Leveraging the Community Health Strategy and Multi-Sectoral Partnerships Towards Scaling Up Nurturing Care in Rural Communities:

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Madrasa Early Childhood Programme's Implementation of Care for Child Development in Kenya

THE AGA KHAN UNIVERSITY
INSTITUTE FOR HUMAN DEVELOPMENT

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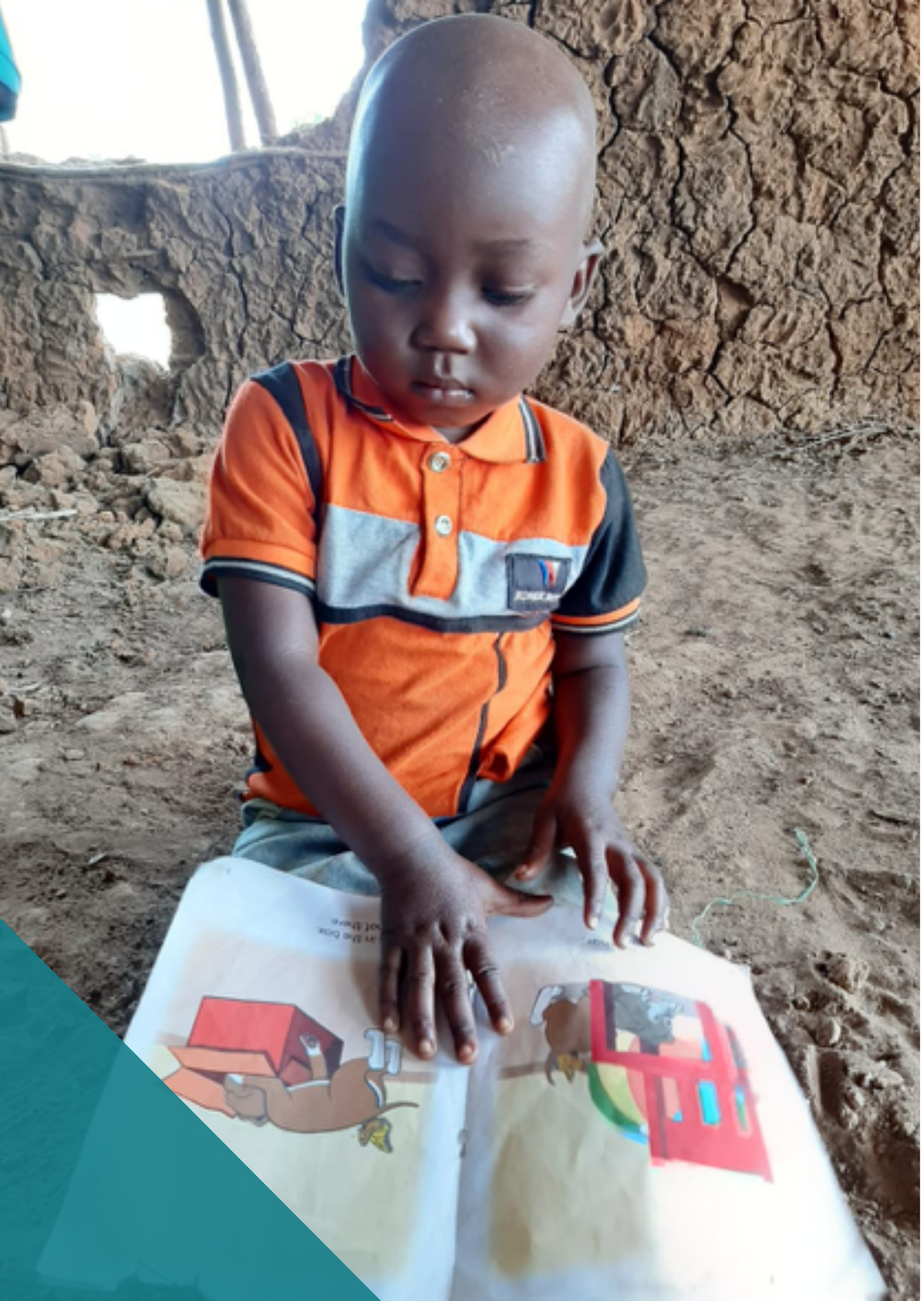

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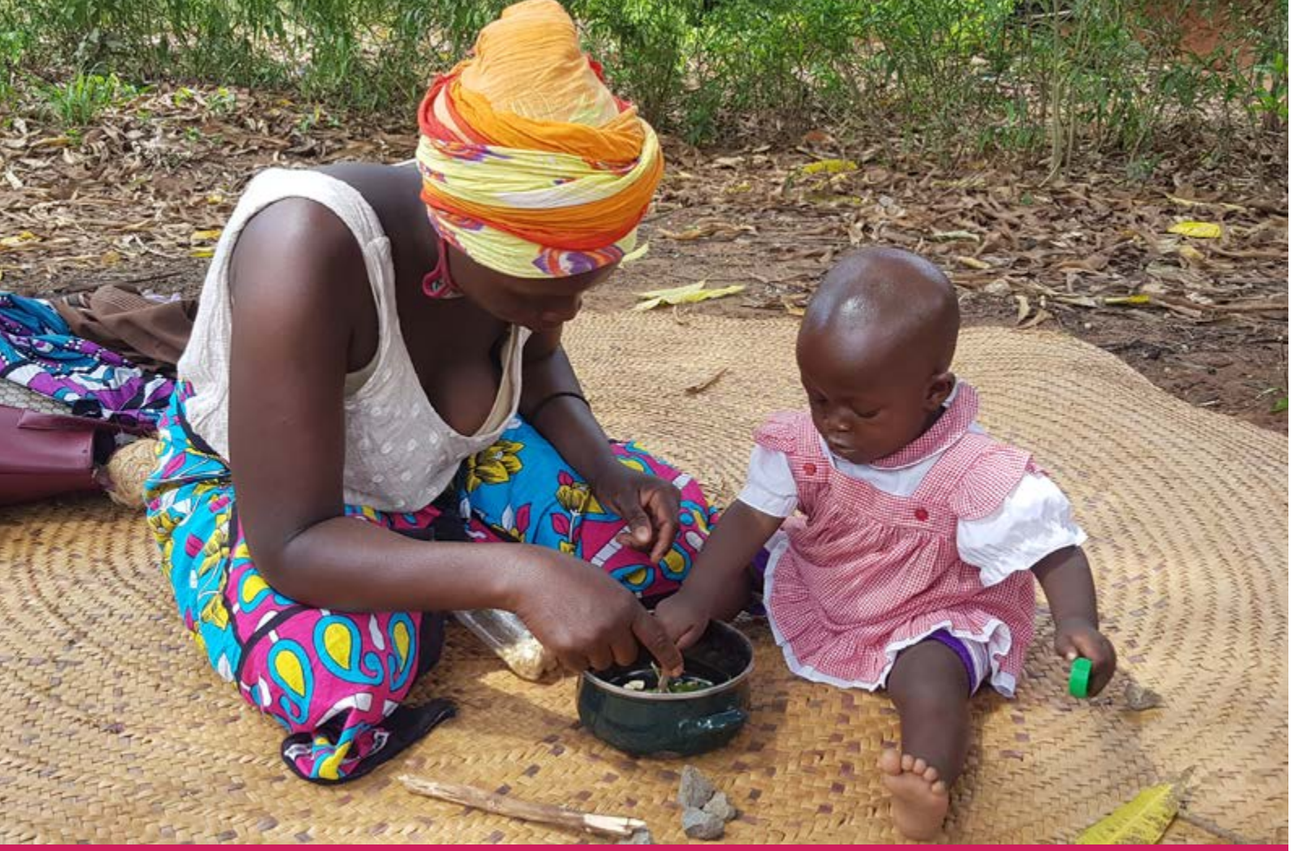
Table of Contents



Executive Summary

This case study describes the role played by the Madrasa Early Childhood Programme (MECP) in implementing Care for Child Development (CCD), in partnership with multi-sectoral stakeholders within a rural community in Kilifi County, Kenya. CCD is an evidence-based approach that aims to strengthen the caregivers' capacity to engage in play and communication activities to support the development of children's motor, cognitive, language and socio-emotional skills. The CCD approach is delivered by frontline workers from health, social protection and other sectors. These workers counsel parents and caregivers on how to effectively interact with their children through play and communication. The frontline workers also encourage caregivers to be sensitive (i.e. conscious of the signals the child is sending), responsive (ready to act on these signals), and playful with their children.

In Kenya, the Community Health Strategy (CHS) aims to enhance community access to health services to improve productivity; reduce poverty, hunger, child and maternal deaths; and improve education performance across all stages of the life cycle. The CHS is an ideal entry point for CCD integration since it allows for effective engagement with various stakeholders from both health and non-health sectors, including local administrators, education officers, and social protection officials. The strategy complements health facility-level interventions at the maternal and child health (MCH), and nutrition departments. For instance, it provides a platform for holding facility-level talks with parents and caregivers, especially during routine counselling sessions with pregnant mothers. These platforms provide play spaces/areas, and toys for children as they access child welfare services such as immunisation, and growth monitoring.

The strategy complements health facility-level interventions at the maternal and child health (MCH), and nutrition departments.

Between 2013 and 2018, MECP in Kenya partnered with the Kilifi County Department of Health Services to adapt and scale up CCD interventions in Junju location of Kilifi South sub-county. MECP worked with public health officials at the county, sub-county, health facility and community levels to adapt and scale up CCD. This was in collaboration with community health units in Vipingo (2013 - 2015) and, later, Gongoni (2016 - 2018). They also engaged additional stakeholders, such as local administrative officers, i.e., area chief and assistant chief, who were critical in providing information on key community issues around childcare in the early years and ensuring support for the implementation of activities. Community Health Volunteers (CHVs) led the community-based activities and were supported by Master Trainers from MECP.

This case study describes the successes and challenges of leveraging these multi-sectoral partnerships in a rural community in coastal Kenya. The insights obtained from this case study suggest that before implementing CCD interventions in similar settings, it is necessary to develop a good understanding of the local social-cultural practices. Moreover, an understanding of the prevailing experiences around child-rearing, norms regarding early childhood development and preschool education, as well as community level of knowledge over these issues is essential to the proper implementation of CCD in such settings. Importantly, the case study shows that CCD interventions nested within community practices are potentially impactful when male caregivers are involved. For instance, the case study found that fathers' involvement boosts child play and communication. The lessons from this case study target two key audiences: practitioners involved in implementing CCD through rural community health services, and other stakeholders considering how to increase their investment in nurturing care. In conclusion, it is possible to ensure all children receive adequate care needed to survive, thrive, and reach their full developmental potential, including in marginalised settings such as rural coastal Kenya.

Key Achievements

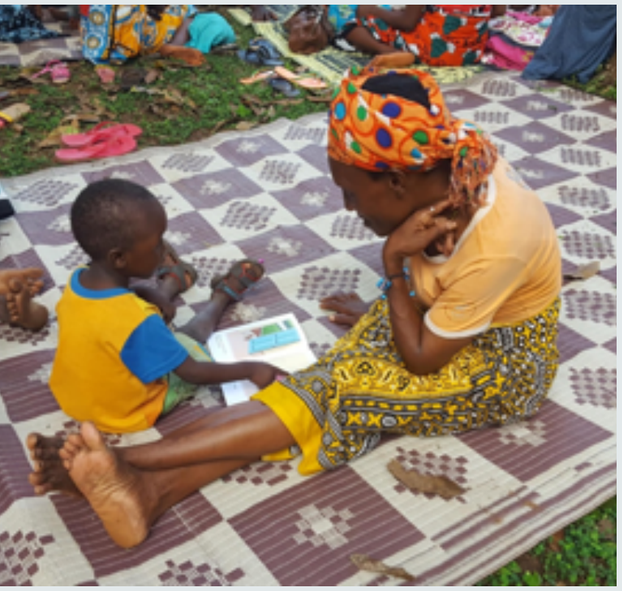
1. Leveraging the Kenya Community Health Strategy to implement CCD in a rural setting
2. Multi-sectoral stakeholder collaboration for successful implementation
3. Integration of CCD intervention within existing frameworks
4. Increasing responsive and sensitive care from caregivers

Key Challenges

1. Lack of adequate resources to support the work of CHVs, given the multiple challenges experienced in low resourced settings such as rural coastal areas
2. High attrition of CHVs (due to lack of monetary benefits), necessitating repeated trainings
3. Low literacy levels among CHVs, affecting programme monitoring efforts (such as data collection, analysis, and reporting)
4. Low demand for CCD by parents and caregivers due to poor understanding of the approach at the outset

Success Factors for Buy-in and Sustainability

1. Understanding local socio-cultural context
2. Use of existing community health strategy and structures
3. Capacity building of staff responsible for delivering child health services and ensuring their understanding and buy-in



Introduction

Globally, approximately 250 million children under 5 years of age, majority of whom are in low- and middle-income countries (LMICs), are at risk of not reaching their developmental potential and this is attributed to poverty and under nutrition, among other risk factors (Chan, Lake et al., 2017). Moreover, in LMICs, about 80 per cent of children aged 2 - 4 years regularly experience violent discipline. A further 15.5 million 3- and 4-year-olds lack cognitive and/or socio-emotional stimulation, which can be achieved through telling stories, singing songs, naming, reading books, counting or drawing and play from adult caregivers (United Nations Children's Fund, 2019). Today's children are tomorrow's future, and helping these young ones reach their full potential will help decrease poverty, increase equity, and promote peace and harmony on our planet (Engle, Fernald et al., 2011). The global community agrees that a child's ability to simply survive is not enough; a child must be able to thrive as well. Scientists maintain that young children need nurturing care to thrive and reach their full developmental potential (Black, Walker et al. 2017). Therefore, nurturing care is critical in fostering holistic development in children, and relevant interventions are necessary in building the strongest foundation for their lives.

The global community agrees that a child's ability to simply survive is not enough; a child must be able to thrive as well.

The Aga Khan University's Institute for Human Development (AKU IHD), in collaboration with the Aga Khan Foundation (AKF) is developing a series of case studies about how implementing the Care for Child Development (CCD) approach in various contexts has supported nurturing care for young children. The goal of this series of case studies is to help practitioners and other stakeholders who want to implement CCD in their local or national settings. Additionally, the information provided in this series will assist government stakeholders as they consider various approaches to adopt, as part of their efforts to operationalise the Nurturing Care Framework. This series of case studies is being produced with the generous support of the LEGO Foundation, as part of the UNICEF-LEGO Foundation Playful Parenting programme. The programme aims to improve access to, dissemination, and uptake of relevant information related to the importance of Playful Parenting initiatives.

This case study tells the story of how the Madrasa Early Childhood Programme (MECP) in Kenya and multi-sectoral stakeholders created an enabling environment for implementing nurturing care for young children with a focus on the adaptation and integration of the CCD approach into the government's Community Health Strategy in a rural setting. It highlights the process of adapting the CCD content for use in the rural context, the key achievements, lessons learned and challenges experienced in the implementation process.

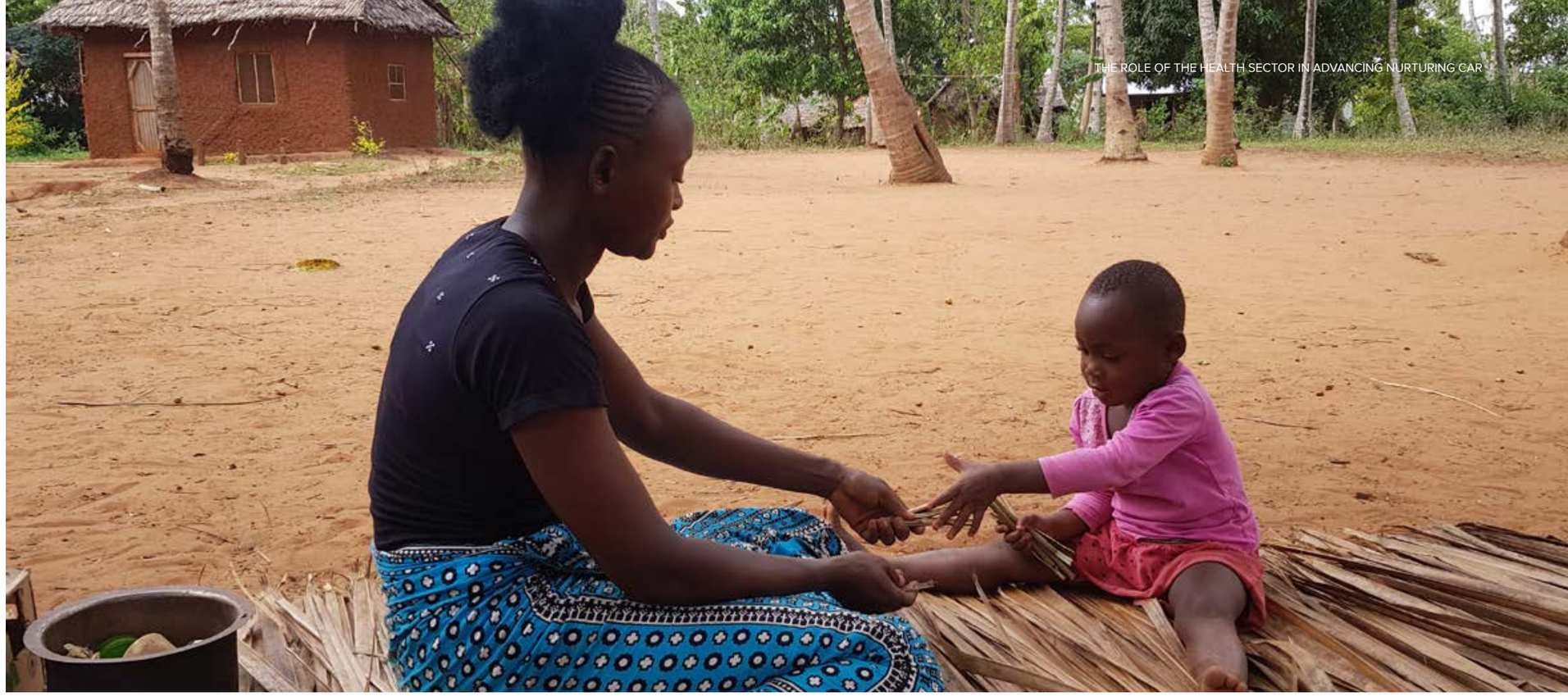
The Nurturing Care Framework and Care for Child Development

The Nurturing Care Framework for early childhood development was launched in May 2018.[1] This framework re-establishes the importance of holistic support for young children and emphasises a critical piece of that puzzle that has been overlooked – responsive caregiving. Nurturing Care comprises five inter-related and indivisible components that cut across multiple sectors: good health, adequate nutrition, safety and security, responsive caregiving, and opportunities for early learning (United Nations Children's Fund, 2019).

While there has been progress in increasing children's access to early education, health care, nutrition, and safety and security, not enough attention has been placed on how parents and caregivers can provide responsive care. Responsive care occurs when caregivers play, communicate with, observe and respond to children's movements, sounds, gestures, and verbal requests. It allows a caregiver to focus intensely on a child's needs and respond in a way that helps him or her feel safe and explore and take risks needed to stimulate connections in his or her brain. Responsive caregiving also includes responsive feeding, which is especially important for low-weight or ill infants. Before young children learn to speak, their engagement and caregivers' engagement is expressed through cuddling, eye contact, smiles, vocalizations, and gestures.

While there has been progress in increasing children's access to early education, health care, nutrition, and safety and security, not enough attention has been placed on how parents and caregivers can provide responsive care.

Many approaches have been tested to enhance the responsive caregiving skills of parents and caregivers. One such model is Care for Child Development. Developed in the late 1990s and updated in 2012 by the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO), CCD aims to strengthen capacity of parents and caregivers to provide responsive care. The CCD approach can be integrated into existing services in all sectors and, while its ultimate aim is to support caregivers, the approach does so through frontline workers (United Nations Children's Fund, 2019). CCD helps these workers acquire knowledge and skills to counsel and empower parents and caregivers to communicate and play with their children. Frontline workers promote responsive care by encouraging caregivers to be sensitive (i.e. recognise signals the child is sending) and responsive (act on those signals). CCD focuses on the period from birth to two years, which aligns with the emphasis of the health sector on the first 1,000 days of a child's life. As of 2017, CCD has been integrated into existing government and non-governmental services in at least 19 countries and 23 sites around the world (Lucas, Richter et al., 2018). It has been translated into 20 languages and tested in over 50 countries.



The Kenyan Context

In 2018, the World Bank classified Kenya as a lower middle-income country based on a gross national income per capita of $1,600 (World 2007, World 2018). The proportion of income held by the lowest 20% of the country's population had nearly doubled from 3.4% in 1992 to 6.2% in 2015 (World Bank, 2021). Notably, the proportion of Kenyans living under the global poverty line of $1.90/day had reduced from 44% in 2005 to 37% in 2015 (World Bank, 2018). Clearly, the country has made substantial investments to improve the wellbeing of its population, including that of women and children, in line with the Vision 2030 blueprint for economic development that aims to '*...create a prosperous country with a high quality of life for her citizens...*' (Government of Kenya, 2007).

Life expectancy at birth increased from 47 years in the 1960s to 66 years in 2018 (World Bank, 2021), while the total fertility rate dropped in the same period from 7.9 to 3.5 (World Bank, 2021). The mortality rate of children under 5 years also dropped from 102 in 1990 to 43 in 2019 per 1,000 live births (UNICEF, 2021), while the immunisation rate increased from 78% to 89% (UNICEF, 2020). Despite these gains, the proportion of children less than 5 years who are stunted (low height-for-age) remains high at 26.2% (KNBS, 2014). Additionally, the number of new HIV infections among children less than 14 years remains unacceptably high at approximately 8,000 (NACC, 2018).

In 2006, the Government of Kenya rolled out the National Early Childhood Development (ECD) Policy Framework to recognise the importance of ECD as a critical lever for accelerating Education for All. The policy provides for effective coordination of ECD stakeholders, including government, communities and caregivers, in providing services for young children *(Kenya, 2006)*, and has a separate service standard guideline developed to operationalise the ECD policy framework. The policy emphasises the critical role of investing in young children by providing, among others, universal school enrolment. Development of the ECD policy framework has led to significant progress in utilising the Nurturing Care Framework in Kenya. It has also encouraged various development partners to invest in various nurturing care interventions, among them the Conrad N. Hilton Foundation and Kays Foundation. However, there is still need to sustain interventions aiming to improve developmental outcomes in early childhood. Various stakeholders in ECD could deliver these interventions through health or education facilities, or community-based settings for maximal impact.

There is also need for targeted support, specifically for vulnerable groups of children such as orphans and those living with disabilities. These challenges are inter-sectoral and present an opportunity for a multi-sectoral stakeholder engagement for early childhood development.

In 2015, Kenya launched the Strategy for Community Health (2014 – 2030) that envisages *"building the capacity of households to not only demand services from providers but also to know and progressively realise their rights to equitable, good quality health care as provided for in the constitution" (Kenya, 2014).* The strategy introduces an innovative developmental approach, where the determinants of health are addressed through people's participation at the community level in health system issues, and a broad range of actions are taken in various sectors (Kenya, 2014). The strategy calls for strengthening of structures and systems at the community level to effectively implement developmental actions across sectors such as health, education, and social services. This strategy provides an ideal opportunity to positively leverage various multi-sectoral stakeholders to impact developmental outcomes among vulnerable and marginalised populations. The strategy also calls for building community resource persons' capacity to enable them deliver development interventions at scale. The community health strategy has previously been evaluated as an ideal entry point for implementing interventions targeting child-caregiver dynamics in Nairobi, Kenya's urban informal settlements.

> Prolonged exposure to adversity, chronic neglect, caregiver mental illness, conflict and violence, and the accumulated burdens of poverty may produce 'toxic stress' responses that affect children's brain development.

Kilifi County, which covers 12,246 square kilometres with an estimated population of 1.4 million people, is one of the 5 counties located along the Kenyan coastal strip. The county has 7 sub-counties, with 2 of them being urban (Malindi and Kilifi North), and 5 rural (Ganze, Kaloleni, Kilifi South, Rabai). The Madrasa Early Childhood Programme implemented the CCD intervention in Kilifi South sub-County, which has an estimated population of 206,753 and, overall, is the largest rural sub-county in Kilifi, population-wise (KNBS 2019). The coastal counties of Kenya have the unfortunate distinction of being among the lowest-literacy regions in the country. Kilifi has 756 primary schools with an enrolment of 287,562 pupils; 249 secondary schools with an enrolment of 60,936; 9 accredited colleges, 28 public vocational training centres, 2 technical training institutes, a medical training college, and a public university (Kilifi, 2018). There is limited data on preschool enrolment, but it is generally acknowledged that preschool enrolment rates are considerably low, especially in rural areas due to lack of infrastructure, shortage of trained teachers, low parental involvement, and poor community understanding on the importance of ECD.

This case study focuses on the experiences of the Madrasa Early Childhood Programme in implementing CCD interventions in rural coastal Kenya. MECP is a non-governmental organisation established in 1986 and operates in three East African countries of Kenya, Uganda and Tanzania. At its inception, MECP's focus was assisting underprivileged communities in establishing, developing, and managing preschools, offering professional development and training courses to new and practising preschool teachers and providing tailor-made technical support to preschools, civil society, government, and private organisations. It has since grown to encompass a holistic approach to ECD by integrating other components of the nurturing care such as health, nutrition and parental support. MECP implemented CCD in Kilifi County between 2013 and 2018 with support from the Johnson and Johnson Foundation.

Preparing CCD Toolkit for use in Kenya

Prior to implementing the Care for Child Development toolkit in Kenya, MECP went through a number of interrelated and overlapping steps. Identification of effective entry points was among the first processes that MECP undertook. The others were forging collaborative partnerships, making adaptations to the CCD content and delivery to suit the context and, lastly, developing capacity to implement.

Identification of an Effective Entry Point and Engaging Key Stakeholders

The CCD approach generally engages the health sector as its primary entry point. For this reason, the main entry point was the health sector. MECP is one of the few agencies in Kenya addressing pertinent matters relating to ECD, especially in rural areas; they have established themselves in the ECD space in coastal Kenya over the years. At the time of initial engagement, no ECD activities involving play and interaction were being implemented through the health sector in Kilifi County. This gap therefore presented an opportunity for MECP to extend their reach in meeting the needs of young children in health facilities, preschools, and in the community through their pre-established systems. To bring relevant stakeholders on board, MECP made formal communication with county government officials through an official letter and sought their approval. This step enabled key officials to understand the proposed interventions and provided guidance to partners to avoid duplication of efforts and resources. For instance, in 2013, Kilifi County government officials emphasised embracing the Community Health Strategy (CHS) approach and developing the capacity of the entire Community Health Unit (CHU). This development led to MECP adapting their approach to focus on only one CHU with 50 CHVs in one county during phase1 and scaling up to another CHU for phase 2.

MECP held initial consultations with county, sub-county, and local government representatives to get their buy-in and approval, and identify the appropriate entry point for the intervention. They held additional consultations with health facility workers in which they introduced the project implementers to the public health team. They then mapped out main stakeholders at the regional, local, and community level, and oriented them to the intervention. It was easy for MECP to engage these various stakeholders due to their long-term presence in the selected regions as well as established collaborative networks.

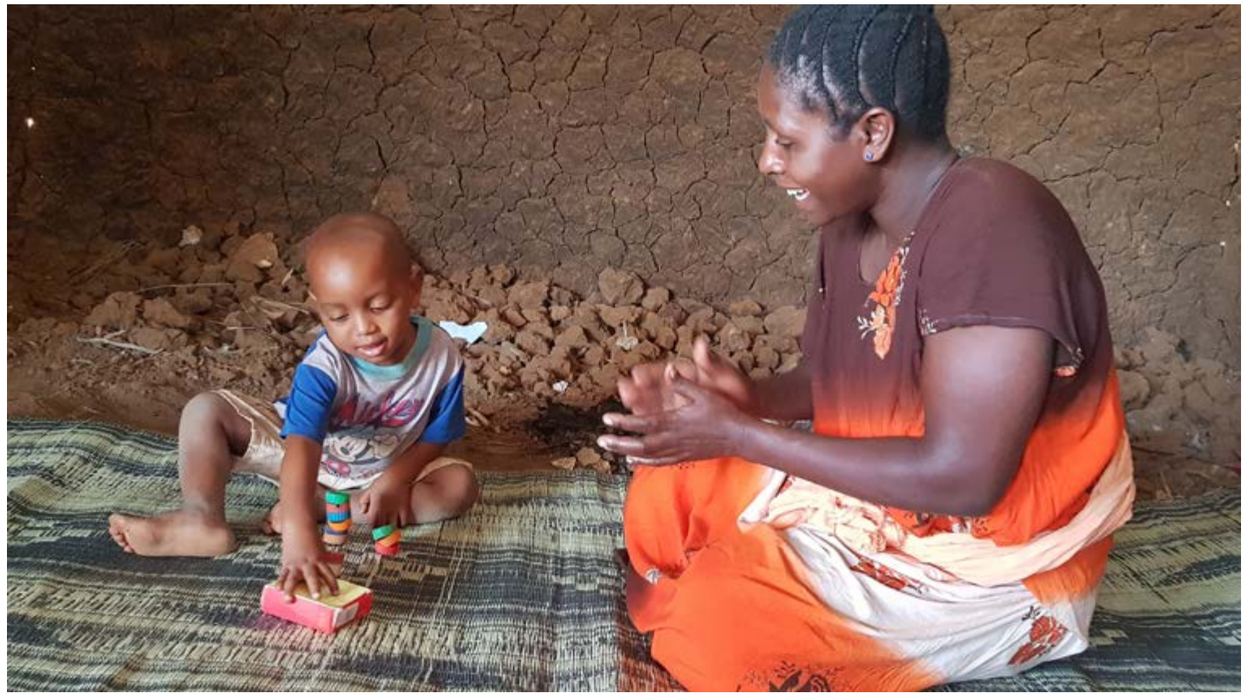
*'.... for us Madrasa, we've been in this region for very long, so we are well known. We do engage in consultative forums annually, semi-annually and participate in different, like care for child development is not the only health bit, we also have other health initiatives that we do, so we participate in meetings, so for us to be able to bring on board the different stakeholders in the discussions and be able to identify [them] doesn't usually take a very long process...' [**Note: All the respondents quoted are MECP CCD Master Trainers.**]*

MECP held meetings with the Kilifi County executive committee (CEC) member for health, the chief officer, and the directors responsible for health, education and children's affairs to explain the project and get their buy-in. The county government assigned a designated person responsible for the project's day-to-day operations who acted as a link between the organisation and the county government. The next level involved introducing the project to the Kilifi County health management team, especially Sub-County Medical Officers, directly responsible for managing activities at health facilities. They also engaged stakeholders in other sectors, including the Ministry of Education as well as local government authorities.

'... [W]e usually work in partnership, either we are working in partnership with communities, or we are working in partnership with the government. So, for all our preschool matters, mostly it's through the ministry of education and for all our health matters, it's through the ministry of health. For this particular one, we actually met with the public health people that we were able to work with. So, we begin from the county level we meet with the CEC of health, the directors to really be able to discuss these, prioritise, identify those communities before we even come down to the sub-county and to the relevant...'

Based on their previous engagement and the county government stakeholders' recommendation, the community health strategy was selected as an effective entry point. This decision was based on the need to integrate CCD interventions into the existing structures that link the health sector with other sectors responsible for early childhood development for sustainability and effective scale-up.

'So, mostly our entry point, the county level and using the community health strategy to be able to reach out to the different partners...once we identify for example the health facilities that we are going to work with, the relevant people there, we are given a contact person if it is the community health assistant who will now be our point person in identifying even in terms of the community health volunteers who are going to be involved in the process'.



Adapting CCD to Local Context

MECP adapted the CCD Toolkit to the local context prior to implementation. This process occurred between 2013 and 2015 in Vipingo, and between 2016 and 2018 in Gongoni, and involved translating the CCD into a language that local participants understood, which in this case was Kiswahili. Other adaptations involved integrating community dialogue sessions to further strengthen understanding on CCD; modifications to ensure the utility of the training content manual for individuals without an ECD background, e.g., CHVs; and inclusion of additional training sessions to emphasise how play and communication could contribute to the development of specific child development domains. These adaptations helped to enhance understanding and instil confidence during parent counselling sessions. Adaptation also involved developing information, education and communication (IEC) materials for creating greater awareness and promoting play and communication practices in the community and at health facilities. During the training sessions, the

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MECP Master Trainers allocated more time to discuss play resource development, emphasising use of local materials.

Developing Capacity for Implementation

Implementation started with building implementers' knowledge and skills required to guide caregivers on play and stimulation for children therapy, model counselling and effective communication. These topic areas were selected since they form the core of the CCD Toolkit. Master Trainers were selected in collaboration with the health facility Community Health Volunteers (CHVs). Those selected were considered to be committed and high-performing CHVs with basic educational level. Master Trainers from MECP were trained in 2013 by a team of international CCD consultants, and this training was cascaded to CHVs to deliver the intervention in the community. Overall, MECP trained 50 CHVs in the first phase of implementation (2013 to 2015), and a further 75 during the second phase (2016 to 2018). Master Trainers were trained for an initial 5 days and supported to train CHVs in the second week for an additional 5 days. During implementation, the MECP staff observed the CHVs as they conducted counselling and engaged in reflection sessions to tackle identified gaps through a 2-day refresher training session. MECP staff's mentorship sessions with the CHVs provided opportunities for further capacity building on a one-on-one basis or in smaller teams.

'We were heavily involved in terms of going to observe what CHVs were doing so that we are able to provide them with feedback, you know.... Umm so we did observe, so we interacted with the families through observation but sometimes our Master Trainers would also come in with like model, a counselling session so that the [trainees] would also observe how it is done, how do you enter [the home], how do you provide the intervention, something like that.'

While the training offered by the Master Trainers had a focus on skills-building, these were complemented by learning received through community engagement with parents and caregivers, which helped them update their model counselling sessions for both home visits and clinic operations. The content learned ranged from how to help a child draw, to colouring, to singing, to the type of home equipment needed to help parents with play therapy, and to how to implement CCD activities in a context of limited resources. Community engagement with parents is part of the CHS; it involves household visits, community dialogue sessions as well as monthly feedback sessions for the CHVs, all of which provided further opportunity for review and capacity development.

Implementation Approach

Implementation took place at the health facility level, community level through household visits and community dialogue sessions delivered by CHVs with the support of Community Health Assistants (CHAs).

At the health facility level CCD was integrated at various service delivery points, such as MCH, maternity and nutrition department. The health facilities provided an excellent opportunity for the delivery of health education talks which were great avenues to deliver a practical session on integrating CCD as caregivers visited the clinics to reinforce understanding and practical experiences with their children. Facility-based activities such as health talks between health workers and caregivers were occasionally done during routine counselling sessions with pregnant mothers. Integration of CCD within the nutrition department was designed to track and increase monitoring of those at risk of severe malnutrition. The MCH clinic and nutrition departments provided services throughout the week. For each identified severe case, the caregiver was linked to a CHV for follow-up and support at the household level. The CHV provided a link between the caregiver and the health facility and was required to report weekly progress at the facility before the next appointment. At the maternity, health workers counselled pregnant mothers to adapt practices such as singing to the unborn child and using a soft touch to regularly caress the womb, and they adopted these practices. Besides, CCD-related questions were incorporated into the health facility assessment tools for pregnant mothers. This incorporation was meant to gauge entry behaviour and practice on responsive caregiving, play, and communication activities and support the expectant mother to understand better.

Further, MECP established outdoor play spaces in three health facilities in Kilifi County, including the Kilifi County Hospital, Vipingo Health Centre and Rabai Rural Demonstration Health Centre; it also provided education on child cognitive stimulation and engagement. CCD recommends play and communication activities to stimulate the learning and development of children. The play spaces enhanced understanding of CCD concepts and facilitated their integration into routine activities for caregivers and health care providers. This also included integration of the recommended play and communication activities into the MCH booklet, building on the understanding of nurturing care.

CHVs responsible for implementing the CCD intervention were tasked with identifying suitable households with caregivers of young children, and organising monthly community dialogue sessions to discuss issues affecting children at the community level. Fathers were among the targeted caregivers during the routine household visits by CHVs. Some of the fathers were involved and supported their families in play and communication activities and play item development. For the period of implementation, no father group sessions were implemented.

Collaborative Partnerships

Through its implementation of CCD in collaboration with the county government among its various other programmes, MECP extended its influence in the region pointing towards its own institutional strengthening. Government health workers regularly invited the MECP team for contribution and expertise in child development. Particularly, MECP helped introduce/embed the CCD approach within the growth monitoring training, which is an important step in ensuring that CCD is sustainably integrated into mainstream health services.

MECP collaborated with stakeholders from various sectors to ensure a multi-sectoral approach to child development. They built on existing networks with ECD stakeholders, and provided them with an opportunity to learn from their experience, and also went ahead to build their capacity through offering technical and training assistance to other organisations. Notably, MECP has provided further training on CCD for different organisations, including the African Population & Health Research Centre (APHRC).

MECP also worked together with different stakeholders from the health and education sector and community-based organisations in capacity building to strengthen CCD interventions at the community level. Kilifi County provided oversight through its annual strategic plan review and quarterly and semi-annual meetings with the CHMTs, and MECP reported to them regularly, which helped foster a strong and mutually beneficial collaboration.

'For us, we continued holding regular updates for example every quarter we held meetings with the County leadership teams briefing them on the project progress and challenges happening on the ground. I remember we develop a small write up, just in bullet points to say how far we have come what we have been able to do and the things that we needed support. So continuous engagement and you know, in a planned manner.'

Key Achievements

As a reflection of the work done in Vipingo and Gongoni health units in Kilifi South sub-county, MECP is optimistic about its initiatives in promoting ECD and ensuring that children survive and thrive. It is evident that despite the barriers encountered, MECP had several achievements, as highlighted below.

Leveraging the Kenya community health strategy to implement CCD in a rural setting

The MECP strategically ensured that CCD was implemented in a rural setting in Kilifi within the national community health strategy. After attaining their training as Master Trainers, they trained community healthcare workers including doctors, nurses, community health assistants and community health volunteers who implemented CCD both in the health facilities and within the communities. Play and communication, which are critical CCD components, were incorporated into the health systems as early as when a mother is pregnant, and had a positive impact on both the mother and the child.

'*....so one of the things that I heard that really like excited me was a confession by one of the matrons in the health facilities who came forward and said that they have actually incorporated some of the questions from the care for child development into the health facility whatever..... So this is something that you know, shows like its being integrated in the system and there was a lot of value for example the parents could also give feedback that when they talk to the children, touch the, you know caress the stomach sang for them, they would actually feel the child move and that would signify that the child is active, healthy and so on and so forth.*'

Multi-sectoral stakeholder collaborations for successful implementation

The MECP worked together with different stakeholders from the initial planning of the CCD intervention to its rollout. At the initial planning stages, the MECP involved the county government to identify the exact location to roll out the intervention. Such discussions helped ensure the local government accepted the CCD intervention. MECP also included government officials in their trainings so they could better understand its importance to the families and communities in their region. The local government

was also involved in the community health workers' training and implementing the CCD intervention.

'...we plan or we we make proposals to, to implement we usually aahh engage county governments in our discussion and try to incorporate their thoughts and their their ideas in terms of how best that implementation can be a success or can have significant impact on the community where we will be implementing so likewise when we get an opportunity to do care for child development we engaged the county government of Kilifi starting from the CEC.'

Integration of CCD intervention within existing frameworks

An important approach employed by MECP was engaging the health sector and integrating the CCD intervention into the existing health frameworks. In this way, they could incorporate CCD into the existing reporting tools and guide the documentation of the intervention. The CHVs embraced the intervention as it became part of their daily routine work.

'We were also able to participate in the monthly feedback sessions that normally the CHUs, community health units conduct with their in charges and also, they were able to provide some guidance when now we experiencing challenges around reporting on how best we can integrate CCD within the existing reporting tool that is being used by the CHVs so that that aspect of the song that we've always been singing as a team CCD is not a stand-alone intervention and it is...integrated within the health component.'

Increased responsive care

Children need their brains to be stimulated before birth and during the first 2 years of life for them to develop optimally and thrive. The CCD intervention provided by the MECP had a positive outcome to both the children and their caregivers. Pregnant mothers were taught how to communicate with their children through different communication modes such as touch, talk, and singing. The mothers were able to apply these techniques and reported positive feelings and responses from their unborn children. Additionally, although fathers are not so involved in the caregiving in this context, the fathers involved in the CCD training were empowered and were happy to better connect with their children.

'...for example the parents could also give feedback that when they talk to the children, touch the, you know caress the stomach sang for them, they would actually feel the child move and that would signify that the child is active, healthy and so on and so forth... we are hearing a father saying that care for child development and particularly the play aspect where they are able to sit, play with their children, give some pictures or dolls and talk about them really was strengthening the bond with their children, you know it's like they are discovering their own children through play and communication.'

Lessons Learned: Success Factors and Challenges

Understanding local sociocultural context: Understanding local sociocultural practices, community knowledge, and prevailing community norms, especially around child-rearing practices, early child development and preschool education before implementing the CCD intervention, was deemed essential in enabling community buy-in and ensuring continuity. CCD interventions nested in community social cultural practices positively impacted male involvement and how fathers/male caregivers offered their support towards effective child play therapy and communication.

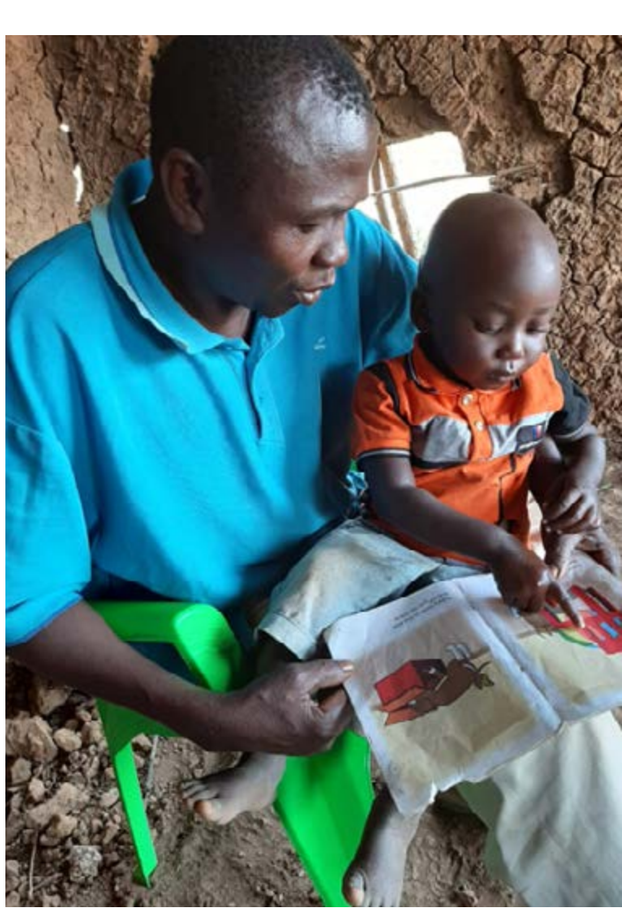
'We started from the lowest level at the household hearing the community, what do you know and how do you practice child development, what do you think, what has been the general way of doing things, what are the prevailing practices and what are the advantages of those practices and such... You know engaging with the community at their level in these discussions before bringing out the global scientific research around these matters to do with brain development and stimulation and nutrition and such like things is very important.'

Use of existing community health structures: Planning for capacity building was formalised, documented and monitored at every stage. This process also included identifying the key personnel (CHVs, CHAs) who could be the levers for facilitating the change. Engagement with CHVs in Kilifi during the process of capacity-building appears to not only have been sustained but also focused – with specific milestones set and met. A similar scenario occurred in CCD training implementation, where the skills building cascade was formalised in a structure that delivered the intervention from Master Trainers to CHVs, with specific individuals tasked with delivery of programme, supervision and routine reporting.

'So, it's almost like a 10-day training yeah for them to be able to, to learn and internalise and for them to be able to practise and get mentorship from the consultants and master trainers. They also supported them in planning for the roll out in terms of how they want to go about it and that's remote communication with them, sharing and so on and so forth, so that is how it happened...after that, when we were able to identify the communities in Vipingo they went through the same process. We had the CHVs and the community health assistants and some of the village health teams identify, team members being identified and trained as ToTs first for 5 days by our team members and then the next 5 days they trained now the other community health volunteers under the guidance of our staff.'

The time spent reviewing the CCD approach alongside the CHS guidelines ensured that implementation was aligned to the way community activities are structured and delivered. In this regard, CHVs utilised existing documentation and monitoring tools.

Capacity building of staff responsible for delivering child health services: At the health facility level, trainings were led by public health staff responsible for delivering child health services. Their engagement early on, at the time of designing the revised package, ensured that they understood and owned the package and training content. It also secured their commitment to ensuring successful implementation and follow-up, and that there is continued delivery even after the MECP project cycle completion.



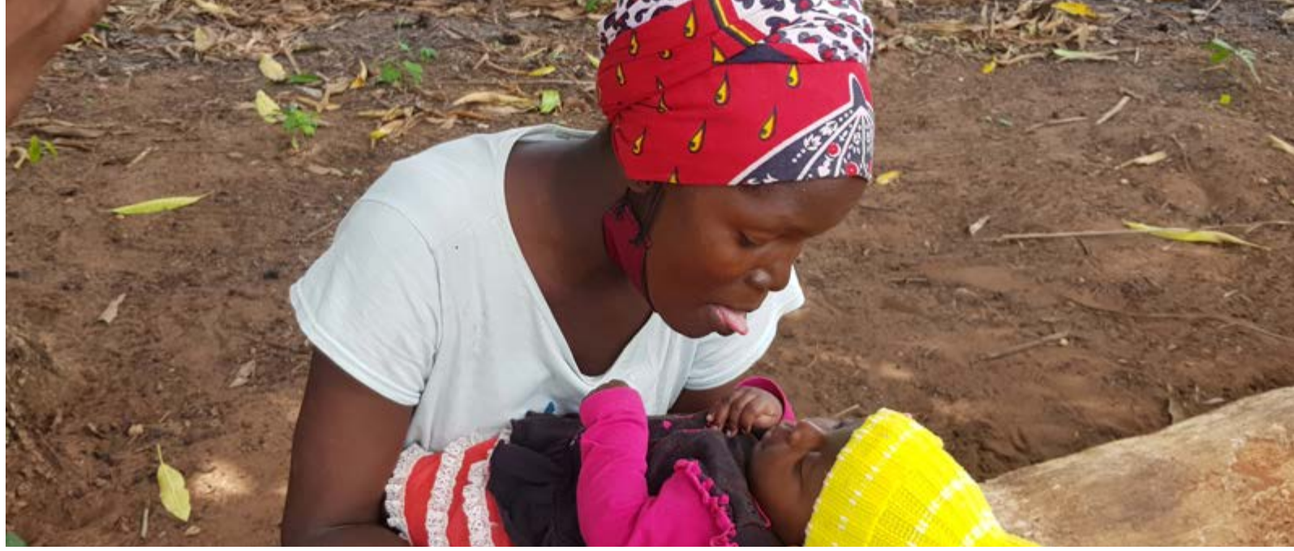
Challenges

Despite its many successes in the implementation of CCD, MECP experienced some difficulties owing to factors that the Master Trainers identified as lack of adequate resources, high attrition of CHVs, low literacy levels among CHVs and initial low demand for CCD by the caregivers.

Being a marginalised rural setting with high levels of poverty, and with communities unable to meet requirements for basic needs such as food, shelter and clothing, it was difficult to implement a tailored intervention targeting early child development, especially one that community members perceived to add practical value. Although CCD is viewed as critical in addressing development and growth, respondents felt that other integrated interventions such as nutritional and dietary programmes were necessary for a successful roll-out of CCD interventions.

Moreover, health workers perceived CCD as an additional task to their already high workload, with no extra compensation. CHVs were enrolled on a volunteer basis without compensation and, as a result, high attrition rate and repeated trainings were common. During the time that MECP implemented the CCD intervention, CHVs did not receive any remuneration. However, other development partners set an expectation of monetary benefit, which raised hope during implementation. Master Trainers interviewed pointed out that low literacy among CHVs affected data collection, entry, analysis, reporting, and appropriate monitoring.

There was low demand of CCD by parents and caregivers at the outset, before they understood its importance to early child development. Continued sensitisation for the parents made them appreciate CCD, while the community dialogue sessions also provided an avenue for experience sharing and cross-learning. For instance, a grandmother who was living with a deaf and dumb child was amused and happy to see her grandson smile and try to communicate as they engaged using picture books. Working closely with the area chief, health facility staff also continued sensitisation, thus enhancing the appreciation of CCD and embracing it to understand that CCD was complementing other components of health, such as immunisation, hygiene and sanitation promotion, and good nutrition.



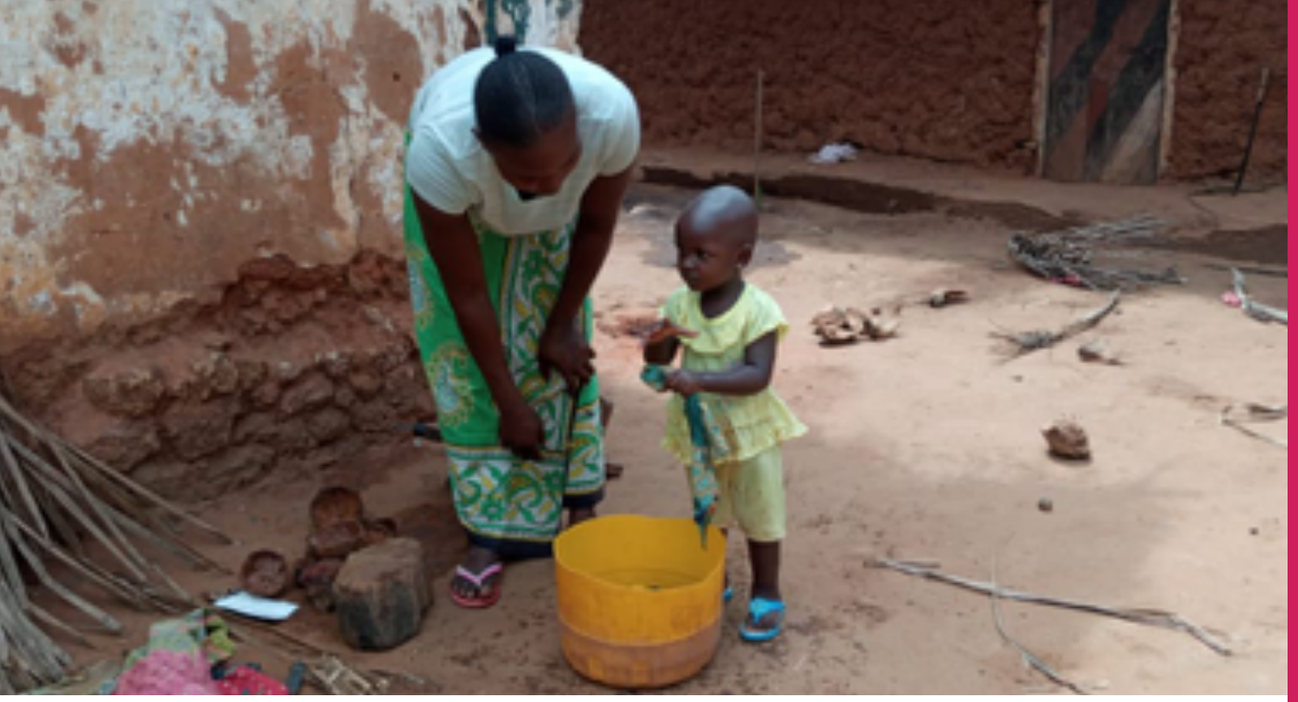
Conclusion: A Way Forward

It is well accepted that responsive, playful parenting is a critical element to young children's ability to survive and thrive. The CCD approach was designed to equip parents and caregivers with the knowledge, skills and confidence to provide the best start in life for their children. It did this by targeting front line health workers and health systems as they are often the best connection points with families and young children. The adaptation of this global approach to each country's needs and context is critical to the approach's relevance and sustainability. This case study outlines how AKDN's partner in Kenya (MECP) adapted and integrated CCD into the existing community health strategy. Together with key multi-sectoral stakeholders, they undertook a collaborative process that helped lay the foundation for seamless CCD integration into a community health programme.

The case study vividly illustrates how organisations can leverage the community health strategy and multi-sectoral partnerships in scaling up nurturing care programmes such as CCD in rural areas or marginalised communities. The MECP realised a gap in the community, identified ways to fill the gap, received adequate training, and worked together with different government sectors to successfully deliver CCD in Kilifi County, Kenya. The implementation of the CCD was done through collective effort between MECP and the multi-sectoral partners. The case study signifies the importance of community engagement, identifying and utilising existing systems, and understanding and incorporating socio-cultural aspects of a community to ensure the nurturing care programmes' acceptability and sustainability. On the other hand, the case study highlights the challenges that are likely to be faced when rolling out interventions in low resourced areas where communities cannot meet basic needs. More robust and holistic community approaches may prove to be feasible in such instances.

Although MECP's implementation of CCD in Kilifi County phased out as its funding came to an end, MECP continues to be engaged by other organisations from time to time to deliver technical advisory services on CCD in other regions. Their initial work in Kilifi County made an impact as there is evidence of the integration of CCD messaging in the community health units where MECP were based (Vipingo and Gongoni). MECP strongly believes that with adequate funding support, the CCD intervention can be scaled if evidence of its impact is adequately documented and disseminated. Additionally, there is need for continued engagements with the government and health sector to ensure that the CCD intervention is well streamlined within the Community Health Strategy, to ensure it is not perceived simply as an accessory to the routine work of health front line workers. This is important for seamless implementation and scale-up of CCD in the country.

Despite the government supporting the CCD and the successful national engagements that resulted in gaining support from the Ministry of Health, most of the initiatives have been donor-driven. There is need, therefore, to continue with other strategic and policy engagements to ensure government uptake and financial investment. Strategic approaches will be required to ensure that the policy makers and the budget holders at the national and county levels are influenced and brought on board. A collective effort to roll out CCD in the country is vital to ensure community ownership and sustainability. The initial work by MECP shows that leveraging the community health strategy and multi-sectoral partnerships in scaling up CCD in rural areas or marginalised communities is promising and has the potential to enhance the wellbeing of children and families.



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