Moments That Matter® Program

Endline Evaluation

of the

18 Month Project Cycle

in Luapula and Central Provinces, Zambia

May 11, 2025

Submitted by Matt Zingel
Evaluation Consultant

Episcopal Relief & Development

Zambia Anglican Council Outreach Programmes

"...Feed my lambs" John 21 : 15

Table of Contents

1 Introduction....11
2 *Moments that Matter*®: Project Background....12
3 Evaluation Purpose....13
3.1 Evaluation Objectives....13
3.2 Limitations....13
4 Methodology....14
4.1 Evaluation Design....14
4.2 Sampling....14
4.3 Data Collection and Data Instrument Alignment....15
5 Findings....16
5.1 Socio-demographic Characteristics....16
5.2 Primary Caregiver Participation....18
5.3 Findings by outcomes....19
5.3.1 Outcome 1: Early Learning and Responsive Caregiving....19
5.3.2 Outcome 2: Child Safety and Security....25
5.3.3 Outcome 3: Psychosocial Well-being....33
5.3.4 Outcome 4: Gender-equitable Roles in Parenting....38
5.3.5 Outcome 5: Economic Empowerment....42
5.4 ECD Promoters....45
5.5 Wider Program Impact on Households and Community....49
6 Challenges and Enablers....51
6.1 Challenges....51
6.2 Enablers....52
7 Comparison of Treatment Effects between the 18- and 24-months Implementation Cycles....54
7.1 Primary Caregivers´ engagement in child stimulation activities (18-month vs. 24-month)....54
7.2 Primary caregiver application of disciplinary methods (18-month vs. 24-month)....55
7.3 Primary caregiver reported parenting confidence (18-month vs. 24-month)....56
7.4 Fathers´ engagement in child stimulation activities (18-month vs. 24-month)....57
7.5 Fathers´ application of disciplinary methods (18-month vs. 24-month)....58
8 Conclusion and Recommendations....59
8.1 18-month MTM program evaluation....60
8.2 Comparison of 18-month and 24-month implementation cycle....62
9 References....63
10 Appendices....65
10.1 PRIMARY CAREGIVER FGD QUALITATIVE INTERVIEW GUIDE....65
10.2 ECD PROMOTER FGD and IDI QUALITATIVE INTERVIEW GUIDE....70
10.3 ECD COMMITTEE QUALITATIVE INTERVIEW GUIDE....76
10.4 FATHERS` QUALITATIVE INTERVIEW GUIDE....78

List of Tables

Table 1: Study participants (survey) 7
Table 2: Table 1: Study participants (qualitative) 7
Table 3: Overview program indicators (baseline vs. endline) 9
Table 4: Quantitative data collection 15
Table 5: Qualitative data collection 15
Table 6: Socio demographic Characteristics of Primary Caregiver 17
Table 7: Percentage of primary caregivers practicing child stimulation activities once per week 21
Table 8: Percent of primary caregivers practicing child stimulation activities by frequency in the last 7 days (baseline) 22
Table 9: Percent of primary caregivers practicing child stimulation activities by frequency in the last 7 days (endline) 23
Table 10: Percent change of primary caregivers practicing child stimulation activities by frequency in the last 7 days (Difference endline-baseline) 24
Table 11: Average number of child stimulation activities (out of 11) in the last 7 days (baseline vs. endline) 24
Table 12: Children´s access to play material 25
Table 13: Percentage of primary caregivers by type of discipline practice 26
Table 14: Average number of physical punishment practices 28
Table 15: Primary caregiver use of psychological aggression 28
Table 16: Primary caregiver use of positive discipline practices 30
Table 17: Average number of positive discipline practices 30
Table 18: Child birth registration 32
Table 19: Primary caregivers´ perception of their parenting confidence 34
Table 20: Primary caregivers who report any parental stress 35
Table 21: Primary caregivers who report full parental stress 35
Table 22: Fathers´ engagement in child stimulation activities 39
Table 23: Primary Caregivers´ engagement in child stimulation activities at least once per week 55
Table 24: Mean number of weekly stimulation activities 55
Table 25: Primary Caregivers´ application of discipline methods 56
Table 26: Primary caregiver reported parenting confidence (18-month vs. 24-month) 57
Table 27: Fathers´ engagement in child stimulation activities at least once per week (18-month vs. 24-month) 57
Table 28: Fathers´ mean number of stimulation activities per week (18-month vs 24-month) 58
Table 29: Fathers´ application of discipline methods (18-month vs. 24-month) 58

List of Figures

Figure 1: Primary caregiver participation 18
Figure 2: Primary caregiver use of physical punishment 27
Figure 3: Primary caregivers´ use of positive discipline practices 29
Figure 4: Primary Caregivers´ Knowledge of Child Rights and Protection (Baseline vs. Endline) 33
Figure 5: Use of any type of positive discipline by fathers 42
Figure 6: SwE membership of primary caregivers (endline) 43
Figure 7: SwE-loan utilization 44
Figure 8: SwE-Group Impact on Entrepreneurship in MTM Households 44
Figure 9: ECD promoters pre- and post-training scores 46
Figure 10: ECD promoters knowledge of child stimulation activities 47
Figure 11: Primary caregivers' ECD learning sources 48
Figure 12: Primary caregivers´ perception of ECD promoters' effectiveness 49

List of Abbreviations

APHRC	-	African Population and Health Research Center
CfW	-	Cash for Work
CIDRZ	-	Center for infectious Disease Research Zambia
CSLGs	-	Caregiver Support and Learning Groups
ECD	-	Early Childhood Development
FGDs	-	Focus Group Discussions
IDIs	-	In-depth interviews
MTM	-	Moments That Matter®
SwE	-	Savings with Education
UNESCO	-	United Nations Educational, Scientific, and Cultural Organization
UNICEF	-	United Nations Children's Fund
ZACOP	-	Zambia Anglican Council Outreach Programmes

Executive Summary

This evaluation of the 18-month Moments That Matter® (MTM) program employs a cohort design and mixed-method approach to data collection, combining quantitative interviews with primary caregivers, fathers and ECD promoters and qualitative interviews with primary caregivers, fathers, ECD promoters, ECD lead promoters and ECD committees in 10 communities in Zambia located in two implementation areas. The study team conducted the following quantitative interviews.

Table 1: Study participants (survey)

Implementation area	Primary caregivers		Fathers as secondary caregivers		ECD promoters	
	Baseline	Endline	Baseline	Endline	Baseline	Endline
Mumbwa	143	159	41	34	-	57
Chipili	177	156	25	50	-	49
Total	**320**	**315**	**66**	**84**	**-**	**106**

Qualitative data was collected from the following population.

Table 2: Study participants (qualitative)

Implementation area	FGDs with primary caregivers	FGDs with fathers as secondary caregivers	FGDs with ECD promoters	FGDs with ECD committees	IDI with ECD lead promoters
Mumbwa	5	2	3	5	4
Chipili	5	2	3	4	7
Total	**10**	**4**	**6**	**9**	**11**

Key Findings

<u>Early Learning and Responsive caregiving</u>

- Endline findings show significant improvements of primary caregivers´ engagement across all tested child simulation activities (11 in total).
- Significant reduction across all child stimulation activities primary caregiver never engaged in at baseline.
- An average increase of 52.4% primary caregivers engaging with their children in child stimulation activities at least once per week (across all eleven activities)
- An increase of the proportion of children (+19.9%) having access to play material.

<u>Child safety and security</u>

- The study found a significant reduction among primary caregivers and fathers applying physical discipline methods and psychological aggression on their children.
- Improvement in the use of positive discipline methods among primary caregivers and fathers.
- Improved child registration at birth.
- Enhanced positive discipline methods among the program´s change agents.

<u>Psychosocial well-being of primary caregiver</u>

- Primary caregivers reported significantly reduced parental stress levels and in turn improved parenting confidence.

- This is a result of improved knowledge levels to address children´s needs, positive family relations, improved community cohesion and having access to mental health support (counselling provided by faith leaders).

Gender-equitable roles in parenting

- Fathers were found spending more intentional time with their children.
- Spousal support in households was found to have improved which has led to an improved nurturing and care environment for children.
- It was reported that cases of domestic violence have reduced in all communities.

Economic empowerment of primary caregiver

- SwE membership was found between 65.4% and 75.5% among primary caregivers. Although program records indicate a lower membership,
- Most primary caregivers participating in the SwE groups have reported financial benefits indicated by improved food security, improved ability to cater for educational expenses for their children and an increase of household assets.
- The entrepreneurial benefit differs between the two implementation areas with a higher proportion of primary caregivers who started new businesses or expanded existing businesses.

ECD promoters

- A discrepancy was found between quantitatively assessed ECD knowledge levels among ECD promoters and qualitative evidence. The latter indicated sound knowledge levels which was confirmed by primary caregivers.

ECD committees

- The composition of the ECD committees has significant strategic benefits in relation to community mobilization and improved access to health care, educational and horticultural services.
- All committees were found to be actively monitoring the activities of ECD promoters and contribute to maintain high motivation levels among ECD promoters.
- The formation of ECD committees varied significantly across the ten communities which according to program staff was related to funding problems and priority being given to the recruitment of ECD promoters.

Wider program benefits

- In all communities, improved child health was reported by different program participants and linked to cooking demonstrations, improved health seeking practices of primary caregivers and horticultural practice (home gardens and distribution of seeds).
- Improved caregiving environment through couple counselling.

Table 3 below highlights all quantitative program indicators and the change between baseline and endline.

Table 3: Overview program indicators (baseline vs. endline)

Key indicators	Baseline	Endline	Change
Average proportion of primary caregivers who engage in child stimulation activities (at least once per week)	43.1%	95.5%	**+52.4**
Average number of child stimulation activities (out of 11) in the last 7 days (baseline vs. endline)	4.66	10.53	**+5.87**
Percentage of children that play with any play material	73.9%	97.8%	**+19.9%**
% of children whose play material are home-made	92.8%	90.7%	**-2.1%**
% of primary caregivers who report **any** confidence in handling parenting responsibilities successfully	31.7%	64.1%	**+32.4%**
% of primary caregivers who report **full** confidence in handling parenting responsibilities successfully	12.9%	41.7%	**+28.8%**
% of primary caregivers who report **any** parental stress	68.3%	35.9%	**-32.4%**
% of primary caregivers who report **full** parental stress	47.8%	16.2%	**-31.5%**
% of primary caregivers who use of physical punishment with their children 0-3	66.8%	21.2%	**-45.6%**
% of primary caregivers who use psychological discipline (any) with their children 0-3	26.8%	13.9%	**-12.9%**
% of primary caregivers who use **any** positive disciplinary practices with their children 0-3	64.1%	98.3%	**+34.2%**
% of children with birth registration documents	48.3%	80.6%	**+32.3%**
Average number of positive disciplinary practices (out of 6)	1.05	2.26	**+1.21**
Average of the number of different stimulating activities (out of 11)	4.66	10.53	**+5.87**
% of primary caregivers that demonstrate adequate knowledge of child rights and protection	35.7%	18.0%	**-17.7%**
% of fathers who engage in at least one child stimulation activity per week	39.9%	95.9%	**+56.0%**
% of fathers who use any positive discipline method	55.0%	99.0%	**+44.0**
% of primary caregivers who are member in SwE groups	0.0%	39.5%	**+39.5%**
% of savings group members who have started businesses using loans or savings	0.0%	20.8%	**+20.8%**
% of savings group members who have expanded businesses using loans or savings	0.0%	17.5%	**+17.5%**
% of ECD Promoters with 80% Test Scores (Pre- vs Post-Training)	1.3%	32.2%	**+30.9**
% of ECD promoters knowledge of child stimulation activities (at least 3 per developmental domain)	n/a	39.1%	**n/a**
% of primary caregivers who consider ECD promoters as most important ECD learning	n/a	93.0%	**n/a**
% of primary caregivers who consider ECD promoters support as very helpful	n/a	92.3%	**n/a**

Challenges

ECD Committee

- Nearly all ECD committees mentioned that their monitoring capabilities are limited due to the distance between household and requested for bicycles.
- Members of the ECD committees also indicated an existing knowledge gap between ECD promoters and them and requested for to participate in the same knowledge transfer workshop ECD promoters participate receive.

Savings & Loan Groups (*also known as Savings with Education Groups, SwE)*

- According to primary caregivers in some communities they felt misinformed about the SwE groups which resulted in late formation of groups or non-participation in the SwE groups.

18-months vs 24-month Implementation cycle

- A comparison between the 24- and 18-month implementation cycle was conducted focusing on the following areas: primary caregivers´ engagement in child stimulation activities, primary caregivers´ application of disciplinary methods, primary caregivers´ reported parental confidence, fathers´ engagement in child stimulation activities, and fathers´ application of disciplinary methods.
- It is noteworthy, that the only existing data for the 24-month implementation cycle in Zambia is from 2021. Since then, the program has evolved, employed different strategies, and developed new educational material resulting from the evaluation conducted in 2021.
- Regarding primary caregivers´ engagement in child stimulation activities, the 18-month cycle produced slightly better results.
- The results regarding physical discipline of children were significantly better in the 18-month cycle.
- Findings for parental confidence of primary caregivers are nearly the same (statistically insignificant)
- With regards to father´s engagement in child stimulation activities, the 18-month cycle is demonstrating better results across all activities.
- Overall, the 18-month implementation cycle is a more efficient implementation design as it will allow the program to reach more children and communities with the required resources

Recommendations

- Earlier and uniform introduction of ECD committees due to the critical role they are playing in community mobilization, participation, the monitoring of ECD promoters, and the creation of important linkages between program participants and public services
- Intensify father engagement activities as fathers expressed a keen interest in having their own activities (male groups)
- Translation of educational/teaching material like FAMA cards as primary caregivers and fathers expressed having problems understanding them.
- Earlier introduction of economic empower incentives (apart from SwE groups) such as small-scale agricultural projects, e.g. chicken or goat rearing projects

1 Introduction

Early childhood development (ECD) is universally recognized as a critical foundation for lifelong learning, health, and well-being. The early years especially from birth to age five are a period of rapid brain development, during which more than 80% of brain growth occurs[1]. High-quality ECD interventions have profound and lasting impacts, including improved school readiness, stronger social and emotional skills, and better health outcomes in adulthood[2]. Globally, investing in ECD is considered one of the most effective strategies for reducing inequality, breaking the cycle of poverty, and fostering economic growth[3]. Evidence shows that children who benefit from early learning environments are more likely to succeed academically, earn higher incomes as adults, and contribute positively to society.

Despite these benefits, millions of children-particularly in low- and middle-income countries still lack access to quality ECD services. This gap is especially pronounced among the poorest and most vulnerable populations, putting them at risk of not reaching their full developmental potential. As a result, international organizations such as UNESCO, UNICEF, and the World Bank advocate for increased investment in ECD, emphasizing its role in building human capital and ensuring equitable opportunities for all children.

In Zambia, early childhood development has gained increasing attention as a cornerstone of the nation's education and social policy reforms. Historically, the sector experienced periods of neglect, but recent years have seen a renewed focus on integrating ECD into the national education system and expanding access, especially in rural and underserved communities. The Zambian government now prioritizes early childhood education (ECE) as an integral part of basic education, recognizing its role in improving school enrolment, retention, achievement, and completion rates.

Studies in Zambia demonstrate that participation in ECD programs leads to significant benefits, including enhanced motor skills, emergent literacy, and better overall health among children[4]. ECD also contributes to broader social outcomes, such as reduced dropout and repetition rates, increased interest in learning, and even lower rates of early childbearing among girls who attended pre-primary programs[5]. Furthermore, ECD programs in Zambia often address health, nutrition, and parenting education, supporting not only children but also caregivers and teachers-especially in communities affected by poverty and HIV/AIDS[6].

In summary, early childhood development is both a global and national priority, offering the highest returns on investment for individuals and societies. In Zambia, strengthening ECD is seen as essential for building an educated, healthy, and productive population, and for ensuring that every child has the opportunity to reach their full potential.

---

[1] https://www.crawfordinternational.co.za/10-reasons-why-early-childhood-development-is-important

[2] https://www.worldbank.org/en/topic/earlychildhooddevelopment

[3]https://www.unesco.org/en/articles/new-unesco-global-report-highlights-critical-role-early-childhood-care-and-education

[4] World Bank Group (2016): Education Global Practice - Early Childhood Development

[5] https://storychanges.com/what-are-zambia-s-early-childhood-education-benefits.html

[6]https://jliflc.com/resources/early-childhood-development-program-volunteer-implemented-program-hiv-prevalent-areas-rural-zambia-2/

2 *Moments that Matter*®: Project Background

Moments That Matter® (MTM) is an early childhood development program partnership of Episcopal Relief & Development focused on the critical 0–3 years age range when the quality-of-care children receive can affect them for the rest of their lives. MTM is currently implemented in six African countries by eight partner implementing organizations. Since 2018, the Zambia Anglican Council Outreach Programmes (ZACOP) has implemented MTM across five dioceses. Episcopal Relief & Development partners with faith and community leaders around the world to advance lasting change in communities impacted by injustice, poverty, disaster and climate change.

MTM is based on the Nurturing Care Framework and takes an integrated approach that equips parents and other caregivers to deliver the quality of nurturing care children require to reach their full potential. Through Caregiver Support & Learning Groups, caregivers learn and practice strategies for engaging with children in ways that stimulate early learning and brain development. Moreover, trained volunteers support caregivers through monthly home visits to check that children are reaching milestones and connect families to health services when necessary. The integrated approach of MTM aims to improve a family's access to nutritious food through kitchen gardens, promote financial resilience through savings and loan groups, and leverage the influence of local faith and community leaders to promote healthy behaviors and help reduce factors that harm a child's development.[7]

Promoting Gender Equality and Involving Fathers
The program actively engages fathers and male caregivers, challenging traditional gender norms and encouraging shared responsibility in child-rearing. By involving men, MTM fosters more equitable family dynamics and enhances the overall caregiving environment.[8]

Enhancing Child Development Outcomes
An evaluation of MTM in Zambia revealed that over 80% of participating children were developmentally on track. This success underscores the program's effectiveness in promoting healthy physical, cognitive, and emotional development during the formative early years.

Building Community Support Systems
MTM fosters community-led initiatives, including the establishment of savings and loan groups, which provide financial stability and resources for caregivers. Additionally, the program trains community leaders, such as faith leaders, to support families and address challenges like neglect or exposure to violence, thereby creating a protective environment for children.

Facilitating Smooth Transitions to School
The program collaborates with local schools to ensure a seamless transition for children from home-based care to formal education settings. This coordination helps children adapt more easily to school environments, laying the foundation for future academic success.

***Moments That Matter*®** is instrumental in transforming the lives of children and families in Zambia by providing essential support during the most critical years of a child's development.

---

[7] Murdock DE, Munsongo K and Nyamor G (2023) Scaling the Moments That Matter® early childhood development model: how communities' monitoring for change contributes to sustainable impact Frontiers in Public Health

[8] Transforming People's Lives Moment to Moment in Zambia

Through its comprehensive approach, MTM not only enhances individual well-being but also strengthens community resilience and fosters a culture of nurturing care that benefits society as a whole.

3 Evaluation Purpose

3.1 Evaluation Objectives

The objectives of this evaluation are manifold and listed below:

Measuring achievement of objectives: It determines the extent to which the project has met its intended goals and objectives by comparing results to the baseline data collected at the project's start.

Assessing impact and effectiveness: This evaluation provides insights into the actual changes and improvements resulting from the project's interventions, assessing the impact on the target population and the broader community

Learning and improvement: This study documents lessons learned, best practices, and factors contributing to success or challenges, which can inform the design and implementation of future projects.

Informing decision-making: The findings support stakeholders in making informed decisions regarding scaling, replication, or modification of similar interventions in the future.

Comparison of the effectiveness between the former 24-months and the new 18-months implementation period: The length of MTM's caregiver activity period, 24 months, was initially set due to the application of the ECD Essential Package and funding for a two-year project period. The evaluation found strong results in primary caregiver parenting outcomes for that time period. The APHRC research of MTM in Kenya and Zambia found that more of the primary caregiver parenting change took place in the first 12 months (measured at midline) than in the second 12 months (months 13-24). Furthermore, other studies of similar but shorter ECD parenting education interventions had found good outcomes in a 12-month period.

Thus, Episcopal Relief & Development decided to test an 18-month MTM primary caregiver activity period, with a total of 36 doses (caregiver group meetings and ECD home visits). If effective, the advantage of a shorter 18-month program cycle with primary caregivers is the capacity to scale and reach more children and families with program resources in less time. In view of the holistic, parenting empowerment, family-centered, community-led program model of MTM, it was decided that 12 months would be too short. The focus of this testing is on primary caregiver parenting outcomes, however other dimensions and outcomes, such as the role of ECD Committees, have a longer timeframe given the continuation of MTM in subsequent program cycles.

3.2 Limitations

Due to limited funding availability several program components could not be assessed quantitatively. These include maternal and child nutrition and health-seeking behavior, HIV-related knowledge levels among primary and secondary caregivers and the measurement of child developmental outcomes. Thus, the focus of this study is limited to the assessment of primary and secondary caregivers´ parenting practices including child stimulation activities,

child discipline practices, knowledge on child safety and protection, ECD promoters´ knowledge levels of parenting and child protection practices, and any observed benefits of the Savings with Education (SWE) groups (commonly known as Village Saving and Loan Associations).

The study design limits this evaluation´s ability to establish a clear causal relationship between program activities and outcomes. However, this limitation is addressed through the extensive use of qualitative data supporting quantitative results. Furthermore, the data collection instruments had to be aligned with the instruments employed in other studies of MTM in Mozambique and Kenya. However, this was not done at baseline in Zambia and limits the comparability of findings as data for indicators were not collected at baseline.
And lastly, the interpretation of evaluation results is limited due to the absence of a control arm.

4 Methodology

4.1 Evaluation Design

This evaluation adopted a cohort study design paired with a mixed-methods approach to data collection. Quantitative data was collected from primary caregivers, fathers as secondary caregivers and ECD promoters employing a survey data collection methodology. All study participants actively participated in the shortened 18-month implementation cycle.

Quantitative data from primary caregivers was collected to assess any changes in the extent of their participation in program activities, application of child stimulation practices, use of inappropriate and appropriate child discipline practices, perception of their caregiving abilities, knowledge of child protection and safety measures and caregivers´ household economic well-being. A shortened survey form was administered to fathers who are secondary caregivers to collect data on their application of child stimulation practices, use of inappropriate and appropriate child discipline practices, and their knowledge of child protection and safety measures. The ECD promoter component focused on assessing their retained knowledge levels of adequate child stimulation practices per developmental domain[9] and a program document review of ECD knowledge test (pre-and post-training knowledge assessments conducted by ZACOP).

Qualitative data was collected from primary caregivers (FGDs), fathers as secondary caregivers (FGDs), ECD promoters (FGDs), Lead ECD promoters (IDIs), ECD committees (FGDs) and program managers (IDIs) in both project implementation areas. The qualitative and quantitative data collection approach was implemented simultaneously, except for the program managers´ interviews which were designed and implemented after reviewing collected quantitative and qualitative data and aimed at gathering information that explain different views and perceptions, varying participation and knowledge levels and the program mangers´ experience with and views regarding the shortened implementation cycle.

4.2 Sampling

Table 4 highlights the type and number of study participants disaggregated by project implementation area. At baseline[10], a total of 320 primary caregivers and 66 fathers as

[9] Cognitive, language, motor, social and emotional.

[10] The baseline study was planned and implemented by Episcopal Relief and Development and ZACOP.

secondary caregivers were interviewed. The baseline data collection did not include any ECD promoters. For the end of project evaluation, the study included 315 primary caregivers, 84 fathers as secondary caregivers and 106 ECD promoters. All primary caregivers for the endline study were selected randomly while the selection of fathers was based on the selected primary caregiver households. Primary caregiver households were allocated an ID from which 30% were randomly sampled for the study participation of fathers.

While the planned inclusion of 300 primary caregivers in this evaluation was exceeded, the study participation of fathers in Mumbwa was proven to be more challenging due to ongoing *Cash-for-Work (CfW)* programs by the Zambian government which provides temporary employment and cash payments to vulnerable individuals in exchange for labor on public works projects. This resulted in a reduced number of fathers participating in quantitative and qualitative data collection activities.

Table 4: Quantitative data collection

Implementation area	Primary caregivers		Fathers as secondary caregivers		ECD promoters	
	Baseline	Endline	Baseline	Endline	Baseline	Endline
Mumbwa	143	159	41	34	-	57
Chipili	177	156	25	50	-	49
Total	**320**	**315**	**66**	**84**	**-**	**106**

Regarding the employed purposive sampling for qualitative data collection, Table **5** shows the conducted qualitative interviews in both project implementation areas. No qualitative data was collected at baseline.

Table 5: Qualitative data collection

Implementation area	FGDs with primary caregivers	FGDs with fathers as secondary caregivers	FGDs with ECD promoters	FGDs with ECD committees	IDI with ECD lead promoters
Mumbwa	5	2	3	5	4
Chipili	5	2	3	4	7
Total	**10**	**4**	**6**	**9**	**11**

4.3 Data Collection and Data Instrument Alignment

The data collection team was comprised of 12 research assistants (10 quantitative and 2 qualitative research assistants) who have substantial ECD-related community research experience with local and international development and research organizations (Save the Children, UNICEF, APHRC, CIDRZ, Episcopal Relief & Development, etc.). All research instruments were translated into the languages spoken in the project implementation areas (Bemba, Nyanja, Tonga).

A key requirement for this evaluation was to align the data collection instruments with the ones used in the studies of MTM in Kenya and Mozambique to allow for a similar data analysis approach and thus to make findings comparable between the countries where the shortened 18-month implementation cycle was implemented. However, the data instruments employed at baseline were not aligned with the Kenya and Mozambique data tools, which meant the data tool alignment had to be balanced between inter- and intra-country comparability of findings. The main adjustments were as follows:

Section	Baseline tool	Endline tool
Stimulation practices	Response categories = “Yes” and “No”	Response categories = “Never”, “Once or twice a week”, “Multiple times a week”, and “Every day or nearly every day”
Discipline practices	Missing of certain discipline practices employed (e.g. shook child, calling child dumb lazy)	Inclusion of missing items
	Administration of this section in baseline tool required interview partner to remember and mention all employed discipline practices	Question administration was changed to single item question per discipline practice and required a “yes” or “no” response.

5 Findings

This section of the evaluation report presents and discusses the key findings of the MTM project evaluation and highlights the key differences between baseline and endline.

5.1 Socio-demographic Characteristics

Table 6 below highlights social demographic characteristics of primary caregivers and their changes between the beginning and end of the first 18-month implementation cycle. In both studies, nearly all primary caregivers were female (baseline: 97.1%, endline: 99.4%). The proportion of biological mothers at endline increased by 8.7% while the proportion of grandparents reduced by 6.8%. This difference is likely explained by the study design as it is not a longitudinal, but a cohort study. The age distribution has remained relatively stable with a slight increase among the lower age brackets and decrease in the older age brackets respectively resulting from the slight increase of primary caregivers being biological mothers instead of grandparents.

The distribution of marital status among primary caregivers has increased significantly by 16.9% (from 65.0% to 81.9) mainly resulting from a reduction of primary caregivers who were single or not living with a partner at baseline and minor variations in the proportions of primary caregivers who were widowed or divorced. Observed changes in the average number of children under a primary caregiver’s care has remained stable between baseline and endline (3.2 children per household).

Table 6: Socio demographic Characteristics of Primary Caregiver

	Baseline (n=320)	Endline (n=315)	Difference
Primary caregiver's gender			
Female	97.1%	99.4%	2.3%
Male	2.9%	0.6%	-2.3%
Primary caregiver relationship to child			
Biological Mother	86.3%	94.9%	8.7%
Grandparent	10.6%	3.8%	-6.8%
Biological Father	0.3%	0.3%	0.0%
Other adult relative	2.2%	0.6%	-1.6%
Other	0.6%	0.3%	-0.3%
Primary caregivers age			
[15 - 35] years	72.2%	74.9%	2.7%
[36 - 49] years	18.8%	21.9%	3.2%
[50 - 64] years	4.7%	1.9%	-2.8%
[> 65] years	4.4%	1.0%	-3.4%
Primary caregivers marital status			
Married or living with a partner	65.0%	81.9%	16.9%
Single or not living with a partner	18.8%	9.8%	-8.9%
Divorced or separated	10.3%	7.6%	-2.7%
Widowed	5.6%	1.0%	-4.7%
Children to take care of as primary caregiver			
Average # children in Household	3.20	3.25	0.05
Average # children age 0-3 years	1.21	0.89	-0.32
Average # children age 3-5 years	0.56	0.51	-0.05
Average # children age 6-11 years	0.85	1.12	0.27
Average # children age 12-18 years	0.58	0.72	0.14
School attendance			
Attended primary	72.8%	63.2%	-9.6%
Attended secondary	23.1%	31.7%	8.6%
Did not attend school	3.4%	4.4%	1.0%
Attended tertiary or higher education	0.0%	0.6%	0.6%
Other	0.6%	0.0%	-0.6%
Occupation			
Agriculture	64.4%	74.9%	10.5%
Self-employed	14.4%	11.4%	-2.9%
Unemployed	14.7%	5.7%	-9.0%
Employed – Informal	0.9%	3.2%	2.2%
Other	4.7%	2.9%	-1.8%
Student	0.9%	1.3%	0.3%
Employed – Formal (Salaried)	0.0%	0.6%	0.6%

A significant increase in the proportion of primary caregivers who attended secondary school (+8.6%) was recorded at endline which is explained by natural progression in educational attainment but also by the inclusion of school representatives on the program´s ECD committees who are advocating for the enforcement of the re-entry policy for young girls who fell pregnant while in school.[11].

Regarding the main occupation of primary caregivers, the most frequently provided response at baseline and endline was agriculture an recorded a significant increase of 10.5% (baseline: 64.4%; endline: 74.9%). This increase can be explained by the reduction of grandparents participating in the endline study, but also by the respondents´ perception that working in agriculture is not an occupation, but a livelihood strategy.

5.2 Primary Caregivers Participation

Primary caregivers were asked regarding their participation frequency in Caregiver Support & Learning Groups (CSLG) during the period between December 2024 to February 2025 (the last three months of the 18-month cycle). As presented in Figure 1, the vast majority of primary caregivers participated in all 3 monthly sessions during the above-mentioned period. All primary caregivers affirmed positive learning benefits about ECD-related topics delivered by the program.

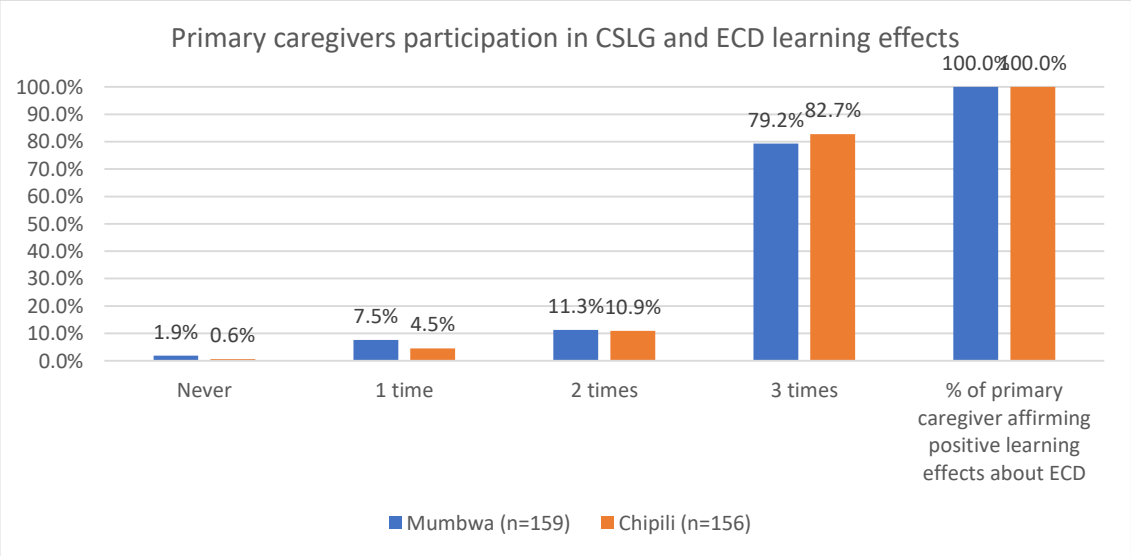

Figure 1: Primary caregiver participation

Primary caregivers during FGDs were asked about the ECD-related topics they learnt through their participation in CSLGs and home visits and their benefits. The responses from all 10 project communities (see quotes below) almost unanimously attest immense learning benefits and also reflect the primary caregivers´ gratitude towards the program.

> *"We have learnt how to bring children up, when a child does something wrong, you are not supposed to quickly get a stick and beat the child, they have taught us how to gently guide children to grow in a good way. And*

[11] S.S. Zuilkowski, et al. (2019), "Zambia's school re-entry policy for adolescent mothers: Examining impacts beyond re-enrollment", 1-7.

they have also taught us the number of times to feed the children, 5 times a day, that's how you are supposed to feed babies." (FGD with primary caregivers)

"I also learnt that a child can be taken care of by the father, the child is mostly with the mother, but I have learnt that a child needs both the mother and the father. The men also have learnt how to take care of children. And the child will also know that there is love between the parents, and the parents love the child and the child can be brought up the way a child is supposed to be brought up." (FGD with primary caregivers)

"I really liked that my husband learnt that children are brought up by both parents. We were also taught that in the morning you wake the child up so that you find out if the child is well or unwell, so I was so happy to learn that a child is supposed to be woken up in the morning to check." (FGD with primary caregivers)

"I have found goodness in everything that we were taught, and we were also taught that if a child is doing certain things, we supposed to praise the child, so that the child will know that when they are praised then they are doing a good thing. They taught us that. So, I am happy with everything that they taught us. And they also taught us those grandparents are also supposed to be part of bringing up a child. So, I am happy with everything and the children are brought up well. When I look at the baby, I can tell that the baby is lacking because we were taught signs that the child is not doing well. I like everything that they taught us." (FGD with primary caregivers)

5.3 Findings by outcomes

5.3.1 Outcome 1: Early Learning and Responsive Caregiving

5.3.1.1 Child Stimulation

This section of the report presents and discusses baseline and endline findings regarding stimulation activities primary caregivers conducted with their children during a 7-day period prior to the survey administration. The types of assessed stimulation activities in the survey were aligned with the project evaluation studies conducted in Kenya and Mozambique.

The following stimulation activities primary caregivers engaged in with their child (24 months and above) were included in the baseline and endline evaluation:

1. Read books or look at picture books with child
2. Sing songs with or to the child
3. Take child out of the home
4. Play with the child
5. Name or count things
6. Draw things with the child
7. Tell stories to the child
8. Provide the child with object to grasp or pick up
9. Encourage the child to crawl, run, or jump up
10. Hug or kiss the child

11. Praise the child

It is important to note that the data tool used for the baseline assessment in Zambia did not include the same response categories to determine the frequency of conducted stimulation activities. The average frequency of activities was calculated by using the primary caregivers´ indication of the average weekly time spent with their child and is thus based on the assumption that all activities were conducted accordingly. Thus, baseline values for the average frequency of activities per week are probably overestimated. In addition, the baseline and endline questions assessing stimulation activities were only administered to primary caregivers whose children were 24 months or older to ensure age-appropriateness of stimulating activities.

Child stimulation activities are essential for a child's overall development – cognitively, emotionally, socially, and physically. These activities, which can range from playing with blocks to singing songs, storytelling, and interactive games, help build foundational skills that children need to thrive both in school and in life.
Stimulation activities engage a child's brain, helping to build memory, problem-solving abilities, and language skills.

For instance, playing with puzzles improves spatial awareness and critical thinking, while storytelling enhances vocabulary and comprehension. During the early years, the brain is highly plastic, meaning experiences have a significant impact on how neural connections are formed.

Interactive play encourages children to express emotions, develop empathy, and learn how to navigate social situations. Activities like role-playing or group games teach cooperation, patience, and how to handle frustration—key skills for emotional intelligence.

Activities involving movement, such as dancing, climbing, or playing with balls, improve motor skills, coordination, and body awareness. Fine motor skills are strengthened through drawing, building with small blocks, or threading beads. Talking, singing, and reading to children exposes them to language in a meaningful context. These interactions help develop listening skills, understanding, and the ability to express thoughts clearly. Early language development is closely linked to future academic success.

Stimulation activities are done with caregivers—whether parents, teachers, or others—strengthen emotional bonds. Responsive interactions, where adults follow the child's lead and respond warmly, foster secure attachments, which are crucial for psychological well-being.
Research shows that early stimulation is strongly linked to better outcomes later in life. Children who engage in enriching activities early on tend to perform better in school, have stronger social skills, and even show better economic productivity and health outcomes in adulthood.

Table 7: Percentage of primary caregivers practicing child stimulation activities once per week

Stimulation activities done with child at least once week	Baseline			Endline			
	Mumbwa (n=138)	Chipili (n=166)	Total (n=304)	Mumbwa (n=108)	Chipili (n=112)	Total (n=220)	Differnce [Endline-Baseline]
Read books or look at picture books with child	34.1%	10.2%	**22.1%**	93.5%	89.8%	**91.7%**	**+69.6**
Sing songs	80.4%	41.0%	**60.7%**	97.2%	99.1%	**98.1%**	**+37.4**
Take child out of home	42.8%	9.0%	**25.9%**	97.2%	93.5%	**95.4%**	**+69.5**
Play with child	47.1%	24.7%	**34.9%**	100.0%	98.1%	**99.1%**	**+64.2**
Name or count things	47.1%	24.7%	**35.9%**	95.4%	97.3%	**96.3%**	**+60.4**
Draw things with the child	39.1%	21.1%	**30.1%**	90.7%	83.3%	**87.0%**	**+56.9**
Tell stories to child	50.7%	29.5%	**40.1%**	88.0%	91.7%	**89.8%**	**+49.7**
Provide child with object to grasp or pick up	68.1%	38.0%	**53.0%**	96.3%	95.4%	**95.8%**	**+42.8**
Encourage child to crawl, run, or jump up	61.6%	32.5%	**47.1%**	100.0%	99.1%	**99.5%**	**+52.4**
Hug or kiss child	81.9%	57.2%	**69.6%**	99.1%	99.1%	**99.1%**	**+29.5**
Praise child	63.0%	45.2%	**54.1%**	97.2%	99.1%	**98.1%**	**+44.0**
Average proportion of primary caregivers who engage in child stimulation activities (at least once per week)			**43.1%**			**95.5%**	**+52.4**

Findings presented in Table 7 show an overall significant improvement across all stimulation activities in both implementation areas between baseline and endline. At baseline, the average proportion of all primary caregivers engaging in child stimulation activities was 43.1% and increased to 95.5% at endline, representing a proportional increase of +52.4%. An analysis of the difference of stimulation activities by implementation area shows a more notable improvement in Chipili where an average proportion of 30.3% of primary caregiver engaged in stimulation activities at baseline, but nearly all primary caregivers (95.1%) were found engaging in stimulation activities at
endline.

With regards to changes in the type of stimulation activity, the most significant changes were observed in "*Read books or look at picture books with child*" (+69.6%), "*Take child out of home*" (+69.5%) and "*Play with child*" (+64.2%). Qualitative data from FGDs with primary caregivers show that in most cases parenting was limited to feeding their children and children would be left alone at home/in the compound for most of the day.

> *"Before the program, we would just leave them [children] at home. They [ECD promoters] have taught us how we should play with our*

children and make sure that they have at least one toy to play with." (Primary caregiver, Chipili)

"I have found goodness in this program, it is now different from the way we used to raise our children in past, we know how to play with our children apart from just breastfeeding them, […]. We make objects from mud/ clay soil and through this it's helping our children to play." (Primary caregiver, Chipili)

Another caregiver from Mumbwa elaborated on how she learnt about the importance of play:

"What I liked the most I never knew or never liked to play with children. When someone would ask me why I do not play with children. I would respond that why would I play with children as if I am a fool? What will people think of me? So, when they came to teach us, I have seen that playing with a child is a very good thing and children would know that 'my parents love me'. When you have come back from somewhere and the children run to welcome you, you embrace them and lift them up. I never used to do all those things, but I have now known that doing all that is a good thing." (Primary caregiver, Mumbwa)

An analysis of the change in frequency of engaging in child stimulation activities between baseline and endline (Table 8 and 9) shows a significant shift from less frequently conducted stimulation activities prior to the implementation of the program towards more frequently conducted activities. The proportion of primary caregivers who never engaged in the assessed stimulation activities ranges from 31.6% (*Never hugged/kissed a child*) to 78.9% (*Never read books or looked at picture books*). Conversely at endline, this range has reduced drastically to 0.5% (*Never encouraged child to crawl, run, or jump*) to 13.0% (*Never draw things with child*).

Table 8: Percent of primary caregivers practicing child stimulation activities by frequency in the last 7 days (baseline)

Stimulating activities at baseline	Never (0)	Once or twice a week (1, 2)	Multiple times a week (3, 4, 5)	Every day or nearly every day (6, 7)
Read books or look at picture books with child	78.9%	3.9%	6.6%	10.5%
Sing songs	41.1%	11.8%	18.1%	28.9%
Take child out of home	75.7%	5.9%	4.9%	13.5%
Play with child	60.5%	6.3%	10.2%	23.0%
Name or count things	65.1%	6.9%	11.5%	16.4%
Draw things with the child	70.7%	5.3%	9.2%	14.8%
Tell stories to child	60.9%	6.3%	11.5%	21.4%
Provide child with object to grasp or pick up	48.4%	11.2%	15.8%	24.7%
Encourage child to crawl, run, or jump up	54.3%	7.9%	14.1%	23.7%
Hug or kiss child	31.6%	13.5%	21.4%	33.6%
Praise child	46.7%	9.5%	16.8%	27.0%

Table 9: Percent of primary caregivers practicing child stimulation activities by frequency in the last 7 days (endline)

Stimulating activities at endline	Never (0)	Once or twice a week (1, 2)	Multiple times a week (3, 4, 5)	Every day or nearly every day (6, 7)
Read books or look at picture books with child	8.3%	27.3%	39.8%	27.3%
Sing songs	1.9%	25.9%	33.8%	41.2%
Take child out of home	4.6%	42.6%	41.7%	13.9%
Play with child	0.9%	12.0%	24.1%	65.7%
Name or count things	3.7%	24.1%	39.9%	32.8%
Draw things with the child	13.0%	19.4%	47.7%	22.7%
Tell stories to child	10.2%	27.3%	28.7%	36.1%
Provide child with object to grasp or pick up	4.2%	21.3%	34.7%	42.6%
Encourage child to crawl, run, or jump up	0.5%	16.7%	42.6%	42.6%
Hug or kiss child	0.9%	21.3%	30.1%	50.0%
Praise child	1.9%	19.4%	34.3%	47.2%

Table 10 highlights the proportional change of primary caregivers´ engagement in conducting child stimulation activities. The biggest changes in activities primary caregivers never engaged in are found in *Taking the child out of home (-71.1%)* and *Read books or look at picture books with child (-70.6%)*. Prior to MTM, it was a common practice that children as young as 2 years would be left at home the entire day being "taken care" of by an older sibling aged 6 years above. With regards to improved reading practices or making use of picture books, it was shared that in absence of any (picture) books in households, primary caregivers would make use of the *Caregiver Action to Practice Passport* document provided through MTM.

> *"In days past, children would burn, we would leave them alone and find that they have been burned. Now they found with their father's playing ball and other activities, I really appreciate this program." (FGD with primary caregiver)*

> *"The ECD promoters used to come home to teach us how to take care of children. They used to come with books and pictures that they used to show us. You are not supposed to leave a child near fire, a child is not supposed to be alone, the child is supposed to be with the grandparents, friends, the father, are supposed to be with the child." (FGD with primary caregiver)*

Table 10: Percent change of primary caregivers practicing child stimulation activities by frequency in the last 7 days (Difference endline-baseline)

Difference stimulating activities [Endline – Baseline]	Never (0)	Once or twice a week (1, 2)	Multiple times a week (3, 4, 5)	Every day or nearly every day (6, 7)
Read books or look at picture books with child	-70.6%	23.4%	33.2%	16.8%
Sing songs	-39.2%	14.1%	15.7%	12.3%
Take child out of home	-71.1%	36.7%	36.8%	0.4%
Play with child	-59.6%	5.7%	13.9%	42.7%
Name or count things	-61.4%	17.2%	28.4%	16.4%
Draw things with the child	-57.7%	14.1%	38.5%	7.9%
Tell stories to child	-50.7%	21.0%	17.2%	14.7%
Provide child with object to grasp or pick up	-44.2%	10.1%	18.9%	17.9%
Encourage child to crawl, run, or jump up	-53.8%	8.8%	28.5%	18.9%
Hug or kiss child	-30.7%	7.8%	8.7%	16.4%
Praise child	-44.8%	9.9%	17.5%	20.2%

With regards to the average weekly conducted stimulation activities (out of 11) at baseline and endline is presented in Table 11. At baseline, primary caregivers reported that they engaged in 4.66 stimulation activities per week, with primary caregivers in Mumbwa accounting for 4.20, and primary caregivers in Chipili for 5.04 activities per week. At endline, the average number of conducted activities has increased significantly in both implementation areas. The findings show that primary caregivers engaged in almost all of the 11 assessed stimulation activities in the week prior to the survey (10.53 out of 11 activities) and indicate a significant improvement in providing adequate child stimuli across all key developmental domains. It is important to note that the measured improvements in primary caregivers´ engagement in child stimulation activities between baseline and endline are statistically significant.[12]

Table 11: Average number of child stimulation activities (out of 11) in the last 7 days (baseline vs. endline)

Mean of stimulating activities out of 11	Mumbwa	Chipili/Mansa	Total
Baseline	4.20	5.04	4.66
Endline	10.55	10.51	10.53
Difference [Endline – Baseline]	+6.35	+5.47	+5.87

5.3.1.2 Play Materials

Primary caregivers in both implementation areas were asked about the availability of play materials/toys to their children and whether any of these toys were home-made. At baseline, the caregiver-reported proportion of children with any kind of play material was relatively high in Mumbwa (82.1%) and moderate in Chipili (65.7%). However, both implementation sites recorded an increase in the proportion of children having access to play material with Mumbwa recording an increase to 98.1% and Chipili recording an increase to 97.4%. The overall average proportional change in children that have access to play material has increased from 73.9% to 97.9% (+19.9% increase from baseline). The proportion of available play material

[12] $p < 0.01$ (unpaired t-test)

that are homemade was found to be relatively high at baseline (92.8%) and experienced a decrease in Mumbwa (from 92.7% to 84.0%), but an increase in Chipili (from 92.8% to 97.4%).

Table 12: Children´s access to play material

		% of children that play with any play material	% of children whose play material are home-made
Mumbwa	Baseline	82.1%	92.7%
	Endline	98.1%	84.0%
Chipili	Baseline	65.7%	92.8%
	Endline	97.4%	97.4%
Total	Baseline	73.9%	92.8%
	Endline	97.8%	90.7%
Difference [Endline-Baseline]		**+19.9%**	**-2.1%**

Primary caregivers in Chipili shared during FGDs that they learnt how to make home-made toys from their participation in the program.

> *"I have learnt how to make, let's say, playing utensils or things for the child, like toys, so that the child is able to play with them." (FGD with Primary caregiver)*

> *"We were taught that a child is supposed to have one favourite thing (toy) to play with, a small child should not be without anything (toy) to play with, the child should have at least one thing to play with." (FGD with Primary caregiver)*

Other caregivers explained the connection between children´s access to play material and its benefit to a child´s development of motor skills and overall physical development.

> *"Even if the child delays in starting to walk, you at least make a small toy car so the child can be rolling or moving it about till the child's bones starts having strength not always putting the child on your back as that won't be physically fit in the body, so I liked this one very much." (FGD with Primary caregiver)*

> *"On the issue of toys that children play with, from the time we were taught on how to make dolls and cars, they helped my child to start walking, so I saw that the lessons we receive are very good." (FGD with Primary caregiver)*

5.3.2 Outcome 2: Child Safety and Security

5.3.2.1 Child Discipline Practices[13]

MTM aims to positively influence parental child discipline practices by reducing physical or psychological punishment practices such as spanking a child or shouting at a child and in turn to enhance positive disciplinary measures such as explaining why a child´s behavior is wrong or take a way privileges from a child. Primary caregivers were asked which discipline practices they employ when their child did something wrong or misbehaved. Regarding primary caregivers' use of physical punishment at baseline, 66.8% reported that they use any form of physical punishment (*slapping child´s hand* or *slapping child anywhere*) in order to discipline their children and to correct a child´s behavior (see Table 13). The proportion of caregivers

[13] The baseline data tools only collected information on two different physical punishment practices ("Hit/ slapped child on the hand" and "Slapped child anywhere"). Data on psychological aggression was only collected for the practice "Shouted/ yelled/ screamed at child")

using physical punishment at baseline was slightly higher in Chipili (70.5%) than in Mumbwa (63.1%), but also recorded the more notable reduction at endline as only 16.0% of caregivers (-54.5%) reported the application of physical punishment compared to 26.5% of caregivers in Mumbwa (-36.6%).

Table 13: Percentage of primary caregivers by type of discipline practice

	Baseline			Endline		
	Mumbwa (n=103)	Chipili (n=132)	Total	Mumbwa (n=151)	Chipili (n=150)	Total
Physical punishment (any)	**63.1%**	**70.5%**	**66.8%**	**26.5%**	**16.0%**	**21.2%**
Hit/slapped child on the hand	63.1%	70.5%	66.8%	6.0%	6.7%	6.3%
Slapped child (anywhere)	49.5%	53.8%	51.7%	n/a	n/a	n/a
Shook child	n/a	n/a	n/a	5.3%	5.3%	5.3%
Spanked child on bottom with bare hand	n/a	n/a	n/a	4.0%	14.0%	9.0%
Hit child with hard object	n/a	n/a	n/a	1.3%	10.0%	5.7%
Hit/slapped child on the head	n/a	n/a	n/a	0.7%	6.0%	3.4%
Beat child up	n/a	n/a	n/a	0.0%	0.0%	0.0%
Psychological aggression (any)	**15.7%**	**37.9%**	**26.8%**	**15.9%**	**12.0%**	**13.9%**
Shouted/yelled/screamed at child	15.7%	37.9%	26.8%	11.8%	14.0%	12.9%
Called child dumb, lazy	n/a	n/a	n/a	1.3%	2.0%	1.7%
Positive disciplinary practices (any)	**69.9%**	**58.3%**	**64.1%**	**99.3%**	**97.3%**	**98.3%**
Distracted the child	10.7%	10.6%	10.6%	54.6%	88.7%	71.7%
Took away a privilege	5.8%	1.5%	3.7%	20.8%	36.0%	28.4%
Sent child away for a time out	12.6%	8.3%	10.5%	4.6%	6.7%	5.7%
Ignored the behavior	9.7%	18.2%	13.9%	9.9%	17.3%	13.6%
Explained why behavior was wrong	26.2%	22.7%	24.5%	82.9%	94.0%	88.5%
Praised good behavior	54.4%	22.0%	38.2%	13.8%	19.3%	16.6%

In total, the proportion of caregivers who use physical punishment practices has significantly reduced from 66.8% to 21.2% (-45.6%) during the 18-month project implementation of MTM (see Figure 2). An analysis of qualitative data from primary caregivers and other study participants (ECD promoters and members of the ECD committees) show a constantly emerging theme that the gained knowledge on discipline practices was one of the key

learnings primary caregivers, their children and households have benefitted from. Prior to the participation in the program the application of physical discipline methods was not understood as punishment, but as a measure that corrects children´s misbehavior.

> *"Not whereby if a child is wrong you shout at the child no, you need to call that child sit down with child and teach the child properly not beating the child because you might be making the child become worse off." (FGD with primary caregiver, Mumbwa)*

> *"Before this program came, I used to have a bad temper even toward my children even when they just make a small mistake I would just grab them and beat them or even encourage other parents to also beat their children but after this program came along even our husbands are part of this program they've also realized and learned that it is not good to deny our children food as punishment. So, I'm a changed person due to this program and no longer deny my child." (FGD with primary caregiver, Chipili)*

> *"I mean, when this program first started, it really changed my approach to treating children. I used to beat my children a lot, but since coming into this program, something has changed in the way I handle them." (FGD with primary caregiver, Chipili)*

> *"They [ECD promoters] taught us that if a child has done something wrong you don't need to beat the child but to talk to the child nicely and not beating and punishing the child but teaching them respectfully and they will also be respectful." (FGD with primary caregiver, Mumbwa)*

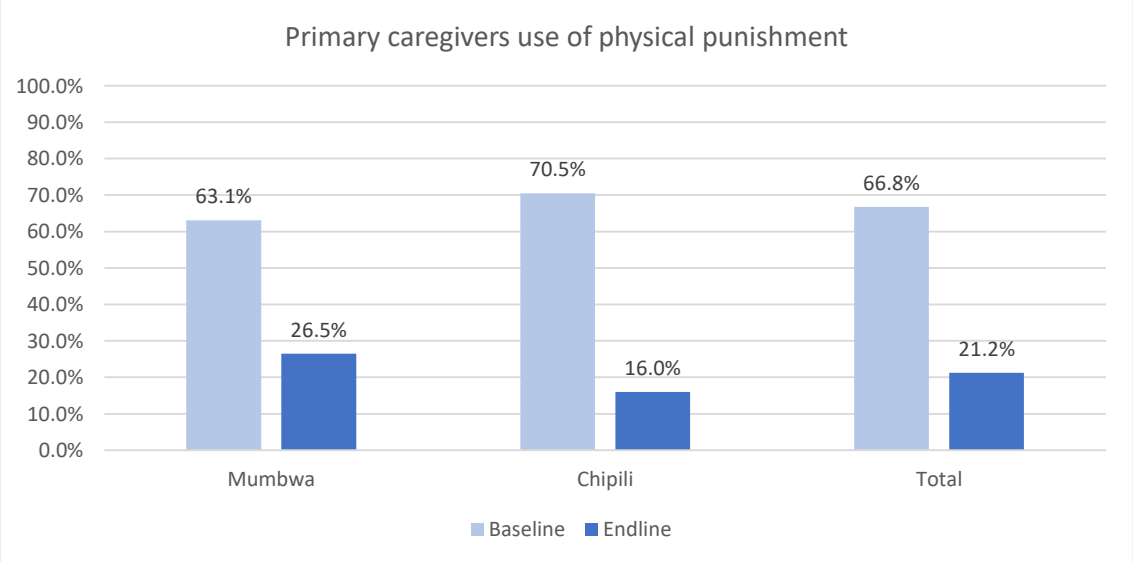

Figure 2: Primary caregiver use of physical punishment

At baseline, primary caregivers reported using an average of 1.19 different types of physical punishment (out of 2) on their children. However, at endline, this average significantly

decreased to 0.30 (out of 6 different types of physical punishment practices), indicating a substantial reduction in the use of physical punishment (see Table 14).

Table 14: Average number of physical punishment practices

Average number of physical punishment practices	Mumbwa	Chipili	Total
Baseline	1.13	1.24	1.19
Endline	0.15	0.46	0.30
Difference [Endline – Baseline]	**-0.98**	**-0.78**	**-0.89**

Regarding the application of psychological abuse/aggression by primary caregivers towards their children, a total of 26.8% of primary caregivers confirmed *shouting, yelling or screaming* at their children at baseline[14]. Quantitative findings in Mumbwa have remained stable between baseline and endline. At baseline, 37.9% of primary caregivers in Chipili reported the use of psychological aggression. At endline this proportion has significantly reduced to 12.0%, indicating a proportional change of -25.9% during the program duration and substantial reduction in the use of psychological aggression. An ECD promoter revealed, "*The change that I have seen is that some caregivers used to shout and scream at their children but now we don't see that anymore."*

> *"I learnt how to take good care of a child, that a child has a right to life, a child needs to play with friends, if a child has taken something that does not belong to them or has fought with a friend you don't need to shout at the child but need to talk to the child properly like, "this thing you have taken does not belong to you, it's for someone else, "and also advising the child against fighting." (FGD with primary caregivers)*

> *"Previously you would automatically shout at a child who was born before the program started but since the start of this program we have changed and stopped shouting at a child who has done something wrong." (FGD with primary caregivers)*

Table 15: Primary caregiver use of psychological aggression

Percentage of primary caregivers who use any psychological aggression	Mumbwa	Chipili	Total
Baseline	15.7%	37.9%	26.8%
Endline	15.9%	12.0%	13.9%
Difference [Endline – Baseline]	**+0.2**	**-25.9%**	**-12.9%**

The survey tool includes two items[15] to test "psychological aggression" or "emotional punishment", but qualitative data gathered from both implementation areas indicate other forms of emotional/physical punishment used, such as denying children food.

[14] The use of insulting words/language was not assessed at baseline

[15] Shouting or yelling at children and using abusive language

"As a woman I used to shout and deny my children from eating nshima, but now I don't do that but I teaching them in a decent manner." (FGD with primary caregiver)

"I feel very good about this program, because I used to shout at my children and denying them food at home but now I have stopped." (FGD with primary caregiver)

"What I learnt about Punishment is that when a child has done something wrong I need to call my child respectfully kneeling before the child saying, "my child, what you've done or stolen is wrong, you need to ask for it", and not for me as a mother deny giving food to the child because of this, that is not good." (FGD with primary caregiver)

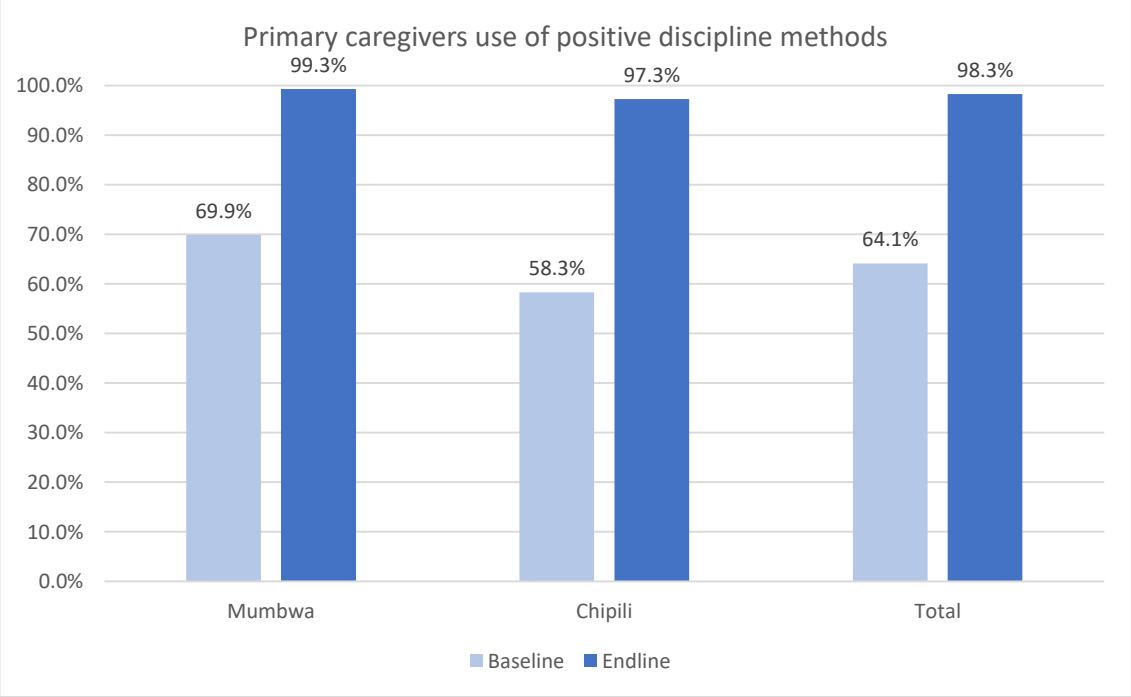

Figure 3: Primary caregivers´ use of positive discipline practices

Following the reduction of primary caregivers´ application of physical and psychological punishment practices, the evaluation found that the program had a significant impact on the application of positive discipline practices (see Table 16). At baseline, 58.3% and 69.9% of primary caregivers in Chipili and Mumbwa respectively reported using any kind of tested positive discipline methods. These proportions have significantly increased to 97.3% and 99.3% in Chipili and Mumbwa respectively, indicating an average proportional increase of 34.2% which is statistically significant.

Table 16: Primary caregiver use of positive discipline practices

Percentage of primary caregivers who use any positive disciplinary practices	Mumbwa	Chipili	Total
Baseline	69.9%	58.3%	64.1%
Endline	99.3%	97.3%	98.3%
Difference [Endline – Baseline]	**+29.4%**[16]	**+39.0%**[17]	**+34.2%**[18]

With regards to the average number of applied positive discipline practices, the average proportional change at endline was 2.26 indicating and improved repertoire of positive discipline strategies among the primary caregiver population (see Table 17).

Table 17: Average number of positive discipline practices

Average number of positive disciplinary practices (out of 6)	Mumbwa	Chipili	Total
Baseline	1.19	0.83	1.05
Endline	1.87	2.63	2.26
Difference [Endline – Baseline]	**+0.68**	**+1.8**	**+1.21**

Qualitative data from all implementation areas support the quantitative findings and indicate a significant shift away from using physical discipline methods towards more empathetic and communicative approaches to child discipline. The program has initiated an important mental and behavioral shift among primary caregivers that the application of physical discipline is now understood as punishment which in the past did not result in any improved behavior of their children. In turn, the newly adopted application of positive discipline methods such as communicating to the child in a calm manner made primary caregivers experience the benefits of this approach – not only with their children, but also with their spouses.

> *"Before the program, we used to beat the children when they did something wrong. But after the program, we no longer beat them. We now take the time to explain to them why what they did was wrong and teach them the right way instead." (FGD with primary caregiver)*

> *"What I have liked about this program is that it has brought unity between me and my husband. We are able to work together better, and the children are now more disciplined. The way they behave has changed since they have been oriented through this program, especially in terms of discipline and punishment." (FGD with primary caregiver)*

Members from various ECD committees validate the findings on the improved application of discipline methods used by primary caregivers.

[16] $p < 0.01$ (unpaired t-test)

[17] $p < 0.01$ (unpaired t-test)

[18] $p < 0.01$ (unpaired t-test)

"There has also been a shift in how children are disciplined. In the past, parents would often beat their children whenever they misbehaved. However, things have improved — parents are now talking to their children instead of resorting to physical punishment. This change has helped improve how children are raised, creating a more positive environment for their development." (Member of the ECD committee)

"Emotional punishment has been controlled. For example, in the past, we would tell a child that they wouldn't eat supper as a form of punishment. This is what I refer to as emotional punishment. Instead of denying them food, we now sit them down and explain the situation. We have learned that using emotional punishment in this way is not effective, and we have shifted to a more understanding approach in dealing with children." (Ward councilor as member of the ECD committee)

"Before this program, we used to discipline children by beating them, but after the program came in and we received orientation, we learned a better approach. Now, instead of resorting to physical punishment, we sit down with the children and explain the wrongdoings and the dangers involved. This has led to a significant change in how we handle discipline, and the difference before and after the program is very noticeable. That's why before, when we used to beat children, they would live in fear, always expecting to be punished. But now, that has changed. We understand the importance of human rights, and we are no longer allowed to beat children. We have embraced the new approach, and it has made a significant difference in how we interact with and discipline the children." (Faith leader as member of the ECD committee)

Additional qualitative data from IDIs with ECD promoters show that the program did not only impact primary caregivers' behavior towards their children but also had a positive impact on other program participants such as ECD promoters and members of the ECD committee. For instance, one ECD promoter provided insights into how the program has positively impacted his application of discipline measure.

"I can give an example of myself, before this program started, I used to beat my children whenever they do something wrong, but now have come to know that that's not the way to discipline children. We are just supposed seat them down and talk to them or counsel them nicely than beating them. Sometimes I used to even punish them by not giving them food when they do something wrong but now have come to learn that it's not right." (Male ECD promoter)

"Previously, when my child did something wrong, I would just take a whip and beat the child. But this time around, I calm down and try to make them understand what they're supposed to do and explain if

they are wrong or not. I try to talk to them rather than just beating them, like I used to do. Previously, when I even beat my child, it could have resulted in injuries, which would lead to more complications, like taking the child to the clinic. But this time around, I'm able to talk to the child properly and make them understand what they're doing and how they should behave, instead of resorting to violence." (Female ECD committee member)

"I loved the topic about punishment and discipline. Some of us we used to punish children instead of just telling [talking to] them. What we used to do, beating the child, was a punishment and not discipline. The implication of this is the child getting used to beating and not changing at all. Nowadays we just talk to our children properly and we have seen change from this." (Female ECD promoter)

5.3.2.2 Birth Registration

With regards to the status of children registered at birth, baseline data show a significant difference between the two implementation areas as only 21.9% of children in Chipili had some form of birth registration while 74.6% of children in Mumbwa were registered at birth. At endline, both implementation areas recorded an increased proportion of children being registered at birth. The average proportional increase in the proportion of children being registered at birth was 32.3% and is statistically significant.

Table 18: Child birth registration

Registered birth of child	Mumbwa	Chipili	Total
Baseline	74.6%	21.9%	48.3%
Endline	81.1%	80.1%	80.6%
Difference [Endline – Baseline]	**+6.5%**	**+58.2%**	**+32.3%**[19]

5.3.2.3 Primary Caregivers´ Knowledge of Child Protection

With regards to the demonstration of adequate primary caregivers´ knowledge of child rights and protection, primary caregivers were asked to mention

- 3 key-things that are important for protecting children from harm and abuse
- 3 basic rights of children, and
- 3 key-action steps to take if there is suspected child abuse or abuses of child rights in the community

[19] $p < 0.01$ (unpaired t-test)

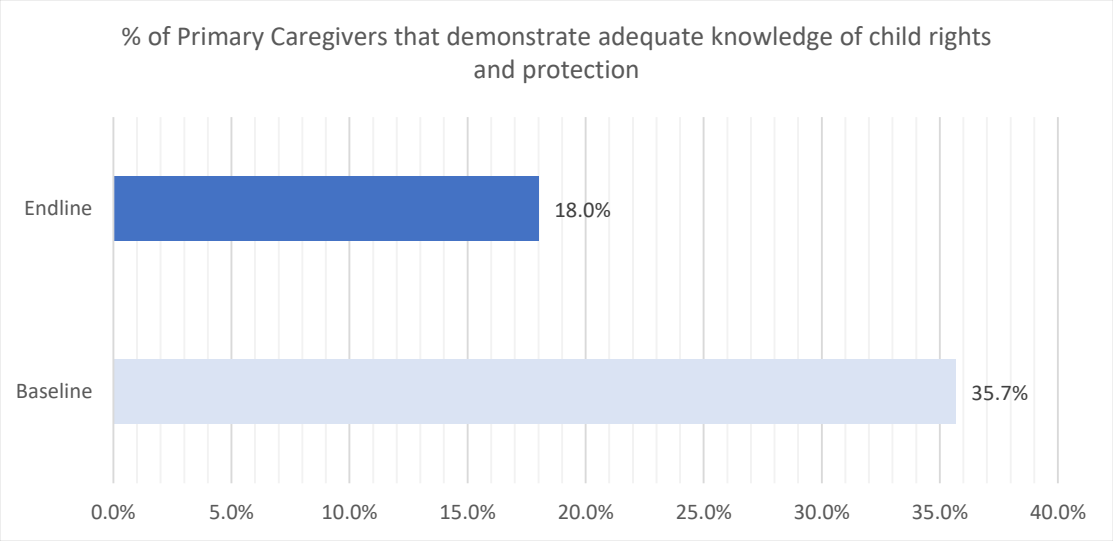

Figure 4: Primary Caregivers´ Knowledge of Child Rights and Protection (Baseline vs. Endline)

Figure 4 demonstrates a 17.7% knowledge decline of primary caregivers of child rights and protection between baseline and endline. An analysis of the provided responses regarding child protection shows the following results:

- **Response item #1**: Never hit, spank or do any physical abuse to children = 41.6%
- **Response item #2**: Never have sex or any sexual activity with children = 7.3%
- **Response item #3**: Never show favoritism or discriminate against any child = 2.2%
- **Response item #4**: Never punish children by hitting or spanking children = 29.5%
- **Response item #5**: Make sure children have someone trustworthy watching them / are always safe = 35.9%
- **Response item #6**: Take children seriously when they tell us about abuse, and get help for them = 3.8%
- 16.8% of primary caregivers failed to mention any response.

However, this could be explained by the following factors:

- Study participants “test anxiety”.
- ECD-lessons on child protection delivered by ECD promoters had a more extensive focus on corporal punishment than other topics.
- Cultural norms not to talk about sensitive issues like sexual abuse.
- Administration of questions as response categories were not mentioned but had to be remembered by study participants.

5.3.3 Outcome 3: Psychosocial Well-being

5.3.3.1 Parenting Confidence

Primary Caregivers´ perception of their confidence in handling parenting responsibilities provided an indication of their ability to create a nurturing environment for their children to thrive in. Their parenting confidence was assessed in two steps.

1. Primary caregivers who feel confident in their role generally do not believe that caring for their child has required more time and energy. They also tend not to feel overwhelmed by their responsibilities **or** worried about whether they are doing enough for their child.

2. Primary caregivers who feel fully confident believe that caring for their child has not taken more time and energy. They have not felt overwhelmed by their responsibilities **and** have not experienced worry about whether they are doing enough for their child

At baseline, 37.6% of primary caregivers reported that caring for their children has not taken more time and energy, and 33.7% reported that they do not feel overwhelmed by their parenting responsibilities. In addition, only 23.9% of primary caregiver were not worried about whether they are doing enough for their child. This resulted in 31.7% of primary caregivers feeling generally confident and 12.9% of primary caregivers feeling fully confident. At endline, this situation has notably improved with 64.1% of primary caregivers feeling generally confident (+32.4%) and 41.7% (+28.8%) feeling fully confident (see Table 19). The above presented findings on parenting confidence attest that the program had a positive impact on primary caregivers´ perception on their parenting confidence and reflects enhanced levels of parenting self-efficacy. Improved levels of parenting self-efficacy "*are strongly associated with an adaptive, stimulating and nurturing child-rearing environment, which encourages social, academic and psychological well-being. The evident importance of PSE has led to the development of interventions that target PSE so that the child-rearing environment can be improved. Interventions such as group-based parenting programs that target parental empowerment have positively influenced PSE.*"[20]

Table 19: Primary caregivers´ perception of their parenting confidence

	Baseline			Endline			Difference [Endline - Baseline]		
	Mumbwa	Chipili	Total	Mumbwa	Chipili	Total	Mumbwa	Chipili	Total
NOT taken more time/energy	49.6%	25.6%	37.6%	74.2%	74.8%	74.5%	+24.6 %	+49.3 %	+36.9 %
NOT overwhelmed	40.1%	27.3%	33.7%	70.4%	70.3%	70.4%	+30.3 %	+43.0 %	+36.6 %
NOT worried doing enough	26.3%	21.5%	23.9%	46.5%	48.4%	47.5%	+20.3 %	+26.9 %	+23.6 %
Feeling confident	**38.7%**	**24.8%**	**31.7%**	**63.7%**	**64.5%**	**64.1%**	**+25.0 %**	**+39.7 %**	**+32.4 %**
Feeling fully confident	**15.3%**	**10.5%**	**12.9%**	**42.8%**	**40.6%**	**41.7%**	**+27.4 %**	**+30.2 %**	**+28.8 %**

5.3.3.2 Parental Stress[21]

With regard to any parental stress reported by primary caregivers, 68.3% reported experiencing any parental stress at baseline. At endline, this proportion has significantly reduced to 35.9%, indicating a proportion reduction of 32.4% between baseline and endline (see Table 20).

[20] Wittkowski, et a. (2017), Self-Report Measures of Parental Self-Efficacy: A Systematic Review of the Current Literature

[21] Any parental stress is the reverse calculation of any parental confidence, while full parental stress reflects the proportion of primary caregivers who provided affirmative responses to ALL 3 questions in Table 19

Table 20: Primary caregivers who report any parental stress

Caregiver reported any parental stress	Mumbwa	Chipili	Total
Baseline	61.3%	75.2%	68.3%
Endline	36.3%	35.5%	35.9%
Difference [Endline – Baseline]	**-25.0%**	**-39.7%**	**-32.4%**

With regard to full parental stress reported by primary caregivers, 47.8% reported experiencing full parental stress at baseline. At endline, this proportion has significantly reduced to 16.2%, indicating a proportion reduction of -31.5% between baseline and endline (see Table 21).

Table 21: Primary caregivers who report full parental stress

Caregiver reported full parental stress	Mumbwa	Chipili	Total
Baseline	38.0%	57.6%	47.8%
Endline	17.0%	15.5%	16.2%
Difference [Endline – Baseline]	**-21.0%**	**-42.1%**	**-31.5%**

Key influencing factors that resulted in increased parenting confidence and reduced parental stress surfaced during qualitative interviews with primary caregivers and can be summarized as follows:

1. **Lack of knowledge to address children's basic needs**: A constantly emerging theme in the qualitative data collected from primary caregivers is their lack of knowledge about how to raise their children and a lack of understanding of what their children need. For instance, many primary caregivers shared that prior to their participation in the program, they failed to understand why their child was crying. Primary caregivers from Mumbwa and Chipili shared the following information.

> *"We did not know a lot of things, like how to feed children, we did not know how to take care of children, maybe if a child was not feeling well, we were not able to tell. But we now know a lot of things, how to take care of children, how to feed and all this is because of the ECD program." (FGD with Primary caregiver, Mumbwa)*

> *"We didn't know how to cook porridge for the children, how to feed them, now we know how to cook for them, mixing Musalu [local root],Chisense, soya beans and mugaiwa mealimeal, we are grateful to this group because we have learned a lot." (FGD with Primary caregiver, Chipili)*

> *"We have learnt how to take good care of the children, we have learnt how to take children to school and have known how to answer our his than before." (FGD with Primary caregiver, Chipili)*

2. **Positive family relationships and general social support**: Prior to the program, any childcare-related activity was considered to be the sole responsibility of the female

primary caregiver regardless of her work schedule or availability. The majority of husbands would not feel responsible to care for the child.

Strong social support from partners, family members, friends, and social circles is one of the most significant protective factors against parental stress. This includes both emotional support (empathy, understanding) and practical support (help with childcare, household tasks).

> *"Husbands never used to know how to take children to the clinic, at least now that the program came, they are able to tell us to go into the field and then they take the child to the clinic." (FGD with primary caregiver)*

> *"Personally, I have benefited greatly from this program. Before, I had forgotten how to write, but through my involvement, I have regained my literacy skills. Additionally, my husband has become more involved in childcare. Previously, I was hesitant to leave my child with him, but now I am comfortable doing so, knowing he can take care of our child while I attend to other tasks." (IDI with ECD promoter)*

> *"Change is there. I have a caregiver who left the husband to care for their 2 children as she went to harvest their groundnuts in the fields. In the past, this never used to happen. When the wife comes, she will find the children are okay; all because of these lessons." (IDI with female ECD promoter).*

> *"Our husbands never used to support us or help us with our children. Husbands are now able to remain with children at home and take care of them." (FGD with primary caregiver)*

> *"Through ECD lessons together with our husbands, I have seen a change that our husbands no longer abuse alcohol or drugs." (FGD with primary caregiver)*

> *"Before this program, things were not good for the family. For example, some husbands used to drink a lot. But now, at least husbands are more responsible and doing responsible things with the money they have, rather than just drinking. This is a very positive change. There is a lot more harmony in families because of the training the ECD promoters have provided. Now, husbands know they should provide for their families. This change has also improved gender equality" (FGD with ECD committee)*

3. **Domestic disputes and gender-based violence:** During qualitative interviews with various program participants, the theme of intimate partner violence (psychological and physical abuse) emerged frequently and is considered a factor that contributes to enhanced parental stress.

> *"There are also cases where there used to be instances of 'Mike Tysons' beating their wives, but with the coming of this program,*

domestic violence has reduced." (FGD with ECD committee)

"Before the MTM program, there was no peace in homes. For example, a woman would just request to be assisted with fetching water from the borehole and the man would refuse saying that is not his duty but the duty of the wife." (FGD with ECD committee)

While primary caregivers did not directly speak about domestic abuse, fathers were more open to directly address their past practices of domestic violence.

"There is huge difference not only on women but also men. Back then we used to shout at the wife or even beat her for the mistake but at the moment we don't do that which is an improvement." (FGD with father)

"This is a very good program. In the past when one is expecting the husband would be rough with the expectant mother, but now he plays with you and the baby is happy to hear the father, they communicate because of this program. We wouldn't want it to end, we want the program to continue because the way we live in our homes has changed." (FGD with primary caregiver)

"If there are a lot of differences at home children in the home don't grow well. But if there's happiness in the home children grow well. There are not supposed to be fights between husband and wife in the homes, that was in the past. We now live happily, that's why we are happy." (FGD with primary caregiver)

4. **Access to Professional Support and Resources:** Professional support from healthcare providers, counsellors, or social workers can improve parents' coping skills and provide guidance tailored to their needs. Access to accurate, understandable educational materials and resources also helps parents manage stress more effectively.

"I am grateful to MTM because we have learned a lot on the health of children and how to take good care of them, plus father's are now participating in the program." (FGD with primary caregiver)

"As the Ministry of Health in this program, we provide health information to the community and caregivers. We also distribute mosquito nets, especially to those with children and everyone else in need. Additionally, we educate them on the importance of accessing health facilities." (ECD committee, Ministry of Health representative)

5. **Social and Community Connections:** Opportunities for parents to connect with others, share experiences, and receive empathy and advice from peers can reduce feelings of isolation and stress. Community programs and recreational activities further support parental well-being.

"Unity is another key lesson we have learned. During group sessions, people cook together, interact more often, and collaborate effectively. This has strengthened the sense of togetherness within the community. Through these activities, we have come to understand that unity is essential in achieving a common goal. Since the program started, it has played a significant role in fostering this spirit of cooperation." (ECD committee, Ward Councilor)

6. **Mental Health and Coping Strategies:** Addressing parental depression and promoting positive mental health through counseling, mindfulness, or stress management programs are effective in reducing parental stress. Interventions that teach coping skills and resilience are beneficial.

"I am a faith leader, and I work together with the ECD promoters. When they have functions or sessions, I am actually with them, working with the caregivers to provide counseling services. I also assist the promoters; if they have problems, I go there to counsel them so that they sort them out." (ECD committee, faith leader representative)

5.3.4 Outcome 4: Gender-equitable Roles in Parenting

5.3.4.1 Fathers´ engagement in child stimulation activities[22]

The study also assessed if fathers (as secondary caregivers) have changed regarding their engagement in child stimulation activities. Findings presented in Table 22 show a significant improvement in the proportion of fathers who engage in various stimulation activities with their children at least once per week in the past 7 days prior to data collection. At baseline, the proportion of fathers engaging in child stimulation activities ranged from 14.9% (*Read books or look at picture books*) to 54.6% (*Encourage child to crawl, run, or jump*). A notable significant increase of the proportion of fathers engaging in all of the 11 tested child stimulation activities was recorded at endline.

[22] The findings for fathers have to be taken with caution as the sample size of fathers who participated at baseline and endline is relatively small.

Table 22: Fathers´ engagement in child stimulation activities

Child stimulation activities done at least once week	Baseline			Endline		
	Mumbwa (n=41)	Chipili (n=25)	Total (n=66)	Mumbwa (n=35)	Chipili (n=50)	Total (n=85)
Read books or look at picture books with child	13.9%	16.0%	**14.9%**	96.0%	97.9%	**97.0%**
Sing songs	66.7%	36.0%	**51.3%**	100.0%	87.5%	**93.8%**
Take child out of home	36.1%	28.0%	**32.1%**	96.0%	95.8%	**95.9%**
Play with child	38.9%	48.0%	**43.4%**	100.0%	100.0%	**100.0%**
Name or count things	36.1%	40.0%	**38.1%**	100.0%	100.0%	**100.0%**
Draw things with the child	36.1%	20.0%	**28.1%**	96.0%	97.9%	**97.0%**
Tell stories to child	30.6%	44.0%	**37.3%**	96.0%	89.6%	**92.8%**
Provide child with object to grasp or pick up	58.3%	28.0%	**43.2%**	100.0%	91.7%	**95.8%**
Encourage child to crawl, run, or jump up	61.1%	48.0%	**54.6%**	100.0%	97.9%	**99.0%**
Hug or kiss child	63.9%	40.0%	**51.9%**	92.0%	75.0%	**83.5%**
Praise child	50.0%	40.0%	**45.0%**	100.0%	100.0%	**100.0%**

The importance and benefits of fathers actively engaging in child stimulation activities is well-documented. Studieshave found that children whose fathers regularly engage in stimulation activities have improved language skills, enhance academic performance and generally better cognitive function.[23] It was also found that positive father involvement has a positive impact on children´s self-esteem, improved emotional regulation, increased sociability and stronger peer bonds.[24] Fathers often interact with children differently than mothers – more physical play, different communication styles, and varied problem-solving approaches. These differences offer children a broader range of experiences, which helps cognitive flexibility, emotional regulation, and resilience.[25] When fathers participate actively in play and learning activities, it strengthens the emotional bond between father and child.[26] This connection builds the child's sense of security and trust, which is essential for healthy emotional and social development. Studies show that children with engaged fathers tend to have stronger language development and perform better on cognitive assessments. Conversations, shared reading, or storytelling from both parents create a richer linguistic environment. Fathers serve as role models for behavior, communication, and emotional expression. Active involvement shows children that nurturing and education are shared responsibilities, challenging outdated gender roles and promoting gender equality. Children with involved fathers tend to show higher self-esteem, better social skills, and fewer behavioral problems. The presence of a loving, attentive father figure creates a sense of stability and support.

5.3.4.2 Fathers´ Discipline Practices

At baseline, 74% of fathers refused to answer the question of whether they apply physical punishment practices to discipline their children. The proportion of those who provided an

[23] Behson et al. (2016): The Effects of Involved Fatherhood on Families, and How Fathers can be Supported both at the Workplace and in the Home

[24] Sarkadi (2008): Fathers' involvement and children's developmental outcomes: a systematic review of longitudinal studies

[25] https://cordellcordell.com/blog/how-does-active-father-involvement-impact-child-development/

[26] https://www.zerotothree.org/resource/the-daddy-factor-how-fathers-support-development/

affirmative response of applying physical punishment was relatively high at 84.8%, but with a response number of n=18 for slapping the child´s hands and n=20 for slapping the child anywhere. However, qualitative data strongly suggests that physical punishment was a generally accepted discipline practice among fathers.
With regards to parental discipline practices, the program has significantly impacted on a positive behavioral shift from physical to positive discipline practices. This in turn – though not measured in this study but extensively researched and evidenced – results in various positive outcomes for children.

a. Reduced psychological and emotional harm protects children from feelings of fear, sadness, shame and guilt.[27] [28]
b. It protects children from an increased risk of developing mental health problems during childhood and later in life – such as depression and anxiety.[29] [30]
c. Reduced risk of impaired brain development in areas such executive functions, emotional regulation, and social cognition.[31] [32]
d. Corporal punishment is linked to slower cognitive growth, lower IQ scores, and impaired educational achievement.
e. It undermines social-emotional skills, such as emotion regulation, conflict resolution, and self-control.
f. Children exposed to corporal punishment are about 24% less likely to be developmentally on track compared to those who are not exposed.
g. There is a strong association between physical punishment and increased aggression, antisocial behavior, delinquency, and later criminal behavior.
h. Rather than teaching appropriate behavior, corporal punishment often leads to more externalizing problems and worsened behavior over time.
i. It is also linked to poorer moral internalization and lower quality of parent-child relationships.
j. The negative effects of corporal punishment can persist into adulthood, including higher risks of mental health issues, aggression, and perpetuating violence in future relationships (e.g., spousal or child abuse).
k. No studies have found corporal punishment to be beneficial for children's health or development in any culture or country.

During the qualitative interviews, fathers were asked what key lessons they learnt from their participation in the program (mainly during home visits).

> *"Parents should also avoid being too harsh or beating their children. Sometimes, when parents are too strict, children get scared and run away, hiding in the maize fields. Then, when it is time to eat, they might not even come home because they are afraid of being beaten. Instead of using physical punishment, we should sit down with the child, talk to them, and guide them on the right way to do things."*
> *(FGD with fathers)*

[27] https://endcorporalpunishment.org/wp-content/uploads/2021/10/Cuartas_end-violence-who-webinar.pdf
[28] https://www.who.int/news-room/fact-sheets/detail/corporal-punishment-and-health
[29] https://www.child-encyclopedia.com/social-violence/according-experts/corporal-punishment
[30] https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/journals-and-magazines/social-policy-journal/spj27/the-state-of-research-on-effects-of-physical-punishment-27-pages114-127.html
[31] https://www.gse.harvard.edu/ideas/usable-knowledge/21/04/effect-spanking-brain
[32] https://inee.org/sites/default/files/resources/early-childhood-briefing-2021.pdf

"I have really appreciated this program, in the past, I used to beat children whenever they did something wrong, after been taught, I have seen change. Children used to run away from me whenever I called on them but these days, they are able to listen to me when I call them and they are comfortable." (FGD with fathers)

One father shared the positive learning effects using the FAMA cards which positively impacted his parenting/discipline practices:

"On the FAMA cards, we learn from the pictures where one side they would put an X on pictures showing that this is wrong, for example, sometimes they would show us pictures with a person showing them beating a child and put an X, showing that this is wrong and on the other hand, they would show a father playing with children showing that this is right, this encourages us and realized that playing with a child is a good thing and it is needed to every person not been harsh to the child, not that every time they do something wrong, the solution should be to beat them, no. We learn that even talking can be helpful." (FGD with fathers)

"Due to limited information, there was little awareness in child care. You would find that there was extreme beating of the child but after this program we learned that we don't beat the child but just speaking to the child is enough." (FGD with fathers)

The understanding of the widely researched physical and long-term emotional/psychological harm resulting from the application of corporal punishment was shared by a father during a FGDs when he said:

"Long time we only knew that to discipline a child is only through beating but through the lessons we have learned that beating a child makes them feel lonely and depressed but when just use words they become happy and they would even help controlling their siblings saying dad does not allow to do it." (FGD with fathers)

Figure 5 below highlights the endline findings regarding the immensely enhanced paternal application of positive discipline strategies which are also supported by qualitative findings (see quotes above).

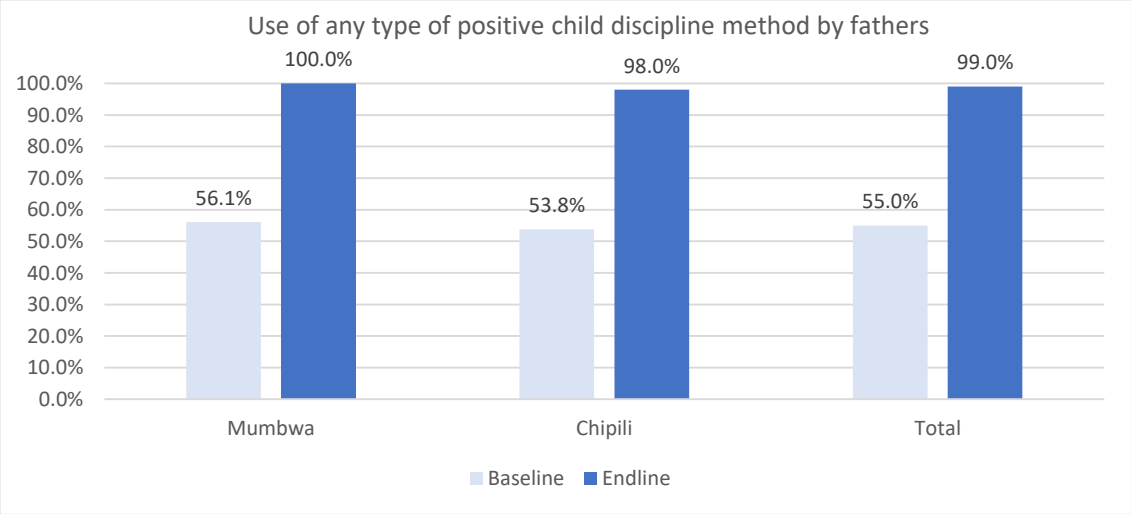

Figure 5: Use of any type of positive discipline by fathers

In summary, positive discipline strategies are essential for nurturing responsible, confident, and emotionally healthy children, while also building stronger family relationships and laying the groundwork for lifelong success.

The program evidently had a positive impact on the promotion of gender-equitable roles in parenting. In addition to the positive behavioral shifts of fathers in engaging with their children and the improvement of discipline measures, it was also found that fathers have taken up family/household-responsibilities which used to be considered the mothers responsibility. Simple household chores like looking after, cooking for or bathing a child used to be activities men would not participate in. Some primary caregivers shared during a FGD:

> *"I have change at home, In the past when I leave the child with the father, he would refuse saying that the child will be troublesome, but now when I leave him with the child, he accepts and takes care of the child. From this I can see that my husband is taking head to what we are being taught in this program." (FGD primary caregiver)*

> *"I have seen change in my household because my husband never used to bath or cook for my child when I go somewhere and leave the child home. But now, my husband can bath, cook for and play with my child in my absence. So, I think I have seen so change in my family." (FGD primary caregiver)*

> *"For me my husband never used to help in taking the children to the clinic for growth monitoring, but now he even takes the child to the clinic even he is sick, he just puts the child on his back and takes him to the clinic." (FGD primary caregiver)*

5.3.5 Outcome 5: Economic Empowerment

The "Economic Empowerment" program component was not included at baseline, but the study assessed this component by assessing membership in Savings with Education (SwE) groups, access and utilization of loans, changes in livelihoods/food security and changes in child-related expenses such health or education expenses. At endline, the majority of primary caregivers in both implementation areas are members of an SwE group as sown in Figure 6

below. However, the reason why SwE membership is not higher is mainly explained by already existing saving groups in the community (commonly known as Village Savings and Loans Associations, VSLAs) from other organizations prior to the implementation of MTM. Qualitative data from primary caregivers highlight the benefits of improved financial literacy levels among the SwE group members.

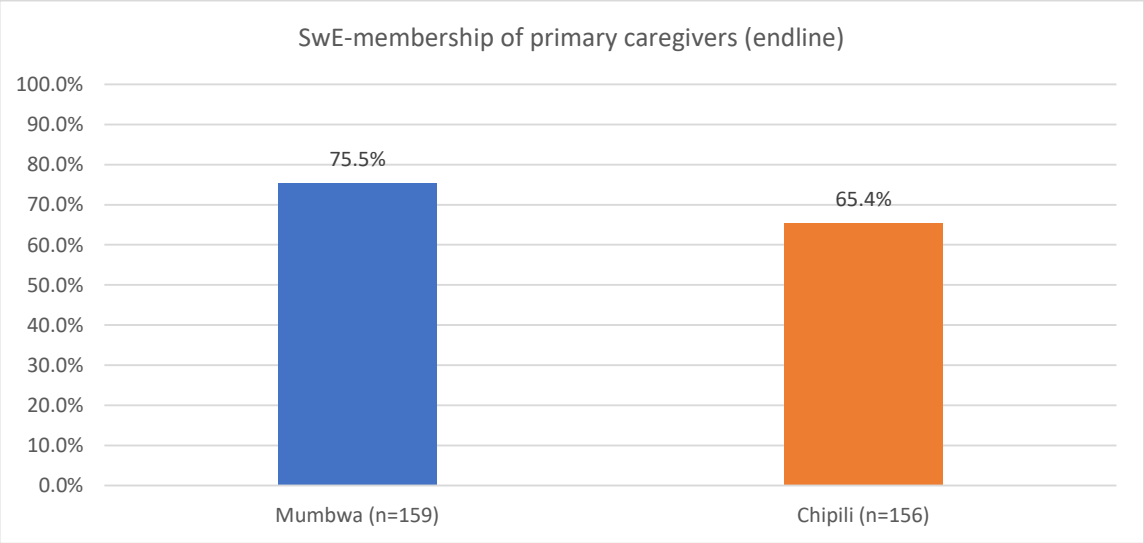

Figure 6: SwE membership of primary caregivers (endline)

According to program documents, a total of 474 primary caregivers (260 in Mumbwa and 214 in Chipili) and 170 men have joined SwE groups with a total savings amounting to ZMW 99,740.0 (USD 3748) and additional amount of ZMW 60,150.0 from interest and penalties.
The data presented in Figure 7 demonstrates the main reasons why primary caregivers access loans from the SwE-groups. In both project areas accessing loans to finance household food expenses was the most frequently provided response, followed by other household expense (for repairs and other expenses). These results are not necessarily surprising as the severe drought experienced in Zambia last year created enormous financial pressure on already very vulnerable households as annual income from agricultural activities were severely reduced.

> *"Being found in the savings group has helped us a lot, because the previous season there was hunger, but when I go to savings group, I can get money and feed my children." (FGD with primary caregiver)*

> *"Yes, thanks to the savings group because if we don't have food at home we just go to the savings group and get some money and buy some food, hence the change is there." (FGD with primary caregiver)*

However, the presented data also indicates that loans are also extensively used for educational expenses of children. While education from grade 1 to grade 12 was made free by the current government, school utensils and uniforms still have to be financed by the parents of school-going children.
Qualitative data from FGDs with primary caregivers support the quantitative findings, as shown below.

"The good I have seen in the program is the savings that they brought, I am not married, I have children who do not have a father, so I deposit whenever I have money and when it accumulates I get a loan and if a child doesn't not have a uniform I buy, and if I do not have mealie meal I buy a small bag. So, I really appreciate the program has really helped us."(FGD with primary caregiver)

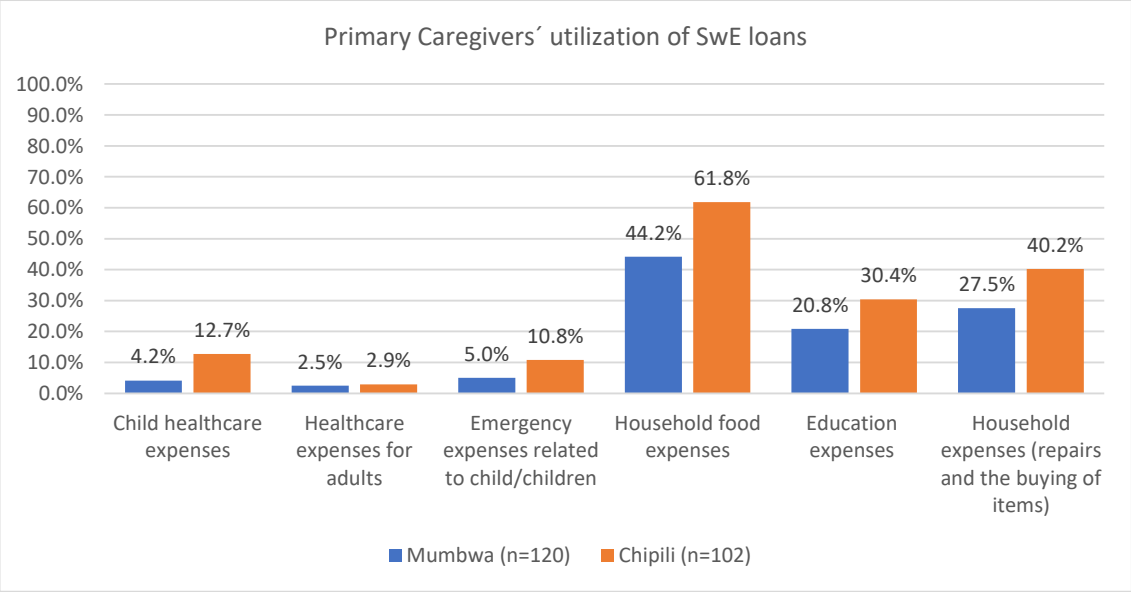

Figure 7: SwE-loan utilization

In addition to cushioning emergency-related expenses – such as food shortages – and helping families to purchase educational utensils, the SwE-groups also had a positive impact on entrepreneurship activities in program households. Quantitative data shows that almost 31% of program participants in Mumbwa and almost 11% in Chipili started a new business, while 25.8% and 9.2% expanded an existing business in Mumbwa and Chipili respectively.

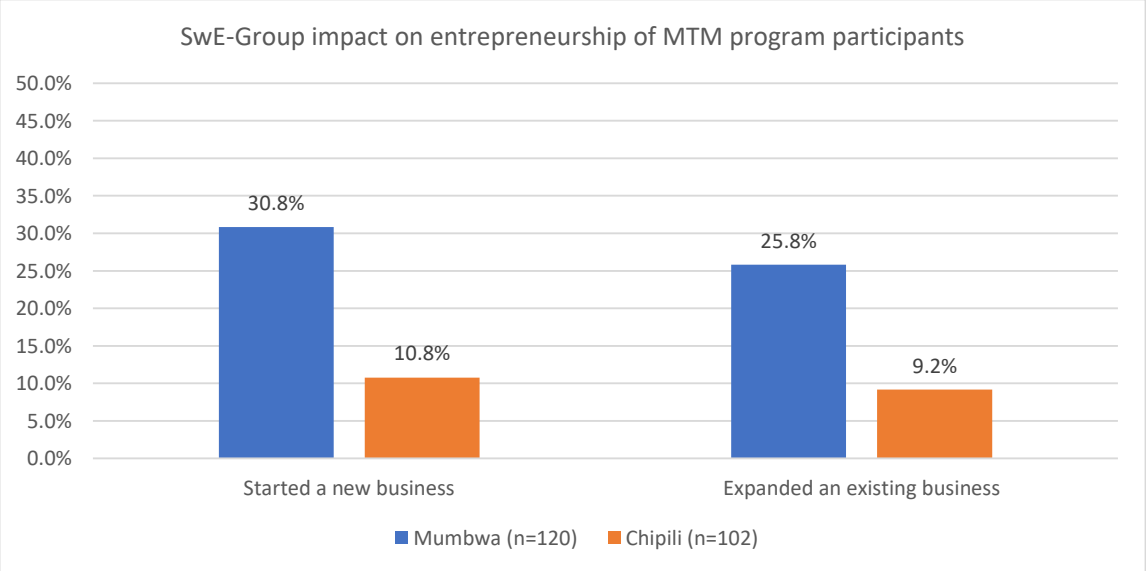

Figure 8: SwE-Group Impact on Entrepreneurship in MTM Households

The proportional differences in the two project areas are not surprising given the geographical and economic context of the locations. Mumbwa is a semi-urban area that offers more business opportunities like trading and selling products in the markets in Mumbwa. Chipili is a rural area where markets access is difficult and expensive and many farming households that are able to produce an agricultural surplus depend on middle-men to access markets. However, households in Chipili reported that their participation in the SwE-groups enabled them to access agricultural fertilizer to improve their harvest and, thus household food security. The positive impact the program had on business-related activities was well-captured during FGDs with primary caregivers and ECD promoters as shown below.

> *"It is savings, I never used to do business, through savings I started a business. Even if I credit money I will be able to return and I will be remembering that it is the savings group that made me reach this far… No it doesn't end since there are others ways to save." (FGD with primary caregiver)*

> *"The benefit in keeping money, in time I can find myself maybe with a K7000 from the money I will buy a goat for my children and when there is no food, they can get milk and use it to eat nshima. When the goat is old they sell it and then buy uniforms or shoes" (FGD with primary caregiver)*

> *"It is the issue of savings, if I have a K100 I want to order tomato in town and it is K180 at the market I will be unable to buy. Instead, I will take the money to be saved then later after it has accumulated, I will credit and order my tomato return the credit and the business is growing." (FGD with primary caregiver)*

> *"Then from the savings group through ECD I started a business from which if my child wants to eat rape I buy, cook and my child eats. I am able to do those things thanks to the ECD program." (FGD with primary caregiver)*

5.4 ECD Promoters

ECD promoters are the key community-based volunteers responsible for implementing the program activities of MTM in their respective communities. These activities include monthly home visits and monthly Caregiver Support & Learning Groups (CSLG). Therefore, at the start of the program, promoters participated in two training workshops in which new information on ECD topics was provided to them. According to ECD promoters, the training contained information on how to interact with children to stimulate their development in an age-appropriate manner, facilitation skills to be used at the group and household level (including FAMA cards), child nutrition and health, child rights and safety, the importance of play and stimulation and the inclusion of fathers in providing nurture and care for children, among others. Figure 8 shows the proportion of ECD promoters who scored 80% before and after the training. While low pre-training test results are not necessarily surprising, the relatively low proportion of ECD promoters who scored 80% in the post-training test comes as a surprise and conflicts with qualitative data from FGDs with ECD promoters and IDIs with ECD lead promoters. However, the post-training test results were not adequately analyzed by the

implementing partner organization as the results imply a certain level of training ineffectiveness and could have led to a consideration of re-training the ECD promoters or planning for a refresher workshop. On the other hand, low post-training scores using conventional testing methods, could also be explained by varying literacy levels, test anxiety and other factors.

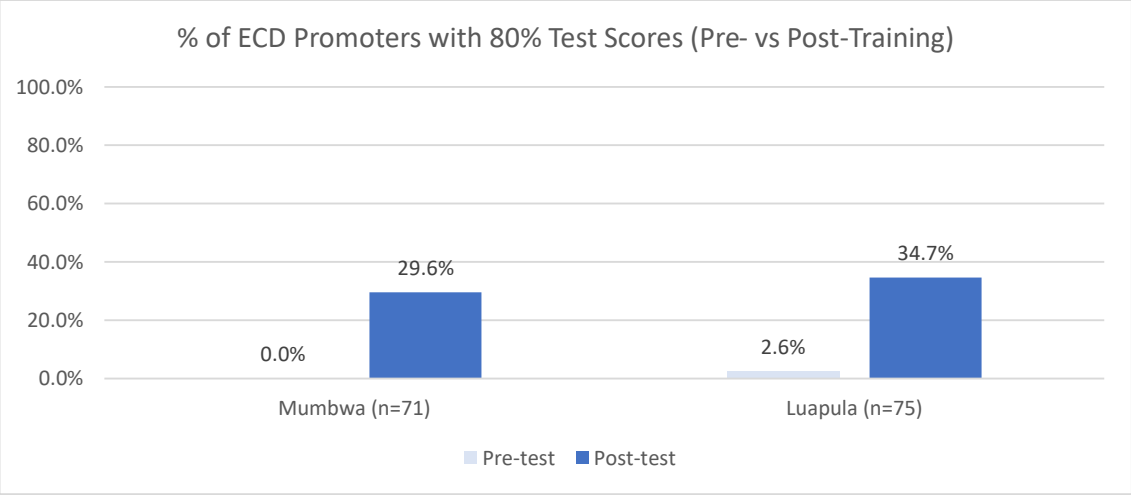

Figure 9: ECD promoters pre- and post-training scores

At endline, this study conducted another knowledge assessment solely focusing on ECD promoters´ knowledge on child stimulation activities in each domain. ECD promoters were asked to mention at least 3 different stimulation activities per domain. The results presented in Figure 10 also indicate rather low knowledge levels of ECD promoters in the area of child stimulation activities parents can engage in with their children. It is highly likely that ECD promoters are not used to an "exam" situation and thus failed to provide sufficient responses but are more comfortable and acquainted to using the FAMA cards to carry out the specific ECD-related topics during home visits and CSLG meetings.

Qualitative findings (see quotes below) indicate that ECD promoters are well-equipped with ECD-related knowledge, the learning and teaching processes during home visits and CSLG meetings and to effectively respond to inquiries, support requests or referral needs from primary caregivers.

> *"On a FAMA cards you find pictures that we need to use to teach, so when we reach a household we start by greeting them and when lessons begin we use FAMA cards, we give them they look at the picture and then we ask them to explain what is on the picture in their own understanding from there we start teaching them what the picture means." (FGD with ECD promoter)*

> *"My thoughts on early childhood development are that learning starts early, from as early as in the womb. That is the reason why some children go astray because as parents we miss this delicate age from the womb to three years which is the age when a Child's behavior is forming. It is important to start speaking with children properly immediately they speak their first word because if we insult a lot in our conversations as a family then definitely this young child will pick up that insolent language and will start insulting from the*

time the start to speak. So, my thought is that it is a very good program." (FGD with ECD promoter)

"Most of the training sessions covered how to take care of a child properly from the womb till the age of three. I personally did not know that a child can hear a parent's voice from the womb and that the child also laughs in the womb. We did not know all that in the past and we even used to beat pregnant women. So, I and other parents learnt that for a child to be born healthy and happy, we need to be laughing with our wives when they are pregnant. If our wives are always sad and worried then they will give birth to a sad baby. There is a big difference between the way we used to do things and the way we are doing things now." (FGD with ECD promoter)

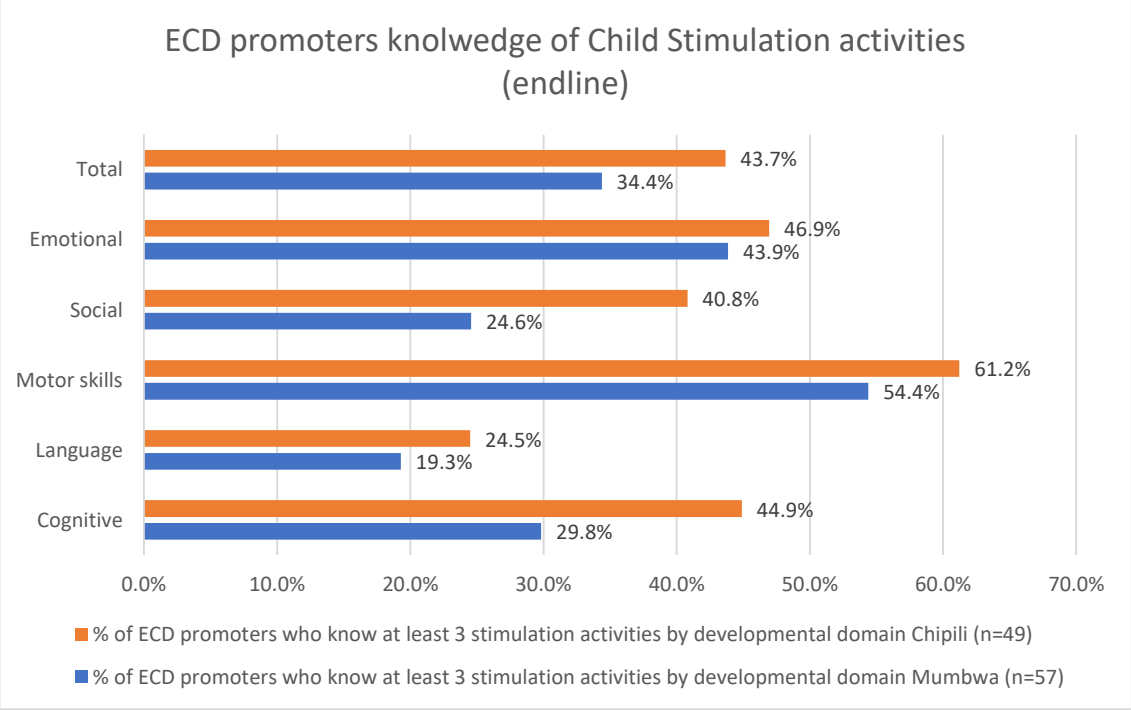

Figure 10: ECD promoters' knowledge of child stimulation activities

In addition to the qualitative evidence (above) that contradicts quantitative findings on ECD promoters´ knowledge, additional evidence on the effectiveness and helpfulness of ECD promoters supporting positive parental behavior change in communities is demonstrated in Figures 11 and 12 (below). More than 90% of primary caregivers in both implementation areas consider ECD promoters as their most important source of learning about ECD-related topics and also affirm ECD promoters´ effectiveness in responding to questions, additional services or referrals as already mentioned above. An overwhelming amount of qualitative evidence regarding the effectiveness of ECD promoters was provided by primary caregivers (see quotes below).

"The ECD promoters are doing well. What I would say is that they just have to continue doing what they are doing and not get tired. For example, the reason we take children to school is because we want them to be educated. In the same line, I don't want this program to

end. I want it to continue educating us." (FGD with primary caregivers)

"We used to learn a lot from the FAMA cards and Practice to Action Passport they brought. They were teaching us how to keep the child safe, move the child away from fire, protect them from danger, and prepare better food for them." (FGD with primary caregivers)

"Again we are thanking this program since it came we've been taught a lot of things I didn't know how to raise my child especially taking them to the clinic but now I've learned that it is important to take my child to their clinic to be administered 10 injections, this also helps me to know the weight of my child. Even our husband support us with this program even our promoter comes to encourage us and monitors on the progress of our children." (FGD with primary caregivers)

"We learned a lot of different things about cooking for children, and taking good care of them, playing with them." (FGD with primary caregivers)

"We are very happy with their visits, checking and monitoring the growth of our children." (FGD with primary caregivers)

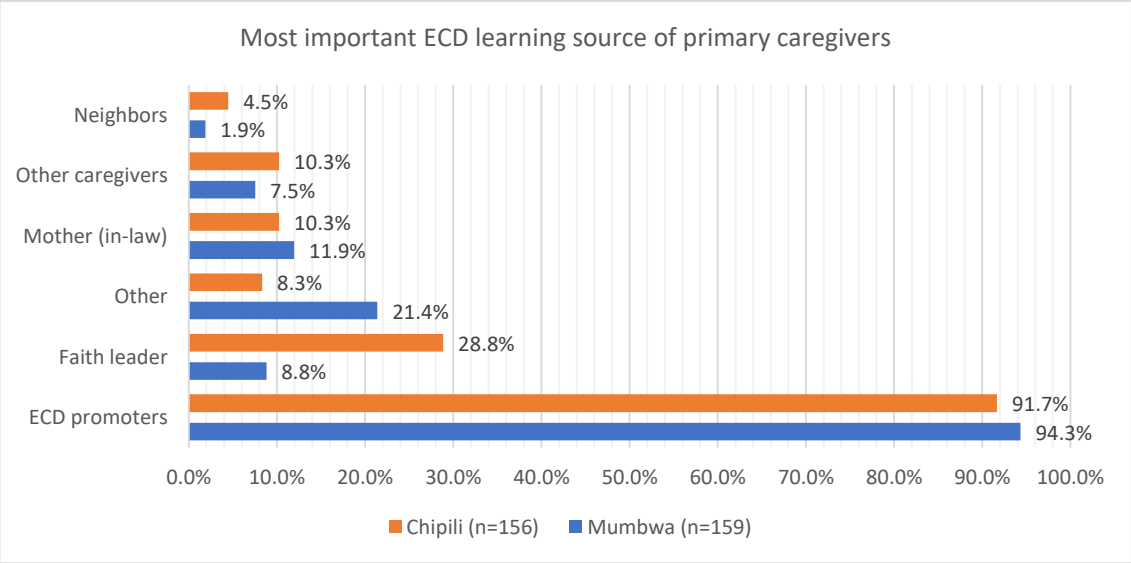

Figure 11: Primary caregivers' ECD learning sources

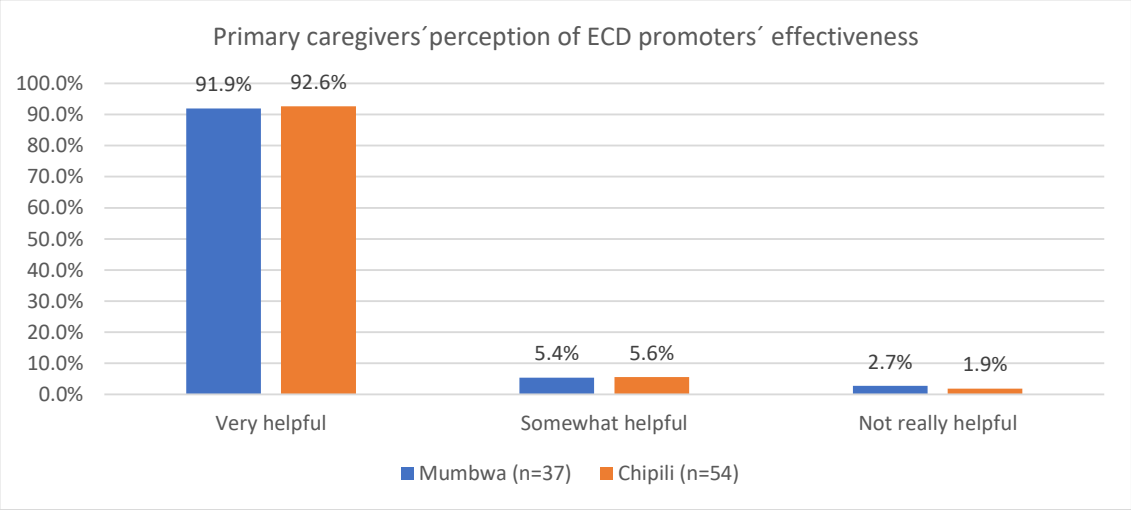

Figure 12: Primary caregivers´ perception of ECD promoters' effectiveness

5.5 Wider Program Impact on Households and Community

In addition to the measured quantitative indicators in the previous chapters, this evaluation found a number of additional positive impacts at child, parent, household and community level through qualitative data collection.

a. Improved child health and nutrition and health-seeking behavior

It was widely reported at all project implementation sites, that general child health and in some cases even child mortality had improved. The majority of respondents connected this to the cooking demonstrations that aim at using locally available ingredients to prepare simple, but nutrient-rich and age-appropriate meals for children. Cooking demonstrations also provided knowledge to primary caregivers regarding the quantity of meals a child should have in a day. An ECD committee member (health representative) shared the following:

> *"Another positive change I can mention is that caregivers now know how to take better care of their children. They have learned how to prepare nutritious meals, which has led to an improvement in child nutrition. The turnout for cooking demonstrations has also improved, and many caregivers now know what type of food to prepare for their children. Additionally, more caregivers are joining the program, showing that it has had a positive impact on the community." (ECD committee member)*

In Chipili, the Community Health Worker (CHW) as a member of the ECD committee did only observe improved feeding practices and child nutrition, but also shared that through the inclusion of the strategic service providers on the ECD committees – such as the Ministry of Health – general health knowledge and health seeking behaviors among primary caregivers has significantly improved:

> *"As the Ministry of Health in this program, we provide health information to the community and caregivers. We also distribute mosquito nets, especially to those with children and everyone else in need. Additionally, we educate them on the importance of accessing*

health facilities. Since some health facilities are about six kilometres apart, we have trained community health workers to provide services within these catchment areas. We also have community change agents who share health information with parents and teach them how to properly feed their children." (ECD committee member)

With regards to child mortality, still births and miscarriages, the CHW added:

"Before the [program] it used to be 10 deaths per year and after the program, we have never recorded any in that age range of 0-3, including still births. What we've noticed is that previously, there were cases of miscarriages among women. Since the program started, we have not heard of any miscarriages." (ECD committee member)

Health seeking practices of primary caregivers and fathers have drastically improved with the implementation of MTM. CHWs shared that the under-5-clinic was poorly visited, and parents didn't have much knowledge on knowing when a child needs professional health services.

"For me, I actually enjoy being a facilitator to bring the children to the Growth Monitoring Program (GMP). Previously, we had a challenge where people didn't want to take their children to the GMP, but right now we're trying to work around that so the children have access to health. So, I work very closely with the ECD promoters to ensure that the children and their caregivers come to the clinic. Just like you have seen today, there's a GMP program, and it's because of this program that the numbers have really turned out well. There has also been an improvement in nutrition. What we usually do has changed, and now caregivers know how to prepare better food for the children." (CHW in Chipili)

Qualitative evidence also suggests that the distribution of vegetables seeds and the teaching of horticultural practices to cultivate home gardens have positively contributed to improved child health and nutrition.

"We were helped through the empowerment of seeds for garden and that really helped us to plant." (FGD with primary caregiver)

"In the past we didn't know how to make gardens but after this program were able to do our garden in our hands all things to this program." (FGD with primary caregiver)

b. Improved caregiving environment in households through counselling

Relationship dynamics between parents were often characterized by arguments, insults and cases of gender-based violence. The inclusion of faith leaders in the program (in general and as members of the ECD committee) has contributed to an improved aggression/violent-free caregiving environment. One of the faith leaders shared: "*A lot of these young men would*

insult and be very abusive towards their wives but now since the program started that is not happening as they are more respectful in terms of how they speak to each other."
Another faith-leader added:

> *"There is a big change because we would tell them [couples] about their bad behaviours many times and they definitely get to change. We encourage couples to love each other because a couple that is happy has happy children, their family is well united. He has given an example of when Jesus got lost and they went looking for him together, Joseph did not tell Mary to look for Jesus alone but they went together to look for him." (Faith Leader, Chipili)*

6 Challenges and Enablers

6.1 Challenges

a. Effectiveness of supervision and monitoring activities of the ECD Committees

The ECD Committees frequently reported that they feel challenged to effectively monitor ECD promoters due to a significant difference in knowledge levels between ECD promoters and members of the ECD Committee. This, according to committee members, has resulted from the different trainings both parties undergo in the program. It was frequently suggested that the ECD Committees should participate in the ECD part 1 and part 2 training workshops in order to enhance the effectiveness of their monitoring efforts through closing the ECD knowledge gap between ECD promoters and the ECD Committees.

> *"There's also a challenge I would say, because as the ECD committee, we don't usually have updated trainings or meetings, but the ECD promoters do. I think this needs to be addressed, and we should also have updated training sessions from time to time. The ECD promoters have received training on savings with education, how to handle home visits, working with caregivers, and conducting group sessions. The faith leaders also have a module on how to carry out the program. What I'm suggesting is that there needs to be inclusiveness, where at least one member from the ECD committee should attend these trainings. This way, we can be updated with the knowledge gained from those sessions and ensure we are all aligned in the work we do." (FGD with ECD Committee, Chulu Luongo)*

Additionally, the ECD Committees frequently mentioned that their monitoring activities are compromised by the sparsely populated communities and long distances between households. Thus, it was suggested to provide the ECD Committees with bicycles to enhance their monitoring activities and effectiveness.

> *„The promoters have bicycles, so it would also be very helpful if faith leaders and ECD committee members also have bicycles because they do monitoring in the communities, so that would also be very helpful to sustain the program." (FGD with ECD Committee, Mukuba)*

„We meet the promoters once a month, so even as much as we do visit their households its difficult because the promoters have bicycles and we all come from different places but us as the ECD committee we do not have bicycles so it makes our work a bit more difficult to operate unlike the promoters have the bicycles and can easily move around and its also a challenge to us." (FGD with ECD Committee, Kampalala)

b. Misinformation and operation of SwE Groups

Despite the frequently reported positive impact of the SwE Groups in the program on household food security, child education-related expense, and entrepreneurship enhancement, many primary caregivers reported initial resistance to participate in the SwE Groups and some are still not members due to initially communicated misinformation of how the groups operate, initial contributions or that the group had reached its maximum member capacity and could not allow anyone else to join.

"The information about the savings with education group was available, but the challenge was that people simply did not have money for the initial contribution." (FGD with primary caregiver)

"When the ECD promoter introduced the savings with education group, they made it clear at the under-five clinic (GMP program) that mothers who wanted to join were free to do so. I joined and was trained elsewhere on how the program operates. However, another issue arose because, after the training, people who later wanted to join found that the group had already reached its maximum number, so they had to wait for another group to be formed." (FGD with primary caregiver)

"I think there may have been an issue with how the information was communicated. People in the community heard about a book where contributions were recorded, and some thought that only those listed in that book could be part of the savings group. That book was kept at my place, as I was the ECD promoter." (FGD with primary caregiver)

6.2 Enablers

a. SwE Groups

The SwE Groups in the program – once communities adequately understood how they work – is an enabling factor to primary caregiver participation due to the many experienced benefits the SwE Groups have resulted in.

"Yes, before, we faced financial challenges and didn't know where to get money from. But now, after the introduction of savings with education, it has become better for us. We can go to the savings group to ask for money to solve some problems, and it has helped improve our situation at home. It also allows us to help other children." (FGD with primary caregiver)

"Oh yes, the importance of these savings is that many of us are involved in farming, so we use the money to buy farming inputs. The savings are usually distributed in November." (FGD with primary caregiver)

"I was part of the group, and what I discovered was that we have a challenge in this village when it comes to finding money. Being involved in this program was difficult for some people because they felt it would be hard to find money to contribute. However, once you became part of the group, it became easier because you could access loans and start small businesses. Lack of information was one of the reasons many people did not join." (FGD with primary caregiver)

b. Combination of faith leaders and ECD promoters

Many primary caregivers reported the complementary benefits of home visits being conducted (separately) by ECD promoters and faith leaders. During home visits, faith leaders focus more on the relationship dynamics between mother and father to ensure that they – as a team – provide a nurturing caregiving environment, while ECD promoters focus on teaching ECD-related content and parenting techniques.

"Previously, we used to encounter problems, but with their collaboration, I think a lot has changed both spiritually and in terms of keeping children safe and maintaining a clean environment." (FGD with primary caregiver)

"It's good that they have to continue working together, just like they have been doing. When we have difficulties at home, they usually talk to us as a couple, and we manage our differences very well. The ECD promoter also does their work concerning our children, keeping them safe and maintaining the environment. A lot of things have changed as a result of the faith leader and the ECD promoter working together." (FGD with primary caregiver)

"For me, the visits by the faith leaders and the ECD promoters were very helpful. The faith leaders would preach about the importance of good morals and how they impact society. The ECD promoters would also come and emphasize key areas that have really influenced my lifestyle." (FGD with primary caregiver)

c. The (composition) of the ECD Committees

The composition of the ECD Committees was a strategically important decision to support overall participation, improve program effectiveness and contributes to the sustainability of the program. The members of the ECD Committees are as follows:

- Representative of traditional leadership (e.g. village headmen/headwomen)
- Representative of primary caregivers
- Representative of ECD promoters
- Representative of local education services (e.g. head teachers)
- Representative of local health services (e.g. nurse in-charge)

- Representative of local agricultural services (e.g. agricultural extension officer)
- Representative of local government (e.g. ward councilor)
- Representative of local faith leaders

The inclusion of traditional leadership in the program is a key factor that fosters community buy-in and participation as traditional leaders are considered as a local authority, govern and maintain order within the community, resolve disputes and conflicts and support the community on important issues that may affect the communities negatively or positively. Their active participation in and support of MTM positively contributes to community mobilization and participation.

The inclusion of various local service providers (health, education, agriculture) bridges communities to available public services such as under-5 clinic, pre-school enrollment, and health promotion for community members instead of seeking medical treatment from traditional healers whose methods are often ineffective in serious medical cases such as malaria, infancy diarrheal diseases, etc.

Faith leaders are usually highly respected and trusted persons who also play an important role in community mobilization and participation. In the MTM program, their role is vital to shaping social norms and attitudes, and their perception as moral authority enables them to promote positive behavior change as it was evidenced in their positive impact on household unity.

7 Comparison of Treatment Effects between the 18- and 24-month Implementation Cycles

A quantitative comparison between the effectiveness of the 18- and 24-month implementation cycle is conducted of the following MTM program components and compares endline data from the APHRC study conducted in 2021 and the endline evaluation conducted in 2025.

- Primary caregivers´ engagement in child stimulation activities
- Primary caregivers´ application of discipline methods
- Primary caregivers´ reported parental confidence
- Fathers´ engagement in child stimulation activities
- Fathers´ application of discipline methods

As described earlier, the aim of this comparison is to establish the most efficient duration of the program implementation duration for MTM. A reduced implementation period would enable the program to reach more communities and households and improve child developmental outcomes more efficiently.

7.1 Primary Caregivers´ engagement in child stimulation activities (18-month vs. 24-month)

Regarding primary caregivers´ engagement in child stimulation activities (out of 11) at least once per week, the findings presented in Table 23 demonstrate that the proportion of primary caregivers from the 18-month cycle show slightly higher engagement rates in 9 out of 11 activities. A significant difference is found in the activity Read books or look at picture books with child *(+63.3%).* However, data on this variable was collected differently in the 24-month evaluation (APHRC Evaluation, 2021) which is likely the reason for this significant difference. In addition, the Caregiver Actions to Practice Passport – which caregivers report using as a picture book – had not been introduced to the program in Zambia at the time the 24-month evaluation was conducted.

Table 23: Primary Caregivers´ engagement in child stimulation activities at least once per week

Stimulation activities done with child at least once week	24-month cycle	18-month cycle	Difference [18m-24m]
Read books or look at picture books with child	28.4%	91.7%	**+63.3%**
Sing songs	94.0%	98.1%	**+4.1%**
Take child out of home	85.1%	95.4%	**+10.3%**
Play with child	88.8%	99.1%	**+10.3%**
Name or count things	90.2%	96.3%	**+6.1%**
Draw things with the child	89.8%	87.0%	**-2.8%**
Tell stories to child	90.7%	89.8%	**-0.9%**
Provide child with object to grasp or pick up	83.7%	95.8%	**+12.1%**
Encourage child to crawl, run, or jump up	82.3%	99.5%	**+17.2%**
Hug or kiss child	94.0%	99.1%	**+5.1%**
Praise child	87.0%	98.1%	**+11.1%**

More interestingly, Table 24 shows the mean number of stimulation activities primary caregivers engaged in the week prior to the study implementation. The findings show that primary caregivers from the 18-month cycle engage in 10.53 stimulation activities while primary caregivers from the 24-month cycle engaged in 9.14 activities per week. However, this difference is not statistically significant and suggests that the difference is unlikely caused by the duration of the program implementation.

Table 24: Mean number of weekly stimulation activities

Mean number of stimulating activities (out of 11)	Total
24-month cycle	9.14
18-month cycle	10.53
Difference [18m – 24m]	**+1.39**

7.2 Primary caregiver application of discipline methods (18-month vs. 24-month)

The comparison of primary caregivers´ application of (negative and positive) discipline methods (Table 25) reveals that a greater proportion of primary caregivers from the 24-month cycle (+19.0%) still used physical punishment methods to discipline their children at the end of the project period, even though more physical punishment items were tested in the 18-month cycle. This difference is unlikely explained by the implementation duration but could be the result of organizational learning. However, the findings on physical punishment indicate that an 18-month implementation cycle has resulted in a circa 45% reduction of primary caregivers´ use of physical punishment. This can be attributed to the intentional revision of materials and new materials that were developed in response to the findings of the APHRC study.

With regards to the use of psychological aggression and positive discipline practices, the overall effect in both implementation cycles is similar even though there are some significant differences in the use of specific positive discipline practices.

Table 25: Primary Caregivers´ application of discipline methods

	24-month cycle	18-month cycle
Physical punishment (any)	**40.2%**	**21.2%**
Hit/slapped child on the hand	24.8%	6.3%
Slapped child (anywhere)	33.0%	n/a
Shook child	n/a	5.3%
Spanked child on bottom with bare hand	n/a	9.0%
Hit child with hard object	n/a	5.7%
Hit/slapped child on the head	n/a	3.4%
Beat child up	n/a	0.0%
Psychological aggression (any)	**18.5%**	**13.9%**
Shouted/yelled/screamed at child	18.5%	12.9%
Called child dumb, lazy	n/a	1.7%
Positive discipline practices (any)	**99.5%**	**98.3%**
Distracted the child	18.0%	71.7%
Took away a privilege	32.4%	28.4%
Sent child away for a time out	26.6%	5.7%
Ignored the behavior	33.9%	13.6%
Explained why behavior was wrong	61.7%	88.5%
Praised good behavior	95.9%	16.6%

7.3 Primary caregiver reported parenting confidence (18-month vs. 24-month)

The comparative findings regarding parenting confidence of primary caregivers presented in Table 26 show no significant difference in the proportion of primary caregivers who feel confident and feel fully confident and suggests that the two different implementation cycle lengths produce similar results in enhancing the parenting confidence among primary caregivers which in turn provides an important parental foundation to create a nurturing caregiving environment for their children to thrive in.

Table 26: Primary caregiver reported parenting confidence (18-month vs. 24-month)

	24-month	18-month	Difference [18m-24m]
NOT taken more time/energy	79.3%	74.5%	-4.8%
NOT overwhelmed	69.7%	70.4%	+0.7%
NOT worried doing enough	60.4%	47.5%	-12.9%
Feeling confident	**69.8%**	**64.1%**	**-5.1%**
Feeling fully confident	**48.6%**	**41.7%**	**-6.9%**

7.4 Fathers´ engagement in child stimulation activities (18-month vs. 24-month)

With regards to the program effect on fathers´ engagement in child stimulation activities between the two implementation cycles the findings show a more positive impact on fathers who participated in the 18-month cycle (see Table 27) with some of the stimulation activities being statistically significant. The findings are even more interesting considering that average baseline values (in developmental domains, not specific activities) in the two implementation cycles were higher in the 24-month than in the 18-month cycle. These improvements could also be attributed to the evolution of the program following the APHRC study as the requirement to enhance the promotion of male engagement was one of the evaluation´s findings.

Table 27: Fathers´ engagement in child stimulation activities at least once per week (18-month vs. 24-month)

Child stimulation activities done at least once week	24-month	18-month	Difference
Read books or look at picture books with child	30.6%	97.0%	**+66.4%**
Sing songs	69.4%	93.8%	**+24.4%**
Take child out of home	75.0%	95.9%	**+20.9%**
Play with child	88.9%	100.0%	**+11.1%**
Name or count things	72.2%	100.0%	**+27.8%**
Draw things with the child	80.6%	97.0%	**+16.4%**
Tell stories to child	55.6%	92.8%	**+37.2%**
Provide child with object to grasp or pick up	83.3%	95.8%	**+12.5%**
Encourage child to crawl, run, or jump up	91.7%	99.0%	**+7.3%**
Hug or kiss child	77.8%	83.5%	**+5.7%**
Praise child	91.7%	100.0%	**+8.3%**

Similarly, the results regarding conducted stimulation activities by fathers at least once per week, the mean number of weekly activities (out of all 11) was also found to be higher in the 18-month cycle as fathers were found to carry out 10.49 activities per week compared to 8.17 activities in the 24-month cycle.

Table 28: Fathers´ mean number of stimulation activities per week (18-month vs 24-month)

Mean number of stimulating activities out of 11	Total
24-month cycle	8.17
18-month cycle	10.49
Difference [18m – 24m]	+2.32

7.5 Fathers´ application of discipline methods (18-month vs. 24-month)

Table 29 below highlights the comparison of the program effect on fathers´ application of discipline methods. Both implementation cycles had a similar positive effect on the reduction of fathers´ application of psychological aggression and the improvement of using any positive discipline methods (despite differences in specific methods), the findings on the application of physical punishment show that a smaller proportion of fathers tend to use physical discipline methods in the 18-month cycle than in the 24-month cycle.

Table 29: Fathers´ application of discipline methods (18-month vs. 24-month)

	24-month cycle	18-month cycle
Physical punishment (any)	**23.8%**	**16.7%**
Hit/slapped child on the hand	16.7%	0.0%
Slapped child (anywhere)	14.3%	n/a
Shook child	n/a	3.6%
Spanked child on bottom with bare hand	n/a	10.7%
Hit child with hard object	n/a	6.0%
Hit/slapped child on the head	n/a	1.2%
Beat child up	n/a	1.2%
Psychological aggression (any)	**14.3%**	**11.9%**
Shouted/yelled/screamed at child	14.3%	10.7%
Called child dumb, lazy	n/a	1.2%
Positive discipline practices (any)	**100.0%**	**98.8%**
Distracted the child	14.3%	88.1%
Took away a privilege	31.7%	64.3%
Sent child away for a time out	22.0%	4.8%
Ignored the behavior	45.2%	11.9%
Explained why behavior was wrong	71.4%	91.7%
Praised good behavior	92.9%	23.1%

8 Summary of Program Indicators (baseline versus endline)

This section provides a summary of all the above presented and discussed program indicators of the 18-month program evaluation in Zambia and the changes that took place between baseline and endline.

Key indicators	Baseline	Endline	Change
Average proportion of primary caregivers who engage in child stimulation activities (at least once per week)	43.1%	95.5%	**+52.4**
Average number of child stimulation activities (out of 11) in the last 7 days (baseline vs. endline)	4.66	10.53	**+5.87**
Percentage of children that play with any play material	73.9%	97.8%	**+19.9%**
% of children whose play material are home-made	92.8%	90.7%	**-2.1%**
% of primary caregivers who report **any** confidence in handling parenting responsibilities successfully	31.7%	64.1%	**+32.4%**
% of primary caregivers who report **full** confidence in handling parenting responsibilities successfully	12.9%	41.7%	**+28.8%**
% of primary caregivers who report **any** parental stress	68.3%	35.9%	**-32.4%**
% of primary caregivers who report **full** parental stress	47.8%	16.2%	**-31.5%**
% of primary caregivers who use of physical punishment with their children 0-3	66.8%	21.2%	**45.6%**
% of primary caregivers who use psychological discipline (any) with their children 0-3	26.8%	13.9%	**-12.9%**
% of primary caregivers who use **any** positive disciplinary practices with their children 0-3	64.1%	98.3%	**+34.2%**
% of children with birth registration documents	48.3%	80.6%	**+32.3%**
Average number of positive disciplinary practices (out of 6)	1.05	2.26	**+1.21**
Average of the number of different stimulating activities (out of 11)	4.66	10.53	**+5.87**
% of primary caregivers that demonstrate adequate knowledge of child rights and protection	35.7%	18.0%	**-17.7%**
% of fathers who engage in at least one child stimulation activity per week	39.9%	95.9%	**+56.0%**
% of fathers who use any positive discipline method	55.0%	99.0%	**+44.0**
% of primary caregivers who are member in SwE groups	0.0%	39.5%	**+39.5%**
% of savings group members who have started businesses using loans or savings	0.0%	20.8%	**+20.8%**
% of savings group members who have expanded businesses using loans or savings	0.0%	17.5%	**+17.5%**
% of ECD Promoters with 80% Test Scores (Pre- vs Post-Training)	1.3%	32.2%	**+30.9**
% of ECD promoters knowledge of child Stimulation activities (at least 3 per developmental domain)	n/a	39.1%	**n/a**
% of primary caregivers who consider ECD promoters as most important ECD learning	n/a	93.0%	**n/a**
% of primary caregivers who consider ECD promoters support as very helpful	n/a	92.3%	**n/a**

9 Conclusion and Recommendations

9.1 18-month MTM evaluation

Conclusion

The 18-month cycle of MTM in Zambia has positively impacted various program areas and has promoted positive parental behavior change among primary caregivers and fathers. It has strengthened responsive caregiving and early learning practices delivered through CSLG meetings and home visits. Increased engagement in child stimulation activities by both primary caregivers and fathers will likely result in improved future child developmental outcomes.

In addition, the significant reduction in physical child discipline methods, enhanced positive child discipline and improved household relationship dynamics between parents have resulted in a safe and nurturing caregiving environment that fosters emotional security and allows children to form trusting relationships with parents/caregivers and helps children develop a sense of belonging and self-worth, which is critical for their socio-emotional development[33].

According to primary caregivers, the program in Zambia has greatly contributed to an enhancement of their caregiving and nurturing knowledge and skills which has in turn positively impacted their parenting confidence and resulted in a reduction of parental stress. Research evidence has shown that increased parenting competence (self-efficacy) are more likely to be consistent and engage in positive parenting practices which further benefits child development[34].

Despite some observed limitations in primary caregivers´ participation in SwE groups, the majority of participants confirmed that their participation has resulted in improved financial assets which in turn helped households to improve their food security, cater for child-education expenses and fostered business development.

Other program activities – such as cooking demonstration, the promotion of health-seeking behavior and improved child feeding practices – have positively impacted on child health and malnourishment which protects children lasting cognitive and behavioral deficits (e.g. delayed language and fine motor skills, lower IQ and poorer academic performance)[35].
Overall, MTM has greatly contributed to improved community cohesion characterized by a safer, more supportive community environment with shared values. As the chairman of one of the ECD Committees shared:

> *"For me, this is a positive change at the community level, as people are more aware and responsible. The program has contributed significantly to this shift in behavior. Even at the community level, I have noticed an improvement, especially in terms of collaboration among people. For instance, during group sessions, they come together, contribute food, or cook together. This has fostered peace and harmony in the community. When they cook and eat together,*

[33] https://www.youngacademics.com.au/the-role-of-safe-and-stimulating-environments-in-childcare/

[34] https://www.ncbi.nlm.nih.gov/books/NBK402020/

[35]https://www.zerotothree.org/resource/distillation/how-does-nutrition-affect-the-developing-brain/#:~:text=Nutrition%20plays%20a%20pivotal%20role,myelination%2C%20and%20glial%20cell%20production.

they are interacting with each other, which is a positive sign. What I have learned from this is that social relationships have changed for the better—they have improved significantly." (Chairman of the ECD Committee in Chulu Luongo)

Recommendations

a. Early introduction of ECD Committees and additional training and equipment

It was observed that the formation, training and introduction of the ECD Committees differed significantly across the ten project communities. Some committees were formed one year after program inception. . Due to the important role the committees play in the effectiveness of the program it is advisable to have a standardized implementation strategy in place or if the latter is in existence, it should be adhered to. It was explained that the reasons for these variations were linked to late or limited funding and priority was given to form the group of ECD promoters. However, as the committees are in charge of monitoring ECD promoters, create linkages between communities and available public services, and play a critical role in community participation, their introduction to the program should happen at an earlier stage. Furthermore, it is recommendable that the committees participate in the ECD Part 1 and Part 2 trainings and equip them with bicycles in order to improve their monitoring effectiveness

b. Separate caregiver groups/activities for fathers in communities where interest is expressed

Program managers for MTM reported that fathers in many communities expressed their interest in participating more actively in the program. Due to existing social norms and traditions it is advisable to design and implement activities specifically for male caregiver. This was also supported by primary caregivers as they labelled their husbands "shy" to participate in women´s groups.

c. Translation of learning and teaching material into local languages

Communities requested that the FAMA cards and the Caregiver Actions to Practice Passport should be translated into local languages as some community members struggle to understand the content.

"However, one change that could be made is translating the material into local languages. This would help both the ECD promoters and the caregivers better understand the pictures and what is being taught in the materials, making it easier for everyone to benefit from the program." (FGD with fathers)

"The difficulty is the translation. If the FAMA cards could be translated into Bemba, I think that would be helpful. I believe this is one of the challenges we are facing." (FGD with fathers)

d. Economic empowerment incentives to promote sustainability

It was frequently mentioned – sometimes requested – that the program should improve on its economic empowerment component at community and household level. Suggestions on the type of economic empowerment measures/incentives the program should provide varied across the 10 project communities. In some cases, the ECD Committees suggested providing farming inputs (such as fertilizer and seeds) to cultivate larger portions of agricultural land. Other communities asked for chicken or goat rearing projects and others suggested the construction of fish ponds. It is recommended that if the program intends to provide economic empowerment measures or any economic incentives, a feasibility and sustainability assessment should be conducted on which results these incentives should be provided on. In addition to economic empowerment projects, it was also frequently requested to have a physical structure – an ECD center – where program activities for MTM could be conducted from.

9.2 Comparison of 18-month and 24-month implementation cycle

Conclusion

The results comparison between the 18-month and 24-month implementation cycles did not reveal any significant differences in the effectiveness of program activities. In fact, overall results were found to be slightly better in the 18-month cycle. The findings support the intention to reduce the program implementation period of MTM to 18 months which allows the program to enhance its efficiency by reaching more children and families with the same program resources.

However, there are a number of factors that should be taken into consideration when reducing the implementation period. The experience and organizational capacities of local partner organizations play a crucial role in the effectiveness of the program. ZACOP is the pioneering local partner in implementing MTM and with the longest organizational learning experience. Hence, the collaboration with local partners is crucial and if the program expands to new regions or countries where new partner organization have to be identified, it is advisable to either start with a 24-month implementation cycle or to pilot an 18-month project on a smaller scale.

However, the results also demonstrate that the program has made significant improvements in its implementation efficiency, organizational learning from earlier evaluations, has improved its educational materials, male engagement strategy and the delivery of child discipline activities.

10 References

Anna Sakardi, et al. (2008): Fathers' involvement and children's developmental outcomes: a systematic review of longitudinal studies. PubMed (97/2).

Anne B. Smit, et al. (2006). The State of Research on the Effects of Physical Punishment. Social Policy Journal of New Zealand. Issue 27

Crawford International (2025): 10 Reasons Why Early Childhood Development is Important. (https://www.crawfordinternational.co.za/10-reasons-why-early-childhood-development-is-important)

Dawn Murdock, et al. (2023): Scaling the Moments That Matter® early childhood development model: how communities' monitoring for change contributes to sustainable impact. Front Public Health.

Jennifer E. Landsford, et al. (2022). Corporal Punishment. Encyclopedia on Early Childhood Development. (chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.child-encyclopedia.com/pdf/expert/social-violence/according-experts/corporal-punishment)

Jill Anderson. (2021). The Effect of Spanking on the Brain. Spanking found to impact children's brain response, leading to lasting consequences (https://www.gse.harvard.edu/ideas/usable-knowledge/21/04/effect-spanking-brain)

Jorge Cuartas (2021): Ending corporal punishment in the early years of childhood: an essential right and need of every young child. Early Childhood Development Agency

Jorge Cuartas (n.d.): The developmental and health consequences of corporal punishment around the globe. Presentation at Harvard Graduate School of Education. (chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://endcorporalpunishment.org/wp-content/uploads/2021/10/Cuartas_end-violence-who-webinar.pdf)

Joseph E. Cordell (2025): How Does Active Father Involvement Impact Child Development? (https://cordellcordell.com/blog/how-does-active-father-involvement-impact-child-development/)

National Academies of Sciences, Engineering, and Medicine. (2016). Parenting Matters: Supporting Parents of Children Ages 0-8. Washington, DC: The National Academies Press.

Rae Fairbanks Mosher (2023): What Are Zambia’S Early Childhood Education Benefits? (https://storychanges.com/what-are-zambia-s-early-childhood-education-benefits.html)

Scott Behson, Nathan Robbins (2016): The Effects of Involved Fatherhood on Families, and How Fathers can be Supported both at the Workplace and in the Home. Paper to be presented at the UNITED NATIONS Department of Economic and Social Affairs (UNDESA) Division for Social Policy and Development’s Expert Group Meeting on Family Policies and the 2030 Sustainable Development Agenda, New York, 12 – 13 May 2016 (chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.un.org/esa/socdev/family/docs/egm16/BehsonRobbins.pdf)

Stephanie Simmons Zuilkowski,et al. (2019): Zambia’s school re-entry policy for adolescent mothers: Examining impacts beyond re-enrollment. International Journal of Educational Development, Volume 64, Pages 1-7.

UNESCO (2024): New UNESCO global report highlights critical role of early childhood care and education. (https://www.unesco.org/en/articles/new-unesco-global-report-highlights-critical-role-early-childhood-care-and-education)

WHO (2021): Corporal punishment and health. (https://www.who.int/news-room/fact-sheets/detail/corporal-punishment-and-health)

Wittkowski A,et al (2017): Self-Report Measures of Parental Self-Efficacy: A Systematic Review of the Current Literature. J Child Fam Stud. 2017;26(11):2960-2978.

World Bank Group (2024): Early Childhood Development. Investing in the early years is one of the smartest things a country can do. Early childhood experiences have a profound impact on brain development – affecting learning, health, behavior and ultimately, lifetime opportunities. (https://www.worldbank.org/en/topic/earlychildhooddevelopment)

Young Academics. Early Learning Center (2023): The Role of Safe and Stimulating Environments in Childcare. (https://www.youngacademics.com.au/the-role-of-safe-and-stimulating-environments-in-childcare/)

Zero to Three (2020): The Daddy Factor: How Fathers Support Development. (https://www.zerotothree.org/resource/the-daddy-factor-how-fathers-support-development/)

Zero to Three (2023): How does nutrition affect the developing brain? (https://www.zerotothree.org/resource/distillation/how-does-nutrition-affect-the-developing-brain/)

11 Appendices

11.1 Primary caregiver FGD qualitative interview guide

Question	Probing
Please tell me about your overall experience participating in the MTM program.	
What did you learn about in the MTM program?	• Probe to ensure there is nothing else ("Is there anything else you remember learning about?") • Which topics or lessons did you enjoy learning about the most? • Were there any topics or messages that you did not enjoy? • Were there any topics you wished you could have learned more about? • How comfortable were you with the language used to deliver the lessons?
What was the role of the ECD promoter in the MTM program? ("What did the ECD Promoter do in the program?")	• What did you learn about from the ECD promoter? • How comfortable did you feel talking with the ECD Promoter? • Is there anything you wish your ECD promoter could have done differently or improved upon?
What was the role of the faith leader in the MTM program? ("What did faith leaders do in the program?")	• What did you learn about from the faith leader? • How comfortable did you feel talking with the faith leader? • Is there anything you wish the faith leader could have done differently or improved upon?
How would you compare the role of your ECD promoter versus faith leader in the MTM program?	• How similar or different were the lessons that you learned from your ECD promoter versus faith leader?

	• How frequently did you interact with your ECD promoter versus faith leader? • Who was more influential in helping you care for your child? • How important is it to have both the ECD promoter and faith leader involved in the program? Or is only one person enough?
Please share with me your personal experience in the caregiver group sessions? What was the normal process of a group session (from beginning to end of a group session)	• How often did you meet and how long was a typical group session? • What did you learn about during group sessions? • Probe: early learning, responsive caregiving, child discipline, child stimulation practices
What did you enjoy/like about the caregiver group sessions?	Please explain in detail WHY you enjoyed/liked it?
Was there anything you didn't like/enjoy about the group sessions?	Please explain in detail WHY you didn't enjoy/like it?
Please share with me your personal experience with the home visits? What was the normal process of a home visit (from beginning to end of a home visit)	• Frequency of home visits? • Length of home visits? • What did you learn about during home visits? • Probe: early learning, responsive caregiving, child discipline, child stimulation practices
What did you enjoy/like about the home visits sessions?	Please explain in detail WHY you enjoyed/liked it?
Was there anything you didn't like/enjoy about the home visits?	Please explain in detail WHY you didn't enjoy/like it?
When you compare the care caregiver group sessions with the home visit, what were the differences?	Probe for • Any differences in how caregivers were learning from these two activities?

	• Any differences in how caregivers benefitted from these two activities?
Would you prefer to have • Caregiver groups session only • Home visits only • Continue with having both activities	Probe for reasons why caregivers prefer • Caregiver groups session only • Home visits only • Continue with having both activities
In total, the MTM program was 18 session that was 18 months (May 2023 to November 2024). How do you feel about the total duration of this program?	• Do you feel the overall program was too long (there were too many sessions; 18 months is too long), too short (there were not enough sessions; 18 months is too short), or the right duration? • What would be a more appropriate program duration or was the current program duration good? • How do you feel about the frequency of the sessions (twice a month)? Were these meetings too frequent? Or do you think the sessions should occur more often?
Please tell me about your experience participating in the Savings with Education (SWE) groups that were introduced as part of the MTM program.	• How did you become involved in the group and how did it function? • Probe: who created the group, who contacted participants, who led the group meetings, how often did you meet for the savings group
What did you discuss during the savings group?	• Probe topics they discussed specifically during the savings groups • Probe for knowledge gains in areas such a. Financial literacy b. Entrepreneurship/business skills (“how to run a business”)

What did you like/enjoy about the saving groups in particular?	Please explain in detail WHY you enjoyed/liked it?
Was there anything you didn't like/enjoy about the saving groups?	Please explain in detail WHY you didn't enjoy/like it?
How, if at all, did you benefit from being a member of a savings group?	Probe in detail for - Financial gains - General impact on livelihoods - Access to agricultural inputs - Household assets
How, if at all, did the savings group impact you or the way you care for your child?	
What could be done to make the savings groups more effective in the future?	
Were the lessons/topics that you discussed similar or different between the CGSL and SWE groups?	• Were there similarities or differences in the people who attended and structure of the sessions? • Which did you enjoy more (CGSL group or SWE group)? Why? • Which was more helpful for you?
How, if at all, has the program changed the way you care for your child?	• Probe: early learning, responsive caregiving, child stimulation, child discipline • Are there any other changes you experienced because of the program?
How, if at all, has the program changed your child?	**Probe for** Child developmental progress - Changes in physical development - Changes in social behaviour - Changes in emotional condition („mood of the child") - Changes in language skills
How, if at all, has the program changed your family or household?	**Probe for**

	- Household dynamics and relationships (between parents and children, between parents only - Livelihoods and economic status of households - Household food security
Have there been any changes to your community because of the program?	**Probe for** - Household dynamics and relationships (between parents and children, between parents only - Livelihoods and economic status of households - Household food security
What specific aspect(s) of the MTM program had the biggest impact in contributing to these changes in you and your child's life?	• Probe about specific topics or lessons that the caregiver feels has made a significant difference in their life or the life of their family or child • Probe: early learning, responsive caregiving • Probe about which delivery agent(s) (ECD Promoter, faith leader) or context (CGSL group, savings group, home visit) played the biggest role in bringing about this change in the caregiver's life
Are there any lessons/actions you learned about in the program but have not been able to do at home or see a difference in your life? Why?	Probe detailed explanation why caregivers have difficulties to putting some of the lessons they learnt in to action
Did a male caregiver in your household (i.e., child's father) participate in the MTM program (ex. Group sessions, home visit, SWE)?	- If yes, who was this male caregiver and to what extent did he participate? - How did this male caregiver react to your participation in the MTM program? (e.g., was he supportive, opposed to, or

	neutral/indifferent to your participation in MTM)? - What were the challenges that make it difficult for a male caregiver from your family to participate in the program? - Have you noticed any changes in the action of the male caregiver because of the MTM program?
Probe: parenting practices, couples' relationship dynamics, family involvement How did the MTM program lead to these changes? If no male caregiver participated in the MTM program: Why did no male caregivers in your household participate in the program? Did you ever try inviting a male caregiver to participate in the program? If yes, how did he respond to your invitation to participate in the program? How did this male caregiver react to your participation in the MTM program? (e.g., was he supportive, opposed to, or neutral/indifferent to your participation in MTM)? What were the challenges that made it difficult for a male caregiver from your family to participate in the program?	
Is there anything that you wish the MTM program could have done differently to engage male caregivers?	
Overall, what did you like the most about the program?	Was there anything that you did you not like as much about the program? What could make the program better in the future for supporting caregivers and improving child development?
Is there anything else you would like to share about your experience participating in the MTM program?	

11.2 ECD promoter FGD and IDI qualitative interview guide

Question	**Probing**
Please tell me about yourself and your overall experience participating in the ZACOP-MTM/ECD program?	
What are your general thoughts on Early Childhood Development?	Have your thoughts changed in any way from before you participated?

	If yes, what thoughts have change and how?
Please tell me what you do as an ECD promoter in the MTM program?	Exhaust probing for all activities Probe for frequency of ALL stated activities
Please tell me about the training you received from ZACOP to carry out your role as an ECD Promoter in the MTM program?	Probe for number of trainings Probe for training content/topics
Please tell me what you enjoyed about the training	**Probe for reasons**
Please tell me what you DID NOT enjoyed about the training	**Probe for reasons**
What additional training would have been helpful for you to carry out your role as an ECD Promoter?	**Probe for reasons**
Besides training, please tell me about the support or supervision you received in your role as an ECD promoter in this program?	**Probe for** a. Type of supervision b. Who provided support/supervision c. Frequency of supervision
Do you feel that any additional support or supervision would have helped you to be more effective in your role as ECD promoter?	**Probe for detailed explanation**
What materials and resources did you receive from the project to carry out your work as an ECD Promoter?	**Probe for all items/resources received** a. Caregiver support and learning group guide b. Home visit guide c. FAMA cards d. Caregiver Actions to Passport Practice (for caregivers) e. Reporting tools f. Any other handouts
Please explain to me in detail how you use these materials during the caregiver group sessions?	
Please explain to me in detail how you use these materials during the home visits?	
What were the main topics/lessons that you counselled caregivers about during the caregiver groups and home visits?	**Probe for** a. Which topics were easy to facilitate and why? b. Which topics were difficult to facilitate and why? c. Regarding difficult topics – ask if ECD promoters have ideas how to make it easier to facilitate the mentioned difficult topics
Please share with me your experience of any differences between home visits and caregiver group sessions?	**Probe for** a. Which was easier to facilitate and why?

	b. ECD promoters perception if caregiver sessions or home visits were more effective for caregiver and why c. What would help make the caregiver group sessions or home visits be more effective for caregivers in the future?
In total, the MTM program was 18 session that was 18 months (July 2023 to February 2025). How do you feel about the total duration of this program?	**Probe for** Do you feel the overall program was…. a. Too long (there were too many sessions; 18 months is too long), b. Too short (there were not enough sessions; 18 months is too short), c. Or the right duration? d. Probe for detailed explanation for the ECD promoters perceptions of the length of the program? e. Try collect as diverse information as possible
Now I would like to talk you about the participation of caregivers. How was the caregivers attendance and participation during home visits?	**Probe for** a. Any challenges regarding caregiver participation, if any, and the reasons? b. Any challenges in caregiver understanding of certain topics, and why? c. If caregivers showed difficulties in understanding certain topics, ask the ECD promoter what strategies the employed to improve the caregivers understanding and if those strategies were effective. Let them explain in detail
How was the caregivers attendance and participation during caregiver group sessions?	**Probe for** a. Any challenges regarding caregiver participation, if any, and the reasons b. Any challenges in caregiver understanding of certain topics, and why? c. If caregivers showed difficulties in understanding certain topics, ask the ECD promoter what strategies the employed to improve the caregivers understanding and if those strategies

	were effective. Let them explain in detail
Overall, how do you think caregivers felt about the program?	**Probe for** a. What aspects of the program do you think caregivers find most beneficial for them? Why? b. What topics did the caregivers not enjoy as much? Why
Have you noticed any changes in caregivers' behaviors or actions because of the program?	**Probe for** a. Positive observations in caregiver behavior change b. Negative observations in caregiver behavior change
Have you noticed any changes in the caregivers' child behavior or actions because of the program?	**Probe for** a. Positive observations in child behavior change b. Negative observations in child behavior change
Have you noticed any changes in families (at general household level)?	**Probe for** a. Positive observations in household dynamics (relationship between parents, between fathers and their children) c. Negative observations in child behavior change (relationship between parents, between fathers and their children)
Which aspect(s) of the program do you believe contributed most to these changes?	**Probe for** a. ECD promoters perception of why they think the mentioned aspects contributed the most to these changes
Did you notice any difficulties caregivers may had in changing certain behaviors or actions?	**Probe for** a. ECD promoters perceptions of why caregivers may faced difficulties in changing certain behavior or actions?
I would now like to talk you about caregiver or child referrals to available social services in your community	
Have you ever referred a caregiver or a child to existing services?	**Probe for** a. Health-related services

	b. Social welfare related services c. Education-related services d. Small-business/agricultural related services (SME loans, CEEC, CDF, FISP, etc)
What were the main issues that caregivers/child in your group faced that necessitated such referrals?	**Probe for** a. Who did you refer them to? b. What was your experience when you had to make that referral? c. What was the outcome of the referral?
Now I want to ask a few questions about male caregivers' engagement in the MTM program.	
Please describe how fathers/male caregivers participated in program.	**Probe for** a. How easy or difficult was it for you to get fathers/male caregivers to participate in the program? b. What made it easy for fathers/male caregivers to participate in the program? c. What made it difficult for fathers/male caregivers to participate in the program?
Did you try to enhance male caregiver/fathers participation in the MTM program?	**Probe for** a. If yes, probe for what strategies ECD promoters employed to enhance fathers´ participation in the program? b. Were these strategies effective? c. If ECD promoter did not attempt to enhance male participation, carefully ask why they didn't do it?
Have you noticed any changes in fathers'/male caregivers' behaviors or actions because of the program?	**Probe for** a. What do you think/suggest could be done in the future to improve male/fathers participation In the program?
I would like to talk to you about the MTM faith leaders in the program	
Please share with me in detail what role MTM faith leaders play in the MTM program	**Probe for** a. Activities MTM faith leaders carried out

	b. Frequency of each activity
How did you interact with MTM faith leaders as part of this program?	**Probe for** a. Did you encounter any challenges when interacting with MTM faith leaders? If yes, what challenges and why?
IF there were any collaboration challenges between ECD promoters and MTM faith leaders, ask the ECD promoter if he/she can propose ideas how the collaboration could be improved in future.	
Now I would like to talk to you about the Savings with Education (SWE) groups.	
Please tell me about the SWE groups. What was the purpose of these groups?	**Probe for** a. How did these groups function? b. How were the groups formed? (members) c. Who led the groups? d. How often did the groups meet?
As ECD promoters, what role did you play in these groups?	**Probe for** a. What was discussed in the groups b. Probe for specific topics and lessons learned
Were the lessons/topics that were discussed similar or different between caregiver groups and SWE?	**Probe for** a. What topics were similar, if any? b. What topics were different, if any?
Please share with me how caregivers participated in the SWE groups?	**Probe for** a. Was their participation different than their participation in the caregiver groups? If yes, why do you their participation was different?
Did you encounter any challenges in the SWE groups? If yes, please mention the encountered challenges.	**Probe for** a. Do you have any suggestions how these challenges can be addressed in the future?
In your opinion, would you say that your participation in the SWE groups has been beneficial to you?	**Probe for** a. If beneficial, please explain how it benefitted you (probe for personal, child, household benefits)

	b. If not beneficial, what could have been the reason?
Now I would like to talk to you about the MTM ECD Committee and what the committee does?	**Probe for** a. How is the committee formed and who are its members? b. How do ECD promoters communicate with the ECD Committee? How does the committee communicate with ECD promoters?
Did you encounter any challenges in collaborating with the ECD committee? If yes, please mention the encountered challenges.	**Probe for** a. Do you have any suggestions how these challenges can be addressed in the future?
In general, and apart from the challenges you mentioned, how could the ECD committee better support the program?	**Probe for** a. Better support for ECD promoters b. Better support for caregivers
We are almost coming to the end of your group discussion. I have a few concluding questions	
Overall, what have you liked the most about this program?	**Probe for detailed reasons**
What have you not liked about the program?	**Probe for detailed reasons**
What do you think can be done to improve the program? Please only suggest improvements we haven't talked about.	**Probe for** a. What additional support or resources could help you as an ECD Promoter to make the greatest impact for caregivers and young children in your community?
Thank you for sharing your insights and experience as an ECD Promoter in the MTM project. Is there anything else you would like to share about this program?	

11.3 ECD Committee qualitative interview guide

Question	**Probe**
1. Please tell me about your role in the ECD steering committee?	1a. When did you start? 1b. What are your responsibilities as member of the ECD steering meeting 1c. What motivates you to be a member of the ECD steering committee? 1d. Apart from your individual role as steering committee member, what do you think is the overall purpose and role the steering committee

	plays in the MTM/ECD program? → What are the key activities you carry out in the ECD program?
2. Please share with me what kind of training/orientation you received	2a. What was the content of the training? 2b. What aspects of the training did you find relevant/helpful? 2c. What aspects of the training were less relevant to you? 2d. Do you feel the training provided could be improved? (facilitator, content, duration) 2e. Did you feel well equipped for your role as ECD steering committee member after the training? → Explain in detail
3. Please explain to me how you collaborate with the ECD promoters?	3a. Frequent meetings with ECD promoters → What is discussed during the meetings? 3b. How do you monitor/supervise ECD promoters? 3c. Any challenges in collaborating with ECD promoters? → Explain in detail 3d. If there any challenges, how could they be addressed?
4. Please explain to me how you collaborate with ZACOP?	4a. Frequent meetings with ZACOP → What is discussed during the meetings? 4b. Any challenges in collaborating with ECD promoters? → Explain in detail 4c. If there any challenges, how could they be addressed?
5. How do you engage with primary caregivers and fathers in the ECD program as steering committee members?	
6. In what way has your work as ECD Leadership Committee led to changes in: a. Primary caregivers' responsive care of infants and toddlers? b. Young children learning in the home? c. Primary Caregivers' well-being? d. Primary Caregivers' livelihoods? e. Fathers' parenting attitudes and practices? f. Families/Caregivers' connections to health care services?	6.a Could you provide examples?
7. How do you as Leadership Committee members ensure that children in your community are protected and are free from any forms of physical abuse?	7a. Can you cite an example of how you as community leaders individually or jointly responded to an incident of child abuse in your community (without giving out names)?

8. When you think about the time before the ECD program and today, what changes have you observed which you perceive as result of the ECD program?	8a. Probe for: - Attitudes & behaviour of children - Knowledge, atttitudes and behaviour of primary caregivers - Knowledge, atttitudes and behaviour of fathers - Changes at household level - Changes at community levels
9. The current set of families have graduated from the project after 18 months of caregiver group/home visits, do you think the ECD Committee can continue the program with ECD Promoters working with new families?	9a. How do you intend to ensure that the ECD program will continue with new primary caregivers and their children without the extensive support from ZACOP? 9b. What minimum support would you expect from ZACOP in order for the ECD program to continue? 9c. How do you see the ECD steering committee, the communities you serve, the caregivers and children three to five years from now?
10. What are the key elements to achieving sustainability, i.e. continuation, of what you have started?	
11. What are some of the lessons you have learned from participating in this ECD program?	
12. Have you put in place any strategies to promote and manage the transition of children to local preschool programs] [to set up community pre-schools - Zambia]?	
13. If you had to decide to make changes to the ECD program in order to improve the program, what changes would you make?	
14. Do you have any questions/comments for me?	Is there anything you would like to add

11.4 Fathers` qualitative interview guide

Question	**Probing**
Please tell me about yourself and your overall experience participating in the ZACOP-MTM/ECD program?	
What are your general thoughts on Early Childhood Development?	Have your thoughts changed in any way from before you participated? If yes, what thoughts have change and why?

What do you see as the mother's role in raising children?	**Probe for** a. What are the common roles undertaken by female siblings? b. How has mother role changed, if at all, based on the teachings from the MTM project activities?
What about the father's role?	**Probe for** a. Do you think it is important for fathers/men to be involved in parenting young children? Why or why not? b. How are men involved in childcare in this community? c. What is their responsibility in parenting? d. Have you observed any changes in the role of fathers in child care in your community? If yes, why do you think have these changes occurred?
Have you changed the way you think about the roles and responsibilities of mothers and fathers?	**Probe for** a. If so, what has changed and why? b. If not, why not?
Do you ever participate in the home visits with (primary caregivers)?	**Probe for:** a. If yes, what is your opinion about these home visits? b. If not, why did you not participate?
What did you talk about with the ECD promoter during the (picture card) visit?	
Did the ECD Promoter use FAMA cards (picture cards) during the home visit?	**Probe for:** a. How are these FAMA cards helpful?
What did you learn about the MTM program during those home visits?	Probe to ensure there is nothing else ("Is there anything else you remember learning about?") Probe: early learning, responsive caregiving
Which topics or lessons did you enjoy learning about the most?	**Probe for:** a. Why did you enjoy those topics the most?
Were there any topics or messages that you did not enjoy?	**Probe for:** a. Why did you not enjoy those topics?
Were there any topics you wished you could have learned more about?	**Probe for:**

	a. Type of topics b. Reasons why fathers think these topics should be included
What role did the ECD promoters play during those home visits?	
How comfortable were you talking with the ECD promoter?	**Probe for:** a. If comfortable, what did the ECD promoter do to create a comfortable situation for you? b. If not comfortable, please explain why!
Is there anything you wish the ECD promoter could have done differently?	**Probe for:** a. Why do you think the ECD promoter could have done it differently?
Did you find it difficult to participate in the home visit sessions when the ECD promoter came to visit your household	Please explain why it was difficult?
What was the role of the faith leaders in the MTM program? ("What did faith leaders do in the program?")	
What did you learn about from the faith leader?	**Probe for:** a. Did you feel the gained knowledge from the faith leaders has been beneficial to you? If so, please explain why b. If not, why not?
How comfortable did you feel talking with the faith leader?	
Is there anything you wish the faith leader could have done differently or improved upon?	
How would you compare the role of your ECD promoter versus faith leader in the MTM program?	**Probe for:** a. How similar or different were the lessons that you learned from your ECD promoter versus faith leader? b. How frequently did you interact with your ECD promoter versus faith leader?
Who was more influential in helping you care for your child?	**Probe for:** Why do you feel/think so?
How important is it to have both the ECD promoter and faith leader involved in the program? Or is only one person enough?	
Could you explain to me in detail if the knowledge you have gained from participating in the ECD program has enabled you in the way you interact with your child/children?	**Probe for:** a. Quantity of time spent with child(ren)

	b. What activities are you carrying out with your child(ren) which you did not carry out prior to your participation in the ECD/MTM program? *Probe if they teach their children names of objects, read with the child, sing, tell the child stories. If not, why?* *Please exhaust the probing to collect all activities fathers engaged in with their children*
Are there any activities you would like to engage in with your child you are still struggling with?	**Probe for** a. What could be the reasons why you are still struggling? b. Ask if they have any ideas how to overcome those struggles?
How do you tell that a child is developing well or not developing well?	**Probe for** a. What challenges do you or other families in your community face in meeting children's needs and helping them develop?
How, if at all, has the program changed your child?	**Probe for** a. Positive AND negative changes in the child´s/children´s attitudes and practices? Please exhaust this probing
How, if at all, has the program changed your family or household?	
Have there been any changes to your community as a whole because of the program?	
What specific aspect(s) of the MTM program had the biggest impact in contributing to these changes in you and your child's life?	**Probe for** a. specific topics or lessons that the caregiver feels has made a significant difference in their life or the life of their family or child b. which delivery agent(s) (ECD Promoter, faith leader) or context (home visit) played the biggest role in bringing about this change in the caregiver's life
Are there any lessons/actions you learned about in the program but have not been able to do at home or see a difference in your life? Why?	**Probe for** a. What makes this action difficult to change in your life?
Please tell me if your participation in the ZACOP MTM/ECD program has influenced the way you interact with your child, if at all?	

Sometimes children do not behave how parents want them to behave. How do you react when your child misbehaves? [Provide examples like eating food without permission, coming home late from playing with their friends, being loud in public, etc.]	**Probe for** a. How do you discipline your child in such situations? b. Did you learn anything about discipline your child in the MTM program? If yes, please provide examples c. Have you tried to use those discipline methods? If yes, how did your child respond to different discipline methods?
Overall, what did you like the most about the program?	
Is there anything else you would like to share about your experience participating in the MTM program?	