

Meeting report
14-16 October 2018

Stakeholders' meeting on how to operationalize the Nurturing Care Framework in the health sector



World Health
Organization

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Safari Park Hotel, Nairobi, Kenya



World Health Organization 2018

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Glossary

Caregiver – a person who is very closely attached to the child and responsible for the daily care and support. Primary caregivers include parents, families and other people who are directly responsible for the child at home. They also include carers outside the home, such as people working in organized or informal day care.

Developmental delay – a description used when a young child's development is delayed in one or more areas, compared to the development of other children. This can include the development of gross-motor skills, fine-motor skills, speech and language, cognitive and intellectual, and social and emotional skills, as well as executive functions.

Developmental difficulty – any condition that puts a child at risk of suboptimal development or that causes a child to have a developmental deviance, delay, disorder or disability. The term encompasses all children who have limitations in functioning and developing to their full potential. It includes those living in hunger or social deprivation, those who had a low birthweight, and those with cerebral palsy, autism, sensory problems, cognitive impairments such as Down syndrome, or other physical disabilities, such as spina bifida.

Disability – any difficulty encountered in three interconnected areas: impairments in body functions or alterations in body structure; limitations or difficulties in executing activities; and restrictions in participating in any area of life. Disability arises from the interaction of health conditions with contextual factors, including environmental and personal factors.

Early childhood development – children's cognitive, physical, language, motor, and social and emotional development, between conception and age 8. Within that, the Nurturing Care Framework focuses on the period from pregnancy to age 3 years.

Family-centered approach – policies, procedures and practices tailored to focus on children's and families' needs, beliefs, and cultural values. This approach means working in partnership with families, recognizing and building on their strengths.

Nurturing care – an environment created by caregivers. It ensures children's good health and nutrition, protects them from threats, and gives them opportunities for early learning, through interactions that are emotionally supportive and responsive.

Whole-of-government approach – public-service agencies working across portfolio boundaries, formally and informally, to achieve a shared goal. This produces an integrated government response to particular issues. It aims to achieve policy coherence in order to improve the effectiveness and efficiency of policies and programming.

Whole-of-society approach – all relevant stakeholders working to support national efforts. These stakeholders include individuals, families, communities, intergovernmental organizations, religious institutions, civil society, academia, the media, voluntary associations and – when appropriate – the private sector and industry. This approach aims to strengthen coordination among these stakeholders, in order to make their efforts more effective.

1. INTRODUCTION

Rationale for the meeting

The launch of the Nurturing Care Framework on 23 May 2018, at the time of the 71st World Health Assembly in Geneva, Switzerland, has inspired many countries to request guidance on how to operationalize its content in the health and other sectors. This meeting was the first opportunity in the region of sub-Saharan Africa for representatives from 7 countries to share experiences, exchange good practices, and learn about challenges in integrating the nurturing care components. The participating countries were at different stages, with some having built a rich experience of strengthening programming for nurturing care in the health sector (Kenya, Mozambique, Zambia). Therefore, the meeting enabled country teams to form a learning community around what is needed for the conceptualization of nurturing care and how existing service delivery platforms can be strengthened to support pregnant women and families of young children to provide nurturing care.

Early Childhood Development in the global context

Early Childhood Development (ECD) has been placed at the center of the Sustainable Development Goals (SDG) and the Global Strategy for Women's Children's and Adolescents' Health 2016-2030. SDG 4.2 sets an ambitious challenge of ensuring that *"all girls and boys (will) have access to quality early childhood development, care and pre-primary education so that they are ready for primary education"* by 2030. The inclusion of this goal has created the urgency for increased coordination and accelerated investments towards achieving this goal and related target.

The concept of early childhood development covers the period from conception to 8 years of age. It encompasses cognitive, physical, language, socio-emotional and motor development. However, it is during pregnancy and the first 3 years that the brain develops at an astounding rate, and that development is most sensitive to external influences. It is also the time when interventions to support pregnant women and young children and their families are most cost-effective because the brain architecture is still the most malleable.

Nurturing care, that is **good health, adequate nutrition, security and safety, responsive caregiving, and opportunities for early learning**, is critical for the fetus and young children to develop and achieve their potential. However, evidence shows that many children do not receive nurturing care because of risk factors such as poverty, malnutrition, low levels of parental education, violence in the home and community, exposure to HIV, poor parental mental health, and unclean or unsafe environments.

The health sector has a responsibility and opportunity to support nurturing care. Many interventions for reproductive, maternal, newborn, child and adolescent health and nutrition have a direct impact on child development. They can be enriched by missing components such as supporting caregivers in their capacities to provide responsive caregiving and opportunities for early learning. Moreover, the health sector has a unique reach to families and caregivers during the early years through services for pregnancy and childbirth, and for well and sick child care.

The Nurturing Care Framework provides a roadmap for action. It lays out five strategic action areas for how to promote early

childhood development from pregnancy to age 3 years¹. It builds on efforts that are already ongoing in countries and seeks to strengthen the role of the health sector, together with that of other sectors, in supporting nurturing care.

Meeting objectives and participants

The purpose of this meeting was to develop a shared understanding of the Nurturing Care Framework, learn from country experiences, and exchange ideas to accelerate the implementation of nurturing care in countries.

The workshop objectives were to:

1. Orient participants on the Nurturing Care Framework for ECD.
2. Share practical country experiences in strengthening the role of the health sector to support nurturing care at national and district levels: Lessons learnt and challenges.
3. Discuss a monitoring framework and draft indicators for assessing nurturing care, at population and individual levels, covering aspects of: inputs, outputs, outcomes, and impact alongside measures of implementation fidelity and quality.
4. Develop country specific action plans to integrate and institutionalize nurturing care into national policies and systems, with a specific focus on the health sector, and with attention to all five strategic actions of the nurturing care framework; and
5. Agree on next steps for implementing country plans on nurturing care.

The meeting brought together nearly 100 professionals, representing 7 countries and a

host of partners. Country teams from Ethiopia, Kenya, Malawi, Mozambique, the United Republic of Tanzania, Zambia and Zimbabwe were composed of technical experts from ministries of health (child health, maternal health, nutrition and HMIS focal persons) and included representatives from local partner agencies and research groups. They were joined by staff from the WHO, UNICEF and PATH at country, regional and global levels as well as the Partnership for Maternal, Newborn, Child and Adolescent Health (PMNCH) and the ECD Action Network (ECDAN). Representatives from Aga Khan Foundation/Aga Khan Development Network, the Bernard van Leer Foundation, the Centre of Excellence for Human Development South Africa, the Children's Investment Fund Foundation, the Conrad N. Hilton Foundation, Partners in Hope, the United States Agency for International Development and the World Bank Group actively contributed to the meeting. The full list of participants and observers is available in Annex 1.

The agenda included technical sessions, country updates, group work, and a market place (see Annex 2 for details). Participants made available hard copies of local materials. The focus of the country experiences was largely oriented towards integration of support for responsive caregiving and opportunities for early learning in maternal newborn and child health and nutrition services in health facilities and communities. Technical sessions on maternal mental health, children with disabilities, measurement and accountability widened the scope of actions that are eventually needed to build the enabling environments required by caregivers to be able to provide nurturing care for all children and specially those who are most vulnerable.

¹ Children's need for nurturing care does not stop at age 3. The time period was defined to provide a focus in the framework and recognize that around age 3, many children

start engaging with preschool education and hence the role of the education sector to support their development becomes more important.

Report content

This synthesis report summarizes the key messages and action points to guide country action and is divided into four main sections:

- Creating a shared understanding of the Nurturing Care Framework
- Current country engagement in nurturing care and implementation challenges
- Learning from each other in tackling the strategic actions, and
- Planning for next steps.

2. CREATING A SHARED UNDERSTANDING OF THE NURTURING CARE FRAMEWORK

What is Nurturing Care?

Nurturing care is what the child's brain needs and expects to develop its potential. Nurturing care ensures good health, nutrition, security and safety, responsive caregiving and early learning opportunities for the young child. Children's need for nurturing care does not stop at the age of 3 years. However, it is particularly important for children to receive nurturing care in the period from pregnancy to age 3 years because it enables them to build a solid

foundation for their current and their future development. Children who have a strong foundation will be more resilient to future adversities. And providing nurturing care to children who are facing adversities has been shown to enable them to develop their potential despite the adversities they are facing.

Some definitions

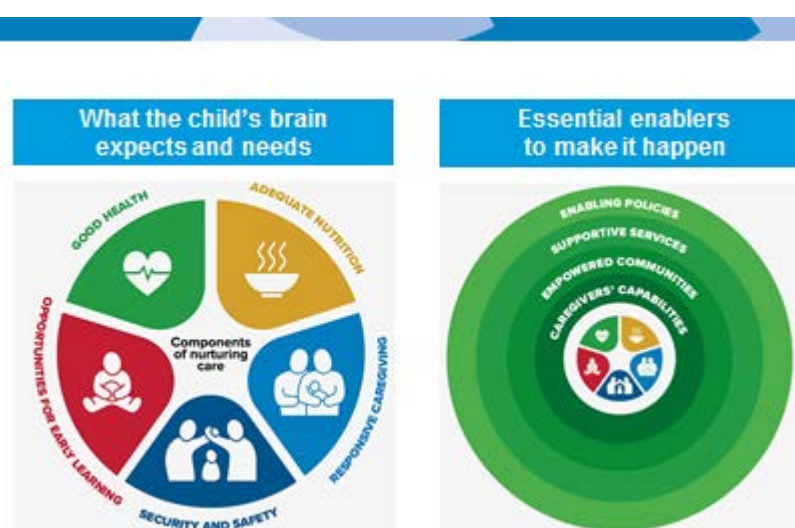
- **Early childhood development:** Early child development (ECD) refers to the cognitive, physical, language, temperament, socio-emotional, and motor development of children from conception to 8 years of age.
- **Nurturing care:** Nurturing care is what the child's brain needs and expects to develop its full potential. Nurturing care ensures good health, nutrition, security and safety, responsive caregiving and early learning opportunities for the young child. The home environment is a primary location for provision of nurturing care to young children.
- **Early years:** The early years refer to the preschool period from pregnancy to age 8 years, with 4 stages: i) pregnancy and peri-natal period; ii) 0 to 3 years of age; iii) 3 to 5 years of age (preschool-age), and iv) 6 to 8 (transition to formal education).
- **Care for Child Development:** Care for Child Development is an intervention package that strengthens the capacity of providers to support caregivers in their interaction with children. Through activities of communication and play, providers help caregivers to strengthen their capacity for responsive caregiving and to create opportunities of early learning.
- **Nurturing Care Framework:** the Nurturing Care Framework summarizes policies, interventions and indicators that are relevant for caregivers to provide nurturing care for early childhood development. It provides a roadmap of action and focuses on the critical period from pregnancy to age 3 years, as this is the time when brain development is most sensitive to external influences and to interventions.

Building enabling environments for nurturing care

While caring for their offspring is an innate behavior of many species, evidence shows that this can easily be compromised. To provide nurturing care, primary caregivers need knowledge, time and resources. They may need support to develop confidence and they may need guidance on what it is that the child expects and needs. To provide nurturing care, caregivers need to be able to enjoy a minimum of good health themselves, physically and

mentally. Nurturing care also requires that caregivers have time to care for children and can access financial and material resources to ensure that the environment in which children grow is clean, safe, and stimulating. Hence there is a need for policies, services, community- and family capacities that together create the enabling environments in which caregivers can provide, and in which young children enjoy nurturing care.

Figure 1. Two interlinked frameworks to drive the nurturing care agenda



Parents and other proximal caregivers are the primary providers of nurturing care for young children. During the earliest years, the home environment is an obvious and common place where most young children are cared for.

However, child day care is increasingly becoming a part of life for many young children and therefore, the quality of such care deserves attention as well.

Addressing the needs of all children

The NCF addresses the needs of **all children**. It is built on a **universal approach** in which all families and children receive some support through national policies that support quality child rearing, information and 'light-touch' counselling in routine services.

The framework highlights the importance of identifying and addressing **families and children at risk**, e.g. those living in poverty, young mothers, HIV affected communities, displaced communities. Evidence shows that children at risk will benefit most from

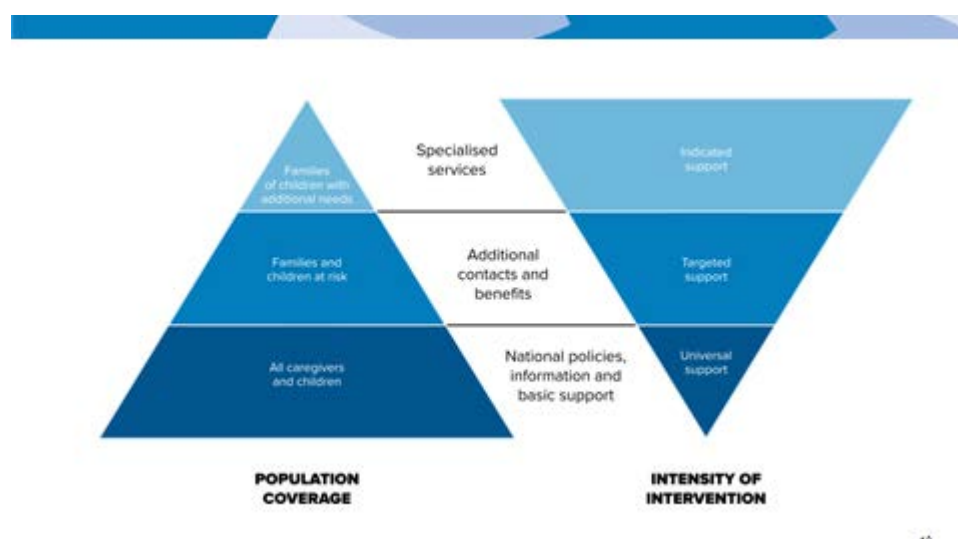
interventions. Their families need extra support through policies that are tailored to provide additional resources, and through services that are more intensive and designed to help overcome or mitigate some of the risks. These are **targeted services** and can involve cash transfers, free quality child care, parenting groups and home visitation, amongst others.

The universal as well as the targeted services create platforms for identifying **individual children and families who require more intensive support**, such as caregivers suffering from mental illness or living with HIV, children

with disabilities and/developmental difficulties, and families with issues of violence, abuse or neglect. It is estimated that 53 million children worldwide are living with disabilities and that 1 in 6 children suffers from developmental difficulties. These children require **indicated services** that can provide more specialized care that is tailored to their individual needs.

The nurturing care framework promotes a population-based approach in which policies, systems and information are progressively strengthened to meet the needs of all children.

Figure 2. A progressive population-based approach to meet the needs of all



A spotlight on caregiver mental health

Mental health disorders are common and still largely neglected. Perinatal depression affects around 15% of women in low and middle-income countries during pregnancy and 20% after birth. This condition results in poor obstetric outcomes, contributes to maternal suicide, results in increased rates of prematurity and low birth weight, and affects the mother's capacity to provide nurturing care. Research reviews have shown that interventions that primarily focus on the mother's health can reduce maternal anxiety and depressive

symptoms, and that they can be delivered by trained non-specialists. Importantly, evidence also shows that supporting mothers in caregiver-child interaction and other aspects of nurturing care improves their self-reported sense of well-being and reduces maternal anxiety and depression. Hence, there is a strong justification for integrated programming that addresses parental mental health as part of the nurturing care agenda and optimizes contacts with services to address the needs of caregivers as well as the child.

Responsive caregiving and opportunities for early learning

Two components of nurturing care, **responsive caregiving** and **opportunities for early learning** were at the center of this workshop, as support for them is commonly not part of existing services and will need to be integrated into the contacts families have with health providers. Particularly during pregnancy and the first months, caregivers may not be aware of what a fetus or young child are able to sense

and communicate, and how caregivers can interact and respond appropriately. Observing caregiver-child interaction is therefore an essential element of what health workers can do to support nurturing care. It enables them to engage with caregivers in a dialogue on how they can recognize what the child needs, and on how to respond to these needs appropriately.

Transforming the health facility waiting room

Using homemade toys, caregivers and young children are encouraged to engage in play while waiting for services. Community health volunteers carefully observe caregiver-child interactions and demonstrate and model responsive caregiving and early learning through activities of communication and play. They promote the production and use of simple toys in the home and the monitoring of young children's development. As a result, one may find caregivers and providers who are engaged, eager to attend the services, and smiling while they wait.

Responsive caregiving is effectively a mediator for all other components of nurturing care: good health, adequate nutrition, safety and security and opportunities for early learning. Interventions, such as the WHO/UNICEF **Care for Child Development package**, help caregivers to develop these competencies and

build confidence in their abilities to address their young children's needs. And there is now ample experience and evidence that they can be successfully integrated in existing services in health facilities, the community, the home and early childcare settings.

Key Messages

- Nurturing care is based on five indivisible components: good health, nutrition, responsive caregiving, opportunities for early learning, and security and safety. They all need to be addressed together to ensure that children's brains and bodies can develop to full potential.
- Many interventions that support nurturing care are already promoted in health services. What is new is the need to bring them together at the level of the caregiver and the child.
- The components of responsive caregiving and opportunities for early learning are often not addressed in programs and services for women and children. Interventions to support these components are often new and need to be integrated in health and nutrition services in facilities and communities.

- While nurturing care is targeted to the child, it is the capacity of caregivers to provide nurturing care that requires careful attention. Addressing parental mental health is particularly relevant since it is a common problem that has a major impact on child survival, health and development.
- It is important to consider enabling environments in all their dimensions. Policies, information and services are needed. Strengthening services alone may not be enough to provide the conditions that enable families to provide nurturing care particularly the most vulnerable.
- Services to address the needs of families at risk and of families that have children with special needs must be built incrementally alongside basic support for all.

3. CURRENT COUNTRY ENGAGEMENT IN NURTURING CARE AND CHALLENGES

*“Some things require money; other things require champions.
If we have champions, we can move things.”*

Three countries, Kenya, Mozambique and Zambia shared their experiences on integrating the nurturing care components in their programming.

Kenya has made significant progress in reducing child mortality and improving nutritional status, and there is growing recognition that a mother’s health affects her child’s health and development. At the national level, nurturing care has been integrated into policies, technical guidelines, tools and standards (e.g. the Neonatal, Child, and Adolescent Health Policy, Integrated Management of Childhood Illness, the Mother and Child Handbook, and job aids for counseling families). The government also has master trainers who are cascading nurturing care for ECD content and interventions to the county level. To date, in Siaya alone, they have trained around 1,500 health workers and CHWs (more than 200 nurses and other health facility staff and about 1300 CHWs). Some trainings have also been provided in other counties. Trainings were initially stand-alone, but over time, the government has incorporated nurturing care content into existing training platforms, such as IMCI, Baby-Friendly Communities, and CHWs—referred to as a “top-up” approach.

Siaya, one of 47 Kenyan counties, has been a leader in the scale-up of policies, programs and services in support of nurturing care and attempts to ensure that caregivers have the tools and information needed to promote health, nutrition, safety and security, responsive caregiving and early learning. All sub-counties and one-third of health facilities now offer

nurturing care services with a target of universal coverage by 2020. Said Dr Martin Chabi of WHO, “we are targeting every provider to use every touchpoint to reach every caregiver.” Siaya also has developed a set of indicators that correspond to each of the components of nurturing care.

The experience of Siaya demonstrates the importance of political will. The Governor endorsed the need for new nurturing care policies and created an inter-ministerial coordination committee focused on increasing coverage and quality of nurturing care services. The First Lady serves as the County patron of nurturing care. Other lessons-learned include the importance of integration into existing platforms and training/orientation at all levels—from health workers to politicians for a full government approach.

Scaling-up nationally, however, remains a challenge, as Siaya is just one of 47 counties. Overcoming sector-specific silos also proves difficult, but coordination mechanisms at the national level and in Siaya are taking form and are working to address this. Moving forward, the delegation is also making efforts to integrate NC into national discussions around the President’s plan for universal health coverage.

In **Mozambique**, a comprehensive health system approach has been deployed to support nurturing care integration into antenatal consultations (counseling on bonding with baby and stress reduction), childbirth care (the new neonatal approach to IMCI includes developmental monitoring, counseling on responsive care and early stimulation), and

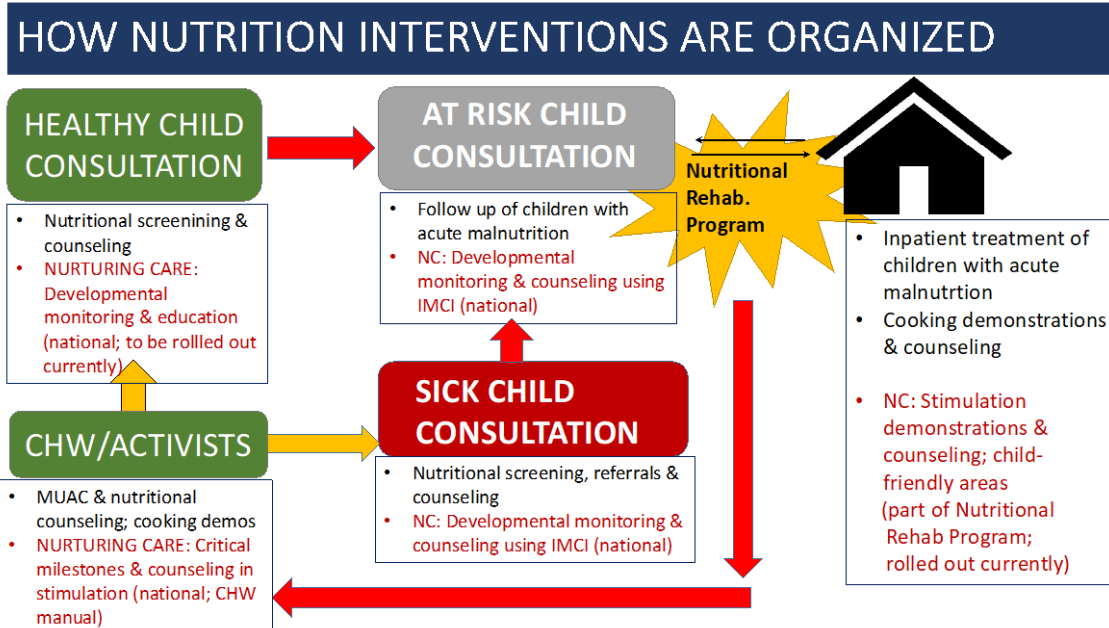
during the postpartum consultation (screening for maternal depression and counselling: "Thinking Healthy", support for responsive care and early stimulation, and developmental monitoring). Interventions to support nurturing care are also integrated into healthy, at-risk, and sick child consultations at facility-level, in the work of CHWs, and during in-patient treatment. Services are being delivered universally in one of the 11 provinces, and expansion to a second province is underway now in collaboration with a consortium of government partners.

When community health volunteers (CHWs) have concerns, they refer families to the health facility. A new flow chart placing increased emphasis on providing more comprehensive support for nurturing care during sick child visits was approved by the MoH. For children in rehabilitation programs for malnutrition, activities for stimulation and cooking demonstrations are delivered in an integrated way. At all touchpoints with families, there is an emphasis on developmental monitoring and counseling for nurturing care. Efforts are underway to include the concept of nurturing care into the *Strategy for Child Feeding*. The draft *Action Plan for Nurturing Care*, developed after a multi-stakeholder advocacy meeting, also will promote the integration of nurturing care support into the strategies and documents of the Ministry of Gender. CHWs are being

trained in interventions that promote play and communication, and job aids address counseling on responsive care and play during feeding. Attention to nurturing care has also been integrated into the pre-service training of CHWs as well as in their job aids.

The program is already collecting information for the DHIS2 on the percent of children with possible signs of developmental delay detected in various contacts with the health system. There are plans to monitor the % of caregivers of children 0-5 years of age who report to have been counselled on responsive caregiving, stimulation, opportunities for early learning and presence of toys in the home. The last MICS in 2008 did not collect this type of information. Several studies on provider interpersonal communication skills and counseling, the viability of integrating nutrition and developmental counseling, and on caregiver knowledge, attitudes and practices related to feeding and stimulation of children aged 0-2 years have also been completed. In addition to scaling up and consolidating activities at the various touchpoints, the integration of developmental monitoring and counseling into the nutritional monitoring activities of the upcoming MOH project supported by World Bank will contribute to strengthening support for nurturing care in nutrition and health activities in Mozambique.

Figure 3. Mozambique's integration of the nurturing care components via nutrition services



Zambia has made significant progress in reducing infant mortality rates, but there has been little impact on stunting over the years. The monitoring of developmental milestones during growth monitoring promotion activities was introduced in 2007. The country has embraced the launch of the 2016 Lancet series on ECD and the Nurturing Care Framework, however, national data on the domains of responsive caregiving and opportunities for early learning are very limited. Zambia uses the DHS and not the MICS as its national survey. Government with the support of partners is finalizing the integration of the nurturing care framework into the relevant policies and guidelines for Reproductive Health, Child Health and Nutrition.

Currently, the intervention of Caring for the Child's Healthy Growth and Development is being promoted through ongoing efforts in coordination with several ministries and their partners. To reach populations that live more than 5 km from a health center, a series of home visits are scheduled at birth, day 1, 3 and 7 (and

an extra visit for small infants on day 14), focusing on immediate newborn care, support to breastfeeding, assessment for danger signs and growth monitoring, stimulation of the newborn, and referral if needed. These are followed by visits at 1-2, 3-4, and 5 months with key actions focusing on i) Feed the child, ii) Stimulate the child, iii) Prevent illness, and iv) Respond to illness.

Opportunity contacts with infants and young children up to 5 years are used to provide guidance on caregiver-child interaction, play and communication, thus making every contact count. Training packages and job aids cover these components. Indicators to be included in the health management information systems (HMIS) at the end of the year track the number of caregivers with children under three attending MNCH services that are counseled on responsive caregiving and early stimulation and the proportion of children monitored for developmental milestones and identified at risk. The plan for scaling up these activities will be finalized at the end of the year.

Key issues raised in group discussions

Governance and policies

- How can we improve our advocacy so that policies and health services fully support nurturing care, and nurturing care becomes the norm at home?
- Only 10 southern African countries have non-contributory social protection for mothers and children. How can the challenges that mothers face in generating time and resources for providing adequate child care be addressed?
- What is the best process for revising national policies and guidelines to address nurturing care? Should this be done systematically or opportunistically depending on what policies are scheduled to be revised?
- How can we deepen our understanding of which interventions to integrate and how to strengthen services in order to have the greatest impact on nurturing care practices at home?
- What are the optimal entry points for coordination within and between sectors?

Workforce

- What have been successful experiences in strengthening pre-service training to support nurturing care?
- How are health workers dealing with increased demands on their time due to counseling on child development?

Services

- How can we move from pilot projects to programming at scale? How can resources be mobilized?
- How can we ensure the necessary quality in the interventions that support responsive caregiving and early learning?
- How do we make sure that families can enjoy a seamless continuum of care, from community to referral level, and between the health and other sectors?
- How do we monitor children's development and ensure that those families and children with additional needs receive appropriate care?

Monitoring

- How can we best and most efficiently track inputs, outputs, outcomes, and impact? What are the indicators that are most relevant at programmatic level to assess progress?
- What are the experiences in gathering qualitative data? What are mechanism to ensure fidelity in programme implementation?

Community

- How can we engage men more effectively in the provision of nurturing care?
- How can we address the needs of populations that are hard to reach (e.g., pastoral populations)?

These discussions were followed by a panel with representation from Ethiopia, Malawi, the Republic of Tanzania and Zimbabwe, and some of the progress made in addressing the nurturing care needs in these countries was highlighted.

Ethiopia has made significant progress in reducing the under 5 child mortality, but children are not achieving their developmental milestones. Early child development was included in the Government's annual workplan for 2018, and an ECD technical working group consisting of different partners, programmes/directorates and representatives of various ministries has been established. A famous children's TV show was also asked to participate. Much of the discussion has centered on inserting nurturing care into existing platforms and programmes without additional costs. To generate evidence and support program implementation, the research advisory council established a working group that is collaborating with universities, focusing on child development.

Early child development has also been discussed in multiple forums, including developing messages for mobile phones targeting mothers with children which started earlier this year. There are plans to conduct a national advocacy workshop to sensitize higher level officials on the concept of nurturing care review RMNCH materials and job aids to ensure nurturing care is integrated into all relevant materials and job aids, and strengthen multi-sectoral collaboration further.

The Government is also establishing better day care services through the Ministry for Women and Child Support, whereby nurturing care inputs such as stimulation, are a part of the services provided. Nurturing care is considered to be transversal, and it is therefore expected that additional resources are not required for implementation.

Malawi is one of a few countries that have developed a multi-sectoral ECD policy, with the Ministry of Gender, Disability and Social Affairs as lead agency. A first policy on ECD was already issued in 2003 based on the Government's commitment to prioritize the early years. A new policy has been in place since 2017 informed by a formal situational analysis of the needs of young Malawian children.

All relevant sectors and stakeholders have come together, including the Ministry of Public Works which has a critical role to ensure that infrastructure meets the needs of young children. There were some concerns about resources being reallocated to other sectors, but ultimately, the involved agencies came to understand that this was as an opportunity to work together. Coordination has been supported by having shared strategies for implementation, strong leadership, prioritizing ECD, partnership building, capacity building, joint quarterly supervision visits, planning and reporting. Some religious organizations have opened-up child play spaces in private health facilities, but this intervention still remains to be extended to public health facilities. With much progress made, early childhood development still needs more prioritization, compliance with set standards, more adequate resources, and additional attention to strengthen the capacity of implementers.

In **Tanzania**, HIV funding from USAID and the Conrad N. Hilton Foundation are used for strengthening early childhood development within the government system. EGPAF, a leading NGO partner in this effort, is not providing nurturing care services directly but aims to build the government's capacity in advocacy as well as the development of policy and guidelines. The Conrad N. Hilton Foundation supported the integration of ECD with HIV as a pilot in one region and is looking at opportunities for scaling up early stimulation. The focus was on building the capacity of health

management teams at regional and local level, create master trainers in communication for development, and train CHWs, community leaders and volunteers. The idea is to integrate nurturing care into the existing policies and guidelines for RMNCH, TB, Family Planning, PMNCT and nutrition rather than create parallel approaches.

At local level, "mother-baby pairs" are targeted starting in pregnancy until the child reaches two years. Health staff are trained in early stimulation and make monthly visits to provide medications as well as counselling. The CTCs are being re-organized to have child-friendly corners as well. The number of HIV+ children has been decreasing. However, there are now many young children that are HIV negative, but were exposed to ART in utero. The programme is providing integrated services to both HIV + and negative children and is identifying other entry points for introducing the package of services and strengthening the overall M&E framework. This has already resulted in the introduction of ECD indicators within the Health Management Information System.

Zimbabwe has not yet formally adopted the Nurturing Care Framework, but some components are addressed through the nutrition programme, civil protection, social welfare and the Ministry of Primary and Secondary Education. There has been a continued strong focus on reducing stunting

and many elements of the framework are included. The country has faced a serious drought associated with El Nino, and a pediatrician at a hospital in Zimbabwe's second largest city, Bulawayo, has been providing rehabilitation services that include play and counseling for young children recovering from severe acute malnutrition. The emergency response was also an opportunity for improved integration of social protection and nutrition, and the mechanism of coordination between the two ministries was adopted in the 25 most-affected areas and continues to this day, even after the emergency response ended.

A multi-sectoral module for nutrition in health facilities and communities for children under age 2 has been developed, building on the platforms of IYCF and Baby Friendly Hospital Initiative. A new manual on infant and young child feeding includes responsive feeding and caregiving. The nationwide cadre of village health workers plays an important role and is being trained. The Ministry of Primary and Secondary Education is in process of developing an early learning policy for children ages 3-7, and a multi-sectoral consultation is planned for the first half of 2019 to build momentum for investing in ECD. There are also plans to establish a multi-sectoral technical working group to develop a national ECD policy.

Table 1. Challenges and innovative approaches to nurturing care programming

CHALLENGES FACED BY COUNTRIES	EXAMPLES OF INNOVATIVE APPROACHES
<i>Working together across sectors and agencies</i>	
<ul style="list-style-type: none"> Agencies have different priorities and resources. Sectorality, territoriality, different workplans, and competition for limited resources can impede coordinated action. 	<ul style="list-style-type: none"> Center the work of all stakeholders clearly around the needs of the child. Assign one agency to coordinate. Establish a resourced and functional secretariat that supports the technical working group and coordinates all stakeholders. Conduct regular joint supervision meetings to implementing sites for a shared understanding of needs and progress (e.g. Malawi). Develop and adopt shared standards, integrated training modules and supervision tools.
<i>Financing</i>	
<ul style="list-style-type: none"> Resources are limited and encourage continued sectorality. 	<ul style="list-style-type: none"> Leverage resources across donors and use to fund activities in a shared approach across agencies/sectors.
<i>Integrating NC into existing services</i>	
<ul style="list-style-type: none"> Existing services do not allow for the time and space to implement NC counseling and support. 	<ul style="list-style-type: none"> Review and adjust workflows of services, including the workloads of facility and community-based health providers.
<i>Building and sustaining provider capacities</i>	
<ul style="list-style-type: none"> Providers need more training in counseling skills for nurturing care, informed by local context and with contextualized counseling training materials. Supportive supervision to sustain the quality of services is often lacking. 	<ul style="list-style-type: none"> Train facility and community-based health providers in their local health facilities and their own context of work. Build supervision capacities at district and local level. Adjust existing supervision tools for the new components that are to be delivered in an integrated manner with the already existing content, i.e. early stimulation and responsive caregiving (e.g. Tanzania).

- Develop checklists for the mentoring of providers.

Improving outcomes for children affected by HIV and AIDS: Lessons learned from community-based programs

In 2017, the Centre of Excellence for Human Development and the University of Stellenbosch conducted a review of community-based programs to support families and children affected by HIV in 2017. The review included a programmatic assessment of projects in countries of sub-Saharan Africa that were supported by the Conrad N. Hilton Foundation and a global literature review. The focus was on home visiting, parenting groups, and early child care and education (ECCE). Some of the important results from the review were shared as follows:

The standard implementation model requires re-thinking, as many programmes evolved from the PEPFAR emergency model for OVC which relies heavily on volunteers (unpaid or stipends) as frontline health workers. Interventions to improve psycho-social wellbeing have included home visiting, parenting groups, community-based child care centers (CBCC) and pre-school and early child care settings (ECCEs). To benefit from lessons-learned from different approaches, the Hilton Foundation commissioned a review of the available evidence (studies, evaluations, guidance documents and other reports). It was noted that the available documentation had a Western bias, varied in quality, and positive results were more likely to be published. Additionally, the ECCE and CBCC approaches were not directly comparable. Without having a better understanding of key program factors, such as quality, dosage, and targeting, scaling

up too quickly may reduce programme effectiveness. Some key findings included:

- More studies reported positive child outcomes. The positive outcomes with respect to cognitive development, language and academic performance were almost double in the reports covering high income countries than LMICs.
- With respect to parent outcomes, fewer positive effects were obtained, but in cases with positive effects, there was a similar gradient between high and LMICs.

Positive outcomes for caregivers and children were reported when programmes were more structured, conducted regularly (at least one hour per week or every other week) over 9-12 months, used formal quality assurance or improvement processes. Implementers, professional or non-professional, had to have at least a two-week training and refresher trainings, use job aids (posters, pamphlets, workbooks..), and be paid.

Results from questionnaires on home visiting and parenting groups showed that most home visiting programs had a training package (e.g., CCD) and some had government guidelines; volunteers were trained for 5-10 days, with half of the programs including counseling skills, and most reported supervision, mainly reflective supervision. Visiting frequency and duration was highly variable, and mostly limited to the duration of project funding. Few home visitors had clear goals and did not leave materials or material assistance with the families, and likewise there was no clear process to monitor their performance and impact. The findings

were similar for parenting groups (highly variable in dosage, duration and frequency). Efforts were made to include fathers, with two projects conducting separate groups for fathers.

There is a tension between Implementation Research and Programme Implementation, with the former looking at what is the minimum that needs to be done to achieve impact, while programme implementation focuses on the maximum that can be done with available resources. However, it was concluded that implementers would benefit greatly from the following elements:

- A Theory of change – a clear understanding of how to get to the intermediate outcomes that should be achieved;
- Conducting pilots to better understand what parents and children need and to test iterative improvements in the intervention;
- More emphasis on targeting so that the most vulnerable are prioritized with quality and intense services, starting early in pregnancy and involving men, grandparents, and other caregivers. One should ask whether CHWs may be avoiding the most vulnerable households, where there is not a strong referral network or situations where there is child abuse;
- A few clear outcome measures should be used;
- Harsh discipline needs to be addressed; and
- The materials used should be consistent across programs and multiple channels, so they become highly familiar (e.g., materials in SA). Also, the materials used should be of high quality and produced and procured at scale.

Lessons from an HIV care and treatment program – Partners in Hope, Malawi – Option B+ with ECD Integration

Malawi's programme "Option B+ with ECD Integration – Lessons-learned", funded by Conrad N. Hilton Foundation and implemented by Partners in Hope with support from University of California and Witwatersrand targets Option B+ Mothers with 0-24 month old infants using *Care for Child Development* to strengthen the caregiver-child bond and support child development. A total of 8 health facilities (5 government and 3 Christian health facilities (CHAM) in 3 districts were covered by the programme.

Care for Child Development counseling was provided by health workers who were already counseling in the national ART program. They encouraged caregivers in early stimulation, play and communication by demonstrating and assisting caregivers in toy making with local resources. Morning health talks included child development messages integrated with basic HIV information during MIP clinics, and male participation was encouraged. Pamphlets with child development messages were distributed during health talks, and participants were referred on a timely basis to other services, such as family planning and immunizations.

Of the 141 mothers were reached over a 9-month period, 95% of graduating mothers noted improvements in child development compared to other children in the household. While 24% of infants had shown some development delays initially, routine monitoring noted that 90% had moved to normal development. The model of integrating services proved feasible and acceptable, and the sharing in groups was a good use of clinic waiting time. However, full integration was constrained by limited human resources, unclear procedures, lack of coordination among partners and a lack of clear understanding of

the respective roles of the sectors driving the agenda. It was also concluded that

- Further research is needed to investigate the risk of developmental delays among HIV exposed uninfected (HEU) children and the impact of child development services on HIV care and treatment.
- Implementation needs to proceed in a planned manner, allowing time to monitor, review and confirm the direction of approaches undertaken regularly to stay focused on quality of care and prepare for sustainable scaling up.

4. LEARNING FROM EACH OTHER IN TACKLING THE STRATEGIC ACTIONS

Multi-country exchange around the *Strategic Actions of the NCF* – Working groups reporting back

“This must be a table of many players focused on one end goal—the survival and thriving of the child.” (Workshop participant)

Mixed country groups were formed to allow participants to learn more about country achievements, innovations and shared challenges related to integrating the nurturing care components. This exchange and the “market place” were two important activities of

this workshop that contributed to opportunities for learning from each other and strengthening collaboration. They made use of the fact that countries have followed different paths and have addressed barriers and challenges in different ways.

Table 2. Some examples of how countries are addressing the Strategic Actions

Examples of what some countries are already doing

Strategic Action 1

- Advocacy (communication, events...) with policy makers and the public
- Development of new policies (e.g. ECD) and review and revision of existing policies
- High-level steering committees
- Use of a lead agency with strong cross-sector convening power
- Strategic plans across sectors
- Clarification and revisions of contributions and roles of sectors, harmonization and alignment of responsibilities and contributions
- Mechanisms for inter-sectoral WGs
- Lobbying for resource allocations
- Establishing a national ECD Network
- Identifications and involvement of champions (first ladies...)

Strategic Action 2

- Exploring indigenous parenting practices
- Using special health and nutrition events and mobile technologies

Strategic Action 3

- Use a local university to build leadership capacities in ECD
- Improve the coordination and reporting matrix

Strategic Action 4

- Set up multi-sectoral monitoring systems

Strategic Action 5

- Setting up research mechanisms to generate evidence

Addressing Challenges, seizing opportunities – what can be done

- Leverage high-level convening power (Prime Minister's Office...)
- Link NC and ECD to Universal Health Care, as the latter will revitalize the PHC system
- Use planned events (e.g. ECD week in Malawi, multi-sectoral nutrition summit in Zambia)
- Use global advocacy to enhance national commitments (e.g. letter from WHO to government to strengthen country action)
- Take greater advantage of the "thrive" component, a part of the SDGs, in country level advocacy
- Strengthen what some staff are already doing in related activities (e.g. growth monitoring conducted by HSAs in Malawi)
- Convey that in a recent disease outbreak multi-sectoral action was shown to be highly effective

Interesting approaches used by other countries

- Use a Ministry with convening power and reach across the sectors for coordination
- Develop a common strategic plan
- Make use of national and local champions
- Develop a good strategy, so that funding can be attached to concrete activities

- Maximize existing international, bilateral, national, and sub-national funding sources more effectively: explore how WB, country, sector or municipality line items can be used for NC activities
- Lobby parliaments to allocate funding for NC and ECD
- Identify new and use all potential touchpoints with pregnant women and families of young children, not just in the health sector
- Make better use of data to inform policy and resource allocation
- Make use of new technologies: develop and use apps to reach families, including fathers with NC messaging; collect data in hard-to-reach areas involving members of the community, etc.

Market place

All countries, WHO HQ, and some of the partners had brought materials to share. With a brief sales pitch of what was on offer at each market place table during the plenary, participants invited colleagues to have a closer look at policies, standards, job aids and other materials that might be relevant for NC programming. After the session, many of the materials had found new owners and may be

adapted to other contexts and settings. In the workshop evaluation, six participants specifically mentioned the market place as one of the most useful components in the agenda, because it allowed for a direct exchange and discussion of these materials with colleagues from other countries. Plans are underway to make a number of materials from the Marketplace available on line.

5. PLANNING FOR NEXT STEPS

Country plans

Given that countries are at different stages of planning and implementing nurturing care interventions and that country delegations did not have the same composition, the respective work plans reflected somewhat different priorities. Most countries included setting up or strengthening technical working groups; reviewing existing guidelines; developing or revising guidelines, training materials, job aids and tools; training various groups of workers and volunteers; and implementing NC via different existing platforms. Some more unique highlights included an emphasis of sensitizing stakeholders at all levels, including the community and the setting up of a Research Advisory Council for early childhood development (Ethiopia); developing a strategy to ensure that the revised tools reach all health workers and volunteers in the Kenya pilot area and integrating NC into pre- and in-service curricula; ensuring harmonized planning with all line sectors and advocacy with all relevant partners for increased financing (Malawi); conducting an in-depth knowledge, attitudes, and practice assessment of parenting, enhancing existing communication strategies, and identifying ECD indicators to track progress in relevant sectors (Tanzania); strengthening existing community platforms and services for NC (Zambia); and preparing a major multi-stakeholder meeting in the first half of 2019 and

consolidating the support for pre-term/LBW babies with KC in communities (Zimbabwe).

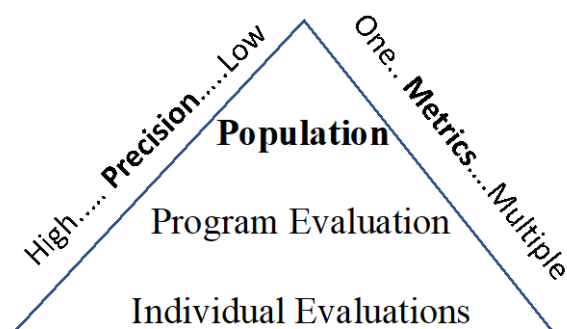
Countries delegations agreed to share their draft work plans with the organizers. Upon return, they will then present their plans to the MOH and other ministry stakeholders and refine/finalize them by October 31st. They will then integrate them as feasible into annual work plans. WHO will facilitate the development for a joint plan of action to provide support to country with its partner agencies.

Monitoring & Evaluation

Global Monitoring and Development of Indicators

Developing shared metrics, specifically for nurturing care, has been a great challenge to the ECD community. It is essential to track progress for all children and for those most vulnerable to see that equity gaps are reduced. It is also critical to identify what works and under what circumstances. A small number of relatively gross indicators are sufficient at the global level, but multiple indicators measuring different aspects of implementation and outcomes are needed at the programme level. Precision is most important at the level of the individual child, with tools that identify children that are truly in need of additional services (see slide below)

Measurement of Early Child Development



At the global level, work has been ongoing for several years to develop tools that can be used with children under three, that are short, easy to administer, and have sensitivity as well as specificity. Some tools to look out for are the UNICEF *Revisions to Early Childhood Development Index* (ECDI), the *Global Scales for Early Development* (GSED) that brings together several tools, and the *Measuring Learning and Quality Outcomes* (MELQO).

At the national level, countries are interested in monitoring progress across relevant sectors for an integrated ECD approach. SDG, Global Strategy, and MICS indicators can be used, but inputs (e.g. the existence of the necessary policy framework, curricula, guidance materials, tools and job aids that reflect all NC domains...) and outputs (e.g. the proportion of CHWs that have reached competency levels to deliver NC interventions or the proportion of caregivers

who report engaging in key practices regularly...) are also useful to monitor. Measuring the quality of the NC interventions is also critical for achieving impact. Assessing whether NC practices are actually being applied may also require the use of observations and knowledge tests.

At the level of the child, there must be a clear purpose of why information is being collected. At this point, in many countries there is still a lack of clarity with respect to the terms used and which tools provide the most appropriate and useful information to support a child's developmental needs. In addition, some tools (particularly when developed in high income countries) require country-by-country validation and come at a cost to the user. More recent efforts have focused on tools that are validated cross-culturally.

Developmental surveillance and monitoring

- Process that monitors the development of a child to identify risk and protective factors, provide feedback and advice to parents, and document child development over time.

Developmental screening

- Use of an accurate, valid, reliable standardized tool to proactively test all children with the purpose of identifying those who need a more comprehensive assessment

Developmental assessment of a child

- To determine whether a child has a developmental disorder (is "off-course")

- Identify strengths and weaknesses that can be addressed to support and maximize further development
- Determine whether the child needs a more in-depth assessment.

It is important to have a shared understanding of the terms used and to promote a more coordinated use of tools globally, nationally, and at the level of the individual child. UNICEF, WHO and the World Bank are currently working together on greater harmonization and a more unified measurement framework for all levels.

Mapping of what is available. Identification of young children at-risk or with identified developmental difficulties and community-based interventions to address their needs has been a major neglected area in this region. To provide recommendations for entry points in the health sector with respect to developmental monitoring, screening, and counseling, a mapping study looked at what is currently available at community, PHC and secondary level in Ethiopia, Kenya, Mozambique the Republic of Tanzania and Zambia. Key stakeholders, i.e. MoH managers and providers, members of local pediatric associations and NGO ECD intervention project managers, were interviewed using semi-structured questionnaires. In addition, guidelines and job aids were reviewed, and challenges in providing early interventions were assessed. All five participating countries are providing some developmental monitoring activities in pilot areas, but not consistently across the whole country; and coverage information is not available. Developmental assessments at referral level does not seem to be available due to a lack of training of providers, as well as a lack of guiding technical standards, policies and tools.

Some developmental monitoring was reported to take place at MCH, nutrition, and sick and well-child services at the PHC level and at maternities. However, staff workloads, training

and monitoring and assessment tools remain key constraints. Additionally, two and three-year olds are seen less frequently in health facilities, because they have completed their vaccination schedules and therefore, they may not benefit from developmental monitoring. All five countries have planned visits for children at 18 months and provide Vitamin A supplementation every six months. Key informants did not agree whether any contact with the health system should be used for developmental monitoring or whether visits at specified ages should be prioritized. There is also significant variability in the materials that used by the countries for the age groups targeted, the messages that are provided, and the recommendations for action when a developmental delay is noted. The capacity of providers at the secondary level appears to be similar to the capacity at the PHC level, indicating that referrals to the secondary level are unlikely to lead to advanced and more skilled assessments or interventions. This mapping exercise provided some of the following recommendations to strengthen health systems for early intervention:

- Develop a strategy to allocate developmental monitoring and counseling responsibilities to the platform best suited to achieve coverage without disrupting service delivery.
- Prioritize funding to ensure delivery of developmental monitoring and counseling service (staff, tools, training, etc.).
- Incorporate the training in developmental monitoring and

counseling in pre-service education and in-service training opportunities;

- Develop innovative strategies to cascade training.
- Incorporate indicators of developmental monitoring and counseling service delivery in supervision guides and quality of care forms.
- Strengthen the referral system and referral level itself to manage developmental delays.
- Build consensus on the tools most suited for developmental monitoring and counseling at the primary care level and at referral level facilities.
- Develop and then include ECD intervention indicators in the health information system.

Country Profiles for Monitoring

With the increased focus on programming for the early years, the inclusion of **ECD**, with **Nutrition, Adolescent Health**, and **Conflict Settings**, in an **expanded Countdown to 2030**, was an important political achievement, as it will increase visibility and intensify the move towards shared indicators globally. At this point in time, 91 countries (some of the highest-burden) are included, but others might join up these efforts. The country profiles use the best available data and indicators (not older than 2005) and are carefully sourced. Unfortunately, many countries do not have national surveys, such as MICS (only MICS has indicators on the nurturing care components) or DHS, and changing or adding indicators to these surveys is a lengthy process. Change over time in the reduction of burden and improvements in each country is compared across time (2005, 2010, and 2015). Challenges include the fact that data on responsive caregiving (i.e. parental mental health, mechanisms for parenting support, access to

quality early childcare...) and indicators on disability are still lacking. Additionally, resources need to be mobilized for developing, adapting, and including new indicators in national household surveys; strengthening national and regional capacities to access, analyze and interpret these data; and demonstrating their usefulness for policy making at the national level and for advocacy purposes at the global level.

Resource Mobilization

Opportunities for resource mobilization and investments

The financing of new initiatives remains of course a major concern for countries, and several presentations emphasized the need to seize opportunities and think outside of the box. With respect to the World Bank, it is important to understand the funding cycle and processes to engage during critical times. Almost all World Bank loans and grants are made to the government and there are several different funding mechanisms available:

1. The Country Partnership Framework is negotiated between the WB and the country. every 3-5 years. The Government, with inputs from line ministries, guides the priority areas for financing. NC needs to be a priority in this Framework. The research, analytical and advocacy for NC (best with data from pilots...) is best done 1-2 years before a new Framework is signed. In addition, opportunities, linkages and lines across WB projects should be explored.
2. The Global Financing Facility (GFF) is established to finance the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). The Fund consists of a Trust Fund and a loan replenished every three years. It covers funding gaps for RMNCAH, with

investments for health financing reforms and MCH, with a knowledge and learning agenda. First, RMNCAH priorities are established at country level, followed by a coordination of resources (domestic government, private sector, other WB funding). This can include reforms to prioritize health (incentivize governments to invest), reforms to raise revenue (e.g. earmarked taxes), and strategic planning to spend smarter etc. The idea is to bring all the players together in the country to talk about priorities. Country works together on an investment case, which then drives the investment. NC needs to be introduced into this investment case.

There is an increasing emphasis on shared communication and materials across WB activities in country. In summary, to influence funding, it is important to

- Reach out to country teams to identify needs and opportunities,
- Generate evidence to make the case to prioritize NC and ECD, and
- Focus on lobbying the government with evidence and not the WB.

At **USAID**, the environment is becoming increasingly favorable for nurturing care initiatives. ECD is included in the multi-sectoral nutrition strategy, in the USG (which includes investments prior to the pre-school years), and the USG Action Plan for Children in Adversity which advocates within USAID for children 0-5 years. The nutrition follow-on project was just awarded to John Snow International. It includes a focus on early childhood development and will look into supporting pilot activities.

With respect to **foundations**, CIFF shared that foundations are often interested in the more catalytic work and innovations rather than supporting large-scale implementation costs.

Having a good investment case and supporting at-risk vulnerable populations in urban areas are emerging as important considerations.

The case of **Chile** served as an inspiring example of country-financed services for the early years. At the direction of the President of Chile, the country took a multi-sectoral approach: ministries of health, education, and social protection worked hand-in-hand with the ministry, including participating in many field and site visits and meeting with stakeholders across the country. This ensured that the Ministry of Finance was also fully aware about the importance of the early years, what services were already available, what else was needed, and what new resources needed to be allocated. This resulted in an approved budget line item for the nationally legislated program *Chile Grows with You* in 2009. To reduce competition and conflict between the ministries of education and health, the Ministry of Social Development coordinated the program and channeled additional resources to the other ministries dependent on their achieving the agreed-upon results. Each sector was also responsible for mobilizing and maximizing their own existing resources. For example, when adding 20 minutes to a 20-minute antenatal consultation to support nurturing care content, the MoH was only reimbursed for these additional minutes and not for the total 40 minutes. A decision was also made to work with high quality equipment and tools, but to procure these at-scale at the national level, and thus at a reduced cost. Chile will be used as one of the PMNCH case studies to inspire others showing that innovative approaches to financing and implementation can result in a shift in national priorities with favorable investments in the country's youngest generation.

Wrapping-up

“Let’s start thinking big... but it is a journey...” “We need to go home and work as a multi-sectoral team.

Communities look at us as one, so we should work together as one. We need to continue harmonizing our efforts so that we avoid duplication.” (Workshop participant)

Reflections and takeaways during the closing session highlighted some key issues for the participants:

- Focus on building the political will within countries. If we increase government demand for NC/ECD, the government can request funds that already exist or put them into country plans that guide donor investment.
- Start with strengthening the services that are already in existence. Their quality matters—mentoring and supervision are important supportive functions to optimize services provided to the families.
- Stimulation and responsive care are two key components– but they do not address the whole story – countries also must take the social determinants into account and reduce adversities.
- The Nurturing Care Framework has to be adapted to national priorities and needs.
- Many materials can be accessed on line or will be made available shortly. For example, ECDAN www.ecdan.org will have country pages where you can upload and share materials and look for materials provided by other countries.
- Use the country’s countdown information to start discussions with the MoH and other agencies.

Participants reflected on the importance of integrating nurturing care into existing programs and piggybacking on larger investments (e.g., SUN); working more effectively across disciplines and sectors; addressing maternal depression, a highly unsupported condition in the region; and seeing how to involve families of children 2-3 years old, that no longer present as frequently (immunization schemes completed, fewer illness episodes), while at the same time many developmental delays become more apparent during this period. Countries that have not yet been as involved felt that there was great benefit to have an opportunity to learn from others.

Additionally, participants expressed that there is value in staying connected, share reports, and make use of the materials from the marketplace. The country teams also indicated that it would be helpful to national efforts if WHO/UNICEF issued a communication to relevant ministries summarizing meeting results, with key take-aways, commitments and follow up plans. Participants were hopeful that the upcoming high level regional meeting of ministers organized by the WHO Regional Office for Africa -- where ECD will also be on the agenda -- will further strengthen national commitments to young child health, development and wellbeing.

Next steps. The participants committed to sharing their draft workplans with colleagues in their respective countries and agencies and seeing how the actions they had planned might be integrated into existing workplans or plans that are still under development. The delegations agreed to share the more final workplans by October 31, 2018, with periodic updates thereafter supported by WHO, UNICEF and partners.

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ANNEX 2. AGENDA

Day 1: 14 October 2018

12:00- 13:15 Lunch

Chairperson: **Constance Shumba**

Co-Chair: **Geoffrey Bisoborwa**

<i>Time</i>	<i>Topic/Activity</i>	<i>Presenter or facilitator</i>
13:30 – 14:00	Registration	WHO Kenya- secretariat
14:00 – 15:00	Welcome and introduction of participants Objectives and expected outcomes Brief remarks Official opening	Master of Ceremony: <ul style="list-style-type: none"> • Dr Kabaka/MOH/Kenya. • Teshome Desta, WHO/AFRO Representatives from <ul style="list-style-type: none"> • Ms. Maniza Ntekim- UNICEF • Dr. Cyril Engmann- PATH • Dr. Rudy Eggers-WHO • Dr. Peter Cherutich- MOH, Kenya
15:00 – 15:30	The Nurturing Care framework & evidence to support it	Bernadette Daelmans
15:30 – 16:00	Group photo and Coffee/Tea Break	
16:00 – 16:15	Administrative briefing Security briefing	WCO Kenya UNDSS
16:15 – 16:45	Interventions for responsive caregiving and early learning: What do they look like and how can they be integrated into existing services	Sheila Manji
16:45 – 17:10	Proposed implementation approach to meet the needs of all children (universal, targeted and indicated support)	Tarun Dua
17:10 – 17:40	Audio-visual presentation on the role of the health sector in supporting nurturing care: What might it look like?	Svetlana Drivdal

17.40 – 18.00	Plenary discussion and key messages of the day	Maniza Ntekim
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Day 2: 15 October 2018		
Time	Topic/Activity	Facilitators
08:30 – 08:40	Introduction of Day 2	Sheila Manji, Shekufeh Zonji
08.40 – 09.00	INTEGRATING NURTURING CARE WITH MCH SERVICES: <ul style="list-style-type: none"> Kenya experience (20 min) 	MOH
09:00 – 09:20	INTEGRATING NURTURING CARE WITH NUTRITION SERVICES: <ul style="list-style-type: none"> Mozambique experience (20 min) 	MOH
09.20 – 09.40	INTEGRATING NURTURING CARE WITH CHW SERVICES: <ul style="list-style-type: none"> Zambia experience (20 min) 	MOH
9:40 - 10:10	Discussion on relevant experiences from countries	
10.10 – 10.45	Panel discussion on strengthening health services	Matthew Frey, Teshome Desta Representatives from Ethiopia, Malawi, Tanzania, Zimbabwe
10.45 – 11.15 : Coffee/Tea Break		
11:15 – 11.45	Country profiles for monitoring country progress and accountability	Linda Richter
11:45 – 12.00	Introduction of group work 1	Debbeet Sen
12:00 – 13:00	Participants work in mixed country groupings to discuss at least one of the following themes: <ol style="list-style-type: none"> Promoting governance and leadership and multi-sectoral collaboration for Nurturing Care – Teshome, Ana. Strengthening MCH and nutrition services to support Nurturing Care and creating a well-prepared health workforce – Lana, Sheila Engaging families and communities in designing Nurturing Care interventions and creating demand for these services- Maureen, Debbeet Ensuring quality, scalability and sustainability of health interventions for Nurturing Care- Tarun, Tanya. 	

13:00 – 14:00 : Lunch

14:00 – 15:00	Groups finalize discussions and prepare a short presentation	
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Chairperson: **Andrea Torres**Co-chair: **Ana Nieto**

15:00 – 16:00	Feedback from the groups Discussion	
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16:00 – 16:30 : Coffee/Tea Break

16:30 – 17:15	Parental mental health and caring for children with developmental difficulties or/and disabilities	Tarun Dua
17:15 – 17:45	Implementation of interventions to improve the developmental outcomes of young children affected by HIV and AIDS - lessons learnt	Linda Richter
17:45 - 18:00	Market place pitch – each country team in 1 minute to make a case why people should come to your table!	Each country
18:00 – 19:30	Reception and Market place	Country teams and partners

Day 3: 16 October 2018

Time	Topic/Activity	Facilitators
08:30 – 08:40	Key messages of day 2 – online survey introduction of day 3 agenda	Rob Huges, Bernadette Daelmans
08:40 – 09:20	Global monitoring and development of indicators for assessing early childhood development at population level	Tarun Dua Ana Nieto
09:20 – 10:05	Summary of the landscaping of monitoring, screening and counseling for child development Discussion	Manjari Quintanar
10:05 – 10:45	Opportunities for resource mobilization and investment	Amanda Devercelli – World Bank Inputs from the floor Discussant Andrea Torres

10:45 – 11:15 : Coffee/Tea break

11:15 – 11:20	Introduction of group work -2	Teshome Desta /Matthew Frey
11:20 – 12:30	Group planning in country teams and next steps	

12:30 – 13:30 : Lunch

13:30 – 14:15	Country teams prepare a short presentation on next steps	
14:15 – 15:30	Country presentations Questions and answers	Teshome Desta, Matthew Frey (facilitators)
15:30 - 15:45	Evaluation	
15:45 – 16:15 : Coffee/Tea Break		
16:15 – 16:45	Reflections and key take home messages	Lisa Bohmer (Facilitator)
16:45 – 17:15	Closing	WHO, UNICEF, PATH, MOH

ANNEX 3. RESULTS FROM WORKING GROUPS – DAY 2

Working Group Instructions:

In your discussion, ask yourselves the following questions:

- What are you already doing?
- Where do you see gaps or challenges?
- What are opportunities or solutions including planned activities and **funding opportunities**?
- What new ideas have you picked up during the preceding presentations and the panel discussion?

Group 1. Promoting good governance and leadership and multi-sectoral collaboration for Nurturing care

What countries are already doing:

- Technical Working Groups for multi-sectoral engagement
- Evidence generation through research advisory council
- Some countries are in process of policy modifications, others have this achieved already
- Child development policy is available in some countries
- Joint sector strategic plan (e.g. Ministry of Gender)
- Members of parliament are being lobbied to support works of ECD
- Inter-sectoral task clarification and harmonization of activities
- ECD inclusion in national strategic plan

Gaps and challenges

- Not being included in some sectors' action plans
- Having no plan for the central steering committee and weak convening power (e.g. of the TWG)
- No baseline data for spring board planning and for advocacy
- Not having sub-national (regional) TWGs
- Horizontal coordination that goes down the vertical health system is being a challenge

Opportunities

- Every country striving for universal health coverage and ECD being one of the agendas in SDG
- Global interest
- Possibilities for funding (GFF, World Bank)
- Opportunities in technology advancement
- Health development strategies available building on the concepts of child thrival

New ideas

- Having joint strategic document
- Being open in the approach of implementation and Use the existing system to implement nurturing care components
- Use of technology to build up the implementation of ECD
- Use of data is key in evaluating gaps and seeing the impacts
- Engaging Key champions in the sector is mandatory
- Having a focal person who follows coordination and integration
- Advocacy to parliament about ECD has increase resource budgeting for ECD by 9% (Malawi experience)

Other points of discussion

- General budgeting for ECD (mostly being related to infrastructure, and primary school teacher salaries). How can we use the same budget and disaggregate the budget to accommodate all nurturing care components
- Having a strategic document with separate shared responsibility for each sector and if each sector deducts their annual plan from the strategic plan and get it approved, it can lead to budgeting for each activity.

Group 2. Strengthening MCH and nutrition services to support Nurturing care and creating a well-prepared health workforce

What countries are already doing:

- Integrated MCH and Nutrition services in Nurturing Care
- Training HWs and CHWs to deliver nurturing care in health facilities and communities through home visits and group sessions
- Targeted Nurturing Care for malnourished children in and outside health care
- Inter-sectoral coordination in delivering MCH and nutrition services that integrates components of nurturing care
- COMPACT- contracts signed by regional commissions

Gaps and challenges

- No explicit strategies showing nurturing care activities
- No common set of process indicators
- Inability to scale up

Opportunities

- Integration

- Local Resources e.g traditional songs, games
- Knowledge Sharing platforms
- Coordinated training and supportive supervision

Group 3. Engaging families and communities in designing Nurturing care interventions and creating demand for these service

What countries are already doing:

- Parenting communities – implement the activities,
- Exploring indigenous child rearing practices and adopting some
- Neighborhood health committee planning, monitoring and linking of community health workers with facilities (Ethiopia)
- Health extension program - health post with 2 health workers providing services and raising awareness
- Women development army; each engages 30 households created demand, awareness, help plan activities
- Family Health Guide- key health messages, 69 including ECD- all households, priority is for < 5 yrs
- Village Health and Nutrition Day, ECD
- Mother Child Health week- ECD

In Planning / Designing

- Identifying needs and prioritizing through community assembly meetings conducted annually and forwarding to district level for including in district council plans (TA)
- Parent committees planning – Malawi
- Village health and nutrition days planned by CHWs and community leaders conducted at community level for ECD interventions- all services converge at community for children under 3- GMP, Vaccination, CCD, Nutrition counselling, etc. (Tanzania)

Demand Creation

- Community health care workers supporting facilitating counseling group sessions / mothers conference for pregnant women and care givers of under 5- TZ, Ethiopia
- Village/Community health and nutrition days- Ethiopia, Tanzania
- Women development army reaching households with health messages – Ethiopia
- Use of mobile technology – MNCH SMS and Birth Registration – TZ, Ethiopia, Malawi
- Use of family health guide and family health and nutrition counseling tools/flip charts- Ethiopia, TZ
- Mother child health weeks – Kenya

Gaps and challenges

- ECD/Nurturing plan not comprehensive in most countries
- Families not involved in designing interventions
- Interventions not comprehensive enough
- Lack/low male involvement and gender norms related to male engagement
- Gender inequality- women
- Heavy work load of Community Health Workers and women
- Lack of coordination among stake holders
- Funding gaps
- Some indigenous child rearing practices currently used have no evidence as being reliable/safe for young children
- Challenge in meeting the interest of donors to fund sector interventions
- Inadequate coordination

Opportunities

- Develop national road maps
- Setting agreed priorities for effective implementation
- Coordination of ECD at all levels
- Cross sectorial integration
- Improve information sharing horizontally for all involved in 5 domains of Nurturing Care.
- Waiting Mother shelters – Nurturing care, discussed, create demand
- Pregnant and lactating women conference - opportunity for integrating ECD
- Involving traditional leaders in engaging men
- PVT sector engagement
- Families to be re-engaged in designing of interventions.
- Play and learning materials
- Engaging local and traditional leaders/key figures to enhance discussion on gender relations
- Enhancing and setting clear agreed priorities for effective coordination
- Financial
- Buy-in from donors to take up ECD Integrated packages if there is better packaging and advocacy
- New donors on ECD available e.g. World Bank
- Leveraging domestic funding
- Government to government funding
- Local resource mobilization e.g. Allocation of Tsh 1000 per child/ year in Tanzania for 1000 days' activities

New ideas

- Community health workers model interacting with families on stimulation, counselling, and play which encourages families to engage children
- Creating Free Play space within institutions
- Effective monitoring tools for coordination
- Enforcing accountability
- Use of technology for hard-to-reach areas, mobile phones
- Facility/Home visits /community-based NC interventions e.g. child spaces
- Multi-sectoral coordination and setting M&E mechanism
- Enforcing accountability –Malawi

Group 4a. Ensuring quality, scalability and sustainability of Health Interventions for NC

Definitions

Quality

- Meeting five components
- In line with set standards
- Have guidelines and standards operating procedures
- Training and mentorship
- Supervision
- Monitoring and Evaluation

Definition of Scalability

- Resources – financial commitment
- Structures at all levels
- Scale up plans

Definition of Sustainability

- Clarity of coordination – inter and intra
- Clear guidelines
- Government ownership
- Integration of other programmes
- Resources

Gaps and challenges

- Lack of data at country level
- Policy standards for other countries not complete
- Responsive care coverage is low
- Limited funding

Opportunities

- Integration of Nurturing Care into:
- Newborn & child health guideline
- Policies
- Strategies

- Existing M&E Tools
- Leverage existing resources; examples:
- PEPFAR
- Budget lines in health
- Leveraging existing infrastructure
- Engaging private partnerships

New ideas

- Create focal point in National and Sub-National Ministries of health on ECD
- Integrate into newborn child health support supervision tools
- Create visibility for ECD within Health Sector e.g. Budget lines for ECD but don't create parallel system
- Budget lines for National & Sub-National Budgets
- Implementation Research & Evaluation