

A conversation with mothers2mothers, March 22, 2018

Participants

- Dr. Kathrin Schmitz – Director, Programmes and Technical Support, mothers2mothers
- Frank Beadle de Palomo – President and Chief Executive Officer, mothers2mothers
- Chelsea Tabart – Research Analyst, GiveWell

Note: These notes were compiled by GiveWell and give an overview of the major points made by Dr. Schmitz and Mr. Beadle de Palomo.

Summary

GiveWell spoke with Dr. Schmitz and Mr. Beadle de Palomo of mothers2mothers to learn about mothers2mothers' progress since 2009. Conversation focused on mothers2mothers' monitoring and evaluation, its programs, its current funding, and its funding gaps.

Background

mothers2mothers employs, trains, and helps to empower HIV-positive women as community health workers. These “mentor mothers” provide family-centered support for a range of related health and social issues spanning pregnancy, birth, childhood, and adolescence. mothers2mothers' flagship program is working with HIV-positive women and their families during pregnancy and after birth to improve adherence to interventions aimed at preventing mother-to-child transmission (PMTCT) of HIV.

mothers2mothers was founded in Cape Town, South Africa in 2001 and now works in eight countries in Africa.

Changes to mothers2mothers programming

In the last 10 years, mothers2mothers has expanded beyond its original focus on PMTCT starting at four to five months into pregnancy and extending until 24 months after delivery. mothers2mothers now begins providing comprehensive reproductive, maternal, newborn and child health and sexual and reproductive health services earlier in pre-pregnancy, during pregnancy, and continues engaging with clients until 18 to 24 months after delivery and beyond. In some areas, it also provides early childhood development programs.

Until 2013, mothers2mothers employees were exclusively based in health facilities. Now, Mentor Mothers also work door to door in communities surrounding facilities. By collaborating with facility colleagues, these Community Mentor Mothers aim to drive access to healthcare, and enhance adherence and retention rates.

This expansion of services has become closer to a community health worker program, and has parallels and some overlap with work being implemented by the following organizations:

- Amref Health Africa
- Living Goods

- Muso
- Last Mile Health
- Possible Health

Key differences

mothers2mothers considers there to be three key differentiators between its programs and that of other organizations. The first is a focus on having a peer mentor in the role of the community health worker. The second is employing its mentor mothers rather than providing them stipends. The third is the level of investment in training, supportive supervision, and ongoing quality improvement/quality assurance initiatives.

In each country, mothers2mothers' mentor mothers have a defined scope of work that is graded and aligned to that government's pay scheme. The work normally falls in the semi-skilled labor space, and mothers2mothers pays in line with the required minimum wage for that job category. For Kenya, that means a wage of around 12,460 Kenyan shillings, and for South Africa, around 3,300 Rand.

Monitoring and evaluation

mothers2mothers conducts an annual internal impact evaluation across all eligible countries of operations using a framework based on its theory of change and pathway to impact.

Each annual evaluation follows a 36-month retrospective cohort of mothers2mothers clients, and looks at outcome data related to PMTCT and HIV, including retention in care and adherence to antiretroviral therapy as well as along the cascade of PMTCT services, early identification rates, and final transmission rates. The evaluations also look at more general reproductive, maternal, newborn and child health factors, such as uptake of services, retesting, breastfeeding, male involvement, and incidence of tuberculosis as well as early childhood development and maternal wellbeing. In 2016 and 2017, about 33% of the HIV positive women of reproductive age enrolled in mothers2mothers' programs were adolescents and young women, so mothers2mothers does further analyses of the HIV care cascade to look for any differences between these young women and women beyond that age group.

mothers2mothers uses these annual evaluations to assess organizational program performance by comparing its achievements to national benchmarks in cases where it is able to find a reliable data source, though it is not always successful in finding technically appropriate benchmarks. One example of a sound benchmark it has used is UNAIDS data on the number of HIV-positive women who deliver at a health facility in a given country context.

Internal control groups

In addition, to better understand whether engagement with the program has an influence on clients' behavior, mothers2mothers analytically creates what it refers to as an internal control group. The internal control group is a cohort of women with one visit to the mothers2mothers program. mothers2mothers compares key outcomes/behaviors of the

cohort of women with one visit (that took place after the outcome under investigation) to the outcomes/behaviors of a cohort of women with multiple visits (the exposure group) to determine whether enrollment in the program influences uptake of specific services, and with that, client behavior. In order to be able to do that, mothers2mothers investigates statistically significant differences between the internal control group and the exposure group on key behavior (and related indicators).

mothers2mothers notes that the internal annual evaluation methodology is not as rigorous as a quasi-experimental or experimental research design. The results have an inherent selection bias, given that all women self-selected into the program, whereas with an experimental or quasi-experimental design, self-selection is dealt with in the design. The two main challenges to adopting a more rigorous research design have been resource and timing issues; it is not feasible to conduct a more rigorous quasi-experimental or experimental study annually. As it stands, the annual evaluation yields meaningful descriptive results that are useful in assessing program performance, and indicative of program efficacy.

Recent monitoring improvements

In July 2017, mothers2mothers launched Project BIO, an internal quality assurance and quality improvement project. Originally, using Lot Quality Assurance Sampling (LQAS), mothers2mothers site staff would extract longitudinal client outcome data, and program performance management was done on the basis of a 3-6 month enrollment cohort analysis. As mothers2mothers' programmatic platform expanded, this outcome-based cohort data extraction became burdensome. Furthermore, the time-lag inherent in the cohort analysis resulted in program performance issues identified up to 7 months after they had occurred. Similarly, the effect of quality improvement interventions was at best noticeable 7 months after the intervention.

In order to address these flaws, over two years starting with structural changes in client management tools, mothers2mothers overhauled the entire routine monitoring and evaluation system that drives program performance management. Informed by a comprehensive conceptual framework, the emphasis now is on cross-sectional analysis of key service delivery outputs that directly drive client outcomes (early infant diagnosis, adherence, retention, and viral load), thus eradicating the cohort-analysis-related time-lag. Furthermore, indicators reported convey information across mothers2mothers' integrated service platform as opposed to merely being platform-specific "data points", thus enhancing the utility of the routine reports. Since analysis is conducted on monthly output data, site level analysis is meaningful for the first time. Site-appropriate targets are set and a site grading system guides quality improvement.

Currently, mothers2mothers has site-specific, monthly data, as well as an overall-quality composite score by which to evaluate their performance at every site.

Another major component of Project BIO is collecting data on adherence to standard operating procedures and quality of services. The quality audit process starts at the level of site coordinators and the mentor mothers, and moves along each step of the cascade of

client services, tracking utilization of digital health, client volume vs. number of mentor mothers, active client follow-up, and supportive supervision, among other data.

Studies of mothers2mothers programs

In the last 10 years, mothers2mothers has been involved in three key scientific studies:

- An external evaluation of their former PMTCT program done by the Population Council in 2009 for its Horizons Program.
- The PURE study: a randomized controlled trial done under the Lighthouse consortium in Malawi that looked at the difference in retention in and adherence to PMTCT care between facility- and community-based program implementation.
- A current quasi-experimental study in Swaziland being done by the Johns Hopkins Center for Communication Programs' Health Communication Capacity Collaborative. This study looks at the mother-baby pair in the first 1000 days, and evaluates whether household-based interventions targeted at both mothers and babies have an effect on parenting skills, psycho-social support, maternal depression, general PMTCT and health, and the enrolled babies' development milestones. mothers2mothers expects the results of this study to be available in the third quarter of 2018.

Generalizability of studies

Within Sub-Saharan Africa, it is likely that data from the above studies is generalizable from an operational perspective. Furthermore, looking specifically at Lesotho, Swaziland, and South Africa, results are likely generalizable due to their proximity and the similarities between these contexts and the research sites. mothers2mothers would expect the studies' results to be of some relevance—but with limitations—beyond those contexts.

Funding

Budget

mothers2mothers' current budget is roughly \$22 million per year across its eight countries of implementation. Approximately 65% of that budget is used towards mothers2mothers' core PMTCT program, with approximately 35% funding newer programs such as Early Childhood Development and Adolescent Health.

Room for more funding

The majority of the countries in which mothers2mothers operates, including Swaziland, have service gaps and lags. There is a lack of ability to scale up services to reach women in need of these services. The possible exception is Kenya, which has scaled a national mentor mother program with mothers2mothers' help, and has mentor mothers more widely dispersed throughout the country.

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