage enrolment in schools, enhances school readiness and retention of children in school, and facilitates school attendance of elder siblings by freeing them of their sibling care responsibilities.

The anganwadi workers undertake a yearly census of children in the preschool age which increase school enrollment. However, enrolment does not always translate into school attendance – for example, though 67.2 percent of Bajna children aged 3-5 years old were enrolled in an AWC, only 48.3 percent attended the centre. The baseline data show that the attendance was well below the universal in both blocks, as many children were still not attending preschool. Of those who did attend, some children showed up at preschools only a couple of days a week. Children who attended anganwadi preschools spent an average of 2-3 hours per day at the centers (14 hours per week as reported in Bajna, and 10 hours in Sailana). As the areas under study are located on undulating terrain with households spread across vast areas, the location of the anganwadi center emerged as a critical factor in determining access.

Three years down the line, the end-line survey data show that attendance at AWCs/balwadis (preschools) improved vastly in both blocks.. The major increases in both blocks were in the proportion of children whose parents reported that their wards spent more than two hours at the AWC.

Attractiveness of AWCs for children depends in part on the availability of play materials. At baseline, 43% of parents whose children were currently attending preschool in Bajna, and 34% in Sailana, reported that there were some toys at the AWC for their children to play with. At the end-line survey, around 64% of parents each in both Bajna and Sailana reported availability of toys for children.

Table 13: Details of attendance of Anganwadi by 3-5 year old children							
	BASE SURVEY		LINE END SURVEY		Regression coefficients		D-i-D
	Bajna	Sailana	Bajna	Sailana	Bajna	Sailana	
Child (3-5years) enrolled in any AWC/ balwadi	67.2%	59%	90.96%	83.5%	0.48***	0.42***	0.42
	(0.011)	(0.013)	(0.007)	(0.10)	(0.010)	(0.11)	(0.11)
Child attending AWC	48.3%	41.7%	90.35%	83.45%	0.58***	0.33***	0.33***
	(0.013)	(0.013)	(0.007)	(0.010)	(0.011)	(0.12)	(0.12)
Attending AWC for 5+ days	48.3%	31.2%	70.65%	59.8%			
	(0.013)	(0.013)	(0.012)	(0.013)			
% of children spending >2 hours at AWC	38.8%	28.7%	94.95%	84.9%			
	(0.012)	(0.012)	(0.006)	(0.010)			
Anganwadi open for 5+ days	54.2%	40.24%	88.31%	81.09%			
	(0.013)	(0.013)	(0.008)	(0.0107)			
Supplementary nutrition provided every day	59.7%	48.7%	88.5%	80.9%			
	(0.012)	(0.013)	(0.008)	(0.011)			
Provision of toys at AWC	42.7%	34.8%	64.5%	64.2%			
	(0.012)	(0.013)	(0.012)	(0.013)			
Parents able to report what child learns at AWC	28.4%	11.25%	86.2%	37.9%			
	(0.11)	(0.008)	(0.009)	(0.013)			
<i>Figures in parenthesis are the standard errors</i>							

(e) **Testing children for school readiness:** School readiness tests, as prepared by the NCERT (National Council of Educational Research and Training), are for children in the age group of 4-5 years. In both Bajna and Sailana, especially in the former, it was noticed that children were generally enrolled in school at the age of five. This (verbal) test attempts to determine children's school readiness and preparedness by checking their abilities to differentiate between various shapes, pictures, sizes, numbers, and sounds. The tests were originally designed to be used by school to assess incoming grade 1 students, to capture the competencies acquired through pre-school education in anganwadis. In this study, children were tested while they attended the anganwadi centre, before entering class 1. However, the age differences between students tested in AWC and the normal testing in class 1 is not significant. In any case, the main comparison is whether children in the AWCs at the beginning and the end of the Bachpan project were more ready for school (rather than evaluating whether AWC children were ready compared to children in class 1).

Another option would have been to test the children at home, but for the fact that all children are "enrolled" in anganwadis (when the anganwadi workers undertake regular child census, all eligible children were automatically enrolled in both anganwadis and primary schools, (meaning children's names were enumerated in the pre-school enrolment records). Thus, it was found that all children less than 5-years-old were on anganwadi rolls. Therefore, the only difference in school readiness would have emerged from those who attend preschool regularly and "those who did not" attend regularly. In order to ascertain whether or not children have reached the desirable levels of school readiness, we chose the anganwadi as our focal point, as its pupils aged 4-5 years (the oldest age group in anganwadis) would have received preschool education. For capturing the levels of school readiness of those children who were enrolled, but not attending regularly, households were asked to bring the child to the anganwadi on the day of the school readiness test. Thus, even those pupils who did not regularly attend were tested.

To indicate changes that occur between baseline and end-line, a classic indicator is the ability of children to follow the instruction to “touch their left ear with their right hand” (as mentioned earlier, this question was not posed as part of the test, but to make children comfortable with the administrator of the test). During the baseline survey, in Bajna, only 27% children could respond correctly to the challenge of touching their left ear with their right hand (which is a simple task taught by AWC workers), while in Sailana, 73% children knew their left ear and right hand and could follow the instructions on doing this. But by the time of the end-line survey, 95% children attending AWCs in Bajna could do this, while the figures remained more or less the same in Sailana. In terms of improvements, Bajna recorded significantly better improvements than Sailana.

With respect to the school readiness test, the children were asked 32 questions, of which half tested them on reading readiness and the rest tested their number readiness. The 16 reading readiness questions included (a) 4 sets of two questions each aimed at capturing (i) sentence comprehension (for example, a question was in the form of a statement and the child was asked to point out a picture corroborating the statement), (ii) visual perception (for example, here children had to match visually similar pictures / activities), (iii) visual discrimination (children had to identify one picture from many which was dissimilar), (iv) words with the same sounds (two words where there are at least one sound is similar; for example words like “wall” and “ball”); and, (b) two sets of 4 questions each on (v) figure recognition, and (vi) sound recognition. Number readiness questions sought to test the following: (i) number concept, (ii) space concept, (iii) more or less numbers, (iv) near or far distances, (v) thinness or thickness, and (vi) classification of tangible and intangible items.

The end line survey showed that children in Bajna had not only improved dramatically overall in their school readiness – going from an average of 50.4 percent to 67.3 percent, but had improved to such an extent that they now were more ready for school than their peers in Sailana (average score of 64.7 percent was barely better than their baseline average). In addition to scoring better overall, Bajna students improved their schools at a much faster rate than Sailana children across almost all dimensions of school readiness (Table 14).

	BASELINE SURVEY		END-LINE SURVEY		Regression coefficients		Diff in difference
	Bajna	Sailana	Bajna	Sailana	Bajna	Sailana	coefficients
Child confident to tell his / her name	96.39% (0.006)	95.99% (0.006)	99.85% (0.002)	97.52% (0.005)	0.035 (0.007)	0.015 (0.009)	0.019* (0.011)
Child confident to tell his/ her parents name	77.27% (0.014)	87.26% (0.011)	98.78% (0.004)	93.68% (0.009)	0.215 (0.017)	0.064 (0.014)	0.151*** (0.022)
Mean score							
Sentence comprehension	58.62% (0.011)	67.47% (0.011)	82.32% (0.012)	79.55% (0.011)	0.236 (0.016)	0.121 (0.016)	0.116*** (0.023)
visual perception	44.41% (0.0102)	51.39% (0.012)	75.91% (0.013)	69.27% (0.013)	0.315 (0.016)	0.178 (0.017)	0.136*** (0.024)
Visual discrimination	36.07% (0.014)	49.90% (0.014)	79.88% (0.013)	65.92% (0.013)	0.438 (0.02)	0.16 (0.19)	0.278*** (0.028)
Number concepts	58.45% (0.013)	78.31% (0.01)	62.50% (0.013)	64.81% (0.011)	0.041 (0.02)	-0.135 (0.015)	0.176*** (0.024)
Space Concepts	67.13% (0.01)	79.60% (0.099)	84.53% (0.010)	82.22% (0.011)	0.174 (0.015)	0.026 (0.015)	0.148*** (0.021)
Concept of "more"/ "less"	51.28%	62.64%	67.99%	67.66%	0.167	0.050	0.117***

Table 14: Improvements in School readiness of children of 5 years age							
	BASELINE SURVEY		END-LINE SURVEY		Regression coefficients		Diff in difference
	(0.013)	(0.0128)	(0.013)	(0.012)	(0.018)	(0.017)	(0.026)
Concept of "near"/ "far"	30.65%	59.82%	52.59%	55.39%	0.219	-0.044	0.264**
	(0.014)	(0.014)	(0.0114)	(0.014)	(0.019)	(0.02)	(0.027)
Concept of "thick"/"thin"	57.52%	76.36%	77.82%	84.14%	0.203	0.077	0.125**
	(0.013)	(0.011)	(0.012)	(0.010)	(0.019)	(0.015)	(0.024)
Concept of Classification 1	78.98%	80.64%	94.05%	83.44%	0.151	0.027	0.123**
	(0.008)	(0.009)	(0.006)	(0.009)	(0.011)	(0.012)	(0.017)
Concept of Classification 2	83.02%	84.69%	91.51%	86.25%	0.085	0.015	0.069**
	(0.009)	(0.008)	(0.009)	(0.009)	(0.013)	(0.012)	(0.017)
Give words for letters	7.75%	11.15%	12.80%	17.60%	0.051	0.064	-0.014
	(0.012)	(0.01)	(0.013)	(0.012)	(0.015)	(0.015)	(0.022)
Reading readiness	55.7%	61.29%	75.61%	69.5%	0.199	0.084	0.115***
	(0.006)	(0.006)	(0.006)	(0.006)	(0.008)	(0.008)	(0.011)
Number readiness	63.5%	75.6%	78.0%	76.0%	0.145	0.005	0.14***
	(0.006)	(0.006)	(0.005)	(0.005)	(0.008)	(0.008)	(0.012)
Total Score	50.4%	60.4%	67.3%	64.7%	0.169	0.043	0.126***
	(0.005)	(0.005)	(0.005)	(0.005)	(0.007)	(0.007)	(0.009)
PERCENTAGE OF CHILDREN WHO HAVE MASTERED THE CONCEPT							
Sentence comprehension	30.19%	48.51%	70.58%	65.8%	0.404	0.173	0.231***
	(0.016)	(0.016)	(0.018)	(0.017)	(0.024)	(0.023)	(0.033)
visual perception	12.94%	28.16%	61.74%	53.04%	0.49	0.25	0.239***
	(0.011)	(0.0144)	(0.019)	(0.018)	(0.021)	(0.022)	(0.031)
Visual discrimination	23.78%	36.49%	71.04%	49.81%	0.473	0.133	0.339***
	(0.015)	(0.0154)	(0.018)	(0.0176)	(0.023)	(0.023)	(0.033)
Number concepts	40.56%	63.51%	39.48%	37.05%	-0.010	-0.26	0.254***
	(0.017)	(0.015)	(0.019)	(0.017)	(0.025)	(0.023)	(0.034)
Space Concepts	40.79%	65.67%	72.41%	72.61%	0.316	0.069	0.247***
	(0.017)	(0.015)	(0.017)	(0.016)	(0.025)	(0.022)	(0.033)
Concept of "more"/"less"	28.9%	48%	46.95%	45.6%	0.18	-0.024	0.204***
	(0.015)	(0.016)	(0.02)	(0.18)	(0.025)	(0.024)	(0.034)
Concept of "near"/ "far"	20.4%	47.58%	19.97%	37.79%	-0.004	-0.097	0.094**
	(0.014)	(0.016)	(0.016)	(0.017)	(0.021)	(0.023)	(0.032)
Concept of "thick"/"thin"	39.74%	62.08%	61.59%	74.6%	0.218	0.125	0.093**
	(0.017)	(0.016)	(0.019)	(0.015)	(0.025)	(0.022)	(0.033)
*indicates significance at 0.01 confidence level (statistically significant at least at 90% level) ; ** indicates significance at 0.05 level (statistically significant at least at 95% level); *** indicates significance at 0.001 level (statistically significant at 99% level)							
Figures in parenthesis are standard errors of estimation							

Mean scores: Children who attended *anganwadis* were expected to be proficient in most of these skills as these are the aptitudes that the children are required to possess before entering school, as a result of

preparation in AWCs. The NCERT’s baseline study for primary achievement had envisaged at least 80% children attaining 80% or more skills. For school readiness, tests do not have such prescriptions.

The mean score for reading readiness was 50% in Bajna at baseline, which improved to 67% after the interventions. On the other hand, the reading readiness mean score in Sailana was 60% during the baseline survey, which reached only 65% at end-line. In the case of number readiness, mean scores of 5-year-olds in Bajna improved from 64% to 78% between baseline and end-line surveys, while in Sailana, it remained more or less stagnant at 76%.

An analysis of competency-wise gains achieved in Bajna and Sailana in preparing these children for school show that gains in mean score for school readiness were significantly more in Bajna, though children in Sailana gained more when it came to figure and sound recognition.

Parental interest in preschool education: The improvement in children’s attendance at anganwadi centers and schools (and proportionately better gains in this in the intervention block, Bajna) is clearly an indication of better service provisions and how parental demand for preschool and school education is on the rise. What also improved tremendously was the neatness and cleanliness of pupils. For example, at baseline, it was observed that while parents were sending their children to AWCs, they did not ensure their children’s personal hygiene, as is evident from the fact that more than half the children attending AWCs did not look clean (56% children in Bajna and 52% in Sailana). However, a similar measure during end-line shows that 97% of children in Bajna looked neat and clean when compared to only 68% in Sailana (Table 15).

The baseline survey also indicated that children were not trained in practicing the hygiene required at this stage of their development. In the AWCs in Bajna, only 15% of the children in the 4-6 years age groups and attending preschool reported that they washed hands before and after eating food, compared with 67% children in Sailana. The end-line survey demonstrates a significant impact of Bachpan’s education campaigns, as almost all children in Bajna now reported washing hands before eating food (an improvement by 83 percentage points), as against only 81% in Sailana (13 percentage points change).

	BASELINE SURVEY		END-LINE SURVEY		Regression coefficients		Diff in difference
	Bajna	Sailana	Bajna	Sailana	Bajna	Sailana	coefficients
Child looks neat and clean	55.83% (0.017)	52.11% (0.016)	96.65% (0.007)	68.03% (0.016)	0.408 (0.023)	0.159 (0.023)	0.249*** (0.0313)
Children washing hands before eating food	15.38% (0.012)	67.01% (0.015)	99.39% (0.003)	80.67% (0.014)	0.840 (0.014)	0.137 (0.021)	0.703*** (0.026)

*** indicates significance at 0.001 level (statistically significant at 99% level)
 Figures in parenthesis are standard errors of estimation

Parental perception of whether any preschool ‘learning’ activity took place in the AWC also varied between the baseline and end-line surveys. The baseline survey indicates that around 56-57% parents in Bajna and Sailana were unaware of whether ANCs imparted any new learning for children. In Bajna, a third of parents of preschoolers at AWCs had no information about preschool activities. In Bajna, only one-fourth of the parents believed that their preschool children were learning new things at the AWC. However, a third of the parents in Bajna and two-thirds of the parents in Sailana who believed that their children were gaining knowledge had no idea of what comprised this “new teaching and learning.”

	BAJNA			SAILANA		
	Very important	Somewhat important	Not important	Very important	Somewhat important	Not important
Supplementary food	73.34%	24.79%	1.87%	31.35%	50.24%	18.41%
Homely atmosphere	36.29%	53.58%	10.13%	7.45%	32.2%	60.46%
Better learning facilities - drawing	8.87%	47.87%	43.25%	3.33%	17.37%	79.3%
Better learning facilities – counting	13.5%	61.15%	25.35%	1.82%	22.1%	76.1%
Story telling/narrating	19.54%	52.57%	27.89%	1.35%	8.25%	90.4%
Modern teaching practices	8.13%	43.10%	48.77%	4.57%	24.71%	70.7%
Playing/amusement facilities	25.43%	47.13%	27.44%	14.83%	11.9%	84.5%
Close to home	52.24%	35.37%	12.4%	5.95%	17.1%	77%

However, by the time of the end-line survey, most of the parents were able to gauge the importance of preschools, or at least express the importance they assigned to the preschool activities in the anganwadis. For 73% parents in Bajna, the mid-day meal or supplementary food was very important as against only 31% parents in Sailana. A homely atmosphere in the AWC was important for 90% parents in Bajna, as against only 40% parents in Sailana. Better learning facilities (in terms of drawing, counting, story-telling and narrating, and playing and amusement facilities) were important for a majority of parents in Bajna (almost 70%), as against more than 70% parents in Sailana who considered these as unimportant. Having an AWC closer to home was important for parents in Bajna, while it was not an important consideration for parents in Sailana (Table 16).

During the baseline survey, it was found that around half of the households in Bajna and around 41% households in Sailana were happy with the preschool education provided by AWCs in their area. This satisfaction level was higher among households whose children regularly attended preschool. By the time of the end-line survey, parents could articulate the degree of satisfaction/dissatisfaction with the various services provided by AWCs (see Table 17 for details).

	Bajna			Sailana		
	Good / very good	Average	Not satisfactory	Good / very good	Average	Not satisfactory
Individual attention to child	48.02%	33.42%	21.6%	41.1%	37.7%	23.5%
AWW are well-trained	25.56%	39.9%	34.5%	10.10%	36.1%	53.8%
AWW adequately qualified	18.14%	45.3%	36.5%	6.99%	28.6%	64.1%
Cleanliness of AWC	51.5%	26.02%	21.5%	34.9%	35.4%	48.1%
Quality of food	67%	20.1%	12.6%	28%	39.56%	32.4%

The surveys also attempted to get in-depth information on households’ concerns regarding AWC functioning. The baseline survey found that 96% of households in Bajna and 98% of households in Sailana could not articulate a single issue that they thought was a cause for concern and that demanded attention. This is probably the result of a lack of awareness about their entitlements, and what was expected from a preschool as was shown above. However, the small proportion of households who could express their concerns mentioned the following: (a) no proper preschool education; (b) inadequacy of supplementary nutrition, (c) irregular functioning of the center, (d) irregular and disinterested anganwadi worker (AWW), and (e) lack of facilities. Some responses were candid: “AWW is not literate. What will she teach?” Or, “Children are not allowed to play with toys, what they will learn?”

As a result of their lack of knowledge regarding the functioning of AWCs and provisions of preschool education in the centers, 98% of the households in Bajna and 95% in Sailana were unable to make suggestions to improve the functioning of AWCs at baseline. Those households that made suggestions

recommended the appointment of skilled workers and regular provisioning of supplementary food. The suggestions included: “AWW should visit homes more frequently,” “Open AWC for more hours,” and “AWW should use learning materials like colors, charts, etc., to teach”.

However, any propositions to close down the AWC were not welcome among the households in both Bajna and Sailana. Many people felt that such an action would adversely affect the health, education and nutrition of children in the area. During the baseline survey, we also tried to investigate how often the parents interacted with the anganwadi worker for following up with their ward’s health and educational progress, or even generally. Less than 10% of the households reported that they had regular interactions with the AWW. Even among households whose children attended AWCs regularly, only around 15% of the households mentioned that they had regular interactions with AWWs. Another 15% of households whose children attended preschools in Bajna mentioned that they had occasional interactions with AWWs. The end-line survey reveals a change in this. However, the changes were not significantly different in Bajna and Sailana (see table 18).

During the end-line survey, parents in Bajna reported that their wards spent an average of 160 minutes (2 hours, 40 minutes) in AWCs. In Sailana, parents reported on an average of 137 minutes (2 hours, 17 minutes). This is an improvement from the time reported by parents during the baseline survey (1 hour, 40 minutes in Bajna, and 1 hour, 50 minutes in Sailana).

Interaction	BAJNA			SAILANA		
	Rarely	Some-times	Frequently	Rarely	Some-times	Frequently
Regarding child’s improvement and problems	38.2%	50.5%	11.3%	62.4%	31.7%	5.8%
Reg. quality of teaching	36.8%	46.5%	16.7%	43.4%	45.3%	11.4%
Reg. quality of food	38.9%	42.7%	18.3%	33.3%	47.1%	19.6%
Reg. problems created by other children	31.7%	52.8%	15.5%	43.23%	31.6%	25.1%
Reg. general problems of the <i>aganwadi</i> is facing	32.4%	53.8%	12.8%	47.9%	26.6%	25.4%
General discussion	26.0%	63.3%	10.7%	43.3%	34.1%	22.63%

Summary: Stage 3

This stage is a critical period in the life of children because this is when they begin to interact with others beyond their family and immediate surroundings. A child’s weight-for-age is a key measure to gauge nutritional adequacy at this stage, and the socio-cognitive development in terms of school readiness. The analyses so far demonstrate critical net gains in Bajna, especially in terms of preschool learning gains. The impact of reaching out to the community as well as to anganwadi workers to make them (community as well as frontline providers) aware of the needs of the stage under project Bachpan have resulted in better childcare practices.

3.5. Stage 4: Children in School—In Pursuit of an Unfinished Agenda, a “Happy, Healthy, Learning Child”

In this sub-stage, we examine the impact of the interventions through the key indicators of enrolment, attendance, learning outcomes, and completion of primary school. The analysis shows improvements in school participation and learning achievements. However, the available data is limited in that it cannot gauge the completion rates, especially in the context of continued migration and over-representation of overage children in lower grades.

	BASELINE SURVEY		END-LINE SURVEY		Regression coefficients		Diff in difference
	Bajna	Sailana	Bajna	Sailana	Bajna	Sailana	coefficients
Out of School Children (OOSC) among 6-10 years old	10.4% (0.007)	9.01% (0.007)	1.14% (0.002)	13.55% (0.007)	-0.09 (0.006)	0.045 (0.01)	-0.13*** (0.011)
Child attended AWC before joining primary	55.5% (0.017)	62.99% (0.016)	95.1% (0.007)	55.3% (0.017)	0.396 (0.018)	-0.076 (0.023)	0.472*** (0.029)
Attending school regularly	84.5% (0.012)	71.6% (0.015)	94.14% (0.007)	85.8% (0.011)	0.096 (0.014)	0.141 (0.019)	-0.046 (0.024)
Enrolment in age appropriate grades	65.86%	68.95%	74.19%	72.55%			
% of 10-11 years already completed primary			43.35%	31.53%			
*** indicates significance at 0.001 level (statistically significant at 99% level) Figures in parenthesis are standard errors of estimation							

The results show that the incidence of regular school attendance increased significantly in both blocks. However, the percentage of children “out of school” (those who were “never enrolled” and those who dropped out) has reduced tremendously in Bajna, resulting in virtually all children attending school. Also, the proportion of children who attended *anganwadis* for preschool education increased vastly in Bajna, compared to a *decline* in Sailana. While analyzing results in this stage, one should keep various factors in mind: (a) unlike the previous stages where the development is seamless (no preconditions), in this stage, the status of school attendance depend to a large extent on the school calendar and the variance in terms of the time of the survey (as attendance during school vacation time as against school functioning time is different) (b) there could be overage and underage enrolments (as children who is supposed to be attending pre-school may be attending school for various reasons including the availability of mid day meal; and children who are supposed to be attending higher grades may be attending primary grades due to (i) late entry into the system; and (ii) repetition) (c) many children enter school by the age of five in MP as against the national average of six years (as age at entry in MP was not six, but five while six is the national norm); and (d) various other factors such as migration and participation in agriculture work can affect school attendance.

The most significant indicator in this stage is the level of learning outcomes. In order to assess the learning levels of the students, Grade 2 students were tested using the tools prepared by the Madhya Pradesh Education Board, which are based on the formats prepared by the NCERT. The tools were equipped to assess the learning levels of children as per the syllabus of the grade they were in, in congruence with the Madhya Pradesh Education Board’s curriculum. While designing the tests, it was expected that at least 80% of the children should be able to achieve 80% of the skills required.

The tests were conducted at the school level rather than at the household level, and students were examined on their language (Hindi) and Math abilities. The Hindi test required the student to recognize the word that correctly fit with the corresponding picture. The Math test involved simple calculations and number recognition. The tests were of 25 minutes’ duration each.

Mean learning achievement levels: The analysis (see Table 20) shows how mean learning levels of Grade 2 children in both Bajna and Sailana improved between the baseline and end-line survey periods.

Table 20. Learning achievement levels of Grade II students in Government primary schools in Bajna and Sailana (overall total score achievable in each subject: 20; overall: 40)

			Baseline				End line			
			Obs.	Mean score	% mean score	Std. Deviation	Obs.	Mean score	% mean score	Std. Deviation
Bajna	Total	Overall	873	22.06	55.15%	10.5	871	29.4	73.50%	8.08
		Boys	429	22.63	56.58%	10.55	437	29.95	74.88%	7.41
		Girls	444	21.53	53.83%	10.44	434	28.84	72.10%	8.68
	Hindi	Overall	873	11.73	58.65%	5.68	871	14.53	72.65%	4.76
		Boys	429	12.02	60.10%	5.60	437	14.79	73.95%	4.5
		Girls	444	11.44	57.20%	5.75	434	14.28	71.40%	4.9
	Math	Overall	873	10.33	51.65%	6.48	871	14.86	74.30%	4.35
		Boys	429	10.6	53.00%	6.57	437	15.16	75.80%	3.9
		Girls	444	10.01	50.05%	6.39	434	14.56	72.80%	4.71
Sailana	Total	Overall	871	21.85	54.63%	8.84	874	29.05	72.63%	8.48
		Boys	495	26.43	66.08%	8.87	442	29.24	73.10%	8.12
		Girls	376	25.09	62.73%	8.76	432	28.86	72.15%	8.8
	Hindi	Overall	871	13.04	65.20%	4.91	874	16.83	84.15%	5.01
		Boys	495	13.08	65.40%	4.89	442	17.04	85.20%	4.82
		Girls	376	13	65.00%	4.90	432	16.62	83.10%	5.2
	Math	Overall	871	12.88	64.40%	5.64	874	12.21	61.05%	4.58
		Boys	495	13.34	66.70%	5.56	442	12.2	61.00%	4.54
		Girls	376	12.09	60.45%	5.69	432	12.22	61.10%	4.6

Proportion of children with learning outcomes: The proportion of children achieving higher learning outcomes increased between baseline and end-line, and more so in Bajna than in Sailana, especially in the case of Math. In Hindi, the increase in the proportion of children scoring more than 60% correct is better in Bajna, and the increase in the proportion of children scoring more than 70% is more in Sailana. Most interesting is the increase in the coefficients presenting difference in difference or, the difference in the improvements between experimental and comparison groups, both in Math and in overall scores. The extent of difference in relative gains also improves systematically until 70%, and then it comes down.

Table 21: Learning Achievement levels of Grade 2 students in Bajna and Sailana: Overall (Language + Math)

	BASELINE SURVEY		END-LINE SURVEY		Regression coefficients		Difference in difference coefficients
	Bajna	Sailana	Bajna	Sailana	Bajna	Sailana	
Total Score: more than/equal to 50%	56.55% (0.017)	75.03% (0.015)	91.27% (0.010)	90.73% (0.010)	0.347 (0.019)	0.157 (0.018)	0.190*** (0.026)
Total Score: more than/equal to 60%	43.34% (0.017)	61.75% (0.016)	83.35% (0.013)	84.10% (0.012)	0.40 (0.021)	0.223 (0.021)	0.176*** (0.029)
Total Score: more than/equal to 70%	32.56% (0.016)	47.90% (0.017)	71.87% (0.015)	69.11% (0.016)	0.393 (0.022)	0.212 (0.023)	0.181*** (0.032)
Total Score: more than/equal to 80%	24.10% (0.015)	32.01% (0.016)	50.06% (0.017)	47.48% (0.017)	0.259 (0.022)	0.154 (0.022)	0.105*** (0.032)
Total Score: more than/equal to 90%	11.70%	17.25%	21.28%	9.61%	0.115	0.040	0.075***

	(0.011)	(0.013)	(0.014)	(0.014)	(0.018)	(0.019)	(0.026)
Total Score: 100%	2.00% (0.005)	3.9% (0.007)	3.2% (0.006)	2.7% (0.006)	0.011 (0.007)	-0.012 (0.009)	0.235* (0.114)
Mean score	54.56% (0.008)	65.1% (0.007)	74.6% (0.006)	72.96% (0.007)	0.200 (0.011)	0.0785 (0.0102)	0.121*** (0.015)

*indicates significance at 0.01 confidence level (statistically significant at least at 90% level) ; ** indicates significance at 0.05 level (statistically significant at least at 95% level); *** indicates significance at 0.001 level (statistically significant at 99% level)
Figures in parenthesis are standard errors of estimation

Table 22: Learning Achievement levels of Grade 2 students in Bajna and Sailana: Math

	BASELINE SURVEY		END-LINE SURVEY		Regression coefficients		Difference in difference coefficients
	Bajna	Sailana	Bajna	Sailana	Bajna	Sailana	
Math Score: more than/equal to 50%	51.22% (0.017)	69.81% (0.015)	91.16% (0.009)	75.51% (0.015)	0.399 (0.019)	0.057 (0.021)	0.342*** (0.029)
Math Score: more than/equal to 60%	44.15% (0.017)	60.95% (0.016)	83.81% (0.012)	63.62% (0.016)	0.396 (0.021)	0.026 (0.023)	0.37** (0.031)
Math Score: more than/equal to 70%	38.47% (0.017)	51.87% (0.017)	74.86% (0.015)	46.57% (0.017)	0.363 (0.022)	-0.053 (0.024)	0.416*** (0.033)
Math Score: more than/equal to 80%	30.01% (0.016)	41.43% (0.017)	54.08% (0.017)	26.77% (0.015)	0.240 (0.023)	-0.146 (0.022)	0.387*** (0.032)
Math Score: more than/equal to 90%	19.81% (0.014)	28.38% (0.015)	28.93% (0.015)	9.61% (0.01)	0.091 (0.021)	-0.187 (0.018)	0.278*** (0.027)
Math Score: 100%	6.26% (0.008)	13.62% (0.012)	13.2% (0.011)	3.32% (0.006)	0.069 (0.014)	-0.103 (0.013)	0.172*** (0.192)
Mean Math score	51.12% (0.011)	64.4% (0.010)	75.44% (0.007)	61.359% (0.008)	0.243 (0.013)	-0.031 (0.012)	0.274*** (0.0178)

Table 23: Learning Achievement levels of Grade 2 students in Bajna and Sailana: Hindi

	BASELINE SURVEY		END-LINE SURVEY		Regression coefficients		Difference in difference coefficients
	Bajna	Sailana	Bajna	Sailana	Bajna	Sailana	
Hindi Score: more than/equal to 50%	62.1% (0.017)	73.78% (0.015)	88.86% (0.011)	91.53% (0.009)	0.267 (0.019)	0.177 (0.018)	0.090*** (0.026)
Hindi Score: more than/equal to 60%	49.8% (0.017)	62.43% (0.016)	79.68% (0.014)	89.47% (0.010)	0.298 (0.022)	0.270 (0.019)	0.028 (0.029)
Hindi Score: more than/equal to 70%	40.3% (0.017)	50.06% (0.017)	69.23% (0.016)	85.01% (0.012)	0.289 (0.022)	0.349 (0.021)	-0.060* (0.03)
Hindi Score: more than/equal to 80%	31.9% (0.016)	38.14% (0.016)	52.35% (0.017)	75.86% (0.014)	0.204 (0.023)	0.377 (0.022)	-0.172*** (0.032)
Mean Hindi score	58.0% (0.009)	65.8% (0.008)	73.764% (0.008)	84.58% (0.008)	0.158 (0.012)	0.188 (0.012)	-0.0302*** (0.017)

In addition to the above outcomes, the study also looked at some enabling conditions in education in terms of: (a) provision of midday meal and free text books; (b) support at home for learning and homework; (c) parental (and teachers') interest and follow up; and (d) receiving preschool education before joining school.

a) Mid Day meal: The study found that a major incentive for school attendance was the Government of India's Mid-Day Meal (MDM) scheme, initiated with the aim of improving attendance of children in schools as well as to ensure them of at least one full nutritional meal per day. At baseline, around 91% of households in both blocks whose children were enrolled in schools reported that their wards were receiving the meal. The end-line survey shows that 93% of parents in Bajna and 85% of parents in Sailana reported that their children were receiving MDM from school.

Another inducement for students is the provision of free textbooks. Under the SSA and state schemes, all children belonging to Schedule Caste and Scheduled Tribe communities (both formally recognized as disadvantaged) are eligible to receive free textbooks. During the baseline survey, only around 4% (3% in Bajna, and 5% in Sailana) of the children belonging to SC and ST communities reported that they did not receive free textbooks. Similarly, around 3% of the girls who were eligible to receive textbooks also reported not receiving free textbooks. Though the majority of households stated that their children received textbooks in time (in June-July), around one-fifth of households reported their children received textbooks at a later period. The end-line survey shows that almost all parents report receiving free textbooks, in spite of the survey being conducted around the time of the start of the academic year.

All primary schools are mandated to provide health checkups of students by government doctors, and a monthly visit by the ANM to these schools is also compulsory. The baseline survey showed that 45% of the households in Bajna and 50% of the households in Sailana reported that schools did not conduct such checkups. A fourth of the households in Bajna and 36% in Sailana reported monthly health checkups in schools during the three months prior to the survey. Others reported occasional health checkups. By the time of the end-line survey, 71% of households in Bajna reported regular health checkups in school, as against only 53% in Sailana.

b) Support at home for learning and homework: It is a well-documented fact that enhanced learning outcomes are facilitated by at-home learning. Around 47% of the households in Bajna and 71% of the households in Sailana reported that their school-going child carved out some time at home for learning and homework. At end-line, this pattern went up to 60% in Bajna (a 13-percentage point improvement), but barely changed to 72% in Sailana. There were no significant differences between boys and girls.

The help provided at home for learning activities lends an additional boost to knowledge. The baseline survey results showed that overall, only 24% school-going children (14% in Bajna, and 38% in Sailana) received some assistance at home for studies.⁵ Not surprisingly, students with literate parents received more inputs (48%), as against only 18% in the case of students who had illiterate parents. The end-line survey shows that in Bajna, more than 50% of children have support from someone at home all the time, while in Sailana, 31% children get such sustained support.

c) Parental and teacher interest and follow-up: Parental interest in a child's schooling and learning is reflected not only in families following up with their child's studies at home, but also in demanding from teachers an assessment regarding their child's progress. In the predominantly high-illiteracy assessment blocks, without educated and empowering parents, such inputs were not expected. Thus, it was no surprise that during baseline, only around 3% of the households/parents enquired after their children's

⁵ For the most part, however, this assistance was not in form of paying for private tuition. Both baseline and end line surveys show that only less than 2% of the students were getting private tuitions, paying on average, a monthly tuition fee of INR 52 (baseline survey) and INR 58 or around USD 1.28 (end-line survey).

progress. However, they mentioned that teachers took the initiative in reporting their ward's progress to them. In Bajna, 54% of the parents averred that the schools made available their children's progress report, while in Sailana, around 46% of the parents reported the same. Similarly, 35% parents in Bajna and 31% in Sailana reported that they were informed about the performance of their child once (annually), though this primarily had to do with whether or not the child has been promoted to the next level. Only around 3% of the households reported that they received periodical information about their child's learning levels. However, most of the parents were under the impression that their children were making good progress in their studies and were happy with that (Bajna, 86%, and Sailana, 75%). The end-line survey shows improvements in parental demand for understanding their child's progress in learning (98% in Bajna, and 96% in Sailana).

Summary: Sub-Stage 4

Though we did not have data to look at the completion and dropout rates, the analysis of school attendance and learning assessment scores provides an important insight into the progress made by children in the project area. The test scores show significant improvements in Bajna, especially a high net gain in Math learning levels in Grade 2, compared to students in Sailana.

Chapter 4: Bachpan-Lessons Learned

Project *Bachpan* was an effort to understanding whether the community—together with a range of service providers—can work for the improvement of child development outcomes in a more holistic manner. The process documentations (please see Annex 5 for a summary report of all 7 process documentation reports by ERU) detail the lessons from the various processes of engaging community and different sectors together. The documentation also provides an account of factors that needs to be kept in mind at various stages in such a project.

The evaluation study demonstrated that the improvements in child development outcomes and practices were better in Bajna than in Sailana, in most cases dramatically so. These differences can be attributed to Project Bachpan (Table 22). These impressive results hold even for other developments in the two blocks, such as improved road connectivity, electrification, and the introduction of other Centrally Sponsored Schemes (CSSs) like the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA).

Table 22: Summary of Outcomes: "Difference in difference" between treatment and comparison blocks		
Indicators on Outcome for various stages		Changes in treatment – changes in control (Coefficient)
Stage 1	Percentage of pregnant women who received full ante-natal check-up	0.06**
	First ANC within first trimester	0.225***
	Percentage pregnant women regularly received Supplementary food	0.147***
	Percentage of deliveries assisted by institutionally trained	0.358***
	Decline in the percentage of children underweight	-0.129**
Stage 2	Percentage of children fully immunized by year 1	0.292***
	Percentage of children who have completed all prophylaxis Vit A	0.074**
	Percentage of children with normal weight for age	0.108***
Stages 3 & 4	Percentage of children entering in Grade 1 who have an adequate vocabulary in the school language	0.127***
	Percentage of Grade I children who have attended pre-school program	0.472***
	Percentage of children in school clean and neat	0.249***
	Percentage of children who wash hands before eating	0.703***
	Achievement levels in language and Mathematics in Grade II	0.121***
<i>*indicates significance at 0.01 confidence level (statistically significant at least at 90% level); ** indicates significance at 0.05 level (statistically significant at least at 95% level); *** indicates significance at 0.001 level (statistically significant at 99% level)</i>		

The gains in these outcomes were possible for a number of reasons:

- The project interventions were developed in keeping with the especial needs of the population, and rooted in the conditions and circumstances of the area. It drew heavily from the understanding and opinions of local people. The results reflect the fruits of a highly contextualized program.
- The project and impact evaluation design took into account the experiences of previous singular interventions, which had little impact (an experience repeated in this study by Sailana). So, the pilot comprised a bouquet of interventions, chief among them being community information and the forming of Village Resource Groups (VRG). VRG-drawn village plans, if any, were considered as

additional interventions. The success of *Bachpan* lies not in singular interventions, but in a complete, well-rounded engagement package.

- There was a gap of three years between the baseline and end-line surveys, which ensured that the interventions had enough space and time to consolidate some of the outcomes. It also neutralized the impact that might have had resulted from initial energy and enthusiasm, especially in terms of process indicators.
- The logical results framework of the pilot allowed for measuring milestones at each stage of a child's development; rather than aiming at evaluating outcomes that are long term, and that could be resultant of various factors that are perhaps invisible in the context of the interventions.

Lessons from the Pilot

The entire process of implementing the pilot *Bachpan* and the outcomes seen thereafter provide meaningful lessons for interventions in the social sector. These are listed below.

- Contextualization of interventions is important for improving processes and outcomes. For example, information, education and communication (IEC) of child development related messages should be in a manner and language identifiable to the community.
- Similarly, convergence and coordination in planning and implementation are key to improving outcomes, not least because there is no single solution to child development. A slew of complementary and interactive interventions are necessary for impact.
- Community participation is central to better implementation and results, and can be ensured when there is enough awareness and empowerment built into a program. For that to take place, it is important to create local change agents or catalysts, typically by involving civil society organizations. By invigorating the local community and service providers through the provision of information and by facilitating their role in shaping sectoral plans, rapid progress in child related outcomes can be made. It is important to affect a decentralized approach to planning for such a program, especially when incorporating the local context. Thus, it is important to identify and capacitate local resources that can act both as change agents and bridge builders. The government does not have the leverage to ensure prompt action on issues raised in the field, which is why the mediating role of the implementing NGO becomes critical to ensure that local issues receive the attention they deserve.
- For any intervention in the development sector to show results, a critical minimum gestation period is necessary. This pilot demonstrates the importance of providing that space before final evaluation so that the initial enthusiasm of a pilot dies down and actual results are visible.
- An evaluation of the impact of a program will not give the desired insights if the process is not documented fully and correctly. Understanding the direction in which a program is moving and to initiate any mid-course correction, is where monitoring plays a significant role.
- Expanding resources is not sufficient to ensure maximum impact of programs. During the period of this pilot, child development programs were escalating thanks to the country's Centrally Sponsored Schemes. But, despite the same range of programs in the two blocks, significantly better results were obtained with an integrated, community-driven approach.
- Designing bottom-up planning into a program requires attention to the implementation arrangements. Expansion programs were all planned as decentralized, bottom-up interventions, with active community participation – this is true for (*Sarva Shiksha Abhiyan* (SSA – Elementary Education for All), Reproductive and Child Health (RCH), National Rural Health Mission (NRHM) and Integrated Child Development Scheme (ICDS). However, the problem was that: (a) most village communities in

India could not do bottom-up planning due to lack of information and deficiency in coherent action; and (b) each program's committees were in silos, resulting in a fragmented approach to fund management, and piecemeal program planning and implementation. *Bachpan* demonstrates that: (a) community mobilization and facilitating frontline providers and community interaction is an important component to enact better service delivery and behavioral changes; and (b) making the community think and plan for child development more holistically (an outcomes-based approach rather than inputs-based) reaps higher dividends.

- The costs of this intervention were modest, as the focus was on improving the effectiveness of existing programs, which themselves are large, rather than creating new ones. Hence, there are clear opportunities for scaling up this approach to other blocks across Madhya Pradesh.

Limitations of the Study

- There was no attempt to explain the specific reasons why there were improvements in the control block (Sailana) or the magnitude of these improvements. The presence of the same programs in Sailana made it likely that there would be some improvements. However, as we have seen, there were greater improvements on most indicators for Bajna. The fact that in a few cases there were better outcomes in Sailana indicates that some significant changes in the implementation of some programs did take place in that block, perhaps due to political or staffing changes and spillover effects. But the precise reasons for these changes are not available from this study.
- The evaluation design was not structured to test how each of the separate elements of the intervention actually worked, or which one or which set of interventions had the biggest impact. This would have required a quite different (and more complex) approach, with different communities being exposed to different bundles of interventions. Instead, the core comparison was between a community-driven, integrated approach and an approach which worked with different interventions separately.
- The full impact of the *Bachpan* program will likely be felt beyond the time period of this study. The results identified by the evaluation study seem to be because of community mobilization and increased awareness about childcare. However, community mobilization and awareness building is a process that took almost 18 months. While communities had prepared convergent, child development plans by the end of the second year, at national level, the fund flows were designed and continued to flow in sectoral silos, and hence the child plans had to feed into separate district health, education and nutrition plans of the district and not into an integrated child plan. The full impact of the holistic child development plans feeding into the sectoral plans will likely be felt only after a few years.

Annex 1: Process Documentation – Consolidated Report 2005-2009

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1. Background

Despite several significant policy and programmatic provisions for children, the status of poor children continues to be a matter of grave concern. Child malnutrition and the lack of access to quality education for poor children have been widely commented on. This has also been borne out by the multi-sectoral research of the World Bank, 'Reaching out to the Child'⁶. The research reviewed the progress in the status of children over the last decade in comparison to other developing countries and also with reference to the programmes on the ground for children in the health, education and nutrition sectors. Some factors identified as responsible for the limited impact of existing provisions included:

- A fragmented, sectoral approach in implementing the schemes, which does not capture the synergies across sectors;
- Over centralized and standardized programme designs which do not address contextual diversities;
- Inadequate finances and inefficient implementation;
- Inadequate monitoring capacity; and
- Low accountability and issues of service delivery.

One of the major recommendations of the study was to move towards a decentralized and cross-sectoral approach to planning and monitoring of programmes, so that even with sectoral implementation better coordination can be ensured.

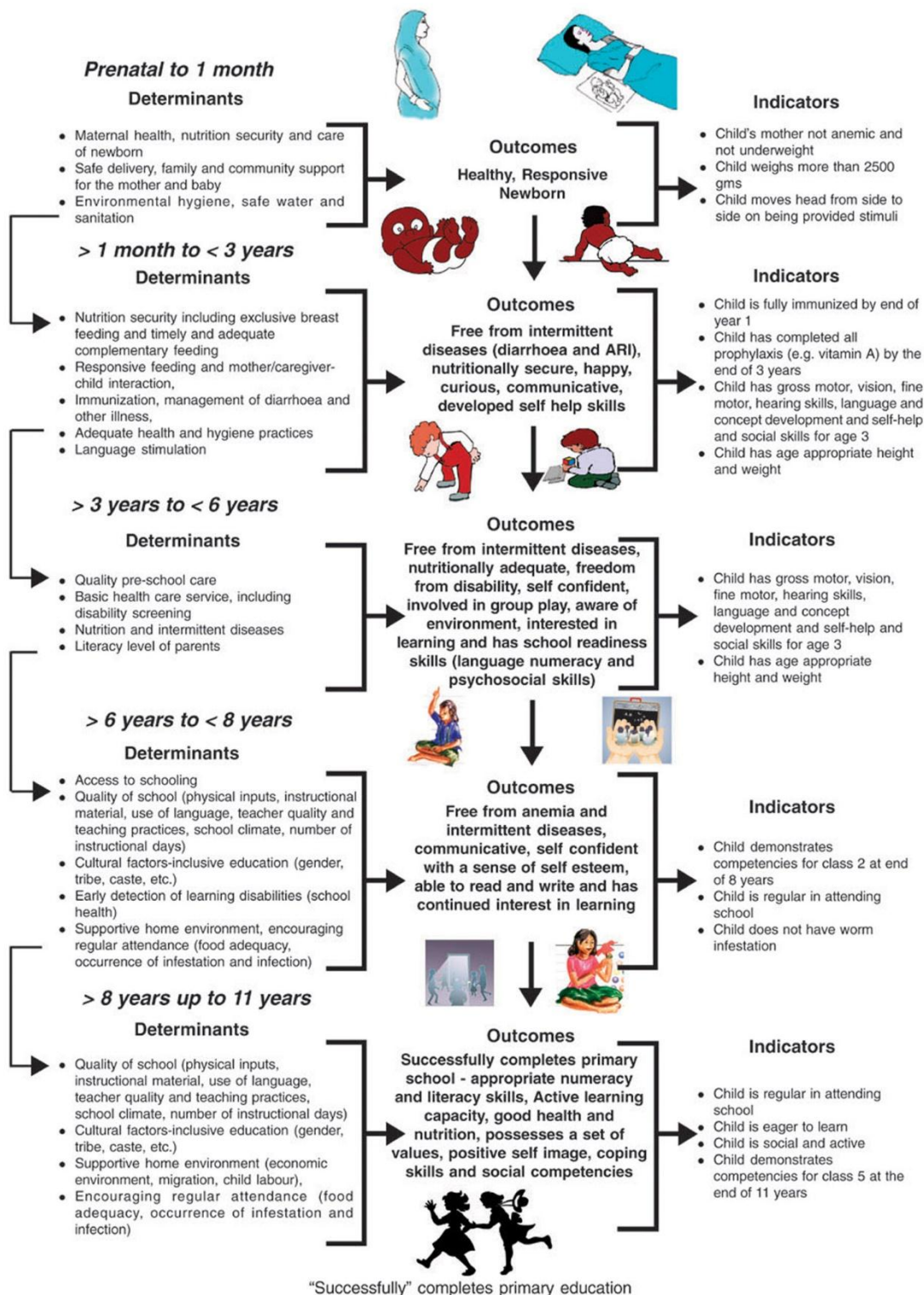
In this context the concept of Village/Ward Plans for Children had been proposed as the basis for financing and implementation of programmes for children in the age range of pre-natal to 11+ years. This concept deviates from the current approaches in two ways:

- 1) It is a bottom up approach for involving participatory planning by each village community for its children to ensure that it is context specific and need based.
- 2) Also, it is in accordance with a multi-sectoral approach which addresses needs of the "Whole Child" and not of health, nutrition and education in isolation.

The research provided a holistic conceptual framework within which the determinants of developmental milestones along a continuum from pre- birth to the primary schooling stage have been laid out. This framework would allow for a more synergistic approach even within the current programmatic arrangements for children sponsored by the Government. See Figure 1, ICD Conceptual Framework below, spelling out children's developmental milestones along a continuum from pre-birth to the primary schooling stage.

⁶ World Bank, (2004) *Reaching Out to The Child- An Integrated Approach to Child Development*, New Delhi

ICD CONCEPTUAL FRAMEWORK



II. From a Concept to a Pilot

While recommendations of the need for a convergent and holistic approach to address the developmental needs of children are passé, there are not too many examples of actually trying out the strategy in a sustained manner on the ground. Before designing the pilot other similar interventions were studied. A similar convergent approach was undertaken by UNICEF in collaboration with the Government of Maharashtra. The study and analysis of this experiment also fed into the design of the World Bank pilot.

The UNICEF Project in Maharashtra⁷ -Practicing Participation in UNICEF Programming: Bridging the Gap between Rhetoric and Reality (2000) was an early attempt to empower local communities to address and resolve local problems, especially schooling. UNICEF, India's Master Plan of Operation (1999-2002) focused on improving the quality of education through enhancing school-community partnerships. The effort was to link parents, community members and educators around the goal of full, equal and meaningful participation by all children in good learning experiences. The Bachpan project in Madhya Pradesh drew upon this experience in designing the pilot. The purpose of the pilot was to assess the feasibility and cost effectiveness of such a holistic and coordinated effort for children throughout the childhood development continuum - prenatal to elementary education. This experience, it was anticipated would inform advocacy with the government for a similar approach to be adopted.

II.1 The Design

Box 1: Key features of the Pilot Project

The key features of the Pilot were to:

- Address the life cycle continuum.
- Establish convergence of provisions for children across health, nutrition and education sectors.
- Engender bottom-up planning through community participation.

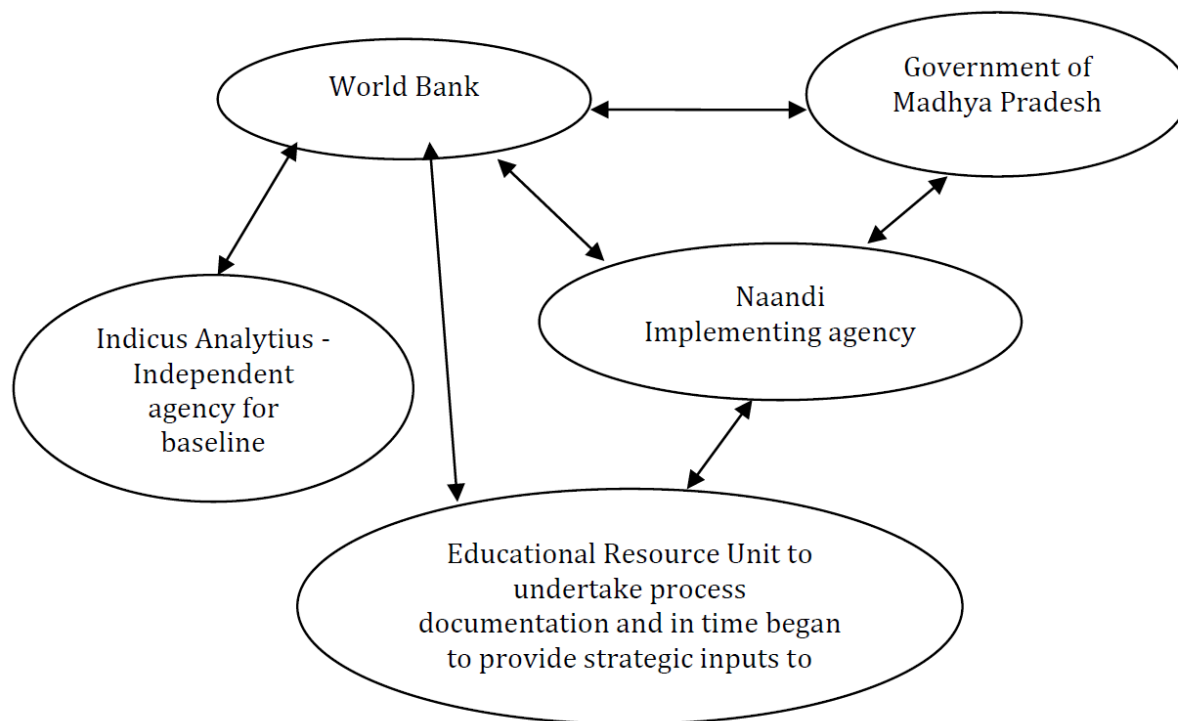
It was also expected that the following will be explored and addressed during the course of the pilot:

- Assess how the four programmes for children – Integrated Child Development (ICDS), Reproductive Child Health (RCH), Sarva Shiksha Abhiyan (SSA) and Mid Day Meal Scheme (MDM) of the three sectors – health, nutrition and education – can lend themselves to micro planning in a convergent mode involving the community and service providers.
- Envisage what adjustments may be required in the existing administrative arrangements allowing for greater convergence and coordination and greater participation of the beneficiaries.
- Explore to what extent convergence and participatory approach with an outcome-focused model could improve service delivery and thereby impact on child related outcomes.

There were other dimensions of the pilot as well - it was to be rolled out through a dynamic partnership of the government and an implementing NGO partner. Further, as this pilot was seen as a learning initiative, the role of external support agencies was also envisaged- an independent agency (Indicus Analyticus), to do the baseline and end line, and another agency (Educational Resource Unit), to undertake a detailed process documentation of the pilot as it unfolded.

⁷ ERU, Assessment Study of Community Participation in Selected UNICEF supported Educational Programmes, 2003

Figure 2: The operational structure



II. 2 The Project Area

Madhya Pradesh was selected as the state for rolling out this pilot. The selection of the project area was determined by several factors- 1) Naandi, the implementing agency was already working in Madhya Pradesh in partnership with the government of Madhya Pradesh. 2) The Government of Madhya Pradesh was very supportive of such an initiative. 3) Finally, given the low child development indicators of the state, it seemed the right place to pilot a convergent approach. (See annexure I).

The Madhya Pradesh Integrated Child Development Pilot project was initiated in Ratlam district, identified on the basis of a cumulative development index computed for this purpose.⁸ See Table 1 below for details:

Table 1: Indicators for Ratlam district, 2001 Census

Population	1215000
Growth rate	25%
Literacy %	67.2 %
Male	80.1 %
Female	54.3%
Rural literacy rate	61.0%
Urban literacy rate	82.2%
SC population	13.4%
ST population	25.9 % (2 tribal blocks)
HDI	.630
Rank in MP - HDI	6

⁸ Ratlam is divided into 6 Tehsils (sub- district divisions) and 6 Blocks

GDI	.633
Rank in MP	2
Sex ratio	959
“ rural	965
“ urban	943
Juvenile sex ratio	960
Life expectancy at birth	59.3
IMR	Girls 132- 1991 (up to 1 yr) 151 (up to 5 yrs)

Within Ratlam district, Bajna one of the 2 tribal blocks with over 95% tribal population (Bheel), was selected for project implementation. Like most tribal areas, Bajna has a comparatively better sex ratio of 989 than the district average. However, the female literacy is at a low of 21%. (MP HDR 2003). The close proximity with Gujarat and Rajasthan is clearly visible in the language of the area where the local dialect is *Bagadi*. The entire population of the block is rural, living in a geographically difficult terrain – hilly, rocky and with sparse green cover. Apart from having low socio-economic indicators this region is also agriculturally poor, relying mainly on rain fed crops like maize, soya beans and cotton. In 2005, due to poor rains, Bajna region experienced severe drought, affecting children’s and people’s lives in terms of health and nutrition.

The project coverage extends to 220 villages, over the entire Bajna Block. For the convenience of management and monitoring, the block has been divided into three clusters – Bajna, Raoti and Kundanpur – each having specific geographical features, since the habitations are widely scattered. While Bajna is hilly and dry, the Raoti area is a fairly fertile river basin (river Mahi) and Kundanpur is an area of sparsely scattered settlements with a poor communication network.

III. Rolling out the pilot

III.1 the Baseline Survey

As mentioned above Indicus Analyticus, an independent agency, was hired to do a baseline survey of 2 blocks, i.e. Sailana and Bajna (which are control and implementation blocks respectively), with a view to provide the basic information for the 8 cross-sectoral child development outcome indicators along the age continuum- from the prenatal stage to 11 years age group for impact evaluation of the initiative.

The baseline conducted in November –December of 2005, included collection of qualitative and quantitative information through intensive questionnaires for households, Aganwadi centers, sub- centre health facilities and primary schools. Each block, with approximately 200 villages was selected to afford socio- economic and socio-cultural comparability. It was ensured that both blocks have the presence of the three centrally sponsored schemes—Integrated Child Development Services (ICDS), Reproductive Child Health (RCH) and Sarva Shiksha Abhiyan (SSA).

Simultaneously, Naandi conducted a resource mapping exercise through its project facilitators to help them get an idea of the situation in the villages. While the baseline by design was a separate academic exercise altogether, with no intermingling with the implementation of the project, some field level government functionaries were evidently confused regarding collection of similar kind of information by the representatives of the two agencies.

III.2 Initial vertical and horizontal dynamics in the field

The coordination meetings held at the state level set the tone for the initiation of the project. The administrative arrangements, indicating clear guidelines for implementation and partnership were drawn up at various levels to roll out the project. See Box 2 below for details:

Box 2: Administrative arrangements

State level

- Constitution of a state-level co-ordination committee by Government of Madhya Pradesh which shall have representatives from Naandi Foundation and the Department of Education, Government of Madhya Pradesh; Department of Health and Family Welfare, Government of Madhya Pradesh; Department of Women and Child Development, Government of Madhya Pradesh (the concerned Departments). The committee shall be primarily responsible for providing guidance on policy issues, reviewing progress and addressing issues, if any, related to the convergence and coordination arrangements. The committee shall meet at least once every six months to ensure smooth implementation of the Project.
- Institutionalizing measures to ensure day-to-day support and cooperation on all matters related to execution of the Project from the concerned Departments. In particular, the concerned Departments shall identify the roles and responsibilities of the officials at the district and block levels in Project implementation and shall ensure their cooperation to facilitate implementation of the Project. The concerned Departments shall also develop and implement effective communication strategies for this purpose.

District-level

A planning and co-ordination committee shall be constituted at the district level which shall be headed by the District Collector or his /her nominee and be required to meet once in 3 months. The convener of this committee may be selected in the first meeting. This committee shall include district level officials of the concerned Departments, representative from the Naandi Foundation and other stake-holders. This committee shall be responsible for the following:

- Review of the implementation plan (activity plan)
- Quarterly progress review of the action research project
- Finalization of Monitoring Indicators for the action research project
- Facilitate convergence of all programmes that are meant for children, namely ICDS, RCH, Elementary Education, Early Childhood Education and Water / Sanitation (Public Health). This will include:
 - Human resource mapping
 - Financial resource mapping
 - Activity mapping to ensure convergence (household survey, fixed day services, immunization / health campaigns)
 - Management of supplies (ICDS SNP, Mid-day meal, textbooks, Vitamin A etc.)
 - Logistics
 - Share data/ information amongst each other and with Naandi Foundation.

Block-level

A Block level coordination committee shall be constituted with the chairperson from the Block Panchayat. Naandi Foundation's representative shall be the convener of this committee. This committee shall meet as frequently as necessary (at least once in 2 months), and shall be responsible for facilitating convergence and coordination among all programmes that are meant for children, namely ICDS, RCH, Elementary Education, Early Childhood Education and Water / Sanitation (Public Health) etc. The specific activities requiring coordination shall include:

- Human Resource Mapping
- Financial Resource Mapping
- Activity Mapping to ensure convergence (house hold survey, fixed day services, immunization / health campaigns
- Management of supplies (ICDS SNP, Mid-day meal, textbooks, Vitamin A etc.
- Logistics
- Share data / information amongst each other and with Naandi Foundation

The coordination steps taken at the state level during the two meetings held in April and May 2005 definitely facilitated the vertical linkages. This was followed by a series of meetings during October and December 2005 at district and block levels with all the 3 departments - Women and Child Development, Education and Health participating. These meetings served several purposes- to introduce the project, create a common understanding of the objectives and thrust as well as to develop a rapport and communication between Naandi and the different departments. Further, these were also the fora in which information and data from the government could be gathered in a non-threatening fashion.

The Government of MP was interested in replicating this Integrated Child Development model in other districts of the State with poor child development indicators. This pilot was seen as a first step towards a large-scale programme for decentralized bottom up planning for holistic child development. At the district level, the Assistant Education Director and acting DPO SSA, were nominated by the District Magistrate as the nodal officer for the project.

These initial efforts at establishing the vertical linkages were not as easily replicated at the horizontal level. The horizontal partnership between Naandi programme functionaries and the village functionaries like the AWWs, the ANMs, the teachers and PRI members took time to evolve and develop.

III.3 Management Structure

The team is led by a State level Project Manager who is in overall charge for supervision and provides guidance. There are three Programme Associates (PAs) for each of the three Clusters – Raoti, Bajna and Kundanpur in the Block. And for every cluster of 10-12 villages there is a local village level facilitator called Jan Mitra (Friend of the community). See Figure 3 below for details.

As the project got grounded, greater role clarity evolved. While in the initial phases, everyone was in the field and seemed to be performing the same tasks, by the beginning of year 2 there was a better understanding and appreciation of the complementary roles that a supervisor and field staff play. Table 2 below, spells out some of the detailing of the roles and responsibilities done by the Bajna team.

To start up the project, 12 local people were identified as volunteers for resource mapping. The basic criteria for selection were qualification (at least 10th pass) with some understanding about the area and were identified from among the local tribal and non-tribal community. Tribals were given priority even if their qualification levels were low, as they belonged to the villages/areas of their operation. Even though this is a predominantly tribal region, the minority non-tribal population, being more educated and economically enabled, was prominent. Gradually the team grew to 20 and the facilitators were named as

Jan Mitras (JMs) – friends of the community. The team comprised of both men and women, of whom 6 were women. Their education levels range from High School to Post Graduation; of course very few of them are post graduates. Over the course of their work the JMs grew to understand their work and were able to define their roles and responsibilities.

It was expected that as the project matures and the Ekta Samuhs (community level collectives) develop a stronger identity the roles and responsibilities would undergo further changes. The vision was that the Ekta Samuhs emerge as local community institutions that promote, nurture and further the cause of integrated child development. *The vision for the field functionaries is that they grow into a resource group at cluster/block level to extend support through training, planning and resource facilitation on a larger scale both within the project area and elsewhere, should the programme expand.*

Figure 3: The Programme Management Structure

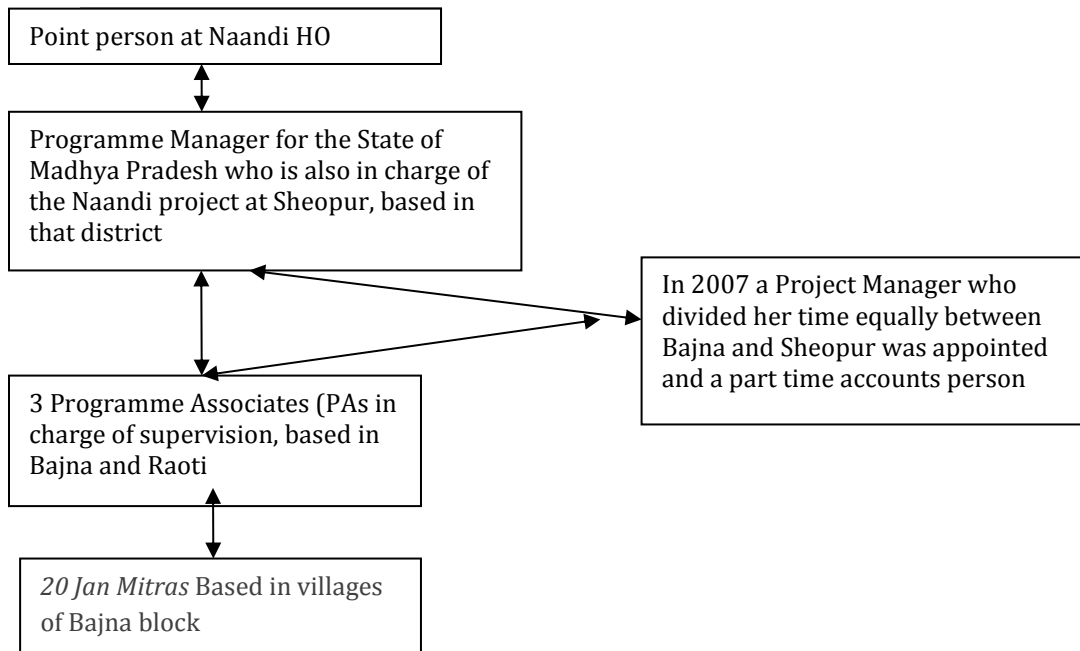


Table 2: Roles and responsibilities

Programme Associates	Jan Mitras
<p>Roles</p> <ul style="list-style-type: none"> • Friends of the community and the JMs • Team leaders at cluster level • Coordinators of meetings and linkages at Block level • Facilitates flow of data and information from the district and block offices • Facilitators for issues and conflicts at village level • Coordinators/ guides of JMs at cluster level • Provide motivation, guidance and support to the JMs <p>Responsibilities</p> <ul style="list-style-type: none"> • Work with the JMs to plan and monitor their activities • Maintain reports and other documentation in the office • Hold regular meetings with the JMs • Obtain information from the block level and share with JMs • Make filed visits in the villages with JMs or other wise • Review the work plans and activities of JMs on a fortnightly basis • Conduct meetings with service providers 	<p>Roles</p> <ul style="list-style-type: none"> • Friends of the community • Motivators/community mobilisers • Facilitate formation of Ekta Samuhs • Facilitators of information, resources • Coordinate linkages among the community and service providers • Trainers at different levels <p>Responsibilities</p> <ul style="list-style-type: none"> • Work closely with the Ekta Samuhs for the integrated development of children • Assist in the development of village plans and follow up activities • Network at community level with the different service providers • Take up initiatives for awareness generation and activities of the community • Undertake trainings of PTA, ES, Mahila Manch, Kishori Manch, AWWs, teachers • Disseminate information about government schemes and programmes for children • Prepare reports of field activities, write case studies • Provide feedback on problems in the villages
<p>Source: This was developed through an interactive exercise with the field team September 2006, by ERU</p>	

III.4 Evolving a shared vision and understanding: What's in a name?

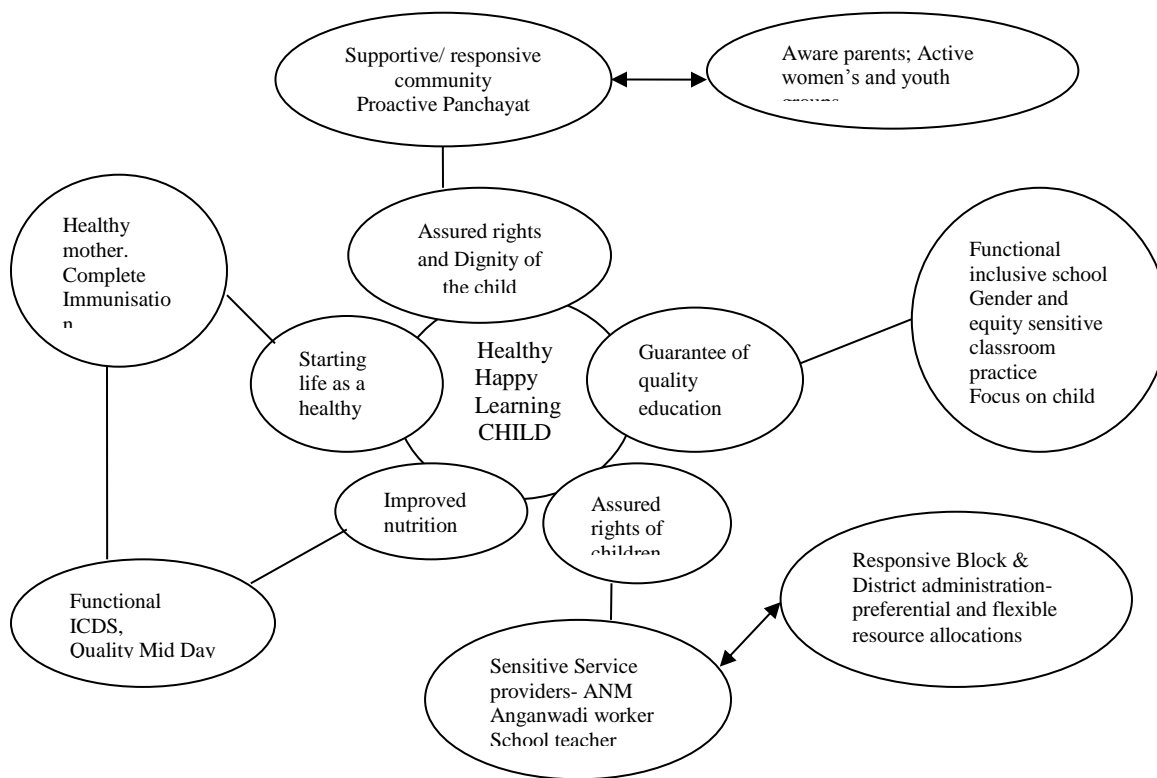
Initially, though the team was worked intensively in the field, but it lacked the clarity of the vision, mission and objectives of the project, which resulted in several activities that did not seem to lead to any concrete outcomes. It was expected that this would sharpen as the programme matures or spreads to other areas. There were several other problems as well. The project title and other terms in the project design made little sense. Initially they were used uncritically and were being parroted at various levels. As long as the messages were in an alien tongue i.e. English creating an ownership as well as internalization of the overall programme objectives both within the implementing team as well as the local communities seemed difficult. There was a suggestion that the project have an identity in a local idiom and language, understood by all and at the same time capturing the essence of the project objectives. After a great deal of discussion, a consensus developed around the word ***Bachpan***, which meant childhood, as a name for the pilot project. As this exercise took place, almost a year after the start of the programme, the Bajna team was able to relate the objectives much more directly to the work in the field. See Box 3, for details.

Box 3: Vision, Mission and Objectives

<i>Vision</i>	Happy, healthy, learning child
<i>Mission</i>	Facilitate integrated child development through convergent community and government action
<i>Objectives</i>	<ul style="list-style-type: none">▪ Create awareness on child development with a focus on the girl child▪ Strengthen linkages between different service providers▪ Strengthen linkages between the community, panchayat and service Providers▪ Facilitate formation of Ekta Samuhs at village level (Village Resource Group) with representatives of the community, panchayat and service providers▪ Develop integrated village level action plans around the needs of the child▪ Advocate and lobby with local, district and state administration for flexible allocation of resources

The roll out of this vision was further detailed as shown in Figure 4 below. The importance of language and translation of other terms into language commonly used and understood by people came up sharply during the field visit of ERU to Piplipada village in 2006. In the project, one of the key strategies is the formation of village resource groups which would be the fulcrum around which it would revolve. The literal translation of Village Resource Group resulted in a difficult and infelicitous name, incomprehensible to most and very low on recall. When the people were asked to come up with a name they suggested Ekta Samuh (the literal meaning being solidarity group), which in a sense took the concept of Village Resource Group (VRG) beyond mere resource support, but also underlined the community level solidarity that is essential, if resource support is to be provided. Hence, it was decided to name the Village Resource Groups as Ekta Samuhs since the people would identify with the name.

Figure 4: Visualizing the objectives



IV. Translating visions into action

IV.1 Enabling a community understanding: A dynamic information and communication strategy

The success of an initiative rests often on the depth of community level understanding and support. Information dissemination and communication is an area that the Bachpan project focused a lot of attention on especially in the first year. The challenges were many- to develop an understanding of the needs of the children, to confront the status of children, to comprehend the concept of integrated child development that underpinned the project, the role of parents and the community in this process, and the need for a dynamic partnership between local communities and service providers.

Communication was given top priority as a strategy of community mobilization, to reach out to a community that has by and large remained outside the mainstream. A variety of strategies have been employed- entertainment, rallies, activities in the village, etc. Since the population in Bajna is predominantly illiterate, it was decided to focus on audio-visual folk media for communication. Different aspects of child development, health, nutrition and education components of government programmes were selected for information dissemination.

The innovative medium of *Sandesh Vahini Dals* (SVD) was used here too, after seeing its success in the Naandi project in Sheopur district of Madhya Pradesh. Local persons familiar with folk drama theatre and music were identified in preparation of the Bajna based *Sandesh Vahini Dals*. The team also collected information on local *melas* and weekly bazaars to make use of these public events for reaching out to the community. This group with orientation on the objectives of the project and some basic theatre and music skills put up low cost, high-powered performances (comprising songs, plays and interactive sessions) in villages.

In Bajna a youth group was identified and a three-day comprehensive cultural workshop was organised for them. The group put up 14 performances in different villages across the area. The creation of Bajna

based SVDs has resulted in the formation of a resource pool from within the community, which should be a sustainable resource for the future. The SVD performances attracted a large number of women as well. The block level officials, especially the Block Medical Officer (BMO) and the Child Development Project Officer (CDPO), made it a point to be present at some of performances and to give support to the programme. Some local musicians and writers were invited to enrich the creation of skits and songs.

Box 4: Impact of Sandesh Vahini Dals

Interactions with the community in Kundanpur revealed that people did remember and retain messages from the Sandesh Vahinis. Sandesh Vahini Dals (SVDs) have had an enduring impact on the memory of the local people. Most people the ERU team met remember messages like – water must be filtered with a cloth, hands must be washed.

Impact of SVD messages as identified by the community-

- More institutional deliveries
- Increase in the enrolment at schools
- Rise in the enrolment of girls
- Increased awareness about iodised salt and clean drinking water.

IV.1.i Need for sustained communication

The impact of the Sandesh Vahinis was widely appreciated by the community, as the information at that time was useful and handy. Its outreach was limited but impact was tremendous in informing people and raising their awareness. This good practice for community mobilization needed to be used at different stages of the project with appropriate messages as per the needs of the people.

What was required was a strategy to disseminate focused and issue specific messages rather than a multiple volley of messages and also to give seasonal messages for example information on diarrhoea prevention and management during the summer. These should either target specific attitudinal changes like sanitation and hygiene promotion, health etc or at a specific audience like the frequently migrating families. SVDs should perform closest to the habitations of difficult to reach sections of the community.

Within the Bachpan project, however, this environment building strategy was budgeted for the first year. Since this component was not budgeted for in subsequent years, it meant that this powerful tool could not be used for deepening the awareness of the community.. Local cultural media are powerful and tend to leave a greater impact than a meeting, rally or campaign as it enables the implementer to intermix serious information and messages along with an entertainment element.

IV.2 Forming Ekta Samuhs and laying the foundation for convergent action

The Bachpan project was designed with the express purpose of enabling convergent action at the village level to ensure that children have the best possible chance of being healthy, have access to schooling and successfully complete elementary education.

The project aimed at developing convergence between the various service providers and the local communities, to enable them to come together to achieve common goals of holistic child development. The objective was to create a common forum at the village level called the Ekta Samuh. The expectation was that this Ekta Samuh would look at the issues facing children, and accordingly develop a village plan for children spelling out what each of the service sectors needs to do and what is the responsibility of the community.

Planning and designing for convergent action is easier than trying to put it into practice. There are several roadblocks that come in the way. Generally service providers work in discrete ways with little cross interaction, starting from the village level going up to the highest level such as the department. The bigger roadblock is actually working with the community and viewing it as an equal partner. Even before getting to the stage of forming an Ekta Samuh, several steps had to be taken:

Step 1: Working with each of the service provider groups separately, to introduce the concept of integrated child development, providing inputs and building capacities to improve the service and essentially providing encouragement and support through the way.

Working with the community, building awareness on children's needs, rights and the role that the community can play.

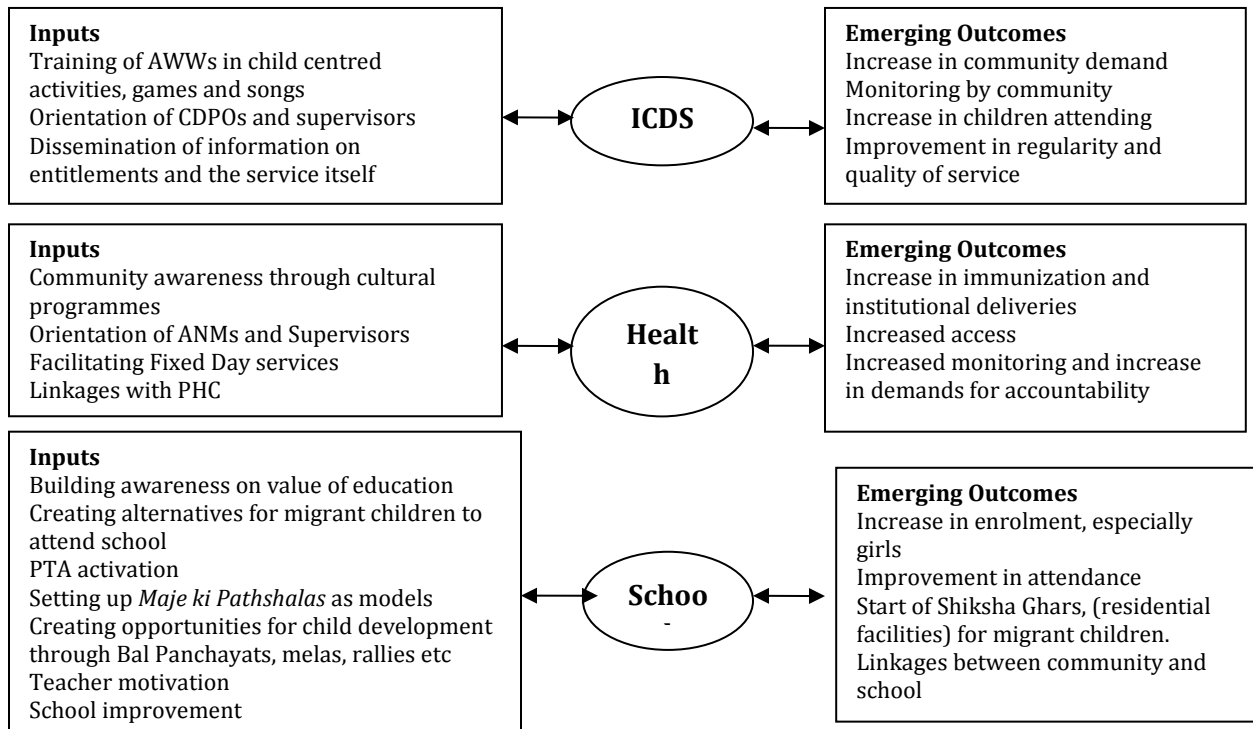
Step 2: Organizing common meetings with service providers and representatives of the community to discuss issues of children in the community and begin a dialogue of how each can support the other to improve the situation of children. Mooting the idea of an Ekta Samuh among the people.

Step 3: Focusing on the Ekta Samuhs. Organizing common meetings, enabling the Ekta Samuh to visualize its role and function, facilitating a common action plan to evolve. Strengthening Ekta Samuhs through building linkages across villages, through panchayat level interactions.

IV.3 Energizing service providers and emerging outcomes

An important first step towards the empowering process of Ekta Samuhs was developing linkages across sectors and with the community was energizing the service providers and services in various ways—through training, dissemination of information and hand holding. The training inputs were particularly useful for the Anganwadi workers, as almost all were illiterate and welcomed the training. From the first reports from the field it appears that the outcomes were encouraging. See Figure 5 below for details:

Figure 5: Energizing service providers



Quite obviously energizing the service providers had its impact on the services themselves. What was important in the strategy was the dual approach- not only the direct inputs to the service provider but also inputs to strengthen the environment and supportive activities. For instance, both in the case of the ICDS and health services, the strong community awareness campaigns not only increased community understanding of the services but also highlighted the manner in which children could benefit and the specific role of the parents and community in ensuring that children access and benefit from these services. In the case of health, the success of the fixed day services depended again not only on the regularity of the service provider, but also the eagerness of the community to access it. Where the community sensitization had a direct impact was in the greater use of the services of the CHC which had a committed doctor and was a vibrant health centre. In the case of the school the work with the PTAs and the *Maje Ke Pathshalas* (Fun learning centres for children before and after schools), were a great push role in sending larger numbers of children into school.

IV.3.i An example of building cross- sectoral linkages and understanding

In the middle of June 2006, a workshop for teachers, ANMs and AWWs was held to enable a common action plan to evolve. The participative methodology evoked a good response. The group discussed inputs for children which were mainly identified as –

- Good health
- Quality education
- Nutrition
- Good school environment
- Proper implementation of government schemes
- Adequate means for economic sustainability/livelihoods

To enable children to grow up in a holistically conducive environment keeping the above points in mind the ANMs, AWWs and teachers put forth their commitments. See Table 3:

Table 3: Commitments of teachers, ANMs and AWWs

Teachers	ANMs	AWWs
<ul style="list-style-type: none"> • Focus on enrollment • Welcome new children • Practice multi-level teaching • Contact PTAs and parents for girls' enrolment • Develop awareness regarding social evils through parents and Ekta Samuhs • Make efforts to enroll dropouts and out of school children • Arrange bridge courses for children- 12 have been sanctioned in Bajna • Facilitate Shiksha Ghars and KGBV • Honestly implement the MDM scheme 	<ul style="list-style-type: none"> • Reach out to pregnant women and register them • Take up institutional deliveries and facilitate incentives for them • Accomplish total immunization • Promote breast feeding and semi-solid food for infants • Disseminate information about hygiene and cleanliness • Create awareness about family planning and spacing of children • Inform women of all health related government schemes 	<ul style="list-style-type: none"> • Actively take up pre school education in AWCs • Ensure that children eat the SNP given to them. Continue to give double nutrition share to the malnourished children • Ensure that women also consume the nutrition given to them • Open the AWCs timely • Weigh the children regularly to monitor growth • Facilitate birth, death and marriage registration • Promote health and hygiene in the village through general health awareness

A consolidated joint action plan was developed for the forthcoming quarter on the basis of the above commitments. What emerged was as follows:

- ♣ Environment creation through communication/advocacy for children's health, education and development through – rallies, campaigns, bal/health *melas*, IEC materials, folk media etc.
- ♣ Fixed day activities/meetings of AWWs, ANMs and teachers at designated places. 100 % registration of pregnant women and 100% immunization of children through fixed day services.
- ♣ Village plans to be developed with all three government functionaries at the village level.
- ♣ Compulsory departmental cooperation for health, sanitation and education at village level.
- ♣ Ensure 10% increase in institutional deliveries.
- ♣ Ensure that all 0-5year old children are registered in AWCs.
- ♣ Examination of pregnant women on a regular basis.
- ♣ Ensuring that all schools and AWCs function with regularity.
- ♣ Motivation of parents to send their children regularly to AWCs and schools.
- ♣ All service providers to support and ensure that all children over 5 years get admitted in Primary schools.
- ♣ Teachers to maintain regular and fair attendance of children in schools.
- ♣ Non-enrolled and dropout children to be enrolled in school/ bridge courses/ Shiksha Ghars through joint efforts of service providers and the community.
- ♣ Monthly PTA meetings with teachers.
- ♣ Motivation of older children to bring siblings to school and help them to study at home.
- ♣ Provide a more joyful learning environment in the school for children through use of TLM and activities.
- ♣ Ensure that children receive all the incentives that are meant for them.

Teachers went a step further and identified some key indicators for themselves:

- Developing attractive schools
- All schools function regularly
- Joyful learning in schools/AWCs
- Increase in TLM usage in schools
- Games and sports equipment used in schools
- All children get the incentives meant for them
- All children attend regularly
- No dropout children

The gap here was the inability to take this momentum to a next plane of purposively following up on it. The assumption that since the plan had been made by the service providers it would be followed through was questionable. While subsequent feedback suggested that action had taken along the lines indicated above, the universality of approach and potential impact remained a moot issue. This was to change in the subsequent periods when there was a better appreciation of the need to bring the Naandi plan in line with that of the service providers.

IV.4 The Ekta Samuhs

The gradual movement of Ekta Samuhs from loose groups to focused action groups over time, with some clarity about village and panchayat level plans for children evolved over a period of two years. See Table 5, for the process and timeline of formation and consolidation of Ekta Samuhs

Table 5: Time line of formation and consolidation of Ekta Samuhs

December 2005	The Bajna villages relatively unaware of what Naandi was doing. Neither the baseline survey by <i>Indicus Analyticus</i> or resource mapping by Naandi seemed to have evoked any interest or curiosity.
January to March 2006	Village level meetings organized and in the process began the formation of the Village resource group. During this period the low conceptual clarity and understanding of the Jan Mitras reflected itself in the field. Active involvement in the field, built up the trust and confidence in the Jan Mitras.
April to December 2006	<ul style="list-style-type: none"> • Changed the name of village resource group to Ekta Samuh, thereby increasing the understanding among the local communities. • Increase in the frequency of village level meeting. • 112 Ekta Samuhs constituted and oriented regarding their roles and responsibilities. JMs held over 600 community meetings in the villages with the assistance of Ekta Samuhs (ES) • Village planning exercises were completed in about 50 percent of the villages, where dropout and never enrolled children, especially those from migrant families were identified to be targeted by the community for enrolment. • ES still unclear about how to take these plans forward.

	<p>Gradual definition of roles started emerging:</p> <p>The roles and responsibilities of Ekta Samuhs</p> <ul style="list-style-type: none"> ▪ Create awareness in the community about health hygiene and cleanliness. ▪ Motivate irregular service providers to be more regular in discharging their functions. ▪ Inform the concerned department about the problems being faced in the village. ▪ Motivate women to adopt institutional deliveries. ▪ Render support for immunization of children and motivate the community to adopt it for children. ▪ Ensure enrolment of all children in the 6-14 age group and motivate parents for schooling of their children. ▪ Be informed about the learning levels of children in schools. <p>Some indicators of a strong ES also began to be articulated:</p> <p>Parameters of a strong Ekta Samuh</p> <ul style="list-style-type: none"> ▪ Has a perspective for holistic child development. ▪ Complete knowledge of the village. ▪ Aware of the problems of the village. ▪ Knowledge of all government schemes and programmes. ▪ Actively ensures that all children are in AWCs/ schools. <p>Some ES began to play an active role in identification and selection of dropout girls and boys for bridge courses and monitoring of schools and AWCs.</p>
<p>April to July 2007</p>	<p>Around 35% of ES were proactive.</p> <p>In order to strengthen the ES, there was a change in strategy moving from village level meetings to facilitating panchayat level interactions between ES. Such workshops were held in 50% of the panchayats with fairly large participation and in some cases with large number of women coming to the meetings.</p>
<p>August to December 2007</p>	<p>ES more confident and reflective. In a self assessment during workshops in all the 3 clusters, ES representatives measured impact in terms of greatest benefit in the following priority order- Children, Anganwadi centres, school, health, Community /ES. 30-35% of ES reported that they are confident of ensuring immunization, ensuring school enrollment, holding ES meetings on their own, and in 2 out of the 3 clusters monitor the school and <i>Maje ki pathshalas</i>.</p>
<p>2008</p>	<p>During the course of a meeting in all the 3 clusters in mid-2008, ES representatives were very enthusiastic in reporting what they saw as changes happening and were also willing to articulate problem areas where they are not making any headway:</p> <ul style="list-style-type: none"> • Education <ul style="list-style-type: none"> ○ Earlier a large number of children were out of school, now many more are in school. School timings are more regular and many

present said that in their villages, schools now ran from 10 to 4 pm. Teacher attitudes they said had a great influence on the functioning of the school as well as on attendance of children. In Semilkhedhi village for instance a sensitive and regular teacher impacted the attendance which went up significantly. In this same village young man offers tuition to 30 children who have just joined the school to ensure that they do not drop out.

- Sensitivity to the problem of out of school children has been built. The Raoti cluster representatives reported that in their villages of 72 enrolment was as follows:
 - 28 villages with 100% enrolment
 - 11 villages with 25% out of school children
 - 5 villages with 10% out of school children
 - 2 villages with 50% out of school children
 - All the 50 villages whose representatives came to the meeting reported that all girls in their village of primary school age were attending school. Quite obviously now the spotlight needs to be thrown on the older girls.
- In Amlipur village for instance 4 years ago only about 8-9 children would take exams. Now around 80 children take exams in the same village.

In Jharaniakela, village in Kundanpur cluster, the situation of the absentee teacher was tackled by the PTA. The PTA took immediate action by confronting the teacher about absenteeism, noted the daily attendance in the register and then complained to the BEO. After the complaint a new teacher was attached, which improved the situation as the children too became regular after this. In Kewdakhurd village, the school had two women teachers who were not so regular, but the ES was active and demanded accountability so they became regular gradually.

In 3-4 villages the situation of schools had not improved as the teachers and the students, both were irregular. This is because the people who are residing in these scattered hamlets migrate during the working season along with their children. For instance in Karakela village, almost 80 children were not going to school, as reported by the ES members. They said that people in this village were poor and less aware about educating their children. They would send their children to school if they had a hostel facility. In such a situation it becomes imperative for the Bachpan team to raise this issue with SSA to explore the possibility of organizing such a hostel.

- **ICDS**

- In several villages where the location of the ICDS centre was changed it has had a positive impact on improving attendance and access. The AWWs reported that now with community support 40-50 children come to the ICDS centre. The AWWs were also very appreciative of the training inputs provided by Naandi and wanted more sustained inputs.
- A major problem the community is faced with is corruption in the

	<p>purchase of the nutritional supplement. Everyone is aware that money for nutrition is being salted away, corruption is rampant and the big question is what to do? “Money meant for children should reach children. We will not tolerate misuse”. Quite obviously the challenge before the Bachpan team is to empower the ES to an extent that they can take independent action. What perhaps needs to be done from the project side is to increase opportunities for interactions between ES and officials at various levels so such issues can be raised in the right fora.</p> <ul style="list-style-type: none"> • Health <ul style="list-style-type: none"> ○ The practice of institutional deliveries is quite evidently becoming common. In Labanipura village for instance over the past year there were 12 institutional deliveries ○ In Bijli village for instance an interesting development is the manner in which the ES and youth groups are adopting an organic and integrated approach to issues of health, livelihoods and schooling., wherein the implementation of NREGS, promotion of institutional deliveries and ensuring children’s education are all seen as the key and strategic interventions that the ES and youth group would focus on. They ensured that 2 very poor families received 100 days work under NREGA. A nursing mother was paid full wages for 6 weeks after delivery as per norms.
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The proactive role of the Ekta Samuh is also borne out by the feedback from government functionaries. At the Block level meeting in 2006, the senior functionaries of the three departments assured support for coordination of activities under the leadership of the Chief Block Officer at Bajna. All the members present acknowledged that people had become far more aware about facilities and schemes of the government. There was a change in the environment at village level, as there was a growing demand for more transparency by the community in the delivery of services.

Health Department - *Dr. Verma from the CHC said that more and more people, particularly women were coming for availing health care. He informed that health check up camps for children could be facilitated within a 3Km radius of middle schools on fixed days.*

Education Department – *The BEO, Mr. Aliya informed that AWC and School timings could be coordinated where the AWCs were running in the school premises. Mr. Pachauri the BRC Coordinator was amenable to support Shiksha Ghars for migrant children if a consolidated list of the needs in the block was given for each village. The idea of training teachers for multi-grade teaching and activity based joyful learning was given a positive go ahead by him and the BEO.*

ICDS Department – *The CDPO, Mr. Bohra was appreciative of the quality of training given to AWWs. He also informed that the construction of 36 AWCs had been sanctioned for which the Ekta Samuhs could play critical role in their location so as to ensure transparency by Sarpanches.*

Chief Block Officer – *Mr. Dandotia was extremely positive about the efforts of the project in the Block saying that, “If you can work and succeed in Bajna you can do it anywhere.” He supported the idea of an orientation of Sarpanches because they play a pivotal role in village politics and development. He suggested that the administration would consider transferring employment guarantee schemes to those villages suggested by the Naandi team where population migration was between 50-75%, in order to*

ensure some livelihood opportunities, besides containing migration. (Source: ERU Report III, September 2006).

In mid 2008 the Block Education Officer (BEO), Mr. Pachauri informed that frequently the members of the ES come to him about school related issues in their villages. So not only does he get a feedback about the functioning of the school, but also the support of the community in tackling errant teachers, who otherwise would use other pressures to neglect their duties. The BEO was also amenable to providing hostels under SSA for migrant children at block level if the ES would give lists of children from various migrant families in the villages. He gave heed to the idea of setting up model primary schools in some clusters where the community, PTA, teachers and Bal Panchayats could work together to achieve quality education.

IV.4.i Village plans for children

The development of village level child development plans was one of the pivotal components of the programme as envisioned in the design of the pilot. It was expected that the Ekta Samuhs would develop such plans which would inform all activities and interventions for children at the village level. It was also expected that such plans would be used to lobby with block and district level authorities for targeted interventions and allocation of necessary resources.

In the initial phase of the project because of poor understanding of the project, its approach and strategies, the whole process of development of village plans was done in a top down fashion with little involvement of the community. Further the village plan once having been made by the project staff did not figure in any of the inputs or interventions at the field level. The process of Ekta Samuh formation was seen as a process independent of the village plan. As the community was mobilized and the ES started understanding their roles and identifying the problems with regard to their children and became proactive, a broad plan of action began to develop in some areas by the middle of 2006.

In Keriapada village, the first tentative village plan was discussed amongst the members of the Ekta Samuh, with facilitation by the JM.

- *The group focused attention on the problem of drop out children, pre- natal care for women and poor health status of children, heavy migration of families (50%) for economic sustainability, alcoholism and smoking among men and the issue of dowry.*
- *They also discovered that many children were in school but the parents did not know in which class they were. The irregularity of the school teacher was another problem they faced.*
- *Here, the Ekta Samuh was fairly active and had already taken a decision to work on certain issues in the second meeting, in the presence of the team and the larger community.*
- *They wanted to identify children from migrant families and motivate them to stay back in a residential centre when the parents migrated. The parents present had consented to this proposal.*
- *The second thing they wanted to organize was a health check- up camp for children of the village in the monsoon season for preventive remedies. Subsequently, they wanted to ensure that all 3-6 year olds were in the AWC and all children under six years were immunized.*
- *The Ekta Samuh members also vowed to become teetotalers themselves while encouraging the practice across the village. The members considered setting up a Bal Kosh in the village for the children, by putting in fifty paise per person as a saving on a monthly basis. This would go towards the needs of any child/ or children for health or educational needs.*

Though as mentioned above, when the strategies for strengthening of Ekta Samuhs shifted from a village focus to a panchayat focus by middle of 2007, the possibilities of evolving a village plan of action were better grasped. For instance the series of cluster level meetings in mid 2008 underscored this possibility as indicated in Table 4 below:

Table 4: Planning at Panchayat level, Kundanpur cluster – Chikni and Binti Panchayats (ES to take the initiative in respective villages)

Children below 5yrs	Actions to be taken		
	Month 1	Month 2	Month 3
Immunisation of children whose parents migrate SNP irregular and nutrition and sanitation weak AW children not regular Children have poor nutrition	Make mothers aware about immunisation. Door to door visits of ANM. Set fixed place for immunization in village Training on importance of SNP Discuss and motivate mothers and ensure AWC is regular Get ANM and AWW to speak about nutrition from local foods	Awareness about pre school education to parents Move for fixed day services Follow up with AWC and panchayat on SNP Discussions with mothers and follow up activities See that nutrition is served in AWCs and ask mothers whether children eat at home	Inform parents about meetings to follow up on issues. ES to follow up motivation of parents and track children. Ensure fixed day services become regular. ES tracks AWC, AWW ANM
Children going to school			
Children from some hamlets absent from school even though enrolled Schools do not open regularly	Talk to parents about shifting of children from sibling care Community to track children who are absent frequently and speak to parents Mobilise parents for enrolling children and making them regular	Motivation of parents hamlet wise Discussions with parents through meetings and discussions PTA to track children in the schools and ensure that incentives are available for them	ES to monitor use of funds in schools through PTA PTA and ES to monitor school regularity and quality and report to Education Department PTA to convene timely and follow up activities – hamlet level meetings and sharing of experiences
Other village issues			
Regular visits of ANMs to AWC Visits of pregnant women to health centre School boundary and beautification	Speak to ANMs telling them of their problems – at meetings Identify and motivate women through AWW and ANM – in the hamlets PTA to become active – speak to the teacher	Set a day for examination of women by the ANM Inform them about services at the health centre Children and parents get involved in school improvement ES speaks to Sarpanch	Track the women and ensure their records are maintained Ask Mahila Manch to track them in the different hamlets School function to showcase school

Drinking water facility dysfunctional	Mobilise people for action		Move to higher level if Sarpanch does not take action
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While individual Ekta Samuhs began to address several child related issues and in many cases with success, the translation of this into village plans did not take place. The idea of village level child plans that should have grown from the initiatives and commitment of the community as above took root only sporadically, in some villages where the leaders of ES were active and the community was mobilized. The development of such plans across the board could not translate on a wider scale as the team itself was not quite clear on the principles and steps for developing village plans. It must be said, however, that the whole process of formation of the Ekta Samuh itself took considerable time. The concept of the village plan evolving into an actual plan of action at the village level and moving up into a block level plan did not take place as anticipated. What the Bajna experience suggests is, that to expect that such a process would get grounded within a 3 year time frame is unrealistic.

IV.5 Working with Children

Enabling environment for children’s participation

The creation of an enabling environment for children’s participation and empowerment in the earlier phase of the project through the Bal Melas with competitions, games, songs and rallies provided them an opportunity to come forth with their talents. This helped parents to feel connected, when their children won prizes awarded by the panchayats, showing a first step in people recognizing the potential of children. The subsequent, Bal Mahotsavs, celebrated on or around Children’s Day, at the block level, brought different school children and teachers together along with the Bal Mitras. This was a successful strategy in building a relationship between children across schools. These events received both support and appreciation from parents and the community. The school teachers saw their involvement with children as something tangible, besides encouraging the students to be recognized through the village community in general and parents in particular.

The creation of Bal Panchayats in 60 schools, where Bal Mitras were attached, helped in tracking drop out children, maintaining school cleanliness, monitoring of regularity of children and in a couple of cases have raised their problems at the community level. This positive move created a platform and an environment where children’s voices could be heard in public domains.

Alternative models – Maje ki Pathshalas

Maje ki pathshalas (Fun learning centres) as models in order to demonstrate qualitative education to the village community were set up in 60 primary schools where schools did not have sufficient teachers and/or teacher/ student absenteeism was high. The purpose of running the *Maje ki pathshala* was to demonstrate to the community and the school system that significant changes can be brought about in the education of the children through a regular and focused approach and adopting a joyful and innovative pedagogy. Volunteer teachers called Bal Mitras were appointed. As in other parts of the country where similar strategies were adopted, in the initial phase a gradual dependency on the Bal Mitras increased with teachers often shirking their responsibilities. This led to a change in the strategy whereby the role of the Bal Mitra and *Maje ki pathshala* was changed. The focus now was to provide special sessions or assistance to the children weak in studies before or after school hours. Interestingly, this intervention has made both a negative and positive impact on the community and the education system. Positive impact has been in the form of communities coming together to pool in money to pay an honorarium to Bal Mitras and teachers became more proactive in some schools. However, on the flip side some teachers became further careless and unburdened their responsibilities on the Bal Mitras.

An evaluation of children of *Maje ki pathshala*, by Jan Mitras to assess the progress made by the children against indicators for language- Hindi/English, reading and writing, understanding and recollection of numbers, tables etc was shared with the communities. The assessment results were made public, pasted in the classrooms, and shared with parents.

During a meeting with various community groups in all the 3 clusters during mid- 2008, change in various forms was reported.

- Earlier a large number of children were out of school, now many more are in school. School timings are more regular and many present said that in their villages, schools now ran from 10 to 4 pm. Teacher attitudes they said had a great influence on the functioning of the school as well as on attendance of children. In Semilkhedi village, for instance, a sensitive and regular teacher impacted the attendance which went up significantly. In this same village young man offers tuition to 30 children who have just joined the school to ensure that they do not drop out.
- Sensitivity to the problem of out of school children has been built. In the villages represented in the cluster meeting, it was reported that enrolment was as follows:
 - 28 villages with 100% enrolment
 - 11 villages with 25% out of school children
 - 5 villages with 10% out of school children
 - 2 villages with 50% out of school children
 - All the 50 villages whose representatives came to the meeting reported that all girls in their village of primary school age were attending school. Quite obviously now the spotlight needs to be thrown on the older girls.
- In Amlipur village for instance 4 years ago only about 8-9 children would take exams. Now around 80 children take exams in the same village.
- When parents go out of the village for work, arrangements are being made to leave their children with relatives so that the schooling is not interrupted. While this is happening in some villages, everyone present felt that this is a good practice to be emulated elsewhere as well.
- The Village headman of Malwasi village was very appreciative of the manner in which children were being encouraged to take on leadership roles at the community level through the Bal Panchayats. The Kishori sarpanch of the Bal Panchayat brought the issue of poor quality MDM being served in the school to the notice of the panchayat. The panchayat warned the cook and also brought the issue to the notice of the block authorities, consequently the cook was changed and now there are no problems with the MDM quality.
- To ensure sustainability of the *Maje ki pathshala*, the teachers in 16 villages were selected by the community, which pays them Rs 10/20/50 per child as per the decision of the ES. Parents feel that if Naandi is not there in the near future then they will keep the BMs to help the children do well in school.

In Manpura village the ES selected the BalMitra (BM) in the village meeting, identified the children who needed remedial children and decided the amount each parent would contribute for the teacher. They also resolved to test the children to see if they are learning before paying the BM. For motivating the children they distributed gifts to them in the functions/events organised at village level. To the newly enrolled children the ES gave slates to encourage them and to ensure that they do not feel left out.

In another village – Ratangarh Peeth, the Panchayat and villagers held a rally to celebrate the enrollment of children and invited the government functionaries and teachers. They distributed pens to all children from class 1-8th, while the Panchayat arranged for the tea and snacks for the event.

Yuvak Mangal Dals and Kishori Manches

The Yuvak Mangal Dals and Kishori Manches initiated in some villages, started the process of a dialogue with them to take on village level development issues. During Ekta Samuh meetings some active young boys took the lead in writing minutes, following up agendas and tracking out of school children. Young adults have aspirations for themselves, as the area does not offer much by way of work or educational opportunities. They perceived that meeting together as a forum would help them to move ahead regarding their own future. Adolescent girls also began to get interested as well. Some sporadic inputs on health were provided with the assistance of ANMs. Within Bachpan no clear strategy for local youth, however, evolved, nor was there a clear understanding of how youth could be mobilized and made an integral part of the Ekta Samuhs.

V. Monitoring and review

Monitoring and review have been problematic issues through out the project .During the rolling out of the pilot, in the initial first six months there were start up problems. There was the problem in setting up a fully functional block level office to carry forward the implementation of the pilot as Bajna was a very backward block. Even the newly selected coordinator left within a few months due to health problems; and the Project Manager was able to give only half his time to Bajna, as he was also in charge of another project in another district in MP. It was difficult to find facilitators, later called JMs, to work in the villages with the community, as no such work had been done by any NGO in the area.

The lack of perspective building and organized training at the beginning of the project led to considerable confusion in understanding the project vision and objectives, as well as their own roles in this process. The entire team of PAs and JMs did not have a clear understanding about their specific roles and tracking milestones and actions taken in convergence, how to build and sustain linkages, etc. The list is long.

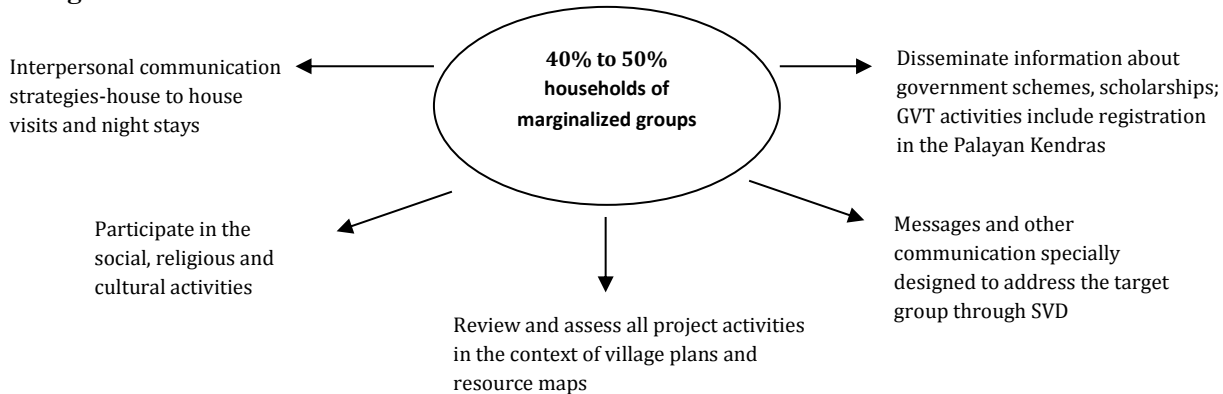
Therefore, in the first year of implementation of the pilot, the management and monitoring systems were fragile, as activities and strategies were being tested and evolved, as reported by the ERU team in its quarterly report of April-July 2006. Planning and review of activities was ad hoc, with management and administration carried out on an as is where is basis. Since the entire team was inexperienced and fairly new, it took time to come to grips with such a process oriented project. The entire need based, bottom up planning and tracking evolved through intensive discussions and dialogue over a two year period.

Firstly, the Jan Mitras and the Programme Associates took some time to adjust to the concept of data / information gathering through resource mapping and surveys as they had no focused training on how to go about doing this. Further on, the collation of field data was also an issue as the team lacked the skills and competencies to do such an exercise. Gradually, through on the job training, doing qualitative documentation of field processes, trainings, events and issues the functionaries understood the purpose of documenting activities and events on a timely basis. Even monthly, quarterly and six monthly progress reports evolved through a gradual process of learning, which drew them into the habit of recording, reporting and reviewing. The JMs started writing brief reports of major field events like Sandesh Vahini programmes, jathas/ rallies, launch of activities etc. During the first year of the project, everyone in the team was involved in a hands-on fashion, so the project was monitored on a ‘learning by experience’ basis.

One of the first attempts to assess the work of JMs was through self appraisal when they did a SWOT analysis of their work with reference to project activities in July 2007. Most Jan Mitras identified their weak areas - ineffective communication skills, lack of planning abilities and time management, inability to write reports, no data assessment/collation skills and inability to organise the community. While on the other side they spoke of how they had grown as field workers with defined roles and responsibilities (see table 2 above) and had acquired new skills.

The team chalked out a plan (as below), to effectively reach out to the hard to reach hamlets after assessing that they had been left out. See Figure 4.

Figure 4: Schedule to reach out to the unreached



(Source ERU Process Documentation Report January - March 2007).

At the same time they learnt to define the parameters of qualitative improvement for each of the components, including Ekta Samuhs by tracking progress in their respective villages based on the parameters they had evolved. See Table 5 below. Using these parameters they ranked the villages vis a vis issues on a scale of A-D:

- A : 76 - 100% of the parameters visible
- B : 51 - 75% of the parameters visible
- C : 26 - 50% of the parameters visible
- D : 1 - 25% of the parameters visible

Jan Mitras were able to rank each issue in relation to the progress made in each of their villages. During this process they were able to visualize and understand that the education component and in some cases Ekta Samuhs obtained high ranking (mostly Bs and A in some 3 villages), while Anganwadi and health components scored poorly (mostly Cs and Ds). This confirmed that the programme emphasis was more on the education component than the other two. Later, each JM graded each of his/ her villages against four issues – health, education, AWC and strength of Ekta Samuh. Once the JMs learnt to do this they were able to qualitatively assess the villages and ES they were working with over each subsequent quarter.

However, this was not an easy task as the team lacked the skills to conduct a comparative analysis of achievements and data quarter-wise. A need was felt for simple pictorial tools to enable Ekta Samuh's to monitor and document what was happening in their villages. This was, however, not taken forward. Monitoring and tracking by Ekta Samuhs began in some villages but was not sustained in a very systematic manner. Another issue that emerged subsequently was that while a lot of data had been collected, its collation, analysis and assessing achievements continued to be weak among the Naandi team. An attempt was made to sharpen this by helping JMs to assess and grade their own work in the villages that they were operating in.

Following this, in May 2007 Naandi sought the assistance of one of the team members of ERU to help develop monthly and quarterly reporting formats and parameters for information/data collection. The Programme Manager, PAs met in Hyderabad to collectively develop the formats, which were shared with the JMs, tested in the field before being finalised.

By 2008 April, with a new manager in place certain administrative changes were brought in. Firstly the monitoring, review and reporting responsibilities of PAs was spelt out. Several systems were now put in place. In addition to the fortnightly/monthly reviews, the team met every quarter to review the previous quarter and develop a detailed plan of action, spelling out the activities and responsibilities of each level. This quarterly plan then became the basis for monitoring. These quarterly reviews also serve the purpose of bringing data collection up-to date along with specific success stories and case studies of significant developments and events. Action plans were developed for individuals and for field activities in terms of deliverables every fortnight so as to keep a track of the progress of planned initiatives. Now specific formats have been developed for reporting, with Jan Mitras submitting their written reports.

Table 5: Parameters of qualitative improvement⁹

Education	Anganwadi Centres	Health	Ekta Samuh
<ul style="list-style-type: none"> ▪ 100 % enrolment of children ▪ Regular attendance of teachers and children ▪ Teaching with fun/activities ▪ Children from class 1-5 have competencies of their levels ▪ Monthly evaluation of children in school ▪ Proper usage of library by the children ▪ Drinking water, toilets facilities in schools ▪ Sports events and cultural programs ▪ Regular health checkups in schools ▪ Motivation of parents whose children are irregular ▪ Ensure parents participation ▪ Ensure participation of members of the community in the PTA ▪ Ensure participation of children in school activities ▪ Work for PTR with the BEO 	<ul style="list-style-type: none"> ▪ Regular attendance of all children between the age of 3-5 ▪ The AWW should regularly teach the children ▪ Mainstream the children in schools ▪ AWCs use the distributed material regularly ▪ Administer polio and Vitamin A drops ▪ Distribute nutrition regularly, as prescribed - quantity & quality ▪ Regular weight / height measurements of children ▪ Tracking of underweight/ grade III/IV children ▪ Registration of all pregnant and lactating mothers ▪ All three examinations before the deliveries (even those women who migrate) ▪ Distribution of quality food to the pregnant and lactating mothers ▪ Distribution of IFA tablets and its consumption by the pregnant women ▪ Registration and vaccination of all new born children ▪ Grading of the malnourished children and their proper treatment ▪ Note – many points overlap for AWCs and ANMs 	<ul style="list-style-type: none"> ▪ Complete vaccination and nutritious food to the pregnant women ▪ Intake of IFA by pregnant women ▪ Institutional deliveries ▪ Ensure all children breastfed immediately after birth and exclusive breast feeding of children till 6 months ▪ Complete vaccination of children between the age group of 0-5 years ▪ Spacing of at least three years between the children ▪ Proper weight, height and growth measurements ▪ Knowledge of diarrhea control/management ▪ Drinking clean water ▪ Consuming iodized salt ▪ Regular visits by the ANM to AWC for check up and immunization 	<ul style="list-style-type: none"> ▪ Punctual/Regular ▪ Good coordination amongst members ▪ Committed ▪ Knowledge about child development programmes ▪ Knowledge about the village ▪ Unbiased ▪ Good understanding and clarity about their roles and responsibilities ▪ Decision making ability ▪ Support activities in the AWC & schools ▪ Support health related interventions ▪ Ensure participation of women & representation of the poorest of the poor in the group

⁹ ERU process Documentation Report IV, Mach 2007

Planning is now a monthly process, split into fortnightly tranches for both PAs and JMs, done along with the Programme Coordinator. This takes into account both activities and budget so as not to face delays in fund flow for field activities. Consequently, reports as per deliverables for each planned activity against set targets are prepared by the JMs and PAs themselves. The JMs maintain records of hamlet wise meetings and Ekta Samuh meetings along with their agendas and plans. The same is done for Panchayat level workshops which are held at cluster level.

Decentralized management, evolved over the course of the project. What started as ad hoc, top down, centralized planning and management slowly turned around to need based, focused planning with constant reviewing on a fortnightly/ monthly basis. The PAs who earlier worked more like the JMs, evolved as team leaders becoming more responsible and accountable within the whole project. They also learnt to handle administration, project coordination and administration on a two monthly rotation basis. They not only have additional roles and responsibilities, but gradually developed management skills setting the trend for accountability and transparency, besides obtaining on the job training.

This illustrates that once a team has been given an opportunity to perform against its own set targets and deliverables, review and monitoring can take place simultaneously. The decentralization of roles and functions and roles had a salutary effect on programme implementation. In mid 2008 during a process documentation meeting the perceptions of change were captured through an interactive exercise. See Table 6:

Table 6: Change as perceived by the JMs and PAs in their areas

Words used to describe change	Some brief Illustrations
Achievement	In one Ekta Samuh meeting, a member had all relevant information at hand
Facilitation, Responsibility	In 3 villages the ES is active in addressing health issues, children's immunisation and as well as ensuring children's education
Excellent	In one village, Gadikala, a decision was taken that if children are not sent to school the family cannot benefit from NREGS
Progress	In 4 villages ES are holding meetings on their own
Change (Many examples were given by the team)	<ul style="list-style-type: none"> • AWWs and community in one village very articulate about a corrupt ICDS supervisor. The issue was raised in the Lok Kalyan Samiti meeting at the cluster level. Ways of tackling this issue very problematic • In several villages the location of the ICDS centre was shifted as a result of community action • In one area wages under NREGS were not received for 3 months. The issue was discussed by the ES and a decision taken that collectively they would raise the issue and get it resolved • New field strategies of organizing hamlet-wise meetings thereby extending the reach of the project. This is especially helpful for far flung and isolated hamlets. At the same time efforts would be made to get 2 representatives from each hamlet to become a member of the ES thereby making the ES representative body • In several villages many more people interested in coming to meetings. • Overall a greater sense of ownership at all levels, at the level of the Bajna team as well at the community level
Change in the office/work	<ul style="list-style-type: none"> • With new people coming into the organization, things have changed for the better in the office • Work is more target oriented and systematized

	<ul style="list-style-type: none"> • Documentation has been tightened and actually takes place- minutes of meetings. Follow up on future plans is happening • Field visits are now planned activities with an agenda • The fortnightly review is helping sharing and discussion of each other's problems
Unity	<ul style="list-style-type: none"> • Evident in the field in the office as well as at the field • Many ES are active and unified in deciding what to do for example if the school or ICDS centre is closed without notice
Leadership	Community leadership emerging in addressing issues
Feeling	Greater sensitivity to the programme and to individual problems and concerns
Source: ERU Process Documentation Report, January – June 2008	

VI. Insights from Project Bachpan

The experience of Project Bachpan has a lot to offer in terms of insights and learning of what worked, gaps, problems in the design itself, the potential of such approaches and areas where there are insurmountable obstacles and barriers.

The project site

The selection of Bajna for project implementation at one level was a strategically good choice as the area was far removed and isolated from any developmental activity and needed such interventions. There was little resistance from local communities to the Bachpan initiatives and on the contrary was welcomed in almost all villages. On the flip side there were many hurdles to overcome. Finding local people with some work experience was difficult. In such a context training and capacity building become critical components. Within the governmental system such areas do not have the leverage to ensure prompt government action on issues raised in the field. In such a situation the mediating role of the implementing NGO becomes critical to ensure that local issues receive the attention they need.

Building in time and space for start up processes

The lack of any start up time in the project design for recruitment and training of staff, putting systems in place and generally for the implementation team to gain some conceptual grasp of the project design, objectives and strategies, before launching into implementation was a major drawback. A clear 3-6 month time is needed to be built in, especially when dealing with a completely inexperienced team, a difficult terrain and a project that was being remotely managed

Sustained perspective and capacity building

The absence of consistent inputs to the Bajna team was a major drawback. Often one tends to believe that an understanding of the project could be gained while working in the field. While this is true to an extent, there is a need for specific training in developing a conceptual understanding of the project and the implications that the project vision has for strategies and roles. There are other dimensions to the problem. The vision of the project and its design was not shared with the team during the start up phase and hence it was not fully internalized by the team. This delayed both the start up phase and consequently impacted the implementation in the first year. It is essential for the implementing team to know of the vision, mission and objectives of the project to have a sense of ownership of what they are doing, with clarity of purpose.

Training cannot be a one time input but requires to be provided over a period of time. This would then have enabled the team to provide inputs appropriate to a specific stage of maturity of the programme.

Strengthening linkages with the block and district administration

Bachpan was set up in consultation with the government, with clear guidelines regarding the quarterly review and sharing arrangement to both enlist support from the government and to share the issues and successes in the field. While this interaction took place at the village level and to some extent at the block level, it did not happen at the district and state level. In the absence of such consistent communication and interactions, the project was unable to leverage the flow of resources and support to the field level.

Embedding the concept of child centred planning at the community level

The time frame of 3 years is insufficient to enable a village community to understand, and develop the ownership of the idea of developing a community child development plan. What the Bachpan project has shown is that a 3 year period is barely enough to enable the Ekta Samuhs to be formed and begin to work in solidarity and gain the confidence to plan and see through a plan for children on their own. What the Bajna project requires is another 2 to 3 years before Ekta Samuhs can function in an empowered and proactive ways.

Annex 2: Methodology-Evaluation through controlled and experimental design

The impact on “outcomes” will be measured based on agreed cross-sectoral indicators estimated from data collected at the beginning and end of the pilot. Since it is a program targeted at difficult-to-reach poor groups which encounter a wide range of social, cultural, economic, and organizational problems, it will throw light into the extent to which planning can be need specific and ensure better service delivery to the poor. The conceptualization of the net effects (in terms of positive behavior changes of households and service delivery of the frontline providers) in the evaluation is in terms of the difference between those who participated in the project (treatment group - those in the participating villages) and comparable group (the non-participating villages – comparison group) in a quasi-experimental design. Since this project evaluation is not done as a randomized evaluation, participation and output processes could be modeled using the standard econometric techniques to arrive at an unbiased estimate of pilot’s impact. The analysis could involve propensity score matching and multivariate regression methods to control for selection on observables and instrumental variable methods to control for selection on unobservable. The general idea is to compare pilot participants and non-participants holding selection processes constant.

Objective of the Impact Analysis: The impact analysis aimed to capture the net effects of introducing the convergent approach to child development culminating in the development and implementation of village plans for children through micro planning as against the sectoral approach, through both pre and post project comparison and control- experimental design.

Method: The impact to be assessed based on the net effects estimated on the basis of outcomes on cross-sectoral indicators identified for milestones for each age group, generated through baseline survey data and end project (end of third year) for the control and experimental blocks.

Data collection: As per the design, data was collected for baseline at the beginning the project (2006) and for comparison at the end of the third year of implementation (2009).

Survey tools: Data will be collected through household survey schedules to assess child development indicators as well as household behavior indicators and facility survey tools to assess service delivery indicators.

Research questions: The impact evaluation addresses the following main concerns:

- Will the intervention lead to enhanced client/ community power and more enabled service providers? Will the resulting impact improve service delivery in terms of better targeting and utilization of funds and services?
- Will the improved service delivery and utilization result in better child development outcomes?
- Is a multi-sectoral intervention as envisaged in the pilot more effective in comparison with the conventional sectoral approach?

Sampling for the Baseline and End line Surveys

The choice of the block from one of the 45 districts of the state for piloting the interventions related to micro-planning and Village Plans for children was based on certain criteria, including a few administrative ones, and as a result, it was a purposive sample rather than an out and out random selection. Ratlam district was identified based on a cumulative development index computed for this

purpose¹⁰. The district shares its western and northern boundaries with Rajasthan. The sex ratio for the district is 959 and literacy rate stands at 55.77, with female literacy rate at 45.05. For all administrative purposes, Ratlam is divided into Six Tehsils (sub- district divisions) and six Blocks.

Selection of blocks

One of the criteria used for identifying the district and blocks were the absence of any specific interventions by non-governmental organizations and agencies for programs that address children's health, nutrition or education issues. Secondly, the GOMP expressed its desire to have the pilot in one of the tribal blocks, the most backward in the state, because it was felt that if the pilot could make some effect on the service delivery model or in the behavior of the beneficiaries, it could be replicated elsewhere in the state. Within the district, two comparable blocks were identified (using the same criteria) one to serve as control block (Sailana) and the other as the experimental block (Bajna). Both blocks are designated tribal blocks by the Government of India. Each block, with approximately 200 villages was selected to afford socio- economic and socio-cultural comparability. It was ensured that both blocks have the presence of the three centrally sponsored schemes—Integrated Child Development Services (ICDS), Reproductive Child Health (RCH) and *Sarva Shiksha Abhiyan* (SSA).

Both Bajna and Sailana have more than 95% tribal population (*Bheel*). Both blocks are on the border of Gujarat and Rajasthan states. The most commonly used local dialect is *Bagadi*. Though the sex ratios in the blocks are better than the state average, only 15-18% of the female population is literate (overall district literacy rate being 26.84).

Sampling Villages

For baseline and end line survey, a total 114 villages out of 220 villages in Bajna block were surveyed. Villages were randomly chosen from each of the 45 Gram Panchayats covered among the identified program villages. This ensured that the sample was spread throughout the program area. A total of 93 control villages were randomly sampled in Sailana out of a total of 234 villages. These were also spread across the whole of Sailana block. This was ensured by dividing the block into 5 sub-regions and sampling from each sub-region.

Sampling of Households

Size of the villages in terms of population: The average village size in Bajna block was about 100 households. Only a handful of villages had more than 250-300 households. Only a few very small villages were encountered during the survey i.e. less than 50 households. Initially the samples size was about 2000 households. However, applying the power analysis for sample size estimation¹¹ for determining the

¹⁰ The choice of the location for the Pilot study required the choice of 2 blocks that (i) are not very different from the state in general (ii) are close to each other and (iii) are not predominantly urban. In addition the districts where the pilot could be conducted should also (iv) have had no education and health related experiments going on currently or in the recent past. The following were the main categories of issues that were considered to be important and for which the analysis of finding the most 'average' block was conducted:

- Infrastructure: % Villages with all weather approach road
- Health Services: % Deliveries by Docs and Nurses, Immunization (BCG, DPT, Measles)
- Education: Literacy Rate, % of out of school who are girls
- Demography: % SC population, % Rural Population, Gender ratio

¹¹ Formula used for estimating required target sample $n = 4 * p * (1 - p) * d_{eff} / e^2$; Using the estimated prevalence of certain indicators at 0.05 estimation margin, number of children needed to be covered and the hence the number of households to be covered were estimated. Indicators used for the target age group covered were DPT3 coverage, BCG coverage,

number of the children to be covered, the total number of households was doubled. Finally, in Bajna 2500 households are being surveyed and 2000 in Sailana. For the end line survey, the same procedure was followed, and it was also ensured that half of the households covered were from the same sample as the base line survey.

The sampling plan undertaken for the household survey was as following:

Table 1. Sampling Plan for the household survey

Village Size	Maximum Sample to be taken	Sampling Rule	Number of Villages Surveyed	
			Bajna	Sailana
Greater than 100 households	25	Sampling every 4-5 th household	41	42
50-100 households	20	Sampling every 3 rd household	51	45
20-50 households	15	Sampling every 2 nd household	20	4
Less than 20 households	50%		2	2
Total Villages Surveyed			114	93

Source: Baseline Survey (January – February 2006)

Table 2. Details of the Survey					
	Baseline		End line		Required target sample as per power analysis
	Bajna	Sailana	Bajna	Sailana	
Number of Households covered	2506	2003	2000	2000	
0-12 months children covered	836	552	560	520	550
12-24 months children covered	634	429	530	519	520
24-60 months children covered	1602	1453	1472	1317	690
5-10 years children covered	2182	1854	2627	2257	660
Primary Schools	112	105	112	105	
Testing children in Language & Maths in Grade II	863	881	871	874	
Sub-Health Centres	23	25	23	25	
Anganwadi Centres	109	147	109	102	
School readiness tests for 4-5 year olds	858	973	851	958	

Source: Baseline Survey (December 2005-February 2006), End line Survey (May – September 2009)

The household schedule takes information for children in the 0-10 years age group. Only those households that had a child in the same age group were sampled. The household schedule is divided into 4 blocks based on the age group of the child. In brief, the major indicators covered in each section are listed below.

- **0-12 month's age group:** ANC, IFA and Tetanus inoculation by the mother, place of delivery of the child, trained assistance during birth and breast-feeding practices are the major issues dealt in this section. These variables basically look into pregnancy related health care issues and other factors influencing child survival in early infancy.
- **12-24 months age group:** Child immunization, intake of Vitamin A and IFA, supplementary nutrition is discussed through questionnaire.
- **24-60 months age group:** This section primarily deals with early childhood education, supplementary nutrition, Vitamin A and IFA intake.

Vitamin A coverage, under-weight percentage, pre-school attendance, and school enrolment; data for indicators were from MICS2 survey.

5-10 years of age: Access to schooling, availability of midday meals are the questions raised in this section.

Sampling of Facilities

The facilities that were surveyed are *anganwadi* centers, primary schools and sub-health centers. Most of the villages have an *anganwadi* centre and a primary school that serve it. There are 26 sub health centers in Bajna and 24 in Sailana. Of these 23-sub health centres which cater to the 200 project villages in Bajna have been surveyed. The same number was covered in the control block. Only those facilities have been studied that served a sampled village. Generally these are the facilities closest or within the village.

Testing of Children

Testing of Grade II students: Achievement level tests were conducted for Grade II in the primary schools that were surveyed. Though grade V is the final grade of the primary cycle, it was decided to test grade II mainly due to two reasons. One, this facilitates the tracking of the progress of some of the students in the same cohort three years down the line; second, changes in the learning levels of those who would attend *anganwadi* now could be traced.

Students present were asked to take the test. Testing of children in Grade II involved testing them for: (a) Hindi; and (b) Math, using tools prepared by NCERT and adapted by the Department of Education in Madhya Pradesh. As the children would be studying under the syllabus designed by the Madhya Pradesh Education Board these tools would be of the same level as their classes.

The Hindi test requires the student to recognize the correct word with the corresponding picture. In the math test simple calculations are to be solved by the student along with recognizing numbers. The tests are 25 minutes each. Initially the children were introduced to the team in an informal manner. Simple games were then played to make them feel comfortable. The children were then asked to answer the questionnaire; the teacher was present in the classroom but was not involved in testing.

Testing children for School Readiness: The school readiness tests, as prepared by the NCERT, are for children in the 4 to 5 years age group. In both Bajna and Sailana, especially in Bajna, it was noticed that children were generally enrolled in school at the age of 5. The test attempts to see whether the children in *anganwadis* are “prepared” enough to attend school, to capture if a child can differentiate between different shapes, pictures, sizes, numbers and sounds. It is a verbal test. The school readiness tests were originally designed to be conducted with grade I students to capture the component of pre-schooling in the *anganwadi* centers. The academic year begins in June and finishes in April. The present class of grade I students would have had about 6 months of school teaching when the survey happened and hence the results from the tests would also reflect on the schooling that they would have received. That is, a better alternative was to capture those children who would be joining school in the coming session in 2006 to test the levels of pre-school education received by them. This, for obvious reasons, necessitated the evaluation of *anganwaadi* students and not those in the first grade.

Another option would have been testing the children at home, but the fact that all children are “enrolled” in *anganwadis* (as the *anganwadi* workers undertake regular child census and all eligible children are automatically enrolled in both *anganwadi* and primary school). There was no child under the 5-year age group who was not on the roll of *anganwadi*. Hence the only difference in school readiness tests would have emerged from those who attend pre-school regularly and those who do not. During household survey, it would have been difficult to test the pre-school attending children since they were in *anganwadis* and not at home. Hence it was decided that the ideal situation is test the children at *anganwadis*, and see whether these children have really reached the desirable levels of school readiness. Those children in the 4 to 5 years age group are the oldest age group at an *anganwadi* centre and would have received pre-school education. For this exercise we chose the *anganwadi* as our focal point. For

capturing the levels of school readiness of those children who were enrolled, but not attending regularly, the households were asked to bring the child to the anganwadi on the day of the school readiness tests – thus even those not regularly attended were also tested.

Annex 3: Socio Economic Milieu and household characteristics of the Study area



Both Bajna and Sailana shares borders with two other states - Gujarat and Rajasthan and more than 95 percent of its population are tribals (*Bheel*) who uses a local dialect, *Bagadi*. Each block consists of around 200-220 villages each and the number of households differs from village to village, ranging from villages with less than 20 households to villages with more than 100 households. The entire population of these two blocks lives in rural areas with geographically difficult terrain – hilly, rocky and with sparse green cover. Around 90 percent of the villages in these two blocks do not have all weather approach roads, and even the existing ones are not congenial for vehicular transport. That makes these villages completely remote

and inaccessible. These blocks are among the most backward in terms of socio-economic indicators within the state of MP, which itself is among the least developed states in the country. The main crops in the area are Maize, Soya bean and Cotton.

What is the living style and standard of the people in Bajna and Sailana?

Majority of the households in these two blocks belong to the “below poverty line” (BPL) category. Most of the households are engaged in subsistence farming or are agricultural or wage laborers. Generally drought prone, these areas have large number of households who migrates seasonally to other parts of the state for a living. Literacy rates among people are very low, with less than 1/4th of the people who could read and write. The sex ratio is highly skewed and there are only 76 girls for 100 boys in the age group of 0-10 in the area (in Bajna, the sex ratio is 77 girls to 100 boys, while in Sailana, it is 75 girls for every 100 boys).

Households in general do not have many general amenities such as private water supply or private toilets. (See table 2 which provides information about household characteristics and physical amenities of the households in Bajna and Sailana, as derived from the analysis of household survey data).

While most of the households lacked several items that are considered as essential for a reasonable standard of living, the relatively ‘better off’ within these more-or-less homogenous societies made differences in terms of the power structure in the society – especially in political and developmental decision making. Hence, it made sense to see which households belonged to the ‘relatively better off’ category, identified using an asset index. The asset index was generated using the information available from these household amenities and ‘assets’. Most of the households belonging to low and middle economic group of the area do not own any items, even a clock, bicycle or mattress. Any households that had some of these items belonged to the “well-to-do” category in these blocks. Very few households have communication and entertainment devises such as telephone, radio or television. Hence, any information about world outside their habitation/village or government schemes reaches the people only through mouth– to-mouth communication. Much socio-economic and development related behavioral aspects get reflected in their practices and facilities – such as not purifying water for drinking purpose or using iodized salt for cooking.

Table. Household Characteristics and Physical Amenities			
<i>Percentage of Households:</i>	Bajna	Sailana	Overall
knew their BPL status	53.87	62.91	57.88
belonging to ST	95.09	87.57	91.75
temporarily migrate to other places	44.43	22.1	34.5
where the respondents could read and write	17.24	21.02	18.9
reporting that they avail the provision under PDS	65.08	84.67	73.79
with electricity connection	50.2	58.7	53.98
with a watch/ clock in the house	24.34	32.05	27.8
with telephone	1.04	1.75	1.35
with a bicycle	16.12	19.02	17.4
with a radio/ transistor	5.91	7.89	6.79
with B&W/ color TV	3.24	5.04	4.04
with scooter/motor cycle/ moped	3.1	4.09	3.55
with pucca roof for the house	3.6	3.25	3.45
with pucca wall for the house	7.0	6.45	6.75
with pucca floor for the house	3.74	3.7	3.72
with private toilet facilities	3.03	3.74	3.35
who depend on public taps for drinking water	72.7	73.04	72.85
who use no methods for purifying water	48.6	42.5	45.9
who strain water with a cloth before using it for drinking	41.7	56.8	45.9
Who uses iodized salt for cooking	18.12	26.66	21.9
Average Monthly Household Expenditure (in Rs)	953	1680	1277

Source: Household Survey of the Baseline Survey, December 2005 – February 2007

Results

	BASELINE SURVEY		ENDLINE SURVEY		Regression coefficients		Difference in difference
	Bajna	Sailana	Bajna	Sailana	Bajna	Sailana	coefficients
Sub-Stage 1							
<i>Percent of pregnant women who:</i>							
Did not receive / availed any ANC	24.9% (0.0149)	19.8% (0.017)	1.3% (0.006)	0.4% (0.003)	-0.22 (0.019)	-0.194 (0.018)	-0.033 (0.027)
Availed at least one ANC	75.1% (0.015)	80.2% (0.017)	98.7% (0.006)	99.5% (0.003)	0.226 (0.019)	0.193 (0.018)	0.033 (0.027)
Availed Full ANC	8.9% (0.009)	23.8% (0.018)	24.4% (0.018)	32.5% (0.021)	0.148 (0.019)	0.087 (0.027)	0.061* (0.032)
Mean number of ANC	1.4 (0.035)	1.7 (0.057)	2.05 (0.03)	2.26 (0.031)	0.627 (0.052)	0.578 (0.067)	0.04817 (0.084)
<i>Of those who received some ANC, those who</i>							
Had their first ANC within the first two trimesters	48.8% (0.017)	55.3% (0.021)	89.01% (0.014)	98.1% (0.006)	0.402 (0.024)	0.428 (0.016)	-0.026** (0.034)
Had their first ANC during 1st Trimester itself	11.8% (0.011)	21.2% (0.017)	56.3% (0.022)	88.2% (0.015)	0.444 (0.022)	0.670 (0.023)	0.225*** (0.032)
<i>Those who received different components of ANC</i>							
Had their weight measured during ANC	64.9% (0.016)	59.2% (0.021)	85.2% (0.016)	83.9% (0.017)	0.202 (0.024)	0.248 (0.027)	-0.045 (0.036)
Had their height measured during ANC	46.5% (0.017)	19.4% (0.017)	56.7% (0.022)	83.1% (0.017)	0.092 (0.028)	0.637 (0.023)	-0.545*** (0.038)
Had their BP checked during ANC	42.0% (0.017)	20.5% (0.017)	63.7% (0.021)	76.8% (0.019)	0.212 (0.027)	0.563 (0.025)	-0.351*** (0.038)
Had their Blood Tested during ANC	23.6% (0.015)	23.2% (0.018)	53.6% (0.022)	59.8% (0.022)	0.300 (0.025)	0.365 (0.028)	-0.0652* (0.038)
Had their Urine Tested during ANC	16.9% (0.012)	12.3% (0.014)	38.5% (0.021)	38.6% (0.022)	0.213 (0.023)	0.263 (0.025)	-0.0499 (0.035)
Had their Abdomen examined during ANC	9.9% (0.010)	58.6% (0.021)	60.2% (0.022)	10.5% (0.014)	0.498 (0.021)	-0.481 (0.026)	0.978*** (0.033)
Had their Internal examined during ANC	16.9% (0.013)	22.9% (0.018)	11.3% (0.014)	5.3% (0.01)	-0.057 (0.019)	-0.176 (0.021)	0.119*** (0.029)
Had their X-ray done during ANC	0.2% (0.001)	0.7% (0.003)	6.2% (0.01)	6.7% (0.011)	0.059 (0.008)	0.060 (0.011)	0 (0.01)
<i>Other aspects of ANC</i>							
Intake of IFA	71.7% (0.016)	78.6% (0.017)	96.5% (0.008)	87.8% (0.015)	0.240 (0.020)	0.092 (0.023)	0.147*** (0.0312)
Vaccination of TT	77.1% (0.015)	83.5% (0.016)	95.0% (0.009)	88.0% (0.015)	0.178 (0.019)	0.045 (0.0218)	0.133*** (0.029)
<i>Place of Delivery</i>							
Home	67.5%	74.9%	31.3%	71.3%	-0.365	-0.036	-0.329***

	BASELINE SURVEY		ENDLINE SURVEY		Regression coefficients		Difference in difference
	Bajna	Sailana	Bajna	Sailana	Bajna	Sailana	coefficients
	(0.016)	(0.018)	(0.0203)	(0.0204)	(0.026)	(0.027)	(0.038)
Government Health	29.8%	16.5%	67.7%	28.7%	0.372	0.121	0.251***
	(0.0158)	(0.0158)	(0.021)	(0.020)	(0.025)	(0.025)	(0.036)
Institutional delivery	31.7%	24.5%	68.0%	28.6%	0.363	0.0415	0.321***
	(0.016)	(0.018)	(0.02)	(0.020)	(0.026)	(0.0273)	(0.038)
Assistance during Delivery							
Health Professional	34.5%	29.0%	76.7%	34.9%	0.415	0.059	0.358***
	(0.016)	(0.019)	(0.019)	(0.022)	(0.025)	(0.028)	(0.038)
Traditional Birth Attendant	49.6%	61.2%	15.9%	32.1%	-0.334	-0.29	-0.0436
	(0.017)	(0.021)	(0.016)	(0.021)	(0.025)	(0.029)	(0.038)
Orientation about child care and post delivery care after delivery	14.8%	33.6%	64.2%	18.3%	0.49	-0.15	0.65***
	(0.012)	(0.021)	(0.021)	(0.017)	(0.022)	(0.03)	(0.034)
New born babies' weight	33.6%	24.5%	78.6%	28.6%	0.450	0.041	0.408***
	(0.016)	(0.018)	(0.018)	(0.020)	(0.033)	(0.027)	(0.037)
Measures of underweight							
Proportion of children							
normal weight	20.6%	21.9%	27.1%	29.3%	0.065	0.073	-0.007
	(0.014)	(0.018)	(0.019)	(0.021)	(0.023)	(0.026)	(0.035)
<-1SD weight	79.4%	78.0%	72.8%	70.7%	-0.066	-0.073	0.007
	(0.014)	(0.018)	(0.019)	(0.021)	(0.024)	(0.027)	(0.035)
<-2SD weight	64.8%	57.9%	43.3%	49.4%	-0.215	-0.085	-0.129**
	(0.016)	(0.021)	(0.022)	(0.023)	(0.027)	(0.031)	((0.041)
<-3SD weight	33.6%	31.0%	21.6%	30.0%	-0.120	-0.010	-0.110**
	(0.016)	(0.019)	(0.018)	(0.021)	(0.025)	(0.028)	(0.037)
No complementary food even at 12+ months	30.0%	17.0%	3.9%	1.8%	-0.26	-0.16	-1.012***
	(0.018)	(0.018)	(0.008)	(0.005)	(2.0)	(2.2)	(3.03)
Mean height- in cm for	53.2	59.6	57.3	58	3.99	-1.59	5.59***
	(0.005)	(0.006)	(0.005)	(0.007)	(0.75)	(0.9)	(1.16)
Mean height – in for girls	52.8	57.4	56.9	57.8	4.11	0.27	3.83***
	(0.006)	(0.006)	(0.005)	(0.007)	(0.79)	(0.90)	(1.19)
Sub-Stage 2							
Proportion of children in 12-24 months who were immunized for							
BCG	82.7%	77.2%	96.3%	94.9%	0.136	0.177	-0.04089
	(0.015)	(0.0202)	(0.008)	(0.011)	(0.018)	(0.023)	(0.03)
DPT 1	77.4%	66.9%	95.6%	94.3%	0.182	0.274	-0.0924***
	(0.017)	(0.0227)	(0.009)	(0.01.2)	(0.02)	(0.03)	(0.033)
DPT 2	47.6%	62.5%	83.1%	91.2%	0.355	0.288	0.0672*
	(0.019)	(0.023)	(0.017)	(0.01.4)	(0.03)	(0.03)	(0.04)
DPT 3	16.4%	55.7%	68.3%	84.8%	0.519	0.291	0.228***
	(0.015)	(0.024)	(0.021)	(0.018)	(0.025)	(0.031)	(0.039)
All 3 DPT	15.8%	54.8%	66.9%	83.8%	0.511	0.290	0.221***
	(0.014)	(0.024)	(0.022)	(0.019)	(0.025)	(0.031)	(0.039)
Polio 0	70.5%	91.8%	94.6%	94.3%	0.241	0.025	0.216***

	BASELINE SURVEY		ENDLINE SURVEY		Regression coefficients		Difference in difference
	Bajna	Sailana	Bajna	Sailana	Bajna	Sailana	coefficients
	(0.018)	(0.0132)	(0.0103)	(0.012)	(0.022)	(0.018)	(0.031)
Polio 1	89.3% (0.012)	94.6% (0.011)	91.9% (0.012)	94.3% (0.012)	0.026 (0.018)	-0.003 (0.016)	0.029 (0.025)
Polio 2	65.9% (0.019)	92.8% (0.013)	81.7% (0.018)	90.9% (0.015)	0.157 (0.026)	-0.018 (0.019)	0.175*** (0.035)
Polio 3	20.2% (0.016)	87.9% (0.0158)	69.8% (0.021)	81.9% (0.0195)	0.496 (0.026)	-0.059 (0.025)	0.555*** (0.037)
ALL 3 POLIO	19.4% (0.0157)	87.9% (0.0158)	68.3% (0.0213)	81.2% (0.02)	0.489 (0.026)	-0.067 (0.025)	0.556*** (0.037)
Measles	26.3% (0.018)	8.2% (0.013)	72.1% (0.020)	70.9% (0.023)	0.457 (0.027)	0.627 (0.026)	-0.169*** (0.038)
Hepatitis B	2.4% (0.006)	0.5% (0.003)	28.3% (0.021)	36.6% (0.024)	0.260 (0.019)	0.361 (0.024)	-0.101** (0.03)
Full imm. Excl measles	9.9% (0.011)	53.4% (0.024)	65.2% (0.022)	79.4% (0.021)	0.553 (0.023)	0.260 (0.032)	0.292*** (0.039)
Full Immunization	5.2% (0.008)	6.5% (0.012)	56.9% (0.023)	66.8% (0.024)	0.517 (0.022)	0.602 (0.026)	-0.086** (0.034)
<i>Measures of weight for</i>							
Weight <-2SD	85.65% (0.014)	78.32% (0.02)	82.08% (0.02)	67.01% (0.023)	-0.036 (0.022)	-0.113 (0.031)	0.077* (0.037)
Mean height – in cm for	68.2cm (0.43)	72.1cm (0.4)	70.33cm (0.45)	70.4cm (0.98)	2.13 (0.63)	-1.69 (0.96)	3.82*** (1.11)
Mean height – in cm for	66.5cm (0.46)	70.4cm (0.4)	68.8cm (0.46)	70.4cm (1.01)	2.28 (0.66)	0.32 (1.1)	1.97 (1.21)
<i>Monitoring of child growth</i>							
Regular measure of height & weight	41.96% (0.02)	56.64% (0.023)	65.21% (0.021)	73.45% (0.022)	0.232 (0.029)	0.17 (0.033)	0.064 (0.044)
Regular growth monitoring	37.54% (0.019)	53.85% (0.024)	52.29% (0.023)	69.07% (0.024)	0.147 (0.029)	0.152 (0.033)	-0.004 (0.045)
Sub-Stage 3							
<i>Weight for Age: 2+ to 5years</i>							
Weight for age <-2SD	82.71% (0.109)	79.64% (0.11)	81.18% (0.10)	75.4% (0.012)	0.064 (0.015)	-0.042 (0.016)	-0.042*** (0.016)
Growth monitoring: 2+ 5							
Measure height and weight	45.68% (0.012)	61.29% (0.0132)	84.04% (0.009)	85.57% (0.009)	0.384 (0.016)	0.243 (0.016)	0.141*** (0.023)
AWC growth monitoring	48.79% (0.0126)	58.85% (0.013)	71.47% (0.012)	73.73% (0.012)	0.227 (0.017)	0.149 (0.018)	0.078*** (0.025)
Vitamin A Supplement	42.57% (0.012)	43.82% (0.0135)	82.61% (0.009)	76.46% (0.012)	0.400 (0.016)	0.326 (0.018)	0.074*** (0.024)
IFA supplement	44.35% (0.013)	43.3% (0.013)	71.2% (0.011)	48.67% (0.014)	0.269 (0.017)	0.054 (0.02)	0.215*** (0.026)
Attending AWC	48.34% (0.013)	41.7% (0.013)	90.35% (0.007)	83.45% (0.010)	0.42 (0.015)	0.418 (0.017)	0.002 (0.022)
Mean days children attending AWC	3.39 (0.067)	2.15 (0.073)	4.74 (0.047)	4.2 (0.01)	1.35 (0.083)	2.05 (0.09)	-0.69*** (0.126)

	BASELINE SURVEY		ENDLINE SURVEY		Regression coefficients		Difference in difference
	Bajna	Sailana	Bajna	Sailana	Bajna	Sailana	coefficients
School Readiness							
Child confident to tell his / her name	96.39% (0.006)	95.99% (0.006)	99.85% (0.002)	97.52% (0.005)	0.035 (0.007)	0.015 (0.009)	0.019* (0.011)
Child confident to tell his/ her parents name	77.27% (0.014)	87.26% (0.011)	98.78% (0.004)	93.68% (0.009)	0.215 (0.017)	0.064 (0.014)	0.151*** (0.022)
Mean score							
Sentence comprehension	58.62% (0.011)	67.47% (0.011)	82.32% (0.012)	79.55% (0.011)	0.236 (0.016)	0.121 (0.016)	0.116*** (0.023)
Visual perception	44.41% (0.0102)	51.39% (0.012)	75.91% (0.013)	69.27% (0.013)	0.315 (0.016)	0.178 (0.017)	0.136*** (0.024)
Visual discrimination	36.07% (0.014)	49.90% (0.014)	79.88% (0.013)	65.92% (0.013)	0.438 (0.02)	0.16 (0.19)	0.278*** (0.028)
Number concepts	58.45% (0.013)	78.31% (0.01)	62.50% (0.013)	64.81% (0.011)	0.041 (0.02)	-0.135 (0.015)	0.176*** (0.024)
Space Concepts	67.13% (0.01)	79.60% (0.099)	84.53% (0.010)	82.22% (0.011)	0.174 (0.015)	0.026 (0.015)	0.148*** (0.021)
Concept of "more"/ "less"	51.28% (0.013)	62.64% (0.0128)	67.99% (0.013)	67.66% (0.012)	0.167 (0.018)	0.050 (0.017)	0.117*** (0.026)
Concept of "near"/ "far"	30.65% (0.014)	59.82% (0.014)	52.59% (0.0114)	55.39% (0.014)	0.219 (0.019)	-0.044 (0.02)	0.264*** (0.027)
Concept of "thick"/"thin"	57.52% (0.013)	76.36% (0.011)	77.82% (0.012)	84.14% (0.010)	0.203 (0.019)	0.077 (0.015)	0.125*** (0.024)
Concept of Classification 1	78.98% (0.008)	80.64% (0.009)	94.05% (0.006)	83.44% (0.009)	0.151 (0.011)	0.027 (0.012)	0.123*** (0.017)
Concept of Classification 2	83.02% (0.009)	84.69% (0.008)	91.51% (0.009)	86.25% (0.009)	0.085 (0.013)	0.015 (0.012)	0.069*** (0.017)
Give words for letters	7.75% (0.012)	11.15% (0.01)	12.80% (0.013)	17.60% (0.012)	0.051 (0.015)	0.064 (0.015)	-0.014 (0.022)
Reading readiness	55.7% (0.006)	61.29% (0.006)	75.61% (0.006)	69.5% (0.006)	0.199 (0.008)	0.084 (0.008)	0.115*** (0.011)
Number readiness	63.5% (0.006)	75.6% (0.006)	78.0% (0.005)	76.0% (0.005)	0.145 (0.008)	0.005 (0.008)	0.14*** (0.012)
Total Score	50.4% (0.005)	60.4% (0.005)	67.3% (0.005)	64.7% (0.005)	0.169 (0.007)	0.043 (0.007)	0.126*** (0.009)
PERCENTAGE OF CHILDREN WHO HAVE MASTERED THE CONCEPT							
Sentence comprehension	30.19% (0.016)	48.51% (0.016)	70.58% (0.018)	65.8% (0.017)	0.404 (0.024)	0.173 (0.023)	0.231*** (0.033)
visual perception	12.94% (0.011)	28.16% (0.0144)	61.74% (0.019)	53.04% (0.018)	0.49 (0.021)	0.25 (0.022)	0.239*** (0.031)
Visual discrimination	23.78% (0.015)	36.49% (0.0154)	71.04% (0.018)	49.81% (0.0176)	0.473 (0.023)	0.133 (0.023)	0.339*** (0.033)
Number concepts	40.56% (0.017)	63.51% (0.015)	39.48% (0.019)	37.05% (0.017)	-0.010 (0.025)	-0.26 (0.023)	0.254*** (0.034)

	BASELINE SURVEY		ENDLINE SURVEY		Regression coefficients		Difference in difference
	Bajna	Sailana	Bajna	Sailana	Bajna	Sailana	coefficients
Space Concepts	40.79% (0.017)	65.67% (0.015)	72.41% (0.017)	72.61% (0.016)	0.316 (0.025)	0.069 (0.022)	0.247*** (0.033)
Concept of "more"/"less"	28.9% (0.015)	48% (0.016)	46.95% (0.02)	45.6% (0.18)	0.18 (0.025)	-0.024 (0.024)	0.204*** (0.034)
Concept of "near"/ "far"	20.4% (0.014)	47.58% (0.016)	19.97% (0.016)	37.79% (0.017)	-0.004 (0.021)	-0.097 (0.023)	0.094** (0.032)
Concept of "thick"/"thin"	39.74% (0.017)	62.08% (0.016)	61.59% (0.019)	74.6% (0.015)	0.218 (0.025)	0.125 (0.022)	0.093** (0.033)
Child looks neat and clean	55.83% (0.017)	52.11% (0.016)	96.65% (0.007)	68.03% (0.016)	0.408 (0.023)	0.159 (0.023)	0.249*** (0.0313)
Children washing hands before eating food	15.38% (0.012)	67.01% (0.015)	99.39% (0.003)	80.67% (0.014)	0.840 (0.014)	0.137 (0.021)	0.703*** (0.026)
Sub-Stage 4							
Out of School Children (OOSC) among 6-10 years old	10.4% (0.007)	9.01% (0.007)	1.14% (0.002)	13.55% (0.007)	-0.09 (0.006)	0.045 (0.01)	-0.13*** (0.011)
Child attended AWC before joining primary	55.5% (0.017)	62.99% (0.016)	95.1% (0.007)	55.3% (0.017)	0.396 (0.018)	-0.076 (0.023)	0.472*** (0.029)
Attending school regularly	84.5% (0.012)	71.6% (0.015)	94.14% (0.007)	85.8% (0.011)	0.096 (0.014)	0.141 (0.019)	-0.046 (0.024)
Enrolment in age appropriate grades	65.86%	68.95%	74.19%	72.55%			
% of 10-11 years already completed primary			43.35%	31.53%			
Learning achievement of Grade 2 students: Overall for Math and Language							
Total Score: more than/equal to 50%	56.55% (0.017)	75.03% (0.015)	91.27% (0.010)	90.73% (0.010)	0.347 (0.019)	0.157 (0.018)	0.190*** (0.026)
Total Score: more than/equal to 60%	43.34% (0.017)	61.75% (0.016)	83.35% (0.013)	84.10% (0.012)	0.40 (0.021)	0.223 (0.021)	0.176*** (0.029)
Total Score: more than/equal to 70%	32.56% (0.016)	47.90% (0.017)	71.87% (0.015)	69.11% (0.016)	0.393 (0.022)	0.212 (0.023)	0.181*** (0.032)
Total Score: more than/equal to 80%	24.10% (0.015)	32.01% (0.016)	50.06% (0.017)	47.48% (0.017)	0.259 (0.022)	0.154 (0.022)	0.105*** (0.032)
Total Score: more than/equal to 90%	11.70% (0.011)	17.25% (0.013)	21.28% (0.014)	9.61% (0.014)	0.115 (0.018)	0.040 (0.019)	0.075*** (0.026)
Total Score: 100%	2.00% (0.005)	3.9% (0.007)	3.2% (0.006)	2.7% (0.006)	0.011 (0.007)	-0.012 (0.009)	0.235* (0.114)
Mean score	54.56% (0.008)	65.1% (0.007)	74.6% (0.006)	72.96% (0.007)	0.200 (0.011)	0.0785 (0.0102)	0.121*** (0.015)
Learning achievement of Grade 2 students: Overall for Math							
Math Score: more than/equal to 50%	51.22% (0.017)	69.81% (0.015)	91.16% (0.009)	75.51% (0.015)	0.399 (0.019)	0.057 (0.021)	0.342*** (0.029)
Math Score: more than/equal to 60%	44.15% (0.017)	60.95% (0.016)	83.81% (0.012)	63.62% (0.016)	0.396 (0.021)	0.026 (0.023)	0.37** (0.031)
Math Score: more than/equal to 70%	38.47% (0.017)	51.87% (0.017)	74.86% (0.015)	46.57% (0.017)	0.363 (0.022)	-0.053 (0.024)	0.416*** (0.033)
Math Score: more	30.01%	41.43%	54.08%	26.77%	0.240	-0.146	0.387***

than/equal to 80%	(0.016)	(0.017)	(0.017)	(0.015)	(0.023)	(0.022)	(0.032)
Math Score: more than/equal to 90%	19.81% (0.014)	28.38% (0.015)	28.93% (0.015)	9.61% (0.01)	0.091 (0.021)	-0.187 (0.018)	0.278*** (0.027)
Math Score: 100%	6.26% (0.008)	13.62% (0.012)	13.2% (0.011)	3.32% (0.006)	0.069 (0.014)	-0.103 (0.013)	0.172*** (0.192)
Mean Math score	51.12% (0.011)	64.4% (0.010)	75.44% (0.007)	61.359% (0.008)	0.243 (0.013)	-0.031 (0.012)	0.274*** (0.0178)
Learning achievement of Grade 2 students: Overall for Hindi							
Hindi Score: more than/equal to 50%	62.11% (0.017)	73.78% (0.015)	88.86% (0.011)	91.53% (0.009)	0.267 (0.019)	0.177 (0.018)	0.090*** (0.026)
Hindi Score: more than/equal to 60%	49.83% (0.017)	62.43% (0.016)	79.68% (0.014)	89.47% (0.010)	0.298 (0.022)	0.270 (0.019)	0.028 (0.029)
Hindi Score: more than/equal to 70%	40.32% (0.017)	50.06% (0.017)	69.23% (0.016)	85.01% (0.012)	0.289 (0.022)	0.349 (0.021)	-0.060* (0.03)
Hindi Score: more than/equal to 80%	31.87% (0.016)	38.14% (0.016)	52.35% (0.017)	75.86% (0.014)	0.204 (0.023)	0.377 (0.022)	-0.172*** (0.032)
Mean Hindi score	58.0% (0.009)	65.8% (0.008)	73.764% (0.008)	84.58% (0.008)	0.158 (0.012)	0.188 (0.012)	-0.030*** (0.017)
*indicates significance at 0.01 confidence level (statistically significant at least at 90% level) ; ** indicates significance at 0.05 level (statistically significant at least at 95% level); *** indicates significance at 0.001 level (statistically significant at 99% level) Figures in parenthesis are standard errors.							

Annex 4: International / National Evidences:

While there have been several attempts before to implement programs targeted at same beneficiaries in a much more coordinated way, very few evidences are available that describe the impact of such efforts, and much less on early child development. One study that evaluated an integrated approach to ECD on child related outcomes is from Philippines, which is briefly described below.

a. Early Childhood Development through Integrated Programs: Evidence from the Philippines (Graeme Armecin, Jere R Behrman, Paulita Duazo, Sharon Ghuman, Socorro Gultiano, Elizabeth M. King and Nanette Lee, April 2006)

In 1999, the Philippine Government launched a five year ECD Project in thirteen provinces covering 2.2 million households, which in 2002 became part of a broader governmental program that was formally adopted through the ECCD Act. The program's overarching goal was to get better the survival and developmental potential of children, particularly those who are most vulnerable and disadvantaged by (a) minimizing the health risks to very young children; (b) contributing to the knowledge of parents and community about child development and encouraging their active involvement; (c) advocating for child friendly policy and legislation; (d) improving the ability and attitude of child related service providers; and (e) mobilizing resources and establishing viable financing mechanisms for ECD projects. The program spans a wide range of health, nutrition, early education and social service programs.

In contrast to some other ECD programs, the Philippine project did not introduce new services; rather, its innovation was to adopt an integrated, multi-sectoral approach to delivering a combination of services that included center-based and home-based interventions. To link the center-based and home-based services, a new service provider, the Child Development Worker (CDW), was placed in all program areas. The CDWs have the task of complementing the roles of midwives and health workers in providing food and nutritional supplements and monitoring children's health status, and were responsible for community based parent education about ECD.

The impact evaluation (using difference in difference propensity score matching "intent-to-treat" program impact estimates) shows that there were nine indicators which showed predominantly positive program impacts (such as cognitive skills, expressive language skills, gross motor skills, self help skills, fine motor skills, weight for height z score, receptive language, and proportion wasted), four indicators with mixed or virtually no program impacts (proportion of children with diarrhea, proportion of children with worms, proportion of children stunted, and proportion of height for age z score) and two indicators with predominantly negative program impacts (proportion of children who are anemic and hemoglobin count).

Practicing Participation in UNICEF Programming: Bridging the Gap between Rhetoric and Reality" (2000) (ERU, Assessment Study of Community participation in Selected UNICEF Supported Education Programs, 2003.

The UNICEF Project in Maharashtra was an early attempt to empower local communities to address and resolve local problems, especially schooling. The intervention focused on improving the quality of education through enhancing school-community partnerships. The effort was to link parents, community members and educators around the goal of full, equal and meaningful participation by all children in good learning experiences. However, the evaluation of the program was more in terms of a descriptive report than a rigorous one where the net effects were captured visa-vis a counterfactual.

b. Building Multi-Sectoral Partnerships To Address Complex Problems: Lessons from the Partnership for Child Nutrition and the Bhavishya Alliance, India; Surita Sandosham and David Winder, November 2008 .

Global Partnership for Child Nutrition (PCN) by Unilever and the Indian partnership *Bhavishya Alliance* (BA) have taken a multi-sectoral approach to fostering innovation in addressing child malnutrition in India. The lessons from their experiences are listed below:

- (a) The process of forming multi-sector partnerships is complex and often requires more time than expected;
- (b) Local ownership and a credible and neutral host organization are critical to partnership success;
- (c) It is important early in the partnership to have thorough knowledge of the underlying causes of the problem to be addressed and solutions already tried;
- (d) It is important to identify and nurture leaders who can act both as change agents and bridge builders;
- (e) Key players in the partnership should possess a range of other skills needed to create strong management and governance systems;
- (f) New interventions should be tested before scaling up;
- (g) Opportunities for reflection should be constantly provided during the Partnership Lifecycle;
- (h) To ensure sustainability resources should be diversified;
- (i) An appropriate mix of qualitative and quantitative instruments needs to be designed to evaluate the impact of the partnership; and
- (j) Communication and documentation policies need to be developed for each phase of the partnership.

Annex 5: Consolidated Resource Mapping Data for Thikariya Gram Panchayat, Bajna, MP (A Sample)

Thikariya

Bazana Block - Ratlam, MP

Panchayat Resource mapping - Jan 06

Population

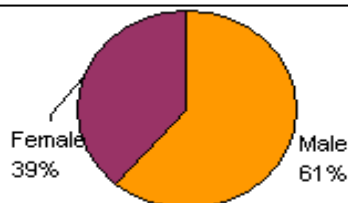
Age group	Male	Female
0-3 year old	98	86
3-5 year old	63	58
5-11 year old	135	126

Households:	340	Caste:	
Population:	1830	Male Literates:	128
Population/Household:	5.4	Female literates:	84
Male: Female ratio	1000:966	Male: Female 0-5 year age group	1000:894

Panchayat/ village level	Panchayat	Thikariya	Khora	Bhandariya	Kotharia	Hlakara Khurd
House holds	340	150	85	51	30	24
Population	1830	327	408	450	290	355

Panchayat	Male	Female
Graduate	3	1
10+2 pass	4	4
10 pass	4	2
8th pass	13	11
Traditional	13	0
Allopathic	0	0
Daai (trained)	0	5
Pharmacist	1	0

Secondary + graduates



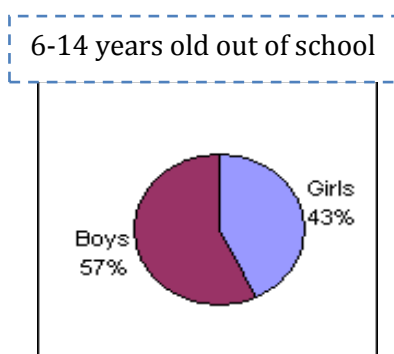
Health services and Accessibility						
Panchayat and village level	Panchayat	Thikariya	Khora	Bhandariya	Kotharia	Hlakara Khurd
Medicine shop (Pharmacist)	1	0	1	0	0	0
No. of Trained Daai	5	1	1	1	1	1
Basic Facility available		Up Kendra	Up Kendra	Up Kendra	ANM	Up Kendra
Emergency service distance+			8		7	10
ANM visits in a month			1	1	1	1

Child Birth & Health	Panchayat	Thikariya	Khora	Bhandariya	Kotharia	Hlakara
Child birth at center	5	0	0	2	2	1
Child birth (dai)	5	0	2	1	1	1
Child birth conventionally	0	0	0	0	0	0
Malnutrition	12	2	2	5	1	2

Child death	1	0	1	0	0	0
During pregnancy, child deaths	0	0	0	0	0	0

Aanganwadi/ICDS/IEC	Panchayat	Thikariya	Khora	Bhandariya	Kotharia	Hlakara Khurd
0-5 year old children enrolled	307	60	68	43	86	50
Pregnant women enrolled	33	5	5	10	9	4
Education level of karyakarta		std. 6	std. 5	std. 5	std. 2	std. 2
Space available at center		20	30	20	40	0
Center open daily?		Daily	Daily	Daily	Daily	Not daily
Nutrition food to child		Yes	80 Gram	80 Gram	Yes	Yes
Care to Pregnant woman		attended	attended	attended	attended	attended
Govt. Primary(std.I-V) /mid. Schools(std I-VIII)	Panchayat	Thikariya	Khora	Bhandariya	Kotharia	Hlakara Khurd
School		Mid. Sch.	Pri. Sch.			Pri. Sch.
Attendance/Enrollment	248/341	124/176	37/46	33/41	13/40	41/38
Child-teacher ratio(On Enrollment)	56.8	88	46	41	40	38
No. of teachers available	6	2	1	1	1	1
No. of rooms	10	3	2	2	2	1
School timing followed		yes	yes	yes	yes	yes
Text book to children		Yes	Yes	Yes	Yes	Yes
Learning tools in schools - in use ^^		4/4	1/1	2/2	2/2	2/1
School building *		6	6	5	6	4
Drinking water in use		in use	unavailable	available	unavailable	in use
Toilet facility for girls in use		not in use	not in use	not in use	unavailable	In use
Mid day meal given		00-Jan	yes	yes	yes	yes
School management committee		training given	training given	training given	training given	training given

		Enrollment	% Attendance
ICDS/age 3-5.	Girls	65	
	Boys	58	
std. 1-2.	Girls	79	75.9
	Boys	75	77.3
std. 3-5	Girls	60	66.7
	Boys	62	69.4
std. 6-8	Girls	24	75.0
	Boys	41	70.7



Out of school/Irregular children (number)		
Panchayat total	Girls	Boys
3-5 year	0	0
6-11 year	1	3
11-14 year old	5	5
TOTAL	6	8

Attendance in test & pass children - No. of children (panchayat total)										
	ICDS children graduated	Std 1-II		Std III-V		Std VI -VIII		Out of school children		
		Girls	Boys	Girls	Girls	Boys		Boys	Girls	
Attendance		73	89	47	71	38	37	6	8	
Pass	20	55	62	41	43	16	27			

Annex 6 Village Micro Plan structure

FORMAT FOR THE MICRO-LEVEL VILLAGE PLANNING, BAJNA												
SL NO	SECTOR	SUCCESS INDICATOR	PRESENT STATUS (Mention both quantitative and qualitative form)	ACTION PLAN FOR NEXT SIX MONTHS						ROLE OF EKTA SAMUHA	ROLE OF NAANDI	ROLE OF GOVT LINE DEPT.
				Activities	1	2	3	4	5			
1	HEALTH	Percentage of Pregnant Women go for Regular ANC .										
		Percentage of Pregnant Regular consumption of IFA tablets										
		Immunization of pregnant women on time.										
		Registration of pregnant women in AWW										
		Institutional Delivery										
		Percentage of Practice of breast feeding										
		Infant mortality rate (%)										
		Maternal mortality rate (%)										
		Monthly measurement of height and weight pregnant women and Children.										
		Availability of Fixed Day Service										
		Regular Mangal Divas										
		Percentage of Children completes full Immunization Dozes.										
2	ICDS	Regular running of AWC (mention no of days in a month)										
		Availability of Supplementary Nutrition to children. (mention no of days in a month)										
		Percentage of Malnourished children										
		Attendance of children in AWC										
		Percentage of Children availing Pre School Education										
3	EDUCATION	Percentage Children enrolled in school(Class 1-5)										
		Percentage of Children out of school(Class 1-5)										
		Attendance of children in school (Class 1-5)										
		No. of teachers present in school.										
		Attendance of teachers in school.										
		Regular meeting of PTA .										
		Initiative of PTA to improve Education standard..										
		Functional Bal Panchayat										

		Increase in learning level of Academically Poor Children in MKK.																
4	THE NIN G OF EKTA	Regular Meeting of EKTA SAMUHA.																
		Major decisions taken to access facilities for well being of women and children																
5	ANY OTHER S	Percentage of families Migrate.																
		Percentage of Families getting benefits under Rojgar Guarantee program.																

Annex 7: Monitoring and Evaluation Plan of Bachpan Plans: Naandi Foundation

SNO.	1	2	3	4
OBJECTIVE	To develop integrated village level action plans around the needs of the child.	To create awareness on child development amongst community and service providers	To strengthen linkages between the different service providers	To build capacity and strengthen the Ekta Samooh
OUTCOME	Completion village level plan in 221 villages, integration of village level plan with the Panchayat Plan	Increased awareness among the community members and service providers towards integrated child development	Improved service delivery and government infrastructure through convergence of community with service providers in the project area	Ekta Samooh started monitor effective implementation of the schemes related to integrated child development. Integration of the village level integrated child development plan with the Panchayat Plan.
INDICATORS	No. of village plans developed	Community participation in ES meeting, change brought about in the quantitative data collected from the villages, reaching the target as set by the previous half yearly village level micro plan	No of FDS started with the active participation of ES and the service providers. No of PTA collaborating working in improving enrolment, regularise the children.	No of ES started regular monitoring of the implementation of the child development schemes. No of villages achieved target set in the village level integrated child development plan. No of village level integrated child development plan incorporated in the Panchayat level plan.
TARGET	221 villages	80% community participation improvement in quantitative data in all 3 sectors by 20%	80% villages	80% in 60% villages

INFORMATION SOURCE	Ekta Samooh	Ekta Samooh village registers, statistical record, Jan Mitra report, Observation report, visitor's feedback, ERU report	Ekta Samooh village registers, statistical record, Jan Mitra report, Observation report, visitor's feedback, ERU report, feed back from the block and district administrations.	Ekta Samooh village registers, statistical record, Jan Mitra report, Observation report, visitor's feedback, ERU report, feed back from the block and district administrations.
DISAGGREGATION	Set indicators in the area of health, education and ICDS	Attendance (men and women), decisions made, follow up, contribution in implementation	Dept wise data, achievements in the set indicators of the project	Set indicators in the area of health, education and ICDS
FREQUENCY	Half yearly	Monthly	Monthly, Quarterly	Monthly
PERSON RESPONSIBLE	Members of the Ekta Samooh and Jan Mitra	Jan Mitra	Jan Mitra and Program Associates.	Jan Mitra
TEMPLATE	numerical (data collection) and descriptive (individual interview, group discussion and non participant observation)	numerical (data collection) and descriptive (individual interview, group discussion and non participant observation)	numerical (data collection) and descriptive (individual interview, group discussion and non participant observation)	numerical (data collection) and descriptive (individual interview, group discussion and non participant observation)
STATISTICAL TOOLS	micro level planning format, mean, mode, percentage	statistical format, progress report format, concept building, mean, percentage	statistical format, progress report format, concept building, mean, percentage	statistical format, progress report format, concept building, mean, percentage
NATURE OF ANALYSIS	Need assessment in accordance to different sectors	Nature of community participation on the basis of indicators, improvement brought about in the three sectors of child development in coordination with the community	Areas of decisions taken, output, follow-up and achievement recorded in the area of integrated child development	Measurement of decisions taken by the ES, achievement against same, coordination between the ES and the different line departments
PRESENTATION MODE	pie chart, bar diagrams, graphical representations, tables	pie chart, bar diagrams, graphical representations, tables	pie chart, bar diagrams, graphical representations, tables	pie chart, bar diagrams, graphical representations, tables
USE OF INFORMATION	To utilize the document for the development of the action plan at the village level. To analyse the current status of the ES, to monitor the implementation process, training of ES members	To bring about an improvement in the desired area, to develop the action plan for the ES and the Jan Mitra	To utilize the document for developing child development approach and incorporate the same in the Panchayat level Plan. To make the ES self-sustainable and provide the necessary training where ever required.	To utilize the document for developing child development approach and incorporate the same in the Panchayat level Plan. To take ahead the coordination at the district level to plan for further expansion of the project.