Special Initiative for Orphans and Vulnerable Children

Assessing the Scalability of an Early Childhood Development-Integrated Intervention in Eswatini

Introduction

The HIV epidemic has a profound effect on children in sub-Saharan Africa, where more than 15.1 million children have lost one or both parents. In June 2014, the United States President's Emergency Plan for AIDS Relief (PEPFAR) announced, as part of its orphans and vulnerable children (OVC) programming, a special initiative for children under age five affected by the epidemic.

The initiative funds interventions and research in southern Africa—Lesotho, Eswatini (formerly Swaziland), and Zimbabwe—to generate data on approaches that improve health. Its goals are to establish evidence to improve and inform programming and determine the potential for program scale-up.

The programs integrate OVC programming with pediatric treatment and prevention of mother-to-child transmission (PMTCT) of HIV. Outcome evaluations of each intervention in the three countries seek to examine both early childhood development (ECD) and clinical aspects of interventions for a more holistic understanding of children's needs. Evaluations of each intervention generate data on successful approaches that improve health and establish evidence to improve programs. However, evidence of effectiveness is not enough to ensure that interventions become part of routine program implementation elsewhere. Achieving that end requires early planning and strong advocacy from multiple stakeholders. To prepare for potential scale-up once the results of the evaluation become available, the United States Agency for International Development (USAID) asked its funded project—MEASURE Evaluation—to assess the scalability of the ECD-integrated intervention in each country. Scale-up pertains to deliberate efforts to use a proven practice to reach more people more quickly and more effectively, to bring about lasting change.

Eswatini m2m staff. Photo: Zulfiya Charyeva, MEASURE Evaluation

This document concerns itself solely with Eswatini. The Eswatini program, implemented by mothers2mothers (m2m), trains "mentor mothers" to provide good-quality early childhood development (ECD) services for vulnerable children ages 0–2 years and their parents and caregivers. The aim is to improve the children's cognitive, social-emotional, language, and motor development and physical growth. Other goals are to reduce HIV vertical transmission, improve adherence to antiretroviral therapy (ART) for household members testing positive for HIV, and create a safe and stimulating environment for ECD within homes and communities.

Researchers outside the m2m program are conducting an outcome evaluation to assess that program's impact on maternal clinical outcomes and on ECD outcomes for the HIV-exposed children, in terms of their HIV status, feeding, nutrition, and growth. This brief summarizes our data collection methods, analysis, findings, and recommendations from the scale-up assessment of the ECD and health-integrated intervention in Eswatini.

[1] Adamou, B., et al. (2014). Guide for monitoring scale-up of health practices and interventions. Chapel Hill, NC, USA: MEASURE Evaluation, University of North Carolina. Retrieved from https://www.measureevaluation.org/prh/resources/guide-for-monitoring-scale-up-of-health-practices-and-interventions

Methods

The scale-up assessment consisted of a desk review, qualitative data collection, and cost estimation. Qualitative data were collected through 37 key informant interviews with program implementers, government and civil society stakeholders, and donors using a semistructured set of data collection tools, adapted for each audience. Qualitative data collection also involved a one-day workshop with m2m staff to gather more information about program implementation.

The cost estimation phase of the assessment included a costing questionnaire and a cost estimation tool. These tools were completed by m2m program staff and supplemented through in-person meetings and conference calls. Offices of m2m in Cape Town, South Africa, and Mbabane, Eswatini, shared their cost data with us. The level of detail in these financial accounts varied over the phases of program implementation, limiting the comprehensiveness of the cost estimates we were able to produce. Although the cost data we received were already allocated by phase, there was some difficulty in allocation of line item and proportion of line item to intervention components. The model we used to estimate the cost of scale-up scenarios tracked key assumptions.

Costs of the pilot project were insufficiently detailed for us to predict the costs of the scale-up scenarios, so we supplemented them with economies of scale, diseconomies of scale, resource substitution, personnel allocation, and intervention modification. Some recurrent costs, such as training, were increased proportionally to account for the scale-up scenario frameworks; other costs were adjusted on an individual basis. Only financial costs are included in the scale-up assessment.

Qualitative data were collated and analyzed in Microsoft Excel through matrices developed to identify commonalities and differences across interviews. Qualitative analysis identified broad themes and factors affecting scale-up, identified assumptions and program elements not documented elsewhere, and assessed support for scale-up.

Results

Description of the Intervention

m2m's ECD program builds on its well-known PMTCT program for supporting children ages 0–2 and their mothers as early as possible in pregnancy, with additional support for other primary caregivers and their families. The model is a community- and home-based intervention to improve maternal and child health outcomes and combines education and peer support (mentor mothers) to caregivers and direct work with children through home visits, links to m2m's facility- and community-based PMTCT program, and parent information and play sessions (PIPS) for caregivers and children. In 2016, m2m provided the program to 2,400 children and their caregivers.

Mentor mothers are central to m2m's programming. The benefits of the mentor mothers strategy surfaced in many interviews, with participants noting the benefits of regular interaction, trust-building, and peer-to-peer rapport, as well as the intense training and professionalism evident in the mentor mothers' early childhood expertise, uniforms, and appropriate behavior. The m2m approach prioritizes recruiting mentor mothers from the communities to build rapport with clients and addresses the practical challenges of transportation for home visits and group learning. Mentor mothers are paid employees, not volunteers, which adds to their professionalism and accountability.

Intervention Strengths

Stakeholders at all levels had positive opinions about the program; they mentioned the positive effects of integrating ECD in PMTCT, of the high coverage of pregnant women in intervention areas, and of the provision of one-to-one support in the home.

- In-home support reduces time, travel, and cost for caregivers, allows the intervention to be tailored to a client's needs, and builds a relationship grounded in mutual trust. Mentor mothers can demonstrate how to play with and engage children, interact with all family members, and offer referrals for family members when indicated.
- PIPS allowed mothers to learn from one another. Other strengths were comprehensive training; locally adapted materials; buy-in at multiple levels; and the organization, supervision, and monitoring of the program. m2m is a trusted organization, which also supported the intervention's credibility and acceptance among clients.

Implementation Challenges

Interviewees from m2m discussed challenges that arose in recruiting qualified mentor-mother candidates in rural areas.

- ECD was a new subject for mentor mothers and for caregivers, making it necessary to conduct extensive training and follow-up supervision.
- Mentor mothers were attractive candidates for other jobs, leading to staff turnover.

- Stigma was an issue, because m2m is primarily known in Eswatini for its work with HIV-positive women. Although the ECD program worked with HIV-positive and HIV-negative women, all mentor mothers are HIV-positive, which sometimes caused concern for potential clients of the program—some of whom didn't want to be associated with m2m mentor mothers for fear others might think them HIV-positive.
    - m2m has worked to overcome this assumption, educating community members that the program includes both HIV-positive and -negative women. Client mobility was sometimes a problem, but few clients left the program for other reasons.

Mixed Strengths and Challenges

The flexibility of home visits—with no standard lesson plans—was a strength and a challenge. Several stakeholders said that placed more responsibility on mentor mothers to develop tailored sessions and ensure that all topics were covered over the course of the intervention. Several mentor mothers mentioned that they would appreciate more scripted lesson plans and activity schedules. However, a researcher working on the outcome evaluation said it was a strength of the program to allow an iterative process responsive to family needs at any stage. The comprehensive nature of the intervention also arose as a strength and challenge: it worked at multiple levels and provided holistic support, which could be a concern for scale-up.

Country Context

Country and local context are crucial to consider when planning for scale-up. As expected, the scale-up assessment revealed a breadth of interrelated institutions, stakeholders, and cultural influences at play.

- Multiple government stakeholders—the Ministry of Health, the Ministry of Education and Training, and the National Children's Coordinating Unit in the Office of the Deputy Prime Minister—have an interest in the m2m program.
    - The Ministry of Education was involved in training mentor mothers. The Office of the Deputy Prime Minister includes several active and potentially relevant stakeholders: the National Children's Coordinating Unit, the Poverty Reduction Unit, and the Parliamentary Portfolio Committee on Children's Affairs.
    - The Eswatini Network for ECD (SNECD) is led by Church Forum and remains active in the ECD community.
- A significant challenge with the stakeholder context was the lack of coordination and oversight. Key informant interviews highlighted that the Ministry of Health focuses on children ages 0–2 for immunization, nutrition, and growth. The Ministry of Education focuses on education and development, but primarily beginning at preschool age. Other departments focus on protection from violence, poverty, or welfare. The comprehensive well-being of children ages 0–2 does not have a "home" in one agency or department. Collaboration and coordination to navigate these disparate players was lacking, in part because of the politics of coordinating government departments that do not report to each other and have different expectations.
- Donor support for the program came from USAID's OVC Special Initiative. Other donors in the country agreed on the need for the ECD program but had no plans to support it financially. Despite this lack of financial commitment and also despite limited understanding of the importance of ECD, particularly the 0–2 age group, most stakeholders advocated scale-up. Additional advocacy may be needed to help others understand the problem and the potential solution piloted by m2m.

Scalability

Stakeholders' thoughts on scalability and the challenges and opportunities they mentioned varied by type of stakeholder. These perspectives are outlined below:

- Eswatini's small size was considered an advantage for national scale-up. Some respondents felt the intervention should be tested in urban and hard-to-reach locations before scale-up. Respondents also noted that Eswatini's size means it does not have significant cultural or social differences; this would aid scale-up.
- Complexity:
    - Ministry staff and donors ranked the intervention as clear and easily replicated, with low complexity and few components that would be easy to add to existing systems. They also felt that the model is not particularly process-intensive and requires

2 A coordinating body responsible for the church's response to HIV and AIDS in Eswatini.

little technical sophistication. According to these respondents, once initial buy-in for scale-up is established, the value of the intervention will be clear, and once adequate personnel are on board, replicating the program will not be a challenge.

- Implementing partners and researchers were more likely to describe the intervention as highly complex, with many integrated components. They were more likely to say the intervention requires technical sophistication on ECD, some expressing doubt that it is scalable without making adjustments.

- Support and funding:
  - Most stakeholders agreed that the intervention had support from important organizations and individuals and that it was based on sound evidence. They felt it addressed a significant, persistent problem and that other current solutions were inadequate.
  - Regarding cost, some thought the model would be costly at scale and all agreed that the intervention would be dependent on external funding.
  - Stakeholders consistently noted the lack of available funds for scale-up as a principle challenge. All representatives of the health and education ministries expressed strong desire and support for the intervention, but dismay at the lack of funds the government has for it. Other donors, implementing partners, and civil society representatives had similar concerns. Health facility representatives said they had come to depend on mentor mothers in the facilities and communities and were concerned that, at the end of the pilot, they would lose the mentor mothers' services.

- Urban or rural:
  - Pilot intervention sites were largely rural or semi-urban where population size was sufficient for the study—urban sites being deemed too mobile. Although these semiurban sites enabled a strong study design and implementation, study results will be limited in generalizability and scale-up success in urban areas could be impacted by mobility and increased outside employment of primary caregivers, meaning that mentor mothers would be working with extended family or rotating caregivers.
  - In extremely rural areas, distance was perceived as a challenge. The distances mentor mothers would have to travel could affect scale-up, as could a lack of available clinics and resources for referral and low caseloads.

Scale-Up Scenarios and Costing

The integrated intervention unit cost per child was $509.84. See the table below for information on scale-up scenarios and corresponding costs for each year.

Table. Costing for scale-up scenarios

	Cost, USD
Scale-up scenario 1: Serve only the most vulnerable children in the PEPFAR-supported districts*	
Number of beneficiaries	6,374
1.a. The same integrated health ECD program that m2m is running now—with health facility, community, and ECD mentor mothers	
Total cost	2,390,387
Unit cost	375.02
1.b. Rural health motivators implementing this program, supported by m2m teaching and supervision	
Total cost	2,293,140
Unit cost	359.76
1.c. Another nongovernmental organization/implementing partner conducting the intervention and m2m providing technical assistance. The IP will have only community** and health-facility mentor mothers.	
Total cost	2,157,534
Unit cost	338.49
Scale-up scenario 2: m2m expanding its ECD component to all communities where they currently have PMTCT peer support/mentor program. Currently, m2m has a PMTCT program in 52 communities but ECD in only 21.	
Number of beneficiaries	5,918
Total cost	2,218,846
Unit cost	374.93

* Assumes 26.3% coverage among 24,234 children 0–2 in the PEPFAR-supported districts

** Community mentors will have both community and ECD mentor mothers' responsibilities.

Strategies for Scale-Up

Depending on the selected scenario for scale-up (see table), we suggest the following strategies:

- Prepare mentor mothers to take responsibility both for ECD and community mentor mothers.
- Reduce biweekly home visits to monthly visits.
- Develop scripted lesson plans and activity schedules for each topic that mentor mothers discuss with caregivers.
- Conduct refresher trainings to ensure quality implementation and adaptation to mentor mothers' experiences in the field.
- Use existing volunteer rural health motivators as one of the cadres to deliver the intervention.

Recommendations

Results of the scale-up assessment revealed interest in and buy-in for the integrated ECD intervention but a lack of resources. We offer the following recommendations for scale-up planning:

1. **Create an institutional home for the ECD intervention to increase ownership and awareness.**
    - Create an interagency taskforce or committee to coordinate the ECD-related work and potential scale-up.
2. **Increase advocacy and awareness of 0–2 ECD policy and program support.**
    - Invest in and support members of the existing ECD network to increase their advocacy and leadership on the importance of ECD, especially for pregnant women and children ages 0–2.
    - Finalize the draft ECD policy.
    - Once available, widely disseminate results of the ECD outcome evaluation among all stakeholders to help move ECD up on the policy agenda.
3. **Generate financial support from government and donors.**
    - Conduct substantial lobbying and advocacy to generate funding from government and donors.
    - Consider creating a donor coalition for funding.

These scale-up recommendations will be fully informed by the outcome evaluation results, once they are available.

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