

**Samarpan: Centre for Early Identification and Treatment of
Children for Disability or Developmental Delay**

Innovative Practice Documentation

For



Centre for Innovations in Public Systems, Hyderabad

By



Centre for Studies in Ethics and Rights, Mumbai

A Unit of Anusandhan Trust

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List of Acronyms

ANM	Auxiliary Nurse Midwife
APL	Above Poverty Line
ASHA	Accredited social health activists
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BPL	Below Poverty Line
CRC	Child Rights Committee
CSER	Centre for Studies in Ethics and Rights
DDRC	District Disability Rehabilitation Centre
ENT	Ear Nose Throat
HR	Human Resources
IAS	Indian Administrative Service
ICDS	Integrated Child Development Services
IEC	Information Education Communication
IGNOU	Indira Gandhi National Open University
IT	Information Technology
NIOH	National Institute for the Orthopaedically Handicapped
NIMH	National Institute of Mental Health
NIMHANS	National Institute of Mental Health and Neurosciences
NIPI	Norway-India Partnership Initiative
RAPID	Reaching and programming for identification of disabilities
RBSK	Rashtriya Bal Shishu Karyakram
SNCU	Sick New Born Care Unit
U5	Under 5 years of age
UNOPS	United Nations Office for Project Services
WCD	Women and Child Development Department

Executive Summary

Samarpan is project for early identification, screening, treatment and rehabilitation of children with any form of disability of a developmental delay. This program draws from the concept of neuroplasticity and critical period of development from psychology and focuses on children between the age groups of 0-5 years. This innovative project is the brain child of Mr. Nishant Wadware (IAS), a former District Collector of Hoshangabad, who had a keen interest and commitment towards the cause.

Samarpan points out a very significant gap in India's programmatic focus and demonstrates an effective model for replication. The project also takes up the responsibility of actively reaching out to the community and is thus a *suo motu* attempt of addressing developmental lag among children by their *en masse* screening and community based treatment and rehabilitation. The project is based on convergence of all key stakeholders, primarily including government departments of health, women and child development and social justice; primer national institutions like NIMHANS, NIMH, NIOH, CRC, National Trust etc and the local clubs and societies like Rotary club and the Red Cross Society. Thus, it is optimizes a pool of resources - material, manpower and technical. Convergence helps the project provide comprehensive care which is base don a multi-disciplinary understanding.

Till February 2013, Samarpan had screened over 105550 children, and registered 1100 children for intervention, based on their screening tests. It has trained about 3000 frontline functionaries, including the AWWs, ASHAs and ANMs for carrying their message to the community and providing for a first round of screening to children. The early intervention clinic of Samarpan provides the following services: medical services, general women & child services, neurological assessments, physical therapy, occupational therapy, psychological services, cognitive development, speech, language hearing and vision related intervention.

Major challenges of the project continue to be in terms of overdependence on the institution of District Collector for financial and institutional sustainability, dismal follow up rates, tertiary links which need improvement and some manpower, infrastructural limitations.

Despite these, Samarpan presents a strong case for replication at the National Level. It is very relevant program and brings valuable lessons on interdepartmental, inter-sectoral and inter institutional convergence, backed by a strong political will can make a he difference to many many children in the country.

Brief Description of the Innovation

Samarpan is a first of its kind model of comprehensive intervention to reach out to community and facilitate early identification, screening, treatment and rehabilitation of children with learning or physically disability or a developmental delay.

What makes this programme innovative is not the idea to of early intervention and identification per se, since this approach has been stressed in both biological and social sciences under the concept of critical period of development. However, what makes Samarpan special is its holistic and integrated system of doing so, achieving convergence, galvanizing much under-utilized government resources and manpower, actively reaching out to communities and finally, its demonstration of bureaucratic efficiency which was the key to success.

Each of these aspects of innovation is briefly described below:

1. Samarpan is a suo motu attempt to reach out to community for early identification of developmental delay or symptom of disability in U5 children by their *en masse* screening and subsequent intervention. Thus, the government takes responsibility for reaching out and screening each and every child of in the given age group in the area, without waiting for them to come to its centre.
2. It is a holistic approach which includes different departments, particularly, Health, WCD, Social Justice and Revenue and reputed organizations/institutes like the CRC, IPGMER Kolkata, Red Cross, Rotary international etc. This convergence allows for pooling of human, financial and technical resources. The program thus demonstrates the efficacy of intersectoral, interdepartmental and inter-institutional convergence model for optimizing resources.
3. Samarpan provides for comprehensive Intervention by adopting multidisciplinary approach. For example, if a child is brought citing a problem of low vision, s/he is not examined for only that attribute, but is in fact screened for a range of development indicators, and is consulted all the experts at the centre, to provide comprehensive screening and treatment.
4. Lastly, the program demonstrates the efficacy of the institution of District Collector in achieving social objectives. It demonstrates what can a district collector who has interest, understanding and commitment to any social issue achieve to do and get done with his active participation and in fact anchoring of the whole programme.

Design of the Case Study

This case study has been documented by CSER (Centre for Studies in Ethics and Rights), which is a research and training institute of the Anusandhan Trust. CSER works with a framework of ethics and rights to primarily study the field of healthcare services, provider behaviour, public health and other social aspects such as education, etc.

CSER used participatory and applied research methods to document the innovative case study of Samarpan with research oriented approach. Participatory method included interviews and focused group discussions with key stakeholders to understand the functionality, processes and impact of the project. Applied component indicated that the case study is being recorded for informing and guiding further replication, thus, it is a strategy oriented documentation, supported by both qualitative and quantitative analysis.

The process of documentation started with secondary data collection from various sources. At first, there was a review of all available information on Samarpan website, newspaper reports, project documents, training literature, screening tools, any reports, evaluations and IEC material. Based on these, a checklist for interviews was prepared for each of the three categories of key informants: a) project staff at various levels and b) project beneficiaries and c) community representatives (see annexure).

Primary research was conducted in July 2013 over a week, starting and ending with the interview of the then District Collector himself. Interviews were also conducted for key stakeholders including medical superintends, ASHAs, ANMs, Anganwadi workers, technical experts involved in direct service delivery, including a few focused group discussions with beneficiaries and observation of screening and treatment facilities.

The data collected was analyzed based on themes relating to documentation objectives, like innovation, challenges, opportunities, replication etc.

Innovation Context

Early childhood, particularly years 0-5 is known as the critical period of development in both biological and social sciences. This implies the experiences and development that occurs in first five formative years can have life long lasting affects. Thus, if the earliest sign of development delay is identified while a child is under 5 (U5) years old, then a specialized intervention can present a window of opportunity to bring the child back to almost a normal curve of development.

However, young children with disability or developmental delay were by and large overlooked by the mainstream policy and programs on persons with disability or children in the country. Thus, the idea of Samarpan germinated in 2009, and was further reinforced after the establishment of SNCU in Hoshangabad in July 2010. While the SNCU was able to improve survival chances of the very sick children, however could not promise them a quality life of beyond that. The administration but felt morally responsible for the quality of life of these children, who had a greater likelihood of experiencing disability or developmental delay later in life. It pointed the need towards availability of services, with the help of a multidisciplinary team to address this issue.

It was in this context that Mr. Nishant Wadware, a former District Collector of Hoshangabad (now posted as Collector Bhopal), who had a keen interest and understanding of psychology and child development took up the leadership and initiated what we call project Samarpan today. He identified a key gap area in public policy and program where there was practically no provision for early identification and treatment of children between 0-6 years for disability or developmental delay. Anganwadis and Sick new born care units helped fight malnutrition under women and child development department and health departments respectively, and grown-up persons with disability came to social justice department for certification at free or subsidized aids, but this catered only to those who came up to the department, without state actively reaching out to them. Many developmental delays in young children or early signs of disability went unnoticed and untreated.



As a first step, a national level workshop of representatives from various national institutes of repute, like NIMH, Secunderabad; NIMHANS, Bangalore; NIOH, Dehradun; IGNOU, NCDS, CRC, National Trust and others was organised in Hoshangabad in August 2010. It was this meeting that confirmed the need for the programme, prepared a blue print

for early identification and intervention, changed the name of DDRC (District Disability Rehabilitation Centre) to Samarpan and built a nucleus of thinkers, supporters and advisors with collector at the helm of affairs.

Technical support for the program was provided by Dr Arun Singh, former Head, Department of Neonatology, IPGMER, Kolkata. Screening test for the community level application, as developed by National Institute for Mentally Handicapped (NIMH), Secunderabad under their



Reaching and programming for identification of disabilities (RAPID) programme was adopted to be used en masse on all U5 children enrolled in Anganwadi centres (AWCs). The tertiary linkages for intervention were explored by district administration to make intervention comprehensive in all aspect. Financial and manpower resources from various departments, particularly Health, WCD and Social Justice were pooled.

For example, Anganwadi Workers from WCD did the first level of screening in the community itself, experts from social justice department in DDRC were used for further screening of suspect cases and intervention and referral services for surgery was provided by the doctors of the health department.

Similarly, resources were galvanised from across the departments, for instance, to transport children and parents to Samarpan clinic, an old bus of health department was used, which was driven by a driver provided by the social justice department at the fuel cost of Women and Child Development department. Society's like Red Cross too came forward to help with some equipment purchase and paid salary for an optometrist



(a post not included in DDRC), while Rotary club provided subsidized food for visitors in the clinic. Thus were put together all assemblage for the beginning of what was to become one of the most relevant and innovative program on early identification of disability in the country.

Implementation Strategy

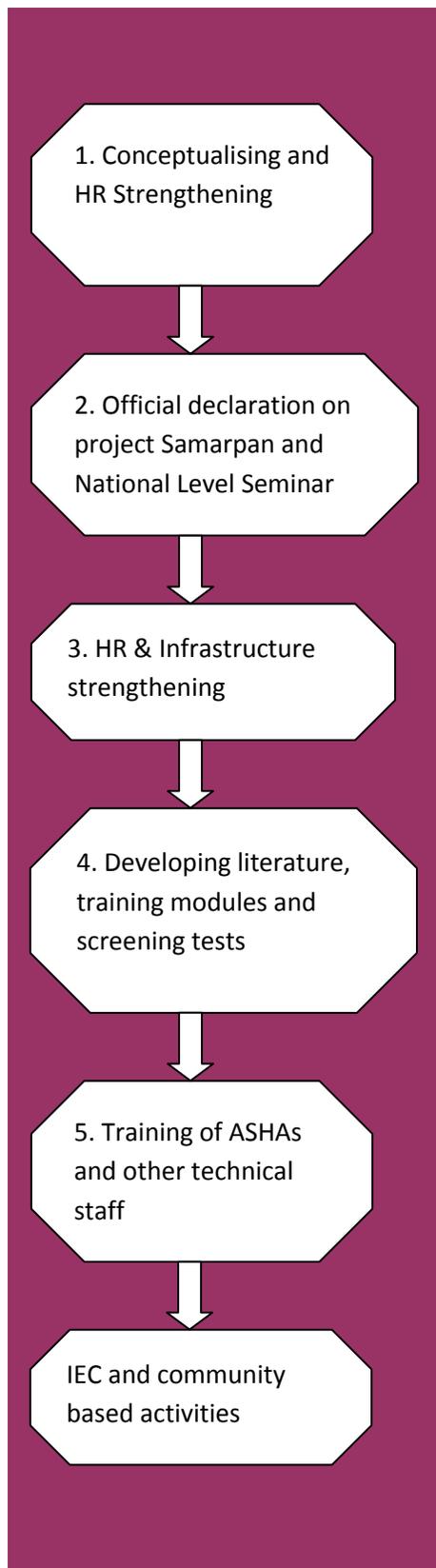
Samarpan was initiated with the following objectives:

1. To understand the concept of early identification and intervention of development delays.
2. Suo motu identification of early signs of delays in U5 children in the district by conducting screening test based on developmental mile stones for early identification of development impediments in newborn and U5 children
3. To have a comprehensive specialized multi-disciplinary evaluation of child for social development, visual development, speech and hearing development, mental development, normal development growth etc., under a single roof;
4. To provide comprehensive specialized multi-disciplinary intervention to remove or reduce developmental impediments.
5. To facilitate acceptance of onset of development delay by a family in their infant.
6. Making society aware about the concept of EIC; increasing acceptability of disability in society and to involve it in society-based and home-based identification.

Implementation strategy of the programme can be divided into two parts, one the initial strategy, which were by and large one time activity, and two the ongoing programme activities. Former was liner in nature and the later is cyclical, although individual treatment of cases within it may also continue on in a linear mode, across these cycles. The various stages are shown below:

1. Stages of Implementation Strategy at the time of Commencement

The first few stages of the programme commencement have already been described in the previous section, while building a context for the innovation. To start with the third in a greater detail - an existing building of the DDRC, under Social Justice was refurbished to start Samarpan activities. Among the various changes, the building included a registration area, a Doctor and ANM station, auditory room, visual area, learning development testing room, and an IEC and play area for children.



The following experts were recruited/made part of Samarpan, cutting across departments and other programs: Psychologist, Audiologist, Optometrist, Physiotherapist, ANM (2), Manager, Visiting specialist (twice weekly) Paediatrician/ ENT specialist/ Orthopedician), Ophthalmologist/ Psychiatrist and Support Staff (Peon, Ward boy, Sweeper etc).

An admin officer or resource coordinator was also appointed to manage data, coordinate, liaison and perform day to day managerial function.

A small library was set up, and technical inputs to build training modules were sought from the participating experts and institutions. The RAPID screening test of NIMH was adopted in local language and situations to become Samarpan screening test (SST).

For capacity building, the following trainings were held:

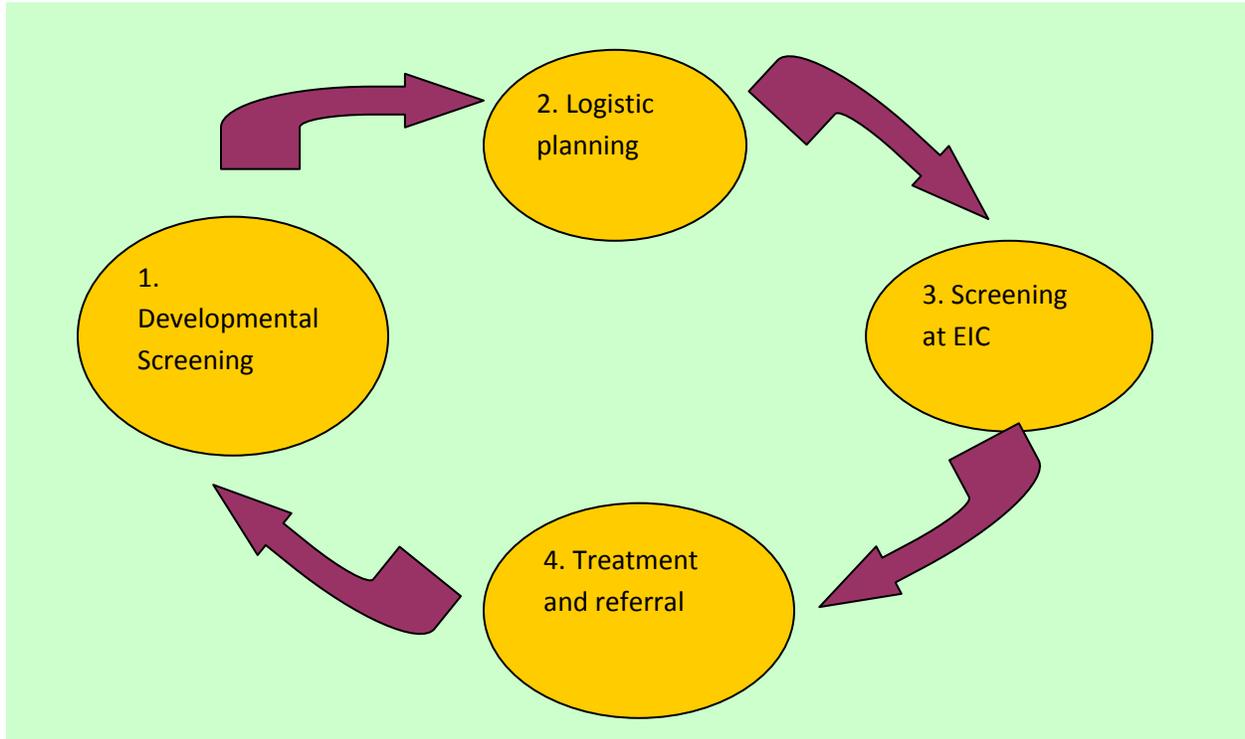
1. Orientation meeting of all government departments to chart out roles, responsibilities and basic requirement from each of them.
2. Training of Early Intervention Clinic Staff, held at different reputed institutes, as suitable, for a period of 15 days.
3. A one day orientation of AWWs and ASHAs (at the Block Level)

A community mobilization campaign was undertaken to create awareness about the significance of early identification and early intervention for development delays among children. These included series of activities like symposium, open discussion with doctors, a total of 13 rallies, press conference, public meetings, chaupals and street play's by Kalapathak Dals etc. The official slogan of the campaign was '*prashashan appke dwar*', indicating the

onus of the government on reaching out to people themselves, while they simply need to respond to the former's initiative.

2. Regular Implementation Strategy of the Programme

The continuing program strategy of Samarpan has been divided roughly into four stages and has been presented in the graph below:



1. Developmental Screening

In the first step to Samarpan intervention, Anganwadi workers used SST (Samarpan Screening Test) on all U5 children enrolled in AWCs. They had already been oriented to fill the early identification form, and were paid extra at Rs. 5 per form, for incentivizing. In the first implementation cycle, about a hundred thousand children were screen at the community level.

2. Logistic Planning and Data Analysis

The data first round of screening by AWWs was used to identify suspected cases of disability or developmental delay. These forms were entered into software for data analysis and continuous monitoring and supervision in future.

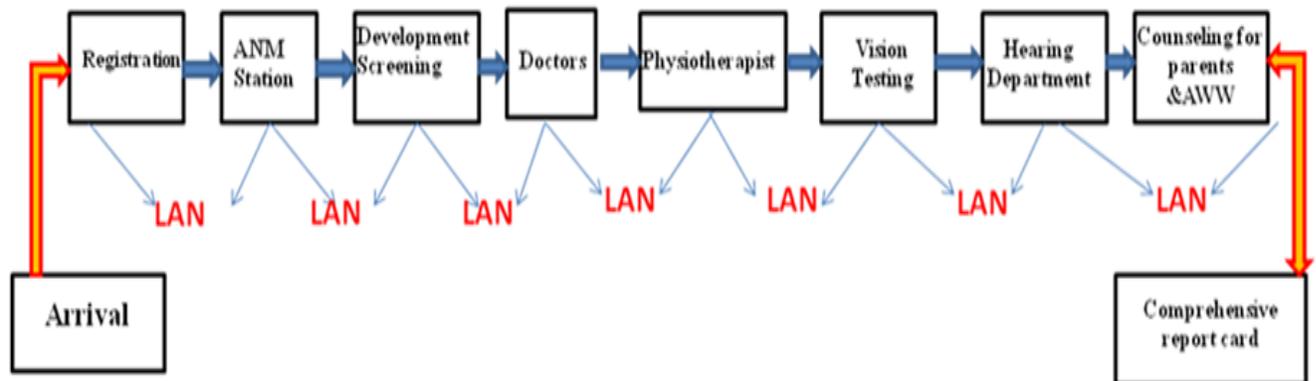
Identified suspect cases were to be screen by specialized staff at the EIC. To enable this, detailed planning was done, including arriving at a maximum number of screenings that can be done at a particular day, preparation of the route chart, arranging for

transportation, AWW as escort with the family, lunch arrangements, and availability of multidisciplinary experts etc.

The support that families received in terms of transport, their AWW as escort and lunch was important to ensure that children came; reached at a predictable time and waited till all the tests were over. This includes also dropping them back at their doorstep. A proposal for payment of daily minimum wage to compensate the adult accompanying the child was in the pipeline, but was never actually practiced for various reasons.

3. Comprehensive Intervention at Early Intervention Centre

A comprehensive screening of children was done for all children, and all data was simultaneously entered in the software for future reference and use. The holistic approach of Samarpan required each child to pass through a series of specialists to be checked on all developmental attributes, as has been represented in the flowchart below:



A dedicated website and software was developed specially for the project to record keeping, storing, monitoring data for future follow up or dissemination etc. This also helps in maintaining accountability and assessing impact of the programme. A snapshot is provided below:



4. Treatment and Referral – After the screening, if a child is identified as suffering from a particular disability or developmental delay, s/he is either provided treatment in the EIC itself or referred to hospital for medical intervention. At present, the following services are being provided at Samarpan:

1. Medical services: General medical treatment, preventive health care and child immunization.

2. General women & Child services: Nutritional advice and guidance of feeding children.

3. Neurological assessment for excluding the possibility of any neurological deficits in those considered high risk births.

4. Physical therapy: To promote motor development or services to prevent or reduce the movement difficulty, along with distribution of customised artificial appliances.

5. Occupational therapy: Services to promote everyday self-help skills, adaptive behaviour, sensory, motor and postural development.



6. Psychological services: Assessment of psychological development through DSCII & DDST and counselling and group therapy if any obstruction to psychological development or behavioural disorders are found in children.

7. Cognitive development: Assessment of child's mental growth and development and making appropriate intervention through play and socialization if a need is found.

8. Hearing: For identification and intervention of hearing deficits in babies with or without risk factors, including distribution of ear moulds.

9. Speech & language: For Identification and intervention of speech language pathology, delay in Oro- motor, language, communication and comprehension skills.

10. Vision: For identification and intervention of visual problems like refractive errors, cataract, glaucoma, amblyopia etc.

Challenges in Implementation

Samarpan has faced its own set of challenges since the very beginning, like coordination between various departments, setting up a well equipped resource centre with specialist staff and questions of incentivizing staff at various levels for the extra work. However, the list below talks about present challenges faced by the project, not ones that have been completely resolved. These are:

1. Overdependence on the institution of the then District Collector - This is perhaps the greatest strength as well the most prominent weakness of the program. The convergence achieved; the mobilization of human and financial resources from various departments, inclusion of clubs and society's and other institutions could be achieved only because the District Collector owned the programme, and was personally involved in all the affairs. He also guarded the programme from bureaucratic delays and corruption.

What is needed, however, is to institutionalise such models, have a written charter of roles, responsibilities and accountability mechanism and separate provision of budget and manpower. The effect of the transfer of Collector from Hoshangabad could already be seen in the program. For example, the present collector was not in favour of a special bus sent to the community to pick up and drop children and their mothers (or other escort) from the Samarpan clinic. Instead, his idea was to issue them bus passes so that they could travel to and fro in the already existing government buses. While the logic of this strategy is understandable, Samarpan staff was ambivalent about it since this would also mean they do not exactly know how many children would visit the clinic in a day and at what time would they reach. Such information had greatly helped them plan the day, since a child needs to go through many screening tests and also to block the days of all specialized staff for availability. Certainly, it would impact on program efficiency. Although this problem was solved when the SBI decided to donate a bus to Samarpan, however, such arrangements may not always be easy to make. It took nearly one year for Mr. Nishant to make a proposal to SBI, under CSR and see it materialise. While this may be yet another example of convergence with companies, a formal inclusion of the programme in the district administration is probably the way out.

2. Rashtriya Bal Shishu Karyakram - an institutionalization of program Samarpan is in the pipeline, in the form of RBSK. Its guidelines have



been formulated and have been displayed on the central government's website. However, they do not recognise project Samarpan and make no note of it. Stakeholders of the Samarpan project expressed some concern about a few provisions of the RSBK. First, RSBK is to be a programme of the health department, very significantly undermining the importance of convergence model established by Samarpan. Some believe that it is not possible to run an effective program like this without the convergence model, for instance, the very first screening of children at the community level would be a failure if anganwadi workers are not involved. While the health department may involve ASHA's in it, ASHA's receive only incentives, and are not of official pay roll of the government. Many reports about over work and low motivational levels of ASHA's are already available. Moreover, while ASHA's work in the community too, they are not as involved with the children as the AWWs are.

The other provisions relate to extending the program from U5 to 0-18 years, while this may be good for the continuum of identification and treatment, special focus has to continue on U5 for early identification. There is a fear that RSBK might in fact be spreading too far and therefore, too thin if this focus is diluted.

Lastly, some departments/posts, like the modern artificial limb unit have not been included in the RSBK. They will be given only to those with a disability certificate and it was told that such certificates are issued only to those who are above 6 years old, therefore, excluding the early childhood age of children. While these are important aspects of disability correction or treatment, and should have been included, these have also led to a great dissatisfaction among Samarpan staff since the salaries scales of different technical staff are different as they come under different departments. Thus, while they may be working in the same project, for same clientele, and somewhat equal work, they do not receive equal salaries. Once the RSBK comes into force, these gaps of those who have been included and included may widen further, and it has already led to a great dissatisfaction among technical experts, particularly those from social justice department, originally belonging to DDRC.

Thus in RSBK, government is repeating some of the same mistakes, that of lack of emphasis on convergence and outlining a blueprint of how this may be achieved And for the convergence to work efficiently, the Samarpan experience says that no matter how over burdened the District Collector is, the program needs to be drive by him.

3. HR Related Challenges - while the program is well staffed, there were requirements for two important posts, one is the data entry operator, and the other is a full time cleaner. Both these were included in the original roll out

plan of Samarpan but could not be recruited for whatever reasons. Considering that many small children visit the clinic, a full time cleaner may help in keeping the floor clean at all times and preventing further infections. A data entry operator may help in maintaining the records, their analysis for better targeting and impact assessment. At present, entering of data in the software is done by technical staffs which create a lot of over work for them.

4. Infrastructural Limitations - While Samarpan is one the better programs, there are some infrastructural limitations. The most important is that some equipment is old, needs up-gradation or repair, particularly with regards to making artificial aids and appliances for children. The oven in the artificial limb unit was not functional at the time of the field visit, there was no exhaust fan to let out air from the machines and raw material were delayed, all this leading to a long list of pending cases. A washbasin in the main screening area is urgently required since children normally put toys and other assessment tools in their mouth, while experts to need to wash up after they have examined an infected child and move on to the next one. While there is washbasin in the centre, it is only in the washrooms, which is a little further away. One which is closer may save time and ensure more frequent hand washing and equipment sanitizing habit among all. The other example is of bureaucratic delay. It took the admin officer of Samarpan nearly six months, and much running around and letter writing before the Samarpan software could be renewed.
5. Follow up and continuity of treatment - Most of the treatments and therapies for enabling the highest possibility of functioning among children identified with disability required continuous treatment, monitoring and follow up. This makes it important for them to visit the clinic at least several times a month. Follow up of children, particularly those belonging to poor, remote areas is certainly the weakest programmatic link in the programme. This is more so when the treatment is long drawn and effects require time and patience to show. The project staff estimated that the follow up has been possible only for 20-30 per cent of the children which were diagnosed for various interventions.

There has been some attempt to teach basics of therapy to parents so that they could practice the same with child in case visiting the clinic is not feasible each time. However, this cannot replace the professional treatment, supervision and monitoring. One unfortunate incident occurred in physiotherapy where while doing some leg exercises with the child at home, the parent went too far and there were some muscle damages.

While it is important to note that project staff did not see any gender dimension in follow up, since most parents seemed to be equally concerned about disabilities among girls, probability due to its relationship with marriage. Nor was there any caste related problem among people who had to sit in the same

bus, each lunch in close proximity with another and get their children examined together.

6. Tertiary link development - While there is a very effective system of tertiary links with doctors of health department, established under Samarpan, there have been some issues recently. Normally, doctors sit in district hospital, which is a health department facility and patients visit them for diagnosis or treatment. However, under Samarpan, an arrangement was made to call doctors for rural camps or in Samarpan's early intervention clinic by paying them some extra fees of Rs 1000 per such day. However, the arrangement has been changed now to patients going to the hospital during the OPD hours to visit the doctor. The question here is that should the government pay its own doctors to treat children diagnosis at Samarpan at additional fees, on a non working day? While there may be two perspectives to it: one to use the already stipulated time of doctors in hospital and pay no extra, and the other, to ensure that doctors are available to children coming to Samarpan, on the day they come, and without their going anywhere else or waiting in long queue for treatment. For the later, it becomes important to find extra time when doctors can work, and extra incentives which motivate them to. This presents a very paradoxical question, and the answers might actually depend on ways of functioning of the leadership and the need for overall efficiency.

Moreover, there are some specialized surgeries and treatments which for which there is no facility in Hoshangabad district hospital. Surgery for cataract in children is one among those. Thus the linkages have been made to Bhopal and elsewhere, but it is often not possible for uneducated, poor families to take their children to far away distances. Moreover, better connections need to be established even with the SNCU. Although all specialists from Samarpan visit the SNCU twice in a week, the follow up and monitoring of these children, once they leave SNCU is weak and may be an important addition to Samarpan project. For example, retinopathy of prematurity has a great chance of improving when it intervention is made within 72 hours of birth, however, even within Samarpan, the general tendency is that more children from age group 3-5 years come. Reaching them at the first instance still remains a challenge.

7. Strengthening Community Mobilization and Home based Intervention - While the project has had some IEC initiatives and community mobilization has been done by AWWs and ASHA's it was felt that a more effective mobilization and awareness building, not just for enabling early screening but also on preventive aspect of disability must be addressed. However, this point cannot be elaborated much further since the field work could not include visiting rural communities (interaction with only parents and children in urban nearby locations could be arranged due to monsoons and logistic issue).

Home based intervention is presently being supported by the Education Department, where the special educators visit children in their homes and try to train parents in their treatment on a voluntary basis. However, the component needs much more strengthening.

8. Data Storage, analysis and Use - while it must be appreciated that Samarpan uses good IT systems for storing and retrieving data, presence of a data entry operator could have helped in its analysis and usage for other purposes as well. For example, at present, the details of the child's caste/ religion and the family income are not recorded during the registration. This is also because Samarpan has developed as a universal programme, and is not targeted at poor or marginalized. However, such inclusions and analysis will help us locate which children is the programme invariably reaching to, who are getting most follow up etc. This huge data base generated format the project can be used for research, documentation and development of vernacular literature. This of course is a medium term plan and we hope that Samarpan becomes forerunner of such knowledge in the country.

Benefits of Innovation

Samarpan is a new project and it is too early to talk about its long term in terms of improvement of quality of life of children. However, some quantitative outcomes are listed below:

S. No	Indicator	Numbers
1	Total Children screened by AWW using SST	105550
2	Delay in developmental Milestones identified	2311
3	Children examined in EIC	928
4	Children identified of delay in development milestones / defects	794
5	Treatment and services provided to identified children	794
6.	Counselling and home based intervention	794
7.	Trained cadre for early detection of disability	About 3000, at least 1 per village

Besides these, there are various other outcomes of the project that merit a discussion:

1. Samarpan points out a very significant gap in India's programmatic focus and provides a model for scaling up. It creates a highly efficient resource centre, optimises already existing staff, infrastructure and budget and makes a huge difference to at least hundreds of children in a small time frame of about two years in a small district of Hoshangabad.



2. What it achieves next is something that most government programmes are criticised for – lack of convergence. It shows the power of convergence and how it can be achieved by those in leadership positions, and makes it work without any hindrances. What is important that this continues, in the same spirit, even after the District Collector

has been changed. The credit, by and large goes to the work satisfaction and sense of ownership that has been instilled in the clinic staff, to continue to work diligently.

3. The project is technically very sound. It uses all upgraded screening tests, and employs all qualified people. Even where some extra training has been required, it has been arranged for the staff. Thus, there has been capacity building and this is obvious when one examines the records of the specialists, watches them interact with the child or hears them describe what, how and why of their work.
4. Following from the above point, the total screening for the child for all major attributes, irrespective of the suspected attribute has resulted in integrated care and holistic treatment.
5. Since the project reaches out to nearly all children in the given age group in the district, it has brought the issue to the forefront, generated dialogue on it, increased community awareness towards disability and its indicators. It has also built the capacity of frontline government functionaries like the AWWs, ASHAs and ANMs.

Financial model

Samarpan did not have a separate budget, and no new financial allocations were made for it. It optimized and utilized already existing resources with the government, hence it is difficult to estimate how much was exactly was its programmatic expenditure.

However, the sustainability of such a model for recurring expenditures may be questionable and therefore institutionalization has been suggested. At present, screening, diagnosis and treatment in Samarpan is free for all, while only aids and appliances are free only for BPL class.

Potential for Replication

The project is feasible and very relevant and therefore there is an urgent need to upscale the model. However, it must be accompanied by rigorous planning, orientation and incentivizing of all stakeholders. The program will be effective only by evolving a convergence model, based on comprehensive set of interventions by adopting multi disciplinary approach. Thus, these standards must be kept in mind.

In fact, Samarpan is already being replicated in all 50 districts of Madhya Pradesh, where funds have been allocated to the health department under RSBK. These districts are at various levels of program formulation, though.

Conclusion

Early Intervention Centre or Samarpan is the first of its kind model in India demonstrating the need for early identification and intervention for all U5 children registered in Integrated Children Development service (ICDS) and in SNCU at district Hoshangabad for any incidence of disability or developmental delay.

It demonstrates the efficiency of intersectoral, interdepartmental and inter institutional convergence model for optimizing resources. It also demonstrates the strength of the institution of the District Collector and what s/he can achieve through his/her leadership. It *suo motu* screens all U5 children in district *en masse* for detecting the earliest sign of development delay, facilitating their possible recovery to normal curve of development.

Thus, while Samarpan offers some very important lessons and experience of early childhood services, the way ahead must include three major components - a) of research/data analysis and dissemination b) follow up and continuity of treatment for all, including strengthening home based intervention and lastly, c) social component of awareness, prevention and creation of an inclusive society. With programs based on true concern and commitment, like Samarpan is, every child will have an opportunity to achieve his/her full potential.

Annexure 1

EIC Registration & Distribution Feb 2012-April 2013		
Se No	Particulars	No of beneficiaries
1	Total Registration	1100
2	Physiotherapy	514
3	Audiologist Counselling	127
4	Vision	175
5	Speech	303
6	MR	427
7	Self help skill training	515
8	Parents Counselling	1100
9	Normal Child	272
10	Abnormal	872
11	Hearing Aid Distribution	64
12	Callipers	7
13	PPAFO	28
14	CTEV Surgery	15
15	Modified Shoe with Arch	93
16	Splint	6
17	CHD Surgery	5
18	Modified Shoes	3
19	Gaiters	0
20	Cleft Lip & Palate Surgery	7

Annexure 2

EIC Follow up Details Jan 2012 to March 2013

Se No	Month	Self Help skill training	Vision	Speech therapy	Physiotherapy
1	Jan	0	0	0	0
2	Feb.	0	0	0	0
3	March	0	0	0	27
4	April	0	0	0	22
5	May	13	0	17	31
6	Jun	39	3	28	46
7	July	21	0	28	21
8	Aug.	25	4	16	18
9	Sep	12	1	13	14
10	Oct	7	2	18	13
11	Nov	1	0	20	3
12	Dec	2	1	24	0
13	Jan	20	0	17	20

14	Feb.	50	8	32	53
15	March	8	3	22	24
16	April	30	4	32	35
17	Total	228	26	267	327

Annexure 3

Checklist for Project Documentation:

a) Project staff/stakeholders at various levels

1. What according to you is the objective and rationale for a program like Samarpan?
2. How long have you been associated with the program and what has been your experience with it?
3. What is the process of registration, screening and testing of children in the programme? What are the types of treatment provided to them?
4. Describe the strengths of this program as well as its areas of improvement.
5. What has been the greatest challenge for you personally, while working with this project?
6. What are the strategies of the program and how have they evolved?
7. How does project elicit local participation and community resources, if any?
8. How has the programme created better awareness on both preventive and curative aspects of various disabilities within the community?
9. What are the transparency and accountability mechanisms available to project staff, and also to beneficiaries?
10. What do you think is most unique about Samarpan intervention?
11. What is the convergence and complementary role played by the project, when other similar programmes government/NGO/Private programmes may exist?
12. How has the programme benefited the quality of life of children identified with any of the disabilities? Please share any case studies.
13. Has the programme been inclusive on all four counts of gender, caste, class and disability?

14. Whether the scale and design of the programme gives a replicable model for implementation? What has been the experience of such replication trials?
15. What are the institutional structures of the programme and how are they maintained?
16. How is project staff recruited, trained and motivated? Do they receive and on-job training or refresher courses (especially ASHA's and ANM's)?
17. What implementation problems have you faced and how did you respond to them?
18. What are the strategies for community mobilization for better coverage and targeting?
19. Have the financial and infrastructural provisions in the programme been adequate? Have you ever faced any financial or infrastructural problems in programme implementation? Describe in detail.
20. What data do you collect and monitor during the programme, how is it recorded, stored and disseminated?
21. How do you think program can be improved?

b) Project beneficiaries and Community Representatives;

22. Do you think the community needed a programme like Samparpan? Why?
23. What is the process of registration, screening and testing of children in the programme? What are the types of treatment provided?
24. How has this programme helped you? As a beneficiary, describe your experience of availing its services. (Probe for details).
25. Have you ever faced a problem(s) in accessing services of the program? Especially account for infrastructural or behavioral problems faced.
26. Have you been associated with the programme at any other level, besides being a beneficiary? If yes, describe your involvement.

27. How does community in general, and its local resources (may be non financial) help the program?
28. How have you contributed to the programme, formally or informally?
29. Describe the situation in the community before the programme and compare it with after its inception.
30. How have you seen the programme change and evolve since its inception?
31. What are the long term changes brought about by Samarpan in the community attitude, knowledge and practices?
32. How do you think is Samarpan different from other such programs (NGO or government or private)?
33. How is the behavior and attitude of project staff towards you? How and who can you complain to, if dissatisfied with a project staff? Describe any positive or negative incidents from your interaction.
34. Do you think Samarpan is a successful programme? Why?
35. To what extent does the programme improve the quality of life of children identified with any of the disabilities?
36. Does the programme cater equally to girls, SC/STs and poor children?
37. Suggest how the programme could be improved.
38. What are your expectations from the programme in future?