



Tanzania | June 2026

Evidence for sustainable parenting and cash transfer programmes in Tanzania

Briefing

thrive



Mpira wa mtoto mlaini ee
au unarangi nzuri,
nyekundu na bluu

Mother, child and a Kizazi Kijacho community health worker. Dodoma, 2023.

This briefing presents findings from the Kizazi Kijacho research programme, which studied the impacts and processes of delivering parenting advice and cash transfers across 314 communities in the Dodoma region, Tanzania. The programme provides evidence to inform the delivery of scalable and cost-effective early childhood development services in low- and middle-income countries.

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Acknowledgements

This research was funded by the European Research Council, the Swedish Research Council, the Research Council of Norway, Thrive/Foreign, Commonwealth & Development Office (FCDO, UK), and the Conrad N. Hilton Foundation, with additional support from the Centre for Experimental Research on Fairness, Inequality and Rationality (FAIR)/NHH Norwegian School of Economics, the Cowles Foundation for Research in Economics, and the Institution for Social and Policy Studies (ISPS) at Yale University. We thank collaborators and advisors for their valuable input throughout the research process. We are grateful to the regional health management team and the council health management teams in the Dodoma region for their collaboration, and especially to the facility and community health workers, parents and community leaders who participated in the research and generously shared their time and experiences. We also thank the Thrive communications team for their support with editing and design on this brief.

Recommended citation

Caeyers, B. et al. (2026). *Evidence for sustainable parenting and cash transfer programmes in Tanzania*. Thrive briefing, Oxford Policy Management.

Disclaimer

The Thrive programme is funded by UK International Development from the UK government 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.

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Background

What is the issue?

Tanzania has placed early childhood development (ECD) at the centre of its long-term development agenda through the National Multisectoral Early Childhood Development Programme (NM-ECDP), aligned with the global Nurturing Care Framework's emphasis on child health, nutrition, responsive caregiving, early learning, and safety and security (Republic of Tanzania, Ministry of Health, Community Development, Gender, Elderly and Children 2021). This commitment is further reflected in Pillar 2 of the Tanzania Vision 2050, which aims for 90% of children under 5 to reach their full developmental potential by 2050 (United Republic of Tanzania, President's Office – Planning Commission 2025). However, achieving this target will require significant progress, as fewer than half of Tanzanian children aged 24–59 months are currently developmentally on track across health, learning and psychosocial wellbeing, leaving many children at risk of being left behind (Ministry of Health, National Bureau of Statistics and ICF 2023).

Achieving these ambitions requires evidence not only on which interventions improve child development outcomes, but also on how they work, whether they can be delivered

sustainably through national systems, and what value they provide relative to their cost.

While cash transfers and nurturing-care parenting support have each been shown to improve child outcomes (Britto et al. 2027; Crosta et al. 2024, Jeong et al. 2021), little is known about whether and how these interventions operate through distinct child developmental pathways, or the relative value they deliver for their cost when implemented alone or in combination. Both strategies also face scalability and sustainability constraints within national systems, including high delivery costs for cash transfers and quality-control and resource challenges for parenting programmes (Richter et al. 2017).

What work have we been doing in this area?

A research programme called Kizazi Kijacho (KK) – meaning 'Next Generation' in Swahili – has addressed evidence gaps on scalable and cost-effective ECD services in low- and middle-income countries. A KK randomised controlled trial (RCT), conducted across 314 communities across all eight district councils of Dodoma, is one of the first large-scale studies to evaluate the effectiveness, implementation and costs of parenting support and unconditional cash transfer interventions, delivered either independently or in combination in similar communities, enabling comparison of their distinct and combined effects on child development. The interventions began during pregnancy and continued into early childhood.

Major strengths of the study are that the parenting programme was designed for scalability, leveraging the

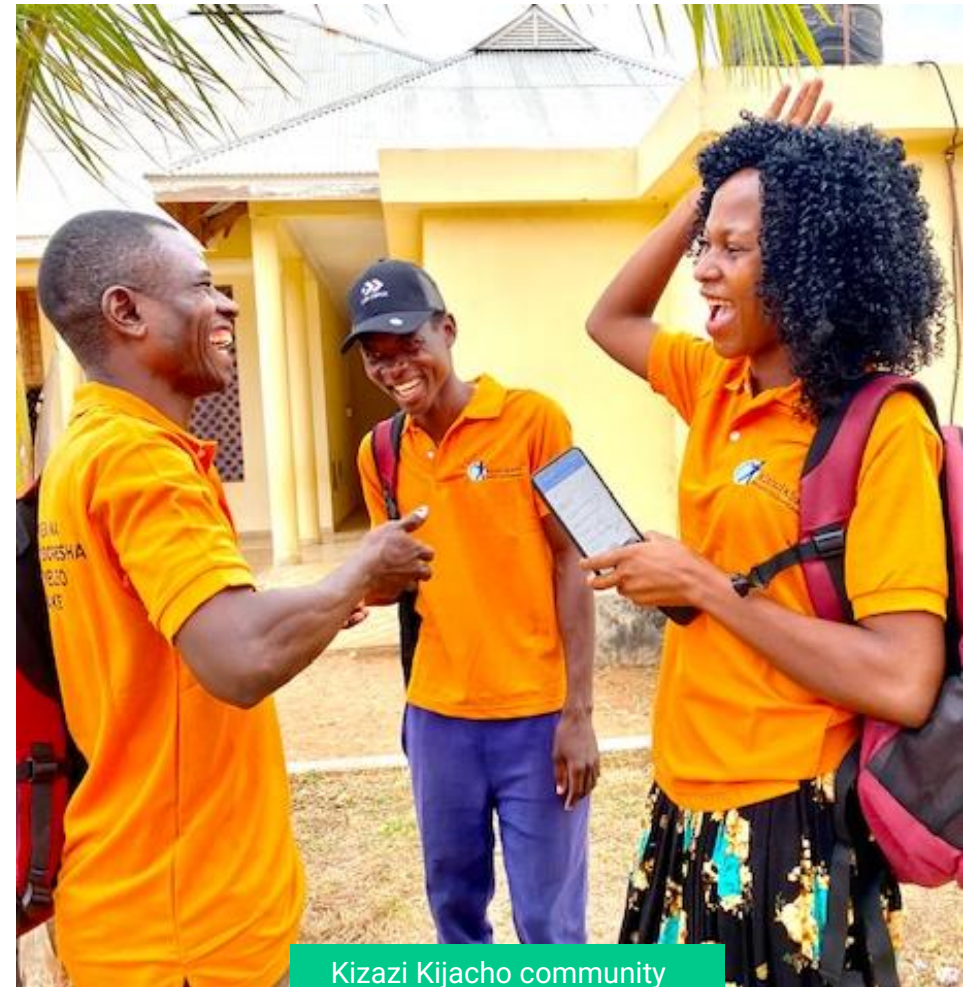
existing health system and digital tools to strengthen delivery, and that it integrates multiple data sources from the same setting:

- large-scale, regionally representative RCT data
- high-frequency digital monitoring data
- longitudinal child development assessments and surveys of community health workers and caregivers and children
- detailed costing analysis
- qualitative research with caregivers, frontline workers, and government stakeholders
- evidence on sustainability and scalability.

Data was collected over a 25-month period, enabling changes in programme performance, frontline worker experiences and caregiver perceptions to be examined – providing rare evidence on how intervention delivery evolves over time.

What does this briefing paper do?

This briefing presents intervention impacts and costs from when the children in the KK study were evaluated up to the age of 1, while drawing on process evaluation data collected across the full 25-month implementation period (i.e. up to child age 2).



Kizazi Kijacho community health workers. Dodoma, 2026.

Key messages

1. A nurturing-care parenting programme delivered by community health workers (CHWs) resulted in large gains in psychosocial caregiving practices and children's socio-emotional development. The gains were greater when caregivers received cash transfers in addition to parenting support.
2. Cash transfers that ease families' economic constraints are essential to improve children's diets and physical growth, and to sustain progress in reducing malnutrition in Tanzania.
3. CHWs' competence, motivation and job satisfaction improved gradually over time, alongside caregivers' growing trust and confidence in their advice. Programme implementation, monitoring and evaluation periods should allow for these maturation effects.
4. To maximise impact, greater efforts should be made to identify and enrol mothers early in their pregnancies.
5. Transitioning to a financially sustainable government-led model of the programme at scale requires a stronger health system (including increased support for CHWs), efficiency gains and cost reductions.

Kizazi Kijacho interventions

Status of policy guidelines at the onset of the study in 2022

- Tanzania Social Action Fund (TASAF): government provided bi-monthly cash transfers of TZS 77,000 (USD 33) targeting the most vulnerable families with children (about 6% of the families involved in Kizazi Kijacho), conditional on health and education service use.
- Standard Maternal, Neonatal and Child Health (MNCH) package, which recommended home visits by trained community healthcare workers (CHWs): 3 antenatal care (ANC) visits, 5 postnatal care (PNC) and infant health visits, and follow-up every 3 months up to 5 years of age.

Parenting intervention

- From pregnancy until child age 2.
- Intended to improve parental skills in creating a nurturing care environment.
- Covered interactive counselling and coaching on early learning, responsive caregiving, and child safety in addition to the standard MNCH package.
- Mainly targeted primary caregiver (99% biological mother) with efforts to engage fathers.
- Delivered by existing CHWs (average age 42, 70% with primary education, 48% female) with supervision from existing healthcare workers (HCWs).
- CHWs received monthly stipends of TZS 50,000 (USD 22) (disbursed quarterly) in line with government guidelines.
- CHW and HCW training and oversight by district council and regional level health management teams and implementing NGO partners.
- Smartphone-based digital application for CHWs to guide counselling and prompt feedback, and digital dashboard for HCWs to support remote supervision.
- Followed existing government home visit schedule until week 5 postpartum (3 ANC plus 5 PNC visits), then monthly home visits from 2 months.
- Addition of monthly group sessions once the average child reached 6 months.
- CHW equipment included a backpack, mobile phone, samples for toy making, crayons and building blocks (which were given to parents), separate handbooks and flipbooks for home visits and group sessions.
- CHW and HCW training included 9 days pre-intervention (new content), 6 days in-service (new content), and 7 refresher days.

High-value UCT intervention

- From pregnancy until child age 1.
- Intended to relax parental financial constraints.
- Six bi-monthly mobile money unconditional cash transfers (UCTs) of TZS 109,000 (USD 47).
- UCT transfer amount was calibrated so that the expected total monthly cost per child matched that of the parenting plus low-value UCT intervention.
- Cash transfer randomly targeted to either mother or father.
- Possibility to nominate someone if beneficiary did not own a mobile phone.
- Implemented by partner NGO.

Parenting plus low-value UCT intervention

- UCT from pregnancy until age 1, and parenting from pregnancy until age 2.
- Intended to improve parental skills in creating a nurturing care environment and to relax parental financial constraints.
- Parenting support plus 6 bi-monthly mobile money UCTs of TZS 77,000 (USD 33).
- Transfer amount calibrated to match the average TASAF transfer to young families, comparable to an adult's monthly food consumption.
- Cash transfer targeted to the mother.
- Other implementation procedures were the same as the high-value UCT.

About the data

About the randomised controlled trial data

Conducted between October 2022 and February 2025, the randomised controlled trial enrolled 3,109 pregnant women and their families across 314 communities in all 8 district councils in the Dodoma region of Tanzania — an area where 39% of children aged 24–59 months are not developmentally on track. Initiating the interventions during pregnancy provides rare evidence on the benefits and challenges of supporting families during this critical period for lifelong health, learning and wellbeing.

Participants were randomly assigned to 1 of 4 groups: a controlled group; a parenting support group; a high-value UCT group receiving 6 bi-monthly mobile money transfers of TZS 109,000 (USD 47); or a combined intervention group receiving parenting support and a low-value UCT of 6 bi-monthly transfers of TZS 77,000 (USD 33). The low-value UCT amount is equivalent to the average Tanzania Social Action Fund (TASAF) transfer disbursed to the most vulnerable families with young children in Tanzania.

The parenting support interventions aimed to strengthen nurturing-care counselling by adding early learning and responsive caregiving content to the standard MNCH package, which did not routinely include these components (United Republic of Tanzania, Ministry of Health and Social Welfare 2012). With scalability and sustainability being central to the study design, parenting support was delivered through Tanzania's existing community health system, by CHWs, rather than through the creation of parallel systems. CHWs were supported through a digital application (app) designed to improve counselling quality, enable remote monitoring and supervision, and strengthen implementation fidelity at scale. This helped to address common barriers to scaling parenting programmes, including supervision burden, quality assurance and resource-intensive delivery.

About the costing data

A detailed costing analysis enabled comparison of costs and cost drivers across intervention packages, informing the design of affordable and scalable government models. Notably, the high-value UCT and the combined parenting plus low-value UCT interventions were designed to have comparable recurrent costs per child. This enabled a comparison of the relative value of investing in larger cash transfers versus combining smaller transfers with parenting support, while maintaining equivalent overall programme costs.



A Kizazi Kijacho community health worker with a mother. Dodoma,

Main findings

Impacts on parenting practices and child outcomes at age 1

High-value unconditional cash transfer

- Child weight-for-height improved (0.15 standard deviations – equivalent to approximately a 6 percentile-point improvement, moving the average child from the 50th to the 56th percentile in the physical growth distribution), but no improvement to height-for-age.
- Gains in physical growth coincided with a 15% increase in household food spending and higher child consumption of two World Health Organization (WHO)-recommended food groups: proteins and fats.
- Cash transfers did not alter breastfeeding practices: 99% of mothers in all study groups were still breastfeeding at age 1 and 82% had exclusively breastfed for 6 months.
- The share of mothers reporting depressive symptoms above the Center for Epidemiologic Studies Depression Scale (CES-D) cut-off declined by 15 percentage points. Improvements in fathers' depressive symptoms were also observed; however, these changes were not large enough to significantly reduce the proportion of fathers scoring above the CES-D threshold.
- There were no significant effects on children's socio-emotional development (early emotional regulation, responsiveness and interaction with others), cognitive development (early thinking, learning and memory), or speech or language development. There were no effects on child stimulation or disciplining practices.

Parenting advice

- Children's socio-emotional development improved by 0.20 standard deviations relative to the controlled group. This is roughly equivalent to a shift of 8 percentile points, moving the average child from the 50th to the 58th percentile in the socio-emotional skills distribution
- The strongest change in parental practice was increased psychosocial stimulation of the children. While levels of caregiver-child play were already high – 83% of caregivers reported playing with their child – and remained unchanged, the intervention improved the quality of interactions. Specifically, caregivers were more likely to tell stories, name or count objects, and sing during play activities. Advice on these practices had rarely been received before this Kizazi Kijacho (KK) intervention. Survey teams also observed a greater number and variety of play materials in the home, particularly homemade toys, with the number of actively used toys increasing to 2.26, compared with 1.5 in the controlled group, including stacking toys such as wooden blocks, musical toys and drawing material.
- There was no measurable impact on child growth (weight-for-height or height-for-age) or on nutrition practices.
- Caregivers valued advice on breastfeeding, nutrition, hygiene and child health, and qualitative findings suggest perceived behaviour changes not (yet) captured in quantitative outcomes.
- Improvements in mothers' depressive symptoms were observed, but these changes were not large enough to significantly reduce the proportion of mothers scoring above the CES-D threshold. There were no changes in paternal depression symptoms.
- At age 1, there were no measurable effects on disciplining practices or children's cognitive, language or speech development.

"This is my ninth child... this is the one I have seen to be truly intelligent because of the training and guidance. This one seems smart and also very cheerful. When he wakes up in the morning, he doesn't cry at all, he starts laughing, which is different from the others – they would just cry immediately when they woke up. This is a big change. This Kizazi Kijacho programme should continue, it is good."

Father

"I like it when we come to the group and start singing, that makes me happy. When we sing, we are asked to croak like a frog, we are told to cluck like chickens, bark like a dog ... how are you supposed to croak like a frog? You start laughing and it makes us happy."

Mother

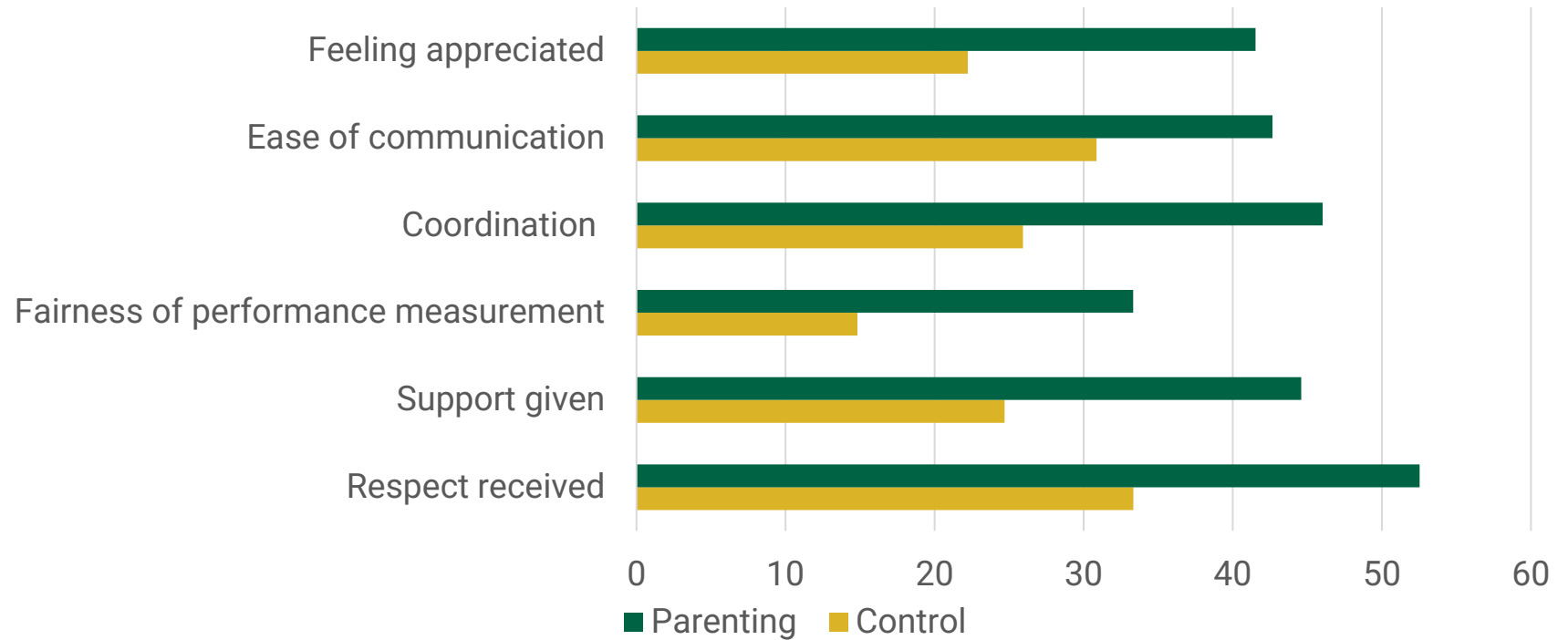
Parenting advice plus low-value unconditional cash transfer

- Combining parenting support with a low-value unconditional cash transfer (UCT) produced larger gains in child socio-emotional development at age 1 (0.27 standard deviations, roughly equivalent to a shift of 11 percentile points, moving the average child from the 50th to the 61st percentile in the socio-emotional development distribution) than parenting support alone, suggesting benefits from pairing advice with financial resources.
- Improvements coincided with substantially greater psychosocial stimulation in the home, largely driven by increased access to play materials: the mean number of toys tripled, rising from 1.5 in the controlled group to 4.5 (compared with 2.26 in the parenting-only group).
- Household food spending increased by 13%, but there were no effects on weight-for-height or height-for-age. Children consumed more proteins (e.g. nuts and pulses), but not more fats (e.g. cooking oil and butter) – which may have limited the impacts on weight-for-height.
- While paternal depression did not reduce, the maternal depression rate declined substantially by 11 percentage points.
- At age 1, there were no measurable effects on disciplining practices or children's cognitive, language or speech development.

Delivery of nurturing-care parenting support through community health workers supported by a digital app

- The parenting intervention uptake was high (92% registration; 89% retention until programme end), despite 40% of families missing support during pregnancy due to delayed enrolment. Overall, access to support remained strong: caregivers received an average of 16 home visits and attended 10 group sessions, with 76%–89% participating in KK activities during any 2-month period.
- Home visits were valued for personalised and private support and convenience, while group sessions provided peer learning, social support and opportunities for children to play together.
- Training, supportive supervision, flipbooks, digital tools and experience strengthened CHW confidence, counselling quality, motivation and job satisfaction over time. After two years, caregiver trust in CHWs and healthcare workers (HCWs) increased substantially (+16 percentage points each, relative to controlled). CHW satisfaction also improved across multiple domains, including supervisory support (+18 percentage points), peer support (+8 percentage points) and feeling valued and adequately equipped for their role (+11 percentage points). In parallel, caregivers' perceptions of CHW competence and communication improved markedly (+32 percentage points). Improvements were already emerging during the first 15 months, but only became significant in the final year, highlighting the need for longer implementation periods to capture programme maturation effects.

Figure 1: Percentage of community health workers who are very satisfied with supervisory support, by area

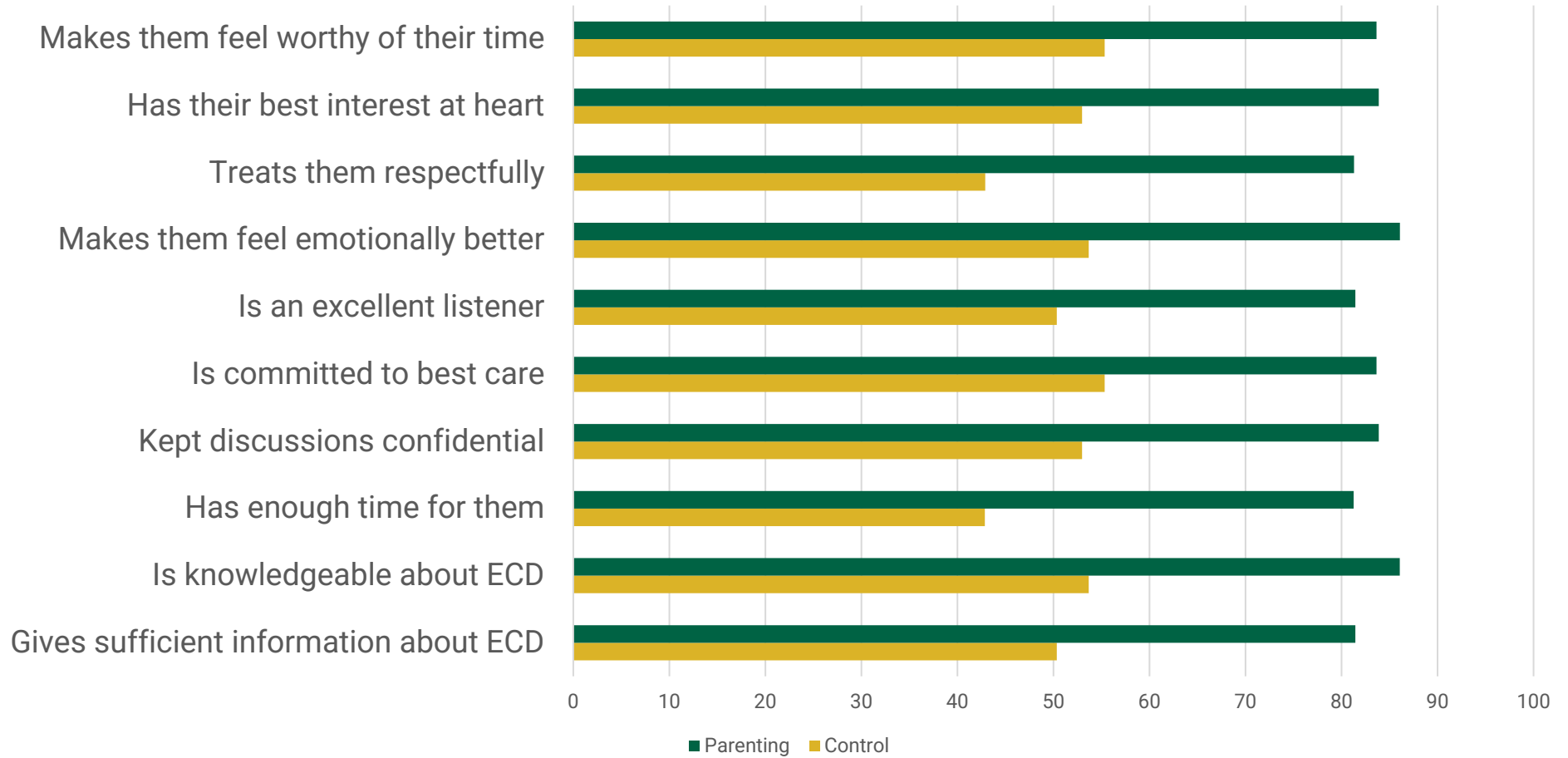


- At the home visits and group sessions, CHWs maintained high fidelity to protocols and procedures, including for example the use of flipbooks and the app, and checking for mother and child danger signs. The smartphone app and flipbooks were widely valued for improving counselling structure, accuracy, and confidence, although connectivity issues, software glitches, and device

maintenance disrupted app use. Many CHWs also applied KK knowledge beyond the programme in routine health services offered in their communities.

- Caregivers valued CHW advice, particularly on early learning and stimulation, and many requested programme continuation or expansion. Advice sometimes spread in the community beyond participating households through family and community networks, with evidence of some non-KK families adopting the parenting practices.
- Male caregiver participation in KK group sessions increased over time but remained modest (reaching 26%–29% in group session participation), constrained by work demands and social norms around childcare.
- Service delivery by CHWs remained sensitive to systematic constraints, including farming seasons, workload pressures, transport costs, caregiver availability, dissatisfaction with financial incentives and uneven supervision quality. Although CHWs' dissatisfaction with their workload and incentives were significantly lower than in controlled areas (a difference of 17 percentage points and 24 percentage points, respectively), concerns remained widespread. CHW turnover reached 15% over 2 years, partially undermining returns on training investments.
- Adherence to the expected supervision schedule by HCWs (monthly supervision for each CHW) was variable, despite moderate overall levels of support (13 visits per HCW; 8 visits per CHW over the implementation period). Completion of expected supervision visits was lower among male HCWs, among HCWs with larger CHW caseloads, and during peak farming seasons, highlighting the influence of workload and competing demands.

Figure 2: Percentage of caregivers who think the community health worker most or all of the time ...



"Over the last two years, I have learned many things through KK that have improved my life; I am now smarter than I was before –I did not know how to use smartphones but now I do, and I have become competent in training many mothers in many topics that I did not know about previously. I used to be terrified of teaching women or visiting them in their homes, but everything has changed for the better; I am happier."

Community health worker

"I feel proud ... When I walk in the street, I see people pointing and saying, 'She is a CHW'. They appreciate my service and sometimes ask for your advice. This is because of the impact of the training and the work I do for KK –they often see me visiting my clients, whereas before KK we rarely visited households. I am respected ... when I carry my bag heading to household visits, I feel important because the mothers enjoy the education, and the more they enjoy, I am also motivated, and that makes happy."

Community health worker

Costs

- Assuming conservatively that each CHW reached only the children included in the KK study (10 per CHW on average), monthly recurrent costs per child were estimated at USD 39 for parenting support, USD 23 for the high-value UCT intervention, and USD 57 for the combined parenting support plus low-value UCT intervention.
- In practice, however, the CHWs were asked to continue serving all children in their official catchment area, not only the KK study children, and many of them did. Based on government guidelines in place at the study onset, which assumed that each CHW would support 60 families, monthly recurrent costs per child were identical for the parenting plus low-value UCT package and the high-value UCT package (USD 21 per child), compared with USD 6 per child for standalone parenting support.
- The parenting programme required substantial upfront investment – particularly for training, curriculum development and digital tools – but had relatively low direct delivery costs due to reliance on existing CHWs, HCWs and government systems. Training was the largest cost component (31%), driven mainly by residential sessions and subsistence allowances, while NGO management and programme design accounted for a further 41%.
- In UCT-only arms, transfers represented the largest provider cost, reflecting the simplicity and low administrative burden of mobile cash delivery. However, indirect NGO management and overhead costs remained substantial at 17%.

- External funds channelled through NGOs financed nearly all delivery costs (95%), with government contributions limited to staff time from HCWs and local officials, indicating an NGO-supported model built on existing government platforms rather than a government-funded system.
- Government-led scale-up could reduce costs through economies of scale and existing infrastructure. Additional potential efficiencies include reducing training and overhead costs, increasing CHW caseloads where feasible, and integrating digital tools into government systems (as is currently happening in Tanzania, see below) – while maintaining adequate CHW incentives and support to sustain motivation and service quality.
- These findings provide an initial basis for decisions on programme adaptation and scale-up. An ongoing second phase costing analysis is expected to offer further recommendations for future investment within national systems.

Sustaining Kizazi Kijacho

- Financial constraints remain the main barrier to sustaining and scaling KK beyond the study period, limiting training, CHW incentives, supervision and replacement of materials such as flipbooks. Reduced donor funding has further constrained support available to district health teams.
- KK parenting advice is now mainly sustained through routine clinic activities rather than home visits, which have largely stopped due to reduced CHW allowances. Continuation varies with CHW motivation and local support. Supervision of CHWs and HCWs has declined. There is some spread of KK practices through informal peer learning, but this appeared limited. Integrating parenting support into routine clinic sessions may improve reach and feasibility, but could reduce impact due to a lack of personalised, one-to-one advice and limited time for explanation, as well as inconsistent caregiver attendance.
- Tanzania's new integrated CHW programme may support sustainability by expanding the CHW workforce, standardising training and allowances, and including ECD content. However, training on play and early learning has so far been less extensive than under KK, and CHWs do not receive KK flipbooks, potentially limiting counselling quality.
- Implementation partners EGPAF and D-tree continue to support government efforts to strengthen and scale community-based ECD services, with lessons from KK informing emerging systems and approaches.
- The KK app is unlikely to continue in its current form, but its content is being integrated into the government's Unified Community System (UCS), a digital tool used by CHWs during home visits, improving prospects for long-term institutionalisation.



Mother and child playing.
Dodoma, 2026.

Conclusion and recommendations

The findings highlight key implications for designing sustainable, affordable and effective ECD services.

What works for different early childhood development outcomes?

Cash transfers and nurturing-care parenting support each drive meaningful impacts through different pathways, together offering a powerful strategy to support ECD.

- Cash transfers improved nutritional outcomes beyond what information provision alone achieved, but impacts emerged only when transfers were sufficiently large. The findings suggest that financial constraints – rather than limited knowledge – may increasingly be the main barrier to improving child growth in Tanzania. This highlights the potential of adequately sized cash transfers, beginning in pregnancy, to improve diets and reduce malnutrition.
- Cash transfers improved weight-for-height but not height-for-age. Dietary improvements during infancy are more likely to affect weight-for-height, while impacts on height-for-age may require earlier and/or longer exposure. In addition, delays in registration and payments meant that the first KK UCT was not received in pregnancy, but when children were around 3 months on average; it is important that interventions do not miss critical windows that can influence prenatal and early infancy factors associated with child height-for-age, which include poor maternal health and inadequate antenatal care, together with early childhood nutritional deprivation and repeated infection (Elisaria et al. 2025).
- Parenting support significantly improved child socio-emotional development, with the greatest gains observed when parenting advice was combined with cash transfers. Cash alone was insufficient to improve this critical domain, which underpins later learning, mental health, and school readiness.
- Consistent with well-documented evidence, cash transfers significantly improved maternal mental wellbeing.
- None of the interventions improved cognition or language at this early developmental stage, possibly because these domains develop more slowly. Effects may emerge later, and qualitative findings already suggest positive changes.

What are the implications for programme design and scale-up?

Sustainable, affordable, and effective parenting programmes depend not only on CHWs, but also on strong health systems, supportive supervision, reliable financing and delivery models that reflect families' realities. Improving child development outcomes at scale also requires stronger links between health and social protection systems, as parenting support and cash transfers address complementary developmental needs.

Strengthen support for CHWs

- Ensure adequate remuneration, transport support, manageable workloads, induction systems, and contingency plans for turnover. Tanzania has signalled its intention to pay regular CHW stipends, and financial remuneration and transport support are recommended in international guidance. Sustaining parenting support after external funding ends will likely depend on continued investment in CHW incentives and supervision.

Improve supervision

- Provide realistic supervisory workloads (considering HCWs' wider responsibilities and strongly seasonal household availability patterns), induction after turnover, and stronger support from health authorities and council health management teams.

Design flexible delivery models

- Hybrid approaches combining home visits, group sessions and routine clinic contacts may improve feasibility, resilience and reach, particularly in seasonal rural settings. Routine clinic delivery can extend coverage but may provide less intensive support and be more vulnerable to missed attendance compared to home visits.

Reach families earlier

- Strengthen coordination between health facilities and CHWs, especially during antenatal care and early postnatal care, to reduce late enrolment and maximise impact during critical ECD windows.

Increase community and family engagement

- More systematically engage fathers and community leaders, using father-directed strategies that accommodate fathers' schedules and preferences to strengthen participation, acceptability, and uptake of nurturing care practices.

Design for affordable scale-up

- Transitioning to a financially sustainable government-led model will require efficiency gains and adaptations to reduce costs. Training and NGO management were the largest cost drivers, suggesting opportunities for lower-cost training approaches (e.g. local or blended models), while government integration may reduce overhead costs through existing systems and economies of scale.

Build on emerging government systems

- Integrate effective parenting content into new CHW programmes and training packages, ensuring this includes key KK components – including play-based learning, home counselling content and practical caregiving guidance, with demonstrated effectiveness. Digital tools may require adaptation and integration into existing government platforms (e.g. UCS) rather than direct replication.

Integrate parenting support with social protection

- Closer links between CHW-delivered parenting interventions and cash transfer programmes (such as Tanzania Social Action Fund (TASAF)) could improve both socio-emotional development and nutrition. Better coordination between health and social protection systems, particularly from pregnancy onward, may maximise early childhood gains.

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Thrive

Thrive is a multi-country research programme that aims to support countries to turn what we know about positive early childhood development into practical, scalable, low-cost programmes, able to transform societies over multiple generations. Working closely with policymakers and other stakeholders, Thrive aims to build understanding of early childhood development service delivery models and how they can be provided cost effectively and at scale, and how these systems can innovate, improve, and better serve children and communities in low- and middle-income countries.

Our five focus countries are Bangladesh, Ghana, Kiribati, Sierra Leone and Tanzania.

The Thrive programme is funded by UK International Development from the UK government 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.

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