Case Studies on Multisectoral Programming for Children

A Literature Review on Select Countries in Africa and Latin America

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Introduction

Achieving health, well-being and optimal growth and development of children is complex and multifaceted. Global strategy objectives have three primary components: (1) Survive: end preventable mortality; (2) Thrive: promote health and well-being; and (3) Transform: expand enabling environments. The Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) is an ambitious new agenda calling for all children to survive and thrive, and for society to transform in ways that make this possible. The agenda focuses on the social determinants of health, optimal growth, development, and protection of children to ensure they can achieve their full potential. To support this agenda, the World Health Organization (WHO) and the United Nations International Children's Emergency Fund (UNICEF) redesigned their vision for child and adolescent health and development, emphasizing the significant role of sectors beyond health.

Between 2017-2019, the Beyond the Building Blocks Framework was developed by the CORE Group to expand upon the WHO Building Blocks of Health framework.[1] The framework provides a model which focus on (1) delivery of high quality, evidence-based services (service delivery), (2) household production of health and (3) social determinants of health. The inclusion of the social determinants of health suggests health services and programs should include other sectors (i.e., Water, Sanitation, and Hygiene (WASH), transportation, and agriculture etc.) in the package of interventions. Therefore, multisectoral approaches (e.g., food security, access to clean water, improved sanitation) should extend services to the hardest-to-reach, and address underlying causes of poor health, and implement effective and sustainable health interventions.

Background

The Alma-Ata Declaration of 1978 emerged as a major milestone of the twentieth century in the field of public health, and it identified primary health care as the key to attaining of the goal of Health [2]for All and was re-affirmed 40 years later in the Astana Declaration of 2018.[3] The Alma-Ata Declaration was the first international declaration emphasizing the importance of primary health care. However, the Alma-Ata commitment to equality, intersectoral action, and community participation also posed challenges when the declaration started encouraging multisector collaboration.[4]

These challenges included:

- Countries lacked a commitment to health as a social goal.
- Few countries had democratic community participation.
- The reality of equity in health service delivery was difficult to achieve and lacked consensus.
- Multisectoral action seemed feasible but was compromised without the commitment to economic development promoting social welfare.
- Other sectors resisted efforts for inter-sectoral action for health, arguing it was difficult to measure the health impact of non-health policies.
- Difficult to attribute specific sector achievements in impact evaluations.
- There were multiple governance issues with working across sectors including the weak position of the health sector in government (compared with finance and infrastructure) and a lack of mechanisms for joint budget approaches.

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[1] Sacks E, Morrow M, Story WT, et al. Beyond the building blocks: integrating community roles into health systems frameworks to achieve health for all. *BMJ Global Health* 2019;3:e001384. doi:10.1136/ bmjgh-2018-001384

[2] https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf

[3] https://www.who.int/teams/social-determinants-of-health/declaration-of-alma-ata (last accessed January 29, 2022).

[4] World Health Organization. Technical series on primary health care: health in all policies as a part of the primary health care agenda on multisectoral action. *World Health Organization*, 2018.

In 1997, the World Health Organization stated, "Intersectoral cooperation for achieving health goals has been accepted as one of the guiding principles of the health strategy that was adopted at the International Conference on Primary Health Care (Alma-Ata, USSR, 1978) – other sectors (in particular, agriculture, animal husbandry, food, industry, education, housing, public works and communications) are explicitly recognized."[5]

Health and Sanitation in Konobougou, Mali, A Case for Collaboration

A 2021 research study covering the city of Konobougou and 50 communes was conducted to determine some of the major health and sanitation issues. The researchers found several factors correlating child health with sanitation, including:

- Three people slept in a room on average. Overall, the houses were in good condition for 84% of the respondents. In all houses there were doors and windows.
- In 64% of families, there were designated places for farm animals and 12% of all families had fenced in areas allowing for further containment.
- 90% of families used tap water for drinking, but 10% of respondents used well water for drinking. 100% of families used well water for other purposes (washing, cleaning, etc.).
- 80% of families had wells with top lining, while no respondents reported a fully lined well. 76% of the wells were treated regularly.
- 94% of families kept their water in containers with lids, but only 80% of families treated their drinking water with bleach. Water was refilled 2-3 times a week in 58% of the cases.
- Only 8% of families had a garbage container but, of those, only 76% had lids.

At the end of the research study, the authors found that many of these water and sanitation challenges correlated with major childhood health issues within the city including malaria, acute respiratory infections, and diarrhea. The authors state that if these major childhood illnesses are to be addressed in Konobougou then water must be equally addressed within the community as a preventive measure.

Figure 1

Coulibaly, M.B, Tembiné, L., Coulibaly, D., Diarra, M., Maïga, M., & Dicko, F. Community diagnosis in health: Cross-sectional study in the city of Konobougou, Mali. Mali Sante Publique, 2021. DOI : 10.53318/msp.v11i1.1897

In 2004, the CORE Group was funded by USAID to research multisector collaboration and wrote a comprehensive literature review and case study analysis of examples of multisectoral child health programs.[6] In 2005, when the CORE group reviewed community-based multisectoral child health programs, it found consistent confusion about how to measure effective implementation of the multisectoral platform. The report found a lack of understanding about the most effective ways to integrate health interventions with other sectors to achieve greater impact and sustainability. The report emphasized that the partnership between health and non-health sectors needed to become more effective, efficient, equitable and sustainable than each sector acting alone.[7]

Although the information in these reports remains relevant, few comprehensive child health studies reviewing the lessons learned, current challenges, and practical implications for multisectoral program development have occurred in the last five years. Previous studies addressing multisectoral actions implemented among socially vulnerable populations reported relevant results in decreasing social

[5] IBID

[6] Bessenecker, C. & Walker, L. Reaching Communities for Child Health: Advancing Health Outcomes through Multisectoral Approaches. CORE Group. December 2004.

[7] World Health Organization. Glossary: Whole-of-government, whole-of-Society, health in all policies, and multisectoral October 2016 . https://www.who.int/global-coordination-mechanism/dialogues/glossary-whole-of-govt-multisectoral.pdf (Last accessed on January 30, 2022).

inequalities, such as improved health, services, income, education, empowered vulnerable groups, increased social capital, social participation, and mobilization.[8]

In 2017, the Child Health Task Force was developed as a network of global and country-based organizations and individuals working to design and implement child health programs that take a life-course approach. The Task Force aims to generate and share evidence on how to implement equitable, comprehensive, and integrated programs that will translate into better outcomes for children. The Task Force facilitates learning and sharing, provides countries and child health stakeholders with access to a pool of technical experts, tested implementation tools, approaches, and engages members to translate knowledge into better practices.[9]

In 2018, the Atstana Declaration put in motion a movement to reevaluate the state of child health care and advance the SDGs. The WHO, UNICEF and Lancet Commission was formed in 2018 to consider the ways governments, medical professionals, and society accelerate child health and wellbeing strategies. The Commission proposed a new global movement to place children at the center of the SDGs.[10] The Commission ushered attention towards a life course perspective and away from a previous exclusive focus on under 5 survival. The intended outcome is to deliver programs supporting an environment enabling all 19-year-olds to be optimally healthy, raised in safe and secure environments, well educated, and prepared physically, mentally, emotionally to contribute socially and economically to society. The COVID-19 pandemic allowed professionals to reconsider the challenges children face globally as the virus caused severe disruptions in in essential health, education, and other services and by increasing poverty and inequality.[11] To further advance the current state of multisectoral child health interventions, the Child Health Task Force established the Re-imagining the Package of Care for Children subgroup to address the expansion of child health services. The task force focused expansion includes: 1) shift towards a life course, rights-based approach, 2) comprehensive integrated care to promote resilience and minimize vulnerability, 3) child centered and child focused using whole government and multisectoral approach, and 4) encouragement of communities and families in playing an active role in the design of child health policies and programs.[12]

The Task Force commissioned a position paper, published in February 2020, on integrating packages for child health services within and across sectors, including nutrition and early childhood development. School health has also been a focus. The Task Force has provided a platform for sharing lessons from countries on collaboration between health and education sectors and reviewing WHO's new Health Promoting Schools guidance. Building on these recent work streams, and the need to work with WHO/UNICEF on how to implement the redesigned child health approach, the Child Health Task Force commissioned this literature review to better understand how to implement multisectoral child focused programs across other health and development sectors in Africa and Latin America.

Literature Review Goals and Objectives

The purpose of this literature review is to 1) identify multisectoral models that exist in scholarly literature to address the survive, thrive, and transform agenda in Africa and Latin America and 2) compare multisectoral approaches to child health within Africa and Latin America. While the

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[8] Graham, W., Kuruvilla, S., Hinton, E., Veitch, E., & Simpson, P. Multisectoral collaboration for health and sustainable development learning together, from success and from failure. British Medical Journal. 2018;363:k4868

[9] https://www.childhealthtaskforce.org/about last accessed March 11, 2022.

[10] Clark, H., Coll-Seck, A.M., Banerjee, A., Peterson, S, Dalglish, S.L., Ameratunga, S., et al. The future for the world's children? A WHO–UNICEF–Lancet Commission. *The Lancet*. February 2020: 395.

[11] Requejo, J., & Strong, K. Child Health Redesign: Redesigning health programmes for all children and adolescents. Achieving the sustainable development goals requires a shift in thinking. BMJ 2021;372:n533
http://dx.doi.org/10.1136/bmj.n533.

[12] Requejo, J., & Strong, K. Child Health Redesign: Redesigning health programmes for all children and adolescents. Achieving the sustainable development goals requires a shift in thinking. BMJ 2021;372:n533
http://dx.doi.org/10.1136/bmj.n533.

multisector approach is globally acknowledged, it poses challenges such as fragmentation (between and within sectors), resource allocation (who pays?), and governance (who leads?).[13] By disrupting health service delivery and implementation, the COVID-19 pandemic made multisectoral collaboration more challenging.[14] This paper will share stories of success and failure in implementing multisectoral action for children, learning from countries collaborating across sectors. This paper assists the Child Health Task Force in analyzing identified evidence and knowledge gaps and articulate a research agenda on multisectoral child health approaches. The evidence reviewed will focus on early childhood up until the age of nine as research on older children often shifts focus to adolescent and reproductive health.

Defining Multisectoral Health

Leading donors and implementation partners have historically defined multisectoral collaboration differently. These definitions include:

- Per USAID, multisectoral programs promote and strengthen coordinated planning and programming across sectors (health, agriculture, WASH, environment, early childcare and development, education, economic growth, and social protection) while geographically converging sector interventions/services to address the multiple causes of childhood illness, disease, and malnutrition.
- The WHO defines multisectoral collaboration as a recognized relationship between part of the health sector and another sector to achieve health outcomes, (or intermediate health outcomes) in a more effective, efficient or sustainable manner than could be achieved by the health sector acting alone.
- Another definition, from the British Medical Journal (BMJ) case study review on multisectoral collaboration, defined it as intentional collaboration with multiple sectors and stakeholders intentionally coming together and collaborating in a managed process to achieve shared outcomes.

To further understand and provide insight into multisectoral implementation practices, this paper seeks to respond to the following questions:

- In which countries in Africa and Latin America are multisectoral approaches implemented and who are the key stakeholders?
- What are some of the multisectoral approaches to child health in the identified countries and why were these approaches selected?
- Which multisectoral approaches have been effective in improving child health in Africa and Latin America, and which were ineffective approaches?

Research Methods

Database Selection

Multiple databases were used to help eliminate bias in developing this paper. Selection criteria focused on medical and public health journals, African and Latin American sourced research, and global multisector child health reports. The databases and search engines utilized include:

- ProQuest Health Science Collection, which includes evidence-based resources from the Joanna Briggs Institute; ProQuest Nursing & Allied Health Source; Pharmaceutical News Index; ProQuest Family Health; ProQuest Health and Medical Complete; ProQuest Health Management; ProQuest Biology Journals; and ProQuest Science Journals.
- PubMed Central (PMC) is the free digital archive of biomedical and life sciences journal literature, which includes the National Institutes of Health (NIH).

[13] World Health Organization. Technical series on primary health care: health in all policies as a part of the primary health care agenda on multisectoral action. *World Health Organization*, 2018.

[14] Schultz, L. & Shors, L. Operationalizing Health & Education Coordination: Recommendations Surfaced through Interviews with Africa Bureau Missions. 2021. Washington, DC: USAID

- LILACS (Latin American and Caribbean Literature on Health Sciences) is a database of health sciences literature published in Latin American and Caribbean countries since 1982. Covering 670 biomedical journals, it includes theses, books, book chapters, conference proceedings, technical and scientific reports, and governmental publications.
- African Journals Online is the world's largest and preeminent platform of African-published scholarly journals. AJOL is a Non-Profit Organization that, since 1998, works to increase global and continental online access, awareness, and use of African-published, peer-reviewed research.
- Programmatic reports and journal articles posted by the World Bank, DFID, USAID (Development Experience Clearinghouse), WHO, and UNICEF on their websites.
- Grey literature search for programmatic briefs and journal articles, including Google Scholar, the Child Health Task Force resource library, and the Child Health Task Force bi-weekly digest.

Key Search Terms

Authors refined search terms to produce results aligning with the literature review mission by searching multiple databases. The keywords (commonly called search terms) were chosen because they are primary/main concepts of the research topic, used commonly to describe multisectoral programming, and synonymous with our topic. Selected articles were reviewed for associated terms, repeated search terms, and key elements. Associated terms were paired with associated sectors, individual countries, and common child health diseases and illnesses.

- *Key Search Terms:* coordination, collaborative, implementation, intersectoral, multisector, mixed methods, health, Africa, Latin America, child and/or children, and multidisciplinary.
- *Associated Terms:* Water, Sanitation, and Hygiene (WASH), nutrition, stunting, food security, HIV/AIDS, healthcare disparities, climate change, diarrhea, pneumonia, vaccines, zika, malaria, dengue, early childhood development, food-borne and water-borne diseases, obesity, education in Latin America and Africa.

Inclusion Criteria

The following criteria were used to identify journal articles and reports aligning with the research goals and objectives of this literature review:

- Articles focusing on multisector interventions including collaborative work between sectors and government ministries to improve outcomes for children (education, health, WASH, nutrition, food security).
- Articles combining at least two sectors from different government ministries to improve child health outcomes
- Articles using English, French, or Spanish text
- Articles discussing projects in the Africa and Latin America and Caribbean (LAC) regions. Latin America typically refers to the parts of the American continents where Spanish or Portuguese is the main national language. This often includes Mexico, Central America, most of South America, and some Caribbean islands. Therefore, the geographic search was increased to include the entire LAC region based on the Pan-American Health Organization (PAHO) and USAID inclusion of the Caribbean countries.

Exclusion Criteria

The following list was used to help streamline research results to ensure articles remained recent, relevant, and focused on child health multisector interventions:

- The children in research literature must not be older than 9 years old to prevent including reproductive health issues and to maintain focus on early childhood health issues.
- If considering maternal, newborn, and child health, only the newborn/child health aspects of the articles were gleaned.

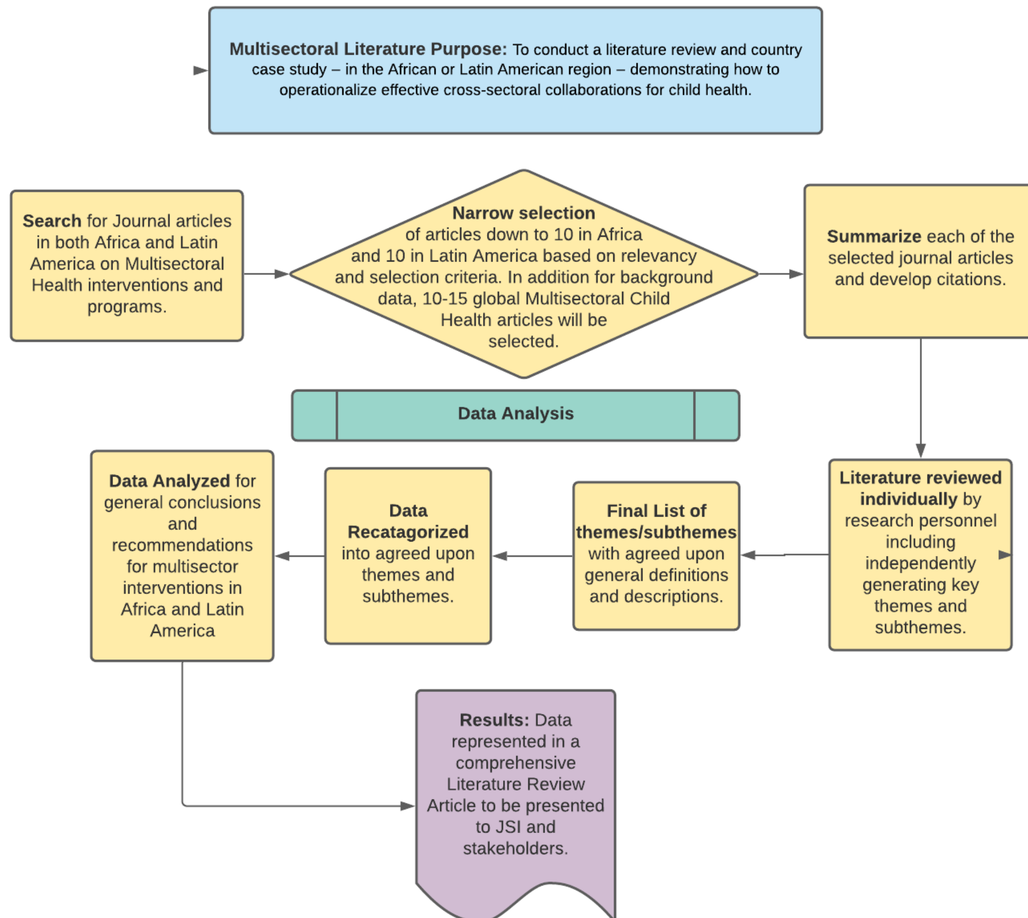
- Specifically looking at peer-reviewed journal articles, program reports/evaluations from major donors including USAID, WHO, UNICEF, USAID, and other government and multilateral organizations.
- Journal articles are no more than 5 years old. Articles published between 2016-2021 unless being used for historical context; and
- Portuguese text excluded

Analysis and Synthesis

Qualitative methods with a thematic approach were used to evaluate the selected journal articles and research that will help inform future research and case study interview candidates. Research personnel searched for relevant peer-reviewed journal publications using five key steps: 1) Searching for relevant literature; 2) Examining sources selected; 3) Identifying themes, program nuances, and gaps; 4) Outlining thematic structure; and 5) Providing written analysis to define multisectoral programs/interventions. (*See graphic next page*)

Study Limitations

This study was conducted to provide further guidance on programmatic implementation in selected African and Latin American countries. Both Africa and Latin America have a vast array of geographic, cultural, and political differences. Therefore, while there are similarities, cultural and geographic differences need to be considered.



Themes and Trends

In 2018, the British Medical Journal (BMJ) launched a series of articles on making multisectoral collaboration work. **A key finding was that multisectoral collaboration has relevance across diverse geographic, economic, social, cultural, and historical contexts, and—crucially—the methods for integration are remarkably similar across settings.** The articles reported a significant knowledge base for sharing "what works" in multisectoral collaboration. In analyzing the literature for Africa and Latin America, four central themes emerged: (1) the need for project coordination across multiple sectors; (2) government, civil society, and stakeholder buy-in; (3) the challenge of health system fragility and decentralization; and (4) the necessity of cultural competence and gender empowerment in program planning and implementation.[15]

Theme 1: Project Coordination Across Multiple Sectors

The BMJ study found successful program development and implementation: 1) recognized that stakeholders and their engagement change across different components and periods, thus stressing the need for realistic time frames, diverse evidence and ideas, and "learning and adapting while doing" to yield transformative results; 2) balanced multisectoral work needs to be managed with intentional, innovative actions so that each sector can contribute effectively; and 3) needs a framework to allow governments and development multisectoral partners to learn from each other and target investments

[15] Graham, W., Kuruvilla, S., Hinton, E., Veitch, E., & Simpson, P. Multisectoral collaboration for health and sustainable development learning together, from success and from failure *BMJ*. 2018;363:k4868

to catalyze transformative change.[16] Implementation of multisectoral programs as proposed requires teamwork across sectors and responsive devoting policies, finance, and governance that work in parallel with workforce development and stakeholder involvement.[17]

Agreement on the Need for Collaboration and Implementation Capacity

In the programs reviewed for this study, there were common program strengths that contributed to their overall success. For the programs reviewed, it was critical to have an agreement on the major problems/challenges to be addressed and that implementing sectors found value within their role and other sectors roles in implementation. Each sector needs to understand its worth and value in the implementation process.[18] All the policies were successfully deployed and implemented following multiple consultations with members of multiple sectors and key stakeholders, including academia, government, advocacy groups, and civil society. Each of these sector advocates and stakeholders brought a different skill set and knowledge base that allowed for strong program implementation. Once the project need was identified, the next step was to evaluate the current capacity of each sector and the capacity needs in reaching overarching goals that lie outside their normal sector implementation areas. Capacity building was needed to ensure all team members had the same understanding and ability for early project success.

Development of a Multisector Oversight Committee

The concept of a management committee coordinating sector activities, budget allocations, and allowing for sector feedback was crucial for project success. In developing the Chile Crece Contigo policy, the oversight committee was responsible for project success and smooth implementation.[19] The government selected the Ministry of Planning and Cooperation (as a third party neutral non-implementing ministry) to manage committee activities and budget divisions to prevent sector competition between implementing ministries. The budget for policy implementation was allocated through the committee and funds were then transferred to sectoral ministries to provide services. This decision sought to avoid “sectorizing” the policy and instead looked to capitalize on the Ministry of Planning and Cooperation’s growing experience in managing social networks and promoting social advancement policies. Other implementing ministries reported that the committee allowed for group discussions in navigating sector challenges, shared project successes with multisectoral partners, and permitted each sector to provide feedback into the program. The multisector committee meetings also allowed for coordinated operational planning of activities between sectors. All programs integrating multisectoral oversight committees reported strong internal and external communication between sector partners.

Geographic and Cultural Context Considerations

Sectors often had assigned geographic zones of implementation and therefore lacked the sector experience in other geographic areas where they normally did not work. Aligning geographical regions with involved sectors allowed for flexibility and adaptation to cultural nuances as needed.[20] Considering cultural and geographic contexts has the potential to improve local program implementation and reduce

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[16] Graham, W., Kuruvilla, S., Hinton, E., Veitch, E., & Simpson, P. Multisectoral collaboration for health and sustainable development learning together, from success and from failure *BMJ*. 2018;363:k4868

[17] Black, M., Lutter, C., & Trude, A. All children surviving and thriving: Re-envisioning UNICEF’s conceptual framework of malnutrition. The Lancet 2020 (8). Elsevier Ltd.

[18] Botero-Tovar, N., Arocha Zuluaga, G.P., & Ramírez Varela, A. Factors influencing delivery of intersectoral actions to address infant stunting in Bogotá, Colombia – a mixed methods case study. BMC Public Health (2020) 20:925

[19] Torres, A., Lopez, B. F., Parra-Vazquez, C., Segura-Pérez, S., Cetin, Z., and Pérez-Escamilla, R. Chile Crece Contigo: Implementation, results, and scaling-up lessons. *Child: care, health and development*, 2017, 44 (1), 4–11

[20] Ouedraogo, O., Doudou, M.H., Drabo, K.M., & Kiburente, M. Facilitating factors and challenges of the implementation of multisectoral nutrition programs at the community level to improve optimal infant and young child feeding practices: A qualitative study in Burkina Faso. October 2020 *Public Health Nutrition* 24(12):1-12

the prevalence of child health issues. At times, multisectoral collaboration means a particular sector may need to expand into a new geographic zone. In this case, the literature supported a full analysis of the specific cultural needs to allow for programmatic adjustments. (*See Theme 4 for more evidence on geographic and cultural considerations*)

Shared framework for project monitoring and evaluation

Although each sector often has an identified set of indicators for its work, standardized implementation and monitoring tools are useful in ensuring proper collection mechanisms at the community level. Literature reviewed shared a need for multisector-based oversight of community activities to ensure proper integration. The authors suggested that overall transparency improved through multisectoral committee supervision reviews and by sharing financial balance sheets at all cross-sector meetings. Feedback loops and research are key to successful policy implementation and guiding programmatic change to improve performance. Overall, implementers reported that program evaluation was most successful when it was utilized throughout the entire process to help identify key evidence. Community support for program implementation and project coordination were linked to the use of evidence and data for coalition outreach, leading to full adoption of the program or policy.[21] The authors also suggested anticipating factors that will support or divert policy adaptation so that there is a plan to gather evidence and present solutions in advance of problems.

Challenges in Multisector Coordination

Divisions of Roles and Responsibilities: Implementers reported a lack of coordination between program managers and policy makers setting institutional limits for interventions and those implementing multisector programs. In evaluating an infant stunting program in Bogota, Colombia, evaluators found challenges included communication regarding the required tasks, sector program manager responsibilities, and how each role connected to others in each sector.[22]

Monitoring and Documenting Project Successes and Strengths: Often multisector oversight committees met, to evaluate the program or problem solve. In Colombia, program managers reported multiplicity of community data collection tools within each sector and difficulty with community volunteers using the tools accurately.[23] Incorrect use led to challenges in developing high quality community reports. Routine community data in sector information systems was used at an insufficient rate. Inconsistency in the tools used by each sector also compounded the confusion and need for capacity building. Little time was spent on monitoring project successes within each sector and project strengths while the majority of the time was spent monitoring program challenges.[24]

Ensuring Project Ownership and Avoiding Sectors Working in Isolation: Commitment and collaboration were major factors in ensuring program ownership and implementing decentralized technical services during development phases. Researchers found community-based organizations were not meaningfully involved in the development phases of programs. While there were planned multisectoral platform sessions, they were inconsistent and siloed in their intervention focus. For example, in Burkina Faso, when reviewing multisectoral infant feeding programs, there was a low level of involvement of nutrition-sensitive sectors (agriculture, livestock, education) and the program design had a stronger emphasis on nutrition than other multisectoral partners. There was an overlap in services provided by the multisectoral nutrition coordination platform at the provincial level and the Provincial Food Security Board (CPSA), which

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[21] Caballero, B., Vorkoper, S., Anand, N., & Rivera, J.A. Preventing Childhood Obesity in Latin America: An Agenda for Regional Research and Strategic Partnerships. *Obes Rev*. 2017 July ; 18(Suppl 2): 3–6. doi:10.1111/obr.12573.

[22] Botero-Tovar, N., Arocha Zuluaga, G.P., & Ramírez Varela, A. Factors influencing delivery of intersectoral actions to address infant stunting in Bogotá, Colombia – a mixed methods case study. *BMC Public Health* (2020) 20:925.

[23] IBID

[24] IBID

affected overall motivation. Other issues included challenges with scheduling and the high mobility of implementing partners.[25]

Lack of Appropriate Resources for Implementation: The authors also reported insufficient financial motivation, human resources, and community workers. Overall, the budget and fiscal support affected program success. For example, when implementing infant and young child feeding practices in Burkina Faso, program staff reported inadequate cash-transfer funding for livestock rearing, lack of funding for program scale-up, and insufficient compensation for project staff.[26] In Senegal, researchers suggested that analysis be performed to examine which investments in multisectoral child health are the most cost-effective and useful in the planning phase to avoid future implementation challenges.[27] In Peru, review of childhood diarrhea programs and policies revealed challenges and barriers including lack of separate funding specified for reduction of diarrhea disease, and lack of effective health strengthening activities.[28] Initially, the program struggled as it competed frequently for limited financial resources resulting in decreased priority and abandonment for vertical interventions.[29] The overall lack fiscal support for multi-sector collaboration risked program failure especially when resources are held by each sector.

Planning for Potential Challenges: In Burkina Faso, the project was affected by insecurity due to terrorist attacks.[30] Local agricultural products were abandoned for imported products and there was a lack of understanding on the nutrient content of locally available foods. Program implementers also had challenges mobilizing women for activities during the rainy season because of field work responsibilities.[31]

Theme 2: Government, Civil Society, and Stakeholder Buy-in

To be effective, collaboration needs to be perceived as worthwhile and an incentive.[32] In a review of multisectoral education approaches in five Strategies for Advancing Girls' Education (SAGE) countries, consistent feedback loops to review program results and recognize achievements by other stakeholders were deemed essential.[33] Out of the stakeholder relationships discussed, government support and backing were emphasized heavily within the case studies and literature reviewed. Global multisectoral child health articles suggest that governments and stakeholders exchange lessons learned and adapt their investments accordingly throughout the collaboration process.[34] When reviewing childhood obesity and food policies in Latin America, researchers found that some of the key elements for effective sustainable policy included evidence-based advocacy by civil society, political will, legislation, and skillful negotiation

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[25] Ouedraogo, O., Doudou, M.H., Drabo, K.M., & Kiburente, M. Facilitating factors and challenges of the implementation of multisectoral nutrition programs at the community level to improve optimal infant and young child feeding practices: A qualitative study in Burkina Faso. October 2020. *Public Health Nutrition* 24(12):1-12

[26] IBID

[27] Brar, S., Akseer, N., Sall, M., et. al. Drivers of stunting reduction in Senegal: a country case study. American Journal of Clinical Nutrition 2020;112(Suppl):860S–874S

[28] Huicho, L. et al. Drivers of the progress achieved by Peru in reducing childhood diarrhea mortality: a country case study. Journal of Global Health. 2019 Dec;9(2):020805. doi: 10.7189/jogh.09.020805.

[29] IBID

[30] Ouedraogo, O., Doudou, M.H., Drabo, K.M., & Kiburente, M. Facilitating factors and challenges of the implementation of multisectoral nutrition programs at the community level to improve optimal infant and young child feeding practices: A qualitative study in Burkina Faso. October 2020. *Public Health Nutrition* 24(12):1-12

[31] IBID

[32] Graham, W.J., Kuruvilla, S., Hinton, E.R., Veitch, E., & Simpson, P.J. Multisectoral collaboration for health and sustainable development Learning together, from success and from failure BMJ. 2018;363:k4868

[33] Rugh, A. Multisectoral Approaches in Advancing Girls' Education Lessons Learned in Five Sage Countries. SAGE Technical Report. 2002. Academy for Education Development.

[34] Graham, W.J., Kuruvilla, S., Hinton, E.R., Veitch, E., & Simpson, P.J. Multisectoral collaboration for health and sustainable development learning together, from success and from failure BMJ. 2018;363:k4868

across government, academia, and the private sector.[35] The research noted that the use of scientific evidence and evaluation played a significant role in achieving stakeholder support for policy launch and sustaining effective program implementation.

UNICEF's report on Ending Childhood Diarrhea and Pneumonia by 2025[36] recommended the following steps to ensure successful stakeholder collaboration before implementation:

- Developing a national strategy and work plan with designated responsibilities for stakeholders.
- Ensuring political backing and desire for implementation.
- Developing/updating a situation analysis for pneumonia and diarrhea.
- Ranking and prioritizing interventions for implementation and investment.
- Designing a costed plan for program scale-up.
- Identifying areas of coordination and collaboration with stakeholders, including in the private sector, academia, and civil society.
- Ensuring that the program is data driven and populations at the greatest risk are targeted first.
- Guaranteeing quality monitoring and evaluation services and using standardized indicators for tracking purposes.

Collaboration with the Government

Throughout the literature, political commitment and backing of multisectoral work by the government were strongly emphasized. The most successful programs were those with sustained political backing. For example, in Cuba, multisectoral pediatric Tuberculosis (TB) control success has been attributed to government support.[37] The national commitment to pediatric TB control has allowed for a political consensus among leaders and fiscal support for multisectoral interventions on social protection and poverty alleviation. The program also included regulatory frameworks for case notification, vital registration, the quality and rational use of medicine, and infection control TB.

In Senegal, a review of multisectoral stunting reduction programs implemented between 1992 and 2017 found they were most successful when nutrition was a national priority.[38] The report also noted a strong linkage between successful projects and those with a strong sustained political backing. Moreover, stunting was significantly reduced in Senegal due to government support, stability, and budgetary provisions for food, nutrition, and agriculture.[39] In the Southern region of Senegal, where political backing was the weakest, stunting and food security were also higher.[40]

Furthermore, the program evaluation in Latin America from the USAID Zika program implemented in Columbia, El Salvador, the Dominican Republic, Honduras, and Nicaragua (2016-2019), noted that government support was critical to program sustainability.[41] To ensure interventions would continue, representatives from the ministry of health and ministry of education in each country agreed to commit to carrying forth the use of the tools, protocols, guides, and databases developed for vector surveillance. The ministries of health in El Salvador and Honduras both signed letters of commitment and the ministry of education in Honduras incorporated the social behavior change strategy for Zika prevention into health and community nutrition courses in their national high school curriculum.[42]

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[35] Pérez-Escamilla, R., et al. Prevention of childhood obesity and food policies in Latin America: from research to practice. Obesity Rev. 2017 Jul;18 Suppl 2:28-38. doi: 10.1111/obr.12574

[36] Executive Summary. Ending Preventable Child Deaths from Pneumonia and Diarrhea by 2025 The integrated Global Action Plan for Pneumonia and Diarrhea (GAPPD). World Health Organization/The United Nations Children's Fund (UNICEF) 2013

[37] Abreu-Suárez, G., González-Valdés, J. A., González-Ochoa, E. , & Suárez-Álvarez, L. The Challenge of Eliminating Childhood Tuberculosis in Cuba. *MEDICC Review*, October 2019, 21 (4)

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[41] Smith, A. Community Action on Zika: Final Report USAID Zika Program. November 2019. Save the Children Federation, INC.

[42] Smith, A. Community Action on Zika: Final Report USAID Zika Program. November 2019. Save the Children Federation, INC.

Bolstering Community Support, Civil Society Engagement, and Private Sector Engagement

Actively engaging community and civil society stakeholders was seen as key to program success – whether through participation in programs, community coalitions to support interventions, civil society, or peer and family networks. Technical sector specialists actively engaged community and civil society members in program development and were seen as front-line actors supported by family members in implementation. The most success occurred when community members were aware of the program, understood the importance of the multisectoral approach, and advocated for its success.

- In Senegal, community level assessments were conducted at the beginning of program implementation and the health sector was actively engaged during the development phase. Community leaders and technical specialists used nutrition sensitive interventions such as promoting cultivation of gardens with nutritious foods, encouraging small livestock rearing, and distributing micronutrient powder.[43]
- In Ethiopia, a school health project focused on malaria education and insecticide treated mosquito nets (ITNs) found a strong correlation between ITNs use and family and peer influence. When families and students began demonstrating new use of ITNs, other students and families also began using them.[44]
- In the Democratic Republic of Congo (DRC), the Tenke Fungurume Mining Company partnered with the government to lead malaria control efforts. They helped distribute ITNs and administered semi-annual inside residual spraying (IRS) and semi-annual school-based malaria prevalence surveys. As a result of interventions and stakeholder collaboration, there was a 62% reduction in malaria prevalence among school children.[45]

Global Stakeholders and Continued Learning

In Cuba, the national success of the pediatric TB control program was also attributed to evaluating best practices, rapid use of newly developed program tools, interventions, and strategies. Cuba participates in both regional and global surveillance on TB and actively integrated global research and standards. Additionally, scientists in Cuba have continued researching best practices at multiple levels including examining risk factors for TB, guaranteed adherence, associations between pediatric TB and other health issues, and case detection efficacy. As a result, the national program was able to identify best practices and needed program adaptations.[46]

Theme 3: Health System Fragility and Community Capacity for Interventions

Health systems need to withstand the influx of requested services created by multisectoral intervention. Far too often, health systems are asked to expand their role alongside multisectoral collaboration without having the staffing, system strength, or expanded budgets/funding. Communities are often strained, and community implementers lack capacity for requested interventions due to project overload. During the COVID-19 pandemic, many programs were halted or stalled. Some had to quickly adapt, shift, and resubmit budgets to work around the challenges of COVID-19.[47] The threats of climate change, future pandemics, and severe weather are risks for program implementation and the success of multisector programming. Climate change can drive shifts in crop cultivation, food security, and alter food prices and economic growth. Environmental disasters can also increase the spread of communicable disease, waterborne illness, and diarrhea. During conflict, food and water availability,

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[43] IBID

[44] Abamecha, F., Sudhakar, M., Abebe, L., et al. Effectiveness of the school-based social and behavior change communication interventions on insecticide-treated nets utilization among primary school children in rural Ethiopia: a controlled quasi-experimental design. *Malaria Journal*. (2021) 20:41

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[46] Abreu-Suárez, G., González-Valdés, J. A., González-Ochoa, E. , & Suárez-Álvarez , L. The Challenge of Eliminating Childhood Tuberculosis in Cuba. *MEDICC Review*, October 2019, 21 (4)

[47] UNICEF. Press Release, March3, 2021. Retrieved at: https://www.unicef.org/press-releases/schools-more-168-million-children-globally-have-been-completely-closed (last accessed January 30, 2022).

access to health services, and service utilization rates are drastically reduced. Sometimes, limiting food access is utilized as a weapon of war. Being prepared for challenges and collaborating with stakeholders to anticipate threats are key parts of program planning. Moreover, health emergencies and environmental disasters require an "all hands-on deck" approach where multisector collaboration is not just preferred but required to meet health challenges.

Examples of program challenges and responses during emergencies include:

- In Haiti, the USAID Emergency Food Security Program found a need to integrate technological innovations to improve resilience and access to climate information, agricultural extension services, early warning, and civil protection. In the first cycle of the program, 5,770 beneficiaries were not reached due to COVID-19 complications. However, all the remaining missed beneficiaries were reached during subsequent program cycles.[48]
- During the 2013–2016 Ebola outbreak in Liberia, skilled birth attendance fell from 52% to 38%, vaccination rates dropped, and 64% of health facilities were not operational.[49] In urban areas, only 20–30% of patients seeking care received services and, in rural areas, only 70–80% of those seeking care were able to access it.[50] Unfortunately, these gaps were not improved until the epidemic subsided.
- USAID's Resilience and Economic Growth in the Sahel – Enhanced Resilience (REGIS-ER) program aimed to increase the resilience of chronically vulnerable people, households, communities, and systems in targeted agro-pastoral and marginal agriculture livelihood zones in Niger and Burkina Faso.[51] Before October 1, 2017, the project worked through local NGO partners to reach 30 communes. On January 1, 2019, security concerns forced the project to reduce its focus to 13 communes. Only 18 days later, the project further reduced its focus to 8 communes due to security issues, eventually reducing implementation to only 4% of the population in Niger and Burkina Faso. The final project evaluation suggested a need for continued capacity building to improve local structures and governance on the issues of disaster risk management, prevention, and conflict mitigation.[52]
- During a focus group with the African Bureau of Education, participants shared post-COVID-19 challenges of multisectoral school heath programs. These included school closures and the shifting focus to catching up on academic learning. This limited the focus on school multisectoral platforms, including integrating health into lessons. Emphasis on staff resources also focused on pandemic response rather than longer term program solutions or advancement.[53]

[48] Ledix, A., Montreuil Jean, A., & Jules, O. Emergency Food Security Program in La Gonâve USAID EFSP #72DFFP19GR00074 Final Evaluation Study. *World Vision Haiti*. August 2021

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Am J Trop Med Hyg. 2017 Sep 7; 97(3): 931–936. Published online 2017 Jul 10. doi: 10.4269/ajtmh.16-0702

[51] Centre d'Expérimentation, d'Etudes Economiques et Sociales de l'Afrique de l'Ouest Afrique (CESAO), and
Centre d'Etudes, de Recherche et de Formation pour le Développement Economiques et Social
(CERFODES). Resilience and Economic Growth in the Sahel – Enhanced Resilience (REGIS-ER) Final Performance Evaluation Report. March 2021

[52] IBID

[53] Schultz, L. & Shors, L. Operationalizing Health & Education Coordination: Recommendations surfaced through Interviews with Africa Bureau Missions. 2021. Washington, DC: USAID

During the USAID Community Action on Zika Project, insecurity stemming from organized crime was a constant risk in several intervention communities. For example, in Honduras, El Salvador, and Colombia where, hand-written copies of surveys had to be used rather than electronic devices to avoid risks to personnel safety. In the case of Nicaragua, the socio-political and security issues that began in April 2018 continued throughout the project and made interventions challenging.[54]

Drivers of Stunting Reduction in Peru: A Country Case Study

Peru was able to reduce its under-five child stunting prevalence from 32.3% in 2000 to 13.1% in 2016. In a review of practices and policies that led to this reduction, the following efforts drove policy and program success:

- There was a commitment by the government and stakeholders to make overall improvements to social determinants, poverty reduction, and social safety net programs, and a general commitment to the Millennium Development Goals.
- The program shifted from a nutrition sector-based feeding program to a multisectoral program which shifted the paradigm and allowed for new interventions and innovations. Prior to this point, both the problem of child stunting and the proposed solution, were viewed as nutrition specific and had not collaborated with other sectors for interventions.
- Civil Society advocacy allowed for continued dialogue with the political parties, including the National Agreement in 2004 focusing on the rights of children. The civil society also worked directly with the Ministry of Economy and Finances to ensure programs were adequately funded.
- The program provided specific goals for municipalities to achieve and included contests involving local governments where winning municipalities received the Municipal Seal, along with a photograph of the President and a plaque
- The President of Peru signed a commitment to reduce stunting and ensured program implementation through results-based budgeting programs that guaranteed financing, and by convening regional governments.

Huicho, L. et al. Drivers of stunting reduction in Peru: a country case study. American Journal of Clinical Nutrition. 2020 Sep 14;112(Suppl 2):816S-829S. doi: 10.1093/ajcn/nqaa164.

Theme 4: Cultural Competence and Gender Empowerment

To make positive change, multisectoral programs must address cultural nuances and differences. If the most vulnerable populations are to be reached then gender sensitivity and empowerment must be incorporated into program design, implementation, and evaluation. Health problems and health inequities are often caused by unequal access to quality services and treatments, psychosocial conditions, and how society is structured.[55] Even within specific geographic zones, differences may affect languages spoken, gender roles, food choices, and housing structures. Programs need to be based on epidemiologic, cultural, and demographic realities to accurately use multisectoral health interventions to help children and their caregivers reach their maximum potential.

In Karamoja, Northeastern Uganda, researchers found that food and nutrition insecurity needed different approaches depending on the sub-county in which the program was implemented.[56] Some communities did not eat fish, while others ate vegetable diets. Researchers found that proximity to water often had a greater impact on food security than actual agricultural output. Accordingly, they

[54] Smith, A. Community Action on Zika: Final Report USAID Zika Program. November 2019. Save the Children Federation, INC.
[55] World Health Organization. Saving lives, protecting futures. Geneva: WHO, 2015. Available from: https://www.who.int/life-course/news/progress-report-global-strategy/en/ (last accessed on January 30, 2022).
[56] Olum, S., Ongeng, D., Tumuhimbise, G.A., et al. Understanding intra-community disparity in food and nutrition security in a generally food insecure part of Eastern Africa. *Journal of Food, Agriculture and Nutrition Development*. 2018; 18(2): 13317-13337 DOI: 10.18697/ajfand.82.17150

recommended that community and cultural differences be considered in designing and targeting food and nutrition interventions.[57] Likewise, in Peru, childhood diarrhea mortality reduced significantly from 1980-2015 utilizing multisectoral approaches.[58] However, the program initially struggled with scattered implementation that was not clearly focused on the poorest regions of the country. Geography of implementation was not coordinated in its clinical and community components. Researchers reviewing the national reduction in diarrhea mortality suggested that interventions be customized to specific geographic, economic, and cultural characteristics of different regions of the country, particularly the rural amazon and Andean regions where diarrhea is still the leading cause of under-five mortality.[59]

In Nigeria, when reviewing the overall effects of climate change on child health interventions, researchers found that women farmers are particularly vulnerable to flooding, run-off, drought, and erosion.[60] They suggested that childhood malnutrition programs integrate gender-sensitive programing, development assistance, and nutrition education to improve overall access to health and economic security for families with young children. In reviewing multisectoral actions to decrease social inequities faced by children in Latin America, researchers noted that programs needed to incorporate technical training for multisectoral management alongside cultural, ethnic, and gender training for health equity to be achieved.[61] The study found that, increasingly, multisectoral interventions are also used to address issues of insecurity, violence, and gender issues including child marriage, care to refugee children, and human rights. The researchers suggested that specific training was needed on these key issues for multisectoral child-focused programs to be effectively adapted.[62]

In Narok, Kenya, evaluators found women needed additional resources, training, and information on nutritional feeding practices, breastfeeding, micronutrient and vitamin supplementation, and introducing complementary foods.[63] The study revealed the need to educate rural women in Narok on improved infant care through sustainable and effective essential nutrition actions. To ensure sustainability, the evaluators recommended program design address maternal information gaps, shortage of qualified health personnel, inadequate health infrastructure and accessibility, and gender equity. They also suggested programs integrate economic empowerment like livestock management/ownership.[64]

In Guatemala, the comprehensive Chagas Vector control program evaluation revealed the importance of cultural and gender integration in ensuring program success. This study aimed to describe and analyze the processes by which an interdisciplinary team, in collaboration with the communities of Comapa, Guatemala, developed an effective solution to address the risk for Chagas disease. Program implementers discovered that the complexity of Chagas disease required effectively integrating interdisciplinary and multisector approaches that build applied knowledge and consider the sociopolitical, economic, and cultural contexts of diverse communities and social groups.[65] Within Comapa, implementers worked with cross-national and multi-lingual communities from neighboring countries. They developed an effective approach to involving a multidisciplinary committee that included technical specialists from regional and national organizations and neighboring countries to develop evidence-based interventions. They were able to analyze processes for social innovations in health and

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[57] IBID

[58] Huicho, et al. Drivers of the progress achieved by Peru in reducing childhood diarrhea mortality: a country case study. Journal of Global Health. 2019 Dec;9(2):020805. doi: 10.7189/jogh.09.020805.

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[60] Ifeanacho, M.O. & Okudo, H.O. Climate Change and Nutrition Security in Nigeria. *Journal of Applied Science and Environment*. November 2020. 24 (11) 1853-1860

[61] Barros de Souza, L. et al. Intersectoral actions in decreasing social inequities faced by children and adolescents. Rev. Latino-Am. Enfermagem. 2021;29:e3427. DOI: 10.1590/1518-8345.4162.3427

[62] IBID

[63] Mapesa, J., Meme, J., & Muthamia, O. Effect of community-based nutrition on infant nutrition and associated health practices in Narok, Kenya. *African Health Sciences*. 2020; 20(2): 724-734. https://doi.org/10.4314/ahs.v20i2.24

[64] IBID

[65] Castro-Arroyave, D. et al. Integrated vector control of Chagas disease in Guatemala: a case of social innovation in health. Infectious Diseases of Poverty (2020) 9:25 https://doi.org/10.1186/s40249-020-00639-w (last accessed on January 29, 2022).

identify their potential for improving community health. The case study provided understanding of the multisectoral and interdisciplinary dynamics within a country context and documented the relevance of innovation criteria in health processes across neighboring countries. The program also actively engaged men and demonstrated that improving housing could not only reduce Chagas disease but also improve overall plot value and ability to raise female-driven incomes.[66]

Key Recommendations

Multisector Collaboration and Coordination Recommendations

Recognizing the unique contribution of each sector is an essential part of program planning and evaluation. Initially, each sector needs a clear understanding of the problem being addressed and their role in solving the problem. Multisectoral coordination platforms are a key to program success. These platforms serve as launching pads for program communication, sector collaboration, discussion of key evidence, norms, and innovation across all project areas. Proposed solutions need to be designed to ensure each sector's capacity is utilized and built throughout implementation. When implemented well, multisector coordinating committees enable program feedback and the exchange of success stories. An assessment of geographic sector implementation zones needs to be conducted before program start-up to ensure proper coverage of beneficiaries and scale-up of services. Finally, the use of standardized qualitative and quantitative measures to monitor project results across sectors will allow for better data collection and improved project evaluation. Evidence resulting from monitoring and evaluation efforts will need to be utilized to help adapt and redefine program interventions to ensure relevance, effectiveness, responsiveness over the program implementation period, and future replication.

Multisector Stakeholder Recommendations

For effective stakeholder multisectoral collaboration, all levels of society need to be considered. Other stakeholder organizations, including local non-governmental, civil society, and the private sector, can be valuable allies in reaching program goals and objectives. However, to do so, all organizations and stakeholders must have the commitment and capacity for intervention in addition to adequate funding. In developing community partners, working through existing organizations and networks of community groups can ensure local participation. Stakeholders need to be involved in program development, assessment, intervention, and ensure full program integration. Periodic events to provide feedback on results and accomplishments to the stakeholder groups should be supported. Program managers and multisector committees should also recognize individual and collective efforts from stakeholders at all levels.

Health Fragility and Community Capacity Recommendations

The world and the context in which we work are constantly changing. Unfortunately, these changes may come in the form of pandemics, epidemics, natural disasters, conflict, and environmental hazards. For multisectoral programming to succeed, program implementers need to be nimble, flexible, and able to adapt quickly to shifting contexts and challenges. Health systems are already strained and urgent needs place additional strain on program implementation. Working on community resilience is extraordinarily complex and interventions should aim to build the capacity of people and systems to advance and protect long-term well-being, despite shocks and stresses. While resilient health systems and universal coverage of quality care are gold standards for women's, children's and adolescents' health, catastrophic events can swiftly undo hard-won health gains, particularly where existing health systems are weak. Lack of a universal framework to strengthen healthy systems within a multisector approach needs to be further explored. Sub-issues that affect child health, including availability of affordable and accessible health care services, sector capacity building, and emergency preparedness and response,

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should be addressed by program implementers and donors. While not all emergencies can be prevented, nimble programs can better respond and adapt when needed.

Cultural Competence and Gender Empowerment Recommendations

Community involvement in designing and implementing culturally applicable programs to improve child health outcomes is crucial. Completing a full geographic and regional assessment of program intervention areas is essential to understanding community level differences and cultural nuances that can impact program delivery. Solutions that may work for one community may not be appropriate for another. Functional and operational approaches to improving gender empowerment need to be further explored. Innovations need to be driven by multisector teams that include diverse cultures and abilities to ensure innovations and practices are research-based and culturally sensitive. Gender empowerment is also a key factor in improving children's health and ensuring improved access to food, nutrition, and economic security. If child health outcomes are to be improved, men need to be involved in child health advocacy and community interventions in meaningful ways.

Study Implications for Future Research

This literature review serves as phase one in a comprehensive report of multisector child health programs in Africa and Latin America. While the literature review was not able to fully respond to the question, "In which countries in Africa and Latin America are multisectoral approaches implemented and who are the key stakeholders?", the authors were able to identify that a large proportion of international programs are using multisectoral interventions to improve child Health needs and identify several key examples of program successes and challenges.

During the second phase of research, case studies from both Africa and Latin America will be selected to gain further insight through key informant interviews at multiple levels and make suggestions for future programs. Case studies will focus on coordination, government buy-in, health system fragility, and gender empowerment. The literature reviewed in this paper will be used to inform the selection of potential case studies. Key informants including community implementers, government actors, stakeholders, and non-governmental organizations will be interviewed. The interviews will be transcribed and independently reviewed for key themes and subthemes and practical recommendations. After the themes/sub-themes are identified, the selected themes and sub-themes will be reviewed collectively and finalized. Key recommendations will be developed after the data has been fully reviewed.

Conclusion

Multisectoral child health programs have been promoted and implemented since the 1978 Alma-Ata Declaration. Taking an ecological systems model approach has been a consistent factor for multisectoral program success, ensuring all factors that affect children and could potentially affect the program are fully considered. The lessons learned from these programs have remained consistent over time: 1) Multisectoral programs work best when the internal communication between sectors is clear, and all sectors have an unclouded vision and goal for engagement and 2) Stakeholder backing is paramount in ensuring program success and full collaboration (at all levels including government, civil society, private sector, and community). Gender and culture also need to be included in program design, implementation, and evaluation so that programs can adjust to each community's unique needs and ensure that there is equitable and inclusive engagement to improve child health. Program evaluation needs to be designed with a comprehensive set of multisectoral program indicators to better monitor program success across sectors. These essential elements have provided a pathway to multisectoral success and helped avoid many of the roadblocks and challenges other programs have faced. However, even the best program can be easily derailed by large emergencies. Preparing for emergencies and being willing to quickly adapt programing to ensure continuity is essential to meet child health and programmatic needs.

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