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CHILD HEALTH LEADERSHIP AND NETWORKS FROM 2000 TO THE PRESENT: COUNTRY PERSPECTIVES FROM MOZAMBIQUE, TANZANIA AND UGANDA

CROSS COUNTRY REPORT

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CONTENTS

ACRONYMS

CHW	Community health worker
CIRCLE	Coordinating and Implementing Research to Communicate Learning and Evidence
CSO	Civil service organizations
DWCH	Department of Women and Child Health (Ministry of Health, Mozambique)
FP	Family planning
GAVI	The Vaccine Alliance
HIV	Human immunodeficiency virus
iCCM	Integrated community case management
IDI	In-depth interview
IMCI	Integrated management of childhood illnesses
IMR	Infant mortality rate
INGO	International non-government organization
ITN	Insecticide treated bed nets
KMC	Kangaroo mother care
MCH	Maternal and child health
MDG	Millennium Development Goals
MNCH	Maternal, newborn, and child health
MOH	Ministry of Health
MOH-RCHS	Ministry of Health, Reproductive and Child Health Services
NGO	Non-governmental organization
NMR	Neonatal mortality rate
ONA	Organization network analysis
ORS	Oral rehydration solutions
PHC	Primary health care
PORALG	President's Office-Regional Administration and Local Government
RCHS	Reproductive and child health services
RED/REC	Reaching Every District/Reaching Every Child
RMNCH	Reproductive maternal, newborn, and child health
SDG	Sustainable Development Goals
SETSAN	Technical Secretariat for Food Security and Nutrition
SWAP	Sector-wide approach
U5MR	Under-five mortality rate
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VHT	Village health teams
WB	World Bank

WHO	World Health Organization
WVI	World Vision International

EXECUTIVE SUMMARY

Over the past three decades, significant progress has been made in child health around the world. Between 1990 and 2015, the mortality rate for children under five declined by 53%[1]. In addition, sixty-two countries achieved the fourth Millennium Development Goal of reducing child mortality by two-thirds. Despite these successes, considerable preventable deaths still occur, and health disparities exist, particularly in Sub-Saharan Africa[2]. Greater attention is still needed on child health to address the unfinished agenda as well as ensuring all children thrive and reach their full potential.

In 2015, the United States Agency for International Development (USAID) commissioned a mapping of global child health leadership to better understand the evolution of child health since the year 2000, the network of global stakeholders and leaders, and implications for its future investments in child health.[3] This landscaping exercise recommended the global child health community strengthen leadership, reframe child health to be more inclusive, and reposition it to improve outcomes. Findings also emphasized that country leadership must be at the center, leading the future child health agenda; and that the study effort go further to document country perspectives on these same issues.

To complement the global findings with country voice, the USAID Coordinating and Implementing Research to Communicate Learning and Evidence (CIRCLE) project conducted the Child Health Country Perspectives Study. The objectives of the study were to: understand how leadership, organizational networks, and political commitment affected progress in child health; identify constraints and enablers of national progress; and determine how these and other contributors to change might advance child health going forward in Mozambique, Tanzania, and Uganda.

This study employed a mixed-methods approach including a desk review and secondary data analysis, in-country in-depth interviews (IDIs) with child health stakeholders at the national level, and an organizational network survey and analysis (ONA)[4]. The evolution of several child health interventions (IMCI, child immunization, newborn health, and child nutrition) were also traced to explore how leadership, networks, and political commitment affected changes in program performance over time. The desk review provided information on policies, plans, programs, evaluations, and lessons learned, as well as mortality and coverage data. The IDIs added perceptions of child health history, leadership, political commitment, stakeholders, coordination, and achievements. The ONA provided a more systematic picture of existing child health networks' structure and function, including strategy, implementation, capacity strengthening, and accountability.

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[1] UNICEF, 2015 Retrieved from https://www.un.org/en/development/desa/population/publications/mortality/child-mortality-report-2015.asp

[2] Bryce, J., Victoria, C.G., Black, R.E. 2013. The unfinished agenda in child survival. The Lancet, 382 (9897) Retrieved from https://www.thelancet.com/action/showPdf?pii=S0140-6736%2813%2961753-5

[3] Taylor, Schumacher, and Davis. Mapping Global Leadership in Child Health. MCSP Program, USAID, April 2016

[4] For a detailed description of study methods and analysis, please see case study reports.

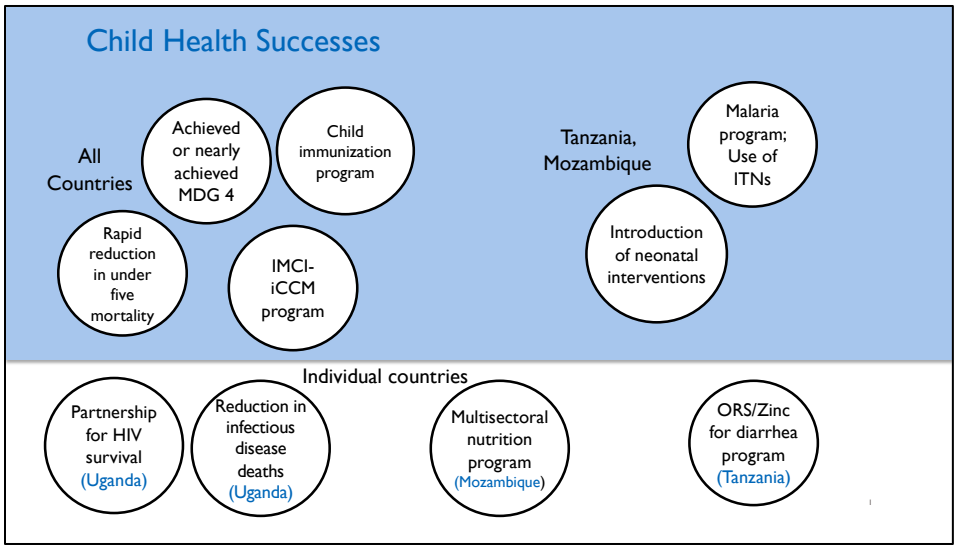
This report provides an overview of the three case studies conducted as part of the Child Health Country Perspectives Study. It summarizes similarities and contrasts from the findings and provides overarching conclusions and recommendations. The individual reports[5,6,7] provide detailed analyses for each country. The findings are intended to inform investment, policy, and programmatic decisions for each country as well as enhance stakeholder collaboration to improve child health outcomes.

FINDINGS

CHILD HEALTH SUCCESSES AND DISAPPOINTMENTS

Respondents' descriptions of child health progress from 2000 to 2015 were consistent with available evidence and similar across countries. All countries experienced large reductions in under-five mortality and either met or came close to achieving MDG4 – a remarkable success. However, this perception led to a sense that the job was done despite persistence of preventable deaths. Child health successes across the three countries are summarized in Figure 1.

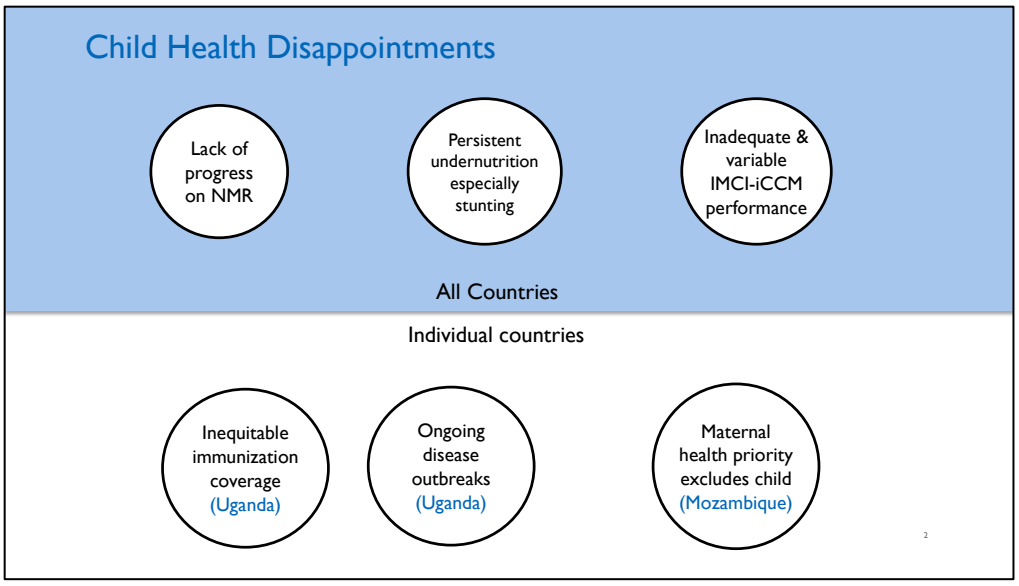
Figure 1: Child Health Successes



[5] Taylor ME, Mrisho M, & Ruducha J. Child Health Country Perspectives Study Tanzania Country Case Study. USAID, January 2020.
[6] Waiswa P, Ruducha J, & Opio, C. Child Health Country Perspectives Study Uganda Country Case Study. USAID, January 2020.
[7] Taela, K & Ruducha J. Child Health Country Perspectives Study Mozambique Country Case Study. USAID, January 2020.

Respondents from the three countries also reported similar disappointments. Most often, they identified lack of progress on neonatal mortality rates (NMR) as the primary problem, with the slow decline of stunting a close second. Figure 2 illustrates these disappointments across countries.

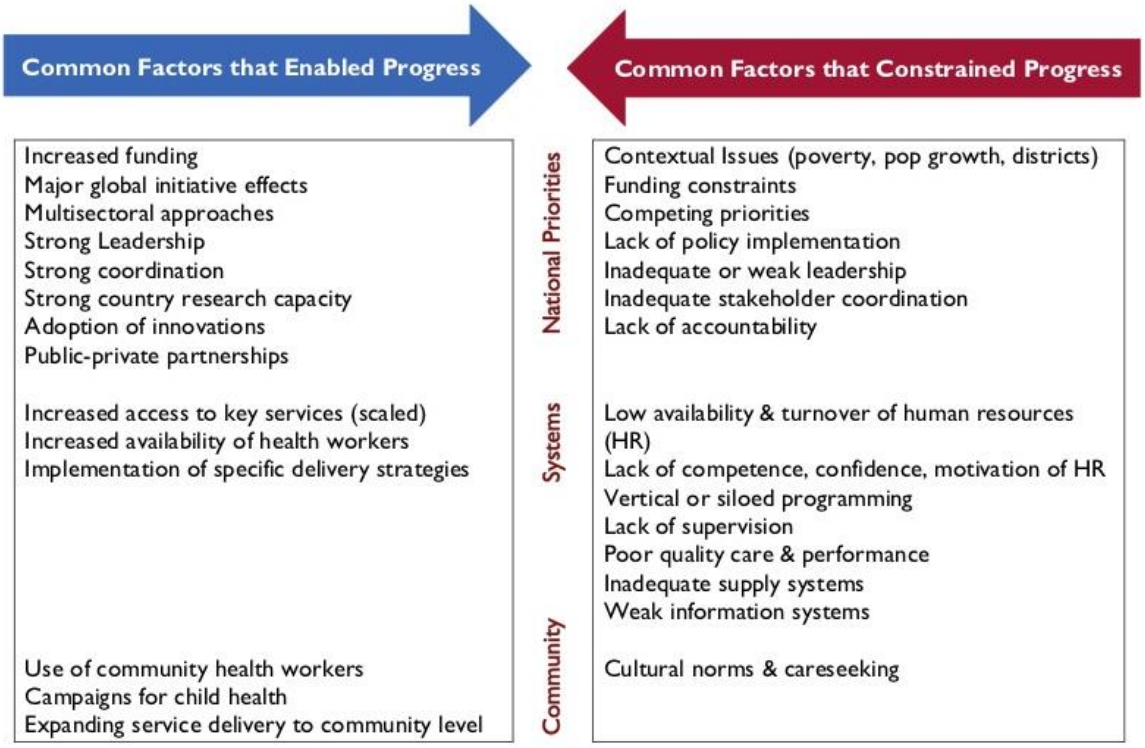
Figure 2: Child Health Disappointments



FACTORS THAT ENABLED AND CONSTRAINED PROGRESS

Factors that enabled and constrained progress in child health were similar in the three countries. The most frequently reported enablers included funding, leadership, coordination among stakeholders, the scaling up of services, increased availability of health workers, and use of community health workers (CHWs). The most common constraints included funding shifts, competing priorities, weak leadership, lack of accountability, lack of competent, motivated health workers, vertical programming, poor quality care and inadequate performance, and lack of care seeking. These themes are summarized in Figure 3 in terms of national priorities, health systems, and community engagement. More detailed descriptions follow in this report.

Figure 3: Common Factors that Enabled and Constrained Progress



GLOBAL INITIATIVES EFFECTS ON COUNTRIES

Respondents were also asked how child health related global initiatives affected child health progress at country level. Respondents spoke of major initiatives such as MDGs, Every Woman Every Child, A Call to Action, A Promise Renewed, and SDGs, as well as intervention-specific initiatives such as IMCI-iCCM, HIV/AIDS and Polio Eradication. Positive and constraining effects are shown below in Figure 4.

Figure 4: Effects of Global Initiatives on Country Progress

The findings from the three case studies describe the evolution of child health programs and outcomes, factors that enabled and constrained progress, and the state of the networks that have emerged to lead and support it, notably the effectiveness of leadership and the stakeholder networks in the three countries.

Characteristics of Child Health as an issue

Effective networks are more likely to emerge if there is sympathy for the group involved and if their problems are thought to be severe and possible to solve. In all three countries children are valued and described as vulnerable and needing care. However, once MDGs were achieved, the sense of urgency diminished, and child mortality was no longer viewed as a leading problem. All three countries refocused attention on newborn mortality, introducing new interventions that have yet to achieve the same level of success.

Network and Actor Features

FRAMING: The framing of child health is important because it positions the issue politically so that priority and commitment can be built by the network. The early framing of child health as child survival was successful in the three countries as well as globally. Later framing around "ending preventable deaths" did not appear to revitalize positioning. More recent framing around "reducing newborn mortality" was understandable given mortality rates but did not generate the same level of political commitment in the context of post-MDGs and appeared to lessen attention to overall child health. Respondents in Tanzania and Mozambique suggested a more inclusive framing to support network interests.

LEADERSHIP: Strong, well connected leadership enables network action and progress. While there was some variability in how active government leaders were over the fifteen year period, those from the Tanzanian and Ugandan MOHs were respected and perceived to be effective. In Tanzania, high level champions added legitimacy to network efforts. In Mozambique, where higher level leadership has not been strong, the network is less well developed.

COMPOSITION: A network that has diverse participation and well-established linkages is more effective. There are many stakeholders for child health in Tanzania and Uganda, their networks are dense, and while there are some differences in how closely organizations are linked, the connections are mutual. Mozambique has some diversity of participation in nutrition and health but has fewer linkages. An important gap in Mozambique and Tanzania is that there is more limited engagement of civil society organizations (CSOs) and organizations related to public accountability.

GOVERNANCE: For networks to be effective, there need to be legitimate governing structures capable of facilitating collective action of the stakeholders. All three countries have established mechanisms for coordination of functions essential to child health programs. Tanzania and Uganda have strong foundations while Mozambique's higher level mechanisms would benefit from capacity building and more visible leadership. All networks need to be more collaborative, essentially working more closely together around their most pressing priorities.

POLICY ENVIRONMENT

The policy environment in which the child health networks function involves an understanding of allies and opponents and of the funding resources available. The challenges with funding identified by respondents are probably applicable to most development issues. The issue now seems to be a question for the future, in which there will be increased reliance on domestic funding and possible competition for resources with a broader social agenda.

In the decade run up to the MDGs, there was support from multiple stakeholder groups whose interests were consonant in Mozambique, Tanzania and Uganda. In some time periods, there was competition between issue areas where organizational interests did not appear aligned. After 2015, the emphasis on newborn health intensified, especially in Tanzania, and, while stakeholder interests did not conflict, it did appear to lead to neglect of the unfinished agenda.

Tanzania and Uganda have solid child health networks that lead and have demonstrated the ability to position child health as a priority. Mozambique's technical network has been more functional than its higher level policy network. Depending on the time period, network priorities drove progress overall (MDG 4), were more exclusionary (maternal focus, newborn focus, lack of newborn facility care focus), or were less able to prioritize and influence health system constraints (HR, IMCI performance at scale). All networks would be more effective if they moved from a predominantly *coordination* level of functioning to *collaboration* around the most significant issues.[8]

COUNTRY RECOMMENDATIONS

FRAMING CHILD HEALTH FOR THE FUTURE

Recommendation 1:

a. **Frame child health to include all children under five and to inspire collective action that can achieve each country's vision for child health, development and wellbeing.**
b. **Leaders should communicate and ensure inclusion of any reframing in health sector plans, government policies, and budget requests.**

Early in the MDG era, child health was framed as "Child Survival" and was addressed by a few critical interventions that managed or prevented illness. By 2008, mortality had declined, and child health was reframed to focus on newborn mortality, which was declining more slowly. According to the respondents in the three study countries, reducing newborn mortality has become the principal focus of child health efforts since 2015.

[8] Coordination entails sharing information on and seeking to align priorities, activities and plans. Collaboration includes coordination along with mutual capacity building and shared responsibility for activities and outcomes.

In trying to focus on one actionable area to the exclusion of others, important needs and approaches are left out. The countries aim to ensure that newborns survive but they would also like children to be well-nourished, well-developed, and healthy as adolescents. Interventions that cut across a broader spectrum of health and survival issues such as nutrition, exposure to air pollution, or violence are likely to be overlooked. If the SDGs capture the vision of these three countries, countries would do well to clarify the importance and fit of broadly framing child health in these movements. The process of reframing should be built into existing child health network activities likely involving strategic planning, reviews of progress on plans, scheduled consultations on primary health care (PHC), universal healthcare (UHC), SDGs, and relevant research or evaluation reviews

There are multiple ways to reframe child health that can help focus on services and systems that meet multiple needs for all age groups for the future. One possible path is for countries to build out and adapt the recent proposal to 'place children at the center of the SDGs' from the WHO-UNICEF-Lancet Commission on the future of children.[9] Ultimately, any changes in the framing of child health and vision need to be understood and have buy-in from leaders, providers, and communities. These might be communicated as part of SDGs and UHC adaptation processes underway, and as part of health sector planning and review efforts.

LEADERSHIP AND POLITICAL COMMITMENT

Recommendation 2: Foster leaders and champions for child health, support active leadership work at national and local levels, and hold leaders accountable for outcomes.

Potential child health leaders in country institutions should be identified and capacity should be built so that they are able to communicate vision, plan, negotiate, and hold the child health network accountable for achieving outcomes. Opportunities to strengthen leadership include mentoring, cross-country exchange, and modelling from the examples of others. It may be possible to address leadership growth directly as an essential part of operationalizing the SDGs for children. This would need meaningful support by the national child health network and by the individual organizations that comprise it.

Another part of ensuring active leadership over time is to build and report on more transparent accountability mechanisms that highlight child health. It is also possible to hold donors and development partners accountable in all countries through country leadership and leveraging global efforts such as the Independent Accountability Panel, UHC2030 or joint evaluation exercises. Donors and funders should

[9] Clark H, Coll-Seck AM, Banerjee A, et al. A future for the world's children? A WHO-UNICEF-*Lancet* Commission. *Lancet* 2020; published online Feb 18. https://doi.org/10.1016/S0140-6736(19)32540-1.

be able to build accountability into the support they provide to organizations as part of contractual arrangements.

Children are a vulnerable population that also need champions to advocate, rally support, and prioritize child health issues. Sometimes political leaders may be in positions and able to function as champions only for a limited time and, while it is useful to have them, others are needed to consistently advocate and publicize how children are faring. Child health champions should be fostered by providing platforms and coverage of their activities. If children are put at the center of the SDGs, their voices will also be essential to raising awareness.

Finally, respondents in Mozambique and Uganda highlighted the positive potential for more active community and CSO involvement in child health. This type of involvement creates public accountability for the health system overall and for the actions of those leaders who serve communities.

COORDINATION AND COLLECTIVE ACTION

All three countries have child health networks usually with the MOH and its divisions, UNICEF, and WHO at the center. These networks are actively engaged in policy development, resource mobilization, planning, monitoring, evaluation and improvement. Tanzania and Uganda reported fairly intensive working relationships between organizations - mostly coordination and collaboration while Mozambique's reports were of somewhat fewer intensive interactions. At the national level, child health networks appear to *coordinate* most work. This is a good foundation on which to build a stronger, *collaborative* network more capable of enhancing child health.

Recommendation 3: Child health network stakeholders should commit to improving national network collaboration and initiate a process of network strengthening.

Most organizations in the networks participate in meetings and events, but there is limited information on other aspects of their participation that are critical for successful collaboration. Are leaders clear and do they invite active participation? How effectively do they communicate? How much trust has been built among the network members? It is likely that networks in all three countries would benefit from strengthening some of these areas by self-assessing and actively building better networking skills and approaches.

Each network would have to agree on a common aim – defining what collaboration look likes in contrast to the current situation and then creating capacity building plans to deliberately improve upon coordination. One way to make this more concrete is to facilitate a process of selecting an important priority, such as improving the quality of care or introducing a new intervention, and then to use the opportunity to apply better networking skills at a collaborative level. It would compel organizations to focus on improving network behaviors, capacities, and processes for the best results.

Recommendation 4: Child health network stakeholders should commit to building and enabling stronger collaboration at district and community levels.

Although strengthening collaboration of the national level network is likely to be more manageable, enhancing coordination at implementation levels (regions, districts) is a more pressing need according to country respondents. One way the national level can help is to set the expectation that staff from their own organizations will collaborate by communicating well, building trust, and actively engaging within the

local health network structure (local government, health managers). The national level network can enable this by holding their own staff accountable for how they work with colleagues in districts or regions and by removing barriers or bottlenecks encountered that may be under national rather than local control.

However, the structure and function of existing child health networks at local levels may not be understood well enough to design capacity building. In this case, it will be useful to document how local child health networks function and most importantly, plan and facilitate capacity building in the context of regular activities.

Implications for the Global Health Community

Given global initiatives' policy and resource impact on child health as well as ensuring that countries be at the center, own, and unequivocally lead programs to improve the health of their children, it is incumbent upon the global child health network to proactively support countries.

The global child health network, including key organizations and their coordinating bodies, should:

Recommendation 1: Support country framing of child health to be more inclusive.

With the recent launch of 'placing children at the center of the SDGs', by the WHO-UNICEF-Lancet Commission, there is an opportunity to engage with countries to both vision and frame child health more broadly for the future. Our study focused on children under five, which is more limited than the 0-18 years and the life course focus for the Commission, but it echoed the need for a more inclusive framing to expand perspective for health, development and well-being. The global level should:

- Build a bridge with country goals and vision for their children, to accomplish the SDGs (rather than drive the goals down as statements and indicators); and to
- Resist exclusion, messaging, and funding that fragments child health

Recommendation 2: Engage with national child health networks such that network capacity for collaboration is built and decentralized to local levels.

National child health networks are responsible for setting expectations of their actions and results, and for how they wish to function. In the case of the three country case study networks, there was a stated desire to collaborate at the national level and to build collaboration at local levels. The national network must build its own capacity over time, but the actions (directives, resources, negotiations) of the global level will impinge on their ability to move toward that goal. If countries choose to engage in placing children at the center of the SDGs, then there are a series of steps that the global level will take that involve the child health and other country networks. How the global level engages in terms of communication, building trust, and supporting leadership will affect network capacity. Thus, the global level should:

- Support any planned activities to build child health network capacity at national and local levels, incorporating them into discussions of multisectoral networks; and
- Assess expected and unintended consequences of new directions on the development of local, regional or district network collaboration and adjust to ensure support.

Recommendation 3: Support accountability systems developed by the child health network.

A number of recommendations for strengthening accountability measures and mechanisms arose in the country studies. These are the remit of governments, within organizations, and with the public. However, many of the development partners and donors have global and country missions or offices that participate in country work. It is important that guidance and incentives allow accountability systems to function as intended within government systems and within individual organizations. It may also be important to provide space for civil society voice.

The three country case studies for Mozambique, Tanzania, and Uganda provided the opportunity to document their perspective on child health leadership and networks, to understand the factors that enabled and constrained progress in child health, and to identify actions that will enhance progress for children in the future. Findings, conclusions and recommendations for each country are documented in the individual country reports. This report summarizes the study approach, overarching findings and conclusions, and provides several generalized recommendations for country level as well as for the global health community.

INTRODUCTION

In 2015, the United States Agency for International Development (USAID) commissioned a study to better understand how child health had evolved since the Millennium Development Goal (MDG) period started in 2000.[10] This global mapping study explored child health leadership, stakeholder networks, and political commitment to improving child health. To reach the Sustainable Development Goals (SDGs) for 2030, this study recommended that:

- Child health be re-framed more holistically to include newborns and older children together with a well-defined aim for equity;
- Leadership for child health among organizations at the global level be clearly and very publicly re-established;
- Fragmentation of child health into exclusive components be reversed and ultimately addressed together;
- Robust data be provided and used for accountability; and
- Countries be at the center of moving child health forward through strong leadership and ownership of policies, plans, programs, and outcomes.

The last recommendation involving countries was based on strong and repeated input from study participants, that countries and their leaders are best positioned and capable of driving the changes needed to end preventable child deaths, to ensure children thrive and reach the SDGs. However, the global study was limited by the lack of country input since all respondents worked at global or regional levels. Country voice is essential to understanding how child health has evolved, how it can progress, how leaders can be supported, and networks strengthened.[11]

This report consolidates findings from case studies conducted in Tanzania, Uganda, and Mozambique; three sub-Saharan African countries that participated in a follow-on study.[12,13,14] The study's objective was:

To understand the effectiveness of leadership and stakeholder networks in improving child health in these countries over the past fifteen years and to suggest how these, and other drivers

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[10] Taylor ME, Schumacher R, & Davis N. Mapping Global Leadership in Child Health. MCSP Program, USAID, April 2016

[11] The full global study report can be found at: https://www.mcsprogram.org/resource/mapping-global-leadership-child-health/

[12] Taela, K & Ruducha J. Child Health Country Perspectives Study Tanzania Country Case Study. USAID, January 2020.

[13] Taylor ME, Mrisho M, & Ruducha J. Child Health Country Perspectives Study Tanzania Country Case Study. USAID, January 2020.

[14] Waiswa P, Ruducha J, & Opio, C. Child Health Country Perspectives Study Uganda Country Case Study. USAID, January 2020.

of change, might be harnessed to advance child health going forward.

More detailed study questions are shown in Box 1. The findings are intended to enhance collaboration and progress in child health to help achieve the vision and goals of each country.

Box 1. Research Questions

- What strategies were employed to improve child health over time?
- What were the key facilitators and barriers to progress in child health since 2000?
- Who were important leaders and organizations in child health in these countries and what role did they play to influence progress and results?
    - Applying organizational network analysis theory, what were the structure, relationship characteristics and dyammics of country child health organizations and networks?
    - What role did USAID contributions play in progress on chld health, with the Call to Action for Child Survival, A Promised Renewed (APR), and Ending Preventable Child and Maternal Death (EPCMD) initiatives?
- Applying a conceptual framework developed by Shiffman and others[15], what factors shaped the development of child health networks? What was their influence on priorities, policy and results in these countries?
- What might be done next by USAID and others to enhance progress on child health over the next 5 to 10 years in these countries?

METHODOLOGY

This study employed a mixed-methods approach including a desk review and secondary data analysis, in-depth interviews (IDIs) with child health stakeholders at the national level, and an organizational network survey and analysis (ONA).[16] The evolution of several child health interventions (IMCI, child immunization, newborn health, and child nutrition) were also traced to explore how leadership, networks, and political commitment affected changes in program performance over time. The desk review provided information on policies, plans, programs, evaluations, and lessons learned as well as mortality and coverage data. The IDIs added perceptions of child health history, leadership, political

[15] Shiffman J, Quissell K, Schmitz HP, Pelletier DL, et al. A framework on the emergence and effectiveness of global health networks. Oxford University Press: Health Policy and Planning, August 29, 2015.

[16] For a detailed description of study methods and analysis, please see case study reports.

commitment, stakeholders, coordination, and achievements. The ONA provided a more systematic picture of existing child health networks structure and function, including for strategy, implementation, capacity strengthening, and accountability. The ONA more explicitly characterizes connections and interactions over the recent past.

The study team conducted 62 IDIs and 63 ONA interviews with respondents from different types of organizations across the three countries (see Tables 1,2). Respondents for the IDIs were selected for their child health expertise and experience; those for the ONAs were selected for their experience with inter-organizational working relationships. The respondents were identified by consulting local researchers, in-country child health leaders, USAID missions, and staff from other development partners.

Table 1: In-depth Interviews by Type of Organization and by Country

Type of Organization	Mozambique	Tanzania	Uganda	Total
Country Government	4	6	3	13
Multilaterals/UN Agencies	4	4	4	12
Bilateral Organizations	2	2	1	5
Academic Institutions	0	8	5	13
Non-governmental Organizations	7	4	6	17
Other (Professional Association, Foundation)	0	0	2	2
Total	**17**	**24**	**21**	**62**

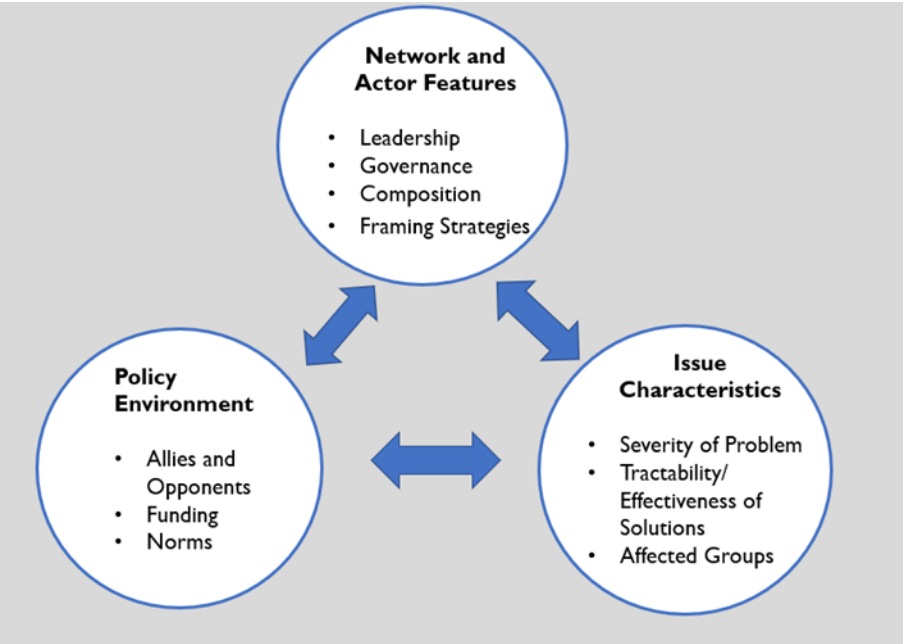
Table 2: Organizational Network Interviews by Type of Organization and by Country

Type of Organization	Mozambique	Tanzania	Uganda	Total
Country Government	2	4	3	9
Multilaterals/UN Agencies	2	4	6	12
Bilateral Organizations	2	3	1	6
Academic Institutions	0	4	5	9
Non-governmental Organizations	9	10	8	27
Total	**15**	**25**	**23**	**63**

Data were analyzed according to method and synthesized to arrive at findings and conclusions. The IDIs were coded based on study questionnaires and the Shiffman et al. framework using the web software

Dedoose[17] (see Figure 5). The Shiffman framework organizes ten factors used to help assess the effectiveness of health networks into three broad categories as illustrated in the circles: network and actor features, policy environment (in country), and characteristics of the issue. ONA data were analyzed using UCINet software and NetDraw. A confirmation process was used to validate relationships.

Figure 5: Shiffman Framework



STUDY LIMITATIONS

While this study provides substantially more information on country perspectives, there are still some limitations. The findings are drawn from a defined number of interviews that had to be limited in length which may have precluded more in-depth consideration of related health topics such as HIV/AIDS or malaria. Although interviews related to child nutrition were conducted with health sector experts, interviews were not conducted with those from other sectors. While some insight into funding constraints was gained, additional data from secondary sources would have been more definitive. Also, given resources available, it was not possible to interview respondents from the district or community levels. At these levels more direct information might have been uncovered on the effects of national programs, the differences that arise from inequities, and the strength of local leadership and networks.

[17] Shiffman J, Quissell K, Schmitz HP, Pelletier DL, et al. A framework on the emergence and effectiveness of global health networks. Oxford University Press: Health Policy and Planning, August 29, 2015.

Despite these limitations, the information provided does assist in understanding the effectiveness of leadership and stakeholder networks in improving child health from the country perspective.

BACKGROUND: COUNTRY CONTEXT

Among the three case study countries, contextual similarities and differences should be considered when interpreting study findings and conclusions. In Mozambique, economic conditions, based on ample natural resources and the country's strategic location, had been improving since the late 1990s. However, in 2016, a hidden debt crisis, the impact of the 2019 cyclones, and ongoing political unrest in some provinces has left the country with significant constraints. Improvements in health systems have been slow to happen because of repeated system insults and corruption.

By contrast, Tanzania has experienced political stability and high economic growth over the past 10 years. As a result, the government has improved infrastructure and expanded health services. However, a high population growth rate has held back efforts to reduce poverty and sometimes overwhelmed health services.

Uganda's economy grew rapidly until 2010, then slowed considerably until 2017, when it again began to improve. In the early part of this time period, public sector reforms led to improved services, but after 2008, public accountability declined significantly undermining health system performance. Uganda has one of the highest population growth rates in the world, and as the largest refugee host country in Africa, the country struggles to adequately fund and support health systems.

Tanzania and Uganda have similar health systems. At the national level, ministries of health serve as institutional leaders, setting policy and coordinating child health stakeholders. Both countries have a history of decentralization with services managed by districts and delivered through facility tiers extending to the community level. In Uganda, village health teams (VHTs) provide health care. Tanzania has recently introduced a newly structured version of community health workers (CHWs). In both countries, NGOs and faith-based organizations serve as important service providers and contributors to district health systems. In Uganda, these organizations and civil society organizations (CSOs) are critical to filling funding gaps for district plans.

Mozambique's health system has a national structure similar to those in Tanzania and Uganda but started decentralizing health management to provinces and districts, with mixed success. The public sector provides most services, while private not-for-profit organizations work directly with the government. Mozambique has invested in revitalizing community health workers (APES) to better reach communities.

All three countries experienced large declines in child mortality and two achieved MDG4, while both maternal and neonatal mortality declined more slowly, missing targets. All three countries have seen some improvement in child nutrition but still have unacceptably high rates of stunting. Uganda and Tanzania's high population growth rates challenge child health programs.

Figure 6: Trends in U5MR for Case Study Countries

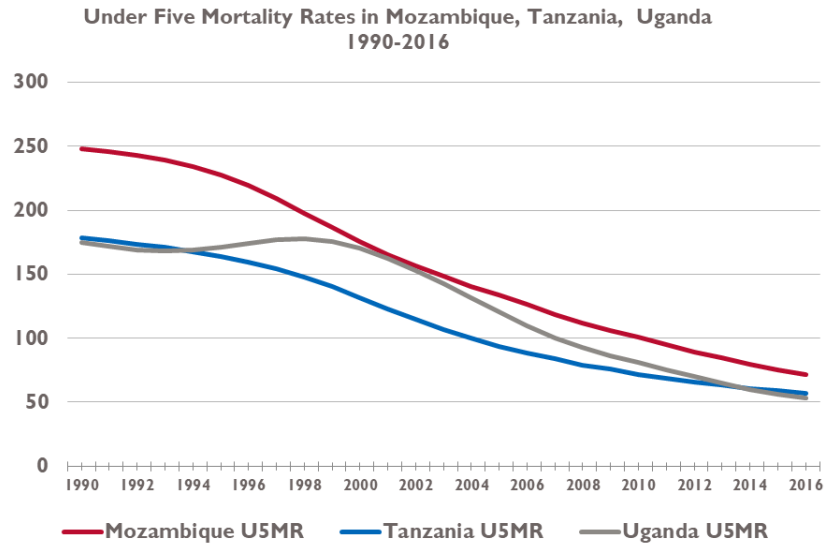
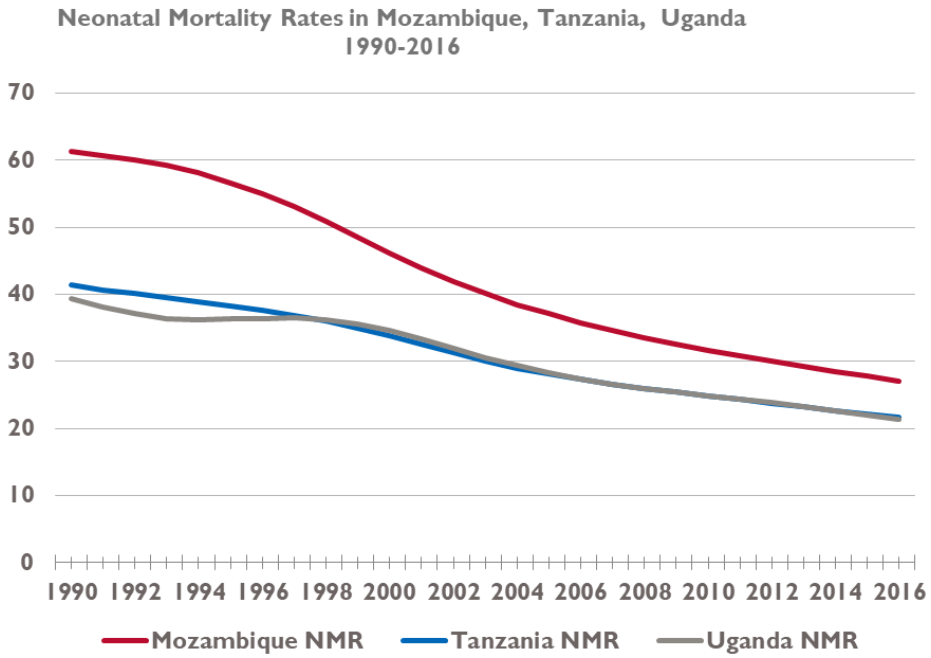


Figure 7: Trends in NMR for Case Study Countries



Source: UN Inter-agency Group for Child Mortality Estimation, 2017 (http://data.unicef.org)

As with most sub-Saharan and low-income countries, geographical differences both within and between the three countries have resulted in considerable inequities in health service coverage and outcomes.

The countries' health plans attempt to identify and target low performing districts that are generally more rural, poor, and less accessible.

FINDINGS

CHILD HEALTH SUCCESSES AND DISAPPOINTMENTS

Respondents' descriptions of child health progress from 2000 to 2015 were consistent with available evidence and similar across countries. All countries experienced reductions in under-five mortality and either met or came close to achieving MDG4 – a remarkable success. However, this perception led to a sense that the job was done despite persistence of preventable deaths. Child health lost focus as attention was directed newborns or maternal health.

Respondents viewed immunization programs as the most successful, followed by IMCI and integrated Community Case Management (iCCM). In Uganda and Tanzania, malaria interventions including insecticide-treated bed nets (ITNs) proved effective, while in Mozambique a multisectoral nutrition program produced results. Finally, respondents in Mozambique and Tanzania regarded the introduction of newborn health interventions as a success. Child health successes across the three countries are summarized in Table 3.

Table 3: Comparison of Reported Child Health Successes

Reported Success	Tanzania	Uganda	Mozambique
Reduction in Under Five Mortality (U5MR)	√	√	√
Achieved MDG 4	√	Very Close	√
Immunization Program	√	√	√
IMCI-iCCM Program	√	√	√
Malaria/ITN Program	√	√	
ORS-Zinc Program	√		
Multisectoral Nutrition Program			√
Reduction in infectious disease deaths		√	
Partnership for HIV Free Survival		√	
Intro of newborn health interventions (KMC, chlorhexidine for cord care)	√		√

Respondents from the three countries reported similar disappointments. Most often, they identified slow declines or no recent change in neonatal mortality rates (NMR) as the primary problem with the lack of progress on stunting a close second. While all respondents viewed IMCI-iCCM a successful approach, gaps persist in assuring health system performance. In Mozambique, maternal health was heavily promoted as a top priority since the 1990s often to the exclusion of newborn and child health, making it difficult to deliver an integrated service package. In Uganda, respondents were concerned with disparities in immunization coverage and disease outbreaks. Table 4 compares these disappointments across countries.

Table 4: Comparison of Reported Child Health Disappointments

Reported Success	Tanzania	Uganda	Mozambique
Slow declines of Neonatal Mortality Rates	√	√	√
IMCI-iCCM program performance is inadequate	√	√	√
Stunting levels remain high; persistent undernutrition	√	√	√
Maternal health overrides attention to child health			√
Inequitable immunization coverage		√	
Continuing disease outbreaks		√	

ENABLING FACTORS AND CONSTRAINTS TO PROGRESS

Respondents identified which factors drove momentum and which constrained progress. Tables 5 and 6 summarize facilitators and constraints organized by major theme and grouped into three overarching categories: National Priorities and Resources; Health Systems; and Community Engagement. There were many similarities among the case study countries as well as some notable differences.

Table 5: Factors that Enabled Progress in Child Health

	Themes	Mozambique	Tanzania	Uganda
National Priorities & Resources	**Increased funding**	For nutrition, immunization (GAVI)	For immunization (GAVI)	For health sector overall; immunization (GAVI)
	Decentralization of funding		For health sector, through local govt	
	Major global initiative effects	Increased accountability	Raised profile of child health	Increased resources & accountability
	Multisectoral approaches	Applied to nutrition	Recently applied to nutrition	
	Strong Leadership	Technical staff; Top leaders in nutrition network	Pres Kikwete as champion, ensured accountability; Centralized, closely connected, clear leadership; MOH-RCHS	MOH-Child Health
	Strong coordination	Technical working groups; recently strengthened	Effective, inclusive mechanisms; collaboration relationships	Coordination, collaboration relationships in network
	Strong country research capacity		Local evidence for situation analysis, cost effectiveness	Applied to child health, universities, centers of excellence

	Themes	Mozambique	Tanzania	Uganda
	Adoption of innovations		Early adopter for IMCI, GAVI, ADDOs, data technology	For immunization
	Public-private partnerships		Expansion including services and standards	
	Child health policy design	Strong, clear framework		
Health Systems	**Increased access to key services (scaled)**	For ITNs, facility delivery	IMCI, new vaccines	For immunization, IMCI-iCCM, PHC
	Increased availability of health workers	Especially maternal & child nurses	Trained health professionals	
	Implementation of specific delivery strategies	Reaching Every Child/ Reaching Every District	Integrating services into packages such as IMCI	Child health days; Reaching Every Child
	Strengthening supervision		Prioritizing strong supervision	
	Expansion of infrastructure	Increased number of health facilities		
	Investment in robust information systems & technology		For immunization program; testing improved approaches; partnerships	
Community Engagement	**Use of community health workers**	Revitalizing CHWs; included in IMCI	Expansion of CHWs nationwide	Expansion of Village Health Teams
	Campaigns for child health	For changing socio-cultural norms and behaviors	For raising awareness of health problems & services available	
	Expanding service delivery to community level			For IMCI-iCCM

Table 6: Constraints to Child Health Progress

	Themes	Mozambique	Tanzania	Uganda
National Priorities and Resources	**Contextual Issues**	Low literacy rates; socio economic vulnerability; deeply ingrained corruption	Lack of long term planning projections (pop growth, urbanization, financing)	Inefficiency of too many small districts
	Funding constraints	Heavy reliance on external funding; geo inequalities; diversion to HIV	Inadequate, inequitable allocation; diversion to HIV/AIDS in some time periods	Uneven; Inadequate, inequitable distribution; SWAP abandoned; project based

	Themes	Mozambique	Tanzania	Uganda
	Competing priorities	MH overrode CH; HIV/AIDS more important	General health infrastructure; HIV/AIDS more important	
	Lack of policy implementation	Poor implementation		Did not impact NMR
	Inadequate or weak leadership	Weak at top levels; MOH-DWCH	Frequent turnover at all levels; lack of delegation	
	Inadequate stakeholder coordination	Poor involvement of CSOs	Apply their own agendas & do not coordinate	Uncontrolled proliferation led to poor coordination
	Lack of accountability	Network is limited; Weak between state actors and citizens	Network is limited; does not happen without political commitment	Network is limited; lack of public accountability by government
	Low political commitment		Shifts in political signature issues	
Health Systems	**Low availability & turnover of human resources (HR)**	Overburdened HR; frequent turnover; brain drain to private orgs	Absolute shortages at all levels; frequent turnover; lack neonatal specialists; capacity building network limited	Inadequate numbers and inequitable placement
	Lack of competence, confidence, motivation of HR	Unqualified or under qualified HR	Inadequate performance; lack confidence especially for newborn care; unmotivated	Inadequate performance
	Vertical or siloed programming	Disease-specific vertical programs; interventions fragmented; patchy IMCI	HIV/AIDS vertical at the outset	FP, immunization are siloed; fragmented health system
	Lack of supervision	Poor supervision and mentoring at facilities	Little mentoring especially in remote areas	Monitoring not well enforced
	Poor quality care & performance		Declined as programs scaled up (IMCI); inadequate generally, lack of improvement system	Poor quality facility-based newborn care; weak implementation of newborn guidelines
	Inadequate supply systems	Shortages of medicines, supplies, materials	Frequent shortages of medicines	
	Weak information systems	Lack of routine, systematized data	Some weak, poor quality systems; hard to establish reliable estimates such as for MMR, PMR, NMR	Monitoring & reporting guidelines not enforced

	Themes	Mozambique	Tanzania	Uganda
Community Engagement	**Cultural norms & care-seeking**	Negative cultural norms for pregnancy, newborn health	Lack of care-seeking for newborns	
	Hidden costs		Free MCH care is not free – family bears many costs	
	CHW system fit	Lack of integration of CHWs into public health sector		

PRIORITIES AND RESOURCES

Increased funding for child health programs, often from donors, drove improvements in child health because it supported policy development, supplies, medicines and vaccines, training, supervision, and evaluation. In some periods, it also supported additional staff, special attention to low performing areas and the scale up of interventions. All respondents singled out the importance of GAVI funding of vaccines and health systems strengthening. In Uganda and Mozambique, global initiatives (e.g., Polio Eradication Initiative, Expanded Program on Immunization, PEPFAR) brought resources and accountability.

By contrast, financing was also a constraint for all three countries because resources were insufficient to support plans, not available long enough to institutionalize and sustain programs, or inflexible and narrowly targeted to certain interventions, functions, geographic areas, or costs. These limited resources were allocated without sufficient attention to needs and equity, leading to uneven support of interventions, regions, and implementing organizations.

The heavy reliance on external funding has led to incomplete implementation and unsustainable programs at different times in all of the countries. In the first decade of the 2000s, funding and associated conditions and boundaries sometimes swayed country priorities detracting from child health. This was especially true for HIV/AIDS in Tanzania and Mozambique.

Strong national leadership has been important to all three countries, but Tanzania especially benefited from high level political engagement. Former President Kikwete made MNCH his signature issue, promoted it, monitored progress from all levels, and linked it to his global leadership on the Committee on Information and Accountability (CoIA) for the MDGs. In the time period he was president, this ensured that all relevant government agencies treated child health as their highest priority and were constantly aware of progress.

For all three countries, divisions within Ministries of Health (MOH) have played lead roles though at different levels and with variability over time. These divisions have provided guidelines and plans, harmonized stakeholders, and held them accountable for their commitments, enhancing progress. Tanzania's MOH and MOH-RCHS have had individuals in recent years that were skilled coordinators. Mozambique has active leaders at technical levels but weaker decision making and follow through at top policy levels in the MOH and the Department of Women and Child Health (DWCH). This has led to greater reliance on external donor and technical agencies. Uganda has a relatively strong MOH with the MOH-CH central to guiding the child health network. Leadership turnover is common everywhere and

all countries noted that at times it has created delays, shifted priorities, and generally slowed program progress.

Child health related organizations report frequent coordination and collaborative working relationships among organizations in the child health network[18] in each country. Across all three countries there were moderate levels of connectivity among organizations (~50 to 60% of relationships confirmed). They work together more intensively than simple communication which is a strength. In Tanzania and Uganda, the MOH, UNICEF, and WHO have the highest number of connections; however, in Mozambique, UNICEF and USAID are the most highly connected. USAID plays a more prominent role in Mozambique than in the other countries perhaps because of the high priority accorded to child health in the Mission, project work, and active promotion by staff and contractors. Other country Missions fund child health activities but have a larger presence and funding from other accounts such as for HIV/AIDS and malaria. International NGOs (INGOs) appear on the periphery of the child health networks in all countries.

The ONA data also provide information on the nature of more specific activity networks within the child health networks. Those focusing on strategy, capacity building, and accountability are shown to have similar densities in all countries, indicating moderate information sharing and engagement. In contrast, the density of the implementation network varies considerably from 12% in Mozambique, to 30% in Tanzania, to 40% in Uganda. The Tanzanian and Ugandan MOHs have the most connections across all activity networks; in Mozambique, the Technical Secretariat for Food Security and Nutrition (SETSAN) and UNICEF have the most connections. Table 7 summarizes ONA findings across all study countries and Box 2 provides additional detail on indicator definitions.

Table 7: ONA Analysis for Tanzania, Uganda, and Mozambique

Findings	Mozambique	Uganda	Tanzania
Whole Network			
Density	Almost half of relationships realized	Almost 60% realized	Half realized
Frequency of interaction	Mostly monthly	Monthly or quarterly	Monthly or quarterly
Quality	Fair and good	Good and very good	Good and very good
Intensity	Mix of collaboration & coordination	Mix of collaboration & coordination	Mix of collaboration & coordination
Degree Centrality: (ordered by highest 1st)	USAID, UNICEF, SETSAN	MOH-CH, UNICEF-Maternal and Child Health (MCH), WHO (all at 20 each)	MOH-RCHS, WHO, UNICEF, Prime Minister's Office Regional Administration and Local Government (PMORALG), MOH-

[18] Child Health Network' refers to the organizations recognized as working in child health in-country. These organizations include government, multilateral agencies, bilateral agencies, non-governmental organizations, civil society organizations, foundations, and private sector entities.

Findings	Mozambique	Uganda	Tanzania
			Immunization (IMM), MOH-NUT) (17-22)
Betweenness Centrality: Influential bridges (ordered by highest 1st)	USAID, SETSAN	MOH-Child Health (CH), WHO, UNICEF-MCH	WHO, MOH-RCH, UNICEF
Peripheral Organizations	INGOs except ANSA	INGO's except: Malaria Consortium, World Vision, PSI, JSI Maternal and Child Survival Project.	INGOs on periphery
Implementation Network (Weakest of all networks)			
Density	12% of relationship realized	40% realized	A third realized
Degree Centrality	UNICEF (5) Others 3 and below	UNICEF, MOH-CH, UNICEF-Nutrition (NUT) (14–19)	MOH-RCHS, UNICEF, MOH-NCH, President's Office Regional and Local Government (PORALG), WHO (16–21)
Betweenness Centrality (descending order)	UNICEF, JHIEGO, MOH-MCH	UNICEF-MCH, World Vision International (WVI), MOH-CH	MOH-RCHS*, UNICEF
Strategy Network			
Density	Third of potential relationships realized	Third realized	Almost 40% realized
Degree Centrality	SETSAN, USAID, UNICEF, ANSA, DFID and MOH (around 5–7 ties)	MOH-CH, WHO, UNICEF-MCH (15–16)	MOH-RCH, WHO, UNICEF, MOH-NCH, PMORALG (16–21)
Betweenness Centrality (in descending order)	ANSA*, SETSAN, USAID	MOH-CH*, UNICEF-MCH, WHO	
Capacity Development Network			
Density	Quarter of potential relationships realized	Third realized	Almost 30% realized
Degree Centrality	UNICEF, SETSAN, WHO (5-7)	MOH-CH, UNICEF-MCH, UNICEF-NUT, WHO (13-16)	MOH-RCHS, UNICEF, WHO, MOH-IMMUN, PMORALG, MOH-NCH (13-16)
Betweenness Centrality (descending order)	UNICEF, SETSAN	MOH-CH, WHO, WB	UNICEF, MOH-Newborn and Child Health (NCH), WHO, MOH-IMMUN, MOH-RCHS
Accountability Network	NOT CONDUCTED		
Density		A quarter realized	A quarter realized
Degree Centrality		MOH-CH, UNICEF-MCH, WB (10-15)	MOH-RCHS, PORALG, UNICEF, WHO, MOH-NCH (13-16)
Betweenness Centrality (descending order)		MOH-CH, Malaria Consortium, WVI	MOH-RCHS, UNICEF

Box 2: ONA Measure Definitions

Degree centrality: Calculated by counting the number of adjacent links to or from an organization or a person. It is a measure of activity and reflects the potential power of having direct relationships. These direct links reduce the reliance on intermediaries to access information or resources. The assumption is that more connections are better than fewer connections.

Betweenness centrality: Measures the extent to which organizations fall between pairs of other organizations on the shortest paths connecting them. It represents potential mediation or flow of information or resources between organizations in the network. The measure is used to assess power, as an organization may control the flow of information and potential resources.

Multiplexity: Describes multiple relationships among the same set of organizations. Four types of binary relationships are specified: 1) developing key strategies, policies, legislation; 2) building capacity; 3) developing/implementing accountability mechanisms; and 4) implementing child health programs.

Intensity: Describes the level of interaction between different organizations or nodes. Two measures of levels of intensity are used: 1) frequency of interaction; and 2) type of interaction (communication, coordination or collaboration).

Relationship quality: Reflects how well a relationship fulfills expectations and needs of the involved parties and is a significant measure of relationship strength. For this study, relationship quality is measured using a 5-point Likert scale: poor, fair, good, very good, or excellent.

Centralization: An expression of how tightly the network structure is organized around its most central point. The general procedure is to look at the differences between the centrality scores of the most central point and those of all other points.

Density: The sum of the ties divided by the number of possible ties. The density of a network may offer insights into the speed at which information diffuses among the nodes and the extent to which organizations have high levels of social capital or constraint.

Effective coordination has been important to harmonizing policies and guidelines, committing to child health plans and programs, optimizing available resources avoiding duplication, reviewing progress, and improving implementation. However, at national levels, coordination could be improved. There have been tensions between partner-driven and country agendas at the national level in Tanzania, and disharmony and overlap as partners proliferate at local levels in Uganda. There is a pressing need in all countries to better coordinate at local levels but there are fewer mechanisms, perhaps with less power, to facilitate this process.

Lack of leadership, coordination, and variable mechanisms have resulted in limited accountability for inputs or outcomes especially in Mozambique and Uganda. As noted earlier, in the decade prior to the MDGs, Tanzania benefited from high level engagement in holding government accountable. A scorecard was applied and has been followed by other mechanisms such as performance-based contracts and monitoring. The relative lack of civil society engagement in Mozambique and Tanzania represents a missed opportunity for public participation in accountability.

Another driver of progress in Tanzania and Uganda was that research was actively undertaken by and disseminated through local academic institutions or research institutes. During the decade of the 2000s, capacity was actively built, and these institutions are closely linked to government (MOH) and development partners that support child health. The availability of local evidence from these research efforts accelerated the adoption of new interventions and refinement of existing interventions. Cross-country exchanges with colleagues further sped the diffusion of innovations across borders of these countries (often convened by WHO).

HEALTH SYSTEMS

Respondents from the three countries frequently identified systems issues as enablers and constraints to progress in child health. In Uganda and Mozambique, programs implemented vertically such as immunization, maternal health or family planning fragmented management at national and district levels, and care at clinic and community levels. As child health interventions such as those for pneumonia, diarrhea, and malaria were integrated into the IMCI or iCCM service delivery package in all countries, there was more progress in child health. The close match of IMCI to the most common causes of child death and the inclusion of community or primary health care levels were important everywhere.

The addition of these interventions and service packages expanded population access to lifesaving services. In Mozambique this was particularly true for ITNs and facility delivery while in Uganda, it was most obvious for immunization and IMCI. Tanzania was an early adopter of IMCI and new vaccines in the immunization program both of which were scaled up rapidly.

The most challenging constraint has been the shortage of human resources in all three government health systems. During the past 15 years, there have been too few human resources overall and too few doctors and/or nurses in speciality areas such as neonatal care. Pervasive problems affecting human resources have been inequitable distribution, frequent turnover, and inadequate training, supervision and support. Those workers who are in place may be unmotivated or lack the confidence to provide needed services. This broad constraint has affected leadership and management as well as access to, and quality of, services. Consequently, public trust in the system has diminished. Some efforts to improve human resources have been effective; in Mozambique, an effort to post MCH nurses to districts and facilities has improved child health services. In Tanzania, requiring stronger personnel accountability has helped ensure staff are at post.

In Tanzania, the need for supervision to ensure effective IMCI was demonstrated early on but maintaining it to ensure quality of implementation proved a challenge, as it did to Uganda and Mozambique. Regular, supportive supervision lagged and was not reliably effective when resources or transport were not routinely available, staff were overloaded, or it was a low priority. When supervision and mentoring were inadequate, performance suffered as evidenced by low adherence to IMCI guidelines or lack of care provided to newborns. This limited the effectiveness of key child health services.

Ensuring quality and improving the performance of child health programs has become a focus area more recently in the countries. Quality improvement programs exist but are not yet widely embedded in health system culture in Tanzania and Uganda. Extending them to all levels of care for children is a challenge, although the basic building blocks of guidelines, measures, training and mentoring are in place.

The quality of care for newborns in Uganda's facilities is a particular problem. Improving quality is a major objective in all three country health plans.

In Uganda and Mozambique, certain system approaches, such as Reaching Every District or Reaching Every Child (RED/REC), strengthened utilization and quality of immunization services. In Uganda, Child Health Days raised awareness and delivered interventions more widely. In contrast, respondents attributed the success of the Tanzanian immunization program to having a consistent system strengthening process that targeted key sub-systems sequentially, starting with supply and cold chain, moving to data and supervision, and finally evaluation, and improvement.

The lack of robust, routine data was a major constraint everywhere. In Tanzania, this has slowed the improvement of maternal and newborn health, and in Mozambique masks gaps in availability and utilization. In Uganda, monitoring and reporting guidelines are good but are not enforced among the many local implementers, making coverage difficult to assess. There have been smaller scale investments to build better information systems that include child health in Tanzania (e.g. Better Data Initiative). Also, the immunization program has leveraged technology improving the efficiency and usability of its system. In Tanzania and Uganda, respondents noted that it was an opportune time to more fully engage information systems technology and to combine it with quality improvement and accountability for better results.

COMMUNITY ENGAGEMENT

Even though the study did not explore child health at the community level, respondents from all three countries identified CHWs as critical to improving child health and reducing mortality. Despite concern with improving utilization of facility-based services, especially for newborns, CHWs are still seen as the most effective bridge to reaching children and their caregivers.

In Tanzania and Mozambique, periodic campaigns to raise awareness about health problems and available services have led to increased utilization and community engagement. In addition, the child health network collaborates particularly well around these events. However, care-seeking and community demand for services remain major constraints to improving the health of mothers and newborns.

CONCLUSIONS AND RECOMMENDATIONS

The findings from the three case studies describe the evolution of child health programs and outcomes, factors that enabled and constrained progress, and the state of the networks that have emerged to lead and support it. What was the effectiveness of leadership and the stakeholder networks in the three countries?

CHARACTERISTICS OF CHILD HEALTH AS AN ISSUE

Effective networks are more likely to emerge if there is sympathy for the group involved and if their problems are thought to be severe and possible to solve. In all three countries children are valued and described as vulnerable and needing care. Before MDGs were achieved, perceptions of high child mortality helped drive attention and action, and key interventions such as immunization, IMCI and ITNs were believed to be effective and feasible. However, once MDGs were achieved, the sense of urgency diminished and child mortality was no longer viewed as a problem. All three countries refocused

attention on newborn mortality introducing new interventions that have yet to achieve the same level of success. Country networks were successfully built initially around child health as an issue that elicited attention and drove commitment. More recently network focus has been divided.

NETWORK AND ACTOR FEATURES

FRAMING

The framing of child health is important because it positions the issue politically so that priority and commitment can be built by the network. The early framing of child health as child survival was successful in the three countries as well as globally. Later framing around 'ending preventable deaths' did not appear to revitalize positioning. More recent framing around 'reducing newborn mortality' was understandable given mortality rates but did not generate the same level of political commitment in the context of post-MDGs and appeared to lessen attention to overall child health. Respondents in Tanzania and Mozambique suggested a more inclusive framing to support network interests. The networks in all three countries are likely at a turning point because SDGs are redefining the universe to be multisectoral with more complex outcomes for child health. To be effective, the child health network will need to successfully interact with many other networks, or fundamental changes in the composition of the network itself may be required.

LEADERSHIP

Strong, well connected leadership enables network action and progress. While there was some variability in how active government leaders were over the fifteen year period, those from the Tanzanian and Ugandan MOHs were respected and perceived to be effective. In Tanzania, high level champions added legitimacy to network efforts. In Mozambique, where higher level leadership has not been strong, the network is less well developed.

COMPOSITION

A network that has diverse participation and well-established linkages is more effective. There are many stakeholders for child health in Tanzania and Uganda with dense networks. While there are some differences in how closely organizations are linked, the connections are mutual. Mozambique has some diversity of participation in nutrition and health but has fewer linkages. An important gap in Mozambique and Tanzania is that there is more limited engagement of CSOs and organizations related to public accountability. By contrast, Uganda has had an increase in CSOs and more attention to the rights of children in network activity.

GOVERNANCE

For networks to be effective, there need to be legitimate governing structures capable of facilitating collective action of the stakeholders. All three countries have established mechanisms for coordination of functions essential to child health programs. Their strengths and weaknesses have been detailed earlier; Tanzania and Uganda have strong foundations, while Mozambique's higher level mechanisms would benefit from capacity building and more visible leadership. All networks could be more collaborative, essentially working more closely together around their most pressing priorities.

POLICY ENVIRONMENT

The policy environment in which the child health networks function involves an understanding of allies, opponents and of the funding resources available. The challenges with funding identified by respondents are probably applicable to most development issues and more is always needed. However, key child health programs such as immunizations have had resources. The issue now seems to be a question for the future, in which there will be increased reliance on domestic funding and possible competition for resources with a broader social and economic agenda.

In the decade run up to the MDGs, there was support from multiple stakeholder groups whose interests were consonant in Mozambique, Tanzania and Uganda. In some time periods, there was competition between issue areas where organizational interests did not appear aligned; the maternal health focus in Mozambique and the early HIV/AIDS focus in Tanzania and Uganda are examples. After 2015, the emphasis on newborn health intensified especially in Tanzania, and while stakeholder interests did not conflict, it did appear to lead to neglect of the unfinished agenda. As the SDGs more definitively guide the health community, child health networks will have to more actively manage allies and opponents with an aim of mutual benefit.

Tanzania and Uganda have solid child health networks that lead and have demonstrated the ability to position child health as a priority. Mozambique's technical network has been more functional than its higher level policy network. Depending on the time period, network priorities drove progress overall (MDG 4), were more exclusionary (maternal focus, newborn focus, lack of newborn facility care focus), or were less able to prioritize and influence health system constraints (HR, IMCI performance at scale). All networks would be more effective if they moved from a predominantly *coordination* level of functioning to *collaboration* around the most significant issues. This may be more complex but especially urgent if the child health agenda is reconceptualized around putting children at the center of the SDGs.

RECOMMENDATIONS

The SDGs present countries with a considerable challenge to maintain and build on child health achievements reached at the close of the Millennium Development Goals in 2015. Among the many challenges is a need to re-establish political and policy priority for child health in the face of broader and less quantifiable goals. Challenges are further complicated by the reality that new goals will require higher levels of attention to service quality, improved measures, more active engagement on the part of local stakeholders and a multisectoral approach. The records of the three countries in the MDG era — achievements and disappointments — demonstrate a range of issues which continue to emerge. They will need to be addressed by national and local child health leadership and the child health stakeholder networks that are the foundation for advancing better health in these countries.

Based on the combined findings from Tanzania, Mozambique and Uganda, there are several common themes that are captured below as more generalized recommendations for country level. To be useful, these generalized recommendations must be adapted to the specific context of any country. However, they may suggest areas that will need to be considered as countries move forward with SDG 3 and child health.

MILLENNIUM DEVELOPMENT GOALS (MDGS), SUSTAINABLE DEVELOPMENT GOALS (SDGS), AND THE WAY FORWARD FOR CHILD HEALTH

In the era of the MDGs, Tanzania, Uganda and Mozambique mobilized commitment and resources to reach the highly motivating goal of child mortality reduction. The era started with many child deaths, demanding urgent action with a set of effective interventions that were ultimately delivered widely. Toward the end of the era, progress was documented and reviewed annually for all countries, guiding the next set of actions to be taken. For all three countries, the change in child health was revolutionary. Reaching the MDGs was seen as a great success and became a source of national pride. As they moved forward, the perception was that much of the work for children under five had been finished and attention should be directed elsewhere.

Country data revealed that despite improvements in the health of older children, newborn mortality rates have declined more slowly. Often, this has been the result of inequitable access to quality maternal and newborn health interventions as well as underlying determinants, such as high fertility and poverty. During the latter part of the MDG period, efforts primarily focused on maternal health and reduction of maternal mortality. In the study countries, particularly Mozambique where maternal health remains the overriding priority, newborns did not receive sufficient attention.

While countries have signed on to the 2030 SDGs which call for improving the health, development and wellbeing of children, findings suggest they are not widely recognized or understood except by a few high-level MOH, UN agency, and bilateral organization leaders. Community and sub-national stakeholders have not been engaged and social and political will remains limited. Following the MDG period, there was focus on reducing newborn mortality but little for improving the health of all children under five. Current country plans document technical goals and indicators for all age groups, but they do not appear to rise to the level that inspires people to strive for a more complex set of SDGs related to children.

FRAMING CHILD HEALTH FOR THE FUTURE

Recommendation 1:

a. **Frame child health to include all children under five and to inspire collective action that can achieve each country's vision for child health, development and wellbeing.**
b. **Leaders should communicate and ensure inclusion of any reframing in health sector plans, government policies, and budget requests.**

Early in the MDG era, child health was framed as "Child Survival" and was addressed by a few critical interventions that managed illness (oral rehydration solution, pneumonia case management, IMCI) or prevented illness (vaccination, vitamin A supplementation). By 2008, mortality had declined and child health was reframed to focus on newborn mortality, which was declining more slowly. Mortality among newborns accounted for the highest proportion of deaths of children under five years of age. Several global initiatives sought to revitalize broader commitment to child health by shifting their objective to "ending preventable child deaths." Although these efforts produced some effects, they were not seen as substantial at the country level. According to the respondents in the three study countries, reducing newborn mortality has become the principal focus of child health efforts since 2015.

In trying to focus on one actionable area to the exclusion of others, important needs and approaches are left out. The countries aim to ensure that newborns survive but plans indicate, for example, that they would like children to be well-nourished at two years, cognitively well-developed at five years, and healthy as adolescents. Also, interventions that cut across a broader spectrum of health and survival issues such as nutrition, exposure to air pollution, or violence are likely to be overlooked. If the SDGs capture the vision of these three countries, efforts are already underway to define Primary Health Care and Universal Health Coverage. Health leadership in countries would do well to clarify the importance and fit of a more broadly framed child health in these movements. The process of reframing should be built into existing child health network activities likely involving strategic planning, reviews of progress on plans, scheduled consultations on PHC, UHC, SDGs, and relevant research or evaluation reviews. For example, this should be included in activities around the development of the Sharpened Plan III in Tanzania and around the dissemination of SDGs in Uganda.

There are multiple ways to reframe child health that can help focus on services and systems that meet multiple needs for all age groups for the future. One possible path is for countries to build out and adapt the recent proposal to 'place children at the center of the SDGs' from the WHO-UNICEF-Lancet Commission on the future of children.[19] The proposal defines children as 0-18 years of age considered in the context of a life course and intergenerational approach, with needs and rights to health that span the determinants of health addressed in the SDGs (environment, economy, education, gender equality, health and nutrition). Framing child health broadly in a country will mean involving multiple sectors working with a common vision and agenda to attain health, development and wellbeing for all children over time. Further, development partners would have to support this vision and framing by collaborating to support country agendas.

Ultimately, any changes in the framing of child health and vision, need to be understood and have buy-in from leaders, providers, and communities. These might be communicated as part of SDGs and UHC adaptation processes underway, and as part of health sector planning and review efforts. If countries choose to take a more multisectoral approach with children at the center, other sectors will need to be involved suggesting action at higher government and political levels. There may be intermediate steps that health leaders can take, such as inviting multisectoral input to reframing and to health sector plan development. Once there is consensus, the child health network should apply the framing in plans, policies, and budget requests.

[19] Clark H, Coll-Seck AM, Banerjee A, et al. A future for the world's children? A WHO-UNICEF-*Lancet* Commission. *Lancet* 2020; published online Feb 18. https://doi.org/10.1016/S0140-6736(19)32540-1.

Related Recommendations from Country Case Studies

Table 8: Country-specific recommendations related to Recommendation 1

Country	Recommendation	Details
Mozambique	**Give greater focus and priority to child health to increase its visibility.**	This can be achieved through two complementary approaches: convening multi-stakeholder child health discussion forums and conducting a participatory child health audit in the MOH. These exercises could foster dialogue and learning around the severity of child health challenges and the existing child health-specific structures, instruments, budgets, and projects at various levels as well as help establish a baseline, identify critical gaps and challenges, and recommend ways of addressing them.
Tanzania	**Based on Tanzania's commitments made to the SDGs, clarify the national vision for child health overall, reframe how it will be approached to be more inclusive of all children under five years and operationalize both in the Sharpened Plan III.**	While current plans document technical goals and indicators, they do not rise to the level of a new vision that inspires people to innovate and reach for the more complex set of SDGs related to children. To galvanize greater government and public commitment, and to better align partner participation in the child health network, government and partners should undertake a rapid adaptation of their 10 year child health vision that will also help guide decisions on the Sharpened Plan III. To support communication of this clarified vision (or SDG 3), child health is likely to need to be reframed in-country. There are multiple ways to reframe it, but the new framing will be more effective if it is more inclusive of newborns and children under five; and of health (e.g. illness) and development or well-being (e.g. nutrition, early child development).
Uganda	**The government, its partners and CSOs should ensure political commitment to SDGs but maintain a realistic focus on what is possible within the available current and future resources for child health.**	Similar to the MDG era, political commitment is needed for the SDGs to be fully embraced in Uganda to drive momentum for further health and health-related investments. To this end, government, donors, global partners, and CSOs should work to increase awareness and understanding of how to prioritize SDGs interventions across all sectors and governance levels to synergize the cumulative gains from multisectoral collaboration. Leaders should be encouraged to implement and/or act on existing child health strategies and commitments, while ensuring that new national policies are well aligned with the SDGs. Finally, children must be placing children at the center of SDG implementation.

LEADERSHIP AND POLITICAL COMMITMENT

Recommendation 2: Foster leaders and champions for child health and support active leadership work at national and local levels.

Potential child health leaders in country institutions should be identified and capacity should be built so that they are able to communicate vision, plan, negotiate, and hold the child health network accountable for achieving outcomes. Opportunities to strengthen leadership include mentoring, cross-country exchange, and modelling from the examples of others. For instance, HIV leaders have been successful at garnering support and commitment in districts and communities in Uganda. To build a foundation for strong country leadership, it will be important to build a critical mass of individuals, and to anticipate and

handle turnover more effectively. It may be possible to address leadership growth directly as an essential part of operationalizing the SDGs for children. This would need meaningful support by the national child health network and by the individual organizations that comprise it.

Another part of ensuring active leadership over time is to build and report on more transparent accountability mechanisms that highlight child health. In Tanzania, these exist within government in the form of scorecards and performance based arrangements. It is also possible to hold donors and development partners accountable in all countries through country leadership and leveraging global efforts such as the Independent Accountability Panel, UHC2030 or joint evaluation exercises. It is less clear how to hold leaders of non-governmental or academic organizations accountable in country, but child health networks should be more engaged around plans and programs. Donors and funders should be able to build accountability into the support they provide to organizations as part of contractual arrangements.

Children are a vulnerable population that also need champions to advocate, rally support, and prioritize child health issues. Sometimes political leaders may be in positions and able to function as champions only for a limited time and while it is useful to have them, others are needed to consistently advocate and publicize how children are doing. Child health champions should be fostered by providing platforms and coverage of their activities. If children are put at the center of the SDGs, their voices will also be essential to raising awareness.

Finally, respondents in Mozambique and Uganda highlighted the positive potential for more active community and CSO involvement in child health. This type of involvement creates public accountability for the health system overall and for the actions of those leaders who serve communities.

Related Recommendations from Country Case Studies

Table 9: Country-specific recommendations related to Recommendation 2

Country	Recommendation	Details
Mozambique	**Build leadership, coordination, and negotiation capacity**	Development partners should invest more in strengthening the capacity of MOH, particularly but not exclusively of the Division of Child Health, to deal with multiple actors and manage competing interests and agendas in a way that equips its staff to have more prominence in the child health network. Technical assistance to the MOH should focus on building capacity to convene and lead through direct intervention or technical advisers. Interactions within the child health network should extend beyond planning to address resource allocation and accountability for outcomes.
Mozambique	**Foster civil society engagement in child health.**	Greater civil society involvement in child health is needed. This should encompass identifying champions at various levels and equipping them to perform a watchdog role, and demand accountability on outcomes. Lessons can be drawn from the nutrition and HIV fields on civil society participation and advocacy, especially on formal institutional mechanisms that include civil society representation.

Tanzania	**Take action to raise national political attention to the health of children and actively collaborate for accountability in pursuit of country health goals.**	Prioritize embedding the most important bundle of child health programs, via the appropriate channels (PORALG, MoHCDEC), into the national statement of priorities (party manifesto).
Uganda	**The government, its partners and CSOs should ensure political commitment to SDGs but maintain a realistic focus on what is possible within the available current and future resources for child health.**	Similar to the MDG era, political commitment is needed for the SDGs to be fully embraced in Uganda to drive momentum for further health and health-related investments. To this end, government, donors, global partners, and CSOs should work to increase awareness and understanding of how to prioritize SDGs interventions across all sectors and governance levels to synergize the cumulative gains from multisectoral collaboration. Leaders should be encouraged to implement and/or act on existing child health strategies and commitments, while ensuring that new national policies are well aligned with the SDGs. Finally, children must be placing children at the center of SDG implementation.
Uganda	**Identify and support leaders and champions for social determinants of child health (e.g., women's empowerment, maternal education, family planning) with a special focus on more vulnerable groups (e.g., newborns) that could have a major impact in reducing overall U5 morbidity and mortality.**	Children are a vulnerable population that need champions to advocate, rally support, and effect prioritization of child health issues. These sustained efforts have the potential to attract commitment and increased financial allocations from government and donor community. Child health leaders can learn from examples of other champion-led campaigns (e.g. HIV arena) that have been successful at garnering support and commitment. These champions can be used to raise public awareness, mobilize resources and empower citizens to demand the health services they need.

COORDINATION AND COLLECTIVE ACTION

All three countries have child health networks usually with the MOH and its divisions, UNICEF, and WHO at the center. These networks are actively engaged in policy development, resource mobilization, planning, monitoring, evaluation and improvement. Organizations within the networks have various roles including government oversight, donors, technical assistance or development partners, NGO providing development or health care services, academic institutions conducting research or capacity building and others. Tanzania and Uganda reported fairly intensive working relationships between organizations - mostly coordination and collaboration while Mozambique's reports were of somewhat fewer intensive interactions. At the national level, child health networks appear to *coordinate*

most work. This is a good foundation on which to build a stronger, *collaborative* network more capable of enhancing child health. [20]

Recommendation 3: Child health network stakeholders should commit to improving national network collaboration and initiate a process of strengthening.

Most organizations in the networks participate in meetings and events, but there is limited information on other aspects of their participation that are critical for successful collaboration. Is leadership encouraging? How effectively do they communicate? How much trust has been built among the network members? (There were some report of organizations lacking sincerity, taking credit or not following through). Is diversity promoted? How 'safe' is the deliberations space for the group as it works together?

It is likely that networks in all three countries would benefit from strengthening some of these areas by self-assessing and actively building better networking skills and approaches. Each network would have to agree on a common aim – defining what collaboration look likes in contrast to the current situation and then create capacity building plans to deliberately improve upon coordination. One way to make this more concrete is to try a facilitated process of selecting an important priority such as improving the quality of care or introducing a new intervention, or completing a section of a sector plan, and use the opportunity to apply better networking skills at a collaborative level. It would compel organizations to focus on improving network behaviors, capacities, and processes for the best results. Once there is appreciation for the benefit of collaboration over coordination, the network should be able to mature more quickly. For this to succeed, the network must monitor and continuously improve its changing capacity.

Related Recommendations from Country Case Studies

Table 10: Country-specific recommendations related to Recommendation 3

Country	Recommendation	Details
Mozambique	**Adopt a multi-level, multi-stakeholder approach to child health coordination.**	The involvement of other actors, such as Mozambican NGOs and professional associations, in child health should be fostered, particularly around the design and implementation of advocacy initiatives on issues identified by the Child Health Technical Group.
Tanzania	**Starting with the RMNCH TWG as the core child health network:** **Choose one or two priorities that the national child health network will**	At the national level, the child health network is well interconnected and *coordinates* most work. This is a good foundation on which to build a stronger, *collaborative* network more capable of enhancing child health. One way to build understanding of collaboration is to try it out. The RMNCH TWG could agree to go beyond

[20] Himmelman, A.T. (2001), On Coalitions and the Transformation of Power Relations: Collaborative Betterment and Collaborative Empowerment. American Journal of Community Psychology, 29: 277-284. doi:10.1023/A:1010334831330

Country	Recommendation	Details
	work on together, and plan, implement, and monitor a more collaborative process that demonstrates tangible results and strengthens network capacity.	coordination for a specific activity that is on their agenda – one or two priority areas of work that matter for the national network and for regional or council health management teams. In addition to the technical plans for these activities, the national network organizations would have to work to strengthen how they interact, work together, monitor process and make improvements such that they are also enhancing each other's capacity and actions. This effort would demonstrate the concrete benefits of collaboration.
Uganda	**The MoH and partners should work to strengthen national and subnational child health networks to accelerate capacity for joint action.**	A network's purpose, member composition, size, and value propositions determine its effectiveness. Many inter-related factors shape network performance and capacity to generate resources and impact. The capacity for collective action is affected by: 1) building knowledge about how network relationships operate and recognizing the unique inter-disciplinary skill-sets needed to build stronger collaborations; 2) having well-resourced and sustainable governance structures; and 3) providing incentives to organizations to reduce their own self-interests by aligning their organizational goals with the goals of the broader child health network. A more functional network will generate organizational commitments to shared network goals and accelerate the capacity for strong, equity-based child health programming in the country.
Uganda	**The government and its partners should develop a governance structure and network capacity building plan to facilitate the emergence and accountability of groups.**	The MOH is the leading player in child health in most activity networks. Many key organizations participate in meetings, but it is unclear whether they are working towards a specific goal, how they are communicating, and whether they have the networking skills to create momentum for joint ownership and action. An explicit governance structure appropriate to the network's size and funding level can unite organizations to work collectively and generates accountability for results. Mutually agreed upon work-plans including expectations regarding outputs and outcomes can lead to development of more trust and commitment to network goals. Support is warranted for a facilitated process to disseminate and use these study results to generate ideas, strategies and build organizational and managerial network capacity to improve the performance of the child health network and groups.

Recommendation 4: Child health network stakeholders should commit to building and enabling stronger collaboration at district and community levels.

Although strengthening collaboration of the national level network is likely to be more manageable at the outset, enhancing coordination at implementation levels (regions, districts) is a more pressing need according to country respondents. This is because lack of coordination and collaboration directly affects services, efficiency, and people. One way the national level can help is to set the expectation that their staff will collaborate by communicating well, building trust, and actively engaging within the local health

network structure (local government, health managers). The national level network can enable this by holding their own staff accountable for how they work with colleagues in districts or regions and by removing barriers or bottlenecks encountered that may be under national rather than local control.

However, the structure and function of existing child health networks at local levels may not be understood well enough to design capacity building. In this case, it will be useful to document how local child health networks function and most importantly, plan and facilitate capacity building in the context of regular activities.

Related Recommendations from Country Case Studies

Table 11: Country-specific recommendations related to Recommendation 4

Country	Recommendation	Details
Mozambique	**Adopt a multi-level, multi-stakeholder approach to child health coordination.**	There is a need to ensure that approaches to coordination, communication, and collaboration "trickle down" to the central, provincial, and district levels to improve interactions between actors that operate at provincial and district level and those at the central level, capitalizing on the recent appointment of child health focal points within the Provincial Directorates of Health.
Tanzania	**Starting with the RMNCH TWG as the core child health network, help build or strengthen child health networks at regional and district levels so that they are capable of more effective collaboration for child health.**	Respondents made it clear that there is a pressing need to enhance coordination and collaboration at implementation levels (regions, districts, facilities). Local level management teams need to be expected to coordinate operationally and to build nascent networks into collaborative bodies. Organizations in the national child health network often support activities at local levels – through staff or other groups so they are in a position to set expectations for how people will work together and to support leadership of the local network. The capacity of existing child health networks at these local levels may not be clear. In this case it can be useful to start with network assessment.
Uganda	**The MoH and partners should work to strengthen national and subnational child health networks to accelerate capacity for joint action.**	Many respondents agreed that districts are key to driving Uganda's child health agenda. A more functional network at the subnational level will help generate organizational commitments to shared network goals and accelerate the capacity for strong, equity-based child health programming throughout the country.

Implications for the Global Health Community

Given global initiatives' policy and resource impact on child health as well as the need to ensure countries own and lead programs to improve the health of their children, it is incumbent upon the global child health network to proactively support countries.

The global child health network including key organizations and their coordinating bodies, should:

Recommendation 1: Support country framing of child health to be more inclusive.

With the recent launch of 'placing children at the center of the SDGs', by the WHO-UNICEF-Lancet Commission, there is an opportunity to engage with countries to both vision and frame child health more broadly for the future. Our study focused on children under five which is more limited than the 0-18 years and the life course focus for the Commission, but it echoed the need for a more inclusive framing to expand perspective for health, development and well-being. This study does suggest that the global level:

- Build a bridge with country goals and vision for their children, to accomplish the SDGs (rather than drive the goals down as statements and indicators); and to
- Resist exclusion, messaging, and funding that fragments child health.

This will become even more important if the intent is to invite multisectoral engagement.

Recommendation 2: Engage with national child health networks such that network capacity for collaboration is built and decentralized to local levels.

National child health networks are responsible for setting expectations of their actions and results, and for how they wish to function. In the case of the three country case study networks, there was a stated desire to collaborate and to collaborate more effectively at local levels. The national network must build its own capacity over time, but the actions (directives, resources, negotiations) of the global level will impinge on their ability to move toward that goal. If countries choose to engage in placing children at the center of the SDGs, then there are a series of steps that the global level will take that involve the child health and other country networks. Since there is a priority focus on multisectoral engagement, there will be even more complexity. How the global level engages in terms of communication, building trust, and supporting leadership will affect network capacity. Thus, the global level should:

- Support any planned activities to build child health network capacity at national and local levels, incorporating them into discussions of multisectoral networks; and
- Assess expected and unintended consequences of new directions on the development of local regional or district network collaboration and adjust to ensure support.

Recommendation 3: Support accountability systems developed by the child health network.

A number of recommendations for strengthening accountability measures and mechanisms arose in the country studies. These are the remit of governments, within organizations, and with the public. However, many of the development partners and donors have global and country missions or offices that participate in country work. It is important that guidance and incentives allow accountability systems to function as intended within government systems and within individual organizations. It may also be important to provide space for civil society voice. These are things that need to be considered in the expansion of child health framing to other sectors.

The three country case studies for Mozambique, Tanzania, and Uganda provided the opportunity to document their perspective on child health leadership and networks, to understand the factors that

enabled and constrained progress in child health, and to identify actions that will enhance progress for children in the future. Findings, conclusions and recommendations for each country are documented in the individual country reports.

The world is embarking on a more ambitious journey to the Sustainable Development Goals and some have recently proposed a more holistic and encompassing approach to attain these goals for children. They have also recommended actions for countries and the global level to launch interventions that will involve large scale change. This study may provide inputs to some of the steps that will be needed to move in this new direction.

FOR MORE INFORMATION

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