CROSS-COUNTRY LEARNING BRIEF

Studying the "Assuring the Essentials of Optimal Development for Children Affected by HIV and AIDS Project in Kenya and Zambia" 2016–2018

ChildFund® International

OVERVIEW

This brief shares learning from ChildFund International's implementation of the project, "**Assuring the Essentials of Optimal Development for Infants and Young Children Affected by HIV and AIDS in Kenya and Zambia.**"

The project, supported by the Conrad N. Hilton Foundation, was conducted in the two Sub-Saharan African countries from January 2016 to July 2018. The overall aim of the project was for children aged 0-5 years in communities affected by HIV and AIDS to meet their developmental milestones while being supported by responsive male and female caregivers.[1]

In this brief, we present a brief overview of the project and share findings from an evaluation of the project.

BACKGROUND

The Eastern and Southern Africa Region remains the region most affected by the HIV epidemic, with an estimated 18.4 million adults aged 15+ living with HIV, the largest percentage by region.[2] Further, an estimated 6 million children are orphaned due to AIDS. Specifically, in Kenya, an estimated 1.4 million adults (aged 15+) are living with HIV while an estimated 580,000 children are orphaned due to AIDS. In Zambia, an estimated 1.1 million adults (aged 15+) are living with HIV, with an estimated 250,000 children orphaned due to AIDS. In partnership with local government stakeholders, ChildFund worked with local non-governmental organization (NGO) implementing partners, hereafter referred to as local partners, to plan, implement, and manage the "Assuring the Essentials of Optimal Development for Infants and Young Children Affected by HIV and AIDS in Kenya and Zambia" project directly in communities.

Through a community mapping process, mentors who were part of existing leadership structures in the communities were identified and trained by local partners. These mentors, in turn, worked with facilitators who came from existing community groups, known as community support structures (CSSs).

PROJECT-AT-A-GLANCE	
Title	Assuring the Essentials of Optimal Development for Infants and Young Children Affected by HIV and AIDS in Kenya and Zambia
Donor	Conrad N. Hilton Foundation
Locations	Kenya (Kisumu, Siaya, and Nairobi Counties) Zambia (Chibombo and Kafue Districts)
Timeframe	January 2016 – July 2018
Budget	$1.4 million USD
Project Goal	For children aged 0-5 years in communities affected by HIV and AIDS to meet their developmental milestones while being supported by responsive male and female caregivers.
Reach	· 36 mentors were trained (12 in Kenya, 24 in Zambia) · 333 facilitators (189 in Kenya, 144 in Zambia) · 5,876 caregivers (2,691 in Kenya, 3,185 in Zambia) · 8,042 infants and young children aged 0-5 (4,081 in Kenya, 3,961 in Zambia)

With support from ChildFund and local and government partners, CSS mentors were trained on and subsequently trained facilitators to utilize a visual curricula with approximately 17 modules with caregivers during group parenting sessions. Each module included reflective questions, key messages and interactive activities on knowledge and practices across components of Nurturing Care (i.e. health, nutrition, child protection, stimulation/early learning, and responsive caregiving). CSS mentors and facilitators were also trained by ChildFund, local and government partners on an approach to targeting the most vulnerable caregivers and how to utilize the WHO and UNICEF Care for Child Development curricula to conduct home visits with the most vulnerable caregivers, instead of or in some cases, in addition to, participating in group parenting sessions. As per the above, CSS facilitators regularly met with caregivers during group parenting sessions and/or individualized home visits. During these parenting interventions, CSS facilitators and mentors also shared information on and made specific referrals and linkages to caregivers in order to access other social services, such as formal early learning centers, obtaining birth certificates, and accessing health check-ups.

In addition to capacity building, local and government partners, CSS facilitators, and CSS mentors were engaged in cascaded ongoing mentoring support through an approach known as reflective supervision, whereby ChildFund provided monthly reflective mentoring and monitoring to Local Partners who in turn provided monthly individual one-on-one and group mentoring and monitoring of activities to CSS mentors who did the same for CSS facilitators.

Using CSSs as an entry point for parenting sessions was an intentional strategy to draw on the strengths of existing community structures and meet caregivers where they were already gathering. This process provided existing groups and volunteers already conducting home visits, in some cases, with the relevant knowledge, skills, attitudes, and practices on parenting young children instead of creating parallel community structures or services through which to integrate early childhood development (ECD). Also, this process had secondary aims of ensuring caregivers' linkages to social services and creating ownership and sustainability of the program within existing community groups where caregivers would meet beyond the project end date.

Lastly, the project had an intentional aim of strengthening local government stakeholders working on ECD across sectors to integrate ECD into policy, plans, and activities/services. Engaging government stakeholders in capacity building and planning efforts were the intended activities to ensure sustainability of ECD efforts after the project close.

Figure 1 details the counties/districts in Kenya and Zambia where the project was implemented and local partners. Indicators of vulnerability, such as housing type and livelihoods/sources of income, were identified at the local level and used to capture the most vulnerable households in each community, which then received household visits from CSS facilitators.

KENYA		ZAMBIA	
County	**Local Partner**	**District**	**Local Partner**
Kisumu and Siaya	Kisumu Development Program	Chibombo	Chibombo Child Development Agency
Nairobi	Metropolitan Childcare Organization (MCO)	Kafue	Kafue Child Development Agency

Figure 1. Project locations and local partners

HOW WE STUDIED THE PROJECT

A pretest-posttest study design with participant assessments conducted at baseline and endline was used to evaluate the project[3]. The primary goals of the evaluation were to understand the effect of the project on the children's well-being and if and how the group parenting sessions and/or home visits enhanced caregiver competencies to provide responsive and stimulating care for infants and young children aged 0-5. Additional aims were to understand if caregivers' access to ECD services changed over time and if the capacity building and parenting sessions influenced local government and community-based stakeholders' ECD efforts. The evaluation also explored factors that served as facilitators and barriers to the implementation of the project.

Data were collected by both qualitative and quantitative approaches at the start of the project (January 2016) and the end of the project (July 2018). At the beginning of the study, quantitative data were collected through 275 household surveys and qualitative data were collected through focus group discussions with 75 caregivers, 55 CSS staff members, 34 mentors, 28 local partner staff, and 37 government officials. Thirteen ChildFund staff members either participated in an organization discussion or focus group discussion. At the end of the study, quantitative data were collected through 667 household surveys and observations by enumerators and two organizational self-assessment tools completed by local ChildFund offices and local partners. Qualitative data were collected through 12 focus group discussions with caregivers and eight focus group discussions with CSS facilitators, 24 in-depth interviews with caregivers, and 49 key informant interviews with county government officials, mentors, facilitators, ChildFund officials, ECD project officers, and staff from local partners.

KEY TERMS AND CONCEPTS

LOCAL PARTNERS

A non-governmental organization (NGO) that works to meet community needs at a local level in partnership with ChildFund.

COMMUNITY SUPPORT STRUCTURE (CSS)

An existing community group that reaches vulnerable caregivers and children. Includes but is not limited to groups such as Strong Safe Motherhood Action Groups, community anti-AIDS groups, child protection committees, Village Savings and Loan Associations, nutrition circles, and caregiver support groups.

EARLY CHILDHOOD DEVELOPMENT (ECD)

A holistic approach to children's development that considers the physical, socio-emotional, cognitive, and motor development of children from the prenatal stage to age eight.[4]

EARLY STIMULATION

The interaction between young children and their caregivers, providing children with the opportunity to learn about their environment from the earliest age, even before children can respond verbally.[5]

REFLECTIVE SUPERVISION

The process of examining, with another person, the thoughts, feelings, actions[6], and reactions evoked in the course of working closely with young children and their families for the purpose of determining future actions which was the ongoing mentoring and monitoring approach used by ChildFund to support CSS facilitators, mentors, and Local Partners over time.

RESPONSIVE CAREGIVING

Caregiving practices that rely upon prompt responses to a child's behavior that are appropriate to the child's developmental phase, needs, and rights.[7] A responsive caregiver has the skills to provide prompt, safe, and attentive care due to their knowledge of infant and child development, nutrition, health, and early learning/stimulation.[8]

It should be noted that data related to individual children's development and well-being were not collected nor monitored; respondents reported information related to observations of changes in child well-being.

KEY FINDINGS

Analyses of the project's household survey data, focus group discussions, and key informant interviews yielded the following results:

Caregiver and Household Demographics for Participating Families

At endline, there was an average of six people living in each household with an average of two children aged 5 and under. Across all children in the study (N = 1009), 57 were identified as having a special need, such as a hearing, visual, speech, mental, or physical impairment.

Primary caregiver profile

- Ninety-five percent of primary caregivers were female.
- In 84% of households, the mother was the sole primary caregiver.
- Most primary caregivers fell in the 25-35 age range (50%), followed by 36-49 age range (22%) and 18-24 age range (20%).
- The largest percentage of primary caregivers completed upper primary school (43%), followed by some secondary school (24%).
- In terms of literacy, caregivers generally said they could read a little (39%), with fewer reporting being good at reading and enjoying it (26%).

Information on caregiver self-care

- Seventy-two percent of caregivers reported facing challenges in self-care, with the most caregivers (71%) reporting financial strain as being a challenge.
- Other challenges reported included the balance between working and caring for the child, stress resulting from caring for the child, and a lack of services to support caregivers on handling their challenges.

Male and female caregivers valued project services on stimulation and responsive care and reported increased access to ECD-related services.

Caregivers rated project services positively. Caregivers reported being satisfied with their participation in the initiative, with most caregivers providing ratings of "very good" or "excellent" regarding the group facilitator/home visitor (60%), the services and information delivered by the project (60% and 42%, respectively), and how the project assisted the caregiver in finding his/her own solutions to household problems (52%).

Caregivers reported improved access to ECD-related services. Over the course of the project period, progress was made in caregiver access to ECD-related services (see Figure 2).

- At the beginning of the project period, most caregivers reported difficulty in accessing ECD-related services. This ranged from 60% of caregivers reporting difficulty in accessing early learning services to 80% reporting difficulty in accessing nutrition support services.
- At the end of the two years, however, far fewer caregivers reported having problems in accessing these services, ranging from 26% (psychosocial services) to 42% (social welfare services).
- The greatest decrease in access challenges was seen in nutrition support, with 44% fewer caregivers reporting obstacles to accessing these services at the end of the project.

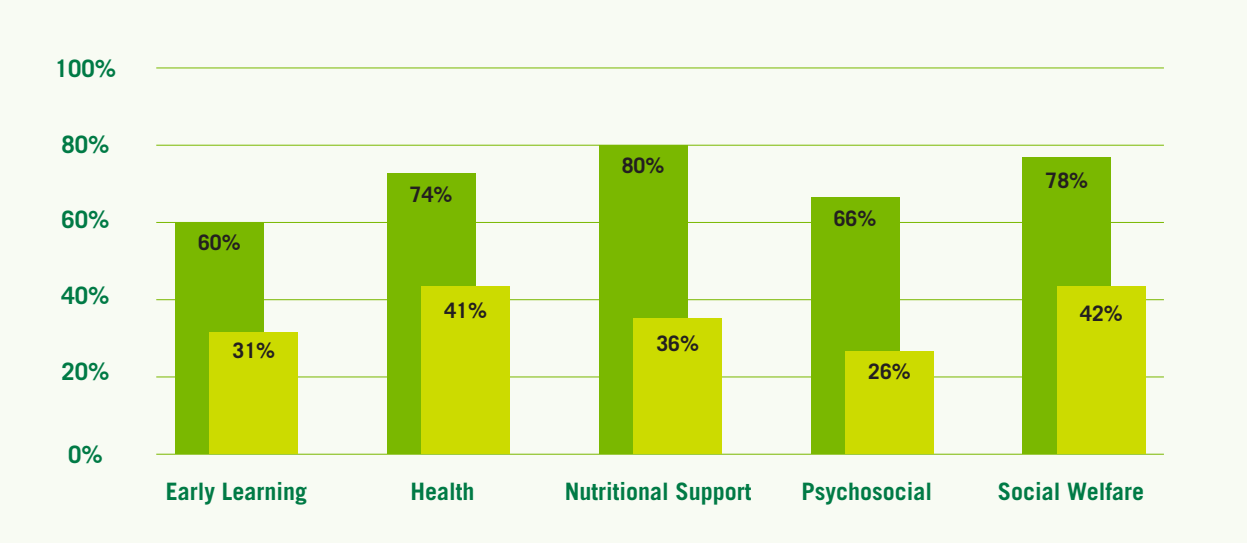

Figure 2. Percentage of caregivers reporting difficulty in accessing ECD-related services, as reported at baseline and at endline.

Barriers still remain in accessing ECD-related services. While some progress was seen in access to ECD-related services, caregivers nonetheless still face difficulties in accessing these services.

- In Zambia, caregivers had more difficulties accessing police/justice, psychosocial, and social welfare services, while caregivers in Kenya had more difficulties accessing health and social welfare services than other ECD-related services.
- Overall, the top barriers to accessing any of the ECD-related services were the service not being available, long distances, and high costs.
    - For example, caregivers in both Zambia and Kenya reported the unavailability of HIV support services and psychosocial services as being a problem. Even if caregivers know they should seek help in managing their HIV status or for any psychosocial issues they may have, they may not be able to because the services simply do not exist.
    - Financial barriers were also particularly troublesome, interfering with the ability of caregivers to transform knowledge into practice. For instance, more caregivers reported high costs as being barriers to accessing early learning services and nutrition support services at endline than at baseline. Caregivers reported that they did not have enough money for uniforms, school fees, and healthy food.

Household well-being levels[9] increased and were linked to ease of accessing services. Although at endline, 86% of households were still found at the two lowest ranks of household well-being, in both countries, household well-being was higher at endline than at baseline (see Figure 3).

- There was a decrease in the percentage of families at the lowest household well-being level ("struggling almost all the time"), from 56% at baseline to 34% at endline.
- Correspondingly, there was an increase in the percentage of families at the next-lowest well-being level ("life is hard, sometimes struggling") from 35% at baseline to 52% at endline, and at the second-highest well-being level ("coping most of the time"), from 8% at baseline to 12% at endline.

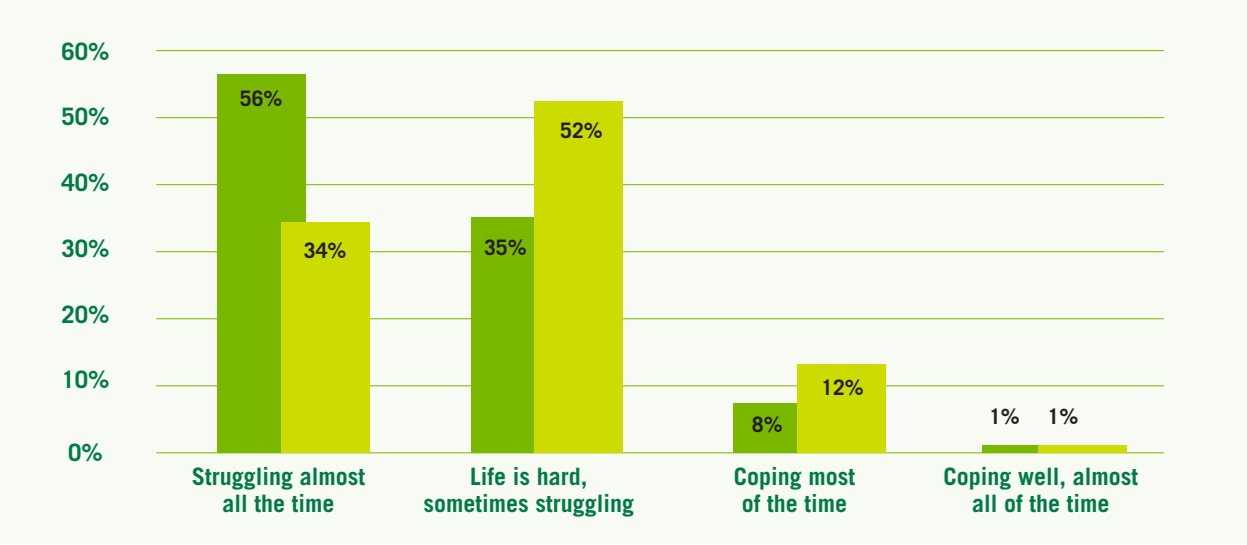

Figure 3. Household well-being levels at baseline and endline.

Positive changes were seen in caregivers' practices, particularly in the areas of play and communication and strengthened positive and protective relationships with their children.

Across all sites in both countries, 92% of caregivers responded that the group parenting sessions/ home visits influenced how they care for their children.

Caregivers reported that play and communication[10], health, and nutrition were the most important topics they learned during group parenting/home visit sessions. Progress was also seen in caregivers' practices over the course of the project period in these areas, among others.

Play and communication. The topic of play and communication was particularly important for caregivers. It was reported most frequently as a topic caregivers learned about and one of the most important topics covered during group parenting and/or home visit sessions. Most parents reported that before the project most of them never bothered to acquire play materials for their children, primarily because they believed play was not important for the child.

- After participating in the project, 93% of caregivers reported providing toys and objects for their children to play with and 91% provided opportunities for their children to interact with others. Fifty-nine percent of caregivers also reported that they played more with their children.

Caregiver relationships with their children. Most caregivers reported they had abandoned negative forms of discipline and adopted positive forms because of this strengthened bond.

- There was a decrease both in physical violence (from 55% at baseline to 28% at endline) and verbal discipline (from 45% at baseline to 12% at endline).
- Seventy-one percent of caregivers at endline reported explaining why something was wrong when a child engaged in negative behaviors, instead of engaging in punitive disciplinary techniques.
- Forty-eight percent of caregivers reported learning about positive discipline from group parenting sessions and 37% from home visits, Sixteen percent also reported learning about such strategies from their parents, demonstrating the importance of and need for widespread education about such topics.

Positive changes in child behavior. Caregivers reported observed positive changes in their children's behavior due to engaging their children in different forms of play and using positive discipline techniques.

> *"I used to have a bad temper, which used to make me spank or beat my children from time to time. But after the training, I'm slowly changing as I have seen the importance of positive discipline."*
>
> **— Caregiver from Zambia**

> *"He doesn't play with things he is not supposed to play with like sharp things. And he talks to me when he is troubled unlike before."*
>
> **— Caregiver**

- Almost all caregivers indicated that children were more creative, disciplined, respectful, happier, and free with their parents and others, implying that children had developed confidence and higher self-esteem.

Observation of child health. Caregivers also reported that engaging with their children in communication and play served an important role in helping them observe their children's health, allowing the caregiver to know whether the child was sick or not.

Local Partners were able to effectively mentor community support structures (CSS)

Local partners were able to successfully mentor community CSS to integrate stimulation and responsive care into programming in coordination with government and social services for children and caregivers affected by HIV and AIDS.

Reflective supervision was an important mechanism in effecting change. CSS facilitators reported that reflective supervision had a major impact on their work. Reflective supervision was seen as a source of motivation, and it encouraged collaboration and teamwork among all members of the group. Keeping facilitators motivated is important in preventing burnout and encouraging investment in the work at hand.

- Facilitators reported that reflective supervision not only helped them improve their own practice but also assisted them in engaging with caregivers who were less than welcoming during the project.
- Facilitators also reported that they listened and observed more and recapped what the caregiver shared/demonstrated, helping them to understand the caregiver better.

Adequate technical support was provided to the local implementing partners. This support enabled effective mentoring and support for volunteer CSS mentors and facilitators.

- Local partners described increased knowledge of child development, while allowed them to have the knowledge and capacity to support mentors and facilitators who were implementing the project at the community level.
- In Kenya, for instance, WhatsApp was used to support local partners and mentors remotely between reflective supervision sessions. This could be an approach ChildFund uses in the future to support local partners and the mentors they work with. This approach could be examined further as a way for government and civil society to support community-level stakeholders that are parenting experts.

Community participation, volunteer engagement, and use of locally available resources encouraged buy-in from the local community and the continued sustainability of the project. Community participation, which is essential in ensuring the long-term impact of any project, was evident at different stages of the current project.

- At the beginning of the project, community members, which included village elders and chiefs in Kenya and headmen in Zambia, were mobilized and given an orientation to the project to make sure they understood what was going on and how they would be involved. Both Kenya and Zambia reported successful community buy-in at this stage. This was key to ensuring community ownership and created a platform for the community to continue with some project components after the end of the project.
- Two other strategies for ensuring lasting impacts were volunteer engagement and using locally available resources.
    - CSS facilitators, who were volunteers elected by community members, lived in and interacted with other community members daily. Even after the project was over, many volunteers reported that they continued to educate the community.
    - The project emphasized using locally available resources to make play materials and locally available food. These strategies contributed to the sustainability of the project and made it possible for such activities to continue even after the project's end.

District/County government partners integrated stimulation and responsive care into health, child protection, and HIV and AIDS services, contributing to the implementation of comprehensive ECD services.

ChildFund and local partners played a critical role in engaging government partners and educating them on the importance of comprehensive ECD services. The project also endeavored to involve relevant local government and departments in both Kenya and Zambia

- In Zambia, these included the departments of education, health, community development, and agriculture, the victims support unit, and the District HIV/AIDS task force, while in Kenya, the departments of health, education, nutrition, and children's services participated in the project. All the departments involved were trained on core concepts of ECD; group parenting and home visiting approaches; and engaged in planning meetings. Almost all the departments had mainstreamed aspects of the ECD parenting content in the government mandated work. For example, officials from the Department of Health and Nutrition in the three Kenyan counties reported that they had integrated components of the group parenting sessions, including play and communication, into health talks they delivered to caregivers.
- The project stimulated the ECD policy debate, especially in Zambia. The first ECD policy in Zambia is currently being developed. While ECD in Zambia used to focus on children 3-5 years, the Ministry of Education broadened its focus to include children 0-3 years. Most of the district government officials interviewed indicated that the project had enlightened them on the importance of ECD and inspired them to contribute to the policy. This will hopefully yield holistic and coordinated ECD being mainstreamed within sector policies and an ECD policy.

IMPLICATIONS

Overall, the picture that emerges from the evaluation of the project is a promising one, with caregivers reporting increased knowledge regarding stimulation and responsive care and other areas of child development. However, despite these gains and other project achievements outlined below, the data suggest there are improvements needed if interventions are expanded to other sites within the countries. Based on the findings, the following approaches are proposed to be integrated in future project design and implementation at a general level.

Enhancements are needed for the contextualized curricula used.

- In this study, caregivers found play and communication to be an important topic but did not consider early stimulation in the same light, though they are closely related. Taking time at the beginning of the study to assess caregivers' understanding of these two concepts would allow the curriculum to be tailored to address these gaps in knowledge and enhance related practices.
- Additionally, child protection is a "newer" concept for many caregivers. Traditionally, parents and community leaders consider protection as having a clean and safe environment instead of preventing violence, neglect, and abuse against infants and young children. Further exploration of how caregivers define and approach child protection would be useful for future parenting initiatives, given hidden protection issues affecting infants and young children.[11]
- Stakeholders expressed the need to utilize home visits to venture beyond emphasizing play and communication. For instance, caregivers indicated they would like to learn more about positive discipline and nutrition. Efforts should also be made to deliver topics such as child protection more systematically, through integrating more messages on preventative child protection into the group and home curricular materials.
- Exploring what other services home visitors have (or lack) the capacity to provide would help caregivers' access to needed services. For example, psychosocial services were needed by caregivers. Thus, exploring options for the provision of community-based psychosocial support through group parenting sessions and home visits could help with caregiver access to this service.
- Curricular materials for group sessions also needs to be better contextualized and their delivery needs to be more standardized. Clear guidelines need to be developed on how many sessions will be delivered; how facilitators will choose which topics to prioritize in their communities; and how to "graduate" caregivers from the parenting interventions over time.

Further streamlining the targeting approach is needed.

- Identify the number of caregivers with children aged 0-5 at project inception through a systematic yet more efficient community mapping process that would also support government improve their data on caregivers and children in geographic coverage areas.
- The above could be done by ensuring future caregiver and young children mapping employs a systematic criteria for better targeting vulnerable groups such as a clear focus on targeting pregnant and adolescent caregivers.

Efforts to strengthen local partners and government multi-sectoral ECD partners' coordination are needed to ensure caregivers are linked to and utilize services such as preventative health and birth registration.

- There were some positive changes in caregiver behavior related to preventative health and birth registration. For instance, there was a 13% increase in children born in primary care facilities and a 9% decrease in children born at home at endline. Additionally, over half of caregivers (58%) reported visiting a health facility immediately when their child became sick and there was an 5% increase in children who had a birth certificate at endline.
- There remains, however, room for improvement to ensure increases in caregiver knowledge translates to more caregivers making changes in access to and utilization of ECD services, such as preventative health and birth registration. This could be accomplished through local partners and government partners across sectors working with community facilitators to better link caregivers to services and follow-up on referrals made.
- Efforts for partners to work closely with sub-national ECD multi-sectoral stakeholders through more frequent planning meetings and joint monitoring visits with the intention of identifying issues with local ECD service provision and problem solving will support strengthening sub-national coordination efforts at the most local, community level.
- ChildFund and partners supporting the development and piloting of individualized messages for caregivers as part of a social behavior change communication campaign to help caregivers remember what they have learned could help reinforce lessons learned and contribute to an increased number caregivers accessing and utilizing ECD social services. These messages could be pulled from the training materials or the caregivers could be engaged to develop their own messages out of their own learning process. Such techniques have been shown to be effective in health-related programs in low-and middle-income countries.[12]

Consider the addition of new programming, such as utilizing the group and home parenting interventions to address caregiver well-being and stress.

- New programming needed is on self-care and caregiver well-being. Even though some of the caregivers had knowledge and skills in stimulation and responsive care, other factors, such as stress due to lack of finances to cover basic needs such as food, were impeding the actual practice of these behaviors. As such, addressing stresses around the financial domain, caring for children, and finding a work-life balance could be topics to address in subsequent interventions.
- Another aspect that could also be added is a peer support/education component of future interventions. Though it was not a planned part of the current project, caregivers in Kenya and Zambia who participated in the project began educating their neighbors on the importance of play and communication and proper nutrition for children. Formalizing this process, perhaps by nominating some caregivers, in addition to the trained facilitators of group and home sessions, to become peer educators could help the project have a larger impact by reaching more community members.

CONCLUSIONS

Calls for continuation of the project were enthusiastic in both Kenya and Zambia. Participants and other stakeholders felt that the project should expand to cover more areas as well as remain in areas where it is already realizing positive changes. The significant changes enhancing the capacity of local partners and local government to work with CSS on ECD at the most local, community level; significant changes in caregivers' knowledge, attitudes, and practices related to play and communication; and local government integrating ECD into their ongoing work suggest the combination of interventions are contributing to building local knowledge on the importance of play and care in the early years, setting children up for success across their life course.

REFERENCES AND ENDNOTES

[1] ChildFund. (2016). *Assuring the essentials of optimal development for children affected by HIV and AIDS Africa Kenya & Zambia*. Final baseline report.

[2] UNAIDS. (2018). *UNAIDS data 2018*. Retrieved from www.unaids.org

[3] The majority of findings and implications presented in the brief come from the endline evaluation.

[4] World Health Organization. (2018). *Early child development*. Retrieved from https://www.who.int/topics/early-child-development/en/

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[8] ChildFund. (2016). *Life stages reference manual.*

[9] There were four categories of household well-being based on indicators of vulnerability including housing type, livelihoods/sources of income, dependency ratio/household size, sanitation and toilet facilities, and local geography.

[10] "Play and communication" was treated as a single topic in the household surveys.

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