A Review of Child Focused Multisectoral Programming in Africa and Latin America

Literature Review and Case Study Analysis of Two Selected Programs Honduras and Malawi

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Executive Summary

The World Health Organization defines 'multisector health' as a relationship between part of the health sector and another sector designed to achieve health outcomes (or intermediate health outcomes) in a more effective, efficient, or sustainable manner than by the health sector acting alone. The child health redesign recognizes that beyond health, other sectors are critically important in shaping child and adolescent health and wellbeing through multisectoral approaches, spanning different platforms.

This paper presents findings from a literature review and two case studies (The Honduras McGovern-Dole International Food for Education and Child Nutrition Project and the Malawai Tiwalere II Project Malawi) commissioned by the Child Health Task Force between November 2021 to August 2022 to inform the multisectoral approach to child health programming. The findings include successes and failures in implementing multisectoral action for children and lessons learned from collaborating across sectors. The aim of the paper is to assist the Child Health Task Force, in particular the Re-imagining the Package of Care for Children subgroup, in **analyzing and identifying evidence**, **challenges, and knowledge gaps** and **articulate a research agenda** on multisectoral child health approaches.

The following findings and recommendations are organized under four themes proposed by the 2018 BMJ series on making multisectoral collaboration work[1]: (1) project coordination across sectors; (2) government, civil society and stakeholder buy-in; (3) system fragility and decentralization challenges; and (4) cultural competence and gender empowerment in program planning and implementation. The literature review and case study provide a foundation for child-focused multisectoral approach considerations that should continue to be investigated. While the sample size was limited, the lessons learned from these programs have remained consistent over time and were reiterated within both the literature review and the case studies. The recommendations are designed to help guide future programmatic design and approaches to multisectoral child health.

Findings & Key Recommendations

Strengthening the need for project coordination across sectors

From the program inception, goals, sector roles, and reasons for involving each sector need to be clearly defined to ensure clear communication, avoid duplication, and programmatic success.

Recommendations

- Recognizing the unique contribution of each sector is essential to program planning and evaluation.
- Clearly define the problem and relevant ministries to be engaged during the co-design phase with donors and implementers. This task should be completed before release of funding and, if possible, during the proposal development stage.
- Build upon existing national and local multisectoral platforms, adapting to the defined local problem, and draw on local knowledge and expertise.

[1] 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

- Use standardized qualitative and quantitative monitoring and evaluation data to adapt and redefine multisectoral child health program approaches ensuring relevance, effectiveness, responsiveness over the program implementation period, and future replication.
- Examine the links between sector-balanced multisectoral programs and programs with a sectoral lead, and the benefits and challenges of both.

Addressing government, civil society and stakeholder buy-in

Developing a multisectoral oversight committee can help ensure clear communication between partners and sector implementors. Government, civil society, and private stakeholders are key partners for program success, obtaining political will, community backing, and fiscal support.

Recommendations

- Advocate for sustainable multisectoral funding with government stakeholders, decisions makers, and funders at national and global levels to ensure future funding and overriding support for multisectoral approaches. Without proper advocacy, program funding can be slowed, and progress stalled.
- Host periodic feedback events to share and discuss data gathered in reports, program results, and accomplishments with private sector and civil society stakeholders.
- Encourage community members, including families, teachers, and parents to actively participate in multisectoral child-health programs and involve all stakeholders in program development, assessments, and interventions.
- Research gaps and challenges in NGO and private sector involvement in multisectoral child health collaboration, including approaches to provision of programmatic feedback to private sector partners.

Addressing the challenge of health system fragility and decentralization

Willingness at the leadership level and mandate at the policy level are required to plan and execute successful multisectoral coordination. Ensuring stakeholders share a common vision and participate in program evaluation helps further achievements and possibilities. Nevertheless, in order from programs to avoid delays and disruptions, it is vital to plan for shocks and fragility. Development programs often lack budgetary and programmatic planning to ensure continuity amid such challenges yet depend on multisectoral interventions to improve resilience.

Recommendations

- Address sub-issues that affect child health, including availability of affordable and accessible health care services, sector capacity building, and emergency preparedness and response.
- When developing program budgets, negotiate with donors and include funds for emergency response so that the program can quickly adapt if needed (e.g. during COVID-19, a small amount of allocated money set aside in programs would have allowed programs to purchase basic items like gloves and masks and to provide a quicker response).
- Research the role of multisectoral interventions in improving resilience and adaptability of programs for children in the context of shocks, stressors, and fragility.

Addressing the necessity of cultural competence and gender empowerment in program planning and implementation

Multisectoral collaboration is a dynamic process that occurs within wider interactions and networks and changing political, social, and environmental contexts that necessitate the need for integrating cultural competence and gender empowerment throughout program design, implementation, and evaluation. Even within specific geographic zones, differences in languages, gender roles, food choices, and housing structures mean programs should be based on epidemiologic, cultural, and demographic realities to accurately use multisectoral health approaches for children and caregivers to reach full potential.

Recommendations

- Complete a full geographic and regional assessment of multisectoral child-focused program approaches to understand community level differences, local sectoral interventions, and cultural nuances that can impact program delivery.
- Research functional and operational multisectoral approaches to improving gender empowerment for children with a focus on innovations driven by multisector teams.
- Evaluate program impact and potential risks of multisectoral programs to increase gender and health disparities and ensure mitigation plans are developed during the program design phase (e.g., distance to health centers, risks of perpetuating norms versus transforming them, WASH issues that could impact populations, etc.).

Introduction

The Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) is an ambitious new agenda calling for all children to survive, thrive, and for society to transform in ways that make this possible. The strategy's objectives have three primary components: **(1) Survive**: end preventable mortality, **(2) Thrive:** promote health and well-being, and **(3) Transform:** expand enabling environments. The agenda focuses on social determinants of health, optimal growth, development, and protection of children ensuring their full potential. In support, 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. The objectives of the Global Strategy and the WHO/UNICEF vision imply a complex and multisector approach to achieving health, well-being, and optimal growth and development of children.[1]

From 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 focuses on the (1) delivery of high quality, evidence-based services, (2) household health, and (3) social determinants, which suggest health services and programs should include other sectors (i.e., Water, Sanitation, and Hygiene (WASH), transportation, agriculture, etc.) for intervention packages. Therefore, multisectoral approaches (e.g., food security, access to clean water, improved sanitation) should extend services to missed communities, and address underlying causes of poor health, implementing effective and sustainable health interventions.

Background

In 2017, the Child Health Task Force was formed as an evolution of the Integrated Community Case Management (iCCM) Task Force that was established in 2010. The changing global child health landscape, including the recognition of a need for multisectoral approaches, prompted the shift from iCCM to a broader child health mandate. The Task Force is a network of implementing organizations; NGOs; academic institutions; UN, multilateral, and bilateral agencies; in-country partners; and individuals working together to support the delivery of high-quality child health services. The Task Force aims to generate and share evidence on how to implement equitable, comprehensive, and integrated programs to promote better outcomes for children. The Task Force facilitates learning and sharing, provides countries and child health stakeholders access to a pool of technical experts, tested implementation tools and approaches, and engages members to translate knowledge into better practices.[2]

In 2018, the Astana Declaration put in motion, a movement reevaluating the state of child health care and progress towards the SDGs. The WHO, UNICEF, and Lancet Commission was formed in 2018 to consider

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

Building on recent work streams and the need to partner with countries to implement redesigned child health approaches, the Child Health Task Force commissioned this literature review and case studies to better understand how to implement multisectoral child health programs in Africa and Latin America.

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.[3] The Commission ushered attention towards a life course perspective and away from an exclusive focus on under 5 survival. The intended outcome is to deliver programs supporting an environment enabling all 0-19-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. To further advance the current state of multisectoral child health approaches, the Child Health Task Force established the Re-imagining the Package of Care for Children subgroup addressing expansion of child health services, including 1) a shift towards a life course, rights-based approach, 2) comprehensive integrated care to promote resilience and minimize vulnerability, 3) child-centered focus using a 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.[4] The COVID-19 pandemic allowed reconsideration of the challenges children face globally. The pandemic caused severe disruptions in essential health, education and other services for children, increasing poverty and inequality adding a new dimension to the issue/need for multisectoral approaches.

In February 2020, the Task Force commissioned a paper on integrating packages for child health services within and across sectors. These approaches included nutrition and early childhood development with school health highlighted as a platform for reaching school-aged children with health services. In September 2021, the Task Force published a report on operationalizing coordination between health and education sectors based on interviews with 16 USAID Africa Bureau Missions. The Re-imagining the Package of Care for Children subgroup also reviewed WHO's new Health Promoting Schools guidelines. Building on recent work streams and the need to partner with countries to implement redesigned child health approaches, the Child Health Task Force commissioned this literature review and case studies to better understand how to implement multisectoral child health programs in Africa and Latin America.

Goals and Objectives

The purpose of this report is to:

1) identify multisectoral models that exist in the literature to address the survive, thrive and transform agenda in Africa and Latin America,
2) compare multisectoral approaches to child health in the two regions,
3) characterize the challenges to an effective multisectoral approach such as fragmentation (between and within sectors), resource allocation (who pays?), and governance (who leads?),

[3] 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.

[4] 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.

4) inform solutions and innovations to overcome challenges through the research agenda.[5]

This paper shares both successes and failures implementing multisectoral action for children and lessons learned from collaborating across sectors. The aim of the paper is to assist the Child Health Task Force, in particular the Re-imagining the Package of Care for Children subgroup, in **analyzing and identifying evidence**, **challenges and knowledge gaps** and **articulate a research agenda** on multisectoral child health approaches.

Defining Multisectoral Health

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

- 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 approaches and services to address childhood illness, disease, and malnutrition (USAID).
- 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 (WHO).
- Multisectoral synonyms include: intersectoral and cross-sectoral.

To further understand and provide insight of said approaches this paper seeks to respond to the following questions:

- Which countries in Africa and Latin America use multisectoral approaches and who are the key stakeholders?
- What multisectoral approaches to child health are being utilized in those countries and why were they selected?
- Which approaches were effective or ineffective at improving child health in those countries?

Research Methods

Phase I: Literature Review Methods

Database Selection

Selection criteria focused on medical and public health journals, African and Latin American sourced research, and global multisector reports and multiple databases were used to help eliminate bias. We excluded articles if they focused more on adolescents and adults than children, focused on reproductive health or HIV/AIDS, and if they were more than five years old. We examined a total of 67 articles that fit our inclusion criteria (focusing on multisector approaches to improve outcomes for children; combining at least

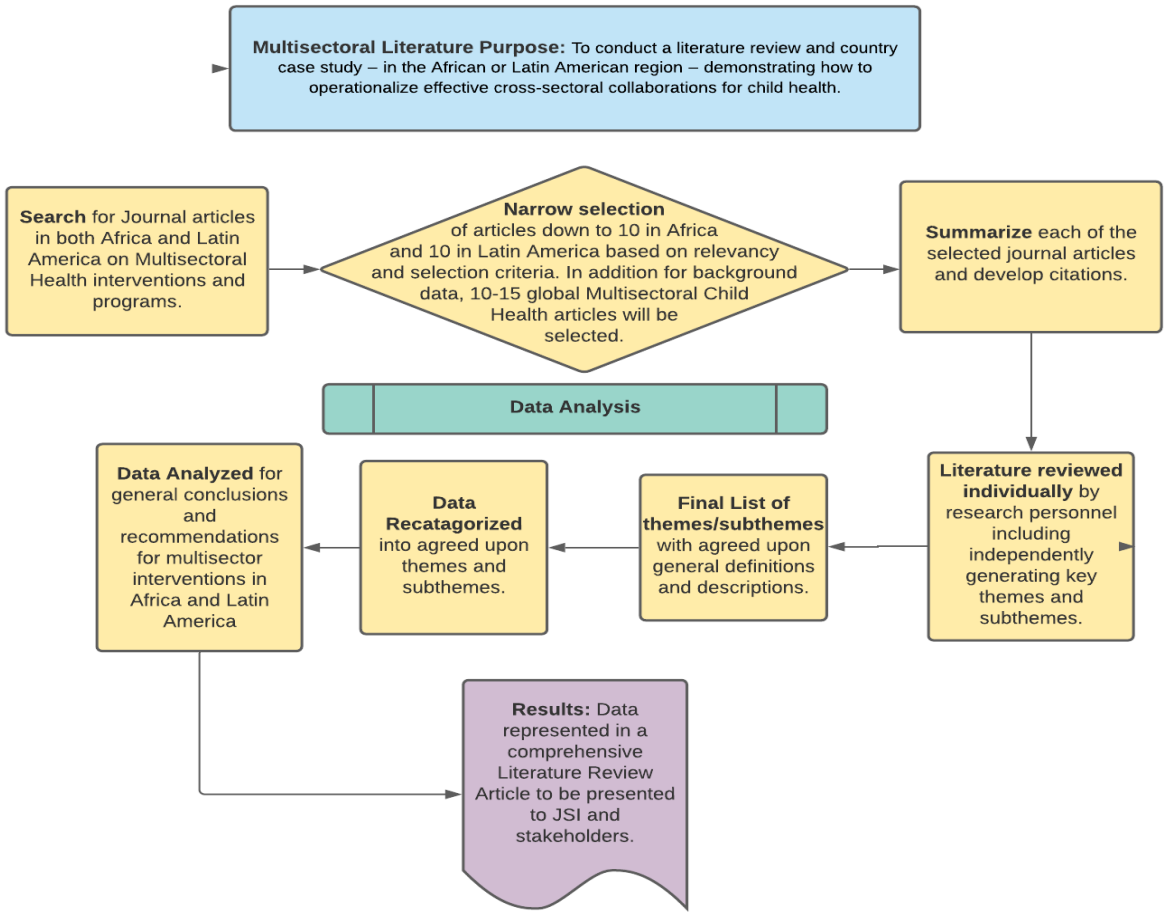
[5] World Health Organization. Technical series on primary health care: health in all policies as a part of the primary health care agenda on multisectoral action. *World Health Organization*, 2018.

two sectors from different government ministries to improve child health outcomes; using English, French, or Spanish text; and discussing projects in the Africa and Latin America and Caribbean (LAC) regions) and narrowed it down to a total of 33 articles.

Analysis and Synthesis

Qualitative methods with a thematic approach were used to evaluate selected articles and identify potential case studies. Research personnel searched for relevant peer-reviewed journal publications using five key steps: 1) Search for relevant literature 2) Examine sources 3) Identify themes, program nuances, and gaps 4) Outline thematic structure, and 5) Provide written analysis to define multisectoral programs/approaches. (See graphic below.)

Find more information in the full literature review.



Phase II: Case Study Research Methods

Case Study Selection

During the second phase of research, case studies from both Africa and Latin America were selected to gain further insight from key informant interviews at multiple levels and to make recommendations. After the literature review, we looked through programmatic reports from WHO, UNICEF, World Bank, and UNICEF and selected ten programs. The selection was based on the programs' overall implementation size,

the extent of focus on children, ease of contacting the organization (and stakeholders), and availability of program documentation. Each program was weighted based on the above factors and the two programs from Latin America and Africa with the highest-ranking score were chosen. The selected case studies each had a unique alignment to key themes within the literature review, including a focus on coordination, government buy-in, overcoming health system fragility challenges, and integration of gender empowerment into child multisectoral programming.

Program	Score	What was missing	Responsiveness to Initial Outreach/Contact
Honduras McGovern-Dole International Food for Education and Child Nutrition Project	6	-Has all required elements	Very Responsive
Guatemala Go-Baby-Go Integrated ECD platform	4	-Need Program documentation (reports/evaluations) -Program size is small -Unknown level of government collaboration	Very Responsive
Project "Wawa Illari" in Peru	3	-Small program with short implementation period -Unknown Level of government collaboration -Would need to request program reports and evaluations as none were available online	Emails provided on website
Emergency Food Security Program in La Gonâve	4	-Small Program with short implementation period	No contacts listed, but contacts may be available through organization networks.
UNICEF Madagascar	5	-Program focuses mainly on Southern region of Madagascar -No available Program reports/evaluations	Contacts listed on website
Victory Against Malnutrition (ViM) Project Burkina Faso and follow-on project ViMplus	7	-Has all required elements	Contacts available through organization networks
Tiwalere II Project Malawi	7	Has all required elements with a strong focus on children	Contacts available and responsive

Study Design

All interviews were conducted over Zoom and lasted 45-60 minutes. Before the interview, researchers provided the participants with an in-depth explanation of the study protocols and aims and obtained verbal consent as well as permission to record the interview. Participants were asked open-ended questions designed

to elicit a narrative (Riessman, 2008)[6] with little to no interruptions from the researchers to facilitate the sharing of firsthand experiences (Bamberg, 2012).[7] All interviews were on video, and the audio was recorded and transcribed verbatim using Go Transcript, with data merged and categorized by responses. For the Honduras McGovern-Dole International Food for Education and Child Nutrition Program (MGD) case study, transcripts were deidentified and uploaded to NVIVO12 qualitative analysis software for data management and analysis. For Malawi Tiwalere II, a similar process was followed, using Microsoft Excel to deidentify responses. All case study data were analyzed to identify key themes across the interviews. The subsequent generation of sub-themes and overarching themes was an iterative process and involved re-reading, coding, and recoding by two research consultants until all data had been included in sub-themes and overarching themes.

Honduras MGD:

- 9 qualitative semi-structured narrative interviews (included 13 key program stakeholders).
- Key informants: representatives from the funding agency (USDA), implementing agency and partners (Catholic Relief Services (CRS), COCEPRADII, regional Department of Education) and external program evaluators (Boston School of Social Work).

Malawi Tiwalere II:

- 9 qualitative semi-structured narrative interviews (included 10 key program stakeholders).
- Key informants: representatives from the funding agency (USAID), implementing agency (Feed the Children), partners (Nu Skin, World Relief), and Ministry of Health officials.

Case Study Background Information

MGD

Implemented by CRS Honduras and funded by USDA, MGD is a school feeding project focused on improving the literacy of school-age children in 17 municipalities in the Department of Intibucá. The first phase of the three-year project ended in December 2015. A new five-year (2016-2020) project (MGD II) was approved in November 2015 and started in February 2016. The MGD II project in Honduras benefitted more than 51,000 children and over 2,000 teachers in the 17 municipalities of Intibucá. The program focuses on education, nutrition, and economic empowerment addressing direct challenges related to the COVID-19 pandemic and mitigation issues. Phase three (MGD III) is currently being implemented.

Tiwalere II Project

A five-year (July 2016-June 2021) multisector project funded by the USAID (US$39.4 million) under Cooperative Agreement AID #612-A-16-00003, it was implemented in 11 districts across Malawi by Feed the Children, along with its consortium partners the USA-based Nu Skin and Proctor and Gamble (P&G). The project's goal was to improve the nutritional status of 473,922 children under-five; 120,529 pregnant and lactating women; 121,399 mothers of children under-two; and 129,656 adolescent girls. Seven primary

[6] Riessman, C. K. (2008). *Narrative methods for the human sciences*. Sage Publications, Inc.

[7] Bamberg, M. Narrative analysis. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), APA handbook of research methods in psychology, Vol. 2. Research designs: Quantitative, qualitative, neuropsychological, and biological. American Psychological Association. 2012: 85–102. https://doi.org/10.1037/13620-006

districts received the full spectrum of approaches: Chitipa, Karonga, Nkhotakota, Salima, Dowa, Lilongwe and Mchinji, while the remaining four – Rumphi, Nkhatabay, Balaka and Machinga – were secondary districts. These four districts receive VitaMeal – a maize-soya blend fortified with vitamins and minerals – daily in-year, reaching a total of 1,368 community-based childcare centers (CBCCs) and 155,694 children aged 3-5 years. Tiwalere I was implemented from August 2010-July 2015 and improved the well-being of orphans and other vulnerable children (OVC). Tiwalere II focuses on maternal and child health/nutrition, nutrition-sensitive agriculture, food security, livelihoods, and water, sanitation and hygiene (WASH).

Literature Review and Case Study Findings

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 the methods for integration are remarkably similar. Articles reported significant knowledge bases for sharing "what works" in multisectoral collaboration. Four central themes from the BMJ series emerged: **(1) the need for project coordination across sectors; (2) government, civil society and stakeholder buy-in; (3) the challenge of system fragility and decentralization; and (4) necessity of cultural competence and gender empowerment in program planning and implementation.**[8] The findings from the literature review and case studies are organized below according to these themes and identified sub-themes with analysis of (1) literature review results, (2) case study results from Honduras, and 3) case study results from Malawi.

Theme 1: Project Coordination across Multiple Sectors

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. The BMJ found: 1) successful program development and implementation balanced multisectoral work[9], 2) was 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 to catalyze transformative change.[10] These three elements of successful child health multisectoral programs were echoed in both the literature review and the case studies.

Agreement on the Need for Collaboration and Coordination

The literature review revealed common program strengths that contributed to overall success. It was crucial to agree on major problems/challenges being addressed and the implementing sectors found value within their roles. Each sector needed to understand its worth and value in the implementation process.[11] All policies were successfully deployed and implemented following multiple consultations with multiple sectors

[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 *BMJ*. 2018;363:k4868

[9] Balanced multisectoral work is where each sector has an equal contribution in program design, development, and implementation.

[10] 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

[11] 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

and key stakeholders, such as academia, government, advocacy groups, and civil society, each bringing a different skill set and knowledge base, allowing for strong program implementation. Once identified, evaluation of the current capacity for each involved sector and its needs was conducted to reach program goals. Capacity along with team building, was needed to ensure all members had the same understanding and ability for early project success.

Both case studies deployed collaboration strategies which helped in making these programs successful. However, we found that in practice neither case study implemented a balanced multisectoral framework as there was an identified sectoral lead within each case study (Honduras: education and Malawi: nutrition).

The **MGD** program, implemented by CRS Honduras, started in Honduras in 2013 with phase 1, and then phase 2 (2015-2016), and is currently in phase 3. Prior to 2013, the World Food Program supplied food in Intibucá Department two or three times a year. The rations that the children received were very limited and they only received a glass of milk and a little rice. There was also no training for children and their parents. Therefore, the CRS program was born from a local and national need because the government's school feeding program did not meet the requirements and expectations of the population of school children and their parents. The ministry of education selected the feeding centers and studies were conducted. With this information, a multisectoral (nutrition, health, and education) design process to identify a critical route began. ***"We motivated the Departmental Directorate to create an inter-institutional table so that from there the actions we were carrying out could be coordinated, both in training and in infrastructure, so that we would not collide and so that we would benefit most of the population. That is an important factor in which we had a leading role."*** (Implementer 1, COCEPRADII, Program coordinator).

The design process not only included institutional implementers (CRS-COCEPRADII-teachers-educational centers) and partners (national director of school feeding program, departmental directors of education, secretariat of education, municipal governments, educational development councils, and community water boards), but also beneficiaries (parents of children). The advantage ***"is that a multidisciplinary team is formed, where each sector contributes its specialty, and we have greater participation when socializing with our local actors."*** (Implementer 2, COCEPRADII Assistant Coordinator). The integration of parents provided the program with a strong operational structure, ***"We depend heavily on the parents to receive the food, prepare the food, counterparts for all the interventions we do."*** (Implementer 1, COCEPRADII, Implementer 1, COCEPRADII, Program coordinator). This support from families encouraged and furthered nutrition and educational approaches.

Malawi Tiwalere II utilized local governance structures which were coordinated through the Ministry of Health and primarily through the Department of Nutrition and HIV and AIDS at national, district, area, and village levels. The internal design team agreed that using built in local structures would provide a streamlined approach. The project focused on the Department of Nutrition and HIV and AIDS due to the built in multisectoral platforms and focus on maternal and child nutrition. At the national level, technical specialists were active members of the National Nutrition Committee, Cluster, and Working Groups, Infant and Young Feeding Task Force, and Scaling Up Nutrition Task Force. These committees included technical specialists from nutrition, WASH, agriculture, and economic empowerment, as well as members from the NGOs, donors, the UN, and Ministry. The lead technical specialist for water and sanitation also participates in technical working groups and clusters aligned under the Ministry of Water and Sanitation/WESnet. It was unclear whether the lead agricultural technical specialist for Total LandCare (subrecipient) participated in national level committees signifying the lesser role that agriculture played in the project. Tiwalere II lacked a technical specialist for Economic Empowerment.

Project staff were active members of the District Executive Committee and worked with the District Nutrition Coordinating Committee and the District Coordinating Committee for Water and Sanitation, both of which were multisectoral and involved multiple stakeholders from the community, civil society and local implementing NGOs. These committees were replicated at area and village levels to ensure grassroots multisectoral coordination. There were few incentives for multisectoral coordinating meetings, especially at the national level. Any incentives were provided to the Malawian Government by outside donors/organizations UNICEF, IRISH AID, and the World Bank. This was particularly important when Ministry level officials were visiting and providing services because lodging, food, and transport were not built into the national budget. Tiwalere II provided bicycles and t-shirts for community volunteers who participated in the project as a further incentive.

Feedback on the multisectoral platforms chosen for the project and their success in ensuring collaboration and communication were mixed: ***"I think it was good because we would have budget meetings, whenever, it was all the people who oversaw a sector in the room, everyone knew what everyone else was doing and what was going to happen where. An easy example is the WASH program. When we were going to drill boreholes, our WASH guy would go out and coordinate with the people on the ground who are covering an area and come up with the location for the boreholes. There was coordination. To me, that's done because you get everybody around the table, and then in the project, the right-hand knows what the left hand is doing."*** (Implementor, Tiwalere II, Chief of Party)

"I think there's a lot of improvements that could be made that's more regular check-ins and more regular progress updates. I also think that's a two-way street. I don't think we were asking regularly for it. Whenever we do ask for something, they're very responsive." (Private Sector Partner, Nu Skin, Global Data and Operations Analyst)

Development of a Multisector Oversight Committee

Management committees coordinate sector activities, budget allocations, and allow for sector feedback, which is crucial for success. One of the major advantages is the optimization of the use of resources by avoiding duplication of inputs and activities that tremendously improve program effectiveness and efficiency. Willingness from the leadership at the the conception phase is necessary to plan and execute the successful multisectoral oversight committees. For example, the literature review revealed a key example from the Chile Crece Contigo program. When developing the Chile Crece Contigo policy, the oversight committee was responsible for project success and smooth implementation.[12] The Government of Chile selected the Ministry of Planning and Cooperation (third party neutral non-implemented ministry) to manage committee

[12] 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

activities and budget divisions to prevent sector competition between ministries. A policy implementation budget was allocated, and funds were transferred to sectoral ministries for services. This decision sought to avoid "sectorizing" the policy and looked to capitalize on the Ministry of Planning and Cooperation's growing experience in managing social networks and promoting social advancement policies. Other ministries reported the committee allowed for group discussions in navigating sector challenges, shared project successes with multisectoral partners, and permitted feedback for the program.

In the case of the Honduras MGD program, the meetings allowed for coordinated operational planning of activities between sectors and committees with strong internal and external communication between sector partners as well as program stakeholders. However, in Malawi, the lack of a multisectoral coordination committee allowed for internal conflict as well as confusion on overall program priorities and the value of each sector's contribution as shown in the examples below:

The **Honduras MGD** program utilized a multisector oversight committee from the start. CRS led committees with active participation from partners like COCEPRADII, Caritas, Ministry of Education, Secretary of Social Inclusion, and local governments. ***"The supervision committee contributed to improving the educational indicators. These sectoral supervision teams not only came to have a pleasant chat with us...they came to carry out an on-site supervision, to verify how the educational centers were and the children before and now with the implementation of the program."*** (Honduras MGD, Departmental Implementer of Education Intibucá, phase 2, Program and Projects Director). The oversight committee, led by CRS the inter-institutional coordination table, facilitated discussions on program scopes, goals achieved, and implementation of strategies built. The program was also part of the CONCORDE group (Education Coordinating Committee), a group of different institutions working in education throughout the country, sharing studies, experiences, and statistics. Grupo Seguridad Alimentación y Nutrición (SAN) supported data collection for the hunger and food security study.

Although the **Malawi Tiwalere II** project lacked an official multisectoral technical oversight committee, project staff met internally each month to discuss challenges, successes, and opportunities. In the project design phase, the project built in capacity building for each sector so that they would have the capacity to take on multiple roles within the project and understand the benefit of each sector's involvement. It was clear from the staff interviews that staff members felt they not only understood their role, but also the roles of other technical specialists. Additionally, they were able to take on/trade off supervisory roles for other sectors when visiting the field to ensure the entire project was well coordinated.

One challenge was the need for more specialized staff at the field level. ***"We had a huge workload for field staff. Two, depending on the professional background of that field staff, would only focus on a field that he's much aware of. You could find other components lagging in some areas because of that professional background…My proposal was, if we have programs of that nature, then let's consider each component to have relevant professional staff at the field level so that they all go nicely."*** (Implementor, WASH, Tiwalere II, Technical Advisor). Technical specialists were embedded in the project at the national level, but at the district and area level, there were often gaps. The other challenge mentioned was competition between sectors. ***"It needs to be put out then to say, we are working as a team, and not necessarily as individuals. The coordination was quite disjointed a bit with other sections. We were not able to appreciate…the relationship between WASH and nutrition. The nutrition and WASH leads would champion different causes with the aim of making sure that they achieve their goals, but not necessarily coming together and working as a team."*** (Implementer, Tiwalere II, M&E Manager). While there was an understanding of goals, at times, one sector would prioritize their goals over another sectors.

Geographic and Cultural Context Considerations

From the literature, sectoral programs (health, WASH, agriculture) often had assigned geographic zones of implementation and lacked presence in other geographic areas. At times, collaboration means a particular sector may need to expand into a new geographic zone, and in this case, literature supported a full analysis of the specific cultural needs to allow for programmatic adjustments. Aligning geographical regions with involved sectors allowed for flexibility and adaptation to cultural nuances as needed.[13] Considering cultural and geographic contexts created potential to improve local implementation and reduce the prevalence of child health issues.

From the case study findings, the Honduras MGD program had to ensure cultural and geographic considerations were taken to ensure program success and that indigenous communities were fully involved in the program. In selecting the districts for Malawi Tiwalere I and II, USAID wanted to ensure maximum impact for their interventions. USAID selected Tiwalere II districts to ensure they were able to build on gains made by previous projects. During the codesign phase of Tiwalere I, the project was also introduced at the district level (to the district executive committees) to ensure alignment with the district priorities and development plans. However, there were no major cultural or geographic considerations mentioned in the findings for Tiwalere II.

The **Honduras MGD program** was represented by different governmental and non-governmental sectors, as well as local partners and parents of students from Intibucá. Some people participated in more than one of the different stages of the project, depending on the nature of their work: design, planning, implementation, supervision, coordination, monitoring, evaluation, and learning, and financing. This allowed from the beginning the program implementers to build trust with the community and to train both fathers and mothers in nutrition and food hygiene, handling, care, and preparation. Community engagement also made parents aware of the importance of quality food and its relationship with better school performance, as well as the importance of their sons and daughters attending school.

Coordination with the communities was key to the success of the program: the food for consumption was purchased from local producers and others were supplied by the beneficiary families, that is, from their crops for self-consumption and/or for sale. The combination of a complete and balanced meal, added to training for parents and educational staff, meant that families saw a benefit, in the short- and long- term, of sending their sons and daughters to school. This allowed a change in a cultural pattern of some families who considered studying to be an expense rather than a monetary return. This shift allowed for parents to increase their focus on education and allowed for a greater understanding of the many ways school supported their family's needs. This multisectoral program provided a complete diet, school supplies, and adequate infrastructure for education, allowing families to enroll children in school because the fear of hunger and poverty was reduced by knowing that it is a complete educational program. For this, the active involvement of fathers and mothers throughout the food life cycle is key.

One of the challenges is to incorporate the intersectionality approach so that, for example, religious beliefs, cultural practices, and traditions/worldviews of indigenous peoples are considered during the design, planning and implementation stages.

[13] 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

"They (Lenca People) were all…part of the communities and know all the actors and are known in the area, in Intibucá and already have relationships with the different actors, so they are key in this aspect to open doors and seek meetings and receive support and coordination with all the different people in the implementation areas." (Implementor, Honduras MGD Program). Otherwise, belonging to Indigenous peoples can become an excluding factor for boys and girls, as well as for their families. ***"There is a pending issue regarding the visibility of indigenous culture, the Lenca people …there are no anthropological or sociological studies on the Lenca culture and Lenca worldview that influences different aspects of life such as food and gender. Every time we do not address a gap we reproduce or increase it, for example: home ownership that is assigned to men"*** (Evaluator Boston School of Social Work). It is also key to understand how their ancestral culture is related to the consumption and preparation of food. And on the educational issue, how it is aligned with their ways of life and learning.

Another challenge is not to reinforce gender-based roles and stereotypes when implementing these programs. All the sources interviewed agreed that the distribution of work related to nutrition stemmed from this sex-gender division of labor: mothers prepared the food and fathers moved and/or packed the food. It is important that these programs contribute to co-responsibility between men and women related to the nutrition, education, health, and care of their sons and daughters and do not reinforce the idea that these unpaid tasks fall on mothers. School dropout rates were affected by gender role expectations for tasks that girls were expected to complete in the home. Given that this program is multisectoral, it must seek, through its different components, both educational and nutritional, to make visible the importance of girls remaining active in school. Girls may be separated from the education system because of maternity at an early age, household chores, and/or unpaid caregiving responsibilities.

Shared Framework for Project Monitoring and Evaluation

Although each sector often has an identified set of indicators for its work, standardized multisector implementation and monitoring tools ensure proper collection mechanisms at a community level. **During the design and inception phase, program designers need to ensure proper integration of multisectoral indicators and evaluation tools.** The literature suggests overall transparency is important, improved through multisectoral committee supervision reviews and by sharing financial balance sheets at all meetings. Feedback loops and research are key to successful policy implementation and programmatic change to improve performance. Overall, reports suggest that program evaluation was most successful when 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.[14] The literature review findings also suggested anticipated factors that support or deter policy adaptation so that there is a plan to collect evidence/present solutions in advance of problems.

Both case studies had a shared and robust framework for monitoring and evaluation. At times the multisectoral framework required several levels of indicators and data collections, which was reported as burdensome to the field. It is important to keep in mind the overall challenge to field-level implementors in collecting large amounts of data routinely and how this effort is multiplied when tracking multiple sectors.

[14] 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.

Program monitoring and evaluation frameworks are the foundation for the **Honduras MGD program**. From the start, CRS built consensus among sector implementors on the program monitoring framework to identify, process, and impact indicators from all sectors to develop a learning cycle by which program strength would be reinforced and weaknesses addressed. Beneficiary participation in this cycle was welcomed by program leaders. Likewise, the monitoring framework was aligned with government outcomes and results. The program was well aligned with national objectives with the goals of improving reading levels in students and ensuring meals and snacks are provided to students.

Tiwalere II was a multifaceted project focusing on child health, but also multisector interventions in nutrition, maternal and child health, economic empowerment, Village Savings and Loan Associations, agriculture, and WASH. The monitoring and evaluation protocol required tracking of all sectoral and multisectoral indicators. ***"Other than the nutrition indicators and the WASH indicators, we had also cross-cutting indicators where, for example, we're monitoring issues to do with fuel-efficient stoves, which I think was a cross-cutting issue because I know all the project was distributing school meals and that then would lead into deforestation as people are preparing the porridge in the communities, so we promoted fuel-efficient stoves and we monitored that as a cross-cutting indicator".*** (Implementor, Tiwalere II, M&E Manager). Feedback from the project was frequently shared at national, district, and community level. Internal reports and success stories were shared at monthly and quarterly staff meetings. Technical specialists were embedded into cluster groups and technical working groups at the national level and would report back challenges and program success during working group meetings.

However, the frequency of technical sharing from the Tiwalere II team at the national level was reported as inconsistent. This occurred due to staff changes and fluctuations within the project which caused shifts in lead technical specialists, as well as the Chief of Party. However, feedback internally and at the local level was consistently reported out so that all staff and local stakeholders understood key program updates and challenges.

The incentives for data collection and the amount of work required to collect data at the field level was daunting. ***"The lack of incentives across the volunteers brought a huge and significant challenge in the sense that the volume of data that we were getting would now be affected, which overall, would affect the overall works. We were working with about 24,000 volunteers; we would get around 60% to 65% of the data from these volunteers."*** (Implementor, Tiwalere II, M&E Manager). M&E staff reported that tools could have been simplified to take in multisectoral information at the care group level. ***"A care group data tool would make so much sense. Those are some of the things that are there but can also be cumbersome …you can look at household census, register, cluster data records, care group monthly record form, and things like that. There are many things that happen at care groups. The other dimension is that these tools are drafted in English and need to be translated into the languages that people use depending on the level of intervention. In Malawi, we also have multiple languages."*** (Implementor, World Relief, Country Director). The amount of data required for collection, level of translations needed, and incentives for community health volunteers were all important factors in ensuring quality M&E standards.

Challenges in Multisector Coordination

Divisions of Roles and Responsibilities

The literature review results revealed a lack of coordination between program managers and policy makers setting institutional limits for approaches and those implementing multisector programs. From the literature review, 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.[15]

Monitoring and Documenting Project Successes and Strengths

Often, multisector oversight committees meet to evaluate the program and problem solve. The literature revealed, program managers in Columbia reported multiplicity of community data collection tools within each sector and difficulty in volunteers using the tools accurately.[16] Incorrect use led to challenges developing quality community reports from routine data systems used at an insufficient rate. Inconsistency compounded confusion and the need for capacity building and little time was spent on monitoring project successes/ strengths while much of the time was spent monitoring program challenges.[17]

The case study results were unique in that only Honduras MGD had a multisector oversight committee. Malawi Tiwalere II used government structures for multisectoral coordination and then communicated internally regarding monitoring and documenting successes, strengths, and challenges.

Monitoring and document challenges within the **Honduras MGD** included ensuring that collaboration on a monitoring and evaluation framework was balanced and avoiding the urge to over concentrate on individual goals and objectives within each sector. For example, the program had community participation indicators which provided programmatic data on participation of community members and girls and boys**. "*The indicator, which measures the participation of community structures (let's call it local actors) is a transversal axis. We have that indicator for all activities. So, we intend that all people be integrated into all the activities that the program has or in those that contribute to better results in the education of boys and girls*"** (Implementer 2, COCEPRADII, assistant coordinator). The program also utilized annual multisectoral committee supervision reviews to increase program accountability and trust. During these reviews, the program presented annual report results by each sector and program expenditure trends.

[15] 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.

[16] IBID

[17] IBID

Malawi Tiwalere II used feedback from reporting mechanisms to understand program challenges and successes. Through data collection, regular feedback from multisector district and village coordinating committees, and communication with internal staff from multiple sectors, the program was able to adapt and change when needed. Feedback and data on programmatic results was used to adapt the program when needed. For example, ***"Feed the Children has one core value. You could design a program, and then, when it doesn't work, we change the course depending on the feedback from the beneficiaries, and field workers, and the district-based stakeholders. For example, we had a problem in WASH where communities could not raise enough funds for borehole maintenance in case of breakdown. We took the component or two of food security where there is village saving and loans and tailored it to the borehole so that a borehole could be part of the village saving and loans. The borehole, through that mechanism, was able to raise some money enough for borehole maintenance."*** (Implementor, Tiwalere II, WASH Technical Advisor). This same type of feedback helped mold the Tiwalere II program as it transitioned from Tiwalere I to Tiwalere II, ultimately improving upon program interventions and community level response.

The program staff shared success stories through the sharing of data on cross cutting indicators. ***"A multisectoral approach from an M&E point of view offers a holistic overview of how things are going. We are responsible of monitoring say indicators to do with child health. Because this is a multisectoral project, we also have an opportunity to monitor empowerment indicators and WASH indicators. Then see how those come together to speak one story…we had a single platform to be able to compare results from different sectors to monitor one single goal."*** (Implementor, Tiwalere II, M&E Manager).

However, the project was challenged by outside factors including procurement processes and funding challenges that often delayed progress on program targets. A key example from the interviews was when discussing the challenge of meeting borehole construction indicators. ***"It's a lengthy process and it requires a lot of procurement process…We failed to meet our target; it was 225 boreholes. We only built about only 179. Not because there were no funds, but because of bureaucratic processes".*** (Implementor, Tiwalere II, M&E Manager). Therefore, technical staff advocated that procurement processes be streamlined to avoid roadblocks to meeting targets.

Ensuring Project Ownership and Avoiding Sectors Working in Isolation

Commitment and collaboration during the development phases are both major factors for ensuring program ownership and implementing decentralized technical services. Yet, the literature review found community-based organizations were often not involved in the development phases. Multisectoral platform sessions were planned but were inconsistent and siloed in intervention focus. For example, in Burkina Faso, multisectoral infant feeding programs had low-level involvement from nutrition-sensitive sectors (agriculture, livestock, education) with the program design having a stronger emphasis on nutrition than other partners. There was an overlap between the program approaches and services provided by the multisectoral nutrition coordination platform at the provincial level, the Provincial Food Security Board (CPSA), which affected overall motivation to collaborate with other sector implementors. Other issues included challenges with scheduling and the high mobility of implementing partners that made it difficult to ensure collaboration among project implementers.[18]

Lack of Appropriate Resources for Implementation

[18] 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

During the design phase of **Malawi Tiwalere II** project, community members were asked to provide feedback on the Malawi Tiwalere I and what they would like to see different. To gather the feedback, the program worked with the District Coordinating Committees in each region to ensure full collaboration. However, funding challenges led the project to cut the agricultural portion of the project despite its perceived benefit from both the field and staff members. However, using the CARE Group model as an integrated platform allowed for a strong integrated focus and community ownership on multisector approaches in Nutrition, WASH, Agriculture, and Small Business Development even after the agricultural subrecipient funding had ended.

Lack of budget and fiscal support led to minimal investment in human resources, including compensation for employees and community workers, which prevented program success. For example, when implementing infant/young child feeding practices in Burkina Faso, program staff reported inadequate funding for livestock rearing, lack of program scale-up funding, and insufficient compensation for project staff.[19] In Senegal, research suggested investments in multisectoral child health are most cost-effective and useful in the planning phase to avoid future challenges.[20] The literature review found that childhood diarrhea programs and policies in Peru revealed challenges and barriers such as lack of separate funding for reduction of diarrhea disease and lack of effective health strengthening activities. While integrated funding is preferable, the aforementioned example revealed how imbalanced funding can cause programmatic gaps.[21] Initially, the program struggled as it competed frequently for limited financial resources, resulting in decreased priority and abandonment of vertical approaches. The overall lack of fiscal support for multi-sector collaboration risked program failure especially when resources were held by each sector.

While the Honduras MGD program did not have funding delays or challenges, the Malawi Tiwalere II program was complicated by US government funding delays in Washington DC that delayed funding to USAID country programs. They found that these delays stalled overall progress on program indicators as well as interrupted multisectoral approaches and partnerships.

Due to funding appropriations from the US Congress, **Malawi Tiwalere II**, experienced an extensive slowdown in funding which not only delayed program activities but disrupted partnerships with World Relief and Total Land Care. During the interviews, the following sentiment was echoed throughout each interview: ***"Challenges in the financing of the project. Yes, in the sense that I know we were funded by USA, and we experienced what they call a slowdown funding between 2018 and 2019 to the extent that I think the implementation of project activities slowed down."*** (Implementor, Tiwalere II, M&E Manager).

World Relief was a partner in a small geographic zone of the project where Feed the Children did not have program operations. Since phase II was nearing the end of the program, Feed the Children took over responsibilities in World Relief areas until the end of the program. However, Total Land Care worked across geographic regions to provide agricultural interventions including climate smart agriculture interventions and integration of natural resource management technologies. These activities were completely halted once funding to their subrecipient ended. Feed the Children was still able to meet progress on agricultural indicators due to care group activities and other agricultural interventions that were ongoing. However, the question many interviewees asked was how many targets they could have exceeded and how many more beneficiaries could have been reached if funding had not been slowed?

[19] IBID

[20] 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

[21] 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.

Planning for Potential Challenges

The literature also found that multisectoral programs often lacked a clear plan for potential challenges and roadblocks to program implementation. For example, in Burkina Faso, one project faced insecurity due to terrorist attacks.[22] Local agricultural products were replaced by imported products causing a lack of understanding on nutrient content of locally available foods. Program implementers also had challenges mobilizing women for activities during the rainy season because of field work responsibilities.[23] The case study in Malawi was also challenged by fiscal challenges that delayed program implementation and both case study programs were challenged by the COVID-19 pandemic (discussed in more detail in Theme 3).

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

To be effective, collaboration needs to be perceived as worthwhile and needs incentives.[24] Out of the stakeholder relationships discussed in the literature and the case studies, government support and backing were emphasized heavily. True collaboration means investing in relationships, shared evidence, strategies, and innovations.[25] Stakeholders played an important role in providing insights into how integration may affect services, community social structure, local and regional governance, access to and cost of services, and household dynamics in both the literature and the case studies.[26] By coordinating and engaging with stakeholders across sectors with shared target populations, donors and program managers can integrate multisectoral child health services into existing delivery platforms, supply chains, and workforce infrastructure to sustain multisectoral approaches.[27] In Strategies for Advancing Girls' Education (SAGE) countries, consistent feedback loops reviewing program results and recognizing achievements by other stakeholders were deemed essential.[28] Global multisectoral child health articles suggest governments and stakeholders exchange lessons and adapt investments accordingly throughout the process.[29] In Latin America, childhood obesity and food policy researchers found key elements for effective sustainable policy include evidence-based advocacy by civil society, political will, legislation, and skillful negotiation across government, academia and the private sectors.[30] As noted, use of said evidence and evaluation played a significant role in achieving stakeholder support, policy launch and sustainability.

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[22] 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

[23] IBID

[24] 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

[25] Kuruvilla S, Hinton R, Boerma T, Bunney R, Casamitjana N, Cortez R et al. Business not as usual: how multisectoral collaboration can promote transformative change for health and sustainable development BMJ 2018; 363 :k4771 doi:10.1136/bmj.k4771

[26] Ahner-McHaffie, T. Brunie, A. Chen, M., Etheredge, G. et al. Guidance for Evaluating Integrated Development Programs. 2016. FHI 360. https://www.fhi360.org/sites/default/files/media/documents/resource-id-evaluation.PDF last accessed July 31, 2022.

[27] Act to End NTDS West Program. Facilitating Multisectoral Coordination and Engagement for Neglected Tropical Disease (NTD) Sustainability. Act to End NTDS. West Technical Brief No. 3. FHI 360. https ://www.fhi360.org/sites/default/files/media/documents/resource-actwest-facilitating-multisectoral-coordination.pdf. Last accessed July 31, 2022.

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

[29] 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

[30] 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

UNICEF's report on Ending Childhood Diarrhea and Pneumonia by 2025[31] recommended the following steps to ensure successful stakeholder collaboration before implementation:

- Develop a national strategy/work plan with clear designated responsibilities for stakeholders.
- Ensure political backing and desire.
- Develop/update situation analysis for pneumonia and diarrhea.
- Rank and prioritize approaches, for implementation and investment.
- Design a costed plan for program scale-up.
- Coordinate and collaborate with stakeholders, private sector, academia and civil society.
- Ensure program is data driven with populations at greatest risk targeted first.
- Guarantee quality monitoring/evaluation while using indicators for tracking purposes.

Collaboration with the Government

Throughout the literature, political commitment to and backing of multisectoral work is strongly associated with program success and sustainability. In Cuba, multisectoral pediatric tuberculosis (TB) control success has been attributed to government support.[32] The national committee of pediatric TB control allowed political consensus among leaders and fiscal support for multisectoral approaches on social protection and poverty alleviation. The program also included regulations of case notification, vital registration, quality, and rational use of medicine for infection control. In Senegal, stunting was significantly reduced due to government support, stability and budgetary provisions for food, nutrition, and agriculture.[33] However, southern regions, where political backing was the weakest, stunting and food insecurity were higher.[34]

It has been widely documented that collaboration with government bolsters community support and continued learning—important activities for program success. Throughout the literature, most successful programs are those with sustained political backing. Both case studies echoed this sentiment by demonstrating a strong collaboration with government structures and alignment with government policies that was replicated at national, regional, district, and village levels.

[31] 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

[32] 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)

[33] IBID

[34] IBID

In the case of the **Honduras MGD program**, the government, due to the government's alignment with policy and operational plans, provided ample support from the get-go. ***"I think that in almost all cases, if not 100%, we are aligned with the objectives and goals (of the government) and that is a very important point and has helped us a lot because we are not coming up with a new idea, we are here as cooperators, really to support."*** (Implementor, Honduras MGD Program | Honduras), chief of party). The program was also validated at the national and local levels through further collaboration on the school feeding program. ***"The Honduran government has a history of supporting school meals, they are members of the Global School Meals Coalition, which was a product of the UN Food System Summit in September 2021. So that is a demonstration of their national commitment. They support and have demonstrated that they have a school feeding leadership."*** (Donor, USDA, MGD Program director).

The program executed a socialization strategy through information sessions with all stakeholders to increase buy-in. The socialization process produced active involvement in the sustainability process. The government had a strong grasp of project interventions, program goals, program staff, and program intervention zones which allowed for increased political backing and will to collaborate and support activity implementation. First, permits were needed from the Secretariat of Education, the governing body of the area, to execute the program with local government support for matters related to product storage, execution of work counterparts, and the transportation of materials. Since the program had the support of government officials at multiple levels, permits were granted with ease.

Primary collaboration for **Tiwalere II** was through the Ministry of Nutrition and HIV and AIDS, national working groups/clusters, and district and local government structures. Working groups within each of the departments allowed for multisectoral collaboration at the local level. Those interviewed strongly praised the Department of Water and Sanitation for consistent collaboration and frequent trips to the field to support program initiatives. For field support to be successful, Tiwalere II found it was necessary to provide incentives to government staff including transportation costs, food allowances, and at times lodging which may not have been budgeted for within their national budget. ***"We know that whenever we engage our colleagues from government, sometimes they were busy with other duties in their departments. Sometimes it was difficult to get them and support you fully whenever we wanted them. Sometimes the other challenge was, whenever we engaged them, they would always request for maybe a lunch allowance, which was not budgeted in the project. Sometimes we had those challenges, but all in all, our work was good. Our collaboration was okay. They were supportive into a Tiwalere II project."*** (Program Implementor, Tiwalere II, Nutrition Technical Advisor).

However, a key challenge was as a point of streamlining. For example, the Ministry of Health's Integrated Management of Childhood Illnesses Department, was not involved in the project directly as a key collaborator. This department is the holder of the Child Health Policy and all Child Health Work in Malawi. ***"The entry point in the beginning was wrongly done. Entry point is about when you have a project or indeed an intervention and then if it is health sector, or indeed if it is agriculture, you need to go to the sectoral departments that are responsible. They started reaching out to the districts instead of reaching out to the national level, and to get advice on who at national level can guide it better, either on the nutrition or agricultural sector or indeed, Child Health part. That was not done at the central level, but the entry was at a lower level ignoring the governance structures at central level."*** (Ministry of Health, Integrated Management of Childhood Illnesses Coordinator). Since the project had a large focus on child health and improving childhood stunting, this was a missed opportunity. It was also unclear from the interview results how involved the project was with the Ministry of Agriculture, particularly after Total Landcare was released as a subrecipient in the latter half of the project.

Bolstering Community Support and Civil Society and Private Sector Engagement

Community, private sector, and civil society stakeholders are also key to program success through participation in programs, intervention support, and society or peer and family networks. In the literature, technical sector specialists who engaged community and civil society members in program development were seen as front-line supporters by family members and friends. Program success in the case studies and literature review was enhanced when the community had awareness of the benefits of a multisectoral approach. Examples from the literature review include:

- In Senegal, community level assessments were conducted, with the health sector actively engaged during the development phase. Community leaders and technical specialists used nutrition sensitive approaches such as promoting gardens with nutritious foods, encouraging small livestock rearing, and distributing micronutrient powder.[35]
- In Ethiopia, a school project focused on malaria education and insecticide treated mosquito nets (ITNs) found a strong correlation between ITNs use and family/peer influence. When families and students began using ITNs, it encouraged other students and families to use them.[36]
- In the Democratic Republic of Congo (DRC), the Tenke Fungurume Mining Company partnered with the government to lead malaria control efforts by distributing ITNs, semi-annual inside residual spraying (IRS) and school-based malaria surveys. This program saw a 62% reduction in malaria prevalence among school children.[37]

From the case studies, both programs worked directly with community programs to ensure program acceptance and uptake. Alignment with national policies and the global Advancing Nutrition Program allowed for further community acceptance and buy-in. In Malawi, the Tiwalere II program also utilized private sector partners to further program targets and reach program objectives.

In addition to a socialization process, the **Honduras MGD program** implemented community-based activities to improve community engagement and support. The program staff ensured the community and schools were provided tools and training at multiple levels (school director, principal, teacher, and parent trainings) and achieved 100% involvement from all parties. ***"With local actors, above all, our coordination work was to establish agreements with these entities such as municipal governments, which played an important role in carrying out school infrastructure works, in the area of school feeding and sanitation"*** (Implementer 1, COCEPRADII, Program coordinator). The program was in part successful because community stakeholders understood their value and that each person had a role to play if the program was to be successful. This sentiment was echoed in the interviews: ***"All the actors knew their role, and took over that role that was theirs, so that the implementation of the program would have the results that we have had to date"*** (Departmental Implementer of Education Intibucá, phase 2, Program and Project Director).

The socialization process produced active involvement in the program's sustainability process. ***"The advantage of this program is that CRS worked with local partners. And that they are well known in the department. So, that is the advantage. From there, an environment of trust is created"*** (Implementer 1, COCEPRADII, Program coordinator). For example, parents contributed a lot of things from their own homes for school meals such as firewood for cooking, condiments (salt/pepper), and sometimes fruits, vegetables, and eggs.

[35] IBID

[36] 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

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

Additionally, incentives to facilitate civil society and community involvement in the program were provided. At the volunteer level, parents who volunteered in the big activities, were given an incentive of a food bag or food ration for their efforts. In the case of government staff at the central level, the project incentivized government staff by paying for lodging, transportation, and food so that they could participate.

Global Stakeholders and Continued Learning

Based on the literature review, the national success of the Pediatric TB Control program in Cuba was attributed to the use of best practices and rapid implementation of newly developed program tools, approaches and strategies. Cuba participates in both regional and global surveillance of TB and integrates global research and standards. Additionally, scientists continue researching best practices at multiple levels for 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 can continue to adapt the program as needed.[38]

Because the case studies were both community-based national programs, they did not participate in improving global research and work with global stakeholders. However, each program has published articles, blogs, and reports that have been shared with the global community allowing a stronger body of evidence for multisectoral child health work.

Tiwalere II was a USAID Global Development Alliance (GDA) project with a focus on public partnership and co-creation. GDA is a public-private partnership model that allows USAID to leverage resources from private sector partners and use those assets in a way that allows the achievement of mutual goals of the partnership.[1] Using a GDA, USAID can partner with companies and NGOs as equals in the development process. The project had two private sector partners, Nu Skin and Procter & Gamble. Nu Skin provided VitaMeal, a highly nutritious meal that provides the right amounts of calories, fats, and carbohydrates for children to grow, averaging about 84,000 2-kg bags of fortified porridge a month, distributed to 1,421 preschools. Procter & Gamble (African Division) provided WaterGuard to communities to purify and create portable water. In both cases the materials for the products were locally sourced and produced, helping to improve employment and use of local products. The Madalisto VitaMeal plant in Malawi has provided over 400 jobs in agriculture and production and allows a more simplified distribution of the product.

Both Nu Skin and Procter & Gamble had previously partnered with Feed the Children's private funding program and provided VitaMeal and WaterGuard to communities. When the GDA opportunity arose, it provided a strategic way to include a private sector partnership into the co-creation project as the partnership was well established. Even after the Tiwalere II project ended, VitaMeal and WaterGuard continued to be delivered to select communities. Overall feedback provided was that both private sector partnerships were successful.

Nevertheless, private sector partners reported inconsistent feedback on program results. Because the relationship and reporting requirements had already been standardized prior to the USAID GDA program design with Feed the Children, there was not much discussion on how to improve or enhance program reporting and collaboration. Interviewees reported that during funding delays from the USG, the products provided by the private sector partners helped to sustain the program impact and ensured the program continued to reach its M&E targets, especially for the health of children under-five. During the COVID-19 pandemic, the challenge of meeting project indicators continued as care groups and community volunteers were unable to meet with beneficiaries. However, VitaMeal and WaterGuard were continuing to be delivered to beneficiaries. If Nu Skin and Procter & Gamble had been updated more on the progress, challenges, and successes of the project, as well as their contribution to the project indicators, they may have been able to better highlight the value and importance of public-private partnerships within their own organizations.

[38] 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)

Theme 3: Health System Fragility and Community Capacity for Multisectoral Approaches

The literature revealed that the threats of climate change, future pandemics, and severe weather all risk program success. Climate change can drive shifts in crop cultivation, changing food security, altering food prices, and economic growth. Environmental disasters also increase spread of communicable disease, waterborne illness and diarrhea. During conflict, food and water availability, access to and utilization rates of health services are drastically reduced, and sometimes limiting food access is used as a weapon of war. Multisectoral programs foster a supportive environment for absorptive and adaptive capacities and strengthen transformative capacities in areas at risk for shock, stressors, and fragility. The WHO acknowledged in the face of the COVID-19 pandemic, the human and environmental interconnectedness and recommended a green recovery to the COVID-19 response.[39] Signifying that overall response to complex and fragile situations will require multidimensional, multisectoral solutions.

USAID's Vision for Health System Strengthening 2030 calls for building resilience to acute, time-bound events, as well as protracted emergencies.[40] To do so, health systems need to be prepared to withstand an influx of requested services created by multisectoral approaches. Far too often, health systems are asked to expand their role alongside multisectoral collaboration without having proper staffing, system strength or expanded budgets/funding. Often strained, communities lack capacity for requested approaches due to project overload.

During the COVID-19 pandemic, many programs were halted or stalled, while others had to quickly adapt, shift, and resubmit budgets to work around the challenges of COVID-19.[41] In May of 2020, UNCIEF reported in a press-release that over 6,000 additional children under five could die a day, without urgent action to the COVID-19 pandemic.[42] Being prepared for challenges and collaborating with stakeholders to anticipate threats are key parts of program planning. Child Health emergencies/environmental disasters require an "all hands-on deck" approach. From the literature, examples of program challenges and responses during emergencies include:

- In Haiti, the USAID Emergency Food Security Program used technological innovations to improve resilience and increase access to climate information, agricultural extension services, early warning, and civil protection.[43]
- In Liberia, during the 2013–2016 Ebola outbreak, skilled birth attendance fell from 52% to 38%, vaccination rates dropped, and 64% of health facilities were not operational.[44] In urban areas, only

[39] World Health Organization. WHO Manifesto for a healthy recovery from COVID-19. May 2020. https://www.who.int/news-room/feature-stories/detail/who-manifesto-for-a-healthy-recovery-from-covid-19. Last Accessed July 31, 2020.

[40] USAID (2022). Vision for health system strengthening 2030. 2022. https://www.usaid.gov/global-health/health-systems-innovation/health-systems/Vision-HSS-2030. Last updated June 10, 2022.

[41] 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).

[42] UNICEF. As COVID-19 devastates already fragile health systems, over 6,000 additional children under five could die a day, without urgent action: UNICEF launches #Reimagine, a global campaign to prevent the pandemic from becoming a lasting crisis for children. May 12, 2020. https://www.unicef.org/press-releases/covid-19-devastates-already-fragile-health-systems-over-6000-additional-children. Last Accessed July 31, 2022.

[43] 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

[44] Kuruvilla, S., Bustreo, F., Kuo, T., et al. The Global strategy for women's, children's and adolescents' health (2016–2030): a roadmap based on evidence and country experience. *Bulletin of the World Health Organization*. 2016;94:398–400.

COVID-19 deeply impacted the **Malawi Tiwalere II project** in late 2019. Program staff and stakeholders reported that the project was not prepared for a pandemic, and there was no extra funding available to reallocate towards needed mitigation supplies or to put a contingency plan in place. Respondents also mentioned that while they did not lose project staffing, their ability to implement was affected in the initial months of COVID-19. During the pandemic, social distancing restrictions were put in place, preventing community volunteers from conducting household visits and hosting community trainings. Staff members and technical specialists were not allowed to visit the field and were forced to work from home. Care groups were also not able to meet due to restrictions on the number of people allowed at group gatherings. Secondary health effects were also a challenge as less people frequented healthcare centers.

However, all the recipients reported that the Government of Malawi responded very quickly to the pandemic

At the start of 2020, the COVID-19 pandemic strained communities and healthcare systems to their limits. In Honduras, the **MGD program** had to quickly adapt, shift, and submit approvals to funding agencies to work around these challenges. The project established agreements with key institutions and obtained permission from the Ministry of Health to maintain program activities including supplying school meals. Food provision was part of the program to ensure that children were being fed at least 1.5 times a day even during community food shortages. (During COVID-19) ***"We all had to reinvent ourselves. I don't know if there was a decrease in personnel or not, but they and the teachers were willing to continue providing the snack. The teachers went to the schools and together with the program's technician distributed the school snack for each child daily. They would give them the snack for the week or for 15 days."*** (Government, former Director of Education of Departament of Intibucá/phase 2).

As a part of COVID-19 mitigation efforts, food distribution shifted from providing meals in schools to providing take-home rations. ***"What we did (during the COVID-19 lockdown) was support our implementers: We switched from providing meals in schools to providing take-home rations."*** (Donor, USDA, MGD Program director). The program also shifted to printing and delivering extra textbooks and reading booklets so that students could take home school supplies while social distancing. ***"As a program, we adapt all our activities to work, so that we can achieve our goals and continue to serve people under quarantine…"*** (Implementer, Honduras MGD Program, chief of party). To do this, the program coordinated with the Secretary of Education to print and deliver home study packages that were easy to study, culturally appropriate, and child friendly. As a result, the schools now have a tutoring program for underperforming children that was previously done after school hours but has been adapted for use at home.

20–30% of patients seeking care received services and in rural areas, only 70–80% were able to access it.[45] Unfortunately, these gaps did not improve until the epidemic subsided.

- During a focus group with the African Bureau of Education, post-COVID-19 challenges for the program included school closures and shifting focus to catching up on academic learning, with limited focus on school platforms, including health lessons. Emphasis on staff resources also focused on pandemic response rather than longer term program solutions or advancement.[46]

[45] McQuilkin, P., Udhayashankar, K., Niescierenko, M., & Maranda. M.L., Health-Care Access during the Ebola Virus Epidemic in Liberia Am J Trop Med Hyg. 2017 Sep 7; 97(3): 931–936. Published online 2017 Jul 10. doi: 10.4269/ajtmh.16-0702

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Theme 4: Cultural Competence and Gender Empowerment

Findings from the literature review showed cultural competence and gender empowerment as important cross cutting themes that need to be addressed to ensure effective child health multisectoral programming. Cultural and gender issues are relevant for all programs, however, are especially important when considered child-focused multisectoral programs because they combine issues and challenges from more than one sector. To make positive change, multisectoral programs must address cultural nuances and differences.

If the most vulnerable populations are to be reached first, gender sensitivity and empowerment must be incorporated into design implementations and evaluations. Health problems and inequities are caused by unequal access to quality services and treatments, psychosocial conditions and how society is structured.[47] Even within specific geographic zones, there are differences in languages, gender roles, food choices and housing structures, and programs should be based on epidemiologic, cultural and demographic realities for accurate use of multisectoral health approaches for children and caregivers to reach full potential. Literature review findings revealed that effective multisectoral child health programs examine its own role in generating health disparities (such as discrimination and abuse, provision of differential quality of care to different groups, and inadequate water and energy supplies to health facilities) and needs multisectoral interventions to tackle this challenge.[48] Examples from the literature review included:

- In Peru, efforts to reduce childhood diarrhea mortality utilizing multisectoral approaches struggled with scattered implementation.[49] The program failed to focus on the poorest regions of the country and geography was not considered in its clinical and community components. Researchers reviewing the national reduction in diarrhea mortality suggested that approaches be customized to specific geographic, economic and cultural characteristics of different regions, particularly the rural amazon and Andean regions, where diarrhea is still the leading cause of under-five mortality.[50]
- In Guatemala, the comprehensive Chagas Vector control program evaluation revealed the importance of cultural and gender integration in ensuring program success. The project worked with cross-national and multi-lingual communities from neighboring countries (as part of a multidisciplinary committee) to develop an effective approach to evidence-based multisectoral approaches. They were able to analyze processes for social innovations and identify potential opportunities for improvement of community health. The program also actively engaged men through gender transformative approaches and demonstrated that improving housing could not only reduce Chagas disease, but also improve overall value and ability to raise female-driven incomes.[51]

[47] 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).

[48] Rasanathan K, Damji N, Atsbeha T, Brune Drisse M, Davis A, Dora C et al. Ensuring multisectoral action on the determinants of reproductive, maternal, newborn, child, and adolescent health in the post-2015 era BMJ 2015; 351 :h4213 doi:10.1136/bmj.h4213

[49] 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.

[50] IBID

[51] IBID

Honduras is one of the world's most dangerous countries for women. Every 18 hours, a woman is killed, according to the Violence Observatory at the National Autonomous University of Honduras. Violence against women is common in the country and activists say it is due to the machismo culture.[1] Gender inequality in Honduras is cemented in a social and cultural understanding of a woman's role. Women are expected to tend to the domestic front and must balance professional work with the responsibility of raising their children and managing a household. These circumstances make it difficult for children, especially girls, to prioritize school. When families are struggling, it is hard for the child to choose to attend school rather than stay home and help. Girls are often expected to choose family life over schooling and stay home to run the house. After children reach the sixth grade, most of them cannot afford to continue their education. One of their only options, after finishing sixth grade, is marriage at an early age (often of twelve or thirteen). In Honduras, 34% of girls get married before the age of eighteen.[1]

For the **MDG program**, managing activities and providing program indicators has been a complicated issue. Gender disparities in educational availability posed challenges to the program's success (including as it relates to reading comprehension). The problem with the school enrollment interventions program is that it focused on younger girls when the challenge is often keeping girls in school as they reach adolescence. The program aimed to increase access to job opportunities by increasing access to formal education.

However, unless women are given more opportunities for employment and men take on more household responsibilities, the status for women often remains stagnant**. "*Intibucá has a very macho society, and let's not say inside, in the communities. So, it's complicated. However, we have achieved substantial changes. At first, the husbands did not want to let their wives go out for training, can you imagine? We have achieved that woman can go, be trained and educated*"** (Implementer 1, COCEPRADII).

True transformation would shift some of the household and cultural norms to give women more employment opportunities and men more opportunities to participate in household responsibilities. This program, since its design, encouraged male involvement in food preparation. **"*There are fathers who continue to participate, it was to look for a father who was interested in participating and that he would be the leader, who looks for his friends or brothers or other men in the community to convince them to share as well.*"** (Implementer, Honduras MGD Program, Chief of Party). For example, one goal of the project was to integrate a percentage of fathers into the school feeding committee (preparing food, recipes, etc.) to encourage the participation of both parents. In this way, the burden is not left to women alone.

Multisector interventions used by **Malawi Tiwalere II** included a gender perspective, but the program initiatives were not gender transformative. Some examples of interventions included:

- Including male community volunteers, care group members, and care group leaders.
- Promoting joint decision making at the household level on issues of food security, agriculture, nutrition, finances, and reproductive health.
- Working to reduce economic imbalances through education, agriculture, WASH, and small business initiatives.
- Implementing Stay in School initiatives to reduce teen pregnancy and keep girls in school.
- Advocating for more male participation.
- Implementing Post-partum depression (PPD) identification, PPD support groups and referrals.

Post-Partum Depression support was one of the most transformative aspects of the gender programming. Tiwalere II pioneered an approach that focuses on treating women with maternal depression using a community-based treatment called Interpersonal Psychotherapy in Groups (IPT-G), with the expectation that the reduction of the women's depressive symptoms will in turn enable them to increase their adoption of health and nutritional behaviors, particularly infant and young child feeding and WASH.

Identified depressed mothers were put in groups of six to ten and requested to meet for 16 weeks, 90 minutes every week[1]. In the groups, the mothers shared their experiences and challenges with trained facilitators leading the groups. They also had one- on- one counseling with the facilitators. The treatment groups had significant decreases in depression as well as ability to do household chores. ***"The success was tremendous and the change it did in these women's lives. I forget the exact percentage, but something like- it was at least 50%. I want to think it's more. Women in the village are depressed. This program had an enormous impact on them. I'll never forget meeting with one of these groups and talking to them and the change this made in their lives. They just were going to keep meeting together informally. That wasn't the only one of those groups that did that."*** (Implementor, Tiwalere II, Chief of Party).

Recommendations from the research indicated that this approach should be scaled up and used beyond the care group model but into other group models such as VSLA groups and expanded into other targeted groups such as new fathers and adolescents as their rates of depression have been shown to have an impact on maternal health.

However, most of the above gender-focused initiatives still maintained the status quo "the woman as the primary caregiver" and "the man as the primary income earner". Gender transformative refers to efforts to change gender and social norms to address inequalities in power and privilege between men and women, to free all people from harmful and destructive norms[1]. These programs did little to shift the status quo/power structure and to transform the cultural norms.

Key Recommendations

Strengthening the Need for Project Coordination across Sectors

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. Consensus on the definition of the problem and how sectors align within a solution is the first prerequisite for success. Financing has an influence on funding mechanisms and problem definitions. The literature revealed that multisectoral programs need to be balanced. However, the case studies demonstrated that if the problem is well defined, each sector can contribute independently to the solution. In both case studies, one sector was the focus (Honduras: education, Malawi: nutrition), but the problem was well defined and there was strong understanding between the sectors of their respective contributions towards program goals and objectives. Multisector coordinating committees enable program feedback and the exchange of success stories and are key to program success. These platforms serve as launch pads for program communication, sector collaboration, discussion of key evidence, norms and innovation across all project areas.

Recommendations:

- Recognizing the unique contribution of each sector is essential to program planning and evaluation.
- Clearly define the problem and relevant ministries to be engaged during the co-design phase with donors and implementers. This task should be completed before release of funding and, if possible, during the proposal development stage.
- Build upon existing national and local multisectoral platforms, adapting to the defined local problem, and draw on local knowledge and expertise.
- Use standardized qualitative and quantitative monitoring and evaluation data to adapt and redefine multisectoral child health program approaches ensuring relevance, effectiveness, responsiveness over the program implementation period, and future replication.
- Examine the links between sector-balanced multisectoral programs and programs with a sectoral lead, and the benefits and challenges of both.

Addressing Government, Civil Society and Stakeholder Buy-In

For effective stakeholder multisectoral collaboration, global, national, and community approaches need to be considered. Incentives such as inclusion of national budget lines for fuel, transportation, lodging if needed, and food for program visits was key to ensuring engagement at all levels. Local engagement of multiple sectoral committees was often encouraged by national level ministry staff, but also through food or transportation support that the government did not provide. At the donor level, the case study in Malawi demonstrated how funding lulls in the U.S. directly affect funding for projects overseas.

For private sector stakeholders, often incentives to be more engaged, explanations of how they could benefit from reports, and more frequent updates were needed. All interviewees in Malawi discussed challenges of

funding and/or stockouts. While the project succeeded in large part due to the private sector partnership in meeting M&E targets, the question loomed how much more could have been accomplished. Private sector partners in this case were simply engaging and receiving reports on the same level as they did for other Feed the Children initiatives. However, they missed an opportunity to see clear data on the benefit of their engagement which was already built into the program reporting process. These data could help them in further advocating for the benefit of private sector partnerships and their own philanthropy.

Other stakeholder organizations, including local non-governmental, civil society, and the private sector, can be valuable contributors to reaching program goals and objectives. However, to do so, all organizations and stakeholders must have the commitment and capacity for approaches in addition to adequate funding and work through existing organizations/networks of community groups to ensure local participation. Program managers and multisector committees should also recognize individual and collective efforts from stakeholders at all levels and ensure that program accomplishments, results, challenges, and success stories are shared on multiple platforms both internally and externally. At the community level, successful multisectoral programs require active participation of community members, including families, teachers, and parents.

Recommendations:

- Advocate for sustainable multisectoral funding with government stakeholders, decisions makers, and funders at national and global levels to ensure future funding and overriding support for multisectoral approaches. Without proper advocacy, program funding can be slowed and progress stalled.
- Host periodic feedback events to share and discuss data gathered in reports, program results, and accomplishments with private sector and civil society stakeholders.
- Encourage community members, including families, teachers, and parents to actively participate in multisectoral child-health programs and involve all stakeholders in program development, assessments, and interventions.
- Research gaps and challenges in NGO and private sector involvement in multisectoral child health collaboration, including approaches to provision of programmatic feedback to private sector partners.

Addressing the Challenge of Health System Fragility and Decentralization

While resilient health systems and universal coverage of quality care are gold standards for women's, children's, and adolescents' health, one catastrophic event can undo hard-won health gains, particularly where existing health systems are weak. The world and the context in which we work are constantly changing due to pandemics, epidemics, natural disasters, conflict, and environmental hazards. Child health multisectoral approaches allow for adaptive and absorptive responses that increase overall resilience. However, program implementors need to consider that already strained health systems and urgent needs place additional strain on multisectoral child health program implementation. Working on community resilience is extraordinarily complex and approaches should aim to build the capacity of people and systems to advance and protect long-term well-being, despite shocks and stresses. Nimble and prepared programs are better able to respond and adapt to emergencies. In both the literature and the case studies, it was clear that few if any programs were fully prepared for the COVID-19 pandemic nor did they have contingency plans for stressors and shocks to their program.

Recommendations:

- Address sub-issues that affect child health, including availability of affordable and accessible health care services, sector capacity building, and emergency preparedness and response.
- When developing program budgets, negotiate with donors and include funds for emergency response so that the program can quickly adapt if needed (e.g., during COVID-19, even a small amount of allocated money set aside in programs would have allowed programs to purchase basic items like gloves and masks and allowed for quicker programmatic response).
- Research the role of multisectoral interventions in improving resilience and adaptability of programs for children in the context of shocks, stressors, and fragility.

Addressing the Necessity of Cultural Competence and Gender Empowerment in Program Planning and Implementation

Community involvement designing and implementing culturally applicable programs improving child health outcomes is crucial for child-focused multisectoral programming. Gender empowerment is also a key factor in improving the health of children and to ensure improved access to food, nutrition, and economic security. If child health outcomes are to be improved, men, in addition to women, need to be involved in child health advocacy and community services in meaningful ways and actions proposed need to be transformative in nature. Asking men to simply help with traditional roles further reinforces those roles. Multisectoral programs need to examine program activities to ensure that programs are truly transforming social constructs and power imbalances.

Recommendations:

- Complete a full geographic and regional assessment of multisectoral child-focused program approaches to understand community level differences, local sectoral interventions, and cultural nuances that can impact program delivery.
- Research functional and operational multisectoral approaches to improving gender empowerment for children with a focus on innovations driven by multisector teams.
- Evaluate program impact and potential risks of multisectoral programs to increase gender and health disparities and ensure mitigation plans are developed during the program design phase (e.g., distance to health centers, risks of perpetuating norms rather than transforming them, WASH issues that could impact populations, etc.).

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 affecting children and potentially affecting the program are fully considered. The literature review and case study provide a foundation for child-focused multisectoral approach considerations which should continue to be investigated. While the sample size was limited, the lessons learned from these programs have remained consistent over time and were reiterated in the case studies:

1) **Multisectoral programs work best when the internal communication between sectors is clear, problems are well-defined, and all sectors have an unclouded vision or goal for engagement.**
2) **Stakeholder backing is paramount in ensuring program success and full collaboration (at all levels including government, civil society, private sector, and community).**
3) **Gender and culture must be considered in program design, implementation, and evaluation of child-centered multisectoral programs. This approach allows programs to adjust to each community's unique needs and ensure equitable and inclusive engagement. Gender programing needs to go beyond simply shifting the status quo and work to deconstruct power imbalances.**
4) **Program evaluations are 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 roadblocks/challenges other programs have faced. However, even the best program can be easily derailed by states of emergency or natural disasters. Preparing for emergencies and being able to quickly adapt programing to ensure continuity is essential to meet both child health and programmatic needs.

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