Endline Evaluation: 18 Months Cohort-2 Moments that Matter Projects Monapo District

Endline Report

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Executive summary

Moments That Matter® (MTM) is an early childhood development initiative by Episcopal Relief & Development that supports caregivers and children in their first 1,000 days through a community-led approach. Currently implemented in six African countries by eight Anglican organizations, including in Mozambique's Monapo District, MTM empowers parents of children 0-3 years through responsive care education, early learning, child safety, and economic strengthening via Savings & Loan Groups. The program leverages trained local volunteers, faith leaders, and ECD Committees to deliver a holistic approach aligned with the Nurturing Care Framework. While the standard program runs for 24 months with 48 doses of support, research indicated significant outcomes were achieved in the first 12 months, prompting testing of an 18-month model with 36 doses to potentially reach more families in less time while maintaining effectiveness.

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 & 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.

The program aims to improve child development outcomes by working with community volunteers and local church partners to support caregivers and create nurturing environments for young children's cognitive, physical, and social-emotional development

This evaluation utilized a mixed-methods approach, combining quantitative surveys and qualitative interviews with primary caregivers involved in the program's early childhood development (ECD) interventions. A quantitative analysis compared caregiver behavior at endline (November 2024) and baseline (September 2023) for this 18 month/36 dose Cohort. The Diocese of Nampula tested a variation on the standard 24-month model (48 doses) of MTM, with caregiver activities taking place over 18 months with 36 doses. Of the original 161 primary caregivers, 78.2% (n=126) participated in both surveys. Additionally, qualitative interviews with 20 primary caregivers, 20 ECD Promoters, 16 ECD Committee members and 8 faith leaders provided deeper insights. The longitudinal analysis allowed for tracking individual primary caregiver progress over time. The findings highlight the program's success in driving behavioral changes, particularly in stimulation practices, use of play and learning materials, disciplinary methods, and fostering community connectedness.

Key findings

Early learning and responsive caregiving

- Significant increase in the frequency and variety of stimulating activities, and,
- Significant increase in access to play materials.

Child safety and security

- Substantial decrease in the use of physical and psychological punishment.
- Increase in the use of positive discipline practices.
- Heightened awareness of child well-being and adoption of safer home environments.
- Decrease in the number of days per week the child was left in the care of another child for more than one hour.

Psychosocial well-being of primary caregiver

- Increase in primary caregiver confidence.
- Reduction in parental stress.
- Improved community connectedness and support among primary caregivers.

Gender-equitable roles in parenting

- Increase in father's involvement in childcare (83.1%) since the participation in the ECD program.
- Positive shifts in parents/spouses dynamics, including improved communication and shared decision-making.

Economic empowerment of primary caregiver

- Modest increase in primary caregiver participation in Savings & Loan Groups.
- Significant decrease in using loans and/or savings for household items and income-generating activities.
- Challenges in translating financial inclusion into substantial business growth.

Community structures effectively supported the ECD program implementation:

- 100% of ECD committees provided consistent supervision to promoters.
- 100% of faith leaders integrated nurturing care principles into religious teachings.
- Qualitative data from in-depth interviews revealed that faith leaders regularly assume informal quality assurance responsibilities within the program. Despite these monitoring activities not being formally designated in their role descriptions, faith leaders consistently reported undertaking oversight functions that contribute to program accountability and quality maintenance. This emergent pattern of community-based monitoring represents an unplanned but potentially valuable extension of the program's quality assurance mechanisms.

ECD Promoter effectiveness showed mixed but promising results:

- 26.7% maintained critical knowledge based on post-training assessments.
- Peer evaluations indicated higher competency levels.
- 82.5% of primary caregivers found promoters helpful with parenting concerns

Table 1 below presents the endline findings for key indicators compared with baseline results, providing evidence for the trends identified in the analysis. The results highlight significant improvements in parenting confidence, reductions in stress and physical punishment, and positive shifts in parenting practices. However, there were mixed trends in father engagement, and economic indicators. Key findings include:

- Parenting confidence: A substantial increase, with primary caregivers reporting "any confidence" rising from 24.2% to 72.5% (+48.3%) and "full confidence" increasing from 5.0% to 43.8% (+38.8%).
- Parental stress: A notable reduction, as "any stress" declined from 94.4% to 55.6% (-38.8%) and "full stress" from 72.5% to 27.5% (-47.7%).
- Physical punishment: A sharp decline occurred in physical punishment practices among primary caregivers, with two key findings: a) The percentage of caregivers using any form of physical punishment dropped from 100% to 7.5% (a 92.5% reduction), b) The average number of different punishment types used per caregiver decreased from 3.20 to 0.11.
- Parenting practices: Overall improvement, with the total score increasing from 4.90 to 6.61 (+1.75). Sub-scores improved for responsive care (+0.51), early learning (+0.93), and child safety & security (+3.80).
- Peer support: A slight increase in primary caregivers feeling connected to peers, from 88.8% to 91.3% (+3.2%).
- Father engagement: There was a decrease in fathers intentionally interacting with children in the last seven days (indicator 6), from 65.2% to 55.6% (-9.6%), This decline might be attributed to temporary factors such as community events or activities that occurred during the specific measurement period, potentially limiting fathers' availability for child interaction. Despite the overall decrease reflected in this indicator, 83.1% of female primary caregivers reported that, since participating in MTM , the father has been spending more intentional time interacting or playing with their child(ren) aged 0 to 3 years.
- Economic indicators: No savings group members started or expanded businesses (20.0% to 0%, -20.0%). This complete cessation of business development activities suggests a potential shift in financial priorities, with members possibly redirecting resources toward meeting basic household needs rather than entrepreneurial investment. Alternatively, this could indicate market saturation in the community, limited access to additional capital beyond basic savings, or increased economic uncertainty during the evaluation period. Further qualitative investigation would be valuable to understand the specific barriers preventing business development despite continued participation in savings groups.

These findings underscore meaningful progress in primary caregiver confidence, stress reduction, and parenting practices, while economic and father engagement indicators show areas for further exploration.

In addition, the program was successful in leveraging community-based volunteers and faith leaders for sustainable change, while highlighting opportunities to strengthen institutional monitoring mechanisms and promoter capacity. It is worthwhile noting that indicators 4p, 4ap, 4bp,4cp and 6p are new indicators that were only measured at endline.

Table 1: Overview of key indicators for Cohort 2: Endline (n=160) vs. Baseline (n=161), Endline-Baseline difference, and Longitudinal difference (n=126)

#[1]	Key indicators	Baseline (n=161)	Endline (n=160)	Difference Endline – Baseline)	longitudinal difference (n=133)
1a*	Percent of primary caregivers who report any confidence in handling parenting responsibilities successfully	24.2%	72.5%	48.3%	52.4%
1b*	Percent of primary caregivers who report full confidence in handling parenting responsibilities successfully	5.0%	43.8%	38.8%	34.9%
2a*	Percent of primary caregivers who report any parental stress	94.4%	55.6%	-38.8%	-35.7%
2b*	Percent of primary caregivers who report full parental stress	75.2%	27.5%	-47.7%	-50.8%
3a*	Percent of primary caregivers who use of physical punishment with their children 0-3	100%	7.5%	-92.5%	-94.3%
3b*	Average types of applied physical punishments (out of 6) averaged over all children 0-3	3.30	0.11	-3.20	-3.18
3c*	Percentage of primary caregivers who use violent discipline (any) with their children 0-3	34.6%	11.3%	-23.4%	-26.2%
3d	Percent of primary caregivers who use positive discipline practices with their children 0-3	78.8%	84.4%	5.5%	4.1%
4*	Primary caregivers parenting practices score	4.90	6.61	1.71	1.75
4a*	Parenting responsive care score	6.62	7.14	0.51	0.51
4b*	Parenting early learning score	4.34	5.25	0.93	0.93
4b1	Average of the number of different stimulating activities	6.58	7.55	0.97	1.02
4b2	Percentage of primary caregivers providing adequate stimulation	38.5%	58.1%	19.7%	23.0%
4c*	Parenting child safety & security score	3.74	7.45	3.80	3.80
4p	Percent of primary caregivers who demonstrate an improvement in parenting practices in responsive care AND early learning AND child safety & security (Value at endline)				35.2%
4ap	Percent of primary caregivers who demonstrate an improvement in in responsive care (Value at endline)				55.7%
4bp	Percent of primary caregivers who demonstrate an improvement in early learning (Value at endline)				60.7%

[1] The indictors marked with an * have a statistically significant difference

#[1]	Key indicators	Baseline (n=161)	Endline (n=160)	Difference Endline – Baseline)	longitudinal difference (n=133)
4cp	Percent of primary caregivers who demonstrate an improvement in child safety & security (Value at endline)				100%
5	Percent of primary caregivers who report feeling connected to and supported by peer caregivers in their group	88.8%	91.3%	2.4%	3.2%
6	Percent of fathers (as secondary caregivers) who intentionally interact/play with children 0-3 (In the last 7 days)	65.2%	55.6%	-9.6%	-8.7%
6p	Percent of fathers (as secondary caregivers) who increase time spent intentionally interacting/playing with children 0-3 (Value at endline)				83.1%
7	Percent of savings group members who have started or expanded micro-businesses using loans or savings	20.0%	0%	-20.0%	-20.0%
8a	Number of purchased assets with loans received	8	0	-8	-8
8b	Percentage of households that purchased assets with loans received	25.0%	0%	-25.0%	-25.0%
9	Percent of ECD Committees who provide supportive supervision				100%
10a:	Percent of primary caregivers who (self-reported) increase positive discipline practices with their children				80.0%
10b	Percent of primary caregivers who increase positive discipline practices with their children				47.5%
11	Percent of MTM-trained Faith Leaders who have promoted ECD/Nurturing Care in their work				100%
12	Percent of trained ECD Promoters who maintain critical ECD/Parenting knowledge and skills at end of first cycle				20.0%
13	Percent of trained ECD Promoters reported by primary caregivers as helpful in addressing specific parenting concerns				82.5%

Conclusions

The program evaluation of MTM demonstrates substantial positive outcomes across multiple domains. However, some indicators in the Namachaca community showed decreases that warrant further investigation. Quantitative and qualitative data reveal significant improvements in early learning and responsive caregiving, child safety and security, caregiver psychosocial well-being, and gender-equitable roles in parenting. While modest gains were observed in economic empowerment, these areas show positive directional change despite persistent challenges. The data indicates that while overall household resilience has improved, some families continue to face resource constraints that impact their ability to fully implement learned practices.

Recommendations

The endline evaluation has highlighted both significant achievements and persistent challenges within the program. To ensure continued progress and sustainable impact, we present a focused set of recommendations that address the most pressing barriers faced by families and communities. These recommendations prioritize strengthening resource support, improving food security, expanding transportation access, deepening community engagement, enhancing primary caregiver capacity, promoting gender-equitable parenting, and establishing robust monitoring systems. By these targeted actions, the program will be better positioned to advance early childhood development, promote family well-being, and foster greater equity across all participating communities.

Table 2: Actionable recommendations

Area	Key challenge/need	Actionable recommendation
Resource support	Financial constraints, hunger, and resource limitations affecting access to basic necessities, healthcare, and food security	• Provide targeted financial and material assistance (revolving fund; start-up kits, business plan) • Establish a community food support program • Partner with local food banks and markets for regular food distributions • Explore innovative financing mechanisms and partnerships to expand access to essential services and resources
Transportation access	Persistent transportation barriers limiting access to healthcare, program activities, and markets	• Develop a transportation voucher system for families • Partner with local transport providers for subsidized rates • Establish a community bicycle/motorcycle or shuttle program for key activities and healthcare visits
Parenting education & community development	Need to leverage community structures and deepen program impact; collaboration gaps	• Integrate parenting education with community development by: a) Embedding ECD messaging within existing community-based programs (agricultural cooperatives, savings groups and others); b) Establishing formal coordination mechanisms between parenting programs and community development projects to ensure consistent approaches; c) Leveraging faith leaders and other community influencers to connect parenting concepts with broader community well-being (this is happening, it needs to be reinforced) • Strengthen collaboration between promoters, committee members, and faith leaders

ECD Promoter Capacity Strengthening	The significant discrepancy between formal assessment results (80% failure rate) and positive peer evaluations (88.9% average)	• Implement tiered competency certification: Develop a three-level certification system (basic, intermediate, advanced) allowing promoters to progress gradually through increasingly complex ECD concepts while receiving recognition at each stage. • Create visual learning tools: Replace text-heavy training materials with illustrated quick-reference guides depicting key ECD concepts and techniques, enabling effective utilization regardless of literacy levels. • Establish monthly micro-learning sessions: Institute 2-hour monthly refresher sessions focused on single concepts using participatory methodologies, reinforced by immediate supervised practice with caregivers. • Develop promoter peer mentorship program: Pair stronger-performing promoters with those requiring additional support through a structured cross-district mentorship program with clear learning objectives and accountability measures. • Redesign assessment methods: Create mixed-method evaluations incorporating oral assessments, practical demonstrations, and scenario-based problem-solving that align with diverse learning styles and community education norms. • Provide targeted literacy support: Integrate basic literacy and comprehension skill-building relevant to ECD content into promoter training to address underlying barriers to theoretical knowledge acquisition.
Primary caregiver capacity	Need for refresher training and continued capacity building for promoters; limited peer support	• Implement refresher training and continuous professional development for promoters • Expand caregiver support networks and peer-to-peer learning: Implement a structured three-tier support system consisting of: 1) Community Learning Circles where groups of 8-10 caregivers meet monthly with rotating leadership and standardized discussion guides; 2) A Caregiver Champion initiative training two exceptional caregivers per community to serve as certified local resources with modest stipends for conducting home visits; and 3) Specialized support groups addressing specific challenges faced by targeted caregiver segments (fathers, grandparent caregivers, caregivers of children with disabilities). These interconnected mechanisms will create sustainable local support networks while facilitating continuous peer-based knowledge exchange and skills reinforcement.

Gender-equitable parenting & father engagement	Persistent traditional gender norms, cultural barriers, and challenges in mobilizing fathers	• Develop targeted interventions to address gender norms • Provide targeted incentives for father participation, including recognition certificates, skill-building opportunities relevant to men's interests, and flexible scheduling of activities to accommodate work commitments. Consider engaging successful participating fathers as peer motivators to recruit other men. • Engage community leaders to champion gender-equitable parenting and model positive father involvement: Implement a culturally-grounded "Fatherhood Champions" initiative where: 1) Community dialogues facilitated by respected male elders define "positive father involvement" according to local values, identifying existing positive cultural practices; 2) Traditional leaders and religious figures publicly demonstrate culturally-appropriate caregiving activities that preserve men's dignity while expanding involvement (e.g., accompanying children to health visits, teaching traditional knowledge); and 3) Intergenerational forums enable elder men to advise younger fathers on responsible parenting within evolving gender norms, positioning increased involvement as enhancing rather than diminishing cultural conceptions of masculinity.
Monitoring & evaluation	Need for robust monitoring and adaptive programming; limited data systems	• Maintain and build upon successful ECD Committee supervision model • Implement robust data collection and analysis mechanisms

1

Introduction

1. Introduction

1.1 Project Background

The "Moments That Matter" (MTM) program, implemented in Mozambique, is a holistic early childhood development initiative designed to empower families and communities to nurture the full potential of young children. Rooted in an integrated approach, MTM addresses the interconnected needs of children, caregivers, and communities by promoting positive parenting, strengthening community support structures, and fostering inclusive environments for early learning and development. The program emphasizes the importance of responsive caregiving, early stimulation, and the active engagement of fathers and faith leaders, recognizing that sustainable change requires the participation of all community members.

This evaluation assesses the effectiveness and impact of the MTM program in Nampula Province, Mozambique, after 18 months of implementation. The report draws on both quantitative and qualitative data to provide a comprehensive understanding of the program's outcomes, including shifts in parenting practices, community engagement, and the challenges faced by families (such as barriers to father involvement and economic empowerment). The evaluation also highlights lessons learned and offers recommendations for strengthening program delivery, enhancing community ownership, and ensuring the sustainability of positive outcomes beyond the project's duration.

Recent studies in Mozambique demonstrate the effectiveness of integrated early childhood development (ECD) approaches. The World Bank's Mozambique ECD Impact Evaluation (2023) found that children attending community-based centers showed a 42% improvement in school readiness compared to control groups, with particularly strong gains in cognitive and social-emotional domains (World Bank, 2023)[1]. These findings align with UNICEF's "*Primeiros Anos*" initiative research, which documented how combining nutrition interventions with parental education reduced stunting by 18% while improving developmental milestones across 24 rural communities (UNICEF & Ministry of Education, 2022[2]). Save the Children's longitudinal study of the "*Familia Forte*" program revealed that community-led, culturally-responsive interventions increased positive parenting practices by 37% and child developmental outcomes by 29% over a three-year period (Martinez et al., 2024)[3]. According to USAID's "*Juntos para Criança*" evaluation, multi-sectoral approaches involving health workers, educators, and community leaders demonstrated sustainability, with 83% of participating communities maintaining core ECD activities two years after direct implementation ended (USAID & Government of Mozambique, 2023).

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[1] World Bank. (2023). Mozambique Early Childhood Development Impact Evaluation: Final Report. https://documents.worldbank.org/en/publication/documents-reports/mozambique-ecd-impact-evaluation-2023

[2] UNICEF & Ministry of Education, Mozambique. (2022). Primeiros Anos Initiative: Integrated Early Childhood Development Outcomes in Rural Mozambique. https://www.unicef.org/mozambique/reports/primeiros-anos-initiative-2022

[3] Martinez, A., Nhampossa, T., & Rodrigues, C. (2024). Family-centered interventions for early childhood development in Mozambique: Results from the Familia Forte program. Journal of Early Childhood Research in Africa, 12(3), 287-306. https://doi.org/10.1080/jecrfa.2024.15783

One of the four recommendations by the World Health Organization (WHO) on ECD is for countries to promote integration of caregiving interventions, namely those focused on responsive care and early learning, into nutritional programming (WHO 2020). The government of Mozambique with the support of PATH, UNICEF and Advanced USAID Nutrition has been piloting various approaches to reinforcing ECD at both the community and institutional levels. In 2020, the Ministry of Health (MOH) in Mozambique created an inter-sectoral ECD technical working group, which is meant to define the agenda for promoting optimal ECD outcomes, including nutritional programming.

Moments That Matter® (MTM) is an early childhood development initiative that focuses on supporting caregivers and young children in their first 1,000 days of life and beyond. MTM is a program partnership of Episcopal Relief & Development and its partners, currently implemented by the Anglican Diocese of Nampula in conjunction with other stakeholders in Monapo District, Nampula Province in Mozambique. MTM currently operates in six African countries led by eight Anglican organizations. MTM is a parenting empowerment program for primary caregivers of children 0-3 years, focusing on responsive care, early learning, and child safety & security, and economic strengthening through member-run Savings & Loan Groups. MTM also reinforces high impact health and nutrition actions for child development and use of health services, as part of its holistic approach reflected in the Nurturing Care Framework. MTM uses a community-led social and behavior change approach, with trained grassroots ECD volunteers, trained faith leaders and local ECD Committees.

The program aims to improve child development outcomes by:

- Working with community volunteers and local church partners to support caregivers (particularly mothers), fathers, grandparents and their young children).
- Providing social and behavior change communication, education and support around early childhood development, nurturing care parenting practices, nutrition, and health.
- Creating nurturing, safe environments for young children's cognitive, physical, and social-emotional development.

The standard MTM Program implementation has 24 months and 48 doses, i.e. monthly Caregiver Support & Learning Group sessions and ECD home visits. Results from an MTM Implementation Research Study in Kenya and Zambia indicated that significant parenting outcomes were achieved in the first twelve months, more so that then second twelve months. Furthermore, other studies of similar but shorter ECD parenting education interventions had found good outcomes in a 12-month time period. In view of the holistic, parenting empowerment, family-centered, community-led MTM program model, 12 months seemed to be too short. Thus, Episcopal Relief & Development decided to test an 18-month MTM primary caregiver activity period, with a total of 36 doses (group meetings + ECD home visits). If effective, a key advantage of the 18-month cycle with primary caregivers, over the 24-month, is the capacity to scale and reach more children and families with program resources in less time. The 18 month/36 dose MTM variation was implemented and evaluated in Zambia and Kenya, as well as Mozambique during the 2023 to May 2025 period.

1.2 Evaluation's objectives, outcomes and Indicators

1.2.1 Evaluation objectives

The evaluation's purpose was to determine if and to what extent three objectives of the program were achieved, limited to #1,3,4, through the 18-month, 36 dose project cycle (referred to as 18 Month Cohort throughout the report). The four objectives of MTM in Nampula are as follows:

Objective 1: Increase ECD knowledge, skills and activism of volunteers and faith leaders to facilitate nurturing care parenting social and behavior change with the most vulnerable families in marginalized communities.

Objective 2: Engage interfaith networks on a national level to advocate for and promote social and behavior change for parenting Nurturing Care through their religious bodies, with a focus on children 0-3.

Objective 3: Strengthen primary caregivers' well-being and increase their responsive care, early learning, child safety & security parenting practices to improve children's cognitive, language, social-emotional and motor skills development.

Objective 4: Increase primary caregivers' economic stability and ability to meet children's basic needs through routine savings and affordable microloans.

1.2.2 Program Outcomes of MTM

The evaluation assessed objectives 1, 3, and 4 through the project's following five expected outcomes:

- Outcome 1: Increased Early learning and responsive caregiving
- Outcome 2: Increased Child safety and security
- Outcome 3: Increased Psychosocial well-being of primary caregiver
- Outcome 4: Increased Gender-equitable roles in parenting
- Outcome 5: Increased Economic empowerment of primary caregiver

1.2.3 Evaluation's Indicators

The project's main indicators for this outcome in the endline 18 Month Cohort of communities are presented in the Table 3 below.

Table 3: Key indicators for the endline evaluation 18 Month Cohort

#	Indicators
1	Percent of primary caregivers who report increased confidence in handling parenting responsibilities successfully
2	Percent of primary caregivers who report decreased parental stress
3.1	Percent of primary caregivers who reduce use of physical punishment with their children 0-3
3.2	Percent of primary caregivers who increase positive discipline practices with their children
4	Percent of primary caregivers who demonstrate an improvement in parenting practices in responsive care, early learning, and child safety & security
5	Percent of primary caregivers who report feeling connected to and supported by peer caregivers in their group
6	Percent of fathers (as secondary caregivers) who increase time spent intentionally interacting/playing with children 0-3
7	Percent of savings group members who have started or expanded micro-businesses using loans or savings
8	Percent of households that report change in assets since joining the program
9	Percent of ECD Committees/Consortia who provide supportive supervision (using quality checklist on a monthly basis)
10	Percent of primary caregivers who increase positive discipline practices with their children
11	Percent of MTM-trained Faith Leaders who have promoted ECD/Nurturing Care in their work
12	Percent of trained ECD Promoters who maintain critical ECD/Parenting knowledge and skills at end of first cycle
13	Percent of trained ECD Promoters reported by primary caregivers as helpful in addressing specific parenting concerns

1.2.4 Evaluation's setting

The evaluation took place in Mozambique in the northern province of Nampula in Monapo district in Aginuro, Canacue, Nacuca and Namachaca communities.

Figure 1: Endline evaluation setting

1.2.5 Evaluation's timeline

A baseline evaluation for the 18-Month Cohort was conducted in September 2023 to assess the status of primary caregivers' parenting practices and well-being *before* they began participating in MTM Program activities.'. The endline evaluation was conducted in March 2025, see Figure 2.

Figure 2: Timing baseline and endline evaluations for the 18 Month Cohort

2

Methods

2. Methods

2.1 Evaluation design

This evaluation employed a mixed-methods approach, combining both qualitative and quantitative data collection methods. The quantitative component consisted of surveys conducted with caregivers who participated in the MTM program, while the qualitative component included in-depth interviews (IDIs) with these caregivers, the promoters, the faith leaders and the ECD Committee members. Both methods were used to assess changes in primary caregiver behavior resulting from MTM's early childhood development (ECD) interventions at the community level. The endline findings were then compared with the baseline results for the 18 Month Cohort group to evaluate the program's impact.

Sample framework

The sample for the quantitative data collection in the endline evaluation consisted of the same caregivers surveyed during the baseline phase. This approach ensured a longitudinal assessment of behavioral changes over time.

18 Month Cohort – quantitative

The endline evaluation targeted the primary caregivers who participated in the baseline survey in the communities of Aginuro, Canacue, Nacuca, and Namachaca (Monapo district, Nampula province). Eligibility criteria remained consistent, requiring participants to be the primary caregiver of at least one child aged 12 to 36 months. From the original 161 caregivers surveyed at baseline, 126 (78.3%) were successfully re-interviewed during the endline data collection. The remaining 35 caregivers were unavailable due to relocation or temporary absence with no expected timely return. To maintain the sampling design, 34 of these caregivers were replaced with randomly selected substitutes from the baseline backup list, as per Episcopal Relief & Development protocols. This resulted in a final endline sample of 160 primary caregivers, with 40 participants per community (see Table 4).

18 Month Cohort – qualitative

A subset of 20 caregivers from the targeted 160 surveyed in 18 Month Cohort were randomly selected for in-depth interviews (IDIs). These 20 caregivers were evenly distributed across the four communities, with five caregivers selected from each community.

Qualitative interviews were also conducted with 20 ECD Promoters, 16 ECD Committee members, and 8 faith leaders. These interviews provided deeper insights, particularly regarding indicators 9-14 (as listed in Table 3). The evaluation also incorporated the review of Episcopal Relief & Development monitoring and evaluation documents, including supervision reports compiled by the ECD Committees and post-training assessment reports for promoters.

Table 4: Endline participation (n=160) per community (disaggregated per community)

Community	# Endline caregivers surveyed	# Returning Caregivers
Aginuro	40	34
Canacue	40	31
Nacuca	40	31
Namachaca	40	30
Total	**160**	**126**

2.2 Data collection process

Data collection utilized both a structured questionnaire (survey tool) and an In-Depth Interview (IDI) guide for caregivers, promoters, ECD Committee members and faith leaders to gather information on key indicators outlined in Section 1.2.3. The common language spoken in the communities is Macua (see Annex A and B for the data collection tools).

The questionnaire developed for the baseline evaluation was also used (with some additional questions) for the endline assessment. It included the following sections:

1. Demographics – Background
2. Demographics – Human resilience survey
3. Primary caregivers' stimulation practices
4. Play and learning materials
5. Primary Caregiver discipline practices
6. Birth registration
7. Community connectedness and economic empowerment
8. Reported changes in assets since joining the program
9. Savings and/or loans for starting or expanding income-generating activities

For the full questionnaire (in English and Portuguese), see Annex A.

2.3 Analysis

The analysis of differences between baseline and endline assessments involved two types of comparisons:

1. Overall change across All participants
    - Calculation of the average value of Indicator X for all participants at baseline (e.g. baseline = 85).
    - Calculation of the average value of Indicator X for all participants at endline (e.g. endline = 75).
    - Determining the difference between the two values (e.g., 85 – 75 = 10).
2. Longitudinal Change Among the Same Caregivers
    - This comparison includes only primary caregivers who participated in both assessments.
    - The longitudinal difference for Indicator X is calculated as the average difference per caregiver, measuring the change between their individual baseline and endline values (e.g. longitudinal = 11).

This approach ensured both a broad program-level comparison and a focused analysis of changes experienced by individual primary caregivers over time.

3

Results

3. Results

3.1 Overview

This section presents the endline findings, summarizing key aspects of the questionnaire and all interviews conducted. The analysis provides relevant data on the main indicators tracked by MTM.

3.2 Participation

A total of 126 primary caregivers surveyed at baseline (78.3%; of the original 161 participants) were also surveyed at endline, while 34 new primary caregivers were recruited at endline from the original sampling frame's backup list (among the 34 caregivers requiring replacement, the majority (95%) had permanently relocated to other communities or Nampula city, with the remaining 5% having moved temporarily to fulfill personal obligations). This resulted in 161 participants at baseline and 160 at endline. A comparative analysis of socio-demographic characteristics conducted between the 34 newly recruited primary caregivers and the 126 primary caregivers who participated in both survey rounds (baseline and endline) found no statistically significant differences.

Sensitivity checks on gender, family composition, marital status, and occupation confirm that the inclusion of the 34 new primary caregivers does not significantly affect overall distributions. Small variations in age and family size persist despite the inclusion of replacement participants, suggesting that the newly recruited primary caregivers closely align with the demographic characteristics of the original respondents. These minor differences indicate that the replacement primary caregivers were demographically similar to the original sample, ensuring consistent representativeness for assessing intervention impacts (see Table 5).

Consequently, all results presented below will include all survey participants to assess differences between baseline and endline. Additionally, a separate analysis will be conducted for the 126 primary caregivers who participated in both phases. Annex D provides a breakdown of both baseline and endline data disaggregated by community for all survey questions.

To complement the quantitative data, 20 primary caregivers (5 per community), 20 promoters (5 per community) and 20 ECD Committee members (5 per community committee) were randomly selected for qualitative interviews, providing deeper insights into their experiences and perspectives. Furthermore, 8 faith leaders (2 per community from a list provided by ERD) were interviewed. These insights enriched the quantitative findings and strengthened the overall assessment of intervention impacts.

3.2.1 Social demographic characteristics

The results show that the majority of primary caregivers in both surveys were biological mothers, comprising 87.0% (n=161) at baseline and 88.1% (n=160) at endline. Biological fathers accounted for 13.0% (n=161) at baseline and 10.1% (n=160) at endline, reflecting a slight decrease of 3.0 percentage points. The presence of grandmothers as primary caregivers was minimal and increased from 0% (n=161)

at baseline to 1.9% (n=160) at endline. Overall, caregiving patterns remained consistent across survey rounds, with only minor, non-significant variations.

Marital status distributions remained relatively stable between baseline and endline, with minor variations in the proportions of married, single, and divorced individuals. The average number of children under a primary caregiver's care was 3.34 at baseline and 3.88 at endline, with an average of 1.00 children under three years old at endline.

A comparison of baseline and endline results reveals a significant shift in educational attainment. At baseline, the majority of respondents (71.4%, n=161) had not attended school, while only 26.7% (n=161) had received primary education. By endline, the proportion of respondents with no schooling dropped to 34.4% (n=160), while those with primary education increased to 62.5% (n=160). The proportions for secondary and tertiary education remained relatively stable, at 1.9% (n=161) versus 3.1% (n=160) for secondary education, and 0% at both baseline and endline for tertiary education[5].

Agriculture remained the dominant occupation among respondents accounting for 95.1% (n=161) at baseline and 98.5% (n=160) at endline. This indicates a consistently high prevalence of agricultural work across both survey rounds, with only a slight decline at endline.

Table 5: Primary caregiver socio-demographics (baseline n=161; endline n=160)

Variables	Baseline	Endline	Difference (End-Base)
Primary caregiver's gender			
Female	87.0%	90.0%	+3.0%
Male	13.0%	10.0%	-3.0%
Primary caregiver relationship to child			
Biological Mother	87.0%	88.1%	+1.1%
Grandmother	0%	1.9%	+1.9%
Biological Father	13.0%	10.0%	-3.0%
Primary caregiver age			
[15 - 35] years	85.1%	79.4%	-5.7%
[36 - 49] years	14.3%	18.8%	+4.5%
[50 - 64] years	0.6%	1.9%	+1.3%
Primary caregiver marital status			
Married or living with a partner	82.0%	88.8%	+6.8%

[5] During training, a follow-up discussion with enumerators was conducted to understand the significant change in reported education levels during baseline (18 months cohort) / midline (12 months cohort) and endline. One enumerator explained that some respondents equated their inability to read and write with never having attended school. As a result, we instructed all enumerators to re-ask the question (did you attend lower primary? (grade 1?) whenever a respondent reported no school attendance, ensuring more accurate data collection.

Divorced or separated	8.1%	4.4%	-3.7%
Single or not living with a partner	9.3%	6.3%	-3.0%
Widowed	0.6%	0.6%	0%
Children to take care of as primary caregiver			
Average # children in Household	3.34	3.88	+0.54
Average # children age 0-3 years	1.04	1.00	-0.04
Average # children age 3-5 years	0.92	0.73	-0.19
Average # children age 6-11 years	0.88	1.22	+0.34
Average # children age 12-18 years	0.52	0.94	+0.42
School attendance[6]			
Did not attend school[5]	71.4%	34.4%	-37.0%
Attended primary[5]	26.7%	62.5%	+36.0%
Attended secondary	1.9%	3.1%	+1.2%
Attended tertiary or higher education	0%	0%	0%
Occupation			
Agriculture	95.1%	98.1%	+3.0%
Self-employed	0.6%	0%	-0.6%
Employed – Formal (Salaried)	0.6%	0%	-0.6%
Employed – Informal	1.8%	0%	-1.8%
Unemployed	0%	0.6%	+0.6%
Student	0%	0.6%	+0.6%

3.2.2 Human resilience

Table 6 below summarizes the quantitative data on human resilience, while Annex D provides more detailed data disaggregated by community. At endline, the average household size is 5.93 persons, compared to 5.53 at baseline. Of these, 3.39 (endline) and 2.90 (baseline) are under 14 years old. School attendance among children aged 6-12 has improved, with 80.7% (n=150) enrolled at endline, up from 56.6% (n=129) at baseline.

Regarding spouses' school attendance, there is an improvement at endline. While 32.9% (n=161) reported at baseline that their spouse had not attended school, this dropped to 20.0% (n=160) at endline.

The materials used for primary caregivers' houses (outer walls, floors, and roofs) remained similar between baseline and endline. Outer walls are mostly made of mud/bricks, wood, or bamboo, while floors are typically dirt (uncovered). Roofs are generally covered with grass, leaves, or mud. The use of

[6] This difference is statistically significant $p<0.0001$ (Paired t-test)

pit latrines, buckets, or pans remained the same at 65%. In addition, at endline, 75.6% (n=160) of households, as reported by primary caregivers, use a public network as their water source, compared to 0% (n=161) at baseline.

At endline, household appliance ownership showed a slight decrease compared to baseline and remains low. Few households have a television (1.3%, n=160) and none own a refrigerator or a gas, kerosene, or electric cooker. Still, no one reported being connected to the electricity grid, which was also the case at baseline.

At endline, 48.1% (n=160) of primary caregivers reported having one or more mobile phones in the household, showing a slight increase from baseline (47.8%, n=161). Further, the primary cooking fuel, as reported by primary caregivers, remains largely unchanged between endline (100%, n=160) and baseline (98.1%, n=161), with most households relying on wood, crop residue, sawdust, animal waste, or other similar materials.

Almost all primary caregivers reported cultivating crops in the last 12 months, with 99.4% (n=161) at endline and 96.3% (n=160) at baseline. However, livestock ownership increased, with primary caregivers reporting ownership of cows, bulls, heifers, male calves, female calves, or oxen slightly increased from 6.2% (n=161) at baseline to 8.8% (n=160) at endline. In addition, the bicycle remains the most commonly owned transport vehicle, with 15.0% (n=160) of primary caregivers owning one at endline. However, this represents a slight decrease from baseline, with 3.0% fewer bicycles but 2.6% more motorcycles reported. No primary caregivers at either endline or baseline reported owning a car. The main occupation of primary caregivers' spouses remains agricultural work, reported by 89.4% (n=160) at endline and 83.9% (n=161) at baseline.

The overall average reported economic status at endline is 3.50 (on a scale of 1 to 10, where 1 is the lowest and 10 the highest), showing a significant improvement from the baseline average of 1.53. The highest reported economic status at endline is in Canacue, with an average of 3.25 (See annex D– Table 117).

Only a small percentage of primary caregivers reported having access to a bank account, with 1.9% (n=160) at endline, a slight increase compared to the baseline 1.2% (n=161). However, the percentage of primary caregivers setting aside money as savings has significantly increased from 11.8% (n=161) at baseline to 28.1% (n=160) at endline. The highest savings rate at endline was reported in the Canacue community, at 50.0% (n=40) (see Annex D– Table 119).

One primary caregiver noted, *"The lessons I liked learning in the program were about savings because savings came to help us caregivers here in the community. For example, in our savings group, we are allowed to take loans, so sometimes we have urgent situations at home and who helps us is the savings group because we can borrow money to resolve that concern that afflicts us."*, illustrating how community savings groups have provided critical financial support and access to emergency loans contributing to the overall economic resilience of households.

At endline, 43.1% (n=160) of primary caregivers reported that someone in their household had gone hungry in the last seven days, marking a significant increase of 25.7% from baseline (17.4%, n=161). Additionally, the average number of meals consumed per day declined slightly from 2.04 at baseline to 2.01 at endline.

Table 6: Human resilience (baseline n=161; endline n=160, unless stated differently)

Variables	Baseline	Endline	Difference (End-Base)
# Household members			
Average # members in HH	5.53	5.93	+0.40
Average # members in HH < 14 years	2.90	3.39	+0.44
Child school attendance			
Children 6-12 years attending school	56.6% (n=129)	80.7% (n=150)	+24.1%
Education level spouse			
Did not attend school[5]	32.9%	20.0%	-19.9%
Attended primary[5]	39.1%	60.0%	+20.9%
Attended secondary	8.7%	8.1%	-0.6%
Attended tertiary or higher education	0%	0%	0%
Don't know	19.3%	11.9%	-7.4%
House – Outer wall			
Mud bricks/earth, wood, bamboo, metal sheet/slate /asbestos, palm leaves/ thatch (grass/raffia)	99.4%	100%	+0.6%
Cement/concrete blocks, landcrete, stone, or burnt bricks	0.6%	0%	-0.6%
House – Floor			
Dirt	98.1%	100%	+1.9%
Cement bricks	0%	0%	0%
House – Roof			
Iron sheets, tiles, concrete, or asbestos	9.3%	6.3%	-3.0%
Grass, leaves, or mud	90.7%	93.8%	+3.1%
House – Toilet facility			
No toilet facility (bush, beach) / other	34.8%	35.0%	+0.2%
Pit latrine, bucket/pan	65.2%	65.0%	-0.2%
Household – infrastructure			
Source of water: Public network	0%	75.6%	+75.6%
Connected to the electricity grid	0%	0%	0%

Variables	Baseline	Endline	Difference (End-Base)
Household – Appliances			
Possesses a Television	1.9%	1.3%	-0.6%
Possesses a Refrigerator	0%	0%	0%
Possesses a cooker	0%	0%	0%
Mobile phone (1 or more)	47.8%	48.1%	+0.3%
Cooking fuel			
Wood, crop residue, sawdust, animal waste, or other	98.1%	100%	+1.9%
Charcoal or kerosene	1.9%	0%	-1.9%
Cultivation			
Cultivated any crops in the last 12 months	99.4%	96.3%	-3.1%
Currently owns any bulls, cows, steers, heifers, male calves, female calves, or oxen	6.2%	8.8%	+2.6%
Transport vehicle			
Bicycle	18.0%	15.0%	-3.0%
Motorcycle	11.8%	14.4%	+2.6%
Car	0%	0%	0%
Occupation spouse			
Farmer, rancher, agricultural worker, or no male head/spouse	83.9%	89.4%	+5.5%
Shop owner, salesperson, service worker, transport and storage operator, or worker in textiles, construction, mechanics, graphics, chemicals, food processing, etc.	5.6%	2.5%	-3.1%
Office worker, transportation operator, professional, technician, director, manager, administrator, or related job	1.9%	1.3%	-0.6%
Other	3.7%	0%	-3.7%
Don't know / No answer / No data or no main occupation	5.0%	6.9%	+1.9%
Self-reported economic status			
Average economic status (1-10)[7]	1.53	3.03	+1.50

[7] This difference is statistically significant $p<0.001$ (Paired t-test)

Variables	Baseline	Endline	Difference (End-Base)
Financial situation			
Household access to bank account	1.2%	1.9%	+0.6%
Household has (money) savings[8]	11.8%	28.1%	+16.3%
Food security			
Anyone in the household went to bed going hungry in the last 7 days[9]	17.4%	43.1%	+25.7%
Any children under 5 years in the household went to bed going hungry in the last 7 days	Not asked	36.9%[10]	N/A
Average #of meals eaten per day	2.04	2.01	-0.03

3.3 Findings by outcomes

3.3.1 Outcome 1: Early learning and responsive caregiving

Types of stimulating activities

The following stimulating activities with the child are covered in the (baseline and endline) surveys:

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

In Table 7 the baseline and endline the percentages of primary caregivers that conducted a stimulating activity at least once a week are listed.

[8] This difference is statistically significant p-value = 0.011 (Paired t-test)
[9] This difference is statistically significant p<0.001 (Paired t-test)
[10] Reasons: Lack of food 53.6% (n= 69); Lack of money to buy food 97.1% (n= 69)

Table 7: Percentage of primary caregivers that did the stimulating activity at least ONCE with their child in the last week, disaggregated per community (baseline n=161, endline n=160)

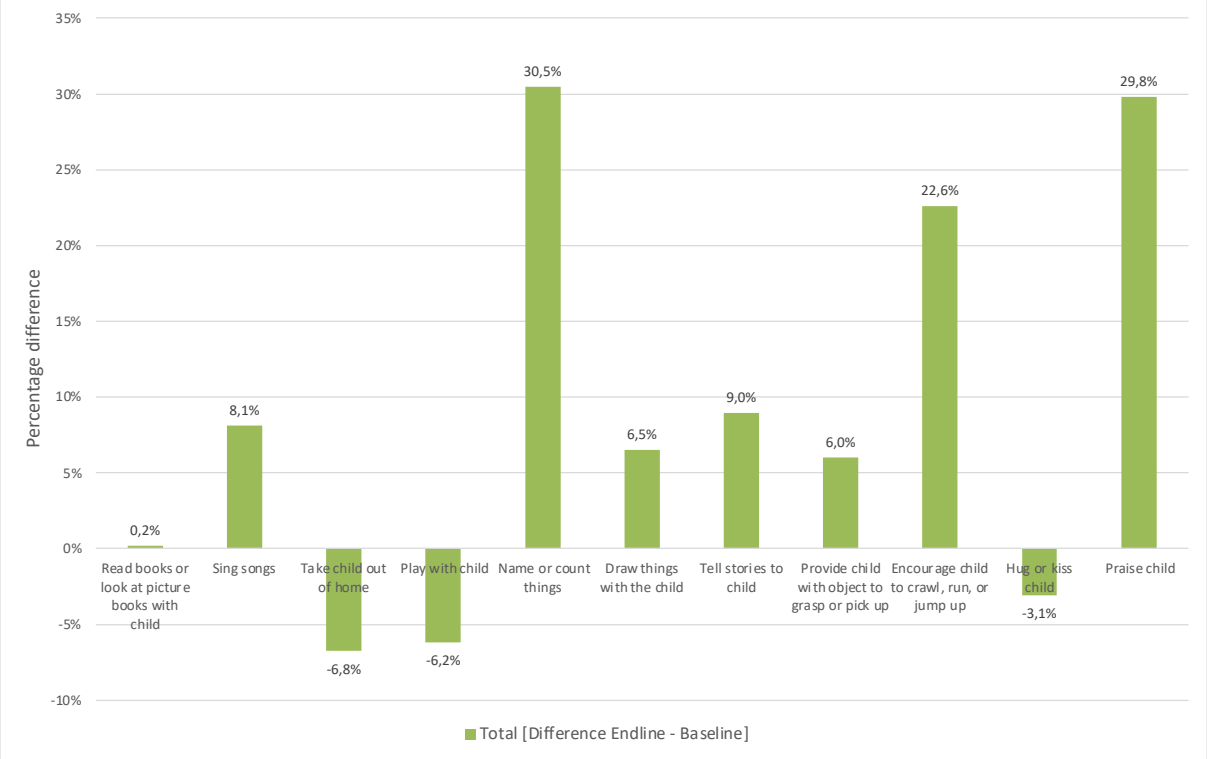
Activities stimulating with child done at least once	Baseline Activity done at least once a week					Endlline Activity done at least once a week				
	Agi-nuro	Cana-cue	Nacu-ca	Nama chaca	**Total**	Agi-nuro	Cana-cue	Nacu-ca	Nama chaca	**Total**
Read books or look at picture books with child	13.2%	14.6%	12.5%	27.0%	**16.7%**	22.5%	15.0%	17.5%	12.5%	**16.9%**
Sing songs	50.0%	46.3%	45.0%	64.9%	**51.3%**	67.5%	52.5%	55.0%	62.5%	**59.4%**
Take child out of home	94.7%	97.6%	95.0%	94.6%	**95.5%**	97.5%	77.5%	92.5%	87.5%	**88.8%**
Play with child	100%	97.6%	97.5%	100%	**98.7%**	100%	82.5%	95.0%	92.5%	**92.5%**
Name or count things	26.3%	29.3%	20.0%	45.9%	**30.1%**	65.0%	37.5%	67.5%	72.5%	**60.6%**
Draw things with the child	31.6%	34.1%	37.5%	54.1%	**39.1%**	45.0%	42.5%	55.0%	40.0%	**45.6%**
Tell stories to child	10.5%	7.3%	15.0%	32.4%	**16.0%**	25.0%	22.5%	27.5%	25.0%	**25.0%**
Provide child with object to grasp or pick up	92.1%	78.0%	85.0%	81.1%	**84.0%**	97.5%	87.5%	87.5%	87.5%	**90.0%**
Encourage child to crawl, run, or jump up	86.8%	58.5%	70.0%	70.3%	**71.2%**	97.5%	92.5%	95.0%	90.0%	**93.8%**
Hug or kiss child	100%	97.6%	97.5%	94.6%	**97.4%**	95.0%	92.5%	95.0%	95.0%	**94.4%**
Praise child	60.5%	56.1%	60.0%	56.8%	**58.3%**	90.0%	90.0%	80.0%	92.5%	**88.1%**

Analysis of caregiver-child activities revealed several changes between baseline and endline measurements. Three activities showed substantial increases: "Name or count things" increased by 30.5% (n=126), "Praise child" increased by 29.8% (n=126), and "Encourage child to crawl, run, or jump" increased by 22.6% (n=125). However, two activities showed decreases: "Take child out of home" decreased by 6.8% (n=126) and "Play with child" decreased by 6.2% (n=126). (See Table 8 and Figure 3).

Table 8: Difference in percentage of primary caregivers who engaged in a stimulating activity at least once with their child in the last week by community: Difference [Endline – Baseline] (baseline n= 161, endline n=160).

Activities stimulating with child done at least once a week	Difference [Endline – Baseline]				
	Aginuro	Canacue	Nacuca	Namachaca	Total
Read books or look at picture books with child	9.3%	0.4%	5.0%	-14.5%	0.2%
Sing songs	17.5%	6.2%	10.0%	-2.4%	8.1%
Take child out of home	2.8%	-20.1%	-2.5%	-7.1%	-6.8%
Play with child	0%	-15.1%	-2.5%	-7,5%	-6.2%
Name or count things	38.7%	8.2%	47.5%	26.6%	30.5%
Draw things with the child	13.4%	8.4%	17.5%	-14.1%	6.5%
Tell stories to child	14.5%	15.2%	12.5%	-7.4%	9.0%
Provide child with object to grasp or pick up	5.4%	9.5%	2.5%	6.4%	6.0%
Encourage child to crawl, run, or jump up	10.7%	34.0%	25.0%	19.7%	22.6%
Hug or kiss child	-5.0%	-5.1%	-2.5%	0.4%	-3.1%
Praise child	29.5%	33.9%	20.0%	35.7%	29.8%

Figure 3: Difference in percentage of primary caregivers who engaged in a stimulating activity at least once with their child in the last week by community: Difference [Endline – Baseline] (baseline n=161, endline n=160).



Furthermore, an analysis of the differences between average baseline and endline values (calculated as Endline – Baseline) reveals notable improvements in the types of specific activities conducted. For instance, Name or count things" increased by 30.5%, and "Praise child" rose by 29.8%, and "Encourage child to crawl, run, or jump up" rose by 22.6%, indicating positive trends in primary caregiver engagement. However, some activities experienced declines, with "Take child out of home" showing a decrease of 6.8% (see Table 8 and Figure 3.) These findings reflect encouraging progress while also pointing to areas that may need additional focus to ensure well-rounded caregiver involvement in early stimulation practices.

The quantitative findings on play and stimulation activities are substantiated by qualitative insights from primary caregivers' interviews. While the data showed significant increases in naming or counting things (+30.5%), praising children (+29.8%), and encouraging physical movement (+22.6%), caregivers' narratives revealed deeper behavioral changes in three key areas (see Table 9):

- First, primary caregivers reported actively engaging in toy-making, creating items like *"cars made from flipflop wheels, dolls, balls"* (ID 1303), with a notable shift in gender roles as *"men no longer leave everything to women"* (ID 402).
- Second, primary caregivers demonstrated increased understanding of play's developmental importance, recognizing that *"when we make toys, we stimulate our children to develop various abilities"* (ID 603). This understanding was reinforced by community leaders, who emphasized that during play, children *"develop many capabilities*" (ID 205).
- Third, despite the quantitative decrease in "taking child out of home" (-6.8%) and "play with child" (-6.2%), qualitative data suggested improved awareness of dedicating time for play, with caregivers noting, *"Before, I didn't see the need to play with my children, but now I know it's important to play with them and take them for walks"* (Multiple interviews).

Table 9: Play and stimulation practices supporting quotes

Topic	Quote	Source
Making toys	*"I also learned to make toys for children to play with, such as cars made from flipflop wheels, dolls, balls, and I learned that we should avoid hitting a child when they do something wrong..."*	ID 1303
	"I never thought that women could also make toys for children instead of just the fathers. Today, because of this program, men no longer leave everything to women..."	ID 402
Importance of play	*"I also learned that when we make toys, we stimulate our children to develop various abilities about their development."*	ID 603
	"...when the promoter talked about children's development, the faith leader also advised us, saying that we have to let the child play freely because when they play, they develop many capabilities, and that we should look for toys for our children to use."	ID 205
Time for play	*"Before, I didn't see the need to play with my children, but now I know it's important to play with them and take them for walks."*	Multiple interviews
	"I now play with my children and take them for walks."	ID 702

Frequency of Stimulating Activities by Type

The frequency with which primary caregivers reported conducting different types of stimulating activities (out of 11) for their child during the past week at baseline is presented in Table 10 while the endline data is shown in Table 11. The difference between endline and baseline is provided in Table 12.

Table 10: Primary caregiver-reported frequency of conducted stimulating activities (out of 11) for their child during the past week (baseline, n= 161)

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	83.3%	11.5%	3.8%	1.3%
Sing songs	48.7%	19.2%	21.2%	10.9%
Take child out of home	4.5%	8.3%	23.7%	63.5%
Play with child	1.3%	0%	7.7%	91.0%
Name or count things	69.9%	21.2%	5.1%	3.8%
Draw things with the child	60.9%	17.3%	12.2%	9.6%
Tell stories to child	84.0%	9.0%	3.8%	3.2%
Provide child with object to grasp or pick up	16.0%	17.9%	35.9%	30.1%
Encourage child to crawl, run, or jump up	28.8%	14.1%	23.7%	33.3%
Hug or kiss child	2.6%	10.3%	28.2%	59.0%
Praise child	41.7%	25.0%	19.2%	14.1%

Table 11: Primary caregiver-reported frequency of different stimulating activities conducted (out of 11) for their child during the past week (endline, n=160)

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	83.1%	12.5%	4.4%	0%
Sing songs	40.6%	25.0%	33.1%	1.3%
Take child out of home	11.3%	9.4%	43.8%	35.6%
Play with child	7.5%	10.0%	31.3%	51.3%
Name or count things	39.4%	32.5%	23.8%	4.4%
Draw things with the child	54.4%	30.6%	12.5%	2.5%
Tell stories to child	75.0%	13.1%	8.8%	3.1%
Provide child with object to grasp or pick up	10.0%	8.8%	42.5%	38.8%
Encourage child to crawl, run, or jump up	6.3%	3.8%	30.6%	59.4%
Hug or kiss child	5.6%	11.3%	21.9%	61.3%
Praise child	11.9%	12.5%	18.1%	57.5%

Table 12: Difference [endline – baseline] in the average of the primary caregiver reported frequency of conducted stimulating activities (out of 11) for their child during the past week (baseline n= 161; endline n=160)

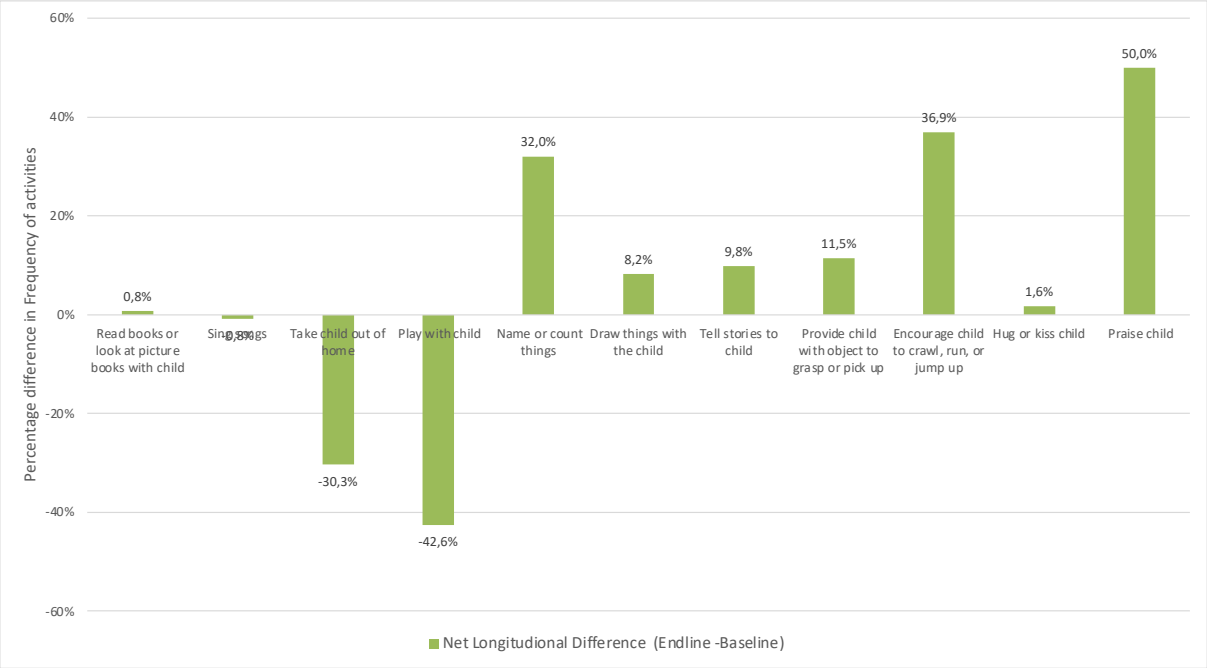
Stimulating activities Difference [endline – baseline]	Never (0)	Once or twice a week (1, 2)	Multiple times a week (3, 4, 5)	Every day or nearly every day (6, 7)
Read books or look at picture books with child	-0.2%	1.0%	0.5%	-1.3%
Sing songs	-8.1%	5.8%	12.0%	-9.6%
Take child out of home	6.8%	1.0%	20.0%	-27.8%
Play with child	6.2%	10.0%	23.6%	-39.8%
Name or count things	-30.5%	11.3%	18.6%	0.5%
Draw things with the child	-6.5%	13.3%	0.3%	-7.1%
Tell stories to child	-9.0%	4.2%	4.9%	-0.1%
Provide child with object to grasp or pick up	-6.0%	-9.2%	6.6%	8.6%
Encourage child to crawl, run, or jump up	-22.6%	-10.4%	6.9%	26.0%
Hug or kiss child	3.1%	1.0%	-6.3%	2.3%
Praise child	-29.8%	-12.5%	-1.1%	43.4%

The longitudinal analysis of the primary caregivers reveals notable increases in certain stimulating activities, particularly " Praise child" (+50.0%, n=126), "Take child out of home" (+45.9%, n=126) and "Encourage child to crawl, run, or jump up" (+36.9%, n=126). Conversely, declines were observed in "Take child out of home" (-30.3%, n=126) and "Play with child" (-42.6%, n=126) (see Table 13, Figure 4).

Table 13: Net longitudinal difference [endline – baseline] in frequency of weekly stimulating activities (out of 11) for their Child (n= 126)

Stimulating activities Longitudinal difference [endline – baseline]	Less frequent at endline	Same	More frequent at endline	Net difference
Read books or look at picture books with child	9.0%	81.1%	9.8%	0.8%
Sing songs	25.4%	50.0%	24.6%	-0.8%
Take child out of home	45.9%	38.5%	15.6%	-30.3%
Play with child	45.9%	50.8%	3.3%	-42.6%
Name or count things	8.2%	51.6%	40.2%	32.0%
Draw things with the child	22.1%	47.5%	30.3%	8.2%
Tell stories to child	12.3%	65.6%	22.1%	9.8%
Provide child with object to grasp or pick up	24.6%	39.3%	36.1%	11.5%
Encourage child to crawl, run, or jump up	14.8%	33.6%	51.6%	36.9%
Hug or kiss child	27.9%	42.6%	29.5%	1.6%
Praise child	18.0%	13.9%	68.0%	50.0%

Figure 4: Net longitudinal difference [endline – baseline] in frequency of weekly stimulating activities (out of 11) for their child (n= 126)

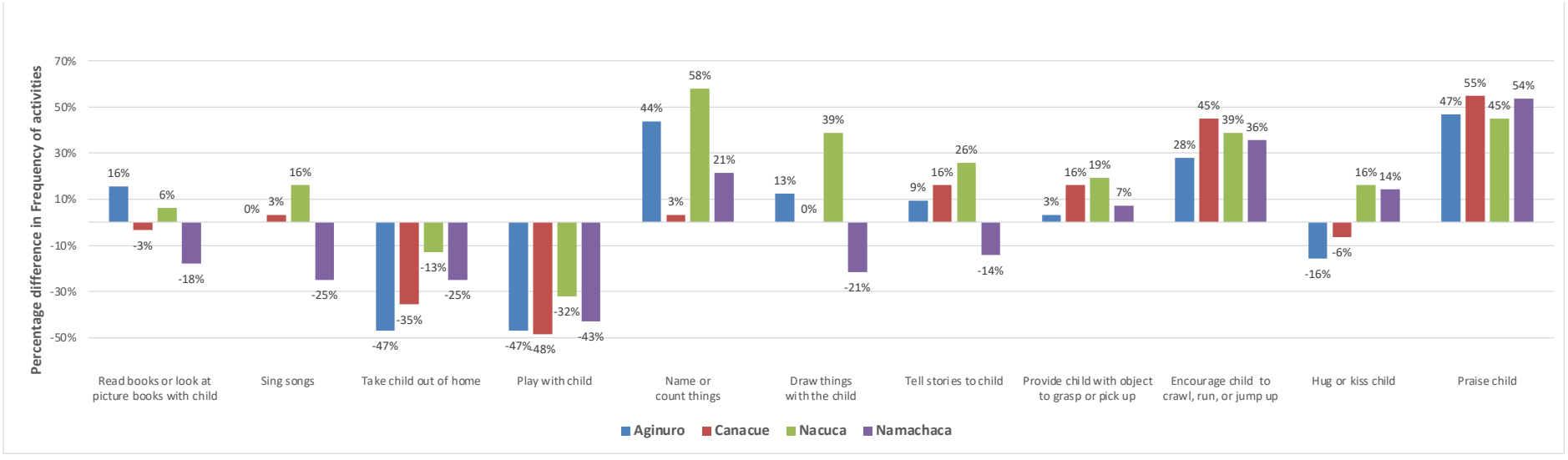


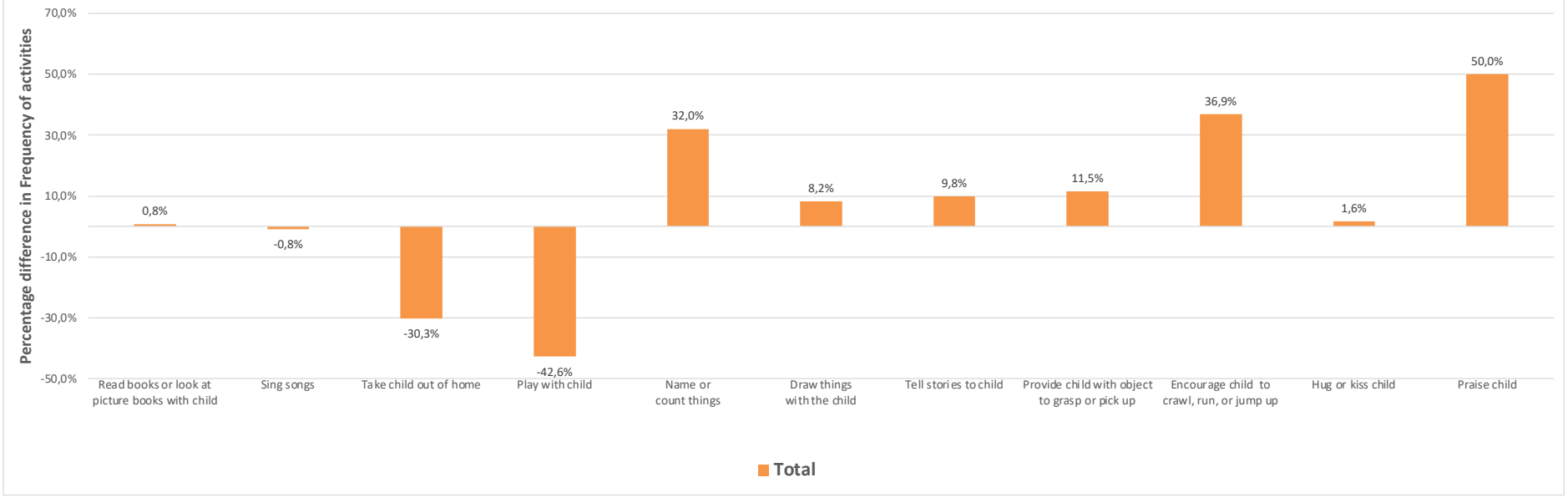
The longitudinal analysis of the difference per community is listed in Table 14 and Figure 5.

Table 14: Net longitudinal difference [endline -baseline] in frequency of weekly stimulating activities (out of 11) for their child by community (n= 126)

Stimulating activities Longitudinal difference [endline-baseline]	Aginuro	Canacue	Nacuca	Namachaca	Total
Read books or look at picture books with child	15.6%	-3.2%	6.5%	-17.9%	0.8%
Sing songs	0%	3.2%	16.1%	-25.0%	-0.8%
Take child out of home	-46.9%	-35.5%	-12.9%	-25.0%	-30.3%
Play with child	-46.9%	-48.4%	-32.3%	-42.9%	-42.6%
Name or count things	43.8%	3.2%	58.1%	21.4%	32.0%
Draw things with the child	12.5%	0%	38.7%	-21.4%	8.2%
Tell stories to child	9.4%	16.1%	25.8%	-14.3%	9.8%
Provide child with object to grasp or pick up	3.1%	16.1%	19.4%	7.1%	11.5%
Encourage child to crawl, run, or jump up	28.1%	45.2%	38.7%	35.7%	36.9%
Hug or kiss child	-15.6%	-6.5%	16.1%	14.3%	1.6%
Praise child	46.9%	54.8%	45.2%	53.6%	50.0%

Figure 5: Net longitudinal difference [endline – baseline] in frequency of weekly stimulating activities (out of 11) for their child by community (n= 126)





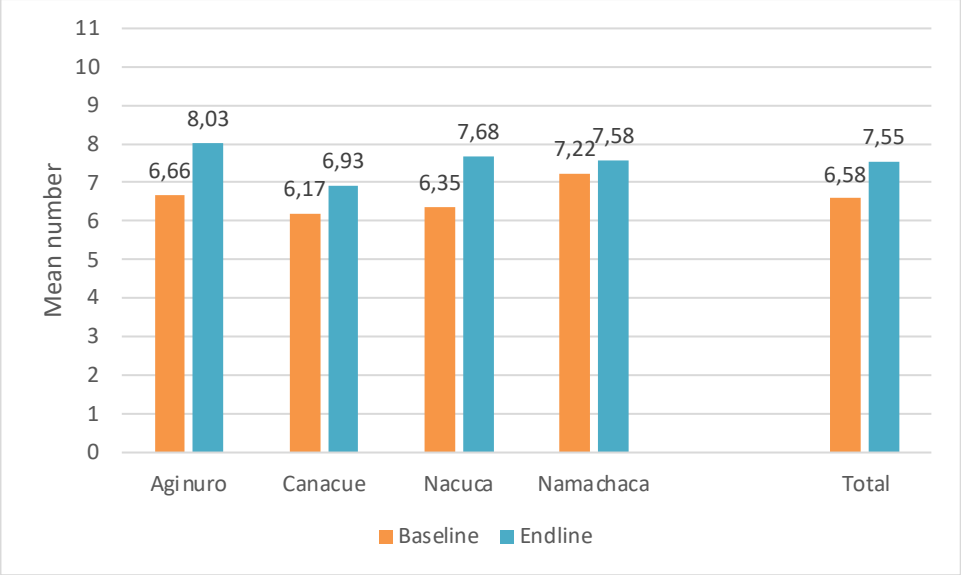
Average of different stimulating activities

An important measure of early learning and responsive caregiving is the average number of different stimulating activities a primary caregiver engages in with a child (out of a total of 11 activities). At endline, this average increased to 7.55 from 6.58 at baseline, with a longitudinal difference of 1.02 for the 126 primary caregivers who participated in both rounds. This difference is statistically significant[11]. The largest increase (1.84) was observed in Nacuca district (see Table 15 and Figure 6).

Table 15: Average weekly different types of stimulating activities (out of 11) by community (baseline n=161; endline n=160; longitudinal n=126)

Mean # of stimulating activities out of 11	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline	6.66	6.17	6.35	7.22	6.58
Endline	8.03	6.93	7.68	7.58	7.55
Difference [Endline – Baseline]	1.37	0.75	1.33	0.36	0.97
Longitudinal diff. [Endline-Baseline]	**1.28**	**0.65**	**1.84**	**0.21**	**1.02**
Standard deviation	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline	1.94	2.19	2.03	2.58	2.21
Endline	1.82	2.30	2.23	1.99	2.11
Longitudinal diff [Endline-Baseline]	1.92	2.73	2.30	2.10	2.34

Figure 6: Average weekly different types of stimulating activities (out of 11) by community (baseline n= 161; endline n=160)



[11] p < 0.001 (Paired t-test)

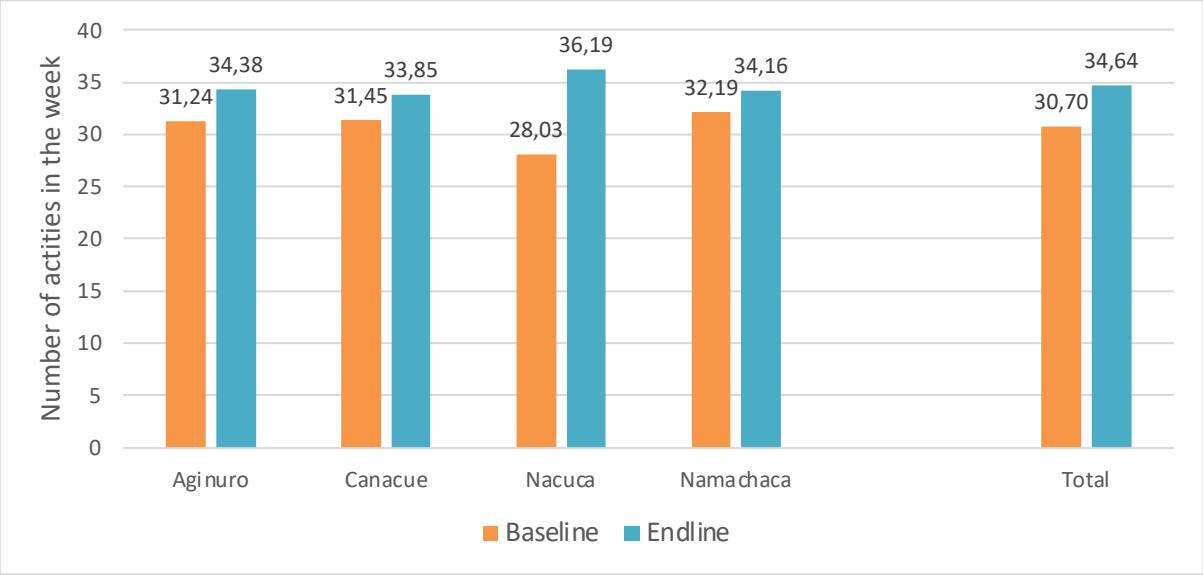
Total number of weekly stimulating activities

The endline results show higher averages in the total number of stimulating activities per week (out of a maximum of 77, based on 11 different activities over 7 days). The longitudinal difference is 3.82 (n=126), with an increase from 30.70 total activities per week at baseline to 34.64 at endline. This difference is statistically significant[12]. The greatest improvement was observed in the Nacuca community (+9.00, n=31) (see Table 16 and Figure 7).

Table 16: Average total number of weekly stimulating activities (out of 77, based on 11 activities over 7 days) by community (baseline n=161; endline n=160; longitudinal n= 126)

Mean # of activities out of 11	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline	31.24	31.45	28.03	32.19	30.70
Endline	34.38	33.85	36.19	34.16	34.64
Difference [Endline – Baseline]	3.13	2.40	8.16	1.97	3.95
Longitudinal diff. [Endline-Baseline]	**3.43**	**1.61**	**9.00**	**0.97**	**3.82**
Standard deviation	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline	6.60	11.24	9.11	11.15	9.77
Endline	10.23	8.40	9.20	9.86	9.40
Longitudinal diff [Endline-Baseline]	11.58	15.25	11.17	10.30	12.52

Figure 7: Average total number of weekly stimulating activities by community (baseline n=161; endline n=160)



[12] p = 0.001 (Paired t-test)

Percentage of primary caregivers providing adequate stimulation

Adequate stimulation is defined as engaging in at least four out of the following seven activities with the child:

1. Read books or looked at picture books with child
2. Sang songs with or to child
3. Took child outside the home
4. Played with child
5. Name counted
6. Drew things with child
7. Told stories to child

The overall percentage of primary caregivers providing adequate stimulation changed significantly from 38.5% (n=161) at baseline to 58.1% (n=160) at endline. However, there were notable differences across communities. Nacuca community showed a substantial improvement of 41.9% (n=31), while Namachaca community recorded a small increase of 3.6% (n=30), (see Table 17 and Figure 8). The average number of these seven activities showed a slight increase of 0.52 at endline (see Table 18 and Figure 9).

Table 17: Percentage of primary caregivers providing **adequate** stimulation by community (baseline n=161; endline n=160; longitudinal n=126)

Adequate stimulation	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline	38.5%	34.1%	30.0%	56.8%	38.5%
Endline	58.1%	45.0%	65.0%	57.5%	58.1%
Difference [Endline – Baseline]	19.7%	10.9%	35.0%	0.7%	19.7%
Longitudinal diff [Endline-Baseline]	**31.3%**	**12.9%**	**41.9%**	**3.6%**	**23.0%**

Figure 8: Percentage of primary caregivers providing **adequate** stimulation for their child by community (baseline n=161; endline n=160)

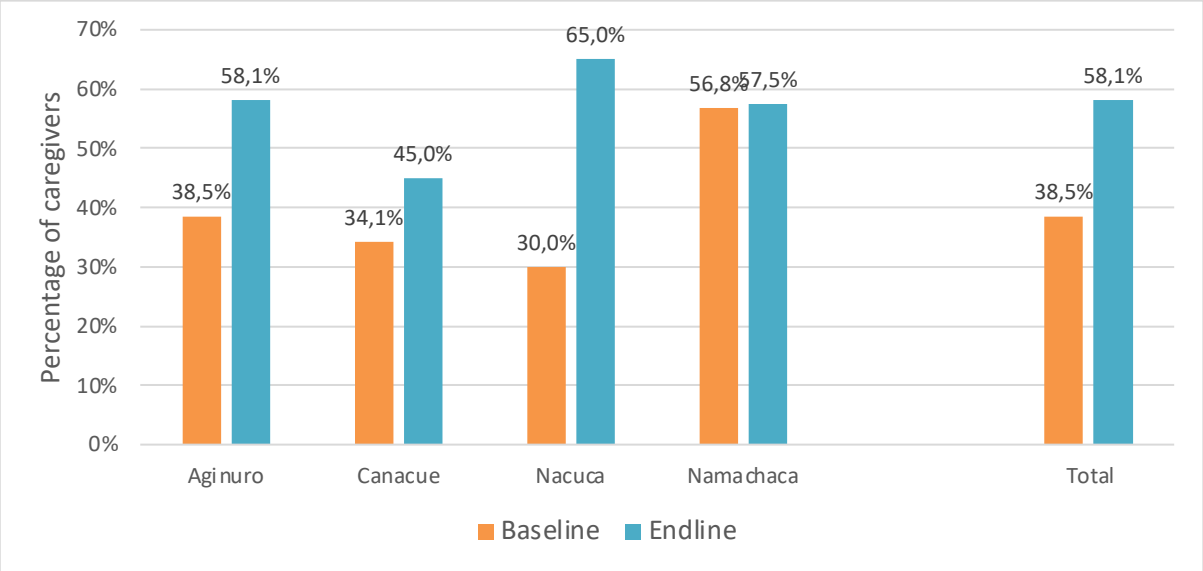
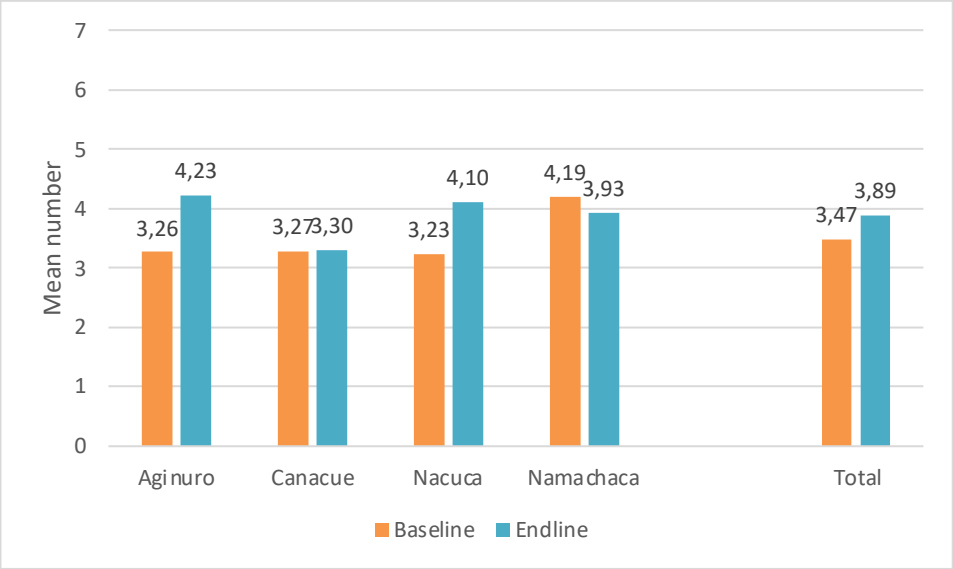


Table 18: Average weekly different types of **adequate** stimulating activities (out of 7) for their child by community (baseline n=161; endline n=160; longitudinal n=126)

Mean # of activities out of 7	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline	3.26	3.27	3.23	4.19	3.47
Endline	4.23	3.30	4.10	3.93	3.89
Difference [Endline – Baseline]	0.96	0.03	0.88	-0.26	0.41
Longitudinal diff [Endline-Baseline]	**0.97**	**-0.03**	**1.32**	**-0.29**	**0.52**
Standard deviation	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline	1.35	1.45	1.48	1.84	1.57
Endline	1.54	1.98	1.75	1.51	1.73
Longitudinal diff Endline-Baseline	1.33	1.87	1.47	1.74	1.73

Figure 9: Average weekly different types of **adequate** stimulating activities (out of 7) for their child by community (baseline n= 161; endline n=160)



The qualitative insights provide valuable context for the observed quantitative improvements in childcare, demonstrating a community-wide commitment to safer and more attentive caregiving. In particular findings from committee member interviews provide important context to the quantitative improvements in child supervision practices. Committee members report *"a positive transformation in their communities regarding childcare practices,"* with enhanced monitoring and support systems in place. A key development has been the increased presence of adult caregivers, particularly fathers who are now *"more involved in activities traditionally considered women's responsibilities, such as bathing children, helping with household chores, and accompanying mothers to health centers (committee member)."*

These findings highlight a positive trend in primary caregiver practices, emphasizing the program's role in strengthening early childhood care and protection.

Play and learning materials

At endline, children engaged more frequently with all types of objects during play, with a particularly notable increase in the use of store-bought toys (+9.8%, n=126) compared to baseline (see Table 19).

Table 19: Percentage of children who played with different types of materials (out of 4), by community (baseline n=161; endline n=160; longitudinal n=126)

Materials the child played with	Homemade toys	Store-bought toys	Household objects	Objects in the natural environment
Baseline	52.6%	12.2%	77.6%	82.1%
Endline	67.5%	25.0%	90.0%	91.9%
Difference [Endline – Baseline]	14.9%	12.8%	12.4%	9.8%
Longitudinal diff [Endline-Baseline]	**14.8%**	**15.6%**	**9.8%**	**9.8%**

The average number of different objects/materials children played with increased at endline compared to baseline, with a longitudinal difference of 0.50 (n=126). The greatest increase was observed in Canacue, with an improvement of 0.77 (n=31) (see Table 20). This difference is statistically significant[13].

Table 20: Average number of different types of materials (out of 4) the child played with, by community (baseline n=161; endline n=160; longitudinal n=126)

Average number of different materials the child played with	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline	2.63	1.98	2.30	2.08	2.24
Endline	2.74	2.80	2.80	2.65	2.74
Difference [Endline – Baseline]	0.11	0.82	0.50	0.57	0.50
Longitudinal diff [Endline-Baseline]	0.13	0.77	0.71	0.39	0.50
Standard deviation	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline	0.91	1.25	1.11	1.28	1.17
Endline	0.95	1.14	0.85	0.92	0.95
Longitudinal diff [Endline-Baseline]	1.18	1.63	1.42	1.23	1.39

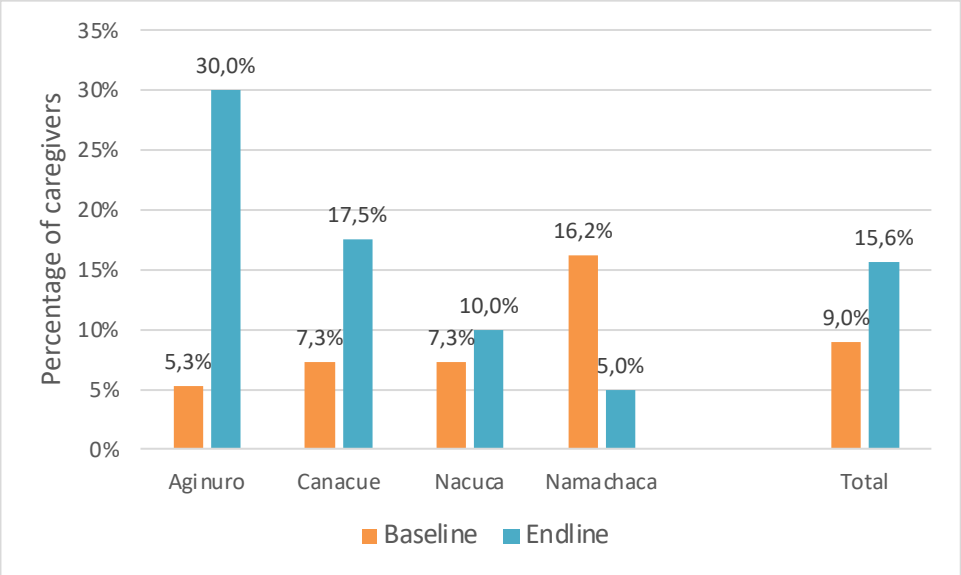
The percentage of primary caregivers with a child book in the household increased by 9.0% (n=126) at endline compared to baseline. The most improvement was observed in the Aginuro community, where 30.0% (n=40) of households reported having a child book (see Table 21 and Figure 10).

[13] P < 0.001 (Paired t-test)

Table 21: Difference in percentage of primary caregivers who have a children's book in the household, by Community (baseline n=161; endline n=160; longitudinal n=126)

Percentage of households with a children's book	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline	5.3%	7.3%	7.3%	16.2%	9.0%
Endline	30.0%	17.5%	10.0%	5.0%	15.6%
Difference [Endline – Baseline]	24.7%	10.2%	2.7%	-11.2%	6.7%
Longitudinal diff [Endline-Baseline]	**25.0%**	**6.5%**	**3.2%**	**0%**	**9.0%**

Figure 10: Percentage of primary caregivers with a children's book in the household, by community (baseline n=161; endline n=160)



The average number of children's books in the household increased by 0.10 (n=126) at endline compared to baseline, (see Table 22)

Table 22: Average number of children books in the household, disaggregated per community (baseline n=161; endline n=160; longitudinal n= 126)

Average number of children books in the household	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline	0.08	0.10	0.13	0.27	0.14
Endline	0.40	0.23	0.13	0.08	0.21
Difference Endline – Baseline	0.32	0.13	0	-0.20	0.07
Longitudinal diff [Endline-Baseline]	**0.41**	**0.19**	**-0.03**	**-0.21**	**0.10**
Standard deviation	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline	0.36	0.37	0.52	0.65	0.49
Endline	0.71	0.53	0.40	0.35	0.53
Longitudinal diff [Endline-Baseline]	0.87	0.65	0.48	0.69	0.72

At endline, quantitative assessments reveal some improvements in the availability of play and learning materials compared to baseline. The use of store-bought toys increased by 12.8%, and the average number of children's books in the household grew from 0.14 to 0.21 These advancements indicate a slightly stronger emphasis on stimulating child learning environments across communities, with particularly remarkable progress in the Aginuro community, where 30% of households now have a children's book.

This is also substantiated by the qualitative findings that demonstrate significant improvements in the availability of play and learning materials, particularly through community-driven initiatives in toy making. Primary caregivers reported learning to create toys from locally available materials, as evidenced by one participant who shared, *"I also learned to make toys for children to play with, such as cars made from flipflop wheels, dolls, balls"* (ID 1303). This newfound skill has led to increased availability of age-appropriate play materials. The program has also fostered gender-inclusive participation in creating learning materials, with one primary caregiver noting, *"I never thought that women could also make toys for children instead of just the fathers". "Today, because of this program, men no longer leave everything to women"* (ID 402). Primary caregivers demonstrated understanding of the developmental benefits of these materials, with one stating, *"When we make toys, we stimulate our children to develop various abilities about their development"* (ID 603). Faith leaders have also reinforced the importance of providing play materials, advising families to *"Look for toys for our children to use"* because *"When they play, they develop many capabilities"* (ID 205) as summarized in Table 23 below.

Table 23: Play materials supporting quotes

Topic	Quote	Source
Making toys	*"I also learned to make toys for children to play with, such as cars made from flipflop wheels, dolls, balls"*	ID 1303
Gender-inclusive toy making	*"I never thought that women could also make toys for children instead of just the fathers. Today, because of this program, men no longer leave everything to women"*	ID 402
Understanding developmental benefits	*"When we make toys, we stimulate our children to develop various abilities about their development"*	ID 603
Community support for play materials	*"...we have to let the child play freely because when they play, they develop many capabilities, and that we should look for toys for our children to use"*	Faith Leader

3.3.2 Outcome 2: Child safety and security

Fourteen (14) discipline practices were surveyed during the endline survey consisting of the following three categories:

a) Physical punishment;
b) Psychological aggression; and
c) Positive discipline practices.

At endline, only 6.3% of primary caregivers (n=160) reported using any form of physical punishment with their child. The most common form of physical punishment was 'Hit/slapped child on hand/arm/leg' (3.1%, n=160). Notably, none of the primary caregivers reported hitting or beating up their child severely. Regarding psychological aggression, 6.9% (n=160) of primary caregivers reported such behaviors, with 'shouting, yelling or screaming at their child' being the most common form. For positive discipline practices, nearly all primary caregivers (84.4%, n=160) reported applying positive approaches such as explaining why behavior was wrong, giving the child something else to do, or using non-violent consequences (see Table 25).

The primary caregivers reported significant changes in how they discipline their children since participating in the MTM program. At endline, almost all caregivers reported conducting less psychological aggression (95.0%, n=160) and less physical punishment (92.5%, n=160). Additionally, a large majority (80.0%, n=160) reported applying more positive discipline practices (see Table 24).

Table 24: Self-reported how primary caregiver disciplined the child/ren since the participation in MTM, disaggregated per community (endline n=160)

Reported disciplinary behavior change	Aginuro	Canacue	Nacuca	Namachaca	Total
Same level of physical punishment	5.0%	0%	7.5%	0%	5.0%
Less physical punishment	**95.0%**	**100%**	**92.5%**	**100%**	**95.0%**
More physical punishment	0%	0%	0%	0%	0%
Same level of verbal punishment	3.8%	0%	5.0%	2.5%	5.0%
Less verbal punishment	**93.1%**	**97.5%**	**92.5%**	**95.0%**	**92.5%**
More verbal punishment	3.1%	2.5%	2.5%	2.5%	2.5%
Same level of positive disciplinaries	0.6%	2.5%	0%	0%	2.5%
Less positive disciplinaries	5.6%	17.5%	0%	0%	17.5%
More positive disciplinaries	**93.8%**	**80.0%**	**100%**	**100%**	**80.0%**

Table 25: Teach the right behavior or to address a behavior problem for their youngest child, disaggregated per community (endline n=160)

Addressed behavior for their child	Aginuro	Canacue	Nacuca	Namachaca	Total
Physical punishment (any)	**12.5%**	**5.0%**	**2.5%**	**5.0%**	**6.3%**
Shook child	2.5%	5%	0%	0%	1.9%
Spanked child on bottom with bare hand	7.5%	0%	0%	0%	1.9%
Hit child with hard object	5.1%	0%	2.5%	0%	1.9%
Hit/slapped child on the head	5.0%	0%	0.0%	0%	1.3%
Hit/slapped child on hand/arm/leg	7.5%	0%	0%	5.0%	3.1%
Beat child up	0%	0%	0%	0%	0%
Psychological aggression (any)	**12.5%**	**5.0%**	**5.0%**	**5.0%**	**6.9%**
Shouted/yelled/screamed at child	12.5%	5.0%	5.0%	5.0%	6.9%
Called child dumb, lazy	2.5%	0%	0%	0%	0.6%
Positive discipline practices (any)	**84.4%**	**75.0%**	**90.0%**	**85.0%**	**84.4%**
Distracted the child	30.0%	10.0%	17.5%	17.5%	18.8%
Took away a privilege	17.5%	0%	2.5%	2.5%	5.6%
Sent child away for a time out	25.0%	25.0%	22.5%	17.5%	22.5%
Ignored the behavior	20.0%	7.5%	5.0%	17.5%	12.5%
Explained why behavior was wrong	75.0%	70.0%	80.0%	77.5%	75.6%
Praised good behavior	50.0%	42.5%	42.5%	47.5%	45.6%

At endline, 11.3% (n=160) of primary caregivers reported applying some form of violent discipline, **including** verbal or physical discipline. This represents a longitudinal reduction of 26.2% (n=126) compared to baseline, indicating a notable decline in the use of violent discipline practices (see Table 26). This difference is statistically significant[14].

Table 26: Percentage of primary caregivers who use any violent discipline with any of their children aged 0-3 years, by community (baseline n= 161; endline n=160; longitudinal n= 126)

Violent discipline (any)	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline	60.5%	29.3%	20.0%	29.7%	34.6%
Endline	20.0%	7.5%	7.5%	10.0%	11.3%
Difference [Endline – Baseline]	-40.5%	-21.8%	-12.5%	-19.7%	-23.4%
Longitudinal diff [Endline-Baseline]	**-40.6%**	**-29.0%**	**-3.2%**	**-32.1%**	**-26.2%**

[14] $p < 0.0001$ (Paired t-test)

3.3.2.1 Physical punishment

Indicator 3

Indicator 3 measures the percentage of primary caregivers who use any physical punishment with their children aged 0-3 years. At baseline, all primary caregivers reported using some form of physical punishment on their children. To further analyze the indicator, two specific aspects were assessed during the baseline survey;

a) Percentage of primary caregivers who use physical punishment with their children aged 0-3 years
b) Average number of different types of physical punishment applied (out of 6), averaged across all children aged 0-3 years

These components provide a deeper understanding of the prevalence and variation in discipline practices used by primary caregivers.

Indicator 3a: Percentage of primary caregivers who use of physical punishment

At baseline, all primary caregivers (100%, n=161) reported using physical punishment to discipline their children under 3 years. However, at endline, this percentage significantly decreased to 36.5% (n=160).

Among primary caregivers who participated in both survey rounds, the reduction in physical punishment is particularly striking: 94.3% (n=126) of primary caregivers no longer use physical punishment. The greatest reduction was observed in the Nacuca district (-96.8%, n=31) (see Table 27 and Figure 11). This difference is statistically significant[15].

These findings indicate a substantial shift towards non-violent discipline practices, reflecting potential improvements in primary caregiver awareness and alternative discipline strategies. Similar shifts toward non-violent discipline practices have been documented in multiple countries through ECD interventions. Here are some examples with sources:

1. Philippines: The Early Childhood Care and Development (ECCD) intervention showed significant reductions in physical punishment by caregivers.[16]
2. Jamaica: Home visiting programs demonstrated decreased use of physical punishment[17].
3. Uganda: REAL Fathers Initiative resulted in significant reductions in physical punishment[18].

[15] $p < 0.0001$ (Paired t-test)
[16] Lachman, J. M., et al. (2021). "Preventing violence against children in the Philippines: A cluster randomized trial." Child Abuse & Neglect, 117, 105080.
[17] Walker, S. P., et al. (2022). "Effects of psychosocial stimulation on the home environment and non-violent discipline in a Jamaican parenting program." Journal of Child Psychology and Psychiatry, 63(7), 847-855.
[18] Ashburn, K., et al. (2017). "Evaluation of the Responsible, Engaged, and Loving (REAL) Fathers Initiative on physical child punishment and intimate partner violence in Northern Uganda." Prevention Science, 18(7), 854-864

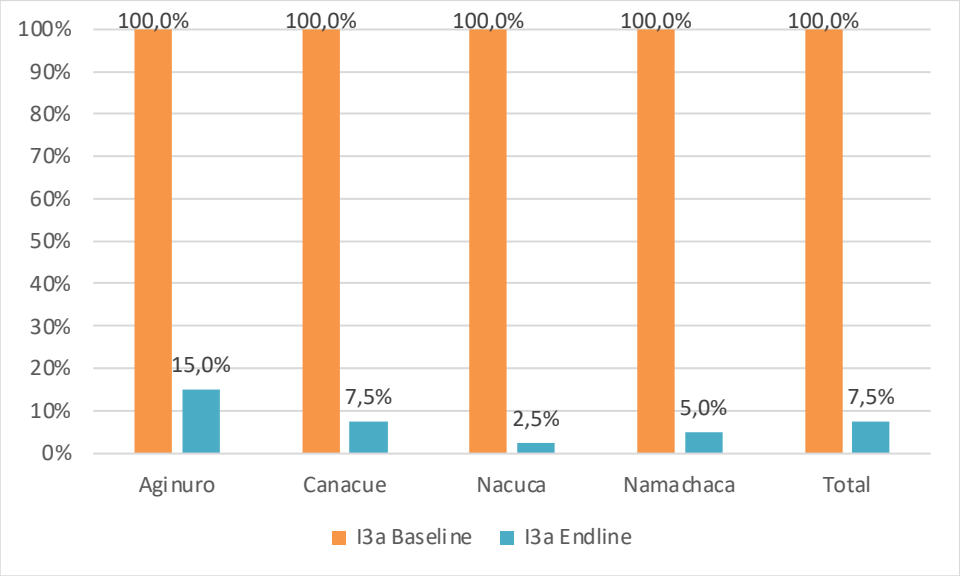
4. Kenya: The Parenting for Lifelong Health (PLH) program in Kenya showed reductions in harsh discipline[19].

Regarding sustainability of these changes as children age, evidence suggests that early intervention effects can persist, but may require periodic reinforcement through booster sessions or continued community support.

Table 27: Indicator 3a: Percentage of primary caregivers who use any physical punishment with any physical punishment of their children aged 0-3 years, by community (baseline n= 161; endline n=160; longitudinal n= 126)

Indicator 3a: percentage of caregivers who use physical punishment with Any of their children (0-3 ears)	Aginuro	Canacue	Nacuca	Namachaca	Total
I3a: Baseline	100%	100%	100%	100%	100%
I3a: Endline	15.0%	7.5%	2.5%	5.0%	7.5%
I3a: Difference [Endline – Baseline]	-85.0%	-92.5%	-97.5%	-95.0%	-92.5%
I3a: Longitudinal diff [Endline-Baseline]	**-87.5%**	**-93.5%**	**-96.8%**	**-80,0%**	**-94.3%**

Figure 11: Indicator 3a: Percentage of primary caregivers who use any physical punishment with any of their children (0-3 years) by community (baseline n= 161; endline n=160).



Indicator 3b: Average number of different types of physical punishments applied

At baseline, primary caregivers reported using an average of 3.71 different types of physical punishment (out of 6) on their children. However, at endline, this average significantly decreased to 0.46, indicating a substantial reduction in the use of physical punishment (see Table 28, Figure 12).

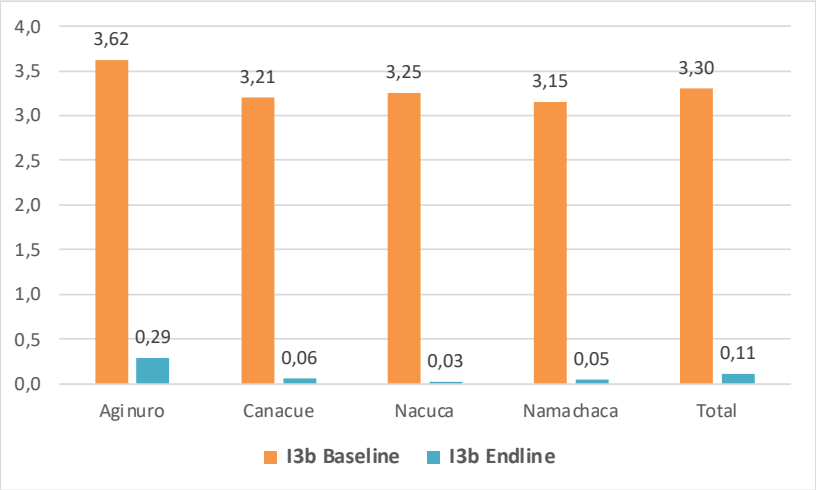
[19] Van Esch, R. P., & de Haan, M. (2016). "Evaluation of Skillful Parenting program in Kenya." International Journal of Psychology, 51, 78

Among primary caregivers who participated in both survey rounds, the reduction in the number of physical punishment types used was -3.20 (out of 6), showing a dramatic shift away from physical punishment. This difference is statistically significant[20]. The largest decrease was observed in the Aginuro district (-3.31), reflecting notable progress in adopting non-violent discipline practices.

Table 28: Indicator 3b: Average number of different types of physical punishment (out of 6) used with their child, by community (baseline n= 161; endline n=160; longitudinal n= 126)

Indicator 3b: Average number of Different types of physical Punishment Applied (out of 6) for their child	Aginuro	Canacue	Nacuca	Namachaca	Total
I3b: Baseline	3.62	3.21	3.25	3.15	3.30
I3b: Endline	0.29	0.6	0.03	0.05	0.11
I3b: Difference [Endline – Baseline]	-3.33	-3.14	-3.23	-3.10	-3.20
I3b: Longitudinal diff [Endline-Baseline]	**-3.31**	**-3.16**	**-3.10**	**-3,16**	**-3.18**

Figure 12: Indicator 3b: average number of different types of physical punishment (out of 6) used with their child, by community (baseline n= 161; endline n=161).



3.3.2.2 Psychological aggression

At baseline, 34.6% (n=161) of primary caregivers reported using psychological aggression to discipline their youngest child under 3 years. However, by endline, this percentage had decreased to 6.9% (n=160).

Among primary caregivers who participated in both survey rounds, there was a 27.7% (n=126) reduction in the use of psychological aggression. The most significant longitudinal decrease (-46.9%, n=34) was observed in the Aginuro district (see Table 29). This difference is statistically significant[21].

These findings suggest a notable shift away from psychologically aggressive discipline practices, reflecting potential improvements in primary caregiver awareness and alternative discipline strategies.

[20] $p < 0.0001$ (Paired t-test)
[21] $p < 0.0001$ (Paired t-test)

Table 29: Percentage of primary caregivers applying any psychological aggression with their child, by community (baseline n=161; endline n=160; longitudinal n=126).

Percentage of primary caregivers who use any psychological aggression	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline	34.6%	29.3%	20.0%	29.7%	34.6%
Endline	12.5%	5.0%	5.0%	5.0%	6.9%
Difference [Endline – Baseline]	-22.1%	-24.3%	-15.0%	-24.7%	-27.7%
Longitudinal diff [Endline-Baseline]	**-46.9%**	**-32.3%**	**-6.5%**	**-28.6%**	**-28.7%**

The average number of verbal punishments used at endline is 0.08 (n=160) out of the 2 different types. The longitudinal difference is -0.29, indicating an improvement at endline (see Table 30). This difference is statistically significant[22].

Table 30: Average number of different types of psychological aggression (out of 2) used with their child, by community (baseline n=161; endline n=160; longitudinal n=126).

Types of psychological aggression (out of 2)	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline	0.61	0.34	0.20	0.32	0.37
Endline	0.15	0.05	0.05	0.05	0.08
Difference [Endline – Baseline]	-0.46	-0.29	-0.15	-0.27	-0.29
Longitudinal diff. [Endline-Baseline]	**-0.44**	**-0.35**	**-0.06**	**-0.32**	**-0.30**

3.3.2.3 Positive discipline practices

Regarding positive discipline practices, there was no significant change in the percentage of primary caregivers using any positive discipline practice (see Table 31). However, there was a slight longitudinal improvement of 0.25 in the average number (out of 6) of different types of positive practices applied during endline compared to the same primary caregivers at baseline (see Table 32).

Table 31: Percentage of primary caregivers applying any positive discipline practices with their child, by community (baseline n=161; endline n=160; longitudinal n=136).

Percentage of primary caregivers who use any positive discipline practices	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline	86.8%	68.3%	77.5%	83.8%	78.8%
Endline	84.4%	75.0%	90.0%	85.0%	84.4%
Difference [Endline – Baseline]	-2.5%	6.7%	12.5%	1.2%	5.5%
Longitudinal diff [Endline-Baseline]	**3.1%**	**3.2%**	**12.9%**	**-3.6%**	**4.1%**

[22] $p < 0.0001$ (Paired t-test)

Table 32: Average number of different types of positive discipline practices (out of 6) used with their child by community (baseline n= 161; endline n=160; longitudinal n=126).

Types of positive discipline practices (out of 6)	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline	1.58	1.29	1.48	1.97	1.57
Endline	2.18	1.55	1.70	1.80	1.81
Difference [Endline – Baseline]	0.60	0.26	0.23	-0.17	0.24
Longitudinal diff [Endline-Baseline]	0.78	0.23	0.32	-0.39	0.25

Primary caregivers reported an increase in the use of positive behavior discipline strategies since their participation in MTM. The following behaviors were most commonly applied:

- Explaining why the behavior was wrong: 75.6% (n=160)
- Praising good behavior: 45.6% (n=160)
- Sent child away for a time out: 22.5% (n=160)

These findings highlight a significant shift toward positive discipline practices among primary caregivers (see Table 33, and note that this question was not asked at baseline.)

Table 33: Positive behavior applied to the child reported by the primary caregiver that they have increased since your participation in MTM, disaggregated per community (endline n=160)

Positive discipline practices	Aginuro	Canacue	Nacuca	Namachaca	Total
Distracting the child	30.0%	10.0%	17.5%	17.5%	18.8%
Took away a privilege	17.5%	0%	2.5%	2.5%	5.6%
Sent child away for a time out	25.0%	25.0%	22.5%	17.5%	22.5%
Ignored the behavior	20.0%	7.5%	5.0%	17.5%	12.5%
Explained why behavior was wrong	75.0%	70.0%	80.0%	77.5%	75.6%
Praised good behavior	50.0%	42.5%	42.5%	47.5%	45.6%
Put things out of reach	30.0%	10.0%	17.5%	17.5%	18.8%

Indicator 10: Primary caregivers who increased positive discipline practices

Indicator 10 captures the percentage of primary caregivers who increased positive discipline practices with their children. We measured this in two ways:

a) Self-reported change (Indicator 10a): Caregivers' own assessment at endline of whether they increased positive discipline practices

b) Observed longitudinal change (Indicator 10b): The measured difference between endline and baseline in the types of positive discipline practices applied

Both measurements show a substantial increase in positive discipline practices: 80% (n=160) of primary caregivers self-reported using more positive discipline, while objective measurement showed a 47.5% (n=126) increase in the types of positive discipline practices used. Further details are presented in Table 34.

Table 34: Indicator 10: Percent of primary caregivers who increase positive discipline practices with their children endline n=160, longitudinal n=126).

Indicator 10: increase of positive discipline practices	Aginuro	Canacue	Nacuca	Namachaca	Total
I10a Self-reported increase by caregiver	93.8%	80.0%	100%	100%	80.0%
I10b Longitudinal Difference: Types of positive disciplinaries	56.3%	38.7%	58.1%	35.7%	47.5%

The results on discipline practices reveal substantial improvements in caregiving aimed at enhancing child safety and security. Key findings, particularly the reduction in physical punishment and psychological aggression, are highlighted as follows:

1. Physical Punishment:

- Prevalence Reduction: At baseline, 100% of primary caregivers (n=161) reported using physical punishment with children aged 0–3 years. By endline (n=160), this figure dropped sharply to 7.5%. Among the longitudinal sample (n=126), this represents a 94.3% reduction, with some communities, such as the Nacuca district, experiencing an 96.8% decrease.
- Reduction in Types of Punishment: The average number of different types of punishment applied decreased dramatically from 3.30 (baseline) to 0.11 (endline).

2. Psychological Aggression:

- Decrease in Verbal Aggression**:** 34.6% (n=160) of primary caregivers reported using psychological aggression at endline. The longitudinal data indicates a 28.7% reduction (n=126) overall. Furthermore, the average number of forms of verbal aggression applied decreased by approximately 0.29 (on a scale of 2) during endline.

The analysis of primary caregivers' interviews demonstrates a clear and meaningful transformation in discipline practices and parent-child communication. Primary caregivers reported moving away from physical punishment, such as hitting and yelling, and adopting more positive approaches, including patient communication, respectful naming, and calmly explaining behaviors to children. The data also highlights a shift from punitive responses to a greater emphasis on understanding underlying issues and fostering emotional connections, such as hugging and showing affection. These changes reflect the program's impact in promoting nurturing, supportive, and developmentally appropriate interactions between caregivers and children (see Table 35 below for details).

Table 35: Discipline practices and parent-child communication supporting quotes

Topic	Quote	Practice Before	Practice After	Source
Shift from physical punishment	*The topics that made a difference in my children's lives are the patience that I had to learn. Before, when I would speak to the children and they wouldn't listen, I would hit them, and this made them start to be afraid of me, but today, having learned to talk to them and call their attention without hitting, they aren't afraid of me and have more affection for me; when they see me coming from somewhere, they come running and hug me.*	Hitting	Patient communi-cation	ID 304
Respectful communication	*"I also learned that we cannot give ugly insulting names to our children".*	Using insulting names	Respectful naming	ID 205
Positive discipline	*"Before, I would hit my children when they did something wrong, but now, I know that I should talk to them and explain what they did wrong".*	Hitting	Explaining wrong behavior	ID 402
Improved parent-child relationship	*"Now I know how to talk to my children, I explain things to them, and they understand better. Before I would just yell at them".*	Yelling	Explaining and talking	ID 501
Understanding child development	*"I learned that children need patience and understanding. When they misbehave, we should check what is wrong instead of just punishing them".*	Punishing	Checking underlying issues	ID 603
Communication methods	*"The program taught me to get down to their level when talking to children, to look them in the eyes, and speak calmly".*	Not getting to child level	Eye-level calm communi-cation	ID 701

These findings underscore the effectiveness of the intervention in encouraging primary caregivers to replace harsh discipline methods with communication-based, empathetic strategies, ultimately strengthening family relationships and supporting healthy child development.

Unsupervised Care and Child-to-Child Supervision

At endline, none of the primary caregivers (n=160) reported leaving their child alone for more than one hour, marking a decline of 1.9% compared to baseline (see **Error! Reference source not found.**).

Table 36: Difference [endline – baseline] in percentage of primary caregivers who did **NOT** leave their child **alone** for more than one hour per day in the last week by community (baseline n=161, endline =160).

Percentage of primary caregivers that did not leave the child alone for more than one hour per day	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline	100.0%	97.5%	100%	97.3%	99.4%
Endline	97.5%	97.5%	100%	100%	97.5%
Difference [Endline – Baseline]	-2.5%	0%	0%	2.7%	-1.9%

At endline, 68.1% (n=160) of primary caregivers reported that they did not leave their child under the care of another child for more than one hour, representing an improvement of 11.7% compared to baseline (56.4%, n=158). (See **Error! Reference source not found.**). This difference is statistically significant[23].

Table 37: Difference [endline – baseline] in percentage of primary caregivers who did **NOT** leave their child under the **care of another child** for more than one hour per day, by community (baseline n=161, endline =160).

Percentage of primary caregivers that did not leave the child alone for more than one hour per day under the care of another child	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline	52.6%	65.9%	65.0%	40.5%	56.4%
Endline	62.5%	65.0%	77.5%	67.5%	68.1%
Difference [Endline – Baseline]	9.9%	-0.9%	12.5%	27.0%	11.7%

The average number of days primary caregivers left their child under the care of another child for more than one hour per day decreased by 0.33 (baseline: n=161, endline: n=160), indicating a positive shift. (See **Error! Reference source not found.**). This difference is statistically significant[24].

Table 38: Difference [endline – baseline] in average number of days the child was left in the care of another child for more than one hour per day, by community (baseline n= 161, endline =160).

Average number of days the child was left in care of another for more than one hour per day	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline	1.39	0.93	0.90	1.62	1.20
Endline	0.90	0.88	0.73	0.98	0.87
Difference [Endline – Baseline]	-0.49	-0.05	-0.18	-0.65	-0.33

The shift toward shared caregiving responsibilities between parents suggests more consistent adult supervision, which aligns with the quantitative data showing reduced instances of children being left unattended or under the care of other children.

3.3.2.4 Birth registration

At endline, 43.5% (n=126) more primary caregivers reported knowing how to register a child's birth compared to baseline (see Table 39). This difference is statistically significant[25].

Table 39: Percentage of primary caregivers who know how to register a child's birth by community (baseline n= 161; endline n=160, longitudinal n= 126)

[23] p= 0.11 (Paired t-test)
[24] p= 0.11 (Paired t-test)
[25] p < 0.0001 (Paired t-test)

Know how to register a child's birth	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline	52.5%	48.8%	40.0%	77.8%	53.4%
Endline	92.5%	97.5%	97.6%	97.1%	96.3%
Difference [Endline – Baseline]	40.0%	48.7%	57.6%	19.4%	42.8%
Longitudinal diff [Endline-Baseline]	**43.5%**	**41.2%**	**57.6%**	**12.0%**	**43.5%**

Furthermore, at endline, 41.8% more primary caregivers (n=126) who reported having registered their child compared to baseline (see Table 40). This difference is statistically significant[26].

Table 40: Percentage of primary caregivers that registered the birth of their child, by community (baseline n= 161; endline n=160, longitudinal n= 126)

Registered birth of child	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline	7.9%	24.4%	12.5%	23.5%	15.4%
Endline	65.0%	75.0%	41.5%	54.3%	55.6%
Difference [Endline – Baseline]	57.1%	50.6%	29.0%	30.8%	40.2%
Longitudinal diff [Endline-Baseline]	**56.3%**	**51.6%**	**29.4%**	**33.3%**	**41.8%**

In summary, there has been significant progress in both awareness and practice regarding birth registration among primary caregivers. At endline, primary caregivers demonstrated a substantial increase in their knowledge of how to register a child's birth, with a 43.5% longitudinal increase. Furthermore, the percentage of primary caregivers who successfully registered their child's birth rose by 41.8%. While these findings reflect positive strides in child welfare practices, challenges persist, particularly in communities with lower rates of progress. Continued support and targeted interventions are essential to ensure the universal adoption of birth registration practices, thereby securing children's legal identity and access to services.

3.3.2.5 Indictor 4: parenting practices score

Indicator 4: Primary caregivers' parenting practices score is used to summarize parental practices into a single score ranging from 0 to 10, where 0 is the lowest and 10 is the highest. The indicator is composed of three core components of parenting: responsive care, early learning, and child safety & security. Each of these components is a relevant sub-indicator, with its own specific aspects. These aspects are mapped to the survey questions, and each sub-indicator is also scored on a scale from 0 to 10. The sub-indicators are as follows:

I4a Responsive Care: Includes the following aspects:

1) Not leaving the child alone
2) Positive corrective behavior

[26] $p < 0.0001$ (Paired t-test)

I4b Early Learning: Includes the following aspects:

1) Total number of stimulating activities per week
2) Average number of different stimulating activities
3) Number of different play materials used
4) Number of books in the household

I4c Child Safety & Security: Includes the following aspects:

1) Physical punishment
2) Verbal punishment
3) Child birth registration

This structure ensures that each aspect of parenting is measured comprehensively while maintaining a clear, consistent scoring system.

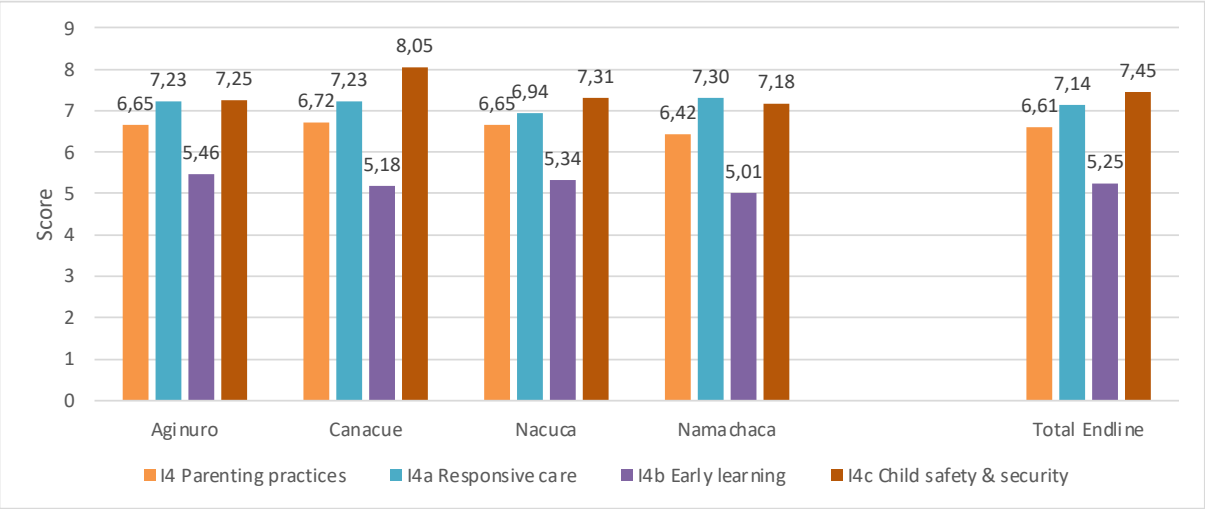
The average parental practice score (indictor 4) for the endline for all the communities is 6.61 [out of score between 0 and 10], as listed in Table 41 and Figure 13 below. The average parental practice score (Indicator 4) is highest in Aginuro community (6.72) and lowest at 6.42 in Namachaca community.

The other parental (sub)indicator scores for the endline survey are: an average score of 7.14 for responsive care; 5.25 for early learning and 7.45 for child safety and security.

Table 41: Indicator 4: Parenting practices [score 0-10]: responsive care (I4a), early learning, (I4b) and child safety & security (I4c), disaggregated per community (endline, n=160)

Parenting practices indicators		Aginuro	Canacue	Nacuca	Namachaca	Total
I4	**Parenting practices**	**6.65**	**6.72**	**6.65**	**6.42**	**6.61**
I4a	Responsive care	7.23	7.23	6.94	7.30	7.14
I4b	Early learning	5.46	5.18	5.34	5.01	5.25
I4c	Child safety & security	7.25	8.05	7.31	7.18	7.45

Figure 13: Indicator 4: Parenting practices = responsive care (I4a), early learning, (I4b) and child safety & security (I4c), disaggregated per community (endline, n=160)



At endline, there was a notable improvement of 1.75 (n=126) in parenting practices (Indicator 4), see also Table 42. This difference is statistically significant[27]. The Aginuro community saw the most significant improvement, with a +1.98 increase. All three sub-indicators of parenting practices showed improvements at endline:

- Child safety & security (Indicator 4c) experienced the largest increase, with a +3.80 improvement. This difference is statistically significant[28].
- Early learning (Indicator 4b) followed closely with a +0.93 increase. This difference is statistically significant[29].
- Responsive care (Indicator 4a) showed a more modest improvement of +0.51. This difference is statistically significant[30].

These results reflect overall progress in caregiving practices across the communities, with particularly significant gains in child safety and security (see Table 42 and Figure 14).

[27] $p < 0.0001$ (Paired t-test)
[28] $p < 0.0001$ (Paired t-test)
[29] $p < 0.0001$ (Paired t-test)
[30] $p = 0.0039$ (Paired t-test)

Table 42: Indicator 4: parenting practices (Score 0-10) – Responsive care (I4a), Early learning (I4b), and Child safety & security (I4c), by Community (baseline n= 161; endline n=160, longitudinal n= 126)

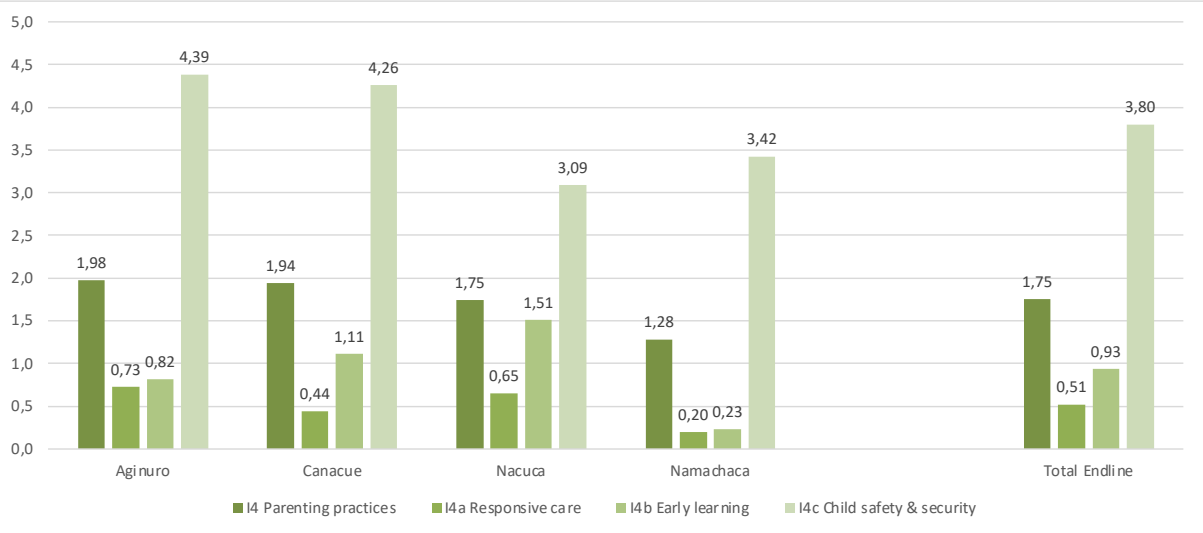
Parenting practices indicators	Aginuro	Canacue	Nacuca	Namachaca	Total
I4: Baseline	4.82	4.82	4.89	5.07	4.90
I4: Endline	6.65	6.72	6.65	6.42	6.61
I4: Difference [Endline – Baseline]	1.83	1.90	1.76	1.35	1.71
I4: Parenting practices: Longitudinal diff [Endline-Baseline]	**1.98**	**1.94**	**1.75**	**1.28**	**1.75**
I4a: Baseline	6.81	6.40	6.63	6.65	6.62
I4a: Endline	7.23	7.23	6.94	7.30	7.14
I4a: Difference [Endline – Baseline]	0.42	0.82	0.32	0.65	0.52
I4a: Responsive care: Longitudinal diff [Endline-Baseline]	**0.73**	**0.44**	**0.65**	**0.20**	**0.51**
I4b: Baseline	4.72	4.03	4.08	4.57	4.34
I4b: Endline	5.46	5.18	5.34	5.01	5.25
I4b: Difference [Endline – Baseline]	0.75	1.14	1.26	0.44	0.91
I4b: Early learning: Longitudinal diff [Endline-Baseline]	**0.82**	**1.11**	**1.51**	**0.23**	**0.93**
I4c: Baseline	2.93	4.02	3.98	4.00	3.74
I4c: Endline	7.25	8.05	7.31	7.18	7.45
I4c: Difference [Endline – Baseline]	4.32	4.03	3.33	3.18	3.71
I4c: Child safety & security: Longitudinal diff [Endline-Baseline]	**4.39**	**4.26**	**3.09**	**3.42**	**3.80**

The percentage of primary caregivers that demonstrated an improvement in all three parental practices categories: Responsive care AND Early learning AND Child safety & security is 35.2% (n=160), see Table 43.

Table 43: Indicator 4: Percent of primary caregivers who demonstrate an improvement in parenting practices in responsive care, early learning, child safety & security disaggregated per community (endline, n=160)

Percentage of primary caregivers who demonstrated improvement		Aginuro	Canacue	Nacuca	Namachaca	Total
I4%	In ALL 3 parenting practices categories: Responsive care AND Early learning AND Child safety & security	40.6%	40.6%	25.8%	28.6%	35.2%
I4a%	In Responsive care	62.5%	62.5%	48.4%	50.0%	55.7%
I4b%	In Early learning	59.4%	59.4%	67.7%	42.9%	60.7%
I4c%	In Child safety & security	100%	100%	100%	100%	100%

Figure 14: Indicator 4: parenting practices (Score 0-10) – Responsive care (I4a), Early learning (I4b), and Child safety & security (I4c), by Community (baseline n=161; endline n=160, longitudinal n=126)



The findings from indicator 4 reveal significant improvements in parenting practices across all communities. The overall parenting practices score increased by 1.75 points from baseline to endline, with the greatest improvement observed in the Aginuro community. Notably, the child safety & security component showed the most substantial progress, followed by early learning and responsive care.

These quantitative results are further enriched by qualitative insights, which provide deeper context for the observed changes. Primary caregivers reported a clear shift in their practices, with many adopting more positive and nurturing approaches to child-rearing. For example, primary caregivers expressed a newfound understanding of non-violent discipline, aligning with the reductions in physical punishment and psychological aggression observed in the data.

Additionally, early learning emerged as a key focus for many primary caregivers, as reflected in their active engagement in play-based learning and stimulating activities with their children. The reported

improvements in healthcare-seeking behaviors and child safety underscore the broader impact of these changes on children's well-being.

In conclusion, the combination of quantitative improvements in parenting practices, along with the qualitative evidence of primary caregivers' evolving attitudes and behaviors, highlights the program's success in fostering healthier, more engaged, and safety-conscious caregiving. Continued support and expansion of these interventions are crucial for sustaining and deepening these positive shifts in caregiving practices.

3.3.3 Outcome 3: Psychosocial well-being of primary caregiver

3.3.3.1 Indicator 5: Community connectedness

Indicator 5 is the percentage of primary caregivers who report feeling connected to AND feel other primary caregivers in their group care about them AND feel supported in their community (see annex C details are provided for the calculation indicator 5).

Almost all the primary caregivers 94.4% (n=160) at the endline in all the communities agree or strongly agree that they feel in solidarity/common with the other primary caregivers, 94.4% (n=160) feel that other primary caregivers in the community care about them, and 93.8% (n=160) feel supported by their community.

These three aspects are combined into a single indicator. Overall, 91.3% (n=160) of the primary caregivers at endline do feel supported and connected by peers in the community (see Table 44).

Indicator 5 showed a 2.4 percentage point improvement from baseline to endline (longitudinal), reflecting an increase in the proportion of primary caregivers who reported feeling connected to and supported by their peers and community (see Table 45).

Table 44: Indicator 5: Feeling supported and connected by peer primary caregivers in the community, by community (endline n=160)

I5: Feel supported in community	Aginuro	Canacue	Nacuca	Namachaca	Total
Feel in common with other primary caregivers	92.5%	87.5%	97.5%	100%	94.4%
Feel other primary caregivers care about you	92.5%	92.5%	95.0%	97.5%	94.4%
Feel supported as primary caregiver by community	92.5%	87.5%	95.0%	100%	93.8%
I5: Feel supported and connected by peers in community	**87.5%**	**85.0%**	**95.0%**	**97.5%**	**91.3%**
Have all the support needed from the community	87.5%	85.0%	95.0%	97.5%	91.3%

Table 45: Indicator 5: Feeling supported and connected by peer primary caregivers in the community, by community (baseline n=161; endline n=160, longitudinal n=126)

I5: Feel supported in community	Aginuro	Canacue	Nacuca	Namachaca	Total
I5: Baseline	80.0%	95.1%	92.5%	87.5%	88.8%
I5: Endline	87.5%	85.0%	95.0%	97.5%	91.3%
I5: Difference [Endline – Baseline]	7.5%	-10.1%	2.5%	10.0%	2.4%
I5: Longitudinal diff [Endline-Baseline]	**8.8%**	**-6.5%**	**0%**	**10.0%**	**3.2%**

Although over 90% of primary caregivers felt connected to their peers at both the baseline and endline, there was a significant increase (+57.9%, n=126) in the number of primary caregivers who reported actually receiving all the support they needed from the community (see Table 46). This difference is not statistically significant.

Table 46: Percentage of primary caregivers who have all the support needed from the community, disaggregated by community (baseline n=161; endline n=160, longitudinal n=126)

Have all the support needed from the community	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline	31.7%	31.7%	30.0%	25.0%	32.3%
Endline	91.3%	85.0%	95.0%	97.5%	91.3%
Difference [Endline – Baseline]	59.5%	53.3%	65.0%	72.5%	59.0%
Longitudinal diff [Endline-Baseline]	**44.1%**	**54.8%**	**64.5%**	**70.0%**	**57.9%**

45.0% (n=160) of primary caregivers at endline reported asking their ECD volunteer (who visited their homes and led their caregiver support groups) for parenting information, advice, help, or referrals for services (either for themselves as primary caregivers or for their children). In addition, 65.6% (n=160) of the primary caregivers reported the support to be very helpful (see Table 47). The topics for assistance were: general childcare, nutrition and health care.

Table 47: Primary caregiver has asked ECD volunteer who visited you at home for parenting information, advice, help or referrals for services (endline n=160)

Support from ECD volunteer	Aginuro	Canacue	Nacuca	Namachaca	Total
Ask for parenting information, advice, help or referrals for service	42.5%	55.0%	42.5%	40.0%	45.0%
Very helpful	60.0%	72.5%	66.7%	65.0%	65.6%
Somewhat helpful	15.0%	15.0%	23.1%	15.0%	16.9%
Not really able to help	10.0%	0%	0%	2.5%	3.8%
Don't remember/don't know/refuse to answer	15.0%	12.5%	10.3%	17.5%	13.8%

All primary caregivers (100%, n=160) at endline reported to have received support (advice, counselling, and other forms of support other than material support) mostly (72.5%, n=160) from the volunteers (ECD Promoters) followed by support from Elders (50.3%, n=160), the community leaders (45.6%, n=160), neighbors (36.9%, n=160) and faith leaders (32.9%, n=160). See Table 48 for the details by community.

Table 48: Support received by primary caregivers (advice, counseling, and non-material support) by Community at Endline (n=160)

Received support by primary caregivers	Aginuro	Canacue	Nacuca	Namachaca	Total
Elders	48.6%	38.2%	64.1%	48.7%	50.3%
Neighbours	35.1%	50.0%	46.2%	17.9%	36.9%
Faith leaders/elders	43.2%	20.6%	35.9%	30.8%	32.9%
Community leaders	32.4%	41.2%	41.0%	66.7%	45.6%
Volunteers (ECD Promoters)	64.9%	82.4%	76.9%	66.7%	72.5%
Family	13.5%	2.9%	4.7%	0%	5.2%

Qualitative analysis of data demonstrates significant strengthening of social connections and collective responsibility for early childhood development. Committee members and promoters report transformative changes in community childcare practices, with promoters regularly meeting to exchange experiences and learn from each other, fostering a network of shared knowledge and support. The program has catalyzed increased male participation in childcare activities, with fathers now engaging in traditionally female-dominated tasks such as bathing children and accompanying mothers to health centers. This evolution in gender norms, combined with promoters' collaborative learning approach, represents a broader transformation in community cohesion and shared responsibility for child wellbeing. While committee members demonstrate strong commitment to maintaining these positive changes through their monitoring and support roles, they identify specific material needs, such as bicycles and basic supplies, that could enhance their capacity to sustain community engagement and program effectiveness. See also Table 49.

Table 49: Community connectedness supporting quotes

Topic	Quote	Impact	Source
Promoter networks	*"Promoters meet regularly to exchange experiences and support each other in their work with families."*	Creates ongoing learning and support system	Promoter (Aginuro)
Social transformation	*"The committee members consistently describe a positive transformation in their communities regarding childcare practices."*	Demonstrates community-wide shift in childcare approaches	Committee Member (Nacuca)
Gender role integration	*"Men are now more involved in activities traditionally considered women's responsibilities, such as bathing children, helping with household chores, and accompanying mothers to health centers."*	Shows breakdown of traditional gender barriers	Faith Leader (Aginuro)

Community monitoring	*"Committee members emphasize their role in ensuring program quality through monitoring promoters and providing additional support when needed."*	Indicates active community oversight	All Committee Members
Sustainability needs	*"Nearly all committee members mention the need for some form of compensation or material support (like bicycles, notebooks, or even soap) to better fulfill their responsibilities."*	Demonstrates ongoing challenges affecting the program	All committee Members

3.3.3.2 Indicator 1: increased confidence in handling parenting responsibilities successfully

Indicator 1 measures the percentage of primary caregivers who have increased confidence in handling their parenting responsibilities. This is based on their level of confidence in managing their caregiving duties. Two versions of primary caregiver confidence are used:

I1a: 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.

I1b: 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[31].

These versions provide a nuanced view of primary caregivers' confidence in their ability to manage their parenting duties. Details for the calculation of Indicator 1 are provided in Annex C. It is important to note that the value of Indicator 1a will always be greater than or equal to the value of Indicator 1b, given that Indicator 1b is a subset of Indicator 1a. At endline, 53.8% (n=160) of primary caregivers reported that caring for their children has not taken more time and energy, 65.6% (n=160) not feeling overwhelmed and 57.5% (n=160) reported that they do not feel worried about whether they are doing enough for their child. Additionally, 72.5% (n=160) of primary caregivers reported feeling confident in their role as primary caregivers (Indicator 1a), while 43.8% (n=160) reported feeling fully confident (Indicator 1b) (see Table 50).

Table 50: Indicator 1: Primary caregivers who report confidence in handling parenting responsibilities successfully, by community (endline, n= 160)

I1: Mental situation	Aginuro	Canacue	Nacuca	Namachaca	Total
NOT taken more time/energy	52.5%	45.0%	57.5%	68.6%	53.8%
NOT overwhelmed	60.0%	57.5%	67.5%	57.5%	65.6%
NOT worried doing enough	52.5%	50.0%	57.5%	68.6%	57.5%
I1a: Feeling confident	**67.5%**	**67.5%**	**77.5%**	**74.3%**	**72.5%**
I1b: Feeling fully confident	**40.0%**	**32.5%**	**45.0%**	**57.5%**	**43.8%**

[31] Key difference: I1a reflects a general tendency ("do not believe", "have not felt") — suggesting moderate confidence of at least one I1b implies a stronger, more consistent confidence — with more definitive wording ("believe that... has not", "have not felt").

Indicator 1a (feeling confident) has increased significantly by +52.4% (n=126) at endline compared to baseline (see Table 51). This difference is statistically significant[32]. Similarly, Indicator 1b (feeling fully confident) has also shown improvement, with a +34.9% increase (n=126) at endline. These improvements indicate a strong positive shift in primary caregivers' confidence in managing their parenting responsibilities (see Table 52). These gains reflect a positive shift in primary caregivers' ability to manage their responsibilities, with more primary caregivers feeling assured in their caregiving role. This difference is statistically significant[33].

Table 51: Indicator 1a: Primary caregivers who report feeling confidence in handling parenting responsibilities successfully, by community (baseline n=161; endline n=160, longitudinal n= 126)

Mental situation I1a: Feeling confident	Aginuro	Canacue	Nacuca	Namachaca	Total
I1a: Baseline	24.2%	24.4%	22.5%	22.5%	24.2%
I1a: Endline	67.5%	67.5%	77.5%	74.3%	72.5%
I1a: Difference [Endline – Baseline]	43.3%	43.1%	55.0%	51.8%	48.3%
I1a: Longitudinal [diff Endline-Baseline]	**44.1%**	**48.4%**	**61.3%**	**56.7%**	**52.4%**

Table 52: Indicator 1b: Primary caregivers who report feeling fully confidence in handling parenting responsibilities successfully, by community (baseline n=161; endline n=160, longitudinal n=126)

Mental situation I1b: Feeling **fully** confident	Aginuro	Canacue	Nacuca	Namachaca	Total
I1b: Baseline	0%	4.9%	15.0%	0%	5.0%
I1b: Endline	40.0%	32.5%	45.0%	57.5%	43.8%
I1b: Difference [Endline – Baseline]	40.0%	27.6%	30.0%	57.5%	38.8%
I1b: Longitudinal diff [Endline-Baseline]	**41.2%**	**16.1%**	**29.0%**	**53.3%**	**34.9%**

The above-mentioned improvements indicate that a majority of primary caregivers are increasingly confident in their parenting roles. The larger gain observed in the broader confidence measure (Indicator 1a) suggests that while many primary caregivers feel generally equipped to handle their responsibilities, there remains a significant gap to achieve full confidence (Indicator 1b). The data imply that while basic supports and information are making a difference, additional targeted interventions may be required to boost the full confidence levels among primary caregivers. Table 53 below highlights themes that emerged from the qualitative interviews to support the findings above.

[32] $p < 0.0001$ (Paired t-test)
[33] $p < 0.0001$ (Paired t-test)

Table 53: Qualitative insights on confidence in handling parenting responsibilities successfully at Endline

Aspect of confidence	Quote	Source
Improved communication skills	*"Before, when I would speak to the children and they wouldn't listen, I would hit them, and this made them start to be afraid of me, but today, having learned to talk to them and call their attention without hitting, they aren't afraid of me and have more affection for me; when they see me coming from somewhere, they come running and hug me."*	ID 402
Applying Knowledge of Child Development	*"I also learned that there are certain phases for a child to begin developing. For example, when a child does not cry from the day they are born until a month or two months pass, if we don't take this child to the hospital, they might have problems speaking in the future. I also learned that when a child completes 3 months and cannot follow an object, they might also have a problem..."*	ID 509
Nutrition and Feeding	*"I really liked learning about how to make enriched porridge, and when I started giving it to my child, I saw her gaining weight and getting beautiful skin."*	ID 603
Healthcare decision-making	*"Yes, the program did change the way I care for and educate my children... before, when the child was sick, I would take them to the traditional healer, but today I always take them to the hospital."*	ID 603
Positive discipline	*"Before, I used to hit my children a lot, and now I no longer do this because when this program came to our community, it spoke about these aspects, and the community in general understood. Yes, I've noticed changes in my children because in the past, some of my children refused to go to school, but now they already go to school, and the younger children already know how to sing and dance by themselves"*	ID 1705
Creating learning environment	*"I never thought that women could also make toys for children instead of just the fathers. Today, because of this program, men no longer leave everything to women..."*	ID 402
Managing family dynamics	*"The program also helped me a lot with my personal and family problems; today I am more patient and tolerant because they teach us ways of coexistence, respect for others, they teach us to have faith and put everything in God's hands, and my relationship has improved a lot..."*	ID 901
Hygiene and Sanitation	*"I also learned how to clean my house, build a bathroom and latrines, and when we use the bathroom, we have to wash our hands with water and soap to avoid diseases. I also learned that we shouldn't give porridge just once a day. We have to give porridge in the morning and afternoon so that the child becomes strong and healthy."*	ID 702
Financial management	*"I'm enjoying the experience of saving, and today I can have money saved up that I later use to buy things for my children and for myself, and I'm even thinking about starting a business."*	ID 402
Sharing knowledge with others	*"Yes, I learned about child development or parenting from another person here in the community, it was my sister who taught me to care for my child, saying that for a child to have good development, we should not make the child sit before they complete at least 6 months of life because it can harm the child's spine. After the child is born, we cannot take the child outside or give them to just anyone in their first days and months of life because that child could be transmitted any type of disease."*	ID 509

In conclusion, the significant increase in general confidence (+52.4%) reflects improvements in primary caregivers' knowledge and skills. However, the lower rate of full confidence (+34.9%) appears to be tied to ongoing external challenges, such as economic and infrastructure barriers, rather than a lack of

knowledge. The gap between general and full confidence suggests that while the program effectively enhances parenting capacity, additional external support is likely necessary to help primary caregivers achieve higher levels of full confidence in their parenting role.

3.3.3.3 Indicator 2: parental stress

Indicator 2 captures the percentage of primary caregivers who report decreased parental stress. For this the level of parental stress is needed. The following two versions are used:

I2a Primary caregivers that report **any** parental stress as primary caregivers do feel that caring for their children has taken more time and energy **OR** have felt overwhelmed by the responsibilities of being a primary caregiver **OR** have felt worried whether they are doing enough for their child.

I2b Primary caregivers that report **full** parental stress: as primary caregivers do feel that caring for their children has taken more time and energy **AND** have felt overwhelmed by the responsibilities of being a primary caregiver **AND** have felt worried whether they are doing enough for their child.

Indicator 2a is the percentage of primary caregivers that report any parental stress and Indicator 2b is the percentage of primary caregivers that feel **full** parental stress. Note that the Indicator 2a value is by definition greater or equal to Indicator 2b value. Though Indicators 1 and 2 look each other inverse based on the same underlying questions, there is a subtle difference as they take different answers into account, see annex C for more details on the calculation of the indicators.

At endline, 55.6% (n=160) of primary caregivers reported experiencing any parental stress, while 27.5% (n=160) reported experiencing full parental stress. Comparing endline with baseline, there was a 35.7% (n=126) decrease in the reporting of any parental stress (Indicator 2a). The difference is statistically significant[34]. In addition, there is a 50.8% decrease in primary caregivers reporting full parental stress (Indicator 2b, n=126). The difference is statistically significant[35]. These reductions indicate significant improvements in primary caregivers' stress levels over time (see Table 54 and Table 55).

Table 54: Indicator 2a: Percent of primary caregivers who report parental stress, by community, disaggregated per community (baseline n=161; endline n=160, longitudinal n=126)

Parental Stress I2a Report any parental stress	Aginuro	Canacue	Nacuca	Namachaca	Total
I2a: Baseline	100%	95.1%	85.0%	97.5%	94.4%
I2a: Endline	60.0%	67.5%	52.5%	42.5%	55.6%
I2a: Difference [Endline – Baseline]	-40.0%	-27.6%	-32.5%	-55.0%	-38.8%
I2a: Longitudinal diff [Endline-Baseline]	-41.2%	-16.1%	-32.3%	-53.3%	-35.7%

[34] $p < 0.0001$ (Paired t-test)
[35] $p < 0.0001$ (Paired t-test)

Table 55: Indicator 2b: Primary caregivers who report feeling full parental stress in handling parenting responsibilities successfully, by community (baseline n=161; endline n=160, longitudinal n= 126)

Parental Stress I2b Report full parental stress	Aginuro	Canacue	Nacuca	Namachaca	Total
I2b: Baseline	72.5%	75.6%	77.5%	75.0%	75.2%
I2b: Endline	32.5%	32.5%	22.5%	22.5%	27.5%
I2b: Difference [Endline – Baseline]	-40.0%	-43.1%	-55.0%	-52.5%	-47.7%
I2b: Longitudinal diff [Endline-Baseline]	**-44.1%**	**-48.4%**	**-61.3%**	**-53.3%**	**-50.8%**

The qualitative interviews reveal that primary caregivers have experienced a notable increase in parental confidence as a result of their participation in the program. Primary caregivers report feeling more capable in managing their children's behavior, making informed decisions, and applying new parenting strategies learned through training and peer exchange. This enhanced confidence is reflected in their willingness to try new approaches, their pride in positive changes observed in their children, and their active engagement in sharing experiences with other parents. The supportive environment created by regular meetings and community networks has further reinforced caregivers' belief in their abilities, contributing to a sustained sense of empowerment and self-efficacy in their parenting roles as summarized by Table 56 below.

Table 56: Parental confidence supporting quotes

Topic	Quote	Impact	Source
Increased confidence in parenting	*"Now I know how to talk to my children, I explain things to them, and they understand better. Before I would just yell at them."*	Caregivers feel more capable and effective	Multiple caregivers
Willingness to try new approaches	*"The topics that made a difference in my children's lives are the patience that I had to learn... today, having learned to talk to them... they have more affection for me."*	Caregivers adopt and trust new strategies	ID 402
Peer learning and support	*"Promoters meet regularly to exchange experiences and support each other in their work with families."*	Confidence reinforced through peer interaction	Promoter
Pride in positive change	*"I learned that children need patience and understanding. When they misbehave, we should check what is wrong instead of just punishing them."*	Caregivers recognize and value their own progress	ID 603

3.3.4 Outcome 4: Gender-equitable roles in parenting

3.3.4.1 Indicator 6: fathers' involvement (as secondary caregivers)

Indicator 6 measures the percentage of fathers (as secondary caregivers) who have increased the time spent intentionally interacting or playing in the last week with their children aged 0-3 years. At endline, more than half of the fathers (55.6%, n=160) across all communities reported spending 3 or more days in the last week interacting or playing with their children in the past week (see Table 57). However, this represents an 8.7% decrease (longitudinal sample of n=126) compared to baseline. The difference is not

statistically significant. This lack of significance could be attributed to natural variability within the short 7-day measurement period, during which some fathers may have temporarily altered their typical involvement patterns due to other commitments or responsibilities.

Table 57: Percentage of fathers interacting with their children per community (baseline n=161; endline n=160, longitudinal n=126)

I6: Fathers interacting with their children	Aginuro	Canacue	Nacuca	Namachaca	Total
I6: Baseline	65.0%	73.2%	72.5%	50.0%	65.2%
I6: Endline	52.5%	65.0%	50.0%	55.0%	55.6%
I6: Difference [Endline – Baseline]	-12.5%	-8.2%	-22.5%	5.0%	-9.6%
I6: Longitudinal diff [Endline-Baseline]	**-14.7%**	**-3.2%**	**-12.9%**	**-3.3%**	**-8.7%**

The qualitative data highlights a significant increase in fathers' involvement in childcare and early childhood development within the community. Interviews reveal that men are now participating in activities traditionally considered the responsibility of women, such as bathing children, assisting with household chores, and accompanying mothers to health centers. This shift not only reflects changing gender norms but also demonstrates a broader commitment to shared parenting and family well-being. Both committee members and caregivers recognize and celebrate this transformation, with mothers specifically noting the positive impact of fathers' increased engagement on family dynamics. The active participation of fathers is identified across multiple stakeholder groups as a key achievement of the program, contributing to stronger family bonds and improved outcomes for children, see Table 58

Table 58: Father behavioral change at home supporting quotes

Topic	Quote	Impact	Source
Participation in Childcare	*"Many committee members also highlight the changing role of fathers in childcare as a significant achievement of the program, noting that men are now more involved in activities traditionally considered women's responsibilities, such as bathing children, helping with household chores, and accompanying mothers to health centers."*	Demonstrates increased engagement in daily care	Committee Member
Support for Mothers	*"Men are now more involved in activities traditionally considered women's responsibilities, such as... accompanying mothers to health centers."*	Fathers provide practical and emotional support	Committee Member
Community Recognition	*"The changing role of fathers in childcare is a significant achievement of the program."*	Community values and encourages fathers' roles	Committee Member
Caregiver Recognition	*"My husband now helps with the children. He bathes them and plays with them. This has made a big difference in our home."*	Mothers acknowledge and value fathers' involvement	Caregiver

This is also corroborated by the majority of the primary caregivers (mothers)that reported that 83.1% (n=142) of the fathers increased their time spent intentionally interacting/playing with child(ren) (0-3)

since the MTM program was commenced, while 6.3% (n=142) reported that the father has spent less time (see Table 59).

Table 59: Percentage of fathers interacting with their children per community (n=142)

Time spent by interacting with child by father since the participation in the program	Aginuro	Canacue	Nacuca	Namachaca	Total
Father interacted more	87.5%	82.9%	76.9%	86.8%	83.1%
Father interacted the same as in the beginning	6.3%	11.4%	7.7%	5.3%	6.3%
Father interacted less	6.3%	5.7%	15.4%	7.9%	6.3%

Several barriers hinder fathers' participation in childcare activities as were highlighted by the interviewees. Traditional gender norms and cultural expectations have historically limited men's involvement in childcare, with these activities being primarily viewed as women's responsibilities. Economic constraints also emerge as a significant barrier, with committee members noting the need for material support like bicycles and basic supplies to facilitate greater participation in program activities. The program's recognition of fathers' increased involvement as a "significant achievement" suggests these barriers are gradually being overcome, though continued support may be needed to sustain this positive transformation, see also Table 60.

Table 60: Barriers for father participation supporting quotes

Topic Barrier type	Quote	Impact	Source
Cultural norms	*"...activities traditionally considered women's responsibilities"*	Childcare viewed as primarily women's role	Faith leader
Traditional gender roles	*"...changing role of fathers in childcare as a significant achievement"*	Historical limitation of father involvement	Committee member
Economic constraints	*"Nearly all committee members mention the need for some form of compensation or material support (like bicycles, notebooks, or even soap)"*	Lack of resources limits participation	Committee member
Historical practices	*"Men are now more involved..." suggesting previous lack of involvement*	Changing social dynamics and roles	Promoter

3.3.5 Outcome 5: Economic empowerment of primary caregiver

Change in Household assets since joining the program

At endline, 32.5% (n=160) of primary caregivers reported being part of a savings group (see Table 61). This marks an improvement of +16.7% (longitudinal sample n=126) compared to baseline, indicating a substantial expansion of financial inclusion among primary caregivers. This difference is not statistically significant.

Table 61: Percentage of primary caregivers who are part of a Savings & Loan Group, by community (baseline n=161; endline n=160, longitudinal n= 126)

Member of a Savings & Loan Group	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline	12.5%	14.6%	5.0%	17.5%	12.4%
Endline	35.0%	35.0%	42.5%	17.5%	32.5%
Difference [Endline – Baseline]	22.5%	20.4%	37.5%	0%	20.1%
Longitudinal diff [Endline-Baseline]	**23.5%**	**9.7%**	**38.7%**	**-6.7%**	**16.7%**

3.3.5.1 Indicator 7: started or expanded micro-businesses using loans or savings

Indicator 7 measures the percentage of Savings & Loan Group members who have started or expanded micro-businesses using loans or savings. Among the 52 primary caregivers who reported being members of savings & loan groups, zero (0%) started new businesses or expanded existing ones using loans or their savings. For further details on the calculation of Indicator 7, please refer to Annex C. None (0%, n = 52) of primary caregivers reported starting or expanding their business with financial products such as loans or savings (see Table 62).

Table 62: Indicator 7: Started or expanded business using loan or savings, by community (endline n= 52)

Business related activities	Aginuro	Canacue	Nacuca	Namachaca	Total
# started or expanded business using loan or savings	0	0	0	0	0
# part of a Savings & Loan Groups	14	14	17	7	52
I7: started or expanded business using loan or savings	**0%**	**0%**	**0%**	**0%**	**0%**

The number of primary caregivers who started or expanded a business using loans or savings decreased by 20.0% (n=20) compared to baseline (see Table 63).

Table 63: Indicator 7: started or expanded business using loan or savings disaggregated per community (baseline n= 24; endline n=20)

Start or expanded a business using a loan or savings	Aginuro	Canacue	Nacuca	Namachaca	Total
I7: Baseline	60.0%	0%	0%	14.3%	20.0%
I7: Endline	0%	0%	0%	0%	0%
I7: Difference [Endline – Baseline]	-60.0%	0%	0%	-14.3%	-20.0%

Table 64: Timeframe of Current Business Establishment by Caregivers (endline, n= 20)

Start of business	Aginuro	Canacue	Nacuca	Namachaca	Total
Before joining the Savings & Loan Groups	0%	0%	0%	0%	0%
After joining the Savings & Loan Groups	0%	0%	0%	0%	0%

The qualitative analysis of data reveals valuable insights into the role and impact of Savings & Loan Groups among primary caregivers. Savings & Loan Groups are mentioned as important community-based initiatives that provide financial support and foster social cohesion. Primary caregivers report that participation in these groups enables them to save money, access small loans, and better manage household expenses. This financial empowerment contributes to increased confidence and stability, allowing primary caregivers to invest in their children's well-being and education. Additionally, Savings & Loan Group serve as platforms for sharing experiences and building supportive networks among caregivers, further strengthening community ties, see also Table 79.

Table 65: Savings & Loan Group benefits supporting quotes

Aspect of Savings Groups	Quote	Impact	Source
Financial Support	*"Through the savings group, I was able to borrow money to buy school supplies for my children."*	Improved ability to meet children's needs	Primary caregiver
Social Cohesion	*"Meeting with other mothers in the savings group helps us support each other."*	Strengthened community bonds and mutual support	Primary caregiver
Empowerment and Confidence	*"Being part of the group makes me feel more confident in managing my finances."*	Increased caregiver confidence and self-efficacy	Primary caregiver

3.3.5.2 Indicator 8: change in assets since joining the program

Indicator 8 measures the percentage of households that report a change in assets since joining the program. To determine this change at baseline, two key aspects are considered: The number of households that purchased household items using loans or savings from being in the savings and loan program; and the number of households that are part of a Savings & Loan Group. Refer to Annex C for further details on the calculation of Indicator 8.

None of the primary caregivers at endline (32.5%, n=160) who reported being part of the Savings & Loan Group purchased any household items (see Table 66).

Table 66: Household that purchased household items using loans or savings from being in the Savings & Loan Groups by community (endline, n=52)

Household that purchased items	Aginuro	Canacue	Nacuca	Namachaca	Total
Household that purchased any item	0	0	0	0	0
Number of saving group members	14	14	17	7	52
I8a: Number of purchased assets with loans received	**0**	**0**	**0**	**0**	**0**
I8b: Percentage of households that purchased assets with loans received	**0%**	**0%**	**0%**	**0%**	**0%**

There was a 25.0% decrease (n =52) at endline in the number of households that purchased household items using loans or savings, compared to baseline (see Table 67).

Table 67: I8b: Households that purchased household items using loans or savings from being in the Savings & Loan Groups, by community (baseline n= 24; endline n=52)

I8b: Percentage of households that purchased assets with loans received	Aginuro	Canacue	Nacuca	Namachaca	Total
I8b: Baseline	40.0%	33.7%	0%	14.3%	25.0%
I8b: Endline	0%	0%	0%	0%	0%
I8b: Difference [Endline – Baseline]	-40.0%	-33.7%	0.%	-14.3%	-25.0%

Savings and/or loans to start or expand income generating activities

At endline, 12.5% (n=160) of primary caregivers reported having a business, highlighting that a segment of participants are actively engaged in income generation (see Table 68).

Table 68: Savings/loans to start/expand income generating activities, by community at endline (n=160)

Business related activities	Aginuro	Canacue	Nacuca	Namachaca	Total
Own or manage a business	10.0%	10.0%	15.0%	15.0%	12.5%
Start new business using loan or savings	0%	0%	0%	0%	0%
Expand business using loan or savings	0%	0%	0%	0%	0%

3.3.6 ECD Committees

Indicator 9: Percent of ECD Committees who provide supportive supervision

Comprehensive progress reports from ECD Committees across all four communities (2023-2025) demonstrate that 100% of committees are providing effective supportive supervision. This is evidenced by completed verification checklists and documented meeting notes. The committees consistently address and document all supervision areas, including:

- Home visits
- Caregiver support group observations
- Program quality improvement activities

Table 69: Indicator 9: Percent of ECD Committees who provide supportive supervision one in each district

Indicator I9: ECD Committee provide supportive supervision	Total
I9: Percent of ECD Committees who provide supportive supervision	100%

The qualitative interviews with committee members revealed that virtually all ECD Committees provide supportive services to both promoters and caregivers in their communities in the following ways:

Support to Promoters:

- Supervision and monitoring of work quality (100% of committees)
- Problem resolution between promoters and caregivers
- Advisory guidance on work improvement
- Performance feedback after session observations

Support to Caregivers:

- Reinforcement of ECD messages
- Community sensitization and program promotion
- Conflict mediation with promoters
- Health service referrals
- Child development guidance

All committees (100%) provide supervision to promoters, though quality and frequency vary. Most committees (80-90%) successfully resolve conflicts, all conduct monitoring visits (with varying frequency), and nearly all (90%+) reinforce program messages in the community. The committees face several challenges in providing optimal support:

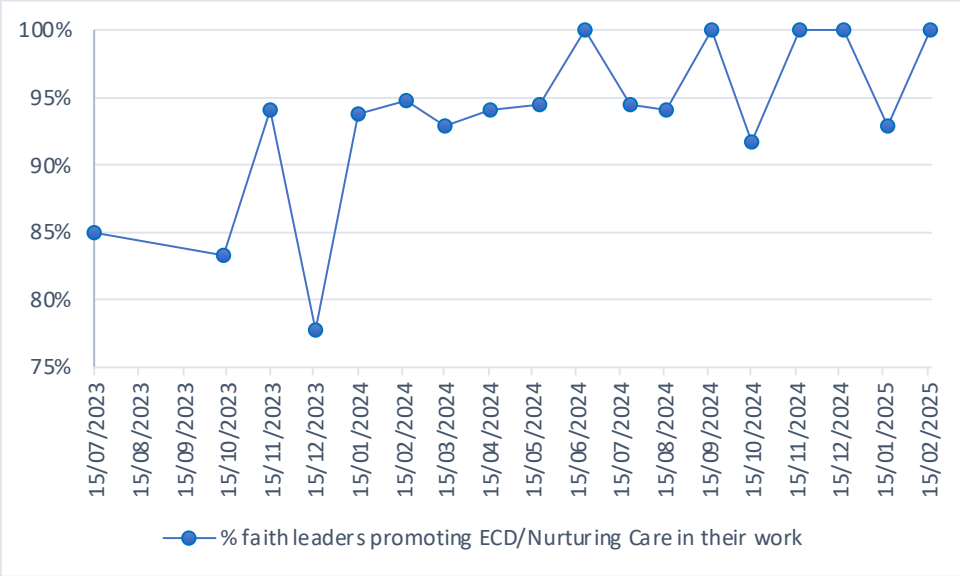
- Lack of transportation to reach distant homes
- No financial incentives or subsidy for committee members
- Limited materials for demonstration (e.g., for enriched porridge demonstrations)
- Inconsistent meeting schedules due to external factors

3.3.7 Faith leaders

Indicator 11: Percent of MTM-trained Faith Leaders who have promoted ECD/Nurturing Care in their work

Figure 15 illustrates how faith leaders (n=20) have promoted ECD/Nurturing care in their work over time. The percentage remained consistently high throughout the entire MTM program period, reaching approximately 100% by the end of the program.

Figure 15: Indicator 11 Percent of MTM-trained Faith Leaders who have promoted ECD/Nurturing care in their work over time (n = 20)



The comprehensive analysis of interviews conducted with eight faith leaders participating in the MTM program across Namachaca, Nacuca, Canacue, and Aginuro communities reveals that majority of faith leaders have effectively integrated Early Childhood Development (ECD) and Nurturing Care principles into their religious work, see Table 70.

Table 70: Faith Leaders' Integration of ECD and Nurturing Care Principles into Religious Work

Integration Area	Description	Supporting Quotes
Religious Teaching Integration	Faith leaders connected ECD principles with biblical verses and religious teachings	*"As a religious leader of the MTM program, I work to provide guidance in communities, especially in churches, on childcare issues, care that men should have for pregnant women, and ways to treat young children, connecting these issues with biblical verses." (Nacuca)*
Community Mobilization	Leaders used their religious platform to mobilize community support for ECD principles	*"In the MTM program, as a religious leader, I have been transmitting the program's messages to my community about caring for children during this very important phase, which is from 0 months to 3 years of age..." (Namachaca)*
Holistic Child Development	Leaders emphasized the importance of early years (0-3) in their religious contexts	*"The training I received to perform the role of leader was good and I learned many things I didn't know, like ways to care for a child from 0 to 3 years which is called the thousand days..." (Nacuca)*
Promoting Gender Equality	Faith leaders challenged traditional gender roles through religious frameworks	*"The aspect that was most difficult to change in this community was gender equality, for men to start doing household chores in their homes in this community seemed impossible..." (Namachaca)*
Counseling and Support	Leaders provided faith-based counseling that incorporated nurturing care principles	*"My role as a religious leader in the community in 2025 and beyond has gained a great responsibility because now besides being a religious leader, I am a counselor for this MTM program..." (Canacue)*

Scripture-Based Conflict Resolution	Leaders applied ECD principles to help resolve household conflicts using religious texts	*"Yes, it changed because when someone learns something new, the way of living and doing things changes. So I think this MTM program increased my abilities to deal with conflicts and solve different types of household problems, and according to the scriptures of the Bible, I consolidate things that I couldn't handle before." (Nacuca)*
Health and Wellbeing Advocacy	Leaders promoted child health and nutrition as part of spiritual wellbeing	*"In children, I saw many changes. Many children in the community had very large bellies and cried frequently before the program, but after it was implemented, they started eating healthily and I see a reduction in these problems." (Agenuro)*
Collaborative Ministry	Faith leaders worked with program promoters to reinforce messages through religious authority	*"With the promoters, we would coordinate and they would set the day when we could meet, and they would gather the community and I would go to work with them, to show caregivers that it's not only promoters who talk about the program..." (Agenuro)*

We can conclude therefore that, **indicator 11:** Percent of MTM-trained faith leaders who have promoted ECD/Nurturing Care in their work is 100% The integration of ECD and Nurturing Care principles into religious work by faith leaders demonstrates a powerful synergy between developmental science and spiritual guidance. As evidenced by their testimonies, these faith leaders effectively leveraged their trusted positions within communities to connect ECD concepts with religious teachings, mobilize community support, promote gender equality, and provide holistic counseling. By framing child development within spiritual contexts and using biblical references, they were able to overcome resistance to new ideas and facilitate meaningful behavioral changes in caregivers and families. This integration not only enhanced the effectiveness of the MTM program but also transformed the leaders' own approaches to ministry, expanding their roles from purely spiritual guides to comprehensive advocates for child wellbeing and family harmony. Their success illustrates how religious frameworks can serve as culturally resonant vehicles for introducing and sustaining important developmental practices in communities.

While supervision and quality monitoring fall outside the formal responsibilities of faith leaders, the qualitative interviews reveal they nonetheless provided these functions effectively. Faith leaders naturally assumed oversight roles, observing program implementation, offering feedback, and ensuring quality standards were maintained in their communities, see Table 71.

Table 71: Faith leaders (n=8) Faith Leaders' Engagement with ECD Committees, Promoters, and Quality Monitoring (max score = 30)

Supervision/ Monitoring Area	**Supporting Quotes**
Coordination with Promoters	*"With the promoters, we would coordinate and they would set the day when we could meet, and they would gather the community and I would go to work with them, to show caregivers that it's not only promoters who talk about the program..."* (Aginuro)
Intervention in Challenging Cases	"*The only time they invited me was because of a caregiver who took care of her stepchildren and didn't treat them well, so they invited me to advise her so she would understand that her husband's children are also hers*." (Aginuro)
Monitoring Behavioral Changes in Caregivers	"*Yes, I saw many changes in caregivers due to their participation in the program. Today, many of these caregivers can run small businesses with money they save, I see that they are now clean and also participate in meetings, things they didn't do before*." (Aginuro) "*I noticed changes in the behavior or actions of male parents or caregivers because now fathers take care of their children with love... they now take walks with the children, wash the children's clothes, bathe their children..."* (Namachaca)
Observing Child Development Outcomes	"*The changes in children are physical growth, increased weight, they learn to speak and walk earlier, they are agile and intelligent children." (Canacue)* *"In children, I saw many changes. Many children in the community had very large bellies and cried frequently before the program, but after it was implemented, they started eating healthily and I see a reduction in these problems*." (Aginuro)
Reinforcing Difficult Program Concepts	"*The most difficult topics to facilitate are about early learning, because it was hard for them to understand when they asked how can a child hear my voice while still in the womb*?" (Agenuro) *"The aspect that was most difficult to change in this community was gender equality, for men to start doing household chores in their homes in this community seemed impossible...*" (Namachaca)
Referral and Accompaniment to Services	"*I accompanied some female caregivers to health services. I had some caregivers who had health problems with their children, and most of these children had problems with malnutrition and malaria*." (Aginuro) "*I referred them several times to the health service and to civil registration and notary*." (Namachaca)
Documentation and Record Keeping	"*The materials we received from the project to perform our work as religious leaders were folders, notebooks, pens, some forms to help us register caregivers, and brochures*." (Canacue) "*The supervision has been monthly and is done in three days. The additional support I would like to have that would make me more effective in my role as a religious leader is transportation...*" (Nacuca)
Program Role Evolution	"*My role as a religious leader in the community in 2025 and beyond has gained a great responsibility because now besides being a religious leader, I am a counselor for this MTM program...*" (Canacue) "*Since the program started, I have only received supervision once. In my thinking, the additional support that would have helped me be effective in my role as a religious leader, I would like to have supervision at least twice a year*." (Nacuca)

3.3.8 Promoters

Indicator 12: Percent of trained ECD Promoters who maintain critical ECD/Parenting knowledge and skills at end of first cycle.

The Diocese of Nampula administered post-training tests to 80 ECD Promoters. The assessment consisted of two parts: (1) ECD Knowledge and Skills, and (2) Child Rights and Protection. To demonstrate critical ECD/Parenting competency, promoters needed to score 80% or higher on both sections. Only 20.0% of promoters (16 out of 80) achieved this benchmark. Noticeable is that none (0%, n=20) of the promoters in Canacue district passed the post-ECD knowledge and skills test.

However, when these same promoters participated in peer evaluations (also facilitated by the Diocese of Nampula), their average score was significantly higher at 88.9 out of 100.

The stark discrepancy between formal test performance and peer evaluations likely stems from a complex interplay of factors affecting assessment validity in this context. Limited literacy among promoters may have severely hampered their ability to demonstrate knowledge in written format, while their practical skills flourished in observable, applied settings. Cultural and linguistic barriers could have further impeded formal test performance, as promoters accustomed to oral knowledge transmission and practical demonstration struggled with decontextualized written questions, particularly in non-native languages. The formal assessment's structure might have emphasized theoretical concepts over practical implementation skills (precisely where these community-based promoters excel and what peer evaluations would naturally emphasize). Additionally, the testing environment itself may have introduced significant anxiety and stress, especially in Canacue district where a 0% pass rate suggests systematic rather than individual factors. Meanwhile, peer evaluations, conducted in familiar settings using culturally resonant criteria and possibly local languages, created conditions where promoters could authentically demonstrate their actual capabilities in applying ECD principles with children and families.

This peer evaluation assessed three categories: knowledge, facilitation skills, and media proficiency, see Table 72.

Table 72: Indicator 12: ECD/Parenting Knowledge and Skills Retention Analysis (post training test, n=80, peer promoter evaluation n=80)

ECD post-training promoter tests	Aginuro	Canacue	Nacuca	Namachaca	Total
Average score (out of 100) of promoters for Part 1 Test: ECD knowledge and skills	71.0	48.4	66.2	71.0	64.2
Average score (out of 100) of promoters for Part 2 Test Child Rights and Protection	85.5	76.5	87.5	95.0	86.1
Indicator 12a: % of promoters passed 80% score for Part 1 Test: ECD knowledge and skills	30.0%	0%	20.0%	30.0%	20.0%
Indicator 12b: % of promoters passed 80% score for Part 2 Test Child Rights and Protection	80.0%	65.0%	90.0%	90.0%	81.3%
Indicator 12c: % of promotors passed 80% scores for **both test**	30.0%	0%	15.0%	30.0%	18.8%
Peer promoter evaluation score (out of 100)	89.9	87.6	88.5	88.2	88.6

All twenty (20) promoters (5 from each district) that partook in the in-depth interviews demonstrated successful retention of their ECD and parenting knowledge and skills at the conclusion of the first program cycle. Their interviews demonstrate consistent retention of key programmatic concepts including child development milestones, responsive caregiving, importance of play, nutrition, early stimulation, positive discipline, and health-seeking behaviors. These promoters effectively articulated how they apply this knowledge in both group sessions and home visits, adapting their communication approaches to different caregiver contexts. Evidence of their skills maintenance is further supported by their detailed descriptions of implementation strategies, ability to provide specific examples of guidance given to caregivers, and observations of positive behavior changes in their communities. While some promoters expressed greater confidence in certain topic areas than others, and many requested refreshers training, all demonstrated the functional competencies required to perform their roles effectively and sustainably transfer knowledge to caregivers in their communities. Table 73 below underlines each promoter's assessment based on the interview assessment.

Table 73: Indicator 12: ECD/ Parenting Knowledge and Skills Retention Analysis (of 20 interviewed promoters)

ID	Evidence
1	Demonstrated knowledge of key topics including child protection, nutrition (enriched porridge), health-seeking behaviors, and developmental milestones. Provides specific examples of guidance given to caregivers and shows understanding of early childhood needs.
2	Articulated multiple aspects of ECD including responsive caregiving, nutrition, play-based learning, and parent education. Shows understanding of importance of fathers' involvement and describes specific child development concepts successfully.

3	Strong recall of multiple ECD training topics, provides examples of implementation, and describes observing behavior changes in community. Shows understanding of developmental stages and can explain age-appropriate activities.
4	Demonstrated comprehensive understanding of ECD topics including nutrition, early stimulation, play, hygiene, and father involvement. Provided concrete examples of advice given to caregivers and reported positive outcomes from implementation.
5	Showed retention of key concepts including child development phases, nutrition, and positive parenting. Effectively described communication strategies with caregivers and demonstrated knowledge application through reported community changes.
6	Maintained knowledge of core ECD topics and could explain developmental needs of children at different ages. Demonstrated implementation skills through descriptions of home visits and group sessions.
7	Showed understanding of all major training topics and could articulate appropriate guidance for caregivers. Provided examples of teaching strategies that demonstrated content mastery.
8	Strong recall of DPI curriculum, able to describe implementation methods and challenges. Shows good understanding of parental engagement strategies and child development topics.
9	Demonstrated knowledge of child development milestones, nutrition, and responsive caregiving. Successfully described implementation in both group and home visit settings with concrete examples.
10	Retained knowledge of child development concepts and parenting strategies. Provided examples of successful knowledge application and described observable community change.
11	Maintained understanding of key ECD concepts and showed ability to deliver content effectively. Provided examples of how content is applied in different settings.
12	Demonstrated retention of core training material and ability to apply concepts in group and home visit settings. Shows understanding of child development needs at different ages.
13	Strong knowledge of child development principles and ability to apply them in community settings. Provided specific examples of teaching strategies that showed content mastery.
14	Maintained comprehensive understanding of program content and could articulate how to effectively communicate with caregivers. Demonstrated ability to adapt approach based on caregiver needs.
15	Showed understanding of multiple DPI topics and described effective implementation strategies. Demonstrated ability to explain concepts clearly to caregivers.
16	Retained knowledge of key curriculum elements and described successful application. Provided examples of community impact showing effective knowledge transfer.
17	Demonstrated thorough understanding of child development principles and parenting strategies. Described age-appropriate activities and responsive caregiving techniques.
18	Maintained knowledge of ECD concepts and described successful implementation. Shows understanding of how to adapt communication approaches for different caregivers.
19	Showed retention of core training topics and ability to explain concepts to caregivers. Provided examples of observed behavior change showing effective implementation.
20	Demonstrated understanding of child development principles and parenting strategies. Described concrete examples of successful community-based implementation.

Indicator 13: Percent of trained ECD Promoters reported by primary caregivers as helpful in addressing specific parenting concerns.

Table 74 presents key findings on the perceived helpfulness of ECD Promoters in responding to parenting concerns across four communities at endline (n=160). The data indicate that 45.0% (n=160) of primary caregivers overall, reported seeking themselves information, advice, help, or referrals from

ECD Promoters, with the highest engagement was observed in Canacue at 55.0% (n=22) and the lowest in Namachaca at 40.0% (n=16).

Notably, the vast majority of primary caregivers who interacted with ECD Promoters found them helpful: 82.5% (n=160) overall, reported that promoters were helpful in addressing parenting concerns, with community-specific rates ranging from 75% (n=34) in Aginuro to 87.5% (n=31) in both Canacue and Nacuca. When asked to rate the level of helpfulness, 65.6% (n=160) of primary caregivers described ECD Promoters as "very helpful," while an additional 16.9% (n=160) found them "somewhat helpful." These findings underscore the critical role ECD Promoters play in supporting caregivers, with consistently high levels of satisfaction and perceived value across all communities.

Table 74: Indicator 13: ECD Promoters helpful in addressing parenting concerns (endline n=160)

Indicator 13: ECD Promoters helpful in addressing parenting concerns	Aginuro	Canacue	Nacuca	Namachaca	Total
Percentage of caregivers that asked an ECD Promoter for parenting information, advice, help or referrals for services	42.5%	55.0%	42.5%	40.0%	45.0%
I13: percentage of ECD Promoters reported by caregivers to be helpful in addressing parenting concerns	**75.0%**	**87.5%**	**87.5%**	**80.0%**	**82.5%**
I13a: Very helpful	60.0%	72.5%	65.0%	65.0%	65.6%
I13b: Somewhat helpful	15.0%	15.0%	22.5%	15.0%	16.9%

The qualitative analysis highlights that ECD Promoters are highly regarded within their communities for their dedication, knowledge, and supportive approach. Primary caregivers view promoters as trusted sources of guidance and practical advice, often turning to them for help with child-rearing challenges and new parenting strategies. Promoters are seen as approachable and empathetic, fostering open communication and mutual respect with primary caregivers. This relationship is further strengthened by regular meetings and home visits, where promoters provide tailored support and encouragement.

Faith leaders and ECD Committee members also express positive perceptions of ECD Promoters, recognizing their pivotal role in driving community change and promoting best practices in early childhood development. Committee members often collaborate closely with promoters, working together to monitor program quality, address challenges, and ensure that families receive the necessary support. Faith leaders, meanwhile, acknowledge the promoters' efforts in mobilizing community participation and reinforcing positive values around childcare and development. The collaborative relationships among promoters, caregivers, faith leaders, and committee members contribute to a cohesive and supportive environment that enhances the overall effectiveness of the ECD program, see also Table 75.

Table 75: Stakeholders perception of Promoters' role

Stakeholder Group	Perception of ECD Promotors	Nature of Relationship
Caregivers	Trusted, supportive, knowledgeable, approachable	Open communication, regular support
Faith Leaders	Respect promoters' role in mobilizing participation and reinforcing positive values	Collaborative, value alignment
Committee Members	Recognize promoters' pivotal role, collaborate on monitoring and support	Close partnership, shared objectives

3.4 Overview of all indicators

The following tables (Table 76, Table 77, Table 78) summarize the evaluation's main indicators disaggregated per community. Table 76 shows the percentages for each of the four communities at endline in Monapo district that participated in the evaluation. Indicators 4p, 4ap, 4bp, 4cp and 6p were only measured at endline.

Table 76: Overview of key indicators at Endline, disaggregated per community (endlline, n=160)

#	Key indicators	Aginuro	Canacue	Nacuca	Namachaca	Total
1a	Percent of primary caregivers who report **any** confidence in handling parenting responsibilities successfully	67.5%	67.5%	77.5%	74.3%	72.5%
1b	Percent of primary caregivers who report **full** confidence in handling parenting responsibilities successfully	40.0%	32.5%	45.0%	57.5%	43.8%
2a	Percent of primary caregivers who report **any** parental stress	60.0%	67.5%	52.5%	42.5%	55.6%
2b	Percent of primary caregivers who report **full** parental stress	32.5%	32.5%	22.5%	22.5%	27.5%
3a	Percent of primary caregivers who use of physical punishment with their children 0-3	15.0%	7.5%	2.5%	5.0%	7.5%
3b	Average types of applied physical punishments (out of 6) averaged over all children 0-3	0.29	0.6	0.03	0.05	0.11
3c	Percentage of primary caregivers who use violent discipline (any) with their children 0-3	20.0%	7.5%	7,5%	10.0%	11.3%
3d	Percent of primary caregivers who use positive discipline practices with their children 0-3	84.4%	75.0%	90.0%	85.0%	84.4%
4	Primary caregivers parenting practices score	6.65	6.72	6.65	6.42	6.61
4a	Parenting responsive care score	7.23	7.23	6.94	7.30	7.14
4b	Parenting early learning score	5.46	5.18	5.34	5.01	5.25

4.b1	Average of the number of different stimulating activities (out of 11)	8.03	6.93	7.68	7.58	7.55
4.b2	Percentage of primary caregivers providing adequate stimulation	58.1%	45.0%	65.0%	57.5%	58.1%
4c	Parenting child safety & security score	7.25	8.05	7.31	7.18	7.45
4p	In ALL 3 parenting practices categories: Responsive care AND Early learning AND Child safety & security	40.6%	40.6%	25.8%	28.6%	35.2%
4pa	In Responsive care	62.5%	62.5%	48.4%	50.0%	55.7%
4pb	In Early learning	59.4%	59.4%	67.7%	42.9%	60.7%
4pc	In Child safety & security	100%	100%	100%	100%	100%
5	Percent of primary caregivers who report feeling connected to and supported by peer caregivers in their group	87.5%	85.0%	95.0%	97.5%	91.3%
6	Percent of fathers (as secondary caregivers) who intentionally interact/play with children 0-3	52.5%	65.0%	50.0%	55.0%	55.6%
6p	Percent of fathers (as secondary caregivers) who increase time spent intentionally interacting/playing with children 0-3	87.5%	82.9%	76.9%	86.8%	83.1%
7	Percent of savings group members who have started or expanded micro-businesses using loans or savings	0%	0%	0%	0%	0%
8a	Number of purchased assets with loans received	0	0	0	0	0
8b	Percentage of households that purchased assets with loans received	0%	0%	0%	0%	0%
9	Percent of ECD Committees/Consortia who provide supportive supervision	100%	100%	100%	100%	100%
10a	Percent of primary caregivers who (self-reported) increase positive discipline practices with their children	93.8%	80.0%	100%	100%	80.0%
10b	Percent of primary caregivers who increase positive discipline practices with their children	56.3%	38.7%	58.1%	35.7%	47.5%
11	Percent of MTM-trained Faith Leaders who have promoted ECD/Nurturing Care in their work	100%	100%	100%	100%	100%
12	Percent of trained ECD Promoters who maintain critical ECD/Parenting knowledge and skills at end of first cycle	30.0%	0%	20.0%	30.0%	20.0%
13	Percent of trained ECD Promoters reported by primary caregivers as helpful in addressing specific parenting concerns	75.0%	87.5%	87.5%	80.0%	82.5%

Table 77 below provides an overview of the differences across communities for **all** primary caregivers surveyed including those surveyed at both baseline and endline (as well as the additional 26 caregivers who were only surveyed at endline)

Table 77: Overview of the differences [endline – baseline] for the key indicators between endline and baseline disaggregated per community (baseline n=161, endline n=160)

#	Key indicators	Aginuro	Canacue	Nacuca	Namachaca	Total
1a	Percent of primary caregivers who report **any** confidence in handling parenting responsibilities successfully	43.3%	43.1%	55.0%	51.8%	48.3%
1b	Percent of primary caregivers who report **full** confidence in handling parenting responsibilities successfully	40.0%	27.6%	30.0%	57.5%	38.8%
2a	Percent of primary caregivers who report **any** parental stress	-40.0%	-27.6%	-32.5%	-55.0%	-38.8%
2b	Percent of primary caregivers who report **full** parental stress	-40.0%	-43.1%	-55.0%	-52.5%	-47.7%
3a	Percent of primary caregivers who use of physical punishment with their children 0-3	-85.0%	-92.5%	-97.5%	-95.0%	-92.5%
3b	Average types of applied physical punishments (out of 6) averaged over all children 0-3	-3.33	-3.14	-3.23	-3.10	-3.20
3c	Percentage of primary caregivers who use violent discipline (any) with their children 0-3	-40.5%	-21.8%	-12,5%	-19.7%	-23.4%
3d	Percent of primary caregivers who use positive discipline practices with their children 0-3	-2.5%	6.7%	12.5%	1.2%	5.5%
4	Primary caregivers parenting practices score	1.83	1.90	1.76	1.35	1.71
4a	Parenting responsive care score	0.73	0.44	0.65	0.20	0.51
4b	Parenting early learning score	0.82	1.11	1.51	0.23	0.93
4.b1	Average of the number of different stimulating activities (out of 11)	1.37	0.75	1.33	0.36	0.97
4.b2	Percentage of primary caregivers providing adequate stimulation	19.7%	10.9%	35.0%	0.7%	19.7%
4c	Parenting child safety & security score	4.39	4.26	3.09	3.42	3.80
5	Percent of primary caregivers who report feeling connected to and supported by peer caregivers in their group	7.5%	-10.1%	2.5%	10.0%	2.4%
6	Percent of fathers (as secondary caregivers) who intentionally interact/play with children 0-3	-12.5%	-8.2%	-22.5%	5.0%	-9.6%

7	Percent of savings group members who have started or expanded micro-businesses using loans or savings	-60.0%	0%	0%	-14.3%	-20.0%
8a	Number of purchased assets with loans received	-3	-4	-0	-1	-8
8b	Percentage of households that purchased assets with loans received	-40.0%	-33.7%	0.%	14.3%	-25.0%

Table 78 below shows the longitudinal changes over time by community for those primary caregivers who participated in **both** the baseline and endline surveys.

Table 78: Overview the longitudinal difference [endline-baseline] for the key indicators between endline and baseline of key indicators, disaggregated per community (n=126)

#	Key indicators	Aginuro	Canacue	Nacuca	Namachaca	Total
1a	Percent of primary caregivers who report **any** confidence in handling parenting responsibilities successfully	44.1%	48.4%	61.3%	56.7%	52.4%
1b	Percent of primary caregivers who report **full** confidence in handling parenting responsibilities successfully	41.2%	16.1%	29.0%	53.3%	34.9%
2a	Percent of primary caregivers who report **any** parental stress	-41.2%	-16.1%	-32.3%	-53.3%	-35.7%
2b	Percent of primary caregivers who report **full** parental stress	-44.1%	-48.4%	-61.3%	-53.3%	-50.8%
3a	Percent of primary caregivers who use of physical punishment with their children 0-3	-87.5%	-93.5%	-96.8%	-80,0%	-94.3%
3b	Average types of applied physical punishments (out of 6) averaged over all children 0-3	-3.31	-3.16	-3.10	-3,16	-3.18
3c	Percentage of primary caregivers who use violent discipline (any) with their children 0-3	-40.6%	-29.0%	-3.2%	-32.1%	-26.2%
3d	Percent of primary caregivers who use positive discipline practices with their children 0-3	3.1%	3.2%	12.9%	-3.6%	4.1%
4	Primary caregivers parenting practices score	1.98	1.94	1.75	1.28	1.75
4a	Parenting responsive care score	0.73	0.44	0.65	0.20	0.51
4b	Parenting early learning score	0.82	1.11	1.51	0.23	0.93
4.b1	Average of the number of different stimulating activities (out of 11)	1.28	0.65	1.84	0.21	1.02
4.b2	Percentage of primary caregivers providing adequate stimulation	31.3%	12.9%	41.9%	3.6%	23.0%
4c	Parenting child safety & security score	4.39	4.26	3.09	3.42	3.80

5	Percent of primary caregivers who report feeling connected to and supported by peer caregivers in their group	8.8%	-6.5%	0%	10.0%	3.2%
6	Percent of fathers (as secondary caregivers) who intentionally interact/play with children 0-3	-14.7%	-3.2%	-12.9%	-3.3%	-8.7%
7	Percent of savings group members who have started or expanded micro-businesses using loans or savings	-60.0%	0%	0%	-14.3%	-20.0%
8a	Number of purchased assets with loans received	-3	-4	-0	-1	-8
8b	Percentage of households that purchased assets with loans received	-40.0%	-33.7%	0.%	14.3%	-25.0%

4

Conclusions

4. Conclusions

The analysis of the quantitative and qualitative data from the MTM program reveals several significant improvements across various outcomes. Namachaca community however stands out among the four communities for exhibiting declines across several key indicators. Qualitative interviews with caregivers, promoters, and committee members reveal little to no sense of forward momentum or tangible achievements, in stark contrast to the marked progress seen elsewhere. This pervasive sense of stagnation (evident in diminishing enthusiasm, under-leveraged peer networks, and scant mention of resource improvements during the qualitative interviews) raises concerns about program delivery and local engagement. A focused investigation into implementation practices, stakeholder communication, and contextual barriers in Namachaca is therefore recommended to diagnose and address these gaps.

The following are some of the program's significant achievements per outcome:

Early learning and responsive caregiving behaviors

The data shows that the MTM program was successful in increasing the frequency and variety of stimulating activities, as well as access to play materials and children's books, which are critical for early childhood development. Specifically:

- The average number of different stimulating activities (out of 11) conducted at least once per week increased by
    - 0.97 (difference [endline – baseline])
    - 1.02 (longitudinal difference [endline – baseline])
- The total number of stimulating activities (out of 77) per week increased by
    - 3.95 (difference [endline – baseline])
    - 3.82 (longitudinal difference [endline – baseline])
- The percentage of primary caregivers providing adequate stimulation to their child increased by
    - 19.7% (difference [endline – baseline])
    - 23.0% (longitudinal difference [endline – baseline])
- Difference in average number of days per week the child was left in the care of another child for more than one hour per day decreased with 0.33 days (difference [endline – baseline]).
- The average number of different play materials (out of 4) the child played with increased by
    - 0.50 (difference [endline – baseline])
    - 0.50 (longitudinal difference [endline – baseline])
- The percentage of households with at least one children's book increased by
    - 6.7% (difference [endline – baseline])
    - 9.0% (longitudinal difference [endline – baseline])

- The average number of children's book in households increased by
    - 0.07 (difference [endline – baseline])
    - 0.10 (longitudinal difference [endline – baseline])

Qualitative data revealed significant changes in primary caregivers' understanding and implementation of responsive care and early learning activities. Primary caregivers demonstrated practical application of program teachings through creative toy-making, with one participant sharing, *"I learned to make toys for children to play with, such as cars made from flipflop wheels, dolls, balls."* The interviews showed increased understanding of the developmental benefits of play, exemplified by one primary caregiver's observation: "*When we make toys, we stimulate our children to develop various abilities about their development."* A notable shift in attitudes toward play-based learning was evident, with primary caregivers who previously did not prioritize play now recognizing its importance: *"Before, I didn't see the need to play with my children, but now I know it's important to play with them and take them for walks."* Faith leaders also emerged as advocates for early learning, with one stating, *"Look for toys for our children to use because when they play, they develop many capabilities."* These qualitative insights demonstrate how the program not only increased the quantity of stimulating activities but fundamentally changed primary caregivers' understanding of early childhood development and their role in facilitating it through play-based learning and engagement.

Child safety and security

The data show that the program was successful in reducing the use of physical and psychological punishment, while increasing the use of positive discipline practices, which are critical for child safety and security. Specifically:

- The percentage of primary caregivers using any physical punishment decreased by
    - 92.5% (difference [endline – baseline])
    - 94.3% (longitudinal difference [endline – baseline])

  At baseline, 100% of primary caregivers (n=161) reported using physical punishment with children aged 0–3 years.
- The average number of different types of physical punishment (out of 6) used decreased by
    - 3.20 (difference [endline – baseline])
    - 3.18 (longitudinal difference [endline – baseline])
- The percentage of primary caregivers using any psychological aggression decreased by
    - 27.7% (difference [endline – baseline])
    - 28.7% (longitudinal difference [endline – baseline])
- The average number of different types of psychological aggression (out of 2) used decreased by
    - 0.29 (difference [endline – baseline])

    - 0.30 (longitudinal difference [endline – baseline])

- The percentage of primary caregivers using any positive discipline practices increased by
    - 5.5% (difference [endline – baseline])
    - 4.1% (longitudinal difference [endline – baseline])

- The average number of different positive discipline practices used increased by
    - 0.24 (difference [endline – baseline])
    - 0.25 (longitudinal difference [endline – baseline])

- The percentage of primary caregivers who increased use of positive discipline practices with their children increased by
    - 47.5% (longitudinal difference [endline – baseline])

Qualitative interviews revealed a fundamental shift in primary caregivers' discipline approaches. Primary caregivers described an increased understanding and adoption of non-violent discipline methods, such as explaining why behavior is wrong, redirecting attention, and using time-outs instead of physical punishment. Many reported that they now prioritize positive reinforcement and communication, with one participant sharing, "*I've learned to control my anger and talk to my child instead of reacting with force*."

The program's caregiver group meetings provided a platform for sharing successful non-violent strategies, helping primary caregivers sustain these changes. As one primary caregiver explained, *"When I'm struggling with my child's behavior, I remember the techniques we discussed in our group meetings, and I try those instead of resorting to physical punishment*." Primary caregivers also expressed greater confidence in managing difficult behaviors without aggression, citing the use of consistent routines and clear expectations. These qualitative insights demonstrate that primary caregivers not only understand the importance of positive discipline but have successfully integrated these practices into their daily routines, aligning with the significant reductions in physical punishment and psychological aggression observed in the quantitative data.

Psychosocial well-being of primary caregiver

The program contributed to an increase in primary caregivers' confidence in their parenting abilities, a reduction in parental stress, and a strengthened sense of community connectedness, which are critical aspects of psychosocial well-being. Specifically:

- The percentage of primary caregivers reporting any confidence in handling parenting responsibilities successfully increased by
    - 48.3% (difference [endline – baseline])
    - 52.4% (longitudinal difference [endline – baseline])

- The percentage of primary caregivers reporting full confidence in handling parenting responsibilities successfully increased by
    - 38.8% (difference [endline – baseline])
    - 34.9% (longitudinal difference [endline – baseline])

- The percentage of primary caregivers reporting any parental stress decreased by
    - 38.8% (difference [endline – baseline])
    - 35.7% (longitudinal difference [endline – baseline])
- The percentage of primary caregivers reporting full parental stress decreased by
    - 47.7% (difference [endline – baseline])
    - 50.8% (longitudinal difference [endline – baseline])
- The percentage of primary caregivers reporting feeling supported and connected by peer primary caregivers in their community increased by
    - 2.4% (difference [endline – baseline])
    - 3.2% (longitudinal difference [endline – baseline])

The qualitative findings from the program demonstrate that primary caregivers gained greater confidence in their parenting abilities, citing new practical skills and a deeper understanding of child development. Many primary caregivers described feeling less stressed, attributing this to improved time management, the adoption of effective coping strategies, and the financial and emotional support provided by community savings groups. Furthermore, the program fostered a stronger sense of community connectedness, as regular group meetings and shared learning experiences built lasting relationships and mutual support networks among primary caregivers, transforming individual parenting journeys into a collective, empowering experience.

Gender-equitable roles in parenting

Though the percentage of fathers interacting with children in the last seven days (captured by indicator 6) decreased by 9.6% from baseline to endline, and by 8.7% in the longitudinal comparison, more than three quarter of the female caregivers at endline (83.3%, n=142) reported that fathers have increased the time they spend intentionally interacting or playing with children aged 0–3 since participating in MTM compared to baseline. In contrast, 6.3% (n=142) reported that fathers are spending less time with their children.

Interviews revealed significant shifts in gender roles and father engagement in childcare. Committee members reported observing fathers taking on traditionally female-dominated responsibilities, including *"bathing children, helping with household chores, and accompanying mothers to health centers*." Female primary caregivers emphasized how the program transformed household dynamics, with one noting, "*Men no longer leave everything to women."* Fathers demonstrated increased involvement in direct childcare activities, with multiple primary caregivers describing how their partners now actively participate in playing, feeding, and routine care tasks. The data also showed evolution in traditional gender norms, exemplified by one participant's reflection: *"I never thought that women could also make toys for children instead of just the fathers."* These qualitative insights suggest that while quantitative measures show some variance in father interaction frequency, there has been a fundamental shift in gender roles and the quality of father engagement, with men taking more active roles in childcare responsibilities previously considered exclusively maternal domains.

Economic Empowerment of primary caregiver

There were modest but encouraging improvements in the economic empowerment of the primary caregivers. Despite the program's efforts to encourage entrepreneurship through savings and loan groups, most caregivers reported not investing these resources into business ventures. This decision must be understood within the broader economic context of Mozambique, where rural poverty rates have steadily increased in recent years[36], creating significant hardship for families. The communities of Aginuro, Canacue, Namachaca, and Nacuca (all situated in rural areas) have been particularly affected by this economic deterioration. In such precarious circumstances, families often prioritize immediate survival needs such as food security, healthcare, and educational expenses over business investments that may not yield returns quickly enough to address urgent household needs. This economic reality highlights the complex interplay between poverty reduction programs and the harsh economic conditions that can constrain caregivers' choices, even when financial tools are made available through development initiatives:

- The percentage of primary caregivers participating in a Savings & Loan Group increased by
    - 20.1% (endline - baseline)
    - 16.7% (longitudinal difference)
- The percentage of households using loans or savings to purchase household items decreased by 25%
- The percentage of primary caregivers using savings or loans to start or expand income-generating activities decreased by 25%

Qualitative data revealed that savings & loan groups provided critical financial support to primary caregivers, with participants highlighting their value during emergencies and household needs. As one primary caregiver explained, "*The lessons I liked learning in the program were about savings because savings came to help us caregivers here in the community. For example, in our savings group, we are allowed to take loans, so sometimes we have urgent situations at home and who helps us is the savings group because we can borrow money to resolve that concern that afflicts us."* While the quantitative data shows decreased use of loans for household purchases and business expansion, qualitative insights suggest this may reflect more strategic financial management rather than reduced economic capacity. Primary caregivers reported being more thoughtful about loan utilization, with one noting, *"I am still trying to figure out what kind of business I can start."* The interviews revealed that Savings & Loan Groups served as both financial safety nets and platforms for learning about money management, though some caregivers expressed ongoing challenges in translating financial access into sustainable

[36] The IMF's 2023 Country Report on Mozambique noted that extreme poverty (people living on less than $1.90 per day) increased by approximately 4 percentage points between 2019 and 2022. The United Nations Development Programme (UNDP) Human Development Report 2023 indicated that Mozambique's multidimensional poverty index showed about 35% of rural households fell back into poverty following the pandemic and climate shocks, compared to 23% of urban households.

business growth. This suggests that while the program successfully increased participation in Savings & Loan Groups, additional support may be needed to help primary caregivers effectively leverage these financial resources for income-generating activities.

The following (Table 79) captures the key endline indicators for 18 Month Cohort for the MTM ECD project compared with the baseline indicators.

Table 79: Overview of key indicators for 18 Month Cohort at endline (n=160) compared with baseline (n= 161), Difference [endline – baseline], and longitudinal difference [endline – baseline] (n=126)

#[37]	Key indicators	Baseline	Endline	Difference	longitudinal difference
1a*	Percent of primary caregivers who report any confidence in handling parenting responsibilities successfully	24.2%	72.5%	48.3%	52.4%
1b*	Percent of primary caregivers who report full confidence in handling parenting responsibilities successfully	5.0%	43.8%	38.8%	34.9%
2a*	Percent of primary caregivers who report any parental stress	94.4%	55.6%	-38.8%	-35.7%
2b*	Percent of primary caregivers who report full parental stress	75.2%	27.5%	-47.7%	-50.8%
3a*	Percent of primary caregivers who use of physical punishment with their children 0-3	100%	7.5%	-92.5%	-94.3%
3b*	Average types of applied physical punishments (out of 6) averaged over all children 0-3	3.30	0.11	-3.20	-3.18
3c*	Percentage of primary caregivers who use violent discipline (any) with their children 0-3	34.6%	11.3%	-23.4%	-26.2%
3d	Percent of primary caregivers who use positive discipline practices with their children 0-3	78.8%	84.4%	5.5%	4.1%
4*	Primary caregivers parenting practices score	4.90	6.61	1.71	1.75
4a*	Parenting responsive care score	6.62	7.14	0.51	0.51
4b*	Parenting early learning score	4.34	5.25	0.93	0.93
4b1	Average of the number of different stimulating activities	6.58	7.55	0.97	1.02
4b2	Percentage of primary caregivers providing adequate stimulation	38.5%	58.1%	19.7%	23.0%
4c*	Parenting child safety & security score	3.74	7.45	3.80	3.80
4p	Percent of primary caregivers who demonstrate an improvement in parenting practices in responsive care AND early learning AND child safety & security (Value at endline)				35.2%
4pa	Percent of primary caregivers who demonstrate an improvement in in responsive care (Value at endline)				55.7%

[37] The indictors marked with an * have a statistically significant difference

#[37]	Key indicators	Baseline	Endline	Difference	longitudinal difference
4pb	Percent of primary caregivers who demonstrate an improvement in early learning (Value at endline)				60.7%
4pc	Percent of primary caregivers who demonstrate an improvement in child safety & security (Value at endline)				100%
5	Percent of primary caregivers who report feeling connected to and supported by peer caregivers in their group	88.8%	91.3%	2.4%	3.2%
6	Percent of fathers (as secondary caregivers) who intentionally interact/play with children 0-3	65.2%	55.6%	-9.6%	-8.7%
6p	Percent of fathers (as secondary caregivers) who increase time spent intentionally interacting/playing with children 0-3 (Value at endline)				83.1%
7	Percent of savings group members who have started or expanded micro-businesses using loans or savings	20.0%	0%	-20.0%	-20.0%
8a	Number of purchased assets with loans received	8	0	-8	-8
8b	Percentage of households that purchased assets with loans received	25.0%	0%	-25.0%	-25.0%
9	Percent of ECD Committees/Consortia who provide supportive supervision				100%
10a:	Percent of primary caregivers who (self-reported) increase positive discipline practices with their children				80.0%
10b	Percent of primary caregivers who increase positive discipline practices with their children				47.5%
11	Percent of MTM-trained Faith Leaders who have promoted ECD/Nurturing Care in their work				100%
12	Percent of trained ECD Promoters who maintain critical ECD/Parenting knowledge and skills at end of first cycle.				20.0%
13	Percent of trained ECD Promoters reported by primary caregivers as helpful in addressing specific parenting concerns.				82.5%

Conclusions

The program evaluation of MTM demonstrates substantial positive outcomes across multiple domains, though outcomes in Namachaca community showed a declining trend in some key indicators compared to the other three communities. Quantitative and qualitative data reveal significant improvements in early learning and responsive caregiving behavior, with increased engagement in stimulating activities and enhanced access to play materials. Child safety and security showed marked progress through reduced physical punishment and increased adoption of positive discipline practices. Primary caregiver psychosocial well-being improved notably, evidenced by increased parenting confidence and reduced stress levels. While modest gains were observed in gender-equitable roles and economic empowerment, these areas show positive directional change despite persistent environmental challenges. The data

indicates that while overall household resilience has improved, some families continue to face resource constraints that impact their ability to fully implement learned practices.

Recommendations

The following recommendations reflect the lived realities of participating families, the insights of community leaders, and the lessons learned throughout the project cycle. By targeting critical barriers such as financial hardship, food insecurity, transportation limitations, and the need for greater father engagement, these actions aim to strengthen the program's impact, promote equity, and ensure sustainable improvements in early childhood development and family well-being. The matrix below outlines each key challenge alongside actionable steps for immediate and long-term progress. See Table 80 for actionable recommendations

Table 80: Actionable recommendations

Area	Key challenge/need	Actionable recommendation
Resource support	Financial constraints, hunger, and resource limitations affecting access to basic necessities, healthcare, and food security	• Provide targeted financial and material assistance (revolving fund; start-up kits, business plan) • Establish a community food support program • Partner with local food banks and markets for regular food distributions • Explore innovative financing mechanisms and partnerships to expand access to essential services and resources
Transportation access	Persistent transportation barriers limiting access to healthcare, program activities, and markets	• Develop a transportation voucher system for families • Partner with local transport providers for subsidized rates • Establish a community bicycle/motorcycle or shuttle program for key activities and healthcare visits
Parenting education & community development	Need to leverage community structures and deepen program impact; collaboration gaps	• Integrate parenting education with community development by: a) Embedding ECD messaging within existing community-based programs (agricultural cooperatives, savings groups and others); b) Establishing formal coordination mechanisms between parenting programs and community development projects to ensure consistent approaches; c) Leveraging faith leaders and other community influencers to connect parenting concepts with broader community well-being (this is happening, it needs to be reinforced) • Strengthen collaboration between promoters, committee members, and faith leaders

ECD Promoter Capacity Strengthening	The significant discrepancy between formal assessment results (80% failure rate) and positive peer evaluations (88.9% average)	• Implement tiered competency certification: Develop a three-level certification system (basic, intermediate, advanced) allowing promoters to progress gradually through increasingly complex ECD concepts while receiving recognition at each stage. • Create visual learning tools: Replace text-heavy training materials with illustrated quick-reference guides depicting key ECD concepts and techniques, enabling effective utilization regardless of literacy levels. • Establish monthly micro-learning sessions: Institute 2-hour monthly refresher sessions focused on single concepts using participatory methodologies, reinforced by immediate supervised practice with caregivers. • Develop promoter peer mentorship program: Pair stronger-performing promoters with those requiring additional support through a structured cross-district mentorship program with clear learning objectives and accountability measures. • Redesign assessment methods: Create mixed-method evaluations incorporating oral assessments, practical demonstrations, and scenario-based problem-solving that align with diverse learning styles and community education norms. • Provide targeted literacy support: Integrate basic literacy and comprehension skill-building relevant to ECD content into promoter training to address underlying barriers to theoretical knowledge acquisition.
Primary caregiver capacity	Need for refresher training and continued capacity building for promoters; limited peer support	• Implement refresher training and continuous professional development for promoters • Expand caregiver support networks and peer-to-peer learning: Implement a structured three-tier support system consisting of: 1) Community Learning Circles where groups of 8-10 caregivers meet monthly with rotating leadership and standardized discussion guides; 2) A Caregiver Champion initiative training two exceptional caregivers per community to serve as certified local resources with modest stipends for conducting home visits; and 3) Specialized support groups addressing specific challenges faced by targeted caregiver segments (fathers, grandparent caregivers, caregivers of children with disabilities). These interconnected mechanisms will create sustainable local support networks while facilitating continuous peer-based knowledge exchange and skills reinforcement.

Gender-equitable parenting & father engagement	Persistent traditional gender norms, cultural barriers, and challenges in mobilizing fathers	• Develop targeted interventions to address gender norms • Provide targeted incentives for father participation, including recognition certificates, skill-building opportunities relevant to men's interests, and flexible scheduling of activities to accommodate work commitments. Consider engaging successful participating fathers as peer motivators to recruit other men • Engage community leaders to champion gender-equitable parenting and model positive father involvement: Implement a culturally-grounded "Fatherhood Champions" initiative where: 1) Community dialogues facilitated by respected male elders define "positive father involvement" according to local values, identifying existing positive cultural practices; 2) Traditional leaders and religious figures publicly demonstrate culturally-appropriate caregiving activities that preserve men's dignity while expanding involvement (e.g., accompanying children to health visits, teaching traditional knowledge); and 3) Intergenerational forums enable elder men to advise younger fathers on responsible parenting within evolving gender norms, positioning increased involvement as enhancing rather than diminishing cultural conceptions of masculinity.
Monitoring & evaluation	Need for robust monitoring and adaptive programming; limited data systems	• Maintain and build upon successful ECD Committee supervision model • Implement robust data collection and analysis mechanisms

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Annexes

Annex A1.1: Evaluation tools

PART 1: Demographics-background

#	Question	Response
1.1	Collect GPS location	
1.2	Enumerator's name	
1.3	Study	1) Endline cohort -1 2) Endline cohort -2
1.4a	[If 1.3 = Cohort 2] Community at endline	1) Aginuro 2) Canacue 3) Nacuca 4) Namachaca
1.4b	[If 1.3 = Cohort 2] Community at Endline	1) Aginuro 2) Canacue 3) Nacuca 4) Namachaca
1.5	Do you consent to participate?	1) Yes 2) No If "No" selected, "Consent not given", you should end the interview here. Please thank the respondent for their time and end the interview.
1.6	What is your first and last name?	
1.7	What is your gender?	1) Male 2) Female
1.8	What is your relationship as primary caregiver to child/ren under age 3 in your home?	1) Mother (Biological) 2) Father (Biological) 3) Grandmother 4) Grandfather 5) Sibling age 13 or older 6) Sibling age younger than 13 7) Other relative 8) Guardian not related to the child
1.9	What is your age? (Choose applicable range instead of reading options.)	1) 6-14 2) 15-35 3) 36-49 4) 50-64 5) 65+ 98) Don't know 99) No answer / No response
1.10	If 1.8 = mother or father: How many children do you have? Else: How many children do you take care of as primary caregiver?	1) 0 2) 1 3) 2 4) 3 5) 4 6) 5 7) 6 or more, please specify _____ 98) Don't know 99) No answer / No response
1.11a	[If 1.10 > 0]	1) 0

#	Question	Response
	How many children are between the ages of newborn to 35 months (under 3)?	2) 1 3) 2 4) 3 5) 4 or more, please specify _____ 98) Don't know 99) No answer / No response
1.11b	[If 1.10 > 0] How many children are 3-5 years old?	1) 0 2) 1 3) 2 4) 3 5) 4 or more, please specify _____ 98) Don't know 99) No answer / No response
1.11b1	[If 1.10 >= 1] What is the name of the youngest child	[Name_child1]
1.11b2	[If 1.10 >= 2] What is the name of second youngest child	[Name_child2]
1.11b3	[If 1.10 >= 3] What is the name of third youngest child	[Name_child3]
1.11b4	[If 1.10 >= 4] What is the name of fourth youngest child	[Name_child4]
1.11c	[If 1.10 > 0] How many children are 6 -11 years old?	1) 0 2) 1 3) 2 4) 3 5) 4 or more, please specify _____ 98) Don't know 99) No answer / No response
1.11d	[If 1.10 > 0] How many children are 12-18 years old?	1) 0 2) 1 3) 2 4) 3 5) 4 or more, please specify _____ 98) Don't know 99) No answer / No response
1.12	What is your marital status?	1) Single or not living with a partner 2) Married or living with a partner 3) Divorced or separated 4) Widowed 99) No answer / No response
1.13	What is the highest level of school attended?	1) Did not attend school 2) Primary 3) Secondary 4) Tertiary or higher education 98) Don't know 99) No answer / No response
1.14	What is your occupation?	1) Self-employed 2) Employed – Informal

#	Question	Response
		3) Employed - Formal (Salaried) 4) Agriculture 5) Unemployed 6) Student 7) Other, please specify _____ 98) Don't know 99) No answer / No response

PART 2: Demographics - human resilience survey

#	Question	Response
2.1	Community	[is same as question 1.3 and will be automatically populated]
2.2	How many members does the household have?	1) 0 2) 1 3) 2 4) 3 5) 4 6) 5 7) 6 8) 7 9) 8 10) 9 11) Other, please specify _____ 98) Don't know 99) No answer / No response
2.3	How many household members are 14 years-old or younger?	1) 0 2) 1 3) 2 4) 3 5) 4 6) 5 7) 6 8) 7 9) 8 10) 9 11) Other (please specify) 98) Don't know 99) No answer / No response
2.4	Are all household members ages 6 to 12 currently attending school?	1) Yes 2) No 3) There is no one aged 6 to 12 in household 98) Don't know 99) No answer / No response
2.5	What is the highest educational level that the female head/spouse has reached?	1) Did not attend school 2) Primary 3) Secondary 4) Tertiary or higher education

#	Question	Response
		98) Don't know 99) No answer / No response
2.6	What is the main construction material used for the outer wall?	1) Mud bricks/earth, wood, bamboo, metal sheet/slate/asbestos, palm leaves/thatch (grass/raffia), or other 2) Cement/concrete blocks, landcrete, stone, or burnt bricks 3) Other, please specify. _____ 98) Don't know 99) No answer / No response
2.7	What is the main construction material of the floors of the residence?	1) Dirt 2) Mud bricks, poured concrete, or wood 3) Cement bricks 4) Ceramic tile or granite 5) Other, please specify _____ 98) Don't know 99) No answer / No response
2.8	What is the main building material used for the roof of the main building?	1) Grass, leaves, or mud 2) Iron sheets, tiles, concrete, or asbestos 3) Other, please specify _____ 98) Don't know 99) No answer / No response
2.9	What type of toilet facility is usually used by the household?	1) No toilet facility (bush, beach), or other 2) Pit latrine, bucket/pan 3) Public toilet (e.g., W.C., KVIP, pit pan) 4) Kumasi Ventilated Improved Pit (KVIP) or W.C. 98) Don't know 99) No answer / No response
2.10	What is the household's source of water?	1) Not public network 2) Public network 98) Don't know 99) No answer / No response
2.11	Does this household own a television?	1) Yes 2) No 98) Don't know 99) No answer / No response
2.12	How many working mobile phones are owned by [all] members of the household [in total together]?	1) 0 2) 1 3) 2 4) 3 5) Other (please specify) 98) Don't know 99) No answer / No response
2.13	Does the household possess a refrigerator?	1) Yes 2) No 98) Don't know 99) No answer / No response
2.14	Does the household possess a cooker (gas, kerosene, electric)?	1) Yes 2) No

#	Question	Response
		98) Don't know 99) No answer / No response
2.15	Is your house connected to electricity?	1) Yes 2) No 98) Don't know 99) No answer / No response
2.16	What is the main occupation of the male head/ spouse?	1) No data or no main occupation 2) Farmer, rancher, agricultural worker, or no male head/spouse 3) Shop owner, salesperson, service worker, transport and storage operator, or worker in textiles, construction, mechanics, graphics, chemicals, food processing, etc. 4) Office worker, transportation operator, professional, technician, director, manager, administrator, or related job 5) Other, please specify. _____ 98) Don't know 99) No answer / No response
2.17	If the household cultivated any crops in the last 12 months, does it currently own any bulls, cows, steers, heifers, male calves, female calves, or oxen?	1) No crops, and no cattle 2) No crops, but yes cattle 3) Yes crops, and yes cattle 4) Yes crops, but no cattle 98) Don't know 99) No answer / No response
2.18	What is the main fuel used by the household for cooking?	1) None, no cooking done in household 2) Wood, crop residue, sawdust, animal waste, or other 3) Charcoal or kerosene 4) Gas or electricity 98) Don't know 99) No answer / No response
2.19	Does any household member own a working bicycle, motorcycle, or car? [Multiple answers possible]	1) None 2) Bicycle 3) Motorcycle 4) Car 98) Don't know 99) No answer / No response
2.20	On a scale 1 to 10, where would you place your household on the ladder in terms of economic status? (where higher the number the more economic status, with1 the lowest and 10 the highest)	1) 1 2) 2 3) 3 4) 4 5) 5 6) 6 7) 7 8) 8 9) 9 10) 10 98) Don’t know

#	Question	Response
		99) No answer / No response
2.21	Do you — by yourself or with other people — currently have an account at a bank?	1) Yes 2) No 98) Don't know 99) No answer / No response
2.22	Do you or anyone in your household currently have money set aside as savings?	1) Yes 2) No 98) Don't know 99) No answer / No response
2.23	Did anyone in your household go to bed hungry in the last 7 days? *(***need to ask at same time of year / same season)*	1) Yes 2) No 98) Don't know 99) No answer / No response
2.24	How many meals a day do you eat in your household?	1) 1 2) 2 3) 3 4) Other, please specify _____ 98) Don't know 99) No answer / No response

PART 3: Primary caregiver's stimulation practices

#	Question	Response
If question 1.11a = 0 and >= 98 then skip part 3 entirely Repeat all the questions for all children under 3, so for [Name child1]; [Name child2]; [Name child3] and [Name child4].		
I am interested in learning about the things you (as primary caregiver) do with all children under 3 years. In the past week (7 days), have YOU done any of the following activities with [child name] in the household ? If so, how many times during the past week?		
3.1	Read books or look at picture books with [child name] ?	0) Never 1) Once or twice a week 2) Multiple times a week 3) Every day or nearly every day 98) Don't remember/don't know
3.2	Sing songs to [child name] ?	0) Never 1) Once or twice a week 2) Multiple times a week 3) Every day or nearly every day 98) Don't remember/don't know
3.3	Take [child name] out of home (e.g., to the field, market, or for a walk)?	0) Never 1) Once or twice a week 2) Multiple times a week 3) Every day or nearly every day 98) Don't remember/don't know
3.4	Play with [child name] ?	0) Never 1) Once or twice a week 2) Multiple times a week

#	Question	Response
		3) Every day or nearly every day 98) Don't remember/don't know
3.5	Name or count things [child name] ?	0) Never 1) Once or twice a week 2) Multiple times a week 3) Every day or nearly every day 98) Don't remember/don't know
3.6	Draw things with [child name] (e.g., on the sand)?	0) Never 1) Once or twice a week 2) Multiple times a week 3) Every day or nearly every day 98) Don't remember/don't know
3.7	Tell stories to [child name] ?	0) Never 1) Once or twice a week 2) Multiple times a week 3) Every day or nearly every day 98) Don't remember/don't know
3.8	Provide [child name] with object to grasp or pick up?	0) Never 1) Once or twice a week 2) Multiple times a week 3) Every day or nearly every day 98) Don't remember/don't know
3.9	Encourage [child name] to crawl, run, or jump up?	0) Never 1) Once or twice a week 2) Multiple times a week 3) Every day or nearly every day 98) Don't remember/don't know
3.10	Hug or kiss [child name] ?	0) Never 1) Once or twice a week 2) Multiple times a week 3) Every day or nearly every day 98) Don't remember/don't know
3.11	Praise [child name] ?	0) Never 1) Once or twice a week 2) Multiple times a week 3) Every day or nearly every day 98) Don't remember/don't know
3.12	Other activity with [child name] (specify): _____	0) Never 1) Once or twice a week 2) Multiple times a week 3) Every day or nearly every day 98) Don't remember/don't know
Sometimes adults taking care of children have to leave the house to go shopping, wash clothes, or for other reasons and have to leave young children under 3 years old.		
3.13	On how many days in the past week [child name] was left alone for more than an hour?	0) Never 1) Once or twice a week 2) Multiple times a week 3) Every day or nearly every day

#	Question	Response
		98) Don't remember/don't know
3.14	On how many days in the past week [child name] was left in the care of another child, that is, someone less than 10 years old, for more than an hour?	0) Never 1) Once or twice a week 2) Multiple times a week 3) Every day or nearly every day 98) Don't remember/don't know

PART 4: Play and learning materials

#	Question	Response
If question 1.11a = 0 and >= 98 then skip part 4 entirely Repeat the questions 4.1-4.4for all children under 3, so for [Name child1]; [Name child2]; [Name child3] and [Name child4].		
I am interested in learning about the things that any child under 3 years old plays with when he/she is at home.		
4.1	In the past 7 days, has [child name] played-with home-made toys? (e.g., home-made dolls, home-made cars, home-made ball, or other toys made at home)	1) Yes 2) No 98) Don't remember/don't know
4.2	In the past 7 days, has [child name] played with played with store- bought toys or manufactured toys? (e.g. pencils, plastic ball, store-bought car, blocks, etc.)	1) Yes 2) No 98) Don't remember/don't know
4.3	In the past 7 days, has [child name] played with household objects? (e.g., boxes, bottle caps, capulana (old wraps) etc.)	1) Yes 2) No 98) Don't remember/don't know
4.4	In the past 7 days, has [child name] played with objects in the natural environment? (e.g., sticks, rocks, dirt, etc.)	1) Yes 2) No 98) Don't remember/don't know
[The following questions should only be asked once]		
4.5	Do you have any children's books or picture books in the household?	1) Yes 2) No => skip to part 5 98) Don't remember/don't know=>skip to part 5
4.6	How many children's books or picture books are there in the household?	

PART 5: Primary caregiver discipline practices

#	Question	Response
If question 1.11a = 0 and >= 98 then skip part 5 entirely Repeat all the questions for all children under 3, so for [Name child1]; [Name child2]; [Name child3] and [Name child4].		
Adults use certain ways to teach children the right behavior or to address a behavior problem. I will mention various methods that parents might use with their children, and I want you to tell me if YOU (primary caregiver) have used this method with [child name] in the past month.		
5.1	Shook [child name] ?	1) Yes 2) No

#	Question	Response
		8) Don't remember/don't know/refuse to answer
5.2	Shouted, yelled at or screamed at [child name] ?	1) Yes 2) No 8) Don't remember/don't know/refuse to answer
5.2	Shouted, yelled at or screamed at [child name]?	1) Yes 2) No 8) Don't remember/don't know/refuse to answer
5.3	Spanked, hit or slapped [child name] on the bottom with bare hand?	1) Yes 2) No 8) Don't remember/don't know/refuse to answer
5.4	Hit [child name] on the bottom or elsewhere on the body with something like a belt, hairbrush, stick or other hard object?	1) Yes 2) No 8) Don't remember/don't know/refuse to answer
5.5	Called [child name] dumb, lazy, or another name like that?	1) Yes 2) No 98) Don't remember/don't know/refuse to answer
5.6	Hit or slapped [child name] on the face, head or ears?	1) Yes 2) No 98) Don't remember/don't know/refuse to answer
5.7	Hit or slapped [child name] on the hand, arm, or leg?	1) Yes 2) No 98) Don't remember/don't know/refuse to answer
5.8	Beat [child name] up – that is, hit child name] child over and over as hard as possible?	1) Yes 2) No 98) Don't remember/don't know/refuse to answer
5.9	Distracted the child name child by giving the child something else to do?	1) Yes 2) No 98) Don't remember/don't know/refuse to answer
5.10	Took away a privilege [child name]? (Relevant for children 2 and older)	1) Yes 2) No 98) Don't remember/don't know/refuse to answer 99) Not Applicable
5.11	Sent the [child name] to a time out/go to another space and sit quietly for a short while? (Relevant for children 2 and older)	1) Yes 2) No 98) Don't remember/don't know/refuse to answer 99) Not Applicable
5.12	Ignored the behavior of [child name]?	1) Yes 2) No 98) Don't remember/don't know/refuse to answer

#	Question	Response
5.13	Explained why the behavior was wrong/bad	1) Yes 2) No 98) Don't remember/don't know/refuse to answer
5.14	Praised good behavior instead of correcting bad behavior	1) Yes 2) No 98) Don't remember/don't know/refuse to answer
5.15	Demonstrating the good behavior to the child that he/she should do instead of what the child is doing wrong	1) Yes 2) No 98) Don't remember/don't know/refuse to answer
5.16	Put things out of reach	1) Yes 2) No 98) Don't remember/don't know/refuse to answer
5.17	Having the [child name] experience the consequences of their bad behavior	1) Yes 2) No 98) Don't remember/don't know/refuse to answer
5.18	Have you changed how you discipline your child/ren since your participation in the MTM program regarding **physical punishment?**	1) More physical punishment 2) Less physical punishment 3) Same level of physical punishment
5.19	Have you changed how you discipline your child/ren since your participation in the MTM program regarding **verbal punishment?**	1) More verbal punishment 2) Less verbal punishment 3) Same level of verbal punishment
5.20	Have you changed how you discipline your child/ren since the participation in the MTM program **regarding positive disciplinaries?**	1) More positive disciplinaries 2) Less positive disciplinaries 3) Same level of positive disciplinaries
5.21	What positive behaviour has increased since your participation in the MTM program? [Multi-select]	1) Distracting the child 2) Took away a privilege 3) Sent child away for a time out 4) Ignored the behavior 5) Explained why behavior was wrong 6) Praised good behavior 7) Put things out of reach 8) Having the child experience the consequences of their bad behavior 9) Demonstrating the good behavior to the child that he/she should do instead 10) None 11) Other, specify
5.22	In the last 2 years have you ever asked the ECD volunteer who visited you at	1) Yes 2) No

#	Question	Response
	home (and led your caregiver group) for parenting information, advice, help or referrals for services– either for you as a parent/caregiver or for your children?	98) Don't remember/don't know/refuse to answer
5.22a	If yes, what you asked for?	
5.23	How helpful was the ECD volunteer to you?	1) Very helpful 2) Somewhat helpful 3) Not really able to help 98) Don't remember/don't know/refuse to answer

PART 6: Birth registration

#	Question	Response
If question 1.11a = 0 and >= 98 then skip question 6.1 Repeat question 6.1 for all children under 3, so for [Name child1]; [Name child2]; [Name child3] and [Name child4].		
6.1	Has child name] 's birth been registered with the civil authorities?	1) Yes 2) No 98) Don't remember/don't know
6.2	Do you know how to register a child's birth?	1) Yes 2) No 98) Don't remember/don't know

PART 7 Community Connectedness and Economic empowerment

#	Question	Response
7.1	How much do you feel like you have in common with other caregivers in your community (in your group)?	1) Strongly agree 2) Agree 3) Disagree 4) Strongly disagree 98) Don't know/refuse to answer
7.2	How much do you feel like other caregivers in your community (in your group) care about you?	1) Strongly agree 2) Agree 3) Disagree 4) Strongly disagree 98) Don't know/refuse to answer
7.3	Do you feel that you are supported by your own community as caregiver of children?	1) Strongly agree 2) Agree 3) Disagree 4) Strongly disagree 98) Don't know/refuse to answer
7.4	What are the types of support that have been provided other than material assistance? [Multiple answers possible]	0) No support 1) Advice 2) Counselling 3) Other, specify _____ 98) Don't know 99) No answer / No response
7.5	Who in the past (six) months has provided you with various kinds of	0) No answer / No response 1) Elder

#	Question	Response
	support: advice, counselling, and other forms of support other than material support?	2) Neighbor 3) Faith leader 4) Community leader 5) Volunteer/APE 6) Other, specify _____ 98) Don't know 99) No answer / No response
7.6	Overall, do you feel that you have all the support you need from your community?	1) Yes 2) No 3) Don't know 4) No answer / No response
7.7	If 7.6 is 2) No What support do you feel you lack?	7.7
7.11	In the last month, have you felt that caring for your child(ren) has taken more time and energy than you have to give?	1) Yes, most of the time 2) Yes, some of the time 3) No, not very often 4) No, hardly ever 98) Don't know 99) No answer / No response
7.12	In the last month, have you felt overwhelmed by the responsibilities of being a primary caregiver?	1) Yes, most of the time 2) Yes, some of the time 3) No, not very often 4) No, hardly ever 98) Don't know 99) No answer / No response
7.13	In the last month, have you felt worried about whether you are doing enough for your child(ren)?	1) Yes, most of the time 2) Yes, some of the time 3) No, not very often 4) No, hardly ever 98) Don't know 99) No answer / No response
7.14	How do you feel about your parental stress since your participation in the MTM program?	1) Less stress 2) More stress 3) Same stress level 98) Don't know 99) No answer / No response stress level
7.15	If 7.14 – 1) less stress Which items have contributed to less stress	1) Not taken more time/energy 2) Not feeling overwhelmed 3) Not being worried of doing enough 4) Others, specify
7.21a-7.24a	If caregiver is (biological) father: In the last week, how often did you/as a father find time to interact or play with your child [child name] [for each child this question will be asked separately]	1) Didn't find time (0 days) 2) 1-2 days 3) 3-4 days 4) 5-6 days 5) Every day (7 days) 98) Don't know 99) No answer / No response
7.21b-7.24b	If caregiver is not the (biological) father:	1) Didn't find time (0 days) 2) 1-2 days

#	Question	Response
	In the last week, how often did the father find time to interact or play with his child [child name] [for each child this question will be asked separately]	3) 3-4 days 4) 5-6 days 5) Every day (7 days) 98) Don't know 99) No answer / No response
7.25a	If caregiver is the (biological) father: Have you changed the time spent intentionally interacting/playing with child(ren) (0-3) since your participation in the MTM program?	1) Interacted more 2) Interacted the same as in the beginning 3) Interacted less 98) Don't know 99) No answer / No response
7.25b	If caregiver is not the (biological) father: Has the father changed the time spent intentionally interacting/playing with child(ren) (0-3) since the participation in the MTM program?	1) Interacted more 2) Interacted the same as in the beginning 3) Interacted less 98) Don't know 99) No answer / No response

PART 8 Report change in assets since joining the program

#	Question	Response
8.1	Are you part of a Savings with Education savings & loan program?	1) Yes 2) No => skip to part 9 98) Don't know => skip to part 9 99) No answer / No response => skip to part 9
8.1a	Have you accessed loans in the last 12 months?	1) Yes 2) No 98) Don't remember/don't know 99) No answer / No response
8.2	What household items have you purchased using loans or savings from being in the Savings with Education savings & loan program? [Multiple options 1 and 2 possible]	1) Furniture 2) Household appliances 3) Did not purchase any household items while a group member 98) Don't know => skip to part 9 99) No answer / No response => skip to part 9
8.3	[IF 8.2 = 1] Which furniture items? [Multiple options possible]	1) Armoire/Wardrobe 2) Bed 3) Cabinet 4) Chair 5) Cupboard 6) Sofa 7) Table 8) Other, please specify _____
8.4	[IF 8.2 = 2] Which household appliance items? [Multiple options possible]	1) Air conditioner 2) Clock 3) Fan 4) Fridge 5) Generator 6) Grain grinder 7) Radio 8) Sewing machine

#	Question	Response
		9) TV 10) Water heater 11) Water pump 12) Other, please specify _____

PART 9 Us savings and/or loans to start or expand income generating activities.

#	Question	Response
9.1	Do you own or manage a business?	1) Yes 2) No => skip to part 9 98) Don't know => skip to part 9 99) No answer / No response => skip to part 9
9.2	Since when have you had this business?	1) **After** joining the Savings with Education savings & loan program 2) **Before** joining the Savings with Education savings & loan program 98) Don't know 99) No answer / No response
9.3	Did you start a new business using loans or savings from being a Savings with Education group member?	1) Yes 2) No 98) Don't know 99) No answer / No response
9.4	Did you expand a business using loans or savings from being a Savings with Education group member?	1) Yes 2) No 98) Don't know 99) No answer / No response

Annex A1.2: Qualitative Evaluation tool - In Depth Interview – Caregivers

#	Question
1	Can you tell me about your experience participating in the MTM program so far?
2	What topics did learn in this program? a) Probe about specific topics learned. b) What did you learn specifically in the group meetings? c) What did you learn during the home visits? d) Were any topics unclear to you? e) How comfortable were you with the language used to deliver the lessons?
3	a) Which topics or lessons did you enjoy learning about the most? b) Were there any topics or messages that you did not enjoy? c) Were there any topics you wished you could have learned more about?
2	What topics did learn in this program? a) Probe about specific topics learned. b) What did you learn specifically in the group meetings? c) What did you learn during the home visits? d) Were any topics unclear to you?
3	a) What did you like the most about this program? b) What did you not like about the program?
4	From whom did you learn these messages as part of the MTM program? a) What did you learn specifically from the ECD Promoters? b) What did you learn specifically from the faith leaders? c) Did you learn about child development or parenting from anyone else in the community? If so from whom and what context?
5	What do you think about the ECD Promoters' ability to lead the sessions? a) What do they do well? How can they improve their facilitation skills? b) Probe ECD Promoter's skills too. c) How comfortable did you feel talking with the ECD Promoter? d) Is there anything you wish the ECD Promotor could have done differently or improved upon?
6	What do you think about the faith leaders role in the sessions? a) How comfortable did you feel talking with the faith leader? b) Is there anything you wish the faith leader could have done differently or improved upon?
7	How would you compare the role of your ECD Promoter versus faith leader in the MTM program? 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? c) Who was more influential in helping you care for your child? d) How important is it to have both the ECD Promoter and faith leader involved in the program? Or is only one person enough?
8	What are your opinions about the duration, frequency, and timing of the sessions? Were you able to attend all the sessions? a) How easy or difficult was it for you to attend? b) What changes if any would you make to the program duration/frequency/timing? c) Do you feel the overall program was too long (there were too many sessions; too short too long or the right duration?

#	Question
	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?
9	How has the program changed your parenting? a) What new practices have you applied, if any, since starting the program? b) How, if at all, has the program changed the way you care for your child? c) Have there been any changes to your child or family since starting the program? d) Has the program helped with other personal or family issues? How about in your relationship with your partner? Or the way your male partner cares for the child?
10	What specific aspect(s) of the MTM program had the biggest impact in contributing to these changes in you and your child's life? a) 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 a) 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
11	Were the ECD Promoters helpful in addressing specific parenting concerns? a) What concerns did you have and a) b) How where they addressed?
12	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? a) What makes it difficult or easy to practice the lessons learned from the sessions in your own life?
13	a) Did a male caregiver in your household (i.e., child's father) participate in the MTM program? If **YES** b) who was this male caregiver and to what extent did he participate? c) How did this male caregiver react to your participation in the MTM program? d) What were the challenges that make it difficult for a male caregiver from your family to participate in the program? e) Have you noticed any changes in the action of the male caregiver because of the MTM program? If **NO:** f) Why did no male caregivers in your household participate in the program? g) Did you ever try inviting a male caregiver to participate in the program? h) How did this male caregiver react to your participation in the MTM program? a) What were the challenges that make it difficult for a male caregiver from your family to participate in the program?
14	How, if at all, have fathers and other male caregivers participated in the program? a) What makes it easy or difficult for fathers to be engaged in the program? a) What can be done to make the program more engaging for fathers?
15	Do you think other caregivers will want to participate in this program? Why? What can be done to make the program more engaging for caregivers in the future?
16	Besides this MTM program, do you participate in other group meetings or discussions in your community? a) Where and how often do they take place? b) What have you learned from these meetings?
17	What is your experience with the ECD Committee?

#	Question
	a) Have you engaged with the ECD Committee personally, if yes where and how frequent? b) How have they assisted/helped you? Can you give an example? c) How could they assist you even more/better in the future?
18	What is your experience with the Faith leaders? a) Have you engaged with a Faith leader personally, if yes where and how frequent? b) How have they assisted/helped you? Can you give an example? c) How could they assist you even more/better in the future?
19	Is there anything else you would like to share about this program?

Annex A1.3: Qualitative Evaluation tool - In Depth Interview – ECD Committee members

#	Question
1	Please tell us about what you do as a committee to support the MTM program?
2	How would you describe the purpose of the ECD Committee? • How does the ECD Committee fit into the overall MTM program model.
3	How was the ECD Committee formed?
4	Who is included in the committee? • How many ECD members are working in the district? • Are the right people included? • Probe: If not, who is missing?
5	How do you function as a committee? • What roles are in the ECD Committee?
6	Can you describe a typical ECD Committee meeting? • What happens during the meeting? • How do you set your agenda? • How often do you meet?
7	As the ECD Committee, how involved have you been with caregivers at the community level? • What activities have you been a part of, if any at all? • What kinds of support, if any, do you provide to caregivers? And under what circumstances are you involved?
8	As the ECD Committee, which community partners do you work mostly closely with?
9	How, if at all, has your ECD Committee worked with ECD Promoters? • Probe about the specific activities or types of engagements with ECD Promoters
9	How, if at all, has your ECD Committee worked with Faith Leader? • Probe about the specific activities or types of engagements with Faith Leaders
10	How, if at all, has your ECD Committee worked with the health sector • Probe about the specific activities or types of engagements with the health sector
11	How, if at all, has your ECD Committee worked with the local government • Probe about the specific activities or types of engagements with the local government
12	How many ECD Committees are there in Monapo district?
13	How many of your ECD members have been trained in ECD/Nurturing Care? Probe: Trained by whom? Probe: What ECD topics where covered?
14	How many of the ECD Promoters have been trained in ECD/Nurturing Care?
15	How many of these trained promotors have maintained ECD/Parenting knowledge and skills at the end of the first cycle
16	How do you know they maintain critical ECD/Parenting knowledge and skills at the end of the first cycle?
17	Can you tell me how many of these consortia are fully engaged with the ECD work?
18	How does your ECD Committee ensure that the program is implemented well? Probe: do you have a monitoring plan?
19	How do you work with faith leaders in the program?
20	How is the supervision done for the ECD activities implemented by your ECD Committee? Probe: How do you supervise the work of ECD Promoters?
21	Does your ECD Committee have a full quality monitoring and implementation program? If Yes:

	• Probe: How, does it look like? What do you do to ensure quality? What is done and by whom if the quality is not sufficient? • Probe: Has the quality of the implementation changed over time? And if so how? If No: • Why not?
22	What successes has your ECD Committee achieved in the MTM program so far? • What contributed to these successes?
23	Are there any new service linkages that the ECD Committee has helped establish in the community that were not present prior to the program? • In your opinion, what contributed to these new linkages in your community?
24	What challenges has your ECD Committee faced in this MTM program so far? • What could help to overcome these challenges in the future?
25	**Finally, I would like to hear about your opinions about the impacts of the MTM program.** What have been the most significant changes in your community as a result of the MTM program?
26	In your opinion, have there been any negative impacts of the program?
27	In conclusion, what have you liked the most about the MTM program? What have you not liked about the program?
28	What suggestions or recommendations do you have for improving the MTM program?
29	Is there anything else you would like to share about this program?

Annex A1.4: Qualitative Evaluation tool - In Depth Interview – Faith leaders

#	Question
1	Please tell us about what you do as faith leaders in the MTM program?
2	Please tell me about the training you received to carry out your role as a faith leader in the MTM program? • How often did you receive training, and from whom? • What topics were you trained on? • How satisfied are you with the training that you received as a faith leader? Why • What additional training would have been helpful for you to carry out your role as an faith leader?
3	Tell me about what you did as a faith leader during the caregiver group sessions and home visits. • What were the main topics/lessons that you counseled caregivers about during the caregiver groups and home visits? • Probe: early learning, responsive caregiving • Which topics were easy to facilitate? • Were there any topics that were difficult for you to facilitate? Why • What would make it easier for you to facilitate these difficult topics?
4	Please tell me about the support or supervision you received in your role as a faith leader in this program? • How often did you receive supportive supervision? From whom? • What additional support or supervision would have helped you be more effective in your role as a faith leader?
5	What materials and resources did you receive from the project to carry out your work as an faith leader? • How did you use these materials during caregiver group sessions? During home visits? • What additional materials or resources would you have liked to receive to do your job better as a faith leader?
6	Overall, how do you think caregivers felt about the program • What aspects of the program do you think caregivers find most beneficial for them? Probe: early learning, responsive caregiving • What topics did the caregivers not enjoy as much? • How could the MTM program better support caregivers and meet their needs?
7	Have you noticed any changes in caregivers' behaviors or actions because of the program? • Probe about changes for not only the caregiver, but also the child and family • Which aspect(s) of the program do you believe contributed most to these changes? • What behaviors or actions were difficult for caregivers to change? • What questions did caregivers commonly ask you when you met with them?
11	Have you seen caregivers change because of their participation in the program? • If so how/what? • Any difference in change in behavior with regard to male and female caregivers? • How have you seeing children change? • If so how/what?
12	How often did you refer participants for other services? • What were the main issues that caregivers/child in your group faced that necessitated such referrals? • Who did you refer them to? • What was your experience when you had to make referrals?

13	How, if at all, has your work as a Faith Leader within your community changed since this program started? • With whom and where have you shared what you have learned through the MTM program? • What new messages have you incorporated into your work as a faith leader in these settings?
14	Have you noticed any changes in fathers'/male caregivers' behaviors or actions because of the program? • In the future, what can be done to encourage more fathers/male caregivers to participate in this program?
15	How did you work (collaborate) with ECD Promoters during the program? • How often did you interact with ECD Promoters? • Did ECD Promoters ask you for support? • Probe: If yes, please explain. • What did ECD Promoters do in the program? • What made it easy to work with the ECD Promoter(s)? • What made it difficult to work with the ECD Promoter(s)? • In a future, how could faith leaders and ECD Promoters collaborate better as part of the MTM program?
16	Can you tell me about the MTM ECD Committee and what the committee does? • Who is included in this committee. How does this committee work? • Have you personally had any direct experience with the ECD Committee during the course of the program • How could the ECD Committee better support the program?
17	How many MTM faith leaders are working in the district? Probe: Where are they based?
18	How many of the MTM faith leaders have been trained in ECD/Nurturing Care? Probe: Trained by whom? Probe: What ECD topics where covered?
19	How many of the ECD Promoters have been trained in ECD/Nurturing Care?
20	How many of these trained promotors have maintained ECD/Parenting knowledge and skills at the end of the first cycle?
21	How many of these trained ECD Promoters maintained critical ECD/Parenting knowledge and skills at end of first cycle? Probe: How do you know they maintain critical ECD/Parenting knowledge and skills at the end of the first cycle?
22	How many MTM faith Leaders Consortia are there in Monapo district?
23	Can you tell me how many of these consortia are fully engaged with the ECD work?
24	How do these MTM faith Leaders Consortia ensure that the program is implemented well? Probe: do they have a monitoring plan?
25	How are the supervisions done for these ECD activities implemented by the MTM faith Leaders Consortia?
26	Do the MTM faith Leaders Consortia have a full quality monitoring and implementation program? If Yes: • Probe: How, does it look like? What do you do to ensure quality? What is done and by whom if the quality is not sufficient? • Probe: Has the quality of the implementation changed over time? And if so how? If No: • Why not?

27	We are at the final section now. I have a few concluding questions. Overall, what have you liked the most about this program? • What have you not like about this program?
28	What could be done to improve the program? • What additional support or resources could help you as a faith leader to make the greatest impact for caregivers and young children? • Probe: What could faith leaders do to improve the program?
29	How do you see your role in 2025 and beyond?
30	Is there anything else you would like to share about this program?

Annex A1.5: Qualitative Evaluation tool - In Depth Interview – Promotors

#	Question
1	Please tell us about what you do as a ECD Promoter in the MTM program? Besides being an ECD Promoter, what do you do for your main source of work?
2	Please tell me about the training you received to carry out your role as an ECD Promoter in the MTM program? • How often did you receive training, and from whom? • What topics were you trained on? • How satisfied are you with the training that you received as an ECD Promoter? Why • What additional training would have been helpful for you to carry out your role as an ECD Promoter?
3	Did you attend the caregivers group sessions? • If so, what did you do during the caregivers group sessions? • What were the main topics/lessons that you counseled caregivers about during the caregiver groups? • Probe: early learning, responsive caregiving • Which topics were easy to facilitate? • Were there any topics that were difficult for you to facilitate? Why • What would make it easier for you to facilitate these difficult topics?
4	Did you do home visits? • If so: what did you do during the home visits? • What were the main topics/lessons that you counseled caregivers about during home visits? • Probe: early learning, responsive caregiving • Which topics were easy to facilitate? • Were there any topics that were difficult for you to facilitate? Why • What would make it easier for you to facilitate these difficult topics?
5	How similar or different is your role in the caregiver group sessions versus home visits? • Which was easier for you to facilitate? Why? • Which was more effective for caregivers? • What would help make the caregiver group sessions or home visits be more effective for caregivers in the future?
6	Please tell me about the support or supervision you received in your role as an ECD Promoter in this program? • How often did you receive supportive supervision? From whom? • What additional support or supervision would have helped you be more effective in your role as an ECD Promoter?
7	What materials and resources did you receive from the project to carry out your work as an ECD Promoter? • How did you use these materials during caregiver group sessions? During home visits? • What additional materials or resources would you have liked to receive to do your job better as an ECD Promoter?
8	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; too short too long or the right duration? • 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?
9	How was the attendance and participation of caregivers in the caregiver group sessions? • How was their attendance and participation in the home visits?

	• What was the main reasons why caregivers couldn't attend the group sessions? What about for the home visits? • In the future, what changes could be made to improve caregivers' attendance or participation in the program?
10	Overall, how do you think caregivers felt about the program • What aspects of the program do you think caregivers find most beneficial for them? Probe: early learning, responsive caregiving • What topics did the caregivers not enjoy as much? • How could the MTM program better support caregivers and meet their needs?
11	Have you seen caregivers change because of their participation in the program? • If so how/what? • Any difference in change in behavior with regard to male and female caregivers? • How have you seeing children change? • If so how/what?
12	How often did you refer participants for other services? • What were the main issues that caregivers/child in your group faced that necessitated such referrals? • Who did you refer them to? • What was your experience when you had to make referrals?
13	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. • Did you have any fathers/male caregivers within your group? • How easy or difficult was it for you to get fathers/male caregivers to participate in the program? • What made it easy for fathers/male caregivers to participate in the program? What made it difficult for fathers/male caregivers to participate in the program? • Why do you think fathers/male caregivers participated less than women?
14	Have you noticed any changes in fathers'/male caregivers' behaviors or actions because of the program? • In the future, what can be done to encourage more fathers/male caregivers to participate in this program?
15	How did you work (collaborate) with MTM Faith leaders during the program? • What did faith leaders do in the program? • What made it easy to work with the faith leader(s)? • What made it difficult to work with the faith leaders? • In a future, how could ECD Promoters and faith leaders collaborate better as part of the MTM program?
16	Can you tell me about the MTM ECD Committee and what the committee does? • Who is included in this committee? How does this committee work • How do ECD Promoters communicate with the ECD Committee? How does the committee communicate with ECD Promoters? • Have you personally had any direct experience with the ECD Committee during the course of the program? • How could the ECD Committee better support the program?
17	What have you liked most about the program?
18	What, if anything, did you find difficult or hard about the program?
19	What could be done to improve the program? • What additional support or resources could help you as an ECD Promoter to make the greatest impact for caregivers and young children?
20	Is there anything else you would like to share about this program?

Annex A2.1: Ferramentas de estudo

PARTE 1: Demografia - antecedentes

#	Pergunta	Resposta
1.1	Coleta localização GPS	
1.2	Nome do enumerador	
1.3	Estudo	1) Linha de base 2) Linha média
1.4a	[Se 1.3 = Linha de base] Comunidade na linha de base	1) Aginuro 2) Canacue 3) Nacuca 4) Namachaca
1.4b	[Se 1.3 = Linha Média] Comunidade em linha media	1) Iohoane 2) Canacue 3) Nacuca 4) Namachaca
1.5	Consente em participar / Começar a entrevista?	1) Sim 2) Não Se "Não" selecionado, "Consentimento não dado", deverá terminar a entrevista aqui. Por favor, agradeça ao entrevistado pelo seu tempo e termine a entrevista.
1.6	Qual é o seu nome e sobrenome?	
1.7	Qual e o seu gênero?	1) Masculino 2) Feminino
1.8	Qual é a sua relação como cuidador principal de crianças/crianças com menos de 3 anos em sua casa?	1) Mãe (biológica) 2) Pai (Biológico) 3) Avó 4) Avô 5) Irmãos com idade igual ou superior a 13 anos 6) Idade dos irmãos menores de 13 anos 7) Outro parente 8) Tutor não relacionado com a criança
1.9	Qual e a sua idade?(escolha o intervalo aplicável em vez das opções de leitura)	1) 6-14 2) 15-35 3) 36-49 4) 50-64 5) 65+ 98) Não sabe 99) Sem resposta

#	Pergunta	Resposta
1.10	[Se 1.8 = mãe ou pai]: Quantos filhos tem? [Senão:] Quantas crianças você cuida como cuidador principal?	1) 0 2) 1 3) 2 4) 3 5) 4 6) 5 7) 6 ou mais, especifique 98) Não sabe 99) Sem resposta
1.11a	[Se 1.10 > 0] Quantas crianças têm entre as idades do recém-nascido até aos 35 meses (menos de 3)?	1) 0 2) 1 3) 2 4) 3 5) 4 ou mais, especifique 98) Não sabe 99) Sem resposta
1.11b	[Se 1.10 > 0] Quantas crianças têm entre 3 e 5 anos?	1) 0 2) 1 3) 2 4) 3 5) 4 ou mais, especifique 98) Não sabe 99) Sem resposta
1.11b1	[Se 1.10 >= 1] Qual é o nome da criança mais nova	Nome da criança1
1.11b2	[Se 1.10 >= 2] Qual é o nome do segundo filho mais novo	Nome da criança2
1.11b 3	[Se 1.10 >= 3] Qual é o nome do terceiro filho mais novo	Nome da criança3
1.11b 4	[Se 1.10 >= 4] Qual é o nome do terceiro filho mais novo	Nome da criança4
1.11c	[Se 1,10 > 0] Quantas crianças têm entre 6 e 11 anos?	1) 0 2) 1 3) 2 4) 3 5) 4 ou mais, especifique 98) Não sabe 99) Sem resposta

#	Pergunta	Resposta
1.11d	[Se 1,10 > 0] Quantas crianças têm entre 12 e 18 anos?	1) 0 2) 1 3) 2 4) 3 5) 4 ou mais, especifique 98) Não Sabe 99) Sem resposta
1.12	Qual é seu estado civil?	1) Solteiro ou não morando com companheiro 2) Casado ou morando com companheiro 3) Divorciado ou separado. 4) Viúvo 99) Sem resposta
1.13	Qual é o nível mais elevado de escolaridade frequentada?	1) Não frequenta escola, 2) Ensino primário 3) Secundário 4) Terciário ou superior 98) Não sabe 99) Sem resposta
1.14	Qual é a sua profissão?	1) Trabalhador por conta própria 2) Emprego – Informal 3) Emprego - Formal (Assalariado) 4) Agricultura 5) Desempregado 6) Estudante/Aluno 7) Outro, por favor especifique 98) Não sabe 99) Sem resposta

PARTE 2: Demografia - inquérito sobre a resiliência humana

#	Pergunta	Resposta
2.1	Comunidade	[é igual à pergunta 1.3 e será preenchida automaticamente]
2.2	Quantos membros tem o agregado familiar?	1) 0 2) 1 3) 2 4) 3 5) 4 6) 5 7) 6 8) 7 9) 8 10) 9 11) Outro, por favor especifique 98) Não sabe 99) Sem resposta
2.3	Quantos membros do agregado familiar têm 14 anos ou menos?	1) 0 2) 1 3) 2 4) 3 5) 4 6) 5 7) 6 8) 7 9) 8 10) 9 11) Outro, por favor especifique 98) Não sabe 99) Sem resposta
2.4	Todos os membros do agregado familiar com idades compreendidas entre os 6 e os 12 anos frequentam atualmente a escola?	1) Sim 2) Não 3) Não há ninguém com idades compreendidas entre os 6 e os 12 anos no agregado familiar 98) Não sabe 99) Sem resposta
2.5	Qual é o nível educacional mais alto que a chefe/cônjuge atingiu?	1) Não frequentou escola, 2) Ensino primário 3) Secundário 4) Terciário ou superior 98) Não sei 99) Sem resposta

#	Pergunta	Resposta
2.6	Qual é o principal; materia; de construção usado para paredes externas?	1) Tijolos de barro/terra, madeira, bambu, folha de metal/ardósia/amianto, folhas de palmeira/palha (grama/ráfia) ou outros 2) Blocos de cimento/concreto, concreto, pedra ou tijolos queimados 3) Outro, por favor especifique 98) Não sabe 99) Sem resposta
2.7	Qual é o principal material de construção dos pisos da residência?	1) Terra 2) Tijolos de barro, concreto vazado ou madeira 3) Tijolos de cimento 4) Piso cerâmico ou granito 5) Outro, por favor especifique 98) Não Sabe 99) Sem resposta
2.8	Qual é o principal material de construção usado para o telhado do edifício principal?	1) Grama, folhas ou lama 2) Chapas de zinco, telhas, placa de cemento ou lusalite 3) Outro, por favor especifique 98) Não sabe 99) Sem resposta
2.9	Que tipo de instalação sanitária é normalmente utilizada pelo agregado familiar?	1) Sem instalações sanitárias (mato, praia) ou outras instalações 2) Latrina de fossa, balde 3) Banheiro público (por exemplo, W.C., KVIP, fossa) 4) Poço Melhorado Ventilado de Kumasi (KVIP) ou W.C. 98) Não sabe 99) Sem resposta
2.10	Qual é a fonte de água da família?	1) Rede não pública 2) Rede pública 98 Não Sabe 99) Sem resposta
2.11	Este agregado familiar tem uma televisão?	1) Sim 2) Não 98) Não sabe 99) Sem resposta

#	Pergunta	Resposta
2.12	Quantos telemóveis funciona e são propriedade de todos os membros do agregado familiar [no total]?	1) 0 2) 1 3) 2 4) 3 5) Outro (por favor especifique) 98) Não Sabe 99) Sem resposta
2.13	A casa possui um refrigerador?	1) Sim 2) Não 98) Não Sabe 99) Sem resposta
2.14	A casa possui um fogão (gás, querosene, elétrico)?	1) Sim 2) Não 98) Não Sabe 99) Sem resposta
2.15	A sua casa está ligada à eletricidade?	1) Sim 2) Não 98) Não Sabe 99) Sem resposta
2.16	Qual é a ocupação principal do chefe/cônjuge do sexo masculino?	1) Sem dados ou sem ocupação principal 2) Agricultor, pecuarista, trabalhador agrícola ou nenhum chefe/cônjuge do sexo masculino 3) Proprietário de loja, vendedor, trabalhador de serviços, operador de transporte e armazenamento, ou trabalhador têxtil, construção, mecânica, gráficos, produtos químicos, processamento de alimentos, etc. 4) Trabalhador de escritório, operador de transporte, profissional, técnico, diretor, gerente, administrador ou trabalho relacionado 5) Outro, por favor especifique 98) Não Sabe 99) Sem resposta
2.17	Se a família cultivou alguma cultura nos últimos 12 meses?	1) Sim 2) Não 98) Não Sabe 99) Sem resposta
2.17	Se a família atualmente possui touros, vacas, bois, novilhas, bezerros machos, bezerros fêmeas ou bois?	1) Sim 2) Não 98) Não Sabe 99) Sem resposta

#	Pergunta	Resposta
2.18	Qual é o principal combustível utilizado pela família para cozinhar?	1) Nenhuma, não se cozinhou em casa 2) Madeira, resíduos de colheita, serradura, dejetos de animais ou outros 3) Carvão ou querosene 4) Gás ou eletricidade 98) Não sabe 99) Sem resposta
2.19	Algum membro da família possui uma bicicleta, motocicleta ou carro? [Múltiplas respostas possíveis]	1) Nenhum 2) Bicicleta 3) Motocicleta 4) Carro 98) Não sabe 99) Sem resposta
2.20	Numa escala de 1 a 10, onde colocaria o seu agregado familiar na escada em termos de estatuto económico? (onde maior o número mais status econômico, com 1 o mais baixo e 10 o mais alto)	1) 1 2) 2 3) 3 4) 4 5) 5 6) 6 7) 7 8) 8 9) 9 10) 10 98) Não Sabe 99) Sem resposta
2.21	Você - sozinho ou com outras pessoas - atualmente tem uma conta em um banco?	1) Sim 2) Não 98) Não sei 99) Sem resposta
2.22	Você ou alguém em sua família atualmente tem dinheiro guardado na poupança?	1) Sim 2) Não 98) Não Sabe 99) Sem resposta
2.23	Alguém em sua casa foi para a cama com fome nos últimos 7 dias? *[precisa perguntar na mesma época do ano/mesma estação]*	1) Sim 2) Não 98) Não Sabe 99) Sem resposta

#	Pergunta	Resposta
2.24	Quantas refeições por dia você tem em casa?	1) 1 2) 2 3) 3 4) Outro, por favor especifique 98) Não Sabe 99) Sem resposta

PARTE 3: Práticas de estimulação do cuidador principal

#	Pergunta	Resposta
Se a pergunta 1.11a = 0 e >= 98, salta totalmente a parte 3 Repita todas as perguntas para todas as crianças menores de 3 anos, portanto para [Nome da criança1]; [Nome da criança2]; [Nome da criança3] e [Nome da criança 4].		
Estou interessado em aprender sobre as coisas que você (como cuidador principal) faz com todas as crianças menores de 3 anos. Na última semana (7 dias), VOCÊ fez alguma das seguintes atividades com [nome da criança] alguma das crianças menores de 3 anos na casa? Em caso afirmativo, quantas vezes durante a última semana?		
3.1	Ler livros ou ver livros ilustrados com [nome da criança] ?	0) Nunca 1) Uma ou duas vezes por semana 2) Várias vezes por semana 3) Todos os dias ou quase todos os dias 98) Não se lembra/não sabe
3.2	Cantar para [nome da criança] ?	0) Nunca 1) Uma ou duas vezes por semana 2) Várias vezes por semana 3) Todos os dias ou quase todos os dias 98) Não se lembra/não sabe
3.3	Levar [nome da criança] para fora de casa (por exemplo, para o campo, mercado ou para passear)?	0) Nunca 1) Uma ou duas vezes por semana 2) Várias vezes por semana 3) Todos os dias ou quase todos os dias 98) Não se lembra/não sabe
3.4	Brincar com [nome da criança] ?	0) Nunca 1) Uma ou duas vezes por semana 2) Várias vezes por semana 3) Todos os dias ou quase todos os dias 98) Não se lembra/não sabe

#	Pergunta	Resposta
3.5	Nomear ou contar coisas [nome da criança]	0) Nunca 1) Uma ou duas vezes por semana 2) Várias vezes por semana 3) Todos os dias ou quase todos os dias 98) Não se lembro/não sabe
3.6	Desenhar coisas com a criança [nome da criança] (por exemplo, na areia)	0) Nunca 1) Uma ou duas vezes por semana 2) Várias vezes por semana 3) Todos os dias ou quase todos os dias 98) Não se lembra/não sabe
3.7	Contar histórias para a criança [nome da criança]	0) Nunca 1) Uma ou duas vezes por semana 2) Várias vezes por semana 3) Todos os dias ou quase todos os dias 98) Não se lembra/não sabe
3.8	Forneça à criança [nome da criança] um objeto para agarrar ou pegar	0) Nunca 1) Uma ou duas vezes por semana 2) Várias vezes por semana 3) Todos os dias ou quase todos os dias 98) Não se lembra/não sabe
3.9	Incentiva a criança [nome da criança] a engatinhar, correr ou saltar?	0) Nunca 1) Uma ou duas vezes por semana 2) Várias vezes por semana 3) Todos os dias ou quase todos os dias 98) Não se lembra/não sabe
3.10	Abraça ou dá beijinhos [nome da criança]	0) Nunca 1) Uma ou duas vezes por semana 2) Várias vezes por semana 3) Todos os dias ou quase todos os dias 98) Não se lembra/não sabe
3.11	Elogiar [nome da criança]	0) Nunca 1) Uma ou duas vezes por semana 2) Várias vezes por semana 3) Todos os dias ou quase todos os dias 98) Não se lembra/não sabe
3.12	Outra atividade (especifique)	0) Nunca 1) Uma ou duas vezes por semana 2) Várias vezes por semana 3) Todos os dias ou quase todos os dias 98)Não se lembra/não sabe
Às vezes, os adultos que cuidam de crianças têm que sair de casa para ir às compras, lavar roupas ou por outros motivos e têm que deixar crianças menores de 3 anos.		

#	Pergunta	Resposta
3.13	Em quantos dias na semana passada [nome da criança] foi deixado sozinho por mais de uma hora?	0) Nunca 1) Uma ou duas vezes por semana 2) Várias vezes por semana 3) Todos os dias ou quase todos os dias 98) Não se lembra/não sabe
3.14	Em quantos dias na última semana [nome da criança] foi deixado aos cuidados de outra criança, ou seja, alguém com menos de 10 anos, por mais de uma hora?	0) Nunca 1) Uma ou duas vezes por semana 2) Várias vezes por semana 3) Todos os dias ou quase todos os dias 98) Não se lembra/não sabe

PARTE 4: Materiais lúdicos e de aprendizagem

#	Pergunta	Resposta
Se a pergunta 1.11a = 0 e >= 98, pule totalmente a parte 4 Repita as perguntas 4.1-4.4para todas as crianças menores de 3 anos, portanto para [Nome da criança1]; [Nome da criança 2]; [Nome da criança 3] e [Nome da criança 4].		
4.1	Nos últimos 7 dias [nome da criança] brincou com brinquedos caseiros? (por exemplo, bonecas caseiras, carros caseiros, bola caseira ou outros brinquedos caseiros)	1) Sim 2) Não 98) Não se lembra/ não sabe
4.2	Nos últimos 7 dias, [nome da criança] brincou com brinquedos comprados em lojas ou brinquedos manufaturados? (por exemplo, lápis, bola de plástico, carro comprado em loja, blocos de notas, etc.)	1) Sim 2) Não 98) Não se lembra/ não sabe
4.3	Nos últimos 7 dias [nome da criança] brincou com objetos domésticos? (ex: caixas, tampas de garrafas, capulana (embalagens antigas) etc.)	1) Sim 2) Não 98) Não se lembra/ não sabe
4.4	Nos últimos 7 dias [nome da criança] brincou com objetos no ambiente natural? (por exemplo, paus, pedras, terra, etc.)	1) Sim 2) Não 98) Não se lembra/ não sabe
4.5	Você tem livros infantis ou livros ilustrados em casa?	1) Sim 2) Não=salta para parte 5 98) Não se lembra/ não sabe = salta para parte 5

#	Pergunta	Resposta
4.6	Quantos livros infantis ou ilustrados tem em casa?	

PARTE 5: Práticas disciplinares do cuidador principal

#	Pergunta	Resposta
Se a pergunta 1.11a = 0 e >= 98, pule totalmente a parte 5 Repita todas as perguntas para todas as crianças menores de 3 anos, portanto para [Nome da criança1]; [Nome da criança2]; [Nome da criança3] e [Nome da criança4].		
Os adultos usam certas maneiras de ensinar às crianças o comportamento certo ou para resolver um problema de comportamento. Vou mencionar vários métodos que os pais podem usar com seus filhos, e quero que você me diga se VOCÊ (cuidador principal) usou esse método com [nome da criança] no mês passado.		
5.1	Sacudiu o [nome da criança]?	1) Sim 2) Não 98) Não se lembra/ não sabe /negar-se a responder
5.2	Gritou com o [nome da criança]?	1) Sim 2) Não 98) Não se lembra/ não sabe /negar-se a responder
5.3	Espancou, bateu ou esbofeteado [nome da criança] nas nádegas com a mão.	1) Sim 2) Não 98) Não se lembra/ não sabe /negar-se a responder
5.4	Bateu (nome da criança) no nádegas ou em qualquer outra parte do corpo com algo como um cinto, escova de cabelo, bastão ou outro objeto duro.	1) Sim 2) Não 98) Não se lembra/ não sabe /negar-se a responder
5.5	Chamou [nome da criança] burro, preguiçoso ou algo assim.	1) Sim 2) Não 98) Não se lembra/ não sabe /negar-se a responder
5.6	Bateu ou esbofetear [nome da criança] na cara, cabeça ou orelhas.	1) Sim 2) Não 98) Não se lembra/ não sabe /negar-se a responder
5.7	Bateu ou esbofeteou [nome da criança] na mão, braço ou perna.	1) Sim 2) Não

#	Pergunta	Resposta
		98) Não se lembra/ não sabe /negar-se a responder
5.8	Bateu [nome da criança] – ou seja, bateu-lhe [nome da criança] muitas vezes sem conta e mais forte possível.	1) Sim 2) Não 98) Não se lembra/ não sabe /negar-se a responder
5.9	Distraiu [nome da criança] dando à outra coisa para fazer	1) Sim 2) Não 98) Não se lembra/ não sabe /negar-se a responder
5.10	Tirou [nome da criança] um privilégio	1) Sim 2) Não 98) Não se lembra/ não sabe /negar-se a responder
5.11	Mandou [nome da criança] para um intervalo/ir para outro espaço e sentar-se em silêncio por um tempo	1) Sim 2) Não 98) Não se lembro/ não sabe /negar-se a responder
5.12	Ignorou o comportamento do/a [nome da criança]	1) Sim 2) Não 98) Não se lembra/ não sabe /negar-se a responder
5.13	Explicou por que o comportamento foi errado/mal	1) Sim 2) Não 98) Não se lembra/ não sabe /negar-se a responder
5.14	Elogiou o bom comportamento em vez de corrigir o mau comportamento	1) S im 2) Não 98) Não se lembra/ não sabe /negar-se a responder

PARTE 6: Registro de nascimento

#	Question Pergunta	Resposta
Se a pergunta 1.11a = 0 e >= 98, então ignore a pergunta 6.1 Repita a pergunta 6.1 para todas as crianças com menos de 3 anos, ou seja, para [Nome da criança1]; [Nome da criança 2]; [Nome criança 3] e [Nome criança 4].		
6.1	O nascimento de [nome da criança] foi registrado nas autoridades civis?	1) Sim 2) Não 98) Não se lembra/não sabe
6.2	Você sabe como registrar o nascimento de uma criança?	1) Sim 2) Não 98) Não se lembra/não sabe

PARTE 7 Conectividade Comunitária e Empoderamento Econômico

#	Question	Response
7.1	Quanto você sente que tem em comum com outros cuidadores em sua comunidade (no seu grupo)?	1) Concordo fortemente 2) Concordo 3) Discordo 4) Discordo totalmente 98) Não se lembra/negar-se a responder
7.2	O quanto você acha que outros cuidadores em sua comunidade (no seu grupo) se importam com você?	1) Concordo fortemente 2) Concordo 3) Discordo 4) Discordo totalmente 98) Não se lembra/negar-se a responder

PARTE 8 Relatar a mudança nos ativos desde a adesão ao programa

#	Pergunta	Resposta
8.1	Você faz parte de um programa de poupança com educação poupança ou empréstimo	1) Sim 2) Não => salta para parte 9 98) Não sei => salta para parte 9 99) Sem resposta => salta para parte 9
8.2	Que utensílios domésticos você comprou usando empréstimos ou poupanças de estar no programa Poupança com Educação poupança ou empréstimo? [Várias opções 1 e 2 possíveis]	1) Mobiliário 2) Eletrodomésticos 3) Não comprou nenhum item doméstico enquanto membro do grupo 98) Não sei => salta para parte 9 99) Sem resposta => salta para parte 9

#	Pergunta	Resposta
8.3	[SE 8,2 = 1] Que itens de mobiliário? [Várias opções possíveis]	1) Guarda-roupa 2) Cama 3) Armário 4) Cadeira 5) Armário de caneca 6) Sofá 7) Mesa 8) Outro, por favor especifique
8.4	[SE 8,2 = 2] Quais eletrodomésticos? [Várias opções possíveis]	1) Ar condicionado 2) Relógio 3) Ventoinha 4) Geleira 5) Gerado 6) Moagem 7) Rádio 8) Maquina de costura 9) Televisão 10) Aquecedor de agua 11) Bomba de água 12) Outro, especifique por favor

PARTE 9 Poupanças e/ou empréstimos para iniciar ou expandir atividades geradoras de renda.

#	Question	Response
9.1	Você possui ou gere um negócio?	1) Sim 2) Não => salta para fim 98) Não sabe => salta para fim 99) Sem resposta => salta para fim
9.2	Desde quando você tem esse negócio?	1) Depois de ingressar no programa de poupança e empréstimo Poupança com Educação 2) Antes de ingressar no programa de poupança e empréstimo Poupança com Educação 98) Não sabe 99) Sem resposta
9.3	Começou um novo negócio usando empréstimos ou poupanças por ser um membro do grupo de Poupança com Educação?	1) Sim 2) Não 98) Não sabe 99) Sem resposta
9.4	Expandiu um negócio através de empréstimos ou poupanças por ser membro do grupo Poupança com Educação?	1) Sim 2) Não 98) Não sabe 99) Sem resposta

Anexo A2.2: Instrumento de estudo qualitativo - Entrevista em profundidade - Prestadores de cuidados

#	Pergunta
1	Pode falar-me da sua experiência no programa MTM até à data?
2	Que temas aprenderam neste programa? a) Sonda sobre tópicos específicos aprendidos b) O que aprendeu especificamente nas reuniões do grupo? c) O que aprendeu nas visitas domiciliarias d) Houve algum tema que não tenha ficado claro para si? e) Quão confortável você se sentiu com o idioma utilizado para transmitir as lições?
3	a) Quais tópicos ou lições você mais gostou de aprender? b) Houve algum tópico ou mensagem que você não gostou? c) Houve algum tópico sobre o qual você gostaria de ter aprendido mais?
4	Com quem é que aprendeu estas mensagens como parte do programa MTM? a) O que é que aprendeu especificamente com os promotores de DPI? b) O que aprendeu especificamente com os líderes religiosos? c) Aprendeu sobre desenvolvimento infantil ou parentalidade com mais alguém na comunidade? Se sim, com quem e em que contexto?
5	Qual é a sua opinião sobre a capacidade dos promotores de DPI para dirigirem as sessões? a) O que eles fazem bem? Como é que podem melhorar as suas capacidades de facilitação? b) Sonda sobre as competências dos promotores de DPI c) Quão confortável você se sentiu ao conversar com o promotor de DPI? d) Há algo que você gostaria que o promotor de DPI tivesse feito de forma diferente ou melhorado?
6	O que você acha do papel dos líderes religiosos nas sessões? a) Quão confortável você se sentiu ao conversar com o líder religioso? b) Há algo que você gostaria que o líder religioso tivesse feito de forma diferente ou melhorado?
7	Como você compararia o papel do seu promotor de DPI com o do líder religioso no programa MTM? a) Quão semelhantes ou diferentes foram as lições que você aprendeu com o promotor de DPI em comparação com o líder religioso? b) Com que frequência você interagiu com o promotor de DPI em comparação com o líder religioso? c) Quem foi mais influente em ajudá-lo a cuidar do seu filho? d) Quão importante é ter tanto o promotor de DPI quanto o líder religioso envolvido no programa? Ou apenas uma dessas pessoas seria suficiente?
8	Quais são suas opiniões sobre a duração, frequência e horário das sessões? Você conseguiu participar de todas as sessões? a) Foi fácil ou difícil para você participar b) Que mudanças, se houver, você faria na duração, frequência ou horário do programa? c) Você acha que o programa, de maneira geral, foi muito longo, muito curto ou teve a duração adequada? (Houve sessões demais ou de menos?) d) O que você acha da frequência das sessões (duas vezes por mês)? Essas reuniões foram muito frequentes? Ou você acha que as sessões deveriam ocorrer com mais frequência?
9	Como o programa mudou a forma como você cuida e educa seus filhos? a) Quais novas práticas você começou a usar desde que iniciou o programa? b) O programa mudou alguma coisa na maneira como você cuida do seu filho? c) Você notou alguma mudança no seu filho ou na sua família desde o início do programa?

#	Pergunta
	d) O programa ajudou com outros problemas pessoais ou familiares? e) E sobre o relacionamento com seu parceiro? Ou sobre a forma como ele cuida do seu filho?
10	Qual(is) aspecto(s) específico(s) do programa MTM teve/tiveram o maior impacto nas mudanças na sua vida e na vida do seu filho? a) Quais tópicos ou lições você acha que fizeram a maior diferença na sua vida ou na vida da sua família ou do seu filho? b) Qual agente de implementação (promotor de DPI, líder religioso) ou contexto (grupo de aprendizagem contínua e autónomo , grupo de poupança, visita domiciliar) teve o maior papel em trazer essa mudança para sua vida?
11	Os promotores de DPI foram úteis em abordar preocupações específicas sobre o cuidado e educação dos filhos? a) Quais preocupações você tinha? b) Como elas foram resolvidas?
11b	Há alguma lição ou ação que você aprendeu no programa, mas não conseguiu aplicar em casa ou notar uma mudança na sua vida? Por quê? a) O que torna difícil ou fácil praticar as lições aprendidas nas sessões na sua própria vida?
12	Algum cuidador masculino na sua casa (ou seja, o pai da criança) participou do programa MTM? **Se SIM:** a) Quem foi esse cuidador masculino e até que ponto ele participou? b) Como esse cuidador masculino reagiu à sua participação no programa MTM? c) Quais foram os desafios que dificultaram a participação de um cuidador masculino da sua família no programa? d) Você percebeu alguma mudança nas ações desse cuidador masculino por causa do programa MTM? **Se NÃO:** c) Por que nenhum cuidador masculino da sua casa participou do programa? d) Você tentou convidar algum cuidador masculino para participar do programa? e) Como esse cuidador masculino reagiu à sua participação no programa MTM? f) Quais foram os desafios que dificultaram a participação de um cuidador masculino da sua família no programa
13	De que forma, se é que participaram, os pais e outros cuidadores masculinos participaram do programa? a) O que facilita ou dificulta o envolvimento dos pais no programa? b) O que pode ser feito para tornar o programa mais atrativo para os pais?
14	Você acha que outros cuidadores vão querer participar deste programa? Por quê? a) O que pode ser feito para tornar o programa mais atrativo para os cuidadores no futuro?
15	Além deste programa MTM, você participa de outras reuniões ou discussões em grupo na sua comunidade? a) Onde e com que frequência elas acontecem? b) O que você aprendeu com essas reuniões?
16	Qual é a sua experiência com o comitê de DPI? a) Você já se envolveu pessoalmente com o comitê de DPI? Se sim, onde e com que frequência? b) Como eles ajudaram você? Pode dar um exemplo? c) Como eles poderiam ajudar você ainda mais ou melhor no futuro?
17	Qual é a sua experiência com os líderes religiosos?

#	Pergunta
	a) a) Você já se envolveu pessoalmente com um líder religioso? Se sim, onde e com que frequência? b) Como eles ajudaram você? Pode dar um exemplo? c) Como eles poderiam ajudar você ainda mais ou melhor no futuro?
18	Há algo mais que você gostaria de compartilhar sobre este programa?

Anexo A2.3: Instrumento de estudo qualitativo - Entrevista em profundidade - Membros do Comitê de DPI (Desenvolvimento na Primeira Infância)

#	Pergunta
1	Por favor, conte-nos o que vocês fazem como comitê para apoiar o programa MTM?
2	Como você descreveria o propósito do Comitê de DPI? Como o Comitê de DPI se encaixa no modelo geral do programa MTM
3	Como o Comitê de DPI foi formado?
4	Quantos membros do Comité de DPI estão a trabalhar no distrito? • As pessoas certas estão incluídas? • Sondar: Se não, quem está em falta?
5	Como funciona o comité? • Quais são os papéis no Comité de DPI?
6	Pode descrever uma reunião típica do Comité de DPI? • O que acontece durante a reunião? • Como definem a vossa agenda? • Com que frequência se reúnem?
7	Como Comité de DPI, como têm trabalhado com os cuidadores na comunidade? • Em que atividades participaram, se participaram em alguma? • Que apoio dão aos cuidadores? E em que situações ajudam?
8	Como Comité de DPI, com quais parceiros da comunidade trabalham mais de perto?
9	O vosso Comité de DPI tem trabalhado com os Líderes Religiosos? • Que atividades ou trabalhos fazem juntos?
10	O vosso Comité de DPI tem trabalhado com o setor da saúde? Que atividades ou trabalhos específicos fazem juntos?
11	O vosso Comité de DPI tem trabalhado com o governo local? Que atividades ou trabalhos específicos fazem juntos?
12	Quantos Comités de DPI existem no distrito de Monapo?
13	Quantos membros do vosso Comité de DPI receberam formação em DPI/Cuidados de Carinho? • Quem deu a formação? • Que tópicos sobre DPI foram abordados?
14	Quantos promotores de DPI receberam formação em DPI/Cuidados de Carinho?
15	Quantos destes promotores formados mantiveram os conhecimentos e competências sobre DPI/Parentalidade no final do primeiro ciclo?
16	Como sabem que eles mantiveram esses conhecimentos e competências no final do primeiro ciclo?
17	Pode dizer-me quantos destes consórcios estão totalmente envolvidos no trabalho de DPI?
18	Como é que o vosso Comité de DPI garante que o programa é bem implementado? • Têm um plano de monitorização?
19	Como trabalham com os líderes religiosos no programa?
20	Como é feita a supervisão das atividades de DPI implementadas pelo vosso Comité de DPI? • Como supervisionam o trabalho dos promotores de DPI?
21	O vosso Comité de DPI tem um programa completo de monitorização e implementação de qualidade? Se Sim: • Como é que funciona? O que fazem para garantir a qualidade? O que é feito e por quem se a qualidade não for suficiente? • A qualidade da implementação mudou ao longo do tempo? Se sim, como? Se Não:

#	Pergunta
	• Porquê?
22	Quais são os sucessos que o vosso Comité de DPI alcançou no programa MTM até agora? • O que contribuiu para esses sucessos?
23	O vosso Comité de DPI ajudou a estabelecer novas ligações de serviços na comunidade que não existiam antes do programa? • Na vossa opinião, o que contribuiu para estas novas ligações na comunidade?
24	Que desafios o vosso Comité de DPI enfrentou neste programa MTM até agora? • O que poderia ajudar a superar estes desafios no futuro?
25	Gostaria de ouvir as suas opiniões sobre os impactos do programa MTM. • Quais foram as mudanças mais significativas na vossa comunidade como resultado do programa MTM?
26	Na vossa opinião, houve algum impacto negativo do programa?
27	Em conclusão, o que mais gostaram no programa MTM? O que não gostaram no programa?
28	Que sugestões ou recomendações têm para melhorar o programa MTM?
29	Há mais alguma coisa que gostariam de partilhar sobre este programa?

Anexo A2.4: Instrumento de estudo qualitativo - Entrevista em profundidade - Líder Religioso

#	Pergunta
1	Pode contar-nos o que fazem como líderes religiosos no programa MTM?
2	Pode falar-me sobre a formação que recebeu para desempenhar o seu papel como líder religioso no programa MTM? • Com que frequência recebeu formação e quem a forneceu? • Sobre que tópicos foi formado? • Quão satisfeito está com a formação que recebeu como líder religioso? Porquê? • Que formação adicional teria sido útil para desempenhar o seu papel como líder religioso?
3	Fale-me sobre o que fez como líder religioso durante as sessões de grupo com cuidadores e as visitas domiciliares. • Quais foram os principais tópicos ou lições que abordou com os cuidadores durante as sessões de grupo e visitas domiciliares? • Investigue: aprendizagem precoce, cuidados responsivos. • Quais foram os tópicos fáceis de facilitar? • Houve algum tópico que foi difícil de facilitar? Porquê? • O que poderia tornar mais fácil para si facilitar estes tópicos difíceis?
4	Pode falar-me sobre o apoio ou supervisão que recebeu no seu papel como líder religioso neste programa? • Com que frequência recebeu supervisão de apoio? E de quem? • Que apoio ou supervisão adicional teria ajudado a ser mais eficaz no seu papel como líder religioso?
5	Que materiais e recursos recebeu do projeto para desempenhar o seu trabalho como líder religioso? • Como utilizou esses materiais durante as sessões de grupo com cuidadores? E durante as visitas domiciliares? • Que materiais ou recursos adicionais gostaria de ter recebido para fazer melhor o seu trabalho como líder religioso?
6	No geral, como acha que os cuidadores se sentiram em relação ao programa? • Quais os aspetos do programa que acha que os cuidadores consideraram mais benéficos? • Investigue: aprendizagem precoce, cuidados responsivos. • Que tópicos os cuidadores não gostaram tanto? • Como é que o programa MTM poderia apoiar melhor os cuidadores e responder às suas necessidades?
7	Notou alguma mudança nos comportamentos ou ações dos cuidadores devido ao programa? • Investigue sobre mudanças não só nos cuidadores, mas também nas crianças e famílias. • Quais os aspetos do programa que acredita terem contribuído mais para essas mudanças? • Quais comportamentos ou ações foram mais difíceis para os cuidadores mudarem? • Que perguntas os cuidadores faziam frequentemente quando se reuniam consigo?

8	Você já viu mudanças nos cuidadores devido à participação deles no programa? • Se sim, como/quais? • Existe alguma diferença na mudança de comportamento entre cuidadores homens e mulheres? • Você já viu mudanças nas crianças? • Se sim, como/quais?
9	Com que frequência você encaminhou participantes para outros serviços? • Quais foram os principais problemas enfrentados pelos cuidadores/crianças do seu grupo que exigiram esses encaminhamentos? • Para quem você os encaminhou? • Qual foi a sua experiência ao fazer esses encaminhamentos?
10	O seu trabalho como Líder Religioso na sua comunidade mudou desde que este programa começou? Se sim, como? • Com quem e onde partilhou o que aprendeu no programa MTM? • Que novas mensagens começou a usar no seu trabalho como Líder Religioso?
11	Notou alguma mudança no comportamento ou ações dos pais/cuidadores homens por causa do programa? • No futuro, o que pode ser feito para incentivar mais pais/cuidadores homens a participar neste programa?
12	Como trabalhou (colaborou) com os promotores de DPI durante o programa? • Com que frequência esteve em contacto com os promotores de DPI? • Os promotores de DPI pediram a sua ajuda? ○ Se sim, pode explicar? • O que os promotores de DPI fizeram no programa? • O que tornou fácil trabalhar com os promotores de DPI? • O que tornou difícil trabalhar com os promotores de DPI? • No futuro, como os líderes religiosos e os promotores de DPI podem trabalhar melhor juntos no programa MTM?
13	Pode falar-me sobre o Comité de DPI do programa MTM e o que este comité faz? • Quem faz parte deste comité? Como funciona o comité? • Teve alguma experiência direta com o Comité de DPI durante o programa? • Como é que o Comité de DPI poderia apoiar melhor o programa?
14	Quantos líderes religiosos do programa MTM estão a trabalhar no distrito? • Onde estão localizados?
15	Quantos líderes religiosos do programa MTM foram formados em DPI/Cuidados para o Desenvolvimento? • Quem deu a formação? • Quais foram os tópicos de DPI abordados?
16	Quantos promotores de DPI foram formados em DPI/Cuidados para o Desenvolvimento?
17	Quantos desses promotores de DPI formados mantiveram os conhecimentos e habilidades importantes em DPI/Cuidados com as crianças no final do primeiro ciclo? • Como sabe que eles mantiveram esses conhecimentos e habilidades importantes no final do primeiro ciclo
18	Quantos Consórcios de Líderes Religiosos do programa MTM existem no distrito de Monapo?
19	Pode dizer-me quantos desses consórcios estão totalmente envolvidos no trabalho de DPI?
20	Como é que esses Consórcios de Líderes Religiosos do programa MTM garantem que o programa é bem implementado? • Têm algum plano de monitoria?

21	Como são feitas as supervisões das atividades de DPI implementadas pelos Consórcios de Líderes Religiosos do programa MTM?
22	Os Consórcios de Líderes Religiosos do programa MTM têm um programa completo de monitoria e implementação da qualidade? **Se sim:** • Como é que esse programa funciona? O que fazem para garantir a qualidade? O que é feito e por quem quando a qualidade não é suficiente? • A qualidade da implementação mudou ao longo do tempo? Se sim, como? **Se não:** • Por que não?
23	Estamos na parte final agora. Tenho algumas perguntas para concluir. No geral, o que gostou mais neste programa? • O que não gostou neste programa?
24	O que poderia ser feito para melhorar o programa? • Que apoio ou recursos adicionais poderiam ajudá-lo, como líder religioso, a ter um maior impacto para os cuidadores e crianças pequenas? • O que os líderes religiosos poderiam fazer para melhorar o programa?
25	Como vê o seu papel em 2025 e nos anos seguintes?
26	Há mais alguma coisa que gostaria de partilhar sobre este programa?

Anexo A2.5: Instrumento de estudo qualitativo - Entrevista em profundidade - Promotor de DPI

#	Pergunta
1	Pode falar-me sobre o que faz como promotor de DPI no programa MTM? Além de ser promotor de DPI, o que faz como principal atividade de trabalho?
2	Pode falar-me sobre a formação que recebeu para desempenhar o seu papel como promotor de DPI no programa MTM? • Com que frequência recebeu formação e quem a ministrou? • Quais foram os temas abordados na formação? • Quão satisfeito está com a formação que recebeu como promotor de DPI? Porquê? • Que formação adicional teria sido útil para desempenhar o seu papel como promotor de DPI?
3	Participou nas sessões de grupo com os cuidadores? • Se sim, o que fazia durante as sessões de grupo com os cuidadores? • Quais foram os principais temas ou lições sobre os quais aconselhou os cuidadores durante os grupos? • (Explorar: aprendizagem precoce, cuidados responsivos) • Quais foram os temas fáceis de facilitar? • Houve algum tema que foi difícil para si facilitar? Porquê? • O que poderia ajudar a facilitar esses temas mais difíceis?
4	Fez visitas domiciliares? • Se sim, o que fazia durante as visitas domiciliares? • Quais foram os principais temas ou lições sobre os quais aconselhou os cuidadores durante as visitas? • (Explorar: aprendizagem precoce, cuidados responsivos) • Quais foram os temas fáceis de facilitar? • Houve algum tema que foi difícil para si facilitar? Porquê? • O que poderia ajudar a facilitar esses temas mais difíceis?
5	O seu papel nas sessões de grupo com os cuidadores é igual ou diferente das visitas domiciliares? • Qual foi mais fácil para si? Porquê? • Qual ajudou mais os cuidadores? • O que podia ser feito para melhorar as sessões de grupo ou as visitas domiciliares no futuro?
6	Pode falar-me sobre o apoio ou supervisão que recebeu no seu papel como promotor de DPI neste programa? • Com que frequência recebeu supervisão de apoio? De quem? • Que apoio ou supervisão adicional seria útil para si?
7	Que materiais e recursos recebeu do projeto para realizar o seu trabalho como promotor de DPI? • Como utilizou esses materiais durante as sessões de grupo com os cuidadores? E durante as visitas domiciliares? • Que materiais ou recursos adicionais gostaria de ter recebido para fazer melhor o seu trabalho como promotor de DPI

8	Como se sente em relação à duração total deste programa? • Acha que o programa no geral foi demasiado longo (com sessões a mais), demasiado curto ou teve a duração certa? • Como se sente em relação à frequência das sessões (duas vezes por mês)? Essas reuniões foram muito frequentes? Ou acha que as sessões deveriam acontecer mais vezes?
9	Como foi a participação e frequência dos cuidadores nas sessões de grupo? • Como foi a participação e frequência deles nas visitas domiciliares? • Quais foram as principais razões para os cuidadores não participarem nas sessões de grupo? E nas visitas domiciliares? • No futuro, que mudanças poderiam ser feitas para melhorar a frequência ou participação dos cuidadores no programa?
10	De modo geral, como acha que os cuidadores se sentiram em relação ao programa? • Que aspetos do programa acha que os cuidadores consideraram mais benéficos para eles? Sondar: aprendizagem precoce, cuidado responsivo. • Que temas os cuidadores não apreciaram tanto? • Como é que o programa MTM poderia apoiar melhor os cuidadores e responder às suas necessidades?
11	Já notou alguma mudança nos cuidadores devido à sua participação no programa? • Se sim, como ou o quê? • Há alguma diferença nas mudanças de comportamento entre cuidadores homens e mulheres? • Já notou mudanças nas crianças? • Se sim, como ou o quê?
12	Com que frequência encaminhou os participantes para outros serviços? • Quais foram os principais problemas enfrentados pelos cuidadores/crianças no seu grupo que justificaram esses encaminhamentos? • Para quem os encaminhou? • Qual foi a sua experiência ao fazer os encaminhamentos?
13	Agora gostaria de fazer algumas perguntas sobre o envolvimento dos cuidadores masculinos no programa MTM. • Pode descrever como os pais/cuidadores masculinos participaram no programa? • Teve algum pai/cuidador masculino no seu grupo? • Quão fácil ou difícil foi para si envolver os pais/cuidadores masculinos no programa? • O que facilitou a participação dos pais/cuidadores masculinos no programa? O que dificultou a sua participação? • Por que acha que os pais/cuidadores masculinos participaram menos do que as mulheres?
14	Notou alguma mudança no comportamento ou nas ações dos pais/cuidadores masculinos devido ao programa? • No futuro, o que pode ser feito para incentivar mais pais/cuidadores masculinos a participarem neste programa?
15	Como colaborou com os líderes religiosos do programa MTM durante o decorrer do programa? • O que fizeram os líderes religiosos no programa? • O que facilitou o trabalho com os líderes religiosos? • O que dificultou o trabalho com os líderes religiosos? • No futuro, como é que os promotores de DPI e os líderes religiosos poderiam colaborar melhor como parte do programa MTM?

16	Pode falar-me sobre o Comité de DPI do programa MTM e as suas funções? • Quem faz parte deste comité? Como funciona este comité? • Como é que os promotores de DPI comunicam com o Comité de DPI? E como é que o comité comunica com os promotores de DPI? • Teve alguma experiência direta com o Comité de DPI durante o programa? • Como é que o Comité de DPI poderia apoiar melhor o programa?
17	O que mais gostou no programa?
18	O que, se é que houve algo, achou difícil ou desafiante no programa?
19	O que poderia ser feito para melhorar o programa? • Que apoio ou recursos adicionais poderiam ajudá-lo(a), enquanto Promotor(a) de DPI, a ter um maior impacto junto dos cuidadores e das crianças pequenas?
20	Há mais alguma coisa que gostaria de partilhar sobre este programa?

Annex B: Informed Consent

Study Title: MTM project evaluations Nampula, Mozambique **Interviewee ID: _____**

Read or share this form with each participant before starting

Good morning/ Afternoon. I am ..... from Maraxis working on behalf of Episcopal Relief & Development and the Anglican Diocese of Nampula as part of the Moments That Matter® (MTM) program. MTM is a parenting empowerment program for primary caregivers of children 0-3 years, focusing on responsive care, early learning, and child safety & security. MTM uses a community-led social and behavior change approach, with trained grassroots ECD volunteers, trained faith leaders and local ECD Committees. We appreciate your participation in this survey. Your contribution will help the project and the government to improve early child development services in the community. As part of the survey, we would like to ask some questions about you, and the children [0-36 month] you take care of. Participation in this survey is voluntary and you are not required to answer all questions. If there are any questions you do not want to answer, please tell us and we will move on to the next question. You are free to interrupt the interview at any time. If there is something in this Consent Document that you do not understand, don't hesitate to ask them. We are asking you to take part in this study because have been identified by the Anglican Diocese of Nampula as you are a caregiver of a child up to 36 months.

What will happen if you decide to be part of this study?

If you agree, we will ask some questions about you and the child you take care of. It is possible that some questions might make you feel uncomfortable. If so, you can choose not to answer them. There are no right or wrong answers. We ask just to better understand the context in which you and your child live in. We just need your honest answers.

What are the risks you run when participating in this study?

Some of the survey questions may make you feel uncomfortable. You can refuse to answer any question you do not want to answer. You can interrupt your participation in this survey at any time. In the meantime, the study team will take all steps to keep your study information protected. The study team will take care to ensure that your answers do not get lost or are accidentally viewed by people outside of the study team. The study team will keep all tablets used for data collection in closed archives. Computer records will be protected by a password, so that only study staff have access to them.

Are there benefits resulting from participation in this study?

The study does not guarantee direct benefits.

Costs of participation

Your participation does not have any cost and will not be compensated.

What alternatives are there to participation in the study?

It is your choice to decide whether to participate or not. If you do not want to participate, there is no problem and it will not affect your participation in community-level programming in any way.

What health information will be collected and kept confidential?

If you choose to be in this study, all information collected from you will be kept confidential, including your name, address, telephone number, survey data. This information will only be used by study personnel and will be retained until the follow-up data collection and analyses are complete -about one year from now. You may change your mind and revoke (turn back) your permission to collect or use your health information at any time. To revoke your permission, you should contact Rotafina Donco at 84 331 9428. The results of this study could be published in reports, scientific journals, or presented at scientific meetings. No publication or presentation about the above-described study will reveal your, or

your child's identities. By signing this consent form, you are allowing the use of the health information noted above for the purpose described in this form. If you refuse to give the information, you will not be able to participate in this study.

What are your rights if you participate in this study?

Participating in this study is your choice. Your participation is completely voluntary. If you decide to participate, you can still leave the study at any time. There will be no penalty against you and you will not lose any benefit to which you are entitled. The withdrawal from the study has no repercussions. If you withdraw from the study, no additional information will be collected. Your participation in this study may be terminated at any time by researchers without your consent if you cannot be contacted for any ethical consideration.

What happens if you have questions about the study?

Do not sign this consent form unless you have had the opportunity to ask questions and have received satisfactory answers to all your questions. You should contact the following individuals to answer any additional questions: Rotafina Donco at 84 331 9428.

I confirm that I have read/read the information sheet to the participant and that I understood all the issues described in it and that they also explained to me the objectives and what will be done in this survey. I understood all the information and they gave me the opportunity to ask questions.

I know that participation in this study is voluntary and that I can stop participating at any time without any harm to me.

Does the eventual participant agree to participate in the survey? [ ] Yes [ ] No

Participant: Date: ..... Signature of Participant: .....

For participants who cannot sign: Fill in the name of the person who gave consent and the date. Then request the fingerprints of that person and get the signature of a witness below.

Name of participant: ..... Date: .....

Fingerprint

The above consent was read and the participant agreed to the terms.

Signature of witness: .....

Name of witness: ..... Date: .....

Member of the study team obtaining consent (to be recorded for all participants):

Interviewer's signature: ..... Date: .....

Name of interviewer: .....

Annex C: Indicator calculations

Indicator calculation 1a: % of caregivers who have **ANY** confidence = (% of caregiver that take more time/energy + % of caregivers that are overwhelmed + % of caregivers that are worried doing enough) / 3

Table 81: Indicator 1a Percent of primary caregivers who have ANY confidence in handling parenting responsibilities successfully.

ID	Any confidence (1a)	Calculation
I1a1	% of caregiver that take more time/energy	= % of caregivers that answered Question 7.11: "In the last month, have you felt that caring for your child(ren) has taken more time and energy than you have to give?" with " No, not very often " OR " No, not very often "
I1a2	% of caregivers that are overwhelmed	= % of caregivers that answered Question 7.12: "In the last month, have you felt overwhelmed by the responsibilities of being a primary caregiver?" with " No, not very often " OR " No, not very often "
I1a3	% of caregivers that are worried doing enough	= % of caregivers that answered Question 7.13: "In the last month, have you felt worried about whether you are doing enough for your child(ren)?" with " No, not very often " OR " No, not very often "
I1a	% of caregivers who have **ANY** confidence	= (I1a1+I1a2+I1a2) / 3

Indicator calculation 1b: % of caregivers who have **FULL** confidence = % of caregivers that take do NOT taken more time/energy AND are NOT overwhelmed AND are NOT worried doing enough.

Table 82: Indicator 1b Percent of primary caregivers who have FULL confidence in handling parenting responsibilities successfully

ID	Full confidence (1b)	Calculation
I1b	% of caregivers who have **FULL** confidence	# Caregivers that answered: (Question 7.11: "In the last month, have you felt that caring for your child(ren) has taken more time and energy than you have to give?" with "No, not very often" OR "No, hardly ever" **AND** Question 7.12: "In the last month, have you felt overwhelmed by the responsibilities of being a primary caregiver?" with "No, not very often" OR "No, hardly ever" **AND** Question 7.13: "In the last month, have you felt worried about whether you are doing enough for your child(ren)?" with "No, not very often" OR "No, hardly ever") / Total number of caregivers

Calculation Indicator 2a: % of caregivers who have **ANY** parental stress = (% of caregiver that take more time/energy + % of caregivers that are overwhelmed + % of caregivers that are worried doing enough) / 3

Table 83: Indicator 2a: Percent of primary caregivers who report any parental stress

ID	Any parental stress (2a)	Calculation
I2a1	% of caregiver that take more time/energy	= % of caregivers that answered Question 7.11: "In the last month, have you felt that caring for your child(ren) has taken more time and energy than you have to give?" with "Yes, some of the time" OR "Yes, most of the time"
I2a2	% of caregivers that are overwhelmed	= % of caregivers that answered Question 7.12: "In the last month, have you felt overwhelmed by the responsibilities of being a primary caregiver?" with "Yes, some of the time" OR "Yes, most of the time"
I2a3	% of caregivers that are worried doing enough	= % of caregivers that answered Question 7.13: "In the last month, have you felt worried about whether you are doing enough for your child(ren)?" with "Yes, some of the time" OR "Yes, most of the time"
I2a	% of caregivers who have **ANY** parental stress	= (I2a1+I2a2+I2a2) / 3

Calculation Indicator 2b: % of caregivers who have **FULL** confidence = % of caregivers that take do taken more time/energy AND are overwhelmed AND are worried doing enough.

Table 84: Indicator 2b: Percent of primary caregivers who report FULL parental stress

ID	Parental stress (2b)	Calculation
I2b	% of caregivers who have **FULL** parental stress	# Caregivers that answered: (Question 7.11: "In the last month, have you felt that caring for your child(ren) has taken more time and energy than you have to give?" with "Yes, some of the time" OR "Yes, most of the time" **AND** Question 7.12: "In the last month, have you felt overwhelmed by the responsibilities of being a primary caregiver?" with "Yes, some of the time" OR "Yes, most of the time" **AND** Question 7.13: "In the last month, have you felt worried about whether you are doing enough for your child(ren)?" with "Yes, some of the time" OR "Yes, most of the time") / Total number of caregivers

Table 85: Indicator 3a: Percent of primary caregivers who use of physical punishment with their children 0-3.

ID	Physical punishment (3a)	Calculation
I3a	% of caregivers who use of physical punishment with their children 0-3	# Caregivers that answered for any child (#1, #2) (. Question 5.1 "Shook child" with "Yes" OR Question 5.3 "Spanked, hit or slapped child on the bottom with bare hand?" with "Yes" OR Question "5.4 Hit any child on the bottom or elsewhere on the body with something like a belt, hairbrush, stick or other hard object?" with "Yes" OR Question "5.6 Hit or slapped [child name] on the face, head or ears?" with "Yes" OR Question "5.7 Hit or slapped [child name] on the hand, arm, or leg?" with "Yes" OR Question 5.8 "Beat child up – that is, hit child over and over as hard as possible?" with "Yes") / Total number of caregivers

Table 86: Indicator 3b: Average types of applied physical punishments average over all children

ID	Physical punishment (3b)	Calculation
I3b-c1	Average types of applied physical punishments for child#1 [score between 0-6]	For each caregiver count the number of following questions that are answered with "Yes" for child #1 (Question 5.1 "Shook child" Question 5.3 "Spanked, hit or slapped child on the bottom with bare hand?" Question "5.4 Hit any child on the bottom or elsewhere on the body with something like a belt, hairbrush, stick or other hard object?" Question "5.6 Hit or slapped [child name] on the face, head or ears?" Question "5.7 Hit or slapped [child name] on the hand, arm, or leg?" Question 5.8 "Beat child up – that is, hit child over and over as hard as possible?") / Total number of caregivers
I3b-c2	Average types of applied physical punishments for child#2 [score between 0-6]	For each caregiver count the number of following questions that are answered with "Yes" for child #2 (Question 5.1 "Shook child" Question 5.3 "Spanked, hit or slapped child on the bottom with bare hand?" Question "5.4 Hit any child on the bottom or elsewhere on the body with something like a belt, hairbrush, stick or other hard object?" Question "5.6 Hit or slapped [child name] on the face, head or ears?" Question "5.7 Hit or slapped [child name] on the hand, arm, or leg?" Question 5.8 "Beat child up – that is, hit child over and over as hard as possible?") / Total number of caregivers
I3b	Average types of applied physical punishments average over all children [score between 0-6]	= (I3b-c1+I3b-c2) / 2

Table 87: Indicator 4: Primary Caregivers parenting practices in responsive care, early learning, and child safety & security

ID	Parenting practices (4)	Calculation
I4	Primary Caregivers parenting practices in responsive care, early learning, and child safety & security, with a score [0-10] where 0 is lowest and 10 highest.	For each caregiver = (1/3 * I4a + 1/3 * I4b+ 1/3 * I4c)

Table 88: Indicator 4a: Responsive care [with a score 0-10] is based upon a) Child supervision: 1) leaving child alone and 2) leaving child under care of other child <10 years; b) positive corrective behavior

ID	Responsive care (4a)	Calculation
I4a	Responsive care with a score [0-10] where 0 is lowest and 10 highest	For each caregiver = 1/2 x N-I4a + 1/2 x N-I4b

ID	Child supervision (4a1)	Calculation
I4a1	Child supervision with a score [0-10] where 0 is lowest and 10 highest	For each caregiver = 1/2 x N-I4a11 + 1/2 x N-I4a12

ID	Leaving child alone (4a11)	Calculation	
I4a11-c1	Number of days child #1 left alone [0-7]	For each caregiver: (Question 3.14) the number of days in the past week child 1 was left alone for more than one hour	
I4a11-c2	Number of days child #1 left alone [0-7]	For each caregiver: (Question 3.14) the number of days in the past week child 1 was left alone for more than one hour	
I4a11	Average number of days children left alone [0-7]	For each caregiver = (I4a1-c1+I4a1-c2) / 2	
N-I4a11	Normalized to mapping to a score in the range of [0-10] values, where 0 is lowest and 10 highest	Values of I4a11	Normalized score N-I4a11
		0	10
		> 0 and < = 1	6
		> 1 and < = 2	5
		> 2 and < = 3	4
		> 3 and < = 4	3
		> 4 and < = 5	2
		> 5 and < = 6	1
		> 5	0

ID	Leaving child under care of other child (4a12)	Calculation	
I4a12-c1	Number of days child #1 left alone [0-7]	For each caregiver: (Question 3.14) the number of days in the past week child 1 was left alone for more than one hour	
I4a12-c2	Number of days child #1 left alone [0-7]	For each caregiver: (Question 3.14) the number of days in the past week child 1 was left alone for more than one hour	
I4a12	Average number of days children left alone [0-7]	For each caregiver = (I4a12-c1+I4a12-c2) / 2	
N-I4a12	Normalized to mapping to a score in the range of [0-10] values, where 0 is lowest and 10 highest	Values of I4a12	Normalized score N-I4a12
		0	10
		> 0 and < = 1	6
		> 1 and < = 2	5
		> 2 and < = 3	4
		> 3 and < = 4	3
		> 4 and < = 5	2
		> 5 and < = 6	1
		> 5	0

<table>
<tr><th>ID</th><th>Positive corrective behavior (4a2)</th><th colspan="2">Calculation</th></tr>
<tr><td>I4a2-c1</td><td>Average types of applied positive corrective behavior for child#1
[score between 0-6]</td><td colspan="2">For each caregiver count the number of following questions that are answered with “Yes” for child #1
Question 5.9 “Distracted the child child by giving the child something else to do?”
Question 5.10 “S Took away a privilege for child?”
Question 5.11 “Sent the child to a time out/go to another space and sit quietly for a short while?”
Question 5.12 “Ignored the behavior of child?”
Question 5.13 “Explained why the behavior was wrong/bad“
Question 5.14 “Praised good behavior instead of correcting bad behavior“</td></tr>
<tr><td>I4a2-c2</td><td>Average types of applied positive corrective behavior for child#2
[score between 0-6]</td><td colspan="2">For each caregiver count the number of following questions that are answered with “Yes” for child #2
Question 5.9 “Distracted the child child by giving the child something else to do?”
Question 5.10 “S Took away a privilege for child?”
Question 5.11 “Sent the child to a time out/go to another space and sit quietly for a short while?”
Question 5.12 “Ignored the behavior of child?”
Question 5.13 “Explained why the behavior was wrong/bad“
Question 5.14 “Praised good behavior instead of correcting bad behavior“</td></tr>
<tr><td>I4a2</td><td>Average types of applied physical punishments average over all children
[score between 0-6]</td><td colspan="2">For each caregiver = (I4a2-c1+I4a2-c2) / 2</td></tr>
<tr><td rowspan="8">N-I4a2</td><td rowspan="8">Normalized to mapping to a score in the range of [0-10] values, where 0 is lowest and 10 highest</td><td>Values of I4a2</td><td>Normalized score N-I4a2</td></tr>
<tr><td>0</td><td>0</td></tr>
<tr><td>> 0 and < = 1</td><td>4</td></tr>
<tr><td>> 1 and < = 2</td><td>6</td></tr>
<tr><td>> 2 and < = 3</td><td>7</td></tr>
<tr><td>> 3 and < = 4</td><td>8</td></tr>
<tr><td>> 4 and < = 5</td><td>9</td></tr>
<tr><td>> 5</td><td>10</td></tr>
</table>

Table 89: Indicator 4b: Early learning [with a score 0-10] is based upon: a) Different stimulating activities per child; b) Total number of stimulating activities per week per child; c) Number of different play materials; d) Number of books in the household

ID	Early learning (4b)	Calculation
I4b	Early learning with a score [0-10] where 0 is lowest and 10 highest	For each caregiver = 0.25 x N-I4b1 + 0,25 x N-I4b2 + 0.25 x N-I4b3 + 0.25 x N-I4b4

ID	Different stimulating activities (4b1)	Calculation	
I4b1-c1	Different stimulating activities for child #1 [score between 0-11]	For each caregiver count the number of following questions that are answered with "Once or twice a week" OR "Multiple times a week" OR "Every day or nearly every day" for child #1 as follows: Question 3.1 "Read books or look at picture books with child?" Question 3.2 "Sing songs to child?" Question 3.3 "Take child out of home (e.g., to the field, market, or for a walk)? Question 3.4 "Play with child?" Question 3.5 "Name or count things with child?" Question 3.6 "Draw things with child (e.g., on the sand)? Question 3.7 "Tell stories to child? Question 3.8 "Provide child with object to grasp or pick up?" Question 3.9 "Encourage [child name] to crawl, run, or jump up?" Question 3.10 "Hug or kiss child?" Question 3.11 "Praise child?"	
I4b1-c2	Different stimulating activities for child #2 [score between 0-11]	For each caregiver count the number of following questions that are answered with "Once or twice a week" OR "Multiple times a week" OR "Every day or nearly every day" for child #2 as follows: Question 3.1 "Read books or look at picture books with child?" Question 3.2 "Sing songs to child?" Question 3.3 "Take child out of home (e.g., to the field, market, or for a walk)? Question 3.4 "Play with child?" Question 3.5 "Name or count things with child?" Question 3.6 "Draw things with child (e.g., on the sand)? Question 3.7 "Tell stories to child? Question 3.8 "Provide child with object to grasp or pick up?" Question 3.9 "Encourage child to crawl, run, or jump up?" Question 3.10 "Hug or kiss child?" Question 3.11 "Praise child?"	
I4b1	Average different stimulating activities average over all children [score between 0-11]	For each caregiver = (I4b1-c1+I4b1-c2) / 2	
N-I4b1	Normalized to mapping to a score in the range of [0-	Values of I4b1	Normalized score N-I4b1
		0	0
		> 0 and < = 1	1

	10] values, where 0 is lowest and 10 highest	> 1 and < = 2	2
		> 2 and < = 3	3
		> 3 and < = 4	4
		> 4 and < = 5	5
		> 5 and < = 6	6
		> 6 and < = 7	7
		> 7 and < = 8	8
		> 8 and < = 9	9
		> 10	10

<table>
<tr><th>ID</th><th>Total number of stimulating activities (I4b2)</th><th colspan="2">Calculation</th></tr>
<tr><td>I4b2-c1</td><td>Total number of activities for child #1
[score between 0-72]</td><td colspan="2">For each caregiver calculate the number of weekly activities for questions 3.1, 3.2, 3.3, 3.4, 3.5, 3,6, 3.7, 3.8, 3.9, 3.10, 3.11 for child #1 if answered:
“Once or twice a week” add 1,5
“Multiple times a week” add 4
“Every day or nearly every day” add 6,5</td></tr>
<tr><td>I4b2-c2</td><td>Total number of activities for child #2
[score between 0-72]</td><td colspan="2">For each caregiver calculate the number of weekly activities for questions 3.1, 3.2, 3.3, 3.4, 3.5, 3,6, 3.7, 3.8, 3.9, 3.10, 3.11 for child #2 if answered:
“Once or twice a week” add 1,5
“Multiple times a week” add 4
“Every day or nearly every day” add 6,5</td></tr>
<tr><td>I4b2</td><td>Average total number of activities over all children
[score between 0-11]</td><td colspan="2">For each caregiver = (I4b2-c1+I4b2-c2) / 2</td></tr>
<tr><td rowspan="12">N-I4b2</td><td rowspan="12">Normalized to mapping to a score in the range of [0-10] values, where 0 is lowest and 10 highest</td><td>Values of I4b2</td><td>Normalized score N-I4b2</td></tr>
<tr><td>< 15</td><td>0</td></tr>
<tr><td>< 20</td><td>1</td></tr>
<tr><td>< 25</td><td>2</td></tr>
<tr><td>< 30</td><td>3</td></tr>
<tr><td>< 35</td><td>4</td></tr>
<tr><td>< 40</td><td>5</td></tr>
<tr><td>< 45</td><td>6</td></tr>
<tr><td>< 50</td><td>7</td></tr>
<tr><td>< 55</td><td>8</td></tr>
<tr><td>< 60</td><td>9</td></tr>
<tr><td>60 ></td><td>10</td></tr>
</table>

<table>
<tr><th>ID</th><th>Different play materials (4b3)</th><th colspan="2">Calculation</th></tr>
<tr><td>I4b3-c1</td><td>Number of different play materials for child #1
[score between 0-11]</td><td colspan="2">For each caregiver count the number of following question that is answered with “Yes” for child #1
Question 4.1 “In the past 7 days, has child played with home-made toys? (e.g., home-made dolls, home-made cars, home-made ball, or other toys made at home)
Question 4.2: In the past 7 days, has [child name] played with played with store- bought toys or manufactured toys? (e.g. pencils, plastic ball, store-bought car, blocks, etc.)
Question 4.3 In the past 7 days, has [child name] played with household objects? (e.g., boxes, bottle caps, capulana (old wraps) etc.)
Question 4.4 In the past 7 days, has [child name] played with objects in the natural environment? (e.g., sticks, rocks, dirt, etc.)</td></tr>
<tr><td>I4b3-c2</td><td>Number of different play materials for child #2
[score between 0-11]</td><td colspan="2">For each caregiver count the number of following question that is answered with “Yes” for child #2
Question 4.1 “In the past 7 days, has child played with home-made toys? (e.g., home-made dolls, home-made cars, home-made ball, or other toys made at home)
Question 4.2: In the past 7 days, has [child name] played with played with store- bought toys or manufactured toys? (e.g. pencils, plastic ball, store-bought car, blocks, etc.)
Question 4.3 In the past 7 days, has [child name] played with household objects? (e.g., boxes, bottle caps, capulana (old wraps) etc.)
Question 4.4 In the past 7 days, has [child name] played with objects in the natural environment? (e.g., sticks, rocks, dirt, etc.)</td></tr>
<tr><td>I4b3</td><td>Average number of different materials over all children
[score between 0-11]</td><td colspan="2">For each caregiver = (I4b3-c1+I4b3-c2) / 2</td></tr>
<tr><td rowspan="6">N-I4b3</td><td rowspan="6">Normalized to mapping to a score in the range of [0-10] values, where 0 is lowest and 10 highest</td><td>Values of I4b3</td><td>Normalized score N-I4b3</td></tr>
<tr><td>0</td><td>0</td></tr>
<tr><td>> 0 and < = 1</td><td>3</td></tr>
<tr><td>> 1 and < = 2</td><td>6</td></tr>
<tr><td>> 2 and < = 3</td><td>8</td></tr>
<tr><td>> 3</td><td>10</td></tr>
</table>

ID	Number of books (4b4)	Calculation	
I4b4	Number of books	For each caregiver Question 4.6: "How many children's books or picture books are there in the household?"	
N-I4b4	Normalized to mapping to a score in the range of [0-10] values, where 0 is lowest and 10 highest	Values of I4b3	Normalized Score N-I4b4
		0	0
		1	5
		2	7
		3+	10

Table 90: Indicator 4c: Child safety [with a score of 0-10] is based upon: a) Level of physical punishment (averaged over both children); b) Level of verbal punishment (averaged over both children) and c) birth registration

ID	Child safety (4c)	Calculation
I4c	Child safety with a score [0-10] where 0 is lowest and 10 highest	For each caregiver = 1/3 x N-I4c1 + 1/3 x N-I4c2+ 1/3 x N-I4c3

<table>
<tr><th>ID</th><th>Physical punishment (4c1)</th><th colspan="2">Calculation</th></tr>
<tr><td>I4c1-c1</td><td>Average types of applied physical punishments for child#1
[score between 0-6]</td><td colspan="2">For each caregiver count the number of following questions that are answered with “Yes” for child #1
Question 5.1 “Shook child” with “Yes”
Question 5.3 “Spanked, hit or slapped child on the bottom with bare hand?” with “Yes”
Question 5.4 “Hit any child on the bottom or elsewhere on the body with something like a belt, hairbrush, stick or other hard object?” with “Yes”
Question 5.6 “Hit or slapped [child name] on the face, head or ears?” with “Yes”
Question 5.7 “Hit or slapped [child name] on the hand, arm, or leg?” with “Yes”
Question 5.8 “Beat child up – that is, hit child over and over as hard as possible?” with “Yes”</td></tr>
<tr><td>I4c1-c2</td><td>Average types of applied physical punishments for child#2
[score between 0-6]</td><td colspan="2">For each caregiver count the number of following questions that are answered with “Yes” for child #2
Question 5.1 “Shook child” with “Yes”
Question 5.3 “Spanked, hit or slapped child on the bottom with bare hand?” with “Yes”
Question 5.4 “Hit any child on the bottom or elsewhere on the body with something like a belt, hairbrush, stick or other hard object?” with “Yes”
Question 5.6 “Hit or slapped [child name] on the face, head or ears?” with “Yes”
Question 5.7 “Hit or slapped [child name] on the hand, arm, or leg?” with “Yes”
Question 5.8 “Beat child up – that is, hit child over and over as hard as possible?” with “Yes”</td></tr>
<tr><td>I4c1</td><td>Average types of applied physical punishments average over all children
[score between 0-6]</td><td colspan="2">For each caregiver = (I4c1-c1+I4c1-c2) / 2</td></tr>
<tr><td>N-I4c1</td><td>Normalized to mapping to a score in the range of [0-10] values, where 0 is lowest and 10 highest</td><td>Values of I4c1</td><td>Normalized score N-I4c1</td></tr>
<tr><td></td><td></td><td>0</td><td>10</td></tr>
<tr><td></td><td></td><td>> 0 and < = 1</td><td>5</td></tr>
<tr><td></td><td></td><td>> 1 and < = 2</td><td>4</td></tr>
<tr><td></td><td></td><td>> 2 and < = 3</td><td>3</td></tr>
<tr><td></td><td></td><td>> 3 and < = 4</td><td>2</td></tr>
<tr><td></td><td></td><td>> 4 and < = 5</td><td>1</td></tr>
<tr><td></td><td></td><td>> 5</td><td>0</td></tr>
</table>

ID	Verbal punishment (4c2)	Calculation	
I4c2-c1	Average types of applied Verbal punishments for child#1 [score between 0-2]	Fore each caregiver count the number of following questions that are answered with "Yes" for child #1 Question 5.2 "Shouted, yelled at or screamed at child?" with "Yes" Question 5.5 "Called child dumb, lazy, or another name like that?" with "Yes"	
I4c2-c2	Average types of applied Verbal punishments for child#2 [score between 0-2]	For each caregiver count the number of following questions that are answered with "Yes" for child #2 Question 5.2 "Shouted, yelled at or screamed at child?" with "Yes" Question 5.5 "Called child dumb, lazy, or another name like that?" with "Yes"	
I4c2	Average types of applied Verbal punishments average over all children [score between 0-6]	For each caregiver = (I4c2-c1+I4c2-c2) / 2	
N-I4c2	Normalized to mapping to a score in the range of [0-10] values, where 0 is lowest and 10 highest	Values of I4c2	Normalized Score N-I4c2
		0	10
		> 0 and < = 1	4
		> 1	0

ID	Birth registration (4c3)	Calculation	
I4c3-c1	Birth registration for child #1	For each caregiver count the number of following question that is answered with "Yes" for child #1 Question 6.2 "Has child's birth been registered with the civil authorities?"	
I4c3-c2	Birth registration for child #2	For each caregiver count the number of following question that is answered with "Yes" for child #2 Question 6.2 "Has child's birth been registered with the civil authorities?"	
I4c3	Number of birth registrations [0-2]	For each caregiver = (I4c3-c1+I4c3-c2)	
N-I4c3	Normalized to mapping to a score in the range of [0-10] values, where 0 is lowest and 10 highest	Values of I4c3	Normalized Score N-I4c3
		0	0
		1	5
		2	10

Indicator I5: Percent of primary caregivers who report feeling connected to and supported by peer caregivers in their group.=> Calculated as [Connected = 7.1 = (Strongly) agree AND 7.2 Others care= (Strongly) agree AND Feel Supported = 7.3 = (Strongly) agree

Table 91: Indicator 5 Percent of primary caregivers who report feeling connected to and supported by peer caregivers in their group.

ID	**Feeling connected (5)**	Calculation
I5	% of caregivers who have feel connected and supported by peer caregivers	# For each caregiver count the number of following questions that are answered with "Strongly agree" or "Agree": (Question 7.1: "How much do you feel like you have in common with other caregivers in your community (in your group)?" **AND** Question 7.2: "How much do you feel like other caregivers in your community (in your group) care about you?" **AND** Question 7.3: "Do you feel that you are supported by your own community as caregiver of children?") / Total number of caregivers

Indicator I6: Total number of fathers as secondary caregivers who spent 3 or more days interacting or playing with their children 0-3 in the last week.

Table 92: Indicator 6: Fathers (as secondary caregivers) who intentionally interacting/playing with children 0-3.

ID	Fathers playing (6)	Calculation
I6a	# of interviewed biological fathers who spend 3 or more days interacting and playing with their children	For each interviewed caregiver that is the biological father count the number of following questions that are answered for any of their children with "3-4 days" or "5-6 days" or "Every day (7 days)") Question 7.21a"In the last week, how often did you/as father find time to interact or play with your child?"
I6b	# of interviewed caregivers (not being the biological father) that indicated that the biological spend 3 or more days interacting and playing with their children	For each interviewed caregiver that is NOT the biological father: count the number of following questions that are answered for any of their children with "3-4 days" or "5-6 days" or "Every day (7 days)") Question 7.21b"In the last week, how often did the father find time to interact or play with his child?"
I6	% of fathers who spend 3 or more days interacting and playing with their children	= (I6a + I6b) / Total number of caregivers

Indicator 7 is the percent of savings group members who have started or expanded micro-businesses using loans or savings.

Table 93: Indicator 7: Percent of savings group members who have started or expanded micro-businesses using loans or savings

ID	Start / expand business	Calculation
I7a	Number of caregivers that started who have started or expanded micro-businesses using loans or savings	For each interviewed caregiver count the number of following questions that are answered with "Yes" for (Question 9.3"Did you start a new business using loans or savings from being a Savings with Education group member? **OR** Question 9.3"Did you start a new business using loans or savings from being a Savings with Education group member?)
I7b	Total number of savings group members	For each interviewed caregiver count the number of the following question that are answered with "Yes" for Question 8.1"Are you part of a Savings with Education savings & loan program?"

I7	Percent of savings group members who have started or expanded micro-businesses using loans or savings	= (I7a) / (I7b)

Indicator 8 is the percentage of household that purchased household items using loans or savings from being in the savings & loan program is used.

Table 94: Indicator 8: Number of assets of a household bought with a loan from the program

ID	Start / expand business	Calculation
I8a1	Number of furniture items bought with a loan from the program	For each interviewed caregiver count the number items ticked from the following question: Question 8.3"Which furniture items?
I8a2	Number of household appliances bought with a loan from the program	For each interviewed caregiver count the number items ticked from the following question: Question 8.4"Which household appliance items?
I8a	Number of assets a household bought with a loan from the program	= (I8a1 + I8ab)
I8b	Total number of savings group members	For each interviewed caregiver count the number of the following question that are answered with "Yes" for Question 8.1"Are you part of a Savings with Education savings & loan program?"
I8	Percent of savings group members who have started or expanded micro-businesses using loans or savings	= (I8a) / (I8b)

Annex D: Data details of baseline and endline

D1. PART 1: Demographics – background

Question 1.4

Table 95: Number of surveys per community, disaggregated per community (baseline n=161, endline n=160)

Community	**Baseline**	**Endline**	**Same primary caregivers surveyed during baseline and endline**
Aginuro	40	40	34
Canacue	41	40	31
Nacuca	40	40	31
Namachaca	40	40	30
Total	**161**	**160**	**126**

Question 1.7

Table 96: Gender primary caregiver, disaggregated per community (baseline n= 161, endline n=160)

Gender of primary caregiver	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline					
Female	77.5%	85.4%	92.5%	92.5%	87.0%
Male	22.5%	14.6%	7.5%	7.5%	13.0%
Endline					
Female	82.5%	90.0%	92.5%	95.0%	90.0%
Male	17.5%	10.0%	7.5%	5.0%	10.0%

Question 1.8

Table 97: Relationship primary caregiver with child, disaggregated per community (baseline n=161, endline n=160)

Relationship primary caregiver	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline					
Mother (Biological)	77.5%	85.4%	92.5%	92.5%	87.0%
Father (Biological)	22.5%	14.6%	7.5%	7.5%	13.0%
Grandmother	0%	0%	0%	0%	0%
Endline					
Mother (Biological)	82.5%	90.0%	90.0%	90.0%	88.1%
Father (Biological)	17.5%	10.0%	7.5%	5.0%	10.0%
Grandmother	0%	0%	2.5%	5.0%	1.9%

Question 1.9

Table 98: Age category primary caregiver, disaggregated per community (baseline n=161, endline n=160)

Age primary caregiver	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline					
[15 - 35] years	77.5%	82.9%	90.0%	90.0%	85.1%
[36 - 49] years	22.5%	17.1%	7.5%	10.0%	14.3%
[50 - 64] years	0%	0%	2,5%	0%	0.6%
Endline					
[15 - 35] years	72.5%	70.0%	87.5%	87.5%	79.4%
[36 - 49] years	25.0%	30.0%	7.5%	12.5%	18.8%
[50 - 64] years	2.5%	0%	5.0%	0%	1.9%

Question 1.10

Table 99: Number of children to take care of as primary caregiver, disaggregated per community (baseline n=161, endline n=160)

Number of children to take care of as primary caregiver	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline					
0	0%	0%	0%	5.0%	1.2%
1	15%	14.6%	30.0%	12.5%	18.0%
2	32.5%	19.5%	20.0%	20.0%	23.0%
3	7.5%	22.0%	15.0%	25.0%	17.4%
4	7.5%	12.2%	2.5%	17.5%	9.9%
5	12.5%	17.1%	17.5%	12.5%	14.9%
6	5.0%	7.3%	10.0%	2.5%	6.2%
7	7.5%	2.4%	0%	2.5%	3.1%
8	5.0%	2.4%	5.0%	2.5%	3.7%
9	2.5%	2.4%	0%	0%	1.2%
10 or more	5.0%	0%	0%	0%	1.2%
Endline					
1	10.0%	10.0%	12.5%	7.5%	10.0%
2	22.5%	10.0%	15.0%	22.5%	17.5%
3	17.5%	25.0%	17.5%	27.5%	21.9%
4	2.5%	12.5%	15.0%	17.5%	11.9%
5	10.0%	12.5%	17.5%	12.5%	13.1%

6	12.5%	10.0%	15.0%	7.5%	11.3%
7	7.5%	12.5%	2.5%	0%	5.6%
8	7.5%	2.5%	2.5%	2.5%	3.8%
9	7.5%	0%	0%	2.5%	2.5%
10 or more	2.5%	5.0%	2.5%	0%	2.5%

Question 1.11

Table 100: Number of children under 36 months to take care of as primary caregiver, disaggregated per community (baseline n=161, endline n=160)

Number of children under 36 months to take care of as primary caregiver	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline					
0, but caregiver is pregnant	5.0%	0%	0%	7.5%	3.1%
1	80.0%	95.1%	100%	82.5%	89.4%
2	15.0%	4.9%	0%	10.0%	7.5%
Endline					
1	85.0%	70.0%	77.5%	85.0%	79.4%
2	15.0%	30.0%	22.5%	15.0%	20.6%

Questions 1.11a-b-c-d

Table 101: Average number children per primary caregiver per age category, disaggregated per community (baseline n= 161, endline n=160)

Number of children under 36 months to take care of as primary caregiver	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline					
0-3 years	1.10	1.05	1.00	1.03	1.04
3-5 years	0.95	1.00	0.90	0.82	0.92
6-11 years	0.88	0.98	0.68	1.00	0.88
12-18 years	0.79	0.44	0.45	0.45	0.53
Endline					
0-3 years	1.15	1.30	1.23	1.15	1.21
3-5 years	0.85	0.78	0.73	0.55	0.73
6-11 years	1.15	1.18	1.28	1.28	1.22
12-18 years	1.35	1.10	0.73	0.58	0.94

Question 1.12

Table 102: Marital status of the primary caregiver, disaggregated per community (baseline n=161, endline n=160)

Marital status of the primary caregiver	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline					
Married or living with a partner	87.5%	82.9%	75.0%	82.5%	82.0%
Divorced or separated	5.0%	7.3%	12.5%	7.5%	8.1%
Single or not living with a partner	7.5%	9.8%	12.5%	7.5%	9.3%
Widowed	0%	0%	0%	2.5%	0.6%
Endline					
Married or living with a partner	95.0%	87.5%	80.0%	92.5%	88.8%
Divorced or separated	2.5%	2.5%	10.0%	2.5%	4.4%
Single or not living with a partner	2.5%	10.0%	7.5%	5.0%	6.3%
Widowed	0%	0%	2.5%	0%	0.6%

Question 1.13

Table 103: Highest education level attended by the primary caregiver, disaggregated per community (baseline n= 160, endline n=160)

Education of the primary caregiver	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline					
Did not attend school	80.0%	68.3%	70.0%	67.5%	71.4%
Primary	20.0%	31.7%	25.0%	30.0%	26.7%
Secondary	0%	0%	5.0%	2.5%	1.9%
Tertiary or higher education	0%	0%	0%	0%	0%
Endline					
Did not attend school	35.0%	40.0%	45.0%	17.5%	34.4%
Primary	57.5%	57.5%	55.0%	80.0%	62.5%
Secondary	7.5%	2.5%	0%	2.5%	3.1%
Tertiary or higher education	0%	0%	0%	0%	0%

Question 1.14

Table 104: Occupation of the primary caregiver (baseline n=161, endline n=160)

Occupation of the primary caregiver	**Baseline**	**Endline**
Agriculture	95.1%	98.1%
Self-employed	0.6%	0%
Employed - Formal (Salaried)	0.6%	0%
Employed – Informal	1.8%	0%
Unemployed	0%	0.6%
Student	0%	0.6%

D2. PART 2: Demographics - human resilience survey

Question 2.2

Table 105: Number of members in the household, disaggregated per community (baseline n=161, endline n=160)

Members in the household	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline					
2	0%	0%	5.0%	0%	1.2%
3	17.5%	12.2%	20.0%	7.5%	14.3%
4	25.0%	14.6%	27.5%	20.0%	21.7%
5	5.0%	19.5%	17.5%	35.0%	19.3%
6	7.5%	24.4%	5.0%	15.0%	13.0%
7	22.5%	9.8%	5.0%	10.0%	11.8%
8	12.5%	9.8%	12.5%	5.0%	9.9%
9	2.5%	4.9%	5.0%	7.5%	5.0%
10+	7.5%	4.9%	2.5%	0%	3.7%
Average members in household	5.9	5.8	5.0	5.5	5.5
Average members in household younger than 14	3.2	2.9	2.5	3.0	2.9
Endline					
2	2.5%	0%	0%	2.5%	1.3%
3	10.0%	7.5%	7.5%	0%	6.3%
4	10.0%	17.5%	27.5%	15.0%	17.5%
5	27.5%	15.0%	25.0%	32.5%	25.0%
6	2.5%	17.5%	7.5%	25.0%	13.1%
7	15.0%	10.0%	15.0%	15.0%	13.8%
8	20.0%	15.0%	10.0%	5.0%	12.5%
9	7.5%	7.5%	7.5%	2.5%	6.3%
10+	5.0%	10.0%	0%	2.5%	4.3%
Average members in household	6.10	6.38	5.55	5.70	5.93
Average members in household younger than 14	3.35	3.45	3.33	3.45	3.39

Question 2.4

Table 106: All household members ages 6 to 12 are currently attending school, disaggregated per community (baseline n=129, endline n=150)

Household members ages 6 to 12 currently attending school	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline					
Yes	58.1%	50.0%	53.6%	63.9%	56.6%
Endline					
Yes	71.8%	84.2%	73.	94.4%	80.7%

Question 2.5

Table 107: Highest education level attended by the spouse, disaggregated per community (baseline n=161, endline n=160)

Education level spouse	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline					
Did not attend school	47.5%	39.0%	32.5%	12.5%	32.9%
Primary	37.5%	43.9%	32.5%	42.5%	39.1%
Secondary	5.0%	4.9%	7.5%	17.5%	8.7%
Tertiary or higher education	0%	0%	0%	0.0%	0%
Don't know/No answer	10.0%	12.2%	27.5%	27.5%	19.3%
Endline					
Did not attend school	20.0%	22.5%	25.0%	12.5%	20.0%
Primary	55.0%	57.5%	55.0%	72.5%	60.0%
Secondary	12.5%	7.5%	5.0%	7.5%	8.1%
Tertiary or higher education	0%	0%	0%	0%	0%
Don't know/No answer	12.5%	12.5%	15.0%	7.5%	11.9%

Question 2.6-2.7-2.8

Table 108: Main construction material of the outer wall, floor and roof of the residence (baseline n=161, endline n=160)

Part of the house	Materials	Baseline	Endline
Outer wall material	Mud bricks/earth, wood, bamboo, metal sheet/slate/asbestos, palm leaves/thatch (grass/raffia)	99.4%	100%
	Cement/concrete blocks, landcrete, stone, or burnt bricks	0.6%	0%
Floor material	Dirt	98.1%	100%
	Cement bricks	0%	0%
Roof material	Iron sheets, tiles, concrete, or asbestos	9.3%	6.3%
	Grass, leaves, or mud	90.7%	93.8%

Question 2.9

Table 109: Toilet facility used by the household, disaggregated per community (baseline n=161, endline n=160)

Toilet facility used	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline					
No toilet facility (bush, beach), or other	20.0%	24.4%	52.5%	42.5%	34.8%
Pit latrine, bucket/pan	80.0%	75.6%	47.5%	57.5%	65.2%
Endline					
No toilet facility (bush, beach), or other	25.0%	22.5%	35.0%	57.5%	35.0%
Pit latrine, bucket/pan	75.0%	77.5%	65.0%	42.5%	65.0%

Question 2.10

Table 110: Source of water used by the household (baseline n=161, endline n=160)

Source of water	Baseline	Endline
Public network	0%	75.6%
Other	100%	24.4%

Questions 2.11, 2.13, 2.14, 2.15

Table 111: Household appliance (baseline n=161, endline n=160)

Household	Baseline	Endline
Possesses a Television	1.9%	1.3%
Possesses a Refrigerator	0%	0%
Possesses a cooker (gas, kerosene, electric)	0%	0%
Is connected to the electricity grid	0%	0%

Question 2.12

Table 112: Number of mobile phones in the household, disaggregated per community (baseline n=161, endline n=160)

Number of mobile phones are owned by all members of the household	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline					
0	52.5%	58.5%	55.0%	42.5%	52.2%
1	42.5%	36.6%	37.5%	45.0%	40.4%
2	5.0%	4.9%	5.0%	12.5%	6.8%
3+	0%	0%	2.5%	0%	0.6%
Endline					
0	50.0%	60.0%	50.0%	47.5%	51.9%
1	47.5%	35.0%	42.5%	42.5%	41.9%
2	2.5%	5.0%	5.0%	10.0%	5.6%
3+	0%	0%	2.5%	0%	0.6%

Question 2.16

Table 113: Main occupation spouse, disaggregated per community (baseline n=161, endline n=160)

Occupation spouse	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline					
Farmer, rancher, agricultural worker, or no male head/spouse	85.0%	87.8%	75.0%	87.5%	83.9%
Shop owner, salesperson, service worker, transport and storage operator, or worker in textiles, construction, mechanics, graphics, chemicals, food processing, etc.	5.0%	4.9%	5.0%	7.5%	5.6%
Office worker, transportation operator, professional, technician, director, manager, administrator, or related job	2.5%	0%	5.0%	0%	1.9%
No data or no main occupation	5.0%	4.9%	5.0%	0%	3.7%
Don't know / No answer	2.5%	2.4%	10.0%	5.0%	4.9%
Endline					
Farmer, rancher, agricultural worker, or no male head/spouse	92.5%	80.0%	87.5%	97.5%	89.4%
Shop owner, salesperson, service worker, transport and storage operator, or worker in textiles, construction, mechanics, graphics, chemicals, food processing, etc.	2.5%	10.0%	0%	0%	2.5%
Office worker, transportation operator, professional, technician, director, manager, administrator, or related job	0%	0%	0%	2.5%	1.3%

Other	0%	0%	0%	0%	0%
Don't know / No answer / No data or no main occupation	5.0%	10.0%	12.5	0%	6.9%

Questions 2.17a-b

Table 114: Household (baseline n=161, endline n=160)

Household	**Baseline**	**Endline**
Cultivated any crops in the last 12 months	99.4%	96.3%
Currently owns any bulls, cows, steers, heifers, male calves, female calves, or oxen	6.2%	8.8%

Questions 2.18

Table 115: Main fuel used for cooking (baseline n=161, endline n=160)

Household	**Baseline**	**Endline**
Wood, crop residue, sawdust, animal waste, or other	98.1%	100%
Charcoal or kerosene	1.9%	0%

Question 2.19

Table 116: Household owns transport vehicle, disaggregated per community (baseline n=161, endline n=160)

Owning transport vehicle	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline					
Bicycle	20.0%	26.8%	15.0%	10.0%	18.0%
Motorcycle	12.5%	12.2%	2.5%	20.0%	11.8%
Car	0%	0%	0%	0%	0%
Endline					
Bicycle	17.5%	22.5%	12.5%	7.5%	15.0%
Motorcycle	20.0%	22.5%	7.5%	7.5%	14.4%
Car	0%	0%	0%	0%	0%

Question 2.20

Table 117: Self-reported economic status (1 =lowest – 10= highest), disaggregated per community (baseline n=161, endline n=160)

Self-reported economic status	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline					
1	67.5%	58.5%	75.0%	57.5%	64.6%
2	27.5%	26.8%	22.5%	15.0%	23.0%
3	5.0%	14.6%	0%	15.0%	8.7%
4	0%	0%	2.5%	7.5%	2.5%
5 or more	0%	0%	0%	5.0%	1.2%

Average	1.4	1.6	1.3	1.9	1.5
Endline					
1	15.0%	0%	32.5%	15.0%	18.8%
2	22.5%	12.5%	22.5%	30.0%	24.4%
3	25.0%	22.5%	15.0%	17.5%	21.3%
4	15.0%	27.5%	15.0%	17.5%	14.4%
5	15.0%	10.0%	12.5%	12.5%	15.6%
6	2.5%	22.5%	2.5%	7.5%	3.8%
7	5.0%	2.5%	0%	0%	1.9%
8 or more	0%	2.5%	0%	0%	0%
Average	3.13	3.25	2.60	3.05	3.03

Question 2.21

Table 118: Household access to bank account (baseline n=161, endline n=160)

Household access to bank account	**Baseline**	**Endline**
Primary caregiver has by themself or with other has a bank account	1.2%	1.9%

Question 2.22

Table 119: Household has savings, disaggregated per community (baseline n=161, endline n=160)

Household has savings	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline					
Anyone in household currently has money set aside as savings	12.5%	14.6%	2.5%	17.5%	11.8%
Endline					
Anyone in household currently has money set aside as savings	32.5%	50.0%	22.5%	7.5%	28.1%

Question 2.23

Table 120: Anyone hungry to bed in the last 7 days, disaggregated per community (baseline n=161, endline n=160)

Hungry to bed	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline					
Anyone in the household went to bed going hungry in the last 7 days	17.5%	12.2%	25.0%	15.0%	17.4%
Endline					
Anyone in the household went to bed going hungry in the last 7 days	30.0%	57.5%	45.0%	40.0%	43.1%

Question 2.24

Table 121: Number of meals eaten per a day, disaggregated per community (baseline n=161, endline n=160)

Number of meals eaten per day	Aginuro	Canacue	Nacuca	Namachaca	Total
Baseline					
1	5.0%	2.4%	7.5%	50%	5.0%
2	95.0%	85.4%	87.5%	86.3%	88.1%
3	0%	12.2%	5.0%	7.5%	6.5%
Average	0%	0%	0%	1.3%	0.5%
Endline					
1	2.5%	0%	7.5%	0%	2.5%
2	92.5%	100%	90.0%	92.5%	93.8%
3	5.0%	0%	2.5%	7.5%	3.8%
Average	2.03	2.00	1.95	2.08	2.01