Gindegi Goron

Results from IRC's audio initiative to support nurturing care for early childhood development in Cox's Bazar during the COVID-19 pandemic

Authors

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Executive summary

Decades of rigorous research underscore the critical importance of early childhood development (ECD) starting from conception through the first years of life.[1] It is a window in human development when experiences shape brain architecture, serving as a foundation for learning, behavior and health. Exposure to violence, separation from caregivers and the stress of displacement threaten healthy development. As such, children born and raised in conflict and crisis settings are at significant risk of not reaching their full developmental potential, with consequences that can be highly detrimental to children, their families and their broader communities.

There are several ways ECD interventions can mitigate this risk. A comprehensive approach to nurturing care should foster good health, adequate nutrition, security and safety, responsive caregiving and early learning. But very few humanitarian responses prioritize the holistic and interrelated needs of young children and their families, and the COVID-19 pandemic significantly altered and often halted the delivery of ECD programming in crisis and conflict settings. Given the central importance of ECD, the IRC has adapted its existing ECD interventions for remote delivery amidst the COVID-19 pandemic. Part of that work involves piloting new approaches, aligned with the five interrelated and indivisible components of the Nurturing Care Framework: good health, adequate nutrition, safety and security, responsive caregiving, and opportunities for learning.[2] This report highlights examples of the IRC's ECD programming during the COVID-19 pandemic, including brief summaries of programming in Pakistan, the Middle East and East Africa. This report's main focus is on Bangladesh, where the IRC is working with partners on the ground to deliver ECD programming to pregnant and lactating women living in the Cox's Bazar refugee camps and surrounding communities.

Through a program known as *Gindegi Goron*, a Rohingya phrase for developing future, the IRC delivered behaviorally informed messages to promote healthy development for pregnant mothers and their infants via phone calls and text messages from September through December 2020. The program reached over 400 households, and analysis of pilot data indicates success in promoting behavior change in areas that are critical to child survival and development.

Feedback from caregivers demonstrates the intervention's ability to both close knowledge gaps related to early childhood development and promote responsive caregiving behaviors. After receiving the IRC's Interactive Voice Response (IVR) calls, caregivers reported that they adjusted their infants' diets, consulted with doctors after experiencing pregnancy complications and engaged in play with their children. While this study was not designed to generate results that can be generalized to the broader population and draws from program monitoring and evaluation data, the baseline and endline survey results from 118 randomly selected participants, demonstrate behavior change in the areas of caregiver-child play, growth monitoring and counseling, and reading to the child.

Key findings include:

- **25% increase in mothers reporting that they play with their child**
  (from 80% to 99%, p-value <.05)
- **38% increase in growth monitoring and counseling**
  (50% to 67%, p-value <.05)
- **7.25X increase in mothers reporting they read to their child**
  (from 4% to 33%, p-value <.05)

The results of *Gindegi Goron* suggest the importance and feasibility of deploying ECD interventions during the COVID-19 pandemic in the midst of a humanitarian crisis, and the impact it can have on mothers and their children. The results will also inform the next iteration of this project through the LEGO Foundation's *Play to Learn* initiative in partnership with Sesame Workshop and BRAC. Through the analysis of the pilot data, the IRC demonstrated that responsive caregiving, early learning and health and nutrition can be promoted through remote programming, and can serve as a model for future interventions where there is restricted physical access to highly vulnerable populations.

This analysis should encourage relevant stakeholders to invest in and integrate evidence-based interventions (like *Gindegi Goron*) that build resilience and mitigate the harmful effects of emergencies on childcare practices and children's experiences.

Introduction: Early childhood development (ECD) in humanitarian settings

Why ECD matters and the value of early interventions

Adversity in early childhood* can have severe consequences on brain development, with reverberating negative impacts that may last the rest of a child's life. Globally, over 250 million children have been identified as at risk for failing to reach their developmental potential due to poverty, lack of early learning opportunities and other factors that hamper responsive caregiving. Nearly 1 in 4 children in the world live in a conflict or disaster zone[3] and face compounded risks from exposure to violence, family separation and loss, and weak support services from government health and education systems.

Childhood development experts agree that a child's early life experiences shape long-term health, behavior and learning outcomes. The period of time between the start of pregnancy through the first years of a child's life is marked by tremendous vulnerability, particularly for women and children living in crisis and conflict settings. It is also a time when positive experiences and interventions hold the powerful potential to transform the trajectory of children's lives.

ECD interventions work to build physical and emotional resilience in children and their caregivers. These interventions emphasize responsive care on the part of parents and caregivers, as well as engaging, playful, early learning opportunities for young children such as singing songs, looking at and talking about picture books and using household objects for play. Such interventions protect children from the adverse experiences of crisis and conflict, and bolster childhood development and survival.

The lack of ECD resources in humanitarian setting

Compared to the magnitude of needs facing children and families living in crisis and conflict, there is a significant gap in the delivery of quality interventions that support ECD in a holistic manner.

In low- and middle-income countries that often serve as host communities for refugee and displaced populations, nurturing care initiatives are often underfunded and stymied by a lack of coordination among the various sectors necessary for implementation and delivery. And even when financing for ECD-specific interventions is prioritized and coordinated, services may not reach crisis populations because of a lack of dedicated infrastructure. As a result, there is typically an inadequate in-country provision of services that support ECD in a holistic manner for refugee and displaced populations, further cementing development barriers, particularly for education and responsive caregiving.

National financing gaps are mirrored in global and national humanitarian response plans and accompanying funding. An April 2018 review of 26 active Refugee Humanitarian Response Plans (HRPs) found that only 58% mentioned nutrition interventions, fewer than 25% mentioned safety and security or health interventions, 10% of them recommended responsive care interventions and only 9% of them recommended early learning interventions. Even when ECD goals were part of an HRP, the programs were often inadequate in scope compared to the populations in need.[4] For example, the HRP for Syrian refugee children called for early education and responsive caregiving programs to reach just 150,000 of the 2.5 million Syrian refugee children covered by the plan.

As for donors, of the $25.2 billion in humanitarian aid reported in 2018, less than 2% (US$463 million) was earmarked to support early childhood needs; of the $192 billion total international assistance in 2017, only 3.3% (US$6.3 billion) went to ECD in emergencies.[5]

CASE STUDIES OF OTHER IRC ECD RESPONSES IN COVID-19

This report also showcases other IRC ECD responses to the COVID-19 pandemic. The IRC adapted its early childhood programming for children and their caregivers to reach more families in their home settings through various digital, radio and phone-based interventions. Throughout this report we showcase responses in Pakistan, East Africa and the Syria-response region of the Middle East. The early results are promising.

* Typically defined by IRC and others as the period from birth to age 8.

SOURCE: Habiba Nowrose / International Rescue Committee

Research shows that it is possible for innovative low-cost programs to demonstrably improve a range of outcomes related to ECD and parenting behaviors.[6] Yet, research and implementation funding is also scarce, resulting in incomplete evidence of what interventions most effectively improve development outcomes. As a result, practitioners, policymakers and donors do not have concrete information about how best to prioritize the limited resources that are available.

This dearth of programming, readily available evidence and financing is why the IRC invests in nurturing care interventions in humanitarian settings, currently operating these interventions in more than 17 country programs. The IRC bases its work on the best available evidence and an understanding of the specific needs, contextual factors and constraints of humanitarian settings. Using this knowledge, the IRC offers a range of ECD programming for both children and their caregivers, including: providing technical assistance to existing programs; piloting new programs and studying their impact; and advocating policy makers to adopt the most effective interventions.

COVID-19: Further disrupting access to ECD services

COVID-19 has further disrupted access to ECD services, as governments' virus-mitigation efforts have left families cut off from essential services like healthcare and education. With no or low access to technology in refugee camps, there are few ways for service providers to adapt their ECD programming to remote delivery.

While innovative models exist, increased resources and political will are required to implement these solutions at scale. The Global Humanitarian Response Plan for COVID-19 calls for $10.3 billion in worldwide relief, but little of this is directed at ECD (with less than 4% of the plan's total ask for education as a whole).[7]

Given the central importance of ECD interventions, and the unique challenges of delivering them amidst the COVID-19 pandemic, the IRC is focused on adapting its existing ECD programming to remote modes of communication. Part of that work involves piloting new approaches to ECD initiatives, including in Bangladesh, where the IRC is working with partners on the ground to telephonically deliver ECD programming to pregnant and lactating women and their families living in the Cox's Bazar camps and surrounding host communities.

This report details the IRC's pilot project in Bangladesh, including why it was needed, how it was designed and implemented, and the initial outcomes for pregnant and lactating women and their children. The early success, according to positive feedback from caregivers, underscores the importance of ECD interventions, the feasibility of delivering effective interventions during COVID-19, and the value of fully funding ECD interventions in humanitarian settings during the pandemic and beyond.

Designing a remote-based ECD intervention in Cox's Bazar, Bangladesh

Rohingya refugees in Cox's Bazar, Bangladesh

Since 2012, violence against the minority Muslim population in Myanmar has forced hundreds of thousands of people from their homes; most of these people are from the Rohingya ethnic group, now the world's largest stateless people. In 2017 alone, more than 650,000 Rohingya fled to Bangladesh from Myanmar. More than 1 million Rohingya refugees now live in Bangladesh, in the world's largest refugee camp, located in Cox's Bazar.[8] The scale of the displacement has created dangerously overcrowded refugee camps, where basic services are stretched beyond their limits. Many refugees have been living in the Cox's Bazar camps for at least three years, and it is unclear when they will be able to return to their home country.

Of particular concern are the developmental and educational needs of the children living in the Cox's Bazar camps, who make up 52% of the population[9] and more than 130,000 of whom are 4 years of age or younger.[10]

Identifying a need for ECD programming

Prior to COVID-19, the IRC's education team in Cox's Bazar conducted an assessment of the ECD needs of Rohingya refugees and those living in the surrounding host communities as part of the *Play to Learn* initiative, a collaboration generously funded by the LEGO Foundation and led by Sesame Workshop with the IRC and BRAC as implementing partners. Through focus group discussions (FGDs) with pregnant women, their families and community members, the IRC identified gaps in ECD knowledge related to healthy pregnancy, breastfeeding, basic infant care, vaccination and the value of play.

In the FGDs, families showed some awareness of healthy nutrition practices, but reported lacking the means to follow through on them. For example, though mothers cited milk and eggs as nutritious, they were not always able to procure them because of cost. In general, mothers reported it was a challenge to identify, find and obtain foods that were nutritious and affordable. Pregnant women were aware of the importance of adequate rest and avoiding heavy labor, but had no source of support from family members to alleviate their extensive household workload. The IRC also heard that full childhood vaccination was inconsistent.

In other cases, caregivers based their nutrition practices on misinformation. For example, expectant mothers reported that they were undereating in an attempt to make their babies small to avoid a cesarean section.

And even when caregivers had both accurate information and the means to provide certain kinds of care, engagement was still low. Play with young children was noted as socially acceptable, but with low engagement. The value of play for participants was to keep children calm and quiet, with little understanding of play as a part of early learning.

These gaps in knowledge about nurturing care and the opportunity and means to be able to access such care are not uncommon among parents in general, and can be especially pronounced in humanitarian settings, where parents are navigating the impact of trauma and violence, the disruption of displacement and a lack of essential resources and services.

Based on the FGDs, and additional consultations with government and health officials, the IRC determined there was a need for ECD interventions in Cox's Bazar. As the IRC began planning a service offering, their work was disrupted by the onset of the COVID-19 pandemic.

COVID-19 hits Cox's Bazar, demanding an adapted intervention

After the World Health Organization (WHO) declared COVID-19 a pandemic, governments across the world imposed various restrictions, including lockdowns, the shutdown of non-essential businesses and services and bans on social and recreational activities. In Bangladesh, the government imposed a specialized lockdown on the Cox's Bazar camps, which restricted exit and entry to the area with exceptions for emergency food and medical supplies.

In May 2020, the first COVID-19 case was confirmed in the Cox's Bazar camps, and public health experts warned about the likelihood of rapid spread, given the difficulty of social distancing and quarantining

amidst the camps' high population density, and the shared use of latrines and handwashing facilities by multiple households. As of January 17, 2020, at least 5,720 residents of Cox's Bazar camps and host communities have tested positive for the disease, with 83 deaths reported.

The camps remain unequipped to adequately deal with the pandemic. With only seven testing facilities serving all of the Cox's Bazar camps, the testing capacity is insufficient for the population size. Further, residents continue to congregate in large groups, often without masks, as misinformation about COVID-19 runs rampant in the camps. Movement within the camps by humanitarian relief workers remains restricted, with most relying on trained volunteer residents to educate the public about preventing COVID-19. The Government of Bangladesh frequently bans internet use within the camps, lifting the ban at unexplained times. This intermittent access has made it especially difficult for public health workers to encourage prevention efforts (mask wearing, hand washing) and to combat false rumors about COVID-19.

While some of the camps' lockdowns have been lifted, most non-life saving and life-sustaining in-person services remain shutdown. For example, prior to COVID-19, households in the Cox's Bazar camps were visited regularly by community health workers; those visits are now suspended. Education services were also suspended, with educators deployed to assist in COVID-19 awareness and prevention efforts. With intermittent access to the internet, there are few opportunities for Rohingya refugees to make use of remote services. Operating within these limitations, the IRC—with the assistance of a Bangladeshi human-centered designer—identified a promising modality of supporting caregivers remotely without internet: the delivery of ECD resources through telephone calls, text messages and audio support messages.

Summary of ECD assessment findings during COVID-19

To inform the design of remote ECD programming during COVID-19 in Cox's Bazar, the IRC conducted a survey of pregnant and lactating women and their families living in the camps and the surrounding host communities. The purpose of this assessment was to better understand the impact of COVID-19 on access to ECD services, and to solicit feedback on the proposed intervention design, including the preferred mode and frequency of communication. The assessment would also serve as a baseline in order to compare with endline

SOURCE: Tim Nesmith / International Rescue Committee

results and assess how the IRC's intervention affects key outcomes related to health, nutrition, responsive caregiving, early learning, and safety and protection.

The IRC developed a questionnaire and identified potential participants through outreach to 14 community-based health and nutrition clinics in Cox's Bazar, both in the camps and in the surrounding host communities. A total of 434 women (289 lactating and 145 pregnant) were surveyed. The surveys were conducted over the phone by a team of six enumerators using TAB-based apps (CommCare) and closely supervised and supported by IRC staff, with each survey lasting less than 30 minute on average.

The level of interest in receiving ECD information and services from the IRC was overwhelming: Nearly 100% of women surveyed expressed interest in talking to the IRC, and reported that nearly 90% of their husbands and 70% of their mothers-in-law were also interested in talking to the IRC. The survey identified morning as the best time to reach pregnant and lactating women (nearly 75% preferring this time). In terms of the preferred mode of communication, there was a divergence between respondents living in the camps and those living in host communities: >80% of those living in camps preferred a prerecorded voice call, while >50% of those living in

SOURCE: M Hasan / International Rescue Committee

Key results of the baseline assessment

Pregnant women:

	RESPONDENTS IN CAMPS	RESPONDENTS IN HOST COMMUNITY
# of pregnant women	31	113
% of pregnant women with no delivery plan in place	71%	24%
% of pregnant women who did not understand exclusive breastfeeding	81%	83%

Lactating women:

	RESPONDENTS IN CAMPS	RESPONDENTS IN HOST COMMUNITY
# of lactating women	43	246
% of lactating women who did not practice exclusive breastfeeding	38%	29%
% of lactating women who cited "child's development" as a reason for playing with child	6%	29%

host communities preferred SMS texts. None of the Rohingya participants preferred SMS text. According to the women surveyed, for phone-based communication, mothers and mothers-in-law would overwhelmingly prefer female callers, while husbands would slightly prefer male callers.

In addition to informing the mode and frequency of content delivery, the survey also affirmed key gaps in ECD knowledge (summarized in the table on page 8) that the proposed intervention would aim to fill. The main themes identified were safe birth planning (>70% of pregnant women in the camp did not have a delivery plan in place), breastfeeding (>80% of pregnant women did not have a clear understanding of what exclusive breastfeeding entails), vaccination (>35% of lactating women reported that their mothers-in-law did not encourage child vaccination), and the importance of play in child development.

Finally, the survey measured the impact of COVID-19 on overall perceptions of health and well-being. Almost half of respondents noted negative changes in their health level, and ~20% noted increased levels of stress. Nearly 60% of respondents said their day-to-day routines had changed because of COVID-19, and 40% of those noted having less access to health services as one key change.

Given the results of the assessment, the IRC developed an intervention to fill key knowledge gaps, delivering behaviorally informed nurturing care messages via prerecorded calls, live calls and SMS text messages. This intervention is referred to as *Gindegi Goron*.

CASE STUDY

Pakistan Reading Project

The Pakistan Reading Project (PRP) is a USAID-funded initiative supporting regional and provincial education departments to improve literacy and reading skills of public school children in grades one and two. The project, which began in 2013, has reached more than 1.7 million Pakistani children and trained more than 27,000 Pakistani teachers in reading instruction (as of December 2019).

With the support of the government of Pakistan, PRP leveraged its large network of teachers and families to deliver COVID-19 prevention messaging through various content delivery channels, including PRP's website, WhatsApp channel and weekly newsletters. Those messages reached 47,000 teachers, education officials and community members each week.

PRP signed on with mobile service providers to reach another 5.9 million mobile phone subscribers with its COVID-19 messaging and with information on reading resources for young children. This support included sending out decodable stories to mobile phone subscribers on a weekly basis. A total of 76 stories in five languages have been sent via SMS--each with a web link to download the pictorial version of the book.

For the 47,000 mobile phone subscribers, PRP piloted Interactive Voice Response (IVR) as an automated storytelling system (featuring 88 stories in five languages). With IVR, people with simple mobile devices and landlines could call in and listen to the stories. For users of smartphones, multimedia content was shared on a WhatsApp channel. In total, PRP's IVR number has been accessed more than 70,000 times.

For radio listeners, PRP broadcasted 103 prerecorded radio stories in five Pakistani languages. These stories were produced to entertain as well as educate, incorporating different character voices, music and sound effects. Stories PRP recorded were also posted on the government's education and literacy department's official websites and Facebook pages. This not only helped broaden public access to the stories but also served to develop local ownership of the materials and teaching methodologies.

To make the stories more interactive and involve families of the students, PRP piloted live storytelling sessions titled "Digital Dadi Amaa" (Digital Grandmother) through an audio conferencing system. In all, 13 such sessions were conducted with around 104 children. At the end of each session, a question and answer session was held by the storyteller, where the children who listened to the story with their parents on the phone answered comprehension questions related to the story. PRP, including its COVID-19 response, received the 2020 Literacy Award from the US Library of Congress in honor of its exemplary, innovative and replicable work on ECD in humanitarian settings.

User Profiles

Anowara

Pregnant mother with multiple children, living in host community

Anowara lives in Teknaf, a host community. She is a pregnant 27-year-old mother with three children (ages 3 to 11 years old) and her husband, who is a day laborer. She is able to read Bangla and has some basic knowledge of nutrition. There are several health clinics in her area and she was comfortable seeking services there before COVID-19. Since the pandemic, Anowara doesn't go outside much so as to prevent risk of infection, which worries her a great deal. Her time is mostly occupied by household chores. Her children mostly play with one another, and she does not feel that they need much time from her. The exception is her eldest daughter, whose safety she worries about and who she constantly provides with moral and social education.

About **Mother**

- Lives in Teknaf. Host community
- More than once
- Speaks Chittagonian
- Low nutrition knowledge
- Not breastfeeding
- No disability
- Low digital literacy
- Lives with husband, not in-laws

Infrastructure

- Feature phone shared with husband
- Moderate electricity
- Health clinic within walking distance

Service Delivery Options

- TV
- Shared feature phone

Barriers to overcome

- Moderate network

Ruma

Lactating mother with multiple children, living in Shamlapur Camp

Ruma lives with her husband, two children (ages 2 years and 6 months) and her parents-in-law in Shamlapur Camp. She delivered her baby at home without the aid of a midwife or someone trained in safe delivery. Instead, Ruma's mother-in-law assisted in the birth. Ruma breastfeeds her youngest and gives both her children honey, milk and other snacks. Ruma has not visited the health post since the beginning of the pandemic, as she fears contracting COVID-19. Ruma enjoys smiling at and talking to her baby, but rarely sings or reads to her.

About **Mother**

- Lives in Ukhiya camp
- More than once
- Speaks Rohingya
- No nutrition knowledge
- Breastfeeding
- No disability
- No digital literacy
- Lives with in-laws

Infrastructure

- Feature phone shared with husband
- Solar energy
- No access to health clinic

Service Delivery Options

- No TV
- Shared feature phone

Barriers to overcome

- Moderate network
- Rohingya language

To help foster an understanding of the typical circumstances and experiences of their users, the team created "user profiles" for mothers, fathers and mothers-in-law in both the camps and the host community. The profiles are composites, and were based on common characteristics of those who participated in the baseline assessment. The user profiles featured information on the users' language capabilities, their access to various technologies and potential barriers to service delivery. Some examples of user profiles are included below:

Salamatullah

Husband of a lactating mother with multiple children, living in Ukhiya Camp

Salamatullah, a 28-year-old man, lives with his children (two daughters and a 7-month-old son), his wife, and his mother in Ukhiya camp. He didn't go to school and never visited any health clinics when he lived in Myanmar. He has a day labour job in the camp and has received some basic medicines from the camp clinic. He is pretty satisfied with life here, but is still worried about the future. He tries to help his wife by bringing water and procuring wood for cooking, but the majority of his time is spent searching for livelihood opportunities. When he happens to be home and his 7-month-old son cries, he holds him and walks around the house.

About — **Father**

- Lives in Ukhiya camp
- Daily labor
- No nutrition knowledge
- Breastfeeding
- No disability
- No digital literacy

Infrastructure

- Owns feature phone
- Solar energy
- No access to health clinic

Barriers to overcome

- Poor network
- Rohingya language
- Seldom plays with kids
- Moderate household support

Service Delivery Options

- No TV
- Feature phone

Khadija

Mother-in-law of a lactating woman, living in Jamtoli camp

For the past two years, Khadija has lived with her son and his family in Jamtoli camp. She is 57 years old and spends most of her time supporting her daughter-in-law in taking care of her four grandchildren, one of whom is a newborn. She feels she should make the key decisions regarding their care, given her age and experience. Though the horrors of the past are still chasing her, she feels secure living with her family. She only speaks the Rohingya language, and does not know how to read. When it comes to family meals, Khadija is focused on caloric sustenance rather than balanced nutrition. She loves to recite verses from the Quran and play with her grandkids.

About — **Mother-in-law**

- Lives in Kutupalong camp
- Speaks Rohingya
- No nutrition knowledge
- No disability
- No digital literacy
- Lives with son

Infrastructure

- Using son's feature phone
- Solar energy
- No access to health clinic

Service Delivery Options

- No TV
- Shared feature phone

Barriers to overcome

- Poor network
- Rohingya language

Prototyping and developing *Gindegi Goron*

The IRC partnered with the icddr,b Maternal and Child Health Division to prioritize, plan and draft the content for the audio scripts and SMS and remote capacity strengthening of the facilitation team together with the IRC Bangladesh education team. There were two primary, in-person testing sites, one in the Cox's Bazar camps and one in the host community. Prototyping was conducted by IRC staff in August with eight mothers, supported remotely by a human centered designer.

Before developing the full set of scripts that would form the substance of *Gindegi Goron*, the IRC applied an iterative approach, where various prototypes were tested with small groups of local pregnant and lactating women and then refined based on this feedback. Based on the results of the assessment, the prototypes for the host community included call scripts (in the local Chittagonian dialect) and SMS text messages (in Bangla fonts), while the prototypes for the refugee community included only call scripts (in the Rohingya language) due to literacy barriers noted in the assessment.

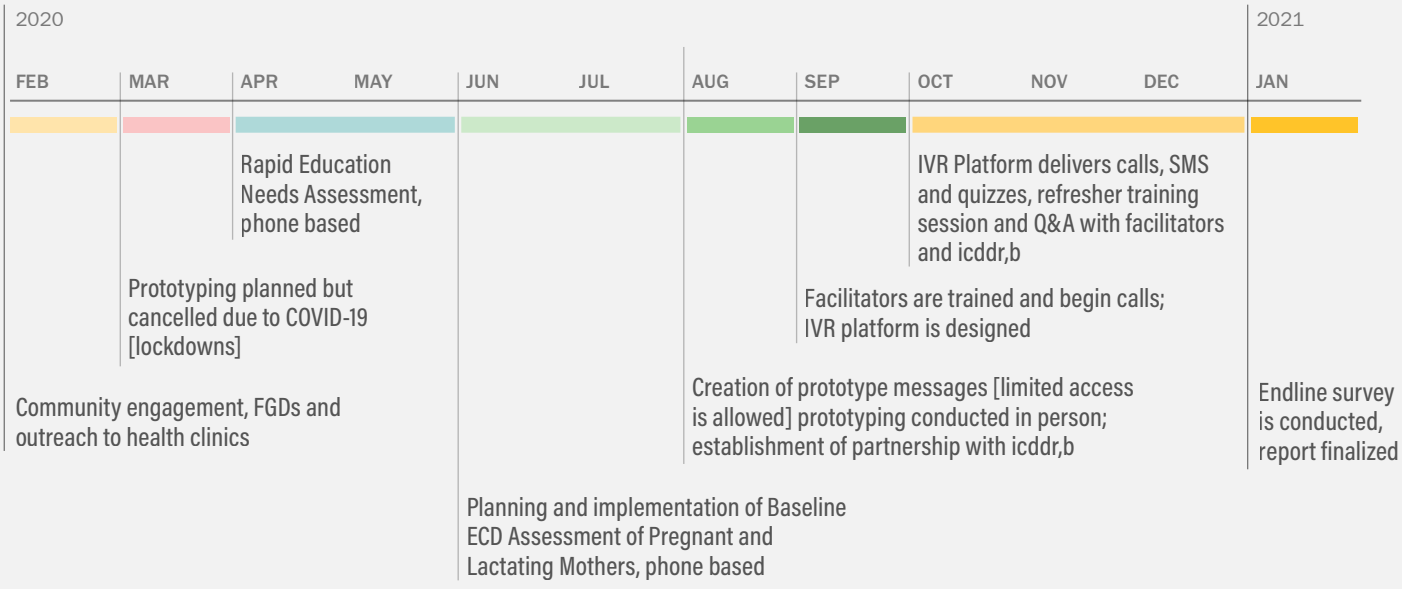
Based on the initial assessment and feedback from prototype testing, icddr,b led in adapting their evidence-based home visiting curriculum[11] to develop call scripts and SMS messages focused on two key groups: for lactating women, there would be a focus on the importance of play, early learning and development, combined with key health and nutrition messaging and how to adapt key caregiving responsibilities during a pandemic; for pregnant women, there would be a focus on the importance of nutrition and rest during pregnancy. Religious references would be woven into the content, after an emphasis from test subjects on the importance of prayer and religion in stress reduction.

For both host and camp communities, messages would be sent to the pregnant and lactating women as well as to their husbands and mothers-in-law. After listening to the audio message prototypes, participants recommended that messaging should also target their husbands and mothers-in-law who often make decisions related to the household, including family nutrition and health. This insight into family decision-making became a key element of the design and approach to promoting behavior change in the household.

Service delivery of *Gindegi Goron*

The IRC delivered *Gindegi Goron* to the same population of households that were part of the initial assessment (434 pregnant and lactating women, and their husbands and mothers-in-law).

Project timeline



SOURCE: Habiba Nowrose / International Rescue Committee

Participants received weekly, prerecorded calls on key ECD topics

WEEKS	PREGNANT WOMEN	LACTATING WOMEN WITH BABY <6 MONTHS OLD	LACTATING WOMEN WITH BABY 7 MONTHS OR OLDER
Week 1	Importance of antenatal care (ANC) check-ups during pregnancy	Importance of immunizations, and adhering to the timeline	The benefits of play and singing songs
Week 2	Nutrition: getting enough iodine	Playing peek-a-boo	Mental health and well-being
Week 3	Nutrition: folic acid and iron	Benefits of breastfeeding baby	Making the home environment safe for crawling and walking babies
Week 4	Nutrition: eating a balanced diet	Benefits of play and singing songs	Introducing complementary foods
Week 5	Avoiding tobacco	Positive interactions with baby during breastfeeding	Peek-a-book with a toy
Week 6	Avoiding un-prescribed medicine	Playing with a soft ball	Playing with blocks and container
Week 7	Mental health and well-being	Mental health and well-being	Healthy, balanced diet
Week 8	Preventing falls and avoiding lifting heavy objects	The benefits of expressing love to your baby	Avoid physical maltreatment
Week 9	Growth and movement in the womb	Methods of breastfeeding	Play with a mirror and baby's reflection
Week 10	Danger signs during pregnancy	Introducing the baby to books	Learning to turn pages of a picture book
Week 11	Gender equity: preparing for a girl child	Breastfeeding challenges: sore nipples	Learning the names of body parts
Week 12	Preparing for safe delivery	Playing with blocks	Making mealtimes fun

In addition to these calls, participants in the host communities also received SMS text messages, which served as truncated reminders of the information contained in the calls. The initiative divided participants and their family members into three main groups: pregnant women, lactating women with babies younger than 6 months, and lactating women with babies 7 months or older. Each of these groups received different messages once a week on 12 different topics spanning: nutrition, breastfeeding, the importance of play, child safety and other key ECD elements. For topics involving play with objects (books, blocks, balls, etc.), the IRC provided a play kit which included these materials for the participants.

In delivering messages on these key topics, the IRC created call and text scripts that were simple and easy to understand, culturally appropriate and empathic. For example, the call script on iodine that went to pregnant women reads:

> *Greetings from IRC. Iodine is a very important mineral for the developing fetus. To get an adequate amount of iodine, you should always use iodized salt. You can check if there's iodine in the salt by mixing it with a few rice grains and a drop of lemon juice. If there is iodine in the salt, it will turn blue. Continue to consume this salt! Salt should be stored away from sunlight and heat and in a closed container, otherwise iodine will vaporize in the air. Iodine is also available in potatoes with the skin on, eggs, milk and seafood. Iodine is the essential nutrient for the healthy brain development of your fetus. Iodine deficiency during pregnancy leads to low IQ and behavior problems in your child. Thanks for listening!*

One call script delivered to lactating women with babies between 0-6 months covered interactions with the baby while breastfeeding:

> *While breastfeeding your baby, the baby's head should be aligned with the baby's body; the ears, shoulders and lower back should form a straight line, facing your breast. You can interact with your baby during breast-feeding. You can look into the child's eyes and sing some songs or recite religious songs for her/him. Call the baby by his/her name, if the baby has a name. Oth-erwise you can call him/her "baby" with a smiling and affectionate face. This will stimulate the baby and help him/her recognize his/her name. Talk and smile at the baby. Respond to all vocalizations. If s/he says "gogogo" you can say "gogogo" back to her/him. Stroke the ba-by's head, forehead, hands and feet gently and talk to him/her. Thanks for listening!*

Facilitator's Handbook

One call script delivered to lactating women with babies between 7-12 months covered reading picture books with the baby:

> *Greetings from IRC. Today we will recommend reading picture books with your baby! Teach him/her to turn pages. S/he might turn several pages at a time, but it is ok and you should be patient. When showing the pictures, point to each picture and say the name of that picture, then show the real thing if possible e.g. show him/her the picture of the rickshaw and then show him/her a real rickshaw. Name each picture and then ask your baby to touch that picture. Help him/her by holding his/her hand if necessary. Make the sounds the vehicles make, for example: car sound peep peep; rickshaw sound tung tung; honda sound bhu bhu etc. Encourage your baby to imitate vehicle sounds and have fun. Praise the baby for looking at the book, pointing at pictures, vocalizing, saying words and/or turning the pages. S/he will learn to speak a lot faster when you talk with him/her about the pictures and will also learn the names of those pictures. Thanks for listening!*

For each message delivered to a pregnant or lactating woman, there was a corresponding message on the same topic delivered to the woman's husband and mother-in-law. In some cases, the messages were slightly modified to address the specific role a husband or mother-in-law should play in maternal and child well-being.

In addition to the weekly prerecorded calls and text messages, participants received biweekly quizzes to reinforce understanding of key elements of ECD knowledge; and biweekly phone call check-ins from trained IRC facilitators, which served as an opportunity for participants to ask questions and share insights, and for the IRC to offer encouragement and support. Participants could request a call back from a facilitator, so none of their own mobile phone airtime was required.

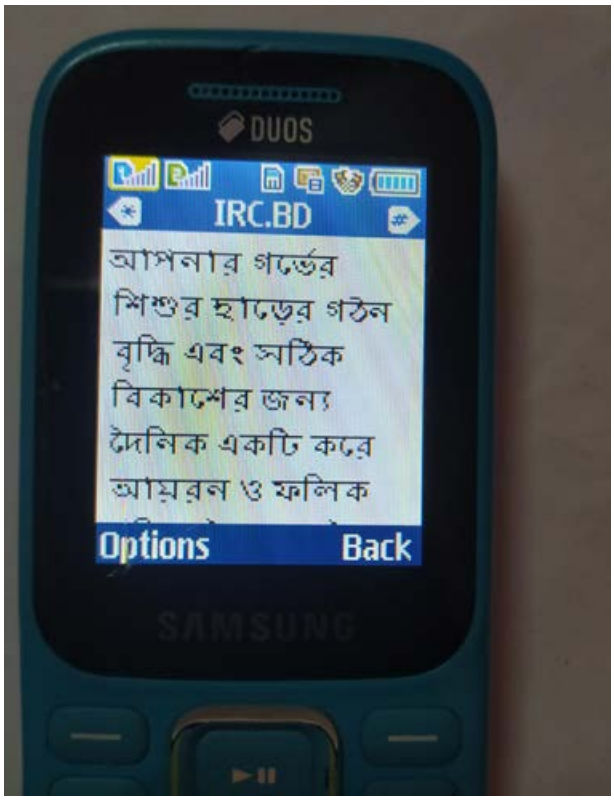
The delivery of *Gindegi Goron* ran from September through December 2020.

Throughout the implementation, the team remotely prototyped a handbook to support facilitators delivering the calls.

In the initial design goals, the IRC identified the need for facilitators to reinforce the automated messages with interactive, supportive communication. Facilitators are a key part of the IRC's nurturing care work, and were especially central to this project, as they were the only major point of IRC contact in this remote delivery model. The design of the IRC's facilitator handbook became especially crucial. It served as a detailed roadmap to develop facilitator knowledge and communication skills and included additional spaces for taking notes. These note sections provided a place for facilitators to document real-time feedback from the users, as well as user questions about nutrition and nurturing care information not included in the guide.

To ensure the material was accessible to facilitators and provided all relevant information, the IRC iterated the guide three different times. The iterations were informed by input from 20 facilitators. During the iterations, the IRC heard from facilitators that the initiative needed to better target the messages to specific milestones of a mother's experience in pregnancy, birth, and post-natal care. In response, the IRC split the messages into three different segments to fit with the stages of a mother's pre- and post-natal journey.

Example of weekly SMS text

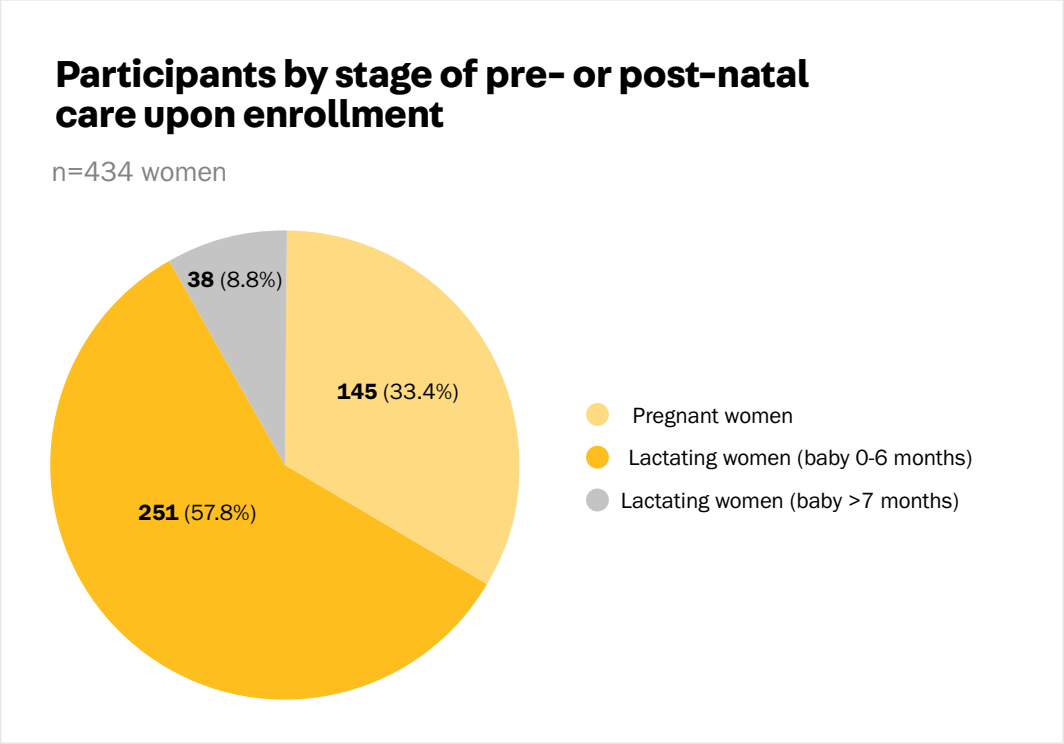


Example of weekly intervention schedule

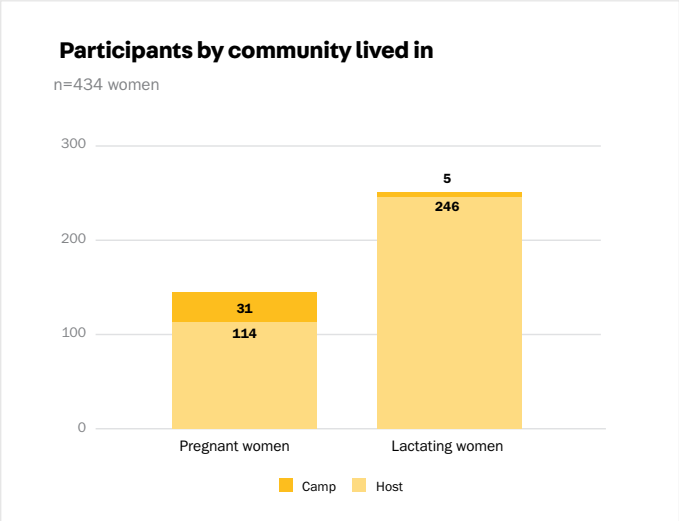
SUNDAY	IVR calls placed with messages for pregnant and lactating women in host community
MONDAY	IVR calls placed with messages for pregnant and lactating women in Rohingya community
TUESDAY	IVR calls placed with messages for husbands and mothers-in-law in both the host and Rohingya community
WEDNESDAY	SMS texts sent to participants in the host community
THURSDAY	IVR quiz (scheduled for every other week for pregnant and lactating women)

SOURCE: Iris Ebert / International Rescue Committee

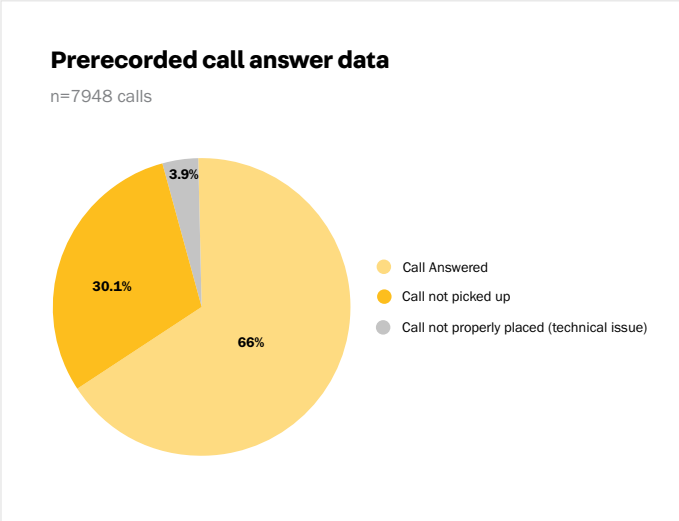
Results from *Gindegi Goron*



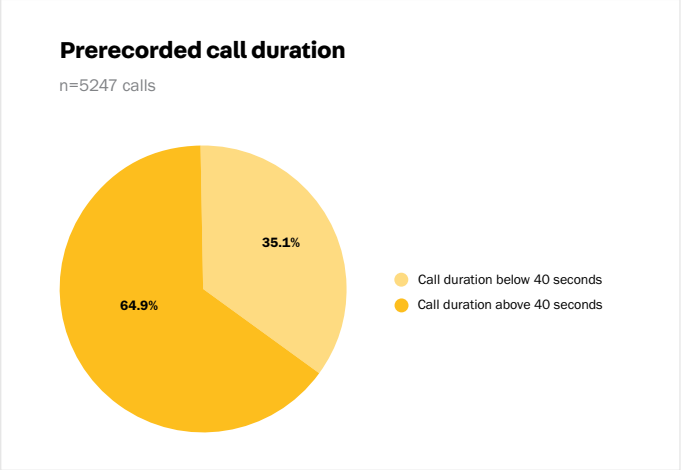
The *Gindegi Goron* Initiative enrolled a total of 434 pregnant and lactating women, their husbands and mothers-in-law (if they lived in the same household).



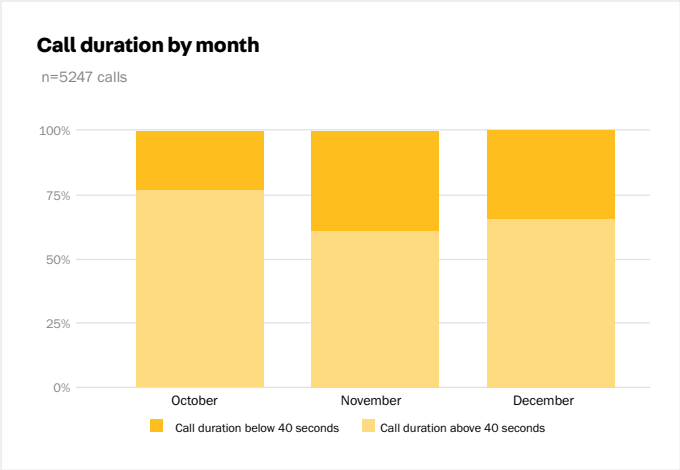
~80% of participants were from host communities, while ~20% of participants lived in camps.



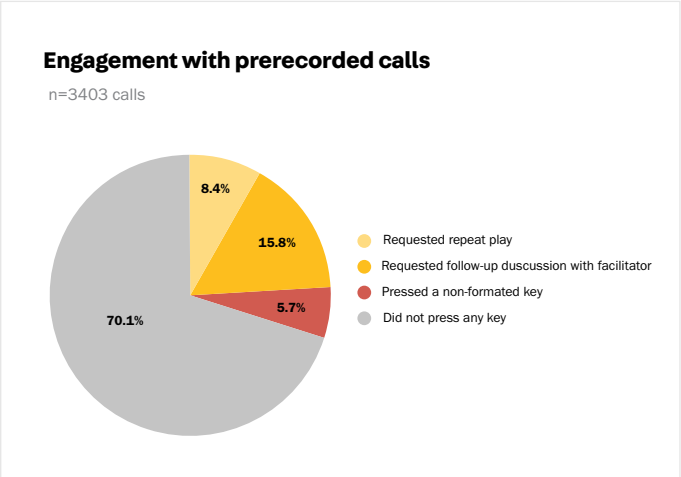
The prerecorded call delivery mechanism was effective in reaching caregivers. Of the nearly 8,000 prerecorded calls placed over the course of the initiative, 66% were answered by program participants, 30% were not picked up, and 4% were not properly placed due to technical difficulties.



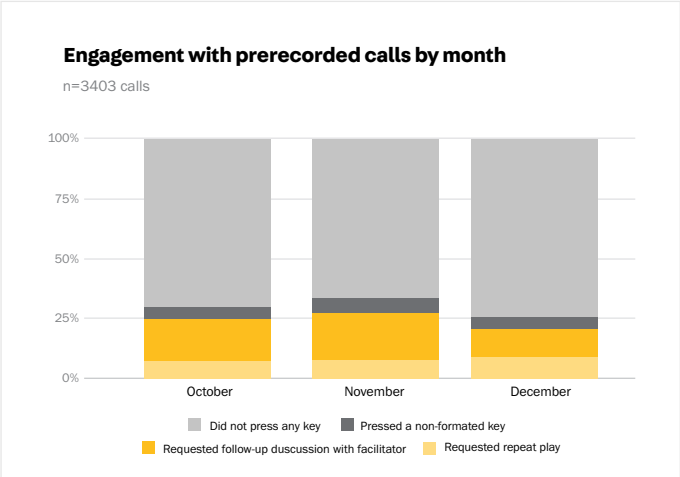
In the instances where the call was answered, the majority of these calls (65%) lasted for more than 40 seconds, which was the standard length of each prerecorded message, and indicates that the caregiver listened to the message in its entirety.



However, the data suggests that fewer answered calls were listened to through completion as time went on (~75% of answered calls were listened through to completion in October, compared to ~60% in November and ~65% in December).



At the end of each prerecorded call, participants could request (via their phone keypads) that the prerecorded message be replayed or that they be connected with a facilitator for a follow-up discussion. In cases where the entire call was listened to and this keypad engagement stage was reached, participants requested a follow-up discussion with an IRC facilitator over 500 times (16%) and requested that the message be played back nearly 300 times (8%).



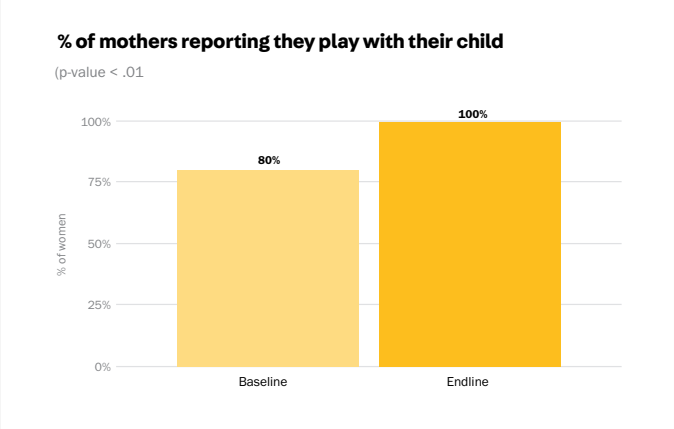
However, data suggests that engagement rates declined slightly over the course of the initiative. Requests for repeat play held relatively constant from month-to-month, but requests for follow-up discussion went from 17-18% frequency in October-November down to 11% frequency in December.

Monitoring and Evaluation Results

To estimate the effects of *Gindegi Goron*, a post-intervention endline assessment was conducted and compared to the baseline assessment. The endline assessment included a random sample of 118 women (camp= 24 women, host community= 94), a sample representing 27% of the baseline group (n=434). For these 118 participants, endline responses were matched to baseline responses to measure changes in parenting behaviors related to key ECD outcomes. Data cleaning, merging and analysis was conducted in R and RStudio statistical packages and included analyses of basic descriptive statistics, including Wilcoxon rank sum tests with continuity correction. Caregiving practices and parenting behaviors at baseline were only collected from mothers with infants (lactating women, n=60), and not pregnant women. Thus, paired tests were used to analyze individual level changes, using the responses from mothers with infants at baseline paired with their responses at endline. As the data were collected as part of a pilot study and not designed to produce results that can be generalized to a broader population, a key limitation is the small sample sizes, which limits the statistical power and our ability to detect differences among sub-groups.

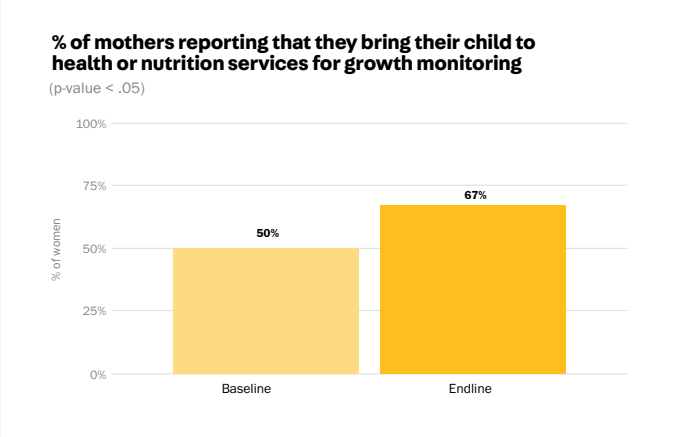
Increase in play activities

While the majority of caregivers with young children reported that they play with their children at baseline (80%, n=48), all of these mothers reported playing with their children at endline (100%, n=60), an increase of 25%, and a statistically significant difference (p-value < .01). When asked about the types of activities, the most common activities at baseline mentioned were talking, smiling and gazing at their child. At endline, in addition to talking, smiling and gazing, 50% of caregivers also mentioned playing with household objects. Others also mentioned playing with blocks and singing.



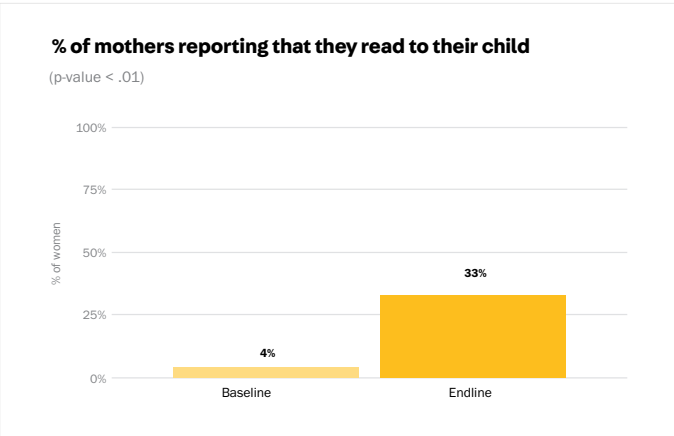
Increase in height and weight tracking

Mothers with infants at baseline were asked if they monitored their child's height and weight at baseline and again at endline. This type of monitoring is conducted at health facilities or nutrition centers, and is accompanied by counseling to support nutrition and healthy growth. At baseline, 50% of mothers (n= 30) reported that they took their child to health or nutrition services for growth monitoring. When the same group of mothers were asked at endline, 67% of mothers (n=40) reported that they brought their child to services for growth monitoring, an increase of 34% (p-value < .05).



Increase in mothers reading to children

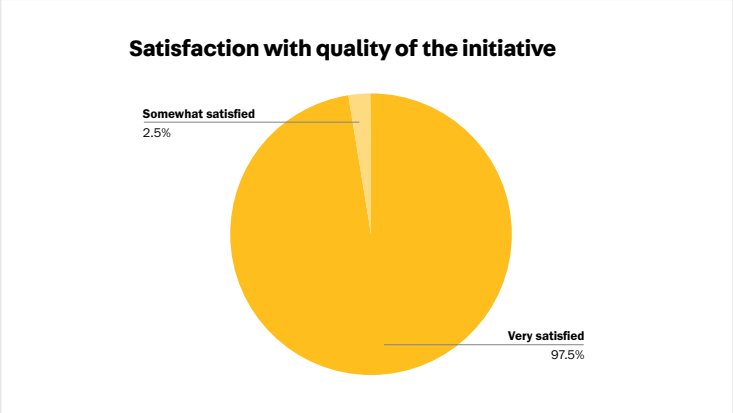
In addition to the play activities mentioned above, there was a statistically significant increase in mothers reporting that they read to their child. At baseline only 4% (n=2) of the mothers with infants reported reading to their child. There was a statistically significant difference at endline (p-value < .01) with 33% of mothers reporting that they read to their child.

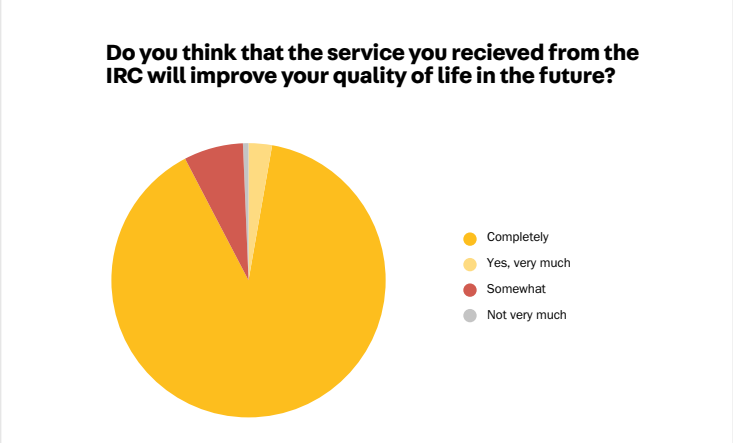


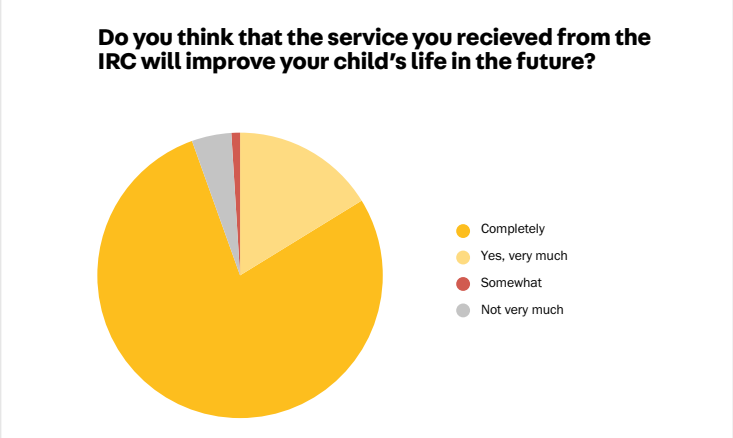
Increase in home births

Though this was not an intended outcome, there was an increase in the frequency of home births from baseline to endline. Among home births across both baseline and endline, traditional birth attendants are the most common support that women receive. Qualitative responses collected in the questionnaire shed light on a possible cause of the increased rates of home births, as participants cited movement restrictions and fear of infection that came with the

> "A few days ago I faced a complication with bleeding during pregnancy. But I received an audio call message earlier that mentioned what I should do in this situation. That's why I visited a clinic, got a consultation from a doctor and now I feel better."







COVID-19 pandemic as reasons why they did not want to visit the clinic.

Improvements in nurturing care behaviors were also reflected in qualitative feedback from participants in *Gindegi Goron*. For example, one of the pregnant women in the host community described how the program's content influenced her decision-making: "A few days ago I faced a complication with bleeding during pregnancy. But I received an audio call message earlier that mentioned what I should do in this situation. That's why I visited a clinic, got a consultation from a doctor and now I feel better."

This qualitative feedback was collected by the program facilitators in the course of their engagement with program participants.

Other results

The baseline-endline surveys also sought to measure caregiver reported timely vaccination, antenatal care visits, use of positive coping skills, specific early learning activities, but no significant changes were seen in these areas. The IRC will continue to examine its intervention model to determine how best to advance these important nurturing care goals.

Participant satisfaction

Those that participated in the endline survey were also asked about their satisfaction with the program. Caregivers saw the value and had a high rate of satisfaction with the program and content. 97% reported that they were "very satisfied" with the quality of the program's content, and with the friendliness and the tone of the program's facilitators.

92% of program participants indicated that the program would improve their quality of life "completely" or "very much" in the future.

95% agreed that the program would improve the quality of their children's lives "completely" or "very much" in the future.

SOURCE: Mohamoud Farah / International Rescue Committee

CASE STUDY

PlayMatters in East Africa

In 2019, the LEGO Foundation awarded a $100 million grant to increase learning through play opportunities for 800,000 pre-primary and primary school aged refugee and host community children in Ethiopia, Uganda and Tanzania. This historic initiative is reimagining learning within the social ecosystems in which children live and learn. Through bringing playful learning experiences into their homes, schools, and communities, the project aims to build children's social, emotional, cognitive, physical, and creative skills to contribute to their long-term well-being. The project, "PlayMatters: Sparking Lifelong Learning Through Play," is led by a consortium of humanitarian relief organizations.†

PlayMatters' interventions were in their nascent stages of development when the COVID-19 pandemic forced school closures around the world, including in East Africa. While ministries of education and other service providers focused on delivering an at-home academic curriculum, PlayMatters prioritized addressing caregiver stress and mitigating learning loss through play-based methodologies that engage the whole family in reading, math, and social and emotional learning (SEL) activities. At the center of the PlayMatters COVID-19 response intervention is a series of paper-based home learning guides: PlayMatters at Home. The guides provide a recommended daily routine, tips for well-being, suggestions for caregivers on storytelling practices, and how to use every day interactions, such as household chores or casual conversation, as learning opportunities.

The IRC has heard from caregiver participants about the impact the program is having on them and their children. Yein is a refugee and early childhood teacher in the Gambella region of Ethiopia, who could no longer teach his class due to COVID-19. He observed the negative impacts of school closure on the children in his community—including his own three children. When he started using the PlayMatters at Home materials with his children, they started practicing the learning games. "My neighbors and other people in the camp are happy and are continuously using the packets to support their children learn in a playful manner," he said. The team also developed a guide for educators on how best to use the PlayMatters learning packet, and how to support personal and community well-being.

Finally, PlayMatters produced PlayMatters at Home Radio Programs, which incorporated activities from the packets and provided health and hygiene messages in a series of broadcasts. Caregivers reported that the tone was friendly and easy to understand and the songs were especially fun and engaging for children.

† Other consortium members include: Plan Børnefonden (Plan), Stichting War Child (WarChild), Innovations for Poverty Action (IPA), and the Behavioral Insights Team (BIT).

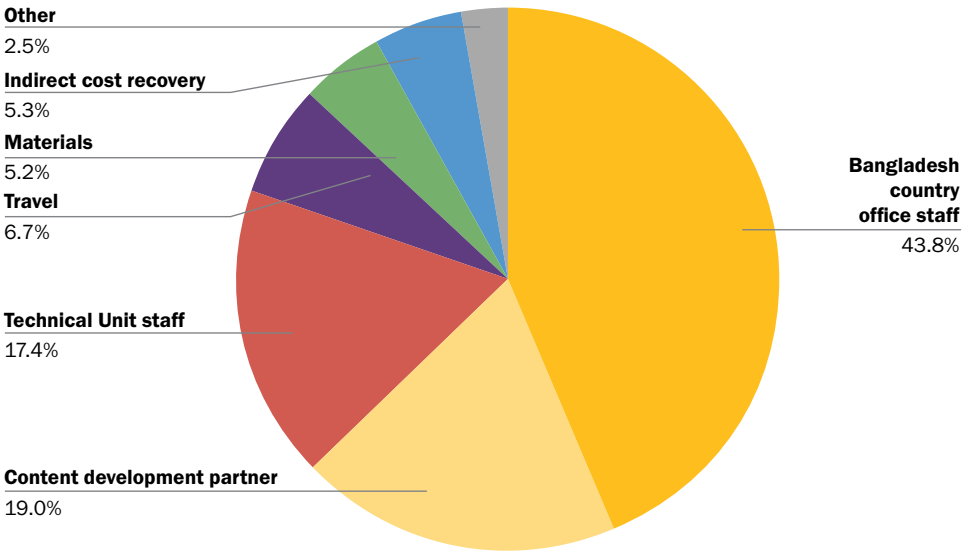
Cost of the initiative

The program activities cost an average of $285 per household in direct costs (or $341 including indirect costs) for the five month intervention.†† This includes both direct and indirect costs, and also accounts for significant one-time startup and initial design expenses. It also includes messaging multiple members of the household. After subtracting start-up costs, technical support and shared costs for office support, the running costs for maintaining key program staff, transportation, training and materials is $165 per household or $33 per household per month. As the program is scaled to more program participants, costs per household would decrease even further. Costs of this pilot phase are broken down in the graph below.

As is typical of nurturing care programs, staff time makes up the largest program expenditure. National staff, including facilitators and on-site researchers, represented 44% of costs; while international staff, including ECD program staff, represented another 17%. An external partner was hired to support content development, representing 19% of total costs. The remaining costs were a combination of program materials (such as books, wooden blocks and soft balls), travel expenses and general overhead. Program materials were intended for distribution, which was later canceled due to a second wave of COVID-19 cases. We intend to distribute these materials when appropriate.

Delivering an intervention remotely offers cost advantages compared to in-person delivery. (Per household, IRC's in-person group parental coaching programs have cost double what the remote *Gindegi Goron* Initiative did.) Without a comparative impact evaluation, we cannot determine which mode of delivery (remote or in-person) is more effective. However, this intervention demonstrates the potential of a remote modality for reaching a large number of people in an acute emergency where access is limited, at a relatively low cost.

Gindegi Goron – Cost Breakdown



†† Costing of the program was conducted using Dioptra, a new inter-agency program costing tool developed by IRC's Best Use of Resources team.

Lessons learned

The implementation and results of the pilot project provided some important lessons learned for the IRC as it works to scale the reach of its *Gindegi Goro*n Initiative.

Outreach to caregivers should extend beyond health clinics

The IRC relied on health clinic rosters to identify pregnant and lactating women for enrollment in this pilot program. While this led to the successful enrollment of households in the pilot project and allowed the IRC to use existing infrastructure to build its pilot project, the IRC recognizes that health clinic rosters, which represent a fraction of camp residents, are not representative of the camp population total as a whole. In order to reach all caregivers in a particular area, the IRC would need to expand the collaborative partnerships.

Reaching caregivers in camps requires more staff time and outreach

Due to the day-to-day stresses of life in the camps and the relative lack of available communication technology (internet, phone), it is harder to reach participants in the camps than in host communities. This was especially true during the pandemic, where in-person outreach was severely limited.

Engagement rates indicate some drop-off might be expected

Engagement rates of the pilot project participants declined slightly each month. The IRC saw a similar trend in its Pakistan Reading Project's COVID-19 response intervention as well, with listener engagement slightly declining over the course of the intervention. In an attempt to solve for this, the team revised its protocol to allow users to dial-in at a time of their convenience to hear stories and messages they previously missed. (For more information on the project, see page 9 of this report.) The IRC's endline survey does not indicate why engagement levels declined slightly as the project progressed, and the IRC will continue to examine the causes of disengagement and strategies to maintain high engagement.

Phone access and literacy limitations impact intervention strategies

Not every caregiver in the camps and host communities has their own dedicated mobile phone, meaning that some households share a mobile phone. This fact made it difficult to ensure the appropriate caregiver received the messages tailored to them. In addition, poor telecommunication networks in the camps made it difficult for Rohingya caregivers to participate consistently.

Phone-based quizzes had low engagement rates, and caregivers often explained to facilitators that the quiz calls were unclear to them. This is another sign that phone literacy is limited that interventions should be designed with this in mind. Facilitators reported that phones were often switched off or unreachable due to network issues, so repeated attempts to reach participants had to be made.

Culturally relevant tools are necessary to maximize results

When interventions are grounded in cultural and contextual realities, they can be highly valued by families and communities experiencing crisis. For example, handmade dolls are often an important element of the IRC's ECD interventions, with various doll-related activities being used as tools for linguistic, social and emotional development. However, dolls were less socially accepted among the program participants in this case. The IRC created play kits including 13 books developed by icddr,b, wooden blocks and a soft ball, but these could not be distributed due to a second wave of COVID infections which prevented all distribution.

Explore integrated messaging techniques to reduce cost

This pilot project offered three separate messaging tracts for three targeted groups: pregnant women, lactating women with babies aged 0-6 months, and lactating women with babies aged 7 months and older. It also addressed programming areas which are critical to both health, nutrition and education sectors. It is critical to explore ways that health and education actors can meet the overlapping needs of mothers and children which leverages both sector expertise to better respond to the interconnected needs of caregiver participants.

Specific, audience-tailored messages were more challenging to implement with IVR

The IVR design was complicated due to the multiple unique groups of participants: mothers in different stages of pregnancy or lactation, fathers/in-laws, and Rohingya/Chittagonian speakers. There was the additional challenge of participants moving from one group to another, for example, when a pregnant woman gave birth. As the program grows and begins enrolling families on a rolling basis, the system will have to track the diversity of participants on a weekly basis, and deliver IVR messages accordingly.

CASE STUDY

Ahlan Simsim in the Middle East Region

Ahlan Simsim, a partnership between Sesame Workshop and the IRC, is the largest ECD intervention in the history of humanitarian response, with the aim of reaching 9.4M children via educational broadcasts and 1.5M children via direct services every year. In 2017, the IRC in partnership with Sesame Workshop won the MacArthur Foundation's first-ever $100 million "100&Change" award to restore hope and possibility for a generation of children in the Syrian response region (Iraq, Jordan, Lebanon and Syria). In December 2018, the LEGO Foundation joined these efforts, awarding an additional $100 million to Sesame Workshop, BRAC and the IRC to bring the power of learning through play to children affected by the Rohingya and Syrian refugee crises.

When the COVID-19 pandemic was declared, the IRC Ahlan Simsim team rapidly adapted its programming and developed new content to meet the need for remote interventions for caregivers and children including a mix of phone call- and digitally-delivered programming. In April 2020, the IRC created and moderated caregiver groups via WhatsApp in Iraq, Syria, Lebanon and Jordan, through which IRC delivered and facilitated conversation covering a series of text, audio and visual content over a two-week period. Content focused on a variety of topics including: COVID-19 prevention measures such as handwashing and social distancing; ECD programming emphasizing the importance of play and sample activities that can be done in the home while schools are closed; and stress management techniques for caregivers and children. Shared content included video clips and episodes from the *Ahlan Simsim* TV show.

Building on feedback from the WhatsApp caregiver group participants (through phone surveys of 1,000 caregivers) the IRC Ahlan Simsim team improved and scaled the next iteration of this digital messaging program for caregivers. As of September 2020, the IRC has reached almost 19,000 caregivers in Lebanon, Jordan, Iraq and Syria through its WhatsApp-delivered programming.

Further, the IRC's Ahlan Simsim team adapted its Reach Up and Learn home visiting program to be effectively delivered over the phone by community health volunteers using scripts targeted to specific age groups, with overwhelming positive response from the caregivers. Lastly, a new phone-delivered school readiness program was co-created by the IRC and the Ministry of Education in Jordan, preparing children for successful entry into grade one and helping their parents/caregivers to support this growth.

Through the work of the Ahlan Simsim team, the IRC was one of the first organizations to provide early learning and development services during COVID-19 to children and their caregivers in the Middle East.

SOURCE: J Wanless / International Rescue Committee

Policy and program recommendations

Based on the results of the pilot project, lessons learned from its implementation, and additional evidence-based best practices in the field of nurturing care interventions in vulnerable populations, the IRC makes the following recommendations to key stakeholders in program funding and delivery:

Increased political will and investment in nurturing care initiatives

- Nurturing care must be embedded in reproductive, maternal and child health, nutrition, education, and protection sector policy and plans among both development and humanitarian authorities.
- Investments should be prioritized to catalyze holistic outcomes as well as the monitoring, evaluation and research. Foreign assistance can be paired with domestic financial commitments, particularly given the limitations imposed by COVID-19.
- Clarify responsibility and accountability for early childhood development in humanitarian settings, given that these types of services are historically underprioritized and underfunded.

Increased integration of nurturing care initiatives across health, education, nutrition and protection sectors

- Interventions must be integrated across health, nutrition, education and protection sectors. This includes leveraging local expertise to identify interventions that meet the diverse and overlapping needs of parents and children.
- Innovative delivery modalities which foster nurturing care should be scaled so that they are available from the very first point of contact with a child and caregiver to ensure no child is left behind.
- Consider which outreach channels provide low-cost and low-contact engagement opportunities with a wide variety of caregivers and activate them for wider use.
- More specifically, integrating a phone and IVR- based nurturing care approach to support pregnant and lactating mothers can deliver targeted engagement with mothers and children everywhere which has applications for families on the move.

Increased monitoring and rigorous evaluation of programs

- Invest in rigorous research, including controlled trials to measure the impact of ECD interventions, as well as implementation research to confirm accuracy.
- Build capacity of community workers capacity to collect, analyze and use data to work cross-sectorally.
- Test the impact of remote interventions against the impact of interventions delivered in-person, allowing stakeholders to assess the cost-benefit tradeoffs of each approach.
- Share cost and impact data in real time, to identify best practices and improve outcomes, with the intent of strengthening planning, policies and services.

Conclusion

While COVID-19 has greatly disrupted access to nurturing care services in humanitarian settings, remote service delivery options provide a viable alternative. *Gindegi Goron* demonstrates that a blended nurturing care intervention of automated and live calls from trained facilitators can be an effective modality to promote nurturing care in humanitarian settings. The promising results from the IRC pilot project suggest that scaling remote nurturing care initiatives is a valuable investment in humanitarian settings, particularly in circumstances where there is little possibility for physical access to highly vulnerable populations.

Endnotes

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2 World Health Organization. "Nurturing care for early childhood development: Linking survive and thrive to transform health and human potential, https://bit.ly/3lnp5Th.

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10 UNHCR, Joint Government of Bangladesh - UNHCR Population Breakdown, October 31, 2020, https://bit.ly/2GXtDBx.

11 Hamadani, J. D., S. N. Huda, F. Khatun, and S. M. Grantham-McGregor. 2006. "Psychosocial Stimulation Improves the Development of Undernourished Children in Rural Bangladesh." Journal of Nutrition 136: 2645–52

SOURCE: Iris Ebert / International Rescue Committee

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