Assessing Scale-Up Potential for the Zimbabwe Expanded IMPACT Project

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 2014, as part of its orphans and vulnerable children (OVC) programming, the United States President's Emergency Plan for AIDS Relief (PEPFAR) announced a special initiative for children under five years old affected by the epidemic.

The initiative funds interventions and research in Lesotho, Eswatini (formerly Swaziland), and Zimbabwe that integrate early childhood development (ECD) with pediatric HIV treatment or prevention of mother-to-child transmission of HIV (PMTCT). Evaluations of each intervention generate data on successful approaches that improve health and early childhood development outcomes; the evaluations also 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 after the results of the evaluation become available (scale-up pertains to efforts to reach more people with a proven practice more quickly and more effectively[1]), the United States Agency for International Development (USAID) asked MEASURE Evaluation to assess the scalability of the ECD-integrated intervention in each country. (MEASURE Evaluation is a project funded by USAID and PEPFAR.)

This document outlines interventions and assessment results in Zimbabwe. The OVC Special Initiative intervention in Zimbabwe was implemented in 17 districts by World Education Inc./Bantwana Initiative (WEI/B) and its community-based partners to evaluate the impact of a comprehensive early childhood stimulation[2] (ECS) parenting education program. The ECS parenting education component augmented WEI/B's ongoing, multicomponent Expanded IMPACT Project (EIP) (2012–2017), which was designed to accelerate access to pediatric HIV care and treatment with antiretroviral therapy (ART) and to strengthen community capacity to sustain children in treatment. Other objectives were to support nutrition and psychosocial needs for enrolled families; to increase uptake of PMTCT services; and to decentralize pediatric ART diagnosis, testing, and treatment from district hospitals to primary healthcare facilities. WEI/B leveraged funding from PEPFAR, USAID, and others to deliver EIP, modeling the intervention around an earlier pilot activity (2009) launched by WEI/B in eight districts.

[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

[2] In Zimbabwe, ECD refers to school-age children 5–6 years old who fall under the oversight of the Ministry of Primary and Secondary Education (MOPSE). To differentiate, childhood development interventions for children ages 0–2 years are referred to as ECS and will be reported as such in this document.

A caregiver engages in stimulating play with a child. Photo by Joshua Kumunda.

Funding from the OVC Special Initiative was harnessed to augment the multicomponent, community-based intervention, with a specific aim of fostering improved pediatric ART uptake and adherence and early childhood development outcomes among HIV-exposed infants ages 0–2 years through a comprehensive parenting education intervention. The programme also sought to improve maternal health outcomes, including increased retention in care among the mothers of HIV-exposed children and improved mental health of mothers. The OVC Special Initiative targeted the following primary and secondary outcomes: improved early childhood development, enhanced pediatric ART adherence and retention in HIV care, and strengthened household economic resilience.

Methods

The scale-up assessment was conducted using a desk review of the OVC context in Zimbabwe, qualitative data collection, and cost estimation. Qualitative data were collected through 21 key informant interviews with implementers, government and civil society, and donors, using a tailored semistructured questionnaire. Data were collated and analyzed in Microsoft Excel with matrixes to identify commonalities and differences across interviews. Qualitative analysis focused on identifying broad themes and factors affecting scale-up, including support for scale-up and identifying assumptions and elements not documented elsewhere.

The cost estimation phase of the assessment involved a questionnaire and a cost estimation tool. These tools were completed by program staff as well as through conference calls and email. Cost data were shared by the World Education office in Harare, Zimbabwe. The costs were mapped to the intervention components, focusing on the costs of ECS. Key assumptions were tracked in the model used to estimate cost of scale-up scenarios.

Costs of the pilot project itself were insufficient to predict costs of the scale-up scenarios and were supplemented with other factors: economies of scale, diseconomies of scale, resource substitution, and personnel allocation. Some recurrent costs, such as training, were increased proportionally to account for the various scale-up scenario frameworks, and other costs were adjusted on an individual basis. In this assessment, only financial costs are included.

Results

Description of the Intervention

Activities focused on enrolling mother-baby pairs in play groups where they received education in ECS, health, and nutrition and were exposed to psychosocial support. Monthly home visits reinforced play group support. Mothers also participated in internal saving and lending groups (ISALs) to improve family income.

The program was implemented through existing community structures and supported by the Ministry of Health and Child Care (MOHCC); the Ministry of Labour and Social Welfare (MOLSW); and the Ministry of Women Affairs, Gender and Community Development (MOWAGD). Community nurses enrolled 304 groups of about 20 mother-baby pairs, each centered on a nearby health facility. Community health workers (CHWs), including village health workers (VHWs) and childcare workers (CCWs), provided case management to mother-baby pairs.

The core components were as follows: **ECS parenting sessions** consisting of 12 teaching modules delivered over 18 biweekly sessions for caregivers; **ISAL groups** for financial literacy, income generation, business development, monitoring expenses, and risk management; and **case management** with visits offering support, health education, treatment adherence, home-based parenting, and referrals to services to meet other family needs.

Project Training and Personnel

WEI/B recruited trainers for activities, sometimes with technical support from government and community departments. Partner project staff were trained on the program model, communications skills, community mobilization, and case management for pediatric and adolescent HIV. ECS facilitators were trained in parenting and young child development; ISAL leaders were trained in helping families meet financial needs; and CHW cadres were trained to manage cases and support clients. In each district, an ECS coordinator supervised a group of ECS facilitators, while an economic strengthening coordinator supervised community-based trainers charged with leading ISAL groups. Community nurses provided health support. Nurses selected had at least three years of professional

training, with priority given to those who were trained in advanced HIV clinical management.

Intervention Strengths

Multisectoral approach

Key informant interviews with implementers, government and civil society, and donors indicate stakeholders were satisfied with the program and its evidence-based approach. Respondents reported that caregivers were happy with the positive effects of the intervention on their families and young children and that beneficiaries especially liked the program's inputs on child nutrition; growing and preparing food; HIV testing and prevention, care, and treatment; and the ISAL schemes. Respondents also felt that caregivers reached by the intervention were well-supported through group activities, home visits, and referrals.

User-friendly program manuals

Respondents felt that manuals were easy to use and that they were in local languages and reflected the Zimbabwean culture and practices.

Outreach to young children for treatment and a supportive ECS component

Respondents said the program intervention was an effective way to reach vulnerable children under age two in Zimbabwe—a group lacking institutional support for HIV testing and treatment, ECS, and parenting skills.

Building on and strengthening community structures

The OVC Special Initiative used community structures and local health clinics to deliver interventions. With match funding from ELMA Philanthropies, clinics received equipment for pediatric testing and treatment, including vehicles and refrigerators. The clinics provided a structure around which to center the program, and the nurses provided oversight for health content as well as the cadre of VHWs. Respondents said that using local clinic personnel and infrastructure (most groups convened meetings at clinic sites) helped to build the participants' relationships with and trust in local health services, making them more comfortable coming to clinics to receive services. Coming to the health facilities increased regular access to testing and treatment for HIV, both for mothers and for their children. Respondents felt this arrangement had an indirect benefit of increasing mothers' adherence to ART.

It also promoted coordination among CHWs and health facility staff through monthly meetings, health center committee meetings, and community dialogues. This coordination fostered more involvement by health facility staff during ECS sessions with mother-baby pairs and stronger engagement in bidirectional referral of clients.

Economic opportunity

Respondents emphasized the importance of the ISAL component. Implementing partners (IPs) shared that many mothers' groups continued to meet after graduating from the program, which provided continued support for income generation and improved status in the household.

Use of existing data to efficiently target beneficiaries

The implementation made use of government information on PMTCT programs and data on people living with HIV to reach mother-baby pairs most in need more effectively.

Implementation Challenges

The program was largely well-received, but the challenges remain.

Hard-to-reach populations

Families in rural areas were difficult to reach, especially when mothers had to walk long distances to attend sessions at the clinic. This also was a challenge for home visits. In farming areas, mothers often were not released from work to attend sessions.

Spousal refusal

For some mothers, spousal consent was an issue. In some cases, spouses worried about stigma around HIV disclosure, and in other cases, they simply did not fully understand the program. Some sites addressed this with additional community outreach to men, sensitizing them on the importance of ECS.

Stigma

The intervention targeted mothers who were HIV-positive, which could expose them to stigma. WEI/B and its IPs enrolled a mix of HIV-positive and HIV-negative mothers and emphasized ECS to diminish concerns around HIV status. One nurse respondent suggested increased community awareness to reduce stigma.

Recruitment of special populations

Female sex workers were difficult to recruit. Respondents felt this group would need its own support group, separate from other mothers. Respondents also noted that children of sex workers were particularly vulnerable to contracting HIV and that these children would be an important population to reach in the future.

Religious objectors

Respondents reported difficulties in recruiting mothers from some religious sects that did not support modern medicine or might encourage congregants to prefer religious leaders or local healers over clinics.

Lack of formal ECS policy or governing body

Zimbabwe has no ECS policy or governing body to oversee services for children under four. Respondents felt that a defined formal policy would be helpful but that the program should retain the district- and community-level health and social welfare structures (e.g., district officers, VHWs, and CCWs), which were most effective in implementation.

Clinic challenges

Government respondents said a shortage of nurses in many areas stretched the cadre of nurses too thin as they cared for many people and that meetings away from clinics took the nurses off of their main duties. Some reported that rural clinics were not as able to test and treat HIV, despite the program's messaging, and lack of medicines, refrigeration, and training would remain a challenge in many areas.

Scale-Up Scenarios and Costing

The integrated intervention unit cost per child was $794.11. See the table for information on scale-up scenarios and corresponding costs.

Table 1. Costing for scale-up scenarios

	Cost, USD
Scale-Up Scenario 1. Serve all OVC 0–2 years currently served in the 20 USAID-supported districts	
Number of beneficiaries	**21,186**
Total cost	20,237,232
Unit cost	955.22
Scale-Up Scenario 2. Serve only HIV-exposed OVC 0–2 years currently served in the 20 USAID-supported districts*	
Number of beneficiaries	**2,966**
Total cost	5,003,204
Unit cost	1,686.85
Scale-Up Scenario 3. Serve all OVC 0–2 years currently served in the 20 USAID-supported districts (another NGO/IP is implementing the intervention)	
Number of beneficiaries	**21,186**
Total cost	15,044,762
Unit cost	710.13

* Calculated as 14% of 21,186 children ages 0–2 in the USAID-supported districts

Scalability

The fact that the project has already been successfully scaled up in several districts including rural, urban, and peri-urban areas suggests that further scale-up is possible. Largely, respondents felt the intervention improved health outcomes, increased HIV testing, decreased viral loads, and strengthened communities. Respondents said adaptations would be required for rural areas distant from clinics; urban areas without village health workers; and key populations, such as female sex workers. Program materials were judged easy to use, and respondents thought they emphasized local foods and play materials; the only adaptation required would be translation into Zimbabwe's 15 official languages. With regard to measurement of ECD outcomes, respondents noted the importance of using simple and contextually relevant tools to assess changes in ECD outcomes. Where possible, future programs should similarly consider leveraging

previously trained personnel (e.g., ECD paraprofessionals) to promote cost-efficiency and enable timelier rollout. However, respondents noted that scale-up would entail costs for additional manuals and session materials, and some suggested stipends for the ECS facilitators. Opinions were mixed on whether the CHW cadres would require stipends.

Country Context

In addition to its reliance on existing structures in communities, the program fostered strong coordination and leadership at the district level among government services, local leaders, and others. Respondents felt any future program should begin with district leadership for support and buy-in, and one respondent suggested training for local leadership to increase support for ECS and HIV testing and treatment. Because IPs exist in most regions, they could support scale-up through existing relationships within communities. Absent a clear coordinating unit or official policy for services for children ages 0–2 and for older preschool children, the locus for securing political will for scale-up is murky. Most respondents felt that the political will to support ECS services existed, but that government funding would not be enough.

Government stakeholders. Collaboration with and involvement by multiple line ministries was important in rolling out the intervention. Within the MOHCC, trained nurses and community health workers are a critical part of this intervention. Additionally, decision makers in the MOHCC who are responsible for AIDS and tuberculosis, nursing, and community health are important for support for scale-up. Planning and coordination of scale-up would benefit from more involvement by the Ministry of Primary and Secondary Education (MOPSE), especially regarding ECS or ECD trainings. The MOWAGD is involved with the ISAL groups that, in some scale-up sites, the ministry adopted after the program ended. The MOLSW is involved, as well, because its CCWs are critical for enhancing awareness around pediatric HIV testing and treatment; identifying children and caregivers in need of support; providing referrals to services for children; and offering adherence support and case management for mothers and babies, as needed.

District coordination. District coordination is strong, as previously mentioned. Many respondents thought that the importance of district-level structures in addressing HIV cannot be underestimated and that any scaling should rely heavily on these structures.

Donors. The leveraging of USAID and ELMA Philanthropies funding enabled implementers to deliver complementary and integrated supply- and demand-side interventions that reached communities and clinics alike, which enabled flexibility and was ultimately beneficial to the overarching program goals. Soliciting this sort of blended funding would be beneficial for scale-up.

Sustainability

Stakeholders liked the skills gained by participants and noted ripple effects as parenting skills were shared in the community. The duration of the ECS program component (nine months) contributed to building a support network among participants, who were in touch after the program ended. Respondents suggested a need to consider the longevity of support groups for mothers and refresher trainings for the CHW cadres to support them.

Conclusion and Recommendations

Overall, the assessment revealed broad support for scaling up the program to additional areas as a successful way to target at-risk children in need of services to support ECD and increase HIV prevention, testing, and treatment. According to respondents, the intervention design was largely successful in increasing community linkages to health services, especially for HIV. Challenges remain in funding and lack of coordination for ECS in the central government. More effort is needed to increase advocacy, government involvement, and ownership in planning and implementation.

Scale-Up Recommendations for National Program Planners

Government ministries and civil society will lay the foundation for successful scale-up. MEASURE Evaluation recommends the following:

Increase advocacy on ECS services in the central government. Increase awareness of the importance of ECS policy and programming for the 0–2 years age group. Promote government responsibility for supporting ECD and ECS through increased coordination and communication. This could include a task force or working group with

members from multiple ministries (particularly MOH and MOPSE) and civil society, led by a government champion.

Generate financial support from donors and government. Conduct advocacy to generate funding through active and engaged champions of ECS to lobby government, decision makers, civil society, and donors. Engage IPs, health facility staff, and beneficiaries to tell the story of the importance of the ECS program.

Work with district government structures to implement scale-up initiatives. Regardless of future efforts to scale up ECS, it is critical to work with central and district governments for efficient and ongoing implementation.

Explore multiple scale-up scenarios and cost implications to determine what is feasible within the Zimbabwe context.

MEASURE Evaluation identified the following scale-up scenarios for consideration:

Scenario 1: Serve all OVC 0–2 years currently served in the 20 USAID-supported districts

Scenario 2: Serve only HIV-exposed OVC 0–2 years currently served in the 20 USAID-supported districts (calculated as 14 percent of 21,186 children 0–2 years in the USAID-supported districts)

Scenario 3: Serve all OVC 0–2 years currently served in the 20 USAID-supported districts. (Another NGO/IP is implementing the intervention.)

Scale-Up Recommendations for Subnational Program Planners

Prioritize scale-up locations. For the greatest efficiency and impact, focus scaling in areas with high prevalence of mothers and children living with HIV to reach the 0–2 years age group and fill the identified service gap.

Extend the intervention to key populations. Some children are at especially high risk for HIV and development challenges and could benefit from special attention. Two populations mentioned were children of sex workers and children of adolescent mothers. Scaling up to reach sex workers would require a targeted support group with tailored content. Respondents noted that adolescent mothers are not always included in interventions, such as this one, that address mother-baby pairs. Reaching them through peer groups could encourage program enrollment.

Ensure community sensitization. Ensure that community sensitization occurs prior to and during rollout of the program, to gain community support and broad participation. Target community leaders and men to promote the benefits of ECS services and provide HIV-sensitive training to reduce stigma.

Continue to support community involvement and ownership. Participation in planning and implementation would aid sustainability.

Recommendations for Ongoing Program Implementation

- Continue collaboration between government and nongovernment actors on planning and implementation to use existing resources efficiently.
- Continue provision of material resources and incentives (e.g., stipend or nonmonetary incentive) for ECS facilitators, as the data suggest.
- Consider a transportation allowance or arrangements for VHWs conducting home visits.
- Work with mothers to choose session locations, times, and dates and assist overburdened nurses when locations outside the clinics are selected.

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