Foundations for the Future Programme

A strong start for every child from birth to school-age

Endline Study Report

May 2026

International Child Development Initiatives

NRDO
Nascent Research & Development Organisation Uganda

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1. Introduction

The Foundations for the Future (F4F) programme was developed as a pilot initiative, building on and adapting the 'Making the First 1000 Days Count!' model developed by International Child Development Initiatives (ICDI) and Education for Sustainable Development (ESD).

The programme is based on an integrated approach that combines home visits, centre-based activities, facilitated access to existing services, local ownership and participation, financial support for vulnerable families, and holistic attention to all dimensions of child health and development. Evidence from implementation has demonstrated the effectiveness of this combination of interventions in supporting improved outcomes for young children and their families.

The positive results achieved in Ethiopia created an opportunity to test the applicability of the model in another African context. The F4F programme was therefore transferred, implemented, and adapted in Uganda, in partnership with Nascent Research and Development Organisation (Nascent-RDO), with a specific focus on the Busoga region. The programme aimed to assess the model's relevance, effectiveness, and adaptability within a new social, cultural, and institutional context.

The programme focused on strengthening the well-being and development of young children aged 0-8 and their caregivers through community-based early childhood development (ECD) interventions. Implemented over two years (January 2024-December 2025), it was delivered in six communities in Uganda's Busoga Sub-Region: Bubaka, Butokolo, Bulamagi, Budhebela, Bwanalira, and Kinawanswa.

The programme was delivered through three main components: (1) participatory community plans for children through the strengthening of 'ECD 0-8 Committees'; (2) facilitation of access to multi-layered and integrated community health and social care support systems; and (3) support for parents to provide rich, safe, and nurturing environments for children aged 0-8.

In 2026, following the completion of two years of implementation[1], ICDI and Nascent conducted an outcome evaluation. The scope of this endline evaluation is the analysis and reporting of data on the programme's outcomes. These data were collected by Nascent across the six target communities. The data are both quantitative and qualitative and were collected through engagement with caregivers, adolescents, community members, and stakeholders.

[1]The period evaluated was from January 2024 to December 2025. Although the programme continues in 2026, budget limitations have resulted in only the main programme activities being maintained during this period. The evaluation therefore covers the first two full years of programme implementation.

The endline evaluation aims to assess the realisation of the programme's key outcome at the conclusion of the implementation period. These outcomes are:

1. **Community support:** Communities and stakeholders foster an enabling, supportive environment for young children and their caregivers.
2. **Improved services:** Authorities and service providers enhance the accessibility and quality of ECD services.
3. **Parental confidence:** Parents feel empowered and capable of providing a safe and nurturing environment for their children.

A key limitation of the endline evaluation is that the baseline and endline studies relied on different data sources and methods. The baseline relied primarily on secondary data from context analysis exercises, whereas the endline draws on primary data collected. Because these approaches were not fully aligned, the findings are not always directly comparable. However, the **endline evaluation provides a comprehensive and robust dataset, offering valuable insights into the programme's outcomes and overall performance.**

Following this introduction, Section 2 presents the endline evaluation's methodology, Section 3 presents the endline evaluation's findings and analysis, and Section 4 outlines its key conclusions.

2. Methodology

This section outlines the data collection and analysis approach for the endline evaluation, covering the methods, participant groups, and tools used across the six target communities.

2.1 Procedure

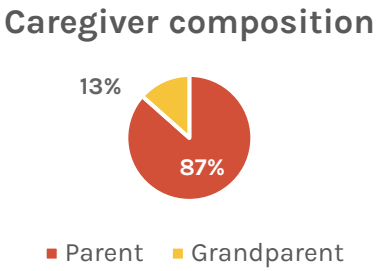
A mixed-methods approach was used in the endline evaluation, integrating **both quantitative** and **qualitative data collection**. Quantitative data were collected through structured interviews with caregivers and teenagers, while qualitative data were gathered through Focus Group Discussions (FGDs) with community members and stakeholders.

Before the data collection, ICDI delivered training to data collectors to ensure quality and smooth implementation. The training covered the use of data collection tools and ethical considerations.

2.2 Data

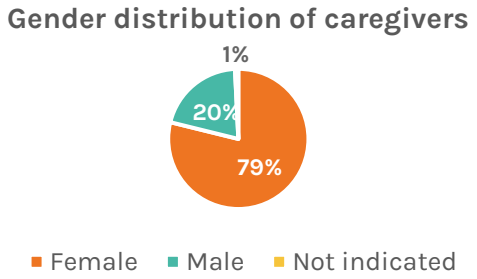
Data was collected from multiple participant groups, including caregivers, teenagers, community members, and stakeholders, across the six target communities.

Caregiver Survey Participants



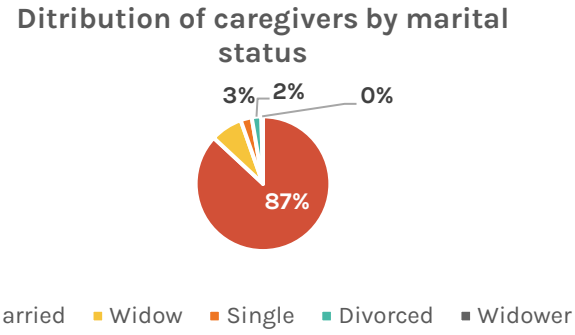
Graph 1. *Caregiver composition (%)*

A total of 260 caregivers participated in the survey. The majority of respondents were parents (87%), while a smaller proportion were grandparents (13%).



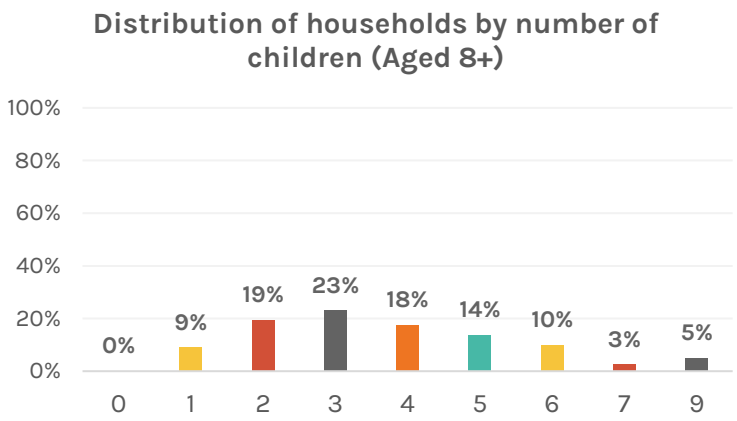
Graph 2. *Gender distribution of caregivers (%)*

In terms of gender, most respondents were female (79%), followed by male participants (20%). A very small proportion of responses did not indicate gender (1%).



Graph 3. *Distribution of caregivers by marital status (%)*

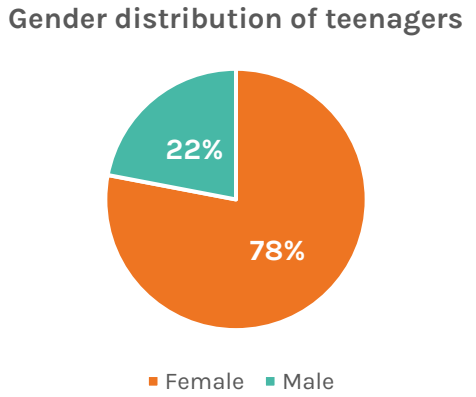
Most caregivers were married (87%), with smaller proportions identified as widowed (8%), single (3%), or divorced (2%).



Graph 4. *Distribution of households by number of children (aged 8 and over) (%)*

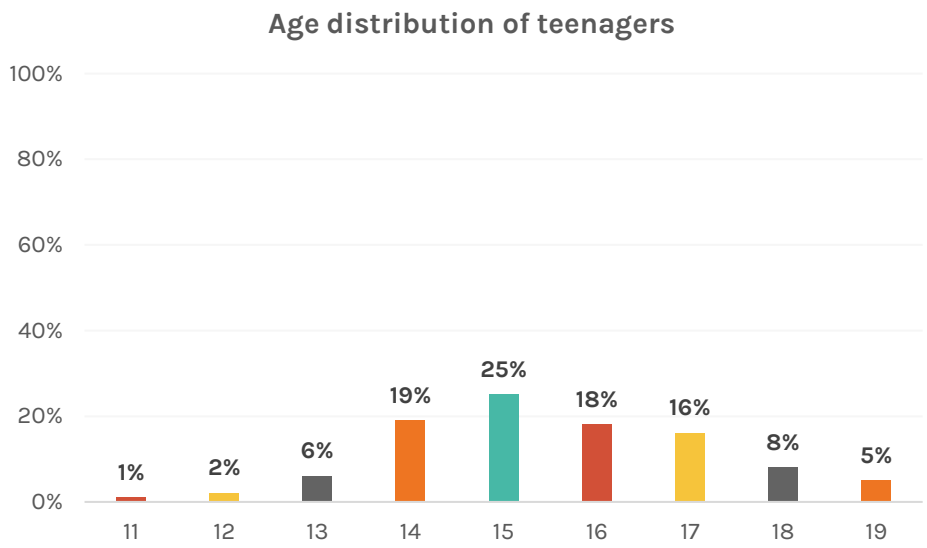
In terms of household composition, caregivers reported varying numbers of older children (aged 8 or over), with the most common categories being households with three (23.03%) and two (19.38%) older children.

Teenage Survey Participants



Graph 5. *Gender distribution of teenagers (%)*

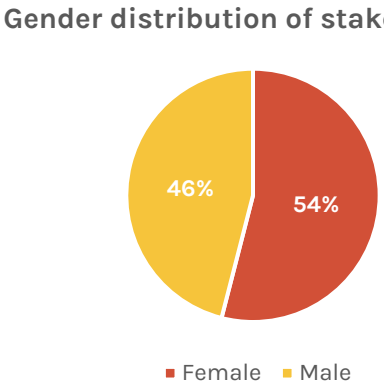
In addition, a total of 171 teenagers participated in the survey. By gender, the majority of respondents were female (78%), with male participants accounting for 22%.



Graph 6. *Age distribution of teenagers (%)*

Participants ranged in age from 11 to 19 years. The largest age group was 15-year-olds (25%), followed by 14-year-olds (19%), 16-year-olds (18%), and 17-year-olds (16%). Smaller proportions were observed among 18-year-olds (8%), 13-year-olds (6%), and 19-year-olds (5%), while very few respondents were aged 12 (2%) and 11 (1%).

Stakeholder FGD Participants

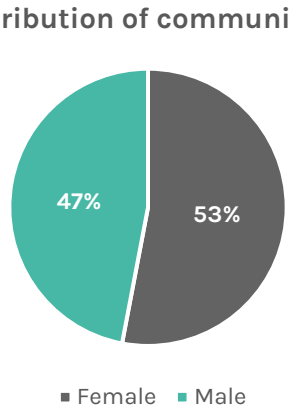


Graph 7. *Gender distribution of stakeholders (%)*

A total of 37 stakeholders participated in the data collection. Of these, 54% (20 individuals) were male, and 46% (17 individuals) were female.

Stakeholders represented a range of sectors, including education, health, social services, community leadership, religious leadership, cultural leadership, youth representation, and local government.

Community FGD Participants



Graph 8. *Gender distribution of community members (%)*

A total of 36 community participants took part in the discussions. Of these, 53% (19 individuals) were female, and 47% (17 individuals) were male.

Participants represented a range of community roles, including religious leaders, teachers, health workers, social workers, local leaders, counsellors, and village health team (VHT) members.

2.3 Evaluation Questions and Data Collection Tools

The endline evaluation addressed a set of research questions on key programme outcomes. These questions were explored using a range of data collection tools, each targeting specific aspects of the programme.

These tools were designed to address evaluation questions on community ownership and advocacy, service availability and accessibility, SRHR-related behavioural change, caregiver confidence and parenting practices, and early learning outcomes.

Caregiver interviews examined parenting practices, child safety, access to services, and caregiver confidence, including perceptions of early childhood development, health, and SRHR-related issues.

Teenager interviews focused on the availability, accessibility, and perceived quality of SRHR services, as well as young people's knowledge, experiences, and help-seeking behaviour.

Stakeholder FGDs explored the availability, accessibility, and quality of education, health, and SRHR services, as well as gaps and areas for improvement.

Community member FGDs examined community ownership, engagement, and involvement in supporting the health and well-being of young children.

Together, these data sources provide a comprehensive understanding of programme outcomes across participant groups.

2.4 Analysis

The collected data were analysed using statistical tools in Microsoft Excel. Quantitative data were analysed using descriptive statistics, while qualitative data were analysed through thematic review to identify key patterns and insights.

3. Analysis

This section presents the findings of the endline evaluation, organised around the programme's key outcome areas. The analysis draws on quantitative and qualitative data and addresses the evaluation questions for each outcome.

2.1 Outcome 1: Communities and stakeholders create an enabling, supportive environment for young children and their caregivers.

QUESTION A) *Have the communities developed a sense of ownership with respect to the health and psychosocial well-being of children aged 0-8? What was initiated in terms of active lobbying and advocacy?*

There is evidence that communities have begun to develop a sense of ownership over the health and psychosocial well-being of children aged 0–8, although this varies across villages.

In communities such as Bubaka, Bulamagi, and Budhebela, ownership is reflected in active engagement and shared responsibility. Community members described organising activities together, including identifying safe locations for Play Hubs [2]and agreeing on suitable timings: "*We worked together to choose a place where children can play safely and agreed on the time for everyone.*" There are also examples of peer support and follow-up, with community members reminding each other about services and supporting access: "*We remind each other and help mothers go to the health centre.*"

> ***"The VHTs and social workers in our community always raise awareness of these services and encourage people to access them both in the community and health facilities. They also provide support and information on balanced diet, sanitation, and hygiene."***

Emerging shifts in caregiving roles are also visible, particularly in increased involvement of men. Participants noted that more men are accompanying their partners to health facilities and supporting childcare: "*Men now go with their wives to the health centre and support them.*"

> ***"Some men have started accompanying their wives to antenatal care because community sensitisation meetings explain the importance of their support. Couples counselling is sometimes offered to encourage men to understand the mother's needs and how to prepare for delivery"***

[2] **Play Hubs** are family-friendly centres that are run in collaboration with community members, educators, and health extension workers. Here, young children can play with toys and join educational activities, and their parents can participate in workshops about child development, education, health, nutrition, and responsive parenting.

Women's groups and peer networks were also highlighted as important sources of knowledge-sharing and mutual support: "*We meet and advise each other on how to care for our children.*"

> *"Awareness campaigns and information on prenatal services are mostly shared by women in this community. When they learn about services offered at health facilities or in the community, they inform each other, which increases accessibility and allows more people to benefit."*

Quantitative findings also indicate greater caregiver involvement at the household level. As presented in subsequent sections, caregivers report regularly playing with their children, attending to health and safety, and using available services. While these indicators do not directly measure community ownership, they suggest a more active and consistent role in children's care, which supports the qualitative findings.

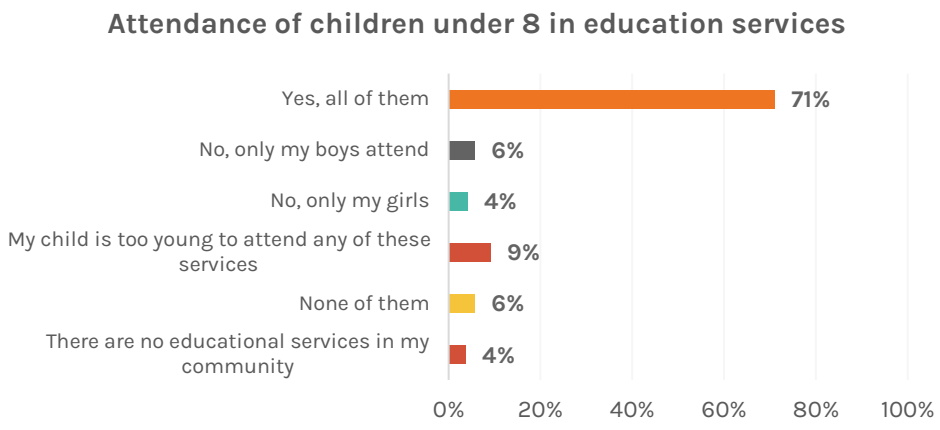
However, ownership is not consistent across all villages. In Bwanalira and Budhebela, participants more frequently highlighted barriers such as distance, transport costs, and competing livelihood demands: ***"The health centre is far, and sometimes we don't have money for transport,"*** and ***"People want to attend, but they have to work and cannot always come."*** These challenges limit the consistency of engagement.

> *"The availability of transportation services like boda boda and bicycles in our community makes it easy for our community members to access these services from the health centres however it comes with a cost if you are to use a boda boda"*

In terms of advocacy, there is **limited evidence of structured or formal lobbying**. While communities clearly express their needs, these remain largely at the level of individual or shared concerns, with current efforts focused on mobilisation, awareness-raising, and support for service use rather than on organised advocacy.

QUESTION E) *What has been achieved regarding improvement of early learning of children aged 0-8 in the local communities?*

Caregiver data indicate strong awareness of early childhood education and development services, with 96% of respondents reporting awareness of such services in their community.



Graph 9. *Caregiver-reported attendance of children under 8 (girls and boys) in early childhood education, preschool, or primary school*

School and preschool participation was also relatively high: among relevant respondents, 71% reported that all their children under 8, both girls and boys, attend early childhood education and care services, preschool, or primary school; 4% reported no attendance, while 9% indicated that the child was too young. In addition, participation in preschool was reported for girls only in 4% of cases and for boys only in 6%, indicating a gender gap, while 6% reported that none of their children attend, highlighting the need for continued support.

These findings are broadly consistent with stakeholder perspectives, which highlight improvements in access to early learning opportunities, particularly through community-based initiatives such as Play Hubs. Stakeholders noted that these platforms have expanded opportunities for younger children to engage in early learning, especially in communities where formal preschool options are limited.

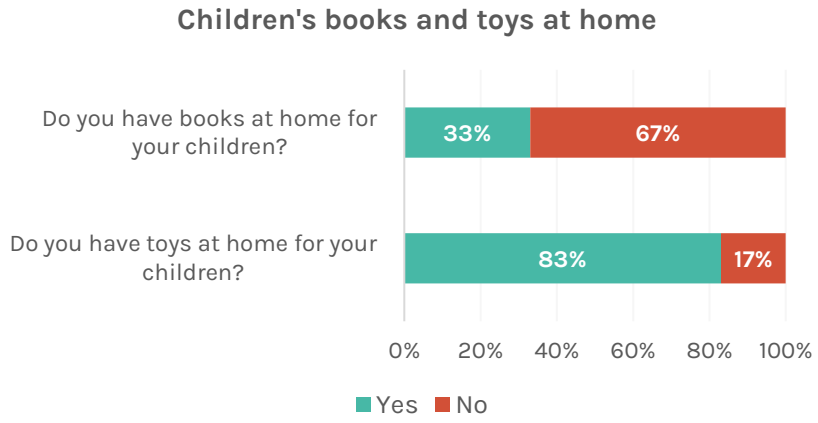
At the household level, there is also evidence of increased caregiver engagement in early learning. Caregivers described supporting their children through play-based activities, such as making simple learning materials, taking children to Play Hubs, and creating everyday opportunities for learning. These changes suggest that early learning is increasingly supported not only through services but also within the home environment.

> *"Parents in this community make playing materials for their children both at home and in play hubs. This has created strong bonding between children and parents, and some parents have been able to understand their children better because they spend more time together"*

Stakeholder findings reinforce this shift, emphasizing that Play Hubs have contributed to improved learning environments by promoting play-based learning and strengthening caregivers' understanding of early childhood development. They also highlighted that these spaces provide inclusive opportunities for children to interact, learn, and develop social and cognitive skills.

> *"The quality of these services are okay because the mobile play hub accommodates all the children without discrimination because we have seen even those with disabilities do come and play with other children*

together. The parents do come and support these children during play and this makes it more educative and safe for the children"



Graph 10. *Availability of books and toys at home for children, reported by caregivers (%)*

However, both data sources point to remaining challenges. While 83% of households reported having toys, only 33% reported having books at home, indicating limited access to diverse learning materials. Stakeholders similarly noted constraints, including limited learning materials, high demand for Play Hub services, and gaps in access to formal early childhood education, particularly due to distance, cost, and limited availability of nursery sections in some communities.

Overall, the findings suggest that early learning has improved through a combination of increased service availability, community-based platforms, and stronger caregiver engagement, although structural and resource-related barriers continue to affect the consistency and equity of access.

2.2 Outcome 2: Authorities and service providers enhance the accessibility and quality of ECD services.

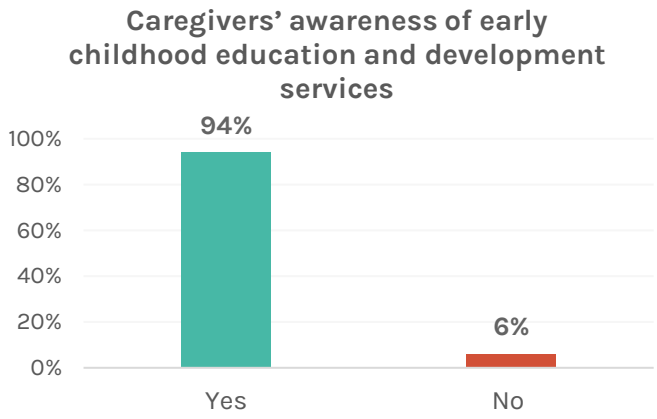
QUESTION B) *Has the social integration of children from 0-8 improved after the start of the project? Has the availability of education services for parents and children increased after the start of the project? Have the quality and accessibility of the health services improved for parents and children aged 0-8?*

There is evidence that the accessibility and perceived quality of services for children aged 0–8 and their caregivers have improved since the start of the project, though progress varies across communities.

Community findings indicate increased participation by children and caregivers in shared activities, particularly through Play Hubs and other community-based initiatives. These spaces were consistently described as inclusive and accessible environments where children interact, play together, and develop social and emotional skills.

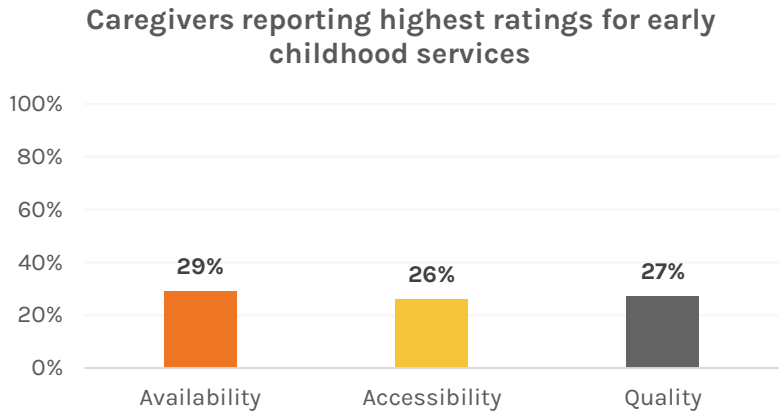
In addition to supporting social interaction, Play Hubs have expanded access to early learning opportunities, especially in areas where services were previously limited. They serve as important entry points for caregiver involvement, bringing parents together and creating opportunities for shared learning and exchange. Caregivers noted that children are more engaged with peers and in community activities, suggesting improvements in social integration and participation.

> *"In our community, we have play hubs that accommodate children under 8 years, and they offer activities on playful learning, responsive parenting, facilitating the emotional development of children and children's nutrition. Parents and children have benefited a lot from these activities and helps on stimulation."*



Graph 11. *Caregivers' awareness of early childhood education and development services (%)*

Caregiver data indicate a very high level of awareness of early childhood education and development services, with 94% of respondents reporting that they are aware of available services.



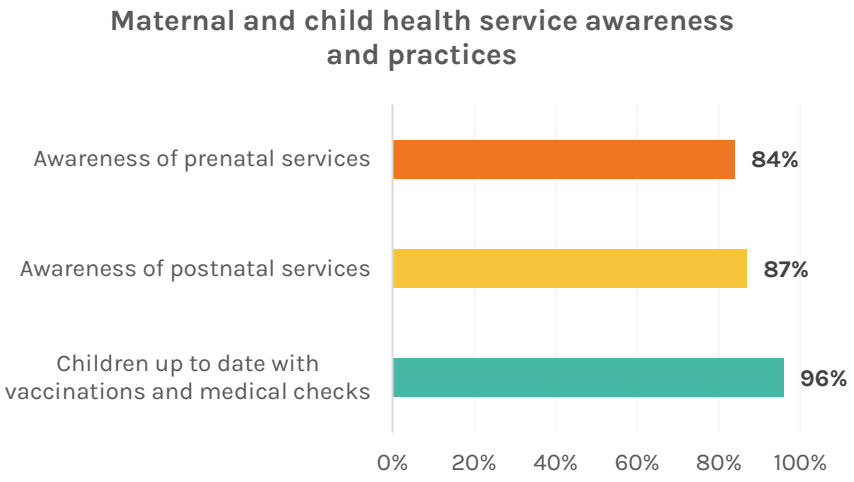
Graph 12. *Caregivers reporting the highest ratings for the availability, accessibility, and quality of early childhood services (%)*

In terms of service experience, caregivers also provided ratings on the availability, accessibility, and quality of early childhood services. Overall, perceptions were moderately positive, with 29% of caregivers rating availability at the highest level, 26% rating accessibility as very easy, and 27% rating overall quality as very good.

The availability of early learning opportunities has also improved, particularly through community-based platforms such as Play Hubs, which have expanded access to learning and caregiver engagement. Community discussions further highlighted that these platforms have created opportunities for

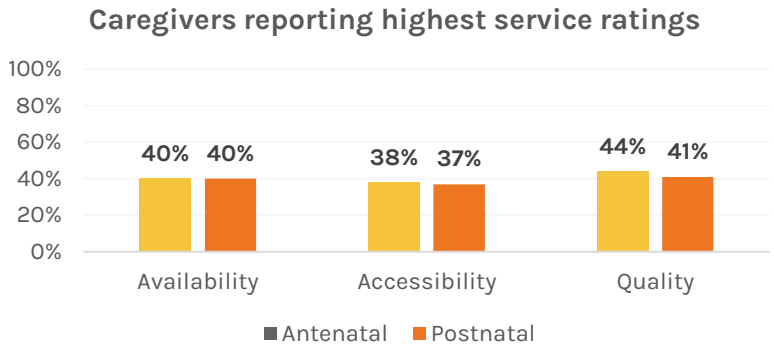
children in areas where services were previously limited and have increased demand among caregivers for continued provision.

Similar patterns are observed in relation to health services.



Graph 13. *Caregivers' awareness of antenatal and postnatal services, and the proportion of children up to date with vaccinations and medical checks (%)*

Findings on health services indicate improvements in both accessibility and utilisation, particularly for maternal and child health services. Awareness of antenatal services was reported by 84% of caregivers, while awareness of postnatal services reached 87%. Preventive health practices were also strong, with 96% of caregivers reporting that children are up to date with vaccinations and medical checks, indicating high uptake of essential child health services.



Graph 14. *Percentage of caregivers reporting the highest ratings for the availability, accessibility, and quality of antenatal and postnatal services (%)*

Caregivers rated these services positively. For antenatal services, 40% rated availability as very high, 38% rated accessibility as very easy, and 44% rated overall quality as very good. Postnatal services showed similar patterns, with 40% rating availability at the highest level, 37% accessibility, and 41% overall quality.

Community members further highlighted the role of outreach activities, including immunisation campaigns and home visits by Village Health Teams (VHTs), in bringing services closer to households and supporting uptake. Birth certificates are issued by health facilities following delivery.

> *"When the health facility extends some of these services in our community like immunization, the community leaders and the VHTs always make awareness before and on the very day of the activity. Many parents attend this service in our community but those efforts come from the community leaders, VHTs and social workers."*

Importantly, both caregiver and community findings point to changes in everyday health and nutrition practices. Participants frequently reported attending cooking demonstrations, improving feeding practices, and establishing nutrition gardens. These activities suggest that services are not only available but also influencing behaviour at the household level. While traditional practices persist, there are indications of increased engagement with formal health services. Community findings also indicate that children sometimes attend activities without adequate nutrition, which can affect participation and concentration, highlighting the importance of food access in enabling children to benefit from available services.

> *"The members of our community are provided and this helps them to prepare nutritious foods for children and prevent diseases. We have seen some organisations like Nascent RDO in this community organising training on nutrition, like cooking demonstrations, where mothers come and learn how to prepare nutritious food for their babies, and get to know that these foods are always in their homes, and it is easy to access them. Many of our mothers in the community can now prepare healthy foods in their households for their children."*

Community and stakeholder findings also highlight the role of informal financial mechanisms, such as savings groups and small loans, in supporting access to services. These mechanisms help caregivers cover transport costs and other related expenses, while also reflecting broader economic constraints that continue to affect access to both health and education services.

At the same time, challenges persist, closely linked to broader economic constraints within households. Caregivers highlighted barriers to accessing education, including long distances to schools, school-related costs, and a limited number of nearby early learning facilities. Stakeholders also noted the absence of nursery sections in some communities, further limiting access for younger children.

Quantitative findings indicate that 20% of caregivers reported their households as vulnerable. Qualitative responses further illustrate these vulnerabilities, including financial hardship, food insecurity, and inadequate housing conditions. Single-parent households, particularly widows, and families caring for multiple children or children with disabilities were frequently identified as facing increased vulnerability. These constraints also affect children's participation in activities, which may be limited by household responsibilities and livelihood demands.

Similar challenges are observed in relation to health services, with both caregiver and community data pointing to barriers such as distance to health facilities, transport costs, limited availability of

medicines, and high demand for services. In some cases, when access to formal services is constrained, caregivers reported relying on traditional or informal practices, including herbal remedies.

> *"The quality of these prenatal services is averagely poor in this community because there is a lot of corruption in these government hospitals where we seek for these services especially in Iganga hospital, the health personnel do ask for money and if you don't have it or give them enough you probably risk of either not getting the services at all or getting them late. This kind of behavior limits our people from going for some of these services because they know what will happen and then they resort to local herbs until they give birth."*

While birth certificates are issued through health facilities, community and stakeholder discussions indicate that the process is not always completed, particularly in home births where follow-up may be limited. This leads to gaps in formal registration and can affect access to services, particularly school enrolment. This reflects persistent challenges identified at baseline, particularly barriers to completing birth registration.

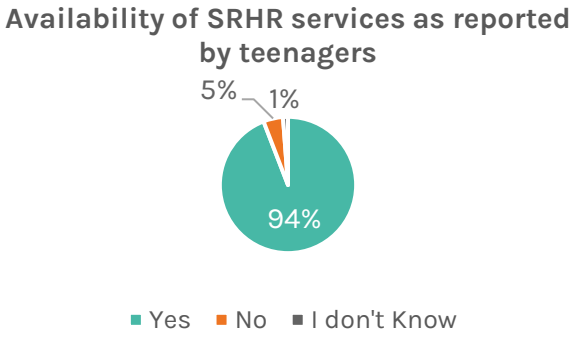
> *"These services become inaccessible for women who gave birth from their homes because they don't even go there to get them fearing to be judged."*

Overall, the findings suggest that service availability, access, and perceived quality have improved, supported by community-based initiatives such as Play Hubs and outreach mechanisms, while structural and economic barriers continue to affect the consistency and equity of access.

QUESTION C) *What behavioural changes related to SRHR, family planning, and early marriage prevention are observed among the participants?*

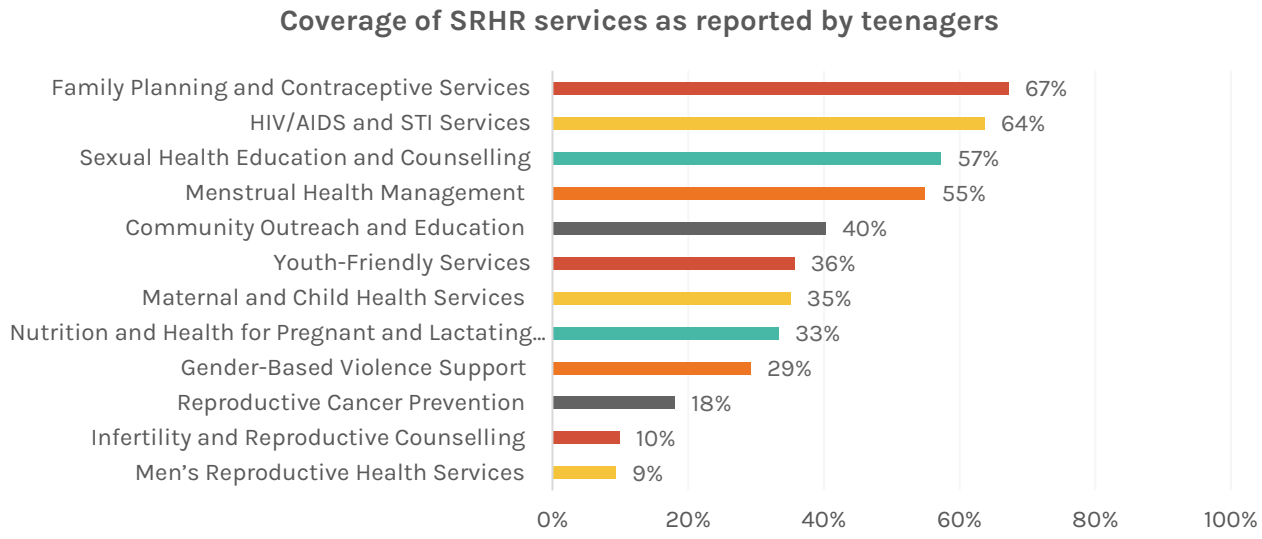
The findings indicate positive behavioural and attitudinal changes related to SRHR, family planning, and awareness of early marriage, although these changes remain gradual and are influenced by existing social norms.

> *"People learn from one another and through community mobilisation which have helped increase awareness about reproductive health and family planning. People now discuss these topics openly and some young people feel more confident accessing services without fear of judgement."*



Graph 15. *Availability of SRHR services reported by teenagers (%)*

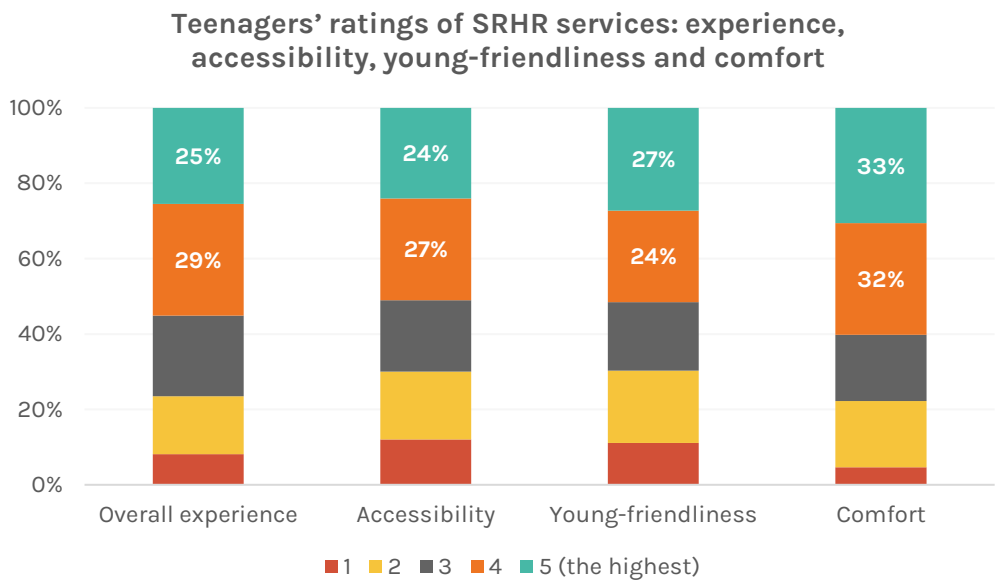
Teenager responses indicate that SRHR services are widely available in their communities, with 94% reporting they are currently accessible. Only a small proportion reported that services were unavailable (5%) or were unsure (1%), suggesting a generally high level of awareness and perceived availability of SRHR services.



Graph 16. *Coverage of SRHR service components as reported by teenagers (%)*

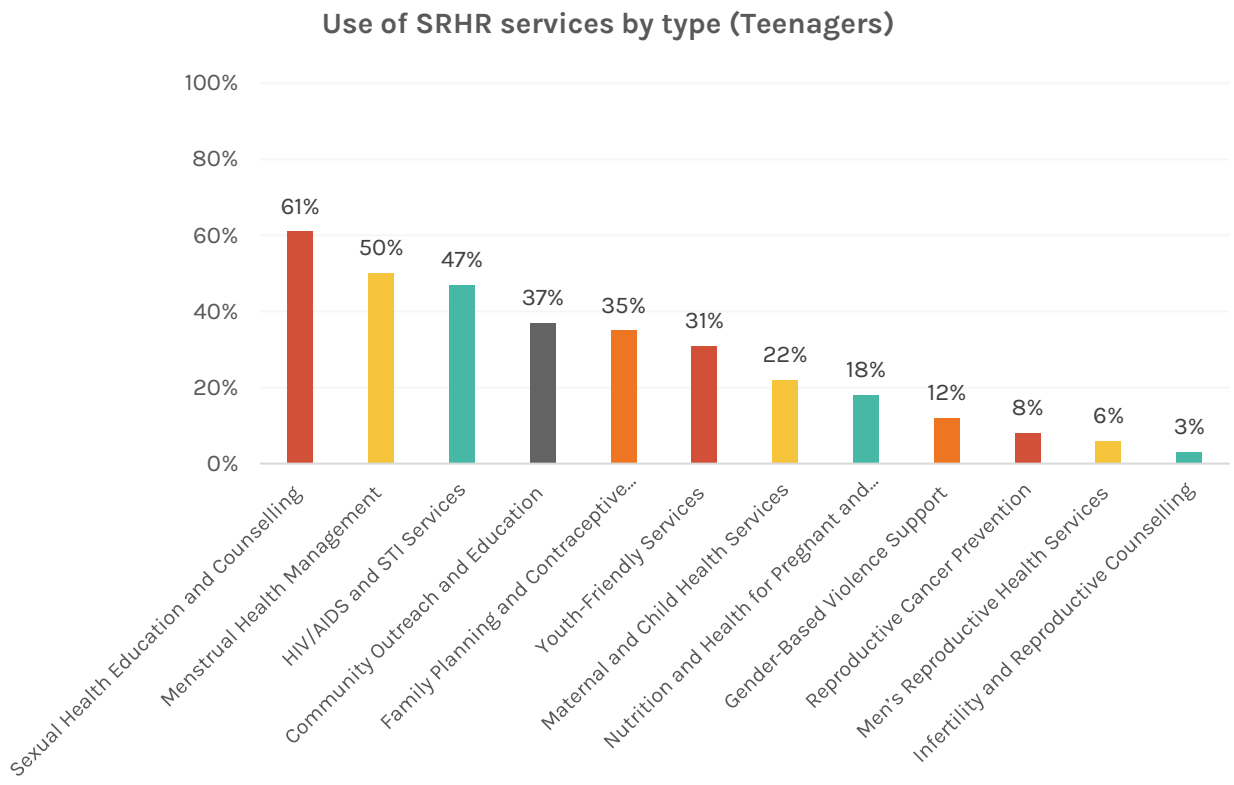
Beyond availability, findings indicate that SRHR services cover a range of key areas. The most commonly reported components include family planning and contraceptive services (67%), HIV/STI prevention and treatment (64%), sexual health education and counselling (57%), and menstrual health management (55%), suggesting relatively broad service coverage.

However, more specialised services, such as gender-based violence support, reproductive cancer prevention, and men's reproductive health services, appear to be less visible and less widely reported.



Graph 17. *Teenagers' ratings of SRHR services: experience, accessibility, young-friendliness and comfort*

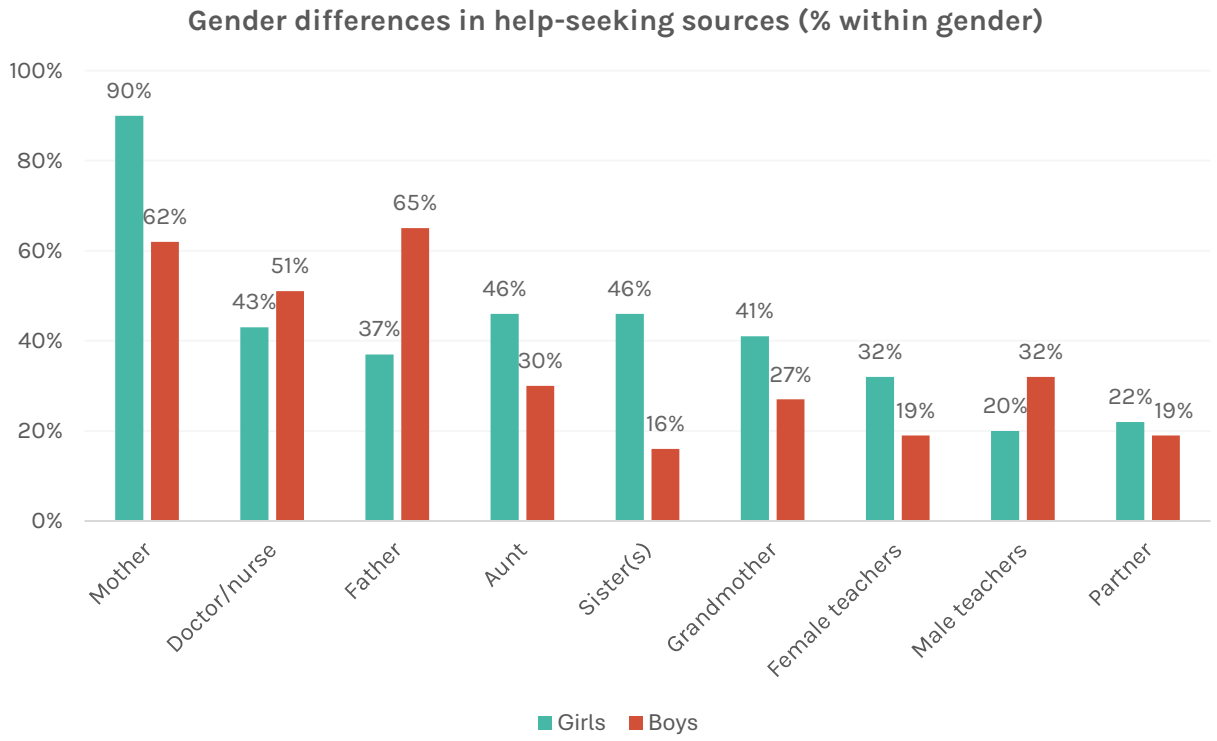
Graph 17 shows that teenagers report generally positive perceptions of SRHR services across all dimensions, with responses clustering between 3 and 5. Comfort and young-friendliness show relatively higher shares of the highest rating (33% and 27%, respectively), while accessibility and overall experience are slightly more distributed, with 24% and 25% of respondents selecting the highest rating. Despite these overall positive perceptions, concerns related to privacy, stigma, and being seen when accessing services may still discourage some young people from seeking support. While awareness of SRHR services appears to be high, this may not necessarily reflect depth of understanding, particularly regarding contraception, risks, and available support options.



***Graph 18**. Teenager-reported use of SRHR services by type (%)*

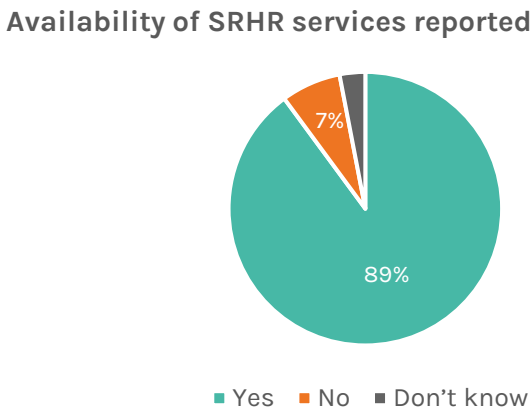
Among teenagers, service use is also relatively high, with 86% reporting use of SRHR services in their communities. The most commonly used services include sexual health education and counselling (61%), menstrual health management (50%), HIV/STI services (47%), and community outreach and education (37%).

This pattern suggests that more specialised SRHR services, such as gender-based violence support, infertility services, and reproductive cancer prevention, remain less known and less utilised within the community.



***Graph 19**. Gender Differences in Help-Seeking Sources for SRHR issues (% within gender)*

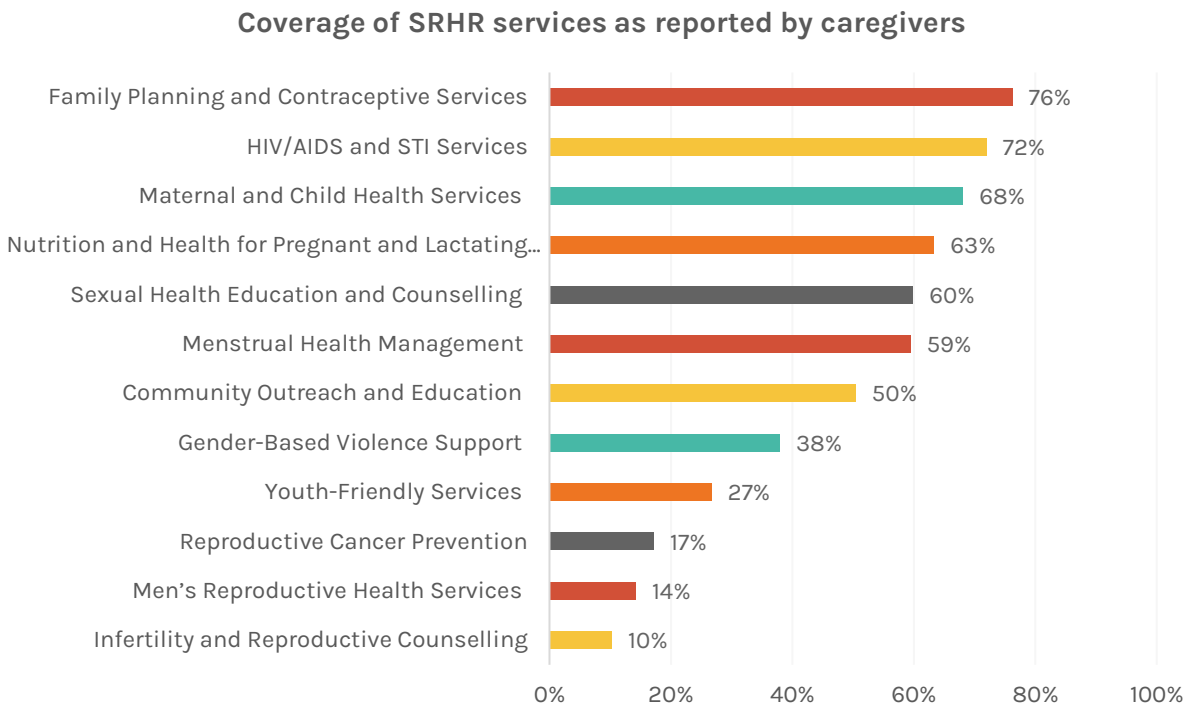
The findings on help-seeking behaviour reveal clear gendered patterns among teenagers. Girls are more likely to rely on a wider network of female family members, including mothers (90%), aunts (46%), and sisters (46%), and grandmothers (41%), as well as on health professionals (43%). By contrast, boys tend to rely on a more limited set of figures, primarily fathers (65%), mothers (62%), and, to a lesser extent, health professionals (51%). This suggests that boys may have fewer avenues for seeking support on SRHR-related issues.



***Graph 20.** Availability of SRHR services reported by caregivers (%)*

Caregiver responses also indicate that SRHR services are widely available within communities, with 89% reporting that such services are available. A smaller proportion reported that services were unavailable

(7%) or were unsure (3%), suggesting that availability is generally well established, though slightly lower than teenagers' perceptions.

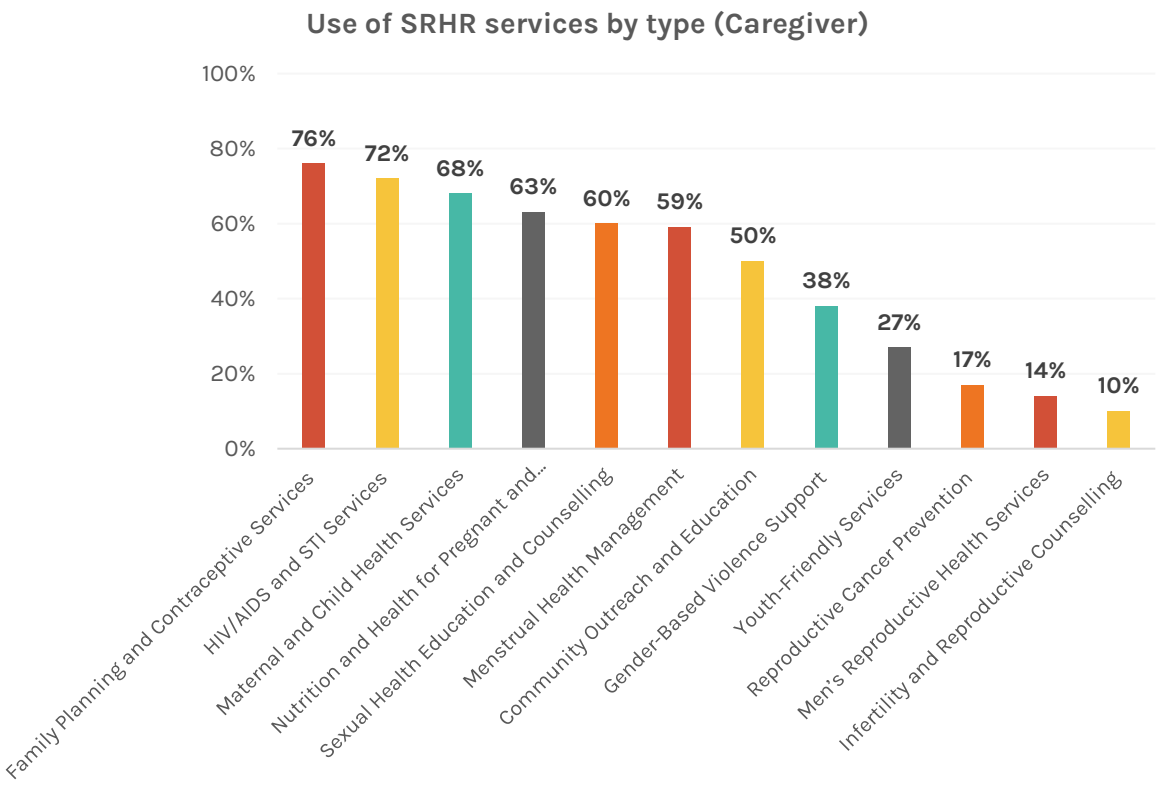


Graph 21. *Coverage of SRHR service components as reported by caregivers (%)*

Regarding coverage, caregivers reported a similarly broad range of SRHR service components. The most commonly mentioned areas include family planning and contraceptive services (76%), HIV/STI services (72%), maternal and child health services (68%), and menstrual health management (63%), indicating strong awareness of core SRHR services.

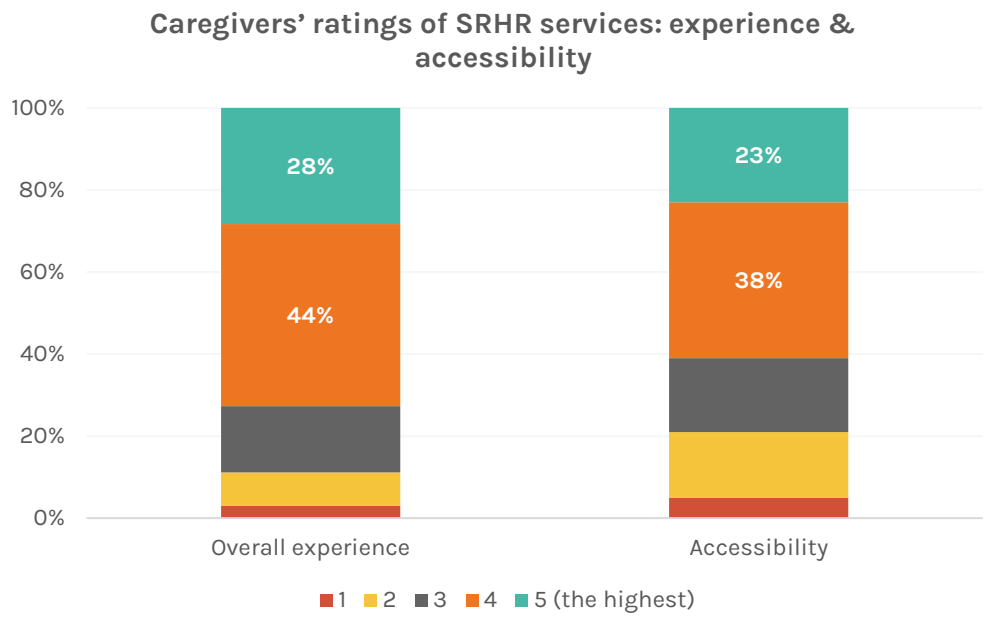
However, more specialised services, such as reproductive cancer prevention (17%), infertility services (14%), and men's reproductive health services (10%), were reported less frequently, suggesting gaps in visibility and reach.

This pattern closely aligns with findings reported by teenagers, reinforcing the overall picture of broad but uneven SRHR service coverage across communities.



Graph 22. *Caregiver-reported use of SRHR services by type (%)*

Caregiver data complement these findings, highlighting high levels of service utilisation and behavioural change at the household level. A large proportion of caregivers (92%) reported using SRHR services, with family planning (76%), HIV/STI services (72%), maternal and child health services (68%), nutrition and health for pregnant and lactating women (63%), sexual health education and counselling (60%), menstrual health management (59%), and community outreach and education (50%) the most commonly used.



Graph 23. *Caregivers' ratings of SRHR services: experience and accessibility*

Caregivers also reported generally positive experiences with SRHR services, with most responses clustering at 4 (44%) and 5 (28%). Accessibility for young people was similarly rated positively, with most responses at 4 (38%) and 5 (23%), indicating overall satisfaction with accessibility and quality.

At the household level, caregivers described increased knowledge and use of family planning and child spacing practices, as well as greater confidence in decisions about family size and well-being.

Qualitative findings further highlight practical behavioural changes in menstrual health management. Participants frequently reported learning to make reusable sanitary pads, which has improved awareness and, in some cases, access to menstrual hygiene solutions. However, community members also noted that obtaining the necessary materials to produce these pads is not always easy, which can limit consistent use.

These challenges are closely linked to girls' school participation. Community members explained that, in the past, girls often missed school due to a lack of menstrual hygiene products. While the introduction of reusable pads has helped address this barrier for some, limitations in access to materials mean that this challenge has not been fully resolved. These limitations suggest that while knowledge and skills have improved, consistent access to menstrual hygiene solutions remains a challenge for some girls.

Qualitative findings also highlight a strong perceived link between early pregnancy and school discontinuation. Community members noted that pregnancy often leads girls to leave school, and in some cases described it as effectively ending a girl's education. SRHR-related awareness and counselling activities aim to address this risk by encouraging informed decision-making and supporting girls to remain in education. However, these relationships are based on community perceptions and are not directly measured in the data. These findings also highlight the broader social

consequences of early pregnancy, including stigma and reduced support, which further affect girls' ability to continue their education.

"Gender inequality is common where girls are often blamed for teenage pregnancies while boys are not equally followed up or counselled. "When a girl gets pregnant, that is the end of her education."

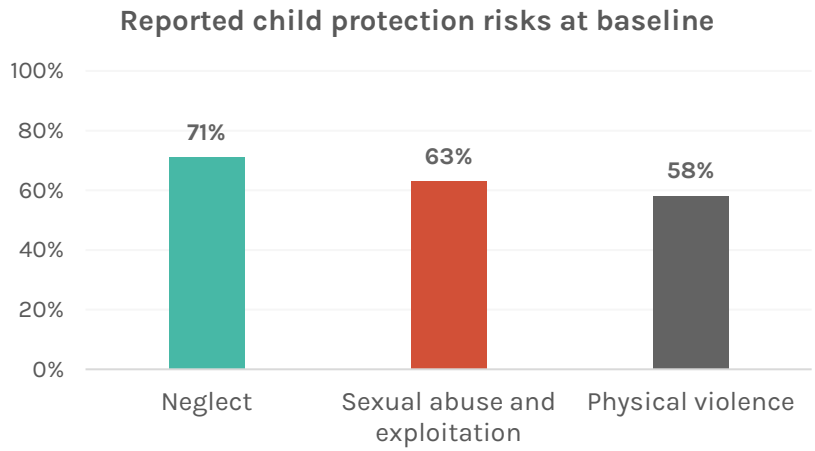
There is also evidence of shifting attitudes towards early marriage. Caregiver responses indicate a general preference for later marriage, with commonly reported appropriate ages for girls between 18 and 25, and for boys between 20 and 30. Although some acceptance of earlier marriage remains, the overall pattern suggests a move away from very early marriage.

Despite these positive trends, some limitations persist. Cultural norms continue to shape behaviours, and family planning remains often framed as primarily the responsibility of women rather than a shared decision between partners. In addition, early marriage prevention is not directly measured in behavioural terms and should therefore be interpreted as indicative of changing attitudes rather than as fully measurable outcomes.

Overall, the findings suggest that SRHR-related knowledge, service engagement, and behaviours have improved, with evidence of increased utilisation, more positive service experiences, and emerging behavioural shifts, while deeper structural and social norms continue to influence outcomes.

2.3.1 Outcome 3: Parents at the post-programme-activities phase are feeling confident and competent in providing a safe and supportive environment for their young children

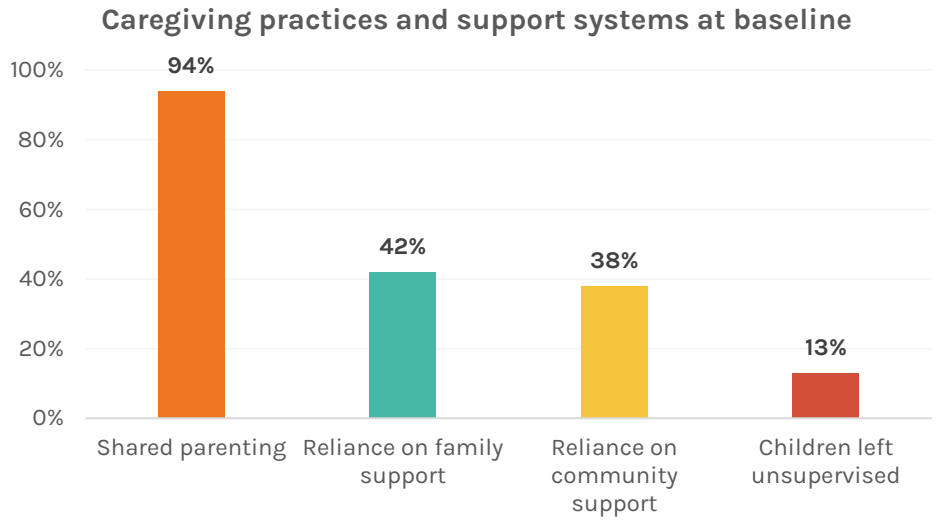
QUESTION D) *Has there been improvement of parent-child interaction for children? Do parents feel more confident in providing safe and supporting environment for their young children? Have parents and other caregivers, with special attention to men, developed a good set of parental skills and practices to create a safe and supporting environment?*



Graph 24. *Reported child protection risks at baseline (%)*

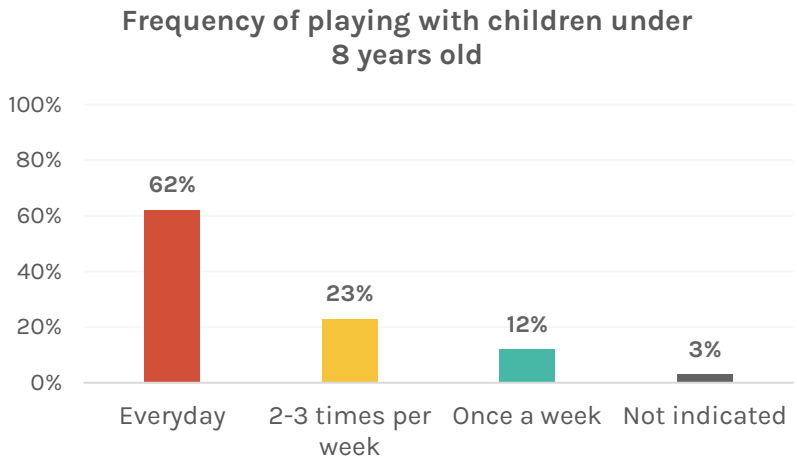
At baseline, childcare in programme communities was largely based on shared parenting (94%), but caregiving practices were often informal and shaped by traditional gender roles. Children faced

significant safety risks, including neglect (71%), sexual abuse and exploitation (63%), and physical violence (58%).



Graph 25. *Caregiving practices and support systems at baseline (%)*

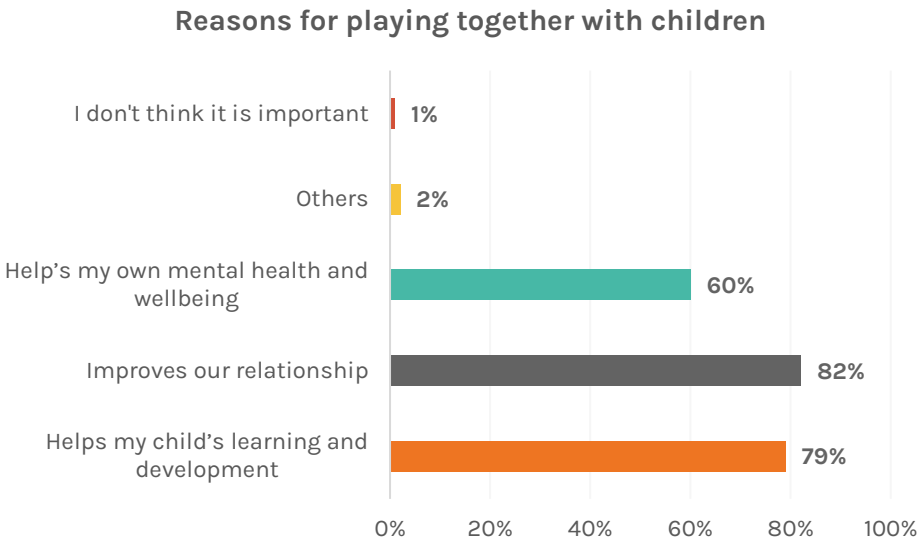
Caregivers primarily relied on informal support systems, including family (42%) and community members (38%), while some practices, such as leaving children unsupervised (13%), highlighted gaps in efforts to ensure safe and supportive environments.



Graph 26. *Frequency of playing with children under 8 years old*

> *"As a parent I take my children to the mobile play hub and play with them and this has helped me to build a good relationship with my children and also to understand their behaviors more. Actually, personally I have gained knowledge on parenting due to the sessions that we participate in on different topics during play hubs"*

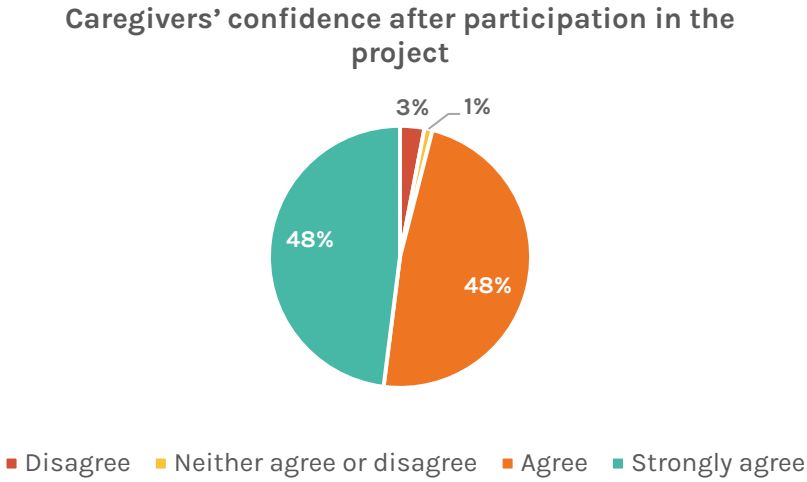
Endline findings demonstrate clear improvements in parent-child interaction and caregiving practices. A very high proportion of caregivers (97%) reported playing with their children, with 62% doing so daily and 23% several times per week, indicating that interaction has become a regular and embedded part of caregiving routines.



Graph 27. *Reasons for playing together with children*

Caregivers also demonstrate a stronger understanding of the value of play. A large majority (82%) reported that play improves their relationship with their children, while 79% indicated that it supports children's learning and development. Notably, 60% also identified their own mental health and well-being as a reason for playing with their children, showing that the perceived benefits of play extend to caregivers themselves. Qualitative findings further illustrate the relational benefits of shared play, with caregivers describing stronger parent-child relationships and a better understanding of their children's behaviour. Together, these findings highlight the potential value of positioning play within programmes as a way to support children's learning and development, strengthen quality parent-child relationships, and promote caregiver well-being and self-care, which may in turn encourage parental involvement in play.

> ***"I offered a place where the organization (Nascent RDO) organizes the mobile play hub in this community and it is for free. This has helped the children from my community to benefit from the playful learning games and parents to understand the beauty of supporting their children during play."***



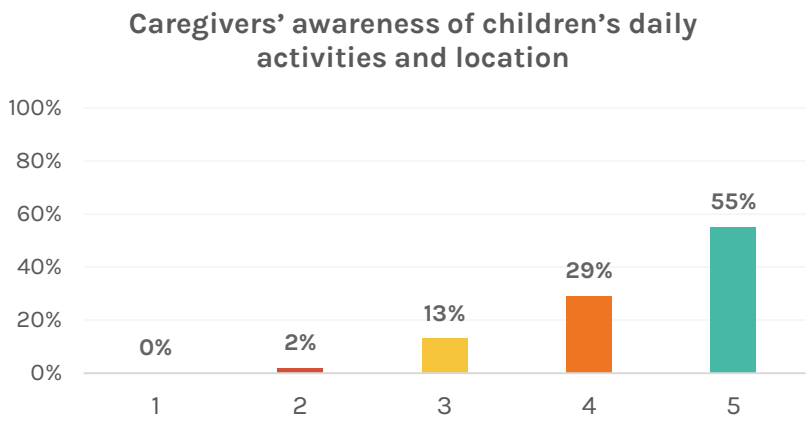
Graph 28. *The extent to which caregivers agree with the statement: "After participating in the project, I feel more confident as a parent."*

Parental confidence has also increased significantly. A total of 96% of caregivers agreed or strongly agreed that they felt more confident as parents after the programme (48% agreed, 48% strongly agreed), with only a small proportion expressing uncertainty or disagreement (4%). Caregivers attributed this increased confidence to a better understanding of their roles, improved relationships with their children, and a greater ability to respond to their children's needs. Qualitative responses also suggest a gradual increase in men's involvement in caregiving roles, particularly in supporting children's play and engaging more actively in daily childcare, indicating early shifts in traditional parenting roles.

> ***"As a man at home, I always support my wife by carrying the baby when she is busy and I discovered that it helps me to connect with my baby but also the mother loves it so much and that way, I help her a lot."***

Participation in VSLAs also emerged as a recurring theme in caregivers' explanations of their increased parental confidence after participating in the programme. Caregivers cited learning to save, meeting their children's basic needs, and improving their families' financial situation. Although references to savings were less prominent in the FGDs, a few examples further illustrate the relevance of these financial skills to families' everyday needs. Stakeholders mentioned saving money to prepare for safe delivery and potential health emergencies, while community members highlighted savings groups as a way for vulnerable households to save their children's school fees.

In parallel, caregiving practices related to safety and well-being have become more consistent and preventive.



Graph 29. *Caregivers' awareness of children's daily activities and location (%)*

Caregivers also report high levels of awareness of their children's daily activities and whereabouts. A large majority of respondents rated their awareness at the higher end of the scale, with 55% selecting the highest rating and 29% rating it as 4. Only a very small proportion of caregivers reported low levels of awareness (2% at level 2 and less than 1% at level 1). This suggests that caregivers are generally attentive to where their children are and what they are doing during the day, reflecting strengthened supervision as part of more consistent and preventive caregiving practices.

At endline, 95% of caregivers reported regularly checking for hazards in and around the household, indicating increased attention to children's safety in everyday environments. Qualitative responses also point to greater attention to hygiene, nutrition, and timely health-seeking behaviour. Compared with preventive caregiving approaches.

Household safety and caregiving practices	Yes	No
Are your children under 8 up to date with their vaccinations and medical checks?	96%	4%
Are the living and cooking space in your house separate?	90%	10%
Is there a separate space for animals (dogs, chicken, donkeys, sheep, goats etc.) to sleep and shelter?	74%	26%
Do you regularly check for hazardous objects and hazards in general in and around the house, to prevent children to get injured?	95%	5%
Do you have toys at home for your children?	83%	17%
Do you have books at home for your children?	33%	67%

Table 1. *Household safety and caregiving practices*

Caregivers demonstrate a clearer, more active understanding of their roles in creating safe, supportive environments. They emphasise providing supervision, ensuring safe spaces for play, allocating time for

children, and actively supporting their development through everyday interactions. These findings suggest a transition towards more confident, competent caregiving.

However, some challenges remain. A small proportion of caregivers (around 4%) still report low or uncertain confidence. In addition, certain safety-related conditions are not fully met across all households, for example, 26% reported not having separate spaces for animals. These constraints indicate that while behavioural and relational changes are strong, structural and resource-related limitations continue to affect some caregivers' ability to provide fully safe, supportive environments.

4. Conclusions

Overall, the programme has contributed to **changes in community engagement, service use, and caregiving practices**, though these changes are not consistent across all communities.

At the community level, there are signs of **increased engagement and shared responsibility for children's well-being**. Community members are **more actively involved in organising and sustaining activities, supporting each other's participation, and engaging with available services**. These patterns suggest a **developing sense of ownership at the community level**. However, this remains largely focused on participation and facilitation, with limited evidence of collective or structured advocacy.

There is also evidence of **improved access to and use of services**. This **includes improved participation in early childhood education, pre-school, and primary school, as well as increased caregiver awareness of learning opportunities.** Community-based activities, **including Play Hubs and home visits, have helped bring services closer to families and create more regular points of contact.** Improvements are evident across several areas, including **increased use of health services, changes in everyday practices such as nutrition and care, and engagement with SRHR-related services among both caregivers and teenagers.** At the same time, access remains uneven, with financial, logistical, and service-related constraints continuing to affect consistency.

Notable changes are evident in caregiving practices. **Caregivers report more frequent, intentional engagement with their children, including play, and greater confidence in their roles**. These changes are accompanied by shifts in **how caregivers support learning, respond to children's needs, and create safer, more structured home environments. Together, these findings point to a broader transition towards more active, responsive, and informed caregiving.**

At the same time, some challenges identified at baseline persist. These include **economic constraints that affect access to services, as well as gaps in formal processes such as birth registration**, which continue to affect service access and participation.

Overall, the endline evaluation's findings indicate that the **programme has achieved its targeted outcomes, while highlighting the need for continued efforts to address persistent barriers and ensure that improvements are more consistent and sustained across communities.** Based on the current analysis, future programming can consider prioritising areas as:

- Community engagement has increased, particularly in participation and shared responsibility for children's well-being. However, evidence of structured advocacy remains limited. Future programming should support communities in moving beyond participation towards more organised advocacy, including engagement with local authorities and service providers to address systemic challenges.

- Community-based initiatives, particularly Play Hubs, have significantly improved early learning, social interaction, and service engagement. To sustain these gains, future programming should focus on strengthening local ownership, integrating these platforms into existing systems, and ensuring continued access to resources and support.

- Findings indicate that gender norms continue to influence SRHR behaviours and caregiving roles, with responsibilities often remaining unequally distributed. Future interventions should more actively engage men and boys, promote shared decision-making in family planning, and address gender norms that limit access to information and services.

- Although awareness and use of SRHR services are high, findings indicate that depth of knowledge remains limited, particularly regarding contraception, risks, and specialised services. Future interventions should focus on strengthening comprehensive SRHR education and on increasing the visibility and accessibility of underutilised services, such as support for gender-based violence, reproductive cancer prevention, and men's reproductive health.

- While improvements in service availability and utilisation are evident, access remains uneven across communities. Future programming should prioritise reducing financial and geographic barriers by expanding outreach, supporting transport solutions, and strengthening community-level service delivery. This would help ensure that vulnerable households can consistently access essential services.

- A significant proportion of caregivers reported household-level vulnerabilities, including financial hardship, food insecurity, and inadequate housing. Future programmes should provide targeted support for vulnerable groups, such as single-parent households, families with multiple children, and households caring for children with disabilities, to ensure more equitable outcomes.

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