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Contents

EXECUTIVE SUMMARY ................................................................................................................................. 8

INTRODUCTION .................................................................................................................................................. 12

PART 1: BACKGROUND ................................................................................................................................... 13
1.1. THE IMPORTANCE OF EARLY CHILDHOOD DEVELOPMENT ................................................................ 13
1.2. INVESTMENT IN EARLY CHILDHOOD ................................................................................................. 13
1.3. CHILDREN AT RISK: THE SCOPE OF THE PROBLEM ......................................................................... 13
1.4. EARLY CHILDHOOD INTERVENTIONS ACROSS THE WORLD ......................................................... 14
  1.4.1. Model Targeted Early Childhood Interventions .............................................................................. 14
  1.4.2. Large-scale Targeted Early Childhood Interventions .................................................................... 15
  1.4.3. Programmes & Services Linked to Health Care Systems .............................................................. 15
  1.4.4. Centre-Based Pre-School Education ............................................................................................. 15
  1.4.5. Home Visiting .................................................................................................................................. 15
1.5. THE FIRST THREE YEARS ....................................................................................................................... 16
1.6. INTERVENTIONS FOR CHILDREN BIRTH TO THREE YEARS IN THE CARIBBEAN ...... 17
  1.6.1. Health-Focused Home Visits ........................................................................................................ 17
  1.6.2. Child Health and Development Focused Home Visits ................................................................ 17

PART 2: ST. VINCENT AND THE GRENADINES: A COUNTRY PROFILE .................................................... 19
2.1. THE LAND ............................................................................................................................................... 19
2.2. THE PEOPLE ......................................................................................................................................... 19
2.3. THE ECONOMY ................................................................................................................................... 19
2.4. THE CHILDREN ...................................................................................................................................... 20
2.5. THE EARLY EDUCATION SYSTEM ..................................................................................................... 21
2.6. THE PRIMARY HEALTH CARE SYSTEM ............................................................................................. 21
2.7. PROGRAMMES TO SUPPORT VULNERABLE CHILDREN 0-3 YEARS ............................................. 21
  2.7.1. The Roving Caregivers Programme ................................................................................................. 21
  2.7.2. The ECHO Programme .................................................................................................................. 23

PART 3: THE ECHO PILOT PROGRAMME .................................................................................................. 25
3.1. PILOT PROGRAMME CONCEPTUALISATION ...................................................................................... 25
3.2. PROGRAMME OBJECTIVES .................................................................................................................. 25
3.3. PROGRAMME DESIGN ........................................................................................................................ 25
3.4. PROGRAMME SUPPORT ...................................................................................................................... 25
3.5. PROGRAMME ADMINISTRATION AND MANAGEMENT ....................................................................... 26
3.6. INVOLVEMENT OF OTHER GOVERNMENT MINISTRIES, DEPARTMENTS OR AGENCIES. . 28
3.7. PROGRAMME INITIATION AND ENROLMENT ................................................................................... 31
3.8. PROGRAMME RECIPIENTS .................................................................................................................. 31
  3.8.1. Selection of Region for Piloting ...................................................................................................... 31
  3.8.2. Selection of Child and Family Participants .................................................................................... 31
3.9. TRAINING ............................................................................................................................................. 32
  3.9.1. Training of CHAs ............................................................................................................................ 32
  3.9.2. CHA Training Programme Curriculum Development .................................................................... 33
  3.9.3. Training of Supervisory Nursing Staff .......................................................................................... 34
  3.9.4. Training of All Nursing Staff: Integration of ECHO Programme in the Nursing Curriculum .35
PART 4: OBJECTIVES OF EVALUATION ................................................................. 43
  4.1. CONVENTION ON THE RIGHTS OF THE CHILD ........................................ 43
  4.2. SPECIFIC OBJECTIVES ........................................................................ 43
  4.3. PRIMARY REASON FOR EVALUATION ...................................................... 43

PART 5: EVALUATION METHODOLOGY ............................................................... 44
  10.1. EVALUATION PRINCIPLES ..................................................................... 44
  10.2. EVALUATION DESIGN ............................................................................. 44
  10.3. IDENTIFICATION AND RECRUITMENT OF PARTICIPANTS ........................ 46
    10.3.1. KEY INFORMANTS AND FOCUS GROUP PARTICIPANTS ...................... 46
    10.3.2. PARENT AND CHILD BENEFICIARIES ............................................. 46
    10.3.3. PARENT AND CHILD CONTROLS (NON-ECHO BENEFICIARIES) ........ 46
  10.4. QUALITATIVE DATA SOURCES ................................................................. 46
    10.4.1. DESK REVIEW OF PROJECT DOCUMENTS ...................................... 46
    10.4.2. IN-DEPTH INTERVIEWS (GOVERNMENT & PROJECT STAFF) ........... 47
    10.4.3. FOCUS GROUPS ............................................................................. 48
  5.5. QUANTITATIVE DATA SOURCES ................................................................. 49
    5.5.1. PROCESS OF DATA COLLECTION ...................................................... 49
    5.5.2. INSTRUMENTS ................................................................................. 49
  5.6. DATA ANALYSES .................................................................................... 50
    5.6.1. QUALITATIVE ANALYSIS .................................................................. 50
    5.6.2. QUANTITATIVE ANALYSIS ................................................................ 50
  5.7. ETHICAL CONSIDERATIONS AND RESPONSIBILITIES ............................. 51
    5.7.1. GUIDING DOCUMENTS ..................................................................... 51
    5.7.2. TRAINING IN RESEARCH ETHICS .................................................... 51
    5.7.3. VOLUNTARY PARTICIPATION & INFORMED CONSENT ...................... 51
    5.7.4. RISKS AND BENEFITS .................................................................... 51
    5.7.5. PRIVACY & CONFIDENTIALITY ......................................................... 51
    5.7.6. ETHICAL RESPONSIBILITIES ........................................................... 52
    5.7.7. PAYMENT & COMPENSATION .......................................................... 52
  5.8. IDENTIFIED BIASES AND MITIGATION STRATEGIES ............................... 52
  5.9. LIMITATIONS TO EVALUATION METHODOLOGY ................................... 52

PART 6: PROGRAMME & THE EVALUATION PROCESS ......................................... 54
  6.1. PROGRAMME CONCEPTUALISATION AND CHILD RIGHTS ......................... 54
  6.2. PROGRAMME OBJECTIVES ...................................................................... 54
  6.3. PROGRAMME DESIGN ............................................................................ 54
  6.4. PROGRAMME SUPPORT AND CONTRIBUTION ........................................... 56
  6.5. PROGRAMME ADMINISTRATION AND MANAGEMENT ................................. 56
PART 7: ECHO RELEVANCE ................................................................. 64
  7.1. ECHO PILOT PROGRAMME – STRATEGIC RELEVANCE ........ 64
  7.2. ECHO PILOT PROGRAMME - RELEVANCE TO CHILD RIGHTS ... 65
  7.3. ECHO PILOT PROGRAMME – STAKEHOLDER RELEVANCE .... 65
  7.4. ECHO PILOT PROGRAMME – EQUITY FOCUS ....................... 66

PART 8: ECHO EFFECTIVENESS ....................................................... 68
  8.1. PROVIDING EARLY CHILDHOOD STIMULATION TO CHILDREN AND FAMILIES AT RISK 69
  8.1.1. IDENTIFICATION OF CHILDREN AND FAMILIES AT RISK .............. 69
  8.1.2. THE ECHO STIMULATION PROGRAMME DELIVERY .................. 70
  8.2. IMPROVEMENT OF PARENTING PRACTICES .............................. 70
  8.3. MONITORING OF CHILD DEVELOPMENT STATUS ....................... 71
  8.4. TRAINING OF COMMUNITY HEALTH AIDES ............................. 71
  8.4.1. TRANSFERENCE OF KNOWLEDGE AND SKILLS TO PARENTS AND COMMUNITIES & PROMOTION OF HEALTHY RELATIONSHIPS .... 71

PART 9: ECHO EFFICIENCY ............................................................... 72
  9.1. COSTS OF ECHO PROGRAMME ............................................. 72
  9.2. COMPARISON OF ECHO AND RCP PROGRAMME ....................... 73
   9.2.1. OPERATIONAL COMPARISONS ........................................ 74
   9.2.2. OUTCOME COMPARISONS ............................................ 74
  9.3. HUMAN RESOURCE REQUIREMENTS AND OTHER COSTS FOR SCALE UP OF ECHO PROGRAMME .............................................. 74
  9.4. OPTIONS FOR MORE LIMITED BUDGETS ................................. 77
  9.5. LIMITATIONS TO COST ANALYSIS ........................................ 77

PART 10: ECHO IMPACT & OUTCOMES ............................................. 78
  10.1. RESULTS OF ASSESSMENTS CONDUCTED DURING THIS EVALUATION ................................................................. 79

PART 11: ECHO SUSTAINABILITY - CONSIDERATIONS & RECOMMENDATIONS FOR NATIONAL IMPLEMENTATION ........................................... 81
  11.1. PROGRAMME STRENGTHS, CHALLENGES, OPPORTUNITIES AND CONSTRAINTS .... 81
   11.1.1. STRENGTHS ........................................................................ 81
   11.1.2. CHALLENGES ..................................................................... 83
   11.1.3. OPPORTUNITIES .................................................................. 85
   11.1.4. CONSTRAINTS ..................................................................... 86
  11.2. CONSIDERATIONS FOR NATIONAL IMPLEMENTATION .................. 86

RECOMMENDATIONS ................................................................. 89

CONCLUSIONS ............................................................................. 93
REFERENCES................................................................................................................................................. 95

APPENDIX A – LIST OF ABBREVIATIONS & ACRONYMS.......................................................................... 98

APPENDIX B - TERMS OF REFERENCE................................................................................................................. 99

APPENDIX C - LIST OF INTERVIEWEES & FOCUS GROUPS........................................................................... 106

APPENDIX D - LIST OF DOCUMENTS REVIEWED................................................................................................. 109

APPENDIX E- CONSENT FORMS & QUESTIONNAIRES...................................................................................... 110

APPENDIX F – FEEDBACK ON RECOMMENDATIONS AT EXIT MEETING ....................................................... 136

APPENDIX G – PARENT FEEDBACK QUESTIONNAIRE FINDINGS.................................................................... 137

APPENDIX H – DETAILED ANALYSIS OF THE LOGICAL FRAMEWORK....................................................... 140
List of Tables

Table 1. Composition of Administrative Committee ................................................................. 26
Table 2. ECHO Pilot Project Work Plan ..................................................................................... 29
Table 3. Eligibility Criteria for ECHO Enrolment (Phase 2) ....................................................... 31
Table 4. CHA Instructional Programme Topics ......................................................................... 33
Table 5. ECHO Final Curriculum Training Programme Goals and Objectives ......................... 34
Table 6. Programme Delivery Resources provided to CHAs .................................................... 36
Table 7. ECHO Programme Visitation Schedule ..................................................................... 37
Table 8. ECHO Programme Logical Framework ...................................................................... 39
Table 9. Data Collection Measures ........................................................................................ 42
Table 10. Weekly Work Plan of a Community Health Aide ...................................................... 57
Table 11. Analysis of Indicators of Project Objectives .............................................................. 62
Table 12. ECHO Relevance - Detailed Evaluation Questions .................................................... 64
Table 13. ECHO Effectiveness Detailed Evaluation Questions ................................................ 68
Table 14. Summary of Outcome of Goal Objectives and Results/Outputs ................................ 69
Table 15. ECHO Efficiency - Detailed Evaluation Questions ..................................................... 72
Table 16. Estimated Cost of ECHO Programme ..................................................................... 73
Table 17. Cost and Operational Comparisons of the ECHO and RCP Programmes ................ 73
Table 18. Estimation of Human Resource Costs for ECHO Programme @ 70 families each per CHA (CHAs and Supervisors) ..................................................................................................................... 75
Table 19. Estimation of Human Resource Costs for ECHO Programme @ 70 families each per CHA (Administrative, M&E, Clerical and Total Costs) .......................................................................................... 76
Table 20. Estimation of Administration Costs for ECHO Programme @ 70 families each per CHA ............................................................................................................................................... 76
Table 21. Total Costs for Delivery of ECHO Programme by Type of Service Provision .......... 77
Table 22. ECHO Impact & Outcomes Detailed Evaluation Questions ...................................... 78
Table 23. Comparison of Cognitive, Developmental and Academic Scores of ECHO Child Beneficiaries and Controls ..................................................................................................................... 80
Table 24. ECHO Sustainability Detailed Evaluation Questions ....................................................... 81
Table 25. Eligibility Criteria for ECHO Programme .................................................................. 137
Table 26. Duration of Enrolment in ECHO Programme .............................................................. 138
Table 27. Frequency of Visits by CHAs .................................................................................. 138
Table 28. Mean Duration of Visits .......................................................................................... 139
Table 29. Primary Focus of Home Visits .................................................................................. 139

List of Figures

Figure 1. Map of St. Vincent and the Grenadines ...................................................................... 20
Figure 2. ECHO Organisational Structure ................................................................. 27
Figure 3. Developmental Progress of Child Participants at the End of the First Phase of the ECHO Pilot ................................................................. 79
EXECUTIVE SUMMARY

St. Vincent and the Grenadines (SVG), a Caribbean island state, cognisant of the importance of early childhood development, and in particular development during the first three years of life, made the decision to implement programmes for vulnerable children in this age group. The Roving Caregivers Programme, an internationally acclaimed home visiting programme delivered by community para-professionals, developed in Jamaica, was implemented in 2004 with the support of the Bernard van Leer Foundation. The RCP, while receiving some support from the government through the health sector operated primarily as a privately run organisation with its own staff. Inevitably, sustainability of the programme became a challenge. As with other countries in the Caribbean, the option of delivering the programme through existing paraprofessional community based health staff, known as Community Health Aides (CHAs) was considered. The Ministry of Health, Wellness and the Environment (MHWE) of the government of St. Vincent and the Grenadines, with technical and/or financial support from other ministries and that of regional and international development partners, developed, planned and implemented its own delivery model, known as the Early Childhood Health Outreach (ECHO) programme. A pilot programme was decided on, the results of which would guide the national implementation of such a programme.

The Programme

The programme, which was piloted in two phases in 2010 and 2011, had as its overarching objective the provision of health stimulation for at-risk children. This was to be met through six sub-objectives:

- To offer early stimulation to young children
- To improve parenting practices in “at risk” communities
- To promote and monitor good health and early development of young children
- To train CHAs from the communities in the pilot district to assist in the delivery of parent support services
- To transfer knowledge and skills to parents and communities
- To promote healthy relationships between parent and child

Some 182 children from a socioeconomically deprived area of SVG received early childhood stimulation services during the pilot project. The pilot was primarily funded by international development partners, and was administered by the MHWE, through the Community Nursing Service. A Project Coordinator was hired to oversee implementation, and the implementation itself was monitored by an Administrative Committee. The Committee was chaired by the Permanent Secretary, and included a broad range of personnel, including senior administrative and technical staff in the Ministry, operational Nursing and Community Health Aide staff, Roving Caregivers and representatives from the Ministries of Education and National Mobilisation.

The pilot programme was located in the Calliaqua health district because of its relatively high rate of poverty. Families were enrolled based on subjective identification of need in the first phase and, in the second phase, by risk criteria including demographic characteristics such as poverty, health risks for developmental delay, minor developmental delay and non-attendance at pre-school. All CHAs working in St. Vincent attended a comprehensive full time training programme, including child health and
development topics, professionalism, communication and teaching and learning principles, prior to working with young children. Though a formal curriculum document was not present at the time of CHA training, one was developed subsequently. Nursing Supervisors, to whom CHAs report directly, participated in a one day training programme. ECHO programme content, not previously in the existing nursing curricula, was added during the pilot programme.

All CHAs were provided with a kit which included brochures on the ECHO programme and on parenting, a leather mat to facilitate floor play with children and materials to teach parents how to make low cost stimulating toys. Once a family was enrolled, an initial visit was made for the purpose of introducing the programme and assessing the child’s developmental status using a standardised screening tool, the Ages and Stages Questionnaire (ASQ). Follow-up visits for stimulation were scheduled to occur twice per month and visits for monitoring of development using the ASQ, once every three months. Supervisory visits by nursing personnel were also scheduled. Additionally, group parent workshops for parent education and support and financial independence support through training in backyard gardening, were held.

Purpose and Objective of Evaluation

In 2014 an evaluation of the pilot programme was commissioned, based on the need of Government partners in the MHWE in SVG to determine programme effectiveness and output in order to guide scaling up, and as an organizational requirement for UNICEF, who invested in the pilot programme. Based on the Terms of Reference, the specific objectives of the evaluation were:

I. To assess how far the ECHO pilot programme has achieved its objectives, the results that have been achieved to date, any unintended results from the programme, as well as outputs at the individual, household, and community levels

II. To identify the opportunities and constraints the programme has faced and draw lessons and good practices from them

III. To evaluate the operational effectiveness of the pilot and to cost its scale up in the current and projected national fiscal situation

IV. To identify the extent to which cross-cutting strategies/issues such as human rights-based approaches, results-based planning and gender equality/mainstreaming have been adopted in the planning and implementation of the programme.

V. To ascertain the requirements and implications (institutional capacity, financial implications etc.) of scaling up and implementing the ECHO programme on a national scale in the model countries, especially St. Vincent & the Grenadines.

Methodology

A mixed method qualitative and quantitative approach was used to obtain data for project evaluation. Qualitative approaches included review of project documents, in-depth interviews of senior administrative personnel and focus groups of stakeholders including CHAs, Rovers, the Administrative Committee, curriculum writers and trainers and district nursing supervisors. The Quantitative approach involved collection of raw data from ECHO beneficiary parents, ECHO beneficiary children and age and gender matched controls. Data collected included a parent beneficiary survey (questions on ECHO
programme) and child development assessments of developmental status (ASQ), verbal comprehension, reading, writing and spelling, using standardised tests. All ethical principles were followed, including confidentiality, informed consent and referral for children identified with developmental or behavioural concerns.

**Major Limitations of Evaluation**

Project evaluation was limited by a number of factors: delayed timing of evaluation with resultant difficulty locating documents and impaired memory recall; poor quality of documents and reports when located (undated, conflicting information); and limited parental participation as cases and age and sex matched controls. The very few control families participating in the programme resulted in an inability to compare parenting knowledge, attitude and practice of ECHO and non-ECHO beneficiaries and child development and educational outcomes of ECHO and non-ECHO child beneficiaries. In the absence of objective evaluation of programme outcome, parental interviews rated the programme highly. However, home visits were less frequent and often shorter than as indicted by the protocol.

**Key Findings**

**Programme Achievements**

In the absence of a comprehensive results based framework, analysis of available data suggested that the ECHO programme had only partially met its goal, while achieving the two objectives related to provision of early stimulation and training of staff to deliver stimulation. The objectives of improving parental practice, promoting and monitoring child health and development and transferring knowledge to parents and community were assessed as partially achieved and that of promoting healthy parent-child relationships was unable to be assessed. The assessment of the achievements of the ECHO pilot was compromised by ineffective targeting of children at risk and uneven programme delivery. Additionally, there was not enough data to assess how the ECHO pilot affected children’s growth and development.

**Programme Efficiency**

Programme recurrent cost was calculated at EC$2,487 (US$931.46), just over twice the cost of the RCP programme. Programme costs were primarily due to human resources. Analysis showed greater efficiency of the RCP model, but child development outcomes of the two programmes were not able to be assessed and compared as result of a lack of available monitoring and evaluation data at all levels of the results chain. Using the current ECHO mechanism, a targeted implementation, to those young children in poverty (estimated at 36%), would require an increase in the health budget of 2% (EC$1.4million, USD $500,000), while a universal programme would require an increase of 4% (EC$3.5 million, USD $ 1.31million).

**Programme Strengths and Challenges**

Identified ECHO programme strengths included a stable political environment; political support for the programme despite changing personnel; a cross-sectoral, inclusive monitoring body; engagement of external partners; adequate financial support provided primarily by donors; development and execution of a comprehensive training programme for CHAs, capacity building of CHAs and utilisation of opportunities for further capacity building in early stimulation by incorporating early stimulation in the training curricula of nurses.
Programme challenges were identified in programme design, where there was a weak human rights framework, inadequate targeting of services and an inadequate results based framework. Additional challenges included the absence of a curriculum to guide home visits, which is standard in many similar programmes; the absence of an assessment component in the training programme for those who deliver early stimulation services; and the disenfranchisement of Rovers, personnel highly trained in and passionate about early stimulation. At the operational level, there was initial limited buy-in of CHAs to the programme. A main concern was the inability of CHAs to deliver the programme with the frequency and intensity required and stated in the protocol, due to additional duties on an existing workload without an increase in staff complement. This also affected supervision of the programme by nurses, who had responsibilities to the community clinics.

**Recommendations**

Recommendations for scaling up of the programme, based on this evaluation, included:

- Addressing programme design challenges, by including a human rights based approach
- Addressing sustainability through adequate financing
- Improving targeting of vulnerable children and families
- Developing a results based framework
- Addressing training and curriculum deficiencies by developing a home visiting curriculum, including assessment in the training programme and developing a comprehensive in-service training programme for nursing supervisors.
- Maintaining and expanding the Administrative Committee to include other government partners and the private sector

Probably most important, however, is the need to address the human resource matter of determining the professional who will deliver the programme at the community level. The RCP model is more cost and operationally efficient. However, the training and engagement of CHAs has potential benefits for children. A design that incorporates both the CHAs and the Rovers may be the best option.
INTRODUCTION

This report describes in detail the evaluation of the pilot of the ECHO programme, a country-specific home visiting model for children 0-3 years. The programme goal is to ensure quality early childhood health stimulation readily accessible to “at risk” parents and families.

The report first presents in the Background, information on the importance of the early childhood period and early childhood development, and in particular, the first three years. The background also reviews international and regional programmes for children 0-3 years, with a focus on home visiting programmes. A description of St. Vincent and the Grenadines (SVG) follows to provide the context in which the evaluation was conducted. Additionally, home visiting programmes in SVG are discussed.

The ECHO Pilot Programme is then described, from its conceptualisation through to monitoring and evaluation. The Objectives of the evaluation are then described, followed by a detailed description of the evaluation methodology, using both qualitative and quantitative methods. Evaluation limitations and ethical considerations are also included.

The results of the evaluation are presented in six segments: Programme and Evaluation Process; ECHO Relevance; ECHO Effectiveness; ECHO Efficiency; ECHO Impact; ECHO Sustainability. These results are then used to inform the Recommendations in the next section of the report. The report culminates with a Conclusions section.

References and Appendices follow. The Appendices include the List of Abbreviations and Acronyms, Terms of Reference, List of Interviewees, List of Documents Reviewed, Consent Forms for parents who completed questionnaires and their children who were assessed and Questionnaires utilised for primary data collection.
1.1. THE IMPORTANCE OF EARLY CHILDHOOD DEVELOPMENT

Early childhood is defined as the period of a child’s life from conception to age eight years and is now regarded as the most important developmental phase throughout the lifespan. It is a time of remarkable physical, cognitive, social and emotional growth. Development in these years is both highly robust and highly vulnerable (Shonkoff & Phillips, 2000). Almost every aspect of early human development is affected by the environments and experiences that are encountered beginning early in the prenatal period and extending throughout the early childhood years (Shonkoff & Phillips, 2000). Research in the fields of anthropology, education, developmental psychology, sociology and medicine indicate the critical impact of early childhood development in health, well-being and the formation of intelligence, personality, and social behaviour.

Essentially, during the early years of human development the basic architecture and function of the brain are established (McCain, Mustard & Shanker, 2007). Early experiences influence the quality of that architecture by laying either a strong or fragile foundation for the health, development and learning that follow (Shonkoff, 2010). Results from developmental neurobiology studies consistently provide evidence that early neurobiological development affects physical and mental health, behaviour and learning in the later stages of life (Mustard, 2010). For example, adverse experiences in early childhood are associated with chronic health problems in adulthood, including alcoholism, depression, heart disease and diabetes (Shonkoff, Boyce & McEwen, 2009).

1.2. INVESTMENT IN EARLY CHILDHOOD

Investment in early childhood is associated with high rates of return (Heckman, 2004). Investment in these early years is a powerful economic strategy, with returns over the life course many times the size of the original expenditure (Hertzman, 2010). Recent studies of early childhood investments along with the basic principles of neuroscience indicate that providing supportive conditions for early childhood development is more cost-effective than attempting to address the consequences of early stress and adversity later on (Knudsen, Heckman, Cameron & Shonkoff, 2006). For example, results from the High/Scope Perry Preschool Study estimated a return to society of more than $17 for every dollar invested in providing high quality care and education in the early years, even after controlling for inflation (Schweinhart, 2004). These results were largely due to the continuing effect that the intervention had in reducing crime perpetrated by males. Like the High/Scope Perry Preschool Project, analyses of other early childhood interventions have revealed economic benefits to society attributed not only decreased criminal justice costs but also to increased earnings due to higher educational attainment, higher employment rates, a decreased need for special/remedial education and decreased burdens on health and welfare systems (Anderson et al., 2003; Engle et al, 2011).

1.3. CHILDREN AT RISK: THE SCOPE OF THE PROBLEM

More than 200 million children under 5 years living in developing countries are not fulfilling their developmental potential (Grantham-McGregor et al., 2007). The poorest and most marginalised children tend to suffer the most. Children living in poverty are at a greater risk than their more advantaged peers for being deprived and receiving lower levels of parental investments during the crucial early childhood
period (Engle et al., 2011). Evaluations of ECD programmes (e.g. parent support and enrolment in preschool programmes) show that targeting the children most in need of services will deliver the best results (Engle et al., 2011). Returns are greatest for the most at-risk children. Interventions for disadvantaged children can strengthen social attachment, raise the quality of the workforce and reduce crime, teenage pregnancy, and welfare dependency (Anderson et al., 2003).

1.4. EARLY CHILDHOOD INTERVENTIONS ACROSS THE WORLD

Based on the evidence presented, it is no surprise that the provision of a high quality early childhood environment enhances the quality of a society’s human capital by promoting individuals’ competencies and skills for participating in civil society and the workforce (Knudsen, 2006). Overall, countries that provide high-quality, universal programmes for very young children tend to outperform countries which do not have well-organised early childhood development programmes (McCain et al., 2007).

Internationally, there are many types of early childhood interventions including programmes linked to health care services, home visitation services, community based programmes, parent support programmes and preschool services. These interventions are highly varied in their methods, target group, eligibility criteria, service type and outcomes. However, they are all share a common objective – to moderate the effects of the various risk factors that may compromise healthy growth and development in the early years of life (Karoly, Kilburn & Cannon, 2005).

There is a strong body of evidence to suggest that ECD programmes have positive impacts on child development, especially related to cognitive and psychosocial development, school readiness and academic achievement (Anderson et al., 2003; Engle et al., 2011). However, many of the evaluation studies have methodological and design weaknesses that make the assessment of their true impact difficult (Anderson, 2003; Geddes, Haw & Frank, 2010). Nevertheless, there are promising results from evaluations of different types of ECD interventions which suggest that early developmental opportunities create a vital foundation for children’s health, well-being and success at school (Anderson et al., 2003).

1.4.1. Model Targeted Early Childhood Interventions

Model ECD programmes have generally been of a high quality and have shown statistically significant positive results and good effect sizes (Geddes, Haw & Frank, 2010). This is mostly due to the fact that these interventions are small-scale, well implemented and intensive programmes targeted at high risk groups. For example, the Abecedarian Project tracked 111 low-income African-American families in North Carolina from infancy to age 21. Intervention groups were provided with high-quality, intensive education from infancy to five or eight years. The intervention groups displayed a number of benefits at follow-up including higher academic achievement, higher rates of high-school and college completion, better employment outcomes, delayed parenthood and lower rates of cigarette and marijuana use. Similarly, the High/Scope Perry Preschool Project demonstrated that children who participated in quality preschools at age 3 – 4 years were more likely to graduate from high school, have steady employment, have higher earnings and commit fewer crimes than children who did not attend these programmes (Schweinhart, Montie, Xiang, Barnett, Belfield, & Nores, 2005).

1.4.2. Large-scale Targeted early childhood interventions

It has been difficult to determine the true impact of many of the large-scale interventions because of poor methodological and evaluation designs, attrition, as well as follow up contacts that are conducted too
soon after programme implementation (Geddes, Haw & Frank, 2010). For example, the evidence on the positive impact of both the US Head Start and the UK Sure Start has been inconclusive (Anderson et al., 2003; National Evaluation of Sure Start Team, 2012). However, there have been a few large-scale interventions (e.g. Early Head Start, Nurse-Family Partnership and Chicago Child Parent Centers) which have used experimental, quasi-experimental or randomized controlled trials to measure efficacy (Geddes, Haw & Frank, 2010). The results of these studies have generally shown that experimental groups have better outcomes in both the short and long term (Geddes, Haw & Frank, 2010).

### 1.4.3. Programmes & Services linked to Health Care Systems

Many interventions for children in the early childhood period, particularly those under the age of three years, are linked to health care systems. This is generally because very young children are most likely to come in contact with the health sector in the first few years of life. One such programme is the WHO’s *Integrated Management of Childhood Illnesses (IMCI)*. The main goal of IMCI is to reduce childhood mortality, illness and disability and to promote health and development among children 0 – 5 years. By adopting an integrated approach to child health and development, the IMCI focuses on the proper identification and treatment of childhood illness within the home, community and health facilities. It also provides counselling for parents and caregivers and referral services for the very sick children. Although there have been major obstacles to the successful wide scale implementation of the programme (e.g. the cost of training and training materials, poor follow-up support, and frequent attrition of trained staff), there is evidence that shows that health workers trained in IMCI provided significantly better care to children and their families than those not trained (Amaral et al., 2004).

*Care for Child Development (CCD)* was developed through a UNICEF/WHO partnership and was designed to be incorporated into existing IMCI programmes. CCD provides information and recommendations for families to help them provide cognitive stimulation and social support to young children as part of the child health visits specified in IMCI. However, adaptations of the CCD module encourage its integration into any programmes that serve young children and their families (e.g. preschools, parenting programmes, community-based programmes for families). There is evidence to suggest that CCD is an effective means of supporting caregivers’ efforts to provide a stimulating environment for their children, improving the quality of the parent-child interaction and improving cognitive, language and motor development outcomes at 12 and 24 months of age (Engle, 2011).

### 1.4.4. Centre-Based Pre-School Education

Research has shown that preschool attendance can provide tremendous benefits for children, especially those children from very poor families (Geddes, Haw & Frank, 2010). These benefits include improved language, prereading and math skills. The general quality of the preschool programme, as well as factors such as the number of trained teachers and level of positive interactions with children impact child outcomes (Geddes, Haw & Frank, 2010).

### 1.4.5. Home Visiting

In home visiting programmes, nurses or other trained parent ‘coaches’ provide child development and parenting information to parents and families. This information is usually geared towards monitoring child development, as well as creating a safe and stimulating home environment for children. It is also an opportunity for practitioners to connect families with essential medical, educational and community services. Although the majority of programmes target newborns, there are many programmes which provide services in the antenatal period and keep families enrolled until children are 3 – 5 years.
Systematic reviews of these programmes have yielded mixed results (Daro, 2006). When home visiting is well implemented, evaluators have seen a significant reduction in child-abuse risk and improvements in child and family functioning (Geeraert, Van der Noorgate, Grietens & Onghena, 2004; Sweet & Appelbaum, 2004). Evaluation research has shown that home visiting programmes can increase positive birth outcomes for children, decrease the rates of child abuse and neglect and increase children’s literacy and language skills and school completion rates (Daro, 2006). One of the most successful home visiting programmes has been the Nurse-Family Partnership (NFP; Olds et al., 1998; Olds, Henderson, Kitzman, & Cole, 1995). The main goal of the NFP is to improve outcomes for families by empowering low-income, first-time mothers through evidence-based nurse home visiting. This programme provides visits ranging from weekly to monthly, beginning during pregnancy through to the child’s second birthday. One unique aspect of the NFP has been its carefully planned and well-conducted randomised controlled trial evaluations. These evaluations have shown that there are benefits in all child development domains (Daro, 2006). Similar Nurse Home-Visiting programmes have had success in countries such as Kazakhstan, Turkey and Australia (Irwin, Siddiqi & Hertzman, 2007).

Despite the successes reported in many of these programmes, some groups have raised concern about the efficacy of home visitation (Gomby, 2005). Some reviews have highlighted inconsistencies in programme quality and outcomes and have cautioned against dependence on a single approach to intervention. In many cases, the high expectations of home visiting impact have not been supported by research (Daro, 2006). Home visitation may be best viewed as an important aspect of a comprehensive approach to supporting families and improving a child’s developmental trajectory. Regardless, for current home visiting programmes to be effective, administrators must focus on issues of quality, training, content and supervision to ensure that programme outcomes are achieved and maintained.

1.5. THE FIRST THREE YEARS

In recent years, there has been a renewed interest in the 0 – 3 year period. New research points to the unique vulnerability of children during particular periods of development such as gestation, infancy and very early childhood (Golding, Jones, Bruné & Pronczuk, 2009). In the first few years of life there is rapid proliferation of neural connections in the brain – as many as 700 new neural connections per second (Shonkoff, 2009). This is to accommodate a wide range of environments and interactions. After this initial period, connections proliferate and prune in a prescribed order, with more complex brain circuits being built upon earlier, simpler circuits (Shonkoff, 2009). In other words, brain plasticity decreases with age. As the brain matures and becomes more specialized, it is less capable of reorganizing and adapting to new challenges. Consequently, the first three years of life are especially important because it is easier to influence a child’s developing brain architecture than to rewire parts of its circuitry during adolescence or adulthood (National Scientific Council on the Developing Child, 2007). The quality of a child’s early environment and the availability of appropriate experiences during sensitive periods of development are crucial in determining the strength or weakness of the brain’s architecture, which, in turn, determines health, cognitive abilities and self-regulation (National Scientific Council on the Developing Child, 2007).

The evidence presented demands that researchers and policymakers pay special attention to ensuring positive outcomes for the most vulnerable young children and the most cost-effective strategies for achieving optimal development (Shonkoff & Phillips, 2000).

Programmes targeted to the first three years have included parent support programmes, community-based home visiting programmes and health sector linked home visiting programmes.
1.6. INTERVENTIONS FOR CHILDREN BIRTH TO THREE YEARS IN THE CARIBBEAN

In the Caribbean region, there are a few home visiting programmes focused on child health and development.

1.6.1. Health-Focused Home Visits

In several Caribbean countries, nurses/midwives or health paraprofessionals, known as Community Health Aides (CHAs), visit families for a few weeks after birth to monitor the mother and newborn. In the case of the newborn, these programmes are generally focused on growth, nutrition and health.

1.6.2. Child Health and Development Focused Home Visits

1.6.2.1. Roving Caregiver Programme

The Roving Caregiver Programme (RCP), developed in Jamaica in 1992, is primarily aimed at providing stimulation to at-risk children 0 – 3 years, who are not in formal day care/education programmes, through a home visitation intervention model. The specific goals of the RCP are to increase parenting knowledge, encourage good parenting behaviour and change inappropriate child rearing practices (Wint & Janssens, 2008). The programme combines health, nutrition, parenting and income generation of parents. The programme is delivered by personnel known as “Rovers” or “Roving Caregivers”, who are often from the community, and have a minimum of passes in two subjects in the regional Caribbean Examinations Council at the Grade 10 level. Rovers receive a two week intensive training programme. An experimental evaluation of the RCP in Jamaica in 2004 demonstrated a significant impact (Effect size of 0.5) on the cognitive abilities, particularly in receptive language, fine motor skills and hand and eye coordination, of children 3 – 36 months (Engle, Black, Behrman et al., 2007; Powell, 2004;). However, while parental knowledge had improved, there was no significant change in parental practice. This was felt to be due to limited involvement of parents in the stimulation of children by rovers. Programme adjustments were subsequently made to ensure greater parental participation. Because of its success in Jamaica, the RCP has been replicated in many other Caribbean and Eastern Caribbean countries.

An evaluation of the replication of the RCP programme in St. Lucia in 2008 showed that one year after RCP programme implementation, there was significant improvement (0.5 SD) in fine motor function and visual reception for the youngest children enrolled in the programme, those 6 – 18 months old, but this was not found for those 18 – 30 months old. Additionally, there was no improvement in cognitive or socio-emotional development. A further evaluation two years after programme implementation showed that the fine motor improvement had faded, but the visual reception improvement had strengthened. In-depth interviews and focus groups with parents, however, indicated that RCP had positive effects on their parenting knowledge and self-confidence (Wint & Janssens, 2008).

1.6.2.2. Community Health Aide Delivered Programme

An experimental evaluation of the integration of an early childhood stimulation programme, primarily focused on parenting support, in the existing home visitation programme of Community Health Aides was conducted in Jamaica in 2008. Children 9 – 30 months showed significant improvement in speech, eye-hand co-ordination and non-verbal reasoning, with an effect size of 0.8. Parenting knowledge and practice also improved.
PART 2: ST. VINCENT AND THE GRENADINES: A COUNTRY PROFILE

2.1. THE LAND

St. Vincent and the Grenadines is an archipelagic country located in the Eastern Caribbean specifically, the Lesser Antilles between Grenada and St. Lucia. The islands are southwest (SW) of St. Lucia and west (W) of Barbados. The country is a part of the Caribbean Community (CARICOM) and the Organisation of Eastern Caribbean States (OECS). The islands gained Independence from Britain in 1979.

St Vincent and the Grenadines consists of thirty two (32) islands and cays; nine (9) of these islands are inhabited and twenty-three (23) uninhabited. The total land mass is 389 square kilometres with St Vincent being the largest island of 344 square kilometres and the Grenadines measuring 45 square kilometres. The largest city and capital of St. Vincent and the Grenadines is Kingstown which is located at the southeast coast of the island. Bequia is the largest island in the Grenadines.

2.2. THE PEOPLE

According to the United Nations (United Nations Statistical Division) in 2013 the population of St. Vincent and the Grenadines was 109,373. The age category accounting for the highest proportion of the population was the 25 – 54 age group (42.6%), this was followed by the age group of birth – 14 years (22.9%), then 15 – 24 years (16.7%), 55 – 64 years (9.2%) and finally 65 years and over (8.6%).

The main ethnic group in St. Vincent and the Grenadines are descendants of Africa accounting for 66% of the population. The other ethnic groups are of mixed descent (19%), East Indian (6%), Europeans (4%) and Caribs (2%). The dominant religion is Christianity and the official language is English.

According to the 2013 Human Development Report (United Nations Development Program, 2013), the country ranked 83 out of 187 countries on the human development index based on the following indicators; expected years of schooling and life expectancy at birth. In 2012, life expectancy at birth was 72.4 years; 75 years and 70 years for females and males respectively.

2.3. THE ECONOMY

St. Vincent and the Grenadines ranked as an upper middle income country by the World Bank, has a GDP of US$ 725.6 million (World Bank. 2013) and a GNI per capita of US$ 6,380. According to the 2008 Country Poverty Assessment (Kairi Consultants Ltd., 2009), St. Vincent and the Grenadines has a poverty rate of 30.2% for households and 37.5% for the population. There is a 15% unemployment rate.
It is one of the poorest islands in the Eastern Caribbean and has one of the highest poverty rates, with only Dominica and Grenada having higher rates (Kairi Consultants Ltd., 2009). Poverty reduction has been a primary target for the government for over a decade. This is in an effort to achieve Millennium Development Goal 7 (MDG7).

2.4. THE CHILDREN

The population of children (i.e. those under the age of 18 years) is 34,000 (31.2%). Those under 5 years account for 8.3% of the population (UNICEF, 2014). There are 2,000 births per year, with 8% of births being less than 2,500g or of low birth weight. The neonatal mortality rate (under the age of 28 days) is 15 per 1,000 live births; the infant mortality rate (under the age of one year) is 23 per 1,000 live births and the under-five mortality rate is 23 per 1,000 live births (UNICEF, 2014). Immunisation coverage for BCG is
97% and for three doses of DPT and oral polio is 96%. The gross enrolment rate for pre-primary education is 80%, for primary education is 98% and for secondary education is 85% (UNICEF, 2014).

Of the 8,288 children 0 – 4 years, 2984 live in poverty. The poverty rate in this age group is 36%, higher than the national population rate of 30.2% for households. Poverty is spread throughout the island, with the highest concentrations in the villages of Calliaqua, Georgetown/Sandy Bay and the suburbs of Kingstown (Charles & Associates Inc., 2011).

2.5. THE EARLY EDUCATION SYSTEM

The Ministry of Education is responsible for the supervision and monitoring of all early childhood education facilities for children under five years. St. Vincent and the Grenadines has 34 day care centres which provide services to the 0 – 2 age group, and are owned by the private sector, faith-based organisations and NGOs. It also has 126 preschools providing services to the 3 – 5 year old age group; nine are owned by the Government and the remainder are owned and operated by the private sector, faith-based organisations and NGOs (Charles & Associates Inc., 2011). Government owned preschools are free of charge and include a feeding programme.

Data from the Ministry of Education indicates that in 2009, only 11.5% (642) of the 5,581 children in the birth to two cohort were enrolled in centre-based day care programmes (Charles & Associates Inc., 2011).

2.6. THE PRIMARY HEALTH CARE SYSTEM

The Ministry of Health, Wellness and the Environment (MHWE) is responsible for all public health programmes in the country. The primary health care system consists of thirty nine (39) health centres spread over nine (9) health districts offering a wide range of services. Maternal and child health services, including prenatal and post natal care, midwifery and child health services, are provided at health centres by the maternal and child health team. The maternal and child health team includes Public Health Nurses, Family Nurse Practitioners, Registered Nurses, Nursing Assistants and Community Health Aides (CHAs). There are forty three (43) Community Health Aides providing service throughout the country, using a mixed home visiting and clinic service model. Home visitation includes provision of basic primary health care to individuals and families; basic education of families in a number of areas including nutrition, family life and dental care; food preparation demonstrations and follow up with defaulters from clinic.

2.7. PROGRAMMES TO SUPPORT VULNERABLE CHILDREN 0-3 YEARS

There have been two main interventions to support vulnerable children 0-3 years in St. Vincent and the Grenadines: the Roving Caregivers Programme and the Early Childhood Health and Outreach (ECHO) programme.

2.7.1. The Roving Caregivers Programme

2.7.1.1. Programme Objectives

The St. Vincent and the Grenadines Roving Caregivers Programme was the first national attempt to provide early stimulation services for the most vulnerable children. Its objectives were:

- To serve as a safety net for children 0-3 years who are denied any form of early stimulation and are generally exposed to inappropriate practices;
- To equip parents with the knowledge, skills and attitude that will be needed to allow them to deliver early stimulation experiences and activities to children;
- To provide training opportunities for children, parents, rovers and supervisors thereby developing a cadre of skilled caregivers capable of implementing and replicating the program as the need for expansion arises; and
- Creating employment opportunities for young persons.

2.7.1.2. Programme Administration
The NGO VINSAVE was the lead agency with responsibility for administering the pilot project. However, the Ministry of National Mobilization began administering the programme in January 2009, in collaboration with the Caribbean Child Care Support Initiative (CCSI). Funding for the RCP programme was provided primarily by the Bernard van Leer Foundation (BvLF); BvLF support covered personnel and administrative costs. UNICEF provided support for training and material production and the Canada Fund for local initiatives which contributed support for public awareness through community radio. The SVG government provided a small subvention in 2010, as well as in kind support including duty concessions on imports, use of the government printery for printing and other forms of in-kind support, when possible. Support was also provided by the Ministry of Education, Youth Empowerment Services, Organization of American States (OAS) and the Basic Needs Trust Fund (BNTF) of the Caribbean Development Bank.

2.7.1.3. Programme Location and Enrollment
The project commenced as a pilot in three communities in November 2004, but was officially launched in July 2005. The pilot phase commenced in three communities: Byera/Chester Cottage at the eastern side of the island; Sandy Bay in the northern region and Barrouallie at the western region. The target areas for the programme were poor communities in which there were no day care centers. The project expanded to a total of eight communities, adding communities of Overland, London, Magum, Orange Hill and Colonaire. The RCP staff report that the main reason for the expansion was the initial success in the first villages and the testimonies of parents who were recipients of the programme. The strong request for expansion came from the parents (Amsterdam Institute for International Development, 2010).

In 2011, the programme served 308 children from 301 families - approximately 17% of the poor children in SVG (Charles & Associates Inc., 2011).

2.7.1.4. Programme Staff
The program staff in May 2011 consisted of a Coordinator, two supervisors, two volunteers and rovers. At the onset of the programme 25 Rovers were employed to carry out the stimulation. This was reduced to 19 in 2009, due to cost. Each Rover served approximately 15 families. Rovers received training in child development, child stimulation, language skills and toy making, in an intensive two-week workshop before commencing activities, and in other fortnightly workshops throughout the year, culminating in a total of 24 in-service training days per year. Practical aspects of the training programme include shadowing of an existing Roving Caregiver. The initial curriculum guide developed in Jamaica, was revised in 2009, with the support of the High Scope Foundation. In 2008, some of the Rovers also completed the National Council on Technical & Vocational Education and Training (NCTVET) certification in ECD (Amsterdam Institute for International Development, 2010).
2.7.1.5. **Parent and Community meetings**

Apart from child stimulation, the Roving Caregivers held monthly parent meetings in each village to share programme progress and receive feedback from parents. Community meetings were also held monthly. These were attended by a broad group of community members and discuss topics which are important for the whole community.

2.7.1.6. **Programme Outcome**

No evaluation of programme outcome has been conducted in St. Vincent and the Grenadines. However, as mentioned earlier, an evaluation in St. Lucia, one year after RCP programme implementation, showed significant improvement in fine motor function and visual reception for the youngest children enrolled in the programme, those 6-18 months old, but this was not found for those 18 to 30 months old. Additionally, there was no improvement in cognitive or socio-emotional development. Two years after programme implementation, the fine motor improvement had faded, but the visual reception had strengthened (Wint & Janssens, 2008).

2.7.1.7. **Cost Analysis**

In 2008, the cost per child per annum of implementing the Roving Caregivers Programme in St. Vincent was $US 416 or EC$ 1110.721. A cost benefit analysis undertaken in St. Lucia showed that at a conservative estimate of modest effects on school enrolment, the programme showed large benefit-to-cost ratios that are in line with other ECD programmes and well above those of traditional investments. A 3 percentage point increase in primary school enrolment yielded a benefit-to-cost ratio of 1.32, or a return on investment of 32%. If both primary and secondary school enrolment increase by three percentage points, the benefits-to-cost ratio increases to 2.67. Return on investments would increase further with an increased number of participants, by reducing unit costs (Amsterdam Institute for International Development, 2010).

2.7.2. **The ECHO Programme**

2.7.2.1. **Genesis**

With the knowledge that support for the RCP programme from the BvLF would end in 2011, mechanisms to sustain an early childhood stimulation programme were actively sought by the government of St. Vincent and the Grenadines.

A review of the RCP programme was done in 2006 with the view of exploring the options for the consolidation of RCP concepts and methodologies, and to extend its reach and coverage in a national context. The RCP programme was identified as being faced with numerous challenges, the primary one being institutionalization and sustainability. However there was also concern about image, certification, finances, advocacy and level and capacity of Rovers and the ability and resources to sustain services to a large cross-section of families (ECHO Proposal, Community Nursing Services, Ministry of Health & the Environment, 2009).

Institutionalisation of the early stimulation programme within the Community Nursing Service Programme was considered to be a possible option. Here, there were Community Health Aides, (CHAs) who received specialized training to work with individuals and families, did home visits and worked under the supervision of the Health Nursing Supervisor. These roles were felt to place them in a strategic position

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1 1 USD = 2.67 EC$
to support parent education and child development. It was recognised that, as child stimulation was not included in their six month training programme, additional training in this area was necessary. The concepts and training tools used by the RCP were to be used in this training programme.

A proposal for this model, known as the ECHO programme was developed for the government of St. Vincent and the Grenadines by the Caribbean Child Support Initiative (CSI). The proposal identified and described four steps for a pilot programme to be undertaken: Assessment, Planning, Implementation and Monitoring and Evaluation and provided a budget. Concerns raised by stakeholders during the consultation process for the pilot were also documented and addressed in the proposal. These included the addition of work tasks to the CHAs without changes in their job description and additional remuneration; the termination of the RCP and its impact and the need for training and administrative support. Importantly, there was also a concern of financing and sustainability of the ECHO programme (ECHO Proposal, Community Nursing Services, Ministry of Health & the Environment, 2009).

It was anticipated that once the pilot programme was completed, evaluated and modified, it would be implemented in health districts across St. Vincent and the Grenadines (ECHO Proposal, Community Nursing Services, Ministry of Health & the Environment, 2009). A pilot ECHO Programme was subsequently implemented in 2010 and 2011.

A report on the institutionalisation of the ECHO programme was completed in 2011, prior to evaluation of the pilot programme (Charles & Associates Inc., 2011). This report recommended immediate institutionalisation of the programme in a phased manner, commencing January 2012 and provided an implementation plan. It was felt that the additional annual costs of EC$ 561,015 were justifiable in the context of the national benefits from this investment.

The report also indicated the institutional adjustments that were required for national implementation. These included:

- Adjustment to the Job Description of CHAs and a commensurate salary increase
- Creation of a new position of Health Care Assistants (HCAs) and hiring the existing 18 Rovers in this post, as well as 38 additional staff to serve the vulnerable children in the 11 census areas
- Provision of budgetary allocation for programme materials
- Development of training programmes for CHAs and HCAs
- Incorporation of record keeping on children’s progress into the Ministry of Health, Wellness and the Environment as a monitoring and evaluation mechanism

**PART 3: THE ECHO PILOT PROGRAMME**

**3.1. PILOT PROGRAMME CONCEPTUALISATION**

The Early Childhood Health Outreach (ECHO) Programme was a response of the Government of St. Vincent
and the Grenadines (SVG) to the available international and regional evidence on the importance of providing stimulation to vulnerable children 0-3 years. The vision was the implementation of an effective national programme that would provide the required interventions for all vulnerable Vincentian children and families. The decision was taken to conduct a pilot programme, and to monitor and evaluate the outcome of the pilot, in order to guide national implementation.

3.2. PROGRAMME OBJECTIVES

The objectives of the Early Childhood Health Outreach pilot programme, as indicated by the 2009 programme proposal (ECHO Proposal, Community Nursing Services, Ministry of Health & the Environment, 2009) were as follows:

1. Increase parental/caregiver awareness of the importance of early childhood cognitive, social and emotional development in addition to techniques to help promote the good health and development of young children.

2. Monitor the early development and health of young children who are not currently exposed to adequate access to early childhood services.

3. Increase the partnership between the parents/caregivers and healthcare providers about early childhood development.

3.3. PROGRAMME DESIGN

The Roving Caregiver Programme (RCP), developed in Jamaica and the High Scope Programme (HSP) for children 0-3 years, developed in the USA, were identified as having those principles and methodologies that would best meet the needs of the children and families of SVG. The ECHO pilot programme was therefore developed by integrating the RCP and HSP programmes into a single model. Based on the RCP, the ECHO programme was designed to be a community based home-visiting programme, delivered to at risk children 0-3 years, with a focus on child stimulation, parent support and education on child development and parental financial independence. It should be noted that parental financial independence was not one of the initial programme objectives. The HSP principles adopted ensured that participatory learning, exploration and playing with infants and toddlers were integral to the programme. An additional feature of the programme was its delivery by health care para-professionals known as Community Health Aides (CHAs) and supervision by community-based nursing staff located at clinics; a recent addition to some models of the RCP.

3.4. PROGRAMME SUPPORT

The pilot had the technical and/or financial support of a number of regional and international development partners, including the Caribbean Child Support Initiative (CCSI), Bernard Van Leer Foundation (BvLF), United Nations Children Fund (UNICEF) and Pan American Health Organization (PAHO).

3.5. PROGRAMME ADMINISTRATION AND MANAGEMENT

The Ministry of Health, Wellness and the Environment (MHWE) had full responsibility for pilot programme development and implementation. The organisational structure of the pilot programme (Figure 2) indicates the management structure within the MHWE. The Minister takes overall responsibility for all
programmes within the MHWE, with the Permanent Secretary having full fiduciary responsibility. The pilot programme was managed by the Maternal and Child Health Services Division in the MHWE, with direct responsibility being that of the Chief Nursing Officer, under whose supervision the Community Nursing Service falls. The Community Nursing Service has responsibility for the community-based well child clinics. At the clinics, the staff/community nurse manages all nursing services, including those provided by the CHAs.

The Administrative Committee and the ECHO pilot coordinator were temporary structures within the MHWE, which provided significant support to the programme. As indicated by the Year 2 Report of the Pilot Project, the Administrative Committee was chaired by the Permanent Secretary and had eleven (11) members in the first year (Year 2 M & E Report, 2012). In the second year, cross-ministerial membership was achieved by the addition of representatives from the Ministries of Education and National Mobilisation (Table 1).

Table 1. Composition of Administrative Committee

<table>
<thead>
<tr>
<th>Title</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent Secretary (Chair)</td>
<td>MHWE</td>
</tr>
<tr>
<td>Health Planner</td>
<td>MHWE</td>
</tr>
<tr>
<td>Chief Nursing Officer</td>
<td>MHWE</td>
</tr>
<tr>
<td>Senior Nursing Officer, Community Nursing Service</td>
<td>MHWE</td>
</tr>
<tr>
<td>Chief Health Educator</td>
<td>MHWE</td>
</tr>
<tr>
<td>RCP Coordinator</td>
<td>RCP Programme</td>
</tr>
<tr>
<td>Health Nursing Supervisor, Calliaqua District</td>
<td>MHWE</td>
</tr>
<tr>
<td>Tutor</td>
<td>Division of Nursing Education</td>
</tr>
<tr>
<td>Paediatrician</td>
<td>MHWE</td>
</tr>
<tr>
<td>ECHO Coordinator</td>
<td>MHWE (Temporary Staff)</td>
</tr>
<tr>
<td>ECHO Administrative Assistant</td>
<td>MHWE (Temporary Staff)</td>
</tr>
<tr>
<td>Representative</td>
<td>Ministry of Education</td>
</tr>
<tr>
<td>Representative</td>
<td>Ministry of National Mobilisation</td>
</tr>
</tbody>
</table>
Unlike the senior management staff at the MHWE, the field staff at clinics and other members of the Administrative Committee, the ECHO Pilot was the primary responsibility of the Pilot Coordinator. The ECHO Work Plan document (Table 2) indicated the roles of the Administrative Committee and the Pilot Coordinator.

**Administrative Committee:**
The Administrative Committee was responsible for monitoring all the activities of the Pilot Coordinator.

**Pilot Coordinator:**
The Pilot Coordinator had a number of roles as indicated below:

- Establishment of Administrative Component for ECHO Project (Identify office space, employ
consultant and Administrative Assistant, and purchase equipment and supplies)

- Facilitate & encourage community involvement in promoting & supporting the ECHO pilot
- Plan and oversee training programme for CHAs
- Assign families to CHAs in pilot
- Periodic programme assessment at 6 months, 1 year and end
- Periodic presentation of programme assessment to Administrative Committee at 6 months and 1 year and implement changes as recommended
- Propose institutionalisation of programme to policy makers
- Oversee institutionalisation of programme

**Staff / Community Nurse:**
The Staff/Community Nurse was responsible for supervising CHAs. The nurse also assisted in identifying families for the pilot programme.

**Community Health Aide:**
The main role and responsibility of the CHA, as part of the community health team, is to bridge the gap between the health centre and the community. CHAs visit homes to provide basic health support to those in need. Specific to the ECHO programme, the Community Health Aide was responsible for stimulating the children, monitoring and tracking children’s developmental status, educating parents about raising healthy children and teaching parents about backyard gardening

### 3.6. INVOLVEMENT OF OTHER GOVERNMENT MINISTRIES, DEPARTMENTS OR AGENCIES

The parental financial independence aspect of the programme was focused on the development of backyard gardens. The Ministry of Agriculture supported the parental independence aspect of the programme by providing seeds for backyard gardens
Table 2. ECHO Pilot Project Work Plan

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>TASK</th>
<th>TIME FRAME</th>
<th>RESPONSIBLE PERSON</th>
<th>RESULT INDICATOR/ SUCCESS CRITERIA</th>
<th>MONITORING PARTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Establish Administrative component for the ECHO project</td>
<td>1:1 Identify temporary and permanent location for office. 1:2 Identify in country consultant. 1:3 Purchase of equipment, supplies and materials. 1:4 Identify Administrative Assistant</td>
<td>February 2010</td>
<td>Administrative Committee &amp; ECHO Coordinator</td>
<td>Office space located and staff in place Consultant appointed Equipment, supplies &amp; materials requisite and purchased Administrative Assistant appointed</td>
<td>Administrative Committee</td>
</tr>
<tr>
<td>2: Facilitate &amp; encourage Community involvement in promoting &amp; supporting the ECHO project</td>
<td>2:1 Continuous education and communication about ECHO project using media; H/C; CBO etc</td>
<td>February – May 2010</td>
<td>Consultant &amp; Coordinator</td>
<td>Community acceptance and active support of the ECHO program</td>
<td>Administrative Committee</td>
</tr>
<tr>
<td>2:2 Plan for training</td>
<td>2:2.1 Discuss with RCP Coordinator — re RCP curriculum 2:2.2 Develop training tools and education programs for ECHO program 2:2.3 Develop monitoring and evaluation tools</td>
<td>Coordinator</td>
<td>Consultant &amp; Coordinator</td>
<td>Discussion held and multilateral agreement reached Training tools and education program in place Tools in place for monitoring and evaluation</td>
<td>Administrative Committee</td>
</tr>
<tr>
<td>3: Train and assign CHA with families</td>
<td>3:1 Select and assign CHA to participating families and children 3:2 Resource persons contacted to train CHA; SN; HNS; FNP in the pilot district</td>
<td>June-July 2010</td>
<td>Coordinator</td>
<td>- 100 families selected &amp; consulted - CHA assigned A cadre of 16 workers trained to provide home-based stimulation from 0-3 years old. (1) 8 wks training course and practical conducted</td>
<td>Administrative Committee</td>
</tr>
<tr>
<td></td>
<td>3:3 Conduct practical field work 3:4 Utilize media to ensure community involvement</td>
<td>Ongoing</td>
<td>Consultant &amp; Coordinator</td>
<td>(2) Fortnightly peer sharing of experiences Mass media utilized, community awareness and active support given to the program</td>
<td>Administrative Committee</td>
</tr>
<tr>
<td>OBJECTIVES</td>
<td>TASK</td>
<td>TIME FRAME</td>
<td>RESPONSIBLE PERSON</td>
<td>RESULT INDICATOR/ SUCCESS CRITERIA</td>
<td>MONITORING PARTY</td>
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</tr>
<tr>
<td>4: Assess program</td>
<td>4:1 First 6 months assessment of the ECHO program</td>
<td>August 2010</td>
<td>Consultant &amp; Coordinator</td>
<td>Data collated and analyzed</td>
<td>Administrative Committee</td>
</tr>
<tr>
<td>5: Present findings</td>
<td>5:1 Presentation of findings and suggestions for programmatic changes noted</td>
<td>September -October 2010</td>
<td>Consultant &amp; Coordinator</td>
<td>Consultation conducted and necessary changes made to the program Changes established</td>
<td>Administrative Committee</td>
</tr>
<tr>
<td>6: Select additional families</td>
<td>6:1 Selection of additional families make a total of 200</td>
<td>November 2010</td>
<td>Coordinator</td>
<td>Families selected and consulted</td>
<td>Administrative Committee</td>
</tr>
<tr>
<td>7: Train staff</td>
<td>7:1 Training of new staff about ECHO program</td>
<td>January – February 2011</td>
<td>Coordinator</td>
<td>New staff trained to provide home-based stimulation 0-3 years old</td>
<td>Administrative Committee</td>
</tr>
<tr>
<td>8: Assess ECHO pilot project</td>
<td>8:1 One year assessment and presentation of ECHO pilot project 8:2 Commence discussion to institutionalize the ECHO program</td>
<td>March – April 2010</td>
<td>Coordinator &amp; Consultant</td>
<td>Project analyzed and findings presented</td>
<td>Administrative Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>April – June 2011</td>
<td></td>
<td>Program accepted and included in the Advance proposal of the CNS for 2011</td>
<td></td>
</tr>
<tr>
<td>9: 1 Propose ECHO program</td>
<td>9:1 Proposal of the ECHO program to Policy makers 9:2 Training remainder of staff &amp; commencement of ECHO program</td>
<td>April – June 2011</td>
<td>Consultant &amp; Coordinator</td>
<td>Policy makers indicated their commitment - New staff trained - Ten families in each H/D selected and consulted</td>
<td>Administrative Committee</td>
</tr>
<tr>
<td>9:2 Train &amp; assign CNS staff to families</td>
<td></td>
<td>July-August 2011</td>
<td>Coordinator &amp; Consultant</td>
<td>- Home-based stimulation provided from birth-3 years</td>
<td></td>
</tr>
<tr>
<td>10: Assess the ECHO program</td>
<td>10:1 Collaborate with field workers to compile data for the assessment of the ECHO program 10:2 Presentation of findings; discussions and suggestions prior the implementation of ECHO program</td>
<td>September – December 2011</td>
<td>Coordinator</td>
<td>Program assessed, documentation and presented</td>
<td>Administrative Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Consultant &amp; Coordinator</td>
<td>Consultation conducted and necessary changes made to the program</td>
<td></td>
</tr>
<tr>
<td>11: Institute the ECHO program</td>
<td>11:1 Institutionalize the ECHO program</td>
<td>January – April 2011</td>
<td>Coordinator</td>
<td>ECHO program integrated into the Primary Health Care System</td>
<td>Administrative Committee</td>
</tr>
</tbody>
</table>
3.7. PROGRAMME INITIATION AND ENROLMENT

There were two phases of the ECHO pilot programme, the first in 2010 and the second in 2011. Once children and families were enrolled in the pilot, they were expected to stay in the programme for a one year period. A total of 182 children and families were enrolled, 84 in year 1 and 98 in year 2.

3.8. PROGRAMME RECIPIENTS

3.8.1. Selection of Region for Piloting

SVG has a total of nine health districts. The health district of Calliaqua, located at the southern tip of the island of St. Vincent, was selected to pilot the ECHO programme. The main reason for selection was its identification as the district with the greatest proportion of disadvantaged citizens, and an expected high proportion of children at risk. The SVG Poverty Assessment identified Calliaqua as accounting for 19.9% of the total amount of poverty in St. Vincent. Additional reasons for the selection of Calliaqua were the absence of any previous or current services for children under the age of 3 years; Calliaqua did not have any day care services and the RCP programme had never been offered there.

3.8.2. Selection of Child and Family Participants

During the first phase of the programme, there were no individual eligibility criteria. CHAs and Nursing Supervisors at community clinics identified families with the greatest need, as indicated by absence of enrolment in pre-school and assessment of disadvantage. At the second phase of enrolment, eligibility criteria were developed to improve targeting. The eligibility criteria included demographic characteristics (e.g. age, poverty), health characteristics (e.g. nutritional status, low birth weight) and developmental characteristics (e.g. minor developmental delay) as indicated in Table 3. Project documents did not indicate how the criteria were defined.

Table 3. Eligibility Criteria for ECHO Enrolment (Phase 2)

<table>
<thead>
<tr>
<th>Category</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographic</td>
<td>Child age 0-3 years</td>
</tr>
<tr>
<td></td>
<td>Low parental educational level</td>
</tr>
<tr>
<td></td>
<td>Living in poverty</td>
</tr>
<tr>
<td>Health</td>
<td>Babies born to mothers with little or no pre-natal care</td>
</tr>
<tr>
<td></td>
<td>Babies born to mothers with pre-natal complications</td>
</tr>
<tr>
<td></td>
<td>Babies born with perinatal complications</td>
</tr>
<tr>
<td></td>
<td>Low birth weight or premature babies</td>
</tr>
<tr>
<td></td>
<td>Poor nutritional status</td>
</tr>
<tr>
<td>Developmental/Educational</td>
<td>Not attending pre-school</td>
</tr>
<tr>
<td></td>
<td>Minor developmental delay</td>
</tr>
</tbody>
</table>
3.9. TRAINING

3.9.1. Training of CHAs

Project documents\(^2\) indicated that the Project Coordinator had major responsibility for designing the CHA training programme. There was no curriculum document available for the first and second phases of the training programme. The programme utilised for the two training phases required CHAs to complete 150 hours of training full time over a 6-8 week period. The training programme included instructional, classroom and practical sessions. The instructional and classroom sessions included 22 topics delivered over 41 sessions, as indicated in Table 4. While highly trained facilitators delivered the theoretical (classroom) aspects\(^3\) of the training programme, CHAs were grouped with Rovers from the RCP to obtain practical work experience in disadvantaged communities.

Forty-one (41) of the total complement of forty-three (43) CHAs completed theoretical and practical training in two phases, consistent with the phases of the pilot. Nineteen (19) CHAs were trained in June-July 2010 and twenty-two (22) in January-March 2011. This number included all CHAs and not just those who would deliver the pilot programme.

Evaluation forms were administered after each session and at the end of the theoretical and practical training. These forms were analyzed and the results presented to stakeholders as part of the pilot project activities. Overall, CHAs from both phases reported positively on the training programme. The majority of trainees gave high appraisals of facilitators and indicated that the training programme was organised and appropriate and that the content and presentation of the training material were good. Excellent rapport between CHAs and Rovers during the practical session was also reported. Most of the unsatisfactory comments related to the theoretical aspects of training were focused on the training facility and meals. However, both groups reported that the session on ‘CHA Job Description’ needed review and that there needed to be more consultation with CHAs regarding changes to their roles.

In addition, 80% of CHAs from the first training group stated that there were inadequate materials for training. This may have been addressed for the second phase of training, as this was not a recurring concern.

Overall, all of the CHAs indicated that they had gained valuable skills and knowledge from the training programme and many believed that ECHO would benefit families in the poorest areas of SVG.

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\(^2\) Early Childhood Health Outreach Pilot Project Monitoring and Evaluation February 2010 – January 2012, Second Year Report

\(^3\) Details on the curriculum and specific topics are provided in the next section
Table 4. CHA Instructional Programme Topics

<table>
<thead>
<tr>
<th>TOPICS FOR INSTRUCTIONAL SESSIONS</th>
<th>NO. OF SESSIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Growth and development at various stages of the life cycle 0 – 3 years</td>
<td>4</td>
</tr>
<tr>
<td>2 Early childhood stimulation</td>
<td>2</td>
</tr>
<tr>
<td>3 Home Visiting</td>
<td>1</td>
</tr>
<tr>
<td>4 Respect for self, others and the environment</td>
<td>2</td>
</tr>
<tr>
<td>5 Developmental assessment in children 0 – 3 years</td>
<td>2</td>
</tr>
<tr>
<td>6 Active participatory learning from infants &amp; toddlers</td>
<td>2</td>
</tr>
<tr>
<td>7 Developmental assessment in children 0 – 3 years</td>
<td>2</td>
</tr>
<tr>
<td>8 Effective Communication</td>
<td>2</td>
</tr>
<tr>
<td>9 Developing and maintaining therapeutic relationships</td>
<td>2</td>
</tr>
<tr>
<td>10 Supportive adult-child interaction</td>
<td>2</td>
</tr>
<tr>
<td>11 Support skills necessary for families</td>
<td>1</td>
</tr>
<tr>
<td>12 Facilitating parental learning</td>
<td>1</td>
</tr>
<tr>
<td>13 Intellectual empowerment</td>
<td>2</td>
</tr>
<tr>
<td>14 Community Health Aides – family partnership</td>
<td>1</td>
</tr>
<tr>
<td>15 Professionalism</td>
<td>1</td>
</tr>
<tr>
<td>16 Child abuse 0 – 3 years</td>
<td>1</td>
</tr>
<tr>
<td>17 Nutrition 0 – 3 years</td>
<td>2</td>
</tr>
<tr>
<td>18 Ages &amp; Stages of development</td>
<td>4</td>
</tr>
<tr>
<td>19 Making inexpensive toys for stimulation purposes</td>
<td>3</td>
</tr>
<tr>
<td>20 Principles of teaching and learning</td>
<td>1</td>
</tr>
<tr>
<td>21 Principles of child development &amp; learning (Neuro-developmental principles)</td>
<td>2</td>
</tr>
<tr>
<td>22 Job description of Community Health Aides</td>
<td>1</td>
</tr>
</tbody>
</table>

3.9.2. CHA Training Programme Curriculum Development

After the two training periods, an education consultant was engaged to formalise the curriculum. This entailed compiling a curriculum guide which described the goals and objectives of the training programme (Table 5) and provided outlines for each instructional session listed in Table 4. The final ECHO curriculum was strongly influenced by both the RCP curriculum and the High Scope 0 – 3 manual.

According to the guide, although the curriculum can be adapted to suit a number of different groups it was specifically designed for the training of CHAs in the Ministry of Health, Wellness and the Environment in St. Vincent & the Grenadines. The facilitators using the curriculum guide are urged to exercise flexibility in delivering their sessions by adjusting the methods, materials and activities based on the needs and composition of their trainees. The curriculum guide also included copies of checklists, evaluation forms and questionnaires to be used in both the ECHO training (Evaluation form for each instructional session; Evaluation form for the training programme; Fieldwork evaluation form) and in the delivery of the ECHO programme (Survey questions on Parent’s knowledge, attitude, behaviour and practice; Parent’s consent form to participate in the ECHO programme; Evaluation satisfaction form for parenting workshop; Parent

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4 The Early Childhood Outreach Programme Curriculum page 7
satisfaction checklist on CHA field work).

### 3.9.3. **Training of Supervisory Nursing Staff**

A one-day ECHO seminar was held in April 2011 for Nursing Supervisors and other Nursing staff. Sixteen (16) participants were exposed to ECHO objectives and procedures during this seminar.

**Table 5. ECHO Final Curriculum Training Programme Goals and Objectives**

<table>
<thead>
<tr>
<th>ECHO Training Programme Goals</th>
<th>ECHO Training Programme Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>✤ Facilitators and participants will help to create a congenial, classroom atmosphere in which the sharing and discussing of experiences will thrive;</td>
<td>✤ Within a congenial, classroom atmosphere, facilitators and participants will share and discuss ideas and experiences, identify pop-up setbacks and appropriately deal with them, in order to sustain effectiveness.</td>
</tr>
<tr>
<td>✤ Participants will be well informed with the overall growth and development in children from birth to three years (0 – 3 years);</td>
<td>✤ Facilitators will construct objectives for their individual sessions, share the objectives with the participants at appropriate times during the sessions, and fashion sessions to achieve the objectives.</td>
</tr>
<tr>
<td>✤ Participants will be better able to assist parents / guardians in promoting good health among their children from birth to three years, thereby resulting in a healthier nation;</td>
<td>✤ Participants will gain new knowledge or expand on previous knowledge concerning the nutrition, growth and development of children at different ages and stages of the life cycle from birth to three years.</td>
</tr>
<tr>
<td>✤ Participants will know what is expected of them – what they should do and how they should act – when they go out into the communities on their visits;</td>
<td>✤ Participants will learn and practise the skills which are necessary to instruct / teach / show families how to produce inexpensive toys and stimulation materials, which will promote healthy growth in children birth to three years.</td>
</tr>
<tr>
<td>✤ In the communities, the Roving Caregivers and the Community Health Aides will work compatibly to ensure that the children and the parents benefit from the exercise;</td>
<td>✤ While employing the knowledge and skills learnt in the classroom, participants, on their visits to the communities, will interact with children, parents / guardians and the Roving Caregivers by demonstrating all round professionalism and competence.</td>
</tr>
<tr>
<td>✤ Parents will co-operate with all the stakeholders of the programme who will visit their homes to carry out prescribed duties;</td>
<td></td>
</tr>
<tr>
<td>✤ Participants will be enriched personally through the knowledge and leadership skills acquired in the classroom, which should positively influence their daily lives.</td>
<td></td>
</tr>
</tbody>
</table>
3.9.4. Training of All Nursing Staff: Integration of ECHO Programme in the Nursing Curriculum

In August 2011, a meeting was held at the Division on Nursing Education (St. Vincent & the Grenadines Community College) to discuss the integration of ECHO programme content into the nursing curricula. This meeting included presentations on the ECHO programme and a detailed review of nursing curricula. ECHO programme content was then compared with the Division on Nursing Education (DONE) curricula for Registered Nurses and Nursing Assistants to determine overlap. Based on this process, the ECHO content areas that were missing from the DONE curricula were added to two courses (Fundamentals of Nursing and Nursing 1), which were deemed suitable for the integration of key concepts. These content areas were:

- Early childhood stimulation
- Active participatory learning for infants & toddlers/play therapy
- Making inexpensive toys for stimulation purposes
- Supportive adult child interaction
- Detection of abnormalities

In addition, the Community Nursing objectives were updated to integrate developmental assessment of young children (0 – 3 years) using the Ages and Stages Questionnaire. A case study focused on the developmental assessment of children 0 – 3 years was also added to the course outlines of the Fundamentals of Nursing and Nursing 1.

From this meeting, several recommendations were made to ensure that the ECHO training programme could be adequately integrated into the DONE programmes. Firstly, there were several recommendations related to ensuring that the lectures who would be delivering the additional ECHO content had adequate training and support. Suggestions were made to provide additional training in specific areas such as play therapy and toy making. This is an area in which it was suggested that the ECHO programme staff could be actively involved. Secondly, there were concerns related to the oversight of the integration process (monitoring and evaluation of integration) and the supervision of lecturers, as well as students’ field practice. In some cases, individuals/committees were identified to carry out these functions. Finally, concerns were raised regarding the allocation of resources for some of the new content areas (e.g. making toys) and for additional teaching materials for course lecturers. It was determined that these items should be budgeted by DONE to ensure the successful delivery of the ECHO programme content.

3.10. PROGRAMME DELIVERY RESOURCES

Each CHA was provided with a kit to support programme delivery. The kit contained printed material for parent information and support, items to facilitate appropriate stimulation and items to promote making of toys for simulation. Please see Table 6 for details of items.
### Table 6. Programme Delivery Resources provided to CHAs

<table>
<thead>
<tr>
<th>Item Category</th>
<th>Item Description</th>
<th>Item Utilisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent Support / Education Material</td>
<td>ECHO Parent Brochure</td>
<td>Provide parents with programme details, objectives and benefits</td>
</tr>
<tr>
<td></td>
<td>Parent Instruction Booklet</td>
<td>Provide information about stimulating activities and making inexpensive toys out of trashables</td>
</tr>
<tr>
<td>Material facilitating child Interaction</td>
<td>McIntosh (Padded Leather Mat)</td>
<td>Spread on the floor so that CHA can be at the child’s level</td>
</tr>
<tr>
<td>Material to make Toys</td>
<td>Material to make multi-coloured sponge ball (pieces of fabric, sponge)</td>
<td>To stimulate child’s gross and fine motor skills and hand eye co-ordination and to teach colours, shapes and textures</td>
</tr>
<tr>
<td></td>
<td>Material to make rattles (discarded juice bottles, peas, rice, beans, pebbles and beads)</td>
<td>To stimulate fine motor skills, hearing and speech</td>
</tr>
<tr>
<td></td>
<td>Material to make sock puppet (cardboard, old sock, a piece of cloth, hair, eyes and nose)</td>
<td>To stimulate creativity, vocabulary, storytelling, problem solving skills, socio-emotional development, hearing and speech</td>
</tr>
<tr>
<td></td>
<td>Material to make 18” x 18” pillow (three different coloured fabrics, zippers, buttons, strings or laces and sponge or stuffing).</td>
<td>To stimulate gross and fine motor skills, vocabulary, creativity, personal-social skills, problem solving skills.</td>
</tr>
</tbody>
</table>

#### 3.11. PROGRAMME DELIVERY PROCEDURE

Programme delivery at the community level included both home visits and parent workshops.

**3.11.1. Home Visits**

Once children and families were identified, CHAs were responsible for scheduling appointments with the ECHO families. Following enrolment, a specific protocol of visits was to be followed. These include an initial visit and assessment, home visits, follow-up visits and assessments and supervisory visits (Table 7).
Table 7. ECHO Programme Visitation Schedule

<table>
<thead>
<tr>
<th>Professional Responsible</th>
<th>Description</th>
<th>Time Allotted</th>
<th>Frequency</th>
<th>Documents completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHAs</td>
<td>Initial Visit and Assessment</td>
<td>-</td>
<td>Within 14 days of enrollment</td>
<td>Ages and Stages Questionnaire (ASQ-3)</td>
</tr>
<tr>
<td>CHAs</td>
<td>Home visits for Stimulation</td>
<td>45-60 mins.</td>
<td>2 times / month</td>
<td>ECHO visitation checklist</td>
</tr>
<tr>
<td>CHAs</td>
<td>Follow up Assessment Visits to document progress</td>
<td></td>
<td>Once / three months</td>
<td>Ages and Stages Questionnaire – 3 (ASQ-3)</td>
</tr>
<tr>
<td>Health Nursing Supervisor/ Supervisory Nurse</td>
<td>Supervisory Visits</td>
<td>-</td>
<td>Once /three months 4 conducted by Health Nursing Supervisor (HNS) 4 conducted by Supervisory Nurse (SN)</td>
<td>CHA Home Visiting Checklist</td>
</tr>
</tbody>
</table>

**Initial Visit and Assessment:**
At the initial visit, the CHA was expected to introduce the ECHO programme to the family and conduct an initial child development screening, using the Ages and Stages Questionnaire-3 (ASQ-3). If at the initial visit, a child was identified as performing below the expected developmental level, he / she was to be provided with an increased number of follow-up visits to optimise development in the specified domain. Any child who did not show the expected improvement after the increased number of visit was expected to be referred for further evaluation.

**Home Visits for Stimulations:**
The main focus of the home visits was to guide parents through stimulation activities with children and demonstrate toy making. Each CHA was expected to first spread the McIntosh on the floor, put out a few of the toys to be used for stimulation, sit on the mat and encourage the child to play with the toys. In doing this, the CHA role played for the parents stimulating activities such as reading books, playing with the puppet or rattle and encouraging the child to colour, draw or write. The CHA was then expected to encourage and guide parents on participating in stimulating activities.

**Follow-Up Assessment Visits:**
At Follow-Up Assessment visits, the ASQ was completed to document progress.

**Supervisory Visits:**
Supervisory Visits were to be conducted by nursing staff from the community clinics.

**Assessment of the Outcome of Home Visits:**
ASQ Screening forms were to be submitted on a quarterly basis to Nursing Supervisors for their review. These forms were to be used to monitor developmental progress of children, and identify those who needed additional specialist intervention.
3.11.2. **Parent Workshops**

Parent workshops, where groups of beneficiary parents in a community meet for support and education, were also the responsibility of CHAs. A Needs Assessment Questionnaire was designed for completion at parent workshops. This focused on identifying areas for skill development of parents.

3.12. **PROGRAMME MONITORING AND EVALUATION**

There was no theory of change or logical framework articulated for the ECHO pilot prior to or at the start of project implementation. However, a Monitoring and Evaluation Framework was considered from the outset as the minutes of an Administrative Committee meeting dated on August 20, 2010 stated that the project coordinator was awaiting a template for an M&E form to be provided by UNICEF.

3.12.1. **Project Work Plan**

In the absence of a logical framework, project implementation was initially guided by an approved work plan, developed by the Project Coordinator and approved by the Administrative Committee. The plan identified objectives, sub-objectives (tasks), time frame, responsible party, result indicator/success criteria and the monitoring party, but primarily focussed on the activities to be undertaken by the Project Coordinator (See Table 2). As such, the Project Coordinator was responsible for the execution of the majority of the activities included in the plan while the Administrative Committee provided oversight.

3.12.2. **Logical Framework**

A Logical Framework was developed towards the end of the first year of the pilot. This framework identified an overall goal of "Quality Early Childhood Health Stimulation readily accessible to “at risk” children and parents ", and six objectives as indicated below:

1. To offer early stimulation to young children
2. To improve parenting practices in “at risk” communities
3. Promote and monitor good health and early development of young children.
4. To train CHA from the communities in the pilot district to assist in the delivery of parent support services.
5. To transfer knowledge and skills to parents and communities.
6. To promote healthy relationships between parent and child.

There were also four outputs/results of stimulating children 0-3 years, trained and skilled parents/caregivers in parenting practices, trained and skilled CHAs and pilot objectives achieved in preparation of mainstreaming. The goal, each objective and each output were in a table with headings of narrative summary of objectives, objectively verifiable indicators, means of verification and assumptions (See Table 8). The implementation date of this logical framework is unclear.

3.12.3. **Data Collection**

Six different data collection forms were identified. The CHA training evaluation form was completed prior to programme delivery, the other five listed in Table 9 addressed different aspects of programme delivery at the community level. Table 9 provides a description of each of the data forms collected and their
intended use. Of all the data forms collected, only that used by the CHAs to monitor child development status (Ages and Stages Questionnaire) was included in the M&E Framework.

### 3.12.4. Monitoring and Evaluation Personnel

A Monitoring and Evaluation Officer commenced duties one year after the start of the pilot and was only engaged for a five month period.

**Table 8. ECHO Programme Logical Framework**

<table>
<thead>
<tr>
<th>NARRATIVE SUMMARY OF OBJECTIVES</th>
<th>OBJECTIVELY VERIFIABLE INDICATORS</th>
<th>MEANS OF VERIFICATION</th>
<th>ASSUMPTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Goal: Quality Early Childhood Health stimulation readily accessible to “at risk” children and parents</td>
<td>At least 90% of the 182 children enrolled in the program reached their milestone by January 2012.</td>
<td>- Collection of data from CHA on Ages &amp; Stages questionnaires (ASQ).</td>
<td>- CHA: will demonstrate acceptance and a positive attitudinal shift to new roles &amp; responsibilities.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Parents feedback forms</td>
<td>- CHA: will be consistency in the delivery of the stimulation techniques.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Knowledge, attitude &amp; practice survey</td>
<td>- Parents will embrace the program and concepts.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Parents will choose to remain in the program throughout project’s life.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Financial resources disbursed on time and appropriately.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Parents empowered to apply information learned.</td>
</tr>
<tr>
<td>Objectives/Purpose 1. To offer early stimulation to young children</td>
<td>90% ECHO children assessed to determine their milestones according to age</td>
<td>- Aggregate results of district</td>
<td>- Timely execution of training curriculum.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Tracking sheets of participation rates/levels.</td>
<td>- Training fully absorbed by CHA.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- ASQ</td>
<td>- CHA, parents &amp; children will complete required number of stimulation exercises.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Maintenance of records of development milestones will be adequate and accurate.</td>
</tr>
</tbody>
</table>

2. To improve parenting practices in “at risk” communities                                      Noticeable developments seen in the children who are in the program. | - ASQ                                                                               | Parents will continue the exercises in between CHA visits.
<table>
<thead>
<tr>
<th>NARRATIVE SUMMARY OF OBJECTIVES</th>
<th>OBJECTIVELY VERIFIABLE INDICATORS</th>
<th>MEANS OF VERIFICATION</th>
<th>ASSUMPTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Promote and monitor good health and early development of young children.</td>
<td>90% of selected families execute the ECHO activities in health, education and social development as measured in the ASQ by the Jan. 2012.</td>
<td>-Training plan  -Parent knowledge, attitude &amp; practice survey  -ASQ report  -Parent feedback  -Supervisor’s checklist.</td>
<td>-Data collection and analysis will be timely and accurate.  -Follow up plans/remedial actions will be timely and appropriate.</td>
</tr>
<tr>
<td>4. To train CHA from the communities in the pilot district to assist in the delivery of parent support services.</td>
<td>90% of ECHO children worked with by CHA attained their milestones by Jan.2012.</td>
<td>-Training results and feedback reports  -Parents feedback  -Supervisor’s checklist</td>
<td>-Timely execution of training curriculum  -Training full absorbed by CHA</td>
</tr>
<tr>
<td>5. To transfer knowledge and skills to parents and communities.</td>
<td>Parents are able to demonstrate the skills taught.</td>
<td>-Planned parent workshops  -Attendance records  -Direct observation of parents demonstrating learned techniques  -Survey questionnaires</td>
<td>-Workshops will be structured and relevant to the needs of stakeholders  -Facilitators and materials will be prepared and available.  -Parents will attend capacity building sessions.</td>
</tr>
<tr>
<td>6. To promote healthy relationships between parent and child.</td>
<td>-Parents are able to make the toys, other homemade props and prepare meals  -Other soft skill and resources provided in collaboration with other partners</td>
<td>-CHA: Observation of toys, props and other skills in use in the home.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OUTPUTS/RESULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stimulate children 0-3 years</td>
</tr>
<tr>
<td>Trained and skilled</td>
</tr>
<tr>
<td>NARRATIVE SUMMARY OF OBJECTIVES</td>
</tr>
<tr>
<td>---------------------------------</td>
</tr>
</tbody>
</table>
| parents/caregivers in parenting practices | demonstrated by CHA in health, education and social developments.  
-Changes evident in response and health of children. | survey.  
-ASQ  
-CHA observations and records.  
-Attendance at parent workshops. | -Follow-through on training exercises. |
| Trained and skilled CHA | -Demonstrated understanding of role.  
-Consistent delivery of techniques | -Curriculum developed and executed  
-Training plan implemented  
-CHA attendance  
-Supervisor’s Checklist  
-Parent feedback forms  
-Direct interviews  
-Tracking sheet of number of visits per child | -CHA availability adherence to concepts and methodologies learned and execution. |
| Pilot objectives achieved in preparation of mainstreaming | -Clear progressive linkages established among the activities, outputs, objectives and overall goal.  
-Mainstream test framework | -Project evaluation  
-Monitoring reports  
-Survey results  
-Log frame review  
-Evaluation reports  
-Field observation  
-Test mainstream application | -Records/documents of program activities are retained and updated. |
<table>
<thead>
<tr>
<th>Data Collection Tool</th>
<th>Description</th>
<th>Person Administering</th>
<th>Frequency of Collection</th>
<th>Utilisation of Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CHA Training Programme Evaluation Tool</td>
<td>Questionnaire to evaluate theoretical and practical aspects of CHA training programme</td>
<td>ECHO Project Co-ordinator</td>
<td>Once, at end of CHA training programme</td>
<td>Summary shared with Administrative Committee</td>
</tr>
<tr>
<td>2. Ages &amp; Stages Questionnaire</td>
<td>Standardised questionnaire used to screen children's development in areas of Communication, Gross Moor, Fine Motor, Problem Solving, Personal-Social.</td>
<td>CHAs</td>
<td>Baseline assessment at initial home visit. Follow-up assessments once every 3 months</td>
<td>Forms submitted to Community Nurse for review and identification of children who require additional intervention</td>
</tr>
<tr>
<td>3. Parent Baseline Questionnaire</td>
<td>Questionnaire on parent knowledge, attitude and practice questionnaire completed by parent beneficiaries</td>
<td>CHA</td>
<td>Once prior to the start of the second phase of the programme.</td>
<td>Report completed and presented to Administrative committee</td>
</tr>
<tr>
<td>4. Parent Satisfaction Form</td>
<td>Questionnaire on parent perception of the ECHO programme and the work of the CHA completed by parent beneficiaries</td>
<td>CHA</td>
<td>Not Known Data collection forms reviewed were not dated.</td>
<td>Not Known. No evidence of data summarised or presented in a report.</td>
</tr>
<tr>
<td>5. Parent Needs Assessment Questionnaire</td>
<td>Questionnaire administered to parents at workshops to identify areas for skills development.</td>
<td>CHA</td>
<td>Per workshop schedule</td>
<td>Not Known. No evidence of data summarised or presented in a report.</td>
</tr>
<tr>
<td>6. CHA Home Visiting Checklist</td>
<td>Questionnaire used to assess the quality of the CHAs work in the field.</td>
<td>Nursing Supervisor</td>
<td>Not Known</td>
<td>Not Known. No evidence of data summarised or presented in a report.</td>
</tr>
</tbody>
</table>
PART 4: OBJECTIVES OF EVALUATION

4.1. CONVENTION ON THE RIGHTS OF THE CHILD

The Convention on the Rights of the Child (CRC) requires that the particular requirements of young children (good nutrition, emotional care, sensitive guidance, time and space for social play exploration and learning) should be met by the adults in their lives and strongly acknowledges that a positive growth promoting environment is critical to development. The ECHO programme, if proven successful, can potentially be one mechanism to ensure that the rights of the most socio-economically vulnerable children are met.

4.2. SPECIFIC OBJECTIVES

The Specific Objectives of this evaluation are as follows:

VI. To assess how far the ECHO pilot programme has achieved its objectives, the results that have been achieved to date, any unintended results from the programme, as well as outputs at the individual, household, and community levels

VII. To identify the opportunities and constraints the programme has faced and draw lessons and good practices from them

VIII. To evaluate the operational effectiveness of the pilot and to cost its scale up in the current and projected national fiscal situation

IX. To identify the extent to which cross-cutting strategies/issues such as human rights-based approaches, results-based planning and gender equality/mainstreaming have been adopted in the planning and implementation of the programme.

X. To ascertain the requirements and implications (institutional capacity, financial implications etc.) of scaling up and implementing the ECHO programme on a national scale in the model countries, especially St. Vincent & the Grenadines.

4.3. PRIMARY REASON FOR EVALUATION

This evaluation has been conducted based on the need of Government partners in the MHWE in SVG to determine programme effectiveness and output in order to guide scaling up, and as an organizational requirement for UNICEF, who invested in the pilot programme.

Added Value of Evaluation

The added value of the evaluation will be in the use of the findings and recommendations for:

(a) Documentation of the viability of the ECHO programme as a means of providing ECD services to the most-disadvantaged in a cost-efficient manner

(b) Documentation of the Caribbean experience in the adoption and modification of the RCP methodology into a country-specific variant that can meet the early childhood stimulation needs of children birth to three.
PART 5: EVALUATION METHODOLOGY

10.1. EVALUATION PRINCIPLES

This evaluation was guided by two main documents. The Program Evaluation Standards developed by the Joint Committee on Standards for Education Evaluation (2011) are designed to help guide the development, implementation and evaluation of programmes, as well as to provide evaluators and evaluation users with a blueprint for quality evaluations. UNCEF’s Evaluation Report Standards (UNICEF, 2004) have been created as a transparent tool for quality assessment of evaluation reports. This document outlines what the standards are, the rationale for each standard and how they are applied. The Standards are used by the UNICEF Evaluation Office to assess evaluations for inclusion in the organisation’s Evaluation and Research Database to strengthen the Database as a learning tool. The Standards are also intended for use by UNICEF offices and partners commissioning evaluations to establish the criteria against which the final report will be assessed. The UNICEF Evaluation Report Standards draw from and are complementary to key references on standards in evaluation design and process increasingly adopted in the international evaluation community.

10.2. EVALUATION DESIGN

The evaluation was designed to examine the ECHO programme in light of criteria related to the relevance, effectiveness, efficiency, impact and sustainability of the pilot. **Relevance** is defined as the extent to which the ECHO programme is aligned with national priorities and policies related to ECD. Under **Effectiveness**, the evaluation team explored the stated objectives of the pilot and the extent to which these were attained. The evaluation team also looked at the major factors that influenced the achievement or non-achievement of these objectives. To determine the **Efficiency**, programme outputs were measured in relation to the inputs. This involved the use of a cost analysis to determine if the project was implemented in the most efficient way compared to alternatives (i.e. the Roving Caregiver Programme). The evaluation also sought to examine (where possible) the positive and negative, direct and indirect and intended and unintended changes produced by the ECHO pilot programme. This relates to the **Impact** that the programme had on beneficiaries and key stakeholders (rights-holders and duty-bearers). Finally, the evaluation team considered issues of **Sustainability** (i.e. factors that would impact the continuity and national-scale up of the programme in the absence of structures, systems and funding similar to the pilot project).

Human Rights Based Approach

Additionally, in keeping with UNICEF’s commitment to a Human Rights Based Approach to Programming the evaluation team considered some of the human and child rights issues related to the design, implementation and administration of the ECHO pilot programme.

Results Based Management

The evaluation also includes an analysis of the ECHO pilot programme’s use of Results Based Management. Specifically, the evaluation team considered the contributions of all key stakeholders (duty-bearers and rights-holders) to the desired outputs, outcomes and impact of the pilot. In addition, the
evaluation team constructed (from project documentation) a Results Matrix – outlining the chain from inputs to impact - so that a critical assessment of the linkages between planning, monitoring and evaluation could be determined.

Consultation

The evaluation process was designed to be consultative and participatory, taking into account the views of all stakeholders. In light of this, a consultation was held with key stakeholders at the end of the evaluation process to give them opportunities to review and provide feedback on the evaluation’s findings and recommendations (See Appendix F).

Methodological Approach

A mixed method approach was employed to examine the ECHO pilot based on the evaluation criteria. The mixed method approach involves the collection and analysis of both qualitative and quantitative data in a single study to examine a research problem (Creswell, 2012). This approach was selected because it provides a comprehensive overview of the processes, experiences and outcomes of the ECHO pilot project while capturing the unique perspective of each of the main stakeholders.

The collection of data through both qualitative and quantitative methods has been utilised by the Bernard van Leer Foundation (BvLF) to conduct an impact evaluation and cost analysis of a similar home visiting programme, the Roving Caregiver Programme in St. Lucia (Wint & Janssens, 2008). The St. Lucia study included in-depth interviews, focus groups, and a quasi-experiment (comparison of treatment and non-treatment groups)

The qualitative methodology utilised a number of common forms of qualitative data collection. These included the following:

- Desk Review of Project Documents
- In-depth or elite Interviews
- Focus Groups

In quantitative methodology, the current gold standard for evaluation is the Randomized Controlled Trial (RCT). When RCTs are well-executed they provide the strongest form of evidence for the impact of an intervention. This is largely due to the RCT’s ability to solve the problem of selection bias through random assignment of the intervention. After the intervention has occurred, differences in outcome between the intervention and control groups provide a measure of the effect of the intervention. As the pilot did not utilize this type of study design, this programme evaluation will not be able to make any causal attributions of programme implementation.

Because there was an indication that baseline data was collected, the evaluation team selected a quasi-experimental design for the assessment of parent and child beneficiary outcomes. In this approach, self-reported parenting practices and child development outcomes are assessed as a function of whether participants were part of the ECHO programme (treatment group) or not (non-treatment group), controlling for variables such as age, gender and socio-economic status.

A parent beneficiary survey on programme characteristics was also undertaken.
The final quantitative methods utilized were as follows:

- Parent Beneficiary Survey on programme characteristics (Post Programme Completion)
- Quasi-Experiment: Comparison of Socio-demographic and parenting characteristics of ECHO and non-ECHO parent beneficiaries (controls), post programme completion
- Quasi-Experiment: Comparison of child development and educational status of ECHO and non-ECHO child beneficiaries (controls), post programme completion

10.3. IDENTIFICATION AND RECRUITMENT OF PARTICIPANTS

10.3.1. Key Informants and Focus Group Participants
For the qualitative aspects of the analysis, informants were purposefully selected for participation based on the roles that they played in the pilot of the ECHO programme. The ECHO Project Coordinator was particularly helpful in identifying and contacting personnel for focus groups.

10.3.2. Parent and Child Beneficiaries
For the quantitative aspects of the analysis, fifty (50) parent and child beneficiaries of the ECHO programme were randomly selected from the complete listing of ECHO families. The random selection process meant that each family had an equal chance of being invited to be a part of the evaluation exercise. This minimises bias in the research process and also ensures that there are fair procedures and outcomes in the selection of participants.

CHAs from the four participating health centres were requested to contact families and invite them to participate in the evaluation process. Because of limited success, a second wave of recruitment of the originally selected ECHO parents was conducted by the evaluation team with the help of the Community Nursing Service. Some interviews were conducted by telephone to facilitate parent participation.

10.3.3. Parent and Child Controls (Non-ECHO Beneficiaries)
Two schools were identified in the Calliaqua district for the selection of controls, based on a school population of children of similar age, gender and socioeconomic status, who were not exposed to the ECHO programme. The first school was selected through the Ministry of Education and was a public primary school. The second school was a private preschool which was identified through an educator in the district. At each school, control children were selected as matches for the ECHO children on the basis of age and gender. Parents were then contacted by telephone and invited to participate. Parent questionnaires were conducted by telephone to facilitate parent participation.

10.4. QUALITATIVE DATA SOURCES

10.4.1. Desk Review of Project Documents
Purpose:
Desk review allowed for the orientation of the evaluation team to the discussions surrounding early childhood development and early stimulation in St. Vincent and the Grenadines. It also allowed for the determination of government policy regarding the programme, programme philosophy, expected
programme implementation steps, challenges and changes in implementation, progress rates and attainment of targets. Desk Review also allowed access to financial records for determination of implementation costs.

**Process:**
The Desk Review involved an intensive search, review and synthesis of project proposals, programme implementation documents, minutes of meetings, presentations, promotional materials, monitoring and evaluation reports, government policy documents, NGO reports and financial documents related to the ECHO pilot project.

The evaluation team obtained most of the programme documents from the Community Nursing Services Department through the ECHO Pilot Project Coordinator. However, several documents were also provided by the UNICEF Eastern Caribbean Office and the Foundation for the Development of Caribbean Children (FDCC) (formerly CCSI). In addition, the evaluation team located a number of useful records in the ECHO Pilot Project Office at the Sion Hill Health Centre. Information on the ECHO programme was also obtained through an internet search. Each document was reviewed by at least 2 members of the evaluation team to ensure that the original material was being described accurately and adequately.

**10.4.2. In-depth Interviews (Government & Project Staff)**

**Purpose:**
In-depth interviews with senior government officials and operational project staff helped to contextualize the ECHO pilot project, including the policy decisions that led to its implementation and maintenance. These interviews were also used to determine policy and programme delivery level successes and challenges. Additionally, the interviews explored the political will of key stakeholders and examined the presence of the required physical, human and financial resources for sustaining the programme.

**Process:**
After a review of project documents and initial meetings with staff in the Ministry of Health Wellness and the Environment, a list of key stakeholders was compiled. This list included individuals at the policy and senior administrative level (staff at the Ministry of Health, Wellness and the Environment and UNICEF Eastern Caribbean Office) and those at the operational or community level (Community Nursing Service staff, ECHO pilot project staff and parents who participated in the pilot project).

Individual interviews were then scheduled with each of these stakeholders. The evaluation team developed a general list of interview questions; these were further adjusted during interviews, based on a better understanding of the roles interviewees played in the ECHO pilot. This interview schedule included specific probing questions and follow-up prompts to ensure that critical information was captured in the interview. Following receipt of consent, the interview was tape-recorded to allow for further analysis. Interviews were of 40-90 minutes duration. Most interviews were conducted face-to-face in St. Vincent & the Grenadines. However, two interviews were conducted via Skype to facilitate the interviewees.

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5 For a complete listing of these documents see Appendix D.
6 For a list of interviewees, see Appendix C.
7 See Appendix E for the interview schedule.
10.4.3. **Focus Groups**

**Purpose:**
The focus groups allowed for participation of a greater number of key stakeholders in the evaluation process. These discussions explored the groups’ views on programme goals, implementation, outputs, outcomes, best practices and challenges.

**Process:**
Findings from the desk review and initial discussions with UNICEF and Ministry staff informed the selection of various groups for this aspect of the evaluation. Focus group discussions were held with CHAs who delivered the pilot programme, Roving Caregivers who assisted in training CHAs for the pilot project, curriculum writers and trainers for the CHA training programme, District Nursing Supervisors and the ECHO Pilot Administrative Committee. All focus groups were held at a Government building in Kingstown and were facilitated by a member of the evaluation team. At each focus group, the facilitator opened and guided discussions using the same semi-structured interview schedule used at the in-depth interviews. In some cases, additional questions were asked based on the characteristics of the group or their specific role in the ECHO pilot. Each focus group was of 60 – 90 minutes duration and was tape-recorded with permission.

Details of each focus group, including recruitment process and main issues discussed are outlined below:

1. **CHAs** - A focus group was held with 6 of the 7 CHAs assigned to the Calliaqua Health District at the time of the ECHO pilot. One CHA who participated in the pilot, now retired, was not at the meeting. Another CHA, present at the meeting, was trained in the ECHO methodologies/research protocol but did not participate in the pilot due to illness. The main aim of the focus group was to learn about the CHAs’ experiences during the ECHO pilot. This included discussions on ECHO objectives, perceptions of the ECHO programme, training, their daily activities, strengths and weaknesses of the programme and current challenges. This was a very productive focus group which laid the groundwork for the other phases of data collection. Importantly, the CHAs were asked to further assist by recruiting families that participated in the ECHO pilot for the evaluation.

2. **Rovers, Roving Caregiver Programme** – Evaluation team members met with five (5) Rovers from the Roving Caregiver Programme. At the time of the pilot, these Rovers were all working in communities in the Barrouallie district of St. Vincent & the Grenadines. In this focus group, the evaluation team gathered information on the operation of the Roving Caregiver Programme in St. Vincent & the Grenadines, the Rovers’ perceptions of the ECHO programme and their involvement in training the CHAs for the ECHO pilot. The Rovers who participated in this focus group were recruited through the ECHO Pilot Project Coordinator.

3. **ECHO Pilot Administrative Committee** – A focus group meeting was held with five (5) members of the Administrative Committee. During the focus group, the committee discussed their role in overseeing the administration of the ECHO programme pilot, as well as the challenges in mounting the pilot. They also had an opportunity to comment on the roles, responsibilities and performance of key administrators of the pilot.

4. **Curriculum Writers and Trainers** – Eight (8) individuals who wrote aspects of the curriculum and/or lectured in the CHA ECHO training programme for the pilot participated in this focus group. The group was comprised of tutors from the Division of Nursing Education (DONE), other Government Ministries and the Community Colleges. This discussion centred on the experience of writing the curriculum and delivering training.

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8 All members of the evaluation team have previous experience in focus group facilitation.
9 These two administrators were also a part of the Administrative Committee and were asked to leave the room at this point to allow for a more objective, unbiased discussion.
of lecturers in the CHA ECHO training programme (specifically the pilot project training) and their general perceptions of the ECHO programme.

5. **District Nursing Supervisors** - An evaluation team member met with five (5) district nursing supervisors to discuss the national scale-up of the ECHO programme. The session was very helpful in terms of outlining some of the challenges facing the programme and the strategies needed to make the programme more efficient and effective. All seven (7) District Nursing Supervisors were invited to participate in the focus group discussion, however two (2) were unable to attend due to prior engagements.

### 5.5. **QUANTITATIVE DATA SOURCES**

Primary data collection were utilized for this aspect of the evaluation. Parent surveys and child assessments were designed to assess programme outcomes relative to parent knowledge, competencies, beliefs and practices and child health and development and on. By comparing ECHO beneficiary families with control families, the team expected to gain insight into the potential benefits of enrolment in the ECHO programme.

#### 5.5.1. **Process of Data Collection**

Parent and child assessment of ECHO beneficiaries took place at one of two Health Centres (Stubbs and Enhams), selected because they had suitable areas were interviews and assessments could be conducted. All assessments of control children took place at their schools in a quiet area designated by the school administration. All phone interviews were conducted in private at the Evaluation team’s research offices. Details of instruments used for primary data collection are presented below.

#### 5.5.2. **Instruments**

**Parent Beneficiary Survey**

The ECHO Parent Experience Questionnaire (Appendix E) was developed specifically for this evaluation. The 38 questions elicit information on parents’ experience in the ECHO pilot programme. The questionnaire gathered data on parents’ perceptions of ECHO, eligibility criteria, duration of enrolment, frequency of home visits, parent training and level of participation in ECHO activities.

**Comparison of Socio-demographic and Parenting Characteristics**

The 58 item ECHO Evaluation Parent Questionnaire included questions on child health and nutrition, parent-child interactions, household and caregiver characteristics and household resources. The majority of questions in this questionnaire were adapted from parent surveys that have been extensively tested and used in a large birth cohort study in Jamaica (JA KIDS: The Jamaican Birth Cohort Study 2011).

**Comparison of Child Development and Education Outcomes**

Three instruments were used to assess child outcomes

1. **Ages and Stages Questionnaire (36, 48, 54 and 60 months)**

The Ages and Stages Questionnaire (ASQ) is a widely used child screening and monitoring system, designed to monitor a child’s developmental progress and identify children with potential developmental delay. Each questionnaire contains simple questions for parents or professionals to
answer about tasks their child can do. Questionnaires are designed to assess development in five domains: Communication, Personal-social, problem Solving, Fine Motor and Gross Motor. The ASQ includes a series of 20 questionnaires, with each questionnaire designed for administration at a specific age band between birth and six years. For this evaluation the 36, 48, 54 and 60 month questionnaires were used.

2. Peabody Picture Vocabulary Test, Fourth Edition (PPVT - 4)

The PPVT-4 is a norm referenced untimed measure of a person’s receptive language and verbal intelligence of English speaking children and adults. It consists of 228 pictures designed for use from 2.5 to 90 years old. The examiner presents a series of numbered pictures and asks the individual to say or point to the pictures that best describes the word.

3. Wide Range Achievement Test (WRAT4)

The WRAT-4 is a norm-referenced test which measures an individual’s ability to compute arithmetic problems, read and spell words. The WRAT-4 can be administered to children and adults; it has been normed for the age range 5 – 94 years. Administration of the WRAT-4 varies depending on the individual’s age, behaviour and abilities; however, it generally takes between 15 – 25 minutes to administer the WRAT for children 5 – 7 years and between 35- 45 minutes for individuals older than 8 years. The four WRAT subtests assess Reading (ability to identify letters and words), Sentence Comprehension (ability to understand information used in sentences), Spelling (ability to decipher sounds) and Mathematical Computation (ability to count, problem solve, identify numbers and use computation to solve problems).

5.6. DATA ANALYSES

5.6.1. Qualitative Analysis

Data (field notes and recordings) from focus groups and in depth interviews were analysed using content analysis. All recordings from interviews and focus groups were transcribed by a member of the evaluation team. Field notes and transcriptions were then examined to identify common themes and patterns. The data were grouped into categories and then used to answer key questions from each of the evaluation objectives. This process was completed independently by two evaluation team members and then compared.

5.6.2. Quantitative Analysis

Data from questionnaires and standardised tests were entered into an electronic database and then verified. The Statistical Package for the Social Sciences (SPSS) was used to generate uni-variate statistics (frequencies and measures of central tendency) and bi-variate statistics (cross tabs). For continuous variables, mean scores were compared using the student’s t-test.
5.7. ETHICAL CONSIDERATIONS AND RESPONSIBILITIES

5.7.1. Guiding Documents

The evaluation team took several steps to ensure that the evaluation exercise was in keeping with the ethical principles outlined in the Belmont Report (1979). The Belmont Report provides guidelines to researchers for research with human participants and mandates that participants enter into research activities voluntarily and with good information about the research objectives and processes. It also emphasizes the responsibility of researchers and research institutions to minimize risks to participants and maximize benefits.

As this evaluation also involved children, the evaluation team reviewed the Ethical Research Involving Children (ERIC) guide (Graham, Powell, Taylor, Anderson, & Fitzgerald, 2013) which outlines principles for conducting ethical research with children. ERIC focuses on children’s rights as set out in the United Nations Convention of the Rights of the Child (UNCRC) and provides best practice and key considerations for each of the highlighted ethical principles.

The evaluation team took into account common ethical considerations as well as the particular social and cultural contexts of the evaluation.

5.7.2. Training in Research Ethics

All evaluation team members have completed training and certification in research ethics.

5.7.3. Voluntary Participation & Informed Consent

All participation in this evaluation was voluntary and involved informed consent. Consent forms clearly stated that participation was completely voluntary and that participants may withdraw their consent at any time, without penalty. Where there were concerns about literacy levels, consent forms were read to participants and each individual had the opportunity to ask questions related to any aspect of the evaluation.

Consent was also obtained for each child from their parent/guardian before any assessments were conducted. In recognition of the rights of children, the procedure of the evaluation was explained to children in language suitable for their age and their verbal consent obtained. Contact information was provided for individuals who wished to contact the principal investigator at a later date to ask questions about the study. Also, all participants were provided with a copy of the consent form (See Appendix E).

5.7.4. Risks and Benefits

This study was considered to have only minimal risks for participants. It was anticipated that some adult participants could experience slight emotional discomfort when being interviewed or participating in focus group sessions. Similarly, children may have felt emotional discomfort when completing standardised assessments. These risks were clearly specified in all consent forms.

5.7.5. Privacy & Confidentiality

All data collected in the evaluation were kept confidential by the following measures:
1. A code number was assigned to each individual’s interview or assessment. Only a single file contained information linking names to code numbers. This file was kept on a separate highly secured computer that only the evaluation team had access to.
2. Pseudonyms were used in all transcriptions of interviews and focus groups.
3. Research records were kept in a locked file and access to the research records was limited to authorized members of the evaluation team.
4. In terms of reporting results, the evaluation team will not publish the names or any other potentially identifying information on study families.

5.7.6. Ethical Responsibilities
The evaluation team had two main strategies for ensuring that ethical responsibilities to children and families involved in the study were met. First, study children who were identified with clinically significant developmentally delay or behaviour problems were referred for further evaluation and intervention. There was only one child who fit these criteria. When the child was identified by the principal investigator, discussions were had with both his parent and the CHA to facilitate referral and intervention. Secondly, all parents (ECHO and control) were provided with reports on their children’s developmental status. These reports also included tips for supporting each child’s areas of strength, as well as strategies for improving weaker developmental domains.

5.7.7. Payment & Compensation
All families who participated in the evaluation received reimbursement for travel to the health centres where the research took place. They were also provided with light refreshments while at the research site. Each child participant received a developmentally appropriate book at the end of the assessment. The Rovers who participated in a focus group session in Kingstown were also reimbursed for their travel expenses.

5.8. IDENTIFIED BIASES AND MITIGATION STRATEGIES
Inherent in all self-report methodologies is the potential for participants to underreport, exaggerate and misrepresent information. This may especially be the case in an evaluation setting where individuals feel that they are being ‘judged’. The evaluation team tried to limit some of this potential bias by building rapport with participants before conducting interviews and focus groups, making the evaluation process open and transparent and conducting checks to clarify matters post interview/focus groups. In addition, all evaluation team members have many years of experience with conducting interviews and focus groups and are able to use their judgment and skill to moderate these processes effectively. Methods used included refocusing discussions, validating all views and opinions, including quieter members of the group and limiting their own biases.

5.9. LIMITATIONS TO EVALUATION METHODOLOGY
There are limitations in all research studies and evaluations. Here we summarize the constraints of this evaluation and mitigation strategies where relevant.

Timing of Evaluation
A major limitation of the evaluation was its timing, which impacted both qualitative and quantitative data collection. The evaluation took place 2 years after the pilot project ended. This had a number of
consequences that negatively impacted the evaluation. First, as a result of recall bias, many participants had difficulty remembering the specifics of programme design, implementation and participation because of the time lapse. The information from key stakeholders at in-depth interviews and some focus groups, was often vague and difficult to interpret. This was also particularly true of ECHO parent beneficiaries. Some who participated in the programme were uncertain about the details regarding ECHO visits and workshops, and a few did not seem to remember enrolment in the programme at all.

Second, the time lag made it difficult to locate important documents, files and items related to the pilot. A few examples illustrate the impact of this:

1. It took several days for the key to the ECHO office to be located. Once it was found, there was limited time for evaluation team members to access the wealth of information housed in that office (which is not currently in use).
2. The team could not locate reports related to key aspects of the programme such as Training, Parent Workshops and Monitoring & Evaluation
3. The database which housed the raw data related to baseline developmental scores for ECHO participants could not be located, despite discussions with the IT Department at the Ministry of Health, Wellness and the Environment. This created a significant methodological challenge for the evaluation team as an analysis of changes in developmental status could not be conducted as a result.

Quality & Availability of Documents & Reports
There were a number of challenges with the review of the available documents and reports on the ECHO programme.

1. Some reports were not dated or had conflicting information, making it difficult to determine important aspects of programme design and implementation timeline.
2. There was no available single, comprehensive final report that provided details on programme philosophy, development, design, implementation, training, administration, strengths and challenges, outcome and costs covering both points of enrollment.

The evaluation team spent inordinate amounts of time locating and linking information sources together. Again, the project coordinator provided useful guidance where possible.

Participation in Post Programme Evaluation
Only a fraction of the participants who were invited for participation in the evaluation attended on the appointed day. The CHAs indicated that it was difficult to locate some families as they had moved out of the area or were uninterested in participating. Comprehensive analyses of child and parent outcomes using the quasi-experimental method were therefore not feasible.
PART 6: PROGRAMME & THE EVALUATION PROCESS

6.1. PROGRAMME CONCEPTUALISATION AND CHILD RIGHTS

The ECHO Pilot Programme documents do not specifically articulate a human or child rights based approach, and also do not specifically address gender equity. However, programme implementation and procedures ensured that a number of child rights, as indicated in the UNCRC, were attained. General Comment 7 (Implementing Child Rights in Early Childhood) emphasises the need for all countries to construct a “positive agenda” to ensure that the rights of young children become a reality. A positive agenda requires the development of a framework of laws, policies and programmes with an implementation plan and a monitoring strategy. The ECHO Programme can be considered to be in support of General Comment 7.

UNCRC Categories of Child Rights

Specifically the following recognised groups of rights were met:

1. **Survival rights**: include the child’s right to life and the needs that are most basic to existence, such as nutrition, shelter, an adequate living standard, and access to medical services.

   The ECHO Programme with its focus on health and nutrition, and an objective to improve the relationship between the health centre and the community ensured that survival rights were attained.

2. **Development rights**: include the right to education, play, leisure, cultural activities, access to information, and freedom of thought, conscience and religion.

   The ECHO Programme aimed to provide parents with the knowledge to support children's education in the home, through play, leisure and culturally relevant activities.

3. **Protection rights**: ensure children are safeguarded against all forms of abuse, neglect and exploitation, including special care for refugee children; safeguards for children in the criminal justice system; protection for children in employment; protection and rehabilitation for children who have suffered exploitation or abuse of any kind.

   The CHAs were specifically trained in the area of child abuse and neglect, allowing them through their interaction and support of families in parenting and child development to reduce the levels of parental stress that promote child abuse. Additionally, through close contact with families, CHAs would be able to identify and bring to the attention of authorities any form of child abuse identified.

4. **Participation rights**: encompass children's freedom to express opinions, to have a say in matters affecting their own lives, to join associations and to assemble peacefully. As their capacities
develop, children should have increasing opportunity to participate in the activities of society, in preparation for adulthood.

The ECHO Programme encouraged parents to interact with their children and improve their vocabulary, both of which promote the right of young children to express their opinion.

**General Principles of UNCRC**

Specifically, the ECHO programme allowed for the attainment of the four articles identified in 2003 as general principles for the implementation of the CRC. These include:

**Article 6: Right to life, survival and development**

As indicated above, the ECHO Programme focussed on improving children's health and development.

**Article 2: Right to non-discrimination**

The ECHO Programme aimed to target the most vulnerable to provide services that were expected to reduce inequality.

**Article 3: The best interests of the child**

Improved health and access to stimulation are aspects of ECD that are in the best interests of the young child.

**Article 12: Right to express their opinion**

The ECHO Programme encouraged parents to interact with their children and improve their vocabulary, both of which promote the right of young children to express their opinion.

**Additional Rights**

Additionally, the ECHO programme allowed for the attainment of the following rights:

**Article 4: Implementation of Child Rights**

The ECHO programme can be considered a State party programme to implement child rights.

**Article 5: Parental guidance and evolving capacities**

The programme respected parental rights in the upbringing of their child, and supported parents in understanding children's evolving capacities at a young age.

**Article 18: Parental responsibilities**

The programme supported parents in meeting their responsibilities to provide an appropriate environment for very young children.

**Article 19: Protection from Child Abuse**

The programme allowed for reduction of parental stress and therefore the likelihood of child abuse, as well as early identification through the presence of the CHAs, as indicated above.
Article 23: Children with a disability

The programme allowed for early identification and intervention for children with developmental delay.

Article 27: Standard of living

The programme supported parents in improving their financial status and that of their children through a new skill of backyard gardening.

Articles 28 and 29: Education and Aims of Education

The programme assisted parents in educating their children at a level suitable for children under three years.

Article 31: Leisure, recreation and cultural activities

The programme encouraged parents to participate in and enjoy play and leisure activities with their young children.

6.2. PROGRAMME OBJECTIVES

The original objectives, stated in narrative form in the programme proposal, were expanded to include an overarching goal and six objectives, within a logical framework. Please see section on Effectiveness for further analysis.

6.3. PROGRAMME DESIGN

The programme design was based on two existing programmes, the RCP and HSP, which had been evaluated as being of benefit to young children and families. Additionally, a pilot programme which trained CHAs to provide stimulation for young children in Jamaica, was highly successful in improving child development outcomes, with greater effect sizes than that of a similar programme undertaken through the RCP (Engle et al, 2007).

6.4. PROGRAMME SUPPORT AND CONTRIBUTION

The pilot had the strong support of the government of SVG, and particularly the Ministry of Health, Wellness and the Environment, through the Community Nursing Service of the Maternal and Child Health Division. Additionally, there was in-kind support for the backyard gardening aspect from the Ministry of Agriculture and financial support and/or technical assistance from a number of local and international development partners.

6.5. PROGRAMME ADMINISTRATION AND MANAGEMENT

A comprehensive administrative and management structure was established. At the senior management level, the Minister and the PS readily embraced the programme located at the MHWE. The PS took responsibility for the Administrative Committee. This monitoring committee engaged all relevant stakeholders including MHWE senior management and community-based staff, the Department of Nursing Education, paediatric staff and the RCP. In the second year, the committee further expanded to become cross-ministerial and cross-sectoral, with the addition of Ministries of Education and Mobilisation.
At the community level, however, there were challenges in the management of the programme. Nursing Supervisors indicated in Focus Groups that they were often unable to cope with the additional work of supervising CHA home visits.

CHAs indicated at the evaluation of their training programme, that there was limited consultation with them on the change to their job description. At Focus Group meetings, they reported initial resistance to the introduction of the ECHO programme, but following their training, there was an understanding of its importance and full acceptance. However, they had difficulty implementing the programme, based on their already strenuous work schedule. In particular, they reported being unable to visit families with the expected frequency.

Table 10. Weekly Work Plan of a Community Health Aide

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician led clinic day</strong></td>
<td><strong>Child Health Clinic</strong></td>
<td><strong>Hypertensive and Diabetic Clinic day</strong></td>
<td><strong>Community adult home visits</strong></td>
<td><strong>Physician led clinic day</strong></td>
</tr>
<tr>
<td><strong>CHA assists with patient registration, anthropometry and vital signs</strong></td>
<td><strong>CHA assists with vital sign and blood sugar monitoring</strong></td>
<td><strong>CHA assists with vital sign and blood sugar monitoring</strong></td>
<td><strong>CHA undertakes counselling, meal preparation, bathing, turning, pressure point care, foot care and family planning</strong></td>
<td><strong>CHA assists with patient registration, anthropometry and vital signs</strong></td>
</tr>
<tr>
<td><strong>Family Planning Sessions</strong></td>
<td><strong>Community adult home visits</strong></td>
<td><strong>Community adult home visits</strong></td>
<td><strong>ECHO home visits</strong></td>
<td><strong>Family home visits</strong></td>
</tr>
<tr>
<td><strong>CHA undertakes counselling, meal preparation, bathing, turning, pressure point care, foot care and family planning</strong></td>
<td><strong>CHA undertakes counselling, meal preparation, bathing, turning, pressure point care, foot care and family planning</strong></td>
<td><strong>CHA undertakes counselling, meal preparation, bathing, turning, pressure point care, foot care and family planning</strong></td>
<td><strong>CHA undertakes child stimulation, parent support and education, monitoring of children’s development and backyard gardening</strong></td>
<td><strong>Family home visits</strong></td>
</tr>
<tr>
<td><strong>ECHO Follow up visits</strong></td>
<td><strong>Family Planning</strong></td>
<td><strong>ECHO Home visits</strong></td>
<td><strong>Dressing of wounds in clinic</strong></td>
<td><strong>ECHO Follow up visits</strong></td>
</tr>
<tr>
<td><strong>CHA visits children with an identified problem and facilitates referral</strong></td>
<td><strong>CHA undertakes child stimulation, parent support and education, monitoring of</strong></td>
<td><strong>CHA undertakes child stimulation, parent support and education, monitoring of</strong></td>
<td><strong>CHA visits children with an identified problem and</strong></td>
<td><strong>CHA visits children with an identified problem and</strong></td>
</tr>
</tbody>
</table>

---

10 Work Plan constructed based on consultations with CHAs in SVG
Only four of twenty sessions (20% of time) is dedicated to the ECHO programme. As a result, follow-up visits were focussed on children who need further intervention.

Roving Caregivers, at their focus group, reported feeling disenfranchised, having been highly trained and effective at their jobs of providing stimulation to vulnerable children. Many were unemployed or under-employed. They also expressed concern at the limited number of home visits to vulnerable children that were able to be provided by CHAs due to their other work load. Despite this, they supported the programme through the training of the CHAs in practical experience in home visiting.

### 6.6. PROGRAMME INITIATION AND ENROLMENT

Of the anticipated 200 children to be enrolled in the programme, based on the Project Co-ordinator’s Work Plan, 182 (91%) were actually enrolled.

### 6.7. PROGRAMME RECIPIENTS

**Selection of Region for Piloting**

There were clearly identified and relevant criteria indicating the reasons for selection of the Calliaqua region for the pilot project.

**Selection of Child and Family Recipients**

The first phase of the pilot project commenced without individual eligibility criteria, resulting in a subjective process of identification of participants. At the second phase of enrolment, eligibility criteria based on demographic, health and educational/developmental characteristics were developed to improve targeting. However, no clear definitions for the criteria or how they were to be used were identified. For example, it was not clear whether a single criterion, or a summation score or multiple criteria were required for eligibility.

A Monitoring and Evaluation Report written at the end of the first phase of the pilot project, stated that “On average, children did not fall into the at risk category at either measurement point” (i.e. baseline or end of the first year). This is consistent with findings obtained by parental interview at this evaluation (See Appendix G).
6.8. TRAINING

Training of CHAs
High-quality training is essential to the achievement of a programme’s goals and objectives. The review of training evaluation forms indicated strong participant satisfaction with the CHA training programme. Additionally, throughout this evaluation exercise, the CHA training programme was consistently lauded as one of the major successes of the pilot project. Almost every focus group and interviewee identified the training programme as an important accomplishment of the ECHO pilot. Examination of training materials and summary reports also reflected the fact that the training programme was comprehensive and appropriate. There are several positive aspects of the training programme:

- The content of the training was extensive. It covered a wide range of topics related to child development, adult and child teaching and learning skills and professionalism.
- The training programme had both theoretical and practical aspects. In a programme such as ECHO, it is important for practitioners to get both a foundation in the theory of child development, as well as practical, hands on experience with programme delivery.
- The training hours were adequate. The number of hours allotted to training allowed for exposure to a number of relevant topics. The training programme was also offered full-time, which would assist in keeping CHAs focussed, allow for scaffolded learning and reinforce the information being taught.
- The programme utilised well trained facilitators who each had several years of experience in their relevant fields.
- The curricula for both the theoretical and practical aspects of the ECHO training programme were based on well-established programmes for Early Childhood Intervention (RCP and High Scope).
- The ECHO training provided an opportunity for the professional development for CHAs. From all accounts, the CHAs derived tremendous benefits from completing this training programme including learning new concepts/skills and increased self-confidence.
- The ECHO training programme was offered to all CHAs (not just those who would deliver the programme in the pilot). This indicates a good use of resources and forward thinking (DONE).

However, there were some deficiencies in the training during the pilot programme.

- A curriculum document was not available at the start of the programme, but this was addressed at the end of the programme
- The mechanisms for assessing the acquisition of knowledge and skills of the CHAs in the ECHO curriculum are unclear. There was no formal evaluation exercise to determine if the CHAs had assimilated the information presented in the training. There was no evidence of an in-take examination or collection of baseline data on the CHA’s knowledge of child development, home visiting techniques, early stimulation or parent education. This, in addition to a post-training
assessment would have been helpful in determining how much knowledge/skill was gained through the training programme. An evaluation exercise would have been especially important for determining a CHA's ability to accurately use the Ages and Stages instrument which was not a part of their previous training and was the main tool for tracking development in the ECHO programme.

Although the CHAs were all trained health workers who would have completed the CHA curriculum at DONE, many would have received their certification several years ago.

Training of Supervisory Nursing Staff
Supervisory nursing staff received only a one day training seminar on the ECHO programme. In their focus group session during the evaluation of the ECHO pilot programme, Nursing Supervisors reported that this was insufficient to provide adequate support to CHAs in the field. The inadequacy of this training is supported by the subsequent analysis of the nursing curriculum and identification of modules for inclusion.

Training of All Nursing Staff: Integration of ECHO Programme in the Nursing Curriculum
The integration of aspects of the ECHO programme in the nursing curriculum can have a number of positive and long lasting effects. Early simulation will be learnt by every nurse in training, improving their own individual knowledge and practice. Nurses are respected professionals whose opinions are influential in any setting. Nurses, particularly community nurses, have frequent contact with children and families in their professional duties. Together, these will facilitate widespread transfer of the importance of early stimulation and the knowledge of how to interact positively with young children.

6.9. PROGRAMME DELIVERY RESOURCES
In focus groups, CHAs reported that the resources provided in their kits were appropriate for programme delivery and were provided in adequate quantities throughout the pilot.

6.10. PROGRAMME DELIVERY PROCEDURE
As mentioned earlier, both supervisory nursing staff and CHAs indicated their inability to undertake the programme visitation and supervisory visits with the frequency established for the programme. Project reports did not contain detailed recording and reporting of data on frequency of visits. The total visits per child can therefore not be compared with the expected number. Similarly, eight (8) parent workshops were held during the pilot. These focused on backyard gardening, child nutrition and making of toys to stimulate children.

6.11. PROGRAMME MONITORING AND EVALUATION
Delayed implementation of the logical framework, gaps in the framework and inadequate data collection have the potential to negatively impact programme operations.

Delayed Implementation of Logical Framework
The monitoring of the ECHO Pilot was hindered by the absence of a Logical or Monitoring and Evaluation (M&E) Framework during the first year of implementation. This means that the theory of change of the
project was not clearly articulated and would result in the absence of clarity about the inputs required and the potential pitfalls that could inhibit the successful implementation of the pilot project. Overall, there was no clear roadmap to guide project implementation at all levels, but most critically for the staff actively involved in project implementation. The absence of the results framework also means that critical project personnel would not be clear about how their roles were linked to project outputs and outcomes. This could have a negative impact of project buy-in. Additionally, expected actions and timelines were not articulated which could have resulted in sub-optimal implementation of pilot activities. The lack of an initial framework also meant that critical baseline data was not identified / collected which makes analysis of the effectiveness of the pilot more challenging.

The absence of baseline data had the following consequences:
- Appropriate inputs required to achieve targets were not identified
- Whether targets were realistic or not could not be determined beforehand
- Feasibility of data collection could not be determined

**Gaps in the M&E Framework**
A log frame was developed towards the end of the first year of the project but this had various gaps. Gaps were noted in a report by the M&E Officer for the ECHO programme which stated that "the log frame was static in its presentation in that the degree of progression from inputs to objectives could not be smoothly ascertained". The framework had additional challenges which are indicated below:
- The framework was not well structured. While objectives were adequately articulated, the inputs, activities and outputs linked to these activities were not clearly identified.
- There was not a clear progression of activities
- Indicators were not clearly defined at each point along the results chain (input, activity, output, outcome, impact).
- There were no baseline data. None of the indicators had baseline data that helped to clarify the intended targets

Table 11 analyses the recommended indicators, with regard to indicator descriptions of type (output or outcome), whether baseline data was obtained or not, frequency of collection, target date for expected achievement and means of verification. An important general concern was that identified indicators were often not aligned to programme objectives.

**Inadequate Data Collection**
- The data collection system to support the ECHO project was not defined.
- There were significant gaps related to the frequency of collection and data collection sources.
- There were no interim achievement dates or targets. Targets, when specified, were all set for the end of the pilot period.
- The party / agency responsible for data collection were also not specified.
- Means of verification were not identified
- Of all data collected in the pilot programme, only data from the Ages and Stages Questionnaire were included as indicators in the M and E Framework.

**Table 11. Analysis of Indicators of Project Objectives**
<table>
<thead>
<tr>
<th>Objective</th>
<th>Indicator</th>
<th>Type / level</th>
<th>Baseline Yes/No</th>
<th>Frequency Specified (Yes/ No)</th>
<th>Target Date Specified (Yes/ No)</th>
<th>Means of Verification</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall Objective:</strong> Quality Early Childhood Health stimulation readily accessible to “at risk” children and parents</td>
<td>At least 90% of the 183 children enrolled in the program reached their milestone by January 2012.</td>
<td>Outcome</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Not clearly specified Milestone domains not specified Data collection / measurement tool not identified</td>
</tr>
<tr>
<td><strong>Objective 1:</strong> To offer early stimulation to young children</td>
<td>90% ECHO children assessed to determine their milestones according to age</td>
<td>Output</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Not clearly specified Data collection / measurement tool not identified Collection data for achievement not specified</td>
</tr>
<tr>
<td><strong>Objective 2:</strong> To improve parenting practices in “at risk” communities</td>
<td>Noticeable development seen in the children who are in the program.</td>
<td>Outcome</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Not specified ASQ changes reported on in M&amp; E report, but details of ASQ use not indicated.</td>
</tr>
<tr>
<td><strong>Objective 3:</strong> Promote and monitor good health and early development of young children.</td>
<td>90% of selected families execute ECHO activities in health, education and social development as measured in the ASQ by Jan. 2012</td>
<td>Output</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Not Specified ASQ suggested in Indicator narrative, but details of how ASQ is to be used not indicated</td>
</tr>
<tr>
<td>Objective</td>
<td>Indicator</td>
<td>Type / level</td>
<td>Baseline Yes/No</td>
<td>Frequency Specified (Yes/ No)</td>
<td>Target Date Specified (Yes/ No)</td>
<td>Means of Verification</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>--------------</td>
<td>-----------------</td>
<td>------------------------------</td>
<td>---------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Objective 4: To train CHA from the communities in the pilot district to assist in the delivery of parent support services.</td>
<td>90% of ECHO children worked with by CHA attained their milestones by Jan.2012.</td>
<td>Outcome</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Not specified</td>
</tr>
<tr>
<td>Objective 5: To transfer knowledge and skills to parents and communities.</td>
<td>Parents are able to demonstrate the skills taught.</td>
<td>Output</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Not specified</td>
</tr>
<tr>
<td>Objective 6: To promote healthy relationships between parent and child.</td>
<td>-Parents are able to make the toys, other homemade props and prepare meals -Other soft skill and resources provided in collaboration with other partners</td>
<td>Output</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Not specified</td>
</tr>
</tbody>
</table>
PART 7: ECHO Relevance

Table 12. ECHO Relevance - Detailed Evaluation Questions

<table>
<thead>
<tr>
<th>Detailed Evaluation Questions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How relevant is the ECHO programme, to the goals or objective of the national strategic or development plan in the health sector? How does it contribute to actions of the Government, to ensure access and quality ECD services to the most disadvantaged communities in St.Vincent &amp; the Grenadines?</td>
<td>Please see below</td>
</tr>
<tr>
<td>2. Does the ECHO Programme promote [the] development of the child’s personality, talents and mental and physical abilities to their fullest potential as specified in the convention on the Rights of the Child?</td>
<td>Please see below</td>
</tr>
<tr>
<td>3. What concerns do the stakeholders, especially the CHAs, have about the ECHO programme? How is this being dealt with? Are there any anecdotal or observable changes in the opinion or views of the stakeholders about the relevance of the ECHO programme etc.?</td>
<td>Please see below</td>
</tr>
<tr>
<td>4. How has ECHO been relevant in terms of promoting Gender and Equity (access, outcomes for girls and boys, etc.)</td>
<td>Please see below</td>
</tr>
</tbody>
</table>

7.1. ECHO PILOT PROGRAMME – STRATEGIC RELEVANCE

The United Nations Convention on the Rights of the Child recognizes that every young child has rights that should be respected. Similarly, the Vincentian Government recognized the importance of child rights and made it an integral part of their Strategic Plans for Health and Education (2007 – 2012). Through these plans, the Government aimed to improve the quality of life for Vincentians with economic growth, job creation, social cohesion and poverty reduction. Additionally, a crucial part of these plans were increased human and social development. The Government acknowledged the need for social and economic development through universal early childhood education. Specifically, they highlighted the following factors as critical to national development:

- universal access to quality education
- universal completion of quality education
- early childhood education for all children
- better overall performance in the Common Entrance Examination
- Poverty reduction

While these plans did not explicitly include the ECHO programme, the programme addresses several of these critical targets.

The Vincentian Government ensured that the ECHO programme was strategically piloted in one of the most disadvantaged communities in St. Vincent and the Grenadines. There were no user fees attached to the programme and it was targeted at the most at risk members of that community. This provided...
these children and their families with opportunities for exposure to early stimulation and positive parent-child interactions.

7.2. ECHO PILOT PROGRAMME - RELEVANCE TO CHILD RIGHTS

The ECHO programme provided opportunities for the promotion and development of a child’s personality, talents, mental and physical abilities as specified by the Convention of the Rights of the Child. However, the programme promoted the development of some abilities more than others as there were more activities related to enhancing talents, mental and physical abilities than to the development of a child’s personality. The ECHO programme used stimulation and toys (multi-coloured ball, rattles, sock puppet and pillow) to enhance mental and physical abilities. The mental abilities targeted were cognitive and developmental skills (vocabulary, hearing and speech, problem solving, personal social skills, hand and eye coordination). Physical abilities were enhanced through activities that encouraged the use of gross and fine motor skills. Talents were developed by enhancing creativity and using the sock puppets to encourage storytelling. Another key component of the programme was the promotion of good parent practices through parent support and training. This training had the potential to not only increase parental knowledge but also to help parents promote and encourage positive personality traits in their children.

7.3. ECHO PILOT PROGRAMME – STAKEHOLDER RELEVANCE

The stakeholders especially the CHAs thought the ECHO programme was a necessity. During the focus group with the CHAs a number of them commented that the ECHO programme was a good initiative which was quite relevant to the growth and development of the society at the time of its introduction. The CHAs greatly appreciated the extensive training received at the inception of the ECHO programme as it encouraged professional development and built self esteem. However, because of their already extensive job description ECHO duties became burdensome and time consuming. Many of the CHAs suggested using the Rovers to carry out the ECHO duties since they were already familiar with the families and the early stimulation process.

Mothers were overwhelmingly positive about the value of the programme with 81.8%, or 18 of the 22 interviewed as part of this evaluation, rating the pilot programme as excellent or very good. Seventeen (17) mothers or 77.3% reported that children were very engaged or engaged whenever the CHA came to visit. A large majority of parents interviewed (18/22 or 81.8%) indicated that the ECHO programme helped them to monitor / track their child's development. This was reported to be a result of the guidance and advice on developmental milestones received from the CHAs. Additionally, all mothers reported that they would re-enrol in the ECHO programme, if given the opportunities.
7.4. ECHO PILOT PROGRAMME – EQUITY FOCUS

There are several key elements in the design of the ECHO pilot programme that promote and address equity issues:

Focus on 0 - 3 years

The ECHO programme focuses on the birth to 3 year age group and on women during the antenatal period. Research has consistently shown that investment in the early years can be a powerful equaliser between disadvantaged children and their more advantaged peers (Irwin, Siddiqi & Hertzman, 2007). In addition, a focus on providing equitable access to high quality early childhood services can have tremendous benefits for a country (e.g. more productive citizens, lower crimes rates etc.) and play a critical role in nation-building.

The ECHO programme was designed to enhance children’s growth and development through stimulation, play, good nutrition and parent support/education. This focus is an important step in addressing the root causes of inequality and providing opportunities for the most deprived children. Specifically, the ECHO programme was aimed at improving health, development and academic outcomes for the most at-risk children and at assisting families to become more self-sufficient (through parent training).

Selection of pilot site and pilot families

The ECHO programme was piloted in the most economically disadvantaged district in St. Vincent and the Grenadines. The programme was also designed to target the most disadvantaged children and families within that district. The programme sought to identify and enrol those children and families most at risk for poor developmental outcomes due to health characteristics, disability, poverty and poor access to ECD services. By targeting the most deprived families, the programme sought to ensure that all children had the opportunity to survive, develop and reach their full potential. Additionally, the programme was not gender specific - both boys and girls were allowed to enrol in the programme and they were encouraged to do the same activities.

Programme elements

Several features of the ECHO programme supported an equity approach. Firstly, the programme was offered free of cost to families. Secondly, the programme utilised a home visiting model and as a result did not prevent participation of families based on their geographic location, resources or lack of ability to travel to a particular location. Also, the programme curriculum and delivery model were based on the Roving Caregiver Programme which had been shown to have some benefits for young children. The ECHO pilot was also designed to make the most of available resources by utilising CHAs who were already working in the community.

Training

During the ECHO pilot all CHAs received training in child development and in recognising warning signs for developmental concerns. These skills are now transferrable to other families and communities who do not have access to these types of services. Overall, the pilot allowed for the development of a cadre of
health workers who are better able to identify children with potential delays and disabilities. This will improve the early identification, assessment and intervention of children with disabilities.
## PART 8: ECHO EFFECTIVENESS

### Table 13. ECHO Effectiveness Detailed Evaluation Questions

<table>
<thead>
<tr>
<th>Detailed Evaluation Questions</th>
<th>Please see section on “Impact – Child Development Outcomes”</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the progress made so far, towards achieving the planned outputs and outcomes? When measured against the baseline situation, how are the children who have passed through the programme since 2010 doing in terms of performance in five areas of development: communication, gross motor skills, fine motor skills, problem solving and personal social skills?</td>
<td></td>
</tr>
<tr>
<td>Were the activities, planned under the ECHO programme, necessary and sufficient (in quantity and quality) to achieve the outputs?</td>
<td>Please see section “Gaps in the M&amp; E Framework”</td>
</tr>
<tr>
<td>How do the stakeholders’ (both duty bearers and rights-holders) perceive or appreciation the results of the ECHO programme? What do they like or dislike about it? What do they want to change? What are the CHAs, parents and health officials saying about the ECHO programme?</td>
<td>Please see below</td>
</tr>
<tr>
<td>How has the ECHO programme implementation mechanisms (coordination, management, etc.) affected the current results/outputs of the programme?</td>
<td>Please see below</td>
</tr>
<tr>
<td>What partnerships have been developed to support the pilot ECHO programme in achieving its objectives?</td>
<td>Please see section on “The ECHO Pilot Programme”</td>
</tr>
<tr>
<td>How has the external environment (political, economic, cultural etc.) affected the internal management of ECHO programme?</td>
<td>Addressed in section on Programme Strengths, Challenges, Opportunities &amp; Constraints</td>
</tr>
<tr>
<td>Are the originally identified assumptions still valid? Has the programme included strategies to reduce the impact of identified risks? Are there any one or two killer assumptions that could “kill” the programme?</td>
<td>See below</td>
</tr>
<tr>
<td>How successful was the programme in targeting, reaching and addressing the specific needs of the most disadvantaged communities, families and children?</td>
<td>See below</td>
</tr>
<tr>
<td>How appropriate has resource allocation been? How adequate is the monitoring system established to support the ECHO Programme</td>
<td>Please see – Strengths &amp; Weakness – Financial Support &amp; “Gaps in the M&amp; E Framework”</td>
</tr>
</tbody>
</table>

The absence of a Monitoring and Evaluation Framework, with well defined and indicators, which were measured and reported on made the analysis of project outcomes against objectives difficult. The approach utilised was to identify from all available data any evidence to support that objectives were met and/or indicators were attained. The analysis was also limited because the objectives and indicators were not well aligned (Please see section on the Gaps in the M& E Framework for a detailed analysis).
### Table 14. Summary of Outcome of Goal Objectives and Results/Outputs

<table>
<thead>
<tr>
<th>Item of Measurement</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal</strong></td>
<td>Quality early childhood health stimulation readily accessible to “at risk” children and parents</td>
<td>Partially Achieved</td>
</tr>
<tr>
<td><strong>Objective 1</strong></td>
<td>To offer early stimulation to young children</td>
<td>Achieved</td>
</tr>
<tr>
<td><strong>Objective 2</strong></td>
<td>To improve parenting practices in “at risk” communities</td>
<td>Partially Achieved</td>
</tr>
<tr>
<td><strong>Objective 3</strong></td>
<td>To promote and monitor good health and early development of young children</td>
<td>Partially Achieved</td>
</tr>
<tr>
<td><strong>Objective 4</strong></td>
<td>To train CHAs from the communities in the pilot district to assist in the delivery of parent support services</td>
<td>Achieved</td>
</tr>
<tr>
<td><strong>Objective 5</strong></td>
<td>To transfer knowledge and skills to parents and communities</td>
<td>Partially Achieved</td>
</tr>
<tr>
<td><strong>Objective 6</strong></td>
<td>To promote healthy relationships between parent and child</td>
<td>Unable to be assessed</td>
</tr>
<tr>
<td><strong>Output/Result 1</strong></td>
<td>Stimulate children 0-3 years</td>
<td>Achieved</td>
</tr>
<tr>
<td><strong>Output/Result 2</strong></td>
<td>Trained and skilled parents/caregivers in parenting practices</td>
<td>Unable to be assessed</td>
</tr>
<tr>
<td><strong>Output/Result 3</strong></td>
<td>Trained and skilled CHAs</td>
<td>Unable to be assessed</td>
</tr>
<tr>
<td><strong>Output/Result 4</strong></td>
<td>Pilot objectives achieved, in preparation for mainstreaming</td>
<td>Partially Achieved</td>
</tr>
</tbody>
</table>

### 8.1. PROVIDING EARLY CHILDHOOD STIMULATION TO CHILDREN AND FAMILIES AT RISK

#### 8.1.1. Identification of Children and Families at Risk

The primary goal of ECHO was to provide a high quality programme of early childhood stimulation to children and parents at risk in SVG. This was partially achieved through establishing the pilot in the Calliaqua health district, which was chosen because of its relatively high rate of poverty. At a national level therefore, the ECHO pilot through the use of geographic and socioeconomic factors, served families that were at greatest risk. At the operational level however, a targeting mechanism to identify the children at greatest risk was not developed until the second year of the pilot. These risk criteria included demographic characteristics such as poverty, health risks for developmental delay, minor developmental delay and non-attendance at pre-school. In year one, however, families were enrolled based on subjective identification of need by the Community Health Aides. The delayed use of an objective targeting mechanism makes it difficult to ascertain whether the ECHO Pilot served the children and families at greatest risk within the Calliaqua district. The survey of parents conducted as part of this evaluation found that 68% of mothers interviewed did not meet any of the eligibility criteria. These issues with targeting at the household level
emerged because the ECHO pilot team lacked technical expertise in identifying risk factors that could be used to develop eligibility criteria.

8.1.2. The ECHO Stimulation Programme Delivery

The delivery of the programme of stimulation was not fully achieved as prescribed by the ECHO guidelines. According to reports by CHAs and parents the prescribed rate of two visits per month was not met. This was partially due to lack of buy in by the CHAs who were responsible for programme implementation. The bigger challenge however, was the fact that the CHAs had to add the ECHO duties to their existing busy workload (see Table 10 for a description of the CHAs weekly work schedule). There was also inadequate training and supervision on the part of the nursing supervisors. The structure of ECHO with a distinct project office, while useful for project execution at an administrative level, proved to be an inhibiting factor in the day to day supervision of pilot activities. This may have given the impression that ECHO activities were the primary responsibility of the ECHO Project Staff and did not require significant inputs from the Senior Nurses in the Community Nursing Service (CNS). As a result of the poor supervisory structure and the lack of adequate documentation, it was difficult for the evaluation team to assess the quality of the stimulation programme delivered. Parents surveyed for this evaluation revealed that there were variations in the number and frequency of stimulation visits with only 22.7% of the 22 mothers interviewed reporting that they received visits twice monthly as required. In fact, 40.9% of mothers interviewed reported they received visits every two months or greater than every two months. The mothers however, reported that regardless of the frequency of the visits, stimulation was the primary focus of the CHA visits. The perceived ease of incorporation of the ECHO activities into the CHAs work schedule and the CNS proved to be a “killer assumption” during the pilot phase.

8.2. IMPROVEMENT OF PARENTING PRACTICES

There was no evidence available to assess whether the ECHO pilot had any effect on parenting practices. There were no data on parenting practices collected at baseline during the first phase of the project. A baseline survey on parenting knowledge, attitude and practice was conducted during the second phase of the project. However, there were no end-of-project data collected in this phase. It is unclear how data from the parenting knowledge and attitude survey were utilised. Improvement in parenting knowledge and attitude, which precedes improvement in parenting practice, is often used as a proxy measure for parenting practice. Improvement in this area would have been more accurately determined by comparing parenting knowledge and attitude of ECHO and control children pre and post programme implementation. Further, the evaluation was conducted more than two years after the completion of the pilot making it challenging to assess the impact of the pilot in this area. The gap in data to evaluate this objective is a result of the absence of a comprehensive monitoring and evaluation system and adequate staff to collect and process data as required.

8.3. MONITORING OF CHILD DEVELOPMENT STATUS

The ECHO pilot was able to partially implement monitoring of child development status via the use of the Ages and Stages Questionnaire by the CHAs. These tools were used at the primary level by the CHAs to ascertain the whether the child had any areas of concern and to guide the programme of stimulation. There was no evidence that showed how these developmental screens were used to guide the
intervention. Also, there was no evidence to suggest that Nursing Supervisors or the Project Coordinator reviewed these tools. This is linked to the relatively undefined role of the Nursing Supervisors in the ECHO protocols and procedures. Parents reported in interviews however, that they were more aware of child development as a result of the ECHO pilot. Use of the data related to child development for planning and analysis was not systematic throughout the pilot. The data from the ASQs were used to inform the report on child development at baseline and exist in year two of the project. This was too late to make any meaningful changes during pilot. The absence of an M&E officer for most of the project resulted in the underutilisation of various potential data sources including those related to child development status.

8.4. TRAINING OF COMMUNITY HEALTH AIDES

Forty-three Community Health Aides successfully completed a training programme that had both theoretical and practical aspects related to early childhood development and stimulation in the early years. This training, a collaborative effort of the ECHO pilot, Community Nursing Service and the Ministry of Education, provided a good refresher for the CHAs but lacked focus on a developmentally appropriate curriculum that should be followed with the participants. The training programme also lacked any kind of formal assessment process; this makes it difficult to assess how well trainees mastered the material that was presented.

8.4.1. Transference of Knowledge and Skills to parents and communities & promotion of healthy relationships

During the pilot there was no assessment of how skills and knowledge were transferred to parents throughout the project or how healthy relationships were promoted. As such, the performance of these objectives cannot be fully assessed. It was noted in the project documents that there were 8 parent workshops that focused on equipping parents with skills in backyard gardening (through a partnership with the Ministry of Agriculture) and nutrition. Parents reported that they viewed these workshops as positive and that they had incorporated the meal preparation techniques into their daily life. Parents also reported however, that they had limited interest in making toys as a result of the availability of relatively inexpensive toys that could be readily purchased. The making of toys such as the ball and pillow required the use of skills such as sewing, which some mothers found burdensome.
PART 9: ECHO EFFICIENCY

Table 15. ECHO Efficiency - Detailed Evaluation Questions

<table>
<thead>
<tr>
<th>Detailed Evaluation Questions</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>What, if any, has been the difference between the allocation of funds at the planning/budgeting stage and the use of funds during the implementation stage?</td>
<td>There was not enough evidence to facilitate this analysis. The original project budget was not present in any project documents. Also, no income &amp; expenditure reports were prepared.</td>
</tr>
<tr>
<td>Are there any inefficiency issues with regards to how the programme is conceptualized, implemented or managed?</td>
<td>Please see section on Programme and Evaluation Process</td>
</tr>
<tr>
<td>How can one compare the relationship between project costs and the results achieved? Justifiable?</td>
<td>Beyond the scope of this evaluation.</td>
</tr>
<tr>
<td>How have the duty bearers and rights holders been interacting in the planning and implementation of the ECHO programme? Is there any potential efficiency gain to be made?</td>
<td>There is not enough evidence to access this question.</td>
</tr>
</tbody>
</table>

9.1. COSTS OF ECHO PROGRAMME

The review of project documents has revealed that the total cost of the ECHO pilot can be estimated at ECD $452,674 (Table 16). As the pilot served 182 children, the cost per child can be estimated at $2,487.2. These figures were estimated from the final project report that detailed expenditure for the two years of the pilot, as well as expenditure reports from UNICEF.

The pilot project records indicate that the project was funded by a combination of local and international development partner support and government funding. The majority of the donor support was reported to be obtained from CCSI, through funding obtained from the Bernard van Leer Foundation. However, these contributions could not be determined from project reports. The cost of CHA time (estimated at 20% of the total) was included to account for the contribution by the Government of St. Vincent and the Grenadines.
Table 16. Estimated Cost of ECHO Programme

<table>
<thead>
<tr>
<th>Pilot</th>
<th>Cost ($EC)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Human Resources</strong></td>
<td></td>
</tr>
<tr>
<td>Project Coordination &amp; Admin</td>
<td>$ 166,175.00</td>
</tr>
<tr>
<td>CHA cost @ 20% Time</td>
<td>$ 71,332.80</td>
</tr>
<tr>
<td><strong>Project Administration</strong></td>
<td></td>
</tr>
<tr>
<td>Utilities etc</td>
<td>$ 51,949.58</td>
</tr>
<tr>
<td>Travelling &amp; Meeting Stipends</td>
<td>$ 16,584.00</td>
</tr>
<tr>
<td>Training</td>
<td>$ 108,221.48</td>
</tr>
<tr>
<td>Parent Workshops</td>
<td>$ 11,741.28</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>$ 26,670.50</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$ 452,674.64</strong></td>
</tr>
</tbody>
</table>

9.2. COMPARISON OF ECHO AND RCP PROGRAMME

Cost Comparison

Table 17 compares the cost of the RCP (Amsterdam Institute for International Development, 2010) with that of the ECHO Programme. The total cost for the RCP Programme was estimated at EC $399,760 with 19 Roving Caregivers serving 360 children. The cost per child of the RCP programme can therefore be estimated at $1110.72 per child. The cost of implementation of the ECHO programme is estimated to be 2.2 times that of the RCP.

Table 17. Cost and Operational Comparisons of the ECHO and RCP Programmes

<table>
<thead>
<tr>
<th>Factors</th>
<th>ECHO Pilot</th>
<th>RCP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost per Child</td>
<td>$2487.22</td>
<td>$1110.72</td>
</tr>
<tr>
<td>Offered by</td>
<td>CHA's</td>
<td>Rovers</td>
</tr>
<tr>
<td>FT vs PT</td>
<td>Part Time</td>
<td>Full Time</td>
</tr>
<tr>
<td>Training</td>
<td>Community Health Aide Programme plus ECHO Training</td>
<td>NCTVET Level 1 or 2</td>
</tr>
<tr>
<td>Supervision</td>
<td>Community Nurse (with other responsibilities)</td>
<td>Community Supervisor ( Full time )</td>
</tr>
<tr>
<td>Number of Home Visits per Annum per Child (Projected)</td>
<td>24</td>
<td>104</td>
</tr>
<tr>
<td>Number of Children per professional</td>
<td>14</td>
<td>19</td>
</tr>
<tr>
<td>Parent Meetings /Workshops</td>
<td>Yes-Frequency Unknown</td>
<td>Monthly</td>
</tr>
<tr>
<td>Community Meetings</td>
<td>Not Known</td>
<td>12 Per Annum</td>
</tr>
<tr>
<td>Assessment of Children's Progress</td>
<td>Yes (ASQ)</td>
<td>No</td>
</tr>
<tr>
<td>Factors</td>
<td>ECHO Pilot</td>
<td>RCP</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Monitoring &amp; Evaluation Framework</td>
<td>Somewhat</td>
<td>No</td>
</tr>
<tr>
<td>Eligibility Criteria</td>
<td>Yes, Social, health,</td>
<td>Yes Children in Disadvantaged</td>
</tr>
<tr>
<td></td>
<td>Educational/Developmental</td>
<td>Communities</td>
</tr>
<tr>
<td>Improvement in Child Development Status</td>
<td>Not Known</td>
<td>Short term improvement in</td>
</tr>
<tr>
<td></td>
<td></td>
<td>fine motor function</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improvement in visual</td>
</tr>
<tr>
<td></td>
<td></td>
<td>reception (St. Lucia)</td>
</tr>
</tbody>
</table>

### 9.2.1. **Operational Comparisons**

Table 17 also compares other operational aspects of the programmes. Comparisons between the RCP programme offering and the ECHO offering illustrate some of the greater operational efficiency offered by the RCP. First, the Rovers and their supervisors were able to provide full time attention to the execution of the stimulation programme. The full time nature of the RCP programme meant that they were able to serve a larger number of poor children as well as provide more contact hours. The competing responsibilities of the CHAs and other stakeholders within the Community Nursing Service made it difficult for them to offer stimulation to young children in SVG at the same frequency. While it would seem logical that greater contact hours will result in greater improvement in children’s development, the minimum number of contact hours required for home visiting programmes to be effective has not yet been accurately determined, though a study in Jamaica suggested twice per week.

The parent and community meetings also seemed to be offered on a more regular schedule in the RCP delivery.

### 9.2.2. **Outcome Comparisons**

The most important comparison of these two programmes, that of improvement in children’s developmental status was not able to be analysed, because of an absence of outcome data for the ECHO programme.

### 9.3. **HUMAN RESOURCE REQUIREMENTS AND OTHER COSTS FOR SCALE UP OF ECHO PROGRAMME**

Should the Government of SVG make the decision to scale-up the ECHO Programme, there are a number of human resource matters that will need to be addressed.

**Community Health Aides**

Based on the estimates of man hours required to deliver the ECHO programme, universal delivery of ECHO to all children in the target age group would prove to be impossible for the current cadre of 43 CHAS. Delivering the programme to all children in the target age group would require 3166 hours per person per year. The typical CHA work year is comprised of 22 days per month or 264 days for the year; this amounts to a maximum of 1,848 working hours including vacation days. Even if the current cadre of CHAS were to serve the estimated 90% of children who are not accessing any day care services it would require 2849 hours per person per annum.
If the programme focused exclusively on children in poverty, it would require more than 60% of CHA’s available work hours. Based on the current work load of the CHAs, there would be one of the five work days each week available to focus on the execution of ECHO activities (Table 10). A CHA would be able to see a maximum of seven (7) families per day taking into consideration lunch and travel time. They are required to see families twice per month so this would result in each CHA being assigned 14 children per year. With the current staff complement this would result in a maximum of 602 children being served each year.

Another option would be to have CHAs, or some other health professional grouping deliver the ECHO programme, on a full time basis. This would require recruitment of staff. Table 18 provides a breakdown of the number of professionals needed to execute the programme.

**Supervisors**

Effective delivery of the ECHO programme requires adequate supervision. The options are increasing the cadre of nursing staff at clinics or engaging nursing staff or other supervisory staff who are dedicated to supervision of the ECHO programme.

**Administrative Support**

An administrative team is required to facilitate the smooth running of the operational aspects of the ECHO programme.

**Monitoring and Evaluation**

An M&E team would be required in order to ensure that the ECHO programme is collecting data required to adequately assess performance. It is proposed that this team be comprised of an M&E Officer, Research Assistant and 2 clerical / data entry staff members. It is critical that this team be in place prior to the commencement of ECHO activities so that an M&E Plan can be developed that has clear targets and a data collection plan. One gap during the pilot phase was the ad hoc nature of data collection and processing. There were some data collected but this did not appear to be systematic nor was the data used in a meaningful manner. A full M&E team would also better facilitate the tracing or tracking of programme beneficiaries over time to allow for the evaluation of the programme’s impact.

Tables 18 and 19 below estimate the human resource cost for programme delivery, while Table 20 estimates programme administration costs.

**Table 18. Estimation of Human Resource Costs for ECHO Programme @ 70 families each per CHA (CHAs and Supervisors)**

<table>
<thead>
<tr>
<th>Service Provision Type</th>
<th>Number of CHAs</th>
<th>Cost at $25,476 per annum</th>
<th>Supervisors (1 per 20 CHAs)</th>
<th>Cost at $68,784 per annum</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Universal Service</strong></td>
<td>81</td>
<td>$2,063,556.00</td>
<td>4</td>
<td>$275,136.00</td>
</tr>
<tr>
<td>[5674 children]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Service for children with</strong></td>
<td>73</td>
<td>$1,859,748.00</td>
<td>4</td>
<td>$275,136.00</td>
</tr>
</tbody>
</table>
**Table 19. Estimation of Human Resource Costs for ECHO Programme @ 70 families each per CHA (Administrative, M&E, Clerical and Total Costs)**

<table>
<thead>
<tr>
<th>Service Provision Type</th>
<th>Number of Admin. Staff</th>
<th>Cost@ $40,000.00 per annum</th>
<th>Number of M&amp;E staff</th>
<th>Cost at $60,000.00 per annum</th>
<th>Number of Clerical/Data Entry staff</th>
<th>Cost at $22000.00 per annum</th>
<th>Total Human Resource Costs (including CHAs and Supervisors)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal Service</td>
<td>2</td>
<td>$80,000.00</td>
<td>2</td>
<td>$120,000.00</td>
<td>3</td>
<td>$66,000.00</td>
<td>$2,604,692.00</td>
</tr>
<tr>
<td>Service for children</td>
<td>2</td>
<td>$80,000.00</td>
<td>2</td>
<td>$120,000.00</td>
<td>3</td>
<td>$66,000.00</td>
<td>$2,400,884.00</td>
</tr>
<tr>
<td>with no access to Day</td>
<td>1</td>
<td>$40,000.00</td>
<td>1</td>
<td>$60,000.00</td>
<td>2</td>
<td>$44,000.00</td>
<td>$1,183,416.00</td>
</tr>
<tr>
<td>Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service for children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>in poverty only</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(36% of population)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>[2099 children]</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Table 20. Estimation of Administration Costs for ECHO Programme @ 70 families each per CHA**

<table>
<thead>
<tr>
<th>Item</th>
<th>Universal Service [5674 children]</th>
<th>No Access to Day Care [5107 children]</th>
<th>Poor children (36%) [2099 children]</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECHO Administration Costs (Stationery &amp; Supplies, Standardised Tests, Printing)</td>
<td>$80,000.00</td>
<td>$80,000.00</td>
<td>$32,000.00</td>
</tr>
<tr>
<td>M&amp;E Activities (Family Eligibility Activities, Parent Surveys, Child Assessments, CHA Evaluations)</td>
<td>$150,000.00</td>
<td>$150,000.00</td>
<td>$60,000.00</td>
</tr>
<tr>
<td>CHA Training Programme for New Recruits*</td>
<td>$108,221.00</td>
<td>$108,221.00</td>
<td>-</td>
</tr>
<tr>
<td>Annual Training Days @100 per CHA</td>
<td>$8,100.00</td>
<td>$7,300.00</td>
<td>$3,000.00</td>
</tr>
<tr>
<td>Parent Workshops @ 30 EC per parent (Once per yr)</td>
<td>$170,220.00</td>
<td>$153,210.00</td>
<td>$62,970.00</td>
</tr>
<tr>
<td>ECHO Materials @ 40 EC per family</td>
<td>$226,960.00</td>
<td>$204,280.00</td>
<td>$83,960.00</td>
</tr>
<tr>
<td>Total</td>
<td>$743,501.00</td>
<td>$703,011.00</td>
<td>$241,930.00</td>
</tr>
</tbody>
</table>

*Additional training required only for services needing more than existing 43 CHAs
The combined cost for the annual implementation of the ECHO programme is indicated in Table 21 below. There is only $350,000.00 difference in cost between a universal service and one that targets children who have no access to Day Care. These universal or near universal programmes targeted at all or most children will require the Ministry of Health’s budget to be increased by 4%, while a programme targeted at poor children would require an increase of 2%.

**Table 21. Total Costs for Delivery of ECHO Programme by Type of Service Provision**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Human Resource Costs</th>
<th>Programme Administration Costs</th>
<th>Total ECHO Programme Delivery Costs</th>
<th>Estimated Health Budget</th>
<th>Percentage Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal Service</td>
<td>$2,604,692.00</td>
<td>$743,501.00</td>
<td>$3,348,193.00</td>
<td>$81,500,000.00</td>
<td>4%</td>
</tr>
<tr>
<td>Service to children with no access to Day Care</td>
<td>$2,400,884.00</td>
<td>$703,011.00</td>
<td>$2,995,674.00</td>
<td>$81,500,000.00</td>
<td>4%</td>
</tr>
<tr>
<td>Service to Poor Children</td>
<td>$1,183,416.00</td>
<td>$241,930.00</td>
<td>$1,425,346.00</td>
<td>$81,500,000.00</td>
<td>2%</td>
</tr>
</tbody>
</table>

It should be noted that the salary costs are based on additional CHAs required for scaling up of the programme, and not the introduction of Rovers as Health Care assistants within the Ministry. This costing does not take into account the request by CHAs for a revised job description and additional compensation for the execution of ECHO activities.

**9.4. OPTIONS FOR MORE LIMITED BUDGETS**

Development of a more accurate system of targeting children who have the greatest need would reduce absolute number of programme recipients, and therefore programme costs. Salary costs for CHAs account for 61.6%, 62.1% and 53.6% of the total ECHO programme budget for universal service, service to children without access to Day Care and poor children, respectively. Engagement of other professional groups, such as Roving Caregivers, would reduce this component of the budget, with additional operational efficiencies as described earlier.

**9.5. LIMITATIONS TO COST ANALYSIS**

Cost analysis was limited to estimation of programme costs, comparison with similar programmes and estimation of costs of the scale-up of the programme. More extensive cost effectiveness, cost benefit and cost efficiency analyses could not be undertaken because of the absence of collection of data on impacts, outcome or output.

A post programme analysis of outcome was attempted during this evaluation, but the small sample size obtained did not allow for this analysis.
PART 10: ECHO IMPACT & OUTCOMES

Table 22. ECHO Impact & Outcomes Detailed Evaluation Questions

<table>
<thead>
<tr>
<th>Detailed Evaluation Questions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Were the indicators selected to monitor the programme Specific, Measurable, Achievable and Relevant enough to determine the outputs and outcomes? Do the indicators need to be revised? Are the indicators disaggregated e.g. by gender, age group and geographic location?</td>
<td>Please see “Gaps in the M&amp; E Framework”</td>
</tr>
<tr>
<td>Has it been feasible to collect data on selected indicators? Were clear baseline data collected on the children in the target communities? Was a logical framework developed to explain how the ECHO programme was expected to work? How frequently was monitoring data collected?</td>
<td>Please see “Gaps in the M&amp; E Framework”</td>
</tr>
<tr>
<td>Are there any observed unintended direct or indirect results at the household level (children, parents, caregivers)?</td>
<td>None to report</td>
</tr>
<tr>
<td>Is there any observable evidence of the contribution of the ECHO Programme to short, or medium term improvements in the selected children, communities etc.? In what ways are the programme staff benefitting?</td>
<td>See below</td>
</tr>
<tr>
<td>Is there any difference in the way the programme affects girls compared to boys? Based on socio-economic status, who is benefiting more? The wealthiest? The poorest?</td>
<td>See below</td>
</tr>
</tbody>
</table>

A review of M& E Reports identified an analysis of the developmental progress children made in relation to their baseline scores in the five domains assessed by the Ages and Stages Questionnaires (Figure 3). However, information on developmental progress was only available for a single point in the programme, October 31, 2011, some fourteen months after collection of baseline developmental scores on August 31, 2010. The report showed that there were small but statistically insignificant declines in scores in all developmental domains.

There were a number of limitations to the interpretation of this data. First, there was no information available on children in the second phase of the pilot project. Second, the raw data was not available for further exploration and analysis of the findings. It would have been useful to know the sample size, and to disaggregate data by age of children and by gender, and by score (at or near cut-off scores). The absence of the raw data also meant that the analysis could not be replicated. Additionally, the scores of children who participated in the current evaluation were unable to be tracked and compared with current scores.
10.1. RESULTS OF ASSESSMENTS CONDUCTED DURING THIS EVALUATION

A randomly selected sample of ECHO parent and child beneficiaries was invited to participate in developmental assessments. Age and sex matched controls were also invited to participate. A total of seventeen (17) ECHO child beneficiaries and fifteen (15) control children participated.

The Jamaican ASQ is designed to be administered up to 60 months of age; children above 5 years were not assessed on this instrument. The WRAT was administered to children four years and older only. Children’s mean scores were compared using the Student’s t-test. The sample size was too small to allow for disaggregation by gender. Table 23 shows that ECHO child beneficiaries had higher mean scores than control children in the Gross Motor and Problem Solving domains of the ASQ and Reading and Arithmetic on the WRAT. However, none of the comparisons were statistically significant.

This analysis was limited by a number of factors. First, it was conducted many years after the pilot programme had ended and other factors that could potentially impact children’s performance positively or negatively since the end of the pilot were not able to be included in the analysis. Second, the sample size is small, and does not have the necessary power to demonstrate programme effects. It is therefore unclear from this analysis whether the ECHO programme impacted children’s developmental outcome or not.
Table 23. **Comparison of Cognitive, Developmental and Academic Scores of ECHO Child Beneficiaries and Controls**

<table>
<thead>
<tr>
<th>Test</th>
<th>Domain Measured</th>
<th>ECHO Child Beneficiaries</th>
<th>Control Children</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>Mean Score</td>
<td>No.</td>
<td>Mean Score</td>
</tr>
<tr>
<td><strong>Peabody Picture Vocabulary Test (PPVT)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbal Comprehension</td>
<td>17</td>
<td>55.4</td>
<td>15</td>
<td>63.9</td>
</tr>
<tr>
<td>Jamaican Ages and Stages Questionnaire (ASQ-J)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>15</td>
<td>48.0</td>
<td>11</td>
<td>50.0</td>
</tr>
<tr>
<td>Gross Motor</td>
<td>15</td>
<td>56.4</td>
<td>11</td>
<td>49.7</td>
</tr>
<tr>
<td>Fine Motor</td>
<td>15</td>
<td>44.3</td>
<td>11</td>
<td>46.8</td>
</tr>
<tr>
<td>Problem Solving</td>
<td>15</td>
<td>44.6</td>
<td>11</td>
<td>43.2</td>
</tr>
<tr>
<td><strong>Wide Range Achievement Test (WRAT)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reading</td>
<td>8</td>
<td>13.2</td>
<td>7</td>
<td>12.8</td>
</tr>
<tr>
<td>Spelling</td>
<td>8</td>
<td>11.8</td>
<td>7</td>
<td>12.7</td>
</tr>
<tr>
<td>Arithmetic</td>
<td>8</td>
<td>10.9</td>
<td>7</td>
<td>9.3</td>
</tr>
</tbody>
</table>

NS – Not significant
PART 11: ECHO SUSTAINABILITY - CONSIDERATIONS & RECOMMENDATIONS FOR NATIONAL IMPLEMENTATION

Table 24. ECHO Sustainability Detailed Evaluation Questions

<table>
<thead>
<tr>
<th>Detailed Evaluation Questions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>What are strengths and weaknesses (design, coordination, management and monitoring) of the ECHO programme? How can these contribute to or hinder the overall sustainability of the pilot programme or other ECD programmes with a similar design?</td>
<td>Please see below</td>
</tr>
<tr>
<td>What has been the buy-in from the duty-bearers and rights-holders and what leadership or supportive roles have they played? What has been the financial and non-financial contribution of Government?</td>
<td>Please see below</td>
</tr>
<tr>
<td>What are the institutional capacity development actions required to ensure effective and efficient management, monitoring and evaluation of the ECHO Programme?</td>
<td>Please see below</td>
</tr>
<tr>
<td>What type of monitoring and evaluation systems were setup to facilitate the rollout of the ECHO Programme on a national basis in the model countries e.g. required tools, training of staff, processes and procedures?</td>
<td>Please see section on Gaps in M&amp;E System</td>
</tr>
</tbody>
</table>

11.1. PROGRAMME STRENGTHS, CHALLENGES, OPPORTUNITIES AND CONSTRAINTS

The strengths, challenges, opportunities and constraints of the ECHO Pilot programme were analysed at the administrative and operational levels.

11.1.1. Strengths

POLICY AND ADMINISTRATIVE LEVEL:

1. Stable Political Environment

There were no major political upheavals in St. Vincent and the Grenadines that affected the implementation of the pilot.

2. Political Support

There have been changes in the policy directorate with the Ministry of Health, Wellness and the Environment having had three different Permanent Secretaries since the ECHO pilot. In addition, the
Director of CNS changed during this evaluation process. Support for the programme has persisted despite the changes.

3. Administrative Structure

There is an identified monitoring committee, the Administrative Committee, with broad and inclusive membership of key stakeholders. The Administrative Committee further evolved to become a cross-sectoral committee. The cross-sectoral approach has been identified as an important feature of ECD administration. The Ministry of Agriculture, though not represented on the Committee, partnered with the Ministry of Health, Wellness and the Environment in providing materials and supporting training in backyard gardening.

4. External Partnerships

The project benefitted from technical support from regional development partners, such as the Caribbean Child Support Initiative (CCSI) and international development partners, such as the Bernard van Leer Foundation (BvLF) and UNICEF.

5. Financial Support

The pilot programme was adequately funded by BvLF and UNICEF. The donors provided funding for all project staff, as well as all equipment, supplies and materials. Interviews with the project coordinator indicated that although there were delays with payments on some occasions, the budget for the pilot was sufficient. Similarly, the CHAs in their focus group explained that they had adequate materials to conduct home visits with the parents.

6. Comprehensive Training Programme for CHAs

The training programme was identified as a strength of the pilot programme by multiple informants. The curriculum was comprehensive, used a mixed theoretical and practical approach, and was delivered full time. Topics were appropriate and ranged from child health and development to communication and professionalism. The training programme utilised the experience of professionals for theoretical aspects and the experience of Rovers for practical aspects.

7. Capacity Building of CHAs in Identification of Developmental Delay

Another important function of the ECHO programme for key stakeholders was the identification of children with developmental delays and disabilities. The CHAs believed that following the training programme, they were better equipped to recognise deviations in child development. The District Nursing Supervisors also said that the CHAs new skills would lead to better coordination and collaboration in the health sector as it relates to child health.

8. Utilisation of Opportunities for Capacity Building in Early Stimulation

The programme made good use of all potential opportunities to expand training in early stimulation. First, all CHAs were trained, rather than just those in the Calliaqua district, who would be involved in the pilot programme. Early stimulation principles and practice were incorporated into nursing curricula by the
Department of Nursing Education (DONE), with all nurses in training now learning about early stimulation. Together, these actions will lead to an expansion of the knowledge and importance of early childhood development across St. Vincent and the Grenadines. Additionally, this would reduce costs for scaling up the ECHO programme at a later date.

OPERATIONAL LEVEL

1. Delivery Model

The programme was delivered by CHAs who were already familiar with the communities and families where the programme was being offered. This made it easier for them to identify and enrol families in need of the programme. This also meant that families would be open to having the CHAs in their homes.

11.1.2. Challenges

POLICY AND ADMINISTRATIVE LEVEL:

1. Pilot Study Design

There were a few challenges with the design of the ECHO pilot programme. First, a Human Rights Based Approach, in this instance focussing on the principles of the Convention on the Rights of the Child and gender equity, was not utilised throughout the programme.

Second, the programme’s targeting methods did not appear to identify the most vulnerable (See section 8.1.1.).

Third, there were many concerns related to monitoring and evaluation (M & E). The M & E elements of the programme were not in place at the beginning of the pilot. For example, limited baseline data was collected on children enrolled in the programme. The baseline was limited to the data from the Ages and Stages developmental screen. No data were collected on the children’s physical health and wellbeing. This makes it hard to determine how much improvement (if any) each child made as a result of participation in ECHO. Similarly, the establishment of a matched control group at the beginning of the study would have also been useful for comparative purposes.

The M&E log frame that was developed was inadequate. For example, objectives and indicators were not aligned, neither were means of verification. Indicators were not written in SMART format: Specific, Measurable, Achievable, Relevant and Time-Bound, and were often vague (See section 6.11.).

2. Absence of Curriculum to Guide the Implementation of the Home Visiting Programme

One aim of the ECHO programme was to provide services to children who were unable to access preschool services. Most preschools are however, following some sort of established curriculum or programme. Additionally, many established home visiting programmes (e.g. Home Head Start in the US) are guided by established curricula. This ensures that a standard programme by age group is delivered as part of the programme. A curriculum with specific guides for parents would also provide more opportunities for parents to work on their own after the CHA’s visit.
3. Training

Though the training programme was considered comprehensive and was rated as excellent by multiple stakeholders, there was no objective evaluation of the skills and competencies gained by the CHAs through the training programme (See section 6.8). This was particularly important for the use of the standardised tool, the Ages and Stages Questionnaire. Project records indicate that this tool was not administered as indicated by the protocol.

Nursing Supervisors did not receive adequate training in ECHO protocols, instruments and methods, or in supervisory activities to monitor programme effectiveness and outcome (See section 6.8).

4. Disenfranchisement of a trained para-professional group

The Rovers, though integral to the training programme of the CHAs, were not employed to support the ECHO programme. In their focus group, Rovers reported feeling personally disenfranchised. Additionally, they had concerns about programme delivery, particularly the limited frequency of home visits received by at risk families. Rovers, a professional group highly skilled in early stimulation, are currently unemployed or under-employed.

OPERATIONAL LEVEL:

1. Buy-in/Enagament by Staff at the Operational Level

There was limited staff engagement in the ECHO pilot at the operational level. While most stakeholders agreed that the objectives of the ECHO programme were important for national development, there were challenges in the administration of the programme due to human resource constraints, ambiguity about roles and responsibilities and resistance to additional duties without additional compensation. The overwhelming view was that while the project was good in theory, it should have been operationalised by another group, not CHAs.

Many of the CHAs complained about tasks typical of an early stimulation programme such as going on the floor in some homes and carrying large bags with toy materials around.

There was also a perception that Roving Caregivers would be incorporated into the Health Care Establishment to execute the ECHO programme. As a result of this perception, the tasks related to ECHO were not fully incorporated into the work of the CHA and Nursing Staff.

CHAs expressed concern about the level of supervision that they received in the field. In the design of the ECHO pilot, a District Nursing Supervisor should supervise at least 2 home visits for each CHA. In practice, the CHAs reported that this did not happen.

2. Delivery Modality

ECHO activities were merged with existing tasks of the CHAs. Although a good idea in theory, in practice the CHAs found it difficult to manage their various roles, especially if there were multiple clients to serve in one household. As such, the intended dosage of 24 visits for the year was generally not achieved. As
noted in the section on Efficiency (part 9), it is not feasible to incorporate ECHO activities into the existing work of the current CHAs.

Developmental Assessments using the Ages & Stages questionnaire were supposed to be useful guides for the CHA’s but the tools were not used in the field according to the standardised protocol.

3. Buy-in by Parents to Aspects of the Programme

There was parental resistance to the toy-making aspect of the programme, obtained at interview. Some parents felt that it was simply easier to buy inexpensive toys, and a few admitted that they did not have the time or skill to make any of the toys that were demonstrated during the home visiting sessions. As toy-making relates to one of the key objectives of the ECHO programme, new strategies may need to be developed to demonstrate the value of having and using toys to stimulate young children and making toys from trashables if they are not affordable.

11.1.3. Opportunities

Belief in the Value of Programme by Stakeholders

Community Health Aides

Based on focus group discussions, the CHAs supported the objectives and content of the programme from its inception. They stated that the ECHO programme was an important initiative that could impact child development in SVG. They also believed that the programme would be especially helpful to families at risk. However, they expressed concern about programme delivery, noting that their workloads did not allow them to incorporate the ECHO programme successfully. They felt that the programme should be delivered by other individuals (such as a cadre of Rovers) who could focus solely on ECHO home visits and parenting classes.

The CHA focus group discussion also revealed that they were somewhat resistant to the programme at its inception and that there was difficulty with buy-in among the CHAs when the programme was introduced. This was confirmed by interviews with the project coordinator, senior nursing staff and members of the Administrative Committee. However, after completing the training programme and the pilot, the CHAs stated that they had a deeper appreciation for the programme. They felt that the training programme was exemplary and that it increased their knowledge and skill regarding parent education, enhancing child development and recognising deviations in development. They also believed that the home visiting sessions went well and that families benefitted from the programme.

All Stakeholders

All stakeholders agreed that the ECHO programme was necessary to help families most at risk. Both the CHAs and District Nursing Supervisors in their focus groups singled out young mothers as a group that needed intervention. Parent support/education was seen as the main role of the ECHO programme by both operational staff and parent beneficiaries.
The strong belief in the value of the programme to families and to the nation by all professional groups involved, even after initial resistance by some groups, should result in easier implementation at the national level.

Absence of Socio-Cultural Barriers to Home Visiting

There do not seem to be any major societal or cultural barriers to the implementation of the ECHO programme. Both CHAs and Rovers who participated in the focus group sessions indicated that parents were very willing to welcome them into their homes and reported good relationships with families. In addition, most Vincentian parents were keen to learn more about their children’s growth and development (based on parental interviews). Parents gave CHAs high scores for their knowledge, method and attitude during home visiting sessions (from parental interviews). This bodes well for national implementation.

ECHO Programme and national development

Several stakeholders (in their interviews and focus groups) also spoke of the importance of the ECHO programme in strengthening families in St. Vincent and the Grenadines and improving national development. Therefore they saw ECHO as having a bigger role to play in propelling the country forward.

11.1.4. Constraints

The main threat to the ECHO programme is sustainability. The pilot programme was almost fully funded by external partners. Operationalising the programme in an effective manner will require an increase in allocation to the health budget of 2% using a targeted approach, and 4% using a universal approach.

11.2. CONSIDERATIONS FOR NATIONAL IMPLEMENTATION

Prior to national implementation, there are a number of considerations to be taken into account by the government of St. Vincent and the Grenadines. The strengths and opportunities of the ECHO Pilot Programme can be built on, while strategies can also be included to address the challenges. Both considerations and related recommendations are presented in this section.

1. FINANCING AND SUSTAINABILITY

The ECHO Pilot Programme was almost fully supported by a grant from the Bernard van Leer Foundation. This grant allowed for the establishment of a project office, employment of project administrative staff and the procurement of public education and PR activities. For national implementation, financial support will need to be obtained within the budget of the government of St. Vincent and the Grenadines. Programme implementation will increase the health budget by 2% for a targeted programme and 4% for a universal programme. The major cost to be incurred would be to remunerate additional staff members. A review of the likely budgetary allocation for national implementation should be undertaken and a decision made on the nature of the programme to be implemented, targeted or universal.

2. ADMINISTRATIVE STRUCTURE FOR MONITORING

The existence of a cross-sectoral monitoring body – the Administrative Committee - is a mechanism to
promote buy-in and support for the programme. Inclusion of other existing partners, such as the Ministry of Agriculture, as well as the private sector (often a strong supporter of ECD) will promote further buy-in.

3. ADMINISTRATIVE SUPPORT

During the pilot there was strong administrative support to the project with an established project office, project coordinator and monitoring officer. The project coordinator functioned external to the Ministry of Health, Wellness and the Environment. The Community Nursing Supervisors office will be required to incorporate the overall management of ECHO into their regular duties. This may require the hiring of additional support staff dedicated to this activity.

4. PROGRAMME DESIGN

A Human Rights Based Approach, and one that ensures gender equity, was not fully utilised. This is important to ensure that children’s rights are upheld in programme delivery. The mechanism for targeting did not always identify the most vulnerable. Research should be undertaken of similar programmes and targeting mechanisms that are used internationally, regionally and locally to identify more relevant targeting criteria.

The M & E component of the pilot programme was weak. This prevented objective analysis of programme impact. Objectives and indicators were unclear. Data collection procedures were also weak, though many appropriate data collection forms were to be utilised. Therefore, an M & E specialist should be engaged as an integral member of the programme. Also, a comprehensive results framework should be developed which articulates the objectives of the programme well, and the intended pathways to achievement. The monitoring and evaluation indicators should be clearly defined, using the SMART approach, with data collection procedures and frequency of collection stipulated. It is imperative to determine programme outcome when national implementation is being considered.

5. TRAINING AND CURRICULUM DEVELOPMENT

A significant gap in the home visiting service provision during the pilot was the absence of a relevant home visiting curriculum that standardises the ECHO intervention. The focus was primarily on making specific toys and general stimulation with no mechanism to ensure that children had similar effective experiences. Though exposed to an excellently rated comprehensive training programme, there was no objective assessment of the training of CHAs. Nursing Supervisors were not adequately trained. The inclusion of early stimulation principles in the nursing curricula means that in-service training will be required only for currently employed existing nursing supervisors. An objective evaluation, combining both theory and practical aspects, should be designed and included in the training programme for the professionals who will deliver the ECHO programme. A home visiting intervention curriculum is required to guide home visiting procedures and ensure that all children have a similar experience when enrolled. The curriculum, like all others for young children, should be child centred, play based and designed to be structured but flexible. Additionally, Nursing Supervisors will require an in-service training programme.

6. HUMAN RESOURCE CHALLENGES AT THE OPERATIONAL LEVEL

Effective programme delivery was hindered by the decision to incorporate ECHO activities in the existing work schedule of CHAs, without increased remuneration or increased staff to ensure that programme delivery was sustained at the required level. A similar concern occurred at the Nursing Supervisory level, resulting in inadequate programme supervision. Yet, highly trained staff in early stimulation are currently unemployed or under-employed. A policy decision needs to be made regarding increasing the number of
CHAs or incorporating a new professional group (Rovers) in the health sector, whose sole responsibility will be early stimulation. Only by these mechanisms will a quality programme be able to be offered. Cost and operational analysis suggests that the latter option is more efficient and more financially feasible.
RECOMMENDATIONS

The following is a list of recommendations, listed in order of priority, for scaling up the programme which is based on the evaluation of the pilot programme.

1. ECHO Strategic & Financial Planning (Highest Priority)

   Recommendation: The relevant stakeholders within the Government of SVG (Ministry of Finance, Ministry of Health Wellness and the Environment & Ministry of Education) need to conduct a comprehensive review of the aims and objectives of the ECHO programme and to identify the scale and scope of the national programme to be introduced. An initial five year plan for ECHO needs to be devised that takes into account the following elements:
   - Human Resources
   - Universal or Targeted Programme Delivery
   - M& E
   - Programme Costs (Universal or Targeting)

   Efforts should be made to involve key stakeholders (rights holders and duty bearers) in the process of developing goals and strategies that include a clear focus on equity.

   Rationale & Timeline: The cost analysis has indicated that the ECHO programme, as piloted, cannot be effectively implemented without increasing the complement of CHAs and restructuring the operations of the Community Nursing Service. Additionally, the ECHO pilot benefitted from donor funding with the Government of St. St. Vincent providing limited financial support. An assessment of the programme requirements (based on objectives) and the associated costs is therefore critical. This plan should be developed within the 2015 – 2016 financial year.

   Benefit: Once a determination of the type of programme to be delivered is done, a review of the likely budgetary allocation for national implementation can be undertaken and a decision made on the nature of the programme to be implemented, whether targeted or universal. This will enable the Government to plan and budget for the programme over the medium term based on clearly defined programme objectives.

2. Human Resources

   A. Review the Operations of the Community Nursing Service by the MHWE to fully facilitate the incorporation of ECHO Activities

   Recommendation: The Community Nursing Supervisors’ office will be required to incorporate the overall management of ECHO into their regular duties. As such, an objective review of the operations of the CNS should be conducted to determine the impact of the additional duties on the department. A job evaluation should be conducted by the Human Resource Department (for relevant personnel within the CNS) to ascertain the impact of the additional duties on their jobs. The addition of ECHO will also require more administrative support.

   Rationale & Timeline: A killer assumption of the ECHO pilot was that the programme activities could be seamlessly incorporated into the regular workload of the CHAs and Nursing Supervisors (See Section 8.1.).
This review should be developed within the 2015 – 2016 financial year.

**Benefit:** This will assist the Government to determine Human Resource Needs for the programme.

### B. Policy Decision Re: Professional Group to Deliver ECHO

**Recommendation:** Once the scope of the National Programme has been determined, the Ministry of Health and Wellness & the Ministry of Finance need to make a policy decision regarding increasing the number of CHAs or incorporating a new professional group (similar to the Rovers) in the health sector, whose sole responsibility will be early stimulation.

**Rationale & Timeline:** As noted in the section on efficiency, the current cadre of CHAs are unable to deliver the ECHO programme as prescribed, due to their workload. Cost and operational analysis suggests that the engagement of a new professional group would be more efficient and more financially feasible. This decision should be made after Recommendations 1 and 2A are completed.

**Benefit:** Clear identification of the group with primary responsibility for delivering the ECHO programme will facilitate better buy-in and programme execution.

### 3. Identifying “At Risk” Families

**Recommendation:** Regardless of the nature of the national implementation, the MHWE must place special focus on identifying and serving families at greatest risk. A mechanism, to be used at enrolment, should be developed that objectively identifies families at risk.

**Rationale & Timeline:** During the pilot the criteria for identifying families were not clearly defined or utilised (See *). In a limited resource environment, maximum benefits are generally attained by serving the most vulnerable populations. This should be considered when the programme is being reviewed in Recommendation 1.

**Benefit:** This will increase the equity focus of the programme and ensure that there is an objective mechanism for identifying programme participants with the greatest needs. A more refined targeting mechanism should ensure that the families most in need of the programme are actually benefitting from it.

### 4. Home Visiting Curriculum

**Recommendation:** The Ministry of Health and Wellness and DONE in conjunction with the Ministry of Education should develop a home visiting intervention curriculum to guide home visiting procedures and ensure that all children have a similar experience when enrolled. The curriculum, like all others for young children, should be child centred, play based and designed to be structured but flexible. Efforts should be made to involve key stakeholders (rights holders and duty bearers) in the process of developing this curriculum.

**Rationale & Timeframe:** This was identified as a gap in the ECHO pilot programme and is essential for any home visitation programme. This curriculum should be developed after Recommendation 1 is completed.
Benefit: This will standardise the home visiting experience for all children enrolled in the programme and will facilitate the evaluation of child development outcomes.

5. M & E System

A. M & E Specialist

**Recommendation:** A Monitoring and Evaluation specialist should be engaged as an integral member of the programme. Also, a comprehensive results framework should be developed which articulates the objectives of the programme well, and the intended pathways to achievement. The monitoring and evaluation indicators should be clearly defined, using the SMART approach, with data collection procedures and frequency of collection stipulated. It is imperative to determine programme outcome when national implementation is being considered.

**Rationale & Timeframe:** This specialist needs to be engaged prior to the start of national implementation so that the necessary planning and data collection activities can occur.

**Benefit:** This will allow for the measurement of programme success.

B. M & E Framework – Equity Focus

**Recommendation:** The M & E system should ensure that the stakeholders (rights-holders and duty-bearers) have opportunities to provide feedback on the design and administration of the ECHO programme. Measurement systems that directly assess equity outcomes should be incorporated into the M & E framework.

**Rationale & Timeframe:** Increased equity focus of the M & E framework will improve targeting and ensure that there is balanced representation of vulnerable or marginalized groups in data collection, analysis and reporting.

**Benefit:** This will increase the equity focus of the programme.

6. Training

**Recommendation:** DONE should develop an in-service training programme for Nursing Supervisors. Additionally, the training curriculum related to monitoring child development (e.g. using the ASQ tool) and the identification and referral of children with developmental disabilities and delays should be strengthened to promote early intervention for this group of children and their families. An objective evaluation, combining both theory and practical aspects, should be designed and included in the training programme for the professionals who will deliver the ECHO programme.

**Rationale & Timeline:** These were identified as gaps in the training programme during the pilot. The inadequate training of Nursing Supervisors led to poor supervision of CHAs. This had a negative impact on programme delivery. Similarly, the evaluation identified that the ASQ was administered inconsistently and the data not utilised systematically. This has implications for the monitoring of child development status. These training gaps should be addressed prior to national implementation.

**Benefit:** This would enhance the overall equity-focus of the programme.
7. Expand the Administrative Committee

Recommendation: Ministry of Agriculture and Private Sector representatives should be invited to join the Administrative Committee. This would help to maintain and expand the Administrative Committee to include other government partners and the private sector.

Rationale & Timeline: A cross-sectoral monitoring body will promote better use of resources and sharing of technical expertise.

Benefit: This would promote a stronger ECD sector and better buy in from all.
CONCLUSIONS

The importance of the early childhood period to national development is now a scientific fact. Children, birth to eight years, who are provided with quality early childhood development, not only have better educational and social outcomes as children, but also become more productive adults, who are able to contribute positively to nation building. Over the last few decades, the importance of brain development, through early stimulation, has been recognised.

The Early Childhood Health Outreach (ECHO) programme represents an attempt on the part of Government of St. Vincent and the Grenadines to improve to ECD services for Vincentian children and families. ECHO is a home visiting programme that was based on the internationally acclaimed Roving Caregiver programme, but delivered by Community Health Aides who were already a part of the healthcare system of the country.

Home visiting models can have benefits for children and families at risk, especially where there is limited access to centre-based services. Reviews of home visiting programmes have demonstrated that they can have positive benefits to families by way of influencing parenting practices, the quality of the child’s home environment, and children’s development (Howard & Brooks-Gunn, 2009).

However, the research has also shown that if home-visiting programmes are to have their maximum impact, individuals delivering the programmes must be appropriately selected and well-trained and must follow the programme guidelines carefully and consistently (Howard & Brooks-Gunn, 2009).

While there were several identified ECHO programme strengths (such as strong political support for the programme and capacity building for the CHAs through the development and execution of a comprehensive training programme) there were key challenges that impacted programme delivery and evaluation. A main concern at the operational level was the inability of CHAs to deliver the programme with the frequency and intensity required as stated in the protocol, due to additional duties on an existing workload without an increase in staff complement. This also affected supervision of the programme by nurses, who had responsibilities to the community clinics. Also the pilot programme suffered from an inadequate result-based framework which is critical for determining programme success.

Therefore key areas for consideration before national scale up of the programme include addressing the human resource matter of determining the professional who will deliver the programme at the community level and implementing an improved Monitoring and Evaluation system. In addition, many home visiting programmes in the Caribbean have concerns about sustainability. This was identified by this evaluation as a major constraint for ECHO. Adequate financing is critical for a national scale up of the programme. Issues related to financing should be examined through the clear identification by all stakeholders of programme goals, delivery modality and programme costs. The Government of St. Vincent and the Grenadines may need to seek funds in the short to medium term to expand the programme. Greater public and private sector partnerships could be forged to assist in obtaining necessary resources for the programme, especially related to materials for the toy-making and parent workshops.

Based on the potential challenges related to adequately financing the programme, national implementation should begin on a phased basis, with an assessment of outcomes to determine if the programme is having the desired impact on the lives of young Vincentians and their families.
REFERENCES


### APPENDIX A — LIST OF ABBREVIATIONS & ACRONYMS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>ASQ - 3</td>
<td>Ages and Stages Questionnaire - 3</td>
</tr>
<tr>
<td>ASQ-J</td>
<td>Ages and Stages Questionnaire - Jamaica</td>
</tr>
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<td>BNTF</td>
<td>Basic Needs Trust Fund</td>
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<td>Bernard Van Leer Foundation</td>
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<td>Caribbean Community</td>
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<td>Care for Child Development</td>
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<td>Caribbean Child Care Support Initiative</td>
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<td>CHAs</td>
<td>Community Health Aides</td>
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<td>Community Nursing Services</td>
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<td>CRC</td>
<td>Convention on the Rights of the Child</td>
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<td>DONE</td>
<td>Division on Nursing Education</td>
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<td>ECD</td>
<td>Early Childhood Development</td>
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<td>ECHO</td>
<td>Early Childhood Health Outreach</td>
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<tr>
<td>ERIC</td>
<td>Ethical Research Involving Children</td>
</tr>
<tr>
<td>FDCC</td>
<td>Foundation for the Development of Caribbean Children</td>
</tr>
<tr>
<td>FNP</td>
<td>Family Nurse Practitioner</td>
</tr>
<tr>
<td>HCAs</td>
<td>Health Care Assistants</td>
</tr>
<tr>
<td>HNS</td>
<td>Health Nursing Supervisor</td>
</tr>
<tr>
<td>HSP</td>
<td>High Scope Programme</td>
</tr>
<tr>
<td>IMCI</td>
<td>Integrated Management of Childhood Illnesses</td>
</tr>
<tr>
<td>IT</td>
<td>Information Technology</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
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<tr>
<td>MHWE</td>
<td>Ministry of Health, Wellness and the Environment</td>
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<tr>
<td>NCTVET</td>
<td>National Council on Technical and Vocational Education and Training</td>
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<tr>
<td>NFP</td>
<td>Nurse - Family Partnership</td>
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<tr>
<td>NGOs</td>
<td>Non Governmental Organizations</td>
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<tr>
<td>OAS</td>
<td>Organization of American States</td>
</tr>
<tr>
<td>OECS</td>
<td>Organisation of Eastern Caribbean States</td>
</tr>
<tr>
<td>PAHO</td>
<td>Pan American Health Outreach</td>
</tr>
<tr>
<td>PPVT</td>
<td>Peabody Picture Vocabulary Test</td>
</tr>
<tr>
<td>PS</td>
<td>Permanent Secretary</td>
</tr>
<tr>
<td>RCP</td>
<td>Roving Caregiver Programme</td>
</tr>
<tr>
<td>RCT</td>
<td>Randomized Controlled Trial</td>
</tr>
<tr>
<td>SN</td>
<td>Supervisory Nurse</td>
</tr>
<tr>
<td>SPSS</td>
<td>Statistical Package for the Social Sciences</td>
</tr>
<tr>
<td>SVG</td>
<td>St. Vincent and the Grenadines</td>
</tr>
<tr>
<td>UNCRRC</td>
<td>United Nations Conventions of the Rights of the Child</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Children’s Fund</td>
</tr>
<tr>
<td>USA</td>
<td>United States of America</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>WRAT 4</td>
<td>Wide Range Achievement Test 4</td>
</tr>
</tbody>
</table>
1. Background and Context

The Early Childhood Health Outreach (ECHO) programme developed out of the Roving Caregivers Programme (RCP). The RCP began as a pilot project in Jamaica in 1992 to address the early childhood development needs of children between the ages of zero and three in vulnerable, mostly rural families, who would otherwise not have had access to such programmes. The model used was a home visitation approach which saw “rovers” intervening directly into the homes of participants and working with the families on a number of key areas including: Parent management techniques; Health and childhood safety issues; Growth promoting child-rearing practices; and Child stimulation activities. This programme was subsequently replicated on a pilot basis in Dominica, Grenada, St. Lucia and St. Vincent. Following successful replications, these pilots were continued as formal intervention activities in all four pilot countries. The RCP was officially launched in St. Vincent and the Grenadines in July 2005.

Subsequent to a review of the Roving Caregivers Programme conducted in 2006, it was proposed that options for consolidation of their concepts and methodologies (using the “High Scope 0-3 manual) be converged, to extend its reach in a national context. The Early Childhood Health Outreach (ECHO) Programme was developed out of this consultative effort to conceptualize the integration of various aspects of the RCP into the Maternal and Child Health (MCH) services and was launched as a pilot project in 2010 in St. Vincent & the Grenadines.

The Caribbean Child Support Initiative (CCSI with support from Bernard van Leer Foundation (BvLF); United Nations Children’s Fund (UNICEF); Pan American Health Organization (PAHO); and the Ministry of Health, Wellness & the Environment joined in partnership to incorporate the ECHO concepts into the Primary Health Care system for “at risk” children 0 - 3 years and their families, by establishing a two-year pilot project in the Calliaqua health district (St.Vincent & Grenadines) with a view of institutionalizing the program through the linkage of early childhood development and the health care services. The Calliaqua Health District was selected as the pilot project site, based on several socio-economic indicators which were highlighted in the SVG Country Poverty Assessment 2007-2008.

Broadly, the ECHO programme has five objectives, namely:

- To offer early stimulation to young children and improve parenting practices in disadvantaged communities.
- Promote and monitor good health and early development of young children.
- To train community health aides (CHAs) within the communities to assist in the delivery of parent support services.
- To transfer the CHAs newly acquired knowledge and skills in working with families and communities to produce a range of local support agencies.
- To promote friendly and healthy relationships between parents/guardians and children.
ECHO provides a safety net for children 0-3 years old who do not have access to formal ECD services, are developing without any form of early stimulation and are generally exposed to inappropriate practices. It is especially targeting parents and guardians of children within the above-mentioned age group, to help strengthen their parenting skills. Additionally, it targets expectant parents (male and female). Community Health Aides (CHAs) were trained at the Division of Nursing Education in St. Vincent and the Grenadines with basic knowledge of early childhood health development principles to conduct home stimulations.

By July 27, 2011 Community Health Aides across St. Vincent and the Grenadines in the ECHO program had reached 425 children. This number has been calculated from the 496 visits during the period July 2010 – June 2011. With regard to training, 41 Community Health Aides had ECHO training and are implementing the ECHO principles and methodologies. The cost of implementing the ECHO programme was approximately USD 203,092.63 and these funds were used to meet costs related to personnel, training, materials, communications and office accommodation. UNICEF contributed approximately USD 74,602.45 to the programme focusing on training, monitoring and Evaluation.

The tentative result of the project seems to indicate that CHAs can successfully deliver stimulation services to children as an ongoing part of their job functions. Institutionalization within the Ministry of Health therefore is a viable option which will result in the sustainability of the RCP early stimulation concepts and methodology. In addition the ECHO programme has the potential to provide early stimulation to a wider population than currently serviced by the RCP. UNICEF is supporting national Governments to conduct an evaluation of the programme to inform further implementation and improvement including addressing sustainability of the initiative (decision-making and learning), and to confirm the anecdotal evidence (accountability).

2. Objectives of the Consultancy

Keeping in mind that, the Convention on the Rights of the Child requires that the particular requirements of young children (good nutrition, emotional care, sensitive guidance, time and space for social play exploration and learning) should be met by the adults in their lives and a positive growth promoting environment is critical to development, the objectives of this evaluation are to:

i. Assess how far the ECHO pilot programme has achieved its objectives, the results that have been achieved to date, any unintended results from the programme, as well as outputs at the individual, household, and community levels.

ii. Identify the opportunities and constraints the programme has faced and draw lessons and good practices from them.

iii. Evaluate the operational effectiveness of the pilot and costing its scale up in the current and projected national fiscal situation.

iv. Identify the extent to which cross-cutting strategies/issue such as a human rights-based approaches, results-based planning and gender equality/mainstreaming have been adopted in the planning and implementation of the programme.

v. Ascertain the requirements and implications (institutional capacity, financial implications etc.) of scaling up and implementing the ECHO programme on a national scale in the model countries especially St.Vincent & the Grenadines.

This evaluation will be formative in its approach and is based, both on the need of Government partners in the Ministry of Health and the Environment in St.Vincent and as an organization requirement for UNICEF. The added value of the evaluation will be in the use of the findings and recommendations for: (a) Documentation of its viability as a means of providing ECD services to the most-disadvantaged in a cost-efficient manner, and the (b) documentation of the Caribbean experience in the adoption and modification of the RCP methodology into a country-specific variant that can meet the early childhood stimulation needs of children birth to three.

3. Major Duties and Responsibilities / Scope of Work

The evaluation will therefore focus on – but will not be limited to – the following issues:
A. Relevance
   a) How relevant is the ECHO programme, to the goals or objective of the national strategic or development plan in the health sector? How does it contribute to actions of the Government, to ensure access and quality ECD services to the most disadvantaged communities in St.Vincent & the Grenadines?
   b) Does the ECHO Programme promote [the] development of the child’s personality, talents and mental and physical abilities to their fullest potential as specified in the convention on the Rights of the Child?
   c) What concerns do the stakeholders, especially the CHAs, have about the ECHO programme? How is this being dealt with? Are there any anecdotal or observable changes in the opinion or views of the stakeholders about the relevance of the ECHO programme etc.?
   d) How has ECHO been relevant in terms of promoting Gender and Equity (access, outcomes for girls and boys, etc.)

B. Effectiveness
   a) What is the progress made so far, towards achieving the planned outputs and outcomes? When measured against the baseline situation, how are the children who have passed through the programme since 2010 doing in terms of performance in five areas of development: communication, gross motor skills, fine motor skills, problem solving and personal social skills?
   b) Were the activities, planned under the ECHO programme, necessary and sufficient (in quantity and quality) to achieve the outputs?
   c) How do the stakeholders’ (both duty bearers and rights-holders) perceive or appreciation the results of the ECHO programme? What do they like or dislike about it? What do they want to change? What are the CHAs, parents and health officials saying about the ECHO programme?
   d) How has the ECHO programme implementation mechanisms (coordination, management, etc.) affected the current results/outputs of the programme?
   e) What partnerships have been developed to support the pilot ECHO programme in achieving its objectives?
   f) How has the external environment (political, economic, cultural etc.) affected the internal management of ECHO programme?
   g) Are the originally identified assumptions still valid? Has the programme included strategies to reduce the impact of identified risks? Are there any one or two killer assumptions that could "kill" the programme?
   h) How successful was the programme in targeting, reaching and addressing the specific needs of the most disadvantaged communities, families and children?
   i) How appropriate has resource allocation been? How adequate is the monitoring system established to support the ECHO Programme

C. Efficiency
   1. What, if any, has been the difference between the allocation of funds at the planning/budgeting stage and the use of funds during the implementation stage?
   2. Are there any inefficiency issues with regards to how the programme is conceptualized, implemented or managed?
   3. How can one compare the relationship between project costs and the results achieved? Justifiable?
   4. How have the duty bearers and rights holders been interacting in the planning and implementation of the ECHO programme? Is there any potential efficiency gain to be made?

D. Impact
   a) Were the indicators selected to monitor the programme Specific, Measurable, Achievable and Relevant enough to determine the outputs and outcomes? Do the indicators need to be revised? Are the indicators disaggregated e.g. by gender, age group and geographic location?
   b) Has it been feasible to collect data on selected indicators? Were clear baseline data collected on the children in the target communities? Was a logical framework developed to explain how the ECHO programme was expected to work? How frequently was monitoring data collected?
c) Are there any observed unintended direct or indirect results at the household level (children, parents, caregivers)?

d) Is there any observable evidence of the contribution of the ECHO Programme to short, or medium term improvements in the selected children, communities etc.? In what ways are the programme staff benefitting?

e) Is there any difference in the way the programme affects girls compared to boys? Based on socio-economic status, who is benefiting more? The wealthiest? The poorest?

E. Sustainability

a) What are strengths and weaknesses (design, coordination, management and monitoring) of the ECHO programme? How can these contribute to or hinder the overall sustainability of the pilot programme or other ECD programmes with a similar design?

b) What has been the buy-in from the duty-bearers and rights-holders and what leadership or supportive roles have they played? What has been the financial and non-financial contribution of Government?

c) What are the institutional capacity development actions required to ensure effective and efficient management, monitoring and evaluation of the ECHO Programme?

d) What type of monitoring and evaluation systems were setup to facilitate the rollout of the ECHO Programme on a national basis in the model countries e.g. required tools, training of staff, processes and procedures?

4. Methodology and Evaluation process

The Evaluation will be conducted in accordance with the evaluation principles (openness, transparency, participation, etc.) and standards using the usual Evaluation criteria (relevance, efficacy, effectiveness, impact, sustainability). It will also adopt an equity-focused approach to evaluation as defined by UNICEF guidance for Equity-focused Evaluations. This will require the consultant to closely work with the UNICEF M&E section at key phases of the evaluation process so as to ensure Equity focused Evaluation standards are fully met in the final evaluation report.

Given its nature and the information it seeks, it is proposed that a mix of the following methodologies be adopted, subject to discussion with the consultant of choice:

<table>
<thead>
<tr>
<th>Methodology</th>
<th>Data sources</th>
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<tbody>
<tr>
<td>1. Desk review of key documents and reports</td>
<td>-Project proposals, Monitoring reports, Baseline reports etc. from MOH MoE</td>
</tr>
<tr>
<td>2. In-depth interviews with key informants (rights-holders and duty-bearers)</td>
<td>-Project staff/CHA Parents/Caregivers, Families in Calliagua, Policy/decision makers in MoH &amp; MoE, UNICEF, PAHO, CCSI staff</td>
</tr>
<tr>
<td>3. Qualitative focus group discussions with rights-holders</td>
<td>-Parents/caregivers, Community Health Aides, MoH Supervisory staff etc.</td>
</tr>
<tr>
<td>4. Community/household-based surveys in the model countries (SVG/SLC), covering the target group of children</td>
<td>-Parents/caregivers and families in Calliagua community in SVG</td>
</tr>
<tr>
<td>5. Review of the operational cost for the pilot and what it means in case of scaling up</td>
<td>-Project document including budgets, Monitoring reports</td>
</tr>
</tbody>
</table>
The participation of various stakeholders, as duty bearer (MoH officials, CHA, parents, caregivers etc.) and on the side of the rights-holder (parents, caregivers, children etc.) will be critical in ensuring a utilization-focus for the evaluation. Stakeholders’ participation will therefore be an important part of evaluation design, planning and conduct (information collection, development of findings, evaluation reporting, results dissemination, etc.). It is proposed that an Evaluation Reference Group be made up of the Regional UNICEF M&E Adviser, the Chief of M&E and PME specialist in UNICEF Barbados, the Permanent Secretary in the Ministry of Health in St.Vincent & Grenadines, Chief Medical Officer, the Chief Nursing Officer and the Chief Education Officer. The Evaluation is estimated to cover at least 16 weeks, from 1st July to 31th October, 2013.

5. Deliverables

The Consultant will prepare:

<table>
<thead>
<tr>
<th>#</th>
<th>Deliverable</th>
<th>Proposed Completion Timeline</th>
<th>Payment</th>
<th>Estimated Person-days</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A detailed draft evaluation work plan (with questionnaires, etc.) within 10 days of the signing of the contract</td>
<td>September 10th</td>
<td>10%</td>
<td>To be defined from the technical proposal received</td>
</tr>
<tr>
<td>2</td>
<td>A final evaluation work plan within one (1) week of receiving UNICEF, Ministry of Health, Wellness and Environment’s and Ministry of Education’s comments on the draft work plan</td>
<td>Latest September 20th</td>
<td>20%</td>
<td>To be defined from the technical proposal received</td>
</tr>
<tr>
<td>3</td>
<td>Interim report presenting progress and initial findings from the evaluation/field work</td>
<td>Latest October 20th</td>
<td>20%</td>
<td>To be defined from the technical proposal received</td>
</tr>
<tr>
<td>4</td>
<td>A draft evaluation report 3 weeks before the end of the consultancy, in accordance with standards identified in the UNICEF/UNEG Evaluation Policy/Guidance.)</td>
<td>Around November 30th</td>
<td>30%</td>
<td>To be defined from the technical proposal received</td>
</tr>
<tr>
<td>5</td>
<td>A final evaluation report (with a complete executive summary) that meets UNICEF standards for good evaluation reports within two (2) weeks of receiving UNICEF’s, Ministry of Health and Ministry of Education’s comments on the draft report. Two powerpoint presentations (one for stakeholders and one for policy makers) will also be submitted as part of the final deliverables. A presentation to key stakeholders (exit meeting at the end of the consultancy work)</td>
<td>Around December 15th</td>
<td>20%</td>
<td>To be defined from the technical proposal received</td>
</tr>
</tbody>
</table>

The consultant will regularly report to the technical committee comprising the Monitoring & Evaluation staff from UNICEF, the Ministry of Health, Wellness and the Environment and Ministry of Education in SVG to provide updates, discuss constraints and if needed, obtain the additional support needed to complete the work with the expected quality and in a timely manner.

6. Competencies

The evaluation will be carried out by an experienced consultant/consulting firm who is expected to have in its employment persons with skills in Evaluation, together with personal and professional ethics and integrity, and basic skills in human rights and gender equality analysis.

7. Qualifications

- **Education:** Master’s degree in social sciences with a specialization in education, Early Childhood Development, health, child nutrition or paediatrics. A good understanding of the education sector as well as policy, gender and children’s issues.
- **Experience:** Minimum eight (8) years of relevant experience. A proven record in conducting evaluations and producing high quality timely evaluation reports. Strong analytical skills. Demonstrable capacity to
apply UNICEF Evaluation standards, Human-rights, Result-based Management, Gender and equality principles

- **Languages:** Fluency in English is required (both written and oral) with excellent writing skills.

8. **Duration:** 1st September to December 30th, 2013 (4 months)

9. **Official Travel / Work Arrangement**

The consultant/consulting team, depending on whether they are based in Barbados or outside Barbados, will work in collaboration with UNICEF and its Government partners. They will be required to travel for consultations in St.Vincent & Grenadines, in the process of data collection/verification and in sharing preliminary or final results with the various stakeholders. Details of travel itinerary and costs will be included in the technical and financial proposals.

10. **Quotations**

**Interested individual and firms will be expected to provide quotations for the contract.**

11. **Payment schedule:** Payments in check or bank transfer, will be made based on the satisfactory and timely submission of deliverables identified in (5.) above

12. **Conditions of Service**

Prior to commencing the contract, the following conditions must be met:

A Corporate Entity will be required to submit samples of previous relevant work, a Certificate of Incorporation for the Company as well as a profile of the individual(s) who would be undertaking the assignment.

An Individual Consultant will be required to submit samples of previous relevant work, a statement of good health, accompanied by a recent Medical Certificate which indicates that the Consultant is fit for work and travel. In addition, the Consultant is required to certify in the Health Statement that he/she is covered by medical/health insurance. The statement includes confirmation that he/she has been informed of any inoculation required for the country or countries to which travel is authorized. He/she takes full responsibility for the accuracy of the statement.

13. **Recourse**

UNICEF reserves the right to withhold all or a portion of payment if performance is unsatisfactory, if work/outputs is incomplete, not delivered or for failure to meet deadlines. Performance indicators against which the satisfactory conclusion of this contract will be assessed include: timeliness/quality of submission and responsiveness to UNICEF and counterpart feedback.

14. **Property Rights**

UNICEF shall hold all property rights, such as copyright, patents and registered trademarks, on matter directly related to, or derived from, the work carried out through this contract with UNICEF.

15. **How to apply**

Proposals should be sent by e-mail to bridgetown@unicef.org with a copy to ainniss@unicef.org no later than Friday 23rd August, 2013, indicating “EVALUATION OF EARLY CHILDHOOD OUTREACH PROGRAMME (ECHO)” in the subject line of the email. The proposal package should include the following:

a. A cover letter
b. A detailed curriculum vitae or background of the corporate entity in English
c. A duly completed United Nations Personal History form (p11) for individual contractors
d. A technical proposal explaining the methodological approach to achieving the results of this consultancy
e. A financial proposal or expected cost, with a detailed budget (including travel if required)

Proposals may also be sent to:

Representative
UNICEF Office for the Eastern Caribbean Area
1st floor, UN House
Marine Gardens
Christ Church
BARBADOS

ONLY SUITABLE PROPOSALS WILL BE ACKNOWLEDGED
### APPENDIX C - LIST OF INTERVIEWEES & FOCUS GROUPS

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organization</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr. Luis de Shong, Permanent Secretary</td>
<td>Ministry of Health, Wellness &amp; the Environment</td>
<td>Prof. Samms-Vaughan met with Mr. de Shong to discuss the current evaluation of the pilot programme and issues related to the relevance of ECHO for national goals and policies. She also sought to obtain financial documents related to the administration of the ECHO programme to assist with cost benefit analyses.</td>
<td></td>
</tr>
<tr>
<td>Sister Kathleen Mandeville Coordinator</td>
<td>ECHO Pilot Project</td>
<td>Sr. Mandeville provided the evaluation team with information on the: -History of the ECHO programme -Objectives of the ECHO programme -Training programme -Administration of the pilot project -Monitoring &amp; evaluation of the pilot -Successes -Challenges</td>
<td></td>
</tr>
<tr>
<td>Dr. Audrey Gittens-Gilkes Permanent Secretary</td>
<td>Ministry of National Reconciliation, the Public Service, Labour, Information and Ecclesiastical Affairs</td>
<td>Dr. Gittens-Gilkes was the Chief Nursing Officer at the time of the ECHO Pilot. She was also promoted to Permanent Secretary of the Ministry of Health, Wellness &amp; the Environment during the ECHO pilot. The evaluation team wanted to interview Dr. Gittens-Gilkes to gain insight into the objectives and administration of the pilot project. This interview also shed light on the relevance of the ECHO programmes to national plans and policies.</td>
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<tr>
<td>Sister Ferosa Roache Sr. Roache has responsibility for all community nurses Head</td>
<td>Community Nursing Service</td>
<td>These interviews were helpful in establishing the role of the CHAs and the Nursing Supervisors during the pilot of the ECHO programme. It provided the evaluation team with</td>
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information about the roles and responsibilities of the Community Nursing staff in the pilot. The interviewees also discussed issues related to the supervision of CHAs, accessing ECHO families and wide-scale implementation of the programme.

<table>
<thead>
<tr>
<th>Sister Arlene James</th>
<th>District Nursing Supervisor</th>
<th>Community Nursing Service</th>
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</thead>
<tbody>
<tr>
<td>Sr. James was assigned to the Calliaqua Health District at the time of the ECHO pilot.</td>
<td>Mrs. Phyllis Jack</td>
<td>Curriculum Coordinator</td>
</tr>
</tbody>
</table>
# LIST OF FOCUS GROUPS

<table>
<thead>
<tr>
<th>Name of Focus Group</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Community Health Aides (CHAs)</td>
<td>The focus group was held with 6 CHAs from the district of Calliaqua. In this focus group the following was discussed:</td>
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<tr>
<td></td>
<td>• ECHO Objectives</td>
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<td>• ECHO Training</td>
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<tr>
<td></td>
<td>• ECHO Duties and how these fit into their regular daily schedules</td>
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<tr>
<td></td>
<td>• The program’s strengths and weaknesses</td>
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<tr>
<td>Roving Caregivers</td>
<td>This focus group was held with 5 members of the Roving Caregiver Programme. We discussed the following:</td>
</tr>
<tr>
<td></td>
<td>• The Objectives and general principles of the Roving Caregiver Programme</td>
</tr>
<tr>
<td></td>
<td>• Rovers’ Involvement in ECHO</td>
</tr>
<tr>
<td>ECHO Curriculum Writers</td>
<td>This focus group was held with 8 members from the team of curriculum writers. We discussed the following:</td>
</tr>
<tr>
<td></td>
<td>• General perceptions of the ECHO programme.</td>
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<tr>
<td></td>
<td>• The program’s strengths and weaknesses.</td>
</tr>
<tr>
<td></td>
<td>• Feedback on the training sessions</td>
</tr>
<tr>
<td>Administrative Committee</td>
<td>This focus group was held with 5 members of the Administrative Committee. The following was discussed:</td>
</tr>
<tr>
<td></td>
<td>• The overall operations and administration of ECHO.</td>
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<td></td>
<td>• Strategies for a successful implication at the national level.</td>
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<tr>
<td>Regional Nursing Supervisors</td>
<td>This focus group was held with 5 nursing supervisor. We discussed the following:</td>
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<tr>
<td></td>
<td>• The plan for ECHO national scale – up</td>
</tr>
<tr>
<td></td>
<td>• Strategies for a successful programme.</td>
</tr>
</tbody>
</table>

# APPENDIX D - LIST OF DOCUMENTS REVIEWED

<table>
<thead>
<tr>
<th>Document Reviewed</th>
<th>Type of Document</th>
<th>Author/Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document Reviewed</td>
<td>Type of Document</td>
<td>Author/Source</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>------------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>Early Childhood Health Outreach Programme: Proposal for submission to BVLF Caribbean Child Support Initiative September 2009</td>
<td>Proposal</td>
<td>Community Nursing Services, Ministry of Health &amp; the Environment, St. Vincent &amp; the Grenadines</td>
</tr>
<tr>
<td>The St. Vincent &amp; the Grenadines Early Childhood Health Outreach Programme Information &amp; Guidelines 2010 - 2012</td>
<td></td>
<td>ECHO Staff</td>
</tr>
<tr>
<td>St. Vincent Applauded for its Efforts in Child Health Care The Early Childhood Health Outreach (ECHO) Pilot Programme</td>
<td>Promotional Material</td>
<td>Unknown</td>
</tr>
<tr>
<td>The Early Childhood Health Outreach Programme Curriculum, St. Vincent &amp; the Grenadines 2011</td>
<td>Curriculum</td>
<td>Phyllis Jack</td>
</tr>
<tr>
<td>Early Childhood Health Outreach Project, Quarterly Monitoring Report Period ending August 31 2011</td>
<td>M &amp; E Report</td>
<td>Gail Diamond</td>
</tr>
<tr>
<td>Early Childhood Health Outreach Project, Quarterly Monitoring Report Period ending October 31 2011</td>
<td>M &amp; E Report</td>
<td>Gail Diamond</td>
</tr>
</tbody>
</table>
APPENDIX E- CONSENT FORMS & QUESTIONNAIRES

INFORMED CONSENT FOR FOCUS GROUPS
Evaluation of the Early Childhood Health Outreach (ECHO) programme

You have been asked to participate in an evaluation of the Early Childhood Health Outreach (ECHO) programme conducted by the United Nations Children’s Fund (UNICEF). The main purpose of the evaluation is to assess how far the ECHO pilot has achieved its objectives, as well as identify programme best practices which can inform national implementation. You were selected as a possible participant in this study because of your involvement in the ECHO pilot project between 2010 and 2012.

Please take time to read the following information carefully and to decide whether or not you wish to take part.

- If you participate in this group discussion, you will be in a group of approximately 8 – 10 individuals. There will be a facilitator who will ask questions and facilitate the discussion, and 1-2 note-takers to write down the ideas expressed within the group. If you volunteer to participate in this focus group, you will be asked some questions relating to your experience with the ECHO pilot programme. These questions will help us to better understand the strengths and weaknesses of the pilot programme and will lead to recommendations for the national implementation of ECHO.
- Your participation is completely voluntary. You may withdraw from this group discussion or the study at any time without penalty. We expect that the focus group will take about 1 hour.
- The focus group will be audio-recorded in order to accurately capture what is said. If you participate in the group discussion, you may request that the recording be paused at any time. You may choose how much or how little you want to speak during the group. You may also choose to leave the focus group at any time.
- The information you will share with us if you participate in this study will be kept completely confidential to the full extent of the law. Reports of findings will not include any identifying information. Everyone will be asked to respect the privacy of the other group members. All participants will be asked not to disclose anything said within the context of the discussion, but it is important to understand that other people in the group with you may not keep all information private and confidential.
- This project will be completed by June 30, 2014. All interview recordings will be stored in a secure place until 1 year after that date. The tapes will then be destroyed.
- No risk greater than those experienced in ordinary conversation are anticipated.
- It is hoped that the results of this evaluation will benefit children, families and communities in St. Vincent & the Grenadines by providing information that can be used to enhance early childhood development services.

I have read the consent form and all of my questions about the evaluation/focus group have been answered. I understand that the focus group will be recorded. I agree to participate in this study.

____________________  ____________________  ____________
Participant’s Name  Participant’s signature  Date

____________________  ____________________  ____________
Researcher’s Name  Researcher’s signature  Date

111 | Page
Please contact Prof. Maureen Samms-Vaughan at msamms@hotmail.com with any questions or concerns.

I have read the consent form and all of my questions about the evaluation/focus group have been answered. I understand that the focus group will be recorded. I agree to participate in this study.

__________________________  ___________________________  _____________
Participant’s Name  Participant’s signature  Date

__________________________  ___________________________  _____________
Researcher’s Name  Researcher’s signature  Date
INFORMED CONSENT FOR INTERVIEWS
Evaluation of the Early Childhood Health Outreach (ECHO) programme

You have been asked to participate in an evaluation of the Early Childhood Health Outreach (ECHO) programme conducted by the United Nations Children’s Fund (UNICEF). The main purpose of the evaluation is to assess how far the ECHO pilot has achieved its objectives, as well as identify programme best practices which can inform national implementation. You were selected as a possible participant in this study because of your involvement in the ECHO pilot project between 2010 and 2012.

Please take time to read the following information carefully and to decide whether or not you wish to take part.

- This interview is voluntary. This means you have the right not to answer any question, and to stop the interview at any time or for any reason, without penalty. We expect that the interview will take about 30 – 45 minutes.
- Unless you give us permission to use your name, title, and/or quote you in any publications that may result from this research, the information you tell us will be confidential.
- We would like to record this interview so that we can use it for reference while proceeding with this evaluation. It will help us to accurately capture your insights in your own words. The tapes will only be heard by the evaluation team for the purpose of this research. We will not record this interview without your permission. If you do grant permission for this conversation to be recorded, you may ask that it be turned off at anytime. You also have the right to revoke recording permission and/or end the interview at any time.
- This project will be completed by June 30, 2014. All interview recordings will be stored in a secure place until 1 year after that date. The tapes will then be destroyed.
- Participation in this study will involve no costs or payments to you.
- There are no known risks associated with participation in the study. However, it is hoped that the results of this evaluation will benefit children, families and communities in St. Vincent & the Grenadines by providing information that can be used to enhance early childhood development services.

I have read and understand the explanation provided to me. I have had all my questions answered to my satisfaction, and I voluntarily agree to participate in this study. I have been given a copy of this consent form. (Please check all that apply):

[ ] I give permission for this interview to be recorded.
[ ] I give permission for the following information to be included in publications resulting from this study:

[ ] my full name [ ] my initials [ ] my title [ ] direct quotes from this interview

_________________________ ___________________________ ________
Participant’s Name Participant’s signature Date

_________________________ ___________________________ ________
Interviewer’s Name Interviewer’s signature Date
Please contact Prof. Maureen Samms-Vaughan at msamms@hotmail.com with any questions or concerns.
PARENT INFORMED CONSENT
Evaluation of the Early Childhood Health Outreach (ECHO) programme

You and your child have been asked to participate in an evaluation of the Early Childhood Health Outreach (ECHO) programme conducted by the United Nations Children's Fund (UNICEF). The main purpose of the evaluation is to assess how far the ECHO pilot has achieved its objectives, as well as identify programme best practices which can inform national implementation. You are being asked to participate in this evaluation because of your (and/or your child’s) involvement in the 2010 – 2012 pilot of the ECHO Programme.

Please take time to read the following information carefully and to decide whether or not you wish to take part.

If you agree to take part, you will be asked to:

- Answer questions about your family and your child’s development and learning at school
- Allow administration of special developmental and behavioural tests for young children. These tests include children playing with special toys.
- All of this should take approximately 45 minutes.

Your participation is completely voluntary and you may withdraw your consent at any time, without penalty. If you decide to participate, you are free to stop participation at any time.

The records of this study will be kept private. In any type of report we may write, we will not include your name or the name of your child. Research records will be kept in a locked file and access to the research records will be limited to the researchers.

This study includes minimal risks. You may have some individual discomfort when questions are being asked about you and your family or when your child is doing the developmental tests.

It is hoped that the results of this evaluation will benefit children, families and communities in St. Vincent & the Grenadines by providing information that can be used to enhance early childhood development services.

If you have concerns about your child you can talk to one of the researchers about resources in your community.

I have read and understand the explanation provided to me. I have had all my questions answered to my satisfaction, and I voluntarily agree to participate in this study. I have been given a copy of this consent form. (Please check all that apply):

[ ] I will allow research staff to conduct developmental assessments with my child
[ ] I will answer questions related to my family and my child’s development and learning at school

_________________________  _____________________  ______________
Participant’s Name  Participant’s signature  Date

_________________________  _____________________  ______________
Researcher’s Name  Researcher’s signature  Date

Version 1 - 2/21/
Please contact Prof. Maureen Samms-Vaughan at msamms@hotmail.com with any questions or concerns.

I have read and understand the explanation provided to me. I have had all my questions answered to my satisfaction, and I voluntarily agree to participate in this study. I have been given a copy of this consent form. (Please check all that apply):
[ ] I will allow research staff to conduct developmental assessments with my child
[ ] I will answer questions related to my family and my child’s development and learning at school on 1-2/21

__________________  __________________  _________
Participant’s Name   Participant’s signature  Date

__________________  __________________  _________
Researcher’s Name    Researcher’s signature  Date
INFORMED CONSENT FOR CHILD ASSESSMENT (Controls)
Evaluation of the Early Childhood Health Outreach (ECHO) programme

We would like your child to participate in an evaluation of the Early Childhood Health Outreach (ECHO) programme conducted by the United Nations Children's Fund (UNICEF). The main purpose of the evaluation is to assess how far the ECHO pilot has achieved its objectives, as well as identify programme best practices which can inform national implementation. Your child is being asked to participate in this evaluation because they are in the same age range as children who were selected for pilot study of the ECHO programme.

Please take time to read the following information carefully and to decide whether or not you wish for your child to participate.

If you agree for your child to take part:

Teachers at your child’s school will complete questionnaires about the health and development of your child. Completing these measures should take approximately 30 minutes per child.

- Your child's participation is completely voluntary and you may withdraw your consent at any time.
- The records of this study will be kept private. In any type of report we may write, we will not include your child’s name. Research records will be kept in a locked file and access to the research records will be limited to the researchers.
- Participation in this study will involve no costs or payments to you/your child.
- There are no known risks associated with participation in the study.
- It is hoped that the results of this evaluation will benefit children, families and communities in St. Vincent & the Grenadines by providing information that can be used to enhance early childhood development services.
- If there are any concerns about your child we will make referrals to appropriate resources in your community.

If you agree for your child to take part, please sign below and return to the school.

- I have read and understand the explanation provided to me. ☐ Yes ☐ No

- I allow_______________________ (Child’s Name) to participate ☐ Yes ☐ No

Parent’s Name Parent’s signature Date

Please contact Prof. Maureen Samms-Vaughan at msamms@hotmail.com with any questions or concerns.

Key Informant Interview/Focus Group Questions
Evaluation of the Early Childhood Health Outreach (ECHO) programme
The following questions will be used to guide interviews and focus groups with all stakeholders in the ECHO programme, including policymakers, administrative committee, health workers, parents and research staff. Questions will be modified or probed based on the group/individual being interviewed.

1. What did you understand as the main objectives of the ECHO programme?

2. Was this programme necessary?

3. What did you understand as the main objectives of the ECHO pilot programme?

4. What do you see as the role of ECHO in National Development?

5. What were you responsible for in ECHO?
   a. Probes:
      i. What is your typical day like? (CHAs, Nursing Staff)
      ii. What are your non-ECHO responsibilities? (CHAs, Nursing Staff)
      iii. How are families identified (CHA's, Nursing Staff; Research Team)
      iv. Describe a home visit (CHAs, Nursing Staff)
      v. Describe a parent workshop (CHAs, Nursing Staff)
      vi. Describe your reporting responsibilities (CHAs, Nursing Staff)
      vii. Who provided supervision for the programme? Was this adequate? How many supervisory visits were conducted during the pilot? What was the relationship between the ECHO Coordinator and your direct supervisor? (CHAs, Nursing Staff)
      viii. Describe the record keeping protocols.
      ix. Describe the monitoring and evaluation protocols?
      x. How did the programme track a child’s progress?

6. What were the strengths of the ECHO pilot programme?

7. What were some of the weaknesses of the ECHO pilot programme?

8. What were the resources needed to fully implement the pilot? (Research Team, CHAs, Nursing Staff)
   a. Were these always available?
   b. Did each CHA have individual materials/kits? Or did they have to share?
   c. Is ECHO cost-effective?

9. Training
   a. What did training entail?
   b. How long was training?
   c. How specific was the training course? Was the general CHA training enough?
   d. Were any refresher training sessions held? How often were refreshers needed?
   e. Were there any topics that CHA’s needed additional training on?
   f. Was the training adequate?
      i. For home visits
      ii. For parent workshops
      iii. Were CHAs given specific training on administering and scoring the ASQ?

   Were there any other standardised M & E tools used the programme? Were
health workers or research staff given specific training on administering and scoring these tools?

g. Were the trainers/facilitators knowledgeable?

10. Impact
a. Probes:
   i. Did you have specific targets to meet as a part of the ECHO pilot? What were these?
   ii. How frequently did you have to report?
   iii. Was there any feedback from ECHO coordinating team (at regular intervals)?
   iv. How do you know that ECHO working?
   v. Do you think boys or girls benefitted more from the programme?
   vi. How did parents view the programme?
   vii. What is the biggest benefit to:
       1. Parents
       2. Children
       3. Community
       4. Health workers

11. Which elements of ECHO would you modify/change?

12. What elements of ECHO would you champion in the national implementation of the programme?
ECHO EVALUATION PARENT QUESTIONNAIRE

A1d. Do you (mother) live in the same home as the baby now?  

A1e. If NO you (baby’s mother) does not live with baby now, who takes care of the baby most of the time?

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<td>Other relative, specify</td>
<td>Other, non-relative</td>
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</table>

CHILD’S HEALTH

*We would like to know what illness [baby’s name] has had. For some things, we want to know whether they have happened since the baby was born and for others we want to know if they have happened since the baby was one year old. Please tell me whether the baby got this illness and if s/he saw a doctor. I will also be asking you whether the baby has been admitted to a hospital or had any serious accidents.*

BH1. Where do you mainly take your baby for immunisation (vaccines, shots)?

BH2. Where do you mainly take your baby when he/she is a little sick?

BH3. Has your child had any of the following sicknesses?

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<td></td>
<td>Yes, No</td>
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<td>Dr. doctor</td>
<td>stated known</td>
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<tr>
<td>Convulsions/ fits</td>
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<td>Gastro-enteritis (Persistent vomiting and diarrhoea)</td>
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<tr>
<td>Persistent cough</td>
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<td>High Fever</td>
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<td>Ear Infection</td>
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<td>Eye Infection</td>
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<td>Wheezing / Asthma</td>
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<td>Pneumonia / Bronchitis</td>
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<td>Flu/cold</td>
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<td>Dengue fever</td>
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<td>Eczema</td>
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<td>Food Allergies</td>
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<td>Skin Allergies/Wheals or itchy rashes</td>
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<td>Urine infection</td>
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<td>Heart problems</td>
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<tr>
<td>Not gaining enough weight (as stated by health professional)</td>
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<tr>
<td>Gaining too much weight (as stated by health professional)</td>
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<tr>
<td>Other</td>
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BH4a). Since your **child was born**, was he/she ever referred to see a specialist


BH4b) **If no, go to Question BH5  If yes, which specialist was your child referred to? (You can tick more than one answer)**

BH7. Since your baby turned 1 year old, has your baby had any of these accidents or injuries?

a. Serious Fall without hitting head
   [1] Yes and saw a Dr.  [2] Yes, No doctor

b. Serious fall, hitting head
   [1] Yes and saw a Dr.  [2] Yes, No doctor

c. Broken bones
   [1] Yes and saw a Dr.  [2] Yes, No doctor

d. Burns or scalds
   [1] Yes and saw a Dr.  [2] Yes, No doctor

e. Other, accidents/ injury specify ______ [1] Yes and saw a Dr.  [2] Yes, No doctor

ABOUT THE MOTHER / PRIMARY CAREGIVER

Now I would like to ask you about your family and household.  IF questions are being answered by PRIMARY CAREGIVER, ONLY answer questions with *. NOTE: The primary caregiver should be answering these questions ABOUT THEMSELVES.

|-------------------------------------|------------|-----------|----------------------------------|----------|

*C. HOUSEHOLD AND FAMILY CHARACTERISTICS

C1. Who, other than the baby, lives in the home with you now?  Tick all that apply
[1] Spouse/partner
[2] Mother
[3] Father
[6] Children of me and my partner
[8] My Partner’s children
[9] Other Children (relatives)
[10] Other Children (not relatives)
[12] Other family members, specify, _________
[14] Other persons, specify _________
[15] No one


*C2. (If YES) Whom do you consider to be your current partner?
[1] My baby’s father (this baby)  [2] My boyfriend / partner (not baby’s father)  [8] Not Stated
*C2a. If father lives with baby, how long has he been in the same household with child _______________ months (age of child).
*C2b. If father does NOT live with baby, how long has it been since he last lived with baby _______________ months (age of child).

*C3. IF PRIMARY CAREGIVER, what age was baby when (s)he started living with you? _______________ Months.

*C4. (If YES, the mother/primary caregiver is in a relationship) What is the status of the relationship with your CURRENT partner?

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<tr>
<td>[3] Living together (less than 5 years)</td>
<td>[7] Widowed</td>
<td>[99] Not known</td>
<td></td>
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*C5a. If NO, who is currently performing the functions of the baby's father? That is, who is the father figure?

|---|---------------------|---------------|-------|


*C9. How often does the biological / birth father see/visit the baby now? [If it is being answered by FATHER ask about MOTHER]

|---|-----------|-------------------|---|-------------------------------|-----------|-----------|-----------|
**C10. How often does the biological/birth father play with baby, not just be around the house or visit? [If it is being answered by FATHER ask about MOTHER]**

|-----------|------------------------|-------------------------------|-----------|-------------|---------------|

**C11. If your partner is not the birth father, how often does he play with the baby, not just be around the house or visit? [If it is being answered by FATHER ask about MOTHER]**

|-----------|------------------------|-------------------------------|-----------|-------------|---------------|

**D. MOTHER – PRIMARY CAREGIVER CHILD INTERACTION / RESOURCES AT HOME**

*I would like to ask you a few questions about the things you do with and for your baby.*

**D1. Have you tried to get information on parenting/raising a baby, since your baby turned one year old?**


If No, go to question D2

**D1a. If YES, where did you try to get information about parenting? (Check all that apply). Allow mother to respond first, then ask about other answers. Mark all that apply**

| [6] Talking to my other male relatives | | [99] Not known |

**D1b. Which of these, if any, do you think provided you with the BEST parenting information?**


**D2. How often do you play with the baby?**


124 | Page
D3. How often do you do these activities with your baby? *(Often means 4 or more days per week, occasionally means 1 to 3 days per week)*


D4. When your child misbehaves do you: *(Often = most days of the week, at least 4 of 7 days, occasionally = 1 to 3 days per week)*

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<tr>
<td>Slap</td>
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<td>Beat with implement</td>
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<td>Shout</td>
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<td>Shake</td>
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<tr>
<td>Pinch</td>
<td></td>
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<tr>
<td>Time Out</td>
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<td>Reason/ Discuss w/</td>
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<tr>
<td>Bite Baby</td>
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<tr>
<td>Other______________</td>
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</table>

D5. Which of these toys does the baby have at home? *(Yes or No)*

- Toys that play music/ makes nois: [1] Yes [2] No
- Toys that teach colours, shapes and size: [1] Yes [2] No
- Toys that teach numbers / letters: [1] Yes [2] No
**D6.** How many hours **per day** does your child spend watching TV / videos?  
- [1] None  
- [2] Less than 1 hour  
- [3] 1-2 hours  
- [4] 3-4 hours  
- [5] More than 4 hours  
- [8] Not Stated  
- [9] Not Known

**D7.** How often does your child play with other children (**not brothers and sisters**)?  
- [1] Never  
- [2] Sometimes (1-3 times per week)  
- [3] Most days (4 or more times per week)  
- [4] Every day  
- [8] Not Stated  
- [9] Not Known (NK)

**D8.** On a scale of one to five, with one being the lowest and five the highest how would you rate yourself as a parent/caregiver (rate your parenting skills)?  
- [1] Well below average, not good at all  
- [2] Below average, not so good  
- [3] Average  
- [4] Better than average  
- [5] Very good  
- [8] Not Stated  
- [9] Not known

**D9.** How would you describe being a parent/caregiver?  
- [1] Harder than you expected  
- [3] Easier than expected  
- [8] Not Stated  
- [9] Not Known

**D10.** Do you try and teach your child things?  
- [1] Often  
- [2] Sometimes  
- [3] Rarely  
- [4] Never  
- [8] Not stated  
- [9] Not known

**D11.** If yes, what things do you try to teach him/her?  
- [1] Yes  
- [2] No  
- [8] Not stated  
- [9] Not known

| a) | Clapping games (e.g. “clap your tiny hands”) | [ ] | [ ] | [ ] | [ ] |
| b) | Parts of the body | [ ] | [ ] | [ ] | [ ] |
| c) | To wave good-bye | [ ] | [ ] | [ ] | [ ] |
| d) | Colours | [ ] | [ ] | [ ] | [ ] |
| e) | Alphabet | [ ] | [ ] | [ ] | [ ] |
| f) | Numbers | [ ] | [ ] | [ ] | [ ] |
| g) | Nursery rhymes | [ ] | [ ] | [ ] | [ ] |
| h) | Songs | [ ] | [ ] | [ ] | [ ] |
| i) | Shapes | [ ] | [ ] | [ ] | [ ] |
| j) | Sizes | [ ] | [ ] | [ ] | [ ] |
| k) | Politeness (e.g. “please” & “thank you”) | [ ] | [ ] | [ ] | [ ] |
| l) | Any other thing, ____________ | [ ] | [ ] | [ ] | [ ] |

**D12.** How often do you do these activities with your child?
E. MOTHER’S – PRIMARY CAREGIVER’S WORK AND CHILD’S CARE

*What types of education have you, the baby’s father or the baby’s father figure (if applicable) completed?

**NOTE:** PRIMARY CAREGIVER can respond for mother/father if (s)he knows the highest level of education completed. Select “not known” if primary caregiver does not know highest level of mother/father.

<table>
<thead>
<tr>
<th>Educational Level (Completed)</th>
<th>Baby’s biological Mother</th>
<th>Baby’s biological father</th>
<th>Baby’s father figure</th>
<th>Primary Caregiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>[1] N/A</td>
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<tr>
<td>[2] Less than primary school</td>
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<tr>
<td>[3] Primary / Jnr High / All Age (Grades 1 – 6)</td>
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<td></td>
</tr>
<tr>
<td>[4] Preparatory</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>[5] Jnr High / All age (Grades 7 – 9)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Secondary High (Traditional)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7</td>
<td>Secondary High (Technical)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>8</td>
<td>Vocational (e.g. NCTVET)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>9</td>
<td>University (Bachelor’s)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>10</td>
<td>University (Master’s / PhD)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>11</td>
<td>Other Tertiary (specify__________)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>88</td>
<td>Not known</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>99</td>
<td>Not stated</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**E1. Are you either working or going to school now?**
*If YES, go to Question E3, if NO, go to Question E2*

| 1 | Yes | 2 | No | 8 | Not Stated | 9 | Not Known |

**E2. If NO to Question E1, have you ever worked since baby was born/started taking care of baby?**

| 1 | Yes | 2 | No | 8 | Not Stated | 9 | Not Known |

**E2a. If YES to Question E2, (i.e. you stopped working since the baby was born/since you started taking care of baby), why did you stop working?**

| 1 | Wanted to stay home with the baby | 2 | The job was seasonal work | 3 | I was fired | 4 | It was too hard to go to work and take care of baby |
| 5 | No one was available to take care of baby | 6 | Other | 8 | Not stated | 9 | Not known |

**MOTHER’S – PRIMARY CAREGIVER’S HEALTH**

*F1. How would you describe your health right now?*

| 1 | Excellent | 2 | Very good | 3 | Good | 4 | Fair | 5 | Poor | 8 | Not stated | 9 | Not known |

*F2. Do you have any ongoing chronic physical illness now?*

| 1 | Yes | 2 | No |
| 8 | Not stated | 9 | Not known |
*F2a. If yes, what kind of illness is it?*

1) Hypertension (Pressure)  
[4] Sickle Cell Anaemia  
[88] Not stated

2) Diabetes (Sugar)  
[5] Seizures (Fits)  
[99] Not known

3) Asthma  
[6] Other illness, specify ________________________________

**[^] G. SOCIAL BACKGROUND**

**[^] G1. How many persons, including you, live in your home?**

a) Number of persons over 18 years   
[88] Not stated

b) Number of persons between 12 – 18 years   
[99] Not known

c) Number of persons between 6 – 11 years   


d) Number of persons under 6 years

**[^] G2. Are you the major wage earner for your household?**  
[1] Yes  
[2] No  
[8] Not stated  
[9] Not known

**[^] G3. How many rooms in your house are used for sleeping?**

[88] Not stated

**[^] G5. Which of the following do you have working in your home?**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Television set</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>b.</td>
<td>Cable/Satellite connection</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>c.</td>
<td>Refrigerator</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>d.</td>
<td>Freezer</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>e.</td>
<td>Living Room Set</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>f.</td>
<td>Stereo equipment</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>g.</td>
<td>Washing machine</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>h.</td>
<td>Cars or other vehicles</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>i.</td>
<td>Telephone (cellular)</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>j.</td>
<td>Telephone (land/fixed)</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>k.</td>
<td>VCR/DVD Player</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>l.</td>
<td>Computer (desktop/laptop)</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>m.</td>
<td>Computer (tablet)</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>n.</td>
<td>Internet connection</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>o.</td>
<td>Radio</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>p.</td>
<td>Sewing machine</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>q.</td>
<td>Fans</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>r.</td>
<td>Gas stove</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>s.</td>
<td>Electric stove</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>t.</td>
<td>Air conditioners</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>u.</td>
<td>CD/DVD burner</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>v.</td>
<td>Water tank</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>w.</td>
<td>Water heater (electric)</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>x.</td>
<td>Water heater (solar)</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>y.</td>
<td>Generator</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>z.</td>
<td>Video gaming equipment (e.g. Game boy/Play station)</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>aa.</td>
<td>Small kitchen appliances (e.g. toaster/microwave/blender)</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
</tbody>
</table>
**ECHO Parent Experience Questionnaire**

**ECHO Criteria:**

- What was baby's birth weight? _____________ Were you told that your baby was small at birth? [1] Yes [0] No
- Did you have any pre-natal complications? [1] Yes [2] No
- Since your child has been born, have you been told that he or she is malnourished? [1] Yes [0] No
- If yes, how many times were you seen during your pregnancy? __________
- Have you been told that [child's name] has a developmental delay? [1] Yes [2] No

**ENROLMENT**

2. What is ECHO? _____________________________________________________________________
3. What does ECHO mean to you? _____________________________________________________________________
5. **How were you introduced to ECHO?**
6. How long were you and your child enrolled in ECHO?
7. **If enrolled for less than one year - why did you leave the programme?__________________________
   ________________________________________________________________________________________
8. How old was your child at enrolment? ________
10. **On average, how long did each visit last?** __________
    1) 30 minutes  2) 45 minutes  3) 60 minutes (1 hour)  4) 11/2 hours  5) 2 hours
14. Please rate the following aspects of the programme
   
15. Did you need the ECHO programme? [1] Yes [0] No

16. If yes, why?

17. If no, why not?

18. In general, were home visits usually scheduled?
   1) Yes  2) No

**ABOUT HOME VISITING**

19. The CHA was always prepared for the visit

20. The CHA had all the resources needed for an effective visit

21. I was comfortable with the ECHO programme taking place in my home

22. The ECHO programme was well organised

23. My family and I had a clear understanding of the objectives ECHO

24. I felt comfortable sharing my concerns with my CHA

25. The CHA took time to address my concerns

**TRAINING**

26. Did you receive training in:

<table>
<thead>
<tr>
<th>Training Activity</th>
<th>Response</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Backyard Gardening</td>
<td>A1) [1] Yes [0] No</td>
<td>A2i) If yes, how would you rate the training?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A2ii) I was able to use what I learned in my everyday life.</td>
</tr>
<tr>
<td>b. Making Toys</td>
<td>B1) [1] Yes [0] No</td>
<td>B2i) If yes, how would you rate the training?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>B2ii) I was able to use what I learned in my everyday life.</td>
</tr>
<tr>
<td>ECHO Activity</td>
<td>Response</td>
<td>Rating</td>
</tr>
<tr>
<td>---------------</td>
<td>----------</td>
<td>--------</td>
</tr>
<tr>
<td>12a. Pillow</td>
<td>[1] Yes  [0] No</td>
<td>i) This toy was useful</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ii) How often did your child use this toy?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>iii) My child enjoyed playing with the pillow</td>
</tr>
</tbody>
</table>

27. Did you complete all the ECHO activities?
<table>
<thead>
<tr>
<th>12b. Ball</th>
<th>[1] Yes</th>
<th>[0] No</th>
</tr>
</thead>
<tbody>
<tr>
<td>i) This toy was useful</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii) How often did your child use this toy?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>iii) My child enjoyed playing with the ball</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>12c. Puppet</th>
<th>[1] Yes</th>
<th>[0] No</th>
</tr>
</thead>
<tbody>
<tr>
<td>i) This toy was useful</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii) How often did your child use this toy?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>iii) My child enjoyed playing with the puppet</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Colouring Book</th>
<th>[1] Yes</th>
<th>[0] No</th>
</tr>
</thead>
<tbody>
<tr>
<td>i) This toy was useful</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii) How often did your child use this toy?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
28. What were your perceptions of the programme at inception?
______________________________________________________________________________________
______________________________________________________________________________________

29. How did ECHO change your concept of parenting?
______________________________________________________________________________________
______________________________________________________________________________________

30. What was the child’s overall reaction to the CHA?
1) Excitement 2) Shy 3) Afraid

31. How engaged was the child when the CHA visited?

32. Was the child’s father/step father present when the CHAs visited?
1) Yes 2) No
If yes, how was he involved?
______________________________________________________________________________________

33. What is the importance of stimulating your child during the early childhood period (esp 0 - 3 years)?
______________________________________________________________________________________

34. Did ECHO help you to be able to assess / track/ monitor your child’s development?
1) Yes  
2) No

35. If yes, how? ______________________________________________

36. Did you see any changes in your child’s ability (development, behaviour) over the period of ECHO? 1) Yes  
2) No

37. If yes, what changes did you observe? __________________________________________________________________________________

38. If you had the opportunity would you re-enrol in ECHO?  
1) Yes  
2) No
### APPENDIX F – Feedback on Recommendations at Exit Meeting

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Responsible Party Group 1</th>
<th>Responsible Party Group 2</th>
<th>Responsible Party Group 3</th>
<th>Time Frame Group 1</th>
<th>Time Frame Group 2</th>
<th>Time Frame Group 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. CNS into Management of ECHO duties</td>
<td>CNO MOH PS</td>
<td>P.S. M.O.H &amp; Education</td>
<td>Staff Nurses HNS FNP (all nursing personnel in community) P.S.</td>
<td>November 2015</td>
<td>1st quarter</td>
<td>January 2015</td>
</tr>
<tr>
<td>4. Training Programme for Professionals</td>
<td>Division of Nursing Ed. (Dean) SEO/ECE VINSAVE</td>
<td>Agreed</td>
<td>(All stakeholders) Education, Health, Development Vinsave</td>
<td>September 2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Policy – including Roving Caregivers</td>
<td>MOH NGO Education</td>
<td>Agreed-Cabinet Decision</td>
<td>Give Rovers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Intervention Curriculum</td>
<td>MOH MOE Ministry of Social Development</td>
<td>Agreed-Nursing School Teacher’s College</td>
<td></td>
<td>June 2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. In-service Training</td>
<td>MOH MOE Ministry of Social Development</td>
<td>Agreed - Early Childhood Stakeholders</td>
<td>Same persons who train CHAs</td>
<td>October 2015</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The table above is from the exit meeting by the evaluators held on December 9, 2014 with major stakeholders and duty holders including members from the MoHWE, MOE, nursing staff and parents.
APPENDIX G – Parent Feedback Questionnaire
Findings

SAMPLE SIZE

Thirty-two Interviews were conducted with parents who participated in the ECHO pilot. Twenty-two (22) parents completed the Parent Experience Questionnaire and twenty-five (25) completed the Parent Evaluation Questionnaire. Ten control parents completed the Parent Evaluation Questionnaire. Seventy-two percent of parent questionnaires were completed through face-to-face interviews with parents in St. Vincent. The remaining questionnaires were conducted by telephone interview.

As the small number of control participants did not allow for comparative analysis of parent outcomes, only analysis of the ECHO Parent Experience Questionnaire is presented.

DEMOGRAPHIC PROFILE OF PARENT PARTICIPANTS

Twenty-two (22) mothers were interviewed about their experience as participants in the ECHO programme. The mothers, who were all biological mothers of children enrolled in the ECHO programme, represent a randomly selected sample of parent participants.

Eighteen (18) mothers or 81.8% indicated that they were currently in a relationship with the father of their child. Almost a third of mothers (31.8%) had completed secondary education, 59.1 completed secondary education and 9.1% completed tertiary education.

ENROLMENT IN ECHO PROGRAMME

Eligibility Criteria
Mothers were interviewed to ascertain if they met any of the individual / family based eligibility criteria. The majority of the mothers/families interviewed (68.2%) did not meet any of the eligibility criteria.

Table 25. Eligibility Criteria for ECHO Programme

<table>
<thead>
<tr>
<th>Number of Criteria</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>15</td>
<td>68.2</td>
</tr>
<tr>
<td>1</td>
<td>5</td>
<td>22.7</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Introduction to ECHO Programme
A half (50%) of parents interviewed (11/22) reported that they were introduced to the ECHO programme at the clinic, while 40.9% (9/22) reported they were introduced at community visits by CHAs.

**Duration of Enrolment**

Ten (10) of the mothers interviewed or 45.5% reported that they were in the programme for six months or less while 36.4% reported being in the programme for between 7 – 12 months. Seven of the ten mothers who were in the programme for six months or less indicated the reason for their shortened time in the programme; five mothers reported that the CHA ceased visiting, one relocated and one child was admitted to preschool.

**Table 26. Duration of Enrolment in ECHO Programme**

<table>
<thead>
<tr>
<th>Duration of Enrolment</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Six Months or less</td>
<td>10</td>
<td>45.5</td>
</tr>
<tr>
<td>Seven - Twelve Months</td>
<td>8</td>
<td>36.4</td>
</tr>
<tr>
<td>Uncertain</td>
<td>4</td>
<td>18.2</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>100.0</td>
</tr>
</tbody>
</table>

**ECHO PROGRAMME FEEDBACK**

**Frequency of Visits**

Overall, there was variation in the pattern of visitation of CHAs as reported by parents. Only 27.2% or 6 of the 22 mothers interviewed indicated that CHAs visited twice monthly or more frequently, as indicated in the ECHO manual. Monthly, or less frequent visits, was most common.

There was no significant difference in the frequency of visits when analysed by the length of time families spent in the programme.

**Table 27. Frequency of Visits by CHAs**

<table>
<thead>
<tr>
<th>Frequency of Visits</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>Twice monthly</td>
<td>5</td>
<td>22.7</td>
</tr>
<tr>
<td>Monthly</td>
<td>6</td>
<td>27.3</td>
</tr>
<tr>
<td>Every two months</td>
<td>5</td>
<td>22.7</td>
</tr>
<tr>
<td>Greater than every two months</td>
<td>4</td>
<td>18.2</td>
</tr>
<tr>
<td>Not known</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Duration of Visits
The majority of parents (13/22 or 59.1%) reported that visits were on average 60 minutes (31.8%) or 30 minutes (27.3%) in duration. Overall, almost two-thirds of parents (14/22 or 63.6%) reported receiving visits for the minimum recommended period of 45 minutes or longer.

**Table 28. Mean Duration of Visits**

<table>
<thead>
<tr>
<th>Duration</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 minutes</td>
<td>6</td>
<td>27.3</td>
</tr>
<tr>
<td>45 minutes</td>
<td>4</td>
<td>18.2</td>
</tr>
<tr>
<td>60 minutes</td>
<td>7</td>
<td>31.8</td>
</tr>
<tr>
<td>90 minutes</td>
<td>3</td>
<td>13.6</td>
</tr>
<tr>
<td>Uncertain</td>
<td>2</td>
<td>9.1</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Focus of Visits
Parents reported that the primary focus of the visits was early childhood stimulation (40.9%) followed by parenting support and toy making (18.2%) and training. Some 70% of parents interviewed, however, reported that parenting education and support was the most valuable aspect of the programme.

**Table 29. Primary Focus of Home Visits**

<table>
<thead>
<tr>
<th>Primary Focus of Visits</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parenting Support</td>
<td>6</td>
<td>18.2</td>
</tr>
<tr>
<td>Training</td>
<td>2</td>
<td>9.1</td>
</tr>
<tr>
<td>Early childhood stimulation</td>
<td>9</td>
<td>40.9</td>
</tr>
<tr>
<td>Toy making</td>
<td>4</td>
<td>18.2</td>
</tr>
<tr>
<td>Developmental Assessments</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Rating of Pilot Programme by Beneficiaries
Mothers were overwhelmingly positive about the value of the programme with 81.8%, or 18 of the 22, rating the pilot programme as excellent or very good. Seventeen (17) mothers or 77.3% reported that children were very engaged or engaged whenever the CHA came to visit.

A large majority of parents interviewed (18/22 or 81.8%) indicated that the ECHO programme helped them to monitor / track their child's development. This was reported to be a result of the guidance and advice on developmental milestones received from the CHAs. Additionally, all mothers reported that they would re-enrol in the ECHO programme, if given the opportunity.
### APPENDIX H – Detailed Analysis of the Logical Framework

#### ANALYSIS OF PILOT GOAL

<table>
<thead>
<tr>
<th>Goal</th>
<th>Indicator</th>
<th>Means of Verification</th>
<th>Assumptions</th>
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</tr>
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</table>
| Quality early childhood health stimulation readily accessible to “at risk” children and parents | At least 90% of the 182 children enrolled in the program reached their milestone by January 2012 | Ages and Stages Questionnaire, Parent Feedback Form, Knowledge, attitude and practice survey | CHA will demonstrate acceptance and a positive attitudinal shift to new roles and responsibilities  
CHA will be consistent in the delivery of stimulation techniques  
Parents will embrace the programme and concepts  
Parents will choose to remain in the programme throughout the project’s life  
Financial resources disbursed on time and appropriately  
Parents empowered to apply information learned | The objective and indicator were not aligned. Each was independently evaluated.  
Project documents indicate that 182 children, from the poorest district in St. Vincent and the Grenadines, were enrolled in the ECHO programme. All (100%) received stimulation services by CHAs.  
All children in the first phase of the programme met their milestones after one year of the programme, despite statistically insignificant declines in developmental scores. | There was no assessment of quality of the services provided.  
The process of delivering quality would be assessed by adherence to a curriculum, observed and documented by a supervisor. The outcome of delivering quality stimulation would be best assessed by comparing changes in developmental status between ECHO and control children.  
M and E evaluation reports and post-programme parental surveys indicate that the majority of children enrolled did not meet criteria of “at risk” children.  
There is no evidence to indicate that the ECHO programme was responsible for children attaining their milestones. |
### ANALYSIS OF OBJECTIVES

<table>
<thead>
<tr>
<th>Objective</th>
<th>Indicator</th>
<th>Means of Verification</th>
<th>Assumptions</th>
<th>Analysis &amp; Verification</th>
<th>Challenges</th>
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<tbody>
<tr>
<td>1. To offer early stimulation to young children</td>
<td>90% ECHO children assessed to determine their milestones according to age</td>
<td>Aggregate results of district</td>
<td>Timely execution of training curriculum</td>
<td>The objective and indicator were not aligned. Each was independently evaluated. Project documents indicate that 182 children were enrolled in the ECHO programme, all (100%) received services by CHAs and had their development assessed using an age appropriate child development measure, the ASQ. Parent surveys indicate that stimulation was a main focus of the home visits.</td>
<td>Focus group discussions with CHAs responsible for providing the services and post programme parent survey data indicate that children did not receive visits at the expected frequency of twice per month and visits were often shorter than the required 45-60 minutes. There was no assessment of the quality of the stimulation provided.</td>
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<tr>
<td>2. To improve parenting practices in “at risk” communities</td>
<td>Noticeable developments seen in the children who are in the programme</td>
<td>ASQ, Child Health Records</td>
<td>Parents will continue the exercises in between CHA visits</td>
<td>The objective and indicator were not aligned. Each was independently evaluated. Project documents indicate that eight (8) parenting workshops were completed; these focussed on backyard gardening, child nutrition and making of toys. Parents received additional parenting support at home visits. Post programme parent surveys of parent beneficiaries identified parenting education and support as the second focus of the programme, only superseded by child stimulation.</td>
<td>Home visits did not occur with the expected frequency or duration. There were no data on parenting practices collected at baseline during the first phase of the project. A baseline survey on parenting knowledge, attitude and practice was conducted during the second phase of the project. However, there were no end of project data collected in this phase. It is unclear how data from the parenting knowledge and attitude survey were utilised. Improvement in parenting knowledge and attitude, which precedes improvement in parenting practice, is often used as a proxy measure for parenting practice. Improvement in this area would have</td>
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<td>To promote and monitor good health and early development of young children</td>
<td>90% of selected families execute the ECHO activities in health, education and social development as measured on the ASQ by January 2012.</td>
<td>Training Plan, Parent Knowledge, Attitude and Practice Survey, ASQ Surveys, Parent feedback, Supervisor’s Checklist</td>
<td>Data collection and analysis will be timely and accurate. Follow-up plans and remedial actions will be timely and appropriate. Maintenance of records of developmental milestones</td>
<td>The objective and indicator were not aligned. Each was independently evaluated. ASQ was used to monitor children’s development. Analysis of post programme parental surveys indicates that the ECHO programme helped a large majority of parents (82%) to monitor/track their children’s development.</td>
<td>been more accurately determined by comparing parenting knowledge and attitude of ECHO and control children pre and post programme implementation. Analyses of child development status in relation to changes in parenting knowledge and attitude would allow inferences to be drawn about the impact of improved parental knowledge on child development outcome. There is no data available to support significant improvement in development of ECHO children.</td>
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<td>To train CHAs from the communities in the pilot district to assist in the delivery of parent support services</td>
<td>90% of ECHO children worked with by CHAs attained their milestones by January 2012.</td>
<td>Training results and Feedback Report, Parent Feedback, Supervisor’s Checklist</td>
<td>Timely execution of training curriculum. Training fully absorbed by CHAs</td>
<td>The objective and indicator were not aligned. Each was independently evaluated. CHAs completed a comprehensive training programme, which they all rated very highly in the training evaluation process.</td>
<td>There is no indication of use of tools to monitor children’s health. There is no data available to indicate parental utilisation of skills that were taught. This would have been accurately determined by comparing parenting knowledge, attitude and practice before and after the ECHO programme. There were no pre and post test evaluations completed to assess effectiveness of the CHA training programme. No information was available on the use of the Supervisor’s checklist to assess CHA programme delivery in the community.</td>
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<td>To transfer knowledge and skills to parents and communities</td>
<td>Parents are able to demonstrate skills taught</td>
<td>Planned Parent Workshops Attendance Records Direct Observation of parents demonstrating learned techniques Survey Questionnaires</td>
<td>Workshops will be structured and relevant to the needs of stakeholders Facilitators and materials will be prepared and available</td>
<td>Eight (8) group parent workshops were held. Individual training was undertaken at home visits. At Post-programme survey, parents reported training to be one of the main foci of home visits.</td>
<td>No data were available to determine whether children in the second phase of the programme had achieved their milestones. There is no evidence to indicate that the attainment of milestones was due to the ECHO programme.</td>
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<td>To promote healthy relationships between parent and child</td>
<td>Parents are able to make the toys, other homemade props and prepare meals Other soft skills and resources provided in collaboration with other partners</td>
<td>CHA observation of toys, props and other skills in use in the home</td>
<td>Workshops will be structured and relevant to the needs of stakeholders Facilitators and materials will be prepared and available</td>
<td>The objective and indicator were unable to be assessed. While the transfer of knowledge of early stimulation from CHAs to parents is expected to improve parent-child relationships, there were no mechanisms to measure this in the project. There were also no mechanisms to measure the indicator of parental ability to make toys.</td>
<td>The absence of measures of the objective means that the status of the objective is unknown.</td>
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ANALYSIS OF OUTPUTS / RESULTS
## Outputs

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<thead>
<tr>
<th>Outputs</th>
<th>Indicator</th>
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<tbody>
<tr>
<td>1. To offer early stimulation to young children 0-3 years</td>
<td>90% of children meet milestones by January 2012</td>
<td>Participation level, Tracking Sheets, Attendance Records, ASQ Reports</td>
<td>Selection process adequately identifies the vulnerable across the pilot area, Consistency in curriculum delivery, so that minimum training/exposure requirements are achieved</td>
<td>This Output/Result is similar to but less specific than Objective 1 and the indicator is the same as that for Objective 4. Project documents indicate that 182 children were enrolled in the ECHO programme, all (100%) received stimulation services by CHAs. All children in the first phase of the programme were documented to have achieved their milestones, despite insignificant declines in developmental scores one year after programme implementation.</td>
<td>Focus group discussions with CHAs responsible for providing the services and post programme parent survey data indicate that children did not receive visits at the expected frequency of twice per month and visits were often shorter than the required 45-60 minutes. No data were available to determine whether children in the second phase had achieved their milestones. There is no evidence to indicate that the attainment of milestones was due to the ECHO programme.</td>
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</table>

2. Trained and skilled parents/caregivers in parenting practices | Parents mimic techniques demonstrated by CHA in health, education and social developments, Changes evident in response and health of children | Parental Attitude Survey, ASQ, CHA Observations and records, Attendance at parent workshops | Parental readiness and acceptance, Follow through on training exercises | Unable to be assessed | No data were available to assess parental training in parenting practices or parental ability to mimic the techniques of the CHA. There is also no data to assess changes in response of children. |

3. Trained and skilled CHA | Demonstrated understanding of role, Consistent delivery of techniques | Curriculum developed and executed, Training Plan implemented, CHA Attendance, Supervisors’ Checklist, Parent Feedback Form, Direct Interviews | CHA adherence to concepts and methodologies learnt, and execution | Unable to be assessed; All CHAs completed a comprehensive training programme, which they rated very highly in the training evaluation process | Though training was completed, there is no evidence (pre and post test training assessments or field assessments) to accurately assess whether CHAs were trained and skilled. These measures would have determined as well whether CHAs understood their roles. Supervisory checklists used at the community level would also have |
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<td></td>
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<td>Tracking Sheet of number of visits per child</td>
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<td>been useful in assessing whether CHAs understood their roles and delivered the programme consistently.</td>
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**Pilot objectives achieved, in preparation for mainstreaming**

- Clear, progressive linkages established among the activities, outputs, objectives and overall goal

- Project Evaluation
  - Monitoring reports
  - Survey Results
  - Log Frame Review
  - Evaluation Reports
  - Field Observation
  - Test mainstream application

- Records/documents of programme activities are retained and updated

- Table 24 below summarises the status of achievement of objectives. Two objectives were fully achieved, three were partially achieved and one was unable to be assessed. The overall goal was partially achieved. Log frame review presented earlier in this report identified many challenges

**Key:** Blue – Achieved, Orange – Partially Achieved, Purple – Unable to be assessed