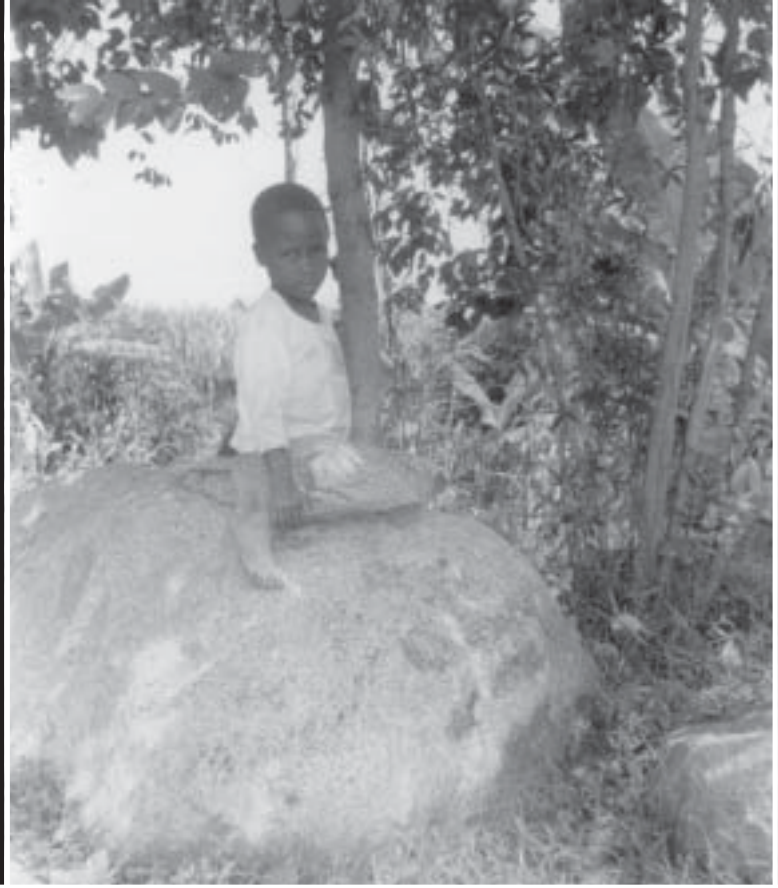
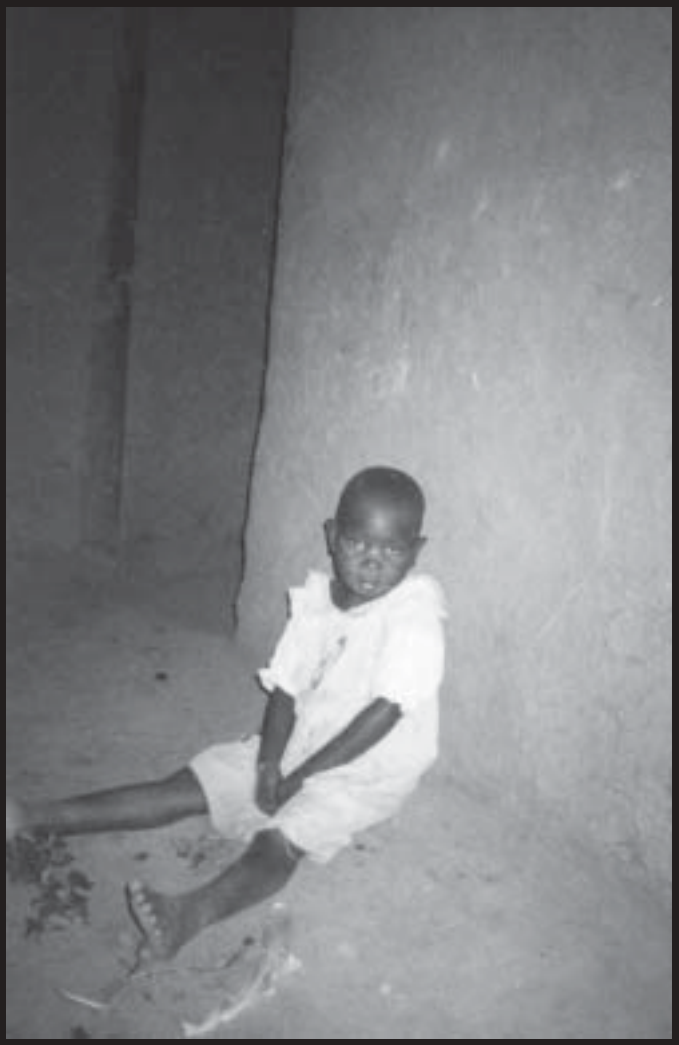


Community care for orphans and AIDS-affected children

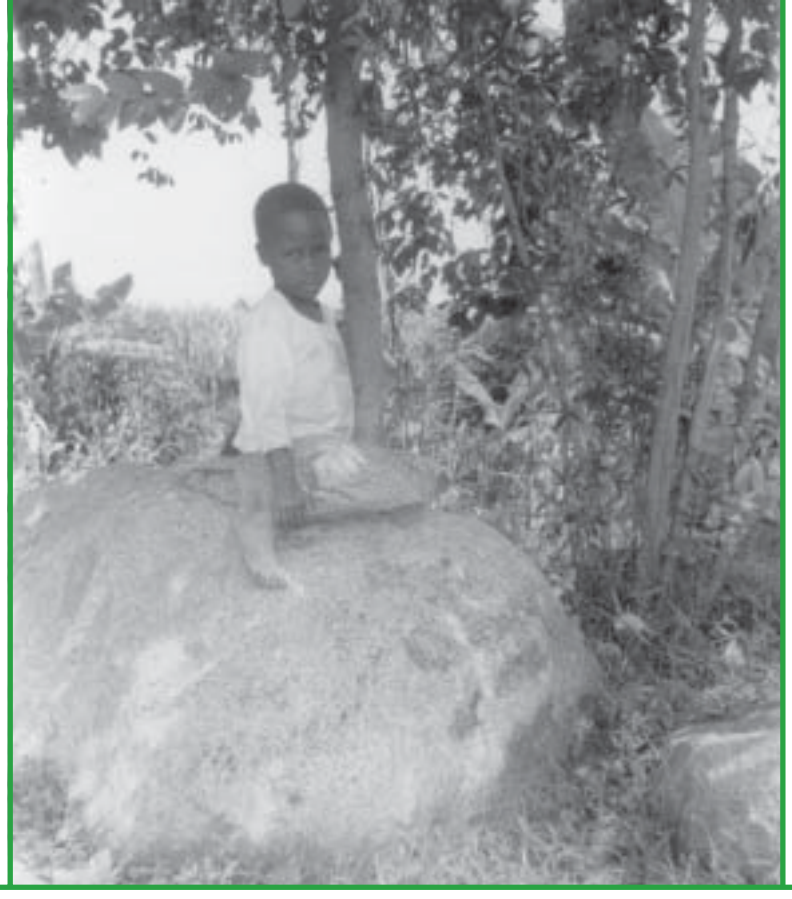
# Speak for the Child

CASE STUDY: KENYA



Photos: AED/Speak for the Child

"We do not want a generation of street children in our community"
-John D. Maina, Chief of South Kabras, Kenya



Community care for orphans and AIDS-affected children

# Speak for the Child

**CASE STUDY: KENYA**

**AUTHORS : Diane Lusk • Jael Mararu • Chloe O'Gara • Sarah Dastur**

AUGUST 2003

Funding for this publication comes from the Bernard van Leer Foundation

# Foreword

This case study shows that—for pennies a day—community programs can help families care for young orphans and AIDS-affected children and do so effectively, efficiently and accountably. Orphanages are not the best answer to the challenges of AIDS. Children who remain within their families and communities get the individual attention they need when they are young and stay connected to their past and their future—a basic human right.

Since March 2001, AED has been implementing *Speak for the Child* in the AIDS-affected community of South Kabras in Kenya's Western Province; funding for the project is provided by the United States Agency for International Development (USAID). Speak for the Child's goal is to improve the physical, cognitive, and emotional care and development of orphans and children affected by AIDS who are five years and younger. Immunization, preschool enrollment, regular home visits by trained mentors, caregiver support groups, income generation, and community organization capacity building are the components of a well-managed, cost-effective program that caregivers and children can rely on for support.

In African countries heavily impacted by AIDS, as many as 20% orphans are below the age of five. More than half of orphans are under the age of nine (UNICEF). Neglecting the youngest children orphaned and made vulnerable by AIDS jeopardizes the future of families, communities, and nations, yet very few programs exist to meet their health, nutrition, education and psychosocial caring needs. Research around the world shows that young children denied the basic human essentials are likely to fail in school and to grow up anti-social and impoverished. AIDS-affected caregivers of orphans and vulnerable children urgently need support to raise safe, happy, and healthy young children.

This case study is dedicated to the young children of South Kabras whose future their caregivers are striving to make safer, happier, and healthier. Thanks to the Bernard van Leer Foundation for their commitment to early childhood development in Africa, for focusing attention on the crisis of young children affected by HIV/AIDS, and for funding this case study. Thanks to USAID for the vision and resources to make the project happen. Lastly, special thanks to South Kabras chief John D. Maina and to the Speak for the Child staff in Kenya: Ms. Jael Mararu, Ms. Mable Umali, Ms. Joy Okinda, Ms. Lydia Aluvala, and Mr. Kiptoo Kiplagat for their dedication to improving the lives of young orphans and vulnerable children in Kenya.

Chloe O'Gara, *Vice President and Director*
Ready to Learn Center
AED

# Contents

# Tables

# Introduction: Young Children Affected by AIDS

From their last infant immunization to their first day of school, young children tend to be invisible to the community. Too young to be part of any system or to operate in the neighborhood on their own, they depend completely on their immediate household for attention and action on their behalf. When households are stretched beyond imagining with grief, care of the sick, depleted labor resources, and intensified poverty—as they are in AIDS-affected households—young children's dependence becomes a terrible liability, not merely the natural order of things.

*Since their mother passed away and father left the community, John, age 2, and Sheila, age 4, have been cared for by their grandmother, Rosemary. When staff first met the family, John was not fully immunized and Sheila did not attend preschool.*

Orphans are likely to be even more invisible. Young orphans are often brought to grandmothers from other districts and left without further contact. No records are left; no birth certificate follows them, no record of immunization. The local administration and local nurse don't know them. Older siblings may be distributed among many relatives living in different areas to thin the expense of fostering, so even many remaining relatives of young orphans grow up not knowing them. Without special efforts, young orphans can remain isolated in households with rural grandmothers, invisible to neighbors and family as well as institutions.

The context of AIDS makes orphans and other children under five years of age especially vulnerable. Orphans and children of sick parents are at greater risk of being malnourished and stunted than are children with healthy parents, as food consumption may drop by as much as 40% in families affected by AIDS. Children orphaned by AIDS also may not receive the health care they need because they are assumed to be infected with HIV and their illnesses are untreatable; the belief that children born to HIV+ parents are automatically HIV+ themselves is widespread.[1, 2] Irregular, infrequent feeding is more life threatening for younger children, as are respiratory infections, diarrhea, and the high fevers most typical of this age group.

Very few programs address the needs of orphans and other vulnerable children under age 5 in the context of AIDS.[3, 4] In heavily impacted countries of sub-Saharan Africa, as much as 20% of orphans are below the age of 5, but they are not a focus of HIV/AIDS mitigation programs. Most mitigation

programs focus on home-based care for adult patients, income-generating activities for caregivers and adolescents, and school fees for destitute school-age orphans.

Many programmers see themselves as assisting young children by assisting adults, households, or communities in general, and they may be right. However, decades of food supplementation research suggest the need for some caution about this assumption: food given to a family to feed young children does not all end up in small children's stomachs. Increasing income to a family does not ensure that the money will be spent on food, medicine, or blankets for children of any age. Where children compete for food and other resources, younger children often lose out.

Most HIV/AIDS programs can *ultimately* benefit young children. Every effective prevention dollar can save a parent and prevent mother-to-child transmission. Counseling, testing, and medicines that prolong and ease parents' lives give young children more parent care when they need it most. Income-generating and skill-building programs hold the promise of money for food and medicine for young children. Capacity-building programs for small groups that help support orphans and foster families generate hope and energy that can translate to better care for young children.

But young orphans also need direct and special attention. Without attention to feeding, health, immunization, and psychosocial care, school age will be too late for too many. There is a gap in programming for AIDS-affected orphans and vulnerable children under 5, and an urgent need for models that are community-based—since the great numbers of young orphans and the expense of orphanage care demand this—and designed to meet the special needs of children under 5. This case study documents the efforts of the Speak for the Child program to create such a model.

## The Pilot Program

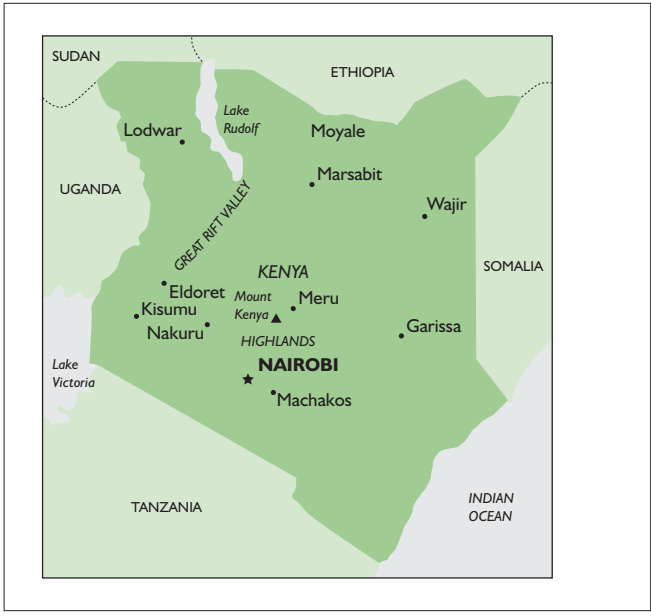
Every program hoping to address some of the needs of young orphans and vulnerable children through community-based action faces at least three challenges:

- connecting with the community
- identifying the most vulnerable children
- creating an effective program

We will present our work in western Kenya in separate sections, addressing each of these challenges. Each section contains a description of "what we did," a "lessons learned" catalogue of the processes and tools developed in the project, and a set of suggestions for how those pro-

cesses and tools might be adapted by other groups to other contexts.

The Speak for the Child pilot project was funded by USAID's Displaced Children and Orphans Fund and USAID/Kenya. As we initiated activities in each sublocation, we modified strategies and tools, then examined the effects of those modifications based on continuous formative research. At this time (summer 2003) more than 250 children are enrolled in the program; that number is expected to double before the year is out, when all eligible children in South Kabras will be enrolled.




## Connecting with the Community

The community in which our pilot program, Speak for the Child (SFC), works is South Kabras, an administrative unit called a "location" in Kenya's Western Province. It is located near Kisumu on Lake Victoria, shown on the map at right. South Kabras, which has a population of about 32,250 people in 6,500 households, is divided into five sublocations—Shianda, Mwere, Mahira, Shamberere, and Chevoso. Each of these sublocations has eight to 13 villages, combining to a total of 47 villages for all South Kabras. The area is rural, with an economy based in small farms and some sugar cane production.

We—an international nongovernmental organization (NGO) with local staff—began connecting with the community through Participatory Learning and Action (PLA) exercises. These exercises inspired formation of a location-wide Speak for the Child Committee and five subcommittees; the PLA and committees are discussed separately below. A third critical connection to the community, the chief for South Kabras, John D. Maina, deserves special thanks here. He understood and supported our efforts at every stage, and his leadership and ongoing communication with the staff and the subchiefs contributed heavily to the project's success.

## Participatory Learning and Action (PLA)

Participatory Learning and Action (PLA) exercises, on any topic, are designed to enlist community experience and energy in defining problems, resources, and best courses of action to address them.

*Community members explored the farthest reaches of their villages to understand their resources, problems, and needs.*

COPHIA (Community-based Program on HIV/AIDS Prevention, Care, Support), a Pathfinder International program, was conducting prevention and home-based care training in the area; we planned to work closely with it. COPHIA had conducted a two-week set of PLA exercises with the South Kabras community on HIV/AIDS the previous year. The exercises had focused on the needs of the adults and adolescents in the community. We built on this work, reconvening the facilitators and participants, and held a four-day PLA, in which people would "Speak for the Child." Over 100 people attended and contributed during these exercises.

## The PLA: What We Did

Focus groups of men, women, and "youth" (unmarried men and women 15 to 49 years of age) met for four days. They defined vulnerable households and the problems of children in such households. They mapped community resources, described typical caregiving patterns and responsibilities, and, on the last day, developed a Community Action Plan (CAP). A small group of six- to 10-year old children was interviewed, as this age group typically takes on many childcare responsibilities in this area.

The focus groups provided extensive information on the community's criteria for vulnerability, but did not generate much information on young children and caregivers. The PLA design called for listings and rankings of problems for young children, and for caregivers; focus groups instead listed the characteristics of vulnerable households in general. The design also called for descriptions of a typical day for children less than 1 year old, for 1- to 2-year olds, and for 3- to 5-year olds; the women's and men's focus groups listed only daily activities for caregivers, nothing for children. Perhaps focusing on children under 5—their problems, their activities—just made no sense to participants or to the facilitators responsible for guiding such discussions.

The South Kabras Community Action Plan called for the project to provide start-up funds for a "child development center" and for the formation of five sublocation subcommittees under a location-wide Speak for the Child Committee. The committees would organize construction work on the childcare

center and establish income-generating activities (IGAs), with project start-up funds, that eventually would support the center. We thought this might be a great way to proceed until we discovered that the "child development center" was actually meant to be an orphanage, and the IGA envisioned was a petrol station. Both these actions were unacceptable to donors. The need to go back to the drawing board for project activity design created considerable confusion and loss of initial energy.

The exercise, even in the limited four-day version we used, was relatively expensive. It involved transportation and meals for 100+ people; a week of fees, lodging and travel for three expert consultants and the local Speak for the Child project director; community facilitator fees; and supply expenses. The total cost was USD$8,800.

## The PLA: Lessons Learned

- **Community Action Plans.** The key difference between PLA exercises and many other participatory activities is the ultimate goal: developing a Community Action Plan. When we set up the PLA, we fully expected to be able to design our program activities based on the community's plan, with only minor adjustments. As this proved not to be the case, we would now recommend (see suggested adaptations section below) a more cautious approach to community participation in project design.
- **Invitees.** Because we were building on COPHIA's general HIV PLA, we reinvited its groups of men, women, and "youth" and added only the small group of 6- to 10-year-olds as a new group. In future we would invite a group of caregivers of orphans and vulnerable children, a group of village elders, and a group of children who were themselves orphaned or identifiably very vulnerable, in addition to men's and women's groups.

Table 1 on the following page summarizes lessons learned about specific tools chosen for the exercises.

## The PLA: Suggested Adaptations

The main achievements of the PLA were community-generated criteria for defining vulnerable children, knowledge about and participatory energy for the project, and direct links to the community through committees. The question for other groups, and for us when we begin in a new area, is whether there are faster, easier, and less expensive ways to achieve the same things. This may depend on the political structure, population density, and local history with projects in general.

PLA exercises may not be needed as an introduction to a community. Groups that already have roots in a community, either because their project sites are long term or because they are local community-based organizations (CBOs), may not need much in the way of special methods of

connecting to communities and could lay groundwork for under-5 activities, mainly through focused discussions and interviews with key groups. NGOs expanding into new geographic territory or taking on this new area of activity may want to use something like the PLA exercises or a longer set of focused discussions. A critical issue in the choice to use PLA activities to connect with a community is the extent to which it is desired and possible to put the full *design* of project activities in community hands through a CAP.

Some variations to taking a PLA approach, and suggestions for new focus group topics, are given below.

**Table 1: Pros and cons of specific PLA exercises**

| Activity | Pros | Cons |
|---|---|---|
| *Focus Groups* | Community criteria for vulnerability helps with transparency | Not all criteria usable for survey, e.g., alcoholism, incest, witchcraft |
| *Mapping* | Good ice-breaker; potential relevance to plan of action; reminder of resources | Time-consuming; not all elements mapped were of relevance to children's care |
| *Problem Listing and Ranking for Children and Caregivers* | Potentially useful for identifying program priorities and raising awareness | Groups listed only general household problems |
| *Child Daily Calendars for Three Age Groups under 5* | Potential for data on local norms for good childcare practices; led to discussion of different family member roles as caregivers | Rejected by most groups as a useful activity; data gathered were very diffuse |
| *Community Action Plan* | Specific planning mobilized committees and described community interests in contributing to solutions | CAP rejected by NGO and donors; raised specific and high expectations for project |

- **PLA with cautions.** In the introductions and on the final planning day, the project staff and facilitators could define exactly what kinds of CAPs the project can support. If the project is relatively undefined, a general CAP can work as long as donor limitations are clear to all. If project activities are already defined, CAPs can be invited *within* what is already specified. Where outside funding is involved, anticipate as much as possible what specific solutions may not be acceptable to donors and provide a general warning that community planning will probably need to be modified in parts to fit donor ideas and budgets.
- **Large group, no CAP.** Projects could use participatory exercises to define criteria for vulnerability in households and in young children and their caregivers, but stop short of asking people to devise a Community Action Plan. They could be asked instead for more general ideas of ways community members are interested and able to be involved.
- **Community leaders advise on use of PLA.** Projects could discuss the key program ideas with community leaders and seek their advice on the usefulness of a full community PLA versus alternate methods of engaging community interest and participation.
- **Work directly with community leaders.** Projects could discuss the program ideas and plans directly with community leaders, counting on their ability to enlist the understanding, sympathy, and practical support the project will need. Individual interviews with key informants—health staff, preschool staff if any, first grade teachers, caregivers, religious groups, and CBOs that involve themselves in children's work, among others—could add perspective on vulnerability criteria and appropriate project activities.
- **Additional focus group discussions.** In this model, volunteer mentors problem solve with caregivers around health, nutrition, and psychosocial issues. Information about local beliefs affecting practice in these areas could be of great help to home-visiting mentors. Areas we think would be especially useful to explore include:
  - **Health:** beliefs about causes and effects of parental AIDS on young children, most common diseases of under-5s, beliefs about causes and best home treatment of common diseases, red flags for emergency action, and beliefs about preventive actions like immunizations and regular hygiene; prioritized lists of difficulties in accessing local health services; special considerations for children believed to be HIV+ and local criteria for such a belief.
  - **Nutrition:** beliefs about ideal diets (frequency and type) of children under 2 and under 5; prioritized lists of nonfinancial difficulties in accessing seeds, agricultural labor, markets.
  - **Psychosocial:** beliefs about the causes and cures of young children's aggression, disobedience, and withdrawal; reasons some children are more ready for school than others; ideas about informing children of parent death and abandonment.

# The Speak for the Child Committees

## SFC Committees: What We Did

Five sublocational Speak for the Child committees and one location-wide committee emerged from the PLA. The committees collaborated with field staff on informing the communities about the program, recruiting survey volunteers and mentors, and targeting the most vulnerable children. Committees were vital to logistics for all activities because they are in close touch with local events and, in this fairly phone-less area, could reach people rapidly.

At the end of the program's first year, it became clear that the SFC committees had not developed their own plans for contributing to the welfare of children or helping to sustain the project. Field staff was already working flat out and did not have time for intensive work with committees. We hired a community development specialist to improve committee work.

*Speak for the Child committees identify orphans and other vulnerable children, recruit survey volunteers and mentors, and provide resources to needy families.*

The specialist identified committee membership as a key issue and expanded the committees to include more women and more local expertise in education, health, and social work. He encouraged more structure in each organization (detailed below) and helped to coordinate activities among all five sublocational committees.

Each of the sublocational committees now has about 14 members, including local residents with backgrounds in education, health, and social work, religious leaders, village elders, leaders of women and youth groups, and caregivers of young orphans and vulnerable children. Committees meet monthly among themselves and quarterly with project staff; each has a chair, secretary, and treasurer. Two committees prepared organization constitutions; three have registered with the Ministry of Culture and Social Services. Each committee drafted memoranda of understanding (MOUs) with project staff that specified their roles and responsibilities. Committee responsibilities now include attending regular meetings, identifying and informing SFC staff of newly orphaned children, networking with other related NGOs, and initiating and maintaining IGA support to orphans and vulnerable children. Two committees have started income-generation activities—bee keeping, a vegetable garden, and a pedigree cow. Assistance from these activities is given

to children in the program and includes food, milk, clothing, first grade textbooks, school supplies, and a medical treatment fund.

*Caregiver members of Speak for the Child committees give voice to their challenges and offer practical, effective ways of improving care for young children.*

## SFC Committees: Lessons Learned

- **Unstructured committees.** SFC committees were originally formed at the PLA, based on volunteerism among those present, and their role in the project was developed in somewhat informal conversations. Recruiting additional community members to include caregivers, elders, and people with child health and education expertise, along with developing MOUs that spelled out expectations for committees and regularized contact with SFC staff, improved committee functioning.
- **Gender issues: Committee/mentor/caregiver interactions.** At the beginning of the project, communications between the all-female caregivers and mentors and the all-male committees were not all they might be. Men and women in this location do not often collaborate directly. The women, however, through their work with staff in the program, built their confidence, skills, and willingness to engage directly with the committees. With their new strength, they now help to balance the gender perspectives in project planning and oversight.

## SFC Committees: Suggested Adaptations

- **Supports for committee work.** Committee work can use extra support. Where resources for this are scarce, projects could enlist a retired, respected member of the community to serve as volunteer field coordinator (after careful consultation with several groups to—ensure acceptability) and enlist local business expertise to assist committees with IGAs for children, saving staff time to make regular checks on the relationships and results.
- **Women on committees**. Gender balance on committees is difficult to achieve in many places, and sometimes unproductive if forced, as many women are not comfortable expressing views in a mixed group. Project staff could seek local advice on the best ways of ensuring that women have the voice they want in local activities; all-female meetings with community leaders might be a good first step.

The PLA, the committees, and the support of the chief all helped to establish strong connections to the community. Staff has worked throughout to maintain and nourish community connections through

*When staff first met Timina, age 2, they learned that her mother and father had both passed away. Her aunt, who has being caring for her ever since, reported that she was a "very sickly child."*

recognition and achievement: regular, specific appreciation of people and committees, verbal and written reports on goals accomplished, personal thanks. These all take extra time and effort, but they have strengthened community ownership of the program and the well-deserved appreciation for the volunteers who make it possible.

## Identifying and Targeting the Most Vulnerable

Most children and households in AIDS-affected communities need more assistance than one program can provide with limited funding and local volunteers, creating the need to identify those that have the *greatest* need for assistance. This "targeting" of the most vulnerable is difficult for everyone when help for all is too scarce. Local opinion leaders and community members need to see that every effort is being made to identify the most vulnerable properly, or else the process invites resentment, suspicion, and further isolation of vulnerable families.

Our efforts to create a transparent, community-driven means of identifying the most vulnerable young children were three-pronged: 1) developing a targeting survey based on community criteria for vulnerability, 2) refining survey forms to a small number of items understandable and usable by all, and 3) giving each community choice and control over the geographic distribution of identified children.

The three sections below describe these efforts. The first section also includes thoughts on using surveys as a method of identifying vulnerable children and ideas for alternative approaches.

## Targeting Surveys

### Creating the First Survey: What We Did

We asked focus groups in the PLA to list their criteria for which children were most vulnerable. Their combined list was:

- Children from very poor families who could not afford food, i.e., going without food for the whole day

- Children whose parents have died from diseases such as HIV/AIDS
- Children from single parents who cannot afford to care for them
- Children abandoned by parents
- Children born out of wedlock and neglected by care providers
- Children born out of incest and thus rejected
- Households headed by children

A further list of "Problems facing vulnerable households" suggested more survey items:

- Hunger and famine
- Diseases in a child's household, e.g., HIV/AIDS, malaria, measles, and diarrhea
- Orphanhood regardless of the cause
- Large family size
- Older children in the household who do not attend school
- Uneducated adults
- Unemployment
- Inadequate shelter
- Lack of care for children and the aged
- Alcoholism
- Negative attitude toward life, despair
- Belief in witchcraft
- Physical disabilities
- Child labor
- Lack of clean water
- Lack of proper hygiene
- Lack of medical care
- Inadequate or fallow land

*Youth volunteers participated in a one-day training before carrying out surveys in their villages.*

The first survey included questions representing most of the items on this list. Staff members added a question about immunizations and a variety of possible wealth indicators for this rural community. We also asked for names and ages of all members of the household including children, with schooling and labor information.

We asked the Speak for the Child subcommittees to recruit volunteers who could spend a week on the survey, attending a one-day training and then collecting information for four days. Committees recruited one elder and one "youth" per village to be surveyed. Volunteers were provided transportation allowance and lunch every day. By the end of the week, volunteers had returned surveys for 837 of the 1,999 households in Shianda, our first sublocation. Surveys in the other four sublocations reached all households, totaling 4,410.

Results of the survey in Shianda revealed that 20% of the identified 1,585 children age 5 and under had been orphaned (one or both parents dead), and 18% had been abandoned (one or both parents gone, provide no contact or support, but are not known to have died). In total, 38% of the children surveyed were orphaned or highly vulnerable due to parental desertion.

All of the surveys involved many people from the community through the logistics and as respondents, which helped to create awareness of the project and, we think, some increased awareness of the difficulties facing orphans and vulnerable children. The surveys also gave physical reality to transparency in identifying families for the project and generated data that can be used later in advocacy. Surveys did take considerable time and energy, however, delaying the beginning of programming longer than we wanted, and, of course, surveys consumed funds. Volunteers required travel allowances and lunch, resulting in data collection costs ranging from USD$475–$785 per survey, varying with the number of villages and volunteers required for each sublocation. Data entry and analysis represented additional costs.

## Surveys: Lessons Learned

- **Volunteer criteria.** Thinking that it was quite enough to be asking volunteers to contribute a week's time for the survey, we gave the committees no other criteria for volunteer recruitment for the first survey. We left it implicit that volunteers would be physically able to do the work,

literate enough to work with the survey forms easily, and familiar with the villages they would be surveying. "Implicit" did not work. For later surveys, three criteria were defined for volunteer recruitment: 1) age 18 to 25 years, 2) able to read and write English, and 3) resident in the village to be surveyed.

- **Contact sheet.** In the first survey, records were not kept of which households were contacted but did not respond to the survey—either did not have young children or were not home. This led to some suspicion that households were surveyed on a personal or political basis. Later surveys all used a contact sheet that recorded all households. The contact sheet increased confidence in the transparency of orphans and vulnerable children targeting and provided reliable percentages of the population affected for use in advocacy.
- **Reliability.** The program was new when the first survey was conducted. People wanted to participate, so birthdates were deflated and reports of parental abandonment were inflated so children would meet the criteria for inclusion. By the third survey, people knew that staff would verify all information before children were enrolled.
- **Community ownership.** The last survey was managed by the Speak for the Child committee with additional community help. They collected and tallied data, assessed results, and recommended the children to enroll using revised criteria. The new criteria are simpler—orphans who have lost either or both parents—and readily verifiable. Pride, capacity, and ownership are critical for program sustainability.

## Surveys: Suggested Adaptations

- **Alternatives to surveys for initial identification.** Groups wanting to avoid the time, energy, and financial costs of surveys while keeping community participation, involvement, and faith in transparency, could consider:
  - **Mapping.** In a single-village or closely knit community with a small population, identifying the most vulnerable households can be done through group discussion and working together with a self-made map of the community.
  - **Combining mapping and surveying.** In a larger community, local leadership through mapping could identify especially vulnerable areas or villages, and those smaller areas could be surveyed.
  - **Using poverty indicators.** Groups in countries where the government identifies the poor or vulnerable through state allowances could use that system, surveying only those families to obtain information on personal variables such as orphanhood and health of caregiver.

- **Alternatives to volunteer literacy.** For areas where it is difficult to find sufficient numbers of literate volunteers, groups can use the simplest form of the survey, in which only 11 criteria are scored. With training and practice, visual symbols might reliably replace written questions and answers. Alternatively, or as backup, literate school children could accompany less–literate adult volunteers.

# Refining the Identification Process

## Refining the Identification Process: What We Did

Including all the vulnerability criteria generated by the PLA focus groups and a few of our own items allowed us to look at frequencies and associations among more than 200 variables. Then, to develop an identification system everyone could use and see as fair, we did three things we expected to do—throw out some items, redefine others, confirm information in initial staff visits—and three things we hadn't expected: develop a scoring system for vulnerability factors, include orphanhood as a separate determinant of selection, and respond to the community's wish to include distribution among villages as a program enrollment factor.

***Discarding items.*** Many survey items proved to be of little use, usually because there was little variability among households on the item or because the information turned out to be unreliable. Table 2 on the following page shows most of the items in the first survey that were discarded for later surveys and gives the reasons.

***Redefining items.*** Several survey items needed reworking to represent the desired information better. "Age of child," "head of household," "caregiver," and information about "illnesses" were in most drastic need of revision.

Getting good information on a child's age plagued staff for the first two surveys. Word spread in the community that the project might pay for preschool fees; this encouraged people to misrepresent children's ages. Nearly half of the first group of identified children turned out to be older than 5—some twice that age. Later versions of the survey asked for birth or baptismal certificates; volunteers were also asked to emphasize that age is always double-checked before a child is enrolled in the program. A second reason for problems with age information was that some children had been left with caregivers without any accompanying records, so caregivers were not always sure of a child's age. Staff observation and probing helped to resolve these instances.

Terminology was challenging, particularly so because survey workers had to translate into several local languages. We concentrated on using items from other surveys in the area, pretesting, and training

## Table 2: Initial survey items later discarded

| Item | Reasons for discarding from final version |
|---|---|
| *Immunizations* | Information most often unavailable or unverifiable; information now obtained during initial visits with documentation, history taking, and probing |
| *Other household members besides caregiver and young children: number, schooling, contribution to food budget, number of illnesses* | First survey showed no strong relationship to other signs of vulnerability; these questions involved volunteers in time-consuming discussions |
| *Number of children per caregiver, caregiver responsibilities, backup caregivers* | Caregiving responsibilities were so widely shared among extended family members of all ages that these questions made little sense in this context, except by contrast with very isolated caregivers |
| *Land, number of acres* | Little local variance; land may all be assigned to cash crop; elderly caregivers may lack labor to work land; many preferred to work on other people's land for cash instead of on their own |
| *Types of crop grown* | Local preference for single crops and food bartering at market rather than planting variety |
| *Number of animals* | Later visits to selected households showed most information given about animals to be inaccurate |
| *Ways of getting food* | Only reliance on food donations/begging was significant, not other, finer degrees of insecurity |
| *What the household ate that day* | Little variance in food types; only the number of meals was significant |
| *Cooking fuel, granary, pit latrine, dish rack, lighting source* | Very little local variance—all used firewood to cook and light, too few granaries and dish racks; pit latrines common but many not functional |
| *Water source; time to get water* | Very little local variance, the area is fed by many small streams |
| *Children's clothing observation* | In this area clothing observations were not useful because even people who own good clothing wear it only for church and other special events |
| *Type of shelter; number of rooms; furniture adequacy* | Little local variance; volunteers unsure without prying about exact situation |

*Field officer, Mable Umali, interviews a caregiver in the Mwere sublocation.*

about the meanings and purpose of each item. Nevertheless, some terms had to be changed, for example:

We expected the term, "head of household," to identify elderly-headed, widow-headed, or child-headed households, but most of the heads of household identified were the official ones, overwhelmingly male, many no longer living. "Daily breadwinner" was substituted.

The term, "caregiver," also failed to yield the information we'd hoped for. Despite volunteer training emphasizing that we meant the person who fed and bathed the child, men listed themselves most often as the primary caregiver, with the responsibilities of paying school fees and medical costs and administering discipline. "Child minder" was used on later versions.

Finally, questions about illness had to be reframed several times. We were looking to identify caregivers too ill to care adequately for children, regardless of cause, and also to be able to estimate the prevalence of HIV/AIDS in the area for donors. In this area many people consider headaches, backaches, and colds, all of which are very common, to be illnesses. As most people continue to work through these sorts of illnesses, the term, "bedridden," was adopted for a while. This, too, proved to be too large a category and was replaced by "too ill to perform household duties for three or more months out of the last year."

These terms now receive special attention during survey training, with translation and explanation in Swahili and several local tribal languages and careful discussion.

***Vulnerability scores.*** For the factors that did vary among households, we expected an analysis of survey results to show fairly strong correlations among such items as number of meals a day, how a family got food, number of chronically sick adults, number of children sent to school—a cluster of poverty and well-being variables. We also expected that families fostering young orphans would look different from other families in some obvious ways. The survey results and analysis for Shianda met neither of these expectations. Poverty indicators showed very little relationship to each other, and families sheltering orphans exhibited no notable differences in most aspects of health and wealth from other families.

Since vulnerability in this community was apparently a somewhat complicated mix of personal situations and poverty indicators, and since in the first year the Speak for the Child committee was determined to include poverty and vulnerability as criteria for enrollment, we worked to represent vulnerability as a set

of weighted factors that could be summarized in a "vulnerability score" for each child. The final version of this approach is shown in Table 3 below. The nature, number, and weight of these vulnerability items were continually refined by experience in other surveys, and staff visits to households.

***Postscript:*** After 18 months, the Speak for the Child committee elected to drop the weighted vulnerability scores in favor of a single simple criterion: orphan (either or both parents deceased)—yes or no.

These scores did not identify double orphans exclusively, nor were they spread evenly among the villages. People in Shianda expected the project to work with double orphans first, then other children if possible, and they expected an equal number of children to be enrolled in the project from each village. So staff enrolled children on the basis of all three criteria: vulnerability score, double orphan-

## Table 3: Assignment of vulnerability scores

| Variable | # of Points |
|---|---|
| *Mother dead* | 5 |
| *Mother gone* | 1 |
| *Father dead* | 5 |
| *Father gone* | 1 |
| *Both parents dead or gone* | 1 |
| *Child minder is very young (<15 years) or elderly (>49 years)* | 3 |
| *Child minder has been too ill to perform household duties for 3 months or more of the last year.* | 3 |
| *Other household members have been too ill to perform household duties for 3 months or more of the last year.* | 3 |
| *Child is <24 months of age* | 2 |
| *Child eats twice a day or less* | 1 |
| *Household obtains food by donations or begging only* | 1 |
| *Adults eat once a day or less* | 1 |

hood, and an equal number of children in each of the villages. This "equal number in each village" approach, which became known as the "equitable" targeting method, is discussed with other methods in the targeting strategies section.

Initial staff visits to households—to confirm survey information, explain the program, take baseline information for monitoring, and if the child qualified, to enroll him or her in the program—proved to be essential to the targeting process. Initial visits also provided crucial information that surveys cannot reveal—the important differences made by personal qualities of caregivers. Some children with medium-range vulnerability scores were in fact more vulnerable than survey information indicated because their caregivers were disabled or mentally ill; some children with high scores were actually less vulnerable than indicated because their caregivers were especially responsive and energetic. Information about height, weight, and diet taken during initial visits provided baseline data for evaluation and confirmed enrollment decisions.

## Refining the Identification Process: Lessons Learned

- **Complexity of task.** Simply using community criteria, or applying absolute criteria like "double orphan," does not easily identify the most vulnerable children, and having a transparent identification process may be only part of satisfying a community that you are enrolling children in a project in a proper way. Over time, as a community learns the complexities and imperfections of any targeting strategy, they may, as these communities did, decide to simplify the criteria for enrollment.
- **Child, not poverty, indicators.** Only two of the eventual 12 vulnerability indicators tested over five surveys and hundreds of household visits were adult poverty indicators: the way a household obtains food and the number of meals adults ate a day. All other useful indicators had to do with children's situations.
- **Stigma.** Importantly, vulnerability scores reinforce the perception that HIV/AIDS is not the only, or even the primary, criterion for program participation. Criteria should not define participants as children or households with HIV/AIDS, particularly in settings like this one, where no voluntary counseling and testing (VCT) services are available, and there is no benefit to such identification.
- **Using scores.** Although somewhat repellent as a concept, a vulnerability summary "score" can be a good way to represent the multiple factors that contribute to vulnerability and gives staff and committees an "official" number on which to hang enrollment decisions; it can be used in combination with other community defined criteria such as village distribution.

- **Initial visits.** Personal observations in follow-ups to surveys are crucial, both to check the accuracy of information and because some markers recognized by a community—like "lack of care for children" and "negative attitude toward life, despair" in this project, expressive of important caregiver qualities—have to be observed to be taken into account.

## Refining the Identification Process: Suggested Adaptations

We would like to think that we could save other projects considerable time by offering the set of variables presented in Table 3 as a way to identify the most vulnerable children. However, every community is unique, so for those wishing to adapt the set of variables to a particular area, here are some ideas to consider:

- **Poverty indicators.** Using our list, or one like it, project staff could engage community members in discussions about useful indicators for the **very poorest** of the poor, not signs of the poverty and stress with which many families were coping. Land ownership, access to water, and number of animals may be important poverty indicators in other areas with greater variation among households.
- **Age of child.** The purpose of limiting project children to those age 5 and under was to develop a model for children who are invisible to the health and school systems. Projects for which this is less important and where age certification is difficult could adopt locally accepted informal measures. For example, in South Kabras, the ability to touch an ear with the opposite hand over the head is used as an index of school age. Children able to do this can be assumed to be eligible for school attendance and therefore are eliminated from the program pool.

*Field officer, Mable Umali, carries out a needs assessment to verify survey information and understand child, caregiver, and household needs.*

- **Cultural practices.** The practices of polygamy and wife inheritance and the inability of wives themselves to inherit material goods added weight to the impact of father's death and father's absence in this community; in places where different practices are in place, project staff could review weights to assign values according to local impact.
- **Participatory weighting.** After a final selection of items has been made, participatory techniques (problem ranking, bean piles, pie charts) could be used to enlist the aid of community members in weighing survey factors.

# Targeting Strategies

## Targeting Strategies: What We Did

For developing a model, we had the funds and time to support monthly stipends for five volunteer mentors in each sublocation, or 25 for the entire location. We planned that each mentor would take responsibility for five families, so we knew in advance that we would be working with 25 families in each sublocation (125 total). The first community, Shianda, let us know that it expected equal numbers of children to be enrolled in each of its 13 villages. This approach came to be called "equitable targeting." The genesis of this lay in local politics; it offered a way for committee members to show that all elements of the community would be attended to and would receive resources.

The travel time for service delivery in 13 different villages, each with only two identified households, made equitable targeting very time-consuming, so we tried another way in the second sublocation, Mwere. There we focused on four villages (of eight) with the most and highest vulnerability scores and recruited mentors from those villages to make travel more feasible. This approach was called "cluster targeting."

In the remaining three sublocations, two SFC committees (Mahira and Chevoso) chose equitable targeting, and the Shamberere committee chose to use the highest vulnerability scores without regard to distribution among villages, or "score targeting." Table 4 on the following page represents a summary of targeting strategies and their relative merits and difficulties.

## Targeting Strategies: Lessons Learned

Respecting a community's desire for a particular kind of geographic targeting (or lack thereof, as in score targeting) increased participation and ownership, but entailed some costs. Most mentors named "traveling to other villages" as the most difficult aspect of the work. Working outside their own villages increased travel and work time and was less comfortable personally, since mentor and caregiver are less familiar with each other. This may also detract from sustained support if the project ends.

## Targeting Strategies: Suggested Adaptations

Not all projects may want to engage communities via choices among targeting strategies. In areas where travel distances between villages are very large, cluster targeting may be essential. In areas where differences in household vulnerability between villages are very large, "equitable" targeting may

## Table 4: Targeting strategies, pros and cons

| Strategy | Definition | Pros | Cons |
|---|---|---|---|
| *Equitable* | Each village in the area has the same number of identified households | Perceived fairness among villages; whole area is aware of project; political value of committee strengthened | Some less vulnerable children are enrolled; travel time and costs for mentors very high |
| *Cluster* | 3 to 4 villages with the most vulnerable households are the focus of work | More of the most vulnerable children enrolled; travel time and costs for mentors lowest; mentors know families, are part of the community | Some very vulnerable children in other villages are not enrolled; less awareness of project in the area; some discontent by villages not selected |
| *By score* | Children with highest vulnerability scores are enrolled, regardless of village | Simple and straightforward; fair to children | Logistics for recruiting mentors not straightforward; mentor travel time and costs high; project awareness and satisfaction variable |

feel very wrong to project staff or volunteers. Keeping a project free to target the most vulnerable and to spend volunteer resources on children instead of travel may mean restricting or eliminating choice in some areas. In this area, choice was valued because the political and social fallout of cluster targeting was unacceptable to some committees.

The wish to achieve transparency to the community—to satisfy its members that the right children were receiving any help we could give—initially guided our efforts to identify the most vulnerable children. Community identifiers, surveys, and committee meetings seemed to be the right path to take, but as things developed, the more personal aspects of children's lives and local politics began to play roles as well.

Poverty that attacks a household's ability to supply adequate food, medical care, and, eventually, school fees is surely part of vulnerability, but all of our efforts to refine the survey led us to the more personal elements in children's situations. Initial staff visits to households showed that, for

*Since her son passed away and daughter-in-law left the community, Injendi cares for her four grandchildren, all of whom are below the age of 5.*

true targeting, personal characteristics of caregivers (mental health, despair, responsiveness, resourcefulness) also need to be taken into account. Participatory research among orphans old enough to speak for themselves[5, 6] confirms this result. It tells us that real vulnerability feels very personal to children: orphans report that they don't mind having few meals, as long as they get the same share of food as everyone else; they'd rather be placed with an impoverished grandmother who will love and defend them than a wealthier aunt or uncle who doesn't know or care about them and is likely to resent them or work them unfairly.

Targeting proved to be a complex balancing of needs: the need for transparency with the need to include the personal, the need for a sense of fairness among villages with the need to serve the truly vulnerable.

## Program Activities for Under-5s

Children under age 5 need diverse food given in frequent feedings, attention to immunization and childhood illnesses, and interactions that nurture mental and emotional development. Providing for these special needs in the South Kabras setting involves many challenges. Some are physical, economic, educational, or cultural; some are a matter of energy and hope. Meals require firewood and water to be fetched from distances; health services are understaffed and long walks away. Health and illness may be seen more as matters of fate, faith, or personal hostilities than hygiene, diet, and injections. Obedience is the most prized quality in children, and personal attention to young children may be suspect as "pampering" that could lead to a disobedient child. Age, health, grief, multiple duties, and multiple children also sap energy for the extra efforts young children take.

Which of these issues would be the biggest obstacles? What would be the best ways of tackling them? Would they be handled differently for orphans or fostered children than they are for other young children in the household? We undertook an intensive assessment study of the first families identified in Shianda to learn what the priority problems were and to get some ideas about how best to approach things. After a brief look at some results from the assessment study, we discuss the five program components chosen and complete the section with some lessons learned about the package of components as a whole.

## Design Phase: The Needs Assessment Study

To assess children's and caregivers' needs and to design the program, staff spent three months visiting caregivers of 42 children 5 years and younger in 26 identified households. Staff interviewed caregivers and observed behavioral and situational factors affecting nutrition, health, and psychosocial, cognitive, and language development, spending two weeks on each of these five areas. When a particular problem emerged in these visits, staff discussed the problem with the caregiver and explored possible solutions with her.

These visits revealed that meals were few and were dominated by maize products and potatoes. Caregivers rarely supervised eating, and children often struggled over food among themselves. Children's health was compromised not only by poor diet but also by incomplete immunization and lack of treatment for disease. The value of immunization was not widely understood, and caregivers, fearing the somewhat "harsh" local nurse, were reluctant to take toddlers or preschoolers for immunizations that should have been given in infancy. Any disability or troublesome behavior was seen as very shameful for family, so it was difficult to evaluate specific language and cognitive skills. Caregivers tended to describe children unable and/or unwilling to perform simple tasks as very shy; some caregivers also said that the child had not gone to preschool yet and so couldn't be expected to know much.

In households with both orphan and nonorphan children, there was no observable discrimination in caregiver behavior against orphans. Staff reported a common belief that the spirits of orphaned children's parents would punish a family that treats orphans unfairly; this may be responsible for a lack of discrimination in households. Many caregivers were isolated from family, neighbors, and the community; the same beliefs inspire fear of contact with orphans.

Caregivers were interested in and actively responded to staff suggestions. Caregivers in the needs assessment study followed through on 78% of staff suggestions, including feeding children more frequently with a greater variety of foods, seeking health services for children and themselves, spending more time talking to and stimulating young children, attending to hygiene issues, planting, and explaining parents' deaths or absence.

These findings, among others, led us to the five program elements eventually chosen:

1) Full immunization for all children

2) Individualized problem solving with caregivers on health, nutrition, and psychosocial care issues through visits with trained volunteer mentors

3) Enrollment in local preschools for children age 3 to 5

4) Caregiver support groups

5) Links and capacity building with the SFC committees and other community resources

# Immunization

## Immunization: What We Did

More than half the children were not fully immunized when first enrolled in the project. There were several kinds of reasons that children had not been immunized:

- **Lack of knowledge.** Sometimes caregivers did not know if immunizations had been given before a child was left with them, and did not know whether immunizations were important. In program evaluations, many caregivers (42%) noted that the project helped them to know the importance of immunization.
- **Special fees.** Although the Government of Kenya aims to provide immunizations at no charge, the local dispensary required that caregivers pay for needles and syringes, a deterrent for most families.
- **Fear of embarrassment.** Caregivers were also initially reluctant to take noninfant young children for immunizations, expecting to be ridiculed or denied because of the child's age.

Staff arranged appointments for children and accompanied caregivers. Accompanying caregivers supported those who were uncomfortable with the local health staff, and provided easy payment and monitoring. All identified children under 2 years have been brought up to date; children over age 2 are 100% immunized. Immunizations included BCG, DPT, oral polio, and measles, unless a BCG scar or caregiver memory indicated that some of these had already been received. Vitamin A was also given during health post visits. The cost of fully immunizing a child and providing a health card has been USD$.78. Since the new government came in, costs have been halved and, eventually, immunizations should be free. SFC also covered transportation fees for disabled caregivers.

Project staff contacted district health officials about the nurse at the health center who regularly shamed and berated caregivers and children. After several interactions between project staff and health officials, the nurse who frightened and alienated clients left. Two new, qualified, supportive health care providers now serve these communities.

### Immunization: Lessons Learned

- The relationship with local health post staff deserves special attention; personalities or reputations, as well as supply and fee issues, have important effects on caregivers' capacity to seek treatment, even basic immunization.
- Staggering caregiver appointments for immunizations with the local health center schedule in mind or prearranging special days and hours to bring in groups of project children kept relations between the project and health staff friendly.

### Immunization: Suggested Adaptations

- Bring community nurses to meetings with caregivers to educate nurses about caregivers' lack of records, funds, and transport difficulties and address all at once the issues of welcome for older children and fees.
- When staff cannot stretch to accompany caregivers for immunization appointments, enlist community volunteers or mentors (see below) to assist caregivers with travel, payment, and monitoring.

## Home Visiting

### Home Visiting: What We Did

The in-depth needs assessment study SFC staff conducted in the first community led us to devise a system of individualized problem solving with caregivers through home visits by trained volunteer mentors.

During the needs assessment study, staff saw that a wide range of actions could improve a child's situation and that, depending on the individual caregiver and her situation, some actions were more likely than others. For example, the food available to a young child depends partly on what is planted, what is cooked, how it is served, how many other children are competing for the same food, whether children's eating is supervised, and several other factors. Each of these aspects of the problem in turn has its own multiple roots. What is planted, for example, can depend on agricultural knowledge, access to land, access to seeds, access to labor, and history with particular plants. Staff discussed any and all of these aspects of the problem as the situation dictated, and caregivers picked up on those that made the most sense to them, or—stimulated by the sharing, support, and conversation—caregivers invented their own solutions: "I didn't do what you suggested, but I tried

*Mentors brainstorm as they learn to listen, encourage, problem solve, and link to other community resources.*

*this* and it worked!" After the two-week nutrition part of the study, for example, one caregiver enlisted the mentor to contact a son-in-law to help her plant; one caregiver got seeds from a neighbor; one caregiver tried out the idea of planting sweet potatoes in between her rows of maize so there would be food after the maize was harvested; other caregivers fed children more often or acquired a separate plate so the youngest child wouldn't have to compete with older children for food.

Staff found that regular visits with this sort of problem-solving approach had impacts in many areas. Mentored problem solving successfully encouraged many caregivers to increase food security through planting, to improve the quality and frequency of meals to young children, to improve hygiene in the households and compounds, to replace beating as the main method of discipline with talk and explanations, and to spend more time talking to children, listening and talking in a gentle manner instead of shouting. Staff had also found that isolation, stress, and depression were common caregiver problems; the regular program of personal visiting and conversation—rather than advice or directions—helped caregivers to feel connected and respected.

The needs assessment study showed that SFC staff could help caregivers to solve problems. Could community volunteers also have an impact? With the assistance of SFC committees, 25 community volunteers from the five sublocations surveyed were recruited to be trained to serve as mentors to caregivers. Criteria for mentor candidates developed with the committees were that volunteers live in the villages participating in the project, and be married, mothers, over age 25, able to read and write English, and have experience in and knowledge of child care. With the exception of the English proficiency, these requirements reflected staff and committee understanding of the kind of person likely to be well received by caregivers. Mentors enlisted ranged in age from 25 to 52; 84% of them are currently married and 16% are widowed; all have children; 56% of them completed primary education; 20% partially completed secondary school; and 24% completed secondary school. Of the 25 "pioneer" mentors, eight are involved in farming, one is a teacher, two are health workers, and 14 are housewives. One is the very able grandmother of a child in the project.

## Mentor training

Project staff carried out a one-week training for the selected mentors, welcoming also the members of the SFC locational committee, COPHIA's Community Health Workers (CHWs), the Children's

Officer for Western Province, and representatives from the National Center for Early Childhood Education (NACECE) and the Ministry of Health's (MOH) Community-based Integrated Management of Childhood Illness (C/IMCI) program. Active participation was emphasized throughout. Three of the five days involved sensitization sessions, brainstorming/buzzing sessions, case studies, role-plays, peer critiques, Q and A, and feedback/recap sessions; the other two days were spent in the field doing "practice visits" with families already familiar with the project through the needs assessment.

Basic technical information about the special nutritional, health, and psychosocial needs of young children was provided in the training and in the mentor manual (and is provided monthly in mentor meetings), but the main focus of mentor training and SFC home visiting was the *problem-solving technique* itself: *LEPO*, for:

- *Listening*,
- *Encouraging*,
- *Problem solving*, and
- *Other* resource links.

Kenyans have been used to a somewhat didactic approach to community service communication: "You should do this." The needs assessment study, the wish to respect caregivers' difficult struggle to provide for their families, and the cultural need to respect the advanced age of many grandparent caregivers suggested the more mutual, problem-solving approach. Making time to listen to caregivers might give them the chance to focus on issues that otherwise get lost in the press of duties, and the chance to focus might lead to solutions by itself. *Listening* would also help to educate mentors about the real, practical obstacles caregivers face. *Encouraging* specific actions that benefit children is worth doing in its own right but is also a way of conveying information about important actions. *Problem solving* would, in theory, make space for both mentors and caregivers to consider a wide range of options for improving a situation, rather than one-size-fits-all advice. Linking with *other resources* was similarly open-ended, making space for caregivers and mentors to explore the role neighbors and relatives might play as well as more official sources of help.

## Appreciation

It is important to approach each caregiver with a positive attitude. When responding to a caregiver's questions or concerns, always begin by expressing appreciation for what the caregiver is doing well. Even a caregiver who is doing many things wrong can be congratulated for how much she loves the child, for all the energy she puts into caring for her family, and for her wish to improve their situation. Change is not easy; caregivers need to be appreciated for every step they take toward a new behavior. While it is easy to point out someone's mistakes and to correct them, if a caregiver is criticized and feels bad about herself, she may never hear or use the advice she receives, no matter how well intentioned you may be.

*—Excerpt from mentor training protocol*

After the training (for mentor training protocol and mentor manual, email ready@aed.org), mentors were each assigned a five-household caseload in their own or an adjoining village. SFC staff accompanied mentors on each visit during the first month to assist mentors in establishing trusting relationships with caregivers and to be there for the first hands-on learning opportunities.

During these weekly home visits, mentors focus on a particular child development issue: health, nutrition, or psychosocial care. Mentors begin by inviting general news and comment: "How are

## Clarifying the Caregiver's Thoughts and Needs

Clarifying the caregiver's own thoughts is very different from interpreting her statements through your own values. Sometimes a person is unclear about her needs. She may tell a long, complicated story containing many problems, so that it is hard to know where to begin to work with her. It may be helpful to paraphrase what you heard the caregiver say, repeating what you heard in different words. It may also help to separate out the problems so the caregiver can listen and see her needs in a different way. Then you can help her set priorities, to see which issue is most important to her.

### Example

For example, a caregiver tells the mentor that she wakes up very early and weeds a neighbor's *shamba* all day to earn only enough money for one meal. Because she is so exhausted, she makes *ugali* and fried Irish potato stew. She has two children and this is their only meal. A mentor may want to give advice and say, "If I were you, I would stop going to weed for people." However, it would be more helpful to say, "it sounds like you have many demands on your time and it's hard to know what to do. Let's see if we can discover together what to do."

- What are the issues here? (time away from children, frequency of feeding, quality/variety of food given to children, lack of kitchen garden)
- Which issue is most important to you?
- Which problem is most immediate?
- Is there one problem that would be easy to solve?

*—Excerpt from mentor training protocol*

## Table 5: New caregiver behaviors

| Type of caregiver action taken after coaching by Speak for the Child mentor (112 caregivers) | Number of caregivers taking action | Percentage of caregivers taking action |
|---|---|---|
| ***Verbal interactions:*** caregivers talking to the children, telling stories, trying to talk in a gentle manner or to shout less, trying to listen more | 64 | 57% |
| ***Stimulation:*** caregivers spending more time with young children, providing play materials, encouraging them to play and socialize | 55 | 49% |
| ***Discipline:*** caregivers trying to replace beating with talk and explanations as the main method of discipline | 54 | 48% |
| ***Education at home:*** caregivers teaching specific skills to young children | 77 | 69% |
| ***Psychosocial Care:*** caregivers addressing young children's fears by explaining death and parents' absence, keeping older children from frightening young ones during the day, reassuring children about fears of abandonment | 55 | 49% |
| ***Nutrition:*** caregivers combining and enriching foods, to improve the diets of children under 5 | 66 | 59% |
| ***Feeding:*** caregivers feeding young children more frequently during the day | 68 | 61% |
| ***Food production:*** caregivers planting new crops or preparing land for planting | 99 | 88% |
| ***Hygiene:*** caregivers washing children with soap more regularly, washing dishes and drying them on dish racks | 83 | 74% |
| ***Health care:*** caregivers seeking needed medical treatment for their children or themselves | 58 | 52% |
| ***Economic security:*** caregivers involved with income-generation activities | 70 | 63% |

you? How are the children? What has been happening since I saw you last?" On a nutrition week visit, a mentor would ask for specifics about a child's eating: "What did [child's name] eat and drink yesterday?" The mentor would work on *listening* carefully to answers and *encouraging* any positive action reported (e.g., feeding several times a day; feeding vegetables or fruit; feeding milk, fish, or beans; sitting with the child during a meal; giving the child a separate bowl of food): "It's great you did that—that will help!" If further actions are practicable, a mentor might discuss some possibilities: "Would you be willing to try… serving fish with *ugali*, giving him/her a banana in the morning, adding milk to his tea/porridge, watching him eat and encouraging him to eat more, feeding him a piece of fruit, adding kale to his meals, adding green, leafy vegetables to diet," and continue to explore possibilities with caregivers, depending on the response, again listening for and trying to address obstacles together. The fourth step, *Linking to other resources*, may involve encouraging caregivers to contact members of their extended family or neighbors to assist with planting, providing, or preparing food.

## Table 6: Most useful suggestions about nutrition

| Caregivers' responses N=45 | First responses | Total mentions |
|---|---|---|
| Feed children 4 to 5 times a day | 13 | 24 |
| Give balanced diet | 11 | 23 |
| Add fruits to diet | 9 | 14 |
| Combine foods | 4 | 4 |
| Plant green vegetables | 3 | 4 |
| Feed children "on time" | 2 | 3 |
| Give milk | 2 | 3 |
| Unique suggestions* | 1 | 4 |
| **Total** | **45** | **106** |

* Unique suggestions: give porridge, give green vegetables, boil children's food, spare some food for the children.

The LEPO approach worked in many directions, with many caregivers. Table 5 on the preceding page gives results from 24 mentors working with 112 caregivers.

To evaluate the home visiting program more specifically, we asked mentors and caregivers (after about a year of visits with 45 caregivers) what they thought were the most and least useful aspects of mentors' problem solving. Results are offered below in separate sections for nutrition, health, and psychosocial issues. Caregivers' and mentors' responses agreed; tables represent the range of caregivers' responses.

***Nutrition.*** Caregivers' answers to, "What was the mentor's most useful suggestion about nutrition?" identified suggestions about greater

frequency of feeding and those about balanced diets in about equal numbers. Table 6 on the preceding page gives the complete set of caregiver answers.

Caregivers identified "adding fruits to children's diets" as the least useful suggestion in nutrition (even though it was the third most-mentioned "most useful" suggestion) because fruit is expensive in this area.

***Health.*** Caregivers chose learning about the importance and use of immunization as the most useful health suggestion. Suggestions about keeping the environment clean, taking children for treatment when sick, and bathing children frequently were also mentioned by 30% to 60% of caregivers as useful suggestions. Table 7 gives the complete set of caregivers' answers.

## Table 7: Most useful suggestions about health

| Caregivers' responses N=45 | First responses | Total mentions |
|---|---|---|
| Importance of immunization | 19 | 27 |
| Clean compound, house, beddings | 8 | 17 |
| Take child for treatment when sick | 9 | 14 |
| Bathe children frequently | 1 | 11 |
| Sponge children with high fevers | 1 | 6 |
| Wash utensils, construct a dish rack | 1 | 7 |
| Construct a latrine | 3 | 4 |
| Give extra fluids during diarrhea | 0 | 2 |
| Cover food | 2 | 3 |
| Improve caregiver health | 1 | 1 |
| **Total** | **45** | **92** |

The least useful suggestion in health, like that for nutrition, was a matter of expense. Mentors' recommendations to caregivers to take children for treatment when they were sick were the most difficult for caregivers to try. Caregivers often reported that they had no money for treatment, so the trip would be wasted.

***Child development.*** Caregivers reported that suggestions about making play materials for children were most useful. Their complete set of answers to, "What was the most useful suggestion about child development?" is given in Table 8 on the following page.

Mentors reported that suggestions to play with children and to tell them stories were most difficult to get people to try; they said caregivers felt themselves to be too old for this, that it was childish, and that they just had no time.

## Mentor monitoring, new training, new groups and roles

Monthly meetings are part of the mentor home-visiting program. SFC staff meet with groups of mentors to help them share their home visit experiences, solve problems about specific family and child issues as a group, receive additional training in health, nutrition, and psychosocial care of young children, review their visit monitoring records, and collect their monthly allowance (USD$8). For each of the five to seven families they visit over the course of the month, mentors record the topics discussed, solutions generated, actions taken by caregivers, caregiver support group activity, and assistance or support they require from SFC staff or the SFC committee. If a problem is urgent or dangerous, mentors are urged to request assistance immediately from their SFC supervisor or from appropriate community members. The costs associated with the home-visiting component of the program (including these allowances) total USD$2.05/child/month (USD$24.60/child/year). Staff supervisors also support mentors by accompanying them on visits every two weeks during their first months of work, and later as a "spot check" for additional training, support, and supervision.

### Table 8: Most useful suggestions about child development

| Caregivers' responses N=45 | First responses | Total mentions |
|---|---|---|
| Make play materials | 23 | 27 |
| Play with the child | 7 | 8 |
| Encourage play with others, being active | 5 | 8 |
| Tell stories | 2 | 9 |
| Sing songs | 1 | 8 |
| Talk to the child | 0 | 2 |
| Count numbers with child | 0 | 2 |
| Don't remind child about death of parent(s) | 1 | 2 |
| Don't use harsh or loud tone of voice | 0 | 2 |
| Unique responses* | 6 | 7 |
| **Total** | **45** | **75** |

* Unique responses: She is free with others; he has developed in many things, e.g., forgetting about the absence of the mother; he has improved in many things, e.g., she knows that she stays with her aunt; the child grows when he is asleep; they were not playing but now they play; teach the child skills.

After six months of weekly visits, mentors and caregivers were ready for new input. We asked mentors for an evaluation of children's and caregivers' most important problems at this point, to supplement training with information they thought would be most valuable. Ninety percent of

mentors ranked health problems as the *children's* most important problems (malaria, diarrhea, cold/flu, sores/rashes, fever, other); 100% of mentors ranked feeding issues as the *caregivers'* most important problem (lack of planting due to lack of seeds or energy, crop failure, lack of time to buy/sell, lack of necessary help to plant/sell). Staff is organizing trainings for mentors on Community-based Integrated Management of Childhood Illness (C/IMCI) and on planting/agriculture for both mentors and caregivers, the latter with assistance from the Kenya Agriculture Research Institute (KARI).

*Mentors report that they are respected in their communities and rewarded by helping children and their caregivers.*

There has been a transformation of mentors' behavior, as well as caregivers', over the past two years. Mentors report that they are respected, have new knowledge and skills, have improved the care they give their own families, enjoy helping people, and enjoy their colleagues—and this has empowered them. Mentors have become outspoken about program planning and management, and they now approach the SFC committees and staff with their concerns, suggestions, and demands. Several mentors have become advocates for the caregivers with other local groups to get resources or legal redress for the families. Some mentors have taken on administrative roles in the project, meeting with preschool and health post personnel, paying fees for caregivers, writing reports for the staff, and convening the mentors in their community for activities and group sessions. These "senior mentors" are now given additional stipends to handle their additional duties.

On their own initiative, mentors have also formed economic support groups in which each member contributes 200 Kenyan shillings to a common fund (called a "Merry-Go-Round"); each month, two mentors have the use of this fund. Mentors have spent this money on uniform fees for children and to purchase seeds for a common garden. Since most mentors live near the caregivers they visit, these activities served as a local model for caregivers and helped to sustain mentors in their community work.

## Home Visiting: Lessons Learned

- **Problem-solving approach.** Much of the training was directed toward helping mentors take a respectful, mutual, problem-solving approach to difficulties perceived by caregivers and tagged by staff on the basis of the needs assessment study. This approach was rather foreign and needed to be tempered by local custom. Accustomed to Community Health Workers' instructional approach, people in South Kabras expected specific suggestions and, we were told, would have felt

cheated of help without them. Furthermore, younger mentors dealing with older caregivers needed to establish that they had special knowledge to share. Training did provide mentors with specific suggestions to offer caregivers in health, nutrition, and child development, and, with staff support in mentor meetings and spot checks, mentors successfully learned to use encouragement and suggestions in place of shaming and instruction. "Show your knowledge, then problem solve" captures the mentor approach in this context.

- **Mentor age.** Mentor recruitment criteria called for experienced mothers over age 25. Even at this age, however, several of the younger mentors reported feeling quite uncomfortable trying to advise older caregivers. Our oldest mentor, a grandmother herself, has had the greatest success in solving problems with caregivers and helping them to organize themselves.

## Home Visiting: Suggested Adaptations

- **Mentor criteria**. Mentors were chosen primarily on the basis of characteristics that would increase the likelihood of good communication with caregivers. In these communities, that meant experienced mothers, age 25 or older, with at least a primary school education. We were concerned about not including men as mentors, but were assured repeatedly that, given the gender roles in these communities, it would invite communication failure. In other communities with different sexual politics, male mentors might be appropriate and effective. Youth mentors, properly trained, might also be a viable or complementary option in communities where experienced mothers are less available for community work. Many caregivers urgently need help with the logistics of daily life: carrying water, shopping, planting.
- **Mentor caseload**. We chose five as the number of families each mentor would work with, based on a calculation of hours involved and comparability with the stipend/travel allowance another NGO in the area was using for that number of hours; offering either more or less would have created a variety of problems. This caseload is common for home visiting programs; mentors with other jobs and family responsibilities have been able to manage this number relatively easily. Groups relying on even busier volunteers, or those with funds to cover more hours, may want to adjust the number of families assigned to each mentor.
- **Visit frequency**. An initial period of weekly visiting can be adjusted later to biweekly, monthly, and quarterly to expand services, depending on family progress and results of ongoing monitoring during and after adjustment. To explore possible savings of time and funds, we asked both mentors and caregivers what they thought was an ideal frequency for mentor visits. When caregivers were asked, "Do you think mentors should visit every week, every two weeks, once a month?" 62% of caregivers said weekly, 28% said every two weeks, and 20% chose once a

month. Staff strongly recommends that the initial frequency of mentor visits be weekly in all cases, and that if and when longer periods between visits are tried, households should be monitored regularly. It is very easy for households on the edge of vulnerability to slip into deeper trouble.

According to field staff, the real power of mentor visiting to change lives lies in its personal, interactive, and learning aspects. The personal connection to a regular visitor who cares about them and their children nourishes, strengthens, and motivates caregivers, and the problem-solving process educates both mentors and caregivers in ways that continually increase the usefulness of visits.

# Preschool

## Preschool: What We Did

The needs assessment revealed that loss of time was one of the greatest impacts of fostering on caregivers, with multiple effects. In answer to, "How has the family life changed since this child came to live with you? How has your life changed?" many caregivers reported they used to work on people's farms or in their own businesses and now couldn't. Loss of time meant loss of income and food security. Loss of time also meant less time to clean, to cook, and to plant their own kitchen gardens, just when all of these things were needed more than usual to care for fostered children. Trying to balance these tasks with childcare meant everything got shorted. These findings, together with the observed generally low level of stimulation for young children and the wish of the community that the project provide preschool, confirmed this programming choice. The Government of Kenya provides preschools in elementary schools for a small fee, but even this fee—when accompanied by costs for uniforms, snacks, and school supplies—was beyond the means of caregivers.

*Preschool is an opportunity for socialization and play for isolated orphans and vulnerable children; it also provides a much-needed break for caregivers.*

Staff first visited preschools to see if enrollment would be a true benefit for children. While some preschools were better than others, all provided a safe, supervised group experience for children. Since the beginning of the program, 90 children between the ages of 3 and 5 have been enrolled in 24 preschools; currently, 71 children are enrolled (some have "graduated" to primary school). The project paid school fees and fees for snack; caregivers contributed a book and pencil for their

## Table 9: Changes in children's behavior at home attributed to preschool

| Caregivers' responses | First responses | Total mentions |
|---|---|---|
| Can be sent*, obedient, not rude, has respect | 8 | 13 |
| Not crying all the time | 6 | 8 |
| Can greet people, free with big people, not shy | 6 | 16 |
| Active | 5 | 9 |
| Reads at home, counts at home | 3 | 8 |
| Tells me what s/he learned | 3 | 4 |
| Know how to play with others | 3 | 6 |
| Is always clean | 1 | 3 |
| Sings songs, ABCs, poems | 0 | 5 |
| Unique responses | 6 | 9 |
| **Total** | **41** | **81** |

* "Can be sent" literally means that a child can be told to go get something in the household or down the road and bring it to the caregiver, but it is also used as a general description of competence, obedience, and maturity—the ability to carry out a chore when asked.

children; through caregiver groups, SFC committee contributions, and personal finances, most were able to provide school uniforms as well. The typical preschool program runs from 8:30 a.m. to 12 noon and includes free activity, outside play, letter/number recitation, drawing/poems, Luhya storytelling, riddles, drama, and a daily snack consisting of sugar, *milind*e, and maize porridge. All teachers maintain attendance records for monitoring and evaluation purposes; SFC staff or senior mentors conduct spot checks at the preschool to verify attendance, to talk with teachers about children's progress, and to pay fees. Primary school is now free of charge in Kenya, but preschools still entail fees. The average cost of the preschool component (levy and snack) was USD$1.18/child/month (or USD$14.16/child/year).

Caregivers put the time freed up from childcare by preschool to good use. When caregivers from the first cohort of two communities were asked (after about a year) what they did during the time children attended preschool, and how life changed since the child started attending, caregivers said that while the children are away, they are able to clean their compounds, farm and plant and perform other casual work, fetch water and firewood, wash utensils and clothes. In poor, rural households these seemingly mundane chores become life-and-death issues for young children. Lacking animal pens, flush toilets, laundry facilities, and even countertops, poor households can very easily develop

multiple disease vectors without constant labor and attention to hygiene. In one overwhelmed household, staff found the compound littered with child and animal feces, dirty "diaper" rags, and urine-soaked clothes and mattresses; eating utensils were lying in the dirt. Time for working on farms and for cooking is important; so is time for cleaning.

Preschool is very valued by caregivers. We asked them to answer the general question, "How has the project helped you?" and specifically, "What has been the greatest help?" Seventy-six percent of caregivers with children old enough to attend preschool gave preschool enrollment or preschool fee payment as their first answer to how they had been helped; 63% designated preschool as the greatest help. Asked, "How has the project helped the children you care for?" 51% of caregivers with children old enough to attend preschool mentioned preschool first, and said it was the greatest help for children.

We also asked caregivers for specifics: "How has the child's being in preschool changed his/her behavior at home?" We expected some of the changes caregivers noted: improvements in playing with other children, some singing and counting at home. More surprising was the number of caregivers who commented on an increase in cooperation and a decrease in "crying all the time" at home. New home competencies were also mentioned: in greeting visitors, sweeping, bathing, and even looking after cattle.

Along with preschool experience, age-related development and improved nutrition may have played a role in these changes. Results are summarized in Table 9 on page 36.

## Preschool: Lessons Learned

- Attending preschool seemed to organize more frequent and more reliable feeding for young children. Asked what activities they do when their children attend preschool that are different from before, several caregivers answered that they made an early breakfast and have time to make lunch, or now make lunch "on time" or have time to look for and cook lunch food. Preschool also provided regular morning snacks for children. The structure of children's preschool absence from the household seemed to ensure that at least three meals happened regularly before supper every day.
- Preschools that are less than what we would want them to be, preschools with difficulties common to under-resourced areas—untrained teachers, overcrowding, lack of resources for play materials, and inconsistent provision of snacks—still benefit children and caregivers.

## Preschool: Suggested Adaptations

Where some preschools are supported by the government, enrollment in local preschools is a cost-effective choice. Paying fees for enrolled children supports services for the entire community and

enrollment with the general preschool-age population mitigates stigma. Lacking local preschool options, groups could consider:

- Lobbying the local elementary schools to provide some preschool supervision in an area within the school compound.
- Creating an informal preschool through volunteer labor and project support for teaching staff.
- Assisting caregivers to organize cooperative childcare groups to maximize time for domestic work and income-generating activities.

# Caregiver Support Groups

## Caregiver Support Groups: What We Did

We asked each mentor to hold monthly support group meetings with her five caregivers. We originally thought of these meetings mainly as an opportunity for caregivers to get out of the household, to share their own problems and those of their children, and to brainstorm solutions as a group. Five of the first 10 mentors successfully organized these group meetings; one other mentor has helped to organize a "Merry Go Round" (see below) that helps caregivers financially.

**Table 10: What caregivers like about caregiver support groups**

| Caregivers' responses | Frequency |
|---|---|
| Learning from each other, sharing ideas, solving problems together | 19 |
| Helps with the merry-go-round | 5 |
| Meetings are good, a great help, feel good | 4 |
| Discussions, knowing each other | 3 |
| **Total** | **31** |

## Caregiver Support Groups: Lessons Learned

Perhaps the biggest surprise was that several caregiver support groups rapidly became sources of financial as well as emotional support for caregivers. Caregivers in the group organized a "Merry Go Round," in which each group member contributes a small sum, most typically KSH 50 (USD$.64) and gives it all to one person that month. When asked, "How has the caregiver group helped you?" 80% of those responding answered in terms of the things the merry-go-round money had made possible for them. Caregivers mentioned a great variety of things they purchased: hens, seeds of all

sorts, medical treatment for children, school uniforms, children's clothes, fruits; cooking oil; millet; books, pencils, and school bag; soap; sugar; children's shoes; materials and labor to build a latrine.

Four caregivers mentioned getting skills from the meetings, especially childcare skills. One caregiver just said, "It helps me. When I get home, I feel free." Asked, "What do you like about meeting with other caregivers?" most mentioned learning from each other first (see Table 10 on the preceding page).

# Links to Community Resources

## Links to Community Resources: What We Did

SFC staff worked on both personal and organizational levels to link resources in the immediate and wider community with caregivers, to make maximum use of available resources, decrease caregiver isolation, and help create long-term sustainability.

- **Community nurse.** Staff worked with the community nurse to make it possible and comfortable for caregivers to come for immunizations, dealing in advance with issues surrounding fees, vaccine supply, age of child, schedule of services, and accompanying them personally on immunization visits. Staff researched alternative health service possibilities and schedules for those uncomfortable with nearest clinic staff.
- **District Medical Officer.** Staff undertook advocacy with the District Medical Officer to improve staffing at the location clinic to officially approved levels of staff quality, numbers, and service provision.
- **Ministry of Health.** SFC staff and mentors took Ministry of Health (MOH) family planning training; mentors received training by the MOH in Community-based Integrated Management of Childhood Illness (C/IMCI).
- **Community Health Workers and Home-Based Care.** SFC welcomed COPHIA (the NGO that organizes home-based care, training, and HIV/AIDS prevention activities in the area) community health workers to mentor trainings and coordinated with them on identifying vulnerable households.
- **Kenya Agriculture Research Institute (KARI).** Training on efficient and effective planting in South Kabras was carried out for caregivers, SFCC members, and mentors.

*Mentors' generous assistance with basic chores such as fetching water, sweeping the compound, or cleaning dishes, is greatly appreciated by caregivers, most of whom are grandparents with little physical energy.*

- **National Council of Churches in Kenya (NCCK).** NCCK will provide technical assistance to mentors', caregivers', and SFC committees' income-generating projects.
- **Neighborhood help.** Previously isolated caregivers now have a much wider circle of support and nearby access to possible help of various kinds when they need it. Their own caregivers' support groups, and their mentors' circles of friends and relatives, provide many potential sources of immediate practical help nearby.
- **Churches.** Through the Speak for the Child committees, churches have mobilized work teams to help elderly caregivers with planting and other agricultural tasks; other assistance has also been forthcoming, e.g., building latrines, emergency transport.
- **Committees.** SFC locational and sublocational committees have become real resources for children and caregivers. Committees now help solve mentors' problems, intervene in caregivers' household and child crises, and provide material support to enrolled families.

## Links to Community Resources: Lessons Learned

Staff had much greater success advocating and working with local government institutions in health and agriculture than in collaborating with AIDS-oriented INGOs and NGOs. The community links exceeded our expectations. We had hoped that caregivers would find ways to support each other verbally; they are supporting each other financially as well. We had no expectation that mentors would form their own support groups outside project meetings, but they have, and these groups are helping to support the mentors' families and serving as a model for other women. We had hoped SFC committee members would get involved at least with finding ways to contribute financially to vulnerable families; they have done so and have become deeply engaged in the administration of the program as a whole and in resolving family and community tensions.

## Links to Community Resources: Suggested Adaptations

- **Agriculture.** Locally respected individuals or cooperatives might provide technical assistance to caregivers where resources for agricultural or business technical support are unavailable or uncooperative.
- **Women's groups.** Local women's or church groups might be asked to reach out to include caregivers, perhaps especially after caregivers have had group experience with mentors in their own support groups.
- **Business groups.** Local organizations such as church groups and Kiwanis or Rotary clubs might be asked to get involved in orphan support on a regular or as-needed basis by organizing work days to help caregivers plant or build latrines.

# Program Costs per Child

Table 11 shows the direct costs for services delivered in 2002 to orphans and vulnerable children and their caregivers enrolled in the Speak for the Child program in South Kabras, Western Kenya.

In 2002 the project was still a pilot, covering only 25 households per sublocation. There were no economies of scale. Total direct costs for the field office that managed the project, conducted all training, monitored and evaluated activities and outcomes, and reported extensively to donors averaged $8,000 per month over the year; international technical assistance involved additional costs. These are big, unsustainable numbers that include costs for development and research, i.e., needs assessment, design, planning, pretesting, training for and implementation of large-scale community surveys, results analysis and intensive targeting, comprehensive training and ongoing support for

## Table 11: 2002 direct services costs per enrolled child *Speak for the Child* program, South Kabras, Western Kenya

| Program Component | Cost per Child/Month* | Cost per Child/Year* |
|---|---|---|
| Immunization and health cards | $0.07 | $0.78** |
| Preschool for 3- to 5-year-olds*** | $1.18 | $14.16 |
| Weekly home visiting by trained community mentors | $2.05 | $24.60 |
| Caregiver support groups | $0.00 | $0.00 |
| Meetings and capacity building of SFC community committees | $0.40 | $4.80 |
| **TOTAL** | **$3.70** | **$44.40** |

*Exchange rate used is 1 USD=78 Kenyan Shillings (KSH).
**The cost of fully immunizing a child and providing a health card in this community is USD$.78.
***Preschool fees include fees for daily snacks.

## Table 12: Costs of SFC program under two management scenarios

| Program Component | Cost per Child/Month | Cost per Child/Year |
|---|---|---|
| Direct costs for services delivered | $3.70 | $44.40 |
| Direct costs plus local management costs; program run by communities, i.e., SFC committees/CBOs; assume 500 children served | $4.44 | $53.28 |

volunteer mentors, and detailed monitoring and evaluation activities. Therefore, these costs are not representative of what a community will spend to implement the program.

We recommend that project communities pay a program manager to ensure efficient and transparent management of funds and to ensure that the quality of services is sustained. Speak for the Child field managers are paid $267 per month by the project, a high salary by local standards. In addition, we budget $100 per month for travel, supplies, and contingencies. A community that hires a program manager should expect to add approximately $370 per month to the direct service costs of $3.70 per month per child. Speak for the Child will serve 500 children by the end of 2003. Assuming this caseload, a paid project manager will add about $.74 to the monthly costs for each child, yielding a total monthly cost per child of $4.44 and an annual cost per child of $53.28 (see Table 12).
The $53.28 per year figure can be reduced in two ways. First, mentor caseloads can be increased. Second, as children age, they enter primary school and the cost for their participation falls because preschool fees disappear and the number of household visits per month is reduced.

The costs in Table 12 do not represent coverage of additional children who benefit but are not enrolled in the program. For example, Speak for the Child preschool fees and snacks benefit many additional children. An impoverished family will typically enroll a child in preschool, pay the first month or two of fees, then not pay for the rest of the year. Reliable Speak for the Child payments now enable teachers to be paid and food to be purchased throughout the school year, benefiting all the children in preschools where Speak for the Child has enrolled children. Mentors and caregivers have improved their childrearing, feeding, and care practices with older children and nonorphans in their households and families.

Analyzing the costs and benefits of investment in community-based care for orphans and vulnerable children is beyond the scope of this paper. However, international research consistently shows

significant and positive costs to benefits ratios on investments in early childhood development programs, ranging from three to 20. Returns are generally greater if 1) participating children are highly vulnerable, and 2) the program is of good quality. The SFC program qualifies on both counts. Over the long term, communities can reasonably count on very high rates of return on this investment.

Comparing these costs to costs for alternative programs is a challenge. Few communities have activities to support caregivers or orphans and vulnerable children younger than school age. There are three other orphans and vulnerable children support programs in Kakamega district where South Kabras is located. All are residential, i.e., orphanages. All refuse to share cost information. One comparison is cited by J. Donahue, S. Hunder, L. Sussman, and J. Williamson: "one high-quality institution in Nairobi reported annual running costs of about $1600 per child.[7]"

## Wrapping Up: Sustainability

We have described here our approach to the first three challenges that face programs planning to address the needs of young orphans and vulnerable children in a community context—connecting with the community, identifying those who are most vulnerable, and creating an effective program. There is a fourth: sustainability. The Speak for the Child project is now focusing on ensuring independent sustainability of its activities in South Kabras.

We believe that the project can continue after current funding ends because of the ways local capacity and local ownership have grown. Sustainability is not a foregone conclusion, but it does appear to be likely. Caregivers, mentors, and committee members have become invested in the project, experienced its benefits, and begun to establish the income-generating activities needed to continue the work. Leaders have come forward who dedicate time and thought to making the project work. Community members know project staff personally, work with them daily, and feel free to tell them (frequently!) what the project should do and how it should be run. We suggest that the community hire its own SFC manager for the future; it is already clear that such a manager would get lots of good advice and great help.

We expect sustainability to come from within, for all the reasons given above. Our hope for these communities and others elsewhere is that national and international funders will contribute as well. We hope they will see the alternative futures the citizens of South Kabras see, the futures to which good care for orphans and vulnerable children under 5 makes the difference. One future reveals neglected, orphaned preschoolers who grow into disaffected street children and who become unproductive, antisocial adults ravaged by the AIDS epidemic. The other future reveals young orphans who are seen and heard by their extended families and communities; schools that enroll all children, including those

whose lives have been affected by AIDS; and villages where young children are valued, protected, and cared for with love. South Kabras is reaching for the better future.

## Endnotes

1 Lusk, D., and C. O'Gara. 2002. The Two Who Survive: The impact of HIV/AIDS on young children, their families and communities. In Coordinators' Notebook, no. 26, pp. 3–21.

2 UNICEF and UNAIDS. 1999. Children Orphaned by AIDS: Front-line responses from Eastern and Southern Africa. Available at www.unaids.org/publications/documents/children/young/orphrepteng.doc.

3 See Lusk and O'Gara, op. cit., for a review of programs for children under 5, and contact the Bernard van Leer Foundation or dlusk@aed.org for a recent update.

4 We use "young orphans," "young children," and "AIDS-affected young children" to indicate "orphans and other vulnerable children under 5 in the context of AIDS." The acronym, "OVC," for "orphans and vulnerable children" can apply to children in the context of violent conflict as well, when we are concerned with the AIDS context. The acronym, "CABA," for "children affected by AIDS," applies, but, like OVC, fails to remind us that, however special their circumstances, they are, most important, children. "Young" and "under 5" refer to children who have not yet had their sixth birthday.

5 Mann, G. 2002. Family Matters: the Care and Protection of Children Affected by HIV/AIDS in Malawi. Save the Children Alliance.

6 Ayieko, M. 1998. From Single Parents to Child-Headed Households: The Case of Children Orphaned by AIDS in Kisumu and Siaya Districts. Research report, Study Paper no. 7, NIV and Development Programmes, UNDP.

7 Children Affected by HIV/AIDS in Kenya: An Overview of Issues and Action to Strengthen Community Care and Support, 1999, p. 11.

Funding for *Speak for the Child, Case Study: Kenya* was provided by the Bernard van Leer Foundation. The Speak for the Child program was made possible through support provided to the Academy for Educational Development (AED) by the Bureau for Global Health (GH/HIDN) of the United States Agency for International Development (USAID), under the terms of Cooperative Agreement No. HRN-A-00-97-00007-00. The opinions expressed herein are those of the authors and do not necessarily reflect the views of the Bernard van Leer Foundation, USAID, or AED.

## The Academy for Educational Development (www.aed.org)

Founded in 1961, AED is an independent, nonprofit organization committed to solving critical social problems in the U.S. and throughout the world. AED operates more than 250 programs in more than 80 countries and all 50 U.S. states. AED's Ready to Learn Center (**www.readytolearn.aed.org**) improves the lives of young children in the developing world using approaches that integrate health, education, and nutrition.


**AED/Ready to Learn Center**
1825 Connecticut Avenue, NW
Washington, DC 20009-5721
Tel: (202) 884-8261/Fax: (202) 884-8408
ready@aed.org

**AED/Speak for the Child**
P.O. Box 1032
Kakamega, Western Province, Kenya
Tel: 254-056-30386
aed@africaonline.co.ke



Funding for this publication comes from the Bernard van Leer Foundation.


A little support to AIDS-affected families and communities goes a long way. Orphans and vulnerable children can grow up safe, happy, healthy and educated.