

Caring for the Caregiver



Implementer's Guide

Acknowledgements

This package was authored and designed by Tamsen Jean Rochat and Stephanie Redinger of the Human Sciences Research Council (HSRC) and the Developmental Pathways to Health Research Unit in the Department of Pediatrics, University of Witwatersrand, South Africa.

The work was generously supported by the United Nations International Children's Emergency Fund (UNICEF) West and Central Africa Region (WCARO) with the support of the LEGO Foundation.

This valuable guidance and contributions of many individuals are appreciated. In particular, we wish to thank the UNICEF project co-ordination and review team – Pia Britto, Ana Nieto, Mariavittoria Ballotta, Radhika Mitter, Adriana Valcarce and Shreyasi Jha.

We would also like to acknowledge the contributions made by:

Content and materials development team: Furzana Timol (HSRC), Rachel Rozentals-Thresher (Dlalanathi) and Lyndal Alexander (Department of Health, South Africa)

Expert review and editing team: Professor Alan Stein (University of Oxford) and Dr Aisha Yousafzai (Harvard University)

Consultation and review teams: Hailemariam Legesse, Katherine Faigao, Lang Ma, Miatta Daramy, Sowo Lebbie, and Hamjatu Daian Khazali (UNICEF Sierra Leone country office); Joa Keis, Johanne Desormeaux, and Theophane S Traore (UNICEF Mali country office) as well as independent consultants Claire Thorne, Jane Lucas and Audrey Kittredge. We thank participants at a technical meeting in New York in November 2018 for their inputs including: Betzabe Butron-Riveros, Tarun Dua (WHO); Nada Elattar, Chemba Raghavan, Anne Detjen, France Begin and Maria Elena Ubeda (UNICEF).

Pilot implementation team: Lyndal Alexander (Department of Health, South Africa), Ntombizodumo Mkwanazi (University of Witwatersrand), Fortunate Lekhuleni (HSRC), Mr Samuel Bangalie (Sierra Leone ECD consultant), Tshidiso Tolla (HSRC)

Training input and support: Dlalanathi team

Design and layout by John Bertram (Tangerine Graphic Design)

Illustrations by Len Sak and Rory Klopper

We would also like to extend our thanks to the Dr Alie Wurie and Mr Mariama Murray (Sierra Leone Ministry of Health) for their assistance in facilitating the pilot, as well as to the training participants for their involvement and valuable feedback.

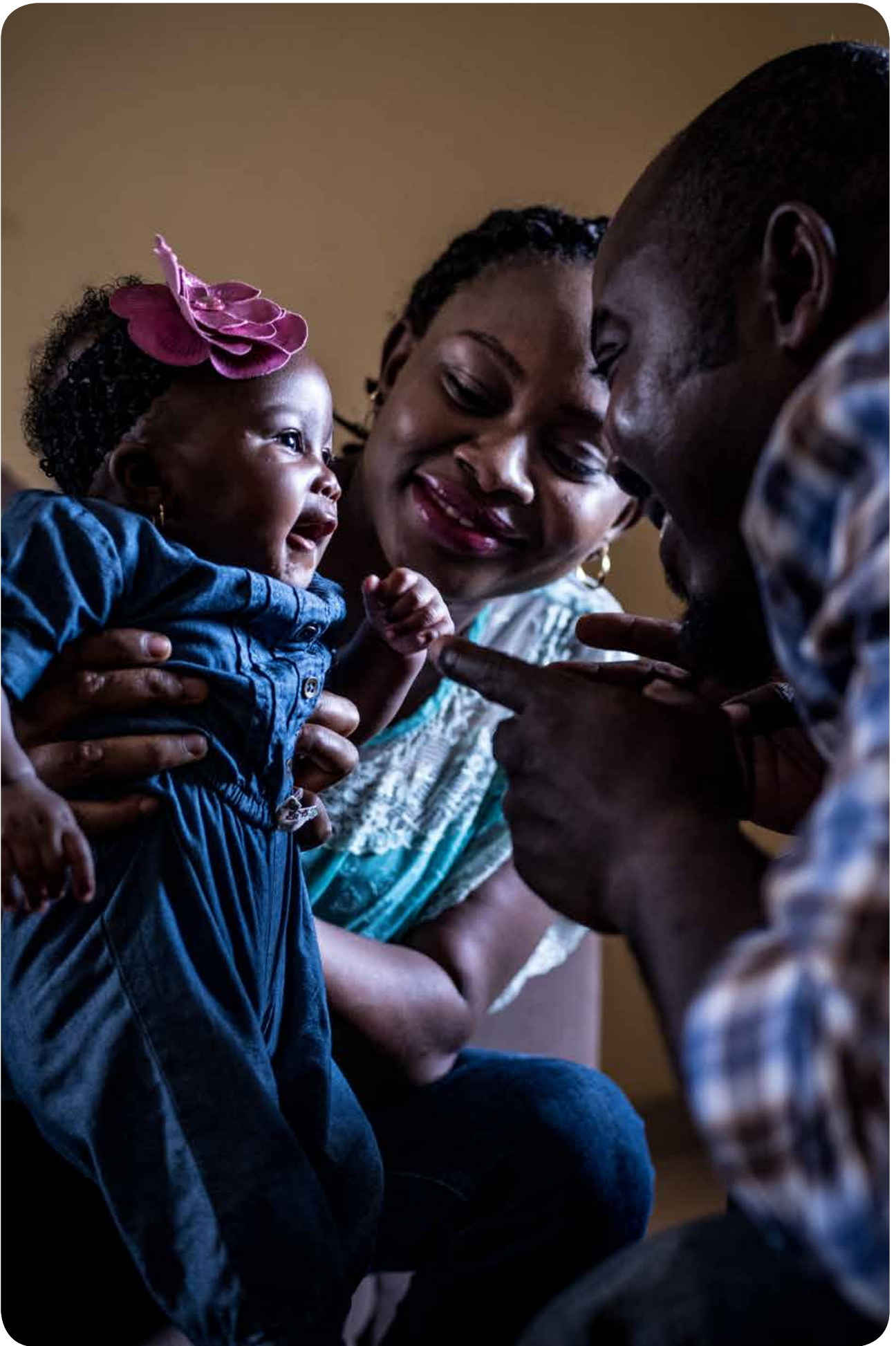
The final revisions to the package materials and report were co-funded by the DST-NRF Centre of Excellence in Human Development, University of Witwatersrand, South Africa.

© UNICEF, New York, 2019

Suggested citation: Rochat T.J. Redinger S. Rozentals-Thresher R. Yousafzia A. Stein A. (2019). Caring for the Caregiver. UNICEF, New York.

Contents

Introduction	3
The Caring for the Caregiver approach	8
CFC training resources and materials package.....	13
Considerations for implementation.....	16
Step 1: Consultation	16
Step 2: Adaptation	18
Step 3: Training	22
Step 4: Community Preparation.....	25
Step 5: Supervised Practice.....	26
Step 6: Monitoring and Evaluation	28



Introduction

Children are living in increasingly threatening times.

The last decade has seen millions of children in Africa affected by the direct and indirect effects of poverty; war and terrorism; natural disasters such as droughts and floods; landslides; outbreaks such as Ebola; and the ongoing threats of preventable diseases such as malaria, HIV and TB.

In the context of such significant threats and coupled with a distinct lack of resources in the regions most affected areas, there is an urgent need to co-ordinate and enhance services to provide holistic support for children – physically, socially, emotionally, spiritually, and cognitively.

This needs to happen within the context of the family, the home, the community, and public service systems such as health and social welfare. Achieving this requires inter-sectoral coordination and that we find practical, cost-effective ways to empower and enable our most powerful assets in support of the care of children – communities and caregivers themselves.

Integrating this kind of training into other sectors (health, nutrition, and sanitation) is critical because the Sustainable Development Goals (SDGs) requires community action to ensure that children not only survive, but also thrive.



The caregiver is central to maternal and child health programming efforts

The success of a child's healthy development is largely dependent on their primary caregiver's capacity. The 2016 Lancet Early Childhood Development Series¹ highlights that efforts to support children are not likely to bear success unless they concurrently provide support for the caregivers upon whom children depend for care.

Many barriers exist to caregiving including that:

- Caregivers may lack the physical, psychological and social capacity to care for their child.
- Highly adverse conditions may introduce threats to caregiver's well-being and their resources for caregiving.

In responding to these barriers, there is also recognition that frontline workers, who are often community volunteers and caregivers themselves, are not equipped with adequate skills to enable them to support caregiver needs.

Caring for the Caregiver (CFC) is a foundational training module that is designed to address these needs, and to complement existing maternal and child health programmes including the UNICEF/WHO Care for Child Development (CCD) Package and the UNICEF Infant and Young Child Feeding (IYCF) Package. CFC can also be utilised as a foundational course for other sector programs whose success is dependent on caregiver and family capacity (e.g. health promotion programmes such as WASH or child protection programmes).

CFC training translates well-established evidence on how to support emotional well-being and mental health, presenting these in practical activities which encourage self-care, family



¹ Britto PR, Lye SJ, Proulx K, Yousafzai AK, Matthews SC, Vaivada T, et al. Nurturing care: promoting early childhood development. *The Lancet*. 2017;389(10064):91-102.

engagement and social support. The training package provides curriculum for training frontline workers to address barriers to responsive caregiving and it provides supporting implementation materials for counselling caregivers.

CFC was developed for the UNICEF West and Central Africa Regional Office (WCARO) by expert consultants, with a series of consultations and pilot training activities in two countries: Mali and Sierra Leone.

The caregiver is central to achieving nurturing care

The 2016 Lancet Early Childhood Development Series defines nurturing care as:

“Nurturing care is characterised by a home environment that is sensitive to children’s health and nutritional needs, responsive, emotionally supportive, and developmentally stimulating and appropriate, with opportunities for play and exploration and protection from adversities”

Supporting the delivery of nurturing care at community level requires an understanding that children do not thrive if we are only getting one thing right (e.g. nutrition or stimulation).

Children need many things (health **and** nutrition **and** stimulation) to come together at the same time in order for them to reach their full developmental potential – especially during the critical developmental period of the first 1,000 days.



Because CFC is simple, flexible and highly adaptable it can be used as a foundational course across sectors, increasing capacity to provide training to large numbers of caregivers and families, from community up, in a sustainable way.

CFC ensures that the investments we make in programming on nutrition, health or child development are amplified because caregivers and their families have been empowered to make use of what has been provided to them.

Caregiving is interconnected with emotional well-being and family relationships

It is well established in the literature that to provide high quality care, caregivers need to monitor the child's emotional state and behaviour and respond (in a timely and sensitive way). They also need access to resources and support to provide for the child's needs. There are various difficult circumstances that can interfere in this process.

A common barrier to caregiving is poor caregiver emotional well-being.

Maternal depression and anxiety are common globally, with the World Health Organization reporting rates of between 10 and 13%. Prevalence's of these disorders are substantially higher in low-income and middle-income countries. In Africa up to a third of women are affected by common mental disorders at any given time, and the antenatal and postnatal periods are particularly vulnerable.



Even when caregivers do not have mental health problems they may still feel down, worried or stressed. They may:

- have low energy,
- not be eating or sleeping well,
- be crying a lot and feeling emotional.

Research has shown that caregivers with these mild to moderate symptoms are less likely to adhere to basic health practices like handwashing, and have poor adherence to health care.^{2,3} In more severe cases maternal depression has been linked directly to low birth weight and undernutrition during the first year of life, as well as to higher rates of diarrhoeal diseases, incomplete immunisation and poor cognitive development in young children. The 2014 Lancet Perinatal Mental Health Series³ has demonstrated that impoverished parenting is the most likely pathway by which maternal mental health impacts on children's development.

The CFC package responds to this need through providing essential skills for identifying and managing stress, practicing self-care and for counselling using 'connect' activities.

A common barrier to caregiver emotional well-being is family and partner conflict.

In Africa, we know that caregivers are living with the threat of multiple adversities including food insecurity, crowded living conditions, high rates of communicable diseases and poor access to health services. Coping with these relies on family support. Interpersonal violence is an increasingly acknowledged threat to both women and children on the continent, with up to 60% of African women exposed to Intimate Partner Violence (IPV) in their daily lives.⁴

Exposure to multiple adversities is known to have negative impacts on caregiver emotional wellbeing, but also on child developmental outcomes. Violence and conflict in the household commonly co-exist with child neglect and abuse, and the disruption of family and community support. The effects of family conflict and interpersonal violence are substantial and intergenerational.

The CFC package responds to this need through providing essential skills for conflict resolution, problem solving, resource mapping and for counselling using 'support' activities.

² World Health Organization, United Nations Children's Fund, World Bank Group. Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential. Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO

³ Stein A, Pearson RM, Goodman SH, Rapa E, Rahman A, McCallum M, et al. Effects of perinatal mental disorders on the fetus and child. *The Lancet*. 2014;384(9956):1800-19.

⁴ Mitchell J, Wight M, Van Heerden A, Rochat TJ. Intimate partner violence, HIV, and mental health: a triple epidemic of global proportions. *International Review of Psychiatry*. 2016;28(5):452-63.

The Caring for the Caregiver Approach

The CFC package has several distinct features aimed at increasing its impact, acceptability and sustainability.

CFC: A caregiver and family-centred approach



CFC is caregiver and family-centred training. Its central focus is to engage the caregiver and family and to strengthen and encourage families to support and protect their own children. The CFC counsellor's role is to develop the family's abilities to problem solve, find solutions suited for their family, and to transfer skills which can be generalised to a wide variety of situations across the life course.

The ultimate goal of CFC is for the family to support caregivers and children independent of the external help of frontline workers. The materials have been designed in such a way that they purposely engage a wider set of family members in fun activities like simple playing card games - ensuring wider distribution of learning and an increased awareness and commitment to caregivers and children at a family level, and across communities.

CFC: A frontline worker and community-centred approach

CFC is developed to be a flexible package which can be used as a stand-alone training for frontline workers (community health care workers, community level volunteers and development aid workers); or as an add-on training package for providers involved in formal service delivery in public services. It is intended for a wide audience of facilitators who may be working in a wide variety of settings.

Potential beneficiaries include:

1. Community members who support parents in their community on a voluntary basis (e.g. mothers groups, community based organisations)
2. Frontline workers providing health, ECD or nutrition services at a community level (e.g. ECD facilitators, breastfeeding counsellors)
3. Nurses and community healthcare workers (working at centralised and decentralised facilities or in home visiting programmes)



Frontline workers come to the training with a rich set of local knowledge, skills and experience. The training workshop activities are highly experiential, ensuring that are accessible and that frontline workers can bring context and experience into the value-add of CFC.

Frontline workers may have their own children and the training approach aims to acknowledge their experience while still guarding against unhealthy normative practices and myths. The training recognises that at a community level it is important to begin to address normative practices which are unhelpful (or in some cases even harmful) for women and children.

You will notice that throughout the training manual effort is taken to provide frontline workers with tools and activities to begin to shift these practices. Particular care has been taken to encourage gender sensitivity and actively engage male partner support and involvement in caregiving.

This training approach is only sustainable when CFC is embedded within existing community structures and carried out by engaged frontline workers. CFC comes alive when frontline workers are able to invest in their own communities, and can mobilise their communities to develop the resources needed for families to raise happy, healthy children. CFC harnesses this opportunity by making the training as pragmatic and accessible as possible, but as a part of implementation community resources also need to be mobilised.

CFC: An adaptive design suited to low resource, low literacy communities

Given that the frontline worker in most countries is a community healthcare worker, the training manual assumes a certain level of literacy, as does CCD and other health trainings.

The implementation materials are however highly illustrative and a series of job aids are provided to support lower literacy frontline workers in their counselling activities. In groups where literacy is lower, training can be extended over a longer period.

Content is developed to be aligned to curricula for community healthcare workers and the package provides opportunities for integration across sectors by linking in health, nutrition and safety messaging.



CFC: A design that is broad-based, preventative and applicable to the majority

CFC fills a particular gap in available frontline worker training packages because:

CFC is preventative not treatment orientated:

Mental health treatment packages (for example the WHO Thinking Healthy Package) are designed to provide treatment. The CFC package has a broader target which is to prevent. It aims to develop resilience amongst caregivers living in adversity and to alleviate mild to moderate mental health symptoms before mental health problems emerge.

CFC is low intensity and targets all women:

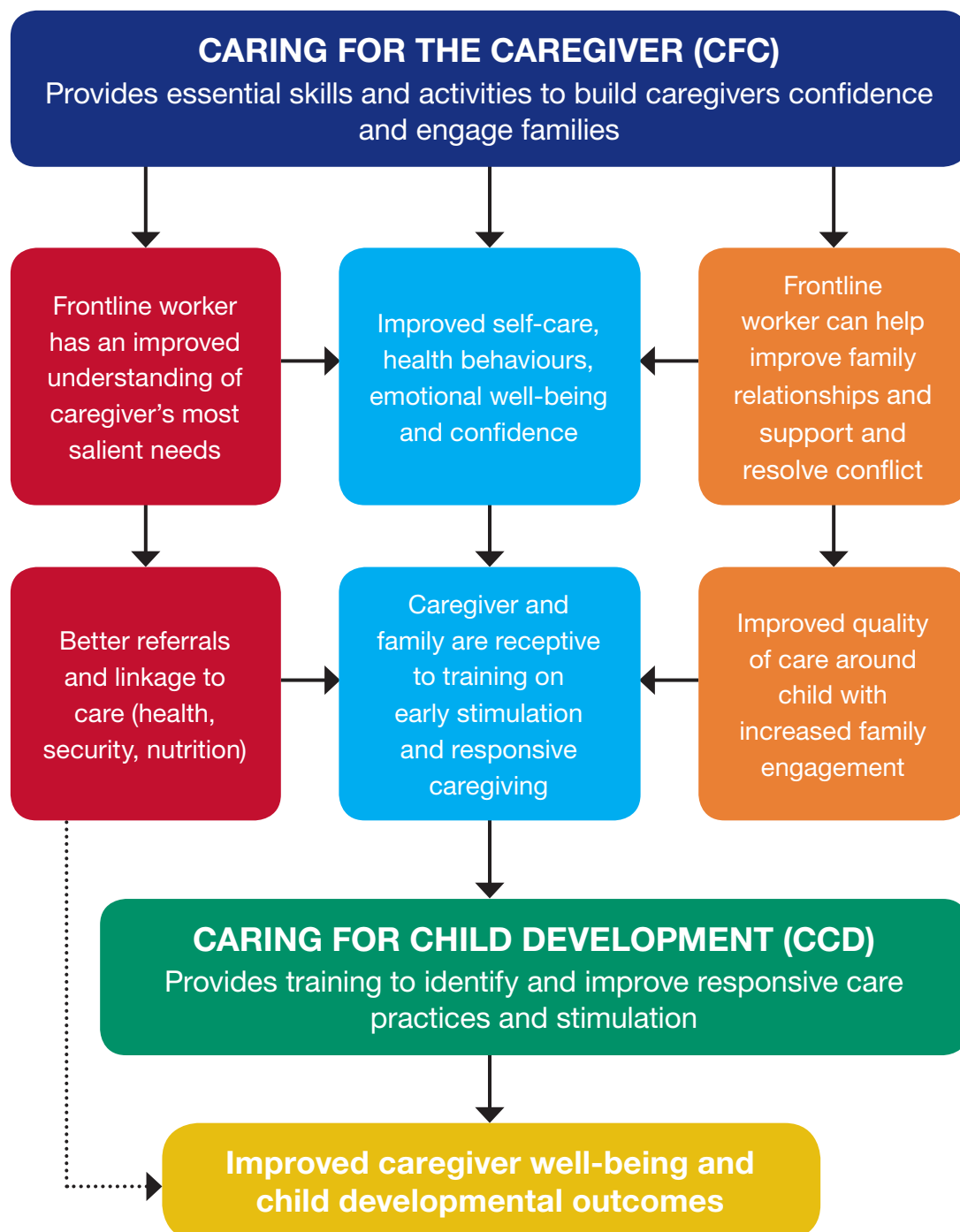
Mental health packages can be intensive and are thus only feasible for targeting those segments of the population with existing mental health problems such as depression. CFC is lower in intensity and provides generalised skills which can be applied across a variety of situations to improve general outcomes.



CFC: A design that can be integrated with other packages

Figure 1 shows an example of how CFC can be linked to CCD in a seamless way; it could also for example be as seamlessly linked to IYCF. CFC is flexible enough that it can be used in many sectors and across a variety of maternal and child health programmes. For this reason investing in CFC training in country has particular value-add.

Figure 1: How CFC and CDD work together



CFC training resources and materials package

The CFC package includes materials for training and materials for use during implementation:

1. Materials for training

Implementer's Guide: Provides guidance for implementation leads and coordinators to ensure the success of the program including making the investment case and considerations for in-country adaptations; information for community preparation and competency testing.

Facilitator's Guide: Provides the trainer with session-by-session content and training activities with which to run the training, along with suggested equipment and materials for planning and implementation.

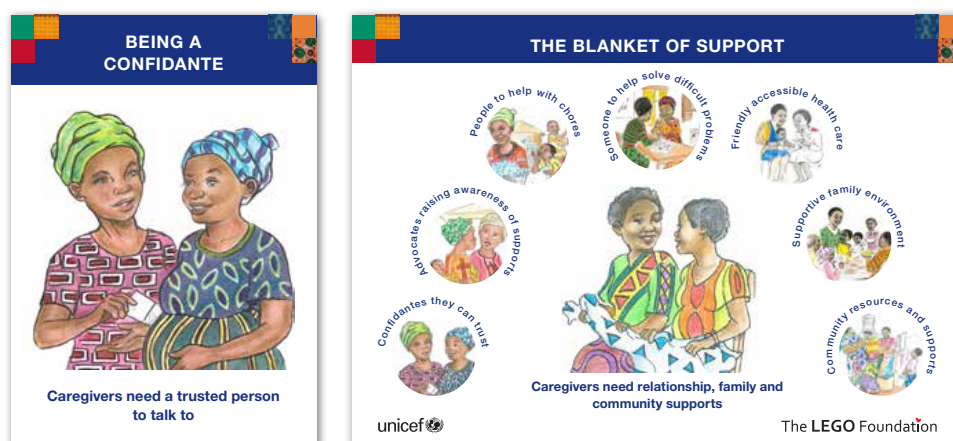
Participant's Manual: Provides frontline workers with a training manual to refer to during and after training which summarises CFC content and activities.



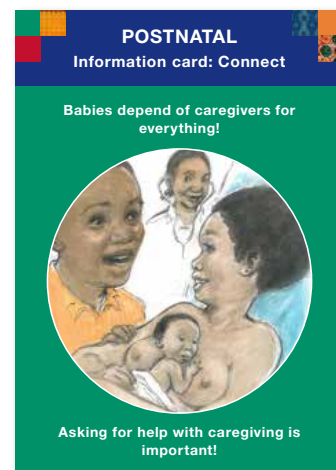
2. Materials for use during implementation

The CFC package includes implementation materials which can be used by frontline workers during counselling with caregivers and families. These are illustrated in Figure 2 on page 15, and include three types of materials:

Activity Cards: These are illustrated counselling cue cards that frontline workers can use when they are counselling on the CFC Essential Skills or CFC Counselling Skills with caregivers.



Information Cards: These are informational cards provide an illustrated summary of key messages. They can be used as counselling cue cards or as talking tools among low literacy caregivers. There are two sets covering both pregnancy and postnatal.



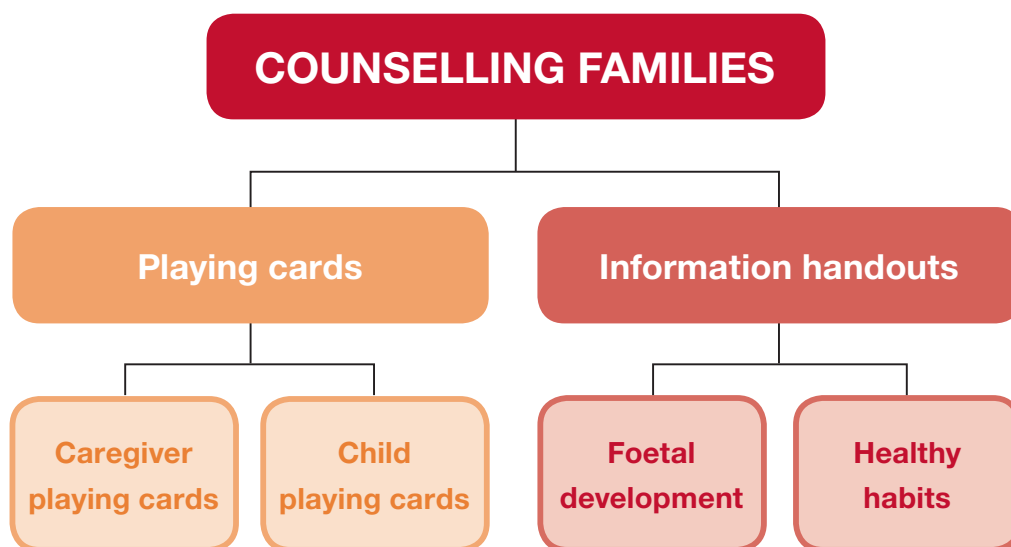
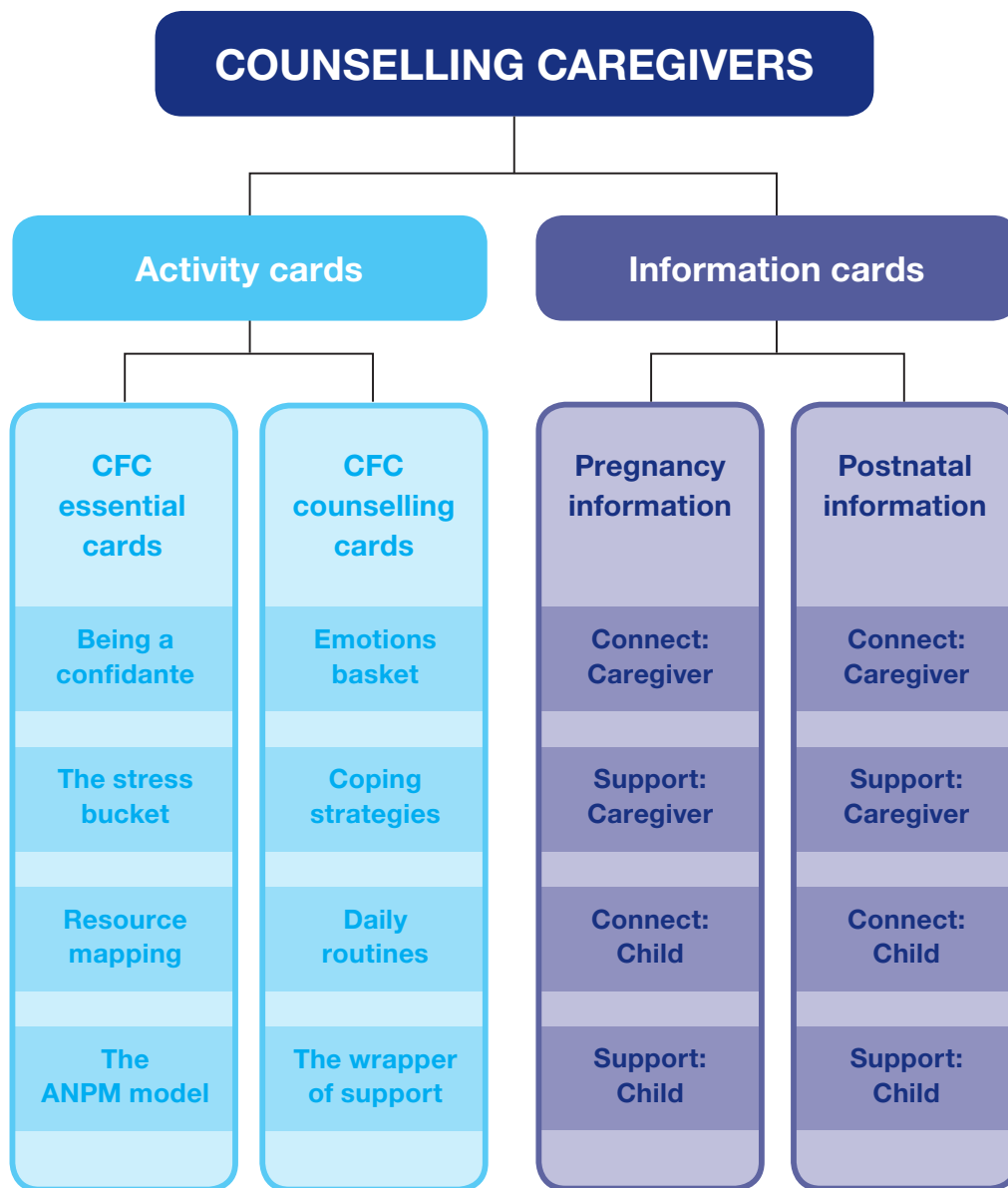
Playing cards: CFC includes two playing card packs – caregiver and child development. The playing cards are developed as an engaging learning tool. They can be used:

1. To deliver key messages as part of a family counselling session and,
2. To invite the family to play a matching pairs card game.



Playing cards requires players to memorise the content of the card and the position of the card. The card game includes two sets of each playing card set; cards are shuffled and then all laid out face downwards. Family members take turn to cards over two cards at a time until they can match pairs. This is a fun way to ensure messaging is repeated and reinforced. They introduce an element of play and learning which is congruent with the principles of both CFC and CCD. During training, the playing cards can also be used by frontline workers as a way of learning and memorising the CFC and CCD messages.

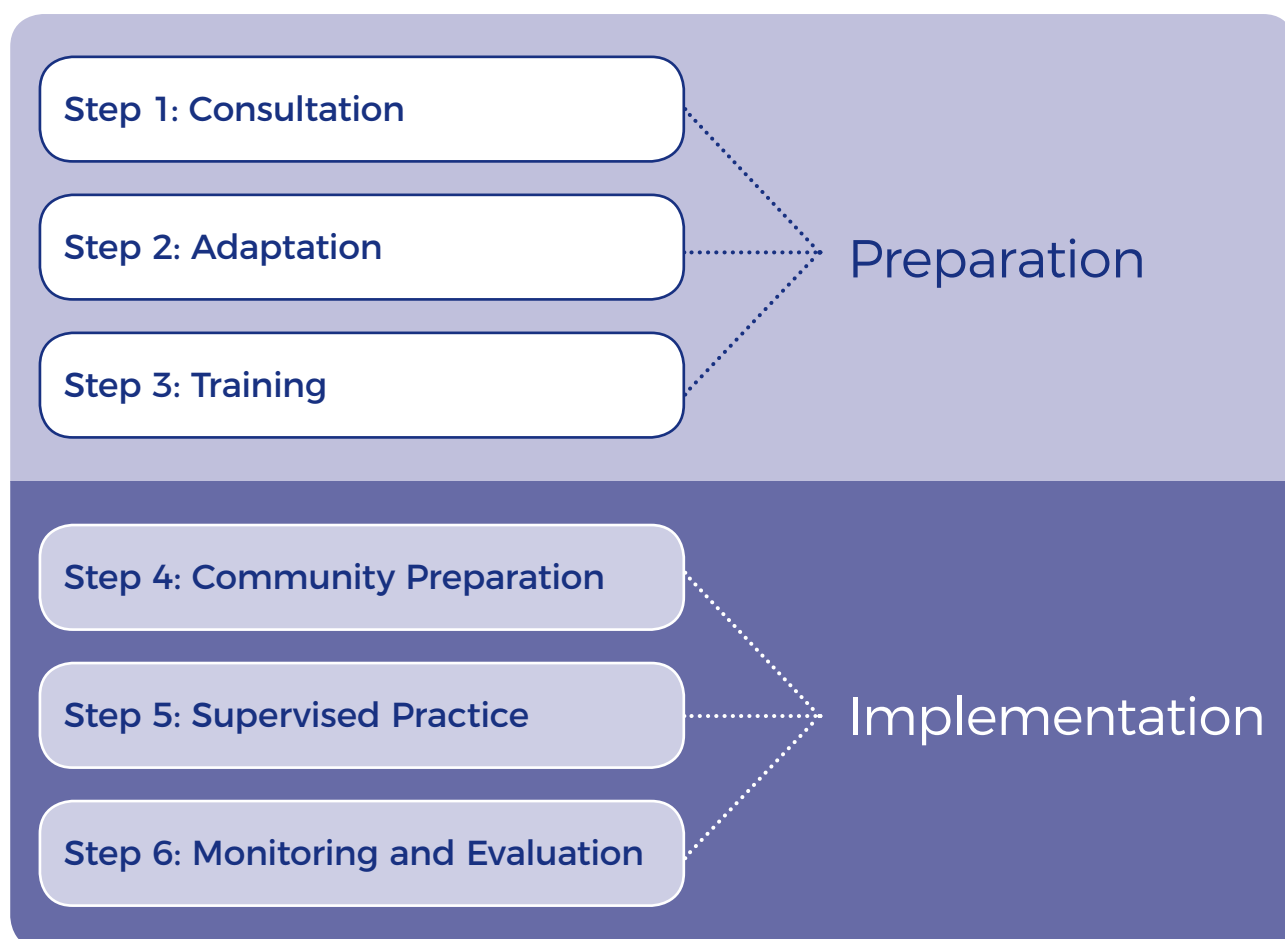
Figure 2: Diagram illustrating Caring for the Caregiver training materials



Considerations for implementation

We recommend that the implementation of CFC is undertaken in six consecutive steps. In this section we provide brief guidance and lessons learnt in the piloting of CFC for implementers to consider.

Schema illustrating the six steps:



Step 1: Consultation

In planning for CFC, it is important to get input from the various sectors currently working with caregivers and children, for example those in Health, Education, Child Protection and Gender.

On introducing CFC it is likely that you will experience resistance from different sectors, particularly when there are multiple competing demands for the same resources. This is particularly common in sectors where there is a strong child focus or where activities are responding to severe and direct threats to children (poverty, malnutrition, malaria or Ebola).

It can be difficult to adjust from a “child focus” to a “caregiver-child focus”. It’s important to invest time helping sectors understand that children are dependent on caregivers to be able to make use of the direct interventions being provided.

You will need to foster an understanding that by addressing caregiver needs we *enhance* impact rather reduce it.

To ensure that the package is useful in your country context it may be helpful to facilitate a workshop to unpack the purpose of CFC, and to allow sector leads (health, nutrition, sanitation, gender and child protection) an opportunity to problem solve potential barriers to the implementation of CFC in your country.

The reality of scarce resources means that there will be resistance to anything that is considered “additional” or “more to do” in overburdened settings. Experiential processes like the Dlananathi ‘Play for Communication’ activities (story telling; doll making) are low cost and highly effective at raising sensitivity to the potential of caregiving and valuing the caregiver in improving outcomes – <http://www.dlananathi.org.za/>. These processes help sector stakeholders view family and community in a strengths based model, rather than a deficit one.

The real value is realised by its integration with other programs that are structured around caregiver capacities. Buy in is thus a crucial first step.



IMPORTANCE OF CFC ACROSS SECTORS

To illustrate the importance of including all sectors in initial consultations we provide an example of the role of the gender sector in CFC.

Caregiving is a social good that benefits societies, economies and individuals. Yet, in most cases, women carry a disproportionately high burden of the care responsibility. Unequal distribution of care work leads to intrahousehold and eventually, labour market, inequalities. As a result, women either drop out of the work because they are unable to keep up with their 'double burden' or move to informal employment and lower wages. Therefore, an unequal distribution of care work leads to higher levels of income inequality and poverty among women. While the main objective of the CFC manual is to support caregivers to care for themselves and to support children, an auxiliary objective is to "recognize, reduce and redistribute women's care responsibility" through the engagement of partners and family, so women can reach their full economic, social and individual potential. While the package uses the gender-neutral terminology "caregivers" it is important to fully acknowledge the disproportionate amount of childcare that is borne by mothers across all cultures. By involving a gender sector representative in consultations around the implementation of CFC you ensure that greater gender sensitivity is brought to your country adaptation of CFC.

Step 2: Adaptation

Prior to implementation the content and activities of CFC may require further adaptation at a country level, dependent on country specific variables such as frontline worker experience, literacy, local language and socio-cultural norms and practices. Adaptation is an important process by which 'buy in' and 'ownership' of the training is ensured.

Countries may opt to use all or part of the training package, however it is strongly recommended that attention is given to including the essential skills.

Three important adaptations will likely be required in most countries:

- i. The translation of content into the local language;
- ii. The adaptation of activities to suit the local culture and normative frameworks;
- iii. The addition of content to respond to local conditions and challenges.

Adaptation of the language and content of CFC

Care must be taken when translating the materials to ensure that core concepts are not changed. The practice of blind back translation is helpful in this regard and we suggest the following steps are followed:

Steps in blind back translation:

- Translate the English materials into the local language using a person who is fluent in both English and the local language.
- Have a different independent person back translate the first translation without giving them access to the original English (blind translation).
- Correct errors against the original and workshop concepts which are difficult to translate in your context with relevant experts in education, health or gender.

Adaptation of activities to suit the local culture and normative frameworks

It is important for the face validity and success of CFC that it is sensitive to local culture and normative frameworks; this increases its feasibility and acceptability in the field. It is also important to control local adaptations of the content, to ensure that these are not co-opting or indirectly supportive of negative or harmful normative practices.



The essential skills are designed to be relatively culturally neutral however training content could be augmented to suit local culture. Some examples are presented here.

Examples of potential cultural adaptations:

Adapting the concept of the confidante:

CFC content proposes that the frontline workers work closely and confidentially with individual caregivers. In some settings this may be problematic if:

- Local frontline workers are males working with female caregivers, which might be unacceptable to partners and families.
- The local culture's permission to speak with a female caregiver separate from others, such as their husbands, may be limited.
- In some settings resources may not allow one-on-one approaches.

Adaptations to content may adjust the approach of being a confidante to ensure that the caregiver feels supported, without introducing or indirectly causing harm to caregiver-family relationships. In some settings working with caregivers in women's groups may be preferred, but the principles of being a confidante should remain.

Addition of content to respond to local conditions and challenges

Approaches to the implementation of CCD or other health promotion trainings may vary according to country context and resources.

Simple adaptations and additions across essential skills and counselling activities can be helpful in increasing the salience of the materials in the local context. Some examples of this might include:

- Adding training content on context specific stressors in the stress bucket;
- Adapting the content and the name of the blanket/wrapper of support to climates which are hot and where blankets are not common;
- Adjusting content on daily routines to include specific religious practices which might be common to a specific time of day in a local culture.



The following example illustrates how the CFC content needs to be augmented to respond to local conditions, myths and beliefs.

Breastfeeding and sex in Sierra Leone

During the training pilot in Sierra Leone, participants shared a common local myth which states that women who are breastfeeding should not have sex with their partners. On unpacking this belief it was revealed that women believe they should immediately stop breastfeeding if they engage in sexual activities as the sperm may be harmful to the child through the breastmilk.

This belief creates many challenges because:

- Women want to breastfeed, but also have valid sexual desires in the postnatal period – creating competing and conflicting desires.
- Women become worried that if they continue to breastfeeding, their husbands may have affairs because they as a couple are not sexually active.
- Women may engage in sexual activity impulsively and then feel guilty and forced to rapidly cease breastfeeding with negative consequences for the child.

In this scenario, using the problem solving model in essential skills was seen to be a particularly useful tool to facilitate open discussion on these myths. It is also a good example of the need to develop an additional family focused or couple focused hand out for the Sierra Leone context which addresses this local myth.

Other examples which were salient in the pilot training included:

Content on how to respond to trauma: If for example a country has been particularly affected by war or conflict, some of the connect activities may elicit painful memories for caregivers and additional content should be added to CFC to address this in the training.

Content on how to set limits on screen time: If a country is highly developed and communities have wide access to cellphones or television, these can be helpful tools to connect individuals. They can also be harmful and including content on limiting screen time may enhance CFC.

Content to address gender and women's sexuality: In many contexts very little information is provided on caregiver sexuality and desires. CFC is a helpful platform where information and knowledge can be shared to normalise caregiver sexual desires and needs, and to encourage healthy practices such as family planning.

Step 3: Training

There are two potential models for consideration during in-country training.

Scenario 1

Training CFC over 3 days if you are running CFC as a foundational course in a generalised approach to frontline workers already trained in other packages like CCD or IYCF or IMCI.

Scenario 2

Training CFC over 5 to 7 days if you are integrating CFC with other trainings. Using CCD as an example, content from CFC can be integrated with CCD training and can take place over 5 days (for experienced literate frontline workers) or over a longer period (for inexperienced non-literate frontline workers) who may need more hands on practice sessions.

A caution of length of training and size of groups

A common comment throughout the consultation was that training needed to be short in order to be feasible. Further, training groups should be large, consisting of 15-20 participants rather than the 8-12 participants recommended for trainings such as CCD, in order to be cost effective. The expert consultancy group argued strongly against this. Opting for bigger groups and shorter trainings may result in inadequate training outcomes and low impact at scale.



There is a particular concern that shortening training time equates to reducing experiential learning and practice opportunities, shifting the training modality to a more didactic approach which has little success in skill transfer amongst lower literacy lay counsellors or frontline workers. Implementers should consider that restricting training may introduce a threat to the potential impact of CFC and similar trainings, resulting in greater training investment wastage than would likely occur if training was implemented with adequate time and resources to ensure the transfer of skills.

Although this requires resource investment, the ability for trainings like CFC to replicate at community level and have wide reach most certainly justifies these initial resource spends.



Frontline workers are one of Africa's most important assets. Their training and professional development is something which requires and warrants investment. By training frontline workers and investing in their development, you amplify the affects you can have at a community level and you communicate the value they hold in addressing the most challenging of situations.

There is growing evidence to support the use of problem-based learning methodology over traditional didactic teach approaches with adult learners. Here are some training principles to consider when training adult learners.

1. Adults are practical

Being practical means that as adults we like to know how things relate to the real world. Most of us are balancing busy jobs with family and other adult responsibilities. We don't want to puzzle over how training relates to our lives. Interactive experiential learning processes help to demonstrate how to perform a task in real-life scenarios, placing training in the context of its practical application.

2. Adults are goal oriented

As adults, we feel the need to learn to solve real-life tasks or problems and our goals need to be clear or we become frustrated and disengage. So it's up to trainers to provide meaningful learning experiences. It is important during training to set up explorative situations for trainees where a goal is stated and then learners use available resources (CFC activities and materials) to solve the problem.

3. Adults are self-paced

As adults, we prefer to have options to self-direct and pace our learning to fit it around the demands of life. This is why individually-driven supervised practice is a helpful way to balance learning with life. Implementers can be creative in how they respond to this need and structure learning appropriately. For example, in some settings there may be scope for mobile learning, podcasts or other technologies that can be listened to on the move, or learning that can be completed across multiple smaller training sessions.

4. Adults have prior knowledge through life experience

Adults already know a lot and don't like being treated otherwise. Adults bring varied life experience and knowledge with them into the learning experience. It's more than likely that a CFC trainee will have had exposure to some of the key concepts in a previous role. Encouraging shared learning through roleplay and group tasks is important as self-reflection activities give trainees the opportunity to relate to the content.

5. Adults learn by doing

After all, adults are grown up children, so we like to learn through play too. Explore using play to bring an element of competition and fun. There are many examples of this in the CFC facilitators guide for how to interactively and creatively set up experiential situations and allow your trainees to wander off the content path and explore, adding local value and content.

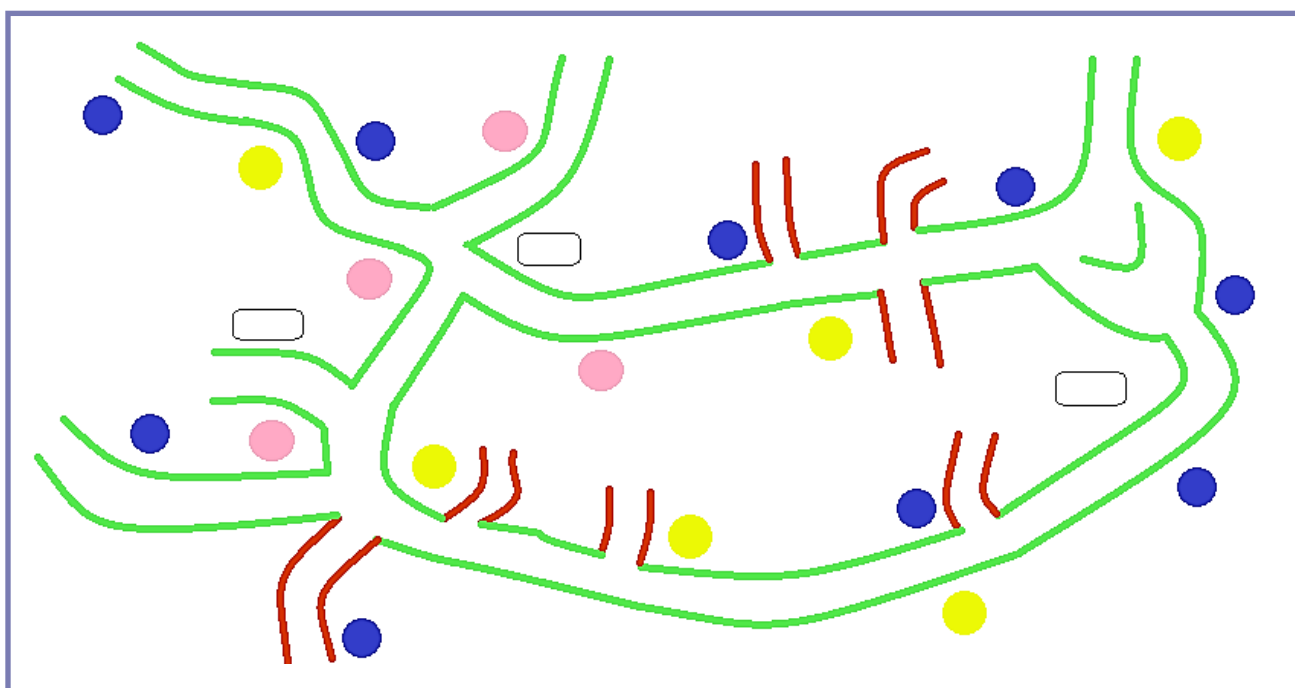


Step 4: Community Preparation

There are two activities which implementation teams should undertake with trainers prior to implementation of training. This ensures that during training, trainers are able to provide clear guidance to frontline workers on community assets and referral networks they can use in their particular communities.

Asset mapping

It is a good idea to do an asset mapping activity with your trainers and supervisors before starting training. Asset mapping involves mapping out all the community resources that are available to frontline workers. These include your local health and social services, municipal services and support available to you through faith-based and community organisations, traditional and community leadership groups.



Referral networks

Ahead of training implementation it is also helpful for trainers to make referral agreements with important assets in the frontline worker's community. This includes:

- The local clinic clerk, counsellor, nurse, psychiatric nurse or doctor.
- The local emergency services and community organisations that respond to emergency situations including ambulance services, help-lines, crisis centres, and the local police station.
- The local social welfare office and any other departments and municipal services that respond to poverty relief emergencies, and community, faith-based and not-for-profit organisations that could assist with these needs.

- A local public service social worker and social welfare officer, who can respond to cases of alleged domestic violence, substance abuse or child abuse and neglect.
- If you work in bigger urban areas, there might be local rehabilitation and auxiliary health care team from your district hospital, including the psychologist, social worker, physiotherapist, occupational therapist, speech therapist, and dentist.
- Local counselling facilities or psychologically trained professionals (at your clinic, district health services or in your community, religious counsellors) who can respond to mental health problems including depression and bereavement and can offer support for any caregivers who are in crisis or feeling suicidal.
- Community leaders who can help you manage issues of stigma and discrimination, and offer general support including religious leaders, traditional leaders and district counsellors.



Inter-sectoral co-operation can enhance this process substantially and engaging with other international and national not-for-profit and community based organisations is strongly encouraged.

Step 5: Supervised Practice

Regardless of the individual country approach taken it is strongly recommended that training in CFC is followed by a period of supervised practice where frontline workers receive supervision to become familiar with using the content and activities in the home and community environment. At least 25 hours of practice over a 6 to 8 week period is recommended to ensure competence in CFC.

Careful consideration should be given to choosing which frontline workers are trained, and to seeking out opportunities for resources to be maximised by training across sectors. At the end of the training trainer/supervisors should pair frontline workers with peer trainees for some one-on-one practice and evaluations. In some settings you may adapt this to be group-based if that works better in your community.

Trainees will need to work through practical hours to achieve competency. Below is an example of a supervision log to support auditing of these processes. This can be adapted to match the country adaptations and the level of skill and experience of the frontline workers being trained.

COMPETENCY TASKS				
Session	Practical Requirements	Practical Evaluation	Completed	Supervisor Signature
1: Essential Skills	Log 2 hours practice time on the 4 Essential skills using the activity cards	Present to supervisor key aspects of each skill and how activity cards will be used.		
	Log 2.5 hours practice with a peer on talking points and script	Supervisor observes role play and provides feedback		
2: Counselling Skills	Log 2 hours practice time on the 4 counselling skills using the activity cards	Present to supervisor key aspects of each skill and how activity cards will be used.		
	Log 2.5 hours practice with a peer on talking points and script	Supervisor meets with you to role-play a Session and provides feedback		
3: Pregnancy	Log 2 hours practice time delivering the material and developing your scripts	Present to supervisor content to be covered in sessions for feedback		
	Log 2 hours practice with a peer on talking points and script	Supervisor meets with you to role-play a session and provides feedback		
4: Birth to 6 months	Log 2 hours practice time	Present to supervisor content to be covered in sessions for feedback		
	Log 2 hours practice with a peer on talking points and script	Supervisor meets with you to role-play a Session and provides feedback		
5: 6 to 12 months	Log 2 hours practice time delivering the material and developing your scripts	Present to supervisor content to be covered in sessions for feedback		
	Log 2 hours practice with a peer on talking points and script	Supervisor meets with you to role-play a Session and provides feedback		
6: 12 to 24 months	Log 2 hours practice time delivering the material and developing your scripts	Present to supervisor content to be covered in sessions for feedback		
	Log 2 hours practice with a peer on talking points and script	Do a role play with a volunteer caregiver, arranged and observed by supervisor		
	Practical hours completed: 25	Evaluations completed: 6	100%	

Step 6: Monitoring And Evaluation



It is recommended that monitoring and evaluation of CFC include two components:

1. Evaluation of the CFC training processes using the training evaluations forms provided here to ensure high quality training and fidelity to training processes.
2. Quality assurance of the implementation of CFC at a community level using the fidelity checklist during CFC frontline worker observed sessions.

Caring for the Caregiver: Training evaluation form

Date of training	
Name of trainer	

We would like to ask you a few questions about your CFC training.

1. What are the three most important things you learned during this training?







1	
2	
3	

2. What are the three areas in which you feel you need more support and practice after this training?

1	
2	
3	

3. Do you feel that the content of this training will change the way you work with pregnant women and caregivers of young children? If no, could you please tell us how to improve?

4. How would you rate your knowledge and ability to carry out the following activities BEFORE training, and AFTER training:

						
0	1	2	Establishing confidante relationships with caregivers.	0	1	2
0	1	2	Teaching caregivers how to identify causes of stress.	0	1	2
0	1	2	Resolving conflicts within families.	0	1	2
0	1	2	The services available to caregivers and how to access them.	0	1	2
0	1	2	Asking caregivers to speak about their emotions.	0	1	2
0	1	2	Strategies for coping with stress (breathing and relaxation).	0	1	2
0	1	2	The importance of daily routines and how to establish them.	0	1	2
0	1	2	Speaking about support needs for pregnant women & caregivers.	0	1	2

Caring for the Caregiver: Observation checklist

Family Identification	
Name of Quality Assurer	
Name of Frontline worker	
Date	

Please complete this checklist during your observation of a counselling session:

	Poor	Average	Good	Excellent
Introduction				
Polite and friendly greeting	0	1	2	3
Recaps from last session	0	1	2	3
Introduces session and explains its purpose	0	1	2	3
Counselling skills (Being a confidante)				
Is respectful	0	1	2	3
Maintains culturally appropriate eye contact	0	1	2	3
Uses simple language	0	1	2	3
Listens attentively	0	1	2	3
Uses non-verbal communication appropriately	0	1	2	3
Avoids gossips and presents as trustworthy	0	1	2	3
Is accepting and non-judgemental	0	1	2	3
Allows caregiver to ask questions	0	1	2	3
Answers questions appropriately	0	1	2	3
CFC Essential skills (Rate appropriate/ accurate use)				
Stress bucket	0	1	2	3
Resource mapping	0	1	2	3
ANPM model	0	1	2	3
CFC counselling (Rate appropriate/ accurate use)				
Emotions basket	0	1	2	3
Coping strategies	0	1	2	3
Daily routines	0	1	2	3
Wrapper of support	0	1	2	3
Closing				
Checks if there are any questions	0	1	2	3
Summarizes the session	0	1	2	3
Discusses action points	0	1	2	3
Discusses solutions to action points	0	1	2	3
Schedules next appointment	0	1	2	3
Subtotal				
Total	_____ /72 (%)			

Note for programme managers:

Items in the AFTER column scored 0 or 1 should be the focus of practice in order to achieve competency during the 6-8 week period.

Establishing confidante relationships with caregivers.	0	1	2	Being a confidante
Teaching caregivers how to identify causes of stress.	0	1	2	Stress bucket
Resolving conflicts within families.	0	1	2	ANPM Model
The services available to caregivers, how to access them.	0	1	2	Resource mapping
Asking caregivers to speak about their emotions.	0	1	2	Emotions basket
Strategies for coping with stress (breathing/relaxation).	0	1	2	Coping strategies
The importance of daily routines and how to establish them.	0	1	2	Daily routines
Speaking about support needs for pregnant women & caregivers.	0	1	2	Wrapper of support

© UNICEF, New York, 2019

When using the content of CFC please acknowledge the contribution of the content development team using this suggested citation:

Rochat T.J. Redinger S. Rozentals-Thresher R. Yousafzia A. Stein A. (2019). Caring for the Caregiver. UNICEF, New York.

For more information on using or adapting this manual please contact UNICEF West and Central African Regional office or UNICEF New York (Ana Nieto or Pia Britto).