

“Child-to-child approach” under ECD Programme of BRAC:  
Any change in knowledge and practice?

*follow-up survey 2005*

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## **Executive Summary**

**Introduction** The Child-to-Child component of the ECD programme began in Sherpur Upazila, Bogra in January 2003 and was completed in December 2004. A brief and focused KAP survey was done to record benchmark information before the intervention began. This report presents findings from a follow-up survey carried out to assess the effects of intervention, and make recommendations for fine-tuning the programme in future during scaling up.

**Materials and methods** For the follow-up survey, the baseline households grouped into three were re-visited and data were collected from the same adolescents, if present at the time of survey. The groups were: a) Treatment Area I: where regular ECD activities as well as ‘child-to-child’ activities were implemented, b) Treatment Area II: where only regular ECD activities were taking place and c) Treatment Area III: this served as Control area where no ECD intervention is taking place.

Respondents were unmarried adolescents aged 12-19 years (2 yrs older than the baseline, to allow for the intervention period of two years and re-visit the same adolescents) who have had an under-five child in the household at baseline. The adolescents were traced following the list prepared for the baseline. In 2003, 2000 adolescents out of a targeted 2200 (850 each from two treatment areas and 500 from control area) were interviewed (response rate 91%). There was attrition due to marriage, migration, death etc in 2005 and thus, during follow-up survey, 1600 out of 2000 baseline adolescents could be interviewed and the response rate was 80%. The quantitative survey was supplemented by three focus group discussions with adolescents from the Community Learning Centres (CLCs) and Union Libraries (ULs).

**Results** A generalized increase in knowledge about care needed for proper physical growth and mental development of children was noted among adolescents of the treatment areas compared to baseline. Adolescents from Treatment area I were more knowledgeable about feeding practices than their peers from Treatment area II. There was high level of consensus about the importance of adequate nutritious diets among all three groups of adolescents.

However, level of knowledge about the effect of harmful practices (such as quarrelling, maltreating others in presence of children etc.) for mental development of children remained low in all groups. However, level of knowledge about the harmful effects of beating and scolding showed improvement from baseline. The knowledge on association of ANC of mother with physical growth and mental development of children, and its importance for the latter, showed improvement from baseline, especially for adolescents of Treatment area I. Also, retention of knowledge on the importance of birth weight for children's physical growth was noted in the treatment areas, and at a lower level in the control area. All adolescents were more knowledgeable than at baseline about the importance of keeping children under close supervision to prevent injury and drowning.

Adolescents were found to spend time with children more at the weekends than regularly compared to baseline. Inequity in spending time with boys and girls appeared to increase in the treatment areas, but not in the control area. Interaction with children in the form of play, story-telling etc. increased in all areas, but at a much lower level in the control area. Increased participation of adolescents in stimulating the mental development of children through different ways was noted in the treatment areas more frequently than control area since baseline. They were also increasingly active in disciplining children in different ways (such as teaching them not to be rude, quarrel or fight, to obey elders etc.) other than rebuking or scolding.

**Discussion** In general, knowledge and practice related to ECD issues in the treatment areas I and II were better than in the control area, when compared with baseline values. The difference between Treatment area I and Treatment area II was marginal in case of most of the variables studied, excepting a few instances. Significant increase in knowledge related to feeding practices of the infant, importance of attending ANC by pregnant mothers for children's growth and development, preventing accidents e.g., injuries and drowning, and the practice of singing songs and reciting rhymes was observed among adolescents from Treatment area I compared to Treatment area II. These quantitative findings are also corroborated by qualitative findings from group discussion with adolescents of Treatment area I. Thus, Child-to-child approach certainly added on to the regular ECD activities by improving the knowledge base and care-giving quality of the adolescents.

## **Implications for programme**

- Motivating adolescents to spend more quality time regularly with children
- Teaching innovative ways to play with, and disciplining, children
- Supplying education materials to adolescents (e.g., story books, drawing materials etc.) that will help them to interact more knowledgeably with the children
- Refresher training to adolescents for follow-up, monitoring and participatory planning for implementing ECD activities
- Involving young parents and would-be parents in the process
- Integrating Child-to-Child activities with regular ECD activities in all programme areas for greater impact and use adolescents as change agents in the families and the communities.

## “Child-to-child approach” under ECD Programme of BRAC : Any change in knowledge and practice?

Early Childhood Development (ECD) is a comprehensive approach to develop full cognitive, emotional, social and physical potentials of children from birth to five years (Evans et al. 2000). BRAC, an indigenous NGO, is taking part in the ECD project of UNICEF, Bangladesh (Mostafa 2001). The ECD project plans to reach a population of more than 4 million households via BRAC's core programmes and infrastructures by 2005 (BRAC 2001). The front line workers (FLW) of BRAC's development, education and health program are used for empowering the family care-givers to create a safe, secure and enabling environment for the physical, emotional, cognitive and social development of children (from conception to five years). The target group is the family. Different forums of BRAC and its Front Line Workers (FLWs) are used to reach the target population. One of the components of the programme is the ‘Child-to-Child’ approach when older children take care of their younger siblings. The objective of the child-to-child approach is to provide adolescents with a knowledge and skill base to interact creatively and effectively with young children, and to develop skills of critical-thinking and problem solving among children. The young children, therefore, can learn in a safe, secure and enabling environment through playful interventions with adolescents. The child-to-child programme is being implemented in Sherpur upazila, Bogra since January 2003.

In all the villages of Sherpur upazila, regular ECD activities are taking place where the community and caregivers are sensitized and trained on ECD issues. BRAC's FLWs (*Shasthya Shebikas*, *Shasthya Karmis*, POs, NFPE Teachers etc.) undergo a three-day training programme to learn how to deliver ECD messages on various aspects of holistic development of infants and young children, and implement relevant activities. Messages are disseminated to pregnant, lactating and working mothers as well as to the newly wed couples, parents, grand parents and other family members, and adolescents through various forums. BRAC's Village Organisations (VOs) have weekly and monthly meetings where *Shasthya Shebikas* (SS), who work as volunteers in village communities, impart ECD information to the target groups. Additionally, all BRAC staff in the ECD programme areas participates in a one-day

orientation session to raise awareness and support for the programme, and influential community leaders also participate in union advocacy workshops.

In villages with Community Learning Centers (CLC) and Union Library (UL), where the child-to-child approach is taking place, adolescents (12-19 years) are being trained on developing skills for creative and effective interaction with children, and problem solving. Each adolescent is tagged with around ten families. The relevant activities undertaken by the adolescents in the families include awareness building among family members and caregivers on the importance and the tools of ECD intervention (e.g., story telling, rhymes, playing, socialization etc.), interaction with the under-fives using these ECD tools, and creation of a "safe haven" for the under-fives as well as an environment for learning while playing. The trained adolescents in turn disseminate these messages to other adolescents in the community. A monthly refresher reinforces the adolescents' skill in holistic child development.

In order to measure the effect of the intervention over time, a brief and focused baseline survey was done to record benchmark information regarding the breadth and depth of ECD knowledge and practice of the adolescents before the intervention began. ECD programme area with the "child-to-child approach" was compared with areas having ECD programme alone and with a non-BRAC area (Nasreen and Ahmed 2004). This was also reinforced by a small qualitative study. The base line survey revealed that most adolescents possessed general level of awareness about early childhood development and some superficial knowledge about the importance of adequate nutrition, birth weight, immunization for the growth and development of children and also need for close supervision for preventing accidents etc. They used to spend time with children by playing, singing rhymes and story telling and displayed love and care during their interaction with children. However, in some cases adolescents also reported using verbal and physical abuse for disciplining the children. Overall, adolescents from treatment areas had better knowledge and practice about ECD than the control area.

The current phase of the programme ended on 31<sup>st</sup> December 2004. A follow-up survey was done in January 2005 to evaluate the effects of intervention, ascertain whether it is on the right track and provide recommendations for expansion of the programme in future.

## Objectives

- A) General: Messages are disseminated to the newly wed couples, parents, grand parents, older siblings and other family members. A follow-up survey of the baseline adolescents to explore changes in knowledge and practice related to ECD issues, if any, following intervention.
- B) Specific:
  - 1. Compare and contrast the findings between the treatment areas to examine the relative effectiveness of child-to-child approach, and to examine the broader effectiveness of ECD programme vis-à-vis the non-programme area (i.e., control area)
  - 2. FGD survey with adolescents to explore in-depth dimension of changes observed in the quantitative survey

## Materials and methods

For baseline survey, villages under Sherpur Upazila were divided into three different groups as shown below and five villages from each group were selected randomly for the survey. The groups were: a) Treatment Area I: This area includes villages with CLCs and ULs, where regular ECD activities as well as the ‘child-to-child’ approach are being implemented; b) Treatment Area II: This area includes villages without CLCs and ULs, where only regular ECD activities are taking place; c) Treatment Area III (Control area): This is a non-BRAC area where no ECD intervention is taking place. In 2003, 2000 adolescents out of a targeted 2200 (850 each from two treatment areas and 500 from control area, drawn randomly) were interviewed (response rate 91%). For the follow-up survey, the households surveyed during baseline were re-visited and data were collected from the same adolescents, if present at the time of survey.

Respondents were unmarried adolescents aged 12-19 years who have had an under-five child in the household at baseline in 2003. The adolescents were traced following the list prepared for the baseline. In 2003, 2000 adolescents out of a targeted 2200 (850 each from two treatment areas and 500 from control area drawn randomly) were interviewed (response rate 91%). There was attrition due to marriage, migration, death etc in 2005 and thus, during follow-up survey, 1600 out of 2000 baseline adolescents could be interviewed and the response rate was 80%. The quantitative survey was supplemented by three focus group discussions with adolescents from the CLCs and ULs

### *Data Analysis*

Data were first analysed for cross-sectional comparison among the three groups, and also pre and post intervention.

## Results

### Socioeconomic characteristics

The socioeconomic characteristics of the study adolescents are shown in Table 1. Compared to baseline, involvement of adolescents increased in income-earning activities in all the three areas. No substantial difference in other indicators from baseline was observed. Thus the adolescents in Treatment area I remained ahead of their peers in 2005 as well.

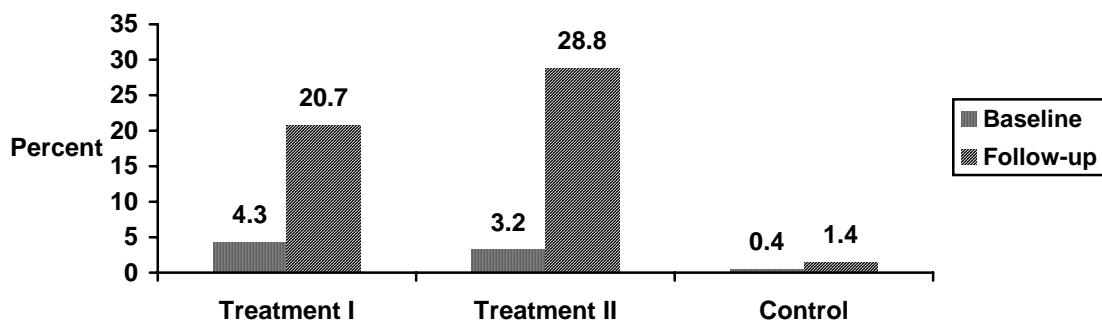
**Table 1: Adolescent respondents' socioeconomic characteristics by study area.**

	Treatment I		Treatment II		Control	
	Baseline	Follw-up	Baseline	Follw-up	Baseline	Follw-up
<b>Sex</b>						
Male	429 (51.2)	353 (52.5)	451 (50.2)	376 (51.4)	130 (49.4)	106 (50.7)
Female	409 (48.8)	319 (47.5)	448 (49.8)	355 (48.6)	133 (50.6)	103 (49.3)
<b>BRAC Eligible HH</b>	358 (42.7)	351 (52.2)	407 (45.3)	353 (48.3)	109 (41.4)	83 (39.7)
<b>Schooling</b>						
None	49 (5.8)	37 (5.5)	71 (7.9)	49 (6.7)	27 (10.3)	21 (10.0)
≤ 5 years	470 (56.1)	393 (58.5)	565 (62.8)	478 (65.4)	187 (71.1)	150 (71.8)
5+ years	319 (38.1)	242 (36.0)	263 (29.3)	204 (27.9)	49 (18.6)	38 (18.2)
<b>Mother's schooling</b>						
None	616 (73.6)	488 (72.7)	643 (71.7)	523 (71.7)	217 (80.6)	172 (82.3)
≤ 5 years	158 (18.9)	129 (19.2)	178 (19.8)	142 (19.5)	36 (13.7)	29 (13.9)
5+ years	63 (7.5)	54 (8.0)	76 (8.4)	64 (8.8)	10 (3.8)	8 (3.8)
<b>Father's schooling</b>						
None	529 (63.3)	423 (63.1)	516 (78.4)	416 (57.1)	176 (66.9)	137 (65.4)
≤ 5 years	140 (16.7)	114 (17.0)	187 (20.8)	157 (21.5)	35 (13.3)	29 (13.9)
5+ years	158 (20.0)	134 (19.9)	194 (21.6)	156 (21.4)	52 (19.8)	43 (20.6)
<b>Adolescent's</b>						
<b>Involve in income earning activities</b>	191 (22.8)	176 (26.2)	134 (14.9)	170 (23.3)	35 (13.3)	55 (26.3)
<b>Mother's involvement in Income earning activities</b>	48 (5.8)	33 (5.0)	30 (3.4)	23 (3.2)	-	-

*Note: Treatment area I: ECD + C-to-C; Treatment area II: ECD only; Control: Neither ECD nor C-to-C*

Birth registration of the newborn appeared to increase substantially in 2005 in both the treatment areas (Fig 1).

**Fig 1: Birth registration of children at baseline and follow-up survey by area**



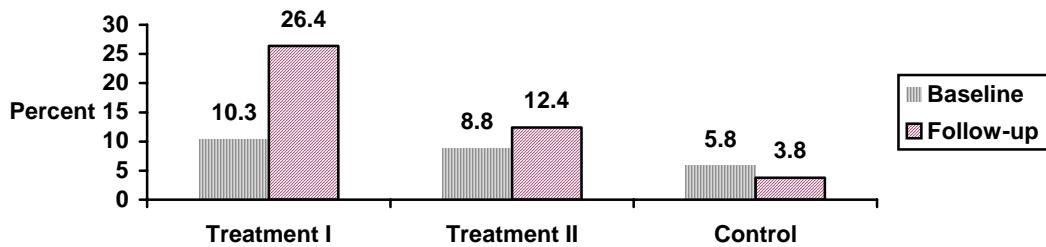
### Knowledge and awareness

Awareness about ECD was universal in the treatment areas. Proportionately more adolescents from treatment areas were knowledgeable about the correct meaning of ‘physical growth’ than in the baseline while a decline in such knowledge was noted in the control area. On the other hand, correct knowledge about ‘mental development’ saw a universal decline in the treatment areas but remained unchanged in the control area (Table 2). However, awareness of the difference between physical growth and mental development improved substantially in all areas.

**Table 2: ECD aware adolescents knowledge on what physical growth and mental development means**

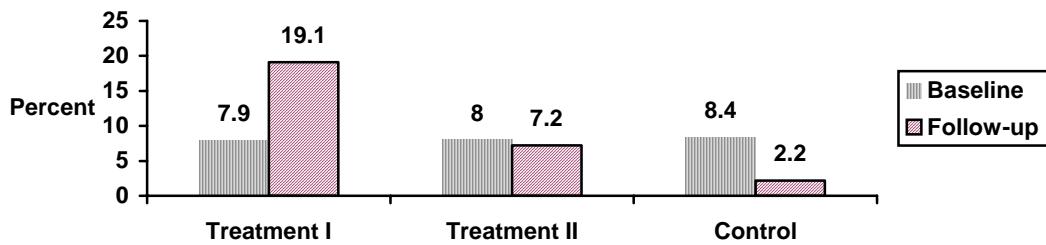
	Treatment area I		Treatment area II		Control area	
	Baseline	Follow-up	Baseline	Follow-up	Baseline	Follow-up
<b>Have heard of ECD</b>	642 (76.6)	671 (99.9)	738 (82.1)	723 (98.9)	155 (58.9)	183 (87.6)
<b>Physical growth</b> is ‘gradual growth of body’	248 (38.6)	347 (51.7)	212 (28.7)	305 (42.2)	66 (42.6)	53 (29.0)
<b>Mental development</b> is ‘intellectual growth’ with bodily development	306 (47.7)	216 (32.2)	354 (48.0)	238 (32.9)	57 (36.8)	67 (36.6)
<b>Aware of difference</b> between physical & mental development	444 (69.2)	613 (91.4)	560 (75.9)	663 (91.7)	108 (69.7)	169 (92.3)
Total valid cases	642	671	738	723	155	183

**Fig 2: Adolescents' knowledge on colostrums feeding for proper physical growth of children by area**



Adolescents knowledge on colostrum and breast-feeding improved compared to baseline especially, in the Treatment area I (Fig 2 and Fig 3 respectively).

**Fig 3: Adolescents' knowledge on breast-feeding for proper physical growth of children by area**



A generalized increase in knowledge from baseline about care needed for proper physical growth and mental development of children was noted among adolescents of the treatment areas while the adolescents of control area lagged behind (Tables 3 and 4). Treatment area I adolescents were more knowledgeable about feeding practices than their peers from Treatment area II. There was high level of consensus about the importance of adequate nutritious diets among all three groups of adolescents (Table 3).

The adolescents' knowledgeable on the importance of fondling with children for their mental development showed improvement in the treatment areas compared to baseline, more so for the treatment area I. (Fig 4).

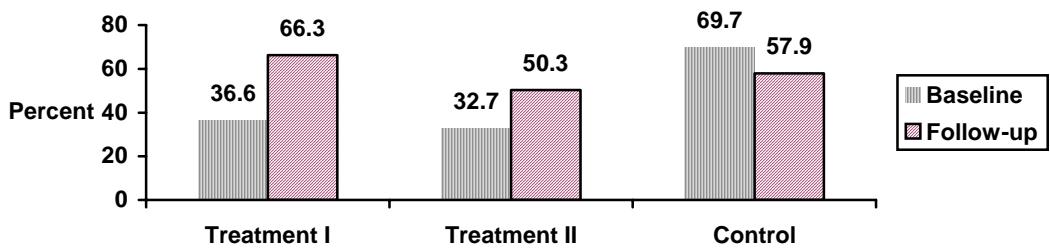
**Table 3: Adolescents' knowledge on care needed for proper physical growth of children.**

	Treatment area I		Treatment area II		Control area	
	Baseline	Follow-up	Baseline	Follow-up	Baseline	Follow-up
Adequate weaning diet (after 5 months)	94 (14.6)	128 (19.1)	51 (6.9)	56 (7.7)	10 (6.5)	9 (4.9)
Adequate nutritious diet	542 (84.4)	558 (83.2)	644 (87.3)	567 (78.4)	123 (79.4)	126 (68.9)
Immunization	137 (21.3)	267 (39.8)	95 (12.9)	137 (18.9)	21 (13.5)	24 (13.1)
Clean environment	197 (30.7)	289 (43.1)	164 (22.2)	290 (40.1)	40 (25.8)	70 (38.3)
Medical care if sickness	96 (15.0)	74 (11.0)	83 (11.2)	81 (11.0)	22 (14.2)	7 (3.8)
Don't know	42 (6.5)	3 (0.4)	42 (5.7)	10 (1.4)	12 (7.7)	4 (2.2)
Others	23 (3.6)	17 (2.5)	31 (4.2)	60 (8.3)	2 (1.3)	18 (9.8)

**Table 4: Adolescents' knowledge on care needed for proper mental development of children.**

	Treatment area I		Treatment area II		Control area	
	Baseline	Follow-up	Baseline	Follow-up	Baseline	Follow-up
Talking to children	120 (18.7)	301 (44.9)	166 (22.5)	244 (33.7)	14 (9.0)	14 (22.4)
Playing with children	183 (28.5)	477 (71.1)	165 (22.4)	407 (56.3)	47 (30.3)	78 (42.6)
Not rebuking, beating and criticizing if they do something wrong	66 (10.3)	95 (14.2)	65 (8.8)	45 (6.2)	8 (5.2)	5 (2.7)
Complementing on good accomplishments	51 (7.9)	88 (13.1)	21 (2.8)	60 (8.3)	4 (2.6)	5 (2.7)
Arranging treatment during illness	26 (4.0)	17 (2.5)	23 (3.1)	7 (1.0)	1 (0.6)	2 (1.1)
Creating opportunity for schooling	179 (27.9)	44 (6.6)	250 (33.9)	14 (1.9)	45 (29.0)	9 (4.9)
Providing nutritious diet	93 (14.5)	20 (3.0)	160 (21.7)	29 (4.0)	13 (8.4)	10 (5.5)
Don't know	123 (19.2)	95 (14.2)	102 (33.9)	182 (25.2)	45 (29.0)	52 (28.4)
Others	82 (12.8)	23 (3.4)	61 (8.3)	67 (9.3)	2 (1.3)	29 (15.8)

**Fig 4: Adolescents' knowledge on fondness to children for proper mental development by area**



However, level of knowledge about harmful practices for mental development of children such as quarrelling, restraining to play with other children, maltreating others in presence of children etc. remained low in all groups, though level of knowledge about the harmful effects of beating and scolding showed improvement from baseline in the treatment areas (Table 5).

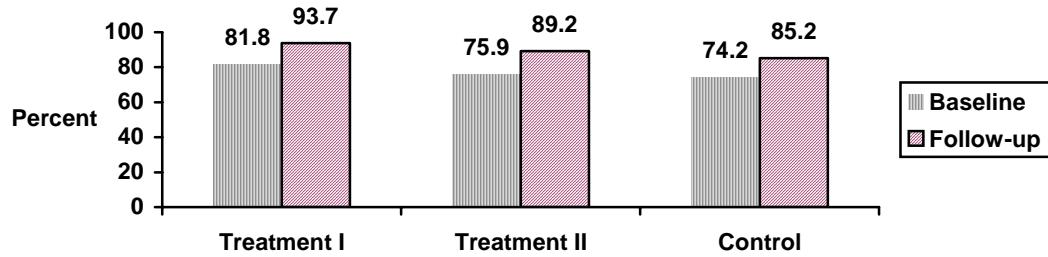
**Table 5: Adolescents' knowledge on harmful practices that would affect mental development of the children**

	Treatment area I		Treatment area II		Control area	
	Baseline	Follow-up	Baseline	Follow-up	Baseline	Follow-up
Quarrelling among family members in presence of the child	43 (6.7)	142 (21.2)	41 (5.6)	100 (13.8)	13 (8.4)	24 (13.1)
Restricting child to play with other children	70 (10.9)	113 (16.8)	44 (6.0)	44 (6.0)	5 (3.2)	38 (5.3)
Beating the child	327 (50.9)	557 (83.0)	407 (55.1)	563 (77.9)	91 (58.7)	121 (66.1)
Scolding the child	376 (58.6)	475 (70.8)	456 (61.8)	522 (72.2)	103 (66.5)	108 (59.0)
Maltreating others in presence of the child	106 (16.5)	197 (29.4)	182 (24.7)	155 (21.4)	25 (16.1)	47 (25.7)
Don't know	92 (14.3)	13 (1.9)	72 (9.8)	12 (1.7)	23 (14.8)	13 (7.1)
Others	203 (31.6)	86 (12.8)	193 (26.2)	123 (17.0)	13 (8.4)	32 (17.4)

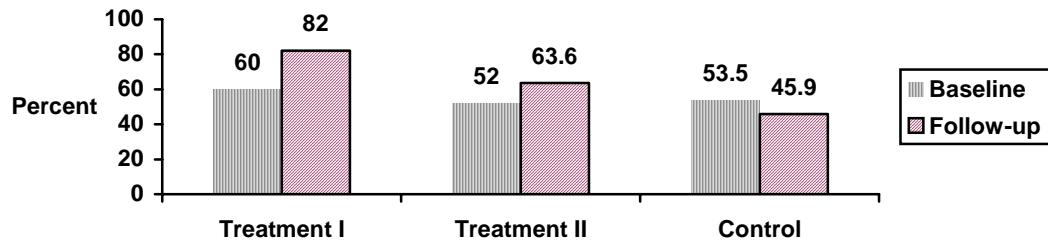
The knowledge about the association of ANC of mother with the physical growth and mental development of children (Fig 5 and Fig 6) showed improvement from baseline,

especially in Treatment area I. However, with respect to their knowledge about how ANC affects children's physical growth and mental development, no clear cut trend was observed (Tables 6, 7). The adolescents of the control area lagged far behind in most of these domains of knowledge.

**Fig 5: Adolescents' knowledge on association of ANC for proper physical growth of children by area**



**Fig 6: Adolescents' knowledge on association of ANC for proper mental development of children by area**



**Table 6: Adolescent's Knowledge on how antenatal care affects children's physical growth.**

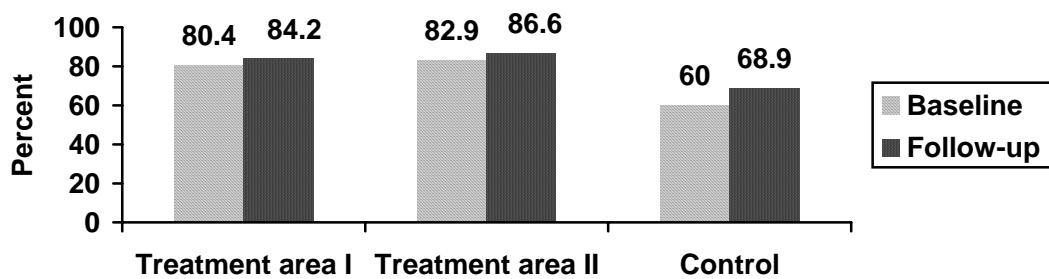
	Treatment area I		Treatment area II		Control area	
	Baseline	Follow-up	Baseline	Follow-up	Baseline	Follow-up
Child's physical growth would be appropriate if mother is in good health	235 (44.8)	314 (49.9)	194 (34.6)	293 (45.4)	17 (14.8)	45 (28.8)
Child will not become sick	258 (49.1)	389 (61.8)	336 (60.0)	376 (58.3)	67 (58.3)	84 (53.8)
Don't know	90 (17.1)	25 (4.0)	89 (15.9)	35 (5.4)	32 (27.8)	21 (13.5)
Others	45 (8.6)	54 (8.5)	60 (10.7)	101 (13.8)	1 (0.9)	59 (28.1)

**Table 7: Adolescents' knowledge on how antenatal care affects children's mental development**

	Treatment area I		Treatment area II		Control area	
	Baseline	Follow-up	Baseline	Follow-up	Baseline	Follow-up
Child's physical health becomes good if mother is in good health	174 (45.2)	393 (71.5)	162 (42.2)	259 (56.3)	44 (53.0)	53 (63.1)
Good physical health influences proper mental development	76 (19.7)	153 (27.8)	95 (24.7)	68 (14.8)	4 (4.8)	8 (9.5)
The child becomes intelligent	81 (21.0)	194 (35.3)	90 (23.4)	179 (38.9)	17 (20.5)	32 (38.1)
Don't know	212 (31.4)	32 (5.8)	89 (23.2)	49 (10.7)	25 (30.1)	8 (9.5)
Others	14 (3.6)	13 (2.4)	26 (6.8)	20 (4.4)	1 (1.2)	(0.0)

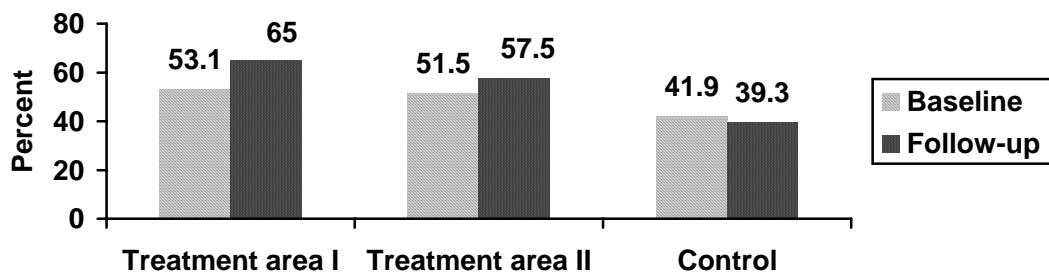
Also, knowledge retention about the importance of birth weight for the children's physical growth was noted in the treatment areas, and at a lower level in the control area (Fig 7 and Fig 8).

**Fig 7: Adolescents' knowledge about the influence of birth weight on physical growth of children by study area**



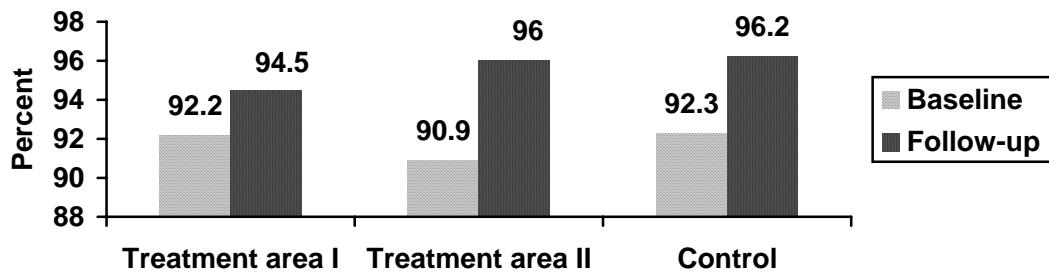
The adolescents were aware about the importance of immunization for child growth and development (Fig 9 and Fig 10). They were found to be much more active in taking children

**Fig 8: Adolescents' knowledge about the influence of birth weight on mental development of children by study area**

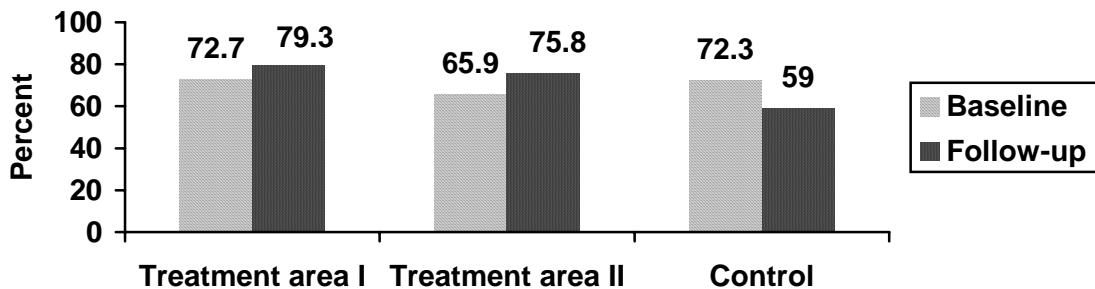


to the EPI centre.

**Fig 9: Adolescents' knowledge about the influence of immunization on physical growth of children by study area**



**Fig 10: Adolescents' knowledge about the influence of immunization on mental development of children by study area**

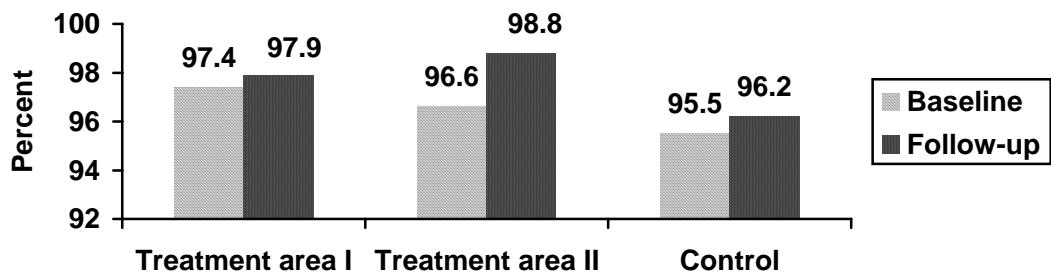


high level of knowledge regarding the importance of weaning diet in all the groups at baseline appeared to be holding at follow-up survey as well (Fig 11 and Fig 12).

**Table 8: Adolescent's participation in immunization activities**

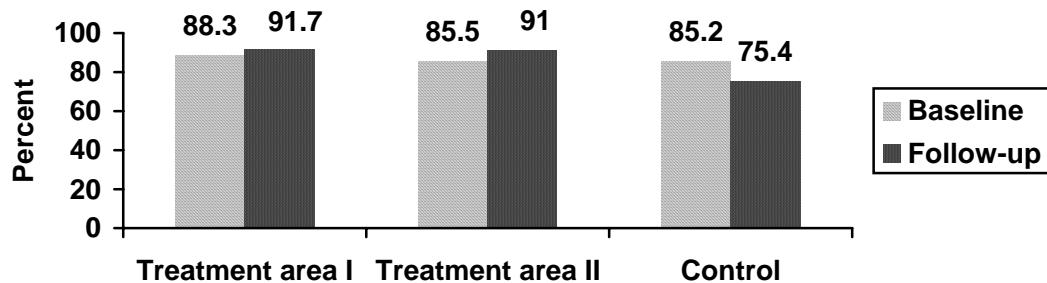
	Treatment area I		Treatment area II		Control area	
	Baseline	Follow-up	Baseline	Follow-up	Baseline	Follow-up
Take community children to the EPI center	130 (20.2)	411 (61.3)	112 (15.2)	347 (48.0)	16 (10.3)	61 (33.3)
Motivate community people to bring their children to the EPI center	180 (28.0)	201 (30.0)	172 (23.3)	182 (25.2)	17 (11.0)	20 (10.9)
Advise mothers to immunize their children	72 (11.2)	263 (39.2)	82 (11.1)	274 (37.9)	3 (1.9)	22 (12.0)
Work with volunteers at the center	8 (1.2)	23 (3.4)	8 (1.1)	14 (1.9)	1 (0.6)	2 (1.1)
Do not participate	295 (46.0)	149 (22.2)	389 (52.7)	196 (27.0)	119 (76.8)	90 (49.2)

**Fig 11: Adolescents' knowledge about the influence of weaning diet on physical growth of children by study area**



The knowledge on the importance of keeping children under close supervision to prevent injury and drowning appeared to increase compared to the baseline in all the three groups (Table 9 and 10). In general, the adolescents of treatment area I were marginally more knowledgeable about these preventive measures.

**Fig 12: Adolescents' knowledge about the influence of weaning diet on mental development of children by study area**



**Table 9: Adolescents' knowledge on protection of children from injury**

	Treatment area I		Treatment area II		Control area	
	Baseline	Follow-up	Baseline	Follow-up	Baseline	Follow-up
Keep the child under continuous supervision	485 (75.5)	614 (91.5)	539 (73.0)	646 (89.3)	119 (76.8)	137 (74.9)
Keep away the child from sharp cutting instruments	165 (25.7)	186 (27.7)	125 (16.9)	159 (22.0)	18 (11.6)	31 (16.9)
The child should remain to one's lap	35 (5.5)	236 (35.2)	69 (9.3)	258 (35.7)	5 (3.2)	61 (33.3)
The child should be away from fire, water, ferocious animal, high-altitude	45 (7.0)	148 (22.1)	63 (8.5)	59 (8.2)	6 (3.9)	11 (6.0)
Do nothing	39 (6.1)	13 (1.9)	35 (4.7)	11 (1.5)	16 (-10.3)	8 (4.4)

**Table 10: Adolescents' knowledge on protection of children from drowning**

	Treatment area I		Treatment area II		Control area	
	Baseline	Follow-up	Baseline	Follow-up	Baseline	Follow-up
Keep the child under continuous supervision	335 (52.2)	600 (89.4)	374 (50.7)	630 (87.1)	95 (61.3)	154 (84.2)
Taking measures to keep away the child from pond, river & boating	492 (76.6)	387 (57.7)	769 (63.6)	356 (49.1)	91 (58.7)	60 (32.8)
Others	17 (2.6)	18 (2.7)	31 (4.2)	16(2.2)	5 (3.2)	5 (2.2)
Do nothing	18 (2.8)	1 (0.1)	18 (2.4)	4 (0.6)	11 (7.1)	2 (1.1)

### Practice

Adolescents were found to spend time with children more at the weekends than regularly compared to baseline (Table 11), and inequity in spending time with boys and girls appeared to increase in the treatment areas, but not in the control area (Table 12).

**Table 11: Adolescents' participation in spending time with under-5 children within households**

	Treatment area I		Treatment area II		Control area	
	Baseline	Follow-up	Baseline	Follow-up	Baseline	Follow-up
Spend time each day regularly	792 (94.5)	551 (83.5)	843 (93.8)	609 (84.3)	236 (89.7)	168 (80.4)
Spend time occasionally	41 (4.9))	109 (16.5)	43 (4.8)	112 (15.5)	27 (10.3)	41 (19.6)
Do not spend any time	5 (0.6)	-	13 (1.4)	1 (1.0)	-	-

**Table 12: Adolescents' time spent with male and female child**

	Treatment area I		Treatment area II		Control area	
	Baseline	Follow-up	Baseline	Follow-up	Baseline	Follow-up
Spend time equally with boy & girl	251 (30.1)	15 (36.6)	257 (29.0)	13 (35.1)	98 (37.3)	14 (28.6)
Do not spend time equally with boy & girl	240 (28.8))	26 (63.4)	241 (27.2)	24 (64.9)	66 (25.1)	8 (16.3)
Not stated	342 (41.1)	-	388 (43.8)	-	99 (37.6)	27 (55.1)

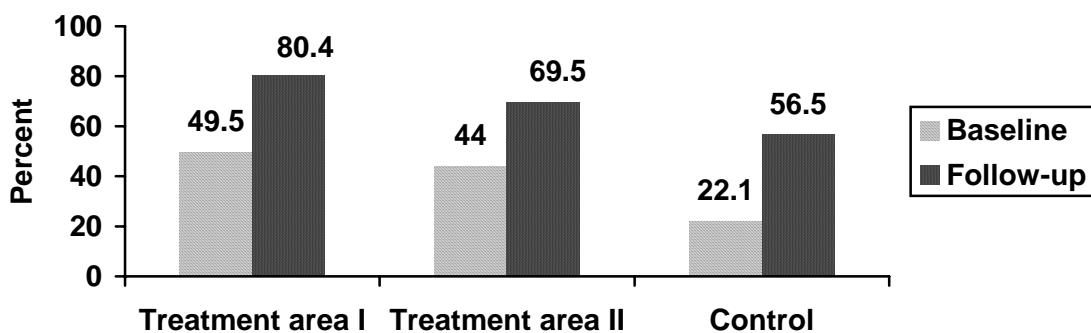
Interaction with children in the form of playing and story-telling increased in all areas, but at a much lower level in the control area (Table 13). However, no improvement was seen in active caring of children e.g., bathing, cleaning or changing clothes.

**Table 13: Practices adolescents follow while spending time with children in household**

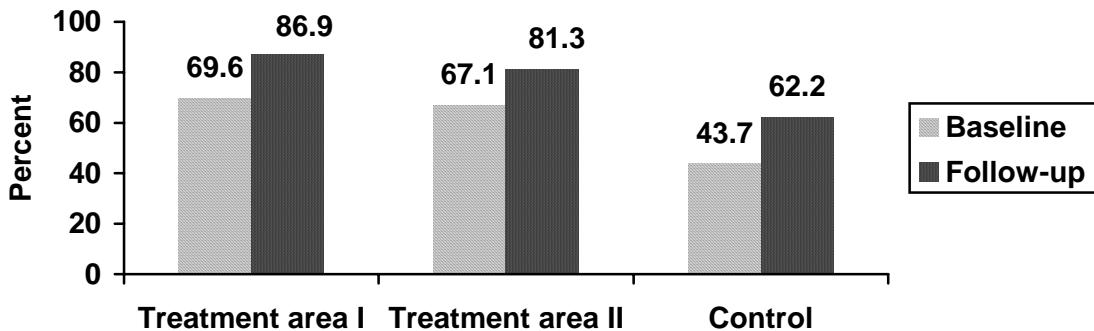
	Treatment area I		Treatment area II		Control area	
	Baseline	Follow-up	Baseline	Follow-up	Baseline	Follow-up
Playing	816 (98.0)	629 (95.3)	866 (97.7)	701 (97.2)	256 (97.3)	196 (93.8)
Singing songs and rhymes	836 (100.4)	514 (77.9)	879 (99.2)	560 (77.8)	149 (56.7)	116 (55.2)
Feeding	192 (23.0)	122 (18.5)	154 (17.4)	105 (14.6)	57 (21.7)	40 (19.1)
Bathing, cleaning & changing cloths	101 (12.1)	99 (15.0)	69 (7.8)	91 (12.6)	47 (17.9)	34 (16.2)
Telling stories & jokes	240 (28.8)	520 (78.8)	258 (29.1)	547 (75.9)	27 (10.3)	117 (56.0)
Taking out & showing different things	314 (37.7)	81 (12.3)	330 (37.2)	104 (14.4)	172 (65.4)	60 (28.7)
Others	48 (5.8)	1 (0.2)	73 (8.2)	7 (1.0)	4 (1.5)	2 (1.0)

The practice of singing songs and reciting rhymes to the children appeared to increase among all groups, more so among the treatment groups (Fig 13 and Fig 14).

**Fig 13: Adolescents' practice of singing songs to children by study area**



**Fig 14: Adolescents' practice of reciting rhymes to children by study area**



However, how this happens, is not yet internalized by the adolescents as obvious from mixed responses in 2005 (Table 15).

**Table 15: Adolescents' knowledge on how singing songs affect mental development of children**

	Treatment area I		Treatment area II		Control area	
	Baseline	Follow-up	Baseline	Follow-up	Baseline	Follow-up
<b>How singing songs affect mental development</b>						
Stimulate child to talk	420 (77.1)	321 (51.3)	527 (80.7)	242 (37.0)	110 (88.0)	73 (47.7)
Stimulate child to sing	47 (8.6)	271 (43.3)	68 (10.4)	210 (32.1)	1 (0.8)	39 (25.5)
Enhance capacity to recall	68 (12.5)	69 (11.0)	50 (7.7)	83 (12.7)	3 (2.4)	9 (5.9)
Don't know	137 (25.1)	(0.0)	122 (18.7)	1 (0.3)	27 (21.6)	(0.0)

Similarly, both the practice of story-telling and knowledge of its association with children's growth and development was found to increase among adolescents from treatment areas to a greater extent than those from control area (Table 16) but the mechanism is still not clear to the adolescents as the responses showed (Table 17).

**Table 16: Adolescents' practice of story telling to children and knowledge on its association with their growth and development**

	Treatment area I		Treatment area II		Control area	
	Baseline	Follow-up	Baseline	Follow-up	Baseline	Follow-up
Telling story to the children	385 (45.9)	565 (85.2)	381 (42.4)	590 (80.9)	32 (12.2)	116 (55.5)
Knows about the association with growth and development of children	512 (61.1)	614 (91.4)	643 (71.5)	641 (87.7)	116 (44.1)	146 (69.9)

**Table 17: Adolescent's knowledge on association between telling stories, and growth and development of children**

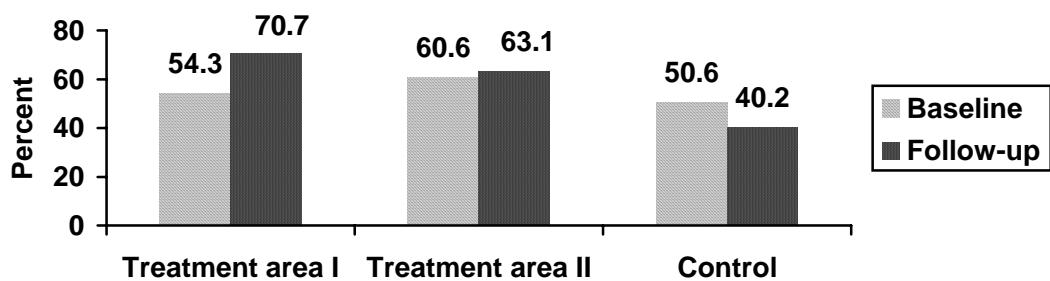
	Treatment area I		Treatment area II		Control area	
	Baseline	Follow-up	Baseline	Follow-up	Baseline	Follow-up
<b>How telling stories effect physical growth</b>						
Have relationship with mental development, not with physical growth	233 (45.5)	129 (21.0)	425 (66.1)	116 (18.1)	60 (51.7)	146 (69.9)
Happiness stimulate physical dev. in different ways through eating, playing, sleeping	147 (28.7)	121 (19.7)	145 (22.6)	148 (25.1)	28 (24.1)	13 (8.9)
Don't know	134 (26.2)	367 (59.8)	76 (11.8)	361 (56.3)	28 (24.1)	118 (80.8)
<b>How telling stories effect mental development</b>						
Enhance capacity to learn a new thing	92 (18.0)	354 (57.7)	117 (18.2)	262 (40.9)	9 (7.8)	61 (41.8)
Increase capacity to understand	404 (78.9)	240 (39.1)	522 (81.2)	201 (31.4)	100 (86.2)	24 (16.4)
Enhance capacity to recall	50 (9.8)	282 (45.9)	59 (9.2)	323 (50.4)	0 (0.0)	75 (51.4)
Don't know	37 (7.2)	4 (0.7)	17 (2.6)	7 (1.1)	11 (9.5)	1 (0.7)
Others	44 (8.6)	14 (2.3)	23 (3.6)	11 (1.7)	8 (6.9)	1 (0.7)

Though frequent occurrence of rebuke and scolding for disciplining children reduced, this practice was resorted to occasionally and it did not change from baseline (Table 18). Their knowledge about the harmful association of these harsh ways of disciplining children with their growth and development increased since baseline for treatment areas, but not the control area (Fig 15 and Fig 16). Also, adolescents' knowledge about the mechanism of how

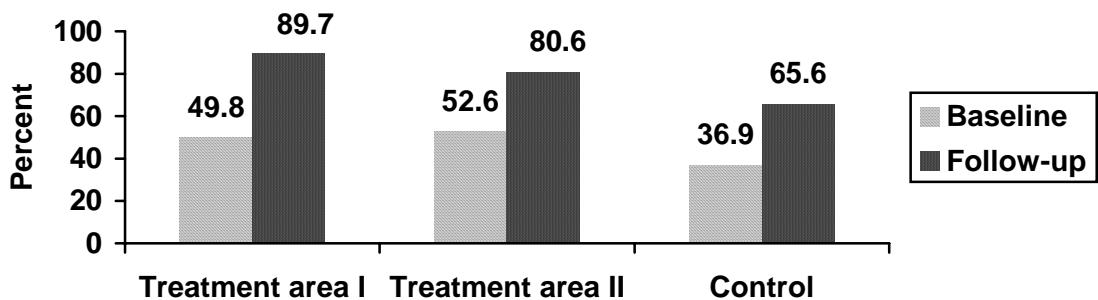
**Table 18: Adolescents' practice related to violence against children**

	Treatment area I		Treatment area II		Control area	
	Baseline	Follow-up	Baseline	Follow-up	Baseline	Follow-up
<b>Nature of violence</b>						
Rebuking/scolding	418 (72.6)	439 (78.1)	466 (75.8)	436 (74.0)	145 (75.7)	131 (79.9)
Beating	245 (42.5)	114 (20.3)	257 (41.8)	140 (23.8)	99 (51.6)	38 (23.2)
Doing other things to get rid of anger	53 (9.2)	25 (4.4)	41 (6.7)	36 (6.1)	9 (4.7)	3 (1.8)
Others	29 (5.0)	26 (4.2)	16 (2.6)	30 (5.1)	3 (1.6)	4 (2.4)
<b>Rate of occurrence</b>						
Quite frequently	15 (2.6)	6 (1.1)	25 (4.1)	4 (0.7)	5 (2.6)	3 (1.8)
Occasionally	518 (89.9)	516 (91.8)	547 (88.9)	513 (87.1)	159 (82.8)	148 (90.2)
Some days interval	37 (6.4)	40 (7.1)	36 (5.9)	71 (12.1)	27 (14.1)	12 (7.3)
Others	6 (1.0)	1 (0.2)	7 (1.1)	1 (0.2)	1 (0.5)	1 (0.6)
<b>Total valid cases</b>	<b>576</b>	<b>562</b>	<b>615</b>	<b>589</b>	<b>192</b>	<b>164</b>

**Fig 15: Adolescents' knowledge on association between violence against children and their physical growth by study area**



**Fig 16: Adolescents' knowledge on association between violence against children and their mental development by study area**

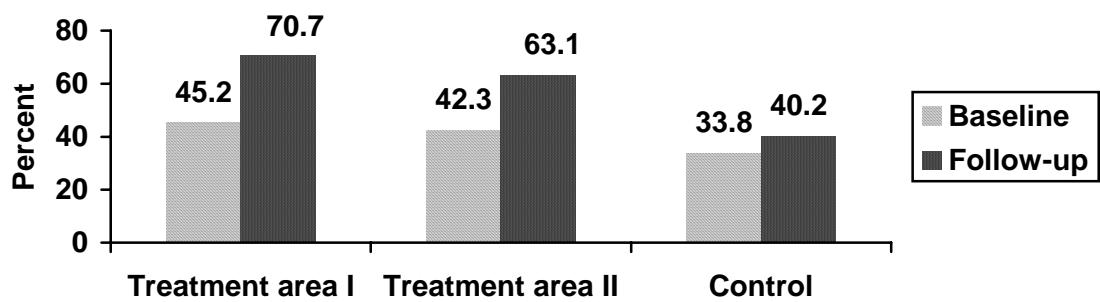


**Table 19: Adolescents' knowledge on association between violence against children and their physical growth and mental development**

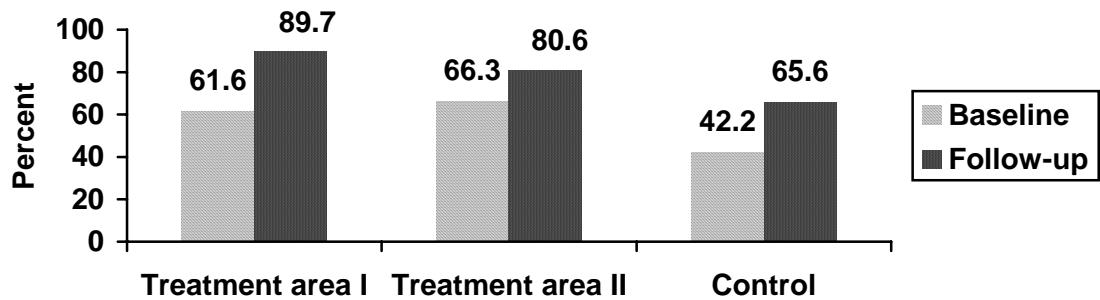
	Treatment area I		Treatment area II		Control area	
	Baseline	Follow-up	Baseline	Follow-up	Baseline	Follow-up
<b>How violence against child affect physical growth</b>						
Organ may damaged by physical assault	285 (62.6)	414 (75.0)	285 (52.3)	391 (65.0)	62 (46.6)	84 (60.0)
Body become thin through anorexia & lowering food intake	85 (18.7)	51 (9.2)	150 (27.5)	36 (6.0)	14 (10.5)	13 (9.3)
Don't know	86 (18.9)	16 (2.9)	110 (20.2)	18 (3.0)	56 (42.1)	7 (5.0)
Others	55 (12.1)	42 (7.6)	59 (10.8)	66 (11.0)	7 (5.3)	14 (9.9)
<b>How violence against child affect mental development</b>						
Child become afraid & would not entertain others	99 (23.8)	298 (54.1)	76 (16.1)	215 (36.8)	33 (34.0)	46 (39.7)
Children remain with themselves, become naughty & would not follow/ obey older	54 (13.0)	86 (15.6)	37 (7.8)	82 (14.0)	3 (3.1)	6 (5.2)
Damage brain & lower intelligence	206 (49.5)	183 (33.2)	286 (60.5)	312 (53.4)	41 (42.3)	51 (44.0)
Don't know	86 (20.7)	21 (3.8)	75 (15.9)	21 (3.6)	25 (25.8)	7 (6.0)
Others	21 (5.0)	40 (7.3)	49 (10.4)	29 (5.0)	5 (5.22)	11 (9.4)

harsh treatment harms physical growth and mental development appeared to increase since baseline, especially in the treatment areas (Table 19). Both knowledge of adolescents on the importance of socialization of children (Fig 17 and fig 18) and practices which enhance it also increased compared to baseline, mainly in the treatment areas (Table 20).

**Fig 17: Adolescents' knowledge on association between socialization of children and their physical development by study area**



**Fig 18: Adolescents' knowledge on association between socialization of children and their mental development by study area**



**Table 20: Adolescents' knowledge on association between socialization of children, and their physical and mental development.**

	Treatment area I		Treatment area II		Control area	
	Baseline	Follow-up	Baseline	Follow-up	Baseline	Follow-up
<b>How socialization enhance physical growth</b>						
Socialization make children happy and grows through playing & eating	211 (55.7)	368 (77.5)	203 (53.4)	328 (71.1)	34 (38.2)	55 (65.3)
Don't know	98 (25.9)	68 (14.3)	73 (19.2)	61 (13.2)	22 (24.7)	13 (15.5)
Others	74 (19.5)	41 (8.6)	112 (29.5)	74 (16.1)	33 (37.1)	17 (20.0)
<b>How socialization influence mental development</b>						
Learn to interact with others	226 (43.8)	387 (64.2)	247 (41.4)	322 (50.9)	49 (44.1)	73 (53.3)
Learn new & good things from others	207 (40.1)	333 (55.2)	318 (53.4)	326 (51.5)	22 (19.8)	56 (40.9)
Would enhance mental development	232 (45.0)	226 (37.5)	253 (42.4)	261 (41.4)	57 (51.4)	45 (32.8)
Don't know	56 (10.9)	17 (2.8)	50 (8.4)	7 (1.1)	16 (14.4)	2 (1.5)
Others	32 (6.2)	8 (1.3)	23 (3.9)	4 (0.6)	1 (0.9)	1 (0.7)

**Table 21: Adolescents' practice for socialization of children in their households**

	Treatment area I		Treatment area II		Control area	
	Baseline	Follow-up	Baseline	Follow-up	Baseline	Follow-up
Allow children to interact with everyone	357 (42.6)	534 (80.5)	398 (44.3)	522 (71.6)	70 (26.6)	98 (46.9)
Allow children to play with other children	244 (29.1)	449 (67.7)	298 (33.1)	415 (56.9)	60 (22.8)	95 (45.5)
Get children admit in the school	24 (2.9)	47 (7.1)	10 (1.1)	37 (5.1)	4 (1.5)	5 (2.4)
Do nothing	354 (42.2)	75 (11.3)	390 (43.4)	117 (16.0)	143 (54.4)	64 (30.6)
Don't know	53 (6.3)	4 (0.6)	25 (2.8)	3 (0.4)	25 (9.5)	13 (6.2)
Others	39 (4.7)	(0.0)	23 (2.6)	4 (0.6)	0 (0.0)	1 (0.7)

Increased participation of adolescents in stimulating mental development of children through different ways since baseline was noted in the treatment areas more frequently than control area (Table 21). They were also increasingly active in disciplining children in different ways other than rebuking or scolding etc. (Table 22).

**Table 22: Adolescents' practice related to stimulating mental development**

	Treatment area I		Treatment area II		Control area	
	Baseline	Follow-up	Baseline	Follow-up	Baseline	Follow-up
<b>Participated in activities to stimulate child's mental development</b>	375 (44.7)	577 (87.0)	433 (48.2)	596 (81.8)	67 (25.5)	111 (53.1)
<b>What did adolescents do</b>						
Try to make the child more curious to different matters	75 (20.0)	96 (16.6)	65 (15.0)	40 (6.7)	10 (14.9)	4 (3.6)
Talking frequently to the child	144 (38.4)	380 (65.9)	158 (36.5)	333 (55.9)	24 (35.8)	55 (49.5)
Try to making the child social	55 (14.7)	130 (22.5)	60 (13.9)	87 (14.6)	10 (14.9)	8 (7.2)
Encourage child to study	102 (27.2)	9 (1.6)	177 (40.9)	11 (1.8)	13 (19.4)	2 (1.8)
Teaching child etiquette, avoiding rebuking or beating & behaving nicely	37 (9.9)	6 (1.0)	44 (10.2)	18 (3.0)	7 (10.4)	2 (1.8)
Providing nutritious diet, immunization and clean environment	46 (12.3)	78 (13.5)	42 (9.7)	144 (24.2)	1 (1.5)	36 (32.4)
Singing songs, telling stories & reading books	13 (3.5)	51 (8.8)	21 (4.8)	33 (5.5)	14 (20.9)	7 (6.3)
Don't know	3 (0.8)	(0.0)	0 (0.0)	(0.0)	0 (0.0)	(0.0)
<b>Total valid cases</b>	<b>375</b>	<b>577</b>	<b>433</b>	<b>596</b>	<b>67</b>	<b>111</b>

**Table 23: Adolescents' practice on teaching discipline to children**

	Treatment area I		Treatment area II		Control area	
	Baseline	Follow-up	Baseline	Follow-up	Baseline	Follow-up
Did nothing	408 (48.7)	69 (10.4)	419 (46.6)	81 (11.1)	191 (72.6)	47 (22.2)
Not to be rude, quarrel or fight to others	115 (13.7)	284 (42.8)	159 (17.7)	350 (48.0)	16 (6.5)	111 (53.1)
To obey older	179 (21.4)	515 (77.7)	243 (27.0)	454 (62.3)	17 (6.5)	105 (50.2)
Ask children to study	67 (8.0)	351 (52.9)	60 (6.7)	283 (38.8)	12 (4.6)	42 (20.1)
Teaching child to keep themselves clean	91 (10.9)	170 (25.6)	58 (6.5)	109 (15.0)	22 (8.4)	29 (13.9)
Doing daily life activities in time	122 (14.6)	36 (5.4)	67 (7.5)	15 (2.1)	23 (8.7)	0 (0.0)
Doing works correctly	33 (3.9)	42 (6.3)	20 (2.2)	30 (4.1)	0 (0.0)	3 (1.4)
Avoid harmful activities to save lives	8 (1.0)	44 (6.6)	10 (1.1)	30 (4.1)	0 (0.0)	3 (1.4)
Others	30 (3.6)	12 (1.8)	14 (1.6)	32 (4.4)	0 (0.0)	7 (3.3)

We tried to summarise key findings on changes in knowledge and practice of the adolescents during the study period (Tables 24 and 25 respectively). As can be seen, Treatment areas performed better than the control areas in most of the issues of interest. The difference between Treatment area I and Treatment area II was marginal in most of the cases excepting in few instances like knowledge on feeding practices, importance of ANC for growth and development of children, preventing injuries and drowning etc. where the differences were significant. Also, Adolescents from Treatment area I were advanced in stimulating children through singing songs and reciting rhymes compared to their peers in Treatment area II.

**Table 24: Summary table showing key changes in knowledge of adolescents on ECD issues in 2004 from baseline by study areas**

Table No.	ECD knowledge	Treatment area I (ECD + C-to-C)	Treatment area II (ECD only)	Control area
2	Knowledge about physical growth	↑	↑	↓
2	Knowledge about mental development	↓	↓	✓
3, 4	Care needed for both the above	↑	↑	↓
Fig. 2 & 3	Feeding practices (colostrums, breast-feeding, weaning diet) <sup>a</sup>	↑↑	↑	↓
5	Knowledge about practices harmful for mental development of children	✓	✓	✓
22	Knowledge on mechanism of above harmful effects	↑	↑	✓
24	Knowledge on the importance of socialization	↑	↑	✓
Fig. 5 & 6	Association of ANC with child growth and development <sup>b</sup>	↑↑	↑	✓
12,13	knowledge on how to prevent accidents (e.g., fall injury and drowning) <sup>c</sup>	↑↑	↑	↑

<sup>a</sup> Treatment I vs Treatment II:  $p<0.001$ ; <sup>b</sup> Treatment I vs Treatment II: Physical growth ( $p<0.05$ ), Mental development ( $p<0.001$ ); <sup>c</sup> Treatment I vs Treatment II: keep child away from fire, water, ferocious animal, high altitude etc. ( $p<0.001$ ); keep child away from pond, river and boat riding ( $p<0.01$ )

**NB.** ✓: unchanged or close to baseline; ↑: improved from baseline; ↑↑: much improved from baseline; ↓ declined from baseline

**Table 25: Summary table showing key changes in practices of adolescents on ECD issues from baseline by study areas**

Serial No.	ECD knowledge	Treatment area I (ECD + C-to-C)	Treatment area II (ECD only)	Control area
14	Time spent with children	↓	↓	↓
15	Inequity in time spent between boys and girls	↑	↑	✓
16	Quality interaction with children	↑	↑	↑
17	Singing songs to children <sup>a</sup>	↑↑	↑	↑
17	Reciting rhymes to children <sup>b</sup>	↑↑	↑	✓
25	Participate in activities to stimulate growth and development of children	↑	↑	✓
26	Practicing different ways to discipline children other than rebuke and scolding	↑	↑	✓

<sup>a</sup>Treatment I vs Treatment II: p<0.001; <sup>b</sup>Treatment I vs Treatment II: p<0.01

**NB.** ✓: unchanged or close to baseline; ↑: improved from baseline; ↑↑: much improved from baseline; ↓ declined from baseline

## **Findings from FGDs with adolescents**

This qualitative study was conducted in Sherpur, Bogra with adolescents aged 10-19 having at least one under-5 child in their household. The method involved three focus group discussions in villages with community learning centers (CLCs) and Union Library (UL). The first two groups consisted of twelve to fifteen adolescents who are a part of the child-to-child approach and the third group consisted of young adolescent/mothers who run *Shishu Bikash Kendro (SBK's)*, a newly started pre-school programme for the toddlers.

### **Knowledge of adolescents in the community**

#### *Defining physical growth and mental development*

Boys and girls defined physical growth as the growth of different parts of the body and change in body and bone structure. Some described it as an increase in body weight. They perceived development as “growing up”. Mental Development was defined as a change in behaviour. According to them mental development is to improve or develop. Mental development implies becoming more intelligent and to think and do something new. “As a child develops mentally he or she becomes more knowledgeable and can distinguish between good and bad”.

#### *Caring practices for physical and mental development*

“Children need to be brought up in a clean and safe environment. In order to help them develop, we need to create that safety for them”, said a 13-year-old boy. According to them, children should be kept away from unsafe or dangerous places. They must be introduced or familiarized with their surroundings. They should not be scolded because that might hurt their feelings, which in turn could drive them to do unpleasant things. Instead parents and older siblings should behave well, so that they also learn what good behaviour is.

Adolescents indicated healthy (nutritious) diet as essential for development. When children are malnourished their growth, both physical and mental, is hampered. It is necessary to feed them milk, eggs and bananas when they are very young. Vegetables and fruits are also required for proper physical growth of the body. Lying and smoking in front of children

must be avoided. A good amount of time must be spent with children through playing games, story telling, singing rhymes, and taking them to relatives house to make them social. Adolescents also emphasized on the importance of toys for their younger siblings. Assisting them to make toys makes them more creative and increases their mental development.

#### *Antenatal care and why it is necessary*

Boys and girls deemed ‘taking care of mothers’ as very important. They expressed that, during pregnancy mothers must be kept stress free. Worry or stress may affect the mental development of the baby inside. Healthy food, rich in nutrients, is crucial for the baby’s growth inside the mother’s womb. Otherwise, malnutrition may hinder growth. Mothers must not be allowed to do taxing jobs or lift heavy things. Whenever possible, it is nice to take them out to keep them happy and make them smile. Plenty of rest is required and regular check-up is necessary to monitor the baby’s progress in growth, structure and shape.

#### *Immunization*

“Immunization is necessary when children are young. If they are immunized, resistance will increase”. It is vital in order to keep them away from diseases, such as tuberculosis and measles. Immunization keeps the child safe and healthy and therefore has an effect on mental development of children. If a child is healthy or physically fit, then his or her mind is also healthy.

#### *Developing a child’s eagerness to learn*

“As older siblings, we must help them develop a curiosity to learn new things, because that is how they will develop knowledge”. ‘Patience’ was described as being imperative when dealing with children’s inquisitiveness. “Often we get irritated or impatient when our younger siblings ask us questions, but we must remember that it is the only way they will know about the world. Hence we must always try to satisfy their eagerness.” Sometimes explaining things in a story-like manner helps to increase their interests. Their enthusiasm must always be encouraged.

### *Developing self confidence*

According to the adolescents, encouraging or assisting children to learn or do something new increases their self-confidence. Encouraging them when they undertake a new task, such as walking or eating on their own, will help them believe in themselves and raise their self-esteem. “Saying ‘you can do it’, cheers up my baby sister and she becomes more confident”. When children achieve something good, they must be praised or rewarded.

### **Practices of adolescents in the community**

Both boys and girls try to spend time with their younger siblings whenever they can. They are eager to carry out activities with children that help to stimulate their brain and thus promote their mental and physical growth. Not only do they spend time with their own siblings, they also facilitate activities that involve all children in the neighbourhood. In general, these adolescents try to create a general awareness about child-rearing practices and the importance of early childhood development in the society.

### *Time spent with children*

Most adolescents spend time with their younger siblings after school hours or during the weekend. They spend a lot of time making toys for them using clay, paper and leaves. Children also play sports and games, such as, hide-and-seek, chase etc. They play with clay pots, dolls and plastic balls. “We take pleasure in playing with our younger siblings because it keeps them happy and we also enjoy it”. The adolescents indicated that spending time with them is important and they wanted their siblings to learn new things through play. They also spend time bathing and feeding them. Most adolescents said that a majority of the time with the children is spent on helping them learn letters etc. In the evenings, they usually talk and laugh with them before going to bed. “We also take them out for a walk or to relatives’ houses to improve their social skills”.

### *Playing, story telling, singing songs and reciting rhymes*

Older siblings often sing when they put children to bed. “Children like stories, songs and rhymes. Imaginary stories help children to increase their desire to listen and learn.” According to them, singing educational rhymes to children facilitates learning.

### *Violence against children*

Hitting children or shouting at them hampers mental development of children. They get scared and it discourages them to do what they want. “When my brother does something wrong, instead of scolding him, I tell him off in a slightly strict manner. Restricting or punishing him will undermine his confidence.” It may also make them socially inept and scared of people. “Sometimes it is hard not to scold but most of the time, I control my anger and explain things nicely (politely)”.

### *Socialization and familiarity with surroundings*

According to the adolescents, they often point out objects to their younger siblings, like sun, trees, birds, animals, houses etc. They also introduce them to distant relatives and other people in the neighbourhood to overcome their shyness and increase their social skills. “All these make my young brother more aware, intelligent and curious. He wants to know more about the world”.

### *Contribution as an older sibling*

As older siblings, they try to keep children happy, enthusiastic and energetic. They often look into what they need, introduce them to the surroundings, help with studies, and play with them whenever they have time. The adolescents also try talking to caregivers to make them aware about ECD. They place a great deal of emphasis to exploration through play, other kinds of mental stimulation, healthy diet and cleanliness for both mental and physical growth of children.

## **Discussion**

This study was done to compare and contrast the knowledge and practice of adolescents who were involved in the Child-to-Child component of the ECD programme with those who were not, and compare these two groups with a non programme area, following two years of intervention. A baseline done before the programme began found the adolescents from Treatment area I much advanced than those from treatment area II with respect to level of awareness, knowledge and practice (Nasreen and Ahmed 2004). Also, the control area could not be prevented fully from contamination because of some agencies that began working in the area recently on similar issues. These limitations have to be noted before interpreting findings.

In general, knowledge and practice related to ECD issues in the treatment areas I and II was better than in the control area, when compared with baseline values. The difference between Treatment area I and Treatment area II was marginal in case of most of the variables studied, excepting a few instances (noted in the last two tables). Significant increase in knowledge related to feeding practices of the infant, importance of attending ANC by pregnant mothers for children's growth and development, preventing accidents e.g., injuries and drowning, and the practice of singing songs and reciting rhymes was observed among adolescents from Treatment area I compared to Treatment area II. These quantitative findings are corroborated by qualitative findings from group discussion with adolescents of Treatment area I. Thus, Child-to-child approach certainly added on to the regular ECD activities by improving the knowledge base in certain specific areas and care-giving quality of the adolescents.

Of interest to note is the fact that in many instances, similar trend in outcome was noted among the adolescents of control group as well. This may be due to contamination of the treatment areas from effects of other government agencies working on the same issues, as well as highlighting child rights issues in mass media. There were some areas where the improvements were not as marked and need more attention such as time spent with children

and the quality of time spent, disciplining children, clarity on different mechanisms through which ECD interventions affect growth and development of children etc.

### **Implications for the programme:**

- Motivating adolescents to spend more quality time regularly with children
- Teaching innovative ways to play with, and disciplining, children
- Supplying education materials to adolescents (e.g., story books, drawing materials etc.) that will help them to interact more knowledgeably with the children
- Refresher training to adolescents for follow-up, monitoring and participatory planning for implementing ECD activities
- Involving young parents and would-be parents in the process
- Integrating Child-to-Child activities with regular ECD activities in all programme areas for greater impact and use adolescents as change agents in the families and the communities.

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## **Appendix**

Specific assignments are given to adolescents who are involved in the Early Childhood Development (ECD) program. They are attached to 10 families to provide ECD messages to the family members and care-givers.

Name of the Adolescent:.....

Name of school/Union Library/Community Learning

Centre:.....

Class:.....

Responsibilities and duties of the adolescents to be implemented in next 4 months:

### **We shall**

- behave well with children
- arrange place of playing for children
- play with children during leisure time
- tell short stories, sing songs to children and teach these to them
- give importance to children's priorities and give opportunity to express their opinions
- teach the children proper pronunciations, and etiquettes
- keep the children neat and clean
- keep children away from smokers
- acquaint children with surrounding environment

### **We will provide counselling**

- to pregnant mothers for vaccination for herself and children in time
- to pregnant mothers to take supplementary diets and abstain from heavy works
- to family members to keep pregnant mothers free from any kind of tension
- to family members for registration of all births
- to guardians to vaccinate all children between 1½ months to 1 year completely
- to mothers to feed colostrum and continue breast feeding till the children are five months old
- to all family members to keep an eye on the children
- to family members to arrange play areas and make toys for children
- to all to behave well with children and to admire children for good works
- to all to acquaint children with his/her surroundings
- to family members to take sick children to health centers for treatment