Policy Brief

Kizazi Kijacho:
Empowering Tanzania's next generation for economic growth and inclusion

thrive
Evidence for Scaling Childhood Development

State-of-the-art research in Tanzania to inform innovative early childhood development programming for the next generation.

Launched in October 2022, nine months after the introduction of Tanzania's National Multi-Sectoral Early Childhood Development Programme (NM-ECDP) in December 2021, the Kizazi Kijacho (Next Generation) research programme is a major learning opportunity in the government's journey towards effectively scaling early childhood development services – contributing to the evidence base on early childhood development outcomes, with an initial focus on the first 1,000 days of a child's life.

In this policy brief, we outline the findings of a baseline survey that forms part of our large-scale study to assess the relative cost-effectiveness and impact of different bundles of early childhood development interventions, tracking their impact on parents, children, and communities in the Dodoma region over a 27-month period.

The findings we present here, while preliminary, outline some of the challenges facing families in terms of accessing services and support. But they also highlight the potential for government policy on early childhood development to make a difference – potentially at affordable cost and using existing national capacity. Crucially, we acknowledge the vital work already being carried out by community health workers and note that investment will be required if their services are to develop and expand beyond health and nutrition to include early learning, responsive caregiving and child safety and security[1].

[1]See the 2018 Nurturing Care Framework by World Health Organization, UNICEF and World Bank Group for further details: https://nurturing-care.org/about/what-is-the-nurturing-care-framework/

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The study is led by the Institute for International Economic Studies (IIES/Stockholm University) in collaboration with Ifakara Health Institute, Chr. Michelsen Institute, FAIR/Norwegian School of Economics, Yale University, University of Chile, Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), D-Tree International and EDI Global.

Where are we working and who with?

We are working with 3,588 mothers who were pregnant in October 2022 and their families in 387 communities in the catchment areas of 258 health dispensaries across all seven districts in the Dodoma region – Dodoma City, Mpwapwa, Kondoa, Chamwino, Chemba, Bahi and Kongwa.

Interviews with people living in these communities, as well as those providing health services (community health workers and health dispensary functionaries) and community leaders, have provided a wealth of insight into socio-demographics, education, health, work activities, household budgets and savings, as well as the type of support available to growing families.

Except for Dodoma City and Kondoa Town, the communities are predominantly rural. Fewer than half of the communities have access to a paved road. Some 70% of the male population and 22% of the female population typically temporarily migrate for more than a month each year.

While nearly all communities report having easy access to pre-primary and primary education – 9 in 10 have a school located within the community boundaries – hardly any (5 out of 387) have access to nursery or childcare facilities.

The average age of the mothers and fathers in our study is 27 years old and 35 years old respectively. Most parents had attended school (75% of mothers and 82% of fathers) and most had completed primary education (75% of mothers and 67% of fathers) and report that they are comfortable with reading and numeracy. Although very few use internet services (only 7% of mothers and 18% of fathers report ever having used the internet), nearly all the women in the study (95%) have access to a mobile phone and nearly half (43%) own a phone.

Hardly any of the parents in our study reported having a personal bank account (2% of mothers and 5% of fathers); one-third of the mothers and half of the fathers reported having some informal savings (such as with a friend/family, or in a village bank).

What are our initial observations about opportunities to support families during early childhood development?

1. **Overall, policies focused on addressing rural barriers to accessing health care and education could significantly uplift living standards and foster child development.**

2. **Targeted investments are required in healthcare infrastructure to ensure the safety of women and children before, during and after childbirth.**
   - On average, each health dispensary serves two communities.
   - 8 in 10 communities rely entirely on health dispensaries for health services.
   - Most health dispensaries have electricity – but the supply is not always stable. In Chemba, Kongwa and Mpwapwa, more than 30% of health dispensaries reported power cuts of more than two consecutive hours on at least one day in the week prior to the survey.
   - Nearly all offer child delivery services (one bed per health dispensary on average) – but few are equipped to deal with complicated deliveries. Only half offer instrumental (assisted) delivery, and hardly any can perform blood transfusions or c-sections.

3. **Community health workers are key early childhood development service providers – investment is required in payment, training and building capacity.**
   - A typical community health worker is responsible for two communities, serving on average 90 families at any point in time.
   - Only 25% of the community health workers in our sample reported being paid for their work (on average TZS75,000 (US$32) per month).
   - Most community health workers (84%) split their time between working in a health facility (on average 10 hours each per week) and working in the community (on average 16 hours each per week). The workers we spoke to would prefer to work 16 hours per week in total as community health worker – on average, they are working an additional 27 hours elsewhere per week in order to support their own families.
   - Virtually none of the communities in the region reported having received any support to provide training for community health workers in the 12 months prior to the survey visit.
   - While only 4% of the women in our survey reported having received a home visit from a community health worker during their last pregnancy, almost half of them knew the name of their health worker. This suggests that a significant number of mothers and their young families are being actively supported by community health workers, though not yet through home visits during the antenatal period.

4. **Broader financial support could help address disparities in living standards and help young families with the upbringing of their children.**
   - While 9 out of 10 heads of household had heard of the Tanzania Social Action Fund (TASAF), only 10% reported having ever been eligible, with just 5% benefiting from it at the time of the survey, compared to 15% nationally. Only half of those receiving it reported having had a transfer in the 12 months prior to the survey (averaging TZS79,000 (US$34) per eligible family).

What interventions are we testing and why?

It is in this context that we are conducting a randomised controlled trial to test the relative effectiveness of three interventions in addressing at least some of the baseline barriers described above and to improve child development, nutritional status and caregiver wellbeing. Specifically, we are testing the following interventions – each initiated during pregnancy:

- **Parenting:** This holistic intervention combines the Care for Child Development (CCD) package by UNICEF and the World Health Organization (WHO), with elements of the Reach Up parenting programme, tailored to the Tanzanian context. Delivered by existing community health workers, who are supported by Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) officers and a digital app developed by D-Tree International, the intervention aims to enhance caregiver skills in creating a nurturing environment for children. In addition to health and nutrition counselling, this includes early learning stimulation and responsive caregiving messaging to improve child development. It is implemented through home visits and group sessions, providing support to 763 women in the final trimester of pregnancy until their child reaches 2 years old.
- **Unconditional cash transfers:** This intervention entails the provision of six unconditional mobile money transfers to 1,241 households over a 15-month period from the final trimester of pregnancy until the child reaches approximately one year old. This financial support aims to alleviate economic barriers, empowering families to invest in their child's wellbeing. These bi-monthly transfer amounts vary (from TZS32,000 or USD14 to TZS109,000 or USD47) to allow for a nuanced examination of how financial resources impact household behaviours and child outcomes.
- **Combined parenting and cash transfer intervention:** In this combined approach, which is being trialled by 728 households, pregnant mothers receive, in addition to the parenting intervention, six unconditional mobile money transfers (TZS77,000 or USD33) over a period of 15 months until the child reaches approximately one year old.

The rationale behind these interventions is for the cash transfers to relax any financial constraints that caregivers may face when making decisions about child development investments, and for the parenting intervention to relax – through strengthening the capacity of community health workers - any non-financial parental constraints to caregiving, such as parental preferences, beliefs, knowledge, household decision-making, mental well-being, perceived social norms, and so forth. The objective of the combined intervention is to simultaneously relax both financial and non-financial constraints.

Child cognitive, speech, language, and nutritional outcomes will be measured through direct assessment and parental reports against a control group of 856 households in 81 health dispensary catchment areas. The research is also investigating parental behaviour and practices (financial and non-financial) as well as the potential drivers of this behaviour, such as social norms relating to parenting and gender, preferences, beliefs, empowerment, intimate partner violence, and mental wellbeing.

[2]For further information on CCD, see https://www.unicef.org/documents/care-child-development. For further information on Reach Up in Tanzania, see https://reachupandlearn.com

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Next steps

We are collecting first follow-up survey data between February and May 2024 (when the children are approximately 1 year old) and will report on programme medium-term impacts shortly after. A longer term impact evaluation will be carried out in 2025, when the children are approximately 2 years old and we plan to report on impact assessment results then.

Acknowledgements

The Kizazi Kijacho study is generously funded by Research Council of Norway, Swedish Research Council, European Research Council, Conrad N. Hilton Foundation and Thrive programme.

Suggested Citation:

Almås, I., Caeyers, B., Elisaria, E. and Williams, E. (2024) 'Kizazi Kijacho: Empowering Tanzania's next generation for economic growth and inclusion', Policy brief, Thrive. https://www.thrivechildevidence.org/kizazi-kijacho-a-randomised-controlled-trial-of-parenting-and-unconditional-cash-transfers-in-tanzania

Read the baseline report

https://www.thrivechildevidence.org/kizazi-kijacho-a-randomised-controlled-trial-of-parenting-and-unconditional-cash-transfers-in-tanzania

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About Thrive

Thrive is a large-scale, multi-country research programme which aims to build understanding of early childhood development (ECD) service delivery models, at scale, and how they can transform to significantly improve childhood health, nutrition, education and well-being in low- and middle-income countries. Thrive seeks comprehensive, practical answers about how ECD systems innovate, improve, and better serve children and communities. The programme is funded by the UK's Foreign, Commonwealth & Development Office (FCDO) and by New Zealand's Ministry of Foreign Affairs and Trade (MFAT). It is managed by Oxford Policy Management in collaboration with the Institute for Fiscal Studies and Yale University. It is implemented in five countries – Ghana, Sierra Leone, Tanzania, Bangladesh and Kiribati.

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