

Scale-Up Assessment for the Mphatlalatsane Project—“Early Morning Star”—in Lesotho

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 funded interventions and research in southern Africa (Lesotho, Eswatini [formerly Swaziland], and Zimbabwe) to generate data on successful approaches that result in improved health, to establish evidence to improve and inform programming, and to determine the potential for program scale-up.

The programs integrated OVC programming with pediatric treatment and prevention of mother-to-child transmission (PMTCT) of HIV. Evaluations of each intervention generated data on successful approaches that improve health and early childhood development outcomes; the evaluations also established 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 effectively¹), 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.

This document outlines intervention and assessment results in Lesotho. The Mphatlalatsane project, or “Early Morning Star,” was implemented by Management Sciences for Health (MSH), in partnership with Stellenbosch University, University College London, and Oxford University. The aim was to increase HIV testing and treatment while improving early childhood development outcomes in the mountainous Mokhotlong District. The project was implemented through existing early childhood

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>



Photo by James Walsh, Sinamatella Productions

care and development (ECCD) centers to evaluate the intervention in a remote and hard-to-reach region.

The intervention targeted all families and caregivers of children ages one through five in the area, who were welcomed to join without the typical fee. Enrolled caregivers (defined as a family member in the child's household responsible for providing daily care) attended a series of nine weekly sessions at the local ECCD center in groups of three to eight. During the two-hour sessions, trained facilitators and community mentors delivered information on health and demonstrated book sharing techniques with a child.

The objectives of the scale-up assessment were to describe the intervention, its stakeholders, and their relationships; to assess the interest and readiness of stakeholders to scale up; to identify opportunities and barriers to scale-up; and to generate information for strategy and recommendations for scale-up. This brief summarizes the background, data collection methods, analysis, findings, and recommendations of this scale-up assessment.

Methods

The scale-up assessment included a desk review, qualitative data collection, and cost estimation. Qualitative data were collected through 26 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.

The cost-estimation phase of the assessment included a costing questionnaire and a cost-estimation tool. We considered scale-up scenarios in which the intervention was continued with an international and a local implementing partner. We also varied the number of sessions provided as part of the intervention in five PEPFAR priority districts of Lesotho.

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

The Intervention

Content on health topics and book sharing techniques was delivered by a trained intervention facilitator and a community mentor to a group of three to eight caregivers. During book-sharing sessions, caregivers learned how to sit and share a book with a child for about seven minutes a day. A new book was provided each week. The nine sessions were followed by a community outreach day, during which health services were offered to children, their families, and other members of the community: birth registration, nutrition screening, TB screening, and testing for HIV/AIDS.

The sessions were given by pairs of trained facilitators and community mentors for the Mphatlalatsane project, delivered in ECCD centers. MSH, with support from Stellenbosch University, recruited facilitators in the Mokhotlong and Maseru Districts. Successful candidates had backgrounds in ECCD or social sciences or experience with group facilitation. Candidates were trained by a team from Stellenbosch University and two ECCD experts from the University of Reading.

Facilitators and community mentors were trained on book sharing, nutrition, use of local food for cooking, food preparation and sanitation, HIV transmission, importance of knowing HIV status and adhering to antiretroviral therapy, and information on TB. The book-sharing component focused on building relationships, developmentally appropriate techniques for sharing stories with children, and ways to discipline a child appropriately. Caregivers also learned how children typically express their emotions. A facilitator's level of education was not thought by the implementers to be as important as their comfort with children and knowledge of the local language.

Project Training Materials

Training materials were developed by Stellenbosch University and refined in consultation with representatives from the Lesotho Ministry of Education and Training (MOET). Program materials were manuals for the facilitators and mentors, books for the families, instructional videos, battery power banks, and battery-powered lamps. Program



Photo by James Walsh, Sinamatella Productions

materials, food, and supplies for each week were transported by the facilitators and mentors who traveled to their posts in the Mokhotlong District.

An advisory committee with district representatives from the MOET, the ministries of health, agriculture and food security, local government and chieftainship, and social development provided support in planning for community outreach days. Local chiefs were engaged to provide community support to the project.

Assessment of Intervention Strengths and Challenges

Intervention Strengths

Increased exposure to ECCD concepts

Stakeholders at all levels had positive opinions about the project. Session facilitators and community mentors said the sessions facilitated community building among the caregivers and that the book sharing strengthened the relationship between caregivers and children. Facilitators also thought the sessions exposed the community to important concepts related to child development, such as emotional and developmental milestones.

Readily available workforce

Program facilitators for implementation were easily recruited, owing to Lesotho's high level of education and low

employment rates.² Project managers could select candidates who worked best with children. Facilitators were given in-depth training and ongoing supervision, and refresher trainings were delivered halfway through. Facilitators and mentors reported they were well-versed in the subject material and could switch roles as needed. In addition, preexisting ECCD centers provided a readily available venue.

Coordination of stakeholders

Stakeholders from the MOET, the MOH, and the Ministry of Social Development (MOSD) also spoke highly of the intervention's approach, saying that stakeholders from the various ministries were engaged throughout the planning and implementation process. They also thought it was important that the intervention had avoided stigmatizing people living with HIV by inviting participants from all families.

Multisectoral approach to HIV testing and treatment

Stakeholders from USAID and nongovernmental ECCD organizations spoke about the value of combining an intervention focused on HIV/AIDS—which is a sensitive subject—with ECCD, a nonsensitive subject. The outreach component was a good way to deliver services to hard-to-reach populations who often don't have access to testing

² According to the United Nations, unemployment in 2017 was 27.5% of the labor force; secondary school gross enrollment ratio was 62% female and 46% male (<http://data.un.org/CountryProfile.aspx?crName=lesotho#Social>).

and treatment in their communities. The intervention was successfully implemented in a very rural region, suggesting it could be implemented in other remote regions.

Implementation Challenges

Geography

The remote location was chosen, in part, to test geographic challenges. Transportation was a concern, and many of the villages served could not be reached by motor vehicle. Often, session facilitators, community mentors, and supplies for each week traveled by horseback—some facilitators even had to learn how to ride a horse. The need for additional supplies—and unforeseen cost—presented a challenge; for example, caregivers found they needed battery-powered lights to read to children when electricity was not available.

Recruitment of caregivers

Another challenge was recruitment of parents to attend, because they were often busy during the daytime, when sessions were offered. Most attending caregivers were grandmothers who lived with the child. Fathers and other male caregivers attended far less frequently, although this may have been influenced by session facilitators all being female, and perceptions that childcare is a woman's responsibility.

Lack of knowledge about ECCD

Session facilitators also commented that many people did not understand why ECCD was important or why caregivers should be required to attend every session. However, facilitators reported that people began to understand more about the topic and its value after one or two sessions. Some stakeholders mentioned that the limited time of the intervention also limited its sustainability, suggesting that a prolonged or repeated program could be more effective in ensuring that new ECCD skills and practices persisted. The fact that facilitators did not live in the villages also limited sustainability. Respondents thought that caregivers who attended sessions were not well equipped to share skills with the community.

Community outreach events

Coordinating the many groups offering services presented a challenge during planning for the community outreach day. Health and social services offered were HIV testing,

tuberculosis screening, birth certificate registration, and more—varying in each location. Although it was important to offer a comprehensive range of services, coordination was a challenge.

Scale-up Scenarios and Costing

The intervention unit cost per child was \$1,027.³ These costs were collected for delivering the intervention to rural villages, including training of facilitators, development of program materials, start-up costs for stakeholder engagement, and annual above-site costs incurred during the intervention period. Each of these sites had an ECD center where the intervention could take place, so no costs for space rental were incurred. See the table for information on scale-up scenarios and corresponding costs.

We considered scale-up scenarios in which the intervention was continued with an international or a local implementing partner. We also varied the number of sessions provided and applied the intervention in five USAID priority districts: Berea, Leribe, Mafeteng, Maseru, and Mohale's Hoek. Note that PEPFAR has expanded services to 10 districts since the time of this study. In scale-up scenarios, we assumed that start-up activities, such as meetings for community orientation and stakeholder engagement, would be carried out in each district. We assumed that training for facilitators and mentors could be streamlined into a two-week initial session and a one-week refresher, instead of the multiple trainings used in the Mphatlalatsane project. We consulted with MSH staff to determine the above-site staffing needs and calculated the number of facilitators and mentors needed to reach the number of children in each scenario over one year. We assumed that the above-site staff costs and overhead costs were 50 percent less for local implementation than implementation by an international partner.

Travel costs were estimated based on the share of urban and rural sites in each scale-up district. Supplies for the intervention were refreshments for the participants and learning materials such as measurement devices and art supplies. In each scenario, we assumed that the books used in the intervention would be reused for multiple intervention

³ All dollar amounts are U.S. dollars.

sites, instead of being given to the participants at the end of the sessions. For rural sites, supplies such as solar chargers and battery packs were included. Office costs increased in proportion to the number of office-based staff. All other recurrent costs increased in proportion to the number of beneficiaries. We assumed that all intervention sites would use existing ECD locations or other centers and would not pay a fee for the use of the space.

Table 1. Costing for scale-up scenarios

Scale-Up Scenario 1. Serve all OVC ages 1–5 currently served in the 5 USAID-supported priority districts, using 9 sessions and an international implementing partner (IP)	
Number of beneficiaries	17,688
Total cost	\$ 2,422,758
Unit cost	\$ 136.97
Scale-Up Scenario 2. Serve all OVC ages 1–5 currently served in the 5 USAID-supported priority districts, using 9 sessions and a local IP	
Number of beneficiaries	17,688
Total cost	\$ 2,054,926
Unit cost	\$ 116.17
Scale-Up Scenario 3. Serve all OVC 1–5 ages currently served in the 5 USAID-supported priority districts, using 6 sessions and a local IP	
Number of beneficiaries	17,688
Total cost	\$1,619,952
Unit cost	\$ 91.58

Scalability

Most stakeholders expressed that this intervention was relatively simple in design, required a small amount of resources, and would be easy to replicate throughout most of the country, especially in rural areas similar to the pilot district. Most of the Lesotho population has a single tribal heritage, and Sesotho is the first language of about 90 percent of people.⁴ However, stakeholders noted that some remote areas where locals speak a different language would require native speakers as facilitators.

⁴ <https://www.worldatlas.com/articles/languages-of-lesotho.html>

When asked who could be recruited as future facilitators or community mentors, responses varied. Stakeholders representing ECCD organizations reported that candidates would need at least some background in education and that recent graduates could be recruited from the teacher's college. Session facilitators and mentors indicated that the most important skills were the ability to interact well with parents and children and that even completion of secondary education may not be necessary. Respondents from the MOET and MOSD said that current ECCD center teachers and community health workers could be trained to be session facilitators. Others, including project researchers, said those people would not be able to add these additional responsibilities to their work.

Stakeholders noted that the number of equipped ECCD centers throughout the country, including in remote areas, would benefit program scale-up. Another strength cited was that the MOET focuses on increasing access to ECCD services, either through ECCD centers or home-based ECCD centers, so the infrastructure to support centers and staff exists in most areas of the country.

Almost all stakeholders expressed that the intervention would have to be adapted significantly if it were expanded to urban or industrial areas, because most caregivers in those areas work during the day, and children attend daycare centers. Therefore, a different scenario would be needed to reach these caregivers, although the content and training for facilitators could be the same.

Most stakeholders reported that the intervention was supported by eminent individuals and institutions, such as the MOET, MOH, and USAID. There was general agreement that the project addresses a significant, persistent problem and that current solutions are inadequate. Respondents were divided regarding the level of funding necessary for the intervention at scale. Most said it could be implemented at a very low cost, making use of existing resources, but others said that additional funding would be needed to pay session facilitators, cover transport costs for caregivers in urban areas, and provide supplies for a large number of families.

Most potential donors and government representatives said that the MOET was well-situated to spearhead a scaled-up intervention. Respondents specifically mentioned that the

ECCD unit was well equipped to lead because it already organizes a quarterly meeting of ECCD stakeholders, representing governmental ministries and nongovernmental organizations. However, they reported that the MOET would require additional funding to scale up the intervention.

Most respondents reported that the simplicity of the program would make it easy to implement widely. But they added that simplicity also could be a detriment because the program's short duration might limit its impact. Some ECCD stakeholders thought that another shortcoming of the program was that the content did not give enough information about childhood developmental milestones and therefore might not teach caregivers enough about recognizing cognitive or developmental delays in their children.

Country Context

In addition to the cultural and geographical factors noted above, ECCD is a new topic in Lesotho and, therefore, recognition of its need for support and funding is limited. The creation of a national ECCD policy in 2013 and establishment of a multisectoral ECCD coalition are important steps forward. Centers for early childhood education are already available throughout the country for a fee, but most children do not attend. Only 37 percent of children in Lesotho attend preprimary education, compared to 76 percent in neighboring South Africa (source: <https://data.unicef.org>).

Urban and industrial areas usually have daycare centers rather than ECCD centers. Daycare centers do not often use a standard curriculum, focusing mainly on childcare. Reading with children is not a common family activity, and parents do not typically spend time with a child for the purpose of building a relationship. ECCD is not recognized by most government representatives as a funding priority. Stakeholders noted the need for additional advocacy and Lesotho-specific evidence at the community and government levels to support ECCD programs.

There are, however, several institutions engaged in ECCD work in Lesotho. These groups should be involved in a scale-up of ECCD programs, as follows:

Government stakeholders. Outside of the MOET, national government stakeholders for the ECCD program are the MOH, the MOSD, the Ministry of Local

Government and Chieftainship Affairs, and the Child and Gender Protection Unit of the Ministry of Police. These stakeholders are included in the ECCD policy, which is meant to address the holistic well-being of children and has goals related to nutrition, health and social services, and legal protections.

Civil society and the ECCD sectoral team. A national ECCD team meets quarterly to provide updates on work in Lesotho. This committee consists both of governmental and nongovernmental stakeholders and supports implementation of the national ECCD policy and advocacy for ECCD activities. Stakeholders noted that this would be a good forum to support any scale-up initiatives.

Donors. Donor support for the ECCD program has been provided through USAID's OVC Special Initiative. Other donors active in the ECCD space in Lesotho are UNICEF and World Bank. UNICEF has expressed support for scaling up the Mphatlalatsane model, and stakeholders interviewed from UNICEF indicated the possibility of future funding for such an initiative.

Sustainability

Although most stakeholders spoke favorably about the program, many questioned its sustainability. Their concerns were related to (1) the short duration of the program, (2) facilitators being brought in from outside the community, (3) ECCD skills and knowledge being limited to program participants, (4) logistics issues for program supplies, and (5) limited support for ECCD policy and funding at the national level.

Stakeholders made several recommendations to address sustainability:

- Recruit session facilitators from the community to ensure that ECCD knowledge and skills remain
- Create lending libraries for books, to decrease supply costs
- Increase community demand for ECCD services by engaging community leaders
- Disseminate evaluation results to increase support at the national level
- Coordinate with local clinics to increase access to HIV testing and treatment

Recommendations

To lay the foundation for successful scale-up, the following recommendations are directed at government officials; ministries of education, health, and social development; the ECCD network; and civil society. MEASURE Evaluation recommends the following:

1. Increase advocacy and awareness for ECCD policy and program support.

Although policy and structures exist, there is a need for increased ownership and integration of ECCD.

- 1.1 Invest in and support the existing ECCD network to increase advocacy and leadership.
- 1.2 Advocate expansion of the ECCD policy and engage ministries beyond the MOET to support related policies.
- 1.3 Engage chiefs and gatekeepers in each community to understand the importance of ECCD, increasing ownership and sustainability.

2. Generate financial support from government and donors to address lack of funding.

- 2.1 Lobby for additional donor and government funding through wide dissemination of the study evaluation results and through champions of ECCD and health integrated services in multiple sectors, in the MOET and beyond.
- 2.2 Identify funding streams to sustain ECCD and health integrated programs after donor support ends.
- 2.3 Advocate at local and community levels to support demand for ECCD and health integrated services.

3. Explore multiple scale-up and cost scenarios. MEASURE Evaluation identified these scenarios:

- 3.1 Scenario 1: Provide the program to all OVC currently served by OVC IPs, ages one through

five, in five districts, using libraries, nine sessions, and MSH or another international IP.

- 3.2 Scenario 2: Provide the program to all OVC currently served by OVC IPs, ages one through five, in five districts, using libraries, nine sessions, and a local IP.
- 3.3 Scenario 3: Provide the program to all OVC currently served by OVC IPs, ages one through five, in five districts, using libraries, six sessions, and a local IP.

4. Improve programming based on scale-up assessment and study results and monitoring.

MEASURE Evaluation identified potential adjustments for improved functioning.

- a. Recruit program facilitators and community-based mentors from the community when possible.
- b. Engage community leaders in planning and advocacy related to program services.
- c. Ensure that supportive supervision by IPs is continuous and ongoing.
- d. Adapt the program to suit the contexts of urban and industrial areas.

The results of this assessment reveal support for ECCD services and the potential of this program to increase HIV testing and treatment. The intervention design was largely successful in bringing both ECCD and health services to hard-to-reach populations. Challenges remain in sustainability, funding, and low recognition of ECCD as a priority concern. Additional steps are needed to increase awareness of, secure a funding mix for, and increase community involvement in and ownership of intervention planning and implementation.