

Performance Evaluation Report

INCLUSIVE FAMILY STRENGTHENING - ZAMBIA
POSITIVE PARENTING ANNEX FOR CAREGIVERS
OF CHILDREN WITH DISABILITIES

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Volunteers lead a session on inclusive parenting for caregivers of children with disabilities in Luanshya, Copperbelt province, Zambia.
[Photo by Dooshima Tsee]



Introduction

As part of its Vision 2030 agency strategy, CRS is investing in six strategic change platforms to catalyze outcomes at scale. The Strengthening Families - Thriving Children Strategic Change Platform is a bold initiative aiming to:

- Support vulnerable children to thrive in safe, healthy, and nurturing families
- Create more resilient and supportive communities
- Work with our Catholic partners, civil society, and governments to establish policies and systems that strengthen families
- Influence governments, donors, Catholic actors, and other regional and global stakeholders to redirect resources and support to strengthening families.

The Inclusive Family Strengthening (IFS) Project in Zambia is part of a global project that is implemented through the platform. In this project, CRS builds upon decades of experience in community and family strengthening activities to:

- Ensure families in targeted communities have the resources and skills to care for children strengthen families,
- Promote positive parenting behaviors
- Support caregivers to connect with supportive communities, to access health and social services, and to build resources.

IFS-Zambia has a particular focus on children with disabilities. According to the 2015 Zambia National Disability Survey, the national prevalence of disability was estimated at 10.9% among adults and 4.4% among children aged 2 to 17 years of age. IFS-Zambia is implemented in five sites across Luapula and Copperbelt Provinces, which had among the highest estimates of child disability. Accessibility to various services and resources remains a challenge in rural areas of Zambia, especially for knowledge around inclusive childcare support.

Intervention Description

To ensure an inclusive approach is taken towards improving positive parenting practices, IFS-Zambia developed a supplemental parenting manual to support caregivers of children with disabilities. The Positive Parenting (PP) Annex for caregivers of children with disabilities was developed to complement the government endorsed Parenting without Violence (PwV) curriculum that was developed with support from Save the Children.¹ The PP Annex provides a disability-inclusive approach to building skills and coping mechanisms for caregivers of children with disabilities and caring for their children with different needs. The PP Annex is a set of sessions that are complementary to the key topics from the national curriculum with a disability-inclusive lens. The curriculum aims to:

¹ The positive parenting annex for caregivers of children with disability will be referred to as the PP Annex for the remainder of the report.

- 
- Increase fathers', mothers' and caregivers' understanding on child development, child rights, and positive parenting for children with disabilities
 - Increase knowledge of available support services and institutions for persons with disabilities
 - Increase support seeking behaviors of guardians for their children with disabilities.

To test the performance of the PP Annex, IFS-Zambia conducted a mixed-methods evaluation of the sessions. Children enrolled in the IFS-Zambia project were screened for functional difficulties using the Washington Group/UNICEF Child Functioning Modules and parenting groups were formed. The guardians were organized into groups of 20 to 25 and sessions were rolled out at group level. Household visits were offered for caregivers who could not make it to group sessions. After a baseline survey was conducted, the PP Annex was rolled out to 1,043 households that had children with disabilities.

Sessions of the Positive Parenting Annex for Caregivers of Children with Disabilities

1. Family dreams and positive parenting goals
2. Caring for children with emotional warmth and structure
3. Understanding the stress and the importance of self-care
4. Child protection for children with disabilities
5. Understanding child development (younger children 0-5 years)
6. Understanding child development (older children 6-9 years)
7. Understanding child development (older children 10-17 years)
8. Problem solving

Methodology

This performance evaluation used a mixed-methods approach to address a set of key evaluation questions. The baseline consisted of a household quantitative survey. The follow-up, or endline, repeated the survey with the same respondents and included individual-level qualitative interviews with participants and staff. This report describes the evaluation findings of the endline survey with comparison to the baseline survey findings.

Evaluation Questions

Overall, the performance evaluation aimed to address four primary evaluation questions:

1. How do participants perceive the PP Annex activities?
2. To what extent do select outcomes (e.g., positive parenting behaviors, protective factors, stigma) change among caregivers over the course of participating in the PP Annex sessions?
3. To what extent do select knowledge, attitudes and behaviors change among caregivers over the course of participating in the PP Annex sessions?
4. How should the PP Annex be improved?

Data Collection Methods

For the baseline survey, a structured questionnaire was administered to caregivers of children with disabilities who were registered to participate in parenting groups that used the Positive Parenting Annex. The same survey, with some additional questions, was administered in the endline assessment to participants who completed the PP Annex.² At baseline, a random sample of 293 caregivers was drawn using project participant lists. The survey covered a number of topics, including (1) background characteristics of the caregiver/child, (2) perceived stigma associated with having a child with disabilities, (3) caregivers' perceived protective factors, (4) select household economic strengthening indicators, including food security, (5) positive parenting behaviors, and (6) additional knowledge, attitudes, and practices covered in the Positive Parenting Annex. The survey took approximately 45-60 minutes to complete. At endline, additional qualitative data were also collected. Individual semi-structured interviews were conducted with PP Annex participants, volunteers, and supervisors. The qualitative interviews covered multiple topics, including the perceived usefulness of the PP Annex sessions, recommendations for improving the PP Annex, and perceived changes in participating households.

Evaluation Populations

The performance evaluation was implemented among caregivers of children with disabilities who were enrolled in the IFS-Zambia parenting groups that received the PP Annex. Eligible survey respondents were parents/guardians of children with disabilities who were enrolled in the PP Annex sessions. Among the caregivers, one index child with a disability was randomly selected, and caregivers were asked a set of questions about the index child. Qualitative data were collected from the PP Annex participants, community volunteers, and supervisors at endline. All respondents were at least 18 years old and could provide voluntary informed consent.

² The survey is available for CRS staff in the MyCRS disability compendium and available upon request to others by writing to john.hembling@crs.org

Sampling

Survey: The sample of caregivers were selected using a 2-stage cluster sample, and a design effect of 2.0 was used. The first stage of selection, or cluster, was the positive parenting group. The clusters were sampled probability proportional to size using systematic random sampling. The second stage of sampling comprised selecting a set number of caregivers from each cluster, using systematic random sampling. The sample size for the survey uses the following formula to estimate the sample size:

$$n = D * [(Z_{\alpha}/2 + Z_{\beta})^2 * (p_1(1-p_1) + p_2(1-p_2))] / (p_1 - p_2)^2$$

An estimated baseline proportion of 50% was used to calculate a conservative sample size. The sample size was calculated to detect a 12 percentage point change from baseline to endline. The Z-score for a 95% confidence level (1.64) and the Z-score corresponding to 80% power were used. A correction of 15% resulted in an estimated sample size of 295. This accounts for an estimated population of 1000 caregivers with children with disabilities who are eligible for the Positive Parenting Annex curriculum.

At baseline, a total of 266 of the sampled caregivers of children with a disability were found and interviewed.³ Prior to conducting the endline survey, the project team confirmed the availability of the individuals interviewed at baseline (Figure 1). At that point, 230 of the 266 individuals interviewed at baseline could be located. Several of the participants had left the area, dropped out of the project, or could not be located at the time of the survey.

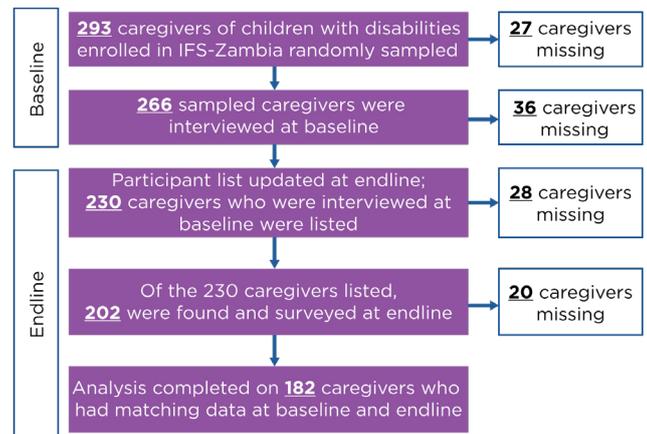


Figure 1: Recruitment and follow-up flow chart

When endline data collection took place, 202 of the 230 confirmed participants could be found and interviewed. Baseline/endline comparisons were conducted on 182 caregivers who could be matched across the two time points.

Qualitative interviews: Individual qualitative interviews (i.e., semi-structured interviews) were conducted at endline only to capture the perceptions of participants, volunteers, and supervisors regarding the (1) implementation of the PP Annex, (2) any changes in related outcomes, and (3) recommendations for programmatic improvement. Respondents were chosen using purposive sampling, allowing the most relevant actors across the program area to provide insights into the research questions.

A total of 32 semi-structured interviews (Table 1) were conducted in Copperbelt (19) and Luapula (13). Interviews were conducted with 18 caregivers of children with disabilities, 11 volunteers who facilitated the Annex sessions, and 3 supervisors.

³ Only caregivers of children with a disability who were between 5-17 years old at baseline were included in the original sample frame.

Table 1. Qualitative Interview Sample

POPULATIONS	COPPERBELT		LUAPULA			TOTAL
	NDOLA	LUANSHYA	MANSA	LUBWE	KASABA	
Participants	4	5	2	4	3	18
Volunteers	4	4	1	1	1	11
Supervisors	1	1	0	1	0	3
Total	9	10	3	6	4	32

Data Collection

Interviewer training: Three interviewer teams were assembled to collect both quantitative and qualitative data across the study sites at endline. The first team collected data in the Luanshya and Ndola sites. The second team collected data in the Kasaba and Lubwe sites. The third team collected data in Mansa. Each team received a 3-day training and covered the following topics:

- Evaluation purpose, overview of IFS-Zambia, and description of the PP Annex,
- Data collection ethics, review/translation of the consent forms, informed consent roleplay,
- Quantitative and qualitative interviewing skills
- Review/translation of survey tool and roleplay of survey administration,
- Review/translation of qualitative interview guides and interview roleplay

The third day of the training consisted of piloting the quantitative and qualitative tools with project participants who were not sampled for the evaluation.

Ethical considerations: All participants provided oral consent to participate in the evaluation. The informed consent process met CRS' consent standards set out. In addition to training data collectors on data collection ethics, procedures were established to protect the participants' confidentiality. All surveys were conducted using the CommCare digital data collection platform, and data were securely stored on Android devices and then synchronized to CommCare cloud. Unique identification numbers were used for sampled caregivers and the index children to protect the confidentiality of the respondents. The final dataset was downloaded from the cloud and saved on password-protected computers. Qualitative interviews were recorded using Android devices. Recordings were downloaded and saved on password-protected computers. Recordings were transcribed directly into English and were de-identified.

Analysis

Survey: Descriptive statistics, such as frequencies, percentages and means, were used for the primary analysis. Statistically significant differences between baseline and endline values were calculated using the statistical analysis software Stata SE version 17. To analyze baseline-endline differences of paired data for categorical indicators (e.g., percentage of respondents who agreed or strongly agreed that 'caring for my child with a disability has enabled me to develop a more positive attitude toward life') McNemar's tests were used. Wilcoxon matched pairs signed rank tests were used to test statistical differences between continuous paired data (e.g., average scores on the Parents' Assessment of Protective Factors scale). Statistical significance was determined at $p < 0.05$.

Qualitative interviews: All 32 interviews were transcribed and translated into English following a common transcription format. Transcriptions were coded with Dedoose analysis software using a mix of a priori and inductive codes. Codes were grouped in themes and reviewed considering the quantitative findings from the baseline and endline surveys.

Evaluation Findings

The results of the performance evaluation are organized by key themes. Both quantitative (survey) and qualitative findings are integrated throughout the presentation of the findings.

Background Characteristics

Most of the sample who participated in the Annex sessions lived in Luapula Province (55.5%), in the Kasaba (15.9%), Lubwe (23.6%), and Mansa sites (16.0%). The remainder were in Copperbelt (45.5%), in the Luanshya (25.3%) and Ndola (19.2%) sites. The majority of caregivers (55.5%) participated in parenting groups implemented by CRS partner, the Sisters of Mercy. The remainder of caregivers were in groups directly operated by Dominican (19.2%) and Franciscan (25.3%) congregations.

Table 2: Percent distribution of caregivers of children with disabilities, by geographic area and by congregation (N=182)

GEOGRAPHIC AREA OR CONGREGATION	(n)	%
Province		
Copperbelt	(81)	44.5
Luapula	(101)	55.5
District		
Kasaba	(29)	15.9
Luanshya	(46)	25.3
Lubwe	(43)	23.6
Mansa	(29)	16.0
Ndola	(35)	19.2
Congregation		
Sisters of Mercy	(101)	55.5
Dominican	(35)	19.2
Franciscan	(46)	25.3

Caregiver characteristics

Most caregivers of children with disabilities who participated in the PP Annex activities were female (94%) (Table 3). On average, the caregivers were 47.6 years old. Most of the caregivers were between 35-49 years old (41%) (Figure 2). About 26% of caregivers were between 50 and 64 years old, 18% of the were between 18 and 34 years old, and 15% were 65 years or older. Over 76% of caregivers had a primary school education or less.

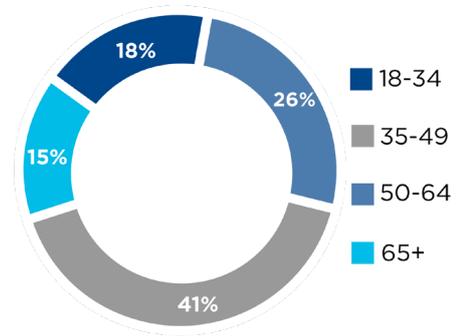


Figure 2: Caregiver Age Distribution

Nearly 17% had at least some secondary school education, and over 6% had at least some post-secondary education. Forty-four percent of caregivers were married, and almost 36% were widowed. Over 18% were divorced or separated and 2.2% were single, never married.

Table 3: Percent distribution of caregivers of children with disabilities by caregiver background characteristics (N=182)

CAREGIVER CHARACTERISTICS	(n)	%
Caregiver Age		
18-34	(33)	18.1
35-49	(75)	41.2
50-64	(47)	25.8
65+	(27)	14.8
Caregiver sex		
Female	(171)	93.9
Male	(11)	6.1
Caregiver education status		
None/no formal education	(17)	9.3
Primary	(115)	63.2
Secondary	(44)	24.2
Higher	(6)	3.3
Caregiver marital status		
Married	(80)	44.0
Widowed	(65)	35.7
Divorced / Separated / Single	(33)	18.1
Single, never married	(4)	2.2

Almost 19% of caregivers had at least one functional difficulty as measured by the Washington Group Short Set tool at baseline. The most common caregiver functional difficulties were concentration (7.1%) and walking (7.1%) followed by vision (5.3%) and hearing (2.9%).

Table 4: Percent distribution of caregivers of children with disabilities by caregiver disability status (N=170)

FUNCTIONAL DIFFICULTIES	(n)	%
Number of functional difficulties		
0	(138)	81.2
1	(26)	15.3
2-6	(6)	3.5
Specific functional difficulties		
Vision	(9)	5.3
Hearing	(5)	2.9
Walking / Mobility	(12)	7.1
Concentration	(12)	7.1
Communication	(1)	0.6
Self-care	(3)	1.8

Index child characteristics

Exactly half of the index children with a disability were female (50%) (Table 5). Eighty-three percent of the children were between the ages 5 and 14 years old, and 17% were 15-17 years old.⁴ Given the eligibility criteria and sample frame, 100% of index children had at least one functional difficulty.⁵ Over 17% of the children had two functional difficulties and 4.7% had 3 to 13 functional difficulties. The most prevalent functional difficulty was communication (35%), followed by learning (31%), and walking/mobility (31.4%).

⁴ Only caregivers of children with a disability who were between 5-17 years old at baseline were included in the original sample frame.

⁵ Child disability status was measured using the [Washington Group/UNICEF Child Functioning Module](#). The CFM, finalized in 2016, aims to identify the subpopulation of children who are at greater risk than other children of the same age of experiencing limited participation in an unaccommodating environment. The set of questions is intended for use in household surveys. The module has undergone extensive review by experts and testing in several countries. It has been incorporated into the most recent round of UNICEF-sponsored Multiple Indicator Cluster Surveys (MICS). An individual was considered to have a functional difficulty for this analysis if they responded “cannot do at all” or “a lot of difficulty” for a specific functional area.

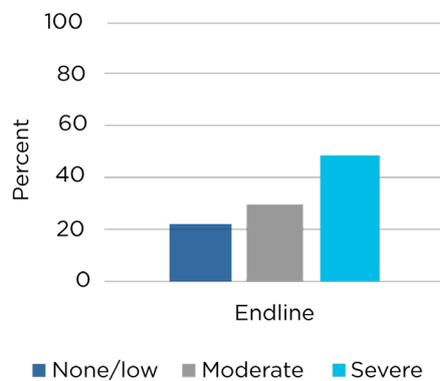
Table 5: Percent distribution of index children with a disability, by background characteristics (N=182)

INDEX CHILD CHARACTERISTICS	(n)	%
Child sex		
Female	(91)	50.0
Male	(91)	50.0
Child age groups		
5-9	(71)	39.0
10-14	(80)	44.0
15-17	(31)	17.0
Number of functional difficulties		
1	(133)	78.2
2	(29)	17.1
3-13	(8)	4.7
Specific functional difficulties		
Vision	(24)	14.3
Hearing	(27)	15.9
Walking / Mobility	(53)	31.4
Communication	(59)	34.9
Learning	(53)	31.2
Remembering	(40)	23.8
Behaviour	(43)	25.4
Self-care	(41)	24.3
Concentration	(27)	16.0
Accepting change	(38)	22.8
Making friends	(36)	21.2
Anxiety	(25)	14.9
Depression	(26)	15.6

Household Economic Strengthening Indicators

Table 6 presents the results of select household economic strengthening indicators at endline only. Nearly two out of three caregivers of children with disabilities (63%) indicated that they had worried often about money in the 30 days prior to the survey. Over one-third of caregivers (35%) reported that they were able to save money in the 30 days prior to the survey. At endline, over 44% of caregivers reported that they could come up with approximately \$75 for an emergency.

Among caregivers with a child enrolled in school at endline (n=158), 60% were able to pay all required school fees at endline. Nearly a quarter (24%) of caregivers reported they were able to pay for an unexpected HH expense that they had experienced in the past year. Among the caregivers who had a child in need of healthcare (n=115), just over a quarter (26%), were able to pay for those services.



Finally, this population indicated high levels of food insecurity, which was measured by the [Household Hunger Scale](#). At endline, nearly half (49%) of caregivers reported severe household hunger and 30% reported moderate household hunger. (Figure 3)

Figure 3: Baseline and endline food insecurity

Table 6: Percent distribution of household economic strengthening indicators at endline only (N=182)

	(n)	%
Always worried about money in past 30 days	(114)	62.6
Saved money in the past 30 days	(63)	35.2
Could meet emergency costs	(80)	44.2
Able to pay all required school expenses in past 3 months (among 158 caregivers with children enrolled in school)	(94)	59.5
Able to pay for unexpected household expenses when needed (N=155)	(18)	24.0
Able to pay for child's health services when needed (N=115)	(30)	26.1
Food insecurity (Household Hunger Score)		
Little to no hunger	(37)	20.9
Moderate hunger	(53)	29.9
Severe hunger	(87)	49.2
In the past 30 days, was there ever no food to eat of any kind in your house because of lack of resources to get food?		
No/rarely	(35)	19.4
Sometimes	(48)	26.7
Frequently	(97)	53.9
In the past 30 days, did you or any HH member go to sleep at night hungry because there was not enough food?		
No/rarely	(50)	27.6
Sometimes	(46)	25.4
Frequently	(86)	47.0
In the past 30 days, did you or any HH member go a whole day and night without eating anything because there was not enough food?		
No/rarely	(84)	46.7
Sometimes	(35)	19.4
Frequently	(61)	33.9

Participation in Positive Parenting Annex Sessions

Self-reported participation data showed that 88% of caregivers attended “all” (40%) or “more than half” (48%) of the PP Annex sessions. (Figure 4) The remaining 12% attended “less than half” (11%) or “none” (1%) of the sessions. Qualitative interviews with volunteers and caregivers highlighted the facilitators and barriers to participation. A key facilitator to participation was caregiver interest in the content.

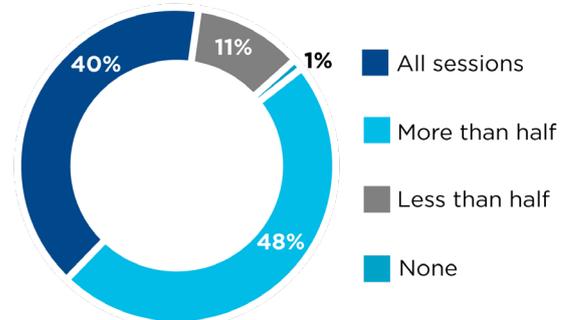


Figure 4: Participation in PP Annex Sessions

Several qualitative interviews highlighted the participants’ felt need for the information that was shared during the PP Annex sessions. A female caregiver in Luanshya, for example, stated:

“...if you ever got sick of a disease, and someone told you that there’s somewhere where you can get some medicine for the disease, I believe you would rush there. I found it to be very important to participate in this program because I have a child with disabilities so I wanted to know how best I can take care of him [her child with a disability].

(Female caregiver, Luanshya site)

This caregiver equated the program with a medical treatment, highlighting both the need and urgency to participate in the PP Annex sessions.

Most caregivers agreed that the central location and the timing were convenient. A caregiver from Mansa indicated that, “**The location was very easy. They chose location, which is nearby, and we did not have to walk for long distances.**” (Female participant, Mansa site). Similarly, one volunteer stated:

“...we would ask them where the sessions should be held. So, among the caregivers themselves, they would offer their homes. They’d offer that we could have the sessions at their place...then even the time, we would pick like 15:00hrs when they had already worked, cleaned their children and done household chores. So by 16:00 hours we are done, then people will get back to their homes, so the time was okay.

(Female volunteer, Luanshya site)

This volunteer explained that the caregivers were consulted during the process of selecting the session location and timing, ensuring relevancy and facilitating participation.

In terms of challenges to participation in the PP Annex sessions, several volunteers and caregivers could not name any barriers. Some volunteers mentioned that participants' schedules proved to be the most common barrier. A male volunteer from Mansa indicated: **"Yes, some people are very busy. For instance, this time, this is a period of harvesting, so there are those that are busy in their fields, and they cannot come for the sessions."** Generally, the idea of "being busy" was equated with livelihood activities. For example, a volunteer from Luanshya stated:

“...they [caregivers] would miss, say, for two weeks. Then when they get back, we'd ask them why they missed, and they'd tell us that they had to go do some jobs to make money, to buy food for the children.

(Female volunteer, Luanshya site)

Another barrier to participation that was identified were personal problems, such as sickness of the child or caregiver. A female caregiver from Lubwe indicated that she had to miss sessions because she had fallen ill and then had to attend a funeral, **"Again I got sick with malaria. I went back three times to the clinic. I just finished getting sick and the funeral happened, our brother just fell off a car."** Similarly, others indicated that their children had fallen sick, and they had to attend to them, limiting participation.

Satisfaction With and Acceptability of Positive Parenting Annex Sessions

There were high levels of satisfaction with the PP Annex sessions. Three out of four caregivers (75.0%) were "completely" satisfied with the PP Annex sessions (Figure 5). Twenty-three percent were "mostly" satisfied (23.0%) and only 2% were "slightly" or "not at all" satisfied with the sessions. At endline 100% of survey respondents indicated that they would recommend the PP Annex to other caregivers of children with disabilities.

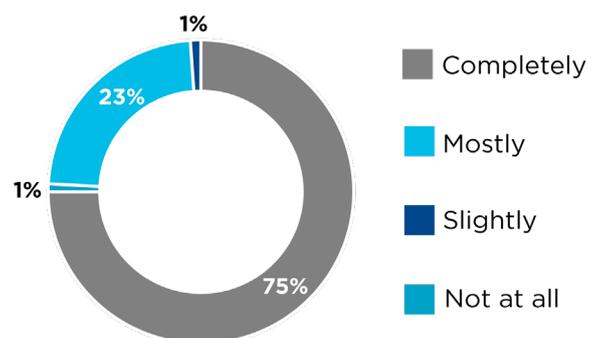


Figure 5: Level of satisfaction with PP Annex

The qualitative interviews highlighted the high levels of acceptability of the PP Annex sessions. Like the survey results, nearly all caregivers indicated that they would recommend the PP Annex sessions to other parents of children with disabilities. A female caregiver from the Kasaba site stated, **"Yes, I would recommend this. There are many people in the world who need this...I would want others to have the opportunity to learn what I have learned."** Like the responses of most of the caregivers, this quote highlights the respondent's belief that others should benefit from the sessions in the same way as she did, again emphasizing the value of the curriculum content.

Table 7 presents the results of the [CRS Project Respect for Participant Dignity Scale](#). This 10-item measure asks participants to indicate their level of agreement with a series of statements about how they were treated while participating in project activities. At endline, most respondents agreed that during PP Annex activities, several different aspects of their dignity were respected. For example, nearly 98% of respondents indicated that the project valued them as a person. Over 97% indicated that staff from the project actively listened to them during PP Annex activities. Nearly a quarter, however, felt that the project treated some people worse than others.

Table 7: Percent distribution of caregivers who agreed/strongly agreed with how they were treated during project activities at endline (N=182)

	(n)	%
The project treated some people worse than other people.	(43)	23.9
The project valued you as a person.	(178)	97.8
Staff from the project said or did something to humiliate you.	(9)	5.1
The activities implemented by the project were open to all groups.	(161)	90.5
Staff from the project treated you with respect.	(175)	96.2
The project took steps to learn about your community.	(166)	93.8
Staff from the project actively listened to you in activities.	(175)	97.2
Staff from the project understood your needs and goals.	(173)	96.1
You felt safe from violence or harm while participating in project activities.	(178)	97.8
You felt free to express your opinions with project staff without concern of being shamed or humiliated.	(177)	97.3

Rights of the Child with Disabilities

The PP Annex sessions covered the rights of the child with disabilities. At baseline, the survey indicated that among caregivers of children with disabilities there were already high levels of awareness of these rights in general (Table 8). At both baseline and endline, over 90% of caregivers agreed that “children with disabilities should have equal rights as children without disabilities”. Similarly, at baseline and endline, almost all caregivers agreed that Zambia had laws aimed to ensure the equal enjoyment of human rights by people with disabilities” (p=0.90).

At endline, 100% of respondents indicated that people with disabilities had a legal right to access health care and education.

Table 8: Percent distribution of caregivers with knowledge of the rights of children with disabilities at baseline and endline (N=182)

	BASELINE %(n)	ENDLINE %(n)	P-VALUE
Children with disabilities should have equal rights as children without disabilities (Agree)	91.2(166)	95.6(174)	0.07
Zambia has laws that aim to ensure the equal enjoyment of human rights by people with disabilities (true)	95.4(164)	97.1(167)	0.90
People with disabilities have a legal right to access health care (agree)	N/A	100.0(182)	N/A
People with disabilities have a legal right to access education (agree)	N/A	100.0(182)	N/A

The qualitative interviews of caregivers and volunteers generally highlighted that the PP Annex sessions contributed to greater recognition of the rights of children with disabilities. A female volunteer stated, for example, that **“On the issue to do with the rights of the children, most parents have really changed because most of them are now aware that their children also have rights.”** (Female volunteer, Mansa site) The recognition of the rights of children with disabilities was often expressed as treating the child like other children without disabilities. One female caregiver stated:

“ There has been a lot of change. In the past we never used to pay attention to him. We never even used to comfort him, and we were constantly shouting at him. But now all this has changed. We have accepted his condition, and we love him just the way he is. This change has come about from the sessions that we’ve been having because we have been taught that he is a human being, just like anyone, and we should treat him just as we treat any other child.

(Female caregiver, Kasaba site)

Like others who expressed a change in the awareness of the rights of children with disabilities, this caregiver associated her recognition with improvements in other behaviors, such as providing the child with love and affection, accessing services, and including children with disabilities in family and community activities.

Parenting Behaviors

The survey also incorporated two sub-scales of the [Alabama Parenting Questionnaire](#) (APQ) to measure positive parenting and use of corporal punishment. These sub-scales have been used widely in southern Africa.⁶ The Positive Parenting sub-scale includes 6 parenting behaviors and the Corporal Punishment sub-scale has 3 items. For each item, caregivers were asked the frequency of engaging in the behavior, choosing among “never”, “almost never”, “sometimes”, “often” or “always”. The Cronbach’s alpha was 0.62 and 0.70 at endline for the Positive Parenting and Corporal Punishment sub-scales respectively. See Annex 1 (Tables C1 and C2) for an analysis of these behaviors by item and region.

Positive Parenting Behaviors: Table 9a presents the percentage of caregivers who reported at baseline and endline that they frequently engaged (always or often) in the six positive parenting behaviors included in the APQ. Frequent use of three out of the six behaviors increased between baseline and endline. The percentage of caregivers who reported frequently rewarding their child/ren for obeying them or behaving well increased from 33% at baseline to 59% at endline ($p=0.00$). There was an 18-percentage point increase in complimenting their child/ren when they did something well (baseline: 51%, endline: 69%, $p=0.00$). There was a large increase between baseline (25%) and endline (64%, $p=0.00$) in the percentage of caregivers who hugged or kissed their child/ren when they did something well.

One positive parenting behavior moved in a negative direction. There was a 37-percentage point decrease between baseline (63%) and endline (26%) in the caregivers who frequently told their child/ren that they liked it when they helped around the house. There was no statistically significant difference between baseline and endline for two of the behaviors (“Tells child when they are doing a good job at something,” and “Praises child if they behave well”).

Table 9a: Percent distribution of caregivers who responded they “always” or “often” engaged in the positive parenting behaviors at baseline and endline

	BASELINE %(n)	ENDLINE %(n)	P-VALUE
Tells child when they are doing a good job at something	52.8(96)	44.0(80)	0.07
Rewards child for obeying them or behaving well	33.2(60)	58.6(106)	0.00
Compliments child when they do something well	50.6(92)	68.7(125)	0.00
Praises child if they behave well	57.7(105)	55.0 (100)	0.60
Hugs or kisses child when they have done something well	24.7(45)	64.3 (117)	0.00
Tells child that they like it when they help around the house	62.6(112)	26.3(47)	0.00

6 Examples: Lachman, Jamie M., Lucie D. Cluver, Mark E. Boyes, Caroline Kuo, and Marisa Casale. “Positive parenting for positive parents: HIV/AIDS, poverty, caregiver depression, child behavior, and parenting in South Africa.” *AIDS care* 26, no. 3 (2014): 304-313.;

Cluver, Lucie D., et al. “Parenting for Lifelong Health: a pragmatic cluster randomised controlled trial of a non-commercialised parenting programme for adolescents and their families in South Africa.” *BMJ global health* 3.1 (2018): e000539.

An average score for the Positive Parenting sub-scale (range 0-4) increased by 0.1 between baseline (2.6) and endline (2.7, $p=0.30$), which was not a statistically significant difference.

Through the qualitative interviews, most participants indicated that the sessions contributed to their ability to better care for their child with a disability. Almost half of the caregivers interviewed mentioned that they demonstrated more love and affection towards their children with disabilities. A female caregiver in Ndola, for example, stated:

“*What I learned that was important for me was how to take care of the children. I learned that these children, we are not supposed to stay away from them. We need to be closer to them and show them love.*

(Female caregiver, Ndola site)

Like other respondents, this caregiver alludes to her duty or responsibility to demonstrate warmth and love towards their child with a disability, like any other child. Several caregivers attributed this change to lessons learned from participating in the PP Annex sessions. One caregiver from Luanshya stated “I also learned that I have the responsibility to show love to my child who has disabilities.” (Female caregiver, Luanshya site)

Corporal Punishment: Table 9b presents the percentage of caregivers who responded that they “always”, “often” or “sometimes” engaged in specific acts of corporal punishment at baseline and endline. One out of the three behaviors decreased between baseline and endline. The percentage of caregivers who reported “spanking their child/ren with the hand on a part of the body that was not their face when they did something wrong” decreased by 30 percentage points between baseline (41%) and endline (11%, $p=0.00$).

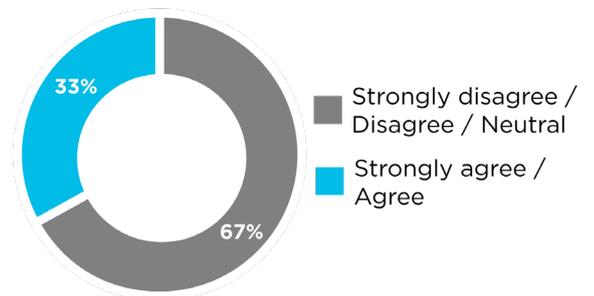


Figure 6: Percentage of caregiver who agree that beating a child is an effective way to help them behave (endline only)

There were no statistically significant differences in the use of the other two corporal punishment behaviors (slapping the child in face, hitting the child with a cane/belt/switch) between baseline and endline. At endline between 30-33% of participants reported engaging frequently in those behaviors. Additionally, at endline, 3 out of 10 caregivers agreed that beating a child was an effective way to help them behave.⁷ (Figure 6)

⁷ This question was not part of the Alabama Parenting Questionnaire.

Table 9b: Percent distribution of caregivers who responded “always”, “often” or “sometimes” engage in the corporal punishment at baseline and endline

	BASELINE %(n)	ENDLINE &(n)	P-VALUE
Spans child with hand on a part of the body that is not their face, when they have done something wrong	40.7(72)	11.3(20)	0.00
Slaps child on the face when they have done something wrong	25.1(45)	30.2(54)	0.28
Hits child with a cane/belt/switch or other object when they done something wrong	34.5(61)	33.3(59)	0.81
Any of the 3 behaviors	49.1(85)	41.6(72)	0.13

Alternatively, through the qualitative interviews, many caregivers and volunteers indicated that physical or corporal punishment was used less frequently since they started participating in the PP Annex sessions. A female caregiver from Kasaba site stated:

“ Yes, like I have said, in the past, we used to use physical punishment. We would often slap him [her child with a disability] when correcting him, but this has changed now. We used to do this because we did not know any other way.

(Female caregiver, Kasaba site)

The caregiver highlighted the change in how she managed her child’s challenging behavior. This sentiment was reiterated by a female volunteer in Mansa who said:

“ ...most of the families are more patient toward their children with disabilities as compared to the way it used to be in the past, when most of the parents used to react with anger towards their children. This is what I have seen as the most notable changes the result of this program.

(Female volunteer, Mansa site)

Although not a predominant sentiment expressed in the qualitative interviews, some caregivers indicated that physical punishment was necessary to ‘discipline’ children. A female caregiver from Luanshya site stated, “I spank him [her child with a disability] when he is wrong. I have to discipline him.” Another female caregiver from Lubwe remarked, “I do pick up a stick and whip him.” These qualitative findings seem to align with the minority of survey respondents who indicated at endline that beatings were necessary to improve behavior.

Parents' Assessment of Protective Factors

Caregivers of children with disabilities also completed the Center for the Study of Social Policy's Parents' Assessment of Protective Factors (PAPF) at baseline and endline (Box 1). The PAPF assesses "presence, strength, and growth of parents' self-reported beliefs, feelings, and behaviors" that build a caregiver's protective factors to mitigate risks and promote child well-being.⁸ This tool measures the following domains: parental or caregiver resilience, social support and connections, concrete assistance in times of need, and social and emotional competency. The Changing the Way We Care (CTWWC) Initiative applied this measure to assess family strengthening efforts in Kenya and Guatemala as part of its Year 3 and Year 5 Reviews.⁹

Each domain was measured by the mean agreement scores for 9 statements, to which respondents rated their agreement on a scale of 0 ("not at all like me") to 4 ("very much like me").

An overall score called the Protective Factors Index was calculated as the respondent's mean score of all 36 statements. Scores ranged from 0 to 4, where 4 represented higher levels of protective factors. For each individual statement of the PAPF, an indicator was created to show the percentage of caregivers who responded that the statement was "like me" or "very much like me." Cronbach's alpha for the overall Protective Factors Index was 0.89 at endline.

Table 10 presents the mean scores for the Protective Factors Index and each sub-scale at baseline and endline. There are no cut-offs that indicate whether a score should be considered high, medium, or low, however higher scores indicate that the caregivers report higher levels of protective factors.¹⁰ The average scores for the overall PAPF and each sub-scale improved between baseline and endline ($p < 0.05$). The average overall PAPF score increased by 0.33 between baseline and endline ($p < 0.05$).

The mean **Parental Resilience** domain score improved by 0.32 points ($p = 0.00$). There was an 18-percentage point increase between baseline (63%) and endline (81%) in the caregivers who agreed that "they found ways to handle problems related to their child(ren)" (Table A1a). There was a statistically significant increase in the percentage of caregivers who agreed that they "took good care of their child/ren even when they had personal problems" (baseline: 69%; endline: 84%, $p = 0.00$).

Box 1: Parents' Assessment of Protective Factors Domains

Parental resilience: Managing stress and functioning well when faced with challenges, adversity and trauma.

Social support and connections: Positive relationships that provide emotional, informational, instrumental and spiritual support.

Access to concrete support in times of need: Access to concrete support and services that address a family's needs and help minimize stress caused by challenges.

Social and emotional competency: Family and child interactions that help children develop the ability to communicate clearly, recognize and regulate their emotions, and establish and maintain relationships.

⁸ <https://cssp.org/resource/papf-user-guide/>

⁹ [CTWWC Household Survey Reports - Kenya and Guatemala, 2022](#)

¹⁰ The internal reliability of the overall Protective Factor Index and each construct or sub-scale is measured using Cronbach's Alpha. These alpha scores show a high level of reliability for each sub-score and for the overall measure. An alpha score of 0.7 or above is considered as indicating good reliability. Protective Factors Index: 0.92; Resilience: 0.82; Social connection: 0.82; Concrete support: 0.80; Social emotional: 0.83. See Annex 1.

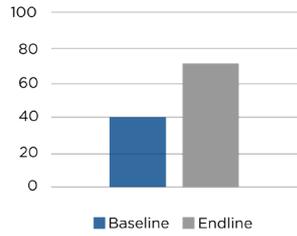


Figure 7: Percentage of caregivers who agreed that they had someone who they could ask for help (p=0.00).

The mean **Social Support and Connection** domain score improved by 0.30 points between baseline and endline (p=0.00). There was a 30-percentage point increase in the caregivers who agreed that they “had someone who helped get them through hard times” (baseline: 41%, endline: 71%, p=0.00). (Table A2a) There was a statistically significant increase between baseline (45%) and endline (71%) in percentage of caregivers who agreed they had someone who they could ask for help” (p=0.00) (Figure 7).

The mean **Concrete Support** domain score increased by 0.42 points between baseline and endline (p=0.00). The percentage of caregivers who knew “where to get help if they had trouble taking care of emergencies” increased between baseline (49%) and endline (66%, p=0.00). Similarly, the percentage of caregivers who knew “where to go if child needs help” increased by 14 percentage points between baseline (56%) and endline (70%, p=0.00).

The mean **Social Emotional** domain score increased 0.28 points between baseline and endline (p=0.00). There was an improvement in the percentage of caregivers who indicated that they could “control themselves when they got angry at their child” between baseline (90%) and endline (97%). Similarly, the percentage of caregivers who agreed that they “helped their child/ren calm down when they were upset” increased between baseline (87%) and endline (95%, p=0.02).

Table 10: Mean PAPF scores (scale of 0 – 4 with 4 representing greater protective factors)

	BASELINE MEAN(SD)	ENDLINE MEAN(SD)	P-VALUE
Protective Factor Index (36 items)	2.8(0.48)	3.13(0.40)	0.00
Parental resilience sub-scale (9 items)	2.79(0.64)	3.11(0.50)	0.00
Social support and connection sub-scale (9 items)	2.56(0.68)	2.86(0.75)	0.00
Concrete support sub-scale (9 items)	2.64(0.68)	3.06(0.52)	0.00
Social emotional sub-scale (9 items)	3.18(0.46)	3.46(0.37)	0.00

See Annex 1, Tables 1a, 1b and 1c, for baseline and endline results for each PAPF statement – both average items score (from 0 to 4) and the percentage of caregivers who responded “like me” or “very much like” to the specific statements.

Social Support

To complement the Social Support and Connection sub-scale of the PAPP,¹¹ additional social support questions were included in the endline survey. About 44% to 46% of respondents reported receiving support from other caregivers of children with disabilities, family members, and people in the community (Figure 8). Nearly three out four (73%) reported receiving support from other members of the IFS Zambia parenting groups.

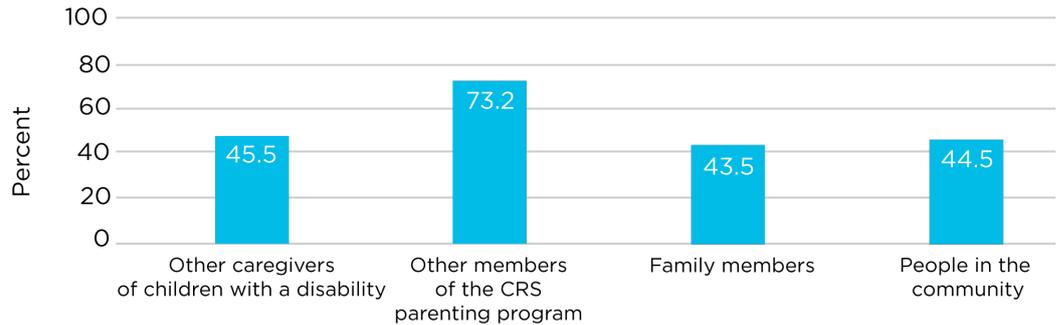


Figure 8: Percentage of caregiver who “always”, “often,” or “sometimes” that they received support from select groups

Qualitative interviews with caregivers and volunteers indicated that the level of support that caregivers received had increased over the course of the PP Annex sessions. Although some caregivers mentioned that they received support from their neighbors, it was more common for them to highlight increased support from family members. A female caregiver from Luanshya remarked:

“...in the past I never had anyone who was willing to help me to take care of my child. Each time I would be away from home, I would worry that my child will not eat because there would be no one to feed him. After attending the sessions, we sat down as a family to find a better way in which we were going to take care of [Child], I told them that I cannot manage to take care of him alone.

(Female caregiver, Luanshya site)

Like other caregiver responses, this respondent highlighted the need to proactively engage her family to care for the child better. Some respondents also indicated that they regularly shared what they learned from the PP Annex sessions with their family. A caregiver from Lubwe described it this way:

“My family was not supportive at the beginning but as the program progressed, we had a chance to sit down and discuss some of the things we were learning especially on obtaining support to care for this child, so even up to now they help me.

(Female caregiver, Lubwe site)

The caregivers associated the dissemination of the PP Annex content with an increase in support by family members to care for their child with a disability.

¹¹ As described above, the average Social Support and Connection score of the PAPP increased between baseline and endline (Table 7). A more detailed description of those findings can be found in Tables A3a and A3b of Annex X.

Accessing Services for Children with Disabilities

In addition to the Concrete Support sub-scale of the PAPF, the caregiver survey also included specific items to measure access to health, educational, and other social services at endline. There was a 14-percentage point increase in caregivers who indicated that “they knew where to go if their child needed help” between baseline (56%) and endline (70%, $p=0.02$) (Table A3a). At endline, 88% indicated that they knew “where to get assistance for their child’s disability.”

The qualitative interviews highlighted the perceived contribution of the PP Annex sessions to increasing the access of children with disabilities to needed services, including health, education, and social cash transfers. A male caregiver from Ndola remarked:

“As we are speaking, the day before yesterday he [respondent’s child] was just from getting an identity card from ZAPD. CRS has been working together with us to ensure that all these children are members of ZAPD. This is in an effort to make it easier for them to access help such as the social cash transfer.

(Male caregiver, Ndola site)

Increased access to assistive devices for children with disabilities was mentioned by about half of the caregivers. Specifically, increased access to wheelchairs was viewed as transformative for their children. A female caregiver from Lubwe stated:

“I sought assistance for him because I was not managing to provide for his needs. His needs are increasing the older that he is growing. For instance, before I received a wheelchair from the Catholics and CRS, I had to carry him on my back whenever we needed to go anywhere. This time around it’s easy to take him to school and to church because I can just put him in his wheelchair.

(Female caregiver, Lubwe site)

This caregiver, like several others, indicated that access to wheelchairs through IFS-Zambia increased their child’s mobility, social interaction, and access to other services, such as school.

Caregivers and volunteers also indicated that the PP Annex participants sought health and education services. A female volunteer from Luanshya stated:

“My parents never knew the rights of the children, like the right to education. Now they know, and the children are now going to school. Some caregivers used to think that they could only take their children with disabilities to special schools but after we taught them, they now know that a child has the right to learn at any school.

(Female volunteer, Luanshya site)

Like other respondents, this caregiver explicitly linked the increased access to services with the increased recognition of the rights of the child with disabilities. This increased recognition led caregivers to demand these services for their children.

While overall there is a sense that PP Annex participants had improved access to basic services, a minority of caregivers indicated that they still had limited access. A female caregiver from Mansa stated, ***“From the government there is nothing that I have gotten from them. The only help I have received is from CRS.”*** A female caregiver from Kasaba site remarked, ***“No, I have never gone anywhere else. It is just CRS that gave us help. We have never asked from anywhere else.”*** The caregivers acknowledge the support that have received from IFS-Zambia, however, either they did not pursue services, or they felt that the government could not or would not help them.

Family Stigma Index

The baseline and endline surveys also included select sub-scales of the Family Stigma Index (FAMSI).¹² This measure assesses different types of affiliate stigma. (Box 2). While children with disabilities are often the direct targets of stigma, caregivers, or affiliates, of these children may internalize it. Four FAMSI sub-scales were used in this evaluation. The affective affiliate stigma sub-scale assesses negative feelings (e.g., distress, embarrassment) that caregivers may experience in relation to their child with a disability. The cognitive affiliate stigma sub-scale assesses the caregivers’ perception of being treated differently because they care for a child with a disability (e.g., I am excluded from activities when people find out that I have a child with a disability).) The behavioral affiliate stigma sub-scale assesses the caregivers’ behavior in response to the affiliate stigma (e.g., avoiding making new friends because they have a child with a disability). The surveys also included a sub-scale to assess the positive aspects of caring for a child with a disability.

Box 2: Family Stigma Index Sub-Scales

Affiliate Stigma involves the internalization of stigma by associates (e.g., caregivers) of individuals targeted by stigma (e.g., children with disabilities).

Affective Affiliate Stigma includes the negative feelings of associates of individuals targeted by stigma.

Cognitive Affiliate Stigma involves the associates’ feelings of being treated differently because of their relationship to the targeted individuals.

Behavioral Affiliate Stigma are the associates’ negative behaviors (e.g., avoiding making new friends) because of their relationship with the targeted individuals.

Positive Aspects of Caring for a Child with Disability includes caregivers’ feelings of the benefits and strengths of having a child with a disability.

Table 11 shows mean scores for the FAMSI sub-scales at baseline and endline. There are no cut-offs to indicate whether a score should be considered high, medium, or low. However, lower scores indicate lower levels of affiliate stigma for the affective, cognitive, and behavioral affiliate stigma sub-scales. Higher scores of the positive aspects sub-scale reflect higher levels of positive perceptions of caring for a child with a disability.

Between baseline and endline, there were no statistically significant differences between the overall mean FAMSI score, the mean affective affiliate stigma score, or the mean cognitive affiliate stigma score. While the overall index score tended to

12 Mitter, N., Ali, A., & Scior, K. (2018). Stigma experienced by family members of people with intellectual and developmental disabilities: multidimensional construct. *BJPsych open*, 4(5), 332-338.

move in the desired direction (towards lower levels of affiliate stigma, $p=0.07$) with marginal significance, both affective and cognitive affiliate stigma sub-scales tended to stay the same across the two time points.

Behavioral affiliate stigma decreased between baseline (mean: 1.73) and endline (mean: 1.57, $p=0.00$). Similarly, reported positive aspects of caring for a child with a disability improved between baseline (mean: 3.93) and endline (mean: 4.33, $p=0.00$).

Table 11: Mean FAMSIS scores (scale of 1 to 5, with 5 representing higher levels of affiliate stigma)

	BASELINE MEAN (SD)	ENDLINE MEAN (SD)	P-VALUE
Overall mean FAMSIS score	2.16(0.51)	2.06(0.46)	0.07
Affective affiliate stigma sub-scale	2.05 (0.94)	2.18(0.85)	0.15
Cognitive affiliate stigma sub-scale	2.84(1.08)	2.96(1.08)	0.25
Behavioral affiliate stigma sub-scale	1.73(0.53)	1.57(0.71)	0.00
Positive aspects of caring for a child with a disability*	3.93(0.60)	4.33(0.58)	0.00

*Increasing scores on this sub-scale means reporting more positive aspects of caring for a child with a disability.

See Annex 1B for baseline and endline results for each FAMSIS statement, showing both average items score (from 1 to 5) and the percentage of caregivers who responded “strongly agree” or “agree” to the specific statements.

Inclusion of Children with Disabilities

To complement the FAMSIS data, questions about including children with disabilities in family and community activities were added to the endline survey. Qualitative interviews showed that most caregivers and some volunteers felt that the PP Annex sessions contributed to greater inclusion of children with disabilities in community and family life. Several respondents remarked that previously children with disabilities were hidden from others. A caregiver from Luanshaya remarked, **“I also learned that I should not hide a child with disabilities. I should be proud of that child”** at endline. One supervisor of the PP Annex Sessions from Lubwe stated:

“ Before, they used to hide their children. They never used to let their children to play with other kids. They used to lock the children up in their houses. But for now, there is a big change. They allow their children to play and sometimes they even come with them to the sessions.

(Supervisor, Lubwe site)

As the supervisor highlighted, there was a perception that more caregivers were bringing their children with disabilities outside of the household, allowing them to play with other children and participate in community activities. Similarly, a female caregiver from Lubwe stated, “**...when there was World Disability Day, he [child with disability] took part in the celebrations together with other children. He was even able to participate in the dances that they were doing.**” (Female caregiver, Lubwe site)



The qualitative interviews also showed that most caregivers felt that the sessions contributed to greater inclusion of children with disabilities in family life. Many indicated that there was a greater acceptance of the child with disabilities within the family (less discrimination). A female caregiver from Lubwe remarked that the PP Annex sessions were important to her “**...because I learnt that we should not discriminate this child within this household. We can eat together with him and do everything else with him.**” (Female caregiver, Lubwe site) Similarly, a female caregiver from Luanshya stated:

“*What has changed the most about my child is that my family now accepts him. They never used to consider him as someone who can achieve anything. But after I sat them down to explain some of the things I have learned, their attitude towards him has changed. This time around on Fridays my sister comes to pick him up and she spends most of the weekends at her home.*

(Female caregiver, Luanshya site)

This caregiver highlighted the positive change in attitude of her family members towards her child with disability. She indicated that increased acceptance of the child allowed for more engagement and greater family support. Like other caregivers interviewed, she attributed this change to having shared the lessons she had learned in the PP Annex sessions with them.

Caregiver Stress

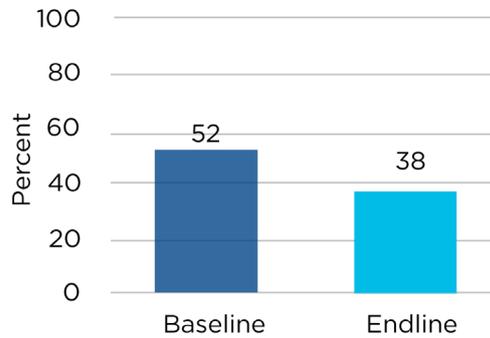


Figure 9: Percentage of caregiver who stated that they felt “too much” or “a lot” of worry because they have a child with a disability at baseline and endline (p=0.00)

Table 12 presents baseline and endline differences in caregiver stress related to caring for a child with a disability. Over 90% of caregivers at baseline (93%) and endline (96%) agreed that “caregivers of children with disabilities often face additional challenges that bring stress and worry” (p=0.35). There was a nine-percentage point decrease in the caregivers who were “worried or stressed because of these challenges” between baseline (85%) and endline (76%, p=0.03). There were also fewer caregivers at endline (38%) who felt they worried “too much” or “a lot” because of their child with a disability compared to baseline (52%, p=0.00). (Figure 9).

Importantly, at baseline and endline, over 90% of caregivers indicated that they engaged in practices to actively reduce stress/worry. The total number of different stress-reducing activities that the caregivers practiced increased between baseline (mean: 2.9 activities) and endline (mean: 3.3 activities, p=0.02).

At endline, caregivers reported that they practiced the following to reduce stress/worry: praying (88%), talking with someone (79%), taking a walk (47%), sitting alone (40%), taking deep breaths (23%).

Table 12: Percent distribution of caregivers who agreed with the following statements about caregiver stress

	BASELINE %(n)	ENDLINE %(n)	P-VALUE
Caregivers of children with disabilities often face additional challenges that bring stress or worry	93.4(168)	96.1(172)	0.35
They felt worried or stressed because of challenges related to caring for their child with a disability	85.1(154)	76.2(138)	0.03
They felt too much/a lot of worry because of their child with a disability	51.9 (94)	37.6(68)	0.00
There are things one can do to deal with stress/worry or keep it low	92.8(168)	96.7 (175)	0.09
They do something to reduce stress/worry	93.4(168)	96.1(172)	0.35
	MEAN (SD)	MEAN (SD)	
Number of activities to reduce stress/worry that caregivers practice	2.87(1.8)	3.25(1.5)	0.02

Through the qualitative interviews, caregivers and volunteers also reported improvements in the levels of stress and worry felt by participants. They associated these improvements with learning techniques to manage stress. A caregiver in Luanshya indicated:

“*The most important thing that has changed about me as a parent is that most of the time when moving around with my child in the community, people would stare at me a lot. That made me start isolating myself. I stopped visiting other people. I just used to stay home. After we were taught about how to manage stress, I realized that my child is a blessing and he has a purpose here on earth. Since then a lot of things have changed.*

(Female caregiver, Luanshya site)

This caregiver expressed that by managing her stress, she was able to see her child with a disability as a blessing rather than a burden or source of worry. A volunteer from Kasaba remarked that the caregivers' greater acceptance of a child with a disability could also reduce stress:

“*I think they used to be very stressed in the past because they had not accepted their children with disabilities. We have taught them these children are also created in the image of God and in the future, they may be the ones who can take care of their family. Developing this mindset has helped to reduce stress.*

(Female volunteer, Kasaba site)

The volunteer highlights that the caregivers' changing attitudes towards their children, recognizing the inherent value of the child with a disability, had reduced caregiver stress and worry.

Child Protection

Caregivers were asked a series of questions about child protection at baseline and endline. At both timepoints, nearly 82% of caregivers agreed that “children with disabilities were at increased risk of abuse and neglect” (Table 13). About a quarter of caregivers agreed that “it was impossible for children with disabilities to communicate that abuse had happened to them” at baseline (21%) and endline (27%, $p=0.18$). There was a 13-percentage point decrease between baseline (48%) and endline (35%, $p=0.01$) in the percentage of caregivers who agreed that “abuse of children with intellectual disabilities was not as harmful because they were not aware of what happened”. At both time points, over 90% of caregivers agreed that it was important to communicate with children with disabilities about their bodies. Finally, there were statistically significant increases in the percentage of caregivers who “knew where to go for support” (baseline: 83%, endline: 92%, $p=0.01$) and who would “seek support if they suspected that a child with a disability had experienced abuse or harm” (baseline: 82%, endline: 91%, $p=0.02$).

Table 13: Percent distribution of caregivers who agreed with the following statements about child protection (N=182)

	BASELINE %(n)	ENDLINE %(n)	P-VALUE
Children with disabilities are at increased risk of abuse and neglect	81.7 (143)	81.7 (143)	1.00
It is impossible for children with disabilities to communicate that abuse happens to them	21.0 (38)	27.1(49)	0.18
Abuse of children with intellectual disabilities is not as harmful because they are not aware of what is happening	48.0(86)	35.2(63)	0.01
It is important to communicate with children with disabilities about their bodies	92.9(169)	96.7(176)	0.10
They know of people/services to go to for support if they suspected that a child with disabilities had experienced abuse or harm	82.8(149)	91.7(165)	0.01
They would seek help/support if they suspected that a child with disabilities had experienced abuse or harm	82.2(148)	90.6(163)	0.02

Table 14 shows the sources of support from which caregivers who suspected abuse/neglect of a child with disabilities would seek help at baseline and endline. There was a significant increase in the percentage who would seek support from a Social Welfare Officer between baseline (28%) and endline (65%, $p=0.00$). Similarly, the percentage who would seek help from the Child Protection Unit, a hospital, or a non-governmental organization (NGO) also increased significantly between baseline and endline. There was no change in the percentage who would seek help from the police (baseline: 64%, endline: 65%, $p=1.00$).

Table 14: Percent distribution of caregivers who would seek help from the following sources if they suspected abuse/neglect of a child with disabilities at baseline and endline (N=182)

	BASELINE %(n)	ENDLINE %(n)	P-VALUE
Social Welfare Officer	27.6(62)	64.9(107)	0.00
Police	64.2(106)	64.9(107)	1.00
Child Protection Unit	29.7(49)	52.7(87)	0.00
Hospital	57.0(94)	67.9(112)	0.04
Non-Governmental Organization	47.3(78)	67.9(112)	0.00

Suggestions for Improving PP Annex Sessions

At endline, caregivers, and supervisors were asked to identify key suggestions for improving the PP Annex. These recommendations can be grouped into two major categories: (1) materials and support for volunteers and (2) programmatic updates.

Materials and Support for Volunteers

- Provide volunteers with teaching materials that include images of children with disabilities and illustrated examples of key messages.
- Ensure that volunteers have all the required/appropriate materials needed to implement PP Annex Sessions (e.g., flip charts, markers, PP Annex Guidebook).
- Provide volunteers with materials (e.g., parenting guide) that have simpler Bemba translations.
- Provide volunteers with refresher trainings in PP Annex and disability-related topics.
- Train volunteers on sign language.
- Provide volunteers with larger allowances to increase their motivation.

Programmatic Updates

- Conduct additional community sensitization activities to complement PP Annex and to reduce stigma.
- Continue implementing the PP Annex Sessions and expand them to other caregivers in the target communities.
- Provide trainings to caregivers on braille and sign language.
- Help communities to develop educational services that can meet the needs of children with disabilities
- Advocate in communities for accommodations for people with disabilities
- Provide caregivers with additional capital support to enhance their livelihoods.

Conclusions

High Satisfaction with and Acceptability of Positive Parenting Annex Sessions: Both survey and qualitative data indicated that the participants of the PP Annex Sessions were extremely satisfied with the intervention. They also clearly articulated the acceptability of the sessions, with 100% reporting that they would recommend them to other caregivers of children with disabilities.

Improvement in Several Important Outcome Measures: Several outcome measures improved between baseline and endline among caregivers of children with disabilities who participated in the PP Annex sessions. Overall, the scores for the Parents' Assessment of Protective Factors (PAPF) increased between baseline and endline, demonstrating improvements in parental resilience, social support and connectedness, concrete support in times of need, and social emotional regulation. This aligns with qualitative data that highlighted perceived improvements in caregiver support from family, community, and institutions.

Additionally, some positive parenting behaviors also improved between the two time points, as measured by the Alabama Parenting Questionnaire. For example, a greater percentage of caregivers reported hugging or kissing their child when they did something well between baseline (25%) and endline (64%, $p=0.00$). These findings were supported by qualitative data that highlighted how caregivers demonstrated more affection and care for their children with disabilities.

Finally, both qualitative and quantitative data showed that caregivers were better able to manage the stress and worry associated with caring for a child with a disability. There was a 14-point decrease in the percentage of caregivers who felt "too much" or "a lot" of stress/worry about caring for their child with a disability ($p=0.00$).

Rights of the Child with Disabilities: The recognition of the rights of children with disabilities was repeatedly considered to be critical content of the PP Annex sessions. Quantitative data demonstrated high levels of the knowledge of these rights at both baseline and endline. Qualitative interviews, however, consistently indicated that the caregivers perceived improvements in their recognition of these rights. They also clearly connected the knowledge of the rights of children with disabilities with improved caregiver behaviors. For example, respondents clearly associated the recognition of these rights with increased demand for and access to health and education services.

Use of Corporal (Physical) Punishment to Manage Challenging Behavior: Through qualitative interviews, most caregivers reported decreased use of physical punishment between baseline and endline. The caregivers indicated that they grew more patient with their children and tried to remain calm when managing challenging behavior. The survey, however, did not indicate a decrease in the use of any physical punishment. While the percentage of caregivers who used spanking to manage challenging behavior decreased ($p<0.05$), other practices remained the same. At endline, over 40% reported using any corporal punishment "sometimes", "often" or "always." One-third of caregivers also agreed that beating children was an effective way to manage challenging behavior.



Child Protection: A large majority of caregivers surveyed (82%) recognized that children with disabilities were vulnerable to child protection issues, including abuse and neglect. There was a statistically significant increase between baseline and endline in the percentage of caregivers who would seek help if they suspected that a child with a disability was being abused or harmed. Nearly 91% of caregivers at endline indicated that they would seek help in the case of abuse/harm of a child with a disability. Critically, at endline, almost all caregivers (92%) knew where to go to receive help for a child protection issue. There were significant increases in the percentage of respondents who know that they could receive help from NGOs, hospitals, the Child Protection Unit and Social Welfare Officers. It is noteworthy that at endline fewer caregivers felt that “abuse of children with intellectual disabilities was not as harmful because they did not know what was happening to them”. However, over one-third (35%) still maintained that belief at endline. Similarly, at endline over a quarter (27%) of caregivers perceived that it was “impossible for children with disabilities to communicate that abuse happens to them”.

Increased Demand for and Access to Basic Services: Quantitative and qualitative data consistently demonstrated an increase in demand for and access to most basic services by caregivers of children with disabilities. Survey data showed that nearly all caregivers knew where to go to get help for their children with disabilities. The qualitative interviews highlighted increased use of health and education services for children with disabilities. Respondents associated this increase in access to their increased recognition of the rights of the child. Access to assistive devices, such as wheelchairs, was mentioned frequently as a critical service to which IFS-Zambia facilitated access. Some qualitative respondents did indicate that they had not accessed additional services, especially government services, beyond the PP Annex Sessions and other IFS-related activities.

Stigma Related to Children with Disabilities: Both quantitative and qualitative data indicated that most children are accepted and included by their families and communities. Fewer children, for example, are perceived to be “hidden” in their homes. Nearly 75% of caregivers reported that “my community includes my child” and almost 80% indicated that “my community treats my child with kindness”. However, overall affiliate stigma, affective affiliate stigma, and cognitive affiliate stigma, as measured by the FAMSII, did not change between baseline and endline. These findings allude to the possible need for additional stigma reduction activities in project communities.

Overall Programmatic Recommendations

Recommendations for internal CRS programming

Layer and sequence household economic strengthening (HES) activities and the PP Annex: Given the high levels of food insecurity and the precarious economic situations that many participants reported, HES and social cohesion programming should be layered with the PP Annex to support key parenting outcomes. More learning is needed to inform a “differentiated approach” for HES activities to meet the specific needs of caregivers of children with disabilities (e.g., cash support amount, childcare needs) and how best to layer and sequence these interventions.

Enhance PP Annex content targeting caregiver stress: While caregivers reported a decrease in the level of stress felt related to caring for a child with a disability, most caregivers still report experiencing high levels of stress. It will be important to integrate additional content into the PP Annex to support further reducing stress among caregivers.

Strengthen PP Annex content related to use of corporal punishment: While caregivers reported a decrease in the use of corporal punishment (through the qualitative interviews), almost a third of survey respondents still believed it was important to use physical punishment to raise their children. It will be important to integrate additional content into the PP Annex to support further limiting the use of corporal punishment. Additional programming at the community level to shift norms may also be needed.

Implement additional community-level activities to reduce stigma: Additional activities are needed to reduce stigma for children with disabilities and their caregivers. Most respondents indicated that their communities were welcoming to their children with disabilities. However, there was not much improvement in the measure of affiliate stigma between baseline and endline. Social behavior change activities should be started earlier to complement the PP Annex sessions and ensure that there is time to contribute to stigma reduction. A set of community-based sessions/activities and related flip book and other materials should be developed to complement the PP Annex. These community-level activities should be coordinated with the 3B4D social cohesion activities.

Strengthen referral system prior to implementation of PP Annex: To improve access to services for children with disabilities, service points and referral systems should be strengthened prior to delivering the PP Annex.

Improve accessibility of PP Annex session to people with disabilities: To make the PP Annex sessions more accessible to people with vision and hearing impairments, the curriculum materials should be printed in braille. Additionally, sign-language interpreters should be contracted as needed.

Build skills in alternative and augmentative communication: Several caregivers and volunteers indicated that they would like to improve their ability to communicate with children with disabilities who have hearing impairments. The PP Annex curriculum should be updated to include alternative and augmentative communication training for caregivers. Ensure that CRS and partner staff and volunteers are trained in alternative and augmentative communication strategies.

Research and learning needs: Additional learning/research is needed to understand the most impactful layering and sequencing of individual, group, and community-level interventions. The research should be designed prior to implementation of the intervention to ensure a more rigorous methodology.

Identify disability inclusion focal person on the project: To ensure adaptation of layered activities to promote disability inclusion and to train all project staff on programming for people with disabilities, it will be important to assign a project staff person to focus on disability inclusion activities.

Recommendations for external partners

When designing parenting training for caregivers of children with disabilities, ensure content and activities:

- Are relevant to caregivers' interests
- Include sessions on rights of the child with disabilities and specific rights in their locality and country
- Encourage caregivers to share what they are learning with other family members to improve support and engagement in the care for children with disabilities
- Provide parents with information about protection risks for children with disabilities and where they can go for support if there is a protection concern.

Projects should plan for holistic support to parenting session facilitators. Centralized training should be accompanied by supportive supervision, follow-up training, and pictorial job aids to ensure quality implementation of the parentings sessions.

Government partners should encourage all implementers to use disability-inclusive parenting training resources. They should consider updating Parenting without Violence curriculum to be disability inclusive to meet the needs of caregivers of children with disabilities. Government should leverage existing resources, including this Positive Parenting Annex for Caregivers of Children with Disabilities.

Government partners should disseminate information about the rights of children with disabilities and where parents of children with disabilities can receive services.

Annex 1: Additional Tables

A: Parents' Assessment of Protective Factors

Table A1a: Percentage of caregivers who reported that the statement was “like me” or “very like me” at baseline and endline

PAPF: PARENTAL RESILIENCE	BASELINE %(n)	ENDLINE %(n)	P-VALUE
Feels positive about being a parent	87.4(159)	93.4(170)	0.04
Takes good care of child when sad	75.7(137)	93.4(170)	0.01
Finds ways to handle problems related to child	63.0 (114)	81.3(148)	0.00
Takes good care of child even when they have personal problems	69.4 (125)	84.4(152)	0.00
Manages daily responsibilities of being a caregiver	56.7(101)	68.0(121)	0.02
Has strength to solve problems	42.1(75)	48.3(86)	0.05
Is confident that they can achieve goals	59.9(106)	83.1(147)	0.00
Take care of daily responsibilities even if problems make them sad	62.4(111)	67.4(120)	0.05
Believes that life will get better, even when bad things happen	86.4(153)	92.1(163)	0.08

Table A1b: Mean caregiver PAPF score at baseline and endline (Range: Not at all like me - 0 to Very much like me - 4)

PAPF: PARENTAL RESILIENCE	BASELINE MEAN	ENDLINE MEAN	P-VALUE
Feels positive about being a parent	3.3	3.6	0.00
Takes good care of child when sad	2.9	3.3	0.00
Finds ways to handle problems related to child	2.6	3.1	0.00
Takes good care of child even when they have personal problems	2.8	3.2	0.00
Manages daily responsibilities of being a caregiver	2.6	2.9	0.02
Has strength to solve problems	2.2	2.4	0.35
Is confident that they can achieve goals	2.6	3.1	0.00
Take care of daily responsibilities even if problems make them sad	2.6	2.8	0.03
Believes that life will get better, even when bad things happen	3.2	3.4	0.00
Overall Average Parental Resilience Score	2.8	3.1	0.00

Table A2a: Percentage of caregivers who reported that the statement was “like me” or “very like me” at baseline and endline

PAPF: SOCIAL SUPPORT AND CONNECTIONS	BASELINE %(n)	ENDLINE %(n)	P-VALUE
Has someone who helps get them get through hard times	40.9 (70)	71.4(122)	0.00
Has someone who helps them calm down when they get upset	76.0(136)	81.6(146)	0.20
Has someone who helps them calm down when they get frustrated with child	72.8(131)	76.7(138)	0.39
Has someone who encourages them	79.9(143)	83.2(149)	0.43
Has someone who they can ask for help	45.1(78)	70.5(122)	0.00
Has someone who tells them in a caring way if they need to be a better caregiver	78.7(140)	73.0(130)	0.22
Has someone who helps them feel good about themselves	77.7(139)	77.7(139)	1.00
Is willing to ask for help from their family	42.8(74)	52.6(91)	0.06
Has someone to talk about important things	72.6(127)	78.3(137)	0.20

Table A2b: Mean caregiver PAPF score at baseline and endline (Range: Not at all like me – 0 to Very much like me – 4)

PAPF: SOCIAL SUPPORT AND CONNECTIONS	BASELINE MEAN	ENDLINE MEAN	P-VALUE
Has someone who helps get them get through hard times	1.9	2.7	0.00
Has someone who helps them calm down when they get upset	2.8	3.0	0.03
Has someone who helps them calm down when they get frustrated with child	2.7	2.9	0.05
Has someone who encourages them	2.9	3.0	0.26
Has someone who they can ask for help	2.0	2.7	0.00
Has someone who tells them in a caring way if they need to be a better caregiver	2.9	2.9	0.47
Has someone who helps them feel good about themselves	2.9	2.9	0.59
Is willing to ask for help from their family	1.9	2.5	0.00
Has someone to talk with about important things	2.8	3.0	0.09
Has someone who helps get them get through hard times	2.5	2.8	0.00
Overall Average Social Support and Connections Score	2.6	2.9	0.00

Table A3a: Percentage of caregivers who reported that the statement was “like me” or “very like me” at baseline and endline

PAPF: CONCRETE SUPPORT	BASELINE %(n)	ENDLINE %(n)	P-VALUE
Does not give up when having trouble getting needed services	66.5(117)	78.4(138)	0.01
Makes an effort to learn about helpful resources in their community	76.0(136)	80.5(144)	0.32
Does not give up until they get help they need	74.2(132)	79.2(141)	0.25
Knows where to go if child needs help	55.5(91)	69.5(114)	0.01
Willing to ask for help from gov, community, NGO programs	78.1(139)	79.8(142)	0.69
Knows where to get helpful information about caring for children	81.8(144)	88.6(156)	0.07
Asking for help for their child is easy to do	70.4(121)	78.5(135)	0.08
Knows where to get help if they have trouble taking care of emergencies	48.9(85)	66.1(115)	0.00
Tries to get help for themselves when they need it	63.3(112)	76.7(135)	0.01

Table A3b: Mean caregiver PAPF score at baseline and endline (Range: Not at all like me - 0 to Very much like me - 4)

PAPF: CONCRETE SUPPORT	BASELINE MEAN	ENDLINE MEAN	P-VALUE
Does not give up when having trouble getting needed services	2.6	3.0	0.00
Makes an effort to learn about helpful resources in their community	2.9	3.2	0.02
Does not give up until they get help they need	2.8	3.1	0.00
Knows where to go if child needs help	2.2	2.9	0.00
Willing to ask for help from gov, community, NGO programs	2.9	3.1	0.02
Knows where to get helpful information about caring for children	2.9	3.2	0.02
Asking for help for their child is easy to do	2.7	3.1	0.00
Knows where to get help if they have trouble taking care of emergencies	2.1	2.7	0.00
Tries to get help for themselves when they need it	2.6	2.9	0.00
Does not give up when having trouble getting needed services	2.6	3.1	0.00
Makes an effort to learn about helpful resources in their community	2.6	3.0	0.00

Table A4a: Percentage of caregivers who reported that the statement was “like me” or “very like me” at baseline and endline

PAPF: SOCIAL EMOTIONAL	BASELINE %(n)	ENDLINE %(n)	P-VALUE
Maintains self-control when child misbehaves or does not listen	82.4(15)	87.9(160)	0.15
Helps child learn to manage frustration	90.1(164)	94.5(172)	0.12
Stays patient when child cries or gets upset	87.3(158)	89.5(162)	0.50
Plays or has conversations with child when together	92.8(168)	94.5(171)	0.49
Can control self when they get angry with their child	89.6(163)	96.7(176)	0.01
Makes sure child gets the attention they need, even when life is stressful	83.5(152)	88.5(161)	0.20
Stays calm when child misbehaves or does not listen	85.1(154)	90.6(164)	0.10
Helps child calm down when they are upset	87.4(159)	95.1(173)	0.02
Is happy when with their child	96.7 (176)	98.4(179)	0.32

Table A4b: Mean caregiver PAPF score at baseline and endline (Range: Not at all like me – 0 to Very much like me – 4)

PAPF: SOCIAL EMOTIONAL	BASELINE MEAN	ENDLINE MEAN	P-VALUE
Maintains self-control when child misbehaves or does not listen	3.0	3.4	0.00
Helps child learn to manage frustration	3.2	3.5	0.00
Stays patient when child cries or gets upset	3.2	3.4	0.00
Plays or has conversations with child when together	3.3	3.6	0.00
Can control self when they get angry with their child	3.2	3.5	0.00
Makes sure child gets the attention they need, even when life is stressful	3.1	3.3	0.02
Stays calm when child misbehaves or does not listen	3.0	3.4	0.00
Helps child calm down when they are upset	3.1	3.5	0.00
Is happy when with their child	3.5	3.7	0.00

Table A5: Mean PAPF scores between baseline and endline, by province

	COPPERBELT (n=81)			LUAPULA (n=101)			TOTAL (n=182)		
	BASELINE MEAN	ENDLINE MEAN	P-VALUE	BASELINE MEAN	ENDLINE MEAN	P-VALUE	BASELINE MEAN	ENDLINE MEAN	P-VALUE
Parental resilience	2.86	2.99	0.07	2.73	3.20	0.00	2.79	3.11	0.00
Social support and connections	2.49	2.64	0.07	2.60	3.00	0.00	2.56	2.86	0.00
Concrete support	2.40	2.95	0.00	2.80	3.15	0.00	2.64	3.06	0.00
Social-emotional	3.26	3.44	0.00	3.12	3.47	0.00	3.18	3.46	0.00
Overall PAPF	2.78	3.00	0.00	2.82	3.22	0.00	2.80	3.13	0.00

B: Family Stigma Index Sub-Scales

Table B1a: Percentage of caregivers who reported that they “agreed” or “strongly agreed with the following statements at baseline and endline statement

FAMSI: AFFECTIVE AFFILIATE STIGMA	BASELINE % (n)	ENDLINE % (n)	P-VALUE
I feel embarrassed about my child with a disability	16.7(30)	6.1(11)	0.00
I feel distressed about being associated with my child with a disability	23.9(42)	43.2(76)	0.00
I feel guilty about having my child with a disability in the family	19.0 (34)	44.7(80)	0.00
I feel uncomfortable when I have friends over because of my child with a disability	13.9(25)	13.3(24)	0.88

Table B1b: Mean caregiver PAPF score at baseline and endline (Range: Strongly disagree - 1 to Strongly agree - 5)

FAMSI: AFFECTIVE AFFILIATE STIGMA	BASELINE MEAN	ENDLINE MEAN	P-VALUE
I feel embarrassed about my child with a disability	1.9	1.5	0.00
I feel distressed about being associated with my child with a disability	2.2	2.7	0.00
I feel guilty about having my child with a disability in the family	2.1	2.8	0.00
I feel uncomfortable when I have friends over because of my child with a disability	1.9	1.7	0.02

Table B2a: Percentage of caregivers who reported that they “agreed” or “strongly agreed with the following statements at baseline and endline

FAMSI: COGNITIVE AFFILIATE STIGMA	BASELINE % (n)	ENDLINE % (n)	P-VALUE
I feel embarrassed about my child with a disability	16.7(30)	6.1(11)	0.00
I feel distressed about being associated with my child with a disability	23.9(42)	43.2(76)	0.00
I feel guilty about having my child with a disability in the family	19.0 (34)	44.7(80)	0.00
I feel uncomfortable when I have friends over because of my child with a disability	13.9(25)	13.3(24)	0.88

Table B2b: Mean caregiver PAPF score at baseline and endline (Range: Strongly disagree - 1 to Strongly agree - 5)

FAMSI: COGNITIVE AFFILIATE STIGMA	BASELINE MEAN	ENDLINE MEAN	P-VALUE
I am treated differently by some people when I am with my child with a disability	2.7	2.9	0.19
I am excluded from activities when other people find out about my child with a disability	2.5	2.7	0.25
I am aware of how some people look at me when I am out with my child with a disability	3.3	3.3	0.52
I am treated differently by some people because of my child with a disability	2.8	3.1	0.01

Table B3a: Percentage of caregivers who reported that they “agreed” or “strongly agreed” with the following statements at baseline and endline

FAMSI: BEHAVIORAL AFFILIATE STIGMA	BASELINE % (n)	ENDLINE % (n)	P-VALUE
I avoid introducing my friends to my child with a disability	7.2 (13)	4.4 (8)	0.28
I avoid telling people that I am related to my child with a disability	4.4 (8)	3.9 (7)	0.80
I avoid making new friends because of my child with a disability	10.1(18)	11.7(21)	0.60
I avoid being seen with my child with a disability	2.8 (5)	3.9 (7)	0.56

**Table B3b: Mean caregiver PAPF score at baseline and endline
(Range: Strongly disagree - 1 to Strongly agree - 5)**

FAMSI: BEHAVIORAL AFFILIATE STIGMA	BASELINE MEAN	ENDLINE MEAN	P-VALUE
I avoid introducing my friends to my child with a disability	1.7	1.5	0.00
I avoid telling people that I am related to my child with a disability	1.7	1.5	0.00
I avoid making new friends because of my child with a disability	1.9	1.8	0.12
I avoid being seen with my child with a disability	1.7	1.5	0.00

Table B4a: Percentage of caregivers who reported that they “agreed” or “strongly agreed” with the following statements at baseline and endline

FAMSI: POSITIVE ASPECTS OF CARING FOR A CHILD WITH A DISABILITY	BASELINE % (n)	ENDLINE % (n)	P-VALUE
Enabled them to develop a more positive attitude toward life	85.2(150)	91.5(161)	0.06
Made them feel needed	87.4(153)	87.4 (153)	1.00
Strengthened their spirituality and faith	95.0 (172)	96.1(174)	0.59
Allowed them to form friendships with others in a similar situation	86.4 (153)	93.8 (166)	0.02
Made them feel like they make a positive contribution to society	72.5 (29)	85.4 (152)	0.00
Strengthened their relationships with family / friends	82.9 (145)	96.0 (168)	0.00

**Table B4b: Mean caregiver PAPF score at baseline and endline
(Range: Strongly disagree - 1 to Strongly agree - 5)**

FAMSI: POSITIVE ASPECTS OF CARING FOR A CHILD WITH A DISABILITY	BASELINE MEAN	ENDLINE MEAN	P-VALUE
Enabled them to develop a more positive attitude toward life	3.9	4.4	0.00
Made them feel needed	4.0	4.2	0.07
Strengthened their spirituality and faith	4.3	4.6	0.00
Allowed them to form friendships with others in a similar situation	3.9	4.3	0.00
Made them feel like they make a positive contribution to society	3.6	4.1	0.00
Strengthened their relationships with family / friends	3.9	4.3	0.00

Table B5: Mean FAMSI scores between baseline and endline, by province

	COPPERBELT (n=81)			LUAPULA (n=101)			TOTAL (n=182)		
	BASELINE MEAN	ENDLINE MEAN	P-VALUE	BASELINE MEAN	ENDLINE MEAN	P-VALUE	BASELINE MEAN	ENDLINE MEAN	P-VALUE
Affective	1.84	2.27	0.00	2.23	2.09	0.33	2.05	2.17	0.15
Cognitive	2.66	3.13	0.00	2.98	2.84	0.34	2.84	2.96	0.25
Behavioral	1.62	1.53	0.39	1.83	1.60	0.00	1.73	1.57	0.00
Positive aspects	3.93	4.40	0.00	3.94	4.28	0.00	3.93	4.34	0.00
Overall FAMSI	2.08	2.08	0.86	2.23	2.03	0.02	2.16	2.06	0.07

C. Parenting Behaviors

Table C1: Percent distribution of caregivers who responded they “always” or “often” engaged in the positive parenting behaviors at baseline and endline, by province

	COPPERBELT			LUAPULA			TOTAL		
	BASELINE % (n)	ENDLINE % (n)	P-VALUE	BASELINE % (n)	ENDLINE % (n)	P-VALUE	BASELINE % (n)	ENDLINE % (n)	P-VALUE
Tells child when they are doing a good job at something	59.3(48)	45.7(37)	0.08	47.5(48)	42.6(43)	0.57	52.8(96)	44.0(80)	0.07
Rewards child for obeying them or behaving well	40.0(32)	60.0(80)	0.01	27.7(28)	57.5(58)	0.00	33.2(60)	58.6(106)	0.00
Compliments child when they do something well	63.0(51)	71.6(58)	0.32	40.6(41)	66.3(67)	0.00	50.6(92)	68.7(125)	0.00
Praises child if they behave well	71.6(58)	51.9(42)	0.01	46.5(47)	57.4(58)	0.17	57.7(105)	55.0(100)	0.60
Hugs or kisses child when they have done something well	33.3(27)	63.0(51)	0.00	17.8(18)	65.4(66)	0.00	24.7(45)	64.3(117)	0.00
Tells child that they like it when they help around the house	69.1(56)	22.2(18)	0.00	57.1(56)	29.6(29)	0.00	62.6(112)	26.3(47)	0.00

Table C2: Percent distribution of caregivers who responded “always”, “often” or “sometimes” engage in the corporal punishment at baseline and endline, by province

	COPPERBELT			LUAPULA			TOTAL		
	BASELINE % (n)	ENDLINE % (n)	P-VALUE	BASELINE % (n)	ENDLINE % (n)	P-VALUE	BASELINE % (n)	ENDLINE % (n)	P-VALUE
Spanks child with hand on a part of the body that is not their face, when they have done something wrong	35.4(28)	11.4(9)	0.00	44.9(44)	11.2(11)	0.00	40.7(72)	11.3(20)	0.00
Slaps child on the face when they have done something wrong	24.7(20)	34.6(28)	0.17	25.5(25)	26.5(26)	0.87	25.1(45)	30.2(54)	0.28
Hits child with a cane/belt/switch or other object when they done something wrong	37.5(30)	48.8(39)	0.10	32.0(31)	20.6(20)	0.07	34.5(61)	33.3(59)	0.81
Any of the 3 behaviors	48.7(38)	51.3(40)	0.72	49.5(47)	33.7(32)	0.03	49.1(85)	41.6(72)	0.13

Annex 2: Qualitative Interview Guide

Section 1: Demographic characteristics

101	RECORDING NAME		
102	PROVINCE	COPPERBELT	1
		LUPALA	2
		KASABA	1
		LUANSHYA	2
103	SITE	LUBWE	3
		MANSA	4
		NDOLA	5
104	CONGREGATION	SISTERS OF MERCY	1
		DOMINICAN	2
		FRANCISCAN	3
105	RESPONDENT ALSO PARTICIPATED IN SOCIAL COHESION ACTIVITIES [ASK VOLUNTEER OR SUPERVISOR]	YES	1
		NO	2
106	SEX OF PARTICIPANT	FEMALE	1
		MALE	2
107	[ASK] How old are you?	[____] [____] years	
108	What is the highest level of education that you completed?	Primary	1
		Secondary	2
		Vocational	3
		University	4
		No formal education	5
109	Thinking about your participation in the parenting group activities, would you say that you participated in all the parenting group meetings, more than half of them, half of them, less than half of them, or none of them?	All of them	5
		More than half	4
		Half	3
		Less than half	2
		None	1
		Do not know	99

Section 2: Opening Questions

201. Please tell me about your experience participating in the CRS positive parenting group for caregivers of children with disabilities.

A. What did you enjoy most about participating in the groups?

202. Would you recommend the positive parenting group to other caregivers of children with disabilities?

Probe: IF YES: Why would you recommend it to other caregivers of children with disabilities?

IF NO, Why would you NOT recommend it to other caregivers of children with disabilities?

Section 3: Participation in the Inclusive Parenting Groups for Caregivers of Children with Disabilities

301. What made it possible for you to participate in the inclusive parenting group meetings?

Probe: [If not mentioned, ask about the following factors:]

What about:

- Location of the meetings,
- Support or encouragement from family members
- Support encouragement from friends or neighbors
- Somebody to watch your children
- Length of the meetings,
- Time of day when meetings are held

302. What made it difficult for you or others to participate in the inclusive parenting group meetings?

Probe: [If not mentioned, ask about the following factors]

What about:

- Location of the meetings,
- Lack of support or encouragement from other family members
- Lack of support encouragement from friends or neighbors
- Length of the meetings,
- Time of day when meetings are held,
- Being too busy (if yes, ask what else are they doing)
- Too many other project activities

Section 4: Changes in Knowledge, Attitudes, Practices

401. Please describe the most important change for you, your child with a disability, and/or your family that has resulted from your participation in the positive parenting sessions for caregivers of children with disabilities.

Probe:

- What is different now compared to before this important change?

402. How, if at all, did the positive parenting sessions for caregivers of children with disabilities contribute to this change?

403. What information or skills that you learned in the positive parenting sessions for caregivers of children with disabilities have been most important to you?

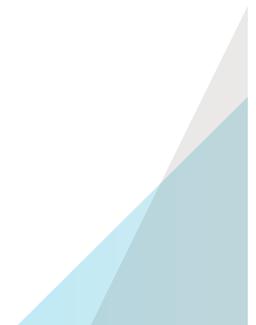
Probe: [For each type of information or skill mentioned:]

What's an example of when you have used that information or skill in your daily life?

[After they provide an example, ask:] Is there any other important information or skills that you learned in the CRS parenting program?

404. Several different topics were covered in the CRS Parenting Program. How useful were the following topics to you and your family? [READ EACH TOPIC]

<p style="text-align: center;">TOPIC</p>	<p style="text-align: center;">WAS IT? VERY USEFUL (2) SOMEWHAT USEFUL (1) NOT AT ALL USEFUL (0) DO NOT REMEMBER TOPIC (99)</p>	<p style="text-align: center;">(IF THEY ANSWER “VERY USEFUL” OR “SOMEWHAT USEFUL”, ASK: WHAT ABOUT IT HAS BEEN USEFUL?)</p>
Knowing the rights of children with disabilities		
Communicating with your child with a disability		
Obtaining support in your family and community to care for your child with a disability		
Managing your own stress and worry		
Identifying abuse and harm among children with disabilities and ways to keep them safe		
Promoting the health and development of young children with disabilities (children under 5 years old)		
Managing challenging behavior of your child with a disability		
Supporting your child with a disability to do things more independently		
Including children with disabilities in family and community activities		
Supporting older children with disabilities in livelihood activities		



[READ] Caring for a child with a disability can be challenging. I would like to ask you a few questions about how you care for your child with a disability.

405. Since you began participating in the positive parenting sessions for caregivers of children with disabilities, what services have you sought for your child with a disability?

Probe: [For each service mentioned, ask:]

- What prompted or made you seek this service?
- How difficult was it for you to obtain this service?
- Had you sought those services before participating in the parenting program?
- Are there any other services you sought?

[If they are not mentioned, ask if they received:]

- Health, nutrition, or education services for their child with a disability,
- Sought a disability certificate,
- Sought cash support

406. Since you began participating in the CRS Inclusive Parenting Groups, have you sought support from people you know to help care for your child with a disability?

Probe: [If yes, ask:]

- From whom did you seek support? Other parenting group members, family, friends or neighbors, other community members?
- What kind of support were you seeking?
- Did you seek support from anyone else?

407. Managing the behaviour of children, including children with disabilities, can be challenging for caregivers. Share with me how you manage the behaviour of [NAME OF CHILD WITH DISABILITIES]?

Probe:

- Tell me an example of when you had to manage [NAME'S] challenging behaviour.
- What did you do?
- Since you began participating in the positive parenting sessions for caregivers of children with disabilities, how, if at all, has your ability to deal with [NAME'S] challenging behavior changed?
- To what extent do you use physical punishment to manage [NAME'S] behavior, for example hitting him or her?

408. What rights do children with disabilities have?

Probe: [Ask about these specific rights if they do not mention it:]

- Right to an education
- Right to health care
- Right to live free from discrimination
- Right to register with the government as a person with a disability

A. What is the role of the parent or caregiver in ensuring the rights of children with disabilities are upheld?

409. People experience different levels of isolation and loneliness. How often do you feel isolated or lonely?

Probe:

- Has this stayed the same, gotten better or gotten worse in the last year? Why?
- What do you typically do when you feel isolated or lonely?

Section 5: Suggestions for Improvement

[Read]: Now I would like to learn from you about how we can improve the positive parenting sessions for caregivers of children with disabilities. We appreciate your open feedback about the project activities.

501. Thinking back over the positive parenting sessions for caregivers of children with disabilities, what did you like least about them?

Probe:

[For each area of improvement, ask:] How would you improve it?

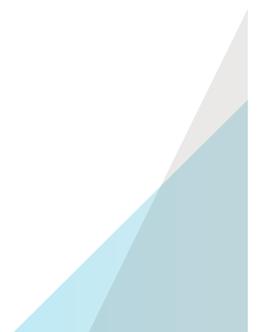
[Then ask:] Is there anything else that could be improved?

502. What suggestions do you have to improve the CRS Parenting Program?

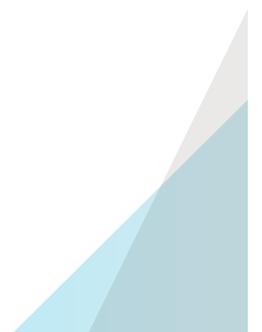














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