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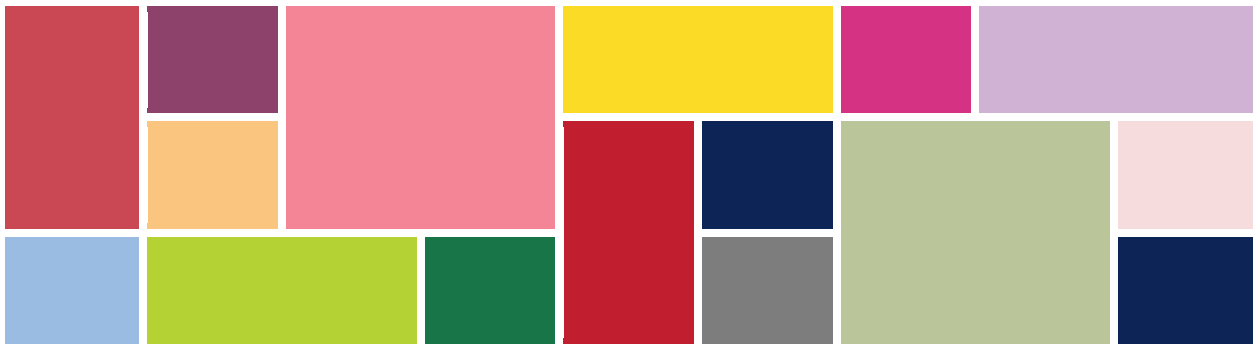
Maternal and Child
Survival Program

Landscape Analysis of Survive, Thrive, and Transform Interventions for Children

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The Maternal and Child Survival Program (MCSP) is a global, \$560 million, 5-year cooperative agreement funded by the United States Agency for International Development (USAID) to introduce and support scale-up of high-impact health interventions among USAID's 25 maternal and child health priority countries,* as well as other countries. MCSP is focused on ensuring that all women, newborns and children most in need have equitable access to quality health care services to save lives. MCSP supports programming in maternal, newborn and child health, immunization, family planning and reproductive health, nutrition, health systems strengthening, water/sanitation/hygiene, malaria, prevention of mother-to-child transmission of HIV, and pediatric HIV care and treatment.

* USAID's 25 high-priority countries are Afghanistan, Bangladesh, Burma, Democratic Republic of the Congo, Ethiopia, Ghana, Haiti, India, Indonesia, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Nepal, Nigeria, Pakistan, Rwanda, Senegal, South Sudan, Tanzania, Uganda, Yemen and Zambia.

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Acronyms and Abbreviations

7NDP	7 th National Development Plan (Zambia)
ANPECTP	<i>Agence Nationale de la Petite Enfance et de la Case des Tout Petits</i> (national agency for young child centers, Senegal)
CHW	Community health worker
CLM	<i>Cellule de Lutte Contre la Malnutrition</i> (malnutrition control unit, Senegal)
DHS	Demographic and Health Survey
ECD	Early childhood development
ECDAN	Early Childhood Development Action Network
ECE	Early childhood education
HMIS	Health management information system
iCCM	integrated Community Case Management
IMCI	Integrated Management of Childhood Illness
IYCF	Infant and young child feeding
MCSP	Maternal and Child Survival Program
MNCAH&N	Maternal, newborn, child and adolescent health and nutrition
MOH	Ministry of Health
NCAH	Newborn, child, and adolescent health
NCF	Nurturing Care Framework
SDGs	Sustainable Development Goals
SUN	Scaling Up Nutrition (movement)
UHC	Universal health coverage
UN	United Nations
USAID	United States Agency for International Development
WASH	Water, sanitation, and hygiene
WHO	World Health Organization

Executive Summary

The Sustainable Development Goals, founded on the principle that they are “integrated and indivisible,”¹ envision children surviving, thriving, and becoming transformative agents in their communities. The United Nations (UN) Secretary-General’s Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030) articulates the strategies needed to achieve the three pillars of survive, thrive, and transform. While many thrive and transform interventions are ongoing, the extent to which they have been implemented in the context of child survival platforms is not known.

The Maternal and Child Survival Program (MCSP), with support from the United States Agency for International Development (USAID), conducted a review on behalf of the Child Health Task Force to explore countries’ experiences adding thrive and transform interventions to platforms used to deliver child survival interventions. The review seeks to map out existing global guidance and understand operational experiences primarily in three African countries, Kenya, Senegal and Zambia, with some examples also presented from Ghana and Rwanda. For each primary country, the experiences are presented in the form of narratives that describe the context, main areas of attention, main sectors in addition to health, coordinating structure, and delivery platforms.

Information was collected through a review of global documents and literature, discussions with carefully targeted key informants at global and regional levels, and discussions with key people in selected countries. Fifty-nine key informants were interviewed, 17 of whom are at either the global or regional level, 37 from the three case study countries (Kenya, Senegal, and Zambia), and five from Ghana and Rwanda. Respondents represented ministries of health, the World Health Organization, UNICEF, USAID, nongovernmental organizations, universities, and other implementing partners.

Interventions and approaches that complement child survival to promote thriving are clearly in the spotlight at both global and country levels. Numerous global initiatives have emerged in recent years, including the UN Secretary-General’s Global Strategy for Women’s, Children’s and Adolescents’ Health, an ongoing “redesign” of child health programming linked in part to the strategic review of child health/Integrated Management of Childhood Illness, and the development and promotion of the Nurturing Care Framework. A substantial number of publications are available that describe the evidence base and support implementation of interventions.

Interventions and approaches that promote thriving are clearly in the spotlight.

There was clear convergence across the three case study countries on the successes and challenges related to intervention areas, entry points, driving forces, tracking progress, and funding. Intervention areas focused mainly on early childhood development, early childhood education, and nutrition. Associated interventions covered birth registration; water, sanitation, and hygiene; and financial or social protection. Most entry points for action were through existing child survival platforms, of which the thrive interventions are perceived as a natural extension.

The driving forces behind the decision to move forward with adding thrive and transform interventions are inextricably linked to the commitment to develop human capital, the availability of convincing global evidence, and a push/pull from the highest levels of government. This last force translates into political momentum that has been capitalized on and needs to be maintained.

There has been some movement towards tracking progress, however this is perceived as a weak point needing global and national attention. This includes the development, integration, and measurement of indicators, as well as the need to document experiences. Funding is an ongoing challenge, particularly as much of it has been external.

¹ <https://www.un.org/development/desa/dspd/2030agenda-sdgs.html>.

Considering these lessons, a list of recommendations has emerged for consideration by the Child Health Task Force, country partners, and funders as they expand their mandates to include thrive and transform. It is recommended that these partners:

1. Support countries to institute and maintain mechanisms for multisectoral collaboration and coordination that will be sustainable over time.
2. Support efforts to implement the Nurturing Care Framework, which is built on a strong evidence base and is gathering interest and momentum with partners and countries. Note that while doing this, it will be important to keep an eye on interventions beyond early childhood development/early childhood education.
3. Help monitor and improve the quality of care and counseling skills within the health sector.
4. Learn about experiences in additional countries in Africa and other regions.
5. Continue to explore means of delivering or implementing thrive and transform interventions that would complement ongoing work.
6. Support the development and use of global indicators for monitoring process and impact to allow comparison across countries, while supporting countries to institutionalize the use of these indicators across sectors.
7. Ensure that countries can adequately document processes and progress, and share results.

Introduction and Background

The Sustainable Development Goals (SDGs), founded on the principle that they are “integrated and indivisible,”² envision children surviving, thriving, and becoming transformative agents in their communities. Of special note, SDG 2 targets zero hunger, SDG 3 targets good health and wellbeing, SDG 4 targets quality education, and SDG 6 targets clean water and sanitation.

Given the critical importance of enabling children to have the best start in life, the health sector has a responsibility to support interventions to help children thrive. Moreover, the health sector is in a unique position to reach out to families and caregivers during the early years of a child’s life.

The United Nations (UN) Secretary-General’s Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030) articulates the strategies needed to achieve the three pillars of survive, thrive, and transform. It provides global objectives and examples of evidence-based interventions, but does not specify how these should be implemented. In particular, while many thrive and transform interventions are ongoing, the extent to which they have been implemented in the context of child health and survival platforms is not known.

To help address this knowledge gap, the Maternal and Child Survival Program, with support from the United States Agency for International Development (USAID), conducted a review on behalf of the Child Health Task Force to explore countries’ experiences with adding thrive and transform interventions to platforms used to deliver child survival interventions. This review seeks to map out existing global guidance relevant to the thrive and transform pillars and to understand operational experiences in three African countries: Kenya, Senegal, and Zambia. In particular, it seeks to explore the following questions:

- Why have countries decided to address the thrive/transform agenda?
- What interventions have they chosen to include?
- Which interventions have been linked to child health programming, and how was this done? What other entry points and delivery platforms have been used to deliver thrive and transform interventions?
- What additional evidence would be helpful to inform country implementation efforts?
- What lessons or advice could implementers provide for other countries intending to move forward with thrive and transform interventions?

Conclusions from this review are intended to provide direction to the Child Health Task Force and the global community as they expand from a focus on child survival to a broader agenda of enabling children to thrive and reach their full potential. It is hoped that the review will also be helpful to the three participating countries, and to other countries in various stages of integrating the thrive and transform agenda.

² <https://www.un.org/development/desa/dspd/2030agenda-sdgs.html>.

Methodology

Information was collected through a review of global documents and literature and discussions with key informants at global and regional levels. These discussions were then followed by interviews with key informants in selected countries and a document review.

Global documents were identified based on recommendations by key informants and through web searches. For the three countries identified for more in-depth study, key informants provided documents upon request. Additional information was collected online to provide detail and insight on interventions and policies mentioned by the key informants.

This review focused first on existing global-level policy and program guidance for implementing thrive and transform interventions for children. The review concentrated specifically on thrive and transform interventions that were built upon or linked to a child survival/health platform, those that targeted the 0–5-year age group, and those that could potentially be acted upon by child health practitioners.

To identify country experiences in Africa or Asia that could be followed up for more in-depth review, recommendations were solicited during interviews with global and regional key informants. Those recommendations resulted in an initial mapping of countries and interventions that in turn informed the final selection of countries by the advisory group.³ Criteria for country selection included an indication by regional key informants of national commitment to the thrive and transform agenda, evidence of initial activities to implement this agenda, variations in approach and context, and the ability to remotely access key informants and documents. Three countries, Kenya, Senegal and Zambia, were selected for in-depth country reviews. During the mapping process, interviews were conducted with a small number of people in Ghana and Rwanda; this review also includes salient points from those interviews.

Country case studies were informed by both document review and key informant interviews. Country key informants were recommended by global and regional key informants as well as by initial country key informants. Criteria included first-hand knowledge and experience with planning, funding, implementing, monitoring, and evaluating survive, thrive, and transform interventions. Interviews were conducted via telephone or Skype using predefined questionnaires aimed at identifying specific interventions selected by each country, reasons for selection, length and scale of implementation, early challenges, and lessons learned.

The reviewers carried out interviews with a total of 59 key informants: 17 at the global or regional level and 42 at the country level. Country-level interviews were conducted with three key informants in Ghana, nine in Kenya, two in Rwanda, 17 in Senegal,⁴ and 11 in Zambia. Respondents represented ministries of health, the World Health Organization (WHO), UNICEF, USAID, nongovernmental organizations, universities, and implementing partners.

The principal limitation of this review is the relatively small sample size of key informants and countries. Despite efforts to include countries from several geographic regions, the review is limited to representing only one.

The review is intended to identify early experiences and provide insights into a few countries' experiences. The fact that information was only gathered remotely, with no site visits, limited the potential depth and breadth of understanding, and the small sample size limits generalizability. Thrive and transform are fairly new concepts and the review recognized that countries seem to be in the early days of implementation. As a result, most documentation is at the level of policies, strategies, and plans and few evaluations or implementation reports are available. Finally, most key informants provided insights related to thrive

³ The advisory group was composed of representatives from MCSP, UNICEF, USAID, WHO, and the co-chairs of the Child Health Task Force subgroups representing Action Against Hunger (Nutrition), Boston University (Implementation Science), Save the Children (Expansion of the Child Health Package), and World Vision (Institutionalizing iCCM).

⁴ The number of respondents from Senegal is high because of the large multisectoral group that participated from the UNICEF country office.

interventions as opposed to those related to transform. It is likely that the purview of key informants is more directly related to the intersection of survive and thrive, and information related to advancing knowledge and understanding of the transform pillar may involve different informants.

Survive, Thrive, and Transform Objectives

The complete list of survive, thrive, and transform objectives established by the UN Secretary-General's Global Strategy is presented below.

AT A GLANCE:

THE GLOBAL STRATEGY FOR WOMEN'S, CHILDREN'S AND ADOLESCENTS' HEALTH (2016-2030)

VISION

By 2030, a world in which every woman, child and adolescent in every setting realizes their rights to physical and mental health and well-being, has social and economic opportunities, and is able to participate fully in shaping prosperous and sustainable societies.

OBJECTIVES AND TARGETS aligned with the Sustainable Development Goals (SDGs)



SURVIVE *End preventable deaths*

- Reduce global maternal mortality to less than 70 per 100,000 live births
- Reduce newborn mortality to at least as low as 12 per 1,000 live births in every country
- Reduce under-five mortality to at least as low as 25 per 1,000 live births in every country
- End epidemics of HIV, tuberculosis, malaria, neglected tropical diseases and other communicable diseases
- Reduce by one third premature mortality from non-communicable diseases and promote mental health and well-being



THRIVE *Ensure health and well-being*

- End all forms of malnutrition and address the nutritional needs of children, adolescent girls, and pregnant and lactating women
- Ensure universal access to sexual and reproductive health-care services (including for family planning) and rights
- Ensure that all girls and boys have access to good-quality early childhood development
- Substantially reduce pollution-related deaths and illnesses
- Achieve universal health coverage, including financial risk protection and access to quality essential services, medicines and vaccines



TRANSFORM *Expand enabling environments*

- Eradicate extreme poverty
- Ensure that all girls and boys complete free, equitable and good-quality primary and secondary education
- Eliminate all harmful practices and all discrimination and violence against women and girls
- Achieve universal and equitable access to safe and affordable drinking water and to adequate and equitable sanitation and hygiene
- Enhance scientific research, upgrade technological capabilities and encourage innovation
- Provide legal identity for all, including birth registration
- Enhance the global partnership for sustainable development

Global Findings

Interventions and approaches that complement child survival to promote thriving are clearly in the spotlight at both global and country levels. Numerous global initiatives have emerged in recent years, including the UN Secretary-General’s Global Strategy for Women’s, Children’s and Adolescents’ Health; an ongoing UNICEF and WHO-led “redesign” of child health programming, linked in part to the strategic review of child health/Integrated Management of Childhood Illness (IMCI); and the development and promotion of the Nurturing Care Framework (NCF). A substantial number of publications are available that describe the evidence and support implementation of interventions. (Note that the current review did not attempt to examine or summarize the sizeable body of literature on early childhood development [ECD]).

Global Findings I: Global Initiatives

UN Secretary-General’s Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030)

The UN Secretary-General’s Global Strategy for Women’s, Children’s and Adolescents’ Health encourages the global community to expand from child survival programming to encompass interventions that help children “thrive” (“ensure health and wellbeing”) and help the health and other systems “transform” (“expand enabling environments”). The Global Strategy articulates objectives and targets for survive, thrive, and transform that are aligned with the SDGs. Annex 4 of the Global Strategy provides four pages of evidence-based interventions critical for the overall health and wellbeing of women, children, and adolescents. Thrive intervention packages for children include the promotion of breastfeeding, infant and young child feeding (IYCF), and responsive caregiving and early stimulation.

Scaling Up Nutrition (SUN) Movement

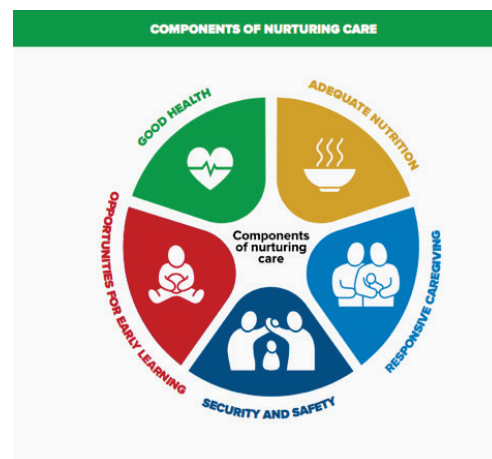
Initiated in 2010, the SUN Movement is committed to working collaboratively to end malnutrition across its 61 member countries. The SUN Movement principles of engagement guide actors as they work in a multisectoral and multi-stakeholder space. Focused on the first 1,000 days, the SUN Movement helps to illuminate the importance of nutrition in achieving the SDGs.

Child Health Redesign

In 2018, a series of stakeholder consultation meetings was held across WHO regions to discuss the “redesign” of child health programming and IMCI. This effort emerged from the 2016 global child health strategic review “Towards a Grand Convergence for Child Survival and Health,” that called for addressing the broad multisectoral approach of the SDGs that includes social determinants for health. The synthesis report from the stakeholder consultations states that, for the “thrive agenda,” all WHO regions have prioritized empowering parents and families to ensure care of the healthy child. For young children, this includes nutrition, child development, risk prevention, and promotion of healthy lifestyles. While emphasis should be maintained on preventable deaths of children, especially in high mortality regions, the redesign of child health programming should aim at achieving optimal health, growth, and wellbeing of all children and adolescents. A global meeting was convened by UNICEF and WHO in January 2019 with the purpose of generating consensus on the paradigm shifts and public health response required for newborns, children, and adolescents to survive, be healthy, and grow and develop to achieve their full potential.

Nurturing Care Framework

To fill the perceived gap in ECD for children younger than 3 years old, UNICEF, WHO, the World Bank Group, the Partnership for Maternal, Newborn and Child Health, and the Early Childhood Development Action Network (ECDAN) developed the NCF. This framework, published in 2018, provides strategic directions for supporting the holistic development of children, starting in pregnancy and going up to 3 years old. It aims to inspire multiple sectors, including health, nutrition, education, labor, finance, water and sanitation, and social and child protection to work in new ways to address the needs of the youngest children. It articulates the importance of responsive caregiving and early learning as integral components of good-quality care for young children. It also enumerates laws, policies, and interventions for each of the five components of nurturing care: good health, adequate nutrition, responsive caregiving, opportunities for early learning, and security and safety.



These five components are intended to be viewed in the context of an enabling environment, so that they can be implemented differently and more effectively than in the past. The NCF seeks to re-package survive and thrive interventions to lead to transformation, provide an evidence-based roadmap for action, and outline how policies and services can support parents, families, other caregivers and communities in providing nurturing care for young children.

A global meeting to operationalize the framework was convened by WHO in August 2017 in Geneva, and the framework was launched at the 72nd World Health Assembly in 2018. A stakeholder consultation meeting to operationalize the framework by the health sector was held in October 2018 in Nairobi, facilitated by WHO, UNICEF, PATH and other partners; this was followed up by a multi-country meeting to jointly support operationalization of nurturing care country plans in Ethiopia, Kenya, Malawi, Mozambique, Tanzania, Zambia, and Zimbabwe in Nairobi in April 2019.

The Nurturing Care Framework was launched at the World Health Assembly in 2018.

The Lancet Commission on Child Health and Wellbeing

A January 2019 commentary in *The Lancet* described *The Lancet* Commission on Child Health and Wellbeing.^{5,6} This commission will frame an agenda for children (0–18 years) thriving in the SDG era. The goal of the commission is to identify the best ways to optimize, reposition, and redesign child health to meet the SDG targets and advance the resulting agenda. A report is expected to be published in 2019.

Global Findings 2: Evidence Base

There are a number of seminal documents that provide the evidence and hence support the investment case for expanding child survival interventions beyond curative care. In 1999, WHO published “Critical Link.” This review, which could be considered the precursor to many thrive interventions, summarizes three types of interventions: those that support psychological development, nutrition interventions to support physical growth, and combined interventions to improve both growth and psychological development. It argues that feeding behaviors that increase nutrient intake and psychosocial support for children’s development require similar skills and resources from caregivers. The review found that combined interventions to improve both physical growth and psychological development have an even greater impact in disadvantaged populations at risk of malnutrition. Children who are most vulnerable to growth faltering are also at the highest risk of disruptions in psychological development. The dual focus of combined programs can address both needs.

⁵ [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(18\)32821-6/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32821-6/fulltext).

⁶ The Commission is chaired by the former Prime Minister of New Zealand, Dr. Helen Clark, and the Senegalese Minister of State, Dr. Awa Marie Coll Seck. It is led by Dr. Anshu Banerjee, Director of the Maternal, Newborn, Child and Adolescent Department in WHO, headquarters, and Dr. Stefan Peterson, the Chief of Health in UNICEF, headquarters.

“The Importance of Caregiver-child Interactions for the Survival and Healthy Development of Young Children” (WHO 2004) presents the theory of and evidence for the importance of caregiver-child relationships for the survival and healthy development of children from birth to 3 years old.

Similarly, a paper in the *Bulletin of the World Health Organization* in 2006 on responsive parenting found that interventions that enhance maternal responsiveness result in better child health and development, especially for the neediest populations. These interventions were feasible even in poor settings; the paper concludes that responsiveness interventions should be integrated into child survival strategies.

In 2007, the Commission on Social Determinants of Health published a report “Early childhood development: a powerful equalizer,” that synthesizes knowledge about opportunities to improve the state of ECD on a global level.

The 2016 *Lancet* Early Childhood Development Series considers new scientific evidence for interventions, builds on the findings and recommendations of previous *Lancet* series on child development (2007, 2011), and proposes pathways for implementing ECD at scale. The series emphasizes “nurturing care,” especially of children below 3 years old, and multisectoral interventions starting with health, which can have wide reach to families and young children through health and nutrition.

Global Findings 3: Global Guidance

The search for information on operational experiences linking survive, thrive, and transform interventions revealed a large number of materials that support the implementation of thrive interventions. Most of these focus on ECD. Materials are presented here under the categories of training, advocacy, and reports of country or multi-country experiences. A planning handbook for “Caring for Newborns and Children in the Community” was developed in 2015 by WHO and UNICEF with guidance from members of the Child Health Task Force. This handbook addresses the multiple issues related to implementation interventions to improve child health and development.⁷

Training Packages

In order to operationalize the recommendations of the reviews on caregiver-child interactions, WHO and UNICEF developed the training courses “Care for Child Development” (2012), aimed at workers in health facilities, and “Caring for the Child’s Healthy Growth and Development” (2015), targeting community health workers (CHWs).

Most global documents focus on early childhood development.

“Care for Child Development” can be implemented as a stand-alone course or integrated into health facility IMCI, to support families to care for their children and help them thrive and develop. The package provides information and recommendations for cognitive stimulation and social support to young children, through sensitive and responsive caregiver-child interactions. It is also linked to the UNICEF “Early Childhood Resource Pack,” designed to help program planners and managers understand the basic elements of the best start in life for children and how to most effectively work together to achieve those goals. The updated second edition of the pack includes new topics, such as child poverty, and expands some of the existing modules to include new information on ECD.

“Caring for the Child’s Healthy Growth and Development” is designed to train CHWs on promoting thrive-related activities during individual home visits or group sessions. This is one of three packages for CHWs developed by WHO/UNICEF, and complements “Caring for the Sick Child” and “Caring for the Newborn at Home.” Numerous organizations, agencies, and countries have developed or adapted their own versions of ECD training.

⁷ <http://www.who.int/iris/handle/10665/204457>.

Advocacy

The 2016 *Lancet* ECD series has been launched in numerous countries to share the evidence base related to ECD and nurturing care. These launches provide an opportunity to engage high-level political support at an advocacy event in order to spearhead national efforts and engage multiple government ministries.

PATH, in collaboration with UNICEF and the Aga Khan Foundation, put together two short films to help policymakers, donors, government, and nongovernmental organizations understand how ECD and nurturing care can be integrated into health service delivery.⁸ Aga Khan has a course on the science of ECD to help caregivers and parents in providing a foundation for children to thrive during a critical time.⁹ PATH is currently working on a variation of the course for policy makers and first ladies.

Global Findings 4: Implementation Reports of Country/ Multi-Country Experiences

The majority of information on implementation experiences revealed a focus on ECD and on the integration of ECD with the health sector.

In 2017, the Early Learning Partnership of the World Bank Group published “Promising Approaches in ECD,” a series of 11 case studies and two cautionary tales.¹⁰ Each one covers how the effort was implemented and financed, a summary of results, and a discussion of key contributing factors. The Nurturing Care website presents success stories from nine countries (Bulgaria, Greece, India, Kazakhstan, Kenya, Serbia, South Africa, and Viet Nam). Save the Children recently published the “Building Brains” toolkit, which provides case studies and guidance on developmental activities for the perceived gap of 0 to 3 years old. A multi-partner website on Saving Brains supports bold ideas to improve early brain and child development, and focuses on health and nutrition, food enrichment and child protection.

The ECDAN provides a platform for knowledge exchange, collaboration, advocacy, and communication around ECD. They are committed to catalyzing action at scale to help achieve the SDGs for young children. ECDAN co-developed the NCF and is currently developing an electronic hub for materials, including training manuals, policies, and guidelines.

In 2018, the Bernard van Leer Foundation published a series of articles called “Early Childhood Matters” that, among other things, highlights work supported by PATH on integrating ECD into the health system. PATH has been involved in efforts to integrate and scale up of health systems-based ECD services in Cote d’Ivoire, Kenya, Mozambique, South Africa, and Zambia. In Mozambique, PATH conducted evaluations on the feasibility and acceptability of integrating nurturing care content into home visits by CHWs and facility-based services, as well as installing play boxes in health facility waiting areas. Child caregivers at intervention sites showed better child care, nutrition practices, and early learning support than controls.

Global Findings 5: Results of Interviews with Global Key Informants

The main points raised by key informants at the global and regional level related to integrating thrive and transform interventions into a child health platform concerned: 1) scale of and funding for implementation, 2) the main intervention areas seen in countries, 3) implementation platforms for thrive and transform, 4) the tension and balance needed between priorities, and 5) the complex issue of multisectorality.

⁸ <https://www.path.org/articles/eecd-advocacy-films/>.

⁹ <https://www.akfusa.org/ourwork/the-science-of-early-child-development/>.

¹⁰ The Educate Your Child Program (Cuba), Aga Khan Early Childhood Development Program (East Africa), Community-Based Preschool Program (Mozambique), Early Childhood Education and Development Project (Indonesia), Releasing Confidence and Creativity (Pakistan), Prospera Conditional Cash Transfer Program (Mexico), Home-based ECCE Centers (Colombia), Mother-Child Education Program (MOCEP) (Turkey), Radio Instruction to Strengthen Education (RISE) (Zanzibar), Early Education Program (Educacion Inicial) (Mexico), Incorporating ECD teacher training into a skills training program (Liberia), Cautionary Tales: Learning from Programs that Missed Their Intended Impact.

Scale of and funding for implementation: Key informants were quick to point out that most work is still in the policy and planning stages, with some pilot activities. The issues facing countries are scalability and the funding to expand the focus of activities.

Intervention areas: Parallel to what was found in the literature, the main intervention areas seen in countries related to ECD. The NCF was identified as an important framework for organizing thrive interventions and mobilizing efforts at the country level. Key informants reported a strong focus on addressing responsive caregiving within nutrition and IYCF programming.

Key informants identified the following thrive intervention areas related to child health:

- ECD
- Early learning
- Nutrition: malnutrition, the nutritional needs of children, IYCF, and micronutrient supplementation
- Financial risk protection
- Cash transfers
- Access to essential services
- Prevention and management of child abuse
- Gender-based violence
- Injuries and drowning
- Children with special needs/disabilities

Several key informants also discussed the importance of addressing the needs of children older than 5 years, and especially adolescents.

In general, key informants quickly identified thrive interventions, but saw transform interventions as significantly more complex. While several informants discussed initiatives to link and expand birth registration within the health system, it was commonly only raised at the prompting of the interviewer. Water, sanitation, and hygiene (WASH) initiatives were also mentioned, but most frequently as an adjunct to child survival or child development.

In general, key informants found it easier to identify interventions that promote thriving than those that promote transformation.

Implementation platforms: Key informants stressed the importance of strengthening community platforms for integrated service delivery. Examples were provided of introducing nurturing care content into maternal health, IMCI, Essential Nutrition Actions, integrated Community Case Management (iCCM), and pre-service curricula for CHWs, nurses, and midwives.

Comments about implementation platforms revolved around whether or not child survival is the best platform for thrive interventions. Some felt that clinics were developed long ago to address the survival agenda, mainly communicable diseases. They are not designed for managing chronic or noncommunicable diseases, and may require an overhaul that does not seem to be in current discussions. On the other hand, it was recognized that a sick child is especially in need of ECD and responsive care.

Tension and balance among priorities: Key informants recognized the challenge of adding additional tasks to already overstretched workers. Current work was discussed related to conducting time studies and costing various options for service packages to inform national decision-making. Some key informants raised the question of the need for a designated provider who focused on thrive interventions, while others saw the nurturing care content as a way to improve quality of care from existing providers. Key informants felt that

the messaging was strong related especially to responsive caregiving, but that counseling skills in general were fairly weak within the health sector.

Developmental milestones: Screening for developmental milestones was raised as an important intervention that could be integrated into well-child visits. Questions arose around what happens when a health worker identifies a developmental delay, whether services exist for referral, and whether all milestones are culturally appropriate.

Multisectorality: Multisectoral collaboration is seen as essential to effectively addressing thrive and transform objectives. Questions arose around experiences with various governance models, including coordination from within one ministry, at a higher government level, or within a different, technically-neutral group. How this coordination plays out at the subnational level was of interest. Subnational levels across different sectors raise additional questions related to alignment of catchment areas for joint actions. Especially in countries that are decentralized, catchment areas for local government, schools, and health, for example, may form very different boundaries. One health center may serve up to three municipalities or part of just one.

Multisectoral collaboration at all levels is essential for addressing thrive and transform.

Country Findings

As noted in the section on methodology, Kenya, Senegal, and Zambia were selected for in-depth consideration. The following section provides a narrative for each country on the context, main areas of attention, main sectors in addition to health, coordinating structure, and delivery platforms.

In the course of conducting the global and regional scan, exploratory interviews were held with individuals from Ghana and Rwanda. While these countries were not selected for full case studies, there were some interesting, complementary findings related to the implementation of thrive interventions (specifically related to ECD) in both countries. Short descriptions of these can be found at the end of this section.

Case Studies from Kenya, Senegal, and Zambia

Kenya Case Study

Brief summary of context

Kenya has made significant progress on improving child health and on enacting relevant policies. According to the Global Health Observatory¹¹ and UNICEF Monitoring data,¹² in 2017, the under-5 mortality rate was 45.6 per 1,000 live births, down by nearly half since 2003. The newborn mortality rate was 20.9, and continues to decline, albeit more slowly. According to the USAID nutrition profile, the national prevalence of stunting has also fallen from 35% in 2008 to 26% in 2014. Stunting is highest in the Coast, Eastern, and Rift Valley regions, and is most prevalent among children 18–23 months, indicating that poor complementary feeding and hygiene and sanitation practices may be important factors.

A constitutional change in 2010 established the devolution of many government roles from the national level to the 47 counties. The national level creates the enabling policy environment so that counties can take up their mandate. While policies and strategies originate at national level, county governments have been given the responsibility for, among other services, ECD, pre-primary education, and health care. Counties are charged with establishing policies to fit their unique contexts and designing, budgeting, and providing services.

Kenya is committed to the SDGs and achieving universal health care (UHC) in the next five years. The financing component of UHC, specifically, is a high priority of the government.

2018 saw the publication of a new national policy that regroups Newborn, Child and Adolescent Health (NCAH)—the first time that adolescents have been included in child health policies. The policy is part of a broader policy framework that focuses on the life course and includes a proposed Newborn, Child and Adolescent Health Act, currently under review in parliament. It provides a unified approach to planning, prioritizing, and implementing newborn, child, and adolescent health programs at national and county level across the continuum of care. It provides direction on national child health priorities, interventions, investments, and partnerships. Most importantly for this review, the NCF is embedded within the policy, with integration of nurturing care interventions for ECD into relevant newborn and child health programming. ECD, WASH, and other social determinants, as well as special needs and disabilities, are included as cross-cutting themes for all age groups.

¹¹ <https://apps.who.int/gho/data/node.cco.ki-KEN?lang=en>.

¹² <https://data.unicef.org/country/ken/#>.

The NCAH policy names various other initiatives that demonstrate the country’s commitment to the health and wellbeing of its children. These include:

- 1) the elimination of user fees for primary health care in all public health care facilities and provision of various health payment schemes, such as the national health insurance fund;
- 2) the community health strategy, to better link communities to facility and referral services; and
- 3) innovative financing mechanisms, such as the Linda Mama program¹³ under the national health insurance fund and the reproductive, maternal, newborn, child, and adolescent health investment framework (Global Financing Facility).

The NCAH vision: “A Kenya where all newborns, children and adolescents survive, thrive and live to their fullest potential” and the interior page heading: “Towards the highest attainable standard of health for all newborns, children and adolescents in Kenya” confirm the intention of the country to extend child health interventions well beyond those targeting only survival.

Main areas of attention

Nurturing care

The main focus related to helping young children thrive is implementation of the NCF.

Current work in Kenya related to the components of nurturing care include:

1. Health: Services for antenatal care, postnatal care, child health, and immunization
2. Nutrition: Promotion of nutrition-sensitive and -specific interventions; promotion of breastfeeding and exclusive breastfeeding; Baby-Friendly Hospital Initiative and Baby-Friendly Community Initiative promoted in communities and facilities; capacity building of caregivers; diversified diets (as opposed to balanced diet)
3. Responsive caregiving: Baby-Friendly Community Initiative includes a responsive care component that builds capacity and uses the existing evidence base to incorporate psychomotor, cognitive, and psychosocial supports; community health strategy with community health volunteers connecting to households; digital platforms (under development) to allow volunteers to access the information and real-time support needed for resolving questions and making decisions about responsive care
4. Security and safety: The National Council for Children’s Services is mandated to support child rights and ensure area advisory committees, such as child protection committees, and to bring in the Department of Children’s Services, education sector, and justice system to address the needs of children vulnerable to abuse, neglect, orphaning; child health hot lines to report abuse happening in the community
5. Early learning: Teaching caregivers that children learn and communicate as infants and even within the womb; encouraging caregivers to develop play items using what they have as low- and no-cost options to enable the child to explore their environment

Nurturing care in Kenya includes health, nutrition, responsive caregiving, security and safety, and early learning.

Early childhood development

In Kenya, the NCF is primarily operationalized as ECD. The Office of the First Lady of the Republic of Kenya supported the launch of the 2016 *The Lancet* special series on early childhood development, “Advancing Early Childhood Development: From Science to Scale,” which promoted the importance of investing in these interventions. At their 2018 annual scientific conference, the Kenya Pediatrics Association, with over 500 members present, affirmed leadership in integrating nurturing care in routine health care practice both within the public and private sectors.

The WHO/UNICEF Care for Child Development package was adapted for training health care providers. Nurturing care content has also been incorporated into existing training platforms such as IMCI, Baby-

¹³ Linda Mama is an expanded program for free maternity package of benefits. It is a publicly funded health scheme that will ensure that pregnant women and infants have access to quality and affordable health services. By providing a package of basic health services accessed by all in the targeted population on the basis of need and not ability to pay, it positions Kenya on the pathway to UHC.

Friendly Communities, and CHWs. Current work is underway to incorporate nurturing care content into iCCM training modules.

Kenya is working on a strategy to distribute nurturing care tools to all facility-based health care workers and community health volunteers in the eight counties (Kisumu, Siaya, Migori, Nairobi, Baringo, Mombasa, Kilifi, and Homabay) that are piloting its integration. Aspects of monitoring developmental milestones have been incorporated into selected guidelines and documents. Examples include:

- Integrated Management of Newborn and Childhood Illness guidelines: 1) check for child’s developmental milestones, 2) recommendations for Care for Child’s Development, and 3) care for development problems
- Maternal and child health booklet: “Recommendations for Care for Child Development”
- IYCF: brief mention of the contributions of delayed developmental milestones to poor breastfeeding practices

Government-hired master trainers are cascading nurturing care training to the county level. These new tasks have been taken on by existing Ministry of Health (MOH)—and some Ministry of Education—staff at the national and subnational levels, some of whom have been trained on nurturing care through partner support.

Guidelines for CHWs are currently under revision to include nurturing care. It is useful to note that CHWs are not on the government payroll. However, various partners provide incentives using different strategies that include paying stipends. Since the devolution of health services, the responsibility for supporting CHWs moved to the county governments, and some counties pay CHWs while others do not. The lack of a consistent county-level legal/policy framework for this is perceived by key informants as an obstacle to scaling up activities.

Next steps for the government in collaboration with national partners¹⁴ include:

- Developing clear guidelines to operationalize the delivery of nurturing care at national and county level
- Developing content and incorporating nurturing care training into pre-service and in-service curricula
- Developing a national implementation plan for 2019–2020, that includes costing¹⁵
- Finalizing the integrated ECD policy that spells out the responsibilities of concerned line ministries
- Defining and agreeing on program indicators for nurturing care to be included in the district health information system/health management information system (DHIS/HMIS)

Government, partners, and donors agreed to focus their initial NCF/ECD efforts on Siaya County. Siaya County has especially poor child health indicators and has been a popular site for projects such as research on care for newborns, improving the quality of clinical care for mothers and newborns, and the early deployment of CHWs. In the context of devolution, working at the county level is vitally important and Siaya County is seen as a “living university” model in Kenya to test NCF/ECD implementation. In November 2018, all sub-counties and about one-third of health facilities offered these services. Siaya County aims to reach universal coverage of nurturing care services by 2020. Other counties are invited to visit implementation sites.

Efforts in Siaya County include:¹⁶

- Providing a supportive policy environment by enacting a health bill to anchor nurturing care in health service delivery as a high-impact intervention

¹⁴ Partners involved in NCF action planning include the National Child and Adolescent Health Unit of the Kenya MOH, WHO, UNICEF, Africa Early Childhood Network, PATH, and the Conrad N. Hilton Foundation.

¹⁵ There are efforts to nail down actual costs; PATH is involved in one such initiative.

¹⁶ Gray K, Scaling up nurturing care in Siaya County, Kenya, PATH USA, <http://nurturing-care.org/resources/nurturing-care-case-study-kenya.pdf>.

- Building the capacity of service providers to promote responsive caregiving and monitor children’s development as part of routine health service delivery
- Ensuring priority services in health facilities, including:
 - Clinical monitoring of developmental milestones
 - Referral of children with suspected developmental delays
 - Counseling on responsive caregiving
 - Early learning and structured play sessions
- Using CHW networks to provide nurturing care-related counseling and to offer additional support through home visits
- Developing a behavior change campaign to increase demand for ECD services and promote improved nurturing care practices in the home

Efforts are also taking place in Kisumu County where there is budgeting for a county ECD policy as well as legislation to streamline the provision of quality ECD services and the development of child day care guidelines.

Water, sanitation, and hygiene

The most recent UNICEF annual report available, 2017, indicates increased attention to WASH and other social determinants of health. This effort includes supporting the utilization of safe water and sanitation and improved hygienic practices by caregivers and children, and ensuring the availability of adequate safe and clean water and sanitation at health facilities and other service provision points for newborns, children, and adolescents.

Other thrive-promoting efforts in Kenya include ECD, WASH, and birth registration.

Birth registration

According to the 2017 Kenya Demographic and Health Survey (DHS), 67% of child births were registered. Key informants stated that birth registration is a multi-ministerial issue. Primarily the responsibility of the Ministry of the Interior, birth registration is included in the child health package. It is a legal obligation and is required for education, health care, inheritance, and obtaining social assistance. UNICEF Kenya continues to advocate for birth registration for all children at ECD centers “because it enhances the right of a child to access services and facilitates counties having accurate population data for use in budgeting for ECD services.”¹⁷

Main sectors in addition to health

Key informants in Kenya recognized that the “thrive agenda” goes way beyond health. The new integrated ECD policy, currently in draft, is intended to move the country away from “silo policies” and provide a legal and institutional framework for the multisectoral delivery of services for children up to 8 years old and their families. The aim is to have an ECD secretariat staffed by technical experts from line ministries who will then work in concert with the proposed National Children’s Authority (successor to the National Council for Children’s Services); this will in turn lead to dedicated budget lines and recognition for the secretariat and further replication at the subnational level.

Ministries to be included are: Health, Education, Interior and Co-ordination of National Government, Agriculture, Livestock, Fisheries and Irrigation, Transport, Infrastructure, Housing, Urban Development and Public Works, Information, Communication and Technology, Labour and Social Protection, Water and

¹⁷ UNICEF Kenya annual report 2017.

Sanitation, and National Treasury and Planning. Each line ministry will be tasked to mobilize resources to address their identified priorities. Since all government efforts align to national blueprint flagships, the thrive agenda links to Kenya's global commitments and will in significant ways mirror the five-year Global Health Security Agenda roadmap.¹⁸

The National Health Policy 2012–2030, Objective 6 aims to strengthen collaboration with other sectors. The objective will be reached by adopting an approach of “Health in all policies” and specifies that the health sector should interact with and influence all sectors that have an impact on health including: women’s literacy, access to safe water and adequate sanitation, nutrition, safe housing, occupational hazards, road safety, security, and income.

It is important to note that ECD is considered the responsibility of the Ministry of Education, however, key informants state that the Ministry of Education is strongly focused on education and school-age children. Nurturing Care is seen as going beyond early childhood education (ECE) to include the first 1,000 days and is therefore considered appropriate for coordination under the MOH. The education sector has indicated an openness to revising their ECD policy to include NCF components.

Coordinating structure

At the national level, there are two main coordinating committees related to the NCF: the national NCF stakeholders, who meet twice a year, and the multisectoral technical working group that meets quarterly. The stakeholder group is new; it is a response to the multisectoral approach promoted by the NCF and is a forum for stocktaking and collaboration. The technical working group sits within the NCAH Unit and is managed by the NCAH Director. Original plans called for a rotation of management among the various line ministries, but with the existing competencies, strengths, and availability, it was agreed that it remain in the MOH for the time being. It is anticipated that the technical working group will have formal recognition from the line ministries, as appointment will originate from the permanent secretaries of these ministries.

In Kenya there are two national coordinating committees for NCF: the national NCF stakeholders and a technical working group.

In Siaya County, there is a multisectoral working group on ECD that reports to the governor. Tasked with increasing the coverage and quality of nurturing care services, this working group convenes all sectors and stakeholders involved in child development, including health, finance, social protection, education, agriculture, civil society, and the private sector. The governor’s wife, the First Lady of Siaya, has spearheaded the campaign to focus on ECD and serves as the patron of nurturing care. PATH and other partners are funded by the Hilton Foundation to create a model in Siaya County for how different arms of government can work together.

Delivery platforms and how integration is happening

Entry points may be multiple. One key informant suggested that at the community level the entry point for thrive interventions is nutrition, whereas, at the health facility level, it is skilled attendance at delivery.

According to the report of the November 2018 intercountry meeting on the NCF, a major focus of technical efforts in Kenya has been the integration of nurturing care into national policies, technical guidelines, tools, and standards. Examples include the NCAH policy, IMCI, the Mother and Child Handbook, and job aids for counseling families.

Siaya County seeks to target every provider to use every touchpoint to reach every caregiver. The County Health Management team, in conjunction with nongovernmental health partners, seeks to include nurturing

¹⁸ The GHSA enhances community-based surveillance through engagement of CHWs to respond to infectious disease threats, it uses a multisectoral approach to combat antimicrobial resistance to infectious diseases, and trains the health workforce to prevent, detect and respond to infectious disease threats.

care content in training and capacity building for nutrition, maternal and child health, community health, HIV, and reproductive health.

In a PATH-conducted cluster-randomized controlled trial in the Bondo sub-county of Siaya, the health facility-based ECD intervention is defined as integration of developmental monitoring and counseling content into routine well-baby services and play sessions in health facility waiting areas. More detail is provided in the discussion section of this report.

Senegal Case Study

Brief summary of context

Senegal has moved towards a new vision of care for young children, with a focus over the last 15 years or so evolving to the integrated development of the young child. In 2000, the then president steered the country towards investing in the capital of children. Health care is free for children under 5, and there is a focus on the first 1,000 days, with the child health card starting during pregnancy. It is noted that, according to the 2017 DHS, 54% of children under 5 benefit from the free care. The ICPD+25 (International Conference on Population and Development–25th anniversary) report puts the numbers of cases of sick children having benefited from the free care initiative at 2,697,309 in 2016 and 2,635,509 in 2017. The proportion of functioning health insurance schemes rose from 55% in 2016 to 96% in 2017, nearly reaching the target of 100%. Also, by 2017, all health insurance schemes had signed agreements with public health structures.¹⁹

Senegal provides free health care for all children under the age of 5.

In 2004, the government developed a policy on integrated ECD (*Politique Nationale de Développement Intégré de la Petite Enfance*) with three main focus points: 1) an integrated approach to case management, illness prevention, and early childhood stimulation; 2) the involvement of the collective (families and communities); and 3) the integration of values. This policy sets forth the vision, strategies, and organizational structure for the national agency for young child centers (*Agence Nationale de la Petite Enfance et de la Case des Tout-Petits* [ANPECTP]), a central implementing structure for the national policy for integrated ECD.

The main delivery mechanism for ANPECTP is through the young child centers, which are run on a local community basis and aim to provide holistic preschool education, such as infant education, health and hygiene, nutritional management, early stimulation, and development activities.

Senegal has a number of national documents and strategies relevant to the promotion of thrive interventions. These include the National Policy for Nutrition Development, 2015–2025, that describes the context, vision, objectives, opportunities, and threats. The policy is built on four pillars: 1) production of nutritionally rich foods; 2) appropriate transformation, distribution and pricing; 3) education/hygiene/sanitation; and 4) essential health and nutrition services. Its three strategic orientations cover integrating nutrition with other sectors, decentralizing implementation, and implementing a community approach.

Moreover, there is a Multisectoral Strategic Plan for Nutrition, 2017–2021,²⁰ and an Integrated Strategic Plan for Maternal, Newborn, Child and Adolescent Health, 2016–2020. Although the maternal, newborn, child, and adolescent health integrated plan focuses mainly on improving health services with a focus on community, it also addresses birth and death registration.

The 2017 DHS shows that child mortality rates decreased from 139 per 1,000 live births to 56 between 1997 and 2017; between 2010 and 2016 stunting rates decreased from 27% to 17%. It may be considered illustrative of a change in the overall perception of and approach to health that the WHO Cooperation Strategy 2016–2018 puts an emphasis on social determinants of health, including equity, gender, human rights, poverty, social inequality, socio-cultural barriers, and risk factors for noncommunicable diseases. A

¹⁹ Ministry of Economy, Finance and Planning /UNFPA report CIPD+25 report, 2018.

²⁰ <https://extranet.who.int/nutrition/gina/sites/default/files/SEN-2017-2021-Plan%20Strategique%20multisectorel%20de%20la%20Nutrition.pdf>.

2012 retrospective study on the 10 main causes of childhood morbidity and mortality in Senegal also covers the influences of sociocultural variables.

Main areas of attention

Key informants expressed concern that child survival interventions still need improved quality, coverage, and sustainability and should not be compromised. At the same time, there is a move towards using all platforms (health, nutrition, education, and others) for the delivery of integrated interventions related to thrive and transform. In addition to the education sector, nutrition has played a key role in the implementation of integrated ECD activities in the country, led by the *Cellule de lutte contre la malnutrition* (CLM), the malnutrition control unit. Activities include support to early stimulation and development, addressing severe and chronic malnutrition, growth faltering, exclusive breastfeeding, complementary feeding, and micronutrient supplementation. The ANPECTP, CLM, the MOH, and UNICEF have worked together to articulate and validate 16 essential family practices in the areas of health, nutrition, child protection, and early stimulation as a crucial step towards founding an integrated ECD ecosystem.²¹ The integrated approach of the different ministries involved reinforces both the positioning of ECD as a national priority, especially for the health and nutrition sectors, and the coherence and coordination of interventions among actors.

Key informants find it challenging to distinguish between interventions that promote thrive and those that promote transformation.

According to the 2017 DHS, birth registration overall is 77%. The proportion of births registered had decreased from 75% to 70% between 2010 and 2016, and went back up to 77% in 2017.²² However, this is variable within the country, with the highest proportions of newborns registered in urban areas. Interventions to increase birth registration are being evaluated in two districts in the south of the country, Kolda and Sédhiou. A proof of concept study, in collaboration with UNICEF and the University of Oslo, is exploring the potential of linking health (DHIS) and civil registration and vital statistics using a computerized system called RapidPro.

Main sectors in addition to health

Senegal focuses on poverty reduction, education, and innovative ways to increase birth registration. At the time of this writing, the national program to end poverty (*Programme National de Bourses Familiales*) currently covers about 300,000 households, against a 2017 target of 300,000 and a 2018 target of 400,000. In collaboration with the World Bank, a system has been developed to identify and register families most at risk. Unconditional cash transfers are made for social protection, education, and hygiene. According to key informants, the scale of activities is currently still embryonic.

Collaboration between the Ministry of Education and the Ministry of Water and Sanitation is leading to the promotion of hygiene facilities, for example separate, private toilets to help keep young adolescent girls in school. Other WASH interventions focus on improving the quality of water in rural areas and small villages, through home treatment of water and the promotion of handwashing.

The draft Multisectoral Strategic Plan for Nutrition, 2017–2021, involves 12 sectors and sets forth the nutrition targets for 2025 in food security, WASH, social safety nets, ECD, formal and non-formal education, quality of care, and prevention of obesity. Specific plans for each ministry or sector can be found annexed to the plan. In addition, the plan promotes the involvement of the private sector and civil society. Examples of relevant activity areas for each of the 12 sectors are:

- Agriculture and rural equipment (the production of nutritious or fortified foods)
- Higher education and research (nutrition education, physical exercise, and nutrition research)
- Industry and mining (salt production and iodization)

²¹ At the time of this writing, the draft list is under review by the MOH.

²² <https://dhsprogram.com/publications/publication-fr345-dhs-final-reports.cfm>.

- Animal husbandry (raising small animals and developing apiculture)
- Water and sanitation (potable water and hygiene behaviors)
- Decentralization and local communities (participation, home gardens, WASH micro-projects, breastfeeding, IYCF, community child care, integrating ECD into activities of nutrition sites, distribution of foods to families at risk, growth monitoring)
- Fisheries and maritime economy (aquaculture and algaculture)
- Health and social action (preventing and treating chronic and acute malnutrition, treating and preventing micronutrient deficiency, community initiatives for treating and preventing common communicable illnesses and HIV, treating and preventing common noncommunicable illnesses, promoting IYCF and breastfeeding, food security and food safety, emergency preparedness)
- Commerce, informal sector and local production (fortified foods, marketing, international code of marketing of breast-milk substitutes)
- Environment and sustainable development (reforestation, water pollution, forest-related products)
- Education (integrating essential nutrition actions into basic education, nutrition education in communities and school settings (state and Koranic), improvements in school lunch programs, early childhood stimulation, integrated ECD, integration of nutrition and development activities for children 3 to 6 years old)
- Family and social protection (nutrition education, women's autonomy, cash transfers for at-risk households, micro-gardens, reinforcing ECD including early stimulation in public day care centers)

Coordinating structure

The CLM was established in 2001 and coordinates all activities related to nutrition, using a multisectoral approach. The CLM is constantly looking to develop and maintain alliances and synergies. Originally housed in the office of the Prime Minister, it is now under the office of the government General Secretariat. The issue of funding flows remains unclear, since all child health activities are under the MOH, even if they are linked to other sectors. A technical working group was established to improve the implementation of activities in this multisectoral approach.

Delivery platforms and how integration is happening

Most thrive actions are delivered via the education, nutrition, and health platforms, with a focus on community interventions. Community participation was formally initiated during the period of primary health care; the integrated strategic plan for Reproductive, Maternal, Newborn, Child, and Adolescent Health, 2016–2020, cites at least 11 relevant documents and laws (p 47, section II.8.3.1).

So far, the key structure for implementing thrive interventions is the system of young child centers. At the same time, there is a move towards using all platforms for the delivery of integrated interventions related to ECD, particularly for aspects related to the nurturing care. The ANPECTP was established in 2002 under the then Ministry of Family and Women, now the Ministry of Good Governance and Child Protection. One impetus for this was to bring together numerous parallel sector-specific programs and activities that targeted the same populations to provide a more holistic approach to the ECD. The national policy on integrated ECD describes five groupings of children; newborns, 0–2 years, 3–5 years, 6–8 years, and those with special needs. Representing a convergence of actions by various ministries, each age grouping has its specific set of interventions under the categories of health, nutrition, child development, education, culture, and introduction to computer skills.

Zambia Case Study

Brief summary of context

Zambia reports significant progress in reducing infant and child mortality rates, but little impact on stunting. With national under-5 stunting rates of 40%,²³ major political and policy attention has shifted to focus on addressing stunting and using a multisectoral approach to address the underlying causes of malnutrition.

Several documents outline national support for a multisectoral focus and an expansion beyond child survival to enable children to thrive. These include the National Child Policy of 2015, the 7th National Development Plan (7NDP) 2017–2021, and the Zambia National Health Strategic Plan 2017–2021.

- The National Child Policy of 2015 sets out a vision of a society where children survive, thrive, and reach their full potential.
- The 7NDP 2017–2021, sets the tone for integration and invokes the SDGs. As stated in the UNICEF 2017 country office annual report, “With an overall theme of ‘leaving no one behind’, the 7NDP marked a fundamental paradigm shift from a sectoral to an integrated, multisectoral approach to development.”
- The Zambia National Health Strategic Plan 2017–2021 commits the country to expanding beyond traditional child survival interventions. It states that “While children are surviving fairly well in Zambia, there are no effective interventions that could foster child development beyond survival. Children need to survive and thrive. Seen in the context of the high rates of chronic malnutrition, limited skills in play, and communication, interventions that support thriving become imperative.” The strategic plan includes a shifting of priorities that places community-based preventive services at the first rung of the health service ladder.

As further evidence of national support, in 2017, the MOH established the Department of Health Promotion, Environment and Social Determinants, as a multisectoral approach to address individual, societal, and environmental factors that affect health.²⁴

In the same year, the country passed a national health insurance bill that intends to put the country on the path to universal health coverage.

Main areas of attention

Nutrition

Key informants acknowledged that nutrition and child health were intricately linked. The Zambia IMCI Mentorship Tool, Chart Guidelines, and Service Quality Assessment tools were highlighted as evidence of the large number of competence areas related to nutrition and the focus on assessing feeding and counseling caregivers.

Key informant comment: “For as long as Zambia has had primary health care, nutrition has been a part of it.”

A major link between nutrition and ECD involves the monitoring of developmental milestones during growth monitoring and promotion sessions. Other examples of incorporating nutrition into health actions include monitoring to detect faltering; maternal nutrition through antenatal care, including iron and folic acid supplementation; and focus on high-impact interventions, including breastfeeding in the first hour, exclusive breastfeeding for six months, complementary feeding, and immunizations.

²³ 2013/2014 DHS.

²⁴ Zambia Country Supplement Report on Primary Healthcare Progress, Africa Region: Zambia Ministry of Health Contribution to the Global Report - 2018, UNICEF ESARO, 2018.

After developing the National Food and Nutrition Strategic Plan (2011–2015), the country launched the First 1000 Most Critical Days Programme 2013–2015 as the flagship to address stunting in 14 districts under the SUN Fund. A final evaluation conducted in two districts found positive, but statistically insignificant improvements in stunting. The report identified various implementation challenges as a result of which very few houses had received the complete intended package.²⁵ In 2018, a high-level nutrition summit transformed the agenda and placed reduction of stunting as a key focus for all six line ministries involved.²⁶ In April 2018, the six ministries signed the second phase of the program, 2018-2022, which will scale activities up to an additional 86 districts for a total of 100 districts over the 5-year period.²⁷

USAID has recently funded a new bilateral mechanism, Scaling Up Nutrition Technical Assistance in Zambia (Zambia SUN TA) aimed at improving nutrition in targeted provinces and districts in conjunction with the National Food and Nutrition Council and other partners. Zambia SUN TA intends to include interventions in nutrition, health, agriculture, and water, sanitation, and hygiene.²⁸

Early childhood development

In order to expand child survival and address stunting, Zambia identified ECD as an important intervention area for national attention. According to key informants, ECD was initiated in Zambia in 2012 with play centers in health clinics, orientation of health workers and community volunteers, and parent counseling on responsive parental care, talk, play and stimulation.

In 2017, USAID commissioned a “Stock Taking Exercise of Early Childhood Development Activities in Zambia” to inform future programming and policy efforts. The report identified an extensive array of research, partners, funders, courses, and implementation, finding 19 implementing partners with 32 projects in 64 (out of 106) districts. In addition, it highlighted the confusing legislative framework for ECD and the “multiplicity and fragmentation of current policies related to ECD” to be a critical policy challenge. With each relevant ministry having ECD incorporated into their own policies, issues include discrepancies around the age ranges and service areas to be included. The authors recommended the creation of a Zambia-driven, multisectoral national ECD policy with a policy inclusive of all line ministries and covering the whole age range of 0 to 8 years.

The current legislation or policy relevant to ECD, by various ministries includes:²⁹

Ministry	Legislation/Policy
Ministry of General Education	<ul style="list-style-type: none"> • Education Act, 2011 • Nursery School Act of 1957 (revised 1994) • National ECE Policy, 2015 (under review at parliament) • Teaching Professions Act, 2013
Ministry of Youth Sport and Child Development	National Child Policy, 2015
Ministry of Community Development and Social Services	Social Protection Policy, 2014
Ministry of Health	Health Policy, 2012

²⁵ Brudevold-Newman A, Dias P, Ring H et al., Final Evaluation Report, Evaluation of Zambia’s First 1000 Most Critical Days Programme, American Institutes for Research, May 2018.

²⁶ Ministry of Health, Ministry of Agriculture, Ministry of Livestock and Fisheries, Ministry of Community Development and Social Services, Ministry of Water Development, Sanitation and Environment, and Ministry of General Education.

²⁷ The First 1000 Most Critical Days Programme (MCDP) II “Zambia’s Five Year Flagship Stunting Reduction Programme” 2018- 2022, National Food and Nutrition Commission of Zambia, draft September 2017.

²⁸ DAI to Launch USAID Zambia Program to Reduce Stunting in Young Children, February 19, 2019, retrieved from <https://www.dai.com/news/dai-to-launch-usaid-zambia-program-to-reduce-stunting-in-young-children>.

²⁹ Folutiya JJ, Spensley A and Kachinga M. Stock Taking Exercise of Early Childhood Development Activities in Zambia, USAID, August 2017.

It is interesting to note that, in Zambia, a policy that originally focused on ECD and ECE was adjusted, based on political recommendations to focus solely on ECE. There is a currently a move in the country to create one single integrated policy related to ECD to address the current confusion between various policies, definitions, and targets.

Starting in 2015, Zambia got ECD in the budget, thereby creating a line item and opening the opportunity for future budgetary increases. Multiple key informants raised the issue of funding support for ECD and identified the challenge that government does not currently have funding for meaningful coverage in ECD.

The June 2017 launch in Zambia of *The Lancet* ECD series was seen as a major accomplishment, placing ECD as a national-level priority. The launch was officiated by the vice president and included high-level representation from various ministries and extensive sharing of the evidence base for ECD.

The Zambian adaptation of WHO/UNICEF's "Caring for Child's Healthy Growth and Development" was a crucial step. Consistent with the global standard, the package provides a 5-day training for CHWs and establishes routine counseling visits at three age points (infant 1-2 months; child 3-4 months; and child 5 months) with actions focusing on feeding, stimulation, preventing illness, and responding to illness. These are followed by additional opportunity contacts up to 5 years to provide guidance on caregiver-child interaction, play, and communication. The package was launched in June 2017.

UNICEF also reports that they have been supporting the National Food and Nutrition Council to integrate ECD and nurturing care into nutrition-specific activities.

A key effort moving forward is to create and track indicators related to ECD through various ministries. The NCF multi-country meeting report states that indicators to be included in the HMIS will track: 1) the number of caregivers with children under 3 years attending maternal, newborn, and child health services who are counseled on responsive caregiving and early stimulation; and 2) the proportion of children monitored for developmental milestones and identified at risk.

Birth registration

According to the 2013/2014 DHS, 11.3% of children under 5 were registered with the civil registration authority and only 4% of these had a birth certificate. Key challenges included the centralized birth certification system, the lack of a harmonized legal framework, long distances to registration centers, and the lack of knowledge on the importance of registration from communities. The Birth and Death Registration Act was amended in 2016 to allow for certification at provincial and district levels. With this change, UNICEF has worked with the Ministry of Home Affairs to institutionalize a desk in maternity homes for contact right after birth. A memorandum of understanding was signed between the Ministries of Home Affairs and Health to establish and guide operations of the birth registration desks in health facilities and there are ongoing efforts to harmonize the legal and policy framework to expand birth registration services for children born outside of health facilities. A community sensitization and communication strategy is planned for piloting in early 2019.³⁰

Early childhood education

Early childhood education, generally focused on center-based services for the 3–6-year-old age group, is coordinated out of the Ministry of General Education. Since 2013, the government has taken on a proactive role as service provider, annexing and extending early childhood centers and primary school, standardizing ECE training programs, and deploying more than 1,400 teachers as government employees. In August 2017, the Minister of General Education stated that the government had established 3,367 early childhood centers, predominantly targeted in rural and far-to-reach areas of the country.³¹ The Zambian government is in the early stages of developing a publicly offered preschool package. The Early Childhood Education Policy

³⁰ Birth Registration in Zambia, UNICEF, 2018.

³¹ Nyondo, L. (August 31, 2017) Early Childhood Education Essential – First Lady. Daily Mail. <http://www.daily-mail.co.zm/early-childhood-education-essential-first-lady/>.

Implementation Plan 2017–2021 states that the focus in the first phase of implementation is on expanding access for 5–6- year olds as preparation for primary school with a target of at least 30% enrollment by 2021. For the 3 to 4-year-old age range, the focus is on regulating and supporting community and private provision of services.

Social protection

Since 2010, the Ministry of Community Development and Social Welfare has provided two types of grants for social cash transfers: child grants and multiple categorical targeting grants. Following a significant increase in government budget allocated to the program, the overall caseload for social cash transfers increased from 145,000 households at the end of 2014 to 185,000 households at the end of 2015. The child grant provides monthly cash payments in selected districts to mothers with children under 5 years old. The overall objective of child grants is to reduce poverty and the intergenerational transmission of poverty. Specific objectives are to improve food security, reduce child mortality and morbidity, reduce stunting and wasting, increase school enrollment and attendance, and increase asset ownership.³² The multiple categorical targeting grant provides monthly cash payments to widow-headed households caring for orphans, elderly-headed households caring for orphans, and households having a member with a disability.³³

Main sectors in addition to health

Each of the main intervention areas listed above encompasses multiple sectors.

Government entities involved in ECD in Zambia include the Ministry of General Education, Ministry of Health, Ministry of Community Development and Social Services, and Ministry of Youth Sport and Child Development. Additional ministries with informal involvement include: Ministry of National Planning and Development, Ministry of Finance, Ministry of Gender, Ministry of Local Government and Housing, and Ministry of Agriculture.

The following table is excerpted from the 2017 Stock Taking Exercise on the age ranges and focus areas of development of the various ministries related to ECD.

Table 1: Zambian ministries and their focus areas in the ECD space

	MoH	MoGE	MCDSS	MYSCD
Pregnancy	X			
0–3	X		X	X
3–6	X	X	X	X
6–8	X	X	X	X
Health and nutrition	X		X	X
Simulation and care	X			X
Safety and protection			X	X
ECE		X		X

MOH, Ministry of Health; MoGE, Ministry of General Education; MCDSS, Ministry of Community Development and Social Services; MYSCD, Ministry of Youth Sport and Child Development

³² The Child Grant Programme-A comprehensive summary of impacts (2010–2014); Social Cash Transfer Programme Impact Evaluation Series (randomized control trial), Republic of Zambia, Ministry of Community Development and Social Welfare, American Institutes for Research, May 2016.

³³ The Multiple Categorical Targeting Grant – A Comprehensive Summary of Impacts (2011–2014); Social Cash Transfer Programme Impact Evaluation Series (randomized control trial), Ministry of Community Development and Social Welfare, American Institutes for Research, May 2016.

For nutrition, the main line ministries involved include: MOH, Ministry of Agriculture, Ministry of Livestock and Fisheries, Ministry of Community Development and Social Services, Ministry of Water Development, Sanitation and Environment, and Ministry of General Education.

Coordinating structure

Most key informants focused their discussion of coordination around emerging ECD efforts. Coordination related to ECD is seen as an ongoing challenge and one that partners are actively working to address. The 2017 Stocktaking report highlighted confusion around national-level government leadership and coordination. There was a call for a clear delineation of the roles of each ministry.

When discussing the challenges of multisectoral coordination for ECD, several key informants highlighted the success achieved with the model of coordination across ministries for nutrition. Zambia initially established the National Food and Nutrition Commission as the convening body for action on nutrition. To facilitate coordination across different line ministries, high-level coordination is now managed from the office of the Vice President, with the National Food and Nutrition Commission serving as the secretariat.

Following this model, there is currently a draft concept paper and terms of reference for a similar type of high-level steering committee for ECD. Analogous to the nutrition model, the MOH is proposed as the secretariat.

Another recent advance was the creation of ECDAN Zambia. Modeled after the global ECD Action Network, ECDAN Zambia launched in 2016 as a mechanism for coordination across partners and government. With quarterly meetings, the network aims to: support the development of an integrated ECD policy and implementation plan; advocate for the establishment of an ECD technical working group within the human development pillar of the 7th National Development Plan; champion the establishment of a framework for multisectoral coordination; ensure improved ECD advocacy and communication; set an ECD learning agenda focused on generating Zambia-specific ECD data; develop ECD indicators; and strengthen ECD monitoring and evaluation.³⁴

Key informants also credited the creation of several new positions with having improved the opportunities for collaboration around ECD: an ECD focal person within the National Food and Nutrition Commission, a new directorate for ECE within the Ministry of General Education, and an MOH officer in charge of ECD efforts. The secondment of a PATH staff person to the MOH was also mentioned as an important advancement for coordination.

Delivery platforms and how integration is happening

Significant national effort has focused on the development of the draft Reproductive, Maternal, Neonatal, Child, Adolescent Health and Nutrition Roadmap and ensuring that ECD is both incorporated and costed in this document.

ECD has been integrated into a variety of health packages and trainings, including reproductive health and nutrition guidelines, pediatric HIV, newborn package, community-IMCI, iCCM, antenatal care, Essential Newborn Care, IMCI training, IMCI health facility strategy, and the first national food strategic document.

The national nurturing care action plan states that a 2019 goal is to identify opportunities to integrate ECD content into existing service delivery platforms in a range of sectors, including health, education, child and social protection, youth sport and child development, agriculture, and the environment.

Research is currently being conducted to test a model of improving ECD through community-based parenting groups. More detail is provided in the discussion section of this report.

³⁴ <https://www.sdghilanthropy.org/index.php/Re-engineering-Early-Childhood-Development-in-Zambia>.

Country Findings: Ghana and Rwanda

Ghana

Over the past 20 years, deaths during early childhood in Ghana decreased by more than 66%. This change is largely credited to shifts in policies and investments in health and social protection. Initiated in 2000, the Community-Based Health Planning and Services (CHPS) brought health services to the community level, improving access to basic health care, especially reproductive, maternal, and child health. In order to remove financial barriers to basic health services from vulnerable households and expand the financing options for health care nationally, Ghana introduced the National Health Insurance Scheme in 2003 and free maternal and child health care in 2008. In addition, Ghana's flagship cash transfer program for the poor, Livelihood Empowerment Against Poverty, provides basic income to the poorest households for food and children's education, and policies such as paid maternity leave ensure that mothers can bond and nurse their children during children's first months of life.³⁵

Work on ECD in Ghana initially focused on developing an ECD policy, and was coordinated by an inter-ministerial group led by the Ministry of Gender, Children and Social Protection.³⁶ The Early Childhood Care and Development Policy was established in 2004 to “promote the survival, growth and development of all children (0–8 years) in Ghana.”³⁷

While the MOH was officially part of the ECD inter-ministerial group, key informants report that in the beginning they were not actively engaged. The introduction of the NCF, however, provided an entrée from the child health and nutrition perspectives for active MOH involvement with ECD. Additionally, the NCF expanded the original perspective of the ECD inter-ministerial group by adding the component of safety and security to their orientation.

Ghana built on the global launch of the NCF to organize a national launch in June 2018. Led by the Second Lady and the Minister of Health, a panel of specific agency support included JICA, UNICEF, World Bank, USAID, UNFPA, and WHO.

The MOH recently rolled out a combined mother and child health booklet, which promotes the continuum of care and includes monitoring of developmental steps and birth registration. A training cascade is planned. The newborn strategy is currently being revised for the next 5-year plan and informants report the addition of early stimulation components along with bonding, attachment, singing, skin-to-skin contact, follow-up care, and massage.

Rwanda

The Government of Rwanda aims to become a high-income country by the year 2050. Achieving this goal means moving from an agrarian to a knowledge-based economy, and will depend largely on the assets of human capital. ECD is seen as one of the main interventions that will develop that capital.

ECD programming was originally intended for children aged 3 to 6 years, and was situated under the Ministry of Education. It was later moved to the Ministry of Gender and Family Promotion to be able to accommodate younger children.

In a shift of focus towards thrive and transform, the government assigned 24 employees to coordinate activities across the five ECD pillars: ECE, sanitation, nutrition (reduction of stunting), health, and child protection. There are quarterly meetings of an interagency group of stakeholders (government, international agencies, civil society organizations, private sector, bilateral agencies, and soon to include parents and

³⁵ Early Moments Matter: Why Invest in Early Childhood Development in Ghana? 2018.

³⁶ The Ministry of Women and Children's Affairs was renamed the Ministry for Gender, Children and Social Protection in 2013.

³⁷ Republic of Ghana, Ministry of Women and Children's Affairs, Early Childhood Care and Development Policy, 2004.

community representatives). There are two technical working groups, one for ECD and one for nutrition and hygiene.

To complement ECD centers, Rwanda has a home-based approach that is initiated by parents. For the home-based approach, one family volunteers to provide an indoor room, outdoor play space, and an area to store and cook nutritious porridge for the children. Each site is fitted with handwashing and latrine facilities. Parents (in practice, almost exclusively mothers) develop a rotating schedule in which each woman oversees the home-based ECD for one morning a week. One person is trained on ECD for the various age groups, and uses learning materials made from local items. A CHW comes at periodic intervals to do growth monitoring.

A mapping of ECD carried out in 2017, before the program was formally established, identified more than 4,000 ECD centers and more with government, civil society organization, or other support. At the village level there is also a program for child protection, “friends of the family,” that helps identify and deal with children at risk of or experiencing domestic violence or physical abuse.

Discussion

The desk review and key informant interviews revealed a high level of convergence among the case study countries on the main intervention areas implemented, entry points for integration, political momentum, tracking progress, and need for funding. These are discussed below and are followed by a series of factors for success and challenges to successful implementation, and a brief discussion of research issues raised. Since the Rwanda and Ghana experiences were collected in a shortened format, they are included below where appropriate, but are not included in overall analysis.

There was strong convergence on the main intervention areas selected for implementation, entry points for integration, political momentum, tracking progress, and need for funding.

Discussion I: Convergence

- 1. Intervention areas include ECD, ECE, nutrition, birth registration, WASH, and financial or social protection.** Other intervention areas, specifically concerning child abuse and neglect, gender-based violence, prevention of injuries, and attention to children with special needs were mentioned by key informants, however, no information on their implementation was found.

The global launch of the NCF in 2018 provided a political opportunity to initiate or advance a number of thrive and transform interventions. In Ghana, Kenya, and Zambia, ECD is conceptualized and integrated within the NCF. All three countries incorporated high-profile launches of the NCF and/or *The Lancet* ECD series to galvanize support for a national movement. (It is noted that, at the time of this writing, the NCF has not yet been translated into French for introduction in Francophone countries).

Some key informants interpreted the ubiquitous choice to focus on ECD as a concept akin to “low-hanging fruit.” At the same time, there is strong evidence to support the effects of ECD on health and on longer-term education and development, and in particular, on the nutritional status of children. Global tools and guidance are readily available, and ECD can be implemented through health facilities and community health structures. In all three countries, ECD connected to nutrition is the umbrella under which other health- or non-health sector interventions are linked.

Recognizing the interconnectedness of water/sanitation and child health and development, all countries have also incorporated long-standing WASH approaches and activities into the concepts of thrive and transform, and work to expand them. Kenya supports the use of safe water, promotes improved hygiene practices, and is working to ensure the availability of water and sanitation services in health facilities. Senegal is focusing on ensuring that potable water, from taps or home treatment, is available to all households. A global key informant stated that in many countries, CHWs are supervised by environmental health officers and the link with health and WASH is thereby reinforced.

It should be noted that quite a number of informants were hesitant to distinguish between interventions that promote thrive and those that promote transform. Although the construct is found to be conceptually useful, it is perceived that there is a great deal of overlap. Furthermore, several key informants stressed that countries do not plan their activities according to the structure of survive, thrive, and transform, making it difficult to tease out which interventions support which pillar.

- 2. Entry points for thrive interventions are seen as a natural addition to the existing child health platform.** Interventions may be integrated into sick child consultations, well-child clinics, immunization days, growth monitoring and promotion, antenatal care, or postnatal care services. The approach is a logical application of building on what exists. The jury is still out concerning the practicality of adding tasks to already-full workloads. Challenges of time, scale, and cost are well known; it is nonetheless perceived that the quality of care has been improved.

In Kenya, the recently-published NCAH policy has NCF embedded in it, and integrates ECD interventions into ongoing newborn and child health activities. Senegal works through the

Thrive interventions are seen as a natural extension of interventions for survival.

health sector, particularly at community level, and has updated and strengthened the policies on “young child centers” to include ECD and nutrition. Zambia has integrated ECD into the new Reproductive, Maternal, Neonatal, Child, Adolescent Health and Nutrition Roadmap and is currently working to integrate nurturing care into nutrition-specific activities. Traditionally, the child from 0 to 3 years old has multiple points of contact within the health sector. Beyond age 3, when a child no longer needs regular growth monitoring or immunizations or experiences as many sick child visits, this access is decreased.

- 3. The driving forces behind the decision to move forward on thrive and transform are inextricably linked to the development of human capital, the availability of global evidence and a push/pull from the highest levels of government.** This review explored the question of why countries decided to move forward on thrive and transform interventions. Key informants in all countries referred to the stagnation of child health indicators, particularly rates of newborn mortality and of stunting, and the strong evidence linking surviving and thriving, as presented in *The Lancet* series. Informants in Kenya and Senegal specifically mentioned the importance of investing in human capital. This is consistent with the background of Rwanda’s decision to move forward on ECD and other thrive interventions.

Investing in human capital came across as a central point in all countries.

Most importantly, all three countries stressed the **fundamental role of high-level government commitment to improving health and wellbeing**. According to key informants in Senegal, the decision to move forward with post-survival interventions had been made by the former president many years before the advent of the UN Secretary-General’s Global Strategy. The President of Kenya issued a pledge of support for the Global Strategy and to meeting global recommendations. Zambia’s commitment to adding thrive interventions was seen as a natural product of national endorsement of various global conventions. All three countries have made global commitments to the SDGs, the aspirations of UHC, the UN Secretary-General’s Global Strategy, and the SUN Movement.

The “thrive” concept is entering the common lexicon at the national level. A key informant provided an example of a billboard under development in Zambia that started as “Keeping Children Healthy,” but was changed to “Keeping Children Healthy and Thriving.” This concept was also added as a word and concept in the Integrated Management of Newborn and Childhood Illness Strategic Plan under development. The Kenya case study highlighted the vision for the new NCAH policy as “A Kenya where all newborns, children and adolescents survive, thrive and live to their fullest potential.”

Following these initial drivers, many countries turned to various analyses of existing efforts in order to inform subsequent actions. Zambia and Kenya provide two different examples of analytic reviews. In Zambia, the 2017 stock taking exercise provided a landscape analysis of implementation, funding, and policy in ECD. In Kenya, an economic analysis conducted by the Institute of Economic Affairs looked at the budgetary allocations at national and county levels related to the rights of children.

- 4. There has been some movement in developing and agreeing on indicators to track progress.** Monitoring, as well as documentation of activities, have been identified as weak points in all three countries, and key informants underscored the intention of improving this task. The task is complicated by the need to track cross-ministerial and partner efforts. At the same time, there has been good progress in getting relevant ECD and NCF indicators developed in countries and included in the national and district HMIS.

In both Zambia and Kenya, partners are working towards defining and agreeing on the program indicators for nurturing care to be included in the DHIS/HMIS. In Kenya, specifically, informants acknowledged the challenges with incorporating new indicators into an established HMIS system. In Senegal, monitoring efforts are built into the existing health structures.

Globally, there are several relevant efforts under way. The Countdown to 2030 published a May 2018 report entitled “Country Profiles for Early Childhood Development.” In this report, the authors of *The Lancet* series “Advancing Early Childhood Development: From Science to Scale” developed profiles for 91 low- and middle-income countries as the first step towards developing a global ECD monitoring and accountability system. The one-page profiles for Kenya, Senegal, and Zambia can be found in Annex 1. These profiles identify indicators and data (where available) for the five components of nurturing care.

They also present composite indicators, including “Young children at risk of poor development” and “Lifetime cost of growth deficit in early childhood.” A check list of policies and international conventions defined as facilitating environments are included.

The Countdown to 2030 report highlights additional efforts under development, including a population measure of ECD for 0- to 3-year-olds that could be included in representative national surveys, including USAID’s DHS’ and UNICEF’s Multi-Indicator Cluster Surveys. UNICEF is also working on an ECD index designed to assess child development from 2 years old and upwards.

The Africa Early Childhood Network provides 49 ECD country profiles with statistics on demographics, child protection, early learning, child and maternal nutrition, child and maternal health, and national ECD programming.

Discussion 2: Factors for Success

This review identified three principal factors in the successful introduction of thrive and transform interventions. These are: high-level support, the involvement of many sectors, and the engagement of the community.

1. **High-level support:** High-level support for investing in human capital has been described in the previous section of this report. Key informants were clear that this support, at the level of the president, vice president, prime minister, governor or first lady (national or subnational) was key. Each country is working to find ways to keep the highest level involved and aware, for example, through speaking engagements at national and intercountry conferences. Having high-level political figures also strengthens the ability to attract the presence of and subsequent commitments from the minister level of other relevant sectors.
2. **Multisectorality:** In the global agenda for thrive and transform, health is certainly central, but it is only one aspect of the implementation challenge. The UN Secretary-General’s Global Strategy reports that half of the gains in the health of women, children, and adolescents result from investments outside of the health sector, and it includes multisectoral action as one of the nine action areas. The Global Strategy presents a prioritized list of key policies and interventions that correspond to many of the SDG targets listed under the thrive and transform objectives, and asserts that most of these objectives are beyond the domain of the health sector (see Annex 2).

The three main factors for success are: high-level support, multisector involvement, and engaging the community.

Multisectorality was identified by nearly all country-level key informants as an essential component of successfully promoting thrive and transform. Key informants discussed the numerous difficulties in managing multisectoral action, and noted that everyone seems to be grappling with this issue. One mentioned that for ECD, coordination is a work in progress; another suggested that coordination meetings are more than difficult; still another said that “the biggest pain point is coordination for ECD.”

The points raised by key informants include the challenges of engaging other sectors, and the difficulties in managing effective coordination groups or technical working groups. Despite best intentions, under a multisectoral umbrella it is not always clear who is accountable for the expanded agenda and how governance is best done.

Coordination within any technical area is a challenge as it involves interpersonal dynamics, cross-organizational collaboration, and the inherent complexities of developing, implementing, and monitoring effective joint efforts to accomplish the shared goals. Multisectoral collaboration raises the complexity due to the variety of policies and strategies guiding each sector, different mission and goal statements, and the different “languages” and approaches used by various sectors.

Many of these challenges have been described in the formal literature. The *British Medical Journal* published a series of articles under the title “Making multisectoral collaboration work” (December 2018). This supplement, proposed by the Partnership for Maternal, Newborn and Child Health, recognizes the profound influence that sectors beyond health have on maternal and child mortality. The supplement

includes 12 country case studies that collectively draw together lessons learned in achieving effective multisectoral collaboration. Although it presents relative “success stories,” it is clear that the learning environment in which knowledge was developed and shared across sectors is not easy to create or sustain. SDG 17 highlights the importance of multi-stakeholder partnerships, but there is little recognition of the general principles that contribute to effective multisectoral collaboration for health.

In their article “Governing multisectoral action for health in low- and middle-income countries,”³⁸ Rasanathan K, et al. (2017) wrote that the focus of the health sector in most countries remains almost exclusively on health care services, and the potential of multisectoral collaboration remains untapped in many low- and middle-income countries. Collaborative and distributed leadership, particularly under the umbrella of UHC, is key for effective governance of multisectoral action, with a need to build leadership capacity and cultivate champions who can agree on shared objectives and tasks.

The case studies in this review highlight several different approaches to governance of multisectoral collaboration. As all of these efforts are in their infancy, it is too early to identify any lessons learned. Several countries raised concerns (including legal) about having one ministry oversee the work of another ministry. In Senegal and Zambia, the coordinating structures have been put in neutral spaces. In Zambia, nutrition was held up as an example of an effective structure with six different line ministries coordinated out of the vice president’s office. The same structure is currently being proposed for ECD/NCF governance, but will need to be approved through parliament. In Senegal, the CLM, which coordinates nutrition and ECD, is now under the office of the government General Secretariat. In Kenya, ministries and partners have agreed that the coordination of NCF should remain within the MOH National Child and Adolescent Health Unit. Similar coordinating structures can be found at the county level, which is responsible for ECD, ECE, and health services.

It was noted that key informants feel a need for a common understanding and for having one single policy for child health and development, rather than the current situation of a specific policy for each sector. This demonstrates a certain tension between the benefits of a unifying policy that clearly sets out the roles, actions, and indicators for each sector and an approach of “health in all policies,” where health or ECD is embedded in the existing policies of different sectors. Specifically, in Zambia the current circumstance of fragmented policies has raised challenges to multisectoral collaboration when there are conflicts between the various policies to which each ministry is accountable. Having different policies also introduces an issue with the lack of commonly agreed indicators. Kenya is moving deliberately away from having “silo” policies, and the national health policy specifies incorporating health into all relevant sectors.

In addition, service delivery is seen as fragmented, and different sectors work in their own silos. Work is often haphazard, leaving no systematic way to track and thus to see gaps and accomplishments. Getting institutional alignment and agreement is difficult even on seemingly simple things such as terminology; this is true at the global as well as the country level.

3. **The community is the key.** Community implementation and ownership are seen as crucial to implementing thrive interventions. In Kenya, these are supported in various ways, including by the recent development of a national policy on community development that recognizes the role played by communities in development as community participation in the decision-making processes and during implementation. According to key informants, one activity that has proved useful in Kenya is “confessions” (witnessing), where people share their positive experiences, for example, about integrated community case management of childhood illness. Key informants mentioned hearing such statements from community members as: “We were able to get care for our sick daughter in the community, provided by the CHW, otherwise she would not have survived,” and “my child is able to walk thanks to the intervention of the community”.

In Senegal, a principal delivery channel is through the “young child centers” program, with various age groupings getting specific interventions. “Decentralization and local communities” is one of the 12 sectors under the multisectoral strategic plan for nutrition.

³⁸ PLoS Med 14(4): e1002285. <https://doi.org/10.1371/journal.pmed.1002285> Published: April 25, 2017.

The Zambian health system adopted primary health care following the Alma Ata conference in 1978. Despite a changing health sector landscape, the MOH states that focus on the community level and their participation structures has been a constant feature. Following the global energy around the SDGs and UHC, there has been a new focus in Zambia on social accountability.³⁹

Whereas some key informants identified the need for a well-defined package of community activities, others brought up the need for community-level planning systems that bring people from various backgrounds around the table to agree on actions that are meaningful to the community. At the same time, key informants brought up the need for guidance and successful examples on how best to engage the community.

Discussion 3: Challenges to Implementation

- 1. Funding is an ongoing challenge.** Key informants reiterated that governmental leadership and budgetary support are essential to scaling up and sustaining interventions. In Zambia, ECD now has a government line item in the budget, but the lack of funding for meaningful coverage was acknowledged as a key constraint. With devolution in Kenya, activities, indicators, costs, and timelines need to be incorporated into each County Integrated Development Plan to secure a budget line item. Some counties, however, are still operating without a legal framework, so securing money and accountability are problematic. The reality is that much of the current work on ECD, birth registration, and child rights is externally funded and project oriented. In a key informant interview in the Southeast Asia region, Sri Lanka was held up as a model of a country advocating for and increasing the national ECD budget. In Kenya, the Institute for Economic Affairs completed a budget analysis at the national level in six counties to review the budgetary commitments made towards investing in children.
- 2. Documentation of country experiences needs attention.** The review of global literature found a wide range of older and recent documents. At country level, though, recent documents are largely missing. This was brought up by key informants in Senegal as a recognized weakness, and there is a desire to address it.
- 3. Other issues were mentioned.** Beyond the three main factors for and challenges to success, key informants mentioned issues related to time, capacity, physical space, and competing priorities. The time needed to move from policy and strategy to action is long. This is complicated or slowed even more when multiple sectors are involved. At the same time, there are expectations to increase coverage more quickly. Capacity implies improved skills and the sheer numbers of staff needed. Capacity building is complicated by turnover, and the subsequent need for continuous training. Many health facilities are lacking play space, which is an integral requirement for ECD and nurturing care. Lastly, there are always competing priorities, in particular, related to the introduction of new vaccines, to ongoing immunization campaigns, to disease outbreaks, and to food insecurity.

Tracking impact and documenting process are acknowledged to be challenges that need more attention.

Discussion 4: Perceived Research Needs and Ongoing Research

One key informant pushed firmly for prioritizing implementation over research. In his words “In 2019, we can no longer hide behind the concept that we need more evidence.”

Nonetheless, there are a few issues that were perceived to need evidence or guidance. Several informants requested evidence on how to improve implementation and, in a related vein, how to reach communities in an integrated manner. Others, in expressing frustration at the challenges of maintaining momentum and collaboration, requested research on how cross-sector coordination groups can be made more functional. Questions also emerged around the implications of adding ECD to existing health services, the impact on CHW and health worker time, costs for various service packages, and the relative merits of adding thrive interventions on platforms beyond child survival.

³⁹ Zambia Country Supplement Report on Primary Healthcare Progress, Africa Region: Zambia Ministry of Health Contribution to the Global Report – 2018.

Questions were raised about screening for developmental milestones and addressing the challenge of ensuring that children identified with delays are able to access appropriate services. A mapping recently conducted in Ethiopia, Kenya, Mozambique, Tanzania, and Zambia concluded that, while all five countries provide some developmental monitoring in pilot areas, developmental assessments at referral level do not seem to be available due to lack of training, tools, and guiding technical standards and policy.⁴⁰ More work is needed in this area.

Key informants are aware of global research, however, they felt it will be important to have country-level evidence for the impact of interventions, particularly ECD. It was also felt to be important, in this early phase of implementation, to share ongoing information about research and implementation in other countries.

Sharma et al. (2017) applied the Child Health and Nutrition Research Initiative model to identify the most important research questions related to integrated implementation of ECD and maternal, newborn, child and adolescent health and nutrition (MNCAH&N) platforms. With a strong complementarity to issues raised by key informants in this review, they ranked the top research questions as: 1) “How can interventions and packages to reduce neonatal mortality be expanded to include ECD and stimulation interventions?” 2) “How does the integration of ECD and MNCAH&N interventions affect human resource requirements and capacity development in resource-poor settings?” and 3) “How can integrated interventions be tailored to vulnerable refugee and migrant populations to protect against poor ECD and MNCAH&N outcomes?”

Two studies were identified by key informants within the target countries, one in Kenya and one in Zambia.

In Kenya, PATH is conducting a cluster-randomized controlled trial with results expected in 2021. This three-arm study, will compare a health facility-based ECD intervention; a health facility-based ECD intervention combined with home-based ECD counseling; and a control of standard MOH services without ECD content. PATH reports that the study will explore effectiveness of the ECD interventions in influencing caregiver knowledge, attitudes, and practices, as well as child growth and development. In addition, the study will explore cost-effectiveness, as well as acceptability and feasibility of providing ECD services through the health sector from the perspective of the government, service providers, and caregivers.

In Zambia, funding from Grand Challenges Canada and USAID Zambia were recently awarded to Right to Care–Zambia and Boston University to test a model of improving ECD through community-based parenting groups. A randomized controlled trial conducted between 2013 and 2016 demonstrated the feasibility and positive impact of the newly developed community-based parenting intervention on child growth and cognitive development.⁴¹ The current effort builds on this research to use newly established maternity waiting homes and affiliated Safe Motherhood Action Groups as a platform to launch and support community-based parenting groups in four districts of Zambia. Results are expected in late 2021.

⁴⁰ Stakeholders meeting on how to operationalize the Nurturing Care Framework in the health sector, 14 – 16 October 2018, Meeting report, draft November 2018.

⁴¹ Rockers PC, Fink G, Zanolini A, et al., Impact of a community-based package of interventions on child development in Zambia: a cluster-randomized controlled trial, *BMJ Global Health*, 2016.

Conclusions and Recommendations

To summarize, there was clear convergence across the board on the successes and challenges related to intervention areas, entry points, driving forces, tracking progress, and funding. Intervention areas focused mainly on ECD, ECE, and nutrition. Associated interventions covered birth registration, WASH, and financial or social protection. Most entry points for action were through existing child health and survival platforms, and the thrive interventions are perceived as a natural extension of these.

The driving forces behind the decision to move forward with thrive and transform are inextricably linked to the commitment to developing human capital, the availability of convincing global evidence, and a push/pull from the highest levels of government. This last force translates into political momentum that has been capitalized on and needs to be maintained.

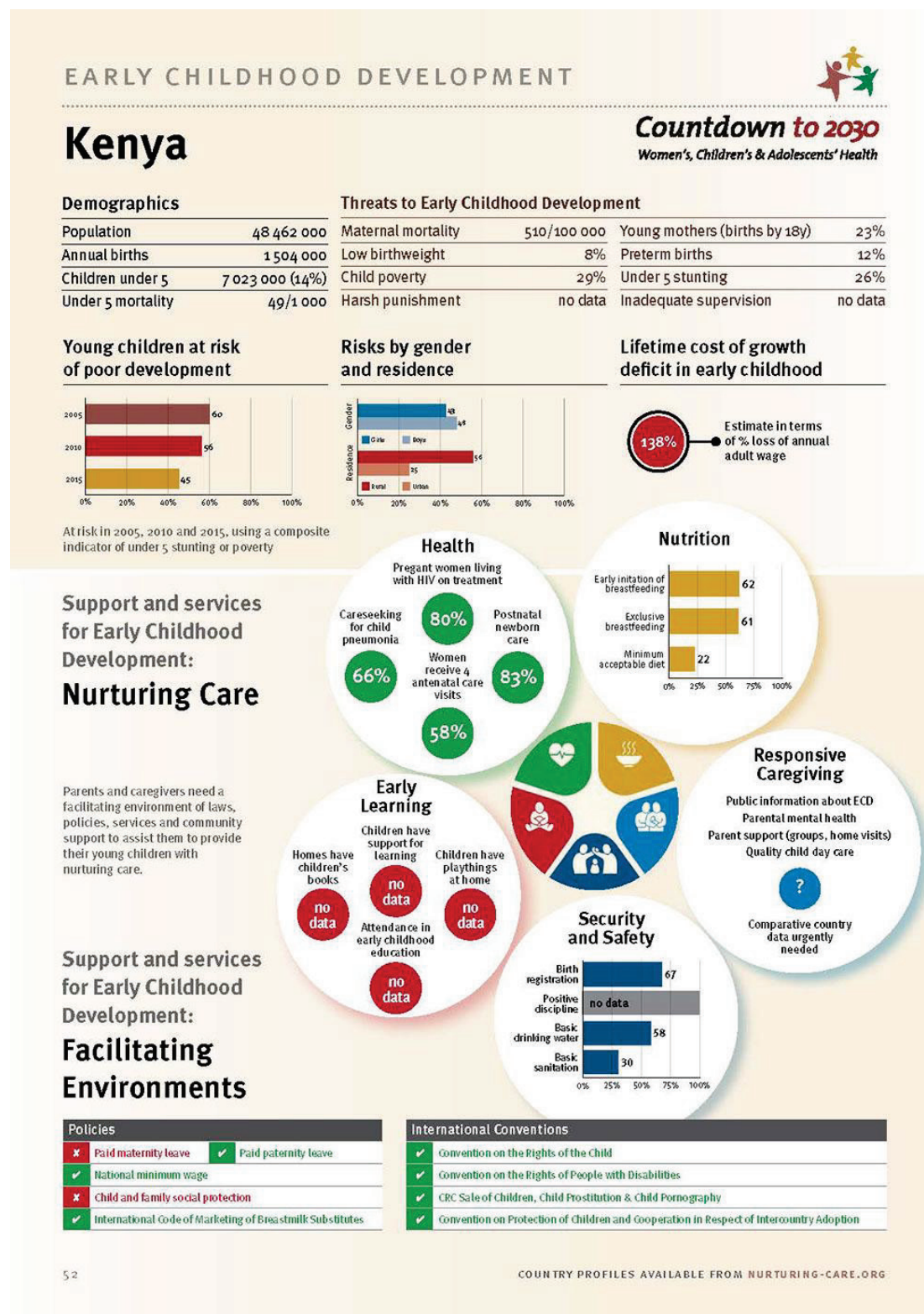
There has been some movement towards tracking progress, however, this is perceived as a weak point needing global and country attention. Funding is an ongoing challenge, particularly as much of it has been external.

There was also convergence on the advice or lessons that country key informants offered for other countries intending to move forward on the thrive and transform agenda. These revolved mainly around the factors for success that came up: having gained high-level support, having established the best use of multisector approaches at all levels and in all steps, and engaging the community.

Considering these lessons, the following list of recommendations has emerged for consideration by the Child Health Task Force, country partners, and funders as it expands its mandate to include thrive and transform. It is recommended that these partners:

1. Support countries to institute and maintain mechanisms for multisectoral collaboration and coordination that will be sustainable over time.
2. Support efforts to implement the NCF. This is built on a strong evidence base and is gathering interest and momentum with partners and countries. Note that, while doing this, it will be important to keep an eye on interventions beyond ECD/ECE.
3. Help monitor and improve the quality of care and counseling skills within the health sector.
4. Learn about experiences in other countries in Africa and other regions.
5. Continue to explore means of delivering or implementing thrive and transform interventions that would complement ongoing work.
6. Support the development and use of global indicators for monitoring process and impact to allow comparison across countries, while supporting countries to institutionalize the use of these indicators across sectors.
7. Ensure that countries can adequately document processes and progress, and share results.

Annex I: Countdown to 2030 Country Profiles: Kenya, Senegal, and Zambia⁴²



⁴² <http://countdown2030.org/country-and-regional-networks/country-profiles>.



Senegal

Countdown to 2030
Women's, Children's & Adolescents' Health

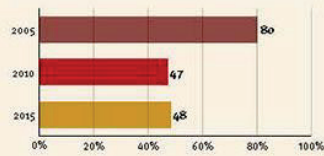
Demographics

Population	15 412 000
Annual births	542 000
Children under 5	2 544 000 (17%)
Under 5 mortality	47/1 000

Threats to Early Childhood Development

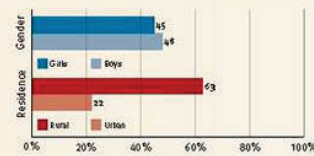
Maternal mortality	315/100 000	Young mothers (births by 18y)	18%
Low birthweight	19%	Preterm births	10%
Child poverty	32%	Under 5 stunting	21%
Harsh punishment	no data	Inadequate supervision	no data

Young children at risk of poor development

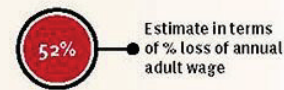


At risk in 2005, 2010 and 2015, using a composite indicator of under 5 stunting or poverty

Risks by gender and residence



Lifetime cost of growth deficit in early childhood



Support and services for Early Childhood Development: Nurturing Care

Parents and caregivers need a facilitating environment of laws, policies, services and community support to assist them to provide their young children with nurturing care.

Support and services for Early Childhood Development: Facilitating Environments

Health

- Pregant women living with HIV on treatment: 55%
- Careseeking for child pneumonia: 48%
- Women receive 4 antenatal care visits: 47%
- Postnatal newborn care: 78%

Nutrition

- Early initiation of breastfeeding: 31%
- Exclusive breastfeeding: 33%
- Minimum acceptable diet: 10%

Early Learning

- Homes have children's books: no data
- Children have support for learning: no data
- Children have playthings at home: no data
- Attendance in early childhood education: 35%

Security and Safety

- Birth registration: 68%
- Positive discipline: no data
- Basic drinking water: 75%
- Basic sanitation: 48%

Responsive Caregiving

- Public information about ECD
- Parental mental health
- Parent support (groups, home visits)
- Quality child day care
- Comparative country data urgently needed

Policies	
✓ Paid maternity leave	✗ Paid paternity leave
✓ National minimum wage	
✗ Child and family social protection	
✓ International Code of Marketing of Breastmilk Substitutes	

International Conventions	
✓ Convention on the Rights of the Child	
✓ Convention on the Rights of People with Disabilities	
✓ CRC Sale of Children, Child Prostitution & Child Pornography	
✓ Convention on Protection of Children and Cooperation in Respect of Intercountry Adoption	



Zambia

Countdown to 2030
Women's, Children's & Adolescents' Health

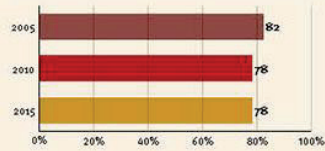
Demographics

Population	16 591 000
Annual births	620 000
Children under 5	2 820 000 (17%)
Under 5 mortality	63/1 000

Threats to Early Childhood Development

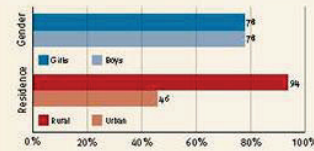
Maternal mortality	224/100 000	Young mothers (births by 18y)	31%
Low birthweight	11%	Preterm births	13%
Child poverty	66%	Under 5 stunting	40%
Harsh punishment	no data	Inadequate supervision	no data

Young children at risk of poor development

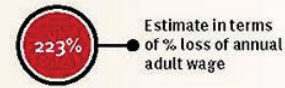


At risk in 2005, 2010 and 2015, using a composite indicator of under 5 stunting or poverty

Risks by gender and residence



Lifetime cost of growth deficit in early childhood



Support and services for Early Childhood Development: Nurturing Care

Parents and caregivers need a facilitating environment of laws, policies, services and community support to assist them to provide their young children with nurturing care.

Support and services for Early Childhood Development: Facilitating Environments

Health

- Pregant women living with HIV on treatment: 83%
- Careseeking for child pneumonia: 70%
- Women receive 4 antenatal care visits: 56%
- Postnatal newborn care: 63%

Nutrition

- Early initiation of breastfeeding: 66%
- Exclusive breastfeeding: 73%
- Minimum acceptable diet: 11%

Early Learning

- Homes have children's books: no data
- Children have support for learning: no data
- Children have playthings at home: no data
- Attendance in early childhood education: no data

Responsive Caregiving

- Public information about ECD: ?
- Parental mental health: ?
- Parent support (groups, home visits): ?
- Quality child day care: ?
- Comparative country data urgently needed: ?

Security and Safety

- Birth registration: 11%
- Positive discipline: no data
- Basic drinking water: 61%
- Basic sanitation: 31%

Policies	
✗ Paid maternity leave	✗ Paid paternity leave
✓ National minimum wage	
✗ Child and family social protection	
✓ International Code of Marketing of Breastmilk Substitutes	

International Conventions	
✓	Convention on the Rights of the Child
✓	Convention on the Rights of People with Disabilities
✓	CRC Sale of Children, Child Prostitution & Child Pornography
✓	Convention on Protection of Children and Cooperation in Respect of Intercountry Adoption

Annex 2: Annex 4 of the UN Secretary-General’s Global Strategy: Multisectoral Action⁴³

ANNEX 4. Multisector policies and interventions on determinants of women’s, children’s and adolescents’ health

Multisector policies and interventions are essential to achieving the aims of the Global Strategy and must therefore form part of national strategies on women’s, children’s and adolescents’ health. They should be monitored in the same way as health sector interventions, linked to corresponding SDG targets. Government leadership is required to ensure there is progress across sectors and to facilitate cross-sector collaborations where required. This Annex draws on the series of technical papers written to inform the *Global Strategy*¹² and A policy guide for implementing essential interventions for reproductive, maternal, newborn and child health (RMNCH): a multisectoral policy compendium (2014).⁷⁸

SECTOR(S)	KEY POLICIES AND INTERVENTIONS
Finance and social protection	<ul style="list-style-type: none"> • Reduce poverty, including through the use of gender- and child-sensitive cash transfer programmes designed to improve health • Implement social protection and assistance measures ensuring access for women, children and adolescents • Strengthen access to health insurance to decrease the impact of catastrophic out-of-pocket health spending, and to insurance related to other essential services and goods
Education	<ul style="list-style-type: none"> • Integrate early child development interventions in child health services, childcare services and preschool education • Enable girls and boys to complete quality primary and secondary education, including by removing barriers that suppress demand for education • Ensure access to education in humanitarian settings and in marginalized and hard-to-reach areas, including for individuals with disabilities
Gender	<ul style="list-style-type: none"> • Promote women’s social, economic and political participation • Enforce legislation to prevent violence against women and girls and ensure an appropriate response when it occurs • Promote gender equality in decision-making in households, workplaces and communities and at national level • Prevent discrimination against women in communities, education, political, economic and public life
Protection: registration, law and justice	<ul style="list-style-type: none"> • Strengthen systems to register every birth, death and cause of death and to conduct death audits • Provide protection services for women, children and adolescents that are age- and gender-appropriate • Establish and enact a legal framework for protection, ensuring universal access to legal services (including to register human rights violations and have recourse to remedial action against them)

⁴³ <https://www.who.int/life-course/partners/global-strategy/globalstrategyreport2016-2030-lowres.pdf>.

SECTOR(S)	KEY POLICIES AND INTERVENTIONS
Water and sanitation	<ul style="list-style-type: none"> • Provide universal access to safely managed, affordable and sustainable drinking water • Invest in education on the importance of safely managed water use and infrastructure in households, communities, schools and health facilities • Provide universal access to improved sanitation facilities and hygiene measures and end open defecation • Encourage implementation of sanitation safety plans
Agriculture and nutrition	<ul style="list-style-type: none"> • Enhance food security, especially in communities with a high poverty and mortality burden • Protect, promote and support optimal nutrition, including legislation on marketing of breast milk substitutes and of foods high in saturated fats, trans-fatty acids, sugars, or salt
Environment and energy	<ul style="list-style-type: none"> • Reduce household and ambient air pollution through the increased use of clean energy fuels and technologies in the home (for cooking, heating, lighting) • Take steps to mitigate and adapt to climate changes that affect the health of women, children and adolescents • Eliminate non-essential uses of lead (e.g. in paint) and mercury (e.g. in health care and artisanal mining) and ensure the safe recycling of lead- or mercury-containing waste • Reduce air pollution and climate emissions and improve green spaces by using low-emissions technology and renewable energy
Labour and trade	<ul style="list-style-type: none"> • Expand opportunities for productive employment • Ensure gender equality • Enforce decent working conditions • Provide entitlements for parental leave and for childcare for working parents, and promote incentives for flexible work arrangements for men and women • Detect and systematically eliminate child labour • Create a positive environment for business and trade with regulations to protect and promote the health and well-being of individuals and populations
Infrastructure, information and communication technologies and transport	<ul style="list-style-type: none"> • Build health-enabling urban environments for women, children and adolescents, through improved access to green spaces and walking and cycling networks that offer dedicated transit, safe mobility and physical activity • Develop healthy, energy-efficient and durable housing that is resilient to extremes of heat and cold, storms, natural disasters and climate change • Ensure that home, work and leisure spaces are accessible to people with disabilities • Ensure adequate health, education and work facilities and improve access by building roads • Provide safe transportation to health, education and work facilities, including during emergencies • Improve access to information and communication technologies, including mobile phones • Improve road safety, including through mandatory wearing of seat-belts and cycle and motorcycle helmets • Improve regulation and compliance of drivers, including introduction of a graduated driving licence that restricts driving options for inexperienced drivers

Annex 3: Key Informant Organizations

Global and Regional

Boston University

PATH

Pediatric Society of Ghana

Ministry of Health, Rwanda

Save the Children

UNICEF Headquarters

UNICEF ESARO (East and Southern Africa Regional Office)

UNICEF WCARO (Western and Central Africa Regional Office)

UNICEF ROSA (Regional Office for South Asia)

UNICEF Ghana

WHO Headquarters

WHO Regional Office for Africa

WHO Regional Office for South-East Asia

Kenya

Ministry of Health

PATH

UNICEF

USAID

WHO

Senegal

ChildFund

Ministry of Health and Social Action (*Ministère de la Santé et de l'Action Sociale*)

Ministry of Good Governance and Child Protection (*Ministère de la Bonne Gouvernance et de la Protection de l'Enfance*)

Malnutrition control unit (*Cellule de lutte contre la malnutrition, CLM*)

UNICEF

USAID

Zambia

Maternal and Child Survival Program

Ministry of Health

PATH

Save the Children

UNICEF
USAID
University of Zambia

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