FEASIBILITY STUDY FOR GOVERNMENT LED SCALING OF

AN INTEGRATED COMMUNITY-BASED CHILD CARE CENTER AND SWIMSAFE PROJECT

FOR THE PROTECTION OF CHILDREN

Submitted to

Bangladesh Shishu Academy

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Abbreviations

BEN	Bangladesh ECD Network
BISR	Bangladesh Institute of Social Research
BSA	Bangladesh Shishu Academy
CBO	Community Based Organizations
CCC	Child Care Centre
CIPRB	Centre for Injury Prevention and Research, Bangladesh
CSO	Civil Society Organization
DAM	Dhaka Ahsania Mission
DGHS	Directorate General of Health Services
DPP (1)	Drowning Prevention Partnership
DPP (2)	Development Project Proforma
DSA	Districts Sports Association
ECCD	Early Childhood Care and Development
ECD	Early Childhood Development
ELCDP	Early Learning for Child Development Project
ELDS	Early Learning & Development Standards
FGD	Focus Group Discussion
GoB	Government of Bangladesh
GPS	Government Primary Schools
HSC	Higher Secondary Certificate
ICDDRB	International Centre for Diarrheal Disease Research, Bangladesh
IEC	Information, Education and Communication
KII	Key Informant Interview
LGI	Local Government Institute
MDG	Millennium Development Goals
MoE	Ministry of Education
MoHFW	Ministry of Health and Family welfare
MoPME	Ministry of Primary and Mass Education
MoWCA	Ministry of Women and Children Affairs
MoYS	Ministry of Youth and Sports
NGO	Non-Government Organization
NGPS	Non-Government Primary Schools
NRPS	None Registered Primary School
RNLI	Royal National Lifeboat Institute
RPS	Registered Primary School
SBK	Shishu Bikash Kendro
SDG	Sustainable Development Goals
SoLiD	Saving of Lives from Drowning
UHFPO	Upazila Health and Family Planning Officer
UIPC	Union Injury Prevention Committee
UNICEF	United Nations International Children's Emergency Fund
UNO	Upazila Nirbahi Officer
UP	Union Parishad
UPEO	Union Parishad Education Officer
VIPC	Village Injury PreventionCommittee
WHO	World Health Organization

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1. Executive Summary

THE CONTEXT FOR THIS STUDY

Bangladesh has made remarkable progress in achieving several MDG targets mostly reducing poverty, maternal mortality and increasing enrollment rate in primary schools, maintaining gender parity at secondary education. Bangladesh also performed better than its neighboring countries in case of infant mortality, its under-five mortality rate per 1000 live births is also lower than other countries in South Asia. Despite impressive gains there remain significant challenges for the safety, health, nutritional and early childhood care and development of children. Notably, mortality rate of children ages 1-4 remains a challenge with drowning being the cause of 43% of deaths of children aged 1-4 years, higher than the death rates from maternal mortality and malnutrition. It is also a major cause of death among children 1-9 years. At least 12,000 child deaths per year are caused by drowning, and 68% of drowning has been found to take place between 9 am to 1 pm, with most incidents occurring in ponds (66%) and ditches (16%) near households.

A Bloomberg Philanthropies funded research supervised by Johns Hopkins University on safety measures for children under 5 in Bangladesh found community-based child care centres to be the most effective prevention measure for drowning of children. The research conducted by local partners (CIPRB and ICDDR,B) in 5 sub-districts of Bangladesh reported that children who participated in the crèche program were 80% less likely to drown. The intervention has also been argued to be cost-effective and has the potential to deliver diverse early childhood care and development (ECCD) benefits. In addition, a UK based agency called Royal National Lifeboat Institute (RNLI) obtained promising findings from their experimentation with prevention strategies for children aged 6-10 years in Barisal division. These 'SwimSafe' activities focused on building safe swimming skills of children and training community volunteers for rescue and first response in the event of drowning.

Recognizing the importance of multi-sectoral action to prevent drowning among young children, and the potential synergies with early child development services, in 2017 Bloomberg philanthropies funded Synergos, a US based agency to facilitate an alliance of cross-sectoral action to prevent drowning. Synergos worked closely with the existing Bangladesh ECD network (BEN) to form the Drowning Prevention Partnership (DPP). In 2018-19, the partnership undertook a significant study (included in annex 3), mapping ECD and other centre-based child care initiatives, the organizations involved in implementing/ delivering these services, and analysis of the sustainability of their models[1]. The study identified two forms of child care interventions relevant for children under 5 (Drowning prevention crechés and ECD learning centres), and mapped agencies such as BRAC, Dhaka Ahsania Mission, Plan International (see table in pg. 18 for more details) delivering these services in various locations in Bangladesh[2]. The analysis surfaced promising findings on paths to scalability and sustainability of a community-based child care centre intervention. It also demonstrated the importance of focused work to guide and enhance sustainability of child care centres, engaging a wide range of stakeholders at every level.

As part of this effort, Synergos together with, CIPRB and BEN has been in close dialogue with the Ministry of Women and Children's Affairs (MoWCA), which has expressed willingness to scale up proven drowning prevention solutions, specifically child care centres and SwimSafe interventions, across all 64 districts. The proposed scaling project has already been included in MoWCA's priority list (shobuj pata) in the Annual

[1] Ahsan, M. T., Thompson, P. M., Patwary, R. I., Kabir, M. E., Yasmin, S. (2019). Mapping of ECD approaches and sustainability analysis of community-based child care centres. Synergos-BEN 2019

[2] Page 3 of sustainability report includes a table and last page includes a map of the orgaizations currently implementing these services and the districts they serve.

Development Plan under the category of an unapproved donor assisted project for the current financial year to be managed by Bangladesh Shishu Academy (BSA).

Prior to the preparation of the Development Project Proforma (DPP), the Planning Commission requires any project likely to exceed the budget limit of BDT 250,000,000, to undergo a feasibility analysis to assess the technical and social feasibility, and financial viability of the project, along with an approximate estimation of its operational and management costs. According to this guidance, Synergos and BEN commissioned a feasibility study for the scaling of a project dedicated to Integrated Community based Child Care Centre and SwimSafe Facilities for Protection of Children. This document is the report of this feasibility study.

DESIGN OF THE STUDY

Seven objectives were developed for the feasibility study exploring: i) The potential for nation-wide scaling of a community-based integrated child care centre model developed to prevent drowning of children under five, and a swimming training and rescue model (SwimSafe) to protect children between 6-10 years of age; ii) Modalities for integration other development objectives and services; iii) Cost and financial considerations for a scalable sustainable program; iv) Coordination and collaboration mechanisms for this multi-sectoral program; v) Capacity strengthening needs; vi) Potential challenges and risks for government-led scaling of drowning prevention efforts; and vii) Broad strokes of a schedule for the first phase of the DPP.

The study used questionnaire surveys to harvest quantitative data variables in selected intervention and non-intervention sites, to explore perceptions of existing and potential drowning prevention and ECD interventions. Intervention sites refer to sites where some iteration of child care centres (ECD learning centres, or drowning prevention crechés) or SwimSafe activities are currently being implemented. Non-intervention sites refer to sites where these activities are not present. Additionally, a Literature Review, Field Observations, 18 Focus Group Discussions, 36 Key Informant Interviews and 9 Consultations with Experts were conducted to qualitatively assess community perceptions, prospects for integration of additional services, and the potential for nation-wide scaling.

The Feasibility Study built upon the findings of the ECD Mapping and Sustainability Analysis of Child Care Centres study (March 2019) that had been convened by DPP alliance, identifying the different types of child care interventions being implemented, the agencies implementing/ delivering these services, and the sustainability potential of their models.

FINDINGS

Following are the findings emerging from the feasibility study, organized by the seven study objectives.

Potential for nation-wide scaling of a community-based integrated child care centre model developed for drowning prevention for children between 1-5 and SwimSafe for 6-10 years of age

The main findings here focus on willingness and interest of parents and other community members and leaders to participate in CCC and SwimSafe services, and the nature of their engagement in these initiatives. From this, there emerge two potentially scalable model for the provision of sustainable integrated centre-based child care services for children under 5 and swimming training and rescue targeting children aged 6 to 10 years respectively.

Community and community leader interest, willingness to participate | Study findings indicate that community members strongly support the need for such facilities in their areas, with 100% of respondents in intervention and non-intervention areas responding positively about the need for such services. In intervention areas, 87% of households are already sending their children to CCCs. In non-intervention areas, 79.1% parents are willing to send their children to child care centres, and the remaining are not

sure. Community leaders are also in favor of such services in their areas, expressing an interest to participate.

Key informant interviews revealed that people are not as interested in the SwimSafe intervention, as it is generally believed that children naturally learn swimming on their own without lessons or supervision. However, in Barisal where drowning mortality is three times the national average, once the SwimSafe intervention began, people began to realize the importance of swimming instruction, and rescue capability. Families that participate in this initiative believe that such a program should be scaled up across the country.

In intervention areas, parents of children and other community members (members of parents' groups, village and union injury prevention committees, and volunteers) were actively involved in activities related to these initiatives. For those who did not participate, the main reason was lack of time, or long distance to meeting venues.

Overall, the study surfaced strong demand from communities, and high interest in child care centres and SwimSafe interventions. Community members, leaders, and local government officials expressed a willingness to participate in establishing and supporting such interventions.

Adaptive scalable models | The ECD Mapping and Sustainability Study had surfaced two main kinds of centre-based child care interventions being implemented by a range of NGOs for children under five: i) rural day care centres covering children aged 1 to 5 which operate from 9am to 1 pm, and ii) ECD centres for children aged 3 to 5 that generally operate for two and a half hours a day. In addition, the SwimSafe intervention for drowning prevention has been developed for children aged 6 to 10 years. Based on these existing intervention designs and perceptions and analysis of their scalability and sustainability, two adaptive models have emerged for government-led scaling of services that protect children from childhood injuries and keep them developmentally on track. The key features of these two models are summarized in the boxes below and detailed in the report:

Community based integrated CCC

- Integrated community-based CCC at the heart of the model, with care-giver and assistant, serving ~25 children < 5, including drowning prevention and ECD related services
- Management committee with participation of parents, UP ward rep, other local stakeholders, with clear set of responsibilities, including resource mobilization to cover a portion of their operational costs
- CCCs legitimized through certification from ECD/childcare board (developed in collaboration with MoWCA's ELCDP project). Formalized Links to ECD committees, Union Parishads and standing committees, and other local services (referrals)
- CCC as hub to attract other service providers. Multi-sector collaboration established at all levels
- Flexibility for local innovation and adaptation
- BSA contracts NGOs to operationalize and supervise in project mode. Supervision later embedded as sustainable function, convened by BSA
- Dedicated attention to key sustainability factors (including resource mobilization) and sustainability monitoring

SwimSafe

- At the heart of the model is a cohort of accredited swimming instructors for children aged 6-10 attached to government primary schools
- Instructors are women and men from local community. They are paid for every child that graduates swimming (targeting 100% of class 2 children)
- Accreditation agency for swimming instructors set up in collaboration with Ministry of Youth and Sports
- Central pool of instructor trainers and inspectors, supervisors
- Close collaboration with MoPME's Primary education officers to identify and engage participating schools
- BSA contracts NGOs to operationalize and house supervision infrastructure. Supervision later embedded as a

• Quality and standards ensured through licensing body for CCC and caregivers – aligned with ELDS standards and operationalization of day care act • Begin with 800 or 1,000 centres across 16 carefully selected districts, aligned to ECDLP and APC areas, and serving areas with highest need • Intensify and spread to new areas in future phases, with support of participating communities	sustainable function, convened by BSA • Begin in same geography as CCC in phase 1. Intensify and spread to new areas through education infrastructure in later phases

NGOs will play an important role in establishing the program and enabling local innovation for sustainability. The experience of organizations already implementing these interventions will be invaluable in setting up and operationalizing the government program and supporting the development of relevant capacities. The role of NGOs is expected to evolve in later phases, as the program matures.

Establishing a project with this kind of integrated and sustainable approach that is dependent on linkages will necessarily need to begin at low scale and grow and evolve over time. In phase 1, the project will begin at limited scale in 16 districts. The selection of these districts will be based on the child deprivation index[3] which UNICEF projects use to guide their decisions on geographic targeting, areas prone to drowning[4], and alignment with the MoWCA's ELCDP project. This will allow for strong collaboration and early investment in high need areas. With the support of phase 1 stakeholders and communities, in future phases, the project will spread within these districts, as well as to new districts. There may be lessons on integration/ convergence to draw from the Government of India's Integrated Child Development program that uses the anganwadi centre (child care centres) to drive convergence between sectors and across different programs.

The proposed adaptive model will help the Government of Bangladesh fulfil multiple SDG and 7th Five Year Plan targets (see Annex 1) major among which are targets related to health, education, child nutrition and female empowerment (3.2, 4.2, 2.2 and 5.4). The establishment of this project based on these models also signals strategic links to several existing policies or policy linked efforts, such as MoWCA's Comprehensive ECCD Policy 2013, Early Learning Development Standards, and draft Day Care Act; MoHFW's Drowning Prevention Strategy that is awaiting approval; and MoPME's National Education Policy 2010. In addition, this project will offer the scope to further the operationalization of aspects of these policies (see section 2.3 for more details).

Modalities for integration of other development objectives and services

The findings of this study show clear potential and strong willingness of stakeholders to **integrate drowning prevention and ECD services as the core offering** in child care centres. In practice this means ensuring coverage for children under 5, operating CCCs for a 4-hour period, and ensuring attention to ELDS standards and drowning prevention protocols. Key informant interviews reveal that parents are also in favor of integrating additional services, such as immunization and nutrition, and educating communities to be more proactive on child safety and care issues.

Further integration may be achieved through a **referral system** to other services that may be provided or certified by the government or other social service providers. They may cover early detection and support for a range of challenges that may be diagnosed in children, for example for sight, hearing, etc. Integration may also be achieved through **field level coordination** and linkages with ECD committees, local

[3] The Child Deprivation index was developed to aid the selection of upazilas for the ELCDP project

[4] Based on the ratio of population to water surface area

government institutions, and infrastructure for other government services at various levels, such as immunization, nutrition, disaster preparedness, etc. In this way the CCCs may serve as a hub over time, attracting and making referrals to additional services, offering a more holistic integrated service to children and their families.

At the start, SwimSafe will clearly focus on building swimming and rescue skills. However, once this component is aligned and embedded with the government primary school infrastructure, it may be possible to integrate additional messaging for children, such as related to hazards, risks and disaster preparedness. Over time, in addition to swimming, greater attention may be paid to leadership skills, team building, etc. building skills of instructors to embed these features in their training.

Cost and financial considerations for a scalable sustainable program

The cost analysis for this study was drawn from the findings of the ECD mapping and sustainability analysis study. The analysis of costs was challenging due to variations in numbers of children enrolled and in operating hours of existing centres, and difficulties in assessing management and supervision costs. However, from an analysis of a range of well-established centres, the study estimated an average total cost of about Tk 7,000 per child per year (a range of Tk 3,400 to 10,000)[5].

The operating cost structure and cost levels for most of the existing rural centres was quite similar, averaging at just under Tk 14,000 a month with the three main components of costs/ resource needs comprising the care givers' remuneration, the value (rent equivalent) of the premises used for the care centre, and supervision. The study showed that a significant portion of these major costs in existing centres are being covered from local contributions including time and in-kind support, necessitating an external fund (project/ donor) contribution of just over Tk 7,000 a month (or 52% of total resource needs). In the rural cases studied, parents contributed average in cash and kind of Tk 132 per child per month (range 50 – 200 per child per month). While user fees generate only a very modest amount and are not collected in several models, the data indicates the potential for using user fees to cover at least an equivalent of a significant portion of the care-giver's salary amount. This also helps in cultivating greater sense of ownership and stronger connection among the parents.

The sustainability analysis notes that the initial costs of establishing community or collaboratively run centres are higher than NGO run ones. The centres take longer to establish, and they demand a considerable effort in strengthening capacities and facilitating linkages before centres can graduate from NGO or project support. However, once centres are established and linked to other stakeholders, the return on investment and potential for integration can be significant, with the centre serving as a hub for integrated services such as immunization for children, or referrals to other existing services for children and their families. CCCs that strongly engage communities are more cost effective and sustainable, as they have greater legitimacy, and are able to leverage local resources and contributions, thus reducing over time the project funds or government subsidy that is needed. They can also be instrumental in supporting the project to spread in new communities.

Findings from the key informant interviews and focus group discussions conducted by the feasibility study team support these findings, demonstrating willingness of communities to contribute in kind, especially if services are improved (62.6% in intervention areas, and 56.8% in non-intervention areas). The most frequent reasons cited by those not willing to pay are their inherent belief that these services should be free. The study found that the value of premises for the centre is a significant cost component, which in many cases is being met by in-kind contributions, eg. operating at the caregiver's home, or in government

[5] This calculation was based on identifying a set of cost heads to estimate monthly operating costs and imputing values for various services and cost heads. Two models were excluded from this calculation - the parakendro approach with multi-purpose government run centres, and an 8-hour urban model catering to mothers working in garment factors.

owned buildings/ infrastructure that may be under-utilized, or in BSA's infrastructure. For SwimSafe, those parents who are aware of the program and whose children have participated, are willing to contribute to it, however, would rather do so in kind, than cash. Key informants from local government institutions also indicated willingness to support the establishment of centres on Khas Land and using the Khas/ Union Parishad ponds for swimming classes.

Based on the findings from the sustainability and feasibility studies, financial viability and sustainability for a nationwide program will be possible in the long-term through an adaptive model that engages the participation and contributions of diverse stakeholders, and that interfaces with a wide range of social services and evolves toward greater integration over time. Nationwide coverage for a cost-effective and sustainable model can be achieved but will need to be built up gradually through consistent investment over multiple phases and unflinching attention to sustainability factors and engagement of stakeholders. The emerging model for CCCs would expect centres to work toward coverage of at least 50% of their operational costs through local resource mobilization.

Coordination and collaboration mechanisms for this multi-sectoral program

There are coordination needs both short-term for project set-up and implementation, and long-term for integrated community-based child care and for SwimSafe. For sustainability it is preferable to establish, support and make use of long-term coordination forums and mechanisms wherever possible for the project, while recognizing that there is also additional project implementation related requirements.
The two components of the project (CCC and SwimSafe) have different coordination and linkage requirements. For CCC, the project should emphasize strong coordination with the recently established ECD committees at district, upazila and union levels, as well as the public health infrastructure. SwimSafe will be heavily dependent on buy-in and support from the Ministry of Primary and Mass Education and their infrastructure of Primary education officers at district and upazila levels.

Both components will benefit from links to local government infrastructure – union parishads and union level standing committees, the government resource pool, as well as other government services. It will also be important for the project to collaborate and align closely with existing MoWCA projects being implemented by BSA – the Early Learning for Child Development Project (in partnership with UNICEF) and the Accelerating Protection for Children project.

Outside of government sponsored and formalized coordination, there will be benefits from less formal practitioner coordination and lesson sharing, for example, through learning forums for implementing NGOs, union level networking meetings for caregivers or care centre management committee chairs. For SwimSafe, these may be upazila level sharing events at the start and end of swimming instruction seasons for swimming instructors and headmaster/ headmistresses.

Stakeholder roles and capacity strengthening needs

Skills development and capacity strengthening for caregivers and SwimSafe instructors has emerged as an obvious major aspect of the planned project, which will require a set of master trainers, including government resource pool trainers, who can train trainers, and also ensure a system in place for refresher training. The master trainers would provide both formal skills building and offer more informal mentoring and regular advice for care givers and community swimming instructors.

In addition, two main areas of capacity strengthening are needed for the collaborative adaptive models that are being recommended – for local communities, especially the care centre management committees; and for government agencies and related proposed certification bodies.

> *Local communities | Transparent decision making; day to day oversight of centres; financial management and basic accounting; planning and resource mobilization; communication; problem solving; understanding public services and entitlements for infants and their families*

Government | Coordinating and overseeing care centres; monitoring and assessing care givers and care centres; capacities to liaise with and mobilize support from other related bodies (government services, NGOs, funding sources -- including private sector)

The above skills and capacities may be delivered by implementing NGOs working in collaboration with government resource pool trainers at the start, with a priority of supporting these stakeholders on a pathway to sustainability. This means that NGO implementing staff and government trainers will themselves need to be capable in these skills and clear on the paths to sustainability.

Certification bodies for care centres and SwimSafe will require specialist skill development, orientation, mentoring, and spend significant time with centre management committees, supporting the regular monitoring of sustainability factors and attention to quality.

Potential challenges for government-led scaling of drowning prevention efforts

The following are among the major challenges and risks that have surfaced through this feasibility study.

Operational challenges | Key informant interviews surface several operational challenges. The main initial challenge for the CCC component is likely to be hiring, strengthening capacities, and retaining care givers (or re-hiring and training someone new if a caregiver leaves). Several examples were cited where centres stopped functioning when the caregiver left. Careful attention will need to be paid to pegging the care giver wage at an appropriate and fair level. Community members participating in the study also reflected on gaps in ensuring ongoing availability of resources, capacities, and equipment at the centres. Management committees will need support early on to address or avert these potential challenges. The main operational challenge for SwimSafe is mobilizing demand, due to lack of awareness of drowning risk, and the widespread perception that children naturally learn to swim without lessons. The project will need to include some investment in raising awareness of drowning risk and the efficacy of proven solutions.

Achieving nation-wide scale | While there is significant demand for the services of this project, there is not yet a prepared infrastructure, personnel or resources to deliver these services at scale. In addition, the pathways to sustainability are locally specific, and can best be achieved by engaging multiple stakeholders around an adaptive community-based model, linking into existing infrastructure, institutions and resources. Achieving nationwide scale is therefore not possible through a short 3-5 year project. In order to achieve nationwide coverage, the project will need to plan for consistent investment in multiple phases over a 10-15-year period.

Achieving sustainability | Achieving sustainability of results and sustainability of services will both be challenging, but achievable through a dedicated focus and long-term vision on sustainability. Sustainability of results can be promoted through attention to quality, led by the establishment of certification bodies and mechanisms for supervision and learning. Sustainability of services will require clarity and attention on key sustainability factors and monitoring and supporting their use, especially supporting management committees of CCCs to work toward mobilizing locally at least 50% of the operational resources they require.

Broad strokes of a schedule for the first phase of the DPP

The first phase of the project is expected to run for three years, but it will be necessary to be followed by additional phases, to achieve greater scale, and to allow the program to mature and become institutionalized (see section 4.6 for breakdown of phases).

RECOMMENDATIONS |

Based on the findings from the sustainability analysis and this feasibility study, the following seven recommendations emerge for the first phase building a scaled program for Community based Child Care Centre and SwimSafe Facilities for Protection of Children.

1. **Capitalizing on demand**

   Capitalize on the high demand of parents for child care and swimming training for children, to engage their support to a government program designed to reach nationwide coverage over time.

2. **Adaptive models**

   Build on existing proven approaches, to establish and scale adaptive models for i) integrated community-based child care centres for children under 5 and ii) primary school-based swimming training and rescue targeting children aged 6-10 years.

3. **Coordination mechanisms**

   Establish or invest in mechanisms that enable multi-sectoral coordination with a focus on protecting children and keeping them developmentally on track.

4. **Strategic approach to nation-wide scaling**

   Strategically pace the scaling of interventions through multiple phases, building on existing child care and swimming training efforts in priority areas, and mobilizing and empowering key stakeholders.

5. **Cost effectiveness**

   Enable cost effective operations through an adaptive approach that builds on and effectively coordinates with existing programming, structures, institutions, and resources.

6. **Changing behaviors**

   Invest in behavior change communication and engagement with parents and communities to harness their participation in implementing child protection and integrated ECD and SwimSafe services.

7. **Monitoring and Accountability**

   From the very start build a system for monitoring, learning and accountability that clarifies and promotes attention to quality standards, key elements of sustainability and participant feedback and accountability.

2. Setting the Scene

Bangladesh was one of the first (1990) to ratify the Convention of the Rights of Children and make it the fundamental principle for all subsequent programs on children. However, despite major progress in MDG targets including advances in reducing poverty and maternal mortality, improving primary school enrollment rates, in recent decades, there still remains significant challenges for the safety, health,

nutritional and educational development of children. Notably the mortality rate of children 1-4 remains a challenge with drowning dominating the cause of death for children 1-4 years.

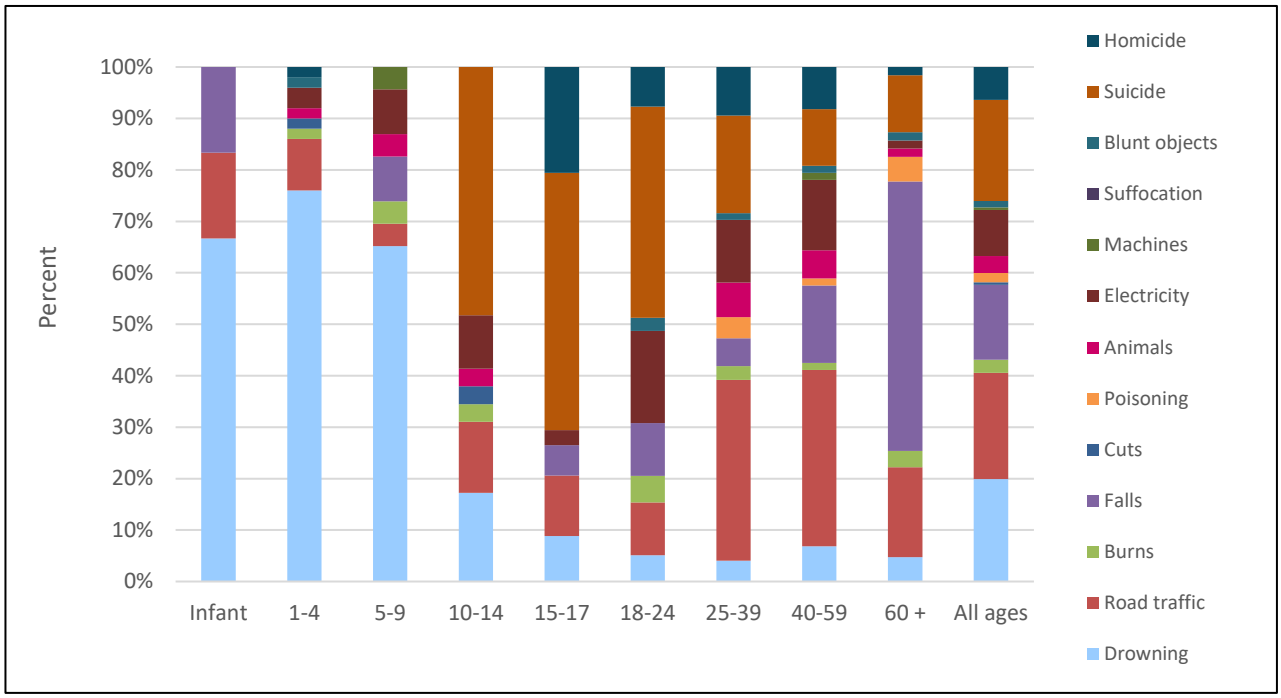


Figure 1Proportion of Injury Morbidity by Age Group-Bangladesh Health and Injury Survey (BHIS 2016)

Threats to Early Childhood Dev Bangladesh country statistics
(Nurturing-care.org)

1.	Maternal Mortality	176/100,000
2.	Low birthweight	22%
3.	Child poverty	22%
4.	Under five stunting	37%
5.	Inadequate supervision	78%
6.	Preterm birth	14%
7.	Young mothers	36%
8.	Harsh punishment	82%

Figure 2 Threats to early childhood development

Drowning is the cause of 43% of deaths of children aged 1-4 years (World Health Organization, 2014), higher than the death rates from maternal mortality and malnutrition. It is also a major cause of death among children 1-9 years. It is terrifying that at least 12,000 child deaths per year are caused by drowning. Based on the Bangladesh Health and Injury Survey 2016, a local research agency called CIPRB[6] (2018) estimated that the drowning mortality rate of 11.7 per 100,000 persons per year corresponds to a total of 19,247 deaths per year, two-thirds of whom are children. Rahman et al. (2017) reported that 68% of drowning takes place between 09h00 and 13h00, and most incidents happen in ponds (66%) and ditches (16%) near households.

It is noteworthy that rates of drowning are higher in rural populations, most likely due to the relatively high number of water sources in rural areas compared to urban landscape. Another key factor is that both parents or elders in poorer households are often busy with chores or work in distant places leaving children unsupervised. Also, Bangladesh country profile of nurturing care framework[7] identified that 78% of children under five are inadequately supervised among other early childhood survival and developmental challenges.

[6] Centre for Injury Prevention Research, Bangladesh
[7] Developed by the World Bank, UNICEF and WHO in 2018

It is noteworthy that Bangladesh Government's 7th Five-year Plan in accordance with the SDG agenda targets to tackle many of these threats that are significant for early childhood development.

WHO Global Report in Drowning (2014) sets out some strategies based on available evidence that might help prevent drowning among small children. Especially, keeping children under five in safe places (for example, a crèche) away from water with capable child care and teaching school-age children (6-10) basic swimming, water safety and safe rescue skills. Raising public awareness on vulnerability of children is also realized as an important remedial measure.

Table 1 7FYP and SDG agendas

Indicators (rate)	Targets for improvement (relevant for early childhood dev)[8]	
	7FYP	SDG
Maternal Mortality	170 to 105	176 to 70 (3.1.1)
Neonatal Mortality	38 to 20	23.3 to 12 (3.2)
Underweight prevalence	32.6 to 20	42 to internationally agreed target (2.2.1)
Stunting prevalence	36.1 to 25	36 to internationally agreed target (2.2.1)
Under-five Mortality	46 to 37	37.6 to 12 (3.2.1)
Child Immunization	78 to 95	96 to Universal Coverage (3.8)
Harsh Punishment		82.3 to No violent method (16.2.1)
% of 3-5 age children attending center based early learning		Universal Coverage (4.2)
% of children have playthings at home		60.3 to Universal Coverage (4.2)
% of children have story books at home		8.8 to Universal Coverage (4.2)

A Bloomberg Philanthropies funded research staring in 2012 supervised by Johns Hopkins University experimented with safety measures for children under five in Bangladesh and proved Community day cares to be the most effective prevention measure for drowning. The research conducted by local partners (CIPRB and ICDDRB) in 5 sub-districts of Bangladesh reported that children who participated in the crèche program were 80% less likely to drown. The intervention has also been argued to be cost-effective and has the potential to deliver diverse ECCD benefits. On the other hand, a UK based agency called Royal National Lifeboat Institute (RNLI) experimented and produced promising findings on prevention strategies for children aged 6-10 years in Barisal division such as skilling children aged 6-10 years on safe swimming techniques and training community volunteers for rescue and first response in the event of drowning.

The above initiatives have completed the first phase of research and implementation and are currently focused on leveraging Government resources and commitments to scale age specific sustainable prevention solutions across the country to prevent drowning. The Synergos-Drowning Prevention Partnership was assigned by Bloomberg Philanthropies to mobilize political will toward sustainable and scalable drowning prevention solutions. The sustainability analysis necessitated promoting the benefits of drowning prevention in a wider frame highlighting the convergence between drowning prevention and early childhood care and development. Correspondingly, the National Comprehensive Early Childhood Care and Development (ECCD) Policy approved by MoWCA in 2013 broadens the scope of early childhood care and development considering the right of children from inception to eight years in relation to survival, safety, care, growth and development. Therefore, over the last year DPP-Synergos along with drowning prevention partners joined an existing Alliance on ECD (the Bangladesh ECD Network - BEN), and mobilized stakeholders from child health and nutrition and injury prevention fields to come together to form a board partnership base to improve the lives of children.

As a part of this advocacy effort Synergos together with, CIPRB and BEN Alliance was in dialogue with the Ministry of Women and Children's Affairs which has expressed willingness to scale up proven drowning prevention solutions, specifically child-care centres and SwimSafe interventions across all 64 districts in coordination with other Ministries, especially health and education. It is important note that the proposed

[8] Data source: compiled from BDHS, BBS,7thFYP, WHO

scaling project has already been included in the MoWCA priority list (shobuj pata) in the Annual Development Plan under the category of an unapproved donor assisted project for the current financial (2019 -2024) year to be managed by Bangladesh Shishu Academy. Prior to the design of the Development Project Proforma (DPP), the Planning Commission requires any project which is likely to exceed the budget limit of BDT 250,000,000, to undergo a feasibility analysis to assess the technical and social feasibility, and financial viability of the project, along with an approximate estimation of its operational and management costs.

2.1 About the Models

The proposed project (Integrated Community based Child Care Centre and SwimSafe Facilities for Protection of Children) is being designed for government-led scaling of two proven drowning prevention solutions contributing to the achievement of SDG goals 3 and 4, especially targets 3.1 and 4.2:

- Community based integrated child-care centre model for children under 5 years of age.
- SwimSafe interventions for children aged 6 – 10 years (teaching children swimming skills

These solutions also include associated activities related awareness raising about drowning risks and their solutions; collaboration between key stakeholders; and cultivation of shared ownership.

The design for the community based integrated child-care centres and SwimSafe interventions will be adaptive in nature, to promote sustainability of results, and to be able to leverage the efforts of other ministries and sectors, and evolving programs and investments. The model is designed to incentivize collaboration between key stakeholders at local level, creating the basis for shared ownership and shared resourcing, leading to sustainable results and contribution to fulfilling development commitments. If successful, the program will offer a platform for increasing integration over time with other development objectives/ services, such as ECD, maternal and child health, nutrition and growth monitoring, etc. thus increasing the value and returns on this investment over time.

Scaling will be phased, beginning with priority areas that are vulnerable to drowning risk, or underserved by other child-care or SwimSafe initiatives. The modalities, pace, and phasing of scaling efforts are explored through the feasibility study and design of the Development Project Proforma (DPP), with the intent of achieving coverage across all 64 districts.

2.2 Objective of the Current Assignment

DPP-Synergos facilitated Bangladesh Shishu Academy commission a Feasibility Analysis Study for the proposed project. Broadly the study tried to assess the nationwide scalability by government, of community-based integrated child-care centres (for children under 5) and SwimSafe interventions (for children aged 6 – 10 years), tested in select research settings for the protection of children, especially from drowning. Following are some key focuses that guided the investigation and analysis of the current study:

1. Assess the potential and modalities for nation-wide scaling of a community-based integrated child-care centre model developed for drowning prevention for children between 1-5 and SwimSafe for 6-10 years of age and present a scaling pathway.
2. Articulate the business case and explore potential modalities for the integration of other development objectives/ services.
3. Assess the cost for implementation and scaling of integrated drowning prevention solutions, along with relevant cost-benefit analysis and financial evidence supporting the project.

4. Propose coordination and collaboration mechanism at various levels to enable coherent multi-ministerial coordination, policy alignment, local government engagement, and the participation and support multiple sectors.
5. Identify key stakeholders at various levels, their roles in the project, and capacity strengthening needs for government-led scaling of integrated child-care centres and swim safe initiatives by the government.
6. Identify potential challenges and risks for government-led scaling of drowning prevention efforts by the government.
7. Outline in broad strokes the phases of work and "best guess" schedule for the first five-year DPP period.

2.3 Policy Context

The Government of Bangladesh has adopted several policies and strategies that are relevant to the proposed project. Following are some examples of most relevant policies in order of relevance:

Policy/Strategy/Act	Status	Relevance
Comprehensive Early Childhood Care and Development (ECCD) Policy 2013 by MoWCA	Also launches an operational Framework and is working on costed action plan. The ECCD coordination or standing committees activated at district/Upazila/Union levels.	Includes comprehensive program for children from conception to 8 yrs. in relation to survival, safety, care, growth and development. The ECCD committees can perform as a coordinating and monitoring bodies for the project interventions.
Early Learning Development Standards by MoWCA	Developed	Validates age specific learning standards for children.
Day Care Act by MoWCA	Awaiting approval	Will set operational standards and regulations for Day Care centres.
Drowning prevention Strategy by MoHFW	Awaiting approval	A national comprehensive strategy on drowning prevention recognizing the problem and with plans to expedite action and integration on drowning prevention for all ages including child drowning.
National Education Policy 2010 by MoE	Launched	Specifies PPE as one-year education prog. for children 4- 5 before starting class 1. Edu prog for 5+ ongoing and planning for including 4+ children in progress.
Bangladesh Shishu Academy ACT 2018	Approved	Will take programs on children's education, physical, mental development, disaster protection and environment development, disability.

3. Methodology

The study made use of questionnaire surveys to harvest *quantitative* data variables that were analyzed using statistical procedures to explore the impact of existing interventions on drowning prevention.

Additionally, Field Observations, Focus Group Discussions (FGDs), Key Informant Interviews (KIIs) and Consultation of Experts were used to *qualitatively* assess the feasibility of scaling the proposed interventions, the community perception and prospects for integration.

Literature Review |The starting point for the investigation and analysis for this study has been literature review of existing research on drowning prevention and ECD related policy analysis. Primarily, to develop understanding the study reviewed the research and evaluation reports on drowning prevention (both on daycare and SwimSafe) produced by CIPRB and health and Injury statistics by DGHS. It is important to note that the multi-year (from 2012- continuing) implementation research called SoLiD[9] carried out by CIPRB and ICDDRB had been supervised by Johns Hopkins University under Bloomberg Philanthropies finance. Likewise, we also reviewed the monitoring reports of a UK based Roya National Lifeboat Institute to grasp SwimSafe intervention benefits and challenges. Most importantly, the current study builds upon the findings of a recent study conducted collaboratively by DPP-Synergos and BEN on *ECD Mapping and Sustainability Analysis Study of Child Care Centres*[10]. The findings of the mapping study contributed towards the feasibility analysis of the childcare centre component and guided the decision on area selection for field investigation. The Mapping study identified agencies which deliver two major forms of child care interventions in various locations in Bangladesh (see table and location map in annex) with two different purposes. They are rural daycare centres called *Anchals* covering children aged 1-5 which operate from 9:00 a.m-1:00 pm, the

Types of childcare services operated by the main NGOs in Bangladesh

NGO	Day Care (1-5 yrs)	Early Learning Center[1] (3-5 yrs)	Pre-primary (5-6 yrs)	Additional Services	Districts Covered
International NGOs					
Save the Children		✓	✓	Parenting; Nutrition	6
World Vision		✓		Parenting; Training; Advocacy	7
Plan International		✓	✓	Parenting	7
ICDDRB	✓			Parenting	1
National NGOs					
BSA[2]		✓	✓	Parenting	64
BRAC		✓	✓	Parenting	61
CARITAS		✓	✓	-	37
DAM	✓	✓	✓	Parenting	8
ESDO		✓	✓	Parenting	23
RIB		✓		Parenting	9
RDRS Bangladesh		✓	✓	Parenting	4
Phulki[3]	✓			Parenting	6
CIPRB	✓			Parenting; Injury Prevention	5
DDEF	✓	✓	✓	Parenting	1
SUROVI		✓	✓	-	1

Bold – selected for case study

1 – Also known as Shishu Bikash Kendro (SBK)

2 – UNICEF funds several of BSA's projects in many districts

Figure 3 Types of childcare services

[9] Saving of (Children's) Lives from Drowning project

[10] Ahsan, M. T., Thompson, P. M., Patwary, R. I., Kabir, M. E., Yasmin, S. (2019). Mapping of ECD approaches and sustainability analysis of community-based child care centres. Synergos-BEN 2019

peak hours during which children are most prone to drowning with the primary objective of drowning prevention.

Another arrangement is ECD centres for children aged 3-5 years generally for two and a half hours primarily for child cognitive and educational development which inadvertently also keeps them supervised. Urban model of day care managed by Phulki runs for 8 hours.

However, *SwimSafe* is a standalone swimming teaching initiative for children aged 6-10 which is mostly operational in CIPRB run Raiganj area and BHASA project in Barisal division.

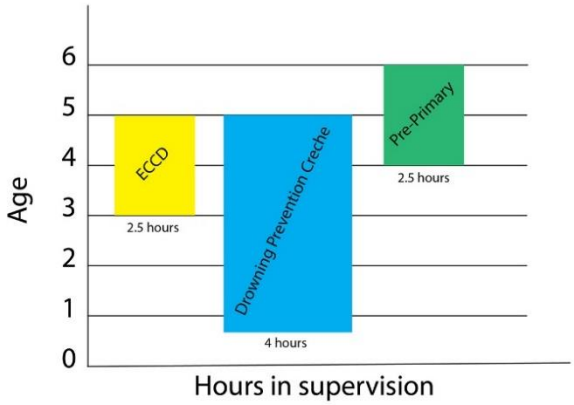


Figure 4 Operation hours to age

Figure 5 Locations of study areas

Justification for Area and Sample Selection | Given the above background, the feasibility study was conducted in 9 districts, including Sirajganj, Chandpur, Sylhet, Moulvibazar, Nilphamari, Kurigram Barguna and Dhaka as shown in the map and table below for field investigation for childcare centres and Patuakhali, Barguna and Shirajganj to visit interventions on SwimSafe. Two sub-districts were selected from each district visited where one sub-district was taken as an intervention area (where some form of childcare/ swimming intervention exists) and one sub-district was taken as a *Non-intervention* area (where no childcare/swim intervention exists). Households were then selected randomly from a union in each sub-district for assessment. However, it is noteworthy that due to absence of children (Eid holiday started) in the ECD Mirpur centre, the study team could only conduct investigation in non-intervention area in Keraniganj,Dhaka.

Table 2: Location and agency wise sample size distribution								
No	**District**	**Intervention Area**	**Service Type**	**Agency**	**Res**	**Non-Intervention Area**	**Res**	**Total**
1.	Chandpur	Matlab South	Anchal (4 hr drowning pre.daycare model)	ICDDRB	22	Chandpur Sadar	8	30
2.	Shirajganj	Raiganj	Anchal (4hr) and SwimSafe	CIPRB	22	Tarash	8	30
3.	Dhaka	Mirpur	Urban day care Model (8hrs)	Phulki	0	Keraniganj	8	8
4.	Patuakhali	Kalapara	Anchal & SwimSafe	CIPRB	22	Patuakhali Sadar	8	30
5.	Barguna	Taltoli	Anchal & SwimSafe	CIPRB	22	Patharghata	8	30
6.	Nilphamari	Jaldhaka	ECD SBK Model (2.5 hrs)	Plan Int/DAM	22	Dimla	8	30
7.	Kurigram	Kurigram Sadar	ECD SBK (2.5 hrs)	BSA	22	Rajarhat	8	30
8.	Moulvibazar	Sreemangal	Day Care in Tea Garden 8 hrs	Phulki	17	Moulvibazar Sadar	8	25
9.	Sylhet	Sylhet Sadar	Day Care in Tea Garden (8hrs)	Phulki	22	South Surma	8	30
					171			243

Data Collection | Aside from the various academic journal articles, books, as well as donor and NGO project documents and reports that were reviewed as a source of *secondary data collection*, Survey Questionnaires, FGDs and KIIs were used as the means of *primary data collection* which yielded variables such as costs of operation and integration, social benefits and costs, economic welfare, etc.

Table 3: Type of Key Informants	Number of Interview
UNO/UPEO	5
District Women and children Officer	2
CBO/CSO	2
Local Government Institute Representatives	8
NGO Representative	6
UHFPO/Community Clinic (for UHFO)	4
Social Welfare Office	3
Municipality Mommission	1
Bangladesh Shishu Academy Representative	4
Total	**35**

Following a standard FGD guideline (Please see Annex C), 18 **Focused Group Discussions** were conducted in 18 sub-districts with men and women participants separately to learn about awareness and socio-cultural characteristics of the local people's perceptions about childcare and development, as well as, injury prevention such as drowning. Also, to get better understanding about the potential project activities, scalability, challenges, etc., present study conducted 9 **Expert Consultations** with representative of UNICEF, BEN, MoWCA, BSA, etc.

Plus, in order to obtain detailed information on the scope of initiating integrated childcare and development services, sustainable strategies of implementation, cost estimations and community involvement, 35 **Key Informant Interviews** were conducted as described in the table above.

4. Findings of the study in accordance to objectives

The analysis of findings under objective 1 are mostly done based on field investigation such as household interviews and focus group discussion. Due to time limitation the study could not engage in detailed cost assessment of interventions required under objective 3. However, to its advantage the recently completed ECD Mapping and Sustainability Analysis (included in annex) Study had already conducted cost assessment for implementation and scaling of centre based child care services which the current study will use as reference. For analysis of Objectives 4-7 the study formulated analysis based on KIIs, workshops and literature review.

4.1 Findings under Objective 1 and 2

4.1.1 Surveyed household/respondent characteristics

Types of Households | The study covered three categories of households, namely households with children less than 5 years old, Households with children 6-10 years old and households with children of both age groups in both intervention and non-intervention areas. In Intervention areas, the highest portion of the interviewed samples were from the category of Households with less than 5 years old children (56.7%) followed by Households with children of both age groups (32.2%) and Households with 6-10 years old children (11.1%). It is to be noted that the respondents who have only under 5 children (56.7%) and have both under 5 and 6-10-years age group of children (32.2%), i.e. in total 88.9% (n=171), responded on child care issues, and similarly, respondents who have 6-10 age group children and child with both age group, have responded on SwimSafe related questions. On the other hand, respondents from these three categories in non-intervention areas had under 5 children (56.7%) and have both under 5 and 6-10 years age group of children (32.2%), i.e. in total 88.9%, responded on child care issues, and similarly, respondents who have 6-10 age group children (34.7%) and children with both age group (31.9%), i.e. in total 66.6%, have responded on SwimSafe related questions.

Table 4: Type of sampled households

Type of Sample Households	Intervention area (%)	Non-intervention area (%)
Households with less than 5 years old child	56.7	33.3
Households with 6-10 years old child	11.1	34.7
Households with children of both age groups	32.2	31.9
Total	**100.0**	**100.0**

Sex | Around 85% of the respondents were female and 15% were male in the intervention areas while in non-intervention area the portion of female and male respondents were 75% and 25% respectively. Since, the mothers are more likely to be responsible for child caring and rearing in Bangladesh society and culture, they preferred to be interviewed in most of the areas.

Fig 6: Sex of the respondents

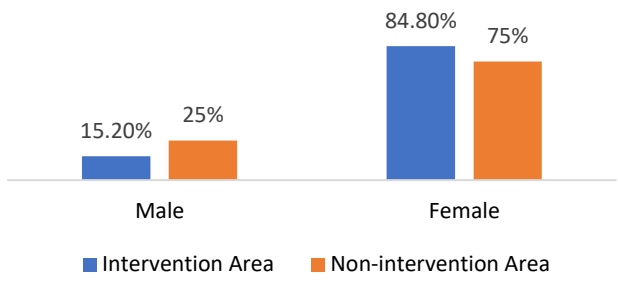


Table 5: Age of respondents		
Age Ranges (years)	**Intervention area (%)**	**Non-intervention area (%)**
20-30	63.2	52.8
31-40	31.0	27.8
41-50	3.5	15.3
50+	2.3	4.2
Total	**100.0**	**100.0**

Age | Majority of the respondents' age ranges were between 20-30 years in both intervention (63%) and non-intervention areas (53%). Around one-third of the respondents belongs to the age bracket of 31-40 years while the lowest portion aged above 50 years in both intervention (2.3%) and non-intervention areas (4.2%).

Occupation | Majority of the respondents in both intervention (75%) and non-intervention (63%) areas were found to be female housewives. Some were in farming, day labor jobs, service, van rickshaw pulling, driving, etc.

Monthly Income | Monthly household income varied among the intervention and non-intervention areas. In intervention area, the highest portion earned monthly BDT. 6000-10000 (35%) followed by BDT. 11000-15000 (26%) while in the non-intervention area the highest portion of the respondent earned above BDT. 20000 (33%) followed by BDT.11000-15000 (28%).

Table 6: Income range of studied households		
Income Range	**Intervention areas (%)**	**Non-intervention areas (%)**
BDT. 1000-5000	12.3	6.9
BDT. 6000-10000	34.5	20.8
BDT. 11000-15000	26.3	27.8
BDT. 16000-20000	11.1	11.1
Above BDT. 20000	15.8	33.3
Total	**100.0**	**100.0**

Intervention 1: ECD – care centres

4.1.2 Willingness and interest of parents across different categories for the service (Anchal, ECD Centres, interest in Non-Intervention area).

Did children attend any day/child-care/pre-primary/other centre? The study covered samples from different areas of Bangladesh where many interventions like ECD/day care centres are being implemented by different organizations/NGOs like CIPRB, ICDDRB, Bangladesh Shishu Academy, Plan International, Dhaka Ahsania Mission, etc. Besides, some areas were also covered where there existed no such childcare/daycare intervention. However, in intervention areas, 87% children attended at least one kind of childcare centre/daycare centre/pre-primary school while in non-intervention areas, only 11% attended the same and 33% mentioned that there was no such childcare facility in their area.

Table 7: Did children attend any day/child-care/pre-primary/other centre					
Intervention area			**Non-intervention area**		
Yes	No	No such scope	Yes	No	No such scope
87.1	**11.1**	**1.8**	**11.1**	**55.6**	**33.3**

Type of care centres | In intervention areas visited, children attended different types of child-care centres and pre-primary school. Among them 40.3% visited Anchal (4 hrs rural day care) followed by 8-hour Community day-care centre in tea estates (29.5%), and ECD or Shishu Bikash Kendra for 2.5 hours (20.1%). Some others attended pre-primary (9.4) and kindergarten (0.7%). Among those who attended any type of care centres in non-intervention areas, majority of them mentioned pre-primary (75%) and rest of them mentioned kindergarten (25%). Among the households who replied positively

(table 6) in the intervention areas 95.3% send at least one child to any type of a centre but about 0.7% households in intervention areas send all of their children to a centre. However, 87.5% expressed their demand to continue child care centre services for their children. in non-intervention areas, among those who said 'Yes' (11.1%)" 87.5% are currently sending only 1 child to a centre, mostly pre-primary or kindergarten.

Community's Willingness to Establish ECD and Swimming Initiatives | Community people in both intervention and non-intervention areas expressed that they would highly appreciate any project on child development and protection that is designed for their areas. In the survey, when community people were asked about the needs of such interventions in their areas, all respondents (100%) in intervention areas responded positively. Qualitative findings also revealed that the community leaders and important figures also appreciated such activities in their areas. They expressed their willingness to take part if required. One community leader in Barishal said:

"Children are our future. So far, we could not ensure adequate services for child development and protection since we couldn't even realize its importance. It is anissue. I, along with other community representatives, am all ready to provide any type of support for such project."

Table 8: Type of care centres

Area of household	Type of centres	Responses (%)
Intervention area	Community day-care centre	29.5
	Anchal Centre	40.3
	Shishu Bikash Kendra	20.1
	Pre-primary	9.4
	Kindergarten	.7
	Total	**100.0**
Non-intervention area	Pre-primary	75
	kindergarten	25
	Total	**100.0**

Table 9: Number of children sent to centres by HHs.

Number of children	Intervention Area (%)	Non-intervention area (%)
1	95.3	87.5
2	4.0	12.5
3	0.7	0
Total	**100.0**	**100**

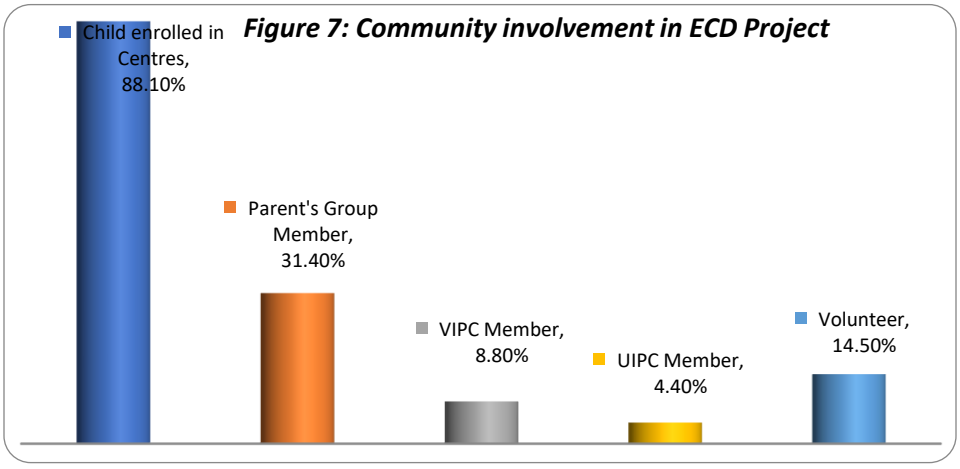


Figure 7: Community involvement in ECD Project

In different ECD and swimming training project areas, community people including the parents were found directly involved in the project activities. Majority of the respondents (88%) were the parents whose children are currently enrolled to the centres while 31.4% respondents were the member of different parents group formed under the project initiatives. Community leader and important figures were also found engaged to the project as part of VIPC (9%) and UIPC (4.4%). Some were also found involved in the project activities as volunteer (14.5%).

Those involved in some committee or bodies formed under the project played key roles by participating in different meetings and activities. Among the respondents, majority (73.7%) regularly participated in the sessions/meetings associated with the operation of ECD/care centre. The frequency of their participation in project activities also indicated that the project activities are well accepted by the community. Among those who participated in sessions/meetings, majority participated once a month (73.8%) followed by twice a month (13.5%). Some (9.5%) attended the sessions once in a week which indicated the eagerness of the community people to run the activities smoothly.

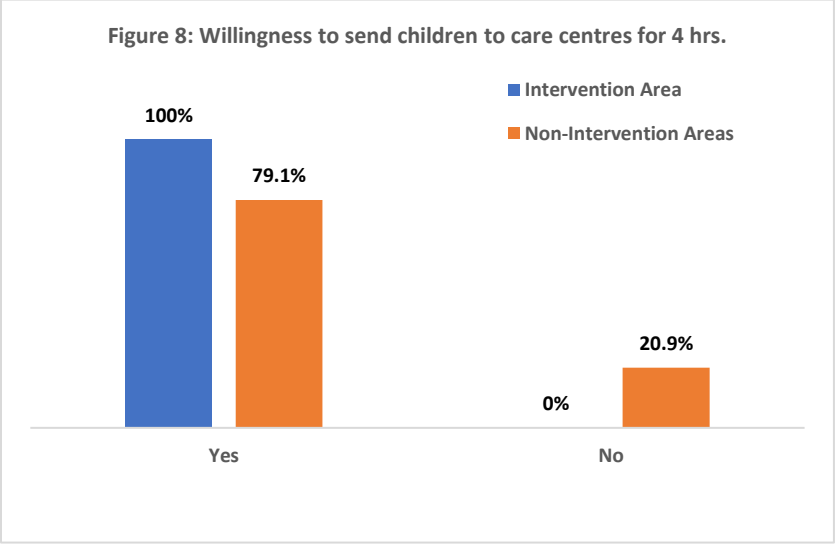
Table 10: Participation in meetings associated with operation of care centre

Participate in operation of care centre	**Responses (%)**
Yes	73.7
No	26.3
Total	**100.0**
Frequency of participation	%
Once in a week	9.5
Twice a month	13.5
Once a month	73.8
Bimonthly	2.4
Quarterly	.8
Total	**100.0**
Reason for not participating in the sessions	**Responses (% of cases)**
Meeting venue is in distance	16.3%
Do not get time	59.2%
I have no role in the meeting	8.2%
Can't say anything	2.0%
Repetition of discussion	6.1%
There is no such scope in the community	42.9%
My child was in SwimSafe	2.0%
I have no child admitted in Anchal	2.0%

Some (26.3%) were also found not to participate in the ECD activities. One of the major causes behind this is that they did not get time to attend (59.2%). This may indicate that they tend to undervalue the importance of the initiatives in their community. The other causes are the long distance of meeting venue (16.3%) and there is no such scope in the community (42.9%).

4.1.3 Willingness for increased hours of service among ECD users and operators (parents, NGO/service providers)

To ensure safety of children from drowning and other injuries Respondents were asked whether they would be willing to send their children to the care centres if the duration of stay is 4 hours. In Anchal intervention areas, 100% parents showed their willingness to send their children to CCC out of which 26.3% are already sending their children to a 4-hour service facility. remaining 73.7% are willing. On the other hand, in non-intervention area, 79.1 % parents are willing to send their children to CCC and 20.9% are not yet sure.



4.1.4 Scope of service for 1-3 yrs among parents in ECD area, non-intervention area

From the Key Informant Interviews, field level observation and the expert consultation, respondents strongly recommended that the childcare and development interventions must be implemented following the "Life Cycle Approach". But while asking the scope of services for the 1-3 years age group children, all Key Informers and the experts mentioned the following activities:

- Parental education at family level will help protect children from any form of injury/drowning
- Caring for children at child care centres as per ECD curriculum (following the ELDS standards) and ensure protecting children from any form of Injury/drowning.
- Ensure immunization, nutrition
- Educating the community to become more proactive on child safety and care issues.

4.1.5 Awareness of benefits

Table 11: Useful services in parents' opinion

Useful services	Int. Area (% of cases)	Non-int Area (% of cases)
Child development related services	18.8%	22.0%
Learning through games and toys	2.4%	3.4%
Education related services	18.2%	28.8%
Children are safe from fire and water	9.1%	3.4%
Children are safe/protected there	16.4%	16.9%
Can learn swimming	9.7%	0%
Parents could get relaxed	13.9%	5.2%
Discipline	7.3%	3.4%
Total	**107.9%**	**83.1%**

Note: multiple responses given

Parents were asked which services of the project were useful for their areas, they mentioned Child development related services (18.8%), Education related services (18.2%), etc. In non-intervention areas, parents were asked which services would be useful for their communities, they mentioned Education related services (28.8%) followed by Child development related services (22%), etc.

Do parents think that such interventions need to exist in their area?

When asked, whether there is any need and/or importance of such interventions (both ECD and Swimming Training), in intervention areas, 100% respondents replied positively and in non-intervention areas, 98.6% informed positively and only 1.4% said, "not that important", mostly for lack of awareness.

Table 12: Do parents think that such interventions need to exist in their area?

Responses	IntAreas	Non-Int Areas
Yes	100.0	98.6
No	0.0	1.4

4.1.6 Willingness to pay for service

Willing to pay or contribute for services | To know the willingness to pay/contribute for their children under such project, we first tried to identify the existing practices of contribution of the parents from where it showed that only 28.1% of the total respondents (in intervention areas only) do contribute either in cash or in kind and remaining 71.9% don't.

Willingness to pay for improved services | In intervention areas 62.6% respondents replied they would be willing to pay and contribute if the service provisions are improved and in non-intervention areas, 56.9% expressed willingness to pay/contribute. Subsequently, while asked, who would be willing to pay and how much for the services, it showed different responses from different income-groups in both intervention and non-intervention areas. They were asked the minimum and the maximum amount they would be willing to pay/contribute. The following table depicts the responses.

Table 13: Willingness to pay for improved services

Responses	Intervention Areas	Non-Intervention Areas
Yes	62.6	56.9
No	37.4	43.1
Total	**100.0**	**100.0**

Table 14: Parents ever contributed for the services (n=171)

Responses	Valid Percent
Yes	28.1
No	71.9
Total	**100.0**

Table 15: Income and affordable amount parents can provide

HH Income Range Per Month	Intervention Area (n=171)		Non-Intervention Areas (n=72)	
	Min. BDT/Month	Max. BDT/Month	Min. BDT/Month	Max. BDT/Month
BDT 1,000 – 5,000	50	300	20	200
BDT. 6,000-10,000	10	400	20	50
DT. 11,000-15,000	10	200	10	100
BDT. 16,000-20,000	10	200	20	500
BDT. Above 20,000	10	500	20	200

Reasons for unwillingness to pay for services | Amongst those who were reluctant to pay for the services**,** in intervention areas almost three-fourths (74.0%) of the respondents demanded the services at free of cost. Some (53.2%) expressed inability to pay. Around 31% of the respondents mentioned that NGOs provide services at free of cost and some (14.3%) of them said that as the govt. primary school do not require any fees then why they should pay for such services for children. On the other hand, majority of (85.3%) the respondents of non-intervention areas demanded the services at free of cost.

Table 16: Reasons for unwillingness to pay for services

Area of household	Reasons	Percent of Cases
Intervention Area	I can't afford any amount	53.2%
	It should be free	74.0%
	NGO provide services at free of cost	31.2%
	Since, govt. school does not need any money why should we pay to Anchal?	14.3%
	Government should bear it	3.9%
	Total	**176.6%**
Non-intervention Area	I can't afford any amount	38.2%
	It should be free	85.3%
	NGO provide services at free of cost	14.7%
	Since, govt. school does not need any money why should we pay to Anchal?	17.6%
	Government should bear it	2.9%
	Total	**158.8%**

Willingness to provide in kind support for services | Respondents were further asked whether they would like to provide any type of support for the improved services, 41.5% in both intervention and non-intervention areas expressed their willingness. In contrast, more than half (58.5%) of respondents of the intervention areas did not show interest to provide any support, similarly in non-intervention areas the finding was close (58.3%).

Table 17: Types of expected services

Types of services expected	% (Multiple Responses)
H&N related Services	67.81
Quality Education	33.61
Protection from Injuries	29.48
Child Care/development related activities	0.10

Among those who were interested to provide support to the centres operating in their own community, almost all the respondents of both intervention and non-intervention areas were interested to provide non-economic support such as toys for children, stationaries, goods like soap, hand wash etc., materials, advices, labor, etc. In intervention areas, 40.8% of the respondents wanted to provide '*MustiChal*' (handful rice) where the percentage was 28.6% in the same cases of non-intervention areas. The ECD Mapping and Sustainability Analysis study also documented (see section 4.2.3) parents making in-kind contributions consistently across all organizations' interventions.

Table 18: Types of in-kind support

Area of household		Percent of Cases
Intervention Area	Toys for children	45.1%
	Some stationaries	31.0%
	Goods like soap, handwash, etc.	36.6%
	MostiChal (handful rice)	40.8%
	Assistance to teacher	2.8%
	Total	**156.3%**
Non-Intervention Area	Toys for children	35.7%
	Some stationaries	42.9%
	Goods like soap, handwash, etc.	28.6%
	MusthiChal (handful rice)	28.6%
	Suggestion/advise	3.6%
	Construction Materials (e.g. bamboo)	7.1%
	Assistance while forming committee	7.1%
	Conduct survey with children	3.6%
	Labor	7.1%

4.1.7 Expectation for additional useful services.

Expectation for additional services to incorporate in childcare centres | When the respondents were asked what more services do you think necessary along with the present services, they mentioned in multiple responses e.g. health and nutrition related services (67.81%), childcare and development related services (40.10%), quality education (33.61%) and injury prevention and protection related services (29.48%).

4.1.8 Care giver interest and expectation for pay and benefits

The study team has interviewed 9 caregivers under 9 Upazilas (study area) and asked about their involvement, responsibilities and remunerations/benefits. Out of 9 caregivers, most of them showed multiple interests for the job. Majority of them are treating this work as an employment opportunity near home. They also think that, in the community, this is viewed as a prestigious job as they work with/for child development and usually people call them "Teachers". A few of them also think that they contribute to the future development of the society, ultimately contributing in "nation building". But many of them expressed dissatisfaction about the remuneration. From the interviews we found that the duration of work varies from 2 hours to 8 hours, depending on type of centres/services and receive remuneration amounting BDT 500 to 3500 depending on work hours and activities. In some centres, we found that one assistant is engaged to support/assist the designated caregiver and paid BDT 700 to 1000 per month. One third of the respondents think that if the service duration is increased the remuneration should be from Taka 6500 to 7500 per month and remaining respondents said that it should be Taka 7500 to 8500 per month. While asked about the number of caregivers per centre, all of them replied that there should be 1 caregiver and 1 assistant for 25 children and if the lower age group (ages 1-3 years) are included, then additional arrangements should be ensured.

The story of Khadija- An "Anchal Ma"

Khadija (30) works as a Care Giver (known as Anchal Ma) under BHASA project implemented by Centre for Injury Prevention and Research Bangladesh (CIPRB). She completed her HSC level education. Khadija joined this project with a desire "To do something" meaningful. She finds joy to be taking care of 17 to 23 (attendance varies) children every day from 9 am to 1 pm (Saturday to Thursday). She is also able to stay close to two of her own children as the Anchal is situated in her homestead. She is paid a salary of BDT 3000 per month most of which is spent on her children. A little raise in salary would be motivating. During her working hours, she is assisted by an assistant, named Bithy Rani and the two have a lot of fun with children. Khadija feels quite accomplished as she is trained on issues of early learning and development and child protection measures. The learning has made her a better parent as well. The She feels she is more respected in family and society and better connected with the community.

4.1.9 Availability of resources (donating land/house/rental opportunities)

Findings from Key Informant Interviews, FGDs and Case Studies revealed that childcare and development services through different childcare centres are now being implemented in different forms. For example, some forms of childcare centres are operating at caregivers' home (for example Anchal centre of CIPRB) and some are in government-owned building and places (for example, Phulki operated Daycare centre at tea garden). On the other hand, Shishu Academy mostly operated its centres at its own infrastructure.

In CIPRB implemented Anchal centres, caregivers (One Anchal Ma) are provided around BDT. 3000 and her Assistant (One Assistant) received BDT. 1000 as monthly remuneration. Mostly, the centres are situated at Anchal Ma's home where the room is constructed with her own expenses. No rent or utility bill are paid for that room. They work for 4 hours a day.

In case of Phulki implemented Daycare centre at the tea garden, it operates at a previously unused room of a government community health centre. Along with the health services, Phulki is implementing its

daycare centre which provides services mostly to the children of tea garden workers. In this form, two caregivers work for 8 hours a day and each of them is paid BDT. 3500.00 as their monthly remuneration.

In Dhaka Ahsania Mission operated Shishu Bikash Kendra (SBK) in Nilphamari. Only one caregiver is responsible to provide service per centre (15-20 children per centre). Caregiver receives BDT 500.00 (five hundred) as honorarium. Although parents are supposed to pay BDT 30-40 against each child but many of them fail to pay. The centre is situated in a government-owned infrastructure (landless rehabilitation centre/office). Other centres are also situated in different unused government land/institution or community-based organizations.

In the case of Shishu Academy implemented ECD activities, it mainly operates in its own building. A caregiver/teacher of its pre-primary section mentioned that their remuneration is a barrier for them to work there (currently BDT 2100). If it increases, they can work for an extended time (4 hours) and services.

For the selection of venue to implement the ECD many recommendations have made by the community and key informants. Anchal ma and some other caregivers expressed their willingness to provide the land/space/room for the services. In some areas like tea garden, caregivers were found less interested in this regard. They suggested that garden authority can provide space there.

With regards to opportunities related to availability of resources (both from KII and FGDs), the participants informed "to select the space for operation of Child Care Centres, initially, the un-used and under-utilized spaces of Community Clinics can be utilized (where available). Even, there are some under-used spaces in the existing government primary schools, Non-registered primary schools, Union Health and Family Welfare Centre. Where it is not available, community will be willing to contribute to set-up semi-permanent structures on govt. Khash Land and also some community people will be willing to provide such supports like the "Anchal Centres" are being set-up. Some LGI representatives expressed willingness to provide support to establish centre in Khash land or use Khas/UP ponds for swimming. They are also willing to establish tube well for drinking water.

For swimming training, there are many usable pond/water bodies in some areas like Kurigram, Patuakhali, and Barguna. District Sports Association (DSA) can be utilized as Resource Centre. Key informants (District level Senior Government Official) commented that the inter-departmental coordination, at district level, will not be a problem as it works smoothly for other projects/programs.

4.1.10 Preference for service provider type (GoB or NGO or Community)

In the intervention areas, while asking about their present service providers on childcare, all expressed that the services are provided by NGOs. But while asked about their preferences, most of them preferred to receive services from Government like pre-school education. But they also expressed that to ensure the quality services, community, LGI and NGO involvements are necessary. As a supplementary question, when the respondents were further asked who should take responsibility for collaborative management to ensure quality services and sustainability of this intervention in the community, they mentioned about several groups (multiple responses). For example, in intervention areas, highest percentage mentioned about NGO (63.2%) followed by local Government (60.8%) and community people (51.1%). In non-

Table 19: Responsibilities for collaborative management

Responsible Group/Persons	Percent of Cases	
	Intervention Area	Non-Intervention Area
Community people	51.5%	55.6%
Local government	60.8%	58.3%
Community clinic	10.5%	15.3%
NGO	63.2%	48.6%
Local school	16.4%	27.8%
President of local committee	0.6%	
Local important figure/ Imam of mosques	1.2%	1.4%
Government	1.2%	0%

intervention areas, on the other hand, local government was mentioned by 58.3% while some also mentioned community people (55.6%) and NGO (48.6%).

While asked, from whom did they want the increased services, more than half of the respondents mentioned that they would like to get the services from government (51.9%) followed by NGOs (34.4%). Some 10.4% desired the services via local or nearby schools.

4.1.11 Participation in parental education rate in Anchal and ECD centre and interest in nonintervention area.

Parents participation in any form of meetings/session on Childcare and Development | About 74% in intervention areas and 12.5% in non-intervention areas had exposure to similar learning sessions/events. The attendees, from intervention areas, learnt about child mental and physical growth (77.6%) followed by nutritious food for children (69.6%), child health (34.4%), child protection (46.4%), preparing nutritious food for children (51.2%) and about potential risks for children (22%). On the other hand, in non-intervention areas, those who attended to such sessions, mainly learnt about how to prepare nutritious food (100%, received from health service providers), children mental and physical growths (66.7%), child protection (66.7%) etc.

Table 20: Parents participation

Parents participated in any session, meeting, event related with childcare	**Intervention Area (%)**	**Non-intervention Area (%)**
yes	73.7	12.5
No	26.3	87.5
Total	100.0	100.0
What they learnt from those sessions	**Intervention Area (percent of cases)**	**Non-intervention Area (percent of cases)**
Children's mental and physical growth in different ages	77.6%	66.7%
About nutritious food for children	69.6%	55.6%
How to prepare nutritious food for children	51.2%	100.0%
About child protection	46.4%	66.7%
Child health related information	34.4%	44.4%
About potential risks for the children	22.4%	33.3

Respondents from intervention areas who did not attend sessions gave as reasons: scarcity of time (38.1%), no such services in this area (41.3%), not informed (11.1%) and 3.2% said that their family, mainly husband and in-laws, don't allow them to participate. On the other hand, in non-intervention areas, a total of 84.5% identified non availability of such facility in their areas as the reason for absence, and only 8.6% mentioned they were not aware about such sessions and 3.4% had scarcity of time.

Table 21: Reasons of non-participation in the sessions/meetings

Responses	**Intervention Area (% of cases)**	**Non-intervention Area (% of cases)**
I was not informed	13.5%	9.1%
My family does not like	3.8%	1.8%
Did not get time	46.2%	3.6%
Not interested	5.8%	0
There is not such scope in my area	50.0%	89.1%
There is no centre in this Upazila	1.9%	1.8%
Total	**121.20%**	**105.40%**

Parents received information on childcare and development | In intervention areas, 70.2% parents were found who received information on childcare and development and in non-intervention area, 32% received information. Among those who received such information, mostly received from the existing project activities (82.9% of cases) in intervention areas and from TV/Radio program (61% of cases) in non-intervention areas.

Table 22: Parents received information on child development and the sources of the information		
Information received	**Intervention Area (%)**	**Non-intervention Area (%)**
Yes	70.2	31.9
No	29.8	68.1
Total	**100.0**	**100.0**
Sources of Information	**Intervention Area (%of cases)**	**Non-intervention Area (% of cases)**
From parents meetings/NGO organized meetings	82.9%	26.1%
From community clinics	19.7%	13.0%
From radio/TV program	25.6%	60.9%
From health worker	23.1%	56.5%
Child care Centre	.9%	0
Neighbors	2.6%	4.3%
Parents' waiting room at Kindergarten	.9%	4.3%
From book	0	8.6%
From Hospital	0	4.3%
Total	**155.70%**	**178.00%**

4.1.12 Community Participation rate (Community involvement in management in Anchal and ECD areas, interest in non-intervention area)

Currently, most of the Anchal and ECD interventions have community engagement in varying degrees. In some interventions like Anchal, Shishu Bikash Kendra, etc. community people took part in decision making processes, fund collection, building and repairing infrastructure, planning, resolving problems, ensuring children's attendance, etc. Generally, in different meeting and sessions like *'Ma Shova', Courtyard Meeting* organized by the projects, parents and community people received information on the progress of and challenges to the project activities. Therefore, the community people get direct scope to provide their suggestions and take ownership to address challenges.

Community leaders were found to be actively engaged through different committees which are mostly formed to ensure smooth day-to-day operation and management of the interventions. One UP Chairman mentioned "I am always informed about the project activities. Although I could not attend all the activities, try to help them whenever they come to consult me. I also visit the centres sometimes."

In intervention areas, community people also expressed their interest in taking responsibilities to implement such ECD interventions for their children in their areas. Most of them wanted to take part in decision making, planning, venue selection, caregiver selection, resolving problems, building and repairing centre rooms, selecting children, etc. Some of them also thought that it would be difficult for them to mobilize funds and managing finances. Few thought that they could take major responsibilities of the project if they are provided with orientation and training on collaborative management of interventions and managing financial resources.

However, KII with NGO staff revealed that in most of the areas they had to work hard to ensure effective community engagement and mobilize parents to avail the facilities. Initially, most of the people expressed their interest in having the interventions in their localities but still many are not ready to take on an active

management role. Therefore, project needs to emphasize on community ownership of the interventions as a key condition for sustainability.

4.1.13 Interest of local government representatives in the intervention and willingness to participate.

KII findings revealed that the community leaders particularly the representatives from local government institutions (LGIs) were directly engaged with child care interventions in studied areas. In CIPRB and ICDDR'B implemented projects, local government institutions were found to be an active part of different groups and committees namely Union Injury Prevention Committee (UIPC) and Village Injury Prevention Committee (VIPC). More specifically, UIPC was led by UP chairman where UP members were the members of the committee. In the cases of VIPC, UP members were the head of the committee and the local important figures were the general members of the committee.

Through these committees and other activities, LGI representatives were playing important roles and helping the NGO staff to implement the intervention in their areas. In other intervention areas, community leaders including LGIs were found to play some advisory roles, attend monthly or periodic meetings, provide important suggestion, and make some resource contributions. Findings also revealed that community people including members of different committee were willing to take some responsibilities, but they demanded adequate orientation and training on relevant issues. A local 'Matbor' (Elite) mentioned:

*"*After getting involved with the project, I could realize how important it is to educate our people particularly women regarding childcare and protection. We have been taking care of our children from very beginning of the civilization, but we did not know what specific care children need in what age. This project taught me that. As community people respect the leaders, I think, our community leaders need training on such issues so that they can enlighten their people".

The key informant interviews with NGO staff, revealed that they struggled to get communities' positive response towards the project activities at the initial stage but gradually when they started seeing some progress like their children's psychological development, cognitive skill development, increased interaction ability, they started finding interest in the project activities. Many of them expressed their willingness to take part or contribute.

However, in non-intervention areas, LGI representatives also expressed their willingness to contribute to ECD interventions. Many of them were willing to take part for example in advisory roles like providing regular suggestions, solving problems, identifying locations/spaces, maintaining liaison with a different institution, etc.

4.1.14 Operational challenges

Field level observation and KII findings revealed that the existing interventions faced some challenges and limitations regarding the services, volunteers, venue, manpower, etc. In most of the forms of studied ECD/care intervention, caregiver post is a part-time basis job for 2-4 hours except daycare centres of Phulki (8 hours) in tea garden but due to the lower amount of honorarium, it is difficult to keep them engaged for a long time. In some cases, Anchal centre has been closed right after the

Table 23: Challenges faced by community people (Intervention area only)

Problems/limitations	Percent of Cases
Centres are far away	26.5%
Children do not want to go	22.6%
Inadequate number of resource persons	41.9%
Lack of qualified resource persons	25.8%
Lack of toys	64.5%
Lack of attractive techniques	21.9%
Volunteer do not treat all equally	1.3%
Need to increase fans	.6%
Total	**205.10%**

Anchal ma left the duty or got married. It is also difficult to find out and trained up another Anchal Ma for the centre. One caregiver of Shish Bikash Kendra stated "I am paid only BDT. 500.00 which is very low considering my financial condition. Although parents are supposed to pay BDT. 30-40 in Shishu Bikash Kendra, most of them do not pay."

Moreover, finding a perfect venue is another challenge. Although people expressed their willingness to arrange space for building the centre, they thought it would be encouraging if the owners were provided any cash amount for the services. The lack of manpower was also a challenge in some interventions. In Anchal, it is observed activities are facing lack of manpower for supervision. For example, each supervisor must cover around 30-40 Anchal centres, which is a big load and a challenge for bringing effective outcomes of the program.

Furthermore, the lack of some essential materials is also impacting on the outcomes. For example: i) a First Aid box was given some years ago but no medicine or medical tools have been provided in recent times; ii) children need more toys to pass their time with more joy; iii) there are no IEC materials for children that they can play and learn with.

However, the study also tried to explore whether the community faced any challenges and limitation to participate in the interventions. While asking about the challenges and limitations faced by community people to participate in the existing care centres, respondents mentioned that lack of toys (64.5%), Inadequate number of resource persons (41.9%), Centres are far away (26.5%), etc.

Parents also expressed their opinion and experience about resources and capacity of the existing care and swimming centres. Some 42.1% thought that the capacity of the care centres was adequate while more than half of them (53.8%) disagreed.

Table 24: Capacity of care and swimming initiatives

Capacity of care centre is adequate	Intervention area only (%)
Yes	42.1
No	53.8
No comments	4.1
Total	**100.0**

There was also unwillingness by parents to send young toddlers (1-2.5 yrs) to the facility out of anxiety to entrust others with their small children, reluctance of children to be separated from mothers among others, no awareness of ECD benefits and safety issues.

Intervention 2: *SwimSafe*

4.1.15 Willingness of parents

KII findings revealed that people initially were not very willing or interested in swimming intervention in their areas. In rural context of Bangladesh, it was thought that children could learn swimming naturally on their own, no special training and supervision were thought to be needed for this. But, many children drowned and died every year. A study showed that 46 children die every day in Bangladesh and the drowning mortality rate is three times higher in Barishal division than rest of Bangladesh (Bhasa 2018).

When the swimming initiatives started in different parts of the Barishal division, community people started realizing the importance of supervision, swimming skill development, etc. One guardian (grandfather) mentioned:

"*I never thought that swimming could be an issue of training. But when I attended a meeting organized under the project, I saw huge prevalence of drowning in our areas. Also saw that they were teaching children basic and survival swimming through systematic and structured lessons. I changed my mind and admitted my grandson to the swimming centre. Since, I am a freedom fighter, people also started following me*."

"My son learnt swimming from SwimSafe program. In the beginning we did not want to send our child there but Raihan bhai (pseudonym of NGO staff) convinced us and promised that it might save his life from drowning. However, my child learnt swimming in one week. There are plenty of water body in our area, but we are not afraid of that because our child can swim now. A few days ago, he participated in a swimming competition organized by the project and became first. Such an achievement made me feel proud. Now I tell my neighbors about the importance of swimming and encourage them to send their children too."

-Rukhsana Akhter

(Mother of the participants of SwimSafe)

In control areas, where there was no such intervention on swimming, respondents made different responses about their willingness. Some FGD participants mentioned that if such training initiatives are implemented in their areas, they would like to get services from it while a few people mentioned people will be less interested in such activities.

However, community people from different areas mentioned that they would be willing to receive swimming training from local schools more specifically from primary schools. They also mentioned that if primary schools provide such services or include this sport as extracurricular activity, community acceptance will also be higher.

4.1.16 Parental participation

In the cases of swimming related intervention, community participation was also found in different areas where such initiatives were present. Under the coverage of present study, swimming related initiatives were found to be implemented only in Patuakhali (KolaparaUpazila), Barguna (TaltoliUpazila) and Sirajganj (RainganjUpazila run by Centre for Injury Prevention Research Bangladesh (CIPRB). But still a major portion of the households are beyond the coverage of swimming related intervention.

During the study, we tried to know the status of participation of the respondents in swimming related activities/training/sessions. Most of the parents replied that they participated in the swimming intervention by sending their children for the training, participating parents and community meeting, attending different events like swimming competition, etc. While asked particularly about the participation in meeting/session in intervention areas (Kolapara, Taltoli and Rainganj), the study found that 36.4% of respondents do participate in such meetings/sessions. The main reasons of non-participation in such session/meetings, in intervention areas, mentioned are unavailability of such training/session in the area, time-constrains, long distant training venue and due to lack of information. And in non-intervention areas, 100% respondents said that there is no such session available or takes place which they feel is necessary for their children.

Table 25: Parents regularly participated in the sessions/meetings associated with SwimSafe

Responses	Intervention Area (%)
Yes	34.8
No	65.2
Total	**100**
	N=66

Table 26: Feedback provided by parents	
Feedback Responses	**Response (%)**
Yes	39.2
No	42.1
No, there is no scope to give feedback	18.7
Total	**00.0**
	N=171

Respondents' Feedback on Project Activities | As parents sent their children to swimming initiatives and regularly participated in different sessions and meetings, they also remained aware of the activities under the interventions and provided feedback and suggestion to the activities. Therefore, while asking the respondents whether they have provided any feedback on the projects of their areas (only in intervention areas of Child Care and Swimming Training), 39.2% responded positively and 42.1% said "No" and 18.7% informed that they didn't have any scope to provide any feedback.

Amongst those who have provided feedbacks, expressed multiple comments, major among which are problems faced by children at the centres (45.8%) due to inadequate availability of toys, difficulty related to latrine use. Moreover, boy children are less willing to attend and children younger than 3 don't want to be separated from mothers; responses related to venue-distance, structure/set-up (33.33%) were mostly relatd to children' restrictions in movement in one room, less scope for outdoor activities inadequate ventilation and heat as some centres don't have fans. Centre caregivers have also identified negligence of parents as a difficulty as some forget to provide change of clothes, follow instructions, lack of childminding awareness.

Table 27: Type of feedback provided by parents	
Feedback	**% of cases**
Limitations of Services	30.6%
Problems faced by children	45.8%
About the injury prevention committee	18.1%
Conditions of the venue/centre	33.3%
Fund collection constrains for the centre	13.9%
Role of volunteers	15.3%
Role of parents	41.7%
Total	**198.7%**

4.1.17 Awareness of benefits

Although the study found that the respondent's awareness of benefits still needs to be increased among community people in all areas; awareness is currently higher in intervention areas than in non-intervention areas where no swimming or injury prevention related services are available.

The participants of the intervention areas where SwimSafe project exists have appreciated the intervention. All of them feel that such initiatives should be scaled up all over the country. The FGD participants of both intervention and non-intervention areas viewed that:

"*People think children learn swimming automatically by themselves, no particular tutor is needed;but those days are gone, we don't give that much importance to it, that's why every year we see increasing trend of drowning and child deaths. Now our children go to school, they have very limited access to different sports/games, so it would be better if all the children of primary schools, are taught swimming from the schools. This will reduce child mortality in our country*".

In intervention areas particularly where 'Anchal' intervention exists, parents thought that their children are safe from drowning and other injury risks during their busiest time (9am to 1pm). One parent mentioned:

"*Since I don't have anybody else to help me do my household chores, I usually remain very busy in first half of the day. Therefore, it was difficult for me to be able to take proper care of my child after managing all the works. Anchal centre has been a relief for me.There my child is not only safefrom potential risks but also,she is learning many things. I can do my works freely."*

4.1.18 Challenges of SwimSafe Intervention

The coverage of SwimSafe project was very much limited in our surveyed area. We found only in KalaparaUpazila of Patuakhali district, TaltoliUpazil of Barguna district and very recently started in RaiganjUpazila of Sirajganj district. The survey identified the following challenges the program implementors faced:

- Less importance perceived on swimming lessons by the community due to lack of awareness;
- Lack of awareness about drowning deaths and benefit of teaching survival swimming;
- Long administrative procedure to link the project with formal Primary schools;
- Selection and drop out of competent trainers mainly male swimming instructors due to very low pay and shutdown of the intervention in winter;
- Female instructors are preferred over male instructors especially by parents of female students.
- Rainy season flooding effects accessibility to ponds.
- Conflict between school and swim class time.
- Lack of suitable clean pond (so far) in some areas; Many ponds are used for fish farming.
- The logistics (pool accessories) are very much expensive for urban areas; and
- Corruption/dishonesty in selection of children (somewhere it is reported that children were selected who already knew swimming).

4.2 Findings under Objective 3: Costs

Context and data sources

This feasibility study focused on surveying parents of children attending or eligible to attend care centres, and focus groups with a range of stakeholders, it did not investigate in depth the costs of providing such care because a recent study commissioned by Synergos investigated in depth the operating costs of representative existing care centres operated under nine projects and NGOs (Ahsan et al. 2018)[11]. Section 6.2 summarizes relevant information from that study. That study did not attempt to investigate or estimate the costs of initiating care centres, its focus was on sustainability and hence on operating costs of well-established centres. Many care centres hold limited information on their operating costs, however through field visits, information from head offices, and imputing values for services provided in kind, monthly operating costs were estimated for the following cost heads:

- *Caregiver's remuneration* (main care giver plus assistants where paid, voluntary service by parents was valued and treated as an in-kind contribution, bonuses were counted where paid by government).
- *Supervision and management* (estimation was difficult, proportions of time and costs from multiple tiers of supervision particularly in government and international NGO run centres were estimated).

[11] M. Tariq Ahsan, M.T, Thompson, P.M., Patwary, R.I, Kabir, M.E., & Yasmin, S. 2018. Mapping of ECD Approaches and Sustainability Analysis of Community Based Child Care Centres. Drowning Prevention Partnership-Synergos & Bangladesh ECD Network, Dhaka.

- *Rent* (value of space/building used for centre and associated play/reception areas, in some cases a cash rent, in others an estimated value for a facility provided by local people or institutions).
- *Utilities, cleaning, and maintenance* (electricity, water, gas, sanitation, cleaning and building maintenance; values estimated where these services are provided by property owners).
- *Play and learning materials* (cost where provided by donors/projects, otherwise an estimate of the time taken by parents to make items and local wage rate).
- *Training and quality control* (not well documented by centres, estimated based on type of training previously provided, associated costs and assuming training is needed every two years).
- *Food* (not provided by most centres, but for several parents arranged a weekly nutritious meal for children and value of this in-kind contribution was estimated).
- *Transportation* (to bring learning materials to centres for care giver, mainly in government run centres).
- *Meetings* (value of time and any refreshments for committee and parent meetings).
- *Marketing and information sharing* (parents reported actively publicizing their care centres to attract more children, cost of this was estimated).
- *Risk and inclusion assessment* (time spent by care giver or others in helping the few children who are disadvantaged or disabled, plus any related costs such as drowning assessment by CIPRB).

Although the costs of nine care centre approaches or examples were assessed, two of these have high costs and are special cases (Phulki urban day care operating for eight hours per day, and Chottogram Hill Tract's Parakendro approach of multi-purpose government run centres) and are not considered appropriate for estimating the costs of collaborative community managed rural care centres. The nine cases comprised:

- The community run ECD centre in Gazipur founded under a program of Plan International Bangladesh run by Dhaka Ahsania Mission, has graduated from external support and is now managed by the community using a low-cost approach.
- BRAC's (Institute of Education) Khelar Jogot (play centre) approach, which maximizes use of its existing facilities through a shift system, was represented by a peri-urban/rural centre in Narsinghdi District.
- CIPRB's Anchal Centre approach is part of its wider program to reduce drowning among children focusing on Barisal District.
- Save the Children's Khelaghors (play centres, case study in Meherpur) operate in mostly rural areas and give a strong role to local communities.
- World Vision's Shikhon Shekor Kendro (roughly, translated as ECCD, case study in Rajshahi) are strongly dependent on external resources.
- The SBK (Shishu Bikas Kendra) approach of the Early Learning Child Development Project of the Government and UNICEF, implemented by BRAC, caters to children of disadvantaged tea-estate workers in the northeast.
- ICDDRB's Anchal Shikhon Kendro approach of crèches operates in Matlab, Chandpur District, integrating with its health care work.

- The Phulki urban care centre approach (case study in Mirpur, Dhaka) caters to mothers working in readymade garments factories.
- The Parakendro approach is restricted to the Chottogram Hill Tracts where it is part of a long-term government and UNICEF program for integrated child development.

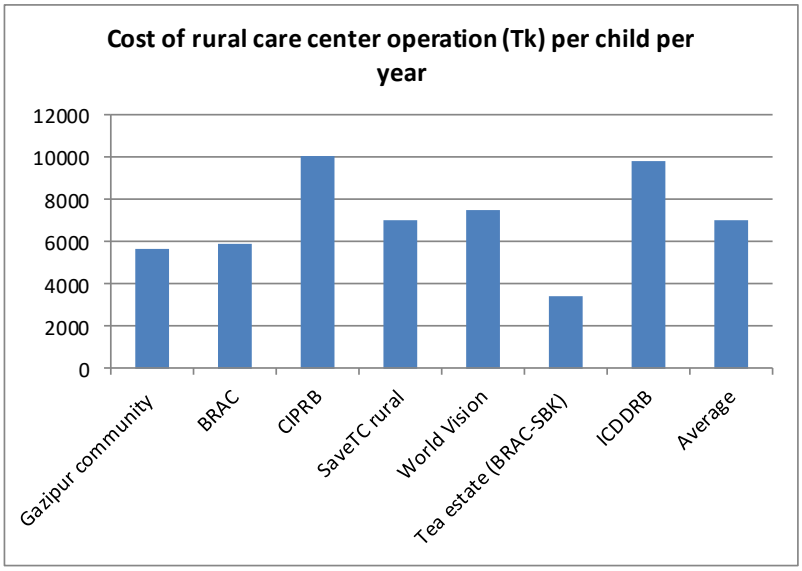


Figure 9 Cost of rural care center operation (Tk) per child year

4.2.1 Per child cost

The care centres studied vary in the number of children enrolled (several had fewer than their apparent capacity) and operating hours. Excluding the exceptional cases (urban and hill tracts), and including imputed values for the various services and cost components of care centres noted in section 6.2.1, the seven rural care centre cases averaged a total cost of about Tk 7,000 per child per year, with a range of Tk 3,400 to Tk 10,000 (see above figure).

Children attend rural centres for 2-4 hours depending on the approach, whereas they attend for 9-10 hours a day in urban care centres. Standardizing costs in 2018 as Tk per child hour of care (see figure opposite) revealed that the NGO, community and private sector linked care centres all operated at costs in the range of approximately Tk 5-12 per child hour, whereas the two government supported approaches were far more expensive (Tk 46/child hour for DoWA and Tk 94/child hour for the Chottogram Hill Tracts Parakendro approach).

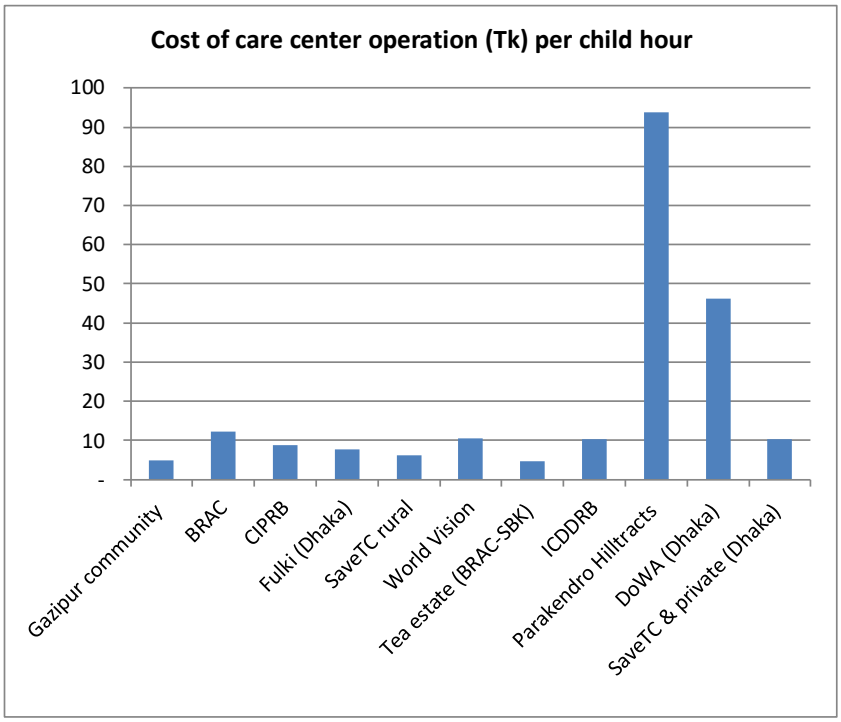
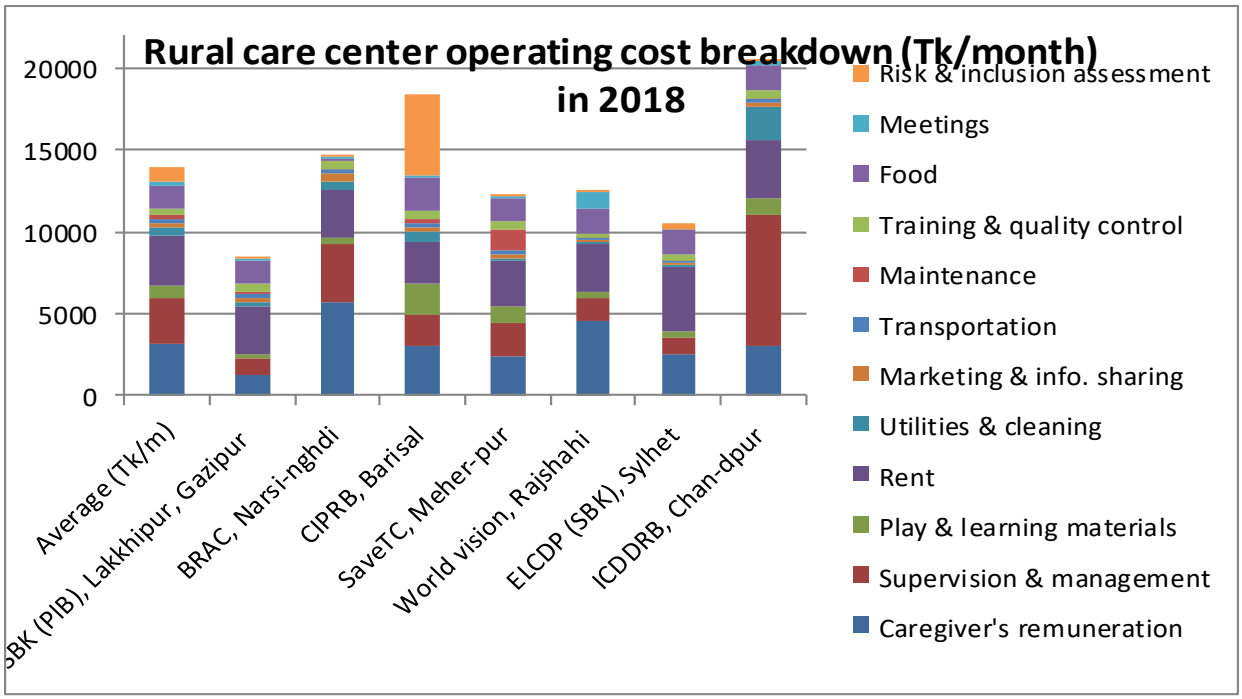


Figure 10 Cost of care center operation (Tk) per child hour

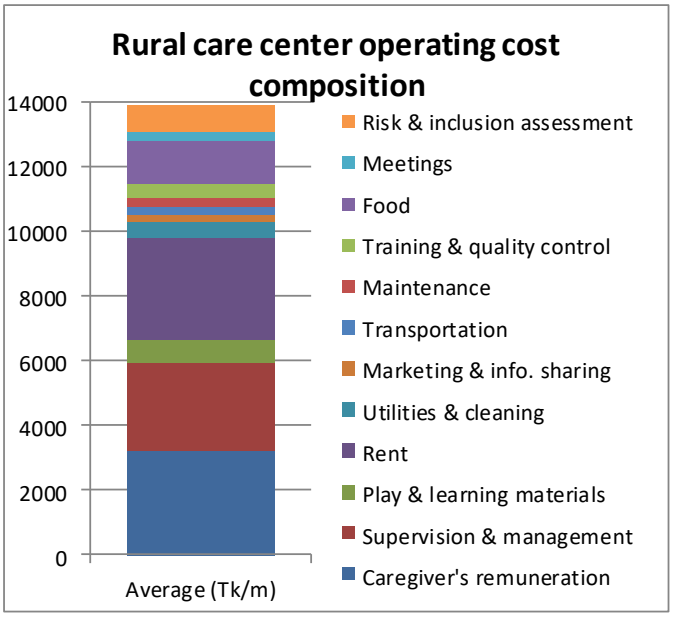
4.2.2 Operational costs

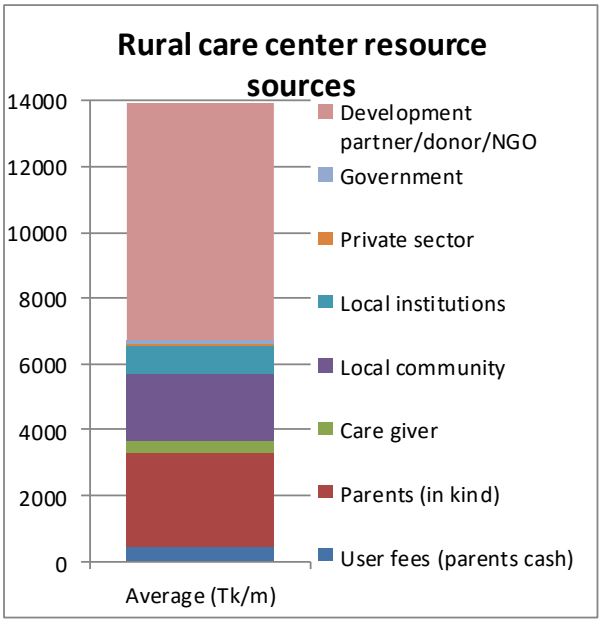
In the high cost government–run centres supervision and management comprised a major part of costs, due to the estimated cost of staff and their resources at multiple tiers of administration overseeing the centres, this was also a substantial proportion of costs for ICDDRB, BRAC and the Save the Children – private sector partnership. Care givers in general comprised 10-40% of costs, while the value of rent or building space was a major operating cost for some lower cost centres such as the Gazipur (ex-Plan International-DAM) community run centre. All other cost headings were generally a small percentage of total costs, although Phulki and the Parakendro approaches had relatively high training costs.

Overall, the cost structure and levels for rural care centres were quite similar (see figure below). They operate for much less (some seven times less) than the costs of the Parakendro approach in the hilltracts (which may not be replicable elsewhere) or the three urban approaches (themselves operating at half the Parakendro costs while delivering more than double the care time per child).



Averaging across these approaches the value of resources used to operate a care centre were calculated as just under Tk 14,000 per month, with the three main components of costs/resource needs comprising the care givers' remuneration, the value (rent equivalent) of the premises used for the care centre, and





supervision (see next figure left side). Much of these "costs" are the value of locally contributed resources including time and in-kind support. The external funding contribution towards operating costs averaged just over Tk 7,000 per month or 52 % of total resource needs (see next figure right side), with the rest provided locally from a range of sources.

Table 28: Monthly revenues, cash and estimated in-kind contributions to studied care centre approaches

Source of revenue / resources	Gazipur comm-unity	BRAC	CIPRB	Save TC rural	World Vision	Tea estate (BRAC-SBK)	ICDDR B	Phulki (Dhaka)	Para-kendro Hill-tracts	DoWA (Dhaka)	Save TC & private (Dhaka)
User fees	900	1,000	-	1,200	-	-	-	5,700	-	7,500	-
Parents (in kind)	2,600	1,600	4,600	2,700	1,800	1,850	4,600	5,200	8,400	3,050	11,800
Care giver	250	450	800	900	100	200	300	900	1,700	700	-
Local community	1,050	250	3,500	950	2,350	150	5,600	2,500	10,400	100	200
Local institutions	3,500	-	200	600	200	200	1,600	1,400	11,200	-	-
Private sector	200	-	-	200	-	100	-	200	-	-	27,500
Government	-	-	-	450	-	200	-	-	107,100	113,300	-
Development partner/donor/NGO	-	11,400	9,300	5,300	8,093	7,800	8,400	40,100	17,200	-	27,000
Total	**8,500**	**14,700**	**18,400**	**12,300**	**12,543**	**10,500**	**20,500**	**56,000**	**156,000**	**124,650**	**66,500**

4.2.3 Cost of parental contribution

The more detailed breakdown of contributions to care centre operating costs shown in the table below includes two categories directly from parents (user fees and in-kind parental contributions) as well as similar contributions from the local community. The variation in monthly operating costs estimated for care centres is reflected in the resources used to cover those costs. The table below shows the differences in the breakdown of how those actual and imputed costs are resourced, confirming the major role of NGOs and donors in most cases except for the community run centre. On average the seven cases of typical rural care centres have 25 children per centre, and parents contributed in cash and kind Tk 132 per child per month (range Tk 50-200 per child per month).

Despite generating only modest funds, user fees are an important indicator of financial sustainability for child care-centres, and at least ought to be able to cover most of the remuneration of care givers. However, only five of the care-centre approaches studied collect user fees from parents. User fees cover 50% of caregivers' remuneration in Save the Children and DoWA centres. In the Phulki-managed urban day care user fees meet 63% of caregiver remuneration, and in the "graduated" community run centre in Gazipur user fees cover almost 70% of payments to the care giver.

Notably among these cases the Gazipur (ex-Plan International-DAM) community run centre only earns 10% of its costs from user fees, but by keeping its costs low and mobilizing in-kind contributions they are entirely locally supported. In this case the parent fees contribute the major part of the caregiver's remuneration, which is further supported by cash from the host-school headmaster. This centre is overwhelmingly supported by the host school (42%) for the space, playground, office and waiting areas, and associated maintenance; as well as parent in-kind support. It is an example of the possible local collaborations and integration that can make child care viable.

4.2.4 Limitations

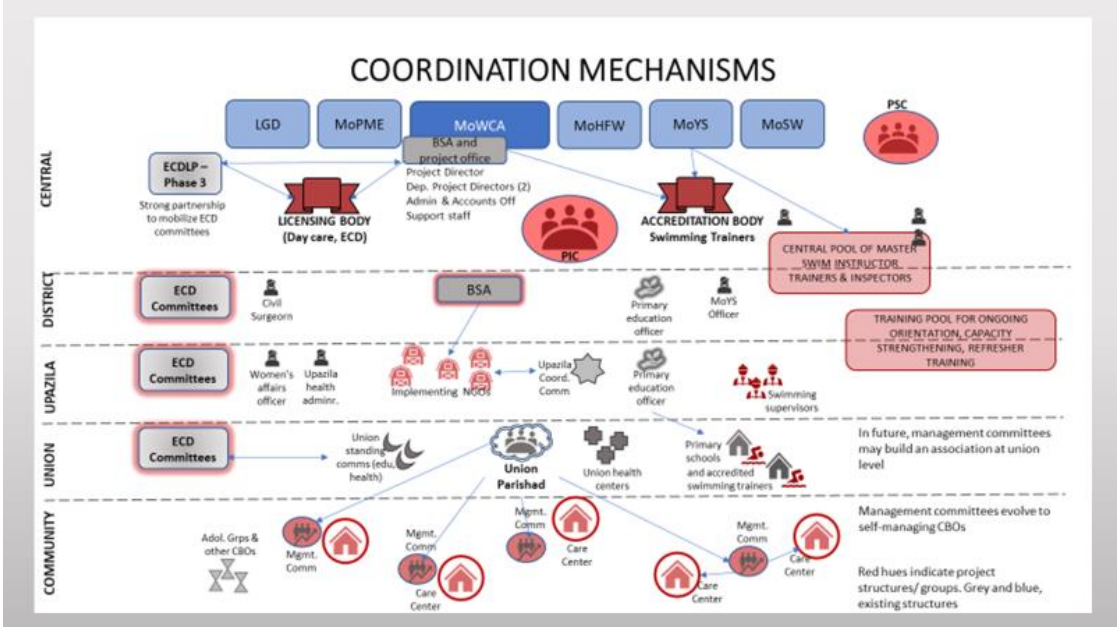
The main limitation to the data available from this study is that most NGOs operating care centres could not determine the full monitoring, supervision and management costs associated with care centres since the staff and resources used for these functions were shared over other activities and programmes of the NGOs. To this extent the costs are underestimated and do not reflect the full extent of care centre subsidization by the concerned NGOs.

Secondly, in most of the cases several of the costs are estimated values for services and materials provided in kind by local stakeholders. The centres and stakeholders may or may not consider these to be costs, but without community engagement and support a care centre would have to spend the equivalent cash amount.

Lastly, the costs of establishing care centres that are community or collaboratively run are reported to be substantially higher, although the concerned NGOs did not provide details. For example, Plan International and DAM reported that it required a long time (around a decade) and considerable effort and resources for capacity building and developing local linkages before care centres could "graduate" from NGO/project support and operate based on a combination of parent-community resources and local institutional support.

4.3 Findings under objective 4: Coordination

There are coordination needs both short-term for project implementation and long-term for integrated community-based child care and for SwimSafe. For sustainability it is preferable to establish, support and make use of long-term coordination forums and mechanisms wherever possible for the project, while recognizing that there are also some additional project related requirements. Hence the project should emphasize coordination through helping to make operational the recently established ECCD committees at District, Upazila and Union levels. A further issue is that the two main components of the planned project (care centres and SwimSafe) have different coordination and linkage requirements. Swimsafe will be heavily dependent on buy-in and support from Ministry of Primary and Mass Education and might benefit from an additional National Project Director nominated by that ministry.



At the central level the project is required to have a Project Steering Committee comprising largely of government officials but also including the relevant development partner(s). This checks on overall progress and has a remit to address significant challenges of coordination and cooperation between government agencies. It typically meets once a year, but the extent of cooperation from other ministries and agencies that are not formally included in the project structure may be limited.

A proposed project implementation committee would coordinate project activities. Unlike the steering committee which includes (although they may not all attend) representatives from a wide range of ministries and government agencies, the implementation committee would be most effective if chaired by the project director and comprising the implementing NGOs and designated representatives (with decision making powers) in the key government agencies expected to cooperate with integrated child care and SwimSafe. Effectiveness might be enhanced if the project implementing committee chairperson were to informally make two working groups - one for integrated child care and another for SwimSafe. These would address technical issues in the respective project component, and then share their key issue, decisions and recommendations/requests in the implementation committee. Meeting every 2-3 months this committee would address more immediate issues and aim to keep the project on track. The key members of the child care working group would be: Bangladesh Shishu Academy, implementing NGOs, BEN, development partner(s), and representatives for health services, social welfare, family planning. The key members of the SwimSafe working group would be: Bangladesh Shishu Academy, implementing NGOs (which may be different from the child care ones), Directorate of Primary Education, development partner(s), Bangladesh Swimming Federation and Department of Youth Development. It may be counter-productive to overload the implementation committee with non-specialist or less relevant government bodies that are best informed in workshops and in the steering committee.

One reason for having two central working groups for project implementation is that these respectively would either evolve into or be closely linked with the respective certification boards to be developed for the two approaches – for care centres and care givers, and for SwimSafe instructors.

The project should aim to activate the three tiers of recently formed/instructed ECD committees (Union, Upazila and District) to meet on a quarterly basis in the administrative units covered by the project. By including the implementing NGOs, these could form the basis for coordination of field-level implementation and integration. At the same time this would regularize long-term recognition and cross-agency support for child care and SwimSafe. For practical purposes the district level ECD committee is less likely to be effective - not only does it cover a large area, but there are more likely to be non-project related issues that it needs to address, membership is more diverse with more government agencies that may have little interest in project activities. To address the lack of connection with the Upazila ECD committees, a representative from each upazila ECD committee could be included in their District ECD committee. The last point is also valid for the lack of link between Upazila and Union ECD committees but is less important since community-based care centres would be directly linked to Union Parishads through a ward member being part of the management committee, while SwimSafe would have a clear formal link with primary schools. At the upazila level a range of officers from specialist agencies are posted and have already been included in the ECD committee. Since the implementing NGOs(s) in an Upazila would be members of BEN and contracted to Bangladesh Shishu Academy those two bodies could nominate the NGO(s) as members of the relevant Upazila ECA committee. This committee would clearly be an appropriate forum covering a significant number of care centres where integration with heath care and other social welfare provisions for infants (and mothers) could be established and verified. If care centre management committees form an association or forum at upazila level then membership of the Upazila ECA committee would give care centres a voice and an opportunity (in addition to the Union Parishad route) for seeking support and assistance from government agencies.

It is less clear what the appropriate local government arrangement for coordination of SwimSafe would be. However, with around 60-100 primary schools in an Upazila this component might also be best coordinated at Upazila level where there is already a Primary Education Officer posted. Since SwimSafe would fall outside the normal remit of the Upazila ECD committee it will need to be determined if it can be added to the remit of this committee or any other existing committee responsible for primary education oversight. If not then a project-specific coordination group/committee would be needed in the

short term, and a recommendation taken up during the project as to the suitable longer-term Upazila oversight for SwimSafe.

Outside of government sponsored and formalized coordination, there will be benefits from less formal practitioner coordination and lesson sharing. For care centre approaches this can best be undertaken by BEN organizing regular events or a forum for implementing NGOs. For caregivers and care centres this can best be achieved by care centres holding Union level networking meetings respectively for care givers and care centre management committee chairpersons which can initially be facilitated by the relevant implementing NGO staff from the Upazila level. This would enable lessons to be shared between care givers and management committees and help to identify issues that could be taken up at the Union Parishad or Upazila levels. For SwimSafe Upazila level sharing events at the start and end of the swimming instruction seasons could be held for the SwimSafe instructors and for the primary school headmasters to resolve any coordination or consistency issues and to take stock of experience each year.

4.4 findings Under Objective 5: Capacity Development Needs

Training and capacity building for care givers and SwimSafe instructors are an obvious major aspect of the planned project, which will require a set of master trainers who can then conduct training of trainers. Those two sets of specialised training and supervisory staff would then provide both formal training and more informal mentoring and regular advice for respectively care givers and community swimming instructors.

In addition to this there are two main areas of capacity strengthening needed for the collaborative approaches set out here: for local communities and for government agencies and the related proposed certification bodies.

For care centre management committees' key capacities that will be needed include: understanding and ability to conduct regular inclusive and transparent decision making; day to day oversight of the care centre; financial management and basic accounting/book keeping skills; planning and resource mobilization; communications; problem solving; and an understanding of entitlements and processes for accessing relevant public services for infants and their families. Developing these capacities in the interests of eventual sustainability of community-based care centres should be a requirement of the implementing NGOs, to be achieved through regular sessions with the committees explaining topic by topic the concepts and their practical application and follow up and feedback to the committees. This means that the supervisory/facilitating staff themselves must be clear and capable in these skills and spend time on this with committees during their regular visits. The implementing NGOs and project as a whole should make centre management committee capacity a priority, regularly monitor a set of related sustainability indicators, and provide feedback to centres and supervisors/facilitators on capacities for further development.

For the key government agencies capacities will be needed in coordinating and overseeing care centres; in monitoring and assessing care givers and care centres (based on an understanding of their curricula and standard operating procedures, but also an understanding of the sustainability criteria for care centres); and capacities to liaise with and mobilize support from other related bodies including government services, NGOs and funding sources including the private sector. In addition, the designated members/ expected members of certification bodies for care centres and SwimSafe, would need specialist skill development, orientation and mentoring. These capacities could be developed through orientation of relevant regular government staff as well as those contracted under the project, not only at central level but also key officers in the District and Upazila ECD committees. Ways of achieving could comprise inclusion in training events, study/exchange visits, engagement in developing guidelines/manuals/standard operating procedures, and involvement in regular assessments of care centres and SwimSafe.

A lot of systems and standards, training manuals, awareness tools have already been developed by existing practitioners of ECD and drowning prevention. Notably, CIPRB, a local research agency on drowning prevention has emerged as an expert agency in injury and drowning prevention. Similarly, on ECD side there are significant players who have developed capacity from government and NGO sector and can be utilized as the resource pool for the proposed project, for example, Bangladesh ECD Network, ELCDP project of Shishu Academy, BRAC IED, Institute of Child Health and Development (ICHD) among others. Bloomberg financed Synergos has been concentrating on identifying sustainability solutions for childcare centres.

4.5 Findings Under Objective 6: Potential challenges and risks for scaling drowning prevention and ECD efforts

Achieving nationwide scale | While there is significant demand for child care services and for swimming training for children as observed from this study [objective 1], there is not yet a prepared infrastructure, personnel or resources to deliver these services at scale. Further, from current experience, it is clear that the paths toward sustainability of these services are context based, especially for child-care centres, and can best be achieved by engaging multiple stakeholders in working together around an adaptive community-based model over time, linking into existing infrastructure, institutions and resources. Achieving nationwide scale is therefore not possible through a short 3-5-year project. In order to achieve nationwide coverage, the project will need to plan for multiple phases over a 10-15-year period.

In phase 1 (this 3-year project), the core child-care centre model could be embedded in high priority geographic areas, building on existing child-care centres, and using a coordinated approach that lays the basis to test integration of additional services. Future phases could intensify and expand coverage, mobilize additional resources, and adapt the model, including for example, engaging private sector participation, or embedding a franchise mechanism for more rapid scaling. Achieving nationwide coverage for SwimSafe should be easier if aligned with and conducted in participation with the primary school system, and the support of MoPME and MoYS in building an accreditation system.

NGOs are important for scaling services through careful attention to their roles. For the child-care centre component, at the start of the project they may be involved in implementation roles to establish community-based child care centres in selected geographic areas, through a coordinated approach that engages parents and community members, and links to local government institutions and other stakeholders. Later, as community-based management associations are strengthened and able to self-manage the centre with some support, the role of NGOs may evolve toward a greater emphasis on supervision, monitoring and learning. For SwimSafe, NGOs play an important role in identifying and training cohorts of swimming trainers and helping them on the path to accreditation, nurturing links to the primary school system, and establishing a swimming training program across their upazila.

Achieving sustainability | The findings from this feasibility study and the ECD mapping and sustainability analysis (March 2019) show that achieving sustainability of results and sustainability of services will both be challenging, but achievable through a dedicated focus and long-term vision on sustainability.

Sustainability of results will demand establishing clear standards and mechanisms to monitor and assess them. Here, the project could align with work being done through the GoB and UNICEF's Early Learning for Child Development Project (Phase 3) that is supporting the operationalization of the Comprehensive Early Childhood Care and Development policy 2013, including the development of Early Learning Development Standards. The projects could together establish an accreditation system for child care centres and caregivers. For swimming training, an accreditation body could be established for swimming trainers in collaboration with MoYS, to ensure high quality training. Besides accreditation, for both components there will need to be careful attention to supervision, initially in a project mode, but gradually embedded as a sustainable function convened by BSA.

Sustainability of services will involve an increasingly integrated approach that is cost effective and lightweight and ensures that community-based services can be made continually available for future cohorts of children. Encouraging the integration of other services, for example, health personnel to use the child care centres as hubs to deliver health services to children or their parents, will contribute to greater cost effectiveness and more holistic services locally available. The ECD mapping and sustainability analysis of child care centres conducted by Synergos and the Bangladesh ECD network highlighted five critical aspects of sustainability and pointed to good practices in each of these areas already in use by several organizations. With careful attention to sustainability and monitoring progress within these aspects, child care centres may be guided toward increasing sustainability, reducing the required subsidy from the government over time. The sustainability of SwimSafe will come from successful collaboration with primary school system.

Coordinating across multiple sectors | Child development and protection from injury are complex issues, as there is no single sector or ministry through which progress may be achieved. It will undoubtedly be a challenge to ensure sustained coordination, which will be vital for quality for sustainable services. The project will need to establish clear coordination platforms at various levels, such as the expected Project Steering Committee and Project Implementation Committee at central level, and strengthening the ECD committees at district, upazila and union level. These committees will play a vital role in coordination, as well as ensure strong links to local government structures. At union level, standing committees will also be important platforms to ensure coordination. Child-care centre management associations at community level will play critical roles in ensuring coordination on the ground for effective and smooth functioning of the child care centres. Coordination for the SwimSafe component rests on collaboration with the MoPME and its primary education officers at various levels.

4.6 Findings Under Objective 7: the phases of work and "best guess" schedule for the first five-year DPP period.

The project should identify a limited geography to begin phase 1 (2020-2022) which consists initially of three years (not five years mentioned in shobuj pata), with a clear vision around sustainability and pathways for scaling beyond three years. Based on cost analysis and feasibility of startup and management for the models proposed, in this phase, the project should not aim to spread beyond 16 priority districts (25% of full scale up in 64 districts). Further, within upazilas, the project should start 800/1000 centres across a limited number of unions, consolidating efforts and links to Union Parishads and union level committees. This will allow them to draw on the support of stakeholders who are trained, oriented, and mobilized to help spread the program.

Table 29: Phase Diagram	Year 1		Year 2			Year 3	
Inception period – approval of DPP, Signing of MOUs with stakeholders; Setting up project office and recruitment of staff							
Orientation of key staff and stakeholders; Preparation of implementation guidelines; Finalization of geography; Refining work plans							
First NGO selection process							
Establishing and implementation monitoring, learning, accountability systems, reporting guidance, Learning forums							
Establishment of certification bodies							
Activation of ECD committees in collaboration with ECDLP							
NGO operationalization in round 1 areas							
Preparation of resource mobilization plans and engaging donor round table							

Second NGO selection process							
NGO operationalization in round 2 areas							
Design of phase 2							

The selection of districts and upazilas may be made considering the following criteria:

- the child deprivation/poverty index followed by UNICEF projects including ECDLP (Phase 3);
- degree of drowning risk as indicated by area of water bodies to population ratios; and
- considerations related to existence of already operational NGO initiated child-care facilities that could facilitate quick start up for the project[12].

The district and upazila selection proposed above is also likely to include strong overlap with ECDLP areas, allowing for a strong partnership on strengthening ECD committees at various levels and working together to support the operationalization of the Day-Care act. There will be some supervisory and project management benefits from having both initiatives operating in the same upazilas.

Future phases of the project over the following 10-15 years, will aim for coverage of additional districts, however, with the consideration of avoiding too sparse a scattering of care-centres and primary schools affiliated with SwimSafe.

Another important evolution in future phases of the project will be a shift in supervision systems, moving from project supervision to embedding a more sustainable infrastructure for supervision and program quality monitoring and learning.

5. Recommendations and Potentials

The following recommendations emerge from the findings of this feasibility study:

RECOMMENDATION 1 | Capitalizing on demand

Capitalize on the high demand of parents for child care and swimming training for children, to engage their support to a government program designed to reach nationwide coverage over time

There currently exists significant demand in communities for child care services and for swimming training for children [section 4.1.1]. In addition, there is evidence that communities are willing to make significant contributions, some in cash and some in kind toward the running of a community-based child care centre in their village/ ward [Table 16 and 17]. It is now possible to capitalize on this demand to begin the establishment of a government-supported integrated program for child care centres and swimming training to serve children under 5, and aged 6-10 respectively.

RECOMMENDATION 2 | Adaptive models

Build on existing proven approaches, to scale adaptive models for i) integrated community based child-care centres for children under 5 and ii) primary school-based swimming training for children aged 6-10 years

The findings of this study suggest the potential to build on existing proven approaches to develop two adaptive models: i) an integrated community-based child care centre service for children under 5, and ii)

[12] Here, the consideration would be to include areas where there is high need and little existing coverage, but to include some areas where there are a reasonable number of established care-centres to be able to be able to draw early lessons from their sustainability evolution.

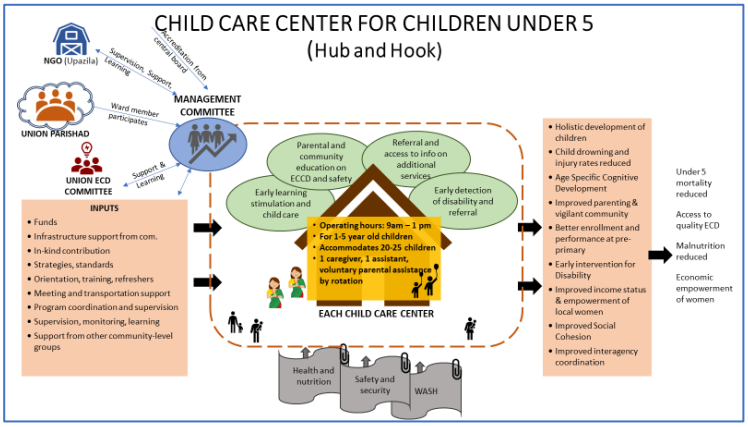
primary school-based swimming training for children aged 6-10. Recommended characteristics of these models are described in the boxes below.

The models need to be adaptive as there are no single rigidly defined models for care centres, and in Bangladesh a range of similar approaches have been developed. There remains a need for supporting and testing interpretations and innovations that may be differentially suitable to different contexts, depending on the engagement of stakeholders. In addition, the models need to allow for adaptation to encourage movement toward greater sustainability over time for a cost-effective, scalable program. Systematic learning and documentation of the process followed, and impacts/outputs achieved in different districts and by different NGOs will be required, including lesson learning forums among implementing NGOs and among caregivers, care centres, and their management committees. (see box below for description of adaptive models of two interventions). The adaptive models will help the Government of Bangladesh to fulfil many SDG and 7th Five Year Plan targets (see annex on SDG alignments).

The Emerging Community-based Integrated Child Care Centre Model

The emerging model is in in direct response to what the feasibility team found in its research on community demands and concerns, and its reading of the ECD sustainability study and existing drowning prevention studies.

At the **heart of the model is a community-based child care centre** that provides a 4-hour service each day for children under 5. The 4-hour time period comprises the morning to middle of the day, which has been identified as the period where infant mortality from drowning is highest. The centre is staffed by a female care-giver and an assistant from the community, both of whom would have completed an appropriate training program. They are supported by volunteering parents on a rotation basis. Caregivers complete a refresher training every two years, and also have support from a mentoring program that links less experienced care-givers with those with more experience, thus encouraging their professional development. The care centre provides in its normal daily timetable both structured learning activities and a general child care service. This includes early learning stimulation and childcare, parental and community education on ECCD and safety, referral and access to information on additional services, and early detection of disability and referral. The centre has the capacity to handle moderate disability. Each child's progress is monitored through individual profiles and analysis of attendance, providing annual reports and feedback to parents. The care centre has an appropriately stocked and up-to-date first aid box and the care giver and assistant have training and skills in first aid.



The care centre may or may not use the same building/ location long term. As described in this model, the **centre is an institutional entity** based on ru les, norms, cooperation, formal and informal status, and people. Thus, in the same way as a business or household, a care centre may move building according to availability, costs and demand; and it may also provide its service temporarily in other suitable locations during and

after natural hazard events. In many cases, the care centre may be established in a room of a home in the community, or existing building made available for this purpose.

Community based operation of the care centre is ensured through a **management committee** comprising of parents and other community representatives (as well as a Union Parishad representative, or equivalent). This will have an agreed membership in terms of numbers and categories of stakeholder represented, and arrangements for replacing members. Based on a set of rules and norms governing the committee functions and procedures, the committee would meet regularly and take decisions regarding operations and activities, check on the care giver's performance, liaise with parents, and oversee finances. Financial records/accounts are maintained by the committee or the caregiver, who is accountable to the committee. In addition, there are regular (at least twice per month) supervision visits to the centre from an agency or body providing expertise for this service. Parents play an active role in the management and governance of the centre through their membership in the management committee, and by attending regular parent meetings, participating in internal checks and annual open day presentations of performance. A key function of the committee is working toward increased sustainability of the centre. This also implies the maturation and formalization of the management committee as an independent community-based organization, with a bank account, reasonable governance and management structure and processes, and the ability to seek, accept and manage small grants.

Standard learning materials and recommended activities are made available to all centres, however, caregivers and parents will **modify activities to fit local culture**, engaging parents in making toys, using local stories/songs/language. Each centre has a clear procedure whereby the committee and caregiver receive and address complaints, and these are documented along with remedial actions taken to mitigate those problems/ complaints. The centre has a systematic and explicit written risk assessment (that includes risk of drowning) which is used to screen and finalize the choice of centre location when it is established. This also covers risks at the centre and the routes children and parents take to reach the centre, as well as plans and actions for coping in hazard events such as floods, cyclones and fires.

The findings from this study show once child care centres are established, they offer the possibility for **integration of services**, especially health and nutrition related services, and protection of children. These services, such as immunization, may be delivered at the child care centre by health department workers. Integration is furthered by a referral system that is well established and covers early detection and support for a range of challenges that may be diagnosed in children, for example for sight, hearing, etc. This links the care centre to services provided or certified by government; and/or to social service providers. Similarly, other services may choose to leverage the centre to reach children and their parents with additional services. The centre thus acts as a hub for early child development and protection, facilitating links and referrals to other services, and also serving as a platform on which other departments or sectors may hook their services. This kind of integration increases the cost effectiveness and holistic nature of services for children. There may be lessons on integration/ convergence to draw from the Government of India's Integrated Child Development program that uses the anganwadi centre (child care centres) to drive convergence between sectors and across different programs.

Most of the child-care centres will initially need to be funded almost entirely by the project, however, **within 4-5 years, centres may be expected to graduate covering at least 50% of their operating costs** from a range of local sources. The ECD mapping and sustainability analysis cites several examples of how local resources are being mobilized in existing initiatives. These sources may include parental contributions in the form of small token fees or equivalent contributions in kind from families that are on or below the poverty line, and higher cost covering fees from better off families. When user fees,

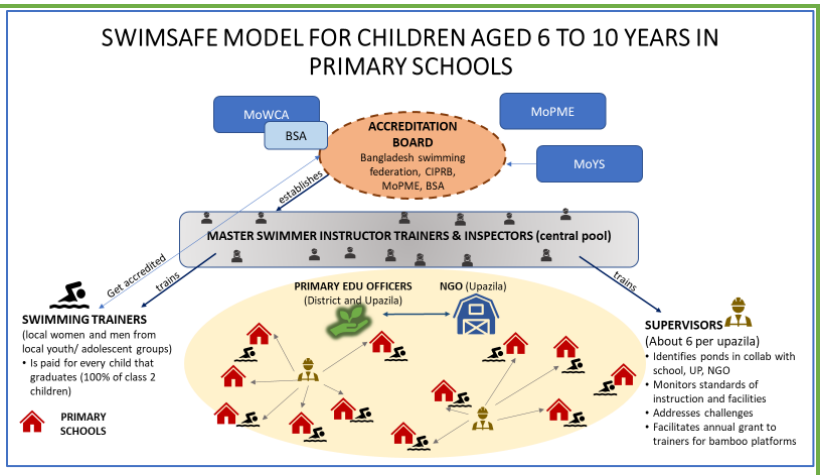
contributions of materials (for making toys or repairing the care centre facilities for example), and time spent on management meetings, making toys, and attending parent awareness sessions are all taken into account this would cover a substantial part of operating costs. In addition, the centre may receive regular contributions from local government and/or local benefactors (individuals or businesses) based on agreements such as sponsorship that last for two or more years and are not just ad hoc. Examples could include industries and businesses sponsoring children, or learning materials, or providing a building/room for the care centre.

Whether future government funding is direct to large numbers of managing committees of individual care centres or is consolidated to aggregations of care centres is an issue to be resolved in the first phase of this project. The options for consolidation comprise: associations of care centres, NGOs or private organizations overseeing or franchising multiple care centres, and Union Parishads (which would have a management stake in all care centres within their jurisdiction).

Quality control and supervision are important features of the model, and will need to evolve as the program scales. A sustainable way of ensuring quality control would be to support the operationalization of a **licensing system for child-care centres** (and care-givers) that includes periodic monitoring or assessment of centres and mechanisms for disbursing grants to qualifying "graduated" care centres. This licensing system may be part of work done to operationalize the Day Care Act, and adapted by BSA for project purpose. In phase 1, supervision will be provided through a BSA and its contracts with implementation NGOs. As the project scales and evolves, and is better linked connected to development institutions, the role of NGOs may shift, and modalities of supervision change. At this stage there may be the role for NGOs or other private organizations to play a purely monitoring, supervision, innovation and learning focused role.

Primary school-based swimming training for children aged 6-10 years

The swimming training model (SwimSafe) is most effective from age six onwards which makes it ideal to target primary school children. The NGO based approach tried in Bangladesh has been unable to link effectively with government supported schools due to the absence of a formal link to the school system, schools not having a clear mandate to teach swimming, and teachers already stretched to cover existing classes. However, as a scaled-up government program it would be logical for Bangladesh Shishu Academy to make a **formal link with the Ministry of Primary and Mass Education** (MoPME) to set up swimming classes linked eventually with every rural primary school. These would be swimming instructor based rather than facility based.



A **swimming training accreditation board** would be established comprising of relevant agencies: Bangladesh Swimming Federation, CIPRB (as representative of the International Lifesaving Federation), MoPME, BSA, etc. This body would recognize a **set of master swimming instructor trainers and inspectors**, to initially be project funded, but ultimately to be government funded. They would make use of existing manuals and training systems tried and tested by CIPRB. **Target primary schools** would be identified in the first instance, and agreements made with their headmasters/ headmistresses that they would adopt SwimSafe as an expected additional course for the benefit of their children. The master swimming trainers would then train as **swimming instructors** selected local women (and men) preferably from local youth groups (for example MOWCA adolescent groups) living in the catchment of the targeted primary schools, as well as a set of supervisors (about ten primary schools per supervisor). In parallel with a swimming instructor undertaking and completing training, and in time for her/him being certified by the board, s/he would (with project/NGO advice) identify in collaboration with the school and with local government (Union Parishad) a **suitable pond** close to the school to operate SwimSafe. The swimming instructors would receive an annual grant for bamboos and other materials and labor for constructing and then renewing their safe swimming platform (or they may receive the materials directly).

The school would identify children to enroll in SwimSafe classes – those who cannot swim to the standard of graduating from SwimSafe. The swimming instructors would be paid a fixed amount per graduating child. The target would be to maximize the number of class 1 children who graduate able to swim, and for **100% of children completing class 2 to have graduated swimming classes**.

The school headmaster/ headmistress and school board would have a day-to-day oversight role to check that swimming classes are being held and that enrolled children are attending, and to ensure follow up for children who do not attend swimming classes. The **swimming supervisors** would make periodic visits to ensure the standard of instruction and facility is maintained, and to help address any problems encountered.

Urban areas lack suitable existing ponds and the model would be adapted to **install "portable pools"**, although with the fixed costs of land and facility development for the pool, these pre-fabricated pools become in fact fixed facilities. A catchment of approximately 1,000 six-year old children (class 1) per year could be served by one urban SwimSafe pool (serving the area of several schools). In this case two instructors per pool (one female, one male) would be regular school staff. An agreement directed by the relevant ministry would be needed between primary schools served by the pool along with designation of the pool location based on available space, utility connections and access for the children of other nearby schools. It may be possible to include children attending private schools in the program, and a decision would need to be taken about whether they are counted in the catchment to receive free swimming lessons or charged a fee.

As swimming is a seasonal activity, SwimSafe operates approximately during May-October due to lack of water availability in ponds and low water temperature unsuitable for classes during the rest of the year.

Sustainability | Both sustainability of results and continuation of services will be important. **Sustainability of services** can be achieved by promoting the sustainability of care-centres accountable to strong management committees. Rather than just setting targets for NGOs in terms of care givers trained, centres established, and children enrolled, a shared vision will need to be established among implementing NGOs (and BSA and BEN) of how care centres will operate after project support ends. Assuming that the model/ approach described above is adopted by all, then **benchmarks for the sustainability of care centres** should be set for each year, so that there is a progression with a target after about 4-5 years of moving from project support to mainstream operations. At this point the result would be self-managed care centres receiving local support and direct government grants based on meeting standards and the number of children enrolled from households below an agreed poverty threshold. A baseline and **sustainability monitoring of care centres** would be established during the project, and a framework put in place that allows for documented and verifiable innovation and flexibility within the model, for different implementing NGOs, and/ or different districts and regions.

For SwimSafe, sustainability of services will depend on **successful linking to the primary school system** through MoPME infrastructure and formalizing the mandate of primary schools to train children in swimming. In phase 1, these linkages will be supported by implementing NGOs, until formal systems are in place, and the mandate for primary school role in swimming established. In this component too, during phase 1, NGOs may be encouraged to innovate around the SwimSafe business model, for example, charging fees in urban areas from students from private schools should their families wish to enroll them.

Sustainability of results I BSA and MoWCA together with BEN, Synergos and other key stakeholders will need to build a shared vision and technical capacities to establish a well-functioning and objective **licensing system for child-care centres** (and care-givers) that includes periodic monitoring or assessment of centres and mechanisms for disbursing grants to qualifying "graduated" care centres. This licensing system may be part of work done to operationalize the Day Care Act, and adapted by BSA for project purposes.

For the SwimSafe component, quality control may be established through an **accreditation system** that would need to be developed that would enable swimming trainers to be accredited. This would need to be developed in collaboration with the Ministry of Youth and Sports, and with the support of the Bangladesh Swimming Federation.

RECOMMENDATION 3 | Coordination mechanisms

Establish or invest in mechanisms that enable multi-sectoral coordination with a focus on protecting children and keeping them developmentally on track

There are coordination needs both short-term for project implementation and long-term for integrated community-based child care and for swim safe. For sustainability it is preferable to establish, support and make use of long-term coordination forums and mechanisms wherever possible for the project, while recognizing that there are also some additional project related requirements. The two main components of the project (care centres and SwimSafe) have different coordination and linkage requirements to the extent that SwimSafe will be heavily dependent on buy-in and support from Ministry of Primary and Mass Education.

The project could work with ECDLP (phase 3) to help activate the three tiers of recently formed/instructed ECD committees (Union, Upazila and District) to meet on a quarterly basis in the administrative units covered by the project. BEN and Shishu academy could nominate the implementing NGOs to these

committees for while they are in this implementation role. These committees could form the main skeleton of coordination for field-level implementation and integration for the child-care centres, especially at union and upazila levels). It would also regularize long-term recognition and cross-agency support for child care and SwimSafe. If care centre management committees form an association or forum at upazila level then membership of the Upazila ECD committee would give care centres a voice and an opportunity for seeking support and assistance from government agencies. At local level, care centres would have a link to Union Parishads and the local government infrastructure through the participation of a ward member in their management committee.

SwimSafe will have a clear, formalized link with primary schools. It is less clear what the appropriate local government arrangement for coordination of swim safe would be. However, with around 60-100 primary schools in an Upazila this component might also be best coordinated at Upazila level where there is already a Primary Education Officer posted. Since SwimSafe would fall outside the normal remit of the Upazila ECD committee it will need to be determined if it can be added to the remit of any existing committee responsible for primary education oversight, or if not then a project-specific coordination group/committee would be needed in the short term, and a recommendation taken up during the project as to the suitable longer-term Upazila oversight for SwimSafe.

RECOMMENDATION 4 | Strategic approach to nation-wide scaling

Strategically pace the scaling of interventions through multiple phases, building on existing child care and swimming training efforts in priority areas, and mobilizing and empowering key stakeholders

The project's success in reaching all 64 districts will depend on the strategic staging and roll out. The project in phase one should focus on a limited number of districts (not more than 16) prioritized based on incidence of child depravation, high concentration of waterbodies, and sharing work areas with ELCDP project for faster activation of ECD coordination committees. The project design should include a clear vision around sustainability and pathways for wider scaling beyond three years in multiple phases. As the models and resource mobilization for their sustainability evolves, there may be opportunities to speed up scaling and coverage of geography by opening a franchising option for care-centres or to set up SwimSafe.

Including NGOs and other actors who are already familiar with the approach, and well accepted in their area of operation (although they would still be required to go through a bidding process) will help save on startup costs and accelerate the scaling. It would also mean that among the care centres established at the start, there will be some existing ones that are mature enough to become ready for licensing and graduating into a sustainable mode soon.

RECOMMENDATION 5 | Cost effectiveness

Enable cost effective operations through an adaptive approach that builds on existing programming, structures, institutions, and resources

The models described above draw on the wealth of experience in Bangladesh on community-based child care, drowning prevention and ECD centres to support models that engage and mobilize the participation and resources from a range of stakeholders. The attention to sustainability is intended to drive cost effectiveness, by finding ways to reduce the subsidy provided by government to at most 50% of operational costs in 5 years. This approach helps leverage local resources (including in kind) and mobilizing increased ownership and commitment to the program from communities, local government, INGOs and NGOs, institutional donors, philanthropists and elites, and the private sector.

Further, the design of the program should avoid creating a stand-alone ground level infrastructure for MoWCA or BSA, but rather harness the participation of NGOS, accreditation bodies, local government

institutions and primary schools, ECD committees, primary education officers, and community-based organizations in various roles to operationalize and help manage a high-quality program.

As there already is an approved government and UNICEF technical project (ELCDP – 3) focused on strengthening ECD infrastructure and capacitate Bangladesh Shishu Academy (including the ECD committees at union, upazila and district levels), the two projects should collaborate to multiply impact and minimize duplication.

RECOMMENDATION 6 | Changing behaviors

Invest in behavior change communication and engagement with parents and communities to harness their participation in promoting child protection and integrated ECD and SwimSafe services

Changes in attitudes and behavior will be required at multiple levels: among parents to see the benefits of child care centres as well as being more aware of how to reduce risks to infants such as from drowning, among parents and local communities, among local government (Union Parishad), and among NGOs implementing the program so that they focus on sustainability of care centres and phasing out their support rather than just implementation and immediate deliverables. The care givers will have an important role in orienting parents, while prior to this implementing NGOs will need to promote child care, ECD and safety from injury including drowning among Union Parishads and target communities.

RECOMMENDATION 7 | Monitoring and Accountability

From the very start, build a system for monitoring, learning and accountability that clarifies and promotes attention to quality standards, key elements of sustainability, and participant feedback and accountability

Some critical elements of the project monitoring, learning and accountability would include:

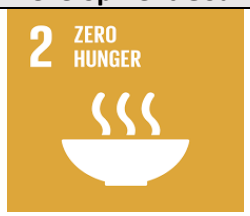
Certification and Accreditation | Setting up a database of certified/ licensed CCCs, along with assessment of key characteristics related to ELDS, drowning prevention standards and Day Care Act requirements. It may also include key learning that may be of use to others. Such a system could also track centres' journey toward sustainability, or readiness to operate independently, with support of a government grant. For SwimSafe, such a system would include information related to accreditation requirements, accredited swimming instructors and facilities for teaching swimming.

Sustainability progress | In order to incentivize and support progress toward sustainability, it will be important for the project to establish clear sustainability factors and monitor progress of centres in these areas. This will require a simple lightweight system that can be used by centres and their management committees, and that can also serve as a tool to learn about the paths to sustainability. This system may also be used to monitor the level and nature of integration of services centres are able to achieve. Such a system may also be used as a planning tool, observing progress across a union, upazila or district, and making links to other development agendas. A sustainability tool will also be useful for schools hosting SwimSafe to monitor and learn about their sustainability trajectory.

Feedback and accountability | Findings from the Feasibility Study indicated that in many cases, parents were not able to provide, or not asked for their feedback on the child care service. The design of the CCC and SwimSafe models are based on the active and regular participation of parents and other community members. A simple, lightweight system for feedback and mechanisms to respond to feedback transparently will help the engagement of community members, as well as build their ownership of the interventions.

In addition to the above features, the monitoring, learning and accountability system must accommodate regular supervision aspects and project progress. It should also enable and support learning platforms, e.g. for management committees, or care givers, to allow the design to continue to evolve and link to

other development services. Over time, the system may be used to support leadership building and mentoring activities, to continue to motivate and engage service providers and stakeholders who play critical roles in the program.

Annex 1-Sustainable Development Goal	Relevant SDG Targets and Indicators	7th FYP Targets related to SDGs
	**2.2:** By 2030**, end all forms of malnutrition, including achieving by 2025 the internationally agreed targets on stunting and wasting** in children under 5 years of age…	• Reduce proportion of stunting among under-five children from 36.1% to 25% • Reduce proportion of underweight children under five from 32.6% to 20%
	**3.2:** By 2030, **end preventable deaths of newborns and children under 5 years of age**… **3.4:** By 2030, **reduce by one third premature mortality from non-communicable diseases** through prevention and treatment and promote mental health and well-being.	• Under 5 mortality rates to be reduced from 41 to 37 per 1000 live births • Immunization, measles (percent of children under 12 months) to be increased to 100% • Integrated management of childhood illness
	**4.2:** By 2030, **ensure that all girls and boys have access to quality early childhood development, care** and pre-primary education so that they are ready for primary education. **4.a:** Build and upgrade **education facilities** that are child, disability and gender sensitive **and promote safe, non-violent, inclusive and effective learning environments** for all.	• Continuation of Pre-primary education • Increase support for inclusive education • Ensure quality development of children
	**5.4: Recognize and value unpaid care and domestic work** through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate.	• Increase access to human development opportunities • Increase protection and resilience from crisis and shocks
	**6.2:** By 2030, achieve universal and equitable **access to safe and affordable drinking water** for all. **Indicator:** *Proportion of population using safely managed drinking water services*	• Safe drinking water to be made available for all rural and urban population
	**16.9:** By 2030, **provide legal identity for all, including birth registration**.	
	**17.9:** Enhance international **support for implementing effective and targeted capacity-building**… to support national plans. **17.4: Enhance policy coherence** for sustainable development. **17.17:** Encourage and **promote effective public, public-private and civil society partnerships**, building on the experience and resource strategies of partnerships.	• Effective national policy on development cooperation to guide development cooperation in Bangladesh