ChildFund International

KENYA LEARNING BRIEF

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

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, focusing on those specific to Kenya.

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 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	Kisumu, Siaya, and Nairobi counties
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	· 12 mentors · 189 facilitators · 2,691 caregivers · 4,081 infants and young children aged 0-5

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 and communities in Kenya 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.

KISUMU	
Participants Reached	· 628 *(Caregivers)* · 1180 (*Infants and Young Children 0-5)*
Communities	Buoye, Chiga, Kasule, Manyata, Nyalenda, Nyalunya
Local Partner	Kisumu Development Program (KDP)

SIAYA	
Participants Reached	· 505 *(Caregivers)* · 909 (*Infants and Young Children 0-5)*
Communities	Gondho, Lunjre, Sira, Siandumb, Naya, Yiro East
Local Partner	Kisumu Development Program (KDP)

NAIROBI	
Participants Reached	· 628 *(Caregivers)* · 1180 (*Infants and Young Children 0-5)*
Communities	Cieko, Ghetto, Santon, KwaNgula, Maji Mazuri, Gacagi, Redsoil, Mwihike Kambi Moto, Mandazi Road, Commercial, Fuata Nyayo, Kisii, Marigoini
Local Partner	Metropolitan Childcare Organization (MCO)

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. 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 164 household surveys and qualitative data were collected through focus group discussions with 42 caregivers, 46 CSS staff members, 18 mentors, 19 local partner staff, and 28 government officials. Eight ChildFund staff members either participated in an organization discussion or focus group discussion. At the end of the study, quantitative data were collected through 333 household surveys and observations by enumerators and one organizational self-assessment tools completed by local ChildFund offices and local partners. Qualitative data were collected through four focus group discussions with caregivers and four focus group discussions with CSS facilitators, 16 in-depth interviews with caregivers, and 29 key informant interviews with county government officials, mentors, facilitators, ChildFund officials, ECD project officers, and staff from local partners.

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 TERMS AND CONCEPTS

LOCAL PARTNERS

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

COMMUNITY HEALTH STRATEGY

A community-based approach to healthcare in Kenya, where households and communities take an active role in health and health-related development issues.

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.[3]

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.[4]

REFLECTIVE SUPERVISION

The process of examining, with another person, the thoughts, feelings, actions[5], 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[6]. 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.[7]

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 five people living in each household with an average of one children aged 5 and under. Across all children in the study (N = 477), 27 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 (59%), followed by the 36-49 age range (17%) and 18-24 age range (14%).
- The largest percentage of primary caregivers completed upper primary school (54%), followed by those who completed secondary school (17%).
- In terms of literacy, 44% of caregivers said they were good at reading and enjoyed it, and 30% of caregivers said they could read a little.

Information on caregiver self-care

- Seventy-eight percent of caregivers reported facing challenges in self-care, with most caregivers (78%) reporting financial strain as being a challenge.

- Other challenges included the balance between working and caring for the child (11%), stress resulting from caring for the child (10%), and a lack of services to support caregivers on handling their challenges (9%).
- Fifty-four percent of caregivers reported that they never felt stressed between caring for the child and trying to meet other family/work responsibilities, while 29% responded they sometimes felt stressed.

The majority of caregivers in Kenya participated in group parenting sessions, which has implications for future delivery of interventions.

Sixty-nine per cent of caregivers participated only in group parenting sessions and another 6% participated in both group sessions and home visits.

- On average, caregivers attended 15 group sessions.
- In comparison, caregivers who participated in home visits participated in an average of 10 visits.

Male and female caregivers reported increased access ECD-related services but obstacles still remain.

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 3).

- At the beginning of the project, many caregivers reported difficulty in accessing ECD-related services. This ranged from 32% of caregivers reporting difficulty in accessing psychosocial services to 95% reporting difficulty in accessing health services.
- At the end of the two years, fewer caregivers reported having problems in accessing many of these services, ranging from 8% (nutrition support services) to 43% (health services and social welfare services).

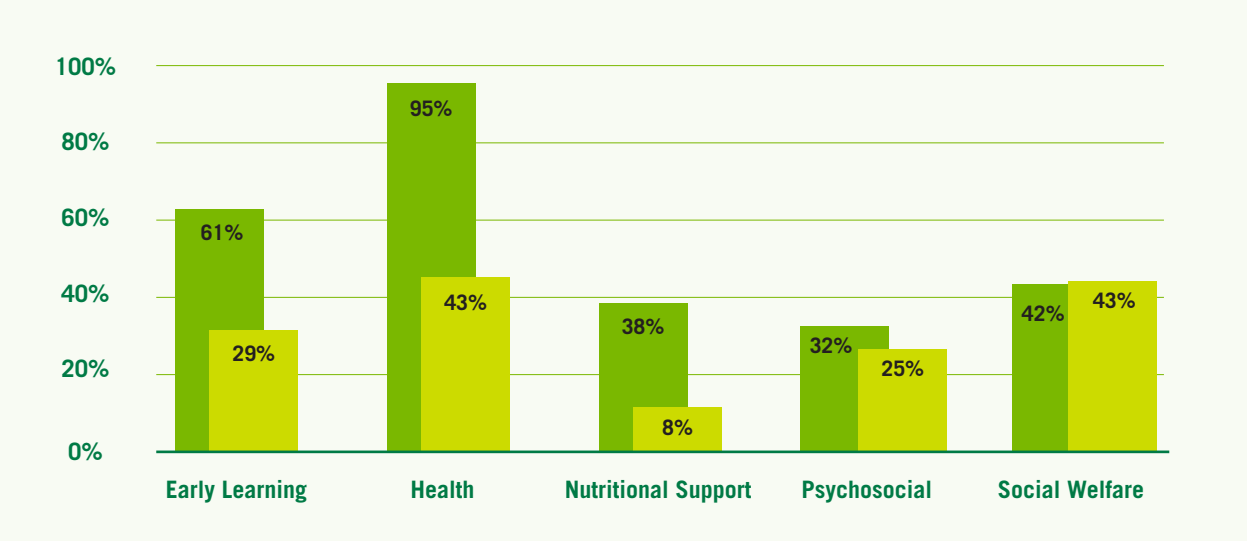

Figure 3. Percentage of caregivers reporting difficulty in accessing ECD-related services, as reported at baseline and at endline.

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.

- There was no change in accessing social welfare services over the course of the project period.
- Caregivers also 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 associated high costs.

Positive changes were seen in caregivers' practices, particularly in strengthened positive and protective relationships with their children

Ninety-one percent of caregivers reported participating in the program influenced how they now care for their children. Of note, 56% of caregivers reported playing more with their child, 46% reported their child now had toys, and 46% reported they spent more time with their child.

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

- Ninety-five percent of caregivers were observed keeping their children in their visual range and also initiating eye contact and smiling.
- Ninety-two percent of caregivers provided toys and objects for their children to play with.
- When children did something considered "good," 92% of caregivers reported praising them, followed by 14% giving gifts.
- When children misbehaved, 70% of caregivers reported that they explained why something was wrong.
- Fifty-two percent of caregivers reporting they learned about positive discipline strategies from group parenting sessions and 16% from home visiting sessions.
- Seventeen percent of caregivers responded that they shook, spanked, or slapped their children and 10% that they pulled their child's ear or pinched their child.

> *"What I gained most from the project was the creation of a good relationship with our children as a result of learning how to correct the children and guide them when they misbehave. I stopped the use of harsh words with them, and I also no longer cane or beat them when they do wrong. After I started practicing this, the children changed and stopped the behavior. Also, I was taught how to make play materials for them from locally available materials, which I practice."*
>
> **— Caregiver from Siaya County**

Positive changes in child behavior. Enumerators observed positive behavior on the part of children due to caregivers engaging their children in different forms of play and using positive discipline techniques.

- Ninety-three percent of children were observed smiling, laughing, and/or playing with the caregiver.

Community support structures were empowered through training and mentorship on responsive parenting.

CSS facilitators reported that they received adequate technical support from the project, including having open channels of communication with fellow CSS facilitators, mentors, and local partner project officers, as well as having access to mentors and project officers when needed.

For instance, Rose Yogo, a mentor and community health volunteer in Siaya County, reported that through her trainings, she was able to "cascade the same [knowledge down] to facilitators working in my area of coverage, and together, we have used the skills acquired to improve parenting practices in the community."

She documented increased participation of male caregivers at local health facilities and that community members had taken a more proactive role in supporting orphans and vulnerable children

Addressing caregivers' challenges through community participation led to sustainable change

Community participation was evident at different stages of the current project.

- In Kenya, the project used the community health strategy structure that was already in place, specifically working with community health volunteers who acted as facilitators and delivered home visits.
- Importantly, CSS facilitators were elected by community members and reported that they continued to educate the community even after the project was over.
- For example, Alloys Owiti, a project mentor in Kisumu East Sub-county, provided reflective supervision to CSS facilitators and also worked closely with the area chief to help caregivers address the obstacles they faced. At the end of the two years, Owiti reported observable changes in his community as a result of the project:
  - Caregivers now understood the importance of delivering their children in health facilities.
  - Breastfeeding practices were more widely understood.
  - Nutrition knowledge and practices had improved.

"As the children [whose caregivers had participated] in the project grow old enough to go to school, they shall be better prepared … and we shall see children who demonstrate better social and emotional behavior, as they are likely to have experienced less … stress from their caregivers."

— Alloys Owiti, Project mentor in Kisumu East Sub-county

- Caregivers had a better understanding of the negative effects of harsh and punitive discipline practices on children's development.

Ethnographic research was conducted and action planning steps were taken to enhance local child protection efforts through strengthening Area Advisory Councils and Local Area Advisory Councils

As part of project activities, an assessment of risk and protective factors for young children was conducted. This included assessing perceptions of child protection and the current status of the community-based child protection system.

- Findings included that more work needed to be done to sensitize communities on core child protection concepts.
- There were a lack of linkages between formal and informal, community-based child protection mechanisms.
- As a result, several activities were implemented under the leadership and guidance of ChildFund Kenya and local partners to support the linkage between community-based child protection mechanisms and one Area Advisory Council in Siaya County. These activities included:
    - Developing an action plan to come up with an organized way to address issues identified by the assessment,
    - Holding reflection meetings with community representatives to assess implementation of the action plan,
    - Reactivating two Local Area Advisory Councils, and
    - Holding trainings on child protection core concepts.

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

Connections were forged with county and sub-county government officials, and early stimulation and responsive caregiving were further integrated into government health and nutrition services at the sub-county and community levels.

- Officials from the Department of Health and Nutrition in the three counties (Kisumu, Siaya, and Nairobi) reported that they had integrated components of the group parenting sessions, including play and communication[8], into health talks and services they delivered to caregivers.
- A health promotion officer from Kisumu East Sub-County worked with the project mentor and a project ECD officer to provide supportive supervision to facilitators. By the end of the project, the Ministry of Health and Sanitation in Kisumu East Sub-County had started offering family planning services and medical supplies through CSS facilitators and community groups.
- The Department of Health also reported that a new government data collection tool had been developed that incorporated aspects of stimulation and responsive care.
    - Even though the government official from the Department of Health interviewed could not specifically attribute the tool's inclusion of stimulation and responsive care to the current project, she reiterated that the component on stimulation and responsive care had not previously existed.
- Officials from the Department of Early Childhood Education also reported that the three counties were now supporting ECD education.
    - They acknowledged that the components of play and communication had previously existed but that they had not been given serious attention.
    - Additionally, the department used to focus on children three years of age or older, but after participating in the current project included children younger than three years in their focal age range.

IMPLICATIONS

Based on the findings, the following approaches are proposed to be integrated in future project design and implementation specific to Kenya.

Enhancing the Contextualized Curricula for Group and Home Parenting Interventions is Needed.

Utilize the baseline assessment to gain a detailed understanding of caregivers' conceptualizations of ECD-related concepts would allow the curriculum to be tailored to better address gaps in knowledge and enhance related practices.

For instance, ethnographic research conducted during the most recent project period found that work was needed to sensitize communities on core child protection concepts. Traditionally, parents and community leaders consider child 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.[9]

Translation of all curricular materials into the local language is needed.

Due to the need for psychosocial support services, community-based psychosocial support facilitation guidance should be developed for facilitators working in group parenting sessions and home visitors. Given that many caregivers report still encountering difficulties in accessing psychosocial support services, providing information for facilitators would help build capacity in this domain.

Additionally, supplemental materials such as a visual aid building on core concepts of ECD could be developed. CSS facilitators sometimes tried to use the small facilitator's guide to conduct additional group sessions when they had already run through topics in the group manual due to increased caregiver interest and conducting more sessions than was required by the project due to demands for additional group parenting.

A strategy for scaling-up services needs to be developed without overburdening existing service providers.

As group parenting sessions were found to be of value to caregivers, guidelines need to be developed on whether and how to create more than one group in communities where demand for caregivers in a group exceeded the recommended number.

This could be accomplished by identifying the scalability of group sessions and home visits and the cost-benefit of each intervention type using various types of service providers. By determining which aspects of the intervention yields the most significant caregiver changes, investments — financial and human resource – can be focused in those areas. A peer education approach could also be considered, where additional caregivers are trained in addition to the CSS mentors and facilitators.

Additionally, given that the majority of caregivers participated in and found value in group parenting sessions, there is the need to improve mapping at the start of the project as well as conduct process evaluation research to identify if and how to take group parenting sessions to scale through existing social services. For instance, parenting sessions could be incorporated as part of growth monitoring and promotion sessions for children and caregivers of infants and young children. For children aged 3 and above, such parenting sessions could be integrated into community-based or government ECD centers where these centers are available.

CONCLUSIONS

Calls for continuation of the project were enthusiastic in Kenya. Beneficiaries 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.

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