



A Guiding Framework for Integrating Child Health, Nutrition and Early Childhood Development

APRIL 2015

Objective

- To help CRS integrate child health, child nutrition, and ECD
- To support CRS in identifying training, evaluation, and documentation needs and opportunities to contribute to CRS learning agenda

PART 1: OVERVIEW OF ECD

Early Childhood Development (ECD) is defined internationally as the period of life that begins prenatally and extends to eight years of age (Siddiqi, Irwin & Hertzman, 2007). The most rapid and crucial developmental processes in cognition, language, social-emotional development, and physical health occur during this period. Early Childhood programs have the greatest impact on improving child nutrition, physical health, and psychosocial development when they are implemented before birth and during the first two to three years of a child's life (Bakermans-Kranenburg, van Ijzendoorn & Juffer, 2008). Children at highest risk receive the greatest benefit from intervention (Ippen, Harris, Van Horn & Lieberman, 2011). Risk factors such as poverty, undernutrition, social exclusion, community violence, sick or absent caregivers, or exposure to violence or maltreatment predict vulnerability to poor developmental outcomes, while protective factors such as supportive caregivers, community involvement, and government policies that provide healthy food, safe spaces, growth monitoring and medical care, and educational opportunities for young children predict resilience even in low-resource, high-risk settings (Cicchetti, Rogosch, Lynch & Holt, 1993). A critical protective factor in the first years of life is positive, supportive, developmentally appropriate interactions with parents and/or caregivers; thus many interventions aim to improve the quality of children's day-to-day interactions with parents and caregivers in addition to addressing risk in other sectors (Grantham-McGregor et al., 2007; Engle et al., 2011).

Combining Early Childhood Development (ECD) interventions with existing interventions in health, nutrition, and across other sectors is efficient and economical, as programs directed towards the same population can make use of the same facilities, transportation, community networks and distribution systems (DiGirolamo, Stansbery & Lung'aho, 2014). In addition, integrating ECD with other programs enables an organization to address risk and protective factors at multiple levels. Healthy development in early childhood is impacted simultaneously for better or worse at the individual, family, community, organizational, and governmental level. An integrated approach to ECD is not only efficient, but also more likely to be effective. Worldwide, a number of interventions that integrate ECD with nutrition and health programs have shown a positive impact on cognitive and social-emotional development outcomes (Bentley, Vazir & Engle, 2010; Nahar et al., 2012). Benefits also include long-term effects on both child and maternal mental health (Walker, Chang, Vera-Hernandez & Grantham McGregor, 2011; Baker-Henningham, Powell, Walker & Grantham-McGregor, 2005; Rahman, Patel, Maselko & Kirkwood, 2008). There is also data supporting the positive impact on nutrition and health by the addition of ECD (Dybdahl, 2001; Aboud, Singla, Nahil & Borisova, 2013).

PART 2: CATHOLIC RELIEF SERVICES' INTEGRAL HUMAN DEVELOPMENT FRAMEWORK AND ECD THEORY OF CHANGE

A theoretical model provides a structure for intervention within an organization, a way to understand the interactions between risk and protective factors, to describe and measure desired program outcomes, and to model the life-course implications of an intervention (Woolfenden et al, 2014). To gain a "big-picture" view of the impact that an integrated program may have on a community, as well as the extent to which it can be built to withstand shocks, cycles, and trends, Catholic Relief Services has developed a conceptual framework to define the agency mission called Integral Human Development (IHD; Heinrich, Leege & Miller, 2008). The goal of the framework is for "people to lead

full & productive lives, meeting their basic physical needs and living their lives in an atmosphere of peace, social justice, and human dignity” (Heinrich, Leege & Miller, 2008, p. 5). The IHD conceptual framework is an over-arching perspective that allows CRS to pull together other frameworks and approaches, and is highly compatible with the combined bio-ecological and life-course perspective recommended for ECD programs, especially in the context of CRS’ work as a disaster-relief agency (Heinrich, Leege & Miller, 2008, p. 5). The IHD framework is shown in figure 1.

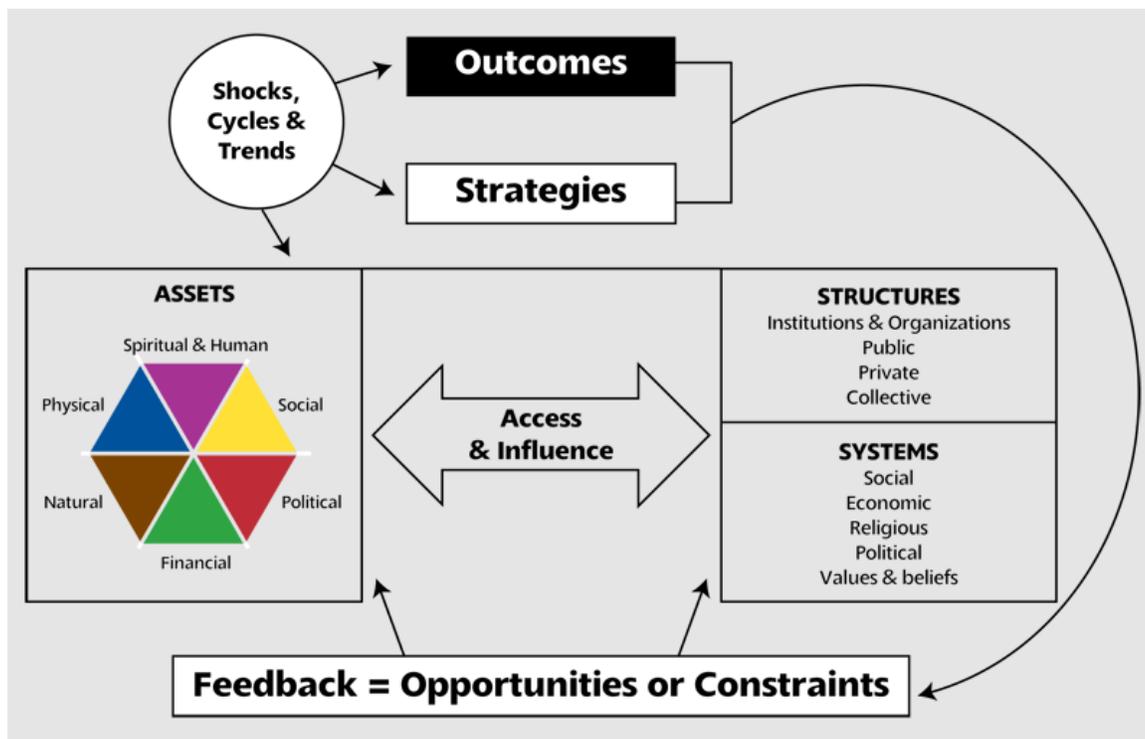


Figure 1. The CRS IHD Framework

The Theory of Change (TOC) process at CRS created a practical model and a process for integrating Early Childhood Development (ECD) within and between sectors, focus areas, and projects. The result is a bio-ecological model that considers ECD at multiple levels and through key lenses including; life-course developmental changes with a focus on birth to age 8, gender, disability & inclusion, child protection, and spiritual development. Throughout the TOC process, theories and assumptions about ECD, values, and goals of the organization (including Integral Human Development), were illuminated, discussed, and integrated into the model. The model gives structure to the variety of programs supporting young children and helps them to place themselves within a larger ECD goal. A second goal is to support programs in creating their own Theory of Change that fits within the larger model. In this way, each new program can be easily viewed as a tool to achieve CRS’ goals in ECD that reflects the underlying values of the organization and a strong theory-based understanding of child development. The TOC is shown in figure 2.

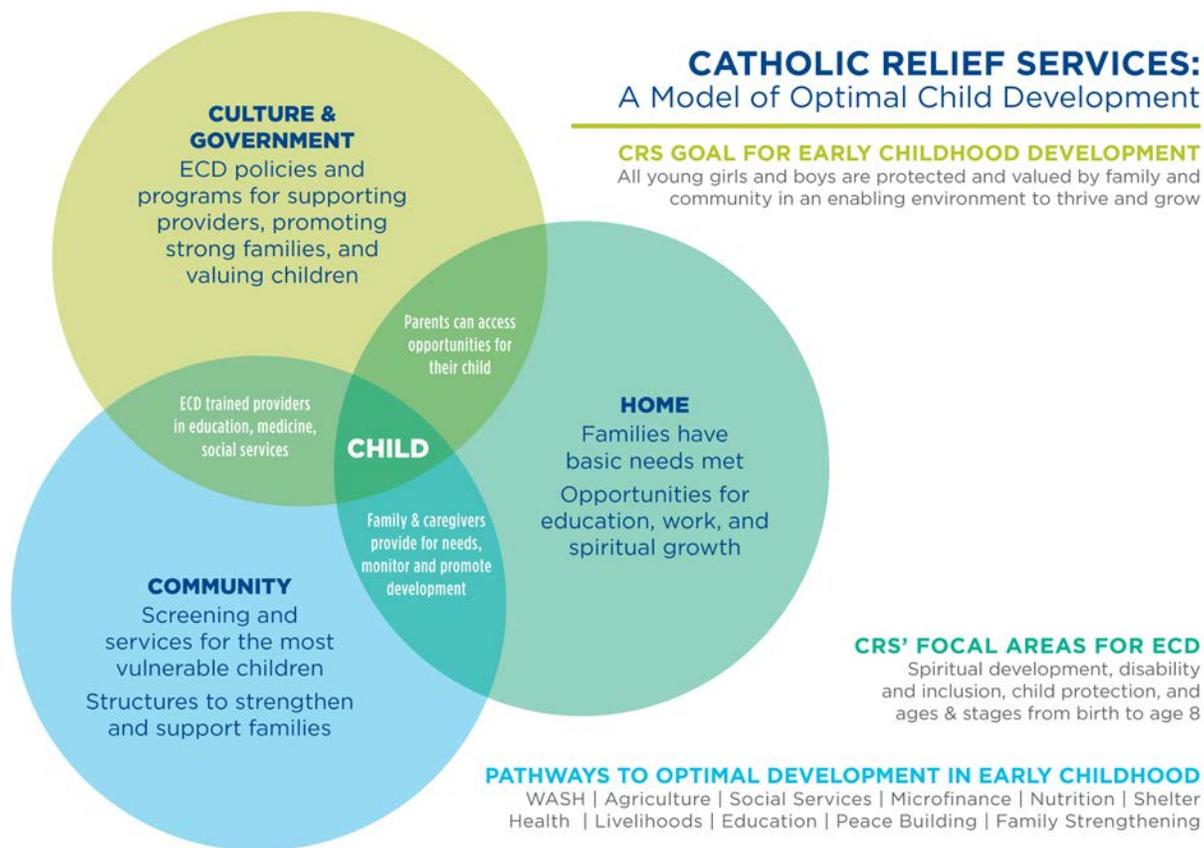


Figure 2. CRS Theory of Change Model for ECD

The over-arching, organizational Theory of Change for CRS states the following goal in Early Childhood Development: “All young girls and boys are protected and valued by family and community in an enabling environment to thrive and grow”. Other sectors and individual projects are encouraged to develop specific goals that fit beneath that umbrella and work towards the same end. The Center for Theory of Change (CTOC) has broken the process down into six steps: 1) Identifying long-term goals and preconditions, 2) Backwards mapping / connecting outcomes, 3) Completing an outcomes framework, 4) Identify assumptions, 5) Develop indicators, and 6) Identify interventions. More information about the process of developing a TOC for an individual project is available in Appendix II.

PART 3: EFFECTIVE IMPLEMENTATION STRATEGIES

A 2013 review of 31 studies integrating health, nutrition, and psychosocial stimulation found the following effective implementation strategies across home, group, and clinical interventions (Yousafzai & Aboud, 2013).

- Curricula: Structured curricula on psychosocial stimulation (for example Care for Child Development, Learning through Play). These curricula all shared in common that there were a small number of actionable messages, low cost materials, and included caregiver-child interactive activities.
- Curricula: Structured curricula on nutrition (for example, Infant and Young Child Feeding Messages from WHO guiding principles, especially on diversity, consistency & frequency). Included responsive feeding messages, and food or micronutrient

fortification combined with an effective communication strategy.

- Dosage: For home visits, at least every two weeks was recommended. Interventions were most effective when only 5-10 messages were provided per training, and those messages were tailored to specific developmental stages. Longer sessions were more effective (the range in these studies for home/center trainings was 30 minutes to 2 hours, although in clinical settings the minimum time was 5-10 minutes). The authors recommend booster sessions if the program sessions need to be shorter, or in the case of clinical settings adding messages to well-baby clinics.
- Participatory learning: Across all delivery locations, the recommendation was to focus on problem solving and observe and provide feedback in place of didactic messages. For psychosocial stimulation interventions, opportunities for trainers to model and for caregivers and children to practice activities together and receive coaching were most successful. Demonstrations utilizing pictorial materials were recommended, especially in clinical settings.
- Training and supervision: In home, group, and community interventions, training for successful outcomes included transferring concrete skills. Short trainings were effective when supplemented with on-the-job coaching and regular refreshers. For home and group interventions, supportive supervision strategies such as modeling, peer-to-peer learning, supervisory checklists and feedback were crucial. In clinical settings, partnerships with health managers was recommended.
- Finally, Targeting is crucial as the most disadvantaged/vulnerable children receive the greatest benefit from ECD interventions, and the earlier the intervention, the greater the development effects (Ippen, Harris, Van Horn & Lieberman, 2011).

PART 4: OPPORTUNITIES FOR ECD INTEGRATION INTO HEALTH AND NUTRITION INTERVENTIONS AT THE FAMILY, COMMUNITY, AND GOVERNMENT LEVEL

Health and nutritional interventions are key to reducing mortality, preventing health problems, and reducing intergenerational transmission of poverty due to chronic illness, cognitive impairment, and a lack of access to education (Engle, Menon & Haddad, 1999). They also provide an opportunity to integrate best practices in ECD to benefit both health and long-term developmental trajectories. Without intervention, stunting in early childhood is related to deficits in cognitive functioning at age 4 and 5 (Desmond, Richter & Casale). Adding relationship-focused intervention to nutritional interventions has resulted in positive cognitive and social-emotional benefits over nutritional intervention alone in studies in Vietnam, Bangladesh, Columbia, Ecuador & Jamaica (Watanabe, Flores, Fujiwara & Tran, 2005; Hamadani et al., 2006 and Aboud & Akhter, 2011; Super, Herrera & Mora, 1990; Tinajero, 2010; Grantham McGregor et al., 1989). Two trials in rural India found that interventions that integrated play and responsive feeding into feeding programs for malnourished children under 24-months of age showed significant cognitive developmental benefits, even though longer, more intensive intervention was needed to correct the severe physical and motor deficits resulting from malnutrition (Bentley et al., 2010; Nahar et al., 2012). The most successful interventions are multi-level and include multiple activities, here is a guide to points of entry at multiple levels of the intervention model.

HOME OR FAMILY-LEVEL INTERVENTIONS

This section will consider two family-level intervention opportunities; home visits and counseling by medical professionals, para-professionals, and others who may interact around nutrition or health with a child and his or her parents.

Many of the recommendations for optimal practices for home visits and community groups for caregivers are the same, and include: manualized curricula, training and refresher training for leaders/home visitors, reflective supervision and monitoring fidelity to strategies, and active strategies to promote behavior change such as feedback, coaching, play or videotaped interactions. However, home visits provide a unique opportunity. First, home visits are frequently preferred by mothers who also participate in groups because they have more time to try things and ask questions (Nelson & Spieker, 2012). Second, a child's primary caregiver may be their mother, grandmother, father, or they may have multiple household caregivers. A home visit can potentially include any and all who provide daily care for the child (UNICEF 2005).

Counseling in this context is defined as “supportive conversation” as opposed to psychological counseling, and is highly recommended by UNICEF and WHO (2005). Recommended counseling strategies encourage the use of manualized visual reference guides or cards that illustrate activities connected with important nutrition, health, and ECD strategies. It's especially beneficial to use these visual aids as a starting point for the caregiver to ask questions and for the counselor to provide demonstrations, or for the caregiver to try the activities and receive feedback (Yousafzai & Aboud, 2014; Engle, Fernald, Alderman & Behrman, 2011).

MATERIALS TO FACILITATE COUNSELING

Counseling cards as well as a counseling checklist are available as a part of the UNICEF Care for Child Development curriculum. The Essential Package, Hands to Hearts International and many other ECD programs include both training guides and visual reference guides that provide pictures of important health, nutrition, and child development concepts, along with a discussion guide for the volunteer or community health worker. Country, population or project-specific manuals may also be available — for example the Mother-Infant Intervention Programme for the Khayelitsha Treatment Trial manual (Cooper et al., 2009) contains a curriculum for building trust with a new mother, observing her infant with her and helping her to build her confidence as well as her bond with her new infant. The manual includes suggestions for approaching topics such as employment, maternal physical and mental health, relationships with the infant's father and other family members, etc. See Appendix I for a list of resources.

CORE ELEMENTS OF PARENTING / CAREGIVER SUPPORT

A review of the literature on supporting and strengthening child-caregiver relationship (Richter & Naicker, 2013) found that the core elements of parenting/caregiver support programs are:

1. Reassurance and support to caregivers—building their confidence
2. Reinforcing their role—emphasizing/providing evidence on the importance of parenting
3. Information about childhood ages and stages, gender issues, etc.

4. Transactional exchanges; i.e., advice for parents about how children respond to adults' words or authority
5. Practice on specific skills and feedback to build competence
6. Meeting others (to break social isolation of caregivers)
7. Strengthening couples/partners
8. Practical material support

For medical professionals, para-professionals, and others who may counsel parents outside of the home-visit paradigm, many of the previous recommendations apply, with the caveat that professionals have other information to impart regarding health behaviors or treatment of an illness, and may have as little as five minutes to share ECD information or answer questions. A curricula specifically designed for health workers and other counselors is "Care for Child Development" (WHO/UNICEF) which is geared towards encouraging caregiver sensitivity in the context of child health and nutrition through modeling, observing the child's behavior together and offering feedback. The program encourages play and communication between caregiver and child and includes a toolkit for professionals with pictures of target behaviors and information caregivers can take home (for details see Appendix 1).

Below are key ECD messages and activities that have been successfully integrated into home visits and visits with medical or other counseling professionals:

KEY MESSAGE	ACTIVITIES
<p>The first years are an opportunity to shape a child’s health and development for life.</p>	<p>Use picture cards that can be left with caregivers to understand ages and stages — this is a useful platform to integrate nutrition (breastfeeding, complementary feeding, etc), health (vaccination schedules, malaria prevention, hand-washing and safe environments) and ECD information about the trajectories of physical growth, brain growth, and developmental skills.</p>
<p>Undernutrition in early life not only limits physical development, but can also impact cognitive, social, and emotional development. Along with dietary changes, changes in feeding behavior can help a child become healthier in all ways.</p>	<p>A home visitor or counselor can present Infant and Young Child Feeding Messages (from, for example, the WHO guiding principles, especially on diversity, consistency & frequency, food or micronutrient fortification) and include responsive feeding messages.</p> <p>Responsive feeding (Black & Aboud, 2011) is the process of a child signaling requests to caregiver through gestures, vocalizations, or expressions; the caregiver learns to understand these signals and responds in a sensitive way; the child then experiences predictable and comforting communication with their caregiver regarding food and other needs.</p>
<p>Starting at birth, play and interaction with caregivers has a lifelong impact on health, mental health, cognitive development, language development, emotional development and coping with adversity, as well as a child’s social capacity for relating to others.</p>	<p>Demonstrations especially by home visitors can include: Developmentally-appropriate talking, singing, and playing with an infant or young child; creating safe play spaces and using available materials to make toys or games. Curricula are available such as “Learning Through Play” (The Hinks-Dellcrest Centre, Jones, Crow, 2007), Hands to Hearts International (for infants and children under 2) and others, see Appendix I for examples.</p>
<p>A young child is learning to interact with their surroundings and will make mistakes.</p>	<p>Home visitor or counselor can provide coaching around discipline practices and how to deal with child behaviors that caregivers find troubling. Focusing on problem solving and observation / direct feedback is the recommended strategy. Possible curricula include “Parenting Education: Caring for Children” (UNESCO) and others, see Appendix I for examples.</p>
<p>Resources may be available to help parents and caregivers.</p>	<p>Home visitor or counselor should be aware of possible referral sources for medical assistance, special needs within the family, child protection or caregiver mental or physical health needs. Maternal depression is a risk factor for low birth weight and early childhood stunting in low and middle-income countries (Grote et al., 2010). Home visitors need special training to counsel families about sensitive topics which may come up and to effectively make referrals (see “materials to facilitate counseling, in the previous section).</p>

COMMUNITY-LEVEL INTERVENTIONS

Community-level interventions in health and nutrition include groups for mothers, other caregivers, breastfeeding support groups, child health days, and growth promotion strategies (defined as weighing, charting, identifying a problem in growth, and responding to promote growth among children) implemented through community “weigh-ins”. The elements of a manualized training can be modified for the population and the specific training needs; for example, a volunteer leading a group would need to focus on skills including group management, demonstrations, individual participatory learning and answering questions. However, a volunteer conducting and charting growth at a community “weigh-in” may only have time for a simple intervention, such as asking mothers how they are feeling and being prepared with referrals, or requesting that mothers stand in front of (rather than behind) their infant while he or she is being weighed and pointing out how the infant looks to them for comfort during the uncomfortable weighing process (Nelson & Spieker, 2012).

A very comprehensive toolkit for community-level intervention is “The Essential Package” (EP) created by CARE / Save the Children (see also the CRS Literature Review, Nelson 2014). The EP includes a number of modules besides training that are very important for a successful community-level intervention, including a template for formative research to determine specific areas of need and available resources in the community and methods of supervising and monitoring volunteers. Whether the EP is selected or another framework, it is presented here as an example of crucial components of community-level intervention:

FORMATIVE RESEARCH

The Situational Analysis & Community Mobilization Guide are used to map resources & services, and provide a step-by-step guide to informing stakeholders in the community.

5-DAY ECD TRAINING FOR VOLUNTEERS

The Frameworks associated with the program are presented as well as tools and strategies for integrating ECD into existing programs at the level of either community group or home based interventions (or both), including a Visual Guide. Many volunteers may be more comfortable and familiar with topics like health, hygiene, education and nutrition than they are with ECD, and increasing the theoretical focus of their training can help them both understand and know how to share the connection between ECD and these other topics (Duncan & Azar, 2011).

TOOLS FOR IMPLEMENTATION, ONGOING SUPERVISION AND MONITORING

The tools provided are a Comprehensive Checklist, a Household Care Plan, and the Implementation Guide for Program Managers. The Implementation Guide for Managers also contains a framework for reflective supervision with volunteers.

VISUAL REFERENCE CARDS

Visual reference cards or booklets are important tools to convey information. The overall world illiteracy rate in 2008 was estimated to be 82% of adults over age 15, so in order to promote health literacy picture-focused curricula are essential (WHO, 2009). The EP, as well as UNICEF's Care for Child Development, Hands to Hearts International and many other ECD programs include visual reference guides that provide pictures of important child development concepts, along with a discussion guide for the volunteer/CHW. However, while visual reference cards are by nature intended to be simple, they actually require a steep learning curve to use effectively and training is essential (Duncan & Azar, 2011). In other literature detailing the successful use of visual reference cards a clear theoretical orientation is recommended as a way to make messages clear and help volunteers understand the underlying purpose and goals of each picture more thoroughly and be able to discuss and apply them more flexibly (Kanj & Mitic, 2009).

GOVERNMENT-LEVEL INTERVENTIONS

ECD requires coordinated services at the national and local government level, and often is achieved in partnership with NGOs (Britto et al., 2014). There is tremendous diversity between countries as to how ECD policies are made, implemented, and what organizations at what level carry out implementation and follow up. A review of national policies on ECD found a particular problem between the national policies in place and how plans were implemented at mid-level government. Often the decision-making process ended up resting more with local government, which then struggled to align with national requirements and to implement the type of horizontal integration (across economic, nutrition, and health programs) that would allow them to bring ECD programs to scale (Britto et al., 2014).

Some countries have developed extensive ECD materials which are available for use. For example, the Republic of Malawi Ministry of Gender, Children & Social Welfare (2012) has created a manual of ECD monitoring and assessment tools for both caregiver and childcare worker education. The childcare module includes a checklist of the minimum requirements of an ECD center for children aged two to five, including caregiver ratios (1 caregiver per 10 children) and training (a government 13 day manualized Basic ECD Training Course). Training is provided for care providers in early learning and stimulation, psychosocial care and support, as well as how to discuss preventive health practices with caregivers (breastfeeding, complementary feeding, vitamin A supplementation, water and sanitation, and use of bed nets). It also includes requirements for nutritional feeding at the center (i.e.: adequate cooking and eating utensils, food served hot, a communal garden), the physical location (roofed play area, child-friendly pit latrines, separate kitchen and food storage), and play materials (includes indoor, outdoor, imaginative and dramatic play, art, music, and book areas).

Also manualized is a parenting education program that includes healthy eating practices in the home, how to teach children problem-solving skills, ages & stages of development, strengthening the parent-child bond and supporting children's emotions, reducing negative behaviors with less harsh discipline, etc.

Early in the planning process to integrate ECD into an existing health or nutrition program within a country, the following questions should be asked (adapted from ECD Group – Country Analysis of the inclusion of Young Children).

COUNTRY ANALYSIS QUESTIONS

1. Is there a national Early Childhood policy?
2. If there is a national Early Childhood policy, who are the primary stakeholders involved in creating the policy, and who has been defined as responsible for the youngest children (birth to age 3 for example)?
3. Are there specific guidelines and suggestions of activities that can be undertaken with young children and their families?
4. What is the capacity of people at the national, regional, district, and local levels to work with young children? What training has been conducted and by whom?
5. What materials are available for use with young children? Have programs or materials from UNICEF or other organizations been modified for local or regional use in educational, childcare, medical or community settings?
6. Is there a need for advocacy with policy makers around ECD?

PART 5: CHARACTERISTICS OF SUCCESSFUL ECD PROGRAMS

Three things have been identified that are critical to the success of an ECD program: Improved access, quality, and sustainability.

Improved Access: Worldwide, there is a large disparity in access to ECD programs. In low and middle income countries, access is lowest among children under three years of age, with participation ranging from 5% to 20%; four year olds range from 25% to 75%, and five year olds from 2% to 55% (Britto, Yoshikawa & Boller, 2011). This is especially concerning in light of evidence that the first years of life are a critical or sensitive period in all areas of development (Shonkoff & Phillips, 2000), and that it is children who are most vulnerable and at-risk who would benefit the most from early intervention (Ippen, Harris, Van Horn & Lieberman, 2011). Many of the elements of integrated ECD/Nutrition/Health programs help to address the issues of access, through the mechanisms of lower cost, more services with fewer logistical challenges for families, established linkages and referral networks, and coordinated messaging (DiGirolamo, Stansbery & Lung'aho, 2014).

Quality: Three aspects of “quality programs” have been identified as crucial; structure, process, and nurturance. Structure includes such things as staff training, group size, and the physical location and materials. Process refers to elements like staff continuity, supervision, and relationships between caregivers, staff, and children. Nurturance refers to support for a child’s developmental processes by being mindful of the ever changing needs of the child through an ages and stages approach, positive & predictable interactions, protection from excessive stress or discipline, and opportunities for enrichment (Siddiqi, Irwin & Hertzman, 2007).

Sustainability: Sustainable ECD programs tend to share certain characteristics. They include cultural sensitivity, community ownership, a common purpose and consensus about outcomes, outcomes that are related to community needs, partnerships between community providers & parents, and a management plan that includes quality control and assessment of program effectiveness (Kagan & Britto, 2005).

PART 6: SUMMARY OF CURRENT ECD PROGRAMS AT CRS

CRS integrates ECD programming within a far-reaching network of programs in nutrition, sanitation, maternal & child health, child protection, HIV care, and economic strengthening. Programs build on organizational strengths in capacity building and monitoring and evaluation, and aim to integrate best practices in dissemination, training, and intervention. Here are some current examples of CRS programs implementing ECD curricula.

CRS' CURRENT ECD PROGRAMS

PROGRAM	THRIVE — KENYA, MALAWI & TANZANIA
Integrated with existing program components in:	Education, Nutrition, child protection and HIV/AIDS
ECD Messages	Stable and responsive relationships, Safe & stimulating environments, Proper health & nutrition. Kenya: additional focus on monitoring and referral for maternal depression Malawi: lead parents use the Care Group model to train 10 other households, with additional support for vulnerable children and families Tanzania: also utilizes PMTCT networks to raise awareness of normal development, developmental issues and the important role of fathers.
Points of Entry	<ul style="list-style-type: none"> • Care groups • Support groups • Home visits • Community Health Days
Training / Learning strategy	Builds on CRS' prior work creating Communities of Practice and developing learning agendas in Nutrition and HIV/AIDS
Materials	Country specific materials are based on toolkits such as the Essential Package, Positive Parenting, and community-based ECD resources from UNICEF
Tools to teach parents & caregivers	"Positive Parenting" curriculum, on-going mentoring. Parents are educated in developmental ages & stages, appropriate ECD activities with children are demonstrated and tried. Reinforced through community messaging.
Measures	Community and Child-level: Monitoring progress in ECD using existing CRS-developed materials (Institutional Strengthening Guide, Partnership Toolbox, child measurement tools), and developing a capacity-building plan for each local partner.

PROGRAM	SCORE ECD (STRENGTHENING THE CAPACITY OF WOMEN RELIGIOUS IN ECD) — KENYA, MALAWI, ZAMBIA
Integrated with existing programs in:	With PMTCT programs, counseling to pregnant mothers. Nutrition, HIV/HIDS, rights and protection, economic strengthening, spiritual, physical, psychosocial and language development.
ECD Messages	HIV positive mothers and their husbands receive information on the importance of disclosure, talking to the child, attachment, and language and behavioral development.
Points of Entry	<ul style="list-style-type: none"> • Counseling pre-natally through delivery • Monthly home visits • ECD advocacy on national TV & radio

Training / Learning strategy	<p>CRS has adopted 10 key principles to guide the implementation of SCORE ECD that include valuing the mission of service, grounding training in research-based principles of ECD, sustainability, and utilizing the Sisters' unique potential as change agents. To date, have trained 55 sisters as Master Trainers in Malawi and Kenya in national ECD curricula, trained 86 superiors from Kenya in leadership, networking, and external relations, and trained 36 sisters in Kenya on human resource management</p> <p>Initiated ECD advocacy on national TV and diocesan radio in Kenya and Malawi</p>
Materials	National ECD Curricula for Malawi & Kenya
Tools to teach parents & caregivers	Parents learn the benefit of mother-child interaction, play and stimulation, responsive feeding, child rights, and become better prepared to welcome and care for newborns. Appropriate ECD activities with children are demonstrated and tried.
Measures	<p>National level: Created Monitoring and Evaluation Plan and accompanying work plans for each country. Identified Global Advisory Committee and country level advisory committees.</p> <p>Community level: Developed small grants criteria and began implementation of small grants program; performed two qualitative assessments: of the congregations (financial and operational) and of 246 sisters to identify areas in need of capacity development.</p>

PROGRAM	WHOSE CHILD IS THIS? LESOTHO
Integrated with existing programs in:	A multi-sector team of service providers in child health, nutrition and education
ECD Messages	<p>Parents — early learning and stimulation skills and activities</p> <p>Educators — Child-focused early learning methods</p>
Points of Entry	<ul style="list-style-type: none"> • Child Health Days • Follow-up Home Visits
Training / Learning strategy	Improve the impact of services on child development through identifying and disseminating best practices in parent-child interaction, increasing community support for ECD. Train providers to utilize Child Health Days to identify the most vulnerable children and families for intervention.
Materials	Materials created for Whose Child is This include a parent and family caregiver training manual, a guide for strengthening teacher capacity, and a picture-based flip book about development and early learning.
Tools to teach parents & caregivers	Parent training including picture-based education about development and early learning, demonstration and coaching of skills and activities to do with children and mentoring and counseling at follow-up home visits.
Measures	<p>National level: Collecting data to implement sustainable and replicable models to facilitate linkages between government, NGO's and communities</p> <p>Community level: Collected preliminary data that indicated that low involvement in ECD in the country is due to inadequate and unequal access to services, poor quality services, lack of parent and community services, and lack of parental support. Collecting data to improve coverage of ECD programs, support educators and train them in the use of child-focused early learning methods, and provide parent and caregiver skills in early learning and stimulation.</p>

To obtain a broad view of how CRS programs work or would like to work with ECD, in October of 2014, 30 – 60 minute Skype interviews were conducted with 12 key informants in CRS programs in Tanzania, Kenya, Lesotho, Sierra Leone, India, Benin, Burkina Faso, and Ghana (Nelson, 2014). All key informants had ECD components currently in use in their programs and/or were in the planning process to integrate ECD. In addition to a series of questions regarding their experiences with training, monitoring and evaluation, interaction with local and national government, materials, and the needs of caregivers and young children, they provided their view on how improved child outcomes would best be accomplished with the population they serve. Participants' qualitative responses were analyzed and summarized in the diagram below (see figure 3).

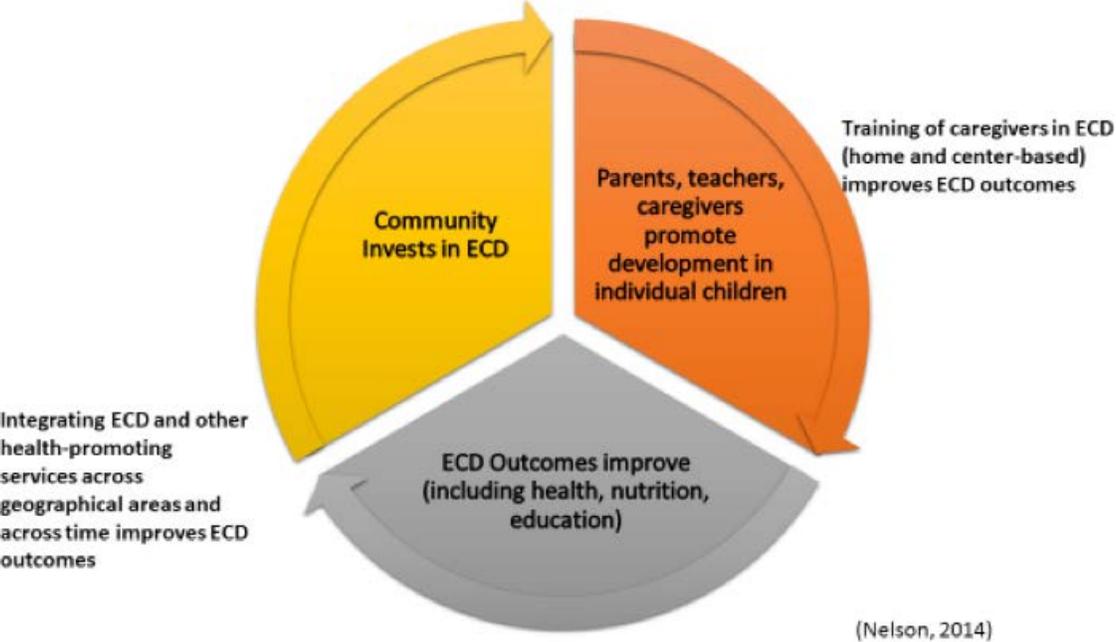


Figure 3. The process of change in ECD as described by Key Informants (n=12) in CRS programs in 8 countries

PART 7: AN ALGORITHM FOR ECD INTEGRATION

ALGORITHM FOR THE INTEGRATION OF ECD INTO HEALTH AND NUTRITION PROGRAMS								
PRELIMINARY STEPS	TOOLS	RESEARCH ON ECD IN THE POPULATION	ADMINISTRATIVE OR PLANNING NEEDS?	TOOLKIT OR PROGRAM	LEVEL	INTERVENTION LEVEL	INTERVENTION EXAMPLES (FOR DETAILED INFORMATION ON INTERVENTIONS SEE APPENDIX I, THIS DOCUMENT)	
Theory: Review the theoretical frameworks of CRS	Integral Human Development Framework CRS' Theory of Change for ECD	What are ECD issues/needs at the individual, family, community, government level?	Situational Analysis	The Essential Package	Community & Government	<p>INTERVENTION IS INFORMED BY</p> <p>ECD NEEDS AT THE GOVERNMENT, COMMUNITY, AND/OR INDIVIDUAL LEVEL; SUPPORTS AVAILABLE, AND</p> <p>ECD GOALS AT THE GOVERNMENT, COMMUNITY, AND/OR INDIVIDUAL LEVEL</p> <p><i>SEE APPENDIX III, THIS DOCUMENT: "QUESTIONS TO ASK WHEN CHOOSING A TOOLKIT OR PACKAGE WITH EXAMPLES"</i></p>	Government	Refer to CRS Partnerships & Capacity Building Situational Analysis & Community Mobilization Guide The Essential Package
Supports: Understand areas of program support at CRS	CRS Monitoring & Evaluation CRS Capacity Building CRS Partnerships CRS ECD Technical Support	What work is already being done through CRS? What is already in place at the country and community level that could support ECD (national ECD curricula? Community Health programs? Educational messages? Religious organizations? Materials?)	Additional tools for implementation Review "Country Analysis Questions"	The Essential Package This document p. 15 & 16	Community Government		Community	Training Program for Health Workers & Counselors Care for Child Development 5-day ECD Training for Volunteers who do Groups / Home Visits The Essential Package Training for ECD teachers, HIV clinic staff, Community Group Leaders Say and Play
Goals: Use the TOC process to establish program goals, understand assumptions, and create pathways to change	Review "Framework for using the Theory of Change process" – this document, p. 26	What assumptions about ECD in the community do you need to evaluate by doing community focus groups, interviews, or desk research?	Community Mobilization Guide Barrier Analysis Policy Brief	The Essential Package The CORE Group The Essential Package	Community Individual Government		Individual	Facilitated Guide to Teaching Parents in Groups Parenting Education: Caring for Children Facilitated Training for Parents in ECD Hands to Hearts International Materials for parents re: Developmental Play Learning Through Play Materials for Early Learning in Emergency Situations Early Child Development Kit

PART 8: REFERENCES

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