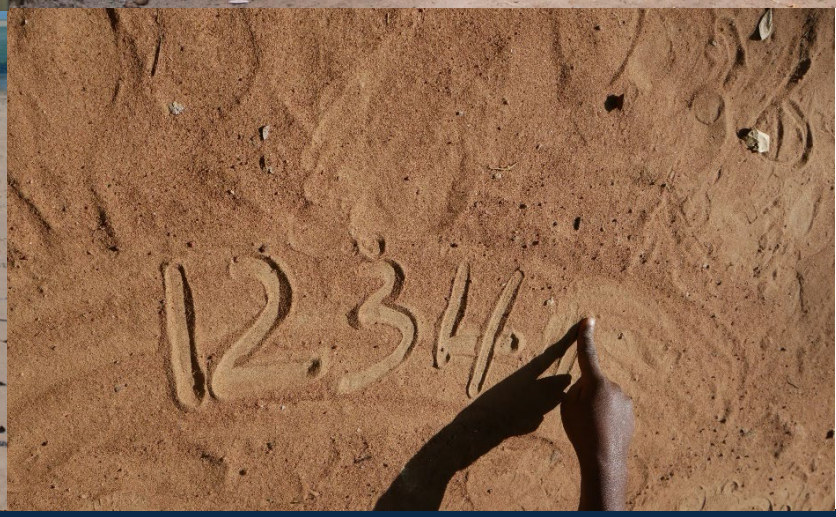

Early Childhood Development Systems in East and Southern Africa

Systems Diagnostic Synthesis Report

January 2023 (Revised 2024)

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Contents

Acronyms

CBO	community-based organization
CECEC	County Early Childhood Education Committee
CHW	community health worker
CSO	civil society organization
CNAS	National Council of Social Welfare
ECD	early childhood development
ECE	early childhood education
ESA	East and Southern Africa
ESAN II	Food and Nutrition Security Strategy
DHS	Demographic and Health Survey
FMC	facility management committee
HMB	hospital management board
HMIS	health management information system
IMCI	Integrated Management of Childhood Illnesses
MDGs	Millennium Development Goals
MGCAS	Ministry of Gender, Children, and Social Action
MINEDH	Mozambique's Ministry of Education and Human Development
MoE	Ministry of Education
MoH	Ministry of Health
MoHCDGEC	MoH Community Development, Gender, Elderly and Children
NECEC	National Early Childhood Education Committee
NGO	nongovernmental organization
NMNAP	National Multi-sectoral Nutrition Action Plan
NM-ECDP	National Multi-Sectoral Early Childhood Development Programme
NPA-VAWC	National Plan of Action to End Violence Against Women and Children
PNAC	Mozambique's National Action Plan for Children
PNAC II	Mozambique's National Action Plan for Children II
PO-RALG	President's Office-Regional Administrative and Local Government
RISE	Research on Improving Systems Education
SDGs	Sustainable Development Goals
ToC	theory of change
TWG	technical working group
UN	United Nations
WHO	World Health Organization

Executive Summary

Early Childhood Development Systems in East and Southern Africa 2022 Systems Diagnostic Synthesis Report

The well-being of children and their caregivers from conception through a child's first years have profound effects on human development and learning, adult earnings, and several dimensions of well-being over the lifetime—as well as the well-being of the next generation. The Nurturing Care Framework outlined by the World Health Organization (2018) provides a road map for addressing the needs of the whole child and their caregivers from pregnancy through age 3 by identifying and linking five key dimensions: health, nutrition, responsive caregiving, security and safety, and opportunities for early learning. Given the interconnectedness of these dimensions, systems-level approaches may prove more effective than single-sector interventions by leveraging multisectoral cooperation and improved governance, policy, and financing structures in support of the whole child. Such approaches should utilize cost-effective, scalable, and measurable solutions that can be implemented by governments despite constraints (Milner 2022).

Mathematica, the Early Childhood Development (ECD) Network for Kenya, Ifakara Health Institute in Tanzania, and KixiQuila Consultoria in Mozambique are conducting systems-level evaluation and learning activities. This report synthesizes the cross-country systems diagnostic results across four system dimensions: policy, governance, multisectoral coordination, and financing.

Status of early childhood development in East and Southern Africa

The health and education of children under age 5 have continued to improve in the past decade yet important challenges persist. The rate of under-5 mortality per 1,000 live births is 70 in Mozambique, and 41 and 43 in Kenya and Tanzania, respectively. Stunting rates, a key indicator of nutrition, have continued to fall across these three countries, affecting 37 percent of children in Mozambique, 30 percent in Tanzania, and 18 percent in Kenya. More than three of every four Kenyan and Tanzanian children are enrolled in pre-primary education, whereas in Mozambique it is less than one in three. Remaining challenges in health, nutrition, and early education translate into young children not reaching their full developmental potential; recent population-level data show that the proportion of children ages 24 through 59 months who are developmentally on track is 78 percent in Kenya, 47 percent in Tanzania, and only 39 percent in Mozambique. Moreover, this indicator shows significant disparities by gender, wealth, rural status, and across different regions.

Methods

The research partners implemented three main analytic processes to develop findings for this report.

- **Systems maps.** Country teams created a list of key ECD system actors, including governmental, nongovernmental, national, subnational, and local actors across ECD-related sectors. The country teams and Mathematica staff then worked together to map the connections among actors. This process also helped to establish boundaries for the systems-level evaluation.
- **Systems diagnostic.** Mathematica developed the ECD Systems diagnostic tool based on the Research on Improving Systems of Education (RISE) systems diagnostic, which analyzes systems by looking at sets of interrelationships among actors. This process was designed to build the measurement frameworks on a strong foundation of systems thinking and a deep understanding of the ECD system dynamics in each country. Mathematica led a series of sessions to orient country teams to the tool and each country research team completed the tool in consultation with stakeholders. In the process, the teams also sensitized stakeholders to systems thinking and measurement processes.
- **Theories of change (ToCs).** The country teams developed country-level ToCs based on the gaps and opportunities identified through the systems diagnostics. The gaps link to the forthcoming measurement frameworks.

This report synthesizes findings from these processes to identify common themes and country-specific challenges and opportunities.

Key Findings

Systems maps

The key structural features of the ECD systems in each country are as follows:

- **Kenya.** In Kenya, the national government is responsible for overall leadership, and the 47 county governments lead direct service delivery. Funding flows are complex, and the Ministry of Health (MoH) bears primary responsibility for ECD-related programs and services for children from birth to age 3 years; county-level departments of education implement and the national Ministry of Education (MoE) oversees pre-primary education for children ages 3 to 5.
- **Mozambique.** Mozambique relies on multiple ministries to support ECD, with the MoH leading nurturing care activities. Limited integration between responsible ministries hinders the activities, and there is no clear champion to guide ECD policies. The Ministry of Education and Human Development (MINEDH) is responsible for preprimary education.
- **Tanzania.** The President's Office-Regional Administrative and Local Government (PO-RALG) coordinates and supervises ECD programming implementation across ministries and levels of governance. Tanzania's newly established national technical working group (TWG) for ECD works alongside the National Multisectoral ECD Program to improve cooperation between ECD stakeholders and will cascade its efforts to the subnational level in the future.

Section III provides a visual depiction of each country system.

Systems diagnostic

Exhibit ES.1 summarizes the systems diagnostic findings from each country across four dimensions of systems change: policy, governance, multisectoral coordination, and financing. The findings identify common challenges and strengths across the three countries.

Exhibit ES.1. Summary country snapshot

	Kenya	Mozambique	Tanzania	Summary of status
Policy				All three countries lack comprehensive ECD legislation but have some type of **policy framework** in place to guide the implementation of sector-specific ECD services. Tanzania recently implemented a new multisectoral ECD policy framework to try to coordinate services vertically and horizontally.
Governance				Roles and responsibilities within the **governance** structures are generally clear; however, there is no coordinated or cohesive vision or leadership for ECD that links national goals with local actions. Availability and use of data for decision-making are limited.
Multisectoral coordination				**Multisectoral coordination** in ECD is nascent in Tanzania and limited in Mozambique and Kenya. Donors, nongovernmental organizations, community-based organizations, and other civil society stakeholders contribute to ECD by funding programs, providing technical assistance, and participating in TWGs; the coordination across these organizations is limited.
Financing				The central government funds most ECD activities in all three countries, but **financing** is fragmented, insufficient, and slow to disburse. A lack of plan costing prevents an assessment of actual needs. Financial accountability measures are not implemented as designed.

Key: ■ System features present | ■ System features partially present | ■ System features not present

Reflections

Based on these findings, the systems-level evaluation team proposes several changes and additional investment strategies to address systems-level gaps and weaknesses identified by country teams through the systems maps, systems diagnostics, and ToCs. The team initially developed these recommendations focused on the Conrad N. Hilton Foundation's existing portfolio and history engagement in East and Southern Africa (ESA), but also the recommendations have broader relevance for other stakeholders involved in ECD, including global donor organizations, researchers, and nongovernmental and community-based organizations (especially those engaged in advocacy).

Summary of proposed cross-country investment strategies

1. Build the capacity of multisectoral ECD coordination bodies.
2. Measure the long-term benefits and cost-effectiveness of ECD activities and communicate results to caregivers and policymakers.
3. Plan advocacy efforts around key junctures in the election and policy development cycles.
4. Support the use of data to drive advocacy, accountability, and decision-making.
5. Support the costed planning process.
6. Continue to advocate for increased investments in primary health care and other sectors that support ECD.

I. Introduction and Context

Overview of the systems-level evaluation

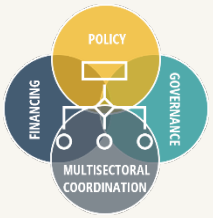
As part of the its 2021–2025 strategy, the Hilton Foundation's Global Early Childhood Development (ECD) Initiative—East and Southern Africa (ESA) aims to improve the well-being of caregivers and their young children facing adversity in ESA In addition to direct support to community organizations, they are making investments to strengthen the global ECD field and conduct research and evaluation activities. Mathematica, along with its research partners in the three focal countries: the ECD Network for Kenya, Ifakara Health Institute in Tanzania, and KixiQuila Consultoria in Mozambique, partnered with the Hilton Foundation to conduct systems-level evaluation and learning activities from 2021 through 2025. The objectives of the Hilton ECD systems-level evaluation include the following:

- Develop an action-oriented ECD systems measurement framework to measure systems-level progress at the national and subnational level in each country. The frameworks include detailed systems stakeholder maps.
- Develop theories of change (ToCs) to guide the changes in the implementation and integration of ECD within and across countries.
- Collect related data on ECD systems progress, focusing on policy, governance, multisectoral coordination, and financing, at the national and subnational levels.
- Create a plan for using data effectively to enable timely and informed decision-making. The data use plan will inform systems-level learning, policy, practice, and programmatic decisions in each of the three countries.

Making sense of multidimensionality

Drawing on foundational literature on ECD and nurturing care, the systems-level evaluation focuses on four dimensions of ECD systems that are critical for achieving systems-level progress on ECD:

1. Policy
2. Governance
3. Multisectoral coordination
4. Financing

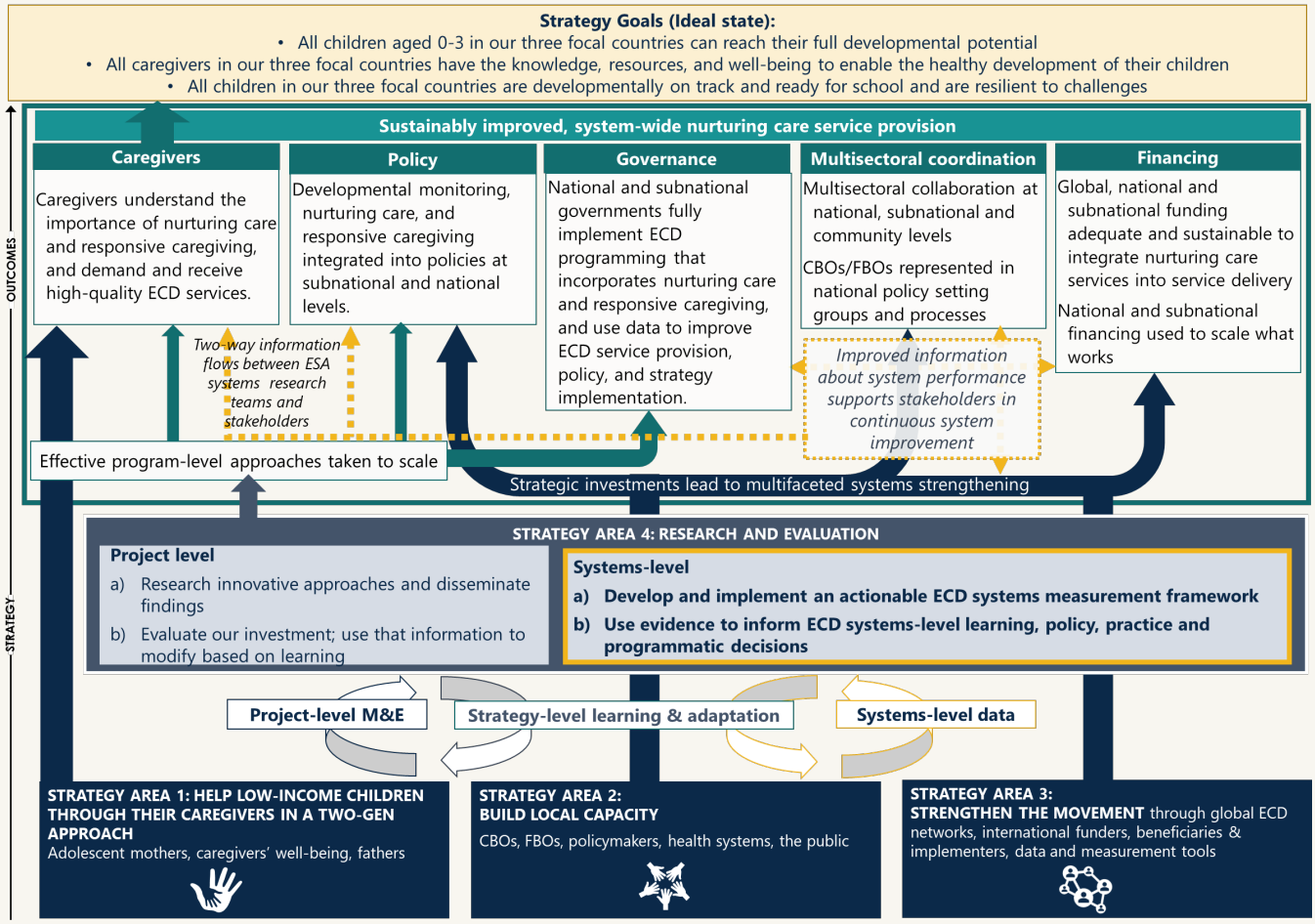


The dimensions function as individual complex subsystems, but also overlap in several aspects—like a Venn diagram. Each section of this report uses broad definitions that account for this potential overlap and each subsection notes areas of overlap.

Project theory of change

The strategy aims to support families with young children facing multiple adversities by engaging caregivers through a two-generation approach; building local capacity; and strengthening the ECD movement through investments in global ECD networks, international donors, beneficiaries, implementers, and data and measurement. Then, all children from birth to age 3 will have the potential to reach their full development; caregivers will have the knowledge, resources, and well-being to enable the healthy development of their children; and all children from birth to age 3 will be developmentally on track for school and resilient to challenges they face in everyday life. Exhibit 1 provides the details of the ToC, focusing on the role of systems-level evaluation in leading to the ideal state of improved outcome for children (birth to age 3) and caregivers in focal geographies.

Exhibit 1. Theory of change for systems-level evaluation



The ToC for the systems-level evaluation depicts how the activities conducted by the systems-level evaluation team connect to the ECD-ESA strategy and to the ultimate outcomes it hopes to achieve. The bottom row in blue depicts the four substrategies: Strategy Area 1, focused on the well-being and capacity of caregivers; Strategy Area 2 focused on building capacity among local organizations, policymakers, systems, and the public; Strategy Area 3, focused on strengthening the capacity and commitment of the global ECD community, funders, and implementers, including through improved data and measurement systems; and Strategy Area 4, focused on research and evaluation. The systems-level evaluation falls under Strategy Area 4.

The systems-level evaluation is highlighted in gold throughout the exhibit. The evidence generated through the evaluation can help inform systems-level improvements and guide strategic investments and implementation by (1) developing a tailored measurement framework for each country; (2) collecting systems-level data (including quantitative indicators and rich qualitative evidence on the strengths, weaknesses, performance, and progress of the system); and (3) analyzing and disseminating these data to relevant decision-makers in national and subnational governments and nongovernmental organizations. These activities, in turn, can contribute to the outcomes in terms of responsive caregiving, policy, governance, multisectoral coordination, and financing that are essential to achieving the ideal state the strategy seeks, where all caregivers are empowered to support the development of their children, and all children, from birth to age 3 are on track to reach their full developmental potential.

Source: Mathematica, based on strategy documentation and conversations with Hilton Foundation staff.

Key: ▢ denotes activities and change pathways associated with the systems-level evaluation.

CBO = community-based organization; FBO=faith-based organization

Country background and context

The Nurturing Care Framework by the World Health Organization (WHO 2018) provides a road map for addressing interrelated challenges for child development from pregnancy through age 3 by identifying and linking five key dimensions:

health, nutrition, responsive caregiving, security and safety, and opportunities for early learning. Exhibit 2 summarizes key indicators for child health, nutrition, and early childhood education (ECE).

Exhibit 2. ECD snapshot: By the numbers

	Kenya	Mozambique	Tanzania
Population ages birth to 5	**7.1 million children**	**5.3 million children**	**9.9 million children**
Nutrition challenges	As of 2022, **18 percent** of children under 5 were stunted. Stunting differs by rural (20 percent) and urban (12 percent) location.	**37 percent** of children were stunted (2022)—with wide disparities by maternal education and income levels.	As of 2022, **30 percent** of children under 5 were stunted; 10 percent were severely stunted.
Under-5 mortality per 1,000 live births	(41)	(70)	(43)
Vaccinations	**80 percent of children** between 12 and 25 months are fully vaccinated (basic antigens). Approximately 2.5 percent of females and 1.8 percent of males are not vaccinated at all. Only 71 percent of children in the lowest wealth quintile are vaccinated.	**38 percent of children** ages 12 to 25 months are fully vaccinated (basic antigens), and this rate has declined since 2015.	**53 percent of children** ages 12 to 23 months were fully vaccinated (basic antigens) and 23 percent were fully vaccinated according to the national schedule.
Early childhood education challenges	**77 percent** of preschool-age children were enrolled in school.	**32 percent** of 5-year-olds are enrolled in school. Most attend primary schools, but about 2 percent are enrolled in ECE	Despite free, compulsory pre-primary education, **gross enrollment was only 78 percent** in 2020.
Early childhood development index (ECDI)	**78 percent** of children ages 24 to 59 months are developmentally on track (health, learning, psychosocial well-being), with significant disparities by wealth and rural or urban status	**39 percent** of children 24 to 59 months are developmentally on track (health, learning, psychosocial well-being), with significant disparities by province and rural or urban status	**47 percent** of children ages 24 to 59 months are developmentally on track (health, learning, psychosocial well-being), with disparities based on gender, wealth, region, and rural/urban status.

Sources: Child population data is from UNICEF and stunting rates from the Demographic and Health Surveys (DHS) when available and World Bank Development indicators otherwise; ECDI results are from the DHS. Other indicators come from country systems diagnostics.

Road map to the report

This synthesis report summarizes the key findings of the initial systems-level analyses conducted by each country, drawing contrasts and comparisons across contexts. Section II provides an overview of the methodology for conducting each country systems diagnostic and the methodology for synthesizing results. Section III provides systems maps of key ECD actors in each country and their relationships as a starting point for a deeper examination of the system. Section IV discusses the status of stakeholder engagement, facilitators of, and barriers to systems-level change—focusing on the dimensions of policy, governance, multisectoral coordination, and financing. Section V includes country-level ToCs that highlight pathways to change along these dimensions, and Section VI provides lessons learned by the country research teams through the mapping, diagnostic, framework development, and ToC development processes. We conclude with recommendations on possible change and investment strategies based on learnings across the three countries to date.

II. Methodology

This report is based on three analytic processes conducted by each of the country research teams with technical assistance and support from Mathematica.

Mapping ECD systems actors

In Phase 1 of the mapping process, the country teams created a list of key stakeholders who were engaged in the ECD system. The teams provided these lists as part of the systems diagnostic (discussed below). Following the completion of the systems diagnostic and indicator frameworks, Mathematica met with each team to map the connections among the stakeholders. Mathematica held the meetings over Zoom and used a MURAL board to create stakeholder maps as each country team discussed the connections among stakeholders and their role in ECD.

Conducting the systems diagnostic

Mathematica developed a systems diagnostic tool to guide the teams through a deep dive into their systems, based on their own expertise, government documents, reports, and informal consultations with stakeholders through their advisory boards and other avenues. This process helped build the measurement framework on a strong foundation of systems thinking and a deep understanding of the ECD system dynamics in each country.

Developing the ECD systems diagnostic

The ECD systems diagnostic is based on the Research on Improving Systems of Education (RISE) systems diagnostic, which focuses on system actors and relationships related to formal education systems (RISE Programme 2022). Researchers developed this tool to help "facilitate and support government actors in selecting reforms that can improve learning outcomes" for children within these systems. Although the RISE diagnostic was designed with education systems in mind, its underlying conceptual framework conceptualizes systems in terms of a set of interrelationships between government and nongovernmental actors, which are easily adaptable and relevant to ECD systems.

Mathematica adapted the RISE tool to assess the extent to which a system design supports nurturing care for ECD by changing the names of the relevant actors; de-emphasizing relationships and concepts with no counterpart within ECD systems (for example, children from birth to age 3 are not capable of providing input on ECD priorities); and adding dimensions that are unique to ECD systems or to the learning needs of the Hilton Foundation (such as the equity focuses of its strategy).

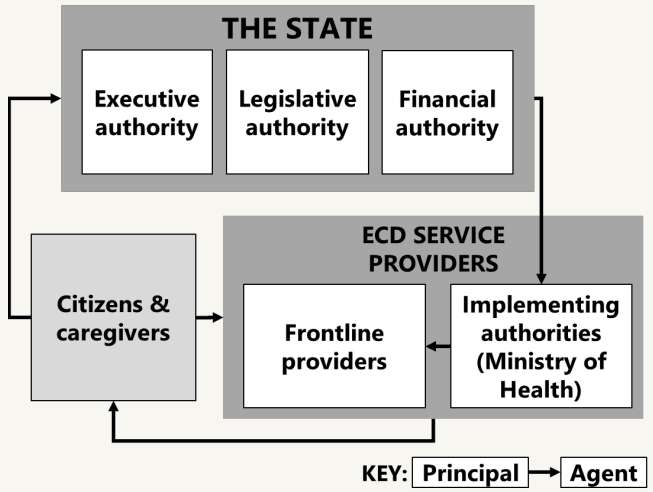
Key concepts embedded in the ECD systems diagnostic are as follows:

- **Actors.** The systems diagnostic focuses on four broad classes of actors: (1) citizens, including caregivers; (2) the highest authorities of the state, such as presidents or prime ministers, legislatures, and subnational leaders at different levels of the system; (3) implementing authorities and organizations, such as ministries of health; and (4) frontline providers.
- **Relationships.** The tool breaks down systems as a set of accountability relationships between these actors, delineating the principal (an individual or organization that wants a task or objective accomplished), and an agent (an individual or organization the principal assigns to complete those tasks and achieve those objectives). Each of these actors is a principal in some relationships and an actor in others. For example, state authorities may task specific ministries and ECD service providers with implementing strategic objectives, such as universal health care, but in relationship to caregivers who are also voters, the state authorities are agents of the public. Exhibit 3 depicts key actors and their relationships within a highly simplified, generic ECD system.
- **Relationship features.** Embedded within each of these relationships are *features* unique to those relationships. Features of relationships include what a principal wants, the resources they allocate to accomplish it, the information they use to assess

performance, the nonfinancial support they provide, and extrinsic and intrinsic ways that agents can be motivated to carry out their assigned role.

- **Alignments.** In practice, these relationships and their features are oriented toward or aligned with different priorities. The ideal state is alignment with providing high-quality care and services that are coherent with the nurturing care framework. Common, but less ideal, states include alignment with access, but not quality, and alignment with bureaucratic process compliance rather than outcomes.

Exhibit 3. Relationships in a generic ECD system



Source: Adapted from the RISE Programme (2022).

The ECD systems diagnostic is designed to be completed by teams of researchers and/or stakeholders with experience in ECD-related systems. It comprises a series of 28 big-picture questions or prompts relevant to one or more relationships within the ECD system, each with a set of subquestions that probe in more concrete terms the features of each relationship. Embedded within each question are short responses that describe, in generic terms, how that relationship would appear if it were aligned for nurturing care, for access, and/or for process compliance. Finally, under each question diagnostic teams are asked to identify any remaining knowledge gaps they cannot address with publicly available information.

Implementing the ECD systems diagnostic

Mathematica led a series of sessions to orient each country team to the systems diagnostic; each country research team approached the tool through its own collaborative process. For example:

- The Tanzania research team organized the tool and participants in their advisory board workshop into two teams (ensuring that participants from various ministries responsible for ECD were represented in each group). Each group completed their assigned sections, and then they met to discuss what they learned through the process.
- The Kenyan team approached the ECD systems diagnostic in two ways. First, they obtained feedback on the ECD systems diagnostic questions from the advisory team and ECD stakeholders. Participants from the two groups worked in teams and focused on different diagnostic thematic areas. Second, the Kenyan team filled in remaining gaps using various policy reports and evaluation studies.
- The Mozambique team began by reviewing a series of key government documents and reports from the relevant sectors and then reviewed the findings with the advisory board, which included members from the key stakeholder organizations.

Mathematica reviewed the resulting drafts and provided feedback and additional support for completing them.

Exhibit 4 provides an example of a prompt, guiding questions, alignment, and the response provided by the Tanzania research team. A blank systems diagnostic tool is in Annex A.

Exhibit 4. Example prompt and short response for Tanzania

High-level targets

Coherent for nurturing care	Aligned for access	Aligned for process compliance
• Priority given to clear goals for child development progress of all children ages birth to 3.	• Targets prioritize maximizing access to services.	• Rule compliance is the highest priority. All risk is perceived as compliance risk.

Guiding questions: *What are the priorities for the health and other relevant systems for the authorities? What would success look like for frontline workers?*

Response: The priority for ECD is children from birth to 8 years but opportunities for early learning and responsive care are limited particularly, for those ages birth to 3 years. High coverage of all components of nurturing care services will be considered a success.

What would the health and other relevant system-level authorities need to see in the frontline delivery to consider it successful?

Response: All nurturing care service indicators are reflected in the information systems, monitored, and reported; nurturing care services delivered the quality and improved child growth and development potential observed.

Outstanding questions and missing information: Lack of indicators on early learning and responsive care within the information system.

Source: Ifakara Health Institute.

Developing action-oriented measurement frameworks

For the systems measurement frameworks to truly generate action, they needed to capture changes in the gaps or barriers that play the largest role in preventing the ECD systems in each country from realizing nurturing care for all children from birth to age 3. These measurement frameworks are composed of quantitative (closed-ended) indicators, qualitative (open-ended) learning questions, and a ToC that links these elements to the pathways toward systems change.

/ **Indicator development.** Mathematica extracted and adapted existing indicators relevant to ECD and categorized them using the Hilton Foundation's four dimensions of systems change: policy, governance, financing, and multisectoral coordination. Mathematica drew the indicators from existing research and literature on health and ECD systems measurement, including resources developed by the WHO, UNICEF, and other researchers. These served as starting point for developing tailored indicators.

  Each country research team reviewed the indicators, and in consultation with their advisory boards and other stakeholders iteratively identified those most relevant to their systems, tailoring them to their country context and generating new indicators. This process produced a set of 10 to 15 indicators explicitly linked to gaps or barriers identified through the systems diagnostic, as well as to broader priorities for national and other stakeholders.

/ **Learning questions.** Each country research team selected a set of learning questions based on the learning needs and knowledge gaps identified in the systems diagnostic process. They will address these questions through qualitative data collection.

/ **Theories of change.** Country research teams also developed ToCs (provided in Section V) and linked the indicators and learning questions to the ToC to determine which components of the measurement framework capture which pathways toward systems change.

The research teams implemented the measurement frameworks in 2023.

III. Systems Maps

This section provides detailed systems maps developed by the country teams and built upon during their systems diagnostic process. The maps depict the key ECD systems actors and outline the relationships among the institutions. The child and caregivers are depicted at the center of the maps because the ECD system should support the development of the whole child. Children and their caregivers interface directly with the frontline health provision system, which differs slightly across countries. Frontline services are funded and governed by different sets of sector-specific and cross-sector ministries, which are governed by legislative and executive authorities and funded by financial authorities. Donors interface sometimes with government when providing financial and in-kind aid to governments, and sometimes directly with children and caregivers when they implement programs directly. Levels of centralization also vary across countries, with Kenya being the most decentralized, Mozambique being the most centralized, and Tanzania falling somewhere in the middle.

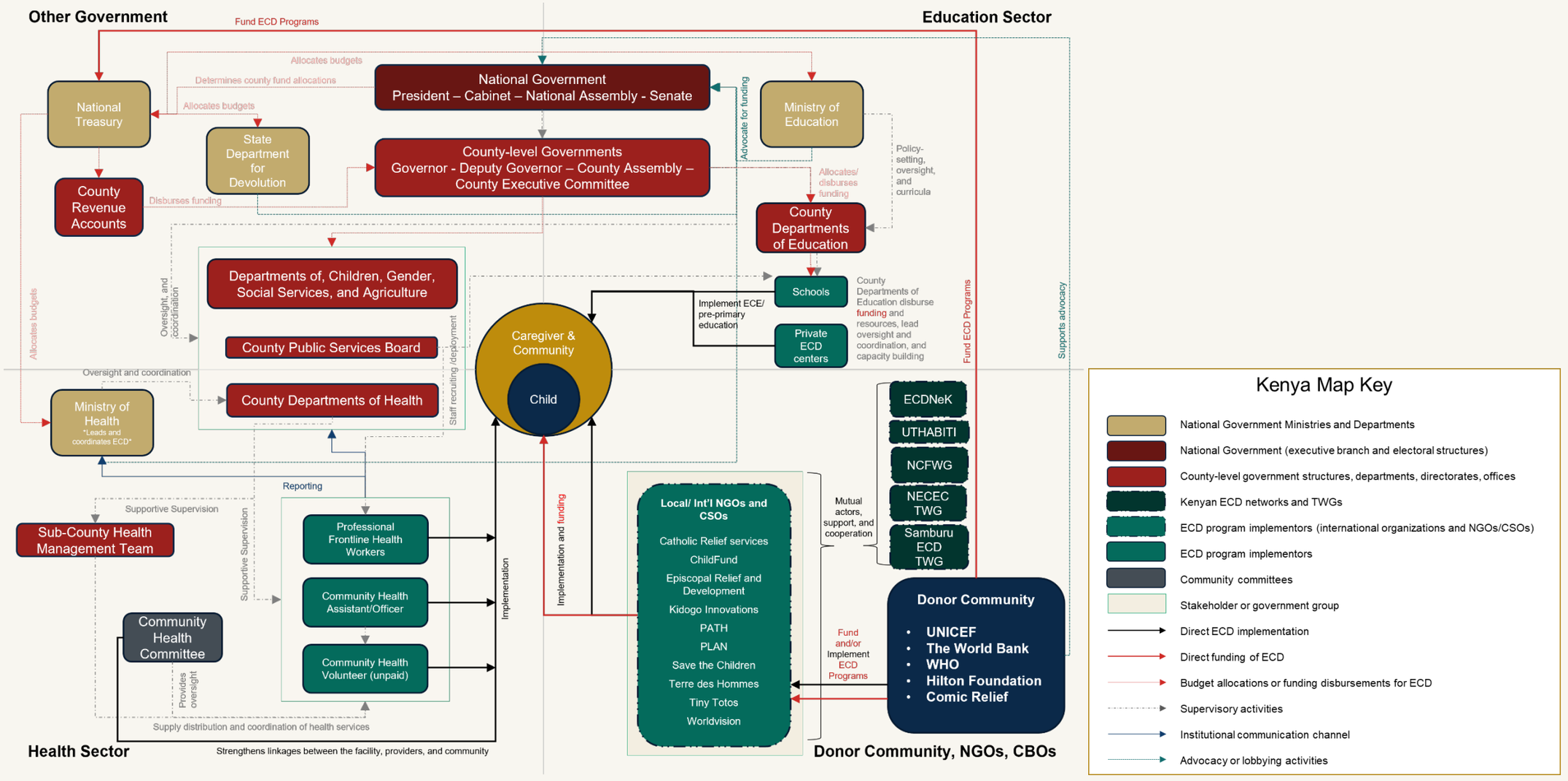
The maps are simplifications of complex, multidimensional systems. We worked closely with the country teams to make analytic decisions to distill the ECD systems down to figures that easily communicate the key dimensions of the systems on one or two pages. The maps focus primarily on systems serving children from birth to age 3, although they include actors in related systems, such as education systems that primarily serve older children if their programming also covers younger children, or if they play a role in ECD policy, governance, or multisectoral coordinating bodies. We also collapsed some relationships and leaders to highlight the most critical aspects of the relationships. Finally, the maps depict the "on-paper" relationships. We understand that every government has both formal (on paper) and informal (how things get done) systems, and although these maps focus on formal relationships, we include some informal relationships in which actors are not as siloed as they appear on paper or in which the differences are important (such as some informal advocacy relationships).

Kenya

The ECD system in Kenya reflects the devolved system of governance from the national to the county level, which began in 2010. The national government is responsible for overall leadership, regulatory and policy guidance, financing the county governments, quality assurance and standards, monitoring, and evaluation, among other functions. The county governments are responsible for their own budgetary allocations, which are not under the control of the national government. The 47 county governments have largely assumed responsibility for direct service delivery. The top-left quadrant primarily depicts the budgeting and expenditure process. The national government collects most revenue and then allocates and distributes it to relevant national ministries and county governments through a complex process. The bottom-left quadrant shows the health sector, where services for children from birth to age 3 and their caregivers are centered. The Ministry of Health (MoH) leads and coordinates ECD at a national level on matters related to children's health, including overseeing County Departments of Health. The County Departments of Health are responsible for managing county health facilities, ambulance services, promotion of primary health care, disease surveillance and response, public health, and sanitation. The health management teams at the subcounty level are responsible for conducting supportive supervision of the frontline health care workers who provide ECD-related services. The subcounty health management teams also distribute health care supplies and coordinate local health services. County Public Services Boards are responsible for recruiting and deploying those frontline workers. Kenya also has a system of community health committees that oversee health services at a community level and help strengthen linkages between the health system and the community.

Kenya's nongovernmental ECD community in the lower-right quadrant includes local civil society organizations (CSOs) and nongovernmental organizations (NGOs), as well as international organizations such as UNICEF, the World Bank, the WHO, and other private funders, including the Hilton Foundation, which fund and/or implement nurturing care and ECD programming. There are also multisectoral working groups with varying degrees of collaboration across sectors and between the government, donors, and implementer communities (Exhibit 5).

Exhibit 5. ECD systems map for Kenya



Mozambique

The ECD system in Mozambique draws from many different ministries to support the development of the whole child, though many of the relationships are not integrated or do not work collaboratively to program nurturing care. The majority of the ECD nurturing care activities flow through the MoH, which is responsible for providing the policy frameworks that guide the local health facilities. A Health Management Committee passes along information from communities to the central government including complaints, needs, and gaps.

The Ministry of Education and Human Development (MINEDH) is responsible for ECE. The MINEDH funds Integrated Family Planning Program, the preprimary teacher training institution, which provides teachers to ECD centers. There are currently very few ECE centers in Mozambique and less than 30 percent of children under age 5 receive preprimary instruction. Other institutions critical to the development of the whole child include the Ministry of the Interior (child safety), the Ministry of Agriculture and Rural Development (nutrition and food security), the Ministry of Public Works and Housing, and the Ministry of Gender, Children, and Social Action (MGCAS). One of the many factors that make ECD in Mozambique challenging is that although MGCAS supports and works with the Ministry of Education and Human Development (MINEDH) and MoH, children in the ECD target to 3 age range are not necessarily included in preschool education. These ministries work tangentially to the primary ECD activities by setting standards and norms within their ministries; however, there is little to no integration in terms of an ECD policy framework that guides and connects all child support services. For example, MGCAS defines the norms for preschool but does not track developmental outcomes in children ages birth to3. The MoH may track stunting and delayed physical and cognitive development but does not necessarily share the data with MGCAS or MINEDH.

Roles and responsibilities of ECD-related ministries in Mozambique

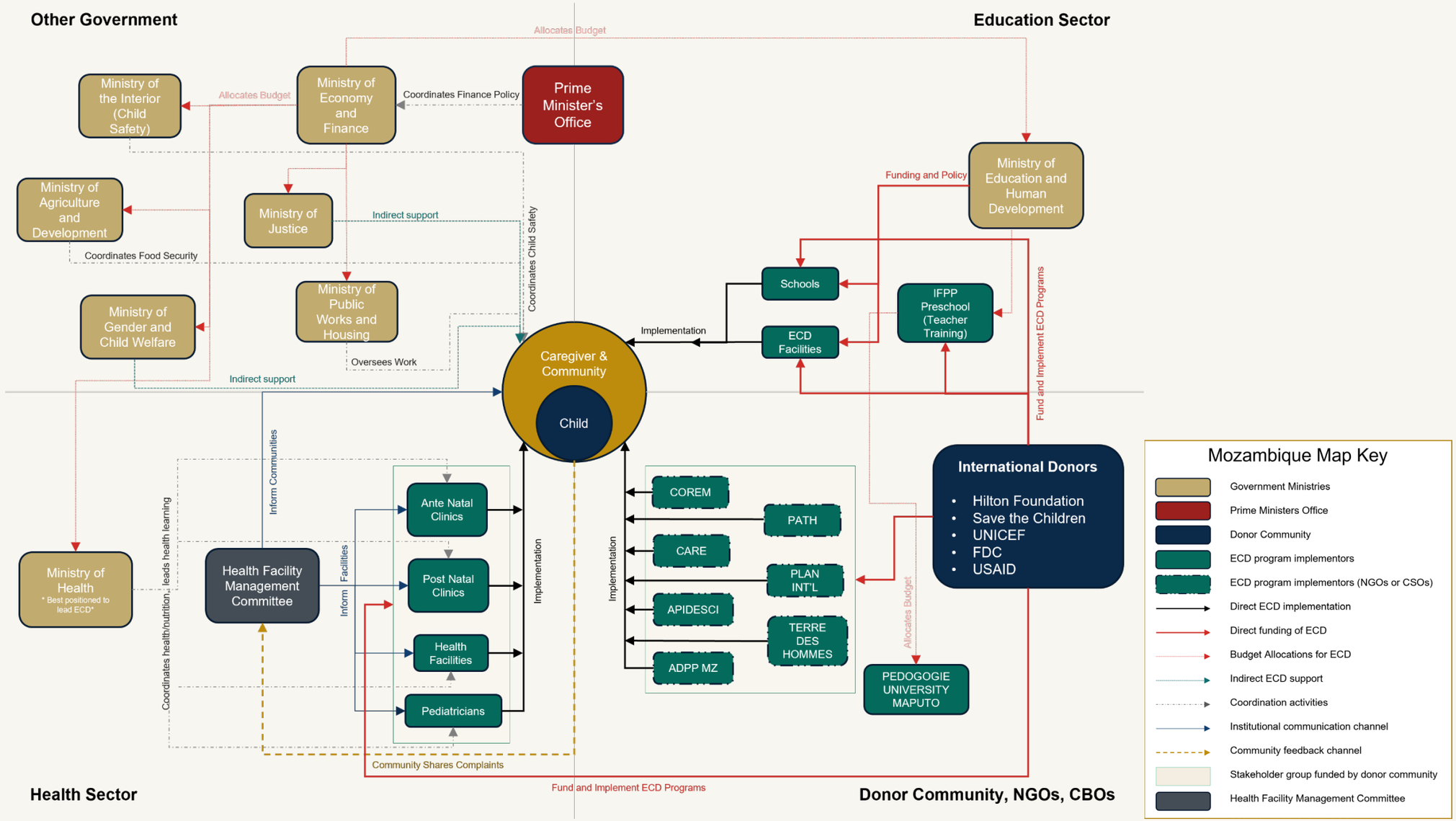
MGCAS: Oversees child and social welfare in coordination with MINEDH and MoH. It helps define the norms of preschool education (under age 6), support, monitor compliance, and define criteria for opening, operating, and closing preschool institutions.

MINEDH: Approves ECE curricula and manages the National Education System, of which preschool education is a subsystem.

MoH: Defines nutrition and WASH standards and assists with other health-related issues in children.

In addition to the government, international donors such as the Hilton Foundation, UNICEF, and the World Bank provide funding to local community-based organizations (CBOs) and international NGOs to support specific ECD activities. Exhibit 6 shows the ECD system stakeholder map. Details on the policy, governance, financing, and multisectoral coordination are discussed in later sections of this report.

Exhibit 6. ECD systems map for Mozambique



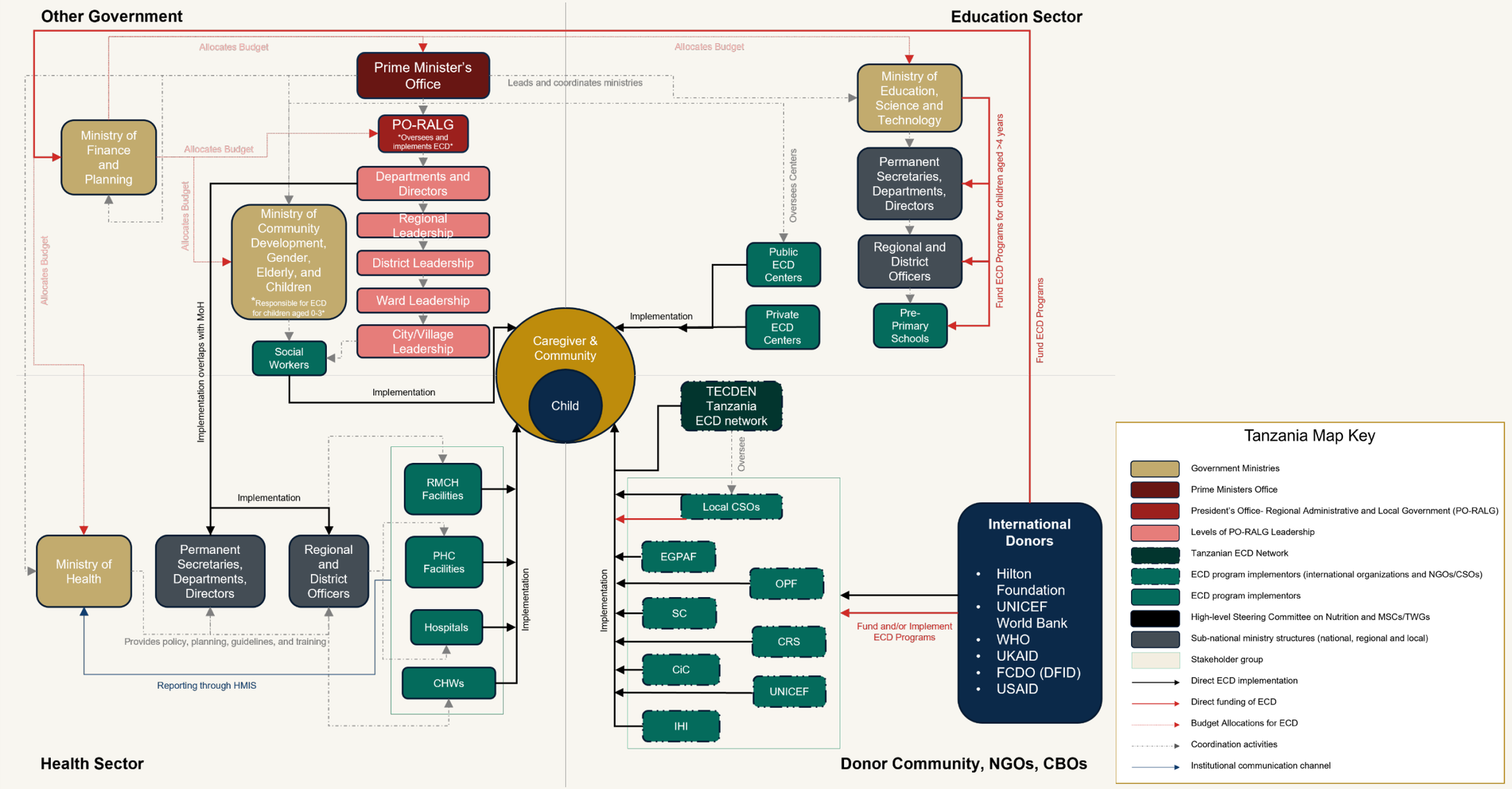
Tanzania

The ECD system in Tanzania depends on multiple ministries to support the whole child. The Ministry of Community Development, Gender, Women and Special Group oversees ECD program implementation, and the President's Office-Regional Administrative and Local Government (PO-RALG) coordinates and supervises implementation across ministries and levels of governance through its numerous departments and directorates, and its regional, district, ward, and village leadership structures.

The Ministry of Education, Science, and Technology supports PO-RALG's ECD mandate by providing nurturing care services in the preprimary and primary education systems for children ages 4 and older, and the Ministry of Community Development, Gender, Elderly and Children provides direct ECD and nurturing care services to children younger than 3 years via social workers and ECD centers. Private ECD centers also operate as licensed (and unlicensed) businesses, which the government is seeking to regulate to improve their quality.

The MoH is responsible for the routine functioning of the health system, but PO-RALG manages the direct implementation of nurturing care and ECD programs in health facilities or within communities by community health workers (CHWs). Domestic and international funding for ECD flows through the Ministry of Finance to PO-RALG and all respective ministries. There is a robust ECD community in Tanzania, including local CSOs; the Tanzanian ECD Network (a multisectoral stakeholder group that provides a platform for coordinating and promoting ECD efforts in the country); and international organizations, such as the Hilton Foundation, the WHO, Save the Children, and UNICEF, which all support nurturing care and ECD programming. Multisectoral councils, technical working groups (TWGs), and high-level steering committees representing governmental and nongovernmental stakeholders discuss ECD and nurturing care or adjacent areas of interest. Although ECD policies, structures, programs, and stakeholders have proliferated, it is yet to be seen if this has benefited the whole child. Ensuring alignment and coordination of stakeholders and financing as well as maximizing the effectiveness of service delivery will be top priorities for the Tanzanian ECD system moving forward. Exhibit 7 depicts these actors and their relationships.

Exhibit 7. ECD systems map for Tanzania



IV. Systems Diagnostic Findings

This section summarizes the findings from each country across four dimensions of ECD systems change: policy, governance, multisectoral coordination, and financing (Exhibit 8). Each subsection draws comparisons across the country systems based on specific criteria that help accelerate change. Later sections present the country ToCs based on the findings from the systems diagnostic, as well as key change strategies that may contribute to reaching the ideal state in each country. The overall findings from the systems diagnostic identify common challenges across the three countries, but the specific strategies for each challenge should be tailored to each country's system features and dynamics.

Exhibit 8. Summary country snapshot

	Kenya	Mozambique	Tanzania	Summary of status
Policy				All three countries lack comprehensive ECD legislation but have some type of **policy framework** in place to guide the implementation of sector specific ECD services. Tanzania recently implemented a new multisectoral ECD policy framework to try to coordinate services vertically and horizontally.
Governance				Roles and responsibilities within the **governance** structures are generally clear; however, there is no coordinated or cohesive vision or leadership for ECD that link national goals with local actions. Availability and use of data for decision-making are limited.
Multisectoral coordination				**Multisectoral coordination** in ECD is nascent in Tanzania and limited in Mozambique and Kenya. Donors, NGOs, CBOs, and other civil society stakeholders contribute to ECD by funding programs, providing technical assistance, and participating in TWGs; the coordination across these organizations is limited.
Financing				The central government funds most ECD activities in all three countries, but **financing** is fragmented, insufficient, and slow to disburse. A lack of plan costing prevents an assessment of actual needs. Financial accountability measures are not implemented as designed.

Key: ■ System features present | ■ System features partially present | ■ System features not present

Policy

The World Bank's Systems Approach for Better Education Results, or SABER framework for ECD notes that an enabling environment is the foundation for effective ECD systems, and that enabling environment grows out of a country's legal and regulatory frameworks (Newman and Devercelli 2013). Because policy interacts with governance, multisectoral coordination, and financing, here we focus on legislation, global and policy frameworks, strategic plans, and other written documents that lay out goals for ECD, how to achieve them, and how to measure progress. Strong policy development in ECD is often linked to strong, supportive leadership and the rule of law. Exhibit 9 summarizes the status of policy development across the three focal countries.

Exhibit 9. Policy snapshot, by country

Country	Policy criteria				Summary of status
	Comprehensive ECD legislation	ECD-related strategic plans	Strategic goals for relevant sectors aligned with nurturing care	Policies provide road map for multisectoral coordination	
Kenya					Kenya's framework governing ECD is from 2006, well before devolution of many powers to the county level and falls under the Ministry of Education (MoE). However, an MoH TWG is reviewing the policy. The devolved system does not provide a clear pathway to scale innovative county-level policy approaches, such as the one implemented in Siaya.
Mozambique					ECD in Mozambique is governed by a patchwork of strategic plans across various sectors. Achieving policy progress on ECD greatly depends on prioritization within the government's five-year programs.
Tanzania					Tanzania has made significant progress with the launch of a new multisectoral plan, but policymakers will need to maintain momentum through sustained implementation.

Key: ■ System features present | ■ System features partially present | ■ System features not present

All three countries adhere to human rights conventions that support ECD. Kenya, Mozambique, and Tanzania are all signatories to the United Nations (UN) convention on the Rights of the Child. Policy documents in each country set out the goal of providing access to the highest attainable standards of health and education to their citizens in a nondiscriminatory manner, in keeping with the WHO constitution and the UN's conceptualization of health and education as fundamental human rights. Although there is no enforcement mechanism to ensure countries are meeting their commitments, global policy and advocacy can help to serve as a shared language and understanding to form the basis for advocacy efforts.

No laws or legislation in any of the three focal countries enshrine nurturing care for ECD. The three focal countries instead rely on a patchwork of different frameworks and strategic plans that are multisectoral to varying degrees. For example, in Mozambique, the National Action Plan for Children (PNAC) I (2006–2012) and PNAC II (2013–2019) define the fundamental areas to ensure the survival, protection, and development of children and reiterate the government's commitment to children's rights. The government's multisectoral plan for reducing chronic nutrition focuses on reducing under-nutrition in children ages birth to 5, while setting up a package of priority interventions to complement the activities included in other relevant sector plans and strategies such as the Food and Nutrition Security Strategy (ESAN II) and the integrated plan for attaining the Millennium Development Goals (MDGs) 4 and 5. The Basic Social Subsidy Plan aims to reduce the vulnerability of children from birth to age 2, promote their development through improving their health and diet and access to basic social services (including education) and protection. It provides grants to support early care and education and nurturing care for vulnerable and marginalized children. The strategic plan for education includes a section dedicated to ECD and notes the importance of focusing on ECD. However, the ministries delegated to implement ECD-related policies do not coordinate implementation with the communities that need the support (discussed more in the Governance section).

Kenya also has a series of policy frameworks in place to support nurturing care in the health sector. The Kenya Community Health policy (2020–2030) and the Community Health Service Delivery package provide guidance on creating and implementing community health structures to enable families to attain the best standard of health. The comprehensive ECD Policy Framework under the MoE (MoE 2006) sets out strategic objectives relevant to ECD and outlines the holistic needs of children in different developmental categories, as well as the roles and responsibilities of their caregivers and communities in meeting those needs. Unfortunately, this framework has not been implemented and the MoE shifted its focus back to the provision of ECE in 2017. The MoH recently reviewed the MoE's ECD policy framework and developed its own ECD policy (2022), which includes a multisectoral coordination framework for nurturing care. Kenya also recently passed the Children's Act No. 29 of 2022, which empowers the National Council of Children's Services to collaborate with relevant state departments and nonstate agencies to monitor and evaluate the efficiency and effectiveness of all social programs established in the interest of children; time will tell whether this is applied to existing ECD programming. A recent analysis found that although health and nutrition are widely incorporated into national- and county-level plans and policies, the elements of nurturing care, namely early learning, responsive caregiving, and safety and security remain gaps (Abboah-Offei et al. 2022).

Tanzania, in contrast to Mozambique and Kenya, recently made progress in establishing policy frameworks for nurturing care in ECD. The government established a National Multi-Sectoral Early Childhood Development Programme (NM-ECDP) in 2022, which is bringing together stakeholders from various ministries and civil society to improve and coordinate interventions in ECD. The NM-ECDP aligns with Tanzania's National Development Plan and builds on previous programs that replaced siloed approaches with a holistic and integrated framework.

Although each of these countries has made strides to establish policy frameworks related to ECD, implementation of these plans is weak (or nascent, in the case of Tanzania), and monitoring of policy implementation is weaker still (see the following section on governance). It remains unclear the extent to which the government policies in each country will translate into substantive improvements in child-level health and educational outcomes.

Current policy frameworks fall short of providing a road map for achieving stated policy goals for children's health. In conducting the systems diagnostics, we learned that each ministry linked to ECD has stated goals for children. These goals, if achieved, would strongly support children to reach their full developmental potential and would promote equity. For example, in Kenya, the MoH aims to achieve the highest attainable standard of health through increased equity; a child-centered, multisectoral approach to care; the integration of technology; promoting equity of access to care; and community-level accountability. In Mozambique, the strategic objective of the health sector is to maintain and deepen health gains by expanding access to and improving the quality of primary health services, primarily the use of maternal health services and increased institutional births, expanding access to antiretroviral therapy for HIV-positive children, expanding services related to malaria, and increasing the number of health providers in primary health and key specialty areas. Mozambique's education system seeks to expand and monitor the provision of ECE to a growing number of children. The Ministry of Agriculture and Rural Development seeks to ensure food security and improved nutrition. However, as the systems maps demonstrate, the goals and policy frameworks are not connected to one another, no one institution is monitoring ECD, and there is not a comprehensive, linked policy framework for ECD. Policies remain siloed in their respective sector-level institutions.

Tanzania's fifth health sector strategic plan (HSSP V; 2021–2026) identifies health as one of the priority sectors that contributes to a higher quality of life for all Tanzanians. The multisectoral strategy plan seeks to achieve lofty goals outlined in the Tanzania Development Vision 2025, including access to quality primary health care for all, significant reductions in infant and maternal mortality, and life expectancy comparable to that of typical middle-income countries. However, HSSP V lacks adequate governance and accountability measures to help ensure that the health system meets its goals.

Policy documents in other related sectors suffer similar challenges in terms of implementation, accountability, and connections to other sectors. Other sectors have documents that identify objectives aligned with and strategies for achieving nurturing care for ECD. The Kenyan MoE's ECD Policy Framework from 2006 identifies the evolving needs of children ages birth through 8 years and emphasizes the importance of special attention to vulnerable and marginalized children, including those with special needs. The policy and the subsequent Early Childhood Education Act No. 3 of 2021 also note the importance of empowering caregivers and communities to provide for those holistic needs. However, the current education system only serves children over age 4—a clear disconnect from the ECD policy framework. Moreover, there is no clear link to the ECD policy frameworks and interventions in the health sector. In Mozambique, the Education Strategic Plan (2020–2029) includes a preschool education program, which intends to develop the subsystem of preschool education for children from birth to 5 years old to stimulate their physical, mental, and intellectual development and encourage school readiness. In contrast to Kenya, the preschool subsystem is managed by multiple ministries including Gender, Children and Social Action, Education and Human Development, and Health. Although the policy frameworks for ECD are not yet strongly connected, there is coordination and collaboration among three critical stakeholders in the ECD system—Health, Education, and the MGCAS. Missing from the coordination circle are school feeding programs and the Ministry of Justice, which oversees child safety. Tanzania was one of the first countries in the region to make early learning compulsory, with the Education and Training Policy in 2014 integrating preprimary education into basic education and requiring each primary school to have an ECE stream catering to preschool-age children. However, there are contradictions between the early learning policy and the Child Act. Although the education policy indicates children under 5 years can access preprimary education, the Law of the Child Act (2009) mandates the Department of Social Welfare oversee integrated ECD for children under age 5.

Launching the NM-ECDP: A success story from Tanzania

The NM-ECDP came into existence on December 13, 2021. It recognizes the work of national programs that take a multisectoral approach to key aspects of child development, including the National Multi-sectoral Nutrition Action Plan II (2021/22–2025/26) and the National Plan of Action to End Violence Against Women and Children (2017/18–2021/22). The NM-ECDP aimed to complement these national programs by strengthening identified opportunities and responding to gaps to promote the provision of comprehensive ECD services to all children (ages birth to8 years) in Tanzania. The development of the NM-ECDP was coordinated by a task force that brought together technical and management personnel from government ministries, departments, and agencies as well as nongovernment stakeholders including development partners. The task force draws members from the MoH Community Development, Gender, Elderly and Children (MoHCDGEC); Ministry of Education, Science and Technology; President's Office–Regional Administration and Local Government (PO-RALG); Prime Minister's Office–Policy, Coordination Parliamentary Affairs, Labour, Youth, Employment and Persons with Disability; Ministry of Finance and Planning; Ministry of Home Affairs; the Tanzania Food and Nutrition Centre; and the University of Dodoma. Members from UN agencies including UNICEF, WHO, and UNESCO provided technical support and financial contributions.

Spotlight on maternal mental health policies

None of the three countries currently have policies that focus on the specific needs of mothers. The Hilton Foundation has identified maternal mental health as a priority for the policy dimension and is supporting the WHO in developing guidelines for maternal mental health. The broader policy framework for mental health care in each country is as follows:

Kenya. The Kenya Mental Health Policy 2015–2030 aims to attain the highest standards of mental health. However, the country lacks a specific policy on maternal mental health. Recently, the Ministry of Health developed the Kenya Mental Health Action Plan (2021–2025), which provides guidance on mental health care based on four major objectives: (1) effective leadership and governance for mental health, as well as financing; (2) the provision of comprehensive, integrated mental health and social care services in community-based settings; (3) implementation of strategies for promotion and prevention, and strengthened information systems; and (4) evidence and research. The national government will take the lead on developing policy and legislation, and county governments will include mental health in their development plans, mobilize county-level resources, and build local capacity. Time will tell whether this is implemented, and whether it makes mental health more accessible to pregnant women, young mothers, and vulnerable populations.

Tanzania. In Tanzania, mental health care (like ECD) is fragmented and siloed across sectors and ministries. Preventive services are offered under the Social Welfare department within the MoHCDGEC, which offers psychosocial support following the National Guidelines for Provision of Psychosocial Care and Support Services, and the MoH is responsible for mental health treatment. WHO is supporting Tanzania to develop tools to track maternal mental health.

Mozambique. The Maternal and Mental Health Departments at the MoH of Mozambique, with technical assistance from PATH, developed and piloted the first-ever protocol for screening and managing post-partum depression within routine postnatal care. The protocol included screening women for symptoms of depression two weeks after birth, followed by referral or counselling. Now, the pilot is being expanded to more health facilities and districts in four provinces. Discussions are ongoing to include mental health disorders in pregnancy and for women of childbearing age.

Governance

Strong governance in any sector means that (1) there are clear structures, roles, and responsibilities; (2) the system supports effective communication among stakeholders; (3) the system allows for some local decision-making allocated across the government and between public-, private-, and community-level actors for operationalization at subnational and community levels; and (4) there is clear vision and leadership at all levels of the system. These factors—or criteria for change—help to accelerate systems change by providing "core capabilities that policymakers need to develop or improve for rapid improvement at scale, and which address common binding constraints in education and health systems" (Ndaruhutse et al. 2019). For ECD, strong governance means that subnational levels of government (such as counties, departments, or community health and education stakeholders) are empowered to adapt programs and practices to their unique challenges; that each level of decision-making has clear roles and responsibilities and the flow of information up and down the system is clear; and that stakeholders at all levels use data and evidence to drive decision-making. It also means that civil society has a voice and can contribute to local decision-making. In essence, a strong ECD governance system is "the glue that holds the system together" (Neuman 2007). Exhibit 10 summarizes the status of ECD governance across the three countries using these criteria and highlights key similarities and differences that the local teams noted in their systems diagnostics.

Exhibit 10. Governance snapshot, by country

Country	Organizational structure	Vision and leadership	Voice and choice	Data for decision-making	Summary
Kenya	●	●	●	●	Kenya's decentralized system gives the central government the authority around policy formulation, standards, and technical support to the counties, whereas the counties focus on service provision. However, there is no defined vision or cohesive leadership for ECD and little decentralized authority below the national level. A lack of strong community health services referral systems gives communities little voice in improving ECD services. Use of data for decision-making is increasing.
Mozambique	●	●	●	●	The Mozambique Health and Education ministries have clear sector-specific governance structures and priorities, which are defined in the government's Five-Year Strategic Plan. In addition, the ECD policy framework (PNAC I and II) encompasses a multisectoral package of services and programs aimed at providing a nurturing environment for young children to thrive. However, there is no strong vision or leadership for ECD. Health committees have some voice, but communities have little choice about the services offered. Use of data for decision-making is limited to priority indicators in the Five-Year Plans.
Tanzania	●	●	●	●	The NM-ECDP, if implemented with fidelity, marks a significant step forward. However, there is a lack of clarity around numerous factors, including mechanisms to address equity and identify children with developmental delays; a clear vision for ECD; little decentralized authority at local levels; weak referral systems; and a limited number of ECD services, which limits families' voice and choice of ECD services. In addition, it is still not clear who is leading the implementation of ECD at the regional and council levels. The ongoing effort to develop an implementation guide might address this challenge. Use of data for decision-making is limited to health and nutrition indicators and by health management information system (HMIS) data quality.

Key: ■ System features present | ■ System features partially present | ■ System features not present

The organizational structure for governance of ECD is in place across all three countries. The governments of Kenya, Mozambique, and Tanzania have good organizational structures in place for supporting ECD programming. The roles and responsibilities of stakeholders in the health and education sectors are clear, and Kenya has a clear, decentralized governance structure to help support local community health systems to deliver services to children from birth to age 4. Although the organizational structures are in place, there is much work to do to improve the governance of ECD. This section highlights the main findings related to the governance of ECD across the different systems and draws out similarities and differences in the governance structures.

The flexibility of subnational governments to set and define policy and programming is relatively limited, except in Kenya. In Kenya's devolved health system**,** the national government retained policy and regulatory roles and national referral services, whereas the county governments took on service delivery roles, including the ownership and management of public

health facilities. Counties are responsible for priority setting, planning, budgeting, allocating resources to the health and other sectors, procurement and human resource management, and the provision of health services. The roles and responsibilities of national and subnational actors are clearly defined through the strategic plans and sector-level policy frameworks (discussed above) and actors at the decentralized levels can make decisions related to managing health and education.

In contrast to Kenya, Mozambique has been slowly moving toward a more decentralized governance structure since 1975. In 1996, the government amended the constitution to empower local government and, by 1997, the government had created a number of new municipalities to support decentralized governance. By 2002–2003, laws were added to provide an overall policy framework for decentralized planning and a deconcentrated process that empowered districts as planning and budgeting units. By 2018, new amendments created devolved governing bodies at the provincial level. Despite the existence of policy devolution, the health system remains highly centralized. The relationship between relevant system authorities and facilities is strictly hierarchical, governed by rigid rules and reporting procedures. In the health sector, the devolved governing bodies, provincial directorates of health, and national power need better coordination. Although each provincial body develops its own budget, bottlenecks in funding primary health facilities remain prevalent in Mozambique. These bottlenecks occur because health facilities fall under the authority of provincial bodies (responsible for setting health priorities), but they rely on funding from the districts. Moreover, health facilities and service providers are expected to deliver similar services at similar times in similar ways. These provincial institutions are accountable for meeting national targets. The misalignment among the different levels of governance—each with its own budget and priorities—makes it difficult to manage the quality-of-service provision, and even more difficult to develop and maintain a cohesive ECD nurturing care system. The lower levels of governance also rely heavily on central government funding, with limited ability to raise needed resources locally.

In Tanzania, the current government structure is considered decentralization by devolution. This management structure assumes that moving the responsibility for managing funds and staff from the central level to district councils would help improve service delivery in all sectors. Local government authorities are responsible for financing services such as health and education by mobilizing local resources to finance programs and the roles and responsibilities for actors throughout the government structure are clear. There are even processes in place at the local government agencies to develop annual plans and move them up through the local systems to the central level. However, although the policy states the need for and existence of a strong, decentralized government and structures social planning to begin at the local government agency level, the planning process still works from the top down. Communities note that the local planning process is a "pseudo-process" (that is, it exists on paper, but not in practice) and the central government mostly ignores requests and wishes from local government agencies (Mollel and Tollenaar 2013).

The systems diagnostics showed that, although different levels of devolved governance exist in all three countries, they all could benefit from greater support for innovation, empowerment, and adaptation at the subnational level.

Communities and civil society in all three countries are actively engaged at the local level and could serve as a starting point for building strategies and resources for nurturing care. At the community level in Mozambique, there is voice and some choice of services. Community health services tend to be integrated with the community. Voices of families are channeled through health committees and complaints are logged in books or boxes. The committees have some power to influence change locally during the planning process; however, competing demands and priorities at the provincial and national levels limit community choices.

In Kenya, the Constitution of Kenya 2010 and Health Act 2017 provide for community and public participation in health facility governance through Facility Management Committees (FMCs) for primary health facilities and Hospital Management Boards (HMBs) for hospitals. The laws have given the FMCs and HMBs an oversight role in the management and governance of health facilities, including overseeing use of facility-level financial resources and the quality of services provided. However, given the outsized role of counties, FMCs and HMBs have become less active, and in some cases have been disbanded. Families pursue quality and responsive community health systems, but although conditions are improving, there is still a lack of responsiveness to community needs. There is little to no effort to improve services through voice.

In Tanzania, there is some innovation at the local level. For example, the introduction in October 2022 of village health and nutrition days, which enable each village to select components of nurturing care to cover, has helped build community interest in ECD. However, communities generally have a limited voice and choice because the local planning process tends to be on paper only and fails to truly work its way up to the regional and national levels. Frontline providers are sensitized to sectoral policies, guidelines, and ratification of international conventions (for example, the Abuja Declaration, Universal Declaration on Human Rights, and the sustainable development goals) that support sectoral actions and strategies. However, except for national and subnational implementing authorities and organizations, frontline service providers generally have a limited understanding of the goals and objectives stated in the national ECD program.

ECD activities in all three countries typically remain siloed in separate sectors, though Tanzania's NM-ECDP, if implemented with fidelity, represents a significant step forward. The NM-ECDP provides a blueprint for strengthening coordination between different public and private sector actors. The program monitors progress and builds in accountability through review meetings at national, council, and community levels. However, implementation of the NM-ECDP strategy is in its nascency and has a long way to go. For example, the mechanism for identifying and hiring highly qualified ECD providers is limited, and equity is not well addressed in the current ECD multisectoral program for nurturing care services in terms of the needs of children in prison, orphans, children in detention centers, those with disability, or those in geographically isolated areas. The health system lacks tools for identifying children with developmental and language delays and there are clear gaps in how stakeholders measure ECD and nurturing care compliance and use data to inform decision-making on developmental milestones and referring children with developmental delays. Capacity to manage a cohesive ECD strategy is lacking, as is support for service providers and caregivers who need training on positive parenting and responsive caregiving. Families lack the knowledge needed to seek ECD and nurturing care services, which limits the ability of communities to contribute to district-level planning.

As noted in the policy section, Mozambique has also adopted an integrated ECD policy framework (PNAC I and II) that encompasses a multisectoral package of services and programs aimed at providing a nurturing environment for young children to thrive. From a decentralized management perspective, the Mozambique team believes that actors understand their roles and responsibilities within their sectors; however, these actors lack an understanding of how to collaborate and act in a multisectoral manner. There are no clear guidelines for multisectoral work, and the lack of clear roles and responsibilities—and true adoption of district-level planning contributions—shows the lack of a cohesive vision and leadership for ECD in Mozambique. Sectors continue to follow their own planning processes and there is little to no collaboration, even at the district levels, to bring the various sectors (that is, health, education, justice, social protection, and nutrition) into a cohesive vision and plan.

As in Mozambique, at the national level Kenya currently lacks a cohesive vision and strong leadership that brings together the diverse areas of ECD and nurturing care, although there has been progress in select counties such as Siaya. Sector plans are developed independently, with health and education focusing on separate areas of ECD (for example, health focuses on stunting and education focuses on developmental delays). At the county level, there are weak referral systems, inadequate understanding of the roles of stakeholders at different levels in the referral system, and a lack of information to support the governance and leadership process.

The availability of high-quality data on ECD is extremely limited in Kenya, Mozambique, and Tanzania. Good governance in any sector relies on access to data to inform decision-makers at all levels about the needs and deficiencies of that sector. For ECD, an area that brings together health, education, and other government social services to support the development of the whole child, access to data is even more important. Although all three governments report on their high-level, sector-specific indicators—such as enrollment in ECE, stunting, and undernutrition—there is an enormous need to develop and collect ECD-specific indicators that can identify gaps, including those related to equity, and measure progress. The Hilton Foundation's investments in population-level child development measurements, such as in recent and upcoming

DHS in Tanzania and Mozambique, respectively, combined with the results from Kenya (which were funded separately), are an important step in the right direction. The HMIS in the three countries include indicators on developmental screening (added partly with support from the Hilton Foundation), but it is unclear whether the indicators are of adequate quality to guide programming. Indicators of other critical measures of nurturing care, including counseling on early learning and responsive caregiving, are not yet included.

Available data are not used effectively for decision-making. Many indicators that policymakers and providers in Kenya and Mozambique collect to inform decision-making around programming, budget allocations, and staffing decisions are rarely used in practice. Government entities rarely share ECD indicators. In Kenya, the HMIS includes indicators on children's growth and developmental monitoring, but data processing, system use challenges, and a lack of clear reporting structures create barriers to using data for decision-making. In Mozambique, the HMIS is relatively up to date on child health indicators and covers several key outcomes, including child growth and development and exclusive breastfeeding. However, the only indicators that play a significant role in decision-making are related to the five-year programs and medium-term expenditure frameworks. Key indicators covered by the current five-year plan include full vaccination, the rate of treating acute malnutrition in children under age 5, key indicators from the DHS, including stunting and child mortality rates and HIV treatment rates. All three countries are now making investments in population-level measurement through ECDI2030, but it is too soon to know how they will use these data.

Integrated management of childhood illnesses: A governance success story from Mozambique

The Integrated Management of Childhood Illnesses (IMCI) is an integrated approach to child survival, growth, and development that aims to reduce mortality in children under 5 years of age; improve the quality, effectiveness, and efficiency of health care; and improve practices that concern the family and the community. IMCI has long been considered the best strategy to help Mozambique reduce mortality among infants and children under age 5—two of the objectives in the government's five-year strategy. The program attracts attention because it is innovative and well structured, and supports children at the systems, family, and community levels. It also clearly defines roles and responsibilities for health professionals and guides collaboration and communication between health facilities and the community.

Tanzania is an example of where policymakers are using data to help drive decision-making. In Tanzania, several information systems collect many salient indicators of child health and nutrition for planning, budgeting, and assessing service providers' performance and human resource and supply needs. However, there are no indicators on responsive caregiving and early learning, and studies have shown that HMIS data quality in Tanzania is weak (Rumisha et al. 2020).

Future investments in integrated data systems, such as the planned NM-ECDP dashboards in Tanzania, combined with greater capacity-building around data management and use could help create more cohesion and vision to bring high-quality, well-targeted integrated ECD services to the forefront of government policy. The dashboards planned under the NM-ECDP will help to create a shared understanding of the status and progress of key ECD indicators.

Multisectoral coordination

Multisectoral coordination is a critical component of accelerating change in a system. This type of cooperation means that the capacity to solve complex problems is distributed across many stakeholders who work collaboratively to find solutions and actions. One example of strong multisectoral coordination is ministry staff, who routinely work together through TWGs and other formal and informal cooperation mechanisms at the national and/or subnational levels. Another example is ministry staff who work closely with the donor community, NGOs, and CBOs to implement policy frameworks, collect and interpret data, cultivate peer learning, and encourage communities to engage with community health and ECD centers, possibly even creating ECD centers that bring together education and health services. Exhibit 11 summarizes the findings from the systems diagnostics related to multisectoral coordination.

Exhibit 11. Multisectoral coordination snapshot, by country

Country	Multisectoral coordination criteria		Summary of status
	Engagement across sectors	Engagement with donors, CBOs, FBOs, community	
Kenya			The systems diagnostic shows there is little cohesive cross-sectoral engagement in ECD. MoH and MoE have mandates to fulfill ECD policy and lead some multisectoral efforts, but the efforts are not coordinated or developed cohesively.
Mozambique			Multiple sectors, including health, education, and social development, implement ECD activities. However, each sector has different roles, responsibilities, and targets pertaining to ECD. There is little budget coordination across sectors, even at the district level, and donors, NGOs, and CBOs tend to focus on specific programs at the local level within a sector.
Tanzania			Tanzania's national government has adopted the NM-ECDP. It defines the roles of stakeholders across levels of government but does not clearly define goals for those stakeholders. There is some collaboration around support for frontline workers through supportive supervisions. The NM-ECDP includes donors but lacks clear mechanisms for budgetary and funding collaboration.

Key: ■ System features present | ■ System features partially present | ■ System features not present
FBO = faith-based organization.

Kenya, Mozambique, and Tanzania are all fostering multisectoral coordination on ECD at some level. ECD in all three countries is part of the national agenda, and in Kenya and Mozambique it is embedded within subnational agendas. All three countries have also delegated and delineated ECD roles and responsibilities to the Ministries of Health and Education, with additional ECD responsibility allocated to the Ministry of Social Development and other subministries in Mozambique and the National Council of Children's Services in Kenya. However, these countries have not fully realized opportunities for cooperation between national and subnational ministry staff; within and between sectors; and with donors, NGOs, and CSOs, and they have little to no engagement at the community level. As a result, a technocratic, siloed approach to problem solving remains dominant across the three countries. The considerable work needed to strengthen multisectoral coordination for ECD in each country represents an opportunity to enhance ECD efforts. The next sections highlight the strengths and weaknesses of the different systems and elaborate on similarities and differences in multisectoral coordination efforts by country.

There are efforts to implement more multisectoral coordination in ECD, but they are nascent at best. In all three countries, the Ministries of Health and Education lead ECD efforts, and other ministries such as the Ministry of Gender, Children and Social Action in Mozambique contribute to ECD programming. At the national level in Kenya, the MoH coordinates advocacy on nurturing care, and the MoE through the National Early Childhood Education Committee (NECEC) coordinates implementation of ECE but there is no lead coordinating agency. With the help of the Hilton Foundation and other partners, Siaya County did implement a successful county-level model of multisectoral coordination on nurturing care in ECD (see inset box), and there are efforts to scale it up to neighboring counties.

In Tanzania, the NM-ECDP outlines stakeholders' responsibilities and coordination planning. The program contains a strategy for resource mobilization and developed the ECD program's organizational structure after consultation with stakeholders, including the Ministry of Community Development, Gender, and Children, the Ministry of Education and Vocational Training, the Ministry of Health and Social Welfare, the Ministry of Social Protection, the Prime Minister's Office, the Ministry of Finance, and the donor community. The current structure does not depend on a few stakeholders but is multisectoral. This makes it less likely to fail across all implementers because a series of committees, including an ECD steering committee, technical committee, and National ECD Secretariat, guide the work, which a panel of staff from the various line ministries engaged in ECD oversees. The hope is that the NM-ECD program will significantly improve multisectoral coordination and that the national coordination will trickle down to local levels. Although the MoH is not as

engaged as it should be as a crucial player, the government is considering elevating the NM-ECDP to a higher office, such as the President or Prime Minister's office, to increase MoH engagement.

In comparison, in Mozambique ECD activities are spread across numerous ministries. Mozambique's PNAC II (2013–2019) provides a framework for multisectoral action toward achieving ECD goals. The PNAC II is a multisectoral plan that the country can integrate with economic and social development plans as well as the financing mechanisms in state institutions and CSO plans, which will help minimize some potential implementation risks. The National Council of Social Welfare (CNAS) coordinates PNAC implementation. For this purpose, it is necessary to strengthen CNAS's human, material, and financial resources so it can fulfill its roles in monitoring, evaluating, and disseminating information about PNAC II implementation. Even with the coordination through CNAS, integrating the system will require more work. For example, the health sector focuses on children from birth to age 18 and aims to monitor growth, provide vaccinations, ensure adequate nutrition, integrate disease management, and facilitate access to HIV diagnosis and treatment. The role of the education sector, for preschool-age children (birth to age 5), directly aligns with ECD priorities and includes implementing the Pre-School Education Program, which aims to stimulate children's physical, mental, and intellectual development and prepare them for school activities. However, just 4 percent of eligible children are enrolled in the program, due in part to underfunding, lack of human resources, and poor infrastructure. The Ministry of Agriculture and Rural Development oversees food security, which links to the nutrition of children from birth to age 3. In addition, the Child and Social Welfare sector is planning to tackle ECD-related issues, including the implementation of minimum child care standards, provision of social assistance for vulnerable populations, and the promotion and expansion of access to ECE for children ages 2 months to 5 years.

Each country has a different network of governmental and nongovernmental stakeholders involved in the ECD space. Stakeholder networks and cooperation among and between them often include TWGs. For example, Tanzania's new national TWG for ECD will work alongside the National Multisectoral ECD Program to improve cooperation between ECD stakeholders. The national ECD TWG is expected to cascade its efforts to the subnational level in the future; however, plans to build capacity across stakeholders are ongoing. In Kenya, there are several multistakeholder TWGs focusing on elements of ECD, including the NECEC TWG, the County Early Childhood Education Committee (CECEC), and the ECD Policy TWG. Although these TWGs represent important stakeholder coordination networks for ECD, it is unclear whether they coordinate with one another, and they have yet to produce any notable outcomes. The advocacy strategy on nurturing care is still awaiting validation and mobilization of county governments under CECEC is stalled. In Mozambique, multisectoral stakeholder groups exist but they do not discuss the specific aspects of children ages birth to 3. However, the working groups focus on issues within the scope of the Multisectoral Plan for the Reduction of Chronic Malnutrition and actions that different sectors can implement to achieve the plan's objectives. Mozambique also has a network of CSOs (see the system stakeholder map) that work on ECD issues.

Kenya, Mozambique, and Tanzania all have active donor, NGO, and CSO communities, but there is little coordinated ECD programming among these organizations. Although donor, NGO, and CSO communities are active in the ECD space in each country, cooperative arrangements between these groups and national and subnational government entities often occur within TWGs, through the financing of specific programs and services. In Kenya, donors play a key role in financing ECD programs and projects as well as steering ECD agendas as active members of ECD TWGs. There are also several networks of actors operating outside of government-led structures that are pushing for improved ECD in the country; these include the ECD Network for Kenya, UTHABITI Africa, and the Samburu ECD TWG. In Mozambique, donors also play a key role in financing ECD programs and services. They are members of TWGs in the health and nutrition sectors and other ECD-related sectors. They also play a key role in policy formulation, as well as the development, implementation, and monitoring of plans, strategies, and programs. CSOs are involved in advocacy for better policies and strategies for ECD as well as resource mobilization and implementation of ECD services. There is also a Network for the Development of Early Childhood, which aims to contribute to improving and ensuring the holistic development of children in early childhood in Mozambique through advocacy and sharing of evidence and knowledge among different actors. In Tanzania, TECDEN

(Tanzania Early Childhood Development Network) is responsible for helping to align ECD stakeholders and harmonize the implementation of ECD activities under NM-ECDP.

Countries lack vision and planning for multisectoral coordination. Although governments are establishing policy documents, plans, and programs for ECD led by with national governments, vision and strategic planning for multisectoral coordination to achieve ECD targets remains stagnant. This stagnancy is evidenced by the lack of coordination between levels of government and associated ministries in all three countries. Multisectoral and interdisciplinary TWGs and advocacy networks exist in Kenya, but they have not greatly increased the implementation of multisectoral ECD programs. In Tanzania, the national ECD TWG has only just formed, so it remains unknown how this program will support multisectoral coordination or ECD advancement. In Mozambique, the PNAC II provides a framework for multisectoral coordination that will integrates ECD actions with the medium-term expenditure framework and in the government's Economic and Social Plan. However, the sectors and their associated ministries focus on their own objectives and identify their priorities based on the government's five-year strategic plan.

Stakeholders do not fully recognize the opportunities for multisectoral coordination. With each ministry working on its own objectives, opportunities to collaborate on ECD efforts, including communication, program integration, resource pooling, data sharing, and engagement with an ECD workforce, remain underdeveloped.[1] Despite national ECD policies and plans and built-in cooperation mechanisms within government, low levels of coordination for ECD in each country impede integration of ECD planning, funding, and service delivery. For service delivery, across all three countries, there is no evidence of cooperation among ministries (that is, the MoH and MoE that are most responsible for ECD services to children ages birth to 3 years and 5 to 7 years, respectively) for delivery of ECD services or coordination to improve the ECD workforce. Likewise, financing mechanisms for ECD-relevant sectors remain siloed. There are no known governmental mechanisms for pooling ECD funds (see the section on financing).

In all three countries engagement around ECD is similarly siloed at the community level. For school-age children, the education sector often conducts engagement, mostly via teachers. In Kenya, the ECE policy requires the education sector to involve community boards of management and parents teacher associations. However, in practice, these entities are not functional, especially in public preprimary schools. Kenya, Tanzania, and Mozambique do not have ECD-specific coordinating structures for effectively reaching communities, collaborating with them to improve ECD, or raising up local voices to demand ECD services from higher levels of government. Existing structures for community engagement, like local health centers in Mozambique, or HMBs or FMBs in Kenya, could potentially help coordinate

Multisectoral coordination in Siaya: A success story from Kenya

The county government of Siaya, through the Smart Start model, utilizes a whole government approach to provide a nurturing care environment for children birth to 5 years old. The model focuses on strengthening systems, structures, and processes. Smart Start acknowledges that opportunities for nurturing care exist across sectors such as education, agriculture, civil registration, national government administration, and social and child protection, which are all important for the continuity of support for ECD. The Smart Start model evolved from the understanding that service delivery alone without support to strengthen government leadership and accountability fails to achieve sustainable high-quality coverage. The model further acknowledges that aligning with and embedding into government processes and structures are critical to building government capacity and leadership for the delivery of sustainable nurturing care for ECD. The actions taken to scale up nurturing care for ECD in Siaya include (1) strengthening leadership capacity and advocacy to lead and invest in nurturing care, (2) strengthening coordination by establishing an integrated multisectoral coordination committee, (3) creating a policy environment that supports nurturing care of young children, (4) strengthening performance of existing systems by integrating nurturing care into service delivery platforms and strengthening linkages with other efforts, and (5) engaging innovative advocates to drive change among other strategies.

[1] Except for cooperation efforts within TWGs and ECD networks.

ECD services, but these are dwindling in number and focus on health, so they are not ideal platforms for multisectoral ECD coordination to enhance community input.

Low levels of awareness of ECD concepts and systems among communities exacerbate efforts to engage local NGOs and CBOs in multisectoral coordination. CHWs and teachers work directly with children and their families, but communities and caregivers do not clearly understand the concept of nurturing care for ECD and the recommended actions and associated services. As a result, demand for and use of ECD services are low and practices that put children at risk of developmental delays continue. This is the case in Tanzania and Mozambique, where ECD information and services are severely limited and public exposure to and knowledge of ECD, including core concepts for nurturing care, are low. The low level of knowledge likely affects district planning efforts, keeping ECD plans siloed within sectors. Locations in Tanzania where communities and caregivers have been exposed to ECD concepts saw a surge in demand for services. It is difficult to garner community support for ECD without community awareness of it, making ECD knowledge-building activities a strategic priority for improving community cooperation. In Kenya, communities associate ECD mostly with ECE, and less with children's health, nutrition, and responsive caregiving.

Financing

Having strong financing structures in place is also critical to accelerating systems change. Countries with strong financing systems (1) have transparent budgeting processes (including at the community level); (2) prioritize funding the primary care (including CHWs), early childhood education, and social welfare systems that provide most nurturing care services; (3) base funding and allocation decisions on measured program costs; and (4) closely monitor performance in terms of cost-effectiveness, cost-efficiencies, and equity, and tie it to funding decisions (this is also a form of governance). Strong systems also offer resources for implementing localized innovations and scaling them if they are successful. Exhibit 12 summarizes the status of financing and accountability across Kenya, Mozambique, and Tanzania.

Exhibit 12. Financing snapshot, by country

Country	Financing criteria				Summary of status
	Clear budgeting structure	Financing adequacy and timeliness	ECD-focused plan costing	Performance monitoring for financial accountability	
Kenya					Financing is fragmented across sectors and between the national and county levels, and disbursement is often delayed and diverted to other purposes. Financial accountability measures largely exist on paper.
Mozambique					Financing in Mozambique is especially opaque, but what little is known is that financing is inadequate to implement existing ECD-related plans and policies. Financial accountability is tied to government five-year plans.
Tanzania					Tanzanian financing for ECD-related services is inadequate and depends on donor contributions, and the process for government budgeting and disbursement is especially slow. Delays to allocation and disbursement may threaten full implementation of the NM-ECDP.

Key: ■ System features present | ■ System features partially present | ■ System features not present

Financing for ECD-related services faces several cross-cutting challenges that are present to varying degrees in the three countries. First, there is little to no evidence of the cost-effectiveness of nurturing care for ECD in ESA, especially in terms of the long-term economic benefits. Without this evidence, it is difficult to communicate concretely the benefits of investing in early childhood services to stakeholders at the national, subnational, and community levels (including caregivers). Moreover, even if stakeholders fully understood these benefits, the fact that they largely accrue long in the future puts nurturing care services at a disadvantage politically. Finally, the inherently multisectoral nature of ECD programming means that the budgets supporting these programs are especially fragmented and difficult to track, coordinate, and align across sectors. This is true of both local government and donor funding. The text below compares financing in ECD-related sectors across the three target countries.

Budgets for services serving young children are deeply fragmented across different funding streams, ministries, and funders. Across all three of the target countries, governments do not have designated budgets or tracking mechanisms for ECD-related services and programs, which makes it difficult to identify, oversee, and use public spending for ECD services. For example, health financing—the primary funding stream for ECD-supportive services in Kenya—falls into different categories of funding. Health care funding comes through health insurance, block grants from national to county governments, NGOs and FBOs, donors, and private firms. There is no designated ("ring-fenced") government budget for ECD-related services at the national or county level. Funds for devolved functions go to the county governments without clear guidelines on how much to use for ECD services. The county government, through public participation, prioritizes what to fund and how much to allocate to ECD-related services. Through this process, ECD services are the least likely to be prioritized compared to giving bursaries to students in primary and secondary schools. Hence, ECD-related services need ring-fenced funds within the different sectors. In Mozambique, there is a lack of information on funding even for broader groups of services that encompass ECD, much less ECD-specific services. In general, health care funding is allocated to different levels of care (for example, different types of facilities) rather than types of care (such as maternal and child health). For this reason, it is difficult to obtain information on resources per health facility apart from district, provincial, and central hospitals, which correspond to less than 10 percent of all public health facilities. Even when line ministries agree to fund ECD-related services within their own budgets, it is difficult to identify such expenditures in publicly available budget data. In Tanzania (as in Mozambique), there is lack of specific budgeting cost centers for ECD activities, which makes financing levels for different ECD services hard to quantify. The lack of a single, designated entity to coordinate on ECD has also contributed to inadequate partner support to the government for implementation of ECD-supportive activities.

Focusing on the primary health care system, which is the most common point of service delivery for children ages birth to 3 and their caregivers (and thus the best proxy for ECD financing), we find that financing levels are generally inadequate to meet targeted standards of care. Moreover, the health system is plagued by delays in disbursements that affect quality and timeliness of care. In 2017, government primary health expenditure ranged from $9 per person in Mozambique to $42 in Kenya, had grown little for nearly a decade, and disproportionately went to curative care and administration rather than preventative care (Institute for Health Metrics and Evaluation 2022; Exhibit 13). Moreover, multiple steps and long time periods between allocation, disbursement, and spending affected critical services.

Kenya's health sector relies heavily on out-of-pocket payments, which are highly regressive and inequitable. There have been attempts to mitigate the underfunding challenges through the formation of the Kenya Health Care Federation's health care financing committee to work on mitigating health care financing issues. Disbursement delays from the national treasury and administrative capacity constraints often undermine budget implementation. Meanwhile, in Mozambique's health sector, the distribution of funding is based on the sector's responsibility under the government's five-year program. The evaluation team will collect more tailored and up-to-date measures of ECD and primary health care budgets for each country (and expenditures, when possible) during implementation of the measurement frameworks.

Costed ECD plans and strategies may help government entities determine the resources they need to fulfill their ECD nurturing care objectives. However, the plans that exist are in their infancy. There are no national-level ECD-focused costed plans in Mozambique or Kenya to take ECD services to scale nationally, or the resources are not allocated specifically

to children ages birth to 3 years. In contrast, Tanzania's NM-ECDP explicitly identifies the resources needed to achieve its long-term objectives.

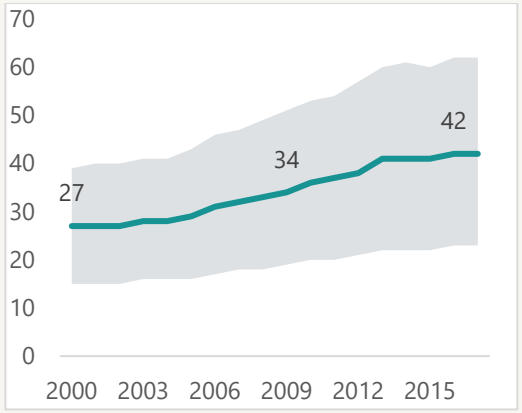
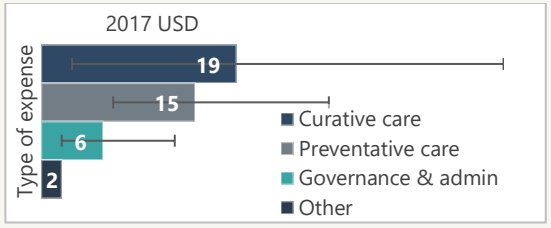
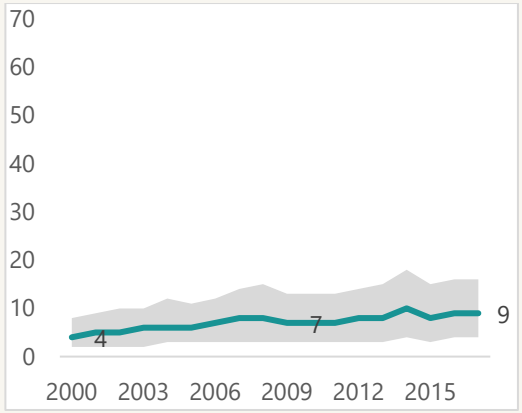
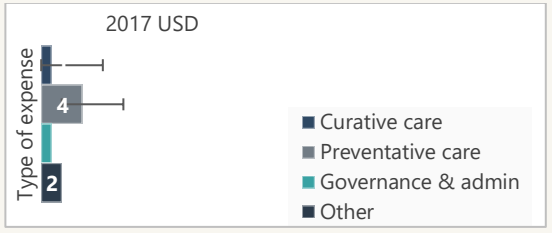
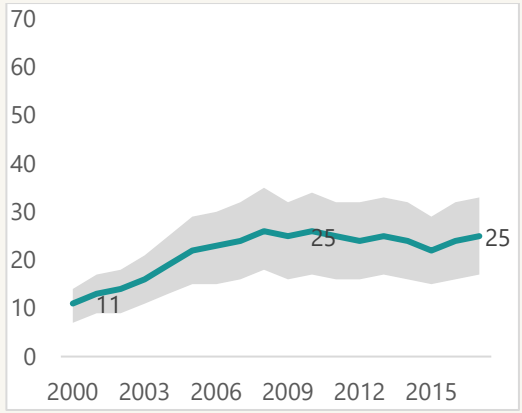
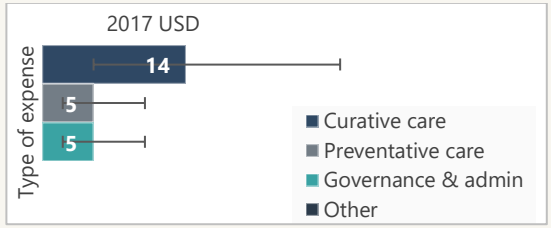
Systems designed to monitor performance and promote financial accountability are not implemented. Kenya's public planning and budgeting framework has incorporated a detailed routine performance monitoring system that supports all government sectors at the county level to undertake a comprehensive annual performance review based on a predetermined set of indicators. The findings from the performance review are supposed to inform priority setting, target setting, and resource allocation for the following financial year. In practice, however, county sectors rarely conduct or conclude the annual performance review, and places that do conduct it rarely use the findings to guide priority setting and resource allocation. Mozambican line ministries produce reports on performance that contain information on the indicators and targets assigned to each ministry in the five-year government program, but there are no specific indicators for children ages birth to 3 to inform use of funds, procurement, or access and efficiency. Theoretically, ministries use performance information to allocate resources, but in practice, other variables govern resource allocation decisions, namely the government's five-year program, the medium-term expenditure framework, the availability of funds, and each sector's ability to negotiate with elected officials for additional funds. The main criteria for allocating resources are to achieve equity and reduce differences in key social indicators.

Local communities have mixed levels of awareness of financing for ECD-related services across countries. In Tanzania, councils inform local communities about the agreed activities and budget allocation for these activities through local community meetings. However, in Mozambique, communities do not receive any information about funding and allocation decisions for any services. In Kenya, the Public Finance Management Act requires county governments to publicize annual budgets, but these are rarely accessible in public portals and, even if they were, the lack of designated funding lines for services focused on young children would hardly help to make resource allocations for these services accessible to communities.

There is limited effort to fund and implement local innovations that support nurturing care for ECD, possibly because of limited local awareness. Although devolution in Kenya has expanded local-level participation in processes to allocate public sector resources, in practice, county-level local leaders tend to prefer investing in visible hardware projects such as buildings and equipment at the expense of improving service delivery systems and other aspects of care that are not public facing. In Mozambique, the health sector and other relevant sectors have some discretion over finances to innovate, but within the limit of the sector budget and to finance activities aimed at achieving the objectives of the government's five-year program. In Tanzania, district, or council plans for the respective sector (health or education) include plans for ECD and nurturing care, and councils have discretion over plans and budgets. However, fund allocation depends on government priorities and available funds.

Sustainable financing for CHWs, a key way to incentivize rollout of nurturing care services to all communities, varies within and across countries. For example, in Mozambique, CHWs receive stipends only through external partners. In Kenya, some receive a small token of appreciation from partners or county governments—usually about 2,000 to 3,000 shillings per month ($16 to $24). In Tanzania, the government is implementing payments, but this process is likely to take time and may threaten the implementation of plans under NM-ECDP that rely on the motivation of CHWs.

Exhibit 13. Health expenditure snapshot

	Kenya	Mozambique	Tanzania
Government expenditures	 • From 2012 to 2017, estimates of government primary health financing per capita in Kenya remained flat at about $41 or $42 per person. • Nearly half of government primary care expenditures went to curative, rather than preventive, care and an additional $6 was spent on governance and administration. 	 • Estimated government primary health expenditures in Mozambique were just $9 per person in 2017. In real terms, spending remained flat from 2012 through 2017. • Nearly half of the primary care expenditure was spent on preventative care. 	 • Estimated government primary health expenditures in Tanzania hovered around $25 per person and remained stagnant in real terms from the mid-2000s through 2017. • Only $5 was spent on preventative care—the same amount that was spent on governance and administration. 
Other sources of health expenditure	• Government spending is supplemented by average out-of-pocket and private insurance costs of nearly $40 per person. • Donor contributions translated to about $19 per person, excluding administrative costs to donors.	• The average Mozambican paid an additional $4 out of pocket. • The global aid community contributed approximately $22 per person, although this remained flat until the beginning of the COVID pandemic.	• The average out-of-pocket expense is $9 per Tanzanian. Prepaid private costs (largely insurance) are not a significant factor in Tanzania. • The global aid community's contributions translate to about $16 per Tanzanian.

Source: Authors' analysis using publicly available data; Institute for Health Metrics and Evaluation 2021a, 2021b.
Notes: All estimates are for 2017 (the most recent year for which both government and other expenditure data are available).

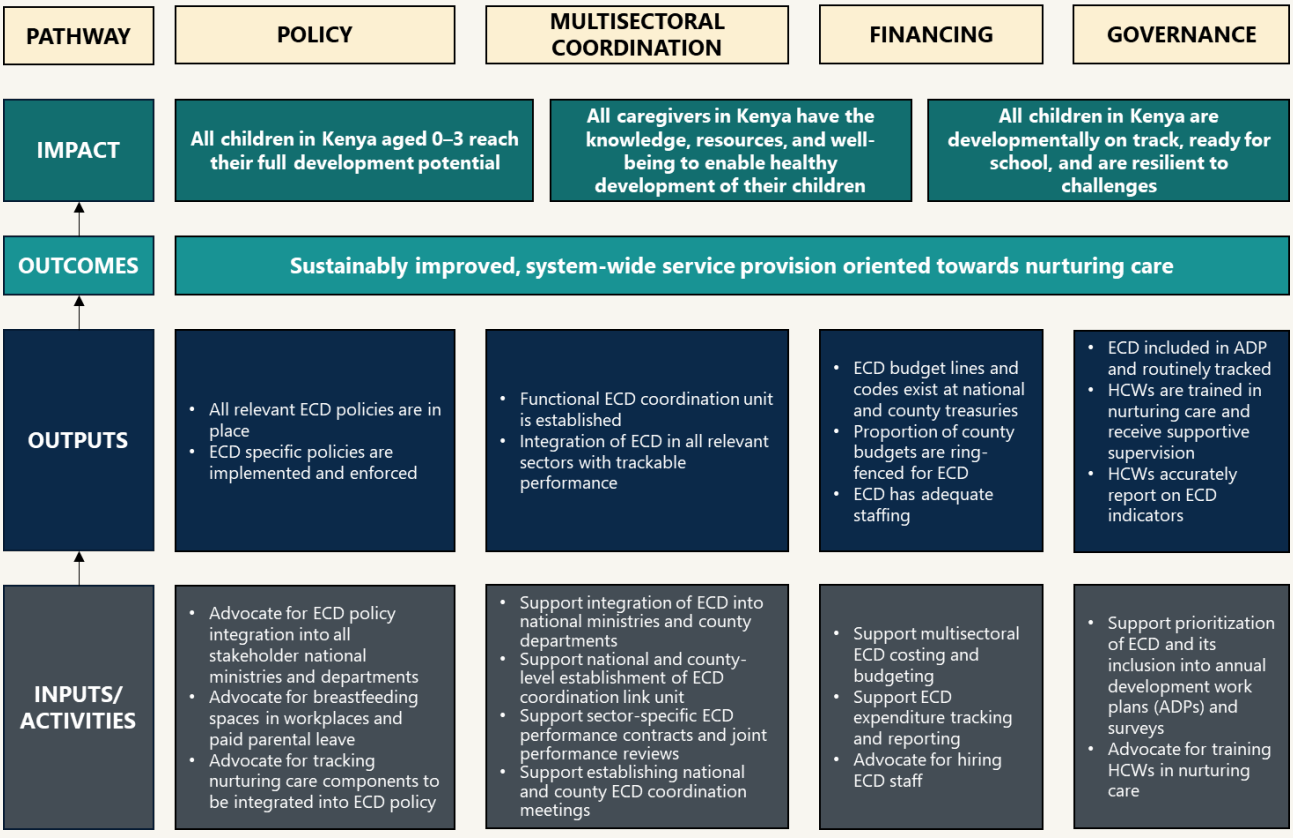
V. Country-Level Theories of Change

The Hilton Foundation and local stakeholders believe that their investments in ECD can help shift the related challenges and improve children's health and educational development. Based on the systems diagnostics, each country team identified the key strengths and weaknesses in their system across the four dimensions. To address the weaknesses and information gaps they identified, country research teams developed measurement frameworks, including country-level ToCs and tailored, systems-level indicators linked to activities and outputs within their ToC. These frameworks will drive the next phase of learning activities under this project and help move stakeholders toward a more cohesive and integrated approach to ECD. This section depicts the proposed ToC for each country. More information can be found in the country-specific measurement frameworks, which the Hilton Foundation is currently reviewing.

Kenya

The Kenyan partners for this project, working with local stakeholders, believe that investments in a variety of activities and inputs focused on policy, multisectoral coordination, government, and financing will lead government officials to include ECD in annual development plans, develop ECD policies at the national and subnational levels, produce a cadre of trained CHWs who are equipped and incentivized to provide nurturing care services and accurately report ECD indicators, and establish a functional ECD coordination unit within the government. They hope that investments in policy and financing will also lead to ring-fenced funding, which will contribute to the sustainability of ECD activities. If these inputs and outputs are successful, the ToC posits that (1) all children ages birth to 3 will reach their full developmental potential; (2) all caregivers in Kenya will have knowledge, resources, and well-being to support their children's development; and (3) all children in Kenya will be developmentally on track and ready for school. Exhibit 14 provides a detailed overview of Kenya's ToC.

Exhibit 14. Theory of change for Kenyan ECD systems



Source: ECD Network for Kenya.

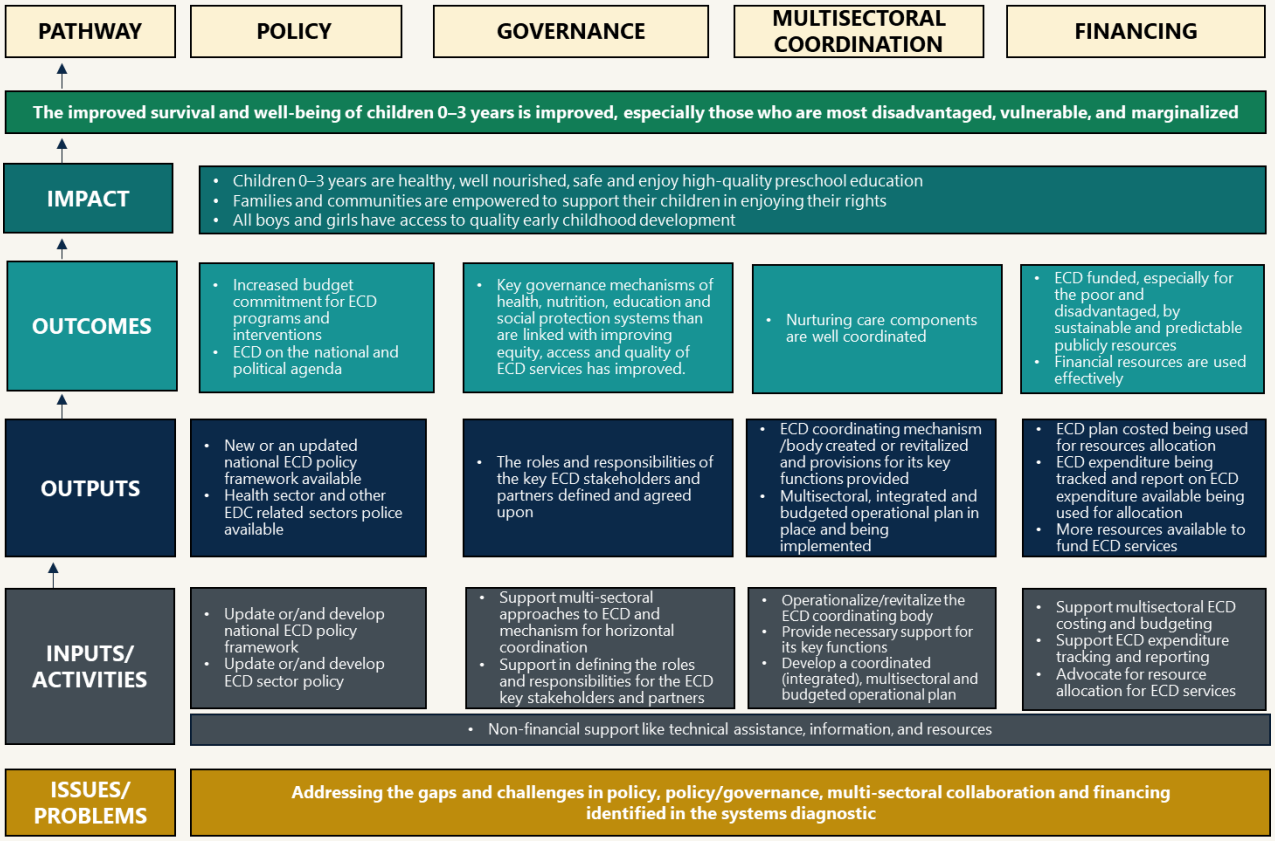
Mozambique

Despite progress in improving children's well-being in the past few decades, children—especially those in the most disadvantaged, vulnerable, and/or marginalized groups—are facing poverty, violence, exploitation, risk of malnutrition, and lack of access to quality education and health and nutrition services. In addition, weaknesses or gaps in the definition and updating of ECD policies, the governance of ECD systems, intersectoral coordination, and funding and budget allocation for ECD programs aggravate this picture. Similarly, there is no common understanding of what ECD is and how best to provide ECD services. KixiQuila believes that investments to improve the areas indicated above could generate changes in ECD systems and improve the survival and well-being of children ages birth to 3 years. The aim of ECD is to improve the survival and well-being of children through strengthening the systems for providing high-quality, holistic ECD services. The ToC outlines the various steps toward achieving the overarching goal of improving the well-being of children, primarily those in vulnerable and marginalized situations.

The ToC begins with several key assumptions that explain why and how the steps in the ToC achieve impacts and outcomes. The assumptions include the creation of a conducive environment that allows for the sustainability of partners in the economic, political, and social spaces. It also includes grounding in human rights that brings in effective ways of changing the lives of children by focusing on developing their holistic well-being. The final assumption focuses on implementers, families, and community as change agents.

Establishing the policies, strategies, and plans makes it possible to clearly define the roles and responsibilities of all ECD stakeholders and the governance of the coordination. Improving the ECD governance will facilitate and improve the coordination. Achieving the outputs will help (1) put ECD on the national and political agendas and enable it to receive more financial resources, (2) improve key governance mechanisms, (3) improve coordination for nurturing care components, and (4) provide adequate funding for ECD services from public resources. Exhibit 15 shows the pathways for Mozambique's ToC.

Exhibit 15. Theory of change for Mozambican ECD systems

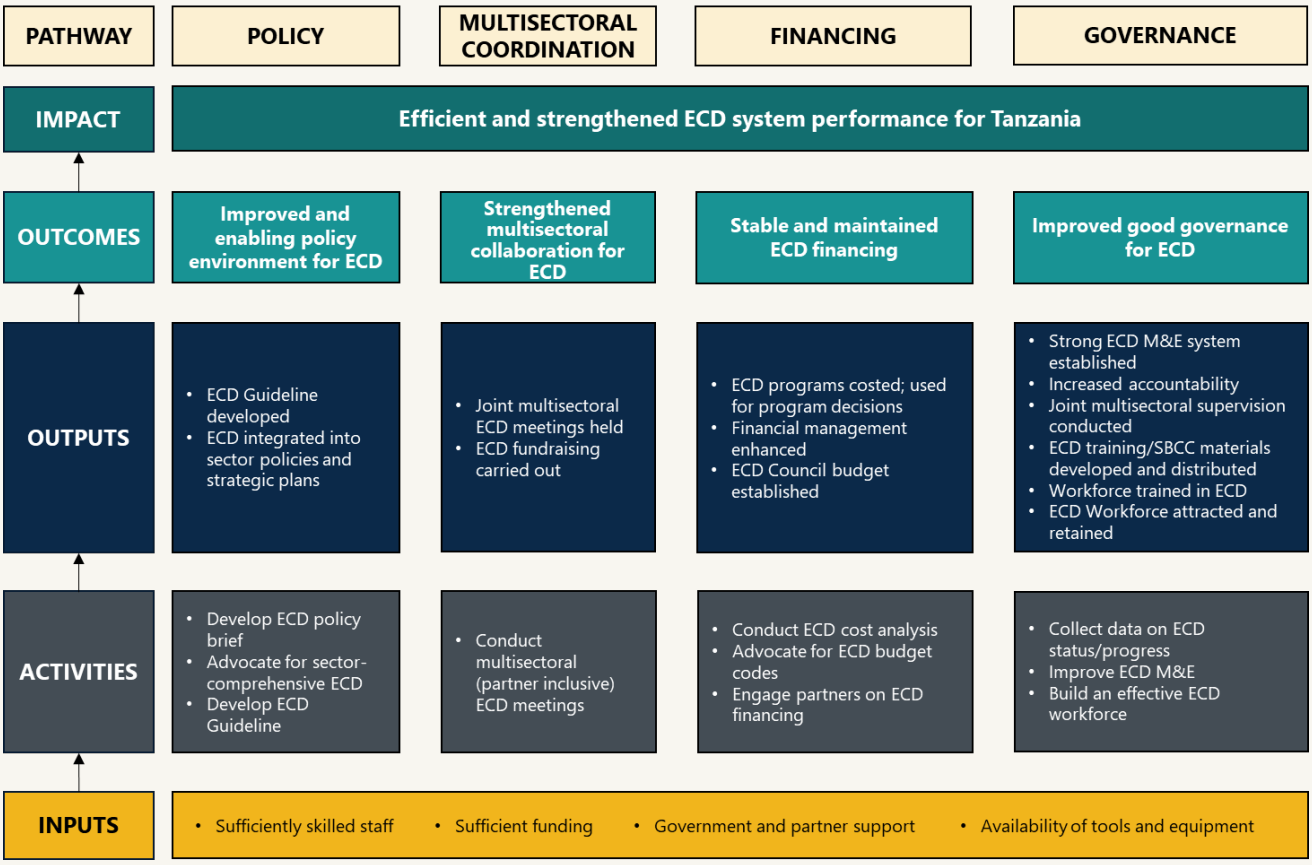


Source: KixiQuila Consultoria.

Tanzania

Based on the findings from the systems diagnostic in Tanzania, the partners developed a ToC to drive their activities over the next 10 months. Their ToC posits that if the government and donor community invest in building the capacity of staff, provide sufficient funding, garner sufficient support, and develop and implement monitoring tools, then the country can build an efficient and strengthened ECD system. At the policy level, activities that help move toward the efficient system include developing ECD guidelines and advocating for comprehensive strategies in ECD. These activities benefit from the multisectoral partner meetings, engaging partners on ECD financing, conducting cost analysis, and even creating and advocating for ECD budget codes that track spending across sectors. If these activities are successful, then one would expect to see (1) an improved and enabling policy environment for ECD, (2) a strengthened multisectoral approach and collaboration among stakeholders, (3) stable and long-term funding for ECD, and (4) improved governance and management of the system. Exhibit 16 presents Tanzania's TOC based on identified needs and gaps from the systems diagnostic.

Exhibit 16. Theory of change for Tanzanian ECD systems



Source: Ifakara Health Institute.

VI. Lessons Learned by the Systems-Level Evaluation Teams

Kenya. The team in Kenya found the process to be a significant learning experience. Through conducting the systems diagnostic and developing the measurement framework, they learned to see the world through more of a systems lens, in the sense that the individuals and the entities they interact with daily are part of a system and decisions made at all levels of the system affect the services provided to children. Moreover, the process identified the important role the public plays in determining implementation and holding the system accountable, but most people lack the knowledge to exercise their voice and choice regarding ECD.

Mozambique. The team in Mozambique noted that conducting the systems diagnostic helped them take a snapshot of the ECD system and identify the existing systematic gaps. The instrument enabled the team to observe the various concepts of ECD among different sectors and the associated documents that delineate the responsibilities of each sector and the coordination mechanisms. However, the challenge of implementation persists in Mozambique. The current snapshot will serve as an advocacy tool for improving understanding about ECD, which will contribute to facilitating complementarity and sectoral accountability. The team noted that, if they were to repeat the systems diagnostic, they would change two main elements. First, they would adapt the instrument to make it shorter and clearer for stakeholders to use. The team felt that the instrument was repetitive and needed to be further adapted to the Mozambican context. Second, they would include more key informants to clarify the gaps found in ECD policies, plans, and strategies and explore in depth their perceptions of ECD. In addition to decision-makers and implementers from the public sector and civil society, the key informants would also include partners, especially those who have influence on decision-making in the various sectors of government. Phase 2 will include key informant interviews to gather qualitative information on gaps and the learning questions the team in Mozambique identified.

Tanzania. The team in Tanzania noted that developing a ToC was the most exciting and valuable assignment over the course of the project. The team oriented participants to key steps and components of the ToC and explained the difference between the logical framework and the ToC. They gave participants an opportunity to develop a simple ToC and later a more complex version. The team then tasked everyone with developing a systems-level ToC, which they shared back with the team. This activity infused new energy into the research team and their government partners and helped to build a new and deeper understanding of the relationship between ongoing research activities, the activities of the government, and the objectives for investing in ECD.

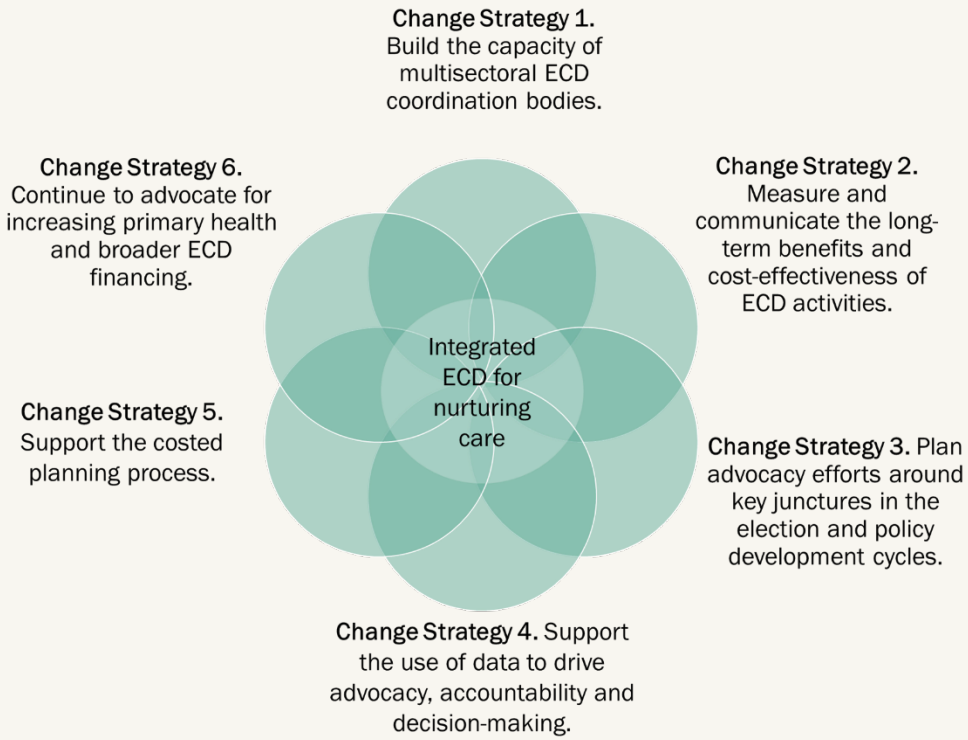
VII. Potential Change and Investment Strategies

Change strategies are plans that help organizations do something different. These plans describe certain ways that policies or the way of doing business differ or how strategies and activities can help catalyze change for the future. The systems-level evaluation team reviewed the systems diagnostics, systems maps, and ToCs for each country and identified change and investment strategies that can best address the ECD systems-level gaps and weaknesses they document. These recommendations were initially focused on the Hilton Foundation's portfolio and engagement in ESA, but also have broader relevance for other stakeholders involved in ECD, including global donor organizations, researchers, and NGOs and CBOs, especially those engaged in advocacy.

Summary of proposed cross-country change and investment strategies

Financing and multisectoral coordination emerged as the two areas that need critical support and change across Kenya, Mozambique, and Tanzania. We developed a series of change strategies that can be adopted by the donor, research, advocacy, and service delivery organizations (including the Hilton Foundation and their partners) to support the further development of these areas, while still informing policy and governance. This section discusses six cross-country change strategies as well as several country-specific recommendations.

Exhibit 17. Proposed cross-country change strategies



Change Strategy 1. Build the capacity of multisectoral ECD coordination bodies.

The systems diagnostics across all three countries showed a clear gap in local capacity to design, implement, and formatively assess ECD systems through a multisectoral lens. Global and national actors should address this gap by continuing to build local capacity through training and capacity-building in multisectoral strategic planning. These efforts should include national and subnational governments, ECD-responsible ministries, and ECD-relevant stakeholders, including donors, NGOs, CSOs, national ECD networks, and local education, health, and community leaders.

Change Strategy 2. Measure the long-term benefits and cost-effectiveness of ECD activities and communicate results to caregivers and policymakers.

The fact that ECD benefits largely accrue in the future puts it at a disadvantage in budget negotiations involving trade-offs with other requests that offer more immediate economic and political payoffs. This situation is regrettable because the benefits of ECD investments are greatest for disadvantaged children and caregivers. Research that provides a full life-cycle perspective on the economic and other benefits of nurturing care within ESA can help to make the case for these investments, for all children, especially those who will benefit the most. However, because longitudinal data collection is best suited to measuring benefits that can take decades to manifest, in the nearer term the research and donor communities could also invest in more cross-sectional studies and innovative methodologies that examine shorter-term benefits, including the cost-effectiveness of investments against short- and middle-term outcomes.

Change Strategy 3. Plan advocacy efforts around key junctures in the election and policy development cycles.

Changes in (or preservation of) ECD-related policies, strategic objectives, and measured indicators across all three countries are tied to critical junctures, namely elections, and the subsequent development of platforms, strategic plans, and corresponding national measurement frameworks. Mozambique is an extreme example where the five-year programs define the policy goals and the key indicators the government will use to measure its progress (with minimal deviation) for a half-decade. Advocacy plans should consider these time frames and explicitly account for them to have the greatest impact on policy. Advocacy plans can include multiparty advocacy efforts ahead of election years, more targeted engagement of funders during key periods in policy development, or strategic identification of ECD champions whose influence is likely to last over several cycles. The research and advocacy communities should plan to share and disseminate key studies and policy briefs throughout key policy cycles and elections to help inform stakeholders about the importance of an integrated approach to ECD and nurturing care.

Change Strategy 4. Support the use of data to drive advocacy, accountability, and decision-making.

The availability and quality of data to inform decision-making for ECD is improving rapidly, thanks in part to the support of the Hilton Foundation. One important step is the availability of population-level child developmental outcomes data through the ECDI's inclusion in the most recent DHS. These data are critical for understanding the current state of child development across countries and provide important insights about equity in child outcomes and factors that support or hinder that development. Another important development is the WHO's ongoing validation of the Global Scale for Early Development tool across various settings. The validation will pave the way for use of the tool in these countries as a way of measuring and tracking the development of children from birth to age 3.

However, there is still a shortage of high-quality data on individual child development outcomes as well as challenges using data to inform decision-making on a continuous basis. The research and donor communities should continue to support data use by supporting integration of child development indicators into HMIS and education data systems and provide capacity-building to improve data quality and teach government leaders to use these data for decision-making. Inputs should come from health facilities, clinics, and ECE centers and should link in a coordinated manner to provide multisectoral coordination groups with data on the status and needs of communities.

Change Strategy 5. Support the costed planning process.

Costed implementation plans are a critical missing link between establishing policy goals and financing and, in turn, achieving those goals. Costed plans can be an important input to help donors, the government, and other funders advocate for increased investments in ECD and nurturing care. Global and national ECD communities, including donors, NGOs, and researchers, should continue supporting costed planning by governments to help ensure sustainable integration of ECD programming into broader funding streams and service delivery mechanisms. This change strategy can be part of Change Strategy 1 (increasing capacity to develop multisectoral costed plans).

Change strategy 6. Continue to advocate for increasing primary health and broader ECD financing.

One of the most consistent findings from the systems diagnostic process is the role of government resource constraints in limiting the implementation of the policies, governance structures, and multisectoral coordination bodies that already exist in the three countries. Continued, growing, and collaborative investments on the part of both country governments and donors are critical to overcoming key constraints and barriers in the realizing of nurturing care.

Country governments will ultimately need to increase investments in the health sector, and in particular the primary health care service provision systems that serve as critical touchpoints for young children and their caregivers. One focal point of advocacy may be the 2001 Abuja Declaration, which contains commitments to spend 15 percent of the national budget on the health sector. All three ESA countries are signatories, and though all three have made progress in their absolute levels of health investments since 2001, none of them has achieved that goal, and Tanzania's health expenditures have fallen relative to the national budget since the early 2000s (WHO n.d.). Although achieving that 15 percent threshold will not by itself be transformative, the Abuja Declaration continues to serve as a powerful common goal, a tool for advocacy, and a path to more sustainable ECD financing through reduced donor dependency. Donors, meanwhile, should still play a role in continuing to invest in ECD programs and activities. To promote sustainable change, advocacy for additional donor funding for ECD should emphasize partnering with governments and integration of any programming and capacity-building within existing systems. Agreements to match national (or county-level in the case of Kenya) allocations or expenditures is one potential avenue of donor support that may both complement and induce additional government spending. This strategy builds on the evidence being developed under Change Strategies 1 and 3, the costed plans discussed under Change Strategy 5, and the role of advocacy and stakeholder engagement that runs across all the other strategies.

These six overarching change strategies together will continue to help the ECD communities in ESA progress toward promise of nurturing care for ECD. Below we provide additional recommendations for county-specific investments that align with the gaps in the systems diagnostics.

Kenya

As discussed in this report, Kenya has made strides in its ECD policies. Implementing nurturing care for ECD has had significant success in Siaya County, but efforts to scale this approach are still ongoing and the systems diagnostic shows that there is a lack of integration among the different ECD policies and little systemic implementation of nurturing care at the national level. To improve the ECD system in Kenya, Kenyan ECD community and global donors and researchers working in Kenya should focus on the following areas that will contribute to helping stakeholders create a more cohesive ECD system:

1. **Provide technical assistance and support to subnational and local entities that are best able to educate the public about the importance of nurturing care.** A recent analysis found that health and nutrition are widely incorporated into the national- and county-level plans and policies, but nurturing care—including early learning, responsive caregiving, and safety—remains a gap in the ECD system (Abboah-Offei et al. 2022). Global donors including the Hilton Foundation and international organizations such as UNICEF with the power to convene key government stakeholders should leverage existing investments in research and evaluation by sharing documents aimed at various stakeholder audiences (from community- to national-level entities. The systems mapping process indicated that sensitizing subcounty health management teams and local community health committees is another promising, but potentially untapped, avenue for raising awareness and supporting implementation of local-level nurturing care services in Kenya.
2. **Provide resources and technical support to institutionalize the training of frontline providers on nurturing care.** When local health centers understand and prioritize nurturing care, their staff can train others, either informally or through more formal supportive supervision—or relocate to other facilities, bringing with them the perspectives and understanding around nurturing care. This process leads to the expanded take-up of nurturing care and contributes to long-term sustainability of ECD throughout the system. Donors and international organizations should continue to make systems-level investments in technical capacity, meaning that they work within existing structures that train and deploy frontline workers and across levels of government and government sectors. They should also support development of normative tools and practical guidance that can be implemented at scale and with fidelity.

3. **Ground efforts within the constraints and opportunities of the devolved system structure.** Decentralized systems have many strengths and weaknesses to account for when trying to scale-up successful interventions. In devolved systems, people at each level in a county must "get it, buy it, and implement it" for scaling to work. In devolved systems, it is important to ground interventions within the constraints and opportunities in the system. Reaching consensus on opportunities and challenges among the stakeholders at all levels can guide the development of plans and initiatives that reflect and respond to local needs.
4. **Advocate for and support adoption of the new, draft ECD policy.** Kenya is in the late stages of adopting a new, national multisectoral ECD policy that, unlike its 2006 predecessor, the health sector oversees and that explicitly employs the nurturing care framework. Stakeholders, including civil society, international organizations and donors should advocate for and support the adoption and implementation of the ECD policy and establishment of strong governance and financing systems and multisectoral coordination bodies that can support robust and sustainable implementation.

Mozambique

The Mozambique systems diagnostic notes that the government has made progress in improving children's well-being in the past few decades. ECD policies exist in both the education and health sectors, and multiple other ministries have policies to protect children. However, weaknesses and gaps in the definition and updating of ECD policies, the governance of ECD systems, intersectoral coordination, and funding and budget allocation for ECD programs prevent an integrated approach to ECD from taking hold in the country. The following change strategies could help to strengthen ECD systems in Mozambique.

1. **Fund and work through local grantees that can support activities related to creating a multisectoral approach to ECD.** Mozambique has some ECD policies in place. However, Mozambique lacks a single coordinating agency that can bring the disparate pieces together in a more cohesive way. Supporting the convening of a central group and initiating work on ECD integration will help Mozambique move toward a more system-level ECD policy framework. There is already strong community-level support stemming from work around orphans and vulnerable children and HIV programs that could generate important lessons for advocacy work on nurturing care.
2. **Invest in quality data collection and dissemination.** Like Kenya, Mozambique lacks strong, quality data on ECE—particularly nurturing care. Long-term investment in quality data can be an effective change strategy when the data can inform different audiences throughout the system. This investment means using the data to create a variety of educational materials appropriate to stakeholders from mothers, local community members, and health facilities to national ministry staff engaged in ECE policies. These materials need to be timely and could be linked to meetings of TWGs to inform more integrated policies. The upcoming data collection by KixiQuila along with the release of the ECDI results for Mozambique could serve as a stepping-stone to creating these materials.

Tanzania

The following change strategies could help strengthen ECD systems in Tanzania through the framework of the NM-ECDP.

1. **Continue to support implementation and monitoring of NM-ECDP.** NM-ECDP marks a significant step forward, but its effectiveness will depend on the strength of implementation. The systems-mapping process identified the central role of PO-RALG in local-level oversight of nurturing care-related services across sectors, but PO-RALG currently lacks the resources and capacity to fulfill this role. One key avenue to support implementation will be to maintain a focus on supporting PO-RALG through well-placed grantees.

   It will also be important to ensure robust monitoring and feedback systems are in place. The Ifakara Health Institute is currently working with the government of Tanzania to include systems-level indicators developed under this grant in official NM-ECDP monitoring efforts to ensure that the monitoring reflects the importance of systems for implementation.

2. **Promote the sustainability of NM-ECDP through continued advocacy.** To ensure that the anticipated benefits of NM-ECDP pass on to future generations, it will be critical to support the sustainability of political support, multisectoral coordination bodies, and financing for nurturing care beyond the political tenure of current leadership. In the financing dimension, one critical step will be establishing and continuing to use a dedicated cost center for ECD to track financing levels over time relative to fully costed plans. The sustainability of policy implementation and multisectoral coordination will also require continued evidence generation and advocacy tailored to stakeholders across sectors and levels of government, as well as Tanzanian caregivers and other citizens who must be empowered to demand high-quality nurturing care services.
3. **Promote accountability around equity goals by addressing information gaps.** A lack of specificity on how to understand and address challenges and measure progress related to equity hinders the NM-ECDP's ability to promote nurturing care for all. Although data are often disaggregated by age, sex and socioeconomic status and local policies consider hard-to-reach populations, there is little information available about the most vulnerable populations, including street children and children in alternative care settings such as detention and orphanage centers. One area of priority for the government of Tanzania is the development of specific yet user-friendly tools to identify children with language delays and developmental disabilities, as none currently exist. This prevents vulnerable children from getting the additional support they need to reach their full developmental potential. Donors should consider how current or future grants could specifically address equity within the Tanzanian context.

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Annex A. ECD Systems Diagnostic, Version 1

Adapted by Mathematica from the RISE Education Systems Diagnostic for the Hilton Foundation ECD Systems evaluation.

Terminology and frequently used terms

Key relationships:

- **Principal:** An individual or entity who wants a task or objective accomplished
- **Agent:** An individual or entity whom the principal engages to complete the task or fulfill the objective.

Relationship	Principal	Agent
Politics	Citizens, when voting, and engaging in political party and civil society activities	Highest national/subnational authorities of the state (e.g., President, legislature)
Compact	Highest national/subnational authorities of the state (e.g., President, legislature)	Implementing authorities and organizations (e.g., Ministry of Health)
Management	Implementing authorities and organizations (e.g., Ministry of Health)	Providers of ECD services (e.g., CHWs, nurses, facility-based childcare providers)
Voice & Choice	Recipients of services (e.g., families, children, and communities)	Providers of ECD services (e.g., CHWs, nurses, facility-based childcare providers)

Three orientations of relationships

Coherent for "nurturing care"
Relationship is aligned around child development outcomes. Clear goals for child development are articulated, financed, and supported.
Aligned for access
Relationship is aligned around access to efficiency of ECD services. System is focused on expanding access efficiency. Systems can talk about quality but usually in relation to "thin inputs" set as the standard of what a minimum "quality" facility health facility is.
Aligned for process compliance
Relationship is dominated by a focus on completing logistical tasks like keeping to scheduled activities and meeting reporting targets. While these may have originally served a purpose, they are now bureaucratic compliance for the sake of compliance. The technical core and purpose are weak or lost all together, and instead the relationship is dominated by support functions (e.g., human resources, information technology, or procurement). Compliance becomes its own self-fulfilling purpose ("we do it because that's what we do").

Relationship features

- **Delegation** is what the principal wants the agent to do. For example, in the management relationship the Ministry of Health delegates what services should be provided at health facilities.
- **Finance** refers to the resources the principal has allocated to the agent to achieve their assigned task. For example, in the compact relationship the Ministry of Finance allocates budget to various ministries to provide ECD services.
- **Information** is how the principal assess the agent's performance. For example, in the Voice & Choice relationship, families can track the availability of key products and services, such as child vaccinations, at their local health facility.
- **Support** refers to the preparation and assistance that the principal provides to the agent to complete the task. For example, in the management relationship the Ministry of Health may prepare health service providers for their job by providing pre- and in-service service provider training.

- **Motivation** refers to how the principal motivates the agent, including the ways in which the agent's welfare is contingent on their performance. This motivation can be extrinsic (mediated by principal) or intrinsic (mediated by agent). For example, in the politics relationship, citizens may vote against the governing party if they feel their children's needs are not being addressed by the relevant systems.

Other terms/considerations

- **Nurturing care:** The Exhibit at the right, which was developed by the World Health Organization and other global partners, depicts all the components of nurturing care that we should consider in assessing the systems in each country. There is more useful information provided at https://nurturing-care.org/what-is-nurturing-care/ to help familiarize yourself with this framework.
- **Health or other relevant sectors/systems:** Please take a multisectoral lens to the following questions. While much of the content has been written with the health system in mind, we should consider all the relevant ministries, systems, and sectors that can provide or support nurturing care for children aged 0–3.
- **Service providers:** This could include frontline service providers at health facilities or in the community, childcare providers at centers or schools, or others serving children aged 0–3.

Starfish vs. spider

If you cut off the leg of a spider, and you have a seven-legged creature on your hands; cut off its head and you have a dead spider. "Spider-like" organizations are highly centralized and highly structured. Authority comes from the top, and local innovations may not be supported.

If you cut off the arm of a starfish and it will grow a new one. Not only that, but the severed arm can grow an entirely new body. Starfish can achieve this feat because, unlike spiders, they are decentralized; every major organ is replicated across each arm. "Starfish-like" organizations are decentralized, organized around common goals and ideals, but authority is more localized. Individuals at lower levels of the organization have flexibility to adapt their approach and innovate solutions that are best suited to their individual circumstances.

Source: Adapted from: https://www.eonetwork.org/octane-magazine/june-2007/the-starfish-and-the-spider-the-era-of-leaderless-organizations.

Documents reviewed:

Document	Source
E.g., ECD Strategic Plan (2015-2024)	Ministry of health (ECD.MoH.Gov/plan2015)

Stakeholder engagement (optional)

Name	Title
E.g., Dr. Nurturing Care	Deputy minister of ECD

A. Compact

A1. Delegation

A1.1. What do the highest national/subnational authorities set as the goal for the system?

Coherent for "nurturing care"	Aligned for access
• Authorities set clear, measurable, achievable goals for progress on quality of nurturing care-related services and child development outcomes. • Authorities consider outcome equity in setting these goals. • Goals are relatively sustainable and stable across political transitions.	• Authorities set and manages towards goals to expand to universal access to nurturing care services for children aged 0-3 and their families. • Equity, equality of opportunity, and inclusivity are all components, and are considered in terms of access to services and efficiency. • Goals are not consistent across leadership and personnel changes.

Guiding questions: *What are the priorities for the health and other relevant sectors for the highest national/subnational authorities? What would success look like for the relevant ministries? What would the executive authority need to see the relevant ministries deliver to consider them to be successful?*

Response:

Outstanding questions and missing information:

A1.2. Human resources: How does the executive set out human resource goals?

Coherent for "nurturing care"	Aligned for access
• Attract and retain high-quality service providers.	• Attract and retain enough service providers. • Acquire adequate thin inputs to deliver quality. Quality is determined by observable features of health and ECE facilities.

Guiding questions: *What are the highest national/subnational authorities' expectations and priorities for the budget allocation process? What are the highest national/subnational authorities' priorities for service providers? What do the authorities want or expect the ministries to do with or for service providers?*

Response:

Outstanding questions and missing information:

A1.3. How much of a gap is there between articulated and actual goals?

Guiding questions: *Do implementing authorities and organizations and frontline service providers understand and share the goals and objective stated in policy documents? Are performance metrics for these agents broadly aligned with these goals?*

Response:

Outstanding questions and missing information:

A2. Finance

A2.1. How is finance for ECD services structured?

Coherent for "nurturing care"	Aligned for access
• Government tracks and reports public ECD budget and expenditures. • Finance adequately structured and provided to meet nurturing care service quality and child development outcome goals. Finance decisions are justified in terms of their outcome effects. • Finance is provided with flexibility to allow for productive innovation.	• The authorities do not track or report on ECD budgets or expenditures. • Financing levels for health and other relevant sectors based on expansion needs, determined by unit costs of access: Demographics and service provider salaries.

Guiding questions: *How are fiscal allocation decisions made (by the highest national/subnational authorities)? How are decisions on approval of budgets to the relevant ministries made by the highest national/subnational authorities? When are changes proposed by the ministries? What is the process and reasoning for accepting or rejecting them?*

Response:

Outstanding questions and missing information:

A2.2. Discretion: Where and to what extent is discretion for finance in nurturing care services distributed throughout the system?

Coherent for "nurturing care"	Aligned for access
• Organization responsible for implementation has discretion over finances that is sufficient to innovate.	• Demand for service expanding, service provider salaries cannot fall. Tension between inputs and salary. To control limited resources, decisions made at top.

Guiding questions: *How are decisions made about finance for ECD services (by highest national/subnational authorities)? What could induce changes to finance allocations (by highest national/subnational authorities)? What was a recent change to a policy or procedure proposed by the relevant ministries? Was it adopted? Why or why not?*

Response:

Outstanding questions and missing information:

A3. Information

A3.1. How is information for nurturing care structured?

Coherent for "nurturing care"	Aligned for access
• The system produces regular, reliable, relevant information on progress towards articulated, shared goals including improved outcomes for children from birth to age 3. (e.g., percentage of children who benefit from early learning activities by socio-economic status; children with developmental delays).	• Organizational providers produce and communicate regular, reliable information on service provision, utilization of inputs (including service provider numbers and availability of health care commodities), process compliance.

Guiding questions: *What information is received by the highest national/subnational authorities about the performance of health and other relevant system authorities? Who is this information shared with (i.e., which offices)? Is early child development raised in highest level meetings as a national issue? What information about performance is produced by health and other relevant sector authorities to report on their performance? If the relevant ministries etc. produce reports on performance, what do they contain (on health outcomes, including indicators for aged 0–3, on utilization of funds, on procurement, on access/efficiency)?*

Response:

Outstanding questions and missing information:

A3.2. Quality: How does the system determine that nurturing care service provision is of sufficient "quality"?

Coherent for "nurturing care"	Aligned for access
• Quality is associated with ECD outcomes. • Information provided on progress toward articulated goals and targets.	• Determination of "quality" of health care based on inputs and service provision. • Service provision based around narrow, quantitative targets.

Guiding questions: *What features or standards does the system consider in its definition of "quality" nurturing care and development outcomes for children aged 0–3 and their caregivers?*

Response:

Outstanding questions and missing information:

A3.3. Equity: How does the system assess equity in provision of nurturing care services?

Coherent for "nurturing care"	Aligned for access
• Equity in quality of care and child development outcomes is monitored (in addition to access) along several dimensions, including gender, rural / urban, socio-economic status, children with disabilities, children with adolescent mothers.	• Equity considerations assessed narrowly in terms of access (e.g., distance to nearest health facility in rural areas).

Guiding questions: *Does the system track any metrics related to equity in the health and other relevant sectors? How and to what extent are they incorporated into decisions about resource allocation?*

Response:

Outstanding questions and missing information:

B. Management

B1. Delegation

B1.1. High-level targets

Coherent for "nurturing care"	Aligned for access	Aligned for process compliance
• Priority given to clear goals for child development progress of all children aged 0–3.	• Targets prioritize maximizing access to services.	• Rule compliance is the highest priority. All risk is perceived as compliance risk.

Guiding questions: *What are the priorities for the health and other relevant systems for the authorities? What would success look like for frontline workers? What would the health and other relevant system-level authorities need to see the frontline delivery to consider it to be successful?*

Response:

Outstanding questions and missing information:

B1.2. Most important responsibilities

Coherent for "nurturing care"	Aligned for access	Aligned for process compliance
• Focus on the quality of service provision, not service providers. Meaning that the focus is on quality of nurturing care provided, rather than on the number of facilities, service providers and their formal qualifications.	• Focus on service providers (the number of them and their on-paper qualifications), not quality of care. • Authority may live with support functions (particularly HR). • Focus on metrics for minimum inputs (HMIS).	• Authority lives with support functions (HR, finance, procurement). • Focus on compliance with procedural metrics (such as service provider attendance and keeping documentation, often evidenced through large amounts of paperwork (physical or digital) that documents procedures are being followed.

Guiding questions: *What areas of the health and other sector authorities hold the most valued or important functions within the organization(s)?*

Response:

Outstanding questions and missing information:

B1.3. Spider vs. starfish: Local discretion granted to subnational authorities/facilities/service providers

Coherent for "nurturing care"	Aligned for access	Aligned for process compliance
• Subnational authorities, facilities, and providers are empowered to be learning, innovative agents. • Subnational authorities, facilities, and service providers are empowered agents in decisions that optimize facility- and community-based care for local needs and/or are best informed by deep local knowledge (e.g., service providers can choose the services that best support individual children's development in conjunction with systemwide standards of care). • Innovation occurs and is valued by the system if it supports nurturing care.	• The relationship between relevant system authorities and facilities/providers is strictly hierarchical, governed by rigid rules and reporting procedures. • There are logistical management structures: All facilities and service providers are expected to deliver similar services at similar times in similar ways. • Innovation occurs and is valued by the system if it increases access or efficiency.	• The relationship between relevant system authorities and facilities is strictly hierarchical, governed by rigid rules and reporting procedures. • There are logistical management structures: All facilities and service providers are expected to deliver similar services in similar ways. • Innovation is repressed and seen as too risky.

Guiding questions: *How does the center relate to the frontline? Is there a "spider" system where all decisions are taken at the center, or a "starfish" system where the frontlines are able to move independently?*

Response:

Outstanding questions and missing information:

B2. Finance

B2.1. How service providers are financed

Coherent for "nurturing care"	Aligned for access	Aligned for process compliance
• Service provider compensation packages (including base pay, pensions, and incentives) are structured to attract, select, retain, and motivate high quality service providers and support caregiver and child outcomes.	• Rules driving finance are based on access to facilities and services. • Simply spending a lot on service provider salaries may attract higher quality applicants, but does nothing to select, retain, or motivate the best service providers. In fact, it may discourage necessary turnover of service providers who have low motivation and performance.	• Finance focus is on compliance, no relationship to outcomes.

Guiding questions: *How is budget line for service providers' salaries structured, and what factors does it take into account? When was the last time a change was made to service provider salary structure (compensation of existing service providers or hiring of new ones)?*

Response:

Outstanding questions and missing information:

B2.2. How inputs are financed

Coherent for "nurturing care"	Aligned for access	Aligned for process compliance
• Decisions and rules for financing inputs are justified based on their relationship to the quality of ECD services and child development outcomes.	• Decisions and rules for financing inputs are justified based on their relationship to access and attendance.	• Finance focus is on compliance, no relationship to outcomes.

Guiding questions: *How are budget lines not related to service provider salary structured, and what do they take into account? When was the last time a change was proposed to funding or a new program? How was this justified? What were questions ministry of finance asked about it?*

Response:

Outstanding questions and missing information:

B2.3. Spider vs. starfish (allocating funds)

Coherent for "nurturing care"	Aligned for access	Aligned for process compliance
• While there may be centralized funding, there is autonomy and discretion in the allocation of funds at the subnational and local level. • Different financing strategies over time lead to organizational learning about how to achieve the quality of ECD services and child development outcomes.	• Centralized funding and allocation of funds. • Nearly all finance is in-kind (i.e., no delegation of discretion over how to spend). • If there is any financial experimentation, it is concentrated on expanding access and efficiency, and the system may learn about how to achieve this.	

Guiding questions: *Are funding decisions controlled as "spider" where all decisions are taken centrally or a "starfish" where there is discretion at lower levels of the system?*

Response:

Outstanding questions and missing information:

B3. Information

B3.1. HMIS

Coherent for "nurturing care"	Aligned for access	Aligned for process compliance
• May have a high quality HMIS for tracking inputs and outputs (e.g., vaccinations), but that is in addition to tracking nurturing care provision by families/ facilities and child outcomes. • HMIS access and decisions based at the subnational and/or local levels where discretion is held.	• HMIS focuses on monitoring the quantity of inputs and services provided. • Feeds data to the top, where allocation decisions are made.	• Information gathered to monitor policy compliance. • Collection of monitoring and compliance information is extremely important - to the point that it becomes one of the chief responsibilities of the lower tiers in the system and the main ways they interact with the higher tiers.

Guiding questions: *What information is included in the HMIS system? How do authorities use this information? What information related to nurturing care service quality and child development outcomes is included in the HMIS system? How do authorities use this information? Is the HMIS considered up-to-date and relatively complete?*

Key child outcome indicators to consider include:

- *Number of children 0–5 suspected with delayed developmental milestones*
- *Number of children referred for developmental delays*
- *Number of newborns with birth defects*
- *Number of newborns initiated on Kangaroo Mother Care*

Response:

Outstanding questions and missing information:

B3.2. Information for facility leadership and service providers

Coherent for "nurturing care"	Aligned for access	Aligned for process compliance
• Detailed information collected about facility leadership and service provider performance. This often occurs through processes such as facility inspections/visits. • These processes place priority on measuring the quality-of-service provision in support of nurturing care.	• Information flows place priority on measuring HMIS-visible indicators on the quantity of inputs and services provided.	

Guiding questions: *What kind of information about service provider and facility performance is collected? How is it used?*

Response:

Outstanding questions and missing information:

B3.3. Information use

Coherent for "nurturing care"	Aligned for access	Aligned for process compliance
• Information (inspections, district monitoring, HMIS data) is used to make child development-oriented decisions. • Decisions about what information to collect involve input from the lower (District/facility) levels of the system. Information is collected and fed up to inform decision-making at the top, but also shared back down in local-level feedback loops.	• Information (inspections, district monitoring, HMIS data) is used to make decisions aimed at expanding access or efficiency. • Decisions about what information to collect are made at the top, information is collected and fed up to inform decision-making at the top but rarely shared back down.	• Information is used to enforce process compliance. Policies or programs are judged successful based on whether paperwork documenting them was properly compiled. • Few decisions that impact facilities, service providers, or families/children are made on the basis of information that is gathered. • Decisions about what information to collect are made at the top, information is collected and fed upward but rarely shared back down.

Guiding questions: *What data and information are available to health and other relevant system authorities? How is that information used?*

Response:

Outstanding questions and missing information:

B4. Motivation

B4.1. Service provider professional status/intrinsic motivation

Coherent for "nurturing care"	Aligned for access	Aligned for process compliance
• Health and other ECD service provision is a purpose-driven profession. • Strong professional and social norms around service provision (including CHWs/CHVs).	• Frontline provider roles are relatively low status professions (including CHW/ CHVs). • Professional and social norms are weak. • Monitoring of service provider rule-following and attendance. • Service providers are often assigned administrative tasks. • Most desirable positions are not those focused on frontline provision (other administrative-focused positions are more desirable).	

Guiding questions: *What is the professional status and professional norms in the frontline provider profession?*

Response:

Outstanding questions and missing information:

B4.2. Career advancement and job security/extrinsic motivators

Coherent for "nurturing care"	Aligned for access	Aligned for process compliance
• Decisions related to service provider career structures (entry, exit, placement, responsibilities, appraisal, promotion, recognition, and autonomy) prioritize information related to the quality of care they provide.	• Decisions related to service provider career structures are made based on information related to indicators from HMIS and budget data (especially seniority).	

Guiding questions: *What is the structure of service provider careers and career progression in the system?*

Response:

Outstanding questions and missing information:

B5. Support

B5.1. Coherence of facility and training materials for nurturing care

Coherent for "nurturing care"	Aligned for access	Aligned for process compliance
• Provider (including CHV/CHW) and facility materials related to nurturing care (service provider guides, forms, and monitoring materials) are high quality and aligned with each other. • Training/instructional materials are aligned with supporting high-quality nurturing care for service providers and caregivers, and child development outcomes.	• Provider and facility materials are low-quality or misaligned with each other. • Service provider training is done, but quality is not of primary importance.	

Guiding questions: *What are the relevant facility guides, forms, and monitoring materials? What kind (type and quality) of service provider training is available for these materials? To what extent do they capture child development outcomes and nurturing care provided by services providers and caregivers?*

Response:

Outstanding questions and missing information:

B5.2. Spider vs. starfish: Instructional materials and service provider training

Coherent for "nurturing care"	Aligned for access	Aligned for process compliance
• In-service training is done in response to identified needs in the quality of care or specific child development outcomes. • There are different pre-service qualifications appropriate for different kinds of service providers.	• Periodic, largely standardized in-service training, often in response to centralized changes. • Standardized pre-service qualifications. • Little facility and classroom level discretion over instructional materials.	• Qualifications for service provider professions are standardized and strongly enforced.

Guiding questions: *How does the system provide service provider training and instructional support? Is it centrally controlled (spider) or is there local discretion (starfish)?*

Response:

Outstanding questions and missing information:

B5.3. Focus and delivery of service provider training

Coherent for "nurturing care"	Aligned for access	Aligned for process compliance
• Pre-service training is characterized by hands-on practice, coaching, and mentorship that facilitate learning and application of skills related to high-quality care. • The typical in-service training approach is characterized by the hands-on practice, coaching, and mentorship that facilitate learning and application of skills related to high-quality care. • Strong professional accountability: monitoring and support are delivered through horizontal professional networks.	• Pre-service training is largely theoretical, with insufficient practical experience. • The typical in-service training approach is a cascade model of one-off sessions away from facilities that generally have little impact on on-the-job practices. • Weak professional accountability, evidenced by little or no involvement of peers in monitoring or support.	

Guiding questions: *What kinds of pre-service and in-service training are required for service providers? How is it delivered? How does the system assess the training is working well?*

Response:

Outstanding questions and missing information:

C. Voice & Choice

C1. Delegation/Motivation

C1.1. Alignment of voice and choice: What do families want?

Coherent for "nurturing care"	Aligned for access
• Families (including fathers) seek out service providers who support them in providing nurturing care to their children, including through individualized care and monitoring of developmental milestones. • Families prioritize quality of care when choosing service providers. • Private (and competitive public) facilities compete on quality.	• Notions of "quality" facility are defined by inputs (i.e., access, infrastructure) and the level of financing. • Families prioritizes expanding access to care, efficiency, and inputs. • Families prioritize inputs to choose facilities (e.g., physical infrastructure). Private facilities compete on inputs.

Guiding questions: *What do families prioritize and demand in care for their children?*

Response:

Outstanding questions and missing information:

C1.2. Strength of voice

Coherent for "nurturing care"	Aligned for access
• There is a feeling of ownership over public facilities by the community. • Service providers are a part of or embedded within the community. • While there may be centrally set goals and standards, there is significant local discretion granted to facilities on how to meet those goals. Districts or facilities may also have the discretion to set additional local goals.	• Public facilities are perceived to belong to the bureaucracy. • There is little local discretion at lower tiers of the system (i.e., district level or below) over how to pursue centrally set goals and standards.

Guiding questions: *How do facilities and providers relate to the communities they serve? Are there ways for community members to engage with facilities and service providers and inform programming and how services are provided?*

Response:

Outstanding questions and missing information:

C1.3. To what degree is there internal community cohesion?

Strong voice	Weak voice
• The voice of families and community members is channeled through representatives. These may be official representatives recognized by the state—such as local committees, politicians—or informal representatives that nevertheless have power—such as traditional leaders (i.e., chiefs) or other forms of local self-governance. • These representatives are perceived as legitimate spokespeople that broadly represent the interests of most stakeholders. The representative mechanism amplifies voice by producing, and reflecting, a high degree of community cohesion. • The relatively high social status of administrators and service providers does not prevent representatives of the community from exercising their voice.	• There is little or no effort to improve services through voice. Voice has been abandoned in favor of choice. (often following mass exit to private facilities). • There is elite indifference to voice, and the elite do not pressure the representatives of voice to take action on ECD issues. The representative organs of voice are likely dysfunctional (while they may exist on paper, they do not meet, or have low participation, or focus on issues other than ECD). • The higher social status of administration and service providers effectively silences community members from exercising their voice (especially when there is elite indifference).

Guiding questions: *Which groups or individuals have a say in the health and other relevant systems? How do priorities differ across groups, and which are emphasized?*

Response:

Outstanding questions and missing information:

C2. Information

C2.1. Do families have enough information to make informed decisions regarding their children's development?

Coherent for "nurturing care"	Aligned for access
• Families are aware of key developmental milestones. • Families understand the key aspects of nurturing care, responsive caregiving, early learning, and their importance for child development. • Families demand quality programs from policymakers. • Families are aware of services and resources that can help support the development of their children aged 0–3, including specialized services for especially vulnerable children.	• Developmental milestones may be opaque to families, who must rely instead on rough (more visible) proxies to understand their children's development. • Families may wait for/rely on schools to provide early learning. • Families are unaware of specialized supports and focus on access to and efficiency of facilities and service providers.

Guiding questions: *What forms of information are available to families to monitor and affect change in system performance?*

Response:

Outstanding questions and missing information:

C3. Finance

C3.1. Does the local level have some discretion over financing for ECD services?

Coherent for "nurturing care"	Aligned for access
• The budget for ECD is transparent, and flexible enough to meet subnational and local needs. • The community has some oversight over local budgets that can support quality and responsiveness of service delivery. • Community on information by making changes to facility and community-based care financing).	• Communities have weaker oversight on decisions around how public funds are spent in local schools. The budget is not transparent, or flexible enough to meet locally nominated needs. • Community has limited ability to act on the information it receives. The main audience for information in the system is the bureaucracy.

Guiding questions: *Is information about resources for facility and community-based care publicly available? How is that information used at the subnational and local levels?*

Response:

Outstanding questions and missing information:

C3.2. Alignment of voice and choice: What information is used to inform financing decisions?

Coherent for "nurturing care"	Aligned for access
• Financing decisions are justified using information about quality of care and child development outcomes.	• Financing decisions are justified using information about access or input levels.

Guiding questions: *How are funding and allocation divisions for ECD services communicated to communities?*

Response:

Outstanding questions and missing information:

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