The Salutogenic Approach to Childcare in Sub-Saharan Africa: A Focus on Children Who Thrive in the Face of Adversity

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Introduction

Promoting child health and well-being in Sub-Saharan Africa (SSA) remains a major aspiration for governments, public health officials and researchers. This is because, despite the global reduction in under-five child mortality, SSA is the worst region for a child to live; a child in SSA being 14 times more likely to die than children in other regions (Blencowe et al., 2016; Liu et al., 2016; You et al., 2015). Most deaths are due to causes directly related to pregnancy and childbirth.

A majority of the causes are preventable with existing, cost-effective interventions (Boschi-Pinto et al., 2010; Kinney et al., 2010; Liu et al., 2012). Yet, these interventions are not up to scale in most SSA countries as a result of wars, the inadequacy of healthcare facilities, trained personnel, information, inadequate referral systems and pervasive poverty. Amidst these disturbing statistics, some children do thrive even in very challenging living situations. This raises one critical question: How do some children thrive in adversity, and how can lessons from such children inform care for others who appear to fail to thrive under the same conditions?

This question is anchored in the growing community of practice with interest in positive aspects of functioning for health and well-being. Antonovsky's salutogenic model and its core concept 'sense of coherence' (SOC) focus on the ability of individuals to cope with stressors in life and stay healthy (Antonovsky, 1987). In this chapter, we focus on children who thrive in the face of adversity in SSA. We examine the potential of a salutogenic orientation in childcare in poor urban settlements, to raise awareness amongst African public health stakeholders, decision-makers, public

health managers and workers. Last, we propose future directions for scaling up the use of salutogenesis in childcare research, policy and practice in the sub-region.

Childcare and Resources for Care

'Childcare' as used here refers to the time, attention and support given to children both at the household and community level, to enable them to thrive physically, mentally and socially (Engle et al., 1997). This may include practices such as observing high-quality home hygiene, preparing nutritious foods, following the recommended optimal breastfeeding and complementary feeding practices, ensuring that the child gets proper psychosocial care and offering various preventive and treatment services. Various scholars have documented the importance of childcare in enhancing child health, development and well-being (Arimond & Ruel, 2004; Black et al., 2008; Engle & Lhotska, 1999; Onyango et al., 1999; Ruel, 2003; Ruel et al., 1999). The importance of the caregiver has equally been emphasised in the literature on child health and development. Practices such as the use of finger foods, responsiveness of the caregiver to the child's feeding situations (encouraging a troublesome child to eat rather than forcing) and physical, visual and verbal interaction with the child are beneficial to the health and well-being of the child (Engle et al., 1999; Kröller et al., 2013). The caregiver's health-seeking behaviour involves taking action to protect the health of the child through ensuring prompt access and utilisation of essential health care whenever the child is unwell, attaining full immunisation and practising other preventative measures (Ruel et al., 1999).

Resources for care are as necessary as the care itself. Better child health and development outcomes are directly affected by the resources at the caregiver's disposal. These resources include resources that guarantee food security and resources that enable the mother to provide optimal care and the existing infrastructure. Important to note is that contextual factors determine how these resources are utilised.

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Beginning with food security, a food-secure household means that there is sufficient food both in quantity and quality accessible to family members to live an active and healthy life (Smith & Haddad, 2000).

Maternal resources include the following:

- Maternal autonomy – a woman's power in the household and her ability to influence and change her environment (Engle et al., 1999; Gupta, 1995)
- Maternal physical and mental health – physical deficiencies, such as anaemia, stunting and low body mass index influences caregiving by reducing energy needed to provide care (Engle et al., 1999), and mental health problems, such as stress and depression, are risk factors that can lead to inadequate childcare and poor growth (Edwards et al., 2003; Patel et al., 2004; Rahman et al., 2004)
- Maternal knowledge and beliefs – proxied by maternal education level confers economic advantage and the knowledge accumulated as a result of attending school to improve child health (Appoh & Krekling, 2005; Barrera, 1990; Brody et al., 1999; Cleland & Van Ginneken, 1988; Frost et al., 2005; Ware, 1984)
- Availability of time for the mother to interact and provide care to the child – is partly influenced by the workload, especially domestic chores (Bernal, 2008; Bianchi, 2000; Lamontagne et al., 1998; Nair et al., 2014)
- Social support – extensive social support networks influence the responsiveness of the caregiver when interacting with the child leading to stronger attachment (Burchinal et al., 1996; Jacobson & Frye, 1991)
- Infrastructure – existence of facilities such as educational institutions, appropriate sanitation facilities, clean drinking water, accessible health care and proper shelter are likely to influence child health more positively (Gamper-Rabindran et al., 2010; Jalan & Ravallion, 2003; Lavy et al., 1996; Thomas & Strauss, 1992)

The Importance of Context

The importance of context as a variable in childcare has been highlighted (Smith & Haddad, 2000). The political, economic and social-cultural environment of a country dictates how natural resources, technological advancement and human capital are exploited for the benefit of the people. Specifically, context influences how resources are utilised to ensure households are food secure, empowerment of mothers to provide optimum care to their children and the location of households in settings with adequate infrastructure. There is evidence that sex differences in children's physical growth deficits have contextual roots (Crognier et al., 2006; Cronk, 1989; Wamani et al., 2007). Child feeding practices and sub-

sequent undernutrition differ by households' socioeconomic status (Frost et al., 2005; Urke et al., 2011; Van de Poel et al., 2008). Residence (urban/rural) is a significant contextual factor for the course of child growth and development (Smith et al., 2005; Trussell et al., 1992).

Many of the threats to the well-being of children in SSA, as in other low- and middle-income countries, are known to include the impacts of poverty, war, disasters, pandemics, climate change and associated displacements (Engle et al., 2011). This is further compounded by health systems that are ill-prepared to meet the health needs of their populations. Most of the health systems cannot yet adjust to current needs, given the longstanding chronic underinvestment in the health sector. Within this environment, additional risks to health and well-being have been described. They include the death of a primary caregiver/parent, exposure to violence (physical and gender-based violence), poverty and low levels of maternal education, amongst other factors (Akello et al., 2010). These interact to predispose individuals to future and lasting mental and physical health problems.

Children Who Thrive: Why It Matters

Amidst dire circumstances perpetuated by poverty, war, disasters, pandemics, climate change and associated displacements in SSA, some children thrive. Children who thrive under challenging circumstances lead us to ask why and under what circumstances do such children manage to do well, against all odds that are stacked against them. To support this, there is a much needed and new trend demonstrating the growing appreciation of positive health concepts, including resilience amongst children in this setting. For these children, several factors may promote resilience. Protective factors include family, social and community assets that together serve to improve a child's ability to thrive amid adversity.

Within SSA, several studies have been conducted showing how children exposed to different stressors thrive despite apparent adversity. Studies on growth and development, specifically those looking at stunting, have demonstrated factors responsible for positive deviance. Amongst groups of children exposed to similar environmental risks, some tend to fare better than others. Critical protective factors include but are not limited to higher maternal education level, healthy birth weight and better socioeconomic circumstances in the home (Donald et al., 2019). On the other hand, risk factors for poor development outcomes encompass poor maternal health, including mental health issues, HIV infection and anaemia in pregnancy (Donald et al., 2019). Amongst former child soldiers in post-conflict northern Uganda, approximately one-third of the respondents showed post-traumatic resilience. Their resilience was associated with better

socioeconomic situation in their families, lower guilt cognition and exposure to domestic violence and perceived spiritual support, amongst other factors (Klasen et al., 2010).

Because childhood establishes a lasting foundation for adulthood, adequate nutrition, good quality childcare, learning opportunities and social support are fundamental prerequisites for lifelong health (Neuman & Devercelli, 2012). These lay the foundation for resilience (Masten & Barnes, 2018). Quality childcare, therefore, is an essential generalised resistance resource (GRR) for coping with life's pernicious stressors.

By focusing on children who thrive, we can identify what enables them to withstand individual and environmental factors that can be harnessed for the improvement of the care for those who do not do as well.

Salutogenesis in Childcare: Why It Matters in SSA

The focus on the pathways to health that pay close attention to resources for health and the many aspects of childcare that encompasses home and community life have been emphasised in various conceptual frameworks of child health and development (Engle et al., 1997; Smith & Haddad, 2000). Of particular importance is the alignment of this view of childcare with the ideas of health promotion as championed by the Ottawa Charter's definition of health as a resource for everyday life (Mittelmark, 2005; WHO, 1986).

Salutogenesis is concerned with how to live well with stressors and not how to eliminate the stressors. The salutogenic model focuses on the use of resources at an individual level and those within one's environment to maintain health. At the core of the salutogenic model are the sense of coherence (SOC), GRRs and specific resistance resources (SRRs). A strong SOC supports an individual's ability to view and manage life stresses as comprehensible, manageable and meaningful. With origins in socialisation encounters, early childhood interactions, sociocultural and environmental conditions and other related factors, the GRRs enhance one's ability to deal with demanding situations. A strong SOC makes it possible for one to use available GRRs and SRRs and enhance thriving.

In line with basic health promotion principles, salutogenesis has a holistic view of health and life in general and provides a vital way in which health can be maintained and enhanced especially during challenging conditions (Eriksson & Lindström, 2008) such as those children in SSA encounter. Research on children in different countries has demonstrated the value of a salutogenic approach in the development and education of children and adolescents (Idan et al., 2017). As research has shown, in different contexts, some children do thrive despite the stressors they encounter. Such children

utilise the GRRs and SRRs at their disposal to strengthen their SOC. As the SOC is mainly developed during childhood, this is the ideal phase of life in which to invest in measures that foster individual and group SOC for better health and well-being.

Salutogenic Research Examples in SSA

The application of salutogenesis in child development specifically, and in healthcare in general, have been elucidated as noted above. Although limited, there is a growing body of evidence on the application of the salutogenic model in research amongst children who experience adversity in SSA.

(a) Orphaned Children Living Without Proper Adequate Care

In Tanzania, amongst orphaned children living without proper adequate care, the model was successfully used to understand the coping strategies of the children (Daniel & Mathias, 2012).

(b) Orphaned Children Living in Group Homes

In Uganda, one study explored challenges faced by orphaned children in group homes, their coping strategies, as well as their ability to thrive (Rukundo & Daniel, 2016). The children's ability to thrive was supported by different factors resources (GRRs) that promoted coping with challenges, attention from caregivers and other personal attributes.

Such studies suggest opportunities be harnessed in understanding and providing childcare through a salutogenic lens.

A Salutogenic Approach to Childcare: Examples from Poor Urban Settings

To demonstrate how a salutogenic approach to childcare in SSA and similar low- and middle- income countries can be applied, we describe several health and childcare programmes in Nairobi, Kenya.

Rapid urbanisation is a global phenomenon, but the challenges are more pronounced in SSA, being the region with the highest urban growth rate (UN-HABITAT, 2007). SSA's urban growth rate is up to 4% annually, and the urban population is expected to grow to 60% by 2050 from 37% in 2011, with the majority of the urban residents living in informal settlements (UN-HABITAT, 2003, 2003, 2010). This growth in urban population is driven by rural-urban migration and further exacerbated by internal displacement of people and the effects of climate change.

In Nairobi, the capital of Kenya, about 60% of the population live in slums or under slum-like conditions. Research

has demonstrated that residents have poor health and socioeconomic outcomes compared to other urban and rural residents. Limited access to essential preventive and curative services for women and their children in addition to the prevailing poverty are the major underlying factors contributing to the high mortality in the informal settlements (APHRC 2002, 2014). As a result, evidence indicates high maternal and infant mortality rates (706 maternal deaths per 100,000 live births and 57 infant deaths per 1000 live births), high rates of undernutrition in children under 5 years (stunting prevalence of 46%) and high rates of morbidity and mortality from diarrhoeal diseases. These poor health and nutrition outcomes are attributable to limited access to social and health services, poor environmental and sanitation conditions and poor livelihood opportunities (Zulu et al., 2011; APHRC, 2002).

While there are individual and community-level barriers to accessing and using maternity and child healthcare services amongst the urban poor, the poor state of both maternal and childcare services in this setting substantially contribute to the high mortality observed in Nairobi (Emina et al., 2011). This environment, rather than being protective (GRR), exposes children to threats.

A Health System's Strengthening Intervention Targeting Mothers, Neonates and Children

Due to the challenges encountered by mothers and their children in the process of accessing care in the informal settlements, they exhibit poor health indicators, including high levels of maternal, neonatal and under-five mortality. Healthcare delivery in this setting is mostly the domain of a thriving but largely unregulated private health sector.

Within this environment, a 3-year project was implemented in Viwandani and Korogocho slums to strengthen public-private partnerships for the improvement of healthcare services and outcomes for mothers, neonates and young children through various strategies: infrastructure upgrade of selected health facilities, capacity building of health workers and managers and strengthening community referral systems (Bakibinga et al., 2014). The intervention was informed by discussions with different stakeholders on what the critical needs were.

High crime rates and violence were identified as barriers to timely access and utilisation of healthcare services by slum residents, especially women. The intervention package included an 'escort' system set up and run by young men to accompany mothers or their children needing medical attention at night, when it is not safe to transverse the dark narrow alleys.

There were increments in various population-level outcomes. Proportions of newborns initiating breastfeeding within 1 h of birth, children with full vaccination, children receiving measles vaccination, sick children <5 years who seek care at a health facility, women using contraceptives and women attending at least three PNC visits increased from 33.3%, 28.8%, 46.6%, 34.9%, 47.2% and 22.1% at baseline to 81.8%, 42.4%, 49.3%, 45.0%, 70.8% and 59.4% at end line, respectively. A 68% increase in obstetric night admission at selected health facilities was seen as well as a reduction in home deliveries. The assessment showed better functionality of upgraded healthcare facilities in terms of variety, quality of services and recognition by regulatory authorities, and stronger relationships between the public and private sector facilities, with the private health facilities benefitting from in-service training and access to publically-supplied health commodities. The private health providers did not continue with some components of the project. It was also discovered that community members expected free health services from upgraded health facilities.

The intervention highlights the importance of GRR in serving the general population, especially the urban poor. Within this, a targeted service with young men serving as escorts for women and children served as an SRR. Furthermore, the targeted support to private health facilities was an SRR. However, not all health providers utilised the resource, as expected. Data from individual facilities showed that some providers embraced the intervention with better results at their facilities while others did not.

A Subsidised Daycare Programme for the Urban Poor

Due to violence, accidents and poor sanitation in the informal urban settlements, children require more attention to avert these dangers. Yet weak social support systems make this impossible. This has contributed to women's absence from the employment sector. For those who must work, the choice is usually to leave infants with their older siblings or with house help, who have limited knowledge on how to care for children adequately. Most women are employed in the informal sector, and many survive from hand to mouth. Affordable childcare is necessary if women are to engage in work outside the family. A randomised intervention of quality and subsidised daycare was implemented in one informal settlement (Clark et al., 2019). The intervention provided daycare vouchers for women to take their children to daycare centres in the community and assessed the economic impact of the vouchers on the women's engagement in economic activities. At the end of the intervention, there was an 8% increase in women employed.

Here, the voucher system for daycare was provided as SRR which enabled women to take their children to an affordable daycare centre where they were assured of quality care for their children, while they went out to fend for their families.

A School Health and Nutrition Programme in Poor Urban Settings

Malnutrition is a risk factor for which researchers and public health programmers have made commendable strides. Here, we consider the nutrition of children in a faith-based school – a GRR – operated in an urban slum (Neervoort et al., 2013). In the absence of the public sector, such schools provide a safe space for children to learn and grow in a supportive environment.

Quite often, nutrition programme managers at the city-county level work with development partners to develop school feeding programmes. Breakfast and deworming services serve as SRRs for children who come from homes where only one meal a day or less is available. Although poverty is common, some children hail from homesteads where both parents are available, employed and able to provide all meals for their children. Since services are made available to all the children, those coming from slightly better homesteads benefit more from the services, potentially widening the inequities amongst the children.

What all the interventions mentioned above have in common is the desire to improve health outcomes for children while improving their chances to thrive both as children and later in adulthood. Although the lack of social and health services is common to all the residents, not all households are at the same level. This means that if interventions are implemented, differences between children hailing from different households would be pronounced, increasing inequities and inequalities. If programme staff do not make deliberate efforts to disaggregate intervention beneficiaries, an unintended outcome of widening inequity gaps is a given. In the spirit of salutogenesis, attention to individual as well as family, social, community and group dynamics is necessary to improve child health and well-being in SSA, as elsewhere. Those with fewer GRRs could benefit more from targeted SRRs.

Conclusions and Future Research Directions

Despite the growing evidence on the benefits of focusing on positive constructs, most child health interventions address mainly deficiencies, working towards responding to what is not available, rather than using available resources to improve health and well-being. These are a reflection of the tradition-

ally appreciated paradigm. Children who thrive under adversity have lessons that can be harnessed to promote the health and well-being of those who struggle under similar circumstance. For this to take effect, a salutogenic approach to research, policy and practice has the potential to add value to the standard approach of focussing on risk factors. In SSA, there is a need for more research using the salutogenic lenses to support an evidence base that will inform policy and practice. Significantly, international research collaborations are needed to highlight issues pertinent to different social-cultural contexts. As most salutogenic research amongst children has been conducted in other regions, collaborations between researchers in other parts of the world and those in SSA are needed.

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