Copal Partners

New Philanthropy Capital

Starting strong

September 2009

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Early childhood development in India

A guide for funders and charities

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Summary

The need

Early childhood development (ECD) refers to the biological and psychological changes that occur in children between conception and the age of six. More than 80% of brain growth occurs in this period and it influences every aspect of a child's future life. In the right conditions, children develop normally, laying the foundations for a good life. In their absence, they effectively suffer brain damage. The consequences are wide-ranging and include a lower IQ, greater susceptibility to illness, lower educational attainment, lower productivity and lower earnings.

The right conditions include a range of things that lead to appropriate **nutrition**, **good health** and **care**—from breastfeeding to access to health services to parental involvement.

There are 158 million children under the age of six in India. Across a range of indicators related to nutrition, health and care, the outlook is poor.

Nearly half of Indian under-threes (45%) are stunted. This is a measure of chronic malnutrition—it means that children have not had the right nutrition for long periods of time. More than a fifth (23%) of under-threes are wasted. This is a measure of acute malnutrition—it means that children have not had the right nutrition recently, or have been very ill.[1]

Around one in ten Indian children suffers from diarrhoea. Almost one in six suffers from fever. Half of under-threes are deprived of full immunisation, with children often beginning but rarely completing vaccination courses.

How much does this matter? In addition to compelling humanitarian arguments in favour of improving the well-being of young children, there is a strong economic case.

The Lancet has cited research that the average deficit in adult yearly income for stunted children is a remarkable 19.8%. A study by the World Bank reported that micronutrient deficiencies alone (only one component of underdevelopment) may cost India US$2.5bn annually.[2]

The immediate causes of underdevelopment relate to inadequate feeding practices, poor prevention and management of illness, and inadequate care. The underlying causes include the low status of Indian women, poverty, and a vicious cycle of low-weight mums having too many children too early and too close together.[3]

The good news is that there are fairly well-established interventions that can help improve child development—from breastfeeding counselling to community-based health services to the fortification of staple foods. Integrated ECD programmes address several components of the problem, typically through a combination of daycare and community-based services.

Role of the public sector

India has the world's largest ECD programme, the Integrated Child Development Services scheme (ICDS), which provides the critical frame of reference for most non-governmental organisation (NGO) activity. The ICDS offers children, adolescent girls, and pregnant and lactating mothers a package of services from local anganwadi (childcare) centres. These include supplementary nutrition, growth monitoring, primary healthcare, immunisation, referral to secondary healthcare and pre-school education.

However, there are significant problems with the ICDS, including inadequate coverage, poor opening hours and neglect of key components such as nutrition services targeted on under-threes. Only one in four parents of children of the relevant age reports getting any kind of service at all under the ICDS in the previous 12 months.[4]

Role of the NGO sector

The ICDS matters because many organisations with an interest in ECD operate in relation to it—whether they are trying to fill in its gaps, make it work better, or reform it. Its weaknesses and omissions are good focus points for donors' funding.

That said, the field of NGOs working on ECD appears relatively small. Most NGOs are issue-based and address the needs of young children through the lens of another social problem. Activities to promote child development have historically been separated between health and education programmes, with inadequate links.

NGOs operate partly to tackle the problems with the supply side of the ICDS, training workers, linking it with other programmes and experimenting with new approaches. They also deliver services outside its scope and in places it is not reaching. And they work on the demand side, trying to mobilise communities to ensure that they can enforce their rights.

Most NGOs working in this space do so on a shoestring, and some manage to achieve impressive results. They face challenges in relation to measuring the impact of their work and scaling up. An underlying problem, not unique to these charities, is recruitment and retention of quality staff, especially professionals and middle management.

Recommendations for donors and funders

A core recommendation is that donors should think young: the first years of a child's life are foundational. It arguably makes more sense to focus here than on older children, because it means that problems can be arrested before they develop.

A second recommendation is that donors should generously support NGOs to build their own capacity. ECD NGOs need to be better resourced with the right skills and long-term funding if they are really to achieve transformational change.

Specific programme funding priorities are hard to identify because need is so widespread, data on NGO activity is weak, and the boundary between government and non-government responsibilities varies between India's 35 states and union territories.

New Philanthropy Capital (NPC) and Copal Partners (Copal) advise that donors should generally be trying to increase government capacity and enforce rights to services. Philanthropists should try to limit funding direct provision of services to those places where state government and local bureaucracies are very dysfunctional, and to interventions that are outside the scope of the government.

Options for donors include:

- funding efforts to strengthen and reform the ICDS, including delivering quality childcare workers and working on convergence between ICDS and other programmes;
- improving services for under-threes—particularly in relation to nutrition. This could involve building the capacity of the ICDS or piloting new approaches;
- tackling the urban deficit on services to improve ECD—urban coverage is the weakest point in the ICDS infrastructure. Again, this could involve building the capacity of the ICDS or piloting new approaches;
- supporting integrated ECD programmes for those who are hard-to-reach or excluded, such as tribals, unauthorised slum dwellers, and people who live in dysfunctional states;
- supporting community involvement and accountability on ECD—this ranges from existing work, such as self help groups, to experiments in increasing demand, such as using mass media; and
- supporting advocacy and lobbying work—NGOs find it hard to get lobbying funded, but it can have large-scale impact. Particular goals include stronger maternity rights and making sure that the government's fundamental right to education covers the pre-school period (it currently runs for children aged six to fourteen).

Contents

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Introduction

New Philanthropy Capital (NPC) is a UK-based organisation that enables charities and funders to do good, better. NPC's vision is of a world in which non-governmental organisations (NGOs) and their funders are as effective as possible in changing people's lives and in tackling social problems. To achieve this vision, NPC's activities include researching social problems and analysing the charitable response to them. NPC makes public its findings and uses them to advise funders and NGOs on being more effective.

Copal Partners (Copal) is a leading provider of financial analytics, business intelligence and research services. It has developed a charity analysis function to advise a wide range of philanthropists on improving the lives of the poor in India through identifying effective NGOs.

Between 2008 and 2009, NPC and Copal worked together on a pilot venture to look at social problems in India. This report is one product of our partnership, which was based in Copal's offices in Gurgaon, Delhi.

The focus of the report

This report considers the welfare of young children in India, with examples drawn from the situation in the country's capital, Delhi, and in the state of Rajasthan.

Its focus is on improving early childhood development (ECD), defined as the biological and psychological changes that occur in children between conception and the age of six.*

The report's aim is to provide guidance and support for donors and NGOs interested in helping improve the lives of young children. To do this, we analyse:

- levels of need;
- evidence of what works;
- activity by other actors—in particular, the Indian government; and
- the nature and effectiveness of the NGO sector.

Collectively, these factors provide a useful context for any donors thinking about trying to improve the lives of children in India. But more than that, they help to highlight specific funding priorities, detailed in the second and third chapters.

This report is published alongside a sister report *Giving in India*[5] and four in-depth analyses of high-performing Indian charities working on ECD. They are examined through a structured methodology pioneered by NPC in the UK.†

The purpose of the report

This report and the accompanying charity analyses have a number of aims.

The primary goal is to help donors who care about Indian children to identify funding priorities and particular organisations that they might want to support.

NPC and Copal have found that philanthropists can be put off funding internationally by concerns about complexity, lack of information, lack of trust and fear about corruption and waste.[6]

This is a general barrier, but it has particular purchase in relation to funding grassroots organisations, where information and relationships are likely to be particularly hard to obtain and establish. We have focused on local NGOs, where information is most scarce, rather than bigger, better known international NGOs (INGOs).

We hope that this research will be of wide use. The kinds of donor with most to gain include:

- time-poor, high net worth individuals, particularly those who do not live in India but who care about the country;
- relative newcomers to international funding who need an overview of the issues; and
- trusts and foundations.

A second goal is to provide useful information to NGOs themselves—to help them identify their place in the wider sector, to see how their peers are tackling ECD and to help them understand how to improve their effectiveness.

* Some definitions go up to age eight in order to cover transition to primary school. For reasons of keeping the research scope manageable, our upper limit is age six.

† For the analysis of the NGO Prerana, NPC and Copal partnered with Dasra, a Mumbai-based organisation that works with Indian NGOs to maximise their efficiency, scale and impact.

Both these aims are the immediate objectives of this report and accompanying analyses. But these materials also aim to support the ambitions of NPC and Copal's wider joint venture, which is concerned with tackling some of the structural barriers to philanthropy in India. Box 1 describes how this report relates to those goals.

Why India, and why ECD?

One of the challenges for NPC and Copal in undertaking this project is, as for any donor engaged in philanthropy, finding a focus.

There are hundreds of troubling social problems facing developing countries. Why privilege any one issue or country in particular? NPC and Copal's answer is based on long-standing experience advising strategic donors on how to choose between good causes. Our view is that there is no single or wholly objective way to do this. However, one helpful approach—elaborated in more detail in the second chapter of *Giving in India*[5]—is to separate out the internal and external drivers of giving.

- **Internal drivers** include individual preferences and passions, what works practically, and the other resources that a donor (or, in NPC and Copal's case, analysts) can bring.
- **External drivers** include the severity of a social problem (some combination of the numbers affected and the harm done) and its susceptibility to being tackled (that there are proven approaches to addressing a problem; and that there are things to fund to deliver those approaches). We also look at the funding gap and the comparative 'social returns' of spending.

To choose a focus, the trick for a donor is finding an issue that brings together both internal and external drivers.

On this basis, India was chosen as a focus for this report. External drivers included the scale of need—one in six of the world's population is in India, but on many indicators the country remains very underdeveloped. We also suspected its philanthropy market is not functioning optimally and would benefit from piloting the application of analysis and research (issues explored further in *Giving in India*[5]). Internal factors included a survey of UK-based donors carried out for a previous NPC report, *Philanthropists without borders*[6], which showed that India is one of the most popular geographies for giving. The choice was also influenced by the fit between the partners—NPC and Copal—offering research synergy and learning opportunities.

Box 1: Starting strong: the bigger picture

The primary goal of this report is to increase the availability of advice for donors, funders and NGOs. However, there are also some wider objectives underpinning this work. *Starting strong* is published alongside another product of NPC and Copal's joint venture: a report entitled *Giving in India*[5], which looks more widely at the state of philanthropy and other giving in India.

Giving in India argues that, although giving levels are increasing, philanthropy in India is not making the difference it should. Flows of funding are going neither to the most urgent causes nor to the NGOs most effective in changing people's lives. India is characterised by a 'broken funding market', where philanthropy is largely driven by subjective and random factors rather than careful consideration of where it can make the most difference.

There are a number of underlying causes of this problem, but the report suggests that one particularly important factor is the lack of independent and accessible information. Publicly available analysis and research can help to improve the quality of funding, including the 'what' (which cause to support), the 'who' (which organisation to give to) and the 'how' (which way to fund). Collectively, these will improve 'social returns', ensuring that more lives are transformed for a given sum of money.

The purpose of *Starting strong* and the accompanying charity analyses is not only to help donors to structure and inform their giving to improve the lives of Indian children; it also has several other aims:

- First, to demonstrate how a social problem and individual organisations can be analysed. This report and the in-depth pieces on particular NGOs implicitly constitute a framework for identifying donor priorities and finding good organisations. It is a model that NPC has tested many times in the UK and is being published in late 2009 as a report entitled *Doing good, better*. We hope that other donors in India will adapt and apply this, or similar, approaches.
- Second, to demonstrate that it makes sense to think strategically and analytically about the best way to spend 'philanthropic capital'. By using evidence to inform giving, donors can make a greater difference.
- Third, to make the case for sharing analysis and research publicly. NPC and Copal believe that by publishing information on causes, approaches and organisations, donors can achieve leverage—using their learning not only to inform their own giving, but also to influence other funding. All our analysis is freely available on our websites www.philanthropycapital.org and www.copalpartners.com.
- Fourth, to serve as a call to arms. Improving the Indian NGO sector is not in the gift of any one organisation. It needs a broad-based effort and support from funders and NGOs across the country. NPC and Copal want to make the case for this to happen.

We picked ECD as the subject of this report following a formal process by which NPC and Copal undertook some high-level mapping of different problems in India. Internal drivers included existing donor concern about children. External ones included our finding that disproportionate attention and funding tends to go to older children—particularly once they have started school. The severity of some of the problems facing young children in India, particularly malnutrition, means that high social returns are on offer. These arguments are elaborated in more detail in the body of this document.

Finally, we chose to focus on Delhi and Rajasthan for our field research into specific NGOs. The internal driver was keeping the project scope manageable. The external driver was achieving a reasonable range: covering ECD in both an urban and rural context, as well as highlighting both inter- and intra-state differences.

Structure

Chapter 1 sets the scene on ECD, including an account of the scale of the problem, its impact and its causes.

Chapter 2 considers what works in improving ECD and summarises lessons applying to some of the key interventions.

Chapter 3 describes what government is doing, and how well. It also identifies priorities for donors.

Chapter 4 describes the NGO sector and considers how well it fits with donor priorities.

Chapter 5 analyses the effectiveness of NGOs working on ECD and lessons for donors considering funding in this space.

Research process

This report is one product of a project that took just under six months to complete.

There is some very sophisticated work being undertaken on development problems by various agencies, including academics, NGOs, multilateral funders and governments. A high-level view can create value by leveraging this work and making sure it is communicated to new audiences, rather than reinvented.

Accordingly, the observations on ECD in this report draw on a range of studies by other organisations. We would highlight in particular important work by the World Bank[2], a major Indian campaign called the Citizens' Initiative for the Rights of Children Under Six[7] (CIRCUS, now the Working Group for Children Under Six, part of the Right to Food campaign), and Save the Children India.[8]

This report adds something new to the existing body of research: NPC and Copal's experience on the ground. In our research, we talked to experts on ECD and analysed the activities and performance of a wide range of NGOs in Delhi and the state of Rajasthan.

The process used by NPC and Copal analysts comprised:

- a literature review and interviews with more than 50 experts, such as civil servants, academics, grant-makers, multilateral agencies, INGOs and NGOs;
- the development of a database of over 100 NGOs working in Rajasthan and Delhi, including core information and data;
- telephone calls with a shortlist of NGOs, selected on the basis of their potential;
- field visits to a sample of 15 NGOs, including in-depth interviews with management and project visits; and
- in-depth analysis of four high-performing NGOs, considering five factors: focus on need, results, management quality, ambition, and use of resources.

It is necessary to highlight one caveat on the analysis in this document. India has relatively good statistics available through the census and a variety of other sources. But there is weak information on size and breakdown of funding flows and, in particular, on the structure of the NGO sector. For instance, there are thought to be more than 1.2 million NGOs in India, but there is no formal register and limited public information is available on size or activities. This makes generalisations difficult and means that researchers sometimes have to rely on impressions or qualitative analysis rather than quantitative data.

A full list of acknowledgements and references is at the end of the report.

A note on terminology

NPC and Copal have used the terms NGO and charity interchangeably in this report.

Photograph supplied by Tara Chand & Iona Miller

Early childhood development in India

There are 445 million children in India, 158 million of them under six.[3]

Donors familiar with the recent economic successes of India would be forgiven for thinking that the welfare of the country's children should not be a matter for philanthropy.

But even a cursory glance at the statistics on child well-being shows that there remains extraordinary need—and on a scale that goes beyond the capacity of the state to respond.

Whether thought of in terms of health, nutrition, education or access to water and sanitation, the defining features of many children's lives are exclusion and poverty.[3]

The most visible consequence of this is early death. Infant mortality in India before the age of one is 1 in 18. Most deaths occur in the first month of life—up to 64% in the first week itself.[4]

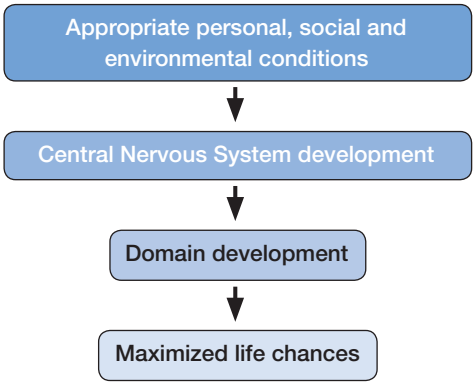
Far less well known is that tens of millions of children are not fulfilling their potential. A whole range of factors—including inadequate nutrition, poor health, and lack of care and stimulation—result in children's brains developing more slowly than they should, or failing to develop properly. This damages their health, their education, their ability to earn as adults, their reproductive choices, their parenting and, ultimately, their life chances.

What is ECD?

Early childhood is the most rapid period of development in a human life. Children develop at different rates, but they all progress through an identifiable sequence of change and growth in different domains. These include:[9]

- physical growth;
- motor development (physical movement and control);
- cognitive development (the ability to learn, remember and solve problems);
- language development; and
- socio-emotional development (such as empathy and understanding social rules).

These shifts, occurring most dramatically in children between conception and the age of six (or according to some definitions, to the age of eight), are referred to as early childhood development. More than 80% of brain growth happens between conception and the age of two, and many of the patterns laid down are permanent.[7] How well children's brains develop depends on the social, cultural and environmental conditions in which they are brought up.



Under the right external conditions, children develop normally, laying the foundations for a productive life. Under the wrong external conditions, children effectively suffer brain damage,[10] with a wide range of personal, social and economic consequences.

Factors affecting development

The right conditions for development are discussed below in detail but include a range of things that lead to good **nutrition, health** and **care**, including breastfeeding, access to health services and parental involvement.[9] The wrong conditions include the absence of these factors and the presence of a range of risk factors.

Key risk factors, set out in Table 1, include stunting (low weight for height) and micronutrient deficiencies.[11, 12] These provide analysts with their metrics of underdevelopment. Researchers do not generally have access to data on brain function or, in poorer countries, performance in different developmental domains. Instead, they tend to look at some of these proxy measures. Many analysts focus on the nutrition component of child development.

Table 1: Risk factors for development[11, 12]

Nutrition	Health	Care
Stunting Micronutrient deficiency—iodine deficiency and iron deficiency anaemia Low birthweight infants who do not grow at the right rate during pregnancy (intra-uterine growth restriction) Zinc deficiency Lack of breastfeeding	Malaria Exposure to heavy metals Low birthweight Worm infections Diarrhoeal disease Pesticides	Inadequate cognitive stimulation Violence Maternal depression Caregiver unresponsiveness

Why does ECD matter?

Children whose brains do not develop properly suffer in several ways.

Lowered IQ

First, they tend to have lower IQs, which directly influences their ability to process information, make decisions, learn and earn a living. Underdevelopment means lower educational attainment, lower productivity, and, on average, lower earnings.[9]

Donors might be surprised by the scale of these effects. A study in the medical journal The Lancet cites evidence that children who are stunted (that is, have low height for age, resulting from long-term undernutrition) have combined reading and maths test scores two years behind that of non-stunted children.[11] Another study it quotes shows that IQs among children growing up in iodine-deficient areas averaged 12.5 points lower than those growing up in areas with sufficient iodine.[11-13]

Poor health

Second, children who are exposed to inappropriate early years treatment are physically smaller in adulthood than they otherwise would be (a serious disadvantage in a country where much employment involves physical labour). They are more susceptible to illnesses like diarrhoea and respiratory infections, and slower to recover from them. They are more prone to early death.[12]

Reduced ability to interact well with other people

Third, underdevelopment is associated with troubled socialisation and low adaptability to new situations and people. This can lead to a range of outcomes, from lower confidence and learning ability through to full-blown emotional and behavioural difficulties.[11]

Reduced personal capabilities

All this clearly matters for moral reasons. Children with underdeveloped brains have reduced personal capabilities, which will on average affect their ability to live free and fulfilling lives.[7, 14]

Economic cost

But it also has a significant economic cost. A report by the World Bank looking at undernutrition—one of the key determinants of inadequate progress in childhood development—found that, while studies are inherently based on some subjective assumptions, they agree that the impact is large (see Table 2):

'One study estimates that the productivity losses due to protein-energy malnutrition, iodine deficiency disorder, and iron deficiency anaemia, in the absence of appropriate interventions, amounts to around US$114bn between 2003 and 2012 ... Other studies suggest that micronutrient deficiencies alone may cost India US$2.5bn annually and that the productivity losses (manual work only) from stunting, iodine deficiency and iron deficiency together are responsible for a total productivity loss of almost 3% of GDP.'[2]

Table 2: Productivity losses due to malnutrition in India[2]

	DALYs* lost due to malnutrition	Estimated annual losses due to malnutrition (US$bn)	Estimated loss of adult productivity (% of GDP)
Stunting	2,939,000	8.1	1.4
Vitamin A deficiency	404,000	0.4	-
Iodine deficiency	214,000	1.5	0.3
Iron deficiency	3,672,000	6.3	1.3

* Disability Adjusted Life Years, a standard measure that combines costs of health problems due to loss of life and to illness.

The social implications of ECD

A final set of considerations are the social implications of ECD. There is convincing evidence that underdevelopment is part of the mechanism by which poverty and deprivation are transmitted between generations.[3, 4] In particular, babies and infants whose development is retarded tend to become adults who produce underdeveloped children.[15]

This is partly because low birthweight is an excellent predictor of the health status of future children—undernourished women have small babies, with a higher prevalence of complications in childbirth, lower quality breast milk and a higher risk of infant and maternal mortality.

But it is also because underdevelopment is part of a vicious cycle of poor skills and poor care. Stunted girls grow up to become stunted mothers, with low IQs and poor levels of education.[3] Low skills and low status are directly associated with early marriages, multiple, closely spaced births, and low use of primary health services. All of this increases stresses on parenting and makes it less likely that children will get appropriate care.[8]

There is a strong case then for donors to think about prioritising ECD.

What is the situation like in India?

In short, the situation is fairly dismal. The statistics in Table 3 paint a grim picture of dreadful nutrition and high levels of illness.

Table 3: Underdevelopment in India[4]

Trait affecting development	Proportion of young children affected (%)	
	1998/1999	2005/2006
Low birthweight	22	22
Stunted[a]	51	45
Wasted[a]	20	23
Not fully vaccinated (excluding not vaccinated at all)[b]	44	51
Not vaccinated at all[b]	14	5
Birth not preceded by any antenatal check-up	34	23
Suffers anaemia[c]	74	79
Suffered fever in the last two weeks[d]	30	15
Diarrhoea[d]	19	9
Acute respiratory infection (pneumonia)[d]	19	6

a. Based on standard anthropometric indicators: height for age for 'stunted'; weight for height for 'wasted'; both for children under three.
b. Age twelve to 23 months.
c. Age six to 35 months.
d. Age under five.

Probably the most striking numbers are that 45% of Indian under-threes are stunted and 23% are wasted.[4] Stunting is a measure of chronic malnutrition—it means that children have not had the right nutrition for long periods of time. Wasting is a measure of acute malnutrition—it means that children have not had the right nutrition recently, or have been very ill.

India is home to a shocking 40% of the world's malnourished children, and 35% of the developing world's low-birthweight infants. Every year, 2.1 million children under five die in India, accounting for almost one in five deaths in the world. More than half of these deaths could be prevented if children were well-nourished.[1]

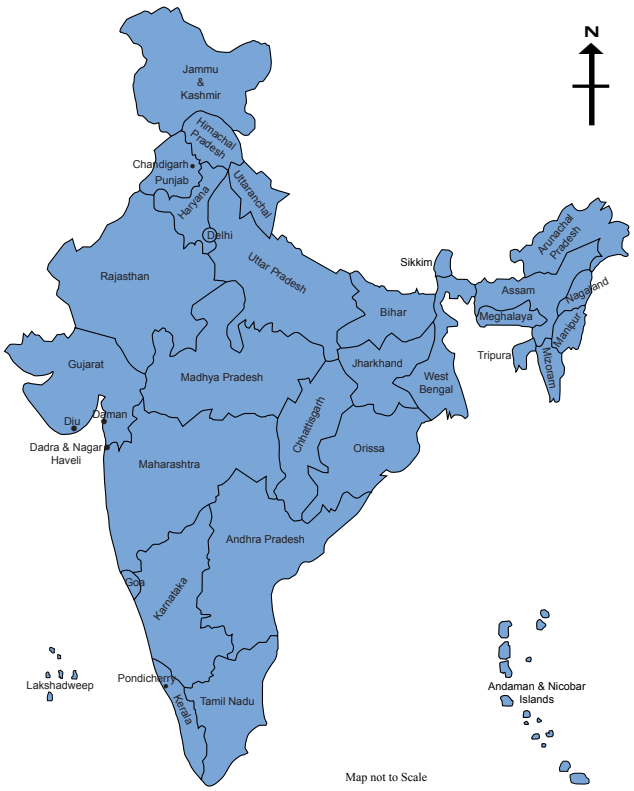
Comparison with other countries

The comparative picture shows that the problems facing Indian children are part of a bigger South Asian trend. Nonetheless, *'whether [it] is measured as the prevalence of underweight, stunting or wasting, it is clear that the nutritional situation in India is among the worst in the world.'*[2] Prevalence rates in India are comparable to those in much poorer countries, such as Bangladesh and Nepal, and are nearly twice as bad as Africa and eight times as bad as Latin America and the Caribbean.

The Global Hunger Index measures three criteria with equal weight: the proportion of undernourished as a percentage of the population; the prevalence of underweight children under the age of five; and the mortality rate of children under the age of five. According to the Index, India is worse than two dozen Sub-Saharan African nations and other neighbouring nations such as Pakistan.[17] Box 2 reflects on the contrast between South Asia and Sub-Saharan Africa.

Trends

Some donors may take comfort in the thought that India is growing rapidly, with diminishing poverty levels. But in terms of outcomes for children, there is little encouragement to be had from trends over time. Though there have been improvements in levels of extreme hunger and undernutrition, progress in other areas is weak or non-existent. In particular, between 1998/1999 and 2005/2006, the last two National Family Health Surveys in India



Photograph supplied by Gaurav Gupta

Box 2: The South Asian Enigma: why is undernutrition in Asia higher than in Sub-Saharan Africa?

Undernutrition rates in India are nearly double those in Sub-Saharan Africa, a fact first highlighted in a famous article in 1996, *The South Asian Enigma*.[16]

The enigma has not really been explained satisfactorily. Three main factors suggested include:[1]

- **Rates of low birthweight:** low birthweight is the single largest predictor of undernutrition, and 22% of Indian babies are born with low birthweight, compared to only 16% in Sub-Saharan Africa.
- **The status of women:** women in South Asia tend to have lower status and decision-making power than women in Sub-Saharan Africa. They often eat after men and have less control of income. There is a lot of evidence that when money is held by women, it is more likely to be spent on children's needs than when it is held by men. Recent research has looked at this problem in more detail and highlighted that status differences in South Asia and Africa are not in fact of a large magnitude.[1] But they have a disproportionate impact in India because they relate closely to childcare.
- **Hygiene and sanitation standards:** these standards are lower in South Asia than in Africa, and play a big part in causing infections that lead to undernutrition in the first two years of life.

(the main source of data on children's health and development) show that the proportion of undernourished children barely changed. There has been some progress in tackling stunting, with a fall from 51% to 45%.[4] But there has been a worsening in full vaccination coverage, and anaemia, a chronic problem in India, has increased by five percentage points.[4] One driver of slow progress is a rapidly growing population, which means government and service providers are constantly chasing a moving target.

Variations within India

Data suggests that there are marked differences between Indian states. Madhya Pradesh records the highest rate of malnutrition in under-fives (60%) with Kerala among the lowest (23%).[4] Bihar, Madhya Pradesh, Uttar Pradesh and Rajasthan between them account for more than 43% of all underweight children in India.[8] Jharkhand and Orissa are also vulnerable. Tamil Nadu by contrast is widely recognised for having made great strides on child development.[4]

An additional point stands out for donors here. Poor development has a complex relationship with regional poverty. Maharashtra and Gujarat, with high per capita incomes, have high undernutrition rates, and Gujurat has actually seen vaccination rates fall, despite economic growth.[4] Intra-state variation can be almost as serious as inter-state. Policy analysts are increasingly looking to the district level (India's 35 states and Union Territories are divided into 625 districts). Even the best-performing states have pockets of serious underdevelopment.[4]

What makes this analysis interesting is not that it is new, but that it has not always seemed to command the attention that might be expected from the media and the political classes. It is hard to prove this definitively, but one unscientific test is that there are 15,000 pages on Google referring to *'India and education'* for every single one referring to *'India and malnutrition'*.[18]

NPC and Copal only have anecdotal evidence, but our experience working with donors is that, though they often think about the needs of children, the primary focus tends to be those of school age. Few have thought about aiming younger.

If this is correct, the breadth and depth of need in the country makes a powerful argument for donors to reprioritise. Moreover, if there are successful approaches to tackling the problem, this is also a strong 'early intervention' case.

The causes of underdevelopment

Why is underdevelopment so bad in India?

Childhood development is the product of a hugely complex array of overlapping factors that fall into three broad areas: nutrition, health and care. The drivers of inadequate **nutrition**, **health** and **care** are therefore the ultimate determinants of underdevelopment.

Nutrition

Child development proceeds normally where there is enough protein and energy, and where there are adequate supplies of micronutrients for growth and development. Box 3 highlights key indicators.

In India, poor feeding practices, low dietary intakes and failure to prevent or adequately treat communicable diseases cause widespread undernutrition.[1]

More than one in five babies in India (22%) is born with **low birthweight**, putting them at risk of undernutrition and illness even before birth.[4] This reflects poor attention to maternal health and nutrition before and during pregnancy. Also, 36% of Indian women are too thin for their height, and 55% are anaemic.[4]

Box 3: Undernutrition as a key metric of poor development[12, 13]

There are two main forms of undernutrition. First, protein-calorie undernutrition, which means not having enough energy or protein for normal growth. Second, micronutrient undernutrition, which means lacking key vitamins and minerals that help the body to function. In India, children often suffer from both, in what is sometimes labelled the 'double burden' of undernutrition. This undermines their ability to work, learn, fight off infections, successfully bear healthy children and live a normal life.

Protein energy undernutrition: main measures

Protein-calorie nutritional status is usually described using ratios of body weight and height, for example:

- **underweight** (low weight for age)—composite measure of long- and short-term nutritional status;
- **stunted** (low height for age)—long-term lack of nutrition; and
- **wasted** (low weight for height)—acute short-term lack of nutrition.

Micronutrient undernutrition

Micronutrient deficiency tends to be described in terms of the prevalence of particular vitamins and minerals.

- **Vitamin A**—helps the body maintain immune system, eyesight, skin and mucous membranes. The impact of deficiency includes a weaker immune system, increased susceptibility to infections such as HIV/AIDS (contracted through mucous membranes), skin infections, damaged foetal development, and corneal damage.
- **Iron**—helps create red blood cells, which carry oxygen to cells to enable respiration. Iron deficiency (anaemia) results in fewer or smaller red blood cells, meaning less oxygen is carried, leading to tiredness and weakness. It causes poor concentration, reduced growth and learning difficulties. Infants, growing children and menstruating women need more iron.
- **Zinc**—supports wound healing, tissue repair, blood clotting, thyroid function, foetal development and sperm production. Zinc supplements cut common infections including pneumonia and diarrhoea. Lack of zinc appears in poor appetite, low immunity, anaemia, birth defects and sterility. Anaemia and stunting usually mean zinc deficiency.
- **Iodine**—needed to produce the hormones that regulate the thyroid gland, which regulates metabolism, growth and development. Lack of iodine is the primary cause of mental retardation globally. It also leads to miscarriage, low birthweight, disease vulnerability, learning disabilities, poor school performance and low IQ.
- **Folate**—refers to the family of B vitamins. They are needed by the foetus to grow properly and avoid neural tube defects. Lack of folate causes spina bifida and anencephaly. Women need it pre-pregnancy and in the first trimester. It needs to be in the general diet for unplanned pregnancies.

The initial determinant of nutritional status after birth is **breastfeeding**. Breastfeeding should be the central component of infant nutrition, as it normally provides all the nutrients and calories babies need. But breastfeeding needs to begin immediately on birth, be exclusive of other foodstuffs for the first six months, and be frequent enough to meet babies' appetites.[19-21]

Late initiation of breastfeeding leads to alternatives like glucose water, honey, ghutti or powdered milk being used, many of which can

increase the chances of infections and diarrhoea and all of which exclude the benefits to babies of the antibodies contained in breast milk.[7]

In India, most mothers with young children breastfeed. But three-quarters of children are not breastfed within an hour of birth. More than half of mums feed their children foods other than breast milk in the first three days of life. By around five months, only 28% are exclusively breastfed.[4]*

Problems with breastfeeding are compounded by **inadequate weaning**. After six months, infants need to be moved on to semi-solid foods. To get enough calories and nutrition, it is a question of making sure children eat frequently and that diet is balanced, including the right micronutrients.[19] Yet 45% of children in India are weaned on fluids. Only 42% of children aged six to 23 months are fed the minimum number of times recommended, and only 35% consume the recommended minimum of three food groups.[4]

The weaning period, at 18 to 24 months, is one of critical risk for Indian children, reflected in stunting and wasting levels peaking. Of children this age, 58% are stunted, 30% are severely stunted and one fifth are severely underweight.[4]

A final component of undernutrition is lack of micronutrients. This is caused by inadequate **diet diversity**, **food fortification** and **direct supplementation**. Amongst others, Vitamin A, iodine and iron are central to physical development. But the Indian population suffers widespread anaemia, with 70% of children aged between six and 59 months anaemic, probably because of dietary composition.[4, 22] Anaemia levels are also extremely high among adolescent girls and pregnant women. A further problem is lack of iodine. Inadequate levels are directly linked to retardation, but 200 million people in India risk deficiency—fewer than half of households use iodised salt.[4] The situation is similar with Vitamin A, essential to eye health and the functioning of the immune system.

Health

Health relates closely to nutrition, with young children vulnerable to diarrhoea, intestinal worms and pneumonia as well as infectious diseases like measles, malaria and TB. These obviously have a direct impact on children's well-being, but they also affect well-being indirectly through damaging children's ability to absorb nutrients.[12]

Around a tenth of children in India suffer from **diarrhoea**, and almost a sixth suffer from fever. More than half of under-threes are deprived of full **immunisation**, with children often beginning but infrequently completing vaccination courses.[4]

Underpinning this is lack of prevention—particularly adequate **sanitation**. Only half of the urban population and 18% of the rural population have access to adequate sanitation ('improved toilets'). Only in 21% of households are children's stools disposed of safely.[4]

Good health also requires carers not to do the wrong things. A range of harmful cultural practices are prevalent in India, including denying newborns the first milk (anti-body rich 'colostrum'), keeping babies too cool and, in some areas, not feeding children during illness.[1] More than a quarter of children with diarrhoea get no treatment; 41% have their fluid intake cut and 45% have food levels cut. Lack of timely and sensible management of childhood illness is at the heart of underdevelopment.[4]

Care

The final key component that supports childhood development is care, understood here in the broad sense of social and emotional care, including **stimulation, affection, security** and **love**.[7]

For babies and young children, this includes engaging with them through look, touch and speech, and responding to them positively. For older infants, it means quality **pre-school education** and **daycare**.[7, 23]

For all children, care requires positives such as parental involvement, spending time together and being listened to, as well as avoiding negatives such as **exposure to stress** and **violence**.[12, 23]

The hormone cortisol is produced under stress and is thought to have toxic effects on the developing infant's brain, particularly the limbic system that governs emotions. This can result in hyperactivity, anxiety and impulsive behaviour.

The picture on stimulation and care is the area of childhood development where analysts have the least data. But we know that the circumstances of many children and families are such that good care is unlikely. High proportions of parents work full time from soon after birth, and young siblings often end up looking after children. Maternity entitlements are generally only available to women working in the formal sector, comprising just 7% of the female workforce. Crèche and pre-school provision is limited in terms of both access and quality. For instance, the FORCES network in Delhi estimates that there are 23,000 crèches available under existing schemes, compared with potential demand of 800,000.[24]

* Of course, breastfeeding rates also drop off in developed countries like the UK. The difference is that the practice is particularly important in less wealthy places: both because the alternatives are generally worse in poorer countries, and because children start from a lower base (eg, on birthweight).

One element unifying many of these factors is the fact that they are embedded in lack of knowledge, low expectations and cultural practices. Table 4 is taken from a Save the Children India report on child nutrition. It highlights the difference between the practices established as essential to child development, and observed practice in terms of what happens on the ground.[8]

Table 4: Disconnection between desired good practice and ground realities[8]

Desired good practice	Observed practice
From conception to birth	
• Healthy mother essential for a healthy child. • Pregnant women eat well and gain weight and keep count of month of pregnancy. • Antenatal care important, at least three or four check-ups, measure blood pressure, check for anaemia and other danger signs. • Anti tetanus injection and iron and folic acid tablets.	• Eat normally, not too much. • Desire small child for easy delivery. • Do not go for antenatal care or to a doctor unless there is a 'problem'; pregnancy a part of life, it is not an illness. • Not really aware of exact weeks of pregnancy, have a rough idea. • Not serious about anti tetanus injection, not sure why it is necessary. • Iron pills thrown away or taken irregularly.
From birth to 18 months	
• Mother eats well and balanced diet, to produce sufficient milk for the child. • Breastfeeding immediately after birth and exclusive breastfeeding up to six months and continue to breastfeed up to one year. • Demand feeding (the child knows best when it needs a feed). • Weaning food after three months. • If supplementary milk is unavoidable, emphasis on keeping bottle clean (sterilised).	• Mother eats well but only 'hot' foods and foods for 'healing the wound'. • Varied practices with respect to breastfeeding immediately after birth. • Breastfeeding until next child is on the way, feed up to two years. Demand feeding and comfort feeding to keep the child quiet, even when the mother has little milk. • No special weaning food among the very poor; child eats whatever is cooked for others. • Supplementary feeding irregular, mostly with spoon or glass. If a bottle is used, it is just washed.
Early childhood care, immunisation and illness	
• Immunisations absolutely essential: triple antigen, polio (three doses), measles. • Approach to illness is preventive. • Proper nutrition and safe water important. • Faeces disposal practices, environmental hygiene essential to prevent infections.	• Not much motivation for immunisations; not all doses given. Polio drops given if available at doorstep and because of sustained campaign. Little knowledge of triple antigen and measles vaccines. Not aware of Vitamin A. Educated parents more serious about immunisations. • Approach to illness is curative. Cold, cough, skin irritations, moderate fever not considered serious. • Nutrition not directly connected with health, special diet (not necessarily nutritious) after an illness, is important. 'Filling the stomach' is of primary importance.
Growth	
• Height and weight for age an important indicator of health. • Also age-specific milestones for assessing physical and mental development. Immunisations and proper nutrition are for achieving these ends. If milestones are inordinately delayed, a doctor should be contacted.	• Height and weight have little meaning to parents unless very noticeably different from other children. • Children not tracked accurately after two or three years. As a result, the height/weight/age charts do not mean much, not even to childcare workers. • There is a different awareness of milestones (not the result of awareness-building efforts).
Environmental hygiene	
• Good health is dependent on cleanliness of the self and of surroundings. • Wash hands before cooking and eating. • Keep surrounding free of household waste, urine, defecation, cow dung etc.	• Poverty, poor housing, no sanitation, no safe drinking water lead to poor personal hygiene and unclean surroundings. • This is not necessarily correlated to illness in the family or persistent diarrhoea.

Particularly striking is a wealth of evidence that parents and communities simply do not recognise that their children are under-sized or ill, or that pregnancy is a special status. Their 'reference norm' is other under-sized or ill children, and regular pregnancy. NPC and Copal analysts were told that mums do not know their child is ill because a stunted two year old can look like a healthy one year old. This makes it hard to change behaviour or create demand for better services, as people do not realise there is a problem or that they need extra care or help. There is a broader literature highlighting the lack of recognition of bad health among the very poor (and their faith in inadequate treatments and health providers).[25] In this respect, ECD stands in profound contrast to an area like education, where demand is widespread.[26]

Structural causes of underdevelopment

As highlighted above, there are many elements that affect a child's start in life. But the preconditions for achieving these elements are likely to go well beyond the immediate circumstances of children themselves, to include the wider social, economic and cultural environment.

Indirect and structural causes of underdevelopment are typically a mix of:[3, 8, 27]

- the knowledge and understanding of individuals, families and communities. This in turn depends on access to information and freedom from disinformation;
- available resources such as income, assets and time, and how these are distributed—especially within the household and between men and women;
- access to services, enjoyment and enforcement of rights;
- government policy and regulation; and.
- the labour market and the wider economy.

For instance, nutrition depends heavily on the health of mothers and the knowledge and support they get in feeding infants. These factors in turn depend not only on food availability and prices in the economy as a whole, but also on how resources are distributed within households, gender attitudes and the availability of health services.[7]

Health depends on a hygienic, safe environment including access to clean water and sanitation. But much rural and urban living in India is characterised by crowding, lack of clean water, poor sanitation, high levels of rubbish, exposure to dirt and (in some cases) environmental toxins. Health services are very limited. In the public sector in India, there are only 1.5 doctors and 8 nurses for every 10,000 inhabitants. 68% of hospitals are in the private sector—a real barrier in a country where more than a quarter of the population is below the poverty line.[3]

The quality of childcare depends on how much time parents have for each child, which in turn depends on diverse factors ranging from the structure of the rural and urban economy to birth spacing.

Most women work in the informal sector—in the fields, on construction sites and as domestic helps—and cannot afford to take time off to look after a new baby. Many of them have to do physical work right up to the birth of their child, lifting rubble, harvesting crops and walking for many miles. Most go back to work a few days after their child's birth. These women are stuck between a rock and a hard place. They either have to take the child to the workplace, where he or she lies neglected and exposed to the elements, or they leave the child at home, often with older siblings, who might be not more than a few years old themselves. Both situations are unsatisfactory. Not only does it place a great deal of physical and emotional stress on the mother, but it threatens the growth and survival of the child, because the mother is not able to breastfeed or care for the child in the day.[7]

An important structural cause, examined more in a later chapter, is the inadequacy of government and other services. There are few crèches in the formal sector, let alone in the informal sector. The most relevant scheme is the Integrated Child Development Services scheme (ICDS), but this only provides daycare for over-threes and then only usually for half a day. Its other services do not reach everyone they should.[2, 7, 8]

On birth spacing and early motherhood, one fifth of fertility occurs among girls aged 15 to 19, and a quarter of those girls give birth to babies at less than 18 month intervals. India has a pregnancy pattern of *'too early, too many and too close together'*.[3] Age of marriage, age at first baby, maternal education and income

levels are all correlated with infant nutrition and development. For example, the proportion of children who are severely underweight is almost five times higher for children whose mothers have no education than for children whose mothers have twelve or more years of education. Three quarters of children with mothers with twelve plus years of education receive all basic vaccinations, while only a quarter of children of mothers with no education receive all vaccinations.[4, 8]

A recurrent theme in the literature and among experts is that the status and well-being of mothers and adolescent girls is at the heart of ECD. NPC and Copal heard many reports during our research highlighting the low status of women: boys and men being prioritised for food, eating first and most; women being second in line for care and help, even during pregnancy; women having little control over their fertility; and women having few attractive options in the labour market. Box 4 highlights other affected groups.

This review of causes strongly underlines the range and complexity of the different factors influencing inadequate child development. Understanding the drivers of the problem is the vital prerequisite for donors to think through the different ways of tackling it. This is the subject of the next chapter of this report.

Box 4: Which groups are particularly affected?

Problems with development are widespread among Indian children, but some groups are particularly likely to be affected. These groups are overlapping and, in some cases, likely cumulatively to be disadvantageous (for example, within excluded segments, girls do worse than boys). Vulnerable groups include:

Low castes and tribals—8% of India's households belong to scheduled tribes and 17% to scheduled castes. The country's 167 million Dalits ('untouchables') still face huge discrimination in access to rights and services. Nearly three quarters of Dalit women continue to have home births, unassisted by a trained birth attendant.[3, 4]

Girls (and mothers)—Boys and girls have an equal chance of being undernourished.[4] Yet between the ages of one and four, the mortality rate for girls is 61% higher than for boys. In addition, the median duration of breastfeeding is about two months shorter for girls than boys. Treatment for illness is more likely for boys than for girls.[4, 8]

Poor children—Poverty rates in India range from less than 10% in the richest states to more than 40% in the two poorest states, Orissa and Bihar. A child born into a family in the wealthiest fifth of the population is around three times more likely to receive all basic vaccinations than a child born in the country's poorest fifth. 28% of severely underweight children are in India's poorest fifth, compared to 5% in its richest.[4] However, this is not a neat picture. The proportion of children who are stunted is approaching twice the proportion of children below the poverty line (possibly because the poverty line is defined in very minimalist terms). There are lots of examples of poorer states that perform better than wealthier peers on aspects of development. In addition, children across different income levels suffer from anaemia, and breastfeeding rates fall with increases in income and urbanisation.[8]

Other overlapping segments highlighted by commentators include disabled children, children affected by HIV/AIDS (either themselves or their parents), children of migrant workers, street children, children of single mothers (bereaved, abandoned), children of sex workers, hill and forest peoples, and Muslims.[7, 8, 28]

Photograph supplied by Tara Chand & Iona Miller

How can early childhood development be improved?

The previous chapter showed that early childhood development is foundational to people's whole life chances. But Indian children often get a bad start. The causes are complicated and multilayered, embedded in India's social structures and economy. This might imply complicated, multilayered solutions.

This chapter examines what works in improving childhood development. The good news is that there are a range of promising approaches—integrated ECD programmes can address some of the key causes. Donors need to understand what works in order to be able to decide how to prioritise funding.

Which approaches work?

There are a wide range of things that need to happen to improve child development. These include:

- better health and nutrition for mothers before, during and after birth;
- improved breastfeeding and feeding practices, including during weaning;
- better access to micronutrients for key groups and the population as a whole;
- prevention of disease;
- treatment of disease through better recognition, management and referral;
- better, time rich, high-quality childcare;
- better planning of families, including better-spaced children and not having children too young;
- more educated, empowered women and men; and
- secure, affordable food.

This is clearly a long list, and there is a danger that donors might be put off by the range and complexity of these factors. However, evidence on the interventions and approaches that produce these outcomes is relatively strong compared to some other fields. There is a large academic and policy literature on many of the problems and possible approaches to them, albeit not always consensus or certainty.[29] One reason for this is that interventions that look promising have not always been repeated in different contexts. While donors need to be cautious about transferring results that are often identified in developed countries to poorer ones,[30] they can play a useful role in applying any approach by making sure they seek to evaluate it. The range of possibilities is listed below. They have been split here for the purposes of convenience between nutrition, health and care, but of course in practice they overlap in their effects. For instance, improvements in breastfeeding will impact nutrition and health; and daycare provision gives a good basis for nutrition and health interventions.

Nutrition

Breastfeeding counselling

A number of evaluations suggest that the very simple step of getting modestly-trained workers or volunteers to help new mothers to breastfeed can improve early initiation, colostrum feeding and exclusivity. Educating mothers during pregnancy, training health providers and providing access to outpatient feeding support also have a reasonable evidence base.[31] But small-scale, short interventions and brief breastfeeding messages do not work, so it is important that support is regular and embedded in communities.[21]

NPC and Copal were advised by workers that early initiation, avoidance of prelacteals and extension of the duration of breastfeeding are easier to achieve than exclusivity and adequate complementary feeding. Addressing wider social norms is particularly hard.

Nutrition education

What works here is less well established, but there is a coherent argument that educating mothers on nutrition improves their feeding practices. The NGO, **Children in Need Institute (CINI)** reduced low birthweight by one third in West Bengal through a combination of getting community health workers to counsel mothers and families (especially husbands and mothers-in-law) and working through panchayats (village councils) and women's groups. General principles of effective programmes include sensitivity to local context (for example, understanding cultural beliefs), using multiple channels (from local workers to folk media) and a comprehensive approach (practical support, not just information; and making sure health services are available).[32]

Micronutrient supplementation

Iron, iodine, zinc and Vitamin A are all important micronutrients that can be targeted to infants, adolescent girls and expectant mothers—there is a good evidence base for taking some specific supplements at particular times.[27] World Health Organisation guidelines recommend, amongst other things, iron and folic acid during pregnancy. But micronutrients need to be delivered in ways that go beyond clinical settings (since many people have limited contact with formal health services).

The NGO **Population Services International** has pioneered 'social marketing' of low-cost iron folate in India. However, there is more of a debate on multiple micronutrient supplements, with some voices warning against a *'narrow pharmaceutical shortcut'* and highlighting conflicting evidence on effectiveness.[33] Experts that NPC and Copal met point out that powders and sprinkles that are added to foods have to be palatable and convenient if they are to be adopted. Otherwise they will be sold or used for cattle feed.

Mass fortification of common foods

There is good evidence that mass fortification of foods can dramatically improve undernutrition that is caused by a lack of micronutrients—for example, in relation to iodine in salt.[34] It is a highly effective approach as it requires no changes in eating behaviours and it is more cost-effective than other interventions used to tackle vitamin and mineral deficiencies. But there are a number of challenges. In particular, poverty and locality can limit access to fortified foods. In India, many staples are produced locally, making fortification hard to guarantee and a potential threat to small producers (salt being a case in point). It can have limited impact where the level of micronutrient deficiency is too severe or where infections are present. Controlling intake of micronutrients where excess is harmful can also be difficult.

Food supplementation

Extra food, in the form of pre-packaged food or hot cooked meals, can be used to improve energy and micronutrient intake for at-risk groups. More widely, they can be used as a incentive for engaging people in other programmes. There is fierce debate (see later chapters) about the merits of pre-packaged food versus hot cooked meals.[7, 14] Food supplementation has a vexed relationship with agricultural production and particular interests in international aid. Some economists and policy-makers criticise 'commodity assistance', where agricultural exports are given away (or 'dumped'). They argue that commodity assistance is a short-term fix that should not be used outside of emergencies because it can undermine farmers and local food production.

Health

Community health education and provision of health services

Sometimes only institutional care will do, but in its absence, community-based approaches have a good track record in prevention and treatment. For instance, simple antenatal care, including clean handling of new babies at birth and for the first month, early recognition of low birthweight, and management of sepsis and asphyxia can reduce newborn mortality by 10–30%.[35]

Treatment of disease

Training mothers and community workers in simple protocols for the monitoring, recognition and management of malnutrition and disease can be effective. The World Health Organisation and UNICEF have developed the 'Integrated Management of Childhood Illness' programme to improve the performance of health and childcare workers treating under-fives (it is also meant to include work on feeding practices). This seems to work well where initial training (typically lasting a few days) is followed up and repeated, and where efforts are made to ensure that communities know the service is available. Otherwise, poor implementation and lack of demand can undermine the approach.[36] There is also a challenge around ensuring availability of treatment, especially where specialist facilities are needed.

Vaccination

Vaccination is a well-established means of preventing disease, often at extremely low cost on a per patient basis. But there are challenges.

On the supply side, making sure vaccines are consistently available depends on price and national and local supply chains. The **Gavi Alliance** promotes long-term, low prices by gathering government and private donations to subsidise vaccination.[37]

On the demand side, parents find it hard to complete vaccination courses for their children. Recent analysis has also highlighted the importance of simple operational details, such as failure to list and track children, to remind families in a timely manner and to ensure supervision of tasks. There needs to be a focus on 'left-outs' and 'drop-outs'.[35]

Improved access to water and sanitation

Toilets and pumps can be built fairly easily. The challenge here is not just about making physical infrastructure available but rather the 'softer' issues—especially persuading people to use toilets and to wash their hands.

Care

Crèche and daycare provision, parenting support, and stronger maternity rights

High-quality crèches can improve child development, and they have additional benefits such as safety, freeing female siblings from caring responsibilities (thus improving school attendance) and improving parental ability to earn an income.[7]

Sexual and reproductive health services

These services include information, provision of contraceptives and education on their use. A recent programme using volunteer couples to promote better 'reproductive health behaviours', as well as social marketing of contraceptives and efforts to educate unqualified local health providers, had a positive impact on efforts to 'birth space'.[35] Counselling and advice appears to have a reasonable track record where women and their families are involved. One study conducted in India found that use of contraception for delaying the first child increased from 5% to 20% over four years using this approach, compared to an increase of 4% to 8% in the control area.[38]

Gender empowerment

Efforts to empower women typically include the establishment of self-help groups, partly to provide support to change attitudes but also for economic development, such as microfinance or job training. There are some small scale evaluations of such schemes. But experts advised NPC and Copal that they do not always directly impact outcomes for children.

For example, a **Save the Children India** evaluation found that *'women's groups working on gender justice and equality were not always open to, or aware of, the grave nutrition and health situation of their children. Similarly, self-help groups that were purely focused on income generation were not sensitive to issues of infant and child malnutrition.'*[8]

The lesson here is that to improve child development in the short- or medium-term, efforts to empower women really have to prioritise children.

Which of these approaches is most effective?

The short answer is: it depends. Recent reviews have found that, of the alternatives available, breastfeeding counselling, Vitamin A supplementation and zinc fortification have the greatest proven benefits. Attention to maternal nutrition through adequate dietary intake in pregnancy and supplementation with folic acid are also likely to provide value.[20, 29]

However, reviews also point out that the design and economics of programmes are vitally important, and that there are no 'magic bullets' on offer. Moreover, the above list of interventions says very little about how they should be designed, funded and delivered.

There are other parameters that donors may wish to weigh up. For instance:

- **Time horizons:** Some interventions (such as food supplementation) offer a short-term impact. Others (such as empowerment) are much more long-term.
- **Complexity:** There is an important distinction between what are sometimes fairly narrow technical interventions (such as delivering vaccinations or building toilets) and those that require substantial behavioural or cultural change (such as changing sexual behaviour or getting people to use toilets).
- **Scale:** Some interventions (such as breastfeeding counselling) are targeted on individuals or small groups. Others (such as food fortification) are done on a mass basis.

The temptation is for donors to prefer interventions that are simple to implement with short time horizons and straightforward measurement. But this is likely to mean that longer-term, more complex approaches are sub-optimally funded. It can also mean a disproportionate share of resources going into visible capital projects (such as pumps, toilets or buildings) rather than funding ongoing 'softer' services.

In addition, these parameters inform the kinds of evidence of impact that get produced by NGOs. There is a strong bias in reporting on outputs (training courses held, self-help groups set up) as opposed to outcomes (breastfeeding practices improved, child morbidity reduced). Donors should guard against this risk.

What can donors do?

Donors can support activity at different levels. At one end of the spectrum is paying for direct service delivery to individual children or parents. Other possibilities include paying for work at the community, policy or society level—for instance, mobilising self-help groups to improve existing services, lobbying for changes to government policy, or campaigning to change attitudes. In general, there is a trade-off between reach and certainty of impact. Feeding an individual child has high certainty of impact but only helps that individual. Lobbying the Indian government to improve crèche provision has low certainty of impact but, if it worked, would reach many people.

Donors can also intervene at different points in the causal chain of underdevelopment. Interventions such as breastfeeding counselling are directly and immediately linked to the risk of undernutrition. Action on women's empowerment or adolescent reproductive health is more about tackling the long-term drivers of underdevelopment.

It is possible to go 'upstream' to address the long-term and structural determinants of undernutrition, bad health and poor care. The challenge here is that the causes are extremely complicated and the evidence base is not consistently strong in terms of the links to child outcomes.

For instance, microfinance programmes are often said to help children indirectly, by empowering women by increasing their income, thus making it easier for them to parent effectively.[39] But as apparent in the Save the Children India example above, the links between initiatives that help women and children are not certain. Others dispute the benefits of microfinance, arguing that programmes influence household power dynamics in much less predictable ways, depending heavily on the detail of design.[40]

In practice, ECD tends to be tackled as part of programmes with multiple components. These often include direct provision of health, nutrition, childcare and pre-school activities—either targeted or generic—and activities that support parents to become better carers themselves. They mix activities designed to improve child survival and development with others seeking to prevent risks and still others that are more ameliorative, addressing the negative effects of underdevelopment.

What makes a good ECD programme?

Although ECD programmes are not always evaluated robustly, policy-makers have identified a number of general principles relevant to their success or failure, which donors should be aware of. Experts that NPC and Copal spoke to mentioned several features of good programmes:

- **They are holistic.** Programmes need to address the range of child and community needs, not just food or health or care alone.
- **They are multi-level.** Programmes need to work with individuals and communities but also try and change systems and attitudes.
- **They look long-term.** Reviews published in The Lancet have shown that existing interventions designed to improve nutrition and prevent related disease could reduce stunting at 36 months by 36% and mortality between birth and 36 months by 25%.[20] The implications are that undernutrition cannot be tackled without addressing factors other than nutrition and disease (such as care, maternal and antenatal factors). Programmes need to be designed to address long-term 'intergenerational' issues.
- **They involve parents and the community.** A lot of initiatives are supply-driven, with solutions imposed 'from above'. To work, programmes need to think about demand. For instance, how to get communities to complete vaccination courses; how to get communities to want services like daycare.
- **They target younger children.** Nutrition is primarily a problem of under-two with interventions making little difference after 36 months. Attention should be focused here. *'A review of school feeding strategies in older children suggests that the effect could lead to an increase in BMI rather than a substantial effect on stunting.'*[20]
- **They consciously focus on quality.** ECD programmes that combine stimulation with nutrition and health benefit from child-initiated activities; from small-group rather than large-group activities; from low children-to-staff ratios; and from warm, well trained caregivers.

A final principle is that good ECD programmes build on what is already there. Donors need to decide how they want to relate to government activity—be it providing services that are not currently on offer, providing extra services on top of what government is doing, or changing how and what government is doing. This is relevant in India because there is a wide range of statutory programmes that directly or indirectly seek to improve ECD. No donor interested in this space is working in a vacuum. Rather, in order to make sensible decisions about allocating resources, they need to know what is happening and its strengths and weaknesses. This is the subject of the next chapter of this report.

What is government doing?

Donors seeking to improve ECD in India are not working in a vacuum. The Indian government has for more than 30 years been trying to improve development itself through its flagship programme, the Integrated Child Development Services (ICDS) scheme.

The programme is meant to be comprehensive in design and, in combination with other government initiatives, theoretically provides many of the services needed to tackle the problem.

Yet in practice the ICDS has not been working well. There are problems of coverage, of reach to disadvantaged groups and in the way its services operate on the ground.

This chapter scrutinises its strengths and weaknesses and uses the analysis to identify funding priorities for donors.

There are a number of government schemes which have as a primary or a secondary aim the promotion of child development. Several of them are profiled in Box 5 and include:[7, 8, 41]

- **Nutrition related schemes:** eg, The Integrated Child Development Services (ICDS) scheme and, for older children, the Mid-day Meal scheme (MDM) in primary schools;
- **Health and social security programmes:** eg, The National Rural Health Mission (NRHM); National Maternity Benefit Scheme & Janani Suraksha Yojana (JSY);
- **Food security programmes:** eg, Public Distribution Scheme (PDS);

Other schemes impacting ECD include:

- **Livelihood related programmes:** eg, the National Rural Employment Guarantee Act (NREGA);
- **Drinking water and sanitation related schemes:** Accelerated Rural Water Supply Programme (ARWSP), Swajaldhara and the Central Rural Sanitation Programme (CRSP).
- **Accountability and better governance legislation:** the Right to Information Act.

For the purposes of this analysis, the single most important government programme is the ICDS, the world's largest specialist programme.

On paper at least, the ICDS looks like a sensible scheme. Its purpose is to provide young children with a package of services delivered out of local anganwadi (childcare) centres. Services are wide-ranging and include many of the elements identified as important to tackling underdevelopment (see Box 6). Thinking back to the previous chapter, which described the traits of a good ECD programme (see page 22), the ICDS seems to score well on being holistic and looking long-term. For instance, it covers children, adolescent girls, and pregnant and lactating mothers, so has an intergenerational dimension.

Of course it does not do everything—there are no elements around gender empowerment for example. But some of its other omissions arguably get picked up in other government programmes. For instance, NREGA supports women in livelihoods. Rural healthcare is partly covered by the NRHM.

The challenge is that, seen from a macro perspective, the ICDS has not really worked.[2, 41] Despite having been in existence for over 30 years, nearly half of India's children remain malnourished, with only modest improvement in the past ten years.[4] Evaluations have found only limited impacts on child development.[1, 2]

What this tells is that there are significant problems with ICDS. Some of them relate to the scheme's design, but many derive from implementation failure. In particular, it is badly under-resourced in terms of staff and funding. Also, local linkages with other services do not work well (absence of so-called 'convergence' or coordination between different providers) and there are many instances of corruption.

As is made clear below, in practice, the ICDS lacks some of the other key features of an effective ECD programme including consistent quality, targeting of younger children and community involvement.

Box 5: Select government programmes affecting ECD[8, 41]

The ICDS—the ICDS is the only major national programme in India to address the care, education, health and nutrition concerns of children under six. Its purpose is to provide young children with an integrated package of services such as supplementary nutrition, healthcare and pre-school education. It also extends to adolescent girls, pregnant women and lactating mothers. Although it is a centrally sponsored scheme, under the Ministry of Women and Child Development, the basic responsibility for implementing the programme rests with the state governments.

The Mid-day Meal scheme (MDM)—since 2005, six to fourteen year olds in government schools have been entitled to a free school meal that provides 300 calories and 8-12g of protein. The key objectives of the programme are protecting children from classroom hunger, increasing school enrolment and attendance as well as improved socialisation, addressing malnutrition, and social empowerment through provision of employment to women. The scheme has faced serious implementation problems but, early evaluations suggest, has nonetheless improved classroom attendance.

The National Rural Health Mission (NRHM)—NRHM was launched in April 2005 to reduce maternal and infant mortality. The main goals of the programme are to provide effective healthcare to rural populations throughout the country with a special focus on 18 weak states. The key components of NRHM are a cadre of Auxiliary Nurse Midwives (ANMs) in a network of sub-centres, who provide simple home-based care and can refer more serious cases to doctors and nurses in Primary Health Centres or (very scarce) district hospitals. These are supported by another worker at village level, an Accredited Social Health Activist or ASHA. In each village, a health plan is meant to be prepared through a local team headed by the Health and Sanitation Committee of the gram panchayat (village council). As its name suggests the programme excludes urban areas, which remain a major gap.

Reproductive and Child Health Programme—the Reproductive and Child Health Programme (RCH) is a component of the NHRM. It covers maternal and child health, reproductive health, family planning, antenatal check-ups and safe delivery.

National Maternity Benefit Scheme (NMBS) and Janani Suraksha Yojana (JSY)—the NMBS was launched in 1995 and made a cash payment to pregnant women below the poverty line prior to delivery. It was modified to JSY in April 2005. This scheme provides cash incentives for any scheduled caste or scheduled tribe woman who undergoes antenatal check-ups and institutional delivery.

Public Distribution Scheme (PDS)—this is an old and vast Indian safety net system under which essential commodities like wheat, rice and sugar are sold at subsidised rates to people below the poverty line through a network of fair price shops (FPS). At the time of writing, the Indian government is planning to pass new Right to Food legislation. It is unclear how this will work in practice, but it will likely involve an expansion of guaranteed cheap staples like rice for below poverty line families.

The National Rural Employment Guarantee Act (NREGA)—this is flagship scheme (2005) providing a legal guarantee for 100 days of employment in every financial year to adult members of any rural household willing to do unskilled manual work at the statutory minimum wage (currently Rs.100 or £1.25 per day). In practice, NREGA has been mainly used by women.

Why should donors care about the ICDS?

Why should donors care about the ICDS? One reason it that its scale and scope mean that any NGO with an interest in ECD will frame its services to a greater or lesser extent in relation to the ICDS. Donors need to know about it to comprehend the landscape of NGOs that they might end up funding.

But more than that, understanding the strengths and weaknesses of the programme is a vital prerequisite to thinking through where donations are best spent.

An important feature of philanthropy is that, even for the biggest donors, the sums involved are inevitably much smaller than those commanded by governments.

If philanthropy is to have impact at scale, rather than just transforming a small number of lives, it will often need to influence what government does.

If private giving matters it is because, theoretically at least, it can do things that government spending cannot, including: bearing risk; thinking long-term—free from electoral pressures; bringing to bear scarce skills; kick-starting innovation; and funding lobbying work to hold government and business to account.[5]

Box 6: ICDS[7, 8, 41]

Launched in 1975, the ICDS offers a package of services for under-sixes, pregnant women and lactating women, which fall under three broad headings—nutrition, health and pre-school education. These services are delivered through a nationwide network of ICDS centres, or anganwadi centres (AWCs). The services include:

Supplementary nutrition. It varies from state to state but under-sixes are meant to get a hot meal or a ready to eat snack providing specified levels of calories and protein. Under-threes get 'take home rations'. Pregnant and lactating women are meant to get a meal or a snack.

Growth monitoring and promotion. Children under three are meant to be weighed once a month to keep a check on their health and nutritional status. Threes to sixes are meant to be weighed once a quarter.

Nutrition and health education. Counselling sessions and home visits are meant to be provided for women aged 15-45, including advice on infant feeding, family planning, sanitation and use of health services. The aim is to help women look after both their own and their child's health and nutrition needs.

Immunisation. Children under six are meant to be immunised against six diseases: polio, diphtheria, pertussis, tetanus, measles and tuberculosis. Pregnant women are meant to be immunised against tetanus. The Health Department and the ICDS are jointly responsible for immunisation. The health staff administers the vaccinations. The anganwadi workers assist them by maintaining records, motivating the parents to participate, and organising immunisation sessions.

Health services. These are meant to include health check-ups for children under six, antenatal care of pregnant mothers, postnatal care for lactating mothers, weight recording, management of malnutrition and treatment of minor ailments.

Referral services. Workers refer sick or malnourished children, and those with disabilities to health staff at the primary health centres.

Pre-school education. The aim is to provide a learning environment to children aged three to six years, and early care and stimulation for children under the age of three.

The ICDS team

There are a number of different people involved in delivering the ICDS. All of these people have to work together in order for the ICDS to be successful.

The main actor is the **anganwadi worker (AWW)**, typically a young woman hired from the local community, but with some education. It is her job to run the centre and carry out a wide range of other tasks, including surveying the families in the neighbourhood, enrolling eligible children, ensuring that food is served on time every day, conducting the pre-school education activities, organising immunisation session with the ANM and making home visits to pregnant mothers and lactating mothers. The AWW receives just Rs 1,500 a month (around £20 a month at the time of writing).

The **anganwadi helper (AWH)** is supposed to assist the AWW, by bringing children to the centre, cooking their food and helping with the upkeep of the centre. Most of them come from poor backgrounds and have had no formal education.

Other services from outside the ICDS

The **auxiliary nurse midwife (ANM)** works for the Health Department. Again typically young women, they provide basic health care services and organise immunisation days. ANMs fall under the National Rural Health Mission.

The **accredited social health activist (ASHA)** is a new post and was created under the National Rural Health Mission. ASHAs are voluntary workers whose main task is to encourage women to access health services eg, ICDS and government hospitals. The ASHA is also supposed to help the AWW to counsel and provide nutrition and health education to women.

Box 7: Tamil Nadu is top of the class in improving child development

Tamil Nadu scores very well on a number of different child development indicators. Its immunisation rate is the highest in India (at 81%), its infant mortality rate is just 31 per 1,000 live births (compared to the national rate of 57 per 1,000), and 55% of children under three years were breastfed within an hour of birth (where it ranks second to Kerala). How has it managed this, despite having a similar levels of poverty to poorly performing states such as Rajasthan?

A great deal of its success can be attributed to the quality of its ICDS. Nearly nine in ten of the centres have their own building (compared to one in six in Uttar Pradesh), 100% of women had at least one prenatal check up before their last pregnancy (compared to 50% in Uttar Pradesh), all AWWs have been paid in the last three months (compared to 87% in Uttar Pradesh) and the centre is open for an average of 6.5 hours a day (compared to 3.5 hours a day in states such as Rajasthan and Uttar Pradesh). The basic structure of its ICDS is just like that in the rest of India. However, unlike many other states, Tamil Nadu has innovated and experimented. Each component of the ICDS has been carefully planned, and backed with adequate resources. For example, it has developed sophisticated training programmes, involving joint training with health teams, regular refresher courses, and inter-district exposure tours for ICDS workers. It has also adopted a two AWW model, which has allowed the ICDS to reach out to children under the age of three, who do not attend the centre.

So why has Tamil Nadu been able to overcome implementation problems when other states have not? NGOs cite political commitment to the social sector. Nutrition is one of its political priorities, and it has been for decades, irrespective of the party in power. One study showed that in 2000 Tamil Nadu was spending more on nutrition than the other states put together.[42]

Tamil Nadu has been able to reach the top of the rankings for child development, not only due to its high-performing ICDS, but because of other improvements in its social sector. For example, it has extended social security to the informal sector, including maternity entitlements such as maternity pay for working women.

Understanding the ICDS then helps identify where philanthropy can generate maximum value—whether that is filling gaps, piloting better ways of doing things or trying to make the existing system work better.

It is also important in ensuring that donors do not replicate government's mistakes or simply displace its funding by taking on its responsibilities.

How is the ICDS performing?

Coverage

The first problem is coverage. There is meant to be one ICDS centre for every 800 people. But large areas have not implemented this—partly because of problems of supply and partly because of demand.

ICDS really began in 1975 as a programme targeted on poor rural areas. It has been scaled up in response to a series of landmark legal judgments in India's Supreme Court. These were prompted by legal campaigns undertaken by organisations such as the People's Union for Civil Liberties in Rajasthan which sought to enforce rights in the Indian constitution (eg, the right to food, which follows from the fundamental "right to life" enshrined in Article 21 of the Indian Constitution).[43] The most important include:[7]

- a ruling in November 2001 which directed the Government of India and state governments to 'universalise' the ICDS ie, make it available everywhere.
- a 2004 ruling directing governments to expand the number of centres from 600,000 in 2004 to 1.4million by December 2008.
- a recent judgment, introducing the concept of 'anganwadis on demand'. Settlements with over 40 children under the age of six, but no centre can now demand one is set up within three months. Populations with fewer than 40 children are supposed to be reached through 'mini-AWCs'.

If the policy ambition for ICDS has been growing, what has happened on the ground is rather different. In particular:

- Universalisation has been slower to occur than hoped. The government failed to reach the 1.4million target with only one million centres in operation in December 2008.[8]
- Urban areas, remote areas and unrecognised settlements in practice find it very hard to enforce their rights. **Lack of coverage is primarily an urban and remote problem.**

Coverage problems are reflected in surveys of parents, asking them directly about their experience of ICDS. Though there are some great examples of practice (Box 7 highlights the situation in Tamil Nadu), the aggregate picture is dismal. The main survey, NFHS-3, found only one in four parents of children of the relevant age reporting getting any kind of service at all under the ICDS in the previous 12 months. Only one in seven in areas covered by a centre went regularly. Only one in five under-sixes got any vaccination in the previous 12 months. Three quarters of children in the areas covered by centres did not get any supplementary food in the previous 12 months. Over 80% had not been weighed in the previous 12 months.[4]

Similarly with parents. Pregnant and lactating mothers are meant to get supplementary nutrition, have their health status monitored and get education on health and nutrition. Eight of every ten women in areas covered by a centre got neither a service during pregnancy (78%) nor during lactation (83%).[4]

Activity within centres

The second problem is with the nature of the services actually delivered within and by centres. A major study by the Citizens' Initiative for the Rights of Children Under Six

(CIRCUS) found that many of the components most critical to child development are being squeezed out.[7] In particular:

- **Work to reach under-threes is neglected**—The anganwadi worker's time tends to be taken up with activities in the centre. Nutrition and breastfeeding counselling in people's homes does not happen. In effect, the ICDS serves more as a place where food is handed out rather than one from where parents are taught how to feed children better.
- **Pre-school education is mixed**—The CIRCUS study says that more emphasis has been placed on supplementary nutrition, and immunisation. Many women do not even know that the centres offer pre-school education and, again, view the ICDS as a place to receive food hand-outs. If correct, this is a serious deficit as pre-school education has clear links to development of socialisation, motor skills and performance at primary school. However, other studies have found that pre-school education is an excessive area of focus.[44]
- **The quality and reliability of food and supplementary feeding is variable**—Food supply is often erratic and in some states food supplies are affected for months due to administrative bottlenecks, corruption or delays in sanctioning funds. Survey findings show that many children (aged between six months and three years) do not benefit from supplementary nutrition in the form of 'take-home rations'.[7] This is because (falling prey to the pitfalls of supplementary feeding interventions highlighted in the previous chapter) the rations are diverted and sold before they reach children—often as buffalo feed. In other cases they are shared with other siblings, or given to cattle because they are inedible. Experts told NPC and Copal that some women found food culturally inappropriate and of poor quality.
- **The health component is also suffering**—Surveys revealed that only 37% of children under the age of six in Uttar Pradesh have been fully immunised, and for only 21% are health check-ups available.[7] In Rajasthan, most mothers had no inkling that home visits and nutrition and health education were available, and they did not see the anganwadi worker as someone who could help them if their child got ill. The situation should improve now that a different post—that of Accredited Social Health Activist—has been created under the National Rural Health Mission. This role is meant to help create awareness and stimulate demand for ICDS health services, as well as providing the first contact care for minor ailments such as diarrhoea.

Reach of centres

The third problem is the reach of centres to excluded social groups. One of their possible functions is as a means of integrating marginal members of the community. But discrimination is widespread. A study of 14 villages in four states found no access for disabled children and limited access for low caste and tribal children.[28] Sometimes the discrimination was direct and public. But more often it was hidden or subtle. For instance, in none of the villages was the centre located in tribal areas. Rather, they tended to be in upper class dominant hamlets. Lower caste children were often made to feel unwelcome. Children of migrant workers missed out completely because they are constantly on the move and often live in temporary housing, and the ICDS has failed to make any special provisions for them.

The anganwadi worker is a Brahmin and does not make home visits to the Maurya (Scheduled Caste) basti'. Field investigator.[7]

This is not a straightforward problem to fix: there are well-documented problems of getting higher caste workers to go to lower caste areas. In addition, where centres have employed lower caste staff, it has led to higher caste children not attending. But it is a serious social issue because the same groups tend to be excluded from other government schemes as well, not just the ICDS.[28]

Why is the ICDS underperforming?

One question for a donor is whether the problems of the ICDS are matters of implementation, or faults in its design.

The former might lead a philanthropist to try and 'capacity-build' parts of the system to make it work better as it stands. The latter would lead a philanthropist to try and devise different, better models.

A lot of NGOs point to the former, and it is certainly the case that the programme has been blighted by practical problems. These include:

Lack of basic infrastructure—Centres are short of basic equipment such as cooking utensils, medical kits, teaching aids, scales, toys and storage. In a 2006 survey of centres across six states, a quarter of the workers did not have an education kit, and four fifths did not have a toilet.[7] In urban areas, many centres are held in the anganwadi worker's home, where there is rarely space to fit 40 children. Anganwadi workers are forced to do this because of the meagre budgetary allocation for rent.[7]

Staff shortages—Many centres are non-functional or poorly supervised due to staff shortages. Supervisors, who are meant to provide much needed support and advice to workers, are too often not in post.[7]

Staff are over-burdened—The centre worker has a high workload with an estimated 21 discrete tasks to carry out—but also low support and training. Each one is supposed to feed, care for and teach 40 children. The reality is that workers spend a lot of their time on supplementary nutrition related activities. This leaves little time for other important ICDS activities such as health and nutrition education, growth promotion, home visits and meetings with the community.[2]

Lack of education and training—The anganwadi worker is supposed to get a one month induction as well as in-service training but this does not always happen in practice—partly because of a shortage in training centres and trainers. In any case, child feeding practices are virtually absent from the training of workers. While most anganwadi workers are educated to some degree, the picture is variable. In Rajasthan most of the workers surveyed had never been to school and relied on their husband, brother or son to fill the ICDS registers. They were unable to maintain the children's growth charts, let alone impart pre-school education to the older children.[7]

Coordination problems—Community health services are the product of a joint effort by the anganwadi worker and the ANM. The worker is meant to promote immunisation days, keep records, refer sick kids to health centres and get mums to seek antenatal care. ANMs are meant to undertake general health check-ups, give immunisation, dispense medicine and contraception. In practice, contact is irregular and referral weak. In rural areas, where distances are big and public transport limited, it is very difficult for the ANM to reach all the centres once every month. The introduction of the Accredited Social Health Activist (ASHA) may help here.

But the challenges do seem to go beyond implementation alone. Debate centres on:

Design—Arguably, the ICDS has historically been too focused on food security, not on (a) improving feeding and educating parents on how to improve nutrition within the family food budget, or (b) linkages with health sector. This reflects the fact that it only has one worker for both centre-based and community-based activities. The World Bank has argued against universal provision of supplementary nutrition on the grounds that it takes up too much cost. It says it should be used strategically '*as an incentive for the poor and malnourished to attend the centre where they, and mothers, can receive health and nutrition education*'.[2]

Opening hours—An additional problem of design is that ICDS centres are only meant to be open for half a day at a time, which makes them ineffective for working mothers.

Money—The CIRCUS report complains of low budgets both overall (*'less than one rupee per child per day'*) and for specific allocations such as rent.[7] However, the World Bank argues that, at an aggregate level, availability of funds '*has not been a major problem*'.[2] It points out that the ICDS supplementary nutrition programme quadrupled its spending in the decade to 2002 without improvement in nutrition outcomes. Most voices seem to agree that spending could be better targeted on poorer states.

Structure—The ICDS could be seen as two distinct programmes housed in one infrastructure: a health and nutrition programme for nought to threes and a pre-school function for four to sixes. On this reading, the underlying problem is that workers have been diverted to food and nutrition for the older age group. The World Bank has hinted that it may make sense for the ICDS to be split in to two separate approaches with its health part being integrated in to relevant services like the NHRM and pre-school part being folded into education.[2] Save the Children India has also recently said that it wants to advocate for the ICDS to be split in to two: one home and community-based programme for under-threes and one centre-based programme for three to sixes.[8]

Accountability—Most commentators agree the ICDS needs more community participation to establish and hold services to account. In most places, workers are hired and paid for by government and end up looking 'upwards' rather than 'downwards'. Local people may not realise they need ICDS-type services because it is not apparent to them that their children are underdeveloped. Where they realise that they need them, they may not understand what there are supposed to be getting so do not complain if services are not delivered. Where they understand what they are supposed to be getting, they may not have effective mechanisms for holding service providers to account. This problem goes beyond 'fault' on the part of anganwadi workers or their supervisors. The need to create demand for services strongly shapes the kind of services that get offered. There is more 'natural' demand for food than for, say, nutrition education.[7, 14]

The current situation

The ICDS then seems to be characterised by problems of implementation and design. The good news is that, thanks in part to the attention that the ICDS has received from analysts at the World Bank and in NGOs, the government has taken on board some of these criticisms. The current plan is that the ICDS will

move in to 'mission' not 'programmatic' mode meaning, among other things, that money will be channelled direct to districts.[8] It will be revised with:

- More emphasis on under-threes and infant and young child feeding practices.
- More focus on linking different services up locally eg, RCH and NRHM.
- More decentralisation and local accountability.

There is a reasonable degree of consensus about the problems that the ICDS has faced and some shared understanding of what needs to happen to make it more effective. But it remains to be seen how easily improvements can be delivered on the ground.

Lessons for donors

What does all this mean for donors? The most obvious conclusions are that there are a range of gaps and weaknesses, but that the government is doing a lot and trying to learn from past mistakes.

This chapter noted earlier that the ICDS lacks particular features identified previously as essential to effective ECD programmes. These include: consistent quality, targeting of younger children and parental/community involvement.

It noted too that donors should think carefully about maximising their impact through leveraging the advantages of philanthropy and being careful not to displace government.

These factors, and the evidence base on what works previously discussed, can be used to start thinking through a possible role for donors.

In the course of the research for this project, NPC and Copal consulted widely with experts on ECD on where philanthropists could make maximum difference.

Donor priorities

There was a surprising degree of consensus around the areas they highlighted where donors could have a role to play. These are broadly supported by NPC and Copal's own analysis and include:

- Delivering a stronger ICDS including convergence and quality anganwadi workers—at the village level or in slums, those in charge of public health, child nutrition, immunisation, treatment of illnesses rarely work well together. The anganwadi worker is the heart of the ICDS and needs to be skilled and motivated, particularly because communities may not be asking for the services she provides. This chapter has highlighted a number of problems with shortages, workload and training;
- Improving services to under-threes—particularly in relation to nutrition. The above analysis has highlighted that there are particular deficits around nutrition, which is most critically an issue affecting very young children;
- Tackling the urban deficit on services to improve ECD—this chapter has pointed out that urban coverage is the weakest point in the ICDS infrastructure. Box 8 highlights the problem;
- Focusing on hard-to-reach groups—the first chapter pointed out that hard-to-reach groups are more prone to underdevelopment; this chapter has highlighted that they are unlikely to be reached by government services. Integrated ECD programmes are likely to be particularly lacking; and
- Supporting community involvement and accountability on ECD—this is a cross-cutting theme within ECD; raising the profile of ECD issues locally is at the heart of improving familial behaviours that support child well-being and putting pressure on government services to deliver.

These objectives were deemed to be important enough to merit extra funding and attention.

Box 8: The ICDS is failing in urban areas

The ICDS model is failing children in urban areas. In general, urban governance in India is weak. There is no programme sensitivity to issues like big urban problems such as migrant and seasonal labourers. For example, many mothers do not have ID cards so they are denied services. Neither does ICDS take into account the increased costs in running a service in urban areas. It costs a great deal more to rent land in the city. However, the rent payment for the anganwadi premises is fixed at Rs.1,500 (c.£20) a month. In Delhi, where property prices are very high, it is difficult to find anything at all for this paltry sum of money, let alone a building which can house 40 children. The end result is that centres are housed in the homes of workers, or in scooter garages or behind the counter in shops. Mothers do not want to send their children to the centre if the provision of care is so poor.

In addition, children most in need, such as slum dwelling and street children, are missed out by the ICDS. This is because many of them live in unrecognised settlements, which are not covered by the ICDS. Communities are supposed to be able to demand centres if there are over 40 children in their location. However, in reality there is no demand for the ICDS because (unlike in the case of schools and education) they do not know what they are meant to be demanding.

How can these priorities be achieved?

Where there was less consensus was on the best means for donors to try to deliver these priorities. The key choice is between whether to work within the system or outside it. Working within the system could mean:

Capacity-building initiatives like training anganwadi workers.

Piloting new and better approaches to the ICDS delivering its objectives. For instance, testing how a second anganwadi worker might operate and what difference she would make to under-threes.

Lobbying to change policy and practice, eg, so that unrecognised slums get enhanced rights to ICDS; to change the ICDS so that it includes crèche services for mums with under-threes.

Working outside the system could mean:

Running services in geographies the ICDS and other government provision does not cover and/or offering services it does not provide. One example would be funding NGOs to run their own ICDS centres (NB some NGOs are contracted to run ICDS by the government in any case). Another would be funding hospitals for malnourished children.

The main advantage of the former approach is leverage. Donors can get much more 'bang for their buck' by being catalytic and influencing government structures. In general then, it makes sense to prefer this.

The disadvantages include that working through government restricts donor freedom. It may not always be possible and, even where it is, it reduces the certainty of impact. For instance, donors can pilot and prove approaches without a guarantee of them being taken up. Certainty of results is most fragile for lobbying work.

Equally, where social need is urgent and government and local bureaucracies are too dysfunctional to work, donors are faced with a moral dilemma. There are groups and issues within ECD that donors should care about but for whom and for which government is unlikely to provide in the medium term.

The ICDS system as it stands simply does not work for, say, prostitutes or seasonal migrants. The most leveraged opportunity for donors here perhaps is to link service delivery to research so that there is some wider impact beyond the funding itself.

Equally, there are services that government is not going to provide at scale any time soon—for example, specialist care for disabled children.

Ultimately a donor needs to decide how viable it is to engage with the government system to achieve the objectives suggested above. It will depend heavily on local circumstances, especially the state government.

As a general rule, NPC and Copal believe that donors should try to limit service delivery to those places where state government and local bureaucracies are very dysfunctional, and to interventions that are outside the scope of the government.

There are particular gaps in urban areas, hard-to-reach rural areas, and in places where lower castes and tribals live. Identifying these will depend on which geographies donors focus upon. The most needy states in India tend to be the so-called BIMARU states (a pun on the Hindi word for 'sick' coined from **BI**har, **MA**dhya Pradesh, **R**ajasthan and **U**ttar Pradesh) as well as some central and eastern states such as Orissa.

The main element of the ICDS that donors may want to be cautious about reproducing elsewhere is the emphasis on (badly targeted) feeding programmes. In emergency situations, humanitarian aid is vital. But otherwise, donors would be better off looking more at sustainable approaches.

Gaps in other government programmes

There are of course some important gaps in government provision outside of the ICDS. A subset directly relevant to ECD concerns maternity entitlements and crèche provision.

Maternity entitlements are available to Indian women under the Maternity Benefits and ESI Acts. However, they are only available to women working in the formal sector, comprising just 7% of the female workforce.[7] There is very little provision for women in the informal sector.

Crèches and childcare facilities are important area of support, not just because they can improve care for children but also because they free up siblings and parents.

The government is supposed to run crèches under the Rajiv Gandhi Crèche Scheme but it meets only a tiny fraction of demand and funding is in any case inadequate even for existing services.[7]

The ICDS itself clearly constitutes daycare provision but it only provides a service for children over the age of three, and in most cases it is only for half a day.

Primary school constitutes a sort of childcare for older children. The government is seeking to enshrine a fundamental right to education in

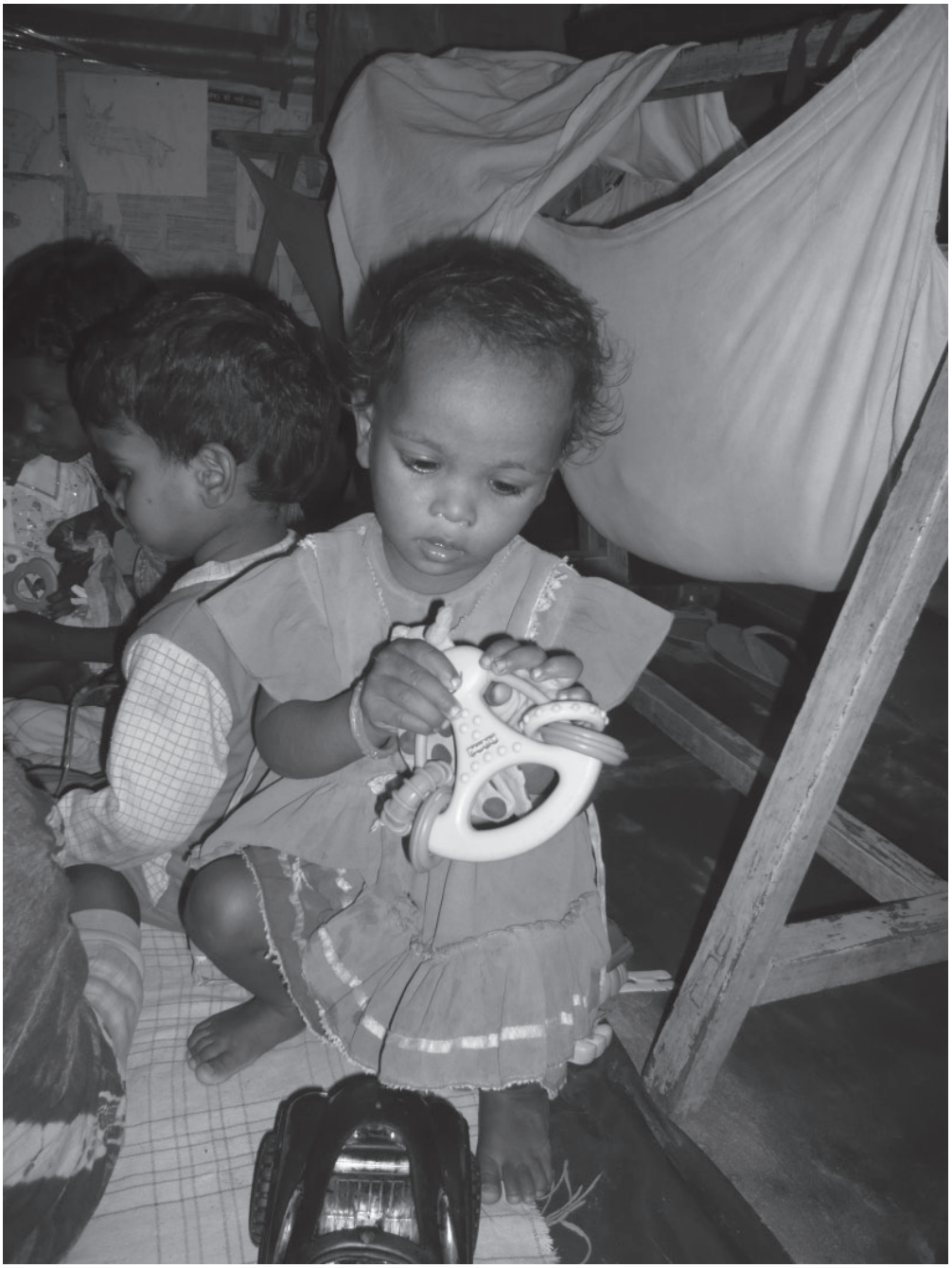
to the constitution (and therefore enforceable in law) but it only applies to six to fourteen year olds and has no pre-school element.

Separately, there are a number of pieces of legislation which require employers to provide crèches. Most significantly, the state-level terms of the National Rural Employment Guarantee Act include a degree of crèche provision. The rules say that a childcare worker should be hired to look after young children at the work site whenever five children under the age of six are present, and that there should be crèche facilities on-site. However, in reality these crèches are low quality. One expert consulted by NPC and Copal said they are defined as '*one woman, no space, no water and without any provision of play, and are not serious competition to sibling care*'.[45]

Finally, the Building and Other Construction Workers Act, 1996 states that crèches should be provided at construction sites when there are over 50 women working on-site. Unfortunately these rules are rarely adhered to, and women and their children continue to be exploited.[46]

All this emphasises a further important area for donor support—supporting lobbying and campaign work to strengthen rights to daycare and to include pre-school in the fundamental right to education.

What donors can do however is not only a function of need and gaps in government services. So far this report has highlighted these areas. But scope for philanthropy depends critically on the availability of organisations to fund and their strengths and weaknesses. This is the subject of the next chapter of this report.



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Photograph supplied by Tara Chand & Iona Miller

What are NGOs doing?

So far this report has looked at the scale of need in India regarding early childhood development and key aspects of what government is doing to improve the situation. It has used this evidence and expert advice to identify a range of priorities for donors. But to understand how they can deliver against these priorities, donors also need insight into the kinds of organisations that they might fund. The presence of robust and effective NGOs is a prerequisite of most funding.

This chapter seeks to describe the early childhood development NGO sector, and how it marries up with the priorities identified in the previous chapter.

As noted earlier in this report, robust information on Indian NGOs is relatively scarce. The views offered here are based on field research by NPC and Copal undertaken in Delhi and Rajasthan. Conversations with experts suggest that our observations have relevance to other areas of India. Nonetheless, donors seeking to support organisations in other parts of the country may wish to carry out additional research and analysis.

What are ECD NGOs?

Relatively few NGOs define themselves as having a focus on ECD.

NPC and Copal's experience on the ground is that many NGOs in India are generalist, working across a range of human welfare issues.[5] The needs of mothers and young children tend to feature as one strand of work, or embedded in other themes. This was particularly apparent among organisations that specialise in 'integrated rural development'.

The 'typical' organisation seen by NPC and Copal during our research had begun by focusing on one issue in one geography—health or education—before rapidly realising that the barriers to improving people's lives went beyond that intervention alone. Other project strands were added to develop a more integrated approach.

There seems to be a big challenge around how holistic organisations actually are in practice. Activities that would constitute an integrated approach to ECD sometimes get split between education and health organisations. The nearest coherent sector is a small body of organisations that look at maternal and child health and nutrition. But these often do not include the child and daycare dimension of the problem. Even where organisations are running a range of relevant programmes, the projects may in practice be happening in different places, with weak linkages between them.

All of this makes it hard to put parameters on the sector. When NPC and Copal encountered the problem we took a pragmatic approach. We decided that we would use a variety of existing NGO databases (see Appendix 1) to identify a big pool of organisations potentially in scope and then gather further information on their activities. We used this additional information to make a judgement about which NGOs were working with a substantial focus on improving the health, nutrition and care of children. Overall we identified just 106 organisations via this methodology, 34 in Delhi and 72 in Rajasthan.

There seems to be particularly limited activity in urban areas. NGOs working with street children often only support children over the age of six, and those working with slum populations are tied up with slum resettlement.

It should be noted that the focus on Delhi and Rajasthan excluded some well known ECD organisations which have a national or substantial regional reach, such as **Chetna** (the Centre for Health Education, Training and Nutrition Awareness), a training and capacity-building organisation in Gujurat, or the **Naandi Foundation**, which, amongst other work, promotes child rights and provides nutritious meals on an industrial scale for the Mid-day Meals scheme.

Because we were interested in identifying grassroots organisations, we also deliberately excluded INGOs. Most of the well known players cover health, nutrition and child survival to some extent. **CARE**, **Save the Children**, **Plan International**, **Catholic Relief Services** and **Family Health International** are examples, and some of **CARE India**'s work is profiled below. Many of these INGOs deliver their programmes through local NGOs, effectively operating like specialist grant-makers. Others bring technical expertise to the table, and work with the private sector to find sustainable solution to malnutrition and disease.

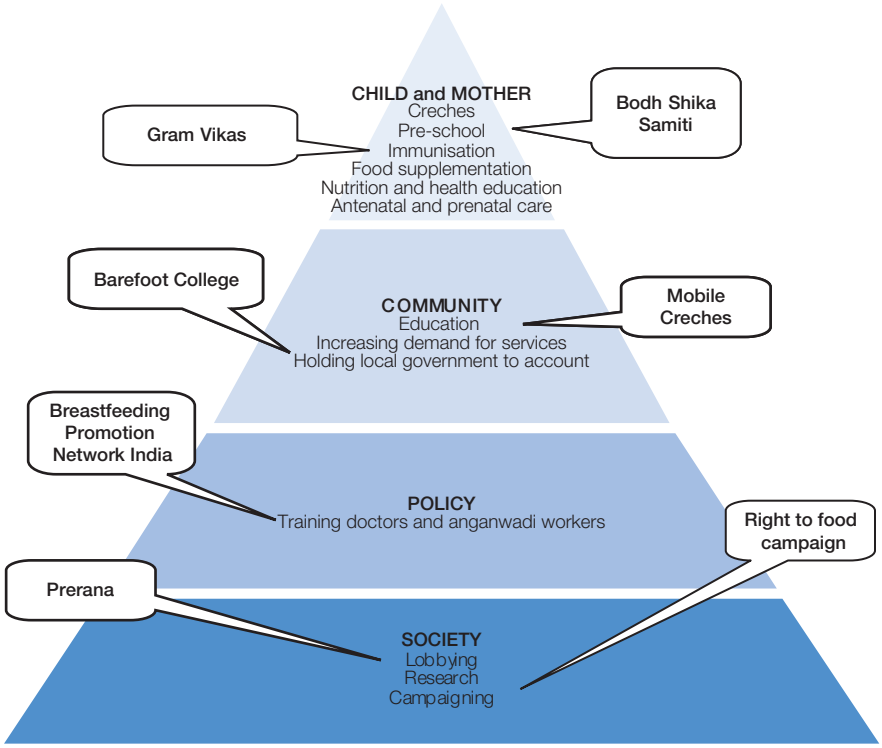
Population Services International (PSI) and the **Global Alliance for Improved Nutrition (GAIN)** are examples.

The modest size of the sector may reflect a dearth of specialist funders. The **Bernard van Leer Foundation**, based in the Netherlands, is the only dedicated international trust identified by NPC and Copal. Domestic leaders include **ICICI Bank's Social Initiatives Group**, which has an Early Child Health Practice that supports some highly innovative work. Against this, lots of generalist funders will support work that impacts on young children. Appendix 2 lists some of these. Box 11 below describes the activity of the most important multilateral and bilateral funders.

What do ECD NGOs do?

Our analysis of NGOs on the ground identified organisations seeking to improve ECD undertaking a range of different activities. Many of them have positioned themselves in relation to the ICDS—either implementing it, supplementing it, improving it or challenging it (see Box 9).

How to make sense of these different approaches? As noted previously, one way of thinking about the activity of NGOs is to analyse it by the level at which it occurs—whether it is targeting individuals, communities, policy or social attitudes. Again, as noted, there tends to be a trade-off between certainty of impact and reach. Direct services to individuals have tangible effects but often only for a limited number of people. Attempts to change policy or attitudes can be much more nebulous and risky, but if they succeed can improve the lives of thousands.



Few organisations fit solely into one part of the framework as most will be doing some activities at more than one level. Nonetheless, applying it can give a sense of the different kinds of activity going on in each area that a donor might support.

Service delivery to the child and mother

Donors will be unsurprised to hear that a lot of ECD NGOs are service-delivery orientated, working directly with mothers and children to improve their lives.

Services are provided in a number of different ways.

Sometimes they are delivered within the framework of the ICDS, from anganwadi centres. In a number of cases this is as a contracted service for government—particularly since 2006 when the state began backing NGO-run ICDS centres in earnest. In others it is supplementary services that are leveraging government infrastructure.

Equally common is services being offered as part of stand-alone programmes run by NGOs—typically in places that the ICDS has failed to reach or for excluded groups. As noted, activities may be part of wider community work rather than specifically described as ECD.

Elements of services include:

Food—NGOs, of all shapes and sizes, are involved in food supplementation and distribution, sometimes as part of development, sometimes via emergency relief. For example, **Plan India** distributed hot cooked meals and dry rations to families affected by the Bihar floods in 2008.

Antenatal and postnatal care—The ANM is supposed to provide antenatal care to pregnant and lactating women. However, as discussed earlier, many women go without because the ANMs are over-stretched. NGOs supplement government-run services. **Gram Vikas Navyuvak Mandal Laporia**, a rural development NGO in Rajasthan, runs antenatal and prenatal care services as part of its maternal and child health programme. Services include registration of pregnant women, immunisation, antenatal check-ups, safe and aseptic delivery, immunisation of newborns at their maternity centre, and referral for institutional delivery and check-ups. Similarly with **KGVK,** an NGO in one of India's poorest states, Jharkhand. Female community health workers (Sahiyas) identify and work with pregnant women from conception until their child reaches two years of age.

Box 9: NGOs working on ECD

NGOs working on ECD:

- Provide ICDS services as a contractor for government.
- Provide ICDS-type services to children who are not covered by the ICDS, eg, those in urban or rural areas, socially-excluded groups such as migrants, or the children of sex workers.
- Run services for children which are not really provided by government, eg, crèches.
- Mobilise self-help groups and/or the gram panchayat (local village council) to demand ICDS services.
- Mobilise self-help groups and/or the gram panchayat to monitor and carry out 'social audits' of ICDS services. This includes providing practical support to enforce rights (eg, using freedom of information requests; helping people complain; taking legal challenges). There are also vigilance groups that monitor the incidence of severe malnutrition and build media and other campaigns to put pressure on the government.
- Run 'model' services so that communities understand what they are missing out on.
- Run grain banks to improve food security.
- Use volunteers, local campaigns and communication to try to change behaviour at a household level.
- Provide assistance to state governments to improve the quality of their services, eg, training ICDS and healthworkers; providing tools for them to do their job better; and research. This can occur at many different administrative levels—district, block or village.
- Develop pedagogy, training and resource materials for ECD.
- Fund and build the capacity of local NGOs.
- Lobby and campaign on issues such as government programmes, maternity rights and the importance of breastfeeding.
- Provide technical and financial support to help NGOs and businesses produce and market nutrition and reproductive health products.
- Undertake longer-term work to promote livelihoods and gender empowerment.

Immunisation programmes—NGOs such as **Seva Mandir** in Udaipur organise camps to provide immunisation to pregnant women and young children from tribal communities in remote areas of southern Rajasthan. These people are not reached by government facilities. Staff visit 180 hamlets every month over the year. Seva Mandir nurses are now trained to treat simple ailments in children and conduct full antenatal check-ups. Seva Mandir has increased the immunisation rate from 6% to 35%.[47]

Balwadis (nurseries)—**Bodh Shiksha Samiti**, an education NGO based in Jaipur, runs balwadis in each of its community schools. It has developed a specific curriculum for pre-school children, involving play, singing and special teaching aids. Where necessary, Bodh refers pupils on to other sources of support, such as immunisation, nutritional supplements and basic healthcare. An interesting innovation by Bodh is its use of 'mother-teachers' (unqualified women from the community) who support the pre-school teacher and share knowledge about child development, nutrition and hygiene back with the community. Bodh also stands out from other NGOs for is emphasis on working in an urban context.

Breastfeeding and nutrition counselling—Many rural development NGOs provide women with education on infant and young child feeding practices, as part of their maternal and child health programmes. **Rajasthan Bal Kalyan Samiti** is one example. It works with mothers on a one-to-one basis, educating them in home-based care and feeding practices, and helps them to produce 'kitchen gardens' in order to grow nutritionally beneficial vegetables and grains. **CINI** works with locally trained women who go from house to house, advising mothers how to add supplementary foods available at home such as rice/chapatti and dal with mashed, locally-grown green leafy vegetables to a child's diet from six months onwards. They convey this simple message by saying that all one needs is a "fistful of food every day" to meet the calorie and protein gap of a child under three.

Providing health and hygiene education—NGOs offer health and hygiene education to mothers (and potential mothers) to help them with feeding and to understand why their children get ill, how to recognise symptoms of disease, and when and how to get help. For example, **Community Led Initiatives for Child Survival** in Maharashtra works on a one-to-one basis with pregnant and lactating mothers, educating them in how to best to care for their child. Staff offer personalised advice emphasising the importance of institutional delivery (in hospitals, not at home), hygienic practices and planned motherhood. **Rajasthan Bal Kalyan Samiti**, in Rajasthan, also counsels pregnant mothers regarding HIV/AIDS to avoid mother to child transmission.

Crèches—**Mobile Creches**, based in Delhi, runs 21 daycare services for children from deprived backgrounds, on construction sites and in slums. The centres operate from nine to five, six days a week, whilst the mothers are at work. Its services are divided into three areas: a crèche (for children aged nought to three years), a balwadi or pre-school (for three to five year olds) and non-formal education (for children aged between six and twelve years). They provide an integrated service, catering for children's and mothers' health, nutrition, care and educational needs with meals, immunisations and very high staff ratios (one to ten for infants).

Nightcare—**Prerana**, an NGO based in Mumbai's red light district, runs night care centres for children of women in prostitution. It houses around 220 children at any one time (around 40% are under the age of six). The majority of children stay at the centres for between six months and five years, getting fundamental healthcare and nutrition, as well as safety from the threats of the brothels where they would otherwise be living.

Some healthcare facilities—Community-based healthcare is a great first step but requires places for malnourished or ill children to be treated. Yet there is a dearth of government provision, especially for chronic conditions like many physical and mental disabilities. Some NGOs run hospitals, specialist facilities or services within them. **Action for Ability, Development and Inclusion** runs an early intervention programme for under-sixes at hospitals in Delhi, bringing together specialist teams of neonatologists, paediatricians, social workers, special educators and therapists. Others such as **Care Nidhi** run community-based rehabilitation programmes.

Activities at the community level

Many NGOs working on service delivery also do things at the second possible level of activity: targeting the local community as a whole. Activity here broadly falls into two main areas.

First, community mobilisation, supporting the establishment and effectiveness of different kinds of village committee. These serve to encourage village involvement directly in the running of services, but also as an accountability mechanism, monitoring what is being provided by government, gathering information and seeking redress. **Barefoot College** in Rajasthan uses the influence of its workers locally to foster the formation of village development committees to monitor government services via freedom of information requests and social audits, and hold them to account. **Mobile Creches**, in Delhi, is supporting the community to set up community-based organisations (CBOs) to activate rights to 'ICDS centres on demand' in settlements where there are 40 or more children.

The second, closely related, area of community level work is behavioural change. **Save the Children India** has recently set up Village Health Committees to promote access to health and nutrition services at the village level. These committees have members from the gram panchayat (village council) religious leaders, community leaders, local teachers, health workers, anganwadi workers and local NGOs. They use pictorial graphs and charts in village centres that promote behaviours related to breastfeeding, hand washing, maternal and newborn care. This reinforces, at a collective level, individual counselling services.

A number of NGOs use community folk education techniques—street plays and puppetry—to generate demand for government ICDS services. **Gram Chetna Kendra** in Rajasthan raises awareness about immunisation days to ensure as many mothers and children attend them as possible. Some NGOs argue that service delivery work itself (eg, running an anganwadi centre) has a community-level impact—raising public expectations by showing what good provision looks like.

The need to create demand for services might sound strange to a donor, but as noted previously, lack of child development is not always apparent to parents whose expectations are shaped by the characteristics of other underdeveloped children.[26] In addition, there is good evidence of a lack of awareness about the services to which people are entitled. Anganwadis, for instance, tend to be viewed as places to pick up food supplements, rather than a one-stop shop to promote their child's health, well-being and future prospects. So demand-generating activities not only get people to access services but are designed to prepare the community to monitor the programme and put pressure on the gram panchayat. As one expert NPC and Copal spoke to put it: '*one of the reasons the ICDS is a failure is that it is just not accountable to the community and nobody in the community is forcing it to be accountable*.'[45]

Activities at the policy level

Policy activity is the third possible level of work. ECD programmes here are typically aimed at changing wider practices—either by targeting government or, perhaps surprisingly, other NGOs.

There are two main sorts of approach. The first is capacity-building existing services by training, providing practical tools and other interventions in order to improve their quality. The second is piloting new approaches and establishing proof of concept in the hope of changing policy and practice.

Capacity-building activity is a major part of the ECD work of charities like **Save the Children India** and **CARE India**.

CARE India has done a lot of work testing new structures to make government services work better—especially for 'convergence' (joined-up working) between different departments and services. One of the most significant programmes in terms of NGO interaction relations with government is its **RACHNA** programme, profiled in detail in Box 10.[35]

Save the Children India has a Memorandum of Understanding with the Department of Women and Child Development to train up young, active anganwadi workers, for instance reaching out to marginalised communities in the slums of East Delhi.

It is also a priority for UNICEF. Its activity is profiled in Box 11 on bilateral funders.

This kind of activity is also undertaken by NGOs with a particular specialism. For example, the **Breastfeeding Promotion Network of India** trains anganwadi workers, supervisors and paediatricians on breastfeeding issues.

These partnerships with government sometimes develop in an *ad hoc* way. But increasingly common are formal public-private partnerships or PPPs. **Bodh Shiksha Samiti** is working alongside the Rajasthan state government to improve the quality of teaching in government schools.

NGOs also support other NGOs. **CHETNA** in Gujurat provides technical and capacity-building support to 'mother' NGOs to implement the government's Reproductive and Child Health Programme (RCH) effectively.

So-called 'mother' NGOs nurture, manage and coordinate local field NGOs, running demonstration projects and facilitating linkages with district level health infrastructure and key people in local government. The field NGOs go on to implement the maternal and child health services as part of the RCH, and cover populations of between 10,000 and 15,000.

There are some specific coalitions of ECD-related NGOs seeking to promote the issue through support and research. Those with most relevance include the **FORCES network**, **Mobile Creches**, **BPNI** and the **National Nutrition Conclave**, convened by the **MS Swaminathan Research Foundation**.

If this is all broadly 'capacity-building' policy work, a lot of NGO activity is concerned with piloting new approaches, testing and documenting their effectiveness and—in some cases—seeking to get them more widely adopted.

Service delivery often has a wider policy agenda bolted on, for instance testing experimental approaches. **Seva Mandir** in Rajasthan has worked with US researchers to conduct randomised control trials of a whole series of schemes, including one to pay incentives to mothers who immunise their children, and one to monitor teacher attendance at primary schools by using digital cameras. The results have been published by the Jameel Poverty Action Lab at the Massachusetts Institute of Technology where they can potentially influence thinking on development more widely.[48]

The City Initiative for Newborn Health, an initiative run by the NGO **SNEHA**, works with healthcare workers to improve the quality of mother and baby facilities available in slum areas in Mumbai. It convenes action groups, whose members are city healthcare workers. They meet regularly to ensure quality antenatal and postnatal care is available at health posts. Through action groups SNEHA has managed to upgrade health buildings and equipment, train health workers and develop health communications material. It has also started weekly clinics on an accessible, approachable and affordable basis for vulnerable women. After an initial monitoring period, SNEHA hands the groups over to municipal officials.

A final example here is the fortification of staple foods. The international NGO **GAIN** works in collaboration with the private and public sector to try to implement financially sustainable models of fortification. **GAIN,** in partnership with the World Food Programme, is providing fortified complementary food for ICDS centres throughout the state of Gujarat. It hopes to cover 400,000 infants between the ages of six months and three years in the preliminary stage. Weekly packets of powdered cereal containing minerals and vitamins are distributed to the mothers who have to mix them with water or milk and feed them to their children. The ultimate aim is that this can be rolled out across India.

Box 10: The RACHNA programme[35, 49]

RACHNA (Reproductive and Child Health, Nutrition and HIV/AIDS, 2001-6) was a five year initiative of CARE India across 9 states and one of the largest NGO-run public health programmes ever undertaken, backed by USAID.

It is an excellent example of the kind of work undertaken by strategic NGOs to capacity-build government, and also of how an NGO can maximise its impact by working at multiple levels and measuring its results.

The Integrated Health and Nutrition project was one of the key elements of RACHNA. On the supply side, it supported the ICDS system and health services to improve the quality and coverage of child and maternal health and nutrition. On the demand side, it engaged communities to support infant feeding and caring practices, and maternal and child health.

What this meant in practice was a package of different interventions, none new to government services, but prioritised in terms of their effectiveness, including antenatal care, community-based newborn care, nutrition, immunisation and food supply.

CARE India's activities included, amongst other things, a whole series of activities to strengthen the government system: strengthening links between different services at different levels of government, training staff, giving them simple tools like home-visit planners, improving the supply chain for services and supplies, helping supervisors better monitor ICDS and health staff, and improving training institutions.

It also worked with grassroots NGOs via 138 partnerships. They were encouraged to develop anganwadi centres as demonstration sites for best practice—the idea was these would be replicated and scaled up through influencing government workers, and also help to mobilise the local community.

Key elements of best practice it thought could be adopted by the state system included:

Nutrition and health days—having a fixed day each month when rations are distributed by the anganwadi worker and the auxiliary nurse midwife provides immunisation and micronutrients.

Community volunteers or 'change agents'—local people trained to work with clusters of 15-25 households, supplementing the anganwadi worker to promote child health and nutrition practices.

What proved interesting was that the former was a fairly successful approach but the latter—a common tool of NGOs—was not. The level of training and mentoring required to get community volunteers to promote behaviour change effectively was more than could be sustained at scale. Far from increasing the reach of workers, as originally intended, the volunteers ended working with fewer people in villages.

Nonetheless the programme ultimately proved effective. A key finding was that relatively modest adjustments to the management of existing services could significantly increase their impact. Advice on feeding from service providers and volunteers saw an increase in exclusive breastfeeding in project areas of 13 percentage points. The proportion of 10-23 months old fully immunised increased by 16 percentage points.[35]

Above all, the programme highlights the merits of NGOs measuring their results. For instance, early on in the programme, it seemed that replication of demonstration centres being run by CARE India's partners was going well. Introduction of a household survey of the target areas however found low levels of coverage and little change in key behaviours the programme was trying to bring about.

Ultimately the programme was corrected, and evaluations are extremely promising. Overall, it is thought RACHNA averted over 13,000 deaths and was responsible for a gain of 380,719 DALYs (Disability Adjusted Life Years) over its lifetime, at a cost of US$1,098 per death averted and US$39 per DALY gained.[50]

CARE India played a catalytic role to deliver improvements in existing systems. It is one of only four innovations now being incorporated in to the ICDS.

Activities at the society level

The last component of NGO activity concerns those that work at what could be called society level—shaping government policy in ways that lead to new rights, and also changing public attitudes. This often involves lobbying and campaigning work, some of which may be controversial.

Though strictly a network of individuals, social activities and NGOs rather than an NGO itself, the **Right to Food campaign** is a great example of a voluntary sector initiative focused on social and national policy change to deliver stronger individual rights. It undertakes research, lobbying and campaigning via the legal system and the media to put pressure on the government to tackle issues like malnutrition. A related network—the **Citizens' Initiative for the Rights of Children Under Six**—has done detailed analysis of the ICDS system (much of which was drawn upon above in this analysis, especially on government policy).[7]

There are a wide range of NGOs that lobby the government to improve services, or to change or enforce legislation on specific ECD-related issues, such as **Prerana** in Mumbai.

Box 11: Multilateral and bilateral funding

There are a wide array of existing funders in India, some of whom are interested in ECD. A key distinction is between foreign government and multilateral funders, most of whom now give mainly to the Indian government, and private funders, many of whom give to NGOs.

Understanding something of their decisions on spending is important for philanthropists. First, because most donors want to focus on gaps so knowing about funding flows is critical to highlighting neglected causes. Second, because philanthropists can draw upon the existing body of knowledge and expertise.

This section focuses on the first type of funder. Two of the largest and more active donors in ECD are the World Bank and UNICEF. DFID and USAID are also somewhat active, providing technical and financial support to state governments. Only smaller bilateral agencies, such as the Canadian Government (CIDA) fund NGOs directly.

Multilateral agencies

Most of the World Bank and UNICEF's energies are focused on improving the quality of the ICDS. They have invested huge amounts of time and money in the state and central governments. For example, the World Bank has invested US$643m in the ICDS since 1990, and has committed a further US$450m over the next five years.[41]

Over the past couple of years both organisations, particularly the **World Bank**, have invested a lot of time and money in designing a package of reforms for the ICDS (this is known as ICDS IV and will be implemented over the next five years). These reforms should deal with some of the bottlenecks in implementation. Under these proposals high-burden areas (58 districts in Rajasthan, Uttar Pradesh, Madhya Pradesh, Bihar, Chattisgarh, Jharkhand, Maharashtra, and Andhra Pradesh) will be targeted and given additional resources and interventions. Reforms will also take place across India. They plan to take away the cookie-cutter approach (eg, some areas may need more than one anganwadi worker, or more mini anganwadis), provide more training to workers, give states more flexibility and decision-making powers, and place more emphasis on the nutritional component for children under the age of three and the education component for children aged three years and over. The World Bank and UNICEF sit on the 'empowered committee' which is responsible for its implementation.

UNICEF is more active at the state level, and it has regional offices in 15 states. It is the leading agency in building community-based childcare models that work. For example, in Rajasthan it implemented *Aanchal se Agan Tak*, a broad programme to manage severe child malnutrition based partly on community and partly on hospital care. It included training of anganwadi workers in WHO protocols and the development of Malnutrition Treatment Centres. Workers had to identify and regularly weigh severely malnourished children, refer them to treatment centres and pay special visits to children at home after discharge. The programme also included the development of a tool which empowers mothers with knowledge or childcare practices. This told them what to do and when do it. At the moment mothers get a lot of different information from lots of different people (AWW, ANM, ASHA). This booklet gave them all the childcare related information they might need in one place, and the information was age specific rather than being issue specific. It also linked breastfeeding and feeding with the importance of being caring and nurturing.

Evaluation of the programme by Tufts University found that overall it had increased growth monitoring and contact with anganwadi workers, with a significant increase in the percent of women feeding their newborn colostrum (47% versus 18% in non-intervention areas) and reduced pre-lacteal feeding (40% versus 51%). But medical facilities alone were not enough. Behavioural change was also needed.[51]

Other UNICEF programmes include Dular in Bihar and Bal Sanjeevni in Madhya Pradesh. It has also worked with the Government of India to promote use of iodised salt and iron, folic acid and Vitamin A supplementation for adolescents and young children.

Bilateral agencies

Only a few bilateral agencies work with (and fund) government directly. They include the British government (DFID), the American government (USAID) and the Japanese government (JICA). Smaller bilateral funders have been banned from working with/funding the government (eg, the Dutch and the Swedish governments) because the Government of India felt that the sums of money they were donating were too small to justify the cost of administering them. Experts have offered other explanations: that the Government does not want to be viewed externally as a developing nation, but 'Incredible India', which is why it has rejected so many aid agencies.

DFID has run health and nutrition programmes in five focus states – Madhya Pradesh, Bihar, Orissa, Andhra Pradesh and West Bengal. It has also funded the central government's Reproductive and Child Health Programme, to expand access to antenatal care, the provision of nutrition advice during pregnancy and to encourage breastfeeding. It has also funded UNICEF to generate best practice and run intensive pilot activities to influence national and state policy in eight key states. Finally, it has provided technical support to eight priority states for the ICDS.

Smaller bilateral agencies such as CIDA fund NGOs running ECD activities directly, as they are not able to fund government.

It campaigns on the rights of the children of prostitutes to tackle the long-term drivers including trafficking.

In Delhi, the **FORCES network** has lobbied the government to strengthen the childcare provisions of the National Rural Employment Guarantee Act. Similarly, the **Breastfeeding Promotion Network of India** has lobbied the Planning Commission to raise the profile of breastfeeding as a central means of tackling malnutrition.

A slightly different approach to impacting ECD at the society level comes from **Sesame Workshop India**, which launched the Indian version of Sesame Street *Galli Galli Sim Sim* in August 2006. The initiative includes a television show and content delivered through other media, as well as a strong educational outreach component. Its goal is to ultimately reach 1.3 million children and their caregivers living in urban slums across India's six largest cities. The *Galli Galli Sim Sim* outreach programme is being rolled out in balwadis (nurseries) and, literally, into the streets in urban slums on vegetable carts equipped with televisions, DVD players, generators and themed educational materials for children and caregivers.

Donor priorities and the ECD sector

So, how does all this NGO activity relate to donors? In the section on government this report identified a number of possible priorities for funding including:

- Delivering a stronger ICDS, including convergence and quality anganwadi workers;
- Improving services to under-threes—particularly in relation to nutrition;
- Tackling the urban deficit on services to improve ECD;
- Focusing on hard-to-reach groups;
- Supporting community involvement and accountability on ECD;
- Lobbying and campaigning.

How well do the different parts of the sector measure up against these objectives? This is important for donors to consider because an ultimate determinant of funding will be whether or not there are organisations and approaches that they can fund. The strengths and weaknesses of NGOs will inform the nature of the funding philanthropists provide.

The good news is that there are a range of organisations delivering against all these priorities. The field is at its most rich in relation to work to capacity-build the ICDS and provision of services in areas where hard-to-reach groups live. In addition, community involvement and accountability is at the heart not just of some ECD players but a wider field of integrated rural development NGOs.

However, there is a difference between funding in these areas and funding well. Promoting effective approaches against all these priority areas is not straightforward.

Tackling the urban deficit in ICDS

Tackling the urban deficit is particularly problematic—partly because of the relative dearth of urban NGOs and partly because the ICDS system fails most dramatically in cities, so there is reduced potential leverage. The underlying problems include that cities are more expensive and have more mobile populations than rural areas (see Box 8). So designing services that are well resourced and can work long-term is difficult. The NGOs that NPC and Copal saw in Delhi often had limited evidence of their impact, because their client turnover was high. In addition, urban governance often works less well than rural, meaning that NGOs that are operating tend to have to focus more on service delivery and less on unlocking government services. NGOs report that urban local bodies (the generic name covering the urban equivalents to the gram panchayat) are much harder to engage with than their village equivalents. This does not mean that donors can do nothing. Rather, they will be picking from a smaller array of organisations and they may need to take a more hands-on approach if this is their emphasis.

Engaging with hard-to-reach groups

Engaging with hard-to-reach groups also raises some interesting questions. Earlier chapters touched on the reach of the ICDS, especially in relation to caste and tribal status. Our impression is that NGOs make much more effort to engage marginal groups than government centres—for instance by placing anganwadi centre-type services in tribal dominated villages. And their social reach is one of the things that grassroots NGOs are best known for. However, there is some evidence that where NGOs are operating in socially-mixed villages, they struggle under the same constraints as government.

A recent assessment of NGO-run ICDS centres for example found that lower caste and tribal groups were often excluded. Bengali Muslim rag pickers in Delhi were shunned within one centre, having been wrongly identified by other community members as Bangladeshis.[28] This is a potentially challenging problem to overcome. Often, the contact points of NGOs in a village—even local volunteers or people

that they employ—will be more 'powerful than average' local figures. Organisations have to tread a fine line, working through existing power structures but also challenging them and entrenched cultural norms (eg, regarding children eating together).

An additional challenge: the study found that even where dalits or tribals did get involved in NGO activities in a village, they tended not to make ECD issues a priority.[28] So there are multiple barriers NGOs need to get through to reach the women and children most in need. Incidentally of course, these barriers make it hard for NGOs to evaluate impact honestly. Reporting of data tends to get mediated or at the very least influenced by the NGO's contacts. If they are the most senior people in the village, responses may not reflect the experiences of the very poorest.

Again, this is not a reason for donors to deprioritise reaching excluded groups. But it does highlight that they should ask NGOs to think carefully about who they are working with and who is excluded. It also means it is important to pay attention to the length and quality of relationships between NGOs and the places they operate.

Community involvement and accountability

A final challenging area concerns community involvement and accountability. Rather as with engaging hard-to-reach groups, this is an area where NGOs pride themselves on their performance. The theory is certainly an attractive one, namely that by involving people, NGOs can develop a resource that can help deliver services and/or make statutory services responsive. But there are some barriers—for instance, making sure that schemes are effective. Most NGOs do some work establishing committees and building community capacity (so much so that it can be hard for donors to spot the difference between alternative approaches). Villagers can suffer from 'committee fatigue' where different NGOs try to mobilise the same people in different directions. A lot of government provision is meant to include community committees at neighbourhood level, but often these are not known about, with meetings rarely held, participants untrained and low awareness of rights. NGOs working in this space need to do something meaningfully different. But they can sometimes underestimate the challenge of building community involvement.

As part of its RACHNA programme (see Box 10) **CARE India** developed a model where village volunteers ('change agents') encouraged use of ICDS services and behaviour change. The approach was used more widely by government services and eventually 250,000 were trained. But the NGO's evaluation found that they did not deliver all that was intended. In particular they ended up providing some support to anganwadi workers, but doing less than expected on promoting behaviour change or counselling villagers.[35, 49]

A recent randomised control trial of community involvement in the India government's flagship programme on universal primary education, the Sarva Shiksha Abhiyan, also produced discouraging results. To begin with, a baseline survey found that villagers were not generally aware of the representative body designed to ensure their involvement, the Village Education Committees, at all (NB These are not NGO-run). Three interventions designed and implemented by **Pratham**, India's most prominent education NGO, sought to enhance involvement by Pratham activists facilitating small group meetings in villages, culminating in a large village-wide meeting. But none of the interventions managed to affect large group indirect or direct control over schools in terms of participation by the parents, the Village Education Committee or the teacher. One intervention that emphasised small groups was successful in training volunteers to teach children to read. Among other conclusions, the authors suggest that interventions that merely give villagers information about the 'state of public goods' are unlikely to work. Villagers also need training and encouragement to use that information.[52]

This chapter's account of different sorts of NGO gives an insight into the range of possible options open to philanthropists. The analysis of donor priorities tries to highlight some of the complexities of effective funding. What it has not done so far is say much about the sector as a whole or how donors should identify and select a particular organisation to support. These matters are the subject of the final chapter of this report.

Photograph supplied by Tara Chand & Iona Miller

How effective are different NGOs?

In order to target funding on priority areas, donors need to understand the strengths and weaknesses of charities working on ECD. They also need to know how to identify effective individual organisations that they might fund. This chapter, the final one of the report, introduces NPC's framework for analysing organisations. It forms the conceptual basis of the accompanying in-depth analyses of four NGOs published alongside this report, so donors should look there to see how it works in practice. This chapter applies it to the sector as a whole to identify general lessons for philanthropists interested in working on ECD.

How can donors assess the effectiveness of NGOs?

This document has talked already about different approaches to improving ECD. But a donor looking at funding needs to think not just about the individual approach being used but about the organisation as a whole that is seeking to deliver it. NPC and Copal would argue that a well-established methodology or intervention is only as good as the effectiveness of the NGO implementing it.

We define organisational effectiveness in terms of five criteria:

- a focus on critical need;
- good evidence of results;
- good management;
- ambition (either to scale or to learn or to improve quality or to influence); and
- efficient use of resources.

These factors are, in NPC and Copal's judgement, the critical things that an organisation needs to be able to show it is achieving. Not all organisations will be succeeding well in each area but without success in some of them, it is likely than an NGO will not be delivering meaningful social change.

NPC and Copal assess an organisation's performance against these criteria by visiting NGOs and interviewing key staff including the chief executive, a trustee, programme managers and frontline workers. We also read carefully relevant documentation such as annual reports and evaluations, and analyse an organisation's financial information. Finally, because we often look at NGOs in the context of a specific sector, we can make comparisons between organisations and their peers as well as soliciting feedback on other organisations where they are known to an NGO we are analysing.

It is important to say that this approach is meant to be very flexible and requires judgement to be applied. It is not a standardised checklist. It is not always necessary to assess all charities against all criteria.

It is distinguished from other approaches used by funders in at least two ways.

First, it aims to be comprehensive and give an overview of an organisation rather than just one part of it. Most funders tend to look at single projects.

Second, it is a publicly available methodology. Any funder implicitly uses some criteria for making decisions about who they will support. The aim of this approach is to be transparent and open about what we think constitutes an effective organisation.

It is presented here not because we think it is the single right approach or the only way to think about NGO performance. Rather, we hope to encourage funders to think about their own priorities. Our approach can serve, at a minimum, as a prompt for discussion.

But what does this approach mean in practice? Separate in-depth reports on four organisations are published alongside this document, and should 'bring to life' the methodology. Donors can find them at www.philanthropycapital.org and www.copalpartners.com.

Separately, Table 5, below breaks the criteria into specific questions that donors visiting ECD charities can ask. The underlying thinking is explained in more depth in *Giving in India*.[5]

Table 5: Towards an analysis framework for early childhood development NGOs

Area for analysis	Guiding questions	Assessment criteria
Activities	What emphasis do you put on meeting the needs of young children? How will the different activities you are carrying out address ECD? Do they address health, nutrition and care in a holistic way? What about elements of the problem that you are not addressing? To what extent are you working with other organisations to fill those gaps? Which social groups are, and are you not, reaching? How does what you are doing fit in with the ICDS and other government services? How is the community involved?	Focus on the greatest needs Match with the NGOs goals Ability to adapt and innovate Potential to grow and replicate Potential synergies
Results	What are you achieving? Not just in terms of outputs, (eg, meals provided) but also outcomes (eg, nutritional status and growth). How do you know? What evidence do you have? What external evaluations have you done? How do you use your results? To improve your services, for fundraising, to share lessons learnt etc.? How do you compare to peer organisations? What have you stopped doing because it was ineffective?	Results-driven culture Evidence of positive results High quality results evidence
Ambition	Where do you want the organisation to be in three years time? Are you seeking to grow and, if so, how? What influence have you had on government and on other NGOs? What do you need funding for? What difference will extra funding make?	A clear 'theory of change' Impact on government Contribution to knowledge/services in sector
Management	What are the key challenges facing the organisation? What are the strengths and weaknesses of your trustees and how involved are they in your work? Do you have a succession plan for your chief executive? Do you have problems with recruitment, and at what levels? What training do you provide for the staff? Do you comply with the norms of transparency initiative *Credibility Alliance*?	Governance Management team Vision and strategy Staff
Use of resources	How stable and diverse is your funding? How many months of reserves do you have? What do your services cost per user? How financially sustainable are your projects? What financial skills does your board have?	Financial security Unit costs Opportunities for donors

How effective are the different NGOs working on ECD?

The factors above can be used as an analytical framework for assessing different organisations.

But for donors who want to identify their own niche, how effective are ECD NGOs as a whole?

In truth, it is very hard to have an aggregate view. What we can say is that, in the places that NPC and Copal looked at (Delhi and Rajasthan), government provision of services was very dysfunctional or, in some areas, non-existent. This meant that the NGOs we saw were trying to meet very high levels of need, often drawing on very modest resources. Most were clearly improving the welfare of the lives of the people

they worked with. But, with a few notable exceptions, they were more focused on 'doing' and 'surviving' rather than on thinking about their impact.

NPC and Copal's framework for analysing NGOs does not just apply to individual organisations—it also lends itself to describing the features of the sector. Key observations based on our research and the organisations we saw include:

Focus on need

Few NGOs focus on young children—As mentioned previously, few NGOs are focused on children under six. NGOs often want to provide resources to the whole community, so do not give as much focus to young children as academic evidence on the importance of early years would suggest is merited. NGOs we have come across in Rajasthan and Delhi have been focused on older children (of school going age), rural development, and sub-groups (eg, street children, migrant populations). These NGOs run projects for young children and their mothers, but it is not always high up on their list of priorities and their activities are not usually integrated. A lot of organisations talk about holistic approaches but are weak at articulating the links between different aspects of their services—especially health and early education. Lack of 'holism' may be partly because the ICDS is already theoretically in place; partly because of funding; and partly because of their skills and resources. Some underlying issues, particularly maternal living and working conditions, do not seem to have been consistently well-integrated into ECD.

Results

Poor results measurement—A central belief of NPC and Copal is that NGOs measuring their results is fundamental to delivering social change well. The reasons for this are outlined in other NPC and Copal research (see the sister report of this one, *Giving in India*[5]) but, in summary: organisations that measure can use information on what is working and what is not to do better at helping the people they work with. In the absence of measurement, organisations may be making mistakes, missing opportunities or even causing harm—intuition is a misleading guide to what works long-term.

The bad news is that most ECD charities visited by NPC and Copal did not do much measurement. Relatively few could provide evidence that they had demonstrably changed children's development.

This is partly because there is no single metric of child development. NGOs have to try to address proxies like nutrition, health and care quality.

But it is also because of wider challenges. Some made no attempt at all to measure their impact, because they 'could see the results with their own eyes'. Others felt the impact of their work could not be captured easily. Some were hamstrung by working with hard-to-track groups like migrants.

Others recorded outputs, such as numbers of children attending a balwadi, or numbers of training sessions, but failed to track what this really meant in terms of improvements to children's lives. A number of organisations tracked progress of individuals, but failed to collate the information in order to see how their service as a whole had performed.

The majority of the organisations measuring results did so because they were asked to by a donor. Only one or two measured results in order to use the findings to make strategic decisions. A handful had partnered with universities to carry out very robust evaluations of particular interventions.

NPC and Copal suspect that poor results measurement is not a characteristic unique to the ECD sector, but one of the voluntary sector as a whole. Box 12 highlights some organisations that did manage to evidence their impact more robustly.

A key challenge is that NGOs sometimes measure improved practices, but these do not always lead to improved outcomes. A programme in Rajasthan being run by UNICEF and a government department (so not an NGO-run activity, but similar to some NGO practice) trained sahyogini outreach workers. Despite improved weighing of babies and awareness of family-based feeding practices, cleanliness and hygiene, women continued to discard colostrum and to delay breastfeeding. Children in the targeted tribal community were over-represented among malnourished children.[8] There is a particular challenge in relation to tracking malnutrition, where NGOs should, but do not always, report on net gains or failures in nutrition status. They sometimes report only on children whose nutritional status has improved. But nutrition is dynamic.[53]

NGO quality is variable—NGO-run services are generally said to be better quality than those offered by government, but this is not always so. There have been surveys of anganwadi centres in Delhi that have been handed over to

Box 12: Examples of organisations that have measured their results

Breastfeeding Promotion Network India (BPNI), as the name suggests, is entirely focused on protecting, promoting and supporting breastfeeding in India. It recently ran a breastfeeding counselling pilot in Lalitpur district, Uttar Pradesh, to improve exclusive breastfeeding practices amongst mothers with young children. A total of 48 anganwadi workers, dais and ASHAs were trained to promote and support optimal infant and young child feeding. They visited around 300 pregnant and lactating mothers in their homes, provided education to mothers on infant and young child feeding and helped and supported them with feeding difficulties. They were supported by trained counsellors from district and block level.

The findings of this pilot (between November 2006 and December 2007) were extremely positive. Initiation of breastfeeding within an hour of birth increased significantly over one year, from 11% to 72%. Initiation of breastfeeding within one to three hours declined substantially. The rate of exclusive breastfeeding increased from 11% to over 50%. About 93% of mothers perceived their child as healthy during the final evaluation survey compared to 27%.[54]

Mobile Creches

Mobile Creches provides daycare for the children of construction workers. Quantitative evaluations show that its daycare programmes have a positive impact on children's health, nutrition and overall development in the short-term. However the majority of children do not stay at the centre for more than six months (because they are migrating with their parents), so the medium- to long-term impact of the daycare centres is less certain.

However, Mobile Creches has evaluated other work it does, providing one-to-one support to women. Its programme, which began in 2004, involves its workers visiting and counselling between 100-200 families in nine slum areas every week if they have a baby under six months old, and every month if their child is older than six months. Mobile Creches records data suggesting it has changed attitudes and practices of mothers.

In particular, it carried out a longitudinal study between 2004 and 2007 in one slum settlement, Madanpur Khaddar. It tracked 250 women, 135 of whom were pregnant and 115 had children under six. An improvement was noted in the practice of colostrum feeding (from 46% to 70%), exclusive breastfeeding (36% to 59%), and complementary feeding at six months (49% to 80%).[46]

NGOs to run by the government. One on the Bawana AWC in Delhi's slums revealed little change in quality.[24] No in-centre health services were provided and no linkages were established with nearby hospitals. The centres were dirty and lacked teaching aids. Finally, there was little concern among the community because *'the NGO centre was considered a private domain'.* Not much community awareness raising had taken place. In the words of the report: *'The NGO's role as implementers of the programme has actually eliminated the role of the community as a partner and advocate'.*[24] It is not clear how much to read into these conclusions in terms of wider implications. Perhaps the key one is that donors need to be sure that NGOs do not lose their core community focus in a rush to provide services for government. Experts NPC and Copal spoke to warned against the *'NGO contractor'* mentality.

Ambition

Exit strategy unclear—The vast scale of the problems facing young children in India present donors with a dilemma. No matter how many children an individual philanthropist supports, there will always be unmet need. This puts a premium on working in ways that have potential for scale and sustainability. In general, most of the NGOs that NPC and Copal visited had not thought as strategically as they might about growing their impact beyond their service delivery. The main kinds of strategy included: influencing government services; influencing other NGOs; contributing to research. But both analysis and activities to deliver these strategies were underdeveloped. The other possible strategy is about finding market mechanisms to tackle ECD but most NGOs were sceptical of this, a point taken up in the next paragraph. Donors needs to look carefully at the wider impact of any funding, asking NGOs to spell out their approach.

A lot of NGOs working on ECD are strongly values driven—A lot of grassroots NGOs in India have strong values including, often, a lean to the left (sometimes framed as Gandhian socialism). However this creed tends to be marked by concern about the intentions and capacity of the state as much as a desire for it to do more, as well as a more traditional suspicion of the private sector. In many cases this is rational: NGOs are working in places where government has not provided; equally, there are grave problems of business monopoly, corruption and abuse, especially around high profile issues like resettlement of communities for natural resource exploitation. In relation to ECD, most NGOs are strong defenders of the ICDS system calling for *'universalisation with quality'.* They tend to see spending as a key indicator of impact.

Political debate in ECD often coalesces around food policy in the ICDS. For instance, many NGOs that we met (though not all) oppose suggestions by the World Bank that extra spending on ICDS nutrition education could come out the existing budget via a narrowing of supplementary nutrition to only focus on at-risk target groups.

NGOs have also been highly visible in ongoing debate over the use of dry rations instead of cooked meals for the Mid-day Meals scheme. The case NGOs advance is that dry rations have low nutritional value, low fibre and high fat. They are easy to divert and sell elsewhere. And in manufacturing them centrally, the local educative and economic effects of cooked meals are lost. The case for rations is usually made in terms of cost, convenience and safety (fewer kitchens in classrooms; better hygiene).

A final iteration of debate on food that gives insight into NGO attitudes is fortification of staple foods. A proportion of grassroots NGOs tend to look at this very suspiciously, even while specialist INGOs like GAIN have been pushing forward. A key concern of opponents is the involvement of business. They also have a wider dislike of the way that fortification-based solutions to malnutrition frame the underlying social problem. Grassroots NGOs tend to see malnutrition as a problem of Indian society that can only be changed by altering power structures, the working of the economy and attitudes to gender, not technical fixes. One example is milk fortification, with GAIN in favour and some NGOs arguing the poor do not access enough milk to make it a priority intervention.

Management and use of resources

Limited capacity—Closely related to problems with results measurement, many NGOs struggle to scale up and fall short in delivering results due to capacity issues. Again, this is not a problem unique to ECD NGOs. The biggest problem is resourcing people. Many of the NGOs visited by NPC and Copal had inspirational staff. But many organisations complained of a lack of specialist skills—particularly professional skills and good quality middle management. NPC and Copal saw a number of NGOs led by a passionate, capable director, who was over-relied upon, stretched and unsupported by a second tier of management. This problem is partly explained by the fact that grassroots NGOs cannot afford to pay quality staff a competitive wage. For example, INGOs typically pay three times as much as national NGOs. This impacts results measurement, fundraising, human resources and financial management. It also affects coordination and learning between different agencies.

Funding constraints and mission creep—Some of the NGOs we saw lacked focus and were suffering from mission creep. NPC and Copal suspect that this is the result of funding constraints. In order to survive, NGOs chase pots of money and end up running tangential, unrelated activities. For example, a rural development NGO we visited in Rajasthan had just 80 staff and spread itself across seven different districts.* It ran a number of different activities across these districts, most of which operated in isolation and failed to join up with other activities. These included schools for child labourers, an environment awareness campaign, fruit sapling planting, bus stand construction and training for ASHAs. Funding constraints can also explain why some NGOs have become implementation arms for INGOs.

Implications for donors

The above discussion has highlighted a lot of points for donors to reflect upon. Where areas of concern about NGOs have been noted, they should not put donors off giving to charity. Many of them are problems across the Indian NGO sector and not just in relation to ECD. They are the inevitable consequence of working in a country as complicated and needy as India.

But the questions raised in the comments above should affect the *way* in which donors support charities.

NPC and Copal would draw two strong conclusions that underline all the rest of the analysis contained in the report and that also have relevance for any other funding in India.

The first is that donors should fund NGOs properly—NPC and Copal have argued elsewhere (see *Giving in India*[5]) that NGOs in India, derived often from the Gandhian tradition of voluntary service, are reluctant to fund their own structures properly. They operate on a shoestring, partly out of necessity and partly out of choice. This has implications for their long-term sustainability, their depth of management, their professionalism and ultimately their effectiveness. Donors often reinforce these problems through the way that they fund. Specifically, they can mistakenly focus excessively on metrics like administrative costs or fundraising costs. These metrics are wrong because costs only make sense in relation to impact.

The problem facing the Indian NGOs that NPC and Copal saw was not that they were wasteful or lavishly well appointed. Rather it was that their costs were too low to be able to run as effectively as they would like. They had very little ability to think strategically about their activities because they were fighting to meet the vast need around them, and to stay afloat.

* As per the 2001 census, the average population size of a district is two million.

Donors will not always be comfortable with the message but one of the best ways they can help charities do more is by (selectively) increasing their cost base—whether that be funding key staff (especially in areas like financial management) or paying for infrastructure like IT. Making grants unrestricted is particularly helpful.

In our experience funding Indian organisations to date, they have been surprised and delighted to receive unrestricted money, but have not always found it easy to get out of a mindset where they take instruction from their funders on where to focus. Having trust in organisations and promoting their autonomy is, in the long run, the vital prerequisite to NGOs pioneering, proving, scaling-up and replicating new solutions to the underdevelopment of India children. However, there is undeniably a tension here. NPC and Copal would argue that funders ultimately get the sector they deserve: the best long-term solution is to combine trust (as represented in unrestricted funding) with capacity-building. Restricting funding because organisations do not have capacity is ultimately a recipe for continued underperformance.

NPC and Copal's second general conclusion is that funding in India alone is often not likely to be enough to deliver transformational solutions to ECD. Because of the depth and breadth of problems, the lack of decent information and their capacity weaknesses, NGOs need other kinds of support, especially skills and networks of influence. Donors able to spare the time and with relevant capabilities should roll their sleeves up and get involved, bringing to bear the range of resources that they possess. Local knowledge and an ethical commitment to an NGO's clients is a prerequisite to hands-on engagement. But there may be a particular space for entrepreneurs to bring business thinking to social problems—for instance, of the kind already seen in some leading NGOs such as PSI. There is also a need for philanthropists to become involved in NGO governance, with boards often lacking key skills like financial management.

Conclusions

The poor state of its children's development is is one of the gravest problems facing India. Yet, until recently at least, it has had relatively little political attention and only modest progress has been made.

As this report has shown, the causes of poor development are multi-faceted and relate closely to complex underlying structural problems including the status of women.

These need long-term solutions. Yet there are established approaches that can measurably improve the nutrition, health and care of under-sixes in the interim.

This report highlights a range of priorities for donors from capacity-building the ICDS through to funding lobbying and campaigning work.

Not all the priority areas are equally easy to work in. Some—such as improving services in urban areas—are likely to need a more engaged donor. Others—such as service delivery—should be focused on areas that government does not reach or interventions that are outside its scope.

Alongside these priorities, this report highlights some broader messages on funding. In particular:

- Donors should focus more on infants and young children than they do at the moment. NPC and Copal hope that this report will influence giving such that a greater proportion of new funding goes to initiatives that will help mothers and younger children.
- Donors should be prepared to fund NGOs generously to develop their own structures. There are specific needs in relation to improving their results measurement and strengthening management. Improvements here would ensure that organisations achieve more, faster.

The underlying ambitions of this report of course go wider than just advising donors on their priorities within ECD and helping specific NGOs.

The conceptual aim of NPC and Copal's joint venture is both to demonstrate the value of analysis and research and to make the case for publicly sharing it so that NGOs and funders can learn from each other.

It is the intention of NPC and Copal that this report is read in conjunction with both its sister report, *Giving in India*,[5] and in-depth analyses of specific ECD organisations published on NPC and Copal's websites.

Collectively, these materials aim to show how social problems in India can be analysed in a structured and thoughtful way. We warmly encourage other attempts to apply this or similar frameworks.

More work is needed

This document, and its sister research, are NPC and Copal's first contribution to the wider discussions of effectiveness in the Indian voluntary sector. More needs to be done to explore and test some of the issues and ideas raised. This includes primary research on the nature and the scope of the voluntary sector in India, as well as efforts to extend analysis to other social issues and other geographies.

Both NPC and Copal continue to investigate ways of improving the effectiveness of the Indian charitable sector. We believe that these documents have helped establish 'proof of concept' for an organisation dedicated to promoting publicly available information on NGO effectiveness. But for it really to work, this initiative needs to include a coalition of India-based organisations.

We hope that this document can be a call to arms for philanthropists and NGOs to develop such work further.

Appendices

Appendix 1: NGO databases

Name	Website
FCRA	www.mha.nic.in/fcra.htm
Indian NGOs	www.indianngos.com
NGOs India	www.ngosindia.com
Planning Commission	pcserver.nic.in/ngo/
CAF India	www.cafindia.org
Karmayog	www.karmayog.org
Ministry of Women and Child Development	wcd.nic.in/
ProPoor	www.propoor.org
Give India	www.giveindia.org
Confederation of NGOs of Rural India	www.cnri.in

Appendix 2: A selection of funders impacting ECD

Name	What ECD programmes does it fund?	Which states does it fund?	Example grantees
Action Aid India	Child Rights (early childhood education, lobbying)	Andhra Pradesh, Bihar, Jharkhand, Chhattisgarh, Gujarat, Karnataka, Madhya Pradesh, Maharashtra, North East states, Orissa, Rajasthan, Tamil Nadu, Uttar Pradesh, West Bengal	Pread, CASUMM
Aga Khan Foundation	Reproductive and sexual tract infections, pre-primary education, newborn care with a focus on reducing neonatal mortality, safe motherhood, birth spacing, immunisation, breastfeeding, nutrition	Gujarat, Rajasthan, Andhra Pradesh, Maharashtra, Madhya Pradesh, Delhi	Water and Development Foundation
Bernard van Leer Foundation	Malnutrition, ICDS centres, pre-primary education and care, sexual and reproductive health	Karnataka, Gujarat, Orissa, Andhra Pradesh, Maharashtra, Delhi, Tamil Nadu, Jharkhand, Chhattisgarh	FORCES, Mobile Creches
Bill & Melinda Gates Foundation	Care during pregnancy and delivery, improved newborn care, improved healthcare for children under two	Gujarat, Tamil Nadu, Maharashtra, Delhi, (all over India)	Ashoka, SEWA

Name	What ECD programmes does it fund?	Which states does it fund?	Example grantees
Care India	Quality care at health institutions, campaigns for status of services and government accountability, nutrition, pre-school education	Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Uttar Pradesh, Rajasthan, Gujarat, Andhra Pradesh, Tamil Nadu, Andaman & Nicobar Islands	
Catholic Relief Services	Distributing micronutrient supplements, providing hygiene and nutrition education, providing take home rations, health worker training, basic community based health services	Delhi, Orissa, Chennai, Uttar Pradesh, Maharashtra, West Bengal, Gujarat, North East states	Christian NGOs
Child Rights & You (CRY)	Child rights, awareness raising on infant and child mortality, nutrition, pre-primary education	Uttar Pradesh, Delhi, Maharashtra, Gujarat, Tamil Nadu, Rajasthan, Jharkhand, Orissa, Bihar, Manipur	ACCORD, Adarsh Seva Sansthan
Christian Children Fund	Nutrition, prenatal care, immunisation, safe motherhood, pre-school education,	Maharashtra, Andhra Pradesh, Tamil Nadu, Karnataka, Uttar Pradesh	PRIDE
Concern India Foundation	Pre-primary education, works with pregnant women on safe delivery	Delhi, Mumbai, Karnataka, Andhra Pradesh, Tamil Nadu, West Bengal	
Michael and Susan Dell Foundation	Pre-primary education	Gujarat, Andhra Pradesh, Delhi, Madhya Pradesh, Rajasthan	Pratham, Nandi Foundation, AID India
EU (delegation of the Commission)	Social marketing of family planning products, reproductive and child health services	All over India	Marie Stopes International
Global Fund for Children	Pre-primary education	Delhi, West Bengal, Andhra Pradesh, Tamil Nadu, Maharashtra, Rajasthan, Karnataka, Uttar Pradesh	Prayas Education Resource Society
ICCO-Interchurch Organisation	Infant and maternal mortality, newborn health, pregnant women	Rajasthan, Orissa	Seva Mandir, Gram Vikas, PRADAN
International Planned Parenthood Federation	Maternal and child health, safe pregnancy and abortion, young people's sexual health	All over India	Family Planning Association of India
MacArthur Foundation	Strengthening birth preparedness, skill building for health professionals, policy and advocacy work on maternal mortality and morbidity, reproductive and child health	Maharashtra, Andhra Pradesh, Gujarat, Rajasthan, Delhi	Arth Mamta
Narayan Murthy Infosys Foundation	Pre-primary education, infant health	Tamil Nadu, Karnataka, Maharashtra, Andhra Pradesh, Orissa, and Punjab	The Red Cross
Oxfam Novib	Reproductive and maternal health, early marriages, adolescent girls	Bihar, Delhi, Rajasthan, Jharkhand, Andhra Pradesh, Orissa, Tamil Nadu, Gujarat	SAMA, SATHI

Name	What ECD programmes does it fund?	Which states does it fund?	Example grantees
Plan International	Birth registration, nutrition, immunisation, training for health workers, sanitation and personal hygiene, pre-school education	Andhra Pradesh, Tamil Nadu, Pondicherry, Karnataka, Maharashtra, Orissa, Bihar, Uttarakhand, Delhi, Uttar Pradesh, Gujarat, Jharkhand, Rajasthan	Chetna, FORCES, Shri, Urmul Trust, Seva Mandir
Population Foundation of India	Reproductive and child health services, reduction neonatal mortality, infant mortality, reproductive rights, malnutrition	All over India	MAMTA, CEDPA, Chetna, CINI
Population Service International	Maternal health, reproductive health, child nutrition	Delhi, Uttarakhand, Rajasthan	Action India, CRY
Save the Children Fund	Pre-school education, child and maternal health, access to basic health services, vaccination, ICDS strengthening	Jammu & Kashmir, Rajasthan, Bihar, Assam, West Bengal, Orissa, Maharashtra, Andhra Pradesh, Karnataka, Tamil Nadu, Andaman & Nicobar Islands, Pondicherry	
Sir Dorabji Tata Trust	Reproductive and child health services, adolescent girls	Tamil Nadu, Assam, Delhi, Orissa, Karnataka, Maharashtra, Jharkhand, Uttarakhand, Arunachal Pradesh, Kerala, Madhya Pradesh	National Foundation for India
Sir Ratan Tata Trust	Maternal and child health care, early diagnosis and treatment of common childhood illnesses	All over India	PSI, Ibtada
Terre des Hommes (TDH)	Pre-primary education, nutrition, maternal and child health, safe motherhood, reproductive health	Andman Islands, Uttar Pradesh, Jammu Kashmir, Delhi, Karnataka, Tamil Nadu, West Bengal, Maharashtra, Andhra Pradesh	Committed Communities Development Trust
The Canadian International Development Agency	Pre-school education, reproductive and maternal health	Southern India (the states affected by Tsunami), Tamil Nadu, Kerala	CARE, World Vision
The David and Lucile Packard Foundation	Family planning, reproductive health services	Jharkhand, Bihar, Maharashtra	Family Planning Association of India
UNFPA	Reproductive and sexual health, safe motherhood, family planning, child marriage, adolescent girls	Maharashtra, Haryana, Gujarat, West Bengal	CINI, NISHTHA

Acknowledgements

We are very grateful to the following individuals – and their organisations – for their input into our research, which informed this report:

Action Aid	Jagat Pattanaik
ARAVALI	Sachin Sachdeva
ARTH	Dr. Sharad D. Iyengar
Asha Deep Foundation	Jothi Chetty & Fr. Rajamoney
Barefoot College	S. Srinivasan (Vasu) & Teja Singh
Bhoruka Charitable Trust	Amitava Banerjee
Bill and Melinda Gates Foundation	Usha Kiran
Breastfeeding Promotion Network of India	Dr. J. P. Dadhich & Dr. Arun Gupta
Bodh Shiksha Samiti	Yogendra Bhushan, Lekha Mohan, Meenakshi Agarwal & Neha Bomb
CARE India	Mukesh Kumar
CARE India (Rajasthan)	Manish Mathur
Chetna	Smita Bajpai
Copal Partners	Jyoti Yadav
Dasra	Neera Nundy, Deval Sanghavi, Shweta Bagai & Alison Adnitt
Doosra Dashak	Anil Bordia
FORCES network	Savitri Ray
GAIN	Dr. Sadhana Bhagwat
Gram Chetna Kendra	Om Prakash Sharma & Prashant Pandey
Gram Vikas Navyuvak Mandal	Laxman Singh, Ramji Lal & Jagveer Singh
ICDS, Rajasthan	B. Praveen, IFS
Indian Council for Child Welfare	Gita Siddhartha
Mahan Seva Sansthan	Rajendra Gamath & Lalit Joshi
Mamta – Health Institute for Mother and Child	Dr. Sunil Mehra
Management Systems International	Rajani R. Ved
Michael & Susan Dell Foundation	Barun Mohanty
Mobile Creches	Mridula Bajaj, Anjali Alexander & Sarita Sharma
Ministry of Women and Child Development, Government of India	Dr. Loveleen Kacker, IAS and Mahesh Arora
National Commission For Protection of Child Rights	S. K. Ravi
National Institute of Public Cooperation & Child Development	Dr. A. K. Gopal
Nav Srishti	Reena Banerjee
Office of the Commissioners to the Supreme Court of India	Harsh Mander & Dipa Sinha
Oxfam India	Nisha Agrawal

Paul Hamlyn Foundation	Ajit Chaudhuri
Plan International	Nirali Mehta
Population Services International	Sanjeev Dham, Lekha Sapra & Deepika Yadav
Pratham	Rukmini Banerjee
Prerana	Pravin Patkar & Priti Patkar
Public Health Foundation of India	Dr. K. Srinath Reddy & Dr. Sangitha K.
Rajasthan Bal Kalyan Samiti	G. S. Sharma & Nitu Singh
Rajasthan paediatrician	Dr. Anurag Singh
Right to Food campaign	Devika Singh
Save the Children India	Dr. Renu Singh
SEDEM	Vanita Suhasini & Arun Shrivastava
Seva Mandir	Neelima Khetan, Ajay S. Mehta, H. R. Bhati, Swati Patel, Deepti Ameta, Sanjeev Jain, Priyanka Singh
Sewa Bharat	Sapna Desai
Shrushti Seva Sansthan	Nareshji Madhawat
Smile Foundation	K. K. Verma & Naresh Chaudhary
UNICEF	Deepika Shrivastava
Vihaan	Dr. Kumkum Shrivastava
The World Bank	Venita Kaul

Additionally we are heavily indebted to the following individuals who were invited to read and comment on the consultation version of this report:

Manish Mathur	Care Rajasthan
Alison Adnitt	Dasra
Dipa Sinha	Office of the Commissioners to the Supreme Court of India
Ajit Chaudhuri	Paul Hamlyn Foundation
Dr Renu Singh	Save the Children India
Deepika Shrivastava	UNICEF

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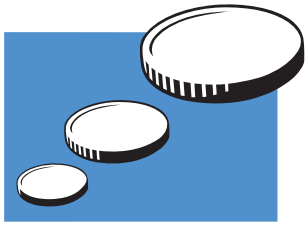

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Registered charity number 1091450.

ISBN 978-1-907262-03-6

Designed and printed by DG3 Europe. (21307)
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