ChildFund Kenya

Endline Evaluation of the Responsive and Protective Parenting Program Model in Kenya

2023

Table of Contents

1.Introduction

1.1. Background

ChildFund is a child-focused international development organization that works in 24 countries to connect children with the people, resources, and institutions they need to grow up healthy, educated, skilled and safe, no matter where they are. ChildFund Kenya we work through 11 Local implementing partners (IPs) to implement various development and humanitarian interventions across 27 counties and does direct implementation in Nairobi, Coast and Western region.. As per our Country's strategic plan (2022-2026) our programming and advocacy priorities include Child Protection, Household Economic Strengthening, Early Childhood Development (ECD), Education, Water, Sanitation and Hygiene (WASH), Emergency Response, and Health and Nutrition.

ChildFund Kenya ECD Programming Approach

Through our ECD programming, ChildFund Kenya and her IPs works in close collaboration with primary caregivers, communities, and national and county Governments to support the improved health, safety, and well-being of infants and young children (IYC) through provision of integrated ECD services. We use a strength-based approach to support/ build on locally led initiatives that strengthen families and communities, helping them to break the cycle of poverty and protect the rights of children. We strive to strengthen partnerships for nurturing care to promote responsive parenting and supportive structures for early childhood development. To this end, ChildFund's ECD program is aligned to the Nurturing Care Framework - a framework for helping children survive and thrive to transform health and human potential. Our program interventions cut across the five interrelated components of nurturing care: Good Health, Adequate Nutrition, Safety and Security, Responsive Caregiving, and Opportunities for Early Learning. Our projects target children, their parents/caregivers, and their communities.

ChildFund's Strengths in ECD programming include: a focus on comprehensive early childhood development aligned with the Nurturing Care Framework with a significant focus on brain development, parental outreach necessary to impact home learning environments along with significant community buy-in including buy-in from government partners and commitment to child protection across the life cycle.

1.2. Overview of the Responsive and Protective Parenting (RPP) Program Model

ChildFund International's Responsive and Protective Parenting (RPP) Global Program is promoting community-based group parenting sessions utilizing contextualized training manuals. The program covers the five components of nurturing care namely good health, adequate nutrition, opportunities for early learning, safety and security, and responsive caregiving, and caregiver well-being. The target group is vulnerable caregivers, and the impact group is infants and young children (IYC) aged 0-5. The RPP program model has three intervention strategies targeting local partners and sub-national governments, community support services (mentors and facilitators) and caregivers of infants and young children (IYC) age 0-5. The program model is implemented (recruitment, training, intervention delivery, M&E) over an 18-month period (6 months of preparatory activities[1] and 12 months of direct engagement with caregivers and reflective supervision of facilitators). The long-term goal of the program is for infants and young children (0-5) to have improved age-appropriate development and early learning outcomes and be protected at home and in their communities. To achieve this goal, the model has a three-pronged approach - capacity strengthening of implementing partner and county government relevant departments staff, community stakeholders, and caregivers. The model uses a cascading approach to support capacity strengthening of various stakeholders by enhancing their knowledge and skills.

RPP has three objectives; to:

1. Strengthen multi-sectoral sub-national government and local partners' capacity to support community stakeholders in ensuring protective and nurturing home and community environments for infant and young children
2. Strengthen community stakeholders' knowledge, attitudes and practices on the components of nurturing care, caregiver well-being, and community-based child protection to support caregivers in group and home parenting sessions.
3. Enhance parents/caregiver's knowledge, attitudes and practices across the components of nurturing care, caregiver well-being; and community-based child protection.

1.3. Purpose of the Evaluation

The endline evaluation of project outcomes sought to measure the RPP program model's contribution toward changing indicators for sets of program model

[1] Includes design workshop, community mobilization of participants (caregivers, group facilitators, mentors), quarterly planning meetings between CF and IP, contextualization and development of technical content, ToT workshops for community support structures, implementing partner staff and government officials.

outcomes that are linked to the program model's: 1) goal and 2) objectives. This report focuses on the assessment of endline results based on delivery of caregiver survey.

1.4. The Evaluation Questions

1. Did the RPP model increase local partners and sub national govt's support for establishing and maintaining a nurturing and protective environment for IYC?

2.Did the RPP model increase sub national government and local partners' knowledge in nurturing care and caregiver wellbeing?

3.Did the RPP model increase sub national government and local partners' knowledge on reflective supervision?

4.Did the RPP model increase communities' support for establishing and maintaining a nurturing and protective environment for IYC?

5.Did the RPP model increase mentors' and community support structures knowledge in nurturing care and caregiver wellbeing?

6.Did the RPP model increase mentors' and CSS's knowledge in facilitation parenting session planning, and reflective supervision?

7.Did the RPP model lead caregivers to see their communities as safe places for their children?

8.Did the RPP model increase caregivers' knowledge in nurturing care and protection of IYC?

9.What nurturing care and protection practices (behavior) of caregivers were enhanced by the RPP PM?

2.Methodology

This chapter presents the caregiver survey research design, sample design, training and pretesting, data collection, data cleaning and analysis, ethical considerations, and study limitations.

2.1. Study Design

The study utilized a cross-sectional approach, with a one group pre and post-test design. The aim was to measure progress towards the program objective (change from baseline to endline).

2.2. Sampling

The sample for the survey was designed to provide estimates for many indicators about children and their caregivers at the community level. The sample was selected in two stages: community and household. The primary sampling unit for the sampling frame is a community. ChildFund Kenya's three implementing partners, Eastern Community Development Program (ECDP), Pioneer Child Development Programme (PCDP) and Lake Region Development Program (LRDP) provided data from a census of caregivers with children under the age of 5. The team assumed that each household will likely have one child below 5. The sampling frame was derived from the expected program participants. The sample size was determined using the Cochran[2] (1977) formula as below.

$$n_0 = \frac{Z^2 pq}{e^2}$$

p=0.5, q=0.5 e=0.05
Where:

- e is the desired level of precision (i.e. the margin of error),
- p is the (estimated) proportion of the population which has the attribute in question,
- q is 1 – p. z(for 95% confidence)

914 caregivers were interviewed. The sample distribution is illustrated in Table 2.1 below.

Table 2.1: Sample Distribution for Caregivers Survey

Partner	Community	Ward	Sample
Lake Region Development Program	Rusinga Island	Rusinga Island	240
Pioneer Child Development Program	Naromoru	Tigithi Gakawa Thegu River Naromoru/Kiamathaga	215
Eastern Community Development Program	Wamunyu Maka Migwani Ngwatanio Masaku Mwala	Matungulu East, Matungulu West Migwani Nguutthani Kyome/Thaana Kyaathani Mbiuni Kathama Yathui Muvuti/Kiima Kimwe Kyangwithya East Kyangwithya West Mulango	459
Total			914

[2] https://www.statisticssolutions.com/sample-size-5/

The households were sampled using multi-stage clustered random sampling. The first cluster was the community (Naromoru, Wamunyu, Masaku, Maka, Ngwatanio, Migwani, Mwala and Rusinga). The next cluster consisted of villages from where households were identified. The household's selection criteria included orphans; child-headed HHs; single-parent HHs; Age (HHs with children 0-5yrs); HHs in difficult to access areas; HHs with children with special needs; high prevalence of malnutrition.

Table 2.2: Sample Distribution for KAP Survey

County	Sub County	Sample
Homabay	Suba North	16
Kitui	Kitui Central	13
Kitui	Mwingi West	14
Nyeri	Kieni East	11
Laikipia	Laikipia East	4
Machakos	Machakos Town	12
Machakos	Matungulu	8
Machakos	Mwala	29
Total		**107**

Source: KAP Survey, 2023

Table 2.3: Sample Distribution for KIIs

Institution	Role	Sample
Department of Childrens Services	Volunteer Children Officer Sub County Children Officer Assistant Director	2 4 1
Ministry of Education	ECD Teacher Early Years Education Coordinator Assistant Education Officer	1 1 1
Ministry of Health	Nursing Officer Sub County Nutrition Coordinator Public Health Officer Nutrition Officer	3 1 1 1
Ministry of Interior and National Coordination	Village elder Senior Assistant chief Area chief Village manager Probation officer	1 3 1 1 1
Ministry of Labour and Social Protection	Sub county social development officer	1
Teachers Service Commission	Curriculum Support Officer	1
Clergy	Pastor	1
CSO/NGO e.g. Legal Resource Foundation	Paralegal	1
Total		**27**

Source: Key informant interview, 2023

2.2. Training and Pretesting

Training for the fieldwork was conducted in Kitui town (Kitui Central ward, Kitui County, Eastern region), Naromoru (Naromoru Kiamathaga ward, Nyeri County, Central region) and Mbita town (Rusinga Island ward, Homabay County, Western region) from February to May 2023. The training sessions included overview of the RPP program model, sampling, interviewing techniques and the contents of the questionnaires. Facilitators used various methods including PowerPoint presentations, audio visual media, illustrations on flip charts, question and answer, case studies and group discussions. The participants paired up and engaged in mock interviews to familiarize themselves with the data collection tool.

Toward the end of the training period, trainees spent a day pretesting the caregiver questionnaire by interviewing sample respondents in selected communities. The caregivers sampled for the pilot were not part of the RPP program participants but with a child under the age of 5. The survey teams were divided into groups. Each group was comprised of interviewers, one team leader, and a staff supervisor from the IP. The team leaders reported to the IP monitoring and evaluation (M&E) focal point.

2.3. Data Collection

The caregiver survey was developed in CommCare mobile application and administered to respondents via the CommCare application in mobile devices. This data collection effort was conducted in the RPP implementation areas between February and May 2023 in the following wards: Rusinga Island, Tigithi, Gakawa, Thegu River, Naromoru/Kiamathaga, Matungulu East, Matungulu West, Migwani, Nguutani, kyome/thaana, kyaathani, mbiuni kathama, yathui, Muvuti/Kiima Kimwe, Kyangwithya East, Kyangwithya West, and Mulango.

2.3.1. Data Collection

Caregiver questionnaire

The survey used a household caregiver questionnaire administered to the household primary caregiver for all children under 5 years of age. The questionnaire included the following modules: child background, household information, birth registration, child functioning, child development, early childhood development index, child discipline, child immunizations, breastfeeding/feeding, childhood illness, access to services, child wellbeing, child protection, child rights, child participation, caregiver wellbeing and a poverty probability index. The tool adopted UNICEF Multiple Indicator Cluster Surveys (MICS) questions, demographic and health survey questions, poverty probability index questions and ChildFund M&E indicators for children ages 0 to 5. The

key terminologies in the English version of the tool were translated into Kiswahili, Akamba, Agikuyu and Dholuo languages.

Key informant interviews

There key informant interview guide provides an insight in the existing knowledge of stakeholders i.e. local partners, sub-national/local government, community and religious leaders. The tool assessed the level of support for establishing and maintaining protective and nurturing home and community environments for IYC, knowledge across nurturing care components, reflective supervision and the importance of caregiver well-being.

Knowledge Attitudes and Practice (KAP) questionnaire

The KAP Survey – Group sessions tool assessed examined the existing and changes in the knowledge of facilitators and mentors about Nurturing Care and child protection, knowledge in facilitation parenting session planning, and reflective supervision and communities that shows support for establishing and maintaining protective and nurturing home and community environments for IYC.

2.4. Data Cleaning and Analysis

Quantitative analysis

The enumerators collected the quantitative data through the caregiver survey. An external consultant conducted data quality checks such as missing values, removal of outliers and recoding sorting before the data being uploaded into the analysis software. The RPP Caregiver Questionnaire Data Analysis Plan[3] was used to guide these processes. For questions adapted from the MICS, the analysis follows the methodology for analysis proposed by the MICS. Similarly, analysis of Global M&E data primarily follows recommended ChildFund M&E guidelines and PPI data follows the PPI methodology. The demographic and endline datasets were downloaded as two separate excel worksheets, then merged before analysis using a unique id code (e.g. formid). Thereafter, the consultant labelled the variables using the RPP standard codebook with recommended variable names. These were later recorded to simplify the analysis. SPSS Software was used to analyze the data into the desired descriptive statistics presented in this report.

[3] The main objective of the RPP data analysis plan is to provide a standardized methodology for the analysis of RPP survey data by program implementers and ensures comparative results across implementing countries. The data analysis plan and tables ensure that all evaluation questions are addressed.

2.5. Ethical Considerations

Before being interviewed, the respondents were informed about the RPP PM project and objectives of the survey, voluntary participation and the confidentiality of the information they provided. The respondents could ask questions on their understanding of the study and the expected benefits or risks of participating in it. The informed consent forms were signed at baseline and endline evaluation. In both surveys, 100% of the respondents provided consent. The interviews were only conducted when the respondent agreed to be interviewed. All enumerators were trained to abide by ChildFund's child protection policy as well as ethical guidelines and internal review processes for evaluation and research.

2.6. Study Limitation

The main limitation during the data collection at endline survey was that some caregivers could not be found due to issues such as marriage break-ups, death, and relocation. These households were replaced with the next caregiver who participated in the program.

3.Results and Findings

3.1. Sample Characteristics

Table 3.1 shows the results of the caregiver interviews. Of the 914 households with caregivers of children under 5 years eligible for interview, 914 were successfully interviewed, yielding a response rate of 100%. Of these, the caregivers were in Eastern (50%), Rusinga (24%) and Naromoru (26%). Eight percent of the households had at least one member with special needs or facing challenges in their lives. Almost half (4%) had a child with disability, developmental delays (2%), other special need (1%).

Table 3.1: Sample Characteristics

Households	**%**	**(n)**	**%**	**(n)**
	Baseline	**Baseline**	**Endline**	**Endline**
Eligible	100	1,576	84%	914
Interviewed	100%	1,569	100%	914
Response rate (%)	99.6%		100%	
Community				
Naromoru	10%	160	26.3%	240
Rusinga	21%	326	23.5%	215
Eastern	69%	1,083	50.2%	459
Households with Special Needs				
Child-headed household	0%	2	2.8%	2
Household with a child with disability	6%	95	45.8%	33
Malnourished child	0%	7	1.4%	1

Orphaned	4%	59	5.6%	4
Chronically ill child	2%	27	5.6%	4
Developmental delays	0%	4	22.2%	16
Other	1%	8	18.1%	13
None	88%	1386	92%	842
HHs with more than one special needs	1%	18	4%	3
Households with				
At least one child <=5 years	100%	1569	95.8%	876
At least one child 6-18 years	0%	0	4.2%	38
Total Number of Children <=5 years		2119		1194
Total Number of Children 6-18 years		0		1613
Number of household members				
1-2 members	14%	223	2.8%	26
3-4 members	42%	655	30.3%	277
5-6 members	29%	451	42.3%	387
7+ members	15%	239	24.5%	224
Mean household size	6	6	6	914

NB: Variables in this table producing a value with fewer than 25 cases, have been suppressed.

3.2. Household Information

The majority (96%) of the respondents were female and 4% male and the primary caregivers[4]. About 14 are adolescent or young mothers and caregivers under 18. Eighty-two percent are the biological or adopted parents of the children and 18% are grandparents. The youth between 18-34 years of age form over half, 52% of the respondents whereas only 3% were over age 65. Most (80%) of the respondents were married or in a union; the rest were widowed (7%) separated or divorced (2%) and 10% are not married or in a union. Just over half (60%) of caregivers had a primary level of education. Overall, 94.5% could read in more than one language and 92% could write in more than one languages[5].

Table 3.2: Demographics

	% Baseline	N Baseline	% Endline	N Endline
Total	100%	1569	100.0%	914
Respondent Information				
Male	4%	56	3.8%	35
Female	96%	1513	96.2%	879
% primary caregiver	98%	1533	98.9%	904
Relationship to child				
Parent (Biological or adopted)	87%	1364	81.8%	748
Grandparents	12%	189	17.5%	160
Another family member	0%	5	0.2%	2
In-laws	0%	7	0.1%	1

[4] Primary caregivers include parents and other people who are directly responsible for the care of the child at home, e.g. feeding, playing with child, bathing, etc.

[5] English, Swahili, Vernacular (Dholuo, Agikuyu, Akamba) languages spoken in the country

Adopted foster parent	0%		0.3%	3
Age of respondent				
<18	1%	14	0.3%	3
18-34	21%	326	52.2%	477
35-64	46%	718	44.9%	410
65-84	26%	405	2.6%	24
85+	7%	106	0.0%	0
Marital/Union status				
Currently married/in union	83%	1,306	80.3%	734
Widowed	4%	57	6.8%	62
Divorced	1%	22	0.4%	4
Separated			1.6%	15
Never married/in union	12%	184	10.1%	92
Living with partner			0.7%	6
Education of respondent				
Prep-primary or None	0%	0	6.7%	61
Primary	53%	825	59.7%	546
Secondary	36%	572	24.5%	224
Tertiary or University	10%	152	8.3%	76
Other	1%	20	0.5%	5
Don't know (DK)/Missing	0%	0	0.0%	0
First Reading Language				
English				
Level of comfort				
Reads a little	33%	515	29.8%	272
Reads comfortably	14%	218	10.5%	96
Enjoys reading	43%	677	48.7%	445
DK/Missing	0%	3	0.0%	0
Not able to read	10%	155	11.1%	101
Second Reading Language				
Swahili				
Level of comfort				
Reads a little	29%	455	26.4%	241
Reads comfortably	14%	226	11.4%	104
Enjoys reading	51%	797	54.9%	502
DK/Missing	0%	3	0.0%	0
Not able to read	5%	86	7.3%	67
Third Reading Language				
Vernacular				
Level of comfort				
Reads a little	21%	332	17.3%	158
Reads comfortably	12%	184	11.1%	101
Enjoys reading	61%	956	64.9%	593
DK/Missing	0%	2	0.0%	0
Not able to read	6%	93	6.8%	62
First Writing Language				
English				
Level of comfort				
Writes a little	33%	519	33.3%	304

Writes comfortably	12%	183	9.2%	84
Enjoys writing	42%	666	45.5%	416
DK/Missing	0%	2	0.1%	1
Not able to write	13%	197	11.9%	109
Second Writing language				
Swahili				
Level of comfort				
Writes a little	31%	485	29.5%	270
Writes comfortably	18%	286	17.3%	158
Enjoys writing	44%	686	44.1%	403
DK/Missing	0%	1	0.5%	5
Not able to write	6%	99	8.5%	78
Third Writing language				
Vernacular				
Level of comfort				
Writes a little	18%	278	21.4%	196
Writes comfortably	9%	138	8.6%	79
Enjoys writing	49%	765	60.7%	555
DK/Missing	19%	291	0.0%	0
Not able to write	6%	96	9.2%	84

3.3. Child Development

For the endline caregiver survey, there was a 41% increase in the proportion of respondents who reported to know child development[6] compared to the baseline (51%). The most popular sources of information were health workers (50%), parents (21%) friends (11%), and neighbors (13%) while the least were grandparents and other relatives at 5%. Overall, there was reliance on more sources of information with healthcare workers being the most reported at baseline and endline.

Table 3.3. Child Development				
Knowledge of child development	**Baseline**	**Baseline**	**Endline**	**Endline**
Yes	51%	793	92.2%	843
No	49%	770	5.8%	53
DK/Missing	0%	5	2.0%	18
	%	**N**	**%**	**N**
Information on child development	**Baseline**	**Baseline**	**Endline**	**Endline**
Parents	23%	179	21.1%	178
Grandparents and other relatives	5%	37	4.6%	39
Friend	8%	67	11.4%	96
Neighbour	8%	61	12.9%	109
Health worker	57%	449	49.9%	421

3.4. Child Background

In the endline caregiver survey, there were more girls (51%) compared to boys (49%). Upon further disaggregation by age, 0-11 months (10%), 12-23 months (13%), 24-35

[6] Child development refers to the growth and physical, cognitive, emotional and social changes an individual experiences from birth to adulthood

months (18%), 36-47 months (20%) and over 48 months (39%) respectively. There was an increase in the proportion of children who accessed and remained in early childhood education programs[7] at forty-two percent from baseline (23%).

In the health sector, there was an increase in the proportion of children covered by health insurance. Most children accessed health services through public insurance (67%) and private insurance schemes (25%). Most births had been reported to occur at a health facility (94%) from baseline (88%) and births at home have decreased from 11% at baseline to 5% at endline. This shows that the program in conjunction with the Ministry of Health and other stakeholders stepped up campaigns on maternal newborn and child health (MNCH) messaging to ensure pregnant women attend a clinic consistently and safely deliver there.

Table 3.4: Child Background Information	Baseline %	Baseline n	Endline %	Endline n
Sex				
Male	50%	778	49.0%	448
Female	50%	789	51.0%	466
Age of children (in months)				
0-11 months	11%	173	9.7%	89
12-23 months	21%	335	12.6%	115
24-35 months	21%	322	18.4%	168
36-47 months	19%	292	20.4%	186
48+	19%	298	38.9%	356
Early childhood education attendance				
Ever attended	24%	383	44.3%	405
Currently attends	23%	358	41.9%	383
Health insurance coverage				
Private insurance	13%	204	24.8%	30
Public insurance	5%	84	66.9%	81
Other	4%	67	8.3%	10
Not sure/Don't know	77%	1214	0.0%	0
Place of birth				
Home	11%	177	5.5%	49
Health facility	88%	1384	94.4%	846
Don't know/Not sure	0%	3	0.1%	1

3.5. Birth Registration

The endline caregiver survey sought to estimate the extent of birth registration of children under 5 years of age. Mothers/caregivers of these children were asked whether children in their household had birth certificates or birth notification slips. If they responded that a child did not have a birth certificate, additional questions were asked on whether the child's birth was registered and whether they knew how to

[7]Includes play groups, daycare, preschool, duksi/koranic schools and madrassa.

register a birth. A child may not have been issued a birth certificate, but the birth may have been registered[8].

In all the communities, 88% of children under 5 years were reported to have been registered at endline. (Table 3.5). There are no significant variations in birth registration depending on sex of the child, but a child would likely be registered as he/she grew older in months. Only 4% of children had mothers/caregivers who do not know where to register from baseline (50%). In addition, a child would likely not be registered when their caregiver is less educated.

For children whose births were not registered with the government, the caregivers find the process too complicated (7%), registration fees is too expensive (1%), registration centre was too far (1%), born at home (7%) and others do not find it necessary to register and where to register respectively. These reasons can inform advocacy and group sessions for caregivers. For those who got a birth certificate, the main reason was enrolment of the child in school. Others mentioned the government policy.

[8] Issuance of an acknowledgement of birth notification (ABN pink slip)

Table 3.5: Birth registration

Percentage of children under age 5 by whether birth is registered and percentage of children not registered whose mothers/caretakers know how to register births- **RPP Endline 2023**

	Children whose births are registered with civil authorities						Number of children		Percent of children whose mothers/ caretakers do not know how to register births		Number of children without birth registration	
	Have birth certificate		No birth certificate		Registered							
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Total	57%	87.6%	7%	11.8%	64%	87.6%	934	848	45.4%	4.3%	98	105
Sex												
Male	28%	86.8%	7%	12.3%	32%	86.8%	478	408	1.6%	2.7%	46	54
Female	28%	88.4%	8%	11.4%	32%	88.4%	456	440	43.9%	5.9%	52	51
Community												
Maka	0%	87.8%	0%	12.2%	20%	87.8%	16	74	15%	0.0%	15	9
Ngwatanio	10%	87.8%	26%	12.2%	5%	87.8%	99	74	23%	0.0%	23	9
Masaku	16%	82.9%	10%	17.1%	5%	82.9%	156	76	8%	0.0%	8	13
Migwani	3%	94.5%	7%	5.5%	19%	94.5%	39	73	14%	0.0%	14	4
Mwala	12%	82.4%	14%	17.6%	23%	82.4%	129	74	17%	0.0%	17	13
Wamunyu	13%	80.0%	23%	14.7%	11%	80.0%	130	75	6%	0.0%	6	15
Rusinga	30%	79.6%	18%	20.4%	14%	79.6%	289	191	15%	4.5%	15	39
Naromoru	16%	98.6%	2%	0.9%	4%	98.6%	156	211	0%	0.0%	0	3
Age (in months)												
0-11	23%	85.2%	21%	14.8%	14%	85.2%	223	88	19%	0.0%	19	13
12-23	24%	85.8%	18%	14.2%	14%	85.8%	232	113	9%	0.0%	9	16
24-35	21%	87.3%	25%	12.1%	6%	87.3%	205	165	23%	9.7%	23	21
36-47	16%	88.5%	21%	11.5%	34%	88.5%	180	183	18%	0.0%	18	21
48-72	16%	88.6%	16%	10.0%	33%	88.6%	174	299	30%	4.3%	29	34
Mother's education												
Pre-primary or none	1%	80.4%	1%	19.6%	1%	80.4%	8	56	2%	13.6%	2	11
Primary	48%	87.6%	58%	11.8%	77%	87.6%	490	502	69%	2.9%	68	62
Secondary+	51%	87.6%	41%	11.9%	22%	87.6%	473	210	29%	0.0%	28	26

3.6. Learning Materials

Exposure to books in early years not only provides the child with greater understanding of the nature of print but may also give the child opportunities to see others reading, such as older siblings doing schoolwork. The presence of books is important for future school performance[9]. Books are not only a pleasure to read but also help children learn their own language as they discover different sounds and phonics. The number of words that a child knows in preschool is an important indicator of brain growth and it is through reading and talking to their parents that children develop their first literacy skills[10]. Caregivers of all children under 5 years were asked about the number of children's books or picture books they have for the child, and the types of playthings that are available at home.

In the sampled communities, Table 3.6 shows an increase in the proportion of children aged 0-59 months (about 5 years) who lived in households with at least three children's books present for the child from 19% at baseline to 48% at endline. The proportion of children with 10 or more books increased by 2% from baseline. There were more male caregivers that were likely to report having books compared to female caregivers. The presence of children's books is positively associated with the child's age: seventy percent of children aged 48-59 months (about 5 years) live in households where three or more children's books are present compared to children aged 0-23 months (18%).

Table 3.6a Availability of Childrens Books

Percentage of children under age 5 by the number of children's books present in the household, and by the type and number of playthings that child plays with, RPP Endline 2023

	Percentage of children living in households that have for the child:			
	3 or more children's books[1]		10 or more children's books	
	Baseline	**Endline**	**Baseline**	**Endline**
Total	286	411	4	18
Sex				
Male	19.2%	61.3%	0.25%	3.20%
Female	19.5%	47.2%	0.25%	2.00%
Age				
0-11 months	2.9%	18.0%	0.0%	0.0%
12-23 months	10.8%	25.2%	0.3%	0.9%
24-35 months	14.6%	36.3%	0.0%	0.0%
36-47 months	27.3%	49.5%	1.0%	1.6%
48-59 months	43.0%	70.1%	0.0%	4.6%

[9] Grantham-McGregor S, Cheung YB, Cueto S, Glewwe P, Richter L, Strupp B, et al. Developmental potential in the first 5 years for children in developing countries. Lancet. 2007;369(9555):60–70.

[10] Why Read Aloud with Your Child? *Brain development, knowledge, language, love of reading, bonding, literacy skills – you name it!* By Zara Sargsyan (June 2020) retrieved from https://www.unicef.org/armenia/en/stories/why-read-aloud-your child#:~:text=From%20birth%20to%20the%20age,discover%20different%20sounds%20and%20phonics.

Caregiver's education				
Primary	18.3%	51.3%	0.0%	1.4%
Secondary+	19.8%	44.7%	0.5%	3.9%
Tertiary/univ	23.8%	0.0%	0.7%	0.0%
Respondent Age				
<18 yrs	0.0%	66.7%	0.0%	0.0%
<34 yrs	18.3%	44.5%	0.3%	2.4%
35 - 64 yrs	21.1%	50.5%	0.2%	1.6%
>=65yrs	20.0%	60.9%	0.0%	4.3%
Relationship to child				
Parent	19.3%	47.5%	0.3%	2.3%
Grandparents	19.6%	48.7%	0.0%	1.3%
Other	25.0%	40.0%	0.0%	0.0%
Community				
Rusinga	18.4%	70.7%	0.0%	0.5%
Eastern	17.6%	39.0%	0.2%	2.2%
Naromoru	33.1%	45.5%	1.3%	3.2%
Functional difficulties (age 2-4 years)				
Has functional difficulty	23.3%	44.6%	0.0%	1.6%
Has no functional difficulty	28.6%	44.1%	0.0%	0.0%

The types of playthings included in the survey contribute to the development of a child[11]. Such playthings are homemade toys (dolls and cars, or other toys made at home), toys that came from a store, and household objects (pots and bowls) or objects and materials found outside the home (sticks, rocks, animal shells, or leaves).

Two-thirds (66%) of children aged 0-59 months (about 5 years) had two or more types of playthings to play with in their homes compared to 58% at baseline. Sixty-four percent played with household objects or objects found outside compared to the baseline (57%), 80% played with homemade toys compared to the baseline (68%) and 39% of children played with toys that came from a store compared to the baseline (42%).

The proportion of children who have two or more types of playthings to play with increased with the child's age: 0-11 months (38%) had two or more playthings compared with children aged 48-59 months (70%). Also, the proportion of children with two or more things to play with increased with the respondents' age and level of education.

[11] UNICEF Care for Child Development via https://www.unicef.org/media/91176/file/3-CCD-Participant-Manual.pdf

Table 3.6b: Availability of Playthings

Percentage of children under age 5 by the type and number of playthings that child plays with, **RPP Endline 2023**

	Percentage of children who play with:								**Number of children**	
	Homemade toys		Toys from a shop/ manufactured toys		Household objects/objects found outside		Two or more types of playthings[2]			
	Baseline	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**
Total	68.0%	80.1%	42.4%	39.1%	56.5%	63.7%	57.8%	65.8%	1,520	862
Sex										
Male	71.6%	77.4%	41.0%	41.9%	55.2%	71.0%	58.3%	74.2%	756	31
Female	64.4%	80.1%	43.7%	39.0%	57.8%	63.4%	57.3%	65.5%	763	831
Age										
0-11 months	36.4%	56.2%	31.0%	37.1%	33.2%	34.8%	30.0%	38.2%	320	89
12-23 months	68.8%	79.1%	47.8%	42.6%	61.9%	58.3%	60.7%	61.7%	330	115
24-35 months	78.9%	81.0%	48.8%	44.6%	59.0%	62.5%	67.4%	71.4%	317	168
36-47 months	79.9%	84.9%	43.7%	41.4%	61.4%	69.9%	64.2%	68.3%	293	186
48-59 months	76.9%	83.9%	40.7%	33.9%	66.8%	71.1%	67.1%	70.7%	257	304
Caregiver's education										
Primary	68.1%	81.1%	36.0%	35.3%	58.3%	66.1%	56.1%	65.9%	639	513
Secondary+	68.9%	80.3%	48.7%	48.6%	53.0%	59.5%	59.4%	65.8%	293	284
Tertiary/univ	65.6%	85.7%	54.3%	71.4%	56.3%	42.9%	60.3%	71.4%	133	7
Respondent Age										
<18 yrs	0.0%	66.7%	0.0%	33.3%	0.0%	33.3%	0.0%	33.3%	5	3
<34 yrs	65.8%	79.8%	44.5%	43.2%	53.3%	60.7%	56.2%	64.5%	948	456
35 - 64 yrs	71.0%	80.5%	38.9%	35.5%	60.6%	66.6%	59.5%	67.4%	549	380
>=65yrs	85.0%	78.3%	35.0%	17.4%	90.0%	78.3%	85.0%	69.6%	18	23
Relationship to child										
Parent	67.3%	80.1%	42.6%	40.3%	55.7%	62.8%	57.3%	66.2%	1320	707
Grandparents	71.4%	80.0%	41.8%	33.3%	61.9%	68.0%	61.4%	64.0%	186	150
Other	83.3%	80.0%	33.3%	40.0%	66.7%	60.0%	66.7%	60.0%	14	5
Community										
Rusinga	59.3%	85.9%	37.6%	30.9%	51.7%	82.2%	50.8%	82.7%	322	191
Eastern	70.7%	78.9%	42.1%	40.8%	59.0%	54.8%	60.4%	55.2%	1038	451
Naromoru	66.9%	77.3%	53.8%	42.7%	48.1%	65.9%	53.8%	72.7%	160	220
Functional difficulties (age 2-4 years)										
Has functional difficulty	78.5%	81.5%	37.9%	43.9%	60.3%	65.1%	62.1%	66.1%	N/A	189
Has no functional difficulty	78.3%	86.7%	45.1%	42.0%	62.5%	70.2%	66.6%	75.0%	N/A	188

3.7. Support for Learning

Information on several activities that support early learning was collected in the survey. These included the involvement of adults with children in the following activities: reading books or looking at picture books, telling stories, singing songs, taking children outside the home, compound or yard, playing with children, and spending time with children naming, counting, or drawing things.

About 42% of children aged 24-48 months engaged with an adult household member in four or more activities that promoted learning and school readiness during the last three days (Table 3.7) compared to 36% at baseline. In addition, more female caregivers (28%) engaged with children compared to fathers. The mean number of activities that adults engage with children was three compared to four at baseline. A caregiver aged 18-34 years was more likely to engage a child compared to those over 65 years. A child in Lake region was more likely to be engaged compared to one in Eastern.

Table 3.7: Support for learning

Percentage of children aged 36-59 months with whom adult household members engaged in activities that promote learning and school readiness during the last three days, and engagement in such activities by biological fathers and mothers, RPP Endline Survey 2023/24

	Adult household members						**Father**				**Mother**				**Number**	
	Percentage of children with whom adult household members have engaged in four or more activities[1]		Mean number of activities with adult household members		Percentage of children with whom no adult household member have engaged in any activity		Percentage of children with whom fathers have engaged in four or more activities[2]		Mean number of activities with fathers		Percentage of children with whom mothers have engaged in four or more activities[3]		Mean number of activities with mothers			
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Total	35.9%	41.5%	4.7	3.05	6.1%	58.5%	5.1%	10.1%	5	0.8	17.2%	28.1%	5	2.2	930	383
Sex																
Male	36.8%	43.8%	4.7	3.08	6.5%	56.2%	5.4%	8.8%	5	0.7	16.2%	25.3%	5	2.1	462	194
Female	35.0%	39.2%	4.7	3.02	5.8%	60.8%	4.7%	11.5%	5	0.9	18.2%	31.0%	5	2.4	468	189
Age																
24-35 months	27.3%	41.1%	4.7	3.01	7.1%	58.9%	1.9%	10.4%	4.7	0.9	14.9%	29.9%	5	2.3	322	168
36-47 months	42.7%	42.5%	4.7	3.12	7.2%	57.5%	7.5%	10.8%	4.7	0.9	19.8%	27.8%	5	2.2	293	186
48-59 months	39.4%	37.9%	4.7	2.83	4.2%	62.1%	6.2%	3.8%	4.7	0.3	17.6%	19.2%	5	1.4	307	29
Mothers education																
Pre-primary	35.1%	31.0%	4.7	2.8	7.6%	69.0%	4.6%	14.3%	4.7	0.9	14.5%	21.4%	5	1.9	498	29
Primary	35.6%	42.0%	4.7	3.0	4.0%	58.0%	4.9%	7.8%	4.7	0.7	21.0%	26.9%	5	2.2	329	238
Secondary+	43.8%	43.5%	4.7	3.2	5.6%	56.5%	9.0%	13.9%	4.7	1.0	21.4%	32.4%	5	2.5	89	115
Respondent Age																
18-34 yrs	33.4%	45.2%	4.7	3.2	7.4%	54.8%	4.5%	12.9%	4.7	0.99	19.4%	33.9%	5	2.6	530	1
35 - 64 yrs	39.8%	38.4%	4.7	2.9	4.4%	61.6%	5.7%	7.4%	4.7	0.64	14.6%	22.1%	5	1.9	384	199
>=65yrs	25.0%	16.7%	4.7	2.2	6.3%	83.3%	6.3%	0.0%	4.7	0.00	6.3%	16.7%	5	0.7	16	177
Community																
Eastern	21.1%	38.4%	4.7	2.9	2.1%	61.6%	3.6%	8.2%	4.7	0.6	8.2%	24.2%	5	2.0	195	198
Naromoru	30.6%	43.0%	4.7	3.0	6.8%	57.0%	6.2%	10.6%	4.7	1.0	21.6%	30.6%	5	2.4	644	93
Rusinga	16.9%	46.7%	4.7	3.3	9.9%	53.3%	0.0%	13.5%	4.7	1.1	5.5%	33.7%	5	2.5	91	92

3.8. Inadequate Care

Leaving children alone or in the presence of other young children is known to increase the risk of injuries.[12]. In the endline caregiver survey, two questions were asked to find out whether the child experienced inadequate care and supervision i.e. children aged 0-59 months (about 5 years) were left alone for more than an hour during the week preceding the interview and whether children were left in the care of other children under 10 years of age. In contrast, adequate supervision was assessed by whether the child was left with another child older than 10 years or another adult or adult family member.

Table 3.8 shows that 18% of children aged 0-59 months (about 5 years) experienced inadequate care from baseline (12%). A child is more likely to be left with inadequate care as they grow older. However, the proportion has reduced from baseline. Moreover, a youth headed household is more likely to leave a child unsupervised compared to the elderly. There were marginal differentials in children under five who are left alone or left in the care of another child younger than 10 years by the community.

However, inadequate care is less prevalent among children whose mothers had university education than children whose mothers had primary education.

Table 3.8: Inadequate Care

[12] Grossman, DC. 2000. The History of Injury Control and the Epidemiology of Child and Adolescent Injuries. The Future of Children, 10(1): 23-52.

Percentage of children under age 5 left alone or under the supervision of another child younger than 10 years of age for more than one hour at least once during the past week, **RPP baseline 2021 and endline, 2023**										
	Percentage of children						**Number of children**			
	Left alone in the past week		Left under the supervision of another child younger than 10 years of age in the past week		Left with inadequate supervision in the past week[13]		Left under the supervision of another child older than 10 years of age in the past week		Left under the supervision of another adult in the past week	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Total	30.2%	17.7%	38.1%	24.8%	49.1%	36.1%	692	336	1,112	501
Sex of child										
Male	32.2%	22.5%	42.8%	27.9%	52.6%	42.6%	378	167	572	236
Female	28.2%	13.2%	33.4%	21.8%	45.6%	30.0%	314	169	540	265
Age										
0-11 months	16.7%	14.8%	20.5%	9.1%	26.8%	22.7%	87	16	169	38
12-23 months	28.1%	15.0%	39.0%	15.0%	49.6%	27.4%	145	30	240	76
24-35 months	34.1%	14.5%	42.1%	26.1%	55.6%	36.4%	164	65	243	104
36-47 months	34.1%	19.7%	41.7%	33.3%	54.9%	44.8%	135	89	225	113
48-59 months	37.8%	20.1%	47.4%	27.1%	59.0%	37.8%	158	136	231	170
Mothers' education										
Pre-primary or none	26.3%	18.5%	26.3%	26.1%	47.4%	36.6%	6	189	13	254
Primary	33.1%	16.2%	43.2%	23.9%	54.1%	36.8%	395	46	573	75
Secondary+	26.9%	20.5%	33.1%	24.7%	43.6%	41.1%	232	24	423	47
University	26.5%	20.0%	30.4%	0.0%	43.1%	20.0%	59	0	103	2
Respondent Age										
<34	28.9%	18.6%	39.7%	25.3%	48.6%	37.7%	407	165	706	281
35 - 64 yrs	32.0%	17.3%	35.0%	24.5%	49.4%	34.9%	275	164	390	209
>=65yrs	35.0%	4.5%	45.0%	18.2%	60.0%	22.7%	10	7	16	11
Relationship to child										
Biological/adopted parents	29.4%	17.4%	38.8%	25.6%	48.9%	36.6%	601	287	959	417
Grandparents	35.0%	18.8%	33.7%	20.1%	50.8%	33.6%	85	47	142	81
Other	27.3%	20.0%	27.3%	40.0%	41.7%	40.0%	6	2	9	3
Community										
Eastern	47.7%	23.1%	63.5%	19.1%	70.0%	37.4%	217	126	255	261
Naromoru	25.7%	7.6%	32.5%	28.9%	44.8%	32.2%	422	94	767	119
Rusinga	24.2%	16.2%	22.9%	33.5%	35.0%	37.2%	53	116	90	121
Functional difficulties (age 2-4 years)										
Has functional difficulty	35.3%	18.5%	52.6%	35.4%	64.7%	46.6%	60	75	91	108
Has no functional difficulty	35.4%	16.5%	42.3%	25.5%	55.2%	36.2%	400	91	612	122

[13] children under age 5 left alone or under the supervision of another child younger than 10 years of age for more than one hour at least once in the last week

3.9. Early Childhood Development Index

In Lake Region, 31 percent of children aged 36-59 months were developmentally on track. A higher ECDI was reported among children who are currently attending an early childhood education programme (69%).

The analysis of four domains of child development showed that children in Rusinga community were on track as follows; physical (18%), learning (18%), social-emotional (12%) but much less on track in the literacy-numeracy domain (15%). In each individual domain, higher scores tended to be associated with children attending an early childhood education programme and in older children.

Table 3.9: Early child development index

Percentage of children aged 3-5 years who are developmentally on track in literacy-numeracy, physical, social-emotional, and learning domains, and the early child development index score, RPP Endline 2023

	Percentage of children aged 3-5 years who are developmentally on track for indicated domains								Early child development index score[1]		Number of children age 3-5 years	
	Literacy-numeracy		Physical		Social-Emotional		Learning					
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Total	N/A[14]	15%	N/A	18%	N/A	12%	N/A	18%	N/A	31%	775.0	484.0
Sex												
Male	N/A	9%	N/A	10%	N/A	6%	N/A	9%	N/A	20%	373	242
Female	N/A	7%	N/A	8%	N/A	6%	N/A	8%	N/A	15%	402	242
Community												
Eastern	N/A	0%	N/A	0%	N/A	0%	N/A	0%	N/A	N/A	529	201
Rusinga	N/A	49%	N/A	59%	N/A	41%	N/A	41%	N/A	51.3	171	146
Naromoru	N/A	0%	N/A	0%	N/A	0%	N/A	0%	N/A	N/A	74	137
Age												
3	N/A	0%	N/A	0%	N/A	0%	N/A	0%	N/A	37%	402	178
4	N/A	35%	N/A	38%	N/A	49%	N/A	50%	N/A	33%	270	159
5	N/A	35%	N/A	37%	N/A	51%	N/A	50%	N/A	30%	101	145
Attendance to early childhood education												
Attending	N/A	100%	N/A	96%	N/A	100%	N/A	96%	N/A	69%	146	336
Not attending	N/A	0%	N/A	4%	N/A	0%	N/A	4%	N/A	31%	629	148
Mother's education												
Pre-primary or none	N/A	18%	N/A	18%	N/A	18%	N/A	18%	N/A	8%	27	37
Primary	N/A	83%	N/A	83%	N/A	83%	N/A	83%	N/A	49%	284	236
Secondary+	N/A	45%	N/A	45%	N/A	45%	N/A	45%	N/A	43%	239	208

[14] The data was not collected due errors in instrumentation.

3.10. Child Functioning

The endline caregiver survey assessed functional difficulties in different domains including hearing, vision, walking, fine motor, communication/comprehension, learning, playing and controlling behavior[15]. The purpose was to identify the subpopulation of children who were at greater risk than other children of the same age or who were experiencing limited participation in an unaccommodating environment.

Children were considered to have functional difficulties if they had difficulty in at least one functional domain. According to the respondents, 50% of children had functional difficulty in at least one domain. Over half of these were male children.

Forty four percent of the children had difficulties associated with controlling their behavior (44%), communication (9%), learning (3%), playing (1%), fine motor activity (1%) respectively. In terms of community, Eastern was more likely to have the children with dysfunction compared to Rusinga. Most of these children are currently not attending school.

Table 3.10a. Child Functionality	**Percentage of children with functional difficulty in at least one domain**		**Number of children aged 2-4 years**	
	Baseline	**Endline**	**Baseline**	**Endline**
Total	13%	50%	810	189
Sex				
Male	6%	53%	393	102
Female	7%	47%	417	87
Community				
Eastern	9%	52%	73	102
Naromoru	1%	51%	10	45
Rusinga	3%	46%	23	42
Age				
2 years	29%	55%	318	43
3 years	34%	53%	297	96
4 years	36%	43%	195	50
Attendance to early childhood education				
Attending	0%	38%	0	37
Not attending	0%	51%	0	30
Mother's education				
Pre-primary or none	1%	46%	5	35
Primary	5%	50%	42	248
Secondary+	7%	51%	55	229

[15] Washington Group/UNICEF Module on Child Functioning, finalized in 2016, covers children between 2 and 17 years of age.

Table 3.10b: Child Functioning for children aged 2-4 years																
Percentage of children aged 2-4 years with functional difficulty in at least one domain, RPP Endline 2023																
	Percentage of children aged 2-4 years who have functional difficulty for the indicated domains															
	Seeing		**Hearing**		**Walking**		**Fine motor**		**Communication**		**Learning**		**Playing**		**Controlling behaviour**	
	Baseline	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**	**Base**	**End**
Total	0%	0%	0%	0%	0.0	0.0	2%	1.1	2%	9.0	2%	2.9	1%	0.8	6%	44%
Sex																
Male	0%	0%	0%	0%	0%	1.0	1%	1.0	1%	10.9	2%	2.1	1%	1.0	6%	45%
Female	0%	0%	0%	0%	0%	0.5	1%	1.1	1%	7.0	1%	3.8	1%	0.5	6%	42%
Community																
Eastern	0%	0%	0%	0%	2.0	0.5	1%	1.5	2%	8.7	2%	3.6	1%	1.0	9%	45%
Naromoru	0%	0%	0%	0%	2.0	1.1	0%	1.1	0%	16.9	0%	3.4	0%	1.1	1%	38%
Rusinga	0%	0%	0%	0%	1.0	1.1	0%	0.0	1%	2.2	1%	1.1	0%	0.0	2%	46%
Age																
2 years	0%	0%	0%	0%	2.0	1.3	0%	2.6	1%	12.8	1%	1.3	1%	2.6	4%	47%
3 years	0%	0%	0%	0%	3.0	1.1	1%	1.1	0%	9.8	1%	3.8	0%	0.0	5%	45%
4 years	0%	0%	0%	0%	0.0	0.0	0%	0.0	1%	5.2	1%	2.6	0%	0.9	3%	39%
Attendance to early childhood education																
Attending	0%	0%	0%	0%	0.0	1.0	0%	0.0	0%	3.1	0%	2.0	0%	0.0	0%	36%
Not attending	0%	0%	0%	0%	0.0	0.0	0%	0.0	0%	3.4	0%	1.7	0%	1.7	0%	49%
Mother's education																
Pre-primary or none	0%	0%	0	0	0.0	3.6	0%	0.0	0%	14.3	0%	3.6	0%	0.0	1%	43%
Primary	0%	0%	0	0	0.0	0.9	1%	0.9	2%	8.5	1%	3.0	0%	1.3	5%	43%
Secondary+	0%	0%	0	0	0.0	0.0	0%	1.8	2%	8.8	1%	2.7	0%	0.0	6%	45%

3.11. Child Discipline

In the endline caregiver survey, Table 3.11 shows that children were still experiencing severe physical punishment[16] from the baseline. However, there was a 30% reduction in the proportion of those who experienced psychological aggression[17]. In addition, there was a 5% reduction in the children who received any form of physical punishment[18] from baseline. There was a significant increase in the proportion of caregivers who utilized non-violent methods[19] from 23% at baseline to 81% at endline. There was 13% reduction of caregivers who used any non-violent method as a form of correcting a child's behavior.

Boys (54%) were subjected to any form of violent discipline more than girls (39%). The proportion of children disciplined increased with the age of child. Grandparents were more likely to inflict any violent discipline compared to biological and adopted parents. Similarly, a caregiver who has no education was more likely to punish the child compared to those in the higher institutions of learning such as the University.

[16] Hit or slapped on the face, head or ears or beat him/her up over and over as hard as one could.
[17] Shouted, yelled at or screamed at him or her or called him/her dumb, lazy or another name like that
[18] Shook him/her, spanked, hit or slapped him or beat him/her over and over as one could.
[19] Took away privileges, forbade something he/she liked or did not allow him to leave the house or explained why behavior is wrong or gave him/her something else to do.

Table 3.11: Child discipline

Percentage of children age 1-14 years by child disciplining methods experienced during the last one month, RPP Endline, 2023

	Percentage of children age 1-14 years who experienced:										Number of children	
	Only non-violent discipline		Psychological aggression		Physical punishment				Any violent discipline method[1]			
					Any		Severe					
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Total	23.4%	80.9%	30.7%	0.5%	51.5%	46.5%	46.6%	46.0%	60.8%	47.0%	1,574	215
Sex (child)												
Male	22.0%	81.7%	29.7%	0.0%	53.5%	53.9%	49.3%	53.9%	62.4%	53.9%	785	115
Female	24.6%	80.0%	31.8%	1.0%	49.7%	38.0%	43.9%	37.0%	59.3%	39.0%	789	100
Age												
0-11 months	18.5%	60.0%	16.9%	0.0%	22.0%	20.0%	18.2%	20.0%	31.3%	20.0%	313	5
12-23 months	25.5%	100.0%	31.2%	0.0%	50.8%	50.0%	45.1%	50.0%	61.0%	50.0%	333	4
24-35 months	24.8%	78.4%	33.9%	0.0%	60.9%	45.9%	54.7%	45.9%	70.2%	45.9%	322	37
36-47 months	21.5%	79.2%	36.2%	0.0%	64.5%	56.3%	60.1%	56.3%	72.0%	56.3%	293	48
48-59 months	26.4%	82.6%	34.9%	0.8%	60.6%	43.8%	55.4%	43.0%	69.7%	44.6%	307	121
Mothers Education												
Pre-primary or none	21.0%	88.5%	34.3%	3.8%	54.1%	46.2%	48.5%	46.2%	64.6%	50.0%	533	26
Primary	26.0%	78.0%	26.7%	0.0%	48.7%	46.5%	44.4%	45.9%	56.3%	46.5%	327	159
Secondary/Tertiary	27.8%	90.0%	27.2%	0.0%	47.7%	46.7%	42.4%	46.7%	57.0%	46.7%	86	30
Respondent Age												
<35	23.4%	83.3%	30.4%	1.0%	50.2%	40.2%	44.7%	40.2%	58.9%	41.2%	983	102
35-64	23.4%	79.6%	30.5%	0.0%	53.6%	52.8%	49.4%	51.9%	63.5%	52.8%	573	108
>=65	20.0%	60.0%	50.0%	0.0%	60.0%	40.0%	55.0%	40.0%	75.0%	40.0%	20	5
Relationship to child												
Parent (Biological/ adopted)	23.6%	80.5%	30.6%	0.6%	51.7%	45.4%	45.9%	44.8%	60.5%	46.0%	829	174
Grandparents	20.1%	82.1%	31.8%	0.0%	51.9%	51.3%	52.9%	51.3%	64.6%	51.3%	122	39
Other	41.7%	100.0%	33.3%	0.0%	33.3%	50.0%	25.0%	50.0%	50.0%	50.0%	6	2
Community												
Rusinga	9.5%	80.9%	52.0%	0.5%	68.8%	46.5%	56.0%	46.0%	72.8%	47.0%	327	215
Eastern	27.6%	N/A	26.7%	N/A	44.6%	N/A	41.3%	N/A	56.0%	N/A	1089	N/A
Naromoru	23.1%	N/A	14.4%	N/A	63.1%	N/A	62.5%	N/A	68.8%	N/A	160	N/A
Child's functional difficulties (age 2-5 years)[B]												
Has functional difficulty	13.8%	69.9%	34.5%	0.0%	69.0%	53.4%	54.9%	52.1%	75.9%	53.4%	233	73
Has no functional difficulty	25.7%	86.5%	35.3%	0.0%	60.7%	43.2%	68.1%	43.2%	69.9%	43.2%	1343	74

3.12. Attitudes towards discipline

Table 3.12 showed that there was a reduction in the proportion of caregivers (from 59% baseline to 42% at endline) who believe that physical punishment is a necessary part of child-rearing. There were more male than female caregivers who believed in physical punishment. Overall, respondents with less educational attainment and those middle aged are more likely to find physical punishment as necessary in disciplining children. Similarly, caregivers in Rusinga are more likely to punish children compared to Naromoru community.

Table 3.12: Attitudes toward physical punishment

Percentage of mothers/caretakers of children aged 1-14 years who believe that physical punishment is needed to bring up, raise or educate a child properly, *RPP Endline, 2023*

	Percentage of caregivers who believe that a child needs to be physically punished		**Number of caregivers responding to a child discipline module**	
	Baseline	**Endline**	**Baseline**	**Endline**
Total	58.6%	42.4%	1,549	380
Sex				
Male	59.1%	48.5%	772	16
Female	58.3%	42.2%	776	364
Community				
Eastern	73.3%	39.2%	326	177
Naromoru	56.2%	38.7%	1066	89
Rusinga	44.6%	53.0%	157	114
Respondent Age				
<34	57.3%	38.3%	964	181
35-64	60.4%	47.4%	565	190
>=65	75.0%	39.1%	20	9
Education				
Primary	61.6%	46.7%	814	251
Secondary	54.6%	33.4%	568	98
Tertiary/ University	57.4%	42.9%	148	3
Functional difficulties[A]				
Has functional difficulty	58.6%	50.6%	116	218
Has no functional difficulty	59.8%	34.8%	800	162

3.13. Immunization

Eighty nine percent of children below 11 months had been fully vaccinated. Most children aged 12-23 months had been vaccinated against BCG (96.9%) and measles (89%) by the age of 12 months and had received the first dose of DPT (96.4%), Pneumococcal (95%) and Rotavirus (99%) vaccines. There were no major declines across the doses.

Table 3.13a. Percentage of children aged 0-11 months vaccinated against vaccine preventable childhood diseases at any time before the survey (Crude coverage), RPP Endline 2023

	Children age 0-11 months:							
	Vaccinated at any time before the survey according to:						Vaccinated by 1 year of age	
	Vaccination records[A]		Mother's report		Either[B] (Crude coverage)			
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Antigen								
BCG[1]	97.8%	97.7%	85.7%	91.4%	90.2%	95.9%	90%	96%
Polio								
At birth[C]	86.5%	97.2%	85.7%	96.6%	81.1%	97.0%	81%	97%
OPV1	85.8%	97.3%	94.1%	96.6%	96.7%	97.1%	97%	97%
OPV2	83.5%	97.0%	3.3%	93.6%	81.1%	96.0%	81%	96%
OPV3	82.4%	97.3%	2.6%	93.6%	79.5%	96.2%	79%	97%
OPV3 /IPV[2]	82.4%	97.3%		96.1%	80.8%	97.0%		97%
HepB at birth[D]								
Within 1 day	0%	0%	0%	0%	0%	0%		0
Later	0%	0%	0%	0%	0%	0%		0
DTP-HepB-Hib								
1	97.4%	97.5%	0%	88.8%	88%	95.1%	86%	96%
2	96.6%	97.3%	0%	87.6%	87%	94.6%	87%	94%
3[3,4,5]	95.5%	97.3%	0%	82.0%	84.0%	93.0%		93%
Pneumococcal (Conjugate)								
1	97.8%	97%	0%	86%	86.3%	94%	86%	94%
2	96.3%	97%	0%	84%	86.6%	94%	87%	93%
3[6]	94.8%	97%	0%	78%	83.7%	91%	84%	91%
Rotavirus								
1	84.3%	97%	0%	0%	73.3%	97%	73%	97%
2	84.3%	96%	0%	0%	73.3%	96%	73%	97%
Measles-Rubella								
1-6m	49%	35%	0%	84%	51%	72%	51%	72%
2-9m	75%	84%	0%	71%	73%	80%	73%	80%
3-18	71%	19%	0%	0%	69%	19%	69%	19%
Yellow fever[10]	67%				67.4%		64%	
Td Booster 1				25%		25%		25%
Fully vaccinated								
Basic antigens[11,E]	81%	82%	22%	88%	76%	89%	**74%**	**89%**
All antigens[12,F]	85%	84%	17%	53%	78%	74%	**76%**	**74%**

The percentage of children 12-23 months of age who had been fully vaccinated by their first birthday was high, at 93 percent. The proportion of children fully vaccinated by 12 months of age was higher for children aged 24-35 months (93 percent). The individual coverage figures for children aged 24-35 months were generally higher to those aged 12-23 months, suggesting that immunization coverage has been, on average, improving in the coverage area.

Table 3.13b: Vaccinations in the first years of life

Percentage of children aged 12-23 months and 24-35 months vaccinated against vaccine preventable childhood diseases at any time before the survey (Crude coverage) and by their first birthday, RPP Endline 23

		Children aged 12-23 months:								Children aged 24-35 months:							
		Vaccinated at any time before the survey according to:						Vaccinated by 12 months of age		Vaccinated at any time before the survey according to:						Vaccinated by 24 months of age (MCV2, Td Booster1 and YF by 24 months)	
		Vaccination records[A]		Mother's report		Either[B] (Crude coverage)				Vaccination records[A]		Mother's report		Either[B] (Crude coverage)			
		Baseline	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**
Antigen																	
BCG[1]		99.2%	99.0%	96.4%	91.8%	92%	96.9%	302	111	99.6%	99.5%	96.4%	95.9%	91.2%	98.5%	290	165
Polio																	
At birth[C]		82.8%	98.3%	93.0%	96.6%	78.7%	97.8%	258	112	84.6%	99.1%	91.2%	96.6%	79.6%	98.3%	253	165
OPV1		83.2%	99.0%	83.0%	96.6%	91.5%	98.3%	300	113	85.4%	99.5%	82.0%	96.6%	91.2%	98.7%	290	166
OPV2		82.8%	99.0%	3.7%	93.6%	76.8%	97.5%	252	112	80.0%	99.5%	6.0%	93.6%	79.9%	97.8%	254	164
OPV3		83.2%	99.3%	13.3%	93.6%	81.7%	97.7%	268	112	83.7%	99.7%	12.0%	93.6%	84.6%	97.9%	269	164
OPV3 and IPV[2]		81.6%	99.3%		96.1%	76.5%	98.4%	205	113	81%	99.7%	42%	96.1%	75%	98.7%	239	166
HepB at birth[D]																	
Within day		0%	0%	0%	0%	0%	0%	0	0	0%	0%	0%	0%	0%	0%	0	0
Later		0%	0%	0%	0%	0%	0%	0	0	0%	0%	0%	0%	0%	0%	0	0
DTP-HepB-Hib																	
1		99.2%	99.3%		88.8%	89.3%	96.4%	293	111	99.1%	99.7%	0%	88.8%	86%	96.7%	274	162
2		98.8%	99.3%		87.6%	77%	96.0%	253	110	99.1%	100%		88%	75%	96%	240	162
3[3,4,5]		99%	99%		82%	79%	94%	260	109	98.7%	100%	81.3%	82%	73.9%	95%	235	159
Pneumococcal (Conjugate)																	
1		100%	99%	0%	86%	77%	95%	253	110	99.1%	99%		86%	74.2%	96%	236	161
2		100%	99%		84%	78%	95%	257	109	99.1%	100%		84%	74.2%	95%	236	160
3[6]		99%	99%	67%	78%	86%	93%	281	107	98.3%	100%	79.2%	78%	92.4%	93%	272	157
Rotavirus																	
1		83%	99%		0%	63%	99%	206	114	85.4%	99%		0%	63.8%	99%	203	167
2		82%	99%		0%	62%	99%	204	114	85.4%	100%		0%	63.8%	100%	203	167
3[7]																	
Measles-Rubella																	
1-6m		50%	86%		84%	50%	84%	165	97	47.2%	94%		84%	57.9%	86%	184	145
2-9m		82%	97%		71%	80%	89%	264	102	84.6%	98%		71%	85.5%	90%	272	151
3-18		69%	93%		0%	65%	93%	213	107	81.1%	98%		0%	71.0%	98%	233	164
Yellowfever		60%	63%				63%	197	73	61.6%	76%	0%			76%	196	128

Td Booster 1		61%				11%	81%	35	93	70.2%				12.6%	76%	40	127
Fully vaccinated																	
Basic antigens[11,E]		83%	96%	27%	88%	76%	93%			82%	98%	47%	89%	77%	94%		
All antigens[12,F]		84%	82%	16%	57%	67%	53%			87%	83%	37%	57%	67%	93%		
Number of children		328						328		293		0		0		293	

3.14. Breastfeeding

Proper feeding of infants and young children can increase their chances of survival; it can also promote optimal growth and development, especially in the critical window from birth to two years of age. Breastfeeding for the first two years of life protects children from infection, provides an ideal source of nutrients, and is economical and safe.

Approximately 94 percent of children aged less than six months were exclusively breastfed (Table 3.14). There was an increase in the proportion of those who are predominantly breastfed, as more mothers were informed about the benefits of exclusive breastfeeding. Boys are more likely to be exclusively breastfed than girls.. A child in Rusinga community is likely to be exclusively breastfed compared to those in Naromoru.

Table 3.14: Breastfeeding status

Percentage of living children according to breastfeeding status at selected age groups, *RPP Endline, 2023*

	Children aged 0-6 months					
	Percent exclusively breastfed		Percent predominantly breastfed		Number of children	
	Baseline	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**
Total	70.5%	94.3%	3%	6%	162	35
Sex (child)						
Male	68.8%	100.0%	0%	0%	78	14
Female	73.1%	90.5%	3%	10%	82	21
Mother's Education						
Primary	65.8%	100.0%	2%	0%	82	1
Secondary+	74.6%	94.1%	1%	6%	62	17
tertiary/univ	75.0%	94.1%	0%	6%	16	17
Respondent Age						
<34	74.8%	96.0%	2%	4%	112	25
35-64	61.2%	90.0%	1%	10%	50	10
>65	0%	0.0%	0%	0%	0	0
Relationship to child						
Parent (Biological/adopted)	73.9%	97.0%	2%	4%	145	25
Grandparents	38.5%	50.0%	1%	10%	15	10
Community						
Eastern	60.5%	100.0%	2%	0%	39	22
Naromoru	72.8%	77.8%	1%	22%	107	9
Rusinga	80.0%	100.0%	0%	0%	16	4

3.15. Infant and Young Child Feeding Nutrition

Overall, there was a 5% increase in the proportion of the children aged 6-23 months who received 5 or more food groups during the previous day. The older the child, the more likely he/she had a diverse diet. This would also increase by the level of education of the caregiver. Conversely, neither a child who was breastfeeding nor not breastfeeding received minimum meal frequency in the previous day. No child had at least the minimum dietary diversity and the minimum meal frequency during the previous day.

Table 3.15: Infant and young child feeding (IYCF) practices

Percentage of children aged 6-23 months who received appropriate liquids and solid, semi-solid, or soft foods the minimum number of times or more during the previous day, by breastfeeding status, RPP Endline, 2023

	Currently not breastfeeding							
	Percent of children who received:						Number of children age 6-23 months	
	Minimum dietary diversity[20]		Minimum meal frequency[21]		Minimum acceptable diet[22]			
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Total	9%	5%	10%	0%	3%	0%	506	176
Sex								
Male	4%	5%	26%	0%	1%	0%	257	81
Female	5%	6%	30%	0%	2%	0%	249	95
Community								
Eastern	6%	9%	38%	0%	2%	0%	349	132
Rusinga	2%	0%	11%	1%	1%	0%	97	5
Naromoru	1%	2%	8%	0%	0%	0%	60	39
Age (in months)								
6-8	1%	1%	9%	0%	0%	0%	88	30
9-11	2%	2%	10%	0%	0%	0%	89	39
12-17	3%	5%	21%	0%	2%	0%	173	46
18-23	2%	3%	17%	0%	1%	0%	155	61
Mother's education								
Pre-primary /none	0%	1%	5%	0%	0%	0%	25	12
Primary	4%	4%	45%	0%	2%	0%	230	84
Secondary+	4%	6%	50%	0%	1%	0%	251	80

3.16. Childhood illness

[20] Minimum dietary diversity is defined as receiving foods from at least 5 of 8 food groups: 1) breastmilk, 2) grains, roots and tubers, 3) legumes and nuts, 4) dairy products (milk, infant formula, yogurt, cheese), 5) flesh foods (meat, fish, poultry and liver/organ meats), 6) eggs, 7) vitamin-A rich fruits and vegetables, and 8) other fruits and vegetables.

[21] Minimum meal frequency among currently breastfeeding children is defined as children who also received solid, semi-solid, or soft foods 2 times or more daily for children age 6-8 months and 3 times or more daily for children age 9-23 months. For non-breastfeeding children age 6-23 months it is defined as receiving solid, semi-solid or soft foods, or milk feeds, at least 4 times.

[22] The minimum acceptable diet for breastfed children age 6-23 months is defined as receiving the minimum dietary diversity and the minimum meal frequency, while for non-breastfed children further requires at least 2 milk feedings and that the minimum dietary diversity is achieved without counting milk feeds.

Table 3.16 presents the percentage of children under-5 years of age who were reported to have had an episode of diarrhoea, symptoms of acute respiratory infection (ARI), or fever during the two weeks preceding the survey. These results measure period-prevalence of those illnesses over a two-week time window.

The definition of a case of diarrhoea or fever, in this survey, was the mother's or caretaker's report that the child had such symptoms over the specified period; no other evidence was sought beside the opinion of the mother. A child was considered to have had an episode of ARI if the mother or caretaker reported that the child had, over the specified period, an illness with a cough with rapid or difficult breathing, and whose symptoms were perceived to be due to a problem in the chest or both a problem in the chest and a blocked nose.

Overall, there was a 24% reduction from baseline to endline in the proportion of children who had been sick/unwell. Twenty-one percent of children under five years of age were reported to have had diarrhea in the two weeks preceding the survey, 81% had symptoms of acute respiratory infection and 70%an episode of fever. A child in Eastern community was more likely to experience fever and malaria compared to Naromoru community. There were no reported childhood illnesses in Rusinga during the survey.

Table 3.16. Reported disease episodes

Percentage of children age 0-59 months for whom the mother/caretaker reported an episode of diarrhoea, symptoms of acute respiratory infection (ARI), and/or fever in the last two weeks, RPP Endline, 2023

	Percentage of children who in the last two weeks had:											
	An episode of diarrhoea		Symptoms of ARI		An episode of fever		Presumed Malaria		Number of children who have been ill		Number of children	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Total	48.8%	21.4%	35.7%	80.8%	71.1%	70.1%	42.9%	8.1%	790	234	1569	726
Sex												
Male	26.1%	18.6%	19.2%	78.8%	70.9%	69.5%	41.6%	9.3%	406	118	778	350
Female	22.7%	24.1%	16.5%	82.8%	71.5%	70.7%	44.4%	6.9%	383	116	791	376
Community												
Rusinga	33.0%	0.0%	31.6%	0.0%	78.3%	0.0%	35.4%	0.0%	212	0	212	144
Eastern	23.6%	25.3%	11.6%	77.2%	72.1%	71.0%	47.8%	9.3%	492	162	492	409
Naromoru	9.3%	12.5%	19.8%	88.9%	47.7%	68.1%	33.7%	5.6%	86	72	86	173
Age (in months)												
0-11	35.2%	32.3%	13.1%	80.6%	70.3%	67.7%	39.3%	3.2%	145	31	145	89
12-23	36.0%	31.4%	22.8%	82.4%	70.4%	72.5%	35.5%	9.8%	189	51	189	115
24-35	24.2%	23.1%	18.2%	73.1%	71.5%	69.2%	40.6%	9.6%	165	52	165	168
36-47	13.0%	13.5%	17.3%	80.8%	66.7%	71.2%	48.2%	11.5%	139	52	139	186
48-59	10.9%	10.4%	17.0%	87.5%	75.5%	68.8%	52.4%	4.2%	147	48	147	168
Mother's education												
Primary	25.8%	0.0%	18.2%	92.9%	72.6%	71.4%	43.5%	7.1%	457	14	457	45
Secondary	23.8%	21.5%	18.3%	74.6%	71.1%	68.5%	42.9%	10.0%	273	130	273	423
Tertiary/university	19.6%	24.7%	10.7%	87.6%	60.7%	73.0%	39.3%	5.6%	56	89	56	254

As part of the endline caregiver survey, respondents were asked whether they sought advice or treatment for the child's illness and where they sought it. There was a 23% reduction in the proportion of caregivers who sought advice or treatment for the illness from baseline.. There was a 64% increase in caregivers who sought care from a health facility or clinic compared to 15% at baseline. About 7.2% sought advice from a relative(baseline=3%), 6.3% from friends/neighbors and 28% from a pharmacy

Table 3.16a: Care-seeking behaviour and treatment

	Health Facility		Care seeking									
	% of children taken to facility		% of caregivers who sought advice for illness		Relative		Friends/ neighbours		Pharmacy		Health facility/ clinic	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Total	59%	83.3%	75.8%	53.1%	3%	7.2%	1%	6.3%	16%	28.3%	30%	78.6%
Sex												
Male	61%	84.3%	76.6%	55.2%	0%	6.7%	0%	4.3%	0%	28.0%	2%	80.5%
Female	56%	82.3%	74.9%	51.2%	3%	7.7%	2%	8.3%	16%	28.6%	28%	76.8%
Community												
Rusinga	61%	77.3%	83.5%	58.0%	72%	0.0%	70%	4.3%	11%	42.0%	20%	78.3%
Eastern	56%	84.0%	70.9%	54.0%	20%	11.2%	23%	8.6%	4%	27.3%	7%	78.1%
Naromoru	70%	87.5%	84.9%	47.5%	8%	3.9%	7%	2.6%	2%	18.4%	3%	80.3%
Age (in months)												
0-11	66%	87.1%	77.9%	48.7%	14%	2.7%	17%	8.1%	3%	24.3%	5%	83.8%
12-23	70%	84.3%	84.1%	57.6%	24%	8.8%	20%	10.5%	4%	24.6%	6%	78.9%
24-35	53%	79.1%	70.9%	53.1%	4%	10.3%	3%	6.4%	3%	25.6%	6%	74.4%
36-47	52%	83.3%	71.9%	50.3%	32%	8.9%	47%	6.3%	4%	31.6%	7%	73.4%
48-59	50%	84.9%	72.8%	55.5%	26%	3.7%	13%	2.5%	3%	32.1%	5%	85.2%
Mother's education												
Primary	56%	77.3%	74.4%	63.2%	2%	8.3%	0%	4.2%	5%	29.2%	5%	70.8%
Secondary	63%	82.1%	76.9%	53.4%	51%	6.3%	52%	7.9%	49%	28.9%	50%	79.5%
tertiary/university	68%	87.8%	83.9%	50.7%	47%	8.7%	48%	4.3%	46%	26.1%	45%	80.0%

3.17. Availability of services

Through our RPP program model, ChildFund and our implementing partners did not directly provide services to the targeted population. However, one of the aims of RPP was to ensure that caregivers are aware of and utilizing existing community programs. Hence at endline, understanding the change in the level of awareness and utilization of existing services, is important. In addition, understanding the experiences of those using these services and challenges and barriers they may face allows for implementing partners to play a continuous advocacy role with the local government and stakeholders to improve service provision in the respective sub counties and counties.

3.17.1. Health services

Eighty-six percent of caregivers were aware of existing health services in their communities compared to 14% at baseline. According to the respondents, these services were provided by the government (96%) and non-governmental organizations (11%). In addition, 97% of the respondents had utilized health services compared to 64% at baseline in their community. For those who accessed the services, 59% faced difficulties compared to 25% at baseline. These challenges included insufficient medicine and supplies, long distances to the health facility, services were expensive and unfriendly staff.

Table 3.17.1. Access to Health Services

	Health									
	Provider						Use		Difficulty	
	% Yes		Govt.		Non Govt		% Y		% Y	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Total	14%	86%	61%	96%	36%	11%	64%	97%	25%	59%
Sex										
Male	1%	100%	2%	100%	1%	3%	2%	94%	1%	68%
Female	13%	86%	59%	96%	35%	12%	62%	97%	24%	58%
Region										
Eastern	73%	84%	67%	94%	71%	17%	67%	97%	69%	54%
Rusinga	17%	100%	22%	100%	19%	6%	21%	97%	21%	70%
Naromoru	10%	78%	11%	97%	10%	7%	11%	96%	10%	55%
Mother's education										
Pre-primary/none	4%	98%	4%	100%	6%	10%	4%	98%	4%	58%
Primary	48%	86%	50%	96%	48%	9%	50%	97%	51%	57%
Secondary+	48%	86%	46%	95%	46%	15%	46%	97%	45%	61%

3.17.2. Early Childhood Development services

Eighty eight percent of caregivers were aware of the existence of early childhood development services such as preschools in their communities compared to fourteen percent at baseline. The major service providers identified by the respondents included the government (83%) and non-governmental organizations (27%).

Almost three quarters (74%) of the respondents had utilized ECD services in their community. For those who accessed the services, 27% faced difficulties that included high cost of education, long distance to school, lack of adequate and age-appropriate learning and play materials, and rude and unfriendly teachers.

Table 3.17.2. Access to ECDE Services

	ECD									
	Provider						Use		Difficulty	
	% Yes		Govt.		Non Govt		% Y		% Y	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Total	14%	88%	61%	83%	35%	27%	44%	74%	13%	27%
Sex										
Male	1%	85%	2%	100%	1%	36%	2%	89%	0%	20%
Female	13%	88%	59%	82%	34%	27%	42%	74%	13%	27%
Communities										
Eastern	74%	92%	68%	81%	69%	25%	69%	66%	71%	30%
Rusinga	16%	86%	21%	96%	21%	48%	20%	88%	19%	29%
Naromoru	10%	84%	11%	74%	10%	10%	11%	79%	11%	18%
Mother's education										
Pre-primary/none	4%	92%	5%	98%	4%	39%	5%	87%	5%	33%
Primary	48%	87%	49%	82%	49%	29%	48%	77%	49%	27%
Secondary+	49%	90%	45%	82%	47%	21%	47%	68%	45%	25%

3.17.3. Parenting/Caregiver wellbeing

Majority 91% of respondents were aware of existing caregiver wellbeing services in their communities. Most of the respondents identified non-governmental organizations (70%) and the government (27%) as the service providers. Ninety-one percent had used the services, of these, only 8% reported having faced challenges in accessing them.

Table 3.17.3. Access to Parenting and Caregiver Wellbeing Services										
	Parenting/caregiver wellbeing									
	Provider						Use		Difficulty	
	% Yes		Govt.		Non Govt		% Y		% Y	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Total	11%	91%	20%	27%	77%	70%	0%	91%	7%	8%
Sex										
Male	0%	100%	1%	15%	3%	88%	0%	100%	0%	6%
Female	11%	91%	19%	27%	74%	69%	0%	91%	7%	8%
Community										
Eastern	8%	93%	14%	28%	52%	53%	0%	93%	5%	10%
Rusinga	2%	90%	4%	44%	17%	87%	0%	90%	2%	4%
Naromoru	1%	89%	2%	8%	8%	87%	0%	89%	1%	7%
Mother's education										
Pre-primary none	4%	95%	6%	32%	4%	82%	0%	95%	3%	7%
Primary	46%	90%	51%	27%	49%	70%	0%	90%	47%	8%
Secondary+	51%	93%	43%	27%	47%	67%	0%	93%	50%	6%

3.17.4. Nutrition services

Thirty eight percent 38% of caregivers were aware of existing nutrition services in their communities. Almost half (49%) of the respondents identified NGOs as a service provider. Eighty-six percent of the respondents had utilized the services and 13% faced difficulties.

Table 3.17.4. Access to Nutrition Services										
	Nutrition									
	Provider						Use		Difficulty	
	% Yes		Govt.		Non Govt		% Y		% Y	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Total	16%	38%	9%	39%	5%	49%	7%	86%	2%	13%
Sex										
Male	1%	30%	0%	40%	0%	70%	0%	100%	0%	0%
Female	15%	39%	9%	39%	5%	48%	7%	85%	2%	13%
Community										
Eastern	11%	53%	7%	44%	5%	36%	5%	84%	2%	12%
Rusinga	2%	3%	2%	57%	1%	57%	1%	71%	0%	20%
Naromoru	2%	42%	1%	25%	1%	79%	1%	91%	0%	13%
Mother's education										
Pre-primary/none	4%	31%	5%	56%	2%	50%	5%	89%	0%	19%
Primary	47%	35%	46%	35%	43%	47%	47%	86%	37%	14%
Secondary+	49%	46%	49%	43%	55%	50%	47%	84%	63%	11%

3.17.5. Psychosocial Support services

Twenty-two percent of the caregivers were aware of existing psychosocial support services, such as peer counsellors, support groups and professional counsellors in their communities. Over half (52%) of the respondents identified the government as service provider and NGOs (36%). From the survey, 60% of the respondents have utilized the services. Over a fifth, 23% of respondents faced difficulties accessing these services.

Table 3.17.5. Access to Psychosocial Support Services

	Psychosocial support services									
	Provider						**Use**		**Difficulty**	
	% Yes		**Govt.**		**Non Govt**		**% Y**		**% Y**	
	Baseline	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**
Total	5%	22%	3%	52%	2%	36%	4%	60%	4%	23%
Sex										
Male	0%	21%	0%	57%	0%	43%	0%	57%	0%	0%
Female	5%	23%	3%	52%	2%	36%	4%	60%	4%	24%
Community										
Eastern	4%	29%	2%	64%	1%	44%	3%	57%	0%	28%
Rusinga	1%	12%	1%	4%	0%	12%	0%	81%	0%	0%
Naromoru	1%	20%	1%	46%	0%	28%	1%	54%	0%	28%
Mother's education										
Pre-primary none	3%	24%	0%	50%	0%	36%	0%	79%	0%	27%
Primary	48%	21%	43%	50%	56%	35%	43%	63%	75%	21%
Secondary+	50%	25%	57%	56%	44%	37%	57%	51%	25%	27%

3.17.6. Police services

Sixty eight percent of the caregivers were aware of existing police services in their communities. Over a third (34%) of the respondents utilized the services. Twenty-five percent of respondents faced difficulties accessing these services.

Table 3.17.6. Access to Police Services

	Provider		**Use**		**Difficulty**	
	% Yes		**% Y**		**% Y**	
	Baseline	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**
Total	10%	68%	3%	34%	1%	25%
Sex						
Male	0%	73%	0%	17%	0%	0%
Female	10%	68%	3%	35%	1%	26%
Community						
Eastern	8%	76%	2%	49%	1%	23%
Rusinga	2%	54%	0%	10%	0%	9%
Naromoru	1%	65%	0%	18%	0%	48%
Mother's education						
Pre-primary or none	6%	76%	0%	42%	0%	21%
Primary	47%	63%	50%	29%	38%	28%
Secondary+	48%	76%	50%	40%	62%	24%

3.18. Child Wellbeing

According to the endline survey, 86% of respondents were aware of child abuse, an increase from baseline (70%). Most caregivers cited physical injuries as one of the signs of child abuse (66%) followed by changes in behavior of the child (43%). In terms of sources of information on child abuse, cited community health volunteers (48%), health workers (44%), parents (26%), friend (16%), neighbors (15%), other relative (11%) and grandparents (6%).

The overwhelming majority of respondents were aware of what to do when a child is harmed or abused (97%) from baseline (61%). Consequently, would report to the police (69%), the children's department (57%), the hospital (48%), the government (e.g. chiefs, administrators (42%)), would solve internally(15%), would report to a religious institution(13%), to a children's home (8%) and would use traditional structures such as a council of elders (7%). The male caregivers (100%) were more likely to act than their female counterparts (97%).

Table 3.18a: Child Wellbeing																
	Awareness of child abuse (%)		Awareness of what to do		Signs of Child Abuse											
					Injuries		Behaviour changes		Reaction to strangers		Sexual assault		Illness		Plays in dangerous environments	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Total	70%	86%	61%	97%	35%	66%	23%	43%	11%	17%	10%	28%	9%	15%	9%	12%
Sex																
Male	2%	97%	2%	100%	1%	75%	1%	41%	0%	9%	0%	34%	0%	9%	0%	16%
Female	68%	86%	59%	97%	34%	66%	22%	43%	11%	18%	10%	27%	9%	15%	9%	12%
Area																
Rural	35%	86%	30%	97%	17%	66%	11%	43%	6%	17%	5%	28%	5%	15%	5%	12%
Community																
Eastern	48%	84%	42%	97%	24%	69%	16%	43%	8%	24%	7%	20%	7%	14%	6%	9%
Rusinga	14%	97%	12%	100%	8%	70%	5%	27%	2%	9%	3%	53%	2%	21%	2%	21%
Naromoru	7%	80%	6%	96%	4%	57%	2%	60%	1%	13%	1%	15%	1%	12%	1%	8%
Mother's education																
Pre-primary or none	5%	73%	5%	100%	5%	72%	4%	35%	9%	12%	7%	51%	6%	12%	7%	16%
Primary	48%	85%	47%	97%	46%	64%	50%	42%	43%	18%	49%	31%	41%	16%	47%	14%
Secondary+	47%	91%	48%	98%	49%	69%	46%	46%	49%	17%	44%	19%	52%	14%	46%	8%

Table 3.18b: Child Wellbeing														
Sources of information about child abuse														
	Parents		**Grandparents**		**Other relative**		**Friend**		**Neighbour**		**Health worker**		**Child protection volunteer (CHVs)**	
	Baseline	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**	**Baseline**	**Endline**
Total	3%	26%	3%	6%	9%	11%	8%	16%	24%	15%	18%	44%	3%	48%
Sex														
Male	0%	38%	0%	9%	0%	16%	0%	19%	1%	16%	1%	47%	0%	47%
Female	3%	26%	3%	6%	9%	11%	8%	16%	23%	15%	17%	44%	3%	48%
Area														
Rural	2%	26%	1%	6%	5%	11%	4%	16%	12%	15%	9%	44%	1%	48%
Community														
Eastern	2%	18%	2%	8%	6%	15%	6%	17%	17%	18%	12%	39%	2%	49%
Rusinga	1%	44%	1%	6%	2%	8%	2%	13%	5%	11%	4%	69%	1%	52%
Naromoru	0%	22%	0%	4%	1%	7%	1%	18%	2%	16%	2%	27%	0%	42%
Mother's education														
Pre-primary	2%	42%	6%	7%	6%	14%	9%	16%	4%	14%	6%	40%	5%	51%
Primary	50%	25%	36%	6%	46%	10%	45%	15%	50%	15%	49%	44%	56%	48%
Secondary+	48%	26%	57%	6%	48%	12%	46%	18%	46%	16%	46%	47%	40%	48%

Table 3.18c: Child Wellbeing																
	Report: children's department		Report to church		Report to govt		Report to police		Solve internally		Take child to children's home		Take child to hospital		Use traditional structures	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Total	30%	57%	8%	13%	23%	42%	46%	69%	9%	15%	4%	8%	31%	48%	2%	7%
Sex																
Male	1%	84%	0%	22%	1%	47%	2%	75%	0%	19%	0%	6%	1%	50%	0%	6%
Female	29%	56%	8%	12%	22%	42%	44%	69%	9%	15%	4%	8%	30%	47%	2%	7%
Area																
Rural	15%	57%	4%	13%	11%	42%	23%	69%	5%	15%	2%	8%	15%	48%	1%	7%
Region																
Eastern	21%	45%	6%	16%	15%	40%	32%	69%	7%	15%	3%	10%	20%	41%	2%	6%
Rusinga	6%	74%	2%	8%	4%	55%	9%	75%	2%	20%	1%	3%	7%	81%	0%	1%
Naromoru	3%	63%	1%	11%	3%	30%	5%	64%	1%	10%	0%	8%	4%	23%	0%	15%
Mother's education																
Pre-primary or none	4%	72%	6%	12%	6%	49%	5%	84%	6%	23%	8%	7%	6%	70%	13%	5%
Primary	50%	54%	44%	12%	46%	41%	46%	67%	47%	17%	33%	7%	47%	50%	35%	6%
Secondary+	46%	60%	50%	14%	48%	42%	49%	70%	47%	11%	59%	10%	47%	40%	52%	7%

3.19. Child Protection

There was a decrease in the proportion of caregivers who were aware of existence of children with intellectual and physical difficulties in the community from baseline (21%). Over half 54% indicated that these children are treated the same as other children.

At endline, there were more child protection services reported by the respondents compared to baseline. These services/structures include childrens department (52%), police/law enforcement (39%), NGOs (41%), ECD (32%),childrens charitable institutions (31%), religious institution (24%) and CSOs (14%).

The sources of information included child protection volunteers (50%), health worker (35%), 24% neighbors and friends, 14% parents, 5% grandparents and 7% other relatives such as in laws.

Overwhelming 91% of respondents feel that their children were safe from danger and violence in the neighborhood or community all or most of the time compared to 65% at baseline.

Table 3.19: Child Protection

	Awareness of children with intellectual and/or physical difficulties (% Y)		Treatment of children with intellectual and/or physical difficulties (% reporting same)		Availability of child protection services/ structures		Perceptions of child safety	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Total	21%	19%	6%	54%	17%	25%	65%	91%
Sex								
Male	1%	30%	0%	70%	1%	21%	2%	82%
Female	20%	19%	12%	53%	16%	25%	59%	92%
Community								
Eastern	14%	22%	8%	54%	11%	26%	42%	94%
Rusinga	4%	19%	2%	44%	4%	12%	12%	82%
Naromoru	2%	14%	1%	70%	2%	35%	6%	94%
Mother's education								
Pre-primary/none	6%	15%	6%	44%	6%	25%	5%	88%
Primary	47%	19%	43%	45%	49%	24%	49%	90%
Secondary+	46%	20%	51%	73%	45%	28%	46%	94%

3.20. Child Rights

Overwhelmingly, 95% of respondents were aware of children's rights at endline compared to 40% at baseline. There were no differentials in gender or level of education of the respondents from the survey. Among the most mentioned rights were the right to parental care (67%), right to education (67%), right to healthcare (60%) and the right to life (51%). The least known rights were the right to protection from drugs (7%), the right to protection from sexual exploitation (8%), the right to protection from child abuse (8%), right for children with disability to be treated with dignity (8%), the right to privacy (8%).

In terms of sources of information, almost half, 46% relied on community health volunteers and health workers respectively, 26% parents, 19% in laws/other relatives, 17% friend, 14% neighbor and 7% grandparents.

Table 3.20: Child Rights

	Awareness of children's rights (% Y)	
	Baseline	Endline
Total	80%	95%
Sex		
Male	3%	97%
Female	77%	95%
Community		
Eastern	55%	95%
Rusinga	17%	99%
Naromoru	8%	90%
Mother's education		
Pre-primary or none	4%	93%
Primary	37%	93%
Secondary+	36%	98%

3.21. Child Participation

From the endline survey, 73% of caregivers made decisions with regards to their children's health, care and education, followed by spouse (59%) and grandparents (5%). Conversely, more parents/caregivers 68% allow their children to make their own choices such as clothes to wear, games to play, toys, school, shoes, who and when to play, hairstyle, books to read compared to baseline (53%). More male caregivers allowed children to make own decisions compared to female. There were marginal differences in the level of education of the respondent.

Table 3.21: Child Participation								
	Decision-making for child							
	Self		Spouse		Child's Grandparent(s)		Child makes own decisions (% Y)	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Total	58%	73%	53%	59%	6%	5%	53%	68%
Sex								
Male	2%	94%	2%	73%	0%	0%	2%	73%
Female	56%	72%	51%	58%	6%	6%	51%	68%
Community								
Eastern	40%	71%	37%	54%	4%	6%	37%	62%
Rusnga	13%	81%	10%	64%	1%	1%	11%	78%
Naromoru	6%	69%	6%	63%	0%	9%	6%	72%
Mother's education								
Pre-primary or none	5%	78%	5%	39%	2%	3%	4%	71%
Primary	48%	74%	49%	59%	43%	5%	52%	68%
Secondary+	47%	71%	46%	62%	55%	7%	44%	68%

3.22. Caregiver Wellbeing

The endline survey established that over the previous two weeks prior to the data collection 66% of caregivers reported to have experienced some challenges when caring for their children. There were no gender differentials. In terms of communities, caregivers in Eastern experienced challenges compared to those in Naromoru.

The challenges reported by most respondents were financial strain (98%), lack of support from partner (14%), inability to make decisions in the household (13%) and intimate partner violence (5%). Some of the ways they have been overcoming challenges include scheduling leisure time to relax, singing, visiting friends, spirituality and faith, support from partner and other relatives, medical checkups, planning tasks, proper diet and hygiene, avoiding negative company.

Table 3.22a: Caregiver Wellbeing										
	Experienced challenges (% Y)		Financial Strain		Intimate partner violence		Inability to make decisions		Lack of support from partner	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Total	60%	66%	57%	98%	4%	5%	6%	13%	4%	14%
Sex										
Male	2%	67%	2%	96%	0%	0%	0%	5%	0%	0%
Female	58%	66%	55%	98%	4%	5%	6%	8%	8%	15%
Community										
Eastern	41%	75%	39%	99%	3%	8%	5%	13%	6%	20%
Lake	13%	61%	12%	99%	1%	1%	1%	2%	2%	8%
Pioneer	6%	54%	6%	96%	0%	2%	0%	1%	0%	6%

Mother's education										
Pre-primary none	5%	70%	5%	100%	1%	5%	9%	5%	6%	17%
Primary	48%	65%	48%	98%	4%	7%	48%	10%	53%	17%
Secondary+	47%	67%	47%	98%	3%	3%	43%	7%	40%	9%

The most common sources of information on self-care reported are health worker (49%), community health volunteer (50%), parents (24%), friend (15%), neighbors (14%) while the least were grandparents (5%) and in laws (6%).

Table 3.22b: Caregiver Wellbeing

	Lessons learned on caregiver wellbeing											
	Livelihood activities		Care for physical health		Care for mental health		Nutrition		Managing emotions		Stress management	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Total	8%	63%	9%	49%	6%	55%	9%	63%	7%	14%	8%	70%
Sex												
Male	0%	74%	0%	44%	0%	61%	0%	52%	0%	44%	0%	83%
Female	8%	63%	9%	50%	6%	55%	9%	64%	7%	13%	8%	70%
Community												
Eastern	5%	57%	6%	66%	4%	57%	6%	80%	5%	0%	5%	69%
Lake	2%	84%	2%	0%	1%	44%	2%	23%	2%	53%	2%	71%
Pioneer	1%	52%	1%	71%	1%	66%	1%	71%	1%	0%	1%	74%
Mother's education												
Pre-primary or none	6%	69%	5%	31%	7%	41%	5%	39%	8%	28%	7%	80%
Primary	46%	64%	44%	45%	46%	51%	46%	61%	48%	16%	45%	70%
Secondary+	48%	61%	51%	61%	47%	64%	49%	73%	44%	8%	48%	69%

4.0. Findings on Community stakeholder's component

4.1. Knowledge of Nurturing Care Components and Child Protection

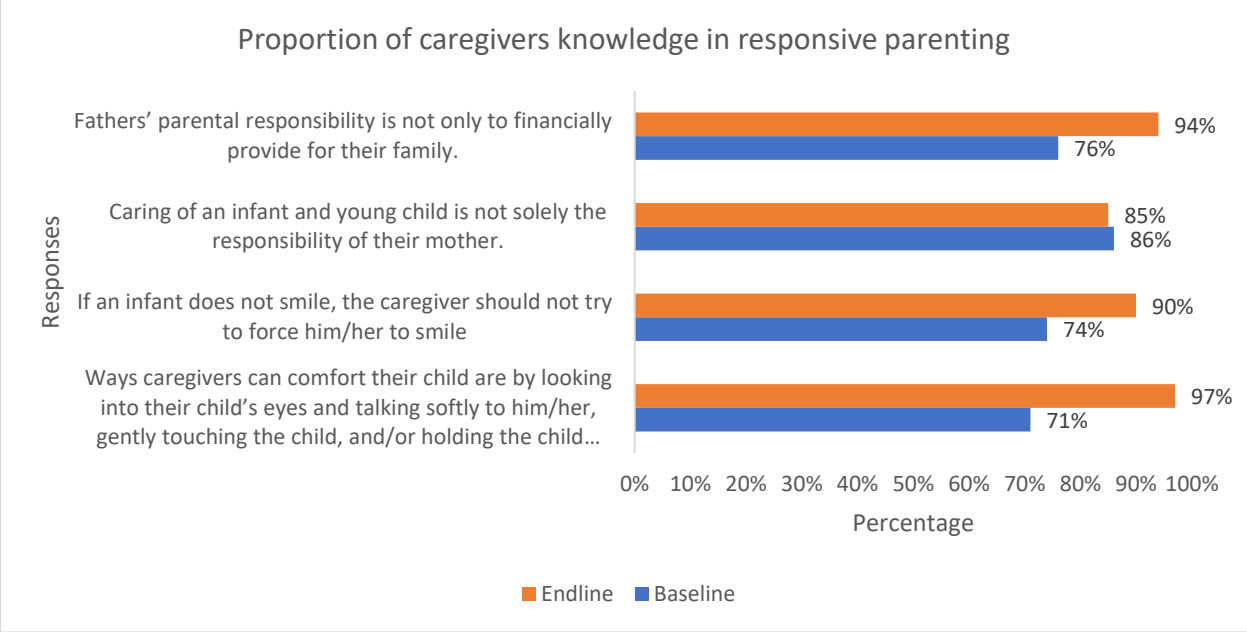
One of the three objectives of RPP is to strengthen community stakeholders' knowledge, attitudes and practices on the components of nurturing care[23], caregiver well-being, and community-based child protection to support caregivers in group parenting sessions. This was done through stakeholders' participation in community mobilization, a series of capacity building workshops and ongoing reflective supervision. These activities helped them build the skills to plan and facilitate parenting sessions at the community level (through group sessions) with vulnerable caregivers of IYC.

[23] responsive caregiving, safety and security/child protection, opportunities for early learning and stimulation, good health, adequate nutrition.

4.1.1. Responsive Caregiving

During the post KAP survey, 94% of the respondents reported that the father's parental responsibility is not only to provide financially for the family compared to baseline (74%). See figure 1 below. Ninety seven percent of the respondents were aware of the ways that caregivers can comfort their children included looking into the eyes, talking softly to them, gently touching and holding them closely compared to baseline (69%). Ninety percent of the respondents were aware that infants who do not smile should not be forced by their caregivers compared to baseline (72%). However, 85% of respondents still reported that the mother's sole responsibility is to care for their infants and young children.

Figure 1: Knowledge in Responsive Caregiving



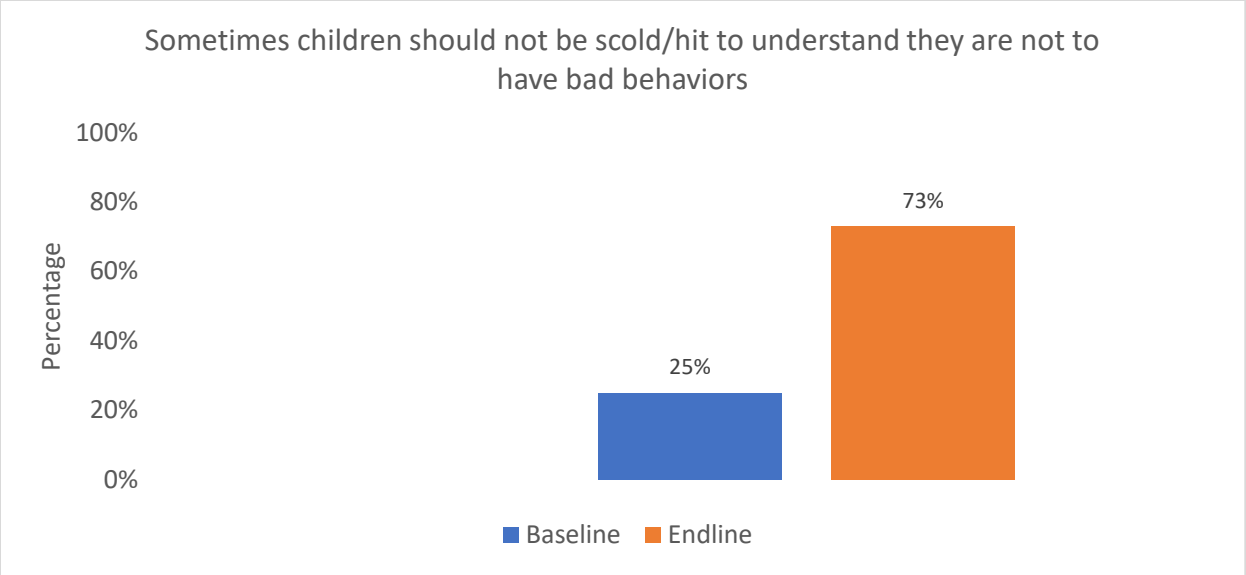
Source: KAP Survey, 2023

4.1.2. Safety and Security

In terms of child discipline, 73% of facilitators believed that a child should not be scolded or hit to understand they are not to have bad behaviors compared to baseline (24%). Harsh discipline such as beating, hitting, talking harshly, pinching, shouting at should not be used on children. Instead, caregivers should spend more time encouraging wanted behaviors[24].(See figure 2 below)

Figure 2: Attitudes towards discipline

[24] Training Manual on Core Concepts of Early Childhood Development (ECD) and Group Parenting Education: Facilitators Guide



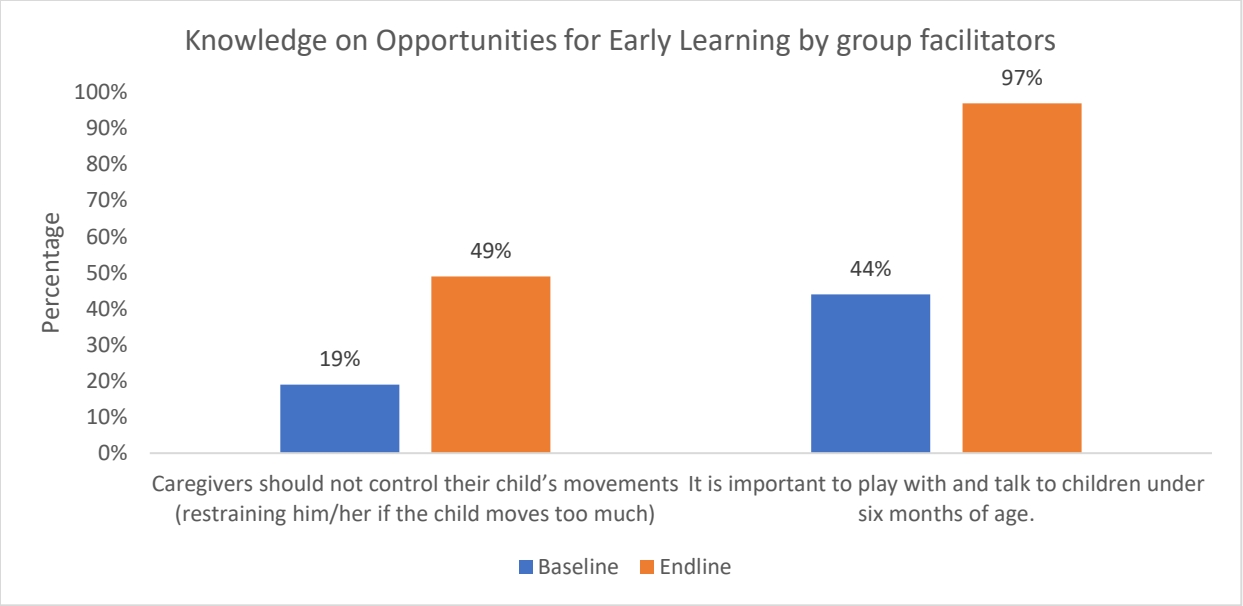
Source: KAP Survey, 2023

4.1.3. Opportunities for Early Learning

From the endline KAP survey, almost half (49%) of the respondents were aware that the caregivers shouldn't control the child's movements compared to baseline (19%). During the TOT training, facilitators learnt that these actions by children are natural ways that provide opportunities to interact with the child, stimulate the child's brain and develop a relationship with their caregivers. It is important for caregivers to respond to their children's vocals or actions to support stimulation of the brain.

Moreover, 97% of the respondents reckoned that it is important to play with and talk to children under 6 months of age compared to baseline (44%). Studies show that experiences and interactions play a very important role in building the pathways in the brain and those pathways are strengthened through many positive experiences over time (See figure 3 below).

Figure 3: Knowledge on Opportunities for Early Learning



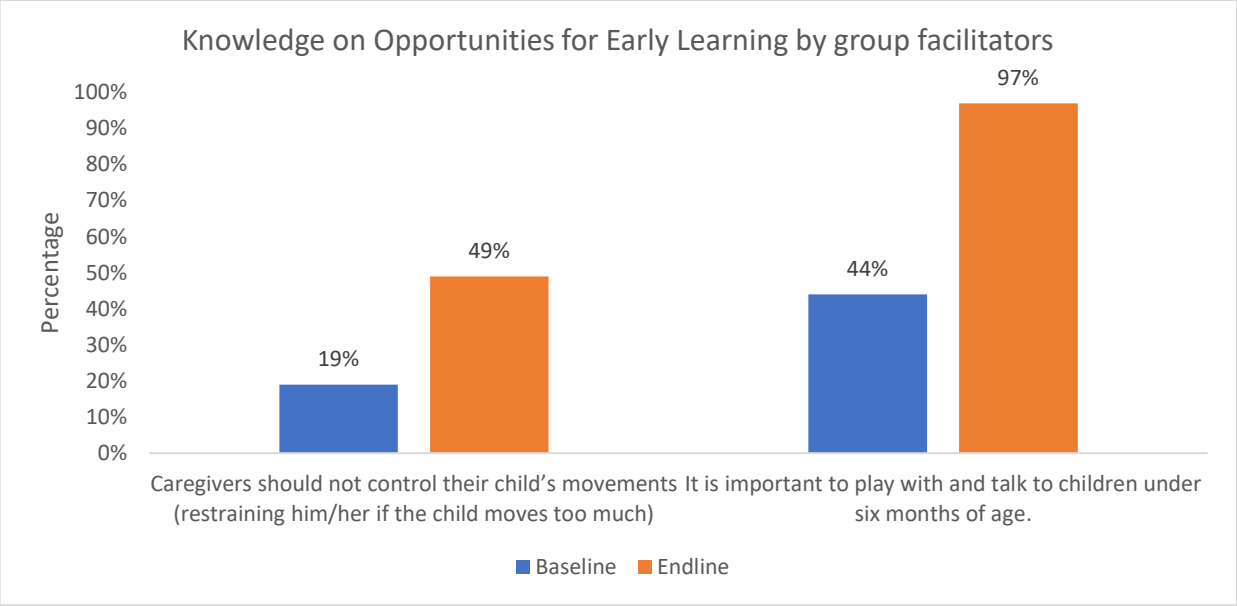
Source: KAP Survey, 2023

4.1.4. Adequate Nutrition

Children under 6 months are supposed to be exclusively breastfed on breastmilk only. Exclusive breastfeeding means that the infant feeds on breast milk only from his/her mother or expressed breast milk and no other liquids, fluids (not even water) or solids except when it is medication prescribed by the healthcare worker.

When asked on this issue during the endline KAP survey, 81% of respondents do know that babies up to six months of age should be exclusively breastfed with no introduction to water like baseline (81%). In addition, 91% know that mothers should look/speak/softly sing to their baby while breastfeeding to facilitate eating compared to baseline (79%). See figure 4 below.

Figure 4: Knowledge on Adequate Nutrition



*Responses were "False" to the above data
Source: KAP Survey, 2023

4.1.5. Good Health

From the endline survey, 45% of the respondents were aware of how they could counsel caregivers on preventing and responding to illness compared to baseline (3%). Some of the ways mentioned included giving a balanced diet, keeping the child warm, ensuring the child is in a clean environment, washing hands before and after feeding, full immunization of the child, covering food, deworming and boiling drinking water. Others mentioned the correlation between caregiver wellbeing and child health thus parents should have enough rest and avoid rest (See table 3.1 below).

In terms of responding to children with development delays such as being "slow to learn", 34% of the respondents mentioned they would advise the caregiver to encourage more activity with the child and refer the nearest health facility for additional assessments compared to baseline (23%).

Table 3.1: Knowledge on Good Health

Component	Baseline	Endline
What are some ways facilitators can counsel caregivers on preventing illness and responding to illness?	3%	45%
If a caregiver says their child is "slow to learn", what should the facilitators do?	23%	34%

Source: KAP Survey, 2023

4.2. Knowledge of planning and facilitating parenting sessions.

During the endline survey, the respondents were asked about their understanding of the different components that should be covered during group sessions. Over half, 55% of the respondents mentioned at least three components compared to 17% at baseline. The components included greetings, introductions including prayers, setting objectives, review of last session and appreciating caregivers for their participation.

4.2.1. Group session planning.

In the endline KAP survey, the respondents were asked about the process of planning for a group parenting session in the community. Eighty six percent of the respondents were aware of the items they should bring with them to each group parenting session compared to 67% at baseline. These items included attendance list, examples of toys/items children can play with, visual discussion cards. Others mentioned notebooks, pens, progress report forms, snacks, food. fruits, learning aids such as charts.

4.2.2. Group session facilitation.

4.2.2.1. Follow Up from the last session.

According to 89% of the respondents, each group session should be linked to another, with topics and key messages addressed in the current session compared to baseline (10%).

4.2.2.2. Introduce topic.

In the endline KAP survey, 94% of respondents indicated that the facilitator needs to show visual aid to caregivers compared to 46% at baseline. Similarly, 53% of the respondents were aware that the group facilitator ought to ensure to explain key messages using nontechnical language so that the caregivers understand the messages compared to 64% at baseline. Furthermore, 96% of the respondents indicated that the facilitator should involve the caregivers in sharing knowledge. (See table 3.2 below)

Table 3.2: Knowledge on group parenting session

Component	Baseline	Endline
During the group session, the facilitator needs to show visual aid to caregiver(s).	46%	94%
Group facilitator should make sure to explain key messages using nontechnical language to ensure the caregiver understands the messages.	53%	64%
During a group meeting, the facilitator should not be the only person speaking as he/she are the ones sharing knowledge.	79%	96%

Source: KAP Survey, 2023

At endline, KAP survey results showed that 21% of the respondents were able to demonstrate ways that facilitators can demonstrate engagement with caregivers compared to 0% at baseline. Some of the behavioral traits that facilitators should show

included being happy and interactive with caregivers, being polite and calm, eye contact and showing respect. In terms of delivery, they mentioned ensuring caregivers share their experiences openly, allowing caregivers to speak, using teaching aids, arranging caregivers on the same level so that they see each other, using language they understand, following up so that they attend sessions.

Infant and young child feeding

Some of the ways respondents mentioned that facilitators can counsel caregivers on feeding young infant children included, asking how the baby is growing, providing balanced diet, singing songs, feeding at the appropriate time, 4-5 times a day.

Play

The respondents were asked about some ways facilitators can encourage caregivers to play with their child. At endline 35% of the respondents mentioned at least two ways compared to 23% at baseline. Some mentioned caregivers can be encouraged to buy or make toys for their children, singing, smiling, laughing, running with the child if he/she is walking, providing learning materials.

"Encourage them to play with their children, create love and relationship with the child, caregivers should support by providing space, time, and variety safe playing materials suitable to age".

"Caregiver can be encouraged by facilitator to improvise playing materials to the children, singing together with children".

Talking to children

Furthermore, respondents mentioned some ways facilitators can encourage caregivers to talk to their child. These include interaction with the child through looking at their eyes when speaking, using hand gestures, being polite in language and mannerisms. Others mentioned activities like washing utensils, playing with the child. This act facilitates affectionate relationships with the child and supports secure attachment and nurturing care.

"Direct eye contact to the child most so during feeding, involve in activity together with the child i.e. playing"

Childhood illness

From the endline survey, 45% of the respondents were aware of how they could counsel caregivers on preventing and responding to illness compared to baseline (3%). Some of the ways mentioned included giving balanced diet, keeping the child warm, ensuring child is in a clean environment, washing hands before and after feeding, full immunization of the child, cover food, deworming and boiling drinking water. Others mentioned the correlation between caregiver wellbeing and child health thus parents should have enough rest and avoid rest.

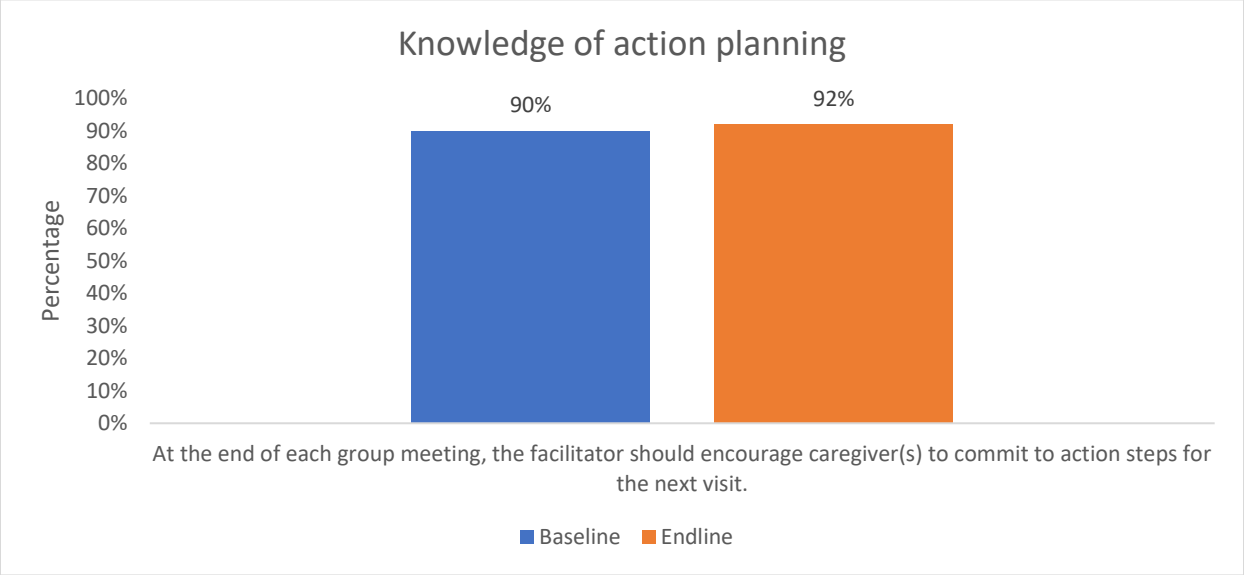
Slow to learn/developmental delays

In terms of responding to children with development delays such as being "slow to learn", 34% of the respondents mentioned they would advise the caregiver to encourage more activity with the child and refer the nearest health facility for additional assessments compared to baseline (23%).

4.2.2.3. Action Planning

The endline KAP survey revealed that 92% of the respondents were aware that facilitators ought to encourage caregivers to commit to action steps for the next group session compared to 90% at baseline. The facilitator should share the key messages, praise and encourage caregivers to bring children in the next meeting, if possible, agree on the date and time of the next meeting and take notes on the group parenting reporting tools[25] (See figure 5 below).

Figure 5: Knowledge on Action planning



Source: KAP Survey, 2023

[25] **TRAINING MANUAL ON CORE CONCEPTS OF EARLY CHILDHOOD DEVELOPMENT (ECD) AND GROUP PARENTING EDUCATION**

5.0. Findings on Multisectoral sub-national government capacity

5.1. Sub national government support for establishing and maintaining a nurturing and protective environment for IYC.

5.1.1. Definition of Early Childhood Development

The respondents cited a variety of definitions of early childhood development (ECD) depending on sector, type of organization and age cohort and developmental milestones of children. However, the common thematic areas were as captured.

> "This is the period of human development from conception through the transition from birth to early years of primary school and it involves the physical growth, psychological development"- KII MOH

Child growth from conception up to 5 years grow physically, mentally and socially.- KII, Ministry of Interior

5.1.2. Importance of Early Childhood Development

In terms of ECD importance in the sub counties, most respondents indicated that it helps build a strong and broad foundation for lifelong learning and wellbeing of children in the community, moulding cognitive, emotional, and physical development of children in life.

> *"It is important to address concerns/needs/wants of human beings of all ages, however it is significant to meet needs of ECD to avert negative consequences of not addressing them at their early years" – KII, MOH*

"It provides healthy development in early years of a child and gives building blocks for educational achievement, lifelong health, economic productivity"- KII, Early Years Education

5.1.3. Government ECD services to the community

Some of the ECD-related services the government offers, manages and is responsible to the community include health services such as growth monitoring, mass screening, immunizations, deworming, Vitamin A supplements, building hospitals, dispensaries, training community health volunteers, provision of insecticide treated nets to pregnant and lactating women. Education i.e. employing and training ECD teachers, child friendly learning environment i.e play material, infrastructural facilities WASH facilities, classrooms, desks and chairs providing learning materials, sensitizing

parents on their involvement in learning, school feeding programs. Nutrition through provision of supplementary feeding, protection, child friendly justice systems.

5.1.4. Multisectoral coordination and collaboration in ECD services

All respondents mentioned that they work with other government departments/agencies and non-governmental organizations. Due to the holistic nature of child development, one agency cannot work alone. For instance, Nutrition officer mentioned that they conduct deworming exercise, vitamin A supplementation, growth monitoring with Ministry of Health and partner with ChildFund implementing partners in responsive care activities and nurturing care and support of enriched porridge to supplement feeding programme, working closely with children's office to ensure children are protected.

"Health i.e immunizations, filling P3 forms, police for child cases, ECD/MOE to ensure children access to education, NGOs to facilitate/support children's activities and meetings to discuss children issues". – ***KII MOH***

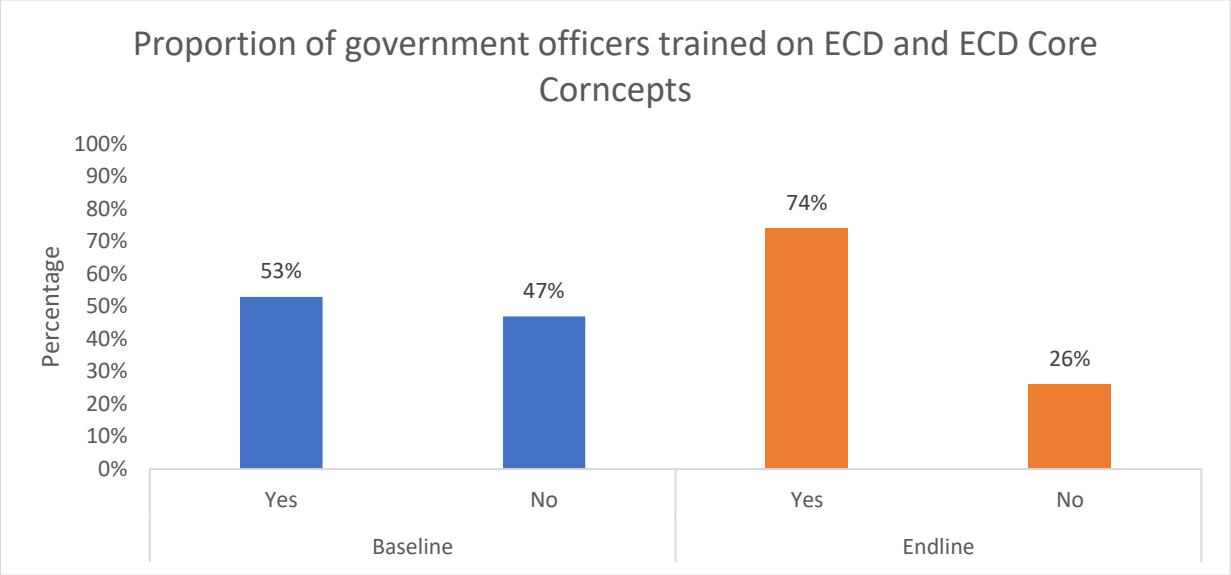
"I work with other government departments to give legal advice to caregivers and parents. I also work with NGO (plan) to educate the community about child protection-how a child can be taken care of" – ***KII Paralegal.***

5.1.5. Training on Early Childhood Development Core concepts.

Almost three quarter (74%) of the respondents mentioned that they had been trained in ECD concepts compared to baseline (53%). Half of the respondents reported that they had been trained by ChildFund implementing partners. Other organizations included UNICEF, Compassion International and government ministries of health and Gender.

The duration of the training ranged from 3 to 5 days. The content of the training included the importance of brain development, Early childhood development & role of caregivers, Secure attachment, Importance of play & how to support child play, group parenting session and home visits, reflective supervision.

Figure 1: Government officers trained on ECD core concepts.



Source: Key informant interview, 2023

5.1.6. Early Childhood Development Policies

All respondents indicated that they have ECD related policies in their departments, an increase of 22% from baseline (78%). Some of the policies include Kenya School Health Policy, Social Protection Policy, Immunization and supplementary feeding, Child Protection Policy. Ninety four percent of the respondents reported that there have been gaps in the policies and increase from baseline (70%).

Some of the gaps identified include lack of adequate finances to address the implementation of the policies and caregivers defaulting immunization cycles. These are being addressed through ongoing resource mobilization through partnerships with non-state actors and continuous sensitization of community members to ensure all children are fully immunized. In terms of support, eighty percent of the respondents have received support (baseline=50%). Seventeen percent cited limited financial resources as a prevailing gap.

> "Information has not been fully disseminated to all caregivers. To some extent human and financial resources have not been sufficient" - KII, DCS

"The shortage of rains leading to drought and famine have led to increased rates of school dropouts and child malnutrition" – KII MOH

5.2. Knowledge in Nurturing Care and Caregiver Wellbeing.

5.2.1. Responsive Caregiving

Responsive caregiving means observing and responding to children's movements, gestures, sounds and verbal requests. This protects children against injury and adversity, enables caregivers to recognize and respond to their needs, enriches learning and builds trust and social relationships. It also includes responsive feeding, which is especially important for infants who are low-weight or ill[26]. The respondents were asked about the role of male caregivers' in caregiving. There was a 7% reduction in the proportion of respondents' who understand that the male caregivers go beyond financial provision. However, there were more respondents who reported knowledge of responsive caregiving role of the father and mother from baseline (61%).

At endline, 78 percent of respondents were aware of some of the ways group facilitators could encourage caregivers to play with their children compared to 67 percent at baseline. Most mentioned the development of play materials.

"When women are pregnant they can touch abdomen and talk to unborn during infancy, look at their face while breastfeeding, smile, dance and teach them how to dance in early childhood" – KII, Nursing officer.

Forty one percent of the respondents were aware of some of the ways in which group facilitators could encourage caregivers to talk to their children majorly through mutual activities such as playing, role playing, singing.

"Talk to them from infancy, appreciate by saying good when they do something good, use of non-verbal communication by nodding or shaking head" - KII

Table 4.1: Knowledge on Responsive Caregiving.

Statement	**Baseline**	**Endline**
Caring of an infant and young child is solely the responsibility of their mother.	61%	85%
Fathers' only parental responsibility is to financially provide for their family.	100%	93%

Source: Key informant interview, 2023

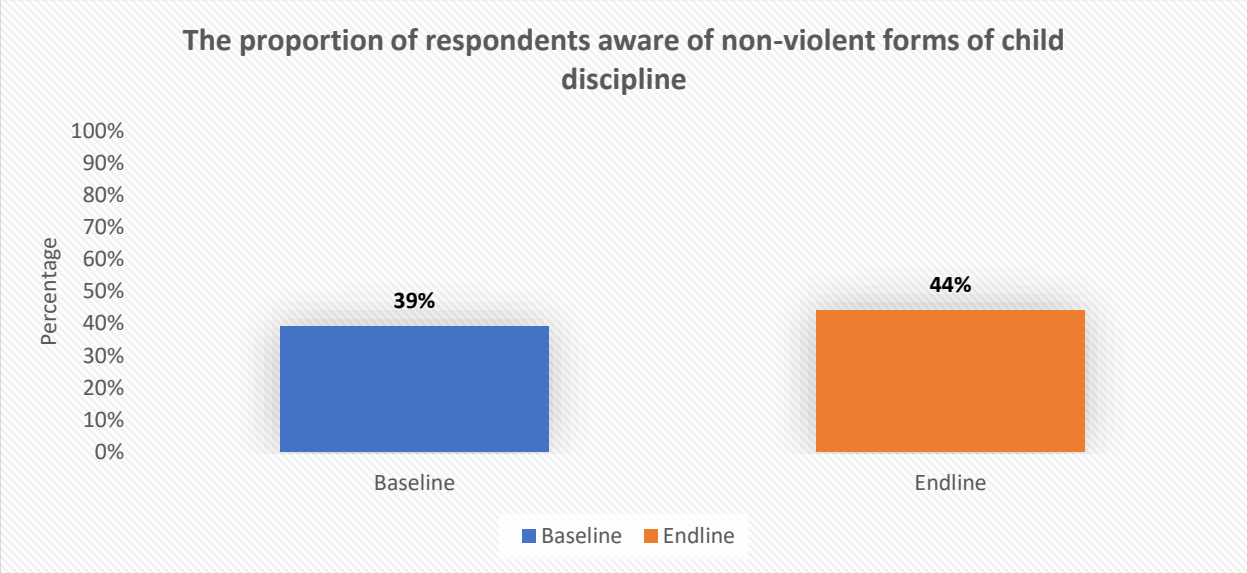
[26] The Five Components of Nurturing Care found at https://nurturing-care.org/wp-content/uploads/2020/12/The-five-components-of-nurturing-care_handbook-excerpt.pdf

5.2.2. Safety and Security

In terms of child discipline, there was marginal difference between perceptions and attitudes at baseline and endline. At endline, 44 percent of the respondents believed that it was not acceptable for a child to be scolded or hit to understand their bad behaviors compared to 39 percent at baseline. In the training conducted for implementing partners and government officers, a session on positive discipline was facilitated by the ECD Specialist. Harsh discipline such as beating, hitting, talking harshly, pinching, shaming, insulting, labelling, shouting at, should not be used on children.

Instead, caregivers should use positive approaches in instilling discipline such as: setting limits, praising or appreciating or rewarding desirable behaviours and giving child guidance on desirable behaviours.

Figure 2: Proportion of respondents aware of non-violent forms of discipline.



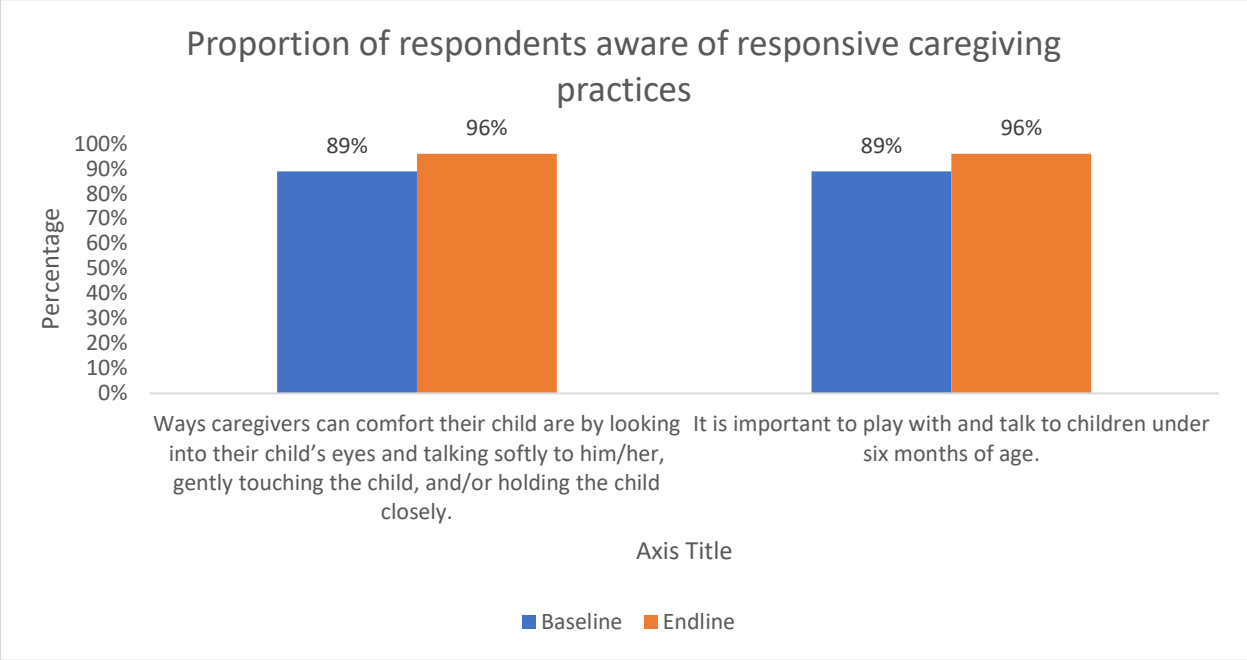
Source: Key informant interview, 2023

5.2.3. Opportunities for Early Learning

At endline, 96% of the respondents understand some of the ways caregivers could comfort their child e.g. looking into their eyes and talking softly, gently touching the child and holding them close compared to 89% at baseline).

Moreover, 96% of the respondents agree that it is important to play with and talk to children under 6 months of age compared to 89%at baseline. At this age cohort, they are less mobile and will use their senses to explore and want their caregivers as play partners (See Figure 3).

Figure 3: Respondents aware of responsive caregiving practices.



Source: Key informant interview, 2023

5.2.4. Adequate Nutrition

Almost two thirds, 56% of the respondents understand that children below 6 months should be exclusively breastfed[27] compared to 44% at baseline. Exclusive breastfeeding means that the infant feeds on breast milk only form her or his mother or expressed breast milk and no other liquids, fluids (not even water) or solids except when it is medication prescribed by the healthcare worker[28].

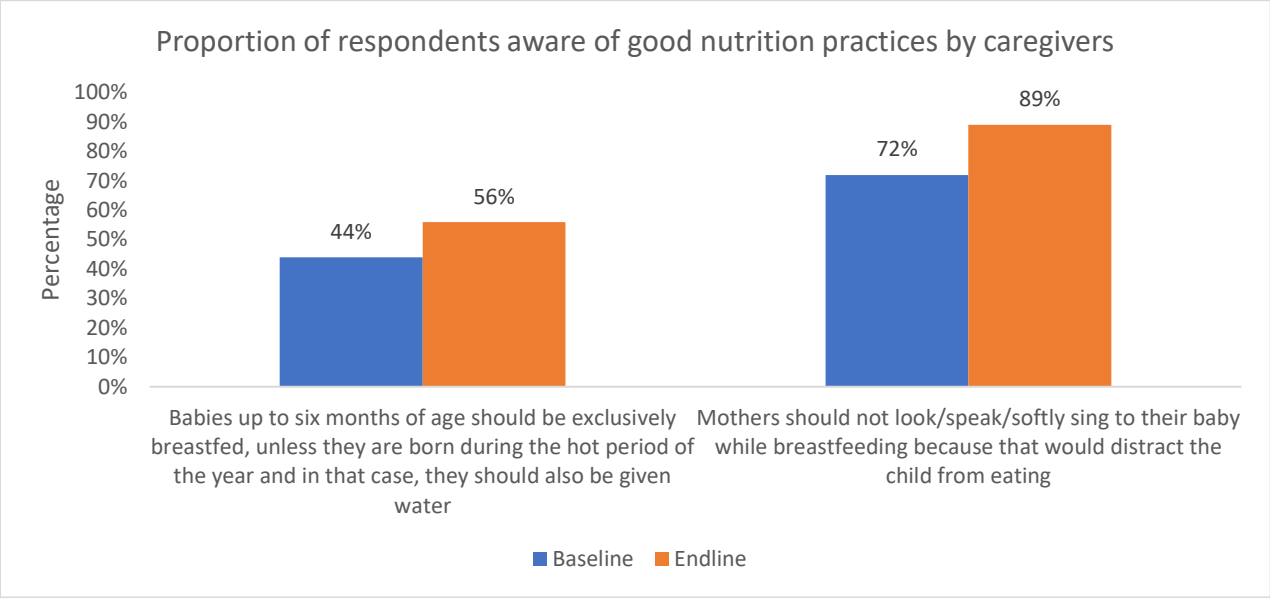
Eighty nine percent of the respondents understood that mothers can look/speak/softly sing to their baby while breastfeeding to encourage eating compared to 72% at baseline. The RPP program encouraged such activities for children under 6 months as it promotes their language and communication skills. It helps soothe them and early chance for them to hear words and recognize the caregivers face[29].

[27] means that the infant feeds on breast milk only form his/her mother or expressed breast milk and no other liquids, fluids (not even water) or solids except when it is medication prescribed by the healthcare worker.

[28] Infant and Young Child Feeding. Model chapter for textbooks for medical students and allied health professionals. World Health Organization 2009

[29] https://www.bbc.co.uk/tiny-happy-people/sing-while-feeding/zjdmjhv

Figure 4: Knowledge of Good Nutrition practices.



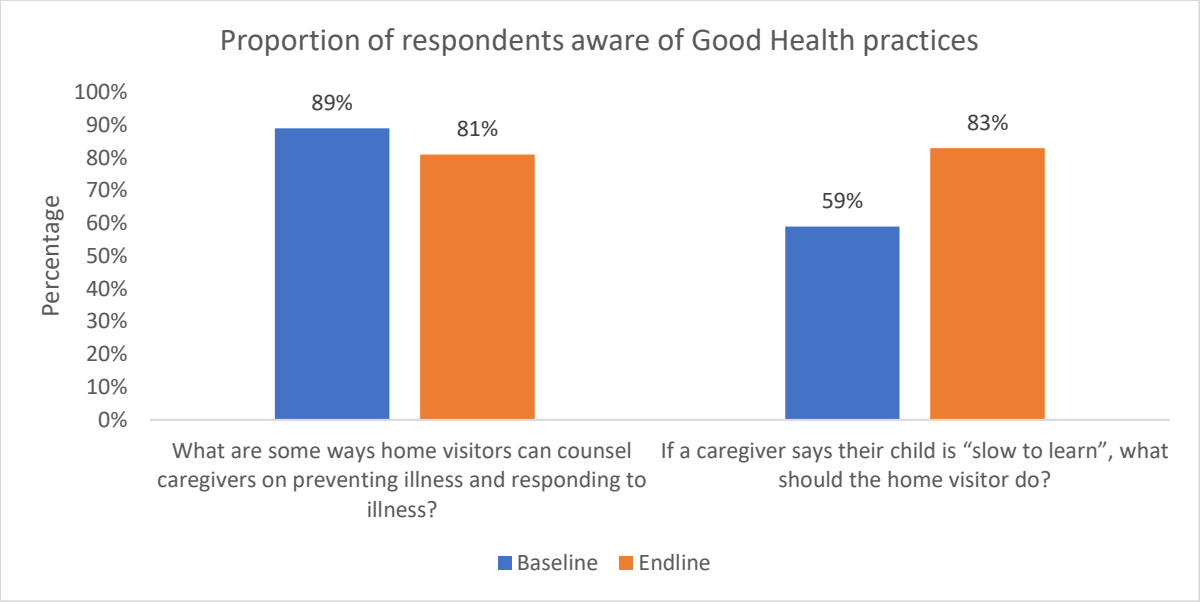
Source: Key informant interview, 2023

5.2.5. Good Health

Good health refers to the health and well-being of the children and their caregivers[30]. We know that the physical and mental health of caregivers can affect their ability to care for the child. Some of the interventions include family planning, HIV testing, prevention of mother-to-child transmission of HIV, essential newborn care including kangaroo care for small babies, immunization of mother and child, growth monitoring and counselling, promotion of health and well-being including health care seeking behaviour, prevention and treatment of childhood illness and caregiver physical and mental health problems and care for children with developmental difficulties or disabilities.

Figure 5: Government officers aware of Good Practices.

[30] https://nurturing-care.org/wp-content/uploads/2020/12/closer_look_nov.pdf

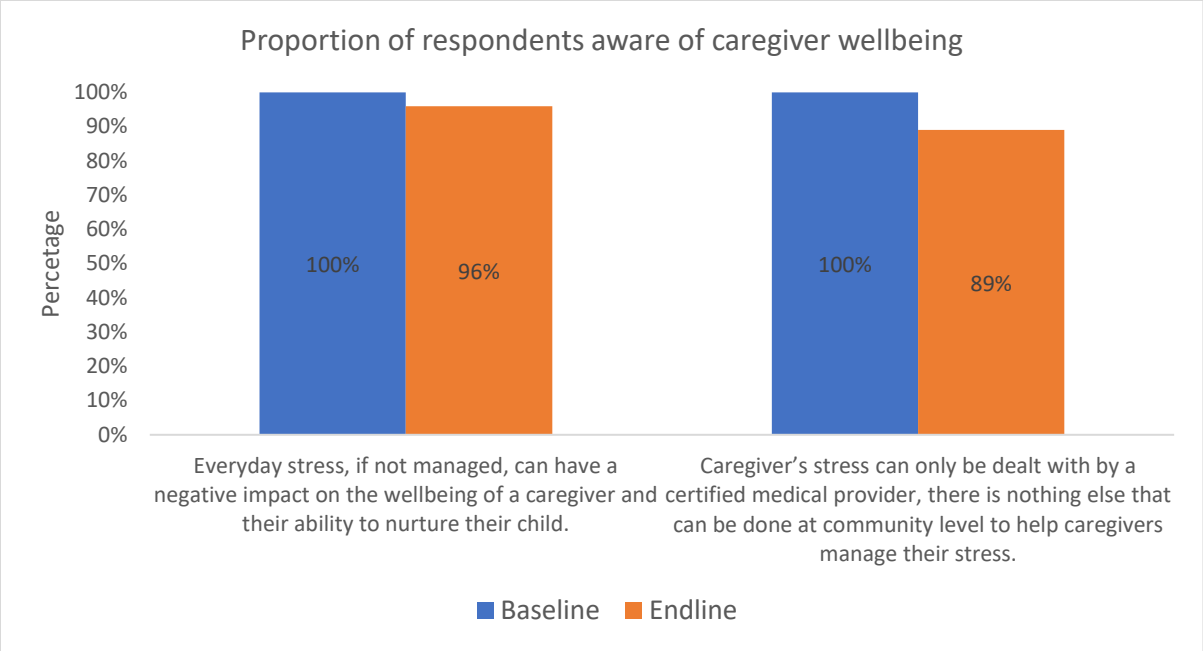


Source: Key informant interview, 2023

5.2.6. Caregiver Wellbeing

Caregivers sometimes experience challenges when caring for their children e.g. work-life balance, illnesses, financial strain, domestic violence, lack of access to services among others. Thus, they need to take care of themselves. To do this, they may need training or information on their wellbeing. According to 96% of the respondents at endline agreed that everyday stress if not managed could have a negative impact on the wellbeing of a caregiver and their ability to nurture their child, a drop from baseline (100%). However, less respondents were aware that there were services at the community level to help caregivers manage their stress beyond a certified medical provider compared to baseline (100%).

Figure 6: Government officers aware of caregiver wellbeing.



Source: Key informant interview, 2023

5.3. Group Parenting Sessions

As mentors, the respondents were assessed on their knowledge in group parenting sessions planning, facilitation and reflective supervision.

5.3.1. Components of group parenting sessions

At endline, only 7% of the respondents demonstrated full knowledge of the components[31] of the group parenting sessions from the respondents with majority mentioning key messages or topics e.g. child development, parenting/caregiver practices, health and nutrition, self-care. The respondents who responded as follows;

"Last sessions report, action planning, new topic introduction" – ***KII, MOE***

"Caregiver participation through various activities such as role playing and linking up from the previous session" – ***KII, Village elder***

5.3.2. Engagement with caregivers

[31] At least three components namely – greetings, follow up from last session, introduction of topic, practice, action planning, sharing key messages and appreciation of caregiver participation. Source: KII Answer Sheet

At endline, 52 percent of the respondents are knowledgeable on how to encourage engagement of facilitators with caregivers compared to 61 percent at baseline. Most were only aware of strategies to encourage caregivers to share experiences with each other. Few mentioned the non-verbal communication strategies such as eye contact, sitting in a circle and active listening.

5.4. Reflective supervision

Reflective supervision is a method of supervision in which a mentor supports and guides a facilitator through challenges that arise in working with caregivers. It is based on a collaborative relationship and the outcome is professional growth[32].

5.4.1. Supportive group parenting session visit.

At endline, according to 85% of the respondents, a mentor should not interrupt the facilitator to correct them in front of the caregiver compared to 100 percent at baseline. A mentor can support mentee by emphasizing or reinforcing the messages shared by mentee; providing additional information /clarification to caregivers and tactfully correcting any misinformation shared by mentee[33].

5.4.2. Purpose of Reflective Supervision

There was no change in knowledge of the purpose of reflective supervision among mentors (44% at baseline and endline). The major purpose mentioned was that the supervision enables the mentor to have overall picture of the gaps in the program and how to respond to them.

"Supports home visiting implementation quality by helping providers develop critical competencies" – KII

"Support, learning and addressing challenges" - KII

"To help the mentor in supporting and guiding facilitators through challenges arising at home in working out with children and families" - KII

[32] Rebecca Shahmoon-Shanok as cited in "A Practical Guide to Reflective Supervision."
[33] Training manual on Reflective Supervision ©January 2023.

6.Conclusion

The objectives of the Responsive Protective Parenting (RPP) program model is to increase caregivers' understanding and knowledge about the protection and optimal development needs and resources available for their infants and young children (0-5) and care for their own wellbeing; strengthen multi-sectoral sub-national government and local partners' capacity to support community stakeholders in ensuring protective and nurturing home and community environments for infant and young children and strengthen community stakeholders' knowledge, attitudes and practices on the components of nurturing care[34], caregiver well-being, and community-based child protection to support caregivers in group and home parenting sessions.

Parents and caregivers

RPP has contributed to increased perception of child safety in the Rusinga Island, Naromoru, Mwala, Migwani, Ngwatanio, Wamunyu, Maka and Masaku communities among caregivers to see their communities as safe places for their children. During one of the group parenting sessions, facilitators took the caregivers through illustrations of a healthy caregiving environment[35]. Most respondents who were affirmative were mothers and biological parents. Improvements from baseline were also generally seen when looking at different nurturing care components.

Health. When looking at **good health**, more caregivers at endline reported their child had a birth certificate and that their child was completely up to date on immunizations as compared to caregivers at baseline. The primary reason for children lacking a birth certificate or birth notification did change between baseline and endline. At baseline, the main reason provided was that the process is too complicated while at endline other reasons were provided. This may be an area where it is easier to effect change, as there are multiple different types of strategies that could make it easier for the caregivers to figure out the process to get a birth notification or birth certificate.

[34] i.e. responsive caregiving, safety and security/child protection, early learning and stimulation, health and nutrition.

[35] Peaceful environment for emotional growth, play spaces, children engaging in play activities, minimal safety risks in the environment, sanitation facilities like toilet, clean water sources, kitchen gardens, food from both animals and plants, school, police station, etc.

Nutrition. There were also improvements seen in **adequate nutrition.** Nearly all caregivers at endline with children under six months of age said their child was currently being exclusively breastfed, which was an increase from baseline. The dietary diversity of meals for children older than six months also increased, with more caregivers at endline reporting their child had more than 5 food groups daily as compared to caregivers at baseline.

Caregiving. When looking at **responsive caregiving**, fewer caregivers reported to have left their children under age 5 alone or under the supervision of another child younger than 10 years of age for more than one hour at least once during the past week. In addition, more caregivers engaged in four or more activities to provide early stimulation and responsive care in the last 3 days compared to baseline.

Learning. In terms of **opportunities for early learning**, at endline, slightly more caregivers engaged in activities that promote learning and school readiness during the last three days. More fathers engaged in these activities at endline compared to baseline. However, the mean number of activities reduced by both genders. There was a slight increase in the percentage of caregivers who said they faced challenges in caring for their children (endline: 62%; baseline: 66%). Over two-thirds of all caregivers also said that they gave children the opportunity to make choices, such as what they wanted to wear.

Safety/Security. In the **safety and security** component, there was increased caregiver knowledge regarding infant and child abuse and knowledge of children's rights. Eighty six percent of caregivers at endline were able to provide a definition of child abuse. Almost all caregivers were aware of what to do in instances of child harm or abuse. Similarly, almost all caregivers said they were aware of children's rights at endline.

Community support structures

There has been increased knowledge in **responsive caregiving** practices among the mentors and group facilitators. 97% were aware of the ways caregivers could comfort their children by looking into their eyes and talking softly to him/her, gently touching the child, and/or holding them closely. In addition, they know that parental responsibility belonged to both the father and mother.

In terms of **safety and security,** more facilitators/mentors were aware that harsh discipline such as beating, hitting, talking harshly, pinching, shouting at should not be used on children. Instead, caregivers should spend more time encouraging wanted behaviors.

Furthermore, facilitators understood that the child's movement and play activities with the caregivers were natural ways that provide opportunities to interact with the child, stimulate the child's brain and develop a relationship with their caregivers. This promotes opportunities for early learning.

In terms of **adequate nutrition,** there was no change in the level of awareness of exclusive breastfeeding for children under 6 months. However, more facilitators were aware of caregiver's activities to facilitate child's interest during breastfeeding, these include look/speak/softly sing to their baby.

For **good health,** more facilitators were aware of how they could counsel caregivers on preventing and responding to illness including medical referrals for growth monitoring for children with development delays such as being "slow to learn". Others mentioned the correlation between caregiver wellbeing and child health thus parents should have enough rest and avoid rest.

In terms of knowledge of **group parenting session planning**, more facilitators were aware of the items they should bring with them to each session such as attendance list, examples of toys/items children can play with, visual discussion cards. Others mentioned notebooks, pens, progress report forms, snacks, food. fruits, learning aids such as charts. For the **facilitation** of the sessions, more facilitators are knowledgeable on linking sessions, use of visual aids, explaining key messages using non-technical language and involving caregivers in sharing knowledge with each other through engagement strategies.

Multi-sectoral sub-national government

The findings revealed that the RPP model increases the sub national government support for stablishing and maintaining a nurturing and protective environment for infants and young children through planning and policy development. From the KIIs, all respondents indicated that they have ECD related policies in their departments, an increase of 22% from baseline (78%). Some of the policies include Kenya School Health Policy, Social Protection Policy, Immunization and supplementary feeding, Child Protection Policy. However, there have been gaps in the implementation of the policies. These include lack of adequate finances to address the implementation of the policies. These are being addressed through ongoing resource mobilization through partnerships with non-state actors. In terms of support, eighty percent of the respondents have received support (baseline=50%).

In terms of knowledge in nurturing care components, for **responsive caregiving**, there was a reduction in the proportion of the respondents aware that the male caregivers responsibility goes beyond financial provision. However, there were more respondents who reported knowledge of responsive caregiving role of the father and mother from baseline (61%). At endline, 78 percent of respondents were aware of some

of the ways group facilitators could encourage caregivers to play with their children compared to 67 percent at baseline.

For **safety and security**, there was marginal difference between perceptions and attitudes at baseline and endline. At endline, 44 percent of the respondents believed that it was not acceptable for a child to be scolded or hit to understand their bad behaviours compared to 39 percent at baseline. The **opportunities for early learning**, 96% of the respondents understand some of the ways caregivers could comfort their child e.g. looking into their eyes and talking softly, gently touching the child and holding them close compared to 89% at baseline.

For **nutrition** almost two thirds, 56% of the respondents understand that children below 6 months should be exclusively breastfed[36] compared to 44% at baseline. Exclusive breastfeeding means that the infant feeds on breast milk only form her or his mother or expressed breast milk and no other liquids, fluids (not even water) or solids except when it is medication prescribed by the healthcare worker[37]. Eighty nine percent of the respondents understood that mothers can look/speak/softly sing to their baby while breastfeeding to encourage eating compared to 72% at baseline. For **good health**, 83% are aware of the actions a group parenting facilitator should take when a caregiver says their child is slow to learn compared to 59% at baseline.

In terms of **caregiver wellbeing**, 96% of the respondents at endline agreed that everyday stress if not managed could have a negative impact on the wellbeing of a caregiver and their ability to nurture their child, a drop from baseline (100%). However, less respondents were aware that there were services at the community level to help caregivers manage their stress beyond a certified medical provider compared to baseline.

For **reflective supervision**, 85% of the respondents are knowledgeable that a mentor should not interrupt the facilitator to correct them in front of the caregiver compared to 100 percent at baseline. A mentor can support mentee by emphasizing or reinforcing the messages shared by mentee; providing additional information /clarification to caregivers and tactfully correcting any misinformation shared by mentee[38]. There was no change in knowledge of the purpose of reflective supervision among mentors (44% at baseline and endline). The major purpose mentioned was that the supervision enables the mentor to have overall picture of the gaps in the program and how to respond to them.

---

[36] means that the infant feeds on breast milk only form his/her mother or expressed breast milk and no other liquids, fluids (not even water) or solids except when it is medication prescribed by the healthcare worker.

[37] Infant and Young Child Feeding. Model chapter for textbooks for medical students and allied health professionals. World Health Organization 2009

[38] Training manual on Reflective Supervision ©January 2023.

7.Acronyms and Abbreviations

ARI	Acute respiratory infection
BCG	Bacille Calmette Guerin
DPT	Diphtheria Pertussis Tetanus
ECD	Early Childhood Development
ECDI	Early Childhood Development Index
ECDP	Eastern Community Development Program
HH	Household
IP	Implementing Partner
IYC	Infants and young children
LRDP	Lake Region Development Program
M&E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Survey
MNCH	Maternal and Newborn Child Health
PCDP	Pioneer Child Development Program
PPI	Poverty Probability Index
PM	Program Model
RPP	Responsive Protective Program
NGO	Non-Governmental Organization
UNICEF	United Nations Children Fund
WASH	Water Sanitation and Hygiene
CSS	Community Support Structures
ECD	Early Childhood Development
IP	Implementing Partner
IYC	Infants and Young Children
KAP	Knowledge Attitude and Practice
MEL	Monitoring Evaluation Learning
PM	Program Model
RPP	Responsive Protective Parenting
SPSS	Statistical Package for Social Sciences
TOT	Trainer of Trainers
WASH	Water Sanitation and Hygiene

8. References

1. Plan International (March 2020), Handbook for Community Birth Registration in Kenya. Retrieved from https://plan-international.org/uploads/sites/26/2022/02/kenya_handbook_for_community_led_birth_registration.pdf
2. Sample size calculation using Cochrans formula via https://www.statisticssolutions.com/sample-size-5/
3. Grantham-McGregor S, Cheung YB, Cueto S, Glewwe P, Richter L, Strupp B, et al. Developmental potential in the first 5 years for children in developing countries. Lancet. 2007;369(9555):60–70.
4. Why Read Aloud with Your Child? *Brain development, knowledge, language, love of reading, bonding, literacy skills – you name it! By* Zara Sargsyan (June 2020) retrieved from https://www.unicef.org/armenia/en/stories/why-read-aloud-your child#:~:text=From%20birth%20to%20the%20age,discover%20different%20sounds%20and%20phonics.
5. UNICEF Care for Child Development via https://www.unicef.org/media/91176/file/3-CCD-Participant-Manual.pdf
6. Grossman, DC. 2000. The History of Injury Control and the Epidemiology of Child and Adolescent Injuries. The Future of Children, 10(1): 23-52.
7. Washington Group/UNICEF Module on Child Functioning, finalized in 2016, covers children between 2 and 17 years of age.
8. BBC article: Why should you sing while feeding your baby? Retrieved from https://www.bbc.co.uk/tiny-happy-people/sing-while-feeding/zjdmjhv
9. Infant and Young Child Feeding. Model chapter for textbooks for medical students and allied health professionals. World Health Organization 2009
10. Nurturing Care for Early Childhood Development: A closer look at components of nurturing care. (December, 2020). Retrieved from https://nurturing-care.org/wp-content/uploads/2020/12/closer_look_nov.pdf
11. Rebecca Shahmoon-Shanok. A Practical Guide to Reflective Supervision."
12. The Five Components of Nurturing Care found at https://nurturing-care.org/wp-content/uploads/2020/12/The-five-components-of-nurturing-care_handbook-excerpt.pdf
13. Training manual on Reflective Supervision ©January 2023.

9.Annexes

9.1. Monitoring and Evaluation matrix

Result Area	Indicator	Baseline	Endline	MoV	Frequency of Gathering Data	Responsible
Goal: Infants and Young Children (0-5) to have improved age-appropriate development and early learning outcomes and be protected at home and in their communities.						
Specific Objective 1: Strengthened capacity of local partners and governments to support community stakeholders in ensuring protective, nurturing and stimulating home and community environments for IYC.	% sub-national government and local partner staff that shows support for establishing and maintaining protective and nurturing home and community environments for IYC, disaggregated by stakeholder type	78% of government departments have ECD policies	100% of government departments have ECD policies	Collection (or Identification) of drafted plans/policies /strategies (endline)	Twice- Baseline and Endline	External consultant
	% of partners with improved knowledge across nurturing care components, disaggregated by gender, partner type and component of nurturing care.	Nutrition:44%, Early Learning:89% Security & Safety:39% Good Health: 79% Caregiving:80.5%	Nutrition:56% Early Learning:96% Security & Safety:44% Good Health: 82% Caregiving:89%	Key Informant Interview Tool Government	Twice – Baseline and Endline	External consultant
	% of partners with improved knowledge on reflective supervision, disaggregated by gender and partner type	100%	85%	Key Informant Interview Tool Government	Twice – Baseline and Endline	External consultant
	% of partners with improved knowledge on the importance of caregiver well-being, disaggregated by gender and partner type	100% of government officers know caregiver wellbeing is important	92.25% of government officers know caregiver wellbeing is important	Key Informant Interview Tool Government	Twice – Baseline and Endline	External consultant
Specific Objective 2: Strengthened capacity of Community stakeholders in	% communities that shows support for establishing and maintaining protective and nurturing home and community	0	3[39]	Collection (or Identification) of drafted plans/policies	Twice – Baseline and Endline	External consultant

[39] Community based child protection mapping action planning conducted in select villages in Eastern (Kiandani), Pioneer (Timau) and Lake Region (Bogambero)

fostering protective and nurturing community environments, and support parents/caregivers in the protection and nurturing care of their infants and young children 0- 5	environments for IYC, disaggregated by stakeholder type, gender			/strategies (endline)		
	% of community leaders and/or CSS stakeholders with increased knowledge on nurturing care, and CBCP, disaggregated by stakeholder type and gender.	Responsive caregiving: 76.8% Early Learning:34% Adequate Nutrition:81% Good Health:24% Safety and Security:25%	Responsive caregiving: 91.5% Early Learning:70.5% Adequate Nutrition:85% Good Health:28.5% Safety and Security:73%	Knowledge Attitude Practice (KAP) Survey for Facilitators	Twice – Baseline and Endline	External consultant
	% of community leaders and/or CSS stakeholders with increased knowledge in facilitation parenting session planning, and reflective supervision (disaggregated by stakeholder type and gender)[40]	49.75%	83%	Knowledge Attitude Practice (KAP) Survey for Group Facilitators	Twice – Baseline and Endline	External consultant
Specific Objective 3: Parents/caregivers have increased understanding and knowledge about the protection and optimal development needs and resources available for their infants and young children (0-5), and care for their own wellbeing.	% of caregivers who report their community is a safe place for children, disaggregated by respondent type & gender	44.7% (F:43.6% M:1.1%) Biological parents=40.3% Grandparents=4.1%	89.3% (M:3% F:86.4%) Bio/adopted parents =72.8% Grandparents=16.3%	Caregiver questionnaire	Twice – Baseline and Endline	External consultant
	% of primary caregivers of children 0-5 with improved knowledge on nurturing care components, disaggregated by topic, caregiver's gender	Good Health:63% Adequate Nutrition: 75% Responsive Caregiving:33% Opportunities for Early Learning:23% Safety and Security:48%	Good Health:76% Adequate Nutrition:96.8% Responsive Caregiving:43% Opportunities for Early Learning:47% Safety and Security:68%	Caregiver questionnaire	Twice – Baseline and Endline	External consultant
	% of primary caregivers who report leaving children alone or in the care of another child aged 10 or younger for more than 1 hour in the past week disaggregated by gender	49.1% (F:45.6% M:52.6%)	36.1% (M:42.6% F:30%)	Caregiver questionnaire	Twice – Baseline and Endline	External consultant

[40] Indicators calculated by averaging the variables under group parenting session planning, delivery.

	% of primary caregivers engaged in 2 or more early stimulation activities with their child 0-5 in the past 3 days (i.e. singing, playing with toys or household objects, reading, telling stories, etc.), disaggregated by gender	35.9% (F:35% M:36.8%)	41.5% (M:43.8% F:39.2%)	Caregiver questionnaire	Twice – Baseline and Endline	External consultant
	% of caregivers who engaged in positive method of parenting (and do not recur to violent forms of discipline) with their children 0-5 in the past month, disaggregated by gender	23.4% (F:24.6% M:22%)	80.9% (M:81.7% F:80%)	Caregiver questionnaire	Twice – Baseline and Endline	External consultant

9.2. Updated RPP Global Program Model Outcome Objectives, Evaluation Questions and Key Indicators

Program Model Intervention Strategy	Objective	Evaluation Questions	Key Outcome Indicators	Baseline	Endline
I**. Training of sub-national government and local partners**	Strengthened capacity of local partners and governments to support community stakeholders in ensuring protective, nurturing and stimulating home and community environments for IYC.	1.Does the RPP model increase LP's and sub national govt's support for establishing and maintaining a nurturing and protective environment for IYC? 2.Does the RPP model increase sub national government and local partners' knowledge in nurturing care and caregiver wellbeing? 3.Does the RPP model increase sub national government and local partners' knowledge on reflective supervision?	% sub-national government and local partner staff that shows support for establishing and maintaining protective and nurturing home and community environments for IYC, disaggregated by stakeholder type % of partners with improved knowledge across nurturing care components, disaggregated by gender, partner type and component of nurturing care % of partners with improved knowledge on reflective supervision, disaggregated by gender and partner type % of partners with improved knowledge on the importance of caregiver well-being, disaggregated by gender and partner type	78% have policies on ECDE Nutrition:44%, Early Learning:89% Security & Safety:39% Good Health: 79% Caregiving:80.5% 100% 100%	100% have policies on ECDE Nutrition:56% Early Learning:96% Security & Safety:44% Good Health: 82% Caregiving:89% 85% 92.25%
II. Training of community stakeholders and support services (facilitators and mentors)	Strengthened capacity of Community stakeholders in fostering protective and nurturing community environments, and support parents/caregivers in the protection and nurturing care	1.Does the RPP model increase communities' support for establishing and maintaining a nurturing and protective environment for IYC? 2.Does the RPP model increase mentors' and CSS's knowledge in nurturing care and caregiver wellbeing?	% communities that shows support for establishing and maintaining protective and nurturing home and community environments for IYC, disaggregated by stakeholder type, gender % of community leaders and/or CSS stakeholders with increased knowledge on nurturing care, and CBCP, disaggregated by stakeholder type and gender.	0 Responsive caregiving: 76.8% Early Learning:34% Adequate Nutrition:81% Good Health:24%	3 CBCPM Action Plans Responsive caregiving: 91.5% Early Learning:70.5% Adequate Nutrition:85% Good Health:28.5%

Program Model Intervention Strategy	Objective	Evaluation Questions	Key Outcome Indicators	Baseline	Endline
	of their infants and young children 0-5.			Safety and Security:25%	Safety and Security:73%
		3.Does the RPP model increase mentors' and CSS's knowledge in facilitation parenting session planning, and reflective supervision?	% of community leaders and/or CSS stakeholders with increased knowledge in facilitation parenting session planning, and reflective supervision (disaggregated by stakeholder type and gender)	49.75%	83%
III. Caregivers-positive parenting, violence prevention, and well-being	Parents/caregivers have increased understanding and knowledge about the protection and optimal development needs and resources available for their infants and young children (0-5), and care for their own's wellbeing.	1.Does the RPP model lead caregivers to see their communities as safe places for their children?	% of caregivers who report their community is a safe place for children, disaggregated by respondent type, gender & engagement type[41]	44.7% (F:43.6% M:1.1%) Biological parents=40.3% Grandparents=4.1%	89.3% (M:3% F:86.4%) Bio/adopted parents =72.8% Grandparents=16.3%
		2.Does the RPP model increase caregivers' knowledge in nurturing care and protection of IYC?	% of primary caregivers of children 0-5 with improved knowledge on nurturing care components, disaggregated by topic, caregiver's gender & engagement type	Good Health:63% Adequate Nutrition: 75% Responsive Caregiving:33% Opportunities for Early Learning:23% Safety and Security:48%	Good Health:76% Adequate Nutrition:96.8% Responsive Caregiving:43% Opportunities for Early Learning:47% Safety and Security:68%
		3.What nurturing care and protection practices (behavior) of caregivers are enhanced by the RPP-PM?	% of primary caregivers who report leaving children alone or in the care of another child aged 10 or younger for more than 1 hour in the past week	49.1% (F:45.6% M:52.6%)	36.1% (M:42.6% F:30%)

[41] By engagement type it is meant home visits only, group parenting sessions only, and both home visits and group parenting sessions.

Program Model Intervention Strategy	Objective	Evaluation Questions	Key Outcome Indicators	Baseline	Endline
			disaggregated by gender & engagement type % of primary caregivers engaged in 2 or more early stimulation activities with their child 0-5 in the past 3 days (i.e. singing, playing with toys or household objects, reading, telling stories, etc.), disaggregated by gender & engagement type. % of caregivers who engaged in positive method of parenting (and do not recur to violent forms of discipline) with their children 0-5 in the past month, disaggregated by gender engagement type	35.9% (F:35% M:36.8%) 23.4% (F:24.6% M:22%)	41.5% (M:43.8% F:39.2%) 80.9% (M:81.7% F:80%)