Creating a Network on Informed Parenting in Salem, Krishnagiri and Dharmapuri Districts

In 2011, Bala Mandir Research Foundation (BMRF), in partnership with UNICEF, facilitated a two-year Early Childhood Care and Development (ECCD) intervention in Salem, Dharmapuri and Krishnagiri districts of Tamil Nadu. By bringing together NGOs working in selected villages in these districts, the program was designed to build an informed network of parents, empowered with knowledge about holistic child development and positive parenting practices which focus equally on psychosocial and emotional development as they do on nutrition and health.

The intervention was carried out in two phases between 2011 and 2013 during which BMRF's primary role was to train field coordinators and NGO personnel to monitor children below the age of 6 and equip them with skills to disseminate important parenting messages to communities that lacked access to quality health care and education. The selected villages were largely inhabited by tribal or scheduled caste populations.

The project covered over 1900 children from birth to 6 years and more than 500 pregnant women across 102 villages.

Various activities such as focus group discussions, interaction with parents through Information, Education and Communication (IEC) meetings as well as monitoring and assessment of children through home visits were carried out by the local NGOs during the course of the project.

This report documents the processes, successes and challenges of the work undertaken along with data collected from the inception of the project to its final stages. It is intended for use by early childhood care practioners and community development organisations who may wish to take on similar endeavours.

TABLE OF CONTENTS

CHAPTER I: Introduction

1.1 Background

Started in 1949 by the late Sri. K. Kamaraj and Smt. S. Manjubhashini, Bala Mandir Kamraj Trust (BMKT), Chennai, is a premier social welfare organisation which has over the years sheltered thousands of orphans, destitute and socio-economically deprived children. The organisation's research and outreach wing, Bala Mandir Research Foundation, conducts various programs to take Early Childhood Care and Development (ECCD) and parenting initiatives forward to different communities and environments across India, working with NGOs, CBOs, schools, and government sectors in both urban and rural contexts.

BMRF's core philosophy is centred on the importance of parent empowerment in any ECCD program:

"All children have a right to an informed parent and All parents have a right to information about child development".

In 2011, UNICEF approached BMRF to coordinate a project to build an informed network of parents in select villages in Salem, Krishnagiri and Dharmapuri districts. BMRF's primary role was to train field coordinators and NGO staff in these districts to carry forward the project and monitor and review their work periodically.

1.2 Objectives

To orient parents of children between 0-3 years on developmental stages and parenting practices in select environments without easy access to ICDS services.

To follow up on pregnant women and children below 3 to ensure child survival & age-specific holistic development, access to services and enrolment into Anganwadis in the same areas.

In Phase I (May to December 2011), the training of field coordinators comprised knowledge on holistic child development as well as health, hygiene and nutrition practices using the Hincks-Dellcrest 'Learning Through Play Calendars' (LTPC). The training helped field coordinators to understand the use of age-appropriate stimulation techniques to ensure physical, cognitive, linguistic, and psychosocial development of the child, as well as gain information on government services. During this phase, the focus was on children from birth to 3 years as well as antenatal and prenatal maternal health care.

Following these intensive training sessions, each NGO conducted baseline surveys designed by a team of experts at BMRF and later also held focus group discussions to assess prevailing attitudes and practices on early childhood care, maternal health, etc. Each NGO then hired field level workers to implement the project activities in the community. These workers were trained by the field coordinators based on inputs they received from BMRF.

Based on the findings of the baseline survey, IEC programs were conducted in the form of street plays, songs and meetings to educate different sections of the community on parenting, maternal health, early identification of disabilities, government health services, etc. The success of the community interactions was ensured by engaging the panchayat leaders and other government officers in the meetings.

In Phase II, based on the feedback of the previous year, the number of NGOs were reduced from ten to five in order to facilitate a more intensive and concentrated intervention. The scope of the project expanded to children up to 6 years of age. It also included training on how to conduct home visits, monitor children on age-appropriate developmental milestones and engage with parents on an individual basis. This led to a defining change in parenting perceptions among the communities; most importantly the prioritisation of holistic development, particularly psychosocial well-being, right from the conception stage.

Several positive outcomes were reported by the field workers. These included increase in knowledge about early identification of children with physical and mental disabilities, awareness on psychosocial impacts of parenting practices and improvements in access to government services like Anganwadi centres and health care.

1.3 Multi-level interventions – A key to success
Health Care Services
• Orientation for SHG members, ASHA workers, and ANMs in the selected villages on the need to follow up with pregnant women and children below 3 years. • Motivation for target groups to access available services: pregnant women – antenatal and prenatal care services; parents of children below three years – registration of birth, immunisation, monitoring of weight, health, development and attendance at Anganwadi centres. • Referrals for children identified with any disability to appropriate institutions.
For the child
• Developmental child assessment based on the Child Assessment Profile (CAP) and necessary follow-up every month with individual pregnant women and parents of children aged 0-3. • Ensure the child meets age-appropriate parameters of development and accesses services.
For the pregnant woman
• Encourage breast feeding and age-appropriate nutrition and feeding practices for the child.
For the family and community
• Dissemination of age-appropriate parenting messages based on the Learning through Play Calendars (LTPC) and helping parents understand holistic child development with particular focus on psychosocial parameters, by conducting orientation camps for parents and IECs. • Enhancing parents' understanding of ECCD with an emphasis on developmental milestones, services available, and parental responsibilities for holistic growth and development. • Awareness creation in the villages on child and maternal health and well-being with a focus on building a child-friendly environment with proper sanitation, water quality, nutrition, and child protection – in convergence with other sectors of UNICEF.

Chapter II: Understanding the Context

2.1 Policy framework

The Integrated Child Development Scheme (ICDS) launched by the central government in 1975 was aimed at the provision of pre-school education through Anganwadi centres, growth monitoring, supplementary nutrition and health services to children aged 0-6 years. However, child rights advocates have been fighting for decades for a more comprehensive legislation and program which guarantees a universal right to holistic development and education for all children which goes beyond health. To a certain extent this was achieved through the enactment of the Right to Free and Compulsory Education (RTE) Act in 2010.

Going further, in 2012, the Government of India drafted the National Early Childhood Care and Education Policy which proposes "*re-structuring the Integrated Child Development Services (ICDS) scheme and integrating early childhood education with the Right to Education Act to ensure a smooth transition into formal schooling*".[i] This policy focuses on the psychosocial development of children below 6 years of age as well as school readiness while recognising the importance of Anganwadi centres and envisions them as a protective and enabling environment for children combining elements of health, nutrition and play.

It also includes programmes and provisions for children from the prenatal stage to six years of age, which cater to all domains of development i.e. physical, motor, language, cognitive, socio-emotional, and creative and aesthetic appreciation; ensuring synergy with health and nutrition aspects. Curriculum frameworks based on this have already been developed for Anganwadi centres in Tamil Nadu.

While the main focus is on ICDS, the policy also emphasises that young children are best cared for in the family environment and accordingly aims to empower families to care for and protect young children. There is also mention of inclusive and universal access which means that mechanisms for early identification of disabilities ought to be in place.

While these policies espouse holistic development, the reality on the ground is very different especially because the policy itself continues to remain in its draft stages. The main focus of most Government programs and services, including ICDS, continues to be limited to health and nutrition. Today, many Anganwadi centres in Tamil Nadu only serve as feeding centres and suffer from neglect and lack of maintenance. Teachers and helpers are over-burdened with several duties and are unable to provide quality childcare[ii]. In many southern districts in Tamil Nadu, where crucial health indicators are below the state average, there are definitely glaring short comings in existing health care delivery systems as well.

It is in this context that UNICEF entrusted Bala Mandir and its NGO partners with the implementation of this early education program, recognising positive and informed parenting as a core area of intervention missing from government programs. This is particularly important in tribal and other remote rural areas where social norms such as early marriage/child marriage, quick pregnancies and lack of reproductive rights offer very little support to young parents. Since most of the population in these areas are engaged in agricultural labour involving long hours of physically arduous work, it limits the possibility of exclusive breast feeding for the first 6 months. Practices such as branding against evil spirits, weaning at an early stage, sex selective abortions, etc. still prevail, as a result of which these groups need extra help and support.

Further, and perhaps more importantly, recent developments in neuroscience research show that the first 3 years are a crucial period for the overall emotional and physical growth of a child. Many patterns of later personal growth are set in this period. Though ICDS workers are supposed to offer support, each worker has a large area to cover especially in remote locations, and very often their skills are inadequate to guide young parents. While nutritional supplements, immunisations, etc. are of vital importance, they remain inadequate without ensuring holistic psychosocial development of the child. This is one of the important gaps that the intervention sought to address.

2.2 Choosing the sites for intervention

Known for its progressive health care and child oriented policies, Tami Nadu is one of the most developed states in India. Its overall health indicators are well above the country's average as several policies which were introduced in the 1960s continue to be in force to ensure good public

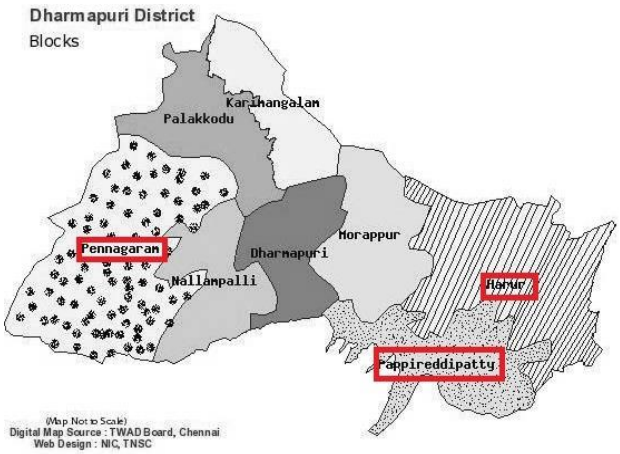
health infrastructure and coverage. In fact, Tamil Nadu was the first to begin the Nutritious Meal Programme which focused on providing protein rich food to all children in government schools and Anganwadi centres. Apart from this, medical care through primary health centres, government hospitals and health care service providers is fairly extensive.

However, the three districts chosen for this project, Salem, Dharmapuri and Krishnagiri remain relatively backward in terms of health and care of mothers and children. The Maternal Mortality Rate (MMR) in the state had come down from 120 in 2000 to 73 in 2011 but in the said three southern districts, the statistics were found to be higher than the state average.

Many villages in these districts have a significant population of Scheduled Tribes (ST) and Scheduled Castes (SC) and lack access to public health care and childcare facilities. These were also villages where government services and messages on parenting were not effectively spread and were therefore chosen as the sites for intervention.

Health indicators in project areas[iii]

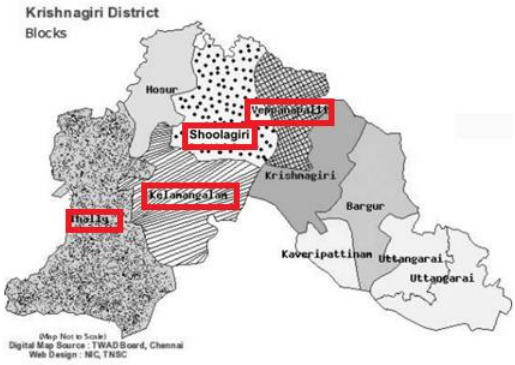
	Tamil Nadu	Salem	Dharmapuri	Krishnagiri
Infant Mortality Rate	22[1] (2011)	26.5	20.9	23.9
Maternal Mortality Rate	73 (2011)	91	79	93
Sex ratio	996 (2011)[2]	954 (2011)	946 (2011)	958 (2011)
Child sex ratio	943 (2011)	916	913	926



Dharmapuri: A third of the residents live below the poverty line. With a sex ratio of 946 women to 1000 men, it falls well below the state average. Gender gap in literacy rates is the highest among all districts. There is a high concentration of disadvantaged SC and ST populations in the blocks chosen for this project - Pappireddipatti (36 percent) and Harur (35 percent) taluks.

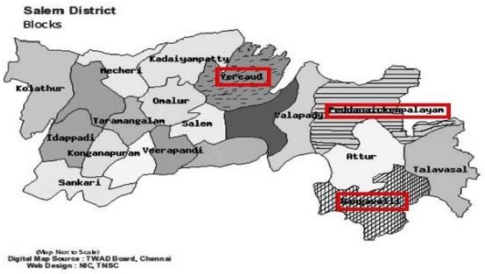
According to a State Planning Commission report in 2010, 16% of infants had a low birth weight. *"Poverty combined with illiteracy has led to poor consumption of iron rich food, worm infestation & fluorosis among adolescent girls and women. The major source of drinking water is ground water, which has large quantities of fluoride, harmful to health. About 80% of antenatal mothers are anaemic, along with multi parity, short spacing and early marriage contribute to LBW children. High prevalence of LBW contributes to IMR."*

[1] https://www.tn.gov.in/deptst/vitalstatistics.pdf
[2] https://www.tnhealth.org/dfw/notification/Apr%202015/At%20a%20glance%202014-15-final-30.3.2015.pdf



Krishnagiri: Krishnagiri is the 4th poorest district in the state and more than 50% of children (below 3 years) are malnourished. 64% of children are anaemic and a third of the children were found to have a low birth weight or were stunted. In 2012 alone 87 infant deaths and 308 still births were reported.

Salem: Salem district recorded 126 infant deaths, 446 still births and 41 maternal deaths in 2012, which places it very low on the human development index.



CHAPTER III: Defining the Parameters for Intervention

3.1 Understanding needs on the ground: Preliminary consultation

On 03 May 2011, a preliminary consultation was held in Chennai with the heads of the ten NGOs involved in this project as well as UNICEF officials. Before the meeting began, each of the participants were asked to fill out a small questionnaire to assess their knowledge about early childhood and parenting.

Mr. Vidyasagar and Ms. Aruna Rathnam (UNICEF) began the meeting by introducing the project. They raised some important points during their presentation including identification of areas where the community is receptive to change and ensuring that there is continuous feedback through constant interactions.

All organisations involved in the project have an established base in their geographical locations and were engaged in some form of community work. Each of the NGO directors gave a brief introduction to their work. Areas of work ranged from micro credit and self-help groups, to working with HIV positive women and children, family counselling and short stay homes. They also shared several challenges that were likely to be encountered during the course of the project as highlighted below -

Changing family patterns:

- Moving from joint family to nuclear family. Increasing individualisation, lack of help and cooperation.
- Migration to urban areas – in some cases only the father, in others the mother and the father move leaving the young children under the care of grandparents.

Occupation:

- Agricultural labour in the rural areas and in the case of tribal areas – food gathering, shifting cultivation, goat herding, etc.
- Girl children employed in cotton fields in Salem.
- Seasonal migration to urban areas.

Education:

- High dropout rates especially among girls who are not sent to school after puberty, or in order to take care of younger siblings.
- Dropouts from school due to illnesses, health problems, nutritional deficiencies and absence of stimulating environment.
- Absenteeism of teachers in schools in tribal and forest areas.
- Absenteeism of Anganwadi teachers
- Lack of proper information reaching Anganwadis in remote locations.

Marriage and Parenting practices:

- Early marriage, soon after girls reach puberty. In some cases, girls have 2-3 children even before they are 19 years old.
- Certain unscientific customs – branding, exorcising, unhygienic feeding practices and seclusion.
- Lack of emergency facilities in the primary health centres; home births still prevalent.
- Lack of informed knowledge on the importance of antenatal care and positive practices with regard to nutrition and health care.
- High rates of infant mortality, child mortality and maternal mortality.

Socio-economic situation:

- Gender discrimination.
- Exploitative environment for children, especially girls, in their growing years.
- Lack of awareness on early detection of disability and prevention methods.
- Lack of full employment.

Inaccessibility of government medical and education facilities was a key issue in many of the villages because of hilly and forest terrain. Lack of regular transport facilities and social isolation due to caste discrimination were also key factors in determining who could access Anganwadi centres.

The discussion led to a consensus on criteria for choosing the villages where the intervention will take place. Two of the following three criteria needed to be fulfilled -

1. ***Serving a tribal area***
2. ***Significant scheduled caste or most backward caste population***
3. ***Community has no/little access to Government services***

The most important task for the NGO was to identify able field workers who would be able to carry on the interactions with the community. The number of field workers was based on the target sample population i.e. pregnant women and parents of children below 3 years of age, and it was ensured that field workers' homes must be accessible for routine and periodic outreach. It was agreed that each field staff would follow up on 10-12 members of the target group in a remote location and/or about 15-20 members in an accessible area. One coordinator would be designated to supervise 4 field staff.

The NGO staff were consulted on which parenting messages to emphasise. Many felt that there may be a need to start with traditional practices which are not detrimental and gradually work towards bringing about an openness to receive information, express curiosity, and accept changes relating to parental readiness, welcoming the baby irrespective of gender, early detection and early intervention for prevention of disabilities, infant stimulation and care of the mother and child. Parents must be encouraged to adapt practices in child rearing and exhibit sensitivity to the needs of the child. The NGO staff noted that building rapport with the community would require coordination with community leaders, SHG leaders and Anganwadi staff.

After the meeting, Ms. Saulina Arnold (Tamil Nadu Voluntary Health Association - TNVHA) presented detailed terms of reference for the project. Her presentation laid out the tasks at various levels and

specified the periodic deliverables. Post lunch, participants were divided district-wise into three groups and asked to discuss the details of the project and presented a tentative budget following which the meeting was concluded.

3.2 Field visits

Between 23-28 May 2011, a team comprising of Ms. Maya Gaitonde (BMRF), Ms. Saulina Arnold (TNVHA) and Ms. Jaya Krishnaswamy (Madhuram Narayanan Centre for Exceptional Children - MNC) visited villages in 10 blocks across the three districts where the work was proposed to be carried out. The main objectives of their visit were to –

- Train field level workers on the Baseline Survey Format, helping them fill in the format in a simulated situation; clarifying any points raised by them, and noting inputs for any changes needed to be made in the format.
- Discuss the surveys conducted by the respective NGOs in identifying the pregnant women and parents of children below 3 in each village and finalising the number of villages to be taken up by each NGO for the project.
- Interact with people in the villages selected for the intervention.

The field visits were designed to give the team a sense of the needs of villages which were worse off and which were better. It enabled them to better understand the ground realities and led to several changes being made in the type of training provided subsequently, particularly to suit the rural community whose concerns were different from those in urban settings.

Target District	Name of the Block	Name of NGO	Villages visited
Salem	Peddanaickenpalayam	OBWWUO	Kireyamalai Chinna Moolapaadi
	Gangavalli	SSSS	Gangavalli
	Yercaud	DEEPAM	Kolagur Karadiyur
Dharmapuri	Pennagaram	DEEPS	Kerllipatty
	Pennagaram	IRDO	2 Villages
	Pappireddipatty	AWARD	Aawarangkaattur
	Harur	CRDS	Kulempatti Boothinatham
Krishnagiri	Thally	RDC	Laksmipuram Choodan Chathiram
	Kelamangalam	ARCOD	Irulapatti
	Shoolagiri	SWCD	Upparathammanarapalli
	Veppanapalli	SWORD	Shikaripuram

A summary of observations:

- Main occupation: Seasonal agricultural work or daily wages. In case of tribal areas, livelihoods were linked to the forest and in some cases, men and women migrated to Karnataka and Kerala as unskilled labour. Self-help groups run by the NGOs helped to supplement incomes in some cases.
- Family pattern: The norm was a traditional joint-family set up with an average of 3 children.
- Housing and basic amenities: In tribal areas, the government has built houses under the Indira Awaz Yojana scheme. Water and electricity were easily available. However, many of the places did not have *pucca* roads and were difficult to access.

- Access to and quality of Anganwadi Centre (AWC) services: In one village, Keerilipatti in Dharmapuri district, there was no AWC. In two instances, caste was seen as the major reason for children not being sent to the AWC. In one case, it was reported that an upper caste teacher neglected the ST children and in the other instance, since the AWC was located in the upper caste area, many of the SC children did not go there. In cases where Anganwadi Centres did exist and were within a 2 km radius, they were still difficult to access due to the scattered nature of the houses and hilly terrain. Moreover, many complained about the poor quality of functioning. For example, in Pappirediipetty, the AWC was functioning merely as a feeding centre in order to provide the mid-day meals to children. The worker was not aware of proper childcare practices. This combined with frequent absenteeism or late coming of the workers acted as a deterrent for parents to send their children there.

- Schooling: While awareness of the need for primary schooling was high, perceptions of its low quality caused many parents to look towards private schools for their children, despite much higher costs. Another incentive was that private schools provided transport for children. It was also quite rare for children to continue to higher studies because they were required to travel much further to reach a high school. Schools in tribal areas also tended to be of a poorer quality due to lack of infrastructure and frequent absenteeism of teachers.

- Poor connectivity: Many villages did not have enough buses and very bad hilly roads, causing children and pregnant women to have to walk at least two hours to reach school and health facilities.

- Health: While the place of delivery was usually hospitals, there were many home deliveries in cases where PHCs were inaccessible due to distance or not preferred because of the attitude of staff. Autos were sometimes available to go to the PHC or the villagers took the pregnant mother on motor bike. Breast feeding was commonly practiced. Both breastfed infants and pregnant mothers looked healthy except for a few cases where mothers look emaciated. Tubectomy was the preferred choice for sterilisation and usually after the third child. Immunisation schedules were followed wherever there were interactions with Auxilary Nurses and Midwives (ANM). Practices during pregnancy not identifiable except for *"poochootal"*.

- Political awareness: Communities, and particularly the elders in rural areas were well aware of the government schemes and politics in general. However, there was a sense of cynicism about pushing the government to provide better services and lack of efficiency was often blamed on a particular individual rather than being seen as a systemic problem.

- Gender dynamics: Drop-out rates in all areas were very high among girls. Very few girls completed schooling as they were forced to drop out after attaining puberty or in some cases due to illnesses or health problems due to nutritional deficiencies. They were usually entrusted with care of younger siblings or in some cases even pushed into early marriage. This was seen particularly in tribal areas where the typical marriage age was between 14-16 years.

3.3 Assessing Knowledge, Attitudes and Practices (KAP) – Survey Findings

Orientations on conducting baseline surveys were given during each field visit by Ms. Saulina Arnold. The survey known as the KAP questionnaire contains 25 questions to assess Knowledge, Attitude and Practice of stakeholders in the project regarding prenatal and antenatal care as well as parenting and child development. After an introduction, the staff and volunteers were asked to work in pairs,

one interviewing the other using the questionnaire and vice-versa. Each of the questions was explained and different categories of interviewees were discussed i.es Dais, Anganwadi teachers (AWWs), adolescent girls and boys, and mothers and fathers. Assessments of interviewing skills and knowledge of the field workers were also done.

Ms. Jaya Krishnaswamy fielded discussions and clarifications on different questions followed with appropriate interventions. Almost all directors and co-ordinators, and sometimes even the office staff, participated in the exercise. It was explained that the results will help to tailor the training and intervention and focus on the themes for special activity.

Based on the training provided, the KAP questionnaire was administered to community members in each of the target areas in the three districts. During June 2011, this covered Dais, AWWs, panchayat leaders, unmarried adolescent girls, married adolescent girls with no children, adolescent boys, pregnant women, mothers and father of children below 3 years of age, and self-help group members. A total of 5,264 respondents' answers were analysed to provide information on the prevailing situation and knowledge among various sections of the community.

3.3.1 Profile of respondents

S. No.	Target	District / NGO			Total
		Dharmapuri	Salem	Krishnagiri	
1.	Dais	76	53	74	**203**
2.	Anganwadi Workers (AWW)	86	53	53	**192**
3.	Panchayat Members	38	35	46	**119**
4.	Pregnant Women	198	131	19	**348**
5.	Adolescent Boys & Girls	578	403	556	**1537**
6.	Parents with Child below 3 years	427	274	355	**1056**
7.	Women SHG members.	391	272	377	**1040**
8.	Men	186	130	283	**599**
	Total	**1980**	**1351**	**1933**	**5264**

Literacy

Education	District		
	Dharmapuri	Salem	Krishnagiri
UG or Diploma	9%	6%	3%
High School	16%	14%	8%
Standard 6 – 10	34%	46%	31%
Primary (up to Standard 5)	8%	14%	10%
Unlettered	33%	20 %	48%

The levels of illiteracy were higher among DAIs (60%) in all three blocks surveyed. In Yercaud block, many adolescent girls (20% among those who are unmarried and 25% among those who are married) were also found to be unlettered. Among adolescent boys, there was less than 5% illiteracy in all three blocks. More than 50% of adolescent boys completed school up to the 10th Standard.

In Krishnagiri, Thalli block had high levels of illiteracy among all sections of the community while Kelamangalam was better off. The number of adolescent girls who were unlettered was double that

of other blocks at almost 40%. A third of the AWWs and DAIs were also found to be unlettered. Most of the men in Kelamangalam, Veppanapalli and Shoolagiri had dropped out between Standard 6 – 10.

About a third of the respondents in Dharmapuri have never attended school. Pennagaram block has the highest percentage (37%) of unlettered population. 10% of AWWs in Harur and Pennagaram blocks were found to have no formal education. Among women, 47% married adolescent women in Pappireddypatti and 57% in Pennagaram were found to be unlettered while the levels were lower for adolescent women who were unmarried at 20% on an average. One fifth of the adolescent boys were found to be unlettered..

The below sub-sections provide a summary of key points including variations between the districts.

3.3.2 Readiness for marriage and child-bearing

In this section there were several questions to assess the prevailing practices and attitudes regarding marriage and child-bearing. It is vital for communities to look at not only age but also the physical and mental health of a woman in order to ensure preparedness for pregnancy and child-rearing responsibilities.

Marriage age**:** In all 3 districts, 19-21 years was believed to be the ideal age for marriage.

- It is important to note that of the total number of respondents, 23% of married women without children, 17% of pregnant women and 8% of women with children below 3 years of age were between the ages of 15-20 years, confirming that 19-21 was the most preferred age for marriage and that marriage even before 19 years of age was prevalent.
- The fact that 15% of respondents in Krishnagiri district felt that 15-18 years was also acceptable confirmed that traditional practices of early marriage still exist. This figure was especially high in Thally block with almost a quarter of the respondents believing that 15-18 years was the ideal age for marriage. The participants also said during the FGDs that they believed that early marriage was a better option in order to ensure safety and to avoid a social stigma in case a girl elopes. Krishnagiri had the highest percentage of married women in the 15-20 years age group of almost 30%.
- In some parts of Salem district there seemed to be some understanding on the need for a later marriage age. Women were able to cite their own experiences as examples and complained of ill-health when they married and gave birth to children early. Peddanaickenpalayam was the exception with about 11% of respondents believing in early marriage. Service providers in Salem believed 22-25 years to be the ideal age of pregnancy when compared to the other two districts.
- Harur and Pennagaram blocks in Dharmapuri district had about 10% of respondents who said 15-18 years was an acceptable marriage age.

Factors to be considered for marriage/pregnancy readiness**:** In all 3 districts health and weight of a woman was generally cited as the most important factor for pregnancy readiness, with more than 50% on average citing these as the most important criteria.

- In Thally and Veppanapalli blocks in Krishnagiri district, both tribal areas, 40% of the respondents believed that age was a higher priority than the woman's health. In Pappireddipatti block in Dharmapuri district, less than a third of the respondents considered health to be an important factor.
- Among the adolescents in all 3 districts, there seemed to less awareness of the above factors – Service providers were able to name more factors compared to the adolescents, men and women.
- District-wise comparisons of the service providers showed that those from Salem were more aware of the key factors to be considered for pregnancy readiness.
- Other than health factors, issues such as financial planning and stability did not figure in any significant way in the responses.

One glaring observation was that there was very little control over child-bearing. As many of the women pointed out during discussions, delay in bearing a child after marriage would lead to conflict or desertion of the girl. This was also the case when it came to the time-gap between pregnancies. The most common practice was to have a tubectomy after 2-3 children.

3.3.3 Pre-Natal care

This section included questions on awareness of registration of pregnancy, medical services, planning for pregnancy, etc. With low health indicators in all 3 districts, prenatal care practices are vital to the survival and development of the child and mother.

Registration: The usual practice in most places was to register pregnancy in the third month at the AWC with a few exceptions. In Thally – Krishnagiri (25%), Harur – Dharmapuri (55%), and Yercaud – Salem (50%) of respondents said that they would register in the fifth month.

Tests and scans: Overall, there was considerably good knowledge about the need for particular tests and scans during pregnancy.

- Krishnagiri faired the poorest with a third of respondents claiming no knowledge of what tests needed to be done to confirm pregnancy and almost 25% of the respondents believed that scans during pregnancy are not important. This was particularly true in the case of Kelamangalam area where almost 44% of total respondents and 80% of adolescents did not know of needed tests or scans.
- 45% of service providers and 40% of adolescents in Pennagaram, Dharmapuri did not know about pregnancy testing.
- Among those who knew about the tests, more than 80% of respondents on average cited blood and urine tests with few being aware of monitoring blood pressure, sugar, etc.
- Most of the respondents in all 3 districts believed that scans were primarily meant to check the position of the baby. Overall, less than 50% of respondents in Salem and 20% in Dharmapuri cited identification of disability as one of the reasons for testing.
- Gangavalli block in Salem was the exception with almost 62% of respondents saying that scans were an important part of early screening for disability.

Health care services**:** Counselling at PHCs and other health care services for pregnant women were provided in most villages. Most of the respondents said that counselling was meant to provide advice on nutrition, iron and folic acid tablets, health during pregnancy, institutional delivery, etc.

- In Shoolagiri block, Krishnagiri district, almost 50% of pregnant women did not receive counselling. The same trend was noticed in Kelamangalam block in the same district.
- Respondents in Harur and Pennagaram in Dharmapuri district also said fewer women, 63% and 75% respectively, received counselling.
- Many adolescents felt that counselling regarding HIV was important during pregnancy.

Knowledge about pregnancy and delivery: Identifying danger signs during pregnancy is vital to preventing infant and maternal mortality. The most widely regarded signs were swelling of feet, bleeding and anemia.

- 40% of respondents in Krishnagiri were not aware of danger signs during pregnancy. Among them service providers like DAIs and AWWs also claimed they had little or no knowledge about when a pregnant woman needs to seek medical attention. In Dharmapuri, a little more than 10% of respondents (mostly adolescent boys and girls) in Shoolagiri and Kelamangalam blocks did not know about these signs.
- In Salem district, there were relatively less numbers who did not know about this, except in Peddaniackenpalyam and Yercaud with about 18% and 8% of respondents respectively.

- One fifth of respondents in Krishnagiri did not know what precautions should be taken during pregnancy. In Salem, particularly in the Peddanickenpalayam area, only 32% of respondents felt that heavy lifting should be avoided and 20% said that the woman must avoid strenuous work. There was also relatively poor awareness among adolescents (22% among adolescent boys and 16% among girls) in Pennagaram, Dharmapuri.
- Sex during pregnancy was also a fairly contentious issue. Many of the respondents felt that it could lead to abortions or HIV (particularly in Salem). However almost half of the respondents in Krishnagiri district and less than one third of the respondents in Salem did not have proper information. In Dharmapuri too, very few people answered the question; almost 50% in the Pappireddipatty area said they did not know.
- Only about 40% of respondents cited contractions as a sign for delivery; most people cited pain in the back and water breaking. In Krishnagiri, about 35% in Shoolagiri, 20% in Thally and 35% in Kelamangalam area did not know of delivery signs.
- Clothes for the mother and baby and logistics were cited as the most important items for preparedness before delivery. Only in Salem, about 90% of respondents said that the choice of hospital was important. In Dharmapuri, only about 50-60% said that the choice of hospital was important.
- While basic medical services for pregnant women were in place, most people believed that prenatal care was important only for a healthy baby or to prevent abortions. Very few considered factors such as a peaceful environment or the emotional well-being of a mother to have direct consequences for the child.

3.3.4 Ante-Natal care

Sound antenatal care practices are not only vital in curbing infant mortality rates but also serve as a foundation for development of the child. Nutrition, feeding and care at this stage is vital.

Breastfeeding practices**:** Overall, breastfeeding practices were good. A little over half of the respondents said that the child should be breastfed in the first half hour after birth. The FGDs showed awareness of colostrum and its importance for building immunity. In some cases, particularly in Pennagaram, Dharmapuri, there were some doubts raised about colostrum causing diarrhoea for the infant. The facilitators explained that this was not true. There were also discussions on the ideal position to be maintained during breastfeeding.

- A third of the respondents in Krishnagiri did not know when the first feeding should be given. This was also reflected in the FGDs where some women said that a mother is usually allowed to feed the child only 3 days after birth (mostly isolated cases in some tribal areas).
- In Peddanickenpalayam in Salem, a significant number said that the baby should be breastfed one hour as opposed to half hour after birth. This was also true for 25% of respondents in Harur and 41% of respondents in Pappireddypatti in Dharmapuri district.

Screening at birth: One of the most common indicators of good health soon after delivery is the cry of the child. However, movement, skin colour, weight, etc., are also equally important.

- Crying and breathing were cited as the most important things to be checked immediately after childbirth, followed by movement and weight.
- About 40% of respondents in Salem district also said signs of disability must be checked at birth. However, in Gangavalli area, almost 50% did not know what needs to be looked at. This was also the case for 25% of respondents in Thally and 39% of respondents in Kelamangalam in Krishnagiri.
- Responses to the minimum birth weight of the baby were varied. While 60% of those in Salem believed that it should be 3.5 kg, a third of respondents in other districts believed that it was 2.5 kg. The most common solution for low birth weight baby was incubation, followed by breastfeeding and wrapping the baby.

- 20% and 30% of respondents in Krishnagiri and Dharmapuri respectively were not aware about vaccines that need to be given during the child's first 3 months (17% in Pappireddipatty, 31% in Harur and 19% in Pennagaram). The most commonly known vaccines were Polio and DPT. In Krishnagiri – SWCD, RDC and ARCORD – more than one third of the respondents did not know about vaccines.

Feeding practices: It is ideal for the baby to be given supplementary food only after 6 months. However, a third of the respondents in Krishnagiri and Dharmapuri and 40% of respondents in Salem believed supplementary food could be given in first 3 months. In Salem, an equal number said that it was safe to give supplementary food after 6 months, while many men felt that food can even be given at 3-6 months.

3.3.5 Parenting and childcare

This section attempted to assess prevailing attitudes about parenting and to understand parenting priorities of different sections of the community.

Monitoring growth: More than a third of respondents in Krishnagiri district were unable to provide any inputs on how to monitor the development and growth of children. More than 90% of respondents in Salem and Dharmapuri said that weight and physical changes were the most important indicators of growth. One fifth of respondents in Peddanickenpalayam, Salem, almost 50% of respondents in Thally and Kelamangalam in Krishnagiri, and less than 10% in Harur and Pappireddypatthy in Dharmapuri said they did not know how to monitor the growth of the child. In general, there were more men and adolescents who did not have accurate information on growth and development.

Identifying development delays: While more than 80% of respondents across all 3 districts believed in the need to identify development delays, about 15% in Krishnagiri did not believe that early identification of disability was possible. The only exceptions within the districts were Peddanickanpalayam in Salem (35%) and Pennagaram in Dharmapuri (25%).

Brain development: In all 3 districts, more than 30% of respondents believed that the brain begins to develop only after birth. Of this, 15% of respondents in Krishnangiri and Dharmapuri and 20% in Salem believed that brain development begins only after 1 year or after the child begins school. In Krishnagiri district, a larger number of DAIs and AWWs said that they did not know when brain development begins.

Communication: Roughly a third of respondents believed that a child could understand and respond to communication after 1 year. In Salem, almost half of the respondents (48%) gave this answer. In Krishnagiri district, almost 30% of respondents did not know when communication begins to develop. During the FGDs many women felt that talking to a newborn would not be of any use as they would not understand. More emphasis was placed on showing affection by cuddling and hugging the baby to promote love and attachment to the mother as well as to provide the baby with a sense of security.

During the FGDs, participants were asked how they would communicate. Most of them felt that common words of endearment are important during infancy but did not think talking to the child had any impact. Non-verbal communication was seen as more effective. Cuddling and fondling the child were seen as important ways for the baby to recognise and bond with the parents. The facilitator also talked of other benefits such as giving the baby a sense of security and confidence.

Role of the father: A majority of respondents felt that expressing love and care for the child was important – more than 80% in Salem and Dharmapuri, and 63% in Krishnagiri. Very few people felt

that the father provided opportunities to learn. Most respondents said that it was very rare for mothers and fathers to take equal responsibility in child-rearing, with many expressing frustration in this regard. The father's role was essentially still seen as a provider and protector of the family whose responsibilities are to earn money and fulfil material needs. In tribal areas like Kelamangalam in Dharmapuri, women participants said that men were simply not expected to participate in child rearing and that they would spend most of their time in the fields.

Parenting priorities: About 80% of respondents in all 3 districts believed that love and care, protection, health and hygiene were the top parenting priorities. Talking to the child as well as play and stimulation were not prioritised by most. Only about one fifth of the respondents in each of the districts cited these as priorities. The trends were more or less the same across each of the blocks in the 3 districts.

Gender discrimination: Gender discrimination between children was a sensitive topic. Among the 3 districts, the number of respondents who admitted to exhibiting different parenting styles for girls and boys was highest in Dharmapuri at 8%. While the surveys reveal that a large majority do not believe that such discrimination exists, the FGDs shed light on unequal division of labour between the sexes. Girls were expected to help with household chores, look after siblings and in some cases were also denied the same quality of education as boys. These particularly came to light during the FGDs when parents were asked about the ideal qualities of a girl child and a boy child. For a girl child responses included assistance in household chores (draw *rangoli* at the doorstep, fetch water, etc.); identification with the mother (imitates acts such as washing vessels, etc.); indoor play; independent in managing themselves; respectful and unassuming; calm and dependable; express interest in singing, dancing and cycling while for a boy it was exploring play materials, especially miniature models of automobiles; hyperactive and mischievous; questioning nature; interest in drawing; identification with father; keen on playing outdoors and contribution in doing petty jobs for the household. Traditional gender roles are thus reinforced at such a young age that they are not really articulated as "discrimination" by most people.

Holistic Development: In Salem district, the majority of respondents felt that factors such as physical growth and psychosocial development are important for the holistic development of the child. This was true for 80% of respondents across all 3 blocks. Physical growth was the main factor for 72% of respondents in Dharmapuri district and 42% in Krishnagiri. In all 3 blocks in Krishnagiri district, very few people could answer questions regarding holistic growth. Language, cognitive development and self-esteem were all given a lower priority.
During the discussions, parents were asked what they felt hindered holistic development of their child. In all 3 districts, parents felt that it was environmental factors, especially television which adversely influenced behaviour, and financial resources which prevented them from sending children to good schools. Emphasis was on discipline, good manners and health.

Handling behaviour: 82% of the participants in Dharmapuri district admitted that they would use corporal punishment if the child threw a tantrum. In some cases, parents did report that this had adverse consequences like the child shouting back at the mother, or if old enough, going out of the house. About 60% in Dharmapuri admitted to buying gifts for their child to stop a tantrum, even though they knew it wasn't the right thing to do. It was felt that academic achievements can be rewarded with material gifts.

3.3.6 State services

These refer to the public health services available specifically for maternal health and childcare, such as free medical services at the PHCs and other government hospitals, health and nutritional counselling, free iron and folic acid tablets, immunisations for pregnant women and children and the

Dr. Muthulakshmi Reddy Maternity Benefit Scheme which provides pregnant women Rs. 12000 in instalments. In general, there was fairly high awareness about all these services in Salem and Dharmapuri. More than three fourths of the respondents in both districts knew about free health services and the maternity benefit scheme. Salem was better off in terms of knowledge about health education, availability of free iron and folic acid tablets, with the exception of Peddanaickenpalayam where on average only 30-40% of respondents knew of these services. Krishanagiri once again revealed low indicators with only around 30-35% of respondents claiming to have knowledge about free health and nutritional services. Thally block was worse off with only 20-30% of respondents claiming knowledge of these services.

3.4 Focus Group Discussions

To supplement the findings of the KAP survey, Focus Group Discussions (FGDs) were conducted in each block. These provided more detailed insights into beliefs and attitudes in the villages regarding prenatal and antenatal care, and particularly parenting practices which were not necessarily captured in the close-ended survey. A total of 1,143 people participated in 76 FGDs in the 3 districts. These discussions also served as a unique opportunity for field workers to interact with community members and have important conversations and disseminate accurate information. The key points post analysis of the responses in the various categories are highlighted below.

3.4.1 Pregnancy, prenatal care and breastfeeding

Pennagaram	• In general, there was a high level of awareness about parental readiness, prenatal care practices and the importance of breastfeeding. However, almost a third of the respondents thought that supplementary food could be given from as early as 3 months. • On aspects of brain development and communication, only about half of the respondents believed that brain development begins at conception. Similarly, most respondent believed that communicating with the child should only start after birth.
Thalli	• Most respondents considered the appropriate age for childbirth to be between 18 to 22 years. It was garnered that the appropriate age was not based on physical, emotional or financial factors but rather the belief that a girl had to give birth to a child soon after she gets married. • Very few respondents said that there should be a gap after marriage and childbirth. Social expectations and norms were cited as the main justifications for having a baby immediately after marriage. • More than half (51%) of the sample population knew that care during pregnancy was important, but only a few could offer any reasons why. Overall the level of awareness in this regard was moderate. Knowledge and clarity with respect to the risks involved in neglect during pregnancy was low. • Regarding brain development and communicating with the child, most respondents felt that both begin only after birth with responses ranging from 1 month to 1 year.
Kelamangalam	• On marital readiness, responses ranged from 14 years at one extreme to 30 years at the other extreme. The median age group was 18-20 years with only 2% outliers at

	14 and 30 years. • There was widespread agreement across the groups about the importance of prenatal care, but the rationale behind this could not be sufficiently explained. About 63% of respondents pointed to prevention of delivery complications and 18% mentioned that prenatal care ensures the health of the mother and child in general. • The multitude of responses on brain development varied between 2 months to 7 years of age, revealing a clear lack of knowledge on this issue. • Responses to when to start supplementary foods varied between 2 months to 1 year. The maximum number of responses (30%) showed in favour of starting supplementary foods at 6-7 months.
Gengavalli	• There was less diversity in responses to the ideal child-bearing age. While responses varied from 18 to 25 years, about 74% of respondents thought 21-25 to be the ideal age range as women attained reasonable emotional maturity by then. • Almost all the groups had a similar number of reasons for the importance of antenatal care. • Almost all the groups thought that brain development starts at conception, and that 25% of the new-born's brain was already developed at birth with full growth by 3 years of age facilitated by experiential learning through the individual's environment. • Discussions on when to start communicating with the baby evoked few responses (at birth; four, five or six months after birth) and did not reflect adequate understanding. • Knowledge about breast feeding was good; while responses varied from 3 months to 10 months (when there is reduced secretion of breast milk), over half the groups surveyed felt that supplementary foods should be started 6 months after birth.

3.4.2 Parenting role

Pennagaram	• More than half of the respondents felt that fathers do not play an equal role in child rearing even if given an opportunity to do so. Their contribution was limited to fulfilling the material needs of the children, such as buying clothes, play materials, food and other things that the child demands. Less than a third of respondents said that both parents take equal part in child care. • Most women admitted to some differentiation in their parenting styles for boys and girls, mainly in terms of division of work at home from a young age. They also said that in some cases girls got less in terms of play materials, food and new clothes. While boys were sent to convent schools and expected to pursue higher studies, girls were usually sent to government schools.

Thalli	• Only about 14 percent of respondents said that fathers played an equal role in child rearing. Many women noted with frustration "He eats and leaves, where does he look after the child"? About 15% of respondents strongly felt that the mother's role alone was essential in child rearing. • More than a quarter of respondents felt that cuddling and fondling builds attachment and gives the child a sense of security. • A significant majority (about 60%) said that they did not differentiate between girls and boys though about 12% gave contradictory statements. While declaring that they bring up girl children as they do boys, they also admitted that girl children were given either less or no share in the maternal property. Most of them justified equal upbringing with the statement "it is we who gave birth to both". • About 10% of the respondents admitted that differentiation existed. This manifested in terms of clear lines of demarcation between men's and women's work, better higher education opportunities for boys, prioritising boys' needs over girls', greater share of household chores for girls and boys being better fed than girls.
Kelamangalam	• About 20% of respondents felt that cuddling and fondling helped the child to approach parents with ease and enhanced feelings of joy in the child. But a small number also felt that it would lead to spoiling the child and excessive demands. • Over half of the mothers surveyed (57%) said that their husbands did not play any role in child rearing, with a prominent segment (29%) justifying the same saying that child rearing was the mothers' duty as they were the ones who gave birth to the children. • A sizeable majority (77%) said that they did not discriminate between their sons and daughters.
Gengavalli	• Many of the groups felt that cuddling and fondling enabled a sense of security and acceptance in the child, created feelings of joy, facilitated personality development and communication. They also felt that other close family members should also show affection in similar ways to reinforce bonding with the baby. • Emotional distress, detachment from parents, dullness, stress and feelings of inadequacy were considered to be some of the consequences of not cuddling and fondling the child. • There were mixed opinions on the role of fathers, with some replying that the fathers played an equal role in child-rearing and some others saying that their contribution was minimal. Many felt that men could not involve themselves to a great extent as they spent most of the day at work. • About 33% of the groups admitted that differentiation prevailed in some form or the other, while the rest said that there was no gender discrimination. It was widely felt that differentiation or confining girl children within conventional boundaries resulted in poor self-esteem.

3.4.3 Handling behaviour

Pennagaram	• There was total agreement across the groups on why tantrums occur – it was invariably due to unfulfilled demands for food/snacks and play materials. • An overwhelming majority of respondents said that they beat the child during tantrums, which usually resulted in the child walking out of the house. While there was some awareness on the negative consequences of hitting the child, the practice still continued. • Most of the parents also said that they don't keep giving children material things as it would lead to repeated demands for more things.
Thalli	• Perceptions of bad behaviour and the various reasons for this were the inability to gauge what is right and what is wrong (7%); feelings of frustration when interrupted by parents during play (8%); mischievousness (6%) and demand for things that other children possess. • About 20% of the women beat their children to control tantrums, but about half of them also pacified their children by buying small gifts/snacks. About 21% of them considered patient reasoning with the child to be the appropriate method for correcting bad behaviour.
Kelamangalam	• Perceptions of bad behaviour and the various reasons for this were the inability to gauge what is right and what is wrong (7%); feelings of frustration when interrupted by parents during play (8%); mischievousness (6%) and demand for things that other children possess. • About 20% of the women beat their children to control tantrums, but about half of them also pacified their children by buying small gifts/snacks. About 21% of them considered patient reasoning with the child to be the appropriate method for correcting bad behaviour. • A majority of about 70% of respondents felt that anger and frightening children would instigate weeping, feelings of fear, dislike and disaffection from parents, and frequent spells of leaving home. • About 24% of women observed that gifts brought feelings of joy to children, and that they loved to show the gifts to other children in the neighbourhood. However, about 11% of the participants contradicted this statement by saying that it made the children more demanding with repeated requests for more gifts. • About 26% of members placed more emphasis on the spending capacity of parents. They firmly said that they do not entertain children's unreasonable demands for expensive gifts that were not within their financial means. About 8% of them confessed that they handled such demands by beating the children. About 17% of members upheld that they never buy gifts for their children.
Gengavalli	• Hitting other children, repeated indulgence in undesirable activities (such as playing in the mud, etc.), petty acts of mischief and disobedience, adamant demands for material needs were considered bad behaviour among respondents.

	• Methods suggested by the groups to discipline children included gentle handling and patient explanation, inculcating good habits in the child, keeping them occupied, expressing appreciation for their petty pranks and correcting them in their own course, and refraining from treating them with harsh forms of punishment. • The groups pointed out both the positive and negative effects of gifts, ranging from feelings of joy, enthusiasm, self-confidence, encouragement and inspiration to repeated demands for more gifts, stubborn behaviour and lethargy respectively.

3.4.4. Parental aspirations

Pennagaram	• Notions about ideal boy and girl traits led to a division of roles. Male children were expected to work in the fields whereas girls contributed towards household chores and looked after the younger siblings. • Nearly all the members were of the same opinion regarding the role of parents in developing their children into 'ideal' individuals. These were – expressing love and affection towards the children, fulfilling their needs to the extent possible, providing good education standards, and inspiring good discipline and moral standards. • Invariably, fathers were expected to instil a sense of security in the child, provide schooling and fulfil material needs of the child and family. • Those who mentioned environmental influences (52%) as a major constraint in the making of an "ideal" child said that television was considered the main source of undesirable influence.
Thalli	• The behaviour, skills and qualities of an ideal child as mentioned by the respondents were – a studious child who helps in household chores (3%), generally good behaviour (2%), good habits if taught by parents (6%), hyperactive and playful (7%), and eats and sleeps well (2%). About 4% of them said that children of 6 years accompanied parents to the hillside to get trained in tasks related to their occupation. • The selected women in Thali block did not show enough awareness on individual parental roles in the shaping of an "ideal" child. There is no mention about influencing the personality of the child which is crucial for holistic development. • The various opinions of the focus group members were – providing good food for the child (11%), giving daily bath (4%), providing proper clothes (2%), sending the children to school (7%), teach them good habits (10%), fulfilling their material requirements (2%), etc.
Kelamangalam	• The general impression from respondents was that an "ideal" child of 6 years of age would study well and be obedient. Boys would be playful as well as responsible whereas girl children would contribute more in helping mothers with household chores. • It was generally perceived that women played a primary role in upbringing while

	fathers need to care for the child only in the absence of the mother and fulfil the material needs of the family. • Major emphasis was on feeding the child well and teaching moral standards.
Gengavalli	• According to the various groups, the behaviour, qualities and skills of an "ideal" girl child of 6 years of age were – notable assistance in household chores (interest and insistence to draw *rangolis* at the doorstep, fetch water, etc.); identification with mother (imitates acts such as washing vessels, etc.); indoor play; independent in managing themselves; respectful and unassuming; calm and dependable; expresses curiosity to explore singing, dancing and cycling; stubborn at times; rapid physical growth. • The behaviour, qualities and skills of a "typical" boy child of 6 years of age were listed as – hitting and pinching other children; enthusiastic about exploring play materials, especially miniature models of automobiles; hyperactive and mischievous; questioning nature; interest in drawing; courteous; adamant and engaging in forbidden behaviour; identification with father; keen on playing outdoors; contribution in doing petty jobs for the household (buying milk, grocery items, etc); slower physical development than girls.

Chapter IV: Tools for Intervention

Insights from the findings of the KAP survey led to the teams realising the importance of visual tools to impart parenting messages, particularly for with parents who are unlettered or have low levels of literacy. At various levels of the projects i.e. training, home visits and community outreach, BMRF and its team of experts used the following tools.

- Learning Through Play Calendars (LTPC) – Birth to 3 Years, and 3 to 6 Years:

Developed by the Hincks-Dellcrest Centre, Toronto, these pictorial "calendars" depict the successive stages of child development, along with brief descriptions of simple play activities that show parents what they can do to promote healthy child development. They focus on five key areas of development; Sense of Self, Physical, Relationships, Understanding the world, and Communication (SPRUC) They emphasise the importance of positive parent – child relationships, as critical to a child's sense of well-being. This was the core tool used in the training of field staff and coordinators to impart knowledge on child development.

- 'Joy of Parenting' Guide Book:

The accompanying 'Joy of Parenting' Guide Book developed by BMRF addresses parents and those in a parenting role. The Guide Book helps to explain, in detail, the 'calendar' pictures, and LTP messages. It also elaborates on the concept of 'holistic development', through the questions 'WHAT' children do, 'WHY' they do it, and 'HOW' parents can ensure, and facilitate further development. It also adds stage-wise information regarding health, hygiene, nutrition, and safety, as well as addressing parenting concerns on issues such as school readiness, communicating with children, behaviour management, different competencies, and learning difficulties. The book was used to equip field workers with more detailed information to facilitate interactions with parents.

- Flash Cards:

The Learning Through Play Calendar (LTPC) visuals have been artistically indigenised into a set of 112 vibrant and colour-coded flash cards. The cards highlight key milestones, behaviours and activities for successive stages of child development from birth to six. The purely visual cards, with no text, encourage open-ended, and thought-provoking discussions on varied aspects of child development and can be used during community outreach and training programs. During the project, flash cards on antenatal care and prenatal care were also developed and field tested.

- Indigenised Learning Through Play Calendar – Birth to 3 Years:

An indigenised adaptation of the Learning Through Play Calendar – Birth to 3 Years developed by BMRF was used to facilitate interactions between field workers and parents. The book provided locally contextualised and stage-wise pictures for each of the domains – SPRUC, making it easy for parents of all levels of literacy to grasp important milestones and concepts.

- Parenting Songs CD:

The CD has 26 parenting songs in Tamil which cover various stages of the child's growth and what the parent must do to stimulate holistic development. The songs also cover a range of issues including well-being of pregnant women, celebration of pregnancy, feeding practices, health and hygiene and child rights.

PHASE I: Piloting the Interventions

During the first phase of the project, emphasis was on establishing contact with the community through the focus group discussions and surveys. Trainings were conducted for coordinators of all 10 NGOs involved across the 3 districts. Contact was limited to parents of children below 3 years of age.

Target District	Name of the Block	Name of NGO	Villages	Pregnant Women	Children	Beneficiaries	Co-ord.	Field Contacts
Krishnagiri	Thally	RDC	10	37	195	232	6	24
	Kelamangalam	ARCOD	20	45	123	168	3	15
	Shoolagiri	SWCD	3	22	80	102	2	9
	Veppanapalli	SWORD	6	45	377	422	4	16
Dharmapuri	Pennagaram	DEEPS	14	34	81	114	3	10
	Pennagaram	IRDO	5	20	109	129	3	11
	Harur	CRDS	14	40	198	215	5	18
Salem	Peddanaickenpalayam	OBWWUO	6	69	122	168	3	14
	Gangavalli	SSSS	12	127	367	494	10	42
	Yercaud	DEEPAM	12	69	325	394	10	40
TOTALS			**102**	**508**	**1600**	**2438**	**49**	**199**

Chapter V: Training and Capacity Building

Training on ECCD for Field Coordinators (13-15 September 2011), Chennai

The first 3-day training was held on 13-15 September 2011 for 31 field coordinators from the 10 partner NGOs on basic concepts of parenting and ECCE. The range of topics included:

- Child development and SPRUC
- Importance of positive parenting, life cycle approach
- Brain development
- Learning Through Play Calendars
- Early identification of disabilities
- Health, nutrition, antenatal and prenatal care

Training of Field Contacts (October-November 2011)
Following the first 3-day training, a team from BMRF comprising Ms. Maya Gaitonde, Ms. Saulina Arnold and Ms. Jaya Krishnaswamy visited each of the organisations in the 3 districts. This gave the team an opportunity to meet with the field contacts who would carry out the community level work.

District	Date	NGO
Dharmapuri	31 October 2011	DEEPS, CRDS, IRDO
Salem	1 November 2011	SSSS and OBWWUO
	2 November 2011	DEEPAM (Yercaud)
Krishnagiri	5 November 2011	SWORD, SWCD
	6 November 2011	ARCOD, RDC (Royakottah)

The following points were discussed with field staff and coordinators during each meeting:

- Highlighting important aspects of and need for the project;
- Introduction to the parenting project as seen by the NGO;
- Self-introduction by participants, focusing on identifying their 'Parenting role';
- Administrative issues and training - Directors and Coordinators with Ms. Maya Gaitonde to discuss the objectives and scope of the project, role of coordinators and the plan of action;
- Training on KAP survey and baseline information booklet - Field contacts with Ms. Saulina Arnold / Ms. Jaya Krishnaswamy.

ECCD Training and Review Meeting (28-30 November 2011), Chennai
The second 3-day training for 45 field staff was held more than 2 months after the preliminary training. During the break, the field staff began their work on the ground, including collection of baseline information of a few families and 1 IEC activity.
This training included a thorough review process comprising:

- Sharing of findings from the analysis of the Knowledge-Attitude-Practice survey;
- Feedback from the IECs; and
- Sharing of successes and challenges by field staff.

This was followed by a more detailed training on the Learning Through Play Calendars – Birth to 3 and 3 to 6 Years), Indigenised LTPC and modules on health and nutrition, all of which pertain to the home visiting baseline information booklet**.**

The NGO coordinators were invited for a review meeting to take stock of their understanding of the objectives and expectations from the project. A detailed analysis of the baseline information was also provided during this meeting and Ms. Saulina Arnold explained what the focus should be for each of the stakeholders based on the findings. This would define how the IECs will be conducted. Ms. Lakshmi Gopal also provided detailed feedback on the training reports submitted by the NGOs. The final session included practical inputs on addressing possible challenges and obstacles like breaking gender stereotypes, superstitions and ritualistic beliefs. Ms. Maya Gaitonde emphasised the need to handle these with sensitivity.

Chapter VI: Collection of Baseline Data - Children & Families

During Phase I, field contacts visited the children's homes and interacted with parents to collect basic demographic details, covering a total of 775 children below the age of 3. The district and block-wise break up is given below:
Kelamangalam and Thally, Krishnagiri District – 353
Gangavalli, Salem District – 319
Pennagaram, Dharmapuri District – 103

6.1. Demographic details of parents

Age: More than 75% of the mothers in the survey were in the age group of 20-30 years. About 21% of mothers were below 20 years of age in Kelamangalam and a small percentage of mothers in Gangavalli were above 40 years. The majority of fathers were also in the age group of 20-30 years and 30-40 years. Only around 1% of fathers in Kelamangalam were less than 20 years old.

Caste and Religion: Scheduled Tribes (ST) formed the majority in Kelamangalam and Thally in Krishnagiri district. In Gangavalli, Salem district, almost half of the group surveyed belonged to Scheduled Castes (SC), while in Pennagaram, almost 60% belonged to the Most Backward Caste category. In terms of religion, an overwhelming majority in all districts were Hindu while around 10% of respondents in Gangavalli block were Christians.

Literacy: Salem district fared better in terms of literacy with only 18.2% of mothers found to be illiterate compared to 70% in Thally and Kelamangalam. In terms of primary education however, all blocks had between 20 to 30% of mothers who had studied up to Standard 10. There were a negligible number in the 4 blocks who completed graduation. Literacy rates among fathers were lowest in Krishnagiri district with more than three fourths of the respondents being unlettered. Only about 10% of fathers Gengavalli, Salem district, were graduates.

Occupation: In all the 4 blocks most of the women were employed as daily wage workers with the highest numbers of working women found in Thally (61%) and Kelamangalam (55%) in Krishnagiri district. Some of the mothers in Pennagaram and Gengavalli were engaged in agriculture.
Most of the fathers were also employed as daily wage workers followed by a smaller percentage who were engaged in agricultural work. In Pennagaram, around a third of the fathers were engaged in semi-skilled occupations and around 12% of them in Gengavalli were in skilled occupations. With the exception of Thally, there were a few fathers in all the other 3 blocks who were not employed.

Income: Kelamangalam and Thally blocks were found to be most economically backward with 86.7 % & 83.7% of families respectively earning less that Rs. 3000 per month. Family income seemed to be significantly higher in Gengavalli with 42% earning between Rs. 3000 to Rs. 5000. Income higher than Rs. 8000 was not commonly seen in all the 4 blocks. Families largely received help in the form of respite care and physical help rather than financial help from their relatives.

Size of family: Around 50 to 60% of families had 1 – 2 children. Only in Krishnagiri district, in both Kelamanagalam and Thally, around 12% of families had more than 3 children**.** Around 40% of families in Thally reported that 1 or 2 of their children had died.
There were more boys than girls in the 0-3 age group and this difference was greatest in Thally. Girls slightly outnumbered the boys in the 3-6 age group. Grandparents and other relatives were living with more than 70% families in all the 4 blocks.

In Gangavalli and Thally, more than 90% of parents said that both parents were involved in parenting. In the other 2 blocks, child rearing responsibilities were primarily taken care of by the mother.

6.2 Access to services and infrastructure

Health education: Almost 91% of mothers in Gengavalli and 89% of mothers in Thally said that they had received health education. However, both mothers and fathers in Pennagaram and Kelamangalam had not been adequately exposed to health education with only a quarter of mothers responding that they had received health education.

Nutrition: Gangavalli in Salem district fared the best in terms of provision of nutrition for mothers and children by the AWC with 57% and 72% coverage respectively. In the other 3 blocks, supply of nutritious powder for mothers was found to be inadequate.

Water and housing: Tap water was the most used form of drinking water supply in all 4 blocks. In Gangavalli and Pennagaram more than 75% of the respondents used tap water. In Kelamangal and Pennagaram, more than 20% of the houses were reported as unclean and needing attention. In Thally and Gengavalli majority of the houses were reported to be clean.
There was a major difference seen in the type of dwelling. In the Gengavalli & Thally blocks 53.3% and 67% of families respectively lived in concrete housing while 94% of the families in Kelamangalam said they lived in neither thatched nor concrete houses.

6.3. Information on children

Delivery: 95% of the children had a normal gestational period in all the 4 blocks. There was an observable difference in the place of delivery, with 59.12% home deliveries and 39.78% hospital deliveries in Kelamanglam whereas in Thally there were more hospital deliveries (49%) than home deliveries (46.51%). Unlike these 2 blocks, in Pennagaram (88.23%) and Gengavalli (97.18%), hospital delivery was the overwhelming norm.
Normal delivery was reported for the majority of children in Kelamangalam (93.37%); in Thally it was 83.12%; in Pennagaram it was 66.67% and in Gengavalli it was 65.52%. Around 22% of deliveries in Pennagaram used forceps and around the same number in Gangavalli were caesarian deliveries.

Condition of the child during birth: The birth weight of the children ranged from 1.3kg to 4.5kg with an average weight of about 2.63kg to 2.75kg in the 4 blocks. Only a very small percentage of children had records on the head circumference and length of the baby at birth. About 5% of parents in Gengavalli were able to provide this information and less than 1% in Thally and Pennagaram.
More than 89% of the babies were reported to be healthy and had a normal birth cry. Some of the children from Kelamangalam and Gengavalli had problems with sucking at birth. However, there was very limited data available on sucking at birth in Gangavalli.

Problems faced by the mother and child: The most common complications faced by the mothers in all the 4 blocks were swelling in the feet (13% to 34%) followed by bleeding, anemia, blood pressure and white discharge. Jaundice was seen in all the 3 blocks except Thally. Seizures were reported among 7.84% of mothers in Pennagaram and about 1% in Thally and Gengavalli.
93.42% of mothers in Gengavalli and 71.43% in Thally reported that they took allopathic medicines prescribed by doctors while 60% of mothers in Kelamangalam relied more on traditional medicines. In Thally, more than a quarter of mothers used traditional medicines. Only very few mothers had problems like bleeding, breathing problems, blood pressure and stomachaches after delivery. None of the mothers from Kelamangalam reported any of these problems.
Not many problems were also noticed in the children after birth. Pennagaram reported the largest number of problems (4.9%) with almost 4% of children being reported as underweight. Children

from Kelamangalam did not have problems of cold, fever or dysentery (reported in Pennagaram alone), fits & upper lip damage (reported in Gengavalli alone), breathlessness (in Thally alone) or being underweight (in Thally & Pennagaram). Physical disability was noted in 1 or 2 cases in Thally & Kelamangalam and chronic health problems were found only in Thally. There were no reports of mental or sensory disabilities in these children. In more than 50% of the cases, children were treated in public health centers in Kelamangalam and Thally blocks. Some of them also had treatments at GH. Getting treatment from private doctors was seen in very few cases in all the blocks except in Pennagaram.

6.4. Health services provided

Immunisation: More than 75% of the children in Pennagaram had received BCG, DPT and OPV. In Gengavalli, around 60% of children received DPT and OPV and about 56% had received BCG. Less than 20% of children in Kelamangalm had been immunised. In Thally, children had been partially covered. Around 35% of the children from Pennagaram and Gengavalli had received measles shots while in Kelamangalam and Thally it was about 10% and 14% respectively. The highest coverage for MMR was in Gangavalli where it was around 19%. In all the other blocks children had not received MMR.

Micronutrients: Only a few mothers received iron supplements earlier than six months in all the 4 blocks. In Kelamangalam more than half of the respondents had received iron supplements during the 6^{th} month. The number was marginally lower in the other three blocks. It was also found that more than 40% of respondents' children received Vitamin A supplements during the 6th month in Kelamangalam, Thally and Pennagaram while most of the children in Gangavalli (48%) received this only during the 18^{th} month.

About 44% of the mothers in Thally and 37% in Kelamangalam were given nutritious powder compared to a much lower percentage (19% and 22%) in Pennagaram and Gengavalli.

Growth monitoring: Each child's growth, as monitored by measuring the weight, height and head circumference, should be recorded in the child's individual growth card. In Pennagaram, around 46% of the respondents said they had a growth card for their children and of which a third said that growth monitoring was done regularly. In other blocks only around a fifth of the respondents said that growth cards were available.

Among the 3 growth parameters, weight was the most commonly known or recorded. In Pennagaram, data regarding weight of almost 55% of children was collected. However, in Thally, information about the weight of only about 8% of the children could be obtained, and there were no records of weight monitoring.

Height and head circumference details were not recorded in Kelamangalam and Gengavalli, and in Pennagaram and Thally it was recorded for only about 1% of the children. With the exception of Gengavalli, details about the child's appearance was recorded in the other 3 blocks. There were more underweight children reported in Kelamangalam (29.41%) and Pennagaram (26.73%). Over 10% of children were reported to be obese in Pennagaram and Thally.

Registration of birth: Child births were registered by more than 80% of parents in Pennagaram and Gengavalli but by less than 50% in the other 2 blocks. Birth certificates were available in more than 98% of cases in Gengavalli, followed by 80% in Pennagaram; this was comparatively less in Kelamangalam (30%) and Thally (35%).

Access to AWC/Childcare: 82% of children attended and availed the nutritional services offered by the AWC in Gengavalli. On the other hand, in Kelamangalam and Pennagarm, this was only true for a third of the children. Around 25% of the children in Gengavalli were taught using the play-way

method of learning in the AWCs. Such services were available to only 3% of the respondents in Kelamangalam. The highest percentage of private childcare centers was found in Gengavalli (7%).

6.5. Feeding habits

Breastfeeding practices: Breast milk was the most common source of food for infants in all the 4 blocks. About 82% of the children in Gengavalli and 72% in Pennagaram were breast fed within the first half an hour. In Kelamangalam and Thally the practice of starting breastfeeding soon after birth was followed by about 41% and 35% of mothers respectively. There was less than 10% occurrence of breastfeeding beginning only on the second day.

More than 75% of infants were fed 'on-demand' in Thally, Kelamangalam and Pennagaram; only in Gengavalli were more babies fed at regular intervals (56%) than on demand (44%).

Breastfeeding was typically continued for about 24 months in Kelamangalam and Thally while most mothers stopped breastfeeding by 6 months in Pennagaram and Gengavalli. There were a few mothers in Thally and Gengavalli who breastfed up to 36 months.

Supplementary feeding: The most common supplementary food introduced in the 4 blocks was rice followed by ragi. Biscuits, milk and store-bought processed food like Cerelac were also given to the children. Compared to the other 3 blocks, more children in Gengavalli were given dhal, greens, fruits and vegetables as well as eggs on a daily or regular basis. In Pennagaram, more than a third of the parents said that they gave children vegetables and greens only on occasion. In all 3 blocks, eggs, white millet and fruits were given only sometimes. Dhal was included in the daily diet to a greater extent in Pennagaram (72%). Non-vegetarian food items were included only sometimes in all the 4 blocks.

Fried foods, chocolates, bread and buns as well as homemade snacks were consumed by children in Gengavalli to a greater extent when compared to the other 3 blocks on a daily basis.

6.6. Play and leisure habits

Play: Almost 75% of respondents said that they played with their children in Gengavalli while the percentage was just over half in Pennagaram. In all blocks, parents said that the children played with neighbours. Only in Pennagaram around one-fifth of the respondents said that the children played alone.

Children in Pennagaram and Gengavalli played with toys more than the children in Kelamangalam and Thally. Only about a third of children in Kelamangalam and Thally said that children played with toys.

Majority of the parents in all three blocks spent considerable time talking to their children. In Pennagaram around 97% and in Gangavalli about 81% said that they made a conscious effort to talk to the children by using affectionate words, telling stories and reciting songs and to some extent by showing pictures and toys.

Almost all parents in Gengavalli played with their children. In Kelamangalam only 58% of the parents played with their children.

The common mode of play was action oriented and physical in Gengavalli (31%) followed by playing with toys. In Kelamangalam a fifth of the parents said they engaged in play with toys with their children while the same number in Thally said that children usually played with neighbors' children or others in the family.

TV watching: Almost half the respondents in Kelamangalam and Thally said that their children watched TV for 1 or 2 hours a day. In Gangavalli, around 70% of children watched television for less than an hour but 16% of parents here also characterized this habit as "watching tv the whole day".

Stories and rhymes: Children in Gengavalli listened to stories much more than in the other 3 blocks with almost 75% of parents saying that children enjoyed listening to stories occasionally or even

daily. In the other 3 blocks, close to one fifth of the respondents said that children rarely listened to stories.
Similarly, only in Gangavalli block, parents said that they teach their children songs and rhymes frequently or sometimes. In Thally and Pennagaram, just over a third of the respondents said that the children listen to rhymes sometimes. The number of parents who rarely taught their children song and rhymes was highest in Thally (19%) followed by Pennagaram (17%).

Sleep: More than 75% of the children in Kelamangalam, Thally and Gengavalli were able to have more than eight hours of sleep every day. In Pennagaram around 44% of the children had less than eight hours of sleep.

Chapter VII: Community Outreach

During Phase I, all NGOs conducted an initial round of IEC meetings between October to December 2011. During these IECs, the focus was on maternal health, antenatal care practices including nutrition, regular health check-ups, preparedness for delivery, etc.
The meetings were conducted for mothers, fathers, women of Self Help Groups, Panchayat leaders as well as adolescents. Since many of the NGOs work on public health issues, they were aware of specific problems in the villages and accordingly stressed on the importance of exclusive breastfeeding for 6 months, vaccination for children after birth, prenatal and antenatal care as well as good hygiene practices. On parenting topics such as holistic child development, monitoring growth of the child and involvement of the father in parenting were discussed. In some cases, especially in villages where ACORD works, the community felt that the children needed an ICDS centre in the area.

IEC meetings with men in the community

Krishnagiri, SWORD

Dharmapuri, DEEPS

Meeting held by with women IRDO staff

PHASE II: Re-grouping and Expansion

Following a review of the interventions in Phase I, BMRF and UNICEF intensified project implementation while narrowing down on 4 NGOs in the 3 districts.

The final 4 NGOs were DEEPS in Dharmapuri, Salem Social Service Society (SSSS) in Salem and ACORD and RDC in Krishnagiri District.

This enabled a sharper focus of activities and regular follow-ups while expanding the scope of beneficiaries to include children below 6 years. While the IECs and community outreach continued in a similar manner, the field staff began home visits to monitor the growth of children in several domains.

Chapter VIII: Capacity Building

Review meeting, 11 September 2012, Chennai
The focus of the meeting was addressing the challenges faced by the NGOs in the core activities. Ms. Maya Gaitonde (BMRF) and Ms. Aruna Ratnam (UNICEF) presided over the meeting and provided a review of the previous year as well as a brief on the second phase of the project which would focus on direct contact with the beneficiaries on a monthly basis.
Each of the coordinators of the 4 NGOs shared their feedback about challenges faced during the implementation of the project in the first phase. These included difficulties faced in mobilising community members for IECs especially due to the men's alcohol consumption. The NGOs also reported several encouraging outcomes including changing attitudes about early marriage, better knowledge about immunisations, and improved health and hygiene practices. Ms. Maya Gaitonde also appealed to the NGOs to use SHGs in their areas to help spread parenting messages, saying that it was an opportunity to interact with SHG members keeping their parenting role, i.e. mother, sister, grandmother, etc. in mind.

Training, 4-6 October 2012, BMRF, Chennai
In Phase II of the project, training sessions were held for 21 field staff from the 4 NGOs. The focus was to build on the basic knowledge and practical experience gained during the first phase. Since most of the NGOs focused on community health, the objective of this 3 day session was to train staff on implementation of early childhood programs and equip them with knowledge on how to take positive parenting messages to the community.
This training included a review and feedback session from the field coordinators as well as field staff implementing the project. Trainees also visited the Bala Mandir Day Care Centre to see how an ECCD centre is run. Mock-IECs were also conducted as part of the training and a refresher on conducting child assessments during home visits was also given.

Assessment of IECs and interaction with beneficiaries (October – November 2012)
During this field visit Ms. Maya Gaitonde and Ms. Saulina Arnold had a discussion with the field coordinators and staff; they also observed IEC meetings and spoke to beneficiaries in some of the villages. In Dharmapuri, the team observed IEC meetings at Kattampati and Kullipatti villages where a large crowd of mothers, adolescents and some men had gathered. The discussion focused on child development and parenting, stressing the importance of maintaining harmony in the family, and providing stimulations for holistic growth. In Vattuvanahalli village, a tribal area with no health or child care facilities, the women reported that home deliveries were the norm and very few children went to the AWC which was in the neighbouring village more than 2km away. In Senganoor, the team met with pregnant women who spoke about the knowledge they had gained through this project, including an enhanced understanding of brain development. The next day, Ms. Maya

Gaitonde conducted a session on how to fill in the Child Assessment Profile while Ms. Saulina Arnold analysed daily diaries maintained by the field contacts and provided feedback.
In Salem, the team observed an IEC meeting in Koodamalai village. The participants were divided into 2 groups as there were a large number of attendees, and various resource materials including flash cards were used to talk about parenting. When the team visited Valasakalpatti and Kamadpur villages, most of the people they met knew about the project and had gained from the advice given by field contacts. The team members added further inputs on stimulation needed for brain development and understanding.

In Krishnagiri district, a joint review meeting was held for RDC and ACORD staff with an orientation on the next phase of the project. The following day the team visited Kodakari village, a tribal village where several people had gathered. The village head met the team and assured his support to the project and said that education of girls, banning early marriages and promoting family planning techniques was important. The IEC also focused on the ill effects of child marriage through a role play. The mothers had brought along the information booklet and were happy to share details and clarify doubts. In Parasumandoddy, the team visited 3 homes and spoke to mothers on various issues including the importance of breast feeding, welcoming the girl child, a happy pregnancy, planning for the hospital delivery, playing and talking to children, avoiding physical punishment, and playing with household toys.

Review meeting, 1 December 2012
Once again this review meeting focused on the challenges and outcomes faced by the NGOs. A common challenge was eliciting information for the baseline information booklet during the home visits as many women were reluctant to give information on abortions/miscarriages, weight monitoring, etc.
However, there was unanimous feedback from the NGOs on the positive reception of the IECs on brain development, child development and SPRUC.
During the second half of the review meeting, the field staff reported on their field testing of the parenting flash cards. Ms. Saulina Arnold compiled all the messages from the staff and gave her inputs on how these could be used creatively.

Training, 6-8 December 2012, BMRF, Chennai
The fourth and final training session was meant to enhance communication skills of the field staff. During this stage of the project, the emphasis was on following-up on children using the Child Assessment Profiles recorded during home visits and dispensing parenting messages through community interactions. During this training, the field staff were introduced to concept of school readiness.

District	NGO	Date	Activity
Dharmapuri	DEEPS	31 October – 2 November 2012	Kattampati(IEC), Vattuvanahalli (tribal areas) and Senganoor (meeting with beneficiaries)
Salem	SSSS	1-3 November 2012	Koodamalai (IEC) Valasakalpatti and Kamadpur (meeting with beneficiaries)
Krishnagiri	ARCOD, RDC	5-6 November 2012	Kodakarai (IEC in tribal colony) Parasumandoddy (meeting with beneficiaries)

Chapter IX: Child Assessment through Home Visits

A key part of the intervention was assessment of children below 6 years based on various development domains as well as monitoring their home environment. During the training sessions conducted by BMRF in Phase I and II, field contacts and coordinators were trained on the use of the baseline information booklet for families and assessment of children through home visits.
The baseline information booklet is a tool which records basic demographic details of the family, medical background during pregnancy, nutritional practices, parenting practices, etc., and assesses if the child has achieved specific age-appropriate milestones under various domains. The information is compiled through observation and inquiry during home visits at specific intervals based on the child's age group.
During the home visits, field contacts engaged with mothers and family members about the development of the child, offered tips for stimulation as well as gave mothers a similar booklet where they would be able to monitor their own child's development.

During Phase II, 149 pregnant women and 1112 children were monitored across 48 villages.

NGO	District	No. of villages	Pregnant women	Birth - 1 year	1-2 years	2-3 years	3 years +
ARCORD	Krishnagiri	18	8	81	65	38	5
RDC	Krishnagiri	10	23	9	66	75	103
DEEPS	Dharmapuri	9	24	39	41	27	44
SSSS	Salem	11	94	223	170	92	34
TOTAL		**48**	**149**	**352**	**342**	**232**	**186**

Data was gathered on the below topics and common problems were identified based on which inputs were given -

- Feeding Practices: Timely immunisation against tuberculosis, polio, diphtheria, whooping cough and tetanus is very important. There were recorded instances of children, especially in Thally block, Krishnagiri, where children were not given vaccinations. Moreover, since diarrhoea is one of the most common illnesses, field contacts advised parents to continue to breast feed to prevent dehydration and supplement it with oral rehydration therapy (ORH) using only boiled water. Parents were informed that the use of mixtures like gripe water and honey were entirely unnecessary and should be avoided. Field contacts also discussed the importance of sleep and maintaining a regular routine.
- Health and Nutrition: To ensure nutritious foods for the infant, preparation of home based foods from semolina, *ragi*, etc. instead of buying tinned foods was encouraged. Tinned foods have very high carbohydrate content that can cause obesity in babies. Homemade porridge is the best supplement. A baby must never be forcibly fed over long periods of time as this leads to overfeeding, stomach disorders, obesity and ultimately aversion of baby to food. Feeding must stop when baby refuses to take any more. Babies remain healthy when fed at the right time with the quantity desired by the baby. Field staff also talked about the best weaning methods.
- Safety and Hygiene: Hygiene and cleanliness of the child and its immediate environment is paramount in protecting the child from infections and other illnesses. Regular bathing and cleaning of children, and frequent hand washing as and when required are essentials of good hygiene. Hygienically prepared/stored homemade foods are best for the child. The children's play area and the entire house should be kept clean. Adequate disposal of wastes is essential.
- Family Involvement: Child's efforts must always be praised and rewarded not materially but through recognition. The developmental stages of the child should be understood by the

parents/caregivers in order to understand the child's behaviour and provide appropriate responses and stimulations. Baby's milestones should be celebrated.

- Special Attention: This topic specifies milestones which the baby should reach at certain ages. If there is an inordinate delay or if the infant displays any abnormal behaviour like not responding to sounds, not turning its head, or not moving its limbs naturally, a doctor should be consulted to clear the child of any disability. Early identification of disability can help the child to grow normally through stimulatory exercises.

Chapter X: Community Outreach

From May to October 2012, the NGOs once again focused on community outreach by conducting IEC meetings with different sections of the community. Meetings were conducted by the 4 NGOs in 82 villages across Krishnagiri, Dharmapuri and Salem Districts. Following the training by the BMRF team on use of flash cards and the indigenised Learning Through Play Calendar, field staff along with the coordinators of each of the organisations organised these programs. The parenting messages were disseminated in creative and engaging ways through street plays, role plays and skits. In some cases, competitions and *melas* were also conducted to mobilise people to attend the meetings.

Krishnagiri District: In Thally and Kelamangalam blocks, ACORD conducted meetings in almost 27 villages. During the first few meetings, they focused on pre-natal and ante-natal care practices, particularly in tribal areas like Tholuvabettapalayur, Kundikarai, Kurubarapalli and Uppallam. It was common practice in these areas to only breastfeed a new-born baby after 3 days, prior to which time the baby is given sugar syrup or in some cases castor oil. The benefits of breastfeeding and colostrum were explained. Marriage and parental readiness and the adverse effects of early marriage also featured prominently during the IECs. During the latter months, topics such as positive parenting, understanding brain development and stimulation were introduced.

IEC meetings in Thottiur village, Thally block and Pudhur village, Kelamangalam block in Krishnagiri district with ACORD field staff.

7 IEC meetings were held in 10 villages (as pictured above) from June to October 2012 with almost 500 participants from the community. During the first meeting in June 2012, there was a general session on parenting conducted through a street play, covering issues such as communicating with the child, catering to the child's needs and holistic development. The second meeting in July focused on hygiene, nutrition for new-born babies as well as the vaccination schedule. In August, the team conducted a small skit to explain how brain development takes place and on how to ensure a safe environment for new-borns. In September and October, flash cards were used to communicate certain psychosocial aspects of parenting, as well as the importance of the mother's well-being during pregnancy. In all the meetings, the importance of breastfeeding and colostrum were stressed upon; at the last IEC some of the participants said that they would avoid giving castor oil to the new-born and ensure that colostrum is given.
The Grama Sabhas in two villages, Kodakarai and Kottaiyrulollai, passed a resolution that in future early marriages will not be conducted and the same was agreed by the adolescent girls in the villages.

Dharmapuri District: DEEPS built a good relationship with ICDS and Panchayat volunteers in Pennagaram block and held discussions with them about the parenting project before the IECs began. The field coordinators also attended several Grama Sabhas meetings in May 2012 before conducting the IECs. During the 6-month period, DEEPS also submitted an application for ICDS sub-centres on behalf of some villages which did not have an AWC.

Salem District: SSSS conducted several meetings in Gangavalli block in Salem District where early marriages were common in many of the villages. The topics focused on pre-natal and ante-natal health care including nutrition, medical testing and the importance of iron tablets. The indigenised LTPC was used to talk about various parenting aspects, particularly involvement of fathers and elders in parental duties. Developmental milestones based on the SPRUC domains were also explained during the IEC meetings that were held later in 2012.

Chapter XI: Re-orientation and Withdrawal

District	NGO	Date	Activity
Krishnagiri	ARCOD, RDC	18-19 January 2013	Siddique Nagar and Balraj Nagar, Kottaiur Kollai Onnukurukai
Dharmapuri	DEEPS	22-23 January 2013	Kattukottai, (SC population) Periyar Samathuvapuram Aranmanai Pallam (tribal area)
Salem	SSSS	25 January 2013	Nagiampatti, Valasakalpatti, Naduvallur

In January 2013, as a final project activity, a review meeting was held with the field staff. It was felt that field staff needed extra training on early identification of disability using the LTPC. This was decided in the interest of sustainability and to ensure that the activities can be carried out by the NGO even after the project is completed.
During the visits, Ms. Jaya Krishnaswamy, an expert on early screening and development delays, conducted a daylong session for each of the organisations where she spoke about the reasons for delays, methods for early identification and also invited local experts who were willing to accept referrals to talk to the field staff.
The team met with children who were exhibiting some signs of delays, including difficulties in speech and walking. In some cases, Ms. Krishnaswamy said that it was due to under-stimulation and advised the field contact and parents to talk to the child and undertake certain activities. In some other cases, children were referred for professional assessment.
Field staff from the 3 NGOs were able to identify a complete list of children below 6 years with disabilities.

- Salem Social Service Society, Salem – 15 children
- RDC, Dharmapuri – 15 children
- ARCORD, Krishnagiri – 25 children

A total of 55 children were identified with various forms of disability including cerebral palsy, mental retardation, speech and hearing impairments, other forms of physical disability as well as few with seizure disorders as well as cleft palate.

Chapter XII: Conclusion

12.1. Impact

Over the 2-year project span, community outreach through IECs as well as individual monitoring of children in the home environment yielded tangible improvements in health care and parenting practices. As more families were reached through awareness programs by field level workers, there was a concentrated effort to make the state provided services more accountable. Involvement of the panchayat members was crucial in achieving this. Given that most of the villages in each of the 3 districts were chosen for their remote locations and lack of access to services, this was a very important outcome.
The 4 organisations which carried out activities in both phases compiled case studies and anecdotes of some of the positive impacts.

Improvement in services

In many of the villages, Anganwadi centres were functioning very poorly. With low attendance and neglect by the teachers, the AWCs were not being used to full capacity. With the introduction of the nutritious meals programme, AWCs became more about distributing food or “feeding centres” rather than ones that provided childcare and a stimulating environment for growth and development. As a result of the intervention, parents have been more proactive in ensuring that the centre functions as a pre-school with appropriate activities to ensure learning and development for children.
Similarly, involving the teacher of an Anganwadi in another village has resulted in more systematic services; the teacher now maintains a proper register of children and updates their details as she monitors their growth. Understanding the importance of brain development, she has also begun basic education by teaching children names of animals, vegetables and fruits through songs. Moreover, she is observed to be much more integrated with the community, participating regularly in programs organised by field contacts.
Field staff from the RDC reported that in Ilaka Chathiram village, Thally Block, the ICDS centre used to serve as a home for goats, pigs and donkeys for the past 4 years. After various IEC activities, the centre began to function. This was mainly due to the active involvement of the panchayat leader

who strongly believed in the importance of the AWC to parents and the community. Similarly, in Nagiyampatti and Kodayampalli, in Krishnagiri district, the Anganwadi workers are monitoring health of pregnant women and the children. There is also regular distribution of nutritious flour and napkins to adolescent girls. In the case of Karungalamedu, even though parents do not send the children to the Anganwadi centre which is 3km away in the neighbouring village, relatives or neighbours are sent to collect the nutritious flour. This was made possible through efforts of the field contacts.

In Naduvaloor and Nagiyampatti, field contacts conducted awareness programs to encourage pregnant woman to register at the PHCs as well as teach them the importance of scans, vaccinations and nutrition during pregnancy. The ANM was also asked to visit regularly to ensure proper follow up. In Kodayampalli, the Village Health Workers participated in all the programs and conduct regular visits. Vaccinations have also improved.

In villages like Thozhuvapetta puthur, Thozhuvapetta pazhaiyur, Kottaiyur kollai, Siddiq nagar, Kottaiyur kollai, and Balraj nagar in Krishnagiri District, children were previously never given immunisations. The Village Health Nurse (VHN), Ms. Ruby, participated in all the IECs and spoke about the importance of vaccinations. The mothers have now begun to take children from vaccinations. In Kurangalmedu village, it was found that the VHN did not provide polio drops to infants. The field staff spoke to the VHN to ensure that it is made available. Similarly in Nagiyampatti, field contacts ensured that folic acid tablets and sanitary napkins are given regularly to adolescent girls.

Early marriages

Some of the NGOs have shared instances where the field staff were able to engage families in conversation about early marriages. For instance, Jayamma from Anlemar village in Krishnagiri district comes from a family of five. She had studied up to the 9th standard and as is standard practice, discontinued school after puberty. She later went for gardening work as a daily wage worker. At 16, her marriage was fixed with a relative in the neighbouring village. The field staff were able to convince her parents about the ill effects of early marriage and the potential harm it could do to Jayamma's health as well as the well-being of a child. Her parents have now decided to wait till she turns 19.

Improved Parenting Practices

DEEPS, whose staff conducted several home visits, said that they were able to change parental attitudes about handling children's tantrums. In Senganoor, Dharmapuri district, Radhika, a domestic worker and Muniappan, a tractor driver, have a 2 year old son, Nadhikesh. During the home visit, the field staff noticed that when Radhika or her mother in law were home doing their household chores, Nadhikesh would be tied to a pillar. Radhika said that Nadhikesh was too naughty and would disturb her when she was sweeping. The field staff explained the importance of play and asked the family to discontinue the practice as it may have an adverse impact on the child's self-esteem. During subsequent visits, the field staff noticed that the child was playing freely.

There was another case of under-stimulation in Kattampatti village, where a 2-year child, Sabari, did not talk or attempt to eat independently. Two more cases of neglect were noticed in Anjehalli panchayat area where mothers were found to be lacking in knowledge about parenting. The children fell ill constantly and in one case the child did not talk. The field staff shared stimulation techniques with parents and there were signs of improvement.

In some villages in Salem, like Krishnapuram, field staff were able to convince families to complete the vaccination schedule. Sumathi's son, Parthiban, who is 3 years old was not vaccinated. The field staff from SSSS explained the importance of the vaccinations and ensured that Parthiban got necessary vaccines. In another instance in the same village, 2 ½ year old Kabilesh's parents told the

field staff that he did not talk. This continued despite their efforts to engage him in conversation. The field staff advised the parents to take the child to the government hospital for assessment after which they found that there was some defect in his tongue and throat. After four operations, his condition has improved.

In Kadamboor village, both parents are often engaged as daily wage workers. The field staff reported that in many cases, children were unclean and parents would never spend time with the child. During home visits, importance of hygiene and spending time with the children was stressed upon.

12.2. Lessons learnt for a way forward

The 2-year intervention led by BMRF in partnership with UNICEF provided valuable insights into prevailing attitudes and practices towards parenting and early childhood in general. Reaching out to vulnerable and poor rural populations on the importance of early childhood was indeed challenging especially when there were no adequate public health services.

There were a few programmatic challenges during the project including resource constraints. These caused some breaks in the implementation that should have ideally been avoided to ensure continuity and rapport building. Another challenge was that the data received from the field contacts was often found incomplete or incoherent limiting the possibility of a more rigorous statistical analysis.

However, there were important lessons learnt throughout the implementation process:

Adapting techniques to grass root realities

While BMRF's primary expertise has been in dealing with children and parents in a more institutional setting, their various community interventions have been important in developing a rooted training programme and capacity building methods.

It became clear from the field visits and close interactions with the field workers that all training had to be adapted to unique contexts present on the ground.

For instance, several examples usually used to illustrate concepts were changed keeping the rural and tribal scenarios in mind. Anecdotes and experiences of the field workers who are most knowledgeable about the community were used to identify parenting practices which could pose a challenge as they contradict basic principles in ECCD. For instance, practices like the father not being allowed to meet the mother and infant and restrictions during the pregnancy have to be dealt with sensitively. BMRF resource persons kept these issues in mind during training and advocated for a more cautious approach on these during the IECs.

Innovating tools for intervention

In order to cater to parents who have varied levels of literacy, BMRF realised the importance of using visual aids to convey concepts about child development as well as health and nutrition. The use of the Learning Through Play Calendars developed by Hincks-Dellcrest for training field workers and subsequently the use of the Indigenised Calendar for use by the field workers during their interactions with parents was an important step in achieving a more universal approach to disseminating parenting messages.

The Calendars were well-received as they were relatable, relevant and communicated concepts like self-esteem, bonding, language, social development, etc., which were thought to be abstract, in a simple way. The flash cards which were developed during this project were used for activities with parents and to evoke responses from visual cues and pictures which are open to interpretation and can therefore facilitate rich discussions.

Inclusion

Equality and inclusion have been a key part of the messages and values throughout the intervention. Identification of disability has been a key component in each of the training sessions for field staff. Even during the final refresher and review in early 2013, it was this issue which took primacy and more than 50 children with disabilities were identified and followed up.

Community ownership in the interest of sustainability

The success of any intervention lies in its sustainability. An ECCD project which permeates attitudes of the parents and community must have well-defined ways to include beneficiaries. While the two year intervention may have been insufficient in this regard, a multi-stakeholder approach was adopted right from the beginning. In this case, Anganwadi workers, dais and panchayat leaders were involved in the KAP survey as well as the community outreach programs later on. This was important to ensure sustainability and effect concrete change by informing and educating the primary stakeholders and ECCD service providers.

Despite being truncated soon after Phase II, each of the NGOs that participated in the project now have fully-trained staff with knowledge on early childhood development, brain development, positive parenting and early identification of disabilities. Despite ECCE not being their core activity, there has, through this process, been a definite realisation of the importance of advocating for early childhood development and positive parenting. NGOs reported that by taking on issues like parenting and child development, community members began to respond to them better. There is scope for integrating elements of this into their existing activities and a strong desire to continue and expand the intervention to ensure that ECCE reaches its fullest potential.

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[i] Special Correspondent (2012, March 26) Early Childhood Care and Education Policy Proposed *The Hindu*

[ii] Reference unobtainable

[iii] DC Correspondent (2014, Nov 19) Infants death; Babies died due to natural causes says TN CM O Paneerselvam**,** *Deccan Chronicle*

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