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Full Length Research Paper

Mobilizing and strengthening community-led childcare through community care groups and coalitions: A study from Ethiopia, Mozambique, Uganda and Zambia

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This article presents findings from a study, involving over 778 respondents from 24 communities in 4 countries, where WV has supported community-led childcare initiatives. The community care coalition (CCC) is a foundational feature of World Vision's programming model for mobilizing and strengthening community-led care for orphans and vulnerable children (OVC), and people chronically/terminally ill. To date, WV facilitates and supports over 3700 such community care mechanism with over 934,500 orphans and vulnerable children being supported by those groups in 20 African countries. To learn from this experience, WV conducted a study from August to November 2006 with the aim of identifying the strengths and weaknesses of different types of community care groups (CCG) – directly involved in child care - and community care coalitions (CCC) –focused on coordination and networking - within different contexts in order to inform and guide World Vision (WV) and its partners' future programs to mobilize and strengthen community-led care for orphans and vulnerable children. Findings indicate, that community led-child care established through strong community mobilization processes, well horizontally and vertically networked, are sustainable mechanisms for enhanced child well being at the community level. However, the quality of care depends largely on the quality of home visitors and the frequency of ongoing home visits. Home visitors have limited capacities in areas such as HIV and AIDS information, psychosocial care, local level service access advocacy, as well as child rights and protection. There is a need to enhance investment in training and strengthening the skill sets of home visitors. Organizational capacity building is an important step towards full ownership and sustainability of CCCs. Stronger, well established CCCs should start to mentor less established CCCs in the same geographical areas. WV needs to see such community-led child care initiatives not "just" as HIV and AIDS projects but as the foundation for long-term sustained and community owned child care and support institutions. Child participation in existing CCCs is either weak or absent. This general lack of children's participation in CCC processes provides significant challenges and opportunities for program innovation and development that have the potential to shift the balance of power in communities in favor of children. Children need to be seen by CCCs and home visitors as active participants and not just beneficiaries. It is important for CCCs to develop strong participation capacities to ensure full and meaningful child participation towards enhanced and sustained quality of life for all children in communities where CCCs exist.

Key words: Orphans and vulnerable children (OVC), community childcare, HIV and AIDS, community mobilization, program performance, participation.

INTRODUCTION

Life expectancy in many countries in East and Southern Africa has declined as a result of AIDS (Piot and Bartos, 2002; Foster and Germann, 2002). This development has reduced the number of caregivers of optimum age. This shortage of prime-age adults has consequences for the

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next generation (Germann, 2005). Increasingly, instead of being cared for by uncles and aunts, many orphans and vulnerable children will grow up in households headed by elderly or adolescent caregivers. In most of Africa the extended family system was the traditional social security system. Family members were responsible for the protection and care of the vulnerable. Although the combined impact of urbanization, HIV and AIDS, and poverty has weakened this social safety system, the extended family remains the predominant care giving unit for orphans in communities with severe epidemics (Ankrah, 1993; Foster et al., 1995; Ntozi, 1997). But the extended family is not a 'social sponge' (Figure 1) with unlimited capacity to care for an ever-increasing number of vulnerable children and orphans (Foster, 2000).

Community-led care for vulnerable children, in the context of poverty, HIV and AIDS and other factors that negatively impact the ability of vulnerable families to adequately support their children, is a primary safety net in providing essential support for those children who have "slipped" through the safety net of the extended family (Donahue and Mwewa, 2006). Reinforcing the capacity of communities to provide care, support and protection is the basis of a response in support of children that will match the scale and long term impact of the compounding crisis of poverty, HIV and AIDS. The global multi-agency framework for the protection, care and support of orphans and vulnerable children living in a world with HIV and AIDS, recognizes the importance of community care, one of the five key strategic response areas, in mobilizing and supporting community-led responses (UNICEF and UNAIDS, 2004).

The community care coalition (CCC) is a foundational feature of World Vision's programming model for mobilizing and strengthening community-led care for orphans and vulnerable children (OVC), and people chronically/terminally ill. CCCs may have different names in different countries depending on the local context and what national OVC policies use to describe such care groups. CCCs are groups of individuals and/or organizations at the local level that join together for the common purpose of expanding and enhancing care for the most vulnerable children in communities. Those groups who provide care directly are called Community Care Groups; those who have mainly a coordination role are called Community Care Coalitions. CCCs typically include representtatives of churches and other faith-based organizations, the government, businesses, and other local NGOs/CBOs in the community. They support volunteer home visitors who provide ongoing care and support to OVC through regular home visits.

World Vision has worked to mobilize and build the capacity of over 3700 CCCs in 20 high prevalence countries across east and southern Africa. By the end of 2007, over 59,000 home visitors operating in these CCCs will jointly monitor and support over 934,500 vulnerable children (CHARMS, 2006). As the CCC structure is intended to be flexible and adaptable to local contexts, the CCC the CCC has taken a variety of different forms. More than three years after the development of CCCs began; there was a need to conduct an in-depth study of the resulting strengths and weaknesses of the CCC structure as it has been implemented in various contexts. The findings of this study will substantially inform and guide WV and its partners' future facilitation role of community-led care across Africa.

Focus of the study

The main aim of this four country study was to identify the strengths and weaknesses of different types of community care groups (CCG) – directly involved in child care - and community care coalitions (CCC) –focused on coordination and networking - within different contexts in order to inform and guide World Vision (WV) and its partners' future programs to mobilize and strengthen community-led care for orphans and vulnerable children in 20 African countries.

METHODOLOGY

The study had a qualitative nature and the information collected was analyzed under five domains of inquiry, namely:

1.) Operational context and linkages.
2.) WV inputs to community care groups and coalitions.
3.) CCC structure, composition, organization and leadership.
4.) CCC ownership and sustainability.
5.) Enhanced orphans and vulnerable children's well-being.

Two main sources of data were used: i.) secondary documentation (National Plan of Action for OVC, project outlines and reports) and ii.) the views and opinions of a range of stakeholders, gathered through focus groups and key informant interviews using standard interviewing instruments. The instrument for use with children and youth involved a drawing activity as a supplemental means of understanding their perspectives. All interviews were digitally recorded.

The study sites were selected using random approaches from purposely-selected lists of CCC to include both community care groups and community care coalitions as well as different operational contexts such as grant funded vs. private funded, rural vs. urban / peri-urban and predominantly literate vs. predominantly non-literate.

The study involved a total of 24 CCCs/CCGs with a distribution of 6 sites in each of the four selected countries (Ethiopia, Mozambique, Uganda and Zambia). The study was led by a study coordinator1 and each country formed a study team that involved at least one independent researcher, staff from WV Africa's regional HIV and AIDS team and staff from the respective country's office. Fieldwork in each country consisted of at least 10 days of interviews and focus group discussions. Over 105 Focus Group Discussions (FGD) and 62 Key Informant Interviews (KII) with a total number of 778 study participants (716 in FGD / 62 KII) were involved in the study over the period of August to November 2006. 23 FGD involved orphans and vulnerable children.

RESULTS AND DISCUSSION

Results of the study are presented following the same

five domains that were used for the data collection process.

Domain 1 – CCC mobilization, structure and capacity

Mobilization: Results indicate that the quality of the CCC depends to a large degree on the inclusiveness and effectiveness of the initial community mobilization efforts. Good investment in the mobilization process in the beginning is critical for future ownership and understanding. The participation of traditional leaders in the CCC is also important in fostering and maintaining positive relationships with all stakeholders in the community. In most CCCs the research teams found that there was not sufficient participation of government representatives in CCCs. In CCCs where there was good, broad government stakeholder representation, the leverage of such CCCs was much stronger. Further, it was discovered that CCCs with a more diverse membership tended to show greater innovation in assisting children in the community. Participation of vulnerable children and youth was absent in almost all CCCs. This might be partly as a result of the language used in *The CCC Guide,* which refers to orphans and vulnerable children as *beneficiaries* rather than as *active participants*.

Structure: Local communities are adapting resource materials such as The CCC Guide (WVI 2003) to set up CCC structures that fit well into the local operational context. The local level implementing community care groups (CCGs) appear to enhance the participation and empowerment of less literate stakeholders, such as grandparents, and vulnerable community members, who seem to be intimidated by a higher-level coalition set up. There was also a risk of CCCs usurping the role of their member organizations because the CCC is often the most visible and powerful organization, receiving more support from WV than its members. This is not problematic when the CCC is only engaged in networking and coordination, however, when CCCs are mixing implementation and coordination, this situation has adverse effect on the CCC and its member organizations.

Capacity: CCCs and home visitors of CCGs demonstrate good capacity in the areas of broad child care and support; however in other areas such as HIV and AIDS information, psychosocial care, and child rights and protection, their capacities are much weaker due to insufficient training and capacity building at the level of volunteer home visitors. To date, CCCs only received very limited organizational capacity building support and formed part of the CCC guide that deals with community mobilization. There is broad consensus among all CCCs, national and other stakeholders that it is critical to strengthen CCCs with structured, ongoing organizational capacity building support. The capacity area of "beneficiary" participation, ensuring that orphans and vulnerable children, chronically ill, and others who benefit from CCC support, are fully engaged in planning, governance and implementation of the CCC, is weak.

Domain 2 – World Vision Inputs in CCC process

Resource materials: Existing training resources and manuals such as The CCC Guide seem to be comprehensive and of good quality. There is a need to enhance the role of the psychosocial material Journey of Life (REPSSI, 2005) as home visitors identified this as a major capacity gap. To strengthen the organizational capacity of CCCs, the draft Organizational Capacity Building manual needs to be made available.

Material support (Gift in Kind) and Grants: In Ethiopia and Zambia, WV is supporting some CCCs with materials in the form of Gift in Kind. Such material support ranges from seeds, fertilizers, home based care materials to clothing and food. Although such support meets certain needs of households, it has proven problematic within communities and among guardians in many cases. It appears that small grant support (piloted in Ethiopia and Mozambique) to CCCs that have sufficient organizational capacity, especially in the areas of project and financial management, is a more useful approach than for WV to provide material support. This enables CCCs to support partners and their home visitors with locally identified specific household needs at a specific time. Most households with orphans and vulnerable children found in the study are extremely poor and in need of material and/or cash support in addition to the benefits of home visits. In every study location both volunteers and guardians expressed frustration at the lack of material support at the household level. The area of how best to provide material support requires further study that includes a review of programs that use cash transfer as a means to address this important issue. Gift in kind that focuses mainly on home based care materials, such as soap, gloves etc. are useful and seem not to create tensions within communities and households. Further, in settings where Gift in Kind support was carefully used as incentives for volunteers, it can be beneficial. This contributes to volunteer motivation but creates the risk that the number of volunteers will be pre-determined by WV's ability to budget and support these inputs, resulting in undermining the growth of CCG volunteer membership of home visitors.

Training: Many home visitors have only received 2 - 3 days, of The CCC Guide recommended 5 - 10 days, training. In most cases, there has been insufficient training provided by CCCs to home visitors. The cas-cading approach to training assists in scaling up the

response of CCCs with the flip side that the content becomes diluted by the time the training finally reaches CCC members.

Domain 3 – Linkages

Horizontal: The strength of horizontal linkages depends largely on the quality of the initial community mobilization process. The better the mobilization and the more inclusive the membership, the better the links will be between all community stakeholders. Where links with government structures are weak, this usually represents missed opportunities for the CCC to access government services and support for members in supporting OVC. In many situations, CCCs are not well integrated into other WV developmental activities in the same community as CCCs are still often seen by the community and WV local staff as an "HIV and AIDS" response, rather than as a critical community platform for care and support regardless of cause.

Vertical: Vertical links (District level) have generally proven difficult. Most existing CCCs presently do not have the size, capacity or budgets to engage effectively with district-level bodies. To date most CCCs are usually dependent on WV to facilitate these links. Those CCCs that have successfully established vertical linkages have experienced positive results. As an example, some CCCs are now accessing government grants that are available at the district level for care and support. Such funds are either from the World Bank or the Global Fund.

Domain 4 – Impact of CCC Activities

Community / Volunteer level: Across all CCCs in the study, there is evidence of improved community sensitization to the needs of orphans and vulnerable children in the community. There is also an increasing perception that the challenge of orphans and vulnerable children requires a concerted community effort and should not be left to individual, struggling, households. CCCs and communities that were involved in the Channels of Hope program (a participative process to work with faith-based communities for a transformed understanding of HIV and AIDS) seem to have a transformed understanding especially in the areas of stigma and discrimination. It appears beneficial to include in the community mobilization elements of the Channels of Hope program.

All CCCs have been successful in mobilizing volunteers. As indicated, in over 3700 CCCs in 20 countries in Africa, over 59,000 volunteers operate as home visitors. The frequency of their visits vary, the consensus seems to be that weekly or bi-weekly visits are reasonable depending on distances between homes to visit. More frequent visits would be a burden on volunteer home visitors. Personal faith and the desire to make a difference in the community and the lives of vulnerable children were stated as the key motivating factors for carrying on the home visitations for years to come.

Child level

The importance, value and impact of home visits cannot be overstated. All children participating in the study stated that even when home visitors are unable to provide any form of material support that they greatly value the visits. It is however important to them to receive such visits at least twice per month and in a sustained manner. The quality and integrity of the home visitors was important to the children and affected their ability to share their concerns with home visitors. One of the most significant findings of the study is related to the impact of CCCs on children. In almost all interviews at the community level (home visitors, children, CCC members, local government) across all four countries, respondents stated that since the CCC or CCG started operation in the community, they have experienced a general increase of orphans and vulnerable children accessing education, health services, birth registration and other services and rights that had previously been denied or were out of reach for vulnerable children in the community. This is important and indicates that despite many shortcomings in quality of mobilization, training and capacity building, coordinated community-led care responses have a positive impact on perceived child-well being at the community level.

Domain 5 – ownership and sustainability

Ownership: Despite WV and The CCC guide's special attention and efforts to ensure and encourage community ownership, many CCCs struggle to experience and communicate an identity independent of WV, and have not yet developed a full sense of ownership by the community. It is evident that the strength of community ownership is linked with the degree and effectiveness of commu-nity mobilization and the quality of WV staff to facilitate that process. When staff is sensitive to the "small pitfalls and traps" that undermine ownership and carefully negotiate through this process in a manner that from the beginning lets the community own the process and outcomes, level of ownership is high. When staff is mainly focusing on "getting the job done" and establishing a CCC that reports upwards on results based performance, then shortcuts in mobilization are more likely and this reduces the level of ownership experienced by the CCC. The area of monitoring data collection is an additional sphere where ownership of CCCs can be easily undermined. In some settings, CCCs were using monitoring forms for home visitation that had the WV logo on them. Albeit a detail, such a factor can easily undermine ownership. The area of monitoring is a challenge. On one

hand, WV, as a facilitator of the process requires some limited reporting data for national level performance and for grant and private donor reporting. On the other hand, the moment WV "demands" from the CCC monitoring data, the issue of ownership is put in question. It requires experienced, quality WV staff at the local level, to be able to manage such tensions in a manner that does not undermine ownership of the often still-nascent CCC and CCG organizations.

Sustainability: While voluntarism appears to be genuine and is seen as the key sustainability factor for CCCs, there are various additional factors that contribute to the sustainability of CCCs. These are;

i.) Improved vertical linkages to government district structures.
ii.) The involvement of community leadership (in rural context, traditional leadership) combined with the strong community demand for the CCC/CCG and home visitor services and support.
iii.) Increased investment in home visitor training and organizational capacity building at the CCC and CCG level.
iv.) As the organizational capacity of CCC increases, their ability to access funding through local, district (decentralized funding from World Bank, Global Fund and others), national and even international fundraising, income generating activities, government sub-contracting of care and support and expanding social protection schemes.

Program implication and conclusion

The level of investment and quality of the initial community mobilization process is critical to ensure a strong foundation for the CCC to operate as a sustainable, community-owned child and community care entity. CCC membership should be as multi-sectoral as possible and needs to include participation of orphans and vulnerable children and people living with HIV. It is suggested that CCCs set up program advisory sub-groups that include children and PLWH, and provide monitoring support of home visitor quality and are part of home visitor recruiting / vetting panels at the community level.

World Vision successfully managed to scale up across 20 countries over 3700 CCC/CCGs. However, it is important to maintain the balance of scale-up with quality implementation. Organizations involved in scale-up need to enhance investment in training and capacity building of volunteer home visitors. This requires sufficient quality field staff with adequate time to facilitate mobilization efforts, provide quality training and hands-on local level capacity building with CCCs, CCGs and home visitors. For some organizations this may require a shift in focus, mainly from seeing the work with CCCs not as a HIV and AIDS project, but as a key programmatic focus, towards achieving sustained quality of life for children.

Therefore, an important programming area for the future is to resource and facilitate a long-term process of organizational capacity building with CCCs. There should be a special focus on enhancing ownership and the ability of CCCs to manage small grants. Once a CCC has grant management capacity, support organizations such as World Vision, should link the CCC to existing grant makers and/or set up grant making mechanisms at the national level for CCCs to access small grants.

CCCs have an important role to ensure horizontal and vertical networking of all stakeholders that need to be engaged in community and child care issues. Whilst CCCs presently operate well on the horizontal level of linking and networking, there is a need to strengthen the capacity of CCCs to link vertically with district and national structures.

The quality of home visitors is the main determining factor for how community-led child care impacts the quality of life of orphans and vulnerable children. Children have contextual preferences to the type of person they would like as home visitors. It is therefore imperative that children are consulted about the selection and allocation of particular home visitors. The general lack of children's participation in CCC processes provides significant challenges and opportunities for program innovations and developments that have the potential to shift the balance of power in communities in favor of children. According to Dominelli (1999):

"It is critical pursuing the objective of empowering children because these can make caring for children a responsibility that can be discharged by a large group of people which are not necessarily related to children through kinship ties, but who, nonetheless, accept that they have a duty of care towards them. These people are those living in the same community as them and who share with them a number of attributes and social links rooted in interdependence, reciprocity and citizenship. For adults to share a reciprocated interdependent citizenship with children requires the empowerment of children, that is, their being treated as citizens from birth."

In conclusion, community-led childcare in the form of community care coalitions and care groups is a powerful, sustainable mechanism to match the scale and long-term impact of the HIV and AIDS crisis. At the same time, organizations should realize that the community led child care responses to the HIV and AIDS crisis provides a unique opportunity for a paradigm shift in the balance of power in communities in favor of children. However, for this shift to take place, it is critical for CCCs to develop strong participation capacities to ensure full and meaningful child participation towards enhanced and sustained quality of life for all children in communities where CCCs exist.

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