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Maternal and Child Survival Program

Ghana Early Childhood Development End-of-Project Report

December 2016–June 2019

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Maternal and Child Survival Program

www.mcsprogram.org

The Maternal and Child Survival Program (MCSP) is a global, $560 million, 5-year cooperative agreement funded by the United States Agency for International Development (USAID) to introduce and support scale-up of high-impact health interventions among USAID's 25 maternal and child health priority countries, as well as other countries. MCSP is focused on ensuring that all women, newborns and children most in need have equitable access to quality health care services to save lives. MCSP supports programming in maternal, newborn and child health, immunization, family planning and reproductive health, nutrition, health systems strengthening, water/sanitation/hygiene, malaria, prevention of mother-to-child transmission of HIV, and pediatric HIV care and treatment.

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Cover photo: Kate Holt, MCSP

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Acknowledgments

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- The Family Health Division of the Ghana Health Service
- The Health Promotion Department of the Ghana Health Service
- The Department of Children in the Ministry of Gender, Children, and Social Protection
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- The Social Welfare Department of the Ministry of Gender, Children, and Social Protection at the national level, and regional and district social welfare directorates of Upper West, Upper East, Eastern, and Central regions

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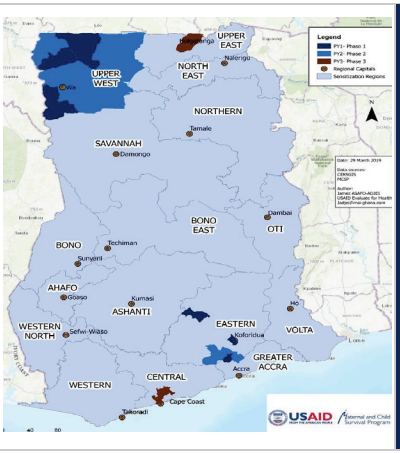
Abbreviations

CHO	community health officer
CHPS	Community-Based Health Planning and Services
CHV	community health volunteer
CREDI	Caregiver Reported Early Development Instruments
CWC	child welfare clinic
ECCD	early childhood care and development
ECD	early childhood development
FHD	Family Health Division
FTFSG	father-to-father support group
GHS	Ghana Health Service
MCSP	Maternal and Child Survival Program
MOH	Ministry of Health
MTMSG	mother-to-mother support group
NCF	Nurturing Care Framework
PML	Princess Marie Louise
PY	program year
RFG	religious fellowship group
SWO	social welfare officer
UNFPA	United Nations Population Fund
USAID	US Agency for International Development
WHO	World Health Organization

Country Summary



Geographic Implementation Areas

Regions
- Central, Eastern, Upper East, and Upper West

Districts
- 21 out of 254 (8.3%)

Primary health care facilities
- 873 out of 5,488 CHPS compounds (15.9%)

Population

Country
- 28 million

MCSP-supported areas
- 9 million

Technical Areas: Primary: Early Childhood Development and Nurturing Care, Child Health, Nutrition
Cross-Cutting: Community Health

Program Dates

December 2016 to June 2019

Cumulative Spending through Life of Project

$3,600,000

Demographic and Health Indicators

Indicator	# or %
Live births/year[(1)]	776,532
MMR (per 100,000 live birth)[(4)]	310
NMR (per 1,000 live birth)[(3)]	25
U5MR (per 1,000 live birth)[(3)]	52
IMR (per 1,000 live birth)[(3)]	37
ANC 4+[(2)]	89%
Early Childhood Development Index (ECDI)[(3)]	68%
ECDI: Social-emotional[(3)]	67%
ECDI: Literacy-numeracy[(3)]	44%

Sources: (1) UNICEF and WHO 2014; (2) Ghana Maternal Survey 2017; (3) Based on 10 caregiver-reported items about children's skills included in the 2017 MICS; (4) World Bank 2015

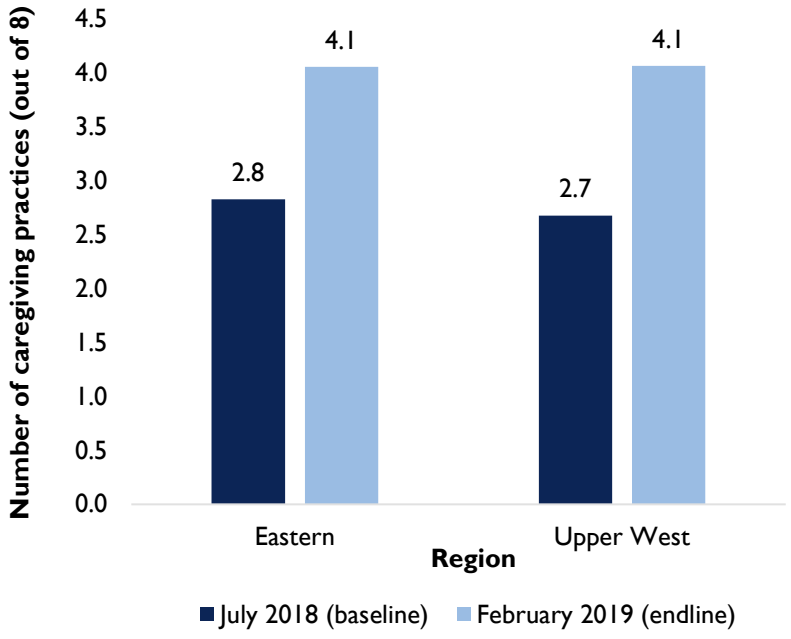
Strategic Objectives through the Life of Project

- Create and disseminate evidence-based early childhood development (ECD) materials focused on early childhood stimulation and responsive parenting for children under 3 years.
- Build capacity of Community-Based Health Planning and Services (CHPS) staff, community health volunteers (CHVs), and social welfare officers (SWOs) to teach caregivers with young children about early stimulation and responsive parenting in targeted districts.
- Assess the ability of CHPS staff, CHVs, and SWOs to integrate early childhood activities into their routine services and document changes in caregiver behaviors and child development.
- Create an enabling environment at the national and regional levels to promote institutionalization of ECD activities into partner and government programming.

Highlights through the Life of Project

- Responded to the global call for cross-sectoral collaboration on ECD. MCSP and the Ghana Health Service developed a comprehensive toolkit and eLearning modules to integrate early stimulation and responsive parenting into community health and nutrition services.
- Built the capacity of 2,268 national-, regional-, district-, and community-level health staff to deliver parenting sessions on ECD with caregivers of children ages 0–3. Health staff reached at least 5,715 caregivers with 5,006 children, increasing positive caregiving behaviors that impact child development.
- Supported continued performance improvement among health staff via ongoing supervision and mentorship visits, documenting facilitation and utilization of the toolkit and retention of ECD messages.
- Leveraged learnings from the MCSP ECD program to make technical inputs into key strategic technical documents, including the National ECD 0–3 Standards, Newborn Health Strategy, and ECD Call to Action.
- Collaborated with the GHS, UN agencies, and other partners to revitalize cross-sectoral working groups on 0–3 ECD, and spearheaded an ECD stakeholder meeting for the upcoming Nurturing Care Strategy.
- Contributed to evidence and learning on 0–3 ECD interventions, including improvement in positive caregiving practices (see Figure 1 for average number of positive practices).[1]

Figure 1. Changes in positive caregiving practices by region



[1] Average number of positive caregiving practices reportedly implemented by caregivers. Caregiving practices include reading, storytelling, singing, play, taking children outside, drawing/writing, hugging, and teaching.

Executive Summary

Globally, 250 million children under 5 years old living in low- and middle-income countries are at risk of not achieving their development potential.[2] In Ghana, more than one-quarter of children ages 36–59 months are behind in language, cognitive, physical, and socioemotional development.[3] Compounding gaps in early childhood development (ECD), children in Ghana face significant nutritional deficiencies. Nearly 20% of children under 5 are stunted, 5% are wasted, and 11% are underweight.[4] Global research shows physical stunting is associated with cognitive stunting. Based on this critical need, there is growing momentum for integrated ECD programming that engages multiple sectors, particularly health, nutrition, social protection, and education, to support parents in their caregiving function. However, many parents and caregivers lack adequate knowledge on how to stimulate their children's development. To date, there has been an absence of early stimulation information in maternal and child health guidelines and parenting sessions. Against this background, the Maternal and Child Survival Program (MCSP) Ghana ECD 0–3 Program aimed to improve caregiver capacity and child development outcomes through four main objectives:

1. Develop a global-level ECD toolkit for children ages 0–3 and adapt it to fit the Ghana-specific context.
2. Build the capacity of frontline health, nutrition, and social protection workers to implement ECD materials through routine, community-level services and to effectively teach caregivers with children ages 0–3 about early stimulation and responsive parenting.
3. Assess the ability of frontline health, nutrition, and social protection workers to integrate ECD activities into their routine services and document changes in caregiver behaviors and child development.
4. Create an enabling environment at the national and regional levels to promote institutionalization of ECD activities into partner and government programming, particularly for children ages 0–3, a cohort not specifically addressed in previous Ghana ECD policy.

From December 2016 through June 2019, MCSP, in collaboration with the Ghana Health Service's Family Health Division (FHD), successfully implemented these interventions, making significant progress toward national-, regional-, and district-level institutionalization of ECD. Through the life of project, MCSP built the capacity of 2,268 national-, regional-, and district-level health staff to deliver sessions about early stimulation and responsive parenting to caregivers. MCSP-supported health workers implemented their new skill set to train caregivers across 21 districts within four regions of Ghana, ultimately reaching 5,715 caregivers and 5,006 children.

As part of the implementation process, MCSP conducted assessments to measure the ability of frontline health, nutrition, and social protection workers to integrate ECD activities into their routine services, and documented the feasibility of adding these additional responsibilities to their workloads. The project also assessed changes in caregiver behaviors and child development. The endline results compared to the baseline demonstrated clear changes in all targeted groups under the study and could be attributed to the MCSP ECD intervention.

At the national level, MCSP also supported prioritization and mainstreaming of ECD 0–3 approaches, contributing to the launch of the Nurturing Care Framework, National 0–3 Early Childhood Care and Development (ECCD) Standards, National Newborn Health Strategy, and the ECD 0–3 Call to Action. MCSP supported the revitalized national ECCD technical working group (led by the Ministry of Gender, Children, and Social Protection) and national stakeholder and media sensitization meetings to educate key stakeholders on the importance of nurturing care and to build consensus toward the development of a nurturing care strategy for the health sector in Ghana.

[2] Black MM, Walker SP, Fernald LCH, et al. 2017. Early childhood coming of age: science through the life course. *Lancet*. 389(10064):77-90. doi: 10.1016/S0140-6736(16)31389-7.
[3] Ghana Statistical Service. 2011. *Ghana Multiple Indicator Cluster Survey with an Enhanced Malaria Module and Biomarker, 2011*. Accra, Ghana: Ghana Statistical Service.
[4] United Nations Population Division. 2015. *World Urbanization Prospects: 2014 Revision*. New York City: United Nations.

The MCSP Ghana ECD 0–3 Program was designed with sustainability in mind, ensuring collaboration with the Government of Ghana on each activity. The program's *Ghana ECD Toolkit* and accompanying eLearning modules have been integrated into the FHD's trainings resources, and all learning documentation has been disseminated to inform future implementation of ECD activities.

Introduction

Background

Early childhood development (ECD) is an interdisciplinary field that supports young children's holistic development. The first 1,000 days of life are recognized as containing the building blocks for lifelong learning and development. During this period, approximately 700–1,000 neural connections are formed every second, a pace not matched during any other period in life.[5] Early experiences and the environments in which children develop can have lasting impact on later success in school and life. These critical early experiences take place through relationships with parents or caregivers. As such, the quality and frequency of interactions between young children and their parents are critical for their growth and development.

In addition to the quality of caregiver engagement and early stimulation, research indicates that chronic undernutrition and poverty can also impair healthy development in young children.[6] Based on this, there is growing momentum for integrated early childhood programming that engages multiple sectors to support young children and families. Compared to early childhood services that are planned and implemented sector by sector, **integrated interventions result in better ECD outcomes for children and their families**.[7]

Moreover, there is compelling new global evidence on the importance of reaching pregnant women and young children with holistic early childhood services. *The Lancet*'s series on ECD (October 2016) provides strong evidence, suggesting that existing maternal and child health services be expanded to include interventions on nurturing care to support families and reach young children. Building upon this evidence, the World Health Organization (WHO), UNICEF, and World Bank launched the Nurturing Care Framework (NCF) in May 2018, declaring that for children to survive and thrive, they require holistic care comprising good health, adequate nutrition, opportunities for early learning, responsive care, and safety and security.

Globally, 250 million children under 5 years old living in low- and middle-income countries are at risk of not achieving their development potential. In Ghana, more than one-quarter of children ages 36–59 months are behind in language, cognitive, physical, and socioemotional development—the four domains of ECD.[8] Compounding gaps in ECD, children in Ghana face significant nutritional deficiencies. Nearly 20% of children under 5 are stunted, 5% are wasted, and 11% are underweight, further stunting brain development.[9]

Previously, ECD services and materials in Ghana tended to focus more on the preschool years (ages 4–5) and the importance of preparing children for primary school. In recent years, stakeholders have expressed strong interest around development of policy guidelines and initiatives for children 0–3 years old. The Maternal and Child Survival Program (MCSP) Ghana ECD 0–3 Program launched at a pivotal time for ECD policy and service delivery in Ghana, playing a significant role in prioritization and operationalization.

Ghana ECD 0–3 Program

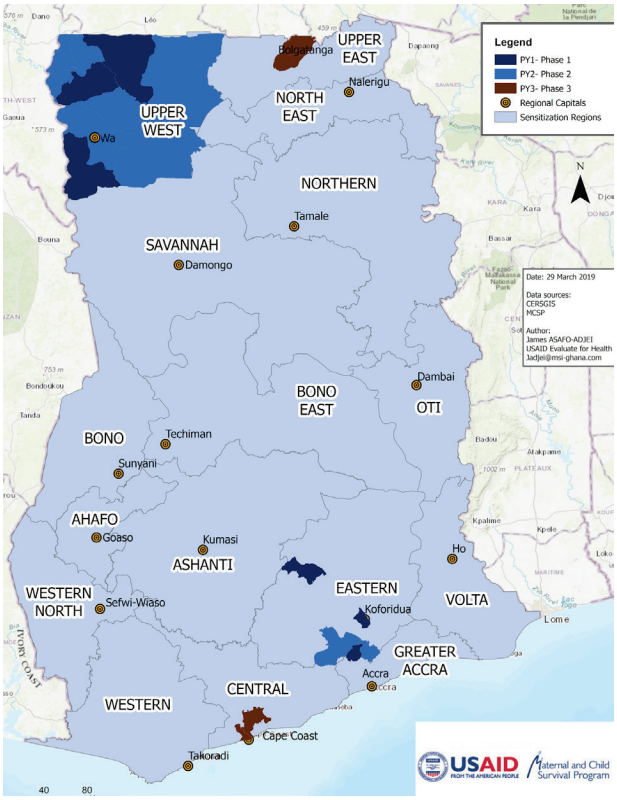
The ECD program in Ghana was funded by the US Agency for International Development (USAID)'s Displaced Children and Orphans Fund, in response to the U.S. Government Action Plan on Children in Adversity (2012–2017) and the newly launched U.S. Government Strategy: Advancing Protection and Care for Children in Adversity (2019–2023). The strategy's first objective seeks to promote nurturing care for the most vulnerable newborns and young children through comprehensive and integrated programming in ECD.

[5] Center on the Developing Child. 2009. *Five Numbers to Remember about Early Childhood Development.* Cambridge, Massachusetts: Harvard University.
[6] Black MM, Walker SP, Fernald LCH, et al. 2017. Early childhood development coming of age: science through the life course. *Lancet.* 389(10064):77-90. doi: 10.1016/S0140-6736(16)31389-7.
[7] Black MM, Walker SP, Fernald LCH, et al. 2017. Early childhood development coming of age: science through the life course. *Lancet.* 389(10064):77-90. doi: 10.1016/S0140-6736(16)31389-7.
[8] McCoy DC, Peet ED, Ezzati M, et al. 2016. Early childhood developmental status in low- and middle-income countries: national, regional, and global prevalence estimates using predictive modeling. *PLoS Medicine.* 13(6):e1002034. 10.1371/journal.pmed.1002034.
[9] United Nations Population Division. 2015. *World Urbanization Prospects: 2014 Revision.* New York City: United Nations.

MCSP's ECD program in Ghana started in August 2016 and completed implementation on June 30, 2019. MCSP Ghana initially focused on the pre-service education/Community-Based Health Planning and Services (CHPS) program to improve health outcomes for HIV, malaria, nutrition, family planning, and maternal, newborn, and child health services, in collaboration with the Ministry of Health (MOH) and the Ghana Health Service (GHS), as well as a program under USAID's Ebola Pillar IV to build technical competency and ability of staff at targeted health facilities to routinely practice strong infection prevention and control practices. In August 2016, MCSP received additional funding furnished through the Displaced Children and Orphans Fund to support the implementation of coordinated health, nutrition, and ECD interventions, with the overarching goal of increasing caregiver knowledge of early stimulation and responsive care, as well as mobilization of frontline health workers to promote and practice early stimulation techniques at the community level.

Given that ECD was not previously part of MCSP's mandate, the team held a scoping activity in December 2016 to better understand the status of ECD in Ghana and platforms for implementation via the health system. MCSP found that the CHPS platform, a national health care program focused on bringing health services closer to communities, presented an ideal entry point to reach the ECD program's target population and an opportunity to leverage the target population's health and nutrition knowledge as a base to integrate related ECD information. Working with the Family Health Division (FHD) and CHPS leadership, MCSP created a plan to develop the capacity of CHPS staff at regional and district levels—community health officers (CHOs) and community health volunteers (CHVs)—to implement ECD activities through preexisting mother-to-mother support groups (MTMSGs). MTMSGs appeared to be a natural fit, as their meeting structure, frequency, and purpose aligned well with the program aims and target population.

Figure 1. Early childhood development implementation sites



The Ghana ECD 0–3 Program was implemented in three phases, from here forward referred to as program years (PYs),[10] to achieve the following objectives (see Results Framework, Table 1):

1. Develop and disseminate an evidence-based set of ECD materials concentrating on early childhood stimulation and responsive parenting for children under 3.
2. Build capacity of CHPS staff, CHVs, and social welfare officers (SWOs) to effectively teach caregivers with young children about early stimulation and responsive parenting in targeted districts.
3. Assess the ability of CHPS staff, CHVs, and SWOs to integrate early childhood activities into their routine services and document changes in caregiver behaviors and child development.
4. Create an enabling environment at the national and regional levels to promote institutionalization of ECD activities into partner and government programming.

[10] For MCSP Ghana ECD purposes, PY1 (December 2016–February 2018), PY2 (March–December 2018), PY3 (January–June 2019).

Table 1. Ghana early childhood development results framework

Project goal: Leverage frontline health workers to promote and practice early stimulation techniques at the community level and increase caregiver knowledge on early stimulation and responsive parenting.			
Objective 1: Develop and disseminate an evidence-based set of early child development (ECD) materials concentrating on early childhood stimulation and responsive parenting for children under 3.	**Objective 2:** Build capacity of Community-Based Health Planning and Services (CHPS) staff, community health volunteers (CHVs), and social welfare officers (SWOs) to effectively teach caregivers with young children about psychosocial stimulation and responsive parenting in targeted districts.	**Objective 3:** Assess the ability of CHPS staff, CHVs, and SWOs to integrate early childhood activities into their routine services and document changes in caregiver behaviors and child development.	**Objective 4:** Create an enabling environment at the national and regional levels to promote institutionalization of ECD activities into partner and government programming.
IR 1.1: Develop and disseminate a global package of materials that addresses early childhood stimulation and responsive parenting.	*IR 2.1: Increase knowledge and utilization of ECD materials among regional- and district-level CHPS staff and SWOs.*	*IR 3.1: Using quantitative and qualitative tools, assess changes in CHPS staff, CHV, and SWO knowledge and perceptions of early stimulation practices before and after MCSP training as well as perceptions of implementation feasibility.*	*IR 4.1: Contribute to the development of national and regional policies and guidelines around ECD.*
IR 1.2: Adapt global-level package to Ghana country context and disseminate at national, regional, and district levels.	*IR2.2 Improve caregiving practices and environments among families of children ages 0–3.*	*IR 3.2: Using quantitative and qualitative tools, conduct assessment of caregivers' knowledge and perceptions of benefits of positive stimulation practices.*	
		IR 3.3: Using quantitative and qualitative tools, assess and compare ECD implementation platforms (i.e., mother-to-mother support groups, child welfare clinics, religious fellowship groups)	

In PY1 (December 2016–February 2018), MCSP focused on developing and field-testing an evidence-based toolkit of ECD materials tailored to the Ghana context. The *Ghana ECD Toolkit* (see Table 2) derived from early stimulation approaches implemented by MCSP partners' globally[11]. After development of a generic, global ECD 0–3 toolkit, MCSP undertook multiple iterations of consultation and revision with partners to adapt the package to the Ghanaian context.

Upon finalization of the package, MCSP commenced capacity development activities in Upper West and Eastern regions, training the first cohort of CHPS staff at regional and district levels across six districts

[11] Save the Children's First Steps parenting and Building Brains

(see Figure 1).[12] As part of field-testing, MCSP assessed CHPS staff knowledge of ECD through pre- and post-tests during trainings, as well as observation and supportive supervision visits after the training. These assessments helped MCSP understand modifications needed for future implementation cycles. Additionally, experiences from PY1 informed further revision of the *Ghana ECD Toolkit*.

Monitoring revealed that certain locations, particularly urban environments, had weak or nonexistent MTMSGs. Therefore, at the onset of PY2 (March–December 2018), MCSP completed additional scoping exercises to identify alternative entry points for session delivery and found that child welfare clinics (CWCs) and social groups (such as religious fellowship groups [RFGs]) presented viable options in locales with weak MTMSGs (see Table 3). Building upon these learnings, the project scaled up to additional districts, reaching all 11 districts of Upper West, six districts in Eastern Region, and two each in Upper East and Central regions. This represents 8.6% (21 of 245) of the districts in Ghana.

In PY2, MCSP also added a learning objective on caregiver behavior and child development outcomes to monitor changes in those participating in MCSP's ECD sessions. Additionally, another objective was included: Objective 4: Create an enabling environment at the national and regional levels to promote institutionalization of ECD activities into partner and government programming. This objective was included to support national-level prioritization of ECD 0–3 and to formalize MCSP's contributions to key technical documents that drive ECD standards and policy. Inclusion of this piece aligned with the global and national launch of the NCF, leading to greater national-level prioritization of ECD.

In PY3 (January–June 2019), MCSP and the GHS scaled up ECD programming to Upper East and Central regions, implementing trainings and supportive supervision activities in two districts per region. As part of this expansion and institutionalization, MCSP responded to a request from the Accra-based Princess Marie Louise (PML) Children's Hospital to receive ECD training and support for their own facility study to assess the impact. Such strong local institution interest offered the opportunity to expand the platform to a hospital setting. This can also serve as a model for other hospitals in Ghana.

Over the life of project, MCSP, in collaboration with the GHS, successfully built the capacity of 2,268 national-, regional-, and district-level health staff, CHPS staff, CHVs, and SWOs to provide high-quality services on early stimulation and responsive parenting to 5,715 caregivers, benefiting 5,006 children ages 0–3.

[12] Upper West and Eastern were selected as focal regions based on proximity to other MCSP Ghana projects, locations with strong MTMSGs, factoring diversity between the two implementation regions (i.e., cultural practices, education, socioeconomic demographics), and proximity to Accra to leverage the existing MCSP Ghana office.

Major Accomplishments

Objective 1: Develop and disseminate an evidence-based set of ECD materials concentrating on early childhood stimulation and responsive parenting for children under 3.

Development

MCSP developed a generic, global set of ECD materials aimed at addressing the early stimulation needs of children in the age 0–3 cohort. The package draws from science on brain development and existing proven approaches of early stimulation packages from MCSP partners' global programming for young children and families. These included the integrated early stimulation and nutrition package implemented by consortium partners in Bangladesh, Building Brains from Nepal, the First Steps parenting program in Rwanda, and the Essential Package, implemented in five African countries.

The *ECD 0–3 Toolkit* was designed to be easy to use for both health worker facilitators and caregivers. The parenting session manual and flip chart, utilized by CHOs, CHVs, and SWOs, guide groups through key child development messages and accompanying games to facilitate stimulation for age groups 0–6 months, 6–12 months, 1–2 years, and 2–3 years. The sessions engage caregivers to be responsive to their children's cognitive, language, emotional, and physical needs from birth onward by playing, talking, and singing, even before children can verbally respond, and exposing them to words, numbers, and simple concepts while carrying out their daily routines. The sessions also guide caregivers through use of positive discipline techniques to ensure that children are protected from physical and emotional harm.

After the global package was drafted, MCSP began the process of adapting materials to the Ghana context. This included a number of stakeholder meetings and focus group discussions (FGDs) to adjust games, language, and illustrations. The draft Ghana package was then field-tested with select MTMSGs to observe session flow and participant reaction. Through feedback collected during field-testing, MCSP further modified language, illustrations, and session structure to improve clarity. Additionally, MCSP worked with FHD's Health Promotion Unit to review the toolkit to ensure technical accuracy and alignment with the FHD's key health messages on topics such as handwashing, complementary feeding, and exclusive breastfeeding. Furthermore, the materials were rebranded with the GHS' GoodLife brand.[13] This step marked the FHD's validation of the materials and ensured their institutionalization and future national use. See Table 2 for the final *Ghana ECD Toolkit* content.

Table 2. MCSP Ghana Early Childhood Development Toolkit

Material	Purpose
Community Health Workers' Manual for Parent/Caregiver Sessions	Provides step-by-step instructions to community health officers for facilitating group sessions.
Flip chart	Pictorial guide for facilitation (aligns with *Manual*). Used by community health officers/volunteers to engage caregivers and illustrate key messages during group sessions.
Mini flip chart	A portable version of the flip chart contents for community health volunteers to use at home visits and during one-on-one counseling.

[13] GoodLife is a unified umbrella brand by the GHS and USAID's Communicate for Health project. It is part of an exciting overarching multimedia campaign in Ghana. The GoodLife initiative encourages self-reflection about what makes life "good" and links personal happiness to the practice of healthy behaviors.

Material	Purpose
Wall chart	Consolidated messages cover each topic and age group. Posted at Community-Based Health Planning and Services compounds and used by social workers during Livelihood Empowerment against Poverty cash transfer meetings. Used to build awareness and educate at child health clinics, antenatal care, etc.
Brochure	A portable version of the wall chart contents meant for household visits by community health volunteers and left behind for caregiver reference.
Training of Trainers Guide	Provides training for those who will in turn be training community health officers/volunteers to facilitate early childhood development group sessions.

Dissemination

The primary dissemination pathway for the ECD materials was directly to CHPS staff during trainings. MCSP also shared the finalized *Ghana ECD Toolkit* with relevant stakeholders at national and regional levels during a launch event held in concert with the FHD on November 6, 2018. This marked an important stage of the program, officially orienting stakeholders to the materials and making recommendations for institutionalization and future use. After the event, organizations such as the Red Cross expressed interest in utilizing the package for their parenting sessions, providing opportunities to roll out and use materials beyond the CHPS system. The United Nations Population Fund (UNFPA) also asked that MCSP conduct a capacity development training on ECD for midwives during a visit from the president of the International Confederation of Midwives.

To further support institutionalization, MCSP adapted the *ECD 0–3 Toolkit* into a set of eLearning modules. The modules were designed to familiarize health care supervisors with basic ECD information and 0–3 toolkit contents to support their managerial role of CHPS staff. Availability of the eLearning modules will increase future access to ECD information as well as minimize the need for and thereby reduce costs of in-person training of supervisory-level staff.

Finally, MCSP also supported global dissemination of the *ECD 0–3 Toolkit* via online learning and networking platforms, including mPowering's ORB platform, and ECD networks, including the ECD Action Network and the Africa Early Childhood Network. MCSP's innovative and timely ECD package serves as a practical example both in Ghana and globally of how to operationalize the NCF.

Objective 2: Build capacity of CHPS staff, CHVs, and SWOs to effectively teach caregivers with young children about early stimulation and responsive parenting in targeted districts.

Developing an ECD Workforce

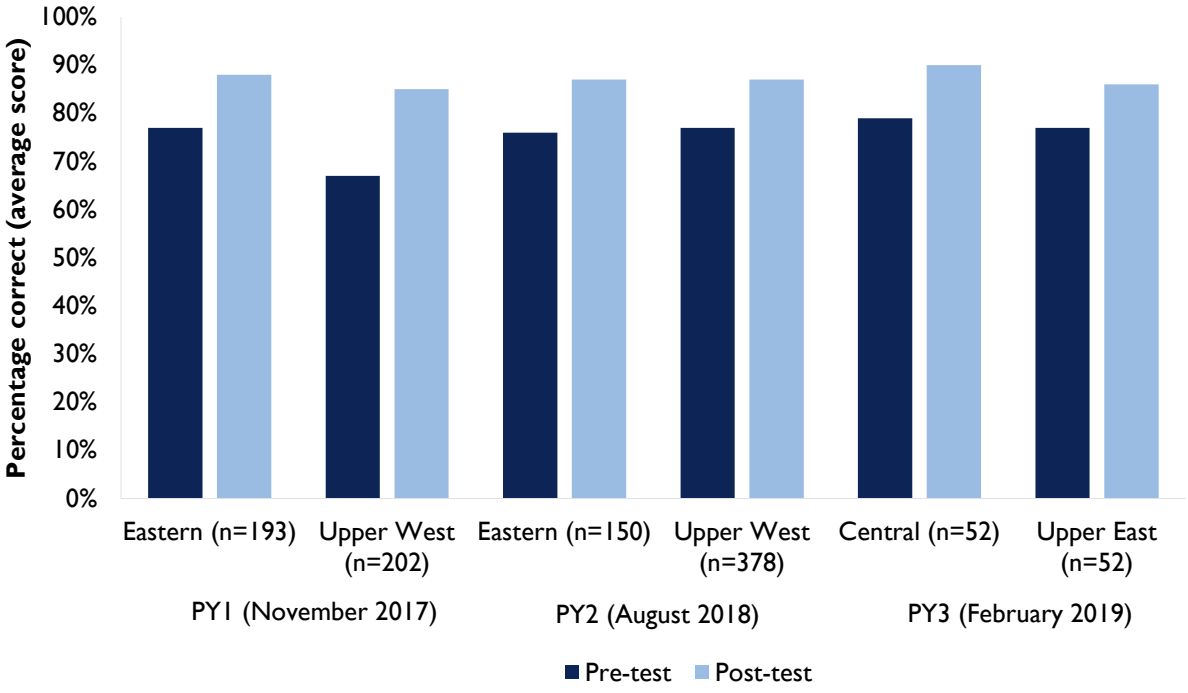
Using the *Ghana ECD Toolkit* developed under Objective 1, MCSP built the capacity of CHPS staff to provide ECD and health education services to mothers, families, and caregivers of children ages 0–3 through training and mentorship of key district CHPS staff, including CHPS coordinators, CHOs, and CHVs. MCSP supported the FHD with the creation of a pool of regional-level ECD trainers, composed of key regional CHPS staff in Upper West, Upper East, Central, and Eastern regions, who in turn trained district-level CHPS staff.

A multilevel cascade approach was used to roll out the training. Throughout the life of project, 114 representatives (FHD, regional health management teams, and district health management teams) were trained to conduct trainings of trainers at the district level for CHOs through an intensive 5-day training. This training equipped staff with the knowledge and skills needed to train and provide supportive supervision to social workers, CHOs, and CHVs in their districts. Selection of step-down trainers was based on performance during the training of trainers, willingness to support other staff and CHVs, and competency to lead a group session. Over three phases, they cascaded the training to 1,251 CHPS staff, 15 SWOs, and 888 CHVs from

21 districts across the four regions. The step-down trainings aimed to build the capacity of CHPS staff to effectively implement and integrate early childhood stimulation and responsive parenting information into their regular health and nutrition activities on platforms identified within their CHPS zones (CWCs, MTMSGs, RFGs, etc.).

MCSP assessed health worker understanding of the *Ghana ECD Toolkit* contents via training pre- and post-tests. Participants demonstrated a marked increase in ECD knowledge, with an average pre-test score of 75.5% and post-test score of 87.2% (see Figure 2). The success of this knowledge transfer indicates that the materials were well understood by participants. This is particularly relevant given the cascade model used for training in the program, which can sometimes lead to reductions in the quality of training and learning as training cascades down the system.

Figure 2. PY1–PY3 average pre- and post-test scores across providers



ECD Session Delivery

While MCSP initially planned to implement all caregiver sessions via the MTMSG platform, in PY1, CHPS staff, CHOs, and CHVs noted that some identified MTMSGs were not meeting frequently or had disbanded. This was most common in urban areas in which caregivers were engaged in formal employment, making it difficult to attend weekday meetings. MCSP set out to identify alternative implementation platforms for urban settings, interviewing a wide range of health workers and community leaders. The team found that CWCs provided an entry point to reach busy caregivers. Many CHOs observed that caregivers tended to adhere to appointments for routine growth monitoring and vaccination despite busy schedules. Other communities indicated preference for other platforms, such as RFGs, as group meetings took place at fixed, convenient locations.

> "In our urban setting, it is not like the rural area where you will be aware of how the community members move. You know they go out, and by 7:00, everybody would have come back from the farm. In our setting, you can even wait and go as late as 4 p.m. and 5 p.m. but will not meet anyone because of the work schedules. But we realized that as for CWC, come what may, the parent has the time to join the CWC even if she has some work to do."
> –CHO feedback on implementation platforms appropriate for an urban setting

To further increase coverage, in PY2, MCSP expanded training to partners beyond the health sector, including SWOs. SWOs were strategically selected to support coverage of children most in need, many of whom receive support from cash transfer programs overseen by SWOs, as well as others who receive household visits as part of social and child protection activities. While the number of SWOs trained during the pilot project was small relative to CHPS staff (due to time and resource constraints), SWOs' close relationship with caregivers and linkages with daycare centers for children ages 0–3 provided a great opportunity for further engagement (see the full list of platforms utilized for ECD session delivery in Table 3). Note that some platforms, due to meeting length and changing membership/participation, were determined to be appropriate for sensitization (information sharing and some demonstration) versus full session delivery, which requires at least 45 minutes and repeat attendance to complete activities as outlined in the toolkit.

Table 3. ECD Session Delivery Platforms

Platform	Description	Average frequency of meeting	Average length of a session	Level of engagement (session or sensitization)
Mother-to-mother support group	Meeting for mothers attending Community-based Health Planning and Services (CHPS) compound services to learn more about health topics. ECD messages added on to health topics or presented every other meeting.	2 per month	45 minutes	Session
Child welfare clinic	Meeting of caregivers attending routine growth monitoring services. After wellness checks, caregivers receive early childhood development (ECD) messages while reviewing child milestones in child health booklet.	1 per month	30 minutes	Session/ sensitization
Home visit	Community health volunteers (CHVs)/social welfare officers (SWOs) visit homes to complete wellness checks and share health and ECD information/resources. Using the ECD 0–3 brochure, key concepts and recommendations are covered. Caregivers keep brochures for reference.	8 per month	30 minutes	Sensitization
Religious fellowship groups	Group meetings held at religious institutions to discuss important community topics, including health information. With support from community health management committees, community health officers (CHOs) deliver ECD messages (primarily to women's groups).	Weekly	120 minutes	Session/ sensitization

Platform	Description	Average frequency of meeting	Average length of a session	Level of engagement (session or sensitization)
Community meetings	Led and organized by community health management committees to provide the public at large with updated health information. Key ECD concepts and recommendations shared, and caregivers invited to attend full sessions where available.	1 per quarter	30 minutes	Sensitization
Parent/teacher association meeting	Parent/teacher meetings take place at daycares and schools to discuss relevant information on child development. CHOs/CHVs/SWOs attend to review key ECD concepts and invite caregivers to attend.	1 per quarter	60 minutes	Sensitization
Antenatal counseling	CHPS staff share developmental milestones and relevant ECD games to support early stimulation during routine antenatal care.	Daily	10 minutes	Sensitization[14]

In PY3, after hearing about MCSP's ECD program from the FHD, PML Children's Hospital approached MCSP to request support to integrate ECD into its outpatient and inpatient nutrition services. To support scale, sustainability, and investment in adapting ECD to urban settings, MCSP trained nurses from PML Children's Hospital as part of the training of trainers group. The trained nurses went on to provide ECD sessions during nutrition services, which are conducted on a daily/weekly basis at the hospital. The hospital committed staff time and resources to support the trainers to conduct internal step-down trainings (with technical support from MCSP staff). In total, PML Children's Hospital trained 40 people, including dieticians, nurses, physiotherapists, nutritionists, and doctors.

MCSP supported adaptation of the training approach into smaller, shorter sessions to fit the hospital's needs. Additionally, MCSP staff adapted monitoring tools to support the hospital's own assessment of its activities. This approach serves as a model for other hospitals throughout Ghana, thereby promoting institutionalization of ECD programming and increasing sustainability.

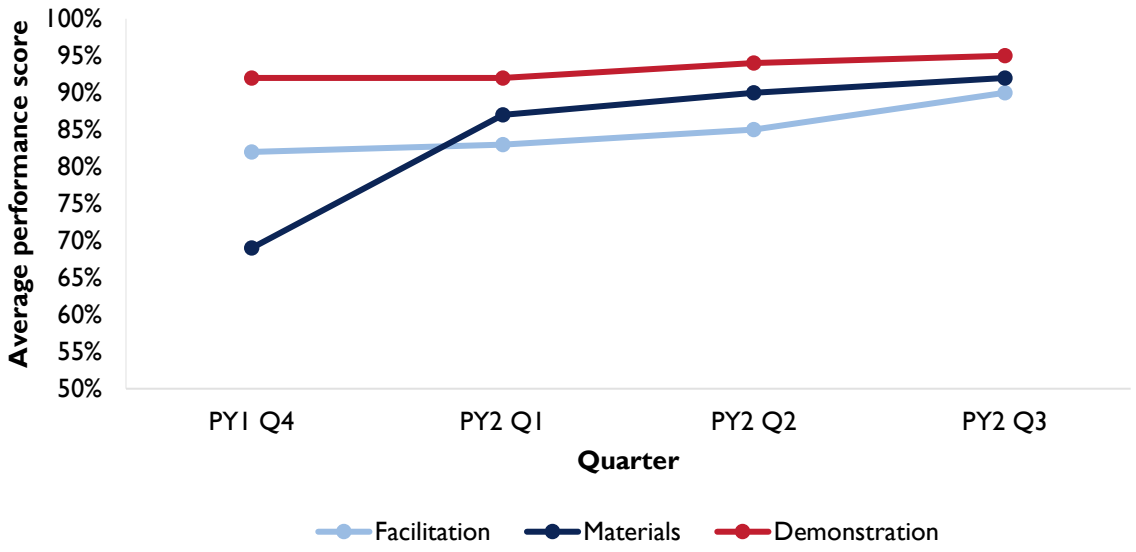
As a result of MCSP's and the GHS' flexibility and ongoing monitoring, the team was quickly able to identify implementation challenges and strategize alternative means to achieve the program aims. By expanding the types of implementation platforms and widening the facilitator pool beyond CHOs and CHVs to include SWOs and PML Children's Hospital staff, MCSP was ultimately able to reach 5,715 caregivers with 0–3 ECD key messages and facilitate early stimulation among 5,006 children. Although the implementation period was short—activities began June 2017 and ended June 2019—MCSP observed significant improvements in caregiver behavior and child development while participating in ECD sessions (see additional details under Objective 3). Future programs can learn from MCSP's process monitoring and documentation to understand field implementation challenges as well as benefits of engaging many cadres/platforms within and beyond the health sector given the multisectoral nature of ECD. Ultimately, the aim of integrated ECD programming should be to meet families where they are and deliver information in an accessible manner.

[14] The frequencies listed in the table represent the opportunities for health workers to deliver ECD messages but not the actual frequency of message delivery.

Supportive Supervision and Mentorship

In addition to supporting training cascades, MCSP also worked closely with regional-level trainers to provide ongoing mentorship and supportive supervision visits to service providers (CHOs and CHVs). During the visits, observers rated session facilitators' performance using the MCSP-developed observation checklist. In total, MCSP observed 50 CHOs during delivery of parenting sessions at MTMSGs and CWCs. By the end of PY2, these 50 CHOs had each received four observation visits. The data show that there was an improvement in CHOs' ability to integrate early stimulation into their activities and to effectively facilitate parenting sessions over time. From PY1 to PY2, CHOs and CHVs improved performance in session topic facilitation from 82% to 94%, material utilization (facilitation materials like flip charts and play materials for children) during the sessions from 69% to 95%, and demonstration of games per age group from 92% to 98%.[15] See Figure 3 for PY1–PY2 comparison.

Figure 3. Average observation checklist scores for community health officers delivering parenting group sessions in Eastern and Upper West regions (n = 50)



Ongoing mentorship led to sustained retention and improvement of key competencies for health workers implementing ECD activities. Mentorship visits and review meetings afforded CHOs/CHVs an opportunity to share their experiences and receive needed support from their peers, their supervisors, and MCSP staff. These platforms were also used to ask questions and address challenges. This approach was part of the program design and was facilitated by MCSP staff and GHS national, regional, and district directorates. Table 4 outlines retention of key competencies from PY2–PY3, comparing PY2 training post-test results with retention checks completed in PY3. Generally, most of the health workers retained key competencies, with very little difference in overall results between Jirapa and Wa West districts, and some decreases in knowledge retention for Nsawam Adoagyiri, which MCSP does not have sufficient information to explain. Future integrated ECD/health programs should consider the importance of ongoing mentorship and its contribution to implementation success. Programs will benefit from designated mentorship time and resources to support similar activities.

[15] Standards for facilitation include CHOs/CHVs are well organized, have clear roles/responsibilities, and actively involve parents in discussions/problem-solving. Standards for materials use include CHOs/CHVs have all materials and display proper utilization of materials. Standards for demonstration include accurate modeling of games and provision of positive feedback/correction on caregiver game practice.

Table 4. MCSP Ghana early childhood development training: average knowledge retention results across assessed health workers

District	Jirapa		Nsawam Adoagyiri		Wa West	
Competency Theme	July 2018 (n = 136)	February 2019 (n = 30)	July 2018 (n = 127)	February 2019 (n = 32)	July 2018 (n = 134)	February 2019 (n = 30)
Overall score	85%	87%	91%	85%	82%	81%
Early brain development	89%	88%	90%	85%	84%	82%
Psychosocial stimulation for children at different ages	78%	85%	93%	84%	76%	80%

Objective 3: Assess the ability of CHPS staff, CHVs, and SWOs to integrate early childhood activities into their routine services and document changes in caregiver behaviors and child development.

Overview

Using a longitudinal mixed-methods approach, MCSP documented changes in perceptions and practices around psychosocial stimulation and responsive care among frontline health workers and caregivers of children ages 0–3 participating in ECD activities. MCSP also assessed and compared different platforms for delivering ECD messaging across the two regions (Upper West and Eastern)[16] to identify the strongest platforms for delivery in Ghana across different geographic areas and cultural contexts. Tools used and samples obtained are described in detail in the following sections (also please see the *Ghana ECD Learning Report and Brief* for more information).

Perceptions of ECD Programming

Health Workers

FGDs were used to understand health workers' perceptions on the benefits and challenges of this new program in more depth. FGD guides included approximately 10 discussion questions related to rollout of the program, perceived value of the initiative, and perceived changes in caregiving practices in target communities. Between July–August 2018 and February 2019, 191 health workers (132 CHOs and 59 CHVs) were included in 51 FGDs.

At the outset of the program, MCSP set a target for CHOs/CHVs to hold ECD sessions twice per month, ideally, or once per month at minimum. When asked about the frequency of ECD sessions, health workers in Upper West and Eastern regions from PY1 and PY2 communities most commonly reported that their ECD groups met once per month. A minority of health workers reported meeting every other week or once per week. The most common reasons cited for meeting once per month were that CHOs had multiple groups to cover or that parents could not attend meetings once per week/biweekly due to their other responsibilities. Health workers commonly reported holding ECD sessions during CWCs and MTMSGs. Overall, CWCs were reported more often than MTMSGs, and only a few health workers reported holding meetings in other locations, such as during RFGs. Overall, CHPS staff did not raise issues about the additional burden of the ECD sessions. This could have been due to the implementation flexibility, which allowed them to set meeting frequencies and locations that were appropriate for their workload.

Regarding attendance, health workers generally suggested that attendance had been increasing over time. For example, a CHV from Upper West noted, "When we started initially, most mothers do not even attend, but

[16] PY3 regions (Upper East and Central) were not included in the assessments, as expansion began in January 2019 and did not afford time to complete assessments before the end of field implementation.

after some several parenting sessions, the attendance increased. This was because of the benefits derived from the program. They all now actively participate in all sessions we organize; this has made every session easier for us as volunteers. Some of their husbands bring their children for CWC and ECD sessions when the child's mother is busy at home or on the farm."

While in many cases attendance at MTMSGs and CWCs increased, other groups found it difficult to determine a time that worked well for all participants. Another challenge included the language of session delivery. Some CHOs reported difficulty with delivering the sessions because they did not speak the mother tongue of the group participants. This issue was raised in both Upper West and Eastern. One CHO from Eastern Region stated, "I can't speak Twi very well, and so during the sessions, expressing myself for the mothers to understand was not easy. They can't speak my language, and most of them do not understand English either, so I had to try my best to speak the Twi into details for them to understand. I can express myself, but because of language barrier, it was not easy."

In terms of the impact of the sessions on caregiver behavior, many health workers stated that there was a reduction in harsh discipline but also noted that behavior change like this takes time. A CHO from Eastern Region stated, "When you go to the field to check whether learning has taken place or not, you would see that the beatings and insults have minimized." Health worker perceptions of ECD sessions function and the benefit to caregivers can help MCSP and other ECD partners to address cultural and systemic implementation challenges that were not previously considered. These findings reveal important considerations for group session structure and key entry points to reach caregivers of children ages 0–3. Future ECD programming should take stock of venues that are convenient for caregivers to encourage regular participation (please see Recommendations section).

Caregivers

FGDs were used to understand caregivers' perceptions of the benefits and challenges of this new program in more depth. FGDs included approximately 10 discussion questions related to rollout of the program, perceived value of the initiative, and perceived changes in caregiving practices in target communities. A total of 158 caregivers from Upper West and Eastern regions participated in 22 FGDs. Each focus group contained a maximum of eight participants.

FGDs with caregivers revealed a number of different ways in which parents perceived they changed their practices due to participation in the MCSP Ghana ECD sessions. The most common change caregivers from Eastern and Upper West reported was using less harsh discipline. A caregiver from Upper West said, "The ECD activities have impact on us and our children in the sense that at first, parents use to insult and beat children to correct them when they do things wrong. This used to make children be afraid of their parents and don't get close to them. When parents call their children, they easily refuse to come with the mindset that the parents will beat them. But with the introduction of the ECD activities, which have made parents resist from using insults and beatings on their children, this has made these children feel courageous and fearless, making the bonding of children to parents very strong." This corroborates health workers' perception of behavior changes in caregivers and provides helpful information on what topics should be emphasized moving forward.

The second most common behavior change reported was engaging in more play and early learning activities with children. A caregiver from Upper West stated, "What they taught is good. We used to have our children, but we do not know how to play with them, but with the program now, we know at every stage of your child development, this is how you should play with that child."

Following discipline and play behavior change, caregivers most often gave examples of improving health practices, such as handwashing before feeding children and use of mosquito nets. A caregiver from Eastern Region stated, "They taught us to wash our hands with soap under running water before playing with our babies because the baby can put our dirty hands in their mouths. That's the topic I like. I have learned how to keep my baby neat."

One challenge highlighted by caregivers in several communities related to spreading the word about sessions so that more mothers would attend. Caregivers suggested that some parents were not benefiting from the sessions because they were not actively in contact with the health centers. They suggested that it would be helpful to make stronger connections with local leaders and religious groups to share information about the sessions and encourage stronger caregiver participation. A caregiver from Eastern Region stated, "From birth to one and half years, women are committed to the weighing. At that time, they get the vaccinations and teaching on how to cater for the children. From that point, they no more attend the weighing, so as for my opinion is that we should notify elders of the various towns, announce, and do it for everyone to benefit from it. With that, it would not only be beneficial to mothers with children from birth to one and half year but to everyone." This important insight can help determine the best entry points to reach more caregivers.

Overall, this information from caregivers and health workers suggests that the MCSP Ghana ECD program has contributed to positive changes in caregiving behaviors and that continued attention to psychosocial stimulation is necessary. Health workers and caregivers report decreases in harsh discipline practices and increases in play, representing a substantial improvement in children's home environments. However, caregivers also reported behaviors such as giving their child a toy to stay occupied while they finished their chores and did not report any feedback related to the more nuanced play and stimulation messages included in the ECD session material (e.g., differentiated activities by age). This suggests that caregivers are beginning to change their childcare behaviors but that repeated inputs on these topics are necessary for them to fully internalize all program messages. This finding is consistent with other behavior change research that suggests multiple exposures are necessary to drive sustainable behavior change in adults.

Caregiver Practice of Psychosocial Stimulation and Child Development

To document changes in caregiver behaviors and child development over time, MCSP deployed a caregiver survey that included a detailed questionnaire about childcare practices and the short form of the Caregiver Reported Early Development Instruments (CREDI).[17] Two subdistricts in Eastern Region and six subdistricts in Upper West Region were randomly selected for inclusion in the study. Within each subdistrict, 10 communities were randomly sampled, and 12 families per community were interviewed. In total, MCSP interviewed 253 caregiver-child dyads at both the baseline and endline. Results from the caregiver questionnaire exhibit significant increases in use of learning materials and play-based caregiving practices in both regions (see Table 5).

Table 5. Stimulation and care practices in the past week (N = 253)

	Baseline (July 2017)	Endline (February 2019)	Significant difference
Average number of stimulation/care activities in the past week (out of eight)	3.3	4.0	**
Read	16%	27%	**
Tell story	24%	29%	
Sing	68%	67%	
Take outside	57%	70%	**
Play	39%	59%	***
Draw/write	19%	45%	***
Teach	34%	50%	***
Hug	79%	80%	

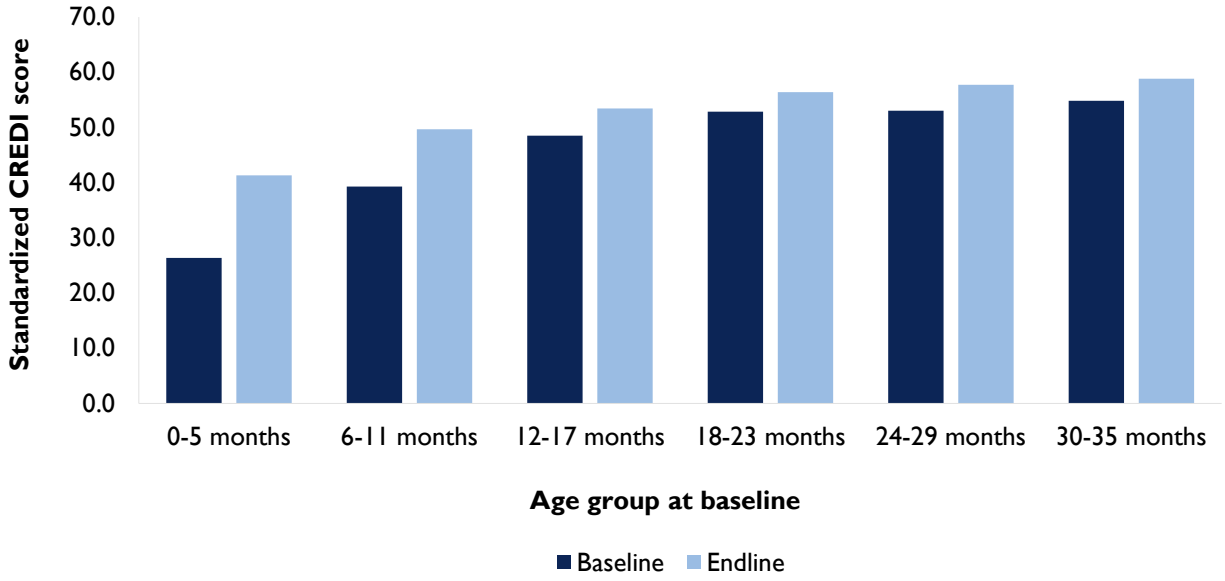
Note: **p < .01, ***p < .001

[17] CREDI has been piloted in 17 low-, middle-, and high-income countries. Results from these pilot suggest that the CREDI short form is a valid and reliable way to measure children's skills and behaviors. CREDI is an open-source tool and consists on a caregiver report format that requires limited training and implementation time. The tool measures motor, cognitive, and socioemotional skills of children under 3 living in low-resource settings. See: McCoy DC, Waldman M, CREDI Field Team, Fink G. 2018. Measuring early childhood development at a global scale: Evidence from the Caregiver-Reported Early Development Instruments. *Early Child Res Q*. 45:58-68. doi: 10.1016/j.ecresq.2018.05.002.

On average, at endline, caregivers reported engaging in four types of learning or play activities with their children in the past week. The most common activities were hugging children, taking them outside, and singing to them, and the least common were reading stories and telling them stories. There were significant changes from baseline to endline in the average number of stimulating caregiving practices (3.3 versus 4.0), particularly in activities such as playing with their children (39–59%) and drawing or writing with them (19–45%). At baseline, caregivers in Eastern Region were significantly more likely to report engaging in activities such as singing with their children or hugging them compared to caregivers in Upper West Region. At endline, the only significant difference between regions was observed in drawing or writing, with caregivers in Upper West more likely to report these activities.

Data from multiple sources also suggest that children are already benefiting from improvements in caregiving practices and home environments. This study cannot make causal inferences about impact of the program on children, but trends in quantitative and qualitative data suggest the MCSP Ghana ECD program is contributing to positive development for young children. CREDI data display significant improvements in overall child development in both regions over time. The largest developmental progression was observed for the youngest group, 0–5 months (see Figure 4).

Figure 4. Changes in child development by age group (n = 253)



Taken together, the caregiver questionnaire and child development assessments provide information on important predictors of child development. Multivariate regression analyses that include variables from the caregiver questionnaire find that age, number of reading materials, number of caregiving practices, and an acceptable dietary diversity were significantly positively related to child development scores (Figures 5 and 6). These results reinforce research shared by the global ECD community: Children who receive appropriate health, nutrition, psychosocial stimulation, and responsive care are the mostly likely to achieve optimal development.[18] In summary, MCSP found three key findings following the multivariate regression analysis:

- Children whose caregivers reported engaging in more psychosocial stimulation and responsive care practices displayed stronger overall development compared to children of caregivers who reported fewer caregiving practices.
- Children whose caregivers reported having access to more reading materials displayed stronger overall development compared to children of caregivers who reported having access to fewer reading materials.

[18] Black MM, Walker SP, Fernald LCH, et al. 2017. Early childhood coming of age: science through the life course. *Lancet*. 389(10064):77-90. doi: 10.1016/S0140-6736(16)31389-7.

- Children whose caregivers reported providing their child with an acceptable dietary diversity (four or more food types) showed stronger development than children with a poor dietary diversity.

Figure 5. Relationship between child development and caregiving practices

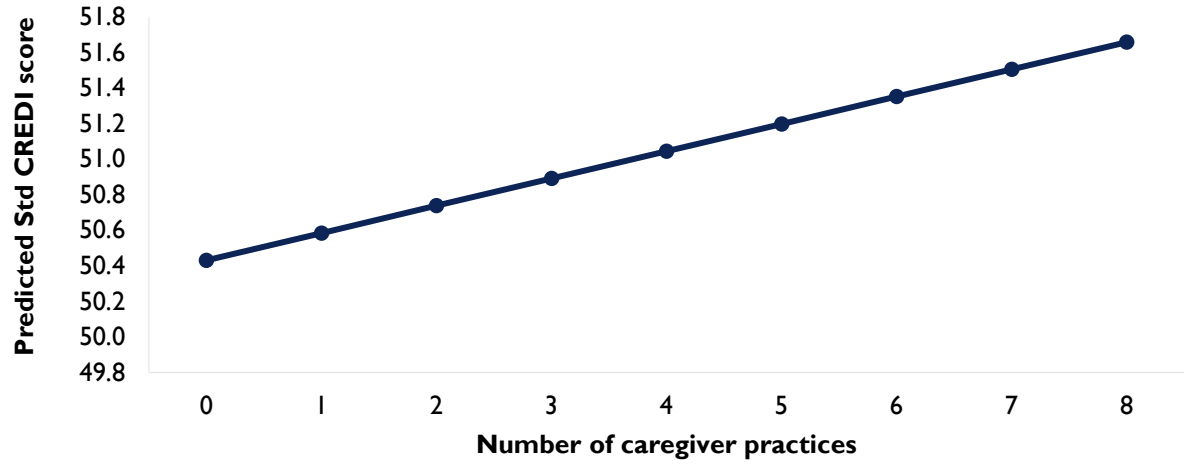
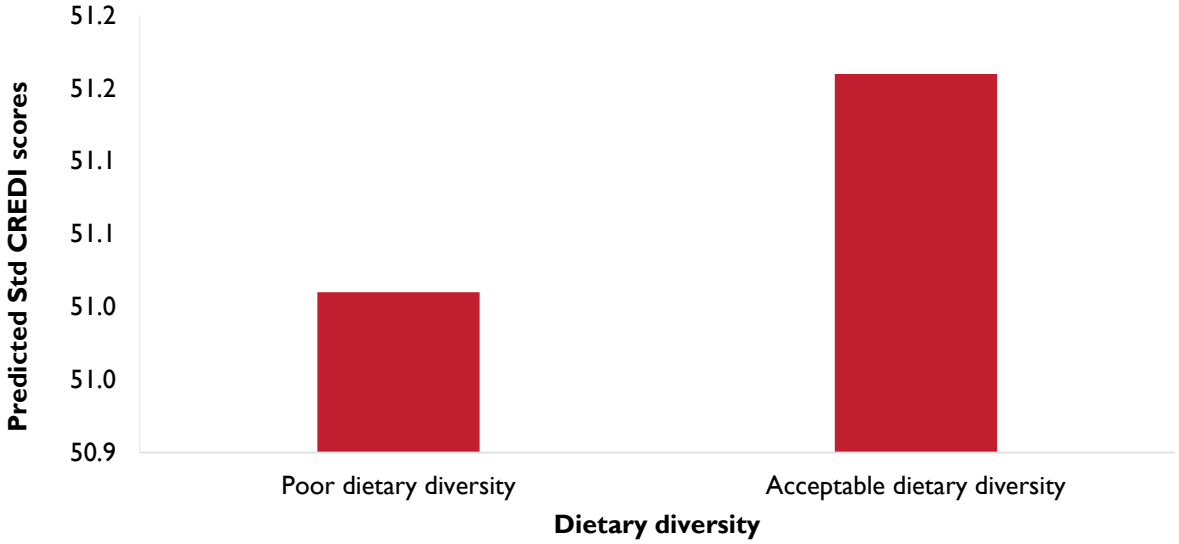


Figure 6. Comparison between children dietary diversity and child development



Implementation Platforms

The various regional implementation approaches for the delivery of ECD content (MTMSGs, CWCs, RFGs, etc.) were documented and compared across rural and urban settings supported by MCSP (see Table 3 for details on each platform). A qualitative approach was used to investigate the viability of these implementation platforms. A sample of 18 CHPS staff were interviewed in three districts in Eastern (Upper West Akim, Ayensuano, and Akwapim South) and three in Upper West (Nadowli, Wa, and Sissala West). Data were also obtained from quarterly review meetings, during which MCSP used a participatory approach to document and assess how ECD sessions were being implemented through alternative platforms in the urban settings across different subdistricts. As part of the quarterly review meetings, CHOs were facilitated to discuss specific successes and challenges reported and ways forward.

Findings show that in some cases, platforms were used to disseminate the full ECD sessions, while in others, they were used for sensitization only. MCSP defines sensitization as sharing of messages in the MCSP Ghana ECD materials but not following the full intervention delivery protocols. CHPS staff delivered the full sessions in four out of eight platforms (MTMSGs, CWC, RFGs, and father-to-father support groups [FTFSGs]), completed sensitization on ECD, and referred caregivers to full session platforms in seven out of eight platforms (MTMSGs were used for full implementation only).

The findings provided MCSP and partners with a clearer understanding of which platforms were most useful for dissemination of ECD messages across different community settings in Ghana. Before the start of the MCSP Ghana ECD program, MTMSGs were identified by program staff and local GHS partners as the target delivery platform for ECD sessions. Stakeholders believed that this would allow CHPS staff to leverage the existing platforms at their health compounds to engage with caregivers of children ages 0–3. However, although MTMSGs were established in all communities, program implementers found that these groups were inactive or did not exist in some places, particularly in urban settings. This posed a challenge to delivering ECD sessions in urban settings, requiring CHOs to explore other platforms to deliver ECD messages to targeted caregivers. Qualitative evaluation data identified CWCs as the most frequently used platform. While some caregivers did not participate in MTMSGs, the majority of families regularly attended CWCs for growth monitoring and nutrition information. The CWC platform is also viable for CHPS staff because they already provide routine services for children ages 0–3 through this medium.

In addition to helping better contextualize the ECD program within Ghana, the assessment also highlighted key platforms for information dissemination in urban and rural communities. Utilizing different platforms empowered multiple community groups to deliver messages about the importance of psychosocial support and playful parenting, which are ideal for enabling behavior change. The platforms identified can be leveraged during future sensitization activities for ECD or other health and nutrition topics. Please refer to Appendix E for additional details on this topic.

Objective 4: Create an enabling environment at the national and regional levels to promote institutionalization of ECD activities into partner and government programming.

MCSP promoted institutionalization of ECD activities at the national and regional levels in Ghana through technical support and partner collaboration. In previous years, ECD services tended to focus more on the preschool years (ages 4–5) and the importance of preparing children for primary school, with limited attention to cognitive stimulation and responsive caring for children under age 3. However, there has been increased attention on children under age 3 globally following the release of *The Lancet*'s ECD series (2016) and launch of the NCF. Leveraging this momentum, MCSP played a central role in convening partners to develop, adapt, and finalize key technical documents and share lessons learned from program implementation through national fora. (See Table 6 for a full list of key technical documents and Table 7 for a list of conferences and workings groups that MCSP supported.)

Particularly important was MCSP's support for and participation in the first Maternal and Child Health and Nutrition Conference organized by the GHS' FHD. MCSP made a presentation during the conference that highlighted the activities of the Ghana ECD Program and organized a booth showcasing ECD activities and the *Ghana ECD Toolkit*. The homemade play items attracted attention and received commendations from partners, who liked the grassroots approach to targeting the community. At the conference, MCSP supported the MOH's national launch of the NCF, following the global launch in Geneva on May 21, 2018. MOH convened the event with support from MCSP, USAID, UNICEF, UNFPA, and WHO. The event marked an important turning point in prioritization of ECD 0–3 in Ghana and provided a valuable opportunity for MCSP to share lessons learned from implementation of an integrated ECD program.

Later in 2018, MCPS partnered with the GHS in the successful official, national launch of the MCSP *Ghana ECD Toolkit*. Present at the launch were all of MCSP's local partners, which included the GHS; USAID; the

Ministry of Gender, Children, and Social Protection; UNICEF; UNFPA; USAID Communicate for Health; USAID Systems for Health; PATH, the Japan International Cooperation Agency, and the Paediatric Society of Ghana. The event served as another key moment to discuss rollout of the NCF in Ghana and the National 0–3 ECCD Standards. The launch of the MCSP *Ghana ECD Toolkit* was timely, as it served as an example of how to operationalize the NCF. As part of the launch event, MCSP presented an eight-point call to action on ECD 0–3. The call to action was co-authored by MCSP and the GHS to draw attention to the importance of ECD and areas for prioritization and improvement. During the meeting, partners endorsed the document and expressed commitment to the call to action messages and advocacy points.

To further support national-level rollout of the NCF, MCSP supported the FHD and other partners to organize a media orientation workshop and ECD stakeholder event in January 2019. The media workshop, organized under the theme Investing in the Future, had the overarching goal of orienting media practitioners on the science, significance, policy, and practice of ECD. Additionally, the workshop served as an opportunity to reinforce media practitioners' capacity to research, report on, and advocate for widespread adoption/practice of responsive parenting, brain stimulation, and interaction among parents or caregivers and their young children. Resource people from the GHS' FHD, MCSP, UNICEF, UNFPA, and WHO encouraged the media practitioners to prioritize stories that capture the essence and relevance of nurturing care, early child stimulation, and responsible and responsive parenting. The ECD stakeholder event served as an opportunity to orient representatives from all 10 regions in the country to the NCF. Other partners, such as UNICEF, UNFPA, and the USAID-funded Communicate for Health project, also attended. Participants were taken through an overview of the NCF and how to position the services to roll them out nationwide. MCSP had the opportunity to present on program deliverables, successes, and lessons learned. MCSP supported the district director of Nadowli/Kaleo in Upper West Region to present on the program's activities in the district. The district director shared benefits derived from implementing ECD, including increased attendance at CWCs, and revitalization of MTMSG meetings. Participants from the six regions of the country that are not included in the MCSP pilot expressed interest and requested to be included in the program. A regional director from Northern Region who was present at the orientation meeting expressed his strong will to look for his own funding to implement ECD in the region.

In addition to national-level dissemination of program findings, the MCSP team capitalized on opportunities to disseminate the results at global conferences. MCSP staff shared insights on operationalizing the NCF in Ghana at the ZERO TO THREE Conference in Denver (October 2018), the Africa Early Childhood Network Annual Conference in Kenya (October 2018), the Comparative and International Education Society Conference in San Francisco (April 2019), and the International Step by Step Association (June 2019). Note that these international conferences were not supported by MCSP funds but rather leveraged external opportunities for dissemination of this program's findings.

Table 6. Key early childhood development (ECD) technical documents

ECD Technical Document	Purpose	Partner(s)	Status
National Early Childhood Care and Development 0–3 Standards	Set national standards for early childhood care and development to ensure that children ages 0–3 receive basic services in the areas of health, education, and protection.	MOGCSP GHS FHD	MCSP engaged in the review process and validation meetings. The document was launched in May 2019.
National Newborn Health Strategy	Revise national strategy for newborn health to reflect updated needs and approaches. ECD included to support monitoring of development milestones and guidance on early stimulation, ensuring children survive and thrive.	MOGCSP GHS FHD	Document finalized and launched at the National Newborn Conference in August 2019.

ECD Technical Document	Purpose	Partner(s)	Status
ECD 0-3 Call to Action	Co-authored by MCSP and the GHS' FHD to garner support and investment from Government of Ghana agencies and partners to prioritize ECD 0–3 in upcoming programs and budgets to achieve the goals set forth in the Nurturing Care Framework.	MOGCSP GHS FHD UNICEF UNFPA JICA WHO Ghana Education Service	The call to action was endorsed by partners and distributed during the Nurturing Care Framework stakeholder meeting held in January 2019.
National Nurturing Care Strategy	National strategy for Ghana to roll out nurturing care across multiple sectors.	MOGCSP GHS FHD UNICEF UNFPA	Discussed development of Nurturing Care Framework strategy during a stakeholder meeting. Participants had the opportunity to share their priorities. UNICEF has offered to fund a consultant to develop this work.

Abbreviations: FHD = Family Health Division; GHS = Ghana Health Service; JICA = Japan International Cooperation Agency; MOGCSP = Ministry of Gender, Children, and Social Protection; UNFPA = United Nations Population Fund; WHO = World Health Organization

Table 7. National early childhood development (ECD)/health conferences

Key ECD Conferences/Working Groups	Description	Partner(s)
"**Strengthening Partnership for achieving Universal Health Coverage in Reproductive Maternal, Newborn, Child, and Adolescent Health and Nutrition**" First Annual National Maternal and Child Health Conference	June 11–14, 2018 • Reviewed progress of implementation of activities for the year 2017. • Provided a platform for sharing innovations, best practices, and lessons learned. • Provided technical updates on new policies and strategies for reaching unreached populations with routine services for maternal, newborn, and child health. • Built consensus on systems for improved coordination and collaboration to foster collective action toward set targets and goals.	GHS
"**Investing in the Future"** National stakeholders meeting on implementation of the Nurturing Care Framework in Ghana	January 30, 2019 National stakeholder meeting raised awareness and mobilized public support on the importance of nurturing care in ECD. The meeting brought together key relevant stakeholders and partners from health, nutrition, education, gender, and social protection, and representation from the private sector.	GHS MOGCSP UNICEF UNFPA
"**Investing in the Future**" Media Orientation Workshop	January 29, 2019 National media sensitization meeting with key media personnel, aimed at raising awareness and mobilizing public support on the importance of nurturing care and building the capacity of the media to report on ECD topics.	GHS MOGCSP UNICEF UNFPA

Key ECD Conferences/Working Groups	Description	Partner(s)
"**Improving Nutrition Services in the Care of the Ill and Vulnerable Newborn and Child"** USAID MCSP nutrition conference	October 30–November 2, 2018 Workshop focused on identifying key barriers and opportunities for strengthening nutrition services delivered to children under 5 years old through routine management of illnesses in household, community, and primary facility levels. • Shared successful practices in implementing current policies and guidelines. • Reviewed persistent barriers to the provision of adequate nutrition interventions during the management of illnesses in children under 5 in primary health care settings and identify reasons for their persistence. • Reviewed nutrition practices for low-birthweight/small-for-gestational-age/premature newborns to optimize human milk and breastfeeding. • Prioritized the most critical barriers and develop key actions to address them.	USAID WHO UNICEF
Newborn Health Strategy Review Meetings	Regular meetings throughout 2018 Following a review of the implementation process, a bottleneck analysis was conducted to identify key barriers to accelerate the rate of decline in neonatal mortality in the country. A stakeholders meeting was conducted to agree on priority areas to be covered under the new strategy. This culminated in the development of a near-final draft of a new strategy for the period 2019–2023.	GHS
Consensus Building Meeting on Revised National Newborn Health Strategy	March 5, 2019 Part of the process to revise the National Newborn Health Strategy in 2018. The consensus-building forum took place to validate the draft document before it finalization.	GHS
GHS/MCSP National Launch of the ECD 0-3 Toolkit	November 6, 2018 MCSP and the GHS Family Health Division launched the ECD 0–3 materials, orienting key stakeholders on usage.	GHS MOGCSP UNICEF UNFPA Red Cross
National ECC Training and Orientation Workshop	January 17–18, 2019 Hosted by the MOGCSP with the support of UNICEF, this meeting brought together members of the National ECCD Coordinating Committee from education, health, social welfare agencies, and local government to orient them to their roles on the committee. MCSP presented on achievements to date.	GHS MOGCSP UNICEF UNFPA Red Cross

Abbreviations: ECCD = Early Childhood Care and Development; GHS = Ghana Health Service; MOGCSP = Ministry of Gender, Children, and Social Protection; UNFPA = United Nations Population Fund; WHO = World Health Organization

Recommendations and Way Forward

The MCSP Ghana ECD 0–3 Program demonstrated that frontline health workers can be effectively mobilized to deliver ECD sessions as part of their routine activities to provide holistic care for improved child health outcomes. The approaches used by MCSP promoted sustainability through integration into existing structures of the GHS. MCSP recommends the considerations for future ECD programming undertaken by the Government of Ghana, the GHS, and partners:

Platforms and Attendance

- Communities have different needs and schedules, and it is important for providers to take the time to understand these needs when seeking to integrate parenting education into existing community platforms. Building onto existing groups is a good place to start.
- It is important to understand the language needs of the community members. As much as possible, content should be delivered in mother tongue to maximize behavior change potential. For a program like this in the future, this might mean that CHVs deliver the content with oversight and supervision from CHOs.
- It is important to continue with the approach of reaching parents through various entry points and platforms. The health sector provides the best promise for leadership of the integrated ECD programs for this target age range, but no one entry point will be adequate for serving all children. Cross-sectoral collaboration and linkages will also strengthen the impact of such programs because the key messages are reinforced when parents hear similar messages from multiple sources. Parenting groups led by frontline health workers can be complemented with other efforts to reach parents through outlets such as church groups, home visits, or social media.
- It should be recognized that the same intensity of programming may not be possible throughout the country and can range from frequent, concurrent group sessions to one-time sensitization meetings. Implementers should account for this difference and plan for both levels of engagement.
- Future programs would benefit from finding ways to further motivate caregivers to attend the sessions. Certificates of completion or recognition at community events can be used to motivate and encourage mothers who attend all sessions and as a form of encouragement for others to attend more frequently. There is also potential to train mothers to serve a "co-facilitator" role to encourage even greater buy-in. The Lively Minds program utilized this approach with positive results.

Behavior Change

- Quantitative and qualitative data outlined under Objective 3 suggest that the program made substantial contributions to behavior change for caregivers of young children in urban and rural areas of Ghana. However, global research shows that behavior change takes time and reinforcement, and this sentiment was confirmed through feedback from caregivers and health workers. For example, the most common behavior change reported during focus groups was a decrease in harsh discipline. While this represents a substantial improvement in the environments within which children are developing, it suggests that perhaps some of the more nuanced messages about different kinds of play and stimulation activities were not yet internalized by caregivers. Continued focus on these messages will be necessary to fully achieve the desired outcomes of ECD programs such as this. ECD promotion should be conceptualized as ongoing, similar to other health programs for young children.

Training

- Data from training activities and session observation suggest that the supported cascade model used in this project was successful and should be used in future work as well. In addition, the facilitation techniques reinforced in the training activities seem to have supported good practice from frontline health workers and should be continued. The GHS' FHD should organize regional-level workshop for district-level administrators and CHOs to learn from the MCSP experience and draw out a plan for rollout of integrated ECD programming across all CHPS zones in each region. This process can be supported by the eLearning modules developed under MCSP to reduce the amount of time and costs needed for in-person training.
- Future trainings and parenting sessions should continue to include practice and demonstration of activities, as this was appreciated by both frontline health workers and caregivers.
- Future trainings should also carefully consider the differentiated roles of CHPS staff and CHVs within target communities. Different cadres of frontline workers may be more appropriate to lead program delivery in different communities, and as seen with this program, a collaboration between these groups is often needed to fully support activity implementation.
- Future programs should initiate a community of practice where CHVs and field implementers can share their experience, such as through WhatsApp groups or other platforms.

Materials

- Toy-making activities meet a need within communities and were greatly appreciated by caregivers and health workers, so this practice should continue. One option for increasing the availability of toys for use during group sessions would be to hold a session specifically focused on making toys for the group. Caregivers can participate in making toys to be used as a group resource, and the toys can be kept in a small toy bank at the health facility.
- In addition, some funding for ECD should be included in the CHPS budget so as to facilitate the purchase of necessary materials or to replace worn or damaged training materials.

Engaging Male Caregivers

- More specific targeting is needed for fathers. If male participation is low in group settings, finding other ways to reach fathers will be important (e.g., with home visits or through social media outlets). Male participation and contribution are critical for improving men's interactions with children and for facilitating mothers' attendance at sessions and behavior change in the home. Future programs could include mass sensitization and campaigns geared at changing attitudes of fathers.

Research and Evidence

- Future programs should incorporate causal research, such as a randomized control trial, to better understand the impact of integrated ECD programs on children's healthy development in Ghana. This research could focus on questions of dosage and duration of ECD activities—how much input is needed to make significant improvements in caregiving behaviors and child development?
- Strong ongoing monitoring data should also be incorporated into future work, especially programs focused on scaling up of services to help ensure quality. Plans and accompanying budgets should be established before beginning implementation.

National-Level Advocacy and Engagement

- Support the GHS and partners to develop the Nurturing Care Strategy building off of MCSP's experience implementing activities at the community level and at PML Children's Hospital. It will be important for future programs to support cross-sectoral collaboration (including the Ministry of Gender, Children, and Social Protection) in development and rollout of the strategy, putting in place a robust learning agenda and communications strategy from the outset of activities. The learning agenda should explore what can be learned to inform ECD programming at the national level. The communications strategy should consider integrating messages into the GoodLife campaign and the capacity of regional media to accurately report on and promote ECD services. Sensitization of the public at large will be key in successful demand creation and scale-up.
- Support linkages between the GHS and the national ECCD committee. Given GHS' central role in moving forward implementation of ECD 0–3, it will be important to have consistent and intentional communication regarding its strategic direction and lessons learned with other sectors.
- The Ministry of Gender, Children, and Social Protection's Department of Social Welfare needs to be empowered to play its required role to ensure the daycare system is performing as expected. The daycare system does not currently provide adequate ECD.
- The Maternal and Child Health Record Book, launched in 2018, is given to caregivers at health clinics, providing an excellent opportunity for health care providers to sensitize parents on brain development and ECD in addition to the other critical elements of nurturing care, as it has a section on ECD milestones. As health care providers are trained on how to optimally use this important tool, early stimulation and responsive care should also be included in the training and messaging materials.
- Working with the professional associations is needed to integrate the elements of nurturing care into pre-service curricula, particularly for nurses and midwives.

Appendix A. Performance Monitoring Plan

Indicator	Frequency of Data Collection	PY1		PY2		PY3		Cumulative to Date (% of overall project target)	Overall Project Target	Comments
		Target	Actual (% of target)	Target	Actual (% of target)	Target	Actual (% of target)			
Objective 1: Develop and disseminate an evidence-based set of early child development (ECD) materials concentrating on early childhood stimulation and responsive parenting for children under 3.										
1.1: Number of global ECD packages developed and finalized	Annually	1	1	NA	NA	NA	NA	1 (100%)	1	Completed, finalized, and disseminated.
1.2: Number of Ghana-specific ECD packages developed, field-tested, and finalized	Annually	1	1	NA	NA	NA	NA	1 (100%)	1	Completed, finalized, launched at the national level.
Objective 2: Build capacity of Community-Based Health Planning and Services (CHPS) staff, community health volunteers (CHVs), and social welfare officers (SWOs) to effectively teach caregivers with young children about early stimulation and responsive parenting in targeted districts.										
2.1: Number of people trained through US Government-supported programs*	Quarterly	700	719 (103%)	1,276	1,351 (106%)	252	231 (92%)	2,328 (104%)	2,228	Trainings completed.

Indicator	Frequency of Data Collection	PY1		PY2		PY3		Cumulative to Date (% of overall project target)	Overall Project Target	Comments
		Target	Actual (% of target)	Target	Actual (% of target)	Target	Actual (% of target)			
2.2: Percentage of CHVs and community health officers (CHOs) who received at least two supervision visits during mother-to-mother support groups/partner programs	Quarterly	95%	97%	95%	96%	NA	NA	96%	95%	Supervision was conducted for PY1 and PY2 districts. Due to time constraints, PY3 CHOs received only one supervisory visit.
2.3: Percentage of supportive supervision visits where CHOs/CHVs performed correctly at least 85% of the checklist	Quarterly	75%	88%	75%	90%	75%	44%	89%	75%	Due to time constraints, CHOs received only one visit. This value represents those who scored above 85% on the checklist. With continued mentoring and coaching, MCSP expects that they would have performed better on a second supervisory visit.

Indicator	Frequency of Data Collection	PY1		PY2		PY3		Cumulative to Date (% of overall project target)	Overall Project Target	Comments
		Target	Actual (% of target)	Target	Actual (% of target)	Target	Actual (% of target)			
Objective 3: Assess the ability of CHPS staff, CHVs, and SWOs to integrate early childhood activities with their regular nutrition services and document changes in caregiver behaviors and child development.										
3.1: Number of studies completed*	**Annually**	**1**	**1**	**2**	**2**	**2**	**2**	**2 (100%)**	**2**	PY1: Supervision/implementation process (1) PY2: Study on supervision/implementation process and caregiver behavior/child development (2)
Objective 4: Create an enabling environment at the national and regional levels to promote institutionalization of ECD activities into partner and government programming.										
4.1: Number of national-level ECD and child health materials for which MCSP provided technical inputs	Annually	NA	NA	1	2	1	2	4 (200%)	2	In PY2, MCSP offered input on National Early Childhood Care and Development (ECCD) Standards and newborn health strategy (2). In PY3, MCSP helped with the call to action (2).
4.2: Number of national and regional meetings attended	Annually	NA	NA	2	2	2	6	8 (200%)	4	Participated in the Ghana Health Service's Family Health Division Maternal, Newborn, and Child Health Conference, and Seventh Annual Newborn Stakeholder Conference in Ghana. contributed to ECCD guidelines. Participated in the USAID MCSP nutrition conference in Accra (October 30–November 2, 2018). Annual performance review in Upper

Indicator	Frequency of Data Collection	PY1		PY2		PY3		Cumulative to Date (% of overall project target)	Overall Project Target	Comments
		Target	Actual (% of target)	Target	Actual (% of target)	Target	Actual (% of target)			
										West and Upper East regions. Planning meetings for 2019 Maternal and Child Health and Nutrition Conference. Newborn strategy review meetings. Consensus-building meetings on revised national newborn strategy. Task team meetings for Nurturing Care Framework. Nurturing Care Framework implementation in Ghana, media orientation workshop. Nurturing Care Framework stakeholder meeting.
4.3: Number of national-level ECD technical working group or steering committee meetings participated in by MCSP staff	Annually	NA	NA	2	3	NA	2	5 (250%)	2	National Maternal and Child Health Planning Committee, National ECCD Coordination Committee (2), Newborn Health Subcommittee, and the National Child Health Steering Committee (2)

* MCSP global indicator

Appendix B. Progress Results Table

A. Number of children and adults directly served

	October 1, 2018–September 30, 2019			Total Since October 1, 2017*–September 30, 2019 (life of project)		
	Male	Female	Total	Male	Female	Total
Children (age 0–3)	625	630	1,255	2,226	2,780	5,006
Caregiver(s)** (age 18 and over)	100	1,236	1,336	410	5,305	5,715

*Beginning of US Government fiscal year; **These figures are from 27 groups

B. Number of people trained

Category	Number Trained
Trainings of trainers	114
Community health officers	1,251
Community health volunteers	921
Social welfare officers	15
Princess Marie Louise Children's Hospital	27
Total	**2,328**

C. Number of organizations strengthened since the beginning of the US Government fiscal year

	Faith-based	Government	Nongovernmental	Community-based	Other	Total
Total this quarter		2				2
Total since October 1, 2016		2				2

Appendix C. Success Stories

A mother's love expressed through early child development sessions in Ghana

Yellowanah shares a playful moment with her 2-year-old daughter Kezia. Photo by Kate Holt, MCSP.

"My husband and I are blessed to have each other and our two children," says Yellowanah, a subsistence farmer. Having children was important to Yellowanah, but it would be after two miscarriages before she finally delivered her first girl, Kezia. Like most women in Segrivengveng, a rural farming community in Upper West Region, Yellowanah credits her faith and family for the life she enjoys.

For too many children born in this region, their earliest years can be a much-neglected time because parents and caregivers are preoccupied with the high demand of meeting the basic needs of their families. As a result, parents often make little or no time to play and interact with their children. In addition, health centers are miles away and not easily accessible because of the road conditions and poor transport systems. At times, a day's meal is not readily assured. Yet research has demonstrated how important it is for children between the ages 0–3 to receive nurturing care, brain stimulation, and interaction to attain optimal growth, which invariably promote and facilitate future potential and sustainable growth of communities and the society.

Yellowanah observed that her daughter, Kezia, was inactive, a little withdrawn, and generally timid for a 2-year-old. This can be worrying for a first-time mother. Fortunately, 6 months ago, Yellowanah happened to hear about an early childhood development (ECD) session organized by Mubarak Mohamadu, a community health officer (CHO), during the mother-to-mother support group in Segrivengveng. "I started attending the sessions every other week at 3 p.m.," says Yellowanah, adding that she "has not missed a session as we have been meeting under a big tree at the center of the village." During the session, Yellowanah was excited to join other parents and caregivers, who took turns to practice the stimulation activities with their children.

Yellowanah notes that the key message of the CHO was that beyond meeting children's physical needs for nutrition, shelter, and hygiene, young children also need plenty of emotional and cognitive support, love, and nurturing, and she took this message to heart. At every turn, she showed love to Kezia in many ways: cuddling, hugging, and tickling. She also nurtures her with statements of love and reinforcing words of praise. The ECD sessions have indeed nourished the bond of love between Yellowanah and Kezia, creating a connection that many parents crave but may not understand how to create.

Today, her relationship with her daughter is deeper than ever. With her husband's support, Yellowanah joins her daughter to make the toys she can play with when they are busy with their daily routine. Kezia's favorite is a string with two hollow calabash shells that rattle when shook. Yellowanah testifies, "Kezia hardly cries these days, and she wants to play with it all the time." Kezia now shows a desire for exploration, play, and creativity that is supposed to define this part of her life cycle.

In Ghana's Eastern, Central, Upper East, and Upper West regions, the Maternal and Child Survival Program (MCSP) is helping families and communities offset generations of poor health and low educational attainment by integrating ECD into existing health and nutrition activities. By addressing the knowledge gaps in ECD through an education session with mother groups and health services, such as child welfare clinics, MCSP is preventing developmental delays and improving health outcomes for children. Today, many parents like Yellowanah and children like Kezia are enjoying the lifetime benefits of early nurturing care and development.

Increasing Caregiver Attendance of Child Welfare Clinics through ECD

A decade ago, Philippa Mawutor chose to pursue a career in community health, a "career that would change her life for the better."

Philippa at a CWC in Eastern Region. Photo by MCSP Ghana.

Every morning at 8 a.m., Philippa walks about Owurakesim, a community in Asamankese District of Eastern Region, going door to door to serve the vulnerable, especially pregnant women and children. Philippa focuses on organizing the community for preventive and curative health, which includes many different types of activities, but her favorite task is the child welfare clinic (CWC), popularly called "weighing" in Ghana.

The Ghana Health Service (GHS) has shown increased commitment for organizing CWCs throughout the country to sensitize parents on exclusive breastfeeding and nutrition, provide curative care for newborn ailments, increase immunization, and offer vitamin A supplements to newborns. Even so, in most cases, health workers charged to organize CWCs have to deal with recurring low attendance.

For a while now, Philippa was at her wit's end. "I did all I can, but the number of mothers who were coming to the CWC kept reducing," says Philippa. "I even took their phone numbers and called to inform them about the meeting the day before, but some parent will rather go to the farm or for trading."

In August 2018, Philippa had the opportunity to participate in the ECD training, organized by the GHS with the support of the US Agency for International Development through MCSP.

Though it was the first time she was hearing of such an intervention, she "became interested in the whole thing because it was going to be useful to the mothers at her CWC too." Given her interest and enthusiasm, Philippa was selected as a step-down trainer in her district, an opportunity she leveraged to further sharpen her knowledge in early stimulation and responsive parenting.

On her return to her Community-Based Health Planning and Services (CHPS) compound at Owurakesim, Philippa integrated lessons on ECD into the health and nutrition lessons she shares at the CWCs. She emphasized at her CWC sessions that "beyond meeting children's need for nutrition and hygiene, caregivers must also prioritize brain stimulation, unconditional love, and nurturing care." Philippa noticed that "parents and caregivers were pleasantly surprised to find health workers were concerned and teaching them how to play with their children, so they always enjoy the lessons since it made their children very excited." Philippa encourages caregivers to make homemade toys and to make time for routine play with their kids to stimulate their brains.

After a few months of integrating ECD into the CWC sessions, Philippa noticed that the number of parents attending CWC had doubled. The ECD lessons made the CWC lively, interactive, and fun. At last, Philippa found a way to increase attendance at the CWC, her favorite task. Even so, Philippa understands that ECD is not supposed to overshadow or replace the health, hygiene, and nutrition lessons at CWCs but complement them. "So we make time for parents and caregivers to enjoy all these lessons at our CWCs," says Philippa.

Little Anyiyi Takes Her First Steps toward a Promising Life

Matilda and daughter at mother-to-mother support group meeting. Photo by MCSP Ghana.

Matilda Ayinyi is a 25-year-old seamstress in Dabo-Siira, a rural community in Wa, Upper West Region of Ghana. Two years ago, she received news of her pregnancy with a mixture of "excitement and fear." Like most first-time mothers, Matilda was not exactly sure of what it would be like to be a mother, but she was committed to being a good one. For her, children are a gift from God, a gift that must be loved, cherished, and adored. "When I saw my daughter for the first time, I was convinced she is worth all the sacrifice," says Matilda.

Matilda was overprotective of her child, particularly concerned that her child might develop infections while playing with others. Sixteen months after birth, Matilda noticed that her daughter was not able to roll over or even take her first steps. Friends and family also observed this and raised the alarm that her daughter might be lagging behind her age group in motor skills development. For a first-time mother, this situation was worrying.

According to UNICEF, over 200 million children under 5 in developing countries are not receiving enough brain stimulation, nutrition, and protection that they require for optimal growth. This can diminish both the child's growth potential and sustainable development for the society at large. MCSP is working closely with the Ministry of Health to educate parents and caregivers about the best practices in early childhood care and development. MCSP's ECD activities offer lessons that combine brain stimulation, nutrition, protection, and supportive parenting.

Matilda was lucky to meet Desmond, a CHO, who introduced her to the early childcare and development activity organized by the Dabo-Siira CHPS zone for their mother-to-mother support groups (MTMSGs). Mothers and caregivers were encouraged to engage their children playfully through various activities, including storytelling for effective brain stimulation. "We were taught how to use things around our homes to make homemade toys, how to play with our children some games," says Matilda. "I practiced it at home and at my workplace, so now when am sewing dresses for my clients, I give her homemade toys to play with, and I hold her hands to walk," she added. In barely 2 months, Matilda experienced her greatest joy when she saw her daughter walking naturally without support. "The ECD lessons have really benefited our family. Our gratitude to the CHPS workers and USAID." Today, Matilda advocates and even invites other mothers to join the MTMSGs to benefit from the ECD sessions.

So far, MCSP's ECD program has adapted a set of global ECD materials to the Ghanaian context and trained over 2,300 health workers to transfer the best practices in ECD to new mothers in four focal regions: Eastern, Central, Upper East, and Upper West.

Appendix D. List of Materials and Tools Developed or Adapted by the Program

#	Material or Tool Name	Technical Area
1	Ghana ECD 0–3 years Community Health Workers Manual for Parent/Caregiver Sessions	Play, Early Communication, Responsive Care, and Positive Parenting
2	Ghana ECD 0–3 years ECD Flip Chart for Community Health Workers	Play, Early Communication, Responsive Care, and Positive Parenting
3	Ghana ECD 0–3 years ECD Counseling Cards/Mini Flip Chart for Community Health Workers	Play, Early Communication, Responsive Care, and Positive Parenting
4	Ghana ECD 0–3 years Early Stimulation ECD Wall Chart	Play, Early Communication, Responsive Care, and Positive Parenting
5	Ghana ECD 0–3 years Early Stimulation Brochure	Play, Early Communication, Responsive Care, and Positive Parenting
6	Ghana ECD 0–3 years Training of Trainers Guide	Play, Early Communication, Responsive Care, and Positive Parenting
7	MCSP Parenting Session Supervisor Observation Checklist	Play, Early Communication, Responsive Care, and Positive Parenting
8	Ghana ECD 0–3 Call to Action	Play, Early Communication, Responsive Care, and Positive Parenting
9	Ghana ECD 0–3 Learning Report	Play, Early Communication, Responsive Care, and Positive Parenting
10	Ghana ECD 0–3 Learning Brief	Play, Early Communication, Responsive Care, and Positive Parenting
11	Ghana Implementation Platforms Review	Play, Early Communication, Responsive Care, and Positive Parenting

Appendix E. Implementation Platform Review

Introduction

Launched in December 2016, the Maternal and Child Survival Program (MCSP) Ghana Early Childhood Development (ECD) 0–3 Program supported the integration of ECD interventions into existing health and nutrition activities in Ghana.

The program implemented activities through Community-Based Health Planning and Services (CHPS), building upon MCSP's existing activities focused on capacity-building of CHPS health workers for improved health outcomes. The aim of the ECD program was to engage parents and caregivers in stimulation and responsive parenting, in which caregivers respond to their children's physical and emotional needs from birth onward by responding to children's cues, playing, talking, singing, and providing exposure to words and numbers, even before children can talk. MCSP was careful to promote integration of ECD into daily routines to promote frequent, developmentally appropriate interactions between caregiver and child.

Ultimately, the goal of the MCSP Ghana ECD Program was to create a scalable approach that could reach all caregivers of young children with information and training about how to engage in meaningful psychosocial support and play activities with their children. MCSP originally identified mother-to-mother support groups (MTMSGs) as the primary delivery platfom for ECD messages because scoping exercises identified that mothers met regularly through this platform in many communities throughout Ghana. However, once implementation began, it became clear that MTMSGs were not active in all communities, especially in urban communities, and there were numerous other fora through which mothers and other caregivers were meeting regularly. The employment and social activities of families living in urban and rural communities across Ghana vary widely, so to maximize the potential reach and success of the program, MCSP empowered local CHPS staff to leverage different implementation platforms for the delivery of ECD content based on the needs of their community. This appendix describes the perceived strengths and weaknesses of the different platforms used across rural and urban settings from the perspective of CHPS staff who have been leading implementation.

Methods

Qualitative methods were employed to document stakeholder perspectives on the feasibility and acceptability of these implementation platforms. A random sample of 18 CHPS staff were interviewed from three MCSP-supported districts in Eastern (Upper West Akyem, Ayensuano, and Akwapim South) and three in Upper West (Nadowli, Wa, and Sissala West). Data were also obtained from quarterly review meetings with CHPS staff, during which MCSP used a participatory approach to document and assess how ECD sessions were being implemented through alternative platforms in urban settings across different subdistricts. As part of the quarterly review meetings, MCSP staff facilitated discussions with community health officers (CHOs) to discuss specific successes and challenges related to implementation and find ways forward. A structured questionnaire was used to interview CHPS staff, and data were analyzed using the content analysis and descriptive approach.

Findings

Platforms for ECD Session Delivery

Table E1 outlines the diff erent platforms that were used by CHPS staff to deliver ECD messages to caregivers with children ages 0–3 years, including MTMSGs, child wellness clinics (CWCs), home visits, religious fellowship groups (RFGs), father-to-father support groups (FTFSGs), community meetings known as *durbars*,[19] parent-teacher association meetings, and counseling during antenatal care. Analysis of data showed that in some cases, these platforms were used to disseminate the full MCSP Ghana ECD Program materials, while in others, they were used just for sensitization. CHPS staff in rural settings more often delivered the full ECD content, compared to those in urban settings. MCSP defined sensitization as sharing messages found in the MCSP Ghana ECD materials but not following the full intervention delivery protocols. For example, a full intervention includes implementation of all steps of a parenting group session, including discussion and practice of early stimulation activities, while sensitization focuses only on delivery of key messages on early stimulation and is less intense.

A caregiver participating in a church early childhood development session. Photo by MCSP.

CHPS staff delivered the full intervention of the MCSP Ghana ECD Program in four out of eight platforms, whereas CHPS staff were able to complete basic sensitization on ECD (and refer caregivers to full session platforms) in seven out of the eight platforms. The CWC was the most frequently used platform because some mothers who did not belong to an MTMSG would still bring their children ages 0–5 to the CWC for growth monitoring and nutrition information. Additionally, CHPS staff leveraged the school health program to engage parent-teacher associations for sensitization sessions. The use of the CWC was the most successful because it is a routine service provided by CHPS staff. Between PY1 and PY2,[20] program documentation indicated that there was an increase in the different types of platforms being used to deliver ECD messages in both urban and rural setttings.

Table E1. Platforms for ECD session delivery

Platform	Description of platform	Average frequency of meeting	Average time spent on a session	Type of delivery (full session or sensitization[21])
MTMSG	A group of 25–30 women of any age come together at CHPS compounds to learn about and discuss issues of infant and young child nutrition and health.	2 per month	45 minutes	Session
CWC	A clinic within a health facility that allows parents to bring children younger than age 5 to get weighed and immunized with Ghana Health Service-approved vaccines.	1 per month	30 minutes	Session/sensitization
Home visit	Direct visit to homes of community members as part of routine activities to achieve universal health care.	8 per month	30 minutes	Sensitization

[19] *Durbar* is a traditional type of community meeting that in MCSP was organized by community leaders and community health management committees specifically for the CHPS staff to deliver health messages to the community.
[20] PY1 (December 2016–February 2018), PY2 (March–December 2018), PY3 (January–June 2019)
[21] Sensitization is defined as sharing messages found in the MCSP Ghana ECD materials but not following the full intervention delivery protocols.

Platform	Description of platform	Average frequency of meeting	Average time spent on a session	Type of delivery (full session or sensitization[21])
RFGs	A church community group that meets once a week outside of the worship day of the church. This platform was only used in Eastern Region.	Weekly	120 minutes	Session/sensitization
FTFSGs	A group of men of any age within the community who come together to learn about and discuss isues of infant and young child nutrition and health. This platform was only used in Upper West Region.	1 per month	30 minutes	Session/sensitization
Durbar (led and organized by community health management committee)	Formal community gatherings that prpvide information and build consensus on issues of importance to the community.	1 per quarter	30 minutes	Sensitization
Parent-teacher association meeting	Formal meetings for parents and teachers in primary schools to discuss issues concerning the children.	1 per quarter	60 minutes	Sensitization
Counseling during antenatal care	Provides women and their families with appropriate information and advice for a healthy pregnancy, safe birth, and postnatal recovery, including care of the newborn and promotion of exclusive breastfeeding.	Daily	10 minutes	Sensitization

Feasibility of Implementation Platforms

Table E2 displays a summary of the information observed and received about the feasibility of different platforms for delivering ECD messages in urban and rural communities in Ghana. Full session delivery requires that the group meets regularly and the same participants attend each meeting. This was found to be possible with MTMSGs, CWCs, RFGs, and FTFSGs. The drawback to these platforms was that they were not operating in all communities, with the exception of CWCs. However, full session delivery was not possible at CWCs in all communities because in some contexts, different groups of parents attended the CWC at each meeting. This was especially common in urban areas, where parents were often too busy to attend regularly or to stay for the entire session (e.g., their work schedule did not allow regular time off to attend the sessions). In contrast, routine health services, like home visits and antenatal care counseling, were present in all communities; however, due to health workers' time constraints with these activities, they were found to be effective platforms only for sensitization activities. For example, all families with young children receive home visits from CHPS staff, but they only receive two visits per month, and there are multiple topics that must be covered in a short period of time. Therefore, basic information about ECD can be provided, but it is not possible to deliver the full package of ECD materials.

Table E2. Feasibility of platforms

Platform	Type of delivery (session or sensitization[22])	Urban communities	Rural communities
MTMSGs	Session	Mixed success; not active in all communities	Well established or able to be revived and serve as a consistent platform for full session delivery
CWCs	Session/sensitization	Many families attend; in some cases, only sensitization occurs because families are too busy to stay for full session	Many families attend; able to be used for full session delivery
Home visits	Sensitization	Consistent platform (routine activity for health care workers); sensitization only	Consistent platform (routine activity for health care workers); sensitization only
RFGs	Session/sensitization	Found in Eastern Region only; full session and sensitization possible	Found in Eastern Region only; full session and sensitization possible
FTFSGs	Session/sensitization	Not found in urban areas	Well-established groups in Upper West only; full session and sensitization possible
Durbars (led and organized by community health management committee)	Sensitization	Sensitization only possible in some communities	Sensitization possible
Counseling during antenatal care	Sensitization	Consistent platform (routine activity for health care workers); sensitization with poster is possible	Consistent platform (routine activity for health care workers); sensitization with poster is possible

Conclusion

- The two most commonly used platforms for delivery of full ECD sessions were MTMSGs and CWCs. MTMSGs existed in many communities before the start of the MCSP Ghana ECD Program, and the majority of mothers in the group had children ages 0–3 (target age group). In communities where MTMSGs were not active, CWCs often served as an effective delivery platform.

- In some communities, health workers used multiple platforms to deliver ECD messages. For example, full sessions were delivered through MTMSGs, and sensitization occurred at CWCs. This was reported to improve the depth and breadth of the reach of the ECD messages, as well as the potential to affect behavior change.

- Integrating ECD activities into existing GHS routine activities made it easier for health workers to establish and sustain the activities over time. This increased the potential for these activities to be incorporated into routine activities for CHPS staff nationally.

[22] Sensitization is defined as sharing messages found in the MCSP Ghana ECD materials but not following the full intervention delivery protocols.

Recommendations

The following recommendations are made for future use of the MCSP ECD materials in Ghana:

- The use of the appropriate platform(s) for ECD message delivery is important for the success of this effort. In the future, it will be important to work with CHPS staff to choose the appropriate platform(s) in the communities they serve and to standardize approaches for each platform. MCSP recommends selecting at least one platform for full session delivery and at least one secondary platform for sensitization.
- If possible, CHPS staff should liaise with the community health management committee and district health assembly to revive dormant MTMSGs, as this remains one of the most effective platforms to engage mothers and caregivers on a more regular basis.
- If possible, CHPS staff should collaborate with the community health management committee and district health assembly to enable RFGs to incorporate ECD into their annual activity plans.