The Role of the Health Sector in Advancing Nurturing Care:

Aga Khan Development Network Syria's Implementation of Care for Child Development

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Executive Summary

Across the world millions of children are not reaching their developmental potential. This is especially the case for young children affected by conflict and humanitarian emergencies. Syria is one such country that has been in conflict since 2011. Millions of people have lost their lives, their homes or have been affected physically and psychologically. Many children have been born after the conflict began and their futures remain tenuous as violence and uncertainty continues. Science makes it clear that children need multiple supports to enable them to survive and thrive.

The Care for Child Development (CCD), developed by UNICEF and WHO, is one such approach that promotes children's holistic development. CCD is an evidence-based approach that aims to strengthen parents' and caregivers' capacity and confidence to play and communicate with their young children in order to support their motor, cognitive and socio-emotional development. The CCD approach reaches parents and caregivers through their interactions with frontline workers from health, social protection, and other sectors. CCD equips these frontline workers with the knowledge and skills to counsel and empower parents/caregivers to communicate and play with their children. Frontline workers also promote responsive caregiving by encouraging parents/caregivers to be sensitive (aware of the signals the child is sending) and responsive (act on those signals) to their children.

This case study describes how the Aga Khan Development Network (AKDN) worked with national and local stakeholders in the Syrian public health system, and in particular the Child Wellbeing programme. AKDN, along with the public health system, adapted and integrated the CCD into the health system's Child Wellbeing programme which serves children 0 to 59 months. The learnings from this case study target two key audiences: practitioners who wish to see how CCD can be implemented through health services, and especially in a country experiencing conflict, and government stakeholder that are considering how to increase their investment in nurturing care.

> The CCD approach reaches parents and caregivers through their interactions with frontline workers from health, social protection, and other sectors.

The case study begins with a description of the six-step adaptation process to revise and adapt CCD so it fit into the existing format of the Child Wellbeing programme. Next the case study outlines the implementation process and key achievements. The case study then highlights lessons learned, including the success factors and challenges. Lastly, this case study closes with a summary of work underway to enable expansion of the model nationwide and greater national focus on parent-child play and responsive care supporting holistic child development.

During the almost three-year process, AKDN made many decisions from the adaptation through implementation phases that are useful lessons learned for others. A key element in the success of the process was active involvement and decision-making role of local health workers from the beginning. AKDN identified key personnel in the health system that were able to convince others and get buy-in to ensure the approach was owned and led by the health system. Key challenges included health workers' ability to manage their workload including paperwork for child visits, generating parent demand, developing counselling skills among frontline health workers and the layout of health facilities.

While the initial intention was to strengthen responsive care and playful parenting just through the adaptation and inclusion of CCD, key health system stakeholders agreed to major changes to the content and operationalisation of the Child Wellbeing programme. The process also resulted in making health facilities more child friendly. This meant changes in the layout of the facilities so all children's health related rooms were near each other rather than in different parts of a building or in another building. This was not the original intent, but a better outcome than planned.

The revised Child Wellbeing programme continues to be implemented in 25 centres in and around Damascus, Hama and Tartous with minimal technical and financial support from AKDN. AKDN's experience in Syria is unique because it showcases how holistic child development can be a priority and can be integrated into a health system even during a long-lasting humanitarian crisis. The insights from the story in Syria illustrate that it is possible to ensure all children, even those in humanitarian settings, receive the care they need to survive, thrive and reach their full developmental potential.

Key Achievements

1. Syrian Public Health System adopted CCD as part of its existing Child Wellbeing programme.
2. Health system stakeholders led the process of adaptation and pilot implementation.
3. Health system stakeholders continue implementing the programme without AKDN's support.

Key Challenges

1. Managing health staff's workload and time.
2. Children's Multiple Records.
3. Generating Parent Demand.
4. Health staff's Counselling skills
5. Location of Child Services in health facilities

Success Factors for Buy-in and Sustainability

1. Identifying existing services and key personnel that could be leveraged.
2. Adapting and aligning the CCD approach with an existing health programme
3. Utilising national trainers in the health system.
4. Linking child health services with ECD
5. Using ECD and Health staff

Introduction

Across the world, there are approximately 250 million children under 5 years of age (about 43%) in low- and middle-income countries at risk of not reaching their developmental potential. Available data from low and middle income countries indicate that about 80 per cent of children aged 2 to 4 are regularly disciplined violently; about 15.5 million 3- and 4-year-olds are not engaged by adults to promote cognitive or socio-emotional wellbeing (e.g., telling stories, singing songs, naming, reading books, counting or drawing and playing with the child). Today's children are tomorrow's future and helping these young people reach their full potential will help decrease poverty, increase equity, and promote peace and harmony with our planet. The global community agrees that the ability of a child to simply survive is not enough; a child must be able to thrive as well. The science is clear that young children need nurturing care to reach their full developmental potential. Nurturing care ensures young children get the holistic supports they need to build the strongest foundation for their lives.

The Aga Khan University's Institute for Human Development and the Aga Khan Foundation are publishing a series of case studies about how the CCD approach has supported nurturing care of young children. The goal of this series of case studies is to help practitioners who want to implement CCD in their local or national context and for governments as they consider various approaches they might want to adopt, as part of their efforts to operationalise the Nurturing Care Framework. This series of case studies is being produced with the generous support of the LEGO Foundation and Aga Khan Foundation, as part of the UNICEF-LEGO Foundation Playful Parenting programme, which aims to improve access to, dissemination and uptake of relevant information related to the importance of Playful Parenting programmes.

This first case study tells the story of how AKDN in Syria together with key health stakeholders in the country created an enabling environment for nurturing care in health facilities and at home. The focus is on the adaptation and integration of the CCD approach into the existing Child Wellbeing programme for children birth to 59 months.

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The Nurturing Care Framework and Care for Child Development

The Nurturing Care Framework for Early Childhood Development was launched in May 2018. This Framework re-establishes the importance of holistic supports for young children and emphasises a critical piece of that puzzle the has been overlooked – responsive caregiving. Nurturing care comprises five inter-related and indivisible components that cut across multiple sectors: good health, adequate nutrition, safety and security, responsive caregiving and opportunities for early learning.

While there has been progress in increasing children's access to early education, health care, nutrition and safety and security, not enough attention has been placed on how parents and caregivers can provide responsive care. Responsive care occurs when caregivers play, communicate with, observe and respond to children's movements, sounds, gestures and verbal requests. It allows a caregiver to focus deeply on a child's needs and respond in a way that helps him or her feel safe and explore and take the risks needed to stimulate connections in his or her brain. Responsive caregiving also includes responsive feeding, which is especially important

Many approaches have been tested to enhance the responsive caregiving skills of parents and caregivers.

for low-weight or ill infants. Before young children learn to speak, the engagement between them and their caregivers is expressed through cuddling, eye contact, smiles, vocalisations and gestures.

Many approaches have been tested to enhance the responsive caregiving skills of parents and caregivers. One such model is Care for Child Development (CCD). CCD, developed in the late 1990s and updated in 2012 by UNICEF and the WHO, aims to strengthen parents'/caregivers' capacity to provide responsive care. The CCD approach can be integrated into existing services in all sectors, and while its ultimate aim is to support caregivers, the approach does so through frontline workers. CCD helps these workers acquire knowledge and skills to counsel and empower parents/caregivers to communicate and play with their children. Frontline workers promote responsive care by encouraging caregivers to be sensitive (recognise signals the child is sending) and responsive (act on those signals). CCD focuses on birth to two years. This aligns with the health sector's emphasis on the first 1,000 days of a child's life.

As of 2017, CCD has been integrated into existing government and non-governmental services in more than 23 countries. It has been translated into 20 languages and tested in over 50 countries.

Context of Syria and its policies

Prior to the conflict, Syria was making progress toward supporting the comprehensive health and developmental needs of young children (0 to 8-year olds). In 2007, the Syrian Commission for Family Affairs and Population produced the first national early childhood development strategy. The commission is responsible for all national level strategies focused on families and children. As part of strategy development, they coordinate and bring together various government sectoral departments. The ECD strategy emphasised the important role all sectors play in young children's ability to survive, thrive, and reach their full developmental potential. The accompanying Executive Plan outlined what each sector needed to do individually and together to ensure all Syrian children get the best start in life. For example, the Ministry of Education set the goal to increase the number of private Kindergartens and the percentage of nurseries across the country. The Ministry of Health set the goal to increase immunisation coverage and training for health workers on Maternal, newborn, child and reproductive health. The onset of the Syrian conflict in 2011 has significantly slowed implementation of the strategy. Some aspects of the strategy needed to be de-prioritised such as general ECD awareness raising activities that were to be led by the Ministry of Information and the Ministry of Education. While the strategy is a good positive foundation for holistic Early Childhood Development in Syria and it continues to be updated periodically, it remains a vision on paper that has been difficult to achieve.

Unfortunately, the onset of the conflict negatively affected the accessibility, affordability and quality of basic services important for children's health, nutrition, and overall wellbeing. For example, in 2019, only 50 per cent of health facilities were fully functioning, compromising access to routine and life-saving health services for pregnant women and children aged five and under. Today, there are rising numbers of families living below the poverty line; growing numbers of severely malnourished children aged five years and under; increased reports of child labour and child marriage; a lack of safe spaces for children to play and learn; and regular direct or indirect exposure to violence at home, on television or in the community . The day-to-day implications of the conflict have made it difficult for parents to put food on the table, find and keep a job, take care of their own physical and mental health, protect their families from physical threats, and provide adequate care for their young children.

Prolonged exposure to adversity, chronic neglect, caregiver mental illness, conflict and violence, and the accumulated burdens of poverty may produce 'toxic stress'

Prolonged exposure to adversity, chronic neglect, caregiver mental illness, conflict and violence, and the accumulated burdens of poverty may produce 'toxic stress' responses that affect children's brain development. These effects can have lifelong negative implications on children's health and educational outcomes. Further, it can hamper families' ability to provide the best care for their children. For children in Syria, prolonged exposure to conflict accompanied by the associated impact on the daily lives of children and their families has put the nearly 7.5 million children, more than 2.6 million that are internally displaced, at risk of not reaching their full developmental potential.

Countries often take a few steps forward and backward as they work to fully operationalise large strategies like the ECD one. With the many challenges the conflict posed on families and on health and other systems in Syria, the presentation of CCD as part of the health system has helped in moving forward some of the national ECD strategy goals.

Preparing CCD for Use in Syria

a.Selecting an Entry point for CCD

In the context of international sanctions on Syria, which restrict direct assistance to the government, working with the health system required multiple modifications that are included in this case study. This type of approach can be similar in other humanitarian contexts where aid support to the government in power is limited. The starting point was looking at existing services that were reaching families with young children at scale. In the Syrian context, the public health system is the first and main point of contact for families with young children. Other systems, such as the education system, engage families when children enter formal education programmes. Hence, opportunities for integration within the public health system were explored in more detail. A variety of health services were explored including maternity care, sick children visits, and the Child Wellbeing programme. The Child Wellbeing programme was selected as the initial entry point because it offers a range of services at the health facility-level for children 0 to 59 months (e.g., growth monitoring, disease prevention, early identification of developmental delays or disabilities), offering multiple touchpoints with the same family over time (15 sessions). The Child Wellbeing programme explicitly states in its objectives that the goal is to promote children's health, growth, and development. Moreover, counselling parents on how to care for their child was listed as one of the services. However, in practice, very little attention was being paid to child development even though there were specific questions regarding child development on the forms completed by the health workers. Multiple touch points with families as well as the finding that the programme was intended to address children's health, growth and development made the Child Wellbeing programme an appropriate entry point that could be built on and strengthened to ensure comprehensive child health and development services for all children.

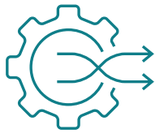
b. Six-step CCD Adaptation Process

The initial adaptation of CCD took a little over a year and involved six steps.

Step 1: Identifying content from the CCD approach that fit the framework of the Child Wellbeing programme was the starting point. However, CCD focuses on children up to 24 months. AKDN needed to find a supplement to CCD that included tips, advice and activities for children 25 to 59 months. AKDN searched for compatible resources and eventually found similar practical tips and advice from the United States Center for Disease Control and Prevention (CDC). Thus, AKDN used both CCD and CDC materials that could be integrated into the routine visits for children 0 to 59 months of age.

Step 2: Adapting and translating the CCD approach for the Syrian context was the next step. The CCD and CDC materials were translated into Arabic. Then the images and tips from both sets of materials were adapted to fit the local context.

Step 3: Comparing the translated materials with the contents of the Child Wellbeing programme to identify similarities and differences was the third step.



Step 4: Modifying the existing Child Wellbeing programme materials used by facility staff was the fourth step. This involved making changes to the child health forms and counselling cards staff used to include recommendations for communication and play and questions about child development milestones.

Step 5: Soliciting feedback from facility staff (e.g., nurses, paediatricians, physicians) on the revised forms and counselling cards was a critical fifth step. Health workers in eight facilities used the materials during their regular consultations and shared feedback with the team on the feasibility, clarity and acceptance to parents. Feedback from the health workers indicated that parents were curious about this new dimension and interested in knowing more.

Step 6: Finalising the content (forms, counselling cards, training) with key stakeholders involved in the Child Wellbeing programme was the last step in the adaptation process.

The Child Wellbeing programme is divided into fifteen visits. Each visit corresponds to a specific age (rather than an age band) and the visits continue until the child is 5 years old. The CCD counselling card provides a total of 12 play and communication recommendations divided into six age bands (i.e., one play and one communicate recommendation for 3 to 6 months). The recommended activities in the original package did not map on directly to the visit schedule of the Child Wellbeing programme. Thus, the play and communicate activities in CCD could not be used as they were. The original 12 were modified and additional ones were added from the CDC materials to create a set of 15 play and 15 communicate recommendations corresponding to the schedule of the 15 visits in the Child Wellbeing programme. These 15 visits are divided into seven visits during the first year of a child's life and then eight visits from age 1 to 5 years.

The forms in the Child Wellbeing programme were revised to elicit two types of information from caregivers. The first set of questions seeks to understand how the child is developing. The second set of questions seeks to understand what the caregiver is doing at home to support the child's development. There are fifteen forms, one per visit. Each form contains unique age-appropriate questions. In addition to recording the responses from the caregiver, the health worker also notes whether s/he made any referrals, summarises what was discussed and recommended, and writes down the date of the next visit. These forms, just like all of the other forms, are kept in the facility.

The revised child wellbeing materials ensure that no matter what the original purpose of the visit (e.g., immunisation, growth monitoring), the caregiver will be asked about how his/her child is doing and what is happening at home to support children's holistic development. This did increase the overall time of caregivers in health facilities, but over the time of the pilot, caregivers reported that they did not mind staying longer.

c.Process for Stakeholder Ownership

AKDN built the health system's buy-in and ownership over time. First, AKDN introduced holistic child development and the Care for Child Development international package with health system staff at national and governorate levels. Part of this awareness raising was to mention that CCD is a globally recognised tool first developed by WHO and UNICEF, two agencies that the Syrian health system look to for advice. The awareness raising also illustrated that many other countries around the world had started using this and showed some ways it was helping other countries meet their national health goals. Once critical decision makers in the health system understood the value of adding CCD and how it could help them accelerate their own national goals, they were open to a pilot in four governorates of Syria. During this process, AKDN and key members of the health system decided that the Child Wellbeing programme within the National Child Health programme was the appropriate place to try this approach. This was an important decision because from early stages the health system was open to modifications of its Child Wellbeing programme rather than suggesting CCD be a separate parallel aspect of child health services.

AKDN specifically worked closely with health staff at the national and governorate levels that were responsible for training, supervising and management of other health staff in health facilities at the local levels. Finding these critical influencers ensured that ownership was built in from the beginning of the process to modify the Child Wellbeing programme. AKDN worked closely with health sector trainers and supervisors at every stage of the process, starting with the design and adaptation phase. These trainers and supervisors were responsible for managing or supervising services in health facilities or they might be health workers themselves who had the additional qualification to make them a trainer. Involving these individuals in the entire process helped capture the perspectives and experiences of the health workers and supervisors in the design and delivery stages. These individuals made all key decisions including those related to the contents of the revised package; the selection of facilities and health workers; training content and schedule; and the frequency and scope of follow-up. Once the national trainers completed their training, they led all the subsequent processes. The role of the AKDN was to provide technical assistance as and when needed. Annual meetings between AKDN and the national trainers provided a platform for joint reflection and action.

One challenge AKDN faced after the health staff were on board was push back from parents about this new approach. After pilot implementation began, health facility staff observed parents were resisting the revised format and content of services. Parents did not initially see value in the changes and were frustrated that their visits were taking longer than normal. Health workers therefore asked paid community-level health workers (called health educators) to work with parents – to mobilise them and sensitise them to the value of these services in the health facilities and get their buy-in. Engaging the health educators was the idea from the health facility staff themselves and not from AKDN which showed even greater ownership of the process and revised approach. The health educators, as part of their ongoing interactions with families at the community level, explained the

changes to parents and distributed brochures either in health facility waiting rooms or through door to door visits where they discussed other health topics. This strategy helped shift the attitudes of the parents and even helped forge new and stronger relationships between health facility staff, community-level health workers, and the communities. In some cases, these new and stronger relationships led to using the health facility as a space to offer activities for families and children that go beyond the scope of traditional health services (e.g., storytelling sessions).

Implementation Approach and Key Achievements

Once the Child Wellbeing programme was revised with the integration of CCD and CDC materials, AKDN and health system colleagues embarked on a multi-step pilot implementation process from 2016-2018. Initially, changes to the Child Wellbeing programme focused on integrating key relevant elements of CCD and CDC. However, the team decided that the physical environment needed to be more child friendly. Later, with support from AKDN's ECD colleagues, AKDN supported health facilities to create child friendly corners in or near waiting areas with toys and books. This process increased the knowledge and skills of many frontline health workers and parents/caregivers on the critical importance of the earliest years of life and how simple play-based responsive parenting approaches can support children's optimal growth and development. The learnings from the pilot process were then used as a stepping- stone for further expansion which continues in Syria.

2016

Orientation meeting (December 2016)

AKDN started the pilot implementation process by convening a meeting to orient key stakeholders at national and governorate levels on the revised draft Child Wellbeing programme and discuss implementation approaches. Participants included frontline practitioners in Primary Health Care, Child Health and Public Health departments from Damascus, Hama, and Tartous. During this meeting, the participants provided feedback to finalise the revised programme package. Further, the participants identified 17 facilities in which to begin the pilot. The participants chose the facilities that they thought would have the highest chance of success. They also opted to select a smaller number of facilities to start with because they wanted to make sure they could make the time to provide in-depth support and use this initial phase for learning that could inform the future roll-out at scale.

2017

National Training of Trainers (April 2017)

In the Syrian context, there is an established pool of national trainers who are responsible for conducting health-related training. These individuals are existing staff in the public health system who normally work as managers, supervisors, or health workers at national, governorate, district or facility levels. They also hold a qualification to deliver training as needed so have dual responsibility. From the pool of national trainers, 20 individuals working at national and governorate levels (four trainers per governorate and four from the national level) participated in a five-day training session equipping them to become national trainers for the revised Child Wellbeing programme. Many of these individuals held responsibility and decision-making authority in child health programming, making them appropriate participants. Participants' pre- and post-test scores showed an improvement in their knowledge, attitudes and practices regarding child health and development (average score: 45% on the pre-test and 79% on the post-test).

2017

Planning at governorate level (May 2017)

Following the national training of trainers' workshop, the trainers and AKDN visited the selected health facilities to roll out the revised package. At each facility, decisions were taken on how to reorganise the flow of services and, if needed, to redistribute tasks among facility staff responsible for child health services. This helped identify which staff would be responsible for the new services (assessing child development, counselling etc.). Next, heads of health facilities were oriented to the revised Child Wellbeing programme and plans were made to train and prepare key health staff.

2017

Training for health facility-level staff (June and July 2017)

In total, 147 health workers were trained over five days. This included nurses, paediatricians, heads of health centres and reception staff. They were selected based on their role at the health facilities. Content of the national and governorate trainings was the same. Normally, health workers are taught to be the authority and tell families what to do. That approach is not in line with the CCD approach. CCD encourages bi-directional conversation and for families to engage in a "serve and return" approach with their children. This bi-directional conversation is something that health workers need to model to the families so the families themselves can replicate that with their children. So, selecting key health workers focused on their ability to model this bi-directional approach was important and proved to be important in the process of implementing the revised Child Wellbeing programme.

2017

Follow-up mentoring visits (July to December 2017)

The trainers at the governorate level led follow-up and mentoring without AKDN. They determined the frequency of follow-up visits to the health facilities. Initially, they decided to provide more frequent and intense support (once or twice a week) and then changed the frequency to once a month. During the intensive period, they observed health workers counselling families and provided feedback. They also discussed and resolved any administrative challenges such as task distribution. They completed a weekly report and submitted this to AKDN and national authorities. AKDN was not directly involved in the follow-up. AKDN staff were available to assist and answer questions, but did not conduct visits as this was already the responsibility of the trainers.

2018

Child-friendly health facilities (December 2017 – December 2018)

Once implementation of the adapted Child Wellbeing programme was underway, a new dimension was introduced to make health facilities more child friendly. AKDN's ECD team supported health facilities to create child friendly corners or spaces in or near waiting areas. For instance, when families entered health facilities and waited for their appointments, there were no books, toys or a space for children to play. Local health staff and AKDN teams decided that adding this element to the overall Child Wellbeing programme and health facility was important. To facilitate this, a set of criteria was developed. In December 2017, a workshop was held with the 20 participants who were involved in the national training of trainers, as well as representatives from Primary Health Care from four areas, to discuss and develop criteria for child-friendly centres. The following year, in August 2018, AKDN and the national trainers conducted workshops at the governorate level for. In the workshop, the participants learned about the ten criteria and accompanying indicators, shared which criteria they were already meeting and how, identified criteria that needed attention and possible solutions, and learned how to establish child-friendly corners in the facilities where children and their caregivers could play while waiting for their appointment. Additionally, AKDN trained health staff on how to make toys and learning materials from existing supplies in their environment and how to engage families to encourage reading, storytelling and cognitive stimulation.

2019

Expand to new health facilities (March 2019)

Based on the experience of starting CCD with health workers and families and establishing child friendly corners in health facilities, AKDN supported eight additional facilities. A total of 117 health workers participated in the training. These eight health facilities were selected with input from the governorate, bringing the total number of facilities implementing the integrated child health and services package to 25. A session on the child-friendly facilities criteria was added to the initial CCD training, though the number of days remained the same. For these eight facilities, the child-friendly facilities criteria and establishment of child-friendly corners were implemented from the start. This holistic approach of looking at the interactions between health workers and families through the integration of CCD along with establishing a child friendly environment in health facilities is now a model the health system plans to make into reality across Syria.

Annual Meetings

AKDN, the national trainers, WHO and others met on an annual basis and continue to do so to review progress, reflect on implementation successes, identify and address challenges, and agree on the way forward. This allows for key stakeholders to make modifications as they go and ensure that the model continues to work for health workers and communities even as things change.

Review of the pilot model

In 2019, AKDN commissioned a review of the adaptation and pilot process. AKDN used mixed methods approach (quantitative surveys and qualitative interviews) to solicit feedback from health care workers, trainers and supervisors in 25 health facility centres. A total of 57 people participated.

65% of participants stated that the changes to the organisation and flow of child health services as well as the distribution of tasks among staff were helping ensure services were smooth and quick while also meeting the comprehensive needs of the child.

65% of participants stated they were more knowledgeable, capable, and able to provide quality child health and development services in an integrated manner.

87% of participants stated that, after the initial period of resistance, parents are now positive about the changes to the health facility, even asking for the date of their next visit.

80% of participants stated that parents have greater confidence in the services and the staff because the parents come to the centre specifically to ask about their children's development and are not skipping their follow up visits as often as they used to.

Prior to implementing the revised child wellbeing package 33% of visits included attention to children's development. This number has risen to 77%.

Lessons Learned: Success Factors and Challenges

Success Factors for Buy-in and Sustainability

Identifying existing services and key personnel that could be leveraged: AKDN took time at the beginning to map out what was already being offered in public health facilities and identified which services offered the greatest potential for reach and success. Only after a clear entry point was identified did the process of integrating CCD begin. This process also included identifying the key personnel who could be the levers for facilitating the change.

Adapting and aligning the CCD approach with an existing health programme: The time spent reviewing CCD approach alongside the contents of the Child Wellbeing programme ensured that the modifications were aligned to the way each well-child visit was structured and delivered. Revisions to existing materials, including forms, avoided the perception that this was something new and extra work. Rather, it was adapted so it was core to the structure and content of the Child Wellbeing programme.

Utilising national trainers in the health system. Trainings were led by public health system personnel responsible for preparing staff who deliver child health services. Their engagement early on, at the time of designing the revised package, ensured that they understood and owned the process and final product. It also secured their commitment to ensuring successful implementation and follow up.

Linking child health services with ECD: An important feature of the training was to unpack the definition of child health, ECD and demonstrate, with evidence, that as health workers they were already working on ECD and what would strengthen their work was the inclusion of responsive care. The process of adaptation and training helped health workers understood that responsive care and playful parenting is part of their job in promoting holistic child development. Once this link was explicitly made and they understood that they were already contributors to children's overall development, it was easier for health workers to see the benefit and value add of integrating attention to early learning and responsive caregiving into Child Wellbeing programme visits.

Using ECD and Health: Using both ECD and health staff was important for the development of a holistic Child Wellbeing Programme. Often ECD programmes are led only by those that have ECD in their title. However, health, education, child protection and other staff also play critical roles in promoting ECD. In the case of Syria, the integration and use of CCD was led by AKDN's health team while ECD colleagues supported in the establishment of child friendly corners in health spaces. This division of labor allowed both teams to use their strengths to support health facilities. Prior to the process of revising the Child Wellbeing programme, AKDN undertook an organisation-wide capacity building initiative that included the "Science of ECD" and "Care for Child Development" training courses. These courses were critical in creating ECD champions among AKDN's ECD and health teams. Further, this initiative was led by a senior member of AKDN's health team who is also a physician. The gravitas the physician brought to the team helped AKDN convince other health workers.

Challenges

Managing workload and time: The revised Child Wellbeing programme required redistribution of tasks in the health facilities which increased the workload on some staff. The training included brainstorming ways that the revised programme could increase workload and how this could be managed at the facility level so no staff had significantly greater workload. This process allowed health staff to decide what extra work they could or could not take on.

Children's Multiple Records: There are distinct forms to be completed for each individual service (e.g., forms for immunisation, for growth monitoring, for counselling on the child's development etc.). The quantity of forms as well as the repetition of content across forms (i.e., child's name, age, gender) was creating an unnecessary burden on health workers. The proposed solution was to create one comprehensive form with different sections for each service. While there has been agreement to use just one form a few road blocks have remained. Changing the whole health system from using multiple forms to using one integrated one, takes time. Currently, health facility staff in the four governorates are using both the comprehensive and the additional forms. Budget limitations have made it difficult to print and distribute this new comprehensive form throughout the whole country.

Generating Parent demand: Initially parents were not positive about the changes at the health facility and wanted services to go back to the way they were. They were not used to facility staff asking questions or trying to have conversations with them. The staff, on their own initiative, engaged community-level health workers to explain and promote the programme using multiple channels (household visits, community dialogue, distributing brochures in waiting areas). This helped shift parents' attitudes, get their support and buy-in, and generate demand for the integrated child health and development services. Parents, themselves, became ambassadors and are now spreading the word to other parents in the community.

Counselling skills:
One of the biggest challenges in implementing CCD has been developing health workers' counselling skills. Counselling skills require bi-directional conversation and other skills (e.g. need to stop and listen, observe, ask questions that leads to conversation, tailor messages and advice) and this is different from health workers' training. Health workers are taught to be the authority and tell families what to do without listening to them or building on their existing assets and strengths as parents. While CCD has recommended messages and tips, it requires a health worker to be flexible in their support of families – to observe, listen, and tailor their advice based on parents' existing knowledge and skills. Role-play was used in the training and this helped, but AKDN learned that developing this skill in health workers takes time and lots of mentoring and practice. AKDN has yet to find a way to scale the development of this particular important skill set.

Location of Child Services in health facilities:
A key component of the revised model is ensuring the flow of services in the health facility was efficient and family-friendly. Many health facilities in Syria are in large buildings or in multiple buildings. This can mean that a mother and baby have to go to multiple rooms or floors, which can take time, thereby discouraging them from obtaining all available services for young children. The process of modifying the Child Wellbeing programme and integrating CCD provided opportunities to change this process in health facilities to make it easier and efficient for families to go to one general area/location for all holistic child development and health services. In some facilities, this required changing room assignments, the locations of the reception and waiting areas, and making decisions about the best place for the child-friendly corner. In some of the smaller facilities the reorganisation of services was a challenge as there was limited space to work with. In these instances, a single room was divided into different areas (e.g., immunisation in one corner, growth monitoring in another, counselling on child development in a third).

Conclusion: A Way Forward

It is well accepted that responsive playful parenting is a critical element to young children's ability to survive and thrive. The Care for Child Development (CCD) approach was designed to equip parents/caregivers with the knowledge, skills and confidence to provide the best start in life for their children. It does this by targeting frontline health workers and health systems as they are often the best connection points with families of young children. The adaptation of this global approach to the needs and context of each country is critical. In the last decade, CCD has been used and adapted by many countries and development partners.

This case study outlines how AKDN in Syria adapted and integrated CCD into the existing Child Wellbeing programme in the public health system. AKDN, together with the key health stakeholders, undertook a six-step adaptation process. This helped lay the foundation for seamless integration of CCD into the Child Wellbeing programme. Moreover, by leveraging and obtaining the buy-in of national trainers and supervisors already responsible for the Child Wellbeing programme, the success of the integration was ensured from the outset. The revised programme continues to be led by health officials in 25 centres in Damascus, Hama and Tartous with routine supervision.

In this example, the role of AKDN was to create and mobilise health workers to be ECD champions. AKDN used existing health structures and found key decision makers. Health staff walked alongside AKDN during the whole process which led to their ownership. AKDN did not do any direct implementation, nor did it play an active role in the follow-up support to the health workers. Implementation was led by the national trainers and supervisors in the health system. There are advantages and disadvantages to this approach. On the one hand, there is commitment and buy-in within the system and trained people who can independently scale the model across the country. There is also confidence among stakeholders that the model is feasible, sustainable, and valuable. On the other hand, the system may need support in monitoring, evaluating, and refining the approach as its further embeds into health systems.

Presently, there is interest within the public health system to expand the model. However, the Syrian health system lacks sufficient funds and national trainers to scale in all parts of the country. When domestic funds were lacking, the plan was put on hold. At the time of writing this case study, WHO had contributed funds that would support the training costs in each governorate, the cost of an annual meeting, and a study to obtain parental feedback, but no funds are available to expand the pool of national trainers. While there are positive steps toward scale, AKDN is partnering with UNICEF, WHO and others to support the development of a jointly owned, costed expansion plan that would be part of health sector plans and budgets. Without this, scaling will be ad hoc and slow. The plan would take into consideration the human resources and other costs such as training and printing materials needed to scale the model. A joint, costed plan will deepen shared ownership of the expansion and create opportunities for partners to work together toward a common goal of introducing the revised Child Wellbeing programme in every facility nationwide. Much is still to be done in Syria to scale playful responsive parenting with the use of the CCD approach. The process of adaptation, pilot implementation and discussions around a costed scaling plan show positive progress to ultimately impact all young Syrian children's ability to survive and thrive.

i. Chan M, Lake A, Hansen K. The early years: silent emergency or unique opportunity? Lancet. 2017;389(10064):11–3.

ii. UNICEF. Syria 9: Facts and Figures. 2020. https://www.unicef.org/mena/sites/unicef.org.mena/files/2020-06/Syria%209%20English%20Pamphlet%20June%20update.pdf

iii. Black, Maureen M., Susan P. Walker, Lia CH Fernald, Christopher T. Andersen, Ann M. DiGirolamo, Chunling Lu, Dana C. McCoy et al. “Early childhood development coming of age: science through the life course.” The Lancet 389, no. 10064 (2017): 77-90.

iv. Chan M, Lake A, Hansen K. The early years: silent emergency or unique opportunity? Lancet. 2017;389(10064):11–3.

v. UNICEF. Care for child development case study. The experience of Paraguay. 2019. https://www.unicef.org/earlychildhood/files/UNICEF_Care_for_Child_Development_Case_Study_-_Paraguay.pdf

vi. Black, Maureen M., Susan P. Walker, Lia CH Fernald, Christopher T. Andersen, Ann M. DiGirolamo, Chunling Lu, Dana C. McCoy et al. “Early childhood development coming of age: science through the life course.” The Lancet 389, no. 10064 (2017): 77-90.

vii. The Nurturing Care Framework’s was developed through a consortium of agencies working on ECD. This included WHO, UNICEF, the World Bank, the ECD Action Network (ECDAN), the Partnership for Maternal, Newborn and Child Health (PMNCH), Aga Khan Foundation (AKF) and others

viii. Ibid

ix. World Health Organization, United Nations Children’s Fund, World Bank Group. Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential. Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO.

x. United Nations Children’s Fund (UNICEF). Care for child development case study. The experience of Paraguay. 2019. https://www.unicef.org/earlychildhood/files/UNICEF_Care_for_Child_Development_Case_Study_-_Paraguay.pdf

xi. CCD White Paper UNICEF and WHO(2017) (Unpublished).

xii. OCHOA. Syrian Humanitarian Needs Overview (HNO). 2019. https://reliefweb.int/sites/reliefweb.int/files/resources/2019_Syr_HNO_Full.pdf

xiii. UNICEF. Syria 9: Facts and Figures. 2020. https://www.unicef.org/mena/sites/unicef.org.mena/files/2020-06/Syria%209%20English%20Pamphlet%20June%20update.pdf

xiv. Center on the Developing Child at Harvard University. 2007. InBrief: The impact of early adversity on children’s development. https://developingchild.harvard.edu/resources/inbrief-the-impact-of-early-adversity-on-childrens-development/

xv. UNICEF. Syria 9: Facts and Figures. 2020. https://www.unicef.org/mena/sites/unicef.org.mena/files/2020-06/Syria%209%20English%20Pamphlet%20June%20update.pdf

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