Endline Evaluation of the *Moments That Matter*® Program in Western Kenya: Evidence from a cluster-randomized controlled trial and qualitative process evaluation

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

Evaluation Overview

The *Moments That Matter*® (MTM) partnership program is a community-led, multi-component parenting intervention designed to empower and support caregivers of children aged 0-3 years in vulnerable rural communities in Western Kenya. The program primarily trains change agents, Early Childhood Development (ECD) Promoters, ECD Committees, and faith leaders, to facilitate social and behavior change with caregivers to enhance their nurturing care parenting knowledge, skills, and wellbeing and in turn improve ECD outcomes. Implemented by Episcopal Relief & Development in partnership with ACK Development Services – Nyanza (ADS-Nyanza) and ADS Western, in this cycle MTM tested an 18-month, 36 dose program model variation that combines monthly Caregiver Support & Learning Group (CSLG) sessions with individualized home visits.

This evaluation assessed the effectiveness and implementation quality of MTM at endline using a mixed-methods approach that combined a cluster-randomized controlled trial (RCT) and qualitative process evaluation. The specific research questions were:

1. What is the effectiveness of the program for improving early child development and caregiving outcomes?
2. How was the program implemented, and what factors influenced its quality and effectiveness?

The impact evaluation enrolled 595 primary caregiver-child dyads across 51 villages in Borabu subcounty (Nyamira County) and Luanda subcounty (Vihiga County). Quantitative surveys were administered to primary caregivers at baseline and endline, with additional direct assessments of ECD at endline. The process evaluation included in-depth interviews with 54 respondents (ECD Promoters, faith leaders, and caregivers) and 4 focus group discussions with ECD Committee members to examine program implementation and the underlying factors influencing program delivery and quality.

Key Findings

The impact evaluation revealed a wide range of positive outcomes across domains of nurturing care and caregiver wellbeing. MTM significantly improved primary caregiver stimulation, availability of early learning materials in the home, child dietary diversity, and social support. MTM also significantly reduced caregivers' use of harsh discipline, experiences of intimate partner violence, parenting stress, and depressive symptoms. Beyond the primary caregiver, MTM also significantly enhanced male caregiver involvement in terms of increased child stimulation and participation in household chores and reduced use of harsh discipline.

In the overall study sample, MTM led to small improvements in ECD outcomes, though most were only marginally statistically significant ($p<0.1$), with the exception of small but

significant gains in child socioemotional development. Notably, a key finding from our impact evaluation was the clear variation in effects on ECD outcomes by county: MTM had large, positive, and statistically significant impacts ($p<0.05$) on ECD outcomes in Nyamira, whereas the effects in Vihiga were consistently null.

The qualitative process evaluation unpacked aspects of fidelity and stakeholders' experiences in the program. ECD Promoters and faith leaders were recognized as important and effective agents of the program and largely carried out their roles with high fidelity and good quality. Change agents and caregivers valued the program content and the various components of the program, including CSLGs, home visits, Savings & Loan (S&L) Groups, and ECD Committees. Barriers to implementation included limited male participation despite outreach efforts trying to engage men, competing responsibilities for female caregivers that hindered consistent participation in group sessions, unmet expectations for financial incentives shaped by exposure to other programs, restrictive social norms, and limited availability of faith leaders due to other commitments. Enablers included the introduction of S&L Groups, the incorporation of diverse behavior change techniques during the sessions, and strong collaboration between change agents.

Implications and Conclusion

The evaluation provides several insights to guide future improvements and strategic decisions. High fidelity of program delivery and strong participant engagement contributed to the effectiveness of ECD Promoters and faith leaders. However, faith leader involvement varied within and across communities, and was not standardized. Enhancing their role clarity and providing necessary resources could amplify their impact on caregiving and ECD outcomes. Despite noted economic boosts from S&L Group and kitchen garden participation, financial concerns among caregivers were a persistent issue; addressing these could enhance program engagement and effectiveness.

Despite MTM's core focus on parenting—particularly early learning and responsive caregiving—and its relatively long 18-month duration, its effects on parental engagement and ECD were smaller than typically observed in the broader evidence on parenting interventions in sub-Saharan Africa. These findings may suggest a need to reexamine how responsive caregiving and parent-child interactions are addressed and promoted in the program, and whether sufficient emphasis is placed on enhancing responsive caregiving – specifically, a caregiver's ability to notice, interpret, and respond appropriately to their child's signals. Given that these behaviors are among the strongest predictors of ECD outcomes, refining how they are supported and reinforced within the program could help maximize effects on these outcomes.

One of the most striking findings was the variation in MTM's effectiveness by county, and particularly for ECD outcomes. While ECD outcomes improved significantly in Nyamira, the effects in Vihiga were consistently null. This difference in effectiveness appears to be driven by a combination of contextual and implementation-related factors. Nyamira benefited from a

more experienced implementing partner (ADS-Nyanza), who had prior experience delivering MTM in Western Kenya and likely a deeper understanding of its components. In contrast, the implementing partner in Vihiga (ADS-Western) was new to MTM and may have needed additional support to implement the intervention effectively. Differences in household wealth and education may have also influenced program engagement, as baseline indicators showed that households in Vihiga were generally poorer than those in Nyamira. This highlights the importance of understanding contextual factors and closely monitoring process indicators throughout implementation. By doing so, program teams can identify implementation challenges early, make necessary refinements, and provide targeted support to enhance parenting outcomes consistently across project sites.

In conclusion, MTM has demonstrated substantial positive effects on nurturing care and family wellbeing universally, and ECD outcomes specifically in one of the two project sites. The insights from this evaluation offer a roadmap for refining and scaling the program, not only in Kenya but also in other sub-Saharan African settings where the program is being implemented.

INTRODUCTION

Early childhood development and parenting programs

Early childhood development (ECD) comprises of young children's cognitive, language, motor, and socioemotional skills, which are critical for laying the foundation for a host of later life outcomes, including health, education, psychosocial wellbeing, and economic productivity (Heckman, 2006). However, it has been estimated that 250 million or approximately 43% of children under five years are at risk of not attaining their early developmental potential (Lu, Black, & Richter, 2016). The regional burden of poor ECD is the greatest in sub-Saharan Africa (Lu et al., 2016).

Various factors can contribute to poor child development, including poverty, malnutrition, infectious diseases, limited access to maternal and child health services, and sub-optimal parenting practices (Walker et al., 2011). Early interventions that reduce these risk factors while bolstering protecting factors are critical for promoting healthy ECD, especially in low-resource settings (Black et al., 2017). One of the most effective evidence-based strategies for improving ECD outcomes are parenting interventions (Britto et al., 2017). Parenting interventions are social and behavioral programs intended to improve primary caregivers' knowledge, attitudes, practices, and skills pertaining to supporting children's development. For example, parenting interventions can range in terms of increasing stimulation, building attachment and parental sensitivity and responsiveness, toy making and providing other early learning materials for children, improving child behavior management, or maltreatment prevention and using non-violent positive disciplinary practices.

Several systematic reviews and meta-analyses have consistently documented the effectiveness of parenting interventions on early child development outcomes in diverse settings around the world (Britto et al., 2017; Pedersen et al., 2019; Zhang et al., 2021). Meta-analyses have further showcased how parenting programs can achieve significantly greater effects in low- and middle-income countries than in high-income countries (Jeong, Franchett, Ramos de Oliveira, Rehmani, & Yousafzai, 2021). However, most of the parenting interventions evaluated in low- and middle-income countries are concentrated among a small subset of countries. For example, as noted in the most recent and comprehensive systematic review, most randomized controlled trials of parenting interventions to date have been conducted in Bangladesh (8 trials), Jamaica (6 trials), and India (5 trials) (Jeong et al., 2021). Consequently, much less is known about the effectiveness and implementation quality of parenting interventions in other country contexts, especially across sub-Saharan Africa.

While most parenting programs to date have relied on a single workforce – such as community health workers, NGO staff, or volunteer caregivers – to engage with caregivers, alternative delivery models may offer additional benefits. In particular, faith leaders are trusted community figures with significant influence on parenting, child development, and family well-being across many LMIC settings, yet they remain largely underutilized in parenting programs (Petro et al., 2018). A multi-agent approach that engages both trained volunteers and existing community leaders, like faith leaders, could enhance program sustainability and impact by leveraging multiple sources of support for caregivers and expanding the reach of such a program. However, such multicomponent and multi-delivery agent approaches can also introduce potential implementation challenges, including the need for greater coordination, additional training, and oversight to ensure that all components are effectively integrated and are delivered efficient and with high-quality.

Kenyan context

In Kenya, early childhood development is both a national priority and a pressing challenge. National data have estimated that between 22% to 45% of preschool-aged children are potentially off-track in their early development (KNBS & ICF, 2023; McCoy et al., 2016). In response to this national challenge, parenting programs during early childhood have gained increasing attention as a national strategy to improve child development outcomes. However, there remains limited rigorous evidence in Kenya.

In Kenya, there are only three known prior implementation research studies that have evaluated the effectiveness of parenting interventions on ECD outcomes. To briefly summarize this evidence, one study trained community health volunteers to deliver a parenting intervention through 16 fortnightly community group meetings and 4 home visits over 7 months to mothers of children 6–24 months in the sub-counties of East Rachuonyo, South Rachuonyo, and Sabatia in western Kenya (Luoto et al., 2021). Using a randomized controlled trial (RCT) design, the researchers found that the interventions significantly improve child cognitive development, receptive language, and socioemotional scores along with maternal parenting knowledge and practices. Another study used community health volunteers to deliver a cognitive-behavioral, group-based intervention (14 fortnightly sessions over 7 months and 5 follow-up booster sessions over 6 months) to pregnant women and mothers of children under age 2 with the aim of addressing maternal mental health and the socio-emotional development of young children in two sub-counties in Siaya County (Kim et al., 2021). Using a quasi-experimental study design, the researchers found that intervention did not significantly reduce maternal depression or improve children's social and emotional development. Finally, the African Population and Health Research Center (APHRC) conducted a study evaluating an earlier version of *Moments that Matter*® (MTM), an early childhood development program led by Episcopal Relief &

Development and implemented in Kenya by ACK Development Services (ADS) Nyanza (Kitsao-Wekulo, 2021). In collaboration with faith leaders, trained ECD volunteers facilitated monthly group meetings and home visits to pregnant mothers or primary caregivers with children 0-18 months over 24 months in the Nyando sublocation of Kisumu County. Using a quasi-experimental design, the researchers found improvements in maternal stimulation but no differences in child development outcomes. Overall, however, this body of evidence remains limited and relatively weak from a methodological perspective, as most studies have not used randomized controlled trial (RCT) designs. Without RCTs, it is more difficult to establish causal relationships between the interventions and observed outcomes, as findings may be influenced by unmeasured confounding factors or selection bias. Additionally, the lack of a well-matched and rigorously defined control group in quasi-experimental studies makes it difficult to determine whether observed changes result from the intervention itself or from pre-existing differences between the groups or other external factors.

Taken together, this limited and inconclusive evidence base underscores the need for further research, particularly using rigorous experimental designs. Following the APHRC evaluation, Episcopal Relief & Development decided to test a shorter duration/lower dosage program by shortening its duration from 24 months to 18 months and dosage from 48 to 36 program contacts per caregiver. The 18/36 variation was also tested in Mozambique and Zambia. This decision was driven by several factors, including the evaluation results that suggested effectiveness by 12 months, the need for greater efficiency and cost-effectiveness. At the same time, ERD prioritized the 18-month model over a shorter duration to align with broader goals such as preparing for community ownership, integrating S&L Groups, and promoting social cohesion, all considered critical for peer-to-peer promotion and long-term sustainability. Evaluating this updated program model presents a valuable opportunity to assess its effectiveness and contribute to this limited evidence base on parenting interventions in Kenya.

The *Moments That Matter*® An ECD Partnership Program

Moments That Matter® (MTM) is a community-led, multi-component parenting intervention designed to support caregivers of children aged 0-3 years in vulnerable rural communities and aims to improve ECD. In Kenya, MTM is implemented through a program partnership involving Episcopal Relief & Development and the ACK Development Services – Nyanza (ADS-Nyanza) in Nyamira and ADS Western in Vihiga. ADS Nyanza has been implementing MTM since 2019; ADS Western implemented its first program as part of MTM with this research study cohort, beginning in 2023. The program is based on the Nurturing Care Framework and operates on the premise that strengthening nurturing care holistically and enhancing caregivers' knowledge, skills, and mental well-being – and specifically increasing

primary caregivers' nurturing parenting practices – will lead to improved cognitive, language, motor, and socioemotional development in children.

Specifically, MTM has a particular emphasis on three components of the Nurturing Care Framework – responsive caregiving, early learning, and child safety and security – with multiple sessions in the curriculum dedicated to these domains and practical strategies caregivers can use in daily life. As defined by the Nurturing Care Framework, responsive caregiving refers to the ability of the parent/caregiver to notice, understand, and respond to their child's signals in a timely and appropriate manner (Black et al., 2017). It is considered the foundational component of nurturing care, as it enables caregivers to better support children across other developmental domains. Early learning refers to a range of experiences and forms of engagement—with people, objects, or the environment—that support children's cognitive and socioemotional development, including playing (with or without objects), social interactions with peers or adults, and learning through guided instruction. Child safety and security refers to ensuring that children grow up in safe and secure environments, which includes protection from physical harm, emotional stress, and access to essentials like food and clean water. The program curriculum also integrates caregiver mental health, family violence prevention, and male caregiver engagement, recognizing these as critical determinants of ECD as well. Social and behavior change strategies and communication tools are used throughout the program to facilitate learning and encourage sustained practice of nurturing care behaviors. The curriculum includes the use of Fact-Association-Meaning-Action (FAMA) picture cards and facilitation of learning-action dialogues.

MTM follows an 18-month hybrid delivery model, combining monthly primary Caregiver Support & Learning Group (CSLG) sessions with individualized monthly ECD home visits, resulting in a total of 36 program contacts per primary caregiver. At the outset of the program, 13 primary caregivers are enrolled per group and receive counseling from a given ECD Promoter. While MTM primarily targets mothers and others who are the primary caregivers (who are most often women), the program tries to actively encourage male caregivers (i.e., fathers) to participate in group sessions or home visits alongside the primary caregiver. By promoting male caregiver engagement, the program seeks to challenge restrictive gender norms, fostering more equitable caregiving roles and enriching male caregiver-child interactions.

MTM employs a multi-pronged approach to drive change. The main change agents of MTM are ECD Promoters, who are volunteers recruited and trained specifically for this program. The learner-centered training investments and materials (e.g., facilitator guides, sermon guides) equips ECD Promoters and faith leaders alike to lead the program's social and behavior change work. ECD Promoters are the lead change agent in conducting monthly ECD home visits and monthly Caregiver Support & Learning Group (CSLG) sessions. In addition to the ECD Promoters, MTM- trained faith leaders are mobilized to promote nurturing care and ECD through leveraging their existing religious leadership roles and congregations to mobilize the broader enabling environment. In addition to the monthly home visits and CSLG sessions that

primarily focus on nurturing care and ECD, member-run Savings & Loan (S&L) Groups are introduced starting in month six of the program, offering participating caregivers as well as other community members the opportunity to join self-managed savings groups that provide access to revolving microloans and education about savings. These member-run groups not only promote financial literacy and economic stability but also serve as a crucial indirect mechanism for reducing financial stress and enhancing caregivers' capacity to provide nurturing care. For the S&L Groups, separate facilitators (i.e., community volunteers also known as Savings with Education (SwE) Facilitators) are recruited and trained to oversee this aspect of the program. Also, around month six of the program, nutrition activities are introduced, including counseling on kitchen garden construction and cooking demonstrations. These activities can be flexibly integrated, such as into CSLG sessions, S&L Group meetings, or home visits. They may be delivered by ECD Promoters, program staff, in partnership with local government ministries, or a designated point person, such as a "mentor farmer". Finally, at the sub-location level, ECD Committees are also established to strengthen community-based nurturing care systems. The ECD Committees are composed of a diverse group of community leaders and representatives from government ministries and are responsible for championing nurturing care, facilitating referrals for children and families, and ultimately over time, taking ownership and ensuring sustainability of MTM.

By combining direct caregiver education and behavior change facilitation, peer support, home-based counseling, financial empowerment, and community-wide mobilization through ECD Promoters, faith leaders, and ECD Committees, MTM leverages multiple pathways to achieve its intended impact. Through these interconnected pathways, the program aims to empower caregivers' knowledge, practices, confidence, and resources while mobilizing communities to promote nurturing care and, in turn, improve ECD and ensure young children thrive (Figure 1).

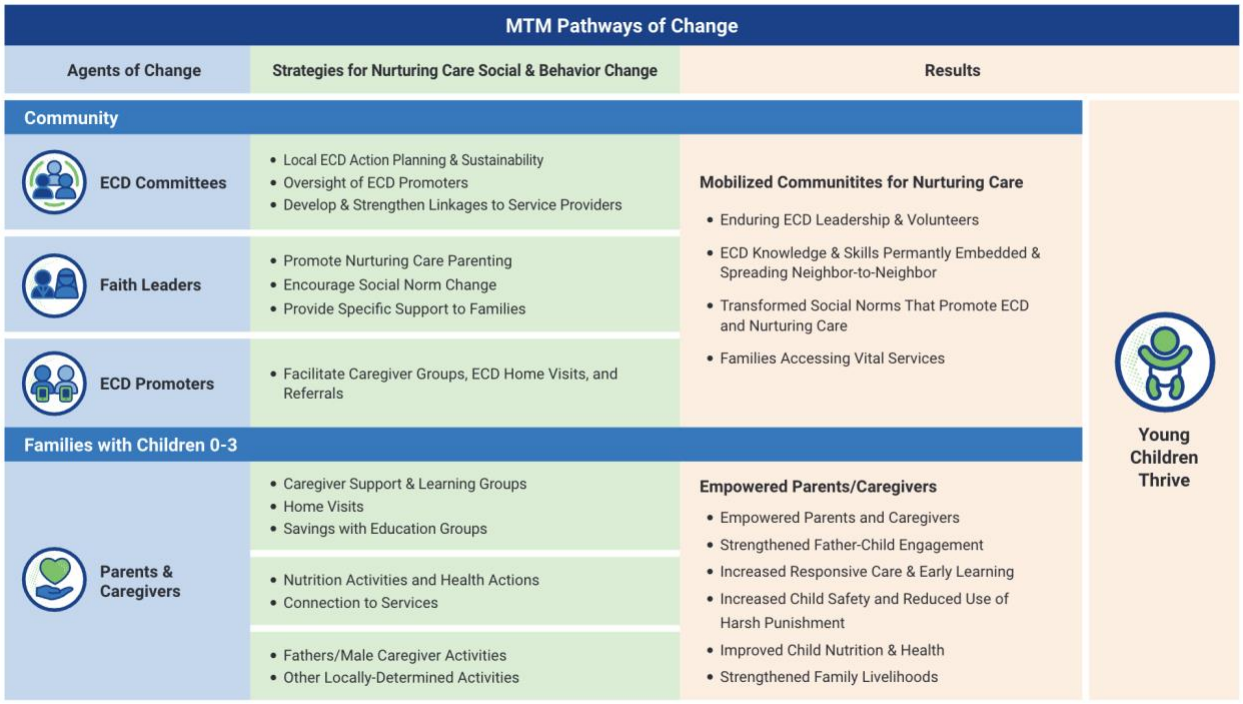


Figure 1. MTM logic model as developed by Episcopal Relief & Development.

Objectives of the evaluation

We conducted a mixed-methods impact and process evaluation to evaluate the effectiveness and implementation of MTM at endline. The specific research questions of our evaluation were:

1. What is the effectiveness of MTM for improving early child development and caregiving outcomes?
2. How was MTM implemented, and what implementation factors influenced the quality and effectiveness of the program?

For the impact evaluation, we designed a cluster-randomized controlled trial with half of the villages randomly assigned to the intervention while another half received the standard-of-care and served as the control group. Primary caregivers and one index child aged 0-18 months at the time of recruitment were enrolled into the trial. Quantitative surveys were administered to caregivers at baseline and then repeated at endline. At endline, we also conducted direct assessments of ECD using an additional measurement tool. A third round of data collection, or 6-month after endline, will also be conducted in May 2025 and reported on later.

For the process evaluation, we conducted in-depth interviews with various stakeholders involved in the implementation of MTM as well as participating caregivers themselves. The interviews explored change agents and caregiver roles, experiences, and perceptions of the program, the barriers and enablers to program delivery, and suggested recommendations for improving program quality, impact, and scalability. Together, the impact and process evaluations will provide a comprehensive picture regarding whether, why, and how the program may have influenced ECD and caregiving outcomes and can inform specific strategies to refine and enhance MTM for future iterations.

METHODS

This evaluation was designed and led by Emory University. The data collection was overseen and managed by B&M Consult, a local research firm in Kenya. Below, we present the study methodology in two parts: first, the impact evaluation at endline, followed by the endline process evaluation. The overall study protocol received ethics approvals from Emory University (Protocol #: STUDY00007935) and the Jaramogi Oginga Odinga Teaching and Referral Hospital – Institutional Scientific Ethics Review Committee (Protocol #: ISERC/JOOTRH/684/22). All research participants provided written informed consent.

Impact evaluation

Study design and sampling

We designed a cluster randomized controlled trial to evaluate the effectiveness of a parenting intervention on early child development and caregiving outcomes. Through a consultative process between the program team and local stakeholders, Borabu subcounty in Nyamira county and Luanda subcounty in Vihiga county were selected as the specific project locations based on these sites having some of the poorest maternal and child health indicators. Within each of the two selected subcounties, the research team randomly selected 4 sub-locations and randomly assigned them to the intervention versus control group. After selecting the sublocations in the study, we then randomly selected 5-6 villages within each sublocation. Finally, we enrolled 13 primary caregivers and their index child in each village, matching the intended group size of the program.

Inclusion criteria for eligibility into the research study included: primary caregivers must have a child aged 0-18 months; the household resides within the geographic boundary of the given research sublocations that were selected into the study; and primary caregiver provides informed consent for themselves and their child under the age of 18 months to participate. Exclusion criteria were teenage caregivers under the age of 18 years (i.e., not legally considered adults) or households in which children were older than 18 months of age.

This sampling plan was guided by a formal sample size calculation, which determined that 285 primary caregiver-child dyads were needed per study arm (570 total between the intervention and control groups). This sample size calculation accounted for up to 20% household attrition at endline, which may foreseeably occur due to various reasons such as families relocating or even dropping out. The sample size calculation was powered specifically to detect a 0.25 standard deviation difference in the primary ECD outcome between the

intervention and control arms. A 0.25 standard deviation difference is considered the minimum meaningful effect size for intervention benefits on ECD outcomes in the field. A recent systematic review indicates that parenting programs in LMICs achieve an average effect size of 0.40 standard deviations on ECD outcomes.

Data collection process

Quantitative data from caregivers and children were collected at baseline, and the same caregiver-child dyads were reassessed at endline. Both data collection rounds followed a similar structure, including enumerator training, piloting, and field implementation. We partnered with B&M Consult to hire and co-train 12 enumerators and 2 supervisors, who were divided into two teams of six enumerators and one supervisor each per County. Training sessions covered key topics such as effective interviewing skills, research ethics, electronic data collection, and a detailed review of each module of the survey tool covering various measures on parenting and ECD. The training weeks were divided to include in-class trainings and field piloting, with daily debriefs and feedback led by the Emory team. Baseline training took place in Kisumu from February 15-22, 2023, and baseline data collection was conducted between February 23 and March 10, 2023. Endline training was primarily conducted from October 30-November 12, 2024 with data collection from November 13-25, 2024.

All quantitative data were collected using Android mobile devices via ODK or KoboToolbox. Survey administration time ranged from 1–2 hours per household, depending on the child's age, as older children required a longer section of the ECD assessments. At the end of each day, supervisors reviewed completed interviews, identified cases requiring follow-ups, and updated the interview trackers to monitor progress. Overall baseline and endline data collection were conducted in close coordination between B&M and ADS project staff in Nyamira and Vihiga to develop a detailed day-by-day plan for effectively reaching caregivers. Data were collected at a central community location in Nyamira. This involved collaborating with ECD Promoters and community health promoters for caregiver mobilization, field accompaniment, verifying household eligibility, or locating caregivers for follow-ups.

A total sample of 595 caregiver-child dyads across 51 villages were recruited into the trial and completed baseline assessments. For endline data collection in November 2024, we were able to revisit and reassess 425 caregivers from the original trial cohort from whom we had baseline data. This represented 71% of the original trial cohort (see Table 1). This endline follow-up rate was lower than the 80% retention rate anticipated in our original sample size calculations. The main reasons for missing caregiver interviews or child assessments included caregiver dropout and replacement, temporary absence (e.g., caregiver attending funeral or visiting relatives for the holidays), or unreachability despite multiple attempts by phone and in-

person. Slightly more caregivers were lost to follow-up in Nyamira compared to Vihiga and in the intervention group compared to control group.

Table 1. Caregivers from the originally enrolled RCT cohort that were reassessed during endline data collection in November 2024.

	Nyamira	Vihiga	Total
Intervention	106/154=69%	112/156=72%	218/310=70%
Control	98/143=69%	109/142=77%	207/285=73%
Total	204/297=69%	221/298=74%	425/595=71%

It is worth contextualizing how our data collection was done at the end of November, which may have been a more challenging time of the year when many caregivers had already left the villages to go to their extended family homes or relatives for the long holiday season. Additionally, heavy rains, particularly in Nyamira, further complicated data collection. Frequent downpours made travel difficult, turning roads rocky and muddy, and the dispersed housing layout in Nyamira added to the logistical challenges of conducting home visits. These conditions may have also hindered caregivers' ability and willingness to travel for interviews. To mitigate these challenges, we extended data collection in Nyamira by an additional four days to improve follow-up rates.

Extending data collection to reach missing households

In January 2025, we raised concerns with Episcopal Relief & Development about our follow-up rates being lower than anticipated or hoped for. In response, Episcopal Relief & Development allocated additional funding to support further data collection and improve retention. We worked together with implementing partners and shared lists of specific missing caregivers to enhance mobilization efforts. We did a 2-day refresher training with data collectors on February 24 - 25, 2025 and then conducted the additional data collection exercise from February 26 - March 10, 2025. This effort proved successful, allowing us to revisit 101 additional primary caregivers. As a result, our final endline sample increased to 526 caregivers, representing 88% of the original trial cohort (see Table 2).

Table 2. Caregivers from the originally enrolled RCT cohort that were reassessed during endline data collection in November 2024 or February/March 2025.

	Nyamira	Vihiga	Total
Intervention	(106+31)/154=89%	(112+21)/156=85%	(218+52)/310=87%
Control	(98+30)/143=90%	(109+19)/142=90%	(207+49)/285=90%
Total	(204+61)/297=89%	(221+40)/298=88%	(425+101)/595=88%

Outcome measures

Primary outcome

Early child development

The primary outcome of this trial was ECD and was specifically measured using the Caregiver Reported Early Development Instruments (CREDI) long form version. The CREDI is a population-level measure for assessing ECD among children aged 0-35 months based on caregivers' reports of their child's milestones and skills. CREDI scores were calculated following the official CREDI scoring procedure. For the impact evaluation, we used internally age-standardized scores and assessed changes in 6 CREDI outcomes: the overall CREDI score (which combines all 4 domains), the four developmental subdomain scores (cognitive, language, motor, and social-emotional development), as well as the CREDI-mental health subscale which specifically assesses child mental health problems.

In addition to the CREDI, we also measured ECD using the Global Scales for Early Development (GSED) long form version, which was included only at endline because it was not publicly released at the time of baseline data collection. The GSED is a direct observational assessment of ECD for children aged 0-35 months, in which a trained research assistant conducts a series of structured activities to observe a child's developmental skills. Unlike CREDI, the GSED provides a single overall ECD score based on cognitive, language, and motor skills but does not generate domain-specific sub-scores. Research assistants received a seven-day training on GSED assessment before endline data collection, and the average duration of the GSED assessment was approximately 45 minutes.

Secondary outcomes

Early learning and responsive caregiving (stimulation, play/learning materials, books)

Caregiver stimulation practices were measured in terms of the number of developmentally enriching activities (e.g., singing, storytelling, praising) the primary caregiver engaged in with the child. The measure was adapted from the Family Care Indicators and comprised 11 items. Primary caregivers also reported on the stimulation activities of a male

caregiver if present in the child's life. Stimulation scores were calculated separately for the primary caregiver and male caregiver.

Caregivers also reported the variety of play and learning materials available to the child. A total index score was created for the number of different types of play and learning materials present in the household (e.g., home-made toys, store-bought toys, household items, objects in the natural environment), with higher scores signaling more materials. Caregivers also reported the number of children's books at home for the child, which was analyzed as a separate outcome.

Child safety and security (discipline, birth registration)

Caregiver disciplinary practices were assessed using the Child Discipline Module from the Multiple Indicator Cluster Survey, capturing the number of harsh discipline (physical and psychological) and positive discipline by the primary caregiver and the child. Separate indicators were created for any violent discipline, physical punishment, psychological aggression, and positive discipline. We analyzed both binary variables (indicating whether caregivers engaged in any such practice) and continuous variables representing the frequency of different disciplinary methods. For harsh disciplinary practices, lower scores indicate better outcomes, whereas for positive discipline, higher scores indicate better outcomes. Similar to stimulation practices, primary caregivers reported on their own disciplinary approaches as well as those used by the male caregiver, if present in the child's life.

Birth registration was measured based on the caregiver's report of whether the index child's birth had been registered with the civil authorities.

Psychosocial wellbeing (parenting stress, social support)

Parenting stress was measured using the Parenting Stress Index-Short Form (PSI-SF) Parental Distress subscale (12 items). A total score was calculated, with higher scores indicating greater distress. In addition to the total scores, we created a binary indicator for "high stress" based on the standard PSI-SF scoring guidelines that defines high parenting stress as above the 81st percentile cutoff.

Social support was measured using the Multidimensional Scale of Perceived Social Support (12 items). This scale included a total of 12 items and captured perceived social support from 3 types of individuals: partner/special person, family, and friends. Higher scores indicate greater perceived social support.

Economic empowerment

Primary caregivers reported their total earnings in the past month from all income sources (e.g., salary, casual labor, small businesses) and total current savings (e.g. Bank, SACCO,

Chama, Mobile saving). Caregivers who reported having accessed credit in the past month also reported the total amount they accessed in credit.

Male caregiver involvement in household chores

In addition to male caregivers' stimulation and disciplinary practices as already noted above, primary caregivers reported the number of household chores (e.g., washing dishes, cleaning the house) performed by the male caregiver in the past two weeks if he was present in the child's life.

Tertiary Outcomes

Nutrition

Child dietary diversity was measured based on the number of WHO-defined food groups consumed (out of 8) in the previous 24 hours: 1) breast milk; 2) grains, roots and tubers; 3) legumes and nuts; 4) dairy products (milk, yogurt, cheese); 5) flesh foods (meat, fish, poultry, liver or other organs); 6) eggs; 7) vitamin A-rich fruits and vegetables; 8) and other fruits and vegetables). Higher scores indicated a higher number of food groups consumed by the child in the past 24 hours.

Health

Caregivers reported whether their child had experienced diarrhea, cough, or fever in the past 2 weeks. In addition to the indicators for each of these three illnesses, an overall indicator was created for a child's experience of any illness. Caregivers who reported a child illness were asked if they sought any advice or treatment for that illness. Accordingly, indicators for care-seeking behaviors were created for diarrhea, cough, and fever.

An overall illness indicator was created per standard UNICEF indicator for child illness (diarrhea, cough, or fever). For those who reported a child illness, they were asked if they sought any advice, care, or treatment for that illness. Per UNICEF guidelines, we defined appropriate care-seeking as seeking care from a formal health providers, hospitals, primary health care facilities, or from healthcare workers, including community health promoters.

Intimate partner violence

Female primary caregivers reported intimate partner violence (IPV) victimization by male partners in the past 3 months. These items covered three subscales – physical, emotional, and economic violence – and we also created an overall indicator for any type of IPV

victimization. We did not ask about sexual violence as it is the least prevalent of the four types, less directly relevant to the MTM curriculum, and to reduce the overall survey length.

Other outcomes (not prespecified)

Finally, we measured a few additional outcomes that were not pre-specified at the outset of the evaluation in the baseline report or the trial registration. The first was whether caregivers reportedly had a kitchen garden on their compound. The second was community connectedness, a measure shared with us by Episcopal Relief & Development, which they use in their internal program monitoring and evaluation. This measure included two questions: "Do you feel that you have things in common with other caregivers in your community?" and "Do you feel that other caregivers in your community care about you?" Caregivers rated their responses on a scale from strongly disagree to strongly agree, and the average score was used to assess overall community connectedness. The third variable was caregiver depressive symptoms, measured using the standardized 10-item version of the Center for Epidemiologic Studies Depression Scale (CESD-10). Another variable was the caregivers' level of financial worries (e.g., concerns about buying food, paying monthly household expenses, and covering child-related costs). We developed this measure specifically for this study. Unlike other outcomes, which were assessed at both baseline and endline, financial worries were measured only at endline, as the measure was developed and added later in the evaluation. As a result, the analysis for this outcome compares scores between intervention versus control groups at endline but not changes over time. Finally, we compared the proportion of caregivers who reported receiving a referral for themselves or their children in the past year. Similar to the financial worries variable, this referral measure was included only in the endline survey.

Quantitative Data analysis

We estimated the effects of the intervention on nurturing care and ECD outcomes using mixed-effects (i.e., multilevel) regression models. We applied a difference-in-differences approach to compare the average changes in outcomes between the intervention and control groups over time after taking into account the baseline levels of each outcome. Specifically, we included fixed effects that controlled for the study county and random-effects at the village level to account for the study design and clustering at the village level. All analyses were based on intention-to-treat (ITT) analysis, which minimizes bias in RCT analyses by including all participants in the trial analysis according to their original treatment assignment (intervention versus control group), even if some participants did not fully participate in the intervention or even dropped out. ITT analysis is considered the gold standard for interpreting RCTs because it provides a more realistic estimate of the treatment effect under real-world conditions, where adherence to interventions is often not perfect.

For each outcome, we estimated difference-in-differences regression models with and without covariates. The covariates represented key sociodemographic factors, including child age, gender, primary caregiver education level, whether the primary caregiver was the child's

mother, and household wealth quintile. Overall, results from the unadjusted and adjusted models yielded similar effect sizes across all outcomes: any overall significant effect was observed in both the unadjusted and adjusted models (e.g., results on stimulation, harsh discipline, child nutrition), while outcomes that were not statistically significant remained so in both models (e.g., results on child cognitive development, language development). Thus, we focus on reporting results from the adjusted analyses. Given that an important feature of our endline data collection was the revisiting exercise to improve response rates and that there was a relatively minor timing gap between rounds (a three-month difference), all analyses included an additional covariate for the timing of endline data collection (i.e., whether data were collected in November 2024 vs. February/March 2025), which was adjusted for across all models.

Ultimately for continuous outcomes, we report intervention effect sizes as standardized mean differences (β) to facilitate in the magnitude across different outcomes and ease of interpretation (i.e., differences expressed in standard deviation units). In social science research, including in the field of parenting programs and ECD, effect sizes of 0.2 are considered small, 0.5 is moderate, and 0.8 or above is large (Cohen, 1988). Binary outcomes were reported as odds ratios. Analyses were conducted in Stata. Statistical significance was set at $p<0.05$.

Qualitative process evaluation

Study Design and Sampling

In addition to the quantitative impact evaluation, we conducted a qualitative process evaluation at endline which was after the full implementation of the program (i.e. primary caregivers had completed the 18 group sessions and 18 home visits). We investigated the factors and contexts that influenced program effectiveness, sought to understand potential explanations for the effectiveness results, generate learnings to inform quality improvement and potential refinements to the program model, and extract other lessons and considerations for future replication, scale-up, and sustainability.

For this qualitative evaluation, we distributed our sample and interviews across the 4 sublocations in Nyamira and the 4 sublocations in Vihiga. Then within each sublocation, we focused within 1-2 randomly selected villages. Within these villages, we randomly selected various key informants for in-depth interviews (IDIs). In total, we conducted 54 IDIs, with 12 ECD Promoters, 10 faith leaders, 22 female primary caregivers, and 10 male caregivers. All women interviewed served as the primary caregivers in their households. We also conducted focus group discussions (FGDs) with the 4 ECD Committee members that were established in each of the study sub-counties (2 in Nyamira and 2 in Vihiga). Committee members were invited to participate in the FGDs through ADS. Ultimately, 6-9 participants were represented in the

FGDs, which comprised various representatives of the ECD Committee including ECD Lead Promoters, faith leaders, caregivers, and government officials.

Data Collection Process

Semi-structured interview guides were developed based on the RE-AIM framework (Glasgow et al., 1999) and the process evaluation framework from Saunders et al. (2005). These guides included questions on program fidelity (i.e., *Is the intervention being implemented as planned?*), satisfaction (i.e., *What are stakeholders' attitudes towards the intervention?*), and effectiveness (i.e., *How, if at all, has the intervention been changing outcomes?*). Topic guides were adapted for each stakeholder group and format (e.g., IDI and FGD). Topic guides were piloted in an MTM community not selected for the qualitative study during which questions were iteratively modified for clarity and flow.

In collaboration with B&M Consult, we hired and trained three data collectors and one field supervisor. All data collectors were fluent in Kiswahili and English, held at least a bachelor's degree, and had prior qualitative research experience with process evaluations of community-based programs for young children. Data collectors underwent a comprehensive 1-week training covering study protocols, ethical research practices, instruction on qualitative research methodologies, interviewing skills, and interview guides. The training also included guided field practice in a non-study community.

Qualitative data collection took place from October to November 2024. IDIs, lasting approximately 60 minutes, and FGDs, ranging from 60 to 90 minutes, were conducted in Kiswahili, either in a private community setting or participants' homes. Audio recordings of all sessions were transcribed verbatim into Kiswahili and subsequently translated into English.

Data Analysis

Qualitative data for the process evaluation were analyzed using thematic content analysis. We developed an initial codebook, which we then iteratively refined using transcripts from the pilot data and initial data. From December 2024 to March 2025, transcripts were coded by a team of trained research analysts using Atlas.ti Web. To ensure coding consistency, approximately 50% of transcripts were independently reviewed by a second analyst. Weekly 2-hour team meetings were held over 12 weeks to discuss any coding questions, synthesize findings across transcripts, review emerging themes, and jointly discuss results. For each theme, the perspectives of the various stakeholder groups were triangulated to enhance the validity of the findings. We also explored similarities and differences by county for any differences in implementation.

RESULTS

The Results section is broken down in two parts. First, we present the quantitative impact evaluation results (pgs. 25-46). Then, we present the qualitative process evaluation results (pgs. 47-105), which are extensive due to the various components of the program model, stakeholder groups and perspectives represented in the interviews, and dimensions of program implementation explored.

Quantitative Impact Evaluation

Sociodemographic characteristics of the trial cohort at baseline

To briefly recap the sample characteristics at baseline, the trial included 595 primary caregivers of children under 18 months of age, with 310 caregivers in the intervention group and 285 in the control group (Table 1). The average age of the index child was 8.7 months (SD = 4.5), with no significant difference between study arms. Most primary caregivers were the child's mother (90.6%), with a significantly greater proportion of mothers in the control group compared to the intervention group (95.8% vs. 85.8%, respectively; $p<0.01$). Grandmothers were the next most common caregivers (7.6%), with more as the primary caregiver in the intervention group than the control group (11.6% vs. 3.2%; $p<0.01$). On average, five individuals lived in each household (SD = 1.8), and 77.5% of caregivers reported being currently in a partnered relationship (married or living with their partner). There were no significant differences by study group in household size or partnership status. In terms of caregiver age, most were between 25–34 years (45.2%) or 18–24 years (34.5%), with more caregivers 45+ years in the intervention group than the control group (9.0% vs 2.8%), likely due to the intervention's inclusion of grandmothers as primary caregivers. While the intervention allowed for the enrollment of grandmothers in this role, fewer households in the control group had a grandmother serving as the primary caregiver, which is why there was a smaller proportion of older caregivers in the control group. Educational attainment was similar across study arms. Overall, 43.4% of caregivers had completed secondary school, 41.7% had completed primary school, 14.2% had some primary schooling, and less than 1% had no formal education. Households in our study sample appeared poorer than the county averages as reported in the Kenya Demographic and Health Survey (2022), with lower access to improved sanitation, electricity, and household assets such as radios and televisions. See Appendix Table 1 for a comparison of key wealth indicators between the study sample and county-level DHS estimates, which helps contextualize the relatively poorer socioeconomic status of participating households.

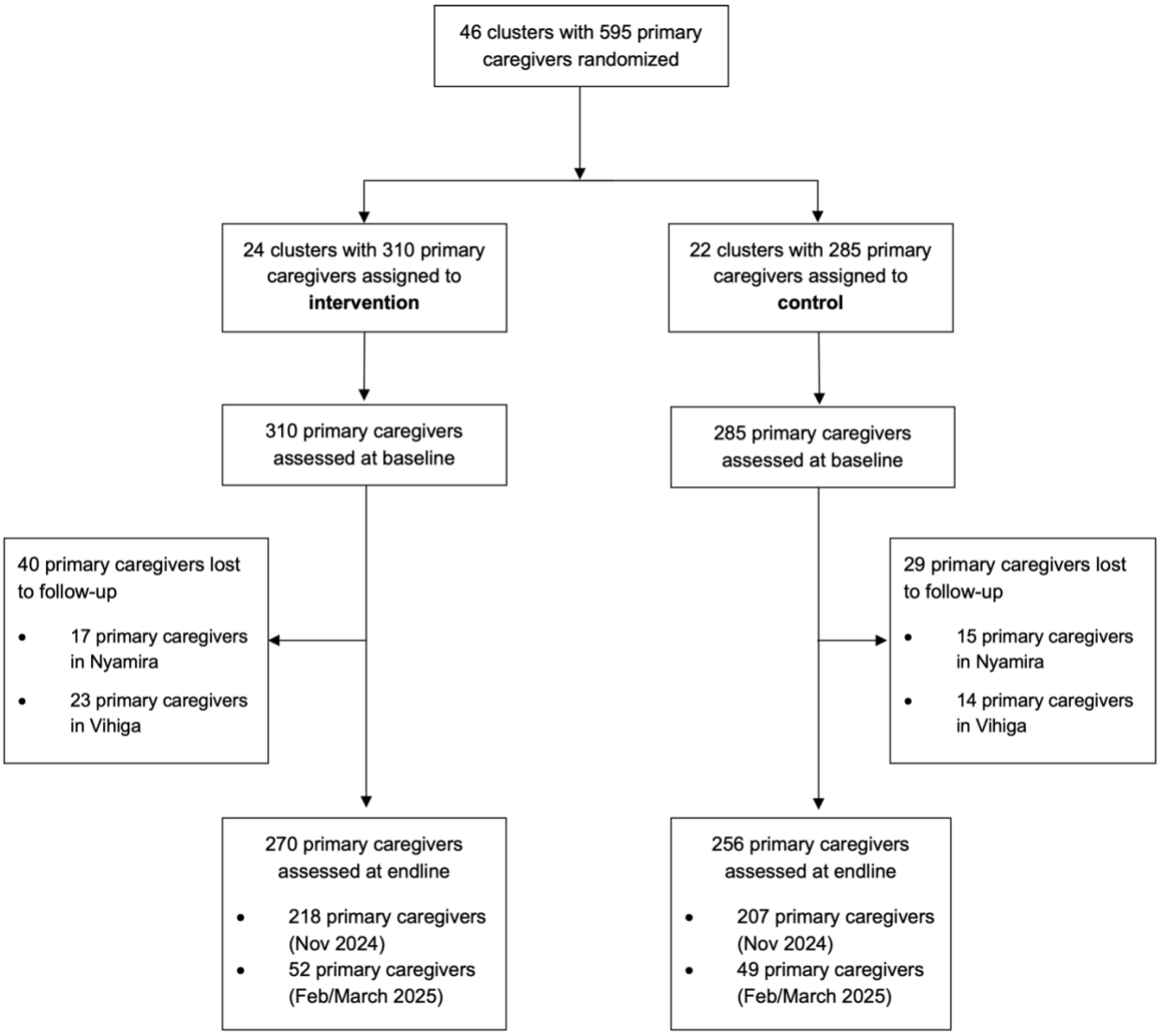
Table 1. Sample demographic characteristics at baseline by intervention arm.

	Overall (N=595)	Study Arm		
		Intervention (N=310)	Control (N=285)	P-value
Child age in months, *mean (sd)*	8.7 (4.5)	8.9 (5.3)	8.6 (5.6)	0.58
Child sex, *n (%)*				
Male	271 (45.6%)	145 (46.8%)	126 (44.2%)	0.530
Female	324 (54.5%)	165 (53.2%)	159 (55.8%)	
Primary caregiver relation to child, *n (%)*				
Mother	539 (90.6%)	273 (85.8%)	266 (95.8%)	<0.01
Father	6 (1.0%)	4 (1.3%)	2 (0.7%)	0.47
Grandmother	45 (7.6%)	36 (11.6%)	9 (3.2%)	<0.01
Grandfather	2 (0.3%)	2 (0.7%)	0 (0.0%)	0.17
Aunt	2 (0.3%)	1 (0.3%)	1 (0.4%)	0.95
Other	1 (0.2%)	0 (0.0%)	1 (0.3%)	0.34
Number of individuals living in household, *mean (sd)*	5.02 (1.8)	4.9 (1.9)	5.2 (1.7)	0.09
Currently in partnered relationship, *n (%)*	461 (77.5%)	239 (77.1%)	222 (77.9%)	0.82
Primary caregiver age, *n (%)*				
18-24 years	205 (34.5%)	107 (34.5%)	98 (34.4%)	<0.01
25-34 years	269 (45.2%)	125 (40.3%)	144 (50.5%)	
35-44 years	85 (14.3%)	50 (16.1%)	35 (12.3%)	
45+ years	36 (6.1%)	28 (9.0%)	8 (2.8%)	
Primary caregiver education completion, *n (%)*				
No education	5 (0.8%)	3 (1.0%)	2 (0.7%)	0.32
Some primary school (incomplete)	84 (14.2%)	51 (16.5%)	22 (11.6%)	
Completed primary school	248 (41.7%)	129 (41.6%)	119 (41.8%)	
Completed secondary school	258 (43.4%)	127 (41.0%)	131 (46.0%)	
Household wealth quintile*, n (%)*				
Lowest	119 (20.0%)	67 (21.6%)	52 (18.3%)	0.66
Second	120 (20.2%)	63 (20.3%)	57 (20.0%)	
Middle	119 (20.0%)	65 (21.0%)	54 (19.0%)	
Fourth	119 (20.0%)	57 (18.4%)	62 (21.8%)	
Highest	118 (19.8%)	58 (18.7%)	60 (21.1%)	

Sample reassessed for endline data collection

Figure 2 shows the trial flow diagram and the sample that was reassessed at baseline and endline. As mentioned above in the Methods, we reassessed 526 primary caregivers at endline out of the original 595 caregivers (88% follow-up rate). Ultimately, this revisit rate was within our sample size calculation, which assumed an 80% follow-up rate.

Figure 2. Participant flow diagram for sample assessed at baseline and endline in cluster-RCT.



Given that we conducted two rounds of endline to increase the ultimate revisit rates, we examined whether there were any systematic differences in the characteristics of caregivers by round of endline data collection (Nov 2024 versus Feb/March 2025) as well as with the group of caregivers who were ultimately lost to follow-up. Table 2 presents the average baseline sociodemographic characteristics between these groups based on endline data collection status: caregivers assessed in November 2024 as originally planned (n=425), caregivers evaluated in February/March 2025 (n=101), and caregivers missing at endline (n=69) (Table 2). Overall, baseline demographic characteristics including child age and sex, primary caregiver's relationship to child, caregiver age, household size, partnership status, and household wealth quintile did not significantly differ across these groups. The only significant difference observed was in county distribution between the two endline data collection periods, which reflected the fact that there was a higher rate of missing data during November 2024 endline data collection in Nyamira. As a result, and to compensate, a greater proportion of caregivers were assessed in February/March 2025 from Nyamira county compared to Vihiga county (60% vs. 40%,

respectively; p=0.025). No significant differences in county distribution were observed between caregivers assessed at any endline and those lost to follow-up. All in all, this analysis suggests that there is not systematic bias underlying the sample who were assessed in the first versus second endline data collection round.

Table 2. Distribution of baseline sociodemographic characteristics comparing participants reassessed at endline in November 2024, February/March 2025, and those lost to follow-up (LTFU).

	November 2024 (n=425)	**Feb/March 2025** (n=101)	**Test between two rounds**	**LTFU (missing endline)** (n=69)	**Test between any endline vs missing endline**
Study arm					
Control	207 (49%)	49 (49%)	0.972	29 (42%)	0.299
Intervention	218 (51%)	52 (51%)		40 (58%)	
County, *n (%)*					
Nyamira	204 (48%)	61 (60%)	0.025	32 (46%)	0.532
Vihiga	221 (52%)	40 (40%)		37 (54%)	
Number of individuals living in household, *mean (sd)*	5.1 (1.7)	5.0 (2.0)	0.897	4.7 (1.8)	0.092
Child age in months, *mean (sd)*	8.6 (5.4)	9.2 (5.4)	0.380	8.8 (5.7)	0.944
Child sex, *n (%)*					
Male	199 (47%)	42 (41.6%)	0.342	30 (43%)	0.714
Female	226 (53%)	59 (58.4%)		39 (57%)	
Primary caregiver relation to child, *n (%)*					
Mother	387 (91%)	87 (86%)	0.183	65 (94%)	0.388
Father	5 (1%)	1 (1%)		0 (0%)	
Grandmother	30 (7%)	12 (12%)		3 (4%)	
Grandfather	1 (0%)	0 (0%)		1 (1%)	
Aunt	2 (0%)	0 (0%)		0 (0%)	
Other	0 (0%)	1 (1%)		0 (0%)	
Primary caregiver age, *n (%)*					
18-24 years	141 (33%)	32 (32%)	0.662	32 (46%)	0.091
25-34 years	194 (46%)	46 (46%)		29 (42%)	
35-44 years	66 (16%)	14 (14%)		5 (7%)	
45+ years	24 (6%)	9 (9%)		3 (4%)	
Currently in partnered relationship, *n (%)*	330 (78%)	80 (79%)		51 (74%)	0.451
Wealth Quintile					
Lowest	78 (18%)	20 (20%)	0.303	21 (30%)	0.191
Second	84 (20%)	22 (22%)		14 (20%)	
Middle	95 (22%)	13 (13%)		11 (16%)	
Fourth	84 (20%)	25 (25%)		10 (14%)	
Highest	84 (20%)	21 (21%)		13 (19%)	

Abbreviations: LTFU, loss to follow-up

Impact evaluation results

In this section, we present the impact evaluation results by organizing outcomes into thematic areas (e.g., ECD, early learning, psychosocial wellbeing). As a reminder and noted in the Methods section, all quantitative outcome data (except for the GSED direct assessment measure of ECD) are reported by the primary caregiver. This includes outcome data on male caregivers, which reflect the primary caregivers' reports of changes in male caregiver outcomes.

When describing intervention effects on each outcome, we report the mean scores or proportions to note how these values changed between groups and over time to provide concrete numbers behind these descriptive statistics. Specifically, Table 3 below contains all the mean scores or proportions for each outcome at both baseline and endline and by study arm. Additionally, we present the intervention effect sizes (in SDs for continuous outcomes or Ors binary outcomes) for each outcome. These effect sizes are derived from adjusted regression models based on a difference-in-differences analysis that controls for baseline scores and adjusts for various covariates (e.g., child age, caregiver education, household wealth). These adjusted effect sizes are the coefficients that are plotted in the figures below. Each point represents the difference in a given outcome between the intervention group relative to the control group, with the extending lines representing the 95% confidence interval. Appendix Table 2 provides the specific values for these intervention effect sizes, which correspond to the values plotted in the figures.

ECD outcomes

Impacts of the intervention on ECD outcomes are illustrated in Figure 3. Both intervention and control groups showed small improvements in ECD scores from baseline to endline, as expected due to the natural development of the child over time. When comparing the change over time for intervention relative to control group, we found that the intervention in the overall sample achieved small positive effects across all outcomes with effect sizes ranging between 0.1-0.2 SDs, which are considered small effect sizes. These differences were marginally significant at the $p<0.10$ level for CREDI-overall, CREDI-cognitive, CREDI-language scores. The only subdomain with a statistically significant effect at the $p<0.05$ level was social-emotional development, where scores improved from 47.0 to 51.7 in the intervention group and from 46.6 to 51.4 in the control group, which corresponded to an adjusted effect size of 0.25 SD ($p=0.038$). Regarding the direct assessment measure of GSED, there was a small positive effect of 0.1 SD improvement in the intervention group, but this was not statistically significant ($p = 0.195$).

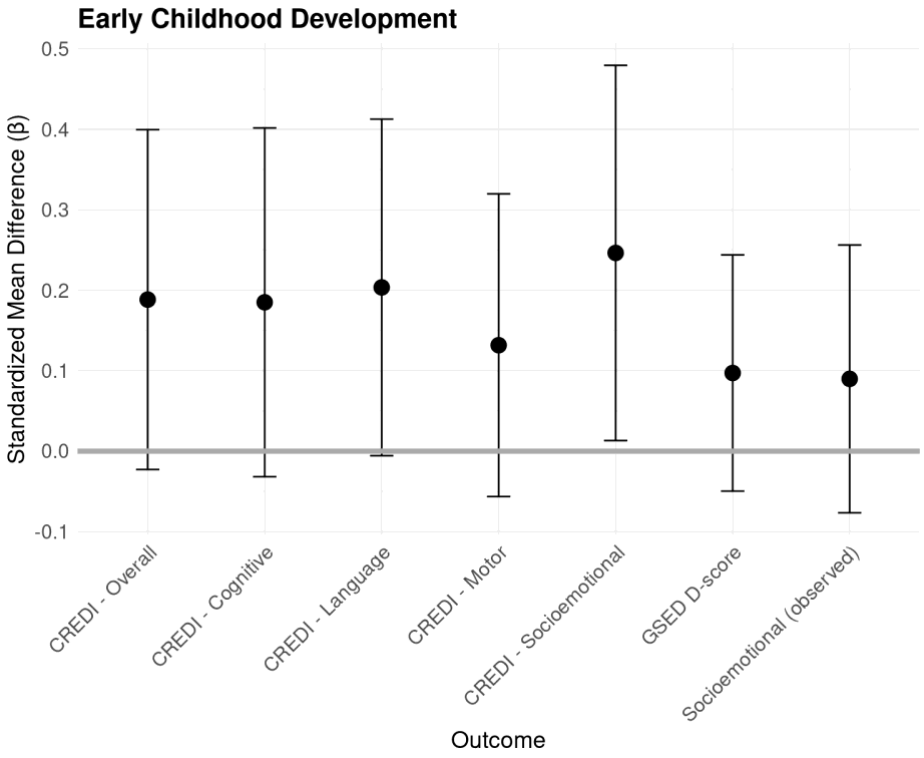


Figure 3. Intervention effects (β) on early childhood development.

Early learning and responsive caregiving

Figure 4 presents the intervention effects on primary caregiver early learning and responsive caregiving practices. Primary caregiver stimulation increased between baseline and endline in both intervention (7.1 to 9.6) and control (6.8 to 8.8) groups, with the increase being significantly greater in the intervention group, where the difference by endline was nearly one additional stimulation activity. This corresponded to an effect size of 0.40 SD ($p<0.001$). Out of all the stimulation activities, the largest increases were observed for telling stories (0.62 SD, $p<0.001$) and drawing with the child (0.51 SD, $p<0.001$). Similarly, there was a greater increase in the variety of learning materials in the intervention group (2.5 to 4.3) than in the control group (2.2 to 3.9), with a significant effect size of 0.43 SD ($p<0.001$). The average number of books in the household also increased significantly more in the intervention group (0.7 to 2.0) compared to the control group (0.5 to 1.4), with an effect size of 0.29 SD ($p=0.002$).

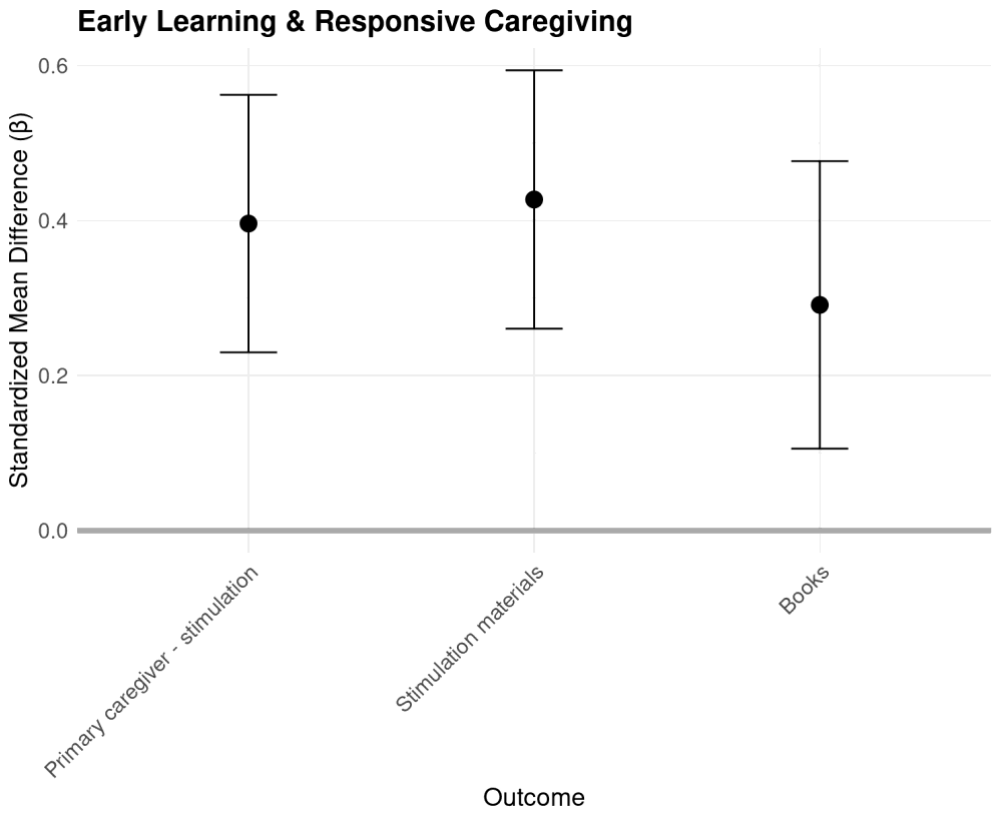


Figure 4. Intervention effects (β) on early learning and responsive caregiving.

Safety and security

Results for intervention effects on primary caregiver discipline practices and birth registration are presented in Figure 5. There were no significant differences between groups in the use of any positive discipline strategies by primary caregivers, though both control and intervention groups saw large increases (53% to 97% and 55% to 95%, respectively). However, the intervention had significant impacts on the use of harsh discipline practices. While the use of any violent discipline (i.e., physical punishment or psychological aggression) increased in the control group from 58% to 88%, it decreased in the intervention group from 60% to 55%. This difference corresponded to 86% lower odds of using harsh discipline at endline in the intervention group compared to the control group, after accounting for baseline differences (OR = 0.14, $p<0.001$). Physical punishment increased in the control group (from 49% to 79%), but remained stable in the intervention group (50% to 48%), suggesting a protective effect of the intervention. This difference corresponded to significantly lower odds of physical punishment in the intervention group (OR = 0.27, $p<0.001$). Psychological aggression also increased in the control group (46% to 69%) but decreased in the intervention group (46% to 39%), with a protective intervention effect against psychological aggression of OR = 0.21 ($p<0.001$). The

proportion of children with birth registration increased over time in both groups—from 35% to 63% in the intervention group and from 31% to 57% in the control group—but the difference in the magnitude of change between groups was not statistically significant (p = 0.230).

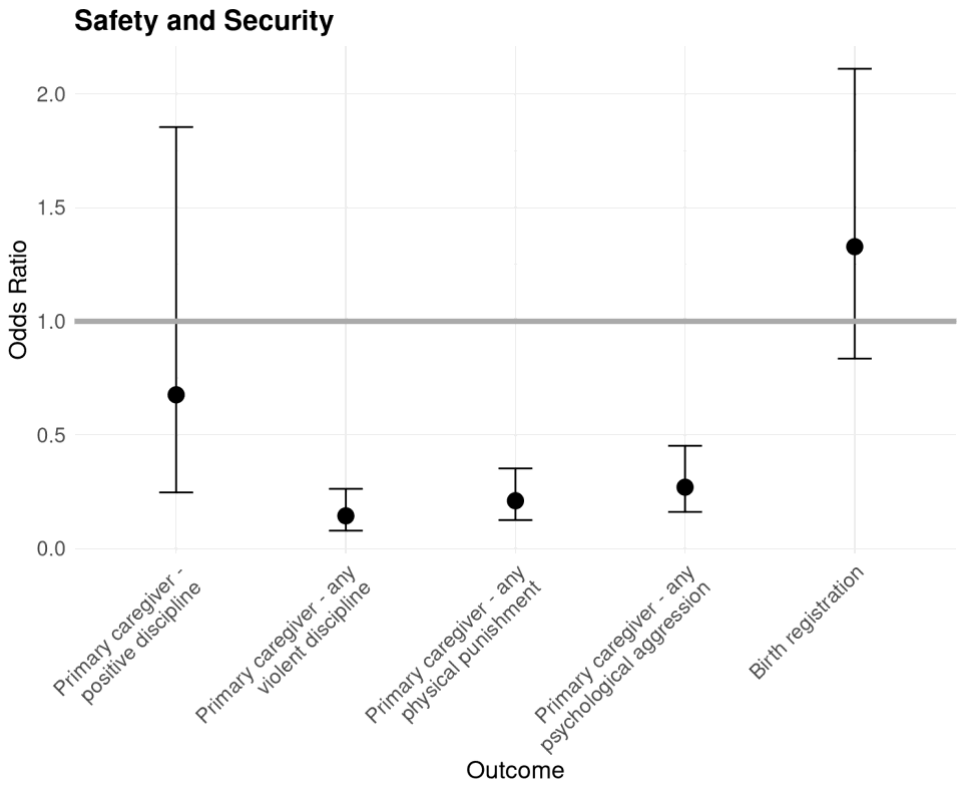


Figure 5. Intervention effects (OR) on safety and security.

Nutrition, health, household food and financial security

We examined intervention effects on a range of nutrition, health, and economic outcomes, presented in Figure 6 and Figure 7 for binary and continuous outcomes, respectively. The proportion of households with a kitchen garden increased more from baseline to endline in the intervention group (from 68% to 85%) compared to the control group (from 72% to 73%), with an odds ratio of 2.41 (p=0.001). Dietary diversity also improved slightly more in the intervention group (from 4.2 to 4.4) than in the control group where there was a reduction over time (from 4.4 to 4.1), which translated to an effect size of 0.26 SD (p=0.009). The proportion of children aged 6–23 months who received a minimum acceptable diet increased slightly in the intervention group (46% to 48%) but declined in the control group (from 48% to 37%), resulting in overall higher odds in the intervention group (OR = 2.31, p=0.002). At endline, the odds of caregivers or

children receiving a referral were over three times higher in the intervention group compared to the control group (OR = 3.04, p = 0.001). The types of referrals that differed between the intervention and control communities were specifically for child protection or neglect issues (i.e., among those who received a referral, 28% was for such cases in intervention vs 0% in control, p=0.001) and family conflict issues such as IPV (13% in intervention vs 0% in control, p=0.027). There were no significant differences in other types of referrals like malnutrition, child health, child disabilities, maternal health, or caregiver mental health. There were no significant differences in caregiver-reported child illness or appropriate care-seeking behaviors at endline. There were no significant impacts of the intervention on household food insecurity scores or financial security (e.g., income, savings, credit).

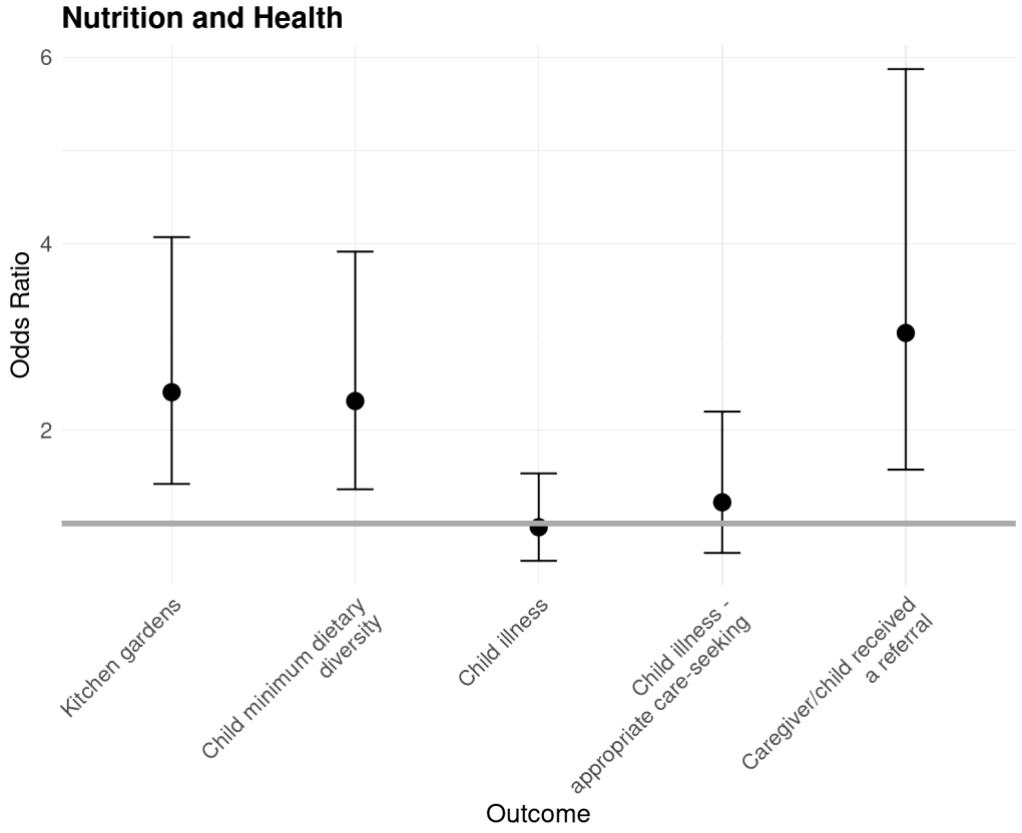


Figure 6. Intervention effects (OR) on nutrition and health.

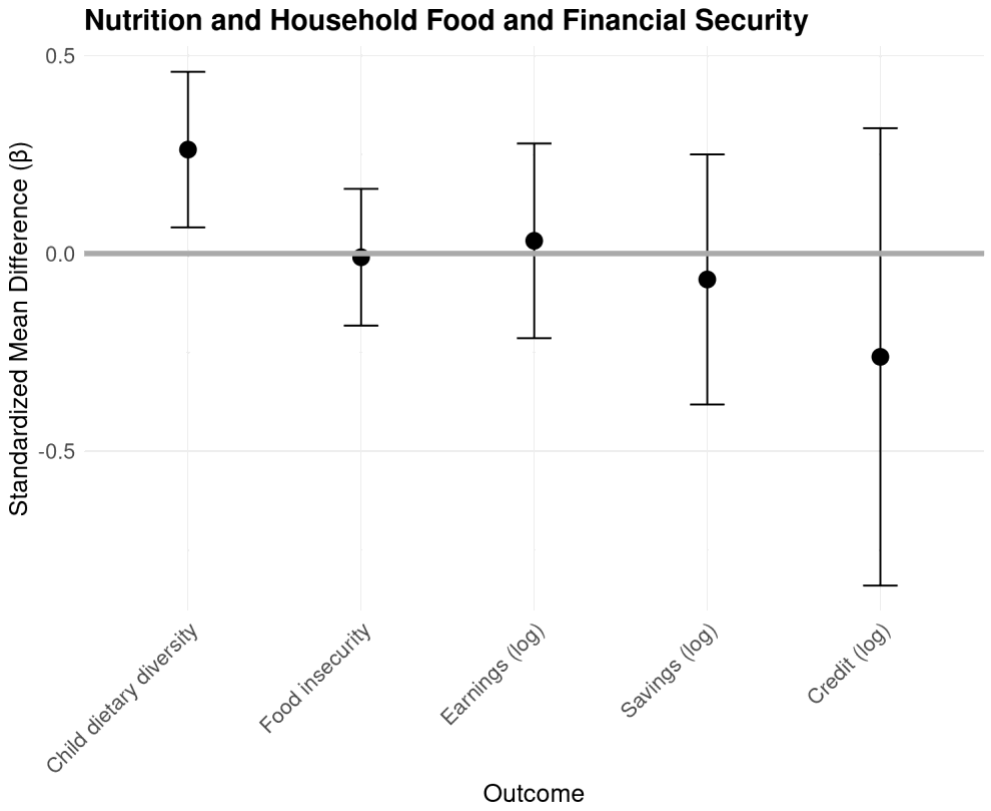


Figure 7. Intervention effects (β) on nutrition and household food and financial security.

Psychosocial wellbeing

Intervention impacts on psychosocial wellbeing outcomes—including social support, mental health, and intimate partner violence—were assessed using both continuous and binary measures, which are presented in Figure 8 and Figure 9, respectively. Primary caregivers in the intervention group had greater improvements in social support scores (from 3.4 to 3.6) than those in the control group (3.4 to 3.3), corresponding to an effect size of 0.43 SD ($p<0.001$). Community connectedness also improved significantly more in the intervention group (from 3.0 to 3.3) than in the control group (from 3.0 to 2.9), with an effect size of 0.44 SD ($p<0.001$).

The intervention significantly reduced primary caregivers' reports of IPV. Reports of any IPV dropped 17 percentage points from 48% to 31% in the intervention group between baseline and endline, yet remained consistent in the control group at 47%. This effect corresponded to an odds ratio of 0.51 ($p=0.003$). Similarly, emotional IPV was significantly reduced in the intervention compared to control group (39% vs 24% at endline), with an odds ratio of 0.45 ($p=0.001$). While there was a decrease in economic IPV in both groups from baseline to endline,

the decrease was 9 percentage points greater in the intervention group compared to the control group (28% to 16% vs. 32% to 29%, respectively), corresponding to 57% lower odds of economic IPV in the intervention group (OR = 0.43, p=0.002). Although physical IPV also declined more in the intervention group (19% to 9%) than in the control group (16% to 15%), the difference in change was only marginally significant (OR = 0.52, p=0.06).

Parenting stress scores significantly reduced for primary caregivers in the intervention compared to the control group (22.1 vs. 24.5 at endline), with an effect size of -0.36 SD (p<0.001). Depression scores also decreased between baseline and endline in the intervention group (from 9.3 to 7.8), while increasing slightly in the control group (from 8.2 to 9.3), with an effect size of -0.30 SD (p=0.001). Financial worries, measured at endline only, were also lower in the intervention group (11.7 vs. 12.9), with an effect size of -0.27 SD (p=0.002).

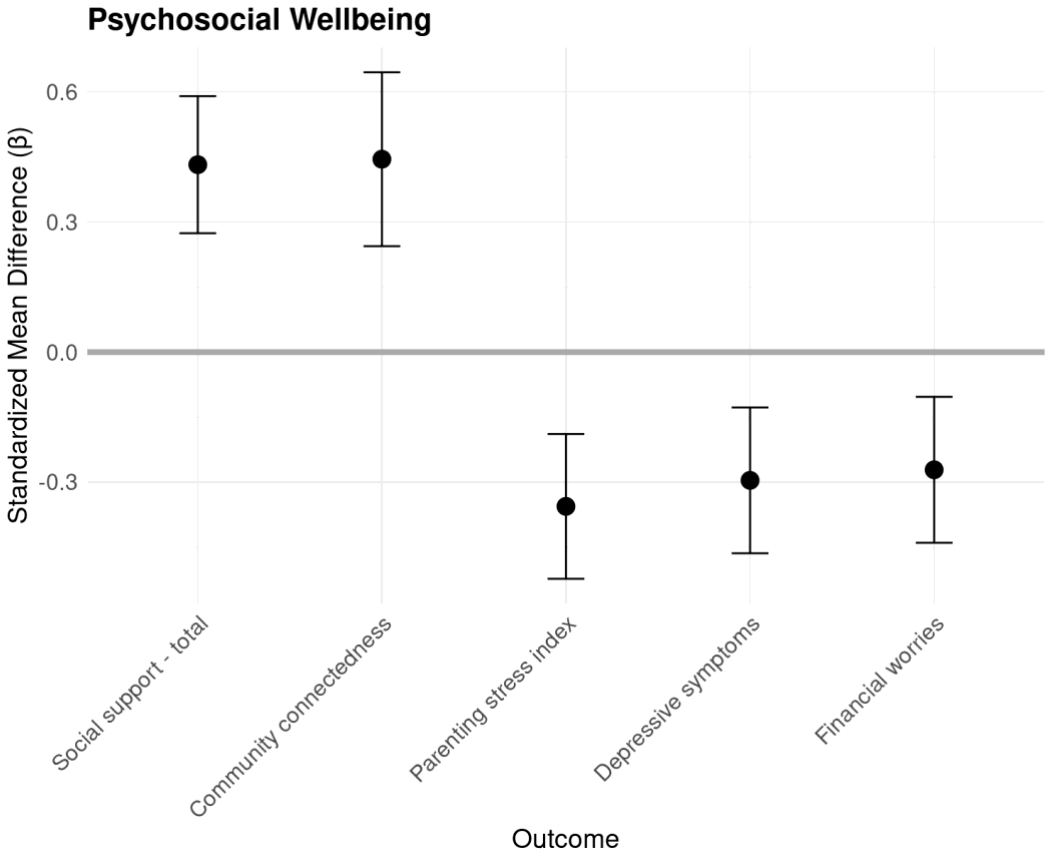


Figure 8. Intervention effects (β) on psychosocial wellbeing.

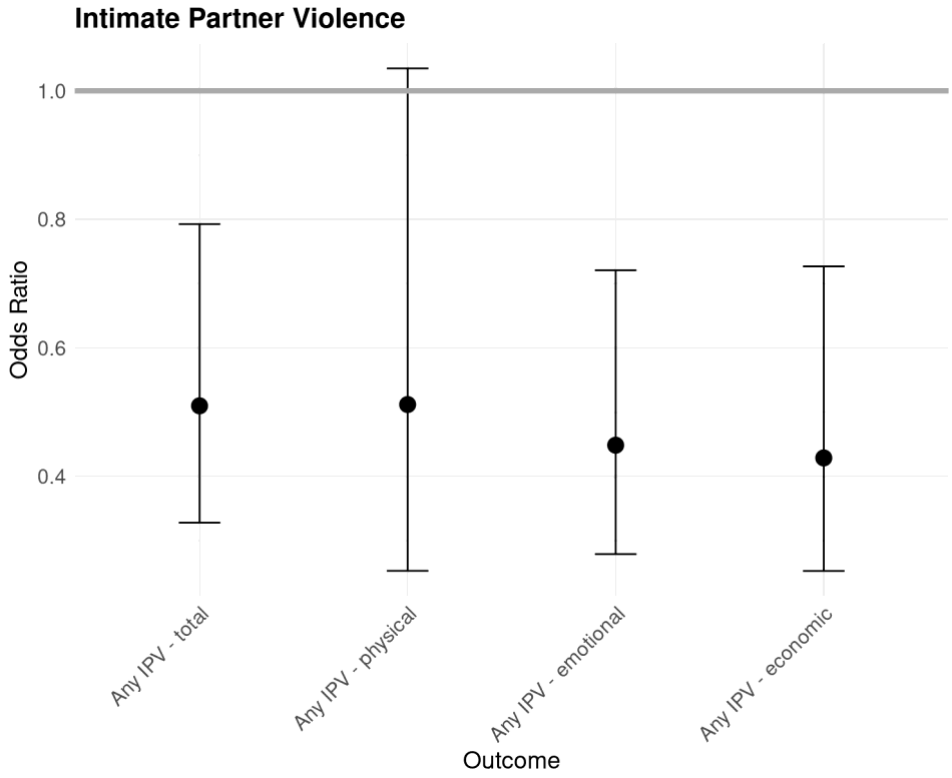


Figure 9. Intervention effects (OR) on intimate partner violence.

Male caregiver outcomes

We additionally assessed intervention effects on male caregiver practices, which are presented in Figure 10 and Figure 11 for binary and continuous outcomes, respectively. Male caregiver stimulation increased more in the intervention group (from 4.8 to 7.6) than in the control group (from 4.2 to 6.0), with an effect size of 0.46 SD ($p<0.001$). Violent discipline by male caregivers declined in the intervention group and increased in the control group. For example, any violent discipline fell from 32% to 27% in the intervention group but rose from 30% to 50% in the control group (OR = 0.38, $p=0.002$). Male caregiver's use of psychological aggression remained unchanged in the intervention group (18%) but increased in the control group (from 20% to 33%), with an odds ratio of 0.47 ($p=0.009$). Physical punishment by male caregivers dropped from 27% to 19% in the intervention group and rose from 23% to 37% in the control group (effect size = 0.41, $p=0.004$). Male caregivers' involvement in household chores increased slightly in the intervention group (from 2.1 to 2.2) but declined in the control group (from 2.2 to 1.1), with a significant effect size of 0.59 SD ($p<0.001$).

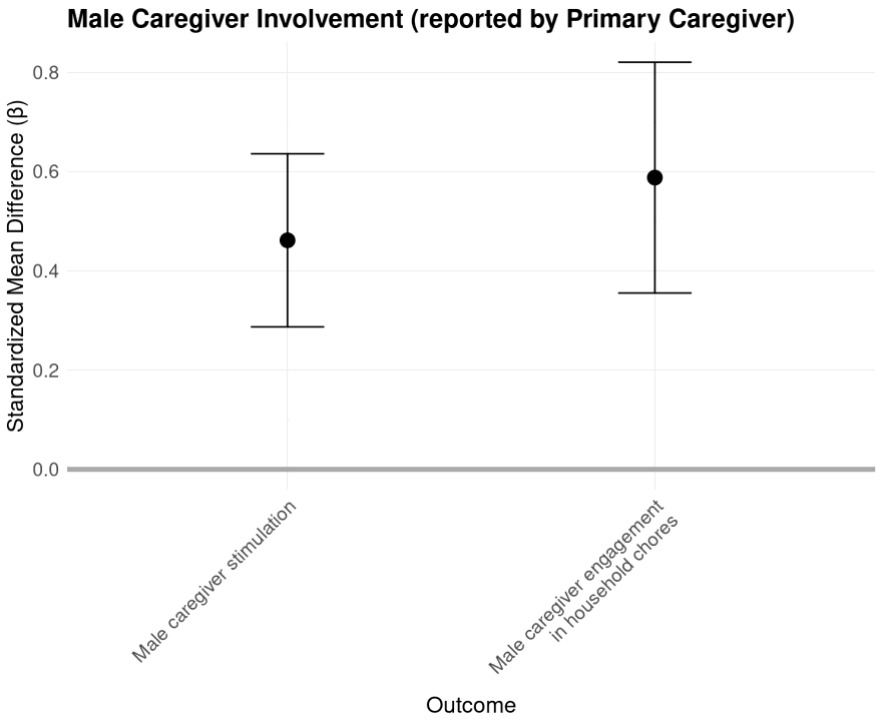


Figure 10. Intervention effects (β) on male caregiver involvement.

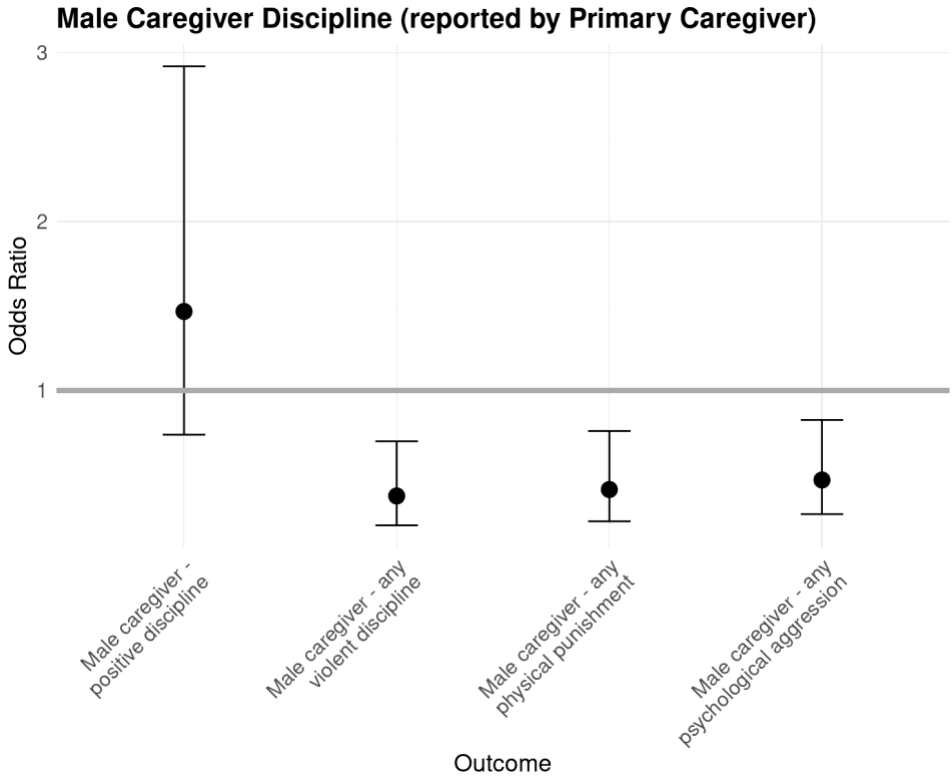


Figure 11. Intervention effects (OR) on male caregiver discipline.

Table 3. Descriptive statistics of outcomes, overall sample.

	Baseline			Endline		
	Control n=285	Intervention n=310	p-value	Control n=256	Intervention n=270	p-value
CREDI Overall score	44.2 (3.9)	44.7 (3.8)	0.101	51.8 (1.5)	52.1 (1.5)	**0.044**
CREDI Cognition score	47.0 (2.3)	47.3 (2.2)	0.104	50.7 (1.0)	50.9 (1.0)	**0.037**
CREDI Language score	47.3 (1.7)	47.5 (1.7)	0.144	51.6 (1.2)	51.8 (1.2)	**0.049**
CREDI Motor score	46.3 (2.6)	46.6 (2.6)	0.115	51.5 (1.2)	51.7 (1.2)	0.104
CREDI Social-emotional score	46.6 (2.6)	47.0 (2.4)	0.124	51.4 (1.1)	51.7 (1.1)	**0.013**
GSED D score				67.2 (8.5)	68.4 (7.8)	0.118
Child socioemotional total score (observed)				32.9 (9.2)	33.6 (9.1)	0.387
Primary caregiver stimulation index score (11 item)	6.8 (2.6)	7.1 (2.5)	0.167	8.8 (2.1)	9.6 (2.4)	**<0.001**
Number of learning materials	2.2 (1.7)	2.5 (1.7)	**0.010**	3.9 (1.0)	4.3 (0.9)	**<0.001**
Number of books in household	0.5 (1.5)	0.7 (1.5)	0.172	1.4 (1.8)	2.0 (2.0)	**<0.001**
Primary caregiver use of any positive discipline	152 (53%)	172 (55%)	0.599	245 (97%)	247 (95%)	0.139
Primary caregiver use of any violent discipline	164 (58%)	186 (60%)	0.543	222 (88%)	144 (55%)	**<0.001**
Primary caregiver use of any physical punishment	140 (49%)	156 (50%)	0.770	200 (79%)	126 (48%)	**<0.001**
Primary caregiver use of any psychological aggression	130 (46%)	142 (46%)	0.962	173 (69%)	102 (39%)	**<0.001**
Birth registration	87 (31%)	109 (35%)	0.253	144 (57%)	164 (63%)	0.188
Kitchen garden in household	206 (72%)	210 (68%)	0.228	184 (73%)	221 (85%)	**0.001**
Child dietary diversity score (24 hr)	4.4 (1.6)	4.2 (1.5)	0.363	4.1 (1.4)	4.4 (1.4)	**0.005**
Children aged 6-23 months who receive a minimum dietary diversity (MDD) in past 24 hours	77 (48%)	85 (46%)	0.715	90 (37%)	117 (48%)	**0.012**
Child experienced any illness (diarrhea, cough, or fever) in last 2 weeks	206 (72%)	241 (78%)	0.124	143 (57%)	143 (56%)	0.838
Appropriate care (hospital, clinic, CHV) sought for any child illness in past 2 weeks	100 (49%)	150 (62%)	**0.004**	64 (45%)	77 (54%)	0.124
Caregiver/child received a referral				35 (14%)	78 (30%)	**0.000**
Food insecurity total score	0.6 (1.1)	0.8 (1.3)	**0.022**	0.9 (1.5)	1.0 (1.5)	0.330

Income in past month (KSH)	1057.4 (2524.7)	1289.1 (3735.8)	0.380	3219.1 (5176.9)	3037.5 (4890.9)	0.738
Total amount currently in savings (i.e Bank, SACCO etc) (KSH)	1892.8 (18053.2)	769.1 (3316.8)	0.282	2202.4 (7393.8)	2831.5 (5055.9)	0.260
Money accessed in credit in past month (KSH)	21047.7 (112862.7)	35104.2 (222838.7)	0.608	9441.0 (23839.3)	5243.2 (11469.3)	0.099
Primary caregiver overall social support total score	3.4 (0.7)	3.4 (0.6)	0.769	3.3 (0.8)	3.6 (0.7)	**<0.001**
Community connectedness total score	3.0 (1.0)	3.0 (0.9)	0.753	2.9 (1.1)	3.3 (1.1)	**<0.001**
Primary caregiver - any IPV victimization (physical, emotional or economic)	110 (47%)	120 (48%)	0.858	94 (47%)	67 (31%)	**0.001**
Primary caregiver - any physical IPV victimization	37 (16%)	47 (19%)	0.396	30 (15%)	20 (9%)	0.078
Primary caregiver - any emotional IPV victimization	95 (40%)	105 (42%)	0.781	78 (39%)	52 (24%)	**0.001**
Primary caregiver - any economic IPV victimization	76 (32%)	71 (28%)	0.317	59 (29%)	34 (16%)	**<0.001**
Primary caregiver parenting stress total score	24.0 (6.4)	25.0 (7.1)	0.081	24.5 (7.5)	22.1 (7.2)	**<0.001**
Primary caregiver depression total score	8.2 (5.9)	9.3 (6.7)	0.050	9.3 (7.2)	7.8 (6.3)	**0.010**
Primary caregiver - financial worries in past month				12.9 (5.1)	11.7 (5.4)	**0.011**
Father stimulation index score (11 item)	4.2 (3.4)	4.8 (3.5)	0.075	6.0 (4.0)	7.6 (4.1)	**<0.001**
Father use of any positive discipline	67 (30%)	82 (36%)	0.216	176 (80%)	174 (81%)	0.884
Father use of any violent discipline	66 (30%)	72 (32%)	0.717	109 (50%)	58 (27%)	**<0.001**
Father use of any psychological aggression	45 (20%)	42 (18%)	0.586	73 (33%)	39 (18%)	**<0.001**
Father use of any physical punishment	51 (23%)	61 (27%)	0.383	81 (37%)	41 (19%)	**<0.001**
Father involvement in household chores subscale score	2.2 (2.3)	2.1 (2.3)	0.773	1.1 (1.8)	2.2 (2.5)	**<0.001**

Variation in program effectiveness by county

We also examined the impacts of the program at the county level. Descriptive statistics and of the outcomes and effect sizes for Nyamira are presented in Appendix 3 and Appendix 4, respectively, and for Vihiga in Appendix 5 and Appendix 6, respectively. Appendix 7 presents the outcome mean values for Nyamira and Vihiga side by side to facilitate comparison. County-level differences in effects sizes are additionally described in Figures 12-20. When interpreting these stratified results by county, it is important to consider the systematic socioeconomic differences between Nyamira and Vihiga at baseline, which may help contextualize variation in program effects. Households in Vihiga were generally poorer than those in Nyamira. For instance, 57% of caregivers in Nyamira had completed secondary school, compared to only 30% in Vihiga. Similarly, 26% of households in Vihiga fell into the poorest wealth quintile, compared to 14% in Nyamira.

The intervention effects on ECD outcomes were systematically greater in Nyamira County compared to Vihiga County (Figure 12). Across the CREDI domains—including overall development, cognition, language, and socio-emotional development—the magnitude of effect sizes in Nyamira was approximately five times larger than in Vihiga, with statistically significant differences in impact between counties. For example, the effect size for overall CREDI scores was relatively large at 0.49 SD ($p = 0.001$) in Nyamira versus -0.14 SD ($p = 0.307$) in Vihiga. Similar patterns were observed for cognitive development (0.52 SD, $p < 0.001$ vs. -0.16 SD, p 0.262), language (0.46 SD, $p = 0.002$ vs. -0.10 SD, $p = 0.453$), and socio-emotional development (0.64 SD, $p < 0.001$ vs. -0.17 SD, $p=0.272$). For motor development and the GSED D scores, effect sizes were not statistically significant in either county, although the magnitudes were greater in Nyamira than in Vihiga.

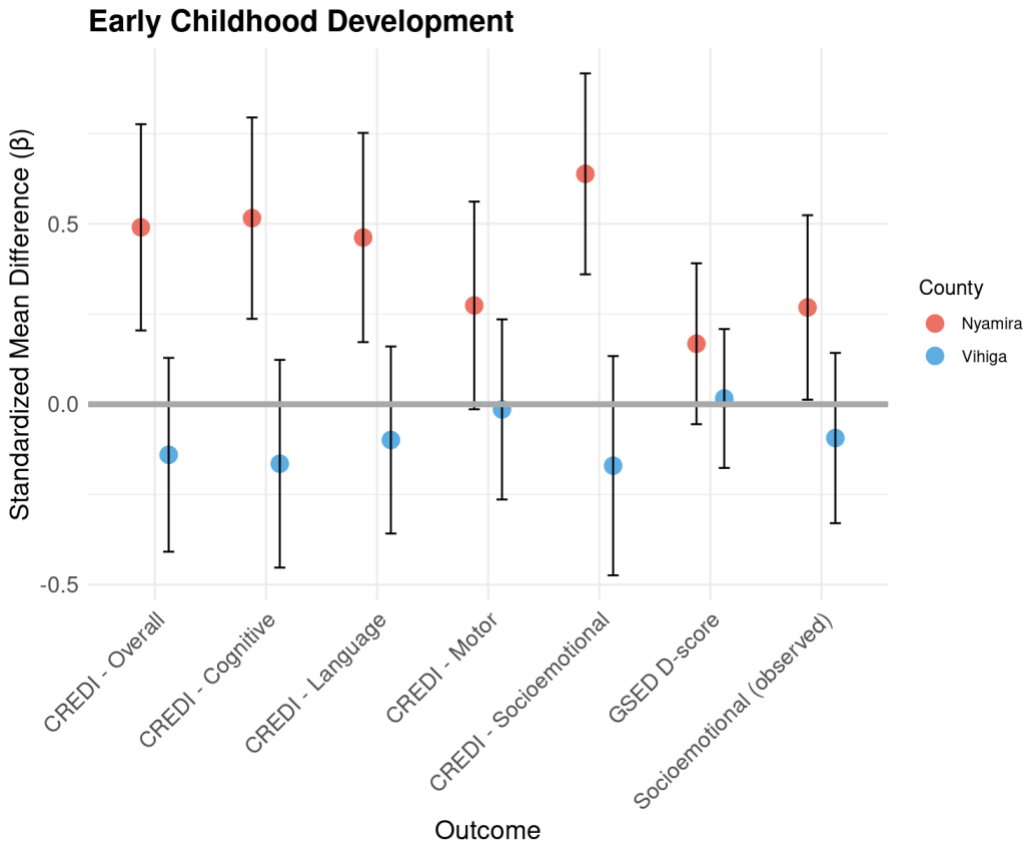


Figure 12. Intervention effects on early childhood development, by county.

Beyond ECD, several additional differences in impacts by county emerged, with Nyamira showing more consistent and pronounced improvements attributable to the intervention across a range of caregiver and child outcomes. Effect sizes for primary caregiver stimulation and variety of learning materials were approximately double in Nyamira compared to Vihiga (0.53 SD, $p < 0.001$ vs. 0.24 SD $p = 0.042$ and 0.57 SD $p < 0.001$ vs. 0.28 SD, $p = 0.017$, respectively; Figure 13). The intervention effect on number of books in the home was significantly greater in Nyamira (0.47 SD, $p = 0.001$) than in Vihiga (0.05 SD, $p = 0.668$), where no significant impact was observed. More specifically, the number of books in the intervention group increased from 0.8 to 2.7 in Nyamira, compared to an increase from 0.5 to 1.3 in Vihiga. The intervention also had a significantly greater impact on birth registration in Nyamira (OR = 2.80, p = 0 .001) compared to Vihiga (OR = 0.65, p = 0.214), with significant intervention effects observed only in Nyamira (Figure 14). Dietary diversity also had grater intervention effects in Nyamira, with an effect size of 0.51 SD ($p < 0.001$) compared to 0.05 SD (0.741) in Vihiga (Figure 15). The intervention effect on achieving minimum dietary diversity among young children was roughly twice as strong in Nyamira (OR = 3.56, p = 0.001) as in Vihiga (OR = 1.77, 0.162) (Figure 16). Similar county-level patterns were observed in for referrals received by caregivers and children received, with significant intervention impacts in Nyamira (OR = 5.81, $p < 0.001$) but not in

Vihiga (OR = 0.17, p = 0.317; Figure 15). Impacts on male caregiver involvement in household chores were also substantially higher in Nyamira, with an effect size of 0.82 SD (p < 0.001) compared to 0.29 SD (0.068) in Vihiga (Figure 19). Again, statistically significant impacts of the intervention on male involvement household chores were only seen in Nyamira and not Vihiga.

However, there were a few outcomes where Vihiga outperformed Nyamira in terms of program effectiveness. Notably, the intervention had a larger effect on caregiver reports of having kitchen gardens in Vihiga (OR = 3.87, p < 0.001) compared to Nyamira (OR = 1.63, p = 0.255), with significant impacts observed only in Vihiga (Figure 16). Additionally, the protective effect of the intervention on IPV was generally stronger in Vihiga as compared to Nyamira. For example, the odds of any IPV at endline were reduced by 54% in Vihiga (OR = 0.46, p = 0.025) compared to only a 36% reduction in odds in Nyamira (OR = 0.64, p = 0.175). Similar patterns of stronger effect sizes in Vihiga compared to Nyamira were also observed for emotional IPV (OR = 0.33, p = 0.003 vs. OR = 0.64, p = 0.198) and economic IPV (OR = 0.34, p = 0.007 vs. OR = 0.55, p = 0.144), with significant intervention effects only in Vihiga (Figure 18).

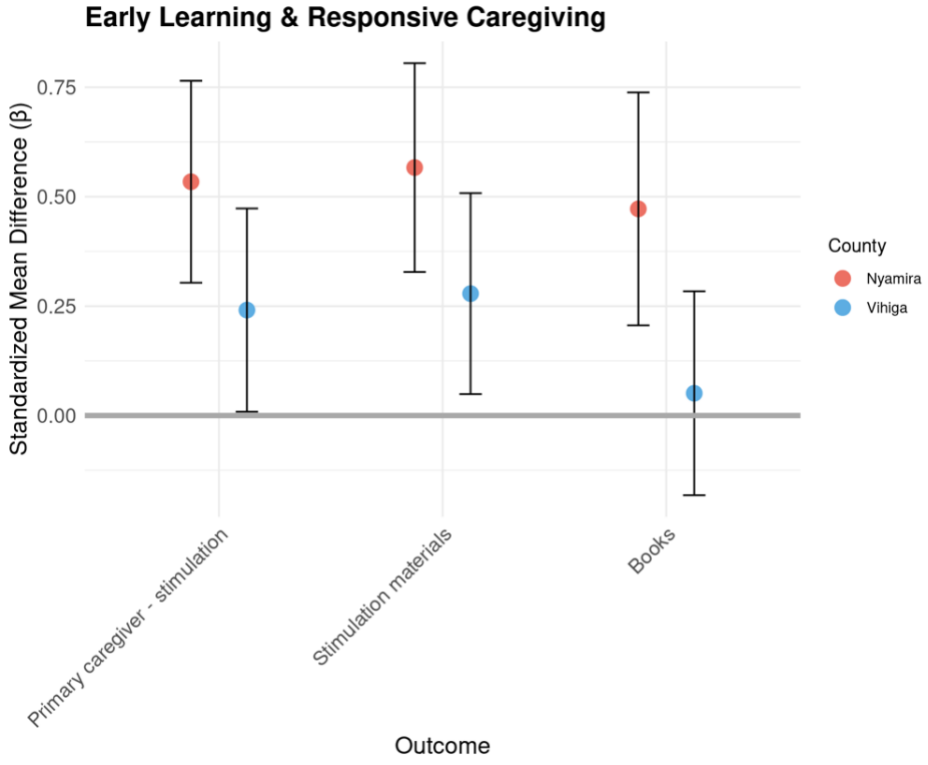


Figure 13. Intervention effects on early learning and responsive caregiving, by county.

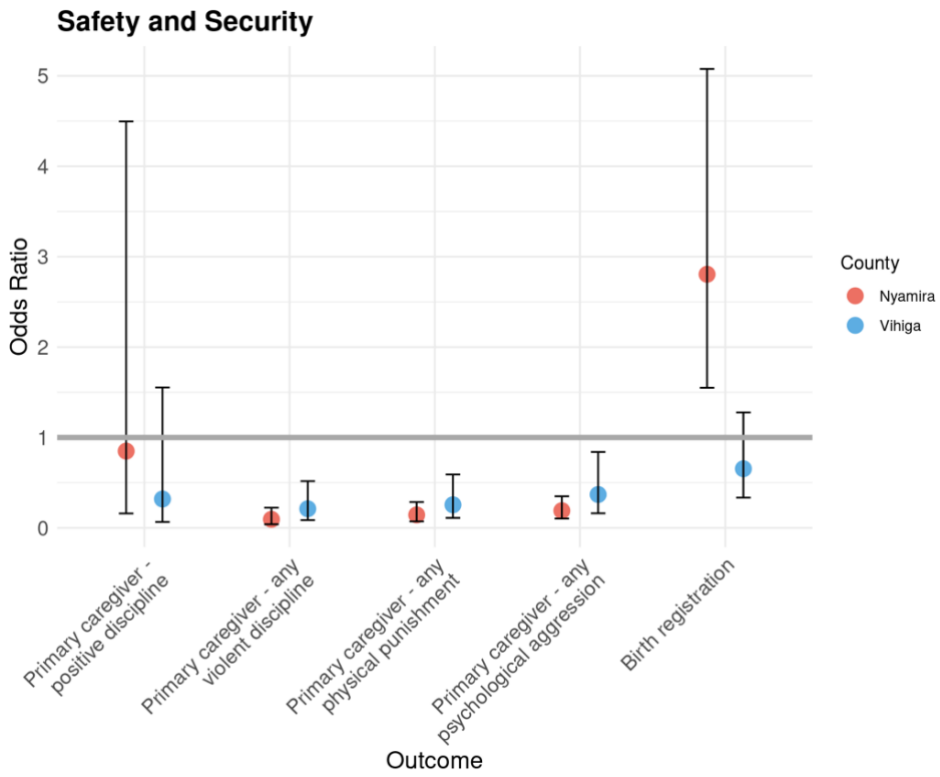


Figure 14. Intervention effects on safety and security, by county.

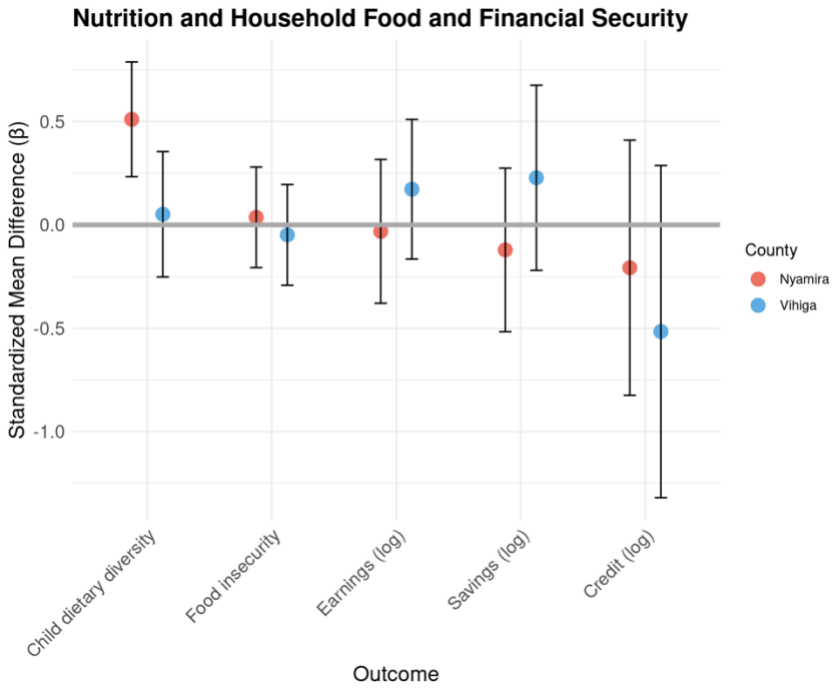


Figure 15. Intervention effects on nutrition and household food and financial security, by county.

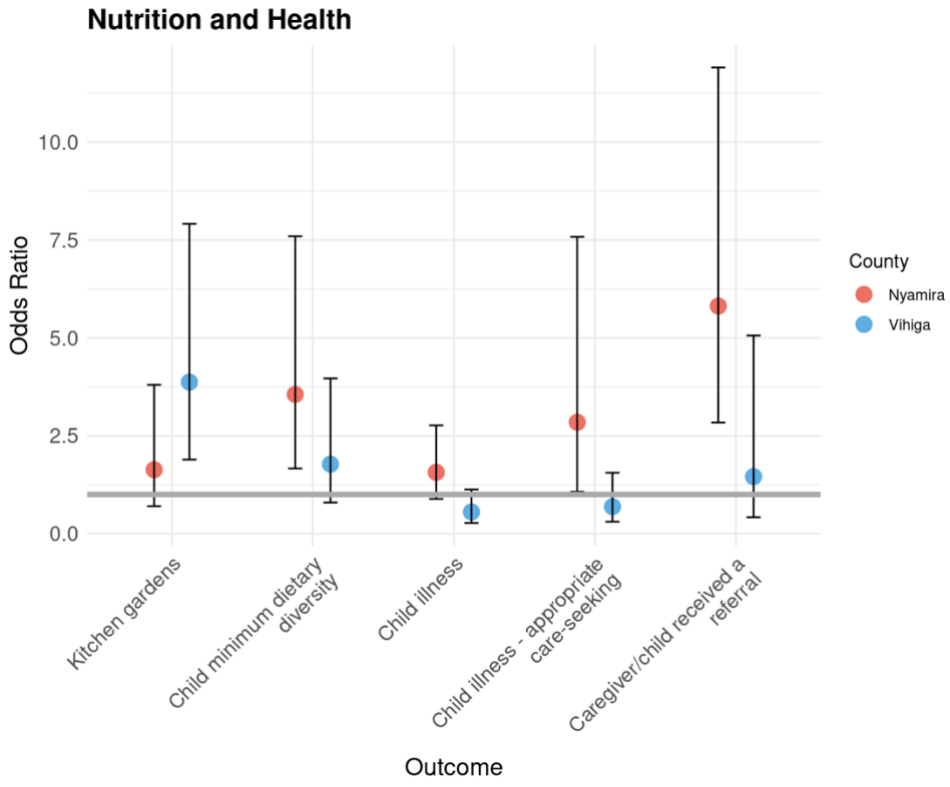


Figure 16. Intervention effects on nutrition and health, by county.

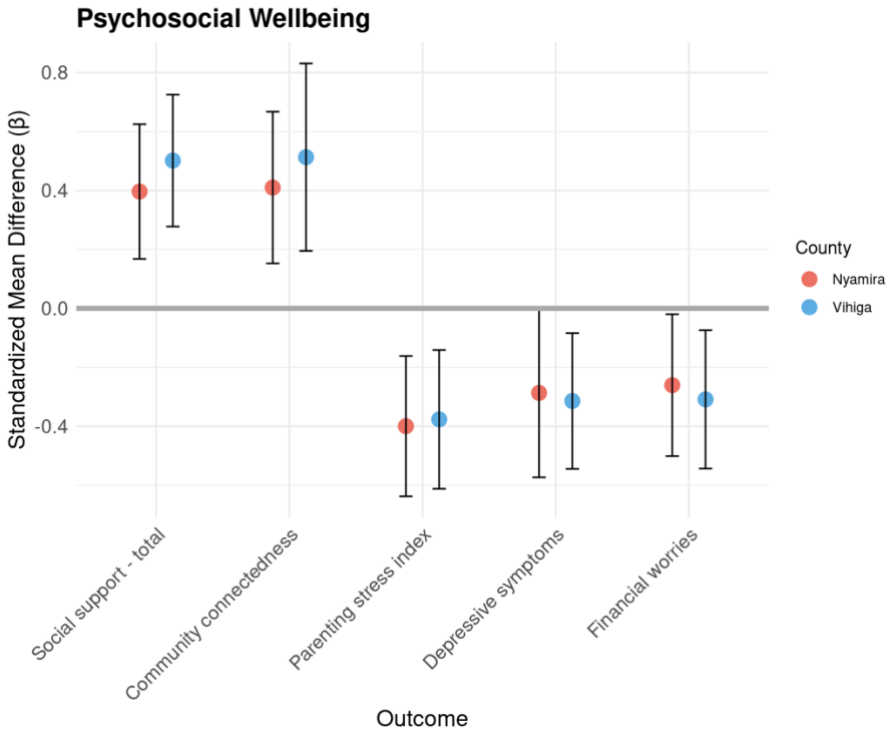


Figure 17. Intervention effects on psychosocial wellbeing, by county.

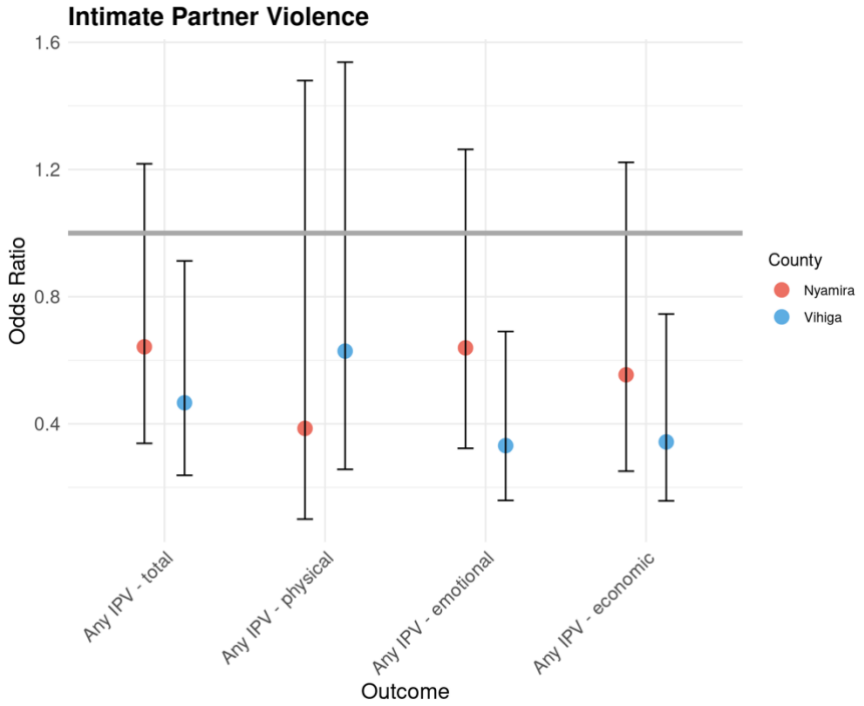


Figure 18. Intervention effects on intimate partner violence, by county.

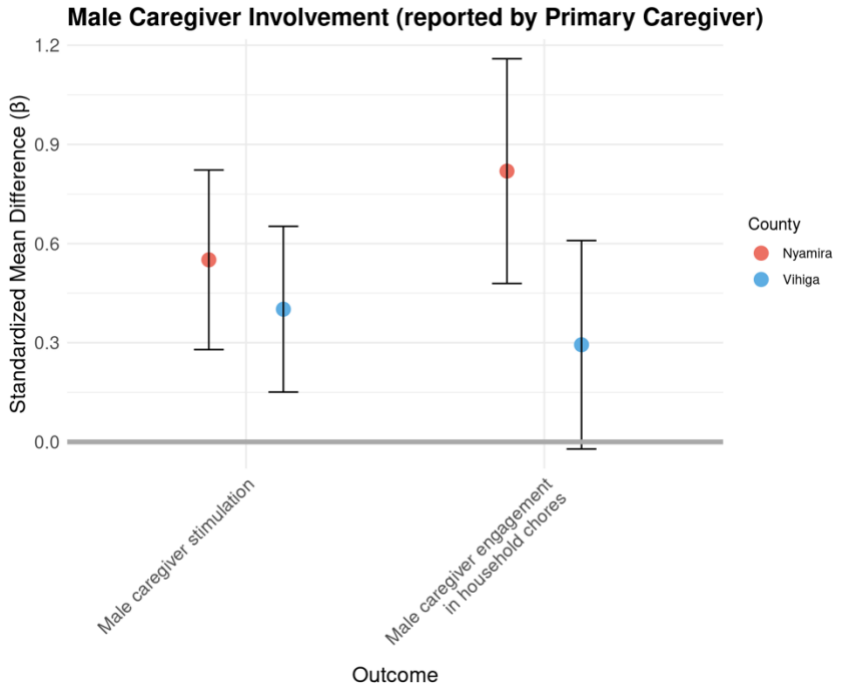


Figure 19. Intervention effects on male caregiver involvement (reported by primary caregiver), by county.

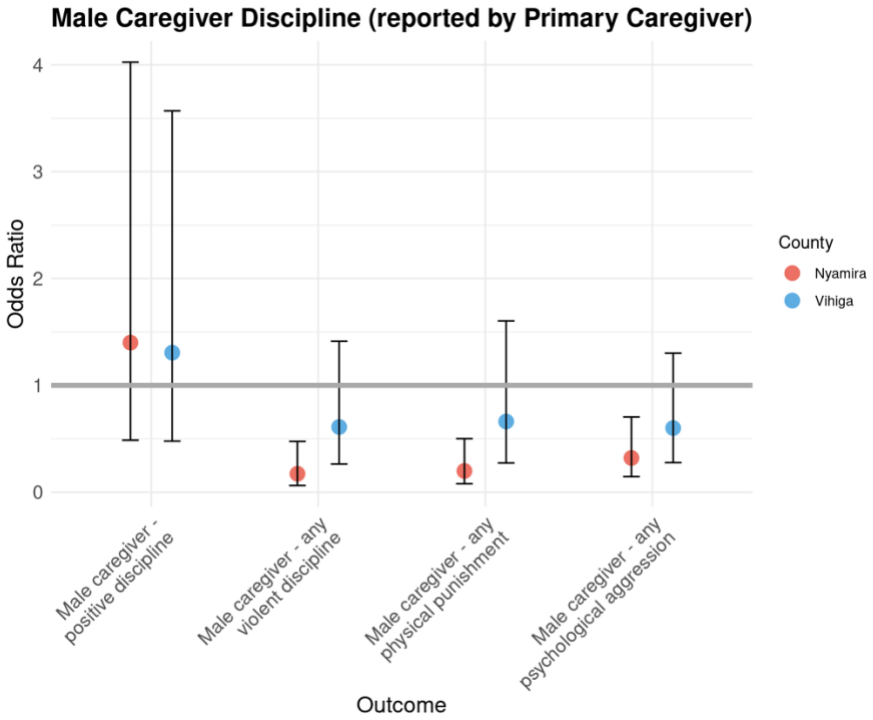


Figure 20. Intervention effects on male caregiver discipline (reported by primary caregiver), by county.

Qualitative Process Evaluation

This section presents the qualitative process evaluation results at endline. We begin by describing the sample characteristics of the respondents included in the qualitative evaluation, followed by our key findings that we organize in various sub-sections. We start with an assessment of program fidelity and with respect to the various program components and stakeholders involved. Then we summarize the perceived satisfaction and dissatisfaction among respondents with the program; highlight the main barriers and facilitators underlying program implementation; present the qualitative changes in outcomes that we organize at various levels from a socioecological framework (e.g., changes at the primary caregiver, child, community levels); and the main suggestions that stakeholders shared for improving the program.

Sample Characteristics for the Qualitative Process Evaluation

We conducted IDIs with 54 respondents: 22 female primary caregivers, 10 male caregivers, 12 ECD Promoters, and 10 faith leaders. Four FGDs were conducted with ECD Committees in each sublocation, two in Vihiga and two in Nyamira. Table 4 presents the sample demographic characteristics of those included in the qualitative evaluation. For the FGDs with the ECD Committees, an average of seven individuals participated, which included a diverse group such as ECD Lead Promoters, faith leaders, government officials, teachers, caregivers, and other local administrators.

Table 4. Sample demographic characteristics

Characteristic	n (%) or mean (SD)
Female primary caregiver characteristics (N=22)	
Age (years)	34.3 (7.7)
Highest education completed	
Some primary school	1 (4%)
Primary school complete	2 (9%)
Some secondary school	4 (17%)
Secondary complete	9 (39%)
College complete	7 (30%)
Female caregiver marital status	
Married	21(91%)
Single	1(4%)
Widowed	1(4%)
Occupation	
Business	3 (13%)
Agriculture	15 (65%)

No occupation	2 (9%)
Other	3 (13%)
Male caregiver characteristics (N=10)	
Male caregiver age (years)	36.0 (13.0)
Male caregiver highest education completed	
Some primary school	1 (11%)
Primary school complete	1 (11%)
Secondary school complete	3 (33%)
College complete	4 (44%)
Male caregiver marital status	
Married	10 (100%)
Occupation	
Business	1 (11%)
Agriculture	5 (56%)
Other	3 (33%)
ECD Promoter characteristics (N=12)	
Sex	
Male	4 (33%)
Female	8 (66%)
Age (years)	40.2 (12.2)
Highest education level attained	
Secondary school complete	8 (66%)
College complete	4 (33%)
Marial status	
Married	9 (75%)
Singe	3 (25%)
Occupation	
Business	1 (8%)
Agriculture	9 (75%)
No occupation	1 (8%)
Other	1 (8%)
Faith leader characteristics (N=10)	
Sex	
Male	4 (40%)
Female	6 (60%)
Age (years)	48.9 (13.1)
Highest education level attained	
Some primary school	2 (20%)
Secondary school complete	5 (50%)
College complete	3 (30%)
Marital Status	
Married	7 (70%)
Widowed	3 (30%)
ECD Committee member characteristics (4 FGDs with N=29 total participants)	
Sex	

Male	10 (34%)
Female	19 (66%)
Age (years)	44 (9.6)
Occupation	
Farmer	4 (14%)
Faith Leader	3 (10%)
Business	1 (3%)
ECD Promoter	6 (21%)
Teacher/Tutor	2 (7%)
MoH	2 (7%)
Assistant Chief	2 (7%)
Ward Admin	1 (3%)
Caregiver	2 (7%)
Other Misc.	6 (21%)

Program Fidelity

This section is organized by facilitator groups and their respective roles in program fidelity. Each subsection highlights facilitators' responsibilities, training, and supports, and engagement in program implementation, alongside structural elements of the program components they deliver. We begin with ECD Promoters, whose roles primarily focus on CSLGs and home visits, and faith leaders, that provided support to caregivers on an as-needed basis. This is followed by an examination of S&L Groups and SwE facilitators as the primary change agents for financial education. Next, we discuss mentor farmers, focusing on seed distribution as a key component of agricultural lessons which have been adapted by ADS as part of their Climate Resilience Program. ECD Committees are then described in terms of their roles in the program. Lastly, we focus on program fidelity from the perspectives of caregivers, assessing their attendance and the topics they reported learning during the program.

ECD Promoters

All caregivers and change agents recognized ECD Promoters as the main change agent for the program.

To support them in carrying out their roles, ECD Promoters explained the trainings they received in terms of learning about various content areas and in facilitating group sessions and home visits. They reported having two initial training sessions facilitated by ADS staff among other people who were brought on by ADS staff. When asked about what trainings they received, ECD Promoters highlighted various topics including childcare-related topics (e.g., ECD, play, communication, discipline), GBV and IPV, male caregiver involvement, nutrition, and kitchen gardens.

Supervision was also highlighted by several ECD Promoters either in the form of session observation and guidance or refresher courses. In both Nyamira and Vihiga, ECD Promoters mentioned ADS Nyanza and ADS Western staff visiting group sessions and home visits to check on the progress of ECD Promoters and offer guidance on how they can improve on a regular basis. For example, one ECD Promoter highlighted ADS supervision monthly or every two months, which was not only useful to check on her progress, but also encouraged her to work better:

> *"I received supportive supervision regularly from the ADS staff, not just once. They would visit at least every month or two months to check on the progress of our activities at the group sessions and at home visits…It was very helpful because it encouraged me to carry on with the work." (ECD Promoter, IDI #3, Nyamira)*

Some ECD Promoters also mentioned quarterly meetings and refresher courses as forms of supervision but did not provide additional details.

The primary responsibilities of ECD Promoters included counselling caregivers during group sessions and home visits. Group sessions lasted 2 hours on average with most change agents and caregivers mentioning a monthly meeting. Few individuals shared meeting more frequently, however they may have been referring to S&L Groups rather than CSLGs. Home visits lasted 45 minutes on average and occurred once a month, they varied based on individual family needs. For example, one ECD Promoter described conducting home visits multiple times a month to support a sick child:

> *"We also met once a month for home visits, but there were some cases like illness where I had to go back to the homestead before the next scheduled meeting to check the progress of the one who was ill." (ECD Promoter, IDI #6, Nyamira)*

In terms of the topics delivered, ECD Promoters reported primarily teaching about nurturing care, specifically highlighting ECD and play as the most commonly delivered messages. For example, one ECD Promoter described the importance of play and communication from an early age and how early childhood development is encouraged through interactions with children:

> *"It is through the play time that the children learn in a faster manner than verbal teachings. The playing materials like toys communicate to a child more than the formal teachings that a caregiver might be using. Like when you use the shakers, if the child was lying down, he or she would want to look at the shakers and that tells you the child is doing well in terms of cognitive ability. At some age, a child would want to hold some things, as much as they won't get hold, they will at least show some effort. So, for early learning, I counseled the caregivers to start teaching their children while they are still young." (ECD Promoter, IDI #5, Nyamira)*

ECD Promoters also frequently highlighted messages related to male caregiver involvement in parenting and household chores and child discipline. **Discussions around child discipline were especially important to ECD Promoters and were often elaborated upon, as these issues were highly relevant yet challenging to address within the community.** For example, one ECD Promoter shared their thoughts on discipline within the community:

> *"There was a topic on discipline and punishment. This topic even when we were on the ground teaching caregivers was a bit challenging because people are used to beating their children if they have done a mistake. But through the training, it has enabled us to at least educate the caregivers on how they can raise the children 0-3 years without punishing them. They should talk to the children in a good way. From that, they will have to adopt the positive discipline method." (ECD Promoter, IDI #4, Vihiga)*

In Vihiga, some ECD Promoters placed a stronger emphasis on gender-based violence (GBV) or intimate partner violence (IPV) specifically. ECD Promoters in Vihiga provided

detailed descriptions of their teachings and the significance within the community. For example, one ECD Promoter described the prevalence of GBV and the lessons around GBV which were taught to caregivers:

> *"Another topic was on gender-based violence which is most prevalent in most caregivers' households because most of them are victims. It has enabled us because we have convinced some of the households on the importance… we have told them both the negative and positive effects of GBV. Where we explain to them how the negative side will affect the 0-3 years children. It can lead to things like suicide and if a parent commits suicide and the child is left at 6 months, this will affect the child." (ECD Promoter, IDI #4, Vihiga)*

In contrast, far fewer ECD Promoters mentioned teaching about these topics in Nyamira and did not elaborate as much compared to ECD Promoters in Vihiga.

Although ECD Promoters frequently highlighted messages about early learning, responsive caregiving was much less frequently mentioned. Most ECD Promoters described responsive caregiving only after research assistants specifically probed about early learning and responsive caregiving. Even upon being probed, most ECD Promoters were unable to define responsive caregiving and instead discussed topics such as early childhood development, male caregiver involvement, or child supervision. For example, one ECD Promoter described child security and safety when asked about counselling on responsive caregiving:

> ***Interviewer:*** *"Did you facilitate about early learning?"*
> ***ECD Promoter:*** *"Yes, I did. Here, I told them of the importance and risks associated with a child attaining or failing to attain the four areas of development which as I said are cognitive, physical, social and emotional."*
> ***Interviewer:*** *"How about responsive caregiving?"*
> ***ECD Promoter:*** *"I told the caregivers to be very responsible in handling and caring for their children. They should not leave the children unattended." (ECD Promoter, IDI #4, Nyamira)*

Messaging around nutrition was mentioned by a few ECD Promoters, including teachings about exclusive breastfeeding for the first six months and ensuring a balanced diet for children. Kitchen gardens were also emphasized as a key component of nutrition, with some ECD Promoters highlighting their role in helping caregivers grow vegetables to incorporate into their children's diets. For example, one ECD Promoter educated caregivers on child nutrition, stressing the importance of achieving a balanced diet by growing vegetables in kitchen gardens:

> *"It is my responsibility to educate caregivers about childcare, how to feed the child nutritionally. The caregiver has to be taught on how to achieve a balanced diet for their*

children. We advise the caregivers that it is not a must they use money to buy food from the market, if they have some piece of land, I teach the caregiver on how to plant vegetables and feed their children a balanced diet and also benefit the family. We referred to it as kitchen garden." (ECD Promoter, IDI #5, Vihiga)

A few ECD Promoters further described their involvement in monitoring kitchen gardens, especially in Vihiga. Some ECD Promoters mentioned checking on caregivers' vegetable gardens, observing their progress, and documenting their challenges during home visits. For example, one ECD Promoter highlighted their role in checking on kitchen gardens during home visits:

"I help in supervising the kitchen garden projects in the group and their progress and in case of challenges, I take them back to those in charge to address them." (ECD Promoter, IDI #4, Vihiga)

Most ECD Promoters mentioned receiving materials and tools to help conduct group sessions and home visits, including caregiver guides, Fact-Association-Meaning-Action (FAMA) cards, passports, developmental milestone checklists, notebooks/diaries, and reporting tools. A handful of ECD Promoters mentioned using PIMA cups for nutrition. Overall, FAMA cards, which facilitate a learning-action dialogue by depicting both positive and negative parenting actions, were most frequently mentioned as being a helpful resource during home visits and group sessions. For example, one ECD Promoter highlighted that FAMA cards were especially useful for caregivers that could not read:

"Tools like FAMA cards were very helpful especially to caregivers who are not able to read and understand. The FAMA cards entailed pictures that helped them comprehend the lessons. They also helped the caregivers to tell the appropriate exercises for different ages of their children. Similarly, the pictures helped tell the development of a child in the cognitive and communication aspects. I would show the child a picture and the child would try and say what is in the picture." (ECD Promoter, IDI #2, Nyamira)

Outside of CSLG sessions and home visits, many ECD Promoters highlighted their active participation in S&L Groups. Some ECD Promoters indicated that they took an active leadership role, including helping to supervise or lead meetings and train on financial and savings topics, while others indicated that they only joined S&L Groups as group members like any other caregiver.

In addition to teaching about the various topics mentioned above, ECD Promoters also checked on the progress of children and filled out reports. Monitoring children's progress involved ECD Promoters making referrals. The main type of referral was related to child illness and was to a hospital or Community Health Promoter (CHP)/Community Health Volunteer (CHV). Only a few respondents mentioned other reasons for referrals, including birth

registrations and GBV. A few caregivers noted that, in addition to making referrals, some ECD Promoters went the extra mile by personally accompanying them to the hospital:

> *"Her main role was to check on the progress of the child because there is a time, she took my wife and child to the hospital at Ebusubi. At that time, we were stranded with no cash for medicine. But when the promoter took her to the facility, my child was attended to and given all the medicine they needed." (Male caregiver, IDI #1, Vihiga)*

Faith Leaders

Faith leaders were well-known in the program, with both caregivers and ECD Promoters recognizing them as key change agents in MTM. Many caregivers highlighted the importance of faith leaders alongside ECD Promoters. For example, a caregiver highlighted how ECD Promoters and faith leaders were both important and how they complemented each other:

> *"It was important to have both the ECD Promoter and the faith leader in the program. Their roles are very important and complement each other. The ECD Promoter will teach you how to raise the child physically, while the faith leader will guide you how to ensure the child and family grow up spiritually." (Primary caregiver, IDI #1, Nyamira)*

Faith leaders had an important role from the beginning as they recruited ECD Promoters to join the program. For example, an ECD Promoter highlighted being identified by a faith leader and having positive relations with them since the initial interaction:

> *"First of all, it's the faith leaders that identified us to participate in the program as ECD Promoters. Throughout the program, we had a positive interaction with the faith leader. We worked closely and we helped each in teaching the caregivers." (ECD Promoter, IDI #1, Nyamira)*

In order to fulfill their roles and responsibilities, faith leaders were trained by ADS staff. When asked about trainings, faith leaders mentioned similar topics to ECD Promoters, such as nurturing care, ECD, male caregiver involvement, and nutrition, with the addition of the religious aspect of using the Bible to spread these messages and encouraging caregivers to attend church. For example, one faith leader shared trainings on some of the topics that were being taught:

> *"We were taught on areas of child development whereby we looked at areas of physical development and mental development. We were also taught about the safety and security of children. We were also taught on parenting, which is so crucial. On matters of faith leaders or congregation, we talked of the importance of bringing up kids with a*

foundation which is strong so that we champion out people who have good morals." (Faith leader, IDI #1, Nyamira)

Faith leaders mentioned receiving ongoing support and supervision, with some mentioning ADS staff attending sessions and few highlighting quarterly meetings. In both Nyamira and Vihiga, ADS staff members were reported to attend group session and home visits to oversee faith leaders. Quarterly meetings were mentioned as a place where faith leaders could discuss challenges. A handful of faith leaders highlighted attending occasional support and supervision meetings with other faith leaders, where they also discussed challenges and learned how to deal with them, as well as received encouragement from others. For example, one faith leader shared how meetings with other faith leaders provided a platform for encouragement and troubleshooting challenges:

"These meetings we have been having, the occasional meetings with other service providers act as supportive supervision. Through the meetings, we get encouragement and learn more pertaining to the program. We also share challenges and get them addressed during such meetings…They have been very helpful because sometimes they help us in dealing with emerging issues during the program. We learn how to deal with caregivers in church and in the community." (Faith leader, IDI #2, Nyamira)

In terms of the messages delivered by faith leaders, all respondents emphasized faith leaders' roles in counseling on male caregiver involvement, resolving issues about couples' conflict and family violence, and providing prayers and "spiritual nourishment". Due to the personal nature of couples' conflict and violence, as well as male caregivers being more present during home visits, these roles, with the exception of prayers, were mostly performed during home visits. For example, one faith leader shared being referred by an ECD Promoter to a home in need of counseling on couples' conflict and violence:

"So, home visits are done by the promoters. But when there is an issue, that's when they invite us there. So far, I have been invited to one household whereby there was family violence. The male caregiver in that household was kicking away the female caregiver in a violent way because he did not want her involvement in the MTM program. I was called in to encourage and counsel them, and the male caregiver took it positively and changed her mind." (Faith leader, IDI #2, Nyamira)

Faith leaders were most effective in delivering these types of sensitive topics because they were respected in the community and were seen as having the spiritual knowledge to be able to resolve issues. For example, one male caregiver highlighted the responsibility of faith leaders in spiritual matters and their unique role in resolving differences between people:

"There is a very huge benefit in having them both in the program because the faith leader is for spiritual matters. When he comes, he talks about the church and how to live

spiritually and deeply talks about violence. You know a faith leader is accorded a lot of respect when dealing with differences. His role is special, that of uniting people whenever there are differences. It is like we have given the faith leader powers to unite people." (Male caregiver, IDI #5, Nyamira)

Multiple faith leaders particularly emphasized their unique roles in incorporating a faith-based or religious approach to promoting nurturing care, nutrition, and discipline. This included connecting lessons taught by ECD Promoters to Bible verses. For example, one faith leader shared how they used a Bible verse to reinforce messages about nutrition and exclusive breastfeeding:

"I talked to them about breastfeeding. Some caregivers gave their children food ahead of the 6 months and so I was asked to advise them. I took a statement from the Bible where Abraham's wife stayed at home when she was pregnant until she gave birth. When she went out, the baby was fully grown; meaning this mother used to breastfeed the baby at home." (Faith leader, IDI #1, Nyamira)

Other topics that faith leaders reported delivering messages on, though less frequently mentioned, included nurturing care such as ECD, play, child discipline, and responsive caregiving. Similar to ECD Promoters, the few faith leaders who mentioned responsive caregiving were unable to define it clearly and instead discussed related topics like ECD, male caregiver involvement, or child supervision. For example, when asked about responsive caregiving and early learning, a faith leader described gender roles and child development:

Interviewer: *"Did you discuss anything to do with responsive caregiving or early learning?"*
Faith leader: *"Yes. In responsive caregiving, we came up with gender roles, where a mother or a father could do their roles. Early learning comes in when the baby starts moving, crawling and then starts developing mentally, physically and socially." (Faith leader, IDI #1, Nyamira)*

To carry out their roles and deliver messages, most faith leaders mentioned using materials such as sermon guides and Bible study guides. They highlighted how sermon guides and Bible study guides allowed them to incorporate religion messaging when counselling caregivers. For example, one faith leader highlighted using Bible guides during group sessions:

"For example, I use those Bible guides when we go for group meetings, when we go for group meetings at least I take one book of the Bible, before we start a meeting I pray, and I give them word of encouragement from that book, that Bible verse." (Faith leader, IDI #5, Vihiga)

Among the few faith leaders that mentioned their role in referring caregivers, most reported referring caregivers to hospitals or CHPs for child illness or to birth registration offices for birth certificates, with the latter being mentioned more frequently. Few faith leaders highlighted finding out about children's lack of birth certificates when performing Baptisms, resulting in them providing referrals. A handful of faith leaders mentioned GBV or child-abuse related referrals. For example, one faith leader shared their referral process for obtaining a child's birth certificate through the registration office:

> *"One of the referrals we did is to the registration office. We realized most of our caregivers and most of the families did not have birth certificates for their children. So, we did refer them. I personally connected a few with the registration office and they received their birth certificates." (Faith leader, IDI #2, Nyamira)*

Although faith leaders played an important role in the program, their involvement with caregivers varied substantially both within and between counties. Unlike ECD Promoters, whose engagement was more regular and structured, faith leaders interacted with caregivers on a more as-needed basis. In some communities, they were highly engaged—frequently conducting home visits or regularly attending group sessions—while in others, their presence was more limited, with caregivers only recalling one or two interactions. Faith leaders were most consistently involved in home visits, occasionally attended group sessions, and were rarely mentioned in relation to S&L Groups. For example, one faith leaders highlighted that ECD Promoters conducted home visits and that as a faith leader he had only visited one household, "Home visits are done by the Promoters. But when there is an issue, that's when they invite us there. So far, I have been invited to one household whereby there was family violence." *(Faith leader, IDI #2, Nyamira).* On the other hand, a second faith leader shared regular home visit attendance: "During home visits, I accompany an ECD promoter and tailor my sermon according to their topic given to me by the ECD Promoter" *(Faith leader, IDI #3, Nyamira)*

A few faith leaders emphasized that they had shared the messaging they had learned from MTM across their other platforms. Examples of other platforms where they counseled on messages learned from the program included at church, funerals, and other group-based meetings. For example, one faith leader shared teaching about nutrition, discipline, and general childcare in church:

> *"I tell them about giving birth and following up to see that the child lives well, eats well according to their age and that she does not beat the child. I teach them about the difference of teaching a child on something or to stop something and beating a child. I mostly teach them this in church. I tell them that the child is like an egg and should be looked after properly. I also teach them about breastfeeding." (Faith leader, IDI #2, Vihiga)*

Savings & Loan Groups and SwE Facilitators

Nearly all change agents expressed having been involved in some capacity with S&L Groups, with the exception of faith leaders. The majority of caregivers and ECD Promoters were able to give detailed descriptions of S&L Groups, including how they operated, who was involved, and what purpose they served. While participants only infrequently mentioned the timing of S&L Group formation, it was expressed that S&L Groups were introduced later than other elements of MTM such as CSLGs and home visits.

ECD Promoters and caregivers acknowledged that SwE facilitators were key change agents for S&L Group meetings. Change agents indicated that caregivers had been selected by ECD Promoters and ADS staff from certain CSLGs to be trained as SwE facilitators and become responsible for training S&L Groups on topics related to savings and finances. They noted that not every CSLG had a trained SwE facilitator and that each SwE facilitator was responsible for working with multiple S&L Groups. One SwE facilitator described the training that he received:

> *"There were seven meeting on which I was trained by the facilitators to teach saving groups. First is group rules and names; Second is group management committee and amount of savings; Third is group rules and management committee then you have loan lending and loan borrowing, then we have management… We have distribution period and personal goal… We have loan duration and interest; you have loan disbursement." (Male caregiver, IDI #3, Vihiga)*

Respondents generally agreed that ADS staff, SwE facilitators, and ECD Promoters all played a role in establishing S&L Groups. It was indicated that ADS staff or a SwE facilitator would visit group sessions and give an introduction to S&L Groups. While respondents recognized the importance of SwE facilitators, it was clear that they were not the only facilitator group responsible for S&L Group leadership; ECD Promoters and elected S&L Group leaders also held responsibilities. The frequency with which SwE facilitators were able to attend meetings with each of their S&L Groups remains unclear. For example, one female caregiver indicated that, although her S&L Group met weekly, the SwE facilitator only came to teach once per month:

> *"The replicator [SwE facilitator] is an outsider who used to visit. During the visits we could give the replicator sometime to teach us about savings. Replicator could teach us on how to save, take records in form of writings on this savings, loan this savings and also how to divide the savings so that there was no one to arise and demand for more." (Primary caregiver, IDI #9, Nyamira)*

Although S&L Groups always seemed to recruit members from the existing group of CSLG caregivers, participants suggested varying implementation approaches with respect to participant inclusion. While some S&L Groups did not allow anyone outside of the CSLG to join, others were open to other community members. Although most CSLG members also appeared to be engaged in the optional S&L Groups, some mentioned that certain program participants opted out of S&L Groups or did not participate for reasons that were not fully clear. Quantitative survey results showed that 66% of primary caregivers in intervention communities reported ever participating in S&L Groups (65% in Vihiga and 68% in Nyamira). One group allowed other community members to join but required that they also come to CSLG sessions, regardless of their parental status. For example, one caregiver highlighted that caregivers that attended the S&L Groups were not always the same as those that attended CSLGs:

> *"There were differences [in those who attended S&L Groups and caregiver groups] because we added some outsiders to the SwE group… and yet some members of the caregiver group did not join the SwE." (Primary caregiver, IDI #1, Vihiga)*

The frequency of member-run S&L Groups varied significantly across communities. Most groups met each week, but there were those who chose to meet less frequently, such as once a month. Overall, the frequency with which groups met seemed to largely be left for the group members to decide for themselves. Some groups added S&L Group meetings onto existing CSLG meetings while most chose to designate different days for S&L Group meetings. For example, one male caregiver shared meeting weekly:

> *"Let me say when we meet in our group, we met every week and every time we meet each member saves one hundred shillings. When we meet in the group we save one hundred shillings. By the end of the month, you would have saved four hundred shillings." (Male caregiver, IDI #1, Nyamira)*

When asked about what they had done in S&L Group sessions, participants mentioned learning about various topics related to savings and finances from SwE facilitators. Many caregivers also spoke about the actual act of saving which happened during S&L Group meetings and included putting money in a savings box, requesting loans, calculating interest, and filling out accompanying documentation. Few people mentioned learning about topics that were not related to savings and finances or application of these lessons (e.g., with respect to gender, caregiving, child-matters).

When directly asked about the topic differences between CSLGs and S&L Groups, most respondents drew a distinct line between the caregiving topics of CSLG sessions and the financial and savings topics of S&L Group sessions. However, some respondents showed an understanding of how the two program components both related to ECD and taking care of children, while other respondents seemed to view CSLG sessions and S&L Group sessions as

largely unrelated programmatic elements. For example, one female caregiver highlighted that, while one group focused on finances and the other on nurturing care, both aimed to create a supportive environment for children's growth:

> *"They were completely different. One was about money, while the other was about nurturing care for the children. What could make them similar is the fact that both groups were meant to provide an enabling environment for the child to grow better." (Primary caregiver, IDI #12, Nyamira)*

The role of ECD Promoters in S&L Groups varied, with some differences by county. While some ECD Promoters in Vihiga indicated that they were S&L Group members, others in Nyamira said that they had been instructed not to join as participants. There was some indication that ECD Promoters in Nyamira who were not members of their respective S&L Group may have been viewed as being in a S&L Group leadership position more frequently compared to those ECD Promoters in Vihiga who joined their S&L Group as members. For example, an ECD Promoter in Nyamira shared joining S&L Groups to provide oversight and highlighted that they were not allowed to be a S&L Group participant:

> *"I only join them to offer support as well as oversee their activities. As a promoter, I was not allowed to join the SWE group but because they are all my caregivers, I join them in their meetings." (ECD Promoter, IDI #4, Nyamira)*

Faith leaders commented on S&L Groups far less frequently than other respondent types and rarely indicated having been involved directly with that component of MTM.

Mentor Farmers and Seeds

Relatively few respondents spoke about mentor farmers, including how they were selected, how they were trained, and what their role in MTM was.

Among the participants who spoke on the matter, it was generally agreed that mentor farmers received specialized training from ADS staff on agricultural techniques and were given the responsibility of training their fellow CSLG members. One interviewee gave details on the training process for mentor farmers and materials that they received:

> *"I was given the chance [to become a mentor farmer] by the ECD Promoter who visited me encouraged and taught me on how to raise the children through the program that she takes us through. I attended a forum/conference that was held at Keroka where we were taught all that, that is feeding from pregnancy to the children, breastfeeding and all that… We were trained for two days by Justus and the team from ADS… We were given*

some materials. There is a booklet and has the poultry section." (Primary caregiver, IDI #10, Nyamira)

Most participants indicated that mentor farmers performed their training as part of CSLG sessions. One participant mentioned that the mentor farmer would give agriculture lessons out in the field. For example, a female caregiver highlighted that mentor farmers delivered messages during the CSLG:

"[CSLG group sessions] lasted like one and half hours… The duration was okay. The 30 minutes were added when the mentor farmer was introduced so that the ECD Promoter takes one hour, and the mentor farmer takes thirty minutes talking to the caregivers. And that was okay with me because I already included that in my schedule." (Primary caregiver, IDI #11, Nyamira)

One caregiver mentioned that although someone from her group had been trained as a mentor farmer, that individual had not followed through with delivering all the lessons to the group:

Interviewer: *"Are there things you learnt but you didn't implement?"*
Caregiver: *"Mostly the agriculture lessons, the farmer who went for the training didn't finish training us on the topics he was taught, so you find that I learnt something, but I didn't implement." (Primary caregiver, IDI #9, Vihiga)*

While mentor farmers were sometimes mentioned as the source of agricultural lessons, such agricultural lessons were also sometimes attributed to ECD Promoters. One caregiver expressed her opinion that, even with the presence of a mentor farmer, ECD Promoters were a necessary part of delivering agricultural messages. ECD Promoters were also often mentioned as having the role of checking on kitchen gardens during home visits. For example, a female caregiver highlighted that despite the presence of mentor farmers, ECD Promoters played a crucial role in supporting activities like kitchen gardens:

"A lot of things are done by the promoter, even the kitchen gardens. As much as we had mentor farmers, the ECD Promoter had to be there." (Primary caregiver, IDI #7, Vihiga))

Many participants mentioned receiving seeds, seedlings, or money to buy seeds as part of the program. However, respondents very rarely specified from whom they received the seeds (i.e., was not clearly mentor farmers).

ECD Committees

Operations

The composition of ECD Committees and some of their primary roles were known to ECD Promoters and faith leaders. However, most caregivers were unaware of the ECD Committee and its roles and did not report any unknown individuals attending group sessions or home visits.

ECD Committees were consistently described as being composed of a diverse group of stakeholders and representative change agents, including ECD Lead Promoters (the ECD Promoter who provides supervision and mentoring to a small group of other ECD Promoters in neighboring communities); faith leaders; representatives from the Ministries of Health, Agriculture and Livestock, and Education; representatives from National Government Administrative Officers (NGAO) and Ward Administrator (County Government representative); security personnel; and caregivers. From the FGDs with the four ECD Committees, most appeared to meet monthly, but it was also reported that some Committees met more frequently to address any urgent community issues or cases as they arose.

The primary roles of the ECD Committee were best summarized by several Committee members as "connecting, championing, and counseling." Among these, the Committee's role of "connecting" was the most commonly and prominently mentioned by both change agents and Committee members. Specifically, the Committee was often described as making or facilitating referrals and doing so effectively since this was part of their routine work. ECD Committee members mentioned getting involved to assist with various types of referrals, including birth registration, health services, and family conflict resolution. For example, a representative from the children's department, who was a member of the ECD Committee, highlighted her role in linking caregivers to the chief and birth registration office to allow children to get birth certificates:

> *"We link the caregivers who do not have the birth certificates to the chief so that they may get the letter from them, and we also link them to the birth certificates office for the processing of the same as you may realize that many of the children didn't have birth certificates at first as many parents didn't have this linkages of the said offices, and nowadays their the help of this committee, it has been easier for them to have the same." (FGD #3, Vihiga)*

Another key role of the ECD Committee was "championing." Championing was described in terms of ensuring the program referrals and requests were being prioritized. A few Committee members also described championing as sharing programming during "barazas"; however, the content of messaging was unclear, with one ECD Promoter in Vihiga highlighting "sensitization" of issues like GBV. For example, a Ministry of Health representative highlighted an example of connecting and championing through her government role, where she would

connect the program with the healthcare department, bring healthcare experts to provide lessons for the program, ensure the health referrals process was smooth, and champion the program in the Ministry of Health when issues arose:

> *"As a nutritionist, I do use my expertise to teach my colleagues nutritional care and other areas of health care at large. I also serve as the linkage between the program and the Ministry of Health and through that, we invite other healthcare experts to offer lessons in the program. I also ensure that the referrals given by the promoter are attended to and whenever there is any issue that has risen regarding the health department, I address it to ensure the program runs smoothly." (FGD #1, Vihiga)*

ECD Promoters and faith leaders also highlighted the ECD Committee's role as primarily championing and connecting, with a focus on crisis management and specific issues raised by change agents which required referrals. One ECD Promoter described how the ECD Committee members could refer change agents to community partners for birth certificates or child rape cases:

> *"The committee helps us as ECD Promoter to reach the needs of children that we are serving in the community. For example, like I said, when I want a birth certificate, I will go to the ECD Committee, there I will get the chief and the administrator that can help me. If I have a rape case for a child, I will still go to the committee and there I will find the chief, so the security of the child will be sorted. Same with education officers and nutrition officer." (ECD Promoter, IDI #4, Vihiga)*

Finally, while some mentioned "counseling" as part of the ECD Committee's role, it was not clearly described as a collective responsibility of the Committee. Instead, discussions about the Committee's role in counseling were only mentioned by representatives of the Committee who were already the change agents in the program. Specifically, ECD Promoters and faith leaders appeared to be the only Committee members that highlighted counselling, which aligned with their existing roles as change agents rather than being a distinct function of the ECD Committee as a whole. For example, a Ministry of Health representative described how, as a committee, they referred the faith leader to counsel and resolve any conflicts that arose for caregivers:

> *"The role of the committee is counseling. As a committee, you can find a caregiver that have issues in their families, the matter is referred to the faith leader who will visit that home and do counseling for that caregiver. Even for CSLG group disputes, the faith leaders are called upon to resolve the conflict in the group. In cases where a promoter has a caregiver that is not committed, the promoter can refer that caregiver to the faith leader." (FGD #3, Nyamira)*

None of the other Committee members, such as government officials or chiefs, were described going to the community to counsel caregivers as part of the program.

When asked about support received from ADS, ECD Committee members reported being trained at the beginning of the program, with some Committee members also stating that ADS staff would follow-up during ECD Committee meetings to provide additional support. The content of the trainings provided by ADS was not clearly articulated. ECD Promoters and faith leaders who were part of the ECD Committee mentioned receiving training on positive parenting, nurturing care, discipline, kitchen gardens, and leadership skills. It was unclear, however, whether these trainings were intended for all ECD Committee members or specifically for change agents in their specific roles. Since some Committee members (e.g., Lead ECD Promoters and faith leaders) are also change agents, while others are government representatives, it was not clear from our interviews whether the trainings referenced were part of the broader ECD Committee support or specific to certain change agents for their specific responsibilities. Only one Ministry of Health representative described the topic of training they received, which included how to work together as a Committee and how to steer the program:

> *"We received training from ADS on how to work together in this committee and steer the program. We also received reading materials that guide our work."* (FGD #1, Vihiga)

ECD Committee members also reported that ADS staff provided materials to help Committee members carry out their responsibilities. Materials including handbooks to better understand the program and diaries to track progress of Committee meetings and interactions with stakeholders.

Experiences with ECD Committees

In terms of the relationships between ECD Committees and the communities, Committee members and change agents alike highlighted that ECD Lead Promoters and faith leader representatives would inform other members of the ECD Committee about challenges in the community. This was mainly how ECD Committee members found out about situations in which they needed to intervene. For example, one ECD Lead Promoter highlighted getting information from ECD Promoters during clusters (monthly meetings) and reporting them during ECD Committee meetings, thereby serving as a link between ECD Promoters and ECD Committee members:

> *"As a Lead Promoter, we have clusters, and I act as a link between them and the Promoters and the ECD Committee." (FGD #1, Nyamira)*

Although most ECD Promoters and faith leaders who were not Committee members reported having little or no direct experience with the Committee, they highlighted

representatives (ECD Lead Promoter and faith leader representative) through which they would convey messages to the ECD Committee. For example, one ECD Promoter highlighted that if an issue arose then he would direct it to an ECD Promoter who was part of the Committee and therefore did not have any direct experience with other Committee members:

> *"How they communicate is that among us the Promoters, there are those elected, and they can reach the ECD Committee, so if we have something we forward to those Promoters then they will communicate to the ECD Committee…. I haven't had a direct experience with the Committee at a personal level." (ECD Promoter, IDI #4, Vihiga)*

Among the few change agents who described having experience with the ECD Committee, interactions mainly occurred during times of crisis, such as rape or abuse cases, or to address specific issues such as requiring referrals for birth registrations. In these instances, ECD Committee members would step in to connect change agents to community partners for referrals. For example, an ECD Promoter highlighted how the ECD Committee helped refer a sick child to a CHP and how the committee also had representatives to help with birth certificate referrals:

> *"For health and nutrition, I referred them to the CHPs who are in the community. I get the CHPs from the ECD Committee. Refer if the child is sick and the CHP will write a notification for the caregiver and then they can go to the hospital. About the birth certificates, there is someone in the committee who handles the issue of the birth certificates, so I refer the caregivers to that committee member or there is the ward administrator where we can also refer the caregivers." (ECD Promoter, IDI #4, Vihiga)*

ECD Promoters and faith leaders highlighted that only when they were unable to resolve challenges faced by caregivers would they involve the ECD Committee. For example, one ECD Promoter described a couple's conflict incident in which an infant was endangered. After attempting to resolve the situation with the aid of a faith leader and a CHP, the ECD Promoter ultimately turned to the Committee for help:

> *"The referral that I ever did was, there is a time one of the primary caregiver had a misunderstanding with the husband and she left leaving the children behind, among the children left was an 8 months old child. I involved the area CHP and the faith leader, and we looked for means of taking the little baby to wherever the mother was. But the mother refused to take the baby and she demanded that the husband apologizes first, I then intervened and involved the ECD Committee and we were able to sort out the issue. Now that child is grown, he can talk, he can walk, he even knows me." (ECD Promoter, IDI #6, Vihiga)*

While caregivers were seemingly unaware of the ECD Committee, Committee members reported having experience with both change agents and caregivers. Some

Committee members reported attending group sessions and home visits to monitor progress and bring any challenges they noticed to Committee meetings. However, these roles were often mentioned by ECD Promoters and faith leaders in the Committee; thus, it was unclear whether they were speaking on behalf of their roles as Committee members or change agents of the program. For example, an ECD Promoter, who was also a Committee member, mentioned the Committee doing spot checks to ensure ECD Promoters were doing their jobs well and to check in on caregivers during home visits and group sessions:

> *"As a committee, we do home visits especially when we are doing the spot checks on how the promoters are doing their work. We do some background check to note if the child is okay, we do assign ourselves to different homes so that it is easy for us to get to all the homes of the caregivers, and also we do the group visits once in a while, but in group visits we agree that all of us can attend them, and during these, we discuss with the member who are the caregivers with the challenges and progresses they have made." (FGD #3, Vihiga)*

Second Cycle of MTM

When asked about the second cycle or roles for next year, ECD Committee members anticipated a larger and more demanding role, with a focus on expansion, monitoring, and continued support for caregivers. Most Committee members generally expected a heavier workload in the second cycle. For example, one ECD Promoter shared that they anticipated having more to do in the second program cycle:

> *"We are going to have more work as we will have a new cohort of caregivers and those who will join the new SwE groups" (FGD #1, Vihiga).*

Expansion efforts also included a specific focus on convincing more male caregivers to join the program and more caregivers to join Savings & Loan groups. For example, one CHP shared that the ECD Committee would continue recruiting caregivers:

> *"The committee is like the steering wheel of the program as it's the one which is championing for the continuation of the program and inclusion of many more stakeholders." (FGD #1, Nyamira)*

ECD Committee members suggested being prepared for the second cycle due to the experience gained in the first cycle. They expressed confidence in their knowledge and their ability to do better during the second cycle. For example, one ECD Promoter shared feeling better prepared because of the trial and error which they completed during the first cycle:

"We are much ready because when we came in at first, we were not that much knowledgeable we were to try and error level but at this point we are more informed, and we much better know how to make the decisions due to more exposure to the field." (FGD #1, Vihiga)

Despite the general understanding of increased responsibility, some Committee members in Nyamira expressed uncertainty about the specific changes in their roles. Members of one ECD Committee in Nyamira highlighted that they were unaware of their additional roles in the second cycle. An ECD Lead Promoter underscored not knowing about additional roles for the second cycle beyond what they had already been doing, to which all other members nodded in agreement:

"Maybe we will still do the same roles that we are currently doing, which is championing, connecting is what we will do in the second cycle. If there will be changes in the roles you can tell us about the changes. We haven't been told about our roles in the second cycle." (FGD #3, Nyamira)

Caregivers Messages Received

Having examined the roles of change agents and ECD Committee members, this last section on program fidelity focuses specifically on caregivers' experiences in MTM. Female caregivers were disproportionately the main direct participants of the program which targets primary caregivers. Caregivers recalled receiving messages on a wide variety of topics. The most frequently mentioned topics were early childhood development, including the role of play and communication, child discipline, and child nutrition. Other topics that caregivers mentioned frequently were religion, kitchen gardens, finances, male caregiver involvement, and child safety and supervision. Topics that were mentioned relatively less frequently, but still by many, included play materials, couples' conflict and family violence, health, WASH, birth registration, parent-child bonding, and disability. Finally, it is worth noting that despite direct probing, very few caregivers were able to explain what they had learned about responsive caregiving and often instead talked about discipline or child safety. Below we discussed these various topics that caregivers recalled in more detail.

Almost all caregivers were able to talk about messages that they had received relating to early childhood development. Many caregivers focused on the messages that they had received about behaviors they could practice to promote ECD. Caregivers emphasized the role of playing and communicating with their child, as well as allowing their child to play with other children, in promoting good development. Some caregivers mentioned learning about specific aspects of ECD such as developmental milestones or the domains of ECD. Further, some caregivers mentioned learning about how to monitor developmental milestones and progress to

know if a child is falling behind or showing signs of disability. For example, one male caregiver shared that he had learned how to nurture his child from infancy through various developmental stages:

> *"I learned on how to nurture my child from when the child is young, until they crawl, how we play with the child. When calling the child and they try to come your way even when they haven't started walking until he learned how to walk, we all do that together, from making one step when trying to walk until now they are grown. When we are reading, the child comes and wants to read and he's fast and wants to just open the next pages. We were taught on how to help the child read until he started reading. When we are at home the mother and we are reading, the child would come, look at the pictures. The promoter taught us that we have to spend time with the child, play with the child until now we can go to church with the child (referring to the index child) and other children in the family." (Male caregiver, IDI #5, Nyamira)*

The majority of caregivers mentioned learning about positive and non-violence ways of disciplining their children. Caregivers often reported being taught that physical punishment (e.g. caning, beating) is not an effective way to discipline their children. Caregivers emphasized learning that instead of resorting to physical punishment when their child made a mistake, they should communicate with their child and explain that what the child did was wrong. For example, one female caregiver shared what she learned and emphasized how this message deviated from her former beliefs on discipline.

> *"I have also learned how to discipline my child. Before the program I thought that the only way to discipline a child is through caning them. However, through the program, I have learned that caning is not the best way to discipline a child. I learned that I should talk to the child and let them know their mistakes and ask them not to repeat." (Primary caregiver, IDI #1, Nyamira)*

Most caregivers emphasized the messages they had received pertaining to nutrition. In addition to more general comments about the importance of good nutrition for children, several specific themes emerged around nutritional messages. Caregivers recalled learning about the importance of feeding their children a balanced diet (i.e. not relying solely on one type of food) and the importance of giving their children an appropriate amount of food at properly timed intervals. Other caregivers emphasized learning about proper breastfeeding practices, including exclusive breastfeeding during the first 6 months of a child's life and communicating with the child while breastfeeding. One female caregiver shared:

> *"The Promoter also taught me on how to feed the child. After the 6 months of exclusive breastfeeding, I should introduce the child to food slowly by slowly starting with light foods. I am also supposed to give the child small portion of food but do it frequently." (Primary caregiver, IDI #11, Nyamira)*

Though not as frequent as ECD, discipline, and nutrition, many caregivers recalled receiving messages about religion. Religious lessons were almost always mentioned by caregivers after being asked about the role of faith leaders or what faith leaders had taught as part of the program. Specifically, caregivers recalled learning how to pray and the importance of being close to God and including spirituality in personal, family, and parenting matters. For example, a caregiver shared that she had learned how to pray from the faith leader and that prayers promoted peace in the household:

> *"From faith leader, I have learnt to stay in peace, when in the house you must pray so that God can help you in everything that you are doing. Even in the group we have learnt from the faith leader how to pray when starting the meetings we need to start with God." (Primary caregiver, IDI #6, Vihiga)*

Some caregivers mentioned learning about kitchen gardens, planting vegetables, or farming. These agricultural lessons were often mentioned in the context of either selling produce for a profit or having fresh vegetables to feed their families. Relatively few caregivers offered specific details about agricultural practices learned, and only a small number mentioned lessons related to animal rearing. As an example, a caregiver shared her teaching on kitchen gardens and their benefits:

> *"I also learned on the importance of having a kitchen garden, one should have a kitchen garden or a small farm, if you don't have that piece of land, they showed us how to make a kitchen garden using sacks and soil and plant your vegetables there. You don't have to go and buy vegetables. You plant your own so that you can use it to feed your children and other family members." (Primary caregiver, IDI #7, Vihiga)*

Many caregivers talked about receiving messages related to savings and finances. These topics were usually mentioned in the context of messages received during S&L Group meetings. Specifically, caregivers reported learning about the mechanics of saving and borrowing, the importance of savings, how to calculate fines and interest, what to do with borrowed capital, and how to make money. Savings and finances were often talked about in the context of using available financial resources to take care of children. For example, a male caregiver elaborated on the financial topics he learned about:

> *"We first discussed the problems one is likely to face when they don't have a job. We then discussed how we can save some money, and the members can borrow from the savings and use it to invest in small businesses. Members could also use the money to pay school fees and those with small children could use the savings to nurture their children in the required way. Members could also borrow money and use it for farming, after which, they could sell the produce and get some income. We also discussed the importance of investing the savings as a group so that members could take loans at times and use it to buy livestock like cows. The members could also take loans for building houses or paying*

school fees. Afterwards, they could return the money with interest." (Male caregiver, IDI #4, Vihiga)

Caregivers often recalled receiving messages about gender roles and the responsibilities of male caregivers in raising children. Both male caregivers and female primary caregivers reported learning about the importance of father closeness and involvement in raising children, including in feeding and playing with children. Caregivers also mentioned learning about the importance of sharing household chores and responsibilities among couples, with several specific mentions of the importance of taking the child to the health clinic together. For instance, one female caregiver shared:

"We were taught that the task of taking care of a child is not delegated to one person but rather both parents should play a role in raising their children. This helps the child to be free with both parents for instance if the child encounters a problem, the child will not fear talking to one of the parents because of fear of being reprimanded and waiting for the other parent to come. So we were thought that it is the responsibility of both parents to take care of their children which includes feeding the children, cleaning the children and raising the children." (Primary caregiver, IDI #9, Nyamira)

Many caregivers mentioned learning about the importance of supervising their children to promote safety. Caregivers reported learning that they should always keep an eye on their young children and ensure that they do not play with or around things that can hurt them, including knives, fire, and farming implements. Caregivers emphasized learning that supervision is particularly important as children begin to crawl or become more mobile. A female caregiver gave a specific example of a common situation that could lead to serious injuries for a young child:

"We learned about child safety and the importance of taking proper care of children at home. For example, you might leave food boiling on the stove while going to fetch water from the river, with the baby still at home. If the child is crawling or trying to stand by holding onto things, such a situation could lead to burns or accidents. Therefore, we were taught the importance of supervising children closely to ensure their safety." (Primary caregiver, IDI #9, Vihiga)

Though not as commonly as the above topics, which were mentioned by the majority of caregivers, caregivers also reported learning about how to make toys and play materials for their children. They emphasized learning that toys and play materials can be made from locally available materials and resources. Further, caregivers reported learning about how this practice can save money by reducing the need to purchase toys. For example, a female caregiver shared:

"We have different learnings that we are taught, for example you may get that previously, I didn't know how to play with a child, I didn't know how to make toys for the child for playing with, but now the experience that I have that I got from this project, I was taught now I play with my child very well… I make toys for them, which we have been taught we make toys from the local available materials, and we had the tendency to think that toys are only bought, but with the learnings we have gotten from MTM we make them ourselves, I make them myself from the local available materials." (Primary caregiver, IDI #8, Vihiga)

Some caregivers mentioned learning about couples' conflict and family violence. Caregivers spoke about receiving counsel, often from faith leaders, on how to resolve conflict amicably and avoid family violence. Caregivers also mentioned learning about how marital conflict and violence can negatively impact children who are exposed to it. One female caregiver recalled specific ways in which couples' conflict might negatively impact her child:

"Another thing I learnt from MTM is that about gender-based violence, and we were taught that when there is that violence in the family, it affects the child. It affects the child's education maybe the child is there when my husband and I are fighting, the child will not have peace, will not eat, and if there is one that is schooling, he will not get time to study." (Primary caregiver, IDI #8, Vihiga)

Some caregivers recalled messages they had received pertaining to child health, WASH, and birth registration. A few caregivers mentioned having been taught about the importance of getting their children vaccinated and attending the clinic if the child was sick. Some caregivers said they had learned about the importance of implementing good hygiene and sanitation practices around their home and with their child, including the role of sanitation and hygiene in preventing disease. A few caregivers mentioned learning about the importance of registering their children's births and procuring birth certificates. For instance, when asked about ways she had learned to take care of her child beyond good nutrition, a female caregiver said,

"We should take the baby to the clinic so that they can get all vaccinations. Apart from that, we should look for birth certificates for our children so that they can have them early enough. When they lack them, it will reach a time when they want to join schools it will be a problem to us as parents." (Primary caregiver, IDI #10, Vihiga)

Very few caregivers mentioned responsive caregiving when describing what they learned from the program. Even when responsive caregiving was explicitly probed during the interview, the majority of caregivers responded in other terms, such as discipline, child safety, supervision, or general awareness of early developmental milestones. These other topics were more commonly reported, as seen above, and are distinct from responsive caregiving. Among all caregivers interviewed, only two explicitly described learning about responsive caregiving in a way that related to improved quality of parent-child interactions or

enhanced parental attunement and responsiveness to their children's cues. In one notable example, the caregiver spoke about understanding that a child's crying is a form of communication rather than misbehavior and that caregivers should respond accordingly:

> *"Previously, I didn't know how to stay and live with my kids, I was so harsh and punished them violently especially the kids I had before the program, I did not nurture them in the right way. I didn't understand why children would cry, I just felt that they were being stubborn for no reason. But after the program, now I understand that when the baby is crying, it means something, like feeding time, changing time or maybe the baby is sick. Crying is a way that the baby communicates because they are not able to talk like adults." (Primary caregiver, IDI #4, Vihiga)*

Program Satisfaction and Dissatisfaction

Overall, caregivers and change agents had positive opinions about the program. They expressed an appreciation for the session topics, the hybrid delivery model (group sessions and home visits), and the S&L Group component. Caregivers specifically praised the performance of both ECD Promoters and faith leaders in fulfilling their roles, while change agents reported having a positive and collaborative working relationship with one another. In addition to their general satisfaction with the program model, change agents were also satisfied with the training, program materials, and the supportive supervision they received. They noted that these resources and guidance facilitated their ability to carry out their roles with ease. Additionally, a few caregivers and change agents also expressed an appreciation for the program's focus on engaging male caregivers, noting that it is gradually changing perceptions about fathers' roles in caregiving.

On the other hand, some caregivers, particularly in Vihiga, expressed dissatisfaction with the lack of financial supports or material goods, noting that they had anticipated receiving such supports based on their prior experiences with similar programs in their communities.

Satisfaction with the program content

The majority of caregivers and change agents expressed that they *"enjoyed"* the program content, highlighting that the various session topics equipped them with valuable knowledge and skills on how to better care for and support the growth of their children:

> *"What I have come to like about the program is the focus on wanting to help a child grow well, to develop a child from an early age. The MTM program, to me, is something I support, and I think it's a good program because it has enlightened us on areas where we were previously unaware, where we had no knowledge. It has opened our minds to these issues." (Faith leader, IDI #5, Nyamira)*

Notably, no topic was singled out as a message that they did not enjoy:

> *"I enjoyed all the topics and lessons because they were very helpful and important to me as a caregiver. There was no topic or lesson that I did not enjoy." (Primary caregiver, IDI #1, Nyamira)*

In particular, caregivers mostly enjoyed lessons on positive discipline, child development, shared responsibilities/gender roles, and play (i.e. the importance of playing with children, and the use of play materials). They highly valued the lesson on positive discipline because it taught them alternative, communication-based methods of discipline, and

they appreciated the child development and play sessions for providing practical ways to better support their child's growth, foster better child-caregiver bonding, and make play materials from locally available resources.

> *"Yes. Those two that is discipline and punishment. I like them very much. Because for the old parents, if a child messed up, they could use corporal punishment which is not good. In my times as a young child, I feared my parents. They scared me. But this program and these topics have helped me be a better parent. That my kids can say, oh my father is coming. Even if they make mistakes, they know they will be punished but it will not be very severe." (Male caregiver, IDI #3, Nyamira)*

Although the lesson on discipline was frequently highlighted by caregivers as valuable, ECD Promoters emphasized that some caregivers disagreed with it and found it *"challenging"* because it went against their own cultural and religious beliefs. Some caregivers even cited the Bible to justify corporal punishment, making the topic particularly challenging to discuss. For example, an ECD Promoter highlighted differences in opinions around discipline that sparked debate among caregivers, with some supporting non-violent correction while others insisted on using corporal punishment for stubborn children:

> *"[What topics did the caregivers not enjoy as much?] Discipline and punishment. There were a lot of arguments in this topic, some caregivers agreed to it, some disagreed to it. And you know you need to agree as a group and have one stand. They didn't all agree that when a child does a mistake you don't beat them but rather correct them with a word of mouth. Some caregivers would say that some children are so stubborn that you have to use a cane, and you know we are not advocating the use of a cane on a child." (ECD Promoter, IDI #4, Vihiga)*

Additionally, the topic on shared responsibilities and gender roles in caregiving was also well-received because it encouraged greater male involvement in household chores and prompted reflections on fathers' roles in caregiving. For example, one female caregiver highlighted that she enjoyed the topic on parenting roles as it encouraged her husband to share childcare responsibilities, thus making her daily life easier:

> *"Number one is on roles parenting at home. That topic made me happy because, as I mentioned earlier, my husband currently helps me take care of our baby. I told him that we learnt the importance of helping one another with childcare duties and that he should not assume that it's solely my responsibility, especially when I'm busy. Thankfully, he has learned to assist me, which has been very beneficial." (Primary caregiver, IDI #9, Vihiga)*

Satisfaction with the program model

Most caregivers were satisfied with the language used to deliver the program. In addition to Kiswahili, many participants appreciated the use of local languages (i.e. Ekegusii in Nyamira and Kinyore and Kiluyha in Vihiga). Furthermore, most participants were satisfied with the length of group sessions and home visits. However, few participants felt that the length of the home visits and group sessions was not enough. For example, one female caregiver shared that the session duration was adequate but wished for longer sessions to allow more teaching and questions and better understanding for all participants:

> *"The duration was okay, but I would like the group sessions to take longer so the promoter can teach more and if I have a question, I ask and be responded to. Because in the group we are many and if my neighbor does not understand well, they can get a chance of the message being elaborated well for better understanding." (Primary caregiver, IDI #8, Nyamira)*

Additionally, many caregivers and ECD Promoters expressed that they liked the hybrid delivery model that utilized both group sessions and home visits. They liked the group sessions because they fostered advice sharing among caregivers and created a more engaging learning environment:

> *"In group meetings, the caregivers meet as a group and they all learn together, sharing ideas on parenting. By so doing, they enrich one another with ideas and skills." (ECD Promoter, IDI #6, Nyamira)*

They also liked the home visits because of the one-on-one interactions, which provided caregivers with a private space to express their concerns, get additional clarification on session content, and receive referrals when necessary. For example, a female primary caregiver highlighted her preference for home visits as they provided a private opportunity to ask questions and seek clarification that might not be possible in group sessions:

> *"I like the home visit more because, during the home visit you could meet the ECD Promoter in person and ask questions. When you are also not satisfied during the group sessions you could extend your questions during the home visits to get clarification. Some questions you could also not ask during the group sessions because there were a lot of people." (Primary caregiver, IDI #9, Nyamira)*

Overall, some participants noted that the two approaches complemented each other. For example, an ECD Promoter expressed reasons why home visits and group sessions were both important:

> *"The difference is that during home visits, you engage with one caregiver at a time. This makes them free to share the issues they are facing at their households. In group*

meetings, the caregivers meet as a group and they all learn together, sharing ideas on parenting. By so doing, they enrich one another with ideas and skills." (ECD Promoter, IDI #6, Nyamira)

Another aspect of the program that the caregivers enjoyed was the S&L Group component, noting that it empowered them financially. Caregivers valued S&L Groups for promoting financial independence, boosting self-esteem, and enabling them to start small businesses for economic growth. For example, an ECD Promoter highlighted how female primary caregivers were empowered through entrepreneurship:

"The way it's encouraging mothers to save. How they can stand for themselves because if someone starts a business, they are starting something where they can earn their own money, and it improves their self-esteem. It makes them believe in themselves. The way they are empowering mothers." (ECD Promoter, IDI #1, Vihiga)

Several caregivers also noted that ECD Promoters counseled effectively during both home visits and group sessions. These caregivers highlighted that ECD Promoters facilitated sessions well, were knowledgeable on the program topics, and served as positive role models. For example, a male caregiver shared that the ECD Promoter was knowledgeable about family issues, delivered lessons in an engaging way that motivated caregivers to listen, and created a comfortable environment where he felt free to ask questions:

"…The way she talked about family issues, when you listen to her well, you will admit that she understood well what she was trained on. The way she delivers the lessons, it motivates you to even keep listening to her. So I felt comfortable talking with her. She even gives you freedom to ask questions." (Male caregiver, IDI #1, Nyamira)

A majority of the caregivers consistently praised the personal qualities of ECD Promoters, describing them as *"friendly", "humble", "very willing to help"*, and *"very good"*. They expressed that they had positive interactions with and perceptions of the ECD Promoter and had built strong relationships with them throughout the course of the program. A few caregivers specifically valued ECD Promoters' trustworthiness when seeking assistance and disclosing personal issues:

"I was very comfortable talking with the ECD promoter. She was very kind, understanding and very polite. She always listened to me and whenever I needed her help or support, she was always ready to offer it." (Primary caregiver, IDI #1, Nyamira)

Similarly, most caregivers also expressed positive feelings towards the faith leaders, describing them as *"friendly", "social",* and easy to communicate with. They particularly appreciated the counseling faith leaders provided, especially in navigating family and relationship conflicts. A few caregivers also appreciated the faith leaders' guidance being rooted

in church and religion, which made them feel especially comfortable. For example, one female caregiver shared that she felt comfort and trusted the faith leader, believing that they brought blessings, healing, and guidance in various aspects of life:

> *"When you always hear about a servant of God you relax. The bible even says, bring all your burdens to me and I will make you rest. We also belief that faith leaders are people that bring good things. If I am sick and the faith leader prays for me, I believe that I will be healed and it happens so. Or if there is a family issue/conflict they unite us and offer guidance and counselling, so that made us feel comfortable because we know that they are carrying blessings." (Primary caregiver, IDI #7, Vihiga)*

At the same time, other caregivers explicitly mentioned having minimal interactions with faith leaders. Multiple caregivers felt the limited involvement made it difficult to get comfortable with them.

In contrast, most ECD Promoters reported having more consistent interactions with the faith leaders. They stated that they had a positive working relationship and good communication, which facilitated their ability to collaboratively teach and counsel caregivers and motivate them to continue participating in the program. They attributed their collaborative partnership largely to the fact that faith leaders personally selected ECD Promoters for their roles. For example, one ECD Promoter shared their positive experience with faith leaders throughout the program:

> *"The faith leaders are the ones who looked for us promoters, encouraged us to join the program, and encouraged male caregivers to participate thus making it easy for us. They are the ones who enlighten us about the goodness of this program.... They chipped in by bringing peace to families. They could also accompany us to home visits and meetings whenever necessary.... It is through the act of being able to convince male caregivers to join program... Their willingness to participate in group meetings which would convince members... There wasn't any difficulty working with the faith leaders." (ECD Promoter, IDI #5, Nyamira)*

Despite an overall positive professional relationship, several faith leaders expressed frustration with ECD Promoters' late notice for meetings and tardiness, especially given their other ongoing religious responsibilities. For example, one faith leader expressed frustration with an ECD Promoters' poor time management, noting that they often arrived significantly late to scheduled meetings, which made it difficult to work with them:

> *"What made it difficult, was [ECD Promoters'] time management, they can plan that we are meeting at 9 am, you can go there at 9 and you have other responsibilities in church, but when you go there at 9 am they come at 10.30 or 11 am, so that made it difficult to work with them." (Faith leader, IDI #5, Vihiga)*

Change agents' satisfaction with the training and program materials

Many ECD Promoters and faith leaders appreciated the training they received, noting that it was thorough and effectively equipped them with the skills, knowledge, and confidence to carry out their responsibilities with ease. Despite being satisfied with the training, one ECD Promoter shared that they had wished there was more time to learn the topics without feeling rushed:

> *"I was satisfied with the training but what I saw, the topics were many and the time was limited. So, you could understand some topics and you will not understand other topics. Even in a class, we have fast and slow learners. In short, the topics were many with very little time to learn them all." ECD Promoter, IDI #5, Vihiga)*

Some ECD Promoters noted that these trainings, coupled with the supportive supervision they received from the ADS staff, further enhanced their ability to facilitate the group sessions and home visits and encouraged them to perform their roles more effectively. For example, an ECD Promoter highlighted the helpfulness of regular visits from ADS staff to boost their morale:

> *"I received supportive supervision regularly from the ADS staff, not just once. They would visit at least every month or two months to check on the progress of our activities at the group sessions and at home visits..... It was very helpful because it encouraged me to carry on with the work. It also boosted my morale and those of caregivers in my group because they realized that we have the support of these ADS Nyanza staff." (ECD Promoter, IDI #3, Nyamira)*

While ECD Promoters generally appreciated the supportive supervision, a couple wished for more advance notice of visits to better prepare and avoid feeling "*ambushed*."

> *"What I have not liked about the program is that sometimes you can be ambushed, like you can be told there is supervision and yet you are not prepared. That makes you panic. I don't like that ambush." (ECD Promoter, IDI #4, Vihiga)*

Besides the training and supportive supervision change agents received, many ECD Promoters also found the home visit guide and FAMA cards provided by the program to be *"very helpful"* and easy to use, serving as reliable references of the session content. One ECD Promoter highlighted how home visit guides were a useful tool to reference:

"Something else I used is the home visit guide. This helped me during home visits. Whenever I forgot something, I would refer to the home visit guide." (ECD Promoter, IDI #2, Nyamira)

The FAMA cards, in particular, made the session content accessible and easy to understand among illiterate and older caregivers:

"FAMA cards that we use to teach. They are so easy and they are making our work easy. You can use them to explain to someone, maybe you are talking to a caregiver that is old in age and doesn't understand what you are talking about, and so in that case you will use a FAMA card, if they see the picture, they are able to relate and can understand." (ECD Promoter, IDI #4, Vihiga)

Among faith leaders, a few specifically expressed appreciation for the sermon guides, noting that they provided guidance on how best to share information with their congregation:

"Sermon guides. They were most useful because we use them while we are preaching in our church and even during other functions within and outside the community. Therefore, the sermon guides have been very helpful." (Faith leader, IDI #2, Nyamira)

In addition to these resources, multiple ECD Promoters mentioned appreciation for the bag, t-shirt, and scarf that they received, noting that these physical items, embroidered with the ADS badge, made them easily recognizable in their respective communities. Additionally, several ECD Promoters also valued the gumboots and bicycles provided. They highlighted that these items made it easier for them to travel from one household to another even during *"bad weather"* conditions. Only one faith leader specifically noted that he received and appreciated the gumboots and raincoat provided.

<u>Dissatisfaction with the lack of financial support (incentives)</u>

While overall most caregivers were satisfied with the program, one repeated area of dissatisfaction with the program was the lack of financial support or incentives for caregivers. This was strongly highlighted by multiple caregivers and several change agents. Caregivers' frustration with the lack of financial support or material goods provided through the program was clearly expressed in both counties, but more respondents mentioned this sentiment in Vihiga than Nyamira. Some caregivers in Vihiga expected to receive material goods because the program was for children and other child-focused programs in their community had set the precedent that the provision of material goods is a key component of such programs. For

example, one ECD Promoter shared how caregivers would express that they expected to receive material things from MTM as they did from other programs:

> *"They were expecting material things so they could ask me, 'We expected something from you and you haven't given anything, other programs do this and that' they start to compare MTM program with other programs from other organizations. They would do this and that for us but you [MTM], you aren't doing that." (ECD Promoter, IDI #4, Vihiga)*

Further, some caregivers believed that change agents were benefiting financially while the caregivers themselves received nothing. Others suspected mismanagement by the program, thinking that promised money was not reaching them. Lack of financial incentives led to resentment among these caregivers and was cited as the reason some dropped out of the program. For example, a female caregiver expressed frustration with being asked to attend meetings and coming with the promise of lunch money, only to return home empty-handed multiple times:

> *"What I didn't like most is that sometimes we are called somewhere, we sit and we are told to sign for some money for even lunch and we come back home with nothing and sometimes I have gone with my children, and also the husband has also left for work, so the money stays for long without getting paid and sometimes some are not paid…It has happened many times like 4-5 times… When you ask, they say it will just be sent." (Primary caregiver, IDI #6, Vihiga)*

A few faith leaders, particularly in Vihiga, voiced concerns about the unequal treatment they experienced compared to ECD Promoters, which contributed to feelings of discouragement and demotivation. While few faith leaders noted not receiving travel allowances for trainings as promised, their deeper frustration centered on a sense of being undervalued relative to ECD Promoters. Unlike ECD Promoters, who received monthly stipends, faith leaders felt their contributions were overlooked despite their early involvement in the program. This perceived disparity in recognition and financial support led some faith leaders to feel undervalued. One faith leader shared that faith leaders should have been valued more since they were involved from the beginning and receive payment like ECD Promoters but instead were left to feel as though they are subordinate to ECD Promoters:

> *"The project, for us as faith leaders, like I told you, faith leaders should be given the first priority because they were the first people to be involved in the project, because at the moment, ECD Promoters are like our bosses, because they are the ones that take monthly reports, they are also paid per month, and faith leaders are not paid, so if you look at that faith leaders are not developing while promoters are taking advantage of developing more than them." (Faith leader, IDI #5, Vihiga)*

Barriers and Enablers of Program Implementation

Barriers

Several types of barriers were identified with respect to program implementation across interviews with various respondents. These barriers included limited male participation in the program, female primary caregivers' responsibilities outside of the program, lack of incentives, religious and cultural norms, and faith leaders' other responsibilities.

Limited Male Participation in the Program

Despite ECD Promoters efforts to engage male caregivers, limited male caregiver participation emerged as a barrier. While implementation targets for male participation were intentionally set lower than those for primary caregivers, change agents nonetheless viewed fathers' minimal involvement as a persistent challenge that limited the program's reach and impact on families. ECD Promoters described actively trying to involve fathers through home visits, individual follow-ups, and encouragement to attend group sessions, but noted that these efforts were often met with limited success. For example, one ECD Promoter highlighted her efforts to engage men, sometimes resorting to female caregivers help, and the struggles she faced in convincing male caregivers to accept the program:

> *"It was very difficult, for you to convincing a man to accept the importance of the program wasn't easy. But we just kept encouraging them and mostly I was using the female caregivers to help me in convincing them to come." (ECD Promoter, IDI #4, Vihiga)*

Male caregivers were often mentioned as being unable to participate in the program due to work-related scheduling conflicts or gender norms, stating group sessions were a women's domain. These constraints—driven by both structural factors such as inflexible work schedules and social norms that associate caregiving with women—made it difficult to meaningfully include fathers in parenting activities and fully realize the program goal of promoting shared caregiving responsibilities and more gender equitable parenting practices in all households. For example, one ECD Promoter shared how men's work commitments prevented them from attending sessions:

> *"It was very difficult for [male caregivers] because most of them were always busy. For example, some of them are bodaboda riders and during the meeting, they would be ferrying passengers hence miss the meeting." (ECD Promoter, IDI #6, Nyamira)*

Female Caregivers' Responsibilities Outside of the Program

For female caregivers, one of the most commonly mentioned barriers towards their consistency in participating in the program was their commitments outside of the program that conflicted with the timing of group sessions. Female caregivers described the challenges of attending group sessions due to various commitments, including the need to attend funerals, care for sick family members, run errands, or attend to their husbands at home. One female caregiver shared the limitations of handling these responsibilities alone while simultaneously being involved in the program:

> *"Sometimes we meet on a Friday which normally finds when I have a lot of things to do in church, sometimes I was committed in Mother's Union, church choir practice. Sometimes back when my mother passed away, I used to be alone and so there are some meetings that I didn't attend." (Primary caregiver, IDI #9, Vihiga)*

A few female caregivers also mentioned work commitments and income-generating activities as barriers to their regular participation in group sessions. For example, a female caregiver shared having to choose between either allocating her time towards earning an income to feed her family or attending group sessions:

> "*Sometimes, I felt some difficulty attending the group sessions because I had to choose between going for casual jobs to fend for my family or attending the group meetings. I always choose the casual jobs so at least I can get money to buy basic food stuff in my household. I cannot be comfortable in the session, yet I am aware my kids haven't eaten the whole day. On the days I had some money to buy food for my kids it was very motivating to go and learn on the topics that we were trained on." (Primary caregiver, IDI #3, Nyamira)*

Lack of Incentives

Another commonly identified barrier to both female primary caregivers' and male caregivers' consistent attendance and satisfaction with the program was the lack of incentives. ECD Promoters, faith leaders, and female primary caregivers described a decline in participation when caregivers' expectations for incentives were not met. While it is clear that demand for the program was still sufficiently high despite drop-outs related to unmet expectations for incentives, the lack of incentives was nevertheless a barrier. The program was accessible only to those caregivers who were able to accept a program that did not offer monetary or material incentives, thus excluding a segment of the eligible caregiver population.

Additionally, as seen in the dissatisfaction section above, even some caregivers who remained engaged felt that the lack of incentives was a negative aspect of the program. As an example, a female caregiver provided further insight into how benefitting from the program was associated with receiving material goods, and how it affected a decline in participation by sharing:

> *"For instance, in our group, we initially had 11 members, but some have dropped out, saying they aren't benefiting from the program. Some individuals only feel supported when they receive money or tangible goods." (Primary caregiver, IDI #9, Vihiga)*

Similar to the necessity for some female caregivers to work, the expectation for incentives was closely tied to the financial hardships they faced. One faith leader shared that caregivers are increasingly frustrated, as they often struggle to meet basic needs like providing food for their children:

> *"But today we have reached a point where [caregivers] are no longer happy. You can go to be with the children and see the children crying and if you assess you realize the children are hungry, and if you tell the mothers that as you come, prepare even tea and put in a bottle for the child to take, some feel it's difficult." (Faith leader, IDI #6, Vihiga))*

Similarly, an ECD Promoter shared that when the program began, people expected material support, such as flour, money, clothes, and mattresses, simply because it was an NGO initiative targeting children:

> *"When we started this program and they heard that this is an NGO program, you when people hear about NGO, they expect that since the program targets children, then they will be getting things like flour, money, clothes and mattresses. So maybe those were their expectations." (ECD Promoter, IDI #5, Vihiga)*

Religious and Cultural Norms

Several ECD Promoters and one faith leader described challenges in teaching caregivers about positive discipline due to religious and cultural norms endorsing the use of physical discipline, such as caning. Harsh discipline was viewed by caregivers as necessary for correcting children's mistakes or misbehavior. For example, one ECD Promoter highlighted these challenges with caregivers by sharing a Biblical proverb which suggested that caning was effective for disciplining children:

> *"The topic on discipline and punishment was a bit challenging because caregivers believe in the Biblical saying that 'spare the rod, spoil the child' meaning caning is the best method to discipline a child. It took time to explain to them that caning is not the best method of discipline, but they understood finally." (ECD Promoter, IDI #6, Vihiga)*

Additionally, a handful of ECD Promoters, faith leaders, and female caregivers described gender-based violence (GBV) as another difficult topic to teach and for caregivers to accept due to cultural norms that regarded it as "taboo" or viewed it as a private matter kept between the husband and the wife. For example, one ECD Promoter described how challenging it was to ask caregivers to vulnerably share about the ongoing family conflicts due to social norms around men's dominance in couples' relationships and how many caregivers are unwilling to disclose such issues:

> "*Mostly the gender-based violence was difficult to facilitate and it still has a challenge because here, like I explained to you earlier, when there is a case of gender-based violence, it becomes hard for me as an ECD Promoter to handle it because even the victims are not ready to share with me. Sometimes, the perpetrator might be threatening the wife and so the wife will not share. Even when you teach the caregivers about this topic, it becomes a challenge, but this is something that happens in the society." (ECD Promoter, IDI #5, Vihiga)*

Faith Leaders' Other Responsibilities

Some ECD Promoters and a few faith leaders highlighted faith leaders' limited time as a barrier. Some ECD Promoters described how faith leaders' ongoing religious commitments outside of MTM made it difficult for them to conduct home visits or attend CSLG sessions with ECD Promoters. For example, one ECD Promoter shared that, while working with the faith leader was generally easy because they were willing to assist when available, this wasn't always the case when church commitments took priority:

> *"…It was easy working together [with the faith leader] because he knew me and trusted me that much. Similarly, the faith leader was always ready to assist me whenever I needed his help. This made it easier for us to work together. It was easy working with the faith leader, although commitments elsewhere on other days made it difficult as we could not attend all the sessions together" (ECD Promoter, IDI #1, Nyamira)*

While few faith leaders agreed that church responsibilities posed a barrier when working with ECD Promoters, others offered a different perspective. They highlighted challenges such as poor time management by ECD Promoters, including issues with arrival times and the duration of home visits or group sessions, as well as the lack of consultation with faith leaders when plans were made. For example, one faith leader shared that difficulties in working with ECD Promoters were caused by transportation issues and poor time management, as meetings often started late:

"What made it difficult, like I have told you is the means of transport, that's the first one, the second one, was their time management, they can plan that we are meeting at 9 am, you can go there at 9 and you have other responsibilities in church, but when you go there at 9 am they come at 10.30 or 11 am, so that made it difficult to work with them." (Faith leader, IDI #5, Vihiga)

Lastly, multiple faith leaders noted that far distances with caregivers and limited resources to travel posed a barrier to performing their duties more efficiently. This challenge was noted when faith leaders were unable to attend to a sick child who lived far away or when traveling between group sessions. For example, one faith leader shared how reaching all caregivers was a challenge due to the long travel distances and lack of effective transportation:

"With 30 faith leaders in the community, traveling between groups was challenging since the area is vast. It would help to have transportation facilities to effectively reach the caregivers." (Faith leader, IDI #3, Nyamira)

Enablers

Several types of enablers were also identified. Program enablers included the introduction of S&L Groups, home visits and encouragement from change agents and caregivers, the use of effective Behavior Change Techniques (BCTs), communication and coordination between ECD Promoters and faith leaders, and teaching about nutrition.

Introduction of S&L Groups

The most frequently mentioned enabler for increasing caregivers' participation in the program was the S&L Groups. Several ECD Promoters described how S&L Groups enabled engagement in the program after attendance had declined in group sessions. One ECD Promoter explained that the S&L Group successfully enabled caregivers' engagement by sharing that caregivers who had previously stopped attending group sessions returned because they could save money and take loans from the group to address their financial challenges:

"In all these, what brought these caregivers back to the program is SwE. Nowadays you will find the attendance in the caregiver support group is low but when you come to SwE you get the attendance is 100% because the caregiver knows that even if she has little money to go and save, she can take some loan from that group and use that money to solve her problems. In fact, SwE saved the program to a great extent because caregivers

had given up and stopped attending the group sessions. Some would not even want the session to last for long hours." (ECD Promoter, IDI #5, Vihiga)

S&L Groups were described as being effective in increasing participation as caregivers saw tangible benefits such as having savings to use during emergencies. The perceived benefits of the S&L Groups led to an increase in the frequency of caregiver meetings. For example, one female caregiver highlighted a similar point as the quote from the ECD Promoter above by explaining how before the introduction of S&L Groups some caregivers attended infrequently but after S&L Groups were introduced the caregivers attended the CSLGs more frequently. She suggested this was because "money nourishes the heart":

Caregiver: *"Through the MTM program they introduced another component which is saving with education though it was introduced towards the end, but it has overtaken everything. Right now if you asked a caregiver randomly about MTM, saving with education is what rings in their mind..."*
Interviewer: *"Why do you think the saving with education 'overtook' everything?"*
Caregiver: *"There is a saying that money nourishes the heart. When the money aspect was introduced, people became more active and some caregivers used to attend the group sessions once in a while but when the savings group was introduced, they are now attending the sessions well." (Primary caregiver, IDI #7, Vihiga)*

Home Visits and Encouragement from Change Agents and Caregivers

An enabler to increase specifically male caregivers' engagement included home visits, alongside encouragement from ECD Promoters, faith leaders, and caregivers. ECD Promoters described home visits as an effective way to reach male caregivers and improve their participation in the program. Further, when male caregivers were provided with encouragements on participation in the program, they felt more inclined to engage in activities. One ECD Promoter described how she was able to engage and convince male caregivers to participate during home visits:

"When I went for home visits, I sometimes met these male caregivers and talked to them about the MTM program. Initially, most of them were not willing to participate in the home visit lessons, but upon my insistence and explanation, they later warmed up to the lessons and started creating time for us. In the caregiver group support, however, very few attended and participated." (ECD Promoter, IDI #2, Nyamira)

Few ECD Promoters highlighted home visits as a space for male caregivers' to privately confide in change agents and confidently participate in caregiving. For example, one ECD Promoter

shared how male caregivers interacted more with their children during home visits as compared to group sessions:

> *"They could easily participate during the home visits like the male caregivers could play hide and seek with their children at home but when it comes to group session they will shy a little bit." (ECD Promoter, IDI #5, Vihiga)*

Incorporating Various Social and Behavior Change Techniques (BCTs)

Another key factor in engaging caregivers in the program was the use of various behavior change techniques (BCTs), such as collaborative group discussions, demonstrations and games, and FAMA cards. **ECD Promoters and a few female primary caregivers described that having collaborative group discussions helped caregivers problem-solve together and encouraged caregivers to ask questions, share advice, and model positive childrearing**. Group sessions were also easier to facilitate as they encouraged active participation, with one female caregiver noting that the group setting helped her open up and receive advice on personal challenges:

> *"I learned that meeting together with other caregivers is a good thing because there are some things I might be ashamed to talk in front of people or I feel is private but when you get to the group and here someone share their experiences, it makes you to open up and share your challenges so that you can get advice from other group members." (ECD Promoter, IDI #7, Vihiga)*

Demonstrations and games were effective in engaging caregivers during group sessions. Caregivers shared that the ECD Promoter's use of demonstrations made the lessons more interesting and easier to understand. ECD Promoters also noted that games increased caregiver enjoyment and participation in the sessions, helping them stay active and interact more.

FAMA cards were described by several ECD Promoters as tools which helped to facilitate their teaching during group sessions and home visits. ECD Promoters shared that the illustrations on FAMA cards facilitated conversations about nurturing care practices, encouraged questions, and guided caregivers in modeling behaviors depicted in the images. For example, one ECD Promoter shared how FAMA cards facilitated teaching by explaining that, during group meetings, they used FAMA cards to revisit topics and clarify actions that caregivers may not have practiced effectively, such as creating time to play with their child, by providing additional illustrations and guidance.

> *"In group meetings, I come with FAMA cards, and the caregivers will come with the passports. We go through the topics, maybe during the home visit you left the caregiver*

with some action and if the caregiver didn't practice well with the child, so when in the group, you use the FAMA cards to illustrate again on how the caregiver was supposed to do that action maybe it was about creating time to play with the child." (ECD Promoter, IDI #5, Nyamira)

Collaboration and Coordination Between ECD Promoters and Faith Leaders

ECD Promoters and faith leaders highlighted that recognizing the importance of each other's roles in MTM served as an enabler. This helped to improve collaborations such as conducting home visits together. For example, one faith leader shared that having good camaraderie with an ECD Promoter helped him conduct his work better:

"Another factor that made it easy is that I am a faith leader, and some of the promoters are my church members. There's that connection between me and them. Even if the church is different, there is mutual respect, and we cooperate, which makes the work more efficient." (Faith leader, IDI #5, Nyamira)

Several ECD Promoters and few faith leaders emphasized collaborations between change agents as a facilitator. ECD Promoters commented on the important role faith leaders played during home visits and group sessions, with few ECD Promoters also sharing their reliance on faith leaders to counsel male caregivers and encourage their participation. Similarly, few faith leaders commented on the unique strengths of ECD Promoters in being familiar with many caregivers and clearly delivering caregiving lessons. This further highlighted the importance of a strong working relationship to improve collaboration and facilitate both ECD Promoters' and faith leaders' work. For example, one ECD Promoter shared that faith leaders supported mentoring male caregivers and assisted in resolving household conflicts through counseling, which helped the promoter to effectively carry out their work, while maintaining a friendly relationship with the faith leaders:

"Secondly, [faith leaders] helped me to mentor male caregivers in the program and they also helped me to counsel, example if I get a conflict in a household, I will have to be accompanied by the faith leader to help me in counselling and when there is peace in a household, it helps me to do my work. And we have had a friendly relationship." (ECD Promoter, IDI #4, Vihiga)

A handful of faith leaders emphasized that coordination with ECD Promoters was a key enabler in maintaining positive working relationships. One faith leader pointed out a previous challenge of working with ECD Promoters but shared how communication had improved, thus leading to a smoother collaboration:

"The ECD Promoters I have are easy to work with. In the early days, there was a problem with planning. The ECD Promoter would plan to make home visits without informing me and this would clash with my plan. We sat down and resolved it; agreeing that calling and planning should be done in advance. Everything is okay now." (Faith leader, IDI #2, Vihiga)

Program Impacts

The program impacted many primary caregivers, male caregivers, children, and change-agents. The program also impacted, to a lesser degree, couples and the community as a whole.

Primary Caregiver Impacts

Most change agents and caregivers (primary caregivers and male caregivers) reported program impacts related to caregiving, including more widespread practice of positive discipline, improved knowledge and practices on child nutrition, and the establishment of kitchen gardens leading to improved nutrition and household income. Many also highlighted the impacts of S&L Groups, mostly in terms of increasing financial access and savings. Some change agents and caregivers focused their perceived impacts on parenting, play, and toy-making. Fewer change agents and caregivers mentioned impacts related to health, child safety and supervision, or early child development.

The most commonly mentioned area of change by primary caregivers was in their approach to discipline. Many primary caregivers described caning as a deeply ingrained cultural practice, making it one of the most challenging behaviors to shift as mentioned above in the barriers section. Despite this initial resistance, the program's persistent emphasis on positive discipline gradually led to changes in both attitudes and practices. Over time, many caregivers began shifting away from physical punishment and toward more positive approaches, such as communicating with children to help them understand their mistakes. For example, a primary caregiver highlighted replacing caning, which she previously thought was the best method of discipline, with communication with her child to explain their mistakes:

> *"I have also learned how to discipline my child. Before the program I thought that the only way to discipline a child is through caning them. However, through the program, I have learned that caning is not the best way to discipline a child. I learned that I should talk to the child and let them know their mistakes and ask them not to repeat." (Primary caregiver, IDI #1, Nyamira)*

Another frequently reported area of change among change agents and caregivers was nutrition. Overall caregiving practices around nutrition improved, including exclusive breastfeeding and dietary diversity. Mothers reported exclusive breastfeeding until children are 6 months, a practice that was previously uncommon. Change agents and caregivers also reported parents providing a more diverse diet to children, such as including more vegetables and proteins like eggs, beans, or chicken. For example, a primary caregiver highlighted how the diet for her child had changed since the program began and how she had incorporated more nutrient-dense foods:

"It has changed many things for me. For instance, I used to feed my child maize porridge in the morning and maize ugali for lunch. However, I have now learnt to balance his meals by including foods rich in different vitamins such as eggs, oranges, porridge, and pineapple." (Primary caregiver, IDI #7, Nyamira)

Many primary caregivers reported having kitchen gardens as a result of the program – specifically through the provision of seeds or seedlings to primary caregivers – which enabled them to plant vegetables. Primary caregivers explained that growing vegetables reduced their need to purchase produce and allowed them to feed their children fresh vegetables. For instance, one primary caregiver explained that the skills gained through the kitchen garden training helped her maintain a diverse selection of vegetables year-round by adapting her gardening practices to seasonal changes:

"I am able to store a variety of food and know how to cope with different seasons of planting like I could be knowing the coming season there won't be rains, so I prepare my kitchen garden and do irrigation and it doesn't take long to have the vegetables. You now have food throughout the seasons." (Primary caregiver, IDI #10, Nyamira)

A few primary caregivers drew an association between the vegetables grown in their kitchen gardens and their children's nutritional status. Additionally, some primary caregivers mentioned that surplus vegetables from kitchen gardens generated extra income to cover child-related expenses. For instance, one primary caregiver described how producing vegetables and eggs not only improved her child's diet but also allowed her to purchase clothing for her child by selling the surplus:

"From the vegetables in the kitchen garden, I get important vitamins for my child and the family at large. The eggs also provide proteins for the child. The money I earn from vegetables and eggs helps me cater for the child's needs like clothes." (Primary caregiver, IDI #1, Nyamira)

Many primary caregivers also clearly noted the S&L Groups as a specific program component that was impactful and largely with respect to financial access, such as taking out loans to start a small business and to have savings. Most of the reported impacts regarding S&L Groups were mentioned in terms of ability to take out loans or accessing money to use for various purposes (e.g., household expenses, to start a small business). Many primary caregivers also mentioned that the lessons from the S&L Groups had helped them to better save money and become more financially knowledgeable. Some primary caregivers took it a step further by articulating how the financial benefits of S&L Groups enhanced parenting and child-related investments. One notable example was a primary caregiver who highlighted the impacts of borrowing money from an S&L Group on caring for her sick child, as well as starting her own business:

"Savings with education has really been good for us and it has brought a positive impact to many people. Because most of us can borrow money from SwE, if the child is sick I take them to hospital, I can buy food to ensure the child has a balanced diet, so you buy what you don't have, and some of us have started some small businesses that brings us income and we continue saving in the group so that we can grow. We have also bought some small chicks that we are rearing now so that we can get eggs in our diet, and we can even cook the chicken for the family." (Primary caregiver, IDI #7, Vihiga)

Another primary caregiver shared how joining S&L Groups had helped her make better financial decisions, including saving money to use later when she needed it for child-related expenses such as food, clothing, and toys:

"When I used to do the casual jobs, I'd get money and use all of it all at once, but with SwE, when I save money and borrow that money later, I was able to do something meaningful with that money like buying food, clothes and the alphabet charts for the child to use." (Primary caregiver, IDI #11, Nyamira)

Finally, two primary female caregivers specifically described S&L Groups contributing to women's financial empowerment in terms of financial independence and reduced reliance on their husbands for household expenses. For instance, when describing the impacts of S&L Groups specifically, one female primary caregiver described:

"It [my life] has changed. This is because nowadays I don't ask him [her husband] for money. For example, if I need 50 shillings for buying something, I sort myself the way I know best." (Primary caregiver, IDI #10, Vihiga)

Another impact was the increased time that primary caregivers devoted to caring for and playing with their children, often using homemade toys. Many respondents highlighted how primary caregivers devoted more time to their children, most of which was described as time spent feeding and playing with the child. For example, one primary caregiver highlighted that the program helped her spend more time with her child, including checking on and playing with the child:

"In the past we never used to spend time with the child. You could be with the child for a few minutes but now, you spend like two hours with your child to see how your baby is doing, check on what they have eaten and assess where the child is playing. In the past we never used to care about where the child is playing. Now you have to check where the child is playing." (Primary caregiver, IDI #8, Nyamira)

The majority noted ECD Promoters specifically as the source of change for these impacts on parenting and early learning outcomes. Primary caregivers reported that previously children did not have toys or had fewer toys because they were expensive. For example, one primary

caregiver highlighted that before the program her child did not have toys since she could not afford to buy them, but since she learned how to make toys with locally available materials her child has had a variety of toys to choose from:

> *"Because you find that me as a parent used to wait until I have money to buy the play things, you see that, and that money for buying play things was not available, but when the project came and trained us that we make from local available material, so I sat down and made them. So my child is benefitting because he has more play things… he has more play things that have been made from local available material, so he is enjoying himself, he plays with this one, when he is tired with it he takes another one, contrary to previous where he used to stay lonely waiting, maybe he would be admiring another one's, but he is okay." (Primary caregiver, IDI #8, Vihiga)*

Although caregivers described impacts related to early learning and play, few detailed changes in responsive caregiving. When mentioned, responsive caregiving was often framed by caregivers as monitoring a child's development or engaging in play, rather than emphasizing the quality of parent-child interactions or attentiveness to the child's cues. According to the Nurturing Care Framework, responsive caregiving involves the caregiver's ability to notice, interpret, and respond appropriately and promptly to their child's signals. However, primary caregivers in our sample tended to describe responsive caregiving in terms of increased awareness and attentiveness to their child's physical growth and developmental milestones, rather than concrete behavioral responses or enhanced interaction quality. For example, one caregiver reflected on how the program increased her attentiveness to her child's development:

> *"What it has taught me most is I have been able to be extra keen on monitoring how my child is growing up. Previously we did not care, the child would just grow, and you see there is growth. But now, when we were taught areas of child development, I now monitor how a child is growing. Then we were also taught about supervising the child, so now we assess children, I look at my child and monitor growth so that when the child gets to a certain age, I expect to see this, so am more observant. It has given me more attention on my child, than before. Yes, it has given me more attention." (Primary caregiver, IDI #12, Vihiga)*

To a lesser degree, a few change agents and primary caregivers reported changes in practices around child health and child safety and supervision. Parents became more likely to take children to the hospital when they were sick rather than considering it unnecessary, which had often been the case previously. For example, one ECD Promoter highlighted parents' reliance on CHVs rather than trying to treat their children at home:

"Yes, I have noticed changes. First, parents who were previously behind in their understanding of how to care for their children have realized that when a child is ill, they should be taken to the hospital. Previously, they would give their children herbs when they were ill, but now they call me or the CHV, who then send them to the hospital for treatment." (ECD Promoter, IDI #7, Vihiga)

One primary caregiver highlighted how she now ensures that her child is kept away from fire and is in a safe environment to limit potential injuries:

"I have one child who was burnt, and it looked normal that children get burnt, but for now, I enjoyed that topic because it taught me to keep things away, things like fire should be away, if the child is on the chair I should know whether he can fall down or not, so I set limits on where I put the child." (Primary caregiver, IDI #12, Vihiga)

Male Caregiver Impacts

In the subsample of men who did participate regularly, many change agents and caregivers highlighted positive changes in male caregivers' involvement with their children as a result of the program. These impacts were frequently described in terms of male caregivers spending more time with their children through play, practicing positive discipline, taking them to the clinic, and attending church as a family. **Among the limited subset of male caregivers who did regularly attend, most male caregivers spent more time playing with their children.** For example, a primary caregiver highlighted a change in her husband's interactions with their child in which he became more involved and began to make time to play with the child:

"Yes, there have been changes. Nowadays my husband has more time to play with the child. He embraces the child more and more unlike earlier on before the program. He spends more time with the child too, something he never did before the program." (Primary caregiver, IDI #1, Nyamira)

Some male caregivers changed their approach towards discipling their children. Previously, male caregivers commonly practiced violent discipline, but lessons from the program resulted in more male caregivers practicing positive discipline and communicating with their children to highlight their mistakes. For example, one male emphasized that before MTM he was more likely to utilize physical punishment, whereas after the program he became less likely to utilize such techniques:

"Let me say for my young child that we have right now, I spend time with the child, even today as I was coming here, the child wanted to come with me here…. At least I enjoy

spending time with the child, and I am seeing it's good…. They [MTM program] are the reason I am enjoying parenting because initially, like for my older child, I was very tough in parenting. I used to cane the child with any slightest mistake, but this MTM program has now helped me." (Male caregiver, IDI #1, Nyamira)

Some change agents and caregivers also reported male caregivers becoming more involved in child health, including taking them to clinic visits, a practice that was previously uncommon. For example, one ECD Promoter highlighted that male caregivers would now take their children to the clinic when she provided a referral:

"Secondly, when I give a referral, you'll find that it is the male caregiver taking that child to hospital. The male caregivers are now free with the children, in instances you find a male caregiver is harsh, even the child can't get close to him. When they come to the CSLG group they come with the child." (ECD Promoter, IDI #4, Vihiga)

Beyond caregiving practices, few male caregivers and faith leaders also highlighted a change in male caregiver's church attendance. Since the program begun, male caregivers started attending church more frequently with their families. For example, one male caregiver highlighted previously it was unlikely that the family would attend church together but now after the program, he attends church with his wife and children:

"The changes like have told you are big. Because like now you wake up early to go to church and you go together with the child. In the past, someone would wake up and go to church alone, there was not much love. Now you wake up, you carry one child, the other one walks, and we all go to church and my wife follows us." (Male caregiver, IDI #5, Nyamira)

Although the program contributed to notable improvements in male caregiver involvement, these changes were not immediate or universal across all households. Female caregivers and program change agents noted how many male caregivers were frequently away from home, making them harder to reach, while others were initially reluctant to engage in program activities due to opportunity costs and restrictive gender norms. Some male caregivers struggled with adjusting to increased caregiving responsibilities, and a few still resisted involvement by the end of the program, viewing childcare as the mother's responsibility. One faith leader described how some men in the community were still not quite involved in their family:

"There are still some men beating their wives but not much and there are men who love their work more than being with a child, they see staying with a child as a waste of time." (Faith leader, IDI #5, Vihiga)

Child Impacts

Caregivers and change agents highlighted children being impacted by the program early childhood development, nutrition, as well as health and cleanliness.

Some primary caregivers and ECD Promoters were able to articulate how the program impacted early childhood development, however not everyone was able to respond in detail. Among those who did expand on the impacts of children in terms of Early Childhood Development, it was primarily in terms of social-emotional development. Social-emotional development was mentioned the most, with primary caregivers highlighting their children's ability to socialize with other children and share toys. For example, one ECD Promoter highlighted how some children have stopped hitting each other, and instead are interacting well by sharing play materials:

> *"In terms of behavior, there are some children who will beat other when they are playing but they have now changed, they can interact well, share playing materials and they are now doing well." (ECD Promoter, IDI #5, Vihiga)*

Few primary caregivers and ECD Promoters mentioned other developmental domains such as language, physical, and cognitive development. Language development was mentioned in the context of children learning to speak faster because of their interactions with others. Physical development was highlighted as general growth and cognitive development in the context of the child's creativity and being able to recognize things. For example, an ECD Promoter described changes in children's social-emotional, physical, and language development:

> *"The biggest change that I have seen in children is that when children play, they grow up in a healthy manner as their bones get strengthened up and speech rate increase. To the children, the group meetings have contributed more through interaction with others." (ECD Promoter, IDI #5, Nyamira)*

Children's nutrition as well as their overall health and cleanliness, was mentioned by few caregivers and change agents as a program impact. They highlighted how children were healthier and had improved growth because of the nutritious foods that have been incorporated into their diets such as vegetables and proteins. They also highlighted that children were healthier with fewer cases of malnutrition. A few change agents and caregivers also highlighted the cleanliness of children having improved. For example, a faith leader highlighted how previously children would attend group sessions hungry and wearing dirty clothes, however that has improved with children being cleaner and interacting with others as they are no longer crying from hunger:

"I have seen changes because initially they were coming with dirty children, crying for food but now when they come to group meetings the children are clean, someone can come and carry the child, even a child can sit on another person because the child is clean, so I have seen the difference." (Faith leader, IDI #4, Vihiga)

Change agent impacts

Many ECD Promoters and faith leaders reported improvements in their skills, particularly in soft skills such as public speaking, communication, and facilitation, as well as literacy and interpersonal relationships. Change agents emphasized increased self-confidence, which enabled them to speak effectively in public and engage with individuals outside their usual circles. For example, a faith leader noted that MTM trainings provided him with the confidence to communicate beyond his church group:

"And through the training I also did obtain self-confidence on talking with different people… I have gained a lot of self-confidence as I can talk to many people at once nowadays unlike before when I was only used to talking to the people of my church only." (Faith leader, IDI #1, Vihiga)

ECD Promoters and faith leaders also described improvements in facilitation skills, including counseling parents, leading groups, and guiding caregivers. A handful of ECD Promoters and faith leaders reported increased community recognition, with various community members, not only caregivers, knowing who they were. For example, one faith leader highlighted the program helping him build friendships and counselling skills:

"I loved this program because it took me to places like Mbale, helping me build friendships and enhance my counseling skills." (Faith leader, IDI #1, Vihiga)

Couples' impacts

To a lesser degree than primary caregiver impacts, male caregiver impacts, child impacts, and change agent impacts, some respondents also noted changes in men's behaviors to improve couples' relationships. Men began taking on responsibilities they previously did not engage in, such as childcare and household chores, which were traditionally viewed as solely the mother's duties. Respondents highlighted improved collaboration between couples, noting that men increasingly shared tasks like cooking, cleaning, and jointly taking the

child to the clinic. As one caregiver described, couples now spend more time together and actively divide responsibilities, demonstrating a meaningful shift in men's involvement at home:

> *"There is great change because in the past if you saw a husband and wife walking together, after passing, you pinch one another and gossip about them. If you see a man going to the river, you say the wife is superior to him. But now you can go to the river together, you draw water, one takes up the hill. When one cooks the other clean the utensils, this one plays with the kids, if you are late out you are sure he will cook for the kids, help with chores, clinics you go together, but in the past, it was not a normal thing" (Primary caregiver, IDI #11, Vihiga)*

Some respondents also reported a reduction in arguments and violence amongst couples. Many couples have highlighted solving problems "peacefully" and "without shouting" based on learning from the program. Few change agents also highlighted couples being less likely to argue in the presence of children as they are now aware of the negative consequences. For example, a caregiver highlighted how her husband is no longer violent towards her after learning about ways to avoid being violent, reasons why this was an issue within the household, and potential outcomes:

> *"Another change I've seen, at times there used to be GBV, but when he was educated on the causes of GBV, how to control, the outcome, so after the education he was taught, currently there is no GBV in the house, because he was taken through all the outcomes, all the causes, we were taught that topic. now he has really changed so much." (Primary caregiver, IDI #8, Vihiga)*

Couples' communication has improved with some caregivers and change agents attributing better relationships with improved communication and understanding between couples. Prior to the program, fathers were less likely to spend time with their wives or communicate in an effective manner. The lessons from the program have resulted in male caregivers being more present and communicative. For example, one male caregiver shared teachings from the program have resulted in a good relationship with his wife, which has resulted in a better relationship for the entire family, as they have learned to communicate better:

> *"My experience in the program has been good, the lessons have been good. There have been teachers that come at home and teach us and the advice that they have given me has brought happiness in my house, there has been good relationship in my house, and we have raised the child and is a child that listens to instructions without having to use a lot of energy. By just talking, you are able to effectively communicate with the child and the wife too. So it has really been helpful to me." (Male caregiver, IDI #5, Nyamira)*

Community impacts

Finally, a few respondents reported community-level impacts or changes within community systems.

Some change agents and ECD Committee members highlighted that since the program has begun, more children have birth certificates and are up to date with their vaccines, suggesting improved linkages within the existing health and social systems. For example, a caregiver representative in the ECD Committee highlighted that through the health sectors connections with the ECD Promoters and CHPs, more children were able to be immunized and receive birth certificates:

> *"So, since this program started, most children have been taken for immunization, about birth certificates, they have been able to get them. The health sector could not have done that on their own, identifying children that haven't received immunization, but through collaboration of ECD Promoters and CHPs that has been made easy, and the health department is now okay." (FGD #3, Nyamira)*

A few change agents and ECD Committee members highlighted a decrease in gender-based violence and child abuse. For example, a caregiver representative in the ECD Committee highlighted a reduction in GBV cases reported to the committee:

> *"I can say we have seen a decrease in GBV among this community like for the past two months we have had only 3 cases from the community compared in the past where we would have even 15 cases in such a time." (FGD #3, Vihiga)*

A few ECD Committee members also highlighted a decrease in poverty due to the introduction of S&L Groups and kitchen gardens. For example, a ministry of education representative highlighted kitchen garden increasing income and savings for women, leading to a decline in overall poverty:

> *"The poverty levels have declined because women have kitchen gardens now and they can sell the produce from their gardens and save some money. They are educated now and there is an improvement through the program." (FGD #3, Nyamira)*

A handful of people reported that the program had changed the community and inspired them to engage in new ways and have better relationships with others. For example, one primary caregiver shared how people were inspired to work on improving their homes or having kitchen gardens, and how people were able to better relate to one another:

"We have witnessed changes. Those people who used to wake up and loiter around now have better things to do like cleaning up their homes and working at their kitchen gardens. People have also stopped shouting at each other and relate better than before, thanks to the program." (Primary caregiver, IDI #1, Nyamira)

Suggested Program Improvements

This final section presents suggestions from caregivers, ECD Promoters, faith leaders, and ECD Committee members on improving the program. Proposed enhancements included incentives for caregivers, physical goods, and stipends, as well as an expanded training for change agents. Respondents also suggested more frequent participation by faith leaders, program expansion beyond the current 18-month time frame, and inclusion of more community members. Suggestions related to S&L Groups, ECD Committees, male caregivers, ADS staff, and additional stakeholders, are detailed below.

In agreement with findings in the dissatisfaction and barriers sections above, one of the main suggestions for improving the program was providing incentives to caregivers, which was raised by all respondent groups. Despite a noted degree of financial relief from participation in S&L Groups and kitchen gardens, caregivers and change agents alike felt that caregivers should be given incentives, whether cash or tangible goods, to help motivate their participation in the program and compensate them for time spent attending sessions. Some respondents shared the expectation that NGOs should provide monetary or material incentives for participants and cited examples of other programs that did so. For example, one caregiver shared that people often believe that child-centered programs should provide material goods or cash to help take care of the child and suggested that MTM do so:

> *"We obviously know that when a program comes it comes with some relief, so for MTM we expected material things we expected we would be given clothes, money or they would give us food. But we didn't see anything of that sort… We understand that when a program comes, it comes with material things… At least they would have given us some money, give the children some clothes, things like those ones… For the program to be better, first, because it is about children under the age of 3 years, they are supposed to bring the children material things when they visit the groups during [CSLG] sessions, they can bring snacks, milk, or clothes. Or if those things are not provided, they can give caregiver two hundred shillings every month when we meet in the [CSLG] session or even give us five hundred shilling if they are able so that you can use that money to buy something." (Primary caregiver, IDI #7, Vihiga)*

While the idea of giving incentives was sometimes noted specifically to help male caregivers become more interested in the program, both male and female caregivers expressed the desire for cash or other incentives to be introduced. **In a similar theme, ECD Promoters and faith leaders both frequently desired to receive certain physical goods and stipends to help them be more effective in their program responsibilities.** Change agents often requested more copies of program materials – including lesson guides, sermon guides, and Bibles for faith leaders as well as flip charts and FAMA cards for ECD Promoters – to support message delivery and, in the case of FAMA cards, to provide caregivers with spare copies. Many faith leaders,

citing the large geographic area for which they were responsible and the importance of being able to reach caregivers, requested a means of transportation. Several ECD Promoters mentioned an increasingly digital world and suggested that technology (e.g. laptops, tablets, smart phones) could help them carry out their roles more efficiently. ECD Promoters also frequently requested new items such as umbrellas, gumboots, and raincoats that could help them visit caregivers in poor weather conditions. For example, an ECD Promoter shared their requests for various items:

> *"The program can provide us with items like gumboots and umbrellas because this region experiences too much rainfall sometimes. This could help us access all households irrespective of the weather. I would also request for laptops to reduce the paperwork and ensure all documents can be accessed easily." (ECD Promoter, IDI #1, Nyamira)*

Furthermore, faith leaders often expressed that they would like a stipend, while ECD Promoters often wanted an increased stipend. Like ECD Promoters and faith leaders, other members of ECD Committees also requested tangible goods and stipends as a means of transportation and to motivate them and facilitate their participation in the program.

Many change agents recommended that they be given more training. Change agents often requested more "refresher" training sessions should be held to help them remember the things they had learned previously. In addition to wanting more refresher courses, some ECD Promoters and faith leaders indicated that they would like to learn more about specific topics within the program. Further, many expressed a desire to strengthen their skills pertaining to counseling, teaching, and leadership that would help them work effectively with caregivers. An ECD Promoter highlighted the potential usefulness of both training on caregiver counseling skills and "refresher" trainings:

> *"Additional training I would love to receive is on guidance and counselling so that I am able to handle it. Maybe you can go to a household and find that a mother is not taking good care of the child or in some instances you find a mother who doesn't want the baby. You can sit down such kind of mothers and offer them guidance and counselling. So if we are trained on that, it can help us. Also for the lessons, when they teach us, they should also repeat the lessons so that in any case you had not understood about something you get to understand it better the next time they are teaching about it because as adults, even taking notes doesn't help us. You can take the notes but when you get home, there are other responsibilities waiting for you there. So you don't even have time to go through the notes that you took. So it is better we have plenty of refresher trainings. Like for case if I understand something, it sticks to my mind rather than reading. When you are reading, you can understand some and the rest you don't understand well." (ECD Promoter, IDI #5, Vihiga)*

When asked about recommendations pertaining to faith leaders, several ECD Promoters and caregivers mentioned that it would be beneficial for the faith leaders to attend CSLGs and home visits more frequently. Respondents generally seemed to feel that faith leaders contributed positively to the program when they were in attendance and that it would be better for them to attend more often and regularly.

> *"I'd wish the faith leader to be accompanying the ECD Promoter during home visits and not only when there is someone sick or conflict that makes them visits us. They should always come and pray for us and not only when we have issues." (Primary caregiver, IDI #7, Vihiga)*

Furthermore, one ECD Promoter mentioned that it would have been helpful if ECD Promoter roles versus faith leader roles had been more clearly defined. For example, a female caregiver shared how the faith leader attending more home visits and group sessions could have helped caregivers develop a better relationship with him:

> *"That faith leader [should] have been visiting groups all the time so that everyone in the group knows him, even in our group he is not known well by everyone. So me I feel in my heart that the way we meet in groups he should visit all of them in their households, he can only be visiting me and not others so I feel that the faith leader should visit everybody he should not discriminate in household visits and I feel he should visit everyone and also attends the group meetings that he has been assigned to." (Primary caregiver, IDI #6, Vihiga)*

Many ECD Promoters, female caregivers, and male caregivers, as well as some faith leaders, expressed the opinion that the program could be improved by adding more session contacts to extend the program beyond its 18-month timeframe. However, people were generally unable to articulate the reason they felt lessons should be added beyond simply stating that they thought more sessions would be beneficial. Additionally, several respondents recommended that the program be expanded to reach more families across the community and in other communities. For example, a female caregiver shared a request to expand the program to more community members and increase the enrollment age limit for children:

> *"More training should be provided to other community members who have not yet been trained. What I would suggest is increasing the age limit for children enrolled in the MTM program from 0-3 years to 0-5 years." (Primary caregiver, IDI #7, Nyamira)*

Similar recommendations were made for S&L Groups as CSLGs, such as extending the program duration of S&L Groups and engaging more with the broader community.

The most frequently suggested improvement from both ECD Promoters and caregivers for S&L Groups specifically was that groups be provided with some initial

capital to start their savings. An ECD Promoter explained that caregivers relied solely on their own savings, with group funds coming from interests, fines, and kitchen garden activities, but that the low savings posed challenged and that funding would strengthen the program:

> *"Right now the caregivers are depending on their own savings, there are no group funds, if the program can boost that fund, and it can make it to be a very good thing and can't be shaken. For example in my group, the group fund is myself from interests, fine, and the other activities they are getting from the kitchen gardens. The number of group members is high yet the group savings are low. So when we share out the calculations becomes a challenge. So if the organization can boost that fund, we will appreciate." (ECD Promoter, IDI #4, Vihiga)*

Additionally, several ECD Promoters suggested that S&L Group sessions and CSLG sessions be combined or held on the same day and at the same place to reduce the burden on caregivers.

As seen in the satisfaction and barriers sections above, many respondents, particularly caregivers, recognized the importance of both parents being involved in childcare and expressed the desire for more men to engage with the program. When asked about ways to encourage male caregivers to be more involved with MTM, respondents of all types often suggested that educating men about the importance of the program (i.e. sensitization efforts) would be a useful way to facilitate more male caregiver participation. As an example, a caregiver shared her thoughts on male caregivers being more involved in the program and how she thought that might happen:

> *"The program should have both man and woman together and not only women alone. I know sometimes men leave to go look for income and females remain at home so they are the majority in the program so both should be involved. The ECD Promoter, when moving in the community, will mobilize them and tell them that they need to be in the program as they talk to them so that they know the importance of the program." (Primary caregiver, IDI #6, Vihiga)*

Other suggestions to increase male caregiver engagement with the program included having sessions that were exclusively for men and, as stated above, introducing monetary or other incentives to compensate male caregivers for their time.

Several respondents of all types recommended that ADS staff visit group sessions more frequently. Respondents expressed the belief that having ADS staff attend group sessions would motivate caregivers and increase the trust they had in change agents. For example, an ECD Promoter suggested that ADS representatives should visit caregivers more frequently to reinforce messages, as prolonged gaps between visits may lead caregivers to doubt the information shared:

"Additionally, they shouldn't stay too long before visiting the caregivers because some of them think that what we occasionally tell them isn't true. This way, when the ADS representatives visit, they'll believe us and feel comfortable answering questions." (ECD Promoter, IDI #7, Vihiga)

Further, some ECD Promoters and faith leaders highlighted a need for greater engagement between the ECD Committee and caregiver groups. This included suggestions around ECD Committee members meeting with caregivers to outline their roles as the ECD Committee and regularly attending home visits and group sessions to understand what is happening on the ground within communities.

Some ECD Committee members also saw the need for stronger collaboration between change agents and government officials as well as better alignment and sharing of work plans to avoid conflicts with government activities. To improve collaborations, government officials highlighted a need for timely communications about meetings and events which they would be invited to join. For example, one participant from the Ministry of Agriculture mentioned how a workplan would enable him to better attend MTM-related activities such as ECD Committee meetings and caregiver trainings. Some ECD Committee members also felt that engaging community leaders early in program implementation and awareness-building efforts would be helpful for the program. For example, an ECD Promoter that was part of the ECD Committee highlighted engaging Chiefs prior to program implementation:

"Before the program starts in the community, the chiefs should be informed first so that they are part of the implementation." (FGD #1, Nyamira)

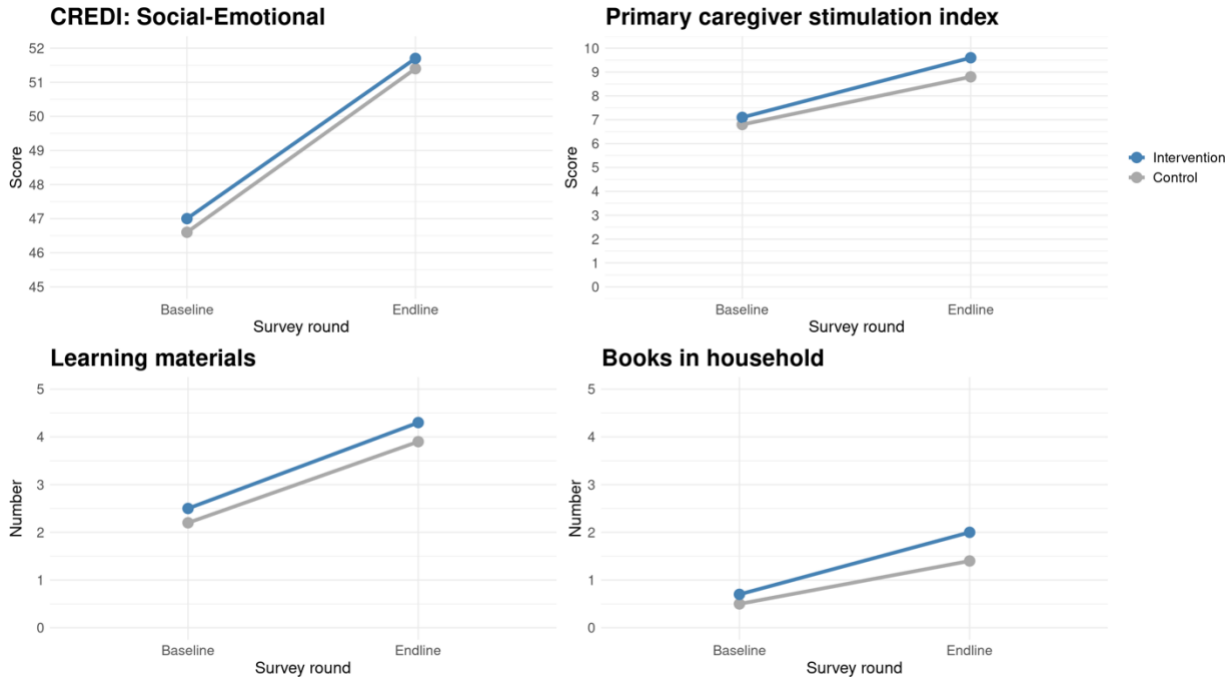
Furthermore, many respondents that were not part of ECD Committees, particularly ECD Promoters and faith leaders, made suggestions that related to connection and integration between the program and other governmental and nongovernmental institutions as well as connecting change agents and program participants from different geographic areas to one another. Specific recommendations included utilizing chief barazas to promote the program's messages, incorporating ways in which change agents may learn from their peers in other geographic areas, introducing additional meetings with stakeholders such as CHVs and representative from other sectors, and allowing additional interested stakeholders to become part of the program. While the specific nature of the recommendations varied widely, the basic idea of wanting to include more people from different places and different sectors was common. One ECD Promoter emphasized the need to involve more supporters in ECD efforts:

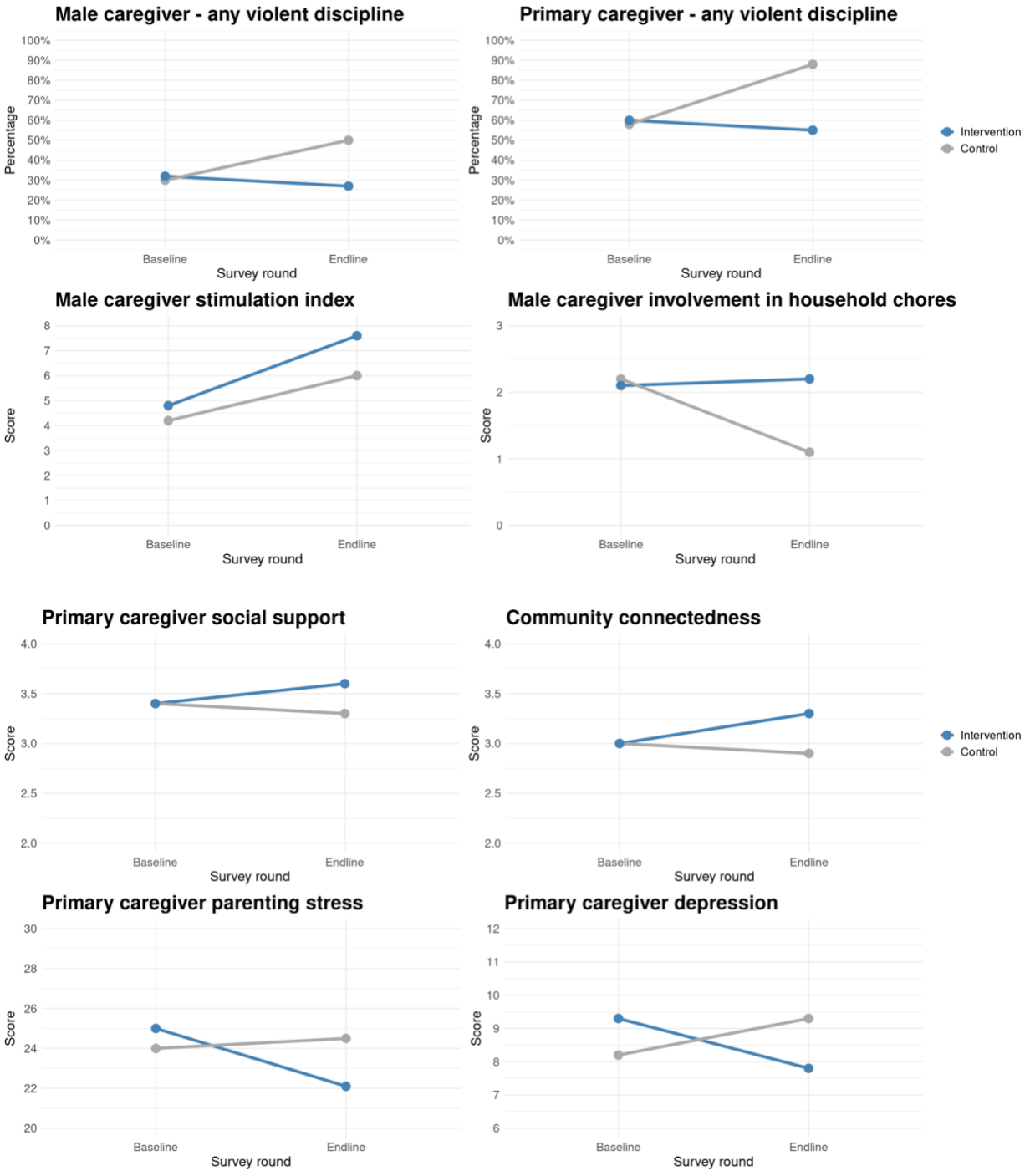
"Those willing to support our work as ECD Promoters should be brought on board because there is a lot of work to be done as far as early childhood development is concerned." (ECD Promoter, IDI #1, Nyamira)

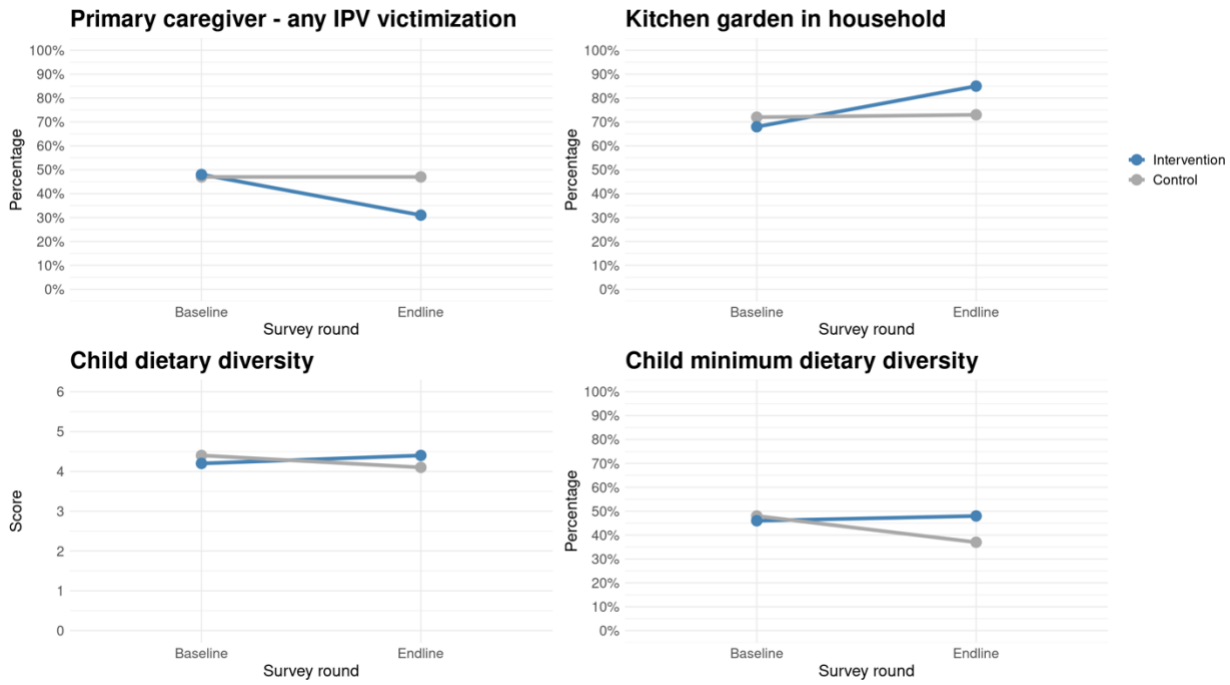
REFLECTIONS ON FINDINGS AND POTENTIAL CONSIDERATIONS FOR FUTURE PROGRAMMING

In this final section of the report, we reflect on the findings from the quantitative impact evaluation and qualitative process evaluation and try to pull out potential implications based on lessons learned. We highlight both the strengths of the program and areas for possible programmatic refinements and strengthening. Overall, this section aims to inform actionable ideas or recommendations to enhance the effectiveness and sustainability of the program not only in Kenya but more broadly as MTM is implemented in other settings across sub-Saharan Africa.

Visual Summary of Outcomes with Statistically Significant Intervention Effects




Male caregiver - any violent discipline
Primary caregiver - any violent discipline
Male caregiver stimulation index
Male caregiver involvement in household chores
Primary caregiver social support
Community connectedness
Primary caregiver parenting stress
Primary caregiver depression
Percentage
Score
Survey round
Baseline
Endline
Intervention
Control



Note: All outcomes shown in the figures above reflect statistically significant improvements for the intervention group ($p<0.05$).

Program Components Were Well-Delivered with High Fidelity

Overall, we found that MTM was delivered with high fidelity and was well-received by participants, particularly the roles of ECD Promoters and faith leaders. ECD Promoters effectively carried out their responsibilities, ensuring that the program's core messages on nurturing care were consistently delivered and with all respondents speaking highly about their roles and skills.

Faith leaders were also recognized as having important roles in the program, albeit secondary and generally described more on an as-needed basis and in terms of complementing or providing support to the ECD Promoters in special circumstances. While midline findings revealed a relatively limited engagement between caregivers and ECD Promoters with faith leaders, by endline, the visibility and positive reception among caregivers and ECD Promoters towards faith leaders clearly improved. Additionally, by endline, faith leaders and ECD Promoters had developed stronger working relationships and valued each other's contributions, which facilitated program implementation. This shift highlights the importance of ensuring the early activation of faith leaders so that their contributions are fully integrated from the outset rather than requiring a bit of a prolonged ramp-up period.

However, despite these improvements, there was still a notable variation in faith leader involvement across communities. Several caregivers and even ECD Promoters expressed a desire

for greater involvement from faith leaders, and faith leaders themselves indicated a willingness to be more engaged if given the necessary resources and supports, such as stipends and transport allowances. Strengthening these linkages could enhance faith leaders' impact and ensure their role is more effectively leveraged in promoting early childhood development.

The S&L Group component was widely praised and well-received by caregivers, who found it beneficial for accessing loans, increasing savings, and improving financial security. Beyond their direct financial advantages, S&L Groups also served as a strong motivator for participation in the program, attracting caregivers to group sessions and fostering greater overall engagement with MTM. However, the implementation of S&L Groups varied significantly across groups and counties, with differences in how ECD Promoters were involved, who was eligible to participate, and how frequently groups met. This lack of standardization raises important questions about the intended scope of S&L Groups—whether they are meant exclusively for program beneficiaries or for the broader community and the purpose by doing so. Additionally, while S&L Groups provided financial benefits, their connection to nurturing care and ECD was not recognized by caregivers. Many participants spoke about S&L Groups in purely financial terms with little mention of how savings could translate into improved caregiving practices. Strengthening this link by explicitly integrating nurturing care messages within S&L Group sessions could enhance the impact on caregiving and ECD outcomes and enable the S&L Group component to be more complementary to CSLGs. Furthermore, better leveraging the expertise of ECD Promoters within S&L Groups could help ensure that financial empowerment translates into meaningful improvements in caregiving and child well-being. While caregivers clearly valued S&L Groups, refining their implementation and reinforcing their connection to ECD could maximize their potential as both a financial and parenting empowerment intervention.

The ECD Committees were well-functioning and operational across all sub-counties, bringing together a diverse group with complementary strengths. However, their engagement at the community level was largely described in terms of the roles that the change agents, particularly ECD Promoters and faith leaders, were already doing as part of their roles. The other committee members had minimal direct interaction with caregivers or community members. Strengthening the committee's role in community engagement—such as having the entire committee participate more actively in outreach—could enhance their impact and support for ECD Promoters and caregivers.

Out of all the program components, the role of mentor farmers was the least clearly defined and articulated by respondents. Neither change agents nor caregivers consistently understood their specific responsibilities, and there was little indication that they played a standardized role across implementation sites. If mentor farmers are to remain part of the program, their purpose, responsibilities, and contribution to the program's broader theory of change must be clarified to ensure they add meaningful value.

One Persistent Concern Pertained to the Lack of Financial Incentives for Caregivers

While overall satisfaction with the program was high, one recurring area of dissatisfaction centered around the lack of financial incentives. This issue emerged prominently in the midline process evaluation and remained a consistent concern at endline. The primary dissatisfaction came from caregivers, who strongly expressed a desire for incentives, but it was also echoed by change agents who observed caregivers' frustrations. Initially, there was an expectation that this concern might diminish over time as caregivers became more accustomed to the program structure. However, its persistence at endline suggests that the absence of financial incentives is a significant issue for participants and warrants attention. Given that caregivers frequently referenced the presence of incentives in other programs, it may be beneficial to either reconsider the program's approach to incentives, even though it was explicitly communicated to caregivers why financial support is not included in MTM multiple times. Additionally, faith leaders at endline continued to express a desire for compensation similar to that of ECD Promoters. Notably, ECD Promoters themselves did not raise similar concerns, suggesting that their level of support was adequate. Addressing these financial concerns—whether through policy adjustments or clearer communication—could help enhance program satisfaction and engagement.

MTM Achieved Positive Effects on Various Outcome Domains, Especially Reducing Harsh Caregiver Discipline, Increasing Male Caregiver Involvement, Caregiver Wellbeing, and Reducing IPV

The program demonstrated robust and wide-ranging positive impacts, with the most pronounced effect being on reducing harsh discipline. Both the quantitative and qualitative data consistently revealed significant reductions in harsh discipline across the study sites in Nyamira and Vihiga. Caregivers reported these changes, and change agents highlighted how the curriculum's messages on positive discipline resonated strongly with participants. The program's ability to improve discipline was a major achievement, with these improvements reinforcing the positive impact MTM had on the broader caregiving environment. Notably, MTM also yielded benefits in male caregiver engagement, a critical area of focus, with both quantitative and qualitative data showing clear improvements in male involvement in nurturing care. This focus on male caregivers, often a challenge in parenting interventions, was recognized by caregivers and program staff alike, marking it as a significant strength of the program. We intend to conduct deeper analyses specifically into the male caregiver results later this year. Moreover, the program showed impressive effects on psychosocial wellbeing, with caregivers in both regions reporting improvements in social support and community connectedness and reductions in parenting stress, depressive symptoms, and financial worries. These findings highlight MTM's effectiveness in

addressing key aspects of caregiving, including discipline, mental health, and male caregiver involvement.

Additionally, MTM had a surprising yet significant impact on reducing IPV, a result that emerged from the data despite the program not explicitly targeting IPV prevention. This suggests that by improving caregiving practices, particularly reducing violence against children, MTM may have fostered broader changes in family dynamics, indirectly contributing to a reduction in IPV. Another unexpected yet notable outcome was the improvement in child nutrition and dietary diversity. Although nutrition was not a primary focus of the curriculum, both change agents and caregivers alike reported significant improvements in these areas, even early on in the intervention, raising questions about how interventions designed for ECD and parenting could naturally integrate nutrition-related content. These findings suggest that MTM's multidimensional approach to caregiving, which includes a broad range of topics like discipline, nutrition, and male engagement, may provide an effective platform for addressing various aspects of family and child health. At the same time, balancing a range of content areas to address ECD holistically should be complemented by a focused integration of key responsive caregiving and early learning practices to optimize developmental outcomes.

Key Area of Improvement is to Enhance ECD and Parenting Outcomes

While the positive effects observed in areas such as discipline, mental health, violence prevention, and nutrition are notable, the overall impacts on ECD and parenting were more modest than anticipated. Specifically, the effect size for stimulation, which was 0.4 SD, was somewhat lower than what is typically observed in the field, where effect sizes of around 0.7 SD are common for similar interventions. Given that MTM is an 18-month program with a clear focus on parenting, one would expect greater impacts on stimulation, early learning, and other key parenting outcomes. This suggests that while the program made notable progress in several domains, the depth of the parenting content may not have been fully ingrained or enacted by caregivers, which can be seen in how the intended improvements in early learning, responsive caregiving, and overall ECD outcomes did not materialize to the extent expected. This is a key area for refinement.

Specifically, the concept of responsive caregiving did not come out strongly by any of the respondents in the qualitative data. Responsive caregiving and the quality of parent-child interactions, parenting sensitivity to a child's cues, and secure caregiver-child bond are one of the strongest predictors of ECD outcomes and highly correlated with intervention effect sizes on ECD outcomes. Thus, it seems that responsive caregiving was not clearly understood or effectively communicated in the program. This gap may stem at multiple potential levels of implementations – starting from the training process, where change agents might not have fully grasped the distinctiveness of responsive caregiving and its role in early childhood development and/or when ECD Promoters went on to counsel parents about this. As a result, caregivers may

not have received the guidance needed to foster these key interactions. It is also possible that there were translation or comprehension issues, and caregivers may have struggled to describe responsive caregiving in Kiswahili. However, we conducted a close analysis of the qualitative data to look for any relevant descriptions of responsive caregiving beyond the literal phrasing and still found little evidence that these behaviors were being described. To address this, strengthening this aspect in the curriculum and the training and delivery of responsive caregiving content should be revisited, ensuring that implementing partner organizations, change agents, and caregivers understand the concept and its application in practice. A key next step would be to reassess the curriculum and optimize the program's content and delivery on early learning and responsive care, rather than lengthening it unnecessarily as the program model of 18-months is already longer than most programs that have been able to achieve larger effects on ECD in shorter duration and may not be the most cost-effective approach.

County-Level Differences in ECD and Parenting Outcomes

A significant and striking finding from the evaluation was the differential effects of the program on ECD and parenting across the two counties involved in the study. While the intervention effects on ECD were small (effect sizes up to around 0.2 SD) and only marginally significant ($p<0.10$) in the overall study sample , two different patterns emerged when unpacking the results by county. We discovered that the program had substantial and positive impacts in Nyamira, where the effect sizes on ECD outcomes were roughly five times greater in Nyamira than in Vihiga and the effect sizes on parenting outcomes were at least two times greater. This discovery suggests that the overall effects on ECD seen in the study are largely driven by the successes observed in Nyamira, while in Vihiga, the effects were much smaller and not statistically significant for ECD outcomes. Notably, no drastic differences were observed for any of the other outcomes, although the effects were consistently a bit better in Nyamira than Vihiga. Interestingly, however, for effects on IPV and kitchen gardens, Vihiga showed stronger results, suggesting that overall there were likely underlying contextual or implementation factors influencing these results. One possible explanation is that ECD Promoters in Vihiga may have received additional training or capacity building around GBV and IPV, potentially through partnerships with local ministries or ongoing interventions which were not standard components of the MTM training package. Further exploration of these contextual differences could help identify strategies that strengthen program impact across sites.

Several factors may possibly explain these striking county-level differences, particularly on ECD and parenting outcomes. One potential explanation relates to differences in the implementation capacity and approach of the two implementing partners. ADS-Nyanza, which worked in Nyamira, has been more deeply involved with the program over a longer period and has greater familiarity with the intervention's complexities and needs. This deeper level of experience likely enabled them to execute the program more effectively, especially in relation to

key content areas such as early learning and responsive caregiving. In contrast, ADS-Western, which implemented the program in Vihiga, was a new partner with no prior experience implementing MTM. This could have created a gap in the capacity to deliver the intervention, especially in the more nuanced aspects of ECD and parenting. Thus, they may have needed additional support and guidance to fully realize the program's potential in these areas. In the qualitative data, we also observed richer and more nuanced responses related to messages received and perceived program impacts in the areas of parenting, early learning, and ECD outcomes being discussed in Nyamira, further supporting the idea that implementation differences may have played a key role in driving county-level variation.

Looking to future implementation, more targeted training on ECD and parenting especially for newer implementing partners and then the sharing of best practices, challenges, and solutions from one county to another throughout the implementation – especially pertaining to ECD – could help to standardize the delivery of these key programmatic components of ECD and ensure that the necessary supports are in place for promoting and delivering these components in both counties. Regular visits, joint training sessions, and shared resources could facilitate cross-learning and collaboration to improve the implementation process, ensuring that all counties benefit from a comprehensive, well-supported approach to ECD and parenting. This would not only enhance the quality of program delivery but could also contribute to better, more consistent outcomes across different contexts.

Another critical factor that could explain the differences is the socioeconomic context of the counties. Households in Vihiga were generally poorer than those in Nyamira, with baseline wealth indicators revealing stark contrasts in education levels and wealth quintiles between the two counties. For instance, 57% of the sample in Nyamira had completed secondary school compared to only 30% in Vihiga, which could influence caregivers' ability to engage with the program and apply the lessons learned. Additionally, 26% of households in Vihiga were in the poorest wealth quintile, compared to only 14% in Nyamira. These socioeconomic disparities likely created different conditions for program uptake and engagement, with households in Vihiga potentially facing more barriers to benefiting from the intervention. This could help explain the generally lower results in Vihiga, particularly for parenting and ECD outcomes.

Further, qualitative interviews revealed that caregivers in Vihiga were more dissatisfied with the lack of financial incentives compared to those in Nyamira, which could have impacted their motivation to engage with the program. This dissatisfaction was more prevalent in Vihiga, where respondents expressed frustration over the absence of financial compensation, a feature that some other programs in the area might provide. This dissatisfaction could have deterred caregivers from fully engaging with the program and could have contributed to the lower levels of motivation and morale among change agents in Vihiga. Although we did not have direct data from the program staff in either county, these insights suggest that the differences in caregiver engagement and satisfaction may have played a role in the observed disparities.

In light of these reflections, a key takeaway is the importance of maintaining continuous oversight of internal program monitoring data to track any possible trends veering towards major county-level differences in implementation and eventual program effectiveness. This includes monitoring the fidelity of key messages, emerging challenges faced by change agents, and participants' reported changes in outcomes and behaviors. These internal monitoring data should not be analyzed in isolation within individual counties or by different project partners but should be shared across counties and partners to enable real-time identification of issues and foster cross-county collaboration. Knowing these findings impact results, it would be interesting for the implementing partners to look back into their monitoring data and see if there were any early signs or indicators that may have signaled county-level differences in our observed ECD and parenting outcomes. This analysis would be valuable for future iterations of the program, especially in multi-partner contexts, by enabling timely course corrections or additional support to ensure consistent delivery of parenting and ECD content across all sites. By closely monitoring key indicators and caregiver-level changes earlier in the process, challenges could have been addressed before they emerged as significant findings at endline data collection.

Lessons from Field Experience During Endline Data Collection

A key lesson learned from our endline data collection process was the importance of ensuring an optimal timeline, particularly considering the end-of-year period and the rainy season. Planning for additional data collection as soon as possible, if the budget allows, is ideal. It is essential to allocate sufficient time and resources for revisiting and planning, especially for end-of-year data collection and during challenging seasons. Additionally, clarifying to the project team that reassessing dropouts is crucial for estimating the "true" unbiased intervention effect could also reduce assumptions or misunderstanding about which caregivers are appropriate for revisiting and how including dropouts are part of understanding the full picture of program effectiveness, and those who drop out should be included in the evaluation.

A positive outcome of our approach was that revisiting households missed during the initial November 2024 endline data collection and capturing them in follow-up data collection in Feb/March 2025 did not alter the overall results—except for socioemotional development outcomes, which became a statistically significant effect when including the revisited sample. Overall, this exercise helped confirm that our results were not biased by missing households in November and ruled out that possibility. In fact, the additional follow-up data strengthened the November results. The overall null effects observed across counties remained robust, confirming that the effect was indeed null in Vihiga but positive in Nyamira. We are grateful for Episcopal Relief & Development's additional investment in supporting this extra data collection, which enabled us to achieve close to 90% follow-up rates. This high follow-up rate strengthens the validity of our research findings, rules out potential biases such as missing data, and ensures an ultimate rigorous evaluation.

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APPENDICES

Appendix 1. Wealth indicators by county

Indicator	Nyamira		Vihiga	
	Our study sample at baseline	Demographic and Health Survey	Our study sample at baseline	Demographic and Health Survey
Improved source of drinking water[1], *n (%)*	60.6%	77.5%	7.1%	85.6%
Improved sanitation facilities[2], *n (%)*	34.0%	36.9%	34.2%	80.1%
Electricity[3], *n (%)*	48.2%	66.7%	45.3%	44.4%
Mobile phone[3], *n (%)*	97.3%	93.4%	85.9%	93.2%
Radio[3], *n (%)*	62.0%	82.5%	51.0%	74.2%
Television[3], *n (%)*	37.7%	45.5%	38.3%	39.1%

[1] Includes piped water, public taps, covered well, rainwater, and bottled water. DHS statistics for this indicator come from the Kenya Demographic and Health Survey 2022. Nairobi, Kenya, and Rockville, Maryland, USA: KNBS and ICF.

[2] Includes flush/pour flush toilets that flush water and waste to a piped sewer system, septic tank, pit latrine, or unknown destination; ventilated improved pit (VIP) latrines; pit latrines with slabs; or composting toilets. DHS statistics for this indicator come from the Kenya Demographic and Health Survey 2022. Nairobi, Kenya, and Rockville, Maryland, USA: KNBS and ICF.

[3] DHS statistics for this indicator come from the Kenya Malaria Indicator Survey 2020. Division of National Malaria Programme (DNMP) [Kenya] and ICF. 2021. Nairobi, Kenya and Rockville, Maryland, USA: DNMP and ICF.

Appendix 2. Intervention effects on outcomes, overall sample.

	Coefficient	Effect Size	Lower Bound (95% CI)	Upper Bound (95% CI)	P>|z|
CREDI Overall score	β	0.19	-0.02	0.40	0.080
CREDI Cognition score	β	0.18	-0.03	0.40	0.094
CREDI Language score	β	0.20	-0.01	0.41	0.057
CREDI Motor score	β	0.13	-0.06	0.32	0.170
CREDI Social-emotional score	β	0.25	0.01	0.48	0.038
GSED D score	β	0.10	-0.05	0.24	0.195
Child socioemotional total score (observed)	β	0.09	-0.08	0.26	0.290
Primary caregiver stimulation index score (11 item)	β	0.40	0.23	0.56	0.000
Number of learning materials	β	0.43	0.26	0.59	0.000
Number of books in household	β	0.29	0.11	0.48	0.002
Primary caregiver use of any positive discipline	OR	0.68	0.25	1.85	0.447
Primary caregiver use of any violent discipline	OR	0.14	0.08	0.26	0.000
Primary caregiver use of any psychological aggression	OR	0.27	0.16	0.45	0.000
Primary caregiver use of any physical punishment	OR	0.21	0.13	0.35	0.000
Birth registration	OR	1.33	0.84	2.11	0.230
Kitchen garden in household	OR	2.41	1.42	4.07	0.001
Child dietary diversity score (24 hr)	β	0.26	0.07	0.46	0.009
Children aged 6-23 months who receive a minimum dietary diversity (MDD) in past 24 hours	OR	2.31	1.37	3.92	0.002
Child experienced any illness (diarrhea, cough, or fever) in last 2 weeks	OR	0.96	0.60	1.54	0.864
Appropriate care (hospital, clinic, CHV) sought for any child illness in past 2 weeks	OR	1.23	0.68	2.20	0.493
Caregiver/child received a referral	OR	3.04	1.58	5.87	0.001
Food insecurity total score	β	-0.01	-0.18	0.16	0.915

Log of income in past month	β	0.03	-0.21	0.28	0.798
Log of total amount currently in savings (i.e Bank, SACCO etc)	β	-0.07	-0.38	0.25	0.684
Log of how much money accessed in credit in past month	β	-0.26	-0.84	0.32	0.376
Primary caregiver overall social support total score	β	0.43	0.27	0.59	0.000
Community connectedness total score	β	0.44	0.24	0.65	0.000
Primary caregiver - any IPV victimization (physical, emotional or economic)	OR	0.51	0.33	0.79	0.003
Primary caregiver - any physical IPV victimization	OR	0.51	0.25	1.03	0.062
Primary caregiver - any emotional IPV victimization	OR	0.45	0.28	0.72	0.001
Primary caregiver - any economic IPV victimization	OR	0.43	0.25	0.73	0.002
Primary caregiver parenting stress total score	β	-0.36	-0.52	-0.19	0.000
Primary caregiver depression total score	β	-0.30	-0.46	-0.13	0.001
Primary caregiver - financial worries in past month	β	-0.27	-0.44	-0.10	0.002
Father stimulation index score (11 item)	β	0.46	0.29	0.64	0.000
Father use of any positive discipline	OR	1.47	0.74	2.92	0.274
Father use of any violent discipline	OR	0.38	0.20	0.70	0.002
Father use of any psychological aggression	OR	0.47	0.27	0.83	0.009
Father use of any physical punishment	OR	0.41	0.22	0.76	0.004
Father involvement in household chores subscale score	β	0.59	0.36	0.82	0.000

Appendix 3. Descriptive statistics of outcomes, Nyamira county.

	Baseline	**Endline**

	Control n=143	Intervention n=154	P>|z|	Control n=128	Intervention n=137	P>|z|
CREDI Overall score	44.8 (3.9)	44.9 (3.7)	0.959	51.7 (1.5)	52.3 (1.4)	0.005
CREDI Cognition score	47.4 (2.3)	47.3 (2.2)	0.947	50.7 (1.0)	51.2 (0.9)	0.002
CREDI Language score	47.6 (1.7)	47.6 (1.7)	0.990	51.4 (1.2)	51.9 (1.2)	0.008
CREDI Motor score	46.6 (2.5)	46.7 (2.5)	0.862	51.6 (1.3)	51.8 (1.2)	0.126
CREDI Social-emotional score	47.1 (2.5)	47.0 (2.4)	0.731	51.3 (1.0)	51.9 (1.0)	<0.001
GSED D score				68.1 (9.4)	69.0 (7.3)	0.389
Child socioemotional total score (observed)				31.9 (9.0)	33.5 (8.6)	0.155
Primary caregiver stimulation index score (11 item)	6.8 (2.5)	7.1 (2.6)	0.371	8.9 (2.2)	9.9 (2.2)	<0.001
Number of learning materials	2.3 (1.7)	2.6 (1.8)	0.192	4.0 (1.1)	4.5 (0.8)	<0.001
Number of books in household	0.7 (1.7)	0.8 (1.5)	0.751	1.8 (1.9)	2.7 (2.1)	<0.001
Primary caregiver use of any positive discipline	97 (68%)	101 (66%)	0.681	121 (97%)	124 (95%)	0.561
Primary caregiver use of any violent discipline	86 (60%)	87 (56%)	0.524	107 (86%)	54 (42%)	<0.001
Primary caregiver use of any physical punishment	76 (53%)	73 (47%)	0.323	97 (78%)	48 (37%)	<0.001
Primary caregiver use of any psychological aggression	73 (51%)	70 (45%)	0.335	83 (66%)	36 (28%)	<0.001
Birth registration	48 (34%)	71 (46%)	0.031	69 (56%)	99 (77%)	<0.001
Kitchen garden in household	112 (78%)	110 (71%)	0.172	99 (79%)	109 (84%)	0.339
Child dietary diversity score (24 hr)	4.7 (1.7)	4.5 (1.5)	0.348	4.3 (1.3)	4.8 (1.2)	0.001
Children aged 6-23 months who receive a minimum dietary diversity (MDD) in past 24 hours	48 (53%)	49 (54%)	0.882	51 (42%)	73 (59%)	0.007
Child experienced any illness (diarrhea, cough, or fever) in last 2 weeks	101 (71%)	118 (77%)	0.241	54 (44%)	70 (55%)	0.088
Appropriate care (hospital, clinic, CHV) sought for any child illness in past 2 weeks	45 (45%)	80 (68%)	<0.001	22 (41%)	45 (64%)	0.009
Caregiver/child received a referral				12 (10%)	48 (37%)	0.000
Food insecurity total score	0.4 (1.0)	0.7 (1.3)	0.013	0.7 (1.4)	0.9 (1.5)	0.202
Income in past month (KSH)	1431.5 (3271.7)	1721.4 (4093.9)	0.503	3444.9 (5568.8)	2741.0 (4765.5)	0.332
Total amount currently in savings (i.e Bank, SACCO etc) (KSH)	3642.0 (25404.5)	982.5 (2829.4)	0.198	3456.0 (9792.6)	3757.3 (6292.4)	0.769

Money accessed in credit in past month (KSH)	27229.0 (129972.1)	45712.6 (257903.6)	0.614	15074.7 (34782.7)	7864.3 (16172.3)	0.185
Primary caregiver overall social support total score	3.4 (0.7)	3.4 (0.6)	0.939	3.4 (0.8)	3.6 (0.6)	0.011
Community connectedness total score	3.2 (0.9)	3.3 (0.9)	0.662	3.0 (1.3)	3.4 (1.2)	0.001
Primary caregiver - any IPV victimization (physical, emotional or economic)	56 (47%)	66 (49%)	0.776	37 (38%)	33 (29%)	0.145
Primary caregiver - any physical IPV victimization	18 (15%)	30 (22%)	0.150	13 (13%)	10 (9%)	0.272
Primary caregiver - any emotional IPV victimization	47 (40%)	58 (43%)	0.579	30 (31%)	28 (24%)	0.284
Primary caregiver - any economic IPV victimization	40 (34%)	38 (28%)	0.342	22 (23%)	17 (15%)	0.139
Primary caregiver parenting stress total score	23.6 (7.1)	23.4 (7.3)	0.762	24.5 (6.8)	22.0 (6.5)	0.003
Primary caregiver depression total score	7.3 (5.8)	8.0 (6.5)	0.283	8.9 (5.9)	7.7 (5.6)	0.100
Primary caregiver - financial worries in past month				12.8 (5.0)	11.6 (5.4)	0.059
Father stimulation index score (11 item)	5.0 (3.3)	5.2 (3.5)	0.581	6.6 (4.2)	8.4 (3.9)	<0.001
Father use of any positive discipline	45 (42%)	50 (43%)	0.828	94 (86%)	95 (85%)	0.765
Father use of any violent discipline	34 (31%)	37 (32%)	0.947	60 (55%)	23 (21%)	<0.001
Father use of any psychological aggression	25 (23%)	22 (19%)	0.442	37 (34%)	16 (14%)	<0.001
Father use of any physical punishment	28 (26%)	32 (28%)	0.779	49 (45%)	16 (14%)	<0.001
Father involvement in household chores subscale score	2.3 (2.4)	2.3 (2.5)	0.953	1.3 (1.9)	3.0 (2.6)	<0.001

Appendix 4. Intervention effects on outcomes, Nyamira county.

	Coefficient	Effect Size	Lower Bound (95% CI)	Upper Bound (95% CI)	P>|z|
CREDI Overall score	β	0.49	0.20	0.78	0.001
CREDI Cognition score	β	0.52	0.24	0.79	0.000
CREDI Language score	β	0.46	0.17	0.75	0.002
CREDI Motor score	β	0.27	-0.01	0.56	0.062
CREDI Social-emotional score	β	0.64	0.36	0.92	0.000
GSED D score	β	0.17	-0.06	0.39	0.141
Child socioemotional total score (Wolkes)	β	0.27	0.01	0.52	0.040
Primary caregiver stimulation index score (11 item)	β	0.53	0.30	0.76	0.000
Number of learning materials	β	0.57	0.33	0.81	0.000
Number of books in household	β	0.47	0.21	0.74	0.001
Primary caregiver use of any positive discipline	OR	0.85	0.16	4.50	0.848
Primary caregiver use of any violent discipline	OR	0.09	0.04	0.22	0.000
Primary caregiver use of any psychological aggression	OR	0.19	0.10	0.35	0.000
Primary caregiver use of any physical punishment	OR	0.14	0.07	0.29	0.000
Birth registration	OR	2.81	1.55	5.08	0.001
Kitchen garden in household	OR	1.63	0.70	3.80	0.255
Child dietary diversity score (24 hr)	β	0.51	0.23	0.79	0.000
Children aged 6-23 months who receive a minimum dietary diversity (MDD) in past 24 hours	OR	3.56	1.67	7.59	0.001
Child experienced any illness (diarrhea, cough, or fever) in last 2 weeks	OR	1.57	0.89	2.77	0.121
Appropriate care (hospital, clinic, CHV) sought for any child illness in past 2 weeks	OR	2.85	1.07	7.58	0.036
Caregiver/child received a referral	OR	5.81	2.84	11.91	0.000
Food insecurity total score	β	0.04	-0.21	0.28	0.768

Log of income in past month	β	-0.03	-0.38	0.32	0.859
Log of total amount currently in savings (i.e Bank, SACCO etc)	β	-0.12	-0.52	0.27	0.548
Log of how much money accessed in credit in past month	β	-0.21	-0.82	0.41	0.510
Primary caregiver overall social support total score	β	0.40	0.17	0.62	0.001
Community connectedness total score	β	0.41	0.15	0.67	0.000
Primary caregiver - any IPV victimization (physical, emotional or economic)	OR	0.64	0.34	1.22	0.175
Primary caregiver - any physical IPV victimization	OR	0.39	0.10	1.48	0.165
Primary caregiver - any emotional IPV victimization	OR	0.64	0.32	1.26	0.198
Primary caregiver - any economic IPV victimization	OR	0.55	0.25	1.22	0.144
Primary caregiver parenting stress total score	β	-0.40	-0.64	-0.16	0.001
Primary caregiver depression total score	β	-0.29	-0.57	0.00	0.050
Primary caregiver - financial worries in past month	β	-0.26	-0.50	-0.02	0.034
Father stimulation index score (11 item)	β	0.55	0.28	0.82	0.000
Father use of any positive discipline	OR	1.40	0.49	4.02	0.532
Father use of any violent discipline	OR	0.17	0.06	0.48	0.001
Father use of any psychological aggression	OR	0.32	0.15	0.70	0.005
Father use of any physical punishment	OR	0.20	0.08	0.50	0.001
Father involvement in household chores subscale score	β	0.82	0.48	1.16	0.000

Appendix 5. Descriptive statistics of outcomes, Vihiga county.

	Baseline			Endline		
	Control n=142	Intervention n=156	P>|z|	Control n=128	Intervention n=133	P>|z|
CREDI Overall score	43.6 (3.9)	44.6 (4.0)	0.025	51.9 (1.5)	52.0 (1.6)	0.835
CREDI Cognition score	46.5 (2.3)	47.2 (2.2)	0.018	50.8 (1.0)	50.7 (1.0)	0.813
CREDI Language score	47.0 (1.6)	47.4 (1.7)	0.038	51.8 (1.2)	51.8 (1.2)	0.786
CREDI Motor score	46.0 (2.6)	46.6 (2.6)	0.043	51.4 (1.2)	51.5 (1.3)	0.501
CREDI Social-emotional score	46.2 (2.5)	46.9 (2.5)	0.012	51.4 (1.2)	51.4 (1.1)	0.993
GSED D score				66.4 (7.5)	67.7 (8.2)	0.184
Child socioemotional total score (observed)				33.8 (9.2)	33.7 (9.6)	0.897
Primary caregiver stimulation index score (11 item)	6.7 (2.7)	7.1 (2.5)	0.291	8.7 (2.0)	9.2 (2.6)	0.120
Number of learning materials	2.0 (1.7)	2.4 (1.7)	0.017	3.8 (1.0)	4.1 (1.0)	0.028
Number of books in household	0.4 (1.2)	0.6 (1.5)	0.079	1.1 (1.5)	1.3 (1.6)	0.292
Primary caregiver use of any positive discipline	55 (39%)	71 (46%)	0.237	124 (98%)	123 (94%)	0.137
Primary caregiver use of any violent discipline	78 (55%)	99 (63%)	0.134	115 (91%)	90 (69%)	<0.001
Primary caregiver use of any physical punishment	64 (45%)	83 (53%)	0.161	103 (81%)	78 (60%)	<0.001
Primary caregiver use of any psychological aggression	57 (40%)	72 (46%)	0.295	90 (71%)	66 (50%)	<0.001
Birth registration	39 (28%)	38 (24%)	0.517	75 (59%)	65 (50%)	0.128
Kitchen garden in household	94 (66%)	100 (64%)	0.705	85 (67%)	112 (85%)	<0.001
Child dietary diversity score (24 hr)	4.0 (1.5)	3.9 (1.6)	0.916	3.8 (1.5)	4.0 (1.4)	0.347
Children aged 6-23 months who receive a minimum dietary diversity (MDD) in past 24 hours	29 (43%)	36 (39%)	0.654	39 (31%)	44 (36%)	0.418
Child experienced any illness (diarrhea, cough, or fever) in last 2 weeks	105 (74%)	123 (79%)	0.319	89 (70%)	73 (58%)	0.044
Appropriate care (hospital, clinic, CHV) sought for any child illness in past 2 weeks	55 (52%)	70 (57%)	0.493	42 (47%)	32 (44%)	0.670
Caregiver/child received a referral				23 (18%)	30 (23%)	0.341
Food insecurity total score	0.8 (1.2)	0.9 (1.3)	0.404	1.1 (1.6)	1.1 (1.5)	0.879

Income in past month (KSH)	680.6 (1332.0)	862.2 (3302.9)	0.541	2936.8 (4664.0)	3527.5 (5088.6)	0.473
Total amount currently in savings (i.e Bank, SACCO etc) (KSH)	131.3 (518.7)	558.5 (3733.6)	0.178	968.5 (3381.7)	1912.8 (3182.2)	0.022
Money accessed in credit in past month (KSH)	2503.6 (3704.2)	4289.2 (15100.4)	0.602	5365.5 (8945.1)	2875.8 (2118.2)	0.037
Primary caregiver overall social support total score	3.3 (0.6)	3.3 (0.6)	0.744	3.2 (0.8)	3.5 (0.8)	0.001
Community connectedness total score	2.8 (1.0)	2.8 (0.9)	0.414	2.9 (0.9)	3.3 (0.9)	0.001
Primary caregiver - any IPV victimization (physical, emotional or economic)	54 (46%)	54 (46%)	0.952	57 (55%)	34 (34%)	0.003
Primary caregiver - any physical IPV victimization	19 (16%)	17 (14%)	0.697	17 (16%)	10 (10%)	0.181
Primary caregiver - any emotional IPV victimization	48 (41%)	47 (40%)	0.852	48 (46%)	24 (24%)	<0.001
Primary caregiver - any economic IPV victimization	36 (31%)	33 (28%)	0.637	37 (36%)	17 (17%)	0.003
Primary caregiver parenting stress total score	24.4 (5.6)	26.5 (6.7)	0.003	24.6 (8.3)	22.3 (8.0)	0.024
Primary caregiver depression total score	9.2 (5.8)	10.4 (6.7)	0.089	9.8 (8.3)	7.9 (6.9)	0.048
Primary caregiver - financial worries in past month				12.9 (5.1)	11.8 (5.4)	0.088
Father stimulation index score (11 item)	3.5 (3.3)	4.3 (3.5)	0.059	5.4 (3.7)	6.8 (4.0)	0.010
Father use of any positive discipline	22 (20%)	32 (29%)	0.118	82 (74%)	79 (76%)	0.724
Father use of any violent discipline	32 (29%)	35 (31%)	0.662	49 (44%)	35 (34%)	0.115
Father use of any psychological aggression	20 (18%)	20 (18%)	1.000	36 (32%)	23 (22%)	0.090
Father use of any physical punishment	23 (21%)	29 (26%)	0.342	32 (29%)	25 (24%)	0.426
Father involvement in household chores subscale score	2.1 (2.2)	2.0 (2.2)	0.676	0.9 (1.6)	1.3 (1.9)	0.188

Appendix 6. Intervention effects on outcomes, Vihiga county.

	Coefficient	Effect Size	Lower Bound (95% CI)	Upper Bound (95% CI)	P>|z|
CREDI Overall score	β	-0.14	-0.41	0.13	0.307
CREDI Cognition score	β	-0.16	-0.45	0.12	0.262
CREDI Language score	β	-0.10	-0.36	0.16	0.453
CREDI Motor score	β	-0.01	-0.26	0.24	0.910
CREDI Social-emotional score	β	-0.17	-0.47	0.13	0.272
GSED D score	β	0.02	-0.18	0.21	0.871
Child socioemotional total score (Wolkes)	β	-0.09	-0.33	0.14	0.436
Primary caregiver stimulation index score (11 item)	β	0.24	0.01	0.47	0.042
Number of learning materials	β	0.28	0.05	0.51	0.017
Number of books in household	β	0.05	-0.18	0.28	0.668
Primary caregiver use of any positive discipline	OR	0.32	0.07	1.55	0.157
Primary caregiver use of any violent discipline	OR	0.21	0.09	0.52	0.001
Primary caregiver use of any psychological aggression	OR	0.37	0.16	0.84	0.017
Primary caregiver use of any physical punishment	OR	0.26	0.11	0.59	0.001
Birth registration	OR	0.65	0.33	1.28	0.214
Kitchen garden in household	OR	3.87	1.89	7.91	0.000
Child dietary diversity score (24 hr)	β	0.05	-0.25	0.35	0.741
Children aged 6-23 months who receive a minimum dietary diversity (MDD) in past 24 hours	OR	1.77	0.79	3.96	0.162
Child experienced any illness (diarrhea, cough, or fever) in last 2 weeks	OR	0.55	0.27	1.13	0.104
Appropriate care (hospital, clinic, CHV) sought for any child illness in past 2 weeks	OR	0.69	0.31	1.56	0.371
Caregiver/child received a referral	OR	0.17	-0.17	0.51	0.317
Food insecurity total score	β	0.40	0.15	0.65	0.002

Log of income in past month	β	0.23	-0.22	0.68	0.319
Log of total amount currently in savings (i.e Bank, SACCO etc)	β	-0.52	-1.32	0.29	0.208
Log of how much money accessed in credit in past month	β	0.50	0.28	0.73	0.000
Primary caregiver overall social support total score	β	0.49	0.23	0.74	0.000
Community connectedness total score	β	0.47	0.24	0.91	0.026
Primary caregiver - any IPV victimization (physical, emotional or economic)	OR	0.63	0.26	1.54	0.309
Primary caregiver - any physical IPV victimization	OR	0.33	0.16	0.69	0.003
Primary caregiver - any emotional IPV victimization	OR	0.34	0.16	0.75	0.007
Primary caregiver - any economic IPV victimization	OR	-0.38	-0.61	-0.14	0.002
Primary caregiver parenting stress total score	β	0.69	0.34	1.39	0.299
Primary caregiver depression total score	β	0.54	0.31	0.95	0.034
Primary caregiver - financial worries in past month	β	-0.05	-0.29	0.20	0.696
Father stimulation index score (11 item)	β	1.31	0.48	3.57	0.603
Father use of any positive discipline	OR	0.61	0.26	1.41	0.249
Father use of any violent discipline	OR	0.60	0.28	1.30	0.196
Father use of any psychological aggression	OR	0.66	0.27	1.60	0.360
Father use of any physical punishment	OR	-0.13	-0.39	0.14	0.361
Father involvement in household chores subscale score	β	-0.14	-0.41	0.13	0.307

Appendix 7. Descriptive statistics of outcomes at endline, with results for Nyamira and Vihiga counties presented side-by-side.

	Nyamira			Vihiga		
	Control n=128	Intervention n=137	P>|z|	Control n=128	Intervention n=133	P>|z|
CREDI Overall score	51.7 (1.5)	52.3 (1.4)	0.005	51.9 (1.5)	52.0 (1.6)	0.835
CREDI Cognition score	50.7 (1.0)	51.2 (0.9)	0.002	50.8 (1.0)	50.7 (1.0)	0.813
CREDI Language score	51.4 (1.2)	51.9 (1.2)	0.008	51.8 (1.2)	51.8 (1.2)	0.786
CREDI Motor score	51.6 (1.3)	51.8 (1.2)	0.126	51.4 (1.2)	51.5 (1.3)	0.501
CREDI Social-emotional score	51.3 (1.0)	51.9 (1.0)	<0.001	51.4 (1.2)	51.4 (1.1)	0.993
GSED D score	68.1 (9.4)	69.0 (7.3)	0.389	66.4 (7.5)	67.7 (8.2)	0.184
Child socioemotional total score (observed)	31.9 (9.0)	33.5 (8.6)	0.155	33.8 (9.2)	33.7 (9.6)	0.897
Primary caregiver stimulation index score (11 item)	8.9 (2.2)	9.9 (2.2)	<0.001	8.7 (2.0)	9.2 (2.6)	0.120
Number of learning materials	4.0 (1.1)	4.5 (0.8)	<0.001	3.8 (1.0)	4.1 (1.0)	0.028
Number of books in household	1.8 (1.9)	2.7 (2.1)	<0.001	1.1 (1.5)	1.3 (1.6)	0.292
Primary caregiver use of any positive discipline	121 (97%)	124 (95%)	0.561	124 (98%)	123 (94%)	0.137
Primary caregiver use of any violent discipline	107 (86%)	54 (42%)	<0.001	115 (91%)	90 (69%)	<0.001
Primary caregiver use of any physical punishment	97 (78%)	48 (37%)	<0.001	103 (81%)	78 (60%)	<0.001
Primary caregiver use of any psychological aggression	83 (66%)	36 (28%)	<0.001	90 (71%)	66 (50%)	<0.001
Birth registration	69 (56%)	99 (77%)	<0.001	75 (59%)	65 (50%)	0.128
Kitchen garden in household	99 (79%)	109 (84%)	0.339	85 (67%)	112 (85%)	<0.001
Child dietary diversity score (24 hr)	4.3 (1.3)	4.8 (1.2)	0.001	3.8 (1.5)	4.0 (1.4)	0.347
Children aged 6-23 months who receive a minimum dietary diversity (MDD) in past 24 hours	51 (42%)	73 (59%)	0.007	39 (31%)	44 (36%)	0.418
Child experienced any illness (diarrhea, cough, or fever) in last 2 weeks	54 (44%)	70 (55%)	0.088	89 (70%)	73 (58%)	0.044
Appropriate care (hospital, clinic, CHV) sought for any child illness in past 2 weeks	22 (41%)	45 (64%)	0.009	42 (47%)	32 (44%)	0.670
Caregiver/child received a referral	12 (10%)	48 (37%)	0.000	23 (18%)	30 (23%)	0.341
Food insecurity total score	0.7 (1.4)	0.9 (1.5)	0.202	1.1 (1.6)	1.1 (1.5)	0.879

Income in past month (KSH)	3444.9 (5568.8)	2741.0 (4765.5)	0.332	2936.8 (4664.0)	3527.5 (5088.6)	0.473
Total amount currently in savings (i.e Bank, SACCO etc) (KSH)	3456.0 (9792.6)	3757.3 (6292.4)	0.769	968.5 (3381.7)	1912.8 (3182.2)	0.022
Money accessed in credit in past month (KSH)	15074.7 (34782.7)	7864.3 (16172.3)	0.185	5365.5 (8945.1)	2875.8 (2118.2)	0.037
Primary caregiver overall social support total score	3.4 (0.8)	3.6 (0.6)	0.011	3.2 (0.8)	3.5 (0.8)	0.001
Community connectedness total score	3.0 (1.3)	3.4 (1.2)	0.001	2.9 (0.9)	3.3 (0.9)	0.001
Primary caregiver - any IPV victimization (physical, emotional or economic)	37 (38%)	33 (29%)	0.145	57 (55%)	34 (34%)	0.003
Primary caregiver - any physical IPV victimization	13 (13%)	10 (9%)	0.272	17 (16%)	10 (10%)	0.181
Primary caregiver - any emotional IPV victimization	30 (31%)	28 (24%)	0.284	48 (46%)	24 (24%)	<0.001
Primary caregiver - any economic IPV victimization	22 (23%)	17 (15%)	0.139	37 (36%)	17 (17%)	0.003
Primary caregiver parenting stress total score	24.5 (6.8)	22.0 (6.5)	0.003	24.6 (8.3)	22.3 (8.0)	0.024
Primary caregiver depression total score	8.9 (5.9)	7.7 (5.6)	0.100	9.8 (8.3)	7.9 (6.9)	0.048
Primary caregiver - financial worries in past month	12.8 (5.0)	11.6 (5.4)	0.059	12.9 (5.1)	11.8 (5.4)	0.088
Father stimulation index score (11 item)	6.6 (4.2)	8.4 (3.9)	<0.001	5.4 (3.7)	6.8 (4.0)	0.010
Father use of any positive discipline	94 (86%)	95 (85%)	0.765	82 (74%)	79 (76%)	0.724
Father use of any violent discipline	60 (55%)	23 (21%)	<0.001	49 (44%)	35 (34%)	0.115
Father use of any psychological aggression	37 (34%)	16 (14%)	<0.001	36 (32%)	23 (22%)	0.090
Father use of any physical punishment	49 (45%)	16 (14%)	<0.001	32 (29%)	25 (24%)	0.426
Father involvement in household chores subscale score	1.3 (1.9)	3.0 (2.6)	<0.001	0.9 (1.6)	1.3 (1.9)	0.188