

## **Training and capacity development: the foundation of interventions to support young children affected by HIV and AIDS in sub-Saharan Africa**

Linda Richter<sup>a,b\*</sup>, Julia Louw<sup>a</sup> and Sara Naicker<sup>a</sup>

<sup>a</sup>*HIV/STI and TB (HAST) Programme, Human Sciences Research Council, Durban, South Africa;*

<sup>b</sup>*DST-NRF Centre of Excellence in Human Development, University of the Witwatersrand, Johannesburg, South Africa*

*(Received 23 September 2014; accepted 10 March 2015)*

Many programs to support young children and families affected by HIV and AIDS depend substantially on a model of cascaded training from international nongovernmental organizations, through in-country groups and organizations to services on the ground. In this paper, we describe the training and capacity building – as described in proposals, progress reports, and individualized questionnaires – offered by 10 international organizations funded by the Conrad N. Hilton Foundation to provide supportive services for young children and their families in five southern and eastern African countries. We related the findings to effective features of training described in the literature. Training and capacity development were found to be the most substantial activities in rendering services to children and families, both in terms of effort and human and financial resources. A total of 67 trainings were conducted over a period of 18 months. Almost all trainings combine lecture-based instruction, group work/discussions, and role play, but only half of the trainings report some form of mentoring, supervision or coaching following the training. Drawing on the literature, it is likely that more purposeful planning is required in terms of the selection of trainees, local adaptation and development of materials, participatory training approaches, and techniques to develop and sustain skills as well as knowledge. Demonstration and mentorship in the field together with quality assurance procedures, pre-and post-assessment to evaluate training, processes to transfer learning into subsequent practice, as well as certification, are all fundamental steps to ensure that training plays a supportive role in the behavior changes necessary to support young children affected by HIV and AIDS and their families.

**Keywords:** children; families; HIV/AIDS; support; training; community

### **Introduction**

There is extensive literature on the challenges faced by children affected by HIV, but disproportionately less is known about effective interventions to support children and families (Richter & Mofensohn, 2014). Over the course of the last two decades, several reviews have highlighted the lack of evidence. For example, King, De Silva, Stein, and Patel (2009) found no methodologically rigorous studies that tested interventions to improve the psychosocial well-being of children affected by HIV and AIDS. Schenk (2009) identified 21 evaluations of community interventions to assist orphans and

---

\*Corresponding author. Email: [lrichter@hsrc.ac.za](mailto:lrichter@hsrc.ac.za)

vulnerable children (OVC) from a variety of perspectives in high-prevalence African settings, from which she concluded that promising findings were, unfortunately, compromised by methodological weaknesses and inconsistent data quality. A similar conclusion was reached by Bryant et al. (2012) in summarizing evaluations conducted of President's Emergency Plan for AIDS Relief (PEPFAR)-funded programs to support affected children. It is only recently that reports of effective interventions have started to appear (for example, Kumakech, Cantor-Graae, Maling, & Bajunirwe, 2009; Sherr, Croome, Bradshaw, & Castaneda, 2014).

There is clearly a substantial gap between research and practice in the field of OVC programming (Richter, Foster, & Sherr, 2006) with little, as yet, rigorous documentation of the many approaches used to support millions of children reported to be helped by nongovernmental and community-based organizations (CBOs) working independently or in collaboration with government services (Rosenberg, Hartwig, & Merson, 2008). In one of the few attempts to classify practice, Richter, Manegold, and Pathe (2004) identified 74 intervention approaches, excluding advocacy, to support children affected by HIV and AIDS, and classified them into four main categories: meeting basic needs (e.g. economic strengthening, shelter, food, health care, clothing, education), protection (e.g. from abuse and labor exploitation), legal assistance (such as protecting inheritance rights), and emotional and psychological support (e.g. home visits, youth clubs, counseling). In addition, the authors also discuss drawbacks and risks of each approach, many of which included the substantial investments in training to be effective.

From the first signs of the HIV epidemic's effects (Hunter, 1990; Preble, 1990), extended family structures have been the foundation of assistance and support for children (Ankrah, 1993). In instances where family ties have weakened under strain (Foster, 2000), community groups have stepped in to provide a second front of support (Foster, 2002). Reliance on kin and community support is a long-established pattern amongst the poor in sub-Saharan Africa, who remain very underserved by formal protection and services (Illiffe, 1987). While a few national and international philanthropic organizations supported families and communities in their efforts to assist affected children, the publication of *Children on the Brink* mobilized a massive international response (Hunter & Williamson, 1998). International funds, expertise, and programs expanded exponentially when, in 2003, the US Congress created the PEPFAR. Ten percent of the PEPFAR budget was allocated to programs for children affected by HIV and AIDS. In less than 10 years, \$2 billion have been disbursed and, in 2010, PEPFAR recorded that 4.1 million children in 30 countries received direct services (Nyberg et al., 2012). In what has been called the emergency phase or Track One, PEPFAR identified seven fundamental domains of services to protect and promote child well-being: education, health, shelter and care, food and nutrition, psychosocial support, protection from abuse and neglect, and economic strengthening (Yates, O'Connell, Davies, & Oladosu, 2008). The *modus operandi* adopted was to contract international organizations that, in turn, passed on technical assistance, training, and funding to hundreds of national and CBOs in highly HIV-affected countries.

The 2011 review of OVC programs in 26 countries concluded that capacity-building was one of the major achievements of the first phase of PEPFAR (Yates, Richter, Zingu, Yates, & Wolfe, 2011). Countless volunteers, community and faith organizations, and government employees received training, as did national and international managers and directors of programs. Building capacity is also seen to be essential to accomplish the second phase of PEPFAR, which is to ensure a locally owned and sustainable response (Nyberg et al., 2012). Training and capacity development are pervasive in OVC programs;

for example, training community and government agencies in child rights, training caregivers in parenting and income generating activities, training teachers in psychosocial support, and training young people in vocational skills (Yates et al., 2008).

Besides identifying reliance on training for the success of programs (Yates et al., 2008), lack of certification of training, meager stipends, unrealistic expectations leading to burnout and high turnover (Nyberg et al., 2012), as well as low coverage by volunteers and others (Bryant et al., 2012), we have not been able to find any published evaluation of the adequacy and effectiveness of training and capacity building as the fundamental basis of programs to support children affected by HIV and AIDS.

This paper describes training and capacity building provided by international non-governmental organizations (NGOs) in support of children and families affected by HIV and AIDS. We use data gathered from 10 international organizations funded by a large philanthropy in the United States to estimate the resources devoted to training in the program portfolios, characterize the training provided, evaluate the likely effectiveness of training provided against criteria identified in the published literature and factors in addition to training that likely determine the contribution of training to effective implementation.

## **Methods**

The data is based on proposals and routine reporting over an 18-month period captured in a monitoring and evaluation (M&E) Database as well as an individualized training questionnaire completed voluntarily by 10 leading international NGOs<sup>1</sup> in five countries (Mozambique, Zambia, Malawi, Tanzania, and Kenya). The organizations are funded by a private philanthropy, the Conrad N. Hilton Foundation, to implement a range of interventions to support the development of young children in communities affected by HIV and AIDS. The Foundation, established in 1944, funds and provides support to both domestic US and international programs. Access to clean water and preserving sight have been the main focus of the international program until fairly recently when, after an extensive phase of exploration, the Board resolved to fund programs that promote the early development of young children affected by HIV and AIDS. The Foundation's strategic approach is to invest in international and national NGOs, to strengthen CBOs and other community groups, to support parents, caregivers, and families, and to provide enabling environments that are intended to directly benefit young children's development.

### ***Monitoring and evaluation database***

The Human Sciences Research Council (HSRC) in South Africa is contracted to provide a monitoring, evaluation, and learning (MEL) platform for the Foundation's initiative with the aim of, amongst others, benefitting the broader community of policy-makers, program implementers, and researchers from knowledge and experience gained. The MEL platform tracks M&E activities across all organizations, but more importantly, provides support through joint collaboration to create a learning environment. This includes assembling and making available materials, i.e. child measures, indicators, interventions, and so on, demonstrating innovative approaches for data collection, such as digital methods, and hosting learning and sharing forums through a regular newsletter, an interactive website, and conducting workshops. To this end, the HSRC created a multi-dimensional database to reflect each organization's proposed and

achieved activities, outcomes and outputs as submitted through regular reporting to the Foundation. The data is coded to identify and describe, amongst others, the three focus areas of the Foundation's strategic vision – ensuring skilled parents and caregivers, strong CBOs, and effective policy and practice. At the primary level of analysis, progress is tracked against each organization's own goals. At the secondary level, data is aggregated to estimate *effort* based on the proportion of a partner's activities that are directed toward each of the three strategic goals. Financial data is allocated by organizations to the achievement of each of the strategic goals, and the HSRC also classifies budgets by management, M&E, training and capacity building, and implementation, personnel versus non-personnel costs, in- and out-country expenses, and variation across time. The financial coding thus manifests the variance between intended effort and the funding resources allocated to achieving that goal.

### ***Training and capacity development questionnaire***

Once it became clear that training comprised the major effort of all organizations in terms of activities and costs allocated, individualized questionnaires were developed based on each organization's proposal and progress reports to collect more detail about the specific training activities the organization conducted or supported. In addition, drawn from the literature on effective training, a standard set of questions was posed regarding the format of training; materials and tools used; facilitation, skill and knowledge transfer; pre- and/or post-assessments; supervision, mentoring and follow-up on the job, and certification.

The 10 organizations agreed to participate voluntarily, based on a collaborative relationship established over a period of 18 months that involved in-person introductory meetings with each organization as well as regular follow-up telephone meetings and a 2-day interactive workshop in which all organizations participated.

No human subjects' approval was obtained as no personal information is included. The data is based on routinely submitted M&E information as well as questionnaires on training activities completed by the responsible person in the organization. The questionnaire was based on a shared learning exercise conducted at a face-to face meeting with all participating organizations.

## **Results**

### ***Training and capacity development are currently core to interventions for young children affected by HIV and AIDS***

As indicated above, training is the single largest activity of all organizations, by budget allocated and activities. Specific interventions listed by organizations include activities to promote early child development (ECD) at household, clinic, child care center, community, district, and national levels. These are targeted at a number of individuals and groups: officials and other stakeholders working in district and national structures; representatives and leaders of CBOs; ECD facilitators, teachers, and clinicians; community health workers (CHWs) and volunteers, and parents and caregivers. At each level, the interventions listed depend on training in the organization's theory of change, leading to effective and efficient implementation, and improvements in children's development (see [Table 1](#)).

Table 1. Interventions listed that have training requirements.

| Level of intervention                  | Aim  | Training  |
|--|--|---|
| Household                              | Increase parental awareness, knowledge, and responsiveness to young children’s needs   | Parents are trained and supported by community workers and volunteers   |
| Community                              | Increase knowledge of, for example, early stimulation, the importance of play, secure attachment, nutrition, and child rights and protection | Community workers and volunteers are trained by varying levels of CBO and NGO trainers to transfer knowledge and skills through parenting and psychosocial counseling in the home and community |
| Community-based child care centers     | Improve care, stimulation, and preschool teaching for young children   | ECD facilitators, motivators, and teachers are trained  |
| Clinics                                | Improve identification of children with disabilities and support for them and their families in the clinic and home                          | Various levels of clinic staff are trained in developmental assessment, as well as care and support for children with disabilities and their caregivers   |
| Members and leaders of CBOs            | More effective services for young children and their families  | CBOs are trained in governance, leadership, resource mobilization, financial management, communication  |
| District and national government staff | Improve policy, services, and implementation of programs for young children and their families   | Government staff are trained in child rights, ECD policy, child development, effective interventions, M&E   |

**Training effort and budget**

Across the initiative and over a 5-year period, the Foundation aims to support 1000 CBOs, train 100,000 home- and center-based community workers, about 1100 professionals, and just over 50,000 parents/caregivers, with the intention of supporting 500,000 children. Progress during the first 2 years places the initiative about halfway to its targets. With respect to the Foundation’s three strategic goals, 25% of the effort of the 10 organizations included in the analysis was directed toward providing skills to parents and caregivers, 60% to strengthening CBOs, and 15% of overall program activity was aimed at building effective policy and practice. Across all three areas, training and capacity building was by far the largest activity, with the greatest amount of effort among all 10 organizations. Two-thirds of the organizations strengthened CBOs by training home- and center-based community workers and program staff; the remaining activities focused on improving the coordination of services to children and families. Analysis of financial allocations indicated that, on average, more than 50% of budgets were allocated to direct training and capacity development, excluding personnel and non-personnel management and administrative costs.

**Details of training provided**

Over the first 18 months of implementation, a total of 67 trainings were conducted by the 10 organizations (see Figure 1). The majority of training is cascaded through four levels



Figure 1. Number of training activities (total = 67) indicating the number of trainings offered by each of the 10 organizations.

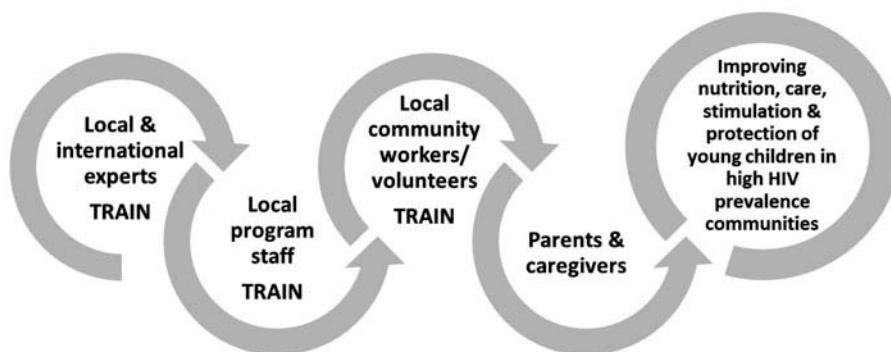


Figure 2. Schematic of cascaded training from international and local experts to the level of service provision to children and families.

using the training-of-trainers (ToT) methodology, as illustrated in Figure 2. About 15% of the training is designed to be phased, that is, delivered sequentially with increasing complexity and most commonly used for training caregivers and parents. Over 80% of training takes place as a one-off event with no refresher training planned. This type of training commonly takes the form of workshops, seminars, learning circles, and peer exchanges. Most of the training, without refresher activities, was aimed at professionals, partner staff, master trainers or ToT trainers, or was planned as phased trainings. Where refresher training is offered, it is usually scheduled to take place 6 months to a year after implementation in the field. Some partners incorporate what they consider to be refresher training into monthly or quarterly meetings with supervisors, where trainees can share and discuss challenges they face in implementation.

### **Training format**

Almost all training reported is a combination of lecture-based instruction, group work/discussions, and role play. There is often a practical component to theory/content training (in over 90% of the trainings reported on), which includes some form of demonstration or in-field practice. The number of participants trained at one time ranges from small groups of 4–5 to bigger groups of 20–30, sometimes even reaching 40–50. Program staff is usually trained in smaller groups than home- and community-based workers and volunteers.

Depending on how familiar participants are with the training topic and how much there is to cover, the duration of training is reported to run on average between half a day and 14 days, most commonly 5–6 days, and as long as 5 weeks. Duration and format tend to be different for professional and nonprofessional staff and volunteers; for example, clinic staff (familiar with conducting health assessments) were trained for one day to complete a developmental checklist, whereas in another program, community-based Early Child Care and Development (ECCD), teachers were trained in an intensive 5-week program over three months on a range of ECD topics and in the development of teaching and learning materials. Knowledge and skills are usually passed onto parents and caregivers during one-on-one two-weekly or monthly home visits and in parent group sessions that might continue for 2–3 months depending on the program.

### ***Training content***

The broad categories of training include topics in ECD and well-being, conducting child development assessments and making referrals, psychosocial support, M&E, and organizational development (for example, resource mobilization, governance, and fundraising). Over 90% of the trainings used materials and manuals to facilitate learning, such as the Essential Package developed by Save the Children, CARE, and others; the WHO/UNICEF Care for Child Development package; the Regional Psychosocial Support Initiative's (REPSSI) Journey of Life, and materials developed by government or other agencies, such as a standardized parenting education curriculum. About half of the training packages used were developed in-country, locally adapted, or supplemented with local teaching aids. Where materials were used in the trainings, participants were generally provided with resources such as handouts for reference. Our data did not allow for analysis of whether these, or any other materials, were made available for use in the field by community workers, or whether they reached parents, families, or facilitators in community-based child care forums.

### ***Participant selection***

In terms of training program staff, selection is based on whether the training is relevant to their role in the organization or necessary for their work, an important criterion being their employment stability so that benefits of training were more likely retained in the organization. In one example, local partner staff was trained in the Essential Package with the understanding that they would lend expertise to adapting it to the local context afterwards. Selection criteria for individuals being trained ranged from basic literacy levels to experience in the field and professional qualification. [Figure 3](#) gives some examples of selection criteria used for specific groups.

### ***Evaluations and assessments***

Only about a third of all trainings (36%) included post-training evaluation. In some cases, evaluations are done on an informal basis with verbal feedback from participants. Formal evaluations tend to assess, for example, training venue, content, methodology, and facilitation. Of the 24 trainings that were followed by an evaluation, only five reported using the evaluation to inform or improve future trainings. In some cases, evaluations were conducted but had either not been analyzed or, where external consultants were involved, had not been shared with the organization.

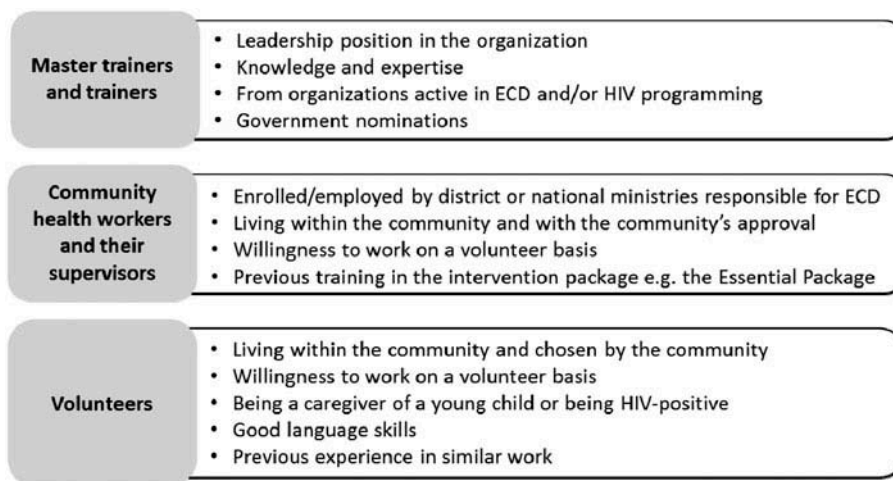


Figure 3. Examples of criteria used for selection of training participants.

Pre- and post-training assessments of participants' knowledge, skills, or competencies were only done in 10 (15%) of the trainings. Only five trainings (one from one organization and four from another) had pre- and post-test assessment results, both showing improvements in post-test scores. More generally, organizations used informal assessments, in which participants were asked how much they had understood at the end of the training. Two organizations reported that, instead of pre- and post-assessments, training outcomes were assessed as part of their capacity development plans for the CBOs they work with.

### ***Mentoring and supervision***

About half of the trainings report some form of mentoring, supervision, or coaching following the training. This is usually incorporated into the overall supervision of duties, which is generally done on a monthly or quarterly basis, rather than targeted follow-up on how the training is being implemented to achieve specific outcomes in-field. For example, CHWs trained on developmental assessments and referrals are less likely to be supervised on their ability to conduct assessments in the field, than on the number of home visits and referrals made. A method of follow-up of training used by two organizations is regularly held reflective meetings in which all work issues are raised, including areas where participants feel they need to go over a specific area of training again.

### ***Certification***

In only 26 of the trainings (39%) did participants receive certificates. Out of this proportion, three of the training certificates were recognized by a governmental or committee body and only two were recognized nationally; the remainder was certificates of attendance.



### *Aspects of training valued by organizations as good practice*

Five of the 16 components included in the training questionnaire on the basis of the literature review were considered by the participating organizations to be best practice to include in a training activity. The first three refer to the actual training activity: the inclusion of training materials, tools, and/or aids; a trained facilitator; and adequate time during sessions to ensure skill development through demonstration and practice. The other two involve post-training activities in the form of mentoring and/or supervision in the field and the regular monitoring of training outcomes for quality assurance and program improvement. Although a trained facilitator was ranked one of the most important criteria for training, only one organization reported including facilitation skills in the training of their trainers. The three components identified that received the lowest ratings for best practice were participant-related: selection of participants according to some pre-decided criteria; the need for participants to be at the same level of knowledge, skill, and competency; and certificates on completion of the training.

### **Discussion**

Our study found, as did the PEPFAR OVC evaluation, that the majority of effort and resources in programs to support children affected by HIV and AIDS goes into training and capacity development in a cascade from international organizations to child and family services. Considering this, it is surprising that so little has been written about training and how its role in effective and efficient service delivery can be enhanced through implementation guidelines and organizational strategies.

By way of summary, we found that in general, selection into training for all groups is opportunistic rather than deliberate, and does not take interpersonal skills into account nor train for them. Training tends to be one-off, with little ongoing in-field supervision or knowledge and skills acquired; there is little systematic evaluation of learning or skill development and practice, and a general lack of attention to career pathing of community workers and volunteers through recognized certification. There are a variety of instructional modes used in the training of community workers, such as role-playing, simulation, and group discussion, to enhance instructional training sessions (WHO, 1989), and it is encouraging that almost all of the training reported does indeed follow some sort of interactive or participatory approach. We also found that about half of all training materials were developed locally or adapted. This is important to ensure that the material is relevant, and to avoid the example given in one evaluation, of a mother who found it frustrating to be given advice to take her child to the hospital when it was five hours' walking distance away (Jyung & Tan, 2013).

It is generally regarded as good practice to have a set curriculum and training material, and that materials should be tailored to the needs of the task and the different backgrounds of participants (Lehmann & Sanders, 2007). Many training activities were supplemented with training material, and some organizations did adapt manuals to their local context. However, it is not clear that these materials are available for use by community agents in the field. An evaluation of the Essential Package in Malawi and Zambia found that workers did not have copies of the Visual Guides and strongly recommended that these are used in practice (Jyung & Tan, 2013).

Much can be learnt about selection, training, evaluation, and supervision from past experience, for example, in ECD and home visiting programs in the United States, as well as from recent efforts at task shifting in health care through the expansion of CHW

programs (Fulton et al., 2011). For example, in a review of staffing issues in home visiting programs, Wasik (1993) drew attention to the importance of selection, especially the assessment of suitability for the work, as demonstrated in interpersonal and helping skills, and to the fact that skills like these needed to be further developed in training programs as well as through regular in-field supervision. Similarly, Haines et al. (2007) argue that, to be effective, CHWs need, not only information about health and illness, but also “skills in assessing community situations, interacting and negotiating with people in groups, as well as with individuals, and teaching using participatory techniques” (p. 2127). O’Brien, Squires, Bixby, and Larson (2009) identified leadership, interest, willingness to learn, and compassion as important characteristics.

As has also been reported with respect to CHWs (O’Brien et al., 2009), we found a great deal of variation in training, with respect to duration, content, materials, pre- and post-evaluation, and assessment of skill transfer and skills in practice. Most often, community workers and volunteers are trained in content as, in this case, in the development of young children, with less emphasis on how much information is retained and the assessment and support of skills in putting this knowledge into practice. An assessment of training activities using the Essential Package found that in spite of positive feedback from volunteers about training, when probed, they differed in their recall of messages and tended to remember hygiene messages better than others, probably because they were more familiar (Jyung & Tan, 2013).

The same applies to supervision, which when supportive, leads to program benefits and to health worker development (Haines, Kuruvilla, & Borchert, 2004). As apparent also in this study, supervision and support in community worker programs tend to be weak (Walt, Perera, & Heggenhougen, 1989). Contrary to guidelines in the Essential Package, the evaluation in Malawi and Zambia found that support to volunteers varied widely (Jyung & Tan, 2013), with few instances of one-on-one *in situ* supportive supervision.

It is known that ongoing refresher training over the course of implementation is needed to counter the decay of learned skills and knowledge (Bhattacharyya, 2001; Lehmann & Sanders, 2007). Refresher training, which focuses on recall and reinforcement of knowledge and skills, was highly rated in this study as good practice. However, many of the trainings surveyed did not plan refresher training, and it was usually not incorporated into the training of professionals, trainers, and the like. In this, and in the other components identified, there is something of a disjuncture between what is valued in training and what is practiced. One explanation is that resources – funds, time, staff – are limited and elements that don’t relate to the core training activity are cut.

The data gathered in this study was collected after trainings had been initiated and with the implementation of the interventions already underway. Even though this provides a clear picture of where key improvements are needed, addressing challenges and difficulties immediately after the training and before implementation of the intervention would provide valuable lessons to share and would be beneficial to the intended beneficiaries. Furthermore, the variation in programs being implemented as well as the different types of training provided did not allow for a more focused analysis of a particular program and training approach that would provide more concise guidance and direction. However, the study contributes to the gap between research and practice in the field of ECD in high HIV prevalence settings, particularly as it applies to training and capacity building to improve service delivery.

In conclusion, the dependence on training in programs to support children and families affected by HIV and AIDS means that we need to ensure training is maximally effective and, for that reason, training needs to be more systematic and purposeful. Organizations

relying on training for service provision must ensure that knowledge imparted is accompanied by skill development and competence in the field, and that quality assurance mechanisms are in place. Understanding how central training is in effectively supporting children and families highlights the need for planning of training, accurate documentation of selection, the design of evaluation processes to inform improvement (Liket, Rey-Garcia, and Maas (2014), skill transfer and supervision, and greater emphasis on the impact of training on those trained as well as end-user beneficiaries. Improvements in training are also dependent on more research. In particular, we need to assess, among others, how to improve the retention of key messages and their implementation in the field, and how parents and ECD workers receive, understand, retain, and implement key messages at home, in the child development center and during their interactions with children. These are essential steps in the implementation process and, currently, there seems to be little, if any, published work on these topics. Research in the field of child health (for example, Kelly et al., 2007) and an unpublished assessment of receipt and use of training messages in the initiative assessed here (Jyung & Tan, 2013) suggest that accurate knowledge and appropriate skill transfer require concerted attention to the quality of all aspects of training, including selection, practice, assessment, supervision, and refresher courses.

### Acknowledgments

This study was supported by Conrad N. Hilton Foundation to promote the development of young children affected by HIV and AIDS in southern and eastern Africa. The views expressed in this document do not necessarily reflect those of the Conrad N. Hilton Foundation.

### Disclosure statement

No potential conflict of interest was reported by the authors.

### Funding

This work was supported by the Conrad N. Hilton Foundation [grant number 20120136]. This grant awarded to the HSRC under the MEL initiative.

### Note

1. CARE, ChildFund, Catholic Relief Services, Episcopal Relief and Development, Elizabeth Glaser Pediatric AIDS Foundation, The Global Fund for Children, Firelight Foundation, Save the Children, PATH, and Plan International. Although six other organizations are also funded, two are not engaged in program implementation and four have only recently been funded and have not yet submitted progress reports.

### References

- Ankrah, E. (1993). The impact of HIV/AIDS on the family and other significant relationships: The African clan revisited. *AIDS Care*, 5, 5–22. doi:10.1080/09540129308258580
- Bhattacharyya, K. (2001). *Community health worker incentives and disincentives: How they affect motivation, retention and sustainability*. Virginia: Basic Support for Institutionalizing Child Survival Project (BASICS II) for the United States Agency for International Development.
- Bryant, M., Beard, J., Sabin, L., Brooks, M., Scott, N., Larson, ... Simon, J. (2012). PEPFAR's support for orphans and vulnerable children: Some beneficial effects, but too little data, and programs spread thin. *Health Affairs*, 31, 1508–1518. doi:10.1377/hlthaff.2012.0230

- Foster, G. (2000). The capacity of the extended family safety net for orphans in Africa. *Psychology, Health and Medicine*, 5, 55–62. doi:10.1080/135485000106007
- Foster, G. (2002). *Understanding community responses to the situation of children affected by AIDS: Lessons for external agencies*. Geneva: United Nations Research Institute for Social Development (UNRISD).
- Fulton, B., Scheffler, R., Sparkes, S., Auh, E., Vujicic, M., & Soucat, A. (2011). Health workforce skill mix and task shifting in low income countries: A review of recent evidence. *Human Resources for Health*, 9, 1–11. Retrieved from <http://www.human-resources-health.com/content/9/1/1>
- Haines, A., Kuruvilla, S., & Borchert, M. (2004). Bridging the implementation gap between knowledge and action for health. *Bulletin of the World Health Organization*, 82, 724–733.
- Haines, A., Sanders, D., Lehmann, U., Rowe, A. K., Lawn, J. E., Jan, S., ... Bhutta, Z. (2007). Achieving child survival goals: Potential contribution of community health workers. *The Lancet*, 369, 23–29. doi:10.1016/S0140-6736(07)60325-0
- Hunter, S. (1990). Orphans as a window on the AIDS epidemic in sub-Saharan Africa: Initial results and implications of a study in Uganda. *Social Science & Medicine*, 31, 681–690. doi:10.1016/0277-9536(90)90250-V
- Hunter, S., & Williamson, J. (1998). *Children on the brink: Strategies to support children isolated by HIV/AIDS*. Washington, DC: United States Agency for International Development (USAID).
- Illiffe, J. (1987). *The African poor: A history*. Cambridge: Cambridge University Press.
- Jyung, D., & Tan, V. (2013). *Reaching the most vulnerable: An evaluation of the impact of the Essential Package and strategies to scale in Malawi and Zambia* (Unpublished report). Cambridge, MA: Harvard Kennedy School of Government.
- Kelly, J., Rowe, K., Onikpo, F., Lama, M., Cokouits, F., & Deming, M. S. (2007). Care takers' recall of integrated management of childhood illness counselling messages in Benin. *Tropical Doctor*, 37, 75–79. doi:10.1258/004947507780609257
- King, E., De Silva, M., Stein, A., & Patel, V. (2009). Interventions for improving the psychosocial well-being of children affected by HIV and AIDS. *Cochrane Database of Systematic Reviews*, 2, CD006733. doi:10.1002/14651858.CD006733.pub2
- Kumakech, E., Cantor-Graae, E., Maling, S., & Bajunirwe, F. (2009). Peer-group support intervention improves the psychosocial well-being of AIDS orphans: Cluster randomized trial. *Social Science & Medicine*, 68, 1038–1043. doi:10.1016/j.socscimed.2008.10.033
- Lehmann, U., & Sanders, D. (2007). *Community health workers: What do we know about them? The state of the evidence on programmes, activities, costs and impact on health outcomes of using community health workers*. Geneva: WHO.
- Liket, K. C., Rey-Garcia, M., & Maas, K. E. H. (2014). Why aren't evaluations working and what to do about it: A framework for negotiating meaningful evaluation in nonprofits. *American Journal of Evaluation*, 35, 171–188. doi:10.1177/1098214013517736
- Nyberg, B., Yates, D., Lovich, R., Coulibaly-Traore, D., Sherr, L., Thurman, T. ... Howard, B. (2012). Saving lives for a lifetime: Supporting orphans and vulnerable children impacted by HIV/AIDS. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, 60(Supplement 3), S127–S135. doi:10.1097/QAI.0b013e31825da836
- O'Brien, M., Squires, A., Bixby, R., & Larson, S. (2009). Role development of community health workers: An examination of selection and training processes in the intervention literature. *American Journal of Preventive Medicine*, 37, S362–S369.
- Preble, E. (1990). Impact of HIV/AIDS on African children. *Social Science & Medicine*, 31, 671–680. doi:10.1016/0277-9536(90)90249-R
- Richter, L., Foster, G., & Sherr, L. (2006). *Where the heart is: Meeting the psychosocial needs of young children in the context of HIV/AIDS*. The Hague: Bernard van Leer Foundation.
- Richter, L., Manegold, J., & Pather, R. (2004). *Family and community interventions for children affected by AIDS*. Pretoria: HSRC Press.
- Richter, L., & Mofenson, L. (2014). Editorial: Children born into families affected by HIV. *AIDS*, 28, S241–S244. doi:10.1097/QAD.0000000000000361
- Rosenberg, A., Hartwig, K., & Merson, M. (2008). Government-NGO collaboration and sustainability of orphans and vulnerable children projects in southern Africa. *Evaluation and Program Planning*, 31, 51–60. doi:10.1016/j.evalprogplan.2007.08.005

- Schenk, K. (2009). Community interventions providing care and support to orphans and vulnerable children: A review of evaluation evidence. *AIDS Care*, 21, 918–942. doi:10.1080/09540120802537831
- Sherr, L., Croome, N., Bradshaw, K., & Castaneda, K. (2014). A systematic review examining whether interventions are effective in reducing cognitive delay in children infected and affected with HIV. *AIDS Care*, 26, S70–S77. doi:10.1080/09540121.2014.906560
- Walt, G., Perera, M., & Heggenhougen, K. (1989). Are large-scale volunteer community health worker programmes feasible? The case of Sri Lanka. *Social Science & Medicine*, 29, 599–608. doi:10.1016/0277-9536(89)90179-2
- Wasik, B. H. (1993). Staffing issues for home visiting programs. *The Future of Children*, 3, 140–157.
- WHO. (1989). *Strengthening the performance of community health workers in primary health care*. Geneva: WHO.
- Yates, D., O’Connell, C., Davies, N., & Oladosu, M. (2008). *President’s emergency plan for AIDS relief track 1.0 orphans and other vulnerable children (OVC) program evaluation*. Washington, DC: United States Agency for International Development (USAID).
- Yates, D., Richter, L., Zingu, J., Yates, R., & Wolfe, J. (2011). *PEPFAR HKID portfolio review*, (Report No. 11-01-453). Retrieved from USAID website: [http://pdf.usaid.gov/pdf\\_docs/pdact323.pdf](http://pdf.usaid.gov/pdf_docs/pdact323.pdf)