Endline evaluation report:
Assuring the essentials of optimal development for children affected by HIV and AIDS in Kenya and Zambia

September 2018

Acknowledgements

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List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CBO	Community-based organization
CCDA	Chibombo Child Development Agency
CHV	Community health volunteer
CSS	Community support structure
DCS	Department of Children's Services
ECD	Early childhood development
FGD	Focus group discussion
HIV	Human Immunodeficiency Virus
KCDA	Kafue Child Development Agency
KDP	Kisumu Development Program
KII	Key informant interview
LVSCP	Lake Victoria Child Support Program
M&E	Monitoring and evaluation
MCWC	Mukuru Child Wellness Centre
MOH	Ministry of Health
NGO	Non-government organization
NIP	Nairobi Integrated Program
PEPFAR	President's Emergency Plan for AIDS Relief
PQR	Program quality reflection
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Executive Summary

Background

According to recent data published by the United Nations Children's Fund (UNICEF, 2018), as of 2017 approximately 12.2 million children worldwide have lost one or both parents to AIDS, and more than 75% of these children live in Sub-Saharan Africa. In addition to obstacles related to physical and psychosocial wellbeing faced by children orphaned due to any cause, children orphaned by AIDS are at an especially heightened risk of malnourishment, abuse and exploitation, stigmatization, illiteracy, lack of education and school drop-out, medical neglect, not being immunized, and psychosocial distress (Cluver, Orkin, Boyes, Gardner, & Meinck, 2011; Cluver, Orkin, Boyes, Gardner, & Nikelo, 2012; Guo, Li, & Sherr, 2012; Sachs & Sachs, 2004). In addition to children orphaned by AIDS, many more children have been made vulnerable due to family illness and the widespread impact of HIV/AIDS on their communities (President's Emergency Plan for AIDS Relief [PEPFAR], 2009).

Figure 1. Assuring the essentials of optimal development for children affected by HIV and AIDS.

Considering the high prevalence of HIV and AIDS and the vulnerability of children in both Kenya and Zambia, ChildFund International, supported by the Conrad N. Hilton Foundation, implemented a project known as, "Assuring the Essentials of Optimal Development for Infants and Young Children Affected by HIV and AIDS in Kenya and Zambia." The aim of the project was that children aged 0-5 years in communities affected by HIV and AIDS meet their developmental milestones while being supported by responsive men and women caregivers (ChildFund, 2016) and was guided by three overarching objectives (see Figure 1).

Program Description

Implemented from January 2016 to July 2018, the project employed a community-based model, involving ChildFund providing technical support to partner community-based organizations (CBOs). The CBOs worked directly with communities to identify and build the capacities of caregivers part of existing community groups, known as community support structures (CSS), at the household-level and in community groups through home visiting sessions and/or group parenting sessions. The WHO/UNICEF (2012) Care for Child Development (CCD) package was used in conducting home visits, and in Kenya, PATH's ECD Counseling Cards were also used. An adapted curriculum comprising of the CCD package and the Essential Package for Children and Caregivers Affected by HIV/AIDS (EP; CARE International, Save the Children, & the Consultative Group on Early Childhood Care and Development, 2012) were used to hold group caregiving sessions.

Description of the Endline Evaluation

The purpose of the endline evaluation was to evaluate the impact of the project, "Assuring the Essentials of Optimal Development for Children affected by HIV and AIDS in Kenya and Zambia." Guided by the three overarching objectives of the project, the evaluation sought to answer the following research questions:

Objective 1

- RQ 1.1: How were vulnerable households with children aged 0-5 engaged with the initiative?
    - RQ 1.1.a: Did vulnerability of households change over time*?*
    - RQ 1.1.b: Were caregivers satisfied with their participation in the initiative?
- RQ 1.2: As a result of the current initiative, how did caregivers' knowledge and practices regarding the following areas change: 1) stimulation and responsive care; and 2) other aspects of their children's development?
- RQ 1.3: How did caregivers' current access and barriers to stimulation and responsive care services linked to HIV and AIDS change over the course of the initiative?

Objective 2

- RQ 2.1: What was the knowledge of the various stakeholders (ChildFund, Partner CBOs, government partners, identified community mentors, facilitators from existing community support structures) regarding: 1) foundational ECD topics; 2) competencies in executing home and group parenting sessions; and 3) reflective supervision?
- RQ 2.2: What project processes and tools facilitated project quality and expected caregiver outcomes and impact?

Objective 3

- RQ 3: What was the role of ChildFund (and Partner CBOs) in engaging government partners to 1) build capacity; and 2) influence the take-up of services on stimulation and responsive care?

A mixed methods approach was adopted, integrating both qualitative and quantitative approaches. Quantitative data was collected through household surveys and household observations. Qualitative data was collected through focus group discussions with caregivers and CSS facilitators, in-depth interviews with caregivers, and key informant interviews with county government officials, mentors, facilitators, CSS facilitators and ChildFund officials, and CBO partner ECD project officers.

To answer the first three research questions, descriptive analyses were conducted of the quantitative data from the household survey and observations and chi-square analyses or ANOVAs, as appropriate, were conducted to make comparisons between countries or program type. Where applicable, baseline and endline comparisons were made. To answer the latter three research questions, qualitative data from the focus group discussions, in-depth interviews, and key informant interviews were examined and common themes extracted.

667 caregivers of children aged 0-5 (334 from Zambia, 333 from Kenya) participated in the Household Survey. In 84% of households, the mother was the sole primary caregiver and 95% of primary caregivers were female. The majority of primary caregivers fell in the 25-35 year age range (50%), followed by the 36-49 year age range (22%) and 18-24 year age range (20%). In terms of primary caregiver education, the largest percentage completed upper primary school (43%), followed by some secondary school (24%). There were an average of 6 people living in the household (*M* (*SD*) = 5.95 (2.49), Range: 1-18 people) and an average of 2 children aged five and under (*M* (*SD*) = 1.51 (.68), Range: 1-5 children). Additionally, a total of 20 focus group discussions were conducted (12 in Zambia, 8 in Kenya), 24 in-depth interviews (8 in Zambia, 16 in Kenya), and 49 key informant interviews (20 in Zambia, 29 in Kenya)

Key Findings

Caregivers were generally satisfied with the initiative. Generally, caregivers reported being satisfied with their participation in the initiative, with the majority of caregivers generally providing ratings of “very good” or “excellent” regarding the group facilitator/home visitor, the services and information delivered by the project, and how the project assisted the caregiver in finding his/her own solutions to household problems.

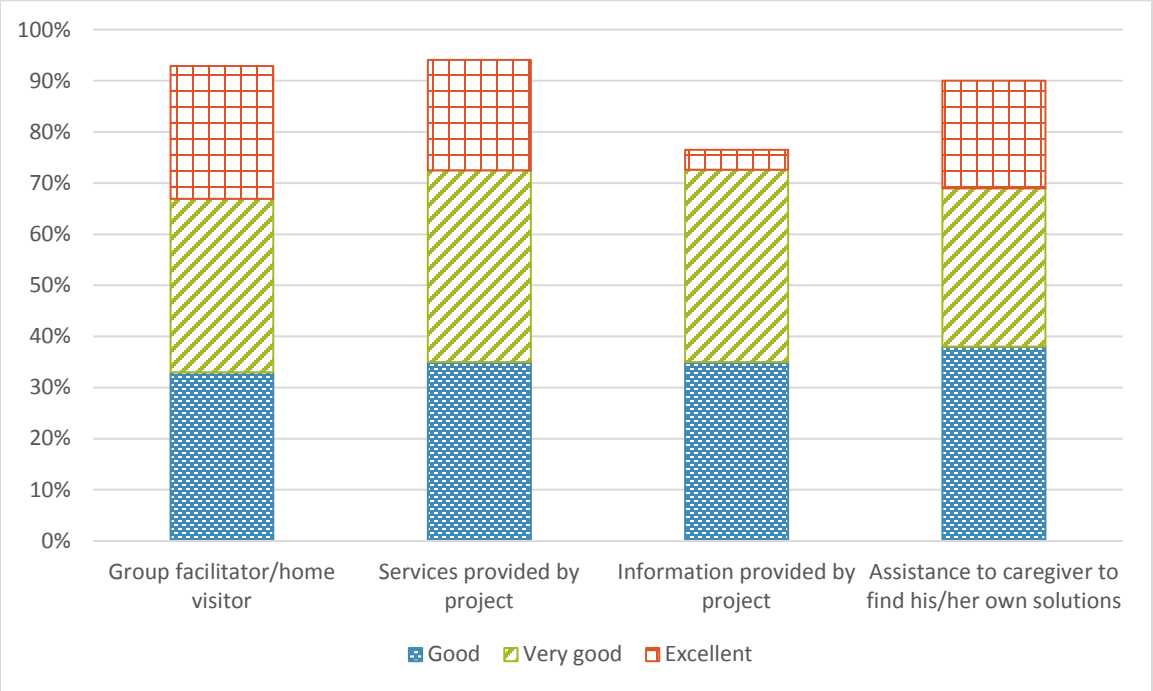

Figure 2. Caregiver ratings of their participation in the initiative.

Caregiver participation in the program differed depending on whether they participated in group sessions or home visits. There were differences in the types of sessions caregivers participated in and, correspondingly, some differences in what caregivers reported learning. In Kenya, the majority of caregivers participated in group parenting sessions, while in Zambia the majority of caregivers participated in home visiting sessions. Not surprisingly, the majority of caregivers in Kenya reported they received information from group parenting sessions while their counterparts in Zambia reported home visiting sessions. Additionally, home visitors in Kenya were community health workers and may have emphasized health and nutrition more, perhaps leading to more caregivers in Kenya reporting nutrition, health, and water, sanitation, and hygiene as topics learned more often than caregivers in Zambia, while more caregivers in Zambia participated in home visits or both group and home sessions, were play and communication and early stimulation messages were more emphasized due to the CCD curricula.

Positive change was seen in caregivers' practices. In this study, at endline, caregivers most frequently reported learning about health, nutrition, and play and communication in the group parenting and home visit sessions and also reported that these topics were the most important ones learned about in these sessions. Reassuringly, there were some gains made over the course of the project period in these areas. Across all sites, in aggregate, 92% of caregivers responded that the group parenting sessions/home visits influenced how they care for their child. 59% said that they now play more with their child, while 50% said that their child now has play toys. Other areas of change include spending more time with their child (46%), communicating with their child (41%), using positive discipline with their child (39%), and taking their child to the health facility immediately if the child becomes ill (33%). Other changes mentioned by caregivers also include feeding children appropriately, the ability to read children's emotions, and not harassing children.

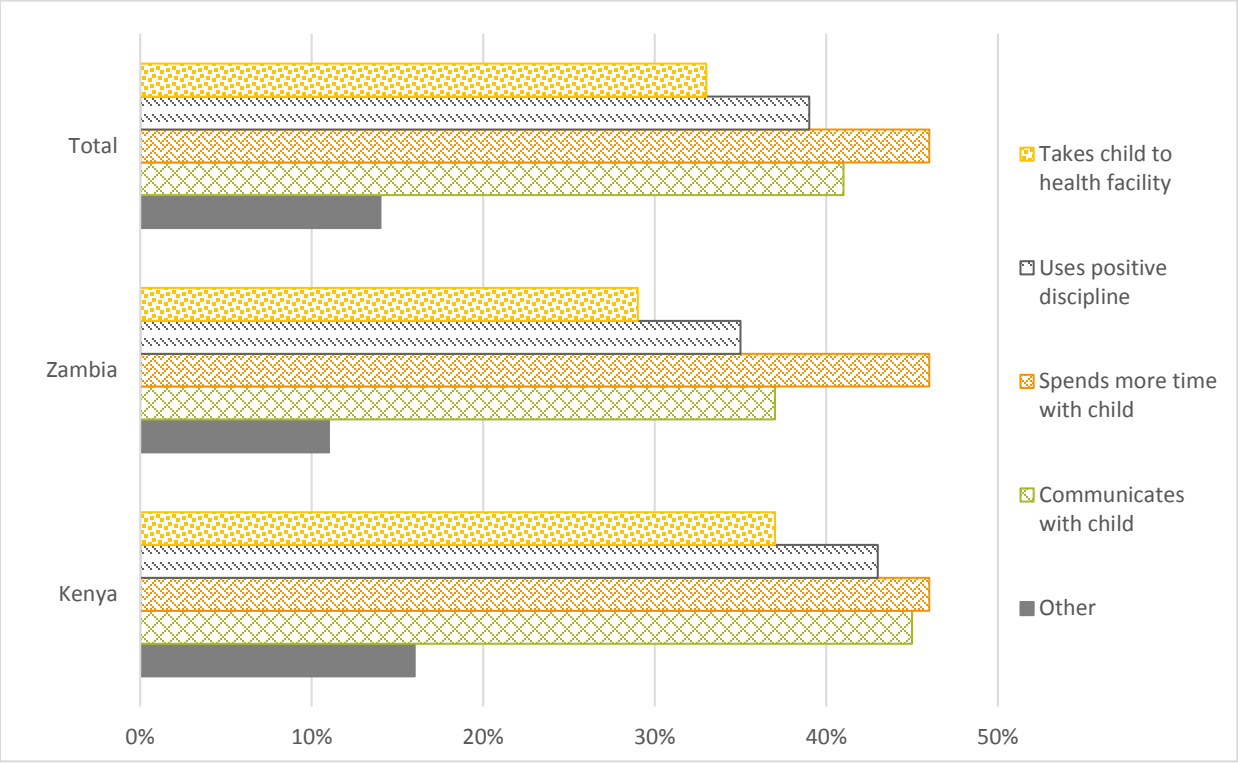

Figure 3. Caregiver-reported changes in interactions with children post-training.

For example, in the area of health, there was a 13% increase in the percentage of children born in primary care facilities at endline as well as a 9% decrease in children born at home (Figure 2). This is particularly important because children's access to ECD-related services begins at birth, if not prenatally. Being born in a health care facility makes it easier not only for children to receive medical interventions at birth or soon thereafter if needed, thereby hopefully avoiding infant mortality, but it also makes it easier for caregivers also to access ECD-related services for their children.

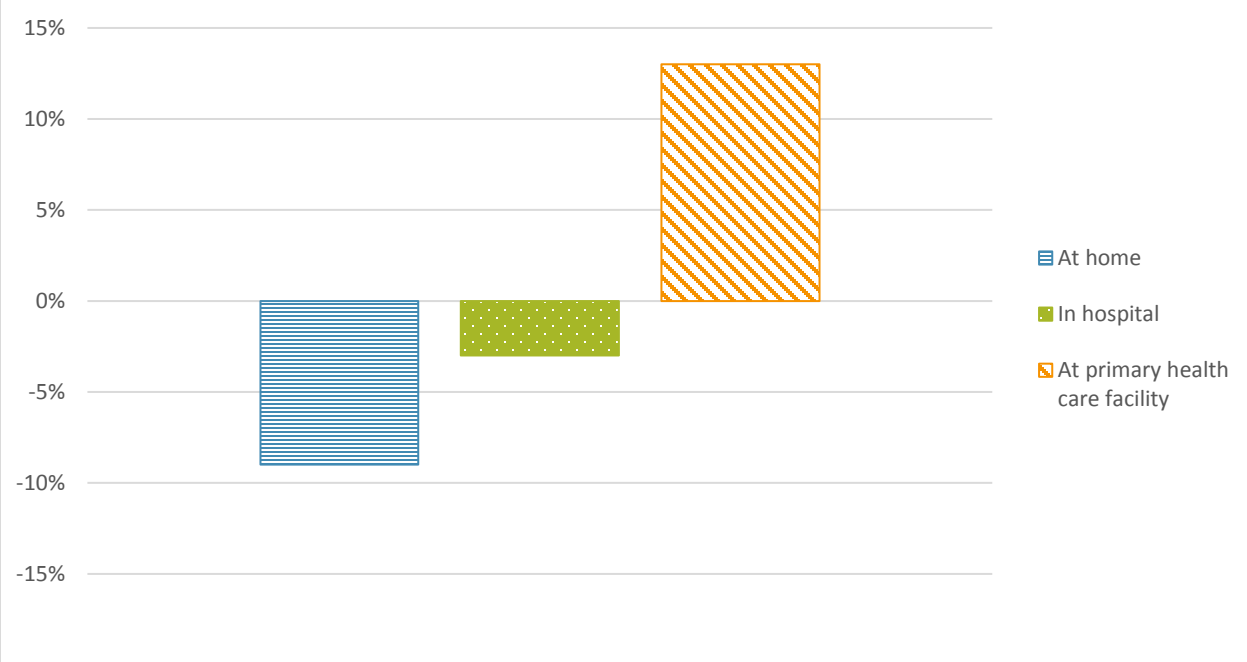

Figure 3. Percent change in location of child births, baseline vs. endline.

Play and communication was a particularly important domain for caregivers. After participating in the project, 93% of caregivers reported providing toys and objects for the child to play with and 91% provided opportunities for the child to interact with others. As a result of play, caregivers reported strengthened positive relationships with their children, as well as positive changes in the caregiver's behavior, specifically with regard to their perception concerning children and discipline. Most caregivers reported that they abandoned negative forms of discipline and adopted positive forms of discipline as a result of a strengthened bond between the child and caregiver. At baseline, 55% of caregivers mentioned some form of violence in their responses. At endline, when looking at the aggregate data, 22% of caregivers mentioned shaking, spanking, or slapping their child and 6% mentioned pulling the child's ear or pinching the child, which is a decrease from baseline. While at baseline, 45% of caregivers mentioned verbal discipline when punishing their child, at endline only 12% of caregivers report the same. Caregivers, in turn, reported varied observed positive changes in their children as a result of engaging their children in different forms of play.

Other areas where there is self-reported change in caregivers' behaviors are in the domains of child safety and protection, hygiene practices, and nutrition – all areas where

caregivers report receiving training. Of note, caregivers' child protection knowledge largely came from only the CSS. For instance, improvements are seen in nearly all areas of household environmental safety (Figure 4). The biggest decreases were regarding open rubbish or other pits and unprotected fire. At baseline, 53% of households were observed to have rubbish while this decreased to 35% at endline. Also at baseline, 35% of households were observed to have unprotected fire as compared to 12% of households at endline. The only exception was open or damaged drainage/stagnant water, with 22% of households at baseline having this problem and 26% at endline.

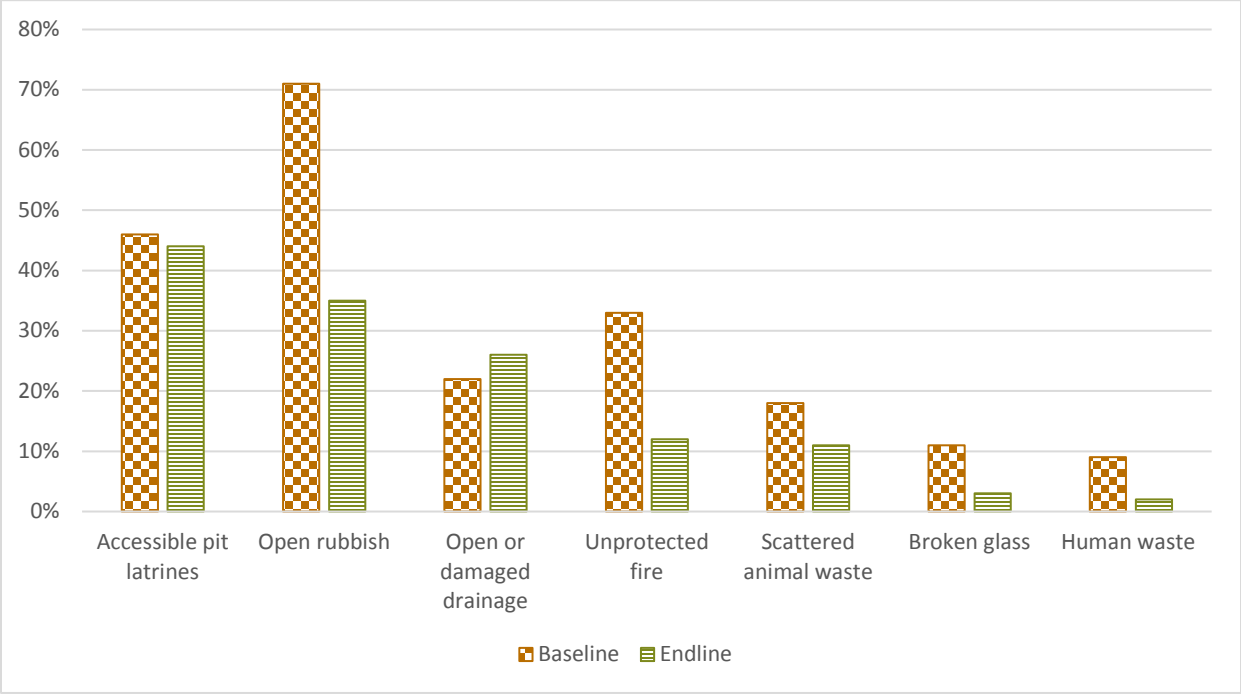

Figure 4. Observed issues with household environmental safety, baseline vs. endline.

Caregivers reported improved access to ECD-related services. Generally, half or more of caregivers reported that they did not have problems in accessing ECD-related services at endline and fewer caregivers reported difficulty in accessing these services at endline as compared to baseline. The greatest decrease was seen in nutrition support services while the smallest decrease was seen in early learning services, with 44% and 29%, respectively, fewer caregivers reporting obstacles to accessing these services.

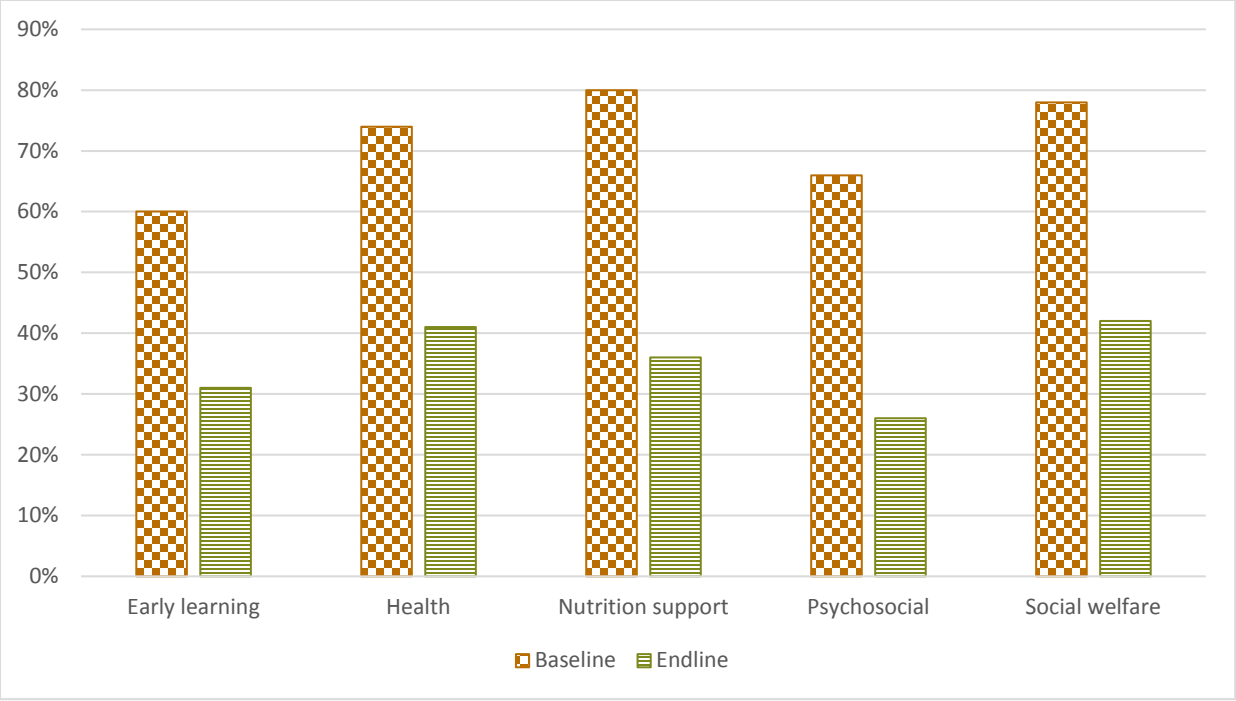

Figure 5. Percentage of caregivers reporting difficulty in accessing ECD-related services, as reported at baseline and at endline.

Nonetheless, there are still difficulties faced by caregivers in trying to access ECD-related services, particularly police/justice, psychosocial, and social welfare services for caregivers in Zambia while caregivers in Kenya have more difficulties accessing health and social welfare services as compared to other ECD-related services. Across the board, when looking at the data in aggregate, generally the top barriers to accessing any of the ECD-related services are the service not being available, long distances, and high costs.

Household well-being levels increased. A positive finding to highlight is that the percentage of households in both Zambia and Kenya who were at higher well-being levels was higher at the endline as compared to baseline. There is a general pattern of more households being categorized at higher well-being levels. From baseline to endline, there is an overall decrease in the percentage of households at the lowest well-being level, “struggling almost all the time”, and overall increases in the next two well-being levels, “life is hard, sometime struggling,” and “coping most of the time.” The largest increases are generally in the second lowest level, “life is hard, sometimes struggling”, with 32% of households at baseline categorized at this well-being level as compared to 53% at endline (see Figure 6). While this cannot be directly attributable to the project, it is nonetheless encouraging to see households doing better, particularly as household well-being was associated with fewer difficulties in accessing services.

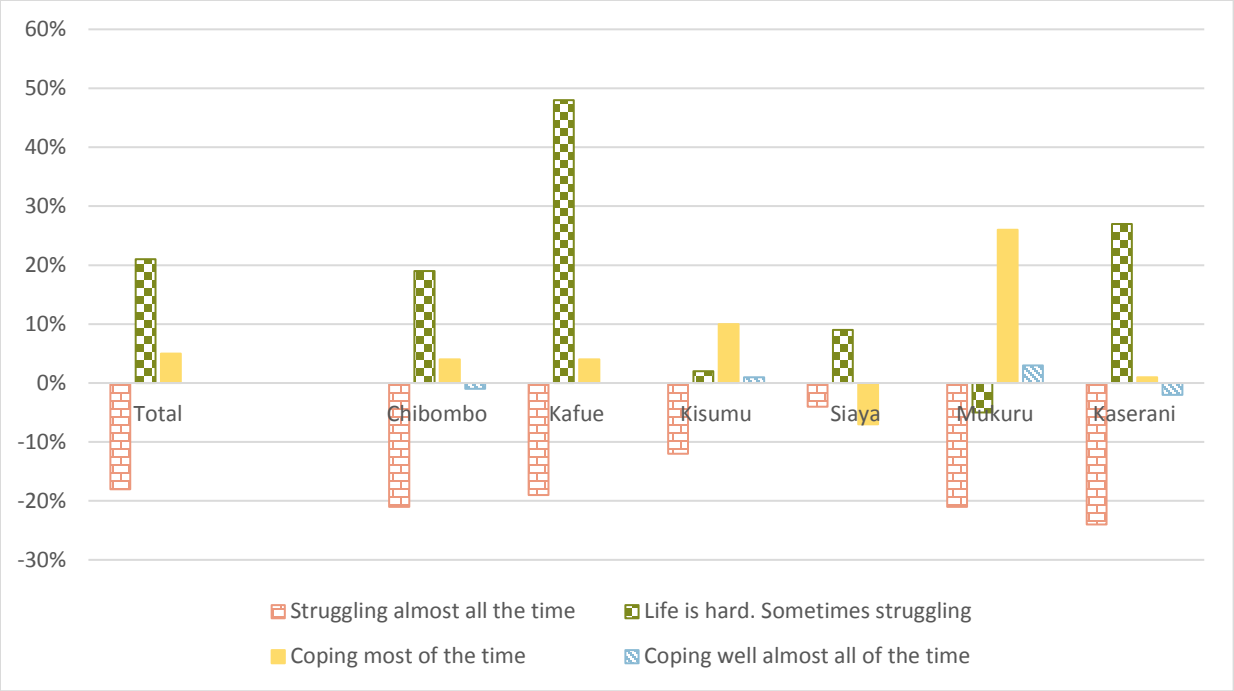

Figure 6. Change in percentage of households categorized at each well-being level, baseline vs. endline.

Reflective supervision was an important mechanism by which change was effected. CSS facilitators reported that reflective supervision was a source of motivation and that it encouraged collaboration and teamwork amongst all members of the group. Additionally, facilitators reported that reflective supervision not only helped them improve their own practice but also assisted them in engaging with caregivers who were less than welcoming during the project.

Recommendations

Calls for continuation of the project were overwhelming in both Kenya and Zambia. The beneficiaries and other stakeholders felt that the project should be expanded to cover more areas as well as remain in areas where it is already realizing positive changes. General recommendations include aspects around unpacking concepts, allowing adequate time for project mapping, and project continuation and coverage expansion as well as incorporating the local context. Of note, better understanding caregivers' stressors and how this impacts their uptake of responsive and protective caregiving behaviors would be an important area to explore in the future. Additionally, recommendations around monitoring and evaluation that would help with evaluating the impact of the future project are also discussed. Concepts from the field of implementation research would also be important to incorporate to understand if and how to continue/enhance the intervention to improve fidelity and potentially increase the intervention's impact.

Country-specific recommendations for Zambia and Kenya address specific needs in these two countries. In Zambia, recommendations include managing expectations, providing assistance to CSS facilitators, and strengthening and supporting the monitoring and evaluation component, while in Kenya, recommendations include developing visual aids and guidelines and strategies for scaling-up home visiting programs.

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Introduction

Project Background

According to recent data published by the United Nations Children's Fund (UNICEF, 2018), as of 2017 approximately 12.2 million children worldwide have lost one or both parents to AIDS, and more than 75% of these children live in Sub-Saharan Africa. In addition to obstacles related to physical and psychosocial wellbeing faced by children orphaned due to any cause, children orphaned by AIDS are at an especially heightened risk of malnourishment, abuse and exploitation, stigmatization, illiteracy, lack of education and school drop-out, medical neglect, not being immunized, and psychosocial distress (Cluver, Orkin, Boyes, Gardner, & Meinck, 2011; Cluver, Orkin, Boyes, Gardner, & Nikelo, 2012; Guo, Li, & Sherr, 2012; Sachs & Sachs, 2004). In addition to children orphaned by AIDS, many more children have been made vulnerable due to family illness and the widespread impact of HIV/AIDS on their communities (President's Emergency Plan for AIDS Relief [PEPFAR], 2009).

Children orphaned by AIDS tend to be younger than other orphans. UNICEF estimates that one in three children orphaned by AIDS is younger than five years (Sachs & Sachs, 2004). Children under the age of five who are exposed to multiple risks, including poverty, malnutrition, poor health, and under-stimulating home environments, suffer from detrimental effects to their cognitive, motor, and socio-emotional development (Gratham-McGregor et al., 2007). These disadvantaged children are more likely to do poorly in school, subsequently have lower incomes and higher fertility rates, and are more likely to provide poor care for their children, thus contributing to the intergenerational transmission of poverty (Grantham-McGregor et al., 2007). As a result, there is a growing consensus on the need to support the integration of services across the areas of health, nutrition, education, responsive caregiving, and child welfare and protection, as well as pay attention to the well-being of parents and caregivers, in order to meet the developmental needs of young children to help them attain their optimal developmental potential (Britto et al., 2017; Britto, Ulkuer, & Meyers, 2009; Center on the Developing Child, 2007; Engle et al., 2007; Yoshikawa, Aber, & Beardslee, 2012; World Health Organization, 2018).

Eastern and southern Africa remains the region most affected by the HIV epidemic (UNAIDS, 2018). Recent data by UNAIDS (2018) reports that in 2017, there was an estimated 18.4 million adults aged 15+ living with HIV in the Eastern and Southern Africa Region (ESAR), the largest percentage by region (35.1 million 15+ worldwide). In ESAR, an estimated 6 million children are orphaned due to AIDS. Specifically, in Kenya, an estimated 1.4 million adults (15+) are living with HIV while an estimated 580,000 children are orphaned due to AIDS. In Zambia, estimated 1.1 million adults (ages 15+) are living with HIV with an estimated 250,000 children orphaned due to AIDS.

Considering the high prevalence of HIV and AIDS and the vulnerability of children in both Kenya and Zambia, ChildFund International, supported by the Conrad N. Hilton Foundation, implemented a project known as, "Assuring the Essentials of Optimal Development for Infants and Young Children Affected by HIV and AIDS in Kenya and Zambia." The aim of the project was that children aged 0-5 years in communities affected by HIV and AIDS meet their developmental milestones while being supported by responsive men and women caregivers

(ChildFund, 2016). The project employed a community-based model, involving ChildFund providing technical support to partner community-based organizations (CBOs). The CBOs worked directly with communities to identify and build the capacities of caregivers part of existing community groups, known as community support structures (CSS), at the household-level and in community groups through home visiting sessions and/or group parenting sessions. The project was implemented from January 2016 to July 2018 and had three overarching objectives (See Figure 1):

Figure 1. Assuring the essentials of optimal development for children affected by HIV and AIDS.

1. Men and women caregivers access and value services on stimulation and responsive care linked to HIV and AIDS and social services;

2. Partner CBOs effectively mentor community support structures (CSS) to integrate stimulation and responsive care into programming in coordination with government and social services for children and caregivers affected by HIV and AIDS; and
3. District/Country government partners integrate stimulation and responsive care into health, child protection, HIV and AIDS programming contributing to implementation of comprehensive ECD services.

Literature Review

Importance of stimulation and responsive care in the first five years. The first five years are the most important in a child's life as the foundations of brain architecture are established through dynamic interactions of genetic, biological, and psychosocial influences, and child behavior (Walker et al., 2011). Most of the brains' neural pathways supporting communication, understanding, social development, and emotional well-being grow rapidly in these formative years (UNICEF, 2017a). This process is fueled by adequate nutrition, health care, protection from harm, and responsive stimulation, including early learning opportunities (UNICEF, 2017a; UNICEF & WHO, 2012). "Serve and return" interactions[1] between caregivers and children are particularly important in shaping brain architecture. (Harvard University Center on the Developing Child, 2004). Such infant stimulation improves a child's attention span, memory, curiosity, and nervous system development (Black, et al., 2008; UNICEF & WHO, 2012). That is, to grow and develop, children need responsive care and a stimulating environment that helps to sculpt the brain. Thus, for all children, a rich and stimulating environment with safe, stable, and nurturing relationships in childhood has been shown to contribute to improved developmental outcomes, thus increasing the likelihood of an individual breaking the cycle of poverty (Grantham-McGregor et al., 2007; Engle et al., 2011; UNICEF, 2017a). For example, a 20-year study showed that children from poor households who received high-quality stimulation at a young age earned an average of 25% more as adults as compared to those who did not receive this intervention (UNICEF, 2017a).

On the other hand, deficiencies in children's interactions with their caregivers and the amount of cognitive stimulation and responsive care they receive can also affect the kinds of adults they become. Such deficiencies in interactions can lead to stunted long-term emotional, social, physical, and intellectual development (Black et al., 2008). Chronic neglect, together with the accumulated burdens of family economic hardship and/or physical or emotional abuse, results in prolonged stress for the child which can result in disruptions of the development of the brain's architecture and later physical, mental, and behavioral problems in adulthood (Harvard University Center on the Developing Child, 2012). Such disadvantaged children are not only more likely to do poorly in school, but they subsequently are more likely to have lower incomes, higher fertility, and provide poor care for their children, thus contributing to the intergenerational transmission of poverty (Grantham-McGregor et al., 2007).

Developmental (and other) issues for children affected by HIV/AIDS. Among developing countries, countries in Sub-Saharan Africa have been the worst hit by HIV and AIDS. Among all people infected by HIV, over 70% live in Sub-Saharan Africa (UNAIDS, 2017). Recent data by UNAIDS (2018) reports that in 2017, there was an estimated 18.4 million

[1] In "serve and return" interactions, young children naturally reach out for interaction with their caregivers through babbling, facial expressions, and gestures, and caregivers respond in kind. This back-and-forth builds and strengthens brain architecture and creates a relationship where the baby's current experiences are affirmed while new abilities are nurtured.

adults aged 15 and older living with HIV in the Eastern and Southern Africa Region (ESAR), the largest percentage by region (35.1 million worldwide). In ESAR, an estimated 6 million children have been orphaned due to AIDS. Kenya has the joint fourth largest HIV/AIDS epidemic in the world (alongside Mozambique and Uganda) (Avert, 2018). In Kenya, an estimated 1.4 million adults 15 and older are living with HIV and an estimated 580,000 children are orphaned due to AIDS (UNAIDS, 2018). In Zambia, estimated 1.1 million adults aged 15 and older are living with HIV and an estimated 250,000 children have been orphaned due to AIDS (UNAIDS, 2018).

Children are impacted in many ways by HIV/AIDS. While, with continued improvement in the coverage and quality of prevention of mother-to-child transmission interventions, it is becoming increasingly rare for children to directly contract the disease themselves through vertical transmission, there are numerous indirect pathways linking adult HIV infection to negative outcomes for children (Desmond et al., 2014; Sherr et al., 2014). Additionally, Sherr and her colleagues (2016) highlight the importance of understanding HIV in caregivers in the presence of treatment, where illness and death are less common and caregiver life expectancy is longer. Further, understanding how HIV in the family, home, or household may affect child development is important, particularly in sub-Saharan Africa where the wider extended household contributes to younger children's care (Sherr et al, 2016).

Children are not just impacted by the burden of the disease itself, but rather the multiple domains the disease affects. Recent reviews of the literature found that children living with adults who have HIV/AIDS suffer in a number of domains, including physical health, emotional health, and schooling, and there are both direct and indirect risks for children (Goldberg & Short, 2016; Sherr et al., 2014). For instance, there is increased infant and child mortality among children born to HIV-infected mothers compared to those born to uninfected mothers, and there are also positive associations between maternal HIV status and malnutrition and other illnesses in children under the age of five.

There are also linkages between maternal HIV status and increased internalizing and externalizing problems, decreased adaptive functioning, and post-traumatic stress as well as lower school attendance and increased rates of school dropout and deficits in grade progression (Goldberg & Short, 2016). For example, children may have increased or new responsibilities and work as caregiver and family composition change, as a result of death and migration, and there is increased financial stress and economic burden, as parents or other caregivers incur medical and funeral expenses and are less able to farm and work for wages, resulting in a loss of home and assets (Gilborn, 2002; Richter, 2004). These increased/new responsibilities and work, in combination with the stigma of being affected by HIV/AIDS, may affect children's ability to access educational services, and in turn lead to increased school dropout rates (Goldberg & Short, 2016; Richter, 2004).

Children also suffer in the areas of health and nutrition as well, as routine immunizations and other preventive care can be overlooked by sick parents or new guardians, leaving AIDS-affected children more prone to illness (Gilborn, 2002). In foster households, poverty deepens with each orphan taken in. Thus, overwhelmed guardians may choose to feed their own children first, leaving orphans hungry and malnourished (Gilborn, 2002). The psychosocial impact on children is huge as they confront exhaustion and stress from work and worry, insecurity and stigmatization, as well as psychological reactions to parental illness and death (Richter, 2004).

Disruptions of the parent-child relationship are especially paramount, as without a supportive relationship with a parent (or other primary caregiver), it can be difficult for children to cope with adversity. Stein and his colleagues (2014) liken the emotional, financial, and social

disruptions faced by children who are affected to HIV to those faced by children who have experienced divorce or parent death, focusing on how the quality of the parent-child relationship suffers, in turn adversely affecting the child. Additionally, mental health issues that may arise in parents who have HIV/AIDS, such as depression, may in turn lead to a number of psychological and developmental disturbances in children, particularly in the domains of attention and cognition; emotional and behavioral adjustment, and attachment or the quality of the parent-child relationship (Stein et al., 2014). Without a supportive relationship with a parent or primary caregiver, the "serve and return" interactions mentioned in the previous section, which are so critical to shaping brain architecture, are not able to exist.

It is important to note, however, that risks do not inevitably lead to harm (Sherr et al., 2014). Not only do the child and infected caregiver need to be considered, but also the context the child lives in and the social support received by affected families. Stein and his colleagues (2014) found that in terms of long-term outcomes for children affected by HIV/AIDS, the majority of children exhibit resilience and do not experience any long-term negative outcomes. However, for those children who do experience long-term negative outcomes, they often experience multiple risks which endure over time and result in numerous negative and enduring impacts, such as significant developmental difficulties in adjustment, cognitive function, and social behavior.

Building capacity of caregivers and parents. In effect, when children are affected by HIV/AIDS, they are not just affected in one domain but rather experience a constellation of stressors that may lead to poorer developmental outcomes in a number of areas.
Despite the grim situation in these regions most affected by HIV and AIDS, there is still hope that employing prompt interventions would support children's age-appropriate short- and long-term development. Extant research has demonstrated that methodologically rigorous parenting programs can support the capacity of caregivers to provide the early learning environments that young children need. Such programs can take multiple forms, such as home visits delivered by community workers linked to the health or social sectors and community-based group sessions (Black et al., 2017; Engle et al., 2007, 2011). For instance, there is a broad evidence base supporting the role of home-based interventions in building parenting capacity, which in turns leads to positive child cognitive and socioemotional development, with effects extending to adulthood (Walker et al., 2007, 2011; Walker, Chang, Vera-Hernández, & Grantham-McGregor, 2011).

An element essential to the success of such parenting programs is consistent mentoring and coaching of service providers of such programs (UNICEF, 2015). One evidence-based approach to providing service providers with ongoing mentoring is the reflective supervision approach, a form of professional development, in which the practitioner shares experiences s/he has had with families that may have been especially challenging or emotionally intense with her/his supervisor. The supervisor, in turn, helps the practitioner to reflect on her or his work and they work jointly to develop a shared understanding of the experience and future plans of action (Bernstein & Edwards, 2012). Given that many home-based early childhood development activities are implemented by community health workers (Black et al., 2017), reflective supervision is particularly important as it allows such practitioners to work effectively with vulnerable families, support parent-child relationships, and prevent burnout (Amini Virmani & Ontai, 2010; Bernstein & Edwards, 2012; Emde, 2009; Gilkerson, 2004). Reflective supervision is proposed as a way to support change toward relationship-based practice with infants and their families (Gilkerson, 2004).

Theory of change. A theory of change helps to analyze interventions and the desired change needed by the target population (Weiss, 1995). It helps establish connections between a system's mission, strategies, and actual outcomes, while creating links between the populations being served, the strategies or activities that are being implemented, and the desired outcomes (International Network on Strategic Philanthropy (INSP), 2005).

In this evaluation, a theory of change was used to ascertain the intervention process and changes realized. In this regard, it helped to evaluate how the project had engaged in activities aimed at building the capacities of the CSS and formal government service providers through training, the improved coordination of ECD-related services at the community-level, integrating responsive caregiving and holistic ECD curricula within existing ECD-related social services, such as health, child protection, and nutrition, as well as facilitating the availability and quality of these services to community caregivers and their infants and young children. At the same time, the theory of change helped to understand how male and female caregivers in existing CSS gained knowledge and skills, through group parenting sessions and home visits, which in turn changed their attitudes and practices on stimulation and responsive care for their young children. Group parenting sessions were integrated into caregivers' existing CSS meetings while home visits targeted the community's most vulnerable families with children aged 0-5.

Through the home visits/group parenting sessions, caregivers' knowledge of ECD will be increased, ultimately leading to changes in attitudes and practices while simultaneously facilitating caregiver access to and uptake of relevant ECD-related services. Improved caregiver knowledge and access to ECD-related services will then result in a positive change regarding the overall age-appropriate development and well-being of the child.

Implementation of the Project

Project locations. In Kenya, the two-year project was called the Nitunze Project and was implemented in Kisumu, Siaya, and Nairobi counties. In Zambia, the project was called the Founding Futures Project and was implemented in Chibombo and Kafue Districts. The implementation process involved ChildFund enhancing the capacity of local CBO partners to plan, implement, and manage project activities at the county/district and community levels. Table 1 shows the CBOs who served as local implementing partners in each county/district as well as the communities within each county/district in which the intervention was implemented.

Table 1

Implementation Partners and Communities

Partner CBO	Communities in which intervention was implemented
	Zambia
Chibombo	
Chibombo Child Development Agency (CCDA)	Chisanshi, Kantupu, Katumbi, Kayosha, Muntemba
Kafue	
Kafue Child Development Agency (KCDA)	Joseph Conte (Lukamantano), Mtengo, Mungu, Siyachinyama
	Kenya
Kisumu	

Kisumu Development Program (KDP)	Buoye, Chiga, Kasule, Manyata, Nyalenda, Nyalunya
Siaya	
Lake Victoria Child Support Program (LVCSP)	Gondho, Lunjre, Sira, Sirandumb, Naya, Yiro East
Nairobi	
Nairobi Integrated Program (NIP)	Cieko, Ghetto, Santon, KwaNgula, Maji, Mazuri, Gacagi, Redsoil, Mwihike
Mukuru Child Wellness Centre (MCWC)	Kambi Moto, Mandazi Road, Commercial, Fuata, Nyayo, Kisii, Maragoini

Note: During this project, in Kenya, KDP and LVSCP consolidated their programming into one organization, retaining the name of KDP as they were already sharing many key administrative and support roles in the Kisumu office. The consolidated KDP covered the same communities in Kisumu and Siaya counties. Further, in 2017, ChildFund Kenya also supported the Nairobi-based CBOs (NIP, MCWC) to consolidate into MCWC in order to leverage their administrative and support services and lower their overhead costs to maximize funding for community interventions.

Curricula and training approach. In implementing the project, the WHO/UNICEF (2012) Care for Child Development (CCD) package was used in conducting home visits and an adapted curriculum comprising of the CCD package and the Essential Package for Children and Caregivers Affected by HIV/AIDS (EP; CARE International, Save the Children, & the Consultative Group on Early Childhood Care and Development, 2012) were used to hold group caregiving sessions. PATH's ECD Counseling Cards, inspired by the WHO/UNICEF (2012) CCD package, were also used in Kenya for home visits[2]. Appendix A presents a brief description of the CCD Package and the adapted CCD and EP-established group parenting visual aid. The curricula were administered through a cascaded capacity building approach (see Figure 2). At the project's onset, ChildFund Zambia and ChildFund Kenya project personnel (Zambia: project monitoring and evaluation (M&E) officer, program manager, education technical advisor; Kenya: ECD project officer – Western; project M&E officer, program manager, ECD technical advisor) trained the local implementing partner CBO's staff as well as officers from relevant government ministries and departments on core concepts of ECD (adapted from the Science of Early Child Development [SECD]), the CCD package for home visiting sessions, and group parenting curricula, as well as how to employ a reflective supervision approach to enhance their knowledge, skills, and capacities in monitoring and implementing the project. The trained CBO staff, together with government officers, replicated the same model at the community level by training mentors from existing CSS that were nominated from the groups using selection criteria on the same content (see Appendix B for criteria used to select mentors and facilitators). The mentors trained the CSS facilitators who had direct interaction with community members at the household level and/or in group parenting sessions bi-weekly or monthly, depending on the community and/or group and how often it met.

[2] A Memorandum of Understanding was established with PATH for utilization of the counseling cards.

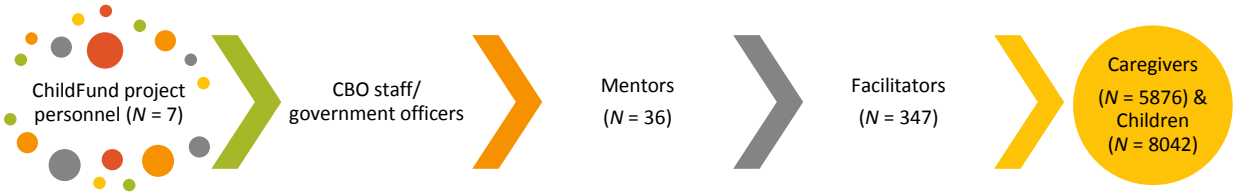

Figure 2. Cascaded capacity building approach to administering curricula[3]

Delivery through the CSS was meant to draw strengths from existing community-based systems and meet caregivers where they were already gathering, in order to enhance the existing groups with relevant knowledge, skills, attitudes, and practices. This also avoided the creation of extraneous parallel community structures and additionally created ownership and sustainability within existing groups where caregivers would meet beyond the project end date.

Group parenting sessions. Group parenting sessions took the form of a series of 17 modules that lasted between 30-45 minutes, covering topics in child development, play, communication, health, nutrition, and protection. Communities had the flexibility to prioritize the order of sessions they conducted, with some covering all sessions (and sometimes all sessions more than once) and others not covering all sessions. Flexibility was an intended part of the design, as the training covered how facilitators could prioritize certain topics they determined were more urgent based on feedback from community members. See Appendix C for a full list of the topics covered. The content of each module was developed by cross-walking messages from the WHO/UNICEF (2012) CCD package on early stimulation, responsive care, health, nutrition, and protection. This information was supplemented with existing messages from the Essential Package. Each module was designed to be implemented in thirty minutes as to not overburden the existing meetings or keep caregivers from their daily activities. These tools were reviewed in detail with both teams in Kenya and Zambia to ensure their local relevance. Significant input was also provided by Project Managers from both countries to adequately contextualize the information.

Home visiting sessions. Home visiting sessions also used the CCD curricula. Using CCD, home visitors were able to support caregivers by: 1) identifying the interactions taking place between a child and the child's primary caregiver; 2) counseling the family on activities to strengthen the relationship between the child and caregiver; and 3) advising the family on appropriate play and communication activities to stimulate the child's growth and healthy development.

Project reach. Through the training process, 36 mentors were trained (24 in Zambia, 12 in Kenya), who trained 347 facilitators (144 in Zambia, 203 in Kenya). These facilitators reached a total of 5,601 caregivers across both countries who participated in the intervention (2,900 from Zambia, 2,701 from Kenya), who cared for 8,042 children aged 0-5 (3,961 in Zambia, 4,081 in Kenya).

Identification of participating households. The most vulnerable households in each community were identified during the baseline phase of the study and received individualized household visitations and learning sessions from CSS facilitators. Enrolling households was

[3] The number of government staff participating fluctuated per training type and while training records for each individual training were kept, detailed records tracking participation of various government stakeholders across trainings were not kept.

based on vulnerability criteria settled on through a participatory process by community members. During the community participatory process, indicators for four categories of estimated household well-being were identified: 1) households which struggled almost all the time; 2) households where life was hard and sometimes struggled; 3) households which coped most of the time and sometimes things were difficult; and 4) households which coped well almost all of the time. Locally-identified indicators of vulnerability, which defined the differences between household categories, included dependency ratio/household size, sources of income and livelihoods, housing type, water sources and access to clean water, sanitation and toilet facilities, energy and cooking facilities, number of meals per day and types and intake of protein, assets, social challenges and appearance, dress, care, and education of children as well as local geography (in terms of distance to service centers and safety in such an environment). See Appendix D for descriptors of estimated household wellbeing level by program site.

Research Questions

The purpose of the endline evaluation is to evaluate the impact of the project, "Assuring the Essentials of Optimal Development for Children affected by HIV and AIDS in Kenya and Zambia." Guided by the three overarching objectives of the project, the evaluation seeks to answer the following research questions:

Objective 1

- RQ 1.1: How were vulnerable households with children aged 0-5 engaged with the initiative?
    - RQ 1.1.a: Did vulnerability of households change over time*?*
    - RQ 1.1.b: Were caregivers satisfied with their participation in the initiative?
- RQ 1.2: As a result of the current initiative, how did caregivers' knowledge and practices regarding the following areas change: 1) stimulation and responsive care; and 2) other aspects of their children's development?
- RQ 1.3: How did caregivers' current access and barriers to stimulation and responsive care services linked to HIV and AIDS change over the course of the initiative?

Objective 2

- RQ 2.1: What was the knowledge of the various stakeholders (ChildFund, Partner CBOs, government partners, identified community mentors, facilitators from existing community support structures) regarding: 1) foundational ECD topics; 2) competencies in executing home and group parenting sessions; and 3) reflective supervision?
- RQ 2.2: What project processes and tools facilitated project quality and expected caregiver outcomes and impact?

Objective 3

- RQ 3: What was the role of ChildFund (and Partner CBOs) in engaging government partners to 1) build capacity; and 2) influence the take-up of services on stimulation and responsive care?

Given that one of the *a priori* goals of this evaluation is to examine country-level differences, comparisons between Zambia and Kenya will be made as part of each research question.

Methods

Study Design

In this endline evaluation, a mixed methods approach was adopted, integrating both qualitative and quantitative approaches. Specifically, a mixed methods approach allows for the

possibility of triangulation, which enables researchers to utilize several methods and data sources to examine and understand a specific phenomenon (Malina, Nørreklit, & Selto, 2011). The overarching goal was to understand the impact of the project on the well-being of children and caregiver competencies for the provision of responsive and stimulating care for infants and young children aged 0-5, as well as on how the capacity of formal and informal community and district structures to support these caregivers was enhanced, particularly in families and communities affected by HIV and AIDS. Depending on the domain, children's well-being was self-reported by caregivers and/or observed by enumerators.

Quantitative data was collected through household surveys, observations, and organizational self-assessment tools completed by local ChildFund offices and local partners. Qualitative data was collected through focus group discussions with caregivers and CSS facilitators, in-depth interviews with caregivers, and key informant interviews with county government officials, mentors, facilitators, CSS facilitators and ChildFund officials, and partner CBO ECD project officers.

Plan of Analysis

For caregiver and household demographics, descriptive analyses were conducted to examine who the primary caregiver in the household was, along with caregiver sex, age, highest level of education, and comfort with reading, as well as the average number of people in the house and average number of children under the age of 5. Chi-square analyses or analyses of variance (ANOVAs), as appropriate, were conducted to make comparisons between countries.

For Research Questions 1.1, 1.2, and 1.3, quantitative data from the household survey and observations were analyzed and descriptive analyses were conducted in order to examine patterns that may emerge from the data. As appropriate, chi-square analyses or ANOVAs were conducted to make comparisons between countries or program type. Due to the baseline data available, any comparisons between baseline and endline data are made only at the descriptive level; statistical tests were not able to be conducted in order to determine whether there were any significant differences between the two timepoints (please refer to limitations in the discussion section).

For Research Questions 2.1, 2.2, and 3.1, qualitative data from the focus group discussions, in-depth interviews, and key informant interviews were examined. Themes were extracted from the various discussions and interviews. Quantitative data from the organizational self-assessment tools were also evaluated for Research Question 2.2.

Participants/Sociodemographic Information

The endline evaluation was conducted in Zambia and Kenya. In Zambia, the evaluation was conducted in the Chibombo and Kafue Districts and in Kenya, it was conducted in Kisumu, Nairobi, and Siaya counties. Table 1, above, presents a breakdown of which districts and communities within these counties and districts participated in the study.

The entire study population included 5,876 caregivers across both countries who participated in the intervention (3,185 from Zambia, 2,691 from Kenya,) who cared for 8,042 children aged 0-5 (3,961 from Zambia, 4,081 from Kenya), along with 36 CSS mentors (24 from Zambia, 12 from Kenya), 347 facilitators (144 in Zambia and 203 in Kenya) as well as local partner CBO staff who implemented the project and government officials such as chiefs, assistant chiefs, children's officers, ECD teachers, and quality assurance officers[4]. How

[4] While training records for each individual training were kept, detailed records tracking participation of various government stakeholders across multiple trainings and sites over time were not kept. Appendix E notes how many participants there were at each training.

participants were selected to be a part of the endline evaluation is included below under each mode of data collection.

Caregiver and household demographics. 690 caregivers participated in the household survey. However, as 23 caregivers indicated that they did not have children under the age of 5 living in the household, these 23 caregivers were excluded from data analysis, resulting in a sample size of 667 (334 from Zambia, 333 from Kenya). In 84% of households, the mother was the sole primary caregiver and 95% of primary caregivers were female. The majority of primary caregivers fell in the 25-35 year age range (50%), followed by the 36-49 year age range (22%) and 18-24 year age range (20%). In terms of primary caregiver education, the largest percentage completed upper primary school (43%), followed by some secondary school (24%). In terms of literacy, caregivers generally said they could read a little (39%), followed by being good at reading and enjoying it (26%). There were an average of 6 people living in the household (*M* (*SD*) = 5.95 (2.49), Range: 1-18 people) and an average of 2 children aged five and under (*M* (*SD*) = 1.51 (.68), Range: 1-5 children).

Chi-square analyses were conducted to determine whether there were any demographic differences between Zambia and Kenya. Significant differences were found in primary caregiver (χ^2 (9, N = 667) = 18.89, $p < .05$), caregiver age (χ^2 (4, N = 667) = 23.97, $p = .00$), highest level of education completed by caregiver (χ^2 (6, N = 667) = 154.35, $p = .00$), and primary caregiver's comfort with reading (χ^2 (3, N = 667) = 149.45, $p = .00$). There were more fathers and grandparents serving as primary caregivers in Kenya (5% and 8%, respectively) than in Zambia (2% and 4%, respectively). There were more caregivers in Kenya in the 25-35 year age range (60%) as compared to in Zambia (42%), but there were more caregivers in Zambia in the 18-24 year age range (24%) than in Kenya (14%), as well as in the 36-49 year age range (Zambia: 26%, Kenya: 17%). In terms of education, more caregivers in Kenya completed upper primary school (54%) than caregivers in Zambia (32%), and more completed secondary school (17%) than caregivers in Zambia (3%). Also, 7% of caregivers in Kenya completed tertiary college while none in Zambia did. However, more caregivers in Zambia completed either lower primary (22.5%) or some of secondary school (34%) as compared to caregivers in Kenya (4% and 14%, respectively). Perhaps a reflection of this pattern of schooling, more caregivers in Kenya report being good at reading and enjoying it (44%) as compared to caregivers in Zambia (8%). The majority of caregivers in Zambia either report not being able to read (31%) or being able to read a little (48%).

Analyses of variance (ANOVAs) were also conducted to determine whether there were any differences in the number of people in the house between the countries. Significant differences were found for total number of people (F (1, 663) = 51.99, $p = .00$) as well as for total number of children under the age of five (F (1, 665) = 9.37. $p = .002$). On average, the Zambian household was slightly larger than the Kenyan one, with an average of 7 people in the house in Zambia compared to 5 in Kenya, and 2 children under five years of age in Zambia compared to 1 in Kenya. See Table 2 for caregiver demographics, in aggregate as well as disaggregated by country.

Table 2

Caregiver Demographics, Aggregated and By Country

	Total	Zambia	Kenya

*Primary caregiver (*N*(%))

Mother	562 (84.3%)	284 (85.0%)	278 (83.5%)
Father	23 (3.4%)	8 (2.4%)	15 (4.5%)
Mother and father	24 (3.6%)	13 (3.9%)	11 (3.3%)
Mother and grandparent	7 (1.0%)	7 (2.1%)	0
Mother and extended family	1 (.1%)	1 (.3%)	0
Mother and older sibling	2 (.3%)	2 (.6%)	0
Grandparent	39 (5.8%)	13 (3.9%)	26 (7.8%)
Extended family	2 (.3%)	1 (.3%)	1 (.3%)
Older sibling	2 (.3%)	2 (.6%)	0
Other	5 (.7%)	3 (.9%)	2 (.6%)
Primary caregiver sex (*N*(%))			
Female	630 (94.5%)	320 (95.8%)	310 (93.1%)
Male	36 (5.4%)	14 (4.2%)	22 (6.6%)
Other	1 (.1%)	0	1 (.3%)
Primary caregiver age (*N*(%))			
17 years and younger	2 (.3%)	1 (.3%)	1 (.3%)
18-24 years	129 (19.3%)	81 (24.3%)	45 (14.4%)
25-35 years	336 (50.4%)	139 (41.6%)	197 (59.2%)
36-49 years	111 (21.6%)	86 (25.7%)	58 (17.4%)
50 years and older	56 (8.4%)	27 (8.1%)	29 (8.7%)
*Highest level of education (*N*(%))			
None	41 (6.1%)	27 (8.7%)	12 (3.6%)
Nursery	0	0	0
Lower primary	89 (13.3%)	78 (22.5%)	14 (4.2%)
Upper primary	288 (43.2%)	107 (32.0%)	181 (54.4%)
Secondary incomplete	157 (23.5%)	112 (33.5%)	45 (13.5%)
Secondary complete	68 (10.2%)	10 (3.0%)	58 (17.4%)
Tertiary college	23 (3.4%)	0	23 (6.9%)
University	0	0	0
*Comfort with reading (*N*(%))			
Not able to read	132 (19.8%)	105 (31.4%)	27 (8.1%)
Can read a little	259 (38.8%)	160 (47.9%)	99 (29.7%)
Can read comfortably, but prefers not to	104 (15.6%)	44 (13.2%)	60 (18.0%)
Good at reading and enjoys it	172 (25.8%)	25 (7.5%)	147 (44.1%)
*Average number of people in house (*M* (*SD*))	5.95 (2.49)	6.62 (2.68)	5.28 (2.08)
*Average number of children under 5 (*M* (*SD*))	1.51 (.68)	1.59 (.72)	1.43 (.63)

Note: * denotes significant differences between Zambia and Kenya.

Caregiver well-being. Looking at the data in aggregate, 72% of caregivers reported facing challenges in self-care. The majority of caregivers (71%) reported financial strain as being a challenge, followed by balance between working and caring for the child (7%), stress resulting from caring for the child (7%), and a lack of services to support caregivers on handling their challenges (7%). Other challenges included caregiver illness (3%), having an unsupportive partner (3%), and the inability to make decisions in the household (2%). A few caregivers also reported low self-esteem 1%), gender-based violence (.6%), intimate partner violence (.4%), and stigma for being HIV-positive (.1%) as other challenges faced. Just over half of caregivers (51%) reported, however, that they never felt that they did not have time for themselves because of time spent with the child while 28% reported that sometimes they felt they did not have time for themselves. 38% of caregivers reported that they never felt stressed between caring for the child and trying to meet other family/work responsibilities, while 28% responded they sometimes felt stressed. See Table 3.

Chi-square analyses were conducted to determine whether there were differences between Zambia and Kenya regarding caregiver reports of self-care (see Table G81). 66% of caregivers in Zambia reported that they faced challenges in self-care compared to 78% of caregivers in Kenya; this difference was statistically significant (χ^2 (1, N = 667) = 11.61, p < .01). Regarding challenges faced, there were a significant difference in terms of financial strain, with 64% of caregivers in Zambia reporting this as a challenge compared to 78% in Kenya (χ^2 (1, N = 547) = 36.34, p < .01). Balance between work and care for the baby was also significantly different between the two countries, with 4% of caregivers in Zambia reporting this to be a challenge compared to 11% of caregivers in Kenya (χ^2 (1, N = 547) = 4.51, p < .05). There were significant differences between caregivers in the two countries regarding caregivers feeling they did not have enough time for themselves because of time spent with the child (χ^2 (3, N = 552) = 17.00, p < .01). 58% of caregivers in Kenya reported never feeling that they did not have enough time for themselves and 5% reported feeling they frequently felt they did not have enough time for themselves, as compared to 41% and 9% of caregivers in Zambia, respectively. Finally, there were also significant differences between caregivers in the two countries regarding caregivers feeling stressed between caring for the child and trying to meet other family/work responsibilities (χ^2 (3, N = 552) = 24.49, p < .01). Over half of caregivers in caregivers in Kenya reported never feeling stressed and 7% reported feeling stressed quite frequently, compared to 33% and 12% of caregivers in Zambia, respectively.

Table 3

Caregiver Well-Being

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
Faces challenge in self-care	477 (71.5%)	219 (65.6%)	258 (77.5%)
Challenges faced			
Financial strain	473 (70.9%)	213 (63.8%)	260 (78.1%)
Balance between work and care for the baby	47 (7.0%)	12 (3.6%)	35 (10.5%)
Stress resulting from caring for the baby	47 (7.0%)	15 (4.5%)	32 (9.6%)
Lack of services to support caregivers	46 (6.9%)	16 (4.8%)	30 (9.0%)

on handling their challenges			
Caregiver illness	20 (3.0%)	7 (2.1%)	13 (3.9%)
Unsupportive partner	20 (3.0%)	5 (1.5%)	15 (4.5%)
Inability to make decision in the household	16 (2.4%)	8 (2.4%)	8 (2.4%)
Low self-esteem	6 (.9%)	2 (.6%)	4 (1.2%)
Gender-based violence	4 (.6%)	2 (.6%)	2 (.6%)
Intimate partner violence	3 (.4%)	2 (.6%)	1 (.3%)
Stigma for being HIV-positive	1 (.1%)	0	1 (.3%)
Other	82 (12.3%)	10 (3.0%)	72 (21.6%)
Feel that don't have enough time for self because of time spent with child			
Never	283 (51.3%)	89 (40.6%)	194 (58.3%)
Rarely	80 (14.5%)	38 (17.4%)	42 (12.6%)
Sometimes	152 (27.5%)	72 (32.9%)	80 (24.0%)
Quite frequently	37 (6.7%)	20 (9.1%)	17 (5.1%)
Feel stressed between caring for child and trying to meet other family/work responsibilities			
Never	254 (38.1%)	73 (33.3%)	181 (54.4%)
Rarely	63 (9.4%)	31 (14.2%)	32 (9.6%)
Sometimes	186 (27.9%)	88 (40.2%)	98 (29.4%)
Quite frequently	49 (7.3%)	27 (12.3%)	22 (6.6%)

Data Collection

A team of 20 and 21 enumerators were selected in Zambia and Kenya, respectively, to be in charge of data collection. Enumerators were chosen through a competitive process based on education level and past research and/or enumeration experience. A participatory training was conducted for five days by the consultant in each country to prepare the enumerators to collect the data for the endline evaluation. This included intensive training for all enumerators on the overall objectives of the project and core ECD concepts as well as how to use digital devices to conduct household surveys. Enumerators were also trained on how to conduct household surveys, focus group discussions, in-depth interviews, key informant interviews, and observations using the data collection tools created for the evaluation. Sample items from the data collection tools are included in Appendix F.

Household surveys. 667 caregivers were administered the household surveys (334 in Zambia, 333 in Kenya). Household surveys were administered via face-to-face interviews with caregivers. The surveys included questions to identify:

- Socioeconomic and demographic characteristics of the caregivers;
- Caregivers' knowledge on and practices related to responsive parenting and holistic ECD; and
- Barriers to and enablers of access to ECD-related social services.

Questions also included whether the intervention(s) influenced any change in caregivers' knowledge, attitudes, and practices in the last two years or had any impact on improved access to or quality of ECD-related social services.

Both stratified and systematic random sampling procedures were conducted in order to select the caregivers to be administered the household survey from the total of 5,601 caregivers across both countries who participated in the intervention (2,701 from Kenya, 2,900 from Zambia). Stratified sampling ensures that key subpopulations are included in a sample. In this case, the sample size was distributed according to the ratio of caregivers who participated in the larger intervention in each location (county or district) and by type of intervention (household visit or group parenting session). To ensure that the views of both men and women who participated in the intervention were captured, systematic random sampling was employed to reach the individual study participants. A target of 350 participants was initially set for Zambia, but due to multiple challenges (long distances between households, heavy rainfall, surveys took place during farming season and caregivers could not spare time for interviews), 339 were ultimately interviewed, and 334 included in these analyses. See Table 4 for a detailed breakdown of the number of caregivers interviewed, by site and gender.

Table 4

Number of Caregivers Interviewed, by Site and Gender

		Female (*N* (%))	Male (*N* (%))	Other (*N*(%))
Zambia				
	Chibombo	188 (94.9%)	10 (5.1%)	0
	Kafue	132 (97.1%)	4 (2.9%)	0
Kenya				
	Kisumu	98 (96.1%)	4 (3.9%)	0
	Siaya	59 (90.8%)	6 (9.2%)	0
	Mukuru	78 (98.7%)	0	1 (1.3%)
	Kaserani	75 (86.2%)	12 (13.8%)	0

Observations. Enumerators observed children in their homes while the Household Survey was administered to their caregivers. Observations focused on aspects related to behaviors of and interactions between caregivers and their infants and young children. Areas of focus included: 1) availability and types of child's play materials; 2) observation of the child's play environment; and 3) interactions between the caregiver and child. During administration of the Household Survey, enumerators completed short checklists in these focal areas.

Organizational self-assessment tools. In Zambia, organizational developmental assessments were completed over email, with the self-assessment tool being sent, separately, to ChildFund Zambia staff and the local partners. Local partners had two project staff (ECD officer and M&E officer) and their Federation Manager complete the organizational assessment. In Kenya, the assessment was completed in person with ChildFund Kenya staff and local partner staff.

Focus group discussions. Focus group discussions assist in gathering a large amount of information from a group of individuals with homogenous characteristics, allowing participants to expand on each other's responses, as well as allowing the researcher to obtain multiple perspectives on the same topic (Benard, 2006; Beyea & Nicoll, 2006). A total of 20 focus group discussions were conducted (12 in Zambia, 8 in Kenya). In Zambia, eight focus group discussions were conducted with caregivers (four in Chibombo [Kantupu and Muntemba] and four in Kafue [Mutengo and Shachinyama]) and four with CSS facilitators (two each in

Chibombo and Kafue). In Kenya, four focus group discussions were conducted with caregivers (one each in Kisumu, Siaya, Kasarani, and Mukuru) and four with CSS facilitators (one each in Kisumu, Siaya, Kasarani, and Mukuru). For the discussions, participants were selected purposively from caregivers who had participated in the intervention, based on gender and whether they were in group parenting or home visiting sessions. In each focus group discussion, there were 8-12 discussants. The process was guided by a moderator with the support of a notetaker. After obtaining informed consent from the participants, the discussion was recorded via notes and voice recording. The purpose of the focus group discussions was to understand the following topics:

- The community's understanding of responsive caregiving and holistic ECD;
- If and how external processes, including but not limited to the home and/or group parenting sessions part of the project intervention, influence their knowledge, skills, attitudes, and practices for providing care for themselves and their infants and young children aged 0-56 in the last two years;
- The identification of barriers and enablers of access to ECD-related social services during the life of the project;
- The extent to which the project impacted accessing aforementioned services and experiences; and
- Lessons learned from participating in the project.

The questions posed as part of the focus group discussions also sought to understand if and how the knowledge, attitudes, and practices gained by caregivers participating in the project translated into observable impacts on their infant's/child's well-being.

In-depth interviews. In-depth interviews involve conducting intensive individual interviews with a small number of respondents to explore their perspectives on a particular idea, program, or situation (Boyce & Naele, 2006). Twenty-four in-depth interviews were conducted with caregivers, eight in Zambia (4 each in Chibombo and Kafue) and 16 in Kenya (4 each in Kisumu, Siaya, Kasarani, and Mukuru). The purpose of the interviews was to gain in-depth knowledge of any significant changes realized over the two-year project period. These in-depth interviews not only focused on participation in the project, but more importantly on how any knowledge gained translated to practice, with a particular focus on how the caregivers currently care for and play with children. Access to other ECD-related social services was also queried.

Convenience sampling was employed to identify the caregivers interviewed. Caregivers participating in the in-depth interviews also had participated in the household surveys and/or the focus group discussions. Those caregivers who were noticed to have "opened up" and talked more about the project and how it had affected them were selected for the in-depth interviews.

Key informant interviews (KIIs). A total of 49 key informant interviews (KIIs) were conducted, 20 in Zambia and 29 in Kenya. The goals of the KIIs were to assess the knowledge of stakeholders on responsive caregiving, integrated ECD, and reflective supervision; assess the capacity of stakeholders on those three domains; and to understand how those domains were integrated in the formal government system as well as the sustainability of the project. Key informants selected included county government officials, mentors, facilitators, CSS facilitators and ChildFund officials, ECD project officers, and local implementing partners.

Baseline Data

Baseline data were taken from a ChildFund International report, "Assuring the Essentials of Optimal Development for Children Affected by HIV and AIDS Africa – Kenya and Zambia",

dated July 31, 2016. No raw data were available; therefore, any comparisons between baseline and endline data were made at the descriptive level.

Findings

Data reported below will generally first be looked at in aggregate to present the overall picture across both countries. Data will then be disaggregated to examine patterns at the country level, and for some research questions, at the site level. Where available, endline data will be compared to baseline data in order to examine change over the course of the project period. Data tables for all figures can be found in Appendix G.

Research Question 1.1: How Were Vulnerable Households with Children Aged 0-5 Engaged with the Initiative?

To answer this research question, caregiver participation in project activities was examined to determine whether caregivers participated only in group parenting sessions, home visits, both, or neither as well as how many sessions of each type they participated in. Caregivers also reported which topics they learned about in during these different sessions and identified what they considered to be the most important topics. Additionally, household well-being status was examined as well as whether well-being status changed over the course of the project. Finally, caregiver satisfaction with the initiative was also considered. For this research question and two sub-questions, data was looked at in aggregate, then disaggregated at the country level and site level.

Participation of caregivers in project activities. Across all sites in aggregate, more caregivers participated only in home visits (42%) than only in group parenting sessions (39%). There was a small percentage of caregivers who participated in both home visits and group parenting sessions (16%). Four percent of caregivers reported not participating in either group parenting or home visit interventions. See Table 4.

When comparing countries, there were significant differences between countries regarding caregivers' participation in project activities (χ^2 (3, N = 667) = 252.18, p = 0.00). More caregivers in Kenya participated only in group parenting sessions (69%) than only in home visits (23%). The opposite was true in Zambia, with more caregivers participating only in home visits (60%) than only in group parenting sessions (9%) and both types of visits (26%). Of note, there were more caregivers in Zambia participating in both types of sessions (26%) than in Kenya (6%). Additionally, more caregivers in Zambia did not participate in either type of session (5%) as compared to in Kenya (2%).

In looking at individual sites (Figure 3), there are different participation rates in the home visit or group parenting sessions by intervention type. The highest percentage of caregivers not participating in either type of intervention was in Siaya County (Kenya), with 11 percent, followed by Chibombo District in Zambia (7%). Further, in Chibombo District, nearly equal percentages of caregivers participated in either home visits or both home visits and parenting groups (40% and 39%, respectively). In contrast, in Kafue District, nearly all the caregivers participated in the home visits (89%), with very few participating in the parenting group (2%) or both types of sessions (7%). In all the Kenyan sites, on the other hand, the majority of caregivers participated in parenting groups and, with the exception of caregivers in Kasarani, very few caregivers participated in both types of interventions. All caregivers in Kisumu and Kasarani participated in either or both types of interventions.

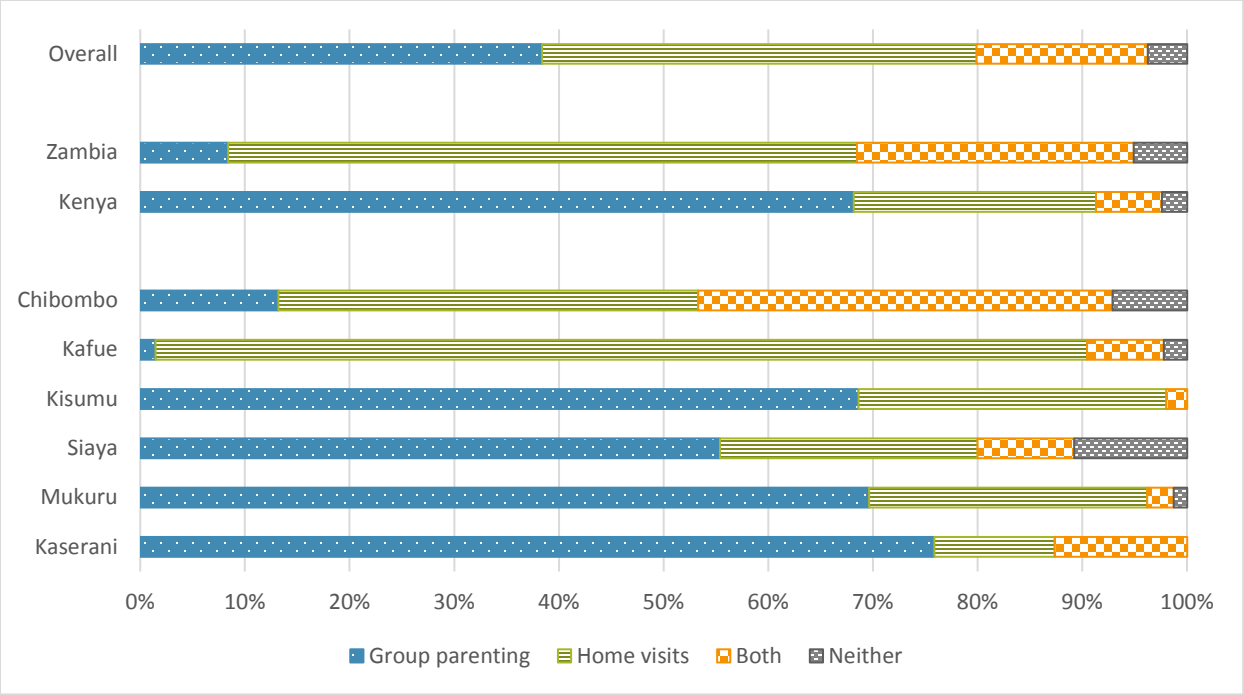

Figure 3. Percentage of caregivers participating in the program.

Across all sites in aggregate, caregivers reported participating in an average of 12 group parenting sessions and 9 home visits (see Table 5). When comparing countries, caregivers in Kenya, on average, participated in more group parenting sessions than those in Zambia (Kenya: 15, Zambia: 6). A one-way analysis of variance (ANOVA) revealed that this difference was statistically significant ($F(1, 363) = 37.16$, $p = .00$). There were no statistically significant differences between participation in home visits (Zambia: 8, Kenya: 11).

When comparing individual sites, an one-way ANOVA revealed statistically significant differences in the number of group parenting sessions in which caregivers participate ($F(5, 359) = 33.21$, $p = .00$). Dunnett's T3 post-hoc tests indicated that caregivers in Kafue participated in significantly fewer group parenting sessions (3) than all other sites, while caregivers in Kasarani participated in significantly more group parenting sessions (27) than all other sites. There were also significant differences between the number of group parenting sessions attended by caregivers in Mukuru (12) and all other sites except Siaya (10).

A one-way ANOVA also revealed statistically significant differences in the number of home visits caregivers participated in ($F(5, 380) = 2.34$, $p < .05$). Dunnett's T3 post-hoc tests, however, did not indicate significant differences between sites[5].

Table 5

Caregiver Participation in Group Parenting Sessions and Home Visits

	Group parenting session			Home visits		
	M (*SD*)	Median	Range	*M*(*SD*)	Median	Range

[5] The lack of significant differences in post-hoc tests may be due to the relatively small sample sizes in the Kenyan sites, ranging from 21 in Kasarani to 32 in Kisumu, compared to the relatively larger sample sizes in the Zambian sites ($n_{Chibombo} = 157$, $n_{Kafue} = 131$), resulting in a lack of statistical power for comparisons.

Overall	12.34 (14.37)	8.0	0-98	8.67 (13.51)	5.0	1-158
Zambia	5.97 (1.46)	3.0	0-98	8.04 (14.09)	5.0	1-158
Kenya	15.34 (14.98)	12.0	1-76	10.53 (11.58)	9.5	1-80
Chibombo	6.36 (10.95)	4.0	0-98	8.87 (17.46)	5.0	1-158
Kafue	2.58 (2.11)	2.0	1-8	7.05 (8.32)	4.0	1-53
Kisumu	4.83 (4.92)	2.5	2-24	5.97 (4.78)	4.0	2-24
Siaya	9.90 (5.89)	10.0	1-20	9.86 (6.22)	10.0	1-20
Mukuru	12.74 (9.66)	12.0	1-76	12.43 (9.93)	12.0	2-45
Kasarani	27.26 (20.02)	20.0	1-76	16.10 (19.89)	10.0	2-80

Topics learned about in group parenting sessions. Figure 4 presents the percentage of caregivers reporting on what topics they had learned about during group parenting sessions. Caregivers were allowed to report multiple topics. Looking at all sites in aggregate, of caregivers who participated in the group parenting sessions, roughly three quarters reported they learned about health (70%), nutrition (77%), and play and communication (76%), and just over half (54%) said they learned about child protection during the group parenting sessions. The lowest percentage of caregivers reported they learned about early stimulation (39%) and water, sanitation, and hygiene (40%).

Chi-square analyses were conducted in order to determine whether there were statistically significant differences between topics learned and country (see Table G3). Statistically significant differences were found between Zambia and Kenya for most topics learned during group parenting sessions, with the exception of child protection and positive discipline. More caregivers in Zambia than in Kenya reported learning about early stimulation (47% and 36%, respectively; χ^2 (1, N = 365) = 4.12, $p < .05$) and play and communication (86% and 72%, respectively; χ^2 (1, N = 365) = 8.21, $p < .01$). More caregivers in Kenya than in Zambia reported learning about health (76% and 58%, respectively; χ^2 (1, N = 365) = 11.87, $p < .01$), nutrition (80% and 71%, respectively; χ^2 (1, N =365) = 3.92, $p < .05$), and water, sanitation, and hygiene (46% and 28%, respectively; χ^2 (1, N = 365) = 10.43, $p < .01$). Just over half of caregivers in Zambia and Kenya reported learning about child protection (55% and 54%, respectively; χ^2 (1, N = 365) = .04, $p > .05$) with just over 40% of reported learning about positive discipline (44% and 42%, respectively; χ^2 (1, N = 365) = .05, $p > .05$).

When looking at individual sites, caregivers participating in group parenting sessions in Chibombo District, Kafue District, Kisumu County, and Siaya County most frequently reported learning about play (84%, 100%, 81%, and 79%, respectively), while those in Kasarani most frequently reported learning about nutrition (91%) and those in Mukuru about health (89%). In Chibombo District, Kafue District, and Kasarani, caregivers least frequently reported learning about water, sanitation, and hygiene (29%, 25%, 51%, respectively), while in the remaining sites caregivers least frequently reported learning about early stimulation (Kisumu: 36%, Siaya: 19%, Mukuru: 16%). Chi-square analyses were conducted in order to determine whether there were statistically significant differences between topics learned and individual site (see Table G4). There were statistically significant differences found between sites for every topic. For instance, significantly fewer caregivers in Mukuru (47%) reported learning about play as compared to all other sites (ranging from 79% of caregivers in Kasarani to 100% of caregivers in Kafue; χ^2 (5, N

= 365) = 34.33, $p < .01$). Fewer caregivers in Siaya (19% and Mukuru (16%) reported learning about early stimulation than caregivers in Chibombo (46%), Kafue (58%), and Kaserani (60%) (χ^2 (5, N = 365) = 37.80, $p < .01$).

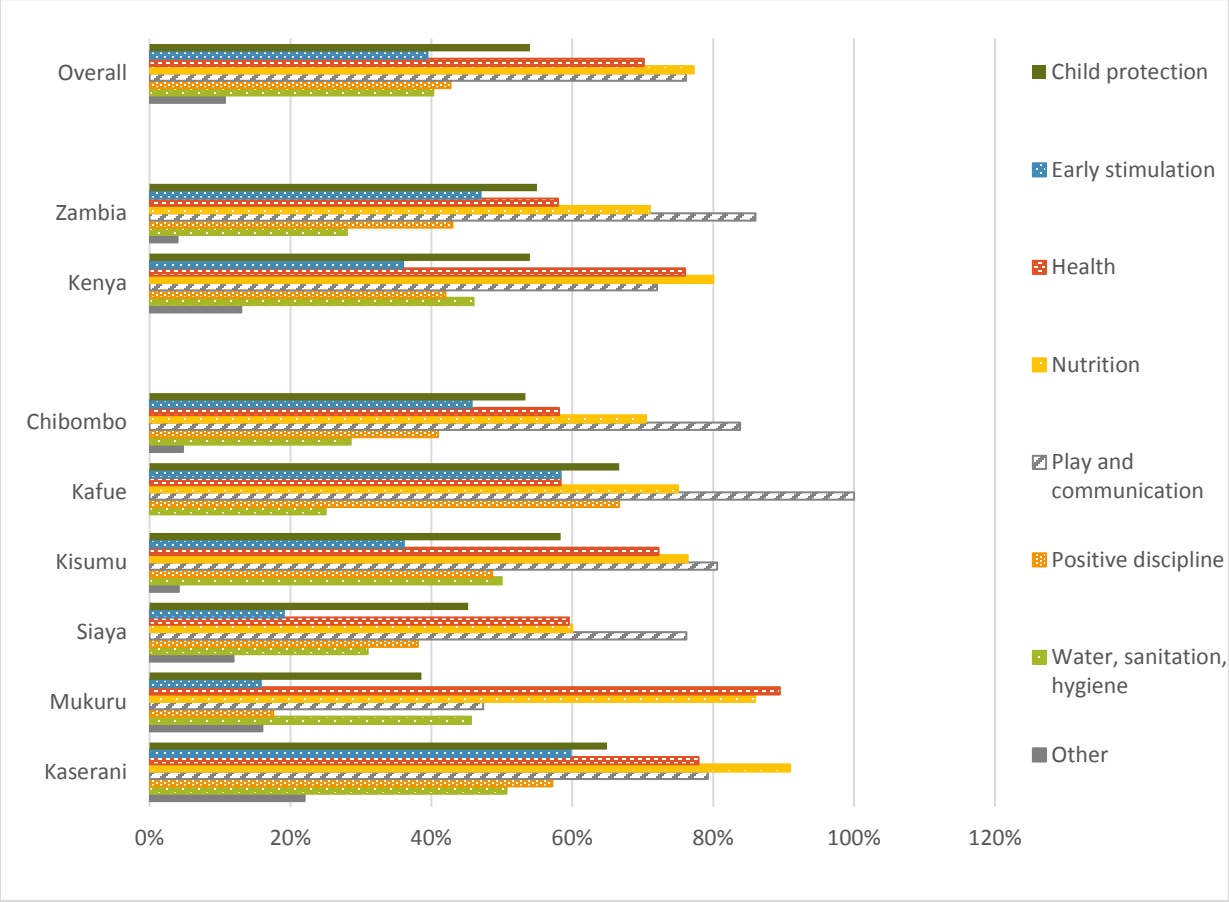

Figure 4. Percentage of caregivers reporting on topics learned in group parenting sessions.

Figure 5 presents the percentage of caregivers reporting on the most important topics learned during group parenting sessions. Caregivers were allowed to mention multiple topics as being important. Looking at all sites in aggregate, caregivers who participated in group parenting sessions reported that nutrition and play and communication were the most important topics they learned about (61% each). Early stimulation was least frequently reported as being an important topic, with a quarter of caregivers identifying it as being important to them.

When comparing countries, in Zambia, play and communication was most often reported by the caregivers as being important (74%), while water, sanitation, and hygiene was least often selected (22%). In Kenya, nutrition was most stated by caregivers as being important (62%) while early stimulation was least often mentioned (21%). Statistically significant differences were found between Zambia and Kenya in early stimulation and play and communication (see Table G6). 32% of caregivers in Zambia mentioned that early stimulation was an important topic learned during group parenting sessions while only 21% of caregivers in Kenya stated the same (χ^2 (1, N = 365) = 4.50, $p < .05$). 74% of caregivers in Zambia mentioned play and communication as an important topic as compared to 54% of caregivers in Kenya (χ^2 (1, N = 365) = 13.24, $p < .01$).

When looking at site-level data, in Chibombo District, Kafue District, Kisumu County, and Siaya County, play and communication was most often reported by parents as being the most important topic learned about in group parenting sessions (72%, 92%, 71%, and 64%, respectively). In the Nairobi sites, however, nutrition was most often mentioned as being the most important topic (Mukuru: 63%, Kasarani, 65%). In Kisumu, Siaya, and Mukuru, early stimulation was mentioned the least often as an important topic for caregivers (32%, 10%, and 9%, respectively), while in Chibombo District, Kafue District, and Kasarani, water, sanitation, and hygiene was mentioned the least often (25%, 0%, and 19%, respectively). Some significant differences were found between topic and site (see Table G7). For example, fewer caregivers in Mukuru selected play and communication as being an important topic learned (33%), compared to caregivers in Chibombo (72%), Kisumu (71%), and Siaya (64%) (χ^2 (5, N = 365) = 35.25, p < .01).

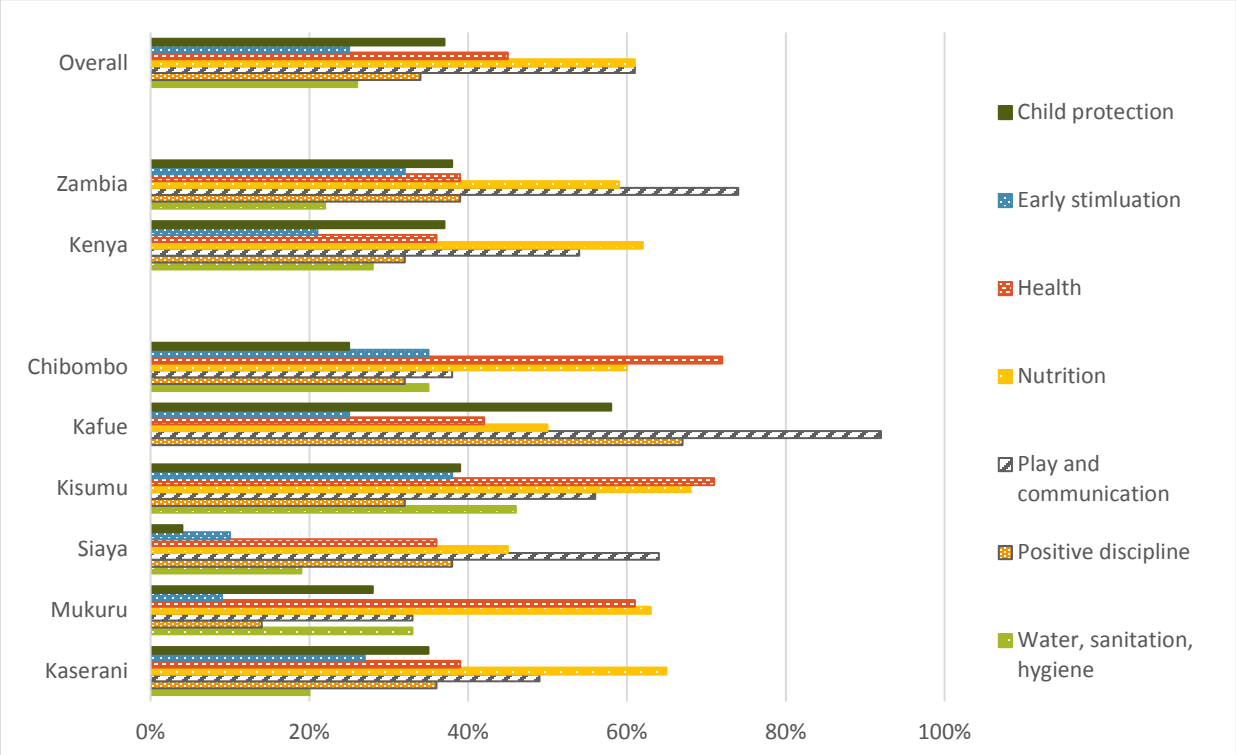

Figure 5. Percentage of caregivers reporting on most important topic learned during group parenting sessions.

Topics learned about in home visit sessions. Figure 6 presents the percentage of caregivers reporting on topics learned during home visit sessions. Caregivers were allowed to mention multiple topics. Across all sites in aggregate, the majority of caregivers (85%) reported learning about play and communication, followed by nutrition (61%) and health (53%). Of all topics reported, the topics least frequently reported by caregivers were water, sanitation, and hygiene (33%), followed by early stimulation and positive discipline (43% each).

Chi-square analyses were conducted in order to determine whether there were statistically significant differences between topics learned about in home visits and country (see Table G9). Statistically significant differences were found between both countries in child protection, early stimulation, play and communication, and water, sanitation, and hygiene. In Zambia, more

caregivers said they learned about child protection (49%) than those in Kenya (35%) (χ^2 (1, N = 386) = 6.00, $p < .05$). Half of caregivers in Zambia reported learning about early stimulation as compared to 21% of caregivers in Kenya ($\chi 2$ (1, N = 386) = 24.95, $p < .01$), and 88% of caregivers in Zambia reported learning about play and communication as compared to 78% of those in Kenya (χ^2 (1, N = 386) = 5.67, $p < .05$). More caregivers in Kenya reported learning about water, sanitation, and hygiene (43%) as compared to those in Zambia (30%) (χ^2 (1, N = 386) = 6.23, $p < .05$).

When looking at individual sites, caregivers participating in home visit sessions in nearly all sites most frequently reported learning about play, from 73% of caregivers in Siaya County to 95% in Kafue District. The only exception was Mukuru, where caregivers most frequently reported learning about health (96%). In both sites in Zambia, caregivers least frequently reported learning about water, sanitation, and hygiene (Chibombo: 30%, Kafue: 28%), while in Kisumu and Siaya caregivers least frequently reported learning about early stimulation (3% and 18%, respectively). In Kasarani, caregivers least frequently reported learning about positive discipline (29%) and in Mukuru, caregivers least frequently reported learning about both positive discipline as well as early stimulation (17% each). Chi-square analyses were conducted in order to determine whether there were statistically significant differences between topics learned during home visits and individual sites (see Table G10). Significant differences were indeed found between reported topics learned and sites. For instance, early stimulation was reported as a topic learned by 65% of caregivers in Kafue District, which was significantly higher than caregivers in Chibombo District (38%), Siaya County (18%), Mukuru (17%), and Kisumu (3%) (χ^2 (5, N = 386) = 61.22, $p < .00$). There was also a significant difference in the percentage of caregivers reporting learning about play and communication ($\chi 2$ (5, N = 386) = 22.88, $p < .01$), with fewer caregivers reporting learning about play and communication in Mukuru (65%) and Chibombo (64%) as compared to those in Kafue (92%), Kasarani (86%), Kisumu (84%), and Siaya (73%).

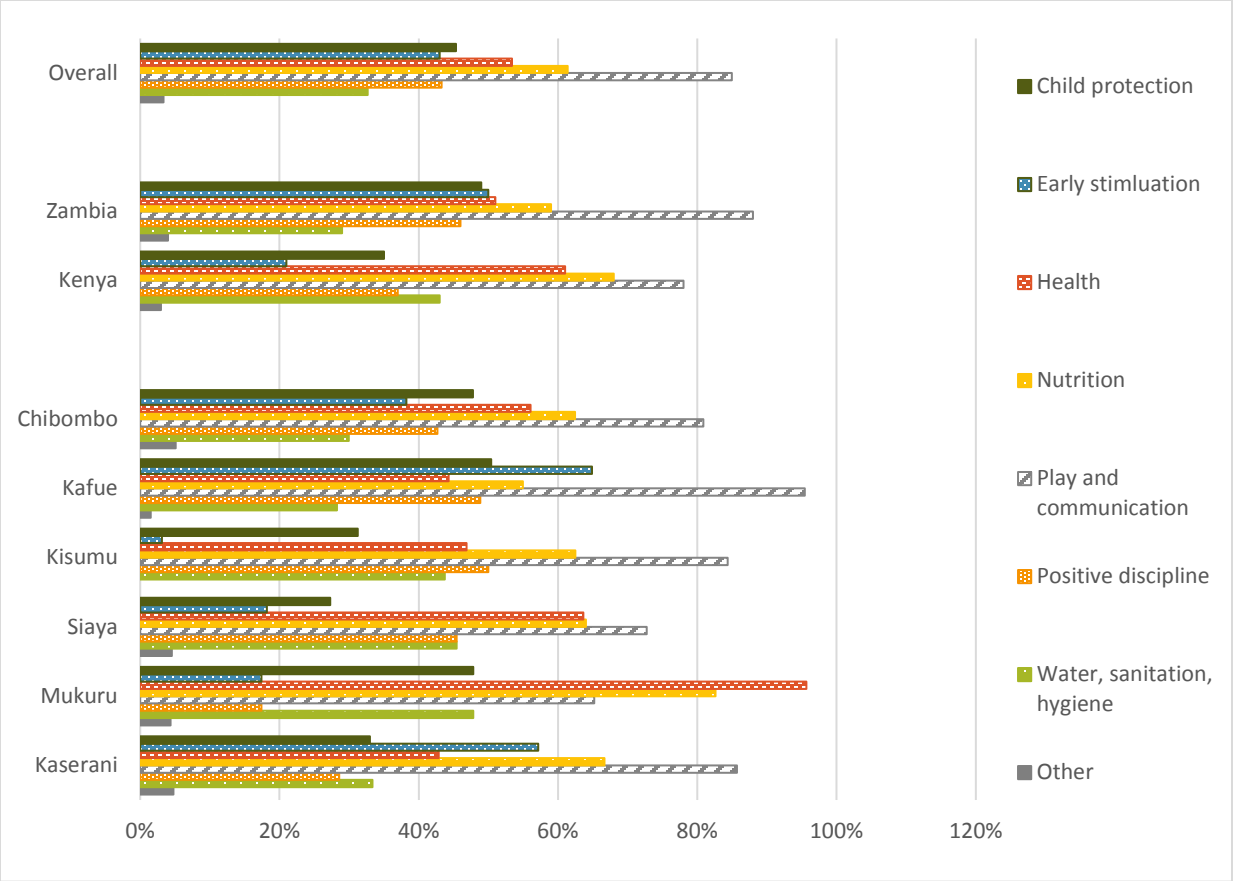

Figure 6. Percentage of caregivers reporting on topics learned in home visiting sessions.

Figure 7 presents the percentage of caregivers reporting on the most important topics learned in home visiting sessions. Caregivers were allowed to report that multiple topics were important to them. Across all sites in aggregate, caregivers who participated in home visit sessions reported that play and communication (72%) was the most important topic they learned about, with nutrition (47%) and health (42%) coming in second and third. Water, sanitation, and hygiene and early stimulation were least frequently reported as being important topics learned (21% of caregivers and 28%, respectively).

When comparing countries, play and communication was mentioned most frequently by caregivers in both Zambia and Kenya as an important topic learned during home visiting sessions (74% and 63%, respectively). Water, sanitation, and hygiene was least frequently mentioned by caregivers in Zambia (19%) while early stimulation was least frequently chosen by caregivers in Kenya (8%). Chi-square analyses were conducted in order to determine whether there were any statistically significant differences between important topics and country (see Table G12). Significant differences were found between both countries in child protection (χ^2 (1, N = 386) = 5.08, $p < .05$), early stimulation (χ2 (1, N = 386) = 25.60, $p < .01$), play and communication (χ^2 (1, N = 386) = 4.37, $p < .05$), and positive discipline (χ^2 (1, N = 386) = 5.03, $p < .05$). Caregivers in Zambia more often chose those four aforementioned topics as being important as compared to caregivers in Kenya.

In Chibombo District, Kafue District, Kisumu, and Kasarani, play and communication was most often reported by caregivers as being the most important topic they learned about during home visiting sessions (67%, 83%, 78%, and 67%, respectively). In Siaya, the most

important topic was nutrition (64%), while in Mukuru it was health (78%). In Chibombo, Kisumu, Siaya, and Mukuru, early stimulation was chosen the least often as being an important topic (26%, 3%, 9%, and 9%, respectively). In Kafue, water, sanitation, and hygiene was least often chosen (9%), while in Kasarani it was health (10%). Chi-square analyses were conducted in order to determine whether there were any statistically significant differences between important topics and individual sites (see Table G13). Some significant differences were found between topics learned and sites. For example, early stimulation was reported most frequently as an important topic learned during home visiting sessions by caregivers in Kafue (45%), which was significantly higher than caregivers in all other sites: Chibombo (26%), Kasarani (14%), Mukuru (9%), Kisumu (3%), and Siaya (3%) ($\chi 2$ (5, N = 386) = 39.09, p < .01).

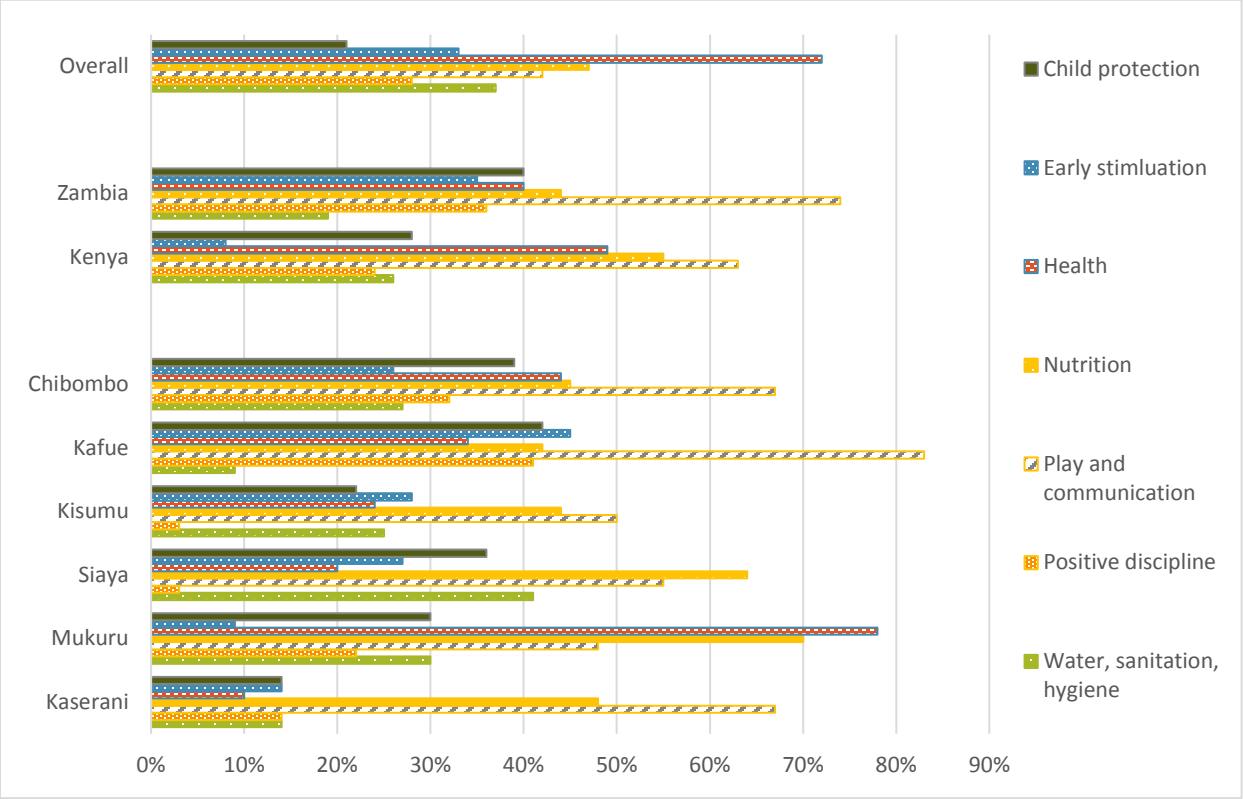

Figure 7. Percentage of caregivers reporting on most important topic learned during home visiting sessions.

Research Question 1.1.a: Did household vulnerability change over time? Figure 8 presents the percentage of households at each well-being level, as estimated by enumerators. Across all sites the majority of all households (53%) were categorized as "life is hard, sometime struggling", the second lowest level, while just over a third (34%) were categorized as "struggling almost all of the time", the lowest vulnerability level. 12% of all households were categorized as "coping most of the time" and only one per cent of households were in the highest well-being level, "coping well almost all of the time."

When looking at country-level data, the overall pattern of household well-being rankings wasis generally the same as the group average, with the smallest percentage of households at the highest well-being level and the most in the second-lowest level, "life is hard, sometimes struggling." There was an association found between country and household well-being ((χ^2 (3,

N = 667) = 16.81, p < .01). Zambia has proportionately more households in the "life is hard, sometimes struggling" level (58%), as compared to Kenya (49%) and proportionately fewer households in the "coping most of the time" level (8%; Kenya = 16%).

When looking at data disaggregated by site, the overall pattern of household well-being rankings was generally the same at all study sites, with the largest percentage in the "life is hard, sometime struggling" level, the second lowest level, and the next largest in the struggling almost all the time" level, the lowest level. The only exception to this is in Mukuru, where there were slightly more households categorized in the "coping most of the time" level (34%) than the "struggling almost all the time" level (33%). There was an association found between site and household well-being (χ^2 (15, N = 667) = 66.81, p < .01). Amongst study sites, Siaya County had s the largest percentage (43%) of households in the lowest well-being level, "struggling almost all the time", though just over half of its households (52%) are categorized as "life is hard, sometime struggling." At the other end of the spectrum, while Chibombo District has the largest percentage of households (3%) in the highest well-being level, "Coping well almost all of the time," Mukuru has the largest percentage of households (37%) in the highest two well-being ranking categories.

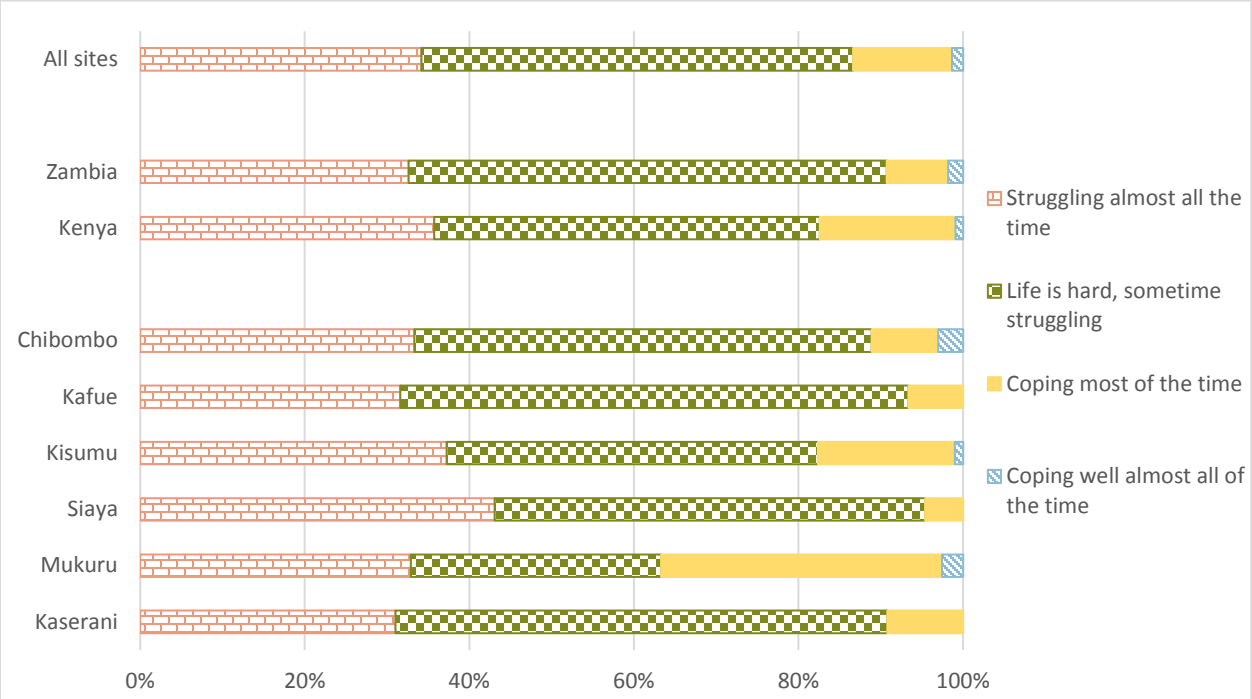

Figure 8. Household vulnerability levels, as reported at endline.

When looking at aggregated data, there is a general pattern of more households being categorized at higher well-being levels at endline. From baseline to endline, there is an overall decrease in the percentage of households at the lowest well-being level, "struggling almost all the time", and overall increases in the next two well-being levels, "life is hard, sometime struggling," and "coping most of the time." The largest increases are generally in the second lowest level, "life is hard, sometimes struggling", with 32% of households at baseline categorized at this well-being level as compared to 53% at endline.

Baseline data did not include comparisons at the country level. In looking at site-level data, the biggest increases at the "life is hard, sometimes struggling" level are seen in Kafue,

with 14% of families categorized at this level at baseline and 62% at endline. At the second highest well-being level, "coping most of the time," the biggest increases are seen in Mukuru (8% at baseline, 34% at endline) and Kisumu (7% at baseline, 17% at endline). There are a couple of instances where fewer households are being categorized at these higher well-being levels. For instance, in Siaya, while at baseline 12% of households were categorized as "Coping most of the time", at endline only 5% of households were in this category. In Kasarani, 2% of households were categorized at the highest well-being level, "Coping well almost all of the time," but at endline, no households were in this category. Similarly, in Chibombo, 4% of households were classified at the highest well-being category but 3% at baseline. See Figure 9.

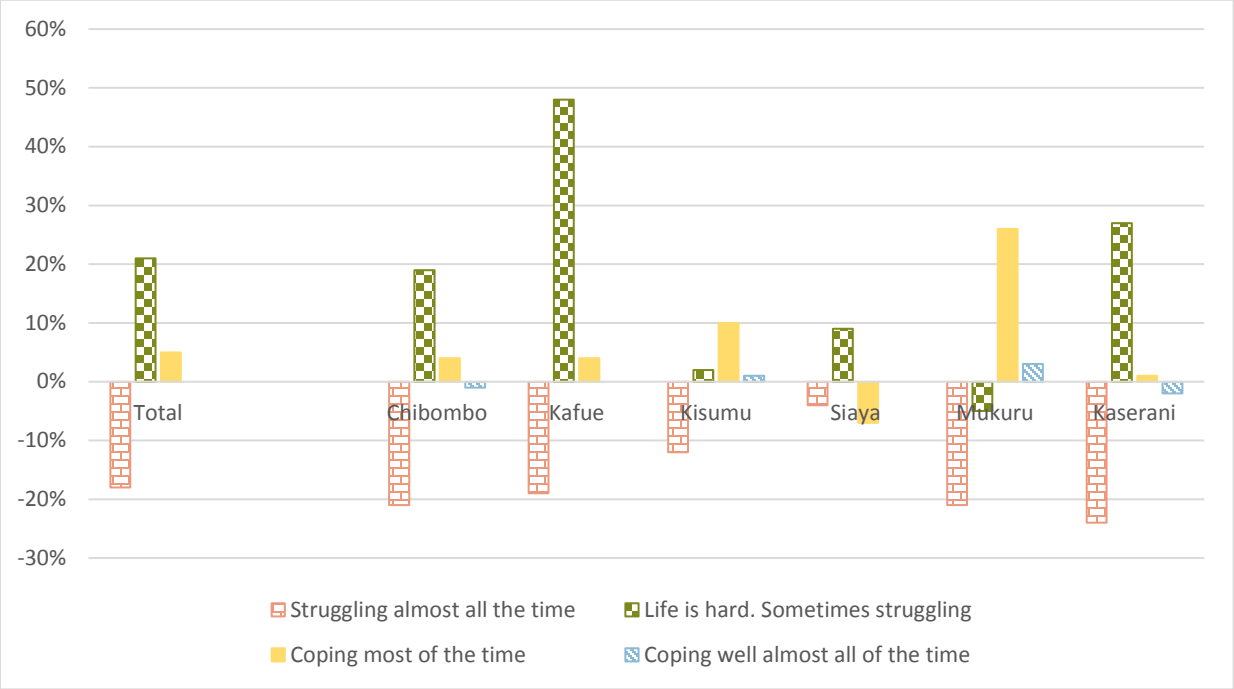

Figure 9. Change in percentage of households categorized at each well-being level, baseline vs. endline.

Research Question 1.1.b: Were caregivers satisfied with their participation in the initiative? Caregivers were asked a series of questions regarding their experience with the intervention. Figure 10 presents overall ratings of the group facilitator or home visitor. Looking at the data in aggregate, 60% of the caregivers rated the service provider as being very good (34%) or excellent (26%). 33% rated the service provider as being good, 3% as average, and .3% as poor.

In looking at data disaggregated by country, more caregivers in Kenya either rated the service provider as being average (4%) or good (38%) than in Zambia (2% and 28%, respectively), while more caregivers in Zambia rated the service provider as being very good (34%) or excellent (30%) than in Kenya (22% and 22%, respectively). This difference, however, was not statistically significant.

In looking at data disaggregated by site, there were statistically significant differences between the ratings of service providers (χ^2 (20, N = 641) = 36.98, p < .05). Caregivers in Mukuru expressed the highest satisfaction with service providers, with 73% of caregivers rating

group facilitators/home visitors as being very good (41%) or excellent (32%), followed by caregivers in Kafue (very good: 32%, excellent: 36%) and Chibombo (very good: 36%, excellent: 25%). Caregivers in Kasarani, on the other hand, expressed the least satisfaction with service providers, with 9% of caregivers rating service providers as being poor (1%) or average (8%).

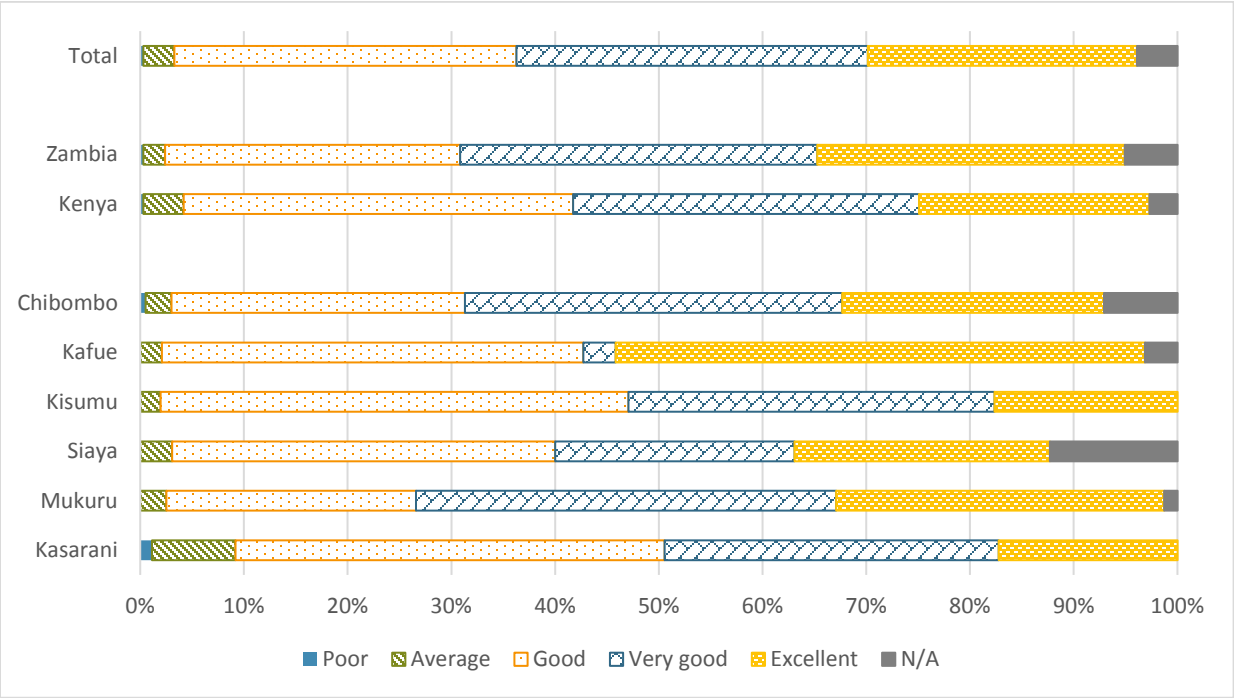

Figure 10. Overall rating of the group facilitator/home visitor.

Figure 11 presents ratings of the project's services, such as being friendly and warm towards the caregiver, treating the caregiver with respect, and not being cold or abrupt. Looking at the aggregated data, 60% of caregivers rated the project's services as being very good (38%) or excellent (22%). 35% of caregivers rated the services as being good, 2% as average, and .4% as poor.

In looking at data disaggregated by country, more caregivers in Zambia gave higher ratings to the project's services than caregivers in Kenya. 40% of caregivers in Zambia rated the services as being very good and 27% as excellent, compared to 35% of caregivers in Kenya rating the services as being very good and 17% as excellent. These differences were statistically significant (χ^2 (4, N = 642) = 22.37, $p < .05$).

In looking at data disaggregated by site, there were statistically significant differences between the ratings of the services provided by the project (χ^2 (20, N = 642) = 42.42, $p < .05$). Caregivers in Kafue District expressed the most satisfaction with the project's services, with 71% of caregivers rating the services as being very good (36%) or excellent (35%). This was followed by caregivers in Chibombo (very good: 42%, excellent: 21%). At the same time, however, there were more caregivers in Chibombo and Kasarani who rated the project's services as being poor (Chibombo: 1%; Kasarani: 1%) or average (Chibombo: 2%, Kasarani: 2%), though these percentages are rather low.

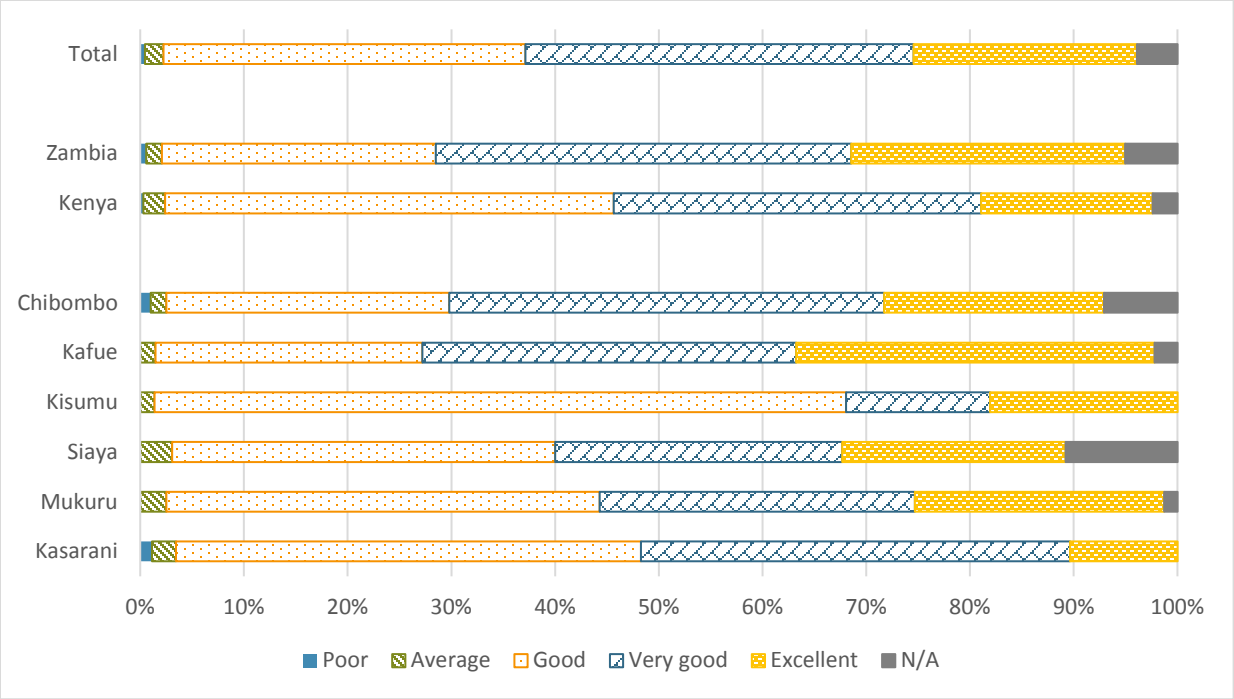

Figure 11. Overall rating of the project's services.

Figure 12 presents ratings of the project regarding providing information valued and needed by the caregiver, such as answering caregivers' questions, providing adequate information to the caregiver, and not being vague. 42% of aggregated caregivers rated the information provided as being very good (38%) or excellent (4%). 35% of caregivers rated the information provided as being good, 2% as average, and .3% as poor.

In looking at data disaggregated by country, more caregivers in Zambia rated the information provided by the project as being excellent (25%) than those in Kenya (16%). More caregivers in Kenya rated the information provided as being good (40%), average (4%), and poor (2%) as compared to those in Zambia (29%, 2%, and .3%, respectively). These differences were statistically significant (χ^2 (4, N = 641) = 13.91, $p < .05$).

In looking at data disaggregated by site, there were also statistically significant differences in ratings of information provided by the project (χ^2 (20, N = 641) = 39.51, $p < .05$). Caregivers in Kafue expressed the most satisfaction, with 66% of caregivers rating the information provided as being very good (34%) or excellent (32%). This was followed by caregivers in Mukuru (very good: 42%, excellent: 23%) and in Chibombo (very good: 41%, excellent: 20%). There were, however, more caregivers in Mukuru who also rated the information provided as being average (6%), though this was a relatively low percentage. Caregivers in Kasarani also expressed the least satisfaction with the information provided, with 1% providing a poor rating and 5% an average rating.

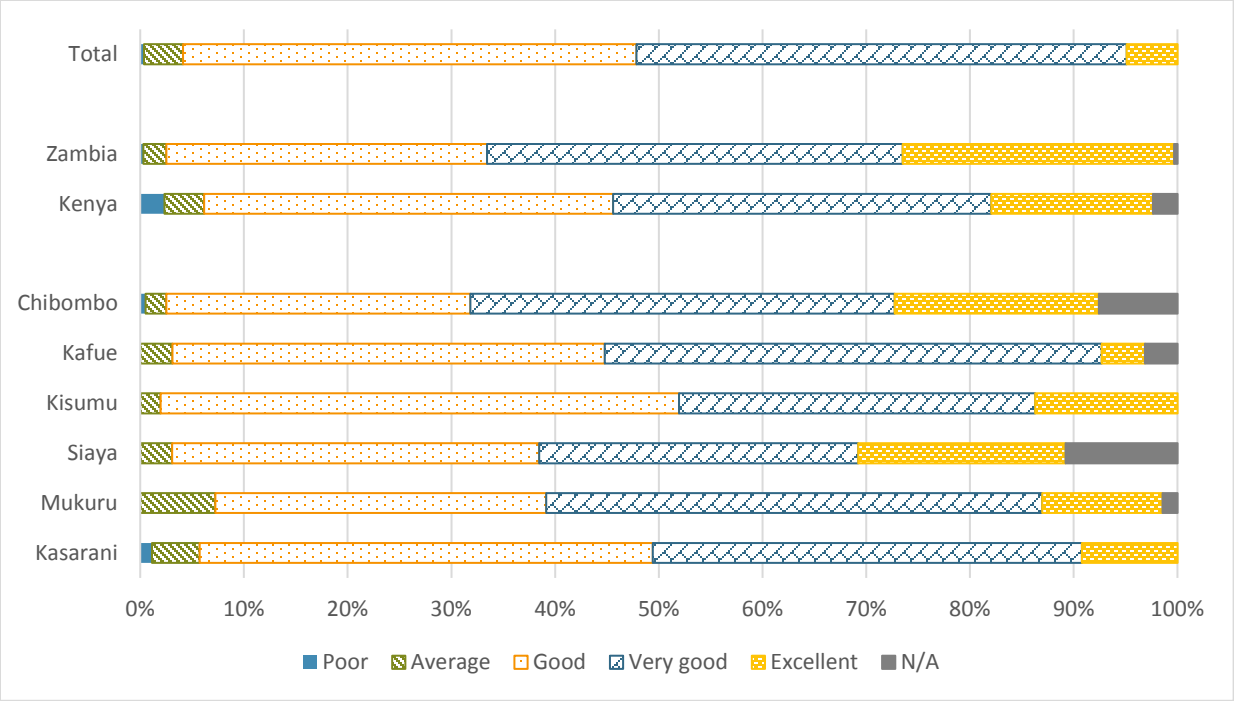

Figure 12. Rating of the project in providing needed information.

Figure 13 presents ratings of the project regarding helping the caregiver take charge and find his/her own solutions to family issues. Examples of this are the group facilitator/home visitor exploring options regarding what the caregiver can do to improve his/her child's health, the group facilitator/home visitor encouraging the caregiver rather than lecturing him/her, and providing referrals and linkages to other services and service providers. Over half of aggregated caregivers rated the project's assistance in this aspect as being very good (31%) or excellent (21%). 38% of caregivers provided a good rating, 4% average, and 1% poor.

In looking at the data disaggregated by country, more caregivers in Zambia rated the project's assistance as being excellent as compared to caregivers in Kenya (23% and 18%, respectively). However, more caregivers in Zambia also rated the project's assistance as being average (5%) or poor (2%) as compared to caregivers in Kenya (3% and 1%, respectively). More caregivers in Kenya rated the project's assistance as being very good (33%) or good (43%) as compared to those in Zambia (29% and 34%, respectively). These differences were statistically significant (χ^2 (4, N = 636) = 10.47, p < .05).

In looking at data disaggregated by site, statistically significant differences were found in site ratings of the project's assistance (χ^2 (20, N = 642) = 44.01, p < .05). Caregivers in Mukuru expressed the most satisfaction with the project's assistance, with 61% of caregivers rating the support as either very good (38%) or excellent (23%). Caregivers in Kasarani provided the lowest ratings of the project's assistance, with 9% of caregivers rating the support as being either poor (2%) or average (7%). This was followed by caregivers in Chibombo (poor: 3%, average: 5%) and Kafue (poor: 2%, average: 4%).

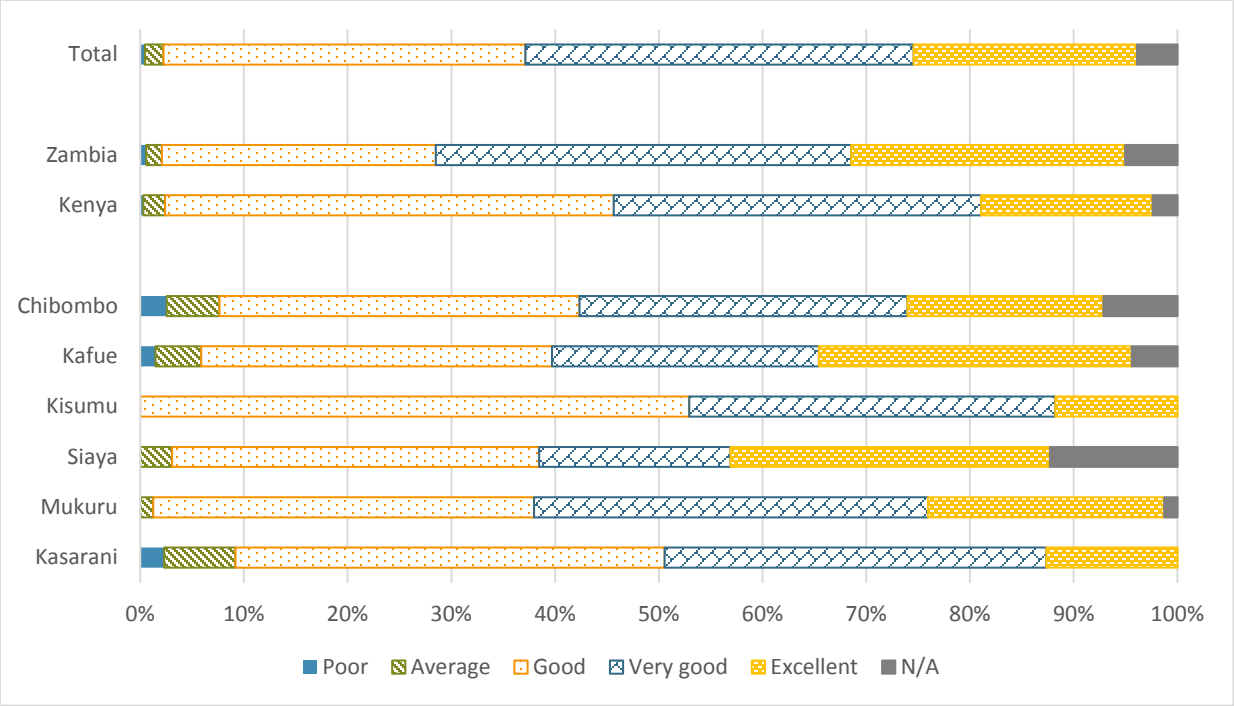

Figure 13. Rating of the project in helping caregiver find own solutions.

Research Question 1.2: As a Result of the Interventions in Group Parenting Sessions or Home Visits, How Did Caregivers' Knowledge and Practices Regarding Stimulation and Responsive Care and Other Domains of Nurturing Care?

For this research question, caregivers' knowledge of child development and responsive care was queried as well as whether there was any change in caregiver practices linked to child-related outcomes, notably around caregiver-child interactions as well as the availability and use of play materials. Other child's rights and participation as well as domains of nurturing care knowledge and practices were also examined, including knowledge of children's rights; child participation; child safety and protection, which included positive discipline as well as environmental and neighborhood safety; preventative health/immunizations; nutrition, which included breastfeeding practices and number of daily meals; and hygiene practices.

Knowledge of child development and responsive care. Figure 14 presents reported sources of information about child development and responsive care. Caregivers were allowed to select multiple options as answers. Looking at the aggregated data, 92% of caregivers responded they had learned and/or received information on child development and responsive care. Approximately half of the caregivers responded that they had learned about child development and responsive care through parenting sessions (54%) and CHVs (53%). 13% also responded they had gotten this information from health workers, and a small handful responded neighbor (2%), grandmother (1%), mother (2%), and father (.3%). Other sources of information include books, church, doctors, and the radio.

Looking at country-level data, 89% of caregivers in Zambia reported having learned about child development while 95% of caregivers in Kenya did. The majority of caregivers in Zambia reported learning about child development and responsive care from CHVs at the household (75%), while in Kenya the majority reported group parenting sessions (74%). 33% of caregivers in Zambia reported learning about child development from group parenting sessions

and 30% of caregivers in Kenya from CHVs at the household. 19% of caregivers in Zambia reported health workers as a source of information while 10% of caregivers in Kenya did.

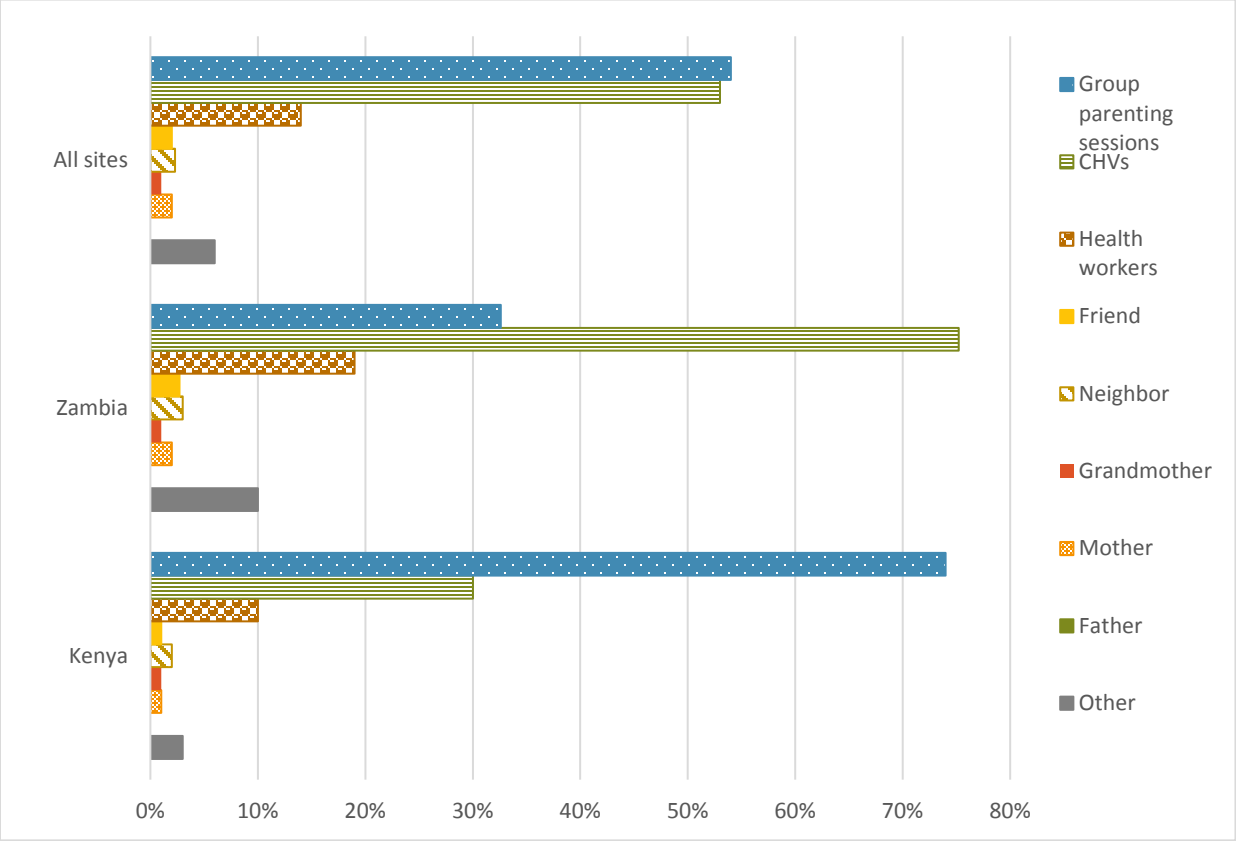

Figure 14. Sources of information about child development and responsive care, by country.

By program participation type. Figure 15 presents sources of information about child development and responsive care, by participation type. Not surprisingly, the majority of caregivers participating in the group parenting sessions said they had learned about child development in their parenting sessions (93%), while the majority of caregivers participating in home visits said they had learned this information through CHVs (82%). Those participating in both kinds of sessions reported learning about child development equally through parenting sessions (76%) and from CHVs (76%).The next most-commonly cited source was health workers, ranging from 12% for those who had participated only in group parenting sessions to 17% for those who had participated only in home visits.

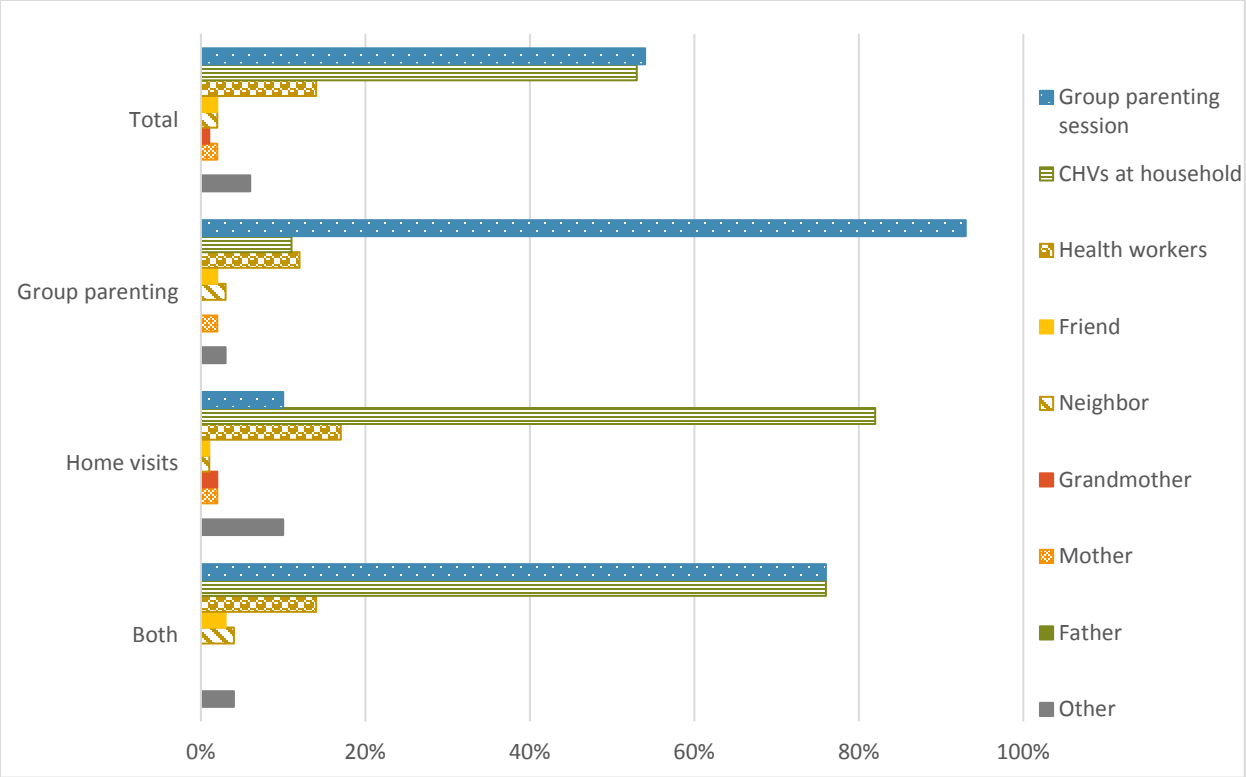

Figure 15. Sources of information about child development and responsive care, by program participation type.

Changes in caregiver practices linked to child-related outcomes. Changes in how caregivers care for their children were examined, as well as child-caregiver interactions, availability and use of play materials, knowledge of children's rights, child participation, child safety and protection (which included content such as positive discipline, child protection, and environmental and neighborhood safety), preventative health, nutrition, and hygiene practices. Where possible, endline data was compared to baseline data in order to examine change over the course of the project period.

Changes in how caregivers care for their children. Figure 16 presents caregiver-reported change in interactions with children post-training, by country and by site. Across all sites, in aggregate, 92% of caregivers responded that the group parenting sessions/home visits influenced how they care for their child. 59% said that they now play more with their child, while 50% said that their child now has play toys. Other areas of change include spending more time with their child (46%), communicating with their child (41%), using positive discipline with their child (39%), and taking their child to the health facility immediately if the child becomes ill (33%). Other changes mentioned by caregivers also include feeding children appropriately, the ability to read children's emotions, and not harassing children.

When looking at country-level data, 94% of caregivers in Zambia and 91% of caregivers in Kenya reported that the group parenting sessions/home visits influenced how they care for their child, Caregivers in Zambia more often report that their child now has toys (55%) and playing more with the child (61%) as compared to caregivers in Kenya reported as changes they have made in interacting with their child. Caregivers in Kenya more often reported that they use positive discipline (43%), communicate with the child (45%), and take the child immediately to a health facility if sick (37%) as compared to caregivers in Zambia.

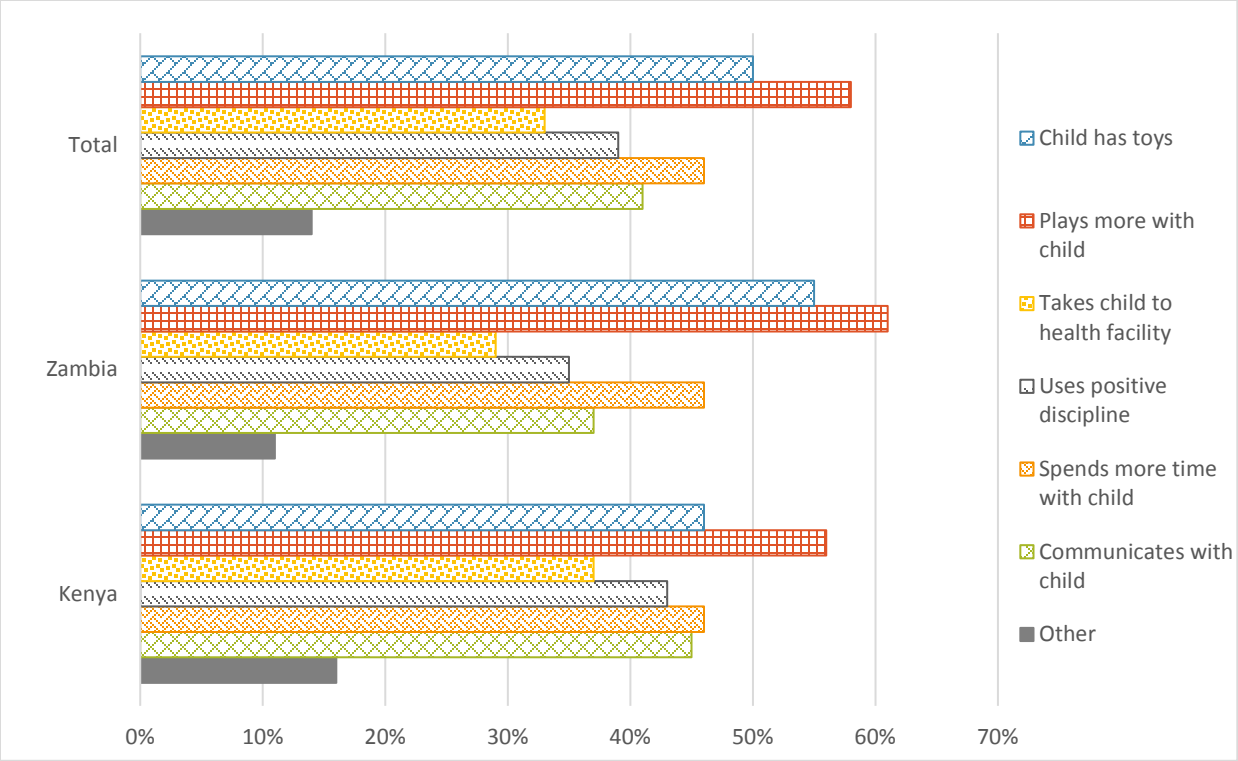

Figure 16. Caregiver-reported changes in interactions with children post-training, by country.

Interactions with young children. Figure 17 presents caregiver-reported interactions with children. Caregivers were asked how often they, or any household member, interacted with their child in the previous three days. When looking at the aggregated data, most parents responded that they (or another household member) sang songs to their child (69%) and 63% that they played with their child. Just over half (51%) reported telling stories, 32% said they counted or drew with their child, and just over a quarter (26%) said they read books or looked at picture books with their child. Finally, 19% responded that they went outside their home compound with their child.

When looking at data disaggregated by country, overall, caregivers in both countries followed the same pattern, with the exception of more caregivers in Kenya reporting playing with the child (69%) as opposed to singing songs or lullabies (68%). Chi-square analyses were run to compare the two countries, and some significant differences existed between Zambia and Kenya (see Table G24). More caregivers in Kenya (23%) reported taking the child outside the home compound as compared to Zambia (χ^2 (1, N = 667) = 5.23, $p < .05$) as well as reading books (Kenya: 29%, Zambia: 22%; $\chi 2$ (1, N = 667) = 4.25, $p < .05$) and playing with the child (Kenya: 69%, Zambia: 57%; χ^2 (1, N = 667) = 10.08, $p < .01$). More caregivers in Zambia reported counting/drawing things with the child (36%) as compared to those in Kenya (28%) (χ^2 (1, N = 667) = 4.20, $p < .05$).

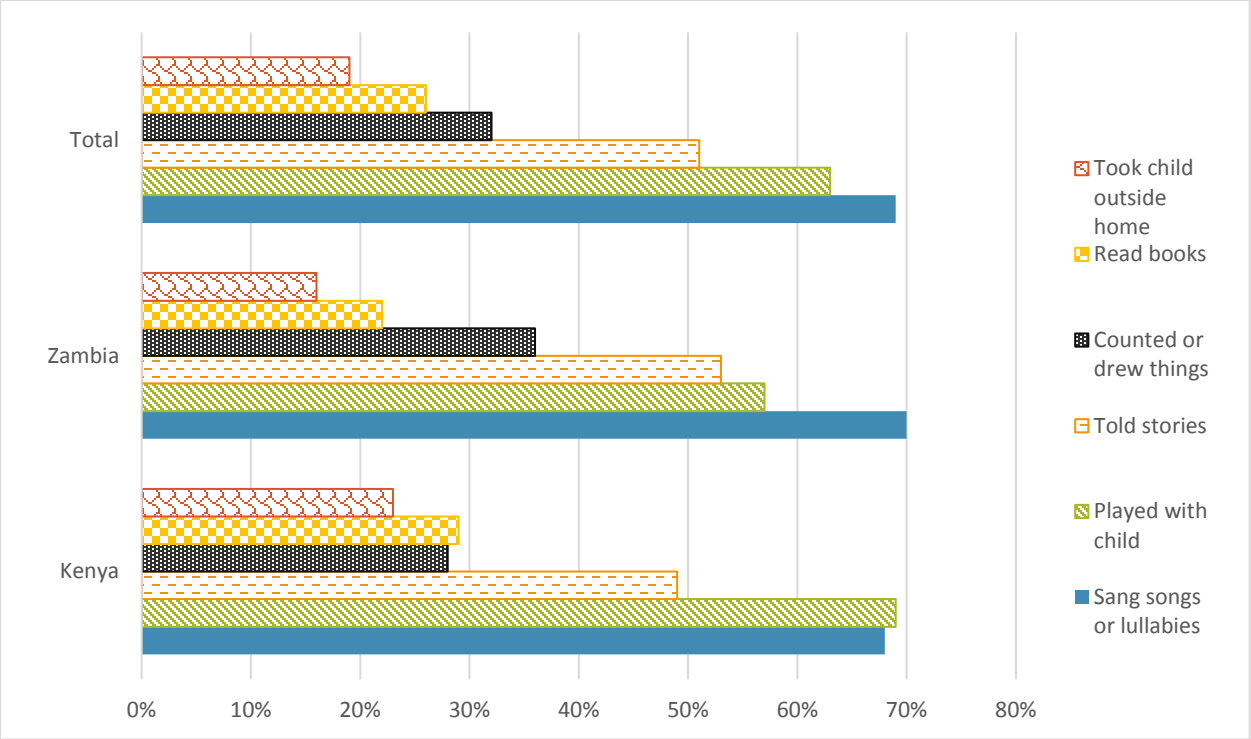

Figure 17. Caregiver-reported interactions with children in past three days, by country.

If the child was present during administration of the household survey, enumerators observed how the caregiver interacted with the child. Figure 18 presents observed child-caregiver interactions, by country and by site. When looking at the data in aggregate, nearly all of the time, caregivers kept the child within visual range and looked at him/her often (96%) and also initiated eye contact and smiled (96%). Caregivers also often initiated interaction with the child, such as talking, touching, singing, storytelling, massaging the child, cuddling, and/or rocking (90%), provided toys and objects for the child to play with (93%), and provided opportunities for the child to interact with others (91%). When observing the child response, enumerators noted that children responded in kind, with 93% smiling, laughing, and/or playing with the caregiver.

When looking at country-level data, by and large, similar patterns are seen in terms of observed child-caregiver interactions. Caregivers in Zambia and Kenya kept their child in visual range 96% of the time, and 95% of the time initiated eye contact and smiling. Chi-square analyses were conducted in order to determine whether there were any statistically significant differences between countries for any of these observed child-caregiver interactions. The only differences seen are that caregivers in Zambia were slightly more likely to initiate interaction with their child (93%) as compared to those in Kenya (87%) (χ^2 (1, N = 485) = 3.86, p < .05).

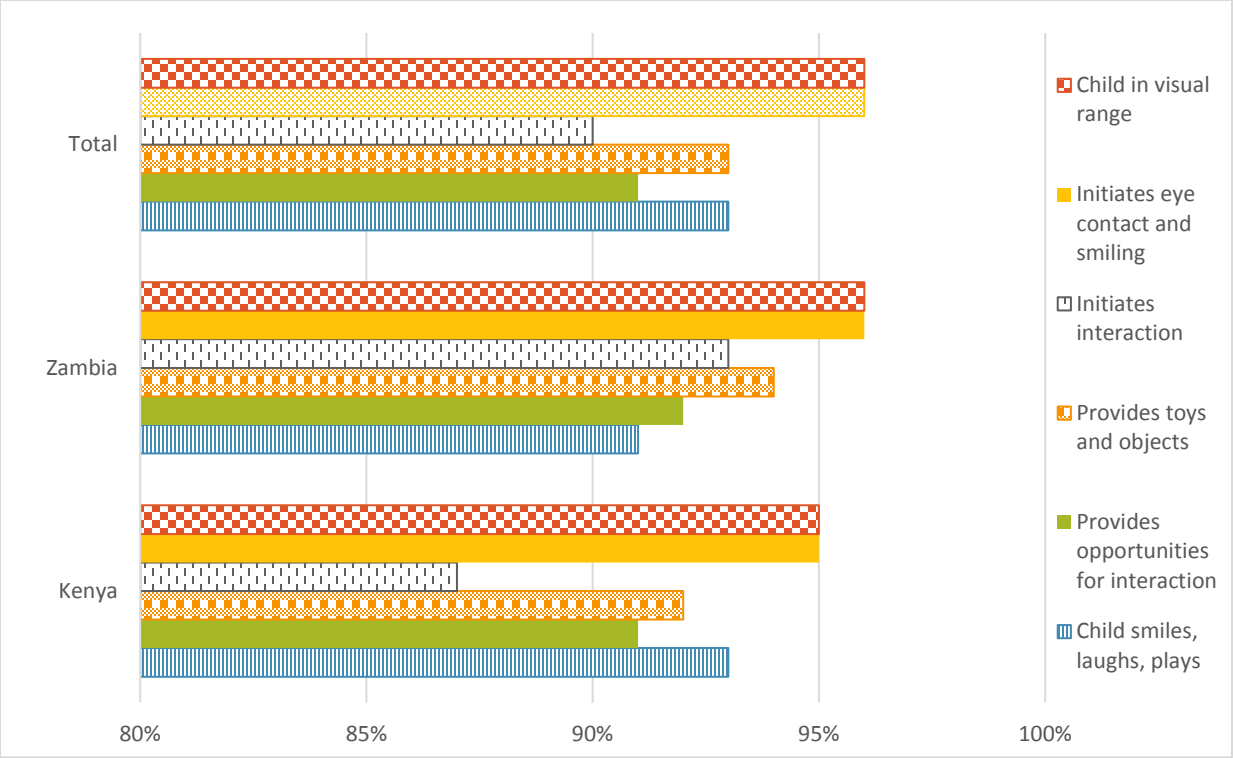

Figure 18. Observed caregiver-child interactions, by country.

Availability and use of play materials. Enumerators observed whether or not there were toys in the household. Figure 19 presents the presence of toys in the house, by country and by site. Enumerators observed toys being available for the child in 75% of households. In 23% of the households, toys were not available, and in 2% of households, caregivers refused to display toys. 99% of toys were observed to be age appropriate.

When looking at the data at the country level, again, the majority of households have toys available in the household (Zambia: 73%, Kenya: 77%) and roughly a quarter do not (Zambia: 25%, Kenya: 20%). There were no significant differences by country (F (1, 665) = 3.20, $p > .05$).

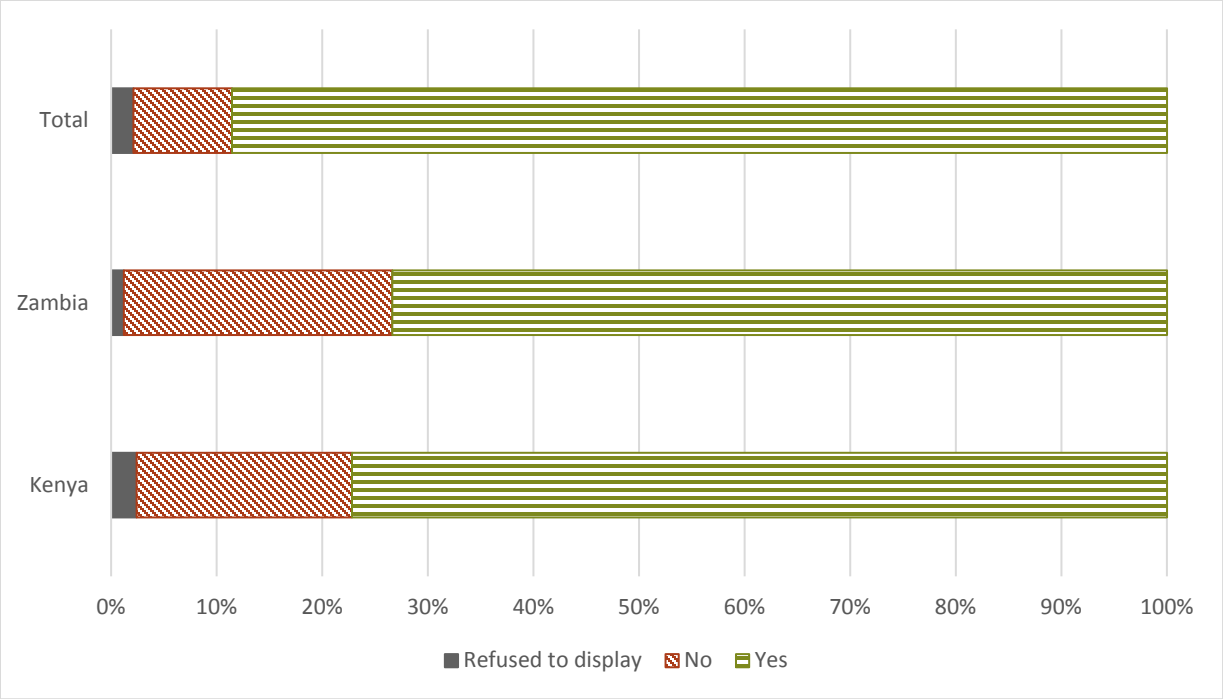

Figure 19. Presence of toys in household, by country and by site.

When caregivers were asked what made them acquire toys for their child, in looking at the aggregated data, over half of caregivers attributed this decision to participating in group sessions and/or home visits (group parenting sessions: 22%; home visits: 30%). 27% of caregivers responded it was their own decision made without any outside influence, and 10% responded that they saw their neighbor's child with toys. Other reasons caregivers provided for why they bought toys for their child were that the child wanted the toy, to make the child happy and active, to keep the child from playing with dangerous objects, and that the toys were given as gifts. Figure 20 presents reasons caregivers acquired toys for their children, by country and by site.

In looking at data disaggregated by country, more caregivers in Zambia said they purchased toys after being educated by the CHVs (44%) than caregivers in Kenya (18%), whereas more caregivers in Kenya reporting purchasing toys after attending group sessions (33%) than those in Zambia (11%). Roughly a quarter of caregivers in each country also reported it was their own decision to purchase toys, and another 10% said that they acquired the toys after seeing a neighbor's child with the toy. Differences between countries, however, was not statistically significant ($F(1, 665) = 3.20$, $p > .05$).

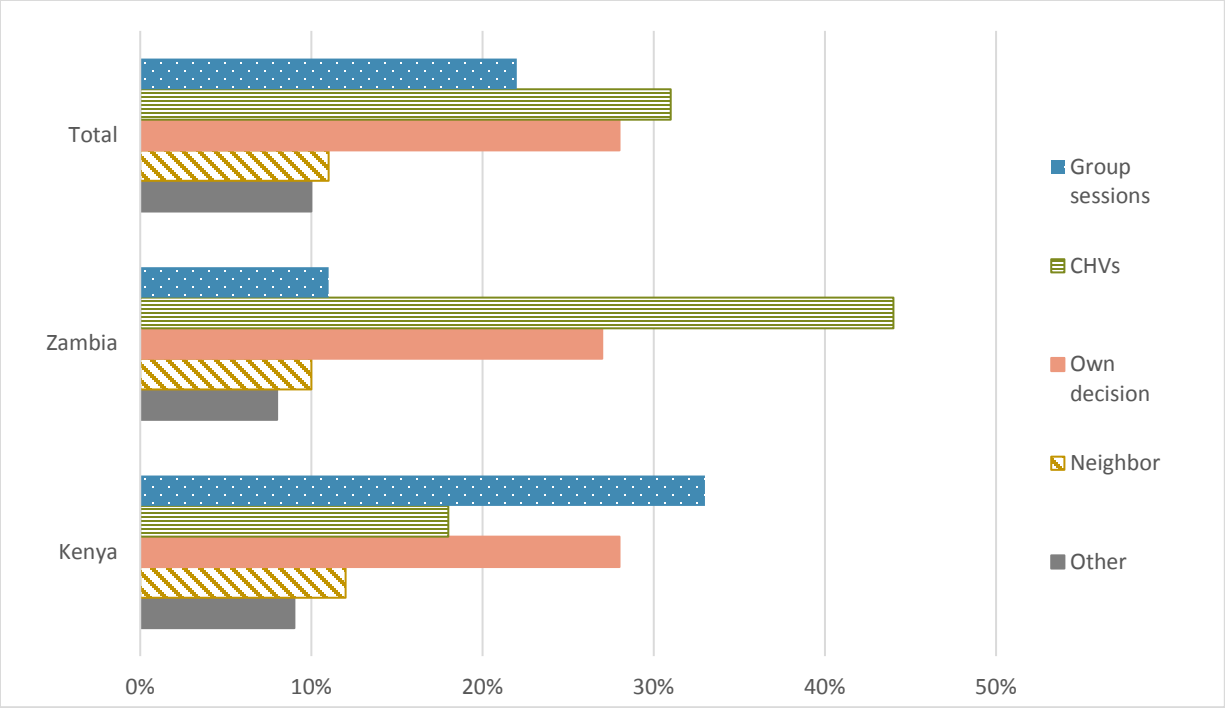

Figure 20. Reasons caregivers acquired toys for their children, by country.

Knowledge of children's rights. In looking at aggregated data, when queried whether they know about children's rights, 73% of all caregivers responded that they did know about children's rights. Right to education was reported by the most caregivers as a right they were aware of (53%), followed by right to parental care (38%), right to health care (36%), and right to life (30%). 12% of caregivers reported knowing about right to leisure and recreation as well as protection from child abuse, respectively. At the other end of the spectrum, fewer than 5% of caregivers reported knowing about protection from harmful cultural practices, protection from drugs, right of children with disabilities to be treated with dignity, right of name and nationality, and right to privacy. See Table 6. Other rights parents reported knowing about included the right to food, right to play, right to security, right to be listened to, and the right to do what they want.

When looking at country-level data, 56% of Zambian caregivers responded they knew about children's rights while 90% of Kenyan caregivers responded in the affirmative. This difference was statistically significant (χ^2 (2, N = 667) = 98.47, p < .05). Amongst caregivers in Zambia, the highest percentages reported knowing about a child's right to education (34%), right to health care (19%), right to life (18%), and right to parental care (18%), while the lowest percentages reported knowing about protection from drugs (4%), right of children with disabilities to be treated with dignity (4%), right to name and nationality (4%), and right to privacy (3%). In Kenya, the highest percentages of caregivers reporting knowing about right to education (72%), right to parental care (57%, and right to health care (54%) while the lowest percentages reported knowing about protection from harmful cultural practices (5%), protection from drugs (5%), right to privacy (5%) right of children with disabilities to be treated with dignity (5%), and right to name and nationality (4%).

Chi-square analyses were conducted in order to determine whether there were any statistically significant differences between countries (see Table G29). A significantly higher percentage of caregivers in Kenya as compared to those in Zambia reported knowing about the

following rights: right to education (χ^2 (1, N = 487) = 19.16, p < .00), right to parental care (χ2 (1, N = 487) = 46.00, p < .01), right to health care (χ^2 (1, N = 487) = 32.37, p < .01), and right to life (χ^2 (1, N = 487) = 10.26, p < .01). A significantly higher percentage of caregivers in Zambia reported knowing about the following rights: right to leisure and recreation (χ^2 (1, N = 487) = 17.88, p < .01), protection from child abuse (χ^2 (1, N = 487) =, 12.90, p < .01), and right to protection from child labor (χ^2 (1, N = 487) =,13.71, p < .01).

Table 6

Knowledge of Children's Rights, by Country

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
Yes, know about children's rights	487 (73.0%)	187 (56.0%)	300 (90.1%)
Right to education	354 (53.1%)	115 (34.4%)	239 (71.8%)
Right to parental care	251 (37.6%)	60 (18.0%)	191 (57.4%)
Right to health care	241 (36.1%)	62 (18.5%)	179 (53.8%)
Right to life	203 (30.4%)	61 (18.3%)	142 (42.6%)
Right to leisure and recreation	81 (12.1%)	48 (14.4%)	33 (9.9%)
Protection from child abuse	80 (12.0%)	45 (13.5%)	35 (10.5%)
Right to protection from child labor	64 (9.6%)	38 (11.4%)	26 (7.8%)
Right to religious education	54 (8.1%)	26 (7.8%)	28 (8.4%)
Right to protection from armed conflict	49 (7.3%)	22 (6.6%)	27 (8.8%)
Protection from sexual exploitation	37 (5.5%)	16 (4.8%)	21 (6.3%)
Protection from harmful cultural practices	33 (4.9%)	18 (5.4%)	15 (4.5%)
Protection from drugs	29 (4.3%)	13 (3.9%)	16 (4.8%)
Right of children with disabilities to be treated with dignity	28 (4.2%)	13 (3.9%)	15 (4.5%)
Right to name and nationality	26 (3.9%)	13 (3.9%)	13 (3.9%)
Right to privacy	25 (3.1%)	11 (3.3%)	14 (4.7%)
Other	66 (9.9%)	24 (7.2%)	42 (12.6%)

Figure 21 presents where caregivers learned about children's rights. Caregivers were allowed to select multiple sources of information; answers were not mutually exclusive. Aggregated data show that a majority of caregivers (80%) learned about child rights from project interventions (group parenting sessions: 45%; home visits: 35%). 11% of caregivers learned about children's rights from health facilities, and a small percentage cited the chief/assistant chief (2%) and village elder (4%) as sources. Other sources of information for children's rights include at school, at church, from parents, from the radio, and always having known this information.

Chi-square analyses were conducted to examine whether there were any statistically significant differences between sources of information about children's rights and country (see Table G31). When looking at data disaggregated by country, significantly more caregivers in

Kenya learned about children's rights from group parenting sessions (63%) than did caregivers in Zambia (9%) (χ^2 (1, N = 487) = 101.27, p < .01), while significantly more caregivers in Zambia learned about children's rights from home visiting sessions (52%) than Kenyan caregivers (25%) (χ^2 (1, N = 487) = 28.80, p < .01). Other significant differences are found when citing village elders as sources of information (Zambia: 10%, Kenya .3%; χ^2 (1, N = 487) = 26.53, p < .01).

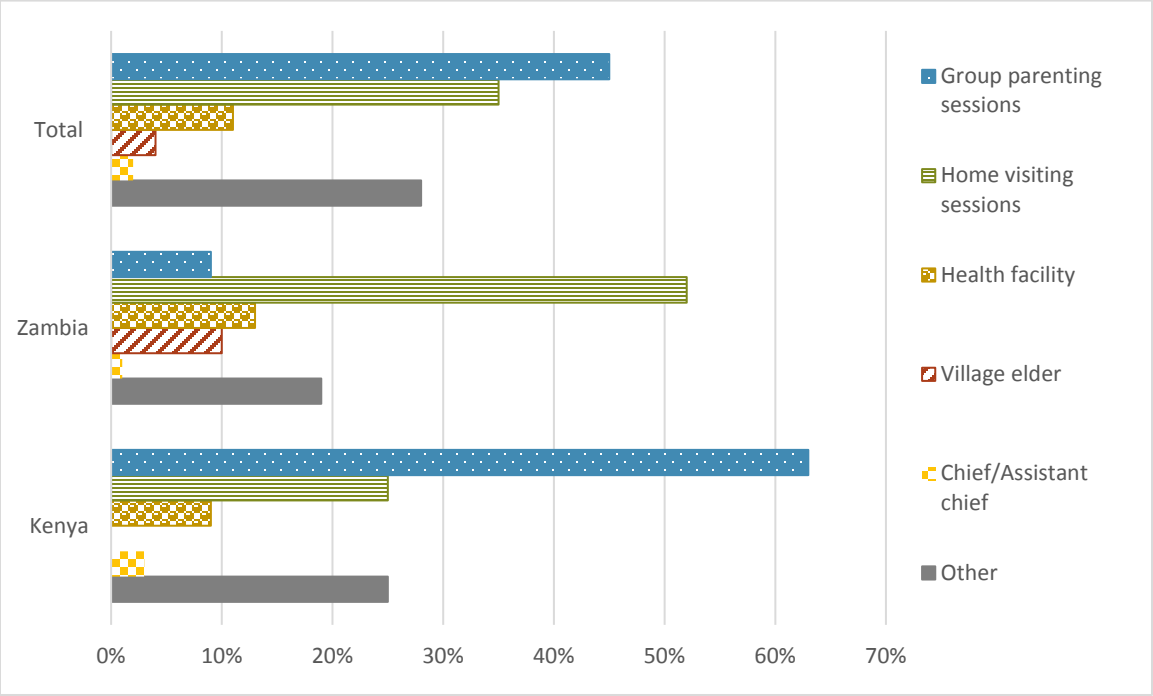

Figure 21. Sources of information about children's rights.

Child participation. Figure 22 presents caregivers' responses regarding children's participation in decision making. Looking at the data in aggregate, 81% of caregivers reported giving their child the opportunity to make choices, such as what to wear and what toys to play with. 69% reported asking their child for opinion on household issues, such as what greens to buy or what to cook for a meal. Looking at the data disaggregated by country, there is a significant difference in the percentage of caregivers who ask their child for opinion on household issues (χ^2 (1, N = 667) = 3.90, p < .05). 72% of Kenyan caregivers report giving their child this option while 65% of Zambian caregivers report the same.

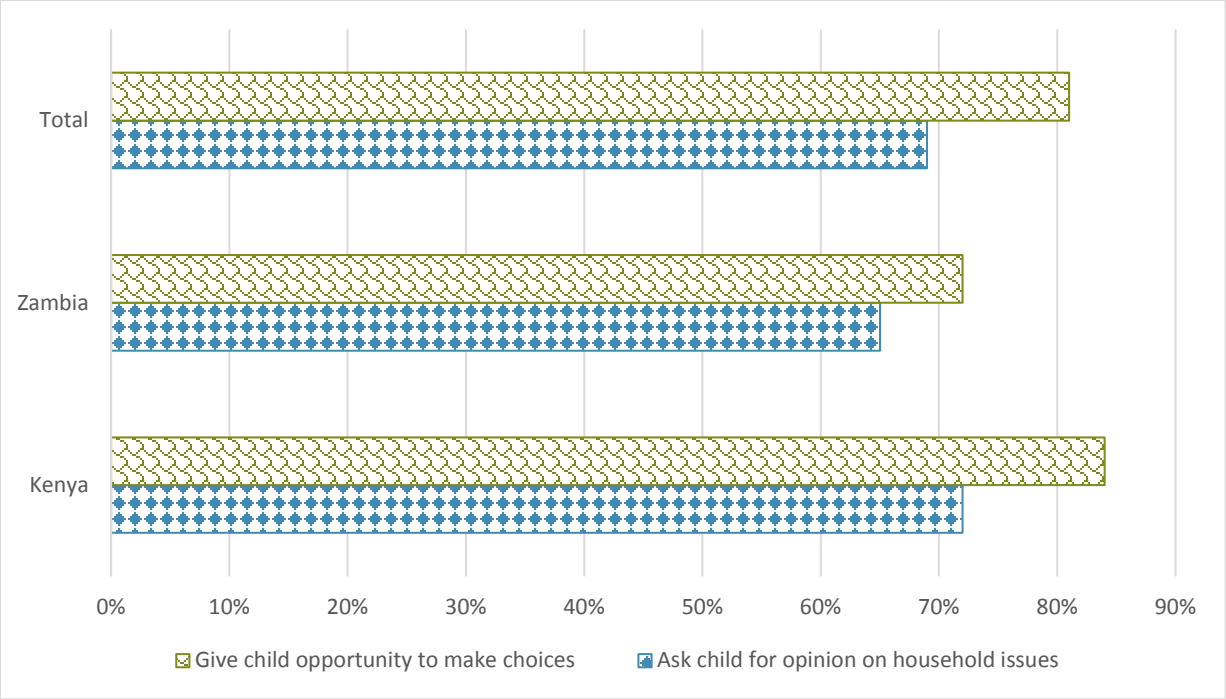

Figure 22. Children's participation in decision making.

Figure 23 presents data regarding sources of information about children's participation. Caregivers were asked to select only one source of information. Looking at the aggregate data in examining sources of information about children's participation, 75% of all caregivers reported receiving information or education on this topic. 94% of caregivers reported learning about child participation from project interventions, specifically, or the project, generally (group parenting sessions: 37%; home visits: 41%; the project in general: 16%). Other sources include health facilities, mothers, the radio, and just knowing this information.

Chi-square analyses were conducted in order to determine whether there were any statistically significant differences between sources of information about children's participation by country (see Table G34). In looking at disaggregated data by country, significantly more caregivers in Kenya (83%) had received information/education on children's participation than caregivers in Zambia (67%) (χ^2 (1, N = 667) = 21.48, p < .01). More caregivers in Kenya mentioned group parenting sessions as a source than caregivers in Zambia (44% and 19%, respectively; χ^2 (1, N = 667) = 50.72, p < .01) as well as the project in general (Kenya: 19.5%, Zambia: 7%; χ^2 (1, N = 667) = 23.24, p < .01). More caregivers in Zambia reported home visiting sessions as a source of information (51%) than caregivers in Kenya (17%) (χ^2 (1, N = 667) = 86.09, p < .01).

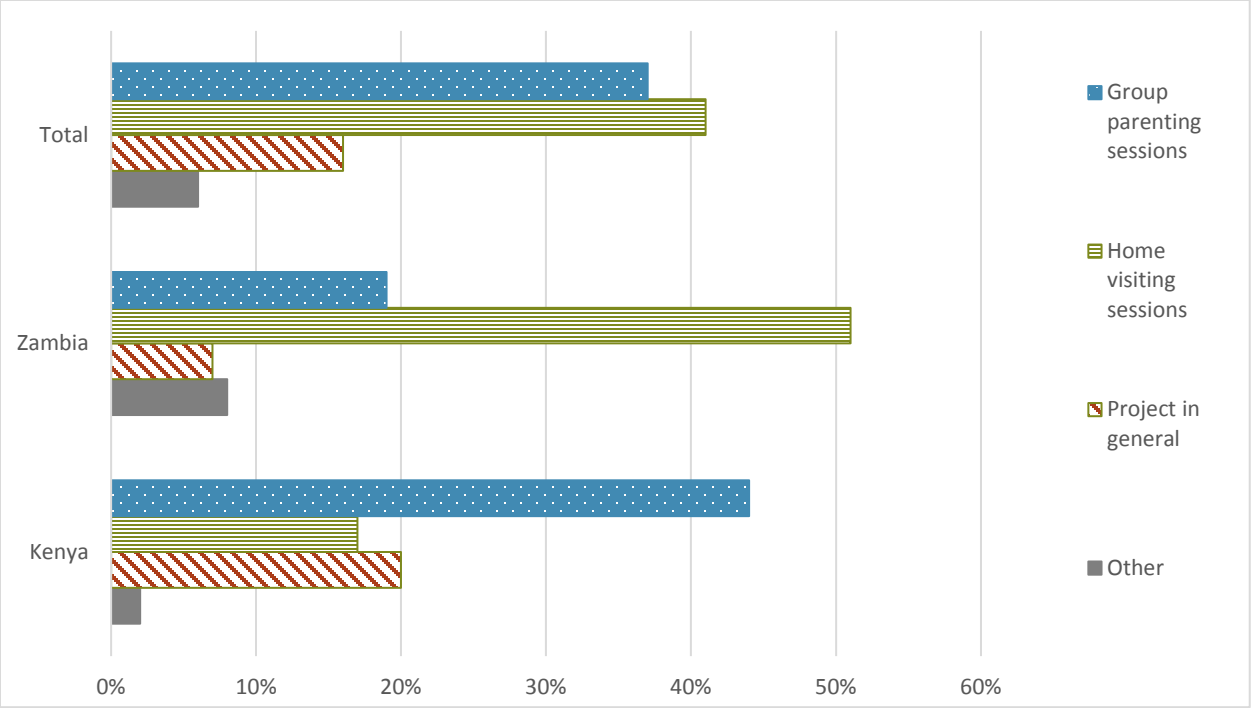

Figure 23. Sources of information about children's participation.

Child safety and protection. Figure 24 presents data regarding what caregivers reported learning about child safety. Caregivers were allowed to select multiple options; answers were not mutually exclusive. When looking at the aggregated data, most caregivers reported learning about keeping the child's environment safe (68%), followed by child protection (58%), positive discipline (33%), and child abuse (23%). Other responses caregivers provided included learning about supervising children while cooking, watching what the child is playing with, the importance of immunization, dressing the child appropriately, and proper nutrition,

Chi-square analyses were conducted in order to determine whether there were statistically significant differences between countries (see Table G36). In looking at the data disaggregated by country, there are significant differences between Zambia and Kenya in caregivers reporting having learned about child protection and child abuse. Significantly more caregivers in Zambia reported learning about child protection (60%) and child abuse (28%) as compared to caregivers in Kenya (56% and 19%, respectively) (child protection: χ^2 (1, N = 542) = 9.32, p < .01; child abuse: χ^2 (1, N = 542) = 11.64, p < .01).

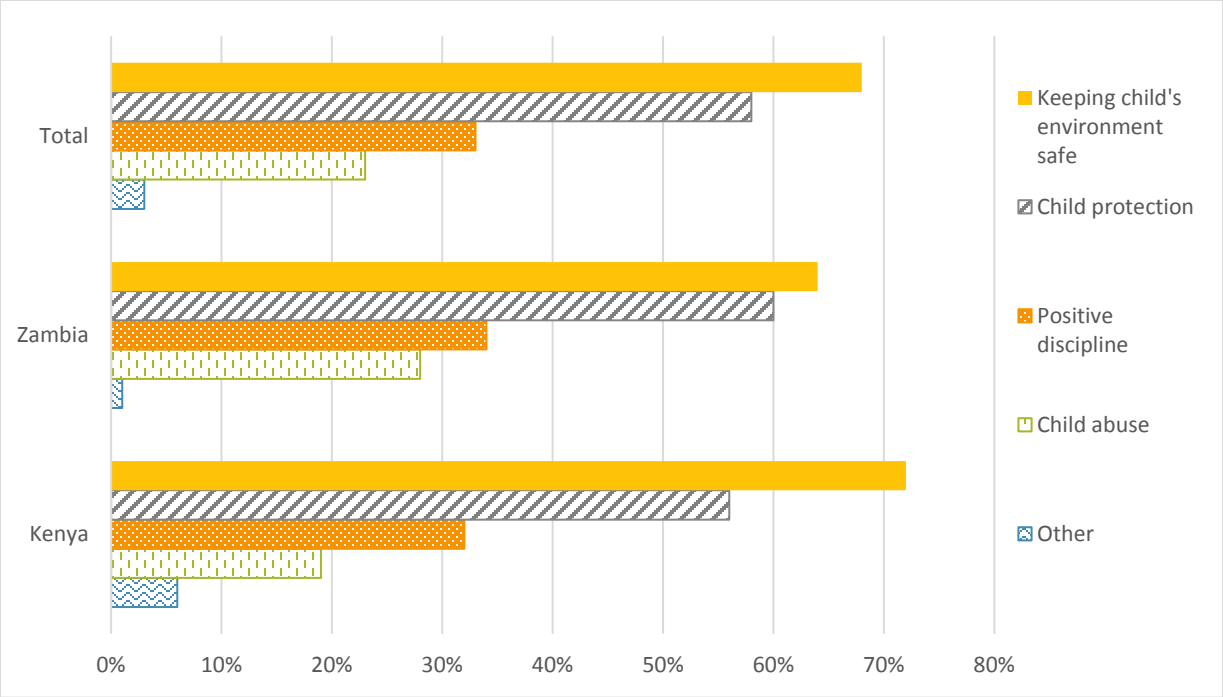

Figure 24. What caregivers learned about child safety and protection.

Figure 25 presents sources of information about child safety and protection. Caregivers were allowed to select multiple sources of information. In looking at aggregated data, 81% of caregivers report receiving information/training on child safety and protection. Caregivers were allowed to select multiple answers. Approximately half of caregivers said they received information from group parenting sessions (51%) and half said they received from home visiting sessions (51%). 12% reported receiving this information from health facilities. A small percentage cite a village elder as a source of information (2.4%), a chief (.4%), and the Department of Children's Services (.2%). Other sources of information mentioned include church, parents, television, and Red Cross trainings.

Chi-square analyses were conducted in order to determine whether there were statistically significant differences between sources of information and country (see Table G38). When looking at the data disaggregated by country, significantly more caregivers in Kenya report having received information/training on child safety and protection (85%) as compared to caregivers in Zambia (78%) (χ^2 (1, N = 667) = 6.06, p < .05). There are significant differences in receiving information from group parenting sessions, home visits, health facilities, and village elders. Significantly more caregivers in Kenya cite group parenting sessions as a source of information (70%, versus 29% in Zambia; χ^2 (1, N = 542) = 90.84, p < .01), but significantly more caregivers in Zambia cite home visiting sessions (72%), health facilities (21%), and village elders (6%) as sources of information (versus 31%, 6%, and 0% in Kenya, respectively) (home visiting sessions: χ^2 (1, N = 542) = 89.70, p < .01; health facilities: χ^2 (1, N = 542) = 31.85, p < .01; village elders: χ^2 (1, N = 542) = 10.58, p < .01).

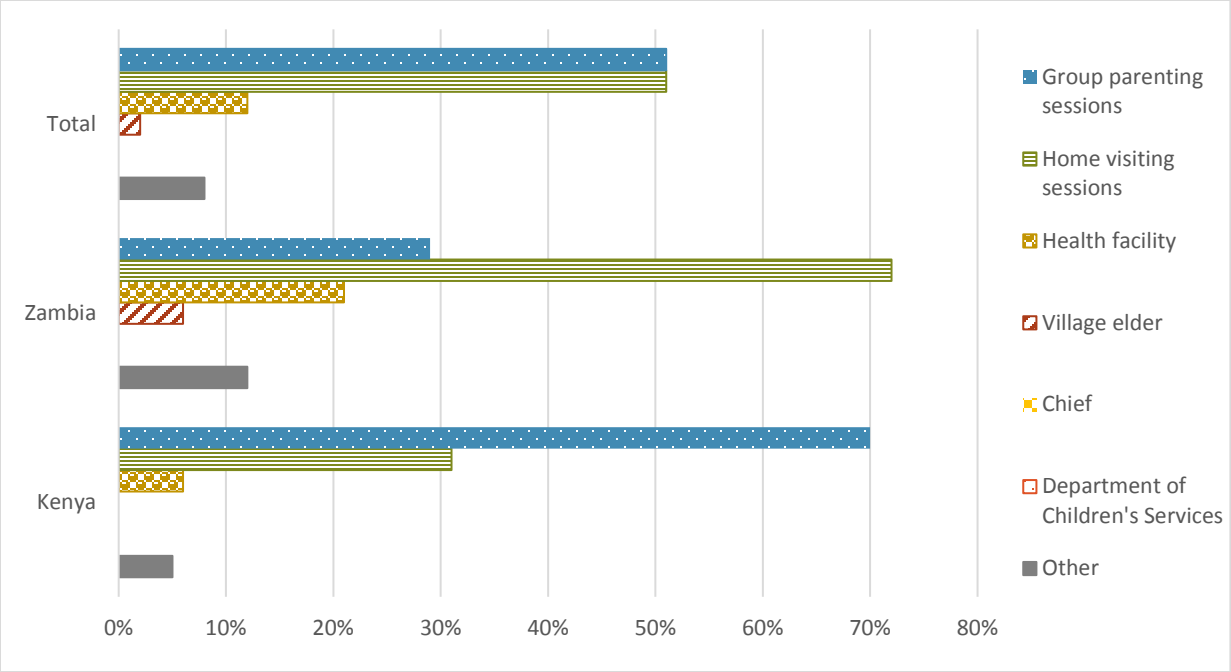

Figure 25. Sources of information about child safety and protection.

82% of all caregivers reported that the child safety and protection information had impacted how they care for their child. When looking at data disaggregated by country, significantly more caregivers in Kenya (86%) reported a change in their parenting as compared to caregivers in Zambia (78%) (χ^2 (1, 667) = 6.77, $p < .05$). Some examples of this change that caregivers give include that they make sure their child's environment is safe, they now feel they can protect their child from harm, they talk to their child before physically disciplining their child, and that they ask for their child's opinion before making decisions that affect their child.

Positive discipline. Figure 26 presents data regarding caregiver response when his/her child did something considered "bad" or "wrong". Caregivers were allowed to select multiple responses. Looking at the aggregated data, the majority of caregivers (71%) report that they explain why something is wrong, followed by shaking, spanking, or slapping their child (22%) and shouting, yelling, or screaming at their child (12%). 6% of caregivers reported they pull their child's ear or pinch the child, 5% reported that they give the child something to do instead, 2% that they take away their child's privileges, and 2% reported doing nothing. Other responses caregivers gave include whipping their children, "I talk to my children in a nice way with a soft voice," and that their child is too young to have done anything wrong or understand wrongdoing.

Chi-square analyses were conducted in order to determine whether there were any statistically significant analyses between caregiver response and country (see Table G40). When looking at the disaggregated child data, the majority of caregivers in Zambia and Kenya reported that they explain why something is wrong when their child does something bad or wrong (73% and 70%, respectively). Significantly more caregivers in Zambia say that they shake, spank, or slap their child (27%) and shout, yell, or scream at their child (19%) than caregivers in Kenya (16% and 5%, respectively) (shake, spank, or slap: χ^2 (1, N = 667) = 10.11, $p < .01$; shout, yell, or scream: χ^2 (1, N = 667) = 29.90, $p < .01$). Significantly more caregivers in Kenya reported that they pull their child's ear or pinch their child than caregivers in Zambia (10% and 2%, respectively) (χ^2 (1, N = 667) = 15.62, $p < .01$).

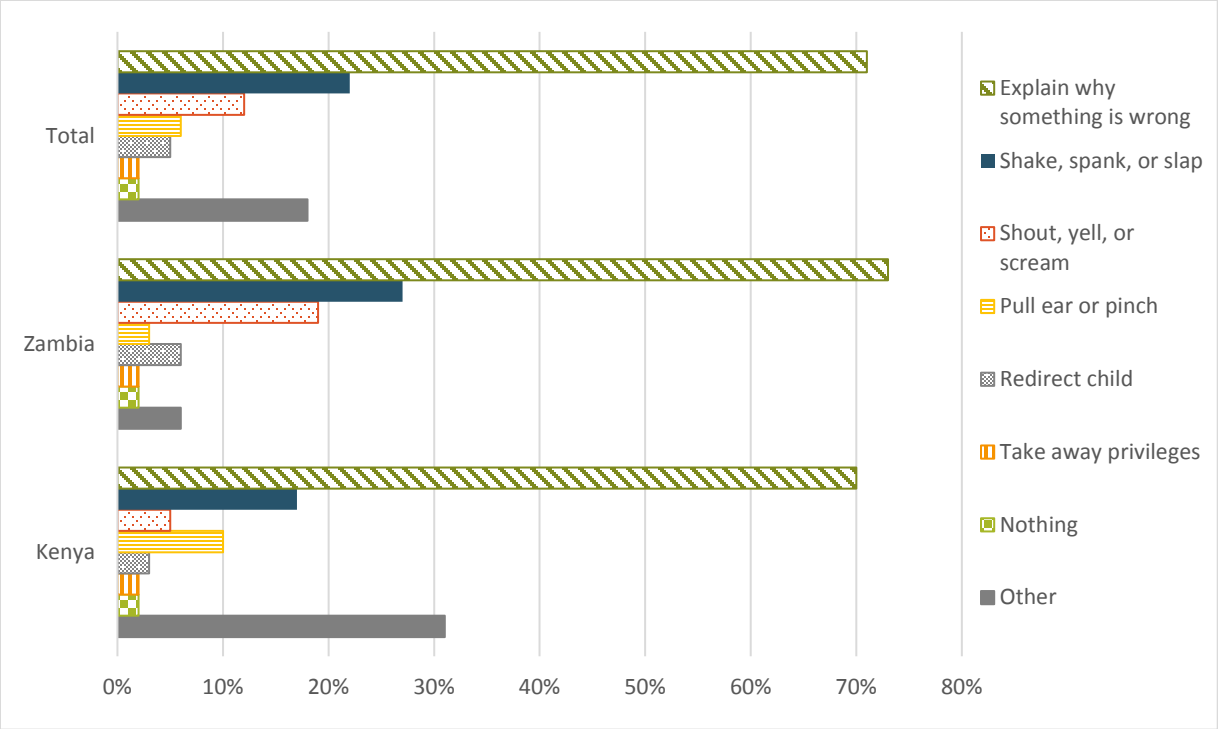

Figure 26. Caregiver response when child does something considered "bad" or "wrong."

Figure 27 presents data regarding where caregivers learned how to discipline their children when children's behavior was considered "bad" or "wrong". Caregivers were allowed to provide multiple answers. In looking at the aggregated data, when children's behavior was considered "bad", 85% of caregivers reported learning about positive discipline from the project interventions (group parenting sessions: 48%; home visits: 37%). 16% of caregivers said they learned how to discipline their children from their parents.

Chi-square analyses were conducted in order to determine whether there were any statistically significant differences between positive discipline when the child's behavior was considered "bad" and country (see Table G42). In disaggregating data by country, significantly more caregivers in Zambia than in Kenya reported learning how to discipline from home sessions (Zambia: 39%; Kenya: 16%; χ^2 (1, N = 515) = 36.09, p < .01), parents (Zambia: 18%; Kenya: 6%; χ^2 (1, N = 515) = 22.96, p < .01)), husbands (Zambia: 2%; Kenya: 0%; χ^2 (1, N = 515) = 5.30, p < .05), and neighbors (Zambia: 2%; Kenya: 0%; χ^2 (1, N = 515) = 4.88, p < .05). More caregivers in Kenya reported learning how to discipline from group sessions (52%, compared to 23% in Zambia) (χ^2 (1, N =5 515) = 81.47, p < .01).

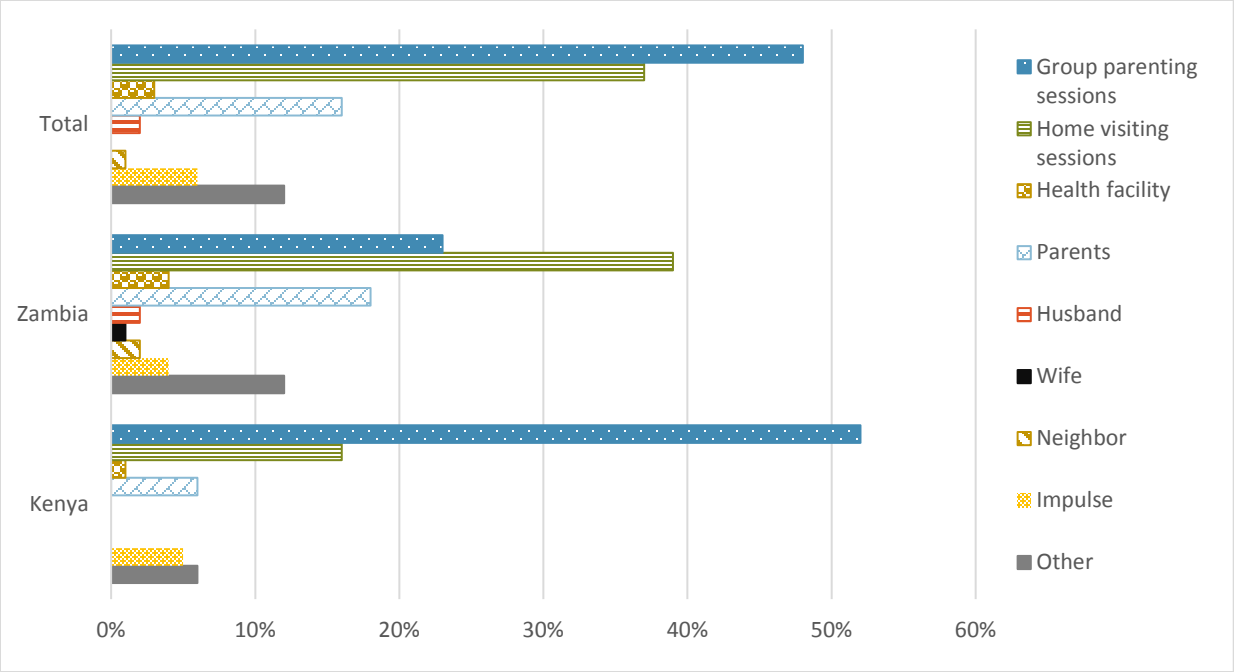

Figure 27. Where caregivers learned to discipline their children when children's behavior was considered "bad."

Figure 28 presents data regarding caregiver response when child does something considered "good." Caregivers were allowed to select multiple responses. When looking at the aggregated data, nearly all caregivers report praising the child (91%). This is followed, to a lesser degree, by giving gifts (19%), hugging the child (13%), and singing for the child (6%). Three percent of caregivers reported doing nothing when the child does something good. Other responses included feeling good/happy, playing with the child, that the child is too young to do anything good, and "I normally slaughter a chicken to make him/her feel love and encourage them to keep it up".

When looking at the data disaggregated by country, again, the majority of caregivers in Zambia and Kenya praised the child (90% and 92%, respectively). Chi-square analyses were conducted in order to determine whether there were any statistically significant differences between caregiver response and country (see Table G44). Significantly more caregivers in Zambia give the child gifts (24%) and hug the child (21%) as compared to caregivers in Kenya (14% and 6%, respectively) (gifts: χ^2 (1, N = 667) = 10.47), p < .01; hug child: χ^2 (1, N = 667) = 33.55, p < .01).

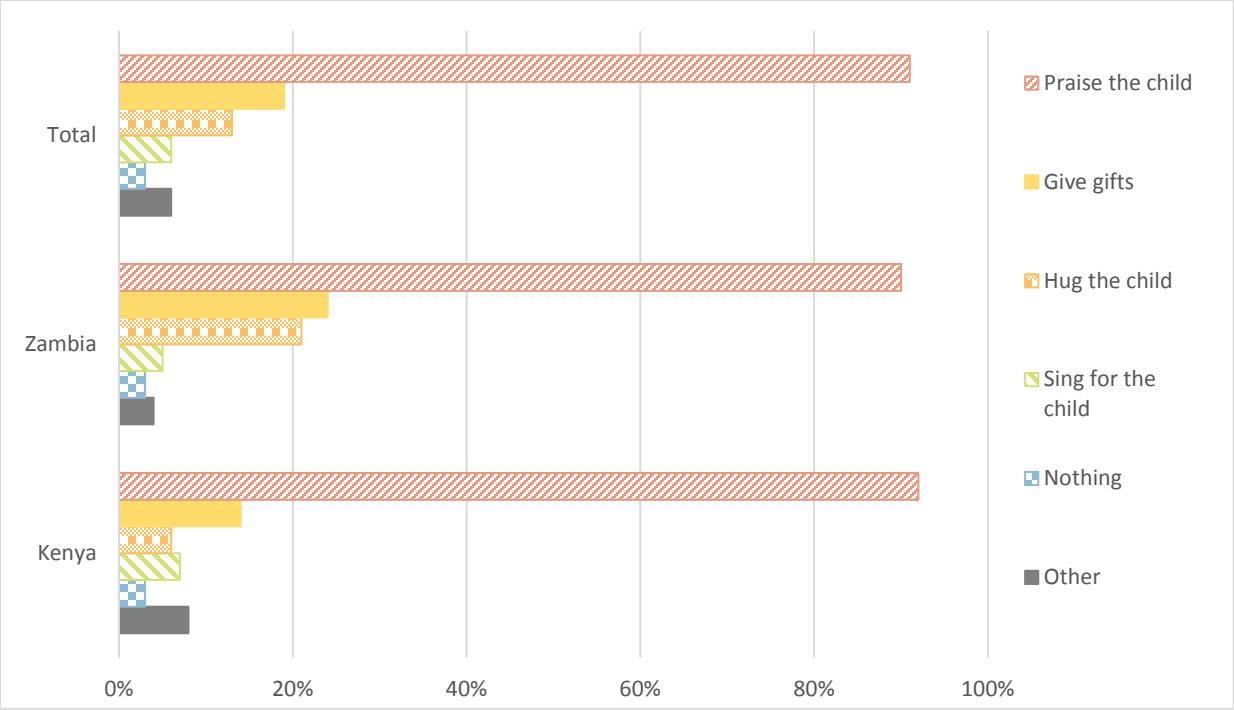

Figure 28. Caregiver response when child does something considered "good."

Figure 29 presents data regarding where caregivers learned about how to interact with their children when children's behavior was considered "good." Caregivers were allowed to select multiple sources of information. In looking at the aggregated data, when children's behavior was considered good, 66% of caregivers learned about praising their children from group parenting sessions and/or home visits (group parenting session: 37%; home visits: 29%). 10% of caregivers said they learned how to praise their children from their parents.

Chi-square analyses were conducted in order to determine whether there were any statistically significant differences between praising children and country (see Table G45). In disaggregating data by country, significantly more caregivers in Zambia than in Kenya reported learning how to praise their children from home sessions (Zambia: 40%; Kenya: 18%; χ^2 (1, N = 488) = 41.39, $p < .01$), parents (Zambia: 16%; Kenya: 4%; χ^2 (1, N = 488) = 24.76, $p < .01$), and husbands (Zambia: 2%; Kenya: 0%; χ^2 (1, N = 488) = 7.68, $p < .05$), while more caregivers in Kenya reported learning how to discipline from group sessions (49%, compared to 23% in Zambia; $\chi 2$ (1, N = 488) = 72.36, $p < .01$).

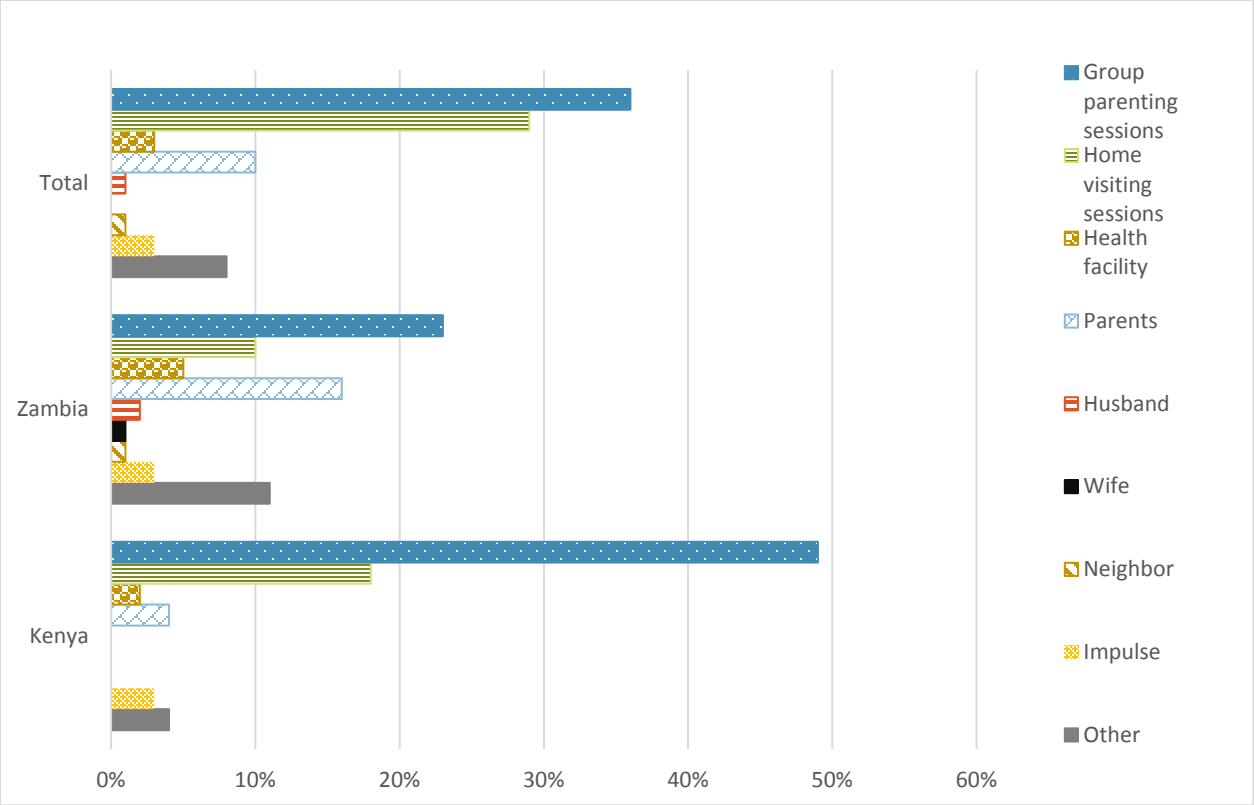

Figure 29. Where caregivers learned to discipline their children when children's behavior was considered "good."

Caregivers were also asked what had changed in their child since they started using positive discipline. Though some caregivers responded that their child's behavior largely remained the same, some reported improvements in their child's behavior and/or relationship between themselves and their child including, but not limited to:

"Communication between me and my child has improved."

"He doesn't play with things he is not supposed to play with like sharp things. And he talks to me when he is troubled unlike before. "

"My child can communicate with me easily without being afraid; I don't beat them without a reason."

"When she does something bad she doesn't hide from me anymore, she just comes and tells me."

"We have a better relationship, he can come tell me when he is wrong."

When comparing endline and baseline data, at a very broad level, caregivers at endline engage in fewer aggressive and physical punishing acts when disciplining their children. At baseline, 55% of caregivers mentioned some form of violence in their responses. At endline, when looking at the aggregate data, 22% of caregivers mentioned shaking, spanking, or slapping their child and 6% mentioned pulling the child's ear or pinching the child, which is a decrease from baseline. While at baseline, 45% of caregivers mentioned verbal discipline when punishing their child, at endline only 12% of caregivers report the same.

Child safety. Child safety focused on children's physical safety with regard to keeping the child safe when the caregiver needed to leave the house for whatever reason (i.e. neglect). Looking at endline data in aggregate, 58% of caregivers reported having regular activities/work

outside the home whereby they reported leaving their child. 28% of caregivers reported leaving their child alone for at least an hour in the previous week. When caregivers had activities outside of the house, such as shopping or washing clothes, 45% reported that they took the child with them and 44% had a familiar relative watch the child. 16% of caregivers said they had a familiar friend watch the child, 4% left their child with their mother-in-law, and 5% left the child at a baby care center. Caregivers were allowed to select multiple options. Other responses caregivers provided to this question included leaving the child with siblings or older grandchildren, leaving the child alone, leaving the child with neighbors, or never leaving the house. Only 40% of caregivers reported changing their behaviors regarding child protection after participating in the project. See Table 7.

Chi-square analyses were conducted in order to determine whether there were any statistically significant differences between child protection items and country (see Table G46). In looking at data disaggregated by country, significantly more caregivers in Kenya have activities outside of the home (64%) as compared to caregivers in Zambia (52%) ($F(1, 664) = 10.07$, $p < .05$), though there were no significant differences between countries regarding whether the caregiver left the child alone the previous week. Regarding who they relied upon to watch children, if necessary, caregivers in Zambia were also significantly more likely to have a familiar relative watch their child if they had activities outside of the house (51%) as compared to caregivers in Kenya (36%) (χ^2 (1, $N = 666$) = 13.57, $p < .01$). Caregivers in Kenya were significantly more likely to leave their child at a baby care center (9%) than caregivers in Zambia (1%) (χ^2 (1, $N = 666$) = 27.00, $p < .01$). 37% of caregivers in Zambia and 43% in Kenya report changing their behaviors regarding child protection after participating in the training, though these differences were not statistically significant (χ^2 (1, $N = 667$) = 3.22, $p > 05$).

Table 7

Child Protection

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
Caregiver has activities outside of home	387 (58.0%)	174 (52.1%)	213 (64.0%)
Child left alone for more than an hour last week	187 (28.0%)	72 (21.6%)	115 (34.5%)
What caregiver does when activities are outside of home			
Go with child	298 (44.7%)	156 (46.7%)	142 (42.6%)
Has familiar relative watch child	290 (43.5%)	169 (50.6%)	121 (36.3%)
Has familiar friend watch child	105 (15.8%)	45 (13.5%)	60 (18.0%)
Leaves child with mother-in-law	27 (4.1%)	11 (3.3%)	16 (4.8%)
Leaves child at baby care center	33 (5.0%)	2 (.6%)	31 (9.3%)
Other	98 (14.7%)	45 (13.5%)	53 (16.0%)
Changed behaviors after participating in training	266 (39.9%)	124 (37.1%)	142 (42.6%)

Environmental and neighborhood safety. While administering the household surveys, enumerators observed the physical structure the family lived in to assess it for aspects regarding the child's environmental safety, child safety and well-being. Figure 30 presents the different

items enumerators looked for when observing the household. Looking at the aggregated data, enumerators most often reported seeing accessible pit latrines (44%), open rubbish or other pits (35%), and open or damaged drainage/stagnant water (26%). Unprotected fire was observed in 12% of households and scattered waste in 11%. Less than 3% of households were observed to have broken glass or human waste in the compound. 22% of households had no observed issues with regards to observable child safety and well-being. Other aspects regarding child environmental safety noted by the enumerators include sharp objects, slippery floors, and leaking roofs.

Chi-square analyses were conducted in order to determine whether there were any significant differences between environmental safety and country (see Table G47). When looking at data disaggregated by country, there are significant differences in nearly all of the categories of observed environmental safety. More households in Zambia were observed to have accessible pit latrines (54%) and unprotected fire (20%) as compared to households in Kenya (35% and 5%, respectively (accessible pit latrines: χ^2 (1, N = 667) = 26.10, p < .01; unprotected fire: χ^2 (1, N = 667) = 35.34, p < .01). On the other hand, more households in Kenya were observed to have open rubbish or other pits (40%), open or damaged drainage/stagnant water (46%), scattered animal waste (14%), broken glass (5%), and human waste in the compound (4%) (open rubbish: χ^2 (1, N = 667) = 7.83, p < .05; open or damaged drainage: χ^2 (1, N = 667) = 141.21, p < .01; scattered animal waste: χ^2 (1, N = 667) = 6.85, p < .05; broken glass: χ^2 (1, N = 667) = 6.59, p < .05; human waste: χ^2 (1, N = 667) = 7.33, p < .05).

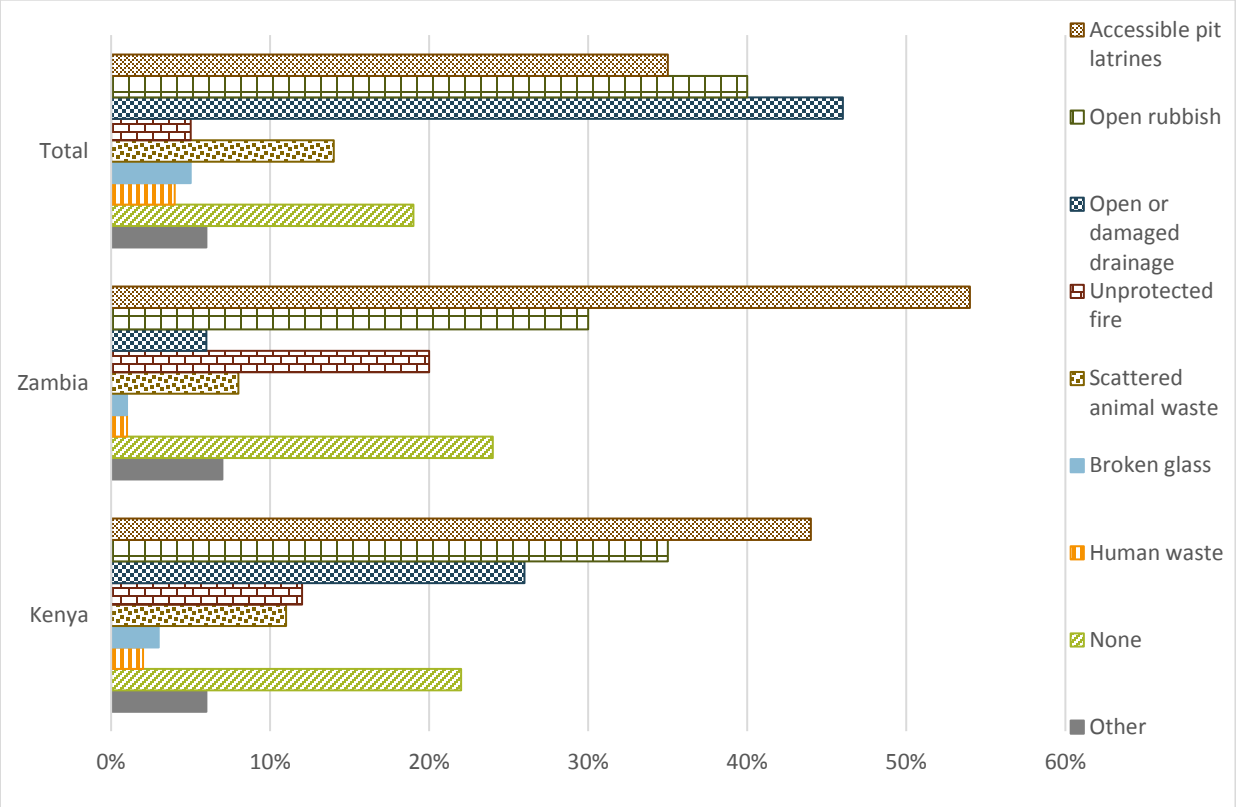

Figure 30. Observed issues with environmental safety in the household.

Comparing the aggregate endline environmental safety data to baseline data shows fewer issues with environmental safety in all categories (see Figure 31). The biggest decreases were

regarding open rubbish or other pits and unprotected fire. At baseline, 53% of households were observed to have rubbish while this decreased to 35% at endline. Also, at baseline, 35% of households were observed to have unprotected fire as compared to 12% of households at endline. The only exception was open or damaged drainage/stagnant water, with 22% of households at baseline having this problem and 26% at endline.

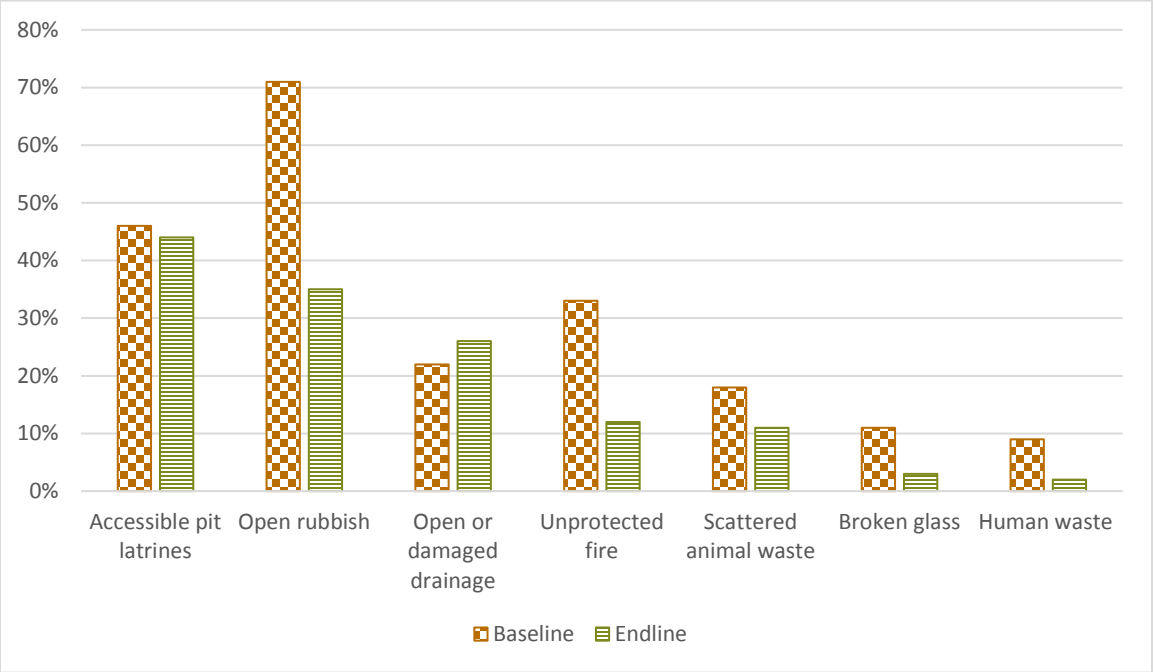

Figure 31. Observed issues with household environmental safety, baseline vs. endline.

Caregivers were also queried as to whether they felt their children were safe from danger and violence in the neighborhood (Figure 32). Looking at the aggregated endline data, 74% of caregivers said that they felt their children were safe most of the time while 25% said that they did not feel their child were safe. When looking at the data disaggregated by country, there were significant differences in responses from caregivers in Zambia and those in Kenya (χ^2 (2, N = 667) = 6.92, $p < .05$). More caregivers in Zambia responded they felt their children were safe (78%) compared to those in Kenya (70%). Correspondingly, more caregivers in Kenya said they did not feel their children were safe (29%), compared to 20% of caregivers in Zambia who responded the same. Baseline data was not available for comparison.

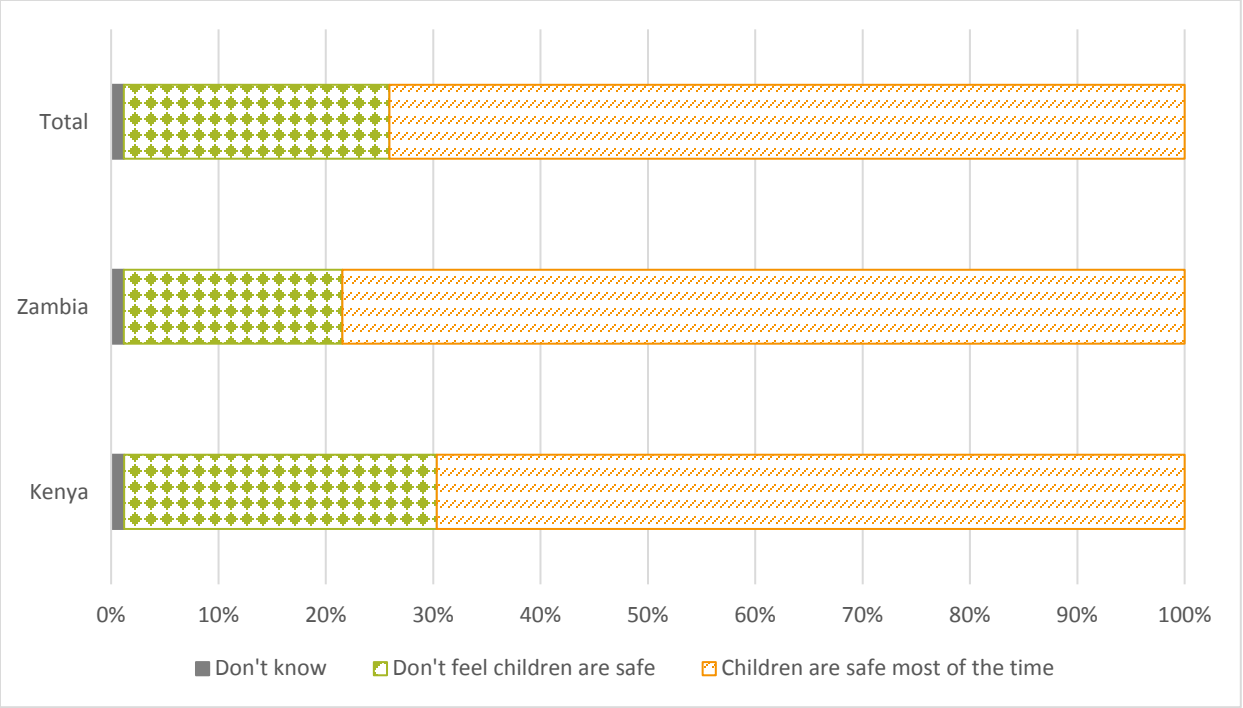

Figure 32. Neighborhood safety.

Preventative health/immunizations. Figure 33 presents the percentage of children whose parents reported that they had received immunizations. When looking at the aggregated data, 63% of caregivers reported that their children were completely up-to-date on their immunizations, while another third (30%) had most of their immunizations complete. 4% of children were incompletely immunized, and .2% had no immunizations. The primary reason caregivers provided for immunizing their children was that they wanted to protect their children from getting diseases, while the main reason they gave for not immunizing their child was that the child's health card was unavailable.

In looking at country-level data, the majority of children in Kenya had all of their age-appropriate immunizations complete or mostly complete (78% and 19%, respectively). While this was also the case in Zambia, there were proportionately fewer completely-immunized children (50%) and proportionately more mostly-immunized children (41%) as compared to in Kenya. In Kenya, 2% of children were incompletely immunized while in Zambia, 5% were incompletely immunized[6].

When disaggregating data by site, approximately half of children in Chibombo District and Kafue District had received all of their age-appropriate immunizations (47% and 53%, respectively), and approximately another 40% in each district had most of their age-appropriate immunizations. A small percentage of children in both sites were incompletely immunized (Chibombo District: 4%; Kafue District: 6%). In Kisumu, just over half of children (53%) had most of their immunizations complete and 43% were completely up-to-date on their immunizations. In Mukuru and Kasarani, almost all children were completely up-to-date on their immunization (99% and 93%, respectively), and in Siaya, 86% of children had all of their age-appropriate immunizations complete.

[6] For these items, due to how the data was collected, it was not possible to conduct analyses to determine whether there were statistically significant differences by country or by site.

Table G50 notes the types of immunizations children received in Zambia and the percentage of children receiving each type of immunization. Data were not available for Kenya.

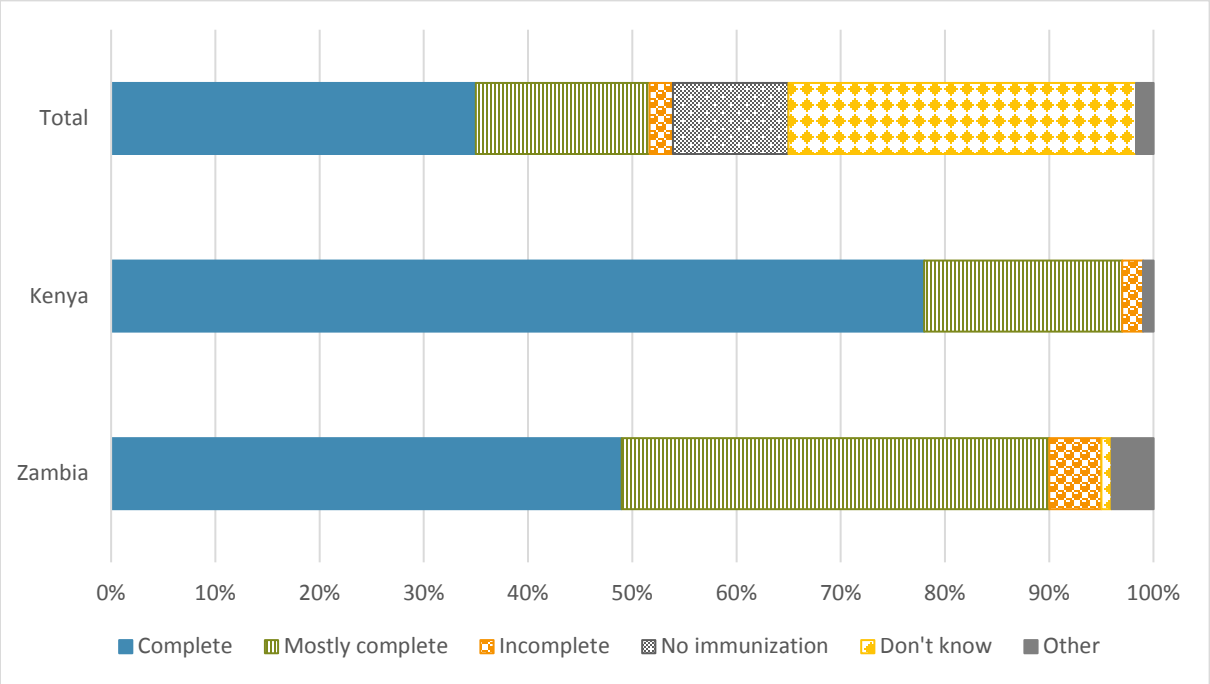

Figure 33. Percentage of children who received immunizations.

Training/Information on immunization. Figure 34 presents the percentage of caregivers who received training/information on immunization. When looking at the aggregated data, the majority of caregivers do report having received training/information on the topic (87%). When looking at country-level data, 90% of Kenyan caregivers and 84% of Zambian caregivers report having received training/information on immunization.

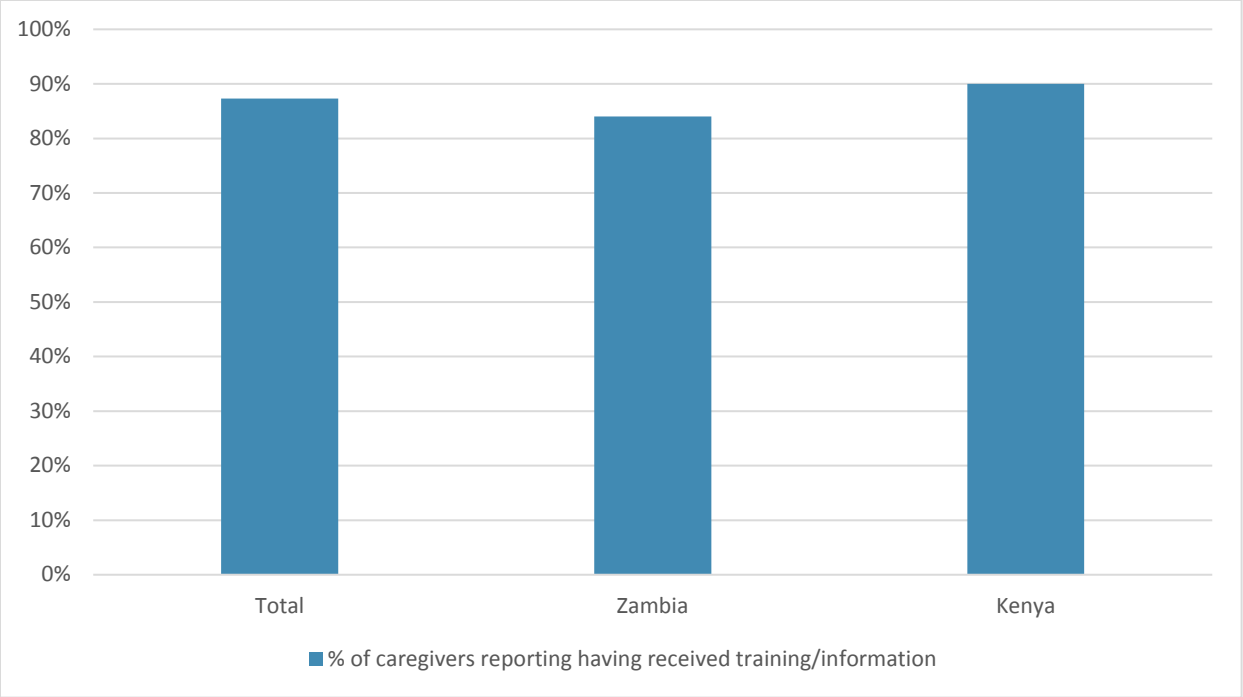

Figure 34. Percentage of caregivers reporting having received training/information on immunization.

Figure 35 presents sources of caregiver training/information on immunization. Caregivers were allowed to select multiple sources. At the aggregate level, over half of caregivers report having received training/information from a health facility (54%), followed by group parenting sessions and CHVs at the household in nearly equal amounts (25% and 29%, respectively). 7% of caregivers report having received information from the project in general without having specified a particular group parenting session or home visit intervention.

In looking at country-level data, over three quarters of caregivers in Zambia (77%) reported having received training/information on immunizations from a health facility. 40% reported having received information from CHVs at the household, 15% from group parenting sessions, and 1% from the FFP Project generally. In Kenya, roughly one third of caregivers reported having received information from group parenting sessions (35%) and another third from health facilities (32%). 19% of caregivers report having received training from CHVs at the household and 11% from the project in general. These differences between countries were statistically significant (χ^2 (1, N = 667) = 4.80, p < .05).

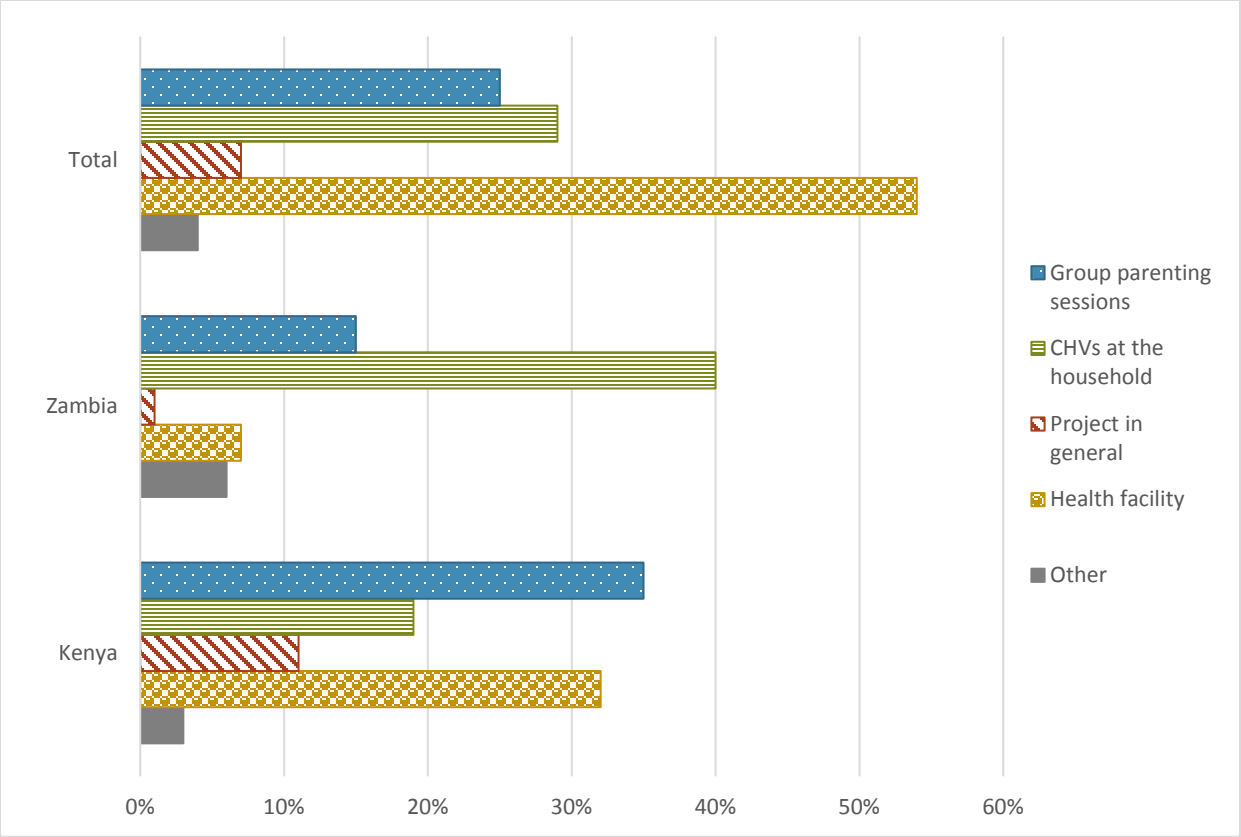

Figure 35. Sources of caregiver training/information on immunization.

Nutrition. Regarding nutrition, breastfeeding practices, the number of meals children had per day, and types of food consumed and their frequency were examined.

Breastfeeding. In looking at the aggregated data, the majority of caregivers exclusively breastfed their last child (81%) for an average of 6 months (*M*(*SD*) = 6.24 (3.06), range: 0=36 months). Health facilities were most frequently reported as being sources of information about breastfeeding (44%), and group parenting sessions and CHVs were reported about equally as being sources of information about exclusive breastfeeding (15% and 16%, respectively). Other sources mentioned by caregivers include health cards, relatives, and that they have always known about exclusive breastfeeding. Just over half of caregivers (53%) also reported that they had always practiced exclusive breastfeeding for the first six months, even before receiving information/training about it. 11% reported they used to introduce other drinks alongside breastfeeding and 12% reported they never used to breastfeed exclusively for six months.

In looking at data disaggregated at the country level, 82% of caregivers in Zambia and 80% in Kenya report exclusively breastfeeding their last child for an average of 6 months. This difference was not statistically significant. In Zambia, more caregivers reported learning about exclusive breastfeeding during household visits (18%) and at health facilities (52%) as compared to caregivers in Kenya (14% and 36%). More caregivers in Kenya reported receiving this information during group parenting sessions (25%) than caregivers in Zambia (5%). These differences between sources of information and country were statistically significant (χ^2 (7, N = 667) = 60.34, p < .00). There were also significant differences regarding what caregivers did before receiving information/training about exclusive breastfeeding (χ^2 (4, N = 667) = 22.41, p <

.00). 60% of caregivers in Zambia reported always practicing exclusive breastfeeding for the first six months of their child's life while 45% of caregivers in Kenya did. Correspondingly, more caregivers in Kenya reported introducing other drinks alongside breastfeeding (16%) and never exclusively breastfeeding for the first six months (14%) as compared to caregivers in Zambia (7% and 10%, respectively). See Table 8.

Table 8

Breastfeeding Practices

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
Exclusively breastfed last child	539 (80.8%)	273 (81.7%)	266 (79.9%)
Sources of information about exclusively breastfeeding			
Group parenting sessions	100 (15.0%)	16 (4.8%)	84 (25.2%)
CHVs	104 (15.6%)	59 (17.7%)	45 (13.5%)
Health facility	292 (43.8%)	173 (51.8%)	119 (35.7%)
Friends	2 (.3%)	1 (.3%)	1 (.3%)
Husband	1 (.1%)	1 (.3%)	0
Mother-in-law	2 (.3%)	1 (.3%)	1 (.3%)
Other	38 (5.7%)	22 (6.6%)	16 (4.8%)
What caregiver did before receiving information about exclusively breastfeeding			
Have always practiced it	350 (52.5%)	199 (59.6%)	151 (45.3%)
Introduced other drinks alongside breastfeeding	76 (11.4%)	22 (6.6%)	54 (16.2%)
Never used to breastfeed exclusively for 6 months	80 (12.0%)	34 (10.2%)	46 (13.8%)
Other	33 (4.9%)	18 (5.4%)	15 (4.5%)

Number of meals children have per day. Figure 36 presents the number of meals children have per day. In looking at the aggregated data, over half of caregivers reported that children have three meals per day (53%), and another third (33%) reported that children have four meals or more (WHO standard). 11% reported that children have two meals per day and 1% one meal. When looking at the data disaggregated by country, caregivers more often reported children having three meals per day in Zambia (58%) as compared to Kenya (48%), but more caregivers in Kenya reported children having four meals a day or more (38%) as compared to Zambia (29%). These differences were not statistically significant. 11% of caregivers in each country reported children having two meals per day.

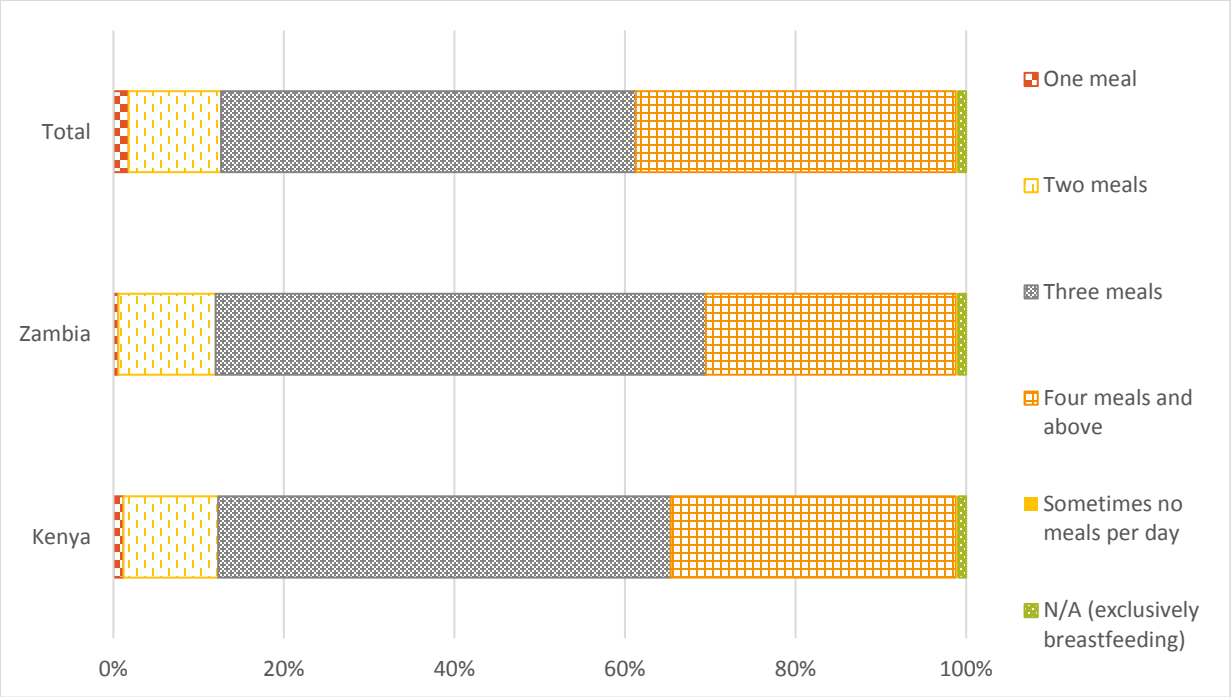

Figure 36. Number of meals children had per day.

In aggregate, 91% of caregivers reported having received training on how often to feed their child. Primary sources of training include group parenting sessions (40%), CHVs and home visiting sessions (31%), and health facilities (32%). Caregivers were allowed to select multiple sources. Other sources of training include church, parents, neighbors, and other non-governmental organizations. When disaggregating data at the country level, more caregivers in Kenya report group parenting sessions as a source of information about meals (60%) as compared to caregivers in Zambia (20%). More caregivers in Zambia, however, cite CHVs (40%) and health facilities (57%) as sources of information than caregivers in Kenya (22% and 8%, respectively). These differences were not statistically significant.

In comparing aggregated data at baseline, children are having more meals per day at endline. At baseline, caregivers most commonly reported children having two meals per day (43%), followed by three meals per day (38%). About 9% of households existed on one meal per day and another 10% of caregivers reported children having 4 meals a day or more. In comparison, at endline, caregivers most commonly reported children having three meals per day (53%) followed by four meals or more (33%). The percentage of children having two meals a day or fewer is also lower at endline (11%) than it is at baseline. Further, at endline, there are only two instances where caregivers reported children sometimes having no meals per day, whereas at baseline over 30% of households report children sometimes not having any meals per day.

Type of food consumed and frequency. Figure 35 presents data regarding the frequency of food consumption across all respondents. Looking at the data in aggregate, at endline, most caregivers report consuming grains/starch and fruits or vegetables on a daily basis (85% and 67%, respectively) and dairy, eggs, legumes, root starch, and meat/fish/chicken on a weekly basis (36%, 61%, 63%, 54%, and 45%, respectively. Honey is the least consumed food item; over half of households report never consuming honey (54%) and another 38% report rarely having it.

Figures 36 and 37 present data regarding the frequency of food consumption as reported by caregivers in Zambia and Kenya, respectively. When looking at the data disaggregated by country, similar patterns are seen in both Zambia and Kenya. Most caregivers report having grains/starch and fruits or vegetables on a daily basis (Zambia: 90% and 68%, respectively; Kenya: 80% and 65%, respectively). Caregivers report having dairy, eggs, legumes, roots, and meet/fish/chicken on a weekly basis (Zambia: 30%, 58%, 56%, 40%, and 48%, respectively; Kenya: 42%, 65%, 70%, 68%, and 44%, respectively). In both countries, over half of caregivers report never having honey (Zambia: 53%, Kenya: 56%). Chi-square analyses were conducted in order to determine whether there were differences between countries regarding how often food was consumed, and statistically significant differences were found for each type of food (see Table G55).

There was some data at baseline with which to make comparisons regarding food consumption frequency. At baseline, 90% of households consumed a starch every day, and 62% reported consuming fruit or vegetables on a daily basis. Dairy products were the most common source of protein. There was not much change over the course of the project. At endline, 85% of families at endline consumed a starch every day, and 67% reported consuming fruit or vegetables daily. Dairy products remained the most common source of protein.

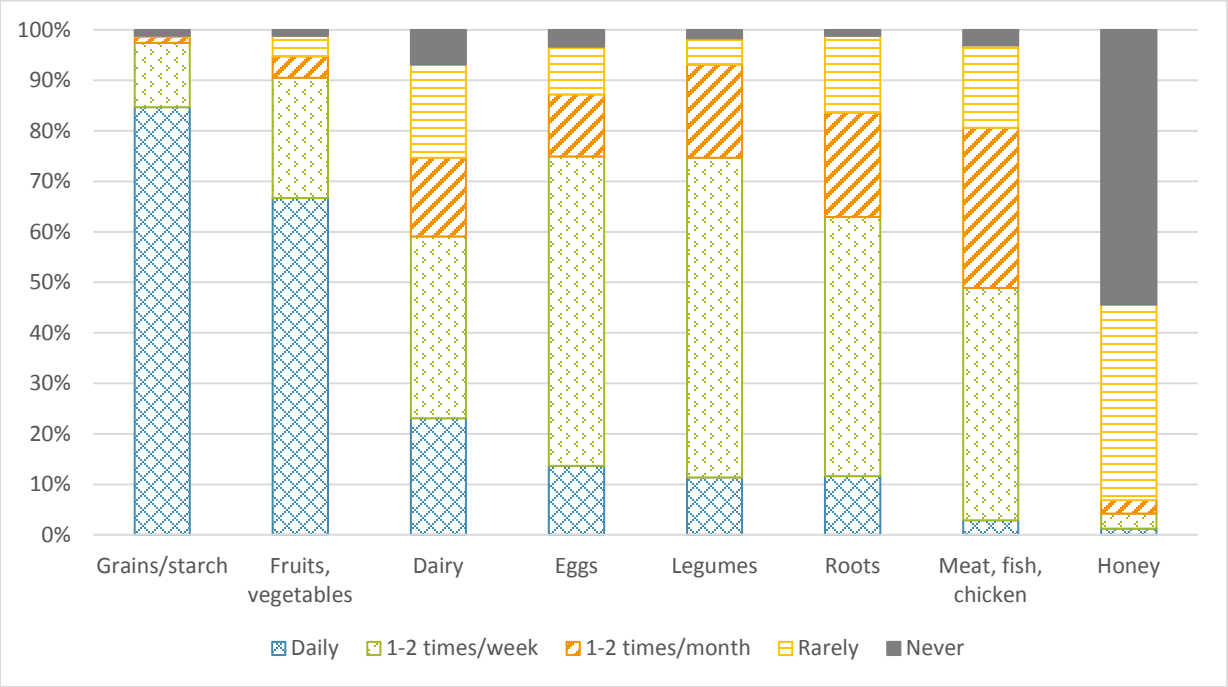

Figure 37. Frequency of food consumption, total.

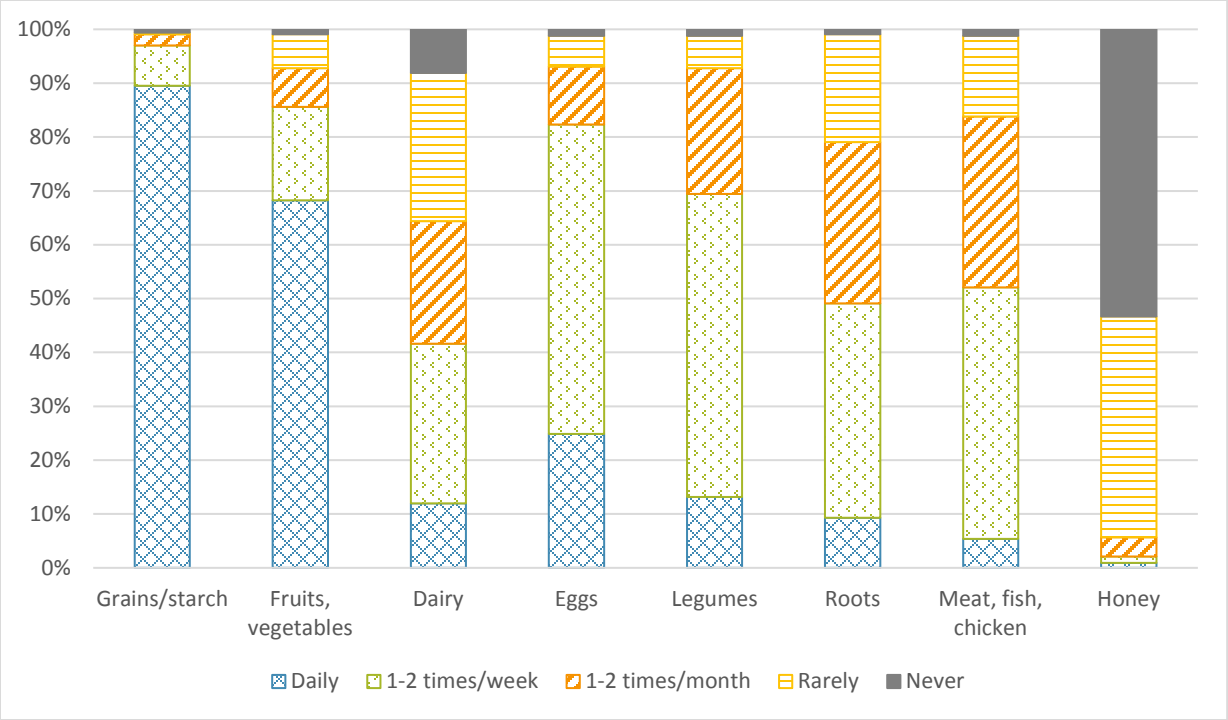

Figure 38. Frequency of food consumption, Zambia.

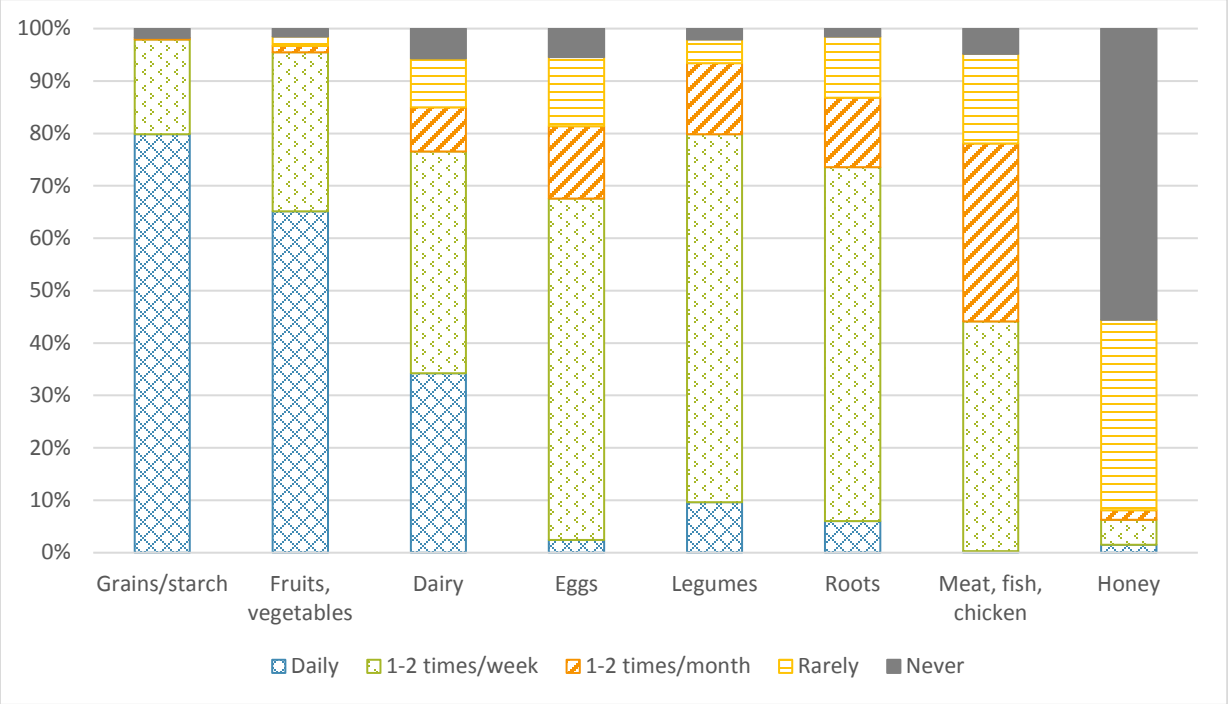

Figure 39. Frequency of food consumption, Kenya.

Hygiene practices. Looking at aggregated data, most caregivers reported washing their hands nearby but outside the house (33%), followed by inside the house (26%). 10% of caregivers reported washing their hands near the toilet and 3% far from the toilet, kitchen, and

house. 27% reported having no specific place to wash their hands. In just over half of households (51%), clean water is available for handwashing, and in another 9% water is available but not clean. In just under a third of households (32%), there is no water available for handwashing. 36% of households reported problems getting clean water. See Table 9.

When comparing Zambia and Kenya, significantly more caregivers in Kenya reported washing their hands inside the house (Kenya: 44%, Zambia: 7%), while significantly more caregivers in Zambia reported washing their hands nearby but outside the house (Zambia: 43%, Kenya: 23%) and near the toilet (Zambia: 19%, Kenya: 3%). These differences were statistically significant (χ^2 (5, N = 667) = 169.24, $p < .01$). There are also significant differences in whether or not water is specifically available for handwashing (χ^2 (4, N = 667) = 35.95, $p < .01$). In Zambia, water is available but not clean in 12% of households as compared to 6% of Kenyan households. More households in Kenya also reported having clean water available (55%) as well as not having water available (36%) as compared to households in Zambia (47% and 27%, respectively). Finally, significantly more households in Kenya reported problems getting clean water (43%) as compared to those in Zambia (28%) (χ^2 (1, N = 667) = 14.68, $p < .01$).

Training/information on handwashing. Looking at the aggregate data, 93% of caregivers reported having received training/information on handwashing. Caregivers were allowed to select multiple sources of information on handwashing. Nearly equal percentages of caregivers reported having received information from group parenting sessions (40%) and from CHVs during home visits (38%). Another 30% of caregivers reported having learned about handwashing from health facilities/health workers. Other sources of information/training include schools, media campaigns on television and radio, church, other family members, and already knowing the information.

Chi-square analyses were conducted in order to determine whether there were statistically significant differences between countries regarding sources of training/information on handwashing. When looking at the data disaggregated by country, significantly more caregivers in Kenya (61%) report having learned about handwashing in group parenting sessions as compared to caregivers in Zambia (20%) (χ^2 (1, N = 667) = 112.41, $p < .01$). On the other hand, significantly more caregivers in Zambia (52%) report having learned about handwashing from CHVs during home visits as compared to Kenyan caregivers (23%) as well as from health facilities/health workers (Zambia: 52%; Kenya: 7%) (home visits: χ^2 (1, N = 667) = 56.08, $p < .01$; health facilities/workers: χ^2 (1, N = 667) = 167.98, $p < .01$).

Table 9

Hygiene practices

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
Where do household members most often wash hands			
Inside the house	171 (25.6%)	23 (6.9%)	148 (44.4%)
Nearby but outside house	221 (33.1%)	144 (43.1%)	77 (23.1%)
Near toilet	71 (10.6%)	62 (18.6%)	9 (2.7%)
Far from toilet, kitchen, and house	17 (2.5%)	17 (5.1%)	0
No specific place	182 (27.2%)	85 (25.4%)	97 (29.1%)
No permission to see	5 (.01%)	3 (.9%)	2 (.6%)

Water present specifically for handwashing			
Yes, clean water available	340 (51.0%)	157 (47.0%)	183 (55.0%)
Yes, but not clean	62 (9.3%)	42 (12.6%)	20 (6.0%)
No	211 (31.6%)	91 (27.2%)	120 (36.0%)
No permission to see/N/A	54 (8.1%)	34 (13.2%)	10 (3.0%)
Problems getting clean water	237 (35.5%)	95 (28.4%)	142 (42.6%)
Received information on handwashing	621 (93.1%)	307 (91.9%)	314 (94.3%)
Source of information			
Group parenting sessions	270 (40.4%)	68 (20.4%)	202 (60.7%)
CHVs	250 (37.5%)	172 (51.5%)	78 (23.4%)
Health facility/worker	197 (29.5%)	175 (52.4%)	22 (6.6%)
Other	34 (5.1%)	22 (6.6%)	12 (3.6%)

Comparison to baseline data. At baseline, overall, 41% of households had clean water available for handwashing and 25% had water available, but it was not clean. At endline, 51% of households had clean water available, a 10% increase from baseline. Also, at endline, 10% of households had not-clean water available, a decrease of 15% from baseline.

Research Question 1.3: How Did Caregivers' Current Access and Barriers to Stimulation and Responsive Care Services Linked to HIV and AIDS Change Over the Course of the Initiative?

In looking at access and barriers to ECD-related services, children's access to these services was examined, including where children were born, whether they had a birth certificate/registration card, whether they had a health card, access to healthcare facilities, and access to ECD centers. Data regarding caregiver-reported improved access to ECD-related services were also looked at, as well as barriers to accessing ECD-related services. Finally, caregiver well-being was also examined.

Children's access to ECD-related services. Given that a child's access to ECD-related services begins at birth (if not prenatally), examining where children were born was determined as one proxy for children's access to health services. Other ECD-related services examined include: whether or not children were reported to have been registered at birth/reported having a birth registration card, whether or not children were reported to have a health card, reported uptake of immunizations, children's reported access to clinics when ill, and children's reported access to ECD centers if of preschool age[7].

***Where children are born*.** Figure 40 presents where children were born, as reported at endline. Across all sites in aggregate, caregivers reported that 38% of children in their household were born at a primary health care facility or clinic, 36% in a hospital, and 26% at home.

When comparing data disaggregated by country, the majority of child births in Zambia took place at a primary health care facility (53%), while in Kenya, the majority took place in a hospital (61%). In Zambia, roughly a third of births took place at home (31%), and 16% took

[7] For items related to children's access to ECD-related services, it was not possible to run analyses to determine statistical significance between countries due to how the data was collected and reported.

place in a hospital. In Kenya, approximately a fifth of births took place each at home and at a primary health care facility (20% and 19%, respectively).

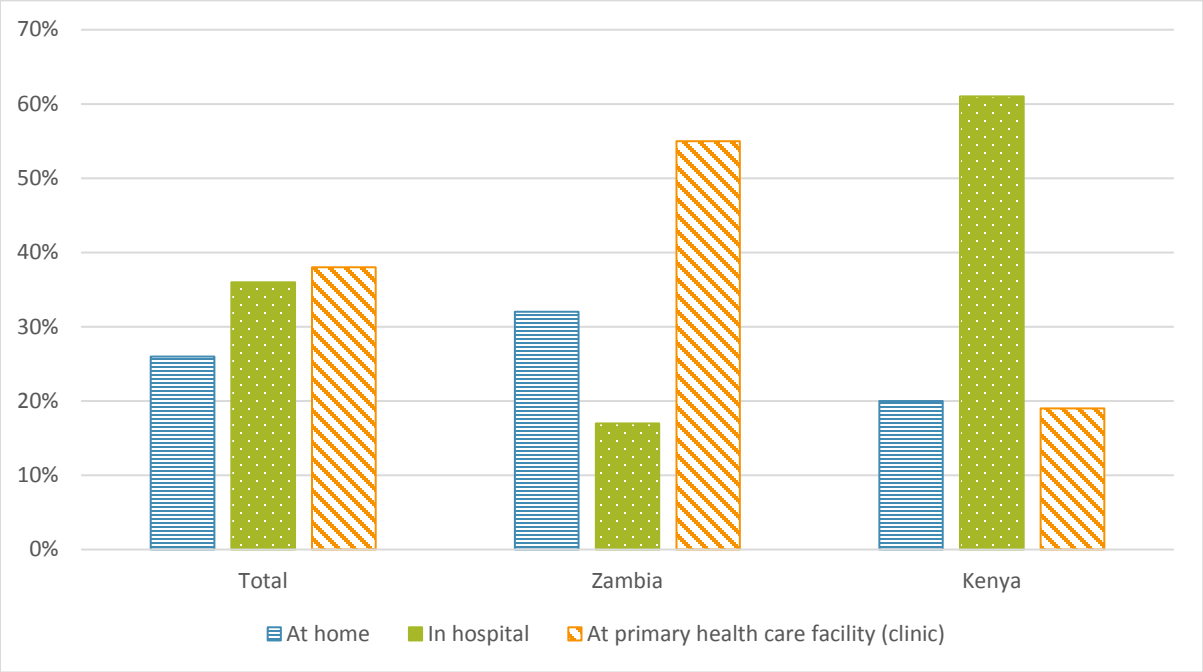

Figure 40. Where children were born, as reported at endline.

When comparing endline data to baseline data, across all sites in aggregate there is a 13% increase in births that took place at primary care facilities and decreases in births that took place at home and at the hospital (9% and 3%, respectively). Figure 41 compares the percent change in location of child births between baseline and endline.

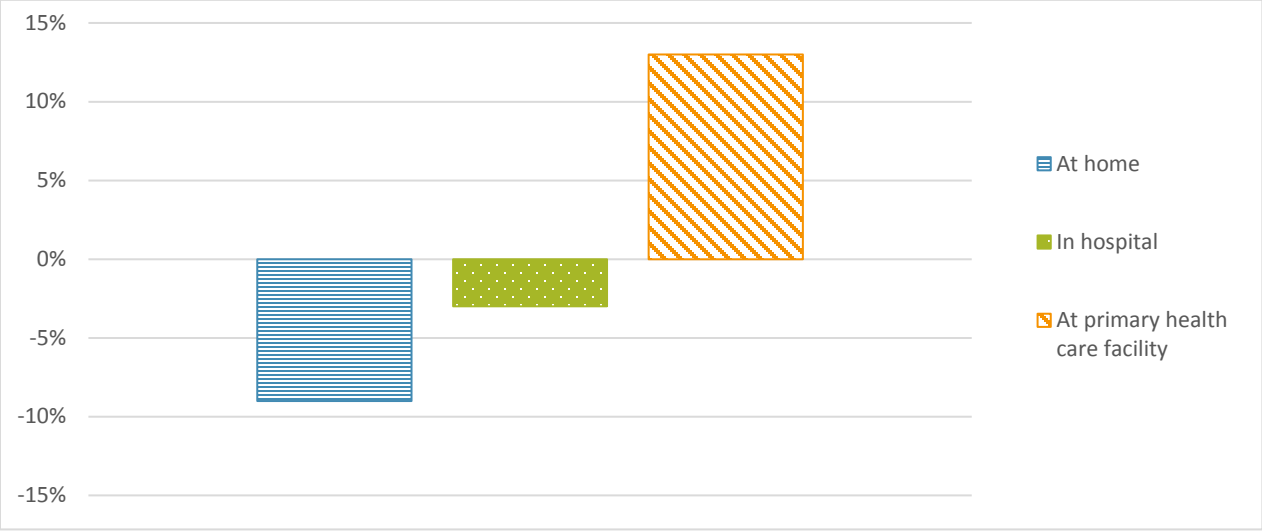

Figure 41. Percent change in location of child births across all sites, baseline vs. endline.

Birth registration. Figure 42 presents the percentage of children who have a birth certificate or notification card, as reported at endline. Looking at the data in aggregate, 56% of

children are reported as not having a birth certificate or notification card while 42% are reported as having one. When comparing data by country, 68% of children in Zambia do not have a birth certificate while 28% do, whereas in Kenya 43% do not have a birth certificate and 57% do.

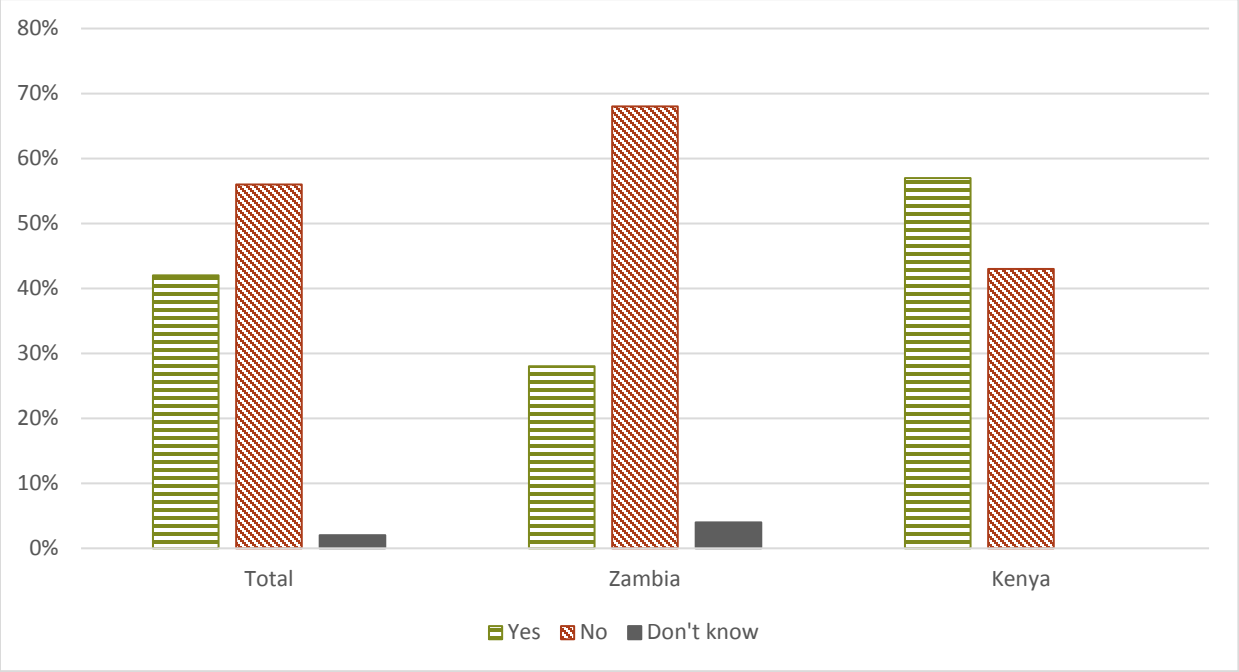

Figure 42. Percentage of children who have a birth certificate or notification card, as reported at endline.

Comparisons to baseline data. Figure 43 presents the percentage of children who were registered, comparing baseline data to endline data. Looking at the aggregated data, 37% of all children at baseline had a birth certificate/registration card, while at endline 42% had one, an increase of 7%.

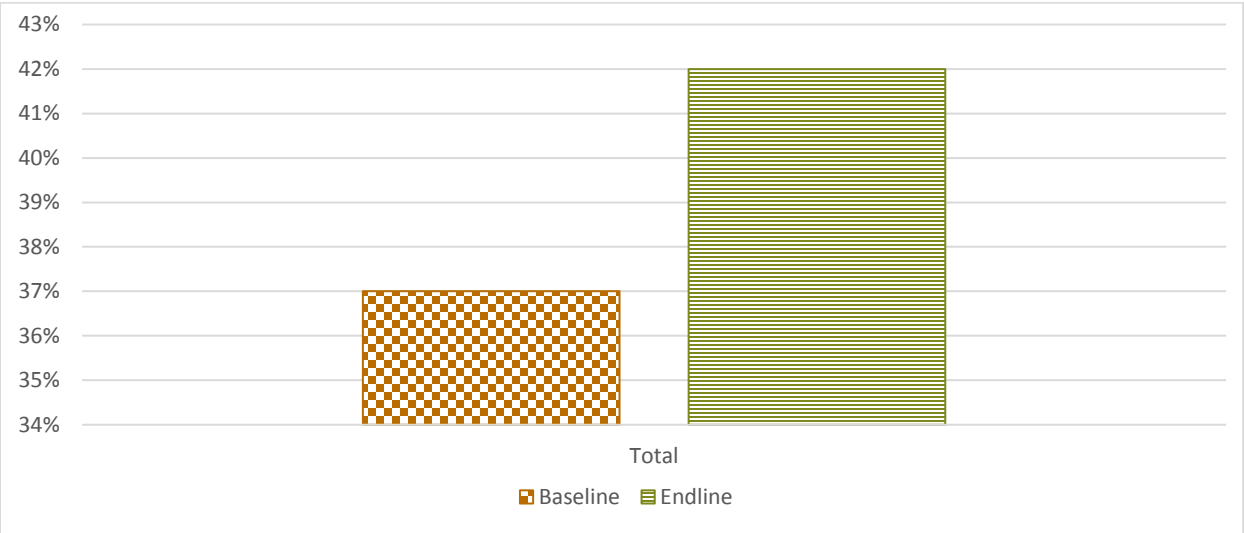

Figure 43. Percentage of children who have a birth certificate or notification card across all sites, baseline vs. endline.

Reasons for registering children. Figure 44 presents the different reasons caregivers provided for why they registered their child at endline. Caregivers were allowed to select multiple reasons; answers were not mutually exclusive. When looking at the aggregate data, nearly half of the caregivers who responded (48%) said that they were advised to register their child at the health facility. 14% said that they learned about registering their child from the CHV during home visits and 8% said they learned during group parenting sessions. Other reasons provided by caregivers for registering their child included radio broadcasts, the father decided to register their child (with no further explanation as to what influenced the father's decision), because it was government policy, because it is a school requirement, and because it will help their child in the future (with no further information with regards to what information or who influenced this caregiver belief).

When disaggregating data by country, caregivers in both countries most frequently reported that they registered their children because they were advised at the health facility, though nearly double the percentage of caregivers in Zambia provided this as a reason (72%) as compared to caregivers in Zambia (35%). This was followed by being taught about child registration from CHVs during home visits (Zambia: 12%; Kenya: 14%) and then from group parenting sessions (Zambia: 6%; Kenya: 10%).

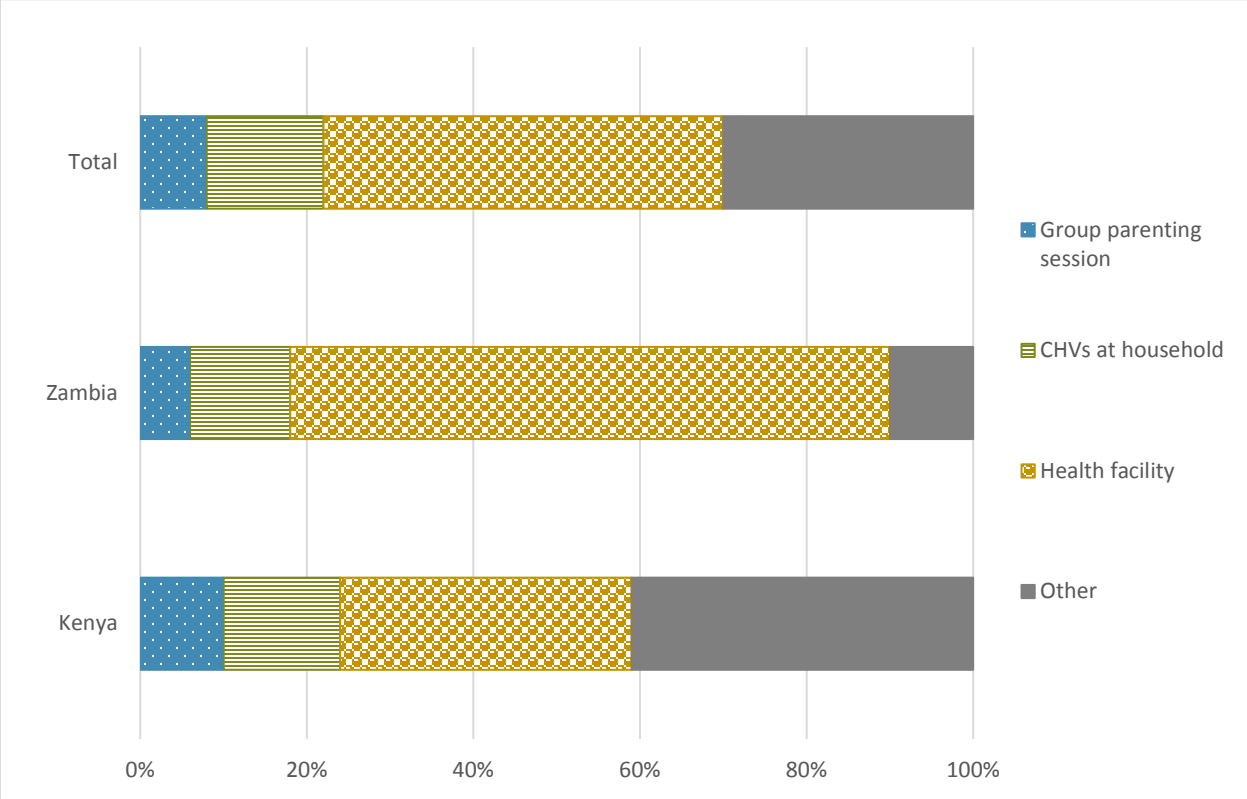

Figure 44. Reasons provided for why children were registered, as reported at endline.

Reasons for not registering children. Figure 45 presents the different reasons caregivers provided for why their children did not have a birth certificate or notification card at endline. Looking at the data in aggregate, when caregivers were asked why their children were not registered, 14% responded that the process is too complicated and another 14% said they did not know why. 11% said they did not know where to register, 10% said that their child was born at

home, 9% said the registration center is too far, and 6% said that they did not find it necessary to register their child. Other reasons caregivers self-reported reasons for not registering their children included that they as the caregiver were "just lazy", financial challenges, having lost the card, not having picked up the card yet, and that the process was ongoing.

When disaggregating data by country, the reason provided by the largest percentage of caregivers in Zambia was that they did not know why their child was not registered (20%), followed by that they did not know where to register (17%). The reason provided by the fewest percentage of caregivers was that they did not find it necessary to register (7%). In contrast, the reason provided by the largest percentage of caregivers in Kenya was that they found the process to be too complicated (22%), and the reasons provided by the fewest percentage of caregivers was that they did not know where to register (1%), that they did not know why their child was not registered (3%) and that the registration center was too far (3%).

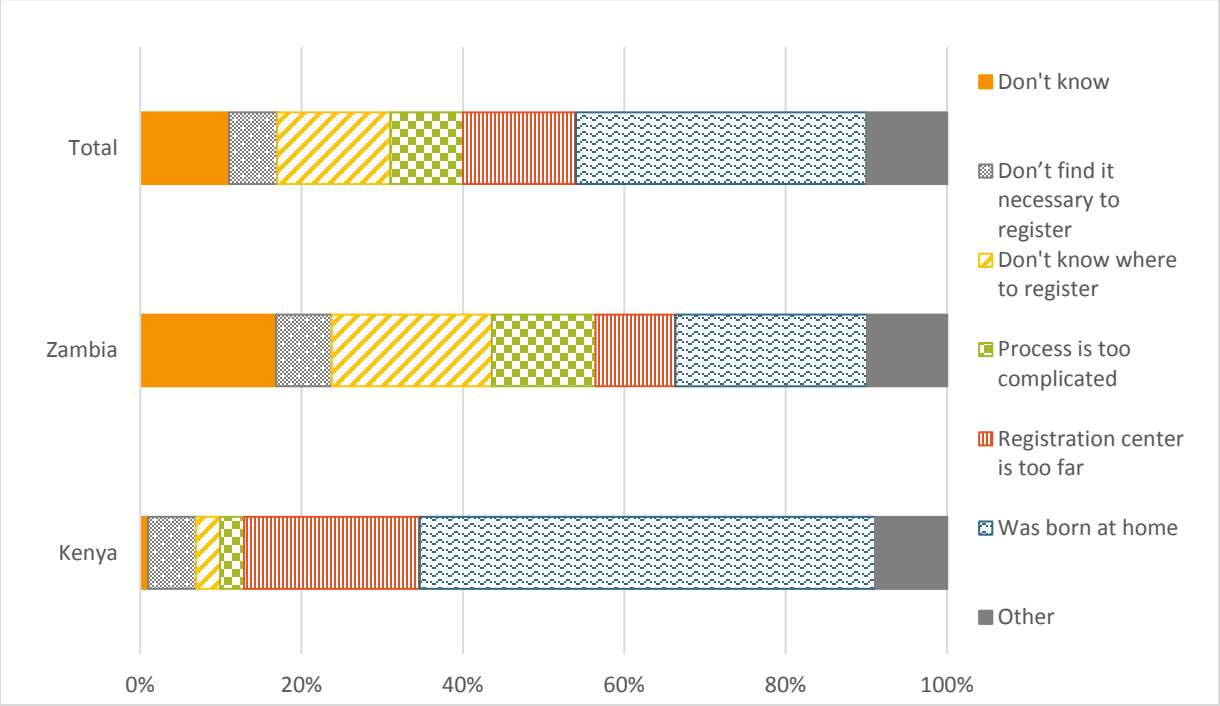

Figure 45. Reasons provided for why children were not registered, as reported at endline.

Health card. Figure 46 presents the percentage of children who have a health card, as reported at endline. In looking at the aggregated data, the vast majority of children (92%) have a health card. When looking at country-level data, 94% of children in Zambia and 91% of children in Kenya have a health card. Health card data was not collected at baseline.

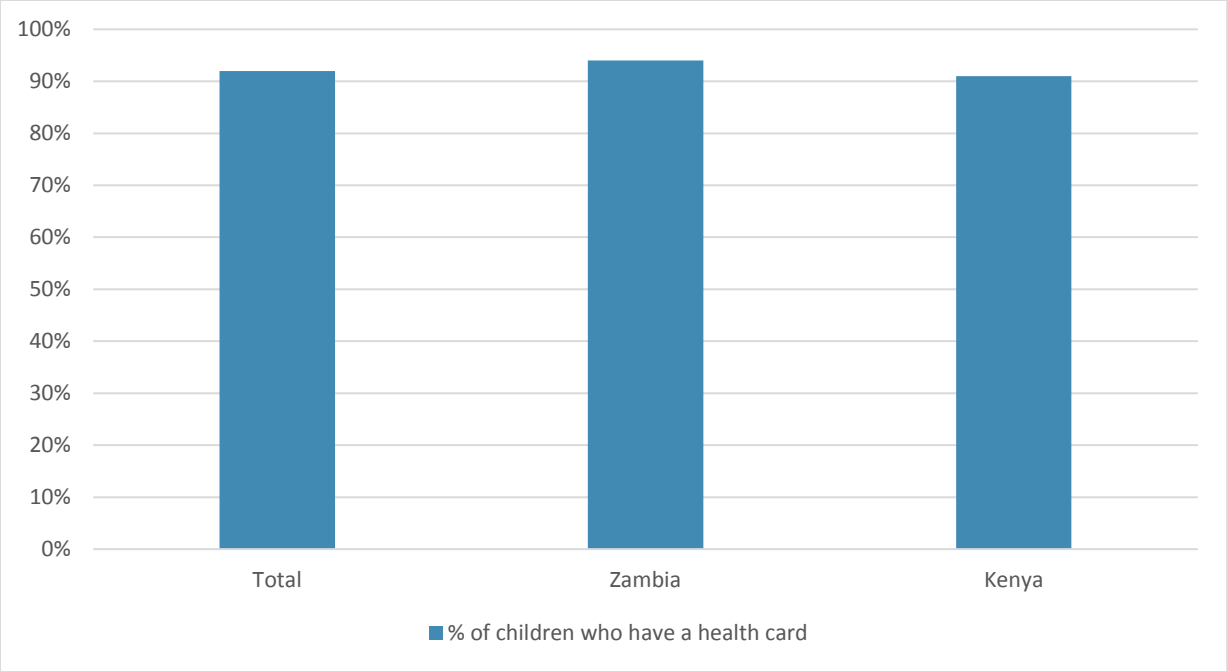

Figure 46. Percentage of children who have a health card, as reported at endline.

Access to healthcare facilities. Figure 47 presents what caregivers did when their children became sick. In looking at the aggregate data, over half of caregivers visited a health facility immediately (58%) followed by visiting the health facility when sickness persisted (14%). 9% bought over-the-counter drugs from the pharmacy and 4% administered pain killers to the child themselves. 3% visited a CHV/CSS for treatment and 2% visited a health facility after being advised by a CHV/CSS. Other responses caregivers gave were asking for a neighbor's opinion, using their own knowledge to give children medicine, breastfed the child, and "didn't [do anything] because they said two months is too young to take to the clinic."

When looking at the data at the country level, over three quarters of caregivers in Zambia immediately take their children to a health facility (77%) while only 43% of caregivers in Kenya do the same. More caregivers in Kenya are likely to visit a health facility if the sickness persisted (19%) as compared to caregivers in Zambia (9%). Caregivers in Kenya were also more likely to buy over-the-counter drugs from the pharmacy (14%) and to administer pain killers to the children themselves (6%) as compared to 3% and 2% of caregivers in Zambia, respectively.

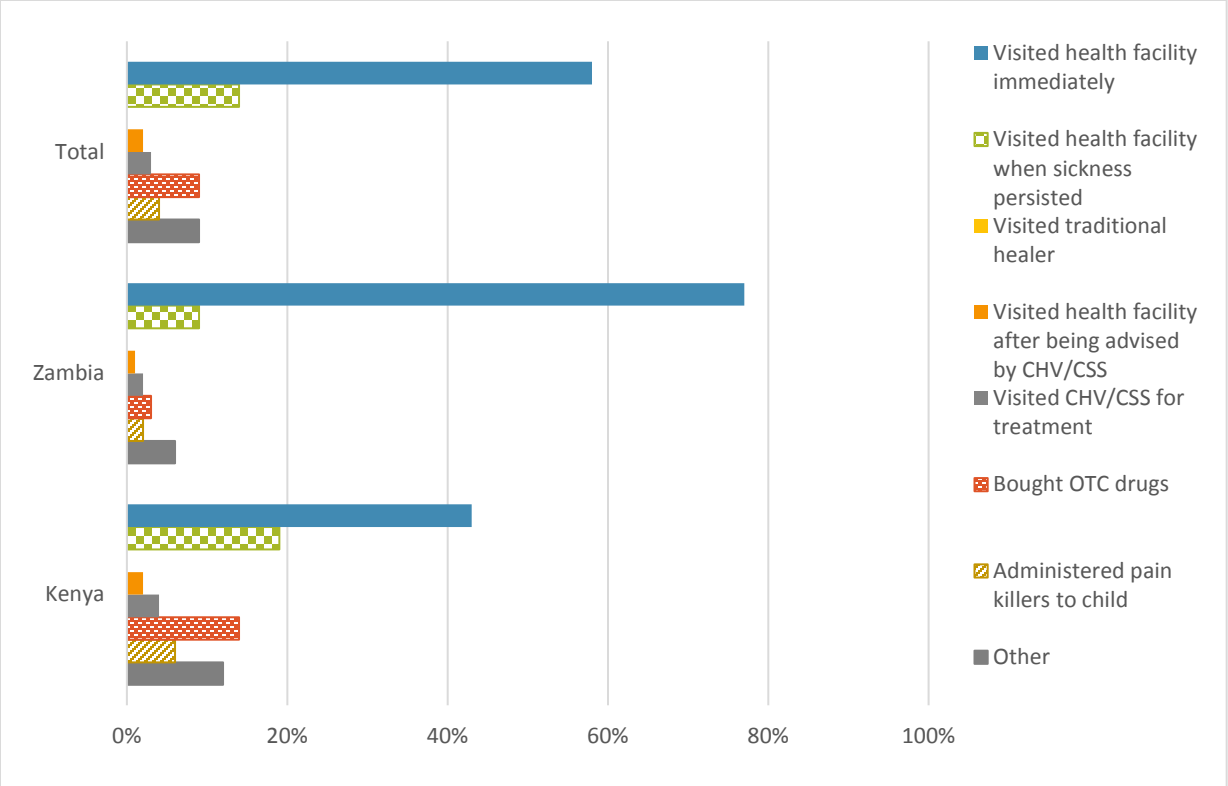

Figure 47. Where children were taken when sick.

Training/Information on what to do when child is sick. In examining aggregate data, 89% of caregivers reported having received training or information on what to do when the child is sick. In looking at country-level data, 85% of caregivers in Zambia and 92% of caregivers in Kenya report having received this training.

Figure 48 presents sources of training/information on what to do when the child is sick. Looking at the aggregated data, over half of caregivers received information from group parenting sessions and/or home visits (group parenting session: 34%; home visit: 28%) and 32% received information from health facilities. Other sources of training/information include friends, people in the community, and parents.

In looking at data disaggregated by country, almost half of caregivers in Zambia received training/information on what to do when the child is sick from health facilities (48%), followed by household visits (31%) and group parenting sessions (14%). In Kenya group parenting sessions were the most-selected source by caregivers (61%), followed by household visits (24%) and health facilities (10%).

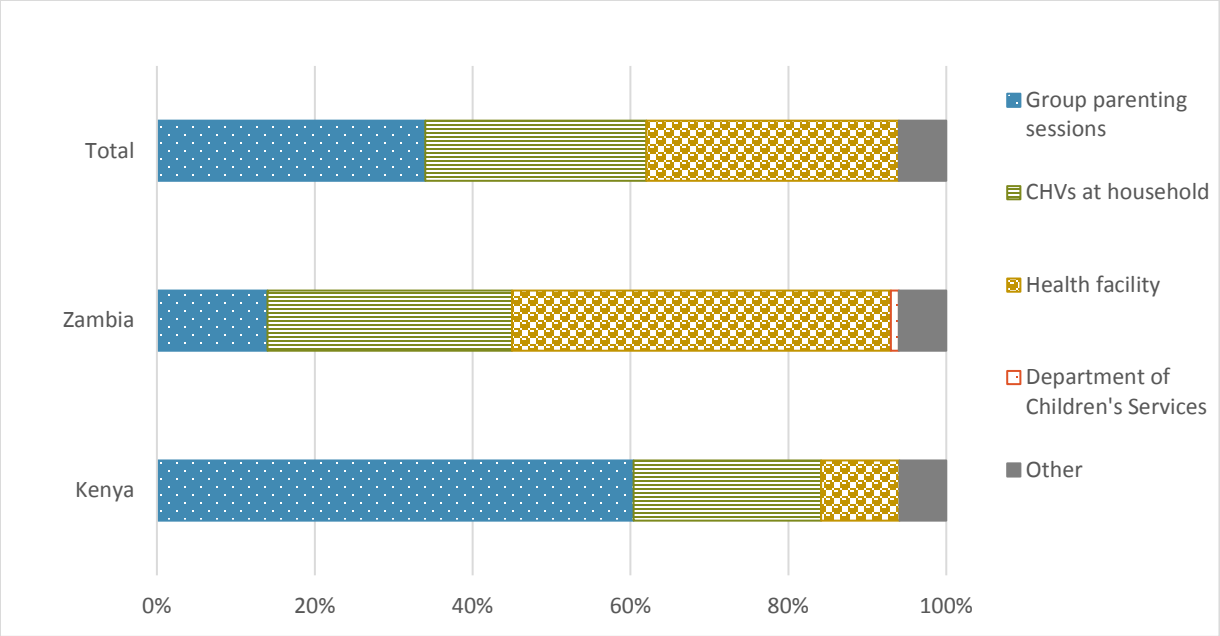

Figure 48. Sources of training/information on what to do when child is sick.

Caregivers expressing improved access to ECD-related services for themselves and their children. Figure 49 presents the percentage of caregivers reporting difficulty in accessing various ECD-related social services, as reported at endline. When looking at the data in aggregate, caregivers had the least difficulty accessing HIV support services, with 80% of caregivers responding that they could easily access these services. This was followed by early learning (67%), psychosocial services (64%), nutrition support (62%), health (59%), and police/justice (58%). The fewest caregivers reported easily being able to access social welfare services (55%).

When looking at data disaggregated at the country level, there are more caregivers in Kenya who reported ease in accessing almost all ECD-related services, with the exceptions of health and nutrition support services. In Kenya, most caregivers reported being easily able to access HIV support (84%) psychosocial (75%), and early learning (71%) services. The fewest percentage of caregivers reported easily being able to access social welfare services (57%). In Zambia, most caregivers reported being easily able to access HIV support (76%), early learning (63%), and nutrition support services (62%). The fewest percentage of caregivers reported easily being able to access police/justice services (47%).

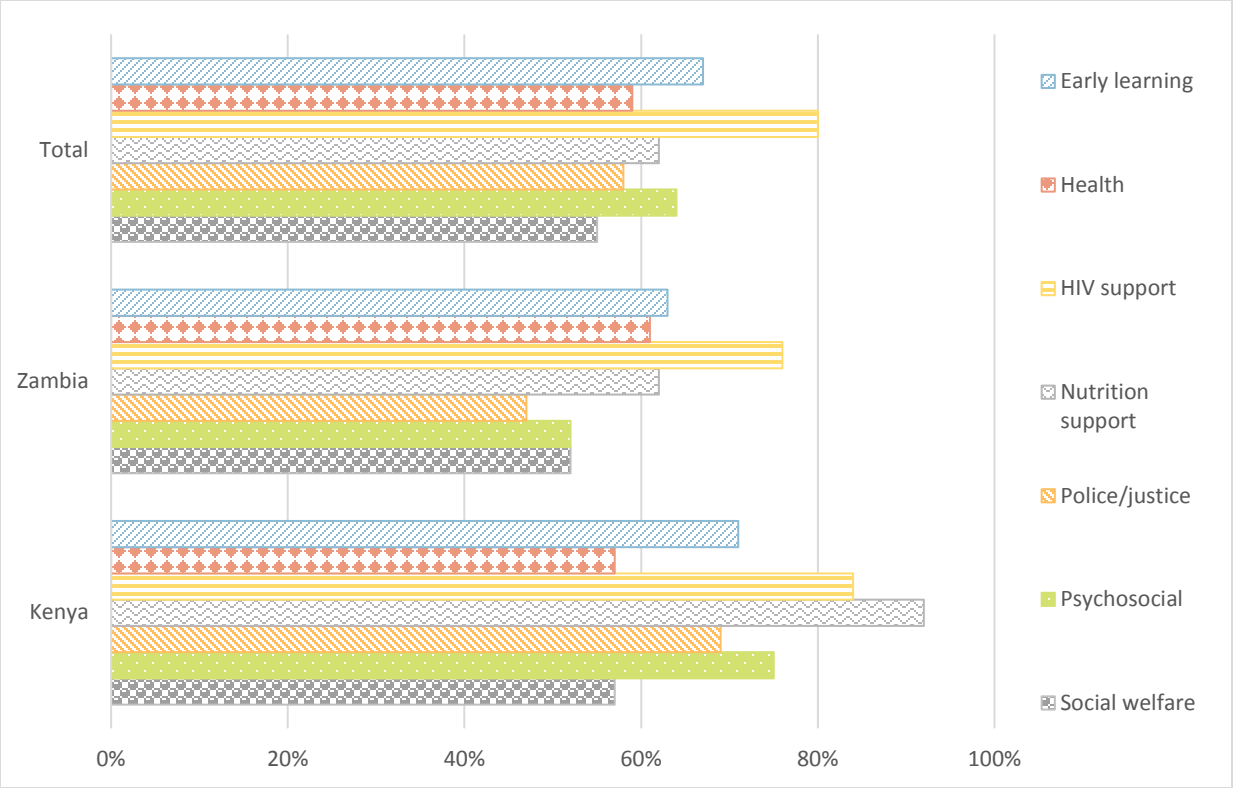

Figure 49. Percentage of caregivers reporting ease in accessing ECD-related services, as reported at endline.

Comparisons to baseline evaluation. At baseline, access to early learning, health, nutrition support, psychosocial, and social welfare services were measured. Figure 50 presents a comparison of the percentage of caregivers reporting difficulty in accessing these ECD-related services, as reported at baseline and at endline. When looking at the aggregated data, fewer caregivers reported barriers to accessing these five services at endline as compared to baseline. The greatest decrease was seen in nutrition support services while the smallest decrease was seen in early learning services, with 44% and 29%, respectively, fewer caregivers reporting obstacles to accessing these services.

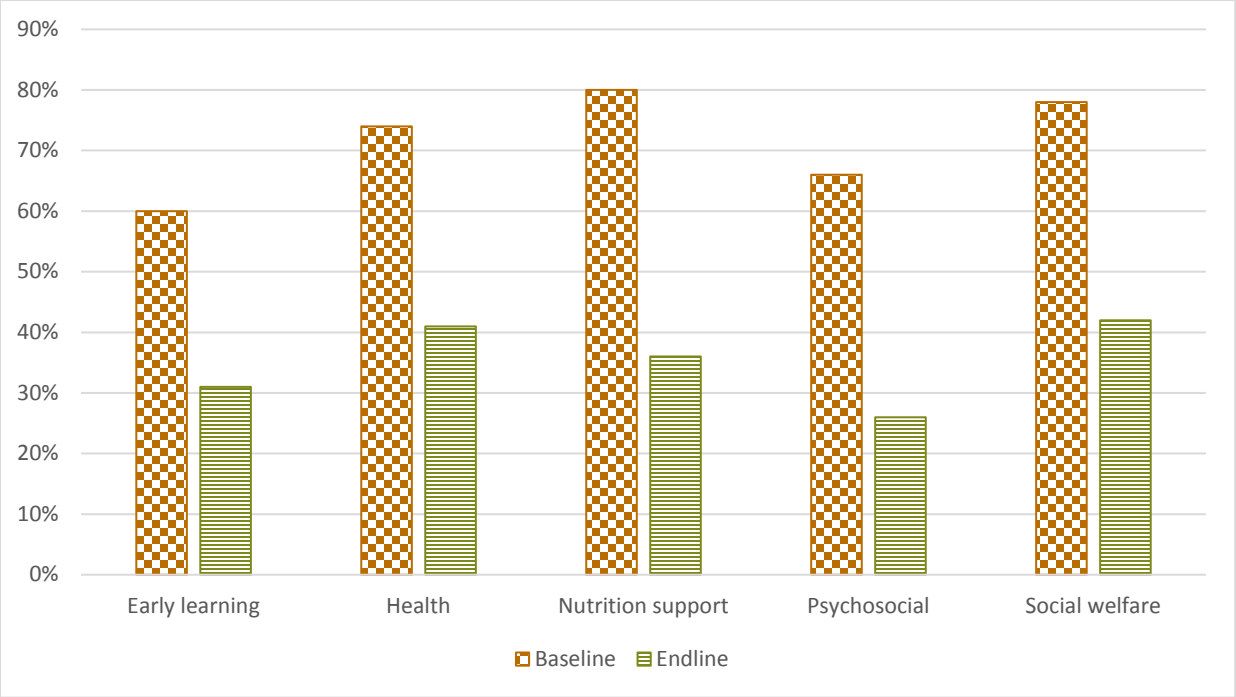

Figure 50. Percentage of caregivers reporting difficulty in accessing ECD-related services, as reported at baseline and at endline.

Barriers to accessing ECD-related services at endline evaluation. When looking specifically at barriers to accessing different ECD-related services, some important barriers include services not being available, long distances required to access services, and the high cost of services. Overall, caregivers reported the most obstacles in accessing health and social welfare services and the least in accessing psychosocial and HIV support services.

Comparison between countries regarding specific barriers to ECD-related services will be made below, in conjunction with baseline study results for those services for which baseline data was available.[8]

Barriers to early learning services. Figure 51 presents the barriers reported by caregivers to accessing early learning services, as reported at endline. In looking at the aggregated data, the top barrier to accessing early learning services was the high cost, as cited by 60% of caregivers. 36% of caregivers gave long distances as another barrier, and 11% the service not being available. Other barriers caregivers provided were not knowing about the service, being told the schools are full, lack of money for uniforms and fees, the need for a birth certificate, and infrastructure accessibility issues (i.e. flooded streams) that prevent the ability to physically access the school.

When looking at the data disaggregated by country, the service not being available and long distances affected proportionately more caregivers in Zambia (16% and 52%, respectively) as compared to caregivers in Kenya (5% and 14%, respectively). Caregivers in Kenya, however, reported high costs of early learning services as being their top barrier (86%), significantly more than the 40% of caregivers in Zambia that reported this to be a problem.

[8] Some of the barriers reported at baseline differ from those reported at endline. Only those barriers which appear at both time points are compared. Additionally, due to the way baseline data was reported, analyses cannot be conducted to determine whether there were statistically significant differences between baseline and endline data.

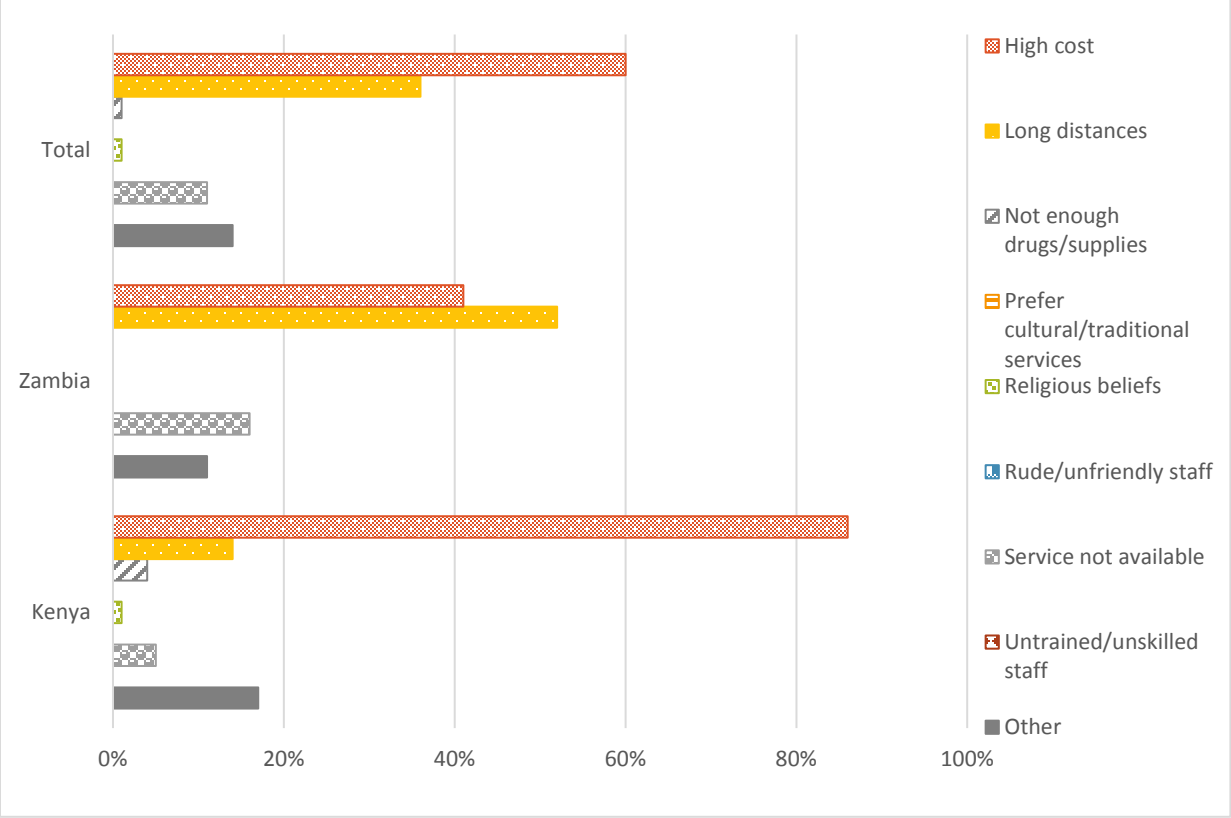

Figure 51. Barriers to accessing early learning services, as reported at baseline.

Comparison to baseline. Figure 52 presents barriers to accessing early learning services, at baseline and at endline. High costs, long distances, and availability of services were also measured at baseline. There were increased barriers to accessing early learning services at endline. The area of biggest increase as reported by caregivers was high costs, a change of 25%. This was followed by long distances, an increase of 19%, and availability of services, a change of 2%.

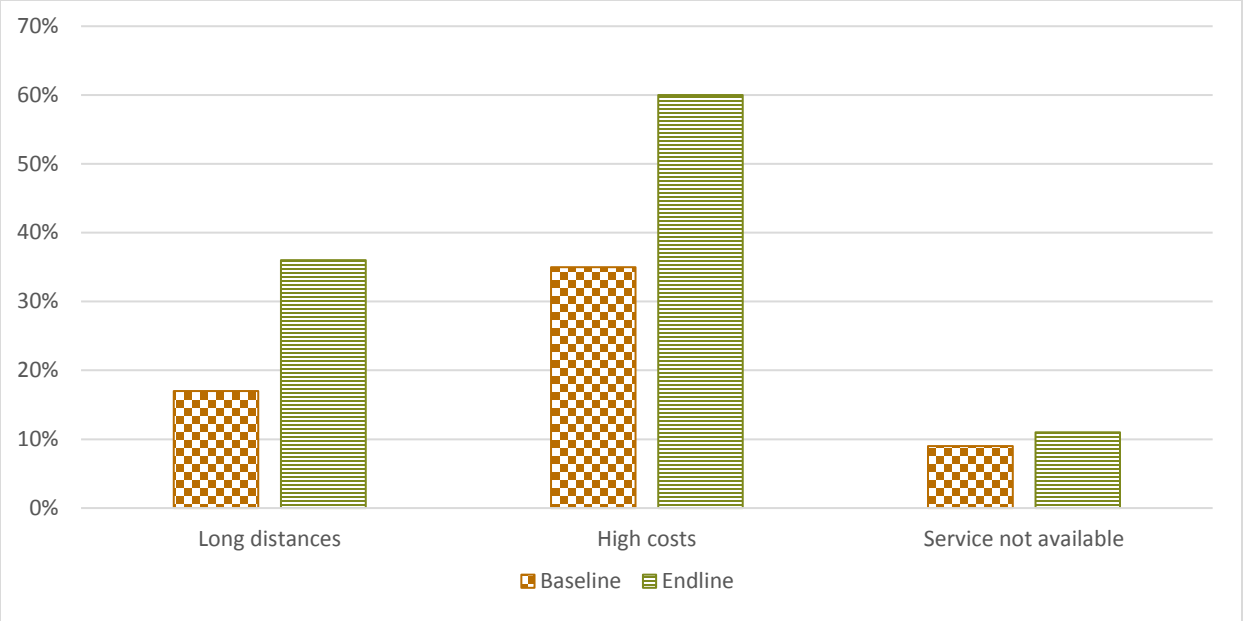

Figure 52. Barriers to accessing early learning services, baseline vs. endline.

Barriers to health services. Figure 53 presents caregiver-reported barriers to accessing health services, as reported at endline. In looking at the aggregated data, long distances were the top-most reported barrier (58%), followed by high costs (51%). 12% of caregivers reported not having enough drugs/supplies as being a barrier, 10% reported the service not being available, and 5% refer to issues with the staff (being rude/unfriendly or untrained/unskilled). Other barriers reported by caregivers included the loss of medical card, long lines, and fear of hospitals.

When disaggregating data by country, significantly more caregivers in Zambia reported long distances being a barrier to accessing health services (83%) as compared to caregivers in Kenya (34%), while significantly more caregivers in Kenya reported high costs (76%) and not enough drugs/supplies (16%) as being barriers as compared to caregivers in Zambia (24% and 8%, respectively).

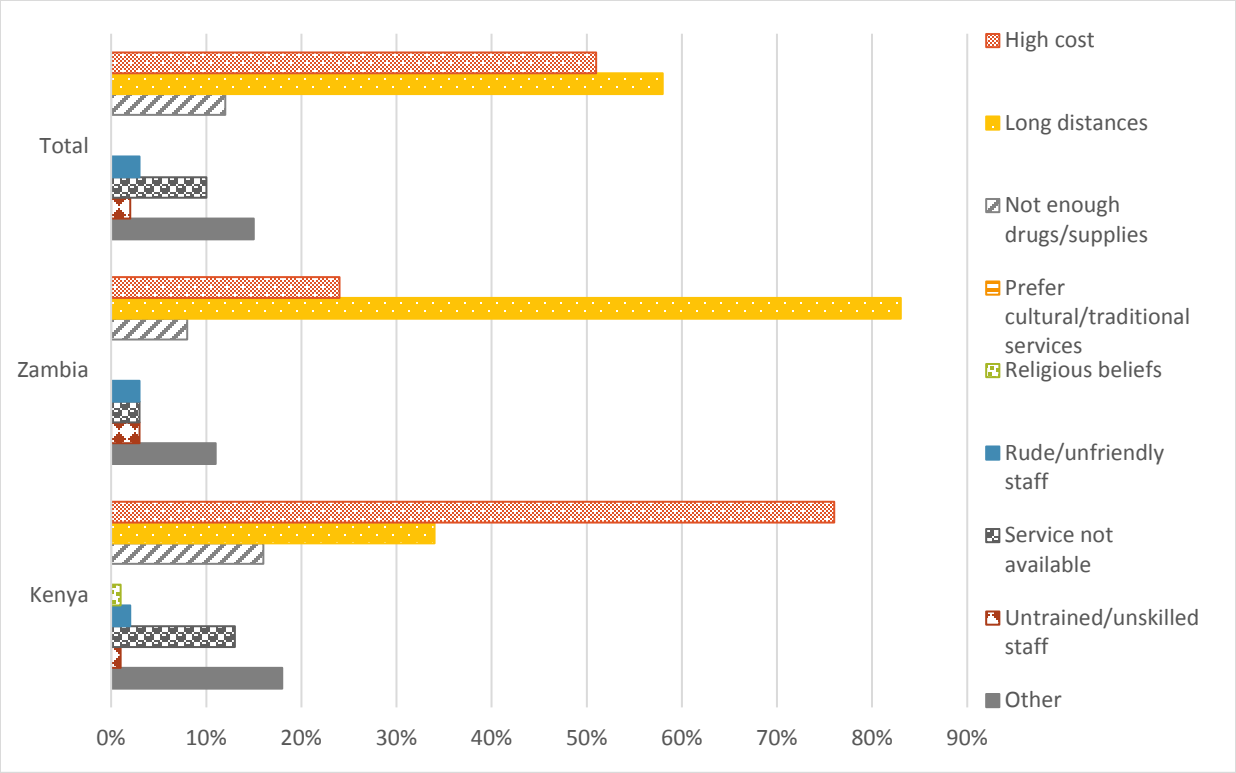

Figure 53. Barriers to accessing health services, as reported at endline.

Comparisons to baseline. Figure 54 presents barriers to accessing health services, at baseline and at endline. Looking at the aggregate data, overall the largest decrease in reported barriers is in not having enough drugs/supplies. This was reported as a barrier by 24% of caregivers at baseline but only 12% at endline, a decrease of 12%. Other decreases are relatively minimal, such as high costs, preferring cultural/traditional services, religious beliefs, and rude/unfriendly staff. Caregivers reported increases in long distances, with an increase from 51% at baseline to 58% at endline.

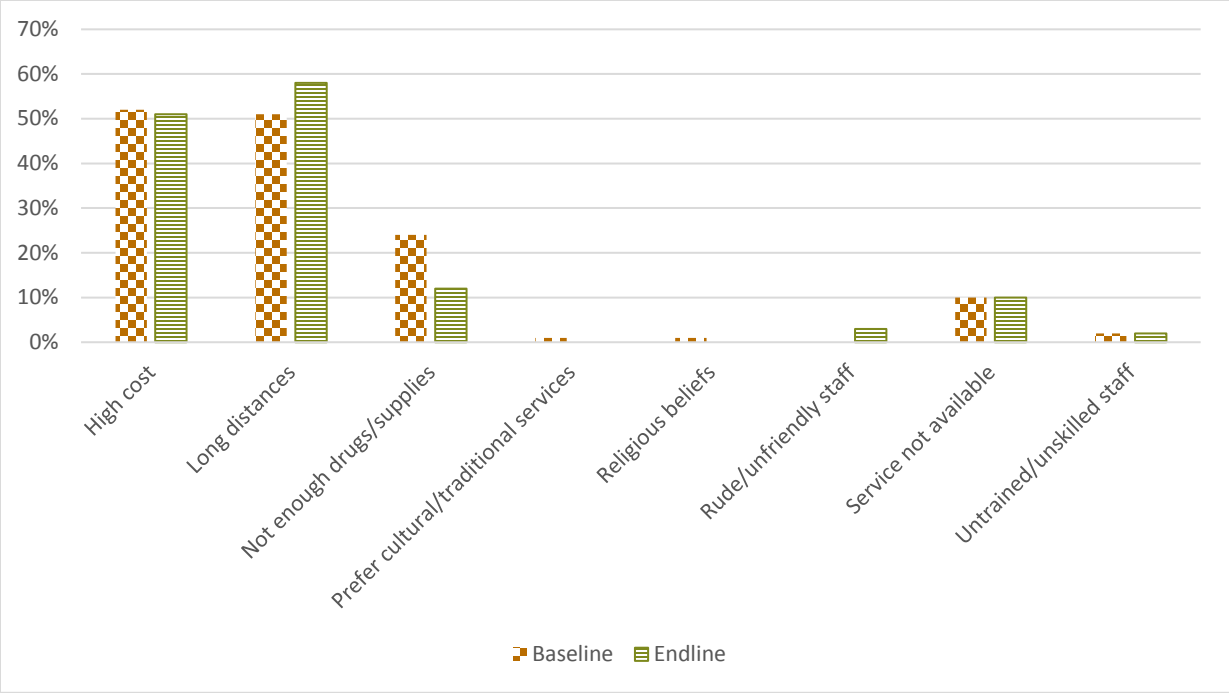

Figure 54. Barriers to accessing health services, baseline vs. endline.

Barriers to HIV support services. Figure 55 presents caregiver-reported barriers to accessing HIV support services. In looking at the aggregated data, most caregivers reported long distances as being a barrier to accessing these services (52%). This was followed by the service not being available (36%), the high cost of services (9%), and not having enough drugs/supplies (9%). Other barriers reported by caregivers include the caregiver not having enough time to access these services, nobody available to guide people on how to access these services, and stigma among community members.

When looking at the disaggregated country-level data, significantly more caregivers in Zambia (66%) report long distances as being a barrier compared to caregivers in Kenya (2%). Significantly more caregivers in Kenya (22%) reported not having enough drugs/supplies as being a barrier as compared to caregivers in Zambia (2%).

Barriers to HIV support services were not queried at baseline.

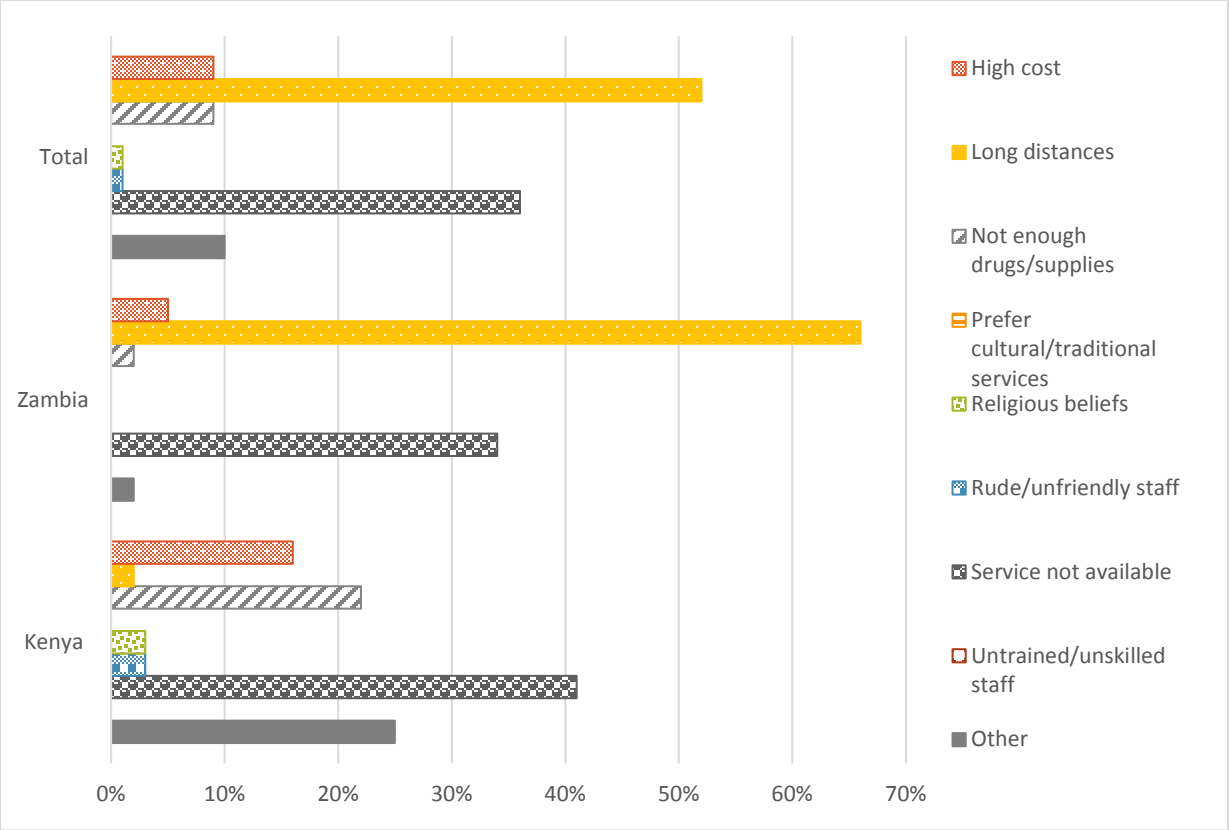

Figure 55. Barriers to accessing HIV support services, as reported at endline.

Barriers to nutrition support services. Figure 56 presents caregiver-reported barriers to accessing nutrition support services, as reported at endline. In looking at the aggregated data, high costs were the top obstacle, reported by 51% of caregivers as being a barrier. This was followed by the service not being available (32%) and long distances (16%). Untrained/unskilled staff were reported by 1% of caregivers as being a barrier as well as not having enough drugs/supplies. Other barriers provided by caregivers included not knowing about the service, not having enough money to purchase healthy food, and children not liking the food purchased.

When comparing data at the disaggregated country level, significantly more caregivers in Zambia (28%) reported long distances as being a barrier as compared to caregivers in Kenya (3%). Additionally, significantly more caregivers in Kenya (65%) reported high costs as being a barrier as compared to caregivers in Zambia (38%).

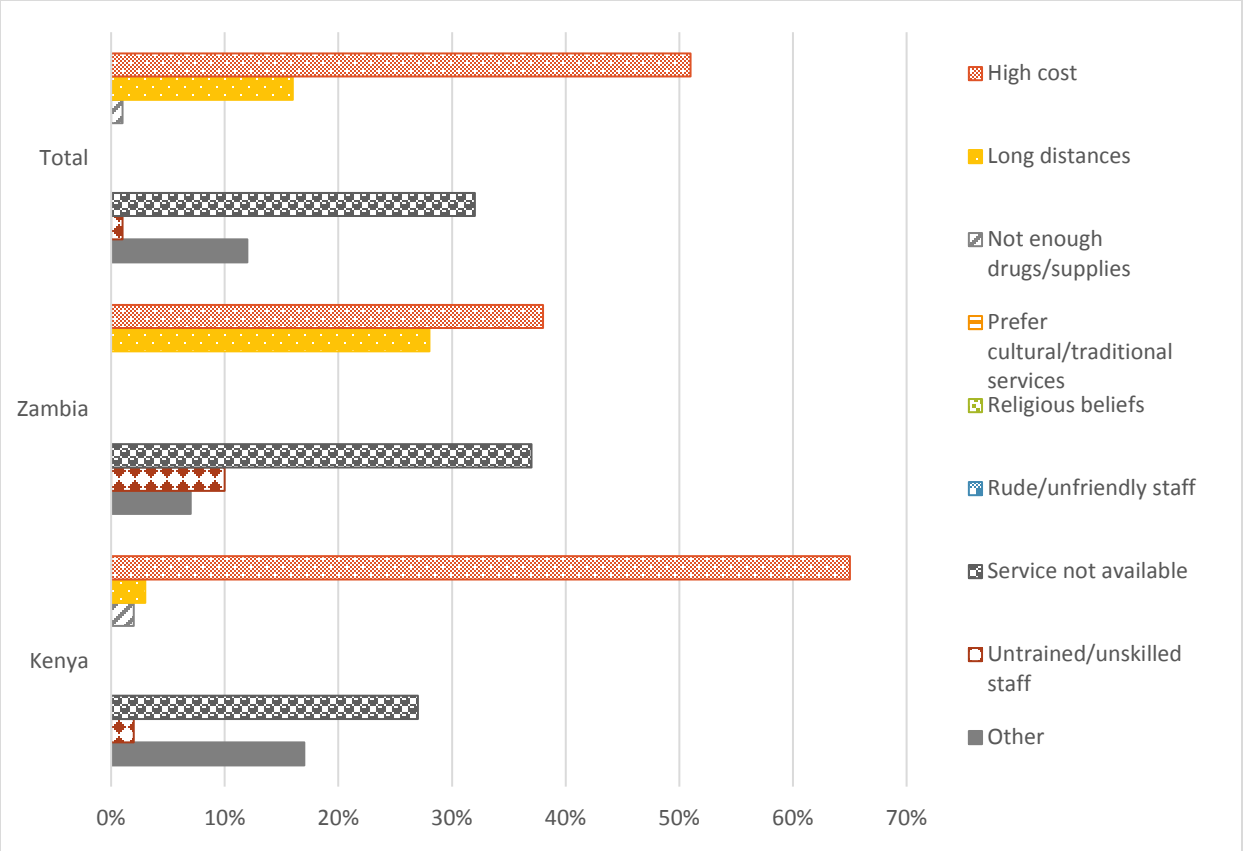

Figure 56. Barriers to accessing nutrition support services, as reported at endline.

Comparison to baseline. Figure 57 presents barriers to accessing nutrition support services, at baseline and at endline. The greatest reduction is seen in the availability of services. At baseline, over half (51%) of caregivers reported nutrition support services not being available as the top obstacle, while at baseline only 32% of caregivers reported the same. Reductions are also seen in terms of service accessibility, with fewer caregivers reporting long distances being a problem at endline (25% at baseline, 16% at endline). However, there is an increase in caregivers reporting high costs as being a barrier, from 9% at baseline to 51% at endline.

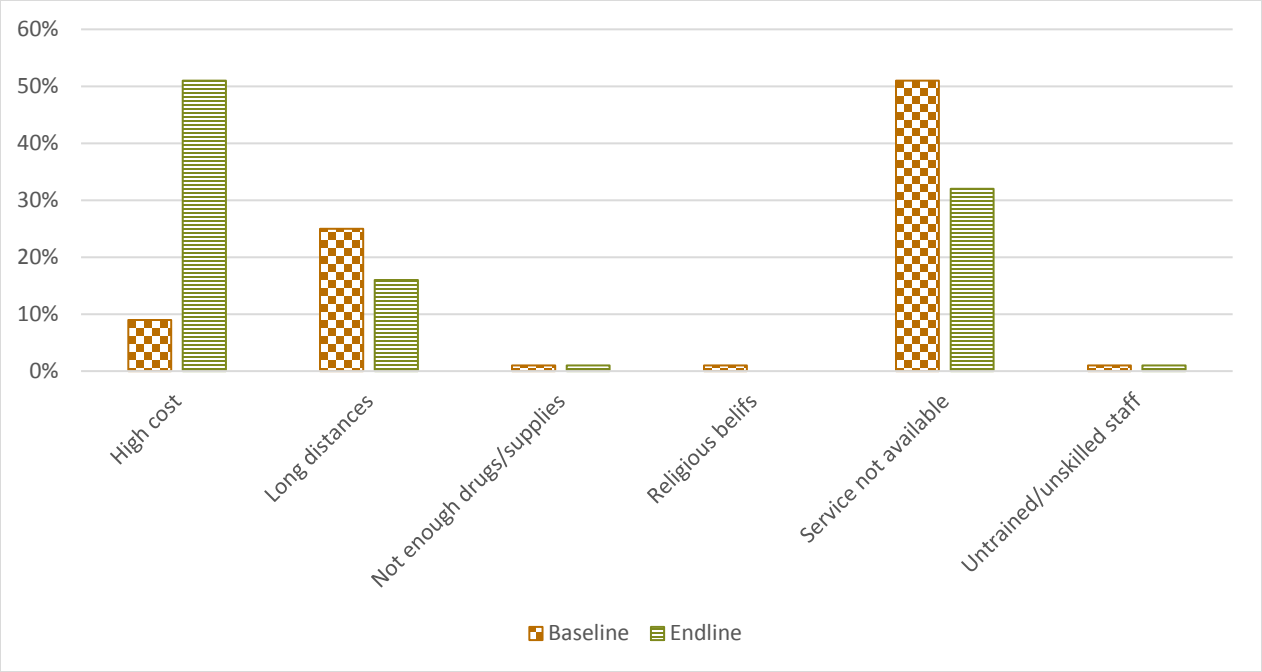

Figure 57. Barriers to accessing nutrition support services, at baseline and at endline.

Barriers to police/justice services. Figure 58, presents caregiver-reported barriers to accessing police/justice services, as reported at baseline. Looking at the aggregated data, the majority of caregivers reported long distances (73%) as being a top barrier to accessing these services. 27% of caregivers cited unavailability of the service as being a barrier and 21% high costs. 5% of caregivers gave rude/unfriendly staff as a barrier and 3% cited untrained/unskilled staff. Other barriers provided by caregivers included needing to bribe police officers, being afraid of how police officers talk to people, long and complicated process, and needing to sort matters at the village level before going to the police.

In looking at data disaggregated by country, significantly more caregivers in Zambia cited high costs (22%), long distances (86%), and service availability (30%) as being barriers to accessing police/justice services as compared to caregivers in Kenya (17%, 22%, and 15%, respectively). Significantly more caregivers in Kenya cite rude/unfriendly staff (20%) and untrained/unskilled staff (12%) as barriers as compared to caregivers in Zambia (1% and 1%, respectively).

Barriers to accessing police/justice services were not queried at baseline.

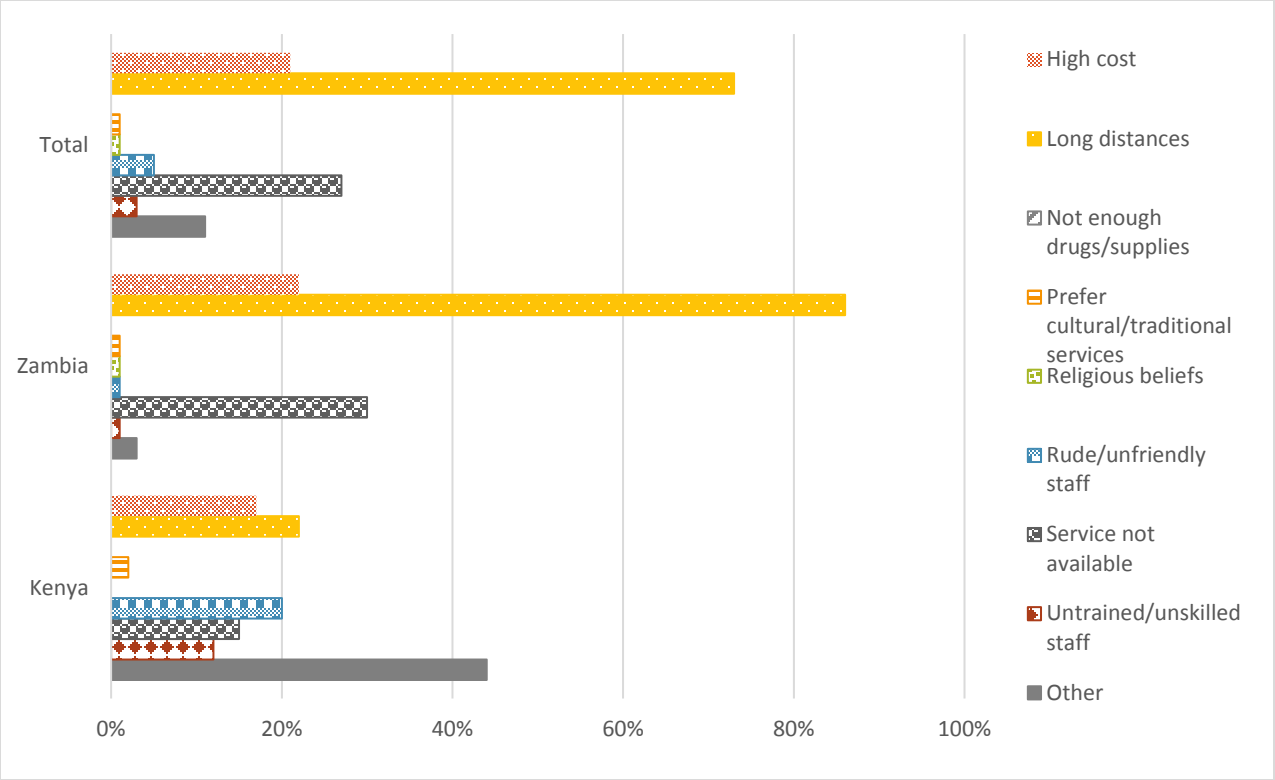

Figure 58. Barriers to accessing police/justice services, as reported at baseline.

Barriers to psychosocial services. Figure 59 presents caregiver-reported barriers to accessing psychosocial services, as reported at endline. When looking at the aggregated data, the most-cited barrier to accessing these services was that the service was not available (76%). Long distances were another barrier (20%), as are high costs (5%). Religious beliefs, not enough drugs/supplies, and untrained/unskilled staff were also all cited as barriers (1% each). Other barriers provided by caregivers are not knowing where to find the services nor how to access them.

In looking at data at the country-level, significantly more caregivers in Kenya (86%) reported the service not being available as a barrier as compared to caregivers in Zambia (72%). Long distances were more frequently cited as a barrier for caregivers in Zambia (25%) as compared to caregivers in Kenya (8%).

While there was some baseline data regarding barriers to psychosocial services, there were very few respondents rendering any comparisons less meaningful.

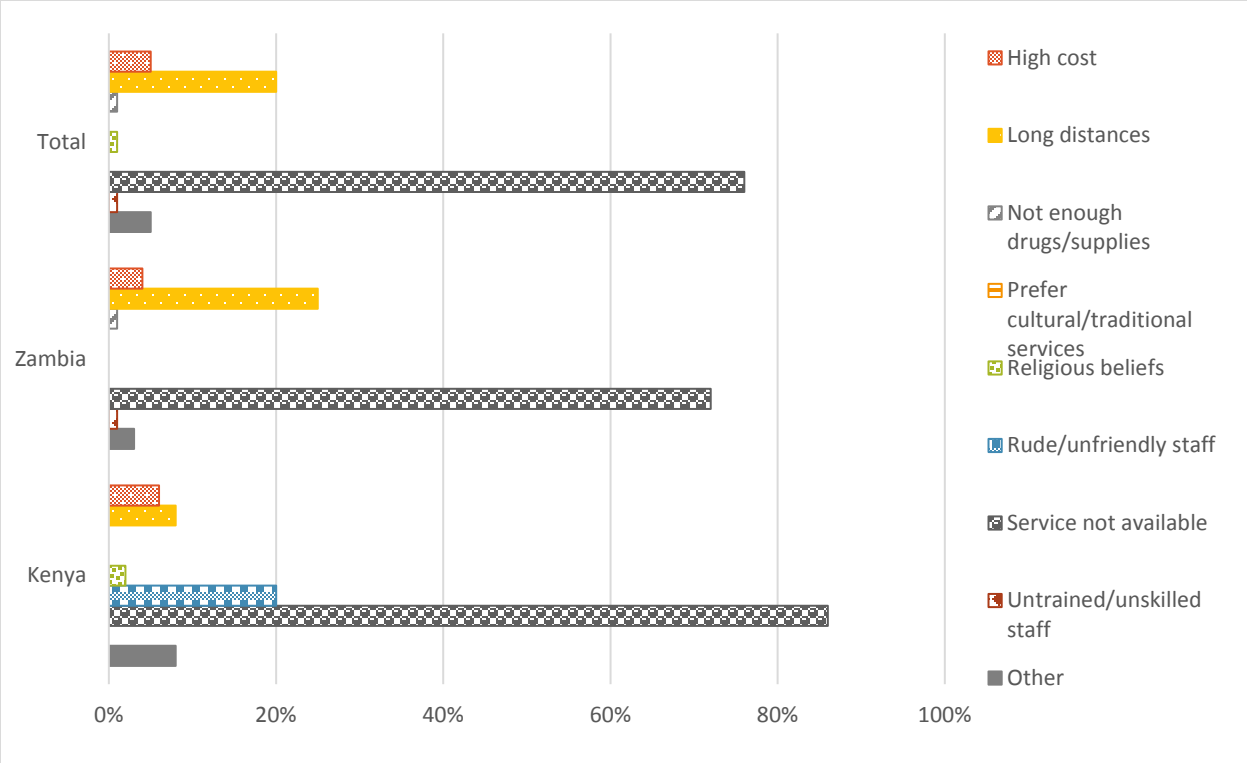

Figure 59. Barriers to accessing psychosocial services, as reported at endline.

Barriers to accessing social welfare services. Figure 60 presents caregiver-reported barriers to accessing social welfare services, as reported at endline. When looking at the aggregated data, long distances (42%) and the service not being available (41%) were the top two cited barriers to accessing social welfare services. High costs were cited by 28% of caregivers, rude/unfriendly staff by 4%, and untrained/unskilled staff by 1%).

When disaggregating data by country, significantly more caregivers in Kenya (47%) cited high costs as a barrier to accessing social welfare services as compared to caregivers in Zambia (10%) along with rude/unfriendly staff (Kenya: 7%, Zambia: 0%). However, significantly more caregivers in Zambia (57%) cited the service not being available as a barrier as compared to caregivers in Kenya (25%)

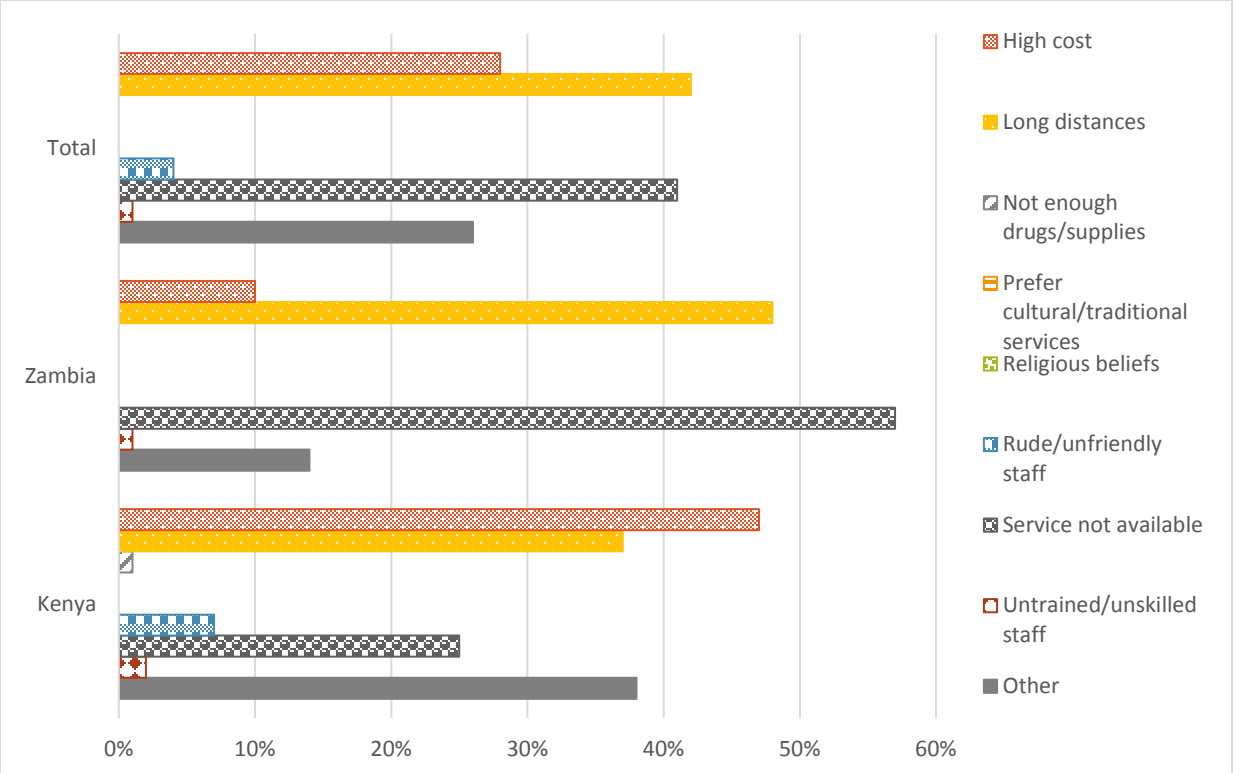

Figure 60. Barriers to accessing social welfare services, as reported at endline.

Comparisons to baseline. Figure 61 presents barriers to accessing social welfare services, at baseline and at endline. There was an increase in the percentage of caregivers reporting long distances as being a barrier, from 22% at baseline to 48% at endline. There was a smaller increase in the service not being available, from 38% at baseline to 41% at endline. There was a decrease in the percentage of caregivers citing high costs as being a barrier, from 14% at baseline to 10% at endline.

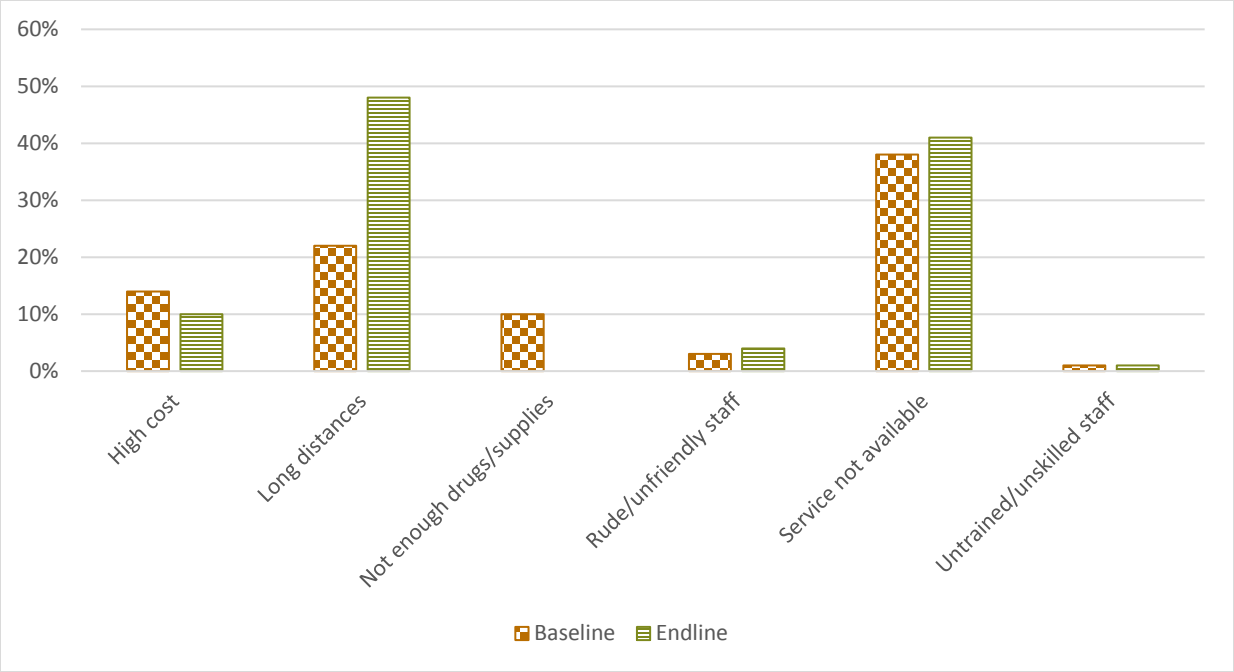

Figure 61. Barriers to accessing social welfare services, at baseline and at endline.

How level of vulnerability affects access to services. Chi-square analyses were conducted between estimated well-being rankings and ease of accessing ECD-related services in order to determine whether the two were related[9]. For early learning, health, nutrition support, and police/justice services, there was indeed a relationship between estimated well-being ranking and access to the service (early learning: χ^2 (6, N = 667) = 19.29, p < .01; health: χ^2 (6, N = 667) = 15.56, $p < .05$); nutrition support: χ^2 (6, N = 667) = 17.21, p < .01; police/justice: χ^2 (6, N = 667) = 23.52, $p < .01$). In general, as well-being ranking increased, difficulty in accessing these aforementioned services decreased (and correspondingly, ease in accessing these services increased). For instance, in looking at health services by estimated well-being ranking, households that were categorized as "struggling almost all the time" were almost evenly split between being easily able to access health services (51%) and having difficulties accessing these services (49%). For households categorized at the next level, "life is hard, sometimes struggling", 61% were able to easily access health services and 39% had difficulty accessing services. For households categorized as "coping most the time", 68% were able to easily access health services and 33% had difficulties. Finally, all households categorized at the highest well-being level, "coping well almost all the time" were able to easily access services. This pattern is also seen in looking at early learning, nutrition support, and police/justice services by estimated well-being level (see Figures 62-65). There were no relationships between well-being ranking and access to social welfare, psychosocial, and HIV support services.

[9] For these analyses, cases where caregivers responded they had never needed the service were omitted.

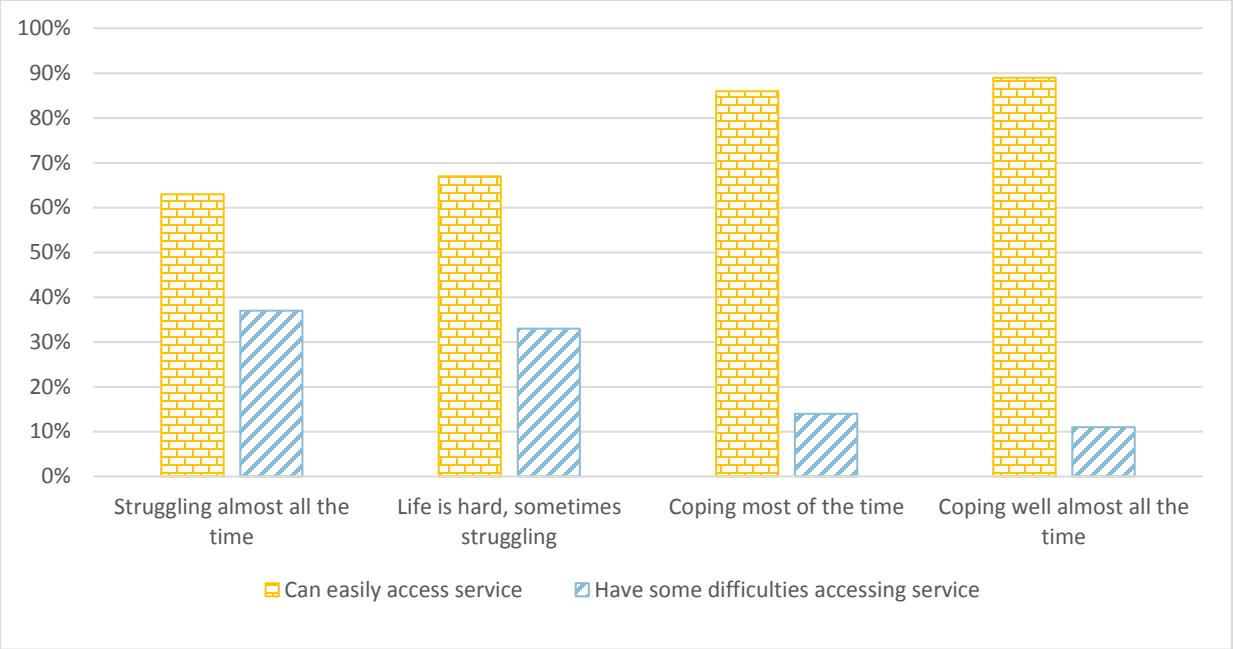

Figure 62. Percentage of caregivers who are able to access early learning services by household well-being ranking.

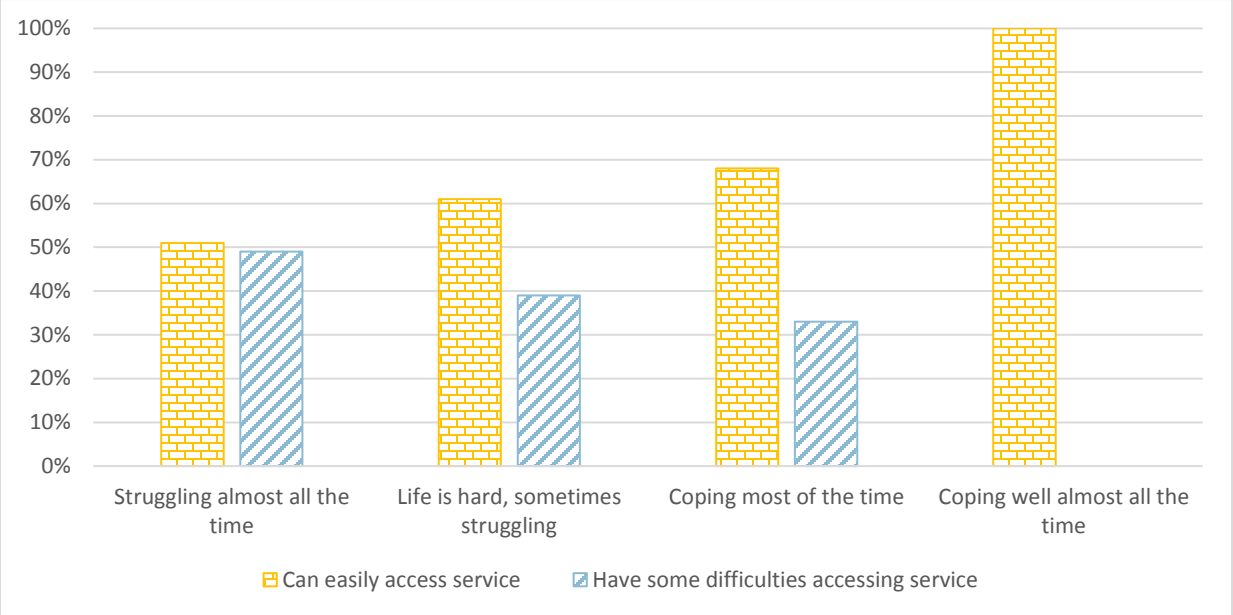

Figure 63. Percentage of caregivers who are able to access health services by household well-being ranking.

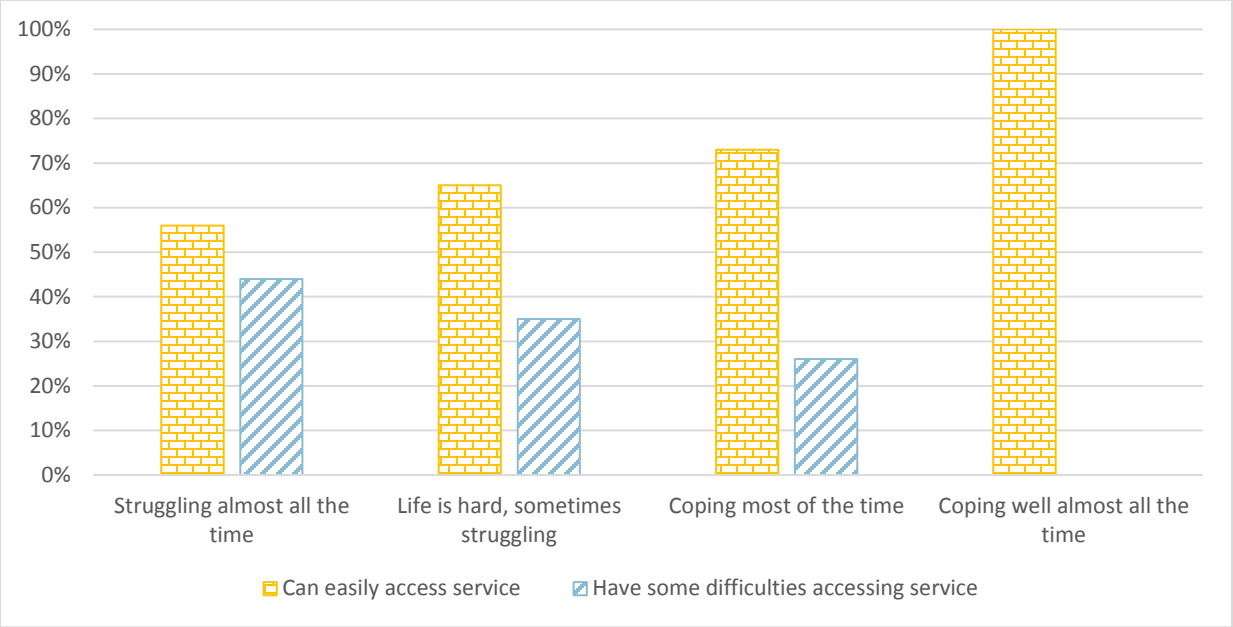

Figure 64. Percentage of caregivers who are able to access nutrition services by household well-being ranking.

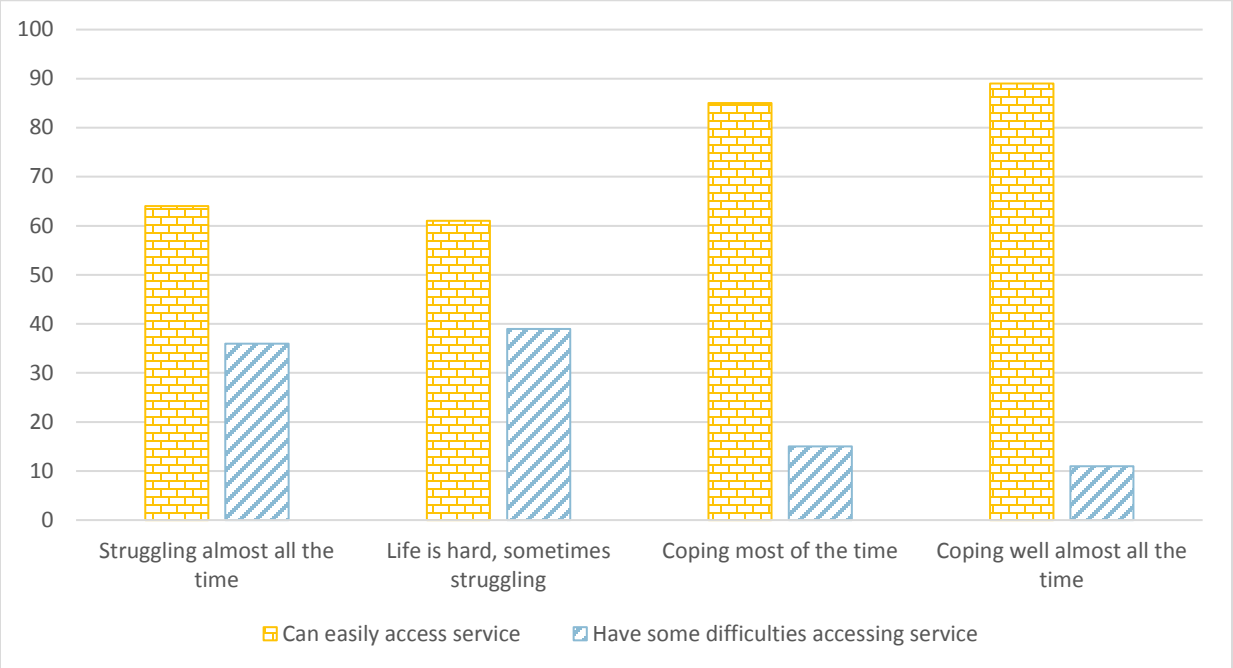

Figure 65. Percentage of caregivers who are able to access police/justice services by household well-being ranking.

Desired ECD-related services. Caregivers were questioned regarding what types of ECD-related services they would like to have continued or new in the future. In looking at the aggregated data, over half of caregivers (51%) responded home visits and over a third (40%) mentioned parenting groups. Of lesser interest was parenting training (22%), keeping children safe (20%), information on feeding children (19%) and health checks (17%). Caregivers were not very interested in programs for disabled children (6%) nor on accessing information cards

(6%). Other services requested by caregivers included HIV/AIDS awareness and management, income-generating activities, economic empowerment, empowering caregivers with survival skills, child-caregiver interactions, and information on child-rearing post-infancy period (See Figure 66).

When looking at data disaggregated by country, caregivers in Zambia more often requested home visits, parenting training, and information on feeding children than caregivers in Kenya. Caregivers in Kenya, on the other hand, more often requested parenting groups than those in Zambia. Caregivers in Zambia and Kenya approximately equally requested health checks, keeping children safe, programs for disabled children, and accessing information cards. The only statistically significant difference between the two countries was regarding home visits, requested by 75% of caregivers in Zambia but only 27% in Kenya ($\chi 2$ (1, N = 667) = 154.54, p < .01).

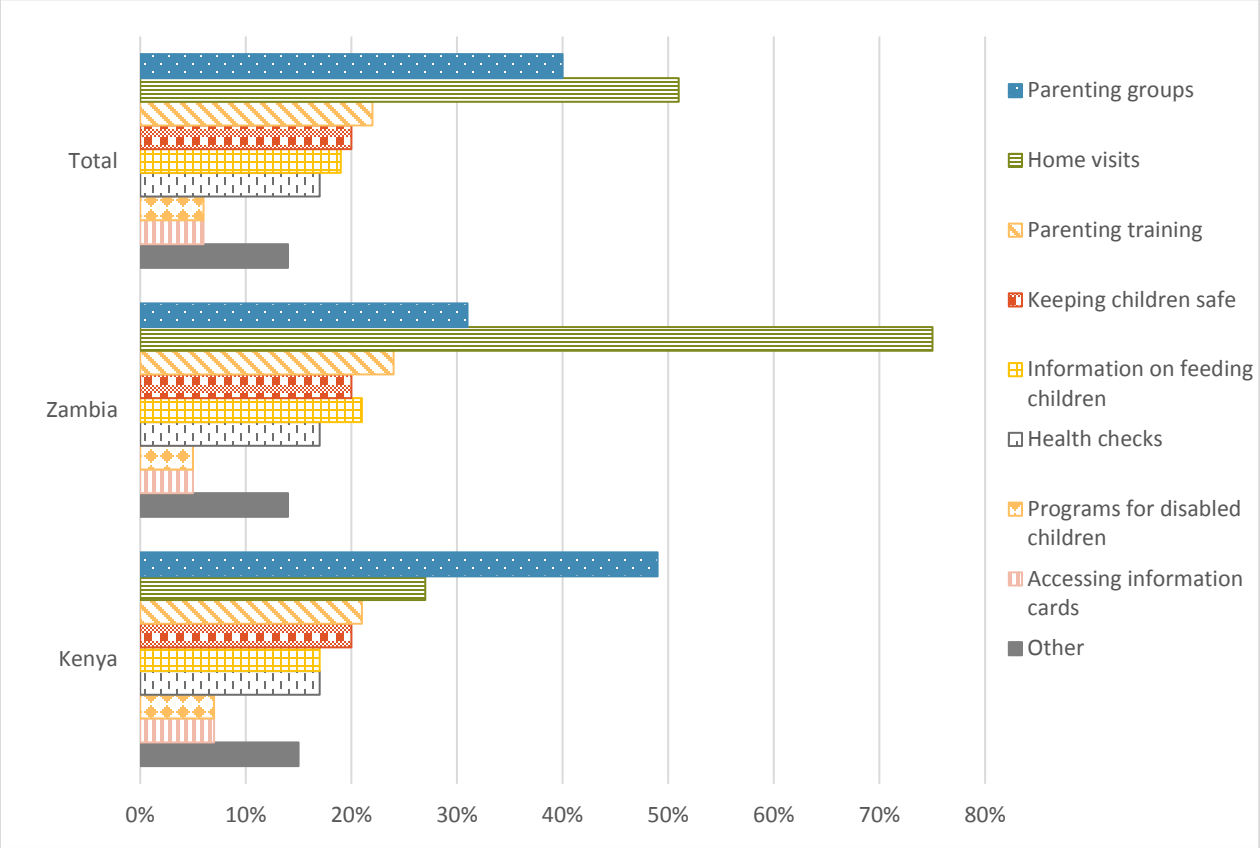

Figure 66. ECD-related services requested by caregivers.

Research Question 2.1: What Was the Knowledge of the Various Stakeholders (ChildFund, Partner CBOs, Government Partners, Identified Community Mentors, Facilitators from Existing Community Support Structures) Regarding: 1) Foundational ECD Topics; 2) Competencies in Executing Home and Group Parenting Sessions; and 3) Reflective Supervision?

CSS facilitators' knowledge (training and capacity building). The CSS facilitators reported that they went through various trainings, including ones on the topics of play and

communication stimulation and responsive care, child protection, child and brain development, stress management, and reflective supervision. As one facilitator mentioned:

> Mostly, we have been trained that development starts at birth, something I did not know myself, and when we apply this at grassroots level, it has brought about positive impact in the villages that we work in… It was about guidance, child's temperament as people are different, stress management, positive stimulation, response care… protection in regards to 0-5 years.

One of the interesting aspects of training offered to the CSS facilitators is that they did not only train the caregivers but also practiced what they learned in their own homes. In this regard, the CSS facilitators did not only cite the impact of the project on the caregivers, but also on their personal lives and those of their families. A CSS facilitator in Kenya reiterated that:

> For me, the program helped me on my side. Now I know how to play with the child because this program came when I had a little baby and I learned how I can interact with a small baby. How I can make play materials. It has helped me a lot; I would not like it to go.

In Zambia, one of the CSS facilitators said:

> I have learned on the importance of play with a child. In the past when the child wants to play with me, I could just tell him go away, am not your size to play with. By showing how I love to play with them, I make them toys.

Competencies in executing home and group parenting sessions. CSS facilitators reported that they received adequate technical support from the project. In Kenya, the kinds of support identified included open channels of communication between the CSS facilitators, mentors, and local community-based organization partners' project officers, as well as the availability of the mentors and project officers when needed. In Kenya, the project had also formed a group on WhatsApp, an opensource messaging and vVoice mobile phone application, to facilitate ease of communications to address issues as they arose between the CSS facilitators, mentors, and project staff. The CSS facilitators in Kenya described their relationship with the project staff as being "friendly, flexible, and always available." As one facilitator said:

> If I chip in, it has been awesome. There is a way they are to us and then if you have any problem in the community, maybe you don't know they have also opened a WhatsApp group where we communicate on the same. So, they are just very friendly.

In Zambia, the CSS facilitators referred to their relationship with project staff as "working together as a team." As stated by one facilitator, "We work as a team hand in hand and share information. We also have some members whereby if there is someone who needs help in the community we put our hands together to help such. Maybe taking a sick child to the clinic." The CSS facilitators in Zambia also noted that the mentors were patient enough in explaining issues whenever they had a challenge: "When we are stuck and don't understand things, our mentor patiently and gently explain things to us until we understand."

Reflective supervision. One of the most important lessons learned, as reported by CSS facilitators, was reflective supervision, which had a major impact on their work. During reflective meetings, everyone being at the same level and given equal opportunity, including the senior officers, was a source of motivation for the CSS facilitators. Themes of collaboration and teamwork were elicited. As mentioned by CSS facilitators in Kenya and Zambia:

> And even to add on that, the good thing about everyone is that even those who are higher in ranking (*wakubwa*), they come for the meetings and this encourages us a lot because

> you find that you are free to share, free to say anything, and they also motivate us…. When we are in a meeting, everyone should be at the same level because this gives people the freedom of expression compared to when there is authority that is watching over them (CSS facilitator, Kenya).

> We were taught on reflective supervision so that we share ideas to improve on our work. For example, when you meet at the group, you cannot be good in everything… where you are behind your friend will be able to guide you and say, No, that approach is not good, and find a new way of approach through the lesson… We used to have during reflective meetings, and the meetings were with the most strength, everyone participates and gives in his own ideas then we select good idea (CSS facilitator, Zambia).

CSS facilitators also attributed their success in engaging with some of the harsh and not-so-friendly caregivers to lessons learned during reflective supervision. Some of the skills CSS facilitators identified as being learned during the reflective supervision process include listening and recap skills as outlined by two facilitators in Kenya and one in Zambia:

> The most important thing I learnt is listening, when we visit caregivers in their households, we listen, and when we listen we learn and share a lot and get to know each other more as a result of listening (CSS facilitator, Kenya).

> This idea of starting from where you ended has really helped, it's like getting into a class and start with recall questions to confirm if what you taught last time are put into practice. You cannot get to a new topic when the previous is not understood (CSS facilitator, Kenya).

> The reflective supervision helps us to review our conducts towards our children, the community (CSS facilitator, Zambia).

Even at the government level, reflective supervision was found to be important. As mentioned by an early childhood officer from Kenya:

> I think every organization should have [reflective supervision]. It helps solve or get solutions as a team so that next time you go to try what was agreed in the reflective meeting and see how it works better. Through it, success stories are also shared and we encourage each other. It helps in achieving better understanding of the community.

Research Question 2.2: What Project Processes and Tools Facilitated Project Quality and Expected Caregiver Outcomes and Impact?

Several project processes and tools facilitated project quality and expected caregiver outcomes: improved coordination between partners and linkages created due to the project; community participation; volunteer engagement; application of the concept of using locally-available resources; employment of a non-incentive approach; and improvements in the organizational capacity of ChildFund country offices and at the local partner/CBO level.

Improved coordination. Improved coordination between partners and linkages created as a result of the project brought together relevant government departments were seen as an

important factor in sustaining the project activities. This coordination had improved case referrals, learning, and having a common agenda on holistic ECD by bringing different stakeholders offering different ECD services together. In addition, through the training, almost all the government officers indicated that knowledge gained during the training can never be taken away from them, and that they will continue to use the same knowledge in providing better services to the community.

> Maybe from education apart from the linkages that they have with some partners, we also have our own structures within the ministry, from the teachers education department responsible for the ongoing training of teachers, for me I take this as a starting point so that we put that of our program on continuing interest of providing the training for these teachers, and the teachers automatically will transfer that knowledge to parents and we also have department of guidance and counselling which works in collaboration with the VSU, health care, community development and also and that department also looks on to learners welfare in school. And should anything come up they actually link up with relevant departments so that, it's also something that is going on within the structures of the ministry of education. So we feel with also this structures we will be able to continue with the practice (Education Officer, Zambia)

Additionally, improvements in the organizational capacity of ChildFund country offices in Zambia and Kenya as well as improvements at the local partner/CBO level were also seen as assisting with the facilitation of project quality and expected caregiver outcomes.

Community participation. Community participation is essential in ensuring long term impacts of any projects. The project ensured community participation at different stages. At the project inception, community members were mobilized, including all the community leaders (headmen in Zambia and Village elders and chiefs in Kenya), and taken through the project design, goals and objectives to make sure the community members understand the whole concept of the project and how they will be involved. Both Kenya and Zambia reported successful community buy-in at this stage. This was key in ensuring community ownership, thus creating a platform for the community to continue with some project aspects even after the project's exit. Furthermore, all the community support structures were created and supported by the community members. In Zambia, all the CSS facilitators were elected by the community members and even though there were challenges with functionality of the groups, the project endeavored to work with the existing groups in the community without creating new groups. In Kenya, the project used Community Health Strategy structure that already existeds and was operational, specifically working with the community health volunteers (CHVs). In addition, the project mainstreamed aspects of the project in already existing community groups that were active. In this respect, the process was participatory and the skills and knowledge gained by the present group of caregivers, might be transferable to other caregivers and also replicable. It is important to note that in Zambia, the caregivers already mentioned that they would like to educate other caregivers in the community who did not participate in the project. In a group discussion with the caregivers, one of the caregivers said, "We would like to be given an opportunity to teach our friends what we have learnt."

Volunteer engagement. One of the strategies employed by the project was to engage volunteers as CSS facilitators. These volunteers were elected and trusted by community members, and were people who were internally motivated and had the interest of the community

at heart. Being members of the same community, living in and interacting with the community members on a daily basis, the volunteers still remain part and parcel of the community and with the knowledge they have gained through the training received from the project, most of the volunteers did not only report continuing with educating the community, but also expressed gratitude of how the project has changed their lives, that of their children and family at large. The volunteers were not taking any salary, but they were motivated to walk long distances in the community to reach the caregivers, sometimes going to the extent of using their own resources such as talk time to communicate, and their own bicycles for transport.

Application of the concept of using locally-available resources. The project's emphasis on use of locally available resources in making of play materials as well as use of locally available food in nutrition plays an important role in ensuring continuity after the exit of the project. Most of the caregivers expressed satisfaction and surprise at the same time that they could use locally available materials to make play materials and use locally available food to provide balanced diet to their children, without actually having to spend money. For instance, as mentioned by a CSS facilitator from Zambia:

> We also have a garden where parents are trained on how to grow different crops in all the seasons. We also encourage them to have backyards garden where they can grow crops and eat the produce instead of buying of which they can't manage every time.

Employment of a non-incentive approach to project activities. While at the inception of the project, some of the caregivers requested tangible benefits such as money or food for participating in the project, the CSS facilitators and project staff consistently emphasized on the benefit of the project to the community, and specifically to their children. This approach to some extent changed the perception of the caregivers, and as the project continued, other caregivers got interested in participating in the project because of either observed benefit from their neighbors' children, or as a result of the demand created by the project through emphasis on how the project would not only benefit a child, but the entire community. The desire by the caregivers to see their children succeed in life became the driving force behind participation in the project. The non-incentive approach implies that the community is not dependent on incentives to participate; rather the goal of every caregiver is focused on their children's wellbeing, thus reducing dependency, and creating internal drive and motivation.

Improvements in organizational capacity at ChildFund country offices. The ChildFund organizational development assessment (see Table G82), that was used by two ChildFund project staff (Project Manager and M&E Officer) at the time of baseline and endline to assess organizational capacity of its community-based organization local partners[10], covered areas of leadership, programs, management, learning, and resources, all of which had the potential to influence local partners' ability to adequately manage technical and operational functions of their organization, as well as implement specific project activities such as capacity building for and reflective supervision of the mentors and facilitators. Similar to baseline, across the two countries, the staff reported leadership structures to be strong and having clear visions and missions. Regular meetings were also held, including quarterly meetings and annual reflection meetings to assess progress of different programs. Staff also reported the existence of annual plans, availability, and allocation of all resources, including funds.

[10] At present, this tool's content and the way it is being scored is undergoing revisions by ChildFund International.

At baseline, it emerged that volunteer contracts, codes of conduct, and terms of reference were limited in both countries. At endline, it was confirmed that all staff and volunteers had a standard written contract and agreements spelling out specific roles and responsibilities. However, all the project staff and mentors interviewed in both countries acknowledged that volunteer contacting processes were delayed during project implementation, along with other expected payments and liquidation that was part of financial compliance procedures.

In terms of timeline, the project implementation seemed to have lagged at the beginning, specifically between the mapping and starting of implementation in the community, which in some ways could compromise subsequent activities of the project. For example, the mapping exercise was not allocated adequate time:

> The mapping exercise took five days to reach the 600 caregivers that were supposed to be identified. So it was a challenge to the facilitators who were identifying the caregivers and you would realize some of them did not look seriously at the criteria we were [supposed to be systematically using] looking because they were working on a deadline and so even on the side of CSSs that is something they say they ought to have been given more time because we did the mapping and then had to stay for months without anything ever happening (Program Officer, Kenya)

Continuous and consistent capacity building to the local partners by technical and project staff from ChildFund International was also highlighted as an important part of organizational development in both countries. The national offices consistently built the capacities of the local partners in project planning, management and implementation, as well as monitoring and evaluation and reflective supervision. For instance, as mentioned by a public health officer from Kenya:

> I received a training on reflective supervision [from ChildFund]… [it was] so much important, so much an eye-opener, and in fact so many gaps have been filled. The training has been able to help in giving information to mothers on child care and safety.

Functional Monitoring and Evaluation systems. In both countries, Monitoring and Evaluation (M&E) systems were in place and functional. In Kenya, the national office reported collecting data on a monthly basis to review project progress. At the national level, a Program Quality Reflection (PQR) also existed. There were also different levels of monitoring and evaluation at the county level and partner level. In addition, all proposals submitted contained a complete M&E framework.

In Zambia, some of the staff members indicated that even though the M&E systems and structures were in place, including monthly data collection and reporting tools, PQR, and frameworks for district and local partner data collection, there was a need for more support and capacity building for the M&E staff both at the national and local partner levels. Also, in Zambia, a project-level data consolidation system did not exist at the national and local partner level until the last quarter of the project, which impacted the ability of the local partners and Zambia ChildFund Country Office from making evidence-based, real-time project implementation changes during the course of the project.

Improvements in organizational capacity at the local partner/CBO level. In Zambia and Kenya, the organizational development assessment tool was administered to approximately

three local partner's project and leadership staff (ECD Officer, M&E Officer, and Federation Manager, at a minimum). In both Zambia and Kenya, progress from the baseline was mainly recorded in the areas of leadership, programs, management, and resource mobilization. For example, at baseline, the item regarding staff and volunteer training was indicated as being about half-way accomplished in all the CBOs. By endline, this item was noted as being fully completed. As shown on the self-assessments (see Tables G83 and G84), staff and volunteer attended training workshops and were always encouraged to use the knowledge and information gained to improve on activities implemented.

Research Question 3: What Was the Role of ChildFund (and Partner CBOs) in Engaging Government Partners to: 1) Build Capacity; and 2) Influence the Take-Up of Services on Stimulation and Responsive Care?

In Kenya, out of the 22 government officers interviewed, 12 were found to have integrated stimulation and responsive care in their work directly attributable to the project while 10 did not. The government officers who had integrated stimulation and responsive care were from the Ministry of Education, Department of Health and Nutrition, Department of Early Childhood Education, and Department of Children's Services. All of these 12 officers cited integrating play and communication into their everyday activities. In Zambia, all ten of the government officers interviewed stated that they integrated simulation and responsive care, namely play and communication, in their work.

Kenya. In Kenya, officials from the Department of Health and Nutrition in the three counties (Kisumu, Siaya, and Nairobi) reported that they had integrated all the components of the group parenting sessions, including play and communication, into health talks they deliver to caregivers. The Department of Health also reported that a new government data collection tool (MOH216) had been developed that incorporate~~s~~d ~~all the~~ aspects of stimulation and responsive care. Even through the key stakeholder interviewed could not ~~categorically~~ specifically attribute the inclusion of stimulation and responsive care in the tool to the current project, she reiterated that the component on stimulation and responsive care had not previously existed.

Officials from the Department of Early Childhood Education reported that the three counties were now~~are~~ supporting ECD education. They acknowledged that the components of play and communication had previously existed but that they had not been given serious attention. Additionally, the department used to focus on children three years of age or older, but after participating in the current project, ~~has~~ included children below three years in their focal age range:

> Previously, we never had training for the caregivers but then they got trained so it is something new and we never had special look at those below three years, ours is three years and above, but now with them we were able to look at those who were below three years and that is where we talked about stimulation of the brain and stimulation of all other parts of the body physically. (Education official, Department of Early Childhood Education)

Table 10 presents a summary of government partners in Kenya integrating stimulation and responsive care into their services.

Table 10

Summary of Government Partners in Kenya Integrating Stimulation and Responsive Care

Government partner	How stimulation and responsive care have been integrated	Aspects of ECD integration	Current status
		Kisumu	
Children's Officer, Children's Department, Kisumu East	-Involvement of the government departments, such as government-line ministries, to continue the current project	-Supporting infrastructural development for the safety of children	Continuing, though on a temporary basis (not permanent)
Nutritionist, Kisumu County Referral	-Trainings for care of child development	-County government has employed ECD caregivers -Feeding program -Training other CSS facilitators not in the current program on CCD to help in their work	Ongoing
		Siaya	
Nutritionist, Ugenya Sub-County	-"I do stimulation and play when mothers come to the clinic, we teach them how to play with their kids, make them appropriate tools, how to communicate with their kids at an early age	-Circulating information through avenues such as mother-to-mother support and also during supportive supervision through CSS facilitators	Ongoing
Sub-County Nutrition Officer	-Integrated stimulation and responsive care in job training to three colleagues -Integrated other aspects such as a mother-to-mother support group	-Circulating information through avenues such as mother-to-mother support groups	Ongoing
Community Health Strategy Officer/Community Health Officer	-"During 'Malezi bora' week, we integrate with ECD centers around here and we offer deworming, vitamin A supplementation, growth monitoring, and weighing to ascertain whether they are growing normally or abnormally"	-"I have integrated them [play and communication] in my daily activities such as referrals, outreaches, and household visitation I normally do as my routine"	Ongoing
		Nairobi	
Chief Advisor to Schools (Quality	-ECD education	-County is in the process of starting one center for	Work in progress

Assurance Officer), Nairobi City County	-Nairobi County's children's policy includes components of care, stimulation, and communication	children under 3 years as a Centre of Excellence -The NCCG is exploring the use of fun days where children come together	
Nutritionist, Kasarani Health Center, Department of Health Services	-Improved MOH 216 (mother-child booklet) includes many aspects of ECD and stimulation -Boosting Malezi Bora program for under 5s by scaling up the knowledge on Care for Child Development	-"Nowadays, during health talk we much cover the importance of play and communication, how the mother and the caregiver can come up with this playing material for their children"	Ongoing
Children's officer, Department of Children's Services, DCS Starehe sub-county	-Added aspects of stimulation when training on child protection	-"When we handles issues of neglect, we also have to bring in aspects of play and communication" -Trained volunteer children's officers and CSS facilitators on play and communication and brain development	Ongoing

Zambia. In Zambia, interviews were conducted with officials from the District HIV/AIDS Task Force, Victims Support Unit (under the Ministry of Home Affairs), Ministry of General Education, Ministry of Health, Ministry of Agriculture, and the Department of Community Development (under the Ministry of Community Development and Social Services). These government departments have embraced stimulation and responsive care in their work. For instance, an officer in Kafue District HIV/AIDS Task Force said that they had integrated aspects of ECD, including play and communication, as well as nutrition, in their activities:

> Normally, we work with mothers who have got children with HIV, we normally do it from such kind of groupings because we normally work with the support groups so whatever we learnt we also take it to support groups. We learned play and communication what is called child stimulation, and we have integrated all aspects of play and communication in all our groups, we have 50 already existing and functioning groups. (Government Official, Kafue District HIV/AIDS Task Force)

According to the education officers in the Department of Education, ECD in Zambia is currently under development, with the first ECD policy currently being developed. Furthermore, ECD in Zambia has focused on learning and thus focusing on children 3-5 years of age. However, with the advent of the Founding Futures Projectproject, sponsored by ChildFund, the Ministry of Education broadened its focus not only to include children who are 0-3 years, but also to induce teachers to make play materials for children using locally-available materials.

> Previously, we never had preschools, but that time when the Founding Futures came in, that is when even the government introduced the preschools came up primary schools. Initially, we had only five big schools that piloted the preschools. With the coming of the Founding Futures, we now have eighteen schools with early childhood education. (Education Officer, Department of Education)

The Department of Education also reported that the current project had influenced discussions and the ongoing development of the ECD policy, not directly, but at the district level where most of the government departments who are waiting to participate in ECD policy discussion are keen on making sure that ECD, especially stimulation and responsive care, are captured and addressed in the ECD policy.

The Department of Agriculture, located in Chibombo, also partnered with the current project to reach caregivers at the community level. The Ministry of Agriculture offers extension services to the community through their local community leaders called "lead farmers." Moreover, the Ministry now talks to farmers about nutrition and having a balanced diet for their children.

> We usually talk about play and communication with them and then also we look at nutrition because when you go out to the field usually what people tell you is that the primary caregivers are not actually parents themselves. So, we tell them about good nutrition during field days. (Agriculture Officer, Department of Agriculture)

The Departments of Health in Kafue and Chibombo reported that they had integrated child stimulation, namely play and communication, in their work. For example, in Chibombo, the Department of Health developed a community-based peer ECD education model to reach 200 households.

> So in addition to the health, the other component that we have also done is that we have two community welfare officers that are trained in ECD. So we took that advantage because of the knowledge that they acquired in that specialty. So what we have done is, we have formed two groups, those who have been trained on ECD and they have selected from the community about ten households each and from those ten mothers they have selected, those ten mothers are also responsible for about ten households. So they have one hundred households each, making it a total of two hundred households…the other one is looking for ten and the other one is looking for ten as well. So what we do is we meet with them on monthly basis, then we share the same knowledge with those that we picked which are ten who are looking after the other households in the community. When you share knowledge, they go back as well to share the same knowledge in the community; the importance of play, better parenting. Then with that we have also actually come up with one for the whole facility, which we want to put pictures for cartoons. When they come for the under-five at the hospital, They are able to appreciate the beauty of the program and the importance of this. So the community we have met three times. Yeah, so in short we are looking at about two hundred households. This other group has got a hundred, the other group has got a hundred. When it comes to nutrition aspect, for cooking demonstrations that one has not been fully implemented because there

> is still working on the logistics on how to bring them on board just to see how best they can prepare food for the little ones. (Health officer)

Discussion

This endline evaluation report evaluates the implementation of "Assuring the Essentials of Optimal Development for Infants and Young Children affected by HIV and AIDS in Kenya and Zambia." Overall, the picture that emerges is a promising one, with caregivers reporting increased knowledge regarding stimulation and responsive care and other areas of child development. Data suggest some changes in caregivers' practices in these areas has also taken place as a result of project interventions. Additionally, over the course of the project period, households in general seem to be faring better and there appears to be increased access to a variety of ECD-related services, which will be discussed further below. Further, reflective supervision appears to be an effective mechanism by which to effect change in stakeholder knowledge regarding foundational ECD topics and how such topics are disseminated at the community level over time. Despite these improvements, however, data suggest there are improvements needed if interventions and/or modifications of interventions based on the findings are continued and/or expanded to other sites in the future.

Key Findings

Caregivers satisfaction with the initiative. Generally, caregivers reported being satisfied with their participation in the initiative, with the majority of caregivers generally providing ratings of "very good" or "excellent" regarding the group facilitator/home visitor, the services and information delivered by the project, and how the project assisted the caregiver in finding his/her own solutions to household problems, and approximately another third of caregivers in each category providing a rating of "good". Caregivers provided high ratings of their service providers, which is particularly important when it comes to program participation. Existing research has found that caregiver perception of the relationship with the home visitor is a significant predictor of program participation, over and above general program satisfaction (Korfmacher, Green, Spellmann, & Thornburg, 2007). Caregivers also gave high ratings to the services provided by the project as well as to assistance provided to caregivers to find their own solutions to family problems. As mentioned by a caregiver in Zambia:

> I feel very happy because of the training with the home visits because I learnt how to interact with my children quite well that sometimes we even sing together and make toys through the knowledge I acquired which I never used to do.

Even more convincing is this story from a caregiver in Mukuru:

> Personally, I have gained much from the Nitunze project. Before I joined the project, I led a miserable life. I was diagnosed with HIV/AIDs before I joined the project. My husband abandoned me and my two kids without notice. He left with everything we owned, which forced me and my two children to sleep on the floor. I lost hope in life and refused to take my drugs. My life was miserable since I lost weight. I avoided my neighbors and warned my children against associating with them. Two years ago, Doreen (CHV) approached me to join the project. I joined Nitunze project, which allowed me to interact with other women. I started attending parenting sessions, asking questions, and suggesting ideas on how to care for children and oneself. The project has helped in various ways. I learnt to care for myself to ensure I give the best to my children. I take my drugs and adhere to them to improve my immunity. Also, I encourage my children to

> play with neighbors and their children. I work hard and right now I can comfortably sleep on a bed, which I did not have before I joined the project. I learnt to make toys for my children. Today, they play with homemade toys. Sometimes, I play with them, which improves my relationships with them. I maintain personal hygiene and clean them regularly. Today, my children are clean and they do not contract opportunistic diseases.

Directly assisting caregivers is important, but also giving them the knowledge and tools to problem solve without needing assistance helps to set these caregivers up for future success. Finally, there were fewer "excellent" ratings regarding information provided by the project as compared to the other categories. This implies that there could be further work done in this area, and recommendations for improvements in this area are provided below in the "Recommendations" section.

Caregiver participation in the initiative. There were differences in the types of sessions caregivers participated in and, correspondingly, some differences in what caregivers reported learning. In Kenya, the majority of caregivers participated in group parenting sessions, while in Zambia the majority of caregivers participated in home visiting sessions. Thus, it should not come as much of a surprise that when queried regarding sources of ECD-related knowledge, the majority of caregivers in Kenya reported they received information from group parenting sessions while their counterparts in Zambia reported home vesting sessions. Additionally, home visitors in Kenya were community health workers and may have emphasized health and nutrition more, perhaps leading to more caregivers in Kenya reporting nutrition, health, and water, sanitation, and hygiene as topics learned more often than caregivers in Zambia, while more caregivers in Zambia participated in home visits or both group and home sessions, were play and communication and early stimulation messages were more emphasized due to the CCD curricula.

These different types of intervention sessions would appear to be an effective way when it comes to disseminating ECD-related knowledge, though depending on the facilitator/home visitor, different messages may be imparted to caregivers. This should be taken into consideration both when implementing the intervention and when evaluating the impact of the intervention. While beyond the scope of this current evaluation, another aspect to consider is the number of visits delivered. A meta-analysis of home visiting programs for at-risk families found that the intensity of delivery mattered; programs with more frequent visitation had higher success rates (Nievar, Egeren, & Pollard, 2010).

It is important to note, however, that when it came to health/nutrition-related topics, such as birth registration, immunizations, what to do when a child is sick, and number of meals a child should have per day, caregivers most often reported receiving information from health care facilities/health care workers and not from their group parenting sessions or home visits. One possible reason for this is an increase in caregivers taking preventive health-seeking behaviors, such as increases in regular visits to the health clinics, impacted the times caregivers heard messaging on the importance of registration. Group sessions/home visits therefore may have caused caregivers to increase their use of the existing ECD-related social service of health centers, which in turn enhanced both health-seeking knowledge and practices and child protection-related caregiving behaviors from information gained at health centers. Regardless, this highlights how important it is that ECD-related services work with one another to ensure that all caregivers receive the information necessary to ensure optimal outcomes for their children. For instance, birth registration in particular is important because without a registration card, it is often harder for caregivers and their children to access other ECD-related services later in life.

A small percentage (4%) of caregivers surveyed reported not participating in either group parenting or home visit interventions. Unfortunately, there is no further data available to determine why this may be the case.

Changes in caregivers' practices. Providing opportunities for caregivers to gain knowledge about various ECD-related practices and behaviors is important, but having this knowledge is useless if it is not actually implemented. In this study, at endline, caregivers most frequently reported learning about health, nutrition, and play and communication in the group parenting and home visit sessions and also reported that these topics were the most important ones learned about in these sessions. Reassuringly, there were some gains made over the course of the project period in these areas. For instance, comparing aggregated baseline data to endline data, there was an increase in the percentage of children born in primary care facilities at endline as well as a decrease in children born at home. This is particularly important because children's access to ECD-related services begins at birth, if not prenatally. Being born in a health care facility makes it easier not only for children to receive medical interventions at birth or soon thereafter if needed, thereby hopefully avoiding infant mortality, but it also makes it easier for caregivers also to access ECD-related services for their children. As the majority of caregivers reported learning about birth registration from health care facilities and/or workers, it could be surmised that having a child in a health care facility, as opposed to at home, would thus expose caregivers to the knowledge of the importance of birth registration and may even make the process easier for them as they could be helped by health care workers to register their newborn children. While there is also an increase the percentage of children who have a birth certificate/registration card at endline as compared to baseline, this increase was a relatively small one of 5%, from 37% at baseline to 42% at endline. This leaves 58% of children without a birth certificate or registration card, and thus at risk for not being able to later access some ECD-related services. Thus, while there is some change in caregiver behavior around this particular domain, given that the majority of children still were not registered, there remains a significant room for improvement. It should be noted that birth registration was not a specific topic in the group or home curricula, suggesting that it should be added in the future, given the large percentage of children still unregistered at endline (see the Recommendations section.)

Another important domain for caregivers was play and communication. Play and communication was reported most frequently not only as a topic caregivers learned about during the program but also as being one of the most important topics covered. Most parents reported that before the project, most of them never bothered to acquire play materials for the children. This was mainly informed by the fact that they believed play was not important to the child. However, after participating in the project, most of the caregivers reported being able to make toys out of locally-available materials, as well as create adequate time to play with their children despite their other demands. As a result of play, caregivers reported strengthened positive relationships with their children, as well as positive changes in the caregiver's behavior, specifically with regard to their perception concerning children and discipline. Most of the caregivers reported that they abandoned negative forms of discipline and adopted positive forms of discipline as a result of a strengthened bond between the child and caregiver. For example, as stated by a caregiver from Zambia, "… I used to have a bad temper which used to make me spank or beat my children from time to time. But after the training, I'm slowly changing as I have seen the importance of a positive discipline."

Caregivers, in turn, reported varied observed positive changes in their children as a result of engaging their children in different forms of play. Almost all the participants indicated that

children were more creative, disciplined, respectful, happier, and free with their parents and others, implying that children had developed confidence and high self-esteem. Additionally, caregivers also reported that play served an important role in helping the caregivers observe the health of the child, thus allowing the caregiver to know whether the child was sick or not.

A possible reason behind the change in play and communication practices was that play and communication was the emphasis of home sessions, which could have influenced parents to identify this topic as being more important of all the content presented in group parenting sessions across the domains of nurturing care. When looking at caregiver practices around play and communication, 59% of caregivers reported that they also played more with their child after the project, and half of caregivers reported that their child had play toys. When asked what made them acquire toys for their child, approximately half of caregivers reported it was due to participating in the group parenting sessions and/or the home visits. Thus, the direct impact of the program on caregiver practices is seen here. Enumerator observations also corroborate these reported practices around play and communication. Enumerators reported that caregivers initiated interactions with their children almost all of the time as well as almost always providing toys or objects for the child to play with. Importantly, the majority of children are observed responding to their caregivers in kind, by smiling at, laughing at, and playing with their caregiver. If these caregiver behaviors only took place because they knew they were being observed by the enumerators, it is unlikely that children would have responded to their caregivers in this fashion. Rather, that children seemed to delight in their interactions with caregivers demonstrates that this is likely something they were used to experiencing rather than it being a one-off experience.

Other areas where there is self-reported change in caregivers' behaviors are in the domains of child safety and protection, hygiene practices, and nutrition – all areas where caregivers report receiving training. In terms of child safety and protection, fewer caregivers mention engaging in aggressive and physically punishing acts when disciplining their children at endline as compared to baseline. The majority of caregivers also report praising their child when the child engages in positive behaviors and explaining why something is wrong when the child engages in negative behaviors. It is important to note that where caregivers receive health information from other stakeholders, the current project is really the only place where, according to the data, caregivers are accessing information about child protection/safety and child abuse. This highlights a strength of the current initiative, though how this information leads to an uptake of behavior such as identifying, reporting, and responding to abuse at the household or community level needs more exploration in the future.

Enumerators also reported that generally, were fewer issues regarding household environmental safety, such as observing a decrease in open rubbish, unprotected fire, and scattered animal waste at endline as compared to baseline. Caregivers also reported better hygiene practices, specifically regarding handwashing, with more clean water available for handwashing at endline as compared to baseline. Finally, while there is no baseline data to examine change over the duration of the project, at endline the majority of caregivers (80%) reported exclusively breastfeeding their last child while reporting that before receiving information about exclusively breastfeeding from the project, only 53% said they exclusively breastfed. Additionally, children were being fed more meals per day at endline, with the majority of children receiving at least three meals per day. As reported by a health care worker in Zambia:

> In health, I can categorically say that since this project started, there are no cases of malnutrition. We used to have cases of malnutrition before, but now there are no such

> cases and one of the reasons is that when the project came with teaching parents how to prepare a balanced meal with locally available food, most of the parents were able to do so. And to add onto that, there were very few parents who used to come for growth monitoring but now the facilitators at the community are referring them to the health facility, and some of them are even bringing them to the health facility. So for sure for me, I can say that the project has really helped in reducing cases of malnutrition because in my health facility, we no longer have those cases

It is important to note, however, that despite these gains, there are still a large proportion of children who did not experience improved outcomes at endline. Thus, while delivering information about various ECD-related practices to caregivers is important, making sure that this knowledge is translated to practice is essential if children's outcomes are to be affected.

Improved access to ECD-related services. There was some progress made over the course of the project period regarding caregiver access to ECD-related services. Generally, half or more of caregivers reported that they did not have problems in accessing these services at endline. Additionally, fewer caregivers reported difficulty in accessing ECD-related services at endline as compared to baseline. A more nuanced look at this finds that caregivers from households at higher well-being rankings have less difficulty accessing services as compared to those at lower well-being rankings.

Nonetheless, there are still difficulties faced by caregivers in trying to access ECD-related services, particularly police/justice, psychosocial, and social welfare services for caregivers in Zambia while caregivers in Kenya have more difficulties accessing health and social welfare services as compared to other ECD-related services.

Across the board, when looking at the data in aggregate, generally the top barriers to accessing any of the ECD-related services are the service not being available, long distances, and high costs. Sometimes the problem lies with the fact that the services are reported as not being available. Caregivers in both Zambia and Kenya reported the unavailability of HIV support as well as psychosocial services as being a problem. Even if caregivers know that they should seek help in managing their HIV status or for any psychosocial issues they may have, they may not be able to because the resources simply do not exist. However, in the current data, it is hard to determine whether the services truly did not exist or whether they did exist and caregivers were unaware of their existence. If it is the latter, a public education campaign alerting caregivers to the existence of these services or being educated about the existence of these services through the program may be helpful in eradicating this barrier. Otherwise, figuring out the community's needs for these services

Sometimes, the long distances required to access services served as a barrier. For instance, caregivers in both countries reported this physical obstacle as being the biggest problem in accessing police/justice services. Long distances were typically more of a problem for caregivers in Zambia as compared to caregivers in Kenya. The "hidden costs" of such services remain to be explored, though such services are supposed to be free, as they are cited as a continued issue in other initiatives. Integrated ECD approaches, such as supporting sub-national government service providers' plan to deliver services on a routine basis at the community level, are approaches to supporting government stakeholders and fulfilling these stakeholders' mandate of bringing services to large numbers of children and their caregivers at the community level in lieu of caregivers and children having to travel long distances to access such services. These integrated approaches are being piloted by ChildFund with support from UNICEF in Eastern Province in Zambia and will soon be piloted by ChildFund Kenya, also with UNICEF support.

Additionally, mobile birth registration is also being piloted by UNICEF with European Union funding in Zambia.

Financial barriers are particularly troublesome. Even if caregivers know what they should be doing, not having the financial resources to transform knowledge into practice is problematic. For instance, high costs are reported as one of the top barriers to accessing early learning services, and there are more caregivers reporting high costs as being a barrier at endline as compared to baseline. This may be due to greater caregiver awareness about the existence of early learning services, so caregivers seek out these services and then are turned away due to not having enough money. For instance, some caregivers reported that they did not have enough money for uniforms and fees. High costs were also a top barrier when it came to access nutrition support services, and as with early learning services, there are more caregivers reporting this as being a problem at endline as compared to baseline. Some caregivers reported that they did not have enough money to purchase healthy food for their children. While these caregivers know what they should be doing, financial barriers keep them from executing this knowledge.

At the conclusion of the project, caregivers reported wanting to continue the program, with caregivers in Zambia wanting continued home visits and those in Kenya continued parenting group sessions. Domain-specific information, such as learning about child protection and safety or about feeding children, while still requested, were not as popular as the home visits/group parenting sessions. Child protection may have been seen as being less important because it was the topic that facilitators and caregivers had less information on prior to the start of the project, given findings that the project was where they learned about this information. Additionally, while there was a session on positive discipline, there was not a specific one on defining and unpacking child protection in a systematic way as there were for other health and nutrition topics, which could also have contributed to caregivers prioritizing child protection less than other topics. Therefore, it will likely take longer for this domain to be seen as an important topic.

The program, which presented information across multiple ECD-related sectors rather than just focusing on one domain, appears be an effective way to convey such information to caregivers, perhaps because it is consolidated into one package.

Caregiver well-being. It is important to note, however, that the majority of caregivers across both countries reported facing challenges in self-care. Financial strain was experienced by nearly three-quarters of caregivers (71%). Other more commonly-reported challenges were trying to find a balance between working and caring for the child, stress resulting from caring for the child, and a lack of services to support caregivers on handling these challenges. This highlights an area where future interventions could play a large role and is discussed further in the recommendations section.

Increase in household well-being levels. A positive finding to highlight is that the percentage of households in both Zambia and Kenya who were at higher well-being levels was higher at the endline as compared to baseline. While this cannot be directly attributable to the project, it is nonetheless encouraging to see households doing better, particularly as household well-being was associated with fewer difficulties in accessing services. This increase in well-being may be due to the fact that project interventions gave caregivers a space to discuss their challenges which potentially improved their ability to take actions related to challenges and/or changed their perceptions of their challenges through discussions with home visitors or in groups of parents facing similar issues. In the future, it would be useful to unpack if and how the sessions may be attributable to caregivers' perception of their personal well-being which

influences how caregivers view their household vulnerability. It should be noted, however, that the majority of households are still found at the two lowest ranks of household well-being ("struggling almost all the time" and "life is hard, sometimes struggling"). Thus, while some progress has been made, there is still a long way to go when it comes to improving overall household well-being levels.

Organizational capacity building. When it comes to capacity building, both the ChildFund organizational development assessment and the local partner/CBO organizational self-assessment found improvements at endline as compared to baseline. For example, in the ChildFund assessment, while at baseline, there were issues around volunteer contracts, codes of conduct, and terms of reference in offices in both countries, at endline these issues had been resolved, with standard written contracts and agreements for staff and volunteers that outlined specific roles and responsibilities. At the local partner/CBO level, there was progress from baseline in the areas of leadership, programs, management, and resource mobilization. Despite these improvements, however, there were some areas where further progress may yet be made. For example, at the ChildFund level, there remained issues with project implementation, namely in the areas of mapping, contacting volunteers, and in just beginning the project. Additionally, in Zambia, a need for further support in terms of the monitoring and evaluation system utilized by the ChildFund team there was also indicated.

Additionally, the increased knowledge of local partners regarding child development demonstrates that the local implementing partners received adequate technical support from ChildFund during their training provided by ChildFund country office and international office staff, resulting in having the knowledge and capacity to mentor and support volunteer CSS mentors and facilitators implementing the project at the community level. Innovative ideas such as using Whatsapp as a way to support local partners and mentors remotely in-between reflective supervision sessions could be an approach ChildFund uses to support local partners and in turn partners supporting mentors that was initiated in Kenya during this project. Recent research conducted by Teachers College, Columbia University professor Mary Mendenhall has looked at using Whatsapp to support peer learning and mentoring for teachers (e.g. Mendenhall, n.d., Mendenhall, Collas, & Falk, 2017). This method could be examined further as a way for government and civil society to support community-level stakeholders that are parenting experts in communities.

The project also endeavored to involve relevant local government and departments in both Zambia and Kenya. Specifically, in Zambia, the departments of education, health, community development, agriculture, victims support unit, and District HIV/AIDS task force, while in Kenya, the departments of health, education, nutrition, child protection participated in the project. All the departments involved were trained on aspects of ECD, and almost all the departments had mainstreamed aspects of ECD in the work. Importantly, the project aroused the ECD policy debate, especially in the education department in Zambia. As the country prepares to have the first ECD policy that has been on draft form for some time, most of the government departments indicated that the project has enlightened them not only to contribute to the policy, but also to understand the importance of ECD. In this respect, through the participation of government department, the project, will, seemingly, ensure improved access to the services offered by the government departments in this direction. This is important because government departments are permanently present in the community and have the constitutional mandate to offer services to the community, thus playing a critical role in not only sustaining the project

activities, but also ensuring that aspects of ECD are internalized and mainstreamed within the system.

Importance of reflective supervision. As reported by CSS facilitators, reflective supervision was found to have a major impact on their work. CSS facilitators reported that reflective supervision was a source of motivation and that it encouraged collaboration and teamwork amongst all members of the group. As mentioned by a group facilitator from Kasarani,

> In the reflective meetings basically when we meet there it is about feedback, what so far we have done. It is about giving reports and giving information, what we have done and the kind of sessions we have conducted within that given month. The challenges we have gone through, the gains we have met through that particular month. It is a session which we interact together. Each of us being a facilitator, CHVs and the CSS's giving the feedback, reports, and information and the way forward because within the course of the month when we were doing these sessions you could have encountered some challenges, then how did you go about it and the gains you met. Sharing all these together as one family because we believe when we ar there we are one family doing the same objective. We share and you find that we are there with our supervisor and come up with a common stand…. [this has helped improve how we do our work] because it is shared together.

Keeping facilitators motived is important to prevent burnout and to encourage investment in the work at hand. Additionally, facilitators reported that reflective supervision not only helped them improve their own practice but also assisted them in engaging with caregivers who were less than welcoming during the project. For example, facilitators reported that they listened and observed more, recapping what the caregiver shared/demonstrated, and it helped them to understand the caregiver better.

Limitations

One of the primary limitations of this report was the status of the baseline data, where several issues made it difficult to compare endline data to baseline. Baseline data was taken from a baseline report completed prior to the start of the current intervention; no raw data was available for analyses. Thus, any comparisons between baseline and endline data were conducted at the descriptive level and analyses could not be conducted to determine whether any change was statistically significant. The same participants were not assessed at baseline and endline, so any change noted should be considered as happening at the population level, rather than change experienced by individual participants, and cannot be attributed solely to the project. Some variables of interest, such as breastfeeding practices, immunization practices, and knowledge of child rights, were not queried at baseline; thus, comparison could not be made in these ECD-related areas pre- and post-project. Further, while some of the same ECD-related areas were examined at baseline, sometimes answer options differed at baseline and endline or percentages were not presented in the baseline report, again rendering comparisons with endline data difficult. For example, in looking at the availability and use of play materials, there is some data in the baseline report on this topic. When asked where toys came from, caregivers at baseline either responded that adults or siblings made toys for children or that children made their own toys. At endline, answer options to this question are bought, homemade, or other, so data was not directly comparable. Finally, there was no country-disaggregated data from baseline to compare with endline data. While comparisons could be made between baseline and endline looking at the aggregated data, it was not possible to examine what the state of affairs was, for example, in Kenya before the implementation of the intervention and to compare it to what it was post-intervention.

The sample target size that was set for Zambia (total of 350 caregivers for Chibombo and Kafue Districts) was not met due a number of challenges, including the long distance from one household to the other; heavy rainfall, which impeded the ability to travel; the commencement of farming season, whereby most caregivers were on the farms and not able to spare time for interviews. The sample interviewed was less than the target by 11 caregivers, resulting in a response rate of 93.7%. Additionally, there was a limited number of male respondents, which did not allow for a robust comparison of male and female caregiver results at endline and from baseline to endline. Caution must be therefore taken when generalizing these findings to a larger population, particularly as context matters quite a bit. While beyond the scope of this evaluation, there were likely site differences as well, as alluded to by the household well-being levels determined during the baseline study.

While change in caregivers' practices was of particular interest, data related to this was limited to caregiver response to questions in the household survey, rather than actual observations of the caregivers' actions. Thus, any change in behaviors is self-reported. Additionally, individual children's development according to age-appropriate developmental milestones and growth were not collected or monitored as part of the project, limiting comparison to the self-reported observable changes caregivers made at endline of the changes they noticed in their individual child's development.

There were also some limitations with the data collected (or not collected). For all questions regarding sources of information about ECD-related topics, caregivers in Zambia only provided one response, while those in Kenya provided multiple responses. While all multiple choice questions were supposed to be asked as an open-ended, self-reported question with the enumerators then probing further, as needed, for various answer choices, it may be possible that enumerators in the different countries understood how to probe differently. Additionally, when caregivers were asked about changing behaviors regarding child protection after participating in the project, the question asked did not note the type of change (i.e. positive or negative) that occurred but just that some change took place. Another limitation was that immunization data from Kenya was not available, so comparisons could not be made between countries. This information will be explored in a forthcoming study. Data regarding participation in ECD centers was also missing. Further, while there was data gathered via questionnaire regarding facilitators' knowledge and practices of child development, this information was not gathered systematically and thus had to be omitted from the current report.

Recommendations

Calls for continuation of the project were overwhelming in both Kenya and Zambia. The beneficiaries and other stakeholders felt that the project should expand to cover more areas as well as remain in areas where it is already realizing positive changes. Need for the project to continue was also based on the fact that new people become parents every day. These new parents need to be reached when they start caring for their first child – if not before – to ensure that they are given the knowledge to raise their child in the best circumstances they can provide. Based on the findings, the following approaches are proposed to be integrated in future project design and implementation at a general level, followed by country-specific recommendations targeted to the specific conditions in Zambia and Kenya.

General recommendations. General recommendations include aspects around unpacking concepts, project mapping, project continuation and coverage expansion as well as incorporating the local context. Additionally, recommendations around monitoring and evaluation that would help with evaluating the impact of the future project are also discussed.

Core concepts of ECD across the components of the Nurturing Care Framework should be more systematically unpacked and defined by caregivers during the baseline of future interventions. Moving forward, better understanding how caregivers define and conceptualize play and communication versus early stimulation is important in order to understand at what age they believe it is important for their child to begin playing. Does play begin at birth, or is it something that takes place as children get older? In this report, parents found play and communication to an important topic, but did not consider early stimulation in the same light as well. Perhaps the term "early stimulation" is too abstract to easily understand, thus requiring more explanation, whereas play and communication is more concrete and more easily understood by caregivers.

Another concept that could be elaborated upon is that of child protection. Child protection, including use of a child protection approach, is a "newer" concept for many caregivers. Traditionally, protection is understood by parents and community leaders as a clean and safe environment and less understood as preventing violence, neglect, and abuse against infants and young children, as highlighted by qualitative data emerging from an ethnographic study on child protection and ECD in Siaya County that took place during the scope of this project. Further unpacking how caregivers define and approach child protection would be an area for further exploration in future parenting initiatives, given hidden protection issues affecting infants and young children (UNICEF, 2017b). For instance, understanding what mechanisms at the community level, both formal and informal, to support the identification of, response to and address child protection risks of children 0-5 need to be explored, as this was done only through ethnographic research in Siaya County. Due to the fact that child protection information was largely gained by caregivers only from CSS associated with this project, even though it was not a topic systematically included in the group or home curricular materials, there is a need to support facilitators sensitize communities part of parenting activities and to strengthen government's mandate to provide this awareness and ensure mechanisms are active and accessible that should be in place to contribute to children realizing their rights to protection and achieving their developmental potential.

Further unpacking, through project monitoring data, ~~on~~ how the group and home sessions specifically promote the uptake of health seeking behaviors would also be useful. Additionally, concepts from the field of implementation research would also be important to incorporate to understand if and how to continue/enhance the intervention to improve fidelity and potentially increase the intervention's impact.

Project mapping needs to have a systematic yet "light" approach at project inception in future ECD parenting projects. Project mapping is an important step and adequate time needs to be allowed for mapping to occur. Time management is a precursor for increased effectiveness and productivity in any organized venture. It forms a key aspect of project implementation and requires skills such as planning, setting goals, and prioritizing for a better performance. Project delivery along set timelines is a critical ingredient in meeting set objectives prudently and fidelity to a timeline is therefore of great necessity. In Kenya, the implementation of the project seems to have lagged at the beginning, specifically between the mapping and start of implementation in the community, which may have compromised subsequent project activities. In the future, a "lighter" approach to mapping is recommended, which would still have specific systematic criteria for targeting groups but should not be as time and resource intensive as was conducted in the last project phase which led to the "lag time." In Zambia, groups were not well targeted at the inception of the project, which could have been due to the turnover of the project

manager who was replaced, which led to a significant attrition of groups during the life of the project. Thus, allocating enough time for project mapping to occur and establishing systematic criteria and a "light" process to use the criteria for identifying groups with existing and/or new communities would help with accomplishing project goals of better targeting the most vulnerable caregivers and households to reach with project interventions.

Project continuation and coverage expansion. In designing a new initiative based on the current project, there are some activities that should be continued and scaled up as well as some that should be discontinued. Additionally, there are some activities that could be added to enhance the existing program.

Activities that should be continued/scaled up include those related to positive discipline, nutrition, child protection, and birth registration as well as revisiting the curricula for home and group visits. Some topics that caregivers mentioned they would like continued include learning about positive discipline and nutrition. Additionally, while there was improvement in birth registration, it was one of the least improved services. Therefore, there is still much more to be done to increase birth registration. While in Kenya, the government has developed a policy to propel the process, the same may be advocated for in Zambia so that all children can get registered. Better understanding the "hidden costs" that exist at multiple levels of birth registration is important as well. For instance, in Zambia, the birth registration process is not decentralized yet and thus there are costs incurred in photocopying National Registration Cards and getting a photocopy of the registration form. Additionally, the district home affairs office has to have funds to process the birth certificates in Lusaka which is an additional cost that needs to be planned and accounted for. UNICEF, with European Union funding, is currently piloting mobile birth registration but not in the current project area. Mobile birth registration could also be piloted in the Hilton project target districts to see if making access easier would increase uptake in behavior.

In addition to addressing birth registration through advocacy, some of the issues that impeded access to the service included a lack of knowledge/ignorance as well as the presence of middlemen who extort money from caregivers. In this regard, caregivers can be educated on the importance and the process of registering their children after birth, while facilitating direct linkages between the caregivers and service providers, thus avoiding any middlemen. Other activities to be continued/scaled up include unpacking other hidden costs that impede the provisions of services and exploring how having mobile "hubs" for services in the communities make the service provision transparent.

Activities should also be explored to identify how to move topics such as child protection this from being a topic learned about on an ad hoc basis depending on the knowledge of facilitators to being a specific topic addressed systematically in the group and home curricular materials to identify if having an explicit session as part of the parenting curriculum and potentially other complementary interventions to strengthen local referral mechanisms and leaders' understanding and accountability for child protection of infants and young children may support changing caregivers' practices in the home and how it can strengthen informal and formal child protection mechanisms at the community level.

Regarding home visits, ChildFund staff, CBO Local Partners, and volunteer CSS mentors and facilitators had expressed the need to utilize the space of home visits to extend beyond emphasizing play and communication to including more holistic ECD content across the domains of nurturing care. In Kenya, materials were utilized from PATH that were inspired by CCD. More work is needed, however, to determine how these materials are used with caregivers

to support their use as a self-assessment tool to enhance what caregivers already know and do across the domains of nurturing care beyond play and communication knowledge and practices.

Regarding group visits, the sequencing of topics presented needs to be explored. If giving CSS facilitators the autonomy to prioritize topics, CSS facilitators should be able to provide a clear rationale for why certain topics were prioritized over others based on data on community needs versus facilitators' comfort or familiarity with topics (i.e. CHVs likely focusing more on health and nutrition topics). There should be clear guidelines on how to orient caregivers at the beginning or continuation of parenting groups on how many sessions they may expect within a calendar year and/or project period in order to understand how to "graduate" groups of caregivers or have a pre-determined point in time to revisit the groups' participants to determine if the same or different session topics are needed.

Additionally, exploring what services the CHVs are able to provide and what services are outside their cope would be useful for future planning. This may help in better figuring out which services caregivers are not able to access that are in demand for themselves and/or their children.

A formal process evaluation should be conducted to inform the discontinuation or modification of aspects of the intervention. While it is difficult to recommend discontinuing any activities, in consideration of the fact that resources – both financial and time – are limited, a formal process evaluation of project implementation could be conducted in the future to determine if the activities are conducted to fidelity and to better understand barriers and facilitators to fidelity. These process findings can then be used to inform how to either discontinue or modify interventions. Further, an area that could perhaps be worked on to reduce participant burden is the amount of paperwork that needs to be completed. This is further elaborated upon below, under recommendations around Monitoring and Evaluation.

New activities to be added could include new programming and peer support/education. In terms of adding new programming to the existing curricula for caregivers, a topic to consider adding training on is livelihood strategies, which was recommended by stakeholders and caregivers. For example, a key barrier to a number of ECD-related services, such as early learning services and nutrition, was their high costs. Key informant interviews in all the sites emphasized the need for economic empowerment, which the project should address in future phases. This will ensure that the project incorporates additional support for families that are at risk and therefore more vulnerable to adverse outcomes. It was evident that even though some of the caregivers had the knowledge and skills regarding stimulation and responsive care, other factors, such as stress emanating from lack of finances to provide basic needs, including food, were impeding the actual practice of stimulation and responsive care.

Another aspect that could also be added as part of a new initiative design is peer support/education and content on caring for the caregiver. Caregivers who participated in the current project were able to influence other caregivers who did not both directly and indirectly. For instance, caregivers in Zambia and Kenya who participated in the project began educating their neighbors on the importance of play and communication as well as proper nutrition for children of their own volition. Additionally, other caregivers who did not participate in the program were able to observe those who did, indirectly expanding the influence of the project. As such, if such peer support/education was formalized, perhaps by nominating some caregivers as being peer educators, the project could reach larger community members and therefore have a larger impact. Also, as noted in the data regarding caregiver well-being, addressing stresses

around the financial domain as well as stresses around caring for children and finding a work-life balance could be topics to explore further and address in subsequent interventions.

For caregivers, new content could be added to the home visiting training component. The CSS facilitators in both Zambia and Kenya reported that as time progressed, some of the caregivers became bored with the same content and being asked the same questions repeatedly. One idea to adding new content would be including the components in the group parenting sessions to the home visiting sessions.

Gathering data on participation in ECD centers is another area to explore in the future, as well as exploring if and how to more intentionally integrate parenting programming and capacity building for ECD government and volunteer teachers to see if this supports children's access to preschool as well as readiness for and access to formal school for 3-5-year-olds.

Incorporating the local context into the intervention though some simple adaptations may help in increasing uptake of information delivered by the program. Understanding the local context in which the program is delivered is of utmost importance, both in terms of the laws and public policies that are in effect as well the characteristics of the communities in which families reside (Azzi-Lessing, 2011). Looking at the different descriptors for the household well-being levels for the different sites provides a glimpse into how varied the contexts are for families participating in this study. A simple way contextualization could take place at the family level is through some adaptations of the training materials and messages ensure that, first and foremost, caregivers resonate with the messages, ultimately leading to acceptance and ownership. Contextualization could be achieved in the following ways.

Materials should be translated into the local language. None of the training materials used were translated into the local language. In Zambia, considering the high illiteracy levels, even most of the CSS facilitators could not understand some of the materials, thus posing a challenge of translating this information to the caregiver. In all of the Kenyan sites, some of the facilitators indicated that *a priori* translation of the tools into the local language would make their work easier. It is also important to note that the translations need to be pre-tested at the community level to make sure they are accurate and understandable, before being adopted and used by the project. For instance, in urban slums in Kenya, the language spoken is not fluent English nor Swahili, but rather a popular language called "sheng", a concoction of English, Swahili, and newly-created and evolving terms. Making sure that translations of materials uses sheng correctly would be important in ensuring comprehension by caregivers living in these urban slums.

Personalized messages should be developed for the caregivers. Overall, the caregivers, CSS facilitators, and government stakeholders felt that there was a need to not only educate the caregivers, but also provide a strategy for helping them remember what they have learned. One way to do this would be through develop specific and individualized messages for caregivers, such as part of a social behavior change communication campaign which can support delivery of the intervention. As described by Briscoe and Aboud (2012), such behavior change techniques have been shown to be effective in health-related programs in low and middle income countries. Given the low literacy rate, it would be important to keep these messages simple and to include more visuals than written text. These messages could be pulled from the training materials or the caregivers could be engaged to develop their own messages out of their own learning process.

An effective monitoring and evaluation strategy is critical to ensure the success of the project. An effective monitoring and evaluation strategy is important in making evidence-based decisions to improve programs and for general project management.

Tools need to be developed that track caregivers' knowledge and practices. Apart from having tools that assess and track outputs such as the number of trainings, it is also important to develop tools that assess and track caregiver's knowledge, attitude, and behavior-related key practices. This could be achieved by developing pre- and post-training assessment tools that could be administered prior to project start and periodically thereafter, such as monthly or quarterly, until the project end. Such tools could also be used after the project is over, in order to track retention of knowledge.

Reporting and monitoring tools need to be relevant and user-friendly. One of the issues that emerged from the evaluation is that there were many reporting tools that required the CSS facilitators to do a lot of writing, even though some of the caregivers, given their level of education, could not write a lot. In this regard, it would be important to develop a few, but more focused, reporting and monitoring tools. If possible, having these tools translated to the local language as well would assist with their use.

Child-focused assessment and monitoring needs to be conducted. Even though the target of the project is the caregivers, the end goal is to improve the well-being of children. In this regard, it would be important to use tools that track the developmental outcomes of the child. While there are a number of existing tools that can be used to assess children's developmental outcomes, certain precautions must be taken when choosing a tool for use with children in low- and middle-income countries. Sabanathan and her colleagues (2015) provide a quick checklist for evaluating whether a child development assessment tool would be appropriate for use in the local context. When selecting a tool, it will be important to make sure that it is appropriate for the population being studied, has been validated with such a population, and optimally, adapted for the local cultural environment. Anthropometric tests could also be conducted in conjunction with the nutrition department to assess and monitor changes in the physical development of children.

Steps need to be taken to enhance capacity building and systems strengthening. There is need to build the M&E capacity of ChildFund and partner staff, mentors, and CSS facilitators. Zambia lacked a centralized data entry and management system managed by one officer. Each local implementing partner had their own system that fed into the national system, managed by the M&E officer at the national level. Every time data was requested, a request could be made from the national office to compile and share data. However, it is important to have a centrally-managed M&E system for the project, where the CBOs can also log in and enter data, and authorized staff, regardless of location, can easily log in and share data. The advantages of having a centrally-managed M&E system are manifold: it ensures security of the data and it greatly reduces the chances of data loss and manipulation. If possible, the M&E system should be digitized to allow for convenient, timely, and a more affordable way to manage and analyze data.

Country-specific recommendations. Country-specific recommendations for Zambia and Kenya address specific needs in these two countries.

Recommendations for Zambia. In Zambia, recommendations include managing expectations, providing assistance to CSS facilitators, and strengthening and supporting the monitoring and evaluation component.

Expectations need to be managed. In Zambia, one of the major challenges for the project was caregivers' frequent and consistent comparisons between the current project and other ChildFund-related projects that offered tangible benefits, such as sponsorship, to participants. The CSS facilitators noted that they were hard pressed to explain why other services from the

same organization had tangible benefits, while this one did not. In this regard, managpping expectations can be achieved in three ways: 1) mapping out and implementing the project in villages in the same jurisdiction where ChildFund has not previously implemented a project; 2) working with the same caregivers who are already benefiting from other ChildFund projects and explaining to them the nature of the project, how it differs from previous projects, and any added benefits the new project would incur; and 3) investing adequate time to engage the community in a slow dialogue process concerning the project.

Assistance needs to be provided to CSS facilitators. In Zambia, even though most of the CSS facilitators were motivated to conduct household visitations, the long distances between households was a major obstacle. Most of the CSS facilitators in Chibombo and Kafue Districts reported walking two to three hours from one household to another. This negatively affected delivery of the program to the caregivers, as well as demotivated some of the CSS facilitators. In addition, the CSS facilitators could be provided with talk time to facilitate piloting remote mentoring and peer to peer learning approaches using Whatsapp. Such strategies which could then be assessed to determine if they contribute to increased CSS capacity, information sharing, and potentially even supporting caregivers' linkages with services and improved caregiving practices by giving the CSS the opportunities to exchange ideas on local solutions amongst themselves.

The monitoring and evaluation component needs to be strengthened. Monitoring and evaluation (M&E) plays an important role in project management and decision making, as well as generating evidence. However, there is a need to build a robust M&E system that facilitates data collection, entry, management, and analysis. The system should also enable sharing of data between those implementing the project as well as those on the monitoring and supervision team. The tools for capturing data should be simple, easy to comprehend, and user-friendly. Focus should also be on building the capacity of the M&E staff, including data collectors, to collect relevant and reliable data within an appropriate timeframe. Additionally, attention needs to be paid to the fidelity of group sessions and improved group targeting as well as supporting home visitors to diversity activities and provide inputs beyond play and communication at the household level.

Recommendations for Kenya. One recommendation for Kenya is to develop a visual aid building on core concepts of ECD. Facilitators sometimes tried to use the small facilitator's guide to conduct group sessions when they had already run through the topics in the group manual due to caregiver interest and conducting more sessions than required due to demands for group parenting. Additionally, guidelines on if and how to create more than one group in communities where groups of caregivers exceeded the recommended amount would be useful to develop as well as identifying a strategy to scale-up home visiting that could build on CHVs but also does not overburden existing service providers.A final recommendation would be to Finally, identify theing scalability of groups vs.and home sessions and the cost-benefit of each intervention type utilizing various types of service providers. This could help to determine which intervention and service provider yields the most significant caregiver changes (from volunteers to CHVs that require a government incentive), which would be important to determine as the County Government in places such as Siaya County, Kenya aims to identify which interventions and how to bring interventions to scale.

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APPENDIX A

Brief Descriptions of the Care for Child Development Package and the Essential Package for Children and Caregivers Affected by HIV/AIDS

Care for Child Development (CCD) Package

Developed by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) (2012), along with a wide range of partners, the Care for Child Development (CCD) package was designed to support families in promoting the development of young children through health services, health workers, community providers, and other people working with families and young children. The CCD package guides these people working with families and their children to help families build stronger relationships with their children and solve problems in caring for their children at home. Particular focus is paid towards play and communication activities for families to stimulate their children's learning and also to learn how to be sensitive to and meet their children's needs.

The CCD package is comprised of simple recommendations health workers and those working with families and their children can make to help families improve their children's development, training materials for health workers and community providers, support for families to solve common problems in providing good care for young children, advocacy materials, and a monitoring and evaluation framework. More information on the CCD package can be found at https://www.unicef.org/earlychildhood/index_68195.html

Essential Package for Children and Caregivers Affected by HIV/AIDS (EP)

The Essential Package (EP) was developed by the Inter-Agency Task Force on ECD and AIDS (IATF) within the Consultative Group and co-chaired by CARE International and Save the Children. The EP is a comprehensive set of tools and guides for program managers and service providers that enables programs to address the needs and competencies of young children, especially those affected or infected by HIV/AIDS, in an integrated and holistic way. It was developed in such a way that components of the package can be easily integrated into existing ECD and Orphans and Vulnerable Children (OVC) programs in different contexts.

The EP is comprised of five interlinking areas in which key actions for both the child and caregiver are provided: health, nutrition, care and development, right and protection, and economic strengthening. More information on the EP can be found at https://resourcecentre.savethechildren.net/library/essential-package-holistically-addressing-needs-young-vulnerable-children-and-their

APPENDIX B

Selection Criteria for Mentors and Facilitators

Criteria	Justification
1. Minimum of class 8 level of education but preferably form four level of education. 2. Must be 18 years old or older (Zambia only). 3. Basic reading and writing proficiency level in English. Person living in the same village or neighboring village to the enrolled caregivers and children. Respectable members of community 4. Willingness to work on a volunteer basis and experience in volunteer work (Zambia only) 5. Currently a member of an existing community structure but not necessarily a Community Health Volunteer. 6. Willing to be vetted by the Area Assistant Chiefs or Sub County Children's Officer and Willing to sign the child safeguarding policy 7. For Facilitators only: Time availability – not engaged in too many other community groups or development partner projects	1. To enable them read, write good reports and help cascade training content effectively 2. For ease of providing service to the caregivers and children 3. For acceptability by beneficiaries (caregivers) 4. Committed to the program and for sustainability 5. Link the project to beneficiaries hence no need to establish parallel structures 6. Work with persons who are willing to protect and promote the rights of all children 7. In order to have the time available to dedicate to facilitating sessions on a monthly basis and make the requisite number of home visits

APPENDIX C

List of Topics Covered in Group Parenting Sessions

How Children Learn and Grow
- Session #1: Introduction to care
- Session #2: Introduction to attachment
- Session #3: Introduction to child development

Play
- Session #4: The importance of play
- Session #5: Age-appropriate play for children and caregivers
- Session #6: Inclusive caregiving
- Session #7: Making toys from local materials

Communication
- Session #8: The importance of communication
- Session #9: Communication, play, and responsive caregiving

Health
- Session #10: Safe pregnancy and delivery
- Session #11: Basic newborn and young child health
- Session #12: Malaria awareness
- Session #13: HIV and AIDS awareness

Nutrition
- Session #14: Breastfeeding and complementary feeding
- Session #15: Dietary diversity

Protection
- Session #16: Safe home environment and WASH
- Session #17: Positive discipline

APPENDIX D

Estimated Household Wellbeing Descriptors

Zambia: Chibombo and Kafue – Rural/subsistence farming areas			
Struggling almost all the time	Life is hard, sometimes struggling	Coping most of the time, sometimes things are difficult	Coping well almost all the time
• Raw (unbaked) mud bricks, small windows, no door, mud floor • A roof that is not well-thatched • Water from an open well or a river • No toilet • No soap • Cook on firewood • 1 meal a day and there is sometimes no food • No meat • No blankets or other possessions • Children are dirty, dry skin, their clothes are very old, they have no shoes • Children not at school, especially in remote rural areas, due to distance or real/believed costs of ECD • Charcoal burners • Small garden/no garden, only a few plans • 1-2 chickens, no other animals	• A roof that is well-thatched, mud bricks, mud floor • Water from an open well or a river • No toilet • Sometimes soap • Cook on firewood • 2 meals a day – lunch and supper • Meat once a month • Possessions: homemade mattress stuffed with grass, carved wooden stools • Children are clean • Survive from piece work • A few lines for a garden, not enough to live on • More chickens, but no goats or other animals • Some of the children in school, depending on distance	• Well-thatched or tin roof, cement floor • Water close by, a covered well or pump • Own pit latrine • Cook on charcoal • Sometimes have 3 meals, but sometimes just have tea for breakfast • Meat once a week • Could own a bicycle, shop mattress, chairs, radio (cannot afford sofa, TV, cattle) • Shoes are “plastics” • Children are clean, their skin is lotioned, clothes are clean, have shoes • A large garden, enough to eat but usually not enough to sell • Animals: goats and chickens • Also work occasionally • All children go to school	• Well-thatched or tin roof, cement floor • Water close by, a covered well or pump • Own pit latrine with a door • Cook on charcoal • Always have 3 meals a day • Might own enough blankets, solar gadgets, TV, radio, proper beds, sofa, radio, and/or gen set • Children are clean, skin is lotioned, clothes are quiet new and clean, have shoes • Adults have better shoes (not tropical/plastics) • A large abundant garden that can feed the family all year and produces surplus to sell • Animals: cows, goats, many chickens • Might also work • All of the children go to school

Kenya: Kisumu– rural area			
Struggling almost all the time	Life is hard, sometimes struggling	Coping most of the time, sometimes things are difficult	Coping well almost all the time
• Mud houses, no windows, small narrow doorways, recycled tin doors • Grass thatched roofs or a flat tin roof • Mud/cow dung floor • Buy water or draw from ponds in rainy season • No toilet • Cook on firewood with three stones • Sometimes no food – 1 meal a day, meat only at funerals • Possessions: panga, hoes, homemade pots; in some cases the house may well-furnished but there may be no food • Children are dirty, have dry skin, often not a full set of clothes, old clothes are very old, do not have shoes • Casual work: farm work, woodcutters, washing clothes, illicit brewing • Small/No garden, only a few plans • Scarcity of chickens, goats, other animals • No fence • Children not at school	• Smooth mud/baked brick houses with a sloped tin roof, may have windows • Water from an open well or a pond • Pit latrine • Cook on firewood • 2 meals a day – breakfast and supper; meat and/or chicken at special occasions • May have a bicycle or motorbike • Children are fully dressed, cheap shoes • Survive from casual work, shop attendants, small-scale business • Small garden not enough to live from • More chickens and/or goats, maybe a cow or other animals • Maybe a fence • Some of the children in school	• Mud house with a smooth finish, sloping tin roof, windows, and doors • May have their own borehole • Own pit latrine • Cook on charcoal, firewood • Sometimes have 3 meals a day; meat once a week • Possessions: bicycle, motorbike, maybe a tuk tuk • Children are clean, smooth skin, clothes are clean, children have shoes, shoes are “plastics” • Small business, sugar cane farming, trading livestock • A large garden, enough to eat but not sell • Animals: goats, cows, and chickens • All the children go to school	• Painted brick house with a well-maintained tin or thatch roof, steel doors • Houses have piped water • Own pit latrine with a door • Cook on gas, kerosene, or electricity • Always have 3 meals and 2 teas a day • Possessions: vehicles, TVs, computers • Children are clean, skin is lotioned, their clothes are quiet new and clean, children have shoes, adults have better shoes • Business owners or employed • A large abundant garden that can feed the family all year and produces surplus to sell • Animals: cows, goats, many chickens • All the children go to school

Kenya: Kisumu– rural area			
Struggling almost all the time	Life is hard, sometimes struggling	Coping most of the time, sometimes things are difficult	Coping well almost all the time
• Mud houses with no windows, small reed doors • Grass thatched roof/tin roof • Cow dung floors • Water from seasonal ponds and far away rivers • No toilet • Donated solar power • Cook on firewood • 1-2 meals/day, sometimes no food • No meat • Children are dirty, dry skin, malnourished, not a full outfit of clothes, they have no shoes • Casual labor • Small garden/subsistence farming • May have 1 goat given to them, no other animals • No fence • Children not at school • May be a child-headed household	• Semi-permanent house/grass-thatched roof • Doors of reeds or old tin • Water from seasonal ponds or far away river • Sometimes soap • May have toilet • May have electricity • Cook on firewood • 2 meals/day • Dry fish once a month • No mattresses, shared blankets • May own a bicycle/motor bike • Children are clean and may have plastic shoes • Small-scale business and/or farming, including chickens • May lease their land for income • Food from garden • Some own chickens, goats, or other animals • Live fence (trees) • Some of the children in school	• Permanent/semi-permanent house • Have electricity • Water close by • Own pit latrine • 3-4 meals/day • Fish three times a week, chicken once a wekk • They could own a vehicle, motorbike • Children are clean, in good health, clean clothes, shoes • Employed by parastatals or head organizations • A large garden with a wall fence • Animals: goats, cows, and chickens • All the children go to school	• Permanent houses, roof of tiles, glass windows, double doors • Cement floors with carpets • Electricity • Water close by, a covered well or pump • Indoor latrine or own outdoor latrine • Children are clean, healthy, their skin is lotioned, new and clean clothes • They always have 4 balanced meals a day • Meat, fish, or chicken usually on a daily basis • Own vehicles, TV, radio, and electrical appliances • Business owners or employed • A large abundant garden with a fence and a gardener • All the children go to school

Kenya: Mukuru – Informal settlement			
Struggling almost all the time	Life is hard, sometimes struggling	Coping most of the time, sometimes things are difficult	Coping well almost all the time
Surroundings for all: drains dirty and overflowing or unblocked into streets and paths; narrow streets serving as roads and pathways; very crowded – all houses single room; garbage everywhere and no removal			
• Mabati walls, leaking roof, earth floor. 10' x 10' • Rent: 1500-2000/= • Water bought at taps – 5/= per 20L, price can increase to 20/= during shortages (taps are disconnected if the broker does not pay) • Sanitation: public toilet at 5/=, "flying toilet" (plastic bag thrown away) • No electricity (cannot pay broker or no connection) • Light: candles, tin paraffin lamps • Cooking on charcoal, homemade briquets from charcoal dust or chips, firewood, waste plastic, sawdust • 1 meal/day, ugali and sometimes sukuma wiki (greens); sometimes miss meal days • Possessions: radio, stools. No furniture or minimal. Family fleeps on floor – a few mattresses or mats/cartons/sacks • Income: washing clothes, irregular casual labor/local casual labor (e.g. clearing drains) • Children may be left without care from 18m or with siblings/neighbor, not clean, old clothes, unhealthy • Larger households could be 10) and	• Mabati walls (corrugated iron) and cement floor houses – 10' x 10' per family • Rent of 2500-3500 /= • Water is bought at a communal tap by the bucket or jerry can • The toilet is public and shared by community, costing 5/= • Electricity through illegal connections, disconnection likely, backup tin lamps and candles • Cook on charcoal/paraffin stove • 2 meals/day (occasionally 1 meal), ugali and veggies, with meat 1/week (kata kata offcuts and omena fish fingerlings usually / mutura – local 'meat mixed' sausage) • Possessions include bed/mattress, sofa, TV, radio (of poor quality than people who are coping better) • Employment (either one high earner or two lower earners): security, more successful small business, more regular casual labor, monthly paid cleaning work which includes food. 8000/= • Children in baby care, all informal and very poor conditions (crammed, only one	• 10' x 10' concrete room shared by a family within a shared building • Rent of 5000-6000/= • Toilet and water supply are shared and inside the building, but can be contaminated through broken pipes • Electricity mostly through illegal connections from a broker – generally connected, but can be unreliable • Electric lighting • Cook on gas/charcoal stove or electric coil stove • Consistently 2 meals/day, sometimes 3. Meat 2x/week, omena (fingerling fish) as much as desired, daily vegetables • Possessions: Bed, table, sofa set, TV, radio, children may sleep on a mattress on the floor • Usually both parents work – 2 incomes • Earnings 10,000-20,000/= for household. Hardware, salon, bar, food kiosk, landlord, butcher, water seller, regular casual in industry, a few have jobs • More expensive ECD schools, but not necessarily better • Health is better. Not unhealthy through HIV	• Does not exist in the slum

often an single parent or only one breadwinner • Even worse off (struggling sana) • Scavengers/rubbish recyclers	carer, no hygiene care, use of sedatives or alcohol on babies) or ECD centers (informal, some of reasonable quality, others lower standards) • Household generally has 4-6 members; smaller households with one breadwinner, larger households with two		

Kenya: Kaserani – Peri-urban, mixed residential area			
Struggling almost all the time	Life is hard, sometimes struggling	Coping most of the time, sometimes things are difficult	Coping well almost all the time
Surroundings for all except those coping well include stagnant water; drains dirty and overflowing or unblocked into streets and paths; garbage everywhere and no removal			
• Mabati walls, leaking roof, earth floor, shared mabati "buildings" • Rent 1500-2000/= • Shared shower, washing, and shower facilities; one point for many residents; sometimes no water • Water sometimes drawn from the Nairobi river, which is 'clean' (filtered by the time it reaches this point), boiled for drinking • No electricity (cannot pay or no connection) • Light: candles, tin paraffin lamps • Cook on chargoal, firewood • 1 meal/day, ugali and sometimes wukuma wiki (greens); sometimes miss meal days; day-to-day shopping in small quantities • Possessions: cheap bed or mattress, some of the family sleeps on mat on the floor • Income: washing clothes, fetching water • Not all children in school due to distance and cost of clothing • Larger households (could be 10) and often a single parent or only one breadwinner	• Block single room with cement floor • Rent of 3500/= • Shared shower, washing, and shower facilities; one point for many residents • Electricity controlled: only in the evenings and only for light • Cook on charcoal/paraffin stove • 2 meals/day (occasionally 1 meal), ugali and veggies; sometimes short at end of month; day-to-day shopping • Possessions: include bed/mattress, sofa, TV, radio (of poorer quality than people who are coping better) • Employment (either one high earner or two lower earners): domestic work, security, more successful small business, more regular casual labor, monthly paid cleaning work which includes food. 8000/= • Children in any local ECD center, standards not considered • Household generally has 4-6 members; smaller households with one breadwinner, larger households with two	• Double room concrete block • Toilet and water supply shared and inside the building, among fewer people than single room residents • Electricity controlled, but more often available than single rooms • Electric lighting • Cook on paraffin stove • Meals: enough food for the month, though it might be simple towards end of month • Possessions: Bed with low-density foam mattress, TV • Employment: trade such as welding or building, low level jobs, small business, salon, selling second-hand clothing • Children in more expensive local ECD center, although standards might be low	• Self-contained apartment, or for the exceptionally wealthy, large self-standing houses • Toilet and water supply for each residence and inside the building • Electricity provided by council in a metered service • Electric lighting • Cooking using electricity or a gas stove • Never short of food and eat meat regularly • Able to shop for the month • Possessions: full range of residential assets of good quality • Employment: at the entry level, government job, clerical work, teacher, moving up the pay scale to well-paid jobs and large businesses • Children at private schools, often outside of the area • Surroundings managed by the council and likely to be better than other categories, although lower-cost apartments might be in poorly-maintained areas

APPENDIX E

Government Officials and Local CBO Staff Participating in Trainings

Training topic	Zambia		Kenya	
	Number of trainings	Participants	Number of trainings	Participants
Core concepts of ECD (brain development, stimulation, toxic stress)	2	• 8 staff from 2 CBOs • 14 government stakeholders from 8 departments	4 (2 planned, 2 refresher)	• 16 staff from 4 CBOs • 17 stakeholder officials from the Ministry of Education, Department of Children's Services, and Ministry of Health representing 4 counties
Stimulation and responsive care curriculum for group-based sessions	2	• 8 CBO staff from 2 CBOs • 14 government stakeholders	2	• 12 staff from 4 CBOs • 18 county government staff
Stimulation and responsive care curriculum for home visits	2	• 8 CBO staff from 2 CBOs • 14 government stakeholders	N/A	• 25 staff from 4 CBOs • 20 county government stakeholders
Project M&E, including reflective supervision	2	• 8 CBO staff from 2 CBOs • 16 government staff from 8 departments	2	• 7 staff from 4 CBOs • 18 government stakeholders

APPENDIX F

Data Collection Tools

Sample Items from the Household Survey

DO CHILDREN 0-5 YEARS IN THE HOUSEHOLD HAVE A BIRTH CERTIFICATE OR ID CARD?

Response	Child 1	Child 2	Child 3	Child 4
Yes				
No				
Don't know				

If No to question above… WHY IS THE CHILD NOT YET REGISTERED?

Response	Child 1	Child 2	Child 3	Child 4
Was born at home				
The registration centre is too far				
I do not know where to register				
I do not find it necessary to register				
I do not know				
The process is too complicated				
Others, please explain:				
If Yes, what made you acquire birth certificate for your child?				
Learned about the importance of birth registration during the parenting group meetings				
Was advised by the CHVs at the household				
Was educated on the importance of birth registration by the CHV				
Was advised at the health facility				
Other (Specify)				

Participation in the project		
	Have you participated in the parenting group or home visit session?	1=Yes 2=No
	How many parenting group sessions have you participated in?	
	If YES, what did you learn in the group parenting sessions? 1. Health 2. Nutrition 3. Child Protection 4. Positive Discipline 5. Play and Communication 6. Early stimulation 7. Water, Sanitation and Hygiene	

	8. Other_____	
	Which of these was most important to you? 1. Health 2. Nutrition 3. Child Protection 4. Positive Discipline 5. Play and Communication 6. Early stimulation 7. Water, Sanitation and Hygiene Other_____	
	How many times has someone visited and trained you on parenting skills to care for your child?	

Sample Items from the Discussion Guides for Focus Groups with CSS/CHVs

- Have you been trained on any aspect of holistic child development and responsive care? (probe for nutrition, health, protection, early learning and stimulation, ECD, CCD If yes, which training, when, and by who? What has been the impact of the training on your work?
- Have you been trained on reflective supervision? If yes, what is your experience with reflective supervision? What is the most important aspect of reflective supervision that you learned? Has reflective supervision helped you in your work?

Sample Items from the Discussion Guides for Focus Groups with Caregivers

- Have you received any information/training on providing responsive care and early childhood development (use same probes as above)? In Yes, Where, from whom, and How?
- Do you think that children need to play? If yes, how do caregivers play with their children in this community? What kind of play materials are available for children and how do parents get them? How does play benefit a child? Has this changed in the last two years? If yes, why and how?

Sample Items from the Guide for Conducting In-Depth Interviews

- How did you participate in the project (what activities were you involved in in the project)?
- How has participation in the project changed your life?

Sample Items from the Organization Self-Assessment Tool

- Do you have an annual plan? Were people consulted?
- Do you have staff management policies (e.g. leave)?

APPENDIX G

Table G1

Percentage of Caregivers Participating in the Program

	Group parenting *N* (%)	Home visit *N* (%)	Both *N* (%)	Neither *N* (%)
Total	256 (38.3%)	277 (41.5%)	109 (16.3%)	25 (3.7%)
Zambia	200 (59.9%)	29 (8.7%)	88 (26.3%)	17 (5.1%)
Kenya	227 (68.1%)	77 (23.1%)	21 (6.2%)	8 (2.4%)
Chibombo	26 (13.2%)	79 (40.1%)	78 (39.6%)	14 (7.1%)
Kafue	2 (1.5%)	121 (89.0%)	10 (7.4%)	3 (2.2%)
Kisumu	70 (68.6%)	30 (29.4%)	2 (2.0%)	0
Siaya	36 (55.4%)	16 (24.6%)	6 (9.2%)	7 (10.8%)
Kasarani	66 (75.9%)	10 (11.5%)	11 (12.7%)	0

Table G2

Topics Learned in Group Parenting Sessions

	N (%)	*N* (%)	*N* (%)	*N* (%)
	Total	Zambia	Kenya	
Child protection	197 (54.0%)	64 (54.7%)	133 (53.6%)	
Early stimulation	144 (39.5%)	55 (47.0%)	89 (35.9%)	
Health	256 (70.1%)	68 (58.1%)	188 (75.8%)	
Nutrition	282 (77.2%)	83 (70.9%)	188 (80.2%)	
Play and communication	278 (76.2%)	100 (85.5%)	178 (71.8%)	
Positive discipline	156 (42.7%)	51 (43.6%)	105 (42.3%)	
Water, sanitation, hygiene	147 (40.3%)	33 (28.2%)	114 (46.0%)	
Other	39 (10.7%)	5 (4.3%)[a]	34 (13.7%)	
	Chibombo	Kafue		
Child protection	56 (53.3%)	8 (66.7%)		
Early stimulation	48 (45.7%)	7 (58.3%)		
Health	61 (58.1%)	7 (58.3%)		
Nutrition	74 (70.5%)	9 (75.0%)		
Play and communication	88 (83.8%)	12 (100%)		
Positive discipline	43 (41.0%)	8 (66.7%)		
Water, sanitation, hygiene	30 (28.6%)	3 (25.0%)		
Other	5 (4.8%)	0		
	Kisumu	Siaya	Mukuru	Kasarani
Child protection	42 (58.3%)	19 (45.2%)	22 (38.6%)	50 (64.9%)
Early stimulation	26 (36.1%)	8 (19.0%)	9 (15.8%)	46 (59.7%)
Health	52 (72.2%)	25 (59.5%)	51 (89.5%)	60 (77.9%)
Nutrition	55 (76.4%)	25 (59.5%)	49 (86.0%)	70 (9.9%)
Play and communication	58 (80.6%)	32 (76.2%)	27 (47.4%)	61 (79.2%)
Positive discipline	35 (48.6%)	16 (38.1%)	10 (17.5%)	44 (57.1%)
Water, sanitation, hygiene	36 (50.0%)	13 (31.0%)	26 (45.6%)	39 (50.6%)
Other	3 (4.2%)	5 (11.9%)	9 (15.8%)	17 (22.1%)

Note: N_{total} = 365, N_{Zambia} = 117, N_{Kenya} = 248, $N_{Chibombo}$ = 108, N_{Kafue} = 12, N_{Kisumu} = 72, N_{Siaya} = 42, N_{Mukuru} = 57, $N_{Kasarani}$ = 77.

Table G3

Chi-Square Analyses Between Topics Learned in Group Parenting Sessions and Country

	df	*N*	χ^2	*p*
Child protection	1	365	.04	.85
Early stimulation	1	365	4.12	.04*
Health	1	365	11.87	.001**
Nutrition	1	365	3.92	.048*
Play and communication	1	365	8.21	.004**
Positive discipline	1	365	.05	.82
Water, sanitation, hygiene	1	365	10.43	.001**
Other	1	365	7.42	.006**

* $p < .05$, ** $p < .01$

Table G4

Chi-Square Analyses Between Topics Learned in Group Parenting Sessions and Site

	df	*N*	χ^2	*p*
Child protection	5	365	11.79	.04*
Early stimulation	5	365	37.80	.00**
Health	5	365	22.88	.00**
Nutrition	5	365	20.96	.001**
Play and communication	5	365	34.33	.00**
Positive discipline	5	365	25.64	.00**
Water, sanitation, hygiene	5	365	15.61	.01**
Other	5	365	20.60	.001**

*$p < .05$, **$p < .01$

Table G5

Caregiver Selection of Most Important Topics Learned During Group Parenting Sessions

	N (%)	*N* (%)	*N* (%)	*N* (%)
	Total	Zambia	Kenya	
Child protection	135 (37.0%)	44 (37.6%)	91 (36.7%)	
Early stimulation	90 (24.7%)	37 (31.6%)	53 (21.4%)	
Health	165 (45.2%)	45 (38.5%)	120 (36.0%)	
Nutrition	223 (61.1%)	69 (59.0%)	154 (62.1%)	
Play and communication	222 (60.8%)	87 (74.4%)	135 (54.4%)	
Positive discipline	124 (34.0%)	45 (38.5%)	79 (31.9%)	
Water, sanitation, hygiene	96 (26.3%)	26 (22.2%)	70 (28.2%)	
	Chibombo	Kafue		
Child protection	37 (35.2%)	7 (58.3%)		
Early stimulation	34 (32.4%)	3 (25.0%)		
Health	40 (38.1%)	5 (41.7%)		
Nutrition	63 (60.0%)	6 (50.0%)		
Play and communication	76 (72.4%)	11 (91.7%)		
Positive discipline	37 (35.2%)	8 (66.7%)[a]		
Water, sanitation, hygiene	26 (24.8%)	0[a]		
	Kisumu	Siaya	Mukuru	Kasarani
Child protection	33 (45.8%)	15 (3.7%)	16 (28.1%)	27 (35.1%)
Early stimulation	23 (31.9%)	4 (9.5%)	5 (8.8%)	21 (27.3%)
Health	40 (55.6%)	15 (35.7%)	35 (61.4%)	30 (39.0%)
Nutrition	49 (68.1%)	19 (45.2%)	36 (63.2%)	50 (64.9%)
Play and communication	51 (70.8%)	27 (64.3%)	19 (33.3%)	38 (49.4%)
Positive discipline	27 (37.5%)	16 (38.1%)	8 (14.0%)	28 (36.4%)
Water, sanitation, hygiene	28 (38.9%)	8 (19.0%)	19 (33.3%)	15 (19.5%)

Note: N_{total} = 365, N_{Zambia} = 117, N_{Kenya} = 248, $N_{Chibombo}$ = 108, N_{Kafue} = 12, N_{Kisumu} = 72, N_{Siaya} = 42, N_{Mukuru} = 57, $N_{Kasarani}$ = 77.

Table G6

Chi-Square Analyses Between Most Important Topics Learned in Group Parenting Sessions and Country

	df	*N*	χ^2	*p*
Child protection	1	365	.03	.87
Early stimulation	1	365	4.50	.03*
Health	1	365	3.16	.08
Nutrition	1	365	.33	.57
Play and communication	1	365	13.24	.00**
Positive discipline	1	365	1.55	.21
Water, sanitation, hygiene	1	365	1.48	.22

* $p < .05$, ** $p < .01$.

Table G7

Chi-Square Analyses Between Most Important Topics Learned in Group Parenting Sessions and Site

	df	*N*	χ^2	*p*
Child protection	5	365	7.00	.22
Early stimulation	5	365	18.63	.002**
Health	5	365	14.10	.02*
Nutrition	5	365	7.17	.21
Play and communication	5	365	36.25	.00**
Positive discipline	5	365	16.81	.005**
Water, sanitation, hygiene	5	365	14.74	.01*

* $p < .05$, ** $p < .01$.

Table G8

Topics Learned During Home Visiting Sessions

	N (%)	*N* (%)	*N* (%)	*N* (%)
	Total	Zambia	Kenya	
Child protection	175 (45.3%)	141 (49.0%)	34 (34.7%)	
Early stimulation	166 (43.0%)	145 (50.3%)	21 (21.4%)	
Health	206 (53.4%)	146 (50.7%)	60 (61.2%)	
Nutrition	237 (61.4%)	170 (59.0%)	67 (68.4%)	
Play and communication	328 (85.0%)	252 (87.5%)	76 (77.6%)	
Positive discipline	167 (43.3%)	131 (45.5%)	36 (36.7%)	
Water, sanitation, hygiene	126 (32.6%)	84 (29.2%)	1 (42.9%)	
Other	13 (3.4%)	10 (3.5%)	3 (3.1%)	
	Chibombo	Kafue		
Child protection	75 (47.8%)	66 (50.4%)		
Early stimulation	60 (38.2%)	85 (64.9%)		
Health	88 (56.1%)	58 (44.3%)		
Nutrition	98 (62.4%)	72 (55.0%)		
Play and communication	127 (64.1%)	125 (91.9%)		
Positive discipline	67 (33.8%)	64 (47.1%)		
Water, sanitation, hygiene	47 (29.9%)	37 (28.2%)		
Other	8 (5.1%)	2 (1.5%)		
	Kisumu	Siaya	Mukuru	Kasarani
Child protection	10 (31.3%)	6 (9.2%)	11 (13.9%)	7 (8.0%)
Early stimulation	1 (3.1%)	4 (18.2%)	4 (17.4%)	12 (57.1%)
Health	15 (46.9%)	14 (63.6%)	22 (95.7%)	9 (42.9%)
Nutrition	20 (62.5%)	14 (63.6%)	19 (82.6%)	14 (66.7%)
Play and communication	27 (84.4%)	16 (72.7%)	15 (65.2%)	18 (85.7%)
Positive discipline	16 (15.7%)	10 (15.4%)	4 (5.1%)	6 (6.9%)
Water, sanitation, hygiene	14 (43.8%)	10 (45.5%)	11 (47.8%)	7 (33.3%)
Other	0	1 (4.5%)	1 (4.3%)	1 (4.8%)

Note: N_{total} = 386, N_{Zambia} = 288, N_{Kenya} = 98, $N_{Chibombo}$ = 157, N_{Kafue} = 131, N_{Kisumu} = 32, N_{Siaya} = 22, N_{Mukuru} = 23, $N_{Kasarani}$ = 21.

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Table G9

Chi-Square Analyses Between Topics Learned in Home Visiting Sessions and Country

	df	*N*	χ^2	*p*
Child protection	1	386	6.00	.01*
Early stimulation	1	386	24.95	.00**
Health	1	386	3.23	.07
Nutrition	1	386	2.69	.10
Play and communication	1	386	5.67	.02*
Positive discipline	1	386	2.28	.13
Water, sanitation, hygiene	1	386	6.23	.01*
Other	1	386	.04	.85

* $p < .05$, ** $p < .01$.

Table G10

Chi-Square Analyses Between Topics Learned in Home Visiting Sessions and Site

	df	*N*	χ^2	*p*
Child protection	5	386	8.46	.13
Early stimulation	5	386	61.22	.00**
Health	5	386	23.74	.00**
Nutrition	5	386	7.03	.22
Play and communication	5	386	22.88	.00**
Positive discipline	5	386	10.44	.06
Water, sanitation, hygiene	5	386	7.53	.18
Other	5	386	4.21	.52

* $p < .05$, ** $p < .01$.

Table G11

Caregiver Selection of Most Important Topics Learned During Home Visiting Sessions

	N (%)	*N* (%)	*N* (%)	*N* (%)
	Total	Zambia	Kenya	
Child protection	143 (37.0%)	116 (40.3%)	27 (27.6%)	
Early stimulation	108 (28.0%)	100 (34.7%)	8 (8.2%)	
Health	162 (42.0%)	114 (39.6%)	48 (49.0%)	
Nutrition	180 (46.6%)	126 (43.8%)	54 (55.1%)	
Play and communication	276 (71.5%)	214 (74.3%)	62 (63.3%)	
Positive discipline	126 (32.6%)	103 (35.8%)	23 (23.5%)	
Water, sanitation, hygiene	80 (20.7%)	55 (19.1%)	25 (25.5%)	
	Chibombo	Kafue		
Child protection	61 (38.9%)	55 (42.0%)		
Early stimulation	41 (26.1%)	59 (45.0%)		
Health	69 (43.9%)	45 (34.4%)		
Nutrition	71 (45.2%)	55 (42.0%)		
Play and communication	105 (66.9%)	109 (83.2%)		
Positive discipline	50 (31.8%)	53 (40.5%)		
Water, sanitation, hygiene	43 (27.4%)	12 (9.2%)		
	Kisumu	Siaya	Mukuru	Kasarani
Child protection	8 (25.0%)	9 (40.9%)	7 (30.4%)	3 (14.3%)
Early stimulation	1 (3.1%)[b]	2 (3.1%)[c]	2 (8.7%)[d]	3 (14.3%)
Health	16 (50.0%)	12 (54.5%)	18 (78.3%)	2 (9.5%)
Nutrition	14 (43.8%)	14 (63.6%)	16 (69.6%)	10 (47.6%)
Play and communication	24 (23.5%)	13 (20.0%)	11 (47.8%)	14 (66.7%)
Positive discipline	9 (28.1%)	6 (27.3%)	5 (21.7%)	3 (14.3%)
Water, sanitation, hygiene	7 (21.9%)	8 (36.4%)[b]	7 (30.4%)	3 (14.3%)

Note: N_{total} = 386, N_{Zambia} = 288, N_{Kenya} = 98, $N_{Chibombo}$ = 157, N_{Kafue} = 131, N_{Kisumu} = 32, N_{Siaya} = 22, N_{Mukuru} = 23, $N_{Kasarani}$ = 21.

Table G12

Chi-Square Analyses Between Most Important Topic Learned in Home Visiting Sessions and Country

	df	*N*	χ^2	*p*
Child protection	1	386	5.08	.02*
Early stimulation	1	386	25.60	.00**
Health	1	386	2.65	.10
Nutrition	1	386	3.79	.05
Play and communication	1	386	4.37	.04*
Positive discipline	1	386	5.03	.03*
Water, sanitation, hygiene	1	386	1.83	.18

* $p < .05$, ** $p < .01$.

Table G13

Chi-Square Analyses Between Most Important Topic Learned in Home Visiting Sessions and Site

	df	*N*	χ^2	*p*
Child protection	5	386	8.82	.12
Early stimulation	5	386	39.09	.00**
Health	5	386	27.17	.00**
Nutrition	5	386	8.79	.12
Play and communication	5	386	18.88	.002**
Positive discipline	5	386	8.73	.12
Water, sanitation, hygiene	5	386	20.06	.001**

* $p < .05$, ** $p < .01$.

Table G14

Estimated Well-being Ranking Based on Community Vulnerability Criteria

	N (%)	*N* (%)	*N* (%)	*N* (%)
	Total	Zambia	Kenya	
Coping well almost all the time	9 (1.3%)	6 (1.8%)	3 (.9%)	
Coping most of the time	80 (12.0%)	25 (7.5%)	55 (16.5%)	
Life is hard, sometimes struggling	350 (52.5%)	194 (58.1%)	156 (46.8%)	
Struggling most of the time	22 (34.2%)	109 (32.6%)	119 (35.7%)	
	Chibombo	Kafue		
Coping well almost all the time	6 (3.0%)	0		
Coping most of the time	16 (8.1%)	9 (6.6%)		
Life is hard, sometimes struggling	110 (55.6%)	84 (61.8%)		
Struggling most of the time	66 (33.3%)	43 (31.6%)		
	Kisumu	Siaya	Mukuru	Kasarani
Coping well almost all the time	1 (1.0%)	0	2 (2.5%)	0
Coping most of the time	17 (16.7%)	3 (4.6%)	27 (34.2%)	8 (9.2%)
Life is hard, sometimes struggling	46 (45.1%)	34 (52.3%)	24 (30.4%)	52 (59.8%)
Struggling most of the time	38 (37.3%)	28 (43.1%)	26 (32.9%)	27 (31.0%)

Table G15

Estimated Household Well-being Levels, Baseline vs. Endline

	Struggling		Life is hard sometimes		Mostly coping		Almost always coping	
	B (%)	E (%)	B (%)	E (%)	B (%)	E (%)	B (%)	E (%)
Total	52%	34%	32%	53%	7%	12%	1%	1%
Chibombo	54%	33%	37%	56%	4%	8%	4%	3%
Kafue	51%	32%	14%	62%	2%	6%	0%	0
Kisumu	50%	38%	43%	45%	7%	17%	0%	1%
Siaya	47%	43%	41%	52%	12%	5%	0%	0
Mukuru	54%	33%	35%	30%	8%	34%	0%	3%
Kasarani	55%	31%	33%	60%	8%	9%	2%	0

Note: B = baseline; E = endline.

Table G16

Overall Rating of the Group Facilitator/Home Visitor

	N (%)	*N* (%)	*N* (%)	*N* (%)
	Total	Zambia	Kenya	
Poor	2 (.3%)	1 (.3%)	1 (.3%)	
Average	20 (3.0%)	7 (2.1%)	13 (3.9%)	
Good	220 (33.0%)	95 (28.4%)	125 (37.5%)	
Very Good	226 (33.9%)	115 (34.4%)	111 (33.3%)	
Excellent	173 (25.9%)	99 (29.6%)	74 (22.2%)	
N/A	26 (3.9%)	17 (5.1%)	9 (2.7%)	
	Chibombo	Kafue		
Poor	1 (.5%)	0		
Average	5 (2.5%)	2 (1.5%)		
Good	56 (28.3%)	39 (28.7%)		
Very Good	72 (36.4%)	43 (31.6%)		
Excellent	50 (25.3%)	49 (36.0%)		
N/A	14 (7.1%)	3 (2.2%)		
	Kisumu	Siaya	Mukuru	Kasarani
Poor	0	0	0	1 (1.1%)
Average	2 (2.0%)	2 (3.1%)	2 (2.5%)	7 (8.0%)
Good	46 (45.1%)	24 (36.9%)	19 (24.1%)	36 (41.4%)
Very Good	36 (35.3%)	15 (23.1%)	32 (40.5%)	28 (32.2%)
Excellent	18 (17.6%)	16 (24.6%)	25 (31.6%)	15 (17.2%)
N/A	0	8 (12.3%)	1 (1.3%)	0

Note: N_{total} = 667, N_{Zambia} = 334, N_{Kenya} = 333, $N_{Chibombo}$ = 198, N_{Kafue} = 136, N_{Kisumu} = 102, N_{Siaya} = 65, N_{Mukuru} = 79, $N_{Kasarani}$ = 87.

Table G17

Overall Rating of the Project's Services

	N (%)	*N* (%)	*N* (%)	*N* (%)
	Total	Zambia	Kenya	
Poor	3 (.4%)	2 (.6%)	1 (.3%)	
Average	12 (1.8%)	5 (1.5%)	7 (2.1%)	
Good	233 (34.9%)	89 (26.6%)	144 (43.2%)	
Very Good	250 (37.5%)	132 (39.5%)	118 (35.4%)	
Excellent	144 (21.6%)	89 (26.6%)	55 (16.5%)	
N/A	26 (3.9%)	17 (5.1%)	8 (2.4%)	
	Chibombo	Kafue		
Poor	2 (1.0%)	0		
Average	3 (1.5%)	2 (1.5%)		
Good	54 (27.3%)	35 (25.7%)		
Very Good	83 (41.9%)	49 (36.0%)		
Excellent	42 (21.2%)	47 (34.6%)		
N/A	14 (7.1%)	3 (2.2%)		
	Kisumu	Siaya	Mukuru	Kasarani
Poor	0	0	0	1 (1.1%)
Average	1 (1.0%)	2 (3.1%)	2 (2.5%)	2 (2.3%)
Good	48 (47.1%)	24 (36.9%)	33 (41.8%)	39 (44.8%)
Very Good	10 (39.2%)	18 (27.7%)	24 (30.4%)	36 (41.4%)
Excellent	13 (12.7%)	14 (21.5%)	19 (24.1%)	9 (10.3%)
N/A	0	7 (10.8%)	1 (1.3%)	0

Note: N_{total} = 667, N_{Zambia} = 334, N_{Kenya} = 333, $N_{Chibombo}$ = 198, N_{Kafue} = 136, N_{Kisumu} = 102, N_{Siaya} = 65, N_{Mukuru} = 79, $N_{Kasarani}$ = 87.

Table G18

Rating of the Project in Providing Needed Information

	N (%)	*N* (%)	*N* (%)	*N* (%)
	Total	Zambia	Kenya	
Poor	2 (.3%)	1 (.3%)	8 (2.4%)	
Average	20 (3.0%)	7 (2.1%)	13 (3.9%)	
Good	232 (34.8%)	98 (29.3%)	134 (40.2%)	
Very Good	251 (37.6%)	127 (38.0%)	124 (37.2%)	
Excellent	26 (3.9%)	83 (24.9%)	53 (15.9%(	
N/A	0 (1.3%)	1 (.3%)	8 (2.4%)	
	Chibombo	Kafue		
Poor	1 (.5%)	0		
Average	4 (2.0%)	3 (2.2%)		
Good	58 (29.3%)	40 (29.4%)		
Very Good	81 (40.9%)	46 (33.8%)		
Excellent	39 (19.7%)	44 (32.4%)		
N/A	15 (7.6%)	3 (2.2%)		
	Kisumu	Siaya	Mukuru	Kasarani
Poor	0	0	0	1 (1.1%)
Average	2 (2.0%)	2 (3.1%)	5 (6.3%)	4 (4.6%)
Good	51 (50.0%)	23 (35.4%)	22 (27.8%)	38 (43.7%)
Very Good	35 (34.3%)	20 (30.8%)	33 (41.8%)	36 (41.4%)
Excellent	14 (13.7%)	13 (20.0%)	18 (22.8%)	8 (9.2%)
N/A	0	7 (10.8%)	1 (1.3%)	0

Note: N_{total} = 667, N_{Zambia} = 334, N_{Kenya} = 333, $N_{Chibombo}$ = 198, N_{Kafue} = 136, N_{Kisumu} = 102, N_{Siaya} = 65, N_{Mukuru} = 79, $N_{Kasarani}$ = 87.

Table G19

Rating of the Project in Helping Caregiver Find Own Solutions

	N (%)	*N* (%)	*N* (%)	*N* (%)
	Total	Zambia	Kenya	
Poor	9 (1.3%)	7 (2.1%)	2 (.6%)	
Average	25 (3.7%)	16 (4.8%)	9 (2.7%)	
Good	256 (38.4%)	114 (34.1%)	142 (42.6%)	
Very Good	207 (31.0%)	97 (29.0%)	110 (33.0%)	
Excellent	139 (20.8%)	78 (23.4%)	61 (18.3%)	
N/A	31 (4.6%)	22 (6.6%)	9 (2.7%)	
	Chibombo	Kafue		
Poor	5 (2.5%)	2 (1.5%)		
Average	10 (5.1%)	6 (4.4%)		
Good	68 (34.3%)	46 (33.8%)		
Very Good	62 (31.3%)	35 (25.7%)		
Excellent	37 (18.7%)	41 (30.1%)		
N/A	16 (8.1%)	6 (4.4%)		
	Kisumu	Siaya	Mukuru	Kasarani
Poor	0	0	0	2 (2.3%)
Average	0	2 (3.1%)	1 (1.3%)	6 (6.9%)
Good	54 (52.9%)	23 (35.4%)	29 (36.7%)	36 (41.4%)
Very Good	36 (35.3%)	12 (18.5%)	30 (38.0%)	32 (36.8%)
Excellent	12 (11.8%)	20 (30.8%)	18 (22.8%)	11 (12.6%)
N/A	0	8 (12.3%)	1 (1.3%)	0

Note: N_{total} = 667, N_{Zambia} = 334, N_{Kenya} = 333, $N_{Chibombo}$ = 198, N_{Kafue} = 136, N_{Kisumu} = 102, N_{Siaya} = 65, N_{Mukuru} = 79, $N_{Kasarani}$ = 87.

Table G20

Sources of Information about of Child Development and Responsive Care, By Country

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
Group parenting session	331 (53.9%)	97 (32.6%)	234 (74.1%)
CHVs at household	325 (52.9%)	224 (75.2%)	101 (30.3%)
Health workers	88 (14.3%)	56 (18.8%)	32 (10.1%)
Friend	10 (1.6%)	8 (2.7%)	2 (.6%)
Neighbor	14 (2.3%)	9 (3.0%)	5 (1.6%)
Grandmother	5 (.8%)	2 (.7%)	3 (.9%)
Mother	10 (1.6%)	6 (2.0%)	4 (1.3%)
Father	2 (.3%)	1 (.3%)	1 (.3%)
Other	39 (6.4%)	29 (9.7%)	10 (3.2%)

Note: N_{total} = 614, N_{Zambia} = 298, N_{Kenya} = 316.

Table G21

Sources of Information about Child Development and Responsive Care, by Participation Type

	Group sessions (*N* [%])	Home visits (*N* [%])	Both (*N* [%])
Group parenting session	226 (92.6%)	25 (9.8%)	226 (75.5%)
CHVs at household	28 (11.5%)	210 (82.4%)	81 (76.4%)
Health workers	30 (12.3%)	42 (16.5%)	15 (14.2%)
Friend	4 (1.6%)	3 (1.2%)	3 (2.8%)
Neighbor	7 (2.9%)	3 (1.2%)	4 (3.8%)
Grandmother	1 (.4%)	4 (1.6%)	0
Mother	5 (2.0%)	5 (2.0%)	0
Father	1 (.4%)	1 (.4%)	0
Other	6 (2.5%)	25 (9.8%)	4 (3.8%)

Note: $N_{groupparenting} = 244$; $N_{homevisits} = 255$, $N_{both} = 106$.

Table G22

Caregiver-Reported Changes in Interactions with Children Post-Training, by Country

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
Child has play toys	285 (50.3%)	148 (54.6%)	137 (46.2%)
Play more with child	331 (58.4%)	165 (60.9%)	166 (56.1%)
Take child immediately to health facility if child is sick	187 (33.0%)	79 (29.2%)	108 (36.5%)
Use positive discipline	220 (38.8%)	94 (34.7%)	126 (42.6%)
Spend more time with child	259 (45.7%)	124 (45.8%)	135 (45.6%)
Communicate with child	232 (40.9%)	99 (36.5%)	133 (44.9%)
Other	77 (13.6%)	31 (11.4%)	46 (15.5%)

Note: $N_{total} = 567$, $N_{Zambia} = 271$, $N_{Kenya} = 296$.

Table G23

Caregiver-Reported Interactions with Children in the Previous Three Days, by Country

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
Took child outside home	127 (19.0%)	52 (15.6%)	75 (22.5%)
Read books	171 (25.6%)	74 (22.2%)	97 (29.1%)
Counted or drew things	213 (31.9%)	119 (35.6%)	94 (28.2%)
Told stories	341 (51.1%)	178 (53.3%)	163 (48.9%)
Played with child	419 (62.8%)	190 (56.9%)	229 (68.8%)
Sang songs or lullabies	458 (68.7%)	233 (69.8%)	225 (67.6%)

Note: N_{total} = 667, N_{Zambia} = 334, N_{Kenya} = 333.

Table G24

Chi-Square Analyses Between Caregiver-Reported Interactions and Country

	df	*N*	χ^2	*p*
Took child outside home	1	667	5.23	.02*
Read books	1	667	4.25	.04*
Counted or drew things	1	667	4.20	.04*
Told stories	1	667	1.26	.26
Played with child	1	667	10.08	.001**
Sang songs or lullabies	1	667	.37	.54

* $p < .05$, ** $p < .01$.

Table G25

Observed Child-Caregiver Interactions, by Country

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
Child in visual range	472 (95.9%)	265 (96.4%)	207 (95.4%)
Initiates eye contact and smiling	464 (95.7%)	259 (95.2%)	205 (95.2%)
Initiates interaction	438 (90.1%)	252 (92.6%)	186 (87.3%)
Provides toys and objects	81 (93.1%)	47 (94.0%)	34 (91.9%)
Provides opportunities for interaction	442 (91.1%)	249 (91.5%)	193 (90.6%)
Child smiles, laughs, plays	447 (92.7%)	248 (91.2%)	199 (93.4%)

Table G26

Chi-Square Analyses between Observed Child-Caregiver Interactions and Country

	df	*N*	χ^2	*p*
Child in visual range	1	492	.29	.58
Initiates eye contact and smiling	1	485	.30	.58
Initiates interaction	1	485	3.86	.049*
Provides toys and objects	1	87	.15	.70
Provides opportunities for interaction	1	272	.13	.72
Child smiles, laughs, plays	1	269	.27	.60

*$p < .05$.

Table G27
Presence of Toys in Household, by Country

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
Yes	502 (75.3%)	245 (73.4%)	257 (77.2%)
No	53 (22.9%)	85 (25.4%)	68 (20.4%)
Refused to display	12 (1.8%)	4 (1.2%)	8 (2.4%)

Note: N_{total} = 667, N_{Zambia} = 334, N_{Kenya} = 333.

Table G28

Reasons Caregivers Acquired Toys for Their Children, by Country

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
Group sessions	110 (22.4%)	28 (11.4%)	82 (33.2%)
CHVs	151 (30.7%)	107 (43.7%)	44 (17.8%)
Own decision	136 (27.6%)	66 (26.9%)	70 (28.3%)
Neighbor	54 (11.0%)	24 (9.8%)	30 (12.1%)
Other	51 (10.4%)	20 (8.2%)	21 (8.5%)

Note: N_{total} = 492, N_{Zambia} = 245, N_{Kenya} = 247.

Table G29

Chi-Square Analyses Between Knowledge of Children's Rights and Country

	df	*N*	χ^2	*p*
Yes, know about children's rights	2	667	98.47	.00**
Right to education	1	487	19.16	.00**
Right to parental care	1	487	46.00	.00**
Right to health care	1	487	32.39	.00**
Right to life	1	487	10.26	.001**
Right to leisure and recreation	1	487	17.88	.00**
Protection from child abuse	1	487	12.90	.00**
Right to protection from child labor	1	487	13.71	.00**
Right to religious education	1	487	2.44	.12
Right to protection from armed conflict	1	487	.97	.32
Protection from sexual exploitation	1	487	.40	.53
Protection from harmful cultural practices	1	487	3.90	.05
Protection from drugs	1	487	.54	.46
Right of children with disabilities to be treated with dignity	1	487	.81	.37
Right to name and nationality	1	487	1.56	.21
Right to privacy	1	487	.35	.55
Other	1	487	.13	.72

*$p < .05$, **$p < .01$.

Table G30

Sources of Information About Children's Rights

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
Group parenting sessions	218 (44.8%)	30 (9.0%)	188 (62.7%)
Home visiting sessions	172 (35.3%)	98 (52.4%)	74 (24.7%)
Health facility	53 (10.9%)	25 (13.4%)	28 (9.3%)
Village elder	19 (3.9%)	18 (9.6%)	1 (.3%)
Chief/Assistant chief	10 (2.1%)	1 (.5%)	9 (3.0%)
Other	138 (28.3%)	63 (18.9%)	75 (25.0%)

Table G31

Chi-Square Analyses Between Sources of Information about Children's Rights and Country

	df	*N*	χ^2	*p*
Group parenting sessions	1	487	101.27	.00**
Home visiting sessions	1	487	38.80	.00**
Health facility	1	487	1.93	.16
Village elder	1	487	26.53	.00**
Chief/Assistant chief	1	487	3.48	.06
Other	1	487	4.28	.04*

*$p < .05$, **$p < .01$.

Table G32

Children's Participation in Decision Making

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
Give child opportunity to make choices	541 (81.1%)	261 (78.1%)	280 (84.1%)
Ask child for opinion on household issues	457 (68.5%)	217 (65.0%)	240 (72.1%)

Table G33

Sources of Information about Children's Participation

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
Received information/education	501 (75.0%)	225 (67.4%)	276 (82.9%)
Group parenting sessions	209 (37.3%)	62 (18.6%)	147 (44.1%)
Home visiting sessions	228 (40.7%)	171 (51.2%)	57 (17.1%)
Nitunze Project	89 (15.9%)	23 (6.9%)	65 (19.5%)
Other	64 (6.1%)	27 (8.1%)	7 (2.1%)

Note: asterisk (*) indicates a statistically significant difference ($p < .05$) between the two countries

Table G34

Chi-Square Analyses Between Sources of Information about Children's Participation and Country

	df	*N*	χ^2	*p*
Received information/education	1	667	21.48	.00**
Group parenting sessions	1	667	50.72	.00**
Home visiting sessions	1	667	86.09	.00**
Nitunze Project	1	667	23.24	.00**
Other	1	667	12.33	.00**

*$p < .05$, ** $p < .01$.

Table G35

What Caregivers Learned about Child Safety and Protection

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
Keeping the child's environment safe	453 (67.9%)	214 (64.1%)	239 (71.8%)
Child protection	387 (58.0%)	201 (60.2%)	186 (55.9%)
Positive discipline	221 (33.1%)	113 (33.8%)	108 (32.4%)
Child abuse	155 (23.2%)	92 (27.5%)	63 (18.9%)
Other	23 (3.4%)	4 (1.2%)	19 (5.7%)

Table G36

Chi-Square Analyses Between What Caregivers Learned about Child Safety and Protection and Country

	df	*N*	χ^2	*p*
Keeping the child's environment safe	1	542	.33	.57
Child protection	1	542	9.35	.002**
Positive discipline	1	542	1.67	.20
Child abuse	1	542	11.64	.001**
Other	1	542	8.89	.003**

*$p < .05$, **$p < .01$.

Table G37

Sources of Information about Child Safety and Protection

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
Received information/training	542 (81.3%)	259 (77.5%)	283 (85.0%)
Group parenting sessions	275 (50.7%)	76 (29.3%)	199 (70.3%)
Home visiting sessions	241 (50.6%)	186 (71.8%)	88 (31.1%)
Health facility	66 (12.2%)	53 (20.5%)	13 (4.6%)
Village elder	13 (2.4%)	12 (4.6%)	1 (.4%)
Chief	2 (.4%)	1 (.4%)	1 (.4%)
Department of Children's Services	1 (.2%)	1 (.4%)	0
Other	43 (7.9%)	30 (11.6%)	13 (4.6%)

Note: asterisk (*) indicates a statistically significant difference ($p < .05$) between the two countries

Table G38

Chi-Square Analyses Between Sources of Information about Child Safety and Protection and Country

	df	*N*	χ^2	*p*
Received information/training	1	667	6.06	.01*
Group parenting sessions	1	542	90.84	.00**
Home visiting sessions	1	542	89.70	.00**
Health facility	1	542	31.85	.00**
Village elder	1	542	10.58	.001**
Chief	1	542	.004	.95
Department of Children's Services	1	542	1.10	.30
Other	1	542	9.05	.003**

*$p < .05$, **$p < .01$.

Table G39

Caregiver Response When Child Does Something Considered "Bad" or "Wrong"

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
Explain why something is wrong	474 (71.1%)	242 (72.5%)	232 (69.7%)
Shake, spank, or slap	144 (21.6%)	89 (26.6%)	55 (16.5%)
Shout, yell, or scream	80 (12.0%)	63 (18.9%)	17 (5.1%)
Pull ear or pinch	43 (6.4%)	9 (2.7%)	34 (10.2%)
Redirect child	32 (4.8%)	21 (6.3%)	11 (3.3%)
Take away privileges	15 (2.2%)	8 (2.4%)	7 (2.1%)
Nothing	14 (2.1%)	6 (1.8%)	8 (2.4%)
Other	122 (18.3%)	19 (5.7%)	103 (30.9%)

Table G40

Chi-Square Analyses Between Caregiver Response When Child Does Something Considered "Bad" or "Wrong" and Country

	df	*N*	χ^2	*p*
Explain why something is wrong	1	667	.63	.43
Shake, spank, or slap	1	667	10.11	.001**
Shout, yell, or scream	1	667	29.90	.00**
Pull ear or pinch	1	667	15.62	.00**
Redirect child	1	667	3.25	.07
Take away privileges	1	667	.07	.80
Nothing	1	667	.30	.59
Other	1	667	71.09	.00**

*$p < .05$, **$p < .01$.

Table G41

Where Caregivers Learned to Discipline Their Children

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
	When child is "bad"		
Group sessions	248 (48.2%)	75 (22.5%)	173 (52.0%)
Home sessions	189 (36.7%)	129 (38.6%)	60 (16.0%)
Health facility	16 (3.1%)	12 (3.6%)	4 (1.2%)
Parents	81 (15.7%)	61 (18.3%)	20 (6.0%)
Husband	9 (1.7%)	8 (2.4%)	1 (.3%)
Wife	2 (.4%)	2 (.6%)	0
Neighbor	5 (.7%)	5 (1.5%)	0
Impulse	29 (5.6%)	14 (4.2%)	15 (4.5%)
Other	62 (12.0%)	41 (12.3%)	21 (6.3%)
	When child is "good"		
Group sessions	241 (36.1%)	77 (23.1%)	164 (49.2%)
Home sessions	193 (28.9%)	134 (40.1%)	59 (17.7%)
Health facility	21 (3.1%)	16 (4.8%)	5 (1.5%)
Parents	68 (10.2%)	54 (16.2%)	14 (4.2%)
Husband	8 (1.2%)	8 (2.4%)	0
Wife	3 (.4%)	2 (.6%)	1 (.3%)
Neighbor	4 (.6%)	3 (.9%)	1 (.3%)
Impulse	20 (3.0%)	10 (3.0%)	10 (3.0%)
Other	52 (7.8%)	38 (11.4%)	14 (4.2%)

Table G42

Chi-Square Analyses Between Where Caregivers Learned to Discipline Their Children When Child Was "Bad" and Country

	df	*N*	χ^2	*p*
Group sessions	1	515	81.47	.00**
Home visits	1	515	36.09	.00**
Health facility	1	515	3.85	.05
Parents	1	515	22.96	.00**
Husband	1	515	5.30	.02*
Wife	1	515	1.94	.16
Neighbor	1	515	4.88	.03*
Impulse	1	515	.08	.77
Other	1	515	6.56	.01*

*$p < .05$, **$p < .01$.

Table G43

Caregiver Response When Child Does Something Considered "Good"

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
Praise the child	606 (90.9%)	300 (89.8%)	306 (91.9%)
Give gifts	127 (19.0%)	80 (24.0%)	47 (14.1%)
Hug the child	89 (13.3%)	70 (21.0%)	19 (5.7%)
Sing for the child	41 (6.1%)	18 (5.4%)	23 (6.9%)
Nothing	21 (3.1%)	10 (3.0%	11 (3.3%)
Other	40 (6.0%)	14 (4.2%)	26 (7.8%)

Table G44

Chi-Square Analyses Between Caregiver Response When Child Does Something Considered "Good" and Country

	df	*N*	χ^2	*p*
Praise the child	1	667	.86	.35
Give gifts	1	667	10.47	.001**
Hug the child	1	667	33.55	.00**
Sing for the child	1	667	.67	.42
Nothing	1	667	.05	.82
Other	1	667	3.87	.05

*$p < .05$, **$p < .01$.

Table G45

Chi-Square Analyses Between Where Caregivers Learned to Discipline Their Children When Child Was "Good" and Country

	df	*N*	χ^2	*p*
Group sessions	1	488	72.36	.00**
Home visits	1	488	41.39	.00**
Health facility	1	488	5.38	.02*
Parents	1	488	24.76	.00**
Husband	1	488	7.68	.01*
Wife	1	488	.28	.60
Neighbor	1	488	.90	.34
Impulse	1	488	.02	.90
Other	1	488	10.91	.001**

*$p < .05$, **$p < .01$.

Table G46

Chi-Square Analyses Between Child Protection Items and Country

	df	*N*	χ^2	*p*
Caregiver has activities outside of home	1	666	9.95	.002**
Child left alone for more than an hour last week	1	666	14.50	.001**
What caregiver does when activities are outside of home				
Go with child	1	666	1.04	.31
Has familiar relative watch child	1	666	13.57	.00**
Has familiar friend watch child	1	666	2.65	.10
Leaves child with mother-in-law	1	666	1.00	.32
Leaves child at baby care center	1	666	27.00	.00**
Other	1	666	.82	.36
Changed behaviors after participating in training	1	667	3.22	.20

*$p < .05$, **$p < .01$.

Table G47

Environmental and Neighborhood Safety

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
Environmental safety			
Accessible pit latrines	296 (44.4%)	181 (54.2%)	115 (34.5%)
Open rubbish or other pits	230 (34.5%)	98 (29.3%)	132 (39.6%)
Open or damaged drainage/stagnant water	172 (25.8%)	19 (5.7%)	153 (45.9%)
Unprotected fire	80 (12.0%)	65 (19.5%)	15 (4.5%)
Scattered animal waste	73 (10.9%)	26 (7.8%)	47 (14.1%)
Broken glass	19 (2.8%)	4 (1.2%)	15 (4.5%)
Human waste in compound	14 (2.1%)	2 (.6%)	12 (3.6%)
None	145 (21.7%)	81 (24.3%)	64 (19.2%)
Other	41 (6.1%)	22 (6.6%)	19 (5.7%)
Neighborhood safety			
Feel children are safe in neighborhood			
Safe most of the time	494 (74.1%)	262 (78.4%)	232 (69.7%)
Don’t feel that they are safe	165 (24.7%)	68 (20.4%)	97 (29.1%)
Don’t know	8 (1.2%)	4 (1.2%)	4 (1.2%)

Table G48

Chi-Square Analyses between Environmental Safety and Country

	df	*N*	χ^2	*p*
	Environmental safety			
Accessible pit latrines	1	667	26.10	.00**
Open rubbish or other pits	1	667	7.83	.01*
Open or damaged drainage/stagnant water	1	667	141.21	.00**
Unprotected fire	1	667	35.34	.00**
Scattered animal waste	1	667	6.85	.01*
Broken glass	1	667	6.59	.01*
Human waste in compound	1	667	7.33	.01*
None	1	667	2.48	.12
Other	1	667	.22	.64

*$p < .05$, **$p < .01$.

Table G49

Percentage of Children Who Have Received Immunizations

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
All have been done	629 (62.9%)	259 (49.3%)	370 (77.9%)
Most have been done	302 (30.3%)	214 (40.8%)	89 (18.7%)
Incomplete	35 (3.5%)	25 (4.8%)	10 (2.1%)
None	2 (.2%)	2 (.4%)	0
Don't know	6 (.6%)	4 (.8%)	2 (.4%)
Other	25 (2.5%)	21 (4.0%)	4 (.8%)

Note: N_{total} = 1000, N_{Zambia} = 525, N_{Kenya} = 475.

Table G50

Immunizations received by children in Zambia

	N (%)
BCG	199 (37.9%)
DPT	108 (20.6%)
IPV	5 (1.0%)
Measles	175 (33.3%)
OPV-0	148 (28.2%)
OPV-1	174 (33.1%)
OPV-2	162 (30.9%)
OPV-3	145 (27.6%)
Rotavirus	97 (18.5%)
Pentavalent 1	74 (14.1%)
Pentavalent 2	68 (13.0%)
Pentavalent 3	65 (12.4%)
Pneumococcal	33 (6.3%)
Polio	183 (34.9%)
Other	11 (2.1%)

Note: BCG = Bacillus Calmette-Guérin vaccine; DPT = Diphtheria-Tetanus-Pertussis; IPV = Inactivated Polio Vaccine; OPV = Oral Poliovirus Vaccine;. Data were not available for Kenya.

Table G51

Percentage of Caregivers Reporting Having Received Training/Information on Immunization

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
Yes	582 (87.3%)	282 (84.4%)	300 (90.1%)
No	85 (12.7%)	52 (15.6%)	22 (9.9%)

Note: N_{total} = 667, N_{Zambia} = 334, N_{Kenya} = 333.

Table G52

Sources of Caregiver Training/Information on Immunization

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
Group parenting	147 (25.3%)	43 (15.2%)	104 (34.7%)
CHVs at the household	171 (29.4%)	114 (40.4%)	57 (19.0%)
Nitunze Project	38 (6.5%)	4 (1.4%)	34 (11.3%)
Health facility	313 (53.8%)	217 (77.0%)	96 (32.0%)
Other	25 (4.3%)	16 (5.7%)	9 (3.0%)

Note: N_{total} = 582, N_{Zambia} = 282, N_{Kenya} = 300.

Table G53

Number of Meals Children Have Per Day

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
Number of meals children have per day			
One meal	8 (1.2%)	2 (.6%)	6 (1.8%)
Two meals	74 (11.1%)	38 (11.4%)	36 (10.8%)
Three meals	354 (53.1%)	192 (57.5%)	162 (48.6%)
Four meals and above	223 (33.4%)	98 (29.3%)	125 (37.5%)
N/A (exclusively breastfeeding)	6 (.9%)	3 (.9%)	3 (.9%)
Sometimes no meals per day	2 (.3%)	1 (.3%)	1 (.3%)
Received training on how often to feed	604 (90.6%)	298 (89.2%)	306 (91.9%)
Sources of training/information			
Group parenting	265 (39.7%)	66 (19.8%)	199 (59.8%)
CHVs	228 (31.2%)	135 (40.4%)	73 (21.9%)
Health facility	216 (32.3%)	190 (56.9%)	26 (7.8%)
Department of Children's Services	6 (.9%)	6 (1.8%)	0
Other	34 (5.1%)	26 (7.8%)	8 (2.4%)

Table G54

Food Consumption Frequency

	Daily	1-2 times/ week	1-2 times/ month	Rarely	Never
			Total		
Grains/starch	565 (84.7%)	85 (12.7%)	8 (1.2%)	1 (.1%)	8 (1.2%)
Fruits, vegetables	445 (66.7%)	159 (23.8%)	28 (4.2%)	27 (4.0%)	8 (1.2%)
Dairy	154 (23.1%)	240 (36.0%)	104 (15.6%)	123 (18.4%)	46 (6.9%)
Eggs	91 (13.6%)	409 (61.3%)	82 (12.3%)	63 (9.4%)	22 (3.3%)
Legumes	76 (11.4%)	422 (63.3%)	123 (18.4%)	35 (5.2%)	11 (1.6%)
Roots	81 (7.6%)	358 (53.7%)	144 (21.6%)	106 (15.9%)	8 (1.2%)
Meat, fish, chicken	19 (2.8%)	302 (45.3%)	219 (32.8%)	107 (16.0%)	20 (3.0%)
Honey	8 (1.2%)	20 (3.0%)	18 (2.7%)	258 (38.7%)	363 (54.4%)
			Zambia		
Grains/starch	299 (89.5%)	25 (7.5%)	7 (2.1%)	1 (.3%)	2 (.6%)
Fruits, vegetables	228 (68.3%)	58 (17.4%)	24 (7.2%)	21 (6.3%)	3 (.9%)
Dairy	40 (12.0%)	99 (29.6%)	76 (22.8%)	92 (27.5%)	27 (8.1%)
Eggs	83 (24.9%)	192 (57.5%)	36 (10.8%)	19 (5.7%)	4 (1.2%)
Legumes	44 (13.2%)	188 (56.3%)	78 (23.4%)	20 (6.0%)	4 (1.2%)
Roots	31 (9.3%)	133 (39.8%)	100 (29.9%)	67 (20.1%)	3 (.9%)
Meat, fish, chicken	18 (5.4%)	156 (46.7%)	106 (31.7%)	50 (15.0%)	4 (1.2%)
Honey	3 (.9%)	4 (1.2%)	12 (3.6%)	137 (41.0%)	178 (53.3%)
			Kenya		
Grains/starch	266 (79.9%)	60 (18.0%)	1 (.3%)	0	6 (1.8%)
Fruits, vegetables	217 (65.2%)	101 (30.3%)	4 (1.2%)	6 (1.8%)	5 (1.5%)
Dairy	114 (34.2%)	141 (42.3%)	28 (8.4%)	31 (9.3%)	19 (5.7%)
Eggs	8 (2.4%)	217 (65.2%)	46 (13.8%)	44 (13.2%)	18 (5.4%)
Legumes	32 (9.6%)	234 (70.3%)	45 (13.5%)	15 (4.5%)	7 (2.1%)
Roots	20 (6.0%)	225 (67.6%)	44 (13.2%)	39 (11.7%)	5 (1.5%)
Meat, fish, chicken	1 (.3%)	146 (43.8%)	113 (33.9%)	57 (17.1%)	16 (4.8%)
Honey	5 (1.5%)	16 (4.8%)	6 (1.8%)	121 (36.3%)	185 (55.6%)

Table G55

Chi-Square Analyses Between Food Consumption Frequency and Country

	df	*N*	χ^2	*p*
Grains/starch	4	667	23.84	.00**
Fruits, vegetables	4	667	35.02	.00**
Dairy	4	667	96.70	.00**
Eggs	4	667	83.39	.00**
Legumes	4	667	17.29	.002**
Roots	4	667	55.69	.00**
Meat, fish, chicken	4	667	23.42	.00**
Honey	4	667	10.83	.03*

*$p < .05$, **$p < .01$.

Table G56

Hygiene Practices

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
Where household members most often wash hands			
Inside the house	171 (25.6%)	23 (6.9%)	148 (44.4%)
Nearby but outside house	221 (33.1%)	144 (43.1%)	77 (23.1%)
Near toilet	71 (10.6%)	62 (18.6%)	9 (2.7%)
Far from toilet, kitchen, and house	17 (2.5%)	17 (5.1%)	0
No specific place	182 (27.2%)	85 (25.4%)	97 (29.1%)
No permission to see	5 (.01%)	3 (.9%)	2 (.6%)
Water present specifically for handwashing			
Yes, clean water available	340 (51.0%)	157 (47.0%)	183 (55.0%)
Yes, but not clean	62 (9.3%)	42 (12.6%)	20 (6.0%)
No	211 (31.6%)	91 (27.2%)	120 (36.0%)
No permission to see/N/A	54 (8.1%)	34 (13.2%)	10 (3.0%)
Problems getting clean water	237 (35.5%)	95 (28.4%)	142 (42.6%)
Received information on handwashing	621 (93.1%)	307 (91.9%)	314 (94.3%)
Source of information			
Group parenting sessions	270 (40.4%)	68 (20.4%)	202 (60.7%)
CHVs	250 (37.5%)	172 (51.5%)	78 (23.4%)
Health facility/worker	197 (29.5%)	175 (52.4%)	22 (6.6%)
Other	34 (5.1%)	22 (6.6%)	12 (3.6%)

Table G57

Chi-Square Analyses Between Hygiene Practices and Country

	df	*N*	χ^2	*p*
Where household members most often wash hands	5	667	169.24	.00**
Water present specifically for handwashing	4	667	35.95	.00**
Problems getting clean water	1	667	14.68	.00**
Received information on handwashing	1	667	1.47	.23
Source of information				
Group parenting sessions	1	667	112.41	.00**
CHVs	1	667	56.08	.00**
Health facility/worker	1	667	167.98	.00**
Other	1	667	22.68	.00**

Table G58

Where Children Were Born, as Reported at Endline

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
At home	366 (26.2%)	247 (32.4%)	119 (19.6%)
In hospital	500 (35.8%)	129 (16.9%)	371 (61.2%)
At primary health care facility	532 (38.1%)	416 (54.6%)	116 (19.1%)

Note: N_{total} = 1398, N_{Zambia} = 732, N_{Kenya} = 606.

Table G59

Percentage of Children Who Have a Birth Certificate or Notification Card

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
Yes	415 (41.5%)	146 (27.8%)	269 (56.6%)
No	561 (56.1%)	357 (68.0%)	204 (42.9%)
Don't know	24 (2.4%)	22 (4.2%)	2 (.4%)

Note: N_{total} = 1000, N_{Zambia} = 525, N_{Kenya} = 475.

Table G60

Percentage of Children Who Have a Birth Certificate or Notification Card, Baseline vs. Endline

	Baseline	Endine	Change
Total	37%	42%	6%
Chibombo	70%	71%	1%
Kafue	33%	63%	30%
Kisumu	23%	48%	25%
Mukuru	15%	26%	9%
Kasarani	22%	38%	15%

Table G61
Reasons Provided for Why Children Were Registered, as Reported at Endline

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
Learned during group parenting session	26 (8.4%)	7 (6.4%)	19 (9.5%)
Learned from CHV during home visit	42 (13.5%)	13 (11.8%)	29 (14.4%)
Advised at health facility	150 (48.2%)	79 (71.8%)	71 (35.3%)
Other	93 (29.9%)	11 (10.0%)	82 (40.8%)

Note: N_{total} = 311, N_{Zambia} = 110, N_{Kenya} = 201.

Table G62

Reasons Provided for Why Children Were Not Registered, as Reported at Endline

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
Don't know	81 (13.8%)	76 (19.8%)	5 (2.5%)
Don't find it necessary to register	36 (6.1%)	25 (6.5%)	12 (5.9%)
Don't know where to register	66 (11.3%)	65 (16.9%)	1 (.5%)
Process is too complicated	83 (14.2%)	38 (9.9%)	45 (22.1%)
Registration center is too far	53 (9.0%)	48 (12.5%)	6 (2.9%)
Was born at home	58 (9.9%)	39 (10.2%)	19 (9.3%)
Other	209 (35.7%)	93 (24.2%)	116 (56.9%)

Note: N_{total} = 586, N_{Zambia} = 384, N_{Kenya} = 204.

Table G63

Percentage of Children Who Have a Health Card

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
Yes	920 (92.4%)	487 (93.5%)	433 (91.2%)
No	62 (6.2%)	21 (4.0%)	41 (8.6%)
Don't know	14 (1.4%)	13 (2.5%)	1 (.2%)

Note: N_{total} = 1000, N_{Zambia} = 525, N_{Kenya} = 475.

Table G64

Where Children Were Taken When They Were Sick

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
Visited health facility immediately	318 (57.7%)	181 (77.0%)	137 (43.4%)
Visited health facility when sickness persisted	79 (14.3%)	20 (8.5%)	59 (18.7%)
Visited health facility after being advised by CHV/CSS	10 (1.8%)	3 (1.3%)	7 (2.2%)
Visited CHV/CSS for treatment	17 (3.1%)	4 (1.7%)	13 (4.1%)
Visited traditional healer	1 (.2%)	1 (.4%)	0
Bought over-the-counter drugs from pharmacy	51 (9.3%)	8 (3.4%)	43 (13.6%)
Administered pain killers to child myself	24 (4.4%)	5 (2.1%)	19 (6.0%)
Other	50 (9.1%)	13 (5.5%)	37 (11.7%)

Note: N_{total} = 551, N_{Zambia} = 235, N_{Kenya} = 316.

Table G65

Sources of Training/Information on What to Do When Child Is Sick

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
Group parenting sessions	246 (34.0%)	60 (14.4%)	186 (60.8%)
CHVs at household	202 (27.9%)	130 (31.2%)	72 (23.5%)
Health facility	229 (31.7%)	198 (47.5%)	31 (10.1%)
Department of Children's Services	3 (.4%)	3 (.7%)	0
Other	43 (5.9%)	26 (6.2%)	17 (5.6%)

Note: N_{total} = 723, N_{Zambia} = 417, N_{Kenya} = 306.

Table G66

Ease in Accessing ECD-Related Services, as Reported at Endline

	Can easily access service (*N*[%])	Have some difficulties (*N*[%])	N/A - never needed service (*N*[%])
		Total	
Early learning	445 (66.7%)	207 (31.0%)	15 (2.2%)
Health	392 (58.8%)	274 (41.1%)	1 (.1%)
HIV support	533 (79.9%)	94 (14.1%)	40 (6.0%)
Nutrition support	413 (61.9%)	238 (35.7%)	16 (2.4%)
Police/justice	389 (58.3%)	202 (30.3%)	76 (11.4%)
Psychosocial	424 (63.6%)	173 (25.9%)	70 (10.5%)
Social welfare	364 (54.6%)	282 (42.3%)	21 (3.1%)
		Zambia	
Early learning	210 (62.9%)	121 (36.2%)	3 (.9%)
Health	202 (60.5%)	132 (39.5%)	0
HIV support	255 (76.3%)	62 (18.6%)	17 (5.1%)
Nutrition support	208 (62.3%)	123 (36.8%)	3 (.9%)
Police/justice	158 (47.3%)	161 (48.2%)	15 (4.5%)
Psychosocial	175 (52.4%)	122 (36.5%)	37 (11.1%)
Social welfare	175 (52.4%)	140 (41.9%)	19 (5.7%)
		Kenya	
Early learning	235 (70.6%)	86 (25.8%)	12 (3.6%)
Health	190 (57.1%)	142 (42.6%)	1 (.3%)
HIV support	278 (83.5%)	32 (9.6%)	23 (6.9%)
Nutrition support	205 (61.6%)	115 (34.5%)	13 (3.9%)
Police/justice	231 (69.4%)	41 (12.3%)	61 (18.3%)
Psychosocial	249 (74.8%)	51 (15.3%)	33 (9.9%)
Social welfare	189 (56.8%)	142 (42.6%)	2 (.6%)

Table G67

Percentage of Caregivers Reporting Difficulty in Accessing ECD-Related Services, as Reported at Baseline and at Endline

	Baseline	Endline	Change
Early learning	60%	31%	-29%
Health	74%	41%	-33%
Nutrition support	80%	36%	-44%
Psychosocial	66%	26%	-40%
Social welfare	78%	42%	-36%

Table G68

Barriers to Accessing Early Learning Services, as Reported at Endline

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
High cost	124 (59.9%)	50 (41.3%)	74 (86.0%)
Long distances	75 (36.2%)	63 (52.1%)	12 (14.0%)
Not enough drugs/supplies	3 (1.4%)	0	3 (3.5%)
Prefer cultural/traditional services	0	0	0
Religious beliefs	1 (.5%)	0	1 (1.2%)
Rude/unfriendly staff	0	0	0
Service not available	23 (11.1%)	19 (15.7%)	4 (4.7%)
Untrained/unskilled staff	0	0	0
Other	28 (13.5%)	13 (10.7%)	15 (17.4%)

Note: $N_{\text{Total}} = 207$, $N_{\text{Zambia}} = 213$, $N_{\text{Kenya}} = 247$.

Table G69

Barriers to Access Early Learning Services, Baseline vs. Endline

	Baseline	Endline	Change
Long distances	17%	36%	19%
High costs	35%	60%	25%
Service not available	9%	11%	2%

Table G70

Barriers to Accessing Health Services, as Reported at Endline

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
High cost	140 (51.1%)	32 (24.2%)	108 (76.1%)
Long distances	158 (57.7%)	110 (83.3%)	48 (33.8%)
Not enough drugs/supplies	34 (12.4%)	11 (8.3%)	23 (16.2%)
Prefer cultural/traditional services	0	0	0
Religious beliefs	1 (.4%)	0	1 (.7%)
Rude/unfriendly staff	9 (3.3%)	4 (3.0%)	5 (3.5%)
Service not available	27 (9.9%)	9 (6.8%)	18 (12.7%)
Untrained/unskilled staff	6 (2.2%)	4 (3.0%)	2 (1.4%)
Other	41 (15.0%)	15 (11.4%)	26 (18.3%)

Note: $N_{\text{Total}} = 274$, $N_{\text{Zambia}} = 202$, $N_{\text{Kenya}} = 142$.

Table G71

Barriers to Accessing Health Services, Baseline vs. Endline

	Baseline	Endline	Change
High cost	52%	51%	-2%
Long distances	51%	58%	7%
Not enough drugs/supplies	24%	12%	-12%
Prefer cultural/traditional services	1%	0%	-1%
Religious beliefs	1%	0%	-1%
Rude/unfriendly staff	0%	3%	3%
Service not available	10%	10%	0%
Untrained/unskilled staff	2%	2%	0%

Table G72

Barriers to Accessing HIV Support Services, as Reported at Endline

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
High cost	8 (8.5%)	3 (4.8%)	5 (15.6%)
Long distances	49 (52.1%)	41 (66.1%)	8 (25.0%)
Not enough drugs/supplies	8 (8.5%)	1 (1.6%)	7 (21.9%)
Prefer cultural/traditional services	0	0	0
Religious beliefs	1 (1.1%)	0	1 (3.1%)
Rude/unfriendly staff	1 (1.1%)	0	1 (3.1%)
Service not available	34 (36.2%)	21 (33.9%)	13 (40.6%)
Untrained/unskilled staff	0	0	0
Other	9 (9.6%)	1 (1.6%)	8 (25.0%)

Note: $N_{\text{Total}} = 94$, $N_{\text{Zambia}} = 62$, $N_{\text{Kenya}} = 32$.

Table G73

Barriers to Accessing Nutrition Support Services, as Reported at Endline

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
High cost	122 (51.3%)	47 (38.2%)	75 (65.2%)
Long distances	37 (15.5%)	34 (27.6%)	3 (2.6%)
Not enough drugs/supplies	2 (.8%)	0	2 (1.7%)
Prefer cultural/traditional services	0	0	0
Religious beliefs	0	0	0
Rude/unfriendly staff	0	0	0
Service not available	77 (32.4%)	46 (37.4%)	31 (27.0%)
Untrained/unskilled staff	3 (1.3%)	1 (9.8%)	2 (1.7%)
Other	28 (11.8%)	8 (6.5%)	20 (17.4%)

Note: $N_{\text{Total}} = 238$, $N_{\text{Zambia}} = 123$, $N_{\text{Kenya}} = 115$.

Table G74

Barriers to Accessing Nutrition Support Services, Baseline vs. Endline

	Baseline	Endline	Change
High cost	9%	51%	42%
Long distances	25%	16%	9%
Not enough drugs/supplies	1%	1%	0%
Religious beliefs	1%	0	-1%
Service not available	51%	32%	-19%
Untrained/unskilled staff	1%	1%	0%

Table G75

Barriers to Accessing Police/Justice Services, as Reported at Endline

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
High cost	42 (20.8%)	35 (21.7%)	7 (17.1%)
Long distances	148 (73.3%)	139 (86.3%)	9 (22.0%)
Not enough drugs/supplies	0	0	0
Prefer cultural/traditional services	2 (1.0%)	1 (.6%)	1 (2.4%)
Religious beliefs	1 (.5%)	1 (.6%)	0
Rude/unfriendly staff	9 (4.5%)	1 (.6%)	8 (19.5%)
Service not available	55 (27.2%)	49 (30.4%)	6 (14.6%)
Untrained/unskilled staff	6 (3.0%)	1 (.6%)	5 (12.2%)
*Other	23 (11.4%)	5 (3.1%)	18 (43.9%)

Note: $N_{\text{Total}} = 202$, $N_{\text{Zambia}} = 161$, $N_{\text{Kenya}} = 41$.

Table G76

Barriers to Accessing Psychological Services, as Reported at Endline

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
High cost	8 (4.6%)	5 (4.1%)	3 (5.9%)
Long distances	35 (20.2%)	31 (25.4%)	4 (7.8%)
Not enough drugs/supplies	1 (.6%)	1 (.8%)	0
Prefer cultural/traditional services	0	0	0
Religious beliefs	1 (.6%)	0	1 (2.0%)
Rude/unfriendly staff	0	0	0
Service not available	132 (76.3%)	88 (72.1%)	44 (86.3%)
Untrained/unskilled staff	1 (.6%)	1 (.8%)	0
*Other	8 (4.6%)	4 (3.3%)	4 (7.8%)

Note: $N_{\text{Total}} = 173$, $N_{\text{Zambia}} = 122$, $N_{\text{Kenya}} = 51$.

Table G77

Barriers to Accessing Social Welfare Services, as Reported at Endline

	Total *N* (%)	Zambia *N* (%)	Kenya *N* (%)
High cost	80 (28.4%)	14 (10.0%)	66 (46.5%)
Long distances	119 (42.2%)	67 (47.9%)	52 (36.6%)
Not enough drugs/supplies	1 (.4%)	0	1 (.7%)
Prefer cultural/traditional services	0	0	0
Religious beliefs	0	0	0
Rude/unfriendly staff	10 (3.5%)	0	10 (7.0%)
Service not available	115 (40.8%)	80 (57.1%)	35 (24.6%)
Untrained/unskilled staff	4 (1.4%)	1 (.7%)	3 (2.1%)
Other	73 (25.9%)	19 (13.6%)	54 (38.0%)

Note: $N_{\text{Total}} = 282$, $N_{\text{Zambia}} = 140$, $N_{\text{Kenya}} = 142$.

Table G78

Barriers to Accessing Social Welfare Services, Baseline vs. Endline

	Baseline	Endline	Change
High cost	14%	10%	-4%
Long distances	22%	48%	24%
Not enough drugs/supplies	10%	0%	-10%
Rude/unfriendly staff	3%	4%	1%
Service not available	38%	41%	3%
Untrained/unskilled staff	1%	1%	0%

Table G79

Percentage of caregivers who are able to access ECD-related services by household well-being ranking

	Can easily access service % (*N*)	Has difficulties % (*N*)
	Early learning	
Struggling almost all the time	63.1% (142)	36.9% (83)
Life is hard, sometimes struggling	67.0% (227)	33.0% (112)
Coping most the time	86.1% (68)	13.9% (11)
Coping well almost all the time	88.9% (8)	11.1% (1)
	Health	
Struggling almost all the time	51.3% (117)	48.7% (111)
Life is hard, sometimes struggling	60.7% (212)	39.3% (137)
Coping most the time	67.5% (54)	32.5% (26)
Coping well almost all the time	100% (9)	0
	Nutrition support	
Struggling almost all the time	56.4% (127)	43.6% (98)
Life is hard, sometimes struggling	64.8% (219)	35.2% (119)
Coping most the time	73.4% (58)	26.6% (21)
Coping well almost all the time	100% (9)	0
	Police/justice	
Struggling almost all the time	64.2% (131)	35.8% (73)
Life is hard, sometimes struggling	61.4% (186)	38.6% (117)
Coping most the time	85.3% (64)	14.7% (11)
Coping well almost all the time	88.9% (8)	11.1% (1)

Table G80

ECD-Related Services Requested by Caregivers

	Total *N*(%)	Zambia *N*(%)	Kenya *N*(%)
Home visits	341 (51.1%)	231 (75.1%)	90 (27.0%)
Parenting groups	266 (39.9%)	104 (31.1%)	162 (48.6%)
Parenting training	148 (22.2%)	79 (23.7%)	69 (20.7%)
Keeping children safe	134 (20.1%)	66 (19.8%)	68 (20.4%)
Information on feeding children	128 (19.2%)	71 (21.3%)	57 (17.1%)
Health checks	113 (16.9%)	56 (16.8%)	57 (17.1%)
Programs for disabled children	42 (6.3%)	18 (5.4%)	24 (7.2%)
Accessing identification cards	41 (6.1%)	17 (5.1%)	24 (7.2%)
Other	95 (14.2%)	46 (13.8%)	49 (14.7%)

Table G81

Chi-Square Analyses Between Caregiver Well-Being and Country

	df	*N*	χ^2	*p*
Faces challenge in self-care	1	667	11.61	.001**
Challenges faced				
Financial strain	1	547	36.34	.00**
Balance between work and care for the baby	1	547	4.51	.03*
Stress resulting from caring for the baby	1	547	1.41	.24
Lack of services to support caregivers on handling their challenges	1	547	.58	.45
Caregiver illness	1	547	.22	.64
Unsupportive partner	1	547	1.96	.16
Inability to make decision in the household	1	547	.68	.41
Low self-esteem	1	547	.11	.74
Gender-based violence	1	547	.17	.68
Intimate partner violence	1	547	.89	.35
Stigma for being HIV-positive	1	547	.67	.41
Other	2	547	31.15	.00**
Feel that don't have enough time for self because of time spent with child	3	552	17.00	.001**
Feel stressed between caring for child and trying to meet other family/work responsibilities	3	552	24.49	.00**

Table G82

ChildFund National Offices Organizational Self-Assessment

Completely True	Largely achieved	Half way there	Some progress	No progress	Not applicable	Don't know

	Zambia baseline	*Zambia Endline*	*Kenya baseline*	*Kenya Endline*
Leadership				
A vision and/or mission has been developed with the staff and the Board, and everyone is reasonably happy with it .				
We have developed an annual plan - this was done with the involvement of staff and other stakeholders, and the plan generally guides our activities.				
Our annual budget is linked to this plan				
There is a Board of Trustees / Executive Committee that plays a useful role in the organisation. There are regular meetings and most members attend regularly The meetings are minuted.				
Members of the Board regularly review the budget against actual spending.				
Major decisions are made with the involvement of the Board / EXCO, and other important decisions are made by the Founder / Director, who usually consults with staff.				
Programmes				
We usually conduct a needs analysis before starting new project activities.				
We consult with our key stakeholders and with the community before designing a new project, as well as during implementation.				
We see our target group as more than just disadvantaged or needy recipients of our project, and as having an increasingly active role in designing and implementing activities.				
We understand the need to deliver projects in a lasting/sustainable way, and we are testing ways of doing this.				
Management				
We have standard written employment contracts for all the staff, and volunteers also have agreements spelling out what they have to do.	Staff Volunteers		Staff Volunteers	
We have a few basic policies that cover things like staff leave, personal phone calls etc.				
We have a proper filing system for keeping files and records, and generally things can be found when they are needed.				
We have enough basic office equipment to do our job effectively.				
We have one admin staff member who makes sure the office is always open, answers the phones and deals with the administration and management of the office.				
Learning				
We do monitor, review and document our activities, with the aim of assessing our impact and improving our projects.				

We regularly measure our progress against indicators and milestones, and we do this to improve our performance.				
We try to build on our successes and learn from our failures, and use our learning to help build for the future.				
~~A~~ttend courses and workshops that we think will be useful - we debrief after these workshops and use the knowledge and information gained to improve our activities.				
We are members of a network organisation and actively participate in some of their activities.				
We try and learn from each other and others, and from our successes and failures, and have some information-sharing sessions in the office and with our partner.				
Resources				
We have secured donor funds for more than one year, and we are not solely dependent on donor funding.				
We raise a considerable proportion of our resources locally, whether this is funding or other benefits-in-kind, or other donations of equipment/supplies.				
There is at least one bank or postal account and we review and keep all our statements.				
We have a system for handling money and there are procedures for requesting and making payments.				
When we have funds we use them for the purpose for which they were intended and in line with the budget.				

Table G83
Local Partners' Self-Assessment - Zambia

Completely True	Largely achieved	Half way there	Some progress	No progress	Not applicable	Don't know

	CCDA baseline	CCDA Endline	KCDA baseline	KCDA Endline
Leadership				
Do you have a vision and mission? Was it made with participation?				
Do you have an annual plan? Were people consulted?				
Our budget is linked to our annual plan				
Do you have an effective board? Does it meet regularly?				
Programmes				
We work together with CSSs and stakeholders when decided what to do.				
Households help us to decide what to do.				
We think about sustainability when we decide what to do.				
Management				
Everyone has a contract				
We have staff management policies (e.g. leave)				
We have a filing system, and can always find our documents				
We have enough basic office equipment to do our job effectively				
Someone is always in the office to answer the phone and keep the door open				
Learning				
We record our activities. We also measure if they are actually working.				
We look at our data when we plan each year and more often to make programming decisions.				
Our staff and volunteers can sometimes go for training as needed. They get enough training to do their job.				
We are members of a network organization and actively participate in some of their activities				
We often talk to each other and stakeholders about project, progress and problems, and learn together. We change what we do based on this.				
We record our activities. We also measure if they are actually working.				
Resources				
We have funding for the next year				
We have more than one donor				
Some of our sponsors (in cash/kind) are local				
We have a bank account				
We have a system for handling money and there are procedures for requesting and making payments				

Table G84

Local Partners' Self-Assessment: Kenya

Completely True	Largely achieved	Half way there	Some progress	No progress	Not applicable	Don't know

	KDP baseline	KDP endline	LVSCP baseline	LVSCP endline	MCWC baseline	MCWC Endline	NIP baseline	NIP Endline
Leadership								
Do you have a vision and mission? Was it made with participation?								
Do you have an annual plan? Were people consulted?								
Our budget is linked to our annual plan								
Do you have an effective board? Does it meet regularly?								
Programmes								
We work together with CSSs and stakeholders when decided what to do.								
Households help us to decide what to do.								
We think about sustainability when we decide what to do.								
Management								
Everyone has a contract								
We have staff management policies (e.g. leave)								
We have a filing system, and can always find our documents								
We have enough basic office equipment to do our job effectively								
Someone is always in the office to answer the phone and keep the door open								
Learning								
We record our activities. We also measure if they are actually working.								
We look at our data when we plan each year and more often to make programming decisions.								

	KDP baseline	KDP endline	LVSCP baseline	LVSCP endline	MCWC baseline	MCWC Endline	NIP baseline	NIP Endline
Our staff and volunteers can sometimes go for training as needed. They get enough training to do their job.								
We are members of a network organization and actively participate in some of their activities								
We often talk to each other and stakeholders about project, progress and problems, and learn together. We change what we do based on this.								
We record our activities. We also measure if they are actually working.								
Resources								
We have funding for the next year								
We have more than one donor								
Some of our sponsors (in cash/kind) are local								
We have a bank account								
We have a system for handling money and there are procedures for requesting and making payments								