

Integrated Early Childhood Development in Zambia

**FIVE-YEAR
PROGRAM REPORT**
2012-2016

Moments That Matter: Strengthening Families So Young Children Thrive



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Episcopal Relief & Development is dedicated to empowering families and communities to strengthen their health, well-being and resilience, with a focus on early childhood development. Working through partnerships with Anglican Communion and ecumenical partners, the agency reaches over 3 million people in nearly 40 countries each year. Its integrated programs address poverty, hunger and disease and respond to disasters. An independent 501(c)(3) organization, Episcopal Relief & Development's work also contributes to the achievement of the Sustainable Development Goals.

The Zambia Anglican Council Outreach Programmes (ZACOP) is the development arm of the Anglican Church in Zambia. Established in 2004, ZACOP works to improve the health and socioeconomic conditions of vulnerable households and communities in collaboration with the Zambian government and other stakeholders. Major program areas are integrated early childhood development, gender and development, and maternal and child health.

The Episcopal Relief & Development and ZACOP Partnership

The organizations have been working together since 2004 leveraging the strengths and permanent presence of faith networks to empower local community development. The ECD Program was developed based on the partnership's successful experiences with asset-based development in rural communities.

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Acronyms

ABCD	Asset-Based Community Development
ADS-Nyanza	Anglican Church of Kenya Development Services of Nyanza
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
CBO	Community-Based Organization
CHW	Community Health Worker
ECD	Early Childhood Development
EP	Essential Package: A Framework to Holistically Address the Needs of Young Children Affected by HIV and AIDS
FAMA	Facts, Association, Meaning and Action
FBO	Faith-based Organization
HIV	Human Immunodeficiency Virus
IYCF	Infant and Young Child Feeding
MCA_s	Malaria Control Agents
MEL	Monitoring, Evaluation and Learning
NGO	Nongovernmental Organization
ORS	Oral Rehydration Salt
PMTCT	Prevention of Mother-to-child Transmission
SBCC	Social & Behavior Change Communication
S&L	Savings & Loan
SwE	Savings with Education
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing for HIV and AIDS
WASH	Water, Sanitation and Hygiene
ZAC	Zambia Anglican Council
ZACOP	Zambia Anglican Council Outreach Programmes

Executive Summary

Moments That Matter: Strengthening Families So Young Children Thrive is a five-year report sharing how the integrated Early Childhood Development Program has sparked transformation in vulnerable children, families and communities in rural Zambia. In the midst of the challenges and stress of poverty exacerbated by HIV/AIDS, communities have organized around their shared goal of helping children thrive.

The ECD Program has developed effective, practical strategies and uncovered key insights into fostering change with primary caregivers to increase their responsive, nurturing care and stimulation with their young children. In the process, communities have played a critical role in providing a stable and supportive environment for children to develop to their full potential.

The Zambia Anglican Council Outreach Programmes and Episcopal Relief & Development have developed and refined this holistic program to engage parents/primary caregivers in vulnerable families. ZACOP implements the program through 53 ECD centers in seven of the 10 Zambian provinces: Central, Copperbelt, Eastern, Luapula, Lusaka, Northern and Southern. The program uses a community-led, volunteer-based approach and leverages the assets of faith networks, which are present even in marginalized rural areas of Zambia. As a result, the program has succeeded in making an impact with vulnerable families in a sustainable, cost-effective way. This program model is well-suited for scaling up and replication by other stakeholders in a variety of settings.

Launched in 2012, the program involves more than 6,000 families, reaching nearly 10,000 young children under 6 years old. At the heart of the program are trained ECD volunteers who facilitate Caregiver Support & Learning Groups and make home visits, using visual guides to lead action-oriented dialogues. The 2016 external evaluation found that the ECD Program has successfully achieved its overall goals to improve young children's healthy development. The goals and their key results:

- **Increase primary caregivers' nurturing care and early stimulation** of their young children
Key results: Women and men caregivers increased the quality and quantity of their interactions with children and increased activities that strengthen children's cognitive, language, motor skills, social and emotional development
- **Strengthen primary caregivers' capacities** so they are healthy and able to respond effectively to children's needs
Key results: Caregivers took actions that improved children's nutrition and health, improved their own health and well-being, and increased their use of available services
- **Empower and equip communities** to manage and sustain ECD activities
Key results: 742 skilled ECD volunteers and 71 active ECD committees are managing activities and developing their own initiatives to sustain and expand ECD programming

The results demonstrate the realization of the program's vision:

***Empowered communities and families are united and caring,
self-reliant, and transforming. . .
so children reach their full developmental potential.***

A. Vision and Program Overview

A shared goal of seeing children thrive has galvanized communities and their leaders around early childhood development. They have spent countless hours volunteering their time, energy and talents to help the most vulnerable families and young children – bringing visible changes and a new spirit of hope as people work together and experience the process of transformation.

The Integrated Early Childhood Development Program (ECD) serves rural communities, where subsistence-farming families struggle with the problems and stress of trying to meet their children’s basic needs. The negative impacts of poverty are further exacerbated by the effects of HIV/ AIDS on many families,¹ with young children suffering disadvantages and having a higher risk of developmental delays. The time between birth and age 5 is a critical, high-impact period for children’s healthy growth and development; investing in parents and children during this time can result in lifelong benefits.² But the science around the multiple interventions that lead to strong early childhood development is better established than the practical applications of effective implementation (see Figure 6, page 8).

Episcopal Relief & Development and the Zambia Anglican Council Outreach Programmes (ZACOP) developed a holistic, family-focused approach to early childhood development. This program built on their long-term partnership and experiences with asset-based development in rural communities. Together they designed a community- led, volunteer-based model to reach vulnerable families and children at scale. The program aims to increase parent/primary caregiver³ nurturing care and early stimulation. It also strengthens families in other critical areas, connecting them to a range of available services – in health, nutrition, food security and livelihoods.

The program engages 6,228 vulnerable families with 9,936 children under age 6. Activities with primary caregivers are facilitated by 742 trained ECD promoters, based in 53 communities in seven provinces. The program began in 2012, with support from the Conrad N. Hilton Foundation, matched by the Margaret A. Cargill Foundation and other donors to Episcopal Relief & Development.

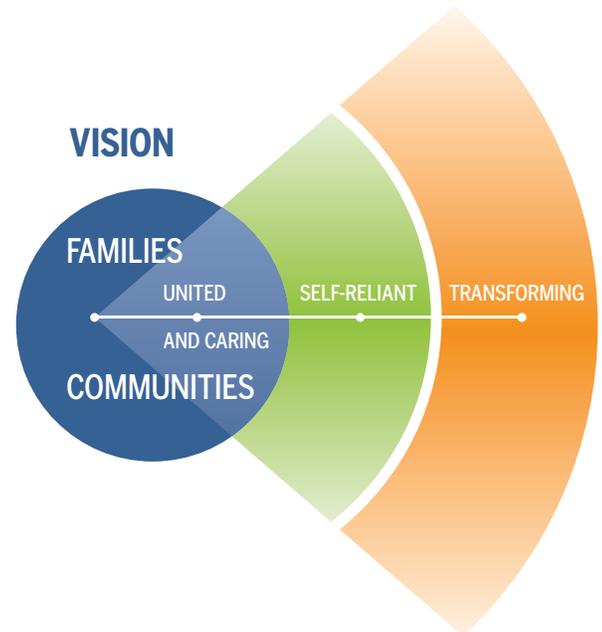


Figure 1. Our Vision: Empowering families and communities so children reach their full potential.

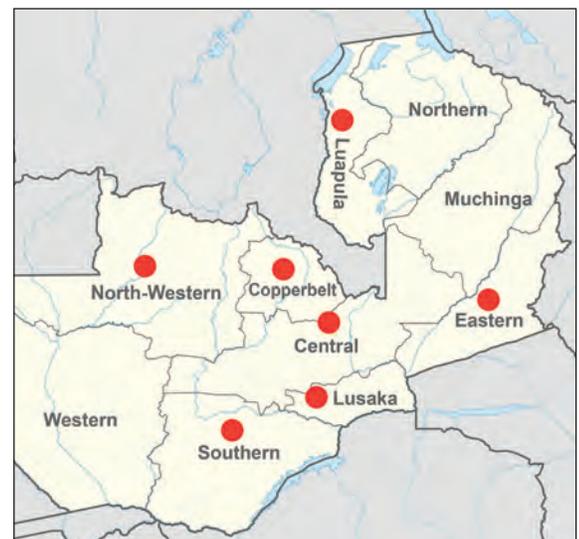


Figure 2. Map of Zambia showing the seven provinces in which the ECD program is active.

¹ Rural poverty rate in Zambia is 80%; HIV prevalence in rural areas is 9%. UNDP. (2016) *Zambia Human Development Report*.

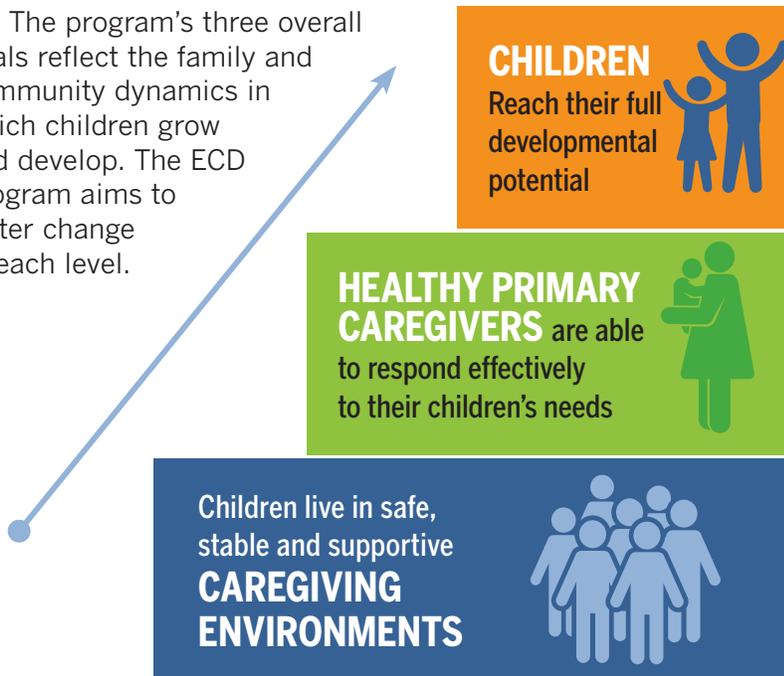
² The Consultative Group on Early Childhood Care and Development. (2013). *A Transformative Solution: Reducing Poverty and Inequality Through a Post-2015 Early Childhood Development Goal*.

³ Primary caregiver is the term used throughout the report for the person who is responsible for the parenting role of the child. The primary caregiver could be a grandparent, other relative, sibling or unrelated adult (“foster” parent).

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B. Goals and Expected Outcomes

The program's three overall goals reflect the family and community dynamics in which children grow and develop. The ECD Program aims to foster change at each level.



Community Outcomes

- **Trained ECD volunteers** effectively facilitate positive parenting practices with primary caregivers and provide support and referrals to broader systems of care.
- **Trained community leaders** are equipped to manage ECD centers and activities through organized committees.

Family and Child Outcomes

The holistic approach to strengthening families so that young children thrive is represented in four family-level objectives and include addressing the special needs of those affected by HIV/AIDS.

1. Strengthen the cognitive, language, social-emotional and motor skills development of vulnerable young children through primary caregiver nurturing care and early stimulation.
2. Improve child health and maternal/primary caregiver health.
3. Improve children's nutrition and family food security.
4. Strengthen family livelihoods and economic well-being.



Primary Caregivers and children in line for growth monitoring

Figure 3.
Children at the Start of Program

9,936
CHILDREN UNDER AGE 6

67%
CHILDREN AGE 0-3

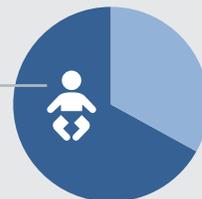
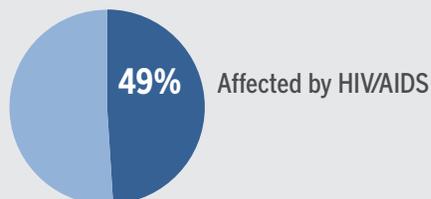


Figure 4.
Reaching Vulnerable Families



Other Vulnerabilities

- Headed by elderly, adolescent, single person or chronically ill (TB, other)
- Malnourishment
- Children with developmental delays or special needs

Chapter 1

Theory of Change

The diagram summarizes how and why the program's goals will be achieved and expected changes will occur in the specific program context. The theory of change is based on the view that (a) the individual is influenced by personal, behavior, social and environmental factors,⁴ and (b) social and individual behavior change require promoting motivating factors for desired changes at individual, family and community levels – and reducing the barriers to reaching them.

MOTIVATING FACTORS

IF communities and their men and women leaders understand ECD and are equipped and organized to take ownership of ECD



THEN communities will create an enabling, supportive environment for children, committing to ECD as the collective responsibility of fathers and mothers and the community as a whole.

IF community volunteers are trained in ECD with practical, visual participatory learning tools



THEN volunteers can facilitate parental skills learning and behavior change with primary caregivers.

IF mothers, fathers and other primary caregivers understand the needs of young children and essential practical parent actions for fostering children's thinking, communication, social-emotional and motor skills development, and good nutrition and health,



THEN primary caregivers will adopt the essential parenting actions for nurturing care and early stimulation, **SINCE** seeing immediate changes in their children will motivate them to continue participating and putting into practice what they learn **SO THAT** children's development and health is improved.

AND IF they have learning opportunities, peer support through group membership combined with individual support by trained ECD volunteers through home visits

AND children's playgroups

REDUCING BARRIERS

IF community leadership takes action to mobilize resources to support ECD,



THEN primary caregivers will be better able to meet their children's basic needs.

AND IF primary caregivers are connected to available services and resources, with opportunities to:

- Improve their health, nutrition and food security, and
- Gain ongoing access to savings & loans through group membership

RESULTS: Children achieve their developmental milestones and reach their full potential.

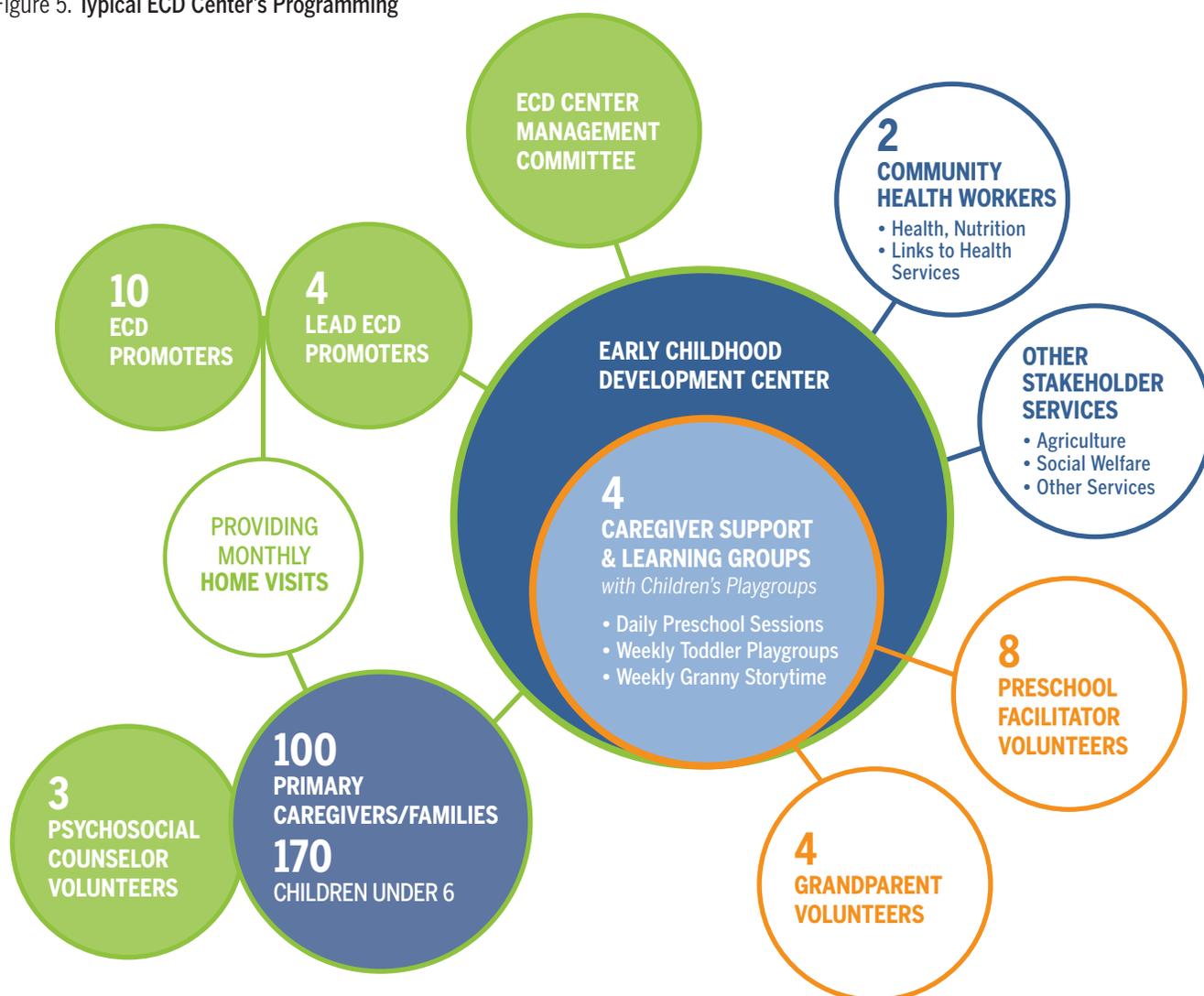
⁴ Social Cognitive Theory. Retrieved from <http://www.med.upenn.edu/hbhe4/part3-ch8-key-constructs.shtml>

Chapter 1

Program Strategies

The primary caregivers participate in the monthly Primary Caregiver Support & Learning Groups facilitated by ECD Promoters, who also make monthly home visits to them. In both group and home settings, ECD Promoters use *The Essential Package: A Framework for Holistically Addressing the Needs of Young Children Affected by HIV and AIDS*.⁵ This is a set of program resources and parenting visual aids appropriate for use by community volunteers. Caregivers are connected to other learning opportunities and resources through the group meetings and activities at the ECD Centers. The ECD Centers serve as a hub for their own community development activities as well as health, nutrition and other services provided by stakeholders. The diagram illustrates the main activities and relationships between program participants and volunteers with the average number of volunteers and participants for a typical ECD Center.

Figure 5. Typical ECD Center's Programming



⁵ Developed by a consortium led by CARE and Save the Children. Retrieved from http://www.care.org/sites/default/files/documents/The_Essential_Package_Holistically_Addressing_the_Needs_of_Young_Vulnerable_Children_and_Their_Caregivers_Affected_by_HIV_and_AIDS_1_0.pdf

Chapter 1

Key Program Dimensions

- **ASSET-BASED COMMUNITY DEVELOPMENT** energizes people and their communities to value their strengths and use existing resources and capacities to catalyze sustainable change and development toward realizing their dreams for the future
- **COMMUNITY-LED PROCESS AND STRUCTURES** engage communities and leaders to work together toward their shared goal of children’s healthy development and to manage local ECD activities
- **TRAINED ECD VOLUNTEERS** work with primary caregivers and children through **Primary Caregiver Support & Learning Groups** combined with **home visits**
- **PARTICIPATORY LEARNING AND SOCIAL & BEHAVIOR CHANGE COMMUNICATION** includes visual aids focused on practical actions with questions to facilitate dialogue
- **NETWORKING AND LINKAGES** allow ECD volunteers to coordinate with stakeholders and service providers to connect families with services and resources to meet needs

While integration is critically needed to empower communities and strengthen vulnerable families, organizations face many challenges to successfully carrying out integrated programs in a manageable, effective and affordable way.

After mapping available services and resources, the integrated ECD program was designed to leverage existing opportunities and fill gaps in a strategic, high-impact way as summarized in the table below, organized by family-level objectives. Another key element in the program’s successful integration was the sequencing of components over a period of 2-3 years, so that staff, volunteers and participants were not overwhelmed with too many trainings and activities simultaneously. The program tested this approach to implementing integrated interventions with the goal of reaching vulnerable families in a cost-effective and sustainable way.

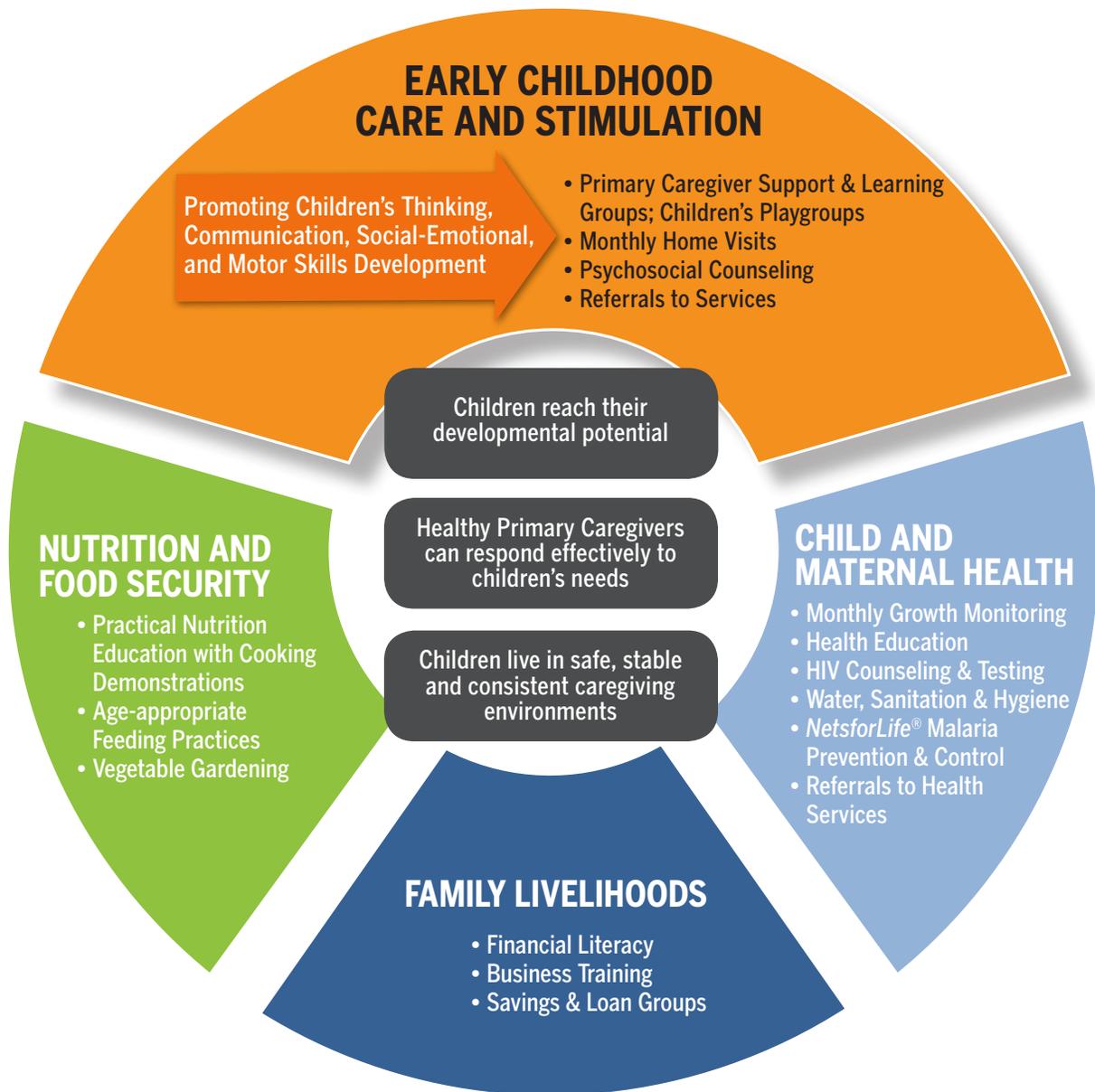
Table 1. The Integrated ECD Program, Leveraging Existing Opportunities

FAMILY AND CHILD OBJECTIVES	PROGRAM TACTIC	STAKEHOLDER/RESOURCES
Early Childhood Development Care & Early Stimulation	Trained ECD Promoters to work with primary caregivers and children Trained Volunteers to provide psychosocial counseling	<i>Essential Package</i> and other ECD Parenting Visual Guides Ministry of Health Counseling Curriculum
Child and Maternal Health	Strengthen family connections to CHWs and health services	Health System: Services and Health Education
Nutrition and Food Security	Link to Nutrition Services and Agriculture Trainers and inputs	CHWs trained in IYCF, Health System, and Ministry of Agriculture
Family Livelihoods	Trained Facilitators help primary caregivers form their own Savings & Loan Groups	Episcopal Relief & Development’s <i>Savings with Education</i> step-by-step manual and education modules

Chapter 1

Figure 6. Integrated Early Childhood Development

The graphic highlights the major activities for each objective. The program's three overall goals reflect the family and community dynamic in which children grow and develop.



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C. Program Results Summary

The ECD Program has evolved over the past five years, realizing its vision and successfully achieving results in each objective. It has also produced additional benefits and unexpected impact. Communities have gone beyond the original plan with their own ideas and collaborative action. This five-year program report, along with the program's external evaluation report⁶, document those results and changes with analysis of how they were achieved. The findings contribute to the evidence base for effective, scalable ECD interventions and project models and the definition of an optimal package for community-led integrated ECD.

Table 2. Program Results Summary

Program Dimension	Highlights of Demonstrated Changes
ECD Promoters	<ul style="list-style-type: none">• Sound knowledge of ECD and Parenting Skills• Capacity to effectively facilitate social and behavior change curriculum with caregivers• Embedded knowledge and skills in community volunteers and caregivers propels wider impact and sustainability
Caregiver Support & Learning Groups and individual Home Visits	<ul style="list-style-type: none">• Primary caregivers participating in both a group and individual home visits with ECD Promoters produced successful learning, peer support and caregiver adoption of improved parenting practices
Primary Caregivers' Parenting Practices	<ul style="list-style-type: none">• Increased caregiver-child interaction in frequency, duration and quality, including fathers• Improved caregiver behavior in responsive care and early stimulation<ul style="list-style-type: none">- Largest increases in activities to foster motor skills, cognitive and language development- Significant increases in activities to foster social and emotional development• Improved skills in positive discipline and psychosocial support
Children 6 and Under – Care, Stimulation and Early Learning	<ul style="list-style-type: none">• Improved cognitive, language, social-emotional and physical development (focus on 0-3 years)• Increased interest in learning and school readiness (focus on 3-6 years)
Parent Capacities to Meet Basic Needs and Access to Services	<ul style="list-style-type: none">• Capacity-building approach contributes to caregiver/family empowerment and sustainable change• Successful collaboration with 9 government ministries and 11 organizations to link families to services and resources
Child and Family Health, Nutrition, Food Security and Livelihoods	<ul style="list-style-type: none">• Improved child health• Increased HIV knowledge, destigmatization, testing and referrals• Improved nutrition and family food security• Increased economic strengthening through savings & loan groups
Community Management and Ownership	<ul style="list-style-type: none">• 53 active ECD Center Management Committees, with 18 Steering Committees who organized and promoted ECD activities• Twelve different volunteer positions; an average of 55 volunteers per community• Community initiatives to set up volunteer-run preschools

⁶ Matafwali, B. & Zingel, M. (2016). *External Evaluation of the Early Childhood Development Program for Children Affected by HIV and AIDS*.

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The ECD Program has successfully mobilized a significant volunteer corps, with twelve different types of volunteers. Program volunteers have shared that they are motivated by their desire to help their vulnerable neighbors and children, contribute to their community, and to learn, develop and use their knowledge and skills. The total of 2,752 active positions is an average of 55 volunteers per ECD Center community.⁷ The ECD Program also collaborates closely with Community Health Workers serving in the 53 communities, who provide health and nutrition services.

Table 3. Average ECD Active Volunteer Positions

TYPE OF VOLUNTEER	NUMBER	% FEMALE	% MALE
Total ECD Promoters	742	55%	45%
Lead ECD Promoters	212	48%	52%
ECD Promoters	530	59%	41%
Preschool Facilitators	424	52%	48%
Grandparent Storytellers	232	64%	36%
Psychosocial Counselors	150	47%	53%
ECD Center Management Committee Members	281	44%	56%
Steering Committee Members	199	29%	71%
WASH Committee Members	220	51%	49%
Savings & Loan Group Facilitators	136	53%	47%
Drama Group Members	91	50%	50%
SBCC Trainers	58	47%	53%
NetsforLife® Malaria Control Agents	219	46%	54%
TOTAL DIRECT PROGRAM VOLUNTEERS	2,752	51%	49%
Community Health Workers Serving ECD Center communities	107	51%	49%

The ECD program has set in motion a virtuous cycle, catalyzing a process for community leaders and members to develop. The adaptive management approach has ensured that the program in each Center is tailored to the local context and priorities. Thus, there are variations among the 53 program sites; however, the major and most common components are presented in this report.

In order to assess both the program's impact and the effectiveness of its strategies, Episcopal Relief & Development and ZACOP contracted external consultants to do quantitative and qualitative research. The consultants conducted baseline and endline surveys with participating primary caregivers, as well as focus group discussions and interviews. ECD Volunteers, program staff and participating stakeholders also participated in the evaluation data collection in November 2016. Results cited in the following sections are drawn from the external evaluation report unless otherwise noted.

⁷ There are fewer than 2,752 people volunteering, since some people serve in more than one position.



Volunteer training and capacity building

THE ECD PROGRAM'S SUCCESS is a result of the commitment and effectiveness of its most important volunteer role – the ECD Promoter. This chapter focuses on the 742 ECD Promoters who work with primary caregivers on parenting – nurturing care and early stimulation – which is the core component of the program. The success and quality of the ECD Promoters' volunteer work is fundamentally determined by the extent to which primary caregivers understand and adopt essential parenting practices in their interactions with their children. The program achieved these parenting outcomes as documented in chapters 3 and 4.

ECD Promoters' Effectiveness Is Also Assessed On:

- **Knowledge:** how well they understand the key ECD messages and essential parent actions that they convey in their interactions with caregivers, both in groups and individually in home visits.
- **Facilitation Skills:** whether ECD Promoters can initiate and lead dialogues with primary caregivers using pictures/visual guides to discuss key messages and how to put parenting actions into practice, both in groups and with individuals during home visits.
- **Quality of Work with Primary Caregivers:** how consistently ECD Promoters follow the Essential Package (EP) tool on home visits and manage caregiver support group meetings using EP and Parenting Skills curricula and visual guides.

Chapter 2

A. Training and Social & Behavior Change Communication Tools

Selection and Responsibilities

The program created a new type of specific community volunteer, the ECD Promoter. The ECD Promoter focuses primarily on positive parenting skills and actions to foster children's cognitive, language, social-emotional and motor skills development. Rather than add this ECD component to the considerable workload of Community Health Workers (CHWs), ECD Promoters complement and reinforce CHWs' health and nutrition work. Program staff collaborated with local leadership in the selection process for ECD Promoters and other program volunteers. Some community members who stepped forward were serving in other volunteer capacities and were willing to take on another position.

Overall, nearly half of ECD Promoters are men (45%). Even though children are traditionally considered the mother's responsibility, some factors that have led more men to volunteer include their traditional status as leaders, their higher education levels (one of the volunteer criteria) or – less positively – their desire for their wives to remain at home rather than out in public. Among men who volunteered, many changed their own attitudes and practices as fathers, recognizing the importance of fathers' active involvement with their young children and realizing that they served as role models for others in their community. In one province, men volunteered because they had more enlightened views, quoting *"it takes the whole village to raise a child."* They explained that the development of their children is not only a matter for women but also for them as parents.

ECD Promoter Responsibilities

- **Facilitate** Primary Caregiver Support & Learning Groups, or Children's Playgroups during group meetings
- **Conduct** Monthly Home Visits to 6-7 Primary Caregivers
- **Make health and other referrals** as needed
- **Prepare** home visit plans and reports
- **Participate** in Volunteer Reflection Meetings and Refresher Trainings

ECD Promoters are not paid for their time and the tangible "incentives" in place are nominal. A small monthly stipend of 75 Zambian kwacha (approximately US\$8) is offered to help defray expenses of their volunteer work, for snacks as they travel for home visits and group meetings and transportation to the monthly

Table 4.

ECD Volunteer Selection Criteria

Living in the same community for five years or more with little possibility of relocation

Basic level of education
(able to read and write)

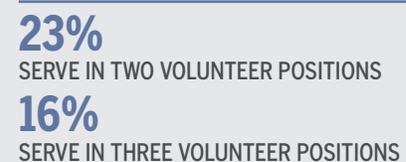
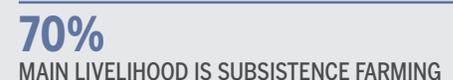
Passionate and willing to contribute to community development through volunteerism

Mature and respected by community members

Able to commit to ECD Program, no conflicts of interests with other organizations

Figure 7.

ECD Promoter Profile



Chapter 2

volunteer reflection meetings held at a central location. In addition to the laminated Visual Guides, the ECD Promoters receive basic job aids to carry out their work – ECD Program T-shirt, backpack, bicycle, rain boots and poncho. The volunteers also receive in-kind contributions from primary caregivers and the participating communities, such as food and labor in their fields to help compensate for the time volunteers spend on program activities.

Training

Episcopal Relief & Development and ZACOP program staff received training first and then provided training to the volunteers. The limited length of time for the trainings, combined with new and sensitive topics such as children's brain development, adult learning, parenting styles and discipline, created a challenge for some training groups. One of the goals was for ECD Promoters to understand the interconnectedness of the knowledge flow from ECD Promoters to caregivers, with a focus on essential parenting actions and how their work relates to improving child developmental outcomes.

The program uses participatory learning, with a focus on using pictures and asking questions. This picture-based, learning-action dialogue promotes behavior change from within individuals', through a discovery, motivation and possibility process. This is more effective for adult learning than traditional lecture-style teaching. Episcopal Relief & Development has found this approach effective with a variety of topics, including child health, gender roles and gender-based violence issues.⁸ It is easy for volunteers with primary level education to learn to facilitate.

The program learning tools emphasize social and behavior change communication, i.e., what actions to take, why and how.

The Parenting Skills Manual and Visual Guide

To increase learning and further improve parent practices, Episcopal Relief & Development and ZACOP staff created tailored parenting skills resources to complement the EP, drawing from several sources.⁹ The Parenting Skills Manual has 12 group sessions, a parent stress assessment and an accompanying visual guide. While the EP guide depicts good parenting practices, the manual also includes pictures of what not to do. The caregiver can compare and contrast, identifying the wrong and right practices. The negative pictures help stimulate deeper discussion and have made it easier to talk about sensitive issues such as corporal punishment.

⁸ Episcopal Relief & Development calls this learning-action dialogue approach FAMA, standing for Facts, Association, Meaning and Action.

⁹ Sources include PATH, ChildFund International, Society for Family Health, UNICEF and HOPE worldwide.



Primary Caregivers learning a new game to play with children

“ This facilitation of adult learning is one of the first things we learned at the workshops. You can't teach adults like children. You cannot stand in front of a caregiver and teach them. You don't know what they have experienced or what they are going through. You need to listen to understand. ”

—ECD Promoter

Table 5.

ECD Promoter Training Courses

Essential Package and Visual Guides (ECD with HIV)	5 days
Parenting Skills and Visual Guide	5 days
Social & Behavior Change Communication	4 days
Drama Skills for Community Development	4 days

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The Essential Package (EP) Visual Guides

The **Essential Package Visual Guides, Critical Needs and Actions for Caregivers of Young Children**, are a set of picture cards illustrating these actions and providing key messages.

- The Caregiver set of pictures illustrates essential actions for caregivers of different types (e.g., mothers, fathers, grandparents, siblings) all of which are important for families affected by HIV/AIDS.
- The Young Children set is organized by age and stage of development. Each picture card has reflection questions on the back, these are used by the ECD volunteer to facilitate dialogue and discussion with primary caregiver around taking these actions, including why the actions help meet children's development needs and what obstacles if any the caregiver faces in adopting the practices. The questions start with: "What do you see happening in this picture?"



Thinking and Communication Key Actions for Children Ages 12-24 Months

- Sing and tell stories
- Provide materials to play with
- Ask children questions about their actions
- Talk to the child; explain what you are doing

B. ECD Knowledge and Facilitation Skills

At program outset, a pre/post-test for the Essential Package had not been developed. The ECD Knowledge Test based on EP training was used in the 2016 evaluation. Results show that the sample of 243 volunteers had a good understanding of ECD basics, with scores from 88% to 99%.

Knowledge was also strong based on the Positive Skills training manual, with ECD Promoters scoring an average of 90%.

With the ECD Program's behavior change focus, Episcopal Relief & Development developed indicators to measure both volunteer knowledge and caregiver behavior in priority areas. ECD Promoters demonstrated high knowledge levels of essential parenting actions for child development, with a range of 82% to 99% able to identify at least two key parenting practices for seven of the eight areas. Only two-thirds could identify two practices for psychosocial support; however, we later learned that psychosocial is a technical term¹⁰ that cannot be translated into the local language.¹⁰

Based on the evaluation findings, the ECD Program staff is developing refresher training on the areas that need strengthening. This training is also done in a participatory manner, with ECD Promoters reflecting and sharing their own perspectives and knowledge with each other.

¹⁰ The evaluation questionnaire used the term "cognitive" development, rather than the Visual Guide term, "thinking" skills; similarly for "psychosocial support" a non-technical term would have been more appropriate.

Figure 8.

ECD Promoter Knowledge of Essential Parenting Actions

Percent of volunteers able to identify at least two parenting actions per area



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While ECD Promoters have a strong understanding of practical actions for each area, they had difficulty explaining the connections and relationships between parenting practices and child developmental progress in focus group discussions. However, this lack of higher-level comprehension or inability to articulate an understanding did not hamper their effective work with caregivers leading to behavior change.

In terms of facilitation skills, ECD Promoters demonstrated a good understanding. For example, 88% correctly affirmed as true the statement that, “A good facilitator does not tell the caregiver what to do, but listens to the caregiver and discusses issues together.” Qualitative findings from evaluation focus group discussions showed that most ECD Promoters were able to describe how they used the visual guides in a participatory way during home visits.

ECD PROMOTER EXPERIENCE

Pathways to Change

Joseph makes home visits 2-3 days per month with the six families he is responsible for. He explains:

When I prepare for my home visits, I need to pay attention to the issues that were discussed last time and other challenges we identified together. It is very important that I prepare the correct visual guide picture cards, because I need to help those households to carry out age-appropriate solutions. Some households have infants, and others have children 3 or 4 years old. Those children have different needs, and I need to be aware of this when preparing my visual guides, which are specific for each age and development area.

After being welcomed by the caregiver, the first thing I do is inspect the surroundings of the home. I look at the cleanliness of sanitary facilities and appropriateness of garbage disposal, and while I do that, I never leave my eyes off the caregiver and the child. I need to observe how they interact with each other – without them feeling observed – and I also need to monitor the appearance of the young chaps.

After Joseph finishes his observation of the caregiving environment, he sits down with the primary caregiver, the child and any secondary caregivers, if they are available. The visual guides he prepared help him to facilitate the discussion with the caregivers, to share pictures and explain problems that require caregivers' attention.



Above: Joseph Chibwabwa
ECD Lead Promoter
Chimoto Copperbelt Province

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C. Achieving Quality Volunteer Work

Since so much of the program's success hinges on volunteers, a comprehensive Volunteer Effectiveness Assessment was carried out in 2015 focused on ECD Promoters. The Assessment examined what was working and what needed to be improved to enhance volunteer effectiveness and strengthen quality, while reducing volunteer burdens and increasing motivation. Program staff shared the findings of this report with ECD Center Management Committees, caregivers and volunteers to get their feedback and perspectives, and to collaborate on developing action plans to solve problems and address emerging priorities. The program plan for 2016 was revised to incorporate needed changes; specific improvements are noted in the following sections.

Supervision and mentoring are critical to effective volunteer work as well as incentives and intangible motivating factors. The program functions well with limited staff overseeing a large volunteer network through the system of community management and use of the Essential Package's practical monitoring tools. A program manager and field officer work primarily with program leadership for each ECD Center – the Steering Committee, ECD Center Management Committee and Lead Promoters. The Committees oversee all the volunteers in their area. Of the 742 ECD Promoters, 212 have a higher-level position called Lead Promoters. The Leads provide direct supervision and support to four or five Promoters. In addition to local procedures for monitoring and quality assurance, program staff members make regular spot checks of home visits and caregiver group meetings.

Lead Promoters meet with ECD Promoters under their supervision on a monthly basis for reflection meetings. At each reflection meeting, the Lead Promoter and the ECD Promoters analyze and discuss their home visits in the past month, guided by the Essential Package Reflection Meeting Reporting Tool. When an issue arises with any one caregiver, the case is discussed as a group and recommendations are made on how to best support the caregiver and the child. Recommendations could include referrals to psychosocial counselors or health specialists. Periodically, program staff members facilitate refresher trainings at the meetings.

Results and Learning

The changes in behavior and health of primary caregivers and participating children demonstrate the overall quality of the ECD Promoters. The program has successfully retained and motivated volunteers, indicating that the basic system in place works well. The program-wide volunteer dropout rate stands at 2.5%, primarily due to relocation, need to focus on livelihoods (farming or small-scale businesses) and death. There were very few cases of volunteers leaving to work in an NGO project that paid a stipend for the time worked. Volunteers who left have been replaced from the reserves list kept at the project sites.



ECD Promoter sharing a parenting action picture with caregiver during a home visit

“ Our expectations [as volunteers] have been met mainly due to the changes we have observed in caregivers and how these positive behaviors have improved the caregivers' and their children's lives – as they are healthier, children have improved their social interaction with other children and adults and are able to count and write. ”

—ECD Promoter

ACTIVITY TOTALS

142,826

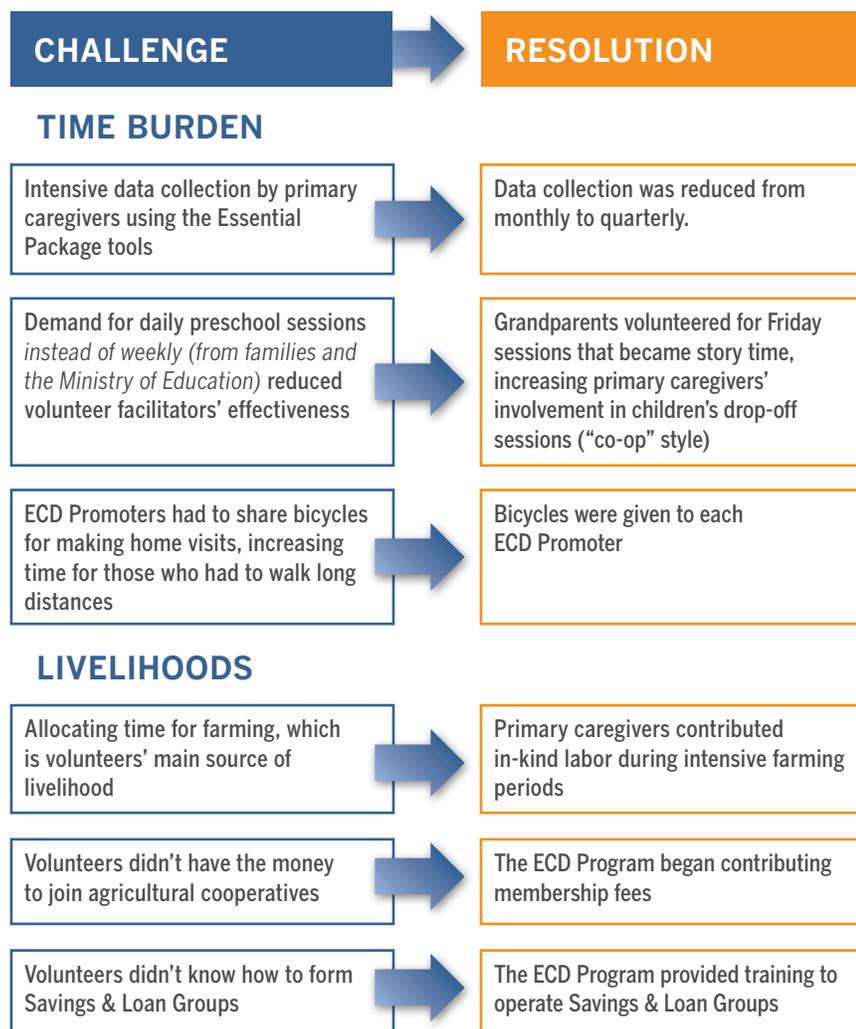
HOME VISITS

8,904

CAREGIVER GROUP MEETINGS

Chapter 2

Challenges and Steps Taken Toward Resolution



ECD PROMOTERS Share What Motivates Them

- Helping people in the community
- The response from the caregivers and children
- Seeing positive changes that caregivers make in their homes
- Learning new things in every interaction with caregivers and children
- It's uplifting when children "address me as teacher"
- Being a role model by "practicing what we are teaching"
- Being knowledgeable and able to share information in the community
- Having knowledge and being regarded as a change agent
- Recognition in the community

“ I learned to read and write as a child, but never had a chance to use it; now neighbors see that I have those skills and am putting them to good use in my volunteer work. ”

—ECD Promoter



232

GRANDPARENT VOLUNTEERS FOR FRIDAY STORY TIMES



954

MEMBERS IN AGRICULTURE COOPERATIVES

63

VOLUNTEER SAVINGS & LOANS GROUPS FORMED



ECD Promoter and children dancing during preschool session

A. Increased Practice of Care and Early Stimulation

Challenges

In rural communities, most families rely on subsistence farming for their livelihoods. They contend daily with arduous farm labor, long walks to fetch water and firewood, and other struggles to provide for their children's basic needs. Young children often are left at home with nothing to do, unattended by a responsible adult or they are taken along to the fields.

For the participating families affected by HIV/AIDS, already scarce resources are further strained by taking care of sick persons or additional orphaned children joining their households. In some situations, an ill parent cannot work or a grandmother serves as the primary caregiver and may lack the energy to care for young children.

Families affected by poverty and HIV/AIDS have a higher risk of psychosocial problems. Caregivers' poor health and/or their feelings of uncertainty or hopelessness can lead to child neglect and unresponsive parenting. Studies show that caregivers' depression is associated with reduced levels of cognitive function and high levels of behavioral problems in their children.¹¹

The value of care and early stimulation in a child's development – through simple activities such as storytelling, drawing in the dirt with sticks and counting games – is not typically known or understood in these communities. Low levels of literacy among adults in rural areas further complicate the educational process with mothers and other primary caregivers.

At the program's inception, Episcopal Relief & Development



Babies go along for the ride as their mothers collect water and do other chores

Primary Caregiver Parenting Practices Before Program Participation

- **High practice of basic social and emotional development activities:** almost 75% of primary caregivers engaged in some of these practices
- **Low practice of cognitive, language and motor skills¹² development activities:** less than 50% of primary caregivers carried out these types of activities

Primary Caregiver Education Levels

56%
LITERATE
(IN LOCAL LANGUAGE, NOT ENGLISH)

¹¹ Walker and Wachs, 2007–2016 External Evaluation

¹² The program materials and communication with primary caregivers use less technical language: thinking (for cognitive), communication (for language) and physical (for motor skills).

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developed indicators based on the parenting practices in the Essential Package. The baseline study findings of primary caregivers' practices by area were not surprising: Nurture is a typical part of basic parenting, whereas early stimulation is not necessarily understood.

The program strategy is to empower and equip primary caregivers with parenting knowledge, skills and practical actions as well as provide peer support and access to counseling. The home visits and monthly Caregiver Support and Learning Groups provide a mutually supportive process that leads to increased motivation in primary caregivers and their adoption of key parenting practices. Their participation also leads to gains in self-esteem and confidence as parents/primary caregivers. Emotional support is critical to reducing the stress they experience and building their confidence. This support has been especially valuable for adolescent mothers to connect with and be mentored by grandmothers. Trained volunteer counselors meet with caregivers privately by request or through referral by ECD Promoters.

During the caregiver support group meetings, some ECD Promoters lead separate toddler and preschool playgroups to foster development, socialization and early learning. This takes advantage of the opportunity to engage the children who were brought with their caregivers, while also enabling caregivers to concentrate on their own activities.

Starting in 2015, with a gradual roll-out, the caregiver groups have had the option to form a member-run Savings & Loan Group. The Savings & Loan Groups are part of the strengthening livelihoods objective on page 36. By integrating savings groups in the caregiver groups, members meet as a group more frequently – on a weekly basis. The caregivers allot one monthly session for parenting education; during the sessions, they share experiences and challenges they face as parents and provide support to each other.

In 2017, the ECD Program is transitioning the 212 caregiver groups to member-led groups. Then the ECD Promoters can start working with new families in the same or neighboring communities and form new caregiver groups.

Results

Primary Caregiver Outcomes

For the following sections on interaction and child developmental areas, the evaluation assessed primary caregiver adoption of key practices. The evaluation asked participants to self-report and compare their behavior from before the program started with that of two to four years later.¹³ Since most of the participating families have more than one child under 6, the indicator was

¹³ For participants in Phase 1 of the program, which started in 2012, there was a four-year timeframe between baseline and evaluation. For participants in Phase 2, which started in 2014, there was a two-year period.



Mother playing with her daughter at the ECD Center playground

“ Before, my child was just there with me, but I didn't pay attention to her. When she cried, I let her cry, or I told her to shut up. Now, I interact differently with my child. I look in her eyes and make faces and sounds, and my baby smiles at me. ”

—Primary Caregiver

Figure 9.

Primary Caregivers by Gender

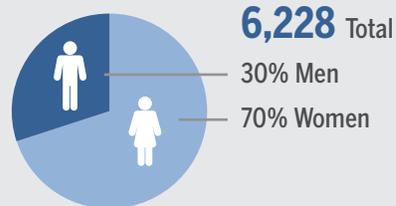
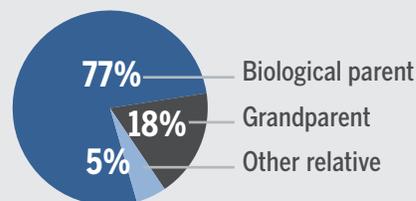


Figure 10.

% of Children's Primary Caregivers

who are biological parent, grandparent or other relative



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expressed as the proportion of children under 6 who engaged in the specific activities with the primary caregivers. The evaluation asked the same the set of questions with primary caregivers in neighboring communities who had not participated in the program. This control group was selected based on having the same demographic profile as ECD Program participants.¹⁴

1. CHILD AND CAREGIVER INTERACTION

by number of days/week in the seven days preceding the survey

This indicator refers to intentional interaction between caregiver and children and does not include common activities such as carrying the child to the field or market. The evaluation shows the proportion of caregivers who interact with their children nearly every day increased by 14%; those who interact 3-4 days per week increased 10%. There was a 17% reduction in caregivers who hadn't found any time in the past week for interaction.

The evaluation also measured interaction time per day. Results indicate that caregivers in the ECD Program spend 50% more time interacting with their children per day compared with control group parents (based on two hours per day or more).

2. COGNITIVE DEVELOPMENT

Percentage of children engaging with caregiver in activities that promote cognitive development

Overall, there was an average 41% increase in the proportion of children engaging with caregivers in activities that develop their thinking and communication skills. Prior to the program, 38% of children engaged with caregivers in such activities; after participation in the program, that percentage doubled to 79%. Using play materials and counting games saw the largest changes.

“Our interactions with our children have greatly improved. We use play materials we've made for activities such as counting and drawing on the ground using charcoal.”

—Primary Caregiver

Figure 11.

Child and Caregiver Interaction

Progress measured in days/week

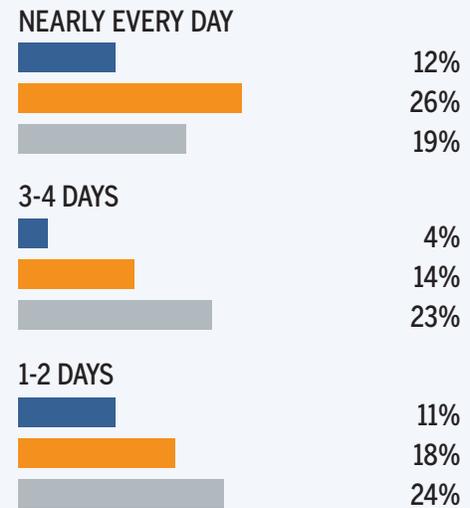
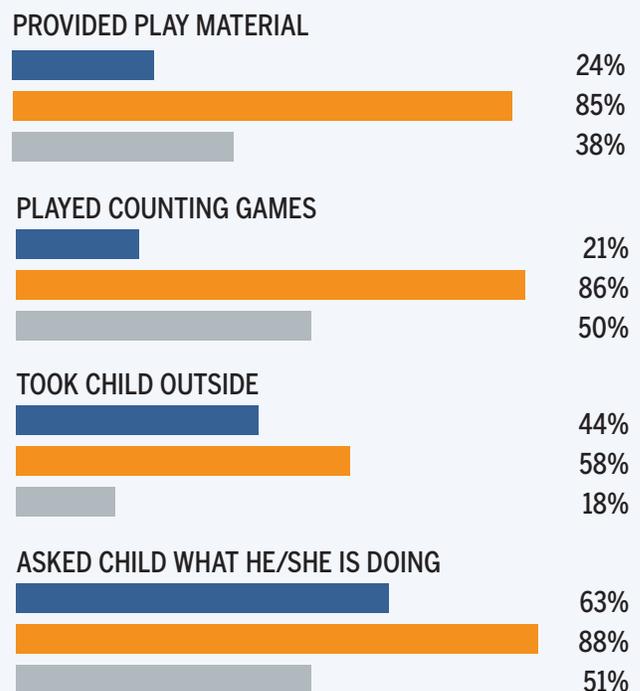


Figure 12.

Cognitive Development

Child/Caregiver Interactions



■ Baseline 2012 ■ Endline 2016 ■ Control

¹⁴ The evaluation employed a quasi-experimental design to strengthen analysis of causal relationships between program activities and observed outcomes of caregiver behavior change. It also used a simple control group design since no control group was used at baseline.

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3. LANGUAGE DEVELOPMENT

There was a significant average increase of 31% in the proportion of children engaging with caregivers in activities that foster language development, with activities involving more than three-quarters of the children.

4. MOTOR SKILLS/PHYSICAL DEVELOPMENT¹⁵

This area showed the largest improvement, with an average increase of 84% in proportion of children engaging with caregivers in activities that promote motor skill development. This area also experienced substantial differences in comparison to the control group.

¹⁵ This area refers to both fine and gross motor skills.



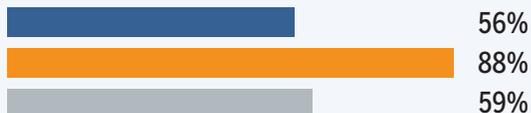
Child playing with a toy made with local materials at a caregiver toy-making session

Figure 13.

Language Development

Child/Caregiver Interactions

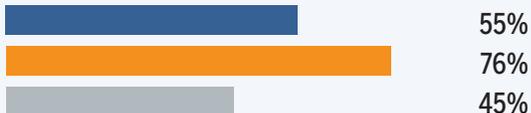
SINGING WITH/TO CHILD



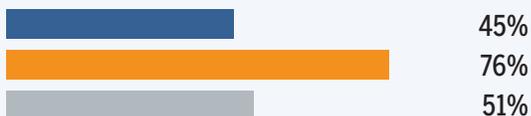
TELLING CHILD A STORY



ENCOURAGING CHILD TO TELL A STORY



EXPLAINING WHAT CAREGIVER IS DOING



■ Baseline 2012 ■ Endline 2016 ■ Control

Figure 14.

Motor Skills

Child/Caregiver Interactions

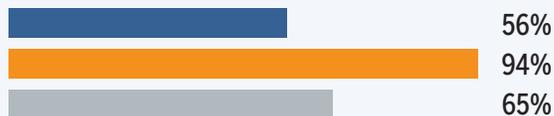
PROVIDING SMALL OBJECTS TO PICK UP



STACKING STICKS FOR DRAWING IN SAND/DIRT



ENCOURAGING CHILD TO JUMP, DANCE, KICK BALL



■ Baseline 2012 ■ Endline 2016 ■ Control

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5. SOCIAL DEVELOPMENT

In terms of social development, caregiver-child interactions were high at the program's outset. Nevertheless, the program showed significant improvement, with an average increase of 17% in these activities. Further, the focus group discussions revealed that a key factor was the opportunity and time to play with other children on a regular basis through the playgroups that met during caregiver group meetings and, later, the volunteer-led preschool sessions.

6. EMOTIONAL DEVELOPMENT

The evaluation assessed three behaviors for strengthening emotional development. As expected, typical activities of hugging/kissing children and comforting children after they got hurt were high – about 75% at the outset with an increase of 7% with the program. However, praising children for accomplishments was 66% prior to the program and increased to 94% after participation. The control group results indicate less engagement on all behaviors than the program participants. On average, ECD activities increased by 13%.

Psychosocial Support and Care

Psychosocial support and care is an important dimension of the child's emotional development. The program emphasizes psychosocial support as part of addressing the special needs of children affected by HIV and AIDS. The major impact in this area – with an increase of 83% – was caregivers talking with children about their feelings. This is a simple activity that has a tremendous benefit on children's development. While 84% of the program children had engaged in this interaction, only 55% of the control group children had done so. More complex behaviors, such as helping the child express feelings through drawings or play and telling the child stories about a loved one who died, showed slight decreases, though still higher than the control group. The program needs to put some emphasis on these two activities that may not have been understood by ECD Promoters or caregivers. One opportunity would be to develop specific participatory learning sessions with Promoters at their reflection/refresher meeting. Then they would facilitate the session at caregiver group meetings.

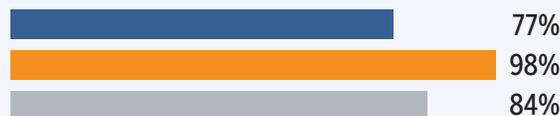
Related to HIV issues, primary caregivers shared in the focus group discussions that children who had lost parents to HIV/AIDS suffered from stigma, and in some situations no one was willing to

Figure 15.

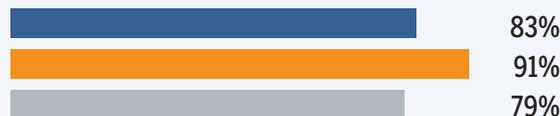
Social Development

Child/Caregiver Interactions

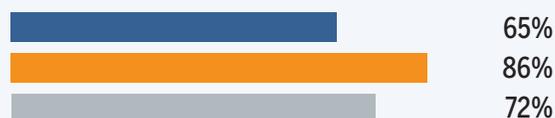
ENCOURAGING CHILD TO PLAY



ATTENDING COMMUNITY/CHURCH ACTIVITIES



HELPING CAREGIVER PERFORM SIMPLE CHORES



■ Baseline 2012 ■ Endline 2016 ■ Control

“ We have learnt that talking to our children is important. In the past, we just used to leave children to play on their own. We now tell stories to our children, we sing to them and we play with them, because we understand that before the child goes to grade one, they are supposed to learn. ”

—Primary Caregiver

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Caregivers discussing parenting practices with ECD Promoter during a monthly home visit

become their caregiver. But the participants explained that the ECD Program has raised community awareness on HIV and AIDS, and these attitudes are changing.

Positive Parenting Skills

This area included parenting styles, communication, positive discipline and child rights and protection. Positive discipline was assessed quantitatively by two activities: *praise child for good behavior*, which caregivers significantly practiced more as a result of the program, with a 37% increase; and *reward child for accomplishments*, which had a 13% increase. Qualitative results confirmed caregiver knowledge and skills in this area, such as how to talk to children when they do something wrong and children's rights (e.g., to go to school).

Focus-group discussions revealed some reduction in the use of corporal punishment. However, responses highlight the need for more work in this area. This is a challenging type of behavior change. For example, some caregivers explained they would talk calmly to the child first, but if that didn't work, they would resort to corporal punishment. The Program Manager from Eastern Province noted that some caregivers still retain the traditional parenting view that children should be punished when they have done something wrong.

“ Now we know that we should not shout at or ignore them when they want something or when they look sad or cry. Instead we ask them what they want or what is wrong with them. Since we started caring this way for our children, our children have changed. ”

—Primary Caregiver

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Psychosocial Counseling Support to Caregivers

The evaluation used a depression-screening tool, which asked if caregivers felt bothered by eight presented scenarios. Compared with baseline data, results indicated that after program participation, there was a 15% reduction in caregivers with the likelihood of moderate depression and no caregivers were at risk of severe moderate or severe depression (reduction of 12% and 4% respectively from baseline); and there was a 15% reduction in caregivers with the likelihood of moderate depression. This may be attributable to the caregiver support group participation and home visits as well as psychosocial counseling. A total of 7,061 caregivers were counseled over the five-year period. This topic was considered to be very personal and confidential, thus caregivers were hesitant to say much about any feelings of depression in the focus group discussions. However, they did indicate they had access to counseling and noted the services were beneficial in solving marital disputes and helping those who were HIV-positive.

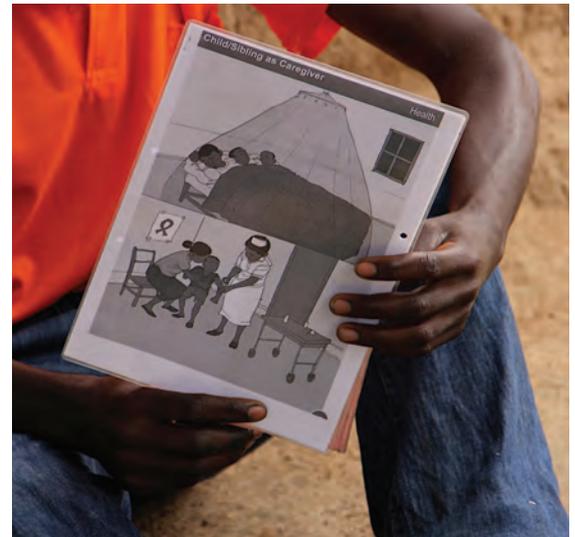
B. Successful Strategies

In summary, the findings clearly demonstrate positive behavior change among primary caregivers participating in the ECD Program, particularly in the initially weak areas of cognitive, language and motor skills development. The longitudinal data shows that primary caregivers have increased their interactions with their children and are providing significantly more nurturing care and early stimulation. The evaluation demonstrated that the observed changes can be attributed to the ECD Program activities that focus on the positive parenting of young children. This also confirms the effectiveness of the program model of:

- **Trained ECD Volunteers** serving as facilitators
- **Caregiver participation in both Learning & Support Groups and home visits** with ECD Promoters
- **Use of visual aids** with a dialogue approach to Social & Behavior Change Communication

To determine whether length of program participation had any influence on caregiver behavior change, a comparative analysis was conducted between the two groups of caregivers – those participating for four years (Phase 1 in 2012) and those active for two years (Phase 2 in 2014). The analysis compared practices in the seven areas detailed and found that the higher levels at the evaluation were very similar for both groups. This indicates that for replication purposes, a full two years of group meetings and home visits is sufficient to achieve the maximum positive effect on primary caregiver behavior in nurturing care and early stimulation.¹⁶

¹⁶ This finding assumes the baseline situation for the 2012 group was similar. The 2012 baseline study did not include the indicators of caregiver practices by development area that were developed for the 2014 baseline.



EP Visual Guide picture card showing malaria prevention and health care-seeking practices

“It’s easier to understand a picture than words... a picture shows the result of a particular behavior and makes the caregivers grasp the benefit to changing their behavior.”

—ECD Promoter

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Learnings

The program combined two evidenced-based interventions and found the effects mutually reinforcing one another. There were also indications of a greater impact when the primary caregiver participated in both programs at the same time. Key findings from each type are outlined below:

Primary Caregiver Support & Learning Groups

- Caregivers develop relationships with each other, generating peer support and learning through sharing of experiences, ideas and solutions to common challenges
- Caregivers develop relationships with the same ECD Promoter, who facilitates their group and visits them in their homes
- Action-oriented learning through discussions based on ECD visual guides and visits by CHWs and other stakeholders

Home Visits by ECD Promoters

- Confidential discussions
- Specific, responsive support tailored to caregiver's needs and priorities
- Encouragement, recognition and reinforcement of caregiver practices
- Engagement with fathers

Monthly meetings of one to two hours at the ECD Centers

Parenting and ECD topics discussed

Toddler and preschool playgroups meet at the same time

Quarterly toy making sessions with local materials

““ The home visits create that relationship and trust between the caregiver and the ECD volunteer, which helps the caregivers to open up and feel appreciated for the positive changes in their households. ””

—ECD Program Manager

C. Enhanced Child Outcomes

The program evaluation methodology for quantitative measurement focused on caregiver parenting behavior change as a proxy for measuring child development outcomes. The ECD Promoter observations, home visit records and program staff documentation of improvements in children's development support the positive findings.

Children's Playgroups

The program started with toddler and preschool-aged playgroups (0-2, 3-4, 5-6 age groupings) during the monthly primary caregiver group meetings. ECD Promoters supervised social play and taught children simple learning songs and games. This introduced

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regular social playtime to children. Each ECD Center received basic playground equipment that the program purchased or communities constructed locally. This was a radical change in rural areas – not seen before except in city parks – and the playgrounds proved to be a big attraction. Children asked frequently to play there with their friends.

Preschool Sessions

As the participating families' children grew older, there was a need for and community interest in supporting more structured preschool groups segmented into appropriate age range for the 0-2, 3-4 and 5-6 year olds (primary school in Zambia begins at age 7). This led to another set of 424 volunteers recruited to facilitate half-day preschool sessions at which children were dropped off.

The daily sessions were a strain on the preschool facilitators, so a corps of grandparents was recruited. They now lead story time every Friday and share traditional stories, rhymes and songs in the local language. This is a wonderful cultural celebration that benefits the children and grandparents alike.

The preschool facilitators received seven days training in the Ministry of Education's preschool curriculum, and this aided the children's learning and school readiness. Preschool education is the government's responsibility, and advocacy with the Ministry of Education is underway. However, while the government is in the lengthy process of organizing preschool services, the ECD Program communities have filled the gap so that the children do not miss out on this important period of development and learning.

Results

The program introduced not only the idea of learning in the home for children under 3 but also the idea of "preschool" learning for 3-6 year olds. The preschool education concept required social and behavioral change communication about its value and why parents should bring their children. Primary caregivers now proudly share their children's learning of the alphabet, songs and counting, in both local languages and English.

By seeing the concrete changes in their children's behavior and knowledge, caregivers have felt more empowered as parents and more hopeful and encouraged to envision new dreams.



Children in a preschool session with ECD Facilitator

ACTIVITY TOTALS

424
VOLUNTEER PRESCHOOL FACILITATORS

13,151
PRESCHOOL SESSIONS

5,997
TODDLER PLAYGROUP SESSIONS

232
VOLUNTEER GRANDPARENTS

1,863
GRANNY STORYTIME SESSIONS

“ Children coming from ECD Centers are doing well in primary school. They come with basic skills such as reading and writing... when they go to grade one they are already prepared to learn. ”

—Head Teacher and member
ECD Program Steering Committee

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From Orphan to Empowered Young Mother

My name is Mary Panji, I am 16 years old and am a single mother of one. I live in Shamputa village in Chibombo. My parents died when I was 10 years old and I was left with my grandmother who is very old. When I was pregnant, I had no one to take care of me because the boy who impregnated me was also a dependent. During my pregnancy, I never went to the clinic because I was shy. I delivered at home with the help of my grandmother. I stayed at home for two weeks without taking the child to the clinic, missing her first immunization of BCG (vaccine for tuberculosis).*

Then an ECD Promoter, Mweshi Mulenga, came to my house and explained about the ECD Program and the benefits of immunizations, growth monitoring and developmental milestones. I was interested in the program and realized that there was no need to shy away. I have now started taking my child to the under-5 playgroup while I attend the caregiver support group, and I would like to encourage my fellow mothers to do the same for the sake of our children.

*name changed



—ECD participant with her child
Chibombo District

A. Improved Child and Maternal/Primary Caregiver Health

Challenges

Healthy and well-nourished children are more likely to develop to their full physical, cognitive and socio-emotional potential than children who are frequently ill. In Zambia, the major causes of child mortality are malaria, respiratory infections, diarrhea, malnutrition and anemia.¹⁷ The obstacles to accessing basic health care are many, particularly in rural areas. Often communities lack health facilities and have limited access to other services. These factors contribute to health challenges for children and women.

When the program started, primary caregivers lacked basic knowledge about child health and how to prevent common diseases, recognize symptoms and know when to go for treatment. Only 58% of children had age-appropriate immunizations.

Program Activities

The ECD Program links with the health system to provide health education and services. Program activities have contributed to primary caregivers building relationships with their local CHWs and strengthening connections with health facilities. The aim is for primary caregivers to improve children's health as well as their own, taking action to prevent diseases and seeking health care when needed.

Caregivers and children participate in health education, growth monitoring and other health services during Caregiver Support & Learning Group meetings at ECD Centers. Families learn how to prevent and treat diarrhea, pneumonia and malaria from CHWs and volunteer malaria control agents (MCAs, part of Episcopal Relief & Development's *NetsforLife*[®] program). Key messages of prevention and treatment are reinforced by ECD Promoters. Wells and latrines at ECD Centers serve as models where caregivers and children can practice hygiene behaviors and replicate them at home.



Child getting vaccinated by a community health worker

“ I have learnt about basic health care. In the past, I never used to take my child for medical check-ups regularly. But now when the child is having high fever, I have an idea that the child might be suffering from malaria so I am able to take the child to the clinic and receive medication. ”

—Primary Caregiver

Children drinking clean water from a newly constructed water pumping station at an ECD Center



¹⁷ UNICEF. (n.d.). Retrieved from https://www.unicef.org/zambia/5109_8457.html

Chapter 4

Essential Health Actions: Topics Promoted in Caregiver Groups and Home Visits

Healthy Babies and Children

- Growth monitoring
- Immunization
- First 1,000 Days – Pre-natal to Age 2 Health
- Participation in Child Health Weeks and health services
- Water, Sanitation and Hygiene (WASH)

Disease Prevention and Treatment

- Malaria
- Diarrhea
- Pneumonia

A TEENAGE MOTHER'S JOURNEY TO BETTER NUTRITION AND HEALTH

I am the mother of two children, and I am 16 years old. When I first enrolled my two children at Mushimba ECD Centre, I never attended caregiver group education sessions because I was a shy teenage mother. One day, my mother pushed me to attend a caregiver support and learning group session after she learned about it from an ECD Promoter. What struck me most was the topic on nutrition, where I learned the importance of giving a child a balanced diet for healthy growth using food we have locally.

I became more comfortable with sharing some of my children's problems. My 2-year-old son Danny had a swollen face and legs, and I suspected that he was bewitched. I showed Mrs. Grace, an ECD Promoter, and asked if she could help. She used an ECD referral form for the Chipili Health Facility.

At the facility, I was further referred to Mansa General Hospital, but I had no money for transport. I went back home to try to gather the money. After an hour, Mrs. Grace came to my home and told me that the project staff at Mushimba ECD Centre would assist me with transport. We went to the hospital, and my child was treated. He recovered and was able to play with his friends and attend play-group sessions at the ECD Centre. I am very thankful to the ECD Program, which has saved the life of my child, opened my eyes and has brought change in our community. As a teenage mother, I find that this is the only forum available to teenage mothers.

—Teenage Caregiver

ACTIVITY TOTALS

3,341

HEALTH EDUCATION SESSIONS
FOR CAREGIVERS

84,831

TOTAL MONTHLY
GROWTH MONITORING SESSIONS



Mother gets updated child health card from CHW at monthly session

ACTIVITY TOTALS

27,235

PEOPLE (primary caregivers and communities)
SENSITIZED ON MALARIA PREVENTION

34,828

TOTAL HOME VISITS BY MALARIA CONTROL
AGENTS to follow up on insecticide-treated net
use, repair and replacement

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Results and Learning

As a result of monthly health education sessions during Caregiver Support Group meetings and home visits, caregivers are better equipped to respond quickly to illness and take their child or themselves to CHWs and health facilities. This is evident from the increase in referrals made. The evaluation showed the number of children who fell ill decreased by almost 18%, and the number of children who received treatment increased by almost 9%. Since then, CHWs and ECD Promoters have observed caregivers' transformation in attitudes and actions – carrying out basic prevention and wellness practices and going to CHWs and clinics to get available services and treatment.

The number of children attending growth monitoring sessions and receiving immunization at ECD Centers increased. Growth monitoring attendance remains high, as sessions happen in conjunction with Caregiver Support Group and preschool playgroup meetings, making it convenient for caregivers to bring their children. In the last quarter of 2016, reports indicate that 18,556 children were monitored and fully immunized. The figure includes an additional 8,620 children who were not enrolled in the program but attended Child Health Week, a biannual initiative for children under 6 to receive free health services (such as micronutrient supplements and immunizations). ECD Promoters observed a positive spillover with caregivers not enrolled in the program learning about the importance of regular growth monitoring and immunization.

The number of malaria cases decreased according to ECD Program Managers and ECD Promoters. Caregivers understand how to put up nets and the importance of having children sleep under one every night. The evaluation showed that 86% of children under 5 slept under a mosquito net on the night before the study, an increase of 35% since the program started and much higher than the national average of 57%.¹⁸

The growth in good practices in water, sanitation and hygiene prompted caregivers and the community to build and rehabilitate over 300 hand-washing stations, latrines and water points at ECD Centers. At the household level, on average 80% of caregivers have built and are using latrines, hand-washing stations, pot racks and refuse pits. Notably, more than 70% of caregivers who lacked access to clean water reported that they treat their water before use, compared to the national average of 33%.¹⁹



Child getting weighed and measured at an ECD Center during a growth monitoring session

“ We are able to know if the child is growing well or not when we check the weight. In the past, caregivers would stop bringing the child for growth monitoring after they completed immunization, but now they bring them up to the time they reach 5 years. ”

—Community Health Worker

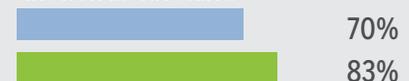
Figure 16.

Health Status of Children

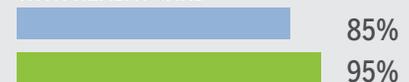
CHILDREN WITH AGE-APPROPRIATE IMMUNIZATION



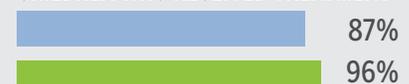
CHILDREN TAKEN TO GROWTH MONITORING



CHILDREN UNDER 5 YEARS WITH HEALTH CARD



CHILDREN WHO RECEIVED TREATMENT



■ Baseline 2012 ■ Endline 2016

¹⁸ Zambia Demographic and Health Survey 2013-2014. (2015). Retrieved from <https://www.dhsprogram.com/pubs/pdf/FR304/FR304.pdf>

¹⁹ UNICEF. (n.d.). Retrieved from https://www.unicef.org/zambia/5109_8457.html

Chapter 4

B. Increased HIV/AIDS Prevention, De-Stigmatization, Testing and Treatment

Challenges

The spread of HIV/AIDS worsens the plight of young children already suffering developmental deficits as a result of severe poverty. Zambia suffers from high HIV and AIDS prevalence rates, with the national average at 13% and rural areas at 9%.²⁰ The rural poverty rate of 80% compounds the damaging effects in those communities.

According to UNICEF, Zambia has 800,000 orphans under the age of 15 affected by HIV/AIDS. Although 90% of men and women have heard of HIV and AIDS, on average only 37% have comprehensive knowledge of prevention and treatment. According to UNICEF, 34% of young people between the ages of 15 and 19 reported to have been tested in the past 12 months or know their status.

HIV stigma and discrimination are barriers to prevention, treatment and support. The ECD Program's baseline study carried out in April 2014 showed high levels of depression among caregivers (40%). This is indicative of their anxiety and uncertainty of infection and its impact on their families' well-being and future. Many caregivers reported having limited knowledge of how and where to get tested and receive treatment for children and themselves.

Program Activities

The ECD Program is addressing the needs of those impacted by HIV/AIDS through education, care for orphaned children and support for extended families. In Caregiver Support Group meetings, the two-and-a-half-hour health education sessions discuss HIV/AIDS, the importance of testing and focus on mother-to-child transmission. ECD Centers have designated private rooms for caregivers and children to get tested. Home visits enable caregivers to feel safe about getting tested and receive treatment and counseling in the privacy of their homes. Drama groups trained in behavioral change perform skits to sensitize the community about HIV/AIDS and increase awareness on prevention and treatment; this program reaches large numbers. Testimonies from HIV-positive caregivers and children shed light on the issue and help them cope.



Caregiver getting tested for HIV/AIDS at ECD Center

“ Since joining the program, there is awareness on HIV and AIDS. When a woman is expecting a child, she goes to the clinic with the husband to be tested so that they know about their status. In the past fathers were reluctant to go for HIV testing. ”

—Primary Caregiver

ACTIVITY TOTALS

1,292

CAREGIVERS COUNSELED AT HOUSEHOLD LEVEL ON HIV/AIDS

998

CAREGIVERS COUNSELED AS A GROUP ON HIV/AIDS

86%

OF CAREGIVERS SCORED 100% ON THE HIV/AIDS TRANSMISSION AND PREVENTION KNOWLEDGE ASSESSMENT

²⁰ Zambia Demographic and Health Survey, 2013-14. (2015). Retrieved from <https://www.dhsprogram.com/pubs/pdf/FR304/FR304.pdf>

Chapter 4

Results and Learning

Beginning in 2015, the program experienced a gradual and steady increase in HIV/AIDS health-seeking behavior, as demonstrated by the number of referrals. Strong networks and linkages to district-level health and social services made it easier for families to stay healthy. More importantly, the confidence and trust built between the caregivers and volunteers through home visit interactions and caregiver support group sessions became entry points for caregivers to seek help and support.

The program's combination of home visits and caregiver support groups was effective in destigmatizing HIV/AIDS and encouraging more families to get tested and treated. Over the years, ECD Promoters have gained caregivers' trust and confidence through home visits. This relationship has resulted in a growing number of caregivers confiding in their ECD Promoters, who safely encourage them to seek counseling.

A MOTHER'S EXPERIENCE, LIVING WITH HIV

I am a mother of five, age 49, living with HIV. During my last pregnancy, I attended a caregiver group meeting at Makafu ECD Center where they talked about different things, but what struck me most was the topic on HIV. The health worker said HIV is just like any other disease, and we should all show love and respect to the people infected and affected. They later talked about the importance of going to Voluntary Counseling and Testing (VCT) and preventing our babies from contracting HIV. I was too shy to ask any questions. Later in the day, I went to Mr. Allan, an ECD Promoter who enrolled my children in the program, and asked if he could shed more light on how I can protect my unborn child from HIV because I've always suspected that I was positive, but never took a step. He was so helpful that I felt my burden had been put down. He personally went with me to the health center and helped me to get tested and receive medication. After I delivered my child, I took my baby for testing and she was negative. This has given me joy because two of my oldest children are HIV-positive and have been sick since birth. I am very thankful to the ECD Program, which has opened our eyes and has brought change in our community.

—Female Caregiver



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C. Improved Child Nutrition and Family Food Security

Challenges

Nutrition's effect on the brain begins before birth, with the mother's nutrition playing a vital role. Lack of nutrition during the first 1,000 days can lead to malnourishment and stunting. This will lead to irreversible consequences including cognitive impairment and predisposition to illness well into adulthood. A rich body of research has shown that improving the nutrition among pregnant women, infants and toddlers can prevent stunting and enhance motor and mental development of the children. In Zambia, 15% of children under 5 are underweight, 40% suffer from stunting and more than 50% are deficient in vitamin A and iron.²¹ The availability of nutritious food is dependent on both agriculture production and caregiver income.

At the start of the program, specific age-appropriate practices and knowledge of local foods that provide needed nutrients were not well understood. At baseline, only half of the primary caregivers in the ECD Program were knowledgeable about age-appropriate feeding for children from birth to 2 years. Only about one-third knew the recommended feeding guidelines for children ages 3-5. In the three days prior to when they took the survey, caregivers reported that 45% of the children had two meals per day and 19% had one meal. Because most of the families are subsistence farmers, the number of meals tends to fluctuate depending on the season; food is most available right after harvest. Dietary intake is largely dependent upon the seasonal availability and affordability of food. In months where food availability is relatively high, children consume a better diet of vegetables, oil, nuts and porridge. In months when food is limited, children often consume only porridge without other nutritious food to improve their diet. A minority of family farmers produces a small surplus to generate extra income, whereas a majority of families produce only enough for personal consumption and, depending on conditions, this production may fall short of their needs. On their small plots, farmers typically grow one crop, such as maize; this practice also makes it difficult for farmers to provide a balanced diet for their families.



Mother preparing nutritious food at a caregiver group session



Caregiver in her kitchen garden

²¹ Zambia Demographic and Health Survey, 2013-14. (2015). Retrieved from <https://www.dhsprogram.com/pubs/pdf/FR304/FR304.pdf>

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Program Activities

Essential Nutrition Actions

The ECD Program addresses these challenges by instilling knowledge and teaching skills to caregivers so they can practice appropriate feeding for their children and themselves. Nutrition education is provided monthly during support group meetings and growth-monitoring sessions by the Community Health Workers, sometimes in cooperation with health center staff. The sessions are interactive, with caregivers given opportunities to share what they know about a particular topic and ask questions. Several sessions are coupled with cooking demonstrations, during which meals are prepared using locally sourced ingredients and nutritional values are discussed. The purpose is to demonstrate different ways to prepare the same food that they normally eat at their homes. Those who need nutritional supplements are referred to health facilities and placed on a feeding program.

Vegetable Gardens

Kitchen gardens are a source of supplementary nutrition and income for families. Each ECD Center has a demonstration garden, which is used as a teaching tool for families to learn how to maintain a garden as well as a source of vegetables used for cooking demonstrations. Families with kitchen gardens use their harvest to improve their children's health and ensure they are receiving adequate meals each day.



Cooking demonstration session with caregivers

ACTIVITY TOTALS

3,367

MONTHLY ESSENTIAL NUTRITION ACTION SESSIONS WITH CAREGIVER GROUPS

1,466

COOKING DEMONSTRATIONS

7,791

CAREGIVERS WITH VEGETABLE GARDENS

Essential Nutrition Actions and Activities with Caregiver Groups

- Importance of exclusive breastfeeding for children under 6 months
- Complimentary feeding
- Nutritional requirements for age-appropriate groups
- Signs, symptoms and treatments of malnutrition
- Cooking demonstrations using locally sourced ingredients
- Importance of eating meals as a family

Food Security Activities

- Training on how to cultivate kitchen (vegetable) gardens
- Provision of seeds to start kitchen gardens
- Linking caregivers to agricultural cooperatives



Caregivers harvesting vegetables from their kitchen garden

Chapter 4

Results and Learning

The number of meals eaten per day improved dramatically, with the percentage of children eating only one or two meals a day decreasing significantly. Compared to the baseline, children eating one or two meals a day decreased by 81 and 55 percentage points, respectively. Children eating three meals a day more than doubled. Although the amount of food available still fluctuates according to the harvest months, families feel secure knowing they have food from their kitchen garden that they can consume or use to barter with neighbors. Knowledge of food preservation techniques also enables families to store food during nonharvest seasons.

The nutritional intake of children from 6 to 24 months improved as a result of caregivers changing their child-feeding practices. The evaluation data shows that the largest increases occurred in protein and carbohydrate consumption. This may not be accurate, since the terms used in the baseline might not have been understood correctly and more common terms were used in the evaluation survey. Cooking demonstrations and nutrition education played an instrumental role in improving caregivers' knowledge and practice in food selection and preparation for their children's balanced diet.

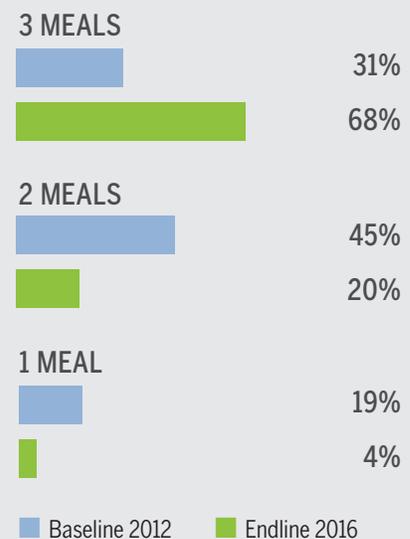
Caregivers demonstrated increased knowledge about the nutritional value of different types of food. Over 90% of caregivers were able to identify nutritious food for children under and over the age of 6 months compared to 55% and 37% at baseline, respectively. Many caregivers understand the importance of exclusive breastfeeding in the first six months. One caregiver



CHW presenting nutritious dishes prepared using local ingredients at a cooking demonstration

Figure 18.

Number of Main Meals/Day % of children < 6 months

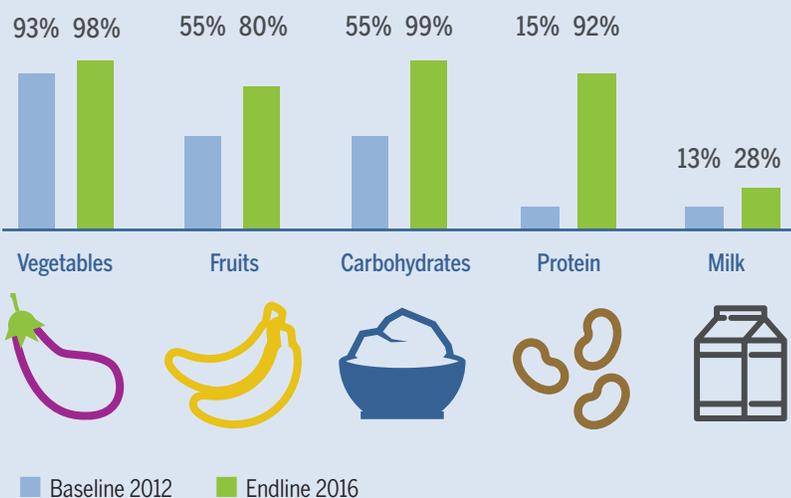


“ The program educated us on preparing a balanced diet as we didn't know that we can mix groundnuts with porridge for example. That way we have improved our children's and our own health. ”

—Primary Caregiver

Figure 17.

Percentage of Children Receiving Good Nutrition Type of food eaten by children at least one time per day



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noticed a significant difference with her second child, whom she breastfed after learning about the benefits during a nutrition session. While her first child – who did not receive breast milk – was constantly ill, her second child is healthy and strong. The caregiver is now educating others about the importance of exclusive breastfeeding and sharing her testimony with others.

The learning and insight gained from the regular participatory exercises continue to improve the program. Caregivers have learned how to identify key food sources, preserve food to cover for shortfalls during lean seasons and maintain a kitchen garden. Selling surplus vegetables from the kitchen garden turned out to be a good income-generating activity, contributing to stronger livelihoods. However, consistent drought and depletion of water resources in some communities led to a shift toward group-based vegetable gardens. Plots were allocated in locations with a dependable water source.

A MOTHER'S EXPERIENCE Importance of Breastfeeding

I am married with three children and am 30 years old. In 2009, I had my first child, and at age 2 months I started giving her water and porridge. Two months after the introduction to solid food, she started having diarrhea from time to time and had pneumonia once. At that time, I did not have knowledge on the importance and benefits of only breastfeeding during the first six months of the child's life. I now have twins who are 6 months old and because of what I learnt from Mr. Fewdays, a CHW in my area, about breastfeeding my twins and not giving them any other foods, not even water, my babies are healthy and have not had diarrhea since. I have been breastfeeding them exclusively since they were born. I will share my experience and information on the benefits of exclusive breastfeeding with other mothers in my community. Breast milk has a lot of benefits. I have learned and believe that now. My babies are healthy and free from diarrhea diseases. I also want to thank Mr. Champo, an ECD Promoter, who gave me the knowledge on importance of exclusive breastfeeding through the Anglican Church in Luamfumu.

—Female Caregiver

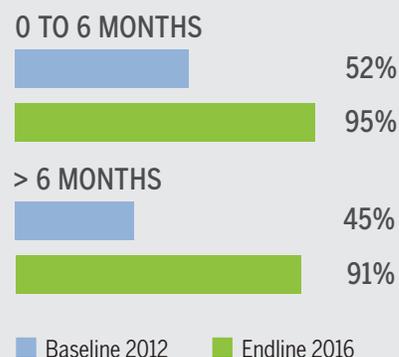


Sample dishes to increase children's intake of vegetables and protein at a cooking demonstration

Figure 19.

Identifying Nutritious Food

% of caregivers who know exclusive breastfeeding is best for baby's first six months and can identify nutritious food for children over 6 months



“Before the ECD Program, going to the antenatal clinic was rare, as most mothers would wait until the time when they were about to deliver. And now we even understand the importance of good nutrition when the mother is expecting.”

—Primary Caregiver

Chapter 4

D. Strengthened Families Livelihoods

Challenges

Extreme poverty increases children's likelihood of exposure to multiple adversities, including family stress, child abuse, food insecurity and exposure to violence. The economic strength of a family directly impacts children's physical health, cognitive, emotional and behavioral development as well as school performance.²² Jobs are scarce in both rural and urban areas, especially for those with limited skills. For many people, owning a small business can be a pathway to earn income, support a family and become self-sufficient. However, without access to basic financial services such as savings and credit, starting an enterprise can be difficult, if not impossible. Savings & Loans Groups are a tool for creating economic opportunities and assisting people with generating income to start and expand small businesses, pay school fees, save money and plan for unanticipated emergencies. Research shows that access to financial services combined with savings mitigates further indebtedness in a way that credit alone does not.

The baseline study found that 26.4% of families do not have regular income. Many caregivers in the program are subsistence farmers who work several months out of the year. Focus group discussions held in the communities revealed that the economic situation was generally described as very poor in all the areas where the ECD Centers are located. Those communities that are located near towns have access to markets where they can sell products such as vegetables, fritters and fruit, or have opportunities to be hired as day or seasonal-laborers on farms or for local companies.

Monthly income levels are generally low. On average, 40% of families in the program were earning less than 600 Zambian kwachas (ZMW), with 16% reporting less than 150 ZMW a month, lower than the national average of 667 ZMW (approximately US\$71) for small-scale farming households.²³ Almost 50% of participating families did not know their monthly income. Rural communities lack access to banks for safe savings, and smallholder farming families are typically not eligible for micro-credit because of the requirements.



Treasurer collecting members' money at a caregivers' Savings & Loan Group meeting

²² Brooks-Gunn, J. & Duncan, G.J. (1997). The Effects of Poverty on Children. *The Future of Children*, Vol 7, 55-71. Retrieved from https://www.princeton.edu/futureofchildren/publications/docs/07_02_03.pdf

²³ Central Statistical Office. (2010). The Zambia Living Condition Monitoring Survey (LCMS). Retrieved from <http://www.zamstats.gov.zm/report/Lcms/2006-2010%20LCMS%20Report%20Final%20Output.pdf>

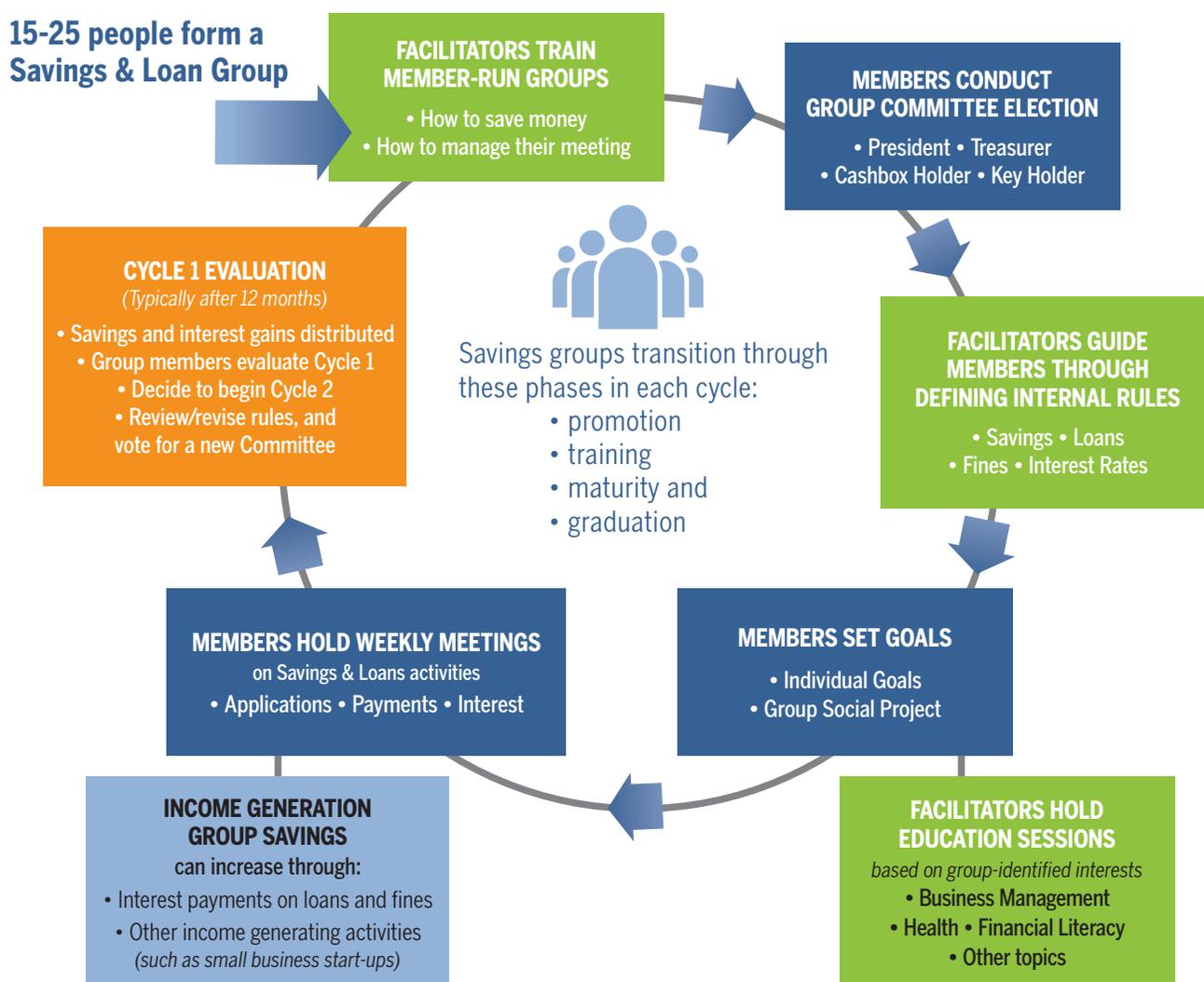
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Program Activities

In 2015 the program introduced the formation of member-run Savings & Loan Groups to promote financial literacy, provide caregivers a safe way to save and give them access to loans at affordable terms. Episcopal Relief & Development's **Savings with Education (SwE)** methodology²⁴ facilitates and reinforces a community-based mechanism for saving and lending on terms set by group members. Caregivers have the opportunity to take loans from the group, and their own savings form the revolving loan capital. Sustainability is created through the savings and loan group members themselves.

Figure 20. Savings With Education (SwE)

The graphic illustrates a typical first year cycle for establishing and operating a Savings & Loan Group. The goal is for each group to operate independently at the end of the first year.

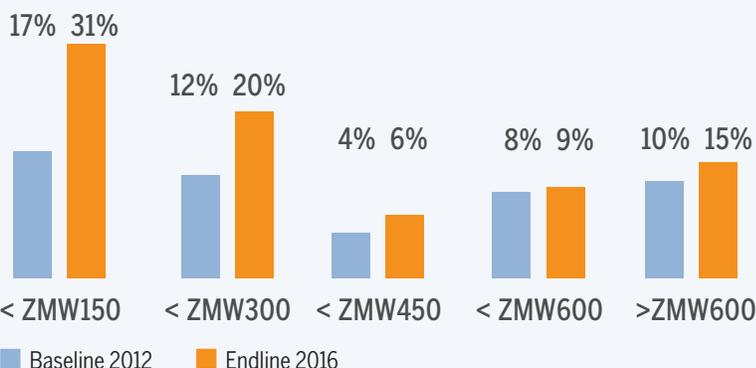


²⁴ Episcopal Relief & Development adapted this approach from a proven methodology developed by Freedom from Hunger and Oxfam.

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Figure 21.

Distribution of Monthly Household Income



Results and Learning

Savings with Education (SwE) was introduced as part of the ECD Program in 2015, and the response has been overwhelming. It is now being rolled out gradually to all ECD Centers. The groups work with a trained facilitator during the first 12 months, then they function independently. Within 18 months, over 50% of caregivers in the ECD Program joined savings and loans groups. Savings & Loan Groups are self-managed, self-determined and empowering. Members make decisions about the management of their group, amount of savings, loan sizes, interest rates and fines, and then they start saving. Education topics covered include: disadvantages of keeping savings in the house, business management, recordkeeping and basics of accounting.

Since SwE was introduced, caregivers in Savings & Loans Groups have seen improvements in their families' socio-economic well-being. Household income levels increased by almost 8%, and caregivers save on average between 5ZMW to 10ZMW a week (about \$.50-\$1.00).²⁵ Caregivers who participate in the groups invest their savings back into the health, nutrition and education of their children. Some members have used loans for business start-ups, such as a chicken enterprise for selling eggs; others have expanded existing income-generating activities.

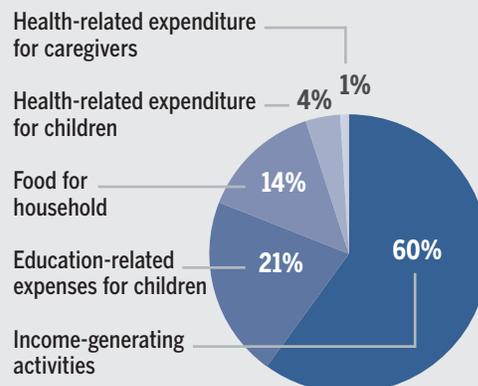
The Savings & Loan Groups have influenced caregivers to build a culture of saving, taking loans and diversifying their income streams. This is true for the women caregivers who make up 90% of the savings and loans groups. In a 2014 baseline study, 26% of participating households were subsistence farmers without regular income. The 2016 evaluation shows nearly a quarter of caregivers transitioned from a no-income household

²⁵ Matafwali, B. & Zingel, M. (2016). *External Evaluation of the Early Childhood Development Program for Children Affected by HIV and AIDS*.

Figure 22.

Strengthening Family Livelihoods

S&L Group members used their loans for:



“ We learn a lot from the support and learning groups. For example we have learned about saving. In the past we didn't know how to save money – we used to spend all the money but now we are able to save money. ”

—Primary Caregiver

ACTIVITY TOTALS

245

CAREGIVER SAVINGS & LOAN GROUPS FUNCTIONING

63

ECD PROMOTER SAVINGS & LOAN GROUPS FUNCTIONING

3,104

TOTAL MEMBERS IN SAVINGS & LOAN GROUPS

535

SAVINGS & LOAN GROUP MEMBERS HAVE TAKEN LOANS

Chapter 4

to an income-generating household. The vast majority of caregivers use loans to start small-scale businesses in trading and agricultural productions that generate new sources of income. Surplus made from their business is used to repay the loan and is reinvested back into their children and families. These new businesses, coupled with management skills training and government seed distribution, contribute to caregivers financial empowerment and self-confidence.

Savings & Loans Groups contributed to building trust and solidarity among caregivers. Several mature groups saw a need to create a social fund that serves as a safety net for caregivers to access in case of emergencies, usually for health expenses, children's education, funerals, etc. Caregivers contribute an agreed amount each week toward the fund. No interest is charged for loans from the social fund and, although caregivers are expected to pay back the loans, repayment is not strictly enforced. Caregivers value this community support for helping them cope with emergencies.

Savings & Loans Groups are a high-impact intervention for improving family livelihoods. Since this component was introduced, program managers reported that female caregivers' feel they can make a difference for their family and the communities. These female caregivers are valued and respected at home, and men no longer see them as a burden. Many couples have started planning and making household decisions together, whereas before men were the sole decision-maker. Many have used loans to start small-scale businesses, often selling and trading agricultural goods. They have requested targeted training on growing their small-scale businesses to generate a higher return.



Savings & Loan Group member depositing her weekly savings

“ We thought we were too poor to save, but we learned amounts can't be too small to save. And even with a small amount, we can do something to earn income. Our neighbors are asking for help to form their own Savings & Loan Groups, because they've seen the results of ours! ”

—Primary Caregiver

A. Community Management

The program design mobilizes local leadership and builds community management from the beginning, facilitating development in the first two years. In the third year, there is a transition to full community ownership of ECD programming. Local leaders, stakeholders and communities are engaged from program design through the development phases. In addition to contributing to sustainability, this cost-effective approach ensures the program can reach more families with limited staff.

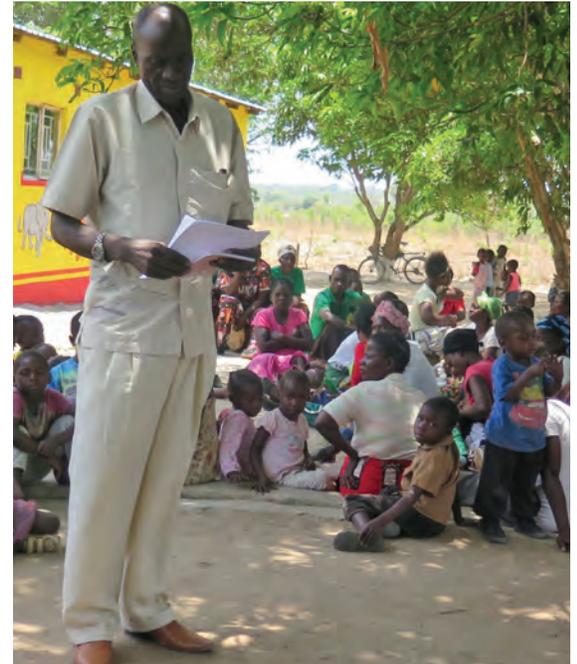
The challenge of striking the right balance between scale and quality requires a systematic process. The process starts with an in-depth analysis of stakeholders, opportunities and strengths with a mapping of local assets. The success of the program relies on mobilizing relevant stakeholders with vested interest and an ongoing commitment to ECD.

Program staff members ensure that local leaders and stakeholders understand the program's guiding principles: a community-led initiative that is inclusive of all, regardless of religion, creed, race, disability or culture. Members of the two overseeing bodies, the Center Management Committees and Steering Committees, bring a diverse set of experience, skills and professional expertise.

These committees are composed of influential village headmen/women, faith and community leaders, community health workers, ECD Promoters and other volunteers and participating primary caregivers.

- **ECD Center Management Committees** directly manage center activities and its ECD Promoters and volunteers, liaise with program staff, coordinate with other stakeholders providing services, develop new activities and initiatives according to community priorities, maintain program records and monitor the program.
- **ECD Steering Committees** oversee a group of ECD Centers jointly to coordinate and streamline ECD activities, make recommendations and set directives based on ECD Center Management Committee reports, mobilize their community and its assets and resources for permanent ECD Centers, and liaise with district and province-level government agencies, faith organizations and civil society organizations working in ECD.

Buy-in from relevant stakeholders has been key to the effectiveness and efficiency of the ECD Program. Stakeholders are involved in the decision-making process and understand the objectives and purpose. They identify similarities in their own



Steering Committee Chair sharing progress updates and results



18
STEERING COMMITTEES

199
TOTAL MEMBERS



53
ECD CENTER MANAGEMENT COMMITTEES

281
MEMBERS

18
STAKEHOLDERS providing resources, training, technical assistance and/or direct services
7 GOVERNMENT MINISTRIES
5 FAITH-BASED ORGANIZATIONS
6 OTHER ORGANIZATIONS

Chapter 5

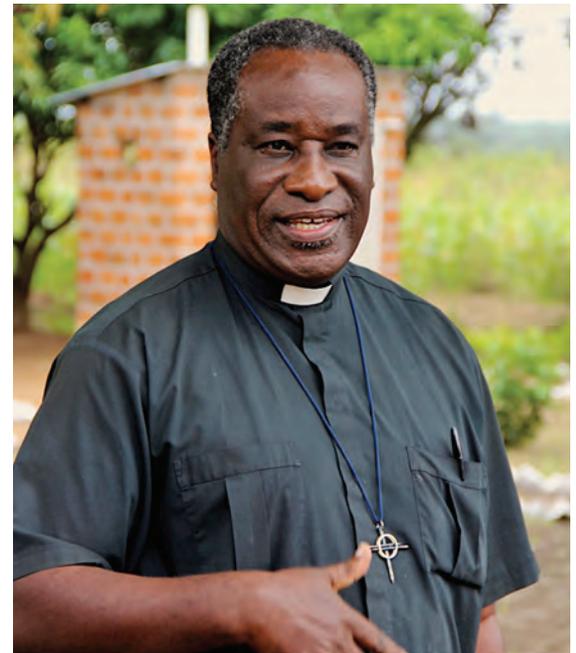
professional objectives as teachers, health workers, social workers, etc. and contribute their assets as volunteers and committee members. Their support and knowledge of the program allow them to facilitate and assist caregivers and their children, and train others.

Establishing a strong community-based leadership body and increasing awareness and knowledge of the importance of ECD strengthens the program from the management level to the village level. The leadership groups give structure to the program and empower the local community to implement and manage the activities. Iterations and adjustments are made to the program based on learnings from previous years, specifically during the intensive start-up period. To sustain the growth and strength of the program, volunteers and other stakeholders receive ongoing training and support by program managers and committee members and participate in regular community visioning processes.

B. Role of Faith Leaders and Organizations

As faith-based organizations implementing community development programs, Episcopal Relief & Development and ZACOP collaborate with community stakeholders and mobilize a range of resources from different religions and Christian denominations in Zambia. The faith-based sector has contributed to the success of the ECD Program in many different ways. Faith leaders are highly influential and respected by the community. Church buildings and land are used as ECD Centers and kitchen gardens for the community. The Mothers' Union (local branches of the national Anglican women's group) uses its platform and meeting forums to facilitate and influence good parenting skills to members and ECD Program Caregiver Support Groups.

Through religious services, faith leaders also convey key messages on the importance of ECD and good parenting practices, using scripture to reinforce these messages. This is also an effective outlet for disseminating information on growth monitoring schedules, Child Health Weeks and other major community events. The ECD Program relies on faith leaders' spiritual guidance and counseling work (such as marriage counseling and family conflict resolution) with participating caregivers and families as needs arise. In particular, the Anglican Diocesan Bishops are actively involved in the ECD Program, making field visits and meeting communities and caregivers periodically. Their recognition and appreciation of the volunteers' work is one key factor that keeps volunteers motivated.



“ I think the role of church leaders in the ECD programme is as it is summarised in the gospel of Luke 2.52. Jesus in his humanity grew physically and mentally. He related well with God and those surrounding him. It is therefore important for the church leaders to ensure that children develop fully physically, mentally, socially and spiritually. These are key areas of development for a full human life that is balanced. ”

—Bishop William Mchombo,
Eastern Diocese, Zambia

Chapter 5

C. Community Innovation and Impact

The ECD Program has successfully served as a catalyst for community action. The program's asset-based, participatory learning-action and appreciative inquiry approaches empower the community to initiate new ideas and bring them to fruition. The ECD Center communities have taken great ownership of the program by introducing new innovations and activities, such as constructing new ECD centers, integrating drama groups to influence behavioral change and facilitate weekly Granny Storytime.

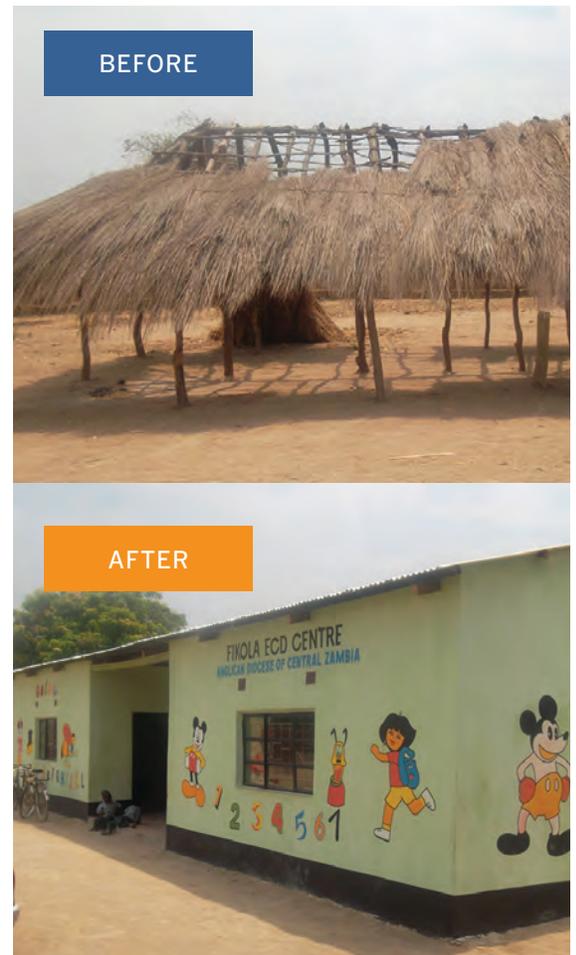
ECD Center Expansion

The community saw a need to replace the temporary shelters used as ECD Centers with permanent buildings to ensure the program's longevity. Committees in 10 project areas mobilized the community to raise funds and secure land for constructing new centers. Community volunteers provided in-kind labor and materials to construct permanent buildings. These community-constructed ECD Centers now compose 17% of the total number of centers. The program matched the local investment by providing funds for roofing material. Communities have also donated and constructed children's furniture and equipment using local resources.

Some communities requested that the designated ECD Center buildings be ones they could use throughout the week. In the start-up phase, centers were housed in shared spaces in school buildings or in churches, but scheduling conflicts and lack of purpose-built space, conducive to children's learning activities, prevented program growth. The Ministry of Education responded by providing access to 10 additional centers with the caveat that the preschool rooms conform to their guidelines. In four areas that are sparsely populated, the communities have set up six satellite locations to serve ECD activities.

ECD Drama and Music Groups

A large number of primary caregivers are young mothers. The 2014 baseline study revealed that almost 44% of caregivers in two project sites were under the age of 25. This finding prompted the community to organize more interventions targeting young people, using drama, role playing and audiovisual presentations to convey key messages. Young caregivers were part of the first drama groups established, and were trained on using drama to influence ECD-related social and behavior change. Drama performances cover a number of topics, including child rights and protection, the importance of sending children to school, positive parenting and positive



Before and after photos of Fikola ECD Center



Kasenga Drama Group performs a skit about why parents and their children should participate in early learning activities

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masculine role modeling. The popularity of the activity led to the formation of nine drama groups, with an average of 10 members in each group.

Other Program Innovations

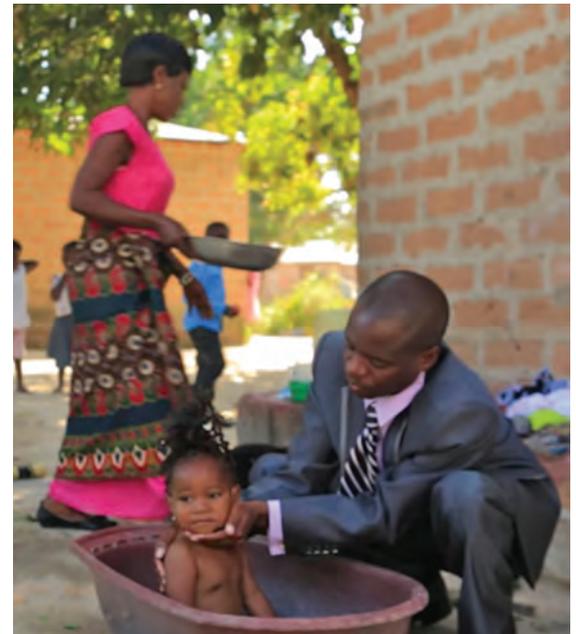
- Preschool sessions using the Ministry of Education's curriculum
- Granny Storytime
- Making toys that use local materials
- Savings & Loans Groups establishing social funds for members' emergencies
- ECD Center demonstration gardens

D. Changing Attitudes Toward ECD and Gender Roles in Parenting

Many community leaders and members have been active participants in the ECD Program since the start of the program. However, in the early years, some caregivers were reluctant to participate and enroll their children. They participated passively in Caregiver Support Group meetings out of peer pressure. Others weren't sure they wanted to enroll their children in the preschool sessions. However, they witnessed vast improvements in their children's physical and cognitive developmental growth (such as counting, writing and speaking in their local language and in English). They experienced their own personal development. As a result, these caregivers realized the importance of ECD and became increasingly involved in strengthening the program and community.

Some caregivers began mentoring each other and neighbors on parenting skills, health practices and services and other personal matters. Older caregivers initiated a weekly Granny Storytime, teaching toddlers values, traditions and life lessons using indigenous stories. The program has empowered caregivers and the community to take ownership of the program and reinforce a sense of community to transform their lives.

There has been transformation at both community and household levels. ECD Promoters and caregivers alike have seen changes in gender roles. Traditionally, women were the primary caretaker of children and responsible for household work, while fathers were seen as the breadwinners. However, as women



Father bathing his daughter before dinner

“ When I prepare lunch or dinner and the baby is on my back, the father now comes to get the baby to spend time with the child and to help me. He even changes napkins [diapers], and he always tries to be around when the ECD volunteer visits us at home. This never happened in the past. He only used to shout at the children to be quiet or to go play somewhere else. ”

—Primary Caregiver

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accumulated knowledge on good parenting skills, nutrition, the importance of saving and strong relationships with other caregivers, their self-confidence grew and they saw themselves as a resource to their families and communities.

Slowly, fathers recognized the positive changes in their families and the benefits of the program. This encouraged them to participate in home visits and accompany their wife and children to playgroup and monthly monitoring sessions. As a result, fathers became more involved in their families' well-being beyond finances, and the program reported more men attending Caregiver Support Groups, taking their children to monitoring sessions independently, reading to their children and acknowledging the contributions of their wives. Female caregivers feel more respected by their husbands and have reported making household decisions together.



Male Preschool Facilitators/fathers leading games with children

MALE CAREGIVER Changing Gender Roles

I am married and we have two children. I am 20, and my wife is 19. Since our children were enrolled in the ECD Program, my wife has learned the importance of early childhood development and preschool. Our older daughter Grace is able to count from one to 10 using her fingers and stones. I help Grace with her schoolwork by asking her what she learnt from school and answering her questions. Grace wants to be a teacher in future.

I realized that male involvement is very important in childcare and development. Sometimes mothers are stressed, and they need fathers to help in childcare. Our participation is important in connecting children and parents. Before men got involved, some were destructive during home visits. With the ECD Program raising awareness on the importance of early childhood development, men started supporting mothers by going with them to antenatal appointments and taking children for immunization and check-ups.

—Male Caregiver
weighing daughter at a growth monitoring session





ECD Program Manager sharing updates and learnings at a quarterly staff meeting

A. Participatory Community and Program MEL

Monitoring, Evaluation and Learning (MEL) has been an integral part of the implementation and ongoing strengthening of the ECD Program. MEL is carried out at both the community and program staff levels. Episcopal Relief & Development and ZACOP use a participatory process that combines quantitative and qualitative methods.

Monitoring Program Progress

Monitoring information is gathered through focus group discussions, questionnaires and recordkeeping. ECD Program volunteers analyze and discuss issues in their monthly reflection meetings. Outcomes of these reflection meetings along with monthly reports are submitted to the Field Officers and then to the Program Manager for the area. Program Managers and national staff have quarterly workshops to assess progress, address any weaknesses and make program improvements. Episcopal Relief & Development staff participate in these workshops. The ZACOP National Office works closely with the Episcopal Relief & Development Zambia team, comprising a Senior Program Officer, the Director of Strategic Learning and other program staff.

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After the first two years, the program staff realized that the data collection was too burdensome – not all the information was needed or used. Staff then selected key output data and streamlined the monitoring system. See Appendix B, page 55 for more information on the multilevel monitoring and quality assurance system.

Throughout the five years, Episcopal Relief & Development and ZACOP have made adaptations to improve the program in different ways, as noted in previous chapters. The externally conducted ECD Volunteer Effectiveness assessment in 2015 was a critical supplement to the monitoring process. The assessment provided more systematic data and a deeper understanding of issues that had been raised through regular program channels. As discussed in Chapter 2, program staff worked together with ECD Promoters and participating communities to make improvements based on the assessment.

Evaluating Program Results

The ECD Program conducted baseline studies for the program areas that started in 2012 and in 2014. Episcopal Relief & Development adapted and improved the survey that was part of the original Essential Package. Staff developed outcome indicators to measure caregiver behavior in each of the child development areas. At the time, the ECD sector as a whole did not have established indicators and proven measurement methods for parenting behaviors in care and early stimulation or in ECD volunteer effectiveness. Another challenge was the lack of available data for Episcopal Relief & Development and ZACOP to use as benchmarks and subsequently set targets for the ECD Program.

The external evaluation conducted in 2016 used mixed methods, a longitudinal survey and a quasi-experimental design. The evaluation design, framework and data collection tools proved very effective. The quantitative survey from the baseline was repeated and measured change in the program participants, comparing the results with a nonparticipating control group of primary caregivers. The use of the control group provided strong evidence for a causal relationship between program activities and observed or self-reported outcomes – that is, the program changed the behavior of primary caregivers.²⁶ The focus group discussions were audio-recorded and transcribed; discussions held in a local language were translated into English for analysis.²⁷

²⁶ Assuming baseline values are the same for the control group as for the program participants, since the baseline studies did not include control groups.

²⁷ Qualitative data was analyzed using both content and thematic analysis with NVivo 10 software. Quantitative data was analyzed using SPSS 23.



ECD volunteers in their ECD Center demonstration garden, with Field Officer

Program Staff Share Learnings

- *Changing mindsets does not come overnight; hence the need to consistently sensitize the communities.*
- *No program can work in isolation. We can only have a holistic program when linked with stakeholders who provide services.*
- *The community needs to be appreciated for their efforts.*
- *A well-trained and motivated community enhances sustainability of community programs.*
- *For a program to be sustainable, we need to embrace a participatory learning approach to development. This will lead to the community having a shared vision, goal and priorities, and ultimately ownership of the program.*

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ECD Steering Committee Members

B. Organizational Learning

Integrated Programming

ZACOP and Episcopal Relief & Development saw positive progress in fighting malaria, promoting child health and supporting people who live with HIV/AIDS in rural Zambia. However, there is still more work to be done to transform families and their young children. The opportunity provided by the Conrad N. Hilton Foundation to design, test and develop a large-scale integrated ECD program in Zambia had positive results at the organizational level. ZACOP saw preliminary results from the holistic focus on young children and made a national commitment to expand ECD throughout all its regions of activity.

For Episcopal Relief & Development, the Zambia program helped determine the “how” of integration and provided solutions to many of the challenges of implementation. The program used a practical, realistic and affordable approach to integrated programming at a community level. The Zambia ECD experience will inform Episcopal Relief & Development’s strategic thinking as it implements integrated ECD across all of its work. Because the program is high in impact and closely aligns with the strengths of the organization and its faith-based partners, integrated ECD is one of the three themes in Episcopal Relief & Development’s new five-year strategic plan.



Staff and volunteers participating in a training on how to facilitate Savings & Loan Group formation

Chapter 6

Role of Faith-Based Organizations

The nature of faith-based organizations aligns with a holistic and community-led approach to ECD. Faith institutions excel in accomplishing goals and offering a wide-range of activities with volunteers and the support of only a few paid staff; it is their *modus operandi*. Faith leaders, their congregations and volunteers are a permanent presence in communities.

As faith-based organizations focus on community development, Episcopal Relief & Development and ZACOP seek to play a facilitating role with local leaders and communities, making investments in building up people's capacities and equipping communities with a sustainable model. This is a different perspective than that of some traditional NGOs, which can function with time-bound project funding and services delivered by paid staff. The goal of Episcopal Relief & Development and ZACOP is to keep communities from long-term dependence on external resources or paid staff who deliver services during a specific project-funding period. Building up the capacities of local volunteer residents embeds community ownership and enhances sustainability.

Asset-Based Community Development

Through its years of development work, ZACOP has trained volunteers and established relationships and networks in many communities throughout rural Zambia. These relationships formed a strong basis for creating an integrated ECD Program with a specific focus on care and early stimulation parenting practices. ZACOP launched the ECD Program with a series of consultations and planning sessions with local leaders to discuss ECD and the overall goals as well as how to implement the initiative, including the identification and selection of volunteers.

This approach is distinctive from a solely participatory approach with the purpose of mobilizing leaders and communities to participate in an NGO/FBO-run project. The ECD Program's strategy has been to facilitate a process whereby communities organize and manage an ECD Program in their area, combining what Episcopal Relief & Development and ZACOP could offer and connecting communities to their own resources.



Mother with ECD Promoter and Bishop who helped her get her baby to the hospital for treatment

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Episcopal Relief & Development is an international nonprofit organization working with long-term Anglican/Episcopal partners to fight poverty, hunger and disease in marginalized communities around the world.

Episcopal Relief & Development collaborates with implementing partners to facilitate community development processes that help families strengthen their well-being, health and resilience, serving all people regardless of religious affiliation.

The Zambia Anglican Council Outreach Programmes (ZACOP) is the development arm of the Zambia Anglican Council (ZAC), with a focus on areas of integrated early childhood development, gender-related issues and health.

ZACOP was established in 2004 by the Bishops' Council to coordinate development activities and work in collaboration with the Zambian government and other stakeholders for an improved social sector.

Its primary objectives are to contribute to the reduction of morbidity and mortality due to major public health problems and to improve the socioeconomic status of vulnerable households and communities in Zambia.

Partnership between Faith-Based International and Local Organizations

Episcopal Relief & Development and ZACOP have been working in partnership since 2004. Episcopal Relief & Development's role in Zambia includes serving as a thought partner and technical partner in monitoring, evaluation and learning, and in institutional strengthening in the areas of board management, finance and administration.

During the past five years, the Zambia Anglican Council undertook a range of organizational development activities and formalized ZACOP as a distinct entity separate from the church structure with its own lay professional board. ZACOP also expanded its national staff, adding experienced development professionals in top leadership positions. The ZACOP national office staff manages program implementation through five regional offices (one per Anglican Diocese), each led by a Program Manager.

Episcopal Relief & Development has invested significant resources, both staff and funding, in this process with ZACOP while concurrently scaling up and strengthening the initial ECD Program. Despite the challenges, the ECD Program results speak to the fruits of this commitment.



Vision is captured on ECD volunteers' t-shirts: Investing in the Child for the Future

A. Addressing Challenges

As documented in its 2016 evaluation, the ECD Program has proven to be a successful model for primary caregiver behavior change, resulting in increased nurturing care and early stimulation with their young children. The program's integrated approach is effective in supporting caregivers to take actions and receive services – improving their families' health and nutrition as well as strengthening their livelihoods. A community-led strategy with local management and trained volunteers provides a solid foundation for sustainability beyond the initial program investment. The Evaluation Report recommended the model be scaled up, while noting some areas for strengthening in the next phase.

Transition of Current ECD Program Communities to Independent Ownership

In the short period since their establishment, the ECD Steering Committees have attained remarkable achievements. Each Steering Committee oversees and supports a cluster of ECD Center Management Committees to ensure children and caregivers receive consistent and quality ECD activities across the centers. To ensure sustainability of ECD activities beyond the scope of the program,

Areas for Program Strengthening

- **DEEPEN TRAINING OF ECD VOLUNTEERS:** To ensure volunteers are as effective as possible, the evaluation found a need to:
 - provide staff-led formal training for new volunteers who join after the program is launched in an area;
 - increase support to volunteers who are also serving as trainers of other ECD Promoters, (e.g. in Social & Behavior Change Communication);
 - expand refresher training for current volunteers; and
 - develop guidelines for participating primary caregivers to become ECD Promoters
- **INCREASE TARGETED ENGAGEMENT WITH FATHERS/ MALE CAREGIVERS:** The program targeted only one primary caregiver per household and these are mostly women. Further gains in male parenting can be made by:
 - intentionally engaging fathers (or other male adults in the household) as direct participants in program activities; and
 - explicitly promoting parenting as a joint responsibility, one important to both women and men, by involving both female and male caregivers where possible
- **INCREASE EMPHASIS ON POSITIVE DISCIPLINE:** Evaluation findings showed a need to further reduce the use of punitive measures for disciplining children. The program can help improve the use of positive discipline by providing additional volunteer training and targeting caregivers with communication and activities to affect social & behavior change.

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Steering Committees are considering registering as Community-Based Organizations (CBOs). Their current plans include:

- **Developing district level ECD resource mobilization strategies;**
- **Strengthening linkages with key district level stakeholders,** in the areas of health, education and social services; and
- **Increasing the participation of faith based organizations and interfaith/denominational coalitions** in their support for community led and managed ECD activities.

B. Defining an Optimal Community-Led ECD Package

The evaluation results confirmed the assumptions in the Zambia program's theory of change, signaling a sound basis for developing an optimal community-led ECD program package based on the program's experience. Going forward, the program will focus on parenting with infants and children under 3 years old, since this is most critical period for healthy growth and development. This priority also reflects a gap in the ECD sector as more attention and resources have gone early childhood education with 3- to 5-year old children. If participating communities want to develop preschool programs or advocate for government provision of them, program staff would link them to the Ministry of Education for coordination and support.

The package addresses the multiple, interrelated needs of these children and their parents by integrating health, nutrition, food security and financial components. This holistic approach improves both the program's results and cost effectiveness by capitalizing on reinforcing messages and addressing common challenges that affect rural families.

The Evaluation Report found that two-year participation in caregiver groups and home visits was sufficient to achieve significant results in care and stimulation comparable to four-year participants. The report also confirmed that the frequency of caregiver activities and curricula was effective in achieving tangible benefits. The report noted, *"In comparison with other programs in which results often take long to materialize, this ECD model produces positive and noticeable results within a timeframe that meets caregivers' expectations and needs."*

The program model is based around an ECD Center as the locus of program's adult learning, activities and children's playgroups. Rather than a specific dedicated building, these Centers would use a local space, such as a church or school. The proposed package timeframe is approximately three years, with volunteers selected and trained in the first six months, followed by 24 months of intensive work with primary caregivers. The package's ECD components are briefly summarized below. The Primary

ECD Volunteers indicated that the program doesn't require a lot of financial support, and is too important to just fade away. They will ensure it continues.

—ECD Program Evaluation Report 2016

Table 6.

ECD Program – Three Year Sequence

FIRST 6 MONTHS: Start-Up Phase

- Community mobilization
- Stakeholder engagement
- ECD volunteer training

24 MONTHS: Implementation

- ECD Volunteer facilitation with caregiver groups and home visits
- Strengthening of community management and stakeholder coordination
- Use of participatory monitoring system

FINAL 6 MONTHS: Community Independent Management and Program Expansion

- Participating caregivers take on their own groups and peer home visits per their own decisions
- ECD Promoters start new cycle with other vulnerable families in the area
- ECD Center Management Committees continue coordination, with periodic contact with program staff

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Caregiver Support & Learning Groups would meet monthly for two years, facilitated by ECD Promoters and working through the parenting curricula on essential actions. Nutrition and health are emphasized from the start, with savings & loan groups and other activities introduced gradually through collaborating stakeholders.

Integrated Early Childhood Development Program Community-Led ECD Package

Community Management

- Community mobilization of local leaders, faith networks and district stakeholders
- Identification of the most vulnerable families with children 0-3 years old
- Capacity-building of ECD Center Management Committees and Steering Committees
- Committees' Networking with key stakeholders
- Supervision and support of volunteers

ECD Promoter Training & Support TRAINING

- Essential Package with Visual Guides
- Parenting Skills with Visual Guide
- Social & Behavioral Change Communication
- Drama Skills for Community Development

SUPPORT

- Basic job aids and transportation support
- Monthly Reflection meetings for support and quality improvement
- Training to form Savings & Loan Groups, and other livelihood-strengthening activities

Primary Caregiver Support & Learning Groups with Children's Playgroups

- Monthly meetings led by ECD Promoters for 24 months
- Transition to member-managed Savings & Loan Groups and/or caregiver groups
- Monthly meetings with CHWs at growth monitoring sessions combined with health and nutrition education (coordinated with health system)

ECD Home Visits by ECD Promoter

- Monthly home visits with action-oriented dialogues with primary caregivers based on Visual Guides for 24 months
- Transition to peer visits by members of a caregiver group per their decision



Grandparent sharing an indigenous story during Granny Storytime



Caregivers Support & Learning Group meeting

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C. Program Replication and Scaling Up with Quality

The Zambia ECD program's successful experience has already been adapted in Nyanza, Kenya, by Episcopal Relief & Development's implementing partner, Anglican Development Services (ADS). In 2014, ADS staff were trained in the Essential Package and helped adapt it to the Kenyan context. ADS then integrated ECD into its Mother2Mother groups of women living with HIV.²⁸ Led by a trained volunteer mentor mother and formed in conjunction with local health centers, these groups focused on prevention of mother-to-child transmission (PMTCT) during the first 18 months of life. ADS broadened these groups' focus by including parenting care and stimulation and other essential actions through age three based on tools and lessons from the Zambia ECD program.

The integrated community-led ECD Program model has wide applicability in rural communities across Africa, particularly in high HIV prevalence areas. As a cost-effective strategy to engage primary caregivers and improve child development, it can be implemented and scaled up by faith networks that exist even in marginalized areas. Another large-scale opportunity exists to

ECD Promoters celebrating at the Kasenga ECD Center

²⁸ The incorporation of ECD into the Episcopal Relief & Development/ADS-Nyanza HIV program was supported by the Margaret A. Cargill Foundation.

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Mothers and children at an ECD Center

partner with health systems by complementing the work of CHWs – providing the intensive engagement with primary caregivers specifically on parenting for care and stimulation to achieve sustained social and behavior change.

The Evaluation Report documented that the model not only demonstrated success with ECD volunteers and direct participants, but that caregivers and children outside the program also benefited from it. This spillover effect improved not just the well-being and resilience of participating families but those around them because primary caregivers' carried ECD key messages to their friends, relatives and neighbors. Caregivers explained they did so because they saw immediate results from the program and their changed parenting behavior on their children.

The 54 communities participating in the ECD program have rallied around its vision, summarized on the ECD Promoters' T-shirts: *Investing in the Child for the Future*.

Across the spectrum of challenges facing vulnerable families in rural communities, this integrated ECD Program has sparked energy, change and hope – in the daily interactions between caregivers and children which will have lifelong impact; in the tangible results volunteers and leaders are seeing from their work; and in the process of family and community transformation in which the communities' youngest children are thriving.



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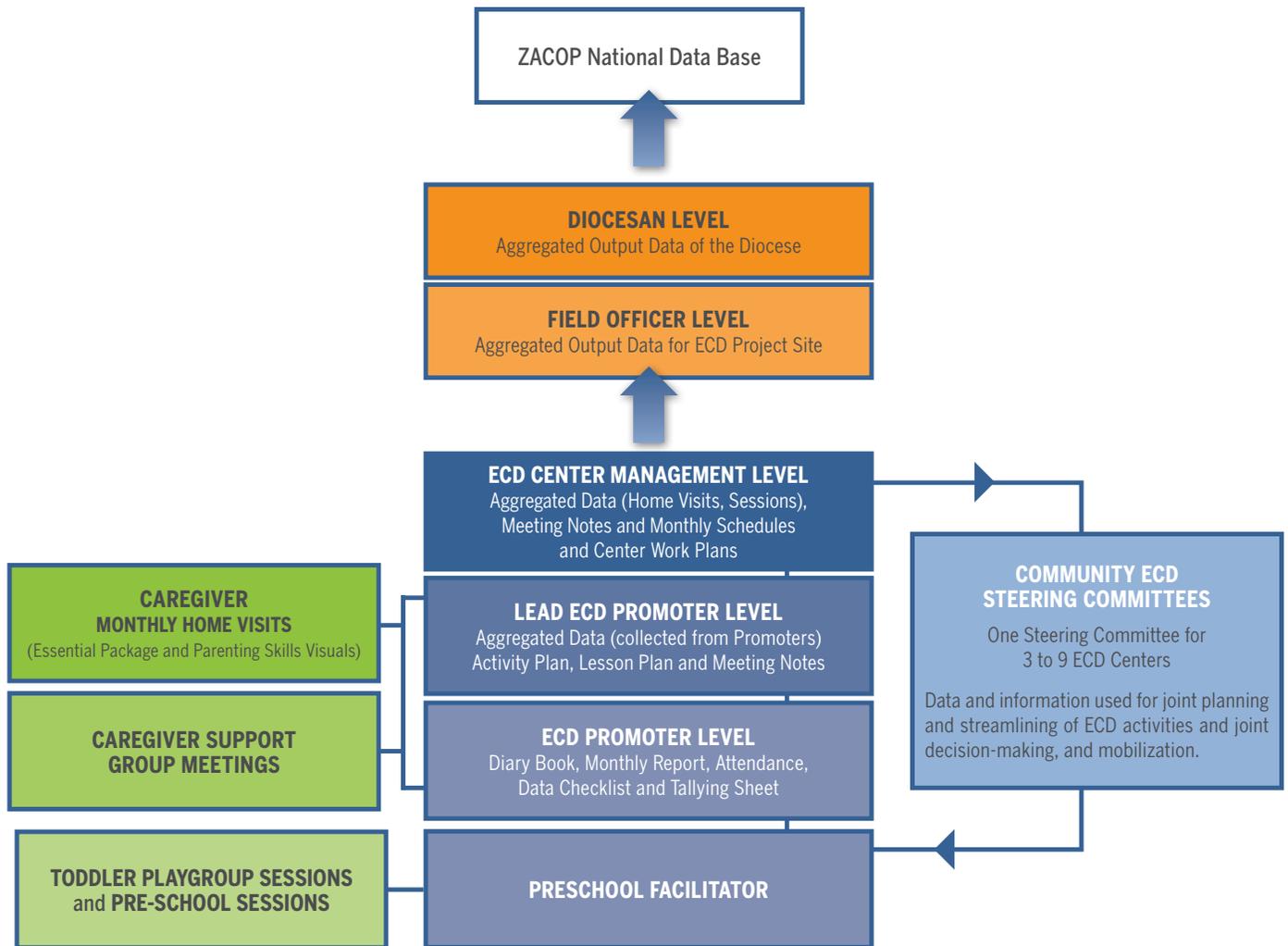
Objective 1		Promote strong cognitive, language, social-emotional and motor skills development in orphans and vulnerable children under 6, addressing the special needs of those affected by HIV/AIDS.	
MAJOR ACTIVITIES	OUTPUTS	OUTCOMES	
Zambia National ECD Committee meetings, Hilton partner meeting, ECD & HIV/AIDS sector workshops	Total Meetings & Workshops 12	 1.1 ECD Volunteer Promoters effectively facilitate social and behavior change with primary caregivers in positive parenting knowledge and skills and care-seeking behavior 	
Steering Committees formed	Steering Committees 18		
ECD Management Committees formed	ECD Management Committees 18		
Essential Package (EP) and ECD Program Stakeholder Orientation	Stakeholders 178		
Essential Package (EP) Training for Staff and Volunteers	Staff 32 Lead ECD Promoters 212 ECD Promoters 1,166 Psychosocial Counselors 32 TOTAL TRAINED 1,442		
Parental Skills Training for Lead ECD Promoters and ECD Promoters	Lead ECD Promoters 212 ECD Promoters 530 TOTAL TRAINED 742		
Preschool Curriculum Training for ECD Facilitators	ECD Facilitators 178		
Social & Behavior Change Communication (SBCC) Training for ECD Promoters	ECD Promoters 212		
Primary Caregiver Support & Learning Group Meetings	Caregiver Support Groups 212 TOTAL MEETINGS 8,909		1.2 Caregivers practice key actions to promote children's cognitive, social-emotional and motor skills, using positive discipline and psychosocial care/support
EP Home Visits	Total Home Visits 142,826		1.3 Caregivers understand parenting includes nurturing and stimulation for cognitive, social and emotional growth
Psychosocial Counseling for Caregivers as needed	Caregivers Counseled 7,081	1.4 Caregivers are able to better handle parenting responsibilities 1.5 Caregivers are less frequently down or depressed	
Preschool Playgroups (ages 3-5) At least two monthly meetings for learning sessions, using preschool curriculum and tools	Preschool Learning Sessions 13,151 Sessions met 5x/week in 59 centers	1.6 Children in preschool playgroups demonstrate school readiness at age 6	
Granny Storytime Weekly granny-toddler reading sessions	Reading Sessions 1,864		

Appendix A

Major Activities, Outputs and Outcomes

Objective 2		Improve the health of orphans and vulnerable children under 6 and primary caregivers addressing the special needs of those affected by HIV/AIDS.	
MAJOR ACTIVITIES	OUTPUTS	OUTPUTS	OUTCOMES
Quarterly CHW Health Education Session Provided to each Caregiver Group	Total Sessions 3,341		▲
Monthly Growth Monitoring (BMI) For children under age 5, focusing on nutrition and referrals to health facilities, as needed	Children Monitored 84,831 Health Referrals for caregivers and children 5,285		2.1 Children have birth certificates 2.2 Caregivers practice key health behaviors to promote their own and their children's health and hygiene and prevent and seek treatment for malaria, diarrhea, pneumonia
Caregiver household access to the five basic sanitation needs (clean water, latrines, bathing, refuse pits and pot racks)	Total Households 302 Construction of handwashing stations (Phase 1)		2.3. Decreased risk of HIV infection among caregivers and children
Quarterly WASH Education Sessions for each ECD Center	Total Sessions 1,949		2.4 Caregivers access VCT for themselves, children or family members at-risk 2.5 Caregivers access and adhere to treatment for themselves and/or children
Malaria Prevention and Treatment Individual sensitivity education and awareness training through, drama, household visits, etc.	Individuals Sensitized 27,235		2.6 Barriers to families' use of health services are reduced
Net use, repair and replacement Household follow-up	Household Follow-up 34,828		▼
Objective 3		Improve nutrition of orphans and vulnerable children under 6 and their household food security.	
Monthly CHWs Training Sessions Caregiver groups receive nutrition and age-appropriate feeding education	Total Sessions 3,367		3.1 Caregivers practice age-appropriate feeding for their children
Cooking Demonstrations to Caregiver Groups	Total Demonstrations 1,466		3.2 Caregivers increase the nutritional value of children's diet, age appropriately.
Vegetable Garden Start-up Training Provision of seeds to caregivers	Caregiver Vegetable Gardens 7,791		3.3 Caregivers provide adequate quantity of food. 3.4 Caregivers incorporate a variety of vegetables in children's diet from kitchen gardens (household or group/ECD center gardens)
Objective 4		Increase economic strength of households with orphans and vulnerable children under 6.	
ZAC Staff SLA Training Volunteer Savings Group facilitation	Staff Trained 9		4.1 Caregivers demonstrate basic financial literacy skills.
Savings Group Training Formation and training for caregivers	Savings Groups Formed 104		4.2 Caregiver households are regularly saving and have access to loans 4.3 Caregivers increase income

Appendix B



Monitoring, Evaluation, Learning and Program Improvements

Community Level Monitoring

Monitoring of community ECD activities carried out at community level is carried out at various levels. Promoters use home-visit diaries to note their observations and the agreed actions that the caregiver needs to take before the next visit. The Essential Package Comprehensive Checklist is filled out on a monthly basis on key developmental growth data. Each Promoter covers seven to eight caregiver families during the home visits. Promoters (up to 7-8 Promoters/Lead Promoter) hold monthly reflection meetings. Work progress and particular caregivers cases are discussed. Plans for next monthly meeting are agreed upon. Referral Monitoring sheets are used for caregivers who have been referred to social services and for HIV/AIDS referral cases (ART and ARD data); aggregate numbers are shared with the ECD Center Management Committees, while names of those referred and actions taken are kept with the Health Center. All data and information gathered by Promoters and Lead Promoters is filed, collated and aggregated by ECD Center Management Committees. Leadership Committees meet on a monthly basis. Schedules for Promoters and events are put up on ECD Center Notice Boards. Key data on ECD outputs are submitted to the ZACOP Field Officer. Data for all project sites are aggregated and submitted to the Diocesan Program Manager, where Diocesan Output data are tallied and sent to the ZACOP National Office. All aggregated data are then entered into the main national database.