

EVALUATION SUMMARY REPORT

**EARLY CHILDHOOD DEVELOPMENT PROGRAM FOR CHILDREN
AFFECTED BY HIV AND AIDS IN RURAL ZAMBIA**

*A Program of Episcopal Relief & Development
and Zambia Anglican Council Outreach Programmes (ZACOP)*

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I. Executive Summary

Launched in 2012, the Integrated Early Childhood Development Program involves more than 6,000 families, reaching nearly 10,000 young children under 6. At the heart of the program are trained ECD volunteers who facilitate Caregiver Support & Learning Groups and make home visits to promote positive parenting behavior with caregivers; using visual guides to lead action-oriented dialogues.

In 2016, an external evaluation was conducted with results measured against baseline data and a control group. Overall, the evaluation found that the ECD Program in Zambia was successful in achieving primary caregiver behavior change, strengthening parent-child relationships, and increasing nurturing care and stimulation with children under 6. The program provides opportunities for families to meet their basic needs in health, nutrition, food security, and livelihoods.

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. Community commitment and strong sense of ownership greatly contributed to the accomplishments of the ECD Program. 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.

The external evaluation found that the ECD Program successfully achieved its overall goals to improve young children's healthy development:

- **Increase primary caregivers' nurturing care and early stimulation** of their young children
- **Strengthen primary caregivers' capacities** so they are healthy and able to respond effectively to children's needs
- **Empower primary caregivers' capacities** so they are healthy and able to respond effectively to children's needs
- **Empower and equip community and volunteers** to manage and sustain ECD activities

Highlights of Key Findings

Communities are Empowered and Equipped to Lead and Manage ECD Activities

- The ECD Program is community-led and includes all relevant local stakeholders at various program management level (from community to district/provincial level);
- Community-led approach has resulted in strong sense of community ownership of the ECD Program.

Trained ECD Volunteers are Effective Facilitators

- Trained ECD volunteers demonstrated strong knowledge levels in ECD, positive parenting and parenting practices that promote child development;
- ECD volunteers have sound facilitation skills and knowledge to engage and lead dialogue with primary caregivers and deliver key ECD messages effectively.

Increased Quantity and Quality Child-Caregiver Interactions

- The quality of child-caregiver interaction improved tremendously; evidenced by primary caregivers, providing a caring and loving environment to their children, and showing more interest in their children;
- Child-parent interaction improved in activities that promote the 5 child developmental areas (i.e. cognitive, language, social, emotion and physical);
- Program implementation of 2 years achieved comparable results to those produced in 4 years.

Improved Child and Maternal Health

- Increased in child health-related indicators such immunization and growth monitoring attendance and a reduction of children who fall ill;
- Primary caregivers improved health seeking behaviors and increased knowledge and practices in disease prevention practices gained through their interactions with ECD volunteers during home visits and Caregiver Support and Learning Group meetings;
- Primary caregivers demonstrated good knowledge of HIV transmission and prevention and an increase number of caregivers are seeking services (i.e. testing and counseling).

Improved Child Nutrition

- Children's nutrition intake improved;
- Caregivers demonstrate improved knowledge in nutrition and cooking skills that enables them to provide a balanced diet for their children.

Strengthened Household Livelihoods

- Caregivers in Savings & Loan Groups feel financially secure and empowered. 66% of all members reported to have used the savings for investments in small businesses from which the households have gained profits.

Overview of the ECD Program in Zambia

The **Integrated Early Childhood Development Program (ECD)**¹ in Zambia was implemented by the Zambia Anglican Council Outreach Programmes (ZACOP) and Episcopal Relief & Development from 2012 to 2013 (Phase I) and from 2014 to 2016 (Phase II). The ECD Program uses an integrated rural development program model to address the holistic needs of young children and their primary caregivers. The target population is primarily families directly affected by HIV and AIDS and other vulnerable households.² The program has reached almost 10,000 children in over 6,000 households in rural communities in Zambia.

The program aims to build sustainable capacities of parents/primary caregivers to provide nurturing care and early stimulation for infants and young children under 5. Targeting this age group is critical, as the period between birth and age 5 is a high-impact period for children's healthy growth and development. Thus, the program uses a holistic model that supports children in reaching their full developmental potential and that focuses on four critical areas:

1. Responsive Care and Early Stimulation (cognitive, language, social-emotional and motor skills development of children)
2. Child and Maternal Health
3. Nutrition and Food Security
4. Economic Empowerment and Family Livelihoods

The program is delivered by nearly 750 trained community volunteers through monthly home visits, caregiver support and learning groups, pre-school learning, savings and loan groups, health and nutrition education, and through linkages to public services, such as health and counseling services

1 Scope of the Evaluation

The scope of this evaluation is to analyze and provide evidence on the quality and extent of primary caregivers' key positive parenting actions in their interaction with their children. Moreover, this evaluation seeks to analyze whether any observed changes in this interaction are the direct results of learning and training delivered by the ECD volunteers through home visitation and/or caregiver group activities and other activities that take place at the ECD centers. The evaluation also provides an in-depth analysis of ECD support structures³ to assess whether these structures deliver relevant and effective services to primary caregivers and children.

2 Literature on Early Childhood Development

We acknowledge that most child development and learning in the first three years of birth takes place in a home environment and most interventions for children 3 to 6 years are preschool or

¹ For more information about the program, see the Five-Year Program Report and Summary Program Report at <http://www.episcopalrelief.org/what-we-do/our-programs/maternal-and-child-health/EarlyChildhoodDevelopment>

² Households led by children/adolescents, grandparents, widows, etc.

³ Program support structures include: ECD Center Management and Steering committees, Caregiver Support and Learning Groups, Saving & Loan Groups, Pre-school Sessions and Toddler Playgroups, and established government structures at community level such as health and counselling services.

center-based. However, we also argue that there is a fluid relationship between the home and the center; both of which support child development and learning during the two critical developmental periods. In low-resource communities, literature shows that while the demand for quality preschools is increasing, demand for services for children below the age of 3 must still be encouraged (Richter et al., 2016) through involvement and mobilization of parents, families, and communities in low and middle income countries to take positive action on child development. For this age group, where the majority of children are cared for at home, greater emphasis on home and community-based programs is important to reach these young children. Also, low-cost activities, such as storytelling, singing, and playing with locally-found objects, expose young children to experiences that promote early development (Barros, Matijasevich, Santos, & Halpern, 2010).

Evidence shows that supporting home-based interventions to build parenting capacity is linked to children's cognitive and socio-emotional development (Walker et al., 2007; Walker, Wachs, et al., 2011) with effects that extend to adulthood (Walker, Chang, Vera-Hernández, & Grantham-McGregor, 2011). Fostering a nurturing environment at home where parents are sensitive to children's health and nutritional needs, responsive, emotionally supportive, and developmentally stimulating advances children's development (Black & Aboud, 2011). For families with low socioeconomic status, nurturing care during early childhood diminishes the detrimental effects of stress, insufficient nutrition and lack of stimulation on brain development (Hanson et al., 2015; Noble et al., 2015; Pavlakis, Noble, Pavlakis, Ali, & Frank, 2015).

Informed by social ecology, (Bornstein & Hendricks, 2012) nurturing care extends beyond families to include community caregivers and support for families (Farnsworth et al., 2014). The systems model that forms the basis for our life course includes both an enabling environment for caregiver, family, and community, and an enabling social, economic, political, climatic, and cultural context. The former represents personal resources, including maternal education and maternal physical and mental health, and community resources including safety, sanitation, and absence of stigma. The latter represents structural aspects, including policies, laws, supportive organizational systems and structures, and financial wellbeing, as well as wars, conflicts, droughts, and cultural variations. These multi-level components are mediated through nurturing care to influence children's development.

3 Methodology

3.1 Evaluation Design

This evaluation study employed a multi-pronged approach to its research design to produce reliable and valid results using a longitudinal and quasi-experimental study design. The longitudinal design allowed for comparison of findings with baseline data collected in 2012 (Phase I) and 2014 (Phase II), and was complemented by data collected through routine monitoring activities. This design allowed the study team to examine any association between program activities and observed outcomes. However, a longitudinal design is not strong enough to answer the question whether observed outcomes resulted directly from implemented program activities or if any other factors may have led to the observed program outcomes. This led to the integration of a quasi-experimental study design. A quasi-experimental design refers to the

inclusion of study subjects who did not participate in any activities implemented by the ECD program (control group) or activities that could have led to outcomes that resemble the outcomes of the ECD program – e.g. an ECD project or program implemented by another organization.

3.2 Data Collection Methods and Study Participants

This study utilized a triangulation of methods, also known as mixed methods research, which involves the joint use of quantitative and qualitative styles of research and data (Johnson & Onwuegbuzie, 2004). Triangulation not only provides an explanation for the same project from multiple perspectives, but also enriches understanding as it permits the emergence of new and deeper dimensions. Table 1 below shows the various data collection methods used by type of study participants.

Table 1: Data Collection Methods and Study Participants

Data Collection Method	Study Participants
Structured quantitative questionnaire	Primary caregivers
Semi-structure qualitative questionnaire	Volunteers: ECD Center Management Committees, staff, program managers and field officers
Focus group discussions	Primary caregivers and ECD volunteers
Quantitative knowledge assessment tool	Primary caregivers and ECD volunteers

In consultation with ZACOP program managers and field officers, participants of the study were selected based on the criteria of equal representation of projects per province and the number of primary caregivers and ECD volunteers per province. In total 338 primary caregivers (1:4 female-male ratio) and 243 ECD volunteers were interviewed in 7 provinces.⁴

4 Overall Results of ECD in Zambia

4.1 Community-Based Program Management

The ECD Program is a community-led model which mobilizes local leadership and builds community management from the beginning, and gradually transitions to full community ownership. This process is guided by the ZACOP program staff who work in collaboration with local stakeholders⁵ on the program’s principles and activities.

⁴ Central, Luapula, Copperbelt, North Western, Lusaka, Southern and Eastern.

⁵ Village headman/women, faith and community leaders, community health workers, ECD volunteers and participating primary caregivers.

Community activities take place at the 53 ECD centers. Each ECD center has its own **ECD Center Management Committee**⁶ develops new activities and is responsible for program administration and monitoring activities. ECD Center Management Committees greatly contribute to a strong sense of community ownership as all planning and decision-making activities are carried out in an inclusive way. For example, the committees coordinate community initiatives such as the building of new ECD Centers and mobilizing locally available resources to construct the building.

The Steering Committees, made up of community and government leaders,⁷ oversee a group of ECD Centers jointly to coordinate and streamline program activities, make recommendations and set directives based on ECD Center Management Committee reports, mobilize their community, their 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. The evaluation found that Steering Committees are well established in all the project sites visited, with the exception of a few where stakeholders were still being recruited.

4.2 ECD Community Volunteers: Committed to change through facilitation, communication and learning

The ECD Program's Theory of Change posits its success largely on the effectiveness of its most important volunteer role – the ECD volunteer. Almost 750 ECD volunteers work with primary caregivers on parenting – nurturing care and early stimulation – which is the core of the program. The success and the quality of the ECD volunteers' work is fundamentally determined by the extent to which primary caregivers understand and adopt essential parenting practices in their interactions with their children and thus increase their abilities to meet their children's basic needs. Thus, ECD volunteers are required to have a **sound understanding of ECD messages and key actions caregivers can take to stimulate their children's development.**

The interaction between caregivers and ECD volunteers mainly takes place during home visits (individual interaction) and during the monthly caregiver support and learning groups (group interaction) at the ECD Centers. Both interactive platforms require ECD volunteers to have sufficient skills to initiate and lead dialogue using visual guides to discuss key ECD messages and how to put parenting into practice. Having **good facilitation skills** is critical to the effectiveness of the ECD volunteers.

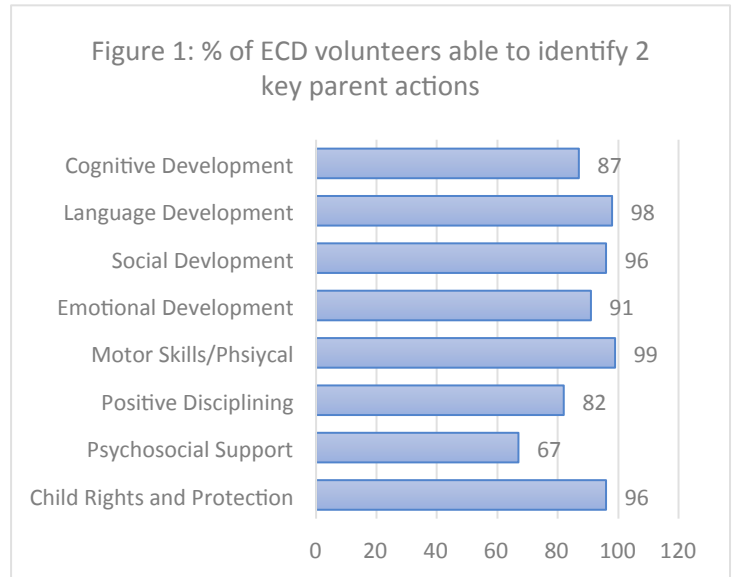
Key Results

ECD volunteers' ECD and parenting skills knowledge were assessed using a knowledge assessment. Volunteers were asked true-false statements. For example, "*A child's development is influenced by the home environment the child lives in*" is this true or false? **On average, 83% of ECD volunteers answered the ECD knowledge questions correctly and 90% of ECD volunteers answered positive parenting questions correctly.**

⁶ ECD Management Committees manage community-based activities and ECD volunteers, liaises with program staff and, coordinates with other stakeholders providing services (e.g. Ministry of Health, Ministry of Agriculture, etc.).

⁷ Village leader, Ministry of General Education, Ministry of Health, Ministry of Community Development and Social Welfare, and the Ministry of Agriculture and a lead volunteer from one of the centers in the area.

This evaluation also assessed whether ECD volunteers are able to guide parents on what key positive actions they can take to promote a specific developmental area of their child. ECD volunteers were asked to identify two key parent actions in the four developmental areas. Figure 1 indicates strong knowledge levels of ECD volunteers in guiding caregivers on using an effective key parent action. **On average, 90% of ECD volunteers were able to identify two key parent actions.**



ECD volunteers demonstrated strong understanding of and the ability to apply facilitation skills during their interaction with primary caregivers. For instance, an ECD volunteer said, *“The visual guides have a great learning effect on caregivers as almost all of them understand the message very quickly unlike when you just talk to them. That’s when you [as volunteer] have to explain and justify yourself and the messages and if you are not fast in explaining, a caregiver will doubt the importance of your message and maybe won’t take you serious.”*

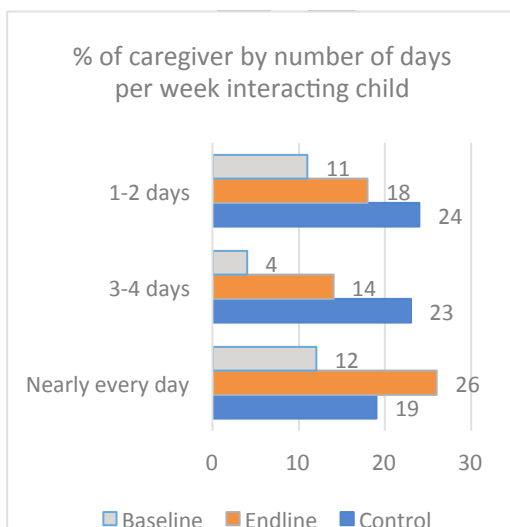
In addition, ECD volunteers successfully gained the primary caregivers trust, which enabled them to talk about sensitive issues in child development. The good relationship between ECD volunteers and caregivers was very instrumental in caregivers adopting the ECD messages.

In summary, ECD volunteers have demonstrated sound knowledge of ECD and parenting skills and have the capacity to effectively facilitate social and behavior change curriculum with caregivers.

4.3 Changed Primary Caregiver Behaviors – Increased practice of care and stimulation

The ECD Program is based on the assumption that caregivers gain critical knowledge and skills in caring for and nurturing their children through monthly home visits and caregiver support and learning groups. Thus, they change their behavior in caring for their children and quality of child interaction.

Figure 1: Child-caregiver interaction



This study did not only assess quantitative aspects of caregiver-child interaction (number of days per week and hours per day), but more importantly interaction that provides child development stimuli in areas such as cognitive, language, physical and social-emotional development. Furthermore, quality of interaction was further investigated by assessing the extent of caregivers understanding and applying principles of

positive parenting and care, which includes positive disciplining.

Key Results

As a result of the program, the study found an increase in caregiver-child interaction. Figure 2 below shows that 14% more caregivers interact with their children on a daily basis and 10% more caregivers spend time with their children on three to four days per week compared to the baseline. Caregivers in the ECD Program also spend 50% more time interacting with their children per day compared with caregivers in the control group.

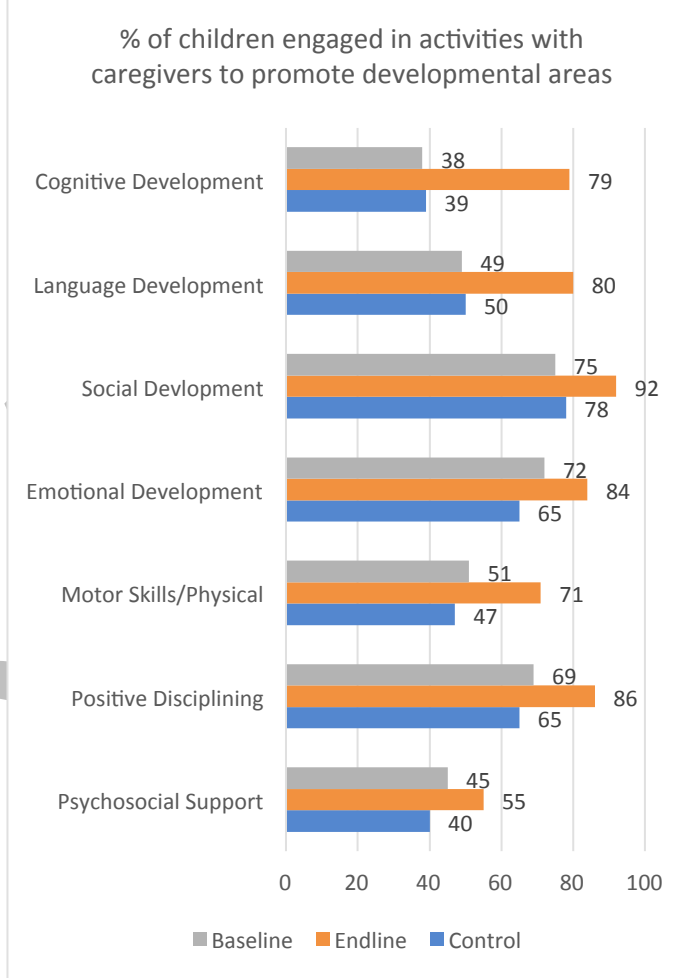
The biggest improvement was in **cognitive development**. There was a 41% increase in the proportion of children engaging with caregivers in activities (such as providing play material and playing) that develop their thinking and communication skills. Prior to the program, only 38% of children engaged with caregivers in such activities.

Similar results were found in the area of **language development**. A significant increase of 31%⁸ in the proportion of children engaging with caregivers in activities that foster language development such as singing with the child/to the child or telling the child a story (Figure 3).

Despite the high baseline values for the area of **social development**, this study found positive changes in all activities. Activities like encouraging the child to play with other children (98% of all children engaged) or taking the child to community and church activities (91%) have increased in a similar way like asking a child to help the caregiver doing simple house chores (86%). On average 17% more children engage with their caregivers in activities fostering social development.

Emotional development of children can be fostered by showing an emotional affection to a child by praising a child for an accomplishment or comforting a child after s/he got hurt. At baseline 72% of children were found engaging in such activities with their caregivers. This proportion has increased to 84% and is significantly higher than the control group. These results are similar to the observations by caregivers when they were asked to explain what they do

Figure 2: Child-caregiver interaction by developmental area



⁸ Average values for all activities.

when the child is feeling sad. Caregivers demonstrated different approaches including hugging, kissing the child, embracing the child or buying them sweets.

Activities that promote **motor skills and physical development** include encouraging a child to be physically active (play balls, jump, dance, etc.) or provide small objects like a stick, a spoon or a small ball and animate the child to pick up the object the caregiver provided.

Caregiver-child interaction in the area of **positive disciplining** includes activities such as praising a child for good behavior. This interaction has increased by 17% compared to baseline. Caregivers also expressed their confidence in their ability to apply the knowledge they have acquired on positive parenting such as children's rights, how to talk to the child when he/she does something wrong, and how to show affection to the child.

Psychosocial support and care refers to activities between children and caregivers that aim to emotionally comfort children in distress, for instance children who lost a parent or a sibling. At baseline 45% of children engaged with their caregivers in activities that provide psychosocial support and care. The study found that this proportion has increased by 10%. Caregivers gave examples of how they care about children who have lost their parents as a result of HIV and AIDS in focus group discussions. Many responded that in the past, children who lost their parents from HIV and AIDS used to suffer from stigma, but since the ECD Program started, this has mitigated with the help of community awareness.

In summary, it was found that primary caregivers participating in both group and individual home visits with ECD volunteers produced successful learning, peer support and caregiver adoption of improved parenting practices. This is evidenced by:

- Increased caregiver-child interaction (duration, frequency and quality, including fathers)
- Improved caregiver behavior in responsive care and early stimulation
- Improved skills in positive disciplining and psychosocial support

4.4 Child and Maternal Health

Primary caregivers were taught the importance of seeking health services for their children and themselves. During Caregiver Support and Learning Group meetings, caregivers participate in health education sessions where they learn about children's growth monitoring, vaccination and malaria prevention, testing and treatment. The evaluation found strong improvements in caregiver's health seeking behavior to improve child health evidenced by 96% of children receiving age appropriate immunizations⁹, 83% of children participating in monthly growth monitoring¹⁰ and 86% of children¹¹ under-5 are sleeping under mosquito nets.

The ECD Program strongly focuses on improving child and maternal health by enhancing knowledge of HIV/AIDS prevention and treatment, mother-to-child-transmission and reducing the burden of stigma and discrimination. Since the program's inception, almost 1,300 caregivers were counseled on HIV/AIDS.

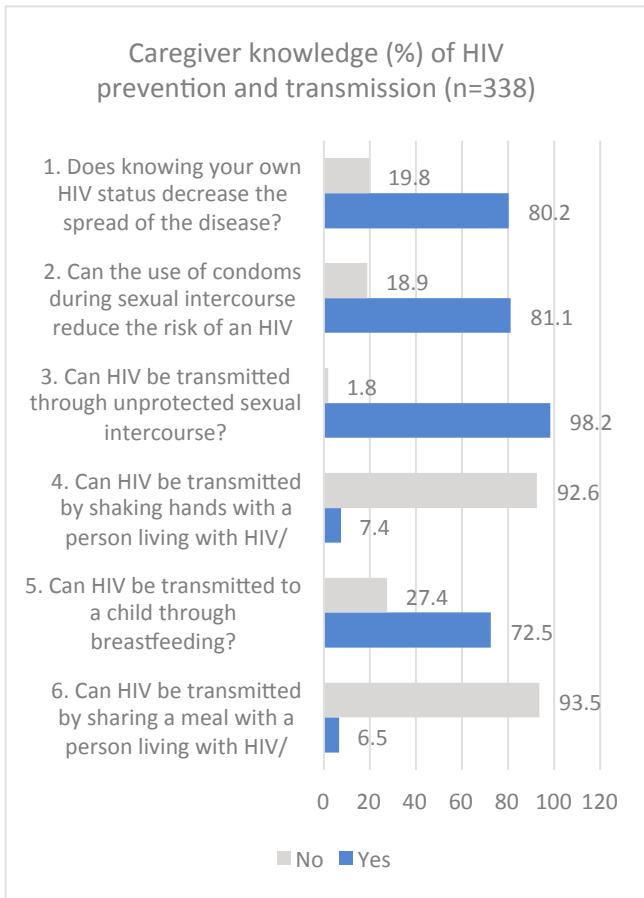
⁹ Baseline: 58%

¹⁰ Baseline: 70%

¹¹ Baseline: 56%

The program’s combination home visit and caregiver support group model was effective in de-stigmatizing HIV and AIDS, and encouraging more families to get tested and treated. Over the years, ECD volunteers have gained caregivers’ trust and confidence. This relationship has

Figure 3: Caregiver knowledge of HIV prevention and transmission



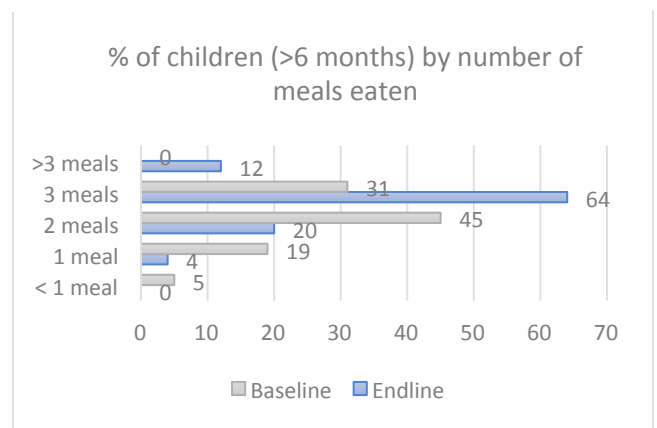
resulted in a growing number of caregivers confiding in their ECD volunteers, who safely encourage them to seek counseling.

Caregivers during focus group discussions indicated that their communities have experienced significant changes in the way people affected by HIV/AIDS are being treated. They reiterated that in the past people infected or affected with HIV and AIDS used be marginalized and stigmatized. The situation was worse for children as the family members were reluctant to take them on once it was known that their parent(s) died of HIV and AIDS for fear of contracting the virus. The caregiver, however, reported improved knowledge and attitudes towards HIV and AIDS, a change which was largely attributed to the ECD Program. Evidence on strong caregiver knowledge on HIV transmission and treatment is presented in Figure 4, which shows that 86% of all interviewed caregivers answered the questions on HIV prevention and treatment correctly.

4.5 Child Nutrition and Household Food Security

Nutrition is a key factor for child development, especially the brain. (Georgieff, 2007). During pregnancy, poor nutrition may result in low birth weight and height and lifelong developmental delays or disabilities (Bhutta et al., 2014). Children who are undernourished or are frequently ill are at high-risk for developmental problems, emphasizing the urgency of developing coordinated early childhood development programs in collaboration with the health and nutrition sectors. It is therefore important for caregivers to adhere to age-appropriate feeding practices.

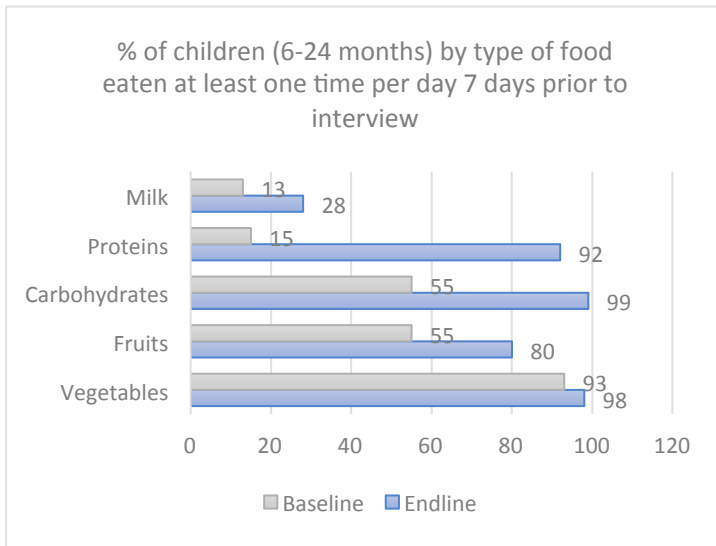
Figure 4: No of meals children have per day



The ECD Program provided comprehensive nutrition education and services. Each month, ECD volunteers trained as CHWs by the Ministry of Health facilitated nutrition knowledge sessions that included cooking demonstration using nutritious and locally available foods, the provision of vegetable seeds for family kitchen gardens.

The study found that caregiver awareness and practice towards their own and their children's nutrition have improved remarkably. These improvements are evidenced by an increase in children aged 24 months to 6 years who received a well-balanced diet frequently throughout the

Figure 5: Type of food given to children



day on a daily basis. Through cooking demonstrations and interactions with ECD volunteers, primary caregivers have gained strong knowledge levels of age-appropriate food that benefits their children's healthy growth and well-being. 95% of caregivers were able to identify nutritious foods that make a healthy diet for children aged 0 to 6 months, and 91% were able to identify healthy food components for children older than 6 months

4.6 Household Livelihoods and Economic Empowerment

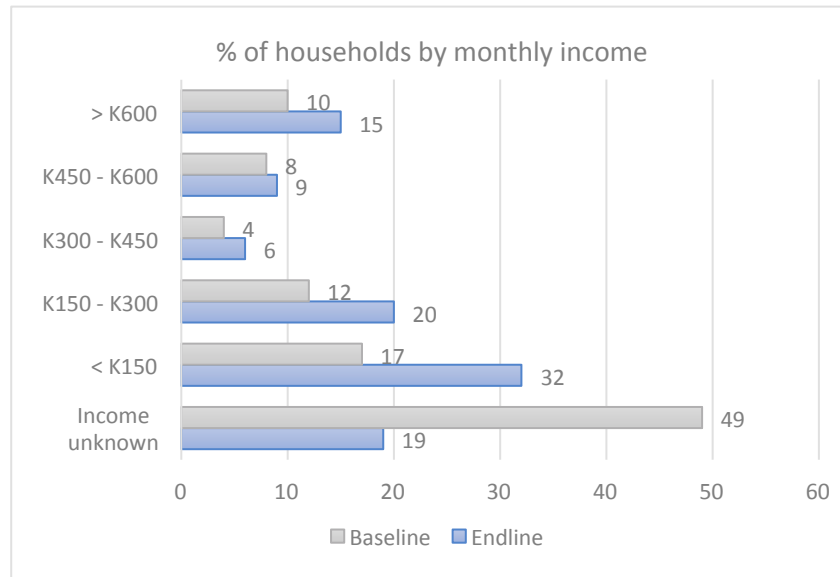
The fourth intervention area of the ECD program is to strengthen family livelihoods so caregivers can provide adequate care to their children. The ECD program adopted a community savings and loan methodology which combines financial education and access to savings and loan. This methodology is known as **Savings with Education (SwE)** as it **combines financial empowerment with an educational component**. Groups manage and set their own rules and principles of saving, borrowing and repaying. Members are allowed to borrow money from the group's savings to either invest in a small business or use the loan for an emergency.

Since inception of the SwE component, the response has been overwhelming. It was found that 54% of primary caregivers were already members of a saving group and the other 46% was readily waiting for new groups to be formed. Nearly all group members who have taken a loan reported the profitability in their investments. Primary caregivers have either started a small business, like a chicken run or a community bakery, while others invested in their existing business. All members reported that they succeeded in paying back the loan and made a profit which they re-invested in their businesses. This program component comes with a ripple effect as it enhances primary caregivers' capacity to meet their children's needs. During the focus group discussion, a female primary caregiver shared,

"The saving groups have been helpful. Money from the saving groups helps in sending children to school, buying food, accessing farming input through Farmer

Input Support Program (FISP) where we are given four bags of fertilizer and a 10Kg bag of seed.” (Female caregiver, Makafu).

Figure 6: Monthly income of caregiver household



The economic benefit of SwE is also evidenced by the increase proportion of households that transitioned from a no-income- to an income-generating household. The findings show a reduction in of households without knowledge of their income from 49% to 19%. Unknown household income usually implies irregular economic activities where small scale farming household sold only few bags of maize or soya beans to bulk buyers.

5 Program Success

This evaluation study found that the success of the ECD Program is attributed to a number of key factors.

I. Community management and ownership

The institutional structures and decision-making procedures include relevant local stakeholders like community leaders, ECD volunteers, program participants, and representative from government and civil society organizations. This management arrangement not only contributes to a great sense of ownership at all program levels, but also embodies the sustainability strategy of the ECD program.

II. ECD Volunteer Effectiveness

ECD volunteers have not only shown sound knowledge levels of ECD and parenting skills, but also proved to have practical skills of facilitating both home visits and caregiver support and learning groups. They are able to lead and engage in dialogue and foster learning among themselves and caregivers. Thus, the ECD volunteers play a crucial part in initiating social behavior change of primary caregivers

III. Dual Component Model of Caregiver Participation the ECD Program

The combination of home visits and caregiver support and learning group meetings has been proven to be a successful program model that caters for caregivers’ learning preferences and personalities. Caregivers’ clearly demonstrated their appreciation of the model as caregivers

differ in how they learn, seek guidance and exchange ideas. Program results would differ due to the positive effects the dual ECD models had on caregiver learning and sharing practices.

IV. Sustainability

The evaluation found an already existing strong foundation to sustain the program without external support. This is evidenced by:

- Community participation at all program levels has led to a great sense of community ownership
- Program beneficiaries have benefitted from the program almost immediately caregivers adopted the ECD key messages
- ECD knowledge resources (ECD volunteers and primary caregivers) are invaluable to helping with the scale-up of programming
- Inclusive local management structures that include all relevant stakeholders such as community leaders and line-ministries;

6 Recommendations for Program Strengthening

Despite the overall success of the ECD program, this evaluation also identified challenges and areas for on which the following recommendations are based on:

1. Improve caregiver understanding and practice on child rights and corporal punishment

Some primary caregivers still resort to corporal punishment of their children when these are overly rebellious. Hence, any positive parenting training in future requires to address this in more detail, by adding a training component to the current training and also by including it in the plays presented by drama groups. Grandparents could also act upon this matter adding stories of over-rebellious children.

2. Increase fathers' participation in ECD program

The evaluation noted that fathers' participation is relatively low, since the program only worked with one primary caregiver per household and the vast majority are women. This calls for the need to identify strategies to foster male participation in ECD program activities, including directly targeting fathers together with the primary caregivers.

3. Capacity building plan for ECD volunteers

The vast majority of current ECD volunteers with sound knowledge levels in ECD and management skills provide an opportunity to carry out internal capacity building activities to address a few shortcomings at the current ECD centers, but more importantly they are capable of training new volunteers if the program will be scaled up. There is also need for on-going capacity building for members of the steering committees on child development.

4. Workforce Development

There is need for workforce development by improving volunteer training and developing a mechanism to reward them for their efforts in the program. This will ensure that the volunteers will improve their qualifications and has potential to reduce volunteer turnover. Linked to incentives, it is important to also professionalize early childhood education to ensure that

volunteers teaching at ECD center preschool sessions are recognized as a para-professional body which is providing care and education for children under 6.

5. Strengthen local ownership and synergies with government departments

Given the newly formed steering committees' role in sustaining the ECD program, there is need to build their capacities in lobbying/advocacy for Ministry of Education provision of preschool education and other ECD services, and local solutions to fundraising activities.

6. Foster strong collaboration with Government of the Republic of Zambia

There is need to foster a strong collaboration between ZACOP and the Government of the Republic of Zambia so that the government can build on the lessons from the ZACOP ECD model and develop a comprehensive ECD package – encompassing, but not limited to health, nutrition, child protection, birth registration, social security, caregiver support through education campaigns, and provision of quality learning for children both at home, health centers and at the ECD centers.

7 Conclusions

This evaluation concludes that this cost-effective, community-led ECD program model is successful and replicable in other rural settings in Zambia and in Sub-Saharan Africa with similar demographic and cultural characteristics. Overall, the evaluation found that the program has demonstrated:

- i. Significant impact in capacity community volunteers who through their consistent and quality interaction with primary caregivers initiated positive social behavior change among parents/caregivers.
- ii. Focus on equity of outcome as opposed to equity of access, thereby providing an intervention to the most vulnerable and needy in rural communities; and evidence that ways of addressing inequalities in ECD and the needs of the most vulnerable can be achieved.
- iii. The creation of very strong roots of ownership and sustainability through its local leadership in implementation and support.
- iv. Effective inter-sectorial collaboration with government institutions at district/provincial level and successfully complemented the service delivery structures in areas such as health and nutrition to address children's needs holistically.
- v. Strong evidence that the program model is a cost-effective strategy for improving the development of young children, with community integration of ECD activities that is a crucial factor for program sustainability.
- vi. Contributions to achieving to national policy priorities and international commitments articulated in the Ministry of General Education's National Implementation Framework and the Sustainable Development Goals to increase access to ECD targeting children from disadvantaged backgrounds.

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