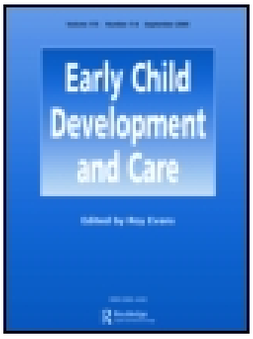

Routledge
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Early Child Development and Care

ISSN: 0300-4430 (Print) 1476-8275 (Online) Journal homepage: http://www.tandfonline.com/loi/gecd20

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To cite this article: Jane Leer & Florencia Lopez-Boo (2018): Assessing the quality of home visit parenting programs in Latin America and the Caribbean, Early Child Development and Care, DOI: 10.1080/03004430.2018.1443922

To link to this article: https://doi.org/10.1080/03004430.2018.1443922

Published online: 14 Mar 2018.

EARLY CHILD DEVELOPMENT AND CARE, 2018
https://doi.org/10.1080/03004430.2018.1443922

Assessing the quality of home visit parenting programs in Latin America and the Caribbean

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ABSTRACT
Home-visit parenting programmes have been linked to positive developmental outcomes among participating children, yet few studies have explored the mechanisms behind this impact. We observe 40 home visits across seven countries in Latin America and the Caribbean, using an observational tool to assess visit content, coaching strategy, and the quality of the relationship between the home visitor (HV) and families. Across nearly all visits observed, we find strong rapport between visitors and families, and active participation in play-based learning activities introduced by the HV. Other aspects of home visit design are weakly implemented, namely the revision of topics from previous sessions, demonstration of activities, and dialogue between caregiver and HV. The visits observed provide an opportunity for caregivers to practice early stimulation activities, but it is unclear whether this strategy contributes to strengthening caregivers' knowledge of child development.

ARTICLE HISTORY
Received 14 January 2018
Accepted 19 February 2018

KEYWORDS
Home visits; parenting programmes; implementation quality; fidelity; Latin America and the Caribbean

Introduction

A diverse body of research demonstrates that the first few years of life have a long-lasting impact on future wellbeing. However, many families' capacity to provide the care, nutrition and stimulation that young children need is limited due to a lack of access to quality health and social services, low levels of parental education, and a limited understanding of caregivers' roles in early childhood development, among other socio-economic and environmental factors (Engle et al., 2007; Grantham-McGregor et al., 2007; Richter et al., 2017; Schady et al., 2015). In the face of these barriers, targeted investments in early childhood development are increasingly recognized as a necessary strategy to ensure that all children develop to their full potential (Berlinski & Schady, 2015).

Home visit parenting programmes are one promising strategy. The objective of these programmes is to provide caregivers the information and skills necessary to promote their children's healthy development and learning through a series of home visits provided by trained professionals or para-professionals. Experimental and quasi-experimental impact evaluations of these programmes have found positive impacts on health, developmental, behavioural and education outcomes across multiple contexts, particularly among the most vulnerable families (see Chapter 3 in Berlinski & Schady, 2015, for a full description of the evidence from Latin America and the Caribbean).

Despite the growing evidence linking home visits to positive child development outcomes, little is known about the causal mechanisms that drive this relation. Few studies have explored to what extent programme curricula is implemented as intended, how visitors deliver programme messages, and the quality of the relationship between visitors and families.

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This study presents a snapshot of the quality of home visits in seven parenting programmes implemented at the municipal, regional or national level in Latin America and the Caribbean (LAC). We define 'home visit quality' following Paulsell, Boller, Hallgren, and Mraz Esposito (2010) and Schodt, Parr, Araujo, and Rubio-Codina (2015) in terms of the *structural* (content and dosage) and *process*-(relationship between visitor and family) variables that characterize a home visit. These domains are what the literature identifies as the critical elements of a high-quality home visit. High quality home visits, in turn, are those with higher likelihood to have an impact on parenting practices and child development outcomes, although that analysis is not the objective of this study.

Using an observational checklist tool, we find strong rapport between visitors and families, and active participation in play-based activities demonstrated by visitors. However, other aspects of home visit design are weakly implemented, in particular the revision of topics from previous sessions, demonstration of activities by the home visitor (HV), and dialogue between caregiver and HV around the purpose of home visit activities in relation to child development.

Given our small sample size and the fact that participating HVs and families were not selected randomly, our results are not representative of the programmes included. Rather, our main contribution is to provide unique insight into what home visits look like in practice, in terms of visit content, processes and relationships, using comparable data from seven programmes in LAC.

Review of evidence-based home visit programmes

Globally, the evidence base for home visit parenting programmes is concentrated in the high income countries. In Australia, France, and the United States, for example, home visits are one part of an intersectoral approach to prevent early childhood violence, abuse and neglect (see Evans, Honig, and Garner (2014) for a conceptual framework and global review of interventions and policy).

The best known home visit programme in the US is the Nurse-Family Partnership, a free programme that provides regular home visits to poor first-time mothers from pregnancy until their child is about two years old (Olds, 2006). Several impact evaluations have found positive effects on multiple maternal health outcomes (Kitzman et al., 1997; Kitzman, 2004; Olds, Henderson, & Kitzman, 1994; Olds, Henderson, Tatelbaum, & Chamberlin, 1986), and child development outcomes, including fewer hospital visits in the first two years of life, improved cognitive functioning, and fewer behavioural problems (Kitzman et al., 2010).

In LAC, parenting programmes have focused mainly (though not exclusively) on early cognitive stimulation and nutrition. One of the most influential studies of a home visit programme from a low-income country context comes from Kingston, Jamaica. In this programme, trained community health aides delivered weekly home visits to demonstrate psychosocial stimulation activities to caregivers of children aged 9 to 24 month. Paticipants were selected based on their malnutrition status (among other factors). Grantham-McGregor, Powell, Walker, and Himes (1991) found a significant effect of 0.8 standard deviations (SD) on children's cognitive development after 24 months of regular home visits. After 11 years, the cognitive scores of treated children in comparison to the control group was 0.4 SD higher. Remarkably, 20 years after the end of the pilot, treated youth had a higher IQ and educational attainment, better mental health, less violent behaviour, and about 25% higher earnings than the control group (Gertler et al., 2014; Walker, Chang, Vera-Hernández, & Grantham-McGregor, 2011).

A number of additional small-scale studies of home visiting programmes in Jamaica (Gardner, Walker, Powell, & Grantham-McGregor, 2003; Powell & Grantham-McGregor, 1989) also found positive impacts on child development, although the magnitude of the effect appears to fall sharply as the frequency of the home visits was reduced. Positive effects of home visits on maternal and child outocmes have also been reported in Brazil (Eickmann et al., 2003), Chile (Lozoff et al., 2010), and Ecuador (Rosero & Oosterbeek, 2011).

One benefit of home-visit programmes is that they are relatively low-cost interventions compared to other types of early childhood interventions, mainly because they do not require infrastructure

investments, such as school or centre buildings. For this reason, home visit parenting programmes and other non-centre-based programmes may be one of the most promising ways to achieve Sustainable Development Goal #4 (*By 2030, ensure that all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education*) (Baker-Henningham & López Bóo, 2010; Save the Children, 2017).

Exploring the quality of home visit parenting programmes

In order to expand existing home visit parenting programmes and bring them to new contexts, it is first necessary to understand what it is that explains their impact. Policy makers need to be able to replicate the success of pilot programmes while keeping costs reasonable. This includes, for example, knowing which elements of programme design must be kept in place in order to maintain quality, and which elements can be modified. To do so requires an understanding of how visits operate in practice, including the specific strategies used by HVs, the content delivered, and the interactions between caregivers, children and HVs. Likewise, for implementing agencies, data on the quality of home visit implementation are critical for ongoing programme improvement and staff training and supervision.

One challenge in systematically measuring the quality of home visits stems from the fact that there is no universal consensus of what constitutes quality. The definition of quality depends on the context and programme design. Home visit content and curricula, the frequency and duration of visits, the qualifications, training and motivation (remuneration) for HVs, and programme beneficiary characteristics vary widely between programmes, as do implementation costs and institutional operating structures.

Thus, rather than defining a standard set of quality benchmarks that programmes must adhere to, the extant literature hypothesizes three dimensions of quality: dosage (the frequency and duration of visits), content (including both the topics covered and the coaching strategies visitors use to deliver content), and relationships (interactions between visitors and families) (Paulsell, Avellar, Martin, & Del Grosso, 2010).

Documentation of these elements of quality – dosage, content, and interactions between visitors and families – is limited. A 2007 study of two home visit programmes in the US, Early Head Start (EHS) and Part C, is one notable exception (Peterson, Luze, Eshbaugh, Jeon, & Kantz, 2007). In this study, trained observers used the Home Visit Observation Form and the Home Visit Observation Form Revised to document the nature and content of interactions between HVs, caregivers and children. Results show that Part C home-visitors spend more than 50% of the visit teaching the child directly, and less than one percent of the time modelling parent–child activities. In contrast, EHS home-visitors spend most of the visit talking with the caregiver about family-related issues and various child development topics, and devoted less than a fifth of the visit to coaching caregiver-child interactions.

These findings are not consistent with the stated objectives of both programmes to strengthen caregivers' skills to support their child's development and enable positive parent–child learning interactions. Moreover, findings from a measure of caregivers' engagement during the visit suggests that caregivers are more likely to initiate conversations about child development and visit content, and to display interest and enjoyment if HVs use coaching strategies, rather than simply having a conversation with the caregiver or interacting with the child directly.

A more recent study of the EHS programme found similar results. Vogel et al. (2015) found that EHS home visits scored between 3 and 4 in the Home Visit Rating Scale Visitors facilitate caregiver-child interactions and coach caregivers only some of the time, and much of the visit is spent teaching the child or providing caregiver mentoring on miscellaneous topics (Vogel et al., 2015).

To our knowledge there is only study from the LAC context that includes mention of home visit programmatic quality. Walker, Baker-Henningham, Chang, Lopez Boo, and Powell (2017) report on the quality of home visits in a randomized controlled trial of a home visit programme and a health centre based parenting programme in Jamaica. The researchers used an observation tool to

assess the HV's ability to demonstrate activities, and the visitor's relationship with the caregiver and child. In all 200 visits observed, all items were rated as 'good,' or 'adequate,' except for two: encouraging the caregiver to talk about visit activities and praising the caregiver. Our study complements this work by including home visit programmes from a total of seven countries in LAC, and exploring the content, coaching mechanisms, and relationship between caregivers and HVs.

Part of the challenge in measuring home visit quality of implementation has to do with measurement. Dosage and content are structural elements, meaning they can be relatively objectively and easily measured through administrative logs or checklists designed to record the frequency, number and duration of visits, the topics covered, and the activities implemented. Assessing relationship quality is more challenging (López Bóo, Araujo, & Tomé, 2016). However, the caregiver and HV relationship is perhaps the most important aspect of home visit programmes, given that the theory of change for home visits is based on the ability of HVs to effectively empower caregivers to adopt new parenting knowledge, attitudes and practices.

All three elements of quality can be measured by self-report (from caregivers or HVs themselves), but measures of the quality of HV/caregiver relationships are especially subject to self-report bias. Observation-based measures implemented by trained enumerators are therefore preferred (Schodt et al., 2015).

The elements of home visit quality that are the focus of this study are (1) content (including the coaching strategy) and (2) relationship quality. Note that content here refers not to the specific activity or curriculum used, given heterogeneity across programmes. Rather, content refers to the type of activity, for example demonstration by HV, explanation, revision of activities from previous visits, or HV-caregiver dialogue.

Theoretical framework

We use Bronfenbrenner's bioecological model of human development (1974, 1986, 2005) to explain the theory of change underpinning home visit parenting programmes. Home visits are designed to affect the quality of the microsystem – specifically, parent–child interactions – the innermost layer of Bronfenbrenner's model. They do so through providing social support services, in the form of home visits. The assumption is that HVs will provide parents (or other caregivers) the skills, knowledge, and motivation necessary to improve their parenting skills. In turn, this will result in more responsive, sensitive, warm, and stimulating parent–child interactions, and consequently, improved child development outcomes (Peterson et al., 2007).

In exploring the quality of home visits, we focus on the first link in the causal chain: the transfer of knowledge and skills from the HV to the caregiver vis-à-vis explanation, dialogue, demonstration and practice of early stimulation activities during the home visit. The research questions guiding our study are, (1) What kinds of content and coaching strategies are employed in seven home visit parenting parents across LAC? (2) What is the nature of the relationship between the HV, caregivers and child?

Methods

Our primary objective is to contribute to unpacking the 'black box' linking home visit parenting programmes to child outcomes. We use an observational tool to provide a snapshot of the quality of home visits in seven countries in which home visit programmes reach a considerable number of children: Bolivia, Brazil, Ecuador, Jamaica, Nicaragua, Panama, and Peru.

Sample

Our sample consists of seven parenting programmes selected because they are among the only large-scale public parenting programmes in the LAC region. These include three national programmes: Cuna Más in Peru, Creciendo con Nuestros Hijos (CNH) in Ecuador and Programa de

Acompañamiento a la Política de Primera Infancia (PAIPPI) in Nicaragua, and three regional programmes: Programa Primeira Infancia Melhor (PIM) in Rio Grande do Sul (Brazil), the Home Visits Programme in Kingston and Saint Andrews, Jamaica, and Atención Integral de la Niñez con Participación Comunitaria (AIN-C) in Panama. We also include one programme implemented at the municipal level by the NGO Consejo de Salud Rural Andino (CSRA) in El Alto, Bolivia.

Five of the seven programmes focus primarily on language, socioemotional and motor development (the Jamaican Home Visit Programme, PIM, Cuna Más, PAIPPI and CNH), and are referred to as *child development programmes* from here on. Some of the child development programmes also include preventing maltreatment (PAIPPI) or sanitation practices (Cuna Más). Child development programmes are a relatively recent initiative in the LAC region, and are not universal.

Two of the programmes (Bolivia and Panama) are *nutrition programmes*, and focus on healthy feeding practices for expecting mothers and young children. In this sense, we take a more comprehensive view of parenting programmes than developmental science, which has typically classified parenting programmes only as those that focus on parent–child interactions for cognitive and socio-emotional development outcomes (e.g. child development programmes), not health and nutrition (Engle et al., 2007; Richter et al., 2017; Walker et al., 2011). Nutrition programmes have a longer history in LAC, in response to high rates of malnutrition, and exist in almost all countries in the region. HVs in nutrition programmes typically provide caregivers with visual material to provide nutrition and feeding guidelines, and visits often includes weighing the child to check for undernutrition and monitor growth.

All seven programmes included in this study are designed to target the most vulnerable population groups in the countries or regions where they operate, although targeting methods vary. Programme participation ranges from about 350,000 children (CNH in Ecuador) to 40,000 children (Cuna Más in Peru), and to 1,000 (CSRA in El Alto, Bolivia). Programme costs vary too, reflecting differences in substantive operational aspects such as staff profile and the frequency of the home visits. For example, while most programmes offer a modest stipend to HVs, CNH and PIM pay HVs a minimum wage. A more detailed overview of the seven programmes included in this study can be found in an Inter-American Development Bank technical note by the authors (Leer, López Bóo, Perez Expósito, & Powell, 2016).

Between May and August 2014, a researcher trained in the application of the Home Visit Checklist observed a total of 40 home visits across all seven programmes (at least five visits and between two to six unique HVs per programme, see Tables 1 and 2 for details).

Procedures

The instrument used in this study is based on a checklist developed by the University of the West Indies (UWI) to provide constructive feedback to HVs from parenting programmes in Jamaica, Bangladesh and Colombia. The original checklist was revised and adapted by the authors for this study, in collaboration with researchers at UWI who have been closely involved with the design

Table 1. Child development parenting programmes visits observed[a].

	Number of visits observed				
	Total	Girl child	Boy child	Duration of visits in minutes (average)	Child's age in months (average)
Jamaica-HV	6	5	1	43	26.5
Brazil-PIM	5	2	3	46	16.6
Peru-Cuna Más	7	6	1	56	25.5
Nicaragua- PAIPPI	6	5	1	45	21.5
Ecuador-CNH	5	1	4	40	16.2

[a]In all of the visits observed the caregiver who participated in the visit was the child's mother, except for in Peru where one visit was conducted with the child's grandmother, who was the child's primary caregiver. There were 2 visits in Peru and 1 in Nicaragua in which both the mother and father participated.

Table 2. Nutrition programmes visits observed[a].

	Number of visits observed					
	Total	Girls	Boys	Expecting mother	Duration of visit in minutes (average)	Child's age in months (averages)
Bolivia – CSRA	6	3	2	1	41	8.4
Panama – AIN-C	5	3	2	0	18	9.4

[a]In all visits observed the primary caregiver who participated in the visit was the child's mother. In two of the visits observed in Bolivia only the mother participated, in one case this was because the child was sleeping at the time of the visit, and in the second case the visit was conducted with an expecting mother.

and implementation of the influential (and well evaluated) Jamaican home-visit programme. The checklist consists of 31 items, covering the following topics:

(1) Basic information: date, location, duration of visit, child's age, child's sex, who the child's primary caregiver is
(2) Visit description: who participated (child, primary caregiver, other adults/children present)
(3) Review of last visit: whether or not the HV checks about play sessions between visits, caregiver demonstrates activities practiced.
(4) Activities and methods: appropriate use of programme manual, explanation and demonstration of activities for caregiver & child, participation (review and feedback).
(5) Relationship HV/caregiver: how well HV listens, responds, encourages, and gives positive/constructive feedback to HV, quality of the overall relationship between HV and caregiver.
(6) Relationship HV/child: how well HV responds and encourages child, time given to complete visit activities, overall relationship between HV and child.
(7) Overall visit participation & environment: whether or not child and caregiver actively participate, HV's effort to promote participation, overall atmosphere

The instrument also assesses how well the HV seems to have prepared for the visit and whether or not the materials and activities used are age appropriate. For child development programmes, we also include a measure of the extent to which the HV promotes language development throughout the visit, given that language development is one of the most important predictors for school readiness and also one of the areas in which socioeconomic achievement gaps are largest in LAC (Schady et al., 2015). Each item is scored on a four point Likert scale.

All items are designed to reflect the theory of change of home visit parenting programmes across the region, emphasizing the quality of the interactions, rather than evaluating the specific curricular content (e.g. games or activities used) or the timing of activities.

For the nutrition programmes, the Home Visit Checklist was modified to focus on the quality of the nutrition and feeding practices discussed. Checklist items referring to the games and activities implemented during the visit and the quality of the relationship between the HV and the child were not included in the nutrition checklist, since the nutrition programmes are directed at the mother/primary caregiver, and do not include activities for the child.

All observations were conducted by one trained researcher (*first author's last name here*). To minimize interruption and ensure that HVs and families conducted as 'natural' a visit as possible, the researcher filled out the checklist in private immediately after each visit concluded, rather than during the visit itself. Inter-rater reliability data were collected for a sub-sample of seven visits in which two trained researchers simultaneously observed. Percent agreement for these visits was between 70% and 90%.

Limitations

The main limitation of this study is the small sample size (40 visits total, five to seven per programme), and the fact that the HVs and families included in the study sample were selected by programme

coordinators. The sample is therefore not representative of the overall quality of home visits in each programme. Furthermore, the programmes are highly heterogeneous in terms of the number of years/months of implementation, coverage, and structure, making cross-programme comparisons problematic. Considering these limitations, this study is not intended to provide a ranking of programme quality between programmes. Rather, we provide a 'snapshot' of home visit quality in prominent parenting programmes in LAC.

Second, despite all efforts to ensure that HVs and families were comfortable with the research study, the presence of the researcher inevitably means that the visits were not necessarily natural. This may have reduced visit quality, if HVs or caregivers were reluctant to fully engage in conversation and activities in the presence of the researcher. On the other hand, the presence of the researcher may have inspired HVs to demonstrate their skills and understanding of home visit methodology, leading to better than average home visits.

Results

Consistent with our objective of providing a snap-shot of the quality of home visits across LAC, rather than comparing between programmes, we present results at an aggregate level, first for the five child development programmes and second for the nutrition programmes

Child development programmes

Table 3 presents the distribution of scores per item for the child development programmes. What stands out as one of the main strengths in the visits observed is the positive relationship between HVs, caregivers and children. Children eagerly await the visit activities, and it is clear that the HV is a welcomed and respected guest in the home. As a general rule, HVs are patient, warm and supportive. They praise and encourage the child throughout the visit, and (as is appropriate) offer the caregiver and child the opportunity to practice learning activities together, rather than dominating the activities. HVs also do a good job of selecting age-appropriate activities.

The following aspects of programme design are weakly implemented, or largely absent, in the visits observed: revision of content and activities from previous visits, emphasis on language development, explanation of the developmental objective of the activities to the caregiver, and demonstration of the activities.

Regarding the first, the objective of home visit programmes is to reinforce behaviours by encouraging caregivers to practice the activities with their children in between visits. Thus, by design, the home visit curricula of the five child development programmes observed includes time during each session for caregivers to describe and demonstrate the activities she or he did with the child throughout the week. However, less than half of the visitors observed devote appropriate time to reviewing the past week's activities verbally, and less than a third encourage the caregiver to demonstrate with the child the activities they had practiced since last visit.

In terms of language development, most visitors mention the importance of reading or looking at books with the child and naming objects in the household, but just half of the visitors observed explain the developmental basis of the activities for the caregiver (for example, explaining that the reason it is important to name objects in the household is so that the child can develop his or her vocabulary). Only one third of observed visitors emphasized language development throughout the visit, and one quarter of the visitors adequately demonstrated activities to the child. Most visitors described the activity and then had the caregiver do the activity with the child, rather than demonstrating first.

Finally, although the relationship between HVs and caregivers is positive overall, the delivery strategies used do not necessarily follow the teaching or coaching model central to the home visit theory of change. For example, the majority of visitors ask caregivers if they have any questions at least once or twice throughout the visit, but this rarely results in meaningful discussion. Most caregivers respond

Table 3. Child development programmes: Score distribution per item[a].

Description of activity		Overall score distribution			
1. Review of activities done since last visit					
	N	Not observed	Inadequate	Adequate	Good
HV asks caregiver about play sessions between visits	24	13.8%	3.5%	20.7%	44.8%
HV asks caregiver to demonstrate w/child the activities practiced during the previous week	24	27.6%	6.9%	17.2%	31.0%
2. Activities and methods: teaching					
	N	Not observed	Inadequate	Adequate	Good
HV uses the programme educational material appropriately (manual/booklet)	17	3.5%	6.9%	31.0%	17.2%
HV prepared for the visit in advance	29	10.3%	10.3%	10.3%	69%
HV demonstrates age-appropriate activities and materials	29	3.5%	3.5%	17.2%	75.8%
HV emphasizes language development throughout the visit	29	13.8%	13.8%	37.9%	34.5%
3. Activities and methods: explanation and demonstration					
	N	Not observed	Inadequate	Adequate	Good
HV's verbal explanation of activities to the caregiver	27	14.8%	18.5%	14.8%	51.8%
HV's demonstration of activities to the caregiver	29	10.3%	3.5%	24.1%	62.1%
HV's verbal explanation of activities to the child	29	6.9%	6.9%	48.3%	37.9%
HV's demonstration of activities to the child	29	6.9%	10.3%	55.2%	27.6%
4. Activities and methods: participation					
	N	Not observed	Inadequate	Adequate	Good
HV asks caregiver to practice activities with child	29	3.5%	6.9%	20.7%	69%
HV reviews activities with caregiver at the end of the visit and agrees on which activities caregiver should practice before the next visit	29	6.9%	13.8%	20.7%	58.6%
5. Relationship between HV and caregiver					
	N	Never	Almost never	Some of the time	Most of the time
HV listens to caregiver	29	0%	0%	10.3%	89.7%
HV is responsive to caregiver	29	0%	3.5%	20.7%	75.9%
HV asks caregiver's opinion /asked for questions throughout the visit	29	10.3%	20.7%	31%	37.9%
HV encourages and positively reinforces the caregiver	29	3.5%	24.1%	34.5%	37.9%
Overall relationship between HV and caregiver is warm and positive	29	0%	3.5%	6.9%	89.7%
6. Relationship between HV and child					
	N	Never	Almost never	Some of the time	Most of the time
HV listens to child and responds to his/her vocalizations/ gestures	29	0%	6.9%	13.8%	79.3%
HV praises child when he/she attempts or completes an activity	29	0%	6.9%	24.1%	69%
HV talks about the activities the child does throughout the visit, or talks to the child while the child does the activities	29	10.3%	27.6%	20.7%	41.8%
HV gives the child enough time to explore materials and complete activities	29	3.5%	3.5%	13.8%	79.3%
Overall relationship between HV and child is warm and supportive	29	0%	6.9%	3.5%	89.7%
7. Overall participation and atmosphere					
	N	Never	Almost never	Some of the time	Most of the time
Child actively participates	29	0%	10%	6.9%	82.8%
Caregiver actively participates	29	0%	10.3%	37.9%	51.7%
HV makes a significant effort to encourage participation	29	10.3%	0%	34.5%	55.2%
		Uncom-fortable	Neutral	Happy/ com-fortable	Very happy
Overall atmosphere of the visit	29	3.5%	3.5%	69%	24.1%

[a]Table does not include 'not-applicable' thus not all rows add up to 100%, and N varies by item.

'no' when asked if they have any questions, and visitors rarely encourage further dialogue around child development or parenting practices. Likewise, only a third of observed visitors provide positive reinforcement or feedback to the caregivers. This means that the visits are generally centred around the activities, with frequent praise for the child, but limited dialogue between the caregiver and visitor.

Scores by item for the child development programmes are illustrated in Figure 1. To calculate the score for each item, a value was assigned to each possible answer, such that: Non-existent/Never = 1, Inadequate/Almost never = 2, Adequate/Some of the time = 3, Good/ Most of the time = 4. Thus,

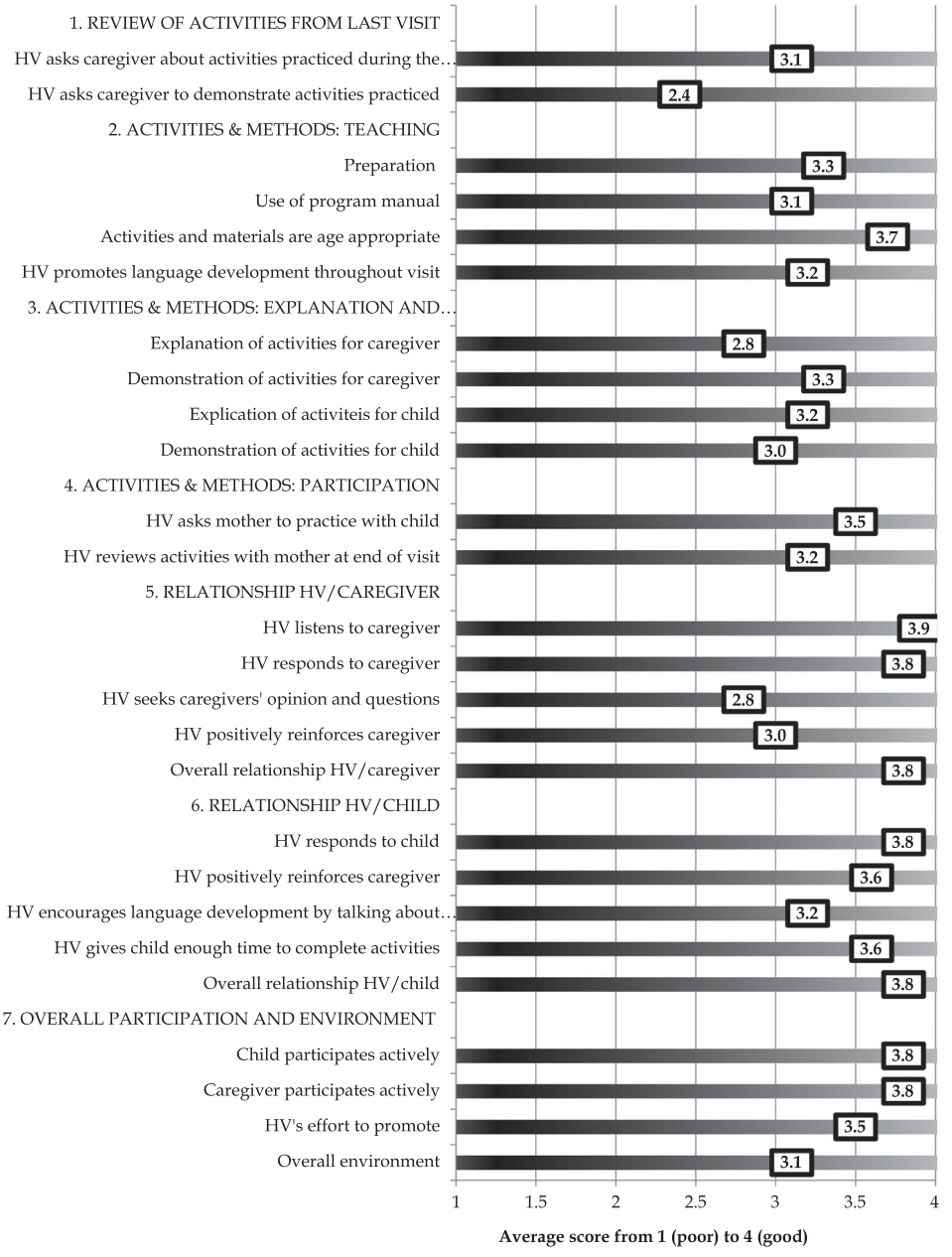

Figure 1. Child development programmes: Average score per item.

scores for each item range from 1 to 4 with 1 being an exceptionally poor performance and 4 being a very good performance. Scores for the child development programmes range from 2.4 to 3.9, with an average score of 3.4, or 'adequate.' Several items are below the 'adequate' threshold: demonstration of activities (2.4), HV's explanation of activities for caregiver (2.8), and HV seeks caregiver's opinion and questions throughout the visit (2.8).

Nutrition programmes

Table 4 describes the distribution of scores per item for both of the nutrition programmes. As in the child development programmes, the warm, respectful relationship between the HVs and families is one of the main strengths observed. A second strength is the use of programme materials. In the CRSA programme in Bolivia, HVs put on interactive puppet shows for caregivers and reinforce the behaviour change messages through the use of poster boards and pictures. In AIN-C in Panama, HVs use storyboard printouts with images and a few words to discuss feeding practices with the caregiver, for example by asking caregivers to point at the image(s) that represent a feeding practice she has done in the past week.

A third strength is that visitors consistently reinforce the content covered. Visitors were consistently asked the participating caregiver to review the nutrition or feeding practices she plans to implement in the following week.

Table 4. Nutrition programmes: Score distribution per item[a].

Description of activity		Overall score distribution			
1. Review of activities done since last visit					
	N	Not observed	Inadequate	Adequate	Good
HV followed up with caregiver about feeding practice discussed during the previous visit	10	45.5%	9.1%	27.3%	9.1%
2. Activities and methods: teaching and participation					
	N	None/ not at all	Inadequate	Adequate	Good
HV prepared for the visit	11	9.1%	0%	63.6%	27.3%
HV used the programme educational material appropriately (manual/booklet/information sheets)	11	0%	9.1%	45.5%	45.5%
HV provided strong explanations and motivations for healthy feeding practices	11	18.2%	9.1%	9.1%	63.7%
HV reviewed feeding practices with caregiver at end of visit and agreed on which practices caregiver would focus on between visits	11	9.1%	0%	18.2%	72.7%
Topics discussed were age appropriate	11	0%	0%	0%	100%
3. Relationship between HV and caregiver					
	N	Never	Almost never	Some of the time	Most of the time
HV listened to caregiver	11	0%	0%	18.2%	81.8%
HV was responsive to caregiver	11	0%	18.2%	9.1%	72.7%
HV asked caregiver's opinion /asked for questions throughout the visit	11	9.1%	0%	54.6%	36.4%
HV encouraged and positively reinforced the caregiver	11	18.2%	18.8%	9.1%	54.6%
Overall relationship between HV and caregiver was warm and supportive	11	9.1%	0%	18.2%	72.7%
4. Overall participation and atmosphere					
	N	Never	Almost never	Some of the time	Most of the time
Caregiver actively participates	11	0%	18.2%	18.2%	63.6%
HV makes a significant effort to encourage participation	11	0%	18.2%	36.4%	45.5%
Overall atmosphere of the visit		Uncomfortable	Neutral	Happy/ comfortable	Very happy
	11	0%	18.2%	81.8%	0%

[a]Table does not include 'not-applicable' thus not all rows add up to 100%, and N varies by item.

The following aspects of implementation are weak or absent in the observed visits: First, similar to the child development visits, the nutrition visits observed rarely include an opportunity for the caregiver to review activities or topics from previous visits. In the visits observed, HVs begin with a general discussion about whether or not the child has been nursing or eating well and questions about the family's overall health, but rarely ask whether or not the caregiver has put into practice the feeding practices discussed in the previous visit.

Second – also similar to the child development visits – visitors in the nutrition programmes do little to encourage caregivers to voice their concerns or questions about feeding and nutrition. At the end of each visit, for example, the HV helps caregivers select which improved feeding practices she will implement in the coming week, but the conversation ends there. There is rarely any discussion about the challenges caregivers may face in adopting these behaviours, and potential solutions (Figure 2).

Scores for the nutrition programmes range from 2 (inadequate/almost never) to 4 (good/almost always), with an average of 3.3 across items. As in the child development home visits observed, the highest scores are those for items having to do with the relationship between the HV and caregiver and the use of age-appropriate activities. The lowest scores are those related to the quality of the explanation given and dialogue between caregiver and HV – including revision of topics from previous sessions, questions, feedback, and positive reinforcement.

Discussion

Using a unique dataset, we provide a snapshot of seven prominent home visit programmes in LAC. We find that HVs are generally successful at establishing strong rapport with families, covering age appropriate activities, and involving the child and caregiver in activities such as songs, dances, and games. Nutrition programme HVs are especially good at using programme material (puppets, story boards) to convey nutrition and feeding messages.

However, in many visits some or all of the required material is missing, and there is only a limited emphasis on language development (in the case of child development programmes, where this is expected). In the five child development and two nutrition programmes observed, visitors rarely

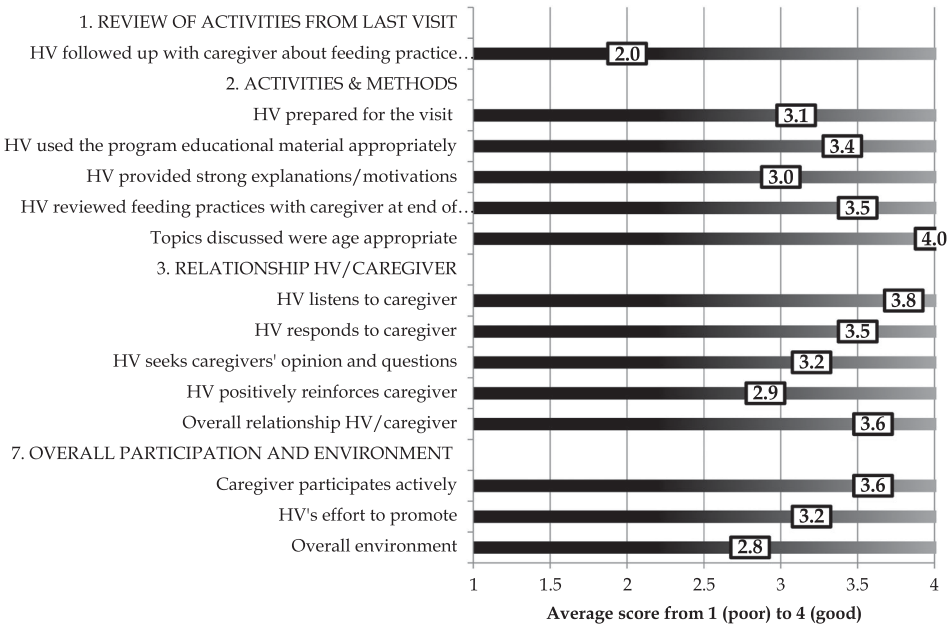

Figure 2. Nutrition programmes: Average score per item.

provide meaningful explanations and feedback to caregivers. This means that the visits centre around activities and praise for the child rather than coaching and learning for the caregiver. Thus, visits provide an opportunity for caregivers to learn and practice specific activities to do with their children, but it is unclear whether the visits also contribute to strengthening caregivers' knowledge of child development.

It is worth noting that the lack of dialogue in the observed visits could be explained in part to the presence of the researcher. Caregivers and HVs may have been reluctant to participate actively during the visit observation. In practice, there may be more meaningful dialogue between caregivers and HVs.

Regardless, the coaching aspect of home visit quality is perhaps the hardest to achieve successfully without greater professionalization of the HV role – including strong training, appropriate incentives (e.g. salary), supervision and coaching. Successful coaching requires both a strong understanding of child development and the pedagogical skills to encourage genuine participation and engagement. This could have implications for the scale-up of home visit programmes, which in many cases rely on community volunteers (for example, AIN-C in Panama, Cuna Más in Peru, and PAIPPI in Nicaragua).

Our objective has been to provide insight into how home visits from seven large parenting programmes in LAC are implemented in practice. In piloting the Home Visit Checklist, we demonstrate the domains of visit quality that can be used to inform programme design and ongoing supervision. Our findings provide an indication of the strengths and weaknesses inherent in the practical implementation of home visits. Future research could expand on this work by incorporating larger, representative samples. This would allow for more meaningful comparisons between and within programmes and provide the statistical power necessary to test the reliability and validity of the checklist measures. Ultimately, systematically collected data on the quality of home visits analysed in relation to effects on child development outcomes is necessary in order to unpack the home visit theory of change.

Disclosure statement

No potential conflict of interest was reported by the authors.

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