Case Studies of Programs to Promote and Protect Nurturing Care during the COVID-19 Pandemic

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Background

Globally, there have been disruptions to services and programs that promote early childhood development (ECD) and nurturing care during the COVID-19 crisis. While necessary to reduce transmission of SARS-CoV-2 (1), non-pharmaceutical strategies, such as complete or partial lockdown, physical distancing measures, and school and childcare closures, have made it increasingly difficult to reach children and caregivers. Yet, the pandemic's social and economic ramifications have put families in even greater need of parenting and family support. A recent rapid review (2) of emerging evidence, mainly drawn from surveys of parents and caregivers, shows striking similarities in how three pillars of nurturing care - parental mental health and responsive caregiving, support for children's learning, and children's safety and security – have been disrupted during the COVID-19 pandemic. While there are some reports of positive unexpected benefits of the pandemic on families including increased involvement in caregiving among fathers, findings also reveal numerous issues of concern, including mental health difficulties and less responsive parent–child relationships, increased screen time among children, limited opportunities for outdoor play, and fractured systems for responding to potential child neglect and maltreatment. As with many other features of the pandemic, not all families are affected equally. Financially vulnerable families are much more likely to experience negative ramifications. The pandemic is also disproportionately affecting parents and caregivers with young children, particularly mothers, those with pre-existing mental health difficulties, and those caring for children with disabilities (2).

Aims and Objectives

There is currently limited published data and evidence of "what works" to promote responsive caregiving, early learning and protection from violence based on program implementation and experiences during the COVID-19 pandemic. However, in response to the COVID-19 crisis, many organizations have been actively adapting both content and delivery of existing ECD programs to continue to reach and meet families' needs during this difficult time. This Case Study Report, prepared in partnership with World Health Organization (WHO) and the LEGO Foundation, describes the implementation experiences and emerging lessons of COVID-19 response strategies of seven programs that prioritize nurturing care and ECD in their work. While studies on COVID-19-related program effectiveness and acceptability will be developed over the coming months and years, rapid qualitative research findings, such as those shared here, capture programmatic experiences in real time and can start to provide evidence of potentially promising strategies, from first-hand perspectives. This report aims to document ECD interventions in the context of the COVID-19 pandemic, including activities or processes that have been implemented to enable the continuation of activities and services during lockdowns. It also presents information on emerging challenges, intended (and unintended) effects, and potential strategies to reach families and meet their needs during the COVID-19 pandemic and future emergencies.

Methods

CASE STUDY SELECTION

Seven programs were the subject of a rapid document review and interviews, conducted over six weeks. The programs were chosen to illustrate a wide range of contexts and types of nurturing care interventions

to compare and identify differences in approaches across organizations providing support during the COVID-19 pandemic. In alignment with our rapid evidence review (1) we focused on programs that address one or more of three nurturing care components: responsive caregiving, opportunities for early learning, and child safety and security. This decision was made to avoid duplication with other planned or recently published studies in the health and nutrition domains. Selected programs are unique in that they continued to provide adapted ECD services during a time when many other initiatives were suspended. The case studies are intended to be illustrative rather than representative. See Annex A for further details on the methodology.

Case Studies: Synthesis of Key Findings

Shifting Needs and The Priority Conundrum

Most programs conducted rapid needs assessments early in the pandemic to understand how lockdown measures affected the caregivers, children, and families they serve. Across contexts, corroborating with the rapid review results (2), caregivers were experiencing increased mental stress, loss of livelihoods and financial hardship, difficulties accessing healthcare and medication, and food insecurity. This scenario presents a priority conundrum for ECD programs, which focused on child protection, responsive caregiving, and/or early learning support before the COVID-19 pandemic. In the early needs assessments, social protection mechanisms for enhanced food security and immediate medical needs emerged as the most urgent and highest priorities. Because of these shifting family needs, ECD program staff and funders re-evaluated their programmatic priorities and responded in innovative ways. They were acutely aware that parents and caregivers were unlikely to benefit from responsive caregiving, playful parenting, and other programming if their basic needs were not met. In general, case study programs focused on three emerging priorities during the COVID-19 pandemic:

1. Responding to **social protection for immediate health/nutrition needs** (either directly or through referral to government aid or other community-based organizations). For example, Associazione 21 Luglio in Italy initiated an extensive fundraising campaign to assemble and distribute “baby packages” containing food, diapers, sanitizing wipes, and infant formula where necessary.
2. Supporting **caregiver and parent mental health** and psychosocial needs through the provision of social support and/or stress-reducing activities. For example, Ummeed Development Center in India developed new training courses to help reduce mental stress among both caregivers and community health workers (who are also caregivers themselves), and MaPa in the Philippines promotes mindfulness-based stress reduction techniques through parenting tips sheets, WhatsApp messaging, and Zoom webinars.
3. Strategies to promote **positive parent-child interactions and, in some cases, playful parenting-related activities**. For example, Canada’s Nobody’s Perfect Parenting program and Jordan’s Ahlan Simsim program trained facilitators to support caregivers by engaging in early learning and playful activities via telephone or Zoom videoconferencing.

Table 1 summarizes each program’s response to the COVID-19 pandemic.

Table 1. Case Study Overview: Programmatic responses to the COVID-19 pandemic in seven contexts

Program/ Organization	Country	Intended beneficiaries	Program focus	Key interventions during COVID-19
Associazione 21 Luglio	Italy	Roma and migrant families residing in emergency housing settlements	Social protection and food security, support for early learning	• Social assistance hotline • Fairytale hotline for children • Distribution of 'baby packages' • Mothers' support groups (WhatsApp/Zoom) • Repurposed outdoor garden for safe/distanced play and seminars
Ummeed Child Development Center	India	Children with developmental disabilities and their caregivers, community health workers (CHW)	Direct clinical services, caregiver and CHW mental health, support for early learning	• Shifted all in-person programming online (Zoom, WhatsApp) • Developed three new training courses for CHWs (Zoom) on mental health support for CHWs and caregivers and Promoting ECD in challenging times
Nobody's Perfect Parenting program	Canada	Parents of children 0-5y (young, single, socially isolated, low income/ education)	Parental mental health, positive parenting, support for early learning	• Shifted in-person facilitator training and parenting groups online (Zoom)
Kangaroo Foundation	Colombia	Premature and low birthweight newborns and their caregivers	Kangaroo Care	• Hospital-based program; protected KMC per WHO guidelines • Individual rooms for COVID+ mothers; separate NICU for COVID+ babies • Blended model for ambulatory visits (in-person + Zoom)
International Rescue Committee (Ahlan Simsim Program)	Jordan	Families affected by conflict and displacement	Support for early learning	• WhatsApp messaging: COVID-19 info, psychosocial support, ECD content • Trained facilitators to deliver one-on-one telephone-based school

				readiness program to caregivers • Distributed mass media ECD content
Parenting for Lifelong Health (MaPa)	Philippines	Families of children 0-18y	Prevention of violence against children through positive parenting	• Parenting tip sheets, booklets, webinars, radio segments, Facebook, SMS texts • "eMaPa" parenting program delivered via Viber or Facebook Messenger groups (under development) • One-on-one counseling in hospital child protection units • Additional content added on COVID-19 information and playful parenting
PATH	Mozambique	Caregivers of young children, including children with disabilities	Positive/playful parenting, support for early learning	• Outdoor, distanced training for providers and CHWs • Home visits with safety protocols • Video & radio segments and podcast • Radio listening sessions in health facility waiting rooms • New printed materials related to COVID-19 and child disability

How are programs adapting to the physical distancing measures imposed by the COVID-19 pandemic?

While each program responded differently to address families' specific needs in their communities, several common strategies emerged. First, 6 out of 7 programs adapted at least part of their programming for digital delivery via Zoom. Second, instant messaging applications for mobile devices (e.g., WhatsApp and Viber) are standard because they are free and widely available, support multimedia sharing, offer low data usage, and facilitate two-way communication. Program staff reported that these approaches were generally effective at establishing and building connections among parents and caregivers during lockdown periods. However, levels of engagement were context-dependent. For example, while WhatsApp parenting and social support groups worked well in some settings, residents of refugee camps in Jordan had concerns regarding their personal information in shared groups. Additional program

adaptations included one-on-one telephone-based school readiness sessions for caregivers, and mass media ECD messaging via social media platforms, podcasts, radio, and television programs.

In terms of support for ***responsive caregiving***, all programs addressed this component of nurturing care to some degree during the pandemic, including developing playful, fun, and interactive ways of engaging caregivers and children via online and mobile platforms. For example, the International Rescue Committee (IRC) developed content for use in refugee camps and emergency settings, where playful parenting activities have been adapted to support families through phone calls. Also, PATH Mozambique created interactive radio dialogues and songs that are shared via portable radios in health facility waiting areas in communities with limited internet access. In India, Ummeed increased the accessibility and engagement of young children and parents in virtual "fun groups" using Zoom, which provide social support and fun activities outside of their prescribed programs. In Colombia, the Kangaroo Foundation worked with hospital staff to promote and protect kangaroo mother care and early initiation of breastfeeding regardless of mothers' COVID-19 status; and both Canada's Nobody's Perfect program and the MaPa program in the Philippines delivered stress reduction strategies via Zoom to help promote positive parent-child interactions.

With respect to ***support for early learning and play***, programming focused on promoting parent-child interaction, bonding and playful parenting during the pandemic. To help facilitate playful interactions, 21 Luglio in Italy launched a 'fairy tale hotline' for children to call during lockdown; PATH Mozambique developed radio and video segments and printed materials that illustrate examples of playful parenting and child activities, and some Nobody's Perfect facilitators in Canada delivered activity kits to families ahead of digital group sessions. Several programs also provided direct school readiness and learning support via telephone calls or Zoom (e.g., Ahlan Simsim program in Jordan, Ummeed Development Center in India).

In terms of support for ***child safety and protection***, some programs provided direct aid (e.g., 21 Luglio's distribution of baby packages in Roma settlements) and leveraged their connections to other community-based organizations and/or government services to refer families to appropriate assistance (e.g., 21 Luglio in Italy, Ummeed in India, IRC in Jordan). In an effort to prevent violence against children, the MaPa program (Philippines) distributes material across multiple platforms to promote positive caregiver-child interactions through nonviolent discipline, positive reinforcement, problem solving, and conflict management strategies.

Shifting to Remote Program Delivery: Facilitators And Challenges

Many of the emerging lessons to date are context-specific. However, there were several common facilitators and challenges associated with the shift from in-person to remote (digital/internet, telephone, radio, etc.) program delivery:

Common ***facilitators***
• Flexibility among staff and donors • Risk-taking and having an innovative mindset • Continuous pilot testing and adaptation • Effective, motivated leadership team • Advocacy skills • Ability to identify/generate resources • Strong community partnerships • Leveraging local contextual knowledge

Common ***challenges***
• Low computer/internet literacy • Inequitable access to technology (smartphones, secure internet connection, airtime) • Competing childcare/household demands • Difficulties engaging participants online • Difficulties integrating play • Difficulties assessing body language online • Lack of physical contact with children

Perceived challenges in delivering remote programming often related to technical difficulties, poor access, and connection issues. There were also initial challenges in building rapport, the flow of conversation, and discomfort sharing personal information on digital platforms. In addition, most program staff reported that promoting playful parenting and play more generally is challenging to implement digitally. Families missed opportunities to see playful and responsive caregiver-child interaction modeled in-person during parenting groups. Despite these challenges, programs found ways to improve interactive engagement, facilitate sharing between parents and caregivers, and integrate play during virtual sessions. Key learnings are summarized below.

Key Learnings

Implementation

- Programs used multiple platforms to engage with families from a distance (e.g., WhatsApp, Viber, Facebook Messenger, Zoom, radio, podcasts, and telephone calls). Collecting rapid feedback from caregivers helped to determine the most appropriate platform(s) in each context, taking cultural preferences and privacy concerns into account.
- Ensuring the required technology (e.g., smartphones, tablets, internet connection, audiovisual capabilities) is in place was an important first step. Some programs implemented strategies to improve accessibility to digital tools, such as providing tablets, earphones, and airtime ahead of time.
- Following a 'hierarchy of connectivity' protocol: Zoom was offered as the go-to (ideal) platform, then a WhatsApp video call if Zoom failed, and finally, a phone call if the first two options were not possible. By reviewing this 'hierarchy' protocol ahead of the sessions, participants knew what to expect and could move efficiently between media if needed.
- Sharing links to related videos and other multimedia content before digital sessions helped to generate discussion and make the sessions more efficient.
- Setting participant expectations through stand-alone introductory sessions was critical. Introductory sessions also provided an opportunity to instruct participants on how to use the technology platform, which saved time during group sessions.
- Having multiple facilitators present during Zoom calls helped to ensure that group sessions ran smoothly.
- Shortening sessions to accommodate caregivers' competing household/time demands; holding shorter, more frequent sessions worked best across contexts.

- Using engaging strategies like role-play and live scenario demonstrations to illustrate parenting techniques and stress reduction skills during Zoom sessions; in some cases these were pre-recorded and sent to participants before the sessions.

New approaches

- Using social media channels to connect parents to each other outside of the planned sessions (though closed Facebook groups, for example)
- Using chat boxes and collaborative tools like Google's *Jamboard* during virtual group sessions helped to reinforce learning and increase participant engagement
- Engaging children in digital sessions using Zoom's 'spotlight' feature to highlight the primary active speaker for all participants
- Encouraging caregivers to send photos/videos of playful parenting and parent-child interactions via WhatsApp for remote feedback and coaching
- Conducting anonymous conference calls to facilitate sharing and learning between caregivers; this was useful if families had privacy concerns
- Running digital 'fun clubs' (cooking, singing, dancing, poetry) to foster social networks among caregivers

Incorporating play

- Live simulations or role-playing via Zoom as opposed to lecturing
- A 'fairy tale hotline' for caregivers and children to call during lockdown
- Encouraging caregivers to use common household items to engage children in play
- Group brainstorming on how to use existing toys in new and creative ways
- Setting up scavenger hunts in the home
- Involving children in playful 'energizers' during group sessions on Zoom
- Encouraging free play during Zoom calls
- Distributing activity workbooks/play kits before Zoom sessions to use as a parent-child activity

Content

- Developed new content to address caregivers' and frontline health workers' mental wellbeing
- Delivered messaging about the benefits of playful parenting and how it can help children to become more resilient during times of crisis
- Improved the relevance of ECD messaging by linking the content directly to caregivers' immediate situation (e.g. in the Philippines, parenting simulations focused on real-life situations encountered during the COVID-19 lockdown).
- Delivered simplified key messages to maximize time during virtual sessions.

Unexpected outcomes and opportunities

While the COVID-19 pandemic caused massive disruptions to nurturing care initiatives globally, it also led to several unexpected positive outcomes:

- **Increased opportunities to engage male caregivers.** In India, the male household head is often the only family member who owns a smartphone, which may pose difficulties reaching women – typically the primary caregivers. However, some community health workers reported that because

men were at home, and not working, they had more time to engage with childcare activities and were keen to participate. Virtual delivery allowed both parents to participate in the programming.

- **Increased appreciation for the role of the primary caregiver.** In several cases, there was a perceived shift in men's perspectives regarding women's work. In India, for example, being 'stuck at home' during the lockdown enabled fathers to gain a better understanding of the household and caregiving labor that typically falls on the shoulders of women in this context.
- **Established meaningful connections with caregivers**. Despite some initial skepticism among program staff, facilitators were able to make meaningful, lasting connecting with caregivers, and reported that informal socializing could indeed happen organically online. In Canada, for example, facilitators found that many participants maintained contact through various platforms, even outside of the Nobody's Perfect parenting groups.
- **Improved social cohesion and community trust.** In some cases, shifting programmatic priorities to address families' immediate needs provided an opportunity to build social cohesion and community trust, especially when serving refugee and displaced families and communities. For example, 21 Luglio's distribution of baby packages attracted new families to the organization. By responding to community needs and engaging families in the process, 21 Luglio strengthened their visibility, and more women and children participate in ECD activities now as a result.
- **Wider programmatic reach and increased participant diversity.** Digital delivery of program content enabled families from diverse backgrounds and rural and remote geographies to participate, expanding program reach to previously underserved communities (for example, in rural Canada). In many cases, caregivers also appreciated the convenience and flexibility of not having to travel or secure childcare to participate and connect from their homes.
- **Online engagement was a better option for some children.** Several program staff noted that online engagement was preferred over in-person learning for some children, for example, those with high levels of social anxiety. Conducting in-person visits in full personal protective equipment (PPE) may be potentially triggering and thus counterproductive for a child with autism, for example.
- **Increased opportunities for inter-sectoral collaboration and ECD integration.** In some contexts, the pandemic provided an opportunity to advocate for crucial ECD content to be integrated into existing government programs because the needs became 'more obvious' during this time (e.g. social-emotional learning in Jordan). In several cases, programs collaborated with other organizations, Ministries of Education, Health and Social Development to develop and integrate content. This is expected to increase inter-sectoral collaboration and sustainability of nurturing care initiatives even beyond the pandemic.
- **Flexible program funding.** In some cases, funders immediately granted substantial and flexible funding in response to the COVID-19 pandemic, which helped programs to adapt quickly during these uncertain times. Loosening or eliminating restrictions on current grants and making new grants as flexible and accessible as possible provided an opportunity to innovate and support communities on the frontlines of the COVID-19 pandemic.
- **Catalyst for quick, creative thinking.** Across diverse programmatic contexts, the COVID-19 pandemic provided a necessary 'nudge' for innovation, catalyzing change, and 'out of the box' thinking.

Implications and Future Research

While the COVID-19 pandemic served as a catalyst for innovation, it also exposed inequities and widened the digital divide. Efforts to ensure equitable access to technologies that enable digital participation must be prioritized moving forward. Additionally, more work is needed to improve digital delivery of some aspects of programs and services to create enabling environments for nurturing care, namely identifying mechanisms to identify and refer suspected cases of child neglect and maltreatment, how to "do" play during confinement, especially for low-income families who are experiencing high levels of stress and few resources for at-home learning. There is also a need for strategies, policy, and advocacy to support learning continuity for pre-school aged children, especially given that school reopening efforts have not prioritized pre-primary in many low-income countries. Lastly, findings point to the importance of addressing caregiver burden and stress to support ECD, particularly during lockdown periods when access to typical sources of social support is limited.

Given the wide-ranging and potentially detrimental impacts associated with the COVID-19 pandemic for parents, children, and families, it is imperative that future research investigate which programs and strategies work best during health emergencies, for whom, through which mechanisms, and in which contexts. Data on programs' reach, impact, and cost effectiveness relative to the pre-pandemic period will be useful; formal evaluation work is already underway in some contexts. Evidence is needed to provide governments, donor institutions, and civil society actors with the information necessary to make informed, evidence-based decisions around which interventions and policy responses to prioritize, both in the current crisis and in the context of future emergencies.

While digital models undoubtedly hold promise, they cannot replace all face-to-face ECD activities, particularly among refugee groups and other socially/geographically vulnerable groups in need of increased social support. Families of children with developmental disabilities also benefit from in-person services, where they learn by observing and replicating therapist-child interactions. Consequently, most program staff stated a preference for hybrid delivery models in the future. To ensure that emerging lessons extend beyond the COVID-19 pandemic and inform future crisis response, promising and inclusive nurturing care delivery strategies should be integrated into existing government programs wherever possible.

Case Studies: Program Profiles

Case Study #1: Associazione 21 Luglio (ITALY)

Program Overview

Before Covid-19

- Mothers support groups
- Play Hub and toy library
- Baby play space
- Home visits for pregnant women and mothers
- School readiness activities
- Social/legal assistance

After COVID-19

- Mothers support groups (Zoom and WhatsApp)
- Distribution of baby packages
- Fairytale hotline for children
- Repurposed outdoor garden for safe, distanced play, mothers groups and seminars
- Social assistance hotline

Founded in 2010, Associazione 21 Luglio ("July 21 Association") is an Italian not-for-profit organization committed to supporting families living in conditions of extreme poverty, cultural deprivation, discrimination and social exclusion. The Association implements its programs in state-sanctioned emergency housing settlements (often referred to as "villages" or "camps") in peripheral neighborhoods of Rome. The settlements are home to self-identified Roma families, as well as migrants from African, Latin American and Caribbean nations. The settlements are largely neglected by State institutions, and living conditions are dire: old shipping containers (226 sq. ft) serve as housing units, often for up to 7 family members at a time (3). Access to electricity, functioning sewage systems, clean water, and outdoor green space is limited. In addition, eviction threats, neighborhood violence and criminal activity are common, and access to social services, including healthcare and legal services is poor. An estimated 41% of residents live in absolute poverty (defined as lacking basic necessities for survival), and 20% have zero income, meaning they engage in informal work or rely on government financial assistance.

Associazion 21 Luglio takes a rights-based, community-driven approach to research, advocacy, capacity building and empowerment activities, with a particular focus on the rights and wellbeing of Roma

caregivers and children. Their efforts to support children and families follow a systemic "concentric circles" framework - acknowledging the complex interplay of multiple layers of influence on child wellbeing, from the individual child, to the family, community, and more upstream institutional factors like the education system and government bodies. The association works to improve child wellbeing by working *within the system* (directly engaging children and caregivers) as well as *on the system* (collaborating with academics, media outlets, journalists and decision makers). A majority of their programs take place at the "Polo Ex Fienile", a large cultural and education center located in Tor Bella Monaca, a peripheral suburb of Rome.

To appreciate the significance of Polo Ex Fienile, it is critical to understand the social context within Tor Bella Monaca. The community is characterized by high crime and school dropout rates, and is home to the largest drug market in Rome. As a result, mistrust and suspicion are deeply engrained and residents are generally reluctant to trust people outside of their immediate families. As a long-term academic collaborator explained, the neighborhood is extremely fragmented, both socially and in terms of spatial identity such that residents tend to feel safe and protected only in their own space, and leave the rest to the "rule of the jungle". In other words, the concept of *common* space is foreign in Tor Bella Monica – space is either private, or it is public, and public space is considered "no man's land". Even prior to the COVID-19 pandemic, a culture of suspicion made it difficult for 21 Luglio to challenge these notions and convince families to embrace Polo Ex Fienile as a common, shared community space. However, little by little, they have made progress in building social cohesion and trust.

Key Interventions

Associazion 21 Luglio implements several programs to promote ECD and improve the wellbeing of children living in settlements, particularly for those who are unable to secure placement in formal pre-school or kindergarten due to illegal residency or lack of Italian citizenship. Key programs are summarized below.

1. **Toy for Inclusion – Toys to Share, Play to Care:**
    - Promotes social inclusion and strengthens integration of Roma and all marginalized young children 0-8y through informal educational services and improves their transition to formal education.
    - *TOY for Inclusion "Play Hub"* – a welcoming indoor space where children, parents and grandparents of diverse backgrounds can play, exchange ideas, and receive information about early childhood education (ECE), health, and development in a fun and inclusive way.
    - A Toy Library for children 0-8y encourages the playful learning. Games and books are available through a loan service for use outside of the library.
    - Bi-weekly intergenerational learning meetings for children aged 0-6y, and their families. Parents, grandparents and other relatives are encouraged to attend and engage in mutual exchange of stories and intergenerational knowledge. An educator and a cultural mediator facilitate the meetings.

2. **Bambini al centro (Children in the Center):**
    - Home visits for pregnant women and mothers with children 0-3y
    - A "baby space" is offered three times per week. The space is managed by an early child educator who encourages parents to engage in free play with their children to promote

positive parent-child interactions. Guest ECE experts hold informal meetings twice per month to discuss parenting skills.

- *Mondi di mamme* ("*Moms' Words"*): Group sessions for mothers of children aged 0-6y to support the cross-cultural exchange of caregiving knowledge and practices. The groups are facilitated by a sociocultural anthropologist from University of Rome Tor Vergata and sometimes supported by an expert on priority areas identified by participants (e.g. pediatrician, nutritionist, midwife, etc.).
- A social/legal help desk that provides assistance for social, health and school orientation aimed at families of 0-6 children facing bureaucratic obstacles.

Response to the COVID-19 Pandemic

In the early stages of the pandemic, Italy was one of the countries hit hardest by COVID-19, and on March 9th 2020, the government announced a countrywide lockdown to contain the spread of the virus. The 70-day lockdown restricted movement of individuals outside of their homes, aside from essential trips for groceries and medication. This initial period suspended 21 Luglio's existing programs and activities and forced all operations to shut down for a number of weeks.

The Association's leadership implemented an immediate needs assessment to develop an effective response strategy. Staff conducted a telephone survey in four of their most socially and economically vulnerable program areas (Tor Bella Monaca district, Via de Salone formal slum, Castel Romano formal slum, and Tor Cervara formal settlement). The survey explored the impact of the lockdown restrictions on the wellbeing of children and their families. Two critical findings emerged:

1) Lockdown restrictions prevented families from conducting informal work needed to ensure daily sustenance, resulting in high levels of food insecurity for families with young children.

2) Families received limited information or guidance from authorities on how to protect themselves from the coronavirus, and experienced increased police presence in their neighborhoods with little explanation. As a result, residents were "paralyzed by fear and uncertainty". This situation disrupted community solidarity and cohesion, which in normal circumstances plays an important role in people's ability to navigate crises collectively (3).

21 Luglio staff mobilized quickly to develop a research-informed response strategy. Addressing the identified needs required a complete re-thinking of program content and delivery mechanisms, as described by an academic collaborator:

> *"21 Luglio managed to really recast its mission. It's been a dramatic change – whereas before, the community center was a knot of social relations, it had to become a station for broadcasting, and for diffusing information, goods and services." - Academic partner, Tor Vergata University of Rome*

While Associazione 21 Luglio's initial pandemic response focused on immediate needs, such as addressing food insecurity, in the post-lockdown period, they implemented interventions that aimed to reduce

inequalities produced by the crisis, and support families and mothers in particular in a "regenerative process of community creation" (4). The Association's various responses are summarized below.

Advocacy and community mobilization

Early in the lockdown period, 21 Luglio launched an appeal to the mayor of Rome to "to urgently activate measures aimed at protecting the right to health and school continuity" (5). Leadership staff also negotiated with donors to swiftly re-direct existing funds towards emergency response activities. When lockdown restrictions loosened, 21 Luglio recruited community volunteers to offer services at the community center (e.g. painting, cooking, teaching African dance and music). This leveraged people's unique skills to help foster a sense of community during the pandemic.

Social protection and food security

Associazione 21 Luglio activated a social assistance 'hotline' to assist families and facilitate access to different forms of public financial support. Families could request assistance from volunteers to help with grocery shopping or pharmacy trips. Staff also developed online seminars on COVID-19 related topics in collaboration with the University of Rome.

To address the issue of food security among young children, the Association initiated a fundraising campaign to collect material goods and cover the cost of basic items for "baby packages". During the lockdown period, 21 Luglio's fundraising efforts generated over 100,000 euro (19,000 euro from individual donations, 20,300 euro from foundations and private institutions, 53,900 euro re-allocated from existing funding sources, and 10,000 euro from a public institution) (5).

At the beginning of the lockdown in March, staff conducted individual interviews with all mothers who expressed food needs for young children. Staff worked with a pediatrician and obstetrician to develop five age-appropriate packages of food, diapers, sanitizing wipes, and infant formula where necessary. Each Saturday, community volunteers participated in the packaging and distribution process (outdoors, distanced, and masked) to promote increased sense of community solidarity and ownership. In total, 85 volunteers were involved in the process. Among the volunteers were ordinary citizens, community activists, and recipient mothers/families themselves. From April 1 to May 18, 2020, association staff and volunteers distributed a total of 1,400 baby packages and 340 family packages (5).

Once per week, caregivers (typically mothers) attend Ex Fienile in person to pick up personalized baby packages while following COVID-19 safety protocols. During this time, caregivers are encouraged to socialize with other families and play with their children – this is another opportunity to share experiences and receive parenting tips from 21 Luglio staff in a relaxed, fun environment. The association invited key stakeholders from the church and other institutions to observe and contribute to the packaging and distribution of packages, which helped to raise awareness of the situation.

Support for children's early learning

To support early learning during the lockdown, 21 Luglio initiated a phone-based service ("Tales on the Phone") which allowed young children to listen to recordings of fairytales in two languages, Italian and in Romanes. Parents received a flyer with their baby packages, which directed them to the phone number. This was intended to signal the importance of play and imagination for children, even during the lockdown period. Additionally, Luglio staff provided children with internet access (tablets and data) to allow them to connect with e-learning platforms used by schools. Volunteers also assisted children with homework via with the help of mobile phones.

Parenting support and outdoor play spaces

The Association continued to implement 'Mom's Words' groups via WhatsApp Groups and Zoom during lockdown. This enabled staff to keep in touch with women, provide advice regarding COVID-19 and other emerging concerns, and to share suggestions for home-based activities for young children. After COVID-19 restrictions loosened, 21 Luglio repurposed their outdoor garden space at Polo Ex Fienile, and Mom's Words groups resumed in person with masking, social distancing and other safety protocols in place.

The outdoor garden space now enables a number of activities to run safely outside, including a mobile library and group seminars with expert guest speakers including obstetricians, nutritionists, and ECE experts. Since September 2020, a mobile Play Hub has been open two days per week in the Ex Fienile garden. The Play Hub contains various toys for different age groups and offers a safe alternative to indoor play activities during the COVID-19 pandemic. Staff run activities at the Play Hub to promote cognitive and relational skills while encouraging inclusion and social integration of families of various ethnic backgrounds. The Play Hub is intended to serve as a bridge to formal early childhood educational services.

Once per week, parents attend outdoor Italian language course while a staff member at the Play Hub supervises their children; this encourages independent play while parents obtain new skills to help advance their professional development and chances of gaining employment.

After the lockdown ended and children could attend Polo Ex Fienile with safety protocols in place, the team knew they would have to respond to new psychological and emotional needs. To facilitate emotional learning, ECE staff focused on a different emotion and culture each week to explore how to process and engage with different emotions (e.g. during "calm" week, children would explore origami and yoga).

Lessons Learned during the COVID-19 pandemic

Challenges encountered and mitigation strategies

When the COVID-19 lockdown began, 21 Luglio staff worried about disruptions to the strength of their relationships with community members – connections they had worked hard to establish over time through community engagement and face-to-face activities at Polo Ex Fienile. Staff also anticipated that this period of isolation would exacerbate families' already precarious, socially excluded status in society, putting them at even greater risk of mental stress, anxiety and depression. Social workers and ECE staff perceived the absence of physical contact with young children to be a major loss.

> *"Interruptions to social cohesion and the lack of physical contact – these were the biggest losses. Not hugging the children when they come to the center is difficult… Physical contact is so important for child development, so that has been a challenge."*
> *- Social Worker, 21 Luglio*

Another challenge related to inequities in access to technology. For example, while WhatsApp groups helped to maintain some connections to mothers, some did not have access to mobile phones or a reliable internet connection. WhatsApp groups were "better than nothing", but staff members reported that they are no replacement for face-to-face social interactions, which instill a sense of safety and trust. A key aspect of the parent group sessions was having snacks and tea together – sharing food brought women

from different cultures and ethnic groups together, facilitated bonding and social cohesion, and encouraged informal discussion. It was not possible to replicate this over WhatsApp or Zoom.

To facilitate the transition to outdoor programming after the lockdown period, the Association hired an expert to conduct an outdoor education workshop for staff. This was an excellent learning opportunity for ECE staff, and helped to transform their entire approach to programming.

> *"Shifting the activities outside has been an exciting challenge for us – it's pushed us to work outside, and discover some old ways of playing like hide-and-seek, for example. Playful learning is actually easier outside - this is so great for kids!"*
> *- Social Worker, 21 Luglio*

A key learning was that in-person activities are possible to implement safely, and in fact these approaches are preferred, so long as the necessary safety protocols are in place. Several staff stated that they wish they had resumed in-person activities in the garden space sooner.

Additional facilitators

Several key facilitators enabled 21 Luglio to implement their response efforts during the COVID-19 pandemic. First, a close acadmic collaborator felt that the Association's reputation and prestige in Rome helped to facilitate fundraising and awareness building; this is a testament to their previous advocacy work, and their 'systemic approach'.

Social workers' interpersonal skills were key to gaining respect from community members. Distribution of baby packages enabled frequent interactions with many women and children, and the team was able to leverage this opportunity to get to know families, learn about their lived realities, and build solidarity over the course of the pandemic.

Importantly, many 21 Luglio staff come from Roma communities themselves. The association's conscious decision to hire people from the same communities ensures that program participants see themselves reflected in the association; this has helped to build trust and strengthen relationships during the crisis.

Furthermore, the association's flexibility, innovative thinking, and willingness to reimagine their entire delivery model to address social protection needs served as a critical catalyst for action. Despite the challenges encountered, 21 Luglio staff came together to think creatively and adapt. This was facilitated by a shared vision and commitment to the Association's mission, which ultimately strengthened their own team as well.

> *"What we learned from this experience is that you cannot surrender to the difficulties. This is yet another example of the fact that you must always think outside the box. You must be able to see things differently, you have to invent, to be creative – this is the lesson." - Academic partner, Tor Vergata University of Rome*

The Association's Local Action Team (LAT), characteristic of the TOY for Inclusion approach, served as another important facilitator. The Association assembled this team about three years prior to the pandemic. The LAT is comprised of key community stakeholders such as municipal social workers, other NGO representatives like Save the Children, Director of the Elderly Center, and University partners, among others. The collaborative effort of the LAT was instrumental in helping 21 Luglio identify specific families in need of assistance, and organize/mobilize volunteers to respond.

Another strength of 21 Luglio's approach was the staff's ability to identify and respond to families' *implicit* needs. As one participant described, marginal groups tend not to ask for what they need and may be less likely to seek services directly. The Association is well aware of this, and staff members strive to identify the unspoken needs of the community. For example, through informal discussions, social workers noticed that mothers were constantly describing challenges with newborn care. Knowing that these women are living far away from any relatives, and are particularly isolated during the COVID-19 pandemic, the team organized a group session and invited an obstetrician to teach participants about newborn care.

Similarly, social workers noticed that many mothers were requesting infant formula with their baby packages. Through informal discussions, staff realized that many were struggling to initiate and/or continue breastfeeding. This reflects a lack of breastfeeding support in hospitals, particularly for immigrant and low-income women. This combined with increased stressors during the pandemic led to increasing reports of low milk supply among postpartum women. To address this problem, 21 Luglio invited a midwife to help facilitate Moms' groups and discuss challenges with breastfeeding. While guest speakers were invited to speak prior to the COVID-19 pandemic, the Association's community engagement during the pandemic has resulted in higher attendance by women and broader reach.

Unexpected Positive Outcomes

Associazione 21 Luglio has been working for years to strengthen community ties and build a sense of trust with settlement families, and they had made progress in this regard, even prior to the COVID-19 pandemic. However, in the absence of providing a shared community space during lockdown, staff were concerned about losing previous gains. The lockdown presented an opportunity to solidify trust by deeply rooting their response efforts in the community, and by including local volunteers and decision makers in the process. One participant described this as a "rite of passage" – the pandemic tested the Association, giving them an opportunity to prove their commitment to the community.

This increased social cohesion and sense of solidarity has led to several community-led initiatives as well. For example, local mothers recently initiated a baby clothing and household goods exchange at Polo Ex Fienile; this emerged organically during the pandemic as a result of their involvement in the baby package initiative. Little by little, and with the COVID-19 pandemic serving as the final 'nudge', Polo Ex Fienile has evolved into a source of common space – a shared place for the community to come together. As a result, the association now has a broader reach, and more mothers and children are attending services than ever before.

> *"This is one of the good things to come of the Pandemic; now we are really building something with the community." – Social Worker, 21 Luglio*

Case Study #2: Ummeed Child Development Center (INDIA)

Program Overview

Before Covid-19

- Direct clinical services for children with disabilities
- Early intervention center and school readiness program
- Parenting support groups
- In-person ECD training workshops for caregivers, service providers, educators
- ECD training for CHWs
- Fun clubs for children and caregivers

After COVID-19

- Shifted all in-person programming and fun clubs online (Zoom, WhatsApp)
- Three new training courses for CHWs on mental health support for CHWs and caregivers and Promoting ECD in challenging times

Ummeed Child Development Center, a not-for-profit organization, was founded by Dr. Vibha Krishnamurthy in 2001 in Mumbai, India. Ummeed's mission is to help children with disabilities and to advocate for greater equity and inclusion of these children in schools, healthcare settings, and society more broadly. Over 52 million Indian children have developmental disabilities, and less than 1 in 4 of them have access to appropriate care (6). Ummeed, which means "hope" in Hindi, aims to help meet this need through a multisectoral approach that includes clinical services, school readiness and parenting support, training for health care workers, and research and advocacy.

Direct clinical services

Ummeed employs an interdisciplinary team of more than 70 child disability specialists (e.g. pediatricians, social workers, occupational therapists, speech and behavioral therapists, and mental health experts). The organization provides specialized clinical care for a range of developmental disabilities including Autism Spectrum Disorder, Cerebral Palsy, Mental Retardation, Learning Disabilities, and Attention Deficit

Hyperactivity Disorder, among others. The Center offers an integrated approach to ECDD (Early Child Development and Disability) services for children and their caregivers, all under one roof. This integrated care model is unique in Mumbai, where caregivers of children with special needs are typically shuffled between fragmented services across the city (7). Ummeed's programming follows a family-centered care philosophy (8) whereby ECDD professionals prioritize family strengths and preferences, and *collaborate* with parents/caregivers to provide high quality individualized care for each child.

Early Intervention Center and School Readiness

In addition to providing one-on-one clinical services, Ummeed hosts an Early Intervention Center (EIC) for children with disabilities ages 2 to 5 years and their caregivers. The EIC is led by an occupational therapist and a physiotherapist, and run by schoolteachers and Child Development Aides (a cadre of ECDD workers trained by Ummeed). Families enroll in the EIC program for one year, and the sessions run three times per week for 2 hours each. EIC staff follow a child-centered, play-based philosophy whereby children learn and flourish at their own pace through free play, social play, songs, and stories. During the sessions, staff use the Keys to Interactive Parenting Scale (KIPS) tool (9) to assess caregiver-child interactions and coach caregivers to facilitate children's learning and development through playful parenting. Caregivers are encouraged to actively participate in early stimulation and play activities, and then replicate them at home. This emphasis on caregiver empowerment decreases dependency on therapists over time, and helps to ensure that children develop the necessary skills and meet key development milestones prior to joining regular schools.

In addition to the EIC's school readiness program, Ummeed has also implemented an adapted version of the Project ImPACT intervention for autistic children (10), a parent-mediated program that applies Naturalistic Developmental Behavioral Interventions (NBDI) to build four core social communication skills: 1) social engagement, 2) language, 3) imitation, and 4) play (11). Prior to the COVID-19 pandemic, these programs were entirely center-based and relied on face-to-face interactions. Lastly, Ummeed's mental health team offers a monthly support group for caregivers of children with disabilities.

Training

A key component of Ummeed's programming is their training centre, which provides ECD workshops and courses for clinicians, professionals, community-based organizations (CBOs), community workers, caregivers and educators. Ummeed's approach to developing training programs is theory and evidence-driven, and trainings are routinely evaluated using theoretical frameworks like the Kirkpatrick Model of Training Effectiveness. The Training Center serves as a "Center-of-Influence" in the ECDD space and is guided by the following goals (12):

- Increase sensitization and awareness about developmental disabilities amongst all stakeholders
- Support parents in learning about disabilities, advocating for their child, and effectively facilitating their child's development
- Build capacity within not-for-profit organizations and schools for early identification and intervention in children
- Train professionals in evidence-based, culturally relevant models of care using the principles of family centered care
- Create greater awareness among policy makers

Through partnerships with CBOs operating in low-income communities across India, Ummeed provides training for frontline community health workers (CHWs) to promote and monitor child development, and to support families of young children with special needs. Ummeed delivers a year-long responsive caregiving training program for CHWs and their supervisors in which they learn to promote ECD in children at risk, recognize signs of developmental delays using standardized tools, and refer families to appropriate local resources and services. This fills an important gap and strengthens health systems, as CHWs typically receive no formal training in ECD or developmental disabilities. Ummeed's strategy of integrating ECDD with CHWs' existing knowledge and skillsets holds promise as a sustainable solution as it is integrated into existing delivery systems with widespread reach.

Ummeed also conducts the World Health Organization Autism Speaks Caregiver Skills Training (CST), an open-access training program for caregivers of children ages 2 to 9 years with developmental delays or disorders, including autism, designed for implementation in low-resource settings by non-specialists (13). The CST program combines nine weekly group sessions with three home visits to promote improved understanding and acceptance of developmental delays and disorders, and help caregivers learn skills that promote development, communication and functioning. More information about Ummeed's implementation of the CST program can be found here.

Research and Advocacy

In keeping with an evidence-based approach, Ummeed engages in community research and impact assessment studies to improve measurement and evaluation relevant to their ECDD work. For example, in partnership with Yale University and the University of Ankara, the Ummeed team developed the International Guide for Monitoring Child Development (GMCD), a tool designed for community health workers in LMICs to monitor ECD. Frontline workers with lower literacy levels, limited formal training/awareness of child development markers, and no direct connections to trained medical professionals, can use the tool, and Ummeed has incorporated the GMCD tool into their trainings. The GMCD facilitates developmental monitoring and early detection of developmental delays in children aged 0-42 months, and has been standardized in four countries (Argentina, India, South Africa, and Turkey) (14).

Response to the COVID-19 pandemic

India's first COVID-19 cases were reported in Kerala in January 2020 and the coronavirus spread quickly across the country over the months that followed. Beginning on March 25, 2020, the government imposed a strict 75-day nationwide lockdown. The restrictions were announced abruptly, with little contingency planning, which led to the widespread movement of urban workers as they travelled to their homes in rural areas. By the end of May, India had reported 5000 deaths.

Initially, all of Ummeed's interventions, which were based on in-person services and programs, were put on hold while the team brainstormed ways to reach families remotely. Given the strict lockdown measures imposed by authorities, Ummeed's initial response involved phone calls to families to provide emotional support, and mobilizing with their partner CBOs with a focus on social protection to ensure families had access to immediate needs like food and medicines.

From May to June 2020, Ummeed conducted a large phone-based needs assessment with their partner CBOs to understand how caregivers were coping with the COVID-19 pandemic, and in particular, how

lockdown measures were influencing their ability to provide nurturing care for their children. Several critical findings emerged:

(a) Lockdown restrictions led to increased household stressors such as food insecurity, reduced access to healthcare services and medicine, and a sudden loss of employment and livelihoods; families perceived these to be the highest priority needs.
(b) Due to the above stressors, many caregivers were completely overwhelmed, experienced increased mental stress, and in some cases experienced increased alcoholism and domestic violence.
(c) Caregivers were unsure of how to engage their young children within the confines of their homes all day, given the heavy double burden of household and work demands. Caregivers also expressed concerns about how to cope with and respond to new behavioral challenges and developmental regressions.

"During the lockdown, people were just trying to survive, so how do we even talk about ECD? But ECD is still so important, so [we asked ourselves], what is the most sensitive way to respond?" - ECD/mental health specialist, Ummeed

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As the COVID-19 situation evolved, it became clear to Ummeed staff that they would need new processes in place to provide clinical services, and innovative strategies to reach families experiencing a range of stressors and with uneven access to technology. Ummeed began to shift their existing programs and re-design their content from in-person to remote delivery format. For example, individual clinical consultations were conducted via by telephone or by Zoom. Similarly, EIC group sessions, the school readiness program for autistic children, Project ImPACT, monthly mental health support groups, the responsive caregiving training program for CHWs, and fun/leisure clubs for caregivers were all redesigned for virtual delivery.

In addition to highlighting the needs of direct beneficiaries, Ummeed's needs assessment found that CHWs, who are often caregivers themselves, were facing similar challenges in their own households. This situation led to a sense of hopelessness and burnout, and making it difficult for CHWs to respond to the needs of children, families and their communities. Consequently, mental health support for CHWs was identified an opportunity for intervention during the COVID-19 pandemic.

"CHWs were saying 'if we don't understand our own mental health, then how do we help others?'" – ECD/mental health specialist, Ummeed

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To address the increased mental stress among parents, other caregivers, and CHWs themselves, Ummeed developed three online 2-hour workshops for delivery to CHWs: 1) Mental health support for CHWs themselves; 2) Mental Health support for caregivers and parents; and 3) Promoting ECD in challenging times. Workshops were designed based on adult learning theory, and using an experiential pedagogical

approach that combines didactic learning with facilitation, modeling, personal reflection, and group discussion.

All three workshops were delivered to CHW participants online via Zoom or Google Meet. Workshops 2 and 3 were accompanied by short animated videos. After watching the videos, participants discussed strategies to disseminate the videos within their communities – for example, via WhatsApp. The videos are available in Hindi, Marathi, Gujarati, and English and are freely accessible online. Table 2 summarizes the content of each workshop.

Table 2. Ummeed's Novel Training Program for CHWs during the COVID-19 pandemic: Content Overview

Workshop	Content areas
1. Mental health support for CHWs	• What is mental health and why does it matter? • What impacts mental health, especially in the context of the COVID-19 pandemic? • What are some "little yet big" things CHWs can do in their everyday lives to take care of themselves?
2. Mental health support for caregivers and parents	• What is the impact of the pandemic on caregivers' and parents' mental health? • What "little big" things (from Workshop 1) could CHWs encourage caregivers to try?
3. Promoting Early Childhood Development in challenging times	• How has the pandemic affected the five components of nurturing care? • How can CHWs support caregivers in their communities to promote child development?

Lastly, Ummeed's mental health staff ran two monthly "fun clubs" on Zoom; one for children with disabilities, and one for families enrolled in their programs. This provided a time to disengage from the clinical/therapy sessions and connect with other families in a fun, relaxed environment. Sharing stories, music, poems, and cooking skills helped to foster a sense of community and provide additional social support during a difficult time. The fun clubs continue to run regularly and are typically scheduled on weekends to facilitate participation by all family members.

Lessons Learned during the COVID-19 pandemic

Challenges encountered and mitigation strategies

The process of shifting services and programming to virtual/remote delivery was no simple feat, and the challenges encountered ranged from social and cultural to technical. For example, parents of children with developmental delays place a major ***emphasis on seeing the child in person***, and many wondered how therapists/clinicians could possibly assess their child without being in the same room.

"Something that became clear from our families is that they really needed us to see their children… to interact with them directly, in person"
– Developmental pediatrician, Ummeed

Because of this, there was initial skepticism among caregivers regarding the effectiveness of virtual therapy sessions. Ummeed staff applied several strategies to mitigate this obstacle:

- set clear expectations about what they could and could not do during a zoom session in advance;
- had live free play sessions during group calls so that therapists could coach the parents in real time, and parents could learn from each other;
- encouraged families to record parent-child interactions outside of the Zoom calls and send clips to therapists for feedback; WhatsApp was an effective application to facilitate these exchanges.

Another cultural issue that emerged relates to the concept of self-care. In the mental health training modules, CHWs learn about the importance of taking time for themselves to help manage stress, and to encourage caregivers in their communities to do the same. Trainers illustrate examples, like taking short breaks throughout the day to sing, dance, or do something that brings them joy. As illustrated below, traditional gender roles and societal norms make this concept difficult to accept:

"In the Indian context, women very rarely give themselves time for self-care – it's considered to be sacrilegious or selfish – they say, 'how can you tell me to do something like this?' The caregiver role is so deeply engrained. […] It could be something as simple as taking a ten minute tea break… This may seem simple and mundane but it's a 'little big thing' that helps you take care of yourself, and be better able to respond to the needs of others"- Mental health specialist, Ummeed

The team also encountered technological issues, as families and CHWs from remote areas often had limited access to reliable internet. One strategy to deal with this was to use a ***hierarchy of connectivity***, first offering Zoom as the go-to (ideal) option, then a WhatsApp video call if Zoom failed, and finally, a phone call if the first two options were not possible. By reviewing this 'hierarchy' protocol ahead of the sessions, participants knew what to expect and could move efficiently between media if needed.

During the initial lockdown period, Internet literacy was generally low, and Zoom was a completely new technology for many caregivers and CHWs. To mitigate these challenges, Ummeed staff also developed ***Zoom orientation sessions***, which covered basic internet and Zoom functions like how/when to mute, how to set up your device for therapy sessions, where to place the camera, and other tips that would facilitate the trainings and virtual child assessments. These strategies required a great deal of staff time and effort up front, but were necessary investments to ensure that virtual delivery ran smoothly.

The challenges encountered when shifting to virtual delivery models and related innovations/mitigation strategies described by Ummeed staff are summarized in Table 3. Additionally, Ummeed has compiled

two detailed working documents that summarize their experiences, learnings and best practices in conducting online trainings and conducting online clinical sessions.

Table 3. Shifting to Virtual Delivery: Challenges and mitigation strategies reported by Ummeed Staff

Challenges encountered	Innovations/mitigation strategies
• **Smartphone penetration in India remains low** • **Inequities in internet connection (unreliable in remote areas, lower-income families may not have enough airtime/data)** • **Low-tech phones do not enable participants to hear the audio**	• Conducted short phone call consultations to help parents solve specific problems if Zoom calls aren't possible • Apply the "Hierarchy of connectivity" to exhaust all communication options • Supply earphones in advance (distributed by partner CBOs) • Check in with participants beforehand and be prepared to support any special needs (auditory, visual, etc.)
• **Cultural preference for in-person/hands-on coaching and support** • **Sharing meals in person is no longer possible (culturally, a very important aspect of social connections/bonding)**	• Ensure clear expectations of what can and cannot be done remotely, in advance • Have at least 2 team members on each Zoom session: one makes notes, the other comments on child's play and coaches parents on how to further engage them in real time. • Have parents record clips of their interactions with the child; therapists send feedback and coaching back via WhatsApp voice notes • Incorporate tea/snack breaks online to encourage casual conversation and socializing • Maintain online "fun clubs" for caregivers
• **Zoom was completely new to many clients and partner CBOs; a lot of time and effort required to orient trainees** • **Basic internet/computer literacy is low** • **Older CHWs less familiar with technology**	• Developed a Zoom orientation session for all participants (standalone first session) • For CHW trainings: Pre-recorded role plays and what ideal home visits might look like
• **Often the male household head owns the only phone in the family, making it difficult to access the mother/primary caregiver**	• See this as an opportunity to engage fathers in ECD (many showed interest because they were home and not working)
• **Participants are not used to spending long periods in front of a screen**	• Send slides/links in advance via WhatsApp • Send pre-recorded videos in advance (YouTube links)

• **Participants have many competing demands at home; difficult to focus on Zoom.**	• Increase the frequency of sessions/touch points but make each session shorter • Simplify content – focus on core messages • Send multiple reminders in advance (digital "flyers" via WhatsApp group chat) • Summarize content every 10-15 minutes
• **More difficult to engage people remotely**	• Ensure that slides are simple yet engaging (more photos, less text) • Send training materials to participants beforehand • Utilize role play, group discussion • Use Zoom's "spotlight" feature to keep children engaged • Ask direct questions to encourage participation, but "warm call" rather than cold call • Put discussion questions on a powerpoint slide, read them aloud, and also send via Whatsapp • Use WhatsApp chat to reinforce learning • Alternate between trainers/facilitators during Zoom sessions to minimize monotony

• **Unable to hold group play sessions virtually (a key aspect of in-person EIC)**
• **Children have limited toys at home, relative to the Center**
• **Unable to provide sensory learning opportunities online (e.g. "table time")**
	• Maintained 'free play' during Zoom sessions; participants unmute during this time.
	• Assign children to dyads for group discussion to encourage virtual social interaction
	• Coach parents to make creative use of household/kitchen items
	• Ask parents take turn brainstorming how to use the same toys (or home items) in different ways
	• Other creative activities via Zoom:
	  ○ Identify a texture within the home (tooth paste, flour, then add water)
	  ○ Use turmeric, beets, and other kitchen staples to learn about colors

Additional Facilitators

In addition to the specific strategies above, Ummeed staff identified a number of factors that helped to facilitate their response to the COVID-19 pandemic (summarized in Table 4 below). For example, having close connections with motivated community members (such as CHWs) who have relevant "contextual intelligence" is critical to understanding the changing needs of children and their caregivers, and innovating to support them. Several staff described the role of "jugaad", which is the ability to adapt and problem-solve, in shaping people's ability to cope with the mental stressors during the pandemic:

"Jugaad is a word we use in India. It's the contextual intelligence needed to modify and adapt, to problem solve… it's the ability to piece things together and make do with what you have. Jugaad is like having 'life hacks', and being able to think outside the box – you figure things out even if the structures around you are not supportive."
– ECD/mental health specialist, Ummeed

Ummeed often uses the concept of jugaad to facilitate their narrative therapy approach. This has been key to contextualizing the content of mental health support strategies across different communities during the COVID-19 pandemic. Mothers participating in Ummeed's mental health support groups during the pandemic created an illustrated booklet on jugaad.

Table 4. Facilitators of Ummeed's COVID-19 Response

• Partnering with CBOs and CHWs with contextual intelligence and creative problem-solving skills (drawing on the concept of 'jugaad' in trainings)
• Having flexible, understanding donors who understand the need to shift program priorities and approaches during difficult times
• Having a strong team motivated and committed to a central mission; shared sense of responsibility to achieve goals
• Being able to 'think outside the box'

Unexpected Positive Outcomes

Ummeed staff noted a number of unexpected positive outcomes related to their COVID-19 experiences during the COVID-19 pandemic. For example, shifting to an online delivery model meant that more families could participate in trainings without having to travel or relocate to Mumbai for a six-week program. This makes the program more accessible for lower-income families living outside of Mumbai and highlights the potential scalability of Ummeed's training curricula. Online training also enabled a more diverse group of CHWs to participate in training programs. Including CHWs from different geographies with diverse experiences helped to enrich group discussions and made the training more engaging. Training staff also found that CHWs were more accountable and committed to the virtual trainings because they could join from anywhere. Whereas the in-person trainings are "all or nothing" – CHWs would have to miss an entire day of training if they couldn't travel – the online option enabled participants to join in for parts of the training and then review recorded materials afterwards ("*something* is better than nothing", as one staff member pointed out).

Furthermore, while it was initially challenging not to provide hands-on, child-focused therapeutic techniques, Ummeed staff found that their virtual parent-coaching model worked surprisingly well. This was largely facilitated by parents' sharing of home videos with staff for feedback via WhatsApp; an innovative approach in the absence of in-person visits. Staff members also reported that despite some initial skepticism, they were able to build rapport via online sessions, and as the sessions progressed, they noted an increase in videos shared by caregivers – this was considered a sign of positive engagement. As

one staff member described, “over time people overcame their fear of technology… now that we’ve crossed that barrier, there’s no living without it”. While most staff felt that face-to-face interactions should resume in the future, a blended model of service/training delivery that combines both in-person and synchronous online content deliver would be ideal, even beyond the pandemic.

Several Ummeed staff noted that online engagement was actually a better option for some children, for example, those with high levels of social anxiety. One staff member also pointed out that while in-person visits would be ideal for some aspects of therapy, conducting them in full personal protective equipment (PPE) may be counterproductive for some children. Seeing a clinician in full PEE could be quite scary and potentially triggering for a child with autism, for example.

As noted above, male household heads tend to be the gatekeepers of technology, and this can be a detriment to reaching female primary caregivers if men receive the phone calls and messages (from CHWs, for example). However, the pandemic presented a unique opportunity to engage fathers in ECD efforts. Because many men were unable to work and home all day, they had more time to engage with household activities, including caring for children. This also meant that CHWs have more opportunities to communicate with men, and encourage them to engage with children while at home. Similarly, because of the lockdown restrictions, other (extended) relatives could also participate in, and benefit from the online trainings.

While violence likely increased in some households due to mental stress associated with the lockdown, some CHWs reported the contrary – in some cases, women reported reductions in domestic violence because the shops that sell alcohol also shut down. Another perceived shift relates to men’s perspectives regarding women’s work. In some cases, being home enabled fathers to gain a better understanding of the household and caregiving labor that typically falls on the shoulders of women in this context:

> *“There’s been a mindset shift for men. One thing that came out during the pandemic is that more men were at home, not working. Before they assumed that women were home doing pretty much nothing, and could not understand why women were exhausted in the evenings. Now [that fathers are home] there is greater awareness of how much work is involved in childcare and household work.”*
> *– ECD specialist, Ummeed*

Lastly, the pandemic presented an opportunity to accelerate mental health initiatives that existed only as ideas or initial discussions prior to the COVID-19 pandemic. Developing three novel mental health training modules was a large investment, and the COVID-19 pandemic served as a catalyst for pushing this idea forward.

Case Study #3: Nobody's Perfect Parenting Program (CANADA)

Program Overview

Before Covid-19

- In-person parenting groups run by trained facilitators

After COVID-19

- Shifted in-person facilitator training and parenting groups online (Zoom)

Nobody's Perfect is a parenting program developed in the early 1980s by the Public Health Agency of Canada for parents of children from birth through age five. While anyone can join, the program is designed to meet the needs of families facing difficult life circumstances – those who are young, single, low-income, socially or geographically isolated, and those with limited formal education. The specific objectives are to promote positive parenting and help prevent family violence; to increase parents' understanding of child health and safety, behaviour and early child development; to improve parenting coping skills and peer support; and to provide referral to other community services and resources. Trained facilitators typically offer Nobody's Perfect parenting sessions to small groups (usually 6-8 parents) in weekly 2 to 2.5 hour sessions over a six to eight-week period. The program has been implemented across Canada, as well as in Japan, Chile, Vietnam, Mexico and Dominican Republic. In Canada, most meetings are held at family resource centers, early learning centers, or Aboriginal Head Start centers.

When it was first developed, Nobody's Perfect was ahead of its time in terms of philosophy and approach to parenting and family support interventions because it adopted a learner-centered and strengths-based empowerment model, at a time when parenting support often employed a deficit lens. Nobody's Perfect draws on the strengths and priorities of families and communities, and at the beginning of each program, group participants identify the parenting needs and interests that they would like to address during the sessions, which means that no two programs are exactly the same. In group sessions, parents' own experiences are valued and recognized through shared learning, knowledge exchange and co-creation of

solutions, with a focus on building parenting confidence and self-efficacy. Facilitators seek to build positive and trusting partnerships with parents by facilitating group discussion and collaborative problem solving. These strengths-based features are now well accepted as best practices in parenting education and family support.

"The magic that happens when parents feel like they have a voice and that they're supported... I actually get goosebumps when I see it. When you use experiential learning and parents actually take away the information that they need, they're able to articulate how they're going to solve a problem – the sense of pride that happens is really special." - Facilitator and trainer, Nobody's Perfect

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During group sessions, trained facilitators reinforce learning and mutual support by creating fun, interactive and engaging activities. The program does not adhere to an expert model – facilitators are trained to facilitate experiential learning rather than passively impart information. Facilitators often have training in public health or social work, but anyone can become a facilitator – including former parent participants. The training sessions and materials focus on developing facilitation skills to promote strength-based learning, and co-creating non-judgemental/inclusive community programming.

"We know we did a good job when people are in tears at the end of the training – the connections are real. People don't want the training to end… the program is all about taking people to a place of vulnerability, but a safe vulnerability. Just enough so that they feel comfortable and confident sharing with others."
- Provincial coordinator, Nobody's Perfect

Thematic areas

Nobody's Perfect was designed to be flexible so that facilitators can tailor content to meet the needs of each group of caregivers; in this sense it is completely participant-centered. Although key topics are used to guide the sessions, there is no "set" curriculum. Instead, the facilitator responds to the needs and issues identified by the group itself. There are 5 printed booklets that participants receive at the beginning of the program, which cover the following topics:

1. Mind – emphasizes the importance of providing opportunities for early learning by talking with children from birth, storytelling, the importance of play and diverse experiences, low-cost play activities at home (e.g. creating 'exploration bags' which have objects from around the house and children with a blindfold have to 'guess' what the objects are by using one of their senses).
2. Behaviour – focuses on positive parenting, improving caregivers' understanding of challenging behaviours, and practical strategies for dealing with challenging behaviours.
3. Body – provides information on common child illnesses, the importance of providing healthy meals, active play and exercise, limiting screen time, providing a smoke-free environment etc.

4. Safety – focuses on how to keep children safe at home and reduce injuries (e.g. stairs, cords on blinds, in the kitchen, lock away medicine); choosing safe child products (e.g. cribs, carseats, toys); and safety outdoors.
5. Parents – focuses on self-care, handling stress, postpartum depression and where and when to seek help.

Evidence

There have been many evaluations of the Nobody's Perfect Program since its inception. For example, a 2009 impact evaluation in Canada found that the Nobody's Perfect led to a significant increase in the frequency of positive parent-child interactions, increased use of positive discipline strategies, and a decrease in negative or punitive practices (15). In addition, the program was effective in increasing participants' abilities to cope with typical parenting stressors, parental problem-solving ability, and parental perceptions of social support. More recently, in Chile, the World Bank conducted a randomized controlled trial and found that the program led to improvements in home environments, parenting behaviours, and child outcomes such as receptive vocabulary and socio-emotional development three years after the end of the intervention (16).

Adaptations of Nobody's Perfect (Pre-COVID-19)

One-on-One Delivery

In 2013, the Nobody's Perfect leadership team identified a need for a low cost and innovative approach to delivering parenting programs to parents who could not meet in group settings due to geographic or social isolation. The project explored whether Nobody's Perfect could continue to support parents through home visits, and still take part in co-sharing of knowledge and experiences with other parents. Facilitators provided the same activities with each family during home visits and created a running log of questions and concerns parents had while doing an activity. These questions were then passed on to the next family while doing the same activity, and so on. Parents could record "answers" to the questions and concerns of other families, which the facilitator would share via the logbook. Facilitators then used the "living document" to engage all parents in a broader discussion. Essentially, even though parents did not attend a group in person, they engaged in experiential learning, and peer and mutual support with others through this facilitated approach. This is an early example of an innovative approach to providing social and peer support that could be implemented in contexts where parents are unable to meet in group settings.

Engaging fathers and other caregivers

Many parenting programs to date are targeted towards women. An important aspect of Nobody's Perfect is that group sessions are open to both women and men, and there are some examples of fathers-only groups. Recently, Nobody's Perfect has increased their efforts to engage fathers and ensure the program is relevant for their needs, including the development of 10 father-specific tip sheets that cover issues such as fathers' role in play, parenting after separation and postpartum depression among men. In 2019, Nobody's Perfect delivered "Dads engaging Dads" parenting sessions in Manitoba, where fathers were recruited and trained as co-facilitators. Supported by the Winnipeg Foundation, project outcomes were as follows:

- increased awareness of the importance of fathers play in children's healthy development

- increased number of fathers participating in community-based parent programs after their initial engagement with Nobody's Perfect
- increased number of agencies running Nobody's Perfect Dads groups.
- increased agency knowledge of best practices and capacity building on how to engage fathers in family resource programs.

In some settings, Nobody's Perfect groups include grandparents who, for various reasons, have shifted into primary caregiver roles. The flexibility and participant-driven nature of Nobody's Perfect allows for easy adaptation in different communities.

In Saskatchewan, Canada, male facilitators adapted the Dads Engaging Dads materials to create "Just for Dads" groups, which are offered at local community centers and in some cases, correctional facilities. Just for Dads groups incorporate the same adult learning principles and broad themes as Nobody's Perfect, but facilitators tailor groups and discussions to reflect the specific needs of fathers. For example, Just for Dads groups are offered at a community center known as the Saskatoon Friendship Inn, which serves a large urban Indigenous population and provides regular meal services, counselling and other sources of social support. Depending on the participants, Just for Dads group facilitators will incorporate First Nations traditions where appropriate. For example, an indigenous elder may be invited to attend, and at the beginning of each session, the elder may say a prayer, or perform a smudging ceremony. The elder will often share a personal reflection or story related to fatherhood, which helps participants feel more comfortable opening up and discussing their own experiences. The success of this Parenting Program inspired several male facilitators to develop complimentary parenting programs such as "Human Values, The Heart of Dynamic Parenting", Parenting Essentials and Anger Management.

Response to the COVID-19 pandemic

A primary goal of Nobody's Perfect is to connect parents who are isolated and lacking social support. The arrival of the COVID-19 pandemic and its associated social distancing protocols increased this need. In some Canadian communities where case counts were low, facilitators managed to run outdoor, in-person groups with physical distancing measures in place. However, this will not be possible in the winter.

Because the program is based on a "tried and true" effective model of group-based parenting support, where interactive and hands-on learning activities were critical pillars, there were never concrete plans to deliver it digitally, and initially many program staff were reluctant to attempt online delivery. This reflected a deeply engrained mindset that facilitators could not achieve the same degree of social connection online as they did in person. Prior to the pandemic, a few staff advocated for an online version of the program to better serve families who could not attend in person, but program managers and staff were generally unconvinced. When the pandemic began, however, the lockdown and physical distancing measures ignited a new sense of urgency. This motivated program staff to move beyond their comfort zones to reach families in need.

In March 2020, two provincial program coordinators in Saskatchewan and Manitoba formed a small guiding coalition to launch the first online version of the program. The findings described below provide an example of a relatively high-tech adaptation of a group-based parenting program. The coalition soon expanded to include the Public Health Agency of Canada Nobody's Perfect national lead and all provincial and territorial coordinators. With increased organizational and donor support to move forward, the coalition set out to achieve three key objectives:

1. Pilot an online version of Nobody's Perfect;
2. Develop national guidelines for online facilitation of Nobody's Perfect; and
3. Pilot an online version of the Nobody's Perfect facilitator training program

The first online sessions were delivered via Zoom, Microsoft Teams, or in some cases, WhatsApp video chat to meet low-bandwidth needs. The pilot project was 7 weeks long with 8 virtual sessions in total. This length turned out to be too long as parents struggled with long-term commitment to parenting programs during the pandemic, so facilitators now recommend that programs run for a maximum of 5-6 weeks.

The learning curve was steep for everyone involved, and there were a number of technological barriers to overcome, but the Nobody's Perfect pilot project was deemed an initial success by the program implementors. As a result, Nobody's Perfect provincial coordinators decided to implement an online training program for new facilitators.

People were really resistant at first; they didn't think we could make the same connections with people online. But over time, that mindset changed. Online delivery opens up so many opportunities! Potentially, this program could be implemented all over the world." - Coordinator, Nobody's Perfect

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Lessons Learned during the COVID-19 pandemic

Facebook was a useful tool to recruit new parents into the program, and allowed for participants from rural and urban communities to connect within the same groups. Nobody's Perfect staff members consider this a positive outcome because diverse participants could share different experiences and generate new parenting knowledge. The team also used social media channels to connect parents to each other outside of the planned sessions (though closed Facebook groups, for example). Use of a Zoom's chat box helped to encourage participant engagement by typing answers to polls or questions throughout. In addition, parenting groups benefited from the use of Google Jamboard, a freely available digital collaboration tool that functions as an interactive whiteboard to facilitate group work online.

Another important lesson was that facilitators received training online via Zoom were much more comfortable implementing the parenting program itself online, so there is good reason to expand the online training program to new (freshly recruited) facilitators. Facilitators who were trained in person prior to the pandemic were more resistant to delivering groups online. Facilitators' experiences during the pilot period informed the development of a set of National Guidelines for online delivery of the program (17). Table 5 summarizes key recommendations from this report.

Table 5. Key recommendations for online delivery of Nobody's Perfect Parenting Groups

• **Maximum of 6 participants per session**
• **Maximum duration of each session no longer than 1 hour**
• **Two facilitators should be present for each session**

• **Call each parent individually before the first session to assess technological capacity (access to internet, screen, smart devices, camera, etc.) and offer support if possible**
• **Give participants the option to use their camera (this reflects trauma-informed best practices)**
• **Dedicate sufficient time in session one to walk through the technology platform**
• **Incorporate visuals and short videos related to the topic, then pose a few open-ended questions**
• **If children are present, try to engage them with a story or song at the beginning of the session with parents, then have the children do a quiet activity while parents are online**
• **Mail parent kits (books) prior to the sessions, or use the tip sheets**
• **Call parents regularly to assess their wellbeing and ensure successful group support**
• **Offer different times of the day for online groups, so parents can join during nap time or after bedtime at night**
• **Pre-record relevant information and make it available before a live session**
• **Discuss the risks of using online platforms**
• **Create a password to enter the sessions to control access**
• **Do not post links to online sessions virtually. Instead send the link as an invitation to each participant**

Shifting priorities during the COVID-19 pandemic

Mental health and psychosocial support

During the pandemic, Nobody's Perfect facilitators noticed several changes in the topics and questions that emerged during the group discussions. The most blatant shift was increased need for mental health support – for example, dealing with isolation and loneliness, increased stress and anxiety, and questions about dealing with children experiencing stress and fear of the virus. Parents also shared concerns about managing competing parenting demands (working, childcare, facilitating online learning for school-age children), and wanted strategies to engage children in safe and supportive learning activities at home.

> *"What I've heard from parents is that their kids pick up on their stress and anxiety [during the pandemic]; they respond to it. If we can help parents be more centered and calm, then the children will be too – because it's a learned response."*
> *- Trainer, Nobody's Perfect*

Play to Learn

Due to the many stressors associated with physical distancing and staying home, facilitators reported that playful parenting is a lower priority topic parents during the pandemic and comes up less frequently in parent-led discussions. Despite this, Nobody's Perfect facilitators have continued to integrate examples of play-based engagement in their online sessions. Most facilitators agreed that although this is more difficult to do online, it can be done with some creative out of the box thinking. For example, 'energizer' activities like 'parent-child rhyme time' are used throughout the session, or children may be asked to go on a scavenger hunt to find something red, and then hold it up to the camera. These activities keep families engaged but also promote playful learning.

Screen time

Because of the COVID-19 pandemic, parents are increasingly concerned about young children's exposure to screen time, and expressed feelings of guilt for allowing it. Although most parents are well aware of the dangers of excessive screen time, they are too overwhelmed to engage with young children in other productive ways. As several facilitators noted, "parents are just trying to make it through the day." Facilitators respond to this by drawing from participants' experiences and brainstorming alternative screen-free activities as a team. Facilitators also help to relieve parental guilt by discussing which shows and content are better choices for young children when screen time cannot be avoided.

> *"When parents are stressed, they look for quick ways to keep their child quiet. If you're mandated to work from home, and then there's no daycare, you can't possibly have the same parent-child interaction. How can you be expected to do that? So we brainstorm alternative activities together." - Provincial Trainer, Nobody's Perfect*

One trainer suggested that in order to promote playful parenting during the pandemic, the benefits must be communicated as a "win-win" solution for parents. Messaging needs to emphasize that playful parenting will help children to be more resilient and develop skills to cope with pandemic-related stress, which in turn may help to lower stress for parents. The implication is that parents may be more likely to invest time and energy into play if they are presented with a more explicit link to immediate, pandemic-related outcomes. Most parents are inundated with "screen time is bad" messaging from various sources, but there is comparatively less messaging around the immediate benefits of playful parenting to both children and parents.

Engagement of fathers during the COVID-19 pandemic

Several program staff reported increases in the number of fathers seeking parenting support during the pandemic. This may reflect the increased amount of time men are spending at home with their children during this time, or flexibility in schedules due to COVID-19 restrictions. Increased interest among men may also relate to previous efforts by the Nobody's Perfect program staff to normalize male engagement in caregiving (for example, through their father-focused tip sheets, which were widely disseminated across Canada).

Implementation Challenges during the COVID-19 pandemic

During in-person parenting sessions, facilitators provide nutritious snacks to facilitate small talk and socialization, and help to model healthy eating habits for children. In some communities, the program is delivered at community kitchens, and parents can receive hot meals before/after the group sessions. With COVID-19 lockdown restrictions in place, this was no longer possible, which was particularly difficult for parents from food insecure households. To respond to this challenge, some facilitators were able to hand deliver snack packs to each household ahead of online sessions and incorporated virtual 'snack time' breaks into the meetings.

The isolation and lack of social support during the COVID-19 pandemic has escalated existing challenges in Canada's First Nations communities, where inter-generational trauma due to residential school experiences run deep. Program staff shared that the COVID-19 pandemic is a major setback for families already struggling with addiction and mental illness. Many facilitators are coping with their own traumas, and trainers/facilitators expressed a felt need for information on compassion fatigue. Implementing an online version of the Nobody's Perfect Program may help to support Indigenous parents during this time, but many participants felt this would be less feasible in Indigenous communities. In addition to technological challenges including a lack of devices and unreliable internet connections, it is more culturally appropriate to build connections in person in certain communities. For this reason, groups with fewer participants and social distancing measures in place may be most appropriate in these contexts.

Facilitators of online program development

Program staff credited the resiliency and creativity of everyone involved (facilitators, parents, the Public Health Agency of Canada) in facilitating the successful transition online. This resiliency played out in several ways. First, a few provincial coordinators served as 'champions' of innovation, and helped to create a sense of urgency to reach families remotely. Prior to the COVID-19 pandemic, there was a lack of purpose for change, a degree of complacency and comfort with the classic in-person model, and a fear of unknown technology.

Second, the initiative was carried forward by a small leadership team who trusted and supported one another. Collectively this team had the positional power, expertise and credibility needed to gain the support and cooperation of the Public Health Agency of Canada. Developing national guidelines for online program delivery was the first step in a broader vision and strategy. As one participant explained, the Public Health Agency of Canada's promotion of the document provided the political support required to propel organizational change.

Finally, throughout the pandemic, a Provincial Nobody's Perfect Coordinator provided weekly video chat sessions to support program facilitators from across Western Canada. During theses sessions, she facilitated discussions to brainstorm ideas and solutions to ongoing challenges, including how to incorporate trauma-informed approaches online. This system was instrumental in consolidating information and translating it into best practices. As one participant described, "she essentially applied what we would do with our participants in groups. It created this sense of not having to do it alone. This really facilitated a process where we could learn from each other."

Unexpected positive outcomes

Online delivery of Nobody's Perfect made it possible to increase the diversity of parent groups, and in some ways made it more accessible to a broad range of participants. For example, online groups

connected parents living in different geographies (e.g. rural and urban settings). Parents found a sense of relief to learn that regardless of their specific circumstances, caregivers were experiencing similar challenges and stressors during the pandemic. In addition, the flexibility offered by online sessions allowed more parents to participate because they could choose from different times that worked with their schedules. For some parents experiencing severe anxiety, having an online option was actually preferred to in-person groups because they could join without having to leave their homes.

> *"It really opens up doorways to access, and in my mind, that's the key positive outcome to come of all this. So parents who may be busy working during the day and wouldn't normally have the opportunity to join a group could access on online group in the evenings." - Provincial coordinator, Nobody's Perfect*

Despite initial skepticism regarding online delivery, coordinators were pleased to learn that facilitators were able to make meaningful, lasting connecting with parents, and that informal socializing could indeed happen organically online. In fact, many group participants maintained contact through various platforms, even outside of the Nobody's Perfect groups.

Shifting online also led to new stakeholder relationships. For example, the *Canadian Canola Growers Association* found that partners of farmers and truckers in rural areas had lost childcare support during the lockdown period and were looking for ways to engage their pre-school children at home. Online Nobody's Perfect groups were seen as a potential solution. Previously, mothers in these remote communities would not have had access to in-person parenting groups. In addition, this demographic was not recognized as a vulnerable group; now Nobody's Perfect program recognizes that these parents may be in need of extra support.

Online delivery of the program has significantly increased the reach of Nobody's Perfect, which is reflected in their social media engagement. From March to September 2020, over 23,000 people had engaged with Nobody's Perfect Facebook posts in the province of Manitoba alone (up 200%). Program staff saw this as an opportunity to recruit more parents and distribute tip sheets online.

While staff noted the benefit of connecting parents from diverse backgrounds, some also pointed out that having an online program may improve their capacity to connect particular 'sub-groups' looking for support from parents in similar circumstances. For example, the Nobody's Perfect Program could be tailored for parents of newborns, co-parents, adoptive/foster parents, or parents affected by specific conditions such as Fetal Alcohol Spectrum Disorders (FASD). Since the Nobody's Perfect program is designed to build on shared values and goals, parents with shared experiences benefit from connecting with each other.

Case Study #4: Kangaroo Foundation (COLOMBIA)

Program Overview

Before Covid-19

- NICU open to parents and family members
- Family members invited to ambulatory care visits
- Public consultations with multiple families
- In-person consultations and trainings

After COVID-19

- NICU open only to parents
- COVID suspected/confirmed mothers/infants separated from other patients
- 1 caregiver allowed for ambulatory visits with COVID-19 safety protocols in place (max: 10 patients)
- Virtual consultations and information provided via Zoom/WhatsApp

Background

The *Fundación Canguro*, or Kangaroo Foundation, has been providing an evidence-based alternative method for neonatal care in Bogotá, Colombia, since 1994. Their mission is to humanize the care provided to newborn babies, particularly those born prematurely or at low birth weight (LBW), by utilizing and promoting the Kangaroo Mother Care (KMC) method. As such, their vision is to serve as the reference point on KMC best practices for medical practitioners, researchers, and implementers nationally and internationally (18). The Foundation has established three integral care clinics: the KMC program in the "Clinica del Niño" of the National University Hospital, the KMC program in the San Ignacio Hospital of the Pontificia Universidad Javeriana, and a new center in Medellín targeted at low-resource communities. Additionally, the Foundation has trained 60 affiliate programs throughout Colombia and 35 programs internationally, including in India, Philippines, and Cameroon, constituting a network of KMC providers.

Program Theory

The KMC method was first developed in 1978 by Dr. Edgar Rey of the Instituto Materno Infantil in Santa Fe de Bogotá in response to the critical needs of high-risk newborns. KMC was seen as a solution to issues of overcrowding, lack of available incubators, high rates of nosocomial infection, and infant abandonment (19). Since then, KMC has been widely recognized for being a cost-effective and empowering alternative

to traditional intensive care, as mothers take on the primary role of caregiving for their infants. This has the additional benefit of rationalizing expensive and often scarce resources to be reserved for the most serious cases. In 2003, the World Health Organization published a practical guide describing the components and early evidence of KMC.

The Kangaroo Mother Care method consists of three pillars (19):

1. *Kangaroo position*: initiating early skin-to-skin contact (SSC) between the baby and his or her mother by nestling the infant in the mother's chest in the vertical position for 24 hours a day, simulating an artificial incubator. SSC continues until the child rejects it.
2. *Kangaroo feeding:* adherence to maternal breastfeeding exclusively, to the extent possible.
3. *Kangaroo discharge:* early departure from the hospital while maintaining the kangaroo position, with strict outpatient follow-up (as opposed to extended stays in the neonatal minimum care units).

The ambulatory follow-up provided by the KMC programs is essential to ensure that the children are receiving quality care at home and are meeting the standards of the neonatal minimum care units. The primary goal is continuous and prolonged skin-to-skin contact, avoiding separation between the mother and the child, even in the Neonatal Intensive Care Unit (NICU).

Key Interventions

Fundación Canguro carries out its mission through four principal activities: (1) partnering with medical professionals at the neonatal care units of the three identified hospitals to assist parents with KMC adoption, (2) providing follow-ups to parents and their children during ambulatory care, (3) training the staff of external KMC programs, and (4) creating and disseminating research on the impact and practices of the KMC method.

"We are a marriage. There's personnel from the Foundation inside the NICU, and our entire personnel is trained in Kangaroo Mother Care."
– Neonatologist at San Ignacio Hospital

The first and second activities are meant to provide support to families as they learn to care for their fragile children. A nurse from the Foundation is present at the NICU every day to assist with the initialization of SSC and breastfeeding. Parents are invited to visit their children in the NICU, which is open 24-hours a day. Other Foundation staff also regularly train NICU staff on KMC best practices. They jointly equip parents to correctly apply KMC through an interdisciplinary approach, involving pediatrics, psychology, audiology, and other relevant care. Prior to leaving the hospital, parents are evaluated on their comprehension of and adherence to KMC.

Once the newborn shows signs of progress, such as increased weight, and the parents are able to maintain the kangaroo position for 24 hours a day, they are cleared by the medical staff to begin ambulatory care. At this time, families continue KMC at home. They attend follow-up care at the KMC integral care center, where unlike traditional medical consultations, their children have individualized public consultations with their pediatrician. A cohort of families observe the consultations together, allowing parents to learn from

each other and further establish a support network. Children are directed to specialists at the clinic as required, and they receive full medical care up to one year after birth, including evaluation of development indicators and vaccinations.

The third and fourth principal activities of the Foundation advance the external facet of their mission. The Foundation regularly equips domestic and international medical teams on the operations of KMC. The Colombian Ministry of Health convenes the network of KMC providers once a year to discuss innovations, challenges, and any updates to the official guidelines. Additionally, the Foundation, under the leadership of Dr. Nathalie Charpak, has been publishing original clinical research on the KMC method since 1994. Some of this research is described below.

Evidence

Since its inception, *Fundación Canguro* has relied on scientific evidence to inform its practices. An early observational study of the KMC method concluded that LBW infants treated through KMC had similar chances of survival as those treated with traditional care (20). The evidence to support KMC has since become much more robust. A meta-analysis of 124 randomized trials and observational studies on the impact of KMC on neonatal outcomes found that LBW newborns treated with KMC had 36% less mortality compared to those receiving conventional care (21). They also showed reduced risk of neonatal sepsis, hypothermia, hypoglycemia, and hospital readmission, amongst other positive results. Another analysis of 21 studies comparing KMC to conventional neonatal care found similar results, adding that KMC was associated with increased weight, length, and head circumference gains (22). Both analyses also point to an increase in exclusive breastfeeding, which has long been linked to stronger immune systems, fewer infections, and better overall infant health (23). Moreover, a study examining the persistence of KMC benefits into adulthood found that "the effects of KMC at 1 year on IQ and home environment were still present 20 years later in the most fragile individuals, and KMC parents were more protective and nurturing, reflected by reduced school absenteeism and reduced hyperactivity, aggressiveness, externalization, and socio-deviant conduct of young adults" (24).

Response to the COVID-19 pandemic

On March 6, 2020, Colombia confirmed its first COVID-19 case. As in the rest of the world, what ensued was a series of restrictions and a national health emergency declaration. At the KMC program in the Universidad Javeriana, staff worried about the virus' potential impact on their patients. Little was known about the virus' risk of contagion or its effect on children. While the NICU remained open to parents, it was now closed off to additional family guests. Public transportation was limited, impacting the ability of families to attend consultations during ambulatory care. As a result, attendance drastically dropped.

While the doctors and nurses were concerned about the virus' potential consequences, they were confident KMC was still the best way to support LBW and pre-term newborns. As such, the program never shut down. Instead, the Colombian Society of Neonatology, the Colombian Ministry of Health, and the Kangaroo Foundation joined together to publish a set of recommendations for the continued and safe operations of KMC programs. These recommendations covered biosecurity measures for both caregivers and personnel, management of asymptomatic and symptomatic mothers, and logistics of outpatient consultations. Utilizing these recommendations, the KMC program at the Universidad Javeriana adapted their existing programming while still preserving its essential components.

Inpatient care has continued with the following measures:

- All personnel and caregivers adhere strictly to biosecurity measures, such as proper handwashing, use of mouth coverings, and regular disinfection of equipment and high-touch areas.
- Asymptomatic mothers with suspected or confirmed COVID-19 infection are still encouraged to practice skin-to-skin contact and breastfeeding with their child if both remain stable. Mothers must comply with biosecurity measures and wear mouth coverings while holding their children. These mothers and their babies are isolated to a single room together. The nursing assistant provides care exclusively to COVID-19 positive or suspected patients.
- Symptomatic mothers with confirmed COVID-19 infection are also encouraged to breastfeed, as long as their health conditions permit it. They must comply with biosecurity measures and wear mouth coverings while holding their children. When possible, these mothers receive consultations virtually via Zoom or WhatsApp video. Nurses caring for these patients exclusively assist COVID-19 positive or suspected patients.
- The neonatal unit remains open 24 hours a day, but entry is only permitted for a child's mother or father. Prior to the pandemic, grandparents and siblings were also allowed to enter. Newborns with suspected or confirmed COVID-19 positive mothers are separated from the others.

"The high level of satisfaction of the parents that come to the center, despite the fear of visiting health centers during the pandemic, is an example of our success."
– Pediatrician, San Ignacio teaching hospital

Outpatient care has continued with the following measures:

- The first consultation is still held within the first 48 hours after discharge, as this is a critical time for the fragile babies. Initial controls are carried out at the KMC program, but they can be made less frequent depending on the health of the newborn.
- Only 1 companion per patient is allowed to attend the consultations. Companions receive a screening call the day before their appointment to check for signs of COVID-19 symptoms, and they must be adults under the age of 60. Parents also receive training on how to prevent COVID-19 diffusion.
- Individualized consultations still happen in a public setting following strict biosecurity measures. Patients and their companions are screened upon arrival for symptoms of COVID-19 and are seated 2 meters apart. In an attempt to serve as many patients as possible, the center has expanded consultation hours, now starting at 6am, in order to provide additional visitation times while limiting the number of attendees to 10 at a time.
- Mothers who are COVID-19 positive but able to breastfeed can do so while wearing mouth coverings. Ideally, another healthy family member holds the newborn in the kangaroo position for most of the day, transferring the child to the mother for brief skin-to-skin contact only while breastfeeding. Because these mothers cannot attend in-person consultations, they participate in orientation and consultations via telehealth.
- Workshops at the KMC center have continued, offering new virtual (Zoom or WhatsApp) options for families who cannot join physically.

- Parents have access to a 24-hour emergency phone line for telehealth consultations. They also participate in a WhatsApp support group, where pertinent information is regularly shared in short capsules.

Facilitators of Program Adaptations

> *"At the beginning of the pandemic, we said 'We have to get together.' It was automatic." – Director, Kangaroo Foundation*

A key facilitator of the rapid response by KMC programs was the strong existing relationship with clinical partners. Almost immediately after the pandemic began, the Colombian Society of Neonatology, the Colombian Ministry of Health, and the Kangaroo Foundation held a meeting to publish the first set of recommendations for Colombian KMC Programs. Unlike in other countries, where official guidelines instructed that COVID-19 infected or suspected mothers be separated from their newborns (25), the close working relationship between these institutions allowed rooming-in practices to continue in Colombia through expedient dissemination of key information. These alliances were also crucial in producing the evidence to support the continuation of KMC by monitoring the evolution of COVID-19 in NICU wards. Seeing the low number of cross-infection between mothers and their infants, even while breastfeeding, these institutions recommended the preservation of the mother-child bond. Moreover, Kangaroo Foundation leadership shared that only 30% of the KMC ambulatory programs saw between 1 and 3 infants diagnosed with COVID-19 in the past 6 months. The Foundation and its partners concluded that the benefits of KMC vastly outweighed the risks posed by COVID-19.

In addition, the "marriage" relationship between the NICU at San Ignacio Hospital and the Foundation facilitated the prioritization of the preservation of as many programming aspects as possible. After 19 years of seeing the results of KMC, pediatricians at San Ignacio's neonatal care unit are convinced that it is the optimal care method for their patients. The suspension of the program during the pandemic was therefore never in question. Even while there was a national peak in infections this past May, the neonatology unit implemented a system of timed visitations by national ID number (typical in Bogotá for restricting traffic), but it never fully closed down to parents.

> *"We can't conceive of a neonatal care unit without Kangaroo Mother Care. It is vital. All its benefits for the baby and its mother are documented." – Neonatologist, San Ignacio Hospital*

Lessons Learned

Several lessons can be drawn from the Foundation's process of adaptation. First, KMC is thriving during the pandemic in this context. At the KMC program in the San Ignacio Hospital they have not had a single case of cross-infection within the NICU, despite remaining open to parents. Instead, all 50 indicators of maternal and child health have maintained at pre-pandemic levels. Moreover, they have seen an increase in maternal lactation, potentially because parents understand its important role in developing the child's

immune system. Seeing it as an extra layer of defense against COVID-19 and other viruses, parents are more eager to exclusively breastfeed. Staff at the center continue to encourage breastfeeding and discourage mother-child separation for COVID-positive mothers, knowing their immense benefits for both the mother and the child (26).

Secondly, the Foundation's adaptation process is an example of an interdisciplinary approach to problem solving. From the beginning of the pandemic the response was a collaborative effort between the Ministry of Health, Colombian Society of Neonatology, and the Foundation. The entities worked together to conduct three series of surveys of the 60 KMC programs across Colombia in order to learn what challenges they were facing. So far, two set of recommendations have been published as a result of these surveys, with a third set of recommendations forthcoming. At the inpatient care unit at the San Ignacio Hospital, pediatricians regularly consulted with epidemiology and infectious disease colleagues to assess risks and establish prevention measures.

There was a lot of stress and anxiety at the beginning because we didn't know exactly what we were facing. But we were fortunate to have an infectious disease unit here in the hospital, who we have worked with 24 hours, 7 days a week."
– Neonatologist, San Ignacio Hospital

Thirdly, as the situation evolves, it is important to regularly assess the success of programming. As mentioned above, the Foundation has distributed three surveys to learn about on-the-ground situation in the implementation of KMC in Colombia: an initial survey in April, a second survey in June, and a third survey in September. These surveys are used to update recommendations and monitor important indicators. Survey results confirm that KMC can be safely and successfully implemented during a pandemic, and that the need for the program remains. For example, a common theme is that though attendance initially dropped, parents increasingly demanded a return to in-person consultations. The KMC center at the Universidad Javeriana is now physically managing 90% of its pre-pandemic volume and is supplementing in-person services with virtual ones.

While there have certainly been challenges, *Fundación Canguro* has demonstrated that KMC remains a viable treatment for LBW and pre-term newborns during the COVID-19 pandemic. The pillars of the program – the kangaroo position, exclusive breastfeeding, and early discharge – have been safely upheld through adaptations such as separation of COVID-positive patients, the introduction of telehealth, and the strict adoption of biosecurity measures.

Case Study #5: Ahlan Simsim Program (JORDAN)

Program Overview

Before Covid-19

- In-person group-based parenting program and ECE activities for children 3-8y
- Home visits for children 0-3y
- Locally adapted mass media ECD content

After COVID-19

- Telephone-based school readiness program delivered by trained volunteers
- WhatsApp groups for caregivers
- Adapted Sesame content for COVID-19 (+ social-emotional learning content)

Globally, nearly 80 million people have been forced to flee their homes, and 40% of the world's displaced people are children (27). More than 12 million people have been displaced as a result of the ongoing conflict in Syria alone. Consequently, millions of children are deprived of the ECD opportunities and nurturing care conditions necessary for them to thrive. In response to this global humanitarian crisis, Sesame Workshop partnered with the International Rescue Committee (IRC) to develop an early learning and nurturing care program called Ahlan Simsim ("Welcome Sesame" in Arabic). The Ahlan Simsim program delivers ECD content including play-based learning activities to children and caregivers in Iraq, Jordan, Lebanon and Syria. The program aims to improve children's cognitive and social-emotional skills through a combination of mass media content and direct services, while working towards a broader goal of mobilizing additional support for children affected by conflict and displacement. With support from the MacArthur Foundation and the LEGO Foundation, Ahlan Simsim is the largest early childhood intervention program ever created in a humanitarian setting.

The Jordanian Context

Due to its location and relative stability, Jordan has become a nation of asylum for refugees fleeing conflict in neighboring Palestine, Iraq, and Syria. IRC began working in Jordan in 2007 to help respond to an influx of Iraqi refugees and the accompanying strain on Jordanian communities and infrastructure. The onset of the Syrian war in 2011 compounded the refugee crisis in Jordan, with hundreds of thousands of refugees crossing the border. This influx of people worsened pre-existing challenges like water scarcity and employment, and both refugees and Jordanian communities are increasingly vulnerable as a result. IRC Jordan is actively involved in service provision across safety, health, education, and economic wellbeing domains. With respect to education, IRC Jordan's key strategic priority is to ensure that young children

living in the most underserved parts of the country develop the cognitive and social emotional skills necessary to ensure their future academic success and well-being.

Mass Media

Sesame Workshop blends music, puppetry and animation to create fun and engaging video content to support the social-emotional needs of children. Ahlan Simsim is a novel, locally produced Arabic-language adaptation of *Sesame Street* for children aged 3 to 8. The show debuted in early 2020, featuring new characters and stories that reflect the lived experiences of children affected by violence and conflict. Season one introduces three new Sesame characters: a young Muppet named Jad, who is new to his neighborhood; Basma – an adventurous and welcoming friend to Jad, and Ma'zooza – a baby goat who follows Jad and Basma on their adventures, eating anything shaped like a circle along the way. Together, Jad, Basma and Ma'zooza tackle difficult topics such as coping with "big feelings" like fear, loneliness and hopelessness, and applying concrete strategies to understand and manage them. For example, "belly breathing" and artistic expression are two coping mechanisms explored in the show. Although internet access is limited in refugee camps, most families have access to a television, and widespread dissemination of mass media content is possible.

Direct Services

IRC is responsible for the direct implementation of services involving community volunteers, caregivers, and children in the Middle East. Sesame Workshop produces materials and content related to children's cognitive and social-emotional development, and then IRC adapts and implements it through direct services. The Ahlan Simsim program implements four direct service models through the IRC's network of early childhood education (ECE) centers and home visit programs in terms of intervention 'dose' or intensity of program exposure.

Center-based ECE services help to meet a critical need in Jordan, where early learning opportunities are limited. The Ministry of Education's grade 1 curriculum was developed under the assumption that children have at least 1 year of formal kindergarten schooling. However, families living in refugee camps are typically unable to access kindergarten, which is a prerequisite for grade one. In addition, many caregivers have low education and literacy levels themselves, and have limited resources to support early learning at home.

Prior to the pandemic, IRC Jordan helped to meet this need through delivery of in-person parenting programs at community centers or health centers. The parenting program consists of 7 in-person sessions (75 minutes per session) for caregivers of children aged 3-8 years. IRC ran dedicated childcare rooms so that caregivers could fully participate in the sessions. In the childcare rooms, trained ECD facilitators led in-person ECE group activities, including Sesame video screenings, storybook readings, and playful learning opportunities. During the sessions, children learned about emotions, and engaged in storytelling, coloring, games, numeracy and literacy activities, with an emphasis on learning through play. The ECE curriculum is grounded in a "whole child" pedagogical approach, which includes brain building, positive social skills, and incorporates themes such as gender equity and inclusion (28).

Home-based ECE services. Through IRC's *Reach-Up and Learn* program, trained community health volunteers (called facilitators) conduct weekly or bi-weekly home visits to caregivers of children aged 0-3 years. Each home visit is about 75 minutes in length, and caregivers enrolled in the program received visits for an entire year. Home visits provided an opportunity for facilitators to educate caregivers on the

importance of ECE, demonstrate play-based learning activities, and give real-time coaching and feedback while observing caregiver-child interactions. facilitators could also refer families to health and other social services where appropriate. As in all IRC programs, facilitators are recruited from the communities in which they work, so they have intimate contextual knowledge of caregivers' lived experiences.

Response to the COVID-19 pandemic

The COVID-19 pandemic led to major disruptions in IRC's programming. In March 2020, all centers and in-person activities were suspended, and IRC's regional and country office had to re-design their delivery models to reach families remotely. To date, IRC's Ahlan Simsim team has piloted two modalities for remote content delivery: WhatsApp groups and a telephone-based school Readiness program.

"March was total chaos for everyone. April was the month of converting, negotiating, and working on finding solutions. And May was the month for kicking off the new initiatives." - ECE Specialist, IRC Jordan

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WhatsApp Groups

During the initial lockdown period, IRC developed and piloted 25 awareness messages for delivery to caregivers via WhatsApp chat groups. The chat group modality allows for bi-directional communication among facilitators and caregivers, so caregivers could follow up with specific questions and share their experiences with peers. The messages focused on COVID-19 prevention, psychosocial support for parents and children, the importance of ECE, and promotion of playful learning at home. Caregivers received 5 messages per week.

The ECE-related messages targeted different age groups, and covered four domains: physical, cognitive, social-emotional and literacy. They integrated relevant content by sending links to related images and videos on Ahlan Simsim's Facebook, Instagram, and YouTube channel. This approach helped to anchor the messaging with interactive components (for example, a video of Elmo demonstrating the proper way to wash hands accompanied COVID-19 hygiene messaging). Activity-based messages provided specific examples of ways for caregivers to engage their children at home. Caregivers were encouraged to send photos of their interactions back to facilitators to demonstrate their learning and receive additional feedback from facilitators.

Remote Readiness Program (Ahlan Simsim Ahlan Bilmadrasah)

IRC converted their center-based school readiness content into 15 phone call-based sessions (30 minutes each) delivered directly to caregivers by trained facilitators. The team compared their school readiness materials to the learning outcomes desired by the Ministry of Education to develop content for the phone calls, with the aim of equipping caregivers to deliver the material to their children. The phone calls cover numeracy, learning letter sounds and how to write them, shapes, colors, patterns, and emotions.

To facilitate the telephone calls, facilitators distributed the following materials to caregivers in advance:

- A manual/booklet for caregivers to use as a guide
- A children's activity work book
- An activity package for children containing stationary, Play Doh, crayons and pencils.

While it was much easier to facilitate 'Play to Learn' activities in person, IRC's distribution of small activity packages helped support playful parenting at home. During the calls, facilitators would adopt a role-play approach in which the caregiver pretends to be the child, and the facilitator pretends to be the teacher. In this sense, the calls served to simulate a real ECE lesson, and parents gained skills to facilitate their children's learning.

Lessons Learned during the COVID-19 pandemic

Feedback from clients

IRC Jordan collected feedback from caregivers and facilitators on the WhatsApp pilot project. The activity-based messages were generally well received, and families appreciated the accompanying Ahlan Simsim content. However, some caregivers were unhappy with the use of WhatsApp groups because other families could see their personal contact information; this raised personal privacy and security concerns. Another important lesson was that sending links rather than large files was the most practical approach in refugee camps, because streaming uses much less data than downloading a video or photo file.

During the pilot period, IRC learned that families found the COVID-19 messaging to be unappealing. This is because the local television station focused overwhelmingly on COVID-19; the media was saturated with pandemic information and families felt bombarded with repetitive messaging. Moving forward these lessons will inform the development of a much larger direct, one-to-one ECE messaging initiative using the Viamo mobile application.

Based on caregiver feedback during the pilot phase, the IRC team decided that a telephone-based approach would be more client responsive when implementing the Ahlan Simsim Ahlan Bilmadrasah (Readiness) program. While the calls are designed for one-to-one delivery, some facilitators implemented anonymous conference calls to facilitate sharing and learning between caregivers. Initial feedback from caregivers and facilitators on the phone call sessions was very positive, and the Ahlan Simsim Ahlan Bilmadrasah Readiness program is ongoing. Caregivers reported that the calls do not use too much data and that they enjoyed the personalized conversations. IRC is piloting accompanying Arabic audio notes sent via WhatsApp and conducting operational research to determine which combination of modalities work best in this context. Based on the early success of the Ahlan Simsim readiness program in Jordan, there are requests for IRC to develop similar programs in Iraq and Lebanon.

"In Jordan, our families did not appreciate the WhatsApp groups. They did not like it. They felt that it invaded their privacy because they do not want to share their contact info with other families. The phone calls on the other hand, were very successful."
– ECE Specialist, IRC Jordan

Challenges with remote program delivery

Disruptions to in-person contact during the COVID-19 pandemic was a major challenge. Previously, facilitators could monitor/observe parent-child interactions during home visits but this was no longer possible via WhatsApp or telephone. Key social-emotional outcomes like manners, and sharing could not be assessed via the telephone readiness program. In addition, caregivers, children and facilitators really missed the opportunity to socialize. Center-based activities "gave people a reason to leave the home", a

sense of purpose and something to look forward to. Staff felt that these dynamics could not be recreated via digital channels, and most stated a preference for in-person services to resume in the future.

While brainstorming ways to leverage technology for remote service delivery, IRC staff anticipated potential challenges with a) equity of access to digital learning platforms among the poorest communities, and b) gender inequities in program exposure. If there *is* a phone or computer in a household, it would likely be given to male children over female children. IRC staff could detect gender-based learning inequities more easily during face-to-face interactions with families and reported difficulties managing these dynamics remotely.

A major challenge in shifting to remote delivery had to do with training facilitators. Prior to the pandemic, IRC staff trained facilitators in-person and their primary method of communication was through face-to-face meetings. When the pandemic began, IRC relied on phone calls and text messaging to reach facilitators and sent mobile money rather than providing physical SIM cards. This was a challenging adaptation since facilitators would often run out of data or would be unreachable by phone.

The facilitator training curriculum was adapted for delivery via Zoom, which was difficult to implement. While IRC staff noted the benefit of training more facilitators simultaneously, they also felt strongly that a trainee's competency could not be reliably assessed remotely. One staff member described Zoom as a "double-edged sword" for these reasons. It is more challenging to understand people's mindsets, how much information they have absorbed, and whether they will maintain their own biases in the counselling delivered without in-person interactions.

Staff explained that being able to assess body language and other non-verbal cues is particularly important when training people who have no ECD background. They also described a "lack of humanity" on Zoom calls, which is particularly important in a humanitarian context, where increased social connection and empathy are critical when interacting with families.

> *In a humanitarian context, you really need to be down to earth to relate to people, and adapt your approach to suit the local culture – this is much easier to achieve in person." - ECE Specialist, IRC Jordan*

Lastly, there were gender dynamics that caused additional challenges during training. Both male and female facilitators participated in the training sessions, but women were more likely to leave their cameras off during Zoom calls. This likely reflects the need to wear a veil in the presence of male facilitators – a practice that women preferred not to do while at home. When videos are turned off, it was much more difficult to engage with trainees and assess their learning.

Low prioritization of ECD: A challenge and an opportunity during the COVID-19 pandemic

ECD is a relatively new area of investment in Jordan, and tends to be low priority among families, the government, and funders. This was exemplified at the beginning of the pandemic, when in response to school shut downs, the Ministry of Education broadcasted learning materials and lessons on the national TV network but included content for older children (grades 4-6) only. Material for younger children was not added until several months later, and ECE advocates viewed this as a lost opportunity. According to

IRC staff, this low prioritization does not reflect an absence of knowledge or understanding of the importance of ECD, but rather a lack of human resource capacity and ECD expertise, as well as funding.

In response to the COVID-19 pandemic, Jordan's Ministry of Education asked multiple organizations to contribute to school readiness efforts for children aged 5-6 years. This was a timely opportunity for IRC to establish a pathway to scale for their ECD work, as the Ministry lacked material on social-emotional learning, and mainstreaming this domain is the ultimate goal of IRC's direct education services. The COVID-19 pandemic ultimately brought this need to light – although IRC had been advocating for inclusion of social-emotional learning in school curricula for years, the pandemic made it easier to advocate for this need. IRC leveraged their strengths in this area to develop materials focused on techniques to reduce stress, and identifying, recognizing, and expressing emotions. By sharing Ahlan Simsim episodes integrating other ECE content into Ministry platforms, IRC has filled a critical need during the pandemic and beyond.

At the beginning of the pandemic, emergency hotlines were open for families to call, and there were no requests for early learning support. Due to their loss of livelihoods, people's priorities focused on more immediate needs such as shelter, healthcare, and cash. In order to mitigate this challenge, staff described the importance of positioning ECD strategically, and linking interventions to other social protection programs (examples described below). As IRC staff explained, partnering with food assistance programs is strategic for two reasons: a) programs can be confident they are reaching the most resource deprived families, and therefore the children most in need of ECE interventions; and b) when people's nutrition needs are fulfilled, they are more open and receptive to other programs.

"The important thing is how the program is positioned. When you think about early childhood intervention, it should be adjacent to another program related to economic empowerment, or social assistance, or food distribution. You must think about different partnerships beforehand. Because ECD is not a priority for families – the demand is for cash, shelter, food, and health. So to position yourself properly, you should think about adhering the program with a different service." - ECE Specialist, IRC Jordan

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Facilitators of IRC Jordan's Pandemic Response

When asked to reflect on IRC's experience during the pandemic, staff emphasized the role of innovation, creative thinking, piloting new ideas, and an organizational culture in which "you don't have to be afraid of failing". The pandemic provided a catalyst for quick, creative thinking. One of IRC's major strengths involves intensive prototyping, operational research and evaluation. In the WhatsApp messaging pilot project, for example, IRC learned directly from the experiences of caregivers and facilitators to ensure their interventions met the needs of community.

"COVID-19 really shifted our mindset – in a way it was a gift. Before we were asking, 'how will our beneficiaries get to our services?' Now we are asking 'how can we adapt our services to reach them?'" - ECE Specialist, IRC Jordan

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In addition, the mass media Sesame content was, in itself a facilitator of IRC Jordan's response. The Sesame brand is well known and respected across the Middle East, especially now with the addition of more locally relevant characters. Caregivers and children understand and connect with the characters and content, so the materials helped to solidify the Ahlan Simsim program's core messages.

It was important for IRC to retain their own network of facilitators during the lockdown period. While facilitators were unable to conduct home visits or center-based activities during this time, IRC continued to pay their stipends (approximately 25 USD per day) through March and April. This was an important strategy to support their own livelihoods and ensure retention beyond the initial months of the pandemic. As staff acknowledged, facilitators are the backbone of direct service delivery; without them, there would be no innovation as only they have the contextual knowledge to implement ideas successfully.

"Frontline workers themselves are the real heroes, the change agents… If there is not hero to fight for a good idea, then it will lose." – ECE Specialist, IRC Jordan

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Another critical facilitator was IRC's ability to strengthen links to other organizations. IRC's databases of under resourced communities were out of date, so a massive outreach strategy was required to facilitate implementation of Ahlan Simsim. To achieve this, IRC Jordan partnered with *Tkiyet Um Ali* ("Food for Life"), a large humanitarian organization that coordinates food aid initiatives across the country. *Tkiyet Um Ali* has a network of 330 community-based organizations (CBOs) who distribute food to households on a monthly basis. Through this partnership, IRC Jordan gained access a large database of families receiving food aid, which allowed them to recruit the country's most vulnerable children and caregivers into the Ahlan Simsim program. The partnership will continue in the long term, even beyond the pandemic. There are plans for IRC to train 20 other CBOs to deliver Ahlan Simsim Ahlan Bilmadrasah and parenting programs in their own venues beginning in January 2021.

Other important partners include the Ministry of Education, the Ministry of Health, and the National Council for Family Affairs (a coordinating and legislative body for all the family and childhood interventions across Jordan). Currently IRC is working with the Ministry of Health to integrate ECD features into *Hakeem*, a national electronic health platform used by healthcare providers to manage patient data and deliver preventive health information to patients. IRC will use the Hakeem database as another means to identify more families in need of ECE services and there are plans to incorporate ECD content in the future by training healthcare providers to be "Sesame Ambassadors".

While the Ahlan Simsim Ahlan Bilmadrasah phone calls worked well during the pandemic, staff anticipate that once physical distancing measures are relaxed and caregivers go back to work, it may no longer be sustainable on its own. Caregivers may be more difficult to reach, and have less time available to apply the ECE lessons with their children. For this reason, IRC plans to develop a blended delivery model comprised of both in-person and remote components. In the longer term, IRC aims to deliver Ahlan Simsim content through their newly established network of CBOs and health centers.

Case Study #6: Parenting for Lifelong Health (PHILIPPINES)

Program Overview

Before Covid-19

- In-person group-based parenting program run by community facilitators; embedded in a government-run conditional cash transfer program (4Ps)

After COVID-19

- Parenting tip sheets, booklets, webinars, radio segments, Facebook, SMS texts
- "eMaPa" parenting program delivered via Viber or Facebook Messenger groups (under development)
- One-on-one counseling in hospital child protection units
- Additional content added on COVID-19 information and playful parenting

Background

To reach families across diverse geographic contexts, there is a need for evidence-based parenting programs that are cost-effective, culturally sensitive, and tailored to local contexts. To address this need, the WHO, UNICEF, Clowns Without Borders South Africa, and researchers at the Universities of Bangor, Cape Town, and Oxford developed *Parenting for Lifelong Health (PLH) for Young Children* - a theory and evidence-driven program that aims to increase responsive parent-child communication and reduce harsh parenting practices in children ages 2-9 years (29). By promoting positive parent-child relations and alternative disciplinary methods that are non-violent discipline, the program may help to prevent and treat disruptive child behaviours, and reduce parental stress and depression (30).

Program Theory

PLH program development was guided by the United Kingdom Medical Research Council's framework for designing and evaluating complex social interventions (31). Program development followed three stages: 1) identifying core evidence-based intervention components; 2) formative evaluation; and 3) integration

of evidence and local context (32). The existing interventions identified in stage 1 are broadly based on the principles of social learning theory, which views harsh parenting as an important contributor to child behaviour problems (32). Researchers developed a theory of change model that includes cross-cutting behaviour change strategies and delivery methods. This model outlines evidence-based intervention components, proximal adult outcomes, and distal outcomes for both children and adults, which contribute to the PLH program's ultimate outcome: reduced risk of child maltreatment.

The PLH team conducted formative research with parents and practitioners in Cape Town, South Africa to identify factors that might increase program acceptability and participation in this context. In consultation with an expert working group, researchers used the evidence synthesis, theory of change, and findings from the formative evaluation to develop a tailored version of the PLH model – the *Sinovuyo Caring Family Program.* While the Sinovuyo Program is considered the PLH 'prototype', the program has been adapted for implementation in over 20 low- and middle-income countries across Sub-Saharan Africa, Southeastern Europe, Southeast Asia, and the Caribbean.

Evidence for PLH for Young Children

A majority of the published evidence for PLH for Young Children is based on the Sinovuyo Program in South Africa, and randomized controlled trials are ongoing in North Macedonia, Moldova, Romania, and Thailand. Another trial was recently completed in the Philippines which found that the risk for child maltreatment decreased by almost 40% one month after program completion, and by 23% one year after the program (33). Table 6 summarizes the current evidence for PLH for Young Children.

***Table 6**. Summary of Existing Evidence for PLH for Young Children*

Study	Location	Key findings
Integrating evidence and context to develop a parenting program for low-income families in South Africa (32)	Cape Town, South Africa	Summarizes PLH program theory, content development, and next steps for rigorous testing.
Process evaluation of a parenting program for low-income families in South Africa (34)	Cape Town, South Africa	High levels of participant involvement, implementation, and acceptability.
Randomized controlled trial of a parenting program to reduce the risk of child maltreatment in South Africa (35)	Cape Town, South Africa	Moderate treatment effects for increased frequency of parent-report of positive parenting (d=0.63) and observational assessments of parent-child play (d=0.57). Moderate negative treatment effects for less frequent positive child behavior (d=-0.56).
Engagement in parenting programs: Exploring facilitators of and barriers to participation (36)	Cape Town, South Africa	Qualitative assessment: barriers to parents' participation included transport difficulties, lack of childcare. Facilitators included family buy-in, readiness to change behaviour.

Unpublished	Metro Manila, Philippines (*N* = 120)	Positive program effects for reduced child maltreatment, including physical and emotional abuse and neglect, reduced dysfunctional parenting, reduced child behaviour problems, reduced endorsement of corporal punishment, reduced intimate partner violence, increased daily positive parenting, and improved parental self-efficacy at 1-month follow-up. Program effects at 13-month follow-up were sustained for reduced child maltreatment, reduced emotional abuse, and reduced neglect.
Unpublished	Udon Thani, Thailand (*N* = 120)	Positive program effects at 3-month and 6-month follow-up for reduced overall child maltreatment, reduced physical abuse, reduced emotional abuse, reduced harsh parenting (observed at 6-months), reduced child behaviour problems, reduced parental mental health problems (including parent depression, anxiety, and stress), increased positive parenting and monitoring, increased child maturity and compliance (observed), and increased parent self-efficacy.

PLH in the Philippines: The Masayang Pamilya (MaPa) Program

The PLH-Philippines team is led by Ateneo de Manila University with the University of Oxford and the Child Protection Network Foundation. Beginning in 2016, the team used community-based participatory approaches to assess the feasibility of the Sinovuyo Program in the Philippines. Formative evaluation findings informed the development of an adapted, culturally appropriate version of the program for the Philippine context, called Masayang Pamiya (MaPa) (37). 'MaPa Kids' is a group-based intervention comprised of twelve sessions targeting parents and primary caregivers of children ages 2-9 years. The group-based parenting program is delivered to caregivers enrolled in the *4Ps Conditional Cash Transfer Program* in low-income urban areas.

Trained community-based facilitators with a minimum of high school education deliver the parenting sessions, which include modules on the following evidence-based parenting strategies (38):

- spending one-on-one time with children
- describing actions and feelings for cognitive development and socio-emotional awareness
- using praise and rewards to encourage positive behaviour
- establishing limits through effective instruction giving and consistent rules
- nonviolent discipline such as ignoring negative attention seeking behaviour, and consequences for noncompliance, rule-breaking, and aggressive behaviour
- problem solving with children

- mindfulness based stress reduction for caregivers.

The development and evaluation of MaPa was funded by UNICEF Philippines and the UBS Optimus Foundation, with ongoing funding from UNICEF Philippines, and implemented as a multi-sectoral collaboration between researchers, service providers, and the Philippine Department of Social Welfare and Development (DSWD). The program is viewed as an important contribution to efforts to shift child safety and protection efforts in the Philippines towards prevention. The PLH-Philippines team has also adapted and piloted an 8-session version of MaPa Kids as well as a 9-session version of PLH for Teens with parents and adolescents aged 10-17 years (MaPa Teens).

Response to the COVID-19 pandemic

After WHO declared COVID-19 a global public health emergency in March 2020, the Philippines moved quickly to impose strict, sweeping lockdowns across the main island of Luzon. On March 16, 2020, President Duterte announced an "enhanced community quarantine" for Luzon, which included strict stay-home orders. People could leave their homes only to purchase food, medicine and other items necessary for survival. The lockdown measures were in place until June 2020.

The prevalence of violence against children was high in the Philippines before the pandemic. A 2016 national violence again children survey found that 80% of respondents reported experiencing violence at some point during childhood (39). With schools shut down, families spending more time confined at home, and mounting stress for caregivers, program staff perceived that children are at even greater risk of violence, including corporal punishment, neglect, child labour, and various forms of cyber violence. As a precaution, the Department of Education has updated its child protection policy for online learning and the reporting protocol for responding to suspected child maltreatment cases (40,41). Programs like MaPa may help to address this heightened need to help identify and respond to child maltreatment during this time.

Under the *COVID-19 Playful Parenting Emergency Response (COPPER) project*, the global PLH team mobilized with partners to develop a suite of open-source and evidence based parenting resources in response to the COVID-19 pandemic, including a series of parenting tip sheets that have been translated into more than 100 languages and are being distributed all over the world. The PLH-Philippines team is adapting these resources for the Philippine context, and developing new delivery strategies as well.

PLH-Philippines delivers MaPa parenting content for families with children ages 0 to 18 years through a variety of low-cost print materials (booklets and tip sheets) and audiovisual/digital resources. While some activities are underway with respect to implementation, others are under development and will be piloted in the coming months with funding from UNICEF Philippines and The Human Safety Net. All resources cover the same content as the in-person MaPa Program with the following additions, which reflect the perceived needs during the pandemic:

- Additional content on learning through play and parent-supported early learning
- Health and safety during the COVID-19 pandemic (e.g., physical distancing, hygiene, online child protection, sexual child abuse prevention)
- Coping with difficulties related to COVID-19 (e.g., managing difficult child behavior using effective nonviolent discipline, family conflict, stress & anger management).
- Online child safety and digital parenting
- Supporting engagement in remote learning, learning through play, and reentry into school

- Additional content for caregivers of children with disabilities.

At the time of this study, discussions between the MaPa team and DSWD are ongoing regarding the dissemination of MaPa content through different modalities.

MaPa Parenting Tip Sheets and Booklets

MaPa Tip Sheets are one-page Tip Sheets developed during the pandemic that outline the necessary "building blocks" of positive parenting skills. In the Philippines, the Tip Sheets have been translated into 12 local languages and can be disseminated as posters or flyers. They may be provided directly to caregivers at health clinics or used by service providers to guide discussions regarding parenting strategies during the pandemic.

MaPa booklets were designed to complement the Tip Sheets, but the information is simplified, less text-heavy, and the booklets include comics that illustrate examples of activities for caregivers to try at home. This resource is ideal for distribution to families who may not have access to internet-based resources.

MaPa Webinars

In MaPa webinars, a trained facilitator delivers core parenting messages during 1 to 2 hour sessions via Zoom. Rather than using didactic lectures, facilitators use engaging strategies like role play and live scenario demonstrations to illustrate parenting strategies and stress reduction skills. Webinar participants are mainly service providers who can then replicate the sessions with caregivers. In addition to learning the content themselves, service providers are introduced to the Tip Sheets and Booklets, and discuss how these resources can be used in clinical practice.

"In MaPa, the delivery of the material is just as important as the content itself. Now (during the COVID-19 pandemic), the content hasn't changed much, but the delivery has […] Most parenting programs don't differ much in their content. But the delivery, which includes role play, time to practice, and role modeling by the facilitator – those things are just as important. In the Philippines, this aspect is unique to MaPa." - Executive director, Child Protection Network Foundation

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MaPa Radio Segments and Facebook Page

PLH-Philippines has developed similar content for national radio segments in which MaPa parenting skills are discussed and "acted out" in audio form. The team has proposed including a "hotline" as part of the segment so that caregivers who tune in can call in with questions and receive immediate, on-air support for parenting during this difficult time. The MaPa Facebook page provides links to all electronic parenting resources, including video versions of the MaPa comics illustrating key parenting techniques.

MaPaText Support

In partnership with UNICEF, DSWD, and the National Telecommunications Commission, PLH-Philippines is in the process of developing a structured chatbot text message delivery system to provide parents and caregivers with core parenting strategies, tips, and learning through play activities. Text messages will be tailored to specific child age groups (i.e., 0-2, 2-9, and 10-17 years), delivered on a particular schedule, or parents who want to learn more can opt for additional on-demand content. Monitoring and evaluation is

embedded into user experience through short weekly surveys that are customized with additional support for parents experiencing challenges.

eMaPa ParentChat Support Groups

Development of a digital version of MaPa's in-person parenting groups is underway. Previously trained facilitators will engage with groups of 6-10 caregivers who are beneficiaries of the DSWD's 4Ps Conditional Cash Transfer Program via smartphone applications like Viber or Facebook Messenger. Facilitators will deliver text and audio messages, illustrated comics, links to YouTube videos, and activity assignments for parents to complete with their children, then facilitate two interactive 60-minute discussions in the chat group per week. Parents will have the ability to engage in group chats and also contact their facilitator directly for additional parenting support. The program will provide free data bundles to support caregivers' participation.

Adapted (one-on-one) delivery in clinical settings

In some hospitals, healthcare providers have been distributing Tip Sheets to all families who access the child protection unit. During the COVID-19 pandemic, child protection unit staff also providing one-on-one counselling using MaPa content in some cases, but this is limited by time and human resource constraints and not intended to replace group parenting programs in the longterm. These are families with children who have accessed services *because* of a child maltreatment incident, so the strategy is considered secondary prevention; however, providers hope that these practices will help to reduce future occurrences of violence in the home.

Lessons learned to date

MaPa Webinars

The MaPa team recently launched a series of parenting webinars that drew participants from across the country. Webinars were delivered in 3 sessions to allow participants to practice what they had learned between sessions and provide feedback the next day. There were some challenges reported, such as unreliable internet, and/or troubles concentrating due to distractions at home. In addition, it is difficult to know whether participants have actually practiced the skills, and retained the information shared. To answer these questions, the MaPa team is evaluating the webinars to assess outcomes immediately following seminars and one month later. Improvement of the webinars is an ongoing process, and the team continues to find new ways to engage participants online.

> *"The webinars are have started… they're going well but it's an evolving learning process, even for the facilitators. They are challenged by the new modality; they are more comfortable face to face. Eye contact helps people connect – how do you replicate this online?" – Child Protection Specialist, UNICEF Philippines*

In a sense, the shift to online delivery has created a broader platform for MaPa content delivery, allowing the team to reach new child protection stakeholders across multiple sectors. For example, the team recently hosted webinars attended by DSWD staff, Child Protection staff across the Philippines – this included government employees and other frontline child protection workers such as physicians, nurses, judges, prosecutors, social workers, and law enforcement officers.

Lessons learned to date include the following:

- Distill the content to the most important messages (simplified messaging works best)
- Less lecturing and more practical demonstration of skills (e.g. role play, live simulations)
- Make the content relatable the to real-life scenarios during the COVID-19 pandemic
- Encourage participants to engage in activities by incorporating time for meditation and physical movement)
- Encourage the use of the chat box to reinforce learning

"The team had to innovate to come up with creative ways to teach the material. They do it in a way that's very practical, through role play. The webinars were simple and contextualized; people appreciate that. Other webinars are just the person lecturing at you, which can be boring." – Child Protection Specialist, UNICEF Philippines

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Government Partnership as a pathway to scale

Integrating parenting content within existing government programs is crucial to the long term sustainability in the Philippines, and is why MaPa collaborated with the Department of Social Welfare and Development from the beginning to implement feasibility studies and small trials. Existing evidence demonstrating the positive effect of MaPa on child protection outcomes provides a rationale for more formal integration of MaPa into existing DSWD services. For example, DSWD administers the 4P Conditional Cash Transfer Program, which requires recipient families to attend regular healthcare check-ups, enroll their children in schooling, and attend a series of Family Development Sessions (FDS) covering topics related to responsible parenting, health and nutrition. A limitation of the current FDS is that it lacks content on developing parenting skills. This is considered an important opportunity to augment the existing program with MaPa content.

Another opportunity has emerged as a result of the pandemic. When distancing measures were put into place, it was no longer possible to do any face-to-face programs (MaPa or FDS); as a result, DSWD is now in the process of developing an electronic version of their FDS program (eFDS). This means that the MaPa has an opportunity to develop their "eMaPa" materials in parallel with the government's eFDS planning. Developing electronic versions of FDS and eMaPa simultaneously will ensure smooth integration of the two resources and ultimately, the best chance for sustainable impact. Discussions about how to do this are ongoing and involve partners like UNICEF and the Child Protection Network Association.

While MaPa's partnership with DSWD presents opportunities for sustainable implementation, there are also ongoing challenges. The biggest obstacle to operationalizing this partnership moving forward is that DSWD is now overwhelmed with delivering a new social amelioration program (SAP), which provides financial support during the COVID-19 pandemic. The department's priorities have therefore shifted to address the social protection needs of people who lost their livelihoods during the pandemic. While discussions regarding the integration of eFDS and eMaPa are ongoing, pandemic-related human resource challenges have slowed down the process.

"DWSD is very much preoccupied with providing immediate relief to the country's poorest families; it's a logistical nightmare for them. So initiatives like eMaPa have dipped in urgency, because of more immediate humanitarian concerns."
- Executive director, Child Protection Network Foundation

Ongoing work and emerging concerns

Integrating Playful Parenting

An emerging concern relates to implementation of playful parenting messaging in the Philippines. In this context, most caregivers do not view playful parenting as a priority because educating children is considered the distinct and primary role of teachers, not parents. In addition, owning toys is rare in low-income households, and if families do have toys, they are viewed as precious and may be locked away in cabinets for safekeeping. Despite these cultural norms, parents are also seeking ideas and activities to keep their children engaged at home during the pandemic, so the MaPa team has added content on playful parenting and learning through play. Further research is needed to evaluate caregivers' level of engagement with this material, and whether MaPa interventions have an impact on playful parenting behaviors.

Identifying cases of child maltreatment

During the pandemic, it has been challenging to identify and promptly respond to cases of child abuse and neglect. The MaPa team is engaging in ongoing discussions with UNICEF, the Child Protection Network Foundation, and DWSD to develop potential solutions. Creating a system that enables two-way SMS text messages between caregivers and social welfare staff is a potential strategy, but the logistics are difficult. While caregivers receive text messages free of cost, there is a cost to reply. If caregivers do not have airtime loaded on their phones, which is common, they are unable to respond. The DSWD recently sent a letter to the National Telecommunications Company (NTC) to seek their support in this endeavor. The NTC has the ability to facilitate a no-cost two-way communication system, but questions remain regarding the source and duration of funding for such an initiative.

"Text messaging is useful, but what is most important is being able to follow-up for more information… if parents have a concern, how are they able to get the support that they need? […] What if there is disclosure of child abuse by a family member? How will we know, and how will they get support? The response has to happen immediately to ensure that no new incident of abuse happens. This is a limitation of the one-way SMS modality." – Child protection specialist, UNICEF Philippines

Engaging Local Government Units

According to a UNICEF staff member, it will be critical for the MaPa program to enhance the social welfare system at the local government unit (LGU) level; as this is a key pathway to scale-up and sustainability. In the Philippines, the Local Council for the Protection of Children (LCPC) is the primary body that develops policies and implements child protection programs in cities, municipalities and barangays (villages) (39). However, LCPCs are not active in many LGUs, and aside from the 4Ps program, the DSWD is less engaged

in urban settings than rural settings. Several respondents emphasized the importance of advocating for a prevention approach at the LGU level but also within the social welfare system more broadly. Dealing with cases of abuse after the fact is very costly. If a child is already a victim, they have to be sent to the hospital, may require different consultations and medicines, there is a lost opportunity to go to school, and so on. Focusing on prevention is thought to be more cost-effective in the long run.

PLH-Philippines and partners have a vision to eventually scale the MaPa parenting program to reach not only beneficiaries of 4Ps, but any caregiver who may benefit from it. To accomplish this goal, the longer-term cost-benefits of MaPa will need to be demonstrated, and LGUs will need to take ownership to adapt and mainstream the program. In addition, a number of data sources on child maltreatment will need to be consolidated and strengthened. While there is much work to be done, the COVID-19 pandemic has created a new sense of urgency with respect to child protection, and some experts are optimistic that this difficult time will spur innovation.

"In a sense, the pandemic has shaken the status quo, so people are more ready to change the way they do things, and they're more receptive to ideas. So maybe, this could be the ideal time to take advantage of that." - Executive director, Child Protection Network Foundation

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Future research questions

As the MaPa program evolves, there are a number of emerging research questions to be addressed:

- How can LGUs adapt and mainstream MaPa through existing programs to reach families beyond the 4Ps program?
- How can MaPa be implemented in other settings outside of the home, where children are being cared for? (e.g. in residential facilities, in schools, etc.)
- What is the impact of the MaPa program on parental behaviour change? (e.g. frequency of spanking, hitting, shouting; incidence of neglect, etc.)
- What additional partnerships are necessary to expand MaPa's reach? (Departments of Health, Education, etc.)
- How can the digital and remote-delivery aspects of MaPa reach those who are most vulnerable and have limited access to technology?
- How can the digital platforms be integrated with in-person support and what is the most effective, cost-effective, and scalable system of delivery?

Case Study #7: Nurturing Care for ECD (PATH MOZAMBIQUE)

Program Overview

Before Covid-19

- Large in-person training for health providers and CHWs
- Home visits
- Facilitated play box sessions at health facilities
- Printed ECD materials

After COVID-19

- Outdoor, distanced trainings for providers and CHWs
- Home visits with safety protocols in place
- Videos, podcasts and & radio segments
- Radio listening sessions in health facility waiting rooms
- New printed materials related to COVID-19 and child disability

PATH is an international nonprofit that takes a multilateral approach to strengthening health systems globally. It partners with government, nonprofits, and private sector entities to identify and scale up effective technologies and practices in the broadly defined areas of policy and advocacy, health behaviors, medical devices, drugs and vaccines, diagnostics, monitoring and evaluation, and market development. The aim of this work is to reduce health disparities and inequities in access to care worldwide (42).

PATH's Nurturing Care for Early Childhood Development Program works to improve the integration of the nurturing care framework and ECD services for children under 3 into existing health systems in low-resource settings (43). This work occurs simultaneously at the levels of policy and advocacy, health provider training and service delivery, and research and evaluation. PATH's model includes:

- partnering with country governments to include ECD in policy, planning, and budgets
- incorporating ECD content into existing training curricula for healthcare providers and community health workers
- evaluating the effectiveness of these integrative efforts

PATH's Nurturing Care for Early Childhood Development Program has supported governments and partners to reinforce ECD in health and nutrition services for young children in Cote D'Ivoire, Turkey,

Kenya, Mozambique, South Africa, Zambia, and Ethiopia. This report focuses on Mozambique, where the program has been active since 2012, with financial support from the Conrad N. Hilton Foundation and UNICEF.

ECD Interventions in Mozambique

PATH Mozambique's work on ECD encompasses efforts towards system-level change through engagement with the national policy environment, developing and improving the capacity of monitoring systems for routine health services, training health workers, and promoting behavior change through media and communications. District health services and provincial health services work closely with PATH on ECD initiatives.

Training and Capacity-Building for Health Providers and CHWs

PATH has partnered with the Ministry of Health and provincial and district authorities to bring ECD content to training curricula and capacity-building activities for both facility-based service providers and community health workers. ECD content includes developmental monitoring and caregiver counseling on appropriate parenting practices, early learning opportunities, and responsive caregiving. These trainings make use of interactive, practice-based methodologies. At the community level, PATH supports capacity building of government community health workers, the disabled people's organization ADEMO and a local partner organization of the USAID-funded COVida project, which seeks to improve the health and well-being of orphaned and vulnerable Mozambican children. CHWs perform integrated management of childhood illness and health promotion, and recently developmental monitoring and counseling. ADEMO volunteers conduct community-based rehabilitation work, including home visits to identify children under 5 with developmental delays and disabilities, connect them to health centers, counsel families on appropriate rehabilitative exercises, nutrition, and play activities, and conduct ongoing weekly home visits to support the child's care.

Government Collaboration

PATH Mozambique has supported the integration of ECD components into the following key national policy and technical documents (44):

- Well Baby and Sick Child consultations and registers
- Pre-service Maternal and Child Health and Nutrition training curricula
- Community Health Worker training, supervision and job aids
- Integrated Management of Neonatal and Childhood Illnesses
- Nutrition Rehabilitation Program
- Nutrition Intervention Package (Community Growth Monitoring Program)
- National Child Feeding Strategy

Educational Programming and Communications

PATH works with government partners to develop, pilot and distribute educational materials and visual aids on child development for health facilities and communities, and to train providers to use these in their routine work. Examples include posters on developmental milestones, responsive feeding, play in daily routines, a parenting education manual, and ECD content for CHW flipcharts (45). Prior to the

pandemic, PATH implemented play box sessions with toys made of recycled materials in health center waiting rooms. Children and caregivers could pass time waiting for services playing together and learning about ECD through sessions facilitated by health center staff. Finally, since 2017 PATH has been working with a local communications NGO to train radio journalists on ECD and to produce and disseminate educational radio content on ECD through community radio broadcasts. During the pandemic, this partnership was expanded to address ECD in the context of COVID-19 including the addition of educational videos. The radio broadcasts are also delivered during home visits.

Response to the COVID-19 pandemic

The first confirmed cases of COVID-19 in Mozambique were reported in late March 2020. Schools were closed on March 23rd, and a state of emergency was declared on April 1st, lasting through July 31st 2020. A second state of emergency was in effect from August 8th through September 6th 2020. Measures to control spread have been in place throughout this time and continue under the ongoing "situation of public calamity" that has replaced the state of emergency. Since March, PATH has participated in the national pandemic response through support to Maputo and Nampula provinces and to technical working groups at the Mozambican Ministry of Health (46). Support activities have focused on prevention education, health system readiness and maintenance, and assistance to families with young children through home visits.

To support CHW trainings at the local and provincial levels, PATH created interactive training activities and content related to nurturing care during the pandemic to be incorporated into the national COVID-19 training package, supported training of 337 community health workers in Maputo Province and Monapo District of Nampula Province, and distributed two quality artisanal masks to each CHW. PATH also helped provide district health services with cleaning supplies and personal protective equipment. At the national level, PATH contributed to communication subsidies and the purchase of a Zoom license for technical staff at select departments at the Ministry of Health, which helped maintain the network of communication between government actors in the health sector nationwide and monitoring of health services under pandemic conditions (46). PATH Mozambique has also worked to continue its Nurturing Care Program activities alongside and in combination with its COVID-19 response efforts.

Disruptions and Implementation Challenges

Challenges to implementation mostly related to the inability to continue activities involving large group gatherings. Though PATH's health facility-based capacity building and technical assistance activities never stopped, measures were taken to reduce in-person contact. Health worker trainings, which previously took place in large groups in the district center and in indoor settings, could not go forward in their usual format for safety reasons. Home visits to families of vulnerable children and children with disabilities were similarly impacted by pandemic conditions. The local partner organization that conducts home visits as a part of the project on orphans and vulnerable children stopped doing visits completely for a period of three to four months. This meant that the ECD components of this intervention that PATH supports, like nutritional screenings and the monitoring of developmental milestones, were put on pause as well.

While pandemic conditions forced the reduction or cessation of many health promotion activities in Mozambican health centers and communities, creative adaptation to meet these challenges has allowed

PATH to continue its pre-pandemic work related to health promotion, ECD training and education, and caregiver support. These adaptations are described below.

Adapted Delivery of Health Worker Training and Community-Based Caregiver Support

Starting in the initial months of the pandemic, rather than maintaining their usual physical presence at facilities, PATH staff worked with health centers to delegate responsibility for providing technical assistance to center clinical directors. In addition, PATH was the first Ministry of Health partner organization to reinstate support of CHW trainings after the state of emergency was lifted. To provide capacity-building trainings and follow-up support safely, the trainings were shifted outdoors and now take place with a reduced number of participants to allow physical distancing. Where they were previously conducted in the district center, they are now held in individual regions of the district. Digital communication is used to share training materials in the form of videos and a follow-up quiz.

These adapted approaches allowed training activities to continue, but were not without challenges. Outdoor, reduced capacity meetings meant that additional trainings had to be conducted over shorter periods of time, increasing operating costs. In the case of online activities, the price of internet connectivity is high in Mozambique, and partners and providers often requested subsidies when asked to use their internet connection for this purpose, which PATH provided. Regional trainings also pose slight logistical challenges because transport for facilitating staff must be organized.

"COVID pushed the capacity of our creativity!"
- Training facilitator/coordinator, PATH

The community-based rehabilitation initiative with ADEMO was able to continue without interruption due to immediate efforts to inform volunteers about appropriate public health measures to take during home visits. Volunteers also distributed masks, soap, and homemade running water devices to over 100 families they supported, and incorporated messaging about prevention measures into their counseling. Finally, volunteers were each given a radio that they could use to play educational dialogues on ECD topics (described below) as well as COVID-19 during home visits. Listening to radio segments together and discussing what they had heard was a helpful way for volunteers to engage with caregivers and children from a safe distance.

Innovative Delivery of Educational Programming

In addition to supporting health worker trainings and community-based rehabilitation/home visits, PATH has collaborated with partner organizations, local government, health facility staff, and community radio stations to produce and disseminate educational programming that promotes nurturing care for ECD in creative ways that complement their pre-pandemic activities.

Health Center Waiting Room Radio Sessions

When the COVID-19 pandemic arrived, PATH's waiting room play box initiative had to be discontinued because children could transmit the virus while playing together and sharing toys. To encourage safe physical distancing while keeping children and caregivers engaged during their wait, play boxes were replaced with radio sessions. Radios were placed in the waiting areas of all health facilities in the pilot

district of Monapo (Nampula province). The radio content PATH produced is directed at both caregivers and their young children and includes dialogues that depict typical household situations and child-friendly educational songs. Dialogues are translated into local languages and aim to create a comfortable environment through humor and familiarity, transmitting information in a way that is relevant and engaging for listeners. Topics include nutrition for children and pregnant women, awareness of disability, the importance of exercise and stimulation for children with disabilities, the importance of play starting from pregnancy and extending through toddlerhood and childhood, and the stress management in households to reduce the incidence of violence and abuse.

In three health facilities that have the necessary technology and connectivity in place, radio sessions are complemented with video programming. Staff members or providers facilitate the sessions, ensuring that all can hear the radio from a safe distance. Program staff report that this can be challenging, but with time people have learned the importance of infection control measures and distancing efforts have grown more collaborative. PATH reports that more than 30,000 caregivers have listened to radio dialogues and songs in the waiting rooms of 16 Monapo health centers since May 2020 (47). As a follow up to this pilot, ECD videos were distributed to all health facilities in Maputo province that had TVs installed in the waiting rooms (over 20 facilities).

Community Radio Programming and Podcast

PATH Mozambique has also continued to produce and disseminate its educational content through partnerships with a national communications NGO, h2n, and over 100 community radio stations it supports across country. Radio stations integrate PATH's spots and dialogues into their normal daily programming. This initiative precedes the pandemic, but it was expanded during this time to include new content focused on COVID-19 prevention and the importance of nurturing care during the pandemic, as well as a new mode of delivery in the form of segments for a daily podcast/news bulletin starting in May 2020. Ten new radio spots, six radio dialogues, and three videos on ECD and nutrition with reference to COVID-19 were produced and disseminated nationally with h2n in 2020. In addition, PATH's programming includes an interactive virtual game on COVID-19 developed with CODE, and educational songs created in partnership with a local ECD teacher. The radio content has been approved by the Ministry of Health and is shared on its public COVID-19 communications' drive, making it available for any interested organization to use. With approval from the provincial government, flash drives containing recordings of PATH's educational songs and radio dialogues have been distributed to all 23 district health directors across Nampula province for wider dissemination.

Printed Materials

PATH's radio and video programming in health facilities is complemented by several printed resources. One is an illustrated children's book that explains what the coronavirus is, and illustrates infection control measures like handwashing and masking, and safe play activities to do at home. The story is written from the perspective of Vania, a 5-year-old Mozambican girl who learns about the virus with help from her brother Paulo. The storybook, produced in partnership with Associacao PROGRESSO and CODE, has been approved by the Ministry of Education and will be printed in early 2021. Another is an illustrated booklet for caregivers of children with disabilities focused on how to protect and care for their children during the pandemic. It includes sections on precautions to take inside and outside the home as well as

recommendations for the continuation of daily routines, adequate nutrition, exercise, stimulation, play, child stress reduction and caregiver self-care. This booklet has been made available in all specialist consultations in health facilities in Maputo and Nampula provinces l along with a step-by-step guide on how to use the booklet as a counseling tool for caregivers of young children with disabilities. So far, the booklet has been well received by providers who note that there was a need for engaging visual aids for counseling. It was also distributed to families of children with disabilities involved in the community-based rehabilitation supported by ADEMO and disability partners in several additional provinces. Finally, PATH published informative posters on COVID-19 symptoms, preventive measures, and the importance of continuing to visit health facilities during the pandemic, for use by CHWs and other community actors. These posters incorporate nurturing care principles in their depiction of parents playing with children and bringing children to the health center.

Lessons Learned from during the COVID-19 pandemic

Integration of Pandemic Response and NCF Interventions

Notably, PATH Mozambique has integrated new messages on COVID-19 prevention and the importance of nurturing care during the pandemic into their existing radio-based educational programming. New radio segments address the ways in which the pandemic is impacting the routines of caregiving and family life (46). For example, one radio spot aims to reassure caregivers that health facilities are safe and ready to receive them and encourages them to continue bringing their children for consultations and check-ups. Other new messages cover the following topics:

- how to help children feel calm and secure during this uncertain period;
- how to take advantage of time at home with family to play and engage with children using daily routines and materials on hand;
- the importance of playful parenting and minimizing children's screen time;
- maintaining proper mother and child nutrition to support the immune system; and
- preventive measures like hand hygiene, mask-wearing, and physical distancing.

"The radio programs always produced content related to health, nutrition, and some also related to early childhood development, but as an organization we started producing the podcast during COVID because we felt like there was a lack of real information spread in the communities. [Some people believed] coronavirus is not for us... 'we're not afraid because it will never come to us.' We felt we must spread prevention information to vulnerable people... And use the radio as a vehicle."
- Communications partner staff, h2n

This integration reflects a focus on continuity and sustainability in PATH's educational initiatives. A staff member at a partner organization (h2n) highlighted the importance of reinforcing messages about playful parenting and fathers' engagement in nurturing care in light of stressors faced by families during the pandemic:

"Now, during COVID...many parents and many kids were at home, with their parents, maybe some of them for the first time. And there [were] a lot of [challenges]...We keep telling parents to play with kids... And I think that it must continue...It is not only for the pregnancy but also for the life of the kid that the father must be involved, play with his kid, because it is both of them, it is not only from the mother, it is [also] from the father. So, it is something that during COVID was maybe stronger, but something we did and have to continue doing." - Communications partner staff, h2n

By using radio programming to provide educational content on ECD during the COVID-19 pandemic, PATH has also established a set of new communications strategies that can be implemented beyond the pandemic.

Optimization and Sustainability: High-Tech and Low-Tech Approaches to CHW Training

Adapting the delivery of CHW training to comply with public health protocols led to new approaches with unexpected benefits. As stated above, PATH responded to this limitation in two different ways: by conducting in-person trainings outdoors in smaller groups and by moving some of the follow-up activities supporting those trainings online. From the latter, PATH staff learned that it was possible to communicate with trainers, supervisors and community partners using digital resources like WhatsApp groups and online videos, and provide materials in this remote format. Digital resources were not widely used for training prior to the pandemic but PATH hopes to continue using them in the future. From the former, staff learned that it was also possible to conduct trainings in simpler, more low-tech formats compared to standard procedures:

"It actually works to do a training under a tree, we don't always need the PowerPoint presentation which our Ministry likes to have, we can print out the slides and distribute them to participants and do it outdoors and still be productive, as opposed to sitting in the classroom." – Training facilitator and coordinator, PATH Mozambique

The decentralization of training locations also makes attendance logistics easier for participants. Increased flexibility in the format of trainings and means of communication with partners in general seems to be an unexpected positive outcome of PATH's COVID-19 response.

Similarly, PATH learned that leadership of health facility-based mentorship activities could be transferred to facilities themselves sooner than expected. When PATH staff reduced their physical presence at facilities, clinical directors were able to take greater ownership of these activities when provided with small monetary incentives for additional work. In a recent data review meeting, the district health leadership commended this approach as innovative and advised all health facility directors to adopt provider mentoring as a routine task. PATH staff believe that by integrating this approach into routine practice, the mentorship activities of health providers may become more sustainable in the long run.

Evidence and Outcomes

There is encouraging initial evidence that PATH's innovative educational programming is reaching caregivers and is well received by communities. A small evaluation of the health center radio initiative, conducted at 11 of 16 health centers, showed that sessions usually occur at least every other day. Caregivers who participated were able to recall practices they heard in the segments and were able to describe some of the practices they adopted themselves, such as speaking to babies in utero, speaking to children daily, or playing with them (47). Furthermore, after a significant decrease in the number of people coming to health facilities at the start of the pandemic, attendance is back up, and staff members partially attribute this to the families listening to and understanding the messages on protective measures they could take to ensure safe facility visits. Health facility staff report that caregivers are now familiar with schedules for radio and video program sessions and look forward to hearing the songs and stories. Some parents also bring their own toys to the waiting rooms following guidance from the radio programs. In this way, the shift to radio programming in waiting rooms due to the COVID-19 pandemic has led to an unexpected positive result.

> *"Now what we are observing is that…the kids are waiting there and the mom either has a doll, or a ball, or a little car, and they even tell our staff and the providers that they have toys at home, that they've heard it on the radio that they have to make toys and they've made toys. They actually enjoy playing with the toys, singing the songs, and time in the health facilities is a happier time right now than before." - Staff member, PATH Mozambique*

Educational radio and video sessions have been integrated into the health facility environment, both in terms of content and ownership. Providers involved in the radio programming act as role models and speak with confidence and authority about the importance of nurturing care practices like appropriate child feeding and learning through play. Health facility staff are able to facilitate radio sessions without the immediate support of program staff. This level of integration, as well as the low cost of providing radios (which are solar powered, eliminating the need for batteries), suggest that radio sessions may be a sustainable approach to providing nurturing care education under pandemic conditions.

Perceived need for PATH Mozambique's educational programming extends beyond the community level to peer organizations and government partners. A recent visit from the provincial First Lady helped draw attention to the importance of ECD, nurturing care for children with disabilities, and the district's pioneering work in this area. Several partner organizations have expressed interest in either adding their own messaging to PATH's radio platform or adapting the method for their own independent use. PATH's educational materials related to COVID-19 have been uploaded to the Ministry of Health's online directory of COVID-19 resources, where they are publicly accessible nationwide. Presently, community radio programming is being integrated into PATH Mozambique's collaboration with USAID Advancing Nutrition to integrate interventions promoting nurturing care for early childhood development with community nutrition interventions ongoing in six districts.

Overall, PATH representatives highlighted that new partnerships (such as those with media and communications organizations involved in production of printed materials and radio content) and strengthened partnerships (such as those with provincial and national health authorities) were unexpected positive outcomes of the pandemic. They are hopeful that the district government and partner organizations who have shown interest in their radio programming initiatives will take full ownership of these activities in the future.

Facilitating Factors

A few key conditions and factors facilitated PATH Mozambique's ability to continue their ECD work during the pandemic. First, strong existing partnerships with local, provincial, and national government, as well as community organizations, health facilities, and other partners, were instrumental in allowing the rapid implementation of adapted and new forms of service delivery. For example, all new communications materials were developed with the approval of the the Ministry of Health, which made it possible to disseminate them quickly and widely. In the case of the community radio initiative, the willingness of local communications partner and radio stations to collaborate on material production and dissemination was crucial.

Second, public health precautions taken to create safe work conditions at PATH itself, and the establishment of these conditions by district and provincial authorities in the case of in-person meetings, made it possible for work to continue. Having staff members live in the district where they work and use district health office as their workspace further reduced the potential barriers posed by restrictions.

Finally, the format for delivery of the innovative educational interventions that PATH introduced during this time aligned with existing practices, norms, and needs. More specifically, it was already typical for daily morning talks by providers to take place in health centers; waiting room radio sessions have fit neatly into this routine, making the activity easy to adopt. Community radio is an efficient and effective means of disseminating information in Mozambique; a staff member at PATH's partner organization on this initiative, h2n, noted that radio is a better medium for mass communication than internet, television, or newspaper, due to barriers related to literacy and access to technology. Furthermore, the design process for new radio content on ECD during the COVID-19 pandemic included in-depth interviews with caregivers that explored their perceptions and current practices related to child health/nutrition and caregiving and asked what topics they wished to have addressed. This made it possible to make the radio dialogues as relevant as possible to the ECD needs and perceptions expressed by communities.

Overall, PATH Mozambique's existing integration and interaction with multiple levels of the health system for ECD work facilitated their ability to respond to the COVID-19 pandemic through its strong partnerships and an approach to programming content and service delivery centered on community needs. The experience of PATH Mozambique and its partners demonstrates both simple and innovative ways to continue to implement ECD interventions during the pandemic.

Annex A: Case Study Methodology

Case Study Selection

The case studies were selected with several criteria in mind:

- Include a range of nurturing care programming across responsive caregiving interventions, early learning interventions, and safety and security interventions;
- Different age groups addressed, ensuring sufficient attention to both the 0-2 years age group (infants and toddlers), and the 3-8 years age group ;
- Diversity in terms of geographical regions;
- Diversity in terms of levels of development, i.e. with a mix of lower-middle and high-income country contexts, but a predominance of the former to learn from both contexts but to ensure strategies could be implemented with low resources;
- Programs for which there is evidence of activities taking place during the pandemic, with the rationale that it is important to ensure the COVID-19 response is of sufficient scale to make a case study worthwhile;
- At least three programs target marginalized groups, including refugees, ethnic minorities, and families living in low-income, highly populated urban settings;
- Include at least one 'lesser known' intervention (i.e. intervention that is underreported, and under researched).

Given the scope and timeline of this assignment, we also considered feasibility issues such as the availability of key informants, the availability of program documentation, as well as other existing case studies and research to avoid overburdening partners and duplicating efforts.

Based on these criteria, we identified the following programs for inclusion in the study: Associazione 21 Luglio (Italy); Parenting for Lifelong Health [MaPa program] (Philippines); International Rescue Committee [Ahlan Simsim program] (Jordan); Kangaroo Foundation (Colombia); Nobody's Perfect Parenting Program (Canada); Ummeed Child Development Center (India); and Nurturing Care for ECD programming by PATH in Mozambique (Figure 1).

Figure 1. Map of Selected Case Study Programs

Overall approach

Semi-structured interviews (SSIs) with key informants and stakeholders engaged in the design and delivery of programs were the main form of primary data collection. A thorough review of previous evaluations, program documents and online resources, and documented COVID-19 strategies was part of the process to maximize the value added and minimize burden on key informants. For each thematic case study, we interviewed between four and eight key informants per program (Table 7). We prioritized interviews that reflect perspectives of staff in charge of delivery at the beneficiary level, staff involved in the design and management of the program, and key partners.

Table 7. Characteristics of Case Study Interview Participants

Participant ID	Sex	Affiliation type	Programmatic role	Country
1	Female	NGO	Social Worker	Italy
2	Female	NGO	Program Manager	Italy
3	Female	NGO	Project Manager	Italy
4	Male	University	Academic Partner	Italy
5	Female	NGO	Developmental Pediatrician	India
6	Female	NGO	ECD Trainer, Program Manager	India

7	Female	NGO	Occupational Therapist, Implementer, Trainer	India
8	Female	NGO	Project manager, Trainer	India
9	Female	NGO	ECE Teacher	India
10	Female	NGO	Training Manager	India
11	Female	NGO	Occupational Therapist	India
12	Female	NGO	Developmental Pediatrician	India
13	Female	NGO	Provincial Coordinator, Master Trainer	Canada
14	Female	NGO	Provincial Coordinator, Trainer, Facilitator	Canada
15	Female	NGO	Provincial Trainer	Canada
16	Female	NGO	Social Worker, Facilitator	Canada
17	Male	NGO	Facilitator	Canada
18	Male	NGO	Facilitator, previous program participant	Canada
19	Female	NGO	Co-founder, Director	Colombia
20	Female	NGO, Health system	Chief Neonatologist	Colombia
21	Female	Health system	Pediatrician	Colombia
22	Female	NGO	ECD content developer	Jordan
23	Female	NGO	ECD coordinator	Jordan
24	Female	NGO	ECD Technical Lead	Jordan
25	Female	NGO	ECD coordinator	Jordan
26	Female	University	Researcher/implementer	Philippines
27	Female	University	Researcher/implementer	Philippines
28	Female	NGO	Director (training)	Philippines
29	Male	NGO	Child Protection Specialist	Philippines
30	Female	NGO, Health system	Pediatrician, Executive Director	Philippines
31	Female	NGO	Trainer, Coordinator	Mozambique

32	Female	NGO	Program Manager	Mozambique
33	Female	NGO	Programs Director, Implementing Partner	Mozambique
34	Female	NGO	Nutrition Advisor	Mozambique
35	Female	NGO	ECD Specialist	Mozambique
36	Male	NGO	District Officer	Mozambique
37	Male	NGO	District Officer	Mozambique
38	Male	NGO	Provincial Coordinator	Mozambique

Sampling approach for interviews. Selection of interviewees involved a combination of purposeful and snowball sampling strategies, with the aim of extracting maximum value from the limited number of interviews that were feasible within the study timeframe. In the first stage, we consulted with colleagues from WHO, LEGO Foundation and our existing networks to identify key contact points for each case study. Based on these initial consultations, we used a snowball sampling approach to identify country and regional level actors for additional interviews.

Tool development. The consent form and SSI guide can be found in Annex C and D. The SSI guide was developed using the ORID (Objective, Reflection, Interpretive, Decision) method for strategic questioning (48) with the following aims:

- Identify noteworthy interventions to support three key nurturing care domains (early learning, responsive caregiving, safety/security) during the COVID-19 pandemic (objective);
- Identify relevant and potentially successful features of nurturing care programs, as well as challenges and unexpected outcomes (reflective);
- Identify implications for nurturing care programs and implementing organizations (interpretive); and
- Developing strategies/recommendations to capitalize on the programmatic lessons learned during the COVID-19 pandemic to scale up coverage and/or support continuation of activities (decisional).

Interviewers used prompts to gather information on why/how certain strategies and initiatives have been successful or unsuccessful in supporting programmatic objectives during the COVID-19 pandemic, and which have been most relevant, transferable and adaptable. We also asked questions to explore the contextual factors that might support or detract from successful implementation of nurturing care programs during the COVID-19 pandemic.

Informed consent and data collection procedures. All SSIs were conducted virtually, via Zoom videoconferencing or by phone if Zoom was not possible. Before beginning the SSI, a researcher reviewed the consent script while the participant followed along on a digital copy. Participants had the opportunity to ask questions about the study prior to stating consent. Researchers requested verbal consent and then signed the consent form on behalf of the participant. All SSIs were digitally recorded with the permission

of study participants. Established qualitative interviewing techniques were applied to ensure rich and nuanced data (e.g. use of probing and prompts, judging tone of voice and body language, asking appropriate, non-leading follow-up questions). SSIs were conducted in English or Spanish by experienced bilingual interviewers.

Data analysis occurred in the three concurrent stages: data reduction, data display and conclusion drawing/verification (49). Immediately following each interview, the interviewer completed a detailed summary of the conversation, highlighting emergent themes, salient topics, and important take away messages. The interview recordings were used to add context, fill in important details and identify illustrative quotes. During the initial data reduction phase, we identified broad themes using a directed thematic content analysis of recorded interviews and notes. At this stage, we used questions and topics from the SSI tool to guide analysis. After this directed analysis, we applied a thematic saturation methodology (50,51) to iteratively identify additional themes with the study aims in mind.

As we analyzed interviews, we summarized key findings and displayed in spreadsheets organized by themes, sub-themes and country. Interpretation and conclusion drawing were based on a combination of interview summaries, analytic memos, contextual notes, and descriptive data from direct quotes. Findings are presented in a case study format to facilitate comparison of implementation strategies, challenges and emerging lessons across contexts. Initial findings will be shared with the country stakeholders interviewed in sampling stage 1 to clarify inconsistencies in the data, improve/verify interpretation, and co-develop programmatic recommendations. This collaborative, rapid feedback approach will ensure that research outputs lead to actionable recommendations to improve implementation of ongoing programs (52).

Ethics. The FHI 360 Institutional Review Board (Office of International Research Ethics) reviewed and approved the study protocol.

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Annex C: Informed Consent Script

Study Title: *Rapid Review of Impact of COVID-19 Pandemic on Nurturing Care and Early Childhood Development*

Study Funders: LEGO Foundation and World Health Organization

Principal Investigator: Kerrie Proulx

You are invited to participate in a virtual interview today as part of a research study. You have been selected because you have important knowledge and views that may help us to better understand how Nurturing Care initiatives have been implemented, adapted or disrupted during the COVID-19 pandemic. We are interested to hear your opinions on why and how Nurturing Care interventions have or have not worked during the pandemic, who has benefited from the interventions, and under what circumstances. We would also like to understand your opinions regarding strategies for sustaining or scaling Nurturing Care initiatives during the pandemic. Your participation will contribute important information that may help to improve ongoing and future Nurturing Care programs in the context of COVID-19. Overall, we expect to interview up to 48 key informants from organizations who are implementing Nurturing Care programs to hear about their perspectives on how COVID-19 has affected Nurturing Care programs.

- If you agree to participate: This interview will take between 60-90 minutes of your time.
- Participation in this interview is completely voluntary.
- You may choose not to answer any question if something makes you feel uncomfortable.
- You may withdraw from the study at any time.
- There are no costs to you to participate in this research.
- You will not receive any compensation for your participation.

There should be very minimal risk from participating in this study. However, some people may feel embarrassed or uncomfortable when discussing personal experiences. If you are uncomfortable answering any of the questions you may ask to skip the question or refuse to answer. You may refuse to participate or stop your participation at any time. There will be no penalty or loss of benefits to which you are otherwise entitled if you choose not to participate.

Given that the interview will be conducted online, there is a small risk of data confidentiality breach in this study. However, the research team will follow protocols to keep the information you provide private. Only members of the research team will be present for today's interview. Study records that can identify you will be kept confidential by storing them on password-protected computers. In addition, only research staff will have access to your information, and will use a unique code to identify your data – instead of your name. The results of this study may be published or presented, but your name or anything else that might identify you personally will not be used.

There are no direct benefits from being in this research study. Taking part in this study may help researchers to better understand how early childhood development programs are responding to COVID-19, which will inform recommendations on how to improve programs in the future.

With your permission, I will audio record and take notes during the interview. You must agree to be recorded in order to take part in this study. Recordings are helpful because they ensure that no details

are missed and will be used for transcription purposes only. Only members of the research team will have access to the recording. We will transcribe the audio recordings and remove any references to your identity which may have been captured. We will permanently destroy the recording as soon as possible after the interview. We will retain anonymized (meaning all names are removed) transcriptions and study data for one year after completion of the research project reports and papers.

Participation in this study is not a work requirement. You are free to choose whether you wish to join this study. You can even decide to take part and later change your mind. You can refuse, skip questions, or quit at any time without penalties of any kind or loss of any benefits you are otherwise entitled.

Do you have any questions?

If you have any questions or comments about:

- General questions about this study, please contact: Dr. Kerrie Proulx, proulx@lunenfeld.ca
- Your rights as a research participant; or to report problems, concerns, or complaints, please contact: FHI 360's Protection of Human Subjects Committee, phsc@fhi360.org

Statement of Consent:

Have all of your questions been answered to your satisfaction? YES NO

Do you agree to participate and be recorded? YES NO

Typed name of note taker confirming verbal consent was given : _____

Date: _____

Annex D: Semi-structured Interview Guide

Study Title: Rapid Review of Impact of COVID-19 Pandemic on Nurturing Care and Early Childhood Development

Study Funders: LEGO Foundation and World Health Organization

Principal Investigator: Kerrie Proulx, PhD

A. Background

1. Can you tell me about your role in this organization?
    a. Role/title
    b. Duties and responsibilities
    c. Length of time in this role

B. Context and program delivery during COVID-19

2. Please describe your organization's involvement in [name of NCF-oriented intervention] during COVID-19.
    a. Describe activities/components
    b. Timing of implementation (pre- or post-COVID-19 onset?)
    c. Partners involved
    d. Intended beneficiaries

3. How were [name of NCF-oriented intervention] activities delivered before the pandemic? How did the COVID-19 pandemic change the way in which program activities were delivered?
    a. Before
    b. After
    c. From WHO: how the program has been "disrupted" and mitigation strategies

4. Did the content or focus of [name of NCF-oriented intervention] activities change during the COVID-19 pandemic, or were new components added that were not provided prior to the pandemic?
    a. Why, or why not?

5. What are the most important components of the interventions?
    a. Describe these components.
    b. Are there components which are less essential?

C. Emerging evidence of effectiveness

6. In your opinion, how have the various [name of NCF-oriented intervention] initiatives been going during the pandemic?
    a. Which initiatives do you believe have been most successful? For whom? Why?
    b. How do you define 'success' during COVID-19? How should program "success" be understood and measured in the context of COVID-19?

a. Have benchmarks changed since before the pandemic began?

7. Are there particular intervention components that have worked better than others? Why?
    a. Which initiatives/programs do you feel are most promising? Why?

8. Which initiatives (or program components) have been unsuccessful? Why?

9. Were there any unexpected outcomes (positive and negative)? For whom?

D. Perceived need

10. Is there a perceived need for the [name of NCF-oriented intervention]? Who perceives this need? Are there individuals outside of the organization who are advocates or champions of the intervention? Why?
    a. Perceived need
    b. Policy champions

E. Facilitators and barriers to implementation during COVID-19

11. What are the main constraints or challenges with implementing the [name of NCF-oriented intervention]? What challenges are unique to implementation during COVID-19?
    a. Were these challenges addressed? How?

12. What are the main opportunities or facilitators that have enabled the implementation of [name of NCF-oriented intervention] during COVID-19?

F. Comparative advantage and partnerships

13. Are you aware of any other organizations working on similar initiatives in your area? How are the various initiatives similar? Different? What is the comparative advantage of the [NCF-initiative] compared to others?
    a. Similar initiatives
    b. Comparative advantage

14. Which resources were consulted when designing/developing NCF-related interventions during COVID-19? Which partnerships were consulted? Are there opportunities for collaboration with other agencies/projects that can help to ensure the immediate success and/or long-term sustainability of the [NCF initiative]?
    a. Resources
    b. Partnerships

G. Sustainability

15. What are your hopes and expectations for scaling up the COVID-19 related activities of [name of NCF-oriented intervention] beyond the pandemic? Five years from now, what do you think [name of NCF-oriented intervention] will look like?

16. Are there plans underway to continue or expand the activities implemented during COVID-19? if yes, what do these plans look like?

17. To what extent have lessons learned about this initiative from the COVID-19 pandemic been shared with other organizations and government stakeholders?

Additional topics and questions[1] to cover (if they do not emerge from discussion above):

- Does this program/organization involved in child protection (through identification of signs of domestic violence/maltreatment?) If so, how is this done during COVID-19?
- Focus on 'play to learn' - how to promote playful parenting/learning during COVID-19? Are there any innovative strategies to do this virtually/remotely?
- Does the program engage directly with fathers or other caregivers? How has this looked during the pandemic?
- Is the program doing anything to address the needs of families of children with disabilities?
- Have home visits continued during the pandemic (for example, role of community health workers if relevant)?

Closing and Summary

This is the end of the interview. Is there anything else you would like to discuss or tell me that you have not done so already?

[Ask to share relevant program documents or resources; and for names, contacts and introductions for participation (e.g. program managers, implementers, funders, beneficiaries) for the next interviews].

Thank you for your time today.

[1] These were incorporated mid-way through data collection to explore topics that emerged as gaps/major findings in the rapid evidence review.