



DEVELOPING A COMMUNITY-BASED TOOL TO ASSESS THE STATUS OF EARLY CHILDHOOD DEVELOPMENT IN LOW- AND MIDDLE-INCOME SETTINGS

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Ellen Goodmanⁱ, Edward Forrestⁱⁱ, Dr Akshay Patelⁱⁱⁱ

Abstract

Early childhood development influences an individual's future intelligence, educational attainment, income, and adult health, and is therefore key to breaking cycles of inter-generational poverty in low and middle income settings. However there is currently a paucity of tools which can be used by community-based workers, which holistically assess the status of early childhood development, early childhood caring practices and guardians' capacity to care in a community. The authors of this paper have designed and piloted a tool building on existing work using validated and widely recognised indicators that are relevant for the assessment of early childhood development. The tool provides a comprehensive measurement of a child's developmental status from the ages 12-60 months, is easy to use and is universally relevant to different cultural and socio-economic backgrounds. The tool measures the status of a child's development using age-appropriate indicators, as well as assessing caregiving practices and the caregivers' capacity to care. The authors believe that this tool has the potential to be of value to organisations looking to further their understanding of early childhood development and caregiving practices in local communities.

Background

Early childhood is a critical period of rapid brain development, which influences the entire course of an individual's life. Research has shown that development during the early years of childhood is a strong determinant of future intelligence, educational attainment, income and adult health.^{1,2} These factors in turn determine children's capacity to fulfil their future potential and lead productive and dignified lives. Furthermore, children's early development and subsequent time in education are important determinants of age at first child and family size, and consequently contribute to intergenerational cycles of poverty in low- and middle- income country settings (LMIC).^{3,4}

It is estimated that 200 million children under the age of 5 years are not fulfilling their developmental potential, with the majority of these children living in south Asia and sub-Saharan Africa.⁵ Despite this significant global burden and the life-course importance of Early Childhood Development (ECD), it is an area that has been relatively neglected in a period when the development agenda has largely been shaped by the Millennium Development Goals (MDGs). While the MDGs' focus on primary education and basic nutrition has led to important benefits

to children globally, further attention is required on children's development during the pre-school period.⁶

Recent recognition that investment in early childhood is one of the most cost-effective paths to improved health, education and human capital indicators has led to an emerging international focus on the importance of ECD and its link to sustainable development, with UNICEF describing it as 'critical for the Post-2015 Development Agenda.'⁷⁻¹⁰

In order to intervene appropriately, track change and evaluate interventions, it is crucial to have a comprehensive understanding of the status of child development, existing care practices and caregivers' capacity to care. However, as ECD encompasses physical, cognitive, language and social/emotional domains and children go through rapid changes with age, assessing ECD status in LMIC has proven to be complex. While tools such as the Home Observations for Measurement of the Environment (HOME) can be useful in high income settings, there are currently few approaches specifically designed for assessing ECD in LMIC.¹¹ As a consequence of this, studies of ECD status often use crude measures; for example the Lancet's 2007 estimate of global un-fulfilled developmental potential in under-5s could only use prevalence of stunting and proportions of people living in absolute poverty as indicators of ECD, because of paucity of data.⁵

As the study authors were unable to find a comprehensive, age-sensitive, easy to administer approach to assess ECD status prior to a planned intervention in an LMIC setting, a tool was developed. This paper presents how the tool was developed and how it may be of value in other settings; particular attention has been given to its ease of use, cultural validity and comparability of variables with indicators found in other large surveys.

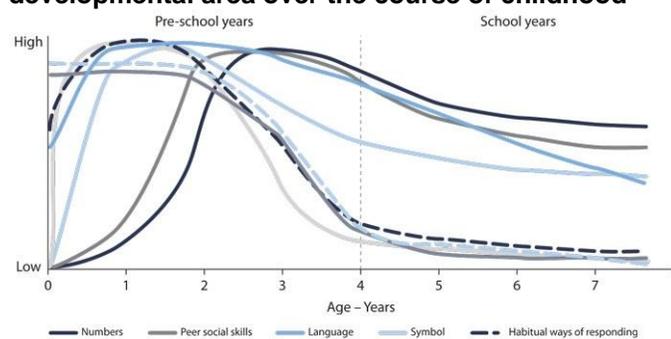
Defining Early Childhood Development

Early Childhood is commonly defined as the period of rapid brain development that occurs from the antenatal period and continues to approximately 8-years of life, influencing health and achievement over the entire lifecourse.^{12,13}

For the purposes of assessment, various sources use modified versions of this definition. For example both the Lancet series on Early Childhood Development and UNICEF's MICS-5 indicators primarily focus on the under-5 population, while many sources consider development from birth up to the age of school entry (under-6) as an appropriate age range to focus on.^{5,13,14} The tool developed by the study team specifically focuses on

assessing development and the care provided from 12 to 60 months. This was considered most appropriate as while rapid development occurs from birth to 12 months, this is primarily physical change and most developmentally appropriate practices (breastfeeding, appropriate weaning, immunization coverage) are promoted through existing maternal and infant health programmes aligned with the MDGs. Beyond this, the period up to 5 years of age constitutes the period in which brain development is most sensitive and plastic, and during which children are reliant on their caregivers for appropriate developmentally friendly stimulation and care (Figure 1).¹⁵

Figure 1: Sensitivity of brain development by developmental area over the course of childhood



Source: Council for Early Child Development¹⁵

ECD itself reflects the range of factors that can influence a child's ability to learn language, to develop physically and emotionally, and to flourish within a family and social unit. This spectrum of factors has been divided into 3 domains as summarized in Table 1.

Table 1: Domains of Early Childhood Development

Domain	Description
Physical	<ul style="list-style-type: none"> How the child develops physical functions using both gross motor and fine motor skills Physical growth
Cognitive & Language	<ul style="list-style-type: none"> How the child organizes information The child's memory, problem solving and understanding of the world around them How the child uses language to understand and communicate with others
Social & Emotional	<ul style="list-style-type: none"> How the child interacts with others How the child develops understanding of social norms How the child creates emotional connections and develops self-confidence How the child relates to other people and shares their own feelings

Three Existing Approaches to Measuring Childhood Development

To guide creation of this tool, existing methods for assessing ECD were reviewed. This section summarises 3 methods of assessing ECD, which have been selected as they are widely cited and differ in indicators used and methods employed: *Lancet's* 2007 series on development of children under-5 in developing countries, UNICEF's Multiple Indicator Cluster Survey (MICS) for under 5s and the Home Observations for Measurement of the Environment (HOME). We assessed their advantages and disadvantages, focusing on relevance for use in LMIC and how comprehensively they measure the status of ECD, the status of caregiving practices and caregiving capacity.

1. *Lancet's* Indicators of Poor Development^{5,16,17}

In 2007, in the first part of a series surrounding child development in developing countries, *Lancet* identified the prevalence of early childhood stunting and the number of people living in absolute poverty as indicators of poor early childhood development. These two indicators are closely linked with poor cognitive and educational performance in children, and informed the estimate that over 200 million children under 5 years are not reaching their full developmental potential. The authors acknowledged that these indicators were chosen purely due to the availability of worldwide data as proxy measures of healthy development in early childhood.

There is a paucity of data concerning other domains of childhood development in developing countries, such as cognitive or social-emotional development. While these indicators may be sufficient for reaching such an estimate, they are not adequate for measuring and understanding the complex components of ECD, and could not reliably be used to guide interventions. Any complex, community-based intervention inevitably operates at multiple levels, this is particularly true for ECD where the interventions are delivered by parents, health workers, nursery and school teams and the wider community. Without baseline information that reflects the situated experience of the child and their development in multiple domains, it is difficult to identify what kind of interventions are most likely to achieve outcomes in a particular setting.

2. MICS under 5s¹⁸

UNICEF's Multiple Indicator Cluster Survey (MICS) measurements provide another, more comprehensive, approach to measuring ECD. Since its inception in 1995, MICS has been carried out in over 100 countries and the number of topics collected has vastly increased, with the current and fifth round of MICS consists of 130 internationally-agreed upon indicators that covering topics around health, education and development.

The indicators are closely aligned with MDGs which relate to childhood, and the survey has become the largest source of internationally comparable data on the wellbeing of women and children worldwide. MICS has pioneered the development of ECD measurement tools and its scale means it is a valid and comprehensive base for the further development of an ECD assessment tool.

What MICS lacks, however, is adequate means for identifying delay, as the ECD indicators listed are applied to all children under 5. The study team felt this is too broad an age-range, to be sensitive to delay due to rapidly changing developmental status. Furthermore, MICS also does not provide indicators regarding caring practices and capacity to care that would provide the information necessary to guide possible future interventions within communities. It was therefore decided to adapt and supplement indicators from MICS-5 to develop a tool to identify developmental delays amongst age groups, and with a greater focus on caring practices and capacity to care.

3. HOME¹¹

The Home Observations for Measurement of the Environment is designed to systematically assess the quality and quantity of stimulation that a child receives in their home environment. It provides a comprehensive understanding of the family environment, caregiving practices and capacity to care. It has been used to identify “at risk” families, planning for family intervention and research in child development in most major cultural groups in the United States as well as other settings.¹⁹

Despite its strengths, HOME does not measure individual developmental status, and also lacks important dimensions featured in MICS such as physical growth and immunization status. Furthermore, many of the HOME indicators reflect Western assumptions about child development and caregiving practices, meaning that for many communities in LMIC it would be necessary to greatly adapt the HOME format to ensure that it was culturally appropriate.

Deciding key features of the tool

While the importance of ECD is increasingly recognized, how to capture and synthesise data on a child’s cognitive, social-emotional and physical development, in a way that provides a valid and reliable measure of current status and change over time, remains a challenge. It is evident from the examples reviewed above, that while data are available from many countries concerning areas such as children’s nutritional and immunisation status, there is no systematic reporting that covers all the above-mentioned aspects of ECD. On the basis of the review undertaken, certain key design features for the ECD tool were agreed upon; these are described individually below.

Assesses 3 dimensions of ECD

In order to comprehensively assess the status of ECD in a setting and plan intervention, the study team considered it important to investigate 3 discrete dimensions:

- 1) The current status of ECD among children in a community
- 2) Caregivers’ existing practices to promote ECD
- 3) The capacity of caregivers to provide appropriate care

These 3 dimensions were included so that practitioners can firstly report on the burden and nature of early childhood developmental delay in communities, and then secondly, and crucially, be able to identify areas for intervention at community and wider structural levels in response to their reports.

Whilst tools such as the “Ages & Stages Questionnaires” involve parents in order to assess developmental progress and identify delays in young children, and the HOME questionnaire assesses existing caring practices, the study team were unable to find an existing tool that was comprehensive enough to assess all three dimensions of interest.²⁰

Individual level assessment

The tool has been designed to measure an individual’s ECD status rather than household, community or national ECD status. It was felt that this approach would be most user friendly and aggregate measures of status can be derived by combining results from individual surveys if an appropriate approach to sampling is used.

Easily adaptable and relevant indicators for diverse LMIC settings

It was important to design a tool that can be easily adapted for use in diverse cultural settings and by community workers as well as professionals. The study team have ensured, as far as possible, that indicators are universal and not wholly framed by cultural or socioeconomic factors. For example it was decided not to include developmental milestones such as whether a child can use a knife and fork or whether a child can ride a bike, as the validity and relevance of these questions might differ according to the cultural and socio-economic background of the child.

Can be administered by a community worker with basic training

As well as ensuring that the tool is easily adaptable, it was agreed that unnecessary barriers to administration should be limited and the tool should be easy for community-based practitioners to administer. As previously stressed, ECD is a complex subject that incorporates several dimensions that must be considered when assessing developmental delay. Nevertheless, the team are confident that with basic training, the tool can be used to provide a comprehensive understanding of young children’s developmental status, which will help to identify opportunities for intervention.

Validate components of survey with direct observation of children's developmental status

It was felt that validity of the responses would be improved if interview of the caregiver was combined with a direct observation dimension to the survey. This is because tools where parental observation and independent observation is triangulated often have higher validity than one or the other alone.²¹ The observation component was also felt to improve the tool as it promotes a more nuanced understanding of the child and their care environment than interview alone.

Include appropriate MICS indicators to improve generalizability and comparability of findings

Multiple Indicator Cluster Survey (MICS) is designed so that the data gathered can be disaggregated by various geographic, social and demographic characteristics.¹⁸ This enables detailed analysis of key variables and cross-site comparisons. For this reason, this tool is closely adapted from the MICS standard so that parts of the data gathered will be comparable with the wealth of data from over 100 low- and middle-income countries available as a result of MICS.

To summarise, the tool was designed to build on existing work using validated and widely recognized indicators that are relevant for the assessment of ECD. This will allow comparisons with other data sources and provide a robust foundation for baselines assessment of children's ECD. To address the identified gaps and limitations in existing tools, the tool includes observation measures, is easy to administer, uses indicators relevant across LMIC settings and encompasses 3 dimensions of ECD identified. The tool has 4 different versions that reflect stages of development at 12 monthly intervals from 1 to 5 years old. It is envisaged that users will find these age-specific questionnaires provide a more specific understanding of the stages of child development and so will be better equipped to identify risks of developmental delay within a community.

Table 2: Design features of ECD tool

✓	Administered at the individual level
✓	Age-group sensitive for 12-60 month olds
✓	Covers 3 domains of Early Childhood Development (Physical, Cognitive & Language, Social and Emotional Development)
✓	Encompasses 3 dimensions of assessment (child's ECD status, caregiving practices, caregiver's capacity to care)
✓	Uses indicators relevant in LMIC settings
✓	Easily administered by community workers
✓	Some indicators adapted and validated from widely used sources such as MICS-5 for comparability

Indicators included in the tool

Assessment of developmental status and delay

Children's development was assessed by a combination of interview and observation against developmental milestones which would be expected to be reached by the child's previous birthday. These indicators were a combination of indicators of nutritional status from MICS and other developmental indicators adapted from reputed sources such as the American Academy of Pediatrics' Birth to age 5 guide.^{22,23} Table 3 provides an indication of the kinds of indicators used to assess developmental status by domain.

Delay in each domain (Physical, Cognitive-Language, Social-Emotional) was defined as being unable to perform any 'red flag' functions in a domain or being unable to perform more than half of other functions which most children would achieve by their previous birthday in a given domain.

As the tool is designed to be administered by low skilled community workers, indicators which did not require complex assessment were included and the tool was designed to have a high threshold for identifying delay, so as to avoid mislabeling children inappropriately. This approach means the tool is less sensitive than expert assessment and is likely to under-estimate the number of children with developmental delay, but is more sensitive than MICS Under 5, which has no age specificity for indicators.

Table 3: Examples of Indicators of Developmental Status

Domain	Description
Physical	<ul style="list-style-type: none"> • Height & Weight (Nutrition and Growth) • Age appropriate ability to sit up unaided, walk and run (Gross Motor Development) • Age appropriate ability to turn book pages, scribble, hold cups, feed themselves (Fine Motor Development)
Cognitive & Language	<ul style="list-style-type: none"> • Age appropriate range of vocabulary • Age appropriate ability combine words and appropriately use prepositions, articles etc. • Ability to listen, understand and follow instructions • Age appropriate imaginative processes such as make believe stories
Social & Emotional	<ul style="list-style-type: none"> • The child's ability to play and enjoy age appropriate games • The child's capacity to care for themselves (toileting, feeding, dressing, expressing basic needs) in an appropriate way • The quality and nature of the child's

interactions with peers, carers and others.

Assessment of Caring practices

The majority of the questions regarding caring practices were adapted and incorporated from MICS under 5 survey. Where questions were regarding practices that would be expected daily or on most days, caregivers were asked if they had been practiced in the last 3 days. This period was chosen to minimize risk of recall bias while allowing for a common practice to have been missed for one or two days; the questions were designed to identify absence of a caring practice, but could not differentiate between daily and less frequent practice.

Indicators of practices for physical development included questions regarding feeding practices, immunization of the child, and appropriate care of the child during illness.

Indicators of practices promoting language and cognitive development included whether or not the child attends an organized early childhood programme, and if in the last three days the child had been read to or sung to.

Indicators of practices promoting social and emotional development included whether or not the child was being supported in washing and toileting practices, being played with and being taken to stimulating environments outside of the household. This section also included questions focusing on sub-optimal practices such as leaving children without supervision, disciplining children with physical violence, or engaging children in work that contributes to the household economy.

Assessment of caregivers' capacity to care for the child

This section combined information regarding:

- 1) The household's socio-economic status
- 2) The caregivers' highest education
- 3) The caregivers' knowledge of songs, stories and poems
- 4) The availability of developmentally friendly resources in the household, such as books, toys, games and stationery for drawing and colouring

Again, relevant indicators were adapted from MICS, while the Multi-dimensional Poverty Index was adapted to assess socio-economic status of the household and highest education of carers.

Piloting the tool

The study team conducted a survey using the tool on 60 children with a team of 2 community workers in a single setting in a community in rural Rajasthan, India, where 86.7% of the community lives below India's 32 rupee per day poverty line (approximately 0.5 dollars per day).²⁴ The small team of local health community workers received two days of orientation and training on how to use the tool and then conducted a day's pilot survey.

This pilot of the tool identified relatively few adaptations to ensure reliability and ease of use. Firstly, we adapted the format of the immunization section further from the MICS under 5 model to create a more user-friendly question layout. Feedback from the practitioners suggested that the question concerning where a caregiver sought advice or treatment on the occasion that their child was ill in the last three months should reflect the range of choices available and medical facilities on offer that were particular to the area – for example, 'Bengali' doctors is a recognised term that refers to practitioners who do not have a registered medical qualification but practice a mix of herbal and medical treatments. It was also identified that it was important to record what kind of hospital was being used – for example it was important to note if public or private hospitals in the area were used, to have a proxy indicator of the quality and cost of service.

For reliability, comparability and generalizability of the data, it was important to keep the question as close to the MICS under 5 original format as possible. Therefore the issue was resolved by assigning each of the local medical practitioners to each of the existing MICS categories – for example, a 'Bengali' doctor would be defined as a 'traditional healer' for the purposes of this survey.

The piloting highlighted that practitioners had some difficulty understanding the 'observation' section of the tool, approaching the task as if it was an on-the-spot test of the child, rather than a relaxed, informal play session. After a feedback session addressing this issue and providing suggestions of how to adapt their approach to the observation aspect, there was considerable improvement in the quality of interaction with the child.

Discussion

The pilot and rollout of the tool has demonstrated that it has the potential to be of value to other organisations looking to further their understanding of early childhood development and caregiving practices in the communities that they serve. The tool has been developed for use in LMIC settings as universally as possible, we would however, expect that small adaptations would be necessary on a case by case basis – for example the indicators looking at the child's responsibilities are only appropriate where this tool is used in a rural, agricultural setting.

There are some challenges to be considered when using this tool, most notably how to train a team to create the informal and relaxed interview setting necessary to capture the context of care, child behaviours at home and how parenting practices are enacted. It is vital that the caregiver and the child do not feel that the interview is in any way invasive or judgmental to their personal life. This was complicated by the fact that the people administering the tool had a known role as community health workers providing advice and support on parenting through a Safe

Motherhood Programme. For many of the children and parents in the pilot survey population, this style of observation-and-interview survey, with such an in-depth focus on one child, was a new and confusing experience. It is important that the child is observed in as natural a setting as possible, and it is equally important that the responding caregiver feels relaxed, as they will therefore be more responsive and engaged in answering questions about their child and home life. Future work could explore with parents their views of participating in this element of the assessment and also test the tool's validity by comparing findings from the tool with a 'Gold Standard' comprehensive assessment of developmental status and caring practices by an expert interviewer. As most elements of the tool have been adapted from existing, validated and widely used resources, this validation against a gold standard was not undertaken during the pilot study.

Subjectivity is a further challenge associated with ECD assessment, and when using a tool such as this one, there is a risk of unreliable responses. We tried to reduce the risk of this firstly through including the observation aspect of their tool, rather than relying solely on the caregivers' reporting, and using a counting system for our indicators – for example, 'has X occurred in the past 3 days', rather than providing multiple choice answers—such as 'how often does X occur?' – 'very often/quite often/not very often/never'. As a further step, it would be of value to formally test the between observer reliability of responses to questions in the tool, although this was beyond the scope of the pilot study reported.

Furthermore, the trial of this tool was conducted by a team of two – the main interviewer and a facilitator, who assisted with translation into local language and who also took on the role of engaging in play with the target child. A single team, who were trained and given a strict protocol to follow on how to conduct the survey, meant that many issues of consistency in data collection and inter-rater reliability were avoided. In order to increase the reliability and external validity of this tool, however, it is necessary that it is trialed in other settings.

It should also be noted that this tool also has the potential to track change over time, to assess the impact of community-based interventions, and this application warrants further investigation.

Conclusion

It has been recognised that the area of ECD has been neglected by the international development community despite the crucial role ECD plays in ending poverty. While there are a number of widely-recognised and valuable tools for measuring ECD, this paper has shown how none of these are adequate for organisations looking to measure child development in LMIC settings.

The authors believe that the tool begins to address the shortcomings of the previous ECD measurement tools, due to its focus on user ease, cultural and socioeconomic sensitivity, and increased comprehensiveness. The authors hope that it will be of value and provide guidance for organisations that wish to design interventions focusing on supporting early childhood development.

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