Study on Parenting for Early Childhood Development in Ethiopia

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Contents

Figures

Tables

Acronyms

AIR	American Institutes for Research
CSO	Civil society organisation
ECD	Early childhood development
ECE	Early childhood education
ECDE	National Early Childhood Development and Education
FDRE	Federal Democratic Republic of Ethiopia
FGD	Focus group discussion
GoE	Government of Ethiopia
ICT	Information and communications technology
IDI	In-depth interview
IDP	Internally displaced people/internally displaced population
IRB	Institutional review board
IYCF	Infant and young child feeding
KII	Key informant interview
MAD	Minimum acceptable diet
MDD	Minimum dietary diversity
MMF	Minimum meal frequency
MoA	Ministry of Agriculture
MoE	Ministry of Education
MoF	Ministry of Finance
MoH	Ministry of Health
MoWIE	Ministry of Water, Irrigation and Energy
MoWSA	Ministry of Women and Social Affairs
NCF	Nurturing Care Framework
NGO	Non-governmental organisation
RQ	Research question
UNEG	United Nations Evaluation Group
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WASH	Water, sanitation and hygiene
WFP	World Food Programme
WHO	World Health Organization

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Executive Summary

This is the final report on the 'Study on Parenting for Early Childhood Development (ECD) in Ethiopia', an in-depth study that takes stock of knowledge, practices and experiences with parenting and parenting services in Ethiopia. United Nations Children's Fund (UNICEF) Ethiopia contracted the American Institutes for Research® (AIR®) to conduct a mixed-methods study that provides a comprehensive overview of parenting for ECD.

Study Purpose

The purpose of this formative study was to inform the strengthening and harmonisation of a holistic parenting support intervention package. The parenting package is closely connected to the plans outlined in the 2022 ECDE Policy Framework and is expected to be led by relevant line ministries of the Government of Ethiopia with support from international development partners, civil society organisations and other partners.

Study Objectives

The study had two overarching objectives: first, to fill the existing knowledge gap in parenting or caregiving beliefs, attitudes, knowledge and practices amongst parents/caregivers of children aged 0–6 years in Ethiopia; and second, to create a product incorporating evidence that can be used to strengthen policy design and implementation of parental support and ECD.

Study Scope and Methodology

The research team used seven research questions as a guide to understand parenting and caregiving knowledge, beliefs and aspirations; caregiving practices; availability and use of information by parents and caregivers; awareness and use of existing services; bottlenecks; and policymakers' awareness of existing services and institutional arrangements. The AIR team addressed the research questions through a mixed-methods design that incorporates input from parents and caregivers, service providers and policymakers.

The quantitative component of the study consisted of 1,034 household surveys with parents and caregivers of children aged 0–6 years to represent five contexts in Ethiopia. The sample included four regions, covering the following five contexts: Amhara and Oromia (rural and urban settings), Afar (pastoralist communities), Gambella (refugee communities) and Amhara (settlements for internally displaced populations [IDPs]).

The qualitative part of the study focused on three of the four regions mentioned above: Amhara (rural and urban settings and settlements for IDPs), Afar (pastoralist communities), and Gambella (refugee communities). It had two main components: The first component was an assessment of parenting support and resources through 23 key informant interviews with national and regional policymakers and with service providers. The second component was an analysis of knowledge, beliefs and practices of parents and caregivers through 6 focus group discussions (FGDs) and 13 in-depth interviews across the regions. The quantitative and qualitative approaches were supported by a desk review of relevant policy documents and thematic reports.

Key Findings and Conclusions

Key findings by the five domains of UNICEF's Nurturing Care Framework (NCF) are described next. In the main report, we present more detail on the findings associated with each research question.

Adequate nutrition. There was a high level of awareness of the importance of exclusive breastfeeding (89 per cent) and high prevalence of exclusive breastfeeding in the first six months (77 per cent). However, from the introduction of complementary feeding (after six months of age), most children's nutritional status is compromised by a lack of parental knowledge regarding nutrition (e.g., on food groups, valid sources of iron or vitamin A), combined with limited access to nutritious foods.

The Nurturing Care Framework (NCF)

The NCF is a framework designed by the World Health Organization (WHO), UNICEF and the World Bank to guide implementers in understanding and designing programming to support ECD. It has five domains: (1) adequate nutrition, (2) good health, (3) safety and security, (4) responsive caregiving and (5) opportunities for early learning. Each domain represents vital aspects of caregiving for children under 5 years of age.

Food insecurity is a major issue, with 57 per cent of caregivers reporting that they cannot give their child healthy or nutritious food due to household resource constraints and scarcity in local markets. As a result, almost none of the children (2 per cent aged 6–23 months) has a minimum acceptable diet, which is driven largely by the lack of dietary diversity (7 per cent of children aged 6–23 months passed the standard of consuming at least five out of eight food groups). In addition, 75 per cent of caregivers who receive food assistance in camps in Gambella are dissatisfied with the quality of the food. Some of the IDPs in Amhara reported that the foods provided to them do not align to their normal diet, which relies heavily on the use of teff flour, and that the food is culturally inappropriate.

Good health. Parents are willing to access health services when it is feasible to do so, and they obtain health care for their child when needed (e.g., 83 per cent reported going for treatment when their child is sick, and 83 per cent reported going for antenatal care). The government is the main provider of healthcare services. When caregivers do *not* engage with needed health services, this is due to barriers such as knowledge, cost, transportation and/or distance. Some caregivers and service providers noted staffing shortages as a barrier. In addition, while access to health care is adequate, follow-through is an issue. For example, children's vaccination rates are good for first doses, but they drop off quickly when repeated doses are needed. Mothers participate in postnatal care (63 per cent) at lower rates than they participate in pre-natal care (83 per cent).

In terms of water, sanitation and hygiene (WASH), improved water sources are available to the majority of families (90 per cent), but households lack improved sanitation (48 per cent) and appropriate handwashing stations (38 per cent). Knowledge about hygiene practices leaves some room for improvement. Knowledge about handwashing is generally high, but caregivers think less often to engage in adequate handwashing before feeding their children (72 per cent) or after cleaning children's bottoms (43 per cent).

Responsive caregiving. Nearly all caregivers understand that children need affection and comforting for their well-being and for parent–child bonding, and both male and female caregivers said they engage in such behaviours. However, parental knowledge of normal

child development is more limited (21 per cent of respondents correctly said a child can hear immediately at birth; 25 per cent said a child can see immediately after birth). In the week before the interviews, more than 1 in 5 children below 6 years of age had been left alone, and one third had been left in the care of another child (under 10 years of age). Caregivers identified healthcare professionals as a main source of information about ECD, and they listen to parenting information on the radio (sometimes delivered over their phones).

Opportunities for early learning. Most caregivers suggested that the primary way to support a child's learning is by enrolling them in school and supporting them in formal education. Their educational aspirations are high for their children and are nearly equal for girls and for boys (79 per cent and 74 per cent of parents expect some tertiary education for their sons and daughters, respectively).

Nevertheless, only 1 in 3 children of pre-primary age attends pre-primary education, but participation varies widely by location – from a high of 4 of 5 children in Gambella to a low of just 1 in 30 children in Afar. When pre-primary programming is available but children do not participate, it is often due to long distances, oversubscribed enrolment, or parents thinking their child is too young. Outside of formal systems of schooling, there is encouragement for curiosity and play, and caregivers across regions noted the use of oral storytelling traditions to teach children about their family history and culture. However, only 2 per cent of caregivers believe they should read to a child younger than 2 years of age at home.

Security and safety. Almost half of the caregivers (48 per cent) across regions believe that to be raised properly, children require negative disciplinary practices such as physical punishment. These beliefs are echoed in high rates of negative physical and/or psychological methods to discipline children (with 6 in 10 reporting that they use these methods). Qualitative findings showed that across regions, caregivers hold harmful traditional beliefs, such as scarring gums (Afar), early marriage before age 18 (Afar and Amhara), removing the tooth of a child to stop their diarrhoea (Afar), and female genital mutilation (Afar). Lastly, only one in three children's births had been registered, with the lowest rates in Afar (7 per cent). Not having birth registration may affect a child's ability to access services.

Overarching considerations. Across all the domains of the NCF, poverty and resource constraints are common barriers to adopting best practices of parenting for ECD. Meeting children's needs is difficult for families in general, but it is of particular concern in refugee and IDP contexts. Caregivers shared that they have fewer opportunities to earn an income and have low access to necessary services to support a family's basic needs. Caregivers and stakeholders reported limited resources to address the unique psychosocial needs of caregivers and children in these settings.

Institutional support. Sector-specific policies and plans (e.g., the National Health Sector Strategic Plan for ECD and the National Strategic Plan for Pre-Primary Education) as well as overarching policy frameworks, such as the new 2022 ECDE Policy Framework, are guiding ongoing efforts to strengthen institutional support for ECD. However, stakeholders highlighted the need for a centralised structure of governance and cross-sectoral coordination due to the interdisciplinary nature of ECD.

While national and regional government representatives across health, education and social affairs showed awareness that ECD programming needs to be tailored to the unique needs of

different populations, they recognise existing policy gaps in terms of guidance in emergency contexts as well as reaching pastoralist communities.

Lessons Learnt

A few lessons learnt emerged from the study findings, which can inform future policymaking and programming regarding parenting in Ethiopia and elsewhere.

- Poverty is a pervasive barrier to families being able to fully realise the NCF with their young children.
- Although aware of the risks of sexual abuse for girls, families may be unaware of the risks of sexual abuse for boys.
- As a concept, dietary diversity can be misunderstood by families if caregivers do not have adequate knowledge of the different food groups and how they contribute to their children's health. This may prevent progress in improving children's nutritional status.
- While general government commitment to ECD is essential for progress, it is critical for the individual ministries to be involved in providing cross-sectoral support to young children and families.

Key Recommendations

To inform the strengthening, development and harmonisation of parenting support services, we highlight fourteen key recommendations. During the validation meeting stakeholders ranked them on priority and feasibility.

1. **Use multiple channels to build parental knowledge concerning nutrition,** using existing touchpoints for families. These could include healthcare providers and ECE providers as well as civil society organisations and community groups such as women's and faith-based organisations. The direct communication with parents and caregivers should be complemented with the use of radio and other communication channels already available to families to ensure broad coverage in urban and rural areas. Community level actors can serve as role models to demonstrate healthy food habits and practices [high priority – high feasibility].
2. **Provide school feeding at the ECE level** to improve children's nutrition and to encourage enrolment and attendance in ECE especially in regions with high levels of food insecurity such as the southern and southeastern pastoralist regions and Tigray [high priority – low feasibility]
3. **Leverage ECE as a resource for building family knowledge of good ECD practices** such as knowledge about nutrition, hand washing, vaccinations, supervision of children, positive discipline and support for early learning. The government, through the MoE together with private ECDE service providers and development partners in the communities, can leverage its ECE system to increase awareness amongst caregivers [high priority – high feasibility].
4. **Hire and train para-professionals for ECDE.** ECDE para-professionals can build parental and community knowledge in the NCF domains – particularly if they are able to use home visits to reach families. Para-professionals can help to demonstrate practices to caregivers around feeding, learning activities, health and hygiene practices etc. [high priority – high feasibility]

5. **Promote ways to make health care more affordable and/or easier to reach, given that cost of care and accessibility of health facilities are amongst the main barriers.** Promising interventions include, for instance, (1) strengthening community-based health systems, (2) leveraging parental coaching or information campaigns to add additional information on topics such as developmental milestones or physical punishment, (3) ensuring ECD services are available through health extension workers or health posts for pastoralist communities, (4) using technology (e.g., telehealth) to improve the reach of existing health systems and address cultural concerns. [high priority – high to low feasibility]
6. **Increase birth registration and implement national birth registration drives, with additional outreach in remote areas.** Besides, integrating birth registration into existing platforms such as existing health services will increase access. At an institutional level, advocacy groups should continue addressing that birth registration should not be a requirement to access services [high priority – low feasibility].
7. **Initiate public health drives** to build national awareness of issues such as the importance of pre- and postnatal care, developmental milestones and why children need to complete the full schedule of vaccinations [high priority – high feasibility].
8. **Train ECDE service providers on holistic child development, provide them with informational materials to share with parents and design a referral system for cross-cutting ECD concerns.** Training should be provided to ECDE service providers in all sectors (e.g. early education, health, child protection) so that service providers can assist with awareness raising of other ECD services and can make referrals to relevant services. As part of the training a national guide for parents that is easy to read (including with illustrations, and local language translations) should be created that conveys key information in a concise, practical, and user-friendly format. The guide covers best practices for parenting for ECD involving female and male caregivers [medium priority – medium feasibility]
9. **Provide policy guidance on ECD service delivery in humanitarian and hard-to-reach contexts within Ethiopia** (e.g., refugee settings, pastoralist communities, and areas with IDPs). The guidance would help to clarify the roles and responsibilities for ministries, departments and other stakeholders involved and it would ensure that they have the resources to continue to support ECD in emergency situations [high priority – high feasibility].
10. **Provide formal mechanisms for cross-sectoral coordination on ECD in refugee camps and IDP communities to improve the availability of high-quality resources for families. This could be in the form of service hubs** where families can go to one location and receive coordinated ECD information and supports. [high priority – low feasibility]
11. When introducing and/or improving ECD programming, it is important to **anticipate the possibility of scale-up and replication if the evidence-base supports the effectiveness of the program.** [high priority – low feasibility]
12. There is a need for **the evaluation of existing programmes to assess their effectiveness and fidelity of implementation**. In addition, the design and implementation of ECD programmes should incorporate a **reliable M&E framework**, which allows for continuous monitoring of programme implementation [high priority – low feasibility].

13. We recommend that **parents of children below age six living with low financial resources are included in existing social protection programmes, especially those that aim at female empowerment**. Increasing women's financial agency can simultaneously help to increase financial resources in the household as well as ensuring that these resources will be spent on the children's well-being [high priority – medium feasibility].
14. **Improve cross-sectoral coordination for implementation of ECD policies across various levels.** The high-level policy committee consisting of MoE, MoH and MoWSA has an important role to highlight opportunities for collaboration focusing on alignment of goals, target populations, relevant age-groups, timelines and avoidance of duplication. For every identified opportunity of collaboration, the committee and focal points should develop targets to measure integration to allow for regular monitoring across levels [high priority – medium feasibility].

1. Introduction

Extensive evidence on early and continuous development from conception to the age of school entry capturing the first 1,000 days and beyond has made a compelling case for promoting early childhood development (ECD) in national and international policy frameworks and programming. Promoting ECD is well aligned with international objectives such as the Sustainable Development Goals and Agenda 2063: The Africa We Want. It also underscores ongoing national efforts in various sectors, including education, health, and social and child protection.

Prior to providing timely support in strengthening the implementation of ECD services as outlined in the 2022 ECDE Policy Framework, the Government of Ethiopia (GoE), together with the United Nations Children's Fund (UNICEF) and its partners, sought to take stock of key indicators on parenting for ECD in Ethiopia and to fill existing knowledge gaps. To this end, UNICEF commissioned the American Institutes for Research® (AIR®) to conduct a study on parenting for ECD in Ethiopia. By producing evidence from an array of caregiving domains (e.g., education, health, adequate nutrition, responsive care) and helping to illustrate the situation of nurturing care across Ethiopia in five contexts (i.e., urban, rural, pastoralist, internally displaced populations [IDPs] and refugees), this study highlights current achievements and focus areas for further attention. These results will help inform ECD policy and programming to strengthen a comprehensive and integrative offering of services, some of which already have been implemented.

Throughout this report, we describe the study background and ECD context in which this study took place (*see Section 2*). We then outline the study's purpose, objectives and scope, after which we provide a detailed description of our mixed-methods methodology (*see Sections 3 and 4*). This is followed by the presentation of our key findings by research question (*see Section 5*). Finally, we describe the conclusions, lessons learnt and policy recommendations (*see Sections 6–8*).

2. Background and Context

This section includes literature on parenting for ECD, an introduction to the Nurturing Care Framework (NCF), and the existing data and evidence about ECD aspects in Ethiopia to date.

2.1 Parenting for Early Childhood Development

Decades of scientific research across multiple disciplines have established the importance of parenting for ECD in the first three years of life (Black et al., 2017; Britto et al., 2017). According to the NCF, during pregnancy and the first three years after birth, the foundational elements of our future health, well-being and productivity are created. This foundation will last throughout childhood, adolescence and adulthood. After birth, a baby's brain already contains almost all the neurons it will ever have. By 2 years of age, large amounts of neuronal connections have been made in response to interactions with the environment, especially interactions with caregivers. A child's brain is exceptionally malleable at this early age, and what happens in early childhood affects how a child's genes are expressed in the future. Parents/caregivers play a critical role in setting the child on a healthy path by providing adequate stimulation and affectionate interaction. These factors affect a child's psychosocial

well-being as well as their ability to learn across the lifespan. A child's early interaction with their parent/caregiver is therefore the blueprint for all future development and growth (Nurturing Care, 2021).

Investment in this critical period will pay dividends in the future and potentially can impact society in many ways besides educational achievement. For example, affectionate caregiving at a young age can improve a child's empathy and lead them to be less aggressive when they become older (Nofziger & Rosen, 2017). The basis of effective ECD programming is a solid evidence base, which Ethiopia is currently seeking to strengthen by harmonising and adding to existing efforts (Ministry of Health [MoH], Ethiopia, 2020).

2.2 The Nurturing Care Framework

The Nurturing Care Framework (NCF) was developed in 2018 by the World Health Organization (WHO), UNICEF and the World Bank. It provides a backbone for understanding and designing programming to support ECD. For instance, the 2022 ECDE Policy Framework has adopted the NCF as a core structure. The NCG has five domains, each of which represents vital caregiving practices for children under 5 years of age (*see Figure 1*).

The **adequate nutrition** domain encompasses maternal and child nutrition, including the mother's nutritional status during pregnancy, the caregiver's knowledge about nutrition and the quality of the child's own nutritional intake.

The **good health** domain of the NCF describes the physical health and well-being of children and caregivers, including elements such as immunisations, disease prevention, caregiver mental health and care for children with developmental disabilities.

The **safety and security** domain emphasises that young children should be free from physical and emotional abuse, be free from the risk of harm in their natural environment and have access to food and water.

The **opportunities for early learning** domain recommends that children have access to formal pre-primary education, but it recognises the necessity of informal learning through children's interactions with caregivers and through play.

The **responsive caregiving** domain refers to the relationship between a caregiver and a young child. Responsive caregiving encompasses an array of practices, such as being sensitive to a child's emotions and needs, speaking and playing with a young child and showing support through touch and eye contact.

Figure 1. Nurturing Care Framework

Source: Nurturing Care, 2021.

2.3 Early Childhood Development Context

Parenting contexts are far from uniform across Ethiopia, due to its diversity in populations and cultures. The evolving conflicts in Tigray and neighbouring countries have resulted in more than 4 million internally displaced people (IDPs) and nearly 1 million refugees in the country (*see text box*). Moreover, Ethiopia is home to several traditionally mobile populations

who are difficult to reach with ECD services – this in addition to its large urban centre at Addis Ababa. Next, we describe the current ECD context in light of the five domains of the NCF.

Adequate nutrition. In Ethiopia, the United States Agency for International Development (2021) reported that 21 per cent of children under 5 years of age are underweight, 37 per cent are stunted and 7 per cent are wasted. Altogether, only an estimated 11 per cent of children aged 6–23 months are fed a minimum acceptable diet, according to the criteria outlined by WHO (WHO, 2008). Through the National Nutrition Plan, the GoE has extended key nutritional support services, including First 1000 days nutritional support, emergency nutrition response, and community- and family-based nutrition interventions. Although malnutrition rates have steadily decreased in recent decades, factors such as mass displacement, conflict and climate change continue to complicate efforts to improve nutritional outcomes and reach all parents with key nutrition services.

Good health. Based on a variety of data sources, Ethiopia's under-five mortality rate is estimated at 49 per 1,000 live births in 2020 (United Nations Inter-Agency Group for Child Mortality Estimation, 2019). Amongst the leading causes of death are communicable diseases such as pneumonia and diarrhoea, while preterm births – which affect 1 in 10 babies in the country – account for 11 per cent of deaths in children under 5 (Ministry of Health, Ethiopia, 2019; Nurturing Care, 2021). The health sector in Ethiopia has led efforts to implement a wide range of infant health services, scaling up capacity amongst community health workers and in its health facilities and hospitals. Nonetheless, a recent study by Biadgo et al. (2021) found that in practice, many health facilities fall short of meeting neonatal healthcare standards set forth by the GoE and WHO.

ECD in Emergency Contexts

Children caught in fragile and conflict-affected situations face compounding barriers to development, and, as a result, are twice as likely to die before their fifth birthday (UNICEF, 2014). In Ethiopia, various emergencies have unfolded in recent years, affecting ECD and parenting practices in the country.

- In Tigray, where conflict has persisted since 2020, GoE and Tigray authorities agreed to a ceasefire in November 2022 (Associated Press, 2022). While humanitarian aid is now pouring into the region, at the height of the conflict last year, an estimated 350,000 people in Tigray faced starvation due to displacement and a lack of support services (HRW, 2022; UNOCHA, 2023b).
- In Amhara, hundreds of thousands of people have been internally displaced since 2021 due to inter-communal violence in the North Shewa and Oromia Special zones and due to the spread of the Tigray conflict into Amhara communities (HRW, 2022).
- The Gambella region is home to nearly 400,000 refugees who have fled South Sudan since conflict broke out in 2013. The conflict in South Sudan continues, indicating no end in sight for refugees in Ethiopia (UNHCR, 2022).
- In late 2022, the GoE reported an outbreak of cholera in the Oromia region. Since that time, the government has counted more than 1,000 cases across 10 *woredas* (administrative divisions) in the Somali and Oromia regions, and reports suggest that 1 million people are at high risk for cholera in the affected communities (UNOCHA, 2023a).
- In focusing on parenting for ECD in Ethiopia, this study sought to include the perspectives of parents caught in emergency situations (*see Section 4.2*).

Safety and security. Ethiopia's children experience risks to their safety and security due to conflict and shocks, which are exacerbated by poverty, lack of identity and orphanhood. For instance, 36 per cent of children under 18 years of age live in poverty, and the majority experience multi-dimensional poverty (MoF & UNICEF, 2019). In addition, only 3 per cent of births in Ethiopia are formally registered – that is, nearly all children in Ethiopia lack this foundational element of their human rights, legal recognition and protection (Nurturing Care, 2021; United Nations General Assembly, 2015). In addition, 10 per cent of children under 18 years of age do not live with a biological parent, and 7 per cent of minors are orphans, with one or both parents deceased (MoF & UNICEF, 2019). Government stakeholders from many ministries work to prevent poverty, abuse and injury amongst young children; however, as the MoH (2019) points out, these efforts have largely been fragmented. Moreover, ongoing conflict, climactic shocks and the effects of the COVID-19 pandemic have further fuelled displacement and threatened the stability of caregiving/parenting contexts in Ethiopia.

Opportunities for early learning. Few data are available on early learning in Ethiopia, but latest Situation Analysis for children in Ethiopia shows that around 44 per cent of children of eligible age for pre-primary education are enrolled (MoF & UNICEF, 2019). More than half of these children are enrolled in a one-year government pre-primary programme called O-class, while the rest are split between child-to-child and kindergarten programmes (Admas, 2016; UNICEF, 2019). Access to pre-primary education is uneven, however, with enrolment rates as high as 93 per cent in Addis Ababa and as low as 5 per cent in the Somali region. Indeed, many pre-primary education services are concentrated in urban areas and provided by private institutions (UNICEF, 2019). Thus, large portions of the population are still excluded from access to this vital resource.

Responsive caregiving. In Ethiopia, there are almost no formally generated data indicating the extent of responsive care in the country. This issue is not unique to Ethiopia: A recent UNICEF study of ECD programming across eastern and southern Africa found that "responsive caregiving" is undefined in the region, leaving stakeholders unsure how to promote it (Spier et al., 2021). The MoH (2019) highlights how widespread attitudes about the inferiority of children reinforce limited interaction between adults and children. In terms of interventions, the report summarises that responsive care services in Ethiopia "are poorly implemented and are cross-sectoral in nature" (p. 21). While the GoE has rolled out some responsive care support services, such as mother/baby clinics, these services are limited in their geographic coverage and lack coordination between ministries.

The GoE and its partners have made progress on some NCF key indicators, but outcomes are still unequally distributed across the country and population. Prior to designing further interventions to support parenting for ECD, GoE, together with UNICEF and its partners, sought to fill knowledge gaps on parenting in Ethiopia.

3. Purpose, Objectives and Scope

In this section we describe the purpose, objectives and scope of the study that guided our research design.

3.1 Purpose of the Study

This formative study on parenting for ECD in Ethiopia intends to inform the strengthening and harmonisation of a holistic parenting support intervention package. The development of a parenting package is closely connected to the plans outlined in the 2022 ECDE Policy Framework and is expected to be led by the relevant line ministries of the GoE with support from international development partners, civil society organisations (CSOs) and other partners. This comprehensive package will build on ongoing efforts, such as the recent revision of the National Early Childhood Development and Education (ECDE) policy framework, which aims to streamline national and international ECDE efforts with social and economic considerations to improve accessibility and quality of ECD programming, as well as sector specific policy efforts. The purpose of the study is to contribute to the knowledge base on ECD in Ethiopia while contributing to the institutional learning of UNICEF Ethiopia, the GoE and other organisations providing services in the ECD space. The study aims to help calibrate the strategic plans of the Ethiopian MoH, the Ministry of Education (MoE) and the Ministry of Women and Social Affairs (MoWSA) – as well as current and future UNICEF country programmes – to the unique needs of caregivers across the country.

3.2 Objectives of the Study

This study had two overarching objectives, and our mixed-methods evaluation was designed to fulfil those objectives:

- To fill the existing, formal knowledge gap and answer fundamental questions on parenting for ECD beliefs, attitudes, knowledge and practices amongst parents/caregivers of children aged 0–6 years in Ethiopia; and
- To create a knowledge product incorporating both qualitative and quantitative evidence that can be used to strengthen parenting support for a holistic ECD intervention package. This intervention package will be implemented through the service platforms in different sectors, including in humanitarian settings, and will inform policy improvement.

3.3 Scope of the Study

This study provides a landscape assessment to document and quantify (to the extent possible) the way parenting practices, beliefs, knowledge and attitudes correspond to the NCF, and to identify areas of possible improvement that are suitable for policy intervention.

Thematic scope. The study used the NCF as a reference point to understand the current state of parenting practices in the five pre-selected settings in Ethiopia. Areas of particular importance to better understand, based on knowledge gaps, include the domains of early stimulation and early learning, child protection (e.g., disciplinary practices, caregiving arrangements, and accidents and injuries) and hygienic behaviours. Across the five domains of the NCF, key areas of inquiry in this study include: (1) parenting beliefs, attitudes, knowledge and practices in different contexts (i.e., urban/rural, pastoralist, and humanitarian); (2) why parents/caregivers do what they do in their care of young children; (3) what sources of parenting information/guidance are consulted by parents/caregivers;

(4) what services are available to support them; and (5) to what extent parents/caregivers use such services and why.

Geographic scope. Within our research design, the AIR study team covered a wide geographic scope to represent the considerable socio-economic and cultural diversity within Ethiopia. In specific, it is focusing on representing five settings (i.e. rural, urban, pastoralist, refugee and IDP contexts), which were proposed by UNICEF and the government in the terms of reference of this study, and verified during the inception phase. To represent various communities in the country, AIR, together with our local partners Dalberg Research and WAAS, conducted field research in four regions for the quantitative analysis (Amhara, Afar, Gambella and Oromia) and in three regions for the qualitative analysis (Amhara, Afar and Gambella). These communities included the multiple, predominant religions of Ethiopia: urban and rural (Amhara and Oromia), pastoralist (Afar), refugee (Gambella) and IDPs (Amhara). The key informant interviews (KIIs) with policymakers and partners took place at the regional and federal levels, capturing the focus areas at the national level as well as the diversity amongst regions. Despite the aim for diversity, the scope of this study did not include a national representative sample and the study sample is unable to represent all social and cultural settings which are represented in the country. We highlighted the limitations of this at the end of the methodology section.

Chronological scope. The project took place throughout the 2022 calendar year. Our study questions focused on current parenting beliefs and practices, and the AIR team concentrated on policy and institutional frameworks that were in place during the study period. We collected data and performed analyses between September and November 2022.

4. Methodology

This section describes the research questions that guide our analysis, the quantitative and qualitative design, ethical considerations, as well as constraints and limitations of the research design.

4.1 Research Framework

To guide this study, the AIR team refined the research questions (RQs) specified in the Terms of Reference (*see Annex D*) by including detailed and measurable sub-questions. To preserve space, we present the RQs and sub-questions below (*see Table 1*), and we provide the full evaluation matrix in the Annex (*see Annex B).*

The RQs sought to further the understanding of parenting knowledge, beliefs and aspirations (RQ 1), parenting practices (RQ 2), availability and use of information by parents and caregivers (RQ 3), awareness and use of existing services (RQ 4), bottlenecks (RQ 5), enabling factors and support (RQs 3 and 4) and policymakers' understanding of existing services and institutional arrangements (RQs 5 and 6). We address the RQs through our comprehensive, mixed-methods design (*see Section 4.2*), which incorporates input from parents and caregivers, service providers and policymakers.

The refinement of the research questions and topics, as well as the research tools (i.e. survey tools and interview guides) that were developed to answer the questions were reviewed and

approved by key stakeholders in the steering committee during the inception meeting prior to starting the data collection.

Table 1. Research Questions and Sub-questions

RQ 1. What are parents'/caregivers' aspirations, expectations, beliefs, attitudes and knowledge regarding their young children's development?
1a. What knowledge do parents/caregivers have about ECD and key developmental milestones for young children? (knowledge)
1b. What common beliefs do parents/caregivers hold about ECD? (beliefs)
1c. How do parents/caregivers see their role in the development of a young child? (aspirations)
RQ 2. What are the parenting practices that parents/caregivers engage in with their children?
2a. What are the parenting practices of parents/caregivers concerning areas of nutrition, health, WASH (water, sanitation and hygiene) for babies, protection, early stimulation and early learning, and responsive caregiving?
2b. What are the parenting practices of parents/caregivers concerning gender socialisation?
RQ 3. What are parents'/caregivers' sources of information, guidance and support on parenting young children?
3a. What are considered sources of information about parenting/caregiving for young children?
3b. How do parents/caregivers evaluate the trustworthiness of information about parenting/caregiving?
3c. How do parents/caregivers navigate situations for which they lack information about the best course of action?
RQ 4. What is the availability, accessibility, acceptability, affordability, contextual appropriateness, and quality and perceived effectiveness of services for young children and families?
4a. What is the availability of services for young children and families?
4b. What is the perceived accessibility, acceptability and contextual appropriateness of these services?
4c. What is the perceived affordability of services for young children and families?
4d. What is the perceived quality of services for young children and families?
4e. What is the perceived effectiveness of services for young children and families?
RQ 5. What factors prevent parents/caregivers from implementing ECD best practices in parenting?
5a. To what extent are parents aware of ECD best practices in parenting?
5b. To what extent do parents'/caregivers' aspirations and trusted sources of information about parenting align with ECD best practices in parenting?
5c. What alternative parenting practices have parents adopted? Why?
5d. What are barriers or influencing factors that affect parents'/caregivers' parenting practices?
RQ 6. What is the understanding of policymakers and service providers at the federal and sub-national levels regarding parenting for ECD and parents'/caregivers' need for support?
RQ 7. What are the institutional arrangements to support parents/caregivers for ECD in different sectors?

4.2 Study Design and Methods

In this section, we articulate our methodological design for the desk review and our qualitative and quantitative approaches. The methods have been designed to answer the research questions for the five selected contexts (i.e. Amhara and Oromia (rural and urban settings), Afar (pastoralist communities), Gambella (refugee communities) and Amhara

(settlements for IDPs)). As highlighted in the limitations section below the current study does not cover other settings or (sub-)populations.

Desk Review

AIR conducted a desk review of existing evidence starting with the study's inception phase. The study team analysed existing reports, local parenting and ECD studies, project documents, and government policy and planning papers and presentations, including documents on ECD policies and contextual information on parenting practices in Ethiopia. The review provided a valuable understanding of the context, the actors involved and the overall ECD environment and parenting services. The study team used desk review sources to address RQ 7 (on institutional arrangements to support ECD) and to inform policy recommendations (*see Table 2*).

Table 2. Sample of Desk Review Documentation

Document Type	Source	Document Name
Policy document	MoE	MoE: Draft ECDE policy framework (December 2022)
Policy document	MoE	MoE: Draft strategic plan for pre-primary
Policy document	MoE	MoE: Final ECDE policy framework layout (5 January 2022)
Policy document	MoH	MoH: National-Health-Sector-Strategic-Plan-for-Early-Childhood-Development with Reference
Policy document	MoWSA	MoWSA: National Child Policy Final 1
Report		Nurturing Care Framework
Report	UNICEF	National Situation Analysis of Children and Women in Ethiopia
Brief	UNICEF and MoWSA	UNICEF and MoWSA – Changing Trends in Gender Equality in Ethiopia
Policy document	UNICEF	UNICEF Country Programme Document (2016–2020)

Qualitative Methodology

The qualitative approach has two main components: (1) a qualitative assessment of parenting support and resources through KIIs with policymakers and service providers and (2) an analysis of experiences, beliefs and practices through FGDs, KIIs and in-depth interviews (IDIs) with parents and caregivers. Together, these complemented our quantitative approach in answering RQs 1–6 and our desk review in answering RQ 7.

Sampling and data collection. The AIR study team conducted **23 KIIs** in accordance with the sampling framework described in the Terms of Reference (*see Table 3*). We interviewed federal and regional policymakers, representatives from civil society and international organisations involved in ECD programming (8 KIIs at the national level and 6 KIIs at the regional level [2 KIIs per region], and woreda-level community leaders and service providers (total of 9 KIIs, including 3 KIIs per woreda). Our sampling framework covered three regions (Amhara, Afar and Gambella) and engaged with different woredas for interviews with service providers and community leaders to ensure variability in religion, pastoralist areas, urban and rural areas, and humanitarian and refugee settings. KIIs explored common practices; beliefs

about young children's development across different NCF domains; available parenting resources; and the availability, accessibility, affordability, acceptability, quality and contextual appropriateness of services for young children and families. Not all KIIs covered all these topics; the research team developed individualised KII protocols on the basis of the initial desk review for each type of respondent. One-on-one interviews with key informants provided an ideal forum for engaging with people who possessed expert knowledge about a topic, such as parenting or a related service. Key informants provided valuable insights about caregiver needs and practices from the perspective of service providers.

Table 3. Qualitative Interview Sample: Policymakers and Service Providers

Federal Level	Regional/Zonal Level*	Woreda Level (3 Woredas)
MoE (1) MoH (1) MoWSA (1) Representative of CSO (1) World Bank ECD/nutrition specialist (1) UNICEF Ethiopia Child Protection Officer (1) UNICEF Ethiopia nutrition specialist (1) UNICEF Eastern and Southern Africa Regional Office (1)	MoWSA MoE ECD sector	*Community leadership* Local leaders (e.g., faith-based organisations, local chief, headman) *Service providers* Health facility staff (e.g., nurses, community health workers) Teachers (e.g., head teachers, preschool teachers) *Parents/caregivers* Mothers/female caregivers Fathers/male caregivers
	2 KIIs per zone/region	3 KIIs per woreda (1 x leader; 1 x TBA or health staff, 1 x teacher); 2 FGDs with caregivers per woreda
8 KIIs total	*6 KIIs total*	*8 KIIs total; 6 FGDs total*
Total: 22 KIIs and 6 FGDs		

* AIR selected the following three regions: Amhara, Afar and Gambella and covered one woreda per region.

AIR conducted **six FGDs** with parents and caregivers, including one FGD with male parents and caregivers and one with female parents and caregivers for each of the three regions. Together with the KIIs with service providers in each woreda, the FGDs provided a variety of caregiver perspectives from pastoralist areas, urban and rural areas, and humanitarian and refugee settings. In the FGDs, primary caregivers discussed their attitudes, beliefs and knowledge regarding ECD; parenting practices across different NCF domains; the resources they used for parenting; and their experiences regarding the availability, accessibility, affordability, appropriateness, quality and perceived effectiveness of services for young children and families. The focus groups enabled the team to efficiently capture a wider range of parent and caregiver experiences. Focus groups were ideal for discussing a broad range of practices and services used.

For the **case studies**, AIR conducted IDIs with the primary caregivers of five families (including male and female caregivers), representing five different contexts (i.e., urban, rural,

pastoralist, refugee settlements, IDPs), and with staff from one institution providing services for children with disabilities (*see Table 4*). The IDIs covered topics similar to those covered in FGDs and explored unique experiences and practices. In the case of caregivers, IDIs investigated sensitive topics such as intra-household dynamics. IDIs were complemented with a 15- to 20-minute direct observation of caregiver interactions with children while conducting a play activity, using a template to note observations about the home environment and interactions observed between caregivers and children (e.g., the use of language and toys, provision of socio-emotional support). The observation protocol was structured according to modules (such as home environment, socio-emotional development, cognitive development, and language and literacy development) and contained detailed notes of the behaviours observed. Observation data were analysed in combination with data from IDIs to add texture and depth to the case studies. In the findings section, we present six case studies with findings from different caregiving contexts based on IDIs and observations (*see Section 5*).

Table 4. Case Study Sample: Families and Institution

Case Studies	Respondent	Type	Number
Families (5)	• Primary female caregiver • Primary male caregiver	• IDI + observation • IDI	• 1 per household; 5 total + 5 observations • 1 per household; 5 total
Institution (1)	• Institutional staff or focal point for families • Institutional leader	• IDI + observation • IDI	• 2 per institution; 2 total + 1 observation • 1 per institution; 1 total
Total: *13 IDIs in total + 6 observations*			

Note: Observations consisted of 15 to 20 minutes of caregiver–child interaction. Families were from five different contexts.

For the KIIs, FGDs and IDIs, interview protocols were prepared with prompts about local and/or cultural parenting practices across different ECD domains, including nutrition, health, safety and security, responsive caregiving, and early stimulation and learning (*see Annex D for qualitative tools*). Our national expert, Dr Belay Hagos Hailu, contributed to the development of data collection tools to ensure contextual appropriateness.

Data analysis. AIR digitally recorded and transcribed all data from interviews and focus groups from Amharic or local languages into English. We coded and analysed KII, IDI and FGD data using NVivo® qualitative software. The research team created a preliminary coding structure based on the RQs and on the interview and focus group protocols, and used the coding structure to organise and analyse KII, IDI and FGD data. At the start of the process, coders selected a sample of interviews to double-code to ensure inter-rater reliability. During this data reduction process, researchers characterised the prevalence of responses, examined differences amongst groups, and identified key findings and themes related to the RQs.

Quantitative Methodology

The study team conducted household surveys with parents and caregivers of children aged 0–6 years. To answer the questions in the research matrix, the AIR study team designed a survey that included questions on parenting knowledge, attitudes and beliefs, practices including discipline and promoting child development, available information and services, and parents' or caregivers' perceptions of these services. The indicators derived from these

questions included information on household socio-economic characteristics, parent/caregiver education level, maternal health (antenatal, delivery and post-delivery care), preventative care and immunisations, food security, breastfeeding and infant-feeding practices, physical child discipline, decision-making and empowerment, and emotional well-being of the caregiver.

Sampling. AIR sampled across four regions in Ethiopia, covering five contexts and settings: Amhara and Oromia (rural and urban settings), Afar (pastoralist communities), Gambella (refugee communities) and Amhara (settlements for IDPs) (*see Table 5*). For each setting, we selected four woredas/camps to ensure variability covering households from different socio-economic or cultural backgrounds (if there was variation in the region). AIR worked with our local data collection partner Dalberg Research/WAAS and UNICEF to select woredas and *kebeles* (small administrative units) that were accessible in terms of safety and seasonal conditions. The quantitative team worked with our local data collection partner to verify that the households in our sample had at least one child in the age range about whom specific questions could be answered. We aimed for a balanced distribution across gender and ages. On the basis of our margin-of-error calculations,[1] the study team aimed for a sample of at least 1,000 households with 200 parents or caregivers in each of the five settings. Total sample consisted of 1,034 households with nearly equal division for each subgroup. We included a stratification by urban and rural populations (except in the refugee camps in Gambella) so that we could account for potential differences by locality. Note that the survey is developed to provide meaningful insights into the five selected contexts. The sample is not nationally representative given that it does not include all regions in the country. The findings will therefore differ from national statistics.

Table 5. Quantitative Sample

Region	Setting	Rural	Urban	Total
Amhara	**General population**	101	109	**210**
Amhara	**IDPs**	102	102	**204**
Afar	**Pastoralist**	101	106	**207**
Gambella	**Refugee settlements**	201		**201**
Oromia	**General population**	104	108	**212**
			Total	**1,034**

Survey tool. The parent/caregiver survey focused on respondents' beliefs, expectations, attitudes and knowledge regarding child development (*see Annex C*). Within our design, the AIR team used standardised and widely validated tools (used globally), national surveys, and AIR's experience collecting data on ECD and parenting practices in various contexts. The survey was vetted with in-country experts and translated into Amharic and Oromo. The survey was answered by the primary caregiver of a specific child selected based on their age and gender. Some questions were about the entire household, while others were about the selected child.

Quantitative data collection. Prior to data collection, AIR conducted an online, three-day training with the enumerators from our local partner Dalberg Research/WAAS. The training

[1] The margin-of-error calculation told us whether the sample size was large enough to capture the true average value of our outcome variables. We calculated the margin of error as follows: $ME = z_{\alpha\backslash 2} * \sqrt{p(1-p) * \left(\frac{1+(m-1)*ICC}{mJD}\right)}$, leading to an overall margin of error of 0.075 for this study.

took place from 29 August 2022 through 1 September 2022, during which we discussed the study objectives and methodology, research ethics and survey questions. At the end of the training, the enumerators conducted a field test with comparable households to test understanding, validity and reliability of the survey. The data collection took place in September and October 2022. Dalberg Research electronically administered all surveys via tablets, which enabled regular quality checks by the Dalberg field supervisor and the AIR team during data collection. The team conducted high-frequency checks using a dashboard of key variables. During the data collection, the research team met weekly to discuss any issues and were in constant communication through WhatsApp or email. The AIR team discussed any unforeseen issues with UNICEF throughout the data collection period.

Data analysis. Our quantitative analysis consisted of descriptive statistics and analyses to understand patterns of parenting knowledge and practices regarding ECD in Ethiopia. We present these analyses graphically and descriptively (as summary tables with averages or proportions on each outcome) throughout the 'Findings' section to provide more insight into the variety of responses. The outputs are as follows:

- General patterns in ECD parenting practices in Ethiopia; and
- Disaggregated analysis of survey responses by subgroup, such as region and rural/urban, pastoralist, refugee or IDP household.

Sample Description

For this study, AIR used the sample of 1,034 households (*see Table 6*). Following our sampling frame, we expected equal distribution by age and gender for the child about whom we asked specific questions. We found that almost half of the children in our sample were female (49 per cent) and that the age distribution varied with a smaller proportion of 6-year-olds (9 per cent). This suggests that the gender distribution was achieved as intended, while the age distribution was slightly more skewed towards children between ages 1 and 3.

Moreover, our sample consisted mostly of households with a married household head (92 per cent); the household head was, on average, 36 years of age. In most cases, the household head knew how to read (70 per cent), but 39 per cent had no education. For the primary livelihood activity, 21 per cent were involved with farming, and 23 per cent were involved with non-farming businesses. One third of households reported depending upon external support, such as aid or remittances, or having a household head who was unemployed. The households in the sample were primarily Muslim (52 per cent) or Orthodox Christian (38 per cent).

Table 6. Sample Characteristics

Sample	Percentage/Mean
Selected Child's Gender and Age (n=1,034)	
Child is female	48.8%
Child is 0 years	13.8%
Child is 1 year old	18.5%
Child is 2 years old	16.8%
Child is 3 years old	15.6%
Child is 4 years old	14.5%

Sample	Percentage/Mean
Child is 5 years old	12.2%
Child is 6 years old	8.6%
Primary Livelihood Activity (n=1,034)	
Farming	21.0%
Non-farm business	23.4%
Herding	6.1%
Salaried/wage labour	17.7%
Support, aid, remittances	20.3%
Unemployed	10.9%
Household Head Education (n=1,019)	
Knows how to read	69.8%
Has no primary education	39.4%
Has some primary education	21.5%
Finished primary education	23.0%
Finished secondary education or some tertiary education	14.1%
Household Head Religious Affiliation (n=897)	
Muslim	51.7%
Orthodox Christian	38.1%
Other Christian	10.0%
Household Head Marital Status/Age (n=1,019)	
Age household head (in years)	35.6
Widowed/separated/divorced	7.5%
Married	92.2%

Regarding the children in the sample, 2 per cent of households had a foster child, an adopted child or a stepchild (*see Table 7*). These children came mostly from elsewhere in Ethiopia (62 per cent) rather than from the same woreda (10 per cent) or from abroad (33 per cent). About 1 in 20 children had lost one or both parents. In 1 in 4 households, the father lived elsewhere.

Our sample included caregivers whose children lived elsewhere (9 per cent). Most children who lived elsewhere lived with family (43 per cent), a host family (36 per cent) or independently (14 per cent). When children lived elsewhere, it was primarily for economic reasons (38 per cent) or education (20 per cent). Note that these figures were for the household overall; they may or may not have referred to a child in the age span for this study.

Table 7. Orphanhood, Foster Care or Adoption

Child Family Status	Percentage (n=1,034)
Fostered/adopted/stepchild	1.5%
Non-relative in household	0.5%
Mother deceased	1.4%
Father deceased	4.7%

Orphan (either mother or father deceased)	5.3%
Mother lives elsewhere	5.7%
Father lives elsewhere	24.6%
Both parents live elsewhere	4.3%
At least one child lives elsewhere	4.3%
Child lives temporary elsewhere (>2 months)	4.4%

4.3 Ethical Considerations

Obtaining ethics approval. AIR's project lead registered the project with AIR's institutional review board (IRB; IRB00000436). IRB approval was obtained on 7 June 2022.

In-country review and approvals. AIR complied with all Ethiopian requirements for ethics review and approval for all research activities. Dalberg Research and its local partner WAAS obtained national and regional research permits and permission to conduct research across all four regions. Further, permits from the Refugee and Returnee Service were obtained to conduct research in the Gambella refugee camps.

All AIR staff, subcontractors and consultants involved in the collection of data from human research participants adhered strictly to the requirements of AIR's IRB, and non-AIR staff were required to sign our Participant Protection Agreement to ensure that the requirements for protecting human subjects were satisfied. The AIR study team asked all participants for their informed consent for activities that were specific to the project's research components. We asked for consent in a language they understood and worded at an appropriate level for their age and educational background.

Compliance with United Nations ethical standards. AIR follows the United Nations Evaluation Group (UNEG) Code of Conduct, which requires both a conflict- and a gender-sensitive approach to research, adherence to the 'do no harm' principle, transparency, confidentiality, accuracy, accountability and reliability, amongst other key principles (United Nations Evaluation Group [UNEG], 2008). Specifically, with regard to the protection of vulnerable individuals, AIR respects and adheres to the United Nations Declaration of Human Rights, the United Nations Refugee Convention, the Convention on the Rights of the Child, and the Convention on the Elimination of All Forms of Discrimination Against Women, as well as other human rights conventions and national legal codes that respect local customs and cultural traditions, religious beliefs and practices, personal interaction, gender roles, disability, age and ethnicity (UNEG, 2008). This study was conducted in accordance with the evaluation principles of openness, transparency and participation. The study was guided by the ethical principles of independence, impartiality, credibility, responsibility, honesty and integrity.

4.4 Constraints and Limitations

AIR designed a study that addressed the specified research questions in a comprehensive and robust manner. Due to limitations in scope and time, however, we acknowledge three limitations to this study:

- Although we created a quantitative sample representative of five settings, and captured various settings in our qualitative design, we were not conducting a study that was nationally representative and therefore fully representative of all the different populations

and contexts in the country. UNICEF and the GoE should take this into account when further developing policies based on the study results.

- Children's development is highly influenced by the interactions they have with their direct environment, and their caregivers' ability to engage in such interactions is therefore key. In this study we incorporated some characteristics of caregivers, such as stress levels, ability to make decisions and ability to read, but we acknowledge that other aspects of caregivers' mental and physical health may significantly influence developmental outcomes at an individual level.
- The study had a limited scope to cover vulnerable populations who came from smaller sub-populations, such as children with disabilities or orphans. With our sample design, the study team was unable to incorporate a representative sample of these children. An in-depth study on the parenting of children with disabilities with a targeted sample would be required to capture this adequately.
- Because the quantitative survey is cross-sectional and reflects a moment-in-time snapshot of household conditions, the nutrition practices modules are potentially influenced by seasonality bias. The study team asked caregivers to describe the foods that a child ate the previous day, but the questions did not take into account the availability of certain foods in the market at the time of the survey. These concerns are mitigated, however, by triangulation with the nutrition knowledge module as well as with qualitative evidence.

5. Findings

In this section, we present the main results of our mixed-methods analysis. We first summarise the key findings (*see Table 8*), after which we discuss each of the seven research questions in more detail. The results are further guided by the NCF, and we have highlighted the relevant domains where applicable. The quantitative and qualitative results are integrated to allow for triangulation and to provide comprehensive answers to each question.

Table 8. Summary of Key Findings

Research Question	Key Findings
RQ 1. What are parents'/caregivers' aspirations, expectations, beliefs, attitudes and knowledge regarding their young children's development?	• Caregivers demonstrated relatively high levels of knowledge of, for example, handwashing (>80 per cent in most scenarios) and the minimum time for exclusive breastfeeding (89 per cent). • Understanding is more limited on some topics that require nuanced knowledge, such as the reasons *why* a baby should be exclusively breastfed or the age at which children reach some key developmental milestones. • Beyond breastfeeding, there are significant gaps in caregiver knowledge of nutrition (e.g., sources of vitamin A, reasons why a diverse diet is necessary). • Almost half of caregivers believe that physical punishment is necessary for proper child-raising. • Most caregivers suggested that the primary way they can support a young child's learning is by enrolling them and supporting them in formal education. Few caregivers (2 per cent) believe that they should read to a child younger than 24 months old. • Educational aspirations are high, with most parents intending for their children to go on to tertiary education.

Research Question	Key Findings
RQ 2. What are the parenting practices that parents/caregivers engage in with their children?	• Breastfeeding initiation at birth (75 per cent) and exclusive breastfeeding through 6 months old were relatively high (78 per cent). • Minimum dietary diversity was achieved by only 7 per cent of children aged 6–23 months. More children (44 per cent) ate an acceptable number of times per day. However, only 2 per cent of children aged 6-23 months had a minimum acceptable diet (an international standard combining meal diversity and meal frequency). • Most caregivers access health care when their child is ill (83 per cent) or for antenatal care (83 per cent). Postnatal care is somewhat less common (61 per cent). • Children are vaccinated, but at rates considerably lower than required to stop transmission of critical childhood illnesses. • While a high percentage of households use an improved water source (90 per cent), only half of households have improved sanitation, and one third lack a handwashing station. • Caregivers in general believe that affection, hugging, cajoling and comforting their children strengthens bonding. • More than one in five young children was left unsupervised, and one in three was left in the care of another child. • Negative psychological and physical disciplinary practices are widespread. • Four in five children have a household member aged 15 years or older who engages in early learning activities with them – usually the mother.
RQ 3. What are parents'/caregivers' sources of information, guidance and support on parenting young children?	• Caregivers rely upon medical professionals, family and social networks (friends or peers) as their main sources of information on pregnancy and newborn care. • About half of caregivers rely upon medical professionals, family and social networks for information on health care and ECD. • Regular mobile phone (without internet access) is by far the most commonly owned information and communication technology device for information access. Caregivers indicated that besides calling and texting they use their phones as a device to listen to the radio. • Self-described information gaps relate primarily to health, nutrition and knowledge of discipline practices. • Caregivers generally trust new information, but they evaluate the information based on their acquired experience and the reliability of the source.
RQ 4. What is the availability, accessibility, acceptability, affordability, contextual appropriateness, quality and perceived effectiveness of services for young children and families?	• About three in four caregivers have access to and use healthcare programmes, while preschool programmes and food assistance programmes are available to only half the respondents. • Respondents identified the government as the main provider for health services. Education and food supply services are distributed between non-governmental organisations and government-run health centres and schools. • Services such as food supply and health referrals are accessible to caregivers in refugee camps and IDP camps. The refugee camps in Gambella have amongst the highest service utilisation rates. • The MoE and MoWSA have initiatives to include different populations, such as IDPs, vulnerable children and pastoralists, and consider the specific needs of these populations. • Satisfaction with a service used is strongly related to the quality of that service. Youth services and food assistance are amongst the services with the highest rates of dissatisfaction, but there are considerable regional differences.

Research Question	Key Findings
	• Distance is the main barrier to using available services. Few respondents mentioned affordability as an issue.
RQ 5. What factors prevent parents/caregivers from implementing ECD best practices in parenting?	• Barriers to good nutrition are mostly economic. In some regions, lack of food availability is a concern. • Factors preventing best practices in health include the distance to the facility, financial constraints and a perceived lack of good personnel. • Distance and availability of services are issues, particularly in pastoralist communities in Afar. • Caregiver feelings of self-efficacy were generally positive. This was less true, however, in IDP communities, where many caregivers shared that their situation makes them unable to support their children. • Mothers are generally the primary caregiver for young children; they monitor their children's health, diet, hygiene and education needs. Fathers are more likely to make the final decisions on important (and costly) matters, like health treatments or education. • Almost two thirds of children lack birth registration – a potential barrier to accessing services and opportunities. • In refugee and IDP communities, caregivers often struggle to care for their children due to lack of opportunities to earn an income, lack of access to supports for basic needs and issues of overcrowding.
RQ 6. What is the understanding of policymakers and service providers at the federal and sub-national levels regarding parenting for ECD and parents'/caregivers' need for support?	• Policymakers, government representatives and service providers are aware of the varying needs of parents and caregivers – by both region and population characteristics. • Respondents recognised gaps in data and emphasised the need for better studies to receive data to respond accurately with appropriate services.
RQ 7. What are the institutional arrangements to support parents/caregivers for ECD in different sectors?	• Key policies and frameworks will be substantially supported by the new ECDE Policy Framework, released in 2022. • Expanding pre-primary education, a policy objective of growing emphasis, can be crucial for facilitating collaboration between the ministries of education and health around service delivery to children aged 4–6 years. • Policy gaps surround the provision of ECD services to refugees and IDPs. For these populations, an action plan is required to outline how best to provide support. • Coordination at the federal and regional levels on ECD is lacking, but stakeholders hope that the ECDE Policy Framework will offer practicable solutions to this need.

RQ 1. What are parents'/caregivers' aspirations, expectations, beliefs, attitudes and knowledge regarding their young children's development?

1a. What knowledge do parents/caregivers have about ECD and key developmental milestones for young children? (knowledge)

1b. What common beliefs do parents/caregivers hold about ECD? (beliefs)

1c. How do parents/caregivers see their role in the development of a young child? (aspirations)

To better understand the knowledge, beliefs and aspirations that caregivers in Ethiopia have regarding ECD and their children, the research team asked caregivers a series of questions about their knowledge of infant and young child feeding; nutrition and healthy diets; health emergencies; water, sanitation and hygiene (WASH); key developmental milestones; learning; and need for physical punishment. RQ 1 is organised by domain from NCF.

Adequate Nutrition

Infant and young child feeding. Basic knowledge about exclusive breastfeeding and complementary feeding is relatively high. However, understanding is more limited on topics that require nuanced knowledge, such as the reasons *why* a baby should be exclusively breastfed or what good sources of nutrition are.

The majority of caregivers (89 per cent) correctly answered the questions until they were asked about the age at which a baby should be exclusively breastfed (i.e., 6 months) (*see Table 9*). Their knowledge was slightly lower when they were probed further: 63 per cent knew the correct age at which babies could start eating solid food, and 73 per cent knew when they should get other liquids besides breast milk.

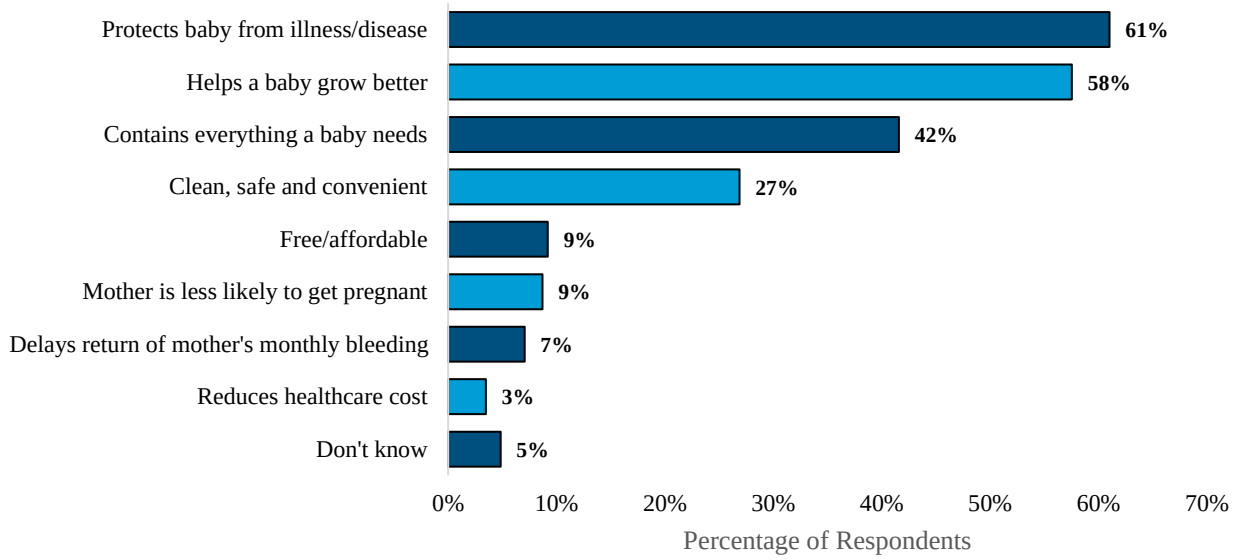
Table 9. Knowledge of Infant and Young Child Feeding

Knowledge Areas	Mean (n=1,034)
Breastfeeding initiation: Immediately/within one hour	89.8%
Age at which a baby should be exclusively breastfed (in months)	5.8
Correct knowledge of age until which a baby should be exclusively breastfed (i.e., 6 months old)	89.3%
Age at which a baby should receive liquids other than breastmilk (in months)	5.9
Correct knowledge of age at which a baby can receive liquid other than breastmilk (i.e., 6 months old)	73.4%
Age at which a baby should receive foods in addition to breastmilk (in months)	6.8
Correct knowledge of age at which a baby can receive food other than breastmilk (i.e., 6 months old)	63.4%
Average number of food groups that parents suggest a child older than 6 months of age should eat	3.2
Correct knowledge of dietary diversity (at least four food groups)	42.7%

The study team asked caregivers to name reasons *why* a baby should be exclusively breastfed; the caregivers answered correctly at lower rates than simply naming the correct age of exclusive breastfeeding (*see Figure 2*). The most common responses were that exclusive

breastfeeding protects a baby from illness/disease (61 per cent), it helps a baby grow better (58 per cent) and breastmilk contains all the nutrients that a baby needs (42 per cent). While respondents could give multiple answers, other options were less frequently mentioned. This suggests that caregivers may have retained high-level information from trainings or other sources of knowledge but may lack comprehensive knowledge.

Figure 2. Reasons Why a Baby Should Be Exclusively Breastfed



Knowledge of healthy diets. For children older than 6 months of age, when children should have complementary fluids and solid foods introduced into their diets for proper development, the research team asked caregivers about their knowledge of food groups, frequency of feeding and sources of vitamin A and iron. The study team followed guidelines developed by WHO (2008) on minimum dietary diversity (MDD) and minimum meal frequency (MMF).

Dietary diversity expected by Ethiopian parents is lower than the WHO guidelines prescribe (WHO, 2008). Less than half of caregivers (43 per cent) expect children to eat at least four different food groups per day (*see Table 9*). Caregivers reported that they expect children to eat a relatively limited diet with, on average, at least three out of seven food groups. Despite these results, most caregivers indicated that they understand the importance of a 'balanced diet' for children beyond the age of exclusive breastfeeding. They described a balanced diet as one that includes a variety of foods, especially those with 'protein' and 'vitamins'. As a male caregiver in Afar described during an interview, "*There are protein-rich foods like eggs and vitamin-rich foods. We give them to use since we know the benefits. We feed them eggs, meat, milk and any other things that are available nearby."* This indicates that caregivers demonstrate a general understanding of the importance of dietary diversity, while lacking an in-depth understanding of different vitamins and nutrients and their sources.

Caregivers mostly expect their children to consume milk (72 per cent of caregivers cited cow's milk, and 55 per cent cited breastmilk), eggs (73 per cent), green leafy vegetables (46 per cent) and orange-coloured fruits/vegetables (45 per cent). Meat is noticeably not expected to be consumed by children, likely due to availability and accessibility issues (See Annex Table A1).

On the other hand, parents demonstrated that they understand how many times a child should be fed per day, regardless of which food the child is given: On average, caregivers responded that young children should be fed about four times per day after 6 months of age, whether they are breastfed or not, which is slightly above the amount recommended by WHO (WHO, 2008).

When asked about foods that are good sources of iron and vitamin A, many caregivers demonstrated a lack of knowledge about foods that contain these nutrients: Only 31 per cent of respondents correctly named at least two foods that are a good source of iron, and 41 per cent of respondents could not correctly name a single good source of iron. 'Lower immunity' and 'impaired development' were the most common responses regarding impacts of iron deficiency. Knowledge of vitamin A sources was slightly higher: 42 per cent of caregivers correctly named at least two sources of vitamin A. Twenty-nine per cent of caregivers, however, could not name any foods with vitamin A, and many provided wrong answers. Of those who provided a correct source of vitamin A, 66 per cent gave only correct answers, indicating that some caregivers had incorrect information and others might have been guessing. The most common incorrect response was that 'meat' is a rich source of vitamin A, with 38 per cent of respondents believing this is the case (*see Table A4 in Annex A*). During interviews, at least one caregiver suggested that men tend to have more knowledge of dietary diversity: "*Ladies simply know how to cook, but they don't know what a carbohydrate is, and which one is a protein. I teach my wife about that.*" The results from the survey on decision making and gender roles support this assertion (*see RQ 5*).

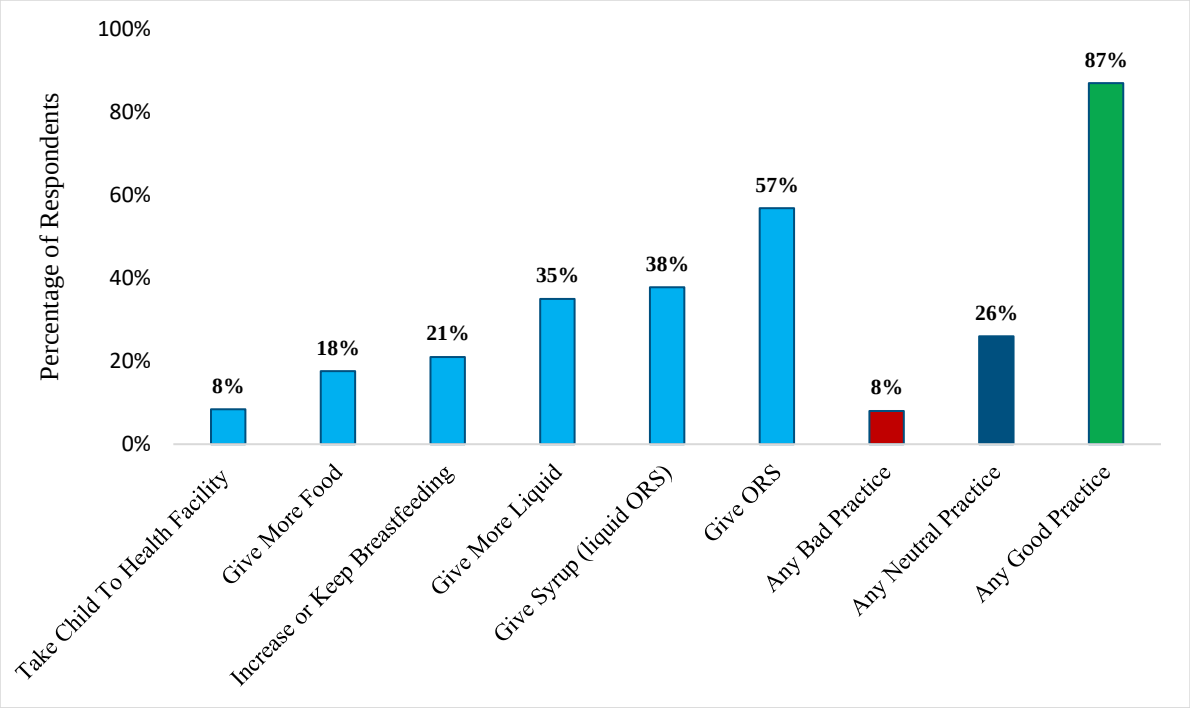
Across the different contexts knowledge about nutrition varies, but not one of the settings is consistently showing higher knowledge than others. IDPs in Amhara are generally showing to have less often correct knowledge on sources of nutrition (e.g. iron, Vitamin A, food groups), but perform above average on knowledge about breastfeeding (see Annex Table A2). A considerable difference is observed by caregivers' level of education (Table A3 in the Annex A). While all caregivers are relatively often correct on knowledge on breastfeeding, caregivers with at least primary education have more advanced knowledge on infant feeding needs.

Good Health

Knowledge about healthcare needs. Caregivers were asked what they would do if their child had diarrhoea, one of the most common health emergencies amongst young children in the Ethiopian context. Eighty-seven per cent of parents knew at least one positive step to take during this emergency (*see Figure 3*), such as giving a (liquid) oral rehydration solution, taking the child to a health facility, continuing or increasing breastfeeding, or giving treated water or additional liquids. However, 8 per cent of caregivers identified practices that would be harmful, such as restricting food or liquids. Additionally, 26 per cent of caregivers provided examples of practices of which the benefits are unknown. For example, traditional medicines may or may not be beneficial or provide children with the same amount of liquids as when they are not sick, which may still lead to dehydration. While these practices are not known to cause direct harm to the child, they indicate some lack of knowledge on the caregivers' part. Knowledge about best practices of what to do when a child has diarrhoea were highest among caregivers in the refugee camps in Gambella and lowest in Afar and Oromia. This is possibly because the refugees may have gotten specific information in the camps (See Table A4 in Annex A).

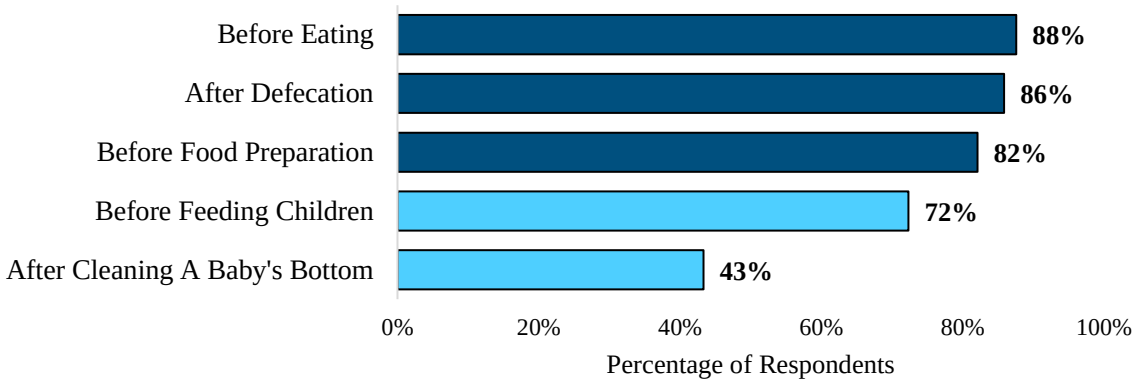
The qualitative interviews revealed positive knowledge about recognising illnesses and their causes. Caregivers commonly reported recognising sicknesses such as malaria, diarrhoea, measles, fever, pneumonia, the common cold, eye infections, allergies and flu in young children. When asked to cite what causes illness in young children, parents offered valid responses, such as the lack of bathing/hygiene, spoiled food, cold weather, untreated water, close living quarters and a dirty environment.

Figure 3. Parental Responses Regarding What to Do When a Child Has Diarrhoea



Knowledge about water, sanitation and hygiene (WASH). Knowledge is generally high in regard to basic hand-washing practices (*see Figure 4*). More than 80 per cent of caregivers were able to identify key situations in which it is important to wash their hands to prevent the spread of disease. The survey results revealed, however, two situations in which caregivers did not cite as a time to wash their hands: Less than half of respondents believe they should wash their hands after cleaning a baby's bottom (43 per cent), and 28 per cent did not cite 'before feeding children' as an important situation in which to wash their hands. These are opportunities for disease to be transmitted to the child. Table A4 in Annex A indicates that knowledge about handwashing was significantly higher among female caregivers with at least primary education (See Table A5).

Figure 4. Situations in Which a Parent Should Wash Their Hands



Regarding handwashing practices, a female caregiver in Amhara reported during an FGD, *"If there is a common cold going around, the children would catch it… [and] their eyes get sick… We have to wash their eyes with water and soap for them to be able to open them again."* Other caregivers described the importance of hand washing to prevent illness. For example, a female caregiver in Gambella said,

> *"Yes, we practice handwashing. The reason we do it is that, first, it's for hygiene. Second, it's because of the new disease, coronavirus. We wash our hands with soap and water after meeting and shaking the hands of others to avoid contamination."*

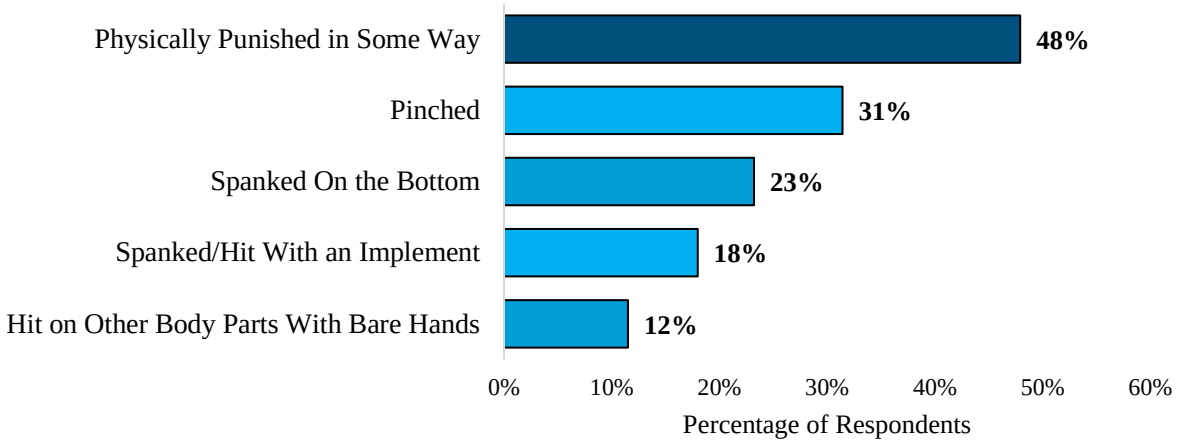
The qualitative data suggest a broad understanding amongst caregivers about the importance of using soap in handwashing and about general hygiene to prevent illness and treat minor infections.

Safety and Security

Environment. One aspect of the safety and security domain is caregivers' concerns for their child's environment. In the qualitative FGDs and KIIs data, caregivers emphasised the importance of a safe environment for keeping children safe and secure. When asked about areas where children should not play for their safety and health, caregivers listed toilets, wells, areas with dirt and animal dung, and around dirty or standing water.

Child discipline. Both the quantitative and qualitative data showed that corporal punishment is still widely believed to be effective and necessary. About half of the caregivers (48 per cent) believe that physical punishment is necessary for proper child-raising (*see Figure 5*). This most often takes the form of mild physical punishment, such as pinching or spanking; however, 18 per cent of parents believe that a child should be hit with a physical implement. These beliefs were not consistent across the different settings, and showed larger proportions of the need for physical punishment in pastoralist regions in Afar and IDP communities in Amhara compared to others (see Annex A Table A6). In additions, these beliefs were also much more commonly held among female caregivers with no or less than primary education (Table A7).

Figure 5. Beliefs Regarding the Need for Physical Punishment



Despite pervasive attitudes in favour of negative discipline, parents and caregivers unanimously reported being aware of positive *and* negative discipline techniques. Statements such as this one, offered during a focus group with male caregivers in Amhara, were common:

> *"As we inherited from our parents, there are two types of discipline methods: advice and physical punishment. To advise is to discuss the misbehaviour and promise to buy something for the child if they abstain from the undesirable behaviour. If this is the case, the child's psychology will improve and become good… However, if the child is beaten when they do something wrong, they become numb, and their mind will be stolen."*

Parents who reported using positive discipline (e.g., advising and counselling children) rather than physical punishment explained that they do so out of sensitivity to children's feelings. In general, the quantitative and qualitative data indicate solid understanding of positive discipline methods, upon which the ECD sector can build in designing child discipline and child protection programming. Such programming must be sensitive to the role of discipline in family and society. In the qualitative FGDs data, parents broadly indicated that discipline serves to ensure that a child behaves well, respects elders, is pious and has good relationships with other people. Further, many believe that an intelligent child is one who demonstrates good behaviour; therefore, parents described discipline as an educational process. In addition, parents explained that when their children are enrolled in pre-primary school, parents empower teachers to be disciplinarians of their children. Qualitative data indicate that aside from parents and teachers, caregivers regard neighbours, friends and other family members as acceptable disciplinarians of young children.

Traditional beliefs and ECD. Traditional beliefs did not feature strongly in our discussions with caregivers; in fact, most parents who mentioned traditional beliefs said they weigh their beliefs against their knowledge of ECD best practice. Nonetheless, the research team noted the following beliefs and practices across regions:

- Scarring gums (Afar)
- Early marriage (Afar and Amhara)
- Removing the tooth of a child to stop their diarrhoea (Afar)

- Female genital mutilation/female genital cutting (Afar)
- Gendered treatment of children
- Seeking traditional healers

The findings from the quantitative survey confirmed that expectations of early marriage are still present and that these aspirations are highly gendered (*see Table 10*). Parents said the ideal age at which a child should be married is, on average, 19 years old for girls and 23 years old for boys. However, 25 per cent of caregivers specified that girls should get married under 18 years of age, while this figure was only 2 per cent for boys. In theory, boys and girls are expected to complete some tertiary school (*see Figure 6*), yet girls are expected to marry at a younger age suggesting a barrier for girls to achieve their parents' educational aspirations.

Table 10. Parental Aspirations for Children's Age at Marriage

Expected age at Marriage	Mean (n=1,034)
Ideal age that daughter should get married (in years)	18.5
Ideal age that daughter should get married is under 18 years of age	24.9%
Ideal age that son should get married (in years)	22.8
Ideal age that son should get married is under 18 years of age	1.8%

Opportunities for Early Learning

Learning at home. Parents indicated that they mostly do not begin reading to a child until after at least 48 months old (i.e., the median age at which parents believed their children should start to read), though answers varied widely (*see Table 11*). The quantitative data made clear that reading to a child is rare in the first years of life: Only 2 per cent of caregivers believe they should read to a child younger than 24 months of age. These results may be related to parental literacy rates, as well as beliefs that schools rather than parents play a large role in children's learning. In Oromia parents are most likely to start reading to children below four years (65 per cent) while the IDPs in Amhara are the least likely at 11 percent (Table A8).

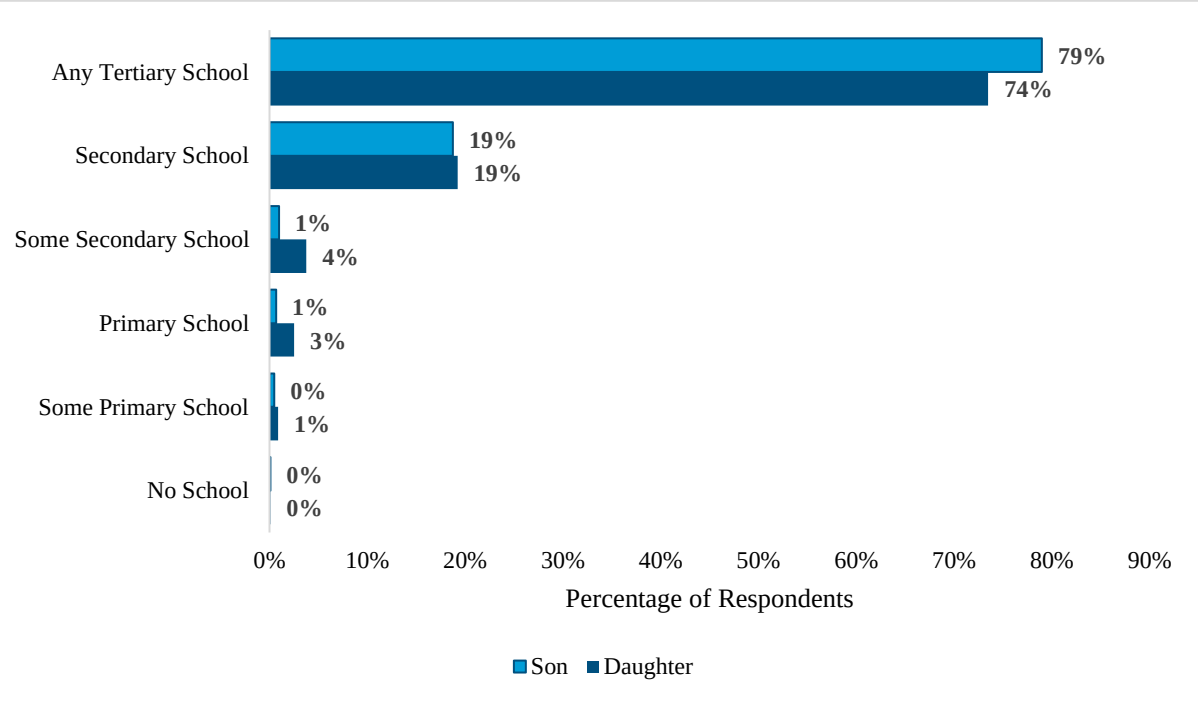
Table 11. Caregiver Beliefs about Early Reading

Caregiver Beliefs about When They Should Start Reading to Their Child	Percentage of Caregivers (n=1,034)
Should read to child under 12 months of age	1.0%
Should read to child aged 12–23 months	1.1%
Should read to child aged 24–47 months	33.0%
Should read to child older than 48 months of age	65.0%

Qualitative data from caregivers suggest that the primary way in which they can support a young child's learning is by enrolling and supporting them in formal education. Few parents suggested that they can support children's learning at home, and only a subset of parents view speaking, reading and playing with children as important for early learning.

Educational aspirations. Parents' expectations for their children's education are high and confirm caregivers' perceptions of the importance of education (*see Figure 6*). Most parents expect their children to complete some tertiary education, with 79 per cent and 74 per cent of parents expecting some tertiary education for their sons and daughters, respectively. While slightly more parents expected their sons to complete some tertiary education, the results do not indicate a significant gender bias in parents' expectations regarding their children's education. Unsurprisingly the educational aspirations are highest among female caregivers who had finished at least primary school compared to caregivers with no or lower education. The differences between the aspirations for boys and girls remain small (Table A9).

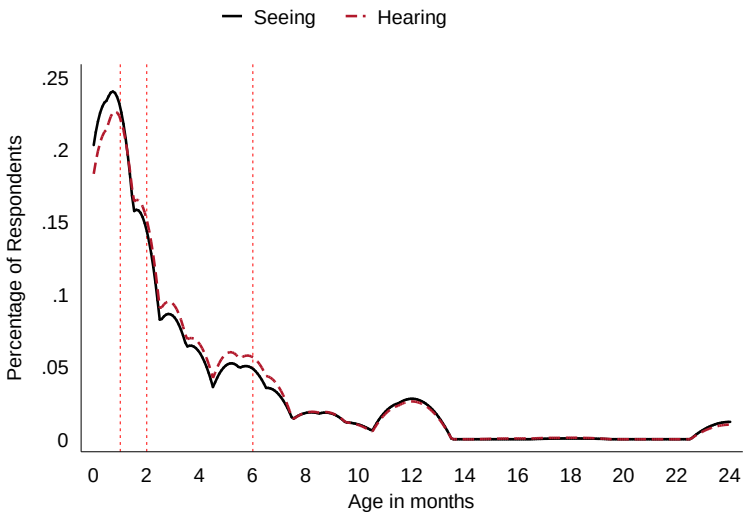
Figure 6. Parents' Expectations Regarding Education for Their Sons and Daughters



Responsive Caregiving

Knowledge about developmental milestones. Most caregivers lack knowledge about when infants begin to see and hear. Just 21 per cent of respondents correctly said a child can hear immediately at birth, and 25 per cent correctly said a child can see immediately after birth (*see Figure 7*). Caregivers mostly believe these developments happen soon after birth (i.e., within 2–6 months) but not immediately.

Figure 7. Age at Which Caregivers Expect Their Child to See or Hear



Note: Graph is truncated at 24 months for visualisation purposes.

In the qualitative interviews, caregivers linked developmental milestones to early learning and explained that signs of intelligence are different for children aged 0–3 years as compared to children aged 4–6 years. For example, a female caregiver from Gambella said, *"If I tell a child that this, for instance, is the number '1' and he is curious to know what comes next, then that is an intelligent child."* Parents attributed different factors to their child's intelligence at different stages of life (*see Table 12*).

Table 12. Caregiver Knowledge of Early Learning from Qualitative Data

Signs of Intelligence in Young Children (0–3 Years)	Signs of Intelligence in Older Children (4–6 Years)
• Speaking at an early age (e.g., 12 months old) • Mimicking • Demonstrating inference skills	• Reading and writing • Communicating wants and needs • Achieving success in pre-primary school • Demonstrating good morals/behaviour • Showing respect for elders

> *"There is a saying by Amhara people which says* kefitfitu fitu *(a facial expression is worth more than the food served). Children look at your face first; they won't approach you if you show them a frown."*
>
> – Male caregiver, Afar

The qualitative data show encouraging signs about existing knowledge and beliefs about responsive caregiving in different regions of Ethiopia. In the qualitative interviews, caregivers almost unanimously said it is important to be attentive to the emotions of young children; only one person told us that love and attention might 'spoil' a child. Across regions, caregivers broadly reported that expressing love to children is good for the child and that being attentive to young children enables the caregiver to understand the child's wants and needs (e.g., if they are sick, if they need new clothes). In terms of knowledge, parents and caregivers recognised laughing, playing, embracing parents and smiling as signs of happiness in young children. They recognised crying or negative facial expressions (e.g., frowning, wincing) as signs of distress. Most felt knowledgeable about how

to recognise different emotions in their children, though some caregivers suggested that a mother is more likely to recognise children's emotions. The data suggest that parental knowledge and beliefs are in favour of responsive caregiving.

RQ 2. What are the parenting practices that parents/caregivers engage in with their children?

2a. What are the parenting practices of parents/caregivers concerning areas of nutrition; health; water, sanitation and hygiene (WASH); protection; early stimulation and early learning; and responsive caregiving?

Adequate Nutrition

Infant and young child feeding practices. To better understand the nutritional needs of young children in Ethiopia, the research team asked primary caregivers a series of questions regarding the breastfeeding and feeding practices that they use with their children. The questions were dependent upon the age of the child and the appropriate feeding practice that should be adopted at a given age, in accordance with WHO guidelines (i.e., children should be exclusively breastfed until they are 6 months old (WHO, 2008)).

Amongst children who were breastfed, on average:

- Mothers stopped breastfeeding at **26 months**.
- Child was first given water or other fluids at **6 months**.
- Child was first given solid/ semi-solid food at **7 months**.

The study team found that breastfeeding best practices amongst mothers are widely adopted but still lag behind knowledge; i.e., caregivers mostly know how to feed newborn babies but do not always put this knowledge into practice. For example, 75 per cent of respondents said that their child was put to breast immediately after birth, compared to 90 per cent of respondents who said this was the correct time to put a child to breast. Additionally, 89 per cent of caregivers responded that a child should be exclusively breastfed until they are 6 months old; however, the results showed that 77 per cent of caregivers exclusively breastfed their child for the first 6 months. Of concern, a small but not insignificant amount of respondents (8 per cent) said that their baby was given something other than breastmilk to drink in the first three days after birth (see *Table 13*). Note that while the demographic health survey (DHS) indicates an increasing trend in exclusive breastfeeding over the past fifteen years, these percentages of self-reported exclusive breastfeeding are higher than nationally representative results of 56 percent. This may indicate a potential social desirability bias in the answer (CSA & ICF, 2016).

Similarly, qualitative data from interviews and FGDs indicate that exclusive breastfeeding is prevalent across all regions and across populations. Most mothers reported that they exclusively breastfed their children from birth to 6 months of age, and that they continued breastfeeding with solid foods until at least 2 years of age. Mothers from Gambella and Amhara, respectively, said,

> *"I started breastfeeding them immediately after they were born. I breastfeed my baby every hour."*

> *"Those working at the health centre told me to breastfeed her from 1 up to 11 times within 24 hours, not to breastfeed her while she is sleeping and to help burp her after breastfeeding before putting her to sleep."*

Further, a representative from MoWSA in the Afar region stated,

> *"The mothers properly breastfeed their children, for two to two and a half years. This is the survival stage of the child before the child enters the development stage. All mothers breastfeed their children, and that is a positive aspect."*

However, caregivers from Afar reported that breastfeeding may stop because pregnancies follow relatively quickly after each other, leading mothers to stop breastfeeding the older child.

Dietary diversity. To assess dietary diversity, the research team used standardised WHO indicators on dietary diversity (i.e., MDD), meal frequency (MMF) and a combination of the two to examine whether young children have a minimum acceptable diet (MAD) (WHO, 2018). The team asked parents to comprehensively name which foods their child ate the previous day and categorised these foods into distinct groups: breast milk; grains, roots and tubers; legumes and nuts; dairy products (milk, yogurt, cheese); fleshy foods (meat, fish, poultry, liver or other organs); eggs; vitamin A-rich fruits and vegetables; and other fruits and vegetables (WHO, 2023). These questions were relevant to children aged 6–23 months.

The quantitative results showed that children aged 6–23 months in Ethiopia, on average, are not eating an acceptably diverse diet. Caregivers identified foods from an average of three out of seven food groups; at least five per day is the norm. Amongst children aged 6–23 months, only 7 per cent achieved MDD. On the previous day, the children were fed primarily breastmilk (93 per cent) or carbohydrate- and starch-heavy foods including potatoes, cornmeal, porridge, teff and bread (89 per cent). However, the rate of eating nutrient-rich foods such as meat and vegetables was significantly lower, with percentages at below 20 per cent (*see Table 13*). About a quarter of children in the relevant age group were given legumes/nuts or dairy products. In terms of frequency, 44 per cent of children aged 6–23 months achieved acceptable MMF.[2] Thus, it is more common for children to be fed a sufficient number of times. With respect to combining both MDD and MMF, only 2 per cent of children aged 6–23 months achieved MAD standards of sufficient frequency and diversity, a result driven largely by the lack of dietary diversity. These percentages are relatively comparable to nationally representative findings in the DHS 2016 (CSA & ICF, 2016).

Table 13. Infant and Young Child Feeding Practices for Children Aged 0–23 Months

Feeding Indicators	Percentage of Respondents
Breastfeeding below 6 months (n=1,034; asked retroactively)	
Child was put to the breast immediately after birth.	75.4
Child was given something other than breastmilk in the first three days.	7.6
Child was exclusively breastfed under 6 months.	77.5

[2] MMF is at least two meals for a child aged 6–8 months who is breastfed, at least three meals for a child aged 9–23 months who is breastfed and at least four meals for a child aged 6–23 months who is not breastfed (WHO, 2018).

Feeding Indicators	Percentage of Respondents
Complementary feeding (6–23 months; n=282)	
Minimum dietary diversity (MDD) (6–23 months)	6.7
Minimum meal frequency (MMF) (6–23 months)	43.6
Minimum acceptable diet (MAD) (6–23 months)	2.5
Food groups consumed in the past 24 hours (6–23 months; n=282)	
Breastmilk	92.9
Grains, roots, tubers and other starchy foods	88.7
Legumes and nuts	28.0
Dairy products	24.1
Other fruits and vegetables	18.8
Eggs	13.8
Vitamin A-rich foods	6.0
Meat and fleshy foods	3.6

From the qualitative data, caregivers reported that they introduced solid foods and diverse fluids at 6 months of age. For example, a caregiver from Afar explained,

> *"I fed my child exclusively breast milk until he was 6 months old. After 6 months, I provided my child with additional food. The additional food that I provide after 6 months old includes foods prepared at home from food items that are mostly available in our locality. This includes pulses, cereals and oil seed."*

Discussions with caregivers on food diversity revealed inconsistent understanding. Some caregivers incorrectly understood dietary diversity to be based on different foods rather than different *types* of foods. As a result, they incorrectly believe that a child's diet is diverse if they ate, for example, pasta and rice. Others correctly consider dietary diversity to include food categories such as carbohydrates, proteins and dairy.

Most caregivers, however, are aware of the importance of food diversity in their children's diet but faced barriers such as unavailability and unaffordability of quality food. A female caregiver in Amhara emphasised her helplessness and noted barriers, and said,

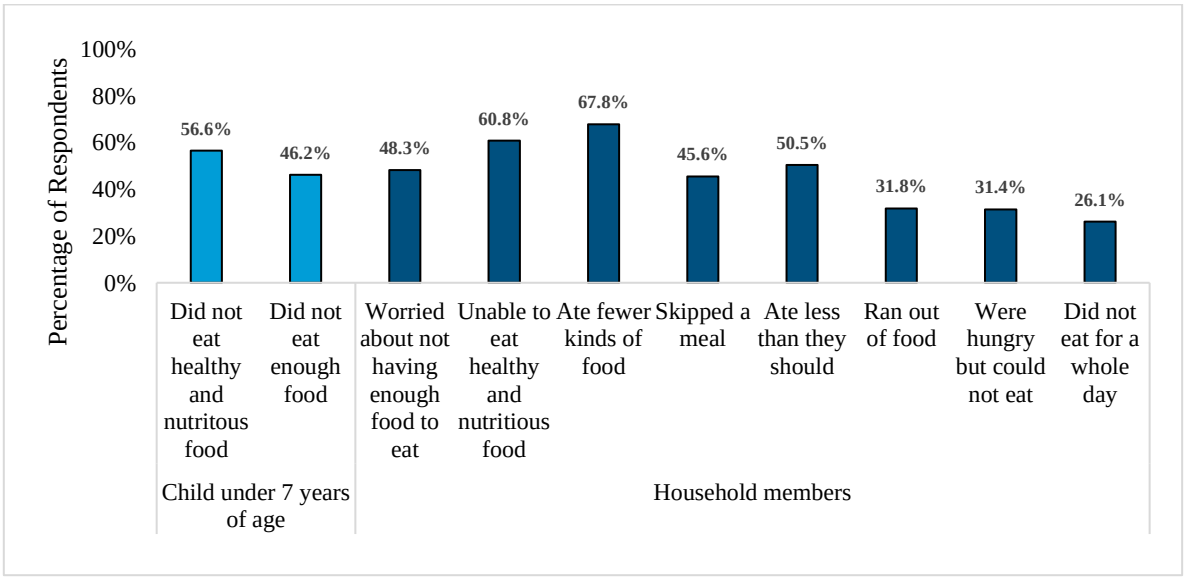
> *"I don't try to prepare them balanced and quality food, I just buy them what I can afford to help with their survival for tomorrow and the next day. I know that it is good to feed them beetroot, potato, and carrot, but I can't afford to buy that for them."*

Caregivers face other barriers such as lack of time and access to resources in IDP camps in Amhara. For example, a priest stated, *"To raise a healthy child, parents should prepare food from barley flour and add sugar, milk and egg to their meals, but as they are living in the camp, parents don't have time or money to buy the food."* Religion is another barrier. For example, a priest from Amhara noted that communities that practice different religions may not eat food such as meat, if the animal (e.g., cattle) was slaughtered by a person who does not practice the same religion.

Food Insecurity. The caregiver survey revealed that money and resource constraints pose a major barrier to the food security of young children. Overall, household members eat an acceptable number of meals per day, on average (2.7); however, it is clear that many households struggle with food insecurity: More than a quarter of households reported that someone in the household did not eat for a whole day due to money or resource constraints over the past four weeks (26 per cent) or were hungry but could not eat (31 per cent) (*see Figure 8*). Similarly, 57 per cent of caregivers did not give their child the healthy or nutritious food that they would have liked to, and 46 per cent did not have enough food for the child due to money or resource constraints. The main concerns of caregivers in relation to food security were about food diversity and the ability to obtain nutritious foods. Large regional differences exist in food insecurity; the highest food insecurity scores were measured in Gambella, where more than 99 per cent are concerned about every situation mentioned in Figure 8. The lowest food insecurity was reported in Amhara (See Annex A Table A10). Food security is also considerably lower among caregivers with at least primary education as opposed to those without. The underlying factor here is likely related to income (Table A11).

Qualitative data highlighted that food insecurity and dietary diversity varies between regions. Caregivers in Gambella and Afar mentioned provision of different types of carbohydrate-rich foods, whereas caregivers in camps in Amhara face barriers in providing varied meals. Further, some caregivers in Gambella, who are largely from refugee communities, mentioned foraging in forests for vegetables. In Afar, carbohydrate-rich and macronutrient-rich food includes pasta/pastina, Cerifam (a wheat- and soy-based porridge) and rice. In Gambella, meals include kop, walwal and porridge with milk. In Amhara, other caregivers stated that they provide children with injera with shiro, if available. However, speaking on the compounded barrier of inadequate facilities available in camps and the lack of diverse ingredients to prepare nutritious meals, a male caregiver in an IDP camp in Amhara said, *"If we had been at our home, I could serve them eggs, milk and other types of foods at each mealtime. However, I have no income, so they will eat whatever I serve."* These data suggest that the living conditions in camps and the lack of space and facilities are barriers to the provision of diverse foods in the Amhara and Gambella regions.

Figure 8. Food Insecurity in the Past Four Weeks Due to Money or Resource Constraints



Good Health

Treatment When Ill. The research team asked caregivers questions about the prevalence of some serious diseases amongst children in the Ethiopian context, including diarrhoea, fever and respiratory illness, and what treatment practices they use when children have these illnesses. While children were found to get sick often (39 per cent), in most cases caregivers demonstrated an urgent response to their child's illness. Nearly two out of five children had any serious illness in the past two weeks, with 25 per cent and 23 per cent of these children suffering from fever and diarrhoea, respectively (*see Table 14*). It is common practice for caregivers to seek treatment for these illnesses for their children, at more than 80 per cent (*see Table 15*). When caregivers do not seek treatment for a child's illness, it is unclear whether this is because treatment is unnecessary, or it is necessary but is not accessed.

Table 14. Children's Illness in the Past Two Weeks

Health Issue	Percentage of Respondents (n=1,034)
Child had any serious illness	39.3
Child had diarrhoea	23.1
Child had fever	25.3
Child had illness with cough or chest problems	11.2

Table 15. Treatment-Seeking When Sick in the Past Two Weeks

Sought Treatment for Given Health Issue	Observations	Percentage of Children Who Were Sick in the Past Two Weeks
Sought treatment when child was sick	406	83.3
Sought treatment when child had chest problems	117	85.5
Sought treatment when child had diarrhoea	239	87.0
Sought treatment when child had fever	262	85.1

Qualitative data support the findings from the survey: Positive health behaviours are prevalent and practiced across regions and populations. Behaviours include seeking treatment or health care when a child is ill, using toilet facilities to reduce open defecation, washing hands and receiving vaccinations. Further, processes implemented to reduce the transmission of COVID-19 are followed in camps, such as refugee camps in Gambella (*see Figure 9*).

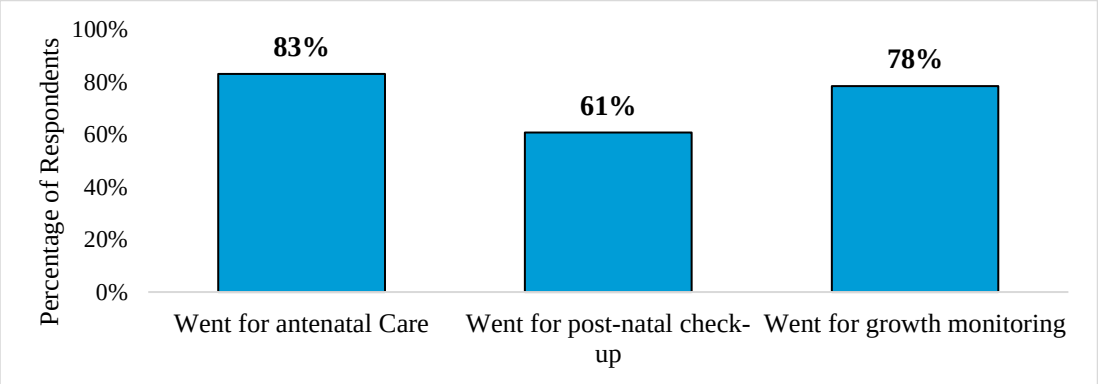
Figure 9. Refugee Settlement Camp, Gambella

Despite the good health practices, common illnesses and endemic diseases such as diarrhoea, sinus problems, pneumonia and malaria are prevalent due to the unhygienic conditions of living environments

such as camps, which are largely crowded spaces and have limited water availability. Speaking to the unhygienic conditions, a female caregiver in Amhara mentioned, *"It is common to also see vomiting and diarrhoea in the children as they touch the dirt and eat their meals without washing their hands."*

Antenatal and postnatal care practices and immunisations. Most respondents (83 per cent) went for antenatal care while pregnant; however, fewer continued this care with a postnatal check-up after giving birth (63 per cent). Respondents who went for antenatal care started doing so at an average of four months into pregnancy and attended an average of four visits. It is common for parents to take children to growth monitoring visits (78 per cent), and they receive an average of four of these visits. Of the 17 per cent of respondents who did not seek antenatal care, the most common reasons were that the health centre was too far away (34 per cent), they deemed antenatal care unnecessary (26 per cent) or no health care was readily available to them (17 per cent) (*see Figure 10*). Nationally representative figures show a lower rate of antenatal are in 2016 of 62 per cent. The trend however has been steeply increasing from 27 per cent in 2000 and 34 per cent in 2011. These results may therefore not be uncommon in our sub-population (CSA & ICF, 2016).

Figure 10. Antenatal and Postnatal Check-ups



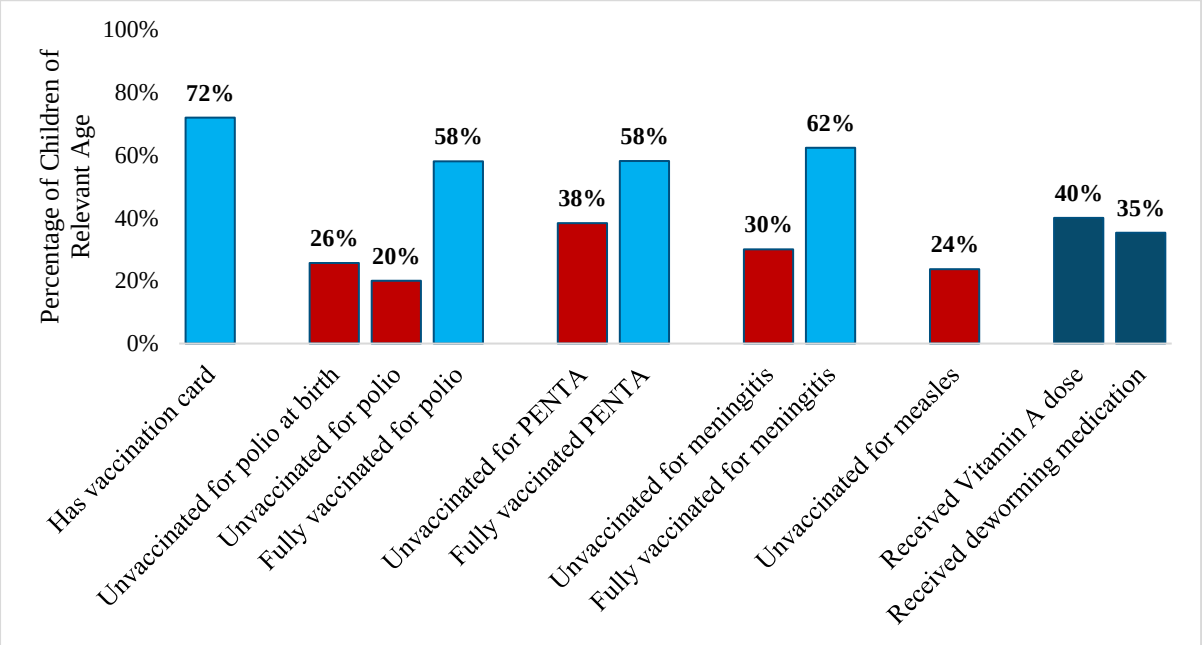
A review of immunisation rates[3] for preventable diseases such as polio, meningitis and measles shows that vaccination is common but that overall rates are considerably lower than the rates required to stop transmission of critical childhood illnesses. Just under 60 per cent of children had been fully vaccinated against polio or had received a full dose of the pentavalent (PENTA) vaccine. A quarter of children were not vaccinated against measles. Some other key early health interventions are less common; for example, just 40 per cent of children had received a dose of vitamin A, which significantly protects against infant mortality. Similarly, rates of deworming are low (35 per cent), which helps mitigate potential stunted growth. This indicates the presence of a significant number of children still missing adequate protection against preventable diseases at a young age. Our data describes the rates of immunisation (for the relevant age group) and the reception of important medications amongst children covered in the study (*see Figure 11*).

Similarly, during interviews and FGDs, when asked about health centre visits, most female caregivers mentioned going to health centres when pregnant and receiving information from healthcare workers on child vaccinations, breastfeeding and hygiene. Most caregivers showed

[3] All immunisation rates were calculated for the relevant ages using only the vaccination schedule for Ethiopia: https://immunizationdata.who.int/pages/schedule-by-country/eth.html.

little hesitancy about receiving vaccines and reported getting their children vaccinated, though they were unclear on what the vaccines were for.

Figure 11. Immunisation Rates and Critical Early Childhood Health Interventions



WASH facilities and hygiene. The use of improved water sources and sanitation facilities is an essential element of preventing the spread of disease. Gastrointestinal parasites and harmful bacteria can be more easily ingested through the consumption of water from unimproved sources and, without treatment, can stunt the physical growth and development of young children. Inadequate sanitation facilities increase the likelihood that a child can ingest harmful parasites and bacteria.

The results indicate that WASH facilities in many households require improvement mostly in regard to sanitation to nurture a safe and hygienic environment (*see Table 16*). The water infrastructure is generally sufficient and safe, but challenges remain for round-the-clock access to clean water. The majority of caregivers use an improved water source (90 per cent).[4] In every region except Oromia, more than 90 per cent of caregivers use an improved water source. In Oromia, this rate is lower at 67 per cent. Water is usually not available in the household, and acquiring water takes time and effort: Respondents travelled a median of 200 meters to get to a water source (but some went as far as 3,000 metres) and spent, on average, 33 minutes round trip to fetch water. Caregivers emphasised that some of these water sources depend on an often unstable flow of electricity. Thus, having an improved water source does not ensure continuous access to clean water.

[4] (UNICEF and WHO, 2022). According to the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation, an improved drinking water source includes piped water on premises (piped household water connection located inside the user's dwelling, plot or yard) and other water sources, including public taps or standpipes, tube wells or boreholes, protected dug wells, protected springs and rainwater collection.

Table 16. WASH Facilities

	Mean (n=1,034)
Percentage of respondents with an improved water source	89.7
Percentage of respondents who have access to an improved water latrine	52.3
Percentage of households with no handwashing site	37.5
Median distance to reach water source from household (metres)	200.0
Average total time to fetch water (minutes)	33.0

In terms of sanitation, the survey results revealed that adequate sanitation facilities are less common than proper water sources.[5] Only slightly more than half of households (52 per cent) have access to an improved latrine, but 27 per cent of caregivers reported being forced to use an open field for the disposal of human waste. The results vary significantly by region. Only 24 per cent of households in Gambella have access to an improved latrine, while nearly all households in Amhara have access (90 per cent). IDPs in Amhara have better-than-average access to improved latrines (61 per cent). Less than half of households in Afar and Oromia have access to an improved latrine (see Annex A Table A12). In addition, about 38 per cent of caregivers have no handwashing site at their home. If they do, in most cases, the site is a mobile object, such as a bucket or kettle. In 32 per cent of households, there is no disinfecting product to clean hands, such as soap, detergent or ash.

Responsive Caregiving Practices

Qualitative data suggest that most caregivers believe that displays of affection, such as hugging, cajoling and comforting children when they are crying, are necessary parenting practices to strengthen the bond with their children. However, a few caregivers reported not engaging with some responsive caregiving practices (such as hugging or singing) to comfort their children but noted that they still express love to their child. For example, a female caregiver from Afar described the practice of comforting their child:

> *"I enjoy giving love to my child. I express my love for my child by trying to be happy with him, smiling, feeding him, dressing him and doing everything. I have never hugged, held, sung or told stories to comfort any of my children so far. I have never done anything else to comfort them."*

> *"The children **feel happy and comfortable whenever the mother or father smiles at them**. They will have the impression that the mother will do things for them."*
>
> – Female caregiver, Gambella

A few male caregivers from Amhara mentioned that showing too much affection could potentially spoil children and make them disobedient. A male caregiver from Afar said, *"Giving a lot of affection can spoil children. It makes them reject orders, disrespect elders and so on. Affection and coddling are disastrous for children. Ultimately, it will make them disobedient and out of order."* When considering the gender of the child, most caregivers from across regions reported little to no differences in how they comfort boys and girls. However, a female caregiver from Gambella mentioned that girls may be less likely to

[5] Improved sanitation facilities are defined as those that hygienically separate human waste from human contact. Improved sanitation includes flush or pour-flush to piped sewer system, septic tank pit latrines, ventilated-improved pit latrines, or pit latrines with slab or composting toilets.

express their needs due to their shy nature and that parents may need to approach girls to learn about their needs, unlike with boys, who approach their parents about their needs.

Between male and female caregivers, the qualitative data suggest similar sentiments of responsive caregiving and little difference between male and female caregivers. Both male and female caregivers view responsive caregiving as an intrinsic part of parenting. However, a male caregiver from Afar noted some difference in that female caregivers physically carry female children and male caregivers carry male children, as it is considered 'haraam' (forbidden or unlawful) if a non-breastfed female child urinates on her father while being carried by the father.

Other qualitative data seem to show that mothers provide care first and interact with children first due to proximity with their children. For example, a female caregiver from Gambella said, *"The mother is always there with them, so this is their means of communicating their feelings."* The same caregiver added, *"The mother and father will then simply encourage the child to feel happy like the other children."* However, there were mixed reactions from institution leaders on gender differences in responsive caregiving practices. One institutional leader observed that people comfort boys more than they do girls, whereas another institution leader reported that there is not enough safe space for boys to truly express their feelings. The leader explained,

> *"As a society, we don't encourage boys to express their feelings and show their sadness, so they usually suppress their emotions. I have also noticed this in our centre. Boys are expected to express their feelings without crying, but it is okay for girls to cry. When people see boys cry, they shame them by saying, 'Aren't you a man? You shouldn't be crying.' So, comforting boys and girls can be different as the way they express their emotion is also different."*

The leader suggested that if male caregivers approach boys and support boys' expression of emotions, boys may feel more comfortable with male caregivers than with female caregivers in expressing emotions.

Safety and Security

Physical safety of children. The survey showed that while young children are generally watched over, it is not uncommon for a child to be left alone or in the care of another child. In the week before the interview, 22 per cent of children below 6 years of age had been left alone, and 30 per cent had been left in the care of another child (lower than 10 years of age). Of these children who had been left alone or in the care of another child, this happened about twice a week (*see Table A15 in Annex A*).

Regarding the physical safety of children, caregivers stated that the environments could be safer. For example, institutions noted a lack of playgrounds with grass for play, and some observation of environments revealed the presence of unsafe objects (such as tools and knives) where children play. In some IDP camps in Amhara, community members are trained by social workers to report cases of unliveable situations, such as living in spaces where there is consistent charcoal burning.

Qualitative data from male and female caregivers, service providers and community leaders across regions indicate that the environment surrounding where girls reside are considered largely unsafe. Female caregivers from Afar mentioned warning their female children of sexual and gender-based abuse and of kidnapping. Other respondents from Amhara and Afar regions noted the prevalence of harmful traditional practices that disproportionately affect girls and women, such as female genital mutilation (FGM), forced marriages, early marriages and scarring of gums. Further, though the prevalence of FGM is considered harmful, there is fear of community retaliation if the practice is reported.

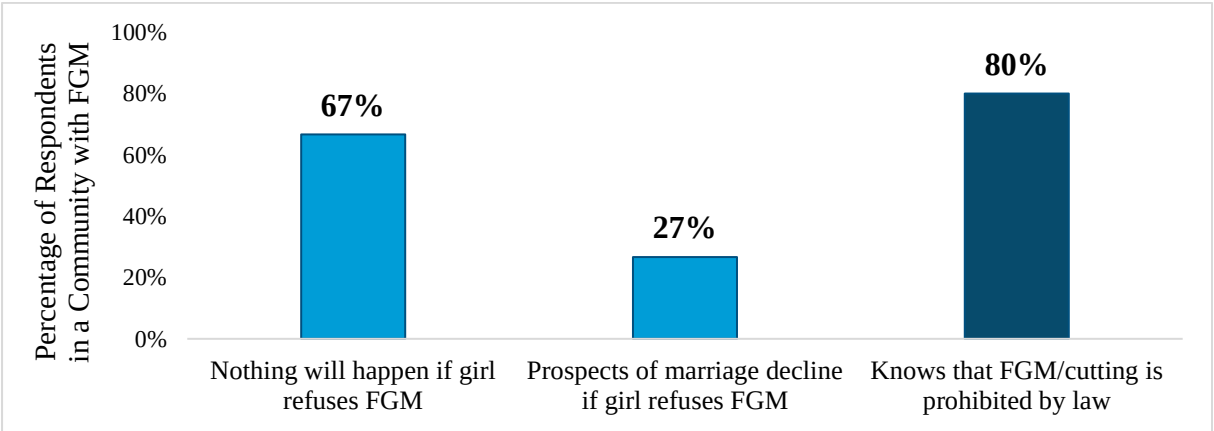
> *"**There's sexual harassment that she could encounter, there's birth giving, there's genital mutilation and so forth.** There's a lot that a girl has to withstand. A boy only eats, drinks and leaves; a boy doesn't have to worry much. It's difficult to raise a girl."*
>
> – Female caregiver, Afar

> *"In the case of IDPs, the women are sexually assaulted and are seen as inferiors."*
>
> – MoE representative, national level

Speaking on the prevalence of FGM, a service provider in Afar emphasised the need for improved awareness amongst parents, and added, *"It would be life-changing if we can create awareness and teach the parents about those topics [the harmful practice of FGM] regularly because people are good at applying what they are told."* Further, according to government representatives, women from vulnerable populations, such as IDPs and refugees, are more likely to have experienced sexual and physical assault.

In the quantitative surveys, the research team asked about FGM practices in the community but received minimal response. Only 1 per cent of respondents mentioned that they know about girls getting circumcised in their community (n=15). Although the AIR study team asked these respondents some additional questions (*see Figure 12*), we advise interpreting these results with caution. Other data suggest higher figures for FGM in Ethiopia. Because 80 per cent of the respondents who are familiar with FGM in the community are aware that it is prohibited by law, it is likely that our figures are underreported.

Figure 12. Knowledge about FGM



Child discipline. While parents in Ethiopia employ non-violent practices most often when disciplining their children, psychological and physical punishment are common. The survey results revealed that about three in four caregivers use at least some positive discipline, such as taking away something the child likes or forbidding them to leave the house, explaining why what they did was wrong or simply giving the child something else to do. At the same time, just one in five uses positive discipline exclusively. More than half of caregivers

(59 per cent) use some form of violent punishment, either physical or psychological. This most often takes the form of shouting or yelling at the child, spanking them, shaking the child or hitting them on the arm or leg. When caregivers use negative psychological discipline (such as shaming), they tend to use physical discipline as well. Slightly more parents acknowledged using physical punishment in some way (54 per cent) versus how many believe that physical discipline is necessary (48 per cent; see RQ 1), indicating that perhaps some parents realise that corporal punishment is taboo but still engage in the practice (see Table A14). Caregivers with at least primary education are not practicing child discipline methods which are very different from those with lower education. However, looking at caregivers' stress and agency levels, it seems that caregivers with higher stress and lower agency are more likely to use any type of discipline including both physical as non-violent options (see Table A15 and A16 in the Annex).

The qualitative data reveal mixed reactions about the use of negative disciplinary practices such as pinching. Most caregivers believe that disciplining children is a necessary part of positive parenting and that it is required to raise well-behaved children. Disciplinary practices seem to be implemented largely as a reaction to a child's behaviour. For example, a female caregiver from Amhara explained, *"I would scold them if they did something bad or beat them, and I would advise them to speak respectfully to their elders."* Similarly, a male caregiver from Afar said,

> *"When children are around 6 years old, it is good to advise them and scold them so that they don't get spoiled. It is necessary to also spank them on their hands when they do something wrong because it will help them in the future."*

Caregivers across regions stated that disciplinary methods for boys and girls do not differ much, though the results of some interviews suggest that caregivers believe boys are more stubborn and therefore more frequently disciplined. In addition, both a male and a female caregiver from Amhara stated that parents could take 'corrective actions' when boys use vulgar languages or when boys are not serious about their education.

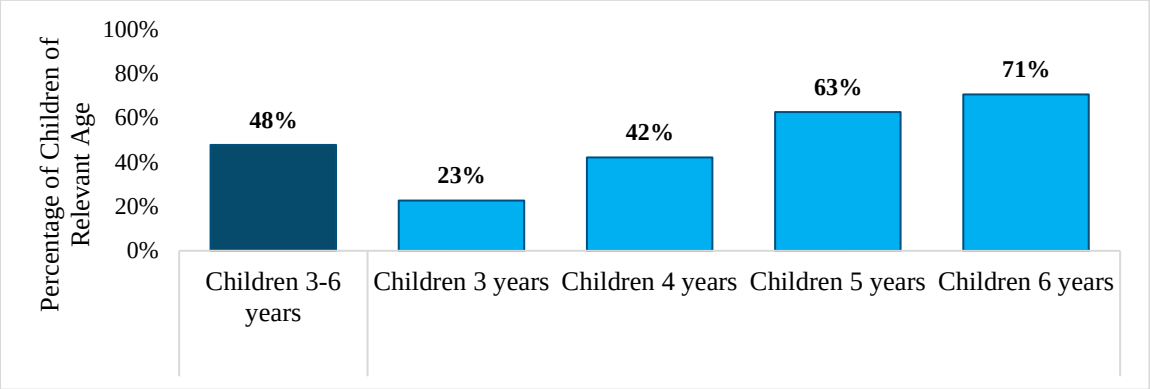
For some caregivers, physical disciplinary practices such as hitting children with sticks are considered normal strategies for disciplining children who misbehave. For example, a community leader said, *"They give children a proper punishment when they hear them using bad words."* Additionally, a representative from one institution described the prevalence of 'soft punishment', such as isolating a child (a negative practice) or withholding something the child wants (an acceptable practice). A representative from another institution emphasised that physical punishments are strictly prohibited.

Opportunities for Early Learning

Early education. Opportunities for early learning are limited for young children. The survey results showed that 48 per cent of children aged 3–6 years are currently attending or have attended preschool. However, this average is pulled down by the low number of children aged 4 or under who had attended or were currently attending preschool (*see Figure 13*). By age 6, more children had found their way to school, but almost 30 per cent had never attended preschool. Of the children aged 3–6 years who were in preschool, 62 per cent attended O-class, and 37 per cent attended kindergarten. Less than 1 per cent attended mobile schools.

Preschool attendance varies widely by region in Ethiopia. Afar (29 per cent) and Oromia (30 per cent) have the lowest preschool attendance rates amongst children aged 3–6. Gambella has the highest rate, at 85 per cent (*see Table A17 in Annex A*).

Figure 13. Preschool Attendance, Children Aged 3–6 Years



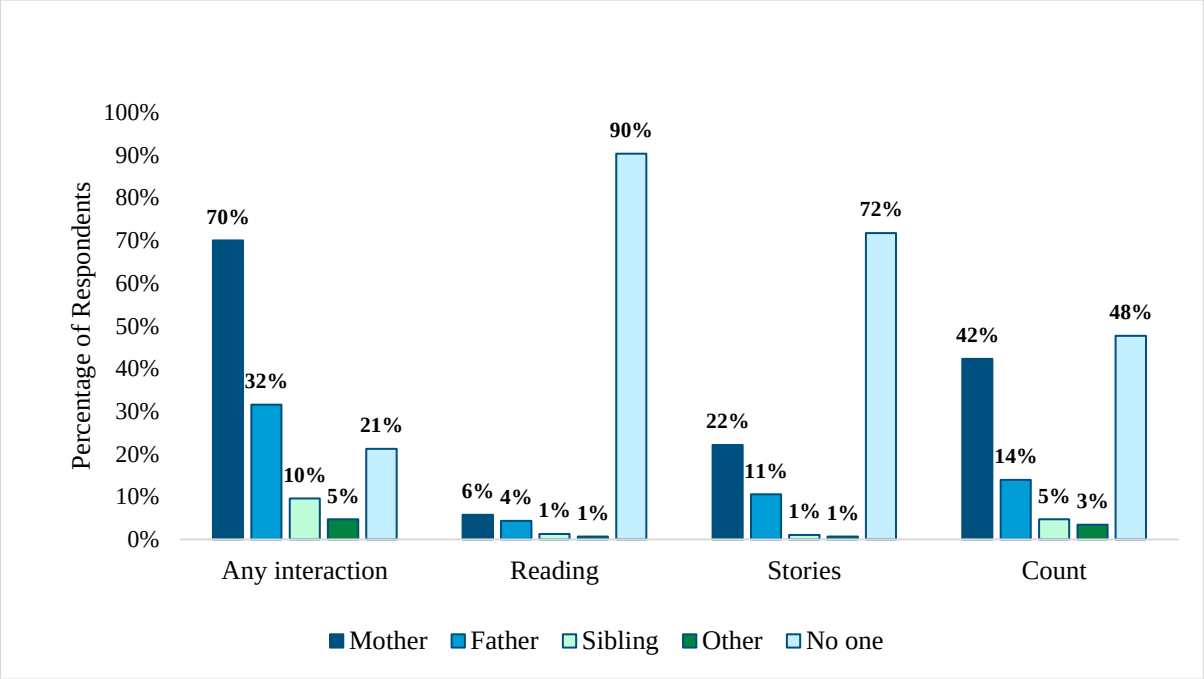
Learning and Stimulation: Early Education and Adult–Child Interaction. The survey results revealed that a considerable number of children (21 per cent) have no parent or other household member (15 years of age or older) who engage in early learning activities with them. Amongst family members, mothers carry out 70 per cent of the activities with their child. Reading and telling stories to young children are rare: 90 per cent of children do not have anyone reading to them, and 72 per cent do not have anyone telling them stories. Counting, walking with the child, singing songs and playing with the child are more common activities; however, between 40 per cent and 60 per cent of caregivers reported that no one in the household does these activities with the child (*see Figure 14*).

In Oromia and Gambella, children are more likely to engage in learning activities (in both regions, only 5 per cent had no interaction) compared to other settings (*see Table A18 in Annex A for a full list of activities*). Caregivers with higher education levels (primary and up) are more likely to engage in learning activities as well as most of the other adults in the household. Stress, however, is negatively related to the likelihood of engaging in learning activities (*Annex A Table A19 and A20*). In addition, qualitative data showed that caregivers understand the importance of schooling and raising literate children, and when schooling is available and accessible, caregivers encourage their children to attend school.

Outside of formal systems of schooling, there is no encouragement for curiosity and play. For example, a female caregiver from Gambella said, *"Yes, it is important, and I have to support and help him in his curiosity and/or creative journey, including the provision of freedom of creativity."* Across regions, most caregivers mentioned that children have opportunities to play with each other. Additionally, some female caregivers across regions mentioned teaching children about family history and culture and doing so through the oral tradition of storytelling.

> *"**They have to learn the things we know, and we are the ones who are supposed to teach them.** We tell them about their grandparents and about their family, **we tell them their history**, and we also show them pictures of the family if we have them."*
>
> – Female caregiver, Gambella

Figure 14. Learning Activities between Child and Household Member (Older than 15 Years of Age)



Note: Any interaction includes reading, storytelling, singing songs, walking, playing and counting.

2b. What are the parenting practices of parents/ caregivers concerning gender socialisation?

Across regions, caregivers follow gender norms and roles within caregiving practices. Caregivers reported teaching household chores such as cooking and cleaning to young girls, with the priority of schooling provided to boys, along with cattle herding duties. For example, a female caregiver from Amhara said,

> *"… we won't tell boys to chop onions, but we will tell the girls to. The boys go to school and go to take care of the cattle in the fields; he doesn't do the house chores because the girl is the one that does house chores."*

A community leader from Afar described the division of caregiving practices by gender, such as teachings about the Quran, checking assignments and punishing children. Nevertheless, as was shown under RQ 1, despite differences according to traditional gender roles, educational aspirations had no gender bias.

RQ 3. What are parents'/caregivers' sources of information, guidance and support on parenting young children?

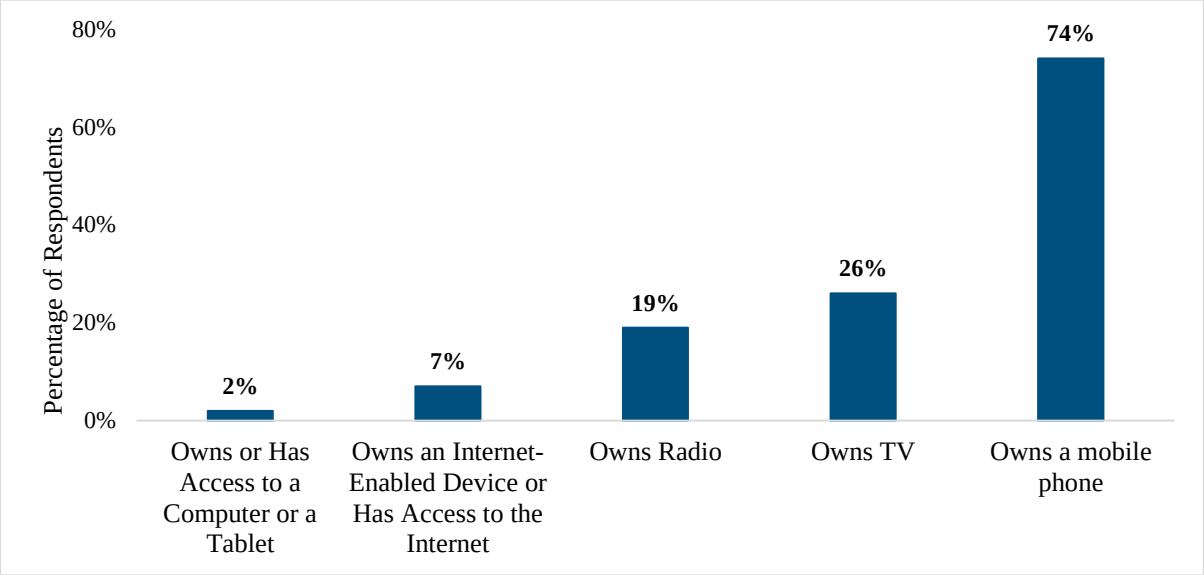
The next section describes the access and use of media and information communications technology (ICT) to further identify the sources of ECD information such as parenting practices.

3a. What are considered sources of information about parenting/ caregiving for young children?

Access to Media and ICT

The research team asked the primary caregivers a series of questions about their ownership and access to media and information communications technology (ICT). The AIR study team found that mobile phones (without internet access) are the most commonly owned ICT devices amongst radios, TVs, computers, or tablets; 74 per cent of caregivers reported that they own a mobile phone (*see Figure 15*). This was true across all regions covered by the survey. Television and radio ownership is much lower at 26 per cent and 19 per cent, respectively. However, the qualitative interviews revealed that caregivers also used their mobile phones to listen to radio messages. A very low proportion of respondents (7 per cent) owned an internet-enabled device or had access to the internet.

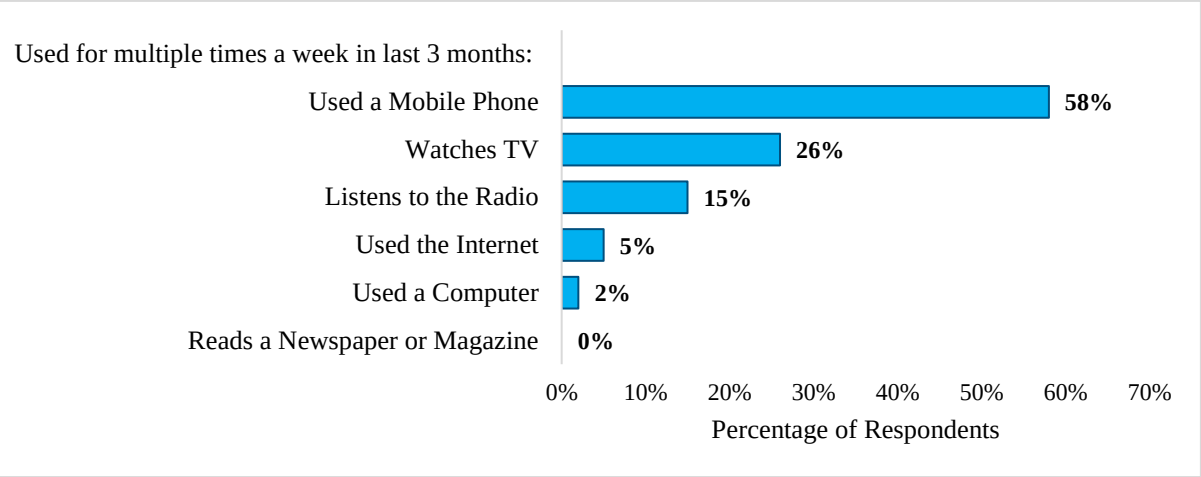
Figure 15. Ownership and Access to ICT



Ownership of ICT devices. Ownership of ICT devices is heterogeneous by region. Nearly all respondents in Amhara (IDP population) and Oromia own mobile phones at 96 per cent, respectively, whereas the rate is 19 per cent amongst refugees in Gambella. TV and radio ownership varies by region; a third of respondents in Oromia own both a radio and TV, whereas in Amhara, more than half own a TV (54 per cent) and only 14 per cent own a radio. The rate of radio ownership is 6 per cent of respondents amongst IDPs in Amhara and refugees in Gambella; no respondents in either subgroup reported owning a TV. In no region did more than 5 per cent of respondents report owning or having access to a computer or tablet.

The research team asked respondents how often they consume or engage with various media sources and ICT technologies (*see Figure 16*).

Figure 16. Media Usage



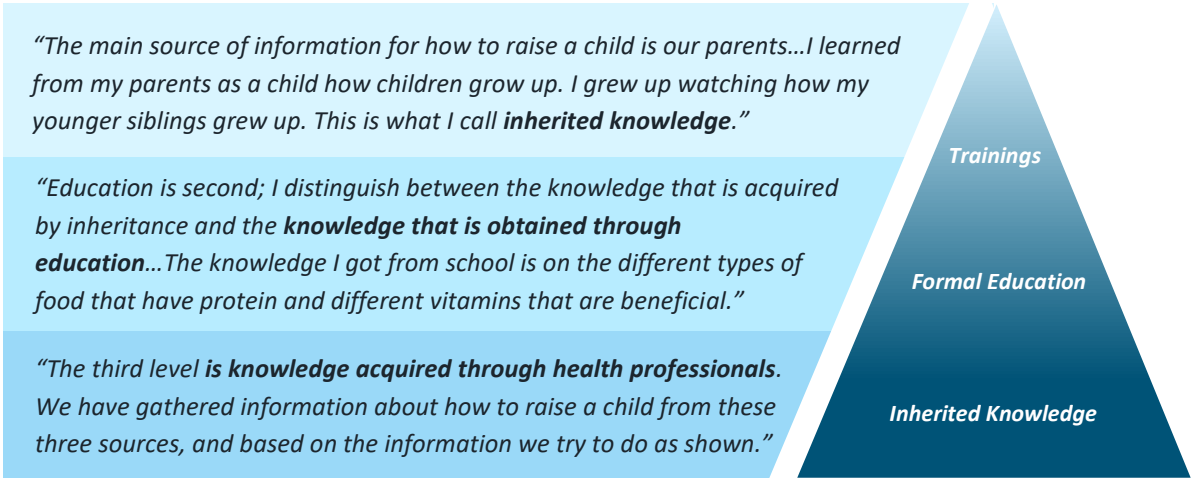
The survey results showed that mobile phones without internet access are the most commonly used devices, with 58 per cent of respondents reporting that they used a mobile phone multiple times a week or more over the last three months. The rate of usage for other forms of media and technology were comparatively low. The next highest rate of usage was watching TV, at 26 per cent. Less than 5 per cent of respondents reported using the internet, using a computer, or reading newspapers or magazines multiple times a week over the past three months.

Media and ICT usage. The survey results showed heterogeneity amongst regions in media and ICT usage. In all regions besides Gambella, respondents frequently use a mobile phone, ranging from 56 per cent in Amhara to 86 per cent in Oromia. TV is the next most common source of media and ICT, but is used frequently amongst less than 50 per cent of respondents in all regions except Amhara (57 per cent). Frequent internet usage is low, at below 12 per cent in all regions. Respondents in Gambella accessed the media and ICT at the lowest rates amongst the regions across all sources: Only 13 per cent of respondents in Gambella frequently used a mobile phone over the past three months; 6 per cent listened to the radio frequently; and less than 1 per cent read a newspaper or magazine, used a computer, or watched TV multiple times a week over the past three months. The results were the same for IDPs in Amhara, with the exception of mobile phone and radio usage (12 per cent), which occurred at higher rates than in Gambella.

Sources of Information

Caregivers shared that their knowledge of ECD topics has been acquired over a lifetime as they watched their families, interacted with health systems, took trainings and consumed different media. A male caregiver from Amhara conceptualised his information sources in a particularly useful and illustrative way (*see Figure 17*).

Figure 17. Model of Caregiver Sources of Information



The inherited knowledge of which the caregiver spoke was widely described as 'advice' and seen as distinct from information provided from the other two, more formal sources, education and sensitisations. Caregivers, both male and female, described how they learned from their parents and elder siblings how to care for young children and prevent harming them. As one mother in Amhara described, her mother informed her understanding of general, day-to-day care of a newborn:

> *"She was the one who taught me how to hold the baby, and what time to feed and bathe them. In the morning, she used to help me bathe my child and then gave it to me to breastfeed afterward. She advised me on when and how to bathe the child, and I do as she advised."*

Despite the importance of familial knowledge, caregivers commonly described the teachings of their parents and elders as outdated and suggested the importance of having other sources of knowledge in addition to inherited knowledge. The qualitative data show that some groups have traditional methods for sharing knowledge. In particular, pastoralist groups in Afar rely on the *dagu* system to share knowledge amongst dispersed community members. For example, a service provider from Afar said,

> *"[Dagu] is a system where people share information. When two people meet, after exchanging greetings, they ask for Dagu/new information… Therefore, if someone meets a person after taking the morning training in our centre, he/she will share all the information they learned with the other person. So, parents also learn from each other through that system."*

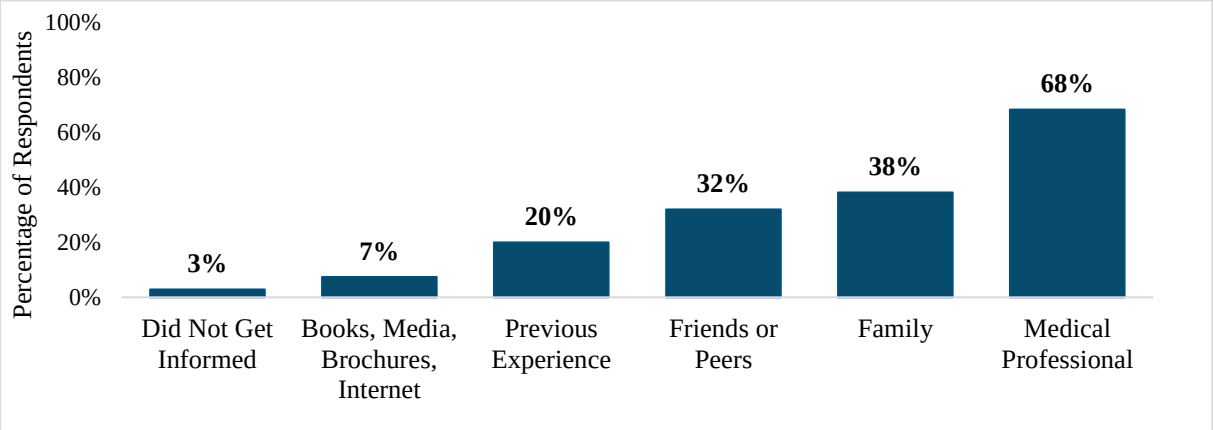
As the respondent highlights, such informal, knowledge-sharing platforms can be used to spread information about ECD best practices when considered in the design of services and programmes. However, a healthcare provider cited barriers within this system, such as a lack of practical demonstrations of best practices, given that the emphasis is on oral exchange of information. The healthcare provider explained,

> *"The parents that come to us get to learn practically, but it is doubtful that they will be able to properly demonstrate what they have learned from us to other parents because it is difficult to share practical information in the Dagu system."*

Similarly, service providers in Amhara IDP camps noted an informal, traditional knowledge-sharing system amongst women.

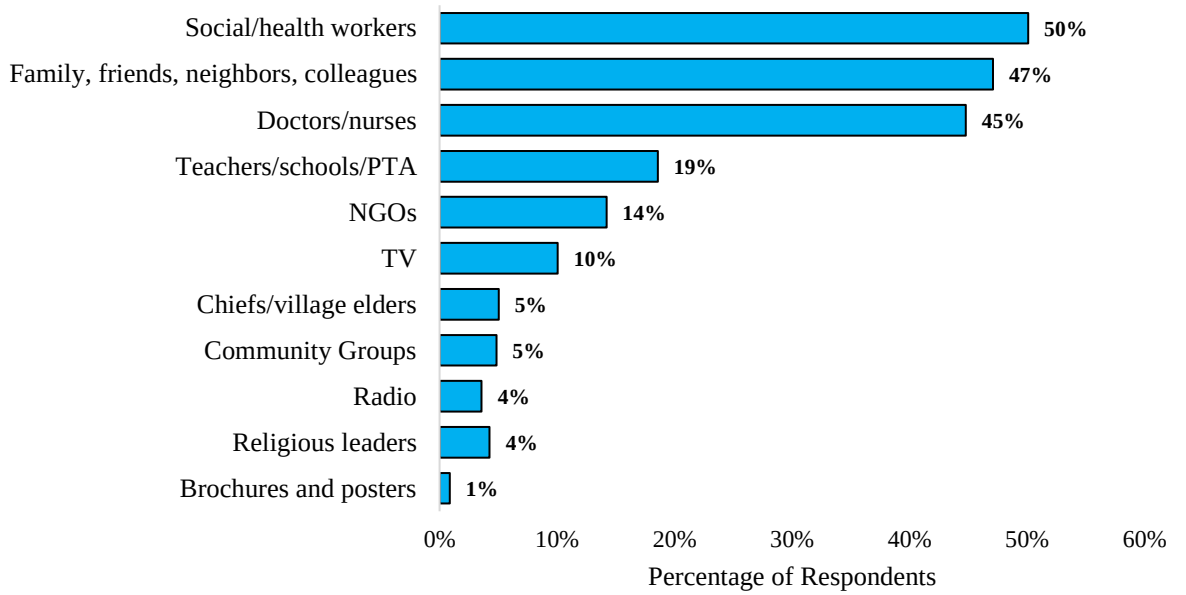
Information on pregnancy and newborn care. For the quantitative data, the research team asked the mother or main caregiver of children in the household how they obtained information about issues related to pregnancy and newborn care of their last child, and the AIR study team found sources that were somewhat at odds with the qualitative findings. Caregivers mainly reported obtaining information from medical professionals (including doctors, nurses and gynaecologists) at a rate of 68 per cent *(see Figure 18).* This was true across all regions. Unlike the qualitative responses, family (38 per cent) and friends or peers (32 per cent) were the next most common responses. Some regional differences stand out, however. For example, compared with other regions, respondents in Amhara are more likely to get information from the media (22 per cent), and respondents in Afar (46 per cent) and Amhara (30 per cent) are more likely to rely on information obtained during a previous pregnancy as compared to other regions. Most respondents are satisfied with the quality of information on pregnancy and newborn care available to them at above 80 per cent in all regions, except Oromia, where only 37 per cent of respondents are satisfied with this quality of information.

Figure 18. Sources of Information on Pregnancy and Newborn Care



Information on childcare, nutrition, health and early education. Respondents were asked where they get information about childcare, nutrition, health and early education. Medical professionals (doctors/nurses), family and social networks are the most common sources of information on health care and ECD (ranging between 45 per cent and 50 per cent). The survey results showed some variation by region. For example, social/health workers made up the highest proportion of responses in Oromia (54 per cent) and amongst Amhara IDPs (85 per cent). Doctors/nurses are the main source of information in Gambella (71 per cent). Family, friends or neighbours are the main sources of information in Amhara and Afar (74 per cent and 73 per cent, respectively). The remaining possible responses (teachers/schools/parent-teacher associations (PTAs), non-governmental organisations (NGOs), TV, chiefs/village elders, community groups, radio, religious leaders, and brochures and posters), at less than 20 per cent overall, are much less common (*see Figure 19*).

Figure 19. Sources of Information on Health Care, Nutrition and Early Education



In interviews, caregivers reported that they receive information from health workers during a variety of encounters. As described above, childbirth is a crucial point of intervention, but parents said that they receive training on ECD when seeking treatment for a child's illness, when doing regular vaccination and check-ups for newborns, during door-to-door sensitisation campaigns (e.g., to visit pregnant women) and at community meetings and trainings. Caregivers reported primarily receiving nutrition and health-related information at such times.

In IDP camps, the qualitative data show that MoWSA formed women's groups to disseminate information about maternal and newborn health. For example, a caregiver explained, *"Besides TV, we get information from meetings held by the Women and Children Bureau. They tell us about ways to look after our children's health. These are meetings held here within the camps."*

Traditional Systems of Information Exchange

- **Amhara (IDP camps):**
  - Information exchange includes a more a traditional form of dissemination between mothers and would-be mothers.

  "… community in this camp also has traditional means of exchanging information. There is a gathering of mothers who have already given birth, and they provide advice and share their experiences with a newly pregnant mother."

  – MoWSA representative
- **Afar (pastoralist communities):**
  - There is presence of Dagu, which is a traditional information exchange platform that involves the verbal exchange of information between people, and which is practiced among nomadic populations in the region.

Caregiver demand for information. Caregivers reported varying levels of satisfaction with the amount of information they receive. In general, they value diverse sources of information, including information passed down from family members and information received at health centres and trainings. Some reported that they lack information from a

multitude of sources and, for instance, rely only on what they have learned from their parents. In such cases, they would like to have more sources of information to supplement the information they receive from their family. When caregivers reported a lack of information, their information gaps related to health, nutrition, supporting children with disabilities and how to employ positive discipline. Such gaps were reported by mothers and fathers alike and across all regions of the study.

3b. How do parents/caregivers evaluate the trustworthiness of information about parenting/caregiving?

3c. How do parents/caregivers navigate situations for which they lack information about the best course of action?

In general, caregivers said that they trust new information, but they evaluate the information based on their acquired experience and the reliability of the source. Sources deemed less reliable include social media and other internet-based information, whereas caregivers regard health workers and formal trainings (e.g., hosted by NGOs) as the most reliable sources of information. A male caregiver from Amhara said, *"If the new education is better and fits our culture and lifestyle, we will trust it and accept it… However, if education or new technology is not suitable for our children, we may not accept it."* Caregivers said that new information must be useful (i.e., addressing a recognised need), and it must be practicable (i.e., adapted to their context and means).

To improve the trustworthiness of ECD information amongst caregivers, service providers and policymakers suggested:

- Usage of trusted interpersonal networks
- Enabling community leaders to share information
- Use of mass media (e.g., radio) for general ECD messaging
- Provision of tailored training and support for targeted groups of caregivers
- Use of engaging media such as TV series, radio drama, poems and pamphlets

Further, when caregivers were asked what their next steps would be if they encountered a situation where they were unaware of how to care for their children, they said they most likely would go to someone nearby – often a neighbour or family member – and would seek guidance from health centres, health workers, or international NGOs. When faced with an uncertain outcome for their child, caregivers shared that they prayed for guidance. (*See RQ 1 for further information on knowledge by NCF domain.*)

For caregivers to navigate such situations, ministry officials suggested more trainings on capacity building for caregivers and mandatory provision of parental education on health, nutrition and other areas through accessible learning methods such as home-based teaching. In other situations, community leaders disseminate valuable information to caregivers when they observe a lack of best caregiving practices. For example, a community leader in Amhara described,

> *"When I see the mistreatment of children, I admonish their practice and advise them to treat their children properly. I also suggest that they provide food on time, wash*

their bodies and clothes regularly, and not negatively punish them when they commit mistakes and crimes. I insist that they advise their children rather than punish them."

Ministry officials noted the presence of health extension offices from MoH and agriculture extension offices from the Ministry of Agriculture (MoA) to address information gaps on caregiving at the household level.

RQ 4. What is the availability, accessibility, acceptability, affordability, contextual appropriateness, quality and perceived effectiveness of services for young children and families?

4a. What is the availability of services for young children and families?

The study team asked parents and caregivers about their awareness of available services for young children and families, such as health care, preschooling, social welfare and income support programmes (*see Table 17*). Caregivers are mostly aware of health services and programmes in the area (78 per cent), followed by kindergarten/preschool (49 per cent) and food assistance (47 per cent). Broader programmes that may affect the family (and children's well-being), such as cash transfers (1 per cent) or income generation programmes (8 per cent), are less available, or caregivers possibly are unaware of them.

Table 17. Awareness of Services for Children and Families

Service	Percentage with Service Available (n=1,034)
Community health services or health programmes	77.8
Kindergarten or preschool services	48.4
Food assistance or school feeding programmes	46.6
Water or sanitation programmes	35.2
Education or school support programmes	34.9
Youth services or activities	12.9
Social welfare or psychological support programmes	12.1
Income generation services or programmes	8.0
Cash transfer programmes	1.4
Not aware of any services or programmes	6.6

Similar to the findings from the survey, qualitative data from across the regions indicate that most caregivers are aware of education services, food supply services and healthcare services available in their communities. Further, education services and food supply services are implemented mostly by NGOs, and aid organisations and health services are made available largely by regional governments. Of the food supply services available, most are implemented by NGOs and aid organisations (e.g., World Food Programme [WFP], Plan International, Red Cross, Mekane Yesus and GOAL), including the supply of grains, nutrient-rich foods (e.g., Plumpy'Nut®) and other essentials such as soaps. Regional governments are responsible for the implementation of 'O-classes' for early learning and are further supported by private institutions and local NGOs (e.g. Ethiopia School Readiness Initiative). Some training programmes on caregiving are provided by NGOs such as World Vision and Geneva Global

and by ministries such as MoWSA. Relevant ministries reported partnerships with aid organisations to implement services to support caregivers across regions. Regarding alternative childcare services, local institutions and foster homes support orphans and vulnerable children, and some include school feeding programmes. With respect to health services, caregivers reported that they most commonly use the antenatal and prenatal services at woreda-level health facilities.

Some caregivers who seemed unaware of services tended to be from pastoralist communities in Afar, and amongst IDP populations in Amhara. These results suggest that awareness of services is equated to availability and accessibility of services. Other factors, however, such as perceived acceptability and cultural appropriateness, may play a role in the awareness of services. We discuss these in the next section.

4b. What is the perceived accessibility, acceptability and contextual appropriateness of these services?

With regard to the accessibility of services for families with children, the study team observed that community health services and/or health programmes are the most commonly used (74 per cent) services amongst families with children, followed by food assistance (42 per cent), water and sanitation programmes (32 per cent) and either preschool services or education programmes (both 31 per cent) (*see Table 18*). Only 5 per cent of parents said they had not used any family or child-related service. Overall, the utilisation rates are in line with respondents' awareness of availability. The government is the main provider of health services (88 per cent); however, some respondents mentioned that they receive health services from NGOs and or religious organisations.

With respect to health services, the study team included any type of community health service, such as routine pre- or postnatal check-ups, treatment of illness and health programmes and campaigns, which might be more frequently provided by NGOs. According to the caregivers, provision of other family or child-focused services seems to be divided between the government and NGOs and/or religious organisations. For instance, food assistance, water and sanitation programmes, youth services and education programmes are slightly more often associated with NGOs, which include international organisations. Private providers of any of the child-focused services are rare, except for kindergarten or preschool services, which has 14 per cent of private providers. Additionally, 72 per cent mentioned public provision and 61 per cent mentioned provision of child-focused services by NGO/religious organisations.

Table 18. Service Utilisation amongst Households with Children

Services	Percentage of Respondents Who Used Service (n=1,034)		Provider		
			Government	Private	NGO/ Religious
			Percentage of Users		
Community health services or health programmes	74.1	766	87.6	8.2	34.1
Kindergarten or preschool services	31.5	326	72.1	14.4	61.3

Services	Percentage of Respondents Who Used Service (n=1,034)		Provider		
			Government	Private	NGO/ Religious
			Percentage of Users		
Food assistance or school feeding programmes	42.0	434	69.4	3.9	72.8
Income generation services or programmes	3.5	36	88.9	5.6	77.8
Water or sanitation programmes	32.1	332	68.4	2.4	75.6
Social welfare or psychological support programmes	10.3	106	73.6	0.0	77.4
Education or school support programmes	31.3	324	64.8	1.2	74.7
Youth services or activities	9.8	101	83.2	0.0	92.1
Cash transfer programmes	0.3	3	66.7	66.7	0.0
Did not use any services or programmes	5.2	54			

There are large differences in service utilisation by region, with the highest usage across the various services in the refugee camps in Gambella (health services were used by 94 per cent of respondents; preschool services, by 88 per cent) and the lowest utilisation amongst the pastoralist households in Afar (e.g., 25 per cent used health services and only 3 per cent used kindergartens or preschool services). The camp registration and relative high population density may facilitate the provision of services to households with children in Gambella, while long distances and lower population density make it more difficult for households in Afar to be reached. Regions with high food insecurity, such as Afar, Gambella and the IDP populations in Amhara, are amongst the main recipients of food assistance (*see Table A22 in Annex A*).

Data from interviews and FGDs support the survey results on accessibility and utilisation services. Caregivers indicated that services such as food supply and health referrals are accessible to them even when residing in refugee camps in Gambella and in IDP camps in Amhara. Further, government representatives recognise the unique needs of vulnerable populations such as IDPs, vulnerable children and pastoralists, and responded with provision of appropriate services to improve accessibility. For example, the MoE developed guidelines to support integration of refugees and children from IDP settings into host community schools; MoE representatives at the regional level in Amhara evaluated the content of information and its method of dissemination to ensure it is aligned with culture and is accessible to community members.

Regarding the acceptability and contextual appropriateness of the services, a representative from an international organisation reported that dissemination of family planning information and services may be too sensitive in some communities. The representative emphasised that the first step involves gaining the trust of community members through the assistance of community-based health extension workers to enable the health workers to share family planning information in the future. Similarly, a MoWSA representative in Afar described assessment of environmental contexts to develop prevention and protection services for caregivers to support children. The representative explained,

> *"In some areas, there might be food shortages. In other areas, there might be a security issue. Some places might have a lack of clothing. Other places might lack educational materials/schools. In other cases, there might not be education provided. There might be various reasons within the community. So, the mother needs to know how to raise that kid in that environment, how she's going to provide food for the child, and how she will protect her child from natural and man-made threats. We were going through all those prevention responses."*

Additionally, an MoH representative described provision of play psychotherapy services called '*Wede lejenet enemeles*' ('Let us go back to our childhood') for children who are internally displaced and who have experienced traumatic events due to conflict. These services are provided in the IDP camps. There were reports on future establishment of permanent ECD services, such as the above psychotherapy services within the IDP camps, and training for health community workers to address the needs of pastoralist communities in Afar and in parts of Gambella. Other government representatives, however, acknowledged barriers such as internal restructuring of the ministry, which led to limited contextualisation of ECD services to meet the needs of IDPs, pastoralists and refugee populations.

Some services, such as food supply services, are considered contextually inappropriate. For example, a few male caregivers reported that the raw ingredients made available to prepare food are not adequate for preparing culturally appropriate foods such as injera. A male caregiver explained,

> *"The aid grain that is provided to us is maize and white flour. Baking injera with these types of grains is unusual. The women are mixing these two types of grain to make injera, but it is hard to eat that, let alone the children eating it."*

Additionally, a social worker said there are limitations in the supply of culturally appropriate foods. It was reported that IDP caregivers given pasta, maize, and rice subsequently sold the supply of grains to purchase more costly teff and injera.

4c. What is the perceived affordability of services for young children and families?

The research team asked whether affordability is amongst the reasons that caregivers would not use a service, but the response rate was too low to report credible results. However, from qualitative results presented in this report, the study team observed that resource constraints play a large role in obtaining goods and services for children.

One of the main results is that high food prices affect food security (*see Figure 8 in RQ 2*). Food supply services are implemented largely by aid organisations, and although the services are not always adequate to meet demand or not always contextually appropriate for some communities, they are mostly free of charge. Similarly, health services that are implemented by the local government appear to be available for free, but some caregivers cited barriers in paying for medications. In addition, service providers indicated that the cost of transportation to hospitals can be a barrier to caregivers in accessing services.

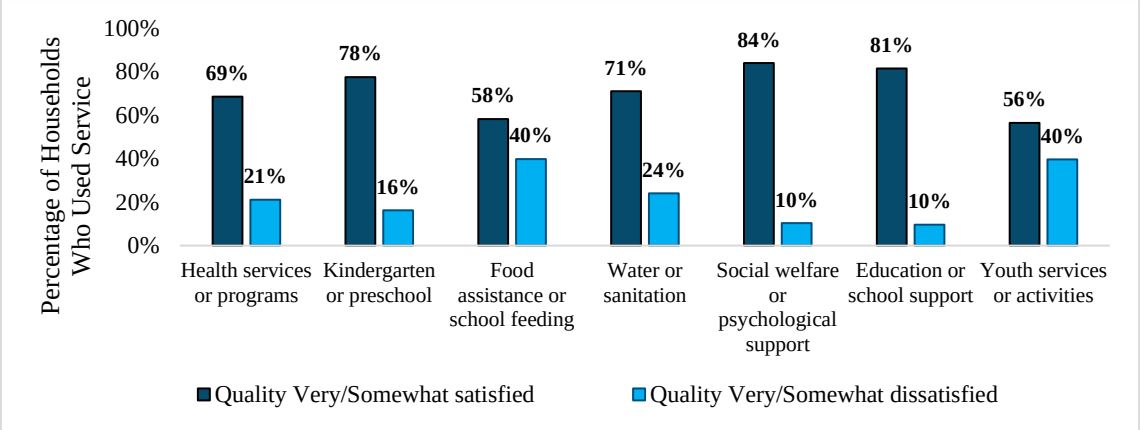
4d. What is the perceived quality of services for young children and families?

4e. What is the perceived effectiveness of services for young children and families?

In this section, we combine RQs 4d and 4e, as data suggest that perceived quality of services affected caregivers' satisfaction with the services.

The research team asked parents who used services for their children about the quality of, and their overall satisfaction with, the programme or service; overall, responses were positive. Eighty-four per cent of users of social welfare services and 56 per cent of youth service or activity users were 'very satisfied' or 'somewhat satisfied' with the quality of the service (*see Figure 20*). The overall satisfaction showed very similar results compared to quality, and the findings were highly correlated with each other.[6] Respondents were most likely to be 'somewhat dissatisfied' or 'very dissatisfied' with food assistance or school feeding programmes, and two out of five users were dissatisfied with youth services (*see Figure 21*). The rates of dissatisfaction with both overall treatment and quality were largely mentioned by respondents in Gambella. While refugees in Gambella had the highest service utilisation rates, 75 per cent of recipients of food assistance, 53 per cent of health service users and 42 per cent of youth service users were unhappy with the service.

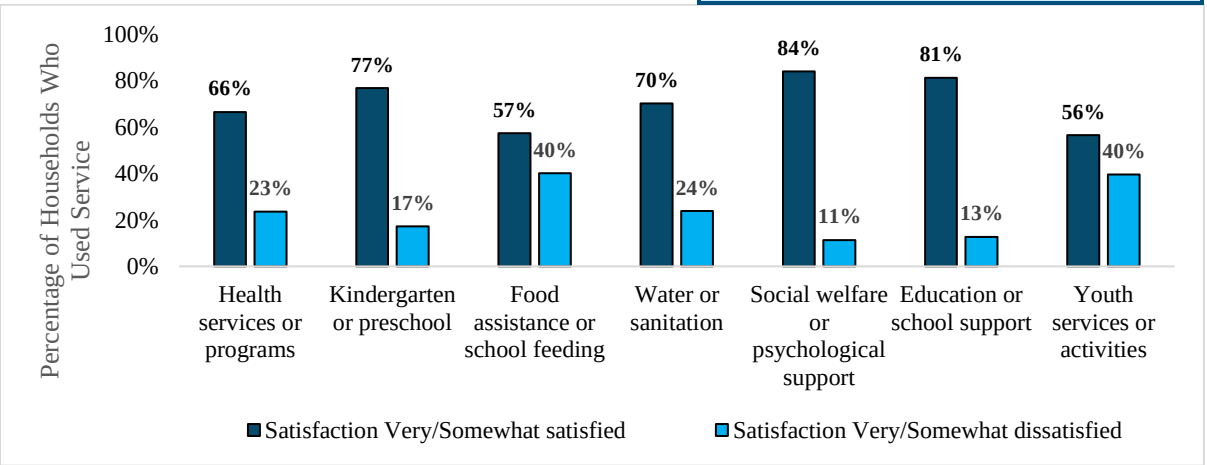
Figure 20. Satisfaction with Quality of Services, by Service or Programme Type



[66] Using Pearson's correlation, we find that overall satisfaction and perception of quality overlap for 77 per cent to 100 per cent of the respondents, depending on the type of service.

Figure 21. Satisfaction with Services or Programmes, by Type

> *"They [parents] need financial support because when we write referrals to government hospitals, they might also write referrals to hospitals located in Addis Ababa, and* ***there are many who don't even have money for transport, let alone for healthcare services****."*
>
> – Teacher, Amhara
>
> *"We get our children treated when they fall ill... we get medicine from them [hospitals] but* ***we have to pay up to 250 birr****."*
>
> – Female caregiver, Afar



The qualitative data show that reactions to the quality of services were mixed. Most caregivers were satisfied with the services. Health and food supply services in particular were the most helpful for caregivers. Some caregivers recommended antenatal care services to others. Respondents, including a community leader in Amhara, and MoWSA and MoE representatives from Gambella, perceived the quality of services as high. The MoE representative said,

> *"The quality of parenting support services is very good. The quality of the food support parents get is top-notch as well. Sometimes there are places that are a bit far and also lack good roads for transportation in order to reach these places."*

This indicates that although quality was perceived to be high, there is still potential for improvements.

Barriers that will be explained in more detail under RQ 5 affected the quality of services. For example, there were reports of food and medicine shortages. A service provider in the IDP camps in Amhara said,

> *"The other challenge is even if we can manage to provide the service, we have a medicine shortage. The camp is very crowded, and whenever there is a communicable disease, trying to control and contain it is very difficult. A few days ago, there was*

measles, a diarrhoeal disease that is very common here, so controlling these communicable diseases is very hard because of the crowd."

In addition, community leaders, service providers and institution representatives reported staff shortages in health centres and institutions, which affect quality of services. For example, a community leader in Afar said, *"The health centre has only one professional who is working. We need more support from health professionals from NGOs or other organisations to improve that sector and give a better service to our community."* A service provider from Amhara emphasised, *"The other problem we face is the number of healthcare staff, and the people who seek medical attention are not proportional. There is only one outpatient department here, and there are 16,536 people, so it's very difficult."* Further, MoE representatives at the national level and in Amhara described educational services as 'average' and acknowledged gaps in services, such as limited coverage. Similarly, a representative from MoWSA in Amhara noted the limited coverage of parenting services to address challenges faced by caregivers across the region. Speaking on the quality of services, the MoWSA representative said, *"It is below the standard because most of the annual physical year budget and resources were mobilised in emergency service provision."* Thus, there were mixed reactions on the perceived quality of services, and there are areas for improvement.

RQ 5. What factors prevent parents/caregivers from implementing ECD best practices in parenting?

5a. To what extent are parents aware of ECD best practices in parenting?

As indicated under RQ 1, most caregivers are aware of ECD practices in parenting, such as exclusive breastfeeding, handwashing practices and accessing healthcare services. Other times, caregivers followed practices recommended by healthcare centres, such as vaccination, even if they did not understand the importance of doing so. Further, there were mixed reactions on awareness of best practices in domains like responsive caregiving (e.g., development milestones) and adequate nutrition (e.g., diet diversity). There are, however, gaps across all domains, which suggest that knowledge is a barrier to best practices for many caregivers in Ethiopia. We provide more details under RQ 1.

5b. To what extent do parents'/ caregivers' aspirations and trusted sources of information about parenting align with ECD best practices in parenting?

As the findings under RQ 3 indicate, parents and caregivers rely heavily on high-quality sources of information for ECD: 68 per cent look to medical professionals for information about pregnancy and newborn care, and 50 per cent look to health or social workers for information about health care and ECD. Yet for both topics, respondents shared that family, friends and trusted social connections are the next source of information. These results indicate that caregivers rely heavily on information that is readily available through their social and familial networks. This was confirmed by responses in the qualitative interviews. Community-centred trainings and sensitisations can address gaps in knowledge/information and can ensure that caregivers' 'inherited knowledge' is evidence based and in line with ECD best practices. We provide more details under RQ 3.

5c. What alternative parenting practices have parents adopted? Why?

5d. What are barriers or influencing factors that affect parents/ caregivers parenting practices?

While knowledge gaps persist amongst parents and caregivers, they face financial, supply-side (e.g., distance and quality) and other barriers that affect their ability to engage in best parenting practices. This section focuses on caregivers' self-reported barriers. Some barriers pertain to a specific domain of the NCF, while others – such as stress levels, decision-making power and self-efficacy – transcend the NCF and may affect respondents' time or resources available for caregiving.

In interviews, caregivers reported three overarching barriers to implementing methods of best practice with their children: (1) lack of information, (2) resource constraints and (3) lack of social and cultural support. They described their lack of information in certain areas – especially in health, nutrition and educational pathways – but they consistently pointed to resource constraints as a key barrier. While caregiver households are diverse in size, location and source of income, caregivers attributed their resource constraints to having many dependents, lack of stable income and rising market prices. Speaking on such trends, a teacher in Afar recounted this anecdote during an interview:

> *"The present time is exceptionally known as the inflated cost of living… For example, I contacted one mother and sincerely advised her to maintain the health of her children, and regularly wash their clothes and bodies. Do you know what she said? 'Miss, are you joking? Do you know the price of one soap? It is 50 birr. So, it is difficult for me.'"*

Lastly, caregivers and service providers reported that a lack of social and cultural support for behaviour change prevents some parents from adopting ECD advice. Respondents highlighted the need for social support as it relates to responsive caregiving and early stimulation/learning.

Barriers to Adequate Nutrition

Financial constraints (57 per cent) are the main barrier to not providing the food that parents or caregivers believe are good for their children (*see Table 19*). However, one in five respondents mentioned a lack of food availability. Lack of availability of food is amongst the main reasons for not giving a child the food that the caregiver wanted to give them (Oromia, 28 per cent; Afar, 20 per cent; and Gambella, 47 per cent).

High food prices and limited food availability are in line with our findings on households' self-reported food insecurity and Ethiopia's food insecurity classification as an 'emergency' and a 'crisis situation' in Tigray, Afar and the southern pastoralist regions in November 2022 (FEWSnet, 2022). In interviews, pastoralist caregivers reported having a limited diet because of the distance to larger markets where diverse foods are available.

Table 19. Reasons for Not Giving Child Preferred Food

	Percentage of Respondents (n=1,034)
Too expensive/not having enough money	57.2
Food/ingredients are not available	20.5
No time to prepare other foods	3.8
Child does not want to eat other foods	1.4
Child is sick	0.9
Child is too young to eat	0.0
Market is too far away	0.0

Barriers to Good Health

RQ 1 showed some of the factors that contribute to barriers to health care as well as barriers to practicing appropriate health behaviour, such as knowing what to do when a child is ill with diarrhoea or knowing when to wash hands. In addition, the study team observed financial and supply-focused reasons for not visiting a health practitioner while sick or for not obtaining antenatal care. Not going to a health practitioner or facility was influenced by people who believe it is not necessary. Because only 42 per cent of households have one or more members with health insurance, it is likely that people are more hesitant to visit a health facility if they are unsure about the costs (*see Table 20*).

Costs of care are the second main reason for 20 per cent of respondents, followed by supply-side considerations such as lack of personnel, poor quality of care, or too great a distance. Reasons for not going for antenatal care were even more focused around availability, including being 'too far' (34 per cent), 'not available' (17 per cent) and concerns about personnel and wait times (3 per cent). As caregivers reported in interviews and focus groups, longer distances to health facilities can add to transportation expenses, compounding the disincentives for visiting the facility. Pastoralist caregivers in Afar reported that the nearest health facility is distant and/or inaccessible. This was corroborated by quantitative evidence from the caregiver survey: Only 26 per cent of respondents in Afar are aware of community health services or programmes in their area, compared to the other regions, where nearly all respondents are aware of such services/programmes (except amongst IDPs in Amhara, where 74 per cent of caregivers are aware of them).

Table 20. Reasons for Not Obtaining Appropriate Health Care

	Percentage with Reason Given (n=1,034)
At least one household member has health insurance (n=1,034).	41.5
Any Household Member	
Reasons for not visiting health practitioner or facility when sick or injured (n=128)	
Does not need medical assistance	60.9
Too expensive	20.3
Lack of health professionals	11.7
Too far	3.1
Does not believe in medicine	1.6
Poor quality/services	0.8
Other	2.3
When Mother Was Pregnant with Child (Aged 0–6 Months)	
Reasons for not going for antenatal care (n=174)	
Distance too far	33.9
Not necessary	26.4
No health care available	17.2
Security concern/conflict in area	7.5
Economic reasons	6.9
Prefers community volunteers	3.4
Health personnel not friendly	2.3
Long waits at facility	0.6
Other	1.7

Barriers to Safety and Security

Safety and security barriers differed across the study sample, with migrant groups, for instance, reporting unique barriers that stem from their lodging situation (*see below*). This study uncovered a key, cross-reaching barrier to safety and security: birth registration.

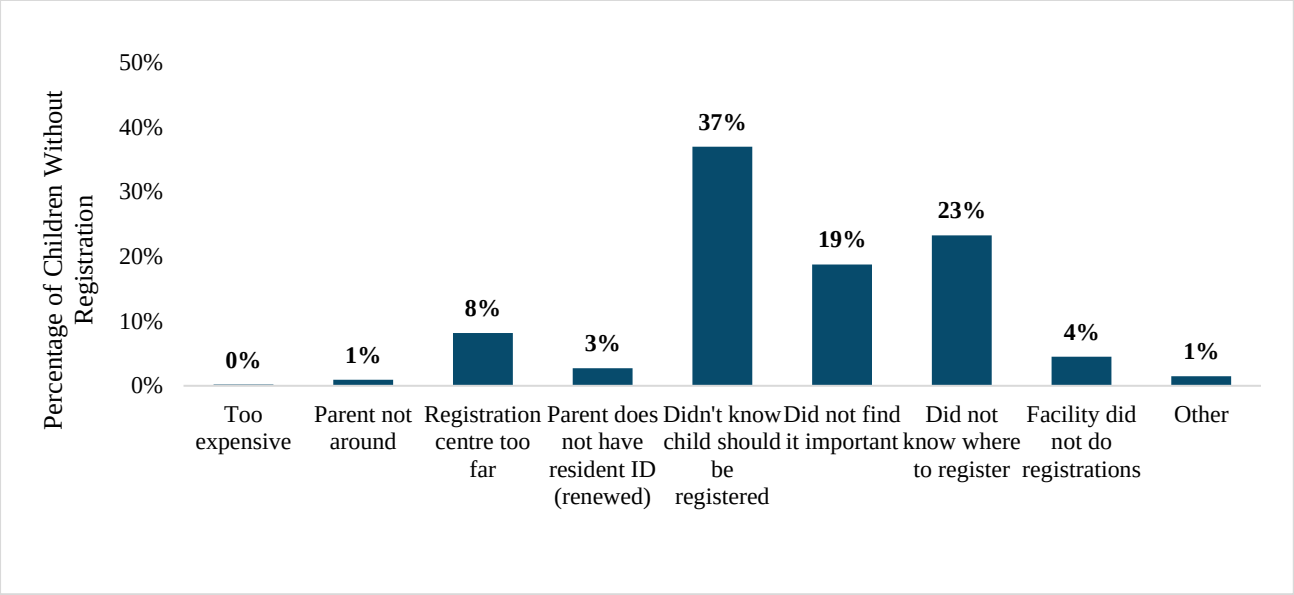
Birth registration and certificates. Low birth registration is a concern for the safety and security of children, as it may affect whether the child is appropriately identified and therefore eligible for relevant services including education, and health care. Only 37 per cent of children's births are registered (*see Table 21*) with the lowest rates in Afar (7 per cent) and amongst IDPs in Amhara (21 per cent). The proportion of children for whom parents or caregivers have a birth certificate (as part of the registration) is slightly lower with 30 per cent. The timing of registration differs, although most caregivers

Table 21. Proportion of Children (Aged 0–6 Years) with Birth Registration

	Percentage of Children (n=1,715)
Child aged 0–6 years is registered	37.3
Child aged 0–6 years has birth certificate	30.1

register their child within 90 days after the birth (52 per cent of registered children), but about 15 per cent of caregivers register their children when they are 1 year or older. The main reasons for not registering are knowledge related: unaware it is needed (37 per cent) and not knowing where to go (23 per cent). Amongst the services that caregivers reported accessing, there were no mentions of programmes or services to support birth registration.

Figure 22. Reasons for Not Being Registered or Having a Birth Certificate



Barriers to Early Learning and Stimulation

As discussed previously, parents and caregivers believe that early learning is largely the responsibility of teachers and schools. Amongst children of preschool age, the parental belief that they are 'too young' to go to school is the main reason that children have never attended preschool (64 per cent of 4- to 6-year-olds) (*see Table 22*).[7] Other reasons such as 'not interested in school' (3 per cent) and 'not mandatory or necessary' (4 per cent) suggest that some caregivers may not see the need for early education. Further, some reasons that children aged 4–6 never attended school are related to accessibility and affordability: The school is too far away (10 per cent), there is no place for the child at the local school (7 per cent) or it is too expensive (6 per cent).

Table 22. Reasons for Not Attending Early Education

Reasons for Not Attending Preschool (Aged 4–6 Years) (n=289)	Percentage
Too young	64.0
School too distant	10.4
No places available in local school	7.3
Too expensive to go to school	6.2%

[7] The study team used ages 4–6 for "never attended preschool" because this is the recommended age range for attending preschool.

Reasons for Not Attending Preschool (Aged 4–6 Years) (n=289)	Percentage
Not mandatory/necessary	3.8
Not interested in school	2.8
Available school not appropriate for lifestyle	1.7
Required for work or care activities, including on farm or household	1.0
Not safe	1.0
Other reason (specify)	1.7

Students enrolled in pre-primary school may still face barriers to learning. The quality of pre-primary education remains an area of concern for the GoE, which stated in 2022 that "57nrolment in [pre-primary education] facilities is often high, resulting in overcrowded classrooms with a teacher–student ratio of 1:30 or greater" (MoE, 2022, p. 6). In interviews, respondents highlighted the link between nutrition and pre-primary education. Further, a community leader from Amhara said, *"There are some who… face a shortage of food. I would suggest that these families get food aid because children should not go to school without satisfying their hunger."* Thus, eradicating nutrition barriers is key to helping improve early childhood education and learning.

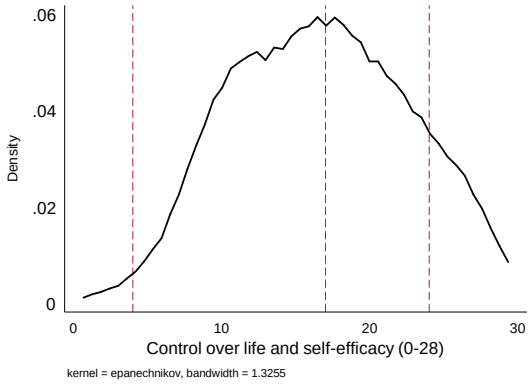
Cross-cutting barriers to parenting best practices. The research team assessed female caregiver self-efficacy, stress and decision-making power to assess some of the other factors that may affect parents' and caregivers' responsiveness to children's needs.

Self-efficacy. The survey included a set of seven statements about female caregivers'[8] feelings of agency regarding their lives, such as: *You have the power to make important decisions that change the course of your own life* and *You have the power to make important decisions that change the well-being of your children.* Combined, the answers form a self-efficacy index ranging from 0 (low self-efficacy) to 28 (high self-efficacy). The caregivers in the sample scored, on average, 17 out of 28 points, but 14 per cent had low self-efficacy (0 to 10 points), and 15 per cent had lo cent had high self-efficacy (24 to 28 points) (*see Figure 23*). Confirming these results, interview data show that caregivers generally feel their actions will affect their children's health and education outcomes.

Stress. Stress was measured through the Cohen Perceived Stress Scale, which asks caregivers about their difficulties, anxieties and control issues within the last four weeks (Cohen et al., 1983; Hjelm et al., 2017). Examples of these questions are as follows: *How often have you found that you cannot cope with what you had to do?* And *How often have you felt that you were unable to control the important things in your life?* Responses are given on a 5-point Likert scale and summed to create a stress scale ranging from 0–40, in which higher measures indicate the perception of a greater amount of stress. Respondents scored, on average, 18 out of 40; 16 per cent had low stress (0–10 points), and 16 per cent had high stress (25–40 points) (*see Figure 24*).

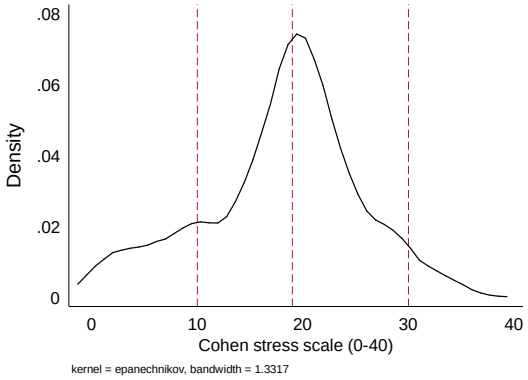
[8] The survey was filled out by the primary caregiver. Because 99.9 per cent of respondents were female, the study team is unable to provide reliable statistics for male primary caregivers.

Figure 23. Distribution of Self-efficacy Rates amongst Caregivers



Note: 28=most self-efficacy

Figure 24. Distribution of Perceived Stress



Note: 0=stress and 40=very high stress

Anecdotally, caregivers – especially women – described feeling that they have to *"deal with a lot of things and thoughts"* in caring for children. Such reports were prevalent across the sample, indicating that many parents lack sufficient psychosocial support, both formally (e.g., through services) and informally (e.g., through community and familial support).

Decision-making power. Wives or female partners are the main decision makers about matters concerning the children or smaller daily purchases (*see Table 23)*. Women are the main decision makers on whether to seek treatment if the child is ill (51 per cent) or making daily household purchases (53 per cent). Wives are more likely than their husbands to make decisions about whether a child should go to school if they do not want to (40 per cent and 25 per cent, respectively). Men are more likely to be the sole decision makers about major household purchases (34 per cent) or purchases of children's shoes or clothes (35 per cent). In both cases, the proportion of households making joint decisions is fairly high. Amongst the respondents, 38 per cent of households make joint decisions on how the husband's earnings are spent; this is more than wives or husbands making these decisions alone (24 per cent and 32 per cent, respectively).

Table 23. Perceptions of Decision-making Power Regarding Key Household Decisions

	Husband Decides Alone (n=1,034)	Wife Decides Alone (n=1,034)	Husband and Wife Jointly Decide (n=1,034)
Purchasing child's clothes or shoes	35.1%	29.3%	35.0%
If child should go to school when they don't want to	25.0%	40.2%	34.5%
When to seek treatment if child is ill	17.1%	50.7%	32.1%
How husband's earnings will be spent	32.0%	23.7%	38.4%
How wife's earnings will be spent	25.0%	29.3%	34.7%
Daily household purchases	23.0%	53.0%	23.3%
Major household purchases	34.1%	27.7%	37.5%
When to seek treatment when wife is ill	22.7%	41.7%	35.2%
Visiting family and friends	24.9%	32.7%	42.1%

Note: Female respondent answered regarding her perception of decision making.

The quantitative data show that wives in Gambella have the most decision-making power compared to those in any other region, followed by wives in Afar. The decision about whether to seek treatment for a sick child and whether a child should go to school when they do not want to is made mostly by wives in Afar and Gambella, at around 70 per cent. For other decisions, wives' decision-making power is also high; for example, around two thirds of households in Gambella mentioned wives making decisions on items such as how to spend earned money, household purchases, when to buy clothes or shoes. In Afar, these items have rates similar to those in the other regions. The qualitative data confirm the findings of the quantitative survey. In two-parent households, mothers usually are more involved in the care of young children and flagged issues related to their health, diet, hygiene or education needs. Fathers, however, reported that they make the final decision on 'important' matters like health treatments or education because they do much of the purchasing for the family. The qualitative data suggest that mothers in the Afar region participate more in decision making regarding young children, because fathers/husbands may be away from the home working most of the week. For most of the respondents in Ethiopia, grandparents (if nearby) are able to make important decisions regarding young children's care.

Caregiver agency and decision making: IDPs. In interviews and focus groups in IDP camps, the topics of stress, grief and depression were discussed at length. The data indicate that poor mental health weighs heavily on parents and caregivers experiencing displacement. In addition, feelings of self-efficacy are lower in IDP camps; caregivers described feeling that their situation makes them unable to support their children. This is exemplified in the following observation from a male caregiver in Amhara.

> *"Some difficulties may restrict me from significantly contributing to their well–being… I am very worried about their future well-being because the money in the bank is currently diminished, and I am very frustrated. I worry they are not eating nutritious foods. If they are not healthy, what will happen?"*

The above quote underscores the importance of caregiver mental health within the NCF and indicate that psychosocial support for displaced communities is a pressing need for improving ECD and other health and wellness outcomes.

Barriers for Refugees and IDPs

Interviews and focus groups with Ethiopia's migrant populations – namely, in refugee camps in Gambella and IDP camps in Amhara – revealed that migrants face unique barriers to parenting for ECD. Refugee caregivers described limited opportunities to earn an income and the barriers related to the inadequacy of humanitarian support (e.g., food and soap) in refugee camps. This is evidenced by the findings under RQ 4e; refugees have high service utilisation but low satisfaction with these services. For IDP communities, key barriers stem from a sudden disruption of caregiver livelihoods. IDP caregivers work in agricultural and agropastoral sectors before displacement, and, as one female caregiver in Amhara described, they fled their homes with few resources:

Unique Barriers amongst Migrant Populations in IDP and Refugee Camps

- Sudden disruption of caregivers' livelihoods
- Heavy reliance on humanitarian aid
- Unfamiliarity with environments and community
- Inadequate living conditions in camps
- Limited opportunities to earn an income

> *"We did farming and weeding, and when it was time to harvest, we fled from there with nothing – without selling our cattle and grains. We fled with only the clothes on our backs. We came here passing through the jungle because if we went on the main road, they would catch us, and there was a chance that we would be killed. I came here carrying this girl on my back and traveling for four hours on foot… I came here with nothing, no items or clothing."*

IDP respondents identified three key barriers to parenting. First, they lack the ability to earn an income in/around the camp, leading them to lack sufficient resources necessary for childcare. Second, camp conditions are unsuitable for raising a young child. Caregivers described the lodging as dirty, crowded and littered with unsafe items. Third, they lack sufficient humanitarian support to overcome the first two barriers. In particular, caregivers said they need mattresses, blankets, clothes and food in Amhara's IDP camps.

RQ 6. What is the understanding of policymakers and service providers at the federal and sub-national levels regarding parenting for ECD and parents'/caregivers' need for support?

Interviews with government officials, CSO representatives, international organisations and service providers across the studied regions indicated high awareness of unique needs of different populations such as children, women, IDPs, pastoralists and refugees. Most government officials and service providers emphasised the unique psychosocial needs and barriers faced by children and caregivers who are internally displaced or who are refugees.

For example, a national government representative from MoH described the situation regarding children's needs: *"Displaced children have passed through terrible conflicting situations and challenges as they have seen when someone is shot, gets injured and died, and they have observed people's homes burn down and turn to ashes."* In response to the trauma resulting from these events, the MoH provides play-psychotherapy services. Further, a regional policymaker from Amhara from MoWSA said,

> *"Children may need legal, psychological, and material support depending on the types of problems that they have faced. Therefore, we try to address their problems in an alternative childcare programme that was envisaged by the bureau. We may not cover the entire vulnerable children in the region, but we may arrange shelter for orphaned children; we may also admit victims of GBV [gender-based violence] to rehabilitation centres, most of which are run by local and international NGOs."*

This indicates that policymakers considered the various needs of children and incorporated services to meet these needs. Representatives from UNICEF Ethiopia indicated accounting for services under both emergency and development sectors, and they described the implementation of services, such as mentorship and training services, for child protection from the government level to the community level to expand reach.

According to some government representatives and UNICEF officers, a common barrier that delays development and implementation of ECD services is the limited investment in ECD services by the government. Respondents explained that the lack of integration of ECD as part of a relevant sector such as education or health prevents adequate investments. Further, there is recognition of gaps in knowledge of household needs. Government and civil society

representatives suggested that more systematic studies should be conducted across the country to capture contextualised needs of vulnerable populations.

In addition, access to better and more specific data would help government officials develop appropriate services. For example, a respondent noted higher prevalence of FGM in regions bordering Somalia and a need to prioritise development of appropriate services to address this harmful practice. A UNICEF officer pointed to a data gap related to FGM:

> *"There are girls in Ethiopia who are subjected to FGM at the age of below 5, and the data looks at after 5 years, so this is one of the gaps. We have hard evidence from age 5. We have that analysis, but what we don't have particularly is those age from 0–4 years. This is something which we need to improve, because it will also make us have an informed ECD-level intervention and increase parenting [practices] around that and have a tailored programme to deal with that."*

At the community level, service providers in Amhara and Gambella mentioned trainings for social workers to communicate with and meet the needs of children who have experienced abuse and trauma, children with disabilities, orphans and children with other vulnerabilities. In Amhara, committee members are selected by social workers to receive intensive training to identify and support children who are depressed, ill, or abused. A referral system exists for cases that need more support beyond what camps can offer.

RQ 7. What are the institutional arrangements to support parents/caregivers for ECD in different sectors?

Policies, frameworks and strategic plans on ECD. Institutional support for ECD in Ethiopia implicates an array of government bodies, CSOs and private service providers from sectors like health, nutrition, child protection and education. The actors working on ECD are organised through a handful of key sectoral and multisectoral policies, laws and international conventions to which the GoE is committed. The recent efforts on the revision of the National Early Childhood development and Education (ECDE) Policy Framework in particular brings together the roles and responsibilities of the involved ministries and stakeholders into a comprehensive and practical guideline for the implementation of ECDE services. Besides the ECDE policy framework the GoE has demonstrated its action in supporting early childhood outcomes over the years through multiple following policies, frameworks and strategic plans (*see Table 24*).

Table 24. Overview of Institutional Support for ECD

International Conventions and Frameworks
Conventions and Charters
Convention on the Rights of the Child (1989)
Convention on the Rights of the Child Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography (2000)
Convention on the Rights of Persons with Disabilities (2007)
African Charter on the Rights and Welfare of the Child (1990)

International Conventions and Frameworks
Africa's Agenda for Children 2040
African Charter on Human and Peoples' Rights on the Rights of the Women in Africa (2003)
Sectoral Initiatives
Education Sector Development Program VI (2020/21–2024/25)
National Strategic Plan for Pre-Primary Education (2020/21–2024/25)*
Health Sector Transformation Plan II (2020/21–2024/5)
National Health Sector Strategic Plan for ECD (2020/21–2024/5)*
Newborn and Child Health Roadmap (2022-2030)*
National Children's Policy (2017)
Multisectoral Initiatives
One WASH National Program Consolidated WASH Account Phase II (2019–2024)
National Food and Nutrition Policy (2019–2029)
National Early Childhood Development and Education (ECDE) Policy Framework (2022)*
Other Policies and Laws
National Plan of Action of Persons with Disabilities (2012–2021)
Productive Safety Net Program (2020–2025)
Seqota Declaration and Roadmap (2015-2030)
Federal Civil Servants Proclamation NO. 1064/2017 Article 48/6
Criminal Code of the Federal Democratic Republic of Ethiopia 2004 (Proclamation No. 414/2004)

* Aligned with the Nurturing Care Framework.

Early Childhood Care and Education Policy Framework 2022. A revision of the 2010 Early Childhood Care and Education Policy Framework, the 2022 ECDE Policy Framework establishes overarching objectives and concomitant implementation modalities for ECD. The establishment of the 2022 revision is a large collaborative effort, which confirms the GoE is cognizant that child development requires a holistic and integrative approach. It outlines the responsibilities of MoE, MoH, MoWSA and six other ministries as it pertains to ECD, and it describes the roles of parents and caregivers, development partners and private sector providers. In interviews, GoE stakeholders said they hope that the policy framework can improve collaboration between ministries at the federal level, standardise reporting mechanisms for ECD indicators, and focus all GoE activities around the NCF domains. Although the final policy framework does not include a standardised set of indicators, it lays out in broad terms how the GoE will improve monitoring, evaluation and learning on ECD: "A strong monitoring and

> *"About four or five years ago when I started working in this space… ECE was considered the luxury and not the responsibility of the Government. But **now the Government is not only accepting this responsibility but committing to provide at least two years of pre-primary**."*
>
> – International organisation stakeholder

evaluation system will be emplaced for policy effectiveness. Accordingly, sector strategic plans will have a monitoring and evaluation framework. Joint forums will be organised to facilitate the participation and operation of stakeholders" (Federal Democratic Republic of Ethiopia [FDRE], 2022, p. 12).

Like several other GoE policies, the ECDE Policy Framework is aligned with the NCF and its five domains of conceptualising ECD. The uptake of the NCF in policy indicates its utility for guiding policy and programming decisions for the GoE, which government stakeholders echoed in interviews.

Despite the strengths of the ECDE Policy Framework, some stakeholders question whether it can provide much-needed multisectoral coordination at the federal level. Such concern led one stakeholder of an international organisation to suggest that the policy framework be further developed:

> *"Elevating [the ECDE Policy Framework] to a policy rather than a policy framework that might add some weight to the work because a policy framework is like what the ministries agree between them… But when it is policy, then it needs to be approved by and will be monitored by the office of the prime minister."*

The respondent added that GoE policies that are linked with indicators, budgets and reporting timelines tend to have better results.

Relevant ministries supporting ECD. Responsibility for ECD in the GoE is allocated primarily to the MoE, the MoH, and MoWSA; however, the GoE's 2022 ECDE Policy Framework involves a total of nine ministries and other key stakeholders, such as the MoA, the Ministry of Peace, and the Ministry of Water, Irrigation and Energy (MoWIE) – amongst others – in supporting ECD. At the sectoral level, MoE, MoH and MoWSA each have different responsibilities in supporting ECD.

Ministry of Education and ECD. The MoE relies on its Education Sector Development Programme and National Strategic Plan for Pre-Primary Education for guidance in supporting ECD (MoE, 2022). The latter in particular lays out a concrete action plan for improving access to pre-primary education for children aged 4–6 across Ethiopia. The plan includes steps to expand access to pre-primary schooling and to improve quality in existing schools, and it calls for the creation of a National Pre-primary Education Steering Committee to ensure multisectoral cooperation on ECE at the federal level. The GoE stakeholders interviewed for this study view ECE as a crucial platform for supporting the development of children above 3 years of age – a group that is difficult to access through health-system-led interventions. In line with the Strategic Plan for Pre-Primary Education, the GoE stakeholders stated that there is multisectoral momentum for expanding pre-primary education in the country.

Ministry of Health and ECD. With respect to ECD, the MoH is guided primarily by the National Health Sector Strategic Plan for ECD and the Newborn and Child Health Roadmap, drafted in 2020 and 2022, respectively. The former is broader in scope, with the intention of delineating how the MoH will work across all five domains of the NCF to support young children in Ethiopia. The document affirms that the MoH is responsible primarily for ensuring Nurturing Care for children aged 0–3, particularly as it relates to good health,

adequate nutrition, stimulation and responsive care for child development. The plan outlines an intervention framework, indicator framework and indicative budget for 2021–2025. On the other hand, the Newborn and Child Health Roadmap is narrower in focus but longer in scope. It provides "strategic direction for newborn and child health programming in Ethiopia for the next 10 years within the framework of Universal Health Coverage," and it indicates strategic recommendations for ensuring that maternal and newborn health outcomes outlined in the Sustainable Development Goals can be achieved by 2030.

Ministry of Women and Social Affairs Health and ECD. The MoWSA guiding framework on ECD is the National Children's Policy. Drafted in 2017, it is Ethiopia's first comprehensive policy aiming to ensure the respect, protection and fulfilment of children's rights and working to "enhance the family and community's role in the healthy growth and personality development of children." Key intervention areas for MoWSA include child protection, family empowerment/parenting; birth registration; legal reform; family reunification and care for Unaccompanied and Separated Children; and training/capacity development and providing daycare services to civil servants, a service guaranteed under Federal Civil Servants Proclamation No. 1064/2017 Article 48/6. Although comprehensive in its policy implementation strategies, the National Children's Policy lacks a detailed indicator framework and an outline of responsibilities for different ministries and directorates within MoWSA.

The policies guiding MoE, MoH and MoWSA indicate many areas of overlapping responsibility. For this reason, Ethiopian policy addresses ECD through several multisectoral initiatives, the most crucial of which is the Early Childhood Development and Education (ECDE) Policy Framework. Although developed in 2022, the policy framework has yet to be fully implemented; however, GoE stakeholders expect the policy framework to make an important contribution to institutional support for ECD in Ethiopia.

International ECD frameworks. In addition to the sectoral and multisectoral initiatives, international frameworks support ECD work in Ethiopia. Research participants in regional and federal government and in NGOs highlighted the continued relevance of the Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child. Further, policy documents such as MoWSA's 'Standard Operating Procedures for working with Unaccompanied and Separated Children in Northern Ethiopia Response' cite the principles of the Convention on the Rights of the Child in laying out guidelines for the care and rights of children.

Together, these policies, frameworks, laws and conventions comprise a sectoral and multisectoral approach to supporting ECD across Ethiopia.

Policy gaps. Despite the above-mentioned policies, government and civil society stakeholders identified two key areas in which policies and institutional support for ECD are lacking.

First, there are policy gaps regarding ECD support for Ethiopia's IDPs and refugees. Policymakers at the federal level described ECD policy as 'broad' and 'holistic', explaining that it lacks guidance on operating in emergency contexts. Yet, as a MoWSA respondent in Amhara noted, the GoE has attempted to respond to the pressing needs of refugees and IDPs through stopgap measures: *"Over the past two years, the current political situation of the country is very impulsive in that almost all government offices were focused on unilateral emergency and lifesaving tasks."* In the absence of clear policy guidance on ECD, some

government ministries are implementing stopgap programming to meet real-time needs of caregivers and young children, but the implementation of these services lacks uniformity and strategic coordination. As a result, humanitarian organisations like UNICEF, UNHCR, WFP, Save the Children, Plan International, and GOAL have an outsize role in supporting ECD for IDPs and refugees.

Respondents described a second policy gap, which relates to reaching pastoralist communities. Service providers reported that they continue to struggle to reach pastoralist caregivers with training and services, and indeed, treatment of pastoralist communities in Ethiopian ECD policy is uneven. Documents like the MoH's Newborn and Child Health Roadmap offer extensive guidance on reaching pastoralist communities, while others, such as the 2022 ECDE Policy Framework make no mention of pastoralists. Across all sectors, policy can be strengthened by assessing the needs of pastoralist caregivers and young children and by offering strategic guidance to service providers in the field.

Non-governmental stakeholders in the ECD sector. While the GoE primarily drives ECD service delivery, the 2022 ECDE Policy Framework highlights the importance of stakeholders like communities, religious institutions, development partners and the private sector. In addition to government support, study respondents cited the following organisations as actively supporting ECD in Ethiopia:

- Amref Health Africa
- DanChurchAid
- GOAL
- International Rescue Committee
- Local CSOs
- Local NGOs
- Plan International
- Save the Children
- SOS Children's Villages
- UNFPA
- UNHCR
- UNICEF
- WFP
- World Bank
- World Vision

Coordination between governmental and non-governmental actors occurs at all levels, from national-level engagement to linkages with community-level service providers. However, regional-level government stakeholders pointed out that service delivery can become burdensome and complex when many NGOs and CSOs are active in the region. For large-scale projects such as the World Bank's Ethiopia General Education Quality Improvement Program for Equity (GEQIP-E), which aims to reach 18,000 MoE schools, government stakeholders at all levels are involved in helping design, monitor and implement the programme (World Bank, 2022).

Overall coordination of ECD. Given the many governmental and non-governmental actors working on ECD, coordination between stakeholders is vital to providing support to parents, caregivers and young children.

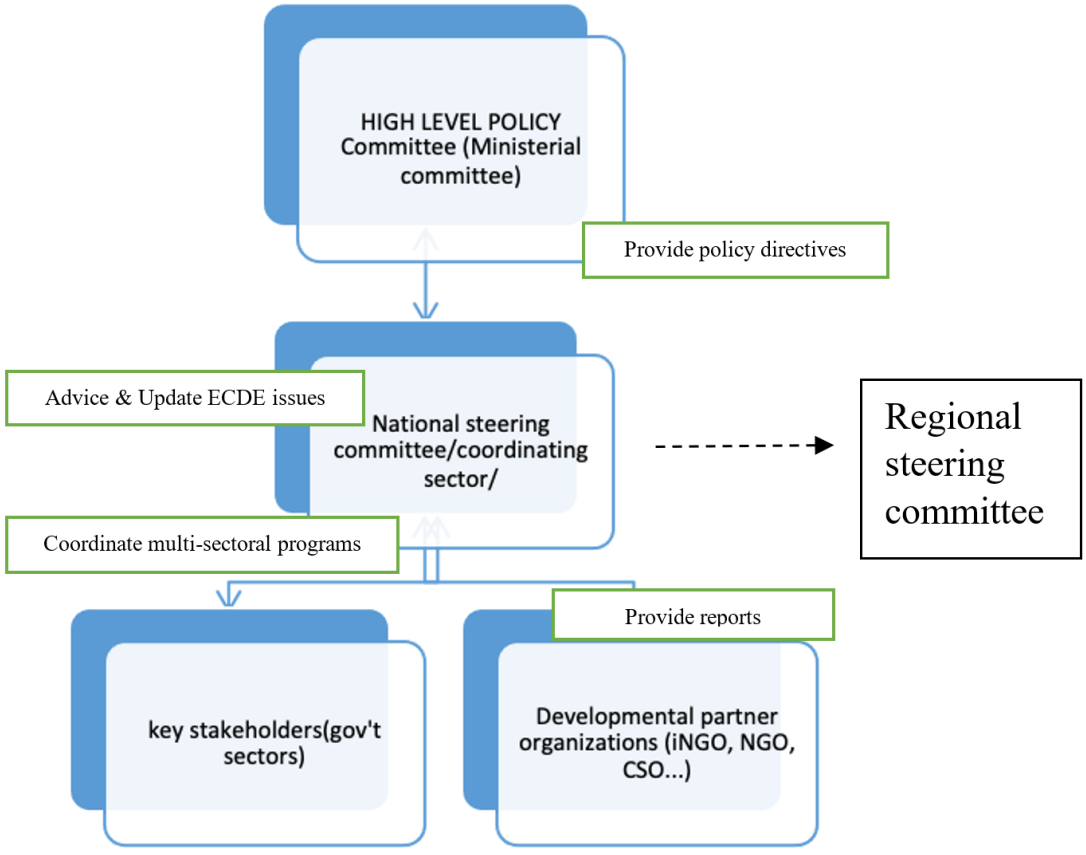
Coordination within MoE, MoH and MoWSA is reportedly effective, with vertical structures to ensure that policies and frameworks are carried out on the ground. However, cross-sectoral coordination historically has been inefficient and limited to occasional, project-based collaboration. As a national MoH official described,

"Partners' coordination by far is better than governmental coordination because we can influence and enforce with partners to implement the programme as per the signed agreement. But when it comes to government ministries, we are on an equivalent playing field, so we don't have the higher position to instruct other ministries and ask them to enforce their work. It is collaboration work… [and] the coordination is very poor. MoH mostly works unilaterally because they are not responsive."

At the regional level, stakeholders cited the use of multisectoral meetings for coordinating service delivery on ECD and other, multisectoral topics. According to those interviewed, the success of these regional meetings varies greatly by region, with some gathering regularly to disburse ECD responsibilities and others reporting little coordination on ECD with counterparts in other ministries.

The 2022 ECDE Policy Framework aims to improve on these coordination mechanisms by centralising reporting and strategic planning related to ECD in Ethiopia (*see Figure 25*). The policy framework marks the first step towards establishing a centralised, integrated structure at the federal level for coordination and reporting on ECD. Specifically, it establishes a High-level Policy Committee/Ministerial Committee charged with "providing evidence-based policy directions" and a National ECDE Coordinating Committee chaired by MoE, MoH, and MoWSA on a two-year, rotating basis. Importantly, the prime minister's office will oversee the Ministerial Committee, providing an overarching structure for reporting on ECD achievements and developing multisectoral strategies.

Figure 25. ECDE Structure, Governance and Coordination



Source: FDRE, 2022.

It is still unclear, however, if the 2022 ECDE Policy Framework can address coordination needs connected to ECD in emergency contexts. A regional stakeholder reported that, as a result of the unfolding conflict and displacement in Ethiopia, *"Sectorial offices mainly [give] priority to emergency service provision, so the coordination is almost not functional"* (MoWSA representative, Amhara, KII). The 2022 ECDE Policy Framework makes no mention of refugees or IDPs, though it allocates the Ministry of Peace (which houses the Refugee and Returnee Services) with responsibilities such as to "provide safety and protection to children in difficult circumstances" (FDRE, 2022, p. 16; FDRE, 2015). Improved coordination for ECD in Ethiopia emergency contexts will require that the Ministry of Peace, along with humanitarian organisations and core ECD ministries, work cooperatively, through the structures prescribed in the ECDE Policy Framework, to meet the needs of caregivers and children.

Case Studies:

Presenting findings from in-depth interviews (IDIs) conducted with five sets of caregivers representing five different contexts:

A. General Urban setting [Amhara] *(n = 1 male and 1 female caregiver)*

B. IDP setting [Amhara] (*n = 1 male and 1 female caregiver)*

C. Refugee setting [Gambella] *(n = 1 male and 1 female caregiver)*

D. Urban setting [Afar] *(n = 1 male and 1 female caregiver)*

E. Rural setting [Afar] *(n = 1 male and 1 female caregiver)*

F. Institution which provides services for vulnerable children, including children with disabilities [Addis Ababa] (*n = 2 institution staff, 1 institution leader).*

Case Study A:

General Urban Setting: Amhara (1 IDI with male caregiver + 1 IDI with female caregiver)

Household Context:

- Female caregiver noted equal responsibility between husband and wife in raising children; and lived in a space with three households. Female caregiver also noted joint decision making with husband on access to healthcare, schooling, and discipline.
- Income is very limited, and there is a lack of employment opportunities. Male caregiver who was a single parent worked as a daily labourer. The same male caregiver said, "*Displacement and conflict is the major problem that restricts me from fulfilling all my children's demands as they need*".

Adequate nutrition:

- Caregiver expressed barriers in accessing quality food and relied on food aid such as government food support called as Sese, or by other donors. Female caregiver said, "*I will feed him what is available and can find*". Male caregiver mentioned poor quality of food (e.g., wheat and corn flour) received from aid organizations
- Female caregiver noted limited awareness of requirements of a balanced diet. A female caregiver from Jari said, "*Here the only option we have is to eat what they are providing. If we were in Wollega, we would have had a lot of options to buy food; either I or my husband will buy any food that we want for our children. We don't have options here to buy food, we are limited to taking what is supplied by donors*". However, male caregiver mentioned requirements of a balanced diet such as consumption of eggs, meat, milk.
- Exclusive breastfeeding was practiced until age 6 months, solid food (e.g. injera and wot) were eaten by children six months and older. Similarly, male caregiver mentioned providing injera and shiro to his children (2 years+)

Good health:

- Female caregiver practiced good WASH practices and all family members washed hands with soap (if available) after using the toilet and before eating. Male caregiver noted bathing youngest child every 3rd day. Further, it was observed that there was no soap in the space or next to the tap by the male caregiver's household.
- Caregivers were aware of flu and pneumonia symptoms, and when to access healthcare facility when child got very sick.
- Information on caregiving: Male caregiver expressed barriers in limited dissemination of knowledge to men on how to care for children; and recalled information received via radios, and from health extension workers before being displaced.
- Caregivers were aware of vaccinations, but only male caregiver knew of the diseases: COVID 19, polio, measles.

Safety and security:

- Children are subjected to negative disciplinary practices to rectify mistakes. (e.g., female caregiver pinched, or hit with sticks; male caregiver mentioned kicking and intimidation.
- Female caregiver did not worry about violence or sexual abuse in their community. However, male caregiver was worried about sexual abuse and noted that they never leave child alone.

Opportunities for early learning:

- Caregivers had little to no knowledge on how to support children's early learning.

Responsive caregiving:

- Caregivers noted importance of showing love to the child through smiling, hugging.

Case Study B:

IDP Context: Amhara (1 IDI with male caregiver + 1 IDI with female caregiver)

Household Context:

- Male caregiver is a single father with five children with him from 3.5 years to 20 years and is currently residing in an IDP camp after being displaced in 2021. He is the main caregiver but noted that oldest daughter prepares food, and manages household chores, indicating that responsibility falls on the female child. Male caregiver also said that when he was not separated from his wife, all caregiving responsibility was on the mother.
- Female caregiver is also a single mother with five children (from 3 months old baby to 20-year-old) residing at the IDP camp and is the primary caregiver. Female caregiver has support of her parents.

Adequate nutrition:

- Caregivers seemed aware of importance of providing quality and nutritious food (e.g., eggs, meat, carrots, beetroots, and milk) to children. However, they emphasized on the unaffordability and unavailability of quality food. Female caregiver explained, "*We don't lack knowledge, but we have a shortage of finance*". Male caregiver also mentioned inability to purchase food regularly from the shops since the caregiver does not have an income in the IDP camp. For example, male caregiver said, "*The most nutritious food that I could feed my children was at the home we were displaced from. Here, they eat whatever they find at the IDP camp*".
- Caregivers were aware of the limited nutrition children were receiving but felt helpless due to dire lack of resources. Female caregiver said, "*I just try as much as possible with what I have but worry about keeping them from dying due to hunger*". Further, caregivers were not very aware of what is considered as a 'balanced diet'.
- Caregivers cited charity organizations as sources of food, along with shops near the IDP camps. Male caregivers mentioned purchasing injera, macaroni, and Koshero biscuits from the shop.
- Female caregiver practiced exclusive breastfeeding, and said, "*My baby doesn't take anything else except for breast milk. Even if she doesn't cry, I will wake her up from her sleep at breakfast time and breastfeed her*".

Good health:

- Caregivers mentioned practicing WASH behaviours such as washing children's' hands after toilet use, and before eating. However, male caregiver mentioned bathing body of child only once in two weeks during the wet season and once in four months during the dry season. Further, the caregiver noted using soap to wash child's extremities such as face, hands, and legs daily.
- Caregivers noted taking children to health centers when they were sick, and cited health workers, and TV as information sources for good health practices such as vaccination against polio.
- Observation notes indicated that home environment had inadequate living standards. For example, female caregiver lived in a small space within a huge, crowded hall. Further, unsafe items such as knives and glass were present and accessible to children.

Safety and security:

- Caregivers worried about children experiencing physical, sexual and gender abuse. Female caregiver noted daily monitoring with a camp supervisor if camp residents faced any gender -based violence. Male caregiver also implied limited mental capacity to care about other children in the area and said, "*My mental setup is a bit disoriented, and I have no space to worry about other children's sexual abuse incidents*".

Opportunities for early learning:

- Caregivers noted that younger children (5 and 7 years) are registered to attend school at the camp but stated that other children have no access to school or learning opportunities. Both caregivers agreed that it was important for children to be curious and have access to school. Observation notes indicated that children had no toys or safe space to play and learn.

Responsive caregiving:

- Male caregiver stated that providing excess affection spoils children and said that practices such as hugging & coddling are disastrous practices which leads to disobedience in children. Same respondent also said that they sing, hum a lullaby, and sing to younger children.

Case Study C:

Refugee context: Gambella (1 IDI with male caregiver + 1 IDI with female caregiver)

Household Context:

- Male caregiver made joint decisions with female caregiver, but there was also acknowledgement that final decisions on schooling, food purchases, and accessing healthcare were ultimately made by male caregivers. Female caregiver secondary caregiver and conducts practices even if there is no knowledge of particular practices.
- Female caregiver is primary caregiver (preparation of food, bathing, washing clothes). Assisted by other family members such as grandmothers.

Adequate nutrition:

- Male and female caregivers were aware of importance of good nutrition. Male caregiver noted different food groups such as carbohydrates and protein, and what encompasses a balanced diet.
- Caregivers cited international NGOs (e.g., Plan International, DCA, and GOAL) as sources of information along with family members and health centers on good nutrition, and food,
- Provision of food is also by food aid organizations such as WFP, and GOAL but is inadequate. Caregivers noted buying food from markets near to camps.
- Exclusive breastfeeding is practiced until age 6 months, solid food (e.g., porridge) is introduced at 6 months.

Good health:

- Caregivers noted awareness of accessing healthcare centers when child is sick (e.g., male caregiver noted when fever temperature crosses 39 C), and male caregiver also identified different diseases caused due to poor nutrition such as Marasmus and Kwashiorkor.
- Usage of soap when available, and implementation of best WASH practices for the prevention of diseases
- Children were vaccinated for Measles, Polio, DPT, and BCG

Safety and security:

- Caregivers worried about children experiencing sexual abuse. Female caregiver noted prevalence of gender -based violence committed by soldiers in the community and not in the camps.
- Respondents (including female caregivers) noted the prevalence of sexual abuse and physical assault amongst these populations.
- Usage of negative disciplinary practices, such as hitting with a stick was practiced only when child disobeys adults.

Opportunities for early learning:

- Caregivers sent children to school and emphasized how curiosity and play were essential for growth. Male caregiver also mentioned income generation (such as selling biscuits which was considered creative).
- Caregivers mentioned teaching children family history through oral stories.
- Both boys and girls assist in chores such as firewood and water collection

Responsive caregiving:

- Caregivers noted importance of showing love to the child through storytelling, smiling, hugging. A male caregiver said, "*When you smile, you are showing them love. When you hug them, they feel free and loved too. It is also respecting the rights of the children*".

Case Study D:

Urban Context: Afar (1 IDI with male caregiver + 1 IDI with female caregiver)

Household Context:

- Female caregiver is a divorced, single mother of four children and is the primary caregiver. Male caregiver lived with his wife, four children, and his father (who supports in caregiving). Male caregiver noted that his wife was the main caregiver, and made decisions on food, and education. However, the male caregiver made decisions on accessing healthcare services.

Adequate nutrition:

- Caregivers had little awareness on food groups for a balanced diet, and mentioned carbohydrate-rich food groups (e.g., macaroni, spaghetti, faffa (baby food), corn, and rice) as children's main food and as part of a balanced diet.
- Male caregiver reported little to no income, and hence limited money to purchase food for the family. Due to the financial barrier, male caregiver reported accessing faffa and other food aid from the regional government.
- Though breastfeeding was practiced, it was not exclusive and female caregiver mentioned providing water to her 2-month-old child. Similarly, male caregiver reported providing 'layla' or spring water at 4 months to his child.

Good Health:

- Caregivers reported their children falling sick frequently (e.g., female caregiver mentioned malaria and typhoid), and caregivers accessed healthcare centers when children were sick and to receive vaccinations.
- Hand washing was practiced, and female caregiver explained the importance, "*The main source of the disease is the hand, and we wash our hands frequently. I advise my children to wash their hands as frequently as they can*". Male caregiver mentioned barriers of no running water, and unaffordability of soaps to practice good WASH hygiene.
- Female caregiver is illiterate, and noted TV as a sole source of information on good health practices (e.g. accessing school, washing hands, and importance of eating fresh foods).

Safety and security:

- Female caregiver reported high prevalence of early pregnancies in the community and protected her female children from having relationships with boys by ensuring they are with the caregiver most times. Further, female caregiver reported that sexual relations were with consent.
- Male caregiver reported the ending of some traditional practice such as FGM and removal of teeth to prevent diarrhea after community sensitization. The male caregiver said, "*We have been told not to circumcise girls because, during the time they are in labor and about to give birth, it is very hard for them, so we've stopped circumcising girls here".*
- Usage of negative disciplinary practices, such as spanking was considered a necessary tool to prevent children from repeating the same behaviour.

Opportunities for early learning:

- Female caregiver's oldest child (in grade 8) goes to school and acknowledged her limitations in being unable to read to her children. Female caregiver reported teaching her female children household chores such as cooking and washing clothes.
- Male caregiver reported encouraging his children to ask questions, and taught his children Afar, Amharic and English alphabets.

Responsive caregiving:

- Caregivers practiced responsive caregiving and showed affection to their children. Male caregiver mentioned mothers usually carrying girls and fathers carrying boys due to a traditional belief.

Case Study E:

Rural Context: Afar (1 IDI with male caregiver + 1 IDI with female caregiver)

Household Context:

- Male caregiver lived with his wife and four children and mentioned shared responsibility and joint decision making with his wife on issues related to raising children with his wife. Female caregiver lived with her husband, and two children and stated that she was primarily responsible for raising her children. However, the female caregiver noted making decisions jointly with her husband.

Adequate nutrition:

- Caregivers were aware of importance of a balanced diet and good nutrition. Female caregiver noted cereals, pulses, oil seeds, meat, and milk as part of a balanced diet. Male caregiver noted different food groups such as protein-rich foods like eggs and vitamin-rich foods.
- Male caregiver was very aware of what is considered as a balanced diet and explained its importance for child development, "*If you raise them with a balanced diet, they will have the capacity to resist diseases*".
- Exclusive breastfeeding was practiced until age 6 months.

Good health:

- Caregivers noted awareness of accessing healthcare centers when child is sick, and male caregiver cited trainings at health centers, NGOs (e.g., AMREF), and dissemination from health extension workers (HEWs), radio (e.g., Debre Birhan FM radio station), and religious leaders as sources of health information. Female caregiver also noted trainings at health centers on antenatal and postnatal care, vaccination, and on breastfeeding practices.
- Caregivers practiced good WASH hygiene and mentioned that hand washing is a must, and hands are washed whenever they need to be. Particularly, the male giver noted access to running water and religious beliefs which allow for eating food only after washing hands and face.
- Female caregiver described unsanitary environmental conditions in the community which led to high prevalence of diarrhea, sinus, and vomiting.
- Children were vaccinated. Female caregiver mentioned vaccination for polio and meningitis.

Safety and security:

- Both male and female caregivers stated that sexual abuse was not something to be worried about in their community. The male caregiver described strict capital punishment for a perpetrator.
- Female caregiver noted prevalence of harmful traditional practices (e.g., scarring of gums, early marriage, and female genital mutilation) and also expressed fear in reporting these practices due to retaliation from the perpetrators. She said, *"Even if you witness a girl kidnapped for marriage, you can't notify the authorities. Because if you do so the perpetrators will beat you and not only beat but remove you out of the community. Even the HEWs do not dare notify the authorities about those people that practice these activities".*
- Caregivers practiced positive discipline such as talking to children. However, male caregiver mentioned children above age 18 years old are disciplined by 'Ada's rule', which includes being tied with a rope.

Opportunities for early learning:

- Caregivers sent children to school and encouraged children to play and be curious. Male caregiver also mentioned female children learning how to cook from their mother.

Responsive caregiving:

- Caregivers practiced responsive caregiving and showed affection to their children. Male caregiver explained that smiling and hugging children was important for children to feel loved. The male caregiver referred to an Amharic saying "*Kefitfitu fitu*" which translates to "*facial expression is worth more than the food served*". Speaking on children's reaction, the same caregiver said, "The *natural way they express their happiness to their parents is unique, they jump on your shoulder, and kiss you. Children's love is very strong".*

Case Study F:

Institution: (2 IDIs with 2 institution staff + 1 Observation)

Institution:

- The institution cares for vulnerable, and separated or orphaned children and youth (most children are older than age 6 years), and some children are with disabilities. Children and youth are referred to the institution by government bodies such as MoWSA.

Adequate nutrition:

- Staff prepare food and provide adequate number of meals for children (three meals and snack).
- Staff prepare meals for children based on an allocated monthly food budget. There is an additional budget line called the Additional Nutrition Budget to ensure children receive adequate nutrition and hydration. Meals are also prepared based on special requirements (e.g., children with epilepsy who need more nutrition).
- Staff follow a program schedule set for different mealtimes. For example: Pasta, Injera, and other vegetables are provided during dinner each day. Couscous, bread with marmalade, peanut, bananas are provided for breakfast.
- There are challenges in delays in funding for monthly food budgets. However, staff resolve the issue by purchasing from suppliers on credit.

Good health:

- Staff take care of hygiene of children, including washing clothes, bathing children, and cleaning the environment.
- Institution has a dedicated nurse, and if needed children are referred to a local hospital which the institution has a contract with.

Safety and security:

- Physical punishments were strictly prohibited. "*It is forbidden to beat any child. The only thing we can do is report children who do not listen to us*". – an institution staff member
- However, staff mentioned using bad language and insults and losing their temper at children who don't listen. "*They know my behaviour, I immediately get angry for any mistakes they make and will insult them for that*". - an institution staff member
- Children have safe play areas within the compounds of the institution.

Opportunities for early learning:

- Institution provides playing and learning materials, and children are enrolled in schools for five days/ week.
- There is also a private teacher assigned to a child with disability.
- Staff noted that children are not very interested in hearing stories from staff.

Responsive caregiving:

- Staff comfort children, and institution has people from overseas who respond to children's emotional needs.
- Staff acknowledged that boys have limited or no space for safe expression of their emotions and feelings.
- One of the pillars of the institution includes psych-social support, and there is provision of group, family, and personal counseling to improve children's mental health.

6. Conclusions

In this section, we first present conclusions on parenting knowledge, beliefs, practices and information that were derived from our findings. We start with overarching considerations that cross domains of the NCF, then address the elements of the NCF separately. The domains of the NCF align with programming areas used in policy frameworks. Lastly, we present conclusions based on the assessment of the existing institutional and policy environment.

Overarching considerations. Poverty and resource constraints are common barriers to adopting parenting best practices for ECD. Across domains of the NCF, these constraints affect caregivers' ability to respond adequately to their children's needs. While meeting children's needs is difficult for families in general, it is of particular concern in refugee and IDP contexts. In refugee and IDP settings, caregivers have few opportunities to earn an income, lack access to support and resources to meet their family's basic needs and face substantial life stressors that affect their caregiving practices. In addition, households in pastoralist communities in Afar experience the most constraints in terms of access to services. Distance and cultural appropriateness of services and programmes create barriers for caregivers to engage with parenting support services.

Nutrition. There is a high level of awareness of the importance of exclusive breastfeeding (89 per cent), and high prevalence of exclusive breastfeeding in the first six months (77 per cent). However, from the introduction of complementary feeding (after six months), most children's nutritional status is compromised by a lack of parental knowledge regarding nutrition (e.g., on food groups, valid sources of iron or vitamin A), combined with a lack of access to nutritious foods. Food insecurity is a major issue, with 57 per cent of caregivers reporting that they cannot give their child healthy or nutritious food due to household resource constraints and scarcity in local markets. As a result, almost none of the children (2 per cent aged 6–23 months) have a minimum acceptable diet, which is driven mostly by a lack of dietary diversity (7 per cent of children aged 6–23 months passed the standard of consuming at least five out of eight food groups). In addition, 75 per cent of caregivers who receive food assistance in camps in Gambella are dissatisfied with the quality of the food. Some of the IDPs in Amhara explained that the foods provided do not align with their normal diet, which relies heavily on the use of teff flour, and that the foods were culturally inappropriate.

Health. Caregivers are willing to access health services when it is feasible to do so and are receptive to messages about children's health from providers (as well as from family). Most families obtain health care for their child when need (e.g., 83 per cent go for treatment when the child is sick, and 83 per cent go for antenatal care). The government is the main provider of healthcare services. When caregivers do *not* engage with needed health services, this is typically due to barriers such as cost, transportation and/or distance. It is worth noting that issues of access and distance to health care are particularly acute for pastoralist communities.

While access to health care is less of a concern for most households, follow-through on some aspects of health care is an issue. For example, children's vaccination rates are relatively good overall for first doses but drop off quickly when repeated doses are needed. Incomplete vaccination is a concern because too few children are fully vaccinated to build herd immunity

against serious childhood diseases. Maternal participation rates in postnatal care are 20 percentage points lower than for prenatal care.

Childhood illnesses were widespread in the study sample, with two in five having recently experienced diarrhoea or a cough. Nearly all parents know good practices for addressing illnesses; however, about 1 in 10 engage in the potentially harmful practice of withholding liquids when children have diarrhoea.

Because childhood illness is often associated with appropriate WASH conditions, it is noteworthy that caregivers typically have clean water available (90 per cent of the households). Only 52.8 per cent of households have an improved toilet facility. Furthermore, even though caregivers follow most (but not all) of the best practices for handwashing, caregivers are less aware of the need for handwashing before feeding children (72 per cent) or after cleaning children's bottoms (43 per cent).

In terms of accessing health, nutrition and ECD information, caregivers identified healthcare professionals as their main source. Some parents said they rely on information from their family and friends and that they listen to parenting information on the radio (sometimes delivered over their phones).

Responsive caregiving. Responsive caregiving involves having a warm and supportive adult present for the child. On the positive side, mothers and fathers recognise that bonding is beneficial for children and described having warm and affectionate relationships with their children. Some fathers said they do worry that indulging children too much could make them disobedient. However, parental knowledge of normal child development is somewhat more limited (21 per cent of respondents correctly said a child can hear immediately at birth; 25 per cent said a child can see immediately after birth), which may lead to parents not being able to adequately recognise any special needs.

Relevant ministries are aware of children's psychosocial needs, and they have instituted initiatives such as play psychotherapy to serve populations that have special psychological needs, such as children in IDP communities.

Lastly, lack of supervision is a serious concern. In the week before the interview, more than one in five children under 6 years of age had been left alone, and one third had been left in the care of another child (under 10 years of age). When children are left without adult supervision, they do not have access to adult support and care and are at significantly higher risk of harm (traffic accidents, drowning, injuries, abuse from child predators).

Security and safety. Findings on security and safety comprise a broad variety of aspects, including birth registration, discipline and the ability to meet children's basic needs. Children face risks to their safety for many reasons. Caregivers recognise safety risks to children in the community (such as uncapped wells) – which is of particular concern given the prevalent lack of supervision. Caregivers warn their girls about kidnapping, gender-based abuse and sexual abuse. Government representatives and parents alike mentioned that in refugee and IDP camps, sexual assault is a concern for females. Nevertheless, there seems to be a lack of awareness (inside or outside of the camps) that boys, too, can experience sexual abuse and assault.

Across regions, almost half of the caregivers believe that corporal punishment is necessary to raise well-behaved children. These beliefs were confirmed in the high rates of negative physical and/or psychological methods to discipline children (with 6 in 10 caregivers

reporting that they use these methods). In child-serving institutions, corporal punishment is strictly forbidden; positive disciplinary approaches are prevalent.

Qualitative findings revealed harmful traditional beliefs by caregivers across regions, such as scarring gums (Afar), early marriage (Afar and Amhara) and removing a child's tooth to stop their diarrhoea (Afar). Most caregivers who are aware of FGM in their community know that it is prohibited by law.

Finally, lack of birth registration is a significant concern. Birth registration is a human right, and lack of birth registration may affect a child's ability to access services now or in the future. Only one in three children's births have been registered – and for just 7 per cent of children in Afar. Most caregivers either do not know about birth registration or do not know where or how to do it.

Opportunities for early learning. Learning and stimulation occur through informal and formal channels, including early learning at home and in preschool. At home, 70 per cent of children have an adult or older child who engages in at least some early learning activities with them. These activities include reading, singing songs, playing and counting. In most cases, the mother or another female is the caregiver. Qualitative findings showed that there is encouragement for curiosity and play, and caregivers across regions reported the use of oral storytelling traditions to teach children about their family history and culture. Most caregivers (98 per cent) are unaware of the value of reading to young children (even though 70 per cent are themselves able to read).

Most caregivers suggested that the main way to support a child's learning is by enrolling them in school and supporting them in their formal education. Caregivers' educational aspirations for their children are high, and nearly equal for girls and boys (79 per cent and 74 per cent of parents expect some tertiary education for sons and daughters, respectively). Nevertheless, only one in three children of pre-primary age attends pre-primary education, but participation varies widely by location – from a high of 4 in 5 children in Gambella to a low of just 1 in 30 children in Afar. When programming is available but children do not participate, it is typically because parents (incorrectly) believe their child is too young, or because the programming is too far away or is oversubscribed. The MoE is aware of this programming gap and has initiatives in place to serve different population, such as IDPs and pastoralists (including consideration of their unique needs).

Institutional support. Sector-specific (e.g., the National Health Sector Strategic Plan for ECD and the National Strategic Plan for Pre-Primary Education) as well as overarching policy frameworks, such as the new 2022 ECDE Policy Framework, are guiding efforts to strengthen institutional support for ECD. Yet stakeholders highlighted the need for a centralised structure of governance and cross-sectoral coordination due to the interdisciplinary nature of ECD.

National and regional government representatives from across sectors demonstrated awareness that ECD programming needs to be tailored to meet the unique needs of diverse populations. However, they recognised existing policy gaps in terms of guidance in emergencies contexts as well as reaching pastoralist communities.

7. Lessons Learnt

A few key takeaways emerged from the study findings, which can inform future policymaking and programming regarding parenting in Ethiopia and elsewhere.

Poverty is a pervasive barrier, and prevents families from being able to fully incorporate the NCF with their young children. Poverty directly affects parenting in multiple ways – for instance, when parents do not have sufficient financial resources to obtain healthy and nutritious foods, or indirectly through associated stress. In addition, parental knowledge and access to information are often associated with factors related to poverty, such as ability to read, social capital and integration into the community.

Families may be unaware of the risks of sexual abuse for boys. In this study, caregivers focused on girls when they talked about the risks of physical violence and sexual abuse in the community (or camp). Yet a 2020 study in Ethiopia found that 19 per cent of adolescent boys had experienced sexual abuse (Takele et al., 2020). Caregivers and communities may not take steps to protect boys from sexual abuse if it is viewed as a female-specific concern.

As a concept, **dietary diversity can be misunderstood by families**. Many caregivers know that dietary diversity is important for their children but do not recognise that diversity involves food *categories*. So, for example, a caregiver would think their child's diet is diverse if the child eats rice, pasta and teff, although these are all starchy foods). Given the serious issue of undernutrition in Ethiopia and in other contexts, this misunderstanding may have significant repercussions for children's well-being.

While general government commitment to ECD is essential for progress to be made, it is critical to have **the commitment of the individual ministries involved in the cross-sectoral support** of young children and families. Cross-sectoral collaboration proved to be essential to drafting the revision of the 2022 ECDE policy. Similar collaboration and coordination are required for successful implementation across sectors and levels.

8. Recommendations

To further inform the strengthening, development and harmonisation of parenting support services, in this section we highlight fourteen key recommendations based on our findings. These recommendations are aligned with the roles and responsibilities as they are described in the ECDE policy framework. Following the inputs of key stakeholders during the validation workshop we ordered the recommendations by priority (i.e. policy that is most needed in the country) and feasibility (i.e. considerations of whether the policy will be easily implemented). During the workshop, respondents used the below definitions to assess a recommendation's feasibility and priority.

Below, we provide a list of all recommendations and in the matrix (see Table 25), we provide re-categorized recommendations from (a) High Priority and High Feasibility (b) High Priority but Low Feasibility

1. **Use multiple channels to build parental knowledge concerning nutrition and to promote social behavioural changes where necessary**, using existing touchpoints for

families. These could include child- and family-serving organisations such as healthcare providers and ECDE providers as well as prominent community groups or individuals such as faith-based organisations, civil society organisations (CSO), women's organisations. Direct communication should be combined with the use of radio and other mass media communication channels already available to families to ensure a wide range of activities that will have a broad coverage in urban and rural areas. The ECDE policy framework describes the roles and responsibilities of mass media, communities and the MoWSA in awareness raising, but existing healthcare and ECDE providers should also play a role. For instance, nutrition messaging should include information on the value and sources of balanced and diverse diets for young children. Health professionals and local role models can help to promote healthier ways of cooking so that the campaigns simultaneously address the knowledge gaps on nutrition as well as potentially harmful or non-beneficial feeding practices.

2. **Provide school feeding at the ECE level** to improve children's nutrition and to encourage enrolment and attendance in ECE especially in regions with high levels of food insecurity such as the southern and southeastern pastoralist regions and Tigray. Building on existing take-home rations or school feeding in primary school may further help to address issues of access to food.
3. **Leverage ECE as a resource for building family knowledge of good ECD practices.** The government, through the MoE together with private ECDE service providers and development partners in the communities, can leverage its ECE system to increase awareness amongst caregivers across areas such as hand washing, vaccination, supervision of children, positive discipline, support for early learning, nutrition, and the important role fathers can and should play in their children's lives
4. **Hire and train para-professionals for ECDE.** ECDE para-professionals can build parental and community knowledge in the NCF domains – particularly if they are able to use home visits to reach families. For example, they can show parents how (regardless of their educational background) the family can use methods like folk songs and stories, counting, and sorting tasks to help build early learning (perhaps with the aid of simple activity cards left with parents). They can discuss nutrition with parents, and show them how they can best meet their children's nutritional needs given the foods available to the family. They can also help parents know how to keep their child safe inside and outside the home, teach parents about positive discipline, help them know best practices for children's health, understand how a warm and supportive relationship with their child will help that child grow and develop, learn about how fathers (and other male family members) can help nurture children, and encourage the family to engage in things like birth registration and ECE enrolment for the child. Finally, they can help parents know where to turn when their child has (or may have) special needs.

   These para-professionals should be part of a national network (and also ideally regional networks) where they can receive ongoing training and coaching, share best practices, get advice, and get peer support.
5. **Promote ways to make health care more affordable and/or easier to reach, given that cost of care and accessibility of health facilities are amongst the main barriers.** For instance, promising interventions include strengthening community-based health

systems, including community health workers; and working with key community leaders and members to reach male and female caregiver populations.

The MoH might consider leveraging parental coaching or information campaigns to add information on, for instance, developmental milestones or the potential harm of using physical punishment. The MoH can collaborate with communities and development partners to build on the existing infrastructure and resources such as women's groups or faith-based organisations.

Ensure that health and nutrition services for ECD are available through health extension workers or health posts for pastoralist communities and other hard to reach populations. If necessary, the MoH should focus on training health professionals to build up capacity into these communities.

Finally, there is potential for the MoH to utilise technology to improve the reach of existing health systems and to address cultural concerns. For instance, telehealth, using text messaging or voice calls may relieve pressure on the health sector, while making it easier for people to connect with someone in their own language.

6. **To increase birth registration, implement national birth registration drives, with additional outreach in remote areas.** To strengthen the awareness of these drives, we suggest using radio campaigns because parents mentioned that radio is an accessible and credible source of information. The national campaign should recruit pre- and antenatal care providers and other healthcare workers to integrate birth registration into existing platforms and to educate families on why birth registration matters and how they can complete it for their child. Justice bodies at the local level can help with awareness raising within communities to help inform parents and caregivers. Simultaneously, we recommend that CSOs and international organizations such as UNICEF continue to have conversations with the GoE on what type of documentation is needed for specific services. These organizations may use advocacy to discuss alternative methods to identifications such that no children are excluded if they do not have a birth certificate or ID.
7. In many cases, parents are not supporting their children's ECD due to lack of knowledge. **Initiate public health drives to build national awareness on issues** such as the importance of pre- and postnatal care, dietary diversity, food groups, why children need adequate nutrition, meal preparation with limited food supplied through food aid, developmental milestones, why children need to complete the full schedule of vaccinations, why adult supervision is critical for protecting the lives and well-being of young children, and how families can support early learning. These campaigns should be tailored as necessary for the diverse populations and contexts across the country.
8. **Train ECDE service providers on holistic child development, provide them with informational materials to share with parents, and design a referral system for ECD concerns.** Training should be provided to ECDE service providers in all sectors (e.g. early education, health, child protection) so that service providers can assist with awareness raising of other ECD services and can make referrals to relevant services if there are concerns about the child or family (including when a child has or may have special needs).

   Where possible also integrate ECD service provision locations, especially for services for pregnant women and children under the age of 3. For instance, providing birth

registration services in health facilities will allow parents to register after the birth or during post-natal check-ups.

Create a national guide for parents that is easy to read (including with illustrations, and local language translations) that conveys key information in a concise, practical, and user-friendly format. The information should include developmental milestones; practical tips on feeding, health, and safety; guidance on how fathers (and other male caregivers) can nurture children's growth and development; and activities that are appropriate for different ages that promote learning and development, and strengthen the parent-child bond (such as playing peek-a-boo with young infants, singing songs with toddlers, and telling stories with preschoolers). The guide should include information on how parents can register their child's birth, how they can access needed services, and how they can get help if they are having issues (such as domestic violence, difficulty parenting, or concerns about their child). It should also cover suggestions for further enhancement of parents' economic capacity to support children's needs due to its cross-cutting importance. The guide could help to promote participation in economic enhancement programs such as village saving and loans, to improve financial literacy and female economic empowerment. Finally, it is very important that the guide is tailored to the socio-cultural context of the parent (for example, in the illustrations used).

9. **Provide policy guidance on ECD service delivery in humanitarian or hard to reach contexts within Ethiopia** (e.g., refugee settings, pastoralist communities, and areas with IDPs). Regional policymakers responding to urgent needs in their localities should be supported by policy and programming documents that outline decision-making protocols, backstopping and additional support upon which they can draw, and strategic channels of coordination amidst emergencies. Such structures would clarify the roles and responsibilities for ministries, departments and other stakeholders involved, including non-governmental organisations, and it would ensure that they have the resources to continue to support ECD in emergency situations.

10. **Provide formal mechanisms for cross-sectoral coordination on ECD in refugee camps and IDP communities to improve the availability of high-quality resources for families.** Families in refugee camps and IDP communities need improved access to services and information to help them meet their children's needs. Given the multitude of actors involved in these contexts, combined with the stressors that families face in meeting their basic needs, it would be very beneficial to establish service hubs where families can go to one place and receive coordinated ECD information and supports. Service hubs may facilitate referrals and help to coordinate the simultaneous provision of services, and they could help to improve feedback or grievance systems. The latter are important so that caregivers have a low-barrier option to express concerns about quality standards of the services or cultural inappropriateness of provided services or in-kind goods.

11. When introducing and/or improving ECD programming, it is important to **anticipate the possibility of scale-up and replication if the evidence-base supports the effectiveness of the program.** Scale-up may include going deeper into the population where services already exist (for example, by encouraging enrolment in ECE amongst caregivers who believe children of pre-primary age are too young for schooling, or by providing ECE for children with disabilities in communities where they are excluded from existing services). Scale-up may involve replication of existing programming for new contexts. If planning

starts early, stakeholders can focus on gaining evidence for best practices and refining programming for new contexts while it is being developed (rather than trying to retrofit programming to new populations or contexts).

12. Related to the previous recommendation, there is a need for **the evaluation of existing programmes to assess their effectiveness and fidelity of implementation**. In addition, the design and implementation of ECD programmes should incorporate a **reliable M&E framework**, which allows for continuous monitoring of programme implementation. The existence of frequently updated monitoring data will help to understand, which programmes are effective successful in providing ECD services to parents and caregivers and therefore reaches the intended population.
    Programme evaluation and monitoring reports on ECD programmes and services should be collected in a publicly available repository, such that implementers can assess lessons learnt from the design and implementation process.
13. While poverty reduction is beyond the scope of the ECDE framework, collaboration with ministries such as the Ministry of Women and Social Affairs (MoWSA) is needed to address the resource constraints that many caregivers experience**.** We recommend that **parents of children below age six living with low financial resources are included in existing social protection programmes, especially those that aim at female empowerment**. Increasing women's financial agency can simultaneously help to increase financial resources in the household as well as ensuring that these resources will be spent on the children's well-being. Income generating activities may consists of community and environmental improvement projects, such as programmes that provide a small income in exchange for environmental cleaning or planting of trees, so that they jointly benefit the community and the households with young children.
14. **Cross-sectoral coordination will be key to the successful implementation of integrated ECDE policies**. While the current study had a limited focus on the implementation side, further research is needed to identify barriers for cross-sectoral collaboration at each level to understand whether there are human resource or financial constraints, a lack of clarity on responsibilities, misalignment of goals, etc. The high-level policy committee consisting of MoE, MoH and MoWSA has an important role to highlight opportunities for collaboration once each of the respective ministries have developed their ECDE/ECD strategies and implementation plans. The committee should focus on alignment of goals, target populations, relevant age-groups, timelines and avoidance of duplication. For every identified opportunity of collaboration, the committee should select focal points. They should develop targets to measure the level of integration to allow for frequent monitoring at regular national and regional level ECD meetings.

Table 25. Matrix of Recommendations categorized by priority and feasibility

FEASIBILITY		PRIORITY	
		High Priority	Medium Priority
	High Feasibility	**Recommendation 1. Use multiple channels to build parental knowledge concerning nutrition and to promote social behavioural changes where necessary**, using existing touchpoints for families. **Recommendation 3. Leverage ECE as a resource for building family knowledge of good ECD practices**. The government with private ECDE service providers and development partners can leverage its ECE system to increase awareness amongst caregivers across areas such as hand washing, vaccination, supervision of children, positive discipline, support for early learning, and nutrition. **Recommendation 4. Training and have para-professionals for Early Childhood Education and Development (ECED).** ECED para-professionals will serve as community and parental trainers to increase the parental understanding of the importance of early learning within the household environment and spark the engagement in learning activities. **Recommendation 5b and 5d. Promote ways to make health care more affordable and/or easier to reach:** (b) The MoH might consider **leveraging parental coaching** or information campaigns to add information on, for instance, developmental milestones or the potential harm of using physical punishment. (d) Finally, there is potential for the MoH **to utilise technology to improve the reach of existing health systems** and to address cultural concerns. **Recommendation 7**. In many cases, parents are not supporting their children's ECD due to lack of knowledge. **Initiate public health drives to build national awareness** on issues such as the importance of pre- and postnatal care, dietary diversity and nutrition, developmental milestones, vaccination schedules, why adult supervision, support for early learning. **Recommendation 9. Provide policy guidance on ECD service delivery in humanitarian and hard-to-reach contexts within Ethiopia** (e.g., refugee settings, pastoralist communities, and areas with IDP areas). Regional policymakers responding to urgent needs in their localities should be supported by policy and programming documents.	
	Med Feasibility	**Recommendation 5a. Promote ways to make health care more affordable and/or easier to reach:** For instance, promising interventions include **strengthening community-based health systems**, including community health workers; and working with key community leaders and	**Recommendation 8. Train ECDE service providers on holistic child development and design a referral system for ECD concerns.** Training should be provided to ECDE service providers in all sectors (e.g. early

		members to reach male and female caregiver populations. **Recommendation 13.** While poverty reduction is beyond the scope of the ECDE framework, collaboration with the MoWSA is needed to address the resource constraints that many caregivers experience**.** We recommend that **parents of children below age six living with low financial resources are included in existing social protection programmes, especially those that aim at female empowerment**. **Recommendation 14: Improve cross-sectoral coordination for implementation of ECD policies across various levels**, by identifying collaboration opportunities and creating integration targets.	education, health, child protection) so that service providers can assist with awareness raising of other ECD services and can make referrals to relevant services if there are concerns that require a cross-sectoral response.
	Low Feasibility	**Recommendation 2. Provide school feeding at the ECE level** to improve children's nutrition and to encourage enrolment and attendance in ECE especially in regions with high levels of food. **Recommendation 5c. Promote ways to make health care more affordable and/or easier to reach: Ensure that health and nutrition services for ECD are available through health extension workers or health posts** for pastoralist communities and other hard to reach populations. **Recommendation 6. To increase birth registration, implement national birth registration drives, with additional outreach in remote areas**. **Recommendation 10. Provide formal mechanisms for cross-sectoral coordination on ECD in refugee camps and IDP communities to improve the availability of high-quality resources for families.** **Recommendation 11.** When introducing and/or improving ECD programming, it is important to **anticipate the possibility of scale-up and replication if the evidence-base supports the effectiveness of the program.** **Recommendation 12.** There is a need for **the evaluation of existing programmes to assess their effectiveness and fidelity of implementation**. In addition, the design and implementation of ECD programmes should incorporate a **reliable M&E framework**, which allows for continuous monitoring of programme implementation.	

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Annexes

Annex A. Additional Findings

Table A1. Responses for Food that Are Rich in Vitamin A

	Percentage of Respondents (n=1,034)
Eggs	42.0
Green Vegetables	37.9
Meat	37.8
Breastmilk	29.4
Beans/peas	25.0
Don't Know	23.7
Commercially Fortified Foods	16.2
Teff	12.0
Other	3.7
Fruits	1.9
Cereal	1.1

Table A2. Knowledge about Nutrition by Region

	Total	Amhara	Oromia	Afar	Amhara (IDP)	Gambella
Correct Knowledge of Time After Birth a Baby Should Be Put to Breast	89.8%	95.2%	65.1%	96.6%	94.1%	99.0%
Correct Knowledge of Age Until Which a Baby Should Be Exclusively Breastfed	89.3%	87.1%	78.8%	95.7%	91.7%	93.5%
Correct Knowledge of Age At Which a Baby Can Receive Liquid Other Than Breastmilk	73.4%	81.0%	69.3%	93.7%	72.5%	49.8%
Correct Knowledge of Age At Which a Baby Can Receive Food Other Than Breastmilk	63.4%	48.6%	89.2%	86.0%	57.4%	34.8%
Knows at least one source of iron	59.1%	65.2%	83.5%	45.4%	43.6%	56.7%
Identifies only correct sources of iron	42.6%	48.1%	63.2%	34.8%	33.3%	32.3%
Knows at least one source of Vitamin A	70.7%	71.0%	96.2%	63.8%	58.3%	63.2%
Identifies all sources of Vitamin A correctly	47.4%	35.7%	76.9%	43.5%	37.7%	42.3%
Knowledge about Minimum dietary diversity: child is expected to eat at least 4 food groups out of 7	42.6%	66.2%	27.8%	52.2%	23.5%	43.3%
Observations	1034	210	212	207	204	201

Table A3. Knowledge about Nutrition by Caregiver's Educational Level

	Caregiver has no or lower than primary education	Caregiver has finished primary education or higher	Difference	P-value
Correct Knowledge of Time After Birth a Baby Should Be Put to Breast	89.0%	92.1%	-0.03	0.14
Correct Knowledge of Age Until Which a Baby Should Be Exclusively Breastfed	89.1%	89.6%	-0.00	0.84
Correct Knowledge of Age At Which a Baby Can Receive Liquid Other Than Breastmilk	71.9%	77.7%	-0.06	0.06
Correct Knowledge of Age At Which a Baby Can Receive Food Other Than Breastmilk	63.8%	62.6%	0.01	0.72
Knows at least one source of iron	52.5%	77.3%	-0.25***	0.00
Identifies only correct sources of iron	38.7%	53.2%	-0.15***	0.00
Knows at least one source of Vitamin A	65.0%	86.3%	-0.21***	0.00
Identifies all sources of Vitamin A correctly	43.8%	57.2%	-0.13***	0.00
Knowledge about Minimum dietary diversity: child is expected to eat at least 4 food groups out of 7	37.7%	56.5%	-0.19***	0.00

Table A4. Knowledge about Health by Region

	Total	Amhara	Oromia	Afar	Amhara (IDP)	Gambella
Knows good practices what to do when a child has diarrhoea	87.1%	83.3%	78.3%	77.8%	99.0%	98.0%
Knows harmful practices what to do when a child has diarrhoea	7.7%	3.3%	29.7%	1.0%	1.0%	3.0%
Knows practices which are neither good or bad on what to do when a child has diarrhoea	26.3%	25.7%	36.8%	53.6%	4.4%	10.0%
Knowledge That You Should Wash Your Hands Before Food Preparation	82.1%	78.1%	87.3%	87.4%	78.9%	78.6%
Knowledge That You Should Wash Your Hands Before Eating	87.6%	89.5%	92.0%	85.0%	95.6%	75.6%
Knowledge That You Should Wash Your Hands Before Feeding Children	72.3%	61.0%	92.5%	82.1%	67.2%	58.2%
Knowledge That You Should Wash Your Hands After Defecation	85.9%	86.2%	84.9%	99.0%	79.4%	79.6%
Knowledge That You Should Wash Your Hands After Cleaning A Baby's Bottom	43.3%	24.8%	71.7%	54.1%	15.7%	49.8%
Observations	1034	210	212	207	204	201

Table A5. Knowledge about Health by Caregiver's Educational Level

	Caregiver has no or lower than primary education	Caregiver has finished primary education or higher	Difference	P-value
Knows good practices what to do when a child has diarrhoea	86.1%	89.9%	-0.04	0.10
Knows harmful practices what to do when a child has diarrhoea	7.7%	7.9%	-0.00	0.91
Knows practices which are neither good or bad on what to do when a child has diarrhoea	26.7%	25.2%	0.01	0.63
Knowledge That You Should Wash Your Hands Before Food Preparation	79.3%	89.9%	-0.11***	0.00
Knowledge That You Should Wash Your Hands Before Eating	87.3%	88.5%	-0.01	0.60
Knowledge That You Should Wash Your Hands Before Feeding Children	69.5%	80.2%	-0.11***	0.00

Knowledge That You Should Wash Your Hands After Defecation	83.4%	92.4%	-0.09***	0.00
Knowledge That You Should Wash Your Hands After Cleaning A Baby's Bottom	39.8%	52.9%	-0.13***	0.00

Table A6. Knowledge about Safety and Security by Region

	Total	Amhara	Oromia	Afar	Amhara (IDP)	Gambella
Belief that Child Needs to be Physically Punished for Proper Raising	47.9%	37.6%	8.5%	76.0%	75.0%	44.3%
Belief that a Child Needs to Be Spanked On the Bottom	23.2%	13.3%	4.7%	36.7%	48.5%	13.4%
Belief that a Child Needs to be Hit on Other Body Parts With Bare Hands	11.5%	4.8%	2.8%	28.5%	15.7%	6.0%
Belief that a Child Needs to be Spanked/Hit With an Implement	18.0%	15.2%	2.4%	22.2%	16.7%	34.3%
Belief that a Child Needs to be Pinched	31.4%	34.8%	3.8%	55.6%	55.4%	8.0%
Belief that a Child Should Be Burned	0.3%	0.5%	0.0%	0.5%	0.5%	0.0%
Belief that a Child Should Have Arms/Legs Tied Together	0.3%	1.0%	0.0%	0.0%	0.5%	0.0%
Observations	1034	210	212	207	204	201

Table A7. Knowledge about Safety and Security by Caregiver's Educational Level

	Caregiver has no or lower than primary education	Caregiver has finished primary education or higher	Difference	P-value
Belief that Child Needs to be Physically Punished for Proper Raising	53.7%	31.8%	0.22***	0.00
Belief that a Child Needs to Be Spanked On the Bottom	27.6%	11.5%	0.16***	0.00
Belief that a Child Needs to be Hit on Other Body Parts With Bare Hands	13.4%	6.5%	0.07**	0.00
Belief that a Child Needs to be Spanked/Hit With an Implement	20.8%	9.7%	0.11***	0.00
Belief that a Child Needs to be Pinched	34.2%	23.7%	0.10**	0.00
Belief that a Child Should Be Burned	0.3%	0.4%	-0.00	0.80
Belief that a Child Should Have Arms/Legs Tied Together	0.4%	0.0%	0.00	0.29

Table A8. Knowledge about Learning by Region

	Total	Amhara	Oromia	Afar	Amhara (IDP)	Gambella
Should read to child older than 48 months	65.0%	58.1%	34.9%	82.6%	88.7%	61.7%
Expect a Daughter to Complete Primary School	2.5%	0.5%	0.9%	0.0%	5.4%	6.0%
Expect a Daughter to Complete Some Secondary School	3.8%	1.4%	1.4%	1.9%	7.4%	7.0%
Expect a Daughter to Complete Secondary School	19.2%	1.4%	34.9%	13.5%	33.8%	12.4%
Expect a Daughter to Complete Any Tertiary School	73.5%	96.7%	61.8%	84.5%	53.4%	70.6%
Expect a Son to Complete Primary School	0.7%	0.0%	0.5%	0.0%	1.0%	2.0%
Expect a Son to Complete Some Secondary School	1.0%	0.0%	0.9%	0.0%	1.5%	2.5%
Expect a Son to Complete Secondary School	18.8%	1.0%	29.2%	15.0%	32.8%	15.9%

Expect a Son to Complete Any Tertiary School	79.0%	99.0%	68.9%	85.0%	64.7%	77.1%
Observations	1034	210	212	207	204	201

Table A9. Knowledge about Learning by Caregiver's Educational Level

	Caregiver has no or lower than primary education	Caregiver has finished primary education or higher	Difference	P-value
Should read to child older than 48 months	69.2%	53.6%	0.16***	0.00
Expect a Daughter to Complete Primary School	2.9%	1.4%	0.01	0.18
Expect a Daughter to Complete Some Secondary School	4.9%	0.7%	0.04**	0.00
Expect a Daughter to Complete Secondary School	23.6%	7.6%	0.16***	0.00
Expect a Daughter to Complete Any Tertiary School	67.2%	90.3%	-0.23***	0.00
Expect a Son to Complete Primary School	0.9%	0.0%	0.01	0.11
Expect a Son to Complete Some Secondary School	1.3%	0.0%	0.01	0.05
Expect a Son to Complete Secondary School	22.9%	7.6%	0.15***	0.00
Expect a Son to Complete Any Tertiary School	74.1%	92.1%	-0.18***	0.00

Table A10. Practices in Nutrition by Region

	Total	Amhara	Oromia	Afar	Amhara (IDP)	Gambella
Infant and young child feeding						
Child Was to Breast Immediately After Birth	75.4%	72.9%	66.5%	82.6%	70.6%	85.1%
Baby Was Given Something to Drink Other Than Breastmilk In the First Three Days	7.6%	6.7%	6.1%	9.7%	15.3%	0.5%
Child was exclusively breastfed under 6 months	77.5%	88.1%	64.2%	67.1%	70.1%	98.5%
Child Achieved Minimum dietary diversity yesterday (at least 5 food groups out o	6.7%	7.4%	16.0%	6.0%	0.0%	6.9%
Child Has Achieved Minimum Meal Frequency	43.6%	58.8%	34.0%	22.4%	58.8%	37.9%
Child has minimum acceptable diet	2.5%	5.9%	6.0%	0.0%	0.0%	0.0%
Food Security						
Worried about not having enough food to eat	48.3%	11.0%	57.1%	25.1%	51.0%	99.0%
Unable to eat healthy and nutritious food	60.8%	24.8%	58.5%	50.7%	72.5%	99.5%
Household members ate fewer kinds of food	67.8%	28.6%	57.5%	58.0%	97.5%	99.5%
Household members skipped a meal	45.6%	13.8%	42.5%	26.6%	48.0%	99.0%
Household members ate less than you thought you should	50.5%	15.7%	42.9%	30.4%	66.2%	99.5%
Household ran out of food	31.8%	5.2%	25.9%	20.8%	10.3%	99.0%
Household members were hungry but could not eat	31.4%	4.3%	27.8%	17.4%	10.3%	99.5%
Household members did not eat for a whole day	26.1%	1.4%	20.8%	9.2%	2.5%	99.0%
Child younger than 7 years did not eat healthy and nutritious food	56.6%	22.9%	54.2%	44.4%	63.7%	99.5%
Child younger than 7 years did not eat enough food	46.2%	9.0%	55.7%	20.3%	48.5%	99.5%
Observations	1034	210	212	207	204	201

Table A11. Practices in Nutrition by Caregiver's Educational Level

	Caregiver has no or lower than primary education	Caregiver has finished primary education or higher	Difference	P-value
Infant and young child feeding				
Child Was to Breast Immediately After Birth	73.6%	80.6%	-0.07*	0.02
Baby Was Given Something to Drink Other Than Breastmilk In the First Three Days	7.8%	7.2%	0.01	0.73
Exclusive breastfeeding for first 6 months	76.0%	81.3%	-0.05	0.07
Child Achieved Minimum dietary diversity yesterday (at least 5 food groups out o	5.3%	9.5%	-0.04	0.19
Child Has Achieved Minimum Meal Frequency	47.6%	35.8%	0.12	0.06
Child has minimum acceptable diet	1.6%	4.2%	-0.03	0.18
Food security				
Worried about not having enough food to eat	54.8%	30.2%	0.25***	0.00
Unable to eat healthy and nutritious food	68.8%	38.8%	0.30***	0.00
Household members ate fewer kinds of food	75.7%	46.0%	0.30***	0.00
Household members skipped a meal	51.3%	29.5%	0.22***	0.00
Household members ate less than you thought you should	57.7%	30.6%	0.27***	0.00
Household ran out of food	34.9%	23.0%	0.12***	0.00
Household members were hungry but could not eat	35.1%	20.9%	0.14***	0.00
Household members did not eat for a whole day	29.2%	17.3%	0.12***	0.00
Child younger than 7 years did not eat healthy and nutritious food	64.3%	35.3%	0.29***	0.00
Child younger than 7 years did not eat enough food	52.1%	29.9%	0.22***	0.00

Table A12. Practices in Health by Region

	Total	Amhara	Oromia	Afar	Amhara (IDP)	Gambella
Received Antenatal Care for last child	83.1%	91.4%	73.6%	83.0%	71.4%	96.5%
Went for post-natal check-up	60.7%	67.1%	54.2%	68.1%	18.6%	96.0%
Child had any serious illness in the last two weeks	39.3%	26.2%	22.2%	47.8%	43.1%	58.2%
Did not seek treatment when child was sick	16.7%	58.2%	4.3%	31.3%	1.1%	1.7%
Used a treated mosquito net last night	18.1%	13.3%	4.2%	33.3%	15.2%	24.9%
Received Vitamin A dose	40.0%	65.3%	57.4%	24.0%	22.0%	31.9%
Received deworming medication	35.3%	57.7%	43.2%	21.6%	24.6%	29.8%
Polio vaccine 3rd dose	58.0%	47.8%	82.9%	80.9%	49.5%	27.8%
PENTA vaccine 3rd dose	58.1%	53.7%	81.4%	79.9%	54.6%	19.6%
Pneumococcal vaccine 3rd dose	62.3%	63.4%	78.4%	77.0%	59.3%	32.5%
Water and sanitation						
Household has improved drinking water source	89.7%	92.4%	67.5%	92.3%	100.0%	97.0%
Household has improved latrine	52.3%	90.5%	42.0%	43.5%	61.3%	23.4%
Observations	1034	210	212	207	204	201

Table A13. Practices in Health by Caregiver's Educational Level

	Caregiver has no or lower than primary education	Caregiver has finished primary education or higher	Difference	P-value
Received Antenatal Care for last child	79.0%	94.6%	-0.16***	0.00
Went for post-natal check-up	55.7%	74.1%	-0.18***	0.00
Child had any serious illness in the last two weeks	41.0%	34.9%	0.06	0.08
Did not seek treatment when child was sick	15.9%	19.6%	-0.04	0.39
Used a treated mosquito net last night	17.9%	18.7%	-0.01	0.77
Received Vitamin A dose	34.3%	56.5%	-0.22***	0.00
Received deworming medication	31.2%	47.1%	-0.16***	0.00
Polio vaccine 3rd dose	55.8%	64.4%	-0.09*	0.01
PENTA vaccine 3rd dose	56.4%	63.3%	-0.07*	0.05
Pneumococcal vaccine 3rd dose	60.1%	68.9%	-0.09*	0.01
Water and sanitation				
Household has improved drinking water source	88.3%	93.2%	-0.05*	0.02
Household has improved latrine	47.5%	65.1%	-0.18***	0.00

Table A14. Practices in Safety and Security by Region

	Total	Amhara	Oromia	Afar	Amhara (IDP)	Gambella
Left child alone for more than 1 hour in past week	22.0%	2.4%	53.8%	21.3%	25.5%	6.0%
Left child in care of another child in past week	29.5%	19.0%	60.8%	28.5%	21.1%	16.9%
Any psychological aggression	43.0%	30.0%	20.3%	48.8%	58.3%	59.2%
Any physical punishment	54.3%	42.9%	43.9%	63.8%	53.4%	68.2%
Any violent discipline (psychological + physical)	59.4%	50.0%	45.8%	66.2%	66.2%	69.7%
Any non-violent discipline	77.4%	77.6%	50.9%	83.1%	89.2%	87.1%
Only non-violent discipline used	22.1%	33.3%	12.7%	19.3%	27.0%	18.4%
	1034	210	212	207	204	201

Table A15. Practices in Safety and Security by Caregiver's Educational Level

	Caregiver has no or lower than primary education	Caregiver has finished primary education or higher	Difference	P-value
Left child alone for more than 1 hour in past week	24.3%	15.8%	0.08**	0.00
Left child in care of another child in past week	32.5%	21.6%	0.11***	0.00
Any psychological aggression	45.8%	35.6%	0.10**	0.00
Any physical punishment	55.6%	50.4%	0.05	0.14
Any violent discipline (psychological + physical)	61.1%	54.3%	0.07*	0.05
Any non-violent discipline	77.7%	76.3%	0.01	0.62
Only non-violent discipline used	21.1%	25.2%	-0.04	0.16

Table A16. Practices in Safety and Security by Caregiver's Stress and Agency Levels

	Caregiver with low stress	Caregiver with high stress	Difference	P-value	Caregiver with high agency	Caregiver with low agency	Difference	P-value
Left child alone for more than 1 hour in past week	20.6%	28.9%	-0.08*	0.02	21.3%	25.1%	-0.04	0.26
Left child in care of another child in past week	30.6%	23.5%	0.07	0.06	29.2%	30.9%	-0.02	0.67
Any psychological aggression	40.3%	57.2%	-0.17***	0.00	40.9%	53.7%	-0.13**	0.00
Any physical punishment	53.3%	59.0%	-0.06	0.18	51.2%	69.1%	-0.18***	0.00
Any violent discipline (psychological + physical)	57.5%	69.3%	-0.12**	0.00	56.5%	73.7%	-0.17***	0.00
Any non-violent discipline	75.2%	88.6%	-0.13***	0.00	75.9%	84.6%	-0.09*	0.01
Only non-violent discipline used	21.8%	24.1%	-0.02	0.51	23.5%	15.4%	0.08*	0.02

Note: High stress is defined as 25-points or more on the Cohen scale; low agency is defined as 10 points or less on the self-efficacy scale.

Table A17. Percentage of Early Education Attendance, by Region

	Amhara	Oromia	Afar	Amhara (IDP)	Gambella
Child has attended any type of preschool	48.2	25.8	55.5	37.6	92.6
Child has attended O-Class	7.2	4.4	46.9	31.0	58.8
Child has attended kindergarten	41.0	21.4	8.6	6.6	29.5
Child has attended mobile school	0.0	0.0	0.0	0.0	4.3
Child 3-6 is Currently Attending Preschool	38.5	29.3	22.0	32.9	81.9
Child has attended any type of preschool	39.3	30.4	28.8	40.7	84.7

Table A18. Learning Activities between Child and Adult Household Members (Older than 15 Years of Age)

Family Member	Any Interaction	Reading	Stories	Songs	Walk	Play	Count
Mother	70%	5.8%	22.1%	35.5%	47.7%	47.7%	42.3%
Father	31.5%	4.4%	10.5%	10.6%	22.7%	15.7%	13.9%
Sibling	9.6%	1.3%	1.1%	2.5%	4.2%	6.9%	4.7%
Other	4.7%	0.7%	0.7%	0.9%	1.5%	1.6%	3.5%
No One	21.2%	90.3%	71.8%	59.1%	39.8%	40.6%	47.7%

Table A19. Learning Activities by Region

	Total	Amhara	Oromia	Afar	Amhara (IDP)	Gambella
Any learning interactions: with mother	70.0%	48.6%	92.5%	58.0%	58.3%	93.0%
Any learning interactions: with father	31.5%	27.1%	64.2%	29.0%	19.1%	16.9%

Any learning interactions: with sibling	9.6%	21.0%	1.4%	9.2%	10.3%	6.0%
Any learning interactions: total	78.4%	65.7%	94.8%	69.1%	68.1%	94.5%
Observations	1034					

Table A20. Learning Activities by Caregiver's Educational Level

	Caregiver has no or lower than primary education	Caregiver has finished primary education or higher	Difference	P-value
Any learning interactions: with mother	66.8%	78.4%	-0.12***	0.00
Any learning interactions: with father	28.2%	40.6%	-0.12***	0.00
Any learning interactions: with sibling	9.0%	11.2%	-0.02	0.30
Any learning interactions: total	75.2%	87.1%	-0.12***	0.00
Child has attended any type of preschool	53.3%	74.7%	-0.21***	0.00
Child 4-6 is currently attending preschool	46.6%	71.0%	-0.24***	0.00

Table A21. Learning Activities by Caregiver's Stress and Agency Levels

	Caregiver with low stress	Caregiver with high stress	Difference	P-value	Caregiver with high agency	Caregiver with low agency	Difference	P-value
Any learning interactions: with mother	72.1%	59.0%	0.13***	0.00	68.7%	76.6%	-0.08*	0.04
Any learning interactions: with father	34.8%	14.5%	0.20***	0.00	31.5%	31.4%	0.00	0.98
Any learning interactions: with sibling	8.4%	15.7%	-0.07**	0.00	9.9%	8.0%	0.02	0.44
Any learning interactions: total	80.0%	70.5%	0.09**	0.01	77.1%	85.1%	-0.08*	0.02
Child has attended any type of preschool	61.0%	35.9%	0.25***	0.00	57.2%	56.4%	0.01	0.74
Child 4-6 is currently attending preschool	53.8%	40.2%	0.14**	0.01	51.9%	50.7%	0.01	0.81

Note: High stress is defined as 25-points or more on the Cohen scale; low agency is defined as 10 points or less on the self-efficacy scale.

Table A22. Percentage of Service Utilisation, by Service and Region

	Amhara	Oromia	Afar	Amhara (IDP)	Gambella
Community health services or health programmes	84.3	95.3	24.6	72.5	93.5
Cash transfer programmes	0.5	0.5	0.0	0.5	0.0
Kindergarten or preschool services	29.0	15.1	2.9	25.0	87.6
Food assistance or school feeding programmes	0.0	5.2	32.4	77.9	98.0

Income generation services or programmes	2.9	0.9	0.0	0.0	13.9
Water or sanitation programmes	11.4	0.9	9.7	47.1	94.5
Social welfare or psychological support programmes	0.5	6.1	0.0	15.2	30.3
Education or school support programmes	1.9	16.5	20.3	23.5	97.0
Youth services or activities	2.9	0.9	0.0	1.5	44.8
Did not use any services or programmes	12.4	0.9	10.1	2.0	0.5
Observations	*210*	*212*	*207*	*204*	*201*

Annex B. Research Matrix

Sub-questions	Concept to be measured (indicators)
RQ 1. What are parents'/caregivers' aspirations, expectations, beliefs, attitudes and knowledge regarding their young children's development?	
1a. What knowledge do parents/caregivers have about ECD and key developmental milestones for young children? (knowledge)	Knowledge about infant and young child feeding (IYCF)
	Knowledge about health emergencies
	Knowledge about water, sanitation and hygiene (WASH)
	Knowledge about developmental milestones
	Parents'/caregivers' perceptions about important components of ECD
1b. What common beliefs do parents/caregivers hold about ECD? (beliefs)	Attitudes towards child discipline
	Decision making about the children's care (i.e., when to start education, when to go to a doctor, spending)
	Parents' and caregivers' reported beliefs about parenting and young children's development
1c. How do parents/caregivers see their role in the development of a young child? (aspirations)	Educational aspirations for the children
	Parent/caregiver perceptions of and aspirations for their role in development of children
RQ 2. What are the parenting practices that parents/caregivers engage in with their children?	
2a. What are the parenting practices of parents/caregivers concerning areas of nutrition, health, WASH for babies, protection, early stimulation and early learning, and responsive caregiving?	Infant and young child feeding (IYCF) and breastfeeding practices
	Antenatal care practices
	Preventive care and care practices when sick
	WASH facilities and hygiene
	Child discipline practices
	Parent-child interaction
	Participation in early childhood care and education (ECCE) programming
	Leaving a child unattended
	Reported practices by parents/caregivers, community leaders and service providers across different domains of caregiving
2b. What are the parenting practices of parents/caregivers concerning gender socialisation?	Male and female caregiver involvement in caregiving and early stimulation
	Educational aspirations for boys and girls
	Attitudes about and reported practices of gendered childrearing
RQ 3. What are parents'/caregivers' sources of information, guidance and support on parenting young children?	
3a. What are considered sources of information about parenting/caregiving for young children?	Sources of information on nutrition, health care, early education, parenting
	Access to radio, TV, phone, internet
	Reported sources of information by parents/caregivers, service providers, community leaders

Sub-questions	Concept to be measured (indicators)
3b. How do parents/caregivers evaluate the trustworthiness of information about parenting/ caregiving?	Criteria for trustworthiness of information about parenting as described by parents/caregivers, service providers, community leaders
3c. How do parents/caregivers navigate situations for which they lack information about the best course of action?	Reported practices by parents/caregivers
RQ4. What is the availability, accessibility, acceptability, affordability, contextual appropriateness, quality and perceived effectiveness of services for young children and families?	
4a. What is the availability of services for young children and families?	Parents'/caregivers' awareness of services for health, nutrition, early childhood, early education/stimulation, parenting support
	Reported availability of services in health/nutrition, early childhood education/early stimulation, and parenting support by policymakers, service providers, community leaders, and parents/caregivers
	Reported available services on ECD
4b. What is the perceived accessibility, acceptability and contextual appropriateness of these services?	Parents'/caregivers' usage of services for health, nutrition, early childhood, early education/stimulation, parenting support
	Parents'/caregivers' reasons for not using a given service
	Parents'/caregivers' understanding of providers of service (if used)
	Perceptions of accessibility, acceptability and contextual appropriateness of services by parents/caregivers, service providers, community leaders, policymakers
4c. What is the perceived affordability of services for young children and families?	Parents'/caregivers' reasons for not using a given service (including financial reasons)
	Perceptions of affordability of services by caregivers, community leaders, service providers
4d. What is the perceived quality of services for young children and families?	Parents'/caregivers' reasons for not using a given service (i.e., including financial reasons)
	Parents'/caregivers' satisfaction with the quality of the service
	Perceived quality of services by parents/caregivers, service providers, community leaders, policymakers
4e. What is the perceived effectiveness of services for young children and families?	Parents'/caregivers' satisfaction with the service
	Perceived effectiveness of services by caregivers, community leaders, service providers, policymakers
RQ 5. What factors prevent parents/caregivers from implementing ECD best practices in parenting?	
5a. To what extent are parents aware of ECD best practices in parenting?	Awareness of ECD best practices by parents/caregivers, community leaders, service providers
5b. To what extent do parents'/caregivers' aspirations and trusted sources of information about parenting align with ECD best practices in parenting?	Alignment of parents'/caregivers' aspirations with ECD best practices
5c. What alternative parenting practices have parents adopted?	Reported practices by parents/caregivers

Sub-questions	Concept to be measured (indicators)
5d. What are barriers or influencing factors that affect parents/caregivers parenting practices?	Barriers to seeking health care when needed
	Reasons for parents'/caregivers' not giving the food they would like to give to their children
	Barriers to attending early education
	Perceived barriers to access or implementation of ECD best practices by parents/caregivers
RQ6. What is the understanding of policymakers and service providers at the federal and sub-national levels regarding parenting for ECD and parents'/caregivers' need for support?	
[No sub-question]	Perceived needs for ECD support of parents/caregivers in study areas by policymakers and service providers
RQ7. What are the institutional arrangements to support parents/caregivers for ECD in different sectors?	
[No sub-question]	ECD across sectors according to policymakers
	Implemented or planned ECD policies/programmes

Annex C. Survey Instrument

ETHIOPIA
PARENTING FOR ECD STUDY
PARENT/CAREGIVER SURVEY

HOUSEHOLD INSTRUMENT

2022

First Draft

Order of modules is illustrative and can be programmed in CAPI in a different sequence.

SECTION 0. COVERSHEET ETHIOPIA CHILD WELLBEING HOUSEHOLD BASELINE SURVEY

0. METADATA

1 Date of interview |___|___| - |___|___| - |___|___|

2 Time start (MM:HH) |___|___| : |___|___| 24-hour clock

Household ID |___|___|___|___|

3 Time end interview |___|___| : |___|___| 24-hour clock

4 Kebele _____ |___|___|

5 Woreda _____ |___|___|

6 Province _____ |___|___|___|

7 Name of mother/ caregiver and PID _____ |___|___|

8 Language used by respondent |___|
Amharic.....1
Oromo……..2
English 3

9 Interpreter used? Yes 1
No 2

10 Enumerator name and code _____ |___|___|

11 Supervisor name and code _____ |___|___|

GPS coordinates

12a Latitude N |___||___||___|.|___||___||___||___||___|

12b Longitude E |___||___||___|.|___||___||___||___||___|

13 Contact number 1 |___||___||___||___||___||___||___||___||___|

14 Contact number 2 |___||___||___||___||___||___||___||___||___|

LAST ITEMS AFTER INTERVIEW (programmed at end of the CAPI)

X. Response status |___|
Complete interview.....1
Partially complete (reason:_____) 2
Non-contact.....3
Refusal 4
Child not in qualifying age range.....5
Child temporary resident in household 6
Other (specify:_____) 7

Xa. Overall Comments/Observations (If refused, give reasons for refusal)

SECTION 0A. INFORMED CONSENT (CAREGIVER & HOUSEHOLD)

The informed consent is administered to all main respondents (primary female or male caregivers of the index child age 0-6 years). In the case the primary female or male respondent is a legal minor (<18 years), the informed consent is administered to their legal guardian and (s)he is administered the assent form. In the case no primary caregiver is available, or another member of the household is expected to be the primary respondent for household-level modules, the informed consent is also administered to this member.

[ENUMERATOR: READ SCRIPT BELOW]

Hello. My name is _____ from WAAS International based in Addis Ababa. We are doing a study to understand how parents raise their children and what people like you think about how children should be raised. We are also interested in the help parents or caregivers like yourself get from different people and groups like the government or church. Because you have a young child under the age of 6, you are selected to answer our questions. We would like you to answer questions about health, school, food, learning at home, and discipline for your children. This includes [name of the index child].

The answers you give will help the Government of Ethiopia as well as other groups such as UNICEF to understand how people like you live and what you need to live better. We will use the answers to improve the services for parents like you with young children. About 1,000 families will answer questions for this study like you in Amhara, Afar, Gambella and Oromia.

I want to be clear that you will not get a gift for answering our questions. If you do not agree to take part in the study, it will not change any services or benefits you or your family receive. This is true today and will be true in the future. If you agree to take part in the study, you can stop at any time and do not need to have an excuse. This will not hurt you in any way. Some of the questions may make you feel uncomfortable. Please know that you do not have to answer any question you do not want to answer. If you tell me that you do not want to answer a question I will move on to the next one. We will not share your answers with anyone in your family or village/town/city. Only the people doing the study in Addis Ababa and the U.S. will be able to see your answers. They will take your name off your answers so they will not know who you are and will store the answers in a safe place.

The questions may take up to 1.5 hours of your time. We will leave a card that you can call after you give your answers about the study and people you can talk to if you have any question about it. Also, after we talk we may give you information about services that can help you to raise your child in a healthy way, like a health or social service. This may help you in the future. If we find that you or a child in your house are in harm or danger, the law says that we will need to refer you to these services.

Do you agree to participate?

Signature of Enumerator_____ Date_____

Enumerator: Sign above to witness the verbal consent of the participant. Keep one copy for the PIs records and leave the second copy with the participant.

Who is sponsoring this study?

This research is funded by UNICEF Ethiopia (the Sponsors). This means that the research team is being paid by the Sponsors for doing the study. If you have questions about this study, you may contact Dalberg/WAAS field manager (Tel:) or (Tel:) at Dalberg Research. If you have questions about your rights you may reach out to the MoH [add Federal board information] (Tel:) or the American Institutes for Research Institutional Review Board (Tel: +1 2024035542).

SECTION 1: HOUSEHOLD ROSTER

Instruction: *Now I am going to ask you questions about each member of your household. Please give me the names of all persons who usually live with this household and eat from the same pot or share economic resources. Start with the head of the household and include visitors who have lived with the household for six months or more. Include usual members, who are away visiting, in hospital, at boarding schools or college or university, etc but who may not be here at this moment.*

1	2	3	4	5		5b	6	6a	7	8	9
									ONLY HOUSEHOLD HEAD		**ONLY FOR THOSE AGED 10 AND OLDER**
ID	Name of the member	Sex 1 = Male 2 = Female	What is [NAME'S] relationship with the head? 1 = Head 2 = Spouse 3 = Child 4 = Grandchild 5 = Parent/Parent-in-law 6= Sibling 7 = Son/Daughter-in-law 8 = Other relative 9 =Adopted/ Foster/Stepchild 10 = Non-relative 999 = don't know	How old is [NAME] now? Record exact age in completed years for all members. For those under 60 months, also record the number of months since the last birthday (use child health book or birth certificate if available.)		What is [NAME]'s date of birth? (using Gregorian calendar) DD-MM-YYYY	Where was [NAME] born? 1 = This village/ nearby (<10 km) 2 = This woreda but village further away 3 = This province but different woreda 4 = Somewhere else in Ethiopia 5 = Different country 999 = don't know	If Q4 is 9=Adopted/ Foster/ Stepchild or 10=Non-relative Since when has [NAME] lived in your household?	What is the religion of [NAME]? 1 = Orthodox 2 = Catholic 3 = Protestant 4 = Muslim 5 = Traditional 6 =No religion 8 = Other, specify		What is [NAME'S] present marital status? 1 = Married 2 = Living together/cohabitated 3 = Divorced or separated 4 = Widowed 5 = Never married or cohabited 6 = Other, specify
				AGE IN YEARS	**IF <60 MONTHS: MONTHS SINCE LAST BDAY**			Years …. Months…. Don't know = .999 [Mark 'Months' as '0' if less than 1 Month]			
01											
02											
03											
04											
05											

SECTION 1: HOUSEHOLD ROSTER (Continued)

	11	12	13	14	15	16	17	18	19	20	21
	ONLY FOR MEMBERS AGE 0 – 17 YEARS							**ONLY FOR MEMBERS AGE 0-6**			
ID	Is the biological mother of [NAME] alive? WRITE ID =YES, MOTHER LIVES IN HOUSEHOLD 88=YES, BUT MOTHER NOT IN HOUSEHOLD 99=NO, MOTHER IS DEAD 999=DON'T KNOW	Does [NAME] have biological siblings from the same mother (living in or out of the household)? 1=Yes 2=No (>> Q14) 999=DON'T KNOW	How many biological siblings are younger than [NAME]? [Enter number, if none = 0]	Is the biological father of [NAME] alive? WRITE ID =YES, FATHER LIVES IN HOUSEHOLD 88=YES, BUT FATHER NOT IN HOUSEHOLD 99=NO, FATHER IS DEAD 999=DON'T KNOW	Does [NAME] have a pair of shoes or sandals? 1=YES 2=NO 999= DON'T KNOW	Does [NAME] have at least 2 sets of clothes? 1=YES 2=NO 999= DON'T KNOW	Does [NAME] have a blanket? 1=YES 2=NO 999= DON'T KNOW	Has (NAME)'s birth been registered with the woreda or kebele? 1=YES 2=NO (>>Q21) 999=Don't know	Does (NAME) have a birth certificate? If yes, may I see it? 1=Yes, seen 2=Yes, not seen 3=No	When was (NAME)'s birth registered? 1=Within 90 days from birth 2=Between 3 months and 1 year since birth 3=After 1 year since birth **(>>NEXT SECTION)**	What is the main reason why (NAME)'s birth is not registered? 1=Can't afford the costs 2=Child's father/mother not around 3=Registration centre too far 4=Don't have renewed resident ID 5=Did not know it should be registered 6=Did not find it important 7=Do not know where to register 8=Other (specify) 999=Don't know
01											
02											
03											
04											
05											
06											
07											
08											
09											
10											

SECTION 2: EDUCATION OF ALL HOUSEHOLD MEMBERS AGED 3 YEARS OR OLDER

	1	2	3		4	5	6	7	8	9	10	11	12
ID	Can [NAME] read and write in any language? 1=Amharic 2= *[add all local languages as options*] 3=Other 4=None	Has [NAME] ever attended school? 1=Yes >>Q4 2=No	What was the main reason [NAME] never attended school? **[SEE CODES BELOW] >>Q4**		Has [NAME] ever attended any early childhood education programme? 1=Yes, O-class 2=Yes, kindergarten 3=Yes, mobile school 4=No>> Q6	Is [NAME] currently attending early childhood education? 1=Yes >> Q10 2=No>>Q7	What was the main reason [NAME] did not attend early childhood education? **[SEE CODES BELOW]** If 2 in Q2 and 4 in Q4 >>> Section 3	What is the highest grade [NAME] completed? **[SEE CODES BELOW]**	Is [NAME] currently attending school? 1=Yes >> Q10 2=No	Why is [NAME] not currently in school? **[SEE CODES BELOW]** >>Move to next household member/next section	Which grade is [NAME] attending? **[SEE CODES BELOW]**	In the last full week of school, how many days did [NAME] attend the full day? [0-5 days exclude weeks with no school] [*Question should be answered when Q5 or Q8 is YES*]	What kind of organisation runs the school that [NAME] is attending? GOVERNMENT.....1 MISSION/RELIGIOUS WITH FEE. .....2 MISSION/RELIGIOUS FREE OF CHARGE. ...3 PRIVATE..... .....4 COMMUNITY.....5 INTERNATIONAL COMMUNITY .....6 OTHER(SPECIFY) 7

Codes for Q7 & Q10: Preschool .....01 Primary grade 1 (G1).....02 Primary grade 2 (G2).....03 Primary grade 3 (G3).....04 Primary grade 4 (G4).....05 Primary grade 5 (G5).....06 Primary grade 6 (G6).....07 Primary grade 7 (G7).....08 Primary grade 8 (G8).....09 Secondary school grade 9...10 Secondary school grade 10…11 Secondary school grade 11…12 Secondary school grade 12...13	Vocational and Technical course Level 1–3 21 College Year 1-3 31 Post-college Education (any)...32 Informal education.....41 Adult literacy course.....42 Satellite schools .....43 Non-regular/informal education (incl. informal religious educations such as kuran or kes).....51 Don't know.....999	**Codes for Q3 & Q6 & Q9:** Too young…….. 1 Already attained the level they wanted. .. 2 Required for work or care activities including on farm or household……. 3 Not interested in school..... 4 Too expensive to go to school..... 5 School too distant..... 6 Not appropriate for female children to go to school (culture)…… 7 Schooling believed not to increase income 8 Everything useful at home .....9 Too sickly to attend.....10 No places available in local school .....11 No school of appropriate religion available .....12 Available school not appropriate for lifestyle (e.g., pastoralist) .....13 Not mandatory/necessary .....14 Not safe .....15 Got pregnant or married .....16 Could not learn because of COVID-19 ....17 Other reason (specify).....98	

	13a	13b	13c		
ID					
	Enrolment fees (In ETB)	School books and other school supplies (In ETB)	School uniform or sports clothes (In ETB)		

SECTION 3: HEALTH OF ALL HOUSEHOLD MEMBERS: OLDER THAN 6 YEARS

	1	2	3	4	5	6	7	8	9	10	11			12
ID	Has [NAME] been sick or injured during the **last 2 weeks**? 1=Yes, sick 2= Yes injured 3=No>>Q8 999=Don't know>>Q8	During the last 2 weeks, did [NAME] have to stop the usual activities because of this condition? 0=No IF YES: PUT NUMBER OF DAYS (1 – 14)	During the last 2 weeks has [NAME] consulted a health practitioner, visited a health facility or consulted a traditional healer for this injury/illness? 1=YES (>>Q6) 2=NO	If no, what was the main reason not to? 1=Lack of money/ too expensive 2=Too far 3=Do not believe in medicine 4=Lack of health professionals 5=Poor quality/services 6=Did not require medical assistance/not severe enough 7=Other, specify >>Q8	On the most recent visit whom did [NAME] consult? 01=Doctor 02=Dentist 03=Nurse 04=Medical assistant 05=Midwife 06=Pharmacist 07=Drug/chemical seller 08=Community Health Worker (APE) 09=Traditional Healer 10=Trained TBA 11=Untrained TBA 12=Religious leader 13=Other (specify) 999=DON'T KNOW [Mark all that apply]	Where did the consultation take place? 1=Public facility 2=Private Facility 3=Pharmacy 4=APE house 5=Traditional Healer 6=Drug store 7=Drug seller 8= Other (Specify) 999=DON'T KNOW [Mark all that apply]	How much in total was spent on [NAME]'s medication and consultation **in the last 2 weeks?** **[INCLUDE BOTH CASH AND IN KIND]** **[GIVE AMOUNT IN ETB]** **[ENTER '00' IF NONE]**	During the last 2 weeks did [NAME] buy any medicine or medical supplies? **[OTHER THAN ALREADY INCLUDED IN Q7!]** 1=YES 2=NO (>>Q10)	How much in total was spent on [NAME]'s other medicine or medical supplies **in the last 2 weeks?** **[GIVE AMOUNT IN ETB]**	Does [NAME] have any disability that limits his/her full participation in life activities: such as seeing, hearing, walking, remembering, self-care or communicating? 1=YES 2=NO (>> Q12)	What type of disability does [NAME] have? 1=Blind 2=Deaf/Mute 3=Mental Deficiency 4=Paralyzed 5=Stunted or amputated arm 6=Stunted or amputated leg 7=Other, specify **[Record up to 3 disabilities]**			Is [NAME] currently registered or covered by health insurance? 1=YES 2= NO
											1st	2nd	3rd	

SECTION 4: HOUSING CONDITIONS

This section taken directly from the IOF 2015 with additions from MICS 6.

	Question	Answers	Skip
1	What is the main source of drinking water used by members of this household?	Water piped inside the house ..... 11 Water piped to the yard ..... 12 Water piped to neighbour's house ..... 13 Water hole (tube well or borehole) ..... 21 Unprotected well water ..... 31 Protected well water ..... 31 Water from protected spring ..... 41 Water from unprotected spring ..... 42 Water from the cistern (or mobile tank or truck) 51 River, lagoon, or lake water ..... 52 Rainwater ..... 53 Bottled water ..... 54 Other (specify) 98	>>Q3 >>Q3
2	How far is it from your home to the source where you draw water to drink and how long does it take to walk there to draw water and come back?	record distance in meters in and time in minutes in the following question Meters ☐☐☐☐ Minutes ☐☐☐	
3	Who usually goes to this source to fetch the water for your household?	Adult woman ..... 1 Adult man ..... 2 Female child under 15 years old ..... 3 Male child under 15 years old ..... 4 Other 98	
4	Do you treat water in any way to make it safe to drink?	1= Yes 2= No 999= Don't know	If 1 >> Q5 If 2–999 >> Q6
5	What do you usually do to make the water safe to drink [Mark all that apply]	Boiling ..... 1 Add Bleach/Chlorine ..... 2 Filter with a cloth ..... 3 Use water filter (ceramic, sand, compost) ..... 4 Solar disinfection ..... 5 Let it stand and settle ..... 6 Other (specify) ..... 8 Don't know 999	
6	We would like to learn about where members of this household wash their hands. Can you please show me where members of your household most often wash their hands? [Record result and observation]	**OBSERVED** Fixed facility observed (sink/tap) in dwelling…..1 Fixed facility observed (sink/tap) in yard/plot…..2 Mobile object observed (bucket/jug/kettle) ..... 3 **NOT OBSERVED** No handwashing place in dwelling/yard/plot ..... 4 No permission to see ..... 5 Other, specify 6	If 1-3 >>Q7
7	[Enumerator: Observe presence of water at the place for handwashing, verify by checking the tap/pump, or basin, bucket water container or similar objects for presence of water]	Water is available ..... 1 Water is not available 2	

8	Is there soap or detergent, or ash/mud/sand present at the place for handwashing or in the house? *[Mark all that apply]*	Bar or liquid soap ..... 1 Detergent (powder/liquid/paste) ..... 2 Ash/Mud/Sand ..... 3 None 4	
9	How much time, in minutes, does it take you to walk from your house to	~~A. Drinking water source~~ B. Market/food store C. Transportation stop D. Primary school E. Health unit F. Police station	
10	What type of toilet do you have in this household? If the response is "Latrine", ask to see it.	Toilet connected to septic tank ..... 1 Improved latrine ..... 2 ~~Improved traditional latrine ..... 3~~ ~~Not improved latrine~~ ..... 4 There is no latrine/No toilet/Open field 5	
11	What is the main source of energy or fuel that the family uses to cook?	Electricity ..... 1 Gas ..... 2 Oil/Paraffin/Kerosene ..... 3 Charcoal ..... 4 Mineral coal ..... 5 Firewood ..... 6 Animal faeces ..... 7 Other (specify) 8	
12	What is the main source of energy or fuel that the household uses for lighting?	Electricity ..... 1 Generator ..... 2 Solar panel ..... 3 Gas ..... 4 Oil/Paraffin ..... 5 Kerosene ..... 6 Candle ..... 7 Batteries ..... 8 Firewood ..... 9 Other (specify) 11	
13	Who owns the house where the household lives?	The family ..... 1 Rented ..... 2 Shelter/Government provided……3 Other (specify) ..... 98 Don't know……..99	>>Q14
16	How many rooms does this house have (incl. the living room)?		
17	Of these rooms, how many do you use for sleeping?		
18	What is the primary material used in the roof?	Concrete slab ..... 1 Roof tile ..... 2 Lusalite sheets ..... 3 Zinc sheets/plastics ..... 4 Grass/stem/palm trees ..... 5 Other (specify) 6	

19	What is the primary material used for the walls?	Adobe/adobe blocks ..... 1 Cement blocks ..... 2 Brick blocks..... 3 Old sticks..... 4 Wood/zinc/plastics ..... 5 Bamboo/cane/palm trees..... 6 Other (specify)..... 7	
20	What is the primary material used in the construction of the floor?	Clay ..... 1 Wooden flooring (rudimentary)..... 2 Adobe ..... 3 Wooden tiles/pieces (parquet) ..... 4 Wooden flooring (sealed) ..... 5 Brick, marble or stones ..... 6 Cement……..7 Other (specify)..... 8	
21	What is the primary activity that you and your family get income/money from?	Farming or fishing ..... 1 Herding and raising livestock ..... 2 Wages and salaries ..... 3 (Non-farming) business activities ..... 4 Money transfer/cash remittance..... 5 Other..... 98 Don't know..... 999	
22	What is the second main activity that you and your family get income/money from?	Farming or fishing ..... 1 Herding and raising livestock ..... 2 Wages and salaries ..... 3 (Non-farming) business activities ..... 4 Money transfer/cash remittance..... 5 No other activity ……..6 Other..... 98 Don't know..... 999	

SECTION 5: FOOD SECURITY (FAO Global Food Insecurity Experience Scale, FIES)

	Question	Answers	Skip
1	How many meals excluding snacks do you normally have in a day?	One ..... 1 Two ..... 2 Three ..... 3 More than three 4	
2	In the **past four weeks**, did you or others in your household worry about not having enough food to eat because of a lack of money or other resources?	Yes ..... 1 No 2	
3	In the past **four** weeks, were you or any household member not able to eat healthy and nutritious food because of lack of money or other resources?	Yes ..... 1 No 2	
4	In the past **four** weeks, did you or any household member have only a few kinds of foods because of a lack of money or other resources?	Yes ..... 1 No 2	
5	In the past **four** weeks, was there a time when you or others in your household had to skip a meal because there was not enough money or other resources to get food?	Yes ..... 1 No 2	
6	In the past **four** weeks, was there a time when you or others in your household ate less than you thought you should because of a lack of money or other resources?	Yes ..... 1 No 2	
7	In the past **four** weeks, was there a time when your household ran out of food because of a lack of money or other resources?	Yes ..... 1 No 2	
8	In the past **four** weeks was there a time when you or others in your household were hungry but did not eat because there was not enough money or other resources for food?	Yes ..... 1 No 2	
9	In the past **four** weeks, was there a time when you or others in your household went without eating for a whole day because of a lack of money or other resources?	Yes ..... 1 No 2	
11	In the past four weeks, was there a time when any of the children younger than 7 years old did not eat healthy and nutritious foods because of a lack of money or other resources	Yes ..... 1 No 2	
12	In the past four weeks, was there a time when any of the children younger than 7 years old was not given enough food because of a lack of money or other resources	Yes ..... 1 No 2	

SECTION 6: ACCESS TO MASS MEDIA AND ICT *Adapted MICS module*

Respondent is the primary caregiver of the child. These questions are for the respondent.

1. Do you read a newspaper or magazine at least once a week, less than once a week or not at all? *If 'At least once a week', probe:* Would you say this happens almost every day? *If 'Yes' record 3, if 'No' record 2.*	NOT AT ALL ..... 0 ONCE A WEEK ..... 1 MULTIPLE TIMES A WEEK..... 2 EVERYDAY..... 3	
2a. Do you own a radio?	YES..... 1 NO..... 2	
2b. Do you listen to the radio at least once a week, less than once a week or not at all? *If 'At least once a week', probe:* Would you say this happens almost every day? *If 'Yes' record 3, if 'No' record 2.*	NOT AT ALL ..... 0 ONCE A WEEK ..... 1 MULTIPLE TIMES A WEEK..... 2 EVERYDAY..... 3	
3a. Do you own a tv?	YES..... 1 NO..... 2	
3b. Do you watch television at least once a week, less than once a week or not at all? *If 'At least once a week', probe:* Would you say this happens almost every day? *If 'Yes' record 3, if 'No' record 2.*	NOT AT ALL ..... 0 ONCE A WEEK ..... 1 MULTIPLE TIMES A WEEK..... 2 EVERYDAY..... 3	
4. Do you own or have access to a computer or a tablet?	YES..... 1 NO..... 2	
5. During the last 3 months, did you use a computer or a tablet at least once a week, less than once a week or not at all? *If 'At least once a week', probe:* Would you say this happened almost every day? *If 'Yes' record 3, if 'No' record 2.*	NOT AT ALL ..... 0 ONCE A WEEK ..... 1 MULTIPLE TIMES A WEEK..... 2 EVERYDAY..... 3	
9. Do you own a device or have access to the internet from any location?	YES..... 1 NO..... 2	
10. During the last 3 months, did you use the internet at least once a week, less than once a week or not at all? *If 'At least once a week', probe:* Would you say this happens almost every day? *If 'Yes' record 3, if 'No' record 2.*	NOT AT ALL ..... 0 ONCE A WEEK ..... 1 MULTIPLE TIMES A WEEK..... 2 EVERYDAY..... 3	
11. Do you (or any household member) own a mobile phone?	YES..... 1 NO..... 2	

12. During the last 3 months, did you use a mobile telephone at least once a week, less than once a week or not at all? *Probe if necessary:* I mean have you communicated with someone using a mobile phone. *If 'At least once a week', probe:* Would you say this happens almost every day? *If 'Yes' record 3, if 'No' record 2.*	NOT AT ALL ..... 0 ONCE A WEEK ..... 1 MULTIPLE TIMES A WEEK..... 2 EVERYDAY..... 3	

SECTION 7: EXPERIENCE WITH EARLY CHILDHOOD SERVICES

		1	2	3	4	5	6
	Name of Programme or Service	Are you aware of any of the following services or programmes in your area? Yes No	**In the last 12 months**, has any member of your household received any information, services, money or goods, including food, clothing, livestock or medicines from any of the following types of programmes? 1=YES>>Q4 2=NO>>**Q3**	What is the reason you did not use the service/programme? 1= Not eligible 2= Not aware it existed 3= Too expensive 4=Too far to travel 5=Not interested/relevant for your child/family 6=Poor quality of service (incl. concerns with staff) 7= Other, specify	Who was providing this support or offering this service? 1 = Private provider 2= Public/Government programme 3 = NGO or church programme 999= DON'T KNOW	Were you satisfied with the effect the service/programme had on your child/family? 1=Very satisfied 2=Somewhat satisfied 3=Neutral 4=Somewhat dissatisfied 5=Very dissatisfied	Were you satisfied with the quality of the service/programme? 1=Very satisfied 2=Somewhat satisfied 3=Neutral 4=Somewhat dissatisfied 5=Very dissatisfied
01	Community health services or health programme						
02	Cash transfer programme/safety net programme						
03	Kindergarten, preschool including O-class, child to child programmes, early childhood education programmes						
04	Food assistance programme (in-kind)/ school feeding programme						

05	Programmes/services for income generation including entrepreneurship or micro-credit, small business training						
06	Water or sanitation programme						
07	Social Welfare or psychosocial support programme						
08	Education or school support programme						
09	Youth services or activities						
10	Other? (specify) *[Any other programme or service that you use for child between 0-6]*						

4	**In the last 12 months ,** has any member of your household received money or goods, including food, clothing, livestock or medicines **from individual people** (friends, family, others) who are not part of your household?	1=YES 2-NO >> **NEXT SECTION**	
5	What is the total value of assistance received from all these non-household members **in the last 12 months** ?	**[CONVERT IN-KIND ASSISTANCE TO ETB]**	

SECTION 8: BIRTH HISTORY OF WOMEN 14 – 49 YEARS OLD

	4	5	6	7	8	9	10	11	12a	12b	13	14	15	14
ASK FOR ALL FEMALES BETWEEN 14-49 YEARS														
ID	Is [NAME] pregnant now? 1=YES 2=NO (>>Q10) 9=DK (>>Q10)	Did [NAME] see anyone for antenatal care during this pregnancy? 1=YES (>>Q7) 2=NO	What is the main reason (NAME) didn't go for antenatal care? (>>Q10) **[SEE CODES BELOW]**	Whom did (NAME) see? [**SEE CODES BELOW: MARK ALL THAT APPLY]**	How many months pregnant was (NAME) when she first received antenatal care for this pregnancy? [Months] 98= DK	How many times did (NAME) receive antenatal care during this pregnancy? [number] 98= DK	Has [NAME] ever given birth? 1=YES 2=NO >> **NEXT WOMAN**	How many children [NAME] has given birth to are alive but do not live in this household? [number] If 0 >>**Q14**	How many of these children are under 18 years old? [number] If 0 >>**Q14**	Where are these offspring now (mark for each)? **[SEE CODES BELOW]**	What is the primary reason the children are not living with you (mark for each)? [**SEE CODES BELOW]**	Have any of [NAME]'s children (below 18 years) lived elsewhere for more than 2 months?	What is the primary reason the children were temporarily not living with you (mark for each)? [**SEE CODES BELOW]**	Has [NAME] ever given birth to a child who was born alive but later died? **[IF NO, PROBE:** I mean, to a child who ever breathed or cried or showed other signs of life – even if he or she lived only a few minutes or hours?**]** [Enter total number, 0 if none]

Codes for Q7
Doctor 01
Nurse.....02
Auxiliary midwife.....03
Traditional birth attendant.04
Community health worker 05
Midwife.....06
Other, specify.....07

Codes for Q12
Extended family.....01
Host Centre 02
Host Family 03
Guardian 04
Lives independently alone or with own family……05
Lives independently on street or outside 06
Other, specify.....07
DON'T KNOW……999

Codes for Q13 & Q15
Economic reasons…….. 01
Education reasons 02
Health reasons.....03
Conflict/violence.....04
Separation/intra-household conflict … 05
They have own family 06
Other, specify.....07

SECTION 9: MATERNAL AND NEWBORN HEALTH & NUTRITION

These questions need to be asked to the mother or main caregiver for the index child (0-6 years) about the child between 0-6 years old

	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	
ID of child	Does [NAME] have a child health card? 1=YES (seen) 2=YES (not seen) 3=NO 999=DON'T KNOW	Did you see anyone for antenatal care during your pregnancy with [NAME]? 1=YES (>>Q4) 2=NO 999=DON'T KNOW (>>Q7)	What was the main reason you did not go for antenatal care for [NAME]? (>>Q7) **[SEE CODES BELOW]**	Whom did you see? **[SEE CODES BELOW, CHECK ALL THAT APPLY]**	How many months pregnant were you when you first received antenatal care for pregnancy with [NAME]? [MONTHS] 999= DON'T KNOW	How many times did you receive antenatal care during the pregnancy with [NAME]? [NUMBER] 999= DON'T KNOW	Who assisted with the delivery of [NAME]? [IF RESPONDENT SAYS NO ONE, PROBE TO DETERMINE WHETHER ANY ADULTS WERE PRESENT AT THE DELIVERY.] **[SEE CODES BELOW, RECORD ALL PERSONS MENTIONED]**	Where did you give birth to [NAME]? **[SEE CODES BELOW]**	During your last pregnancy how did you obtain information about issues related to pregnancy and care about the new-born? **[SEE CODES BELOW, RECORD ALL THAT ARE MENTIONED]**	Were you satisfied with the quality of information about pregnancy that was available to you? 1=Not satisfied at all 2=Somewhat dissatisfied 3=Neutral 4=Somewhat satisfied 5=Very satisfied	From who did you get support during your last pregnancy? **[SEE CODES BELOW, RECORD ALL THAT ARE MENTIONED]**	

Codes for Q3	Codes for Q4 & Q7	Codes for Q8	Codes for Q9	Code for Q11
Economic reasons 01	Doctor..... 01	Home 01	Family members 01	Partner 01
No health care available..... 02	Nurse 02	Someone else's home 02	Friends or peers 02	Mother/Mother-in-law... 02
Health care too far 03	Auxiliary midwife 03	Government hospital..... 03	Doctors, nurses,	Doctors, nurses 03
Not necessary..... 04	Traditional birth attendant 04	Health facility 04	gynaecologists 03	Midwife 04
Health personnel not friendly 05	Community health worker..... 05	Private hospital 05	Books..... 04	Other family members... 05
Long waits at facilities..... 06	Midwife 06	Private clinic..... 06	Media such as radio, tv,	Friends..... 06
Prefers community volunteers ... 07	Relative or friend..... 07	Outside..... 07	magazines and newspapers ... 05	Other..... 98
Other, specify..... 08	No one 08	Other, specify 08	Brochures..... 6	
	Other, specify 09	DON'T KNOW 999	Internet..... 7	
			Previous experience 8	
			I did not get informed 9	
			Other 98	

SECTION 9: MATERNAL AND NEWBORN HEALTH & NUTRITION (CONTINUED)

These questions need to be asked to the mother or main caregiver for the index child (0-6 years) about the child between 0-6 years old

	10	11	12		13	14	15	16
ID of child	When [NAME] was born, was s/he very big, bigger than average, average, smaller than average, or very small? 1=Very big 2=Bigger Than Average 3=Average 4=Smaller Than Average 5=Very Small 999=DON'T KNOW	Was [NAME] weighed at birth? 1=YES 2=NO (>>Q13) 999=DON'T KNOW(>> Q13)	How much did [NAME] weigh at birth? **RECORD WEIGHT FROM HEALTH CARD, IF AVAILABLE. RECORD IN KG AND USE APPROPRIATE CODE:** 1=From health card 2=From recall 999=DON'T KNOW/Don't remember		Was [NAME] born early, on time or late? 1=>3 weeks early 2=2-3 weeks early 2=1-2 weeks early, 3=On time (within a week of due date) 4=>1 week late	Was [NAME] taken for a postnatal check-up? 1=Yes, within 4 hours 2=Yes, between 4 and 23 hours 3=Yes, within 1-2 days Yes, within 3-6 days 4=Between 7 and 41 days 5=No	Since [NAME] was born, how many times did you take [NAME] to growth monitoring sessions?	Couples use various methods to delay or avoid pregnancy. Are you currently using any method to delay or avoid getting pregnant? 1=Female or male sterilisation 2=IUD 3=Injectable/implants 4=Pill 5=Condoms 6=Diaphragm/foam/jelly 7=Standard days method/rhythm method 8=LAM (lactation amenorrhea method) 9=Withdrawal 10=Not using any method 11=Other, specify
			Kilograms	Code				
			|___|.|___|___|					

17	18		19	20	21	22	23	24
Ideally, how many more children would you like to have? [Number]	How long after birth did you first put (NAME) to the breast? If less than 1 hour, record '00' hours and select Immediately. If less than 24 hours, record hours. Otherwise, record days. If never breastfed, record '8' at Code 0=Immediately 1=Hours 2=Days 8=Never breastfed 999=DON'T KNOW **CODE** **NUMBER**		In the first three days after delivery, was (NAME) given anything to drink other than breast milk? 1=YES 2=NO **(>>Q21)** 999=DON'T KNOW (>>Q21)	What was (NAME) given to drink in those first three days? Probe: Anything else? **[RECORD ALL MENTIONED]** A=Honey B=Fruit juice C=Plain water D=Sugar water E=Tea F=Milk (other than breastmilk) G=Infant formula H=Raw butter I=Water with herbal extract J=Other (specify)	Are you still breast-feeding (NAME)? 1=YES (>>Q23) 2=NO	At what age did you stop breast-feeding (NAME)? **[Record age in completed months]**	At what age (in months) did you first give (NAME) water or other fluids besides breast milk? [00=LESS THAN ONE MONTH] [97=NOT YET]	At what age (in months) did you first give (NAME) solid or semi-solid food? [00=LESS THAN ONE MONTH] [97=NOT YET]

SECTION 10: MATERNAL AND NEWBORN HEALTH & NUTRITION

These questions need to be asked to the mother or main caregiver for the index child (0-6 years) about the child between 0-6 years old

25	**26**			
Has [*Name*] been breastfeed yesterday during the day or the night? *[Indicate as "Yes" any child who is breastfed by a woman other than the mother, or who are given breastmilk by another woman from a spoon, a cup, a bottle ...]*	How many times yesterday during the day or night [Child's name] consumed ... [Times]			
1=Yes 2= No 999= Don't know	a. ...Infant formula	b. ...canned milk powder or fresh milk?	c. ...yogurt?	d. ...cookies?

27														**28**
Please, can you say all that [*Name*] ate yesterday, during the day or at night, whether at home or away from home? [*Each time the respondent remembers and says the food consumed by the child, write the corresponding number in the corresponding food groups (lines below)]* 1=Yes 2= No 999= Don't know														How many times has [*Name*] been fed solid, semi-liquid or soft food yesterday? [Times]
a.	b.	c.	d.	e.	f.	g.	h.	i.	j.	k.	l.	m.	n.	o.	
Potatoes, cornmeal porridge, bread, rice, spaghetti, biscuits, teff/injera, or other food made from cereals ?	Pumpkin, carrot, or sweet potato, yellow or orange?	White potatoes, white yams, cassava, or any other tubers or potatoes?	Any leafy greens (beans, cassava, leaves, kale, sweet potato leaves, Nhewe?	Ripe mango, ripe papaya, guava with red pulp or other food rich in vitamin A?	Any other fruit or vegetable (banana, apple, tomato, lemon, orange, tangerine, grapes, cabbage)?	Liver, kidney, heart, or other organs?	Any other meat such as beef, pork, sheep, goat, or duck, or other game meat?	Eggs?	Fresh or dried fish or seafood?	Any food made with beans, peas, lentils, almonds, or seeds?	Cheese, yogurt, or other products made from milk?	Foods made with oil, peanuts, sesame or butter/margarine?	Fluid porridge ("atmit")	Powdered micronutrients/ supplements	

Note this question is for the mother/primary caregiver of the child!

29																		
Now lets see if we've forgotten any food. Did you eat any of these foods during the day yesterday? 1= Yes; 2= No																		
a.	b.	c.	d.	e.	f.	g.	h.	i.	j.	k.	l.	m.	n.	o.	p.	q.	r.	s.
Rice, corn, sorghum, millet, bread, pasta, potatoes, yams, green banana, injera /teff, porridge?	Potato Reno, sweet potato, cassava?	Beans, peas, lentils, soybeans?	Peanuts, almonds, sesame seeds, pumpkin seeds, cashew nuts?	Milk, cheese, yogurt or other dairy products, sour cream?	Liver, kidneys, gizzards, heart?	Beef, pork, goat/sheep, rabbit, chicken, duck, bird, mouse, rat, wild game meat?	Fresh or dried fish, shellfish or seafood (lobster, squid, octopus, oysters, crab)	Eggs of poultry or any other bird like duck or quail?	Tsec (amaranth), watercress, sweet potato leaves, pumpkin leaf, cassava or bean leaves, okra, spinach?	Pumpkin, carrot, red chili, orange squash, sweet potato?	Mango, papaya, passion fruit, peach?	Cabbage, tomatoes, lettuce, eggplant, cucumber, green peppers, beets, kale?	Orange, apple, pear, grape, pineapple, wild berries, tangerine, watermelon, banana?	Have you used oil, fat, or butter to cook?	Sugary foods such as chocolates, sweets, cookies and biscuits, cakes, sweets or ice cream?	Did you take tea leaves (black) or coffee without sugar just before or after food?	Have you used ingredients even if in small amounts to give flavour such as peppers, spices, herbs, fish powder, tomato paste, flavour bouillon, or seeds?	Did you drink sugary juices, fruit juices, soft drinks, chocolate drinks, yogurt, or sugared tea or sugared coffee?

SECTION 11: PREVENTATIVE CHILD CARE AND IMMUNISATIONS

These questions need to be asked to the mother or main caregiver for the index child (0-6 years).

	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**
ID of child	Did you or someone else take (NAME) to a health facility in the past 12 months? 1=YES 2=NO (>>Q3)	How many times was (NAME) there for consultations in the past 12 months?	In the last two weeks, has (NAME) had diarrhoea? 1=YES 2=NO (>>Q10)	Where did (NAME) seek treatment for this condition? 1=Public Facility 2=Private Facility 3=Pharmacy 4=Traditional Healer 5-Drug Store 6=Drug Vendor 7=Did Not Seek 8= Other (Specify)	During the time (NAME) had diarrhoea, was he/she given less than usual to drink, about the same amount, or more than usual? **If less, probe: Was he/she given much less than usual to drink, or somewhat less?** 1=Much less 2=Somewhat less 3=About the same 4=More 5=Nothing to drink 999=Don't Know	During the time (NAME) had diarrhoea, was he/she given less than usual to eat, about the same amount, more than usual, or nothing to eat? **If less, probe: Was he/she given much less than usual to eat, or somewhat less?** 1=Much less 2=Somewhat less 3=About the same 4=More 5=Stopped food 6=Never gave food **999=Don't Know**	During the episode of diarrhoea, was (NAME) given ORS and Zinc supplement? 1=YES 2=NO 999=DON'T KNOW	Was anything else given to treat the diarrhoea? 1=YES 2=NO (>>Q10)

SECTION 11: PREVENTATIVE CHILD CARE AND IMMUNISATIONS (continued)

These questions need to be asked to the mother or main caregiver for the index child (0- 6 years).

	9	10	11	12	13	14	15	16	17	18
ID of child	What else was given to treat the diarrhoea? **Pill or Syrup** A=Antibiotic B=Antimotility (anti-diarrhoeal) C=Zinc G=Other (Not antibiotic, antimotility or zinc) H=Unknown pill or syrup **Injection** L=Antibiotic M=Non-antibiotic N=Unknown injection O=Intravenous Q=Home remedy / Herbal medicine X=Other (specify)	At any time in the last two weeks, has (NAME) had an illness with a cough? 1=YES 2=NO (>>Q14)	When (NAME) had an illness with a cough, did he/she breathe faster than usual with short, rapid breaths or have difficulty breathing? 1=YES 2=NO (>>Q13)	Was the fast or difficult breathing due to a problem in the chest or a blocked or runny nose? 1=Problem in chest only 2=Blocked or runny nose only (>>Q14) 3=Both 6=Other (specify) (>>Q14) 999=Don't know	Where did (NAME) seek treatment for this condition? 1=Public Facility 2=Private Facility 3=Pharmacy 4=Traditional Healer 5-Drug Store 6=Drug Vendor 7=Did Not Seek 8= Other (Specify)	Has (NAME) been ill with fever in the last 2 weeks? 1=YES **2=NO (>>Q16)**	Where did (NAME) seek treatment for this condition? 1=Public Facility 2=Private Facility 3=Pharmacy 4=Traditional Healer 5-Drug Store 6=Drug Vendor 7=Did Not Seek 8= Other (Specify))	How much was spent on (NAME) for health related services including medicines and consultations **in the last two weeks? [GIVE AMOUNT IN ETB]**	The last time (NAME) passed stools, what was done to dispose of the stools? 1=Child used toilet / latrine 2=Put / Rinsed into toilet or latrine 3=Put / Rinsed into drain or ditch 4=Thrown into garbage (solid waste) 5=Buried 6=Left in the open 7=Other (specify) 999=Don't Know	Did (NAME) sleep under a mosquito net last night? 1=YES, a treated net 2= YES, a untreated net 3=YES, but unsure whether it is treated 4=NO
	A B C G H L M N O Q X									
	A B C G H L M N O Q X									
	A B C G H L M N O Q X									

SECTION 11: PREVENTATIVE CHILD CARE AND IMMUNISATIONS (continued)

These questions need to be asked to the mother or main caregiver for the index child (0- 6 years).

	1	**2**											**3**	**4**
ID of child	Do you have a card where (name)'s vaccinations are written down? (IF YES) may I see it please? 1=Yes, seen 2=Yes, not seen 3=No	Check health card for vaccination history. If health card not available inquire from respondent. For PEN, OPV and Pneumococcal and Rotavirus vaccinations record number of times vaccination received. 1=YES; 2=NO; 999 = DON'T KNOW											Has (NAME) received a Vitamin A dose within the last 6 months? 1=YES 2=NO 999=DON'T KNOW	Has [NAME] received deworming medication in the last 6 months? 1=YES 2=NO 999=DON'T KNOW
		BCG Vaccination against tuberculosis – that is, an injection in the arm or shoulder that usually causes a scar	**POLIO** Vaccination drops in the mouth to protect him/her from getting polio				**PENTA** An injection in the thigh or buttocks to prevent him/her from getting tetanus, whooping cough, or diphtheria			**PNEUMO-COCCAL** An injection usually given on the right upper thigh to prevent pneumonia?			**MEASLES** A shot in the arm at the age of 9 months or older to prevent him/her from getting measles		
			OPV 0	OPV 1	OPV 2	OPV 3	PEN1	PEN2	PEN3	1	2	3			

SECTION 12a: CHILD DEVELOPMENT

These questions need to be asked to the mother or main caregiver for the index child (0-6 years); Taken from PATH tool (MICS components)

	1	2	3						4	5	6
ID of child	How many children's books or picture books do you have for (***name***)?	At what age should parents or older household members start reading books to a child? [Months]	In the **past 3 days**, did you or any household member over 15 years of age engage in any of the following activities with [NAME]? **[RECORD ALL MENTIONED]** A=MOTHER (female primary caregiver) B=FATHER (male primary caregiver) X=OTHER Y=NO ONE 999=DON'T KNOW						When during the day do you normally play with [NAME] [ENUMERATOR, read these out one at a time and ask for a response]: Do you play with [NAME]. . . ? A = When bathing the child? B = When feeding the child? C = When changing the child? D = When doing chores? E = During work in the field? F = During free time? [Mark all that apply]	At what age can a child see? [Months]	At what age can a child hear? [Months]
			a. Read books to or looked at pictures with [NAME]?	b. Told stories to [NAME]?	c. Sang songs to [NAME] or with NAME including lullabies?	D. Took [NAME] for a walk outside the home, compound, yard or enclosure?	e. Played with [NAME]? (ex. Peek-a-boo, clapping, hide and go-seek?)	f. Named, counted or drew things with [NAME]? (ex. "It's a dog")			
			A B X Y Z	A B X Y Z	A B X Y Z	A B X Y Z	A B X Y Z	A B X Y Z	A B C D E F		

	7		8	9	10
ID of child	On how many days in the past week was [NAME]:		How often do you have trouble soothing or calming [NAME] when he/she is crying or upset? 1=Almost never 2=Less than ½ the time 3=1/2 the time 4=More than ½ the time 5=Almost always	During the average day, how often does your infant get fussy and irritable? 1=Almost never 2=Once or twice a day 3=Couple times in the morning and afternoon/evening 4=Several times a day 5=Almost every hour	In general, compared to most babies, how often does your infant cry and fuss? 1=Almost never 2=Less than average 3=About average 4=More than average 5=Almost always
	A. Left alone for more than one hour?	B. Left in the care of another child, that is, someone less than 10 years old for more than one hour?			

SECTION 12b: CHILD STATUS INDEX

Respondent for this section should be the primary caregiver (woman) of the selected child index child aged 0-6 years

Question: Child Status Index		Answers	Domain
1	Has [NAME] completed the vaccination schedule?	Yes……1 More or less……2 No……...3 Not applicable…… 9	[Health]
2	Does [NAME] always drink treated water?	Yes……1 More or less……2 No……...3 Not applicable…… 9	[Health]
3	The last three times that [NAME] fell sick, did you take [NAME] to a health facility?	Yes……1 More or less……2 No……...3 Not applicable…… 9	[Health]
4	Does [NAME] have access to a clean latrine or bathroom and access to water to wash his/her hands?	Yes……1 More or less……2 No……...3 Not applicable…… 9	[Health]
5a	Is [NAME] breastfed	Yes……1 No……2	[Food and Nutrition]
5	Does [NAME] eat at least two meals a day?	Yes……1 More or less……2 No……...3 Not applicable…… 9	[Food and Nutrition]
6	Did [NAME] eat a variety of foods in the last 2 days?	Yes……1 More or less……2 No……...3 Not applicable…… 9	[Food and Nutrition]
7	Is [NAME] treated equal to the other children around the same age in the family?	Yes……1 More or less……2 No……...3 Not applicable…… 9	[Protection and Legal Support]
8	Has [NAME] been or is [NAME] a victim of violence (psychological/ physical / negligence)?	Yes……1 More or less……2 No……...3 Not applicable…… 9	[Protection and Legal Support]
9	Does [NAME] play with other children?	Yes……1 More or less……2 No……...3 Not applicable…… 9	[Psycho-Social Support]
10	Can you give an example of a game you play with [NAME]?	Yes……1 More or less……2 No……...3 Not applicable…… 9	Only for 0-5 [Psycho-Social Support]
11	[ENUMERATOR, observe]: Is the house adequate, safe, dry and ventilated, with strong walls and ceiling?	Yes……1 More or less……2 No……...3 Not applicable…… 9	[Housing]

SECTION 13: CHILD DISCIPLINE

The respondent for this section should be the primary caregiver (woman) of the selected child index child aged 0-6 years a [MICS module]

	2									
ID of child	Adults use certain ways to teach children the right behaviour or to address a behaviour problem. I will read various methods that are used. Please tell me if <u>you or any other adult in your household</u> has used this method with ***(name)*** <u>in the past four weeks</u>. 1=Often 2= Sometimes 3= A few times 4= Once 5= Never									
	A. Took away privileges, forbade something [NAME] liked or did not allow (him/her) to leave the house	B. Explained why [NAME]'s behaviour was wrong	C. Shook (him/ her)	D. Shouted, yelled at or screamed at (him/her)	E. Gave (him/ her) something else to do	F. Spanked, hit or slapped (him/her) on the bottom with bare hand	G. Hit (him/her) on the bottom or elsewhere on the body with something like a belt, hairbrush, stick or other hard object	H. Called (him/ her) dumb, lazy or another name like that	I. Hit or slapped (him/ her) on the face, head or ears	J. Hit or slapped (him/ her) on the hand, arm, or leg

After completing the questions for the selected child separately, ask the question below (only ***once*** per household!):

3	Do you believe that in order to bring up, raise, or educate a child properly, the child needs to be physically punished?	Yes.....1 No.....2 Don't know / No opinion.....999
3b	If yes, do you believe a child needs to be: [**READ OPTIONS MARK ALL THAT APPLY}**	Spanked/hit on bottom……..A Hit on other body parts with bare hand….B Spanked/hit with an implement (e.g., stick, rope)…C Pinched…….D Burned……..E Tied arms/legs together……F Other physical punishment, specify……..X

SECTION 14: NUTRITION & FEEDING KNOWLEDGE

Respondent for this section should be primary caregiver of the index child (0-6 years). DO NOT PROMPT OR PROVIDE ANSWERS, ALLOW RESPONDENT TO ANSWER AND THEN MARK ALL THAT APPLY

	Question	Answers	Skip
1	How long after birth should a baby be first put to the breast?	Immediately/ within one hour ..... 1 Within one day ..... 2 After one day ..... 3 After more than one day ..... 4 Baby should not be breastfed ..... 5 Don't know 999	
2	Until what age should a baby by exclusively breastfed (only breastmilk, not even water?)	Age in months: ..... |___|___| Don't know 999	
3	Why should a baby under 6 months be exclusively breastfed? **[DO NOT READ RESPONSES; RECORD ALL MENTIONED]**	Protects baby from illness/disease ..... A Breast milk contains everything a baby needs for the first 6 months ..... B Helps baby grow better ..... C Mother less likely to get pregnant ..... D Delays return of mother's monthly bleeding ..... E Breastmilk is clean, safe and convenient ..... F Breastmilk is free/affordable ..... G Reduces healthcare cost ..... H Other ..... X Don't know 999	
4	At what age should a baby first start to receive liquids (including water) other than breast milk?	Age in months: ..... |___|___| Don't know 999	
5	At what age should a baby first start to receive foods (such as porridge) in addition to breast milk?	Age in months: ..... |___|___| Don't know 999	
6	What can happen to children if they do not get enough iron (either in their diet or via iron supplements)? **[DO NOT READ RESPONSES; RECORD ALL MENTIONED]**	Impaired learning ..... A Impaired development ..... B Slow growth/lower height ..... C Low immunity ..... D Feel tired ..... E Become anaemic ..... F Other ..... X Don't know 999	

7	Can you tell me some foods that are a good source of iron? **[DO NOT READ RESPONSES; RECORD ALL MENTIONED]**	Meat (beef, goat, etc.), chicken, fish ..... A Green leafy vegetables .....B Eggs .....C Breast milk ..... D Beans/peas .....E Commercially fortified foods.....F Teff……G Other ..... X Don't know 999	
8	Vitamin A is a nutrient that helps children see better. Can you tell me some of the foods that are rich in vitamin A? **[DO NOT READ RESPONSES; RECORD ALL MENTIONED]**	Orange colored fruits/vegetables ..... A Green leafy vegetables .....B Eggs .....C Liver ..... D Breast milk ..... E Cow's milk..... F Palm Oil ..... G Other ..... X Don't know 999	
8b	Can you list the food groups a child (6 months to 6 years) is expected to eat in a day? **[DO NOT READ RESPONSES; RECORD ALL MENTIONED; MARK Other if they mention food groups that are not included in the official first 8]/** ***Note: concentrate on food groups/types and not on dishes or meals participants ate. E.g., grains and cereals rather than porridge.***	Breast milk/ Maziwa na mama ..... A Grains and cereals, roots, tubers and plantains/Nafaka, mizizi, mimea .....B Pulses (beans, peas, lentils) nuts and seeds/.....C Dairy products (milk, infant formula, yogurt, cheese)/D Flesh foods (meat, fish, poultry, organ meets)/.....E Eggs .....F Vitamin-A rich fruits and vegetables ..... G Other fruits and vegetables… ..... ……H Other…… .....……X Don't know 999	
9	How many times a day should a 6 months to 6 years that is still breastfeeding eat? (meals and snacks)	Number .....|___|___| Don't know 999	
10	How many times a day should a 6 months to 6 years (who is not breastfeeding) be given meals/snacks in a day?	Number .....|___|___| Don't know 999	
11	Have there been times in the last two weeks that you have not been able to give your child the type food you wanted to give?	Yes .....1 No 2	
12	What are the reasons for not giving your child the food you wanted?	Child does not want to eat other foods.....1 Too expensive/not having enough money 2	

	[DO NOT READ RESPONSES; RECORD ALL MENTIONED]	Food/ingredients were not available .....3 No time to prepare other foods .....4 Child was sick.....5 Other, specify.....99 Don't know 999	
13	What should you do when your child older than 6 months old has diarrhea?	Give ORS..... A Give less food than usual .....B Give same quantity of food as usual .....C Give more food than usual..... D Give less liquids than usual .....E Give the same amount of liquid as usual .....F Give more liquid than usual..... G Keep breastfeeding ..... H Increase breastfeeding.....I Give syrup .....J Give traditional medication ..... K Give treated water .....L Other ..... X Don't know 999	
14	Do you know when you should wash your hands? **[MULTIPLE RESPONSE POSSIBLE. DO NOT READ THE CHOICES BUT PROBE AND MARK ALL THAT APPLY]** YES = 1 NO = 2	Before food preparation .....1 Before eating.....2 Before feeding children .....3 After defecation .....4 After cleaning baby's bottom.....5 Other (specify) 6	
15	Where do you get information about child care, nutrition, health, early education (examples: what foods are good for children, when a child should go to school, when a child should see a doctor)? **[DO NOT READ RESPONSES; RECORD ALL MENTIONED]**	Radio ..... A TV .....B Newspapers and magazines .....C Brochures, posters of other printed materials ..... D Family, friends, neighbours and colleagues .....E Chiefs/village elders .....F Religious leaders ..... G Teachers/schools/PTAs ..... H Social/health workers .....I Doctors/nurses .....J NGOs ..... K Community groups .....L Other ..... X Don't know 999	
16	Are you satisfied with the quality of the information on child care,	1=Not satisfied at all 2=Somewhat dissatisfied	

	nutrition, health, early education that was available to you?	3=Neutral 4=Somewhat satisfied 5=Very satisfied	
17	To whom do you turn if you have a problem concerning child care, nutrition, health, early education?	Partner ..... A Mother/mother-in-law .....B Friends .....C Other family members ..... D Neighbours and community members .....E Chiefs/village elders .....F Religious leaders ..... G Teachers/schools/PTAs ..... H Social/health workers .....I Doctors/nurses .....J NGOs ..... K Community groups .....L Other ..... X Don't know …….999	

SECTION 15: DECISION MAKING POWER, EMOTIONAL WELL-BEING (MOTHER OR CARETAKER OF A CHILD)

Instructions: Ask primary care-giver of the index child age 0-6 years. This can be a woman or a man, please indicate the gender in the first question.			
1	Primary caregiver is female: Yes==1 No==2		
2	If a child is not feeling well, who decides whether to seek treatment?	1=RESPONDENT 2=HUSBAND/WIFE/PARTNER 3=RESPONDENT & PARTNER JOINTLY 4=OTHER	
3	If a child does not want to go to school who would decide whether s/he must go?	**[SAME CODES AS Q2]**	
4	Who usually decides how the money you usually earn will be used?	**[SAME CODES AS Q2]** 9=NEVER EARNED MONEY	
5	Who usually decides how the money your partner earns will be used?	**[SAME CODES AS Q2]** 9=PARTNER NEVER EARNED/NO PARTNER	
6	Who usually makes decisions about making major household purchases?	**[SAME CODES AS Q2]**	
7	Who usually makes decisions about making purchases for daily household needs?	**[SAME CODES AS Q2]**	
8	Who usually makes decisions about purchasing children's clothes or shoes?	**[SAME CODES AS Q2]**	
9	Who usually makes decisions about visits to your family or friends?	**[SAME CODES AS Q2]**	
10	If you are feeling sick, who usually decides whether you should seek treatment?	**[SAME CODES AS Q2]**	
11	Up to what level would you expect a daughter/girl to go to school?	1=NONE 2=SOME PRIMARY 3=COMPLETE PRIM. (grade 7) 4=SOME SECONDARY 5=COMPLETE SEC. (grade 12) 6=ANY TERTIARY	
12	Up to what level would you expect a son/boy to go to school?	**[SAME CODES AS Q11]**	
13	What would be the ideal age for your daughter/a girl to get married in your community?	Age …. In years	
14	What would be the ideal age for your son/a boy to get married in your community?	Age …. In years	
15	Do girls get circumcised in this community? And if so what form of FGM commonly occurs?	1= No, circumcision in this community. 2=Circumcision or Sunna circumcision 3= Excision or clitoridectomy 4=Infibulations or pharaonic circumcision 999= I don't know	If No >> Q19
16	What will happen to a girl and their parents if they refuse circumcision?	1=Nothing will happen 2=They will be outcast/ostracised by the community 3=Girl's prospect of getting married and establishing a family is put at risk 98=Other, specify	
17	At what age will girls typically get circumcised?	Age …. In years	
18	Do you know that FGM/cutting is prohibited by the law?	1=Yes 2=No	

	Question	Answers	Skip
19	[Cohen stress scale] **[Reference period is last 4 weeks]** The following questions ask about your thoughts and feelings during the last month. Please indicate how often you felt or thought a certain way.	**Answer categories:** Never.....1 Almost Never (1 day per week) .....2 Sometimes (2-3 days per week) .....3 Fairly Often (4-5days per week).....4 Very Often/Always (6-7days per week).....5	
a	In the last 4 weeks, how often have you been upset because of something that happened unexpectedly?	1 2 3 4 5	
b	In the last 4 weeks, how often have you felt that you were unable to control the important things in your life?	1 2 3 4 5	
c	In the last 4 weeks, how often have you felt nervous and/or "stressed"?	1 2 3 4 5	
d	In the last 4 weeks, how often have you felt confident about your ability to handle your personal problems?	1 2 3 4 5	
e	In the last 4 weeks, how often have you felt that things were going your way?	1 2 3 4 5	
f	In the last 4 weeks, how often have you found that you could not cope with all the things that you had to do?	1 2 3 4 5	
g	In the last 4 weeks, how often have you been able to control irritations in your life?	1 2 3 4 5	
h	In the last 4 weeks, how often have you felt that you were on top of things?	1 2 3 4 5	
i	In the last 4 weeks, how often have you been angered because of things that were outside of your control?	1 2 3 4 5	
j	In the last 4 weeks, how often have you felt difficulties were piling up so high that you could not overcome them?	1 2 3 4 5	
20	**[Locus of control]** In the last 12 months, how often did you feel that …	**Answer categories:** None of the time.....1 A little of the time .....2 Some of the time .....3 Most of the time .....4 All of the time 5	
a	Your life is determined by your own actions	1 2 3 4 5	
b	You have the power to make important decisions that change the course of your own life	1 2 3 4 5	
c	You have the power to make important decisions that change the wellbeing of your children	1 2 3 4 5	
d	You have the power to make important decisions that change the wellbeing of your household	1 2 3 4 5	

e	You are capable of protecting your own interests within your household	1	2	3	4	5	
f	You are capable of protecting your own interests outside of your household (e.g., in the community, in groups in which you participate)	1	2	3	4	5	
g	You are satisfied with your life	1	2	3	4	5	

Annex D. Qualitative Tools

FGD Protocol: Mothers/Female Caregivers

Enumerator: Please read the consent form and obtain consent from all participants before proceeding. Confirm that all participants have children/care for children between 0 and 6. Throughout the interview, make note of the gender and age of the children being referred to.

Introduction

We are conducting this study to understand how parents raise their children in this part of Ethiopia. We will start with some general questions about childrearing.

1. How old are your children/the children you care for? Are they boys or girls?
2. What do women and girls contribute to raising a child?
   a. What about men? And boys?
   b. Who else helps with raising a child? *(Probe: grandmothers, aunts, uncles, neighbours)*
3. Do you have any children who are not currently living with your family? (i.e., another family or institution takes care of them)
4. In general, which activities do you usually perform in the daily care of your children? (*Probe: feeding, bathing, putting to sleep, washing clothes, purchasing food*)

Information

Now, we will ask about where you get information about raising children.

5. What are your main sources of information which help you know how to raise your child? (Probe: friends, family, neighbours, health center, religious/community leaders, programmes or trainings, TV/radio, social media)
   a. What kind of information do you get from each source?
   b. Is this information sufficient or do you wish you had more/other sources of guidance?
6. If you learn something new about caring for a child, to what extent do you trust this information/advice? Please explain.

Caregiving Knowledge, Beliefs, Aspirations, and Practices

Adequate Nutrition:

We want to find out how you take care of your young children, and we will begin by asking about feeding and nutrition.

7. How would you describe the nutrition of young children in your community?
   a. Who in the family/community will choose the diet of a child under age 6?
   b. Who in the family/community will buy the food for the child?
8. In your community, do mothers breastfeed their children? How often? Until what age?
   a. Do mothers/caregivers also feed other foods to children under the age of 3? What about children age 3-6?

b. Is there a difference between the diet of boys and girls?

9. Can anyone tell me: How do you know if a young child is malnourished? (Probe for source of this information—*how do you know this fact?)*
   a. In your opinion, how soon should a caregiver seek professional help if a child appears to be malnourished?
10. In your knowledge, how should parents act to ensure that children are nourished when they are under 3 years old? What about when they are 3-6 years old?

Good Health:

Now, we will ask you about the physical health of your child and how you keep them healthy.

11. How would you describe the physical health of young children in your community?
    a. What are common illnesses amongst young children?
    b. How do children catch these illnesses?
12. In this community, do many people practice hand washing, for instance after using the toilet or before eating food? Why or why not?
13. In this community, how do caregivers dispose of the faeces of small children? Is this always the case?
14. In general, how do you know if a young child is sick or ill? What signs will they show?
    a. How do you decide if the illness is a serious issue?
15. How can parents in your community best prevent a child from falling ill? (e.g., from diarrheal diseases)

Safety and Security:

Thank you for your answers. Next, we will ask you some questions about discipline and the safety of your young children.

16. What is the importance of discipline? Whose responsibility is it to discipline children?
17. What are some discipline strategies that parents/caregivers of young children use in your community?
    a. Are there different methods for disciplining young children (0-3 years) as compared to older children (4-6 years)?
    b. Are there different methods for disciplining boys as compared to girls?
18. Is there a problem with violence towards children in your community? Please explain but do not use any names of children who experienced violence.
19. Some people use positive discipline with children. This means that if their child misbehaves, they do not use physical punishment or speak harshly to the child. Instead, they try to move the child's attention to something else, talk with the child, ignore small misbehaviours, or praise good behaviour. What do you think about positive discipline for young children? Is it a good or bad strategy?

NOTE: If respondent reports a case of child abuse (physical, emotional, sexual) in their community, follow up encouraging the respondent to seek assistance from a healthcare provider or the district social services office. Further, you may offer contact information for the following services:

[Contact info will be added here]

Responsive Caregiving:

Next, we want to ask about how you help your children feel supported.

20. In your community, how do you describe 'good behaviour' for a child…
    a. Who is 3 years old?
    b. Who is 6 years old?
    c. Is there a difference between good behaviour in boys and girls at these ages?
21. In your community, are children usually nearby their parent or caregiver? For instance, can a parent always see their young child? Can they always hear them?
22. Do you think it is important to talk about feelings with your child? Why or why not?
    a. If a young child (age 0-3) becomes upset or starts crying, how will parents/caregivers usually react? *(Probe: do you feed them, hold them, comfort them, sing to them, tell them it's OK?)*
    b. If an older child (age 4-6) becomes upset or starts crying, how will parents/caregivers usually react? *(Probe: do you feed them, hold them, comfort them, sing to them, tell them it's OK?)*
    c. Is there a difference between how you comfort a boy as compared to a girl?
23. Can someone tell me: how do you show your child that they are loved? (Prompt: telling them that they're loved, telling them they are a good boy/girl, hugging them, holding them, playing with them, providing for them, disciplining them, sending them, buying them presents)

Opportunities for Early Learning:

The next topic we will ask about is how you help your children learn new skills and grow smarter while they are young.

24. In your community, is there a preschool for children under the age of 6?
    a. Do your children attend preschool now, or have they attended in the past? Please explain.
25. What kinds of games or play do young children in your community engage in?
    a. What objects do they use for play? Where do these objects come from? (*Probe: toys, rocks, sticks, old tires, dolls, soccer ball*)
26. Do most parents in your community…
    a. Speak or sing to their child? Please explain.
    b. Read to their child? Please explain.
27. Do you think it's important to read and speak to young children?
28. Can someone explain: What characteristics or skills does an intelligent child have? *(Prompt: When should they start to speak? To read?)*
    a. What should the parents in your community do to ensure that their child will be intelligent in the ways you described?
29. We have now talked about nutrition, health, safety, emotional needs, and learning. Aside from what we discussed so far, do you currently do anything else do to encourage the growth and development of your child/ren?

a. Where did you learn to do this? Why do you do it?

ECD Services

We are nearing the end of our discussion, but we want to ask you about some of the services that you have used to care for your small children.

30. Are there many services or programmes in your community that support families with small children? Can you name them? *(Probe: health services, programmes or trainings, feeding programmes, social protection/cash transfer, preschools)*
    a. What did they offer you? (e.g., financial support, knowledge, confidence, immunisations/medicines, other resources)
    b. Do you recommend that others use the service(s)? Why or why not?
31. Which service or programme has been most helpful to you as a caregiver? Why?
32. Have you heard of services in other communities that you would like to see in your community?

Barriers to Best Practice

Lastly, we want to understand what difficulties you face as a caregiver.

33. As a caregiver/parent, are you always the one to make decisions about the child? Who else will have a say? (*Probe: your spouse, parents, in-laws, neighbours, community leaders, teacher, aunts/uncles, siblings*)
34. Do you think you can significantly contribute the well-being of your children? Why or why not?
35. Are there other times when you have known what was best for your child/ren but couldn't do what was best for some reason? What prevented you from doing what was best for the child? *(Probe: time, geography, money, gender or spousal roles, culture, displacement/conflict)*
    a. What did you do instead?

Conclusion

Is there anything else you'd like to tell me about taking care of your child/ren and helping them grow?

Thank respondents for their time.

FGD Protocol: Fathers/Male Caregivers

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3. Do you have any children who are not currently living with your family? (i.e., another family or institution takes care of them)
4. In general, which activities do you usually perform in the daily care of your children? (*Probe: feeding, bathing, putting to sleep, washing clothes, purchasing food*)

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    a. What kind of information do you get from each source?
    b. Is this information sufficient or do you wish you had more/other sources of guidance?
6. If you learn something new about caring for a child, to what extent do you trust this information/advice? Please explain.

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13. In this community, how do caregivers dispose of the faeces of small children? Is this always the case?
14. In general, how do you know if a young child is sick or ill? What signs will they show?
    a. How do you decide if the illness is a serious issue?
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18. Is there a problem with violence towards children in your community? Please explain but please do not use any names of children who experienced violence.
19. Some people use positive discipline with children. This means that if their child misbehaves, they do not use physical punishment or speak harshly to the child. Instead, they try to move the child's attention to something else, talk with the child, ignore small misbehaviours, or praise good behaviour. What do you think about positive discipline for young children? Is this a good or bad strategy?

NOTE: If respondent reports a case of child abuse (physical, emotional, sexual) in their community, follow up encouraging the respondent to seek assistance from a healthcare provider or the district social services office.

Responsive Caregiving:

Next, we want to ask about how you help your children feel supported.

20. In your community, how do you describe 'good behaviour' for a child…
    a. Who is 3 years old?
    b. Who is 6 years old?
    c. Is there a difference between good behaviour in boys and girls at these ages?
21. In your community, are children usually nearby their parent or caregiver? For instance, can a parent always see their young child? Can they always hear them?
22. Do you think it's important to talk about feelings with your child? Why or why not?
    a. If a young child (age 0-3) becomes upset or starts crying, how will parents/caregivers usually react? *(Probe: do you feed them, hold them, comfort them, sing to them, tell them it's OK?)*
    b. If an older child (age 4-6) becomes upset or starts crying, how will parents/caregivers usually react? *(Probe: do you feed them, hold them, comfort them, sing to them, tell them it's OK?)*
    c. Is there a difference between how you comfort a boy as compared to a girl?
23. Can someone tell me: how do you show your child that they are loved? (Prompt: telling them that they're loved, telling them they are a good boy/girl, hugging them, holding them, playing with them, providing for them, disciplining them, sending them, buying them presents)

Opportunities for Early Learning:

The next topic we will ask about is how you help your children learn new skills and grow smarter while they are young.

24. In your community, is there a preschool for children under the age of 6?
    a. Do your children attend preschool now, or have they attended in the past? Please explain.
25. What kinds of games or play do young children in your community engage in?
    a. What objects do they use for play? Where do these objects come from? (*Probe: toys, rocks, sticks, old tires, dolls, soccer ball*)
26. Do most parents in your community…
    a. Speak or sing to their child? Please explain.
    b. Read to their child? Please explain.
27. Do you think it's important to read and speak to young children?
28. Can someone explain: What characteristics or skills does an intelligent child have? *(Prompt: When should they start to speak? To read?)*
    a. What should the parents in your community do to ensure that their child will be intelligent in the ways you described?
29. We have now talked about nutrition, health, safety, emotional needs, and learning. Aside from what we discussed so far, do you currently do anything else do to encourage the growth and development of your child/ren?
    a. Where did you learn to do this? Why do you do it?

ECD Services

We are nearing the end of our discussion, but we want to ask you about some of the services that you have used to care for your small children.

30. Are there many services or programmes in your community that support families with small children? Can you name them? *(Probe: health services, programmes or trainings, feeding programmes, social protection/cash transfer, preschools)*
    a. What did they offer you? (e.g., financial support, knowledge, confidence, immunisations/medicines, other resources)
    b. Do you recommend that others use the service(s)? Why or why not?
31. Which service or programme has been most helpful to you as a caregiver? Why?
32. Have you heard of services in other communities that you would like to see in your community?

Barriers to Best Practice

Lastly, we want to understand what are some of the difficulties you face as a caregiver.

33. As a caregiver/parent, are you always the one to make decisions about the child? Who else will have a say? (*Probe: spouse, mother-in-law, neighbour, community leader, teacher*)
34. Do you think you can significantly contribute the well-being of your children? Why or why not?
35. Are there other times when you have known what was best for your child/ren but couldn't do what was best for some reason? What prevented you from doing what was best for the child? *(Probe: time, geography, money, gender or spousal roles, culture, displacement/conflict)*
    a. What did you do instead?

Conclusion

Is there anything else you'd like to tell me about taking care of your child/ren and helping them grow?

Thank respondents for their time.

IDI Protocol: Mothers/Female and Fathers/Male Caregivers

Enumerator: Please read the consent form and obtain consent from the participant before proceeding. Confirm that the participant has children between ages 0 and 6. Note the age and gender of the respondent's child/ren.

Household Caregiving Context

We are conducting this study to understand how parents raise their children in this part of Ethiopia. We will start with some general questions about your family.

1. How old are your children? How many boys? How many girls?
2. Who is primarily responsible for raising children in your family? *(Probe: mothers, fathers, siblings, grandmothers, neighbours, other caregivers).*
   a. Who else helps with raising children?
3. Which activities do you usually perform in the daily care of your child/ren? (*Probe: feeding, bathing, putting to sleep, washing clothes*)
4. Can you describe how caregiving decisions are usually made for your young children? Examples include decisions around health, education, and discipline.
   a. Have there ever been disagreements between yourself and another person about the care of your child/ren? What happened?

Information Sources

Now, we will ask about where you get information about raising children.

5. Do you have information about how to raise your child? Where did you learn this information? (Probe: friends, family, neighbours, health center, religious/community leaders, programmes or trainings, TV/radio, social media)
   a. Is this information sufficient or do you wish you had more/other sources of guidance?
6. If you learn something new about caring for a child, to what extent do you trust this information/advice? Please explain.
   a. Are there any caregiving practices that you have been advised to use, or you learned when you were younger, and have chosen to ignore? Why?
7. If you were to face a situation where you don't know how to care of your child, what would you do?

Caregiving Knowledge, Beliefs, Aspirations, and Practices

We want to find out how you take care of your young children, and we will begin by asking about feeding and nutrition.

Adequate Nutrition:

8. How do you know that your children are eating a balanced diet? How do you know if they are not nourished?
9. In your family, who is responsible for making sure children are nourished?
   a. Who purchases food?
10. Please describe what your child will eat and drink in a day, including how often and how much. (*Probe for morning, midday, evening, night*)

a. Has your child's diet changed over the past year?

b. Does your child drink water? If so, at what age did you start giving them water?

11. *For females only:* Do/did you breastfeed your child/ren?
    a. When did you start breastfeeding your child? (Probe for age of child when they were first breastfed). How often do/did they breastfeed?

    b. When did you stop?

    c. Did you start to introduce additional foods such as porridge while you were breastfeeding?

Good Health:

Now, we will ask you about the physical health of your child and how you keep them healthy.

12. Has your young child ever fallen sick? What happened? (*Probe for: age, sickness, symptoms)*
13. How do you decide if a sickness is a serious issue? When is it necessary to seek help for the illness?
14. How often do you wash your child's body? Please describe. (*Probe for soaps or other products used*)
15. Do you practice handwashing in your family? Why or why not? Who participates?
16. Where does your child receive general health services, for instance if they are falling ill? Who usually takes them to this place?
17. Has your child received any vaccinations? If yes, which ones? If no, why not?

If the caregiver has a child with a physical or mental disability:

18. How did you learn of your child's disability? How did you react? How did your spouse, family, and community react? Why?

Safety and Security:

Thank you for your answers. Next, we will ask about the how you some questions about discipline and the safety of your young children.

19. What are the best ways that parents can keep small children safe in your community?
20. Do you recall a recent time when you disciplined your child? Please describe how and why you disciplined them. Probe for age of child.
    a. How does your spouse discipline your children?
21. Is there a problem with violence towards children in your community? If so, why?
22. Should parents in your community be worried about their children experiencing sexual abuse?
23. If a child is harmed by someone in the community, how will the child's parents respond? Why?

NOTE: If respondent reports a case of child abuse (physical, emotional, sexual) in their community, follow up encouraging the respondent to seek assistance from a healthcare provider or the district social services office.

Responsive Caregiving:

Next, we want to ask about how you help your children feel supported.

24. Some people think that it is important to show young children a lot of affection such as by hugging them, smiling at them, and laughing with them. Other people think expressing love can spoil a child. What do you think, and why?
    a. If they disagree: How do you express that you love your child?

25. Does your child communicate their feelings to you, for instance, when they are happy, scared, upset, etc.? How do they communicate these feelings?
    a. Does this change if they are a boy or a girl?

26. How do you react when your child cries or becomes upset? (Prompt: do you feed them, hold them, bounce them, comfort them, sing to them, tell them it's OK?)
    a. What do you do to comfort them?

    b. Is there a difference in how you comfort a younger child (0-3) as compared to an older child (4-6)?

    c. Is there a difference in how you comfort boys and girls?

27. How do you react when your child shows good behaviour?

Opportunities for Early Learning:

Next, we will ask about is how you help your children learn new skills when they are young.

28. In your opinion, what are some of the best ways you can help your child grow to be intelligent?

29. Do you think it's important…
    a. For your child to be curious and/or creative? Why?

    b. For children to play and do games? Why?

30. Do you ever...
    a. Speak to your child? What do you say to them?

    b. Read to your child? If so, what do you read to them?

31. Is your child enrolled in preschool or primary school?
    a. If yes: Do you do anything to help your child do well in school? (Probe: Helping with homework, talking to the teacher)

    b. If no: Why not?

32. When you try to teach your child how to do something (e.g., cooking, play a game, wear clothes), how do you usually go about it? *(Prompt: do you do it yourself or do you instruct your child verbally as they do it?)*

33. We have now talked about nutrition, health, safety, emotional needs, and learning. Aside from what we discussed so far, do you currently do anything else do to encourage the growth and development of your child/ren?
    a. Where did you learn to do this? Why do you do it?

ECD Services

We are nearing the end of our discussion, but we want to ask you about some of the services that you have used to care for your small children.

34. In your opinion, are there adequate services or programmes to support families with small children?
35. What services have helped you care for your child? (Probe for: health support, education support, economic support, etc.)
36. How did you find out about the services you mentioned?
37. Were these services easy to use?
    a. Do you have to pay to use the service(s)? If so, how much?
        i. Who usually pays the fee, if it is required? (e.g., respondent, spouse)
    b. Do you continue to use the service(s)? Why or why not?
    c. Do you recommend that others use the service(s)? Why or why not?
38. Have your caretaking practices have been affected by your use of the services you mentioned? If so, how? If not, why not? *(Prompt: nutrition, discipline, health, education)*

Barriers to Best Practice

Lastly, we want to understand the difficulties you face as a caregiver.

39. Do you think you can significantly contribute the well-being of your children? Why or why not?
40. Are there other times when you have known what was best for your child/ren, but couldn't do what was best for some reason? What prevented you from doing what was best for the child? *(Probe: time, geography, money, gender or spousal roles, culture, displacement/conflict)*
    a. What did you do instead?

Conclusion

Is there anything else you'd like to tell me about taking care of your child/ren and helping them grow?
Thank respondent for his/her time.

IDI Protocol: Institution Caring for Children with Disabilities

Enumerator: Please read the consent form and obtain consent from the participant before proceeding. Note the age and gender of any children mentioned during the interview.

Introduction

We are conducting this study to understand the care provided to children with disabilities in this part of Ethiopia. We will start with some general questions about your position.

1. What is your role here?
    a. How long have you worked here?
    b. What were you doing before you worked here?

Background and Context

To begin, we want to understand how this institution operates and who it serves.

2. How many children does your institution care for?
    a. How old are the children you care for?
    b. How many boys? How many girls?
    c. Do any of them have disabilities? If so, how many?
    d. What types of disabilities are more common?
        i. *Probe: physical disabilities (blindness, deafness, difficulties in walking/moving, paralysis), intellectual disabilities, others*
    e. How do children come to you? How do you decide to accept a child into your care?
3. How many staff do you have here? Can you describe their qualifications?
    a. How do staff learn to care for children with disabilities?
    b. Are there other sources of information, advice, or knowledge that staff rely on to care for these children? Please explain.
4. What are some of the main challenges you face in your role?

Caregiving Knowledge, Beliefs, Aspirations, and Practices

Next, we will ask how this institution cares for the young children in its care, beginning with feeding and nutrition.

Adequate Nutrition:

5. In general, how does this institution support good nutrition for the children in your care? Please explain and give examples.
6. Are any of the children in your care currently given breastmilk? Please explain.
    a. What foods and fluids are usually given to small children (under 3)?
    b. What foods and fluids are usually given to older children (4-6)
7. What are some challenges or barriers faced by the institution in regard to providing adequate nutrition?
    a. Are any of these specific to caring for children with disabilities?

Good Health:

Now, we will ask about your practices for keeping the children here in good health.

8. In general, how does this institution support good health and hygiene for the children in your care? Please explain and give examples.
9. How often are small children bathed? By whom?
10. Do you have adequate facilities to promote good hygiene? (*Probe: latrines, handwashing, bathing, disposal of faeces)*
11. Who usually takes care of cleaning the faeces of small children? How do they/you dispose of the faeces? Is this always the case?
12. What do you do if a child appears to be ill? Where can you seek help?
    a. How often does this happen?
13. Have the children in your care received any vaccinations? Please explain.
14. What are some challenges or barriers faced by the institution in regard to keeping the children healthy?
    a. Are any of these specific to caring for children with disabilities?

Safety and Security:

Next, we will ask you some questions about discipline and the safety of the children in your care.

15. In general, how does this institution support the safety and security of the children in your care? Please explain and give examples. *(Probe: play environments, punishment and violence, poverty*)
16. What do your children do when they are not in school? If your children are not yet attending school, what do they do during the day?
17. How are children disciplined in this institution?
    a. Do you recall a recent time when a child was disciplined? Please describe the situation. (*Note the age and gender of the child*)
18. What are some challenges or barriers faced by the institution in regard to keeping the children safe and secure?
    a. Are any of these specific to caring for children with disabilities?

[To be added: Ethical note about disclosure and reports of physical and/or sexual abuse.]

Responsive Caregiving:

Next, we want to know how you help children feel supported when they are in your care.

19. In general, how does this institution identify and respond to the emotional needs of the children in your care? Please explain and give examples.
20. Some people think it is important to comfort children when they are upset. Other people do not agree. What do people in this region think, and why?
    a. Do people have different attitudes for girls versus boys?

21. Some people think that it is important to show young children a lot of affection such as by hugging them, smiling at them, and laughing with them. Other people do not agree. What do people in this region think, and why?
    a. Do people have different attitudes for girls versus boys?
22. What are some specific activities that this institution does to identify and meet the emotional needs of the young children in your care?
    a. For the younger children (3 and under), what happens when they cry? Who will respond? How will the child be comforted?
    b. For the older children (4 to 6), what happens when they are upset? Who will respond? How will the child be comforted?
    c. Do caregivers ever play with the children in your care? If so, what games? Why do they do this?
    d. Is it the role of this institution to make children feel loved? If yes, how do you try to do this?
23. What are some challenges or barriers faced by the institution in regard to identifying and responding to the needs of the children in your care?
    a. Are any of these specific to caring for children with disabilities?
24. To what extent are children's families involved in their lives? (Probe: Are they able to visit their children whenever they wish? Do they need to make an appointment to visit ? Are they able to take their child out or home? Does the institution encourage families to visit, and help them to do so – such as through flexible scheduling?)
25. To what extent does this institution work with families to help them know how to support their child's development and wellbeing?
26. To what extent are families actively involved in planning their child's services and care at this institution?

Opportunities for Early Learning:

Thank you. The next topic is learning and education.

27. Over the course of a 24-hour day, about how many hours are infants ages 0-1 in their cribs/cots/beds (whether awake or asleep)? What about toddlers ages 2-3? Children aged 4-6?
28. In general, how does this institution support the education and learning for the children in your care? Please explain and give examples.
29. Do caregivers tell stories or speak to children? Read to them? Please explain and offer examples.
30. For children ages 0-3, is there any kind of programming to support their development and learning?
31. For children ages 3-6, how many days a week to they participate in formal educational activities, such as preschool? Is this programming on site or in the community?
32. To what extent is your institution able to support children's special needs through services such as physical therapy?

33. How do the children play and what objects do they play with? *(Probe: toys, rocks, sticks, old tires, dolls, soccer ball)*
    a. Who provides these objects? Are there enough, given the number of children?
34. What are some challenges or barriers faced by the institution in regard to supporting the learning of the children in your care?
    a. Are any of these specific to caring for children with disabilities?
35. Some children have serious disabilities and may not ever be able to care for themselves, finish primary school, or have a job. Some people in the world think it is a waste of time and resources to try to educate these kinds of children. Other people think that you should try to educate them anyway. What do people in this institution think?

ECD Services

We are nearing the end of our discussion, but we want to ask you about some of the services that have assisted and supported this institution in caring for young children.

36. Are there any services or programmes in your community that support this institution in caring for young children? What are they?
    a. Has the health centre provided any services that have helped the institution care for these children? Which ones? What did they offer you?
    b. Are there education services that have helped the institution care for these children?
    i. *If yes:* Have you used them? Why or why not?
    c. Are there any kinds of economic support programmes that have helped the institution care for these children?
    i. *If yes:* Have you benefitted from the programme? How?
37. How did you get connected with these services?
38. Do you have to pay for the services? If so, how much? Who pays?
39. Did they work well for you? Is there anything you would change about these services?

Barriers to Best Practice

Lastly, we want to understand if there are some challenges or difficulties that you face as an institution.

40. What would you consider the strengths of this institution when it comes to caring for young children with disabilities?
41. What are its weaknesses?
    a. What kinds of support is needed to overcome these weaknesses? (Probe: training, financial support, institutional support, community support)

Conclusion

Is there anything else you'd like to tell me about taking care of young children with disabilities?

Thank respondent for his/her time.

KII 1: National-Level Policy Makers & Key Stakeholders

Enumerator: Please read the consent form and obtain consent from the participant before proceeding.

Introduction

I would like to begin our conversation with a few questions related to your position.

1. Can you please introduce yourself and tell me a bit about your background and responsibilities in your current position, specifically your role and responsibilities regarding Early Childhood Development (ECD)?
2. How does your organisation/ministry support ECD in Ethiopia? *(Probe for work around health, nutrition, child protection/safety, responsive caregiving, and early learning).*
    a. What is the regional scope of your organisation's work regarding ECD? Do you work with specific regions (*such as Amhara, Afar, Oromia, Gambela, or SNNPR*) regarding ECD? If so, please describe.
    b. What populations does your organisation engage with in its ECD work?
        i. Does your ECD work involve with pastoralists, refugees, or internally displaced populations (IDPs)?
    c. Does your organisation work specifically on issues of gender or disability as they relate to ECD?
        i. If so, please explain.

Policy Context

Now, I would like to ask some questions about the policy context in Ethiopia and how it supports parents.

3. In your knowledge, what are some key laws, policies, and frameworks that are in place to support ECD in Ethiopia? (Probe for work in nutrition, health, education (early learning), child protection, safety and security, parenting/responsive caregiving, inter-sectoral collaboration).
    a. In your view and professional experience, which of these is most important? Why?
    b. Do you think ECD is a priority for national policymakers? Why or why not?
    c. What are the biggest gaps in policy regarding ECD and parental support?
4. Which organisations/institutions are working at the grassroots level to support parent with children aged 0-6? What activities is each one doing?
    a. What ministries are involved in providing support to parents, and what kind of support do they offer?
    b. What other organisations (non-governmental organisations, donors, civil society groups) are involved in supporting parents in Ethiopia? What kind of support do they offer?
    c. What are the biggest strengths and challenges of existing support structures for parents?
    d. How could these institutional arrangements be improved to better support parents?

5. ECD involves many sectors, such as health, gender, education, and so on. Can you describe how your ministry/organisation coordinates with others on ECD-related work?
    a. Are there formalised methods for coordination? If so, what are they?
        i. When were these put in place? Do they work well?
    b. What are some informal ways that you coordinate with other organisations or other parts of the government for your work on ECD? (e.g., not an organised meeting or work group but ad hoc coordination)
    c. How does this coordination affect the delivery of services to parents and caregivers? Please explain.
    d. Can you think of an area where more coordination is needed?

ECD Caregiving Context

6. What sources of information or data, if any, are available about the practices and needs of parents/caregivers in different regions of Ethiopia?
    a. Where do you get information about the practices of parents and caregivers in this area? (Probe: from ministries, NGOs, service providers, personal observations, news media, trainings)
        i. How do you use this information?
    b. Is there adequate data on parenting practices across Ethiopia? If not, which topics lack sufficient data?
7. Based on your knowledge of the early childhood development landscape in Ethiopia, what are the areas where parents/caregivers need the most support in relation to ECD?
    a. Probe: Nutrition, health, hygiene/WASH, discipline, early stimulation, early childhood education, nurturing care.
    b. Do these needs vary across regions? If so, how?
        i. Probe: Amhara, Afar, Oromia, Gambela, or SNNPR
    c. Do these needs vary across different ethnic groups/populations, such as children with disabilities, pastoralists, refugees, or internally displaced populations (IDPs)?
    d. Do these needs vary according to gender?
8. What are the sources of information available to parents/caregivers about how to care for young children across different regions of Ethiopia?

(Probe: information about nutrition, health, education, discipline, and ECD services. Potential sources of information: health centres, NGOs, government communication campaigns, churches/religious institutions, radio/TV, social media)

    a. Do they have sufficient information about caregiving?
    b. If not, what kinds of information do they lack? *(Probe: nutrition, health, education, child protection, services)*
    c. To what extent do parents/caregivers have access to trustworthy, evidence-based information on ECD?
9. Aside from information, what else do parents and caregivers need in order to better support ECD? *(Probe: financial, community, institutional support)*

ECD Services

We are interested in knowing more details about the scope and delivery of parenting support services.

10. What kinds of parenting support services are available to parents and caregivers in different regions of Ethiopia? Please describe. *(Probe: nutrition, health, education, safety, early learning)*
    a. How do parents and caregivers hear about these services?
    b. Does the programme successfully reach parents/caregivers? Why or why not? *(Probe: cost to user, cultural acceptability, quality of the service, effectiveness of the service)*
        i. Is there a particular group of caregivers or children that you struggle to reach with current ECD services?
    c. What is the quality of existing parenting support services?
    d. How effective are existing parenting support services?
11. To what extent is family separation an issue across different regions of Ethiopia? (i.e., children separated from family as orphans or to receive care)
    a. Are you aware of any resources, services, or programmes that care for children who have been orphaned or separated from their family?
12. Beyond your own, what ministries or organisations take part in the delivery and funding of ECD services and programmes?
13. Aside from those already in place, what services would you like to see to support parents and caregivers? Why aren't these in place currently?

Conclusion

Is there anything else you'd like to tell me about the ECD landscape or existing parent support services in Ethiopia?
Thank respondent for his/her time.

KII Protocol: Regional/Zonal Policymakers

Enumerator: Please read the consent form and obtain consent from the participant before proceeding.

Introduction

I would like to begin our conversation with a few questions related to your position.

1. What is your professional role?
    a. What are the primary responsibilities involved in your job?
2. In what capacity do you work with children ages 0-6 and their parents and caregivers? (i.e., in what context, how many children, etc.).
3. How does your organisation/ministry support ECD in this area? *(Probe for work around health, nutrition, child protection/safety, responsive caregiving, and early learning).*
    a. What is the regional scope of your organisation's work regarding ECD? Do you work with specific regions (*such as Amhara, Afar, Oromia, Gambela, or SNNPR*) regarding ECD? If so, please describe.
    b. What populations does your organisation engage with in its ECD work?
        i. Does your ECD work involve with pastoralists, refugees, or internally displaced populations (IDPs)?
    c. Does your organisation work specifically on issues of gender or disability as they relate to ECD?
        i. If so, please explain.

Policy Context

I want to ask now about the institutional arrangements that exist to support parents and caregivers in raising young children.

4. In your knowledge, what are some key laws, policies, and frameworks that are in place to support ECD in Ethiopia? (Probe for work in nutrition, health, education (early learning), child protection, safety and security, parenting & responsive caregiving, inter-sectoral collaboration).
    a. In your view and professional experience, which of these is most important? Why?
    b. Do these arrangements affect your work in this region? (e.g., providing coordination mechanisms, garnering funding)
        i. If yes, how? If no, why not?
5. ECD involves many sectors, such as health, gender, education, and so on. Can you describe how organisations and institutions that work on these topics coordinate with one another?
    a. Are there formalised methods for coordination? If so, what are they?
        i. When were these put in place? Do they work well?

b. What are some informal ways that you coordinate with other organisations or other parts of the government for your work on ECD? (e.g., not an organised meeting or work group but ad hoc coordination)

c. How does this coordination affect the delivery of services to parents and caregivers?

d. Can you think of an area where more coordination is needed?

ECD Caregiving Context

6. In your view, what are the main challenges parents and caregivers (in this area/community) face in caring for their children?

   a. Conversely, what are the strengths of parents and caregivers in this area? What do they do well?

7. What sources of information or data, if any, are available about the practices and needs of parents/caregivers in different parts of this region/zone?

   a. Where do you get information about the practices of parents and caregivers in this area? (Probe: from ministries, NGOs, service providers, personal observations, news media, trainings)

      i. How do you use this information?

   b. Is there adequate data on parenting practices across this region? If not, which topics lack sufficient data?

8. Based on your knowledge of the early childhood development landscape in this area, what are the areas where parents/caregivers need the most support in relation to ECD? *Probe: Nutrition, health, hygiene/WASH, discipline, early stimulation, early childhood education, nurturing care.*

   a. Do these needs vary across woredas? If so, how?

   b. Do these needs vary across different ethnic groups/populations, such as children with disabilities, pastoralists, refugees, or internally displaced populations (IDPs)?

   c. Do these needs vary according to gender?

9. In your view, do parents and caregivers in this area have sufficient information about how to care for young children?
   (Probe: information about nutrition, health, education, discipline, and ECD services. Potential sources of information: health centres, NGOs, government communication campaigns, churches/religious institutions, radio/TV, social media)

   a. If not, what kinds of information do they lack? (Probe: nutrition, health, education, child protection, services)

   b. To what extent do parents/caregivers have access to trustworthy, evidence-based information on ECD?

   c. In your opinion, what is the best way to provide information to caregivers? Why?

10. Aside from information, what else do parents and caregivers need in order to better support ECD? *(Probe: financial, community, institutional support)*

ECD Services

We are interested in knowing more details about the scope and delivery of parenting support services.

11. What kinds of parenting support services are available to parents and caregivers in this region/zone of Ethiopia? Please describe. *(Probe: nutrition, health, education, safety, early learning)*
    a. How do parents and caregivers hear about these services?
    b. Does the programme successfully reach parents/caregivers? Why or why not? *(Probe: cost to user, cultural acceptability, quality of the service, effectiveness of the service)*
        i. Is there a particular group of caregivers or children that you struggle to reach with current ECD services?
    c. What is the quality of existing parenting support services?
    d. How effective are existing parenting support services?
12. To what extent is family separation an issue in this region? (i.e., children separated from family as orphans or to receive care)
    a. Are you aware of any resources, services, or programmes that care for children who have been orphaned or separated from their family?
13. Beyond your own, what ministries or organisations take part in the delivery and funding of ECD services and programmes?
14. Aside from those already in place, what services would you like to see to support parents and caregivers? Why aren't these in place currently?

Conclusion

Is there anything else you'd like to tell me about typical parenting practices in this area or your role as a [leader/service provider]?

Thank respondent for his/her time.

KII Protocol: Woreda Level Community Leaders

Enumerator: Please read the consent form and obtain consent from the participant before proceeding.

Introduction

I would like to begin our conversation with a few questions related to your position.

1. What is your role in the community?
    a. What are the primary responsibilities involved in this role?
2. Please describe how you typically interact with children and their parents (i.e., in what context, how many children, etc.).

ECD Caregiving Context

3. Do you feel informed about the caregiving practices of parents and caregivers in this community?
    a. Where do you get information about the practices of parents and caregivers in this area? *(Probe: from service providers, personal observations, news media, trainings)*
    b. How do you use this information?
4. In your view, what are the main challenges parents and caregivers (in this area/community) face in caring for their children?
    a. Conversely, what are the strengths of parents and caregivers in this area? What do they do well?
5. Based on your knowledge of this community, what are the areas where parents/caregivers need the most support in relation to raising young children?
    Probe: Nutrition, health, safety/discipline, learning/education, emotional responsiveness.
    a. Do these needs vary across different households? If so, how?
    b. Do these needs vary across different ethnic groups/populations, such as children with disabilities, pastoralists, refugees, or internally displaced populations (IDPs)?
    c. Do these needs vary according to gender?
6. How do parents in this community learn how to care for their children? (*Probe: family, religion, trainings, service providers, etc.*)
7. In your view, do parents and caregivers in this area have sufficient information about how to care for young children?
    (Probe: information about nutrition, health, education, discipline, and ECD services. Potential sources of information: health centres, NGOs, government communication campaigns, churches/religious institutions, radio/TV, social media)
    a. If not, what kinds of information do they lack? (Probe: nutrition, health, education, child protection, services)
    b. In your opinion, what is the best way to provide information to caregivers? Why?
8. Aside from information, what else do parents and caregivers need in order to better support ECD? *(Probe: financial, community, institutional support)*

9. In your view, does a child's gender affect how they are treated when they are young? Please explain. *(Probe for: feeding, health treatment, play, discipline, education)*
10. When children in this community have physical disabilities (such as difficulty with vision, hearing, or movement), does the family help them become part of the community, or are they kept at home and away from others?
    a. Would people in the community allow their children to play with the child who has a physical disability?
    b. Would the child be enrolled in preschool or school with the other children?
11. When children in this community have intellectual disabilities (are slow learners or do not act like other children), does the family help them become part of the community, or are they kept at home and away from others?
    a. Would people in the community allow their children to play with the child who has an intellectual disability?
    b. Would the child be enrolled in preschool or school with the other children?

ECD Services

Finally, we are interested in knowing more details about the scope and delivery of parenting support services.

12. Are you aware of any services that support parents of young children in this community? Please describe. *(Probe: nutrition, health, education, safety, early learning)*
    a. How do parents and caregivers hear about these services?
    b. What is the quality of existing parenting support services?
    c. How effective are existing parenting support services?
13. Who provides these services? (i.e., which ministry or organisation)
14. Aside from those already in place, what services would you like to see to support parents and caregivers? Why aren't these in place currently?

Conclusion

Is there anything else you'd like to tell me about typical parenting practices in this area?
Thank respondent for his/her time.

KII 4: Woreda-Level Service Providers

Enumerator: Please read the consent form and obtain consent from the participant before proceeding.

Introduction

I would like to begin our conversation with a few questions related to your position.

1. What is your professional role?
   a. What are the primary responsibilities involved in your job?
2. Please describe how you typically interact with children and their parents (i.e., in what context, how many children, etc.).

To begin, we want to understand how this institution operates and who it serves.

3. What kind of services do you provide to parents/caregivers to support raising young children?
4. How many staff do you have here? Can you describe their qualifications?
   a. Are there other sources of information, advice, or knowledge that staff rely on to care for children aged 0-6? Please explain.
   b. Are they trained/prepared to care for children with disabilities? Please explain.
5. What are some of the main challenges you face in your role?

ECD Caregiving Context

6. Do you feel informed about the caregiving practices of parents and caregivers in this community?
   a. Where do you get information about the practices of parents and caregivers in this area? *(Probe: from service providers, personal observations, news media, trainings)*
   b. How do you use this information?
7. In your view, what are the main challenges parents and caregivers in this community face in caring for their children?
   Probe for all domains: Nutrition, health, safety/discipline, learning/education, emotional responsiveness.
   a. Conversely, what are the strengths of parents and caregivers in this area? What do they do well?
8. Based on your knowledge of this community, what are the areas where parents/caregivers need the most support in relation to raising young children?
   Probe: Nutrition, health, safety/discipline, learning/education, emotional responsiveness.
   a. Do these needs vary across different households? If so, how?
   b. Do these needs vary across different ethnic groups/populations, such as children with disabilities, pastoralists, refugees, or internally displaced populations (IDPs)?
   c. Do these needs vary according to gender?
9. How do parents in this community learn how to care for their children? (*Probe: family, religion, trainings, service providers, etc.*)
10. In your view, do parents and caregivers in this area have sufficient information about how to care for young children?

(Probe: information about nutrition, health, education, discipline, and ECD services. Potential sources of information: health centres, NGOs, government communication campaigns, churches/religious institutions, radio/TV, social media)

   a. If not, what kinds of information do they lack? (Probe: nutrition, health, education, child protection, services)
   b. In your opinion, what is the best way to provide information to caregivers? Why?

11. Aside from information, what else do parents and caregivers need in order to better support ECD? *(Probe: financial, community, institutional support)*
12. Does a child's gender affect how they are treated when they are young? If so, how? *(Probe: feeding, health treatment, play, discipline, education)*
13. When children in this community have physical disabilities (such as difficulty with vision, hearing, or movement), does the family help them become part of the community, or are they kept at home and away from others?
    a. Would people in the community allow their children to play with the child who has a physical disability?
    b. Would the child be enrolled in preschool or school with the other children?
14. When children in this community have intellectual disabilities (are slow learners or do not act like other children), does the family help them become part of the community, or are they kept at home and away from others?
    a. Would people in the community allow their children to play with the child who has an intellectual disability?
    b. Would the child be enrolled in preschool or school with the other children?
15. To what extent is the community able to meet the needs of children with physical and/or intellectual disabilities?
16. To what extent is family separation an issue in this community? (i.e., children separated from family as orphans or to receive care)
    a. Are you aware of any resources, services, or programmes that care for children who have been orphaned or separated from their family?

ECD Services

We are interested in knowing more details about the scope and delivery of parenting support services.

17. What kinds of parenting support services are available to parents and caregivers in this community? Please describe. *(Probe: nutrition, health, education, safety)*
    a. Who provides these services? (i.e., which ministry or organisation)
18. How do parents and caregivers hear about these services?
19. Does the programme successfully reach the intended users? Why or why not? (Probe: cost to user, cultural acceptability, quality of the service, effectiveness of the service)
    a. Is there a particular group of caregivers or children that does not access current ECD services, even though these services would help them?
20. Aside from those already in place, what services would you like to see in your area to support parents and caregivers? Why aren't these in place currently?

Conclusion

Is there anything else you'd like to tell me about typical parenting practices in this area or your role as a [service provider]?

Thank respondent for his/her time.

Observation Protocol 1: Parent/caregiver and child interaction

Instructions to Enumerator: This observation should be conducted immediately after the IDI with parents/caregivers. The observation will last 15-20 minutes and will be focused on some observable characteristics of the home as well as interactions between the parent/caregiver and their child/ren. We provide a checklist below with some observation items in terms of home environment and parent/child caregiver interaction. **You should also provide descriptive notes of all the behaviours observed.** For example, if you observe the parent/caregiver comforting the child, you should provide a detailed description in the notes. *E.g.: The caregiver held the crying child and said comforting words to them until they stopped crying.*

At the end of the observation, we have some questions about parents' usual practice, to provide more context to the observation.

Enumerator – say to respondent: *We will conduct a short observation of your interactions with your child/ren, to understand the day-to-day interactions between parents/caregivers and children in this area. What do you do when you spend time with your children, during a moment of rest from your chores and daily activities? This is what we would like to observe. Feel free to play with your child/ren or interact with them like you normally do in a moment of rest/relaxation, and we will walk around and take some quick notes. We will also ask you a few short questions in the end.*

Section 1: Context

	Responses
1. How many children were present during the observation?	
2. During the observation, who cared for/interacted with the respondent's children? *(Probes: Mother, father, other caregiver, neighbours, siblings)*	

Section 2: Checklist

2.1. Home Environment

	YES	NO	NOTES
1. Home environment seems generally safe, with no obvious hazards to children nearby. 2. *Ex: homes that are free from dangers such as sharp objects (e.g.: broken glass, exposed nails), open fires, uncapped wells, etc.*			
3. There is a bathroom or dedicated latrine area near the home.			
4. There is an improved source of clean drinking water available in/near the home. 5. *Ex: piped, public standpipe, borehole, protected well, or bottled*			

	YES	NO	NOTES
water but are NOT water from rivers, lakes, ponds, streams.			
6. There is soap available for handwashing/bathing.			
7. Children have access to a safe play space near the home and/or toys.			
8. Children seemed to be well fed/have enough access to food.			
9. Children were generally clean.			
10. There were books or printed materials available.			

2.2. Support for Social-Emotional Development

	SEEN	NOT SEEN	DESCRIPTIVE NOTES
1. Parent/caregiver engaged in direct play with child/ren.			
2. If child/ren cried or became upset, parent comforted child/ren in some way (*provide details on how caregiver comforted child in the notes)*			
3. Parent/caregiver encouraged children, either verbally or through facial expressions.			
4. Parent praised child.			

2.3. Support for Cognitive Development

	SEEN	NOT SEEN	DESCRIPTIVE NOTES
1. Parent/caregiver engaged in direct play with child/ren.			
2. Parent/caregiver engaged in pretend play with children.			
3. Parent/caregiver's play encouraged children to engage in problem solving (e.g.: putting together an object).			
4. Parent/caregiver supported peer interaction or play between children.			
5. Parent/caregiver provided explicit teaching to children.			

2.4. Support for Language and Literacy Development

	SEEN	NOT SEEN	DESCRIPTIVE NOTES
1. Parent/caregiver spoke to child/ren directly.			
2. Parent/caregiver and children took turns when speaking			
3. Parent/caregiver engaged in singing/musical play with children.			
4. Parent/caregiver engaged children in books.			

2.5. Areas of Concern

	SEEN	NOT SEEN	DESCRIPTIVE NOTES
1. Parent/caregiver was physically harsh with children.			
2. Parent/caregiver was verbally harsh with children.			
3. Parent/caregiver ignored children.			
4. Parent/caregiver had poor safety or supervision of children during observation period.			
5. Children seemed overwhelmed or stressed.			
6. Parent/caregiver seemed overwhelmed or stressed.			
7. Home environment seems to have high level of chaos.			
8. Children exhibited extreme behaviour (unsafe, defiant of parents) during observation.			

Section 3: Open-ended observation

3.1. Please provide a brief overview of the context for the observation, including a description of the setting and the main types of activities that parents/caregivers and children were involved in. (Ex: Parents/caregivers were playing in a field near the house, play consisted of drawing on the ground with a stick).

3.2. Please describe what most stood out to you in terms of how parents/caregivers interacted with children.
3.3. Was there anything that surprised you during the observation?

Section 4: Questions for parents/caregivers (After observation is completed)

4.1. How often do you or other caregivers in your home do the following activities with your children?

	NEVER	SELDOM	A FEW TIMES	SOMETIMES	OFTEN	NOTES
1. Talk to your children						
2. Play with your children						
3. Comfort children who are upset						
4. Praise your children						
5. Read stories to your children						
6. Tell stories to your children						
7. Sing songs to your children						
8. Be physically harsh with your children						
9. Be verbally harsh with your children						
10. Ignore your children						

Observation Protocol 2: Institution Caring for Children with Disabilities

Instructions to Enumerator: This observation should be conducted immediately after the IDI with institutions caring for children with disability. The observation will last 15-20 minutes and will be focused on some observable characteristics of the institution as well as interactions between the caregivers and children under their care. We provide a checklist below with some observation items in terms of the environment and caregiver/child interaction. **You should also provide descriptive notes of all the behaviours observed.** For example, if you observe the caregiver comforting a child, you should provide a detailed description in the notes. *E.g.: The caregiver held the crying child and said comforting words to them until they stopped crying.*
At the end of the observation, we have some questions about caregivers' usual practice, to provide more context to the observation.
Enumerator – say to respondent: *We will conduct a short observation of your interactions with the children under your care, to understand the day-to-day interactions between caregivers and children in this type of institution. What do you do when it's time for the children to play and have fun? This is what we would like to observe. Feel free to play with the children or interact with them like you normally do in a moment of rest/relaxation, and we will walk around and take some quick notes. We will also ask you a few short questions in the end.*

Section 1: Context

	Responses
1. How many children were present during the observation?	
2. During the observation, who cared for/interacted with the children? Please note the number of caregivers in the notes. *(Probes: Institution staff members, children's family members, other children)*	

Section 2: Checklist

2.1. Institutional Environment

	YES	NO	NOTES
1. Facilities seem generally safe, with no obvious hazards to children nearby. 2. *Ex: Facilities are free from dangers such as sharp objects (e.g.: broken glass, exposed nails), open fires, unsafe/broken playgrounds, uncapped wells, etc.*			
3. There are enough staff to care for children at this facility (please indicate staff-to-child ratio in the notes).			

	YES	NO	NOTES
4. There is a bathroom or dedicated latrine area near the facilities.			
5. There is an improved source of clean drinking water available in/near the facilities. 6. *Ex: piped, public standpipe, borehole, protected well, or bottled water but are NOT water from rivers, lakes, ponds, streams.*			
7. There is soap available for handwashing/bathing.			
8. Children have access to a safe play space near the home and/or toys.			
9. Children seemed to be well fed/have enough access to food.			
10. Children seemed generally clean.			
11. There are books or printed materials available.			
12. Facilities are accessible to children with physical disabilities.			

2.2. Support for Social-Emotional Development

	SEEN	NOT SEEN	DESCRIPTIVE NOTES
1. Caregiver engaged in direct play with child/ren.			
2. If child/ren cried or became upset, caregiver comforted child/ren in some way (provide details in the notes)			
3. Caregiver encouraged children, either verbally or through facial expressions.			
4. Caregiver praised child.			

2.3. Support for Cognitive Development

	SEEN	NOT SEEN	DESCRIPTIVE NOTES
1. Caregiver engages in direct play with child/ren.			
2. Caregiver engages in pretend play with children.			
3. Caregiver's play encourages children to engage in problem solving (e.g.: putting together an object).			

	SEEN	NOT SEEN	DESCRIPTIVE NOTES
4. Caregiver supports peer interaction or play between children.			
5. Caregiver provides explicit teaching to children.			

2.4. Support for Language and Literacy Development

	SEEN	NOT SEEN	DESCRIPTIVE NOTES
1. Caregiver speaks to child/ren directly.			
2. Caregiver uses varied vocabulary when speaking to children.			
3. Caregiver and children take turns when speaking			
4. Caregivers engage in singing/musical play with children.			
5. Caregivers engage children in books.			

2.5. Areas of Concern

	SEEN	NOT SEEN	DESCRIPTIVE NOTES
1. Caregiver was physically harsh with children.			
2. Caregiver was verbally harsh with children.			
3. Caregiver ignored children.			
4. Caregiver had poor safety or supervision of children during observation period.			
5. Children seemed overwhelmed or stressed.			
6. Caregiver seemed overwhelmed or stressed.			
7. Home environment seems to have high level of chaos.			
8. Children exhibited extreme behaviour (unsafe, defiant) during observation.			

Section 3: Open-ended observation

3.1. Please provide a brief overview of the context for the observation, including a description of the facilities and general activities that staff and children engaged in.
3.2. Please describe what most stood out to you during the observation in terms of how caregivers interact with children.
3.3. Was there anything that surprised you during the observation?

Section 4: Questions for staff member/caregiver (After observation is completed)

4.1. How often do you or other caregivers in this institution do the following activities with the children under your care?

	NEVER	SELDOM	A FEW TIMES	SOMETIMES	OFTEN	NOTES
1. Talk to children						
2. Play with children						
3. Comfort children who are upset						
4. Praise children						
5. Read stories to children						
6. Tell stories to children						
7. Sing songs to children						
8. Be physically harsh with children						
9. Be verbally harsh with children						
10. Ignore children						

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