Integrating Early Childhood Development and Health in Eswatini, Lesotho, and Zimbabwe:

A Scale-Up Assessment

September 2019

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MEASURE Evaluation

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Cover

Mother and child in rural Lesotho. Photo: Courtesy of James Walsh, Sinamatella Productions

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ABBREVIATIONS

ART	antiretroviral therapy
CBM	community-based mentor
CBO	community-based organization
CBT	community-based trainer
CCW	childcare workers
CHW	community health worker
CMM	Community Mentor Mothers
CSO	civil society organization
ECD	early childhood development
ECCD	early childhood care and development
ECS	early childhood stimulation
EID	early infant diagnosis
EIP	Expanded IMPACT Project
IF	intervention facilitator
IMPACT	integrated management of pediatric HIV/AIDS care and treatment
IP	implementing partner
ISAL	internal savings and lending
m2m	mothers2mothers
M&E	monitoring and evaluation
MOA	Ministry of Agriculture
MOH	Ministry of Health
MOHCC	Ministry of Health and Child Care
MOET	Ministry of Education and Training
MOLSW	Ministry of Labour and Social Welfare
MOPSE	Ministry of Primary and Secondary Education
MSH	Management Sciences for Health
MOWAGD	Ministry of Women Affairs, Gender & Community Development
NGO	nongovernmental organization
O&M	operation and maintenance
OVC	orphans and vulnerable children
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PIPS	parent information playgroup sessions
PM	prime minister
PMTCT	prevention of mother-to-child transmission
RMNCH	reproductive, maternal, newborn, and child health
SNECD	Eswatini Network for ECD

TB	tuberculosis
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
VHW	village health workers
WEI/B	World Education Inc./Bantwana
WHO	World Health Organization

EXECUTIVE SUMMARY

The HIV epidemic has had a profound effect on children in sub-Saharan Africa, where more than 15.1 million children have lost one or both parents (UNICEF, n.d.). 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 Eswatini (formerly Swaziland), Lesotho, and Zimbabwe that integrate early childhood development (ECD) with pediatric HIV treatment or prevention of mother-to-child transmission (PMTCT) of HIV. Evaluations of each intervention generated data on successful approaches that improved health; the evaluations also established evidence to improve programs. To prepare for potential scale-up ("scale-up" pertains to efforts to reach more people with a proven practice more quickly and effectively), 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 (Adamou, et al., 2014).

The scale-up assessment had the following objectives:

1. Describe the intervention package and key beneficiaries and stakeholders.
2. Assess the interest and readiness of key stakeholders to scale up OVC integrated interventions.
3. Identify opportunities for and constraints to successful scale-up of OVC integrated interventions.
4. Develop recommendations for scale-up of OVC integrated interventions.

The scale-up assessments were completed in each country with a three-pronged approach: (1) desk review, (2) qualitative data collection, and (3) cost estimation. We interviewed 37 individuals in Eswatini, 25 in Lesotho, and 21 in Zimbabwe, for a total of 83. MEASURE Evaluation researchers conducted the majority of the interviews in person; they conducted all interviews in Zimbabwe virtually. The group workshop in Eswatini was completed in one working day. The cost estimation phase of the assessment included a costing questionnaire and a cost estimation tool. The costing questionnaire was completed by program staff, as well as through in-person meetings, conference calls, and via email. Program implementing partners (IPs) shared the cost data.

In this report, we provide the results from our scale-up assessments of the integrated interventions in Eswatini, Lesotho, and Zimbabwe; suggestions and recommendations related to scaling up these interventions in each country; and our lessons learned from working on these assessments.

Overall, the results from scale-up assessments reveal broad support for the integrated programs and scaling of the programs to additional geographic areas. Respondents saw the programs as successful ways to target an at-risk population in need of services to support early childhood development and increase HIV prevention, testing, and treatment. According to respondents, the intervention designs increased community linkages to health services, especially for HIV/AIDS. Challenges remain because of both funding needs and lack of coordination around ECD at the central government level. Additional steps should be taken to increase advocacy and awareness for ECD policy and program support, secure funding from both the government and potential donors, and continue taking steps to increase government involvement and ownership in intervention planning and implementation. We also provide recommendations on simplifying the intervention to decrease cost and enable scale-up.

A decision on whether to scale up an intervention is to be made by local governments and donors in each country. In making this decision, factors such as intervention impact, cost, complexity, relevance to the

country needs and priorities, ease of implementation, availability of funds, and others would be considered. Once the decision is made to scale up the intervention, this report aims to help stakeholders in each country design and implement the intervention at scale. We also hope that our findings and lessons learned might be useful for future program design, planning, and evaluation efforts. We strongly suggest integrating scalability considerations in both research and intervention design.

INTRODUCTION

The HIV epidemic has had a profound effect on children, particularly in sub-Saharan Africa, where more than 15.1 million children have lost one or both parents to HIV (UNICEF, n.d.). In Lesotho, Eswatini, and Zimbabwe, more than 20 percent of children have lost at least one parent to HIV or other causes (UNICEF, n.d.). In 2014, as part of its OVC programming, PEPFAR announced a special initiative for the youngest children (under five years old) affected by the HIV/AIDS epidemic. The initiative is funding interventions and research in the southern African region to generate data on successful approaches that result in improved health and to focus on using this evidence to improve and inform programming throughout the region. Lesotho, Eswatini, and Zimbabwe are participating in this special initiative, which integrates OVC programming with pediatric treatment and PMTCT (U.S. Government International Assistance for Children in Adversity, 2014). The specific interventions in the three countries were evaluated to examine both ECD and clinical aspects of interventions for a more holistic understanding of child needs.

In Eswatini, mothers2mothers (m2m) provided quality ECD services and reproductive, maternal, newborn, and child health (RMNCH) services and support for vulnerable children ages zero to two and their parents or caregivers, with the aim of improving cognitive, social-emotional, motor, and language development, and physical growth; reducing HIV vertical transmission and improving adherence; and creating a safe and stimulating environment for ECD within homes and communities (mother2mother, n.d.).

In Lesotho, Stellenbosch University, in partnership with Management Sciences for Health (MSH), GROW (a local nongovernmental organization [NGO]), University College London, Oxford University, and Reading University aimed to increase HIV testing and treatment, and improve ECD for young children. The Mphatlalatsane Project, meaning "Early Morning Star," was implemented in the district of Mokhotlong, a remote mountainous area with high rates of extreme poverty and endemic HIV infection (Thomlinson, 2015). The project used a group-based intervention to increase HIV testing rates for children, improve nutrition, and provide cognitive stimulation for children ages one to five. In addition, Mphatlalatsane used community health outreach days to link communities to existing resources, including HIV testing and counseling and tuberculosis (TB) screening, antiretroviral therapy (ART), nutrition assessments, immunizations, community gardening programs, and referral to legal protection and social services.

In Zimbabwe, an enhanced, comprehensive, community-based intervention delivered by World Education aimed to enhance child stimulation by developing skills of their primary caregivers, educating parents about the health and nutrition of children ages zero to two, building household economic resilience by using an internal savings and lending scheme (ISAL), and improving retention in care among HIV-exposed and infected children ages zero to two (Cowan, 2015). This comprehensive intervention worked to improve uptake and adherence to ART for HIV-infected children and improve retention in HIV care among HIV-infected mothers.

Each country's intervention took a different approach but targeted the same health outcomes among children ages zero to five, including HIV testing, ART adherence, ECD outcomes, and nutritional outcomes. To be prepared for potential scale-up once the impact evaluation results become available, USAID asked MEASURE Evaluation to assess the scalability of the ECD integrated intervention across countries. This report summarizes the background, data collection methods, analysis, findings, and recommendations from the scale-up assessment in Eswatini, Lesotho, and Zimbabwe. In the report structure, we first present the background and a summary of the methods we applied to conduct scale-up

assessments in all three countries. Next, we present our findings and recommendations from the scale-up assessment for each country in the order in which data were collected: Eswatini, followed by Lesotho and Zimbabwe. Last, we present lessons learned and recommendations from all three assessments.

Background

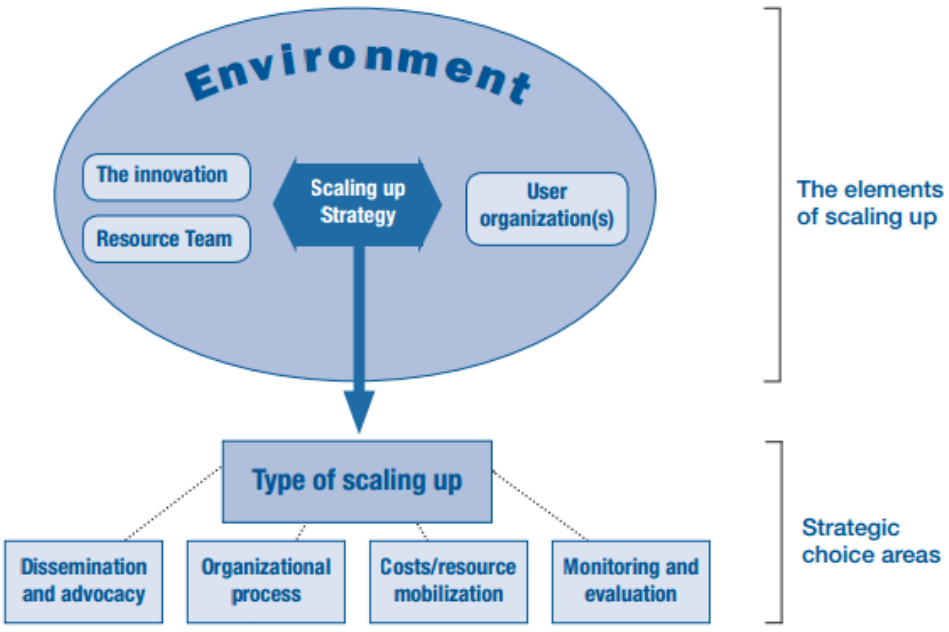
What Is Scale-Up?

Scale-up pertains to deliberate efforts to reach more people with a proven practice more quickly and more effectively to effect lasting change (Adamou, et al., 2014). It is widely acknowledged that evidence of effectiveness is not sufficient to ensure that proven interventions become part of routine program implementation elsewhere. Active and early planning and concerted advocacy efforts from multiple stakeholders and champions are required to take interventions to scale. The success or failure of a scale-up is closely tied to a complex array of contextual factors, such as political will, regulatory requirements, and donor and fiscal environments.

Conditions when scaling up a program may be very different from those experienced during the study period. For example, there may be greater variation in beneficiary charateristics. Trainers, supervisors, and providers may have different qualifications and experience than those participating in a rigorous effectiveness study. The funding levels and sources may have changed. Because the task of scaling up is not exclusively a technical and managerial undertaking unaffected by the outside world, it is important to consider what influences interact when taking an initiative or program to scale. The ExpandNet/World Health Organization (WHO) scale-up framework shown in Figure 1 depicts the five elements that influence scale-up (ExpandNet, 2010):

1. The external environment and conditions that can affect scale-up
2. The innovation or intervention being scaled up
3. The resource team charged with promoting the innovation
4. The user organizations expected to adopt and implement the intervention
5. The scale-up strategy—that is, the plan and actions to establish policies and services

Figure 1. The ExpandNet/WHO framework for scaling up



This framework also includes strategic areas for which decisions are needed about organizational processes, costs/resource mobilization, monitoring and evaluation (M&E), and how best to communicate and promote the program. The methodology of the scale-up readiness assessment is guided by this framework.

A wide range of stakeholders need information about the proposed model for scaling up—including how it is an improvement over other available alternatives—to inform decisions and justify the time, costs, and efforts needed to bring the intervention to scale.

The goal of the readiness assessment is to gather and organize information about the key components and activities of the OVC integrated interventions (i.e., "the innovations" in the Figure 1 framework), those that seek to promote and facilitate wider coverage of the programs (i.e., the resource teams), those expected to implement the programs at scale (i.e., the user organizations), and the external influences (i.e., the environment). The purpose is to develop a strategy and recommendations for all three countries for a potential scale-up of the OVC integrated interventions. In addition, the asessment will help inform policymakers and donors of the value of the interventions and provide information for advocating the adaptation of and investment in the interventions at scale.

Objectives of the Scale-Up Readiness Assessment

The scale-up readiness assessment had the following objectives:

1. Describe the intervention package and key beneficiaries and stakeholders.
2. Assess the interest and readiness of key stakeholders to scale up OVC integrated interventions.
3. Identify opportunities for and constraints to successful scale-up of OVC integrated interventions.
4. Develop recommendations for scale-up of OVC integrated interventions.

To achieve the objectives, the scale-up readiness assessment answered the following questions:

- What is the **vision for scaling up**? How would the scale-up look if it were successful? What are the models being used to implement the specific interventions in each of the countries? How are the interventions being defined? (The term "model" refers both to the intervention and the contextual and operational keys to its success, which are often unarticulated in the original design.)
- What **evidence** do decision makers say they need to be convinced of the value of the intervention?
- What **contextual factors** (e.g., political, environmental, cultural) will promote or inhibit the interventions going to scale?
- What is the level of **interest in and commitment to** scaling up the interventions among key stakeholders? How well do these interventions align with donor and national health sector goals?
- What are the necessary **resources** (e.g., human skills, financial resources, information technology, and so on) for scaling up the interventions? What will be the short- and long-term cost considerations of scale-up? How will the necessary support be mobilized?

METHODS

The scale-up assessments were completed in each country using a three-pronged approach: (1) desk review, (2) qualitative data collection, and (3) cost estimation.

The desk review consisted of gathering background information on the intervention and local context, done through online reviews to locate local ECD policy documents, IP information, and relevant information about the OVC and ECD context in each country. USAID, the evaluation researchers, and IPs shared additional documents. These documents included intervention designs, study protocols, and program documents.

Qualitative data were collected through key informant interviews with program implementers, government and civil society stakeholders, and donors. Interviews used a semi-structured set of data collection tools, each adapted for that particular audience. In Eswatini, qualitative data collection also included a workshop with m2m staff to gather the most information possible in a group format.

Data collection tools included the following (1) defining the intervention, (2) reverse LogFrame; (3) visual mapping; (4) scalability assessment; and (5) estimation of cost (see Appendix A for tools). Tools 1 to 4 were completed with all respondents, whereas Tool 5 was completed only with the finance and executive leadership teams.

Two MEASURE Evaluation researchers conducted key informant interviews—one primary interviewer and one researcher for quality control and note taking—using a semi-structured interview guide. They took thorough notes during interviews, using audio recording for back-up, clarification, and capturing quotes. The interviewer reviewed interview notes for completeness and accuracy. The researchers labeled the Word files using a coding system to denote the location and type of interview.

The researchers interviewed 37 individuals in Eswatini, 25 in Lesotho, and 21 in Zimbabwe, for a total of 83. They conducted the majority of the interviews in person but all interviews in Zimbabwe virtually. Individual interviews lasted between one and three hours. The group workshop in Eswatini was completed in one working day. Data collection in Eswatini and Lesotho took place in May and October 2017. See Table 1 for a list of stakeholder organizations interviewed.

The cost estimation phase of the assessment included a costing questionnaire (Appendix A) and a cost estimation tool. The costing questionnaire was completed by program staff and through in-person meetings, conference calls, and via email. m2m's offices in Cape Town, South Africa and Mbabane, Eswatini; the MSH office in the United States; the USAID mission office in Lesotho; and the World Education office in Harare, Zimbabwe all shared cost data.

Table 1. Stakeholder organizations interviewed

	Agency/organization	# of participants
Eswatini	mothers2mothers • Eswatini staff (Mbabane) • Senior Technical Advisor – ECD/OVC (head office)	 9 1
	Mentor Mothers	11
	Ministry of Health (MOH), Sexual and Reproductive Health (SRH) Division	2
	Ministry of Education, ECD	2
	Eswatini Network for ECD*	3
	Health facility	2
	United Nations Children's Fund (UNICEF)	1
	HC3	2
	Bantwana*	2
	Researchers	2
	Eswatini (total)	37
Lesotho	mothers2mothers	2
	MSH former staff	7
	GROW	1
	Ministry of Health	1
	Ministry of Education	4
	Ministry of Social Development	2
	Catholic Relief Services	1
	UNICEF	1
	Stellenbosch	1
	USAID	2
	Touching Tiny Lives	1
	Caritas Lesotho	1
	University of Lesotho (ECCD)	1
	Lesotho (total)	25
Zimbabwe	World Education	3
	Mavambo Trust	1
	Ministry of Health	2
	Centre for Sexual Health and HIV/AIDS Research (CESHHAR)	1
	USAID	2
	Insiza Godlwayo AIDS Council	1
	Child Protection Society	1
	Chiedza Child Care Center	2
	Wild for Life/Painted Dog Conservation	1
	Hope for a Child in Christ (HOCIC)	3
	Bekezela Home-Based Care Organization	1
	Hospice and Palliative Case Association of Zimbabwe (HoSPAZ)	1
	Pamuhacha HIV and AIDS Prevention Project	1
	Uzumba Orphan Care	1
	Zimbabwe (total)	**21**

Analysis

Qualitative Data

Qualitative data were collated and analyzed in Microsoft Excel through development of matrices to identify commonalities and differences arising across interviews. Qualitative analysis focused on identifying broad themes, concentrating on factors affecting scale-up, identifying assumptions and intangible program elements that may not be documented elsewhere, and support for scale-up. Analyses also elucidated commonalities and differences across interviews and sectors, such as challenges faced in implementation, level of ministry support, or potential obstacles to or facilitators of effective scale-up.

Costing

Financial data were collected for each intervention and allocated to categories (such as staffing, overhead, or implementation); program activities; and, where possible, phases of program implementation, based on the data and information collected in the qualitative interviews. The level of detail in the financial accounts varied by project and phase, so we made and documented key assumptions. Costs were annualized where necessary. In scenarios that considered local IPs, management and some overhead costs were reduced to reflect the lower cost structure of these organizations.

Scale-up scenarios were based on additional assumptions relating to economies and diseconomies of scale, personnel allocation, and intervention modifications based on key informant interviews and correspondence. Recurrent costs, such as training, were generally increased proportionally with the number of beneficiaries, whereas other costs were adjusted on an individual basis. This assessment includes only financial costs.

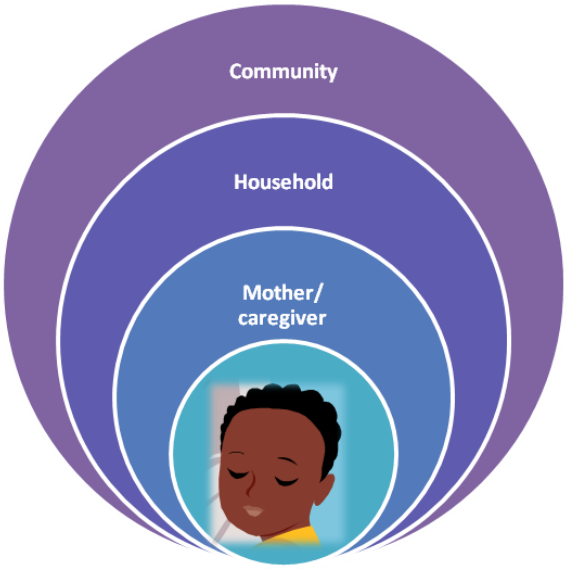
RESULTS—ESWATINI

Describe the Intervention

The goal of m2m's ECD program in Eswatini, Umtfwana Wami Ngumntfwana Wetfu ("My Child, Our Child"), is that "Young children infected or affected by HIV/AIDS have improved developmental outcomes." m2m's ECD program builds on its well-known RMNCH/PMTCT program and focuses on supporting children ages zero to two and their mothers from as early as possible in pregnancy, as well as other primary caregivers and their families. m2m provided this integrated ECD and health program (henceforth referred to as "ECD program") to 2,390 children and caregivers in 2016. The model is a community- and home-based ECD and health intervention to improve a variety of maternal and child health outcomes, including ART adherence. The holistic and comprehensive model combines education and peer support to parents/caregivers and direct work with children through regular home visiting and links to m2m's pre-existing facility- and community-based PMTCT program. It also includes support groups and parent information play group sessions for caregivers and children.

Figure 2 illustrates m2m's orientation to ensure that the child remains at the center of the intervention, with the mother or caregiver closely connected, while also engaging a supportive and enabling caregiving environment for the child within the household and larger community.

Figure 2. m2m's circles of support/caregiving environment for the young child



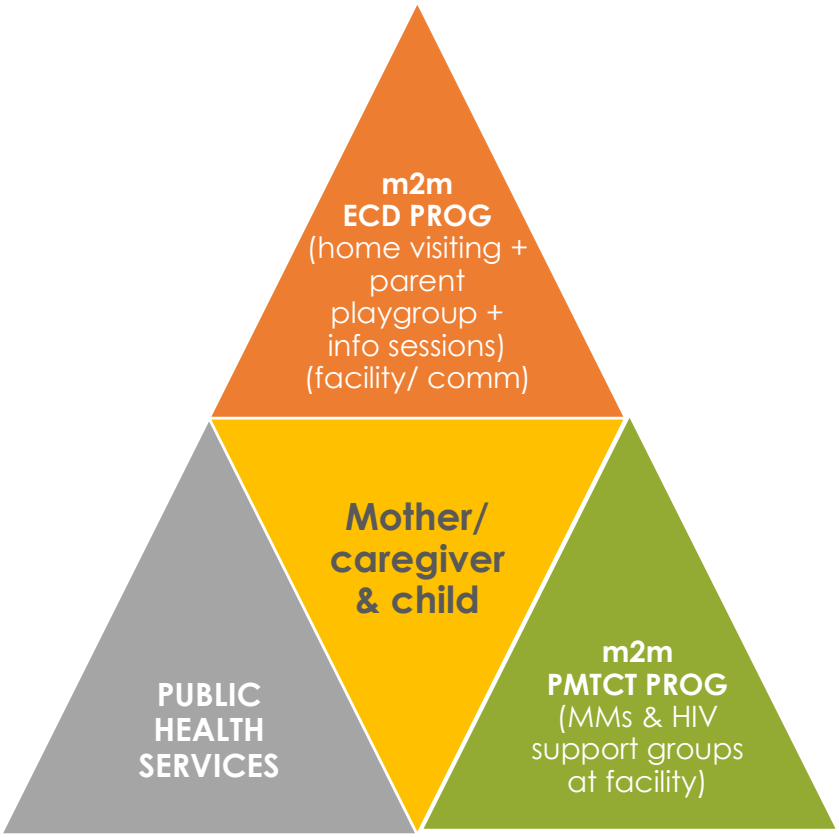
Source: m2m, 2014.

m2m's ECD program is underpinned by three strategic objectives, focusing on service delivery, child and caregiver status, and the broader caregiving environment:

1. Quality ECD services and support are available for vulnerable children ages zero to two and their parents/caregivers.
2. Rates of cognitive, social-emotional, motor, and language development; HIV vertical transmission; child morbidity, mortality, and growth are improved.
3. A safe and stimulating environment for early child development is created within homes and communities.

m2m approaches these objectives through integration of ECD into PMTCT, RMNCH, TB, and other health areas such as nutrition by working through trained ECD Mentor Mothers. The intervention focuses on pregnancy and ages zero to two but works with mothers and caregivers and the wider family because "the child is raised by everyone, not just the mother" (m2m workshop participant). This comprehensive intervention hinges on regular home visits but also includes support groups held at facilities for mothers living with HIV and parent information playgroup sessions (PIPS) held in each community for caregivers to learn and share experiences, and for children to have opportunities for group play with appropriate resources. See Figure 3 for the m2m ECD program intervention structure.

Figure 3. m2m ECD program intervention structure/standard of care



Source: m2m, 2014.

m2m trains and employs three types of Mentor Mothers in Eswatini–facility-based, community, and ECD. Both facility and Community Mentor Mothers (CMMs) are part of m2m's standard of care for PMTCT, whereas the ECD Mentor Mothers were a new addition for this intervention. Facility-based Mentor Mothers are based at health facilities and provide HIV education and support while women are waiting for appointments; they also work with nurses and CMMs to identify clients who miss appointments and need to be followed up by a CMM. CMMs work in the local communities in which they live; they help with loss to follow-up and adherence, complete community profiling, and, during this intervention, identify and refer pregnant women for the ECD program or other services. Once CMMs identify pregnant mothers and caregivers with children under age two in their catchment areas, they refer them to a health facility for enrollment in the ECD program. ECD Mentor Mothers focus on pregnant women and women with children under age two; they have a slightly smaller caseload, with more in-

depth and frequent visits with mothers/caregivers. ECD Mentor Mothers are the focus of this intervention and scale-up assessment.

The focus of the ECD program is stimulation for the physical, cognitive, emotional, and language development of a child, as well as support for primary caregivers, social support, and child protection. Despite the focus on the index client of child and mother, the intervention takes a family-centered approach that includes other family members to ensure they also learn about health and ECD, and promotes linkages and referrals for all family members, including HIV testing.

During pregnancy and the child's first year, home visits occur every 2 weeks and last between 45 minutes and 2 hours if there is a family session. From 12 months to 2 years, home visits occur once per month. The Mentor Mothers tailor the home visit to each client dyad of mother and child, depending on their needs and developmental stages. Sessions may include discussion of HIV, child health, nutrition, modeling various types of play and cognitive stimulation, toy making, and positive parenting techniques. Content covered in the ECD intervention can be found in Appendix B. Mentor Mothers assess developmental milestones every quarter at the household and record them in the "Family Folder," along with documentation of home visit content. This approach also allows for general safety and hygiene assessments of the household and surrounding area. Mentor Mothers include education on water safety, sharp objects or other potentially hazardous items, or areas of the environment.

PIPS also play a significant role in the m2m ECD program. They occur monthly, led by two or more Mentor Mothers, and include education for caregivers and time for children to play together. Caregivers receive opportunities to share their experiences in practicing the ECD activities they learn about during home visits, and share and learn about other parenting challenges and successes from other caregivers. At least five ECD clients must be present to hold a PIPS, but other non-ECD clients are also allowed to attend. This approach also helps build ECD awareness in the community. PIPS offer a time for caregivers to continue learning more about ECD in a group format and offers them the opportunity to share challenges and successes with each other. The caregivers choose the session topic the previous month, with guidance from the Mentor Mothers, who then develop the session plan, incorporating key areas, activities, and songs that link to that topic.

Mentor Mothers. Mentor Mothers are the backbone of m2m's innovative and well-recognized programming. The benefits of Mentor Mothers surfaced in many interviews. Participants noted the benefits of regular interaction, trust building, peer-to-peer rapport, and the employment, intense training, and professionalism evident through Mentor Mothers' early childhood expertise, uniforms, and appropriate behavior. Mentor Mothers are employed, not volunteers, as is common in other community programs, meaning they offer more professional services and have greater accountability.

The m2m approach prioritizes recruiting Mentor Mothers from the local communities to help with rapport building, trust, understanding of local context, and the practical challenges of transportation during home visits and PIPS. Mentor Mothers reported that the m2m program has been very helpful, "even with OUR kids."

Box 1

Eligibility criteria for ECD Mentor Mothers are as follows:

- Completion of high school (later relaxed to 8th grade)
- Living in the community
- Having had a child within last two years
- Being HIV positive and having experienced PMTCT
- Having a disclosed HIV status
- Ability to speak and write English
- Ability to communicate clearly
- Qualities of being trustworthy, respectful, and friendly

When asked what characteristics make the best Mentor Mothers, m2m staff quickly listed many soft and hard skills and qualities: empathy, compassion, respectful, good communicator, good character, good interpersonal and facilitation skills, ability to multitask, well organized, discreet. Another important quality was being knowledgeable about HIV, stigma and discrimination, and not afraid to disclose her positive HIV status. Mentor Mothers must be able to relate and communicate, but also maintain confidentiality while staying organized so as to document sessions and updates in the family folder. Empathy and compassion and respect were key qualities in the discussion of the best Mentor Mothers. m2m staff noted that some of these qualities are more challenging to find than others.

ECD Mentor Mothers are also required to be more educated than facility Mentor Mothers because they need to be able to absorb and relay more complex information and manage more detailed client management tools. See Box 1 for eligibility criteria for ECD Mentor Mothers.

Intervention Strengths and Challenges

Intervention Strengths

Stakeholders at all levels had positive opinions about m2m's integrated ECD project. From health facility nurses, who reported appreciation for Mentor Mothers' ability to counsel and follow up with women for ART retention, to high-level Ministry of Education and Training (MOET) and Ministry of Health (MOH) representatives who valued the integrated and holistic approach, the intervention had many supporters.

> "Mentor Mothers are the biggest strength. They are linked to the communities, they are peers, and they have HIV experience."
>
> —Researcher

Stakeholders specifically mentioned the positive effect of integrating ECD into PMTCT, the intensive (and early) coverage of pregnant women in intervention areas, and the particular benefit of one-to-one support in the home. Nearly all stakeholders discussed the value of in-home support because it reduces time, travel, and cost burden on mothers; the intervention can be individualized based on the client's need; and it emphasizes the importance of building a relationship and mutual trust. Mentor Mothers are able to observe the interaction between caregivers and children, and demonstrate ways to play and how to engage children in various activities. Further, Mentor Mothers are able to engage and interact with all family members on ECD, and offer referrals to other family members when necessary.

The in-home sessions are complemented by the PIPS, which multiple stakeholders discussed as important in allowing mothers to discuss and learn from each other. Several stakeholders discussed increasing the availability or frequency of PIPS. Other strengths of the intervention included the comprehensive training (five weeks for ECD Mentor Mothers; four and three weeks for community and health facility Mentor Mothers, respectively); locally adapted materials; buy-in at multiple levels; and the organization, supportive supervision, and M&E of m2m. m2m is a trusted organization, which also lends credibility to the intervention and fosters acceptance into communities.

Implementation Challenges

In addition to the overwhelmingly positive perspective on the intervention, the assessment identified implementation challenges, as shown in Table 2. Interviewees from m2m discussed challenges around recruiting qualified Mentor Mother candidates because rural areas had fewer applicants with the desired educational experience. Completion of high school was one of the eligibility criteria for Mentor Mothers. However, m2m had to lower this requirement and recruit Mentor Mothers who completed the eighth grade of school. ECD is a new subject area for Mentor Mothers and m2m at the time the program was

introduced in Eswatini; thus, the extensive training is necessary but time-consuming. Mentor Mothers also require significant supervision following the training because of the newness of the ECD concepts and material. In addition, m2m participants mentioned external competition for trained Mentor Mothers, resulting in staff turnover.

Transportation and time to travel to clients' houses arose as an issue, especially during challenging seasonal weather. Mentor Mothers can complete three to four home visits per day if the homes are close together, but that is not always the case. Mentor Mothers often have to walk long distances or take a bus—if one is available—to the next household or community. m2m provides monthly transport stipends for this purpose.

Because m2m is a well-known organization that works with HIV-positive women in Eswatini, stigma surfaced as an issue in the new ECD programming. The ECD program works with HIV-positive and HIV-negative women, but because m2m Mentor Mothers are all HIV positive—generally considered a strong asset to the program—in some cases, it caused concern for potential program enrollees. According to m2m staff, some women or their husbands did not want to be associated with m2m Mentor Mothers because neighbors or community members might assume they were HIV positive, which might or might not be the case. m2m has worked to overcome this assumption by educating community members that the ECD program includes both HIV-positive and negative women; nevertheless, it remains a barrier for some potential clients. Mobility outside of the catchment area was a reason for loss to follow-up, but few clients leave the program otherwise.

Table 2. Implementation challenges and m2m adjustments

Challenge	How m2m addressed the challenge
Recruiting qualified candidates	Adjusted criteria to match educational attainment in the target community
ECD is a new and lesser-known subject area	Intensive training and supervision
Mentor Mother turnover because of increased capacity	Remains a challenge
Stigma associated with m2m's previous work exclusively with HIV-positive clients	Awareness raising that the program is a universal one
Mobility of clients outside of catchment area	Remains a challenge
Mentor Mothers struggle with transportation for homesteads farther away	Provide a small transportation allowance
Initial challenges in finding locations to host PIPS	Persistence and ongoing community engagement opened up some venues; other sessions are held outside

Characteristics of the Intervention that Present Both Strengths and Challenges

Home visits do not follow standard lessons plans; different stakeholders viewed this feature as both a strength and a challenge. This feature allows for flexibility and adjustment based on a child or mother's need, but it also places more responsibility on Mentor Mothers to develop tailored sessions and ensure that all topics are covered over the course of the intervention. Several Mentor Mothers mentioned that they would appreciate more structured or scripted lesson plans and activity schedules. However, a key researcher in the study saw the iterative process of the ECD intervention as a key strength, stressing the importance of being responsive to the needs of dyads at each stage, given that not everyone at the same age needs the same type of education or activities.

The comprehensive nature of the intervention also arose as both a strength and challenge. It is a complex intervention that works at multiple levels and provides holistic support. The intensity of the intervention is highly valued, yet some respondents expressed concern regarding possible scale-up because of potential challenges to intervention fidelity and the efforts needed to ensure a high quality of services.

Scale-Up Scenarios and Costing

The integrated intervention unit cost per a child per year was USD $509.84. PMTCT-only costs were taken directly from the 2012–2014 period without change; integrated program costs were taken from the 2014–2017 period, with all PMTCT costs reduced by a factor of 21/52 to reflect that ECD was implemented at 21 of the 52 total program sites. We then decreased these costs by the number of years the program ran to show an annualized cost. Start-up costs vary by scenario, depending whether these activities and organizations are already in place in the communities. All recurrent costs increase with the number of children served. In Scenario 1a, international travel costs are eliminated and consultant costs are reduced by half. In Scenario 1c, these costs are reduced by 50 percent and office costs are eliminated.

We costed the following various scale-up scenarios, also shown in Table 3:

Scenario 1. Cover only the most vulnerable children or areas in the PEPFAR-supported districts (assume 26.3 percent coverage among 24,234 children ages zero to two in these districts):

a. The same integrated health ECD program provided by m2m, with health facility and community and ECD Mentor Mothers. m2m covers the most vulnerable children in PEPFAR-supported districts.

b. Rural health motivators (a cadre of lay health worker volunteers contracted by the government to provide primary healthcare services) implementing this program, with m2m teaching and supervising them. Rural health motivators would implement the program via monthly visits (combining the roles of ECD, community, and health facility Mentor Mothers).

c. Another NGO/IP implements the intervention, with m2m providing technical assistance. The IP will have only ECD and health facility Mentor Mothers.

Scenario 2. m2m expands its ECD component to all communities in which it has a PMTCT peer support/mentor program now. Currently, m2m has a PMTCT program in 52 communities but ECD in only 21.

Table 3. Costing for scale-up scenarios, Eswatini

		Cost (USD)
Scale-up scenario 1. Serve only most vulnerable children in PEPFAR-supported districts[1]		
Number of beneficiaries		6,374
1.a. 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 implement this program, with m2m teaching and supervising them	Total cost	$2,293,140
	Unit cost	$359.76
1.c. Another NGO/IP implements the intervention, with m2m providing technical assistance. The IP will have only community[2] and health facility Mentor Mothers	Total cost	$2,157,534
	Unit cost	$338.49
Scale-up scenario 2. m2m expands its ECD component to all communities in which it has PMTCT peer support/mentor program now. Currently, m2m has PMTCT program in 52 communities but ECD in 21		
Number of beneficiaries		5,918
	Total cost	$2,218,846
	Unit cost	$374.93

[1]This is assuming 26.3 percent coverage among 24,234 children ages zero to two in the PEPFAR-supported districts.
[2] In this scenario, CMMs will have both community and ECD Mentor Mothers' responsibilities.

Scalability

Thoughts on scalability varied by type of stakeholder. This was particularly evident in several questions that were part of the Scalability Assessment Tool (see Appendix A). Several stakeholders, including ministry and donor representatives, ranked the intervention as clear and easily replicated; of low complexity; and with a few components that easily could be added to existing systems. They also felt the model is not particularly value or process intensive, and requires only a low technical sophistication for implementation. These respondents indicated that once initial buy-in is established, the value would be clear, and once adequate personnel are available, replication would not be a challenge.

Interestingly, IPs and researchers were more likely to feel the intervention is of high complexity with many components, and that it is an integrated package. Implementers were also more likely to see the intervention as value intensive and requiring technical sophistication around the subject area of ECD. For example, one researcher said that the intervention is a comprehensive, intensive intervention with highly trained Mentor Mothers, and expressed doubt that it would be scalable.

Most stakeholders agreed that the intervention was supported by eminent individuals and institutions, such as the MOET, MOH, and USAID. They also generally agreed that the model is based on sound evidence; addresses an objectively significant, persistent problem; and that current solutions for this issue are inadequate. There were mixed opinions about whether the model requires a large or small commitment of funds at scale, but unanimous agreement that the model does not have internal funding and is dependent on external funding.

Significant factors related to scale-up included the lack of ownership of ECD among the ministries, especially with regard to ECD integration into health; lack of implementation experience in urban and extremely rural areas; and a dearth of available funds for scale-up. The MOET is responsible for ECD related to preschool education, usually starting at three or four years of age. The MOH is responsible for

health outcomes of young children (zero to two years of age) but does not focus on cognitive or social development, leaving a gap in connecting the social, cognitive, and health well-being of children in their first 1,000 days. The Deputy Prime Minister's office includes a newly formed National Children's Coordinating Unit tasked with coordinating issues related to child welfare and maltreatment; however, this department has undergone recent reorganization and is being re-engaged.

Site selection for the study intervention excluded urban areas because of the increased mobility of urban populations and included areas around health facilities with a sufficient volume of clients. This approach led to the majority of sites being located in rural or semi-urban areas. Although these practical restrictions enabled a strong study design and implementation, the study results will be limited in generalizability. Interview respondents noted that scale-up success could be impacted by differences in urban areas, such as increased mobility and increased caregiver employment outside the house, leaving the Mentor Mothers working with extended family members or rotating caregivers instead of consistent primary caregivers. In extremely rural areas, scale-up could also be affected by the long distances Mentor Mothers would have to travel for their household visits, lack of available clinics and resources for referral, and low caseloads.

Finally, stakeholders consistently noted the lack of available funds for scale-up as a principal challenge. All representatives of the MOH and MOET indicated a strong desire and support for the intervention but expressed dismay at the lack of funds the Government of Eswatini has available to fully fund a scale-up of the intervention. Other donors, IPs, and civil society representatives also expressed similar concerns, indicating that they highly valued the intervention, but the funds required for scale-up would be challenging to obtain. Health facility representatives in particular expressed concern at the possibility of losing Mentor Mothers in health facilities and communities because they have come to depend on them.

Country Context

Country and local context are crucial to consider when planning for scale-up. As expected, the scale-up assessment revealed a broad spectrum of interrelated institutions, stakeholders, and cultural influences at play in this integrated intervention that cannot be overlooked. See Table 4 for key stakeholders in ECD in Eswatini.

Table 4. Key stakeholders for m2m ECD program

Government
• Ministry of Health (SRH Division) • Ministry of Education and Training (ECD Department) • National Children's Coordinating Unit (Office of the Deputy Prime Minister) – Children's policy coordinating body • Poverty Reduction Unit (Office of the Deputy Prime Minister) • National Child Protection Network • Domestic Violence, Child Protection and Sexual Offences Unit (Royal Swaziland Police) • Ministry of Tinkhundla and Development
Civil Society
• Swaziland Network for ECD • NGOs and IPs
Donors
• USAID • UNICEF

Government stakeholders. Key national government stakeholders for m2m's ECD program in Eswatini include the MOH, specifically the SRH Division, the MOET, and the National Children's Coordinating Unit in the Office of the Deputy Prime Minister. The government began drafting a multisectoral ECD policy in 2009 but it has yet to be finalized. There is an Education Sector Policy, which includes pre-primary education as well as Swaziland Early Learning and Development Standards (SELDS) (Africa Early Childhood Network, Swaziland, 2014). The MOET was involved in the m2m training of ECD Mentor Mothers, including help in developing the training manuals. However, the majority of the MOET's focus on ECD begins at preschool age, and there is often a gap regarding ages zero to two.

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.

Civil society and Swaziland Network for ECD. The Swaziland Network for ECD (SNECD) was formally launched in 2014 at the first national conference on ECD, organized by the Eswatini Church Forum on HIV and AIDS (Church Forum). Participants included representatives from both houses of Parliament, DOE, the Deputy Prime Minister's Office, and civil society. The conference report highlighted the progress made over the past several years, particularly in development of the Swaziland Early Learning and Development Standards, but also acknowledged that "there is a need to raise public awareness to facilitate high level officials in parliament, government and civil society to promote ECD in their programs and activities" (Swaziland National Conference on Early Childhood Development, 2014).

The SNECD continues to be led by the Church Forum and remains active in the ECD community, with approximately 50 civil society members; it hosts monthly meetings with speakers and discussions on various ECD topics. m2m was a founding member and continues to play an active role as an SNECD Board member. Participants are from civil society; stakeholders said that government partners rarely attend and could benefit from a separate monthly meeting to discuss and advocate for ECD. SNECD also noted that the network is not currently sustainable because it would require a full-time staff person to continue moving things forward. UNICEF and the Open Society Initiative for Southern Africa (OSISA) support the ECD network, as does the Church Forum, but financial considerations limit the amount of work the network is able to do.

Coordination. Because of the intersectional and multisectoral nature of ECD, a significant challenge in the stakeholder context is the lack of coordination and oversight. Key informant interviews highlighted that the MOH focuses on ages zero to two for immunization, nutrition, growth, and so on, but does not include social and cognitive development in assessments or health records. The MOET 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 zero to two does not have a "home" in one agency or department. Its cross-cutting nature requires strong collaboration and coordination, which stakeholders noted as lacking, attributed in part to the bureaucracy and political nature of coordinating government departments that do not report to each other and have different hierarchies and expectations.

One participant offered a successful example of multiple ministries working together through a multisectoral task team for violence against children, which was created by the office of the Deputy Prime Minister, who was a member of the team. This task team was called by UNICEF, and the Deputy Prime Minister was a champion and helped to organize it. The team included top levels of MOET, MOH, and the Office of the Deputy Prime Minister, who came together to deal with the issue; they also mandated lower-level technical people to work on the issue, leading to change at multiple levels.

Donors. Donor support for the m2m integrated ECD program has been provided through USAID's OVC Special Initiative. Other donors active in Eswatini include UNICEF and OSISA. UNICEF has expressed appreciation and support for m2m's ECD health program; at the time of data collection, however, it did not have plans to support it financially. There was a consensus among donors that m2m's integrated ECD/RMNCH program is needed and should be supported.

Despite the lack of financial commitment, the majority of stakeholders supports and advocates scale-up, though some expressed the importance of waiting until determining whether positive study results were available before scaling. Stakeholders expressed the desire for scale-up; however, more than verbal commitment will be needed to drive it. Outside of those focused on ECD, a gap exists in understanding of the importance of ECD, particularly the zero to two age group. OVC awareness is more established in Eswatini than is the importance of ECD, which may require additional advocacy to help others understand the problem and the potential solution being piloted by m2m.

Geography and culture. Respondents considered Eswatini 's small size advantageous with regard to scale-up. Multiple participants, both implementers and researchers, mentioned that the small size would increase the feasibility of country-wide scale-up. One researcher observed that the challenges of migration are found in all locations, urban and rural, indicating this circumstance should not preclude attempts at scale-up. Other respondents felt the intervention should be tested specifically in urban and hard-to-reach locations before scale-up.

Respondents also noted that Eswatini does not have significant cultural or societal differences among different parts of the country, such as type of family relationships and structure or cultural and gender norms, that exist in some larger countries.

Sustainability. The majority of stakeholders felt the intervention was worthwhile and an important investment; however, many also had concerns about sustainability. Financial support was a primary factor in sustainability, as were concerns regarding the lack of institutional ownership and coordination for ECD programming for zero to two-year-olds. Stakeholder opinions on sustainability also varied with beliefs about the complexity and intensiveness of the intervention.

The intervention also includes many factors that support sustainability. Recruiting Mentor Mothers from the local communities offers sustainability by using existing and local human capital as well as strengthening the knowledge and capacity of local women to understand and support ECD. Mentor Mothers said their training not only helped them support other community members but also supported them in integrating ECD into their own families. They also said that clients often discussed what they were learning with neighbors and community members not in the ECD program. Many program materials have been locally adapted, and skill-building sessions around using local resources to make toys add to its sustainability.

Strategies for Scaling

Although stakeholders expressed concern that eliminating or combining any elements of the intervention would affect impact, its high cost and intensive nature require consideration of cost-saving efforts. We propose the following strategies for cost reductions during scale-up:

Adding ECD to the CMMs' workload or vice versa. Merging CMMs and ECD Mentor Mothers would result in cost savings through fewer of the latter to be trained, though caseloads may need to be adjusted to account for the loss of both types of workers.

Reduce frequency of visits. Reducing home visits from biweekly to monthly in the first year could allow Mentor Mothers to carry a larger caseload. However, m2m notes that the program was designed based on international evidence indicating the importance of dosage in ECD home visiting interventions and which recommends visits at least every two weeks. Other drawbacks would include reduced personal connection and rapport with families, the possibility of caregivers forgetting lessons in the interim, and potentially missing developmental milestones during the first year. Another consideration in reducing visits is using information technology instead of face-to-face contact every two weeks, with a phone call perhaps taking the place of every other in-person biweekly visit.

Rural health motivators. Across multiple stakeholders, using the already-existing rural health motivators to deliver the intervention arose as a possible solution. Rural health motivators are a cadre of volunteer lay health workers contracted by the government to provide primary healthcare services, such as training households on how to prepare oral rehydration salts and provide first aid. According to reports during data collection, these motivators vary in how active they are in the communities and their levels of training. Several stakeholders felt the rural health motivators would not serve as a practical delivery mechanism for the ECD intervention because of limited capacity and a lack of reliability; many are older women with varying levels of education. They would not meet the current criteria of Mentor Mothers of having completed high school and having a young child themselves. Further, m2m notes that because Mentor Mothers are employed and not volunteers, they are expected to provide a professional service and work full time, thus having greater accountability. Other stakeholders felt it could be worth exploring the possibility of increasing and intensifying the training health motivators already receive to prepare them to deliver the ECD services in addition to the services they already provide. This scenario would offer cost savings in addition to increased local capacity.

PIPS. Eliminating the PIPS was also proposed as a potential cost savings. However, because of the low overall cost of this intervention component and its reported value, cutting this component would not outweigh the cost reduction.

Other recommendations for scale-up that arose during data collection related to intervention improvement and implementation, as follows:

Menu of Options for Mentor Mothers. As mentioned previously, the idea of scripted, structured lesson plans for the Mentor Mothers arose multiple times during data collection, although with varying perspectives. A menu of lesson plan options for Mentor Mothers could offer a compromise between strict schedules of narrowly scripted lessons and the current comprehensive but open lesson plans.[1] This approach could include training on 20–30 semi-scripted lessons organized by topic area or developmental milestone that a Mentor Mother could select based on each child/caregiver pair's need. This approach would help Mentor Mothers select session topics and provide more guidance, possibly leading to more efficient home visits and an increased number of such visits per day.

Refresher trainings. Data collection also revealed a need for ongoing refresher trainings to ensure quality implementation and adaptation to Mentor Mothers' experiences in the field. Annual in-service trainings, and m2m's ongoing supportive supervision by coordinators in the field and program staff, are included in the current intervention, but Mentor Mothers felt trainings could be increased.

[1] Note: Household visits are not strictly "lessons"—they comprise assessments, education, psychosocial support, referrals, etc.

Recommendations

Results showed across-the-board support for the ECD integrated program and its potential scale-up. Although the evaluation study results are forthcoming, it remains clear that health facility staff, IPs, and ministry officials appreciate and support the program. Respondents felt the intervention is beneficial and should be scaled up, though awareness is high that lack of funding remains the greatest challenge.

To lay the foundation for successful scale-up, the following recommendations are directed at the Government of the Kingdom of Eswatini, the ministries of education, health, and social welfare and development, the Prime Minister's office, the ECD network, and civil society.

MEASURE Evaluation's recommendations are as follows:

1. Increase ownership and awareness of ECD's institutional home.
2. Increase advocacy and awareness raising for ECD policy and program support.
3. Generate financial support from government and donors.
4. Explore multiple scale-up scenarios and cost implications to determine what is feasible within the Eswatini context.
5. Continue to improve m2m's ECD program based on scale-up assessment and study results, as well as ongoing program monitoring.

These five recommendations are interconnected and should not be undertaken one at a time, but rather implemented simultaneously to build on and support one other.

1. Increase ownership and awareness of ECD's institutional home

Given the lack of a strong and recognized institutional home for ECD for ages zero to two, MEASURE Evaluation recommends the following activities to garner sustained ownership and coordination:

1.1 Create an inter-agency taskforce or committee to coordinate the ECD-related work and potential scale-up. This committee should include committed champions from the MOH, MOET, Deputy Prime Minister's office children's unit, and civil society.

1.2 Appoint an ECD coordinator or manager to lead this taskforce and ensure that person has the capacity and authority to encourage commitment from taskforce members. It could be a person who reports directly to the Prime Minister or a permanent secretary, lending credibility to this position and task force.

2. Increase advocacy and awareness for ECD policy and program support for ages zero to two

Awareness around ECD is increasing, but much remains to be done, especially in supporting programming and policy during pregnancy and for ages zero to two.

2.1 Invest in and support the existing ECD network to increase their advocacy and leadership on the importance of ECD, especially during pregnancy and for ages zero to two.

2.2 Finalize the ECD policy. In addition to providing a roadmap for ECD in Eswatini, finalizing the draft ECD policy will require collaboration and commitment from multiple ministries and agencies, strengthening the groundwork for recommendations 1 and 3.

2.3 Once they are available, widely disseminate results of the ECD impact evaluation among all stakeholders to help move up ECD on the policy agenda.

3. Generate financial support from government and donors

Because of the significant barrier of lack of funding availability, we recommend the following:

3.1 Conduct substantial lobbying and advocacy efforts to generate funding from government and donors. These efforts will require current supporters to be active and engaged champions of the importance of ECD when dealing with government colleagues, decision makers, civil society organizations, and donors in Eswatini. Engaging Mentor Mothers, health facility staff, and even beneficiaries, as appropriate, can help tell the story of the importance of the ECD program.

3.2 Consider creating a donor coalition for funding; this coalition would share the financial burden and commitment, and potential impact, among multiple donors.

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

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

4.1 Scenario 1. Serve only the most vulnerable children in the PEPFAR-supported districts.

4.1.a. Use the same integrated health ECD program that m2m ran in Eswatini—with health facility, community, and ECD Mentor Mothers.

4.1.b. Rural health motivators implement this program, supported by m2m training and supervision.

4.1.c. Another NGO/IP implements the intervention, with m2m providing technical assistance. The IP will use only community and health facility Mentor Mothers.

4.2 Scenario 2. m2m expands its ECD component to all communities where they currently have an RMNCH program. Currently, m2m has an RMNCH program in 52 communities but ECD operates in only 21.

5 Continue to improve m2m's ECD program based on the scale-up assessment and study results, as well as ongoing program monitoring

MEASURE Evaluation identified the following potential adjustments to program operations for improved functioning. Additional adjustments from ongoing program M&E study results should also be considered.

5.1 Translate M&E tools into SiSwati.

5.2 Revisit in-service training practices and implementation. Ensure that in-service training happens after the initial three months of service provision and consider an increase in-service training generally. Mentor Mothers requested training on gender-based violence (GBV), refreshers on ECD, and more training on toy making.

5.3 Increase supervision; consider decreasing catchment area of regional managers from six health facilities to two to three.

This scale-up assessment reveals an appreciation for and desire to scale up the m2m ECD program in Eswatini across stakeholders. Caregivers, facility staff, government, and civil society place a very high value on m2m's implementation through Mentor Mothers and its one-to-one and group support for ECD, PMTCT, and other health areas in the household. Challenges remain, however, regarding funding for scale-up and coordination of the many stakeholders involved in ECD in Eswatini. These challenges

also underscore the importance of planning for scale-up early. While awaiting results of the evaluation, efforts can and should begin to build awareness and increase support for scale-up. Such efforts are important regardless of the magnitude and scope of scale-up, as ECD in pregnancy and children ages zero to two is a crucial area that requires additional attention and coordination in Eswatini.

RESULTS—LESOTHO

Describe the Intervention

The Mphatlalatsane or "Early Morning Star" project in Lesotho was implemented by MSH, GROW, and m2m Lesotho 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 for young children in the Mokhotlong district. The project was implemented through existing early children education centers in this mountainous area to test the feasibility of bringing such an intervention to a remote and hard-to-reach region of the country.

The intervention targeted families and caregivers of children ages one to five from the surrounding area. All families with children in this age range were welcome to join (typically the ECD centers charge fees for children to attend, but intervention sessions were open to caregivers and families in the target population). Caregivers enrolled in the program were required to attend each of a series of nine weekly sessions held in the area ECD center. During the weekly two-hour sessions, caregivers (defined as a family member living in the child's household responsible for providing daily care to the child) met in the ECD center, could bring the child, and were offered light refreshments. A trained intervention facilitator and a community mentor delivered content on health topics and book-sharing techniques. Sessions were delivered 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 a period of about seven minutes each day. A new book was shared weekly with families to facilitate book sharing in the home. The nine sessions were followed by a community outreach day, during which a variety of health services were offered to children, their families, and other members of the community, including birth registration, nutrition and TB screening, and HIV/AIDS testing.

Mphatlalatsane Project Facilitators

Caregiver sessions were delivered by pairs of session facilitators, who were stationed at individual ECD centers during the intervention period; each pair comprised one session facilitator and one community mentor. Facilitators were recruited by MSH, with support from Stellenbosch, in both the Mokhotlong and Maseru regions. Successful candidates either had backgrounds in ECD or social sciences, or experience in group facilitation. Candidates applied for positions; were interviewed; received an initial round of training; had opportunities to practice book sharing with area children brought in for the training; and then evaluated based on a list of criteria, including their ability to interact well with children (please see Appendix C for more information on training and supervision). A team from Stellenbosch University and two ECD experts from the University of Reading provided extensive training on the intervention roles and activities. Facilitators and community mentors received training on book sharing, nutrition, use of local food for cooking, food preparation and sanitation, HIV transmission, importance of knowing HIV status and taking ART, and information on TB. The book-sharing component focused on building caregiver and child relationships, developmentally appropriate techniques for sharing stories with children, and ways to discipline a child appropriately. Caregivers also learned about typical expressions of emotion in childhood.

When asked about characteristics needed by the facilitators who were selected, staff from Stellenbosch and MSH discussed the importance of being able to easily build rapport with children and families, passion for working with children, and willingness to learn. The level of education was not felt to be as

important as being warm, friendly, and knowing the local language, although all intervention facilitators had completed at least secondary education.

Project Training Materials

Stellenbosch University developed program training materials, which were refined through a consultative process with representatives from the MOET and UNICEF. Program materials included manuals for the facilitators and mentors, books for the families, tablets containing instructional videos, battery power banks, and eventually battery-powered lamps. Facilitators and mentors who traveled out to their posts in the Mokhotlong area weekly transported program materials, along with food and supplies for each week.

Project Outreach Events

Following the eight sessions given by project facilitators and community mentors, caregivers and family members were invited to participate in a community outreach event. During community outreach days, the program offered a selection of comprehensive services to caregivers, families, and any community member attending, including HIV testing and counseling as a core service. It also offered a number of additional services, depending on the community and what service providers were available. Services included TB screening, nutritional counseling, and birth certificate registration.

An advisory committee with district representatives from the MOET; the ministries of health, agriculture, and food security; the local government and chieftainship; and social development provided support in planning for community outreach days. The program engaged local chiefs to provide community support to the project (see Appendix D).

Intervention Strengths and Challenges

Intervention Strengths

Exposure to ECD concepts. Stakeholders at all levels had positive opinions about the ECD-health integrated Mphatlalatsane project. Session facilitators and community mentors felt that the sessions facilitated community building among the caregivers with whom they worked and that the book-sharing exercises served to strengthen the relationship between caregivers and children. In addition, session facilitators also thought the sessions exposed the community to important concepts related to child development, such as emotional and developmental milestones for children.

Readily available workforce. Regarding program implementation, program facilitators were not difficult to recruit because of Lesotho's high level of education and low employment rates (United Nations, n.d.).[2] Project managers were able to implement a thorough selection process to find the candidates who worked best with children. Facilitators received in-depth training before implementing the intervention. The program provided ongoing supervision and delivered refresher trainings halfway through. As a result, facilitators felt very well versed in the subject material. Session facilitators and community mentors reported knowing all of the materials well enough to be able to switch roles as needed throughout the course of the program. In addition, the existing ECD center provided a readily available venue to hold sessions and convene caregivers of young children.

Coordination of stakeholders. Stakeholders from the MOET, the MOH, and the Ministry of Social Development 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 felt it was

[2] According to the UN, unemployment in 2014 was 26 percent of the labor force; secondary school enrollment was 60 percent female, 44 percent male.

important that the intervention had not stigmatized people living with HIV by inviting participants only from families of children living with HIV/AIDS.

Multisectoral approach to HIV testing and treatment. Stakeholders from USAID and nongovernmental ECD organizations spoke about the value of combining an intervention focused on HIV/AIDS—a sensitive subject—with ECD—a nonsensitive subject—to draw participants in more effectively. In addition, the outreach component served as a good way to get services to hard-to-reach populations who often do not have access to testing and treatment in their communities. The intervention was successfully implemented in one of the country's most rural regions, suggesting that it could be implemented similarly in topographically similar regions of the country.

Implementation Challenges

Geography. Although the intervention was implemented as planned and well received, it was not without its challenges (see Table 5). The intervention took place in one of the most rural areas of the country to ascertain how challenging or successful it would be in such a locale. Transportation was a main concern because many of the villages served could not be reached by motor vehicle. Horses were used to transport session facilitators, community mentors, and supplies for each week, including project supplies, food, battery banks to provide power, and books for the families. Some facilitators had to have lessons in how to ride a horse.

The need for additional supplies, accompanied by additional cost, was recognized as the program went on, including a need for battery-powered lights so that caregivers would be able to practice book sharing during sessions when electricity was not available. Additional materials were added as the program continued; program facilitators were responsible for transporting them to the sites each week.

Recruitment of caregivers. Another challenge was in recruiting parents of the children to attend because they were often busy during the daytime, when sessions were offered. The majority of caregivers who attended the sessions were grandmothers who lived with the child; mothers were often working outside of their villages, in Lesotho or South Africa. Fathers and other male caregivers attended far less frequently than their female counterparts, although this circumstance may have been influenced by session facilitators being all female—caring for children is viewed culturally as largely the responsibility of women.

Lack of knowledge around ECD. Session facilitators also commented on the lack of understanding of ECD as a topic area of importance but reported that this lack was why it was so important that caregivers be required to attend every session; they started to understand more about the topic and the value after one to two sessions. Some stakeholders mentioned that the short duration of the intervention limited its sustainability and said that a prolonged or repeated program could be more effective in ensuring that new skills and practices supporting ECD remained in the communities. Also limiting sustainability of the intervention was the fact the program facilitators were brought into the villages; therefore, the new skills did not necessarily stay in the area after they left. Respondents felt that the introduction of new skills was limited to caregivers who attended sessions, who were not well equipped to share these skills further or with others in the community.

Community outreach events. Another challenge resulted from planning for the community outreach day. A number of different health- and social-related services were offered during this day, including HIV testing and TB screening, birth certificate registration, and more. Coordination of the multiple entities who provided these services was difficult, and the services offered at each site (beyond HIV testing) often

varied. However, program managers noted that when birth registration was not offered, the number of people who participated in HIV testing increased.

Table 5. Implementation challenges and adjustments

Challenge	How MSH addressed the challenge:
ECD is a new and lesser-known subject area	Intensive training and supervision for session facilitators; enrolled caregivers were required to attend each weekly session
Parents are typically not available during the day to attend sessions	Any caregiver who lived with the child could attend as long as the caregiver could attend consistently
Fathers/male caregivers did not attend sessions	Continues to be a challenge because raising children is considered culturally to be women's responsibility
Book sharing in the ECD centers was difficult because of the lack of lighting/electricity	Battery powered lamps were provided
Seasonal challenges (weather, harvest season) made attendance difficult	Facilitators allowed flexibility regarding which time slot caregivers attended
Transportation to the rural areas was difficult	Facilitators and community mentors were trained how to ride a horse for transport

Scale-Up Scenarios and Costing

The total intervention cost per child was $1,027. These costs were collected for delivering the intervention to rural villages, including training of facilitators, 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.

We costed the following scale-up scenarios to provide the program to all OVC ages one to five currently served by OVC IPs in five priority USAID districts (17,688 children) (see Table 6):

1. Provide the program using libraries, nine sessions, and MSH or another international IP
2. Provide the program using libraries, nine sessions, and a local IP
3. Provide the program using libraries, six sessions, and a local IP

Table 6. Costing for scale-up scenarios, Lesotho

Scale-Up Scenario 1. Serve all OVC ages one to five currently served in the five USAID-supported priority districts, using nine sessions and an international IP	Number of beneficiaries	17,688
	Total cost	$ 2,422,758
	Unit cost	$ 136.97
Scale-Up Scenario 2. Serve all OVC ages one to five currently served in the five USAID-supported priority districts, using nine 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 ages one to five currently served in the five USAID-supported priority districts, using six sessions and a local IP	Number of beneficiaries	17,688
	Total cost	$1,619,952
	Unit cost	$ 91.58

We considered scale-up scenarios in which the intervention was continued with an international or a local IP. 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 these scenarios, we assumed that start-up activities, such as meetings for community orientation stakeholder engagement, would be done 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 project 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. In scenarios that consider local implementation, we assume that above-site staff costs and overhead costs are 50 percent less than implementation by an international IP.

We estimated travel costs based on the share of urban and rural sites in each scale-up district. Supplies for the intervention include refreshments for the participants and learning materials, such as measurement devices and art supplies. In each scenario, we assume that the books used in the intervention will be reused for multiple intervention 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 are included. Office costs increase in proportion to the number of office-based staff. All other recurrent costs increase in proportion to the number of beneficiaries. We assume that all intervention sites will use existing ECD locations or other centers and not pay a fee for the use of the space.

Scalability

Most stakeholders felt 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 Mokhotlong district where it was delivered. Respondents felt that culturally, the country's population is similar to that in Mokhotlong. Most of the country's population stems from a single tribal heritage. Sesotho is the first language of about 90 percent of the population (World Atlas, 2019), but stakeholders noted that there are some remote areas where locals speak a different language; for those areas, it would be important to recruit facilitators who could speak the local language.

When asked about who could be recruited as future facilitators and/or community mentors, responses varied. Stakeholders representing ECD organizations felt that candidates would need at least some background in education and recent graduates could potentially be recruited from the teacher's college. Sessions facilitators and mentors felt that the most important skills were the ability to interact well with parents and their children, and that even completion of secondary education may not be necessary.

Respondents from the MOET and Ministry of Social Development felt that current ECD center teachers and community health workers could be trained to be session facilitators, although others, including project researchers, felt that such individuals would not be able to successfully add these additional responsibilities to the work they already are doing. Stakeholders noted that the number of already placed and resourced ECD centers throughout the country, including in remote areas, is a strength of the program, along with the focus from the MOH on increasing access to early childhood stimulation (ECS) services, whether it be through the centers or home-based ECD centers. Such centers likely would require additional staffing, but the infrastructure to support centers and staff exists in most areas of the country.

Almost all stakeholders felt that the intervention would have to be adapted significantly if it were expanded to urban or industrial areas because most caregivers in such areas work during the day and would not be available to attend sessions. Many children in urban or industrial areas attend daycare

centers for the majority of the day while their parents work in factories. Therefore, a different scenario would be needed to reach these caregivers, although the content and training of facilitators would not necessarily need to be adapted.

Most stakeholders felt that the intervention was supported by eminent individuals and institutions, such as the MOET, MOH, and USAID. There was also general agreement that the project addresses an objectively significant, persistent problem, and current solutions for this issue are considered inadequate. There were mixed responses as to the level of funding this intervention would need at scale; most respondents felt it could be implemented at a very low cost by making use of existing resources, whereas others felt that additional funding would be needed to pay session facilitators; cover transport costs for caregivers attending sessions in urban areas; and cover the costs of supplies, such as books, for a large number of families.

Most potential donors and ministry representatives felt that the MOET was well situated to spearhead a scaled-up intervention—specifically, the ECD unit, which also organizes a quarterly meeting of ECD stakeholders representing a number of organizations from governmental ministries and NGOs that engage in ECD work. However, the MOET would require additional funding to implement such a program.

Most respondents also felt that the simplicity of the program was a strength that would make it easy to implement widely. This feature also limited the potential impact for caregivers because the program was short, occurring over nine weeks, thus limiting the amount of time and sessions during which they are engaged with the childhood development content. Some ECD stakeholders felt that a shortcoming of the program was that the content did not give enough information about developmental milestones and therefore limited caregiver ability to recognize cognitive or developmental delays in their children. Another challenge was the lack of recognition of ECD as an area of importance; thus, additional work would need to cover advocacy for such a program to secure funding, support, and board participation.

Country Context

In addition to the cultural and geographical factors noted above, there are a number of considerations related to ECD. ECD as a topic is fairly new to Lesotho, and therefore recognition of the need for support or funding for ECD services is limited. Important headway has been made, however, in the creation of a national ECD policy and establishment of a multisectoral ECD coalition. Also, established centers for early childhood education exist throughout the country, to which parents can send children for a fee; most children do not attend such centers, however. The National University of Lesotho does not have a specific ECD accreditation program but does offer some ECD classes. Participation in pre-primary education is at 37 percent, compared to 76 percent in neighboring South Africa (UNICEF, n.d.). Urban and industrial areas usually have day care centers that often do not use a standard curriculum, but rather mainly provide childcare while parents are working. Reading with children is not a common family activity, and parents typically do not spend time with a child for the purpose of building a relationship. ECD is also not recognized by most government representatives as a priority for funding allocation. Stakeholders noted the need for additional advocacy and local, Lesotho-specific evidence to support such programs, both at the community and government levels.

A number of institutions are engaged in work related to ECD in Lesotho, however, and they should be involved in the scale-up of such a program. See Table 7 for key stakeholders in ECD in Lesotho.

Table 7. Key stakeholders in ECD, Lesotho

Government
• Ministry of Education and Training (ECD Unit specifically) • Ministry of Health (National Health Training College) • Ministry of Social Development • Ministry of Local Government and Chieftainship Affairs • Ministry of Police (Child and Gender Protection Unit)
Civil Society
• ECD sectoral team, which meets quarterly • NGOs and implementing partners
Donors
• USAID • UNICEF • EGPATH (supports nutrition-related initiatives for children) • Open Society Foundation

Government stakeholders. Central to ECD initiatives in the Lesotho is the MOET—specifically, its ECD Unit. An Early Childhood Care and Development (ECCD) Policy was created for the ministry by representatives from UNICEF, as well as an ECCD Task Force in 1999. The policy is multisectoral, established early childhood development as "a comprehensive process of the development of the child, which includes cognitive, moral, cultural and spiritual development," and established the goals that all children have access to ECCD services, and education should be free (Llanos, 2019). The policy presents a vision for ECCD, defines stakeholder roles, and provides suggestions for policy implementation.

Under the MOET, the ECD Unit is dedicated to planning, regulating, training, monitoring, and supervision of ECD services and activities. The ECD Unit oversees 30 national teacher trainers who in turn oversee 100 area resource teachers. The Unit and national teacher trainers support trickle-down trainings from area resource teachers to localized ECCD teachers in their catchment areas.

ECD centers do exist in a number of areas throughout the country, and the MOET works to track and, when possible, support such centers. Communities without ECD centers may also have a home-based care center, which is free of charge for families and volunteer based; caregivers in these settings usually take turns teaching children for a few hours a day and change roles on a monthly basis. The MOET is currently working through the area resource teachers to track and support both established ECD centers and home-based care centers.

Outside of the MOET, key national government stakeholders for the ECCD program in Lesotho include the MOH, the Ministry of Social Development, the Ministry of Local Government and Chieftainship Affairs, and the Ministry of Police's Child and Gender Protection Unit. These ministries are implicated in the ECCD Policy, which is meant to address the holistic well-being of the child and includes goals related to nutrition, health and social services, and legal protections for children.

Civil society and the ECD sectoral team. There is a national early childhood education sectoral team that meets quarterly to provide updates on work related to ECD in Lesotho. This committee includes both governmental and nongovernmental stakeholders and supports implementation of the national ECD policy. The sectoral team engages a number of stakeholders in the ongoing implementation of the

ECD policy and advocacy for ECD activities. Stakeholders noted that some organizations are more engaged than others in implementing and advocating for the policy, but that this team would be a good forum to support any scale-up initiatives involving ECD services.

Donors. Donor support for the ECCD program in Lesotho has been provided through USAID's OVC Special Initiative. Other donors active in Eswatini include UNICEF, the Open Society Foundation, and the World Bank. UNICEF has expressed support for scaling up the Mphatlalatsane model, and UNICEF stakeholders interviewed indicated that future funding for such an initiative may be a possibility. IrishAid has previously supported the MOET in providing ECD trainings for caregivers in urban areas, but this initiative has ended.

Despite the lack of financial commitment, the majority of stakeholders voiced the importance of scaling up such an initiative. Respondents also expressed the importance of sharing positive study results with stakeholders, especially at the government level, to increase awareness and advocacy.

Sustainability. Although most stakeholders spoke favorably about the program, many questioned its sustainability, mainly because of the short duration of the program, along with its facilitators being brought in from outside of the community. Respondents felt that the program was beneficial for participants, but that beyond those who directly participated in the program, development of ECD-related skills or increased access to HIV testing may not be sustained. In addition, supplies, especially books, had to be brought into the communities, increasing the cost of the resources needed. The lack of support for ECD through policy and funding at the national level makes the future of the program largely dependent on donors.

Stakeholders did suggest recommendations to address issues of sustainability, including the following:

- Recruit session facilitators directly from the community they will serve to ensure that ECD knowledge and skills, as well as information around HIV testing and treatment, stay in the community.
- Create lending libraries for books to decrease costs for future iterations of the program.
- Increase community-level awareness and demand for ECD services through engaging community leaders in the importance and benefits of such services.
- Widely disseminate intervention results to increase support at the national level.
- Coordinate with local clinic health workers to increase access to testing and treatment and ensure that community health facilities are adequately equipped to test and treat for HIV.

Strategies for Scaling

Respondents spoke positively of a potential scale-up of this intervention. Based on their feedback, we have compiled the following strategies for scaling.

Many respondents felt that children and their caregivers throughout Lesotho would benefit from participation in such an intervention. When pressed to identify priority areas for interventions, stakeholders most often identified a high need in the most rural areas of the country, as well as the five PEPFAR-supported regions of the country considered most vulnerable. To avoid increasing stigma, respondents suggested offering sessions to caregivers of all children ages one to five in the community, not just families of HIV-positive children. A number of MOET representatives also discussed the importance of such an intervention for urban and industrial regions, but pointed out that the intervention would need to be adapted to better suit this context, in which children are often in nonstructured daycare

centers while parents work 12-hour days. Suggestions for this context included visiting parents in their workplace or holding sessions for caregivers on the weekends and providing reimbursement for the cost of transportation needed to attend. Additionally, session facilitators felt the number of sessions in urban areas could be reduced from eight to six while still keeping the same content.

Because most respondents expressed the need for additional advocacy around ECD-related programming, results from the study evaluation should be disseminated widely, especially to policymakers. There are existing structures and resources to support ECD work in Lesotho, although funding is a major constraint. Any scale-up efforts should engage with the ECD sectoral team to reach the greatest number of stakeholders and potential donors. Efforts should be made to ensure that the ECD sectoral team continues to meet regularly to effectively coordinate any ECD-related services. Additionally, the MOET should be engaged to explore tapping into its existing resources, which include national teacher trainers and area resources teachers as well as home-based centers.

When possible, future session facilitators and community-based mentors should be recruited directly from the communities to be served to facilitate sustainability by increasing ownership and ensuring that new skills remain in the community. Additionally, ongoing training and supportive supervision for session facilitators are important pieces of implementation fidelity. When planning sessions, program implementers should communicate with the community stakeholders to plan around important events, such as harvesting and times of difficult weather. Working with chiefs to ensure that they understand the importance of the program will allow local leaders to advocate and provide support. Working through the Ministry of Local Government and Chieftainship Affairs could provide a network for this work. Also, to increase the number of people who participate in HIV testing, birth registration and HIV testing should not be offered during the same community outreach day event.

Recommendations

To lay the foundation for successful scale-up, the following recommendations are directed at government officials, the MOET, MOH, Ministry of Social Development, the ECD network, and civil society.

MEASURE Evaluation's recommendations are as follows:

1. Increase advocacy and awareness raising for ECCD policy and program support.
2. Generate financial support from government and donors.
3. Explore multiple scale-up scenarios and cost implications to determine what is feasible within the Lesotho context
4. Continue to improve ECD programming based on scale-up assessment and study results, as well as ongoing program monitoring.

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

Although policy and structures exist to support ECCD programming and coordinate stakeholders, there is a need for increased ownership and integration of ECD as a sector-wide priority.

1.1 Invest in and support the existing ECD network to increase its advocacy and leadership on the importance of ECD and ensure that regular meetings continue.

1.2 Advocate for expansion of the ECCD policy and engage the ministries beyond the MOET to be more supportive of policies that fall under their purview.

1.3 Engage chiefs and gatekeepers in each community to understand the importance of ECCD, thus increasing ownership and sustainability.

2. Generate financial support from government and donors

Because of the significant barrier of lack of funding availability, we recommend the following:

2.1 Conduct substantial lobbying and advocacy efforts to generate funding from the government and donors. This effort will require wide dissemination of the study evaluation results, as well as champions of ECD services in multiple sectors, in the MOET, and beyond.

2.2 Identify funding streams to sustain ECD programs once donor support ends.

2.3 Engage in advocacy at local and community levels to support awareness of and increase demand for ECD services throughout the country.

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

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

3.1 Scenario 1. Provide the program to all OVC currently served by OVC IPs, ages one to five in five districts, using libraries, conducting nine sessions, and with MSH or another international IP.

3.2 Scenario 2. Provide the program to all OVC currently served by OVC IPs, ages one to five, in five priority districts, using libraries, conducting nine sessions, and with a local IP.

3.3 Scenario 3. Provide the program to all OVC currently served by OVC IPs, ages one to five, in five priority districts, using libraries, conducting six sessions, and with a local IP.

4. Continue to improve programming based on scale-up assessment and study results

MEASURE Evaluation identified the following potential adjustment to program operations for improved functioning. Additional adjustments from program M&E study results should also be considered.

a. Recruit program facilitators and community-based mentors directly from the community when possible.

b. Engage community leaders in planning and advocacy of program services.

c. Ensure that supportive supervision by IPs is continuous and ongoing.

d. Adapt the program to suit the context of urban and industrial areas.

The results from the scale-up assessment reveal a recognition of the importance of ECD services and the potential of this particular program to increase HIV testing and treatment. The intervention design was largely successful in bringing both ECD and health services to hard-to-reach populations. Challenges remain in sustainability because of both funding and lack of recognition of ECD as an area of priority in the country. Additional steps should be taken to increase awareness, secure funding from both the government and potential donors, and take steps to increase community involvement and ownership in intervention planning and implementation.

RESULTS—ZIMBABWE

Describe the Intervention

The USAID OVC Special Initiative intervention in Zimbabwe was implemented in 17 districts by the World Education Inc./Bantwana Initiative (WEI/B) and its community-based organization (CBO) partners. The Special Initiative supported implementation science that evaluated the impact of a comprehensive ECS[3] parenting education program built into WEI/B's multicomponent Expanded IMPACT Project (EIP).

Under EIP, WEI/B built on the achievements of its predecessor project—Integrated Management of Pediatric HIV/AIDS Care and Treatment (IMPACT)—which launched in 2009. With joint U.S. Government and other donor funding, the original IMPACT pilot was designed to increase access to care and treatment for children living with HIV and support mother-baby pairs across eight districts through complementary community- and facility-targeted interventions. Based on the success of the IMPACT model, WEI/B rolled out the program to an additional nine districts between 2012–2017 under EIP.

EIP was designed with the Ministry of Health and Child Care (MOHCC) to continue efforts to accelerate pediatric HIV care and treatment access, targeting an enrollment of 23,000 children into treatment. EIP pursued the following four key objectives: (1) strengthen the capacity of community-level cadres to identify and mobilize children for enrollment in ART, and support adherence, nutrition, and psychosocial needs of families of children living with HIV; (2) increase uptake of and retention in PMTCT services for mother-baby pairs, and access to treatment for HIV-exposed infants, children, and adolescents; (3) decentralize pediatric ART diagnostic, testing, and treatment services from district hospitals to primary healthcare facilities; and (4) strengthen the capacity of the primary healthcare delivery system to initiate early infant diagnosis (EID) and offer pediatric HIV care and treatment services at the community level.

The Special Initiative also supported WEI/B in working with a team of researchers to carry out an evaluation of an ECS parenting education component integrated into EIP, which aimed to improve both early childhood development outcomes and pediatric ART uptake and adherence among HIV-exposed infants ages zero to two, as well as increase household economic resiliency. The ECS program component also sought to impact maternal health outcomes, improved retention in care among the mothers of HIV-exposed children, and improved mothers' mental health. The Special Initiative focused on examining the impact of the ECS intervention on the following primary and secondary outcomes:

- Improved early childhood development
- Enhanced pediatric ART adherence and retention in pediatric HIV care
- Strengthened household economic resilience

In pursuit of these outcomes, program activities focused on enrolling mother-baby pairs into multipurpose play groups in which the participants received a set of layered ECS, health, nutrition, psychosocial support, and economic strengthening service interventions (see Figure 4). First, participants were taught parenting skills through the use of an adapted ECS curriculum. Complementary monthly home visits to mother-baby pairs conducted by trained community health workers (CHWs) comprised part of a broader case management approach to provide health education, psychosocial support, and

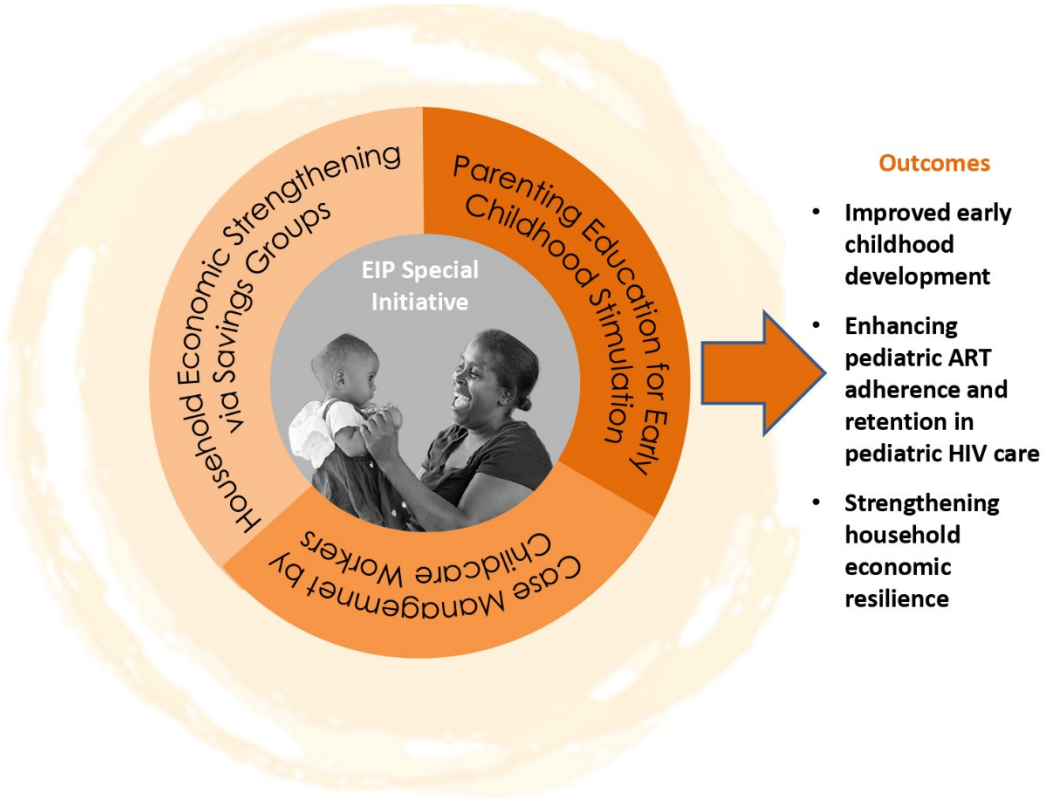
[3] In Zimbabwe, ECD refers to school-aged populations ages five to six who fall under the Ministry of Primary & Secondary Education (MOPSE) oversight. To differentiate, childhood development interventions for ages zero to two are referred to as ECS and will be reported as such in this document.

adherence to treatment counseling. Additionally, the intervention package included mothers' participation in household economic strengthening ISALs to improve the family's income.

The program was implemented mainly through community structures that were already in place and supported by the MOHCC; the Ministry of Labour & Social Welfare (MOLSW); and the Ministry of Women Affairs, Gender & Community Development (MOWAGD). In addition, Mavambo, a WEI/B and program partner, engaged program management staff, ECS coordinators, and facilitators. ECS facilitators worked with community-based trainers (CBTs) for economic strengthening as well as CHWs and other program support staff.

A total of 304 groups were enrolled for this intervention in 17 districts; each group had approximately 20 participants and was centered on a health facility. Mother-baby pairs were recruited with the assistance of CHWs and community health nurses. In three years, WEI/B reached 6,767 mother-baby pairs with the multipronged intervention. Figure 4 outlines the intervention schema.

Figure 4. Intervention schema



The core components of the intervention, which were delivered through the parenting groups, are described below.

ECS Parenting Sessions

The lessons included 12 teaching modules, delivered over the course of 18 biweekly parenting sessions (ISAL group activities) for the caregivers. Each session lasted about 90 minutes. The sessions were designed to be interactive, involving practical demonstrations and sharing of experiences. The participants were also taught to make their own toys using locally and readily available, affordable, and safe materials. See Appendix E for session topics.

ECS sessions were delivered in the following six-step process:

Step 1. Welcome and introduction of the topic: recap key messages from previous sessions and talk about the home practice activities, i.e., implementation at home

Step 2. Exploring, recognizing, and building on the caregiver's existing knowledge of the topic

Step 3. Deepening understanding of the topic through focused discussions and activities

Step 4. Sharing experiences: Involving caregivers in making play materials and doing interactive activities with their children

Step 5. Summary of key learnings, take-home activity

Step 6. A brief evaluation by the participants

Following the 18 sessions, mothers graduated from the program. A graduation ceremony was held and families and other community members were invited.

ISAL Group Activities

Before the parenting and ISAL sessions began, caregivers participated in a five-day training at a local venue agreed upon by participants. Trainings covered the following topics: 1. financial literacy, 2. income-generating activities, 3. business proposal development, 4. ISAL group formation, 5. monitoring/tracking expenditures, and 6. risk management. CBTs coordinated these preliminary trainings. After the training, participants formed ISAL groups and drafted their constitution, which delineated member contribution requirements and lending frequency and interest rates, and identified group leaders, treasurers, and secretaries, and their respective responsibilities. ISAL sessions then began, with groups meeting for 30 minutes after each ECS parenting session. This approach aimed to minimize the opportunity costs of attending two different sessions. CBTs led the meeting sessions and provided guidance on financial literacy and project management. During the meeting, groups also reviewed their books to guide the lending and payment cycle, and tracked expenditures to ensure that participants were using the accrued funds for agreed-upon activities.

Case Management

All beneficiaries of the intervention were encouraged to enroll in case management, whereby a CHW conducted monthly visits (or more when indicated) to the homes of the mother-baby pairs. During these visits, CHWs provided psychosocial support, health education, treatment adherence support, and quality assurance for home-based parenting exercises. The case managers also followed up on other social protection gaps that may have been identified in the household and made necessary referrals.

Project Training

Implementation of EIP's ECS parenting education component comprised three direct trainings for target audiences: (1) IMPACT training; (2) ECS training; and (3) ISAL training. Trainings were facilitated by trainers recruited at the outset of the program and oriented to the respective models and training materials. WEI/B and its partners coordinated the training. Depending on the type of training, technical support was sought from relevant government and community departments. Training was done in several different venues, depending on the type. When trainings could not be held locally, project personnel were provided with travel costs and a per diem. For more information on the specific modules included in each training, see Appendix E.

1. **IMPACT training:** This training was conducted for all project staff following their recruitment to provide participants with an in-depth insight into the IMPACT model and give them management strategies for pediatric and adolescent HIV. Training participants were equipped with basic communication skills and knowledge on community social mobilization to improve HIV case finding and case holding. The training provided a platform for participants to share previous experiences and good practices to improve pediatric and adolescent HIV care.
2. **ECS training:** This training was conducted for recruited ECS facilitators to enable them to deliver the ECS parenting sessions effectively.
3. **ISAL training:** This training was conducted before the formation of ISAL groups by community-based ISAL trainers. It was designed to enable caregivers of HIV-exposed or positive children to acquire sound money management practices to meet the financial needs of caring for their children.

Project Personnel

In addition to general project management and support and administration staff, each district involved in the intervention was staffed with an ECS coordinator who supervised the ECS facilitators. CBTs facilitated ISAL sessions. The project also leveraged existing human resources—specifically, community nurses who provided support during health-oriented sessions and CHWs who managed case management functions.

ECS Facilitators

ECS facilitators were recruited, vetted, and trained specifically to facilitate ECS parenting sessions. They came from the local community; each group of mothers had one ECS facilitator who was responsible for running the biweekly meetings. Candidates for ECS facilitation were identified with the assistance of CHWs and community leaders. Most candidates had some training in ECS and were also chosen based on their ability to facilitate group sessions for adults. ECS facilitators received a five-day training of trainers before project implementation. These cadres were supervised by ECS coordinators.

ECS Coordinators

One ECS coordinator per district was recruited to identify and train community-based ECS facilitators. Coordinators also monitored the work of ECS facilitators, including program data quality check and adherence to standard operating procedures (SOPs) in the delivery of sessions. The ECS coordinators who were recruited had previous ECD training. They were subsequently trained over five days by WEI/B and CBO partners in the IMPACT model and ECS specific to this program. The coordinators received a monthly salary for their work.

Community Health Workers

CHWs played an important role in case management of mother-baby pairs enrolled in the program. These cadres included both village health workers (VHWs) and care workers (CCWs). Each CHW was tasked with following up with 5 to 10 mother-baby pairs (depending on the size of the community, distances between households, and the nature of their work schedules) through home visits. Although these cadres were engaged on a voluntary basis, WEI/B and Mavambo provided them with stipends and working materials (e.g., bicycles, bags, and stationery). Program management staff also provided oversight of the CHW activities.

WEI/B conducted an initial five-day training for CHWs to equip them with the knowledge and skills required to provide case management services. The training built on the standard MOHCC six-week pre-service training required for all VHWs before engagement, as well as the MOLSW's standard training for CCWs. The CHWs thus were supported by the two government departments and engaged in other health and social protection duties. The CHWs involved in the intervention needed to be familiar with their local population and be able to observe the SOPs of the project while treating beneficiaries with respect.

Community Nurses

Each ECS group of beneficiaries was affiliated with a corresponding MOHCC health facility. These health facilities typically served a catchment population of 1,800–3,000 people and were served by community nurses. The nurses selected had a minimum of three years of basic professional training, with priority given to those who already had received further in-service training from MOHCC in advanced HIV management, rapid HIV testing, and clinical mentorship related to HIV/AIDS. For community nurses engaged in the project, WEI/B and its CBO partners provided an additional five-day training before the start of the intervention as part of EIP's health systems strengthening activities, supported by Elma Philanthropies. This training focused on HIV testing, care, treatment, and follow-up, including nutrition assessment and monitoring. The community nurses provided technical support to and supervision of the CHWs. They also facilitated case conferencing, community dialogues, and other health promotion activities within their catchment areas. The nurses received a salary from the MOHCC, but travel and per-diem costs were supported by the EIP program through a stipend.

Community-Based Trainers for ISALs

Community-based trainers supported the economic strengthening component of the project. There was one CBT per group under the supervision of Mavambo and WEI/B. CBTs facilitated ISAL training for program participants and the formation of ISAL groups of participants, monitored ISAL group activities, and supported biweekly meetings, during which they assisted the mothers in conducting small savings and loan activities within the group. CBTs received a five-day training before program start, intended to cascade skills learned during the training to the groups and the community in general.

CBO Partners

WEI/B worked with a cohort of 11 CBO partners across the 17 districts to implement program interventions. These partners were involved in mobilization activities with community leaders, MOHCC, and other community stakeholders to gain acceptance for program activities. During implementation, CBOs participated in recruitment of ECS coordinators and facilitators, and the monitoring of and support to parenting sessions. CBOs consolidated program reports for submission to WEI/B and received technical assistance and ongoing support from WEI/B throughout the course of the intervention.

Intervention Strengths and Challenges

Intervention Strengths

Multisectoral approach. Stakeholders interviewed from across the project implementation had positive opinions about the program and its evidence-based approach. These respondents referenced feedback from beneficiaries that indicated they were happy with the positive impact of the project on their families, especially young children. Additionally, the program provided valuable information on child nutrition, including complementary infant feeding and how to grow and prepare nutritious foods; HIV testing and

prevention; care and treatment for those infected with HIV; and household economic resilience, facilitated by the ISAL schemes. The multifaceted program approach appealed to many and ensured that caregivers were supported through group interaction as well as individual home visits. The cross-cutting nature of the program addressed many vulnerabilities while also linking the beneficiaries to multiple stakeholders who could provide various types of support.

User-friendly ECS program manuals. Respondents felt that program manuals were easy to use and implement, and provided access to the needed technical support throughout the program. The manuals were easy to use because they had been translated into local languages and provided context-specific examples based on local Zimbabwean culture and practices. The facilitators made use of teaching aids and encouraged parents to make toys for their children from locally available materials.

Reaching young children for early treatment and supporting the ECS component. Services available for children under age four in Zimbabwe are limited. Services supported by the government are minimal and do not take a preventive approach, instead focusing on sick or disabled children. ECD programs at schools start at ages four or five, leaving out the population under age four. Mothers may receive support for breastfeeding, but beyond that, there is little to no support for ECS and parenting skills to support healthy children under age four. This also makes the population ages zero to four difficult to reach for HIV testing and treatment. This intervention provided an important means of reaching this vulnerable group and enrolling them into treatment early when necessary to support improved health outcomes for the long term.

Building on and strengthening existing community structures. This intervention was designed to use and build on existing community structures, especially health clinics and affiliated health personnel. The clinics provided a structure around which to center the program, and the nurses provided oversight of health content as well as the cadre of VHWs. Because the nurses are trained and salaried by the MOHCC, they were able to oversee the program and received a small stipend to support the additional work they took on. WEI/B leveraged non-U.S. Government funding outside of the Special Initiative to support the MOHCC at the district level to equip local clinics in supporting pediatric testing and treatment. This support often included building infrastructure for the supply chain, including the purchase of vehicles for transport, refrigerators, or testing equipment.

Respondents felt that using local clinic personnel and infrastructure (most groups convened meetings at clinic sites) helped to build the participants' relationship with and trust of local health services, thus making them more comfortable in coming to clinics to receive services. Coming to the health facilities increased regular access to testing and treatment for HIV, both for mothers and their children. Respondents felt this arrangement had the indirect benefit of increasing mothers' adherence to ART.

In addition, the intervention promoted coordination between CHWs and health facility-based health workers through monthly meetings, health center committee meetings, and community dialogues. This coordination fostered more involvement from health facility staff during ECS sessions with mother-baby pairs and stronger engagement in the bidirectional referral of clients. Thus, those who required HIV testing and ART were referred from the community to the health facility, whereas those who required case management and other social protection services were referred from the health facility to the community.

Large pool of ECS facilitators on which to draw. Respondents reported that currently there is a large pool of paraprofessionals trained in early childhood development because there are free preschool programs for children ages four to five, and the Ministry of Primary and Secondary Education (MOPSE) trains teachers for these programs. Recently, the MOPSE ramped up its training program, training a new batch

of teachers; also, many ECD teachers were let go in favor of more highly trained professionals. These developments have left a crop of people in most of the country from which to hire ECS facilitators.

Increased economic opportunity. Respondents from both the government and civil society emphasized the importance of the economic strengthening (ISAL) component. The opportunity to be supported in income generation and potentially receive a small loan was important to many participants; respondents felt this potential opportunity motivated them to continue attending sessions. Representatives from Mavambo and other IPs said that the mothers' groups in many sites continued to meet after graduation from the program, in large part because of the ISAL groups they had established. These groups continued to provide a support group for the mothers, who were also able to exchange skills, such as knitting or crafting to increase their income generation potential. According to our respondents, there are very low rates of employment throughout the country (the estimated unemployment rate ranges widely, from 5% to 95%; no reliable data on the current unemployment rate in the country exist), so the ISAL component provided a rare opportunity for mothers to generate income and, in some cases, gain status in their households.

Use of PMTCT registers and people living with HIV (PLHIV) data to improve efficiency of targeting mother-baby pairs most in need. Because the program worked directly with government authorities at the district and community levels, it was able to access PMTCT registers and data on the HIV-positive population in the districts. This information increased the program's ability to effectively target the population most in need of these services—the young children of mothers who were HIV positive. Use of the local VHWs also supported this access because they had existing relationships with community members.

Implementation Challenges

The program was largely well received, but it is important to note the challenges encountered along the way so they can be addressed in future program iterations. Some of these challenges were addressed by the IPs who participated in scale-up, as noted below.

Hard-to reach-populations. Rurally located families were difficult to reach. In some cases, the distance to the local clinic deterred mothers from attending or required them to walk 10 or more kilometers to attend sessions. This issue was also a challenge for VHWs tasked with home visits because their caseloads were sometimes spread over a large area and they did not have access to transportation as part of their work. Farming areas were also a challenge when recruiting mothers because the farm owners might not release them from their work to attend sessions, or the mothers may not want to disclose the purpose of the sessions. Project implementers from Mavambo Orphan Care discussed the option of holding the sessions on or near the farms, but mothers had concerns related to stigma and HIV status disclosure.

Spousal refusal. Respondents discussed some difficulty in recruiting mothers for a number of other reasons. In some cases, spousal consent was an issue because husbands did not want their wives to attend sessions. Respondents reported that this challenge occurred for reasons related to stigma around HIV status and disclosure; in other cases, husbands simply did not fully understand the nature of the program. In some sites, this issue was addressed with additional community outreach that targeted men in the community through recruitment and training of volunteer male mobilizers. The male mobilizers were responsible for working with men in the community to sensitize them on the importance of ECS for young children and encourage their wives to attend sessions and attend clinic visits with them.

Stigma. The intervention evaluated under the OVC Special Initiative primarily targeted mothers who were HIV positive. This approach isolated the program beneficiaries, exposing them to stigma within their

community. In response to this problem, when WEI/B rolled out the model following the initial IMPACT pilot to other districts, IPs enrolled a mix of HIV-positive and HIV-negative mothers and babies, and emphasized the program's focus of early childhood development during recruitment efforts so as not to raise concerns around stigma or HIV status. IPs reported that this approach helped minimize concerns around HIV stigma; however, some mothers may not have enrolled initially because of concerns over their status. A clinic nurse spoke about the importance of increased advocacy and community awareness to enable people to disclose their status without fear.

Recruitment of special populations. Female sex workers were another population that was difficult to recruit; respondents felt this group needed their own support group, separate from other mothers in the community. Respondents also noted that children of sex workers were particularly vulnerable to contracting HIV, so this population would be an important one to target in the future.

Religious objectors. Respondents also reported difficulties in recruiting mothers from some religious sects because the religious leaders or sect doctrine did not support modern medicine or might encourage congregants not to attend clinics in favor of using religious leaders or local healers.

Lack of a formal ECS policy or governing body. Respondents stated that programming for children younger than school age was overseen by the MOHCC; once children reached the age of four or five and could attend the school ECD program, they become the responsibility of the MOPSE. However, there is no ECS policy or official governing body to oversee services for the population under age four. Respondents felt that a formal policy would be helpful, but also that district-level community structures were most effective in implementing programming. Respondents also commented on the need for additional coordination among ministries to more clearly define who is responsible for what parts of services for young children. Unfortunately, we were unable to obtain an interview with a representative from the MOPSE during this assessment.

Clinic challenges. Respondents from the MOHCC spoke about the shortage of nurses in many areas because of a funding freeze; also, although the program was extremely beneficial and well situated regarding clinics, nurses were often overworked and tasked with caring for a large number of people. When the support groups met away from the clinics, it also took nurses away from the population they were responsible for serving.

In addition, some IPs reported that some clinics, especially more rural ones, are not resourced as well as others, meaning they may have a limited ability to test and treat HIV, despite the program's messaging. When possible, IPs worked with the MOHCC to supplement those services not funded by the U.S. Government project component, but noted that lack of necessary medicines, refrigeration, and proper training on ART initiation and adherence for clinic staff would be a challenge in many areas.

Scale-Up Scenarios and Costing

The integrated intervention unit cost per child was $794.11. The model assumptions included the following: the costs were collected for the portion of the program that covered beneficiaries who received all three program components in four districts (Mazowe, Harare, Insiza, and Gweru) in which it continued past the end of the EIP model. These costs are annualized because they were provided for a one-year period (three months to work with the ministry and conduct training of trainers). The case management costs reflected here are for a community in which there are already case managers or CHWs in place. In some other communities, CHWs would need to be trained so they could support the ISAL and parenting model. There was an average of 15 sites per district (each site has 1 or 2 groups, with 20 participants per group).

We costed the following various scale-up scenarios, as shown in Table 8:

Scenario 1. Offering full intervention to all OVC ages zero to two currently served by OVC IPs in the 20 USAID-supported districts (21,186 children). World Education would implement.

Scenario 2. Offering full intervention only to HIV-exposed OVC ages zero to two currently served by OVC IPs in the 20 USAID-supported districts (2,966 children—calculated as 14% of 21,186 children). World Education would implement.

Scenario 3. Offering full intervention to all OVC ages zero to two currently served by OVC IPs in the 20 USAID-supported districts (21,186 children). Another IP (perhaps a local, cheaper IP) would implement, as opposed to World Education.

We did not consider start-up costs as part of the program costs/base costing for WEI/B for any of the three scenarios. Thus, we did not annualize them. However, we included the district vehicle costs for scale-up because WEI/B recommended their inclusion. We also considered laptops, desks, and chairs for scale-up for each additional staff member included for the scenario. All recurrent costs increase at number of beneficiaries/number of beneficiaries in the WEI/B program. We held all fixed costs flat. For Scenario 3, we reduced all management and technical labor costs by 50 percent to account for reduced labor costs to a local IP.

Table 8. Costing for scale-up scenarios, Zimbabwe

Scale-Up Scenario 1. Serve all OVC ages zero to two currently served in the 20 USAID-supported districts (World Education implements)	Number of beneficiaries	21,186
	Total cost	$20,237,232
	Unit cost	$955.22
Scale-Up Scenario 2. Serve only HIV-exposed OVC ages zero to two currently served in the 20 USAID-supported districts* (World Education implements)	Number of beneficiaries	2,966
	Total cost	$5,003,204
	Unit cost	$1,686.85
Scale-Up Scenario 3. Serve all OVC ages zero to two currently served in the 20 USAID-supported districts (another NGO/IP implements)	Number of beneficiaries	21,186
	Total cost	$15,044,762
	Unit cost	$710.13

* Calculated as 14 percent of 21,186 children ages zero to two in the USAID-supported districts.

Scalability

When asking about scalability, respondents had a favorable reaction because the project is already being scaled up successfully in a number of districts, including those in rural, urban, and peri-urban areas. Respondents felt that by and large this intervention was important, both for the population it targeted and the anecdotal outcomes they already had encountered, such as increased testing, decreased viral loads, and strengthened community structures. In addition, MOHCC-supported clinics already exist, and there are nurses and trained VHWs and CCWs who are well situated to bring the program to many areas of the country. Respondents said that some adaptation would be needed for rural areas or areas farther from clinics; for key populations, such as female sex workers; and in urban areas where there are no VHWs.

Respondents felt that the program manuals were easy to use and could be easily adapted to most regions of the country. Because Zimbabwe has 15 official languages (excluding sign language), the program materials would have to be translated into the native languages for use in a given local area. Program materials for ECS sessions, such as toy making, were designed to use local materials that could be found

in most communities throughout the country, and nutrition sessions focused on locally available foods. Regarding measurement of ECD outcomes, respondents noted the importance of using simple and contextually relevant tools to assess changes in such outcomes.

Respondents generally felt the program was not very costly because it was built on existing community structures and cadres. Thus, scale-up would involve little need for recruiting and training additional personnel. Respondents also observed that financial resources would be needed for the program to succeed. These resources would include training manuals and session materials for toy making and food preparation (which could be found locally) and stipends for the ECS facilitators. Opinions were mixed on whether the CHWs (inclusive of VHWs and CCWs) required a stipend. VHWs in Zimbabwe receive standard government stipends (currently funded by donors but administered through the government), whereas CCWs working within the National Case Management System do not. Under the project, WEI/B provided stipends to both cadres for the work they did that was specific to the intervention. Some respondents felt that stipends were necessary to motivate the community cadres for follow-up and home visits, whereas others thought it was a responsibility to the community and did not require remuneration. Some IP respondents and World Education representatives felt these cadres should at least have some means to support traveling for home visits—either a bicycle or fare to cover transportation costs.

Country Context

As noted above, one of the main strengths of this program is its ability to rely on existing structures, such as the clinics and volunteer cadres found throughout the country. In addition, respondents often spoke of the strong coordination and leadership at the district level, which coordinates government services, local leadership, and NGOs working in various areas. Many districts facilitate monthly or quarterly meetings of local leadership, both government and civil society. Thus, it is important for any future programs to go through the district leadership for support and buy-in. One IP from a scale-up district suggested conducting training for local leadership as part of the program to increase awareness around support for both HIV testing and treatment and ECS services.

As noted above, there is currently no coordinating unit or official policy for children ages zero to two or preschool-age children. Responsibility for this population is largely perceived as residing with the MOHCC, but this perception is not always accurate in practice. In addition, respondents stated that VHWs have a mandate to work with this young population but in many cases are not well resourced to do so. Further, they may lack sufficient training on HIV testing and treatment adherence or ECS to be able to support parents of young children, especially those exposed to HIV. Most respondents felt that the political will to support ECS-focused services existed, but that funding was not sufficient to support a program such as this one from within the government, or specifically the MOHCC.

Respondents said that IPs that implement donor-funded programs are present in most regions and districts of the country. A number of these IPs are well situated and have existing relationships with the communities, which would enable them to support implementation of this program.

Zimbabwe is known for high levels of education (93.9% enrolled in primary and 47.2% enrolled in secondary school in 2015) (World Economic Forum, 2015), and literacy (88.7% in 2014, per the World Bank Group, 2019). Our respondents also reported a low level of formal employment in the country (as stated previously, unemployment rate ranges widely, from 5% to 95%; no reliable data on current unemployment rate in the country exist), meaning that the opportunity to participate in economic strengthening is important to many participants. In addition, according to the respondents, migration

within country is low because there are not many jobs for which to move around—meaning that in the current context skills and training tend to stay with the community. This situation could be beneficial for program staff continuity and maintaining expertise in the community.

Table 9. Key stakeholders for ECS programming in Zimbabwe

Government
• Ministry of Health and Child Care • Ministry of Primary and Secondary Education • Ministry of Women Affairs, Gender and Community Development • Ministry of Labour and Social Welfare (Formerly the Ministry of Social Welfare)
Civil Society
• Local leadership structures and chiefs • NGOs and implementing partners
Donors
• USAID • Other potential donors include ELMA, UNICEF, WHO, AustraliaAID, and Open Society Foundation

Government Stakeholders

Table 9 lists key stakeholders for ECS programming in Zimbabwe. Within MOHCC, trained nurses and CHWs are a critical part of this intervention. Additionally, decision makers in MOHCC responsible for AIDS and tuberculosis, nursing, and community health are important for obtaining buy-in and support if the program were to be scaled up.

As discussed, MOPSE focuses on children over age four. However, many of the ECS coordinators recruited have undergone previous ECD training, which was coordinated by MOPSE. Future planning and coordination of the intervention scale-up would benefit from more involvement with MOPSE, potentially capitalizing on or coordinating with ECD trainings. Such an approach would also assist children to transition from community-based ECS to formal school-based ECD and learning.

MOWAGD is also involved in the intervention via the economic strengthening (ISALs) component. In some of the scale-up sites, MOWAGD adopted ISAL groups once the program ended. The MOLSW is involved because the case workers support linkages to additional services for children when needed.

Civil Society

District coordination is strong, as noted above in the country context. Many respondents felt that the importance of civil society in addressing the HIV pandemic cannot be underestimated, and that any future scaling of this program should rely heavily on district-level structures. Even though approval would come from the provincial and central level government, actual implementation should rely on district efforts.

Donors. Support thus far has been provided from USAID through the IPs; USAID provided additional funding for scaling the program to additional districts because it felt it was already seeing the benefits of the program. Respondents discussed the need for additional funding from donors because the government currently struggles to fund the initiatives it already supports. Other potential funders that

have previously supported ECS initiatives include ELMA, UNICEF, WHO, AustraliaAID, and the Open Society Foundation.

Sustainability

Stakeholders of this program spoke often about the potential for sustainability of both the program itself and the skills it imparts to participants. IPs spoke about the ripple effects of the parenting skills learned during the sessions back to the community, reaching mothers who were not program participants. Home visits made by the VHWs increased parents' ability to practice new skills at home and in the presence of their neighbors. In addition, the nine-month duration of the program contributed to building a support network among the caregiver participants, enabling them to support one another in parenting after the program ended. Regarding the sustainability of the program itself, the trained workers and volunteers stayed in the community because they were all part of the community to begin with. Respondents spoke about the need to consider the longevity of the support groups for the mothers and ongoing refresher trainings for the VHWs so they could support the mothers in their community.

Strategies for Scaling

When asking about scaling, respondents had a favorable reaction because the project is already being scaled up successfully in a number of districts, including those in rural, urban, and peri-urban areas. As noted previously, some of the challenges listed above have already begun to be addressed in the scale-up efforts. We offer the following program-specific strategies for scaling, based on respondent feedback:

Prioritize scale-up locations. To achieve the greatest impact most efficiently, scaling efforts should focus on high-priority areas having a high prevalence of mothers and children living with HIV. Respondents felt this program was important for targeting the zero to two age group for prevention of mother-to-child transmission and filled a gap in services currently available in the country.

Extend the intervention to key populations. Respondents noted key populations, whose children may be at especially high risk for HIV, are permitted to enroll in the program currently, but they could also benefit from specialized attention. Two specific populations noted in the interviews were female sex workers who also run a business, and adolescent mothers. Scaling to sex workers would entail a support group targeted specifically for them, with tailored meeting times, places, and content. Respondents noted that adolescent mothers were not specifically targeted by this intervention and are not always included in interventions to target mother-baby pairs, and thus could benefit from more targeted outreach. One suggested strategy was to train peer educators who were also teenage mothers to support adolescent mothers in program enrollment.

Ensure community sensitization. To achieve community support and broad participation, it is important to ensure that community sensitization occurs in local implementation areas before and during program roll out. Of particular importance is to ensure that sensitization is targeted to community leaders to promote understanding of the benefits of ECS services. In addition, HIV-sensitive training should be provided for local leaders to target stigma.

Continue to support community involvement and ownership. Increased community involvement in intervention planning and implementation would promote program sustainability.

Other recommendations for scale-up that arose during data collection related to intervention implementation are as follows:

- Continue ongoing collaboration between government and nongovernment actors on intervention planning and implementation to efficiently use existing resources.
- Data collection revealed the importance of support for ECS facilitators in carrying out their work. It will be important to continue providing material resources and incentives (e.g., a stipend) to ensure they are supported.
- Similarly, consider supporting a transportation allowance or arrangements for VHWs who conduct home visits.
- Work with mothers to decide on the best locations, times, and dates to hold sessions, and also work with overburdened nurses when locations outside of the clinics are selected.

Recommendations

Results showed across-the-board support for this multisectoral, integrated program, as well as its potential scale-up. Government representatives, IPs, and members of the community appreciate this program. Respondents felt the intervention was beneficial and should be scaled up. Although government structures and funding are not available to support the program at this time, respondents felt there were a number of donors well poised to support it. In this section, we provide recommendations for program planners at national and subnational levels, followed by recommendations for ongoing implementation.

To lay the foundation for successful scale-up, the following recommendations are directed at government officials, ministries of primary and secondary education, health, child care, labor and social welfare, women's affairs, gender and community development, and civil society.

MEASURE Evaluation's recommendations for scale-up program planners are as follows:

1. **Increase advocacy and awareness raising for ECS services at the central government level**
    a. Increase awareness at the central level of the importance of ECS and ECS policy and programming in targeting the zero to two age group.
    b. Promote government responsibility for supporting ECD and ECS of the zero to two age group via increased coordination and communication, such as regular meetings to define roles and carry out tasks. This approach could include a cross-cutting taskforce or ECS working group that includes members from multiple ministries, particularly MOHCC and MOPSE, and civil society. This effort should be led by a government champion to promote ownership and accountability.
2. **Generate financial support from donors and eventually the government**
    a. Conduct lobbying and advocacy efforts to generate funding from government and donors. This effort will require current supporters to be active and engaged champion of the importance of ECS to government colleagues, decision makers, CSOs, and donors in Zimbabwe. Engaging implementers, health facility staff, and even beneficiaries, as appropriate, can help tell the story of the importance of the ECS program.
3. **Work with district government structures to implement and approach any scale-up initiatives**
    a. Although government support at the highest levels is essential, it is also critical to work with district governments for efficient and ongoing implementation.

4. **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. Offering full intervention to all OVC ages zero to two currently served by OVC IPs in the 20 USAID-supported districts (21,186 children). World Education would implement.

   Scenario 2. Offering full intervention only to HIV-exposed OVC ages zero to two currently served by OVC IPs in the 20 USAID-supported districts (2,966 children). World Education would implement.

   Scenario 3. Offering full intervention to all OVC ages zero to two currently served by OVC IPs in the 20 USAID-supported districts (21,186 children). Another IP (a local, cheaper IP) would implement.

Overall, the results from the scale-up assessment reveal broad support for this program and its scaling to additional areas. It is seen as a successful and easily implemented way of targeting an at-risk population in need of services to increase HIV prevention, testing, and treatment. The intervention design was largely successful in increasing community linkages to health services, especially for HIV/AIDS. Challenges remain both because of funding and lack of coordination around ECS at the central government level. Additional steps should be taken to increase awareness, secure funding both from the government and potential donors, and continue taking steps to increase government involvement and ownership in intervention planning and implementation.

LESSONS LEARNED

In this section, we would like to share our lessons learned to help our colleagues who will design interventions and work on scale-up assessments in the future.

Integrate scalability considerations in both research and intervention designs. We conducted the scale-up assessment simultaneously with the outcome evaluation studies. Because scaling was not built into the research design, we do not know to what extent context matters. For example, all three interventions were conducted in rural or semi-urban areas. We cannot tell whether these interventions will work in urban areas and what adaptations might be needed. When scalability considerations are built into the intervention design, program planners and researchers can examine implementation capacity, resources, supervision, incentives, and so on in each country, balancing the complexity of the intervention with context to design an intervention that would work when scaled up. This approach may have implications for the research findings because design complexity will influence fidelity to the intervention and impact. We acknowledge the challenges of balancing research and intervention design, feasibility and scalability, and cost, but we also recognize the results of this scalability assessment were limited by when the assessment was initiated. In the future, intervention design could be strengthened by building a scaling strategy into both research and intervention designs from the beginning.

Ensure collaboration between research and scale-up assessment teams. In this assessment, to avoid any influence on the research study participants, we could not interview program beneficiaries. Although it was beneficial to obtain the perspectives on the interventions from program implementers and various stakeholders as well as their impressions about the value of the intervention for program participants, it would be useful to interview program recipients to learn about their experiences in participating in the program. In the future, it will be necessary to find ways to integrate scale-up data collection with the research process to avoid contamination while obtaining relevant data. For example, data collection with program beneficiaries could be scheduled after the last research study assessment, or the research team could ask questions to ensure no biasing questions are introduced. This approach would allow concurrent analysis and writing of the scale-up report while researchers work on the data analysis and report writing.

Obtain cost data at the beginning of the assessment. We experienced challenges in getting cost data for the Lesotho intervention because of the change in the funding mechanism. MSH was the main IP for this intervention, and when the project ended it was difficult to obtain the detailed data to cost the intervention and scale-up scenarios. We recommend starting communication with the IP and requesting cost data at the beginning of the scale-up assessment.

Aim for in-person data collection. We conducted nearly all interviews in Eswatini and Lesotho in person, and all interviews in Zimbabwe virtually. In Eswatini, in addition to individual interviews, we conducted a workshop with the IP. Based on our experience, we were able to successfully administer interviews both in person and remotely. However, the intervention mapping and discussion of the scalability assessment tool was easier and more productive in person because it allowed for interaction and collaboration between data collectors and respondents, as well as interaction and brainstorming among respondents. To ensure that comprehensive data for the assessment are collected, we recommend conducting data collection in person, combining both workshop and individual interviews, and conducting some interviews virtually if needed.

CONCLUSIONS AND RECOMMENDATIONS

In this report, we provide the results from our scale-up assessments of the integrated interventions in Eswatini, Lesotho, and Zimbabwe, as well as suggestions and recommendations related to scaling up these interventions in each country. Results showed across-the-board support for these integrated programs and their potential scale-up. Government representatives, IPs, and members of the community all appreciated these programs. Respondents felt the intervention was beneficial and should be scaled up. Also, across the board, sustainability was threatened by a lack of an institutional home and ongoing funding; however, respondents felt there were a number of donors well poised to support these programs.

Research suggests that children impacted by HIV/AIDS are at increased risk of development delay; in particular, cognitive delays have been associated with HIV infection or exposure (Sherr, Mueller, & Varrall, 2009). In light of increasing awareness of the importance of ECD in relation to HIV, governments will be tasked with decision making around next steps and scale-up of these interventions, other evidence-based interventions, and further research. This decision will be made by local governments and donors in each country, based on factors such as country needs and priorities, intervention impact, cost, complexity, ease of implementation, and availability of funds. For each country, we provide recommendations for simplifying the intervention to decrease cost and enable scale-up. We recommend using local delivery systems, such as the existing local workforce; reducing intervention dosage, such as by reducing the number of sessions; and always keeping sustainability considerations in mind when planning the intervention at scale, such as investing and relying on the community workforce to deliver the intervention. In this section, we provide overarching recommendations for stakeholders in the three countries, should they decide to scale up these interventions.

MEASURE Evaluation's recommendations are as follows:

1. Increase advocacy and awareness raising for ECD policy and program support.
2. Generate financial support from government and donors.
3. Explore multiple scale-up scenarios and cost implications to determine what is feasible within the country context.
4. Continue to improve ECD programming based on scale-up assessment and study results, as well as ongoing program monitoring.

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

a. Increase awareness at the central level of the importance of ECD and ECD policy, and programming that targets early childhood.

b. Promote government responsibility for supporting ECD and ECS via increased coordination and communication, such as regular meetings to define roles and carry out tasks. This approach could include a cross-cutting taskforce or ECD working group that includes members from multiple ministries, particularly MOH and MOE/MOET, and civil society. This effort should be led by a government champion to promote ownership and accountability.

c. Develop, finalize, and implement an ECD (or ECS in Zimbabwe) policy, if it does not already exist.

2. **Generate financial support from government and donors**

   Because of the significant barrier of lack of funding availability, we recommend the following:

   a. Conduct substantial lobbying and advocacy efforts to generate funding from the government and donors. These efforts will require wide dissemination of the evaluation results and identifying champions of ECD services in multiple sectors, in the MOE/MOET, MOH, and beyond.

   b. Engage in advocacy at local and community levels to support awareness of and increase demand for ECD services throughout the country.

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

   MEASURE Evaluation identified several scale-up scenarios for consideration. Please see each country's section for details. Country stakeholders would need to determine what is feasible and realistic within the country context.

4. **Continue to improve programming based on scale-up assessment and study results**

   MEASURE Evaluation identified the following potential adjustments to program operations for improved functioning and recommendations for ongoing implementation. Additional adjustments from program M&E study results should also be considered.

   a. Work with district government structures to design and implement any scale-up initiatives. Although government support at the highest levels is essential, it is also critical to work with district governments for efficient and ongoing implementation.

   b. Recruit service providers directly from the community when possible to promote program sustainability and local capacity strengthening.

   c. Continue to provide supporting supervision and refresher trainings to service providers to ensure the high quality of provided services, improve job satisfaction, and decrease turnover.

   d. Provide all monitoring tools in a local language to improve use and data quality.

   e. Ensure ongoing collaboration between government and nongovernment actors on intervention planning and implementation to use existing resources efficiently.

   f. Ensure community sensitization. To achieve community support and broad participation, ensure that community sensitization occurs in local implementation areas both before and during program roll out. Of particular note, ensure that sensitization is targeted to community leaders to promote understanding of the benefits of ECD services. In addition, provide HIV sensitivity training for local leaders to combat stigma.

   g. Continue to support community involvement and ownership. Increased community involvement in intervention planning and implementation will promote program sustainability. Engage community leaders in planning and advocacy of program services.

   h. Focus scale-up efforts on areas that showed significant differences in the respective evaluations.

Overall, the results from scale-up assessments reveal broad support for the integrated programs and scaling of the programs to additional areas. Respondents see the programs as ways to successfully target an at-risk population in need of services to support early childhood development and increase HIV prevention, testing, and treatment. According to respondents, the intervention designs increased community linkages to health services, especially for people living with HIV and AIDS. Challenges

remain because of both funding and lack of coordination around ECD at the central government level. Additional steps should be taken to increase awareness, secure funding from both the government and potential donors, and continue efforts to increase government involvement and ownership in intervention planning and implementation.

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APPENDIX A. PRIMARY DATA COLLECTION TOOLS AND GUIDES

Excerpted from the study protocol

Table of Contents

Introduction

In preparation for scale-up, the tools and guides presented here will guide data collection of the OVC integrated interventions in the three target countries of Eswatini, Lesotho, and Zimbabwe. The tools and guides are organized around key areas from the ExpandNet scale-up framework: defining the intervention; mapping the intervention; assessing feasibility; mobilizing support and resources; estimating costs; and monitoring and evaluating the scale-up process.

Each tool contains a **purpose**, a description of **how to use the tool**, information about **who should be involved** in data collection, and **sources of information**.

The tools and guides help to elucidate the main components of the OVC interventions, understand the context within which the interventions operate, identify the key factors and players that will support and hinder the scale-up, estimate the cost elements of scaling up, and determine what aspects of the intervention can be refined or adapted during scale-up to suit the context.

I. Define the Intervention, Assess and Plan Resources for Scale-Up

This stage entails defining the OVC interventions. Taking the time to articulate all components of the interventions in each country is a necessary first step so program implementers have a clear understanding of what core elements must be maintained when scaling up the intervention and adapting it to new situations. It also helps to assess existing resources for scale-up, such as staff and its competency, and organizational and environmental support; and helps to define adaptations needed for scale-up.

Tool 1: Defining the Intervention, Assessing and Planning Resources for Scale-Up Worksheet (Adamou, et al., 2014)

Purpose

This worksheet (see Appendix Table A.1) helps to identify the core elements of the intervention so that during scale-up it is clear what aspects of the intervention must be included to replicate impact and success.

How to Use the Tool

The worksheet consists of a multipage table that includes basic principles and key questions to guide scale-up assessment data collectors through a process to define the human, financial, and time processes and resources required for scaling up the interventions. It covers the technical elements, process elements, organizational profile, and context for the intervention. Items shaded in dark gray are the main steps, which together serve as a checklist to ensure that all bases are covered in the definition, whereas those shaded in light gray are the probing questions that drill down to the necessary level of detail in each step of the definition process. Additional customized questions may be inserted into the worksheet, and scale-up assessment data collectors should be encouraged to expand the number of rows under each step as needed.

Who Is Involved?

To ensure a well-operationalized definition, the worksheet should not be completed based on interviews with researchers and IPs alone; this work should be done within the context of a participatory process involving multidisciplinary stakeholders who are part of or will be affected by implementation of the HIV-ECD integrated intervention for OVC. It may be useful to ensure representation from each aspect of the intervention, such as government, research, and implementation.

Sources of Information

One-on-one interviews with the ECD community facilitators, researchers, IPs, and potential adopters (e.g., representatives from government ministries) will provide much of the needed information, as will the study protocol, existing documentation about the interventions, and OVC policies.

Table A.1. Scale-up worksheet

Defining the HIV-ECD Integrated Intervention for OVC, Assessing and Planning Resources for Scale-Up Worksheet	
1. Document the principles that underlie the intervention and the particular elements that make up the intervention	
1.1. Please describe the intervention (probes: What are the main activities? Please describe each activity.) Who delivers the intervention? What is the intervention intensity (e.g., how many sessions are caregivers required to attend? What is the intervention duration?)?	
1.2. How does the ECD intervention improve HIV outcomes? What are the HIV elements?	
1.3. What exactly is being tested in the randomized controlled trial (RCT)?	
1.4. What are the key assumptions (e.g., integration of ECD and health interventions improve child outcomes)?	
1.5. What are the underlying principles of the intervention?	
1.6. What are the elements related to equity? (probes: How does the intervention approach or address gender inequity? Socioeconomic inequity? What steps are being taken to ensure the intervention is equitably delivered? Are you including teenage mothers, disabled children?)	
1.7. What are the key elements that must be in place for the intervention to succeed? (probes: community involvement; government support)	
2. Determine for whom the intervention is intended and who is most likely to benefit when the program is implemented as planned	
2.1. Who does the intervention benefit? What is the demand for this intervention? Who should benefit from the intervention but does not? What groups/types of children (e.g., children meet selection criteria but cannot benefit because of low cognitive ability)?	
2.2. Who is the primary audience?	
2.3. What other audiences are involved? (probes: Are elderly caregivers included? Are first-time mothers included?) Are there any individuals or groups that may be disadvantaged or impaired by the intervention?	
3. Enumerate the key features (also known as core components or essential ingredients) under each category that must be present to say that an intervention exists in a given location	
3.1. Service delivery (Please describe what services should be provided)	
3.2. Human resources (Please describe the human resources required)	
3.3. Goods or products (Please describe required information materials or other goods and products that must be present)	
3.4. Information systems (e.g., database of program beneficiaries and data on health and cognitive development outcomes)	
3.5. Governance and leadership (What is the role of local leaders in the intervention? What is the level of their involvement in the intervention? Did they have to approve the intervention? What was the process to obtain approval or buy-in? What was the role of ministries? What was their level of involvement?)	
3.6. Policies (Do you have ECD-specific policies? If yes, which ones? Are they under the education or health ministries?)	
3.7. Finance (Does the intervention rely on volunteers? If yes, to what extent? What are the major expense items (e.g., labor,	

transportation, office supplies, etc.)? What parts are the costliest? Why? Are there hidden costs?	
4. Identify the components related to developing staff competency, organizational support, and technical and adaptive leadership supports, as well as the responsible party for each	
Staff competency/people (individuals or group responsible for managing staff competency)	
Ask IPs and researchers the following questions:	
4.1. Who are/were involved in implementing the intervention?	
4.2. How were they selected?	
4.3. What skills did they need?	
4.4. How were they trained to implement the intervention? (How many hours/days? What were the main topics?	
4.5. Who provided the training? How were the trainers trained? Where did they come from? Would it be possible to use them in a scale-up?	
4.6. What was the ministry's level of involvement in training?	
4.7. What types of ongoing coaching, monitoring, and/or supervision were required? Please describe.	
4.8. To what extent were the coaching, monitoring, and supervision in compliance with ministry guidelines?	
4.9. Who provides /provided the coaching and support? How often?	
4.10. What tools, if any, were needed?	
4.11. What other resources were needed?	
4.12. What were the challenges related to staff competency that you faced? How did you overcome those, or did you? How easy or difficult was it for you to find staff? What were your selection criteria? Can you describe your experiences with hiring supervisory vs. implementing staff? What was the extent to which you depended on existing human resources?	
4.13. What were the main lessons learned? If you were to work on this program again, what would you do differently in relation to training, supervision staff motivation, etc.?	
5. Ask potential adopters the following questions:	
Assuming that you are going to be involved in the intervention scale-up, please let us know your thoughts on the following questions:	
5.1. Who will be involved in implementing the intervention?	
5.2. How will they be selected?	
5.3. What skills will they need?	
5.4. How will they be trained to introduce and maintain the intervention?	
5.5. Who will provide the training?	
5.6. What types of ongoing coaching, monitoring, and/or supervision will be required?	
5.7. Who will provide the coaching and support?	
5.8. What tools, if any, will be needed?	
5.9. What other resources will be needed?	
6. Organizational supports and systems (list individuals or groups responsible for managing organizational supports/systems) – all respondents	
6.1. What kind of administrative support will you have for this intervention?	
6.2. Which organizational norms and policies will facilitate the intervention?	
6.3. Which organizational norms and policies will hinder/serve as obstacles to the intervention?	
6.4. What further systems support will be required?	
6.5. Where will the additional support come from?	

6.6. What activities will be needed to integrate the intervention into existing systems and practices?	
7. Environmental/other elements (list individuals or groups responsible for managing environmental/other elements) – all respondents	
7.1. What national norms and policies will facilitate this intervention?	
7.2. What national norms and policies will hinder or serve as obstacles to the intervention?	
8. Define the adaptations needed for expansion or scale-up to other sites – all respondents	
8.1. How will the intervention need to be adapted for scale-up?	
8.2. Will this adaptation be practical for the field context?	
8.3. If it is not practical, should we adjust or drop it? If it is adjusted, how?	
8.4. What core elements of the intervention will the field application of the adaptation compromise?	
8.5. What additional resources, if any, will be needed for scale-up?	

This tool was adapted from the *Guide for Monitoring Scale-Up of Health Practices and Interventions* (Adamou, 2014).

Additional open-ended questions for IPs and researchers:

1. In your experience, how did the intervention go overall?

1.a. What worked well? Please share a specific example.

1.b. What did not work well? Please share a specific example.

1.c. Please describe any adaptations you made to planned activities (what/when/why?).

1.d. What are some challenges you encountered during your work in implementing the intervention? (probes: law/legislation, system constraints, staff competency, lack of time, etc.)

1.d.i. What aspects of the intervention were most difficult to implement?

1.d.ii. What barriers exist for providing high-quality services?

2. What were some facilitators that helped you do your job? (What helps you do your job well?)

3. What made it difficult to do your job? Why?

4. If you had a chance to work on this intervention again, what would you do differently?

Were there any unforeseen positive outcomes or consequences? Unforeseen negative consequences?

5. What suggestions do you have for those planning to conduct a similar intervention?

Questions for Stakeholder Analysis (ExpandNet, 2012) (all respondents)

6. What are your hopes and expectations for scaling up the intervention?

7. Five years from now, how far do you expect scaling up to have progressed?

8. Do you have any concerns/worries about scaling up?

9. Who will be the resource team or organization that seeks to promote and facilitate wider user of the intervention model? Who will be responsible for scaling up the intervention?

10. What organizations do you envision will be the ones expected to adopt the intervention model or are already in the process of implementing it?

11. Is the intervention supported by respected individuals and institutions? If so, by whom?

12. Can the intervention be simplified to facilitate scaling up (without losing its essential technical, service delivery, or gender and human rights components)?

13. Are there components of the intervention that need to be added or strengthened?

Is the intervention sustainable in the setting in which it was tested? Is it likely to be sustainable in the settings in which it will be scaled up?

14. What can be done to ensure sustainability?

15. Does the intervention need to be presented/packaged differently to make it more compatible? How?

16. Who will organize the necessary advocacy? Are there advocates who will support such change?

17. Will other organizations be involved in advocacy?

18. What needs to be done to increase advocacy? To gain support?

19. Are resources for advocacy and the related costs of vertical scaling up the intervention available, or do they need to be mobilized?

20. What needs to be done to accomplish this goal?

21. What are the different factors or environments likely to influence the process of scaling up the innovation? Health sector? Education or other relevant government institutions? Bureaucratic culture? People's needs and rights? Policy setting/political system? Socioeconomic, gender, and other sociocultural characteristics? Funding agencies? Other?

Is there anything else you would like to tell me?

II. Map the Intervention

The following two tools help to elucidate key components of the intervention, the context within which the intervention was developed, and to organize that information. This process enables a clearer understanding of the key elements of the intervention in preparation for subsequent steps.

Now that the intervention has been defined, the next step is to create a logical framework (LogFrame) to map out the particulars of an intervention, including the assumptions that need to be made to reach the outputs, outcomes, and end goal. Once that has been done, the visual mapping exercise will help in thinking through the components of the intervention in sequential order.

Tool 2: Reverse LogFrame (Management Systems International, 2012)

Purpose

This tool provides a simple and logical description of the results the intervention is intended to accomplish, and how.

How to Use the Tool

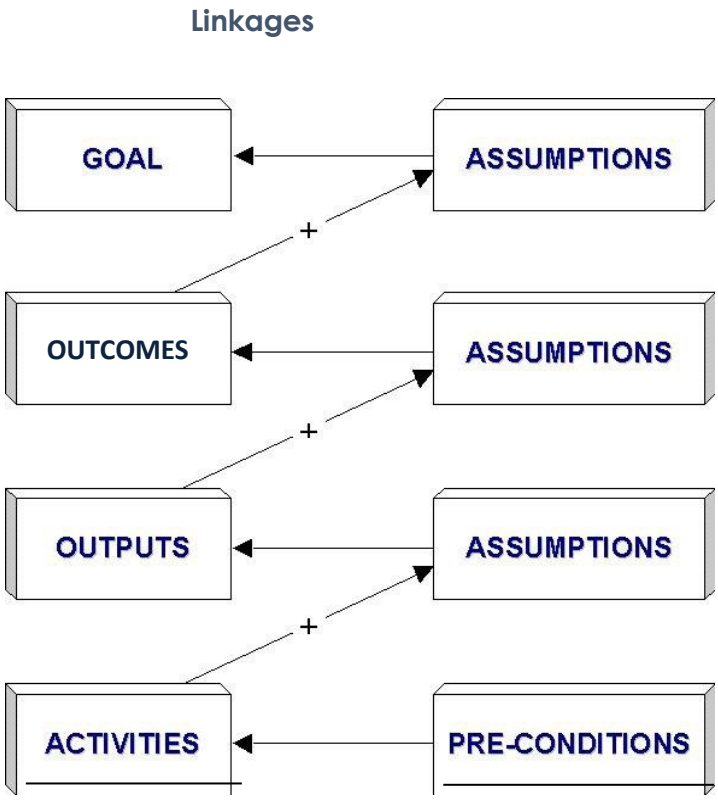
This tool reverse engineers the traditional LogFrame to map out the key goals, outputs, outcomes,

and activities of the interventions in each country. Based on what the program did, the data collectors for the scale-up assessment will talk to researchers and IPs to describe its goals and work backward using the following *Guiding Questions*:

- What outcomes were necessary to produce the goals?
- What outputs were necessary to produce the outcomes?
- What activities were necessary to produce the outputs?

In addition to this "hierarchy of objectives," the LogFrame calls for identifying the most important assumptions implicit in the link between activities and outputs, outputs and outcomes, and outcomes and the overall goal, as reflected in Figure A.1.

Figure A.1. LogFrame linkages



Identifying and testing these assumptions (often unstated in project descriptions and implicit in the minds of those carrying out the pilot program) is an essential first step in validating a model's applicability to new contexts.

Who Is Involved?

The data collectors for the scale-up assessment will talk to the researchers and IPs who will be involved primarily in helping to map out the intervention to activities, outputs, outcomes, and goals, and identify the implicit assumptions between them.

Sources of Information

The study protocol, researchers, and IPs will be the primary sources of information.

Figure A.2. LogFrame illustrative example: home-based newborn care

LOGFRAME ILLUSTRATIVE EXAMPLE: HOME-BASED NEWBORN CARE

GOAL	OUTCOMES	OUTPUTS	ACTIVITIES
Reduce Neonatal Mortality	❖ Home deliveries attended by a VHW (skilled attendance) ❖ Newborns delivered at home examined by a VHW within 24 hours after birth ❖ Newborns in program are exclusively breastfed within 24 hours after delivery ❖ Newborns received at least four visits by a VHW during neonatal period ❖ Newborns received at least one supervisory visit by a supervisor during the neonatal period ❖ Babies with danger signs diagnosed and received treatment from a VHW or referral to a clinic ❖ Mothers received health education in pregnancy and the postpartum period	❖ Home-based care by VHWs ❖ VHW can identify and manage neonatal risk factors ❖ Biweekly supervisor visits ❖ Development of MIS and performance indicators ❖ Semi-annual population census in program villages to record births and deaths ❖ Health education sessions conducted at community and household levels	❖ Obtain community consent ❖ Identify VHWs ❖ Develop standard technical guidelines and protocols ❖ Develop standard training methods and materials ❖ Develop logistics systems, uninterrupted supply ❖ Develop reporting formats ❖ Record vital stats ❖ Engage in health education ❖ Conduct home visits ❖ Provide for fortnightly visits by supervisors for quality control ❖ Provide referral advice, but initial management at home ❖ Develop step-ladder training ❖ Provide performance-based payment, annual incentives

VHW: village health worker; MIS: management information systems

[3] For a full treatment of the logical framework and its use, please see Cooley, 1989.

Interview questions to create a logical framework

1. What are the key intervention goals? (*List all intervention goals. For each goal, ask the following questions)*

2. What outcomes are necessary to produce the goal? What are the most important implicit assumptions in the link between each of the outcomes and the goal?

3. What outputs are necessary to produce each of the outcomes for the goal? What are the most important implicit assumptions in the link between each of the outputs and outcomes?

4. What activities are necessary to produce each of the outputs? What are the most important implicit assumptions in the link between each of the activities and outputs?

Tool 3: Visual Mapping (Management Information Systems, 2012)

Purpose

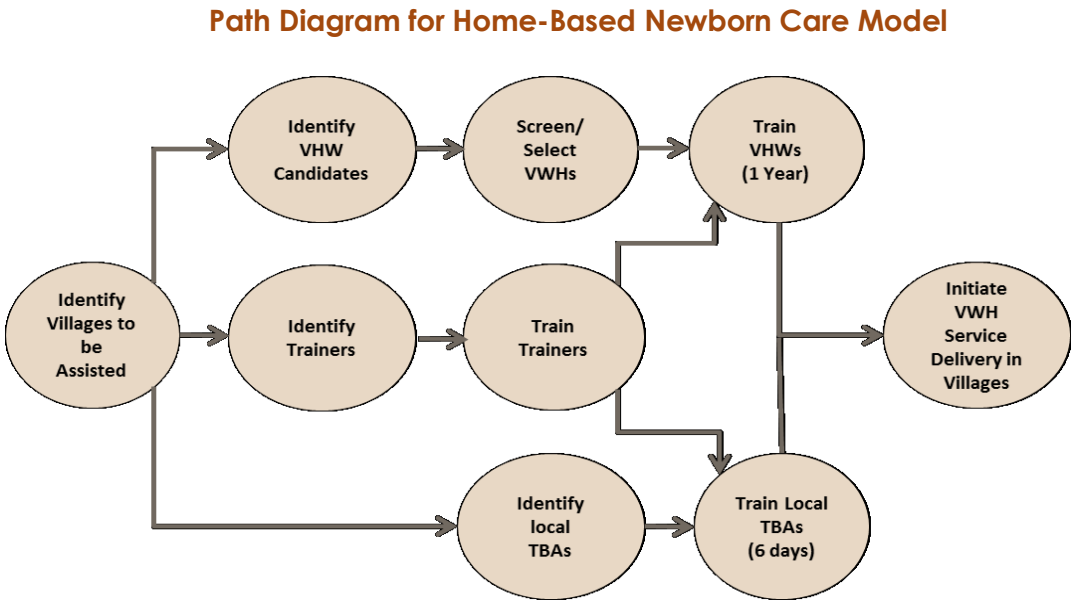
Visual mapping of the sequence of steps in an intervention—including steps contingent on specific conditions—is useful because it helps to ensure that all steps are identified, no key components are missed, and those involved have a better understanding of the sequencing issues.

How to Use this Tool

These graphics, called path diagrams, help to capture a model's essence before delving into the detailed requirements associated with each process step in an intervention. The idea is to take a large sheet of paper and markers to chart the steps of the OVC interventions for each activity. First, data collectors will list all activities of the OVC interventions. Then, for each activity, they will draw a diagram presenting all of the steps needed to implement the activity, and their sequence. Each main intervention activity should have its own diagram.

There are several sequences important in the home-based newborn care case example (see Figure A.2); one of them, the preparatory or training sequence, is illustrated below in Figure A.3.

Figure A.3. Path diagram for home-based newborn care model



Who Is Involved?

The same individuals involved in developing the LogFrame (primarily the researchers and IPs) should be involved in the visual mapping exercise, especially in validating the path diagram, because they go hand in hand.

Sources of Information

Primary sources of information will be researchers, IPs, impact evaluation study protocols, workplans from the IPs, and M&E plans.

III. Assess Feasibility

The Scalability Assessment Tool (SAT) helps to determine more closely the contextual factors affecting scalability and how those factors will facilitate or complicate scale-up. It provides the basis for a detailed scale-up plan.

Tool 4: Scalability Assessment Tool (Management Information Systems, 2012)

Purpose

The SAT enables the recognition and differentiation of contextual factors affecting the scalability of the intervention and the key features intrinsic to the intervention itself. The tool has the following multiple purposes:

- Helping to decide whether scaling up is a **viable** option
- Assessing how relatively **hard or easy** that process will be
- Identifying **ways to improve its scalability**

How to Use this Tool

The SAT is divided into the following seven sections in the accompanying score sheet:

1) **Credibility:** The extent to which the model of the intervention is credible in the eyes of potential adopters, funders, implementers, and other stakeholders, including beneficiaries or end users. The sources of credibility can take many forms, from qualitative, quantitative, and anecdotal evidence to the recommendations of experts or endorsements by prominent people.
2) **Observable:** The extent to which the results (impact or effectiveness) of the intervention are observable. Observability is especially significant because most relevant stakeholders and decision makers in the context of scaling up will not be technical experts in the field; for them, seeing is believing.
3) **Relevance:** The extent to which the intervention is relevant to the concerns of potential adopters, funders, implementers, beneficiaries, and other stakeholders. It is hard to "sell" a new solution when the problem or issue is not considered important. From a scalability perspective, relevance has three dimensions:
    a. There is an objective problem (not just someone's opinion)
    b. There is a problem from the perspective of policymakers or other relevant decision makers
    c. There is a problem in the eyes of potential beneficiaries
4) **Relative advantage:** The extent to which the intervention has relative advantages over existing practices. Sometimes relative advantage means there are no alternative solutions or responses.
5) **Easy to adopt:** The adoption of the intervention by other organizations and its transfer to other social contexts. Scaling up through other organizations depends on the characteristics of the intervention itself, such as how complex or resource consuming it is and the capacity of the adopting agency to manage these difficulties. It also involves how well the requirements of the intervention match up with the culture, capabilities, and incentives of potential large-scale implementers.

6) **Testable and adaptable**: The first part of this characteristic refers to the ease with which the intervention can be tested on a small scale by potential adopters without a large commitment of resources. The second part is whether the intervention can be adapted to new contexts and still retain its effectiveness, even with modifications.

7) **Affordable:** This criterion refers to the extent to which the intervention is more cost-effective than existing and competing interventions. It also includes the extent to which the total cost at scale fits realistically within the resources or financial envelope of possible adopters and funders, and the nonfinancial capacities, especially human resources and infrastructure, available to implement it. This criterion is especially important when considering scaling of a program that has been largely donor funded.

The primary purpose of the assessment is not to give a **yes or no** regarding scaling up, but to provide a very rough indication of the scalability of the intervention and a basis for anticipating the most likely challenges to be faced.

Once respondents (researchers, IPs, potential adopters) have reviewed the SAT, and all of the indictors are explained clearly to the respondents, the checklist is scored by respondents or scale-up assessment data collectors by simply putting a check mark or X in the appropriate column for each criterion. The scores in each of the two columns are added to provide a crude assessment of scalability. The MEASURE Evaluation scale-up assessment team can then look at those criteria on which the intervention was scored that make scaling up more difficult and assess how critical a complicating factor will be to scaling up; the team can then consult with respondents on what can be done to address it. For example, if the intervention lacks cost data, what can be done to generate such data? If the intervention appears to be expensive relative to resources available, what can be done to make it less expensive to implement? In areas where information is not available, flagging the need to do research on this issue should be added to the list of actions to take.

Who Is Involved?

The SAT will be implemented by the data collectors for the scale-up assessment, consulting with people who have the following:

- An understanding of the intervention itself and the context in which it has been effective
- An understanding of any evidence of efficacy, efficiency, or both
- A basic understanding of the potential adopting institutions and infrastructures in place, and their capacities and capabilities
- An understanding of relevant policy, budget, and resource issues in the OVC sector

People who meet these criteria are likely to be the researchers, IPs, USAID OVC technical working group experts, local stakeholders, and USAID Mission staff.

Sources of Information

To complete the score sheet, the data collectors for the scale-up assessment will rely on the information gathered from the previous two steps: defining and mapping the intervention. This information includes the intervention study protocols, evidence that the intervention works (e.g., published evaluations of similar interventions, evidence from OVC randomized control trials), OVC policies, guidelines, and others.

Table A.2. Scalability assessment checklist

Categories		A	Scaling up is easier	Scaling up is harder	C
A. Is the model credible?	1		Based on sound evidence	Little or no solid evidence	
	2		Independent external evaluation	No independent external evaluation	
	3		There is evidence the intervention works in diverse social contexts	There is no evidence the intervention works in diverse social contexts	
	4		The model is supported by eminent individuals and institutions	The model is supported by few or no eminent individuals and institutions	
B. How observable are the intervention's results?	5		The impact is very visible to casual observation; tangible	The impact is not very visible; not easily communicated to the public	
	6		Clearly associated with the intervention	Not clearly associated with the intervention	
	7		Evidence and documentation exist, with clear emotional appeal	Currently little or no evidence with clear emotional appeal	
C. How relevant is the intervention?	8		Addresses an objectively significant, persistent problem	Addresses a problem that affects few people or has limited impact	
	9		Addresses an issue currently high on the policy agenda	Addresses an issue either low or invisible on the policy agenda	
	10		Addresses a need sharply felt by potential beneficiaries	Addresses a need not sharply felt by potential beneficiaries	
D. Does the intervention have relative advantage over existing practices?	11		Current solutions for this issue are considered inadequate	Current solutions are considered adequate	
	12		Superior effectiveness to current solutions is clearly established	Little or no objective evidence of superiority to current solutions	
	13		Superior effectiveness compared to other innovative models established	Superior effectiveness compared to other innovative models not established	
E. How easy is the intervention to transfer and adopt?	14		Implementable within existing systems, infrastructure, and human resources	Requires new or additional systems, infrastructure, or human resources	
	15		Contains a few components easily added into existing systems	Is a complete or comprehensive package of multiple components	
	16		Small departure from current practices and behaviors of *target population*	Large departure from current practices and behaviors *for target population*	
	17		Small departure from current practices and culture of *adopting organization(s)*	Large departure from current practices and culture of *adopting organization(s)*	
	18		Few decision makers are involved in agreeing to adoption of the model	Many decision makers are involved in agreeing to adoption	
	19		Demonstrated effectiveness in **diverse** organizational settings	Demonstrated effectiveness **in only one**/pilot organizational setting	
	20		The model is not particularly value or process intensive	Process and/or values are an important component of the model	
	21		Low technical sophistication of the components and activities of the model	High technical sophistication of the components and activities of the model	
	22		Key innovation is a clear and easily replicated *technology* (e.g., vaccine)	Focus of the model is not a *technology*, or one that is not easily replicated	
	23		Low complexity; simple, with few components and easily added to existing systems	High complexity with many components; integrated package	
	24		Includes little supervision and monitoring	Includes substantial supervision and monitoring for implementation	
F. How testable is the model?	25		Able to be tested by users on a limited scale	Unable to be tested without complete adoption on a large scale	

G. Is there a sustainable source of funding?	26		Superior ***cost**-effectiveness* compared to existing or other solutions clearly established	Little evidence of superiority regarding ***cost-effectiveness***	
	27		Requires a small absolute commitment of funds at scale	Requires a large commitment of funds at scale	
	28		The model has its own internal funding (e.g., user fees) or endowment	No internal funding; the model is dependent on external funding source	
Total # of checks					

Once the data collectors have competed the SAT above, they will summarize the major findings in a chart such as the one below and conduct additional interviews to craft recommendations for how to address the more challenging components. Table A.3 shows a completed table from the Promoting Change in Reproductive Behavior (PRACHAR) project as an example.

Table A.3. Completed table from the PRACHAR project

Summary of major findings and recommendations based on the SAT

SAT categories A&B	**Credibility and observability**
Positive results	•
Challenges	•
Recommendations	•
SAT categories C&D	**Relevance of the intervention and comparison to alternatives**
Positive results	•
Challenges	•
Recommendations	•
SAT category E	**Ease of transfer and adoption**
Positive Results	•
Challenges	•
Recommendations	•
SAT categories F&G	**Ease of further testing and funding**
Positive results	•
Challenges	•
Recommendations	•

Below are the additional interview questions to craft recommendations for how to address the more challenging components:

What would you recommend to address the challenge X, Y, Z?

The PRACHAR project aimed to increase the age of women at first conception and promote child spacing. Implemented in Bihar, India, the interventions were a combination of training, behavioral

change communications, and service delivery activities designed to bring about significant changes in the knowledge, attitudes, and behavior regarding these issues. MSI applied the SAT to Phase I of the PRACHAR model. Below is a summary of the results from the SAT.

Table A.4. Summary of SAT from the PRACHAR Project

SAT categories A&B	**Credibility and observability**
Positive results	• Strong, robust evidence that model achieves its stated goals and key outcome indicators • Results are clearly associated with the intervention
Challenges	• Evidence that a model works in diverse social contexts is mixed (good across pilot state; unproven outside of Bihar State) • Has not (yet) received the support of influential individuals or institutions
Recommendations	• Conduct a two-pronged advocacy campaign: 1. Target influential individuals or institutions with strong evaluation data as the core of the message to gain their support and add status and legitimacy to the model 2. Add to qualitative evidence with additional personal testimonies and anecdotes in a media campaign to the general public to garner widespread support • To make a plausible argument that it may work outside Bihar without evidence, add a description of the social diversity of the pilot areas and provide analysis of how the model is affected by differences in socioeconomic status that may be applied to similar settings
SAT categories C&D	**Relevance of the intervention and comparison to alternatives**
Positive results	• Model moderately relevant: Of the three factors, it did well on (1) addressing an objective problem and moderately well on (2) issues perceived as problems by policymakers and decision makers • No other solutions being implemented at scale
Challenges	Project ranked poorly on a third factor: (3) issue is seen as a problem by beneficiaries (early marriage and births were the cultural norm)
Recommendations	Greater advocacy for the *issues* (not just solutions) of adolescent reproductive and sexual health, age of first births, and child spacing generally would help
SAT category E	**Ease of transfer and adoption**
Positive results (from the PRACHAR II Model)	• Evidence showed that a simpler model could be effective • Small departure from current practices for NGO adopters and beneficiaries • Implementable within existing systems and resources
Challenges (from the PRACHAR I Model)	• Complex and comprehensive • Process and resource heavy (intense training, supervision, and monitoring activities) • Model is a substantial departure from current practice for the Bihari government • To provide the training, monitoring, and coordination of the NGO implementers themselves, i.e., the role that the IP played in pilot phase
Recommendations	• Four different model options developed (one per scale-up method), but expansion of the existing pilot seems most promising • Alternative: test effectiveness of the model under conditions of average implementation
SAT categories F&G	**Ease of further testing and funding**
Positive results	• Model does not have obvious economies of scale or scope so that potential adopting organizations, such as Bihar State, should be able to test or roll it out gradually
Challenges	• No data on either absolute cost or relative cost-effectiveness, so it is impossible to assess these criteria or state-wide implementation • The model does not generate any funding
Recommendations	• Develop cost data on the PRACHAR model and different versions tested under PRACHAR II, and cost-benefits of simpler versus more complex models

IV. Estimate Costs

After the intervention has been clearly defined, the key activities identified and mapped, and the relative ease or difficulty of scaling up assessed, the next step is to estimate what it cost to implement the OVC integrated interventions in each of the three target countries, because cost is a critical factor influencing whether the scale-up will happen and, if so, the extent and pace of the scale-up process.

The information on costs will be useful to program managers and policymakers, who will need to analyze the estimated change in costs when the interventions are scaled up to cover more people. For example, they may be interested in the cost of extending the interventions to the poorest people, who often live in previously uncovered rural or remote areas. Without a means of determining the costs of expanding the OVC interventions into such areas, they cannot assess the desirability or feasibility of scale-up or budget and plan for it.

Cost Analysis Guide

Purpose

The purpose of this section is to describe the steps in conducting cost data collection and data analysis. The actual costing data collection forms will be developed in Excel spreadsheets after more information is available from the previous data collection steps about the intervention activities. This section provides guidance on what costs need to be collected and how to analyze the cost data to estimate resource needs for implementing the intervention. These costs will be the basis for estimating the cost of bringing the OVC interventions to scale.

Steps to Conduct the Cost Analysis of the Intervention

To conduct the cost analysis of the intervention, the following steps should be followed (Population Foundation of India, 2012):

1. List all of the activities that are part of the intervention.
2. Identify the costs for capital inputs.
3. Identify the costs for recurrent inputs.
4. Allocate all costs to each activity.
5. Compute the total and unit cost for each activity.

Step 1: Identify the key activities

To compute the unit costs, we need to start by listing all of the activities that relate to the intervention (see previous data collection forms) to which direct and indirect costs can be assigned.

Step 2: Identify the costs for capital costs (or nonrecurrent inputs)

Capital assets are those assets having an economic useful life exceeding one year and not acquired primarily for resale. Examples would be vehicles, equipment, building space, training (nonrecurrent), and social mobilization activities (nonrecurrent). From the interventions, we will list likely capital assets in the Excel spreadsheet and gather information on those assets through interviews.

Step 3: Identify the costs for recurrent inputs

Recurrent costs usually are defined as the costs associated with inputs that will be consumed or replaced in one year or less. **Salaries and benefits** usually represent the largest cost component of public health programs. They typically represent from one-third to three-quarters of the total program costs, which

means that considerable time and effort should be devoted to identifying precisely all personnel-related costs, accounting for every employee who was connected with the intervention in any way. When we cannot gather actual information (or where it may be sensitive to do so), we will gather average personnel costs or personnel costs from a similar type of personnel.

The category of **supplies** is for materials (drugs, consumables, book, stationeries, etc.) that were used or would be used up in year as direct inputs to the principal activities. In addition to the item cost, the full cost of supplies should also include the cost of transport to the point of use. The cost should include all of the materials used, including waste or damaged items. The cost, however, should not include the inventory stocks (i.e., those kept in stores and not used).

The capital inputs—building, vehicles, equipment—require regular maintenance; costs on this account are grouped under recurrent costs. For buildings, **operation and maintenance** (O&M) costs include charges for utilities, insurance, cleaning materials, painting, repairing, and so on.

The residual category of **other recurrent costs** covers all recurrent inputs not dealt with elsewhere. They may include O&M costs of equipment, postage, printing, photocopying, etc.

From the interventions, we will list likely capital assets in the Excel spreadsheet and gather information on those assets through interviews.

Step 4: Cost allocation

The total cost of providing a service (e.g., a supervision visit) is equal to the sum of shared and nonshared costs. Hence, to identify the unit cost of the service, it is essential to allocate the proportion of resource value in each category. Of nonshared costs, 100 percent is devoted to the service (e.g., fuel costs for transportation to the site for supervision). For shard costs, such as the cost of the vehicle, a percentage less than 100 percent is applied to that service (e.g., a supervision visit). This allocation is done for all services and activities that make up the intervention.

Step 5: Calculate unit costs

At this point, we will know the total costs incurred by each of the intervention's components and will identify the relevant output (e.g., the number of beneficiaries actually covered by the components). The unit cost would be $x/beneficiary (e.g., per child enrolled in the intervention).

Guidelines for Costing Scale-Up Operations

Once we have calculated the costs of the intervention, it is important to consider the factors that will influence the cost of scale-up. A scale-up assessment has the benefit of documenting the costs of an intervention and also identifies where the costs in a scale-up scenario may be different for a given input, or where the numbers of given inputs may be different (more or less) in a scale-up scenario compared to the intervention. There are four major factors on which we need to focus and count as additional costs when we plan for scaling up:

- Geography and infrastructure
- Human resources
- Fixed costs
- Management and support system

The general guidelines for costing scale-up operations are summarized in Table A.5.

Table A.5. General guidelines for costing scale-up operations

Scale factors	Specific points of interest	Selected key additional areas in the costing process
Geography & infrastructure	• Higher cost of transport, training, and supervision • Some topographies are more costly to build in/maintain/travel in	• "Difficulty" weights in the infrastructure • Supervision estimation of unit cost
Human resources	• Not enough trained and professional people to implement scale-up • Staff may need incentives/pay to locate in rural areas	• Additional cost for recruitment, people to implement scale-up, training of new staff • Retention incentives rural areas
Fixed costs	• Programs with high fixed costs/centralization will show declining unit costs • May need different technologies in rural and low-demand areas (e.g., mobile health)	• Additional fixed costs • Costs of alternative technology
Management & support system	• Increased need for system support • Lack of management infrastructure • Need for expansion of technical support • Increased need for demand generation and infrastructures communication	Additional costs for: • New infrastructure for capacity building or leveraging existing infrastructures • Technical support team • Coordination team (project management unit) • Demand generation through mass communication • MIS infrastructure • Logistics hubs (e.g., distribution centers, etc.)
Changes in the intervention	• The composition of components in the pilot stage may change in the scale-up stage	• Change in the proportion of cost components

It is important to note that for the scale-up assessment, the most important aspect is to document the costs of the activities of the interventions so that when it is time to plan for scale-up, those costs can be used to plan and advocate to fund it. In this scale-up assessment, it may not be possible to know the planned units for scale-up (which new beneficiaries in which new area, for example). The scale-up assessment can identify what costs may be likely to change in a scale-up scenario (e.g., where a local staff person is used in place of international technical assistance or where there will be 1,000 children enrolled instead of 200).

Who Is Involved?

The researchers, IPs and potential adopters will likely be the ones with the expenditure information and knowledge of costs. The data collectors for the scale-up assessment will gather the information from these respondents.

Sources of Information

Sometimes cost information can be obtained through budgets or expenditure reports, usually in the hands of the IPs. Typically, however, information has to be collected from interviews with IPs.

Tool 5: Costing Questionnaire (Questions for IP Staff)

1. Would it be possible to share the [program] budget categories used in the proposed budget for the project? That is, not the actual amounts but rather the categories.
    - Likewise, would it be possible to share the estimated number and types of capital purchases made during the life of the project, (i.e., six vehicles in Year 1, etc.?)
2. How many program staff works on [program]? See examples below and provide the titles and number of staff from the program
    - Technical
    - Program management
    - CHW/field staff
    - Grants
    - Finance/administration
    - Human resources
    - Procurement
3. Do staff work on multiple projects/programs/activities or just [program]?
    - Fixed-term employees vs. shared staff (i.e., drivers, receptionist, IT personnel, cleaners)
4. Do staff on [program] work on multiple activities or are they focused on one aspect or technical area (i.e., saving groups, education, PMTCT, etc.)?
5. How are the offices set up? Is there more than one office in [country]? (i.e. headquarters, regional offices, etc.)
6. How many staff are located in each office?
7. How is [program/organization] capturing and tracking costs?
8. Over what period of time have costs been captured?
9. Over what period of time do all major service delivery activities occur?
10. How would it make the most sense to track the time staff spend on different activities? Hours, days, percentage of time, etc.?
11. Would it be possible to estimate start-up costs (e.g., beneficiary identification and enrollment, hiring staff) vs. recurrent and capital costs? If yes, please provide these start-up costs.
12. Is [program] able to capture and track staff (and volunteer) time at the intervention level?
13. Would you be able to provide a breakdown of the expenditure categories by which you track expenditures? If yes, please provide the breakdown.

Information and Consent Form for an Interviewee

Introduction Hello. My name is _____ and I am working for MEASURE Evaluation. We are conducting a scale-up assessment of the early childhood development (ECD) integrated intervention to develop a strategy and recommendations for scaling up the intervention. The intervention aims to improve health outcomes among young children, including HIV testing, ART adherence, early childhood developmental outcomes, and nutritional outcomes. The purpose of the scale-up strategy is to help communicate to policymakers and donors the value of the intervention and give them the strategies and recommendations they will need to advocate for adapting and investing in the intervention on a greater scale.

To gather information for the assessment, we are interviewing some researchers, implementing partners, potential adopters, and other stakeholders. As part of this assessment, I would like to have a discussion with you regarding opportunities for and constraints to successful scale-up of ECD integrated interventions, as well as the readiness of key stakeholders to scale up the ECD integrated intervention. We would very much appreciate your participation in this interview.

Consent for participation

The interview with you will take between 45–60 minutes to complete. If you agree to participate, we will ask you questions about opportunities for and constraints to successful scale-up of ECD integrated interventions, as well as readiness of key stakeholders to scale up the ECD integrated intervention. Some people find that some of the questions may be difficult to answer. You may skip any questions you do not wish to answer or stop the interview at any time without giving any reasons. The risks to you as a participant in this study are minimal. Other people will not know if you are included in this study. We will put the things we learn from you together with things we learn from other people from your country, so no one can tell what things came from you. When we tell other people about this assessment, we will never use your name, so no one will ever know what answers you gave. Only a few researchers will have access to this information, and all data will be stored in a locked cabinet under the care of the principal investigator until it is destroyed after three years. Your participation in this study will not benefit you directly, but it may benefit others in the future, because your responses will improve our understanding about ways to scale up the ECD intervention. Your participation in this assessment is voluntary. If you don't want to be in the assessment, it is OK. If you want to be in the assessment now and change your mind later, that's OK too. You can stop at any time. If you agree to participate, you can decide not to answer certain questions and can stop the interview at any time. Your decision about whether to participate in this assessment or to answer any specific questions will in no way affect your work.

There are no "right" or "wrong" answers, so please be very frank with us. Please note that this interview is very informal; you can talk about anything you think is important for us to know. We do not want to miss any information from this interview, so I am requesting your permission to record our interview.

Before you say yes or no to being in this assessment, we will answer any questions you have. If you join the assessment, you can ask me questions at any time. Do you have any questions now? [Pause and answer all questions.] If in the future you have any questions regarding this interview, or concerns or complaints, we welcome your contacting Zulfiya Charyeva, the MEASURE Evaluation technical advisor and evaluation specialist by e-mail: *[email listed here*]. We will leave one copy of this form for you so that you will have a record of this contact information and information about the assessment.

Before we can continue, I need to have your verbal consent.

CONSENT STATEMENT FOR RESPONDENT

I have read this entire consent form or had it read to me, and any questions I had have been answered to my satisfaction. I agree to participate in this assessment.

For Interviewer:

RESPONDENT AGREES TO BE INTERVIEWED 1

RESPONDENT DOES NOT AGREE TO BE INTERVIEWED . . . 2 END

Signature of Interviewer: _____ Date: _____

APPENDIX B. M2M'S ECD INTERVENTION CONTENT

Essential services	Focus	
	Parent/caregiver level	**Child level**
Primary level maternal and child health	• Support for/referral to antenatal care (ANC)/postnatal care (PNC) • Support for/ referral to PMTCT services • Support for/referral to HIV testing/ART • Understanding child development/ risks *in utero* • Maternal mental health conditions/ depression • Alcohol/tobacco/substance abuse • Key risks to child health including fever/diarrhea/acute respiratory infections (ARIs) • Home hygiene/sanitation	• Childhood illness (IMCI) • Child health card • Referral for immunization (primary immunization complete by 12 months) • Failure to thrive • Identification of/referral for developmental delay/disability • HIV • Referral for TB screening (children at risk) • Malaria – mosquito nets (where relevant) • Regular bathing/hand washing
Nutrition	• Exclusive breastfeeding (first six months)/continuing breastfeeding • Understanding of infant dietary requirements: nutrients/complementary feeding • Referral for iron/calcium/folate during pregnancy • Referral for postnatal Visit A (6–8 weeks) • Healthy eating • Food security (referral for food/ nutritional support)	• Growth monitoring (height/length, weight for age/mid upper-arm circumference (MUAC) • Referral for micronutrient supplementation (Vitamin A/iron) • Referral for de-worming (12–24 months) • Food security (referral for food/ nutritional support)
Social services	• Referral for grants (where applicable) • Gender-based violence • Trauma counseling	• Referral for birth registration • Child protection (including referrals to appropriate services, where necessary) • Child rights
Support for primary caregivers	• HIV disclosure/overcoming stigma • Effects of parent behavior on child development • Coping ability/skills • Caring/responsive/nurturing/loving parenting skills and attachment • Nonviolent parenting/positive discipline (as alternatives to physical discipline) • Setting limits • Involvement of fathers • Teenage mothers • Alternative caregivers • Household/family ECD understanding/support	

	• Community ECD understanding/ support • Home safety • Links to key available services	
Stimulation for early learning	• Understanding age-appropriate cognitive/language/motor development (including post-24 months) • Age-appropriate responsiveness/ affectionate care • Age-appropriate language stimulation • Age-appropriate cognitive/academic stimulation • Play/stories/songs/dance/talking/ culture • Using household objects • Access to resources (book/toy libraries, etc.) • Toy making	• Cognitive development • Socioemotional development • Language development • Numeracy • Motor development • Visual-motor perceptual development • Exploration/experimentation • Preparation for socialized learning (play groups)

Source: m2m, 2014.

APPENDIX C. INTERVENTION FACILITATORS AND COMMUNITY-BASED MENTORS: SELECTION AND TRAINING PROCEDURES, LESOTHO INTERVENTION

Selection

Applicants were selected to attend an interview based on their experience and/or prior training in working with children and facilitation of group activities. (We looked for local Sesotho-speaking women but also interviewed some men.) Each potential candidate attended an interview with a panel of interviewees that included staff members from Stellenbosch University and GROW. Candidates answered questions about their previous work experiences and any professional and personal skills they believed would be of value for the position. They were also asked to share their personal outlook on childrearing activities and ECD with the panel. Last, each candidate delivered a short presentation to demonstrate how they would motivate a group of reluctant parents to enroll their children at an ECCD center.

Each interviewee received independent scores from all four interviewers. We calculated a total score for each interviewee and, based on these scores, asked candidates to attend the next selection round. We interviewed 30 candidates, of which 26 were selected to attend the 7-day training workshop. The aim of the training workshop was to provide basic training and practice opportunities in intervention delivery, and help the panel select 18 (8 facilitators, 8 mentors and 2 reserves) candidates who would then be offered these positions.

Training

1. Pre-selection training (basic training)

The seven-day training workshop included basic training in book-sharing skills (Peter Cooper and Lynne Murray, Reading University) and basic training in facilitation skills (Dr. Jackie Stewart). Each session included a didactic presentation that covered the basic principles of book sharing or group facilitation, followed by practical sessions in which candidates were given the opportunity to practice the skills they had learned. The presenters used the practical sessions to score participants' performance. Based on these scores, we narrowed down the 26 candidates to 18 selected staff who were split into 2 categories: community-based mentors (CBMs) and intervention facilitators (IFs).

2. Training for Pilot Intervention

All IFs and CBMs completed an additional five full days of training before implementation of the pilot intervention. The training was hosted at the GROW offices in Mokhotlong. Stellenbosch University staff conducted the training for the pilot intervention content. The IFs and CBMs were trained as a group on how to use the tablet devices, how to make referrals, how to provide informed consent, and training on troubleshooting. The CBMs and IFs were also trained separately on their respective session content, which also included practice opportunities.

Intervention Facilitators

This additional training served as a refresher in basic book sharing for the IFs.

- Two book-sharing sessions were discussed and practiced per day, ensuring that all six sessions were covered over the three days of training.

- Caregivers and their children came in two waves each day (three in the morning and three in the afternoon) so the IFs could practice presenting the sessions and facilitate the one-on-one exercises with groups of caregivers and children.
- This activity happened under the supervision of Stellenbosch staff.

Community-Based Mentors

The same format was followed for the CBMs as for the IFs, and a more detailed training in two of the sessions was introduced and practiced each day.

- The training for CBMs was a participatory and interactive process. Local songs and dances were included for each session as an ice-breaker activity. The group also contributed ideas for practical tasks (such as carrying a water bucket on one's head; a children's story about chicks and an eagle that helps to demonstrate how ART works; recipes that used ingredients specified in the nutrition component of the intervention).
- Nutrition experts from the Ministry of Agriculture (MOA) conducted a half-day training session on how to measure height, weight, and mid upper-arm circumference (MUAC), as well as training on appropriate feeding recommendations. During the pilot, these MOA trainers also attended the growth monitoring session to observe and assist the CBMs with the growth measuring activity for each participant.
- The CBMs created a short film about HIV testing and treatment to use as a discussion point for the HIV messages that form part of Sessions 4 and 5. The video tells the story of a mother with a child who goes for an HIV test, discovers that she is HIV positive, and her journey through this process. The CBMs acted out the story, and it was filmed for the pilot.

Following the pilot training, Stellenbosch University edited the intervention content for use during the pilot period to include the local songs and metaphors, appropriate feeding recommendations, and referral steps in the manual. Each IF and CBM received a simplified version of the main intervention manual that included a summary about session structure (what happens when) and materials needed.

3. Training for Full Intervention

Before the start of the full intervention in October 2015, the IFs and CBMs attended a two-week training workshop in Mokhotlong. The first week consisted of advanced book-sharing training, presented by the developers of the book-sharing intervention, and included additional principles for conducting book sharing with slightly older children. In the second week, the teams were trained in the final health and nutrition session content (which had undergone changes based on the pilot intervention). IFs and CBMs attended both book-sharing and health and nutrition training sessions to support their partners (each team consisted of one IF and one CBM) and become familiar with the integrated nature of intervention delivery. The training also included M&E procedures, such as scheduling sessions, documenting attendance, making referrals, and completing feedback questionnaires after every session.

Each training workshop followed a similar structure and approach to the training of participants. During the didactic sessions, group members were continually encouraged to participate and contribute by sharing their experiences and give input on how the principles discussed could be applied in a culturally acceptable way. The participants were approached as local experts, and their knowledge about the context was a valuable addition to the training that added to the groups' understanding of delivering the intervention in this particular setting. Didactic sessions were followed by opportunities for practice. During practice

sessions, the training facilitators offered constant positive feedback and support. Praise, affirmation, and celebrating the staff successes formed a big part of the training procedure. Facilitators used tokens, setting goals, and an emphasis on positive feedback to establish a warm and supportive group environment that encouraged staff members to participate fully and feel empowered in their roles as IFs and CBMs. It was important to model this approach to the IFs and CBMs, because it is the same approach that they in turn are expected to incorporate into their delivery of the intervention sessions.

An intervention refresher training workshop was conducted with all IFs and CBMs to provide refresher training for all intervention procedures before the IFs and CBMs returned to the field to conduct the Phase 2 intervention activities. In preparation for Phase 2, the intervention teams reviewed both the book-sharing and health and nutrition content of each session to make sure the order of activities and instructions for those activities were correct and that they achieved consensus about each session's procedures. The training workshop also included an opportunity to review the documenting, reporting, and filing systems for the intervention. The teams had gained significant experience since the Phase 1 Mphatlalatsane intervention, Selemela and Community Outreach, which was further confirmed by their active participation in the refresher training, the experiences and knowledge they shared with the rest of the group, and their valuable suggestions for conducting the intervention during Phase 2.

Supervision

Weekly supervision meetings: Intervention supervision activities included weekly supervision meetings with all IFs and CBMs to discuss their week in the field. All intervention teams met with supervisors for a group feedback session so that challenges and successes could be shared and discussed as a group.

Site visits: A "clinical" supervisor conducted a site visit with at least one team each week throughout the intervention. Any supervisor who attended an intervention session in the field filled out the **Supervision Observation Form,** which included questions about the session in general and how the IF and CBM functioned as a team. It also included an individual evaluation sheet for each CBM and the IF. The supervisor also documented the type of feedback she gave to the team.

Daily check-ins: Intervention teams were encouraged to report on general progress, challenges, referrals, and any other concerns in the field via the WhatsApp group chat.

APPENDIX D. PLANNING FOR OUTREACH DAYS, LESOTHO INTERVENTION

Outreach process steps (listed in order)

- Conducted stakeholder consultations.
- Held multiple meetings with the MOH and Baylor University on how best to run the event and take lessons learned drawn from their implementation activities, including discussion around tools.
- Developed outreach document—sent letters for the first stakeholders meeting.
- Held first stakeholders meeting; introduced the idea of outreach and received the first commitments from participants in relation to the resources they could provide.
- Modified outreach planning tool.
- Developed and made a request for test kits from the hospital lab and had it signed by the AIDS officer (in the process, other materials, such as tables, chairs, and tents were procured in South Africa).
- Submitted a request to the hospital lab and waited for the materials—refresher training held for the CBMs on nutrition assessment by the nutritionists.
- Conducted refresher training for the HIV lay counselors on the new HIV guidelines by Baylor; developed an outreach message for the community (the message to be given to the public health nurse to inform the health centers about the outreach services, dates, and villages).
- Health center nurse delivered the outreach message to the respective chiefs, with dates; CBM followed up on the message with the chiefs after delivery.
- Hired cars to use for the outreach, as per the number of participants or stakeholders, including securing the catering places.
- CBMs visited the village to ask for houses to use for the outreach and plan the outreach according to the outreach patient flow at the service stations; this process was called the site inspection (took pictures and labeled them according to the specific station—they could be shifted around depending on how the whole team viewed it).
- Allocated tasks among the project staff to ensure the smooth running of the outreach, including who was responsible for each station to make sure that everything was well monitored.
- Organized outreach materials in different departments and got them ready for collection during the outreach days.

Outreach days

Staff divided into two teams. The first team left the office, usually around 6:30 a.m. to go to the field to set up stations. (Setting up included loading the trucks with all available materials, both at the office and from partners. However, after the first outreach, all material was stored in one place for easier logistics.)

The second team left around 8:00 a.m.; this team comprised only the service providers. One or two of the CBMs left to make sure that all partners were on time and collected the lunch packs. Participants' movements from one service to the other were monitored by the patient flow card received at the registration point.

APPENDIX E. LIST OF TRAININGS, ZIMBABWE INTERVENTION

IMPACT Training Modules

1. Basic facts of HIV and AIDS
2. Pediatric TB/HIV co-infection
3. Pediatric HIV symptoms and management
4. Pediatric ART, adherence, and adverse events
5. Pediatric nutrition
6. Adolescent HIV care and treatment
7. Child rights and counseling techniques
8. Communicating with children
9. Management of grief
10. Monitoring and evaluation
11. Field visit and plenary session

ECS Training Modules

1. Relationships with people around caregiver and child (social support and accessing services)
2. Role of a good parent; responsive parenting practices
3. A healthy infant and young child
4. Pregnancy and infancy
5. Child development
6. Physical/motor development
7. Social and emotional development
8. PMTCT and treatment adherence
9. Complementary feeding
10. Communication and language development
11. Developing thinking about and understanding the world (cognitive)
12. Positive discipline

ISAL Training Modules

1. Financial literacy
2. Income-generating activities
3. Business proposal development
4. ISAL group formation
5. Monitoring/tracking expenditures
6. Risk management

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