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COMMUNITY-BASED EARLY CHILDHOOD DEVELOPMENT CENTERS FOR REACHING ORPHANS AND VULNERABLE CHILDREN: CONSIDERATIONS AND CHALLENGES

ISSUE PAPER

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ACRONYMS

CBCC	community-based childcare center
CRS	Catholic Relief Services
ECD	early childhood development
ICDS	Integrated Child Development Services
MOESC	Ministry of Education, Sport, Arts and Culture
OGAC	Office of the U.S. Global AIDS Coordinator
OVC	orphans and vulnerable children
PC3	Positive Change: Children, Communities and Care
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PMTCT	prevention of mother-to-child transmission
SDC	school development committee
UNICEF	United Nations Children's Fund

INTRODUCTION

According to 2009 data, approximately 16.6 million children aged 0 to 17 years have lost one or both of their parents due to HIV (Joint United Nations Programme on HIV/AIDS 2009), and millions more are vulnerable to the physical, psychological, and economic effects of HIV within their households and communities (Joint Learning Initiative on Children and HIV/AIDS 2009). The HIV epidemic extends far beyond the health sector and those who are sick. Many youth, particularly girls, are forced to drop out of school and assume caregiver status for ailing parents and younger siblings (Office of the U.S. Global AIDS Coordinator [OGAC] 2009). Especially at risk are young children age 0 to primary school-aged who are not receiving services (including HIV care and treatment), are too young to attend primary school, or are left unattended at home as overburdened caregivers are forced to choose between work and childcare (CARE n.d.).

Intervening during the early childhood years with high-quality early childhood development (ECD) programs is critical to ensure positive outcomes for vulnerable and at-risk children. Extensive research worldwide has demonstrated that quality ECD programs for vulnerable children can promote positive cognitive and emotional development in the early years (CARE n.d.; Engle, Dunkelberg, and Issa 2008; Fonseca et al. 2008); lead to reduced incidence of stunting, heart disease, and mental illness; increase school attendance; improve social and gender equality; and enhance prospects for income generation throughout life (AIDSTAR-One 2011; Irwin, Siddiqi, and Hertzman 2007; National Scientific Council on the Developing Child 2007). When done well, these programs can be sustainable because of their emphasis on engaging caregivers, parents, and the family in programming, as well as fostering community ownership.¹

This issue paper focuses on community-based ECD centers, defined as centers established at the community level for the holistic development (i.e., physical, socioemotional, and cognitive) of young children, age 0 to primary school-aged, to meet their needs and those of their caregivers, family, and community through a childcare setting. Community-based ECD centers can be an important focal point for delivering comprehensive services to young children while enhancing the capacity of caregivers, families, and communities to support the healthy development of young children. While this paper focuses specifically on children affected by and living with HIV, it is important to note that as per the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) orphans and vulnerable children (OVC) guidance, in areas with greater than 5 percent HIV prevalence, all children are considered vulnerable.

This paper is intended to provide OVC program managers with examples of best practices in quality community-based ECD center programming from which to draw in order to meet the ECD needs of the children they serve. Four case studies are provided (see pages 5 and 13, and Appendix 1 and 2) as examples of how OVC programs have integrated aspects of community-based ECD. There is also a list of considerations when planning for quality community-based ECD centers.

¹ For more information, see CARE USA and Save the Children's in-depth literature review, which provides the rationale for mainstreaming ECD into programming for orphans and vulnerable children (via their essential package of critical services for young vulnerable children and their caregivers; see Resources section).

As program managers know, implementing high-quality programs is often difficult or even impossible. Many of the recommendations in this document may not be immediately attainable with current resources, priorities, or knowledge. It is important, however, that program managers understand the elements of a quality ECD program toward which their programs can strive, and integrate those components as possible. One approach is to focus on small, doable actions, taking into account the most cost-effective intervention that suits the environment.

EARLY CHILDHOOD DEVELOPMENT PROGRAMS

Early childhood development programs aim to meet the cognitive, physical, and emotional health and developmental needs of children from age 0 to primary school-aged. Quality ECD programs integrate health, nutrition, education, and child protection; build on community strengths; support caregiver education; provide equitable access for children and their caregivers; and use various approaches that support diversity, address the needs of both boys and girls, involve multiple generations, and ensure ongoing monitoring and quality improvement. Community-based ECD centers incorporate the best of family-based and center-based ECD programs.

Family-based ECD programs generally refer to care provided in the child's home. In these scenarios, trained outreach workers or mentors provide parents or caregivers with basic skills and knowledge in child development so that evidence-based approaches and age-appropriate activities can be incorporated into traditional childrearing and cultural practices and beliefs. Family-based ECD programs build the capacity of at least one parent or caregiver to interact with their children in a way that fosters language development, exploration, and learning. The outreach workers or mentors help parents or caregivers access services such as immunization, health care, caregiver support groups, and income-generating activities. Outreach workers or mentors are trained to identify issues and locally appropriate solutions (United Nations Children's Fund [UNICEF] 2006).

Center-based ECD programs are sometimes called crèches, nursery schools, daycares, preschools, children's centers, and kindergartens. The center could be a stand-alone, designated school building, community building, religious structure (e.g., church, mosque, or pagoda), or even a spot under a tree. Ownership, financing, and management of the center can be from the government, community, nonprofit organizations, private businesses, or religious institutions. A common element of all center-based ECD programs is that they take place in a group setting where children interact with their peers and attempts are made to provide nutrition, education, and stimulation in an integrated manner (Naudeau et al. 2011). Center-based ECD programs provide certain advantages for OVC and their caregivers and families that are not always possible through family-based ECD programs. For example, center-based programs can:

- **Relieve caregiver burden** for those ill-equipped or facing challenges caring for young children. Caregivers of young children may also be caring for a child or an adult who is chronically ill, may be chronically ill themselves, or may feel depressed and hopeless, and thus may be unable to provide adequate support or responsive caregiving (Fonseca et al. 2008). Adults living with HIV often lose their ability to work, and other household members may be pulled away from their normal livelihood and childcare activities to care for the sick. Older children, especially girls, whose parents are ill or are busy caring for someone living with HIV may be kept out of school to care for younger siblings or other young children (Fonseca et al. 2008).
- **Free caregivers** for economic activity, schooling (including vocational schools), or attending to their own needs including, mental health.

- **Promote consistency of care** if children attend regularly, and follow-up is conducted when children are absent from the center.
- **Be a source of social support and relief** for children from household “toxic stress;”² be an opportunity to be away from challenging family situations; and be an opportunity to thrive in an outside environment.
- **Provide regular, nutritious meals** via center-based feeding programs, take-away rations, or center gardens.
- **Serve as an effective focal point for provision of (or referral to) various, comprehensive services** such as growth monitoring and immunizations, as well as specialized services such as for those with disabilities.
- **Put systems in place to identify and respond to abuse, neglect, exploitation, and violence** affecting children (Save the Children n.d.), including referrals to specialized services such as appropriate health care, social care, and child protection or legal services.
- **Provide an environment conducive to children’s mental and psychosocial growth** by offering age-appropriate psychosocial support to help children understand and deal with bereavement. An important component of child development in this regard is interaction with other children, which all center-based programs provide.
- **Offer opportunities for community members and parents or caregivers** to connect in groups such as parenting support groups, community meetings, or classes (CARE n.d.; Engle, Dunkelberg, and Issa 2008; Seifmann and Surrency 2003).

² *Toxic stress* is a term used to describe high levels of stress an individual experiences when he or she faces intense, frequent, or prolonged adversity without adequate support. In the HIV context, examples of toxic stress for children may include physical or emotional abuse related to stigma, chronic neglect, caregiver depression, loss of parents and immediate family members, and other hardships (Center on the Developing Child n.d.).

Positive Change: Children, Communities and Care (Ethiopia)

Between 2004 and 2011, the Positive Change: Children, Communities and Care (PC3) program reached over 500,000 OVC throughout Ethiopia. Funded by PEPFAR through the U.S. Agency for International Development, PC3 has been one of the largest bilateral investments to date in OVC programs since the advent of PEPFAR. A key initiative of the program was to support community efforts in early childhood care and development through: construction of community-based childcare centers (CBCCs), training of ECD facilitators, support for locally available learning and play materials for children, and parental education. Through supplementary funding, Save the Children supported over 72 childcare centers. The centers served the needs of children aged 3 to 5 and were a critical entry point for other services for children living with HIV. The CBCCs used a community-based approach for the management of acute malnutrition to identify malnourished children, refer for treatment, and provide rehabilitation; this approach was also a valuable entry point for identifying HIV-positive children. Facilitators were trained to recognize signs of malnutrition and other illnesses and to refer children to health facilities for further assessment and diagnosis. Each quarter, the facilitators invited health care personnel to visit the centers to screen children for malnutrition and other health conditions. Children with symptoms of ill health, including malnutrition, were referred to the health center; most would be tested for HIV. Between June 2007 and December 2008, 6,081 children were referred by the community, some through the CBCCs, and admitted to the health centers. Of this total, 2,202 (37 percent) were living with HIV (status known or exposed).

Source: Blackett-Dibinga 2011

CRITICAL COMPONENTS OF EFFECTIVE COMMUNITY-BASED EARLY CHILDHOOD DEVELOPMENT CENTERS

There are two considerations for quality ECD programming: *structural quality* and *process quality*. Well-functioning community-based ECD centers should have both. Characteristics of *structural quality* include care that can be easily regulated and measured, such as child-to-teacher ratios; small class size; educated, experienced, and ECD-trained teachers; fair staff wages; appropriate learning tools; well-developed refresher training for teachers; and tailored program content/curriculum. *Process quality*, which is more difficult to regulate, refers to what occurs in childcare settings and is measured by observations of children's interactions with caregivers and other children, and engagement with the activities and materials provided. Process quality includes nurturing and stimulating learning activities, outreach to caregivers, a safe environment for children that is gender equitable and free of stigma and discrimination, and support for the multiple needs of young children, including immediate medical care and nutritional support (Naudeau et al. 2011; Seifmann and Surrency 2003).

Quality community-based ECD centers for OVC foster a childcare setting that:

- Serves as an effective *community focal point* around which a portfolio of services benefiting children, caregivers, and households can be organized and delivered. Community-based centers can meet the needs of young children and their families or caregivers by providing comprehensive, child-friendly services (e.g., education, nutrition, health, HIV care and treatment, and water and sanitation) through a central location. This includes incorporating strategies that involve parents, caregivers, and community members in the healthy development of young children (Seifmann and Surrency 2003). These centers can also serve as a gathering point for community meetings, classes, and health services (e.g., growth monitoring and vaccinations).
- Trains staff to deliver *age-appropriate and developmentally appropriate curricula* that address HIV and nurture children's cognitive and linguistic skills and socioemotional health. Curricula should also allow for flexibility so that teachers can tailor their approaches to be responsive to children's needs and circumstances, which may differ based on factors such as sex, age, ability/disability, orphanhood, or HIV status. Quality ECD curricula are relevant to the cultural context, centered on the child's needs, and rooted in children's rights. The curricula should also emphasize verbal expression and be based on play, interaction, exploration, and discovery using all five senses including learning through movement; use culturally relevant materials; and respect diversity and individuality (Myers 2006; Naudeau et al. 2011).
- Includes *linkages to the caregivers and households*. Evidence suggests that programs that combine children's cognitive enrichment with caregiver engagement, including helping caregivers learn various skills for supporting young children, have more benefits than either approach used alone

(Seitz 1990). Community-based ECD centers should create a strong link to the household and involve caregivers. The link between caregivers and children underpins the need for programs that target both the caregiver and child (Kim et al. 2008), including making efforts to engage fathers and positive father figures (see “increase men’s involvement” bullet).

- *Educates caregivers and ECD center caretakers* on issues pertinent to the young HIV-positive and HIV-affected children in their care and what they face on a daily basis (including HIV, adherence to treatment, and stigma and discrimination), and how to respond to these issues.
- *Mobilizes and generates commitment* from caregivers, local authorities, and community leaders. Communities lay the foundation for children’s well-being and provide a social setting where children grow, develop, and thrive. Engaging volunteers, other community members, and such groups as parent-teacher associations has proven successful for ensuring effective management of ECD centers; for example, community volunteers may be involved in activities such as rotational cooking, painting, and upkeep of the center.
- Carries out community education to *increase men’s involvement* in meeting the needs of young children. This includes encouraging fathers to register their children so they can access services and engaging men as active participants in caring for children in their community (Jain et al. 2011). Several ECD centers have added a parenting component to their interventions (Naudeau et al. 2011), and the best of these engage fathers and attempt to refashion ideas about men’s involvement in the lives of their children.
- Incorporates *child-centered activities* into the curriculum. This includes providing opportunities for children to choose some activities that they are most interested in, and building the confidence and skills of teachers so they can adapt their activities to suit the flow of children’s choices when appropriate (Naudeau et al. 2011).
- *Hires teachers committed to ECD* who receive frequent training (both preservice and in-service) in child-centered teaching skills and use of a variety of learning materials, receive acceptable financial rewards, and have opportunities for professional growth and networking (Naudeau et al. 2011).
- *Is healthy, safe, and hygienic* with periodic checkups to ensure that the health of staff is monitored; that toilet facilities and drinking water are clean; that there are regular cleaning and hygienic cooking facilities; that personal care routines are taught (e.g., washing hands, brushing teeth, grooming, and using the bathroom independently); that there are emergency procedures for accidents and that staff are trained in first aid or natural disaster response; that child diagnostic and referral procedures are provided; and that attention is paid to nutrition, growth monitoring, and proper diet (Myers 2006).
- *Builds ECD teacher competence in child protection* to understand and address physical and sexual abuse and neglect as well as stigma. Community-based ECD center staff should be able to identify and appropriately intervene in cases of child abuse, exploitation, neglect, and violence. Staff should be able to make referrals for specialized care and psychosocial support, and monitor progress at home, while supporting the child at the center (CARE n.d.).
- *Ensures that ECD center staff know how to access legal services* and that community members understand how these services can assist them and the children under their care. The center has referral relationships with paralegals and holds training and awareness campaigns on child rights

for ECD staff, caregivers, and local and traditional leaders that include how to identify child abuse and neglect and how to access services for effective intervention (CARE n.d.).

- *Offers specialized support to children with unique needs* such as physical, learning, emotional, and other disabilities. Community-based ECD center staff should be able to support children with disabilities and be able to make referrals for specialized care and psychosocial support. They should also have the knowledge, attitudes, and skills to minimize stigma and help other children and adults engage with all children positively.

CONSIDERATIONS FOR PROGRAM MANAGERS: DEVELOPING EFFECTIVE COMMUNITY-BASED EARLY CHILDHOOD DEVELOPMENT CENTERS

The following list can be used by OVC program managers as a guide for developing community-based ECD centers, integrating OVC into existing ECD centers, or enhancing a current center for OVC that does not include an emphasis on early childhood or have strong linkages to the community (CARE n.d.; Engle, Dunkelberg, and Issa 2008; MEASURE Evaluation and Pathfinder International 2007; Myers 2006; Naudeau et al. 2011; Seifmann and Surrency 2003). The tools listed in the Resources section can also help with planning and developing community-based ECD centers for OVC.

Effective community-based ECD centers provide:

- A stimulating and healthy childcare environment that promotes physical, cognitive, and socioemotional development; and inclusive learning that builds on children's strengths and attends to their health and safety.
- A curriculum that focuses on physical, cognitive, language, and socioemotional development; allows children to be active and engaged; has clear goals shared by all stakeholders; is gender-sensitive and evidence-based; structures learning through investigation, play, and focused, intentional teaching; and builds on prior learning and experience.
- Psychosocial programs and referrals that are age and serostatus appropriate.
- Reduced or no fees for young children in communities highly affected by HIV.
- Services that combine the provision of resources and materials with education, training, counseling, and other support.
- Centers located near primary schools so older children, particularly girls, who are caregivers can attend school while the younger children are cared for.
- Partnerships with nearby health facilities that can receive referrals or make regular visits to the center.

- Teachers who are committed to ECD and receive frequent training (both preservice and in-service) that improves knowledge, acceptable financial rewards, and opportunities for professional growth and networking.
- Processes by which quality is recognized (through systems such as certification, regulation and accreditation); and group size and adult–child ratios appropriate to the children’s ages and overall cultural context.
- Complementary outreach programs that provide female and male caregivers with culturally appropriate information on how to nurture and promote equal development of both male and female children.
- Food supplies for OVC and their families to address food insecurity such as through food donation programs or vegetable and fruit gardens and permaculture at the center.

When done well, community-based ECD center programming can meet the needs of the caregiver and the family as well as the child.

The individual child receives:

- *An inclusive learning environment* that provides equal opportunities for all children, respects diversity, builds on the child’s strengths, and includes stimulating group experiences, play and interaction with other children without stigmatization, and opportunities for children to express themselves and have a voice in decisions.
- *Age-appropriate psychosocial support* that readies the child for primary school; enhances and supplements a child’s psychosocial need for love, attachment, consistency, normalcy, and a sense of their history and family; and integrates them into their community.
- *Integrated services* that meet the child’s various needs, including health care, vaccinations, HIV care and treatment (including antiretroviral adherence), education, and social welfare through strengthened linkages between the center and health clinics. These integrated services strengthen clinics’ ability for outreach by offering a central location where children and their families can be reached.
- *Complete childhood vaccination regimens* through collaborations between centers and local clinics. The centers can serve as vaccination sites with records of the child’s vaccinations, formal links with clinics and hospitals to bring prevention services to the center, and referral mechanisms for HIV testing, care, and treatment. Preventive and curative health care services provided include antiretroviral therapy and referrals to health centers for further investigation and treatment.
- *A nutritious meal at least once (preferably twice) each day*, which may require linking community-based ECD centers with food donation programs that require appropriate food storage and sanitation. In rural areas, centers can establish vegetable and fruit gardens and instruct community members and ECD providers on environmentally responsible farming methods such as permaculture (Greenblott and Nordin 2012) and types of produce that provide the most nutritious diets.

Caregivers and families benefit from:

- *Easily accessible quality services* for their children provided without discrimination and at low or no cost.

- *Referrals to vocational schools for skills training* (especially for child-headed households) and other income-generating activities, and skills enhancement as strategies for alleviating economic stress on the household.
- *Additional time for older OVC* who are caring for younger children at home, which may enable them to attend school or participate in economic strengthening activities.
- *Improved parenting skills* through parenting classes, mentoring, and child rights training so both women and men have the skills and commitment to learn to listen to and stimulate their children; recognize changes in young children's behavior, such as withdrawal or aggression, which can be due to loss; and recognize other symptoms of bereavement and stress, as well as the warning signs for depression and mental health concerns (for both the child and caregivers) and receive referrals for specialized services.

Integrated Child Development Services (India)

One of the world's largest ECD programs is Integrated Child Development Services (ICDS) in India, with over 40,000 centers nationwide. In each area it operates ICDS establishes a community-wide daycare and maternal care center. The center is staffed by a trained community worker and an assistant from the community, who both receive an honorarium from the government.

Children aged 0 to 6 and pregnant and lactating women receive integrated services through the ICDS centers, including immunization, growth monitoring, and supplementary nutrition; children 3 to 6 years old receive preschool education. On average, 37 children are registered in each preschool component of the program, which aims to provide a natural, joyful, and stimulating environment for optimal growth and development through such activities as singing and storytelling.

Integrated Child Development Services has not yet been rigorously evaluated, but studies show promising findings. A survey of 16,000 children found that children who attend ICDS centers were less likely to be severely malnourished and more likely to attend school than children who do not attend the centers. Another study found that children at ICDS centers aged 3 to 5 years performed better on measures of child development than the matched nonparticipants.

Source; Naudeau et al. 2011

CHALLENGES TO COMMUNITY-BASED EARLY CHILDHOOD DEVELOPMENT CENTER PROGRAMMING

Orphans and vulnerable children program managers considering ECD programs should be aware of several potential challenges. Those challenges include the following.

- A dilemma for OVC program managers who want to include community-based ECD centers in their programs is whether to target children living with or orphaned by HIV, rather than enrolling all eligible children in the community (noting that many children may be negatively affected by HIV, although this is not recognized or known by the larger community). While OVC are more likely to lack access to the support needed for healthy development, ECD centers that exclusively serve, prioritize, or favor OVC can lead to further stigma and discrimination. Guidance from PEPFAR on OVC programming says, “Programs must implement effective measures to prevent gender inequity, avoid further degradation of family structures, reduce stigma, avoid social marginalization, and that do not generate jealousy and conflict for beneficiaries. Services need to be designed to reduce stigma, not increase it” (OGAC 2006, 4). The 2009 PEPFAR *Next Generation Indicators Reference Guide* further states: “Individuals eligible for preventive and support services...Children made vulnerable due to HIV (<18 years old) including children who have lost one or both parents to AIDS who live in households made increasingly vulnerable because of HIV/AIDS. In high prevalence communities, all children may be affected due to break down in community support, loss of teachers, or other social support as a result of [the] HIV epidemic” (PEPFAR 2009, 125).
- Quality community-based ECD centers require sufficient resources. Limited resources can result in services being uneven from one site to another, being overcrowded, having too few or inadequately trained staff, and being incapable of providing the care needed by the children, and instead just a place where they will be passively watched for much of the day. One of the ways to be cost-effective is to engage the community and build on existing resources. For example, rather than build a new structure, programs can borrow space from community centers or renovate unused buildings. Instead of taking children to specialized services, programs can bring one or two professionals to the center itself. Rather than purchasing teaching aids, programs can teach staff and caregivers to make their own. Making linkages to the donor community is another approach, as well as working with donors to support certain activities and/or inputs. For example, feeding programs such as the World Food Programme may donate food, and a local or international nongovernmental organization may provide health care services (Seifmann and Surrency 2003). Another option is to engage the community, beginning with advocacy so they understand the importance of ECD, and working with the community on activities such as

rotating cooking for schools, or the donation of land for schools or community buildings for ECD classes. It may also be possible to identify local organizations that will sponsor ECD centers.³

- Fees for ECD centers can be prohibitive for families struggling with HIV. Depending on the particular context, there are some ways to address the burden of fees. One option is establishing partial or full scholarships for OVC through a government bursary system or advocating to local or national education agencies to provide support for underserved schools. Governments may compensate centers that waive fees for OVC. Using volunteer community teachers is another approach, limiting the need for fees that serve to pay teachers so that children can attend free of charge or for a nominal fee. Of course, there may be challenges retaining teachers who are not paid, and this may reduce the quality of teaching.
- Teacher salaries and staff turnover can be an issue for ECD centers. If ECD staff are employed by the host government, they may not have opportunities for refresher training, may face human resources constraints, and may be rotated in and out of the center, affecting the quality of the childcare provided. It is important not to place too much burden on staff. For example, in one ECD center in Malawi, staff are responsible for cooking the children's food, which takes time away from their focus on the children (see Appendix 1).
- National-level HIV policies and interventions are generally not designed to address the developmental needs of young OVC. For example, ministries of education often focus on school-aged children and provide schooling and health education, while ministries of health may focus more on the medical aspects of prevention and treatment and less on mitigation efforts for young children. This leaves a gap in policies and programs targeting the ECD needs of preschool-aged children and makes it difficult for projects to achieve the scale of coverage required to effectively address the needs of this growing group of children (Engle, Dunkelberg, and Issa 2008). Key national planning documents such as the Poverty Reduction Strategy Papers, HIV national strategic plans and frameworks, and national OVC policies need to include the specific needs of young children as development priorities (CARE n.d.). Efforts to mainstream ECD within HIV policies should not compete with the OVC agenda, but rather strengthen it. These agenda pursue the same objective: the well-being of OVC.

³ See the J.F. Kapnek Trust case study (Appendix 2) for examples of these approaches which they take in their ECD work.

RESOURCES

AIDSTAR-One. 2011. *Early Childhood Development for Orphans and Vulnerable Children: Key Considerations*. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

This technical brief gives an overview of critical ECD elements and existing evidence for program managers who are interested in implementing ECD programs or incorporating ECD elements within existing programs to support OVC. The brief describes the three critical elements of ECD, summarizes key findings from program evaluations and literature on ECD, and answers commonly asked questions about developing ECD programs for OVC. It also includes examples of promising ECD interventions that either target or offer relevant models for OVC programs, as well as references to useful resources for learning more about ECD for OVC. Available at www.aidstar-one.com/focus_areas/ovc/resources/technical_briefs/ecd_ovc#tab_1.

CARE USA and Save the Children. 2011. *The Essential Package: An Age Appropriate Framework for Action for Young Children and Their Caregivers Affected by HIV and AIDS*.

Resource is in draft (the draft is available via emailing Nicole Richardson at nrichardson@savechildren.org).

Christian Children's Fund (now Child Fund International). 2005. *CCF Development Scale*. Richmond, VA: Christian Children's Fund.

This scale was designed for children who live in poverty in developing countries. It uses materials familiar in the children's environment, and it can be administered by trained volunteers rather than skilled child development professionals. It helps parents understand their children's needs and identifies children who require further evaluation. The scale covers several areas of child development for children from birth to age five. It contains 165 indicators; each age range contains three indicators per development area. For example, the fine motor skills of children in the 9- to 12-month age range are tested by the children's ability to move objects into a container, in addition to two other indicators for that developmental area. The scale was designed and developed by a team representing 10 countries. It was tested to determine the usefulness of indicators, validity, reliability, and ease of administration. Translated into local languages, the scale can be used to screen children in their own homes or ECD centers. Perhaps most important, it can help strengthen and target programs to children's specific needs. Contact Child Fund International for more information at questions@childfund.org.

Maryland State Department of Education, Division of Early Childhood Development. 2007. *Standards for Implementing Quality Early Childhood Programs: Center-based Child Care and Head Start Instrument for Self-Appraisal and Validation*. Baltimore, MD: Maryland State Department of Education, Division of Early Childhood Development.

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APPENDIX I

CASE STUDY: COMMUNITY-BASED CHILDCARE CENTERS IN MALAWI

In Malawi, the current HIV prevalence rate for adults aged 15 to 49 is estimated at around 12 percent; approximately 840,156 adults and 111,510 children were estimated to be living with HIV in Malawi in 2009 (Republic of Malawi 2010). Estimates put the number of orphans in Malawi at 1.1 million (one or both parents dead), 436,500 of whom are estimated to have been orphaned as a result of AIDS-related deaths (Republic of Malawi 2010).

In 2003, as a result of the recognition of the importance of providing holistic care to children, the National Policy on Early Childhood Development in Malawi was developed to provide guidelines and coordination of ECD activities with the country (Republic of Malawi 2006). More recently, the National Strategic Plan for Early Childhood Development (2009–2014) was developed to speed up implementation of the national ECD policy and align it with the Millennium Development Goals. One of the Government of Malawi’s major ECD initiatives is the promotion of community-based childcare centers (CBCC) for children aged 3 to 5 years. The centers are also endorsed by the government as a response to the situation of OVC, especially those living in rural communities, and are a key element of Malawi’s Extended National Plan of Action for OVC (2010–2011).

Community-based childcare centers are intended as a service owned and operated by parents, guardians, caregivers, and community members, and a convergence point for safe childcare, early learning, play, stimulation, and primary school readiness (Munthali, Mvula, and Silo 2008). The centers were conceptualized as a point of access for additional services for children under five years, such as immunization and growth monitoring and promotion, referrals for sick and malnourished children, and nutritional support and supplementation. Where possible, linkages between CBCCs and other services are established. All children in a community are invited and encouraged to participate in CBCCs, especially those considered highly vulnerable or orphaned. An early childhood training syllabus, ECD training manual, CBCC profile, caregivers’ guide/training manual, CBCC committee training manual, and operational guidelines set forth a common philosophy for the development, structure, and maintenance of the CBCCs. The CBCC profile, for example, includes services to be rendered, minimum standards for a CBCC, how to monitor CBCC activities, architectural design for the centers, and costing information.

Catholic Relief Services (CRS)/Malawi is one of a number of international partners that support the CBCC system and has worked to ensure comprehensive care and community engagement. Catholic Relief Services’ work with CBCCs and Malawi’s Children’s Corners project⁴ is funded by UNICEF,

⁴ See www.tnsglobal.com/assets/files/Unicef_malawi_projects.pdf for more about the Children’s Corners project.

and CRS holds a Global Development Alliance award through PEPFAR, called IMPACT, which directly complements the work of the CBCCs by providing other care and support services in many of the same targeted communities. Catholic Relief Services' work with the CBCCs includes coordinating all project activities such as training, procurement, storage, distribution, monitoring, and data collection among the partners. Catholic Relief Services engages key stakeholders such as UNICEF; the Ministry of Gender, Children, and Community Development; the Ministry of Health; and the Ministry of Agriculture to ensure that ECD programming falls within the realm of CRS and Government of Malawi standards.

Elected CBCC committees, consisting of village leaders and parents, are tasked with overseeing CBCC daily functioning. These committees ensure the CBCCs run smoothly, help obtain needed resources, and provide overall managerial and financial oversight. They also mobilize the community to provide food inputs for the children during CBCC sessions and identify people to cook a daily meal for children. Community decision makers such as village chiefs and religious leaders participate in supporting the CBCC through activities such as offering land, helping facilitate the formation of the CBCC committees, and mobilizing community support. Volunteer caregivers are selected during open community meetings and are responsible for running the day-to-day activities (UNICEF and Government of Malawi 2007a), creating a safe and stimulating environment for children, monitoring children's growth and development, and registering and tracking daily attendance (UNICEF and Government of Malawi 2007b). Tracking daily attendance helps identify children who attend sporadically, are chronically ill or abused, and facilitates making household visits or referrals as appropriate. Play kits are provided by UNICEF to the CBCCs to promote learning and stimulation through play and recreation. These kits contain items such as soft dolls and pieces of materials, ropes, balls, musical instruments, art materials, different colored and sized blocks, and wooden or plastic beads. At selected CBCCs, UNICEF also provides playgrounds, including equipment such as swings, see-saws, and slides, to increase the variety of outdoor play activities (UNICEF and Government of Malawi 2007b).

Throughout Malawi, training of CBCC staff is the responsibility of the national core team of trainers. Yet there are significant shortages of trainers, and at the district level many nongovernmental organizations and community-based organizations provide most of the support for the recommended 10- to 14-day ECD training (UNICEF and Government of Malawi 2007b). Specifically designed for the CBCCs, the training curriculum focuses on the developmental domains of children (physical, mental/cognitive, social/emotional, moral/spiritual) and the needs of children and pregnant and lactating mothers in the areas of health, nutrition, hygiene, sanitation, protection, psychosocial care, and HIV (Government of Malawi and UNICEF 2004). The highly detailed curriculum offers clear guidelines for the facilitator, including topics to think about before the training begins, reminders to respect participants' individuality, and values clarification. Caregivers are taught how to make toys from local materials such as games from maize bags, storybooks from magazines and newspapers, teaching aids from bottle caps, and bamboo for sorting and counting. District social welfare officers are tasked with overseeing the quality of these trainings but suffer from staff shortage, so a CRS/Malawi staff member trained in the national standards provides additional supervision support.

The majority of Malawi's CBCCs do not have a dedicated facility, operating instead in the open air or under insecure grass-thatched structures that are unsuitable during the rainy season. Others function in borrowed buildings, such as churches, which are not always available. Supporting basic rehabilitation of the CBCC structure is a primary component of CRS/Malawi's program. Yet before the organization and partners will support CBCC rehabilitation, communities must demonstrate

their commitment to the program by allocating land and beginning to stockpile materials. Typically, communities contribute labor, basic building materials, and land (with land often provided by the village chief). Catholic Relief Services/Malawi then provides tin sheets, roofing beams, binding wire, cement, and other construction items generally not available in the communities or too expensive for communities to procure. Catholic Relief Services/Malawi provides the materials in a “performance-based” manner: communities must show they are in the process of building the facility before receiving the next stage of materials.

Food security in Malawi is a major problem, with overall low food productivity, low income, low micronutrient feeding content, and lack of food diversification. Catholic Relief Services/Malawi provides all its CBCCs with cooking utensils and rocket stoves, which ease food preparation by using less fuel wood; some communities receive inputs including fertilizers, maize seed, and soya beans to support community gardens to grow food for the CBCC. They also work to link CBCCs to extension workers employed under the Ministry of Agriculture, who can offer support in areas such as the application of fertilizer and best practices in the spacing and configuration of crops. While communities supported by CRS/Malawi receive agricultural inputs for communal gardens, yield from these gardens is affected by post-harvest losses and does not always provide enough food for CBCC attendees. While communities are encouraged to start a community fund for the provision of food, this support does not always materialize, as many households are struggling to feed their own members.

In April 2008, CRS/Malawi began a pilot program funded by the U.S. Agency for International Development and the World Health Organization to improve water, sanitation, and hygiene behaviors and outcomes within their ongoing home-based care and CBCC HIV programming, focusing on “small, do-able actions” (CRS 2009; Dedza Catholic Health Commission and CRS/Malawi 2009). The project promoted six target behaviors including hand washing at critical times, appropriate hand washing technique, point-of-use water treatment, safe water storage, consistent latrine use, and safe disposal of feces. These activities were also designed to benefit the whole community to help improve overall health outcomes and minimize stigmatization of those affected by and living with HIV. In a May 2009 evaluation, respondents from both home-based care households and CBCCs reported substantial improvements in targeted behaviors (Fisher et al. 2009).⁵

Despite progress, challenges remain. A major challenge for the program is the cost of caregiver training. Refresher training is indicated at six months, but CRS/Malawi found that this was not feasible financially and was too time-consuming. As with many volunteer-based programs, maintaining caregivers is one of the biggest challenges. Some caregivers trained with CRS/Malawi support are hired away by private nursery schools. To address the issue of volunteer turnover, CRS/Malawi and partners employ a number of approaches. They encourage villagers to select caregivers who have a higher likelihood of staying with the program (e.g., they have found young women are less likely to stay with the program, as compared to older caregivers), encourage caregivers to rotate and develop a shared schedule, and encourage communities to develop a schedule whereby neighbors assist in volunteer caregivers’ gardens. Yet the burden on these volunteer caregivers remains high and turnover persists.

⁵ Note that there was a small sample size for this study: at baseline and evaluation, 12 CBCC caregivers were included in the survey. At baseline, four CBCCs were sampled from each catchment area. At final, three CBCCs were sampled from Gumbi, five from Namitengo, and four from Chakudza.

Another challenge is demand outstripping supply. Caregivers report that when the CBCCs were opened, they would only see 10 to 15 children per day. But as the CBCCs became more established, facilities rehabilitated, and community outreach increased, more children came to the center (some even reporting daily increases in attendance). While the Government of Malawi's standard child to caregiver ratio is 1:15, some CBCCs face child to caregiver ratios of 1:75.

The CBCC interventions have been evaluated on an ad hoc basis by various implementing partners. Evaluations have generally found improved school readiness among children participating in CBCCs as compared to children from the same communities and from similar socioeconomic conditions who did not participate in CBCCs. Catholic Relief Services uses the Child Status Index as a baseline survey tool and planned to administer the endline evaluation in January 2012. The Government of Malawi has recently acknowledged the need for longer-term evaluation of the effect of CBCC participation on completion of primary school and possibly performance indicators related to secondary school. The World Bank is currently sponsoring a revised ECD curriculum on a pilot basis in selected districts, while districts supported by CRS and other partners have been asked to continue with the standing curriculum as a control group. The findings of this study will be used to inform adjustments to the national ECD curriculum for CBCC caregivers.

APPENDIX 2

CASE STUDY: J.F. KAPNET TRUST IN ZIMBABWE

Zimbabwe is acutely affected by HIV, with an estimated 1.2 million people living with HIV in 2009. Of this 1.2 million, the number of children aged 0 to 14 living with HIV is estimated at 150,000, while there are an estimated 1 million orphans aged 0 to 17 due to HIV (Joint United Nations Programme on HIV/AIDS 2009). The education system at one time was one of the strongest in Africa, but it has deteriorated rapidly in the past 20 years. Teacher salaries remain low relative to their daily expenses, facilities are collapsing due to poor maintenance, and many schools lack basic school supplies. All of Zimbabwe's children are affected by the collapse of the national school system, but especially the most vulnerable. The 2004 national ECD policy requires primary schools to offer a minimum of two ECD classes for children aged 3 to 5. Because the government recognized the dearth of teachers with the appropriate ECD training, paraprofessionals can participate in six-week training programs to receive formal certification. However, lack of government resources in recent years has prevented formal implementation of the national ECD policy.

J.F. Kapnek Trust is the leading provider of prevention of mother-to-child transmission (PMTCT) programs in Zimbabwe and also offers ECD programming. Kapnek currently implements a comprehensive ECD approach, in line with the government's national ECD policy, and utilizes ECD centers as the key entry point for community-based interventions. Objectives of Kapnek include developing partnerships with the Ministry of Health, the Ministry of Education, and nongovernmental organizations to decrease the incidence and impact of HIV on children, and support OVC and their families through community-based programs including preschools and primary education support.⁶ Their program carries out, or facilitates, the following activities: renovation of derelict classrooms; parent/guardian education; in-service training for ECD paraprofessional teachers; donation of grade one classroom resources; payment of school fees, text book donations, and provision of playground equipment; encouragement of the establishment of community-based child protection committees; carrying out supplementary feeding and routine health care; and ensuring that children obtain birth certificates.

At program onset, Kapnek utilized small grants ranging from U.S.\$10,000 to \$30,000 from several small U.S.-based foundations. In 2007, a three-year grant (at U.S.\$350,000/year) from a pool of donor funding administered by UNICEF enabled Kapnek to scale-up the project to another district.

⁶ Other Kapnek objectives include to support excellence in medical- and health-related education and research in Zimbabwe; develop youth-focused programs that address issues relevant to the lives of young men and women, including psychosocial support, self-empowerment, HIV/sexual awareness, gender issues, and life skills; support the development of comprehensive, community-based rehabilitation programs for disabled children and their caregivers; encourage and support the education and training of young women for leadership positions; and foster collaboration between medical, research, academic, and donor communities worldwide, and particularly in Zimbabwe, sub-Saharan Africa, the United States, and the United Kingdom (J.F. Kapnek Trust n.d.).

This funding ended in 2010, however, Kapnek received a grant of U.S.\$100,000 from the Doris Duke Foundation and a similar amount from the Bernard van Leer Foundation to complete the development of preschools in a second district. Despite diverse funding sources, Kapnek's funding comes to an end in June 2012.

The target population of these ECD interventions is children aged 3 to 6 and their parents/guardians in communal, rural areas of two districts. At program onset, discussions with the community usually take place through the school development committees (SDCs), and partnerships are formed to develop an ECD center. The SDC is seen as the bridge between parents/caregivers and Kapnek. As part of this partnership, the community determines what it will contribute in terms of the renovation and maintenance of the ECD center. For example, a suitable unused or derelict classroom in the local primary school is identified by the headmaster and SDC, which is then renovated and furnished by Kapnek. The local community typically contributes building materials and labor toward the project.

The SDC selects three volunteers from the community to serve as paraprofessional ECD teachers. As part of ongoing capacity building, paraprofessional ECD teachers and teachers-in-charge attend monthly in-service training based on preapproved Ministry of Education, Sport, Arts and Culture (MOESC) preschool curriculum. The monthly in-service trainings are led by a professional ECD trainer employed by Kapnek who works with the district ECD trainer, who is employed by the MOESC. There are also workshops for school headmasters and SDCs that provide talking points and guidance on the importance of ECD. The goal of the program is to have MOESC personnel available to conduct all trainings as the program expands and when resources are available.

Community sensitization is an important component of program implementation. A common misperception is that the paraprofessional ECD teachers just "play" with the children and therefore do not need to be compensated for their work. Kapnek staff work to sensitize the community and first-grade teachers on the importance of ECD by discussing how the children at the ECD center learn through play, which is typically a different model than the one adopted in the first grade. First-grade teachers are made aware of what happens at the ECD centers and why, facilitating a smoother transition from the center to primary school. The community is also encouraged to take an active role in the sustainability of the ECD center (e.g., mothers prepare and serve lunchtime meals for their children according to a roster system they devise).

Through Kapnek's assistance, monthly parenting support meetings allow a space for parents and guardians to discuss a range of issues aimed to improve individual and community-wide knowledge of how to care for and support children. The parents share ideas on child development among their peers, and all topics discussed come from initial and ongoing discussions with the community. Various district officials, in conjunction with Kapnek staff, facilitate the meeting each month. It is important to note that the focus of the parenting classes is on parents who have children attending the ECD center, parents who may have children attending in the near future, and caregivers of OVC. The topics covered are for both men and women, and while it is sometimes a challenge to get men to attend the classes, there is an effort to attract them.

Kapnek aims to provide a hot, vitamin-fortified meal to all children in their sponsored preschools. When funds allow, Kapnek purchases and delivers these meals quarterly to ECD centers. Supplies of the nutrition supplements are usually not a problem in-country, and Kapnek has learned how better to distribute the supplies over the years, primarily through decentralizing the delivery process. Instead of delivering to each primary school individually, a cluster of schools receive provisions at one predetermined location. It then becomes the community's responsibility to store the supplies.

The ECD centers aim to integrate health and community outreach to parents under one roof and establish synergies between ECD and PMTCT programs. Kapnek has a separate PMTCT initiative and office, but there are linkages between the two programs even though the target populations are different. For instance, Kapnek encourages discussions of PMTCT in the ECD parenting classes. Further, the Government of Zimbabwe previously promoted an expanded program on immunization. However, this has been curtailed severely in most rural areas due to lack of resources. Kapnek currently provides nurses from health clinics with the means of reaching communities to perform health assessments on a quarterly basis. While families are waiting their turn to see the nurse for the health assessments, they receive information on nutrition, family planning, PMTCT, and other topics. The quarterly checks ensure that all children graduating from the ECD centers are fully immunized.

All children in Zimbabwe are supposed to be registered with the government and provided with a birth certificate. Without a birth certificate, citizens cannot vote, get a driver's license, or sit for exams. Although many caregivers have the required documents, registering a child can be difficult if both parents are not present. In addition to conducting community sensitization discussions that focus on the importance of birth registration, Kapnek provides transportation to the registrar's office, which is informed that community members will be arriving on a particular day. Community members are given a few weeks between the sensitization event and the visit to the registrar's office to collect the necessary documents. In cases where both parents cannot attend, provisions exist such as having witnesses attend; Kapnek has built a good relationship with the registrar and manages these cases with reasonable efficiency.

Despite the successes, challenges remain. As with many programs, turnover is high without financial or other incentives to retain committed volunteers. Teachers and support staff expect remuneration for their work, and the financially strapped communities can no longer find funds to pay them. Setting up a system to make the nutrition supplements sustainable has been difficult due to lack of financial resources at the national and local levels. The proposed teacher to child ratio of 1:20 has not been possible in most communities due to the limited capacity of communities to pay teachers. In many locations, the ratio is closer to 1:40. The importance of immunization is questioned in some sites, which has affected implementation of routine health checks for children at these centers. Further, birth registration is a politically sensitive issue as birth certificates are necessary to vote. Nongovernmental organizations could be looked upon with suspicion when helping teenagers eligible to vote obtain birth certificates in the case that the organization's influence could affect their voting.

A 2010 "best practice" review showed excellent progress, noting: "The achievements of the Kapnek Trust in Zvimba are remarkable. A whole generation of children in this area has benefited from their intervention" (Price and Marimo 2010, 27).

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