

About Thrive

Thrive is a multi-country research programme that aims to support countries in turning what is known about positive early childhood development into practical, scalable programmes. Working in collaboration with a global community of academics and development organisations, and with national policymakers, decision-makers and experts, Thrive aims to build an understanding of early childhood development service delivery models, and how they can be provided cost effectively and at scale to improve childhood health and wellbeing in low- and middle-income countries. Thrive's five focus countries are Bangladesh, Ghana, Kiribati, Sierra Leone and Tanzania — but the insights being generated will be applicable to other low- and middle-income countries as they expand public early childhood development services. The programme is funded by the UK's Foreign, Commonwealth & Development Office (FCDO) and New Zealand's Ministry of Foreign Affairs (MFAT), and is managed by Oxford Policy Management in collaboration with the Institute for Fiscal Studies.

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Kizazi Kijacho

Evidence for sustainable parenting and cash transfer programmes in Tanzania

Kizazi Kijacho (KK) — meaning 'Next Generation' in Swahili — has produced novel evidence to inform the design of scalable, sustainable, and cost-effective early childhood development programmes in low- and middle-income countries. Through a randomised controlled trial (RCT), more than 3,100 families in Tanzania's Dodoma region received one of several support packages, in addition to routine care:

- No additional support (control group).
- Parenting advice from pregnancy until age 2, on health and nutrition, safety and security, early learning, and responsive caregiving. Community health workers provided the advice during home visits and group sessions in the community and were guided by a mobile phone app, a KK flipbook and other materials (including a handbook on how to make toys from locally available materials).
- A high-value unconditional cash transfer (UCT) of six bi-monthly mobile money transfers of TZS 109,000 (USD 47) during the first year of the child's life.
- Parenting advice exactly as described above, plus a low-value UCT of six bi-monthly mobile money transfers of TZS 77,000 (USD 33) during the first year of the child's life.

This brief presents KK findings on intervention impacts and recurrent costs up to age 1, and process evaluation findings on delivery and acceptability across the full 25-month implementation period.



Key messages

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.

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.

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.

To maximise impact, greater efforts should be made to identify and enrol mothers early in their pregnancies.

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.

Costs

The programme was designed to keep the direct delivery costs low, using locally available materials and existing community health workers and healthcare workers.

The detailed costing study shows there is scope to improve efficiency and lower costs as the programme model is scaled up and becomes more integrated into government systems.

Training was the largest cost component (31% of total programme costs), driven mainly by high-frequency residential sessions, daily subsistence allowance rates, and trainer salaries. Indirect NGO management and NGO programme design together accounted for a further 41% of total costs.

Type of support / impact / cost at age 1	Parenting advice	High-value UCT	Parenting advice plus low-value UCT
	✓	×	✓
	+6pp* storytelling		+8pp storytelling
Did the proportion of caregivers who engaged in child stimulation practices increase?	+6pp naming or counting objects while playing		+9pp naming or counting objects while playing
	+8pp singing		+10pp singing
	✓	×	✓
Did the number of toys in the home increase?	+0.76 toys		+3 toys



Programme delivery process



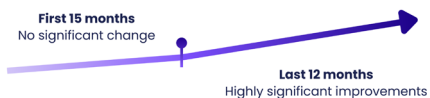
Cash transfers reached nearly 90% of targeted families. The parenting intervention uptake was high (92% registration; 89% retention until programme end).



Delays in registration meant that many families missed the critical antenatal care and postnatal care period:

- 40% of families eligible for parenting support registered only after birth
- The average age of children at the time of the first cash transfer was 3 months

Community healthcare worker (CHW) competence, motivation and job satisfaction, alongside caregiver trust and confidence in their advice, improved substantially over time — helped by training, the app, flipbooks, and supportive supervision.



CHW performance and programme delivery were affected by community, health system and wider geographic factors, including:

- Workload pressures for health facility staff supervising CHWs/variable levels of supervision
- CHW dissatisfaction with the level and payment schedule of stipends
- Low availability of households during peak farming periods
- Problems related to the KK app
- Geographic access and infrastructure issues, particularly for CHWs serving more remote communities
- High CHW turnover — reaching 15%
- High healthcare worker turnover — reaching 23%

76%-89% of families engaged in either a home visit or a group session in any two-month period throughout the 25-month implementation period.

Father participation in KK group sessions increased over time, from 10% at the beginning to 29% at the end of the group session implementation period.

Challenges to engaging fathers included:

- Lack of clear invitations by the CHW
- Competing priorities (mainly income-generating activities)
- Limited advance notice of visits
- Gender norms

Type of support / impact / cost at age 1

Parenting advice

High-value UCT

Parenting advice plus low-value UCT

Type of support / impact / cost at age 1	Parenting advice	High-value UCT	Parenting advice plus low-value UCT
Did children's socio-emotional development improve?	✓ +0.20 SD** This is roughly equivalent to a shift of 8 percentile points relative to the control group distribution.	×	✓ +0.27 SD This is roughly equivalent to a shift of 11 percentile points relative to the control group distribution.
Was there any impact on cognitive or language development? ¹	×	×	×
Did expenditure on food increase?	×	✓ +15%	✓ +13%
Did the percentage of children consuming proteins/fats change? Proteins include nuts and seeds, pulses (peas, beans, lentils), meat, etc. Fats include oil, butter, etc.	×	✓ +7pp* proteins +8pp fats	✓ +7pp proteins
Did weight-for-height improve?	×	✓ +0.15 SD Equivalent to approximately a 6 percentile-point improvement compared with children in the control group.	×

Type of support / impact / cost at age 1	Parenting advice	High-value UCT	Parenting advice plus low-value UCT
Did height-for-age improve? ²	×	×	×
Did the proportion of mothers reporting depressive symptoms above the Center for Epidemiologic Studies Depression Scale (CES-D) cut-off decline? ³	×	✓ -15pp	✓ -11pp
Did the proportion of fathers reporting depressive symptoms above the Center for Epidemiologic Studies Depression Scale (CES-D) cut-off decline? ⁴	×	×	×

Type of support / impact / cost at age 1	Parenting advice	High-value UCT	Parenting advice plus low-value UCT
Did parents' use of corporal punishment to discipline their children decline?	No change ×	No change ×	No change ×
What were the monthly recurrent costs ⁵ per child (only considering the 10 children per community health worker (CHW) in the KK study sample)? ⁶	USD 39	USD 23	USD 57
What were the monthly recurrent costs per child (considering all 60 children that are officially included in the CHW catchment area)?	USD 6	USD 21	USD 21

* pp = percentage points
 ** SD = Standard Deviations

¹ This may reflect developmental timing, as cognition and language develop more slowly and often become more measurable during the second year of life.

² Dietary improvements from cash transfers during the first year of life are more likely to improve weight-for-height; impact on height-for-age may require longer follow-up and possibly longer exposure.

³ 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.

⁴ Improvements in fathers' depressive symptoms were observed, but these changes were not large enough to significantly reduce the proportion of fathers scoring above the CES-D threshold.

⁵ Recurrent costs cover ongoing programme management (indirect and direct) and direct delivery expenses such as staff time, supervision/labour costs, travel/transport stipends, communication bundles, and transfers for the UCT arms. Recurrent costs exclude fixed investment costs that do not vary with the level of scale.

⁶ KK recruited a random sample of approximately 10 children per CHW catchment area for the study, while CHWs were expected to continue serving all eligible children. Restricting cost-per-child calculations to the study sample would therefore overestimate programme costs per beneficiary. Official government guidelines at study onset indicated that CHWs should serve 60 children; estimates based on this assumption are illustrative of costs under full implementation according to government guidelines.

