Scaling up playful parenting in Zambia

EVIDENCE BRIEF

Photo: UNICEF/Zambia

Playful Parenting Implementation Research Study

ZAMBIA | **2022–2024**

This evidence brief summarizes the emerging findings from FHI 360's implementation research on the UNICEF Zambia Care for Child Healthy Growth and Development (CCD) program, implemented with LEGO Foundation funding under the Playful Parenting portfolio.

RESEARCH QUESTIONS

- What are the effective pathways to bring play and responsive stimulation parenting programs to **scale and sustainability**?
- How can such programs ensure sustainable **quality and impact** on caregiver and child outcomes?

METHODS

- **Surveys** with service providers & caregivers
- **Observations** of home visits & group counseling sessions
- **Direct assessments** of child & caregiver outcomes
- **Focus group discussions** with caregivers
- **Interviews** with service providers, program implementers & government

The Program | unicef

This study looked at the CCD program implemented by UNICEF/Zambia for caregivers of children ages 0–3 in Katete & Petauke districts of the Eastern province, which along with play and responsive stimulation includes messaging on nutrition, health, hygiene and sanitation.

Community-based volunteers were... → trained on **CCD curriculum** and used CCD counseling cards, poster, & guide... → to deliver **home visits**, and later **group sessions** in 2023... → targeting **7–10 families** in **4–7 home visits** & delivering group session curriculum across **4 sessions**.

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Key Findings

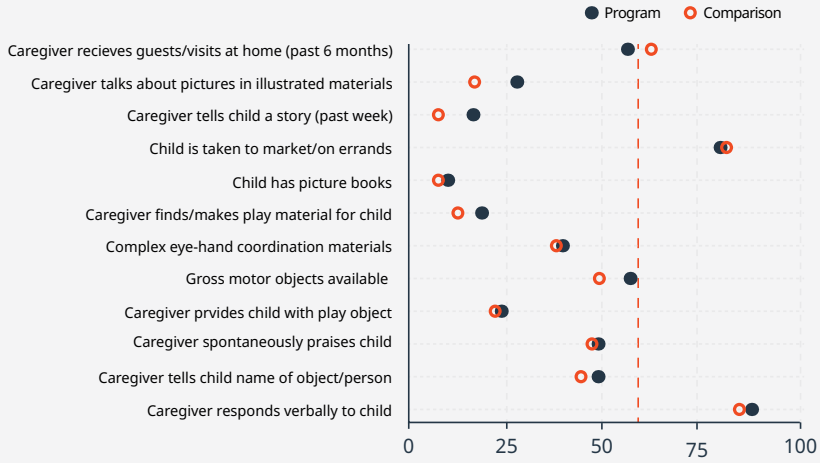
1 Overall, parenting outcomes did not substantially change, but small positive shifts are observed

Caregiver-child interaction and child outcomes were measured in 2021, 2022 and 2023 in the program districts of **Katete**[1] and **Petauke** and in the comparison districts of **Chipata** and **Chongwe** (initially selected as future scale up areas for the UNICEF Zambia program). While **some differences on individual items can be observed** between program and comparison areas, the **differences on the overall 45-item HOME inventory were not large or statistically significant**. Further, there were no differences on child outcomes as measured by the MDAT or GSED observed between program district families and families in comparison areas. Modest positive differences between program and comparison areas were noted on the module measuring father engagement in child rearing, although the sample sizes of fathers were too small to be conclusive (n=320).

At the same time, focus group discussions revealed a **greater emphasis on the importance of play**:

> "Many of us never knew how to take care of our children and **the importance of using positive words** with our children..."
>
> *–Mother, Zuze*

HOME Inventory: % caregivers scoring a point in a selection of critical items, by treatment status (Oct 2023)



2 CBV visits are appreciated by caregivers, but reach remains a challenge

With the program operating at full intended scale, the **reach of CBVs remained limited**: only 36% of sampled families in program districts reported having received a CBV visit in 2023, compared to 40–50% in 2022 and 2021. The two districts have trained approximately 1250 CBVs in individual and 350 in group counseling. Introduction of group counselling might relatively increase reach but more CBVs should be trained. Caregivers who did receive a visit reported that the CBVs covered play and responsive stimulation (90% of those who received a visit).

> "**We have support** from these people who teach us how to make toy things for playing with children."
>
> *–Mother, Zuze*

The lack of observable effect on outcomes may be related to the fact that only 30% of surveyed caregivers reported having learned something new from the visit in 2023 (a drop from 50% in 2022). Despite this, caregivers had generally a **favorable view of the CBV visits**, and those who reported receiving visits showed higher outcomes on a range of items on the caregiver-child responsive stimulation scale (HOME Inventory). In interviews, many CBVs noted that reaching all families is challenging due to the large distances and lack of transportation and incentives.

1 Katete district had started the program before the implementation research study began and therefore does not have a true baseline

3 CBVs are a viable workforce, but need continuous support, mentoring and supervision

CBVs reported **being committed to the core messaging and importance of play and responsive stimulation** for early childhood development. They **recognized the challenges of existing norms around parenting of infants** in particular, noting that play and talk are not normally introduced until later in a child's life. Many CBVs carry their responsibilities with pride and see their role as important in their communities.

> "...playing with the child, there are **a lot of benefits**, because as the child grows... [it] opens up brain, their thinking..."
> *–Community Based Volunteer*

However, as is common with volunteer workforce, **attrition and gradual waning of motivation are risks when no compensation is provided**. CBVs report that **supervision they receive is mostly administrative** and they do not receive coaching and mentoring on the quality and fidelity of their work – which they would welcome.

During a visit, the research team was shown a monitoring form designed by the program to assure fidelity, but CBVs reported not having seen its use. While the Ministry of Health (MOH) has a policy in place for compensation of CBVs, at the time of the study's completion none of the CBVs interviewed or surveyed had received compensation. Stakeholders were concerned that these factors might affect optimal sustainability of the program.

4 CCD counseling cards are often not sufficient for CBV visits

Our observations of home visits and group sessions showed that **CBVs tightly follow what they were trained to do**, namely follow the script of the counseling cards during program delivery. This meant that they were bound by the limitations of the curricular material. Because the content is structured in 3-month age bands, **providers quickly run out of content of new games and activities to cover during their monthly sessions with parents**. While nearly all observed CBVs used visual aids provided on the cards or posters, only 30% were seen coaching caregivers on a new practice they introduced, and about 30% demonstrated responsiveness to the caregiver and child during the session. Further, in asking the caregivers to demonstrate how they play with their child, how they talk with their child, and how they make their child laugh, many providers miss the opportunity to provide new ways to play and talk, and themselves miss opportunities to focus on responsiveness to the child's interest and focus.

> "...**translation is required,** sometimes we could interpret English words but maybe wrongly."
> *–Community Based Volunteer*

In interviews, CBVs noted that the counseling cards were in English, which led them to self-translate into local languages for caregivers, and they were often not certain if their translation fully conveyed the original intent of the materials. When explaining the benefits of play and responsive stimulation, some CBVs indicated that they were needed to test or to help develop sensory functions of the child, rather than for cognitive development – a misunderstanding that likely stems from incorrect interpretation of developmental milestones.

5 Group counseling sessions at health facilities are a promising practice exploring further

The group counseling sessions held at health facilities, which began after a training in 2023 in response to emerging evidence of low reach of families, hold **promise for reaching larger numbers of caregivers** who come to the facilities for growth monitoring and immunization. The research team observed large numbers of caregivers with young children attending clinics on certain days of the week, and the lengthy wait times offer opportunities to engage parents in group sessions with minimal impact on their schedules. In some facilities, staff and CBVs take groups of as many as 15–20 caregivers to a group

session at a time. This can be an effective vehicle for the program, if the sessions are well designed and facilitated to capture and maintain caregiver interest.

At this time, the study holds only **very limited data on the effectiveness of the group sessions**, which nonetheless revealed some key areas for quality improvement. Namely, only **35% of observed sessions had most parents practicing play activities** with their children. Furthermore, parents are not required to attend group sessions, and the CBVs who were interviewed were not certain whether the same parents attended the full set of four age-banded sessions for which CCD materials were available. CBVs reported that the sessions vary in parent participation, and that they often encounter parents who are reluctant to attend group sessions, particularly when they are offered after the parent has completed the growth monitoring and immunization visit.

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35%
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Recommendations & Ways Forward

The study showed that at the end of Year 4, much remains to be done to achieve quality and impact at scale in the area of play and responsive stimulation for early childhood development in Zambia. While there are indications that the volunteer service providers can be a viable workforce, much more needs to be done to ensure that the content they are delivering to caregivers, their ability to reach all families in the target areas, and the mentoring and supervision they receive meets the needs of the moment.

Photo: UNICEF/Zambia

1 The *content of the counseling cards needs to be revised and translated,* followed by training and monitoring

Counseling cards must be structured to support a variety of play and communication activities and provide CBVs with a repertoire of activities, as well as evidence-based behaviour change methods to coach caregivers.

2 The *focus on play and communication must be elevated and emphasized*

Much work that has already taken place to socialize parents to proper nutrition and health, while play and talk remain new to many, and therefore needs reinforcement and emphasis in messaging. Both frequency of messaging and homework should be enhanced.

3 More CBVs need to be *trained and incentivized* to deliver the program

The current numbers of trained CBVs are not sufficient, and without incentives, attrition will erode the number of providers who can deliver the sessions. While financial incentives are important, interviews and surveys with CBVs indicate that frequent acknowledgment, training manuals, and branded materials are critical motivators.

4 A viable *supportive supervision structure* is needed to ensure CBVs are delivering with quality

Nurses at health facilities, as well as CBVs that show excellence can be tapped as Coaches and Master trainers for peer supervision, with requisite additional incentives and support.

5 *Health facilities can do more* to broaden expectations of caregivers and messaging on responsive stimulation

Broadening group counseling to large groups of caregivers as they wait for immunization or growth monitoring is a key opportunity that should be leveraged by all health facilities. In addition, including attendance of group counseling as a requirement on an immunization and growth monitoring card as an expectation for caregivers may help socialize parents to their importance and strengthen attendance.