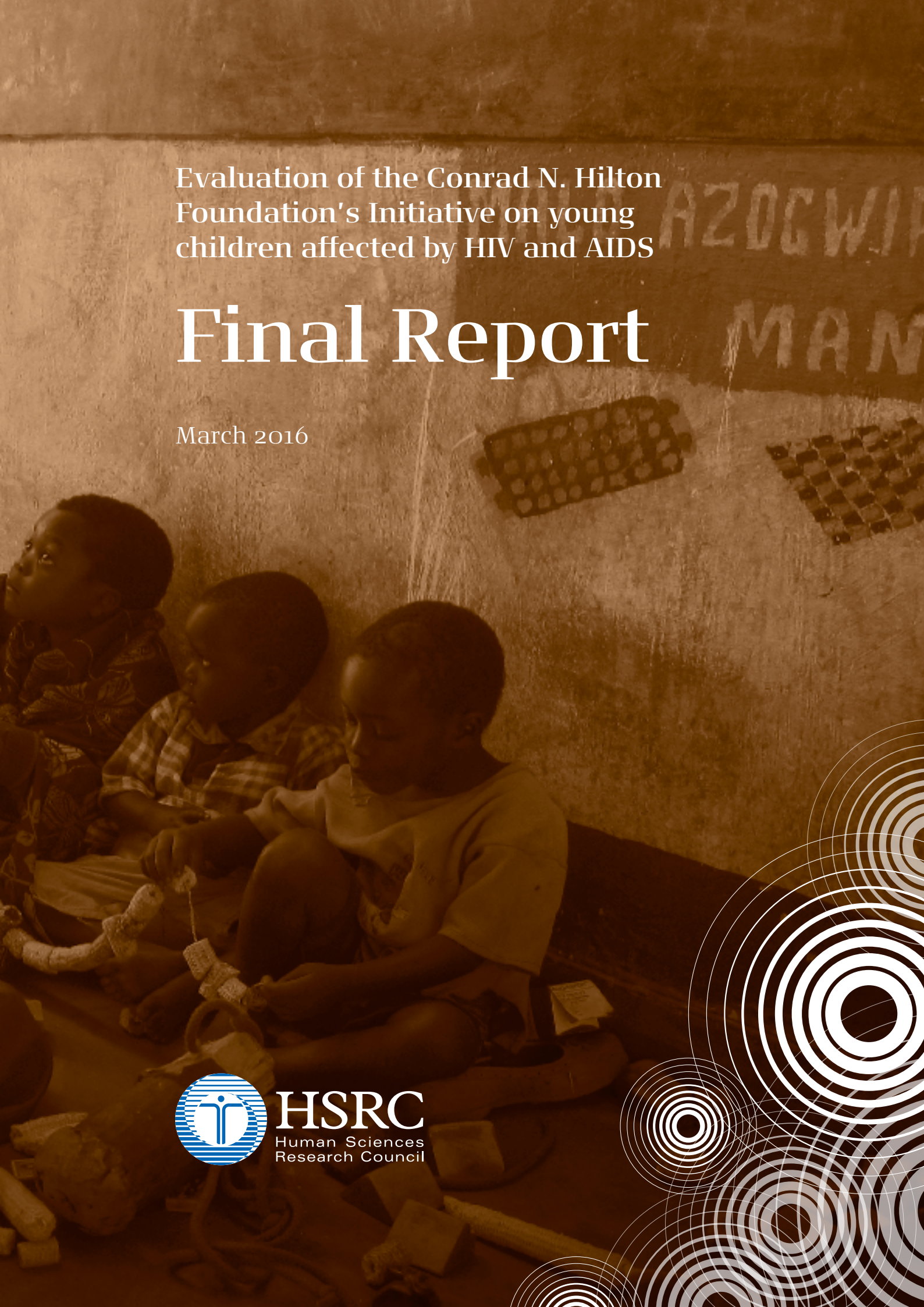
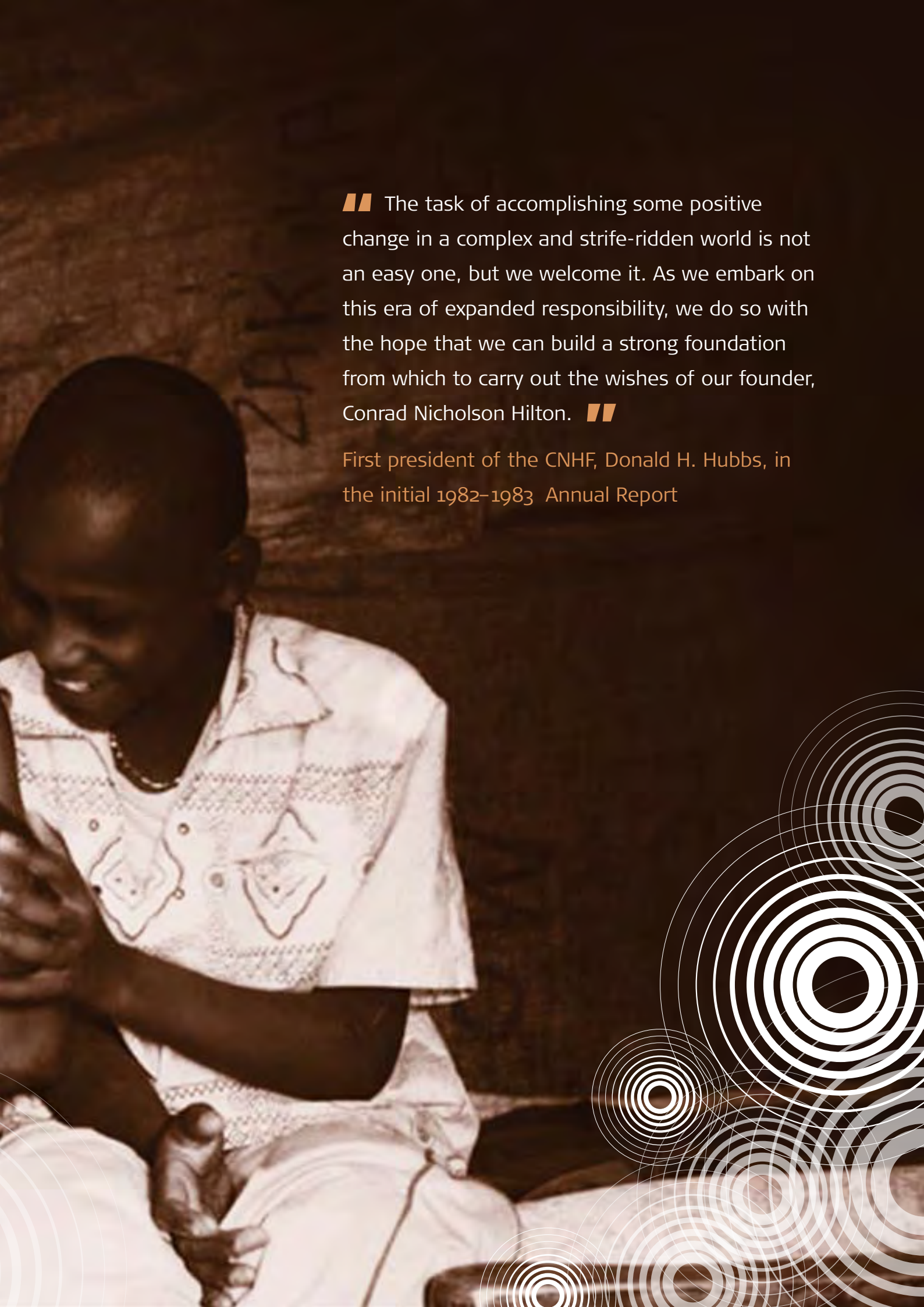
Evaluation of the Conrad N. Hilton Foundation's Initiative on young children affected by HIV and AIDS

Final Report

March 2016



HSRC
Human Sciences Research Council



"The task of accomplishing some positive change in a complex and strife-ridden world is not an easy one, but we welcome it. As we embark on this era of expanded responsibility, we do so with the hope that we can build a strong foundation from which to carry out the wishes of our founder, Conrad Nicholson Hilton."

First president of the CNHF, Donald H. Hubbs, in the initial 1982–1983 Annual Report

Executive Summary

In 2011, the Conrad N. Hilton Foundation launched what has become a remarkably successful strategic initiative to protect, promote and support the development of young children affected by HIV and AIDS. Highlights of the Initiative include the Foundation's leadership and leverage, opening up a new area and generating international and national interest in the work; the partnerships it has established with many of the largest and most experienced implementers of programs for children and communities affected by HIV and AIDS in sub-Saharan Africa; the large numbers of children and families who have been supported through the activities of partners and collaborating community-based organizations and local government services; the unique learning network created among researchers, implementers, policy makers and community groups; the growing awareness in the sub-Saharan African region of the importance of supporting families during the earliest years of a child's life; improved implementation and accountability through joint work on logic models and measurement tools, and innovation in assessment, practice, and advocacy.

In the three years that we have monitored the Foundation's Children Affected by HIV and AIDS (CABA) Initiative, 320,549 children have been provided with one or more services (see Figure 5), as have 177,754 parents or caregivers. A third of children (119,180) attended partner-supported community-

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based child care centers. Nearly three hundred thousand (277,054) home visits were made to approximately 54,000 households and more than 37,000 professionals, community and government workers received some form of training.

There is a lot to celebrate, but still a lot to do. The success of the Initiative has opened doors and there are new thresholds to cross. The Foundation has the opportunity to take the lead on several fronts. Our balanced scorecard analysis points the way to areas that need strengthening, particularly regarding the quality of programs on the ground and evidence for their effectiveness. We recommend that the Foundation identify the niche it wants to occupy, and the areas in which it will continue to lead. The Foundation should consider either directly supporting, or addressing the following via partnerships: ensuring that community workers are properly trained, accredited and remunerated; very young children receive the diverse foods they need to fuel their development; that sufficient small media learning aids are produced to make community work more effective and maintain changes in parent behavior, and that philanthropically funded programs get closer and more aligned to government provisions so that, at least with respect to some interventions, we can anticipate that they are provided for all children.

" ... our balanced scorecard analysis points the way to areas that need strengthening ... "

Background

Through a contract signed in November 2012, the Human Sciences Research Council (HSRC) in South Africa has provided a Monitoring, Evaluation and Learning (MEL) platform for the Foundation's Initiative on *Young Children Affected by HIV and AIDS* (CABA).

This new international investment by the Foundation emanates from the charge in Conrad N. Hilton's will to the Foundation to, amongst others, "shelter little children". The Initiative was based on a careful landscape analysis, including the burden of HIV and AIDS and available funding and gaps in the response. Backed by recent scientific evidence and policy interest, the focus is on the youngest children in the most vulnerable families living in countries with high HIV prevalence in southern and eastern Africa.

With the goal of supporting young children living in high HIV and AIDS prevalence areas to better realize their cognitive, social and physical potential, **the Initiative is directed to three mutually reinforcing areas of work:**

- **Building the capacity of caregivers and parents to meet the developmental needs of their young children;**
- **Strengthening community-based organizations to ensure that families and young children receive quality early childhood development services;**
- **Achieving more effective practice and policy through shared knowledge and advocacy.**

Up to the end of 2015, awards have been made to 16 international and national NGOs and academic institutions, working with community-based organizations (CBOs) and local and national governments in Kenya, Malawi, Mozambique, Tanzania and Zambia. Five additional grants have been awarded to new organizations. Grantees are facilitating holistic early childhood development services in households, clinics, community support groups and early childcare centers. They are building capacity among caregivers, community workers, health care professionals, CBOs, NGOs and government officials, using both established

and innovative approaches and tools, and they are sharing knowledge and advocacy through national, regional and global networks.

Strong emphasis is placed on monitoring, evaluation and learning, and the HSRC in South Africa* was awarded a contract to provide MEL support, roughly a year into the CABA Initiative. This report, covering the period 2012–2015, gives an overview of the achievements of the Initiative, and it points to areas where success has revealed additional challenges. Many of these challenges exist generally in the field, providing opportunities for the Foundation to take the lead in addressing them. In order to be fair to all funded partner organizations, no partners are named in the report. However, short summaries of the country and program activities of each of the 16 partners are available on our website (melycaba.com). Greater detail about all aspects of this Final Report are given in the HSRC's annual, country and convening reports to the Foundation and in reports on specific topics, such as the Information for Action app, the Community-Based Child Care Centers Evaluation Study and the Balanced Scorecard Analysis.

* Appendix 1: Bio-sketches of the HSRC team attached

The Foundation's children affected by HIV and AIDS priority area

In preparation for the development of their Children Affected by HIV and AIDS strategy, the Foundation conducted a landscape analysis of the needs, current efforts, service provision and policy, and of preliminary opportunities for intervention in the area. The results of the analysis informed the Foundation's strategic approach, including selection of their target group – children affected by HIV and AIDS from birth to age 5, their families and communities; the geographic regions in greatest need – high prevalence countries in East and Southern Africa with factors crucial for success, and the potential partner organizations with whom impact could likely be achieved.

The CABA Initiative was built on a number of observations: 1) While a large portion of the available funding is allocated to HIV health care, very little is given to support early childhood development (ECD). Children are affected by HIV and AIDS in many ways. Child development in the early years is highly susceptible to the ill effects of adversity and, simultaneously, to the benefits of interventions. It is a period of life in which the harms done by HIV can be prevented and compensated for, stopping them from accumulating across childhood and rendering adolescents especially vulnerable. 2) The best way to support and promote children's early development is through parents and caregivers because they have sustained contact with children and the greatest investment in children's wellbeing. But in the context of poverty and HIV prevalence, they may lack the support

necessary to meet their children's needs to grow and learn. 3) The most effective channels for the provision of support is through existing health and education systems, community-based child care centers and other community-based groups and home visiting programs. 4) Despite limited capacity and resources, community-based organizations, which are prevalent all over Africa, are well positioned to work through these channels.

As a philanthropic family foundation, the Foundation made exploratory grants, beginning in 2009, to develop and test an *Essential Package* of guidelines and standards for child development services and interventions for young children affected by HIV and AIDS. The portfolio was expanded to include several grants to international non-governmental organizations to provide early childhood development services for children affected by HIV and AIDS.

As with other portfolios under the Foundation's priority areas, the CABA Initiative required a monitoring and evaluation component that would inform the continual refinement of the strategy. This enables the Foundation to **a) improve benefits to *those children reached*, and b) improve services for *many more children* as a result of more effective programing based on learning.**

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In November 2012, the HSRC joined the Initiative as the MEL partner. The HSRC was tasked to assist the Foundation to assess the impact of the Initiative as a whole; to develop, maintain and promote a learning agenda across all partners and, in collaboration with other stakeholders nationally, regionally and internationally, to innovate, and to improve the strategy through evaluation of impact.

The Monitoring, Evaluation and Learning Initiative

The HSRC was established in 1968 by an act of parliament (Human Sciences Research Act, No. 23 of 1968) as South Africa's statutory research agency in the human and social sciences. Now functioning under a revised Act (HSRC Act No. 17 of 2008), the organization is the largest dedicated research institute in the social sciences and humanities on the African continent conducting cutting-edge research in areas crucial to development. Led by Professor Linda Richter, an internationally recognized expert in child development and in the field of children affected by HIV, the HSRC team designed its MEL Initiative based on the premise that "***programs* are the way you benefit the children you reach, *MEL* is the way you benefit all affected children**".

Through a multidisciplinary team and a multi-pronged approach, the MEL Initiative has made significant contributions in a number of areas:

- Eleven of the twelve initial grants preceded the HSRC which limited input into both M&E and program designs. Nonetheless, we provided **continuous support for programs and M&E** being conducted by partners.
- The HSRC undertook a number of **new research components** in response to gaps and opportunities which the team identified in the Initiative. These ranged from working with one partner in Malawi to assess the impact of quality and quantity of preschool participation in child care centers on school readiness; to standardizing the *Ages and Stages Questionnaire* in

South Africa and Zambia to make available in the region a rigorously normed instrument for the assessment of the development of young children.

- A key area for the Foundation and the HSRC is **innovation**. Through the development of the *Information for Action* app the HSRC team demonstrated how technology could be used to generate information and improve practice at all levels of program implementation.
- The HSRC assisted in **leveraging the Initiative through a range of networking activities**, including interactions with in-country government departments and country and regional networks; strengthening links with UNICEF New York, US Assistance for International Development (USAID), the US President's Plan for Emergency Relief (PEPFAR), the Coalition for Children Affected by AIDS, the World Health Organization and the Aga Khan University. These networks resulted in, amongst others, the Foundation funding the Science of Early Childhood Development training courses; and the Foundation's representation at the AIDS 2014 conference, including Foundation Chairman Steve Hilton's commentary in a Special Issue of the prestigious scientific journal *AIDS* on *Children Born into Families Affected by AIDS*.
- As a research organization, and through the efforts of team members with extensive research and practice careers, the **HSRC brought expertise and experience to the Initiative that emphasized strong theory and science in child development, HIV and AIDS and the implementation and evaluation of intervention programs**.
- Throughout the Initiative, **new learnings were developed and shared across the network of partners**. These included current training practices; how training fits into the logic models implicit to most programs and how it must be enhanced to improve practice; what features in evaluation designs are essential to making claims about the effects of interventions on child and family outcomes, and so on.

Highlights of the Initiative

1. On the crest of the wave
2. Influential partnerships for young children
3. Large numbers of children and families supported
4. Establishing a learning network
5. Supporting families in a child's earliest years
6. Implementation is being improved
7. Assessment and accountability is being invigorated
8. Rigorous evaluation is being encouraged
9. Multiple benefits through integration
10. The learning mileu encourages innovation
11. Learning from a balanced scorecard

1 On the crest of the wave

The Foundation is leading the worldwide early childhood development wave with respect to children affected by HIV and AIDS, and the Foundation's identification of this critical intervention point for children has generated greater interest in the area. As a result, it is stimulating the ECD field more generally and linking young children to the broader HIV response through, amongst others, the prevention of mother-to-child HIV transmission, and support for families affected by HIV.

1 On the crest of the wave

The careful groundwork undertaken ahead of embarking on this new priority area[1] put the Foundation's work on children affected by HIV and AIDS on the crest of the emerging wave of increased global attention to the field of early childhood development. Examples of this increased global attention are given below.

- The United States Government published its Action Plan on Children in Adversity: A Framework for International Assistance 2012–2017 under Public Law 109–95* in December 2012. The Plan brings together all international assistance provided for children. It has six implementation objectives of which *Strong Beginnings* is the first. The rationale for this is that *"In light of the mounting evidence of the long-term effects of severe adversity in early childhood, comprehensive strategies that incorporate promotion of secure and stimulating relationships, safeguarding against malnutrition during the critical 1,000 days between pregnancy and age two, and other lifesaving health services are essential to the future success of communities and nations."*[2]

> "the Foundation's singular investment in young children affected by HIV, to date more than $50 million, has led to a new focus on young children affected by HIV and AIDS..."

- In 2013, 2014 and 2015, the Director-General of the World Health Organization, Dr. Margaret Chan, and the Executive Director of UNICEF, Mr Tony Lake, made statements in influential scientific journals advocating for increased attention to early childhood development and its important influence on lifelong health and wellbeing.[3-5]
- Other global leaders speaking out in 2015 concur. The Secretary-General of the United Nations, Ban Ki-moon, stated that "*... we know so much more about how nutrition, stimulation, protection and loving care are essential to the healthy development of children's brains. They help them to grow and learn, to be more resilient in adversity and to be better able to embrace opportunity. Investing in early childhood development does not just benefit children, it benefits societies.*"[6] Speaking in

relation to the Sustainable Development Goals (SDGs), the first of which aims to "ensure that all human beings can fulfil their potential in dignity and equality,"[7] World Bank Group President, Jim Yong Kin said *"There can be no equality of opportunity without...appropriate stimulation, nurturing, and nutrition for infants and young children. Conditions of poverty, toxic stress and conflict will have produced such damage that they may never be able to make the best of any future opportunities. If your brain won't let you learn and adapt in a fast changing world, you won't prosper and, neither will society."*[8]

In this environment, the Foundation's singular investment in young children affected by HIV, to date more than $50 million, has led to a new focus on young children affected by HIV and AIDS.

* Public Law 109-95: Assistance for Orphans and Other Vulnerable Children in Developing Countries Act of 2005 (PL109-95) calls for a comprehensive, coordinated, and effective response on the part of the U.S. Government to the urgent needs of the world's most vulnerable children. The U.S. Agency for International Development (USAID) is the lead agency for PL109-95.

Stimulating the ECD field

Through the Foundation's investment, more than 16 major international program implementers in sub-Saharan Africa are focusing on the early development of young children affected by HIV and AIDS. The programs, awareness raising, training, and convening activities that the partners have undertaken, together with the Foundation and the MEL team, have **raised the profile of early childhood development in the five countries in which the Foundation is working, and far beyond their borders**.

Training in the *Science of Early Childhood Development (SECD),* for example, is said by many partners and others working in related fields to be having a profound influence on their understanding of early childhood development and its importance in the life course. The SECD is an interactive educational resource developed by Red River College in partnership with the University of Toronto and the Aga Khan Foundation.[9] It consists of five modules built on research with clear links to practice: Brain Development, Coping and Competence, Communication and Learning, and the Ecology of Childhood and Developmental Health. The Foundation supported the extension and adaptation of the training to low-resource countries and with relevance to HIV. Further, the Foundation is funding the participation of staff and associated individuals in partner organizations in both the 18-week online and 6-day in-person courses.

1 On the crest of the wave

The Foundation has also provided financial support for the forthcoming Early Childhood Development series to appear in *The Lancet*, led by Professor Linda Richter, the MEL Initiative project leader. This third series follows the influential series in 2007 and 2011. It brings together experts from around the world to review the latest scientific research on the biological and social mechanisms underlying child development as well as on the effectiveness and long-term impact of interventions to promote child development. It advocates for the scale-up of early childhood development programs, building on service platforms in health, education, social and child protection. Coming as it does, with interest in early childhood development rising, the series is anticipated to have a major influence on positioning early childhood development as intrinsic to the Sustainable Development Goals (SDGs).

> *"The Sustainable Development Goals recognize that early childhood development can help drive the transformation we hope to achieve over the next 15 years".* – Secretary-General Ban Ki-moon, UN Headquarters, 22 September 2015.

Partners funded in the Initiative are taking up, adapting, and training community-level workers in and learning from the WHO/UNICEF *Care for Child Development* (CCD) package. CCD was originally designed as a module of the Integrated Management of Childhood Illness (IMCI), the syndromic approach adopted in primary care in the majority of low- and middle-income countries. CCD can be delivered by home visitors and community workers, as well as facility-based providers through a variety of health, education, family and social protection services and has been shown to benefit children and parents and caregivers in three trials (China, Jamaica and Pakistan). The Foundation is funding implementation of CCD by several partners and, working with UNICEF and other partners, is supporting training of expert trainers and program staff.

Linking young children to the broader HIV response

Children have been left behind in the HIV epidemic. Diagnosis (testing), treatment, and care and support for children lag far behind provisions for adults and are a long way from reaching the 90:90:90 targets (90% diagnosed, 90% on treatment, 90% virally suppressed i.e. adherent).

In 2013, 38% of adults living with HIV worldwide received antiretroviral therapy, but only 24% of children. Without treatment, 50% of vertically infected children are likely to die before their second birthday and, in 2012/2013, an estimated 240,000 children acquired HIV and 210,000 children died from preventable AIDS-related causes.[10] The majority of these children (85%) live in high impact/high priority countries, including the five countries in sub-Saharan Africa in which the Foundation works. UNAIDS identifies the top four reasons for this neglect as being: 1) limited access to health services, especially sexual and reproductive and HIV services, 2) limited access to HIV treatment, 3) failure to prioritize children, and 4) poorly integrated health care.

* Further herein referred to as 'parent/s' but may be a biological parent, caregiver, grandparent, other relative or any other primary caretaker of a child.

"The Foundation is funding projects to integrate efforts to improve early childhood development with prevention of mother-to-child HIV transmission (PMTCT) programs through the work of partners in Malawi and Zambia."

The Foundation is funding projects to integrate efforts to improve early childhood development with prevention of mother-to-child HIV transmission (PMTCT) programs through the work of partners in Malawi and Zambia. The other strength of the work funded by the Foundation is support for families affected by HIV. However, implementers need to increase efforts to encourage and assist in the early testing of children and linking them to treatment, and supporting parental adherence to HIV treatment, which benefits children by keeping their parents* alive and well.

Thresholds to cross

The biggest challenges to improving assistance to young children affected by HIV and AIDS are:

1. **Generating scientific evidence for the effectiveness of feasible interventions to improve the developmental outcomes of young children in countries with high HIV prevalence**. This requires randomized impact evaluations that lead to unambiguous conclusions that the intervention resulted in observed changes in parents and/or children. Trials are costly, and many philanthropic organizations shy away from supporting impact evaluations on the grounds that their funds

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On the crest of the wave

are better spent helping children and families. The two counters to that position are, firstly, until the evidence is generated no one knows whether or not a particular intervention is helping children and families and so valuable resources may be misspent on interventions that have no positive benefits and may potentially do harm through unexamined unintended consequences. Secondly, good evidence releases critical sources of funding – from governments, PEPFAR, the Global Fund and other mega-donors – that support ongoing programs that benefit millions of children beyond the reach of most philanthropic foundations or short-term grants.

2 **The need for implementation research, as well as quality assurance (QA) and quality control (QC) procedures to improve the fidelity of interventions** to parameters known to improve benefits for young children and families. Our in-field observations and experience indicate that this is a major weakness of current programs, not limited to those supported by the Foundation.

> "until the evidence is generated no one knows whether or not a particular intervention is helping children and families"

3 **Reaching the youngest children**. Health services are focused on improving infant survival and education is focused on school readiness through pre-primary schools. Between these two major sectoral efforts is the period of life – birth to three years – most susceptible to harm and help. Programs to improve nutrition,[11] and thus brain growth, have most benefit during this time, as do psychosocial interventions, with reduced positive effects of interventions delivered after three years of age.

4 **Adopting a family-centered approach.** Many societies, including in high HIV prevalence countries, are patriarchal. This means that men decide when women go to health services, whether or not a mother participates in a program, what visitors are allowed to come into the

home, the credibility given to a program's home visitors and the like. ECD programs must include men to engage in and promote the value of ECD, to change attitudes to physical punishment of young children, and to support their wives in the care and protection of young children.

5 **Targeting services to the most needy.** Foundation-funded programs that try to reach all children in HIV-affected areas may face declining efficiencies and dilution of services by resource constraints. Testing of pregnant women in PMTCT programs is the most timeous entry point for ECD services. It also enables complementary benefits from two or more services for children and families. Also to be targeted are children made vulnerable by birth outcomes associated with maternal HIV-exposure even when the child is not infected.

On the crest of the wave

6 **Recognition of the vulnerabilities of HIV-exposed children**. As a result of increased access to antiretroviral (ART) drugs, substantially fewer children are being vertically infected with HIV (from 26% in 2009 to 16% in 2003). However, in 2013, 1.3 million women living with HIV gave birth (unchanged since 2009), meaning that 1.3 million children were exposed to HIV in utero, during birth or through breastfeeding. A recent systematic review found that uninfected but HIV-exposed children are more likely to be stillborn, premature, of lower birth weight and smaller-for-gestational age than unexposed children, especially in sub-Saharan Africa. The effects of ART on birth outcomes, in addition to or independently of HIV, are not yet known. ECD programs need to specifically target these exposed uninfected children because it has long been known that adverse birth outcomes, in combination with disadvantaged life circumstance, are associated with poorer child development outcomes.

7 **Reduction of stigma as a barrier to testing, treatment and support.** Several partners indicated that they could not target families directly affected by HIV through parental or caregiver infection because of stigma associated with HIV. Given that stigma is a significant barrier to the most vulnerable children and families receiving services, ECD programs should try and find innovative ways to contribute to stigma reduction at a community level.

8 **Ensuring young children in high prevalence areas, such as the countries in which the Foundation works, are tested for HIV** six weeks after birth, and on regular occasions while they are breastfed, and that they receive treatment immediately on diagnosis. In 2013, only 42% of infants born to mothers living with HIV in low- and middle-income countries were tested for HIV within two months of birth.[10] Of course, testing and treatment of children assumes that their parents have access to HIV testing and treatment and, where this is not yet the case, ECD programs should join efforts to expand parental access as parent health and wellbeing provides primary protection for children.

9 **Receipt of integrated services**, for example, PMTCT and ECD programs, adult and child testing and treatment, treatment and support. ECD programs for HIV-

> ... in 2013, 1.3 million women living with HIV gave birth (unchanged since 2009), meaning that 1.3 million children were exposed to HIV in utero, during birth or through breastfeeding ...

affected families cannot achieve maximum benefits or efficiencies when they stand alone.

10 **Adoption of a life course approach to supporting children affected by HIV**. A life course approach means considering health and wellbeing outcomes in the context of continuous development across the lifespan. For example, a statistical model based on Ugandan data showed that prevention of unwanted pregnancies, largely resulting from lack of access to sexual and reproductive services, averted 21% of paediatric infections, while the PMTCT program averted 8%.[12] It is thus likely to be more efficient to help prevent unwanted pregnancies than it is to try and prevent vertical infection. Considerations such as these raise questions about the scope of ECD programs funded by the Foundation.

2 Influential partnerships for young children

Partnerships have been established with more than 16 of the top implementers and policy drivers in the global response to young children and children affected by HIV and AIDS.

2 Influential partnerships for young children

Under its CABA Initiative, the Foundation has brought together the most influential implementing and policy organizations supporting community-based efforts to provide assistance to young children and families affected by HIV in southern and eastern Africa. Most of the partners have one to two decades of experience working at large-scale on projects funded by PEPFAR, USAID, the Global Fund and other multi- and bi-lateral donors. A number of partners work in more than one country and their activities span several regions or districts. Many are accredited as non-governmental organizations and have established administrative offices in the countries in which they work. Most have consolidated relationships with local, regional and national government.

Through regular interaction between the partners and the Foundation, between the partners and the MEL team including through site visits, and annual convenings of partners, a strong alliance of advocates, expertise and experience for early childhood development in the context of HIV and AIDS is being forged. This group, which is beginning to have critical mass, is functioning as a crucible for innovative work in this area.

In addition to the horizontal connections between partners, networks have been formed in countries. In Mozambique, several organizations funded by the Foundation have joined with governmental and non-governmental actors to advocate for the establishment of a platform to try and achieve a coordinated and holistic approach to child development. In a different sector, partners are helping to build inter-faith connections that include the Catholic and Anglican Churches and Jehovah's Witnesses to provide ECD services for young children in communities in Zambia, as well as training for ECD teachers.

Connections further extend downwards and outwards into communities through sub-grants to community-based organizations. For example, Foundation partners made 143 sub-grants to community-based organizations with a value of more than US$4 million. Connections also extend upwards and outwards beyond the five Foundation-selected countries in the region and internationally, for example, USAID, the World Health Organization in Geneva, UNICEF in New York in addition to regional and country offices, the Institute for Human Development at the Aga Khan University in Nairobi,

Figure 1: Distribution of partners in each target country

and the Coalition for Children Affected by AIDS, now chaired by Lisa Bohmer, the CABA Senior Program Officer at the Foundation.

Thresholds to cross

The implementation model used by the Foundation is one established more than two decades ago when international agencies first began to respond to what was seen as the *AIDS orphan crisis* in Africa. It was consolidated with PEPFAR funding for AIDS support more generally. In this model, US government and philanthropic funds are made available to large implementing organizations in the US

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Influential partnerships for young children

in response to calls for proposals. These US organizations either transfer funds to their in-country offices or to local country organizations independently or through their in-country offices in response to calls for proposals or under sub-contracts. Further transfers of funding may occur through grants to local non-governmental or community-based organizations.

There are two main reasons for the use of this model. First is financial and relates particularly to the US as the single largest donor for programs for children and families in southern and eastern Africa. Stringent fiscal conditions for large transfers of funds from the USA can be better monitored and action taken for breach under US law with respect to US grant recipients. In addition, funds transferred to charities and non-profit organizations are exempt from tax, and it is easier for US organizations to obtain accreditation as a charity than it is for African-based organizations. Experience to date also indicates that audit and reporting conditions attached to very large transfers (such as made by PEPFAR and the Global Fund) can over-burden local organizations and reduce their capacity to deliver programs and services. The second main reason why grants are made to large US-based organizations rather than local organizations is that many of the US organizations have built up levels of expertise in training, capacity development, service delivery and advocacy that may not yet exist in local organizations.

This implementation model is beginning to be questioned in the field of development aid and philanthropy in general, as well as for work to benefit children affected by HIV and AIDS, for the reasons listed below.

a Many governments, bi-lateral funders and foundations are increasingly focused on the sustainability of their efforts. Local organizations have growing capacity to manage funds, implement programs, and advocate for their causes with local government. Exploration of models for local fund and program management are overdue.

b The model is expensive in that a substantial portion of any grant is taken up by direct overhead charges in both the US organization and its local office and by indirect costs of running international and local offices. Exploration of more efficient alternatives is needed.

c While there are many advantages to having large partners in the CABA Initiative, particularly leverage, the Foundation's grant (and other funds received for ECD) may be a very small part of the total funding received by a large organization and of its program portfolio. The push given to ECD within such large organizations may therefore not be strong. Alternative mechanisms for integrating ECD into the existing large-scale health, education, livelihood and community development activities of partners could be tested.

d The short-term nature of project grants, usually three years, can be disruptive. The adverse effects are most clearly seen in community-based child care centers. Basic structures exist in many communities. These are revived when a project gets funded, volunteer staff and children are encouraged to join, only to be abandoned 2-3 years later when the project ends. Frequently, the structure lies moribund until the next organization with a grant comes along. Many poor communities do not have even the basic funds to keep a community-based child care center going, including chlorine to clean water, wood to cook food for children, and stipends or in-kind payments for volunteer teachers and caregivers.

"Alternative mechanisms for integrating ECD into the existing large-scale health, education, livelihood and community development activities of partners could be tested."

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Influential partnerships for young children

e Ultimately, **programs are delivered at the level of the household and the community, requiring a workforce of trained community-based people**. Various models have evolved, generally characterized in the following way. Unpaid community workers are selected or nominated by a local community authority or government service such as health or welfare. These community workers are thus 'authorized' to move around communities and to approach households. They implement a number of programs on behalf of multiple implementing agencies; for example, distributing bed nets to prevent malaria, encouraging immunization, promoting antenatal care, and providing support for young children and their families affected by HIV. Most agencies pay the community worker an honorarium to implement their program activities and, in a sense, compete with other agencies for the time and effort of the community worker. Because of undeveloped field supervision systems, few agencies have a handle on what services community workers render other than

"Ultimately, programs are delivered at the level of the household and the community, requiring a workforce of trained community-based people."

what is reported to them by the community worker. To address the challenges, some implementing agencies allocate significant portions of their budget to staff employed in the local office to monitor community workers. Our experience is that this monitoring is nonetheless infrequent with no clear evidence of skills transfer, mentorship or supervision. Alternative delivery systems need to be tested, including having programs transfer funds to a local authority to enable them to pay community workers a salary and, in turn, control their workload, develop their skills, and monitor and mentor their activities in the delivery of services to meet the multiple needs of very disadvantaged communities.

"Alternative delivery systems need to be tested, including having programs transfer funds to a local authority to enable them to pay community workers a salary..."

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Large numbers of children and families supported

Large numbers of children and families have been supported through the work of community-based organizations and government services supported by partner activities.

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Large numbers of children and families supported

An integral aspect of the MEL platform is the development and maintenance of a flexible multi-level database of activities of partners derived from their proposals, regular reporting, interactions with partners, and special purpose data collection through questionnaires. The MEL database tracks information on aspects of the Foundation's strategic parameters. These include numbers of children, caregivers, parents and families reached through home visits, community groups, parent groups, community child care centers, play groups and clinics. It also includes the numbers of people trained, both professionals and community workers, number of community-based organizations supported, and expenditure.

The targets projected at the start of the five-year Initiative are indicated in Figure 2 below, the Initiative timelines in Figure 3, and progress as at the end of 2015 is shown in Figure 4.

Figure 2 : Five year projected targets for the Initiative

5-Year Strategic Goals

- 500,000 children benefit from early childhood services resulting in better birth-to-five developmental outcomes
- 300,000 caregivers receive knowledge and resources to help them enhance their children's development
- 100,000 community workers are trained to help parents and caregivers develop and practice support skills
- 1,000 community-based organizations receive resources to improve technical and organizational capacity to deliver early childhood development services
- 150,000 families affected by HIV/AIDS have measurably increased access to government, civil society, or private sector services (precise measure to be determined through evaluation planning)
- Knowledge transfer has taken place to inform practice and policy in and beyond target countries—i.e., findings are published and presented and other geographies have adapted/adopted best practices

Figure 3: Timeline over which progress is tracked in the MEL Initiative

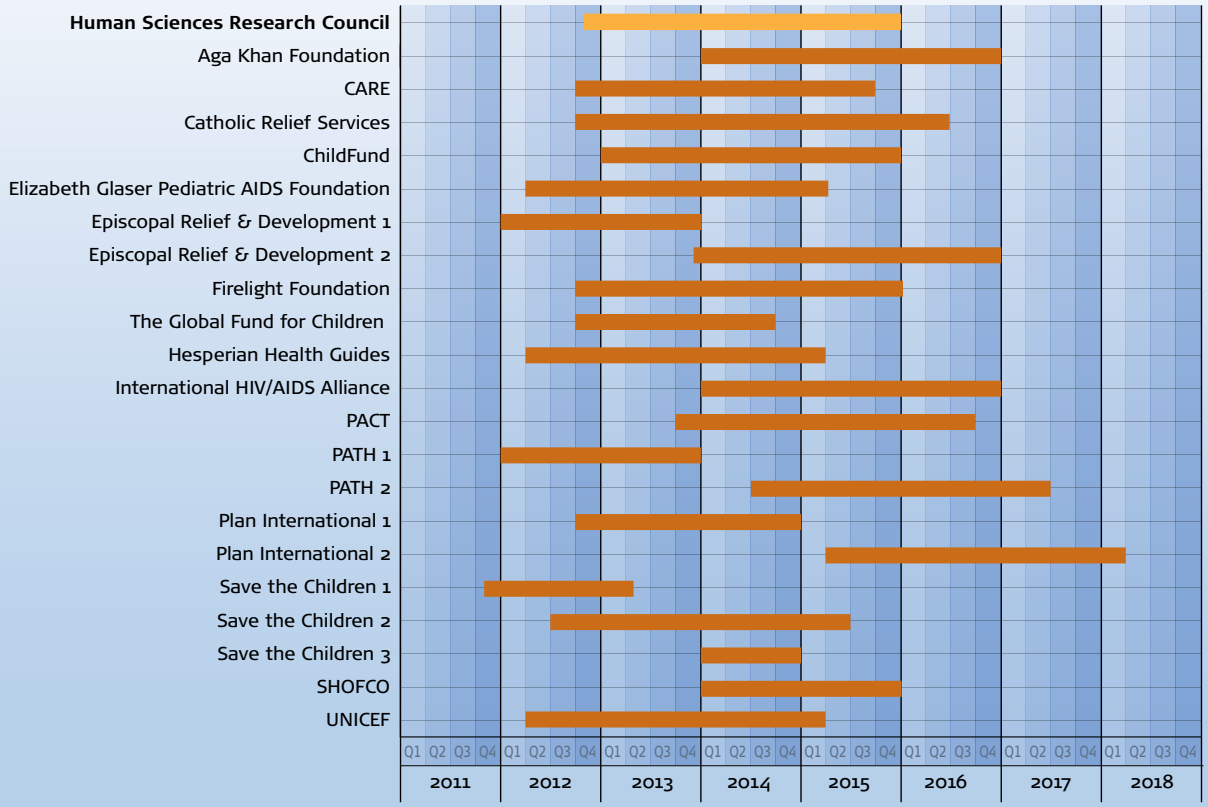


Figure 4: Number of children and parents/caregivers targeted and reached: Malawi, Mozambique, Kenya, Tanzania, Zambia

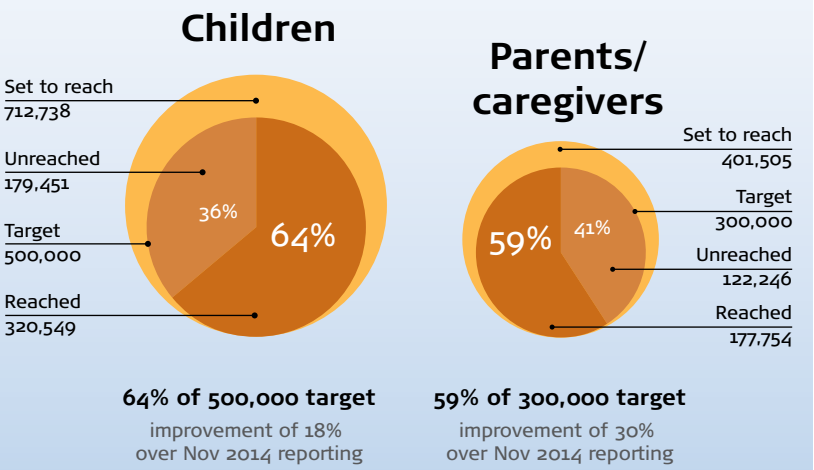


Figure 3 (above): Timeline over which progress is tracked in the MEL Initiative

Figure 4 (left): Number of children and parents/caregivers targeted and reached

3

Large numbers of children and families supported

To date, 320,549 children have been provided with one or more services (Figure 5), **as have 177,754 parents or caregivers.** A third of children (119,180) were reached through community-based child care centers. Nearly three hundred thousand (277,054) home visits were made to approximately 54,000 households and more than 37,000 people received some form of training (see Figure 6). **These are impressive figures and a huge achievement in the first four years of the Initiative.**

> To date, 320,549 children have been provided with one or more services, as have 177,754 parents or caregivers.

Thresholds to cross

1 ***Reach* is a term commonly used in this field, quoted in annual reports of large donors implying the numbers of children or families who have benefitted from services**. However, with qualification, the word *reach* can encompass also minimal services likely to have only transient if any positive impact (such as including a child in an afternoon activity or giving a child a pencil case). In fact, it has been observed that many so-called orphans and vulnerable (OVC) services that are reported to have large reach, are so thinly spread that they are unlikely to have positive effects.[13] As a result, efforts have been made, especially by PEPFAR and USAID to define a minimum package of services to qualify as having served or reached a child. The 2006 PEPFAR OVC Guidelines identified seven domains of child wellbeing: education, health, shelter and care, food and nutrition, psychosocial support, protection from abuse and neglect and economic strengthening. In order to improve program quality, PEPFAR advised partners in some countries that at least three services should be provided to a child before they could be counted as having been reached.[14] While this is a valiant effort to improve the dose and quality of programs, minimal services may still be provided within each of the three domains.

As the Foundation and its partners strive to reach a target number of children, families and community groups, the quality and potential benefit of services

Figure 5: Range of services a family under the Initiative may benefit from

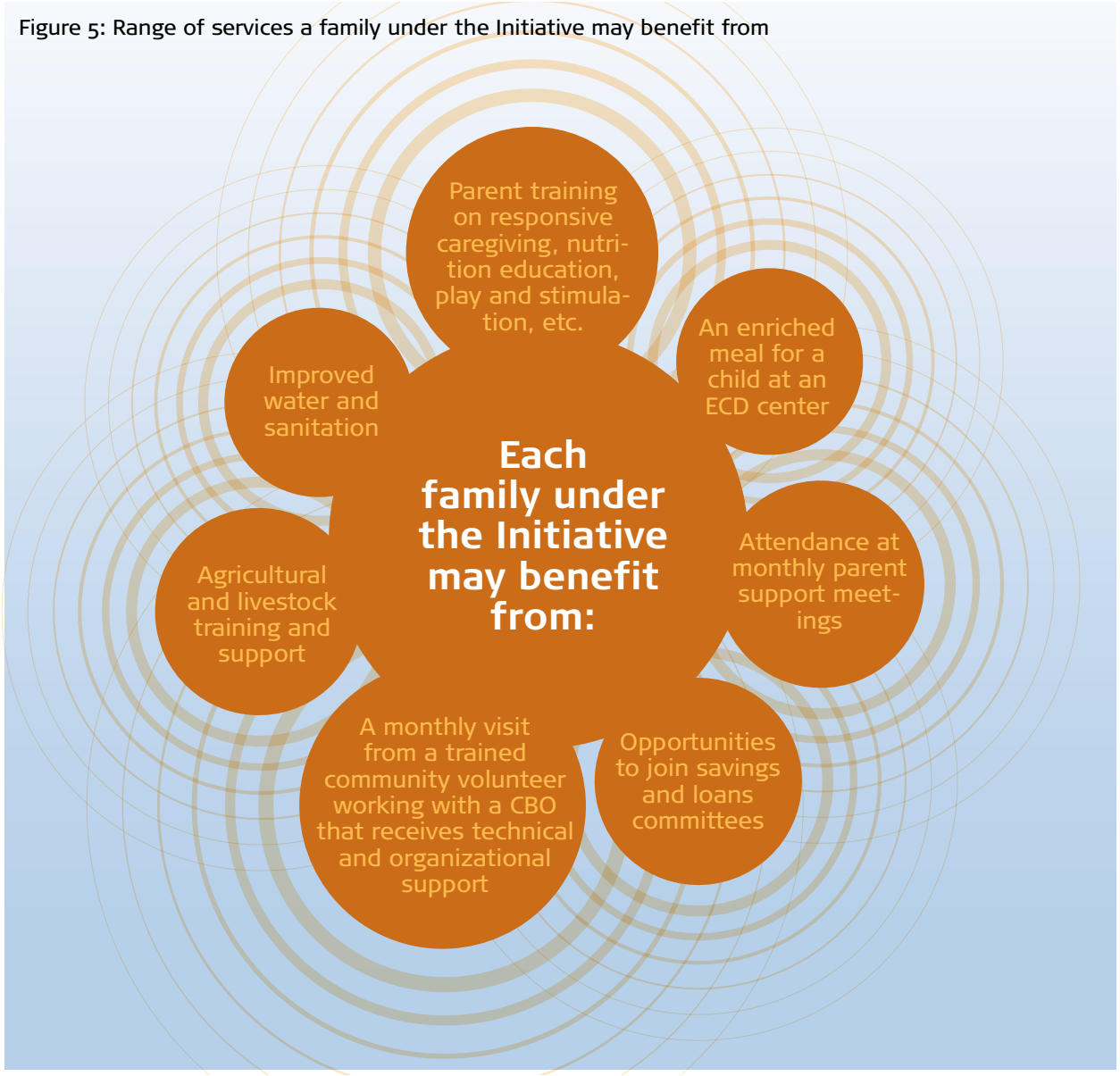


Figure 6: Number of individuals trained in the Initiative

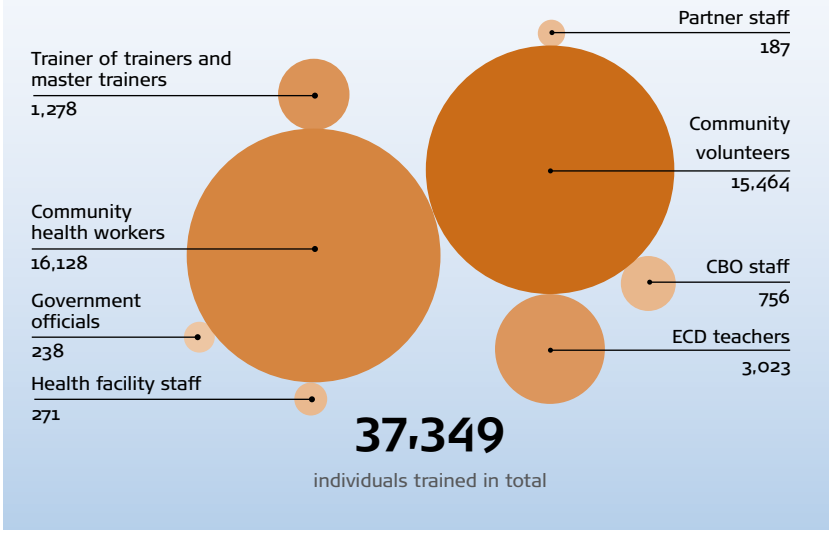


Figure 5 (above): Multiple services available to families under the Initiative

Figure 6 (left): Individuals trained in the Initiative

3

Large numbers of children and families supported

must also be improved to realise the value of investments made. Ideally, a minimum package of services, dosage and duration should be defined, based on existing evidence, together with guidelines and requirements for assuring quality implementation in the field.

2 **Training is**, as has been demonstrated in a published paper by the MEL team,[15] **the core activity in programs to support young children affected by HIV and AIDS**. Training usually occurs through a cascade starting with the training of professionals who train program staff; program staff train community workers and community workers train carers in preschool centers and parents at home. **However, very little operations research has been done to examine how to improve the acquisition of knowledge and skills through training**, what on-task supervision is needed to ensure good practice, and how to maintain and replenish knowledge and practice in the field.

"However, very little operations research has been done to examine how to improve the acquisition of knowledge and skills through training..."

4 Establishing a learning network

A unique learning network has been created through which knowledge and programmatic effectiveness is being shaped and disseminated.

ELIZABETH GLASER PEDIATRIC AIDS FOUNDATION
LET'S HELP OUR

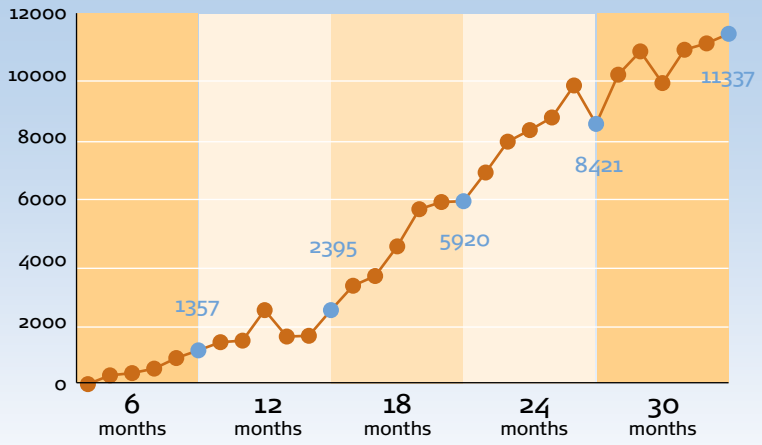
4 Establishing a learning network

As indicated earlier, **all the partners in the Initiative have several years of experience implementing HIV and AIDS and/or child programs in southern and eastern Africa**. Amidst them are people with high levels of expertise in child development, HIV and AIDS and program implementation and evaluation.

Creating learning forums, such as the MEL newsletter and website, webinars, joint in-country meetings, and annual convenings provided opportunities for sharing knowledge and experience. The MEL team visited all partners annually, including site visits, and had regular phone conversations with partners. Partners shared their successes and learnt that they are not alone in their challenges and sometimes, failures. Program material, adaptations and translations of programs, measurement tools, training modules and media material have been shared and passed on, creating a chain of learning and influence.

Foundation partners made presentations on program learning at the International AIDS Society pre-conference symposium of the Coalition on Children Affected by AIDS, entitled *Children and HIV: Start Early, Start Now! Integrated Interventions for Young Children Born into HIV-affected Families* in Melbourne, July 2014. Presentations were made on adaptation of and experience with the WHO-UNICEF Care for Child Development program, the Essential Package, and on learning in trying to integrate ECD into PMTCT programs. In addition, the Coalition launched a special issue of the prestigious journal *AIDS* on *Children Born into Families Affected by AIDS* with a foreword by Steve Hilton, President

Figure 7: Page view growth of melycaba.com



of the Foundation. Ed Cain, Vice-President of Programs at the Foundation, participated in the launch discussion at the symposium. The participation of senior Foundation staff attributed influence to these activities.

Many Foundation partners also participated in the Inaugural Conference of the Institute for Human Development at the Aga Khan University in Nairobi in February 2015. Presentations were given by Lisa Bohmer from the Foundation, who provided an overview of the CABA Initiative; on the mobile app developed by the HSRC and piloted in collaboration with a partner in Kenya, on the integration of Care for Child Development into the health services in Mozambique; on ECD activities for mothers living with HIV; on clinic-community linkages, and on assessment of depression and social support for mothers. Members of the MEL team also presented on topics related to the CABA Initiative: Linda Richter on parenting and the new science of child development, Chris Desmond on modelling the impact of HIV on children, and Alastair van Heerden who gave an overview of the MEL activities.

> Program material, adaptations and translations of programs, measurement tools, training modules and media material have been shared and passed on, creating a chain of learning and influence.

In three years the MEL team distributed 18 electronic newsletters (six per annum) to a growing list of people, reaching 603 by the end of 2015. The newsletter provided a space in which to introduce people from different partner organizations to each other and to profile the work of the partners, as well as connect partners to upcoming events, policy developments and new scientific evidence. The newsletters are archived on the MEL website (www.melycaba.com) and provide a historical record of activities in the first three years of the Initiative and the people who participated in it.

The website is an extensive and deep resource, with links to program materials, tools, scientific and policy documents. Page views doubled from the second to the third year. Analyses of the hits indicated that the majority was initiated as links from the Newsletter or searches for measurement tools and program packages (see Figure 7).

4 Establishing a learning network

We hosted two webinars to facilitate knowledge exchange, but they did not prove to be a very useful form of discussion, learning and dissemination. Internet connections are still tenuous and slow, and individuals signed on to webinars tend to go on with routine work on their computers resulting in low levels of engagement. One way around this would be to organize group participation in webinars at different sites. This would enable discussion among participants at the sites as well as making inputs and asking questions through the webinar technology.

> "The website is an extensive and deep resource, with links to program materials, tools, scientific and policy documents...."

In addition to learning exchanges, the MEL team facilitated two new learning initiatives. The first was training in the Science of Early Childhood Development (SECD). The second is the WHO/UNICEF *Care for Child Development* (CCD) package.

Thresholds to cross

1. As has been observed in the field of development aid more generally,[16] **there was significant staff turnover in most partner organizations**, at least at the professional and high-skill levels which we were able to monitor. We did not have the names of staff, community workers and volunteers in sub-contracting organizations so were not able to track turnover throughout any partner's organizational networks. A wry comment on high turnover rates was that funders should support people (as they move) rather than organizations!

   Staff turnover is due to a number of factors. Amongst these are high levels of competition for skilled staff among NGOs and with government, as well as the relatively short time-bound nature of projects which results in staff members seeking new employment as the end of a project looms. Staff turnover tended to have a deleterious effect on ECD expertise and M&E. Learning across the Initiative was progressive and less effective when people with skills in ECD and M&E left or joined a partner organization mid-way.

2 Compounding the challenges to the work of partners arising from staff turnover was the fact that some organizations started with **significant gaps in ECD and M&E knowledge and expertise.** Sometimes gaps resulted from ECD being a new application for an otherwise field-experienced organization, in others the gap emanated from inadequate training in either ECD and/or M&E. Some partners had received all the information they had on ECD from introductory training, and some M&E officers could enter responses form questionnaires into Excel spreadsheets, but had little knowledge of how to manipulate data or extract trends, let alone training in evaluation and monitoring methodologies to exclude bias and increase validity.

" A promising strategy is to form in-country networks of local experts, supported by a strong team like the MEL, to provide on-going technical support to partners working in country.... "

The solution most commonly sought to address these gaps in knowledge and expertise was to bring in consultants from outside of the country, usually from the USA. This misses a significant opportunity to use, foster and develop the considerable expertise in the region. Many university and NGO research organizations employ staff with high levels of expertise in one or more fields relating to HIV and AIDS, ECD, and M&E. A promising strategy is to form in-country networks of local experts, supported by a strong team like the MEL, to provide on-going technical support to partners working in country. This would also help to compensate for staff turnover in organizations.

5 Supporting families in a child's earliest years

Awareness of the importance of supporting families during the earliest years of a child's life has been raised through formal and informal training and learning.

5 Supporting families in a child's earliest years

The CABA Initiative targets children to five years of age, or the years prior to formal schooling. When the Initiative began, a disproportionate share of partner activities were proposed for 3-5-year-olds, that is, for preschool children rather than for infants and toddlers younger than three years of age. By the close of the MEL, 37% of partner activities targeted 0-3-year-olds. The bias towards the preschool age group is evident in wider early childhood development, policy, research, programming and advocacy arising from the conviction that school readiness and educational success depends on preschool programs.

However, scientific evidence accumulated in the past two decades indicates that the greatest opportunities for achieving long-term benefits for children into adulthood are in what is called the first 1,000 days (270 days of pregnancy plus 365 days in each of the first 2 years of life). The scientific evidence comes from two sources. Firstly, evidence of a window of opportunity of increased susceptibility to environmental influences or plasticity.[17] During this time the genetic capabilities of the developing foetus and young child adapt to the immediate environment in which development takes place (pregnancy and the maternal and family milieu) through epigenesis to maximize the child's chances of survival. For example, in an environment of danger and/or uncertainty, high levels of stress hormones are aroused in the mother and child, and the child may remain primed with high vigilance, anticipating future adversity. As a corollary though, increased efforts to support, promote and protect the developing child in such conditions, reduces the child's experienced stress.[18] This means that interventions delivered during this time can ameliorate the harmful effects and foster resilience.

The second source of evidence for the importance of the first 2-3 years of life comes from long-term studies recently published. For example, receipt of a protein supplement in Guatemala before, but not after, three years was associated with an increase of 1.2 grades in education among women[19] and a 46% increase in average adult wages among men.[20]

The approaches being used by partners to reach the youngest children generally include a combination of two or three strategies, such as: training community health workers and volunteers to use the *WHO/UNICEF Care for Child Development* guidelines to intervene with mothers through health services; training community workers in the *Save the*

Children/Care Essential Package to support mothers and other caregivers in the home; running parent education and support groups, including for parents of very young children; advocacy for early childhood development services for very young children and their families, including mobilizing local actors such as women's groups to influence service provision; practical food preparation demonstrations to improve feeding practices of young children in the home; establishing or supporting community-based playgroups and ECD centers for young children; economic strengthening activities such as the coordination of Savings and Internal Loans Committees, vegetable gardens and smallholder farms, and strengthening existing links or establishing referral systems to basic health, nutrition and child protection services.

> "To achieve maximum benefits, programs need to start early. The best start in life for children begins even before pregnancy. Mothers' age at first birth has been shown to predict long-term educational outcomes ..."

Thresholds to cross

To achieve maximum benefits, programs need to start early. **The best start in life for children begins even before pregnancy.** Mothers' age at first birth has been shown to predict long-term educational outcomes,[21] and birth spacing is also important, as is maternal health, including mental health, and social support in stable relationships and families. A healthy and safe pregnancy, and close protective human relationships activate biological, social and psychological learning mechanisms in the foetus and young child which enable children to adapt well to their environment and thrive. However, many ECD programs begin much later, when children are three years of age or older and the child's capacity for adaptation has lessened. It is harder for a child at this age to fill gaps in experience and overcome already acquired patterns such as fear and inhibition which hamper exploration, learning and social engagement.

We also have to do more to prevent and treat undernutrition in the first 1,000 days. **Nutrition is essential for early childhood development**, especially during pregnancy and the first 2-3 years of life. **The human brain is large at birth and grows very fast, consuming 74% of energy (food) intake at birth and more than 50% up to two years;** this proportion drops progressively thereafter.[22] If nutrients are insufficient during pregnancy and infancy, energy is directed away from internal organs, skeleton and muscles to feed the brain, resulting in growth deficiencies such as stunting. Stunting increases the risk for metabolic diseases later in life because the structure and function of physiological systems change

5

Supporting families in a child's earliest years

in response to nutritional deficiencies. When nutritional deprivation is severe, the brain's structure and function are also affected. We now know that later supplementary nutrition can't compensate for this early deprivation and that affected children are at high risk of completing fewer years of schooling, earning less as adults and being more prone to chronic disease.

Many funders and implementers shy away from feeding interventions because they fear creating "dependency" on food handouts. However, under-5 stunting in the five countries in which the Foundation is funding programs is severe – 36% in Kenya, 56% in Malawi, 51% in Mozambique, 48% in Tanzania and 47% in Zambia. At present partners address young child nutrition by referring parents to government and non-government nutrition services, by livelihood and food gardening programs and by educating

> "... adequate supplementation for 18 months in infancy, together with nutrition education, would go a long way to prevent stunting, and its associated impacts ..."

parents and caregivers on the specific nutritional needs of young children. Several partners informally raised concerns around lack of funding to provide vulnerable children with the necessary nutrition, the absence of which they felt hampered the success of their ECD programming.

Livelihood and food gardening programs can render benefits, but long-term, and infants under-nourished now are unlikely to benefit from them. In addition, because of hunger and food insecurity, very poor families tend to buy and grow bulk food, generally starch, to satisfy hunger, but which do not address the needs of the growing child. Nutritional education does produce positive results, particularly by improving diversity in children's diets. But where the problem is severe, better results are obtained if combined with complementary nutrition for young children.[23] Micronutrients are what infants (6-24 months) need and don't get. To ensure nutrients get to young children in the household, two home delivery

strategies are used: 1) micronutrient powders or sprinkles[24] and 2) small quantity lipid-based pastes to add to traditional complementary foods.[25] Both can also be used to prevent small birth size when used during pregnancy.[26]

Stunting is a multiply determined problem with known adverse effects on short- and long-term health and human capital. The deleterious effects of stunting on children may well outweigh benefits from early learning programs. Prevention of low birth weight and the promotion of exclusive breastfeeding are part of the solution, but adequate supplementation for 18 months in infancy, together with nutrition education, would go a long way to prevent stunting, and its associated impacts. **Innovative programs that combine ECD and nutritional interventions in the first 2-3 years of life which are rigorously evaluated and taken to scale have the potential to transform the lives (and futures) of nearly half of all children living in the five countries in which the Foundation is working.**

"Innovative programs that combine ECD and nutritional interventions in the first 2-3 years of life which are rigorously evaluated and taken to scale have the potential to transform the lives (and futures) of nearly half of all children ..."

6

Implementation is being improved

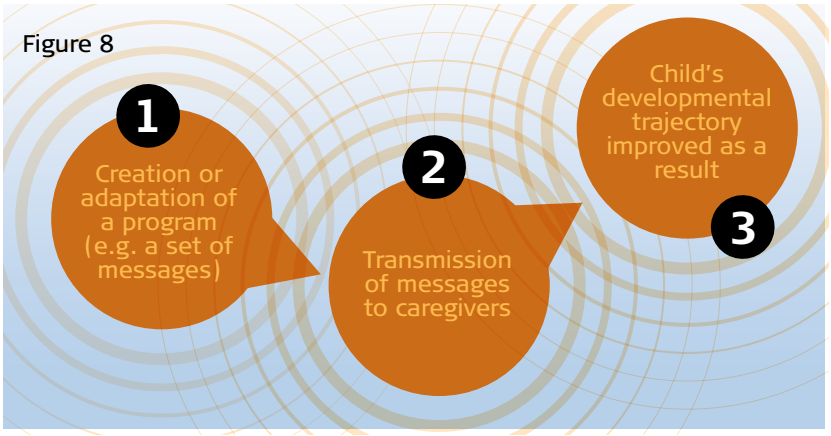
Implementation is being improved through customized logic models and increased emphasis on chains of influence that build quality services.

Feel Free!!

6 Implementation is being improved

At the beginning of the Initiative most partners set out their rationale for implementation as a series of stages, exemplified by the following: the creation of a 'program', usually a set of messages; a strategy to transmit these messages to caregivers, usually by training caregivers but more often by training a group of intermediaries who subsequently train caregivers, with the assumption these steps would lead to improvements in children's developmental trajectories (see Figure 8).

Figure 8



Without peering into the 'black box' of these processes, it is difficult to 1) see which processes are effective or not at achieving the ends desired, and how to create effective links to the next phase, and 2) understand what needs to be improved or added to achieve the effects anticipated from one phase to the next.

In order to examine this approach, the MEL team worked with partners to elaborate the details of each phase. For example:

1. Are these the best messages to address the identified problems? Are the messages accurate, culturally appropriate, phrased in language suited to the target population, simple enough for easy understanding, illustrated through micro-media e.g. pamphlets, posters etc.?

2. Is the training effective? Do trainees understand the messages; can they frame them in their own language and answer questions about them? Can the trainees transmit the messages to the people who need to hear, understand and implement them, either community workers or caregivers? Do the trainees have the social skills to be accepted and trusted as a source of information, the ability to put caregivers at

ease, and support and assist them rather than criticize and instruct?

3 Have the trainees had opportunities to practice and correct the transmission of information and to demonstrate their skills in the real-life environment under supervision of a mentor?

4 Are there quality assurance (QA) and quality control (QC) procedures in place to ensure fidelity of implementation in the field?

5 Are there processes to feed information on QA and QC back into the program for improvement on a regular basis, and are they used effectively?

6 Are parent/caregiver intermediate factors in place to achieve improved parent-child interactions; that is, do parents understand and accept the messages; do they put them into practice habitually and in the correct way?

7 Are changes in practice and outcomes measured in sufficient detail to guide program improvement and gauge positive changes?

8 Are factors other than the intervention, which could influence the ultimate outcome, also being measured and taken into account; for example, a de-worming program in the same households as a result of which all treated children become more active and exploratory, and therefore learn better?

> "Is the training effective? Do trainees understand the messages; can they frame them in their own language and answer questions about them? ..."

6 Implementation is being improved

Because training was the major link in the chain of influence towards desired outcomes, we conducted a survey on training which we discussed with partners and published in a peer-reviewed journal so that a wide audience of implementers could benefit from the insights gained.[15] As a result of presentations and discussions, **partners have carefully improved training models, paying more attention to the selection of trainees, the length of training and materials needed during training and implementation, assessment of training effectiveness and supervision, feedback and support for implementation in the field.**

Work on explicating logic models was emphasized in the annual convenings. Partners found these extremely helpful, including emphasis on measuring proximal actions leading to desired changes. Partners report that their implementation processes have improved as a result of putting more time and resources into building, putting into practice, and evaluating their program according to a well thought-through logic model.

Thresholds to cross

Widespread across community implementation models is the implicit assumption that good intentions lead to good outcomes, with still few scientifically publishable evaluations of benefits of programs or their unintended adverse consequences.[27] Evaluations are costly, but there is no other way of ensuring that investments are made in programs that work versus programs that are driven by good intentions.

In order to prepare programs for evaluation, they have to be made explicit, shown to be feasible, that fidelity can be achieved and that, in addition to in principle reasons for thinking they may work, pilot studies suggest that their effects are promising. There is no point in evaluating programs prematurely, and premature evaluations may in fact do harm. Programs that are not ready for evaluation are unlikely to be effective and results indicating no benefit of an intervention may lead to the conclusion that the intervention is not worth pursuing when, in fact, the program was incompletely or insufficiently implemented.

Our experience in the field with partners indicates that 1) the construction of logic models needs to be continuously improved and 2) **practice must be improved through appropriate quality control and quality assurance procedures**.

When programs are evaluated scientifically, QA and QC is made explicit. That is, the number of times and how the fidelity of implementation of the program is assessed within the study (e.g. supervisor visits and reports, re-training and re-certification of community workers, accuracy and sign-off of work reports, number of visits to each household, etc.) as well as external evaluation of QA and QC (e.g. field visits by staff in a companion program to assess fidelity according to agreed criteria).

> In order to prepare programs for evaluation, they have to be made explicit, shown to be feasible, that fidelity can be achieved and that, in addition to in principle reasons for thinking they may work, pilot studies suggest that their effects are promising ...

It is our experience that, with some admirable exceptions, field supervision is generally poor, not only in the programs funded by the Foundation. Some supervisors we observed, by and large, ensured that data for reporting was being collected or were collecting it themselves, rather than ensuring quality provision or upgrading the knowledge and skills of community workers. In one case it was apparent that supervisors had not visited the field site in months, community workers were not being paid as agreed and, as a result, work was not been done, or not done with the level of commitment and regularity required for program benefits.

Real advancements in practice and effectiveness in this field, including beyond the Foundation Initiative, could be achieved by putting in place practices and measures which raise the standard of field implementation of programs, bearing in mind that implementation is currently conducted by generally unpaid, poorly resourced and inadequately supported and supervised community workers.

One immediately applicable method for improving practice is to make simple visual guides containing the main messages of the programs available in training programs, and for community workers and for parents. One example is the attractive poster on ECD that UNICEF made available in South Africa, which had found its way into many of the programs we visited (Figure 9).

A recent systematic review of more than 20 interventions aimed at enhancing the early learning environment found,

6

Implementation is being improved

amongst other things, that the use of **'small media' (small posters, cards, calendars or brochures illustrating stimulation practices and given to parents to keep at home) is one of the most important components of interventions**. The authors of the review hypothesize that these materials serve both as a means of instruction, particularly for less educated mothers, and as a reminder at home.[28] Given the capacity of programs and the expertise shared in the group, distributing large quantities of *small media* amongst community workers, in homes and child care and health services, is eminently achievable.

" One immediately applicable method for improving practice is to make simple visual guides containing the main messages of the programs available in training programs, and for community workers and for parents ... "

Early Learning and Development
Ideas for Parents and Caregivers
Your child is going through a journey of development that started at conception. This guide provides you with ideas on how to support your child's development. Remember, your child is unique and will follow her or his own journey, perhaps a bit slower or faster than other children of the same age.
Birth to 3 months
4 – 6 months
6 – 12 months
1 – 2 years
3 – 4 years
education
Department: Education
REPUBLIC OF SOUTH AFRICA
Prepared by and obtainable free-of-charge from:
Directorate: Early Childhood Development, Department of Education,
Private Bag X895, Pretoria, 0001
unicef
unite for children

Figure 9

7

Assessment and accountability is being invigorated

Assessment and accountability is being invigorated through enhanced links between monitoring and program improvement.

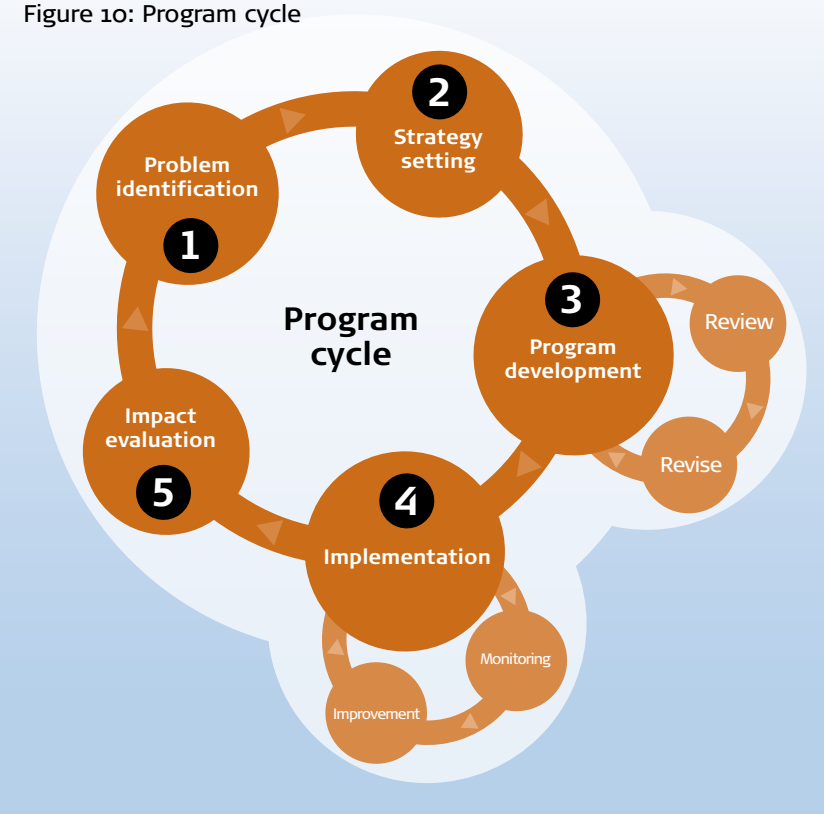
USAID

7 Assessment and accountability is being invigorated

For a number of reasons, in the field of young children affected by HIV and AIDS, measurement is generally under-developed. The first reason is that data collection efforts were originally put in place by large funders for purposes of reporting and accountability, with less attention given to the role of data in the program cycle (see Figure 10). Secondly, in these settings there are few valid and feasible tests for assessing child development, the outcome measure for programs implementing the Foundation's strategy.

Early on in the Initiative, the MEL team agreed we had the expertise to begin to address both issues.

Figure 10: Program cycle



Development of a tool to serve both the program cycle and the demands of reporting

Monitoring and evaluation data collected in donor-funded projects is often not as useful as it could be for improving programs and practice because it is usually designed and packaged for accountability and reporting directed at head office and the donor. Instruments to collect data on outputs (such as the number of families visited), services (the number of families provided with parent training), outcomes (the number of children who are school ready at age 5), and

impacts (the number of children proceeding successfully through the first five years of school) are typically designed at international or national levels of governmental and nongovernmental organizations that are distant from the point of data collection. The people using these tools to collect information from beneficiaries work for a local, usually non-governmental or community-based organization, or are volunteers in community programs in resource-poor communities. The strategies and tools may be adjusted for local conditions, but data is usually collected in the field by people and from people who have almost no information on the rationale for collecting the data or the use to which is being put in a distant head office. We were not told of any instance in which an interim or grant report was shared with community level workers and volunteers.

Further, the data collected seldom has direct bearing or relevance to the goals of service delivery and operational management at the local level. Once data reaches a governmental or nongovernmental organization's head office, it is summarized, analyzed for useful patterns and trends are submitted to the funder and/or the government health management information system in the form of periodic and final reports. Unfortunately, useful insights gleaned from the data seldom find their way back in a timely or systematic manner to those who would benefit most from the feedback – namely, community workers and local implementing partners in communities, or caregivers in homes, crèches and community child centers.

If and when data does 'come back' to the field, it is usually too late to be especially useful. Even when data is immediately available in the field, for example, when measuring a child's height or weight, without training in the use of a growth chart, the community-based worker or volunteer does not have the knowledge or skill to interpret the measurement in relation to the child's age or gender, nor do they necessarily have training in what feeding, nutrition and health care recommendations to make. In general, even though community and home visitors play a critical role in addressing gaps in the coverage of health services by relaying health education messages, conducting basic health assessments, and making simple referrals, in reality, they may not have the tools, support, and feedback required to carry out these functions. As a result, community and home visitors are often considered as data collectors, rather than

> "Monitoring and evaluation data collected in donor-funded projects is often not as useful as it could be for improving programs and practice because it is usually designed and packaged for accountability..."

7 Assessment and accountability is being invigorated

frontline service providers. In addition, **there are generally no systems that enable community and home visitors to convert the data they collect into actionable information that can be shared immediately with caregivers to improve the health, nutrition, and development of their children**. As a result, typical M&E data is not used to improve program effectiveness at the point of service delivery by assisting community and home visitors and, simultaneously, to render aggregated M&E data up through the reporting chain.

With a view to transforming this scenario, we prototyped and developed an easy-to-use mobile phone *Information for Action* (IFA) app that can simultaneously provide information and tailored messages to parents and other caregivers, health and social community workers and volunteers, case managers, program managers and funders. We use emerging data collection approaches, referred to as 'first mile', combined with app technology to support feedback and learning at all levels of the service delivery chain. In this way, **data is converted to provide useful, real-time decision support particularly to caregivers and health workers as well as field supervisors, project managers, organizational directors and funders to jointly improve parenting and early childhood development.**

> "Results indicated all stakeholders (beneficiaries, service providers, and supervisors) appreciated: (1) the ability of the app to facilitate dialogue during home visits and (2) to convert routinely collected data into actionable information ..."

For illustrative purposes, we selected two critical domains for monitoring young children's development: growth (height and weight), an excellent proxy for both child wellbeing and development,[29] as well as a measure of psychosocial development. Growth is interpreted using the World Health Organization (WHO) norms disaggregated by age and gender. Although specialized equipment is needed for gold standard growth monitoring, an inexpensive bathroom scale that can be calibrated and a stadiometer (or measuring tape) is used in this context of home- and community-based service

delivery. The *IFA* app is loaded with the WHO normative z-scores and is able to calculate percentile scores for weight-for-height, weight-for-age, height-for-age and Body Mass Index. Psychosocial development is assessed with the *Ages and Stages Questionnaire Third Edition* (ASQ-3), a widely used early childhood development tool, which was tested for applicability in the context.[30] The ASQ-3 is an easy to use, reliable, and valid screening instrument to identify potential developmental delays among children aged two months to five years. It taps into five domains of children's development: communication, gross motor, fine motor, problem solving, and personal-social, with each domain consisting of six developmentally appropriate items at 21 time points. Caregivers respond to each item by selecting 'yes', 'sometimes', or 'not yet'.

Using the IFA app, a community worker inputs identifying information about a child which can be anonymized at any level of data output. However, with the required consent, biographical data can also include name, a photograph, date of birth, sex, location and other required social information. The assessment domain (height, weight, developmental screening in five domains) is then selected, in the case of the ASQ-3 also by age (e.g. items for 9-15 months are automatically displayed for a 12-month-old child). Based on the measures made, data from the ASQ-3 and growth measurements are compared to norms by the *app* and immediate feedback is provided to caregivers and parents about their child's growth and development using simple messages and diagrams (a range of smiley faces, stars, traffic lights and so on to show good versus problematic developmental indicators). Feedback in the form of simple counselling and targeted messages, relevant to the specific child, are generated. The messages were extracted from international feeding guidelines based on WHO and UNICEF recommendation[31] and the WHO-UNICEF Care for Child Development Package.[32] Any version of the assessment judged to be suitable as well as the intervention messages can be viewed and read directly off the screen, or printed on a portable printer and left with the caregiver. Historical information for the child is stored, and longitudinal assessments can be made available to community workers to track and demonstrate progress. Additional information, such as a map of the households under the care of the health worker and an indication, by colour, of the length of time since their last visit are also available.

7

Assessment and accountability is being invigorated

A pilot study using the IFA app was conducted among government health authorities and workers as well as community personnel in collaboration with PATH in Kenya with smart phones donated by Google.[33] Results indicated all stakeholders (beneficiaries, service providers, and supervisors) appreciated: (1) the ability of the *app* to facilitate dialogue during home visits and (2) to convert routinely collected data into actionable information and facilitate use of data for decision-making at the point of data collection.

A valid and feasibly implemented developmental assessment test

It is widely agreed that there are few valid and feasibly used developmental assessment tools for low- and middle-income countries, and those that are available are not always used correctly because practitioners are not aware of the structure of the tests or their psychometric properties.[34] We selected the ASQ-3 based on our own and others' assessment of its suitability. The ASQ is regarded as a good screening tool, appropriate for use in large samples of children, and covering multiple domains in sufficient detail for reliable assessment.[35] The ASQ-3 has been translated into several languages and used in a number of countries besides the United States and Canada; for instance, China, Ecuador, India, Korea, Norway, Peru, Spain, Taiwan and Turkey.

The ASQ-3 was adapted and translated before being administered to 853 children living in South Africa and Zambia. It was translated and back-translated from English into Zulu for the South African sample and into Nyanja for the Zambian sample. The translated versions were evaluated by experts in the field of child development assessments to examine language and cultural appropriateness. Trained research assistants, with higher education and a background in child development were trained to administer the questionnaires to the caregiver and assess the child when there was some ambiguity in the parent's response.

While it is well known that southern African children perform ahead of their peers in other countries in the first year of life, by the age of five children in Zambia and South Africa were performing significantly worse than their peers in the areas of fine motor and problem-solving. The results indicate the applicability of the ASQ-3 in southern Africa as a reference

and point to the importance of early interventions to protect the early good development of African children in order to promote positive life trajectories and to provide learning experiences that prepare young children for school. Two papers have been submitted for peer-reviewed publication and one is in preparation.[36-38]

> "It is widely agreed that there are few valid and feasibly used developmental assessment tools for low- and middle-income countries ..."

Thresholds to cross

We have demonstrated the feasibility and usefulness of the *Information for Action* app and one partner has extended its use in a large project in South Africa.[39] Features to track community workers as the basis for management systems to reduce time and match home visitors to recipient profiles have been added to the assessments.

For both the IFA app and the ASQ to be used by partners, considerable local work still needs to be done. We have demonstrated their feasibility. This is only the first of many steps to adapt the tools to local conditions and to integrate them into routine use.

Firstly, the content material has to be translated into the local language in the site where it will be used. This is not a simple process and requires both colloquial language experts and university graduate-level understanding of early child growth and development. Translation is checked by back-translation and subject to pilot testing to ensure meaning equivalence.

Secondly, local managers, supervisors and community workers have to be trained in the use of the ASQ. In South Africa, Kenya and Zambia this training took at least a week, followed by regular supervision and quality control. We used videotape feedback while training assessors to use the ASQ in order to ensure uniform levels of competence in administering the test and managing social interaction with a mother or caregiver and a young child.

Thirdly, materials have to be procured locally. The ASQ requires simple toys and it is best that these are recognizable to the staff and children. Phones with the required features have to be donated or purchased, and the software and local language versions loaded and tested.

Innovation is the start, but implementation of innovation is a long road that requires support.

8

Rigorous evaluation is being encouraged

The MEL team encourages rigorous attempts by partners to test program effectiveness to ensure evidence-based practice.

SEVERIANO CHIGWINSA
TRIFONIA PITER.
VICTORIA CHANGOMBE
STANLEY BENJAMIN
LINDA SADALACK F P/E
CATHLEN NYANGU F J.L.E
SEX
NO
Simply irresistible
Katch a snack today
ZOUMBA.
ZOSEMA SUMA.
MALINGALIRO

8 Rigorous evaluation is being encouraged

Grant-funded programs can expand and reach more children, but they cannot go to scale with sufficient coverage and effectiveness to enhance healthy growth and development of young children at national levels. To do this requires system infrastructure and fiscal commitment, usually enabled by legislation. In this sense, governments, with the help of development partners have the unique capacity to take programs to scale. Whether or not governments take programs to scale depends on two major factors: 1) The program is compatible with the political goals of the country. Compatibility can be achieved either by framing (e.g. early childhood development addresses poverty and inequality by preventing early disadvantages from taking hold and increasing) or by generating political priority and lobbying.[40] 2) There is strong evidence of the program's effectiveness at achieving political goals (e.g. reducing poverty and inequality) and its affordability. For this reason, building evidence of program effectiveness is critical to ensuring that all children benefit from the interventions the Foundation supports.

There is unfortunately still very little evidence of program effectiveness in the field of children affected by HIV and AIDS. Funders have tended to take the view that resources are better used to help children and families, rather than to test whether programs are effective. The problem is that, without empirical tests of effectiveness, it is not known whether any program produces benefits.

For these reasons, **the MEL team encouraged rigorous attempts by partners to test program effectiveness and worked with one partner to mount an evaluation of community-based child care centers**. Two other partners attempted rigorous evaluations. One aimed to test a particular model and another aimed to test the effect of using a particular intervention package. Unfortunately, neither evaluation was completed as planned, and the design features necessary to subject the intervention to rigorous evaluation were not achieved.

The MEL team worked with a partner in Malawi whose program aimed to support a large number of child care centers. Given the scale of the intervention it was possible to identify centers which varied widely in quality. It was also clear from reports from program staff that children's attendance at the centers was highly variable. From the available literature on preschools, both quality and dose (both length of time attending and daily attending) affect outcomes.

These dimensions are important in the context because preschool preparation is unequally provided and accessed in Malawi. **The most recent national survey covering the issue found that fewer than 10% of children attended preschool before starting primary school.[41] In urban areas, 39% of children, compared to only 6% of children in rural areas, attended a nursery school prior to beginning primary education.**[42] Primary education is free in Malawi, but the highest repetition rate occurs in Grade 1, being 19% for boys and 20% for girls.[43]

Center-based ECD services in Malawi are delivered through two channels. The first is through formal ECD centers, which include preschools, nursery schools, crèches, day care centers, and play groups. These are generally privately run and fee-based. The second is through community based childcare centers (CBCCs) which are informal ECD centers or rural/ village preschool care. CBCCs are established and managed by communities, often have poor facilities and infrastructure, and are staffed by volunteer caregivers with low levels of education and training. Financial support is typically provided by philanthropic organizations with little budgetary contribution from local government.[44] Parents sometimes give in-kind contributions (generally food) to volunteer facilitators for their time and effort.

The partner organization was asked to rate all the CBCCs they support based on their assessment of their quality and categorize them into low, medium and high-quality. Independently, the HSRC team adapted the well-known Early Childhood Environmental Rating Scale (ECERS)[45] to make it applicable to the context in Malawi. The ECERS has been adapted and used in, among others, India, Bangladesh, Mexico, Germany, England, Chile, and Ecuador. The adapted scale had six sub-scales (health, safety and nutrition; play materials and physical space; teacher-child interactions; child observations; program structure; and caregiver training).

From the pool of CBCCs, the MEL team randomly selected 30 CBCCs (10 from each of the partner rated quality categories) which were then rated on the adapted ECERS and each center was requested to use a daily register to measure each child's attendance (dose), rather than simply recording the number of children who attended each day. Children at the CBCCs were assessed using a measure drawn from the ZamCAT (which has more items assessing school readiness)[46] and the ASQ-3. To provide a comparison group, children not

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8

Rigorous evaluation is being encouraged

attending centers from communities surrounding nine of the centers (three from each of the quality categories) were also assessed.

> "Grant-funded programs can expand and reach more children, but they cannot go to scale with sufficient coverage and effectiveness to enhance healthy growth and development of young children at national levels ..."

Children were not randomly assigned to centers by quality and dose levels, which is a requirement to determine impact; therefore it would not have been appropriate to simply compare the unadjusted outcomes of children attending CBCCs and those not attending to determine if quality and dose are important. The children who attend centers may have come from households with higher socio-economic status or had parents with more commitment to their children's education. As a result, these children may well do better than children not attending, even if they too did not attend the CBCC. Similarly, there may be bias selection into higher quality centers and higher levels of attendance determined by the same family and parental factors. To control for these biases, we collected detailed household data on all children for whom we collected child development outcomes. These data included socioeconomic status and measures of attitudes towards education. In the final analysis we are able to adjust the child development outcomes for biases introduced by these variables. This helps us provide a more accurate estimate of the impact of ECD center attendance and ECD center quality.

The study re-assessed the children after the year in the CBCC and the data analysis is in progress. If significant differences are found between children attending and not attending CBCCs, and by quality and dose, the children will be assessed again at the end of their first year of primary school to determine educational outcomes of CBCC attendance and the quality and dose dimensions.

Thresholds to cross

M&E in program implementation for young children affected by HIV and AIDS is still relatively poorly understood and under-valued. In the main, it is imposed by funders rather than initiated by programs in an effort to, one, improve the implementation cycle and two, evaluate effectiveness. Although many program partners employ M&E staff, by and large, they enter data and produce simple reports for donors rather than contribute to overall efforts to improve program effectiveness.

The MEL team sought to effect improvements in this area in a number of ways: 1) by re-framing M&E as a useful tool for programs beyond being an accountability requirement; 2) demonstrating the value of the *Information for Action* app and the value of logic models for improving program implementation; 3) using the evaluation study to illustrate how to overcome obstacles to rigorous evaluation design, and 4) by giving advice to partners on M&E issues through regular contact, country visits and annual convenings.

However, **partners may continue to derive insufficient gains from funds and effort given to M&E unless they receive more ongoing local technical support.** Currently, M&E support is mainly given through international consultants who don't usually stay the course of the project. An alternative approach is to network local experts into supportive M&E relationships with partners and programs in country. Each of the five countries in which the Foundation works has several universities, some with outstanding M&E, HIV and AIDS and even child development expertise. While not all have experience in supporting field implementation projects or programs to improve the development of young children affected by HIV and AIDS, the overarching MEL function could include convening the network of local M&E support professionals, jointly trouble-shooting, sharing methods and assessment procedures, and contribute to local capacity and knowledge generation through the inclusion of post-graduate students and peer-reviewed publications.

9

Multiple benefits through integration

New approaches to achieving multiple benefits to families through service integration are being tested.

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9 Multiple benefits through integration

While the body of evidence for integrated health, nutrition and early childhood development interventions is steadily growing, the practice of combining these intervention components is still relatively limited. One of the advantages of the Foundation's partners is their ability to implement promising innovative approaches to address the needs of young children. In this respect, a number of partners are piloting and implementing exploratory integrated ECD programming.

Two types of integration can be discerned from programs in the field. The first is primarily focused on integrating health, nutrition and ECD to promote optimal child development; the second type of integration seeks to build ECD onto economic strengthening and child protection services for vulnerable young children and their families. Some partners are trying to combine all the dimensions into their programs, although there is the danger that this can stretch expertise beyond the capacity of the organization.

The two dominant strategies to integrated programming are a) providing ECD services and parent/caregiver support programs, linked to other projects that provide another component such as livelihood support, and facilitating a referral system to government and other organizations for health, nutrition and other services; and b) supplementing an existing government structure that provides either health or education services with ECD and parent support components. Good examples of this are adding parent programs to CBCCs and integrating ECD into existing health facilities.

There are advantages to both a community-based and a government service-based integration strategy, in terms of potential for scale, sustainability and optimal impact, and these depend largely on the context in the country, the region, and the community. Partners are finding new combinations of integration components, new strategies to facilitating this integration into existing structures and systems, with the ultimate aim of providing a comprehensive set of services and multiple benefits to families, guided by their understanding that a hungry child can't learn and an overwhelmed caregiver can't provide responsive, loving care.

Thresholds to cross

Currently ECD is usually a stand-alone service that is either paid for by parents through fees-for-service or organized by philanthropic organizations and supported by communities or local government structures. However, poor countries cannot afford vertical services, each requiring infrastructure, human resources, training and management. Nor can poor communities contribute much more than approval and appreciation, despite the fact that families and young children desperately need services.

Stand-alone or vertical services are not appropriate also from three other perspectives. The first is the integrated nature of human beings and especially children. Children cannot develop well if they are only protected from violence, or only receive stimulation or nutrition from their parents. **Children need the full range of nurturing care, and nurturing care needs to be stable across time. This is what developing human brains and bodies anticipate and what they depend on for fulfillment of their human potential.**[47] Secondly, there are complementarities between experiences. Children who receive highly supportive care in infancy, but neglect and deprivation in their preschool years will lose advantages gained from their early experience. The same is true of each developmental phase. To reap the benefits of enhanced experiences in one developmental phase requires that experiences in the subsequent phase are also enhanced or at least don't work against the earlier benefits. This means that there needs to be coordination between services provided for different aspects of human development and in different phases of the lifecycle. Lastly, it is inefficient to provide services in parallel silos. These frequently result in duplicated expenditure and effort through separate infrastructure, training, and management. It also requires recipients of services to expend out-of-pocket costs to access one service separately from others.

Implementers, such as the partners with the Foundation in this Initiative, are in an ideal position to experiment with different forms of integration of services, from early health care and nutrition combined with ECD to child care and preschool preparation in concert with family support, child protection, and livelihood strategies. They are also in an ideal position to establish innovative relationships with government services that move the field closer to universal services and sustainability.

"Children need the full range of nurturing care, and nurturing care needs to be stable across time. This is what developing human brains and bodies anticipate and what they depend on for fulfillment of their human potential ..."

10

The learning mileu encourages innovation

The learning milieu is encouraging innovation in assessment, practice, and advocacy, as well as a re-think of traditional approaches.

ChildFund
Kenya

10

The learning mileu encourages innovation

The exploratory nature of the first phase of the Foundation's CABA strategy, coupled with the fact that many partners had limited experience in ECD programming for young children affected by HIV and AIDS facilitated the formation of a learning environment. Initiatives such as the inclusion of stories of challenges and setbacks in the newsletters, creating an atmosphere that encouraged *learning from doing* through interactions with partners, and **reinforcing the idea that the current stage of work, although not without limitations, were critical to informing better designs and stronger strategies.**

A number of opportunities to share learnings were created, most notably the MEL annual convenings, the Coalition on Children Affected by AIDS symposium, the AKU's Institute for Human Development Inaugural Conference and the training offered in the *Science of Early Childhood Development*, the *Essential Package* and *Care for Child Development*. In addition to the cross-pollination of ideas and solutions, there was a shared recognition that all partners were facing challenges in some area of their programming, and therefore less pressure to follow traditional tried and tested approaches, albeit with results in small steps. **The sense that there was freedom to explore different approaches in different settings was a driving force behind innovations in assessment, practice and advocacy.**

A substantial amount of innovation comes from being reflexive about the context and the culture of each community. A good example is the adaptation of the ECERS. The original ECERS tool focuses largely on formal aspects

of facility and infrastructure, curriculum and teaching. This was adapted in the version used by the MEL team and the Foundation partner in Malawi, where center quality is better reflected in social aspects. Firstly, the endorsement and support received from the traditional chief who, in better quality centers, tended to solicit support from several donors for facilities that helped the CBCC but didn't solely serve it, such as a windmill for water supplies. It was also manifested in caring aspects of caregivers' behavior, such as responding to children's distress.

> Innovation is one of the most important products of the Foundation's Initiative, but innovations must be tested, disseminated and inserted into practice

In Kenya, one partner working with the MEL team is using mobile technology to enhance service access and referral management. Another example of change in a traditional approach is the articulation of a simple premise in a Mozambican program that has bigger implications for the success of the program. This strategy rests on the basic tenet that **most families want to do the best for their children but cannot always achieve this because the context works against them.** The idea that 'families want to provide but need support to do so' has informed the content of their home-visiting material and their intervention approach.

10

The learning mileu encourages innovation

Aside from insights into technical programming gained during this phase, there are lessons on what processes are necessary for success. The tracking of resources, negotiations for collaboration in services between organizations and the development of directories of services to strengthen referral links have been shown to be crucial to ensuring that once first contact is made with a vulnerable family, they get the help they need. There is also increased awareness about the health and wellbeing of the individuals who deliver the interventions. A novel approach in one program was the development of an asset transfer program to encourage community-based volunteers to remain in the program supporting caregivers. The program offered volunteers productive assets (such as fertilizer, cooking equipment, seeds and tools) which they could use to improve their own livelihoods in exchange for the labour, commitment and care they provided in their communities.

"Aside from insights into technical programming gained during this phase, there are lessons on what processes are necessary for success...There is also increased awareness about the health and wellbeing of the individuals who deliver the interventions."

Thresholds to cross

Innovation is one of the most important products of the Foundation's Initiative, but innovations must be tested, disseminated and inserted into practice. The first step in doing this is to ensure that partners carefully document their experiences and findings, and that these case studies find their way into the published peer-reviewed literature. There are a number of journals that publish practice and program implementation. The 'grey literature', which refers to unpublished organizational reports, is disparaged by national and international policy makers, and we owe it to the children and families we strive to help to ensure that we communicate our learnings to policy makers who rely on evidence-based material.

The second step is to support tests of promising innovations through operations research and, eventually, randomized trials. The third step is dissemination of successful innovations and support for their implementation at large scale. This is what is currently happening with the WHO/UNICEF *Care for Child Development* package. A case study of its implementation around the world is in preparation for publication in a peer-reviewed journal, and one of the CABA Initiative partners, with the support of the Foundation and the MEL team, is preparing an application for a randomized trial.

11

Learning from a balanced scorecard

A balanced scorecard approach points the way to areas that need strengthening.

11 Learning from a balanced scorecard

One of our primary obligations as the MEL partner was to provide the Foundation with an overall evaluation of the first phase of their CABA Initiative to report on progress and inform future directions. For this, we used the multi-dimensional database to develop a balanced scorecard with which to assess activities at the partner level, simultaneously enabling us to roll up the collective activities of partners in an assessment of the Initiative as a whole.

The scorecard consists of a number of elements under five assessment domains: a) activities against proposed program, timeline and budget; b) sustainability of in-country activities; c) program contribution to the Foundation's strategic goals; d) M&E activities in support of program goals; e) quality, appropriateness and efficiency of the program.

> "When activities are slow to start, timelines are delayed and unless strategies are put in place to recover lost time, full implementation of activities with proper training and monitoring is affected."

Completion of the scorecard was balanced in that 1) it is derived from a number of indicators in each domain and 2) it is based on data from partner proposals and progress reports submitted to the Foundation, responses from partners to the scorecard in a narrative format, and discussions between the HSRC team and partners about their scorecard responses. Balanced scorecards were able to be completed for 10 partners. The individual partner balanced scorecards were collated into an integrative scorecard for the Initiative as a whole (Table 1). The colour coding is an aid to gaining a general impression of performance across the domains assessed. In general, *project activities* show strength, as do the *contribution of the programs to the Foundation's strategic goals*. Weaker areas are *sustainability* and *quality and efficiency of programs*. There was unfortunately too little information on the *contribution of M&E activities to program objectives* to make an informed judgement of achievements.

In terms of specific areas, the following can be observed:

- Project activities, spending and timelines are intertwined in terms of the overall flow of proposed work. When activities are slow to start, timelines are delayed and unless strategies are put in place to recover lost time, full implementation of activities with proper training and monitoring is affected. Many of the partners are working in resource-constrained settings, and more often than not services are implemented in communities that are under-resourced. While few partners reached all the targets they set themselves or completed all activities within their stipulated timelines, the setbacks were minimal compared to the progress made.

- Sustainability is affected by, amongst other things, staff turnover and expertise. While some ECD expertise is being built through the *Science of Early Childhood Development, Essential Package, and Care for Child Development* training, all of which tend to focus on very young children, programs would also benefit from training in children's preschool learning. Considerable expertise on preschool teaching and learning exists in the region, built up by the Association for the Development of Education in Africa (ADEA), the University of Victoria's Early Childhood Development Virtual University (ECDVU) initiative, Kenya's expansion of pre-primary education* and others. New partners could be sought to help build capacity in enabling children be better prepared for formal education.

  Sustainability is also affected by low levels of alignment and referral networks with existing government services, such as health, education, social and child protection, poverty reduction and local government. All partners report that they are either working to strengthen existing referral systems or to establish links to basic health and social services for young children where a comprehensive set of services does not exist in a community. In the main though, NGO programs continue to run in parallel with government services. It is time to remedy this situation and for expansion-ready programs to find ways to be scaled up by government. Not all of the partners supported by the Foundation are expansion-ready or aspire to be, and this should be considered in the

* 60% of children attend pre-primary education in Kenya. http://data.worldbank.org/indicator/SE.PRE.ENRR

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Learning from a balanced scorecard

Foundation's strategy. The Foundation needs to consider what proportion of effort and funding it will give to stand-alone programs that are limited in scope and coverage but offer opportunities for innovation, and how much into programs with the potential to realize children's rights if expanded through government services to all children.

Lastly, **sustainability is affected when organizations are highly dependent on the Foundation's financial support for their activities in country. The implication is that, without the Foundation's support, the program activities will cease.** Currently, the Foundation is the largest in-country funder of more than a third of the partners supported.

- With regard to the contribution of programs to the Foundation's strategic goals, two areas merit attention. The first, the balance between programs targeting 0-3 and 3-6-year-old children is already being addressed and increasingly greater attention by partners is being directed to the youngest children. The second, targeting effectiveness, remains largely unexplored. Generally, partners chose a geographic area in which to deliver services. Given widespread poverty and deprivation in the countries in which the Foundation works, most families in any given geographic area need services. However, they might not be the most needy, and **there is some evidence that poorly equipped community workers avoid the most problematic families because they have not been trained and have no immediate backing or referral systems to deal with domestic violence, substance abuse, mental disorder and disability,** amongst other challenges.

  In addition, the scenario regarding HIV is changing with expanded treatment, and more effort is being made to assist children and families directly affected by HIV, including reaching mothers during pregnancy and children from pre-birth through PMTCT programs. The Foundation needs to consider how HIV-targeted it wants the programs it supports to be.

- As has been noted in other parts of this report, the role of M&E in the program cycle is generally a weak area with only a few good examples of how M&E is used to improve program quality, assess impact or enhance efficiency. While partners feel that the indicators and

data they collect are relevant to their primary project objectives, the ability of these indicators to a) assess the success of intermediate steps in a logic model; b) be fed back into the program for improvement; and c) indicate impact on distal child and caregiver outcomes is still tenuous. Work done by the MEL team during the last three years has specifically attempted to remedy this, especially by helping partners see the value of M&E information, how to align M&E to the logical model of the program, and how to use M&E data to improve programs.

- External quality assurance mechanisms must be improved. Our experience is that there is still a fairly large gap between what many programs say they are

"Given widespread poverty and deprivation in the countries in which the Foundation works, most families in any given geographic area need services."

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Learning from a balanced scorecard

doing and what is actually done in the field. The most common combination of approaches to improve quality are the inclusion of supportive field supervision, monthly reflection meetings, and refresher training on content, tools and data collection. However, these approaches often depend on a caregiver raising an issue with a volunteer who carries it forward to a supervisor or meeting forum. **Partners require assistance to develop assurance and control mechanisms to improve the quality and effectiveness of implementation.** In this area, the Foundation could support ground-breaking work.

- Referral is used by all partners to fill gaps in their services. However, given the very limited services available in most communities, more attention must be given to maximizing the value and effectiveness of referrals. Mapping the availability and accessibility of services in a community is an important activity for programs and the extent to which these referrals result in a positive outcome for a family is largely dependent on the strength of the office or service to which the individual is referred. The challenges in this area are to some extent external to the partner organization in that they depend on the availability and strength of existing referral systems. However, obstacles also include a lack of family or caregiver follow-up once first contact is made, weak or non-existent M&E systems to track referrals, long distances to the nearest service provider, and service provider limitations. While these challenges are context-based, partner organizations have room to improve how they strategize around referrals and link to basic health, education and social services.

- Only three partners have information available on the cost of service provision per beneficiary i.e. one child or family. The variability in the method used to derive the cost per beneficiary makes comparison between partners, even those who provide similar services in similar contexts, very difficult. However, what we do know is that **for one program reaching one child with the current service provision repertoire, the cost is estimated at between $66.63 and $139.17**. In the same target countries, the PEPFAR cost per child estimate for OVC/CABA support is $52;[48] the Global Fund cost per child estimate in 2010 sits at $35.[49] Higher costs per

child are not necessarily a bad thing, as they may mean better quality services. But costs also have a ceiling if programs are going to be affordably scaled up. Partners must be encouraged to collect information on costs so that better information is available on which strategies for scale-up can be considered.

- The primary provision by programs is training of community workers, supportive information provided to families about child care, and care and stimulation of children in community-based child care centers. The latter two activities are usually provided by people who are not paid. Apart from one partner who helps build the basic structure of child care centers, there is very little transfer of material assistance to beneficiary communities in terms of infrastructure, food, equipment, salaries and stipends for community-based service providers, transport to referral services, and so on. This means that the bulk of most grants are absorbed by the recipient partner organization in terms of international and national staff salaries and running costs. Given the extreme poverty of the communities in which partners work, some discussion is needed on the balance of financial investments between partner organization and community needs. The success of cash transfers, family health insurance cards, school grants and other mechanisms for transferring financial resources to the poorest people have raised questions about funders' erstwhile reluctance to make direct material and financial investments in communities and families.

"The success of cash transfers, family health insurance cards, school grants and other mechanisms for transferring financial resources to the poorest people have raised questions about funders' erstwhile reluctance to make direct material and financial investments in communities and families."

11

Learning from a balanced scorecard

Table 1: Collective Impression-based Initiative Scorecard

Assessment domains	
Activities, timelines & budget in relation to program proposal	**Sustainability of in-country activities**
1.1. Targets met as set out in the program proposal	2.1. In-country expertise in ECD (either in program or consultants)
1.2. Outcomes achieved that were not set out in the program proposal	2.2. In-country expertise in M&E (either in program or consultants)
1.3. Spending according to plan	2.3. Staff turnover in the organization (international and in-country)
1.4. Activities following timelines	2.4. Volunteer turnover in the organization
	2.5. Internal capacity building activities
	2.6. Networking with other organizations/service providers
	2.7. Referral/links to health, child protection, disability services, etc.
	2.8. Services in alignment with or through existing health, education or social systems
	2.9. Engagement with government: at which level and at what frequency; alone or as a collective
	2.10. Largest in-country funder and term of funding
	2.11. Percentage of ECD activities funded by the Hilton Foundation
	2.12. Payment received from government for ECD or other services rendered
	2.13. Program's potential for scale (in terms of size, geographic coverage, systems etc.)

Areas with strengths

Areas with challenges

Areas with weaknesses (including areas in which there is not enough data to make an informed assessment)

Program contribution to the Hilton Foundation's strategic goals	M&E activities in support of program objectives	Quality, appropriateness & efficiency of the program
3.1. Basis for targeting e.g. poorest, highest HIV prevalence, existing work areas, etc.	4.1. Data collected in relation to objectives and logic model	5.1. Total cost of services provision for one child/family (beneficiary)
3.2. Assessment of targeting effectiveness (how to ascertain that the program reaches intended beneficiaries)	4.2. Methods for using M&E data for program improvement	5.2. Community contribution to total cost
3.3. Leverage of additional funding for ECD activities on the back of Hilton Foundation-funded activities	4.3. How data is used to indicate impact	5.3. Beneficiary contributions to services e.g. payment, in-kind, labour etc.
3.4. Primary point of entry into communities e.g. preschools, clinics, homes, services, traditional leaders etc.	4.4. Data on any indicators of efficiency	5.4. Service to overhead ratio
3.5. Proportion of effort split across 0-3 and 3-5 year olds	4.5. Levels of access to data (who and how)	5.5. Alignment of activities with best practice guidelines
3.6. Proportion of effort across: a) skilled parents/caregivers b) CBO capacity building c)policy and practice improvement	4.6. Audiences for reporting on activities, outcomes, impact e.g. funders, head office, etc.	5.6. Service delivery quality assurance mechanisms e.g. refresher training, supervision in field
3.7. Advocacy activities and level (local, national etc.)	4.7. Objective (external) quality assurance mechanisms for M&E	5.7. Feedback from beneficiaries e.g. user surveys
3.8. Nature of community mobilization efforts		5.8. Transfer of material resources to beneficiaries, e.g. physical infrastructure, food, play equipment, salaries/stipends etc.
		5.9. Integration e.g. with health, nutrition, education through government or NGO provision

Recommendations

Throughout the report, under the sections *Thresholds to cross*, we have highlighted challenges for the field as a whole. We have done this to enable the Foundation to consider which of these challenges it feels it can and would like to address, given its mandate and leadership in the field. In this section, based on our experience and the information we have collected over the past three years, we make some specific recommendations for taking the Initiative further and for increasing its impact. These recommendations are made in three categories: 1) Finding the Foundation's niche in the broader environment of funders, programs and services; 2) Improving practice to increase the likelihood of beneficial impact on young children and their families, and 3) Building the evidence.

- As we have indicated in a previous annual report, the Foundation needs to decide on **the role it is best positioned to play with respect to the scale of the problem and what other actors and agencies are doing.** We have indicated the scale of the problem in the five countries in which the Foundation works – some 407,000 children 0-5 years living with HIV and an estimated 2 million children 0-5 years affected by HIV and AIDS. These numbers are clearly beyond the reach of the Foundation, but the target of government programs, PEPFAR and Global Fund-supported programs. In general, the Foundation is spending over 3-4 years only a small proportion of what PEPFAR is contributing in one. However, while the Initiative's funding is not of the scale of bi- or multi-lateral donors, the commitment from the Foundation makes it a large player relative to other private funders. The challenge is to determine the role when not large enough to fund national programs, but too large to settle for small projects.

What then is the niche of the Foundation and its purpose, *vis-a-vis* PEPFAR and other agencies, big and small, working towards the same ends? Coverage of large numbers of children by light touch programs is what PEPFAR and the Global Fund have been supporting for more than a decade.

Children Affected by HIV and AIDS/ Orphans and Vulnerable Children Support

FACT SHEET

Global OVC/CABA Support in a year

2013
PEPFAR: 5 million[1]

2010
THE GLOBAL FUND: 2 million[3]

US $

2013
PEPFAR: 260 million[5]

2010
THE GLOBAL FUND: 60 million[3]

Hilton-funded Countries OVC/CABA Support in a year

2013
PEPFAR: 2 million[2]

2012-2017
HILTON FOUNDATION: 0.1 million[4]

US $

2013
PEPFAR: 103 million[4]

2012-2017
HILTON FOUNDATION: 10 million[6]

$35 per

$51 per

$52 per

$100 per

15 130 000
Children who have[8] lost one or both parents to AIDS in Sub-Saharan Africa

4 600 000
Orphans due to[7] AIDS aged 0-17 in Hilton funded countries

Malawi	790 000
Mozambique	810 000
Kenya	1 100 000
Tanzania	1 300 000
Zambia	600 000

2 300 000
Children aged 0-[10] 14 living with HIV in Sub-Saharan Africa

950 000
Children aged 0-[10] 14 living with HIV in Hilton funded countries

Malawi	190 000
Mozambique	150 000
Kenya	190 000
Tanzania	170 000
Zambia	250 000

1. Shared Responsibility-Strengthening Results for an AIDS-free generation: Latest PEPFAR Funding fact sheet - http://www.pepfar.gov/documents/organization/199571.pdf
2. PEPFAR figures - Gain: Gerd FY2013 Orphans and Vulnerable Children Results - http://www.pepfar.gov/press/222826.htm
3. The Global Fund: Resource decisions for 2011-2013 and the long term cost and health impact of Global Fund programs. The Global Fund 3rd Voluntary Replenishment (2011-2013), First meeting. The Hague, the Netherlands, 24-26 March 2010
4. CNHF Five year Strategic Goals – 500 000 children benefit (100 000 per year)
5. How is PEPFAR funding used? Expenditures By Country/Region – spending - https://dashboard.pepfar.net/fear/country-region/
6. CNHF Summary fact sheet (prepared for AIDS conference in Melbourne) - Initial investment of $50 million over 5 years (2012 – 2017)
7. United Nations Children's Fund: Towards an AIDS-Free Generation – Children and AIDS: Sixth Stocktaking Report, 2013, UNICEF, New York
8. UNAIDS 2013 estimates - UNAIDS website - http://www.unaids.org/en/regionscountries/countries/malawi/ - Initial investment of $50 million over 5 years (2012 – 2017)
9. United Nations Children's Fund: Towards an AIDS-Free Generation – Children and AIDS: Sixth Stocktaking Report, 2013, UNICEF, New York, 2013 – p78 - 81
10. http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/20101123_globalreport_en.pdf

In our view, the Foundation has the unique capacity to promote learning so that larger numbers of children can be served by programs that are more effective than is currently the case. In addition, the Foundation has opportunities to promote the value of, and to demonstrate achievements in 'intermediate' ends, especially those that reflect quality and dose that have the potential to effect positive changes in children and caregivers. The niche and purpose that the Foundation decides upon will have ramifications for which programs and other activities it supports and to what end. For example, should the focus be on children directly, or should some attention be given to improving women's pregnancy health and wellbeing; or supporting policies that benefit children, such as free pre-school provision; or helping communities and families combat stigma, including referred stigma to children because of their parents' HIV status. How targeted should the Foundation's goals be with respect to HIV and AIDS? How much attention should be given to testing and treatment of HIV-infected children in addition to psychosocial support? Is the Foundation prepared to take up the challenge of HIV exposed but unaffected children, many of who are likely to have poor developmental trajectories? Does the Foundation want to fund only partner-led programs or is it willing to give some direction to a field that has not moved significantly during 2-3 decades.

Practice needs to be improved through better programs training, supervision, mentorship, quality control and quality assurance procedures, as well as staff retention and professionalization to increase the likelihood of benefits at the child and family level. Several strategies would contribute to these ends:

- If the Foundation chooses not to explore the option of micronutrient supplementation for children in their first three years of life, it should seek one or more partners who do this to complement the programs the Foundation is currently supporting. The special issue of the 2014 Annals of the New York Academy of Sciences, *Every Child's Potential: Integrating Nutrition and Early Childhood Development Interventions*[50] and other recent publications leave little doubt that both nutrition and learning have to be addressed to effectively protect and promote the development of young children.

- There is now good evidence that trained and well-supervised community workers can deliver interventions that effectively reduce maternal depression[51] and improve child outcomes.[52] The Foundation could encourage its partners to join forces with initiatives that advocate for the recognition and advancement of social welfare,[53] community health[54] and other community workers who are, in the main, voluntary or unpaid workers. In addition, it could require that all training supported by the Foundation is certificated and that partners work together in country, and with other national and regional groups, using the leverage of the Foundation to jointly certify training of community workers. These two approaches would help to recognize the value of community workers, advance efforts to get them paid through program and government budgets, and create a formal avenue for community workers to advance their skills and consolidate their employment prospects. This can only benefit the quality and sustainability of programs.
- The Foundation could require all proposals to contain plans, with proposed data to be collected for monitoring, to improve selection into training, training itself, supervision and mentorship in the field, and re-training where needed. The Foundation could also support training for partners in quality control and quality assurance procedures, their rationale and benefits. Such training could include how to make observations of adherence to practice guidelines, conduct exit interviews with beneficiaries, undertake surveys of beneficiaries to gauge their views on the quality of services received, and so on.
- Under consideration by the Foundation is the development of guidelines for practice, based on a careful review of the effectiveness and implementation literature as the gold standard to which partners could be expected to adhere. A start has already been made to do this with respect to integrated nutrition and psycho-stimulation programs.[55] The Foundation could ensure that the guidelines are evidence-based, appropriate to the context and the strategic direction being charted by the Foundation, that they cover both the 0-3 and the 3-6-year age groups, and that they are not so prescriptive that they inhibit exploration and innovation.

- A similar initiative could be explored with respect to indicator data. It would be extremely useful if all programs collected a small set of common indicators of undoubted import. These include developmental status (using a standardized instrument administered by a trained person), growth (height and weight), birth date, maternal education, and disability status, together with sufficient data to re-contact the family and trace the child's progress over time. Other data, such as the collected in the UNICEF Multi-Indicator Cluster Surveys, especially MICS3, could be added. These include household characteristics (e.g. access to clean water) socioeconomic status (e.g. assets), physical punishment, as well as formal and informal sources of learning in the home. In the indicator work, the Foundation could also help partners, and others in the field, to arrive at consensus regarding the definition of 'reach'; that is, when we can be satisfied that a child and family have been provided with the quantity and quality service and support that can conceivably be linked to improvements in children's development.
- There is good evidence that manualized interventions and small media, such as booklets, posters and calendars with important messages, improve the effectiveness of interventions.[28] The Foundation could encourage partners to work together to produce manuals for training and implementation, and help to source cost-effective processes for producing large quantities of small media materials to be used in training, by community workers and left with parents in home visits or through community child care centers.
- Programs should be encouraged to collect standardized costing data so, when impact can be demonstrated, it can be put together with cost estimates to advocate for the expansion of cost-effective programs. This information could also be used to explore, with partners, alternative ways of funding programs that help to contain costs and might be more efficient.
- Programs should be required to work towards closing the gap between NGO efforts and government programs. All programs that strive for the realization of the right of all children to reach their developmental potential are dependent on universal government provision. This

requires that NGO programs find ways to collaborate with and insert themselves into government structures and systems. This will show the way for government services to take on board effective program approaches. Narrowing the gap can be done in a variety of ways that are already emerging in partner strategies and some still to be explored, including joint funding of NGO-government alliances to deliver services. To help develop these further, and to give them legitimacy with local government, the Foundation could issue Requests for Proposals (RFPs) from partners in collaboration with local government structures to pilot and test a range of approaches to joining up programs and services.

The Foundation could play a very important role, given its size and stature, in bringing other funders together to jointly increase the evidence for interventions to protect and support the development of young children affected by HIV and AIDS. Throughout the term of the MEL and in this report, we have stressed the importance of building evidence; evidence of effectiveness and evidence of implementation processes that increase effectiveness, efficiency and sustainability. The leverage rendered by this evidence is of inestimable value in mobilizing interest in and expanding support for programs to help young children affected by HIV and AIDS. A well-designed outcome study costs about the same and needs as much time as the average program grant awarded in the CABA Initiative; well thought-out and designed operational research much less than that. It is one of our strongest recommendations that the Foundation invest more in research to generate evidence of the value of its investments in the CABA Initiative, and that it uses its influence and leverage to publicize and disseminate results, and ensure they are communicated to and taken up by governments and agencies working in this field.

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Appendix 1:

Bio-sketches of HSRC MEL team

Professor Linda Richter is the former Executive Director of the Child Youth Family and Social Development Programme at the HSRC and currently holds an Emeritus Distinguished Research Fellow at the organization. She is a NRF A-rated scientist and, since July 2015 has joined the University of Witwatersrand as the Director of the DST-NRF Centre of Excellence in Human Development, the first such CoE in the human and social studies. In 2015 Linda received the President's Award from the Medical Research Council's (MRC), the first recipient of this award working mainly in the social sciences field. Linda is a highly productive researcher with more than 204 peer-reviewed publications. Linda's work in the fields of early child development, children affected by HIV, and child health and wellbeing is internationally recognized. From 2003-2006, she was a Visiting Researcher at the University of Melbourne, and from 2007-2010 a Visiting Scholar at Harvard University (USA), and more recently had been seconded to the Global Fund to Fight AIDS, Tuberculosis and Malaria in Geneva as a Senior Specialist in Health of Vulnerable. Linda has mentored many scholars who are now accomplished researchers in their own right and she is consulted by local and international government and non-governmental organizations for her ability to translate new science into implementation guidelines. Linda has led the Conrad N. Hilton's MEL Initiative since its inception in 2012.

Dr. Chris Desmond's research has focused on children affected by HIV and AIDS, and the economic aspects

of consequences and interventions related to child development, and on methods of economic evaluation. More recently he has focused on the use of models to predict the impact of adult HIV on affected children and on the use of behavioral economics in HIV prevention and primary care. He holds a PhD from the London School of Economics. Currently Chris works as a Research Director at the Human Sciences Research Council in the Human and Social Development research programme at the HSRC. Chris was a Senior Researcher at the Development Pathways to Health Research Unit at the University of Witwatersrand, a Research Associate at Harvard Medical School, a Research Associate at the FXB Center for Health and Human Rights, Harvard University and a Senior Researcher at the Health Economics and HIV/AIDS Research Division at the University of KwaZulu-Natal. Chris coordinated the Cost of Inaction project at Harvard University, led by Professors Amartya Sen and Sudhir Anand, which enumerated the multiple social and economic costs of failing to address the pressing needs of children. Chris is the Deputy Lead of the MEL Initiative, guiding method development and implementation.

Dr. Julia Louw is a Senior Research Specialist in the HIV/AIDS, STIs and TB programme at the HSRC. Her areas of research focus on HIV/AIDS and TB, childhood sexuality and issues related to disabilities. She holds a PhD in Rehabilitation Counseling from Michigan State University in the US. MSU awarded her with the Nelson Mandela scholarship in 2007 after she received a Ford Foundation scholarship to complete the PhD. Her PhD dissertation focused on teachers and child care providers' views of teaching HIV and AIDS programmes to learners with disabilities in Special Schools. She conducted research on a number of projects, including the Health of our Educators, the South Africa HIV Prevalence and Incidence Behaviour and Communication Survey, loveLife Evaluation Survey, Pregnant-Mother-To-Child-Transmission Implementation study and most recently as a project director on the *Screening and Brief Intervention (SBI) for harmful alcohol use among TB patients* study. Julia served as the Project Manager of the MEL Initiative from 2012 to the end of 2015 when she moved back home to HSRC Cape Town Office to be closer to her family.

Dr. Alastair van Heerden is a Senior Research Specialist in the Human and Social Development programme at the HSRC. Prior to joining the HSRC in 2008, Alastair worked for five years in the field of public health informatics. His work included research for the National Department of Health on their District level Health Information System, a task analysis of the KwaZulu-Natal TB programme and business analytic support for Inkosi Albert Luthuli Central Hospital (a state-of-the-art public hospital opened in June 2002). In these various roles he expanded expertise in the use of large data sets for decision support, operational management and data mining. Since joining the HSRC, Alastair has managed two large multi-year grants in the fields of maternal and child health, HIV/AIDS and early child development. He has also begun building a body of work around his PhD topic of pervasive computing in heath; particularly, how to harness inexpensive mobile technology to support health research in low resource settings. The research has focused on the acceptability; cost effectiveness and opportunities that mobile phone based data collection affords behavioral science researchers. He received a meritorious young investigator award for this work at the 2010 mHealth Summit in Washington DC and has published on the topic in both peer-reviewed journals and oral paper presentations at a number of both local and international conferences. Alastair has led on the technical aspects of the MEL Initiative, including on the prototyping, design and development of the *Information for Action* app.

Dr. Tawanda Makusha is a Senior Research Specialist in the Human and Social Development programme at the HSRC. Tawanda holds a PhD in Gender Education and a Master's Degree in Development Studies from the University of KwaZulu-Natal, South Africa. He is primarily interested in exploring issues relating to families and children with a specific focus on the role of men in supporting children in families in the context

of HIV/AIDS and poverty. Tawanda has coordinated a number of studies at the HSRC, including a project on the role of Child Care Forums in supporting children in need of care and support in the South African context, a feasibility study on HIV self-testing in South Africa and the qualitative component of the project on child and family well-being in the context of HIV and AIDS and poverty entitled "Sibhekelela izingane zethu" (SIZE) based Pietermaritzburg, KwaZulu-Natal. Tawanda serves as the In-country Focal Person on the MEL Initiative. Tawanda is managing the evaluation study in Malawi and is coordinating the standardization of the ASQ in South Africa and Zambia.

Sara Naicker is a Senior Researcher in the Human and Social Development programme at the HSRC. Sara holds a Masters degree in Public Health Promotion from the University of KwaZulu-Natal and is pursuing a PhD focusing on the effects of exposure to early life stress and adverse events on young adult outcomes at the University of Witwatersrand. Sara has experience in aspects of early childhood development and public health interventions, working with the Birth to Twenty group on the quality of early child care, the COHORTS group on a review of the factors influencing childhood stunting, and the development of the South African National Early Childhood Development Programme and Policy Guidelines. Sara served as the Project Coordinator on the MEL Initiative, maintaining the databases, newsletters, website, and the Scorecard analysis. Since Julia's move, Sara has taken over the project management of the MEL Initiative.