Situational Analysis of Early Childhood Care and Development Services in Ghana

Final Report

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Acronyms

CDO	community development officer
CHPS	community-based health planning and services
CHN	community health nurses
CHO	community health officers
CHV	community health volunteers
CWC	child welfare clinic
DHMT	district health management team
ECCD	early childhood care and development
GHS	Ghana Health Service
GMP	growth monitoring and promotion
ISSOP	Inter-Sectoral Standard Operating Procedure
IYCF	infant and young child feeding
LEAP	Livelihood Empowerment Against Poverty
MCHRB	Maternal and Child Health Record Book
MCSP	Maternal and Child Survival Program
MoGCSP	Ministry of Gender, Children, and Social Protection
NCCE	National Commission for Civic Education
PNC	postnatal care
RING	Resiliency in Northern Ghana
SPRING	Strengthening Partnerships, Results, and Innovations in Nutrition Globally
SWIMS	Social Welfare Information Management System
SWO	social welfare officer
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization

Executive Summary

Background

Ghana has made strong political commitments to improve children's development, including a multi-sectoral Early Childhood Care and Development (ECCD) Policy launched in 2004. Nevertheless, 45 percent of children in Ghana are at risk of not meeting their developmental potential due to stunting or extreme poverty (Lu et al. 2016). USAID Advancing Nutrition conducted a complementary study in 2021 by collecting service-level data through interviews and observations across three USAID-supported districts in Ghana. The study aimed to—

1. Understand the current status of services in the health and social welfare sectors to promote optimal early childhood development outcomes.
2. Explore the sustainability of promoting responsive care and early learning in mother-to-mother support groups in Community-based Health Planning and Services (CHPS).
3. Identify opportunities to promote optimal physical, cognitive, and psychosocial development in early childhood.

The study revealed a positive landscape for strengthening support for child development through both the health and social welfare sectors.

Methods

The study's mixed-methods design featured key informant interviews, qualitative observation, and quantitative assessments of workforce competencies to answer the following four research questions:

1. What are health and social welfare workers' knowledge, attitudes, and practices with regard to early childhood development?
2. How do health and social welfare workers see the current and future role of the health and social welfare sectors in supporting children's optimal development?
3. To what extent have the CHPS mother-to-mother support groups continued to integrate the responsive care and early learning content that was developed with support from the Maternal and Child Survival Program?
4. During routine child health and nutrition services and social welfare programming, what opportunities exist for integrating developmental support, such as monitoring development and counseling caregivers in providing nurturing care?

The study took place in one district in each of the three regions prioritized by USAID and Ghana Health Services (Eastern, North East, and Upper East). We prioritized regions in consultation with the USAID Mission and the Government of Ghana, currently or previously receiving support from USAID that have some of the best and worst early childhood indicators in the country. The chosen sites included diverse levels of services, such as CHPS compounds, health centers, hospitals, and social welfare delivery platforms. At each site, we selected participants for the key informant interviews and competency assessments based on a convenience sampling of the staff and caregivers available on the dates of data collection. The key informant interviews were semi-structured, in-depth interviews. We collected a total of 70 interviews, 26 observations, and 316 competency assessments. The study tools included a quantitative competencies assessment, semi-structured interview guides, and observation grids. All were pilot-tested and refined for ease of comprehension and length prior to data collection.

Key Findings

The competency assessment found inconsistencies between self-reported competency and confidence of health and social welfare workers and the accuracy of their knowledge responses. Health and social welfare workers rated their knowledge and abilities across a variety of topics as good on average. Similarly, they reported being confident in talking with caregivers about different aspects of nurturing care. However, a direct assessment of knowledge showed a number of gaps. On average, both health workers and social workers answered less than half the questions correctly, at 44 percent and 43 percent, respectively. While health and social welfare workers were able to correctly identify children who were developing well, knowledge was lower on children's early learning, communication, and identifying children who are falling behind on developmental milestones.

The qualitative study sought to understand knowledge of child development. Generally, respondents demonstrated a good understanding of the subject, and there were no meaningful differences between ECCD-trained by the Maternal and Child Survival Program and untrained health workers. The majority of respondents seemed to have relatively good knowledge of ECCD; however, there was more emphasis on nutrition and physical growth and less on developmental milestones and ways to support early learning. Generally, health and social welfare workers had relatively clear roles and considered supporting ECCD as part of them. Respondents also viewed ECCD as the responsibility of all sectors, and believed it was feasible to include more support for ECCD within their roles if given proper training and resources.

The study also found that the Maternal and Child Health Record Book, used during service delivery, facilitates counseling on developmental milestones. However, its use may not yet be optimized due to shortage of the book, limited staffing, and possible inadequate training on the developmental milestone section of the book. Similarly, although staff turnover challenged CHPS ECCD services, the respondents who received the training viewed it as useful and appreciated it. We presented several opportunities for integrating developmental support in routine services, specifically integration of ECCD support through multiple sectors, including education and agriculture, and all contact points (i.e., antenatal and postnatal care). However, there were constraints related to limited staffing and general access to services.

Recommendations

The study concluded with four recommendations to promote early childhood development in Ghana's health and social welfare sectors:

1. Strengthen responsive care, early learning, and safety and security counseling and support services, which are underemphasized compared with services for and information on nutrition and physical growth.
2. Strengthen workforce ECCD competencies through pre- and in-service trainings. Results showed that service providers received limited training on ECCD, and that there were significant gaps in ECCD knowledge among health and social welfare workers.
3. Strengthen services and support to children with disabilities and their families. Many families with disabled children are inclined to keep their children at home. Community-level activities to reduce stigma while providing home visits by both health and social welfare workers would support children with disabilities.
4. Provide clear tools and processes to aid in routine identification, support, and referral of caregiver mental health issues. Supporting the mental health of caregivers directly benefits the development of young children, and Ghana Health Services has made efforts to expand mental health services across the country. While there is need to strengthen mental health services generally, a great opportunity exists to ensure caregiver mental health is included as a priority group for services. Currently, non-psychiatric health workers and social welfare workers do not routinely assess the

mental health of the caregivers they come into contact with; however, several of them claimed it would be feasible to do so if they were trained.

Background

The first 1,000 days—from conception to a child's second birthday—are the most rapid period of brain development (Georgieff et al. 2018). A child's health, nutrition, and experiences during this period set the foundation for lifetime educational attainment and economic productivity. Early adversities, such as lack of responsive caregiving, poverty, and undernutrition, are associated with lower school achievement and lifetime earnings (Black et al. 2017). Children need nurturing care, provided by trusted adults, to achieve their developmental potential. Nurturing care comprises behaviors and an environment that helps ensure that a child has adequate nutrition, good health, responsive caregiving, opportunities for early learning, and security and safety (Britto et al. 2017). Integrating the promotion of responsive care and early learning into health and nutrition services can amplify improvements in early childhood development outcomes (Jeong, Franchett, and Yousafzai 2018). As a result, the World Health Organization (WHO) recommends integrated service delivery, including linking nutrition and caregiving interventions and the promotion of maternal mental health, as a key strategy to improve early childhood development outcomes (WHO 2020).

Ghana has made strong political commitments to improve children's development, including a multi-sectoral Early Childhood Care and Development (ECCD) Policy launched in 2004 and currently under revision. Nevertheless, 45 percent of children in Ghana are at risk of not meeting their developmental potential due to stunting or extreme poverty (Lu et al. 2016). A third of Ghanaian children ages 36 to 59 months do not meet expected milestones in physical, cognitive, social-emotional, or communication skills (Ghana Statistical Services 2019). In addition, 73 percent of children have been identified as multidimensionally poor, meaning that they are experiencing deprivation in three or more core domains of well-being, including health, nutrition, learning and development, child protection, water, sanitation, and hygiene, and information (NDPC 2020). Under the leadership of the Ministry of Gender, Children, and Social Protection (MoGCSP), an inter-ministerial group coordinates the implementation of the comprehensive ECCD policy for children from birth to eight years. Following the introduction of this policy, Ghana was the first country in sub-Saharan Africa to include kindergarten for children ages four and five as part of compulsory, free basic education (Gratz and Putcha 2019). Ghana has more children enrolled in kindergarten—half a million—than any other sub-Saharan African country (UNESCO 2019). However, the ECCD policy did not receive much traction outside the education sector until the national launch of the Nurturing Care Framework in June 2018. A year following the launch, the second lady and the minister of health, along with a multi-sectoral panel from the U.S. Agency for International Development (USAID), the Japan International Cooperation Agency, the United Nations Children's Fund (UNICEF), the World Bank, the United Nations Population Fund, and WHO, released a call for action paper for integrated ECCD programming. This was when the health sector began to engage in ECCD, and given its mandate to provide regular care for pregnant women and children during the first 1,000 days, is an ideal touchpoint for promoting holistic nurturing care to improve early childhood development outcomes (Richter et al. 2020).

In the last few years, several key initiatives to strengthen ECCD services and promote the optimal development of children in the first years of life have launched in Ghana. Most notably, the MoGCSP developed ECCD standards in 2018 to guide service providers and caregivers to help children achieve appropriate developmental milestones from birth to age three and for government and nongovernmental agencies to support children's achievement of the competencies outlined in the standards. Other key efforts include—

- development and implementation of the Maternal and Child Health Record Book (MCHRB) for monitoring developmental milestones

- the Maternal and Child Survival Program's (MCSP's) support of a 2016–2019 pilot that integrated responsive care and early learning content into mother-to-mother support groups in Community-based Health Planning and Services (CHPS)
- the integration of nurturing care promotion as part of the Ghana National Newborn Health Strategy and Action Plan (2019–2023)
- the scale-up of Livelihood Empowerment Against Poverty (LEAP)1000, a targeted social protection program for vulnerable pregnant women and children in the first 1,000 days.

Several challenges related to coordinating and delivering services to promote improved ECCD have been identified in Ghana, despite efforts by the network established to oversee implementation of ECCD activities. These include limitations in cross-sectoral coordination at the national and sub-national levels, an outdated ECCD policy, and weak mechanisms to ensure service quality (Bentsi-Enchill, Giuffrida, and Oyatoye 2018). Another major barrier is insufficient funding for the national ECCD Secretariat in the MoGCSP. A baseline study to inform the development of the ECCD standards identified gaps in services, particularly in rural areas, but also noted that health services were the most accessible (MoGCSP 2017). The study also found that the general population had a limited understanding of children's development (MoGCSP 2017).

UNICEF funded the Government of Ghana to review the existing ECCD policy. The funding included an evaluation to guide policy revision, provide direction for mid-term national development planning, and inform a costed strategic plan to accompany the revised policy (Clear Outcomes 2020). The evaluation provided crucial information about the relevance, effectiveness, efficiency, and sustainability of the ECCD policy from the perspectives of national and sub-national stakeholders and parents (UNICEF and MoGCSP 2018). However, it did not include direct observation of service delivery and had limited perspectives from direct service providers, such as health care workers.

USAID Advancing Nutrition conducted a study in 2021 to fill this gap by collecting service-level data through interviews and observation across three USAID-supported regions in Ghana. In these regions, the study aimed to—

1. Understand the status of services in the health and social welfare sectors to promote optimal early childhood outcome.
2. Explore the sustainability of promoting responsive care and early learning in mother-to-mother support groups in CHPS.
3. Identify opportunities to promote optimal physical, cognitive, and psychosocial development in early childhood.

Methods

Study Design

The study had a mixed-methods design featuring key informant interviews, qualitative observation, and quantitative assessments of workforce competencies to answer the following four research questions:

1. What are health and social welfare workers' knowledge, attitudes, and practices with regard to early childhood development?
2. How do health and social welfare workers see the current and future role of the health and social welfare sectors in supporting children's optimal development?
3. To what extent have the CHPS mother-to-mother support groups continued to integrate the responsive care and early learning content that was developed with support from MCSP?
4. During routine child health and nutrition services and social welfare programming, what opportunities exist for integrating developmental support, such as monitoring development and counseling caregivers in providing nurturing care?

Study Context

The study took place across Ghana's North East, Upper East, and Eastern Regions, covering both the northern and southern geographies and focused on the health and social welfare systems. We prioritized regions currently or previously receiving support from USAID that include some of the best and worst early childhood indicators in the country. In 2018, the Northern Region was divided into the Northern, North East, and Savannah Regions. The Northern Region, which includes the North East Region, has, at 29 percent, the country's highest rate of stunting in children under five years of age, compared to 18 percent nationally (Ghana Statistical Service 2018). In addition, fewer children aged three to five are developmentally on track in the Northern (54 percent) and Upper East (51 percent) Regions compared to the national level of 68 percent, which is similar to the rates in the Eastern (65 percent) Region. Support for learning—defined as children ages 2–4 years with whom an adult has engaged in four or more activities to promote learning in the last three days—is consistently low across the country at just 33 percent. In the study regions, it is lowest in the Northern (22 percent) and highest in the Eastern (41 percent). Literacy among women ages 15–49 in the north is lower than the national rate of 65 percent (Northern Region: 29 percent and Upper East: 44 percent). However, literacy rates among women in the south are slightly higher than the national average, at 69 percent in the Eastern Region.

Table 1. Study Context Indicators, by Percentage

Indicator	Northern Region*	Eastern Region	Upper East Region	National
Stunting among children under 5	29	16	18	18
Children aged 3–4 who are developmentally on track	54	65	51	68
Support for learning	22	41	36	34

Indicator	Northern Region*	Eastern Region	Upper East Region	National
Literacy among women aged 15–49	29	69	44	65

(GSS 2018)

*New administrative regions were established in 2018, following the Multiple Indicator Cluster Survey (MICS) study, which divided the Northern Region presented here into the Northern and North East Region.

Ghana's Health System

The Ghanaian health system has a decentralized structure, with three levels of primary health care. CHPS zones are the first point of access to the health care system, followed by health centers at the sub-district level and district hospitals at the district level. Regional hospitals provide more advanced and specialized care for an entire region. The district health administration consists of the district health management team (DHMT), which is responsible for managing and supervising health services and public health in the district. A regional health directorate oversees all district health administrations, including district and regional hospitals.

Ghana's CHPS program is the principal platform for delivering primary health care services in the first 1,000 days. CHPS is staffed by community health officers (community health nurses with additional training to manage a CHPS compound), who provide a structured package of curative, preventive, and promotive care. A growing number of midwives are also assigned to CHPS zones to provide delivery care (MoH Ghana 2016) and enrolled nurses who provide curative services. One of the CHPS program's core services is child welfare clinics (CWCs), which provide routine health check-ups, such as immunizations, vitamin A distribution, and growth monitoring and promotion (GMP). Ghana is rapidly scaling up CHPS services to improve access to care across the country. The number of functional CHPS zones nearly doubled from 2014 to 2017 (MoH Ghana 2018).

The MCSP Ghana Early Childhood Development 0–3 pilot introduced in December 2016, implemented activities through the CHPS platform. The program strengthened the capacity of CHPS community health officers (CHOs) and community health volunteers (CHVs) to promote caregiving practices for improved health outcomes. The aim of the MCSP Early Childhood Development program was to engage parents and caregivers in early learning and responsive parenting, in which caregivers attend to their children's physical and emotional needs from birth onward by responding to children's cues, playing, talking, singing, and reading even before children can talk. By design, MCSP promoted the integration of early learning activities into daily routines to increase frequent, developmentally appropriate interactions between a caregiver and child. Mother-to-mother support groups and CWCs delivered the intervention, using a structured manual, flipchart, and posters for facilitation as part of the Ghana Early Childhood Development 0–3 Toolkit. CHOs and CHVs were trained to facilitate the groups. A 2019 evaluation at the end of the project showed that the intervention was delivered with fidelity and improvements in CHO and CHV knowledge and children's developmental outcomes. The geographic area for the MCSP-supported caregiver groups included the Eastern Region, which was included in this study.

Ghana's Social Welfare System

The Child and Social Welfare Policy (MoGCSP 2015) provides guidance to structure a robust child welfare system to prevent and respond to violence, abuse, and the maltreatment of children. Starting at the community level, the policy calls for coordinated efforts to promote dialogue to improve parenting and support vulnerable children and families. Beyond community-level prevention and identification, the Social Welfare and Community Development Department manages cases of child protection violations

at the district level. This includes supporting community-level prevention and identification efforts, providing prevention and response services, linking with social protection programs, conducting case inquiries, managing child and family welfare violations, and reporting data to the regional level. Social workers in the Social Welfare and Community Development Department have standard operating procedures for case management and the assessment of children identified as potentially having been abused (UNICEF and MoGCSP 2018).

The Ministry of Local Government and Rural Development has been responsible for social welfare service delivery since this function was devolved to districts from the MoGCSP in 2010 (Local Government Service Secretariat 2014).

The primary actors from the social welfare sector at the district level include social welfare officers (SWOs) and community development officers (CDOs), as well as chiefs and queen mothers at the community level (UNICEF 2018). There are varying numbers of SWOs and CDOs across districts (UNICEF and MoGCSP 2018; UNICEF 2018). A competency assessment found that workers were most confident in the practical or technical knowledge aspects of their roles (e.g., case management, child development), and least confident on policies and legislation that guide how services are delivered (MoGCSP 2020). Another major challenge identified in the competencies assessment was limited staffing and the lack of clear requirements for social work qualifications in the scheme of service for SWOs, which contributes to challenges in service delivery (MoGCSP 2020).

The LEAP program is Ghana's flagship social protection program, which provides unconditional cash transfer to vulnerable households. The LEAP Management Secretariat and the Department of Social Welfare under the MoGCSP implements the program. The program provides bi-monthly cash payments to severely disadvantaged households across the country. Additionally, LEAP offers families free registration in the National Health Insurance Scheme. The program targets extremely poor households that must also have at least one member who is elderly, living with a disability, or an orphaned and vulnerable child. In 2015, an extension was added to support the window of opportunity in the first 1,000 days by adding pregnant women and mothers with infants to the criteria for selecting vulnerable households. A 2018 evaluation of the 1,000 days extension found that although beneficiaries were making investments to improve their lives, including those of their children, after two years there was no impact on one of the program's key targets, improving child health and nutrition (Palermo et al. 2018).

Regardless, LEAP cash distribution meetings and home visits remain one of the primary touchpoints for children and families in the social welfare sector. Others include community-sensitization events and home visits by SWOs responding to a reported/potential case of child welfare violation, or for family reunification visits after a child has been in institutional or foster care placement.

Study Sites

The study took place in one district in each of the three regions prioritized by USAID and Ghana Health Services (GHS) (Eastern, North East, and Upper East). We chose sites that included diverse levels of services, such as CHPS compounds, health centers, hospitals, and social welfare delivery platforms. To identify the study district in each region, we reviewed maternal and child health and nutrition indicators from the routine health information system from July 2019–June 2020 to identify both high-performing and low-performing districts. We ranked districts based on five performance indicators, which were selected due to their direct link with child development outcomes (i.e., anemia in pregnancy, low birth weight), their status as a proxy for measuring service access (skilled deliveries), or as a proxy for measuring the quality of care (stillbirths). We also considered whether there was a hospital in the district and the implementation of the MCSP Early Childhood Development program in a given district. Based on this ranking process, we selected Tempane (Upper East Region) as a high-performing district and East Mamprusi (North East Region) and Kwahu West (Eastern Region) as low-performing districts.

Within each district, USAID Advancing Nutrition selected specific sites involved in the delivery and/or management of services provided by the health and social welfare sectors. We purposively selected the sites within each district based on the schedule of services provided during the time of data collection. We chose CHPS sites based on the availability of CWC, immunization, and postnatal care (PNC) services scheduled during the time of data collection. This is because, at the CHPS level, services such as CWC, immunization, and PNC are not provided daily and are only scheduled to take place once or twice a month. On the other hand, we selected health centers to cover all the sub-districts within each district since the services included in the study are provided on a daily basis. Tempane does not have a district hospital and both East Mamprusi and Kwahu West have only one, which were both included. We chose study sites for the social welfare sector based on the availability of key informant interview participants and available services during the time of data collection. We detail these study sites in table 2.

Table 2. Study Sites

Site	Staffing	Services	District	# per District	Total #
CHPS compounds	Community health officer, community health nurses (CHNs)	Primary health care services, including antenatal, immunizations, child welfare visits, family planning, and others; mother-to-mother supports to improve child development were established in select CHPS compounds.	East Mamprusi Kwahu West Tempane	4 7 7	18
Health centers	Medical assistants, nurses, etc.	Basic curative and preventive health services, such as deliveries	East Mamprusi Kwahu West Tempane	4 6 5	15
District hospitals	Pediatricians, doctors, medical assistants, nurses, etc.	First level of referral; provide emergency and inpatient services	East Mamprusi Kwahu West Tempane	1 1 0	2
District health administration offices	DHMT members	Management and supervision of health services in the district	East Mamprusi Kwahu West Tempane	1 1 1	3
Social welfare and community	SWOs, CDOs	Community-level sensitization and case management in instances	East Mamprusi Kwahu West	1 1	3

Site	Staffing	Services	District	# per District	Total #
development departments		of child abuse, neglect, and maltreatment	Tempane	1	
Cash transfer payment point	SWOs and LEAP cash payment agent	Bi-monthly distribution of cash payments to extremely poor households	East Mamprusi Kwahu West Tempane	2 0 0	2

Sampling

In the study districts and sites, we purposively sampled participants to include a variety of health and social welfare workers and key stakeholders, as outlined in table 3. At each site, participants for the key informant interviews and competency assessments were selected based on a convenience sampling of the staff and caregivers available on the dates of data collection. (See figure 1).

Figure 1. Overview of Study Participants by District

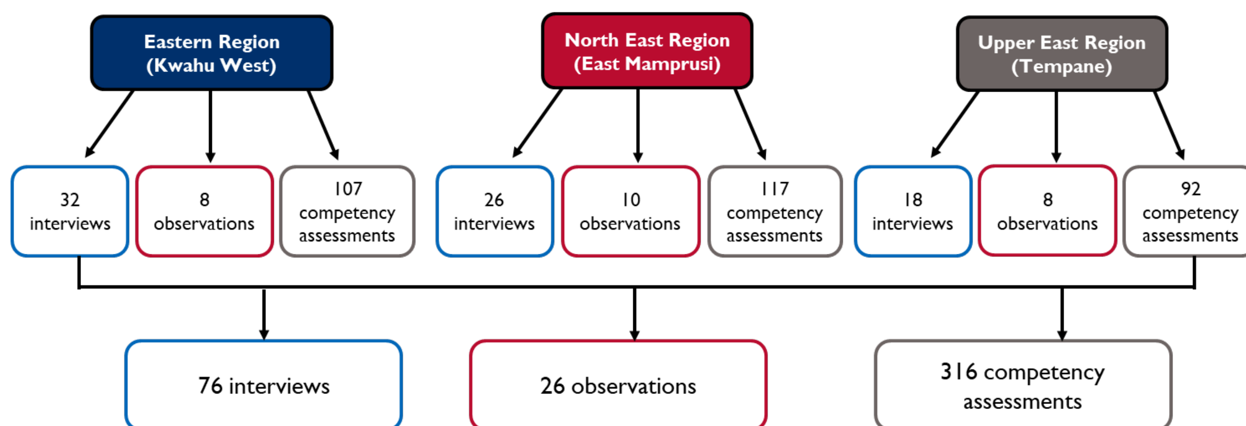

Table 3. Sampling of Study Participants

Participant	Method	Sampling approach	District	Sample size per district	Total sample
CHPS health care providers (CHOs, CHNs)	Key informant interviews	Health care providers available on the dates of data collection	East Mamprusi Kwahu West Tempane	4 3 3	10

Participant	Method	Sampling approach	District	Sample size per district	Total sample
	Competency assessments		East Mamprusi	14	63
			Kwahu West	16	
			Tempane	33	
Health center health care providers (nurses, midwives, medical assistants)	Key informant interviews	Health care providers available on the dates of data collection	East Mamprusi	5	14
			Kwahu West	5	
			Tempane	4	
	Competency assessments		East Mamprusi	55	156
			Kwahu West	47	
			Tempane	54	
District hospital health care providers (nurses, midwives, medical assistants, doctors)	Key informant interviews	Health care providers available on the dates of data collection	East Mamprusi	4	7
			Kwahu West	3	
			Tempane	0	
	Competency assessments		East Mamprusi	40	73
			Kwahu West	33	
			Tempane	0	
SWOs, CDOs	Key informant interviews	SWOs/CDOs available on the dates of data collection	East Mamprusi	4	10
			Kwahu West	3	
			Tempane	3	
	Competency assessments		East Mamprusi	8	14
			Kwahu West	1	
			Tempane	5	
Stakeholders at the district level (supervisors, district health	Key informant interviews	Purposive sampling of key stakeholders in	East Mamprusi	4	10
			Kwahu West	3	

Participant	Method	Sampling approach	District	Sample size per district	Total sample
and social welfare staff)		the sampled districts	Tempane	3	
CHPS ECCD-trained health care providers (CHOs, CHNs)*	Key informant interviews	Providers available on the dates of data collection	East Mamprusi Kwahu West Tempane	0 10 0	10
Caregivers of children ages 0 to 36 months	Key informant interviews	Random sample of caregivers identified during service visits	East Mamprusi Kwahu West Tempane	5 5 5	15

*Throughout this report, ECCD-trained health workers refers to health workers who received training on the Ghana 0–3 Early Childhood Development package by the Maternal and Child Survival Program.

Sample Size

The target sample size for qualitative data was a minimum of six interviews per participant type across all districts (i.e., at least six CHPS workers, six health care providers each at health center and hospitals, six SWOs, six stakeholders, and six caregivers). We calculated estimates for the number of competency assessments to be conducted based on staffing norms for the health and social welfare sectors in Ghana (MoH 2015; WHO 2016; MoH 2016; Mwinnyaa et al. 2020). We recognized that staffing deployed in the study locations may vary from norms, and projected the largest potential sample size based on conservative estimates of the maximum staffing for mid-size hospitals and health centers. We needed a sample size of 283 to estimate knowledge and competencies with 95 percent confidence intervals with a level of precision of +/- 5 percent.

Inclusion and Exclusion Criteria

No one under the age of 18 participated in the study. Only health workers and SWOs assigned to work in the selected locations for at least three months and provided child health and social welfare services for at least three months preceding data collection were included in the sample.

To be included in the selection of caregivers for qualitative interviews, the child of a primary caregiver had to have received health or social welfare services in the past three months from the selected location and the child had to be younger than 36 months.

Instruments

All study tools were in English and developed specifically for use in this study. They were pilot tested and refined for ease of comprehension and length prior to data collection. The study tools included a quantitative competencies assessment, semi-structured interview guides, and observation grids. Table 4 summarizes how the tools related to the study's research questions. All study tools are included in annex 1.

Table 4. Study Tools, Participants, and Sites by Research Question

Question	Sites	Participants	Instrument
1. What are health and social welfare workers' knowledge, attitudes, and practices with regard to early childhood development?	CHPS compounds, health centers, district hospitals, and social welfare and community development departments	Health care providers, SWOs/CDOs	Competencies assessment
		Health care providers, SWOs, CDOs, caregivers	Semi-structured interview guides
2. How do health and social welfare workers see the current and future role of the health and social welfare sectors in supporting children's optimal development?	CHPS compounds, health centers, district hospitals, district health administration offices, and social welfare and community development departments	Health care providers, SWOs/CDOs, district-level stakeholders	Semi-structured interview guides
3. To what extent have the CHPS mother-to-mother support groups continued to integrate the responsive care and early learning content that was developed with support from MCSP?	CHPS compounds	CHOs, CHNs	Semi-structured interview guides
		CHOs, CHNs, caregivers	Observation grid
4. During routine child health and nutrition services and social welfare programming, what opportunities exist for integrating developmental support, such as monitoring development and counseling caregivers in providing nurturing care?	CHPS compounds, health centers, district hospitals, and social welfare and community development departments	Health care workers, social welfare workers, caregivers	Observation grid

Competency Assessment Tool

In this context, competencies are the knowledge, skills, and abilities that health care providers and SWOs need to provide services to improve early childhood development outcomes. We measured the competencies and confidence of health care providers and SWOs using a closed-ended self-administered survey and captured data through paper-based forms that the study team entered into a KoboCollect database. We used the same form for health care and social welfare workers.

We created the competency assessments for this study and piloted them prior to use. Questions drew from existing ECCD workforce competencies (Putcha 2018) and the USAID Advancing Nutrition (2020) Pre-Service Assessment tool. There were also questions about children's development and nurturing care needs based on Ghana's national ECCD standards, Care for Child Development knowledge assessments (WHO 2012), and milestone messages from Ghana's MCHRB. The assessment also asked about current practices (e.g., how frequently the respondent talks about nurturing care or child development with caregivers of young children) and their confidence in using the practices.

Key Informant Interviews

The key informant interviews were semi-structured and in-depth interviews with district stakeholders, health workers, and social welfare workers that focused on—

- current ECCD practices and perspectives
- current services provided and referrals made
- perspectives on the feasibility of monitoring children's development and counseling caregivers on ECCD
- experiences with MCSP Early Childhood Development program and how it is functioning.

With caregivers, interviews explored—

- social norms related to child development
- understanding of child development
- availability of services to support young children's development.

Observations

We observed routine health services and social welfare services using a structured grid to identify opportunities for integrating early childhood development support. Information gathered included—

- Who was present?
- What services were provided?
- The length of consultation/service
- Details about the service provision environment (location)
- The interaction between service providers and clients.

Data Collection

Saha Consulting, a research-consulting firm based in Tamale, in the Northern Region of Ghana, collected all data. We informed the regional health directorate and regional director for the Department of Social Welfare of the study objectives and approach prior to contacting districts. The data collection team informed the District Health Administration and Department of Social Welfare and Community Development about the study objectives and approach. Working with designated officials at the district level, the study team scheduled visits to each study site. The site visits, which involved distributing competency assessments, conducting key informant interviews, and structured observations, lasted between one-to-two days per site. We invited a random selection of caregivers with young children (ages 0–3 years) who were present on the days of data collection to participate in key informant interviews.

The study team conducted interviews in English or the local language if the caregiver and/or provider preferred. We recorded interviews if the participant consented, and interviewers took detailed notes during the interviews. On the first day of a visit to a site, the study team offered eligible providers an opportunity to complete the competency assessment, which was done as a self-report in English. In addition, the study team conducted observations of the services provided on the day of data collection. We scheduled data collection visits to coincide with scheduled priority services, such as CWC days or LEAP beneficiary meetings. Observations lasted for two hours, or less, if the service being observed was briefer. Due to the COVID-19 pandemic, there was a limited number of social welfare activities taking place so the study team could only complete two observations of social welfare sector services.

Data Analysis

The study team analyzed quantitative data from the competency assessments using descriptive statistics, including frequencies and percentages for categorical variables, and means and standard deviations for variables assessed on a Likert or continuous scale. We calculated the total mean knowledge score for the ECCD knowledge section by obtaining the total percentage of correct answers for each participant and then calculating the mean total percentage of correct answers. Only participants who completed the entire ECCD knowledge section were included in the calculation of the total mean knowledge score. When appropriate, we disaggregated descriptive statistics by district and workforce type (i.e., health or social welfare workforce).

The study team analyzed the qualitative notes from interviews and the observation grids following a structured codebook and using Atlas.ti qualitative analysis software. The codebook was developed based on deductive (predetermined) codes from the interview guides, and refined by the study team with inductive (emerging from the data) codes by analyzing a subset of interview and observation notes to capture additional topics present in the data. During this process, the coding team discussed the codes to ensure that all team members understood and applied them in a similar manner. After we agreed upon the final codebook, we used it to reanalyze interviews analyzed during the process of codebook development. The coding team met regularly to resolve questions that arose and agreed on consistent approaches for coding. Following coding, we analyzed the data in Atlas.ti to identify key themes.

Ethics

The study was reviewed by the JSI Institutional Review Board, and deemed exempt (IRB #20-54E), and reviewed and approved by the Ghanaian Health Services Ethics Review Committee (Approval #GHS-ERC 015/05/21). All study participants provided written informed consent prior to participating in interviews and competency assessments. The service providers and caregivers provided verbal informed consent prior to observations.

Study Participants

Qualitative Study Participants

We conducted a total of 76 semi-structured in-person interviews with health workers, social welfare workers, caregivers, and district stakeholders (see table 5). All caregivers that were interviewed with the mother of children ages zero–three years (average age of children was 11 months), and the mother's average age was 27 years. We also completed 26 observations, 24 of which were in the health sector and 2 in the social welfare sector. The limited number of social welfare observations was due to the limited number of community engagement activities conducted at the time of data collection.

Table 5. Demographic Characteristics of Qualitative Study Participants

Variable		Health Workers n (%)	Social Welfare Workers n (%)	Caregivers n (%)	District Stakeholders n (%)
Total		41	10	15	10
Sex	Male	13 (32)	8 (80)	0	6 (60)
	Female	28 (68)	2 (20)	15 (100)	4 (40)
Highest education level completed	Primary	0	0	5 (33)	0
	Secondary	0	0	4 (27)	0
	Certificate or diploma	28 (68)	3 (30)	3 (20)	1 (30)
	Bachelor of Arts (BA)	12 (29)	7 (70)	0	7 (70)
	Postgraduate	1 (2)	0	0	2 (20)
	Other	0	0	3 (20)	0
District	Kwahu West	21 (51)	3 (30)	5 (33)	3 (30)
	East Mamprusi	13 (32)	4 (40)	5 (33)	4 (40)
	Tempane	7 (17)	3 (30)	5 (33)	3 (30)
Role		CHN: 13 (32) Nurse or midwife: 20 (40) Doctor: 2 (5)	SWO: 7 (70) CDO: 3 (30)	N/A	DHMTs: 10 (100)

Variable		Health Workers n (%)	Social Welfare Workers n (%)	Caregivers n (%)	District Stakeholders n (%)
		Other: 6 (15)			
Mean years in current role		5	7	N/A	4

Quantitative Study Participants

A total of 316 participants completed the competency assessments (table 6); 34 percent from the Eastern Region (Kwahu West District); 37 percent from the North East Region (East Mamprusi District), and 29 percent from the Upper East Region (Tempane District). Tempane District had fewer overall participants because the district does not have a hospital. Social welfare workers represented a much smaller proportion of participants (8 percent) compared to health workers across CHPS compounds (20 percent), health centers (48 percent), and hospitals (25 percent). This is not surprising given that the social welfare workforce is much smaller than the health workforce in Ghana. Fifty-eight percent of participants were nurses. Participants worked for a mean of 3.7 years in their current positions, and the majority (56 percent) were female.

Table 6. Demographic Characteristics of Competency Assessment Participants

Demographics	Percentage (n) of Participants			
	Eastern Region (n=107)	North East Region (n=117)	Upper East Region (n=92)	Total (n=316)
Site				
CHPS compound	14 (15)	12 (14)	36 (33)	19 (62)
Health center	40 (43)	47 (55)	59 (54)	49 (152)
Hospital	35 (38)	34 (40)	0	25 (78)
Social welfare service	10 (11)	7 (8)	5 (5)	8 (24)
Role of Participant				
CHN/CHO	19 (20)	12 (14)	19 (18)	16 (18)
Enrolled nurse	20 (22)	38 (44)	39 (36)	32 (102)
Registered nurse	20 (22)	19 (22)	21 (19)	20 (63)
Midwife	20 (21)	11 (13)	10 (9)	14 (43)
Medical assistant	4 (4)	2 (3)	3 (3)	3 (10)
Doctor	0 (0)	0 (0)	0 (0)	0 (0)

Demographics	Percentage (n) of Participants			
	Eastern Region (n=107)	North East Region (n=117)	Upper East Region (n=92)	Total (n=316)
Social welfare officer	4 (4)	1 (1)	2 (2)	2 (7)
Social development officer	6 (7)	3 (4)	0	3 (11)
Other	6 (7)	14 (16)	5 (5)	9 (28)
Highest Level of Education Completed				
Secondary	0	5 (6)	0	2 (6)
Post-basic	2 (2)	0	0	1 (2)
Certificate	39 (42)	46 (54)	58 (53)	47 (149)
Diploma	41 (44)	39 (45)	34 (31)	38 (120)
Bachelor's degree or higher	18 (19)	9 (11)	9 (8)	12 (38)
Mean years of experience in current role	4 (4)	4 (4)	3 (3)	4 (4)
Sex				
Male	24 (26)	48 (56)	63 (58)	44 (140)
Female	76 (81)	52 (61)	40 (34)	56 (176)

Study Findings

Knowledge and Practices of Health and Social Welfare Workers Related to ECCD

Competency Assessment Results

The competency assessment found inconsistencies between self-reported competency and confidence of health and social welfare workers and the accuracy of their knowledge responses. Participants rated their knowledge and abilities as good (on a Likert scale from "very poor" [1] to "very good" [5]) on average by both health and social welfare workers, across a variety of topics as shown in table 7. Health workers, in most cases, rated their own knowledge and abilities higher than social welfare workers. We also disaggregated data by district, found in annex 3, and scores were similar across districts.

Table 7. Self-Reported Knowledge and Abilities of Health and Social Welfare Workers

Competency	Total		Health Workers		Social Welfare Workers	
	Mean Score (total)	SD	Mean Score	SD	Mean Score	SD
Knowledge of different domains of young children's development	3	0.75	3	0.76	3	0.66
Knowledge of the role that nutrition plays in children's growth and development	4	0.74	4	0.75	4	0.59
Knowledge of children's age-appropriate development (i.e., milestones)	4	0.75	4	0.75	3	0.78
Ability to counsel caregivers on early childhood development	4	0.74	4	0.72	4	0.92
Ability to counsel caregivers on nurturing care (i.e., good parenting practices, supporting learning, health, nutrition)	4	0.71	4	0.70	4	0.78
Ability to counsel caregivers on developmental milestones	4	0.75	4	0.75	3	0.56
Ability to identify risks or situations that could disrupt a child's development	4	0.82	4	0.83	3	0.72
Ability to demonstrate responsive caregiving practices	3	0.77	4	0.76	3	0.78

Competency	Total		Health Workers		Social Welfare Workers	
	Mean Score (total)	SD	Mean Score	SD	Mean Score	SD
Ability to demonstrate age-appropriate learning (play) activities for young children	4	0.83	4	0.83	3	0.82
Ability to use the MCHRB to identify a child who is not meeting developmental milestones	4	0.92	4	0.90	4	0.78
Ability to provide screening and referral services for developmental delays and disabilities among children under age three	4	0.86	4	0.82	3	0.93
Ability to provide screening and referral services for cases of child abuse, neglect, or maltreatment among children under age three	3	0.90	3	0.89	3	0.93

Note: Self-reported knowledge and ability was reported on Likert scale from "very poor" (1) to "very good" (5).

Similar to self-reported knowledge and abilities, health and social welfare workers reported being confident in talking with caregivers about different aspects of nurturing care (table 8). The topics that workers were most confident in included infant and young child feeding (IYCF) practices (mean: 2.66); demonstrating breastfeeding (mean: 2.62); child health (mean: 2.62); and hygiene (mean: 2.68), with health workers having slightly higher mean nutrition and child health topic scores than social welfare workers. The one area where social welfare workers reported higher confidence than health workers was in talking about issues of child abuse or maltreatment.

Table 8. Self-Reported Confidence in Supporting Caregivers of Young Children

Question	Total		Health Workers		Social Welfare Workers	
	Mean Score	SD	Mean Score	SD	Mean Score	SD
How confident are you talking with caregivers about the importance of playing with their child?	2	0.65	2	0.65	2	0.66
How confident are you talking with caregivers about IYCF practices?	3	0.57	3	0.55	2	0.69
How confident are you talking with caregivers and demonstrating breastfeeding?	3	0.61	3	0.59	2	0.72

Question	Total		Health Workers		Social Welfare Workers	
	Mean Score	SD	Mean Score	SD	Mean Score	SD
How confident are you talking with caregivers about their child's health?	3	0.61	3	0.60	2	0.72
How confident are you talking with caregivers about how to discipline young children?	2	0.67	2	0.67	2	0.71
How confident are you talking with caregivers about their concerns about their child's development or developmental milestones?	2	0.62	2	0.62	2	0.65
How confident are you talking with caregivers about abuse or maltreatment of young children?	2	0.68	2	0.69	3	0.56
How confident are you talking with caregivers about hygiene for young children?	3	0.61	3	0.61	3	0.58
How confident are you in referring a child with developmental delay or disability for additional services?	2	0.66	2	0.66	2	0.70

Note: Confidence was rated on a Likert scale of "not confident at all" (1) to "very confident" (3).

However, a direct assessment of knowledge showed a number of gaps (see table 9). On average, health and social welfare workers answered less than half of the questions correctly, at 44 percent and 43 percent, respectively. Across districts, knowledge scores were similar, with East Mamprusi scoring slightly lower (42 percent) on average than Kwahu West and Garu Districts (both 45 percent, annex 3). Only 19 percent of respondents correctly identified the four domains of development set forth in the national ECCD standards for children ages 0–3 years, though social welfare workers were more frequently correct (38 percent) than health workers (18 percent). Most respondents were able to correctly report that children with disabilities are able to improve (75 percent), as well as identify when a child was developmentally on track in two small case studies: one for children aged three months (79 percent classified correctly); the other for two-year-olds (65 percent correct). However, only 51 percent were able to identify a child aged 12 months old who was not on track based on the national ECCD standards. Very few (18 percent) participants correctly answered that vision develops in utero; that children are able to play from birth (19 percent); and that children are able to communicate in ways other than crying even if they cannot yet speak (22 percent).

Table 9. Direct Assessment of ECCD Knowledge among Health and Social Welfare Workers

Knowledge Question	Participants Who Answered Correctly		
	Total Workforce % (n)	Health Workers % (n)	Social Welfare Workers % (n)
What are the four domains of development in the Ghana ECCD standards?	19 (60)	17 (51)	37 (9)
Children who have impairments in their development or disabilities cannot improve. (True or false?)	77 (244)	77 (225)	79 (19)
Which of the following would be a sign of delay or impaired development for a child aged 6 months?	42 (132)	43 (126)	25 (6)
Which of the following would be a sign of delay or impaired development for a child aged 12 months?	27 (84)	27 (79)	21 (5)
When does a baby start to be able to hear?	51 (161)	52 (153)	33 (8)
When does a baby start to be able to see?	18 (58)	18 (53)	21(5)
When does a child begin to play?	19 (61)	19 (56)	21 (5)
Before a child can speak, the only way she communicates is by crying. (True or false?)	22 (71)	23 (67)	17 (4)
A child should be scolded when he puts something into his mouth. (True or false?)	56 (177)	57 (167)	42 (10)
Children can learn by playing with pots and pans, cups, and spoons. (True or false?)	47 (150)	48 (139)	46 (11)

Knowledge Question	Participants Who Answered Correctly		
	Total Workforce % (n)	**Health Workers % (n)**	**Social Welfare Workers % (n)**
Physical punishment is necessary to bring up, raise, and educate children properly. (True or false?)	50 (159)	48 (141)	75 (18)
Young children learn by putting objects in their mouths. (True or false?)	36 (113)	35 (103)	42 (10)
Kofi is 3 months old. He is able to hold his head up when he is lying on his belly. He smiles and laughs when playing with his dad. He does not roll over. How is Kofi developing?	78 (248)	80 (233)	62 (15)
Ami is 12 months old. She is sitting up on her own. She is starting to feed herself using her fingers. She communicates by pointing, but she does not make any words or sounds like "ba ba." How is Ami developing?	51 (162)	51 (150)	50 (12)
Ekow is two years old. He loves to play, such as imitating that he is cooking like his mom. He runs all around and talks all the time. Only his mom and dad can understand what he is saying. How is Ekow developing?	65 (206)	65 (189)	71 (17)
Mean percentage (SD) total knowledge score*	44 (14.69)	44 (14.68)	43 (15.09)

*We calculated the mean total knowledge score by dividing the total number of correct questions by the total number of questions in the assessment (15).

The competency assessment also asked health and social welfare workers to report how often they talked to caregivers about various nurturing care and development topics in their daily work (annex 3). On a typical day, the most common topics that health and social welfare workers discussed with

caregivers of young children were IYCF (50 percent of caregivers), breastfeeding (57 percent), health (55 percent), and hygiene (61 percent). Health workers more often discussed these topics than social welfare workers. The topic that was least discussed with caregivers on a typical day was the importance of play (38 percent of caregivers).

Table 10. Self-Reported Activities of Health and Social Welfare Workers

On a typical day, with what percentage of the caregivers you see do you…	Total		Health Workers		Social Welfare Workers	
	Mean (%)	SD	Mean (%)	SD	Mean (%)	SD
Talk about importance of playing with their children?	38	27.11	39	27.58	31	19.59
Talk about IYCF practices?	50	28.48	51	28.68	33	18.92
Talk about breastfeeding?	57	30.44	58	30.58	39	22.15
Talk about children's health?	55	28.82	56	28.86	42	25.55
Talk about how to discipline young children?	40	29.00	41	29.48	36	22.36
Talk about their children's development or developmental milestones?	42	28.18	43	28.77	33	17.72
Talk about abuse or maltreatment of young children?	42	29.65	43	30.10	38	23.51
Talk about hygiene for young children?	61	28.89	62	29.15	49	23.02

Qualitative Results of Knowledge Regarding Early Childhood Development

The qualitative study sought to understand health worker, social welfare worker, and caregiver ECCD knowledge. Generally, respondents demonstrated a good understanding of the subject, and there were no meaningful differences between MCSP ECCD-trained and untrained health workers.

Most participants stated that child development begins from the intrauterine phase and extends through to about three years old. They emphasized the importance of the first 1,000 days, of obtaining optimal nutrition from exclusive breastfeeding, and timely introduction of complementary feeds. They also noted

that child development involved various domains of physical, cognitive, and emotional growth. These domains are usually understood through the developmental milestones that children are expected to attain at various ages.

> Early childhood development means all the things we need to do to help the child to develop well in terms of his/her physical, social, and mental well-being right from conception until the child turns 5 years. For example, at 6 months, the child is expected to be able to perform certain things so if the child is not able to perform those things, then it means there is some deficiency. Early Childhood Development also involves responsive care, playing with the child, correcting the child when he does something wrong and good nutrition, which is critical [for] the physical and brain development.
>
> ***— District stakeholder, East Mamprusi***

In addition, participants understood early childhood development links to children's care.

> Early childhood has to do with responsive parenting and how caregivers care for their children and their nutrition from zero to three years.
>
> ***— ECCD-trained health worker, Kwahu West***

Respondents identified various individual, family, and community-level factors that affected children's early development. Individual factors included the general health of a child, birth weight, gestational age at delivery, and the presence or absence of various congenital anomalies. At the family level, factors included educational and wealth status of the parent, which influenced health-seeking behaviors, practice of good hygiene, and access to good nutrition. Respondents also noted positive parent-child interactions, family peace and harmony, as well as family and social support, especially for orphaned children were essential to early learning. At the community level, respondents considered access to health care, schools, and social amenities such as playgrounds essential to ensure optimal early childhood development. In some communities, participants identified negative cultural norms and practices such as forbidding pregnant or lactating women to eat certain foods as impediments to children's growth and development.

> Love and care by parents, families, and community members help the children to develop well. Also, providing the children with their basic needs by prioritizing their needs first, helps them to develop well. Availability of early childhood development schools, religious and good community leadership in the community that governs with the needs of children in mind, ensures children get access to education and other support that help the children to develop well.
>
> ***— Social welfare worker, Kwahu West***
>
> Lack of access to the health facility due to distance is another social factor. If they don't have access to health workers, they will not be privy to some of the health information. Socioeconomic factors too are where the parents are not able to feed the children due to lack of money…you are asking them to prepare meals in a way assuming they have access to resources that they don't… most of them, they are peasant farmers, whatever they farm is what they eat. And here mostly, it is the women that are more or less working. You see that they are always busy and they don't get the time to even feed the children well.
>
> ***— District stakeholder, Tempane***

Caregivers also demonstrated a reasonable understanding of ECCD, though they seemed to focus on the importance of a healthy diet and regular attendance at various CWCs to promote steady weight gain and achievement of developmental milestones. The majority of caregivers said that they had received this information from health workers during routine CWCs.

> Early childhood development is in stages, with the first stage being from birth to 6 months. And from 6 months to one year [is] when you start giving her other food. This is all I can say. She learns through play, looking at things, and listening to sounds.
>
> ***— Caregiver, East Mamprusi***

Roles and Practices of Health and Social Welfare Workers in Supporting Children's Optimal Development

Health Sector Roles

According to respondents, the role of the health sector in supporting children's development is the provision of various clinics and outreach programs such as antenatal care, PNC, CWC, and home visits. This includes programs that are sponsored by or partnered with international organizations, such as the community-based management of acute malnutrition services, supported by UNICEF, USAID, etc. and run by health facilities, and the stunting and micronutrient prevention program by the World Food Program, in collaboration with GHSs.

> Our responsibilities working with children under 3 years and their caregivers include labor and delivery services…after which we immunize the children with polio [vaccine]. We also provide postnatal care service on the first and seventh day of delivery and on the sixth week to ensure both mother and baby are doing well. We also provide nutrition counseling services…to promote their good growth and development. We also conduct home visits on those who defaulted in coming for the CWC services.
>
> ***— Health worker, East Mamprusi***

DHMT members organize capacity-building training for staff, provide on-the-job coaching, and ensure programs run smoothly. They also implement policy and oversee the dissemination and implementation of various national-level policies and guidelines.

Health workers—midwives, ward nurses, and community health nurses, and others—are in charge of the CWCs, malnutrition clinics, outreaches, and occasional home visits for children ages zero–five years. At these service points, they conduct GMP and offer tailored counseling to caregivers. They also provide immunization and vitamin A supplementation services and reported being able to counsel various caregivers using the developmental milestone section of the MCHRB. Pediatricians run sick child clinics, and diagnose and manage various conditions affecting children. Midwives work directly with pregnant and lactating women at the antenatal clinic, delivery rooms, and postnatal clinics. However, due to issues, such as overwhelmed staff and increased workloads, they are unable to always fulfill all these tasks in one visit.

Although home visits are the responsibility of CHN/CHO, they conduct visits infrequently due to challenges, such as high workloads, time constraints, and lack of transportation; more than half the caregivers interviewed mentioned never having received a home visit.

> Concerns of [a] child refusing to eat is the hardest for me to address because, it's like I give all the feeding option and I don't get results. With such children, the ideal thing is also to conduct home visits on them but due to the workload, I am unable to do that and that is a challenge.
>
> ***— Health worker, East Mamprusi***

Across all three districts, the caregivers that mentioned receiving home visits, ranging from monthly to yearly. Home visits were primarily related to GMP and immunization. In addition, several caregivers mentioned receiving information on feeding, nutrition, proper sanitation, and hygiene. One said she

received information on child development, and specifically on ensuring the safety of her child as he plays and learns to crawl.

> They don't usually come for the home visit; unless like I said when there is weighing and maybe I'm sick and not able to go for the weighing and they call me and I say I am not well, then they will follow me to the house to provide the CWC services to my child.
>
> ***— Caregiver, Tempane***

Researchers observed minimal counseling, and no individual counseling on ECCD-related topics. When health workers did counsel caregivers, it was most frequently related to nutrition and child feeding. Based on researcher observation and assessment, there was no notable difference in the counseling between ECCD-trained health workers and other health workers. Additionally, neither trained nor untrained health workers asked open-ended questions to assess children's development.

Social Welfare Sector Roles

The social welfare sector in Ghana is responsible for educating and sensitizing the community on topics such as child protection, child rights, and government social interventions. Respondents specifically highlighted education around health, nutrition, and childcare. The sector disseminates information through home visits, community durbars, radio discussions, and targeted programs for women. The sector also monitors standards at daycare centers and implements and monitors the local government[1] distribution of the Disability Component of the District Assemblies Common Funds to persons with disabilities and LEAP funds to various community beneficiaries. The LEAP funds are distributed using structured criteria approved by the government to reduce the financial burdens of families in extreme poverty, those that have children with disabilities, and/or that have limited ability to work for income. They also help place orphaned children in caring homes.

> We educate community members on how to take good care of their children by bathing them regularly, feeding them with nutritious foods, creating an environment for them to play and interact with others, teach them mannerism and the local language first to form the basis for learning the English language in school. Also in the social welfare sector, we provide financial support for children with disabilities.
>
> ***— Social welfare worker, East Mamprusi***
>
> In our department, children welfare is essential…we do community sensitization on child protection and child rights. We…organize community durbars, discussions, dialog, and all those things to educate parents on how to take care of the children. The future [re]lies on how well you take care of your child today. We also do radio discussions.
>
> ***— Social welfare worker, Tempane***

A majority of social welfare workers supported the LEAP program and identified it as an influential service for children and caregivers in Ghana.

> LEAP provides cash transfer to extremely poor pregnant women and children who are less than two years old, which can support the nutrition, education, and the health of the child.
>
> ***— Social welfare worker, East Mamprusi***

The majority of social welfare workers believe that assessing children's milestones and supporting and observing caregivers' interactions with their children fall under the services provided by all workers within the social welfare sector. However, the social welfare workforce comprises two different cadre

[1] Metropolitan Municipal and District Assemblies

of workers (CDOs and SWOs) following the district-level merger in 2016 and some CDOs believe that these services fall primarily under the role of SWOs.

Use of National Tools and Standards

The Early Child Care and Development Standards

The ECCD standards were developed to highlight the importance of promoting the care and development of children aged 0–3. The standards are meant to be used by all stakeholders that care for or work with children aged 0–3 to develop further policies on ECCD, review or create trainings or curricula, monitor ECCD activities, and educate communities on ECCD. Of all study participants, only a few social welfare workers had heard about the national ECCD standards. The few who had a working knowledge of the standards recalled receiving information on them from various media platforms and friends. They said that transport and logistics challenges made it difficult for them to visit communities to educate them on the standards. None of the interviewed health or social welfare workers had received training on the ECCD standards.

> Yes, I have read the ECCD standards once…I have not received any specific training on the national ECCD standards. We only educate them to know that if they abuse any child with a disability, the law will deal decisively with them because those children also have rights. The challenge in implementing the national ECCD standards is the lack of means of transport and fuel to regularly visit the field to talk to the people as part of the implementation of the standards.
>
> ***— Social welfare worker, East Mamprusi***

The Maternal and Child Health Record Book

GHS developed the MCHRB to integrate the Maternal Health Record book and Child Health Record book into one book. The combined MCHRB aims to bridge the gap between maternal and child health services and improve the continuum of care for mothers and children. The book provides easy access to information such as a list of the continuum of services, messages on nutrition during pregnancy and complementary feeding, information on early childhood developmental milestones, and immunization records. The majority of health workers stated that they used the developmental milestone sections of the books to educate mothers on what to expect at each stage of their child's development. Some caregivers confirmed this finding.

> I open to the page on children's developmental milestones in the MCHRB, which has pictures of what a child should be able to do at various ages of the child's development. I then show it to the caregiver and ask … if the child is able to do what the picture is saying … Those who answer yes … I praise and commend them for taking good care of the child. Those who answer no … I counsel them on what they can do to help the children meet the developmental milestones.
>
> ***— Health worker, East Mamprusi***
>
> Health workers use the MCHRB a lot. They record the weight, next visit, immunization, and anything they counsel on in it**.**
>
> ***— Caregiver, Kwahu West***

However, no health worker was observed counseling caregivers using this section of the books. In a few places, it appeared that there was a shortage of the books and health workers improvised using exercise books. Although health workers and caregivers most commonly use the MCHRB, as GHS designed it, one social welfare worker did mention using the developmental milestones in the MCHRB to counsel a caregiver.

> In using the developmental milestones in the MCH record book to counsel a caregiver, what I do is to open the page in the book that shows pictures of the various developmental milestones and show it to the caregiver. I then ask what she sees in the book… to help the mother know what to expect in the development of the child and know when to seek for help to help the child's development.
>
> ***— Social welfare worker, East Mamprusi***

Training

The majority of health and social welfare workers had not received any training specific to ECCD, with the exception of the health workers interviewed in Kwahu West trained through MCSP. A few health workers learned about child development in their pre-service training from nursing school. Others had benefited from programs, including the USAID-funded Strengthening Partnerships, Results, and Innovations in Nutrition Globally (SPRING) and Resiliency in Northern Ghana (RING) projects. They provided training, which included aspects essential for improving early childhood outcomes, such as IYCF, which was the most commonly referred to training package.

> I have learned about that while in school, but on the job, I haven't had that training. I learned about developmental milestones from 0–59 months and at each age, the child has some developmental actions that he or she should be able to perform: at 6 months, the child should be sitting; at 8–9 months, the child should be crawling and trying to take a few steps.
>
> ***— District stakeholder, Kwahu West***

> I received training on IYCF, which has a component on responsive care. I also received on the job support on early stimulations from the doctors we work with in the wards. But that is not an official training but on the job support. I also learnt about children's developmental milestones in school.
>
> ***— Health worker, East Mamprusi***

Referrals within and across the Health and Social Welfare Sectors

Health workers reported that a structured system for referrals existed within the health sector in which they could refer cases that required more support or intervention. The majority of health workers stated that they were able to refer caregivers to services to support children that were experiencing problems with their development, but noted that barriers, mainly financial, prevent many caregivers from following through with referrals. Most health workers also mentioned the ability to refer caregivers that identify with having mental health problems to services that can further support them.

> The challenge has always been how to convince the caregivers to accept the referral because referring her to the district will require some financial commitments, which most often they are not able to afford.
>
> ***— Health worker, Kwahu West***

> People face challenges like stigma and lack of money to send the child [with a disability] to the hospital.
>
> ***— Caregiver, East Mamprusi***

Health workers mentioned following up on referrals through phone calls or home visits. They also mentioned several challenges to follow-up, such as the lack of feedback from services they have referred cases to, limited time due to workload, and lack of caregiver contact information. To mitigate some of these challenges, health workers described contacting referred services directly and visiting communities to follow-up with caregivers.

> Mostly when you do referrals, you don't get feedback except if you happen to go to the community where they are then you ask about them and go and see the child.
>
> ***— Health worker, East Mamprusi***

The majority of health workers stated that they do not refer cases to the social welfare sector. The few health workers that did mention referring cases to social welfare were mainly in relation to child protection or financial assistance, and some referred to specific social welfare and chaplaincy services within the hospital. Conversely, all social welfare workers stated that they refer cases to the health system, particularly for malnutrition. (Interestingly, only a few health workers claimed to have received referrals from the social welfare sector.) Similar to the health sector, social welfare workers noted caregiver barriers (e.g., financial and logistical) to completing referrals.

> We do refer them to the health facilities and the caregivers do follow the referrals. We are able to make follow-up by visiting the caregivers in their homes as we always take records of the details of the clients we refer, which help us to locate their homes and to visit them.
>
> ***— Social welfare worker, East Mamprusi***

> The experience is that when we refer them to the health facility, some go but others do not with the claim that they don't have money. But those who are able to go, their children get better while those who don't go, their children get worse.
>
> ***— Social welfare worker, Tempane***

Collaboration and Coordination of Services across Sectors

The majority of district stakeholders (80 percent) said that in their area there are no mechanisms for coordinating services across different sectors for children under the age of three years and their caregivers. Many district stakeholders stated that the sectors work independently, but recognize the need for more collaboration and coordination. One district stakeholder mentioned that there was previously some coordination for nutrition under the USAID/RING project. A second noted that there are plans to facilitate coordination with support from USAID Advancing Nutrition.

> There is actually no coordination among the various sectors but that is about to change because the USAID Advancing Nutrition Project has started working to promote coordination among the various sectors. [It has] helped us to form a district nutrition coordination committee…at the last meeting all the various sectors had included nutrition into their medium [term] plan and submitted it to the municipal assembly for implementation.
>
> ***— District stakeholder, East Mamprusi***

Specialized Services for Vulnerable Groups

Mental Health Services

In Ghana, there are specially trained health workers, including psychiatric nurses and Community Mental Health Nurses who are equipped to handle mental health issues at the primary health care level and in the communities they serve. Both health and social welfare workers reported that they readily refer cases of mental health issues to these persons.

> I do assess the mental health of caregivers but not much, only a few due to the workload on me as the only community health nurse in this facility attending to several communities ... I have been able to identify a few caregivers with mental health problems and referred them to the psychiatric unit of BMC [hospital] for treatment ... There is one woman I referred to in this community. She went and got treated and she is back and now doing well.
>
> ***— Health worker, East Mamprusi***

Health workers do not routinely assess the mental health of the caregivers they interact with unless there are clear signs of problems, which may be too late. A few health workers said it would be feasible to add this specific counseling if they received training, but others were unwilling to do mental health counseling because they considered it the sole responsibility of mental health nurses.

> We don't really make conscious efforts to assess the mental health of caregivers in the course of our services to them unless they show obvious signs of mental problems then we refer them to the mental health unit of the facility for assessment and management.
>
> ***— Health worker, East Mamprusi***

The health workers recommended that all caliber of health workers need to be trained to incorporate mental health screening in their various primary care settings. Health workers advocated for staff of day care centers, traditional leaders, and heads of religious bodies to be included in such sensitizations because they have key community roles and often interact with mothers/caregivers. It was also noted that if health workers were able to identify that a caregiver's mental health problem was due to financial challenges or abuse, they could refer them to social welfare workers.

> The midwives at the maternity ward are also suited to assess the mental health of caregivers and refer them because … after the mother has gone through all the struggles and pains of labor and delivery, that is where some of these mental health conditions like postpartum depression set in.
>
> ***— Health worker, East Mamprusi***
>
> Yes, it is feasible for us to begin to assess the mental health of the caregivers we see if we are trained because we are willing to add that to our work.
>
> ***— Health worker, East Mamprusi***
>
> The religious bodies as I stated earlier [are well suited to provide mental health counseling] because some of the cases just need counseling which can be provided by the pastor or Imam in the community because some of the problems have spiritual connotations.
>
> ***— Health worker, Tempane***

All but one social welfare worker from the East Mamprusi and Tempane Districts reported assessing or supporting caregivers' mental health as part of the services they currently provide and refer or report these cases for further support and treatment. One respondent from Tempane mentioned occasionally assisting in the procurement of medications through district mechanisms for patients who have diagnosed mental health issues. This reduces the burden on families for purchasing medicine and encourages compliance.

> The financial management committee will recommend and approve a certain amount of money to the health directorate to procure mental health medicines and this is what they use to administer … mental health [medication to] children and their caregivers as well.
>
> ***— Social welfare worker, Tempane***

The majority of social welfare respondents that did not assess or support mental health said it would be feasible to do so in collaboration with other institutions. However, one respondent did not think assessing the mental health of caregivers was feasible, as it requires specific training and expertise that they did not feel qualified to do.

Disability Services

Both the health and social welfare sectors provide services to children with disabilities and their families. The health workers are primarily in charge of identifying and recognizing signs of developmental delays or disability in children, and follow up with them over time and manage any acute illness. Health workers

follow the established referral systems such that they refer children with disabilities to the next-level facility for management or physiotherapy that is unavailable at their unit. Health workers were usually overwhelmed and unable to conduct home visits, which are essential for identifying and managing children with disabilities kept at home and not brought into public spaces due to stigmatization. They also faced challenges accessing specialized equipment to assist in the care of children with disabilities.

> Caregivers find it hard to visit health facilities with their children with disabilities due to stigma.
>
> [The] lack of required equipment to manage the disabilities at the lower health levels, coupled with caregivers' financial challenges, also impede their accessibility of health services for children with disabilities.
>
> ***— District stakeholder, Kwahu West***

> Lack of specialized equipment in my facility to manage such cases. These cases are always referred to the higher facility; the main challenge has to do with caregivers failing to send the children to the referred facility.
>
> ***— Health worker, Kwahu West***

Social welfare workers also connect families of children with disabilities to financial support through available mechanisms including the Disability Component of the District Assemblies Common Fund. This fund is a district-level fund that social welfare workers can distribute to beneficiaries meeting certain criteria. However, allocation of these funds is based on complex criteria so social welfare workers are not always able to meet the needs of families that do not qualify for financial support. Even when families do meet the criteria, the funds are not always transferred on time for social welfare workers to distribute them. Ideally, they should also conduct home visits but are unable to do so due to challenges with transport and other logistics.

> With the disability common fund, we expect it to reach children with disabilities. But the only time it gets to the children with disabilities, are children with disabilities who are staying at home and their parents are taking care of them in their homes. But for children in school, what the big men are saying is that they are in school so education is free and teaching is free for children with disabilities who are in school. They shouldn't enjoy anything with regards to the disability common fund and sometimes it baffles my mind but you can't do anything.
>
> ***— Social welfare worker, Kwahu West***

> [There is a] lack… of transport to reach out to these children in the communities where they are commonly found, which limits our ability to identify such children and provide them with the necessary support and services they need to develop well. People in the communities also stigmatize children with disabilities and their caregivers. People call them names and even use the disabilities the children have to call them or refer to their houses. These make them hide or want to hide the children and not bring them for services and interventions that can help them.
>
> ***— Social welfare worker, East Mamprusi***

Another key aspect of disability services that cannot be overlooked is the caregivers' perspectives. As noted in the quote above, the biggest challenge for caregivers and families of children with disabilities is stigmatization. Generally, there is a misconception that disabilities are a result of curses or punishment for someone else's misdeeds. For this reason, families hide children with disability at home, away from public ridicule, and are reluctant to bring them for health care services.

> Caregivers associate disability with spiritual attack and as a result of curses.
>
> ***— ECCD-trained health worker, Kwahu West***

Generally, other caregivers do not let their children associate with these kinds of children. Caregivers also do not bring them to child welfare clinics because of stigma.

— Caregiver, Kwahu West

A few caregivers, however, alluded to the fact that stigma was not so much of a problem in their communities, and that other issues, such as caregivers' of children with disabilities inability to engage in paid labor, were of greater concern. Other concerns include the risk of caregivers developing various mental health conditions such as depression, and challenges related to feeding children with disabilities.

Sometimes, they called them sick children. The challenges are numerous. You have to continually hold the child as you can't leave them on their own. You don't have time to do other activities. Your money gets depleted and you can't even get money to buy [medicine]. There are usually challenges to the feeding of such a child. In some cases, the child can only breastfeed or take only water… [but] stigma against such children…is not common here.

— Caregiver, Tempane

Child Protection Services

The social welfare department is responsible for cases of child abuse and leads the implementation of various child protection policies at the district level. While social welfare workers did not talk about their role in child protection spontaneously, they did speak about child protection services when asked directly. They work with the Domestic Violence and Victims Support Unit of the Ghana Police Service. They educate caregivers on protection issues, such as child sexual abuse, child labor, etc., and help to place orphaned children in appropriate homes.

I am responsible for implementing child protection activities in the communities and sensitization and education of communities on the roles of parents and the effects of abuse.

— Social welfare worker, Kwahu West

Health workers' role in child protection is to remain vigilant and identify any cases of abuse at hospitals, thoroughly examine such children, and provide follow-up treatment. They should report all identified cases to the police or social welfare workers. Health workers see certain injuries as indications of cases to refer.

The physical injuries I see, in such cases, I stabilize and then refer to Social Welfare and Police.

— Health worker, Kwahu West

However, some health workers said they occasionally only threatened the perpetrators of the abuse with punishment or reported to community elders. A few health workers said they had never encountered cases of child abuse. This may be due to under-reporting by community members or underdiagnosing due to poor provider vigilance.

Health and Social Welfare Observations

The data collection team was able to observe several health sector services across the three districts and two social welfare sector LEAP cash transfer provision points to document how facilities and providers supported ECCD through the services they provided. The health services observed included CWCs, sick child visits (Integrated Management of Childhood Illness), immunizations, postnatal care as well as in-hospital counseling. The observers recorded information, such as the types of services provided, individuals present, information on the environment where the services were provided, and the tools and materials that were used specific to the MCSP program.

Health service observations showed that, in some areas, services were provided in spaces that were clean and well-lit. However, observers noted a majority of the spaces were small and congested. At all

the locations observed, there were not any designated areas for children to play in and only one had a single toy for children to play with. Most spaces were not appropriate for children as they were either too small or on dirt surfaces where the child could eat or inhale the dust. Observers also noted that the majority of caregivers experienced long wait times, an average of two hours.

As previously mentioned, due to the COVID-19 pandemic, the study team was only able to complete two observations of social welfare sector services. Health workers conducted both services outdoors for between 1 and 4 hours. Observers considered both spaces inappropriate for children and did not include any toys or designated areas for children to play.

Sustainability of Maternal and Child Survival Program's ECCD Support

The health workers in Kwahu West trained through MCSP generally reflected positively on the early childhood development training and program. They described the training as enjoyable and beneficial, and said they apply the content to their personal lives and work.

> I really enjoyed the early childhood development training and I have been applying it in my work, I will appreciate another refresher training so that I can be a focal person for early childhood development in the district, so that I will be able to train my colleagues and motivate them to revamp all the non-functional mother-to-mother support groups.
>
> ***— ECCD-trained health worker, Kwahu West***

Some health workers particularly appreciated learning that childhood development starts in utero and a few midwives said they counsel pregnant women accordingly. Health workers also valued learning about how play helps children to develop and how caregivers can support their children's play, such as by making homemade toys. They recalled learning during the training not to yell or scold children but rather show love and to talk calmly. They also learned to identify their child's strengths and weaknesses.

Since concluding the program, supervision seems to have tapered off, but while it was occurring regularly, health workers found it motivating because it helped them know if they were on track with the services they provide.

Health workers trained to support the mother-to-mother support groups said the groups had mostly dissolved and were no longer convening. Several noted that staff attrition was a major barrier to program sustainability and others cited poor maintenance or non-availability of early childhood development tools and flip charts. Several health workers said that because the tools belong to the facility, they are not able to keep them when they are transferred. Less frequently mentioned barriers to convening included COVID-19-related restrictions, repetition of early childhood development activities during groups, and recruitment of new mothers, as mothers in the original groups were no longer participating. Despite these challenges, one health worker described testimonies from caregivers that continue to motivate health workers to try to sustain the groups. In an attempt to continue the emphasis on ECCD, one health worker integrates this content into group education for caregivers who attend CWCs since mother-to-mother support groups are inactive in that district.

> In my previous community, we used to convene but where I am now we don't. The community health nurse who was in charge of it left to school for further studies, though she handed over the materials and register to me, it has been difficult to get the mothers...I was still making efforts to reach some of them until COVID-19 also came…since then the group hasn't met.
>
> ***— ECCD-trained health worker, Kwahu West***

Health workers made several suggestions for sustaining mother-to-mother support groups. Most frequently, they recommended refresher training at regular intervals (such as annually) to remind health workers to maintain ECCD content as a priority. Additionally, some proposed monetary incentives for

health workers to incorporate ECCD and refreshments or t-shirts to incentivize caregivers to participate in groups. Other ideas for ensuring continuity included engaging the education sector and involving teachers in ECCD training, providing more frequent supervision, integrating ECCD counseling into CWCs, and encouraging CWC attendance.

> What has made it possible for us to still be able to convene the mother-to-mother support groups is the fact that we don't meet like we used to do. We now use the CWC sessions for the mother-to-mother support groups. So, on days that we have CWC we use the caregivers who are present to form the group for the session.
>
> ***— ECCD-trained health worker, Kwahu West***

Opportunities for Strengthening Support for Children's Development in the Health and Social Welfare Workers

Potential Future Health Sector Role

Respondents all agreed that all cadres of health workers can counsel parents/caregivers during their interactions at antenatal and postnatal clinics, CWCs, and sick child clinics on child development. The health workers themselves agreed and expressed dedication and commitment to their work. Health workers believe that the assessment of children's development is an intrinsic part of the services provided by the health sector, with a majority of health workers stating they already assessed children's developmental milestones. However, they expressed the need for more health staff, further training on ECCD on a large scale, and regular supervision from the district and regional levels for services to better support young children's development. Increasing the numbers of staff would allow health workers to conduct more frequent home visits to identify defaulters—and encourage more families to support and promote the development of young children.

> With capacity building for health staff, it is feasible to add assessing the developmental milestones of children and refer those who are not doing well.
>
> ***— Health worker, East Mamprusi***

The majority of respondents agreed that home visits would be the most effective way to promote ECCD and reach caregivers of young children.

> I have never received any home visit but I believe this is one best way to reach the caregivers, especially the men because it is we the women who mostly bring the children to the health facility.
>
> ***— Caregiver, Kwahu West***

> The best ways to reach families of young children with all the services they need to support their children's development is through the home visits, community engagement, and CWCs…which bring us close to the caregivers and their children.
>
> ***— Social welfare worker, Tempane***

An overwhelming majority of respondents referenced nutrition and growth monitoring when discussing the information or services provided or received regarding the assessment of children's development, indicating a need for further training on ECCD in the health sector. In addition to further training, several respondents reported the need for resources, such as staff and materials to integrate ECCD.

> It is feasible to integrate additional support to improve early childhood development if we are given adequate health staff and if the health staff would be trained … with the requisite knowledge … and materials and logistics.
>
> ***— District stakeholder, Tempane***

Although many services support children's development, respondents saw a need for expansion. All respondents from the health sector agree that further promotion of ECCD is possible and they are willing to further promote ECCD if given the additional support and resources. Furthermore, there is a consensus that there is room within existing services to speak with caregivers about their children's development.

> The health services that are most appropriate for talking to caregivers … are PNC, CWC, and home visit services … the PNC and home visit provide the opportunity to meet the caregivers one-on-one to talk to them about how their children are developing. During CWC, too, we have the health education sessions during which caregivers can share their experiences about their child development.
>
> ***— Health worker, East Mamprusi***

Potential Future Social Welfare Sector Role

All of the social welfare workers said that with coordination it would be feasible to further support child-development services. Social welfare workers also stated challenges, such as the late and inconsistent allocation of funds and logistical obstacles to service provision.

> The major challenge is logistical constraints. We don't have fuel and so, we buy our own fuel for any other thing. We have one motorbike. You can imagine how vast the district is. There is no single community that we don't visit.
>
> ***— Social welfare worker, Tempane***

These challenges may explain why interviewees noted that some health workers and caregivers were unaware that the social welfare sector existed or they had no knowledge of its role in the community. Many caregivers mentioned hearing about social welfare workers, but an overwhelming majority of caregivers interviewed claimed to have never received information from social welfare workers. This lack of interaction and information extended across all three districts in the study. Social worker visibility in communities needs to increase. One suggestion is to give them resources to visit communities and homes so they can raise awareness of topics, including ECCD. Collaborate with bodies such as the National Commission for Civic Education (NCCE) to convey accurate information about child development and disability across communities. Where possible, increase allocations from the LEAP cash transfer program to support more homes with extreme financial difficulties.

> If social welfare can be very active on the ground to support families who are not able to foot their children's health care bills or obtain health insurance for caregivers who cannot afford it would be very helpful. The caregivers sometimes are just hopeless, they have no money to take the child to the health center and sometimes they bring them after treatment with no money to pay for drugs and services.
>
> ***— Health worker, Tempane***
>
> [The] National Commission for Civic Education should intensify education on some of the beliefs and practices in the community that are not favoring proper child growth and development. For example, children with disabilities are labeled as something else and not human beings in this community. Sometimes they are considered as spirits.
>
> ***— Health worker, Tempane***

That said, social welfare workers did express interest in further supporting ECCD and believed that engaging parents was necessary for doing so.

> In the communities, we need to engage with…parents. A committee must be formed… [to] make sure that in terms of anything concerning children, they report back to us because as

officers, we cannot be all around. We have to involve the parents, engage the opinion leaders, the chiefs, and parents so that they will own it, they will feel that as they…are helping the children.

— Social welfare worker, Tempane

Discussion and Recommendations

This study aimed to answer four research questions to better understand the current status of services in the health and social welfare sectors to support children's development and identify opportunities for strengthening this support in the future. We summarize the key findings for each question here and recommendations follow.

What are health and social welfare workers' knowledge, attitudes, and practices with regard to early childhood development?

The qualitative findings showed that, on average, both health and social welfare workers exhibited a good understanding of early childhood development, which included aspects of physical, cognitive, and emotional growth. Participants understood that early childhood development links to children's care. We saw no major differences between health workers who received training through the MCSP program and those who did not. This lack of difference may be attributed to the majority of non ECCD-trained health workers stating they had received information on ECCD through other means, such as their educational institutions, pre- and in-service training, and from their colleagues. The competency assessments also showed that respondents were confident counseling on ECCD-related topics, rated their on knowledge as good, and reported providing counseling on ECCD topics in their daily work. However, a direct assessment of ECCD knowledge revealed significant knowledge gaps among both health and social welfare workers with respondents, on average, answering less than half of the knowledge questions correctly. Furthermore, during observations, researchers did not witness any counseling specifically on ECCD-related topics. The absence of counseling may be related to challenges with time constraints, lack of training, and understaffing, which makes it difficult to include further information on ECCD during their routine services.

How do health and social welfare workers see the current and future role of the health and social welfare sectors in supporting children's optimal development?

Respondents in the health sector viewed the sector's current role in supporting children's development as related most directly to medical and nutrition support, such as providing clinics and other medical and nutrition services. However, most health workers believed that with proper training and increased staff, providers in the health sector can easily incorporate more ECCD support for children and caregivers. Social welfare respondents stated that the role of the social welfare sector mainly revolved around child protection and child rights, distribution of sector funds, and sensitization of communities on various topics. Respondents from the social welfare sector also believed that further support for child development would be possible with better coordination within the sector. Moreover, respondents from both sectors agreed that the best way to support children's development would be to include other sectors and stakeholders, such as workers from the education sector and community leaders. Engaging multiple sectors and stakeholders builds bridges between sectors and strengthens collaboration within communities to better support ECCD.

To what extent have the CHPS mother-to-mother support groups continued to integrate the responsive care and early learning content developed with support from MCSP?

This question only concerned health workers that had been trained on ECCD through the MCSP program, most of which reflected positively on the training. However, these respondents also stated that most of the mother-to-mother support groups were no longer taking place and attributed this to staff attrition and poor maintenance or lack of materials. ECCD-trained health workers mentioned that

the supervision aspect of the MCSP program served as motivation and a method for keeping them accountable; however, the supervision did not continue after the end of the program. The lack of ongoing supervision can be another reason why the mother-to-mother support groups were no longer meeting. Even though ECCD-trained health workers experienced challenges in sustaining the mother-to-mother support groups, they still try to incorporate ECCD content into CWC counseling based on the positive feedback they received from caregivers. Health workers showed an interest in the ECCD content of the training and were eager to recommend ways to integrate the content into the services they offer since the discontinuation of the mother-to-mother support groups.

During routine child health and nutrition services and social welfare programming, what opportunities exist for integrating developmental support, such as monitoring development and counseling caregivers in providing nurturing care?

The majority of respondents, across all respondent types, stated that home visits are the best way to reach families and counsel caregivers on ECCD. However, they also expressed that home visits were challenging to conduct given the constraints of time, heavy workloads, and funding. Moreover, the study findings suggest opportunities to promote ECCD through leveraging existing tools, such as the MCHRB and introducing child-friendly spaces at service delivery points. Observation of health services identified opportunities to maximize contacts, given that the existing spaces are not child-friendly and services have long waiting times.

In addition, expanding services for children with disabilities and caregiver mental health are important gaps to fill. Children with disabilities and their families face several obstacles, such as a lack of workforce competencies on developmental disabilities, stigma, and financial and transportation challenges when trying to access support and services. Addressing these issues would be a great way of expanding developmental support and a tremendous step toward improving the livelihood of children with disabilities and their families. Both health and social welfare workers mentioned they refer cases of caregiver mental health concerns for further support and treatment yet they do not routinely assess caregiver mental health. Furthermore, given the limited mental health resources and personnel, there most likely is a delay in when caregivers receive the support and care they need.

Last, limited numbers of staff affect the existing workforce's ability to provide sufficient counseling and other services, such as home visits. In particular, limited numbers of social welfare staffing and sectoral budget constraints affected social welfare workers ability to provide direct services to the communities during the period of study, which may relate to caregivers reporting limited knowledge of the social welfare sector.

Recommendations

1. Strengthen counseling and support services in responsive care, early learning, and safety and security

A theme that resonated across all stakeholders was the need to incorporate support for ECCD and counseling into services provided by health and social welfare sectors, as well as closely aligned sectors, such as education. Counseling and support services for responsive care, early learning, and safety and security are underemphasized in those sectors compared to services related to nutrition and physical growth. Counseling on play, which is how young children learn, was the least commonly reported activity by both health and social welfare workers in this study. Data from Ghana also highlights the urgent need to focus on these aspects of nurturing care given widespread use of violent disciplinary practices (94 percent) and only 34 percent of caregivers engaged in opportunities to support learning among children ages 2–4 years in Ghana (GSS 2018). However, most children (75 percent) have access

to household objects for play (GSS 2018) and so counseling on caregivers engaging in play with young children is essential to address this gap. Strengthening these services is an important step in supporting holistic child development. Stakeholders emphasized the need for a multidisciplinary approach to coordinate services and referrals across the three main sectors.

Respondents stressed the importance of including the education sector in solutions to support ECCD. For example, the educational sector workers at day care centers could help monitor and counsel caregivers on developmental issues and encourage early learning. Where services are available, children enroll in these centers at an early age, and the teachers interact with parents/caregivers on a regular basis. They can also direct children with delays to the appropriate services for further management. However, the reach of these services is not well documented and may vary across communities.

As is true with any public health initiative, it is important to include key community stakeholders, such as religious leaders, traditional birth attendants, community health volunteers, and heads/leaders of various community groups (e.g., farmers' associations). Offer them training on various child development topics and enlist their support to disseminate key educational and counseling messages and materials. Stakeholders also called on the NCCE to support ECCD education by demystifying negative cultural norms, beliefs, and practices.

International and local nongovernmental organizations should also be encouraged to support the government's efforts and provide tools/job aids and training for health and social welfare workers and teachers on early childhood care and development.

The national ECCD standards for children 0–3 years provide specific guidance on how to support children's development at different ages, but they are not well known among service providers and thus are underutilized. The study also found that the MCHRB aids health workers in counseling on developmental milestones, but a shortage of copies, limited staffing, and possible inadequate training on the developmental milestones section has limited its use. Train providers on the ECCD standards and child development component of the MCHRB, providing specific guidance on when and how to use them (CWC and PNC visits that are focused on well children may be the most appropriate for counseling on development). Although the MCHRB is a health sector resource, it could be a useful cross-sectoral tool, owned by the families, for following the mother and child's health, development, and well-being particularly if other sectors are oriented to the child development section. Access to and knowledge of resources will help service providers guide caregivers on creating a nurturing environment for their children to thrive.

Last, the study's observations showed that an opportunity exists in creating spaces that promote the care and development of children by creating child-friends spaces at service delivery points. All the observations stated that none of the health and social welfare service points had a child-friendly space with toys and supplies that nurture the development of children. Creating child-friendly spaces with toys and resources provides an area where children and caregivers can play and learn together during long wait times. It also creates a location where service providers can counsel caregivers on child development and other aspects of ECCD.

2. Strengthen workforce ECCD competencies through pre- and in-service training

Results showed that service providers received limited training on ECCD, and there were significant gaps in ECCD knowledge among health and social welfare workers. To address these gaps, provide training to support knowledge and competencies on ECCD through pre- and in-service training opportunities. Pre-service will help with longer-term sustainability, and in-service is essential to build skills of those who currently work with caregivers of young children. Some health workers mentioned learning about child development domains in their preservice, so review existing curricula, and ensure that it includes practical guidance on supporting and counseling caregivers to provide all components of nurturing care.

A challenge to in-service training is high cost and staffing turnover. A database or system for tracking trained staff could ensure adequate coverage of training across health, education, and social welfare staff including opportunities for follow-up and supervision, which are essential to maximize investments in training.

Last, to adequately apply competencies it is important for sufficient numbers of staff to be available to provide services in both sectors.

3. Strengthen services for and support of children with disabilities and their families

This study revealed gaps in services for children with disabilities and their families, yet about one in every five children ages 2–17 years old in Ghana has a functional difficulty (GSS 2018). Efforts to reduce stigma, increase access to funding, and strengthen workers' competencies in working with children with disabilities are critical to closing these gaps.

Stigma places tremendous stress and blame on families and is a major barrier to connecting children with disabilities to services. Many families with disabled children are inclined to keep their children at home. Community activities to reduce stigma and home visits by health and social welfare workers should include information on the causes, needs, and care of children with disabilities. Generate and disseminate advocacy briefs on information, resources, and programs available to support children with disabilities and their families.

Poverty, perpetuated because many caregivers are unable to work for income while caring for children with disabilities, reduces access to referral services. Social welfare sector funds can support children with disabilities and their families; however, LEAP has predetermined eligibility criteria with selection determined at the national level and operational constraints that delay transfers thus limiting their effectiveness. The Disability Component of the District Assemblies Common Fund, while determined at the district level, is constrained by fund availability and it is often limited to one-off support. Simplifying eligibility criteria for LEAP that prioritizes children with disabilities and their families and reducing delays in funding transfers to districts would help to ensure that families receive support when children are young so that they can benefit from early interventions. Support from LEAP would lead to more reliable and consistent financial support to these families until they no longer meet LEAP criteria, which is often necessary given the care needs of children with disabilities.

Last, to strengthen services to identify and support children with disabilities and their families, it is necessary to increase service providers' confidence and knowledge on disability. Tools including the MCHRB and ECCD standards, which include age-specific guidance on warning signs that require referral and assessment, can help to identify children who present with potential developmental delays for further assessment in a timely manner. ECCD intervention services must accompany the strengthened system for identification. Health and social welfare workers described linking children with disabilities to services but only those that involved physical therapy and advanced illness management. All services should align with the social model of disability that focuses on the social, institutional, economic, and political barriers in society that exclude persons with disabilities from participating in daily activities and aim to promote child functioning and participation (Al Ju'beh 2015).

4. Provide clearer tools and processes to aid in routine identification, support, and referral of caregiver mental health issues

Supporting caregivers' mental health increases their ability to provide an environment that supports the development of children. Primary health care and social welfare workers have frequent contact with caregivers of children throughout the first 1,000 days. However, as stated in the findings, non-mental health professional health workers and social welfare workers do not routinely assess the mental health of the caregivers they come into contact with, although several of them said it would be feasible to do so if they were trained. It is possible to strengthen the capacity of these workers to identify potential mental health concerns using validated assessments and to provide counseling to caregivers.

Do this alongside investments to strengthen the referral system for mental health more broadly. In general, mental health resources and services are limited across all districts in Ghana, which leads to insufficient access for those that need the support. According to a situational analysis of mental health services, there are minimal opportunities for enhancing mental health professionals' knowledge and skills as well as training of non-mental health professionals to strengthen the delivery of mental health services (Ghana Somubi Dwumadie 2021).

5. Strengthen supervision and monitoring systems to include all components of nurturing care and ECCD

MCSP's support for implementing the Ghana Early Childhood Development Toolkit for children ages 0–3 highlighted the value of regular supervision and showed positive results when supervision was functioning well (MCSP 2018). However, our study showed that although health workers saw value in the group-based education sessions, sustainability was a major challenge when the project ended. Declines in supervision, staff turnover, and weak mother-to-mother support group structures contributed to this. Strengthening regular supervision systems to include follow-up on all components of nurturing care and ensuring that ECCD is included in routinely reported health management information system indicators could promote longer-term sustainability of services that support nurturing care delivered through the health sector. While not mentioned by study participants, the Social Welfare Information Management System, in the early phase of rollout, will help track child protection and related services that social welfare workers provide (Otieno, Mutwiri, and Antwi-Boasiako 2020).

Stakeholder Feedback

After the data collection and analysis were complete, the study team conducted two workshops with in-country stakeholders to present and discuss the study findings. Stakeholders included members from the USAID Ghana Mission, GHS, MoGCSP, UNICEF, WHO, World Vision and World Food Programme. During the workshops, stakeholders provided their feedback on the study findings, as well as on ways to improve ECCD interventions. A representative from GHS recognized the need to expand piloting training programs to reach several districts rather than just one or two. They affirmed the challenge that takes place when health workers are transferred and are unable to implement what they learned in a new district where an initiative does not exist, which affects the success of the training in the long term. A second GHS representative stated the importance of collaboration and coordination by stakeholders at all levels so that everyone was included and could support in the planning and implementation of ECCD initiatives within the country. During the workshop with the MoGCSP, representatives commented on the gap in the study findings, which did not mention the Social Welfare Information Management System (SWIMS) and Inter-Sectoral Standard Operating Procedure (ISSOP) manual. SWIMS and ISSOP manuals support inter-sectoral collaboration and ensure more efficient service delivery for the most vulnerable populations. However, SWIMS and ISSOP were launched in June 2021 so they were still new to the participants interviewed in the study, which took place between July and September of the same year. Representatives from the MoGCSP also shared that the Training Manual for Caregivers of Children with Disabilities was recently launched in Ghana and is currently being piloted but has not yet reached the districts included in this study. Finally, a representative from MoGCSP recommended updating the Ministry's website with new resources and ways of encouraging more play between parents and children. Overall, participants in the stakeholder workshops expressed a great interest in the study findings and provided a deeper understanding of the current landscape in Ghana and opportunities for improving ECCD.

Conclusion

This study indicated a positive landscape for strengthening support for ECCD through the health and social welfare sectors. Features of that landscape include (1) the existence of relevant national tools, and (2) the willingness of health and social welfare workers and district-level stakeholders to do more to support children's development. This includes strengthening services for all children through improved counseling and child-friendly spaces, and specifically for children with disabilities and supporting caregivers' mental health. Further support is needed to fill gaps in knowledge and skills through workforce development strategies that include pre- and in-service training and supervision, alongside additional investments in sufficient staffing. Lastly, the government can improve accountability for ECCD through integration of ECCD indicators in information systems in both the health and social welfare sectors.

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Annex 1. Quantitative Study Tool

Self-Administered Service Provider Knowledge and Competencies Assessment Tool

Please read the information and consent form.

<table>
<tr><td colspan="2">CODE:</td></tr>
<tr><td>DATE:</td><td>INTERVIEWER:</td></tr>
<tr><td colspan="2">DISTRICT:</td></tr>
<tr><td colspan="2">STUDY SITE: [ ] CHPS Compound [ ] Health Center [ ] Hospital [ ] Social Welfare Service
NAME OF SITE:</td></tr>
</table>

Introduction

Follow the informed consent form.

#	Question	Response
1	What is your role?	[ ] CHN/CHO [ ] Enrolled nurse [ ] Registered nurse [ ] Midwife [ ] Medical assistant [ ] Doctor [ ] Social welfare officer [ ] Social development officer [ ] Other, specify: ___________________________
2	What is your highest level of education completed?	[ ] Primary [ ] Secondary [ ] Post Basic [ ] Certificate [ ] Diploma [ ] Bachelor's Degree or Higher [ ] Other, specify: _______________________________________
3	How many years of experience do you have in your current role?	[……….Years]
4	What is your gender?	[ ] Male [ ] Female
5	Have you received any training which contained information on any of the following topics? (Select all that apply)	[ ] Brain development in the first 1,000 days [ ] Early childhood development [ ] ECCD Standards [ ] MCH Record Book [ ] Responsive care, early stimulation, learning [ ] Child development milestones

#	Question	Response
		[ ] Infant and young child feeding (IYCF) [ ] Other relevant topics, specify: [ ] No training received

Self-Reported Knowledge and Ability

For each statement below, rate your own knowledge or ability on this competency on a scale from "very poor" to "very good."

Internal Note: We developed this tool for this study. The items are based on several sources; including the USAID Advancing Nutrition (2020) pre-service training competencies related to ECD and an ECD workforce competences landscape (Putcha, 2018).

#	Competency	Response Options
6	Knowledge of different domains of young children's development	[ ] Very Poor [ ] Poor [ ] Average [ ] Good [ ] Very Good
7	Knowledge of the role that nutrition plays in children's growth and development	[ ] Very Poor [ ] Poor [ ] Average [ ] Good [ ] Very Good
8	Knowledge of children's age-appropriate development (i.e., milestones)	[ ] Very Poor [ ] Poor [ ] Average [ ] Good [ ] Very Good
9	Ability to counsel caregivers on early childhood development	[ ] Very Poor [ ] Poor [ ] Average [ ] Good [ ] Very Good
10	Ability to counsel caregivers on nurturing care (i.e., good parenting practices, supporting learning, health, nutrition, etc.)	[ ] Very Poor [ ] Poor [ ] Average [ ] Good [ ] Very Good
11	Ability to counsel caregivers on developmental milestones	[ ] Very Poor [ ] Poor [ ] Average [ ] Good [ ] Very Good
12	Ability to identify risks or situations that could disrupt a child's development	[ ] Very Poor [ ] Poor [ ] Average [ ] Good [ ] Very Good

#	Competency	Response Options
13	Ability to demonstrate responsive caregiving practices	[ ] Very Poor [ ] Poor [ ] Average [ ] Good [ ] Very Good
14	Ability to demonstrate age-appropriate learning (play) activities for young children	[ ] Very Poor [ ] Poor [ ] Average [ ] Good [ ] Very Good
15	Ability to use the Maternal and Child Record Book to identify a child who is not meeting developmental milestones	[ ] Very Poor [ ] Poor [ ] Average [ ] Good [ ] Very Good
16	Ability to provide screening and referral services for developmental delays and disabilities among children under age three	[ ] Very Poor [ ] Poor [ ] Average [ ] Good [ ] Very Good
17	Ability to provide screening and referral services for cases of child abuse, neglect, or maltreatment among children under age three	[ ] Very Poor [ ] Poor [ ] Average [ ] Good [ ] Very Good

Early Childhood Care and Development Knowledge

Read each of the questions carefully. Then select the one best answer. Do not select multiple answers to a question. We indicate the correct answers in red text.

#	Question	Answer
18	What are the four domains of development in the Ghana Early Childhood Care and Development Standards?	[ ] Nutrition, health, education, and social welfare [ ] Body, mind, language, and relationships [ ] Growth, play, parenting, and learning [ ] I don't know
19	Children who have impairments in their development or disabilities cannot improve.	[ ] True [ ] False [ ] I don't know

#	Question	Answer
20	Which of the following would be a sign of delay or impaired development for a child aged 6 months?	[ ] Not fixing eyes on and following objects [ ] Not crawling [ ] Not breastfeeding [ ] I don't know
21	Which of the following would be a sign of delay or impaired development for a child aged 12 months?	[ ] Not interested in playing with other children [ ] Not walking [ ] Not pointing to communicate needs or ideas [ ] I don't know
22	When does a baby start to be able to hear?	[ ] Hearing develops in utero [ ] Hearing develops on the day of birth [ ] Hearing develops around 6–12 months [ ] Hearing develops after 12 months of age [ ] I don't know
23	When does a baby start to be able to see?	[ ] Vision develops in utero [ ] Vision develops on the day of birth [ ] Vision develops around 6–12 months [ ] Vision develops after 12 months of age [ ] I don't know
24	When does a child begin to play?	[ ] From the day of birth [ ] Around ages 6–9 months [ ] When he is old enough to play with other children. [ ] I don't know.
25	Before a child can speak, the only way she communicates is by crying.	[ ] True [ ] False [ ] I don't know
26	A child should be scolded when he puts something into his mouth.	[ ] True [ ] False [ ] I don't know
27	Children can learn by playing with pots and pans, cups, and spoons.	[ ] True [ ] False [ ] I don't know
28	Physical punishment is necessary in order to bring up, raise, and educate children properly.	[ ] True [ ] False [ ] I don't know
29	Young children learn by putting objects in their mouth.	[ ] True [ ] False [ ] I don't know

#	Question	Answer
30	Kofi is 3 months old. He is able to hold his head up when he is laying on his belly. He smiles and laughs when playing with his dad. He does not roll over.	[ ] Kofi is developing well. [ ] Kofi is not developing well. [ ] I don't know.
31	Ami is 12 months old. She is sitting up on her own. She is starting to feed herself using her fingers. She communicates by pointing, but she does not make any words or sounds like "ba ba".	[ ] Ami is developing well. [ ] Ami is not developing well. [ ] I don't know.
32	Ekow is two years old. He loves to play, such as imitating that he is cooking like his mom. He runs all around and talks all the time. Only his mom and dad can understand what he is saying.	[ ] Ekow is developing well. [ ] Ekow is not developing well. [ ] I don't know.

Experience

Read each of the following questions about working with caregivers and children under the age of three. Select the best answer based on how frequently you perform different tasks.

#	Question	Response
33	On a typical day, what % of the caregivers you see do you talk to about the importance of playing with their child?	______% of caregivers
34	On a typical day, what % of the caregivers you see do you talk to about infant and young child feeding practices?	______% of caregivers
35	On a typical day, what % of the caregivers you see do you talk to about breastfeeding?	______% of caregivers

#	Question	Response
36	On a typical day, what % of the caregivers you see do you talk to about their child's health?	______% of caregivers
37	On a typical day, what % of the caregivers you see do you talk to about how to discipline young children?	______% of caregivers
38	On a typical day, what % of the caregivers you see do you talk to about their child's development or developmental milestones?	______% of caregivers
39	On a typical day, what % of the caregivers you see do you talk to about abuse or maltreatment of young children?	______% of caregivers
40	On a typical day, what % of the caregivers you see do you talk to about hygiene for young children?	______% of caregivers

Confidence

Read each of the following questions about working with caregivers and children under the age of three. Select the best answer based on your confidence to perform different tasks.

#	Question	Response
41	How confident are you talking with caregivers about the importance of playing with their child?	[ ] Not confident at all [ ] Somewhat confident [ ] Very confident
42	How confident are you talking with caregivers about infant and young child feeding practices?	[ ] Not confident at all [ ] Somewhat confident [ ] Very confident
43	How confident are you talking with demonstrating breastfeeding?	[ ] Not confident at all [ ] Somewhat confident [ ] Very confident

#	Question	Response
44	How confident are you talking with caregivers about their child's health?	[ ] Not confident at all [ ] Somewhat confident [ ] Very confident
45	How confident are you talking with caregivers about how to discipline young children?	[ ] Not confident at all [ ] Somewhat confident [ ] Very confident
46	How confident are you talking with caregivers about their concerns about their child's development or developmental milestones?	[ ] Not confident at all [ ] Somewhat confident [ ] Very confident
47	How confident are you talking with caregivers about abuse or maltreatment of young children?	[ ] Not confident at all [ ] Somewhat confident [ ] Very confident
48	How confident are you talking with caregivers about hygiene for young children?	[ ] Not confident at all [ ] Somewhat confident [ ] Very confident
49	How confident are you referring a child with developmental delay or disability for additional services?	[ ] Not confident at all [ ] Somewhat confident [ ] Very confident

Thank you very much for your time.

Annex 2. Qualitative Study Tools

Interview Guide I—Health Workers

Code	
Date	
Interviewer	
Note-taker	
Organization	
District	
Study site (CHPS compound, health center, or hospital)	
Name of site	
Role (CHN/CHO, enrolled nurse, registered nurse, midwife, medical assistant, doctor, social welfare officer, other—specify)	
Highest level of education completed (secondary, post basic, certificate, diploma, bachelor's degree or higher, other—specify)	
Years of experience in current role	
Gender (male, female, other)	
Language interview conducted in	
Consent to interview (Y/N)	
Consent to audio record (Y/N)	

Opening

1. Tell me about your responsibilities working with children under the age of three years and their caregivers.

Understanding of Early Childhood Development

2. What does "early childhood development" (ECD) mean to you?
3. What individual, family, community, or social factors do you think are associated with children who *are* developing well?
    a. What about children who ***are not*** developing well?
4. Can you tell me about any training you have received on early childhood development, such as brain development in the first 1,000 days, responsive care and early stimulation or learning, children's developmental milestones?

   a. If yes, probe when and by whom (i.e., pre-service training, in-service training, etc.)
   b. If yes, what was most useful to you in the trainings?
5. What concerns do caregivers most often share with you about their children?
   a. What concerns do caregivers share with you about their child's development?
   b. What concerns have parents raised about how their child is developing that are hardest for you to answer?
6. What are good things caregivers most often share with you about their children?
   a. What good things do caregivers share with you about their child's development?

Services Available and Feasibility of Integrating Promotion of ECD

7. What existing services in this community are currently promoting monitoring and supporting children's development for ages 0–3? These could be services provided by any government agency or even the private sector, like day cares or crèches.
8. What challenges do you experience when providing services for young children with disabilities?
   a. Probe: Any challenges providing children with disabilities routine health services? Addressing nutrition or feeding concerns for children with disabilities? Any challenges for their caregivers or family such as stigma?
9. Which health services do you think are the most appropriate for talking to caregivers about how their child is developing (i.e., how they move, learn, communicate, and interact with other people)? Why?
   a. For example: child welfare clinics, immunization services, postnatal care, sick-child clinics, malnutrition services, or others?

Use of National Tools

10. Are you aware of the National ECCD standards?
    a. If so, how do you use them in your work?
    b. Did you receive any specific training on the standards?
    c. What was your experience implementing them? What challenges did you face?
11. Have you used the developmental milestones in the MCH Record Book to assess a child's development or counsel a caregiver?
    a. If so, can you tell me about how you did this and how the caregiver responded?

Developmental Monitoring and Referrals

12. As part of the services you currently provide, do you assess a child's developmental milestones, and refer children who are experiencing problems (i.e., developmental delay or disability) to additional services?
    a. If yes, what has been your experience and any challenges?
    b. If yes, are you able to refer these cases?
    c. If yes, what has been your experience with making these referrals? Where do you refer these children? How do you follow-up after a child has been referred?

d. If no, how feasible do you think it would be for you to assess a child's developmental milestones, and refer children who are experiencing problems (i.e., developmental delay or disability) to additional services?

e. What other providers are suited to provide this type of assessment?

13. As part of the services you currently provide, do you observe or support how caregivers interact with their children?
    a. If yes, what has been your experience and any challenges?
    b. If no, how feasible do you think it would be for you to observe or support how caregivers interact with their children?
    c. What other providers are suited to provide this type of service?
    d. Are you able to refer cases when you have a concern about how a caregiver interacts with their children? Why or why not?
14. As part of the services you currently provide, do you assess or support a caregiver's mental health?
    a. If yes, what has been your experience and any challenges?
    b. If no, how feasible do you think it would be for you to assess or support a caregiver's mental health?
    c. What other providers are suited to provide this type of counseling?
    d. Are you able to refer cases when you have a concern about the caregiver's mental health? Why or why not?
15. Do you make referrals to social welfare officers?
    a. What are the barriers? What goes well?
    b. Do they ever refer children to you?
16. Do you encounter children who are being abused or neglected in your work?
    a. If yes, how do you identify children who are being abused or neglected?
        i. What do you do when you identify a case of child abuse or neglect?
    b. If no, do you sometimes see children who regress (are no longer able to perform skills they used to be able to do), have unexplained injuries, poor caregiver-child interactions, caregivers who have negative perceptions of their child, or children who are living in families where there is a lot of conflict in the home?
        i. What do you do if you identify a case like this?

Closing

17. Is there anything else you would like to share?
18. Do you have any questions for us?

Thank you very much for your important contribution to the study.

Interview Guide 2—Health Workers in CHPS Zones that Integrated Responsive Care and Early Learning into Mother-to-Mother Support Groups (Kwahu West)

Introduction

Follow the informed consent form.

Code	
Date	
Interviewer	
Note-taker	
Organization	
District	
Study site (CHPS compound, health center, or hospital)	
Name of site	
Role (CHN/CHO, enrolled nurse, registered nurse, midwife, medical assistant, doctor, social welfare officer, other—specify)	
Highest level of education completed (secondary, post basic, certificate, diploma, bachelor's degree or higher, other—specify)	
Years of experience in current role	
Gender (male, female, other)	
Language interview conducted in	
Consent to interview (Y/N)	
Consent to audio record (Y/N)	

Opening

1. Tell me about your responsibilities working with children under the age of three years and their caregivers.

Understanding of Early Childhood Development

2. What does "early childhood development" (ECD) mean to you?
3. What individual, family, community, or social factors do you think are associated with children who *are* developing well?
    a. What about children who ***are not*** developing well?

4. Can you tell me about any training you have received on early childhood development, such as brain development in the first 1,000 days, responsive care and early stimulation or learning, children's developmental milestones?
    a. If yes, probe when and by whom (i.e., pre-service training, in-service training, etc.)
    b. If yes, what was most useful to you in the trainings?
5. What concerns do caregivers most often share with you about their children?
    a. What concerns do caregivers share with you about their child's development?
    b. What concerns have parents raised about how their child is developing that are hardest for you to answer?
6. What are good things caregivers most often share with you about their children?
    a. What good things do caregivers share with you about their child's development?

Services Available and Feasibility of Integrating Promotion of ECD

7. What existing services in this community are currently promoting monitoring and supporting children's development for ages 0–3? These could be services provided by any government agency or even the private sector, like day cares or crèches.
8. What challenges do you experience when providing services for young children with disabilities?
    a. Probe: Any challenges providing children with disabilities routine health services? Addressing nutrition or feeding concerns for children with disabilities? Any challenges for their caregivers or family such as stigma?
9. Which health services do you think are the most appropriate for talking to caregivers about how their child is developing (i.e., how they move, learn, communicate, and interact with other people)? Why?
    a. For example: child welfare clinics, immunization services, postnatal care, sick-child clinics, malnutrition services, or others?

Mother-to-Mother Support Groups

10. Were you trained on the Ghana ECD 0–3 Toolkit?
    a. If so, when?
    b. What were the most important or useful things that you learned from the training?
    c. What lessons do you continue to apply in your work?
    d. What do caregivers say is the most useful lesson?
11. Do you still convene the mother-to-mother support groups?
    a. If yes, what has made this possible?
    b. If no, what have been the barriers? When did the groups stop?
12. Are you still using the flip chart and other tools in the Ghana ECD 0–3 Toolkit?
    a. If no, what have been the barriers? When did you stop?
13. Do you use other tools to counsel or provide services to improve children's development?
14. Have you received ongoing supervision to support you in delivering the mother-to-mother support groups?

    a. If yes, can you describe the type of support you have received through the supervision?
    b. Has it been helpful?

15. What aspects of the program have been the most useful for you?
    a. What has been most useful for parents?
16. What barriers or facilitators do you see for sustaining these groups in the future?

Use of National Tools

17. Are you aware of the National ECCD standards?
    a. If so, how do you use them in your work?
    b. Did you receive any specific training on the standards?
    c. What was your experience implementing them? What challenges did you face?
18. Have you used the developmental milestones in the MCH Record Book to assess a child's development or counsel a caregiver?
    a. If so, can you tell me about how you did this and how the caregiver responded?

Developmental Monitoring and Referrals

19. As part of the services you currently provide, do you assess a child's developmental milestones, and refer children who are experiencing problems (i.e., developmental delay or disability) to additional services?
    a. If yes, what has been your experience and any challenges?
    b. If yes, are you able to refer these cases?
    c. If yes, what has been your experience with making these referrals? Where do you refer these children? How do you follow-up after a child has been referred?
    d. If no, how feasible do you think it would be for you to assess a child's developmental milestones, and refer children who are experiencing problems (i.e., developmental delay or disability) to additional services?
    e. What other providers are suited to provide this type of assessment?
20. As part of the services you currently provide, do you observe or support how caregivers interact with their children?
    a. If yes, what has been your experience and any challenges?
    b. If no, how feasible do you think it would be for you to observe or support how caregivers interact with their children?
    c. What other providers are suited to provide this type of service?
    d. Are you able to refer cases when you have a concern about how a caregiver interacts with their children? Why or why not?
21. As part of the services you currently provide, do you assess or support a caregiver's mental health?
    a. If yes, what has been your experience and any challenges?
    b. If no, how feasible do you think it would be for you to assess or support a caregiver's mental health?

c. What other providers are suited to provide this type of counseling?

d. Are you able to refer cases when you have a concern about the caregiver's mental health? Why or why not?

22. Do you make referrals to social welfare officers?

    a. What are the barriers? What goes well?

    b. Do they ever refer children to you?

23. Do you encounter children who are being abused or neglected in your work?

    a. If yes, how do you identify children who are being abused or neglected?

        i. What do you do when you identify a case of child abuse or neglect?

    b. If no, do you sometimes see children who regress (are no longer able to perform skills they used to be able to do), have unexplained injuries, poor caregiver-child interactions, caregivers who have negative perceptions of their child, or children who are living in families where there is a lot of conflict in the home?

        i. What do you do if you identify a case like this?

Closing

24. Is there anything else you would like to share?

25. Do you have any questions for us?

Thank you very much for your important contribution to the study.

Interview Guide 3—Social Welfare Workers

Code	
Date	
Interviewer	
Note-taker	
Organization	
District	
Study site (District Social Welfare Office)	
Name of site	
Role (social welfare officer, community development officer, other—specify)	
Highest level of education completed (secondary, diploma, bachelor's degree or higher, other—specify)	
Years of experience in current role	
Gender (male, female, other)	
Language interview conducted in	
Consent to interview (Y/N)	
Consent to audio record (Y/N)	

Opening

1. Tell me about your responsibilities working with children under the age of three years and their caregivers.

Understanding of Early Childhood Development

2. What does "early childhood development" (ECD) mean to you?
3. What individual, family, community, or social factors do you think are associated with children who *are* developing well?
    a. What about children who ***are not*** developing well?
4. Can you tell me about any training you have received on early childhood development, such as brain development in the first 1,000 days, responsive care and early stimulation or learning, or children's developmental milestones?
    a. If yes, probe when and by whom (i.e., pre-service training, in-service training, etc.).
    b. If yes, what was most useful to you in the trainings?

5. What concerns do caregivers most often share with you about their children?
    a. What concerns do caregivers share with you about their child's development?
    b. What concerns have parents raised about how their child is developing that are hardest for you to answer?
6. What are good things caregivers most often share with you about their children?
    a. What good things do caregivers share with you about their child's development?

Services Availability and Feasibility of Integrating Promotion of ECD

7. What existing services in this community are currently promoting monitoring and supporting children's development for ages 0–3? These could be services provided by any government agency or even the private sector, like day cares or crèches.
8. What challenges do you experience when providing services for young children with disabilities?
    a. Probe: Any challenges providing them children with disabilities routine health services? Addressing nutrition or feeding concerns for children with disabilities? Any challenges with for their caregivers or family, such as, stigma?
9. What sector (health, social welfare, education, etc.) do you feel is best positioned to be responsible for supporting children's development?

Use of National Tools

10. Are you aware of the National ECCD standards?
    a. If so, how do you use them in your work?
    b. Did you receive any specific training on the standards?
    c. What was your experience implementing them? What challenges did you face?
11. Have you used the developmental milestones in the MCH Record Book to assess a child's development or counsel a caregiver?
    a. If so, can you tell me about how you did this and how the caregiver responded?

Developmental Monitoring and Referrals

12. As part of the services you currently provide, do you assess a child's developmental milestones, and refer children who are experiencing problems (i.e., developmental delay or disability) to additional services?
    a. If yes, what has been your experience and any challenges?
    b. If yes, are you able to refer these cases?
    c. If yes, what has been your experience with making these referrals? Where do you refer these children? How do you follow-up after a child has been referred?
    d. If no, how feasible do you think it would be for you to assess a child's developmental milestones, and refer children who are experiencing problems (i.e., developmental delay or disability) to additional services?
    e. What other providers are suited to provide this type of counseling?
13. As part of the services you currently provide, do you observe or support how caregivers interact with their children?
    a. If yes, what has been your experience and any challenges?

b. If no, how feasible do you think it would be for you to observe or support how caregivers interact with their children?
c. What other providers are suited to provide this type of service?
d. Are you able to refer cases when you have a concern about how a caregiver interacts with their children? Why or why not?

14. As part of the services you currently provide, do you assess or support a caregiver's mental health?
    a. If yes, what has been your experience and any challenges?
    b. If no, how feasible do you think it would be for you to assess or support a caregiver's mental health?
    c. What other providers are suited to provide this type of counseling?
    d. Are you able to refer cases when you have a concern about the caregiver's mental health? Why or why not?
15. As part of the services you currently provide, do you assess or support children's development?
    a. If yes, what has been your experience and any challenges?
    b. If no, how feasible do you think it would be for you to assess or support children's development?
    c. What other providers are suited to provide this type of service?
16. Do you make referrals to health services?
    a. What are the barriers? What goes well?
    b. Do they ever refer children to you?

Closing

17. What do you think is the best way to reach families of children under the age of three years to provide them with all the services they need to support their children's development?
18. Is there anything else you would like to share?
19. Do you have any questions for us?

Thank you very much for your important contribution to the study.

Interview Guide 4—District Stakeholders—DHMT members (DNO, DPHN, DHPO, DDHS)

Code	
Date	
Interviewer	
Note-taker	
Organization	
District	
Study site (District Health Office, Other)	
Name of site	
Role	
Highest level of education completed (secondary, diploma, bachelor's degree or higher, other—specify)	
Years of experience in current role	
Gender (male, female, other)	
Language interview conducted in	
Consent to interview (Y/N)	
Consent to audio record (Y/N)	

Opening

1. Tell me about your responsibilities working with children under the age of three years and their caregivers.

Understanding of Early Childhood Development

2. What does "early childhood development" (ECD) mean to you?
3. What individual, family, community, or social factors do you think are associated with children who _are_ developing well?
    a. What about children who ***are not*** developing well?
4. Can you tell me about any training you have received on early childhood development, such as brain development in the first 1,000 days, responsive care and early stimulation or learning, or children's developmental milestones?
    a. If yes, probe when and by whom (i.e., pre-service training, in-service training, etc.).
    b. If yes, what was most useful to you in the trainings?

Services Available and Feasibility of Integrating Promotion of ECD

5. What existing services in this community are currently promoting monitoring and supporting children's development for ages 0–3? These could be services provided by any government agency or even the private sector, like day cares or crèches.
6. What sector (health, social welfare, education, etc.) do you feel is best positioned to be responsible for supporting children's development?
7. There are many different health services for children under the age of three years, such as child welfare clinics, immunization services, postnatal care, sick-child clinics, malnutrition services, and others. Which health services do you think are the most appropriate for talking to caregivers about how their child is developing (i.e., how they move, learn, communicate, and interact with other people)?
    a. How about for counseling caregivers on what they can do to improve their child's development?
    b. How about for counseling caregivers on how to play and interact with their child?
8. What challenges are there for providing services for young children with disabilities?
    a. Probe: Any challenges for caregivers of children with disabilities accessing routine health services? Addressing nutrition or feeding concerns for children with disabilities? Any challenges for their caregivers or family, such as stigma?

Use of National Tools

9. Are you aware of the National ECCD standards?
    a. If so, how do you use them in your work?
    b. Did you receive any specific training on the standards?
    c. What was your experience implementing them? What challenges did you face?
10. Are you familiar with the developmental milestones section in the MCH Record Book for assessing a child's development or counseling a caregiver?
    a. If yes, how is this being used?

Service Monitoring and Referrals

11. As part of the services you oversee, how feasible do you think it would be to integrate additional support, such as specific counseling or other activities, to improve ECD?
    a. What do you think are the important considerations when integrating additional responsibilities within your existing services?
    b. What would be your priority to improve services for promoting children's development?
    c. Do you think these services could be used to counsel caregivers on how to play and interact with their young children? Why or why not?
12. Are there clear referral structures for children who have a delay in their development or other disabilities?
    a. If yes, can you describe the referral process to me? Where do children go?
        i. What are some of the challenges you see in the referral system?
        ii. How are children followed up with after they have been referred?

    b. Are there other supports for families to access the services they need? Such as if they have financial or other barriers to accessing referral services?
    c. If no, what do you think is needed to begin to establish a clear referral system?

13. Are there mechanisms for coordinating services across different sectors for children under the age of three years and their caregivers in your area?
    a. How do these function currently? What has been your experience with coordinating services for children? What have been the challenges in doing so?

Closing

14. What do you think is the best way to reach families of children under the age of three years to provide them with all the services they need to support their children's development?
15. Is there anything else you would like to share?
16. Do you have any questions for us?

Thank you very much for your important contribution to the study.

Interview Guide 5—Caregivers

Code	
Date	
Interviewer	
Note-taker	
District	
Study site (CHPS Compound, Health Center, or Hospital)	
Name of site	
Relationship to child (mother, father, grandmother, etc.)	
Highest level of education completed (no education, primary, secondary, diploma, bachelor's degree or higher, other—specify)	
Gender (male, female, other)	
Caregiver's age (in years)	
What is the total number of children you have?	
Age of child at current visit (in months)	
Relationship to child (mother, father, grandparent, other—specify)	
Language interview conducted in	
Consent to interview (Y/N)	
Consent to audio record (Y/N)	

Opening

1. Can you tell me a little bit about your child?
    a. How does your child communicate, relate to people move his or her body, and use his or her hands and fingers?

Their Child's Development

2. **What does early childhood development mean to you?** By development, I mean how your child learns, communicates, understands, relates to people, moves her body, uses her hands and fingers, and also hearing and vision.
3. How do you determine how well your child is developing?

4. What are your hopes and expectations for your child?
    a. What qualities do you want to encourage in your child?
    b. What makes a good girl or a good boy, in your opinion?
5. What are your worries for your child?
    a. What do you do to try and address your concerns?
6. In your opinion, what are the most important needs for your child?
    a. Where do you rank nutrition? Education? Play?
    b. What do you do to try and improve or support your child's development?

Experience with Current Services and Recommendations

7. What information do you receive from health workers?
    a. What information have you received about your child's development (i.e., how she moves, communicates, learns, or plays) from health workers?
    b. What types of advice were you able to put into practice? What types were you not able to put into practice? Why?
        i. Was the advice useful, feasible, or practical?
    c. What additional information do you need?
    d. How comfortable are you talking with health care workers about questions or concerns you may have about your child's development or parenting?
8. Have health care workers ever asked you about whether your child is developing similarly to other children in terms of how your child moves, communicates, learns, or interacts with others?
    a. What type of provider was monitoring your child's development?
    b. What did you learn from the health care worker when they did this?
    c. What advice did they give you?
9. Do you receive any home visits to support your family or children?
    a. Who conducts the visits?
    b. What happens when they visit?
    c. Do they discuss your child's development with you during these visits?
    d. When was the last time they visited?
    e. How often do they visit?
10. What information do you receive from social welfare workers?
    a. What information have you received about your child's development (i.e., how she moves, communicates, learns) from health workers?
    b. What types of advice were you able to put into practice? What types were you not able to put into practice? Why?
        i. Was the advice useful, feasible, or practical?
    c. What additional information do you need?

   d. How comfortable are you talking with social welfare care workers about questions or concerns you may have about your child's development or parenting?

11. Are you attending any community groups (parent groups, lactation groups, support groups, Durbar discussions on child development etc.)?
    a. If so, how often?
    b. Do you discuss your child's development or parenting practices in these groups?
    c. What do you like or not like about them?
    d. If not, why not?
12. In addition to the support, information, and services you've just described, what additional support do you want regarding your child's growth and development? From whom?
13. Do you have a MCH Record Book for your child? Do you use it? How do you see health workers or other service providers using the record book?
    a. Show the Child Development milestones page (pages 58–59) and ask—Has anyone gone through this section of the MCH Record Book with you?
    b. If yes, what did they do when they went through it with you?
14. If a child has a problem with their development (i.e., not talking, not walking, not playing like their peers) or a disability, what do caregivers in your community typically do?
    a. Where can caregivers seek help or services?
    b. What types of issues do caregivers seek services for?
15. In your community, what do people say about young children who have a problem with their development (i.e., not talking, not walking, not playing like their peers) or a disability?
    a. Probe: Any challenges for caregivers of children with disabilities to access routine health services? Caregivers being able to address nutrition or feeding concerns for children with disabilities? Any challenges for caregivers of children with disabilities, such as stigma?

Closing

16. What do you think is the best way to reach families of children under the age of three years to provide them with all the services they need to support their children's development?
17. Is there anything else you would like to share?
18. Do you have any questions for us?

Thank you very much for your important contribution to the study.

Health Service Observation Guide

Introduction

Follow the informed consent form.

Date of session: ______________________

Name of observer: ____________________

Health Facility Information	
District	
Sub-District	
Type of Facility	[ ] Hospital [ ] Health Center [ ] CHPS [ ] Other, specify: ______________________________
Type(s) of Services Observed	[ ] Sick child visit/Integrated management of child illness [ ] Child Welfare Clinic [ ] Immunizations [ ] Postnatal care [ ] Mother-to-mother support group [ ] Other, specify: ______________________________
Are services provided to individuals (one-on-one) and/or groups? *Check all that apply.*	[ ] Individual consultation [ ] Group consultation
Time of Observation	Start __ __ : __ __ End __ __ : __ __

Who is present at the observation?	
What service providers are present?	
What caregivers are present? *Check all that apply.*	*Who are they?* [ ] Mothers [ ] Fathers [ ] Grandmothers *Estimate their age. If more than one caregiver, estimate the number of caregivers present.* *Describe what they are doing.*

Who is present at the observation?	
What children are present?	*Describe their age. If more than one child, estimate the number of children present.* *Describe what they are doing.*

What is the environment where the services are being provided?	
Where are services being provided?	[ ] Private room [ ] Public room (church, school, etc.) [ ] Outside (shade, under a tree, etc.) [ ] Other, specify:
What is the environment like?	*Describe the size of the space, lighting, or cleanliness.* *Is the space appropriate for children? Can they play? Do they have toys?*
Are caregivers waiting around?	*What is the space like where they are waiting (i.e., inside, outside, room for children to move around)?* *Ask caregivers the following:* *How long do caregivers wait before the service begins?* *How long do caregivers spend at the facility?*

What services are being provided?	
Why are the main reasons people have come for the service?	[ ] Child is sick [ ] Regular check-up (immunizations, etc.)

What services are being provided?	
Describe what the providers do with the caregivers.	
Describe what the providers do with the children.	
What tools are used in the service?	[ ] Register [ ] MCH record book [ ] Counseling cards/posters [ ] Other, describe: *How were they used?* *If they used the MCH record book, did they use the section on developmental milestones?*
Describe any counseling provided to the caregivers.	[ ] Group counseling [ ] Individual counseling [ ] None *What topics were discussed individually?* [ ] Nutrition/child feeding [ ] Family planning [ ] Hygiene [ ] When to return [ ] Child development [ ] Play and learning [ ] Other, describe: *What topics were discussed in groups?* [ ] Nutrition/child feeding [ ] Family planning [ ] Hygiene [ ] When to return [ ] Child development [ ] Play and learning [ ] Other, describe: *Were caregivers able to ask questions? What did they ask?* *Describe the quality of the counselling.*
Describe the caregivers.	*How do they appear? Do they appear comfortable? Happy? Stressed? Frustrated?*

What services are being provided?	
	How are they interacting with their child?
Describe the children.	*How do they appear? Do they appear comfortable? Playful? Sick? Upset?* *How are they interacting with their caregiver?*
Provider-caregiver interactions	*Does the provider greet the caregiver? If so, how?* *Are the providers treating the caregivers with respect?* *Does the provider ask open-ended, probing questions to assess child development?* *Does the provider reprimand or praise the caregiver?* *Are caregivers asking questions? If multiple caregivers are present, who is talking?*
Observer's comments on feasibility to add counseling to monitor or promote children's development	

Additional questions if observing a CHPS zone that received support to integrate ECD into mother-to-mother support groups.	
Tools available for ECD	[ ] Ghana ECD 0–3 Flipchart [ ] Ghana ECD 0–3 Manual [ ] Toys for play demonstrations [ ] Other, describe:

Additional questions if observing a CHPS zone that received support to integrate ECD into mother-to-mother support groups.	
Documentation	*Is there a register where mother-to-mother support group activities are recorded?* *Is there documentation that the mother-to-mother support groups are happening?* *When was the last mother-to-mother support group?*

Closing	
Any other comments or observations?	

Social Welfare Service Observation Guide

Introduction

Follow the informed consent form.

Date of session: ______________________

Name of observer: ____________________

Site Information	
District	
Sub-District	
Type of site	[ ] Community [ ] Cash transfer payment point: ____________________ [ ] Other, specify: ______________________________
Service observed	[ ] Community education [ ] LEAP services [ ] Other, describe:
Type of observation	[ ] Individual consultation [ ] Group consultation
Time of observation	Start __ __ : __ __ End __ __ : __ __

Who is present at the observation?	
What service providers are around?	
What caregivers are present?	*Who are they?* [ ] Mothers [ ] Fathers [ ] Grandmothers *Describe their age and estimate how many.* *Describe what they are doing.*
What children are present?	*Describe their age and estimate how many children are around.* *Describe what they are doing.*

What is the environment where the services are being provided?	
Where are services being provided?	
What is the environment like?	*Describe the size of the space, lighting, or cleanliness.* *Is the space appropriate for children? Can they play? Do they have toys?*
Are caregivers waiting around?	*Describe the space where they are waiting? (i.e., inside, outside, room for children to move around)* *How long do caregivers wait before the service begins?* *How long do caregivers spend at the facility?*

What services are being provided?	
What is the purpose of the meeting?	[ ] Community meeting [ ] Cash distribution [ ] Other, describe:
Are services provided to a group or individually?	[ ] Group only [ ] Individual only [ ] Both group and individual *How much time is spent in groups?* *How much time is spent in individual consultations?*
Describe what the service providers	

What services are being provided?	
do with the caregivers.	
Describe what the service providers do with the children.	
What tools are used in the service?	[ ] Register [ ] MCH record book [ ] Counseling cards/posters [ ] Case management forms [ ] Case management standard operating procedures [ ] Other, describe: *How were they used?* *If they used the MCH record book, did they use the section on developmental milestones?*
Describe any counseling provided to the caregivers.	[ ] Group counseling [ ] Individual counseling [ ] None *What topics were discussed individually?* [ ] Nutrition/child feeding [ ] Family planning [ ] Hygiene [ ] Child abuse [ ] Child development [ ] Play and learning [ ] Other, describe: *What topics were discussed in groups?* [ ] Nutrition/child feeding [ ] Family planning [ ] Hygiene [ ] Child abuse [ ] Child development [ ] Play and learning [ ] Other, describe: *Were caregivers able to ask questions? What did they ask?* *Describe the quality of the counseling.*

What services are being provided?	
Describe the caregivers.	*How do they appear? Do they appear comfortable? Happy? Stressed? Frustrated?* *How are they interacting with their child?*
Describe the children.	*How do they appear? Do they appear comfortable? Playful? Sick? Upset?* *How are they interacting with their caregiver?*
Provider-Caregiver Interactions	*Does the provider greet the caregiver? Do the providers treat the caregivers with respect? Do the providers reprimand or praise the caregiver?* *Do caregivers ask questions? If multiple caregivers are present, who is talking?*
Observations on feasibility to add counseling to monitor or promote children's development	
Any other observations or comments?	

Annex 3. Competency Assessment Tables Disaggregated by District

Table 11. Self-Reported Knowledge and Abilities of Health and Social Welfare Workers Disaggregated by District

Competency	Total		East Mamprusi		Kwahu West		Tempane	
	Mean	(SD)	Mean	(SD)	Mean	(SD)	Mean	(SD)
Knowledge of different domains of young children's development	3.45	(0.75)	3.34	(0.79)	3.53	(0.69)	3.5	(0.75)
Knowledge of the role that nutrition plays in children's growth and development	4.00	(0.74)	3.96	(0.70)	4.02	(0.76)	4.04	(0.77)
Knowledge of children's age-appropriate development (i.e., milestones)	3.62	(0.75)	3.58	(0.78)	3.69	(0.79)	3.58	(0.65)
Ability to counsel caregivers on early childhood development	3.83	(0.74)	3.74	(0.77)	3.85	(0.70)	3.91	(0.74)
Ability to counsel caregivers on nurturing care (i.e., good parenting practices, supporting learning, health, nutrition)	3.84	(0.71)	3.73	(0.71)	3.92	(0.70)	3.91	(0.71)
Ability to counsel caregivers on developmental milestones	3.65	(0.75)	3.63	(0.76)	3.75	(0.79)	3.55	(0.69)
Ability to identify risks or situations that could disrupt a child's development	3.66	(0.82)	3.65	(0.83)	3.68	(0.77)	3.62	(0.86)
Ability to demonstrate responsive caregiving practices	3.57	(0.77)	3.56	(0.79)	3.68	(0.76)	3.52	(0.73)
Ability to demonstrate age-appropriate learning (play) activities for young children	3.6	(0.83)	3.57	(0.89)	3.79	(0.75)	3.42	(0.80)

Competency	Total		East Mamprusi		Kwahu West		Tempane	
	Mean	(SD)	Mean	(SD)	Mean	(SD)	Mean	(SD)
Ability to use the Maternal and Child Record Book to identify a child who is not meeting developmental milestones	3.73	(0.92)	3.57	(0.88)	3.77	(0.86)	3.88	(0.99)
Ability to provide screening and referral services for developmental delays and disabilities among children under age three	3.58	(0.86)	3.48	(0.88)	3.75	(0.80)	3.52	(0.88)
Ability to provide screening and referral services for cases of child abuse, neglect, or maltreatment among children under age three	3.52	(0.90)	3.45	(0.95)	3.72	(0.85)	3.4	(0.88)

Note: self-reported knowledge and ability was reported on a Likert scale from “very poor” (1) to “very good” (5).

Table 12. Self-Reported Confidence in Supporting Caregivers of Young Children Disaggregated by District

Confidence Question	Total		East Mamprusi		Kwahu West		Tempane	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
How confident are you talking with caregivers about the importance of playing with their child?	2.52	(0.65)	2.66	0.60	2.36	0.69	2.55	0.62
How confident are you talking with caregivers about infant and young child feeding practices?	2.66	0.57	2.74	0.52	2.55	0.65	2.68	0.51
How confident are you talking with demonstrating breastfeeding?	2.62	0.61	2.59	0.59	2.64	0.62	2.63	0.62
How confident are you talking with caregivers about their child's health?	2.62	0.61	2.5	0.70	2.7	0.52	2.68	0.55
How confident are you talking with caregivers about how to discipline young children?	2.39	0.67	2.46	0.69	2.44	0.66	2.25	0.66
How confident are you talking with caregivers about their concerns about their child's development or developmental milestones?	2.51	0.62	2.56	0.62	2.5	0.64	2.45	0.62
How confident are you talking with caregivers about abuse or maltreatment of young children?	2.51	0.68	2.64	0.61	2.5	0.71	2.36	0.70
How confident are you talking with caregivers about hygiene for young children?	2.68	0.61	2.68	0.60	2.64	0.66	2.73	0.56
How confident are you in referring a child with developmental delay or disability for additional services?	2.54	0.66	2.53	0.66	2.54	0.68	2.55	0.65

Note: confidence was rated on a Likert scale of "not confident at all" (1) to "very confident" (3).

Table 13. Direct Assessment of ECD Knowledge among Health and Social Welfare Workers Disaggregated by District

Knowledge Question	Participants Who Answered Question Correctly			
	Total, % (n)	East Mamprusi, % (n)	Kwahu West, % (n)	Tempane, % (n)
What are the four domains of development in the Ghana Early Childhood Care and Development Standards?	18.99% (60)	16.24% (19)	19.63% (21)	21.74% (20)
Children who have impairments in their development or disabilities cannot improve.	77.46% (244)	71.79% (84)	81.31% (87)	80.22% (73)
Which of the following would be a sign of delay or impaired development for a child aged 6 months?	41.77% (132)	44.44% (52)	37.38% (40)	43.48% (40)
Which of the following would be a sign of delay or impaired development for a child aged 12 months?	26.58% (84)	23.93% (28)	27.10% (29)	29.35% (27)
When does a baby start to be able to hear?	50.95% (161)	50.43% (59)	61.68% (66)	39.13% (36)
When does a baby start to be able to see?	18.35% (58)	25.64% (30)	15.89% (17)	11.96% (11)
When does a child begin to play?	19.30% (61)	14.53% (17)	23.36% (25)	20.65% (19)
Before a child can speak, the only way she communicates is by crying.	22.47% (71)	29.91% (35)	19.63% (21)	16.30% (15)
A child should be scolded when he puts something into his mouth.	56.01% (177)	52.14% (61)	36.55% (68)	52.17% (48)
Children can learn by playing with pots and pans, cups, and spoons.	47.47% (150)	43.59% (51)	42.06% (45)	58.70% (54)
Physical punishment is necessary in order to bring up, raise, and educate children properly.	50.32% (159)	53.85% (63)	47.66% (51)	48.91% (45)
Young children learn by putting objects in their mouth.	35.76% (113)	29.06% (34)	43.93% (47)	34.78% (32)
Kofi is 3 months old. He is able to hold his head up when he is laying on his belly. He smiles and laughs when playing with his dad. He does not roll over. How is Kofi developing?	78.48% (248)	76.07% (89)	81.31% (87)	78.26% (72)

Knowledge Question	Participants Who Answered Question Correctly			
	Total, % (n)	East Mamprusi, % (n)	Kwahu West, % (n)	Tempane, % (n)
Ami is 12 months old. She is sitting up on her own. She is starting to feed herself using her fingers. She communicates by pointing, but she does not make any words or sounds like "ba ba." How is Ami developing?	51.27% (162)	38.46% (45)	54.21% (58)	64.13% (59)
Ekow is two years old. He loves to play, such as imitating that he is cooking like his mom. He runs all around and talks all the time. Only his mom and dad can understand what he is saying. How is Ekow developing?	65.19% (206)	65.81% (77)	60.75% (65)	69.57% (64)
Mean % (SD) total knowledge score*	44.01% (14.69)	42.39% (14.50)	45.30% (14.38)	44.57% (15.24)

*We calculated the mean total knowledge score by dividing the total number of correct questions by the total number of questions in the assessment (15).

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