Mapping of ECD Approaches and Sustainability Analysis of Community Based Child Care Centers: Summary report

March 2019
Dhaka

Authors
Professor Dr. M. Tariq Ahsan
Dr. Paul M. Thompson
M. Reza Iftekhar Patwary
Dr. Mohammad Ehsanul Kabir
Ms. Shamima Yasmin

Produced by
Drowning Prevention Partnership-Synergos
& Bangladesh ECD Network

SYNERGOS
Building trust works

Bangladesh ECD Network
বাংলাদেশ ইসিডি নেটওয়ার্ক

Introduction

Research into early childhood care and development (ECCD) has shown that the first five years of a child's life are fundamentally important for influencing and shaping the child's future learning skills, social and emotional abilities, immune system, physical growth and reducing death rates.

In Bangladesh despite major advances in reducing poverty and improving life expectancies, and substantial advances in ECCD in recent decades, there remain significant challenges for the safety, health and development of children up to five years old. Notably the mortality rate of children below five years is dominated by drowning. 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 terrifying that at least 12,000 child deaths per year are caused by drowning. Based on the Bangladesh Health and Injury Survey 2016, CIPRB (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 the majority of incidents happen in ponds (66%) and ditches (16%) near households. One factor is that both parents in poorer households often have to work in distant places leaving children unattended.

Community day care has been argued to be cost-effective and has the potential to deliver diverse ECCD benefits. However, the sustainability of these ECCD programs is uncertain. This study was commissioned by Synergos, a US-based global organization supported by Bloomberg Philanthropies, with technical support from the Bangladesh Early child development Network (BEN). The study aimed to fill this knowledge gap and inform policy regarding sustainability of care centers for ECCD and more specifically as a means to reduce drowning mortality. The study addressed three objectives:

1. Explore and document the range, types and coverage of daycare/crèche center models and delivery approaches operating (or planned) in Bangladesh for children under five.
2. Explore factors affecting and pathways to sustainability of daycare/ crèche center models to inform the work of the alliance on effective, sustainable, and potentially scalable solutions to prevent drowning among children under five.
3. Make recommendations for potential advocacy options for sustainable center-based models for child development and protection including prevention of drowning among children under five years of age.

Methods

The coverage of childcare center approaches in Bangladesh was "mapped" by reviewing secondary information and obtaining data on numbers and locations of care centers from key informants. Based on this, approaches were categorized as supported/ run by: government, international NGOs, national NGOs or the private sector. Nine cases were purposively selected for field-based investigation representing this range across a geographic spread, with a preference for rural centers. In addition, information from central program offices, but without in-depth field investigation was compiled for two cases.

The case studies investigated the operations, institutional arrangements, costs and sources of support of selected centers through interviews and focus group discussions with parents, local community leaders, care givers, and sponsoring agencies. Disaggregated costs (both cash and

imputed) and revenues (both cash and in-kind support) were analyzed. The roles of different stakeholders were assessed. Also, the functioning of care centers was determined in terms of legitimacy, organizational capacity, governance and inclusiveness, adaptive service delivery and resource mobilization.

Main stakeholders engaged to date in Early Childhood Care and Development in Bangladesh

Type of Organization		Service Providing Organizations
Government		Ministry of Primary and Mass Education, Department of Primary Education, Ministry of Women and Child Affairs, Ministry of Religious Affairs, Hindu Welfare Trust, Ministry of Chottogram Hill Tract Affairs, Chottogram Hill Tract Development Board, National Curriculum and Textbook Board, Bangladesh Shishu Academy, Ministry of Social Welfare, Institute of Child and Mother Health, National Institute of Population Research and Training, Sustainable Social Services -Chottogram Hilltracts
NGOs	International	ActionAid Bangladesh, Aga Khan Foundation, CARE Bangladesh, EDUCO, International Centre for Diarrheal Disease Research Bangladesh (ICDDRB), Plan International Bangladesh, Sesame Workshop Bangladesh, Save the Children, Terre des Hommes, World Vision Bangladesh
	National	BRAC, CARITAS, Centre for Injury Prevention and Research Bangladesh (CIPRB), Dhaka Ahsania Mission, Disable Development & Educational Foundation, Environment and Social Development Organization, Phulki, RDRS, Research Initiatives Bangladesh, SUROVI and others
Private Sector		Kindergartens; Private Day Care Centers
Religious Institutions		Not organized under centralized agencies, mainly focused on school age children but some Madrashas and Temples include pre-school
Donors		UNICEF, UK-DFID, USAID, European Union, AUSAID, World Food Programme
Academic Institutions		Institute of Education and Research, University of Dhaka, BRAC - Institute of Educational Development and University

Sources: BEN (2014), CAMPE (2013), MoPME (2013)

The Range of Child Care in Bangladesh

Diverse stakeholders including at least 12 government agencies were identified as currently or previously playing a significant role in ECCD in Bangladesh. Ten international NGOs were found to be active, but ActionAid has dropped this sector, and some of the other NGOs do not support care centers and instead focus, for example, on parenting. Hence five operate center-based approaches. Similarly, 12 national NGOs were identified as operating their own models of center-based approach. As shown below, BSA, BRAC, Caritas and Save the Children each cover 50% or more of districts. Almost all of these NGOs operate early learning centers or their equivalent, with the exceptions of ICDDRB (which terms their centers as crèches), and Phulki (which targets day care for children up to three years old).

Findings on Sustainability of Representative Approaches

The nine case study care center approaches, plus two others investigated through key informants, can be characterized as follows:

- **Plan International Bangladesh**'s community run center in Gazipur, operated by **Dhaka Ahsania Mission**, has graduated from external support and is now managed by the community using a low-cost approach.
- **BRAC**'s *Khelar Jogot* (play center) approach, which maximizes use of its existing facilities through a shift system, was represented by a peri-urban/rural center in Narsinghdi District.
- **CIPRB**'s *Anchal Centre* approach is part of its wider program to reduce drowning among children focusing on Barisal District.
- The **Phulki** urban care center approach (case study in Mirpur, Dhaka) caters to mothers working in readymade garments factories.
- **Save the Children**'s *Khelaghors* (play centers, 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 **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.
- **Department of Women Affairs** operates 22 day care centers in 20 districts. These centers are funded by departmental budget allocation, no site visit was made.
- The **PROTIVA** project of Save the Children works as a partnership with several companies to establish day care and ECCD within or linked with and operated by factories.

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
3 – Funded by Aga Khan Foundation

Financial sustainability

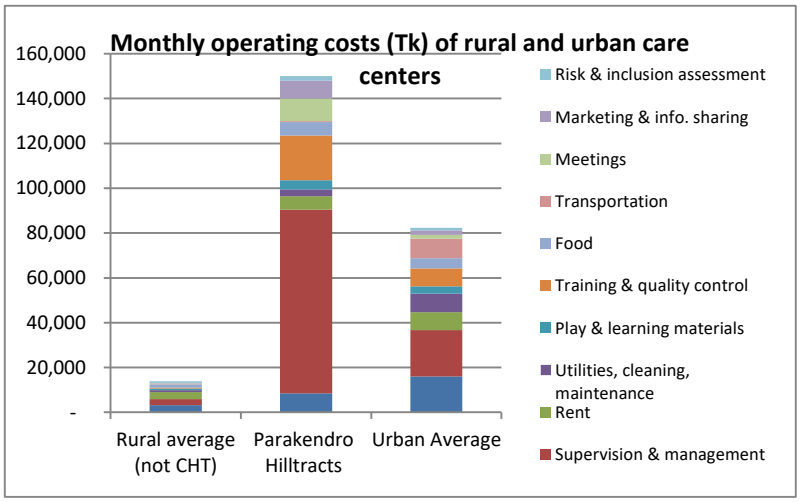
Costs considered

The study did not attempt to investigate or estimate the costs of initiating care centers, its focus was on sustainability and hence on operating costs of well-established centers. Many care centers hold limited information on their operating costs. 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 centers were estimated).
- *Rent* (value of space/building used for center 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 centers, estimated based on type of training previously provided, associated costs and assuming training is needed every two years).
- *Food* (not provided by most centers, but several parents arranged a weekly nutritious meal for children and value of this in-kind contribution was estimated)
- *Transportation* (to bring learning materials to centers for care giver, mainly in government run centers)
- *Meetings* (value of time and any refreshments for committee and parent meetings).
- *Marketing and information sharing* (parents reported actively publicizing their care centers 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).

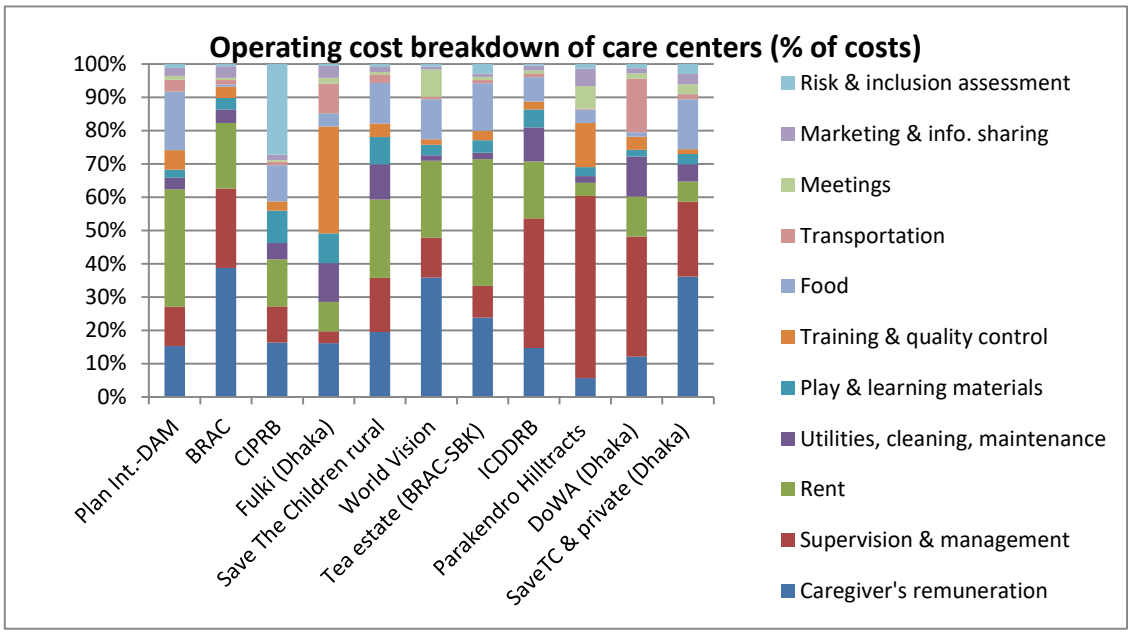
Overall costs

The care centers studied vary in the number of children enrolled (several had fewer than their apparent capacity) and operating hours. Children attend rural centers for 2-4 hours depending on the approach, whereas they attend for 9-10 hours a day in urban care centers. Standardizing costs in 2018 as Tk per child hour of care reveals that the NGO, community and private sector linked care centers 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).



Cost composition

In the high cost government –run centers, supervision and management comprised a major part of costs, due to the estimated cost of staff and ther resources at multiple tiers of administration overseeing the centers. 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 rent or buildig space was a major operating cost for some lower cost centers such as the Plan International-DAM Gazipur center. All other cost headings were generally a small percentge of total costs, although Phulki and the *parakendro* approaches had relatively high training costs.



Overall, the cost structure and level for rural care centers was quite similar. 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).

Revenue and resources

The great variation in monthly operating costs estimated for care centers is of course 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 government approaches and the community run center.

Monthly revenues, cash and estimated in-kind contributions to studied care center approaches

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

Although the Plan International-DAM Gazipur center only earns 10% of its costs from user fees, by keeping its costs low they are entirely locally supported. The parent fees contribute the major part of the caregiver's remuneration, which is further supported by cash from the host-school headmaster. This center is overwhelmingly supported by the host school (42%) for the space, playground, office and waiting areas, and associated maintenance; and parent in-kind support.

BRAC's approach covers just 7% of costs from user fees. The center is overwhelmingly dependent on BRAC and its funding sources which cover the majority (77%) of costs and inputs including professional management and quality control and space.

CIPRB's care center approach is 50% dependent on NGO and donor resources including those provided in-kind. No user fees are charged to parents, although parents and the local community contribute in kind.

The urban day care center in Mirpur, run by Phulki, receives 10% of its support through user fees. Despite in Taka terms high contributions from parents, 72% of costs in cash and kind are covered by Phulki and its donors.

Save the Children's *Khelaghor* receive support from diverse sources including user fees, government and a range of local stakeholders. Including in-kind support, parents cover 30% of operating costs, while the Ngo and its donors cover 43% of costs.

World Vision's *Shikhon* center approach is overwhelmingly funded by the NGO and its development partners (64% including in-kind) and no user fees are charged, making the facility partly dependent on in-kind contributions from the community and parents.

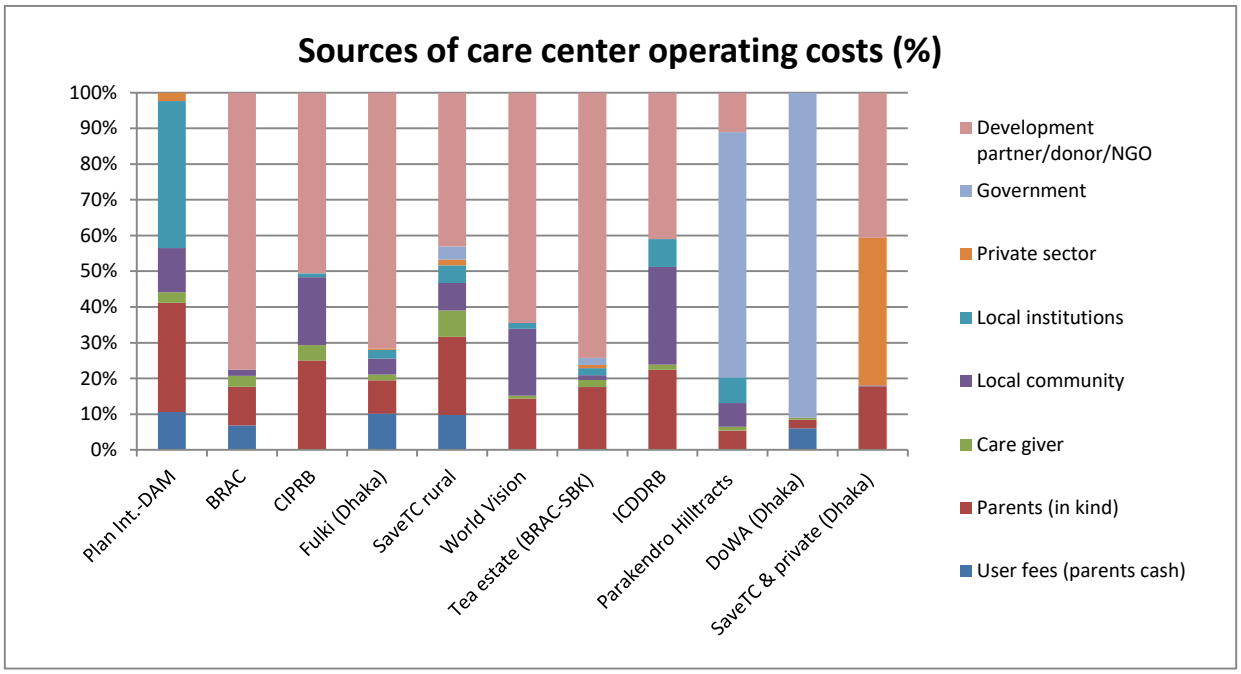
The approach run by BRAC in Srimongol's tea estates does not charge user fees and is dependent on donor funds (GoB 41%, UNICEF 33%), while parents contribute 18% of total support in-kind (food, information sharing, learning materials).

ICDDRB's *Achol Shikhon* centers also do not charge user fees (reportedly some parents could afford to pay but are used to a free service). Parents and the community, however, contribute in-kind half of the estimated costs, with the rest largely from ICDDRB and its donors.

In the Chottogram Hilltracts *parakendros* are supported overwhelmingly (68%) by government and development partners (11%). Many of the *parakendros* offer additional services (e.g. vaccination). The local community and parents provide in-kind information sharing and weekly meals which together account for 12% of estimated costs.

DoWA's urban day care centers with their high costs, which include services of a nurse, are almost entirely (91%) supported by the government.

Ready garments industries providing in-house day care under the PROTIVA partnership program of Save the Children, contribute at least 41%, possibly substantially more, of cost.



Despite generating only modest funds, user fees are an important indicator of financial sustainability for childcare-centers, and at least ought to be able to cover most of the remuneration of care givers. Only five of the care-center approaches collect user fees from parents. User fees cover 50% of caregivers' remuneration in Save the Children and DoWA centers. In the Phulki-managed urban day care, user fees meet 63% of caregiver remuneration, and in the "graduated" community run Plan International-DAM Gazipur center, user fees cover almost 70% of payments to the care giver. Most of the care-centers are heavily dependent on support from government or development agencies (NGO, donors, etc.). The exception is the Plan International-DAM Gazipur center, while Save the Children (rural), ICDDRB and the private sector initiative with Save the Children all had approximately 40% dependence on external (donor and NGO) support. In-kind contributions from parents and the local community play a key role in making many rural centers operationally and financially sustainable.

On a financial basis the approaches were categorized according to cost structure and revenue/resourcing streams and practices as:

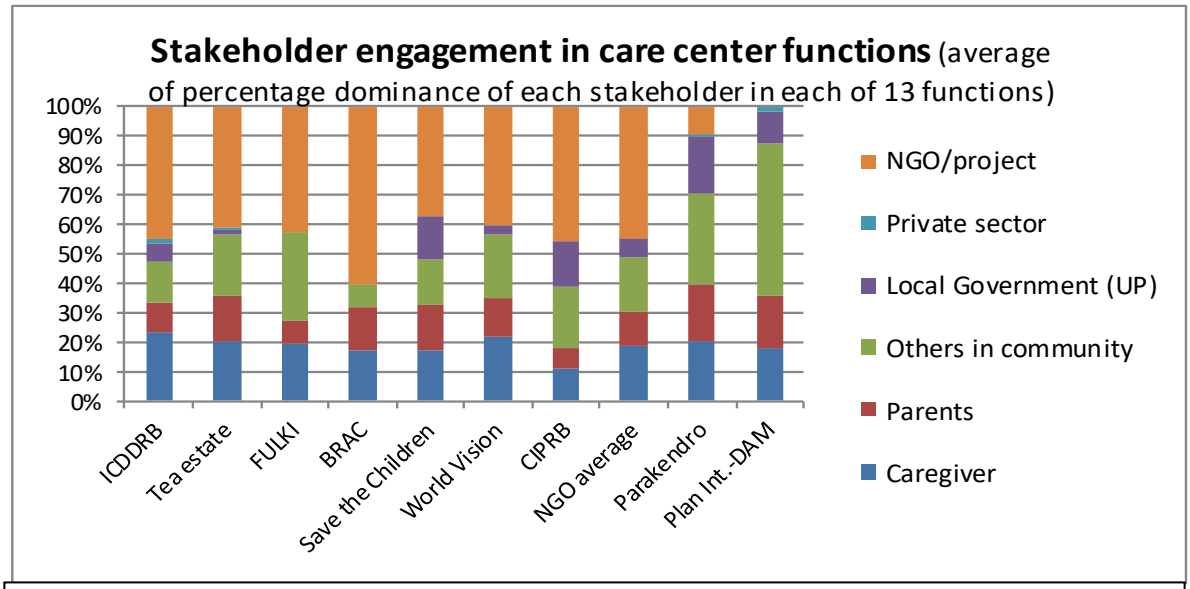
- Unsustainable (fully dependent on project/donor funding) – ICDDRB, CIPRB, tea estate, World Vision;
- Partly sustainable (collecting some fees from parents but most of operating costs dependent on project/donor sources) – BRAC, Save the Children (rural);
- Sustainable (able to cover all or most of operating costs
  a) if government funding continues – Parakendro, DoWA; and
  b) from local contributions – Plan International-DAM Gazipur, Phulki, Save the Children private partnership.

Institutional sustainability

Institutional sustainability was only assessed for the nine approaches or cases subject to detailed field investigation. The detailed case study assessments are summarized in an annex of the main report which also contains a full analysis. Two aspects were considered: the roles played by six stakeholder categories in undertaking 13 functions[1] associated with running a care center; and the performance of the center against five indicator categories.

Stakeholder roles

As might be expected the NGOs and associated projects dominated about half of functions in the NGO-led approaches. Others in the community are engaged substantively in all approaches and have taken over the NGO role in the Plan International-DAM Gazipur center. Caregivers play, of course, an important role in all approaches, but parents and local government show less engagement and active roles in center operations than might be expected.



Note: The percentage dominance of each stakeholder category was calculated for each of 13 functions (score for that stakeholder divided by sum of scores for all stakeholders' times 100, where engagement scored 2 and partial engagement (e.g. in some centers of an approach) scored 1).

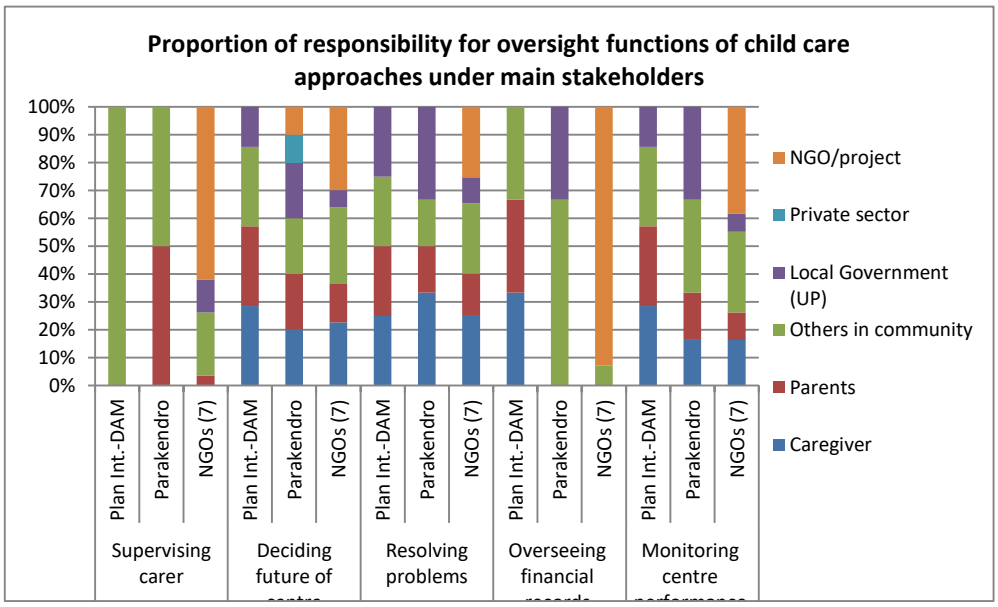
[1] Day-to-day decision making; Enrolling children; Caring for or teaching children; Training the care-giver or others running center; Supervising care-giver; Paying for costs/ donating funds; Providing building /space for center; Providing materials to support center; Providing food for children; Collecting/ generating resources for center; Deciding future of center; Resolving problems; Overseeing/ checking financial records; Monitoring center performance.

Combining the nine approaches and all functions, engagement is greatest with community members who are neither parents nor elected representatives, with 54% of potential active roles (scoring yes as 2 and partial as 1), compared with 43% of potential active roles for parents and 23% for local government - Union Parishads.

With the approaches targeting poorer working parents, their limited engagement is consistent with limited time available to care for children or to contribute to running the centers. However, local government buy in and substantive support was less than might be expected, even in the hilltract *parakendro* approach which is intended to be run by local government.

The nine approaches have together achieved at least half of the possible engagement/role with one or more of the three main stakeholders (parents, others in the community, and local government) for all but providing food to children (since most do not include meals), generating resources, and overseeing/checking financial records. The last two are notable gaps among eight of the approaches. Childcare centers are unlikely to sustain without local initiatives for generating resources in cash or kind, and the Plan International-DAM Gazipur center shows that this is possible. In just this case the caregiver and parents, as well as other local stakeholders, through their committee manage and oversee all finances and actively seek to mobilize resources.

Four approaches differ in terms of engagement and roles from the average. BRAC has a closer control of activities with little or no local contributions. Phulki is relatively more hands-off in operations but still controls bigger decisions. The *parakendro* approach is the only case where the program manager has no role in day-to-day decisions, does not supervise the caregivers (the task of the local committee), where the local government pays for costs, and where the NGO has no say in the future of the centers. Finally, the Plan International-DAM Gazipur center stands out as the one example where there is no NGO now involved in any role, with all responsibilities left in the hands of a combination of caregiver, host school headmaster and local committee, and where costs are covered by parents, the local school and the caregiver accepting reduced pay.

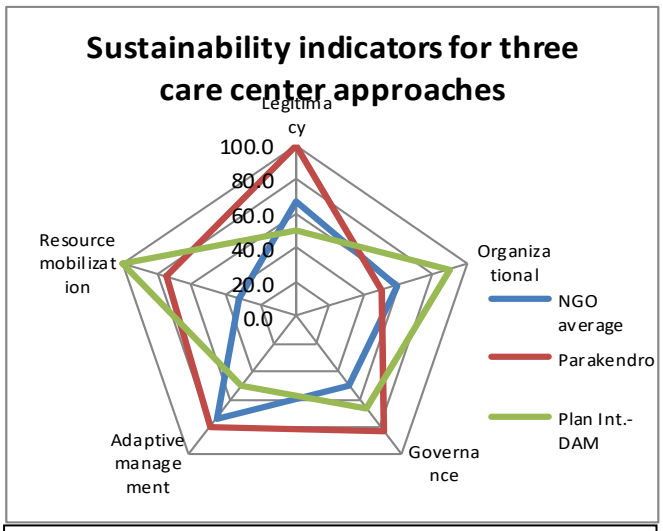


The relative engagement of different stakeholders in functions needed to run and sustain care centers need not be standardized and may evolve according to local circumstances and interests. However, for sustainability and good management there should be checks and balances and accountability which are best achieved by involving more clearly combinations of at least the three

main non-paid stakeholders (parents, others in community and local government) in the main functions needed to run and support centers, including oversight and monitoring of finances.

Sustainability indicators

Five aspects of sustainability (legitimacy, organizational functioning, governance, adaptive management and resource mobilization) were investigated.



A simple score (0, 1 or 2) was allocated based on a judgment of how each sustainability aspect was met in a way that involved local stakeholders and was less dependent on project/NGO support. To compare approaches and status with respect to sustainability themes, the total score for each theme was converted to a percentage of the maximum possible score for that theme.

Legitimacy - the role of local government (Union Parishads), the extent of formal or informal involvement of government agencies and departments, and the role of local communities including parents in centers were qualitatively assessed. In general, several approaches formalized a link with local government, and most have an active role for local communities, but the majority of center approaches (with the exception of *parakendro*) only have informal links with government agencies.

Local organizational capacity – all of the approaches have formed local committees for their respective care centers. However, there appear to be very few rules and norms for these committees. They do not have a formal status but meet once a month (except for the tea estate and *parakendro* approaches where they meet once in two months). In the Plan International-DAM Gazipur center the committee was reported to have full responsibilities for overseeing operations and decision making. In the CIPRB and in tea estates approaches the committees were reported to take major decisions such as recruiting care givers or the location of the center. However, none of the nine approaches were reported to have clear processes for selection and replacement of committee members. Unlike child records, financial records and transactions are strongly controlled by the NGOs and projects and are not kept by the centers or their committees, except in the Plan International-DAM Gazipur center.

Governance and inclusion – five cases reported an active role for parents, via meetings, in taking practical decisions on center direction or in day-to-day decisions. All the approaches reported a non-discriminatory approach to enrolling children. All reported that they would or do enroll children with moderate disabilities of different types, but several in fact have no disabled children enrolled, and all lack the capacity to support more severely disabled children. Only the tea estate and *parakendro* approaches reported referring children with disabilities to Upazila level health facilities with capacity to help those families further. However, only five out of nine approaches have regular sharing of some financial details such as expenditure and income with their center committees.

Adaptive management of risks and learning - minimizing risks to children under five is obviously a major objective of care centers. Avoiding drowning is not explicitly an aim of most approaches, but all reported reviewing risks, mainly in their choice of location. CIPRB and ICDDRB are more systematic in this. Although all care givers receive training, and some also orient parents on child safety, none of the approaches reported any certification or reward system for caregiver performance. Care givers make some form of assessment of children, but in most of the approaches feedback on children is informally given to their parents as and when the caregivers feel there is something to discuss.

Resource mobilization - Several NGO/project run approaches have attempted to mobilize non-project resources, including from parents, to sustain care centers. However, this is constrained by the low incomes of most families and perhaps also a lack of obvious significant government fund sources besides modest local council donations.

Overview of sustainability and drowning prevention

There are similarities between the cases and categorizations, and also inconsistencies as shown in the table below. The two top cases for institutional sustainability (Plan International-DAM Gazipur center and *parakendro* approaches) are also two of the three cases considered financially sustainable, even though they are at opposite ends of the unit cost range.

Although Phulki is considered financially sustainable and is among the higher-ranking approaches for resource mobilization it has low legitimacy and governance since there is no local government involvement and parents have limited involvement in operations and decision making. This urban approach for factory and domestic workers may not be appropriate to rural areas.

Centers with longer operating hours reduce the risk of child drowning, assuming that center locations and routes to the centers have equal (low) risks, but these tend to be the least institutionally sustainable cases and also (except for Phulki) are not financially sustainable. Finding cost-effective ways to extend or change rural care center operating hours to cover the full high drowning risk period is likely to be a challenge and may require some form of subsidy.

Overview of institutional sustainability, financial sustainability and potential for drowning prevention of nine care center cases

Case	Legitim-acy	Organiz-ational	Govern-ance	Adaptive manage-ment	Resource mobiliz-ation	Institutional sustainability average	Financial sustainability	Drowning prevention*
Phulki	33.3	60.0	33.3	80.0	50.0	51.3	Yes	100.0
BRAC	66.7	70.0	50.0	80.0	0.0	53.3	Part	29.0
CIPRB	83.3	50.0	50.0	90.0	0.0	54.7	No	100.0
Save the Children	66.7	60.0	50.0	80.0	25.0	56.3	Part	37.0
Tea estate	66.7	60.0	66.7	70.0	25.0	57.7	No	62.0
ICDDRB	66.7	50.0	50.0	60.0	75.0	60.3	No	100.0
World Vision	83.3	60.0	50.0	60.0	50.0	60.7	Part	37.0
Plan Int.-DAM	50.0	90.0	66.7	50.0	100.0	71.3	Yes	62.0
Parakendro	100.0	50.0	83.3	80.0	75.0	77.7	Yes (but)	62.0

Institutional sustainability average is for five columns to left as a % of potential maximum score; cases are ranked by this column.

* Percentage of the maximum drowning risk period (09.00-13.00) that children attend the respective centers, for BRAC this is averaged over the three shifts operated.

Dark green highlights the best performing cases; pale green mid performing cases (not used for five sub-components of institutional sustainability).

Issues and good practices

Integration of services notably in healthcare and education, as well as of the public and NGO service providers, could improve the effectiveness and sustainability of day care centers and efforts to reduce the drowning rate of children under 5 years old. Informal links with Union Parishads and government agencies, plus referrals of disabled children by care centers show there is scope for low cost integration rather than the high cost *parakendro* approach.

Risk management is limited in most current approaches. Developing and sharing with the center committees clear simple risk assessment and location criteria could reduce risks at care centers.

Good governance and community involvement require time to build capacity and develop. A trained pool of trainers and care givers could help sustain and scale up centers.

Horizontal **coordination** of services between departments and agencies in the field is a challenge since lines of authority are strongly hierarchical within government agencies and might be best achieved at Union Parishad level.

Cost saving has been achieved in some care centers through shift systems, but this defeats the objective of drowning prevention. Locally made learning materials will not be able to replace ones provided by projects when they wear out.

Early child development quality assurance and career/achievement recognition for caregivers could improve performance. However, none of the approaches reported any certification or reward system for caregiver performance.

Inclusion is only partly achieved at present by programs targeting the disadvantaged. Few approaches currently report referring disabled children to facilities able to provide further specialist support, none address issues such as safe travel to the center.

Good practices

A number of notable good practices were found to have been adopted or innovated in care centers investigated, those associated with the different sustainability indicators are highlighted here.

Indicator	Notable good practice
Legitimacy and linkages	
Local government	Including UP in committee
Government departments	Linking via UP with departmental support
Community	Having a management committee
Organizational	
Committee	Formalizing membership
Rules & norms	None - lack of documented clear simple procedural rules and responsibilities
Attendance records	Children recording attendance via pictures (World Vision)
Financial records	Caregiver keeps records (Plan International-DAM Gazipur)
Supervision	Daily checks (Plan International-DAM Gazipur), monthly meeting of all caregivers in a Union (ICDDRB)
Governance	
Parental role	Rotating assistance to classes (tea estate), parent meetings
Inclusion of disadvantaged/ disabled	Referring children to health centers and others for support (tea estates, *parakendro*)
Financial review	Sharing all details with committee (Plan International-DAM Gazipur)
Adaptive management	
Risk	Detailed assessment (CIPRB)
Child safety	First aid box (several), training (several)
Caregiver skills	All similar in education and training
Monitoring children	All keep notes on children and feedback to parents
Adaptation	Adapting to language/ culture, operating multiple sessions (Save the Children)
Resource mobilization	
Planning	Obtaining local government funds (*parakendro*), analyzing costs and sources of income (Plan International-DAM Gazipur)
Cost minimization	Obtaining support in kind, local donations, etc. (several)

Cases using this practice in (), where no case mentioned this was adopted by several

Information Gaps

The steps involved in the Plan International-DAM Gazipur approach, where the founding NGO and community succeeded in a graduation/ exit process, deserve to be documented and assessed.

The extra costs of operating care centers to cover the peak drowning risk period need to be investigated along with the optimal duration of center attendance per day for ECCD.

Parent valuation, willingness and ability to pay for care, ECCD and extended hours to reduce drowning risk are unclear and need investigation.

Recommendations

Overall strategy

Despite recent progress, the challenge of achieving a high coverage of appropriate childcare for both drowning prevention and ECCD in rural areas requires:

- partnerships between government, NGOs and communities;
- community engagement; and
- assurance of high quality but cost-effective services.

Purpose built centers run by government are likely to be relatively high cost and should be avoided. Government support will be more effective and give value for money if conditional subsidies and grants are provided that complement NGO and community initiatives. This will encourage cost savings and local ownership while verifying that supported centers meet criteria to be set for minimizing drowning risk and child development standards.

There is potential for private sector engagement, not only in the form of influencing and regulating private childcare to adopt good practices, but also for industries to provide childcare for their workers, and for corporate support for childcare that achieves drowning risk reduction and ECCD.

The study has not identified one "model" that can simply be replicated to deliver reduced drowning risk and enhanced child development for the 1-5 years age group. Instead we recommend that government and NGOs work together to develop community run care centers and associated parenting and drowning prevention programs. These should incorporate good practices identified here and developed over a number of years by the various projects and bodies involved in ECCD. They should be run by local committees under an enabling licensing framework and have access to services from diverse relevant public agencies. Clear benchmarks and strategies for sustainability need to be set at the outset. These would define the medium-long term expectation of parent, community, local government and central government (revenue budget) support before any investment in capacity development or construction is made.

Coordination and integration

Central high-level coordination of ECCD by Ministry of Women and Child Affairs with other agencies (Ministry of Primary and Mass Education, Ministry of Health, Ministry of Social Welfare, Ministry of Local Government and Rural Development, etc.) is in place, but effective delivery of ECCD services including drowning prevention mechanisms and commitment needs a bottom-up approach where agencies provide services that are coordinated with care centers at Union and Upazila levels. This will require decentralized:

- Development of joint action plans
- Sharing of information on services and cases along with referral systems (for example so that at an early-stage, disabilities or any other problems affecting a child's development can be identified and appropriate services provided).
- Integration and complementarity of services rather than new infrastructure – for example coordinating vaccination programs and other health care with childcare centers.

An integrated approach should make use of existing infrastructure and service provisions wherever possible, to avoid duplication and buildings that might be underused and/or drain resources for maintenance. It should as a minimum incorporate with care: early learning, health screening and monitoring, drowning prevention, referral systems for disabilities.

In addition, the feasibility of a cluster or union-based approach to community management of care centers should be tested in selected unions where there are existing care centers and NGOs/projects interested to phase out. This would assess any enhancement of stakeholder buy-in, integration, cost saving and resource mobilization for potential upscaling. For this pilot districts and within them selected focus unions should be prioritized.

Drowning prevention

The more financially sustainable centers run by NGOs tend to offer shorter-duration care. (e.g. 2-2.5 hours per day) which may ensure ECCD and/or meet demand of low-income families. However, to ensure care extends over the period 09h00-13h00 when drowning risk is highest, BEN should sensitize NGOs and projects on the importance of care centers operating for longer hours through the morning.

A mixed approach of ECCD and day care that serves these dual purposes will need to be developed. Parents may not be willing to pay the extra costs of longer hours and a matching subsidy system should be tested and developed. This could target higher drowning risk regions.

Care centers should include an outreach parenting activity that builds capacity and understanding of injury risks and how to prevent drowning. Appropriate modules and curricula should be developed and adopted.

Resourcing

Government subsidies to care centers could be made conditional on:

- partial cost sharing by parents and communities;
- operating hours that minimize drowning risk; and
- annual performance a) in meeting basic/prescribed child development targets and b) in terms of center governance and stakeholder participation.

The levels of subsidy should take into account local (region/district) differences in operating costs.

To scale up ECCD and care centers greater private sector involvement should be encouraged through a carrot and stick approach under the comprehensive ECCD Policy. This could involve regulating and enforcing compliance by industries above a specified size with establishing and operating care centers for ECCD, and in return providing / subsidizing training and learning materials. For instance, providing day care services in places where women are working (such as garments factories) should become a mandatory requirement. Policy directives regarding use of Corporate Social Responsibility funds could channel part of these funds from the private sector to supporting care centers and/or associated materials and drowning prevention training in the wider community outside of factories.

Quality assurance and monitoring

A set of best practices for care centers should be developed and promoted including simple guidelines on risk assessment and siting (that include drowning and other risks), capacity standards for caregivers, and example terms of reference, operating procedures and related guidance for management committees.

Incentives for effective care that encourage and reward quality and local initiative should be explored - possibly through private sector sponsorship of district level awards in the form of materials or other benefits for children/centers for a range of achievements.

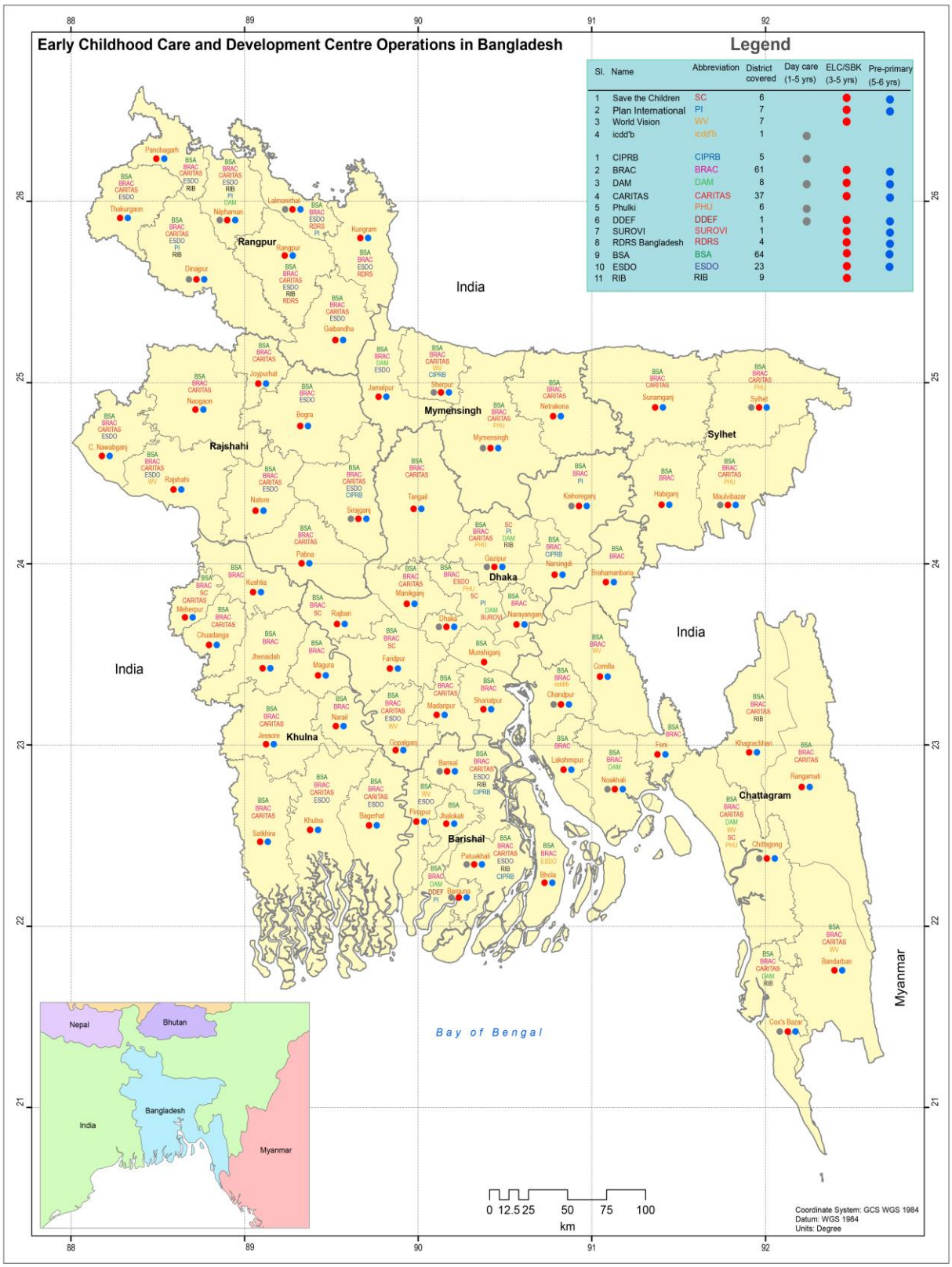
All early child development programs should be delivered within a standardized framework. This will ensure quality of the program delivered. The service packages being offered should also be monitored externally by a standardized tool to assess performance.

The majority of data on early child development initiatives is maintained by BEN. The Directorate of Primary Education collects information on children who are enrolled in pre-primary education programs. Hence, data is split at present and the emerging demand of data regarding children aged 0-5 years is dispersed. Data collection on this age group needs to be enhanced and mainstreamed by the existing government systems. For this Bangladesh Bureau of Statistics should revise data collection tools, entry software and databases and reporting through consultations with BEN so that ECCD can be effectively served and tracked in Bangladesh.

Saving costs

Use of existing public and community facilities for childcare centers should be encouraged. Often adult use of buildings is higher in the afternoon/evening, which would not conflict with operating morning care centers, or there may be underused rooms within larger buildings. Potential facilities include cyclone and disaster shelters/centers in the coastal areas, local government facilities, government health facilities, agricultural and other departmental facilities; as well as the offices/meeting rooms of community organizations. Potential parent groups and local agencies need to be encouraged to identify local facilities, and the concerned agencies will need to authorize and encourage such use and signing agreements on dual / multiple use of facilities. This will reduce start-up costs and time, increase local buy-in, and reduce long-term costs.

Mutually beneficial linkages should be promoted between care centers and services for children in the target age range through regular meetings and contacts between public and NGO/private service providers and care centers. This could enhance support to disadvantaged children and save costs for service providers.


Early Childhood Care and Development Centre Operations in Bangladesh
Legend
Sl. Name Abbreviation District covered Day care (1-5 yrs) ELC/SBK (3-5 yrs) Pre-primary (5-6 yrs)
1 Save the Children SC 6
2 Plan International PI 7
3 World Vision WV 7
4 icdd'b icddr'b 1
1 CIPRB CIPRB 5
2 BRAC BRAC 61
3 DAM DAM 8
4 CARITAS CARITAS 37
5 Phulki PHU 6
6 DDEF DDEF 1
7 SUROVI SUROVI 1
8 RDRS Bangladesh RDRS 4
9 BSA BSA 64
10 ESDO ESDO 23
11 RIB RIB 9
India
Myanmar
Rangpur
Rajshahi
Mymensingh
Sylhet
Dhaka
Khulna
Barishal
Chattagram
Bay of Bengal
Nepal
Bhutan
Bangladesh
0 12.5 25 50 75 100
km
Coordinate System: GCS WGS 1984
Datum: WGS 1984
Units: Degree

Acknowledgements

The study team thank all of the care center initiatives studied and contacted, including care givers, local committees, parents and children for their patience and help in the case studies. The guidance and support of the Synergos team, the advisory group to the study, and members of BEN are all gratefully acknowledged.

References

BEN (2014) *Directory of early childhood development organizations in Bangladesh.* Dhaka: Bangladesh Early child development Network

CAMPE (2013) *Education watch 2013: state of pre-primary education in Bangladesh.* Dhaka: Campaign for Popular Education.

CIPRB (2018) Project bhasa: Ending the drowning epidemic in Barishal division, Bangladesh. Dhaka: CIPRB.

Rahman et al. (2017) Epidemiology of drowning in Bangladesh: An update. *International Journal of Environmental Research and Public Health*, 14(5): 488.

World Health Organisation (2014) WHO global report on drowning. Geneva: WHO.