ECD Program
Impact Evaluation Report

26 November 2016

Homoine and Funhalouro Districts
Inhambane Province, Mozambique

Funded by The Hilton Foundation
Data collected August 2014 (baseline) and August 2016 (endline)

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1. Background

1.1 Motivation for the program

The Mozambican government has been reviewing ECD policy over the last few years. Much of the focus of this policy review has been on pre-schools[1] (Republic of Mozambique, Ministry of Education, 2012). In order to contribute to the policy review, CARE International implemented a home-based ECD program to investigate the implementation and impact of this approach. The CARE ECD program was funded by the Hilton Foundation from 2013 to 2016. Two districts were selected in Inhambane Province that would allow us to illustrate a home-based ECD approach in remote rural villages (Funhalouro) as well as in rural villages closer to urban centers and resources (Homoine). One of the aims was to make sure that the Mozambican government had an example of an ECD model that could work in contexts where a pre-school model would have little chance of being successful. 2013 was spent conceptualizing the model of implementation, with much time spent on ethnographic work in the local area. Implementation began in 2014 with the appointment of local community-based organization (CBO) implementing partners and the selection of home-visitors.

A baseline evaluation was conducted before home visits began in August 2014 with a subsequent endline conducted in August 2016 to measure impact. Additionally, on-going research was conducted throughout the life of the project to ascertain which aspects of the implementation brought about the impact.

This report outlines the results of the impact evaluation conducted between 2014 and 2016 and highlights findings from the on-going research to identify what aspects of the program brought about the impact.

1.2 Context of the program

Before looking at the results of the evaluation it is important to understand the context in which the CARE ECD program was working. Homoine and Funhalouro Districts, both in Inhambane Province in southern Mozambique, vary greatly from each other. Homoine is a small, densely populated district with 107 475 inhabitants (2007 Census data). Consumption poverty rates are around 51% with the majority of the population living along the coastline and along transit routes with access to some good farmland relative to the rest of the province. Residents of Homoine also have access to some economic activities because of their proximity to the town of Maxixe and to the national highway. In spite of this many of the households in the more remote villages of Homoine rely on subsistence agriculture for their livelihoods. Men and young women do migrate to Maputo and South Africa, giving some households access to remittances, but in the main, locally-grown food is the main source of subsistence.

Funhalouro is a large, sparsely populated district with 44 320 inhabitants as of the 2007 census. The area has historically been prone to food insecurity and drought. With a consumption poverty rate above 69%, Funhalouro is one of the most

[1] There has been some movement towards accepting a home-based model of ECD more recently, for example, the National Conference (Confêrencia Nacional da Rede de Desenvolvimento da Primeira Infancia R-DPI) organized by the DPI in Sept 2016 focused on pre-schools though there was some discussion about parent education and home visits, suggesting a shifting emphasis.

vulnerable and impoverished areas of Inhambane. Because it is remote and the population dispersed there are few development interventions in Funhalouro. All households rely on subsistence agriculture in spite of the fact that the area is marginal agriculturally. Many men and some young women migrate to the city and there is a history of migration to South Africa. This means that women, often grandmothers, head many of the households.

Both districts have been significantly affected by the drought of 2014-2016. The last two harvests have failed and in our focus groups run as part of the endline qualitative research in August 2016 we heard many stories of families subsisting on wild fruits and other plants because they have not harvested for two years. During 2015 many used whatever money they had to buy maize meal, but this money is now finished. CARE has been involved in emergency food distribution in both districts. The home visitors[2] trained by the ECD program have played an important role in identifying the most vulnerable households in this food distribution process.

1.3 Model of intervention

The model of intervention employed in the CARE ECD program was based on recent thinking around home-based ECD, especially on the importance of caregiver wellbeing in the development of children under five (Walker, 2011; Richter and Naicker, 2013). A detailed strategy document describing this research is available from the program technical advisor.[3]

The widely accepted Essential Package developed by CARE, Save the Children and the Consultative Group on Early Childhood Care and Development and endorsed by the Mozambican Government informed the structure and content of the program. Additionally, the program was informed by ethnographic work done on traditional child rearing practices in the villages in which the program was implemented.

> … frequently programs are designed without a clear understanding of the culture within which they are being offered. Even programs based on a community-defined need may not be designed in response to the community context (Evans, 1994 p 2).

Evans, in a background document for the Essential Package, points out how important it is to understand local child rearing practices and to gather information, not only on what families do, but why they do this, i.e. on practices, patterns and beliefs. One of the key strategic principles of the CARE ECD Program was to build on traditional child rearing practices that are sound and work to empower women to change those that are known to be detrimental to the health and wellbeing of young children. During the early research conducted for the implementation phase of the program staff discovered an existing practice involving Masungukate who give young women advice on marriage and child rearing. This is similar to practices in other areas of southern Mozambique (Gengenbach, 2005). The CARE ECD program adopted this model and trained villagers (many of whom were already Masungukate) as advisors in child health and development, thereby mobilizing an existing social

[2] Home visitors are known locally as Masungukate ("good advisors" in the local Xitswa language). The word Masungudota was coined by the project to denote the masculine form of Masungukate. In this report we sometimes use the term Masungukate/dota for inclusivity reasons. The singular form is Sungukate or Sungudota.

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resource for the benefit of young children. A significant number of men volunteered to join the program; they are known as Masungudota (an adaptation of the feminine form of 'good advisor'). Many of these men are elders in their local churches and previously carried out relationship counseling in this role, a skill they now use to give help to caregivers of young children.

The Masungukate/dota who worked with the program were elected in a community meeting where they formalized a social contract with the community, undertaking to use the skills and information they get from the CARE ECD program to benefit the children in their community. They attended a training course which was backed up with regular mentoring from 'managers' trained by CARE and employed by local CBOs (CARE implementing partners). Each Masungukate/dota was required to visit six or seven families who live nearby, giving important health information based on a simple visual guide and forming supportive relationships with caregivers, many of whom experience high levels of emotional stress. They also referred caregivers to local services such as the hospital or clinic. Their work was (and still is) entirely voluntary. The establishment of playgroups run by Masungukate/dota in their homes commenced in 2016. This seeks to focus on cognitive and language stimulation for children aged three to five.

1.4 Link to nutrition and livelihood program - PROSAN

The ECD program is linked to the PROSAN[4] intervention which runs in the same districts and villages and with the same households. The PROSAN project runs a range of livelihood programs which include Voluntary Savings and Loan Clubs (VSLA), a chicken vaccination program, a cashew production program and a conservation agriculture program. When the ECD program was developed in 2013 the aim was for the Masungukate/dota to link caregivers to the PROSAN projects in their area and in this way improve nutrition outcomes for young children. The on-going drought has significantly impacted progress on the conservation agriculture project, which would have been the program most useful to the vulnerable households the program works with. As a result, this component of the program was not implemented as originally planned.

1.5 Use of social accountability process

CARE International has developed a particular motivation and mentoring approach that uses checklists (often called community scorecards or CSCs) developed by program participants to gauge progress towards objectives over time. This is sometimes referred to in CARE circles as a "social accountability approach" because it works on the premise that program participants are the best people to hold service providers accountable. The ECD program used a simplified adaptation this approach in which caregivers score Masungukate on their service and Masungukate score caregivers on their behavior change (all in a positive, encouraging environment). This aspect of implementation was included in the impact evaluation, see Section 6 of this report.

[4]Programma de Seguranca Alimentar e Nutricional, funded by Irish Aid from December 2012 through December 2017.

2. Research objectives

The long-term impact aim of the program was to improve comprehensive developmental outcomes, as defined by the Essential Package, for children under five years of age. The aim of the research into the program was to evaluate program impact through nested quantitative and qualitative studies with the ultimate objectives of:

i) Assessing whether the ECD program improved child development and nutritional outcomes and, if improvements did occur,

ii) Determining which program components contributed significantly to that impact in the different environments. These components included nutrition, social accountability and ECD interventions. This is the implementation science aspect of the project.

3. Research plan

3.1 Design

The evaluation used a quasi-experimental comparison group design with repeated measures (Posavac and Carey, 1997) to evaluate the impact of the program over two years through a combination of quantitative and qualitative data collection and analysis. We used before-after and project (intervention)-control components using independent samples. This allowed us to identify significance of difference between groups and over time. Qualitative research conducted throughout the two-year implementation period allowed us to gain a deep understanding of how the program components worked for different categories of people and contexts. This gives important insight for future program development.

The PROSAN[5] livelihoods and nutrition program ran in the same areas as the ECD program and also in other (non-ECD) villages. We accessed the project (intervention) groups in the former and the control groups in the latter. Accessing the control groups where PROSAN was operating was done mainly for ethical reasons because we did not want to work with a control group that experienced no intervention at all. The comparison groups were thus:

- PROSAN only – control
- ECD + PROSAN – project

In each of these groups a sample of households was enrolled at baseline (2014) and a second independent sample was enrolled at endline (2016). Care was taken to ensure that the 2016 households had been in the project for the duration of that time. Impacts were assessed by comparing differences between samples at base- and endline and between project and control at each of these stages.

[5]Programma de Seguranca Alimentar e Nutricional, funded by Irish Aid from December 2012 through December 2017.

The initial research design included a third condition variable (ECD + Social accountability + PROSAN). The holding of service providers and community members accountable to each other was seen as an essential element of the CSC (social accountability) process (B. Schwartz - Head of Health Equity Team, CARE USA and A. DiGirolamo - Director Nutrition and Integrated Programming CARE USA and Penny Ward - Consultant. 8 May 2013. Pers. Comm.) Early on in the implementation of the project it became clear that the ECD program was not going to interact directly with service providers (apart from Masungukate/dota referring caregivers to them). It would focus rather on caregivers and Masungukate/dota who visited them. The CARE team felt that the CSC approach could still be applied but in an adapted form. As such the CARE Mozambique ECD program would be trying out a version of the CSC approach that was new and the decision was taken to not, therefore use it as a key variable in the impact research but to rather pilot this innovation and assess it through qualitative research. It seemed important to understand how it could work within an ECD home visiting setting before testing its impact in a quantitative study. The qualitative research and reflections on implementation of this research are reported on in Section 6.

3.2 Indicators

The indicators for the evaluation fall into the three categories outlined in the Essential Package (EP):

- Caregiver status
- Child status
- Caregiving environment.

Under each of these categories several sub indicators were identified.

Caregiver status
Social support networks and social capital related to community trust
Caregiver emotional stress

Child status
Birth record
Under-five health card
Age-appropriate immunizations
Nutrition status
Anthropometric measures (height for age and weight for age)
Developmental milestones that are appropriate for their age - MDAT

Caregiving environment
Malaria prevention
Stimulation through play
Academic stimulation
Language stimulation
Responsivity to child
Acceptance (positive discipline)
Safe and hazard free home environment.

3.3 Sampling

Quantitative

The project aimed to reach 2,090[6] households in the two-year implementation period (1379 in Homoine and 711 in Funhalouro). The 2090 households are located within 32 villages (povoação) that are within 14 localities (localidade) within Homoine and Funhalouro. These households were selected according to a participatory household wealth assessment. For the quantitative component of the impact study a sample proportional to district numbers and village size was identified. The study worked with children aged 18-48 months[7]. The samples at baseline and endline were independent. The table below outlines sample numbers.

Group	2014 households	2016 households
PROSAN only	212	215
ECD+ PROSAN[8]	432	452
	644	**667**

The 2090 households that participated in the ECD program and all of the PROSAN households were allocated a unique household number. These numbers were used to select households for the evaluation by means of a random selection process. This process involved generating random numbers for the entire list of households, sorting that random number list, thereby randomizing the household list. The calculated sample size of households in each village was then selected from the top of the now-randomized list.

A sampling proportional to village size was done, meaning that each village has different sample sizes proportional to the village size. This ensures that no village has an undue influence in the research outcomes, and all households across the sample have an equal chance of selection.

In cases where we found more than one child in the household of the appropriate age, one of these was selected, also randomly. (The children's names were written on pieces of paper, put in a container and the caregiver was asked to take one of these out).

The 2090 households are located within 32 villages that are within 14 localities within Homoine and Funhalouro.

Appendix 1details each village name, its locality, and the sample sizes per village for 2014 and 2016. The sampling procedures followed in 2014 and again in 2016 were

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6 This number comes from the CARE ECD project proposal to the Hilton Foundation and is based on the following calculations: Estimated nr of CU5 based on INE population projections for 2012. Funhalouro: 8,588 Homoine: 22,537. Absolute poverty levels (approximation) Funhalouro: min 69% Homoine: min 51%. That means the total nr of CU5 affected by absolute poverty in the two districts: Funhalouro 2963 Homoine: 5747 Total: 8709. 30% of 8709: 4180 children

7 This age range is based on an avoidance of breast-fed children because of the need for consistence in the nutrition indicators and the application of the hygiene and safety and play indicators. This age range is based on birth spacing data. Ref: RamaRao, S. Townsend, J. Askew, I. (2006) Correlates of Inter-birth Intervals: Implications of Optimal Birth Spacing Strategies in Mozambique. Population Council: New York.

8 The original sampling for the baseline was based on three condition variables (ECD+PROSAN, ECD+Social Accountability+PROSAN and PROSAN only). Each was allocated a 10% sample (i.e. 209), giving a total number of 618. During implementation the Social Accountability component was removed from the quantitative study, and those households were transferred to the ECD+PROSAN condition variable.

identical. It was hoped that we would be able to locate and include the 2014 sample of children in the 2016 sample, but for various logistical reasons, including increased mobility of households due to the drought and simple issues such as either the child or their caregiver not being available at the time of the research visit, this was not possible. Instead, independent and random samples were taken from within the same villages and the same socio-economic level.

Qualitative

Participants in the qualitative research were randomly selected from all the different villages in which the project worked and in four different control villages. Over the life of the project 263 individuals participated in 25 focus groups and 35 in individual interviews. Some of these interactions were specifically intended for baseline vs endline comparison purposes while others took place during the implementation period in order to track behavior change.

The table below outlines the dates, places and participants for all of the qualitative research.

Impact Evaluation				
When	**Where**	**Approach**	**Who**	**No.**
August 2014	Control Villages: *Homoine* Nhauane Dole *Funhalouro* Massalane Mazive Project villages *Homoine* Mubalo Matimbe *Funhalouro* 25 Septembro Nhaliseqque	Focus groups – 10 participants	Women over 25 Women under 25	80 F
August 2016	Control Villages: *Homoine* Nhauane Dole *Funhalouro* Massalane Mazive Project villages *Homoine* Mubalo Matimbe *Funhalouro* 25 Septembro Nhaliseqque	Focus groups	Women over 25 Women under 25 Note: These were different women from those we engaged with in 2014	80 F
Numbers: 160 participants in FGD				
Behavior change research				
When	**Where**	**Approach**	**Who**	**No.**
September 2015	*Homoine* Ndambene Moguba *Funhalouro* Macuine	Focus groups Interviews	Masungukate Masungukate	14 M 19 F 5 M 6 F

	Mavume Sede	Interviews	Caregivers	14 F
Numbers: 33 participants in FGD 25 in Individual Interviews				
Social accountability research				
When	**Where**	**Approach**	**Who**	**No.**
January 2016	*Homoine* Marengo, Macavane, Matimbe, *Funhalouro* Bulangete, Mbone Mutuzi	Focus groups Focus groups	Caregivers Masungukate/ dota	30 11 M 29 F

Numbers: 70 participants in FGD				
Case studies				
When	**Where**	**Approach**	**Who**	**No.**
July 2015	*Homoine* Ndambine Chindjinguir-sede *Funhalouro* Tsane Mavume Mavume sede	A number of individual interviews A number of individual interviews	Caregivers Masungukate	5 1 M 4 F
Numbers: 10 participants in individual interviews				
Participants in focus groups: 263 Participants in individual interviews: 35 **Total numbers engaged in qualitative research: 298**				

3.4 Instruments

The indicators, quantitative and qualitative instruments used in the Impact Evaluation are summarized in the table below. Each instrument is described in more detail in the paragraphs below the table.

Indicator	**Quantitative instrument**	**Qualitative instrument**
Caregiver status		
Social support and capital	4 questions from the World Bank SOCAT questionnaire	Mapping of "people I trust"
Emotional stress	WHO SRQ20	"Stones in the basket" as problems we face
Child status		
Birth record	EP Checklist question	Discussion of barriers to access
Under-five card	EP Checklist question	Discussion of barriers to access
Immunization	EP Checklist question	Discussion of barriers to access
Nutrition status	Child dietary diversity sore	Discussion of feeding practices
Anthropometric measures	WHO standard measurement of height and weight	
Developmental milestones appropriate for age	Malawi Development Assessment Tool	
Caregiving environment		

Malaria prevention	EP Checklist question	
Stimulation through play	Questions from HOME Inventory	Mapping of interaction with child during day
Academic stimulation	Questions from HOME Inventory	Mapping of interaction with child during day
Language stimulation	Questions from HOME Inventory	Mapping of interaction with child during day
Responsivity	Questions from HOME Inventory	Mapping of interaction with child during day
Acceptance	Questions from HOME Inventory	Scenario discussion
Safe and hazard-free home environment	Safety checklist	

All of the quantitative instruments were collected into a single household questionnaire (see Appendix 2). Each of them is described in detail below.

i) Questions from World Bank Social Capital Assessment Tool (SOCAT)
The best way to measure social capital would have been to use a comprehensive social capital questionnaire such as the World Bank's Social Capital Assessment Tool (SOCAT). However, this would have made the questionnaire too long and onerous for respondents so we made the decision to choose questions from the SOCAT that focus on "cognitive social capital" (trust in others) as this is linked to the process of the ECD intervention.

See Question 8 in the household questionnaire (Appendix 2).

ii) WHO SRQ20
The Self-Reporting Questionnaire 20 items (SRQ20) is a mental health-screening tool developed by the World Health Organization (WHO, 1994). It consists of 20 questions that are usually self-administered, but in our case were administered by the research fieldworkers. A 'yes' score of greater than eight indicates a high likelihood of having a mental disorder such as depression.

The SRQ 20 has been found to have "high face validity, namely it appears to assess relevant symptoms of mental ill health" (Harpham, T. et al. 2003). It has been found to be both sensitive and specific in screening for mental ill health in many countries in Africa, including Mozambique. This tool was included in the household questionnaire (see Appendix 2).

iii) Essential Package Checklist questions
A number of questions were taken directly from the Essential Package Checklist.

iv) Child Dietary Diversity Score
Nutrition is an important element of child development. Dietary diversity is one way of measuring good nutrition for development. The Household Dietary Diversity Score (HDDS) (Swindale and Bilinksy, 2006) was identified for this purpose. We did not use the household component of the instrument, but an adaptation of it called the Children's Dietary Diversity Score (CDDS), also described by Swindale and Bilinsky. The CDDS was adapted further (but very slightly) to suit the specific context of rural Mozambique and the needs of this research study. The CDDS is contained in

Question 6 of the household questionnaire (Appendix 2). The CDDS is used as a proxy measure of the nutritional quality of a child's diet and does not attempt to measure household access to food, which is the focus of the HDDS. Thus across groups and over time, changes in individual children's dietary diversity can be measured. This allowed us to draw conclusions about caregiver's knowledge and commitment to better nutrition.

v) WHO standard weight and height measures

Children's weights and heights were measured using standard WHO methods (De Onis et. al. 2004). This allowed us to assess whether program interventions, for example, the nutrition program, had any impact on these anthropometric measures. Given the relatively short period of time between baseline and endline (two years), the nature of this specific intervention, and the on-going drought major differences in weights and heights are not expected at endline. However, the hypothesis of the program intervention is that over time, in spite of structural determinants such as the drought and deep poverty that restrict access to nutritious foods, knowledge and better care brought about through improved mental health status of caregivers should lead to improved dietary diversity. It would be useful to continue to collect anthropometric data over the next few years to assess impact of this indicator.

vi) Malawi Development Assessment Tool (MDAT)

This research study attempted to assess specific child development indicators. We chose to use the MDAT (Gladstone et al. 2010), developed in Malawi (where conditions closely resemble those in Mozambique) for monitoring and surveillance purposes in clinical settings (see household questionnaire in Appendix 2).

It should be noted that the use of MDAT in this context was not diagnostic and the analysis of results did not attempt to make comparisons with the normative data developed in Malawi. The scores were treated as mere numbers that could be compared across groups and over time, using appropriate statistical analytical techniques.

The MDAT investigates child stages of development across four domains: gross motor and fine motor coordination, language and social development. It does this by asking children to do certain tasks, for example throwing a ball, jumping, hopping and so on, for gross motor coordination, and various other actions, verbal and interactive tasks or activities for the other domains. The tasks are carefully graded and the child is taken through the sequence until they are unable to complete three in succession. The preceding correctly completed tasks then represent the child's score for that domain.

vii) Adapted HOME inventory

Questions 4 and 5 in the questionnaire are taken from the Home Observation for Measurement of the Environment (HOME) inventory devised by Caldwell and Bradley (1984). The inventory measures the quality and quantity of stimulation and support available to children in their homes.

viii) Health and safety checklist

This checklist was devised for an evaluation of the Sobambisana Initiative, a national ECD project developed in South Africa. The checklist was developed in consultation

with the four Sobambisana partners (Dawes and Biersteker, 2012). Items are based on common safety and hygiene hazards identified in the course of Sobambisana fieldwork in rural areas and have been slightly adapted to the Mozambican rural context. (See the household questionnaire in Appendix 2)

Qualitative

Qualitative data was collected through 'research activity focus groups'. These were not merely focus groups but groups where interactive activities adapted from the field of participatory rural appraisal (PRA) were used to get participants reflecting and talking about their behaviors, perceptions and practices. This discussion was recorded and translated and transcribed. The groups were all run in Xitswa.

Impact Evaluation focus groups were run in both Control and Project areas and focused on the particular indicators set for the Impact Evaluation. An outline of these focus groups is given in Appendix 3.

In addition to these focus groups other qualitative research was done to understand what aspects of the implementation strategy worked to create impact and why. These activities related to the second research objective outlined in Section 2. above. The additional qualitative research consisted of:

- Focus groups around specific behavior change in Masungukate/dota and caregivers
- Focus groups around social accountability approach
- Case studies of specific households

An outline of the activities and questions asked in these focus groups is given in Appendix 4.

3.5 Data Analysis

The study design allowed for a comparison of data across years and across quasi-experimental conditions. In order to ascertain differences between the intervention conditions, and across the years, the data was analyzed through a linear mixed model, treating site (Funhalouro and Homoine) as nested random factors, and intervention condition and year of study as fixed factors. In addition, since age is considered an important factor for many of the 19 dependent variables, and age differences are thus a potential source of confound, age was used as a control variable throughout the analyses. The term 'condition' in the analysis refers to the intervention (ECD) and 'study year' to 2014 or 2016. The qualitative data (transcripts) was analyzed using a thematic approach (Braun and Clarke, 2006) based on the indicators we were exploring.

4. Findings

The findings are presented under the three main Essential package domains of:

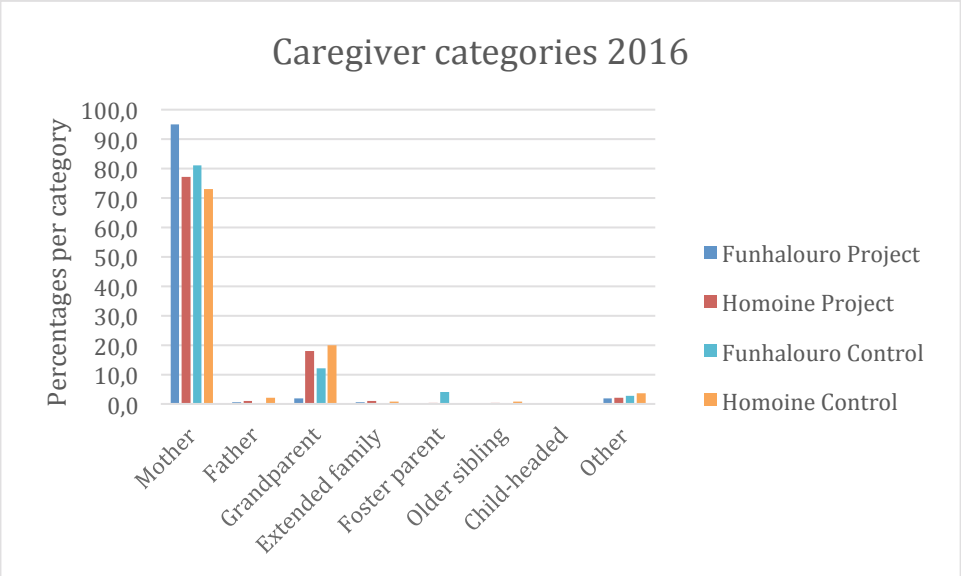
- Caregiver status
- Child status
- Caregiving environment

and then under the sub-indicators listed in Section 3.2. Quantitative findings are followed by qualitative if both were used in the research.

Note that each section of the findings is followed by a section in shaded text that outlines a summary of findings related to impact and a reflection on which areas of implementation brought about the impact.

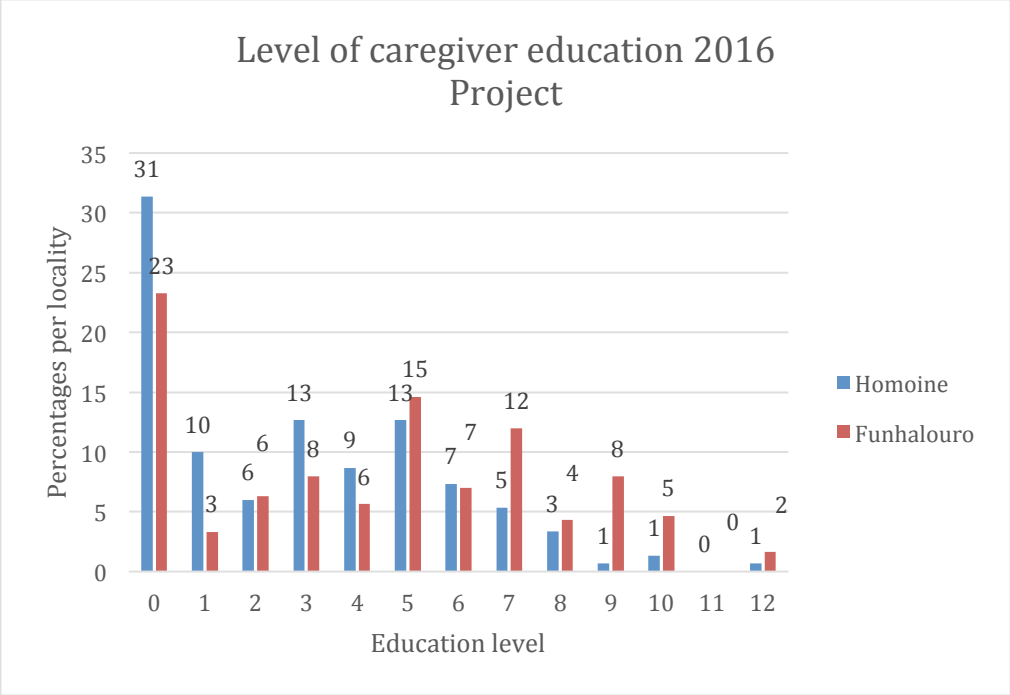
4.1 CAREGIVER STATUS

Before looking at the results related to caregiver status it is necessary to make the point that most caregivers who participated in the study were mothers, but there were a significant number of grandparents as caregivers, especially in Homoine. In 2014 across project and control households, 77.5% were mothers and 15.7% grandparents. The 2016 patterns were very similar (79.4% and 15% respectively).



		Mother	Father	Grand-parent	Extended family	Foster parent	Older sibling	Child-headed	Other
Project	Funhalouro	94.9	0.6	1.9	0.6	0.0	0.0	0.0	1.9
	Homoine	77.2	1.0	18.0	1.0	0.3	0.3	0.0	2.0
Control	Funhalouro	81.1	0.0	12.2	0.0	4.1	0.0	0.0	2.7
	Homoine	73.0	2.1	19.9	0.7	0.0	0.7	0.0	3.5

Caregiver education is another relevant factor because it allows us to assess how well the program worked with parents with lower levels of education. In the 2016 sample (very similarly to the 2014 sample) 31% of primary caregivers in Funhalouro and 23% in Homoine had no formal schooling. In the same year, 81% in Funhalouro and 61% in Homoine reported having been in school no further than Grade 5.



4.1.1 Caregiver levels of community trust

Research into adult wellbeing suggests that the ability to trust others in the community is an important aspect of social capital that vulnerable women can draw on (Harpham, Grant and Thomas 2007). We used four questions that were drawn from the World Bank's Social Capital Assessment Tool (SOCAT) to measure this indicator. These four questions were used as a composite measure which we have called "community trust".

In the 2014 project and control groups, results suggested that most caregivers felt they could **not** rely on people in their community for help with practical or social problems and that most of them trusted only 1 or 2 people (usually a family member). Some (over 5% of the whole sample) said they trusted no one.

In 2016 the answers to the questions about trust in the questionnaire showed that levels of trust were higher in the project group than in the control group. The difference was statistically significant[9].

The qualitative research helps explain and, in fact, reinforces this result. In 2014 many women in both project and control (qualitative) groups said they trusted no one.

In both 2014 and 2016 we asked caregivers to draw a map in the sand of their homes and the village, including people's houses and the main features such as the clinic, church etc. We explored the kind of social support that caregivers had by asking them to indicate on this map where there were people who they trusted to help them with a problem.

In 2014 in both **project** and **control** groups almost all women initially marked their homes saying their husbands were the ones they trusted to support them with a problem. After some discussion, though, many women agreed that they had given an "expected answer" and they did not often talk to their husbands about problems. Many also indicated that they did not talk to anyone outside their homes as, "problems should not be shared outside the family". This left many of them with no one to trust.

> *I don't trust anyone, I only trust in God who keeps me alive, I don't trust a man (angry). (**2014** Younger women, **Project**, Village 25 Septembro, Funhalouro)*
>
> *When I have a problem I discuss it with my husband. If he does not help I will comfort myself. I trust no one.*
> *Me too. If my husband does not help me sort it out, I keep it a secret, because I trust no one. (**2014** Younger women, **Project** Matimbe, Homoine)*

In 2016 this was exactly what happened in the **control** groups; women marked their homes on their maps and most said they trusted their husbands or no one. A few indicated that neighbors or the church could be trusted.

> *Researcher: Show me on your picture where there are people you trust.*
> *My husband is in Joni (South Africa). I only go to the church for help.*
> *I trust my neighbor.*
> *My husband. But no neighbors - sometimes there is no one to trust.*
> *(**2016** Younger women, **Control**, Mazive, Funhalouro)*

In 2016 in the **project** groups a different pattern emerged, many caregivers in all of the intervention groups drew a Masungukate/dota as the person they would go to. What was striking was that most did not draw the Masungukate's home on their map (as the instruction suggested) but the person – often very large and in detail.

[9] Note that the difference was not significant with a 2-tailed test, but significant for a 1-tailed test . Mean = 11.66 vs 11.43, t = 1.79, df = 22, p < .045

*I just go to my Sungukate, Mama Amelia. I am drawing a good picture of Mama Amelia because I love her. (**2016** Younger women, **Project** Matimbe, Homoine)*

Researcher: Draw where you go for help, someone you trust.
(The group is spread out so they cannot copy each other and all but one draws a person in amongst the houses they have drawn).
I drew Sungukate Caterina. I go to her for advice.
I drew Mama Regina (Sungukate).
I drew Sungukate Zinha, my Sungukate.
Mama Elmira (Sungukate).
My Sungukate.
I drew my Sungukate's house.
Researcher: Before you had Masungukate where did you go to for help?
There was no other place to go before.
*(**2016**, Younger women, **Project**, Mubalo, Homoine)*

In one of the **project** groups the caregivers started by saying they trusted people in their families and later mentioned Masungukate when questioned. Some told the Masungukate everything others said some things were for the family only.

I trust my mother in law.
I have two people I trust - My sister in law and my grandmother.
Researcher: Are there any people outside of your family that you can trust?

Sungukate.
The people we talk to are the Sungukate concerning our problems.
I talk to my Sungukate about everything family issues and how to raise our children.
*I don't tell all the problems because they are problems you need to keep in the family. (**2016**, Older women, **Project**, Nhaliseqque, Funhalouro)*

One of the **project** focus group discussions in Funhalouro that stood out in the research was a group with younger women, aged between 14 and 22, all with babies and most unmarried. The Masungukate played a very important role in these women's lives.

Researcher: Who are the people you trust?
I trust my Sungukate and the one they say is my husband.
Mama Amelia - my Sungukate, my neighbor and my husband.
I trust a friend only because I have no neighbor, no husband.
I only trust Sungukate because I have no husband.
Mama Sungukate.
I trust my husband and the Sungukate who advises me.
Researcher: Tell me about these Masungukates. Who are they?
Aah Masungukate. We take them as our mothers because they give us advice that helps us a lot in our households. They help us a lot. They are just like mothers. (2016, Younger women, Project, 25 Sept, Funhalouro)

Trusting someone outside the family – implementation issue
One of the issues that emerged in the qualitative research in 2014 and again in 2016 in both project and control was the fact that traditionally people do not talk about problems within the family to outsiders. This idea was expressed in all of the control groups in 2014 and in 2016 and in the project groups in 2016 there were always one or two in each focus group who said they did not talk about family problems even to their Sungukate. It is also worth noting that the younger groups of women were more willing to talk to Masungukate about issues in the family possibly because they were less bound by tradition than the older women.

The qualitative research on behavior change and one of the case studies helps us understand how the Masungukate dealt with this issue and how many of them overcame this traditional reticence. This is an important aspect of the research into the implementation of the project. Masungukate/dota talked about how at first the caregivers had been suspicious of their visits and that it took some time for them to be trusted. What was important it seems is that they continued visiting no matter how they were treated. They also described how their actions often had to match their words before the family trusted them.

At first the family was not trusting me. They did not know why I was visiting. But I saw the child needed the hospital but they did not listen to me. So one day I took the mother and the child to the hospital. I paid for the transport and then they did trust me. Now they know I am there to care for the children. Now they are changing many things. (2015, Sungudota, Moguba, Homoine)

Case Study 2 about Caregiver Maria and her Sungukate, Eliza is an illustration of the process of perseverance. As all the case studies show what is important is the relationship that develops over time, a relationship that can allow families who before had no one to help, to begin coping. The caregiver quoted below describes this process.

> *I had a problem because since when I was pregnant I was very sick and the baby was delivered at seven months and it was very small. That made me to feel very sad. Sungukate Marta helped me. She helped me such a lot to feel better. I was crying all the time and I was so sick and she encouraged me to never lose hope and she was coming every day to help me. Every day she was coming back. She helped me to never give up hope with the baby. Now I am better and my baby is fine. She even stopped to do her own things, to eat to help us, every day she came back and back. I love her, she is my Mama Marta. (2015, Caregiver, Project, Macuine, Funhalouro)*

Summary of impact

Social support networks and social capital related to community trust
When we look at the quantitative and qualitative findings together we see that in 2014 many caregivers had very little social support (in project and control villages). Generally, caregivers had few trusted adults with whom they could share problems of a more personal nature. This probably exacerbated the emotional stress they experienced.

There is a change in the pattern in 2016. The findings show a small but significant increase in community trust as a measure of social capital in the project group. In the qualitative research many caregivers who were part of the project spontaneously identified a Sungukate/dota as the person they trust. This is in sharp contrast to the groups run in 2014 in the same villages where many caregivers said they trusted no one.

Understanding implementation
The qualitative research also shows us that the issue of trust is a complex one because there is a strong tradition of not talking outside the family about problems. But it is clear that many Masungukate/dota have managed to overcome this reticence through their caring actions and perseverance and have shown that they can really be trusted. This has caused a shift in a well-entrenched cultural norm. This shift will likely improve caregiver and child wellbeing.

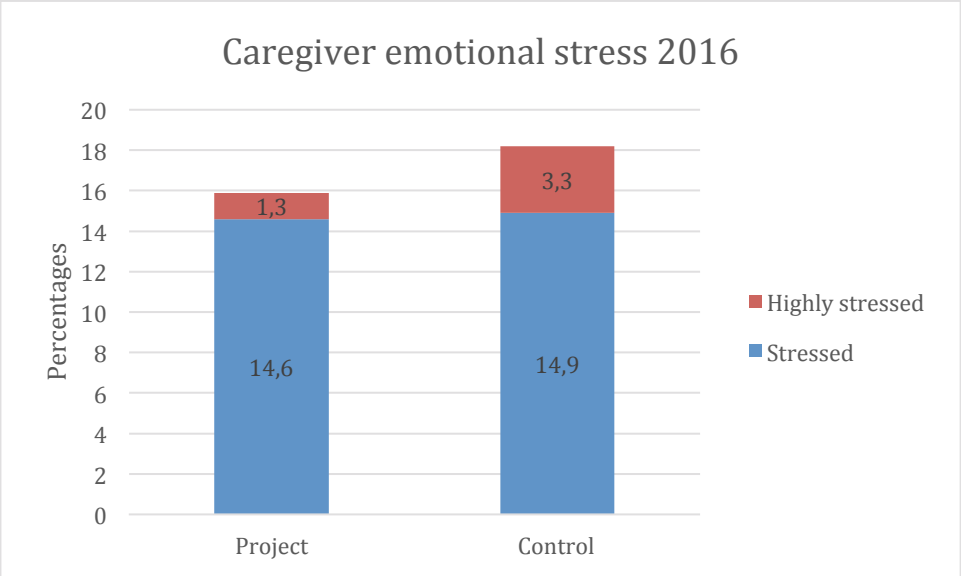
4.1.2 Caregiver emotional stress

The issue of caregiver emotional stress was one of the main problems identified in the situational analysis that was done in 2013 before project commencement. Service providers and caregivers identified depression and anxiety as particular problems for women, particularly those in women-headed households. One of the reasons for adopting the home visiting model was because it has been shown to make an impact in improving mental health outcomes of caregivers (Dawes, Biersteker and Hendricks, 2012). This is, therefore, an important indicator of impact.

Quantitative
The Self-Reporting Questionnaire (SRQ20) is a mental health screening tool developed by the World Health Organization (WHO, 1994). It consists of 20 questions that are usually self-administered, but in our case were administered by the research fieldworkers. The SRQ 20 has been found to be both sensitive and specific in screening for mental ill-health in many countries in Africa, including Mozambique (Harpham, T. et al. 2003). A score of greater than eight indicates a high likelihood of having a mental health problem such as depression.

Data from 2016 shows that the ECD program had a positive impact on caregiver emotional stress. In control villages 18.1% of women had a high likelihood of emotional stress with 3.3% scoring 15 or more (extremely emotionally stressed). In project villages only 15.7% of women showed signs of emotional stress – a statistically significant result[10]. Only 1.3% scored 15 or more, also a significant difference.

The graph below illustrates the differences in relation to intervention condition.



The qualitative research confirms that being part of the program has reduced caregivers' emotional stress, even in a time of extreme drought This section is long and detailed but important to read as it analyses *how* emotional stress was reduced and is therefore important when looking at future implementation of home-based ECD programs.

Qualitative
The issue of emotional stress was explored in a range of qualitative research groups at different times in the project. The comparative research done in August 2014 and 2016 explored the issue through an activity that used a basket of rocks and stones to represent "things that make us stressed". Caregivers named the stresses and discussed when they felt the stress the most. They were then asked if anything over the last year had helped them to remove the stress.

[10] Means = 4.82 vs 6.81, F = 19.48, df = 1, 33, $p < .001$, and with a medium effect size, d = 0.50

In 2014 the stresses women highlighted fell under three themes:

- Powerlessness in relation to food and nutrition.
- Structural constraints such as a lack of water and distance to the hospital
- Being alone with the responsibility of child rearing.

In 2016 the stresses highlighted were much the same in both control and project groups, however, with significant differences of emphasis.

Powerlessness in relation to food and nutrition
The main difference in 2016 was that the issue of food had become even more stressful because of the drought. Women in all groups described how they and their children ate mostly wild fruit and wild spinach and how babies were often ill because of this. Other women described breastfeeding long beyond six months because they had no porridge for the babies.

> *The babies get stomach aches.*
> *We are feeding them cacana (wild plant and leaves) with no porridge sometimes.*
> *It is difficult for me to breastfeed when I don't eat well but I still have to breastfeed two babies (mother of twins). (2016, Young women, Control, Massalane, Funhalouro)*

> *The babies just keep on to breastfeed after 6 months because all we have is cacana and they do not want to eat it.*
> *And they get diarrhea.*
> *We have no porridge. (2016, Young women, Project, Mubalo, Homoine)*

When choosing stones to put in the basket to represent the stressor of 'no food', caregivers consistently chose large rocks as they said the issue was always on their mind.

> *There is no harvest in the shamba (fields). We work hard and there is no food and we get worried. What are our children are going to eat.*
> *Oooh we need a big rock to put in the basket – as big as that house over there.*
> *(2016, Older women, Project Nhaliseqque, Funhalouro)*

> *This big rock must be called 'Hunger and not knowing what to feed the babies'.*
> *We need a bigger rock than that one.*
> *A big one! (2016, Young women, Control, Massalane, Funhalouro)*

When asked if this particular problem had been reduced in any way caregivers in control and project groups mostly agreed that it had not.

> *Researcher: Has anything helped you to take these rocks out of the basket in this year?*
> *Nothing.*
> *Nothing.*

The bag is very heavy still. (2016, Control, Mazive, Funhalouro)

In one project group in Funhalouro and one project group in Homoine some caregivers mentioned that they had support from the Sungukate or Sungudota with this issue.

We sat and talked together about the problem of no food and she advised me to collect wood so I could buy food. I am doing that now. (2016, Older women, Project, 25 Sept, Funhalouro)

The following stories from Masungukate/dota collected in 2015 reinforce this.

I have supported an old grandmother I visit (she has three small grandchildren to look after alone and she gets so sad) to start her own vegetable garden near to the water pump. I helped her to plant it and also to look after it when I water my own garden every day. This helps her as she at least has spinach for the children and she can sell a little bit. (2015, Sungukate, Project, Mavume Sede, Funhalouro)

I have helped this caregiver by suggesting she cuts grass and sells it, I bought some to thatch my house to help her. (2015, Sungudota Mavume Sede, Funhalouro)

Structural constraints
Structural constraints such as water sources that were far away and the long distance to the hospital were again mentioned in 2016 as causing stress. The main difference between 2014 and 2016 was that in Funhalouro the issue of water had got much worse. The drought had resulted in pumps drying up or the water becoming salty. Women in project and control groups described walking for hours and hours to get water.

Water is a big problem because the pump is not working. We have one pump working but there are a lot of people. You have to walk one hour and then wait for an hour or maybe more in the queue. The water comes out very slowly (2016, Young women, Control, Massalane, Funhalouro)

The long distance to travel to the hospital or clinic to get malaria treatment for children and even to get a baby immunized was still as much of an issue in 2016 in both project and control areas as it had been in 2014.

The other problem when the babies are sick and you have to go to Funhalouro you have to walk to the road more than an hour and the baby is so sick. (2016, Older women, Project Nhaliseqque, Funhalouro)

The hospital is so far. Sometimes the baby is sick at night, and you have no one to help you, it's painful because most of time the sickness gets worse at night. It is painful to you as a mother. (2014, Younger woman, Project, Nhaliseqque, Funhalouro)

You can even think that it is too far to walk to take your baby for immunization.

If you have money you take a chapa (communal taxi) but mostly we walk. It can take three hours to walk. (2014, Older woman, Project, Mubalo, Homoine)

Discussions in 2016 with those who were part of the project revealed that sometimes the Sungukate/dota helped them overcome the structural constraints.

Researcher: Has anything helped you to make this heavy stone smaller? The Sungudota went with me to the hospital. (2016, Older woman, Project, Mubalo, Homoine)

There were many stories provided to us during the 2015 research about how Masungukate/dota had intervened in the context of structural barriers. This was often the case in extreme cases such as the one below.

In one of the households I visited I found three-year old Dinéria. Her mother had the baby when she was just 16 and she was living with an uncle who had taken her and the baby in. I could see the child was not having appropriate weight for her age, did not play and her belly was large. I told the mother to take the baby to the health center, but I knew I needed to do more so I asked Mutuque (ECD facilitator from local community-based organization AJEPROJ). We both went with the mother to the health center. The nurse who examined the child said she must have supplementary feeding immediately. But Mutuque knew that to get this, mother and child would need formal registration documents, which they did not have and which would take a long time to get. Mutuque went to talk to the community leader to apply for immediate supplementary feeding for the child while the registration documents were applied for. Dinéria is now receiving "plumpy nut" from INAS (government social action program). At first I visited every day to make sure she was eating but now I visit once a week. Dinéria is playing now and smiles and her mother is learning to take care of her. (2015, Sungukate, Project, Mbanguine A, Funhalouro)

Even without this level of intervention, just having someone to talk to was reported by caregivers in the project group in 2016 that their stress was reduced.

This stone of the 'no food' and this one of 'no water' they are still BIIIG but they are a little smaller because my Sungukate comes each week and we talk. (2016, Older women, Project, Sept 25, Funhalouro)

It seems that the visits did not change the contextual constraints but they helped the caregivers feel better and also reduced the sense of powerlessness they felt. This extract from the case study of caregiver Maria and Sungukate Eliza illustrates this:

Maria feels that she receives vital emotional support from Sungukate Eliza. According to the caregiver, her stress levels have decreased significantly since Eliza began visiting the family in 2014. As Maria tells it, the visits occupy her mind and allow her to think about other things, allowing her present worries to virtually disappear. The visits give her something to look forward to and provide an outlet to talk about any problems that the household is having. (2015, Case Study 2, extract)

In the focus groups and interviews we conducted in 2015 we were interested to know if the recent drought and the resulting stress related to finding food and water for the family brought increased emotional stress. Caregivers and Masungukate/dota agreed that of course it had, particularly in Funhalouro. We then explored with the Masungukate/dota if they were still welcome in the homes they visited or if families got angry that they could not help with food. We asked caregivers the same thing. Everyone agreed that in this time of drought two things were important, one that they continued to learn new knowledge that they could apply later, even knowledge about good nutrition for children that they could not maybe apply now but would apply later when they had more food. They also agreed that having someone like a Sungukate to talk to gave them hope and support in the difficult time of drought.

> *Now we need even more to have some little visits, some talking, some playing, some joking, friends. It helps you to feel better. (2015, Caregiver, Project, Macuine, Funhalouro)*

> *We can talk about the problem together. We can solve some problems together. I do not just think and think alone now. (2015, Caregiver, Project, Mavume Sede, Funhalouro)*

It is worth noting that caregivers mentioned quite often that they knew the Masungukate/dota were volunteers and that they too were suffering from the drought. This made a difference in their acceptance of the advice.

> *I know that she (Sungukate) is also struggling. She is taking time from her field to help me. That is good of her. (2015, Caregiver, Project, Ndambene, Homoine)*

What the quotes above illustrate is that the companionship of the Sungukate in the face of difficulty seems to be important. This is best illustrated by the stress of being alone with the responsibility of children.

Being alone with the responsibility of child rearing
In 2014 the problem mentioned most often in all focus groups (project and control) in Homoine and Funhalouro with both younger and older caregivers was looking after children alone.

> *I am still at my parents. I am not married yet and I have a child that I have to be there for. His father left me when I was pregnant. (My child) doesn't know his father. Since the time he came to acknowledge the pregnancy, he went, until now. The child is five years old now, so I am on my own since then until now. The child has been admitted four times at the hospital. At some point he needed a blood transfusion. I also have been to C to the hospital alone, just me and my sick child. (2014, Young woman, Mubalo Project, Homoine)*

Running the household and providing for the children alone was also frequently mentioned.

He just builds the house and leaves you there. You have to do all things on your own.
Then the other problem us mothers, we are many here that have maybe four or five children, and the fathers passed away, but the children are with me, they depend on me and I am not working. I have to sell wood, work in the field to find money to raise the children, and pay school fees or respond to their needs, they have to depend on me the mother, I have to be the father and mother at the same time. (2014, Older Women, Project, Matimbe, Homoine)

There is no one to help us, we are just left with kids only, so that is one of the biggest problems in N. (very emotional, about to cry). (2014, Control, Older woman, Massalane, Funhalouro)

Most often the fathers of the children were working away or had died, but even if the father was living at home, he often did not take any responsibility for the children.

The other problem is you can start a family with a man then maybe you have five, six or even seven children. The father of the house when he gets up, he does nothing but drinking and smoking. Here at home he does nothing to help, if you want something, or a child wants an exercise book you have to find it your way, by working on other ladies' fields, or selling wood, but he has money to drink every day. That is a very big problem for us as well. (2014, Project, Older woman, 25 Septembro, Funhalouro)

This was not much different to what women described in the control groups in 2016.

You are just alone with the children. My husband left in 2013 and did not come back. I have to be the father to the children. (2016, Younger woman, Control, Mazive, Funhalouro)

I have my daughter's children - three of them. I am alone with them. She is working in Maputo. Sometime she sends money but not often. (2016, Older woman, Control, Massalane, Funhalouro)

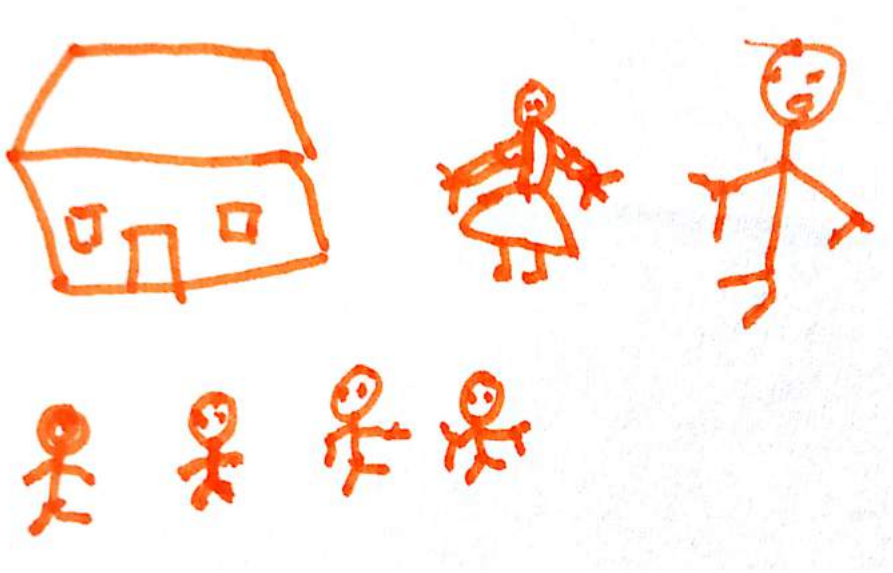
However, in 2016 in the project groups caregivers talked about how much the weekly visits helped them to feel less alone

I have a little help with each visit. The Sungudota talks to the boys every visit and they now help me. (2016, Older woman, Project, Matimbe, Homoine)

My Sungukate comes to visit and she looks at the little ones and helps me to see if they are well. I am happy to see her always. (2016, Younger woman, Project, Nhaliseqque, Funhalouro)

The qualitative research done in 2015 casts even more light on the role that the Masungukate played in reducing emotional stress. Caregivers talked directly about how they had changed. The story below illustrates how the reduction of emotional stress was the main change for this mother.

"I was feeling so sad because I did not have someone to help me."



Ofelia drew her family for us. Her four sons aged 4, 6, 8 and 13 are at the bottom of the drawing. Though she has drawn her husband on the right he died a few years ago, so she is alone with her four boys.

Feeding them is hard, there is no rain and nothing comes from our farms. But my biggest problem was the behavior of my older sons. There is a big difference between caring for boys and for girls. It is difficult to care for boys and because of the Sungukate now they (the boys) understand. Sungukate Felizada talked to them. When she came to visit she found them and sat with them. Before the boys were not accepting to do things and now they listen to me and when I say do something they do something – they don't disrespect me anymore because the Sungukate invited them to sit around and listen and she was coming back every time to see how they were doing, she came back and came back.

The other thing that has changed was that my preference for my kids was traditional medicine and now I go to hospital, so that is the main change.
The big changes can be seen in the little one because he was coughing so much and Sungukate Felizada made sure he went to hospital to get medicine so he is now better.

But the most change is in my heart. The Sungukate helped me in many ways with the stress. There were things I was not sharing with nobody and since Sungukate Felizada was visiting I began to share things and we found little ways to solve things. Before I was feeling I am alone so now I can share with her and she helps me. She is a lovely lady (she laughs softly).

I made the two things from clay to show how I felt before and how I feel now.
This is a lithelo (a flat basket used for winnowing – traditionally this is a symbol of female sadness because new wives who have recently moved to their father-in-law's homes could sit quietly and cry only when they were winnowing nuts or grain with this basket).

I was like the lithelo (on the right of the photo) - I was feeling so sad. It was because I did not have someone to help me I had to do it alone. I was just thinking too much. Now I have the aid of someone else and I am shining because of that. So I made a flower (on the left of the photo). Now I have Sungukate Felizada I am like a flower. (2015, Caregiver, Project, Chijinguiri*, Homoine)*

Caregivers also talked a lot about a feeling of "heaviness" and how this had reduced with the visits from Masungukate or Masungudota. They described how feeling "heavy" often prevented them doing things they knew they should.

> *I knew the mosquito net was needed for the baby but I was so heavy that I could not even do it. To pull it over the sleeping mat was too much, I just went to sleep - I did not even clean the dishes. (2015, Caregiver, Project, Macuine, Funhalouro)*

Another theme that emerged was that depression and hygiene were often linked. This emerged when we asked caregivers if anything had changed since the Masungukate/dota began to visit and many of them told us that one of the biggest changes that had come about was that they now kept their yards and houses neat and tidy. We questioned this (skeptically thinking that this was an easy answer and one that a respondent may think a researcher would like to hear) but the caregivers insisted that this had indeed happened. As we discussed why this had happened it became clear that many caregivers had given up caring because they were depressed or felt so alone with the household tasks and child-care tasks.

Masungukate reported that once women had begun to take care of their house and yard they felt better about themselves, they felt that they had some power and then the Masungukate were able to help them think about their children. Masungukate/dota often seemed to use such an incremental approach,

understanding that the basic care of the yard and house were a symptom of depression and its concomitant lack of powerlessness.

This link is confirmed through the quantitative data. We looked at inter-correlations of some of the predictors. In the context of emotional stress the SRQ20 had statistically significant correlations of moderate to low size with several variables, most notably with stimulation of children through play, trust, and hygiene and safety. What this illustrates is the link between being less emotionally stressed and being able to take action for the wellbeing of children.

What these results tell us is that regular home visits are very important for effective implementation of a project like this. The evidence is clear – the simple act of visiting a home regularly reduces emotional stress. In the quotes from caregivers in this section it is clear that they look forward to the Masungukate/dota's visits. Masungukate/dota reported that the children also looked forward to their visits.

> *At first they were scared of me. But then I played with them each time and now they run when they see me. Now they call after me in the village, "Sungukate, Sungukate".*
> *Yes, they do, "Papa papa" they call to me when I am walking to the forests to collect wood. They are not scared any more. The little ones see us as their friend. (2015, Sungukate and Sungudota, Project, Moguba, Homoine)*

Summary of impact
The quantitative findings show significant impact of the project on levels of emotional stress in caregivers. Caregivers who were part of the project are less likely to have mental health problems than those in the control group. This is an exciting finding.

The qualitative research illustrates *how* this stress has been reduced. The regular visits by Masungukate/dota provide caregivers with ongoing emotional support. In some cases Masungukate/dota were able to solve specific problems that caused emotional stress, especially in the area of family relationships or in helping families access available services. But they could not easily address structural or contextual issues such as crop failure, lack of water or distances to the health facilities. Nevertheless, it is clear that they have mediated these structural problems by 'standing with' the caregivers while they coped with the problems – after all, they too (as Masungukate/dota) also faced these issues. This support clearly meant a lot to caregivers and reduced their stress. Masungukate/dota have become wise and constant visitors, welcomed by the children too. They represented someone to play with, chat to, laugh with and break the hardship of stress, especially in the time of drought.

Understanding implementation
It is worth noting that the research that informed the original model suggested that visits should be made once a week if they were to impact on the emotional wellbeing of caregivers. The findings presented above support this point as it seems that it is the regular and frequent nature of the visits that has the impact.

It is important to point out that once a week is quite frequent in the life of a man or woman whose livelihood depends on their own labor. This means the Masungukate/dota should be allocated no more than 6 or 7 households to visit and these households must be close to their homes. If not, the burden of their role will become too much and motivation will dwindle.

Another important implementation issue is related to the values that were promoted during the training of Masungukate/dota and the way they see their role. The program staff worked hard[11] to build an approach to parents that was not didactic and authoritarian. Masungukate/dota knew they had information to give to parents and skills to teach but they also knew that their role was to be a friend. One of the songs made up by the Masungukate/dota at the training reinforces how important this value was.
We Masungukate don't come to change the rules of your home.
We Masungukate come to exchange experiences.
We will help each other to take care of our children.

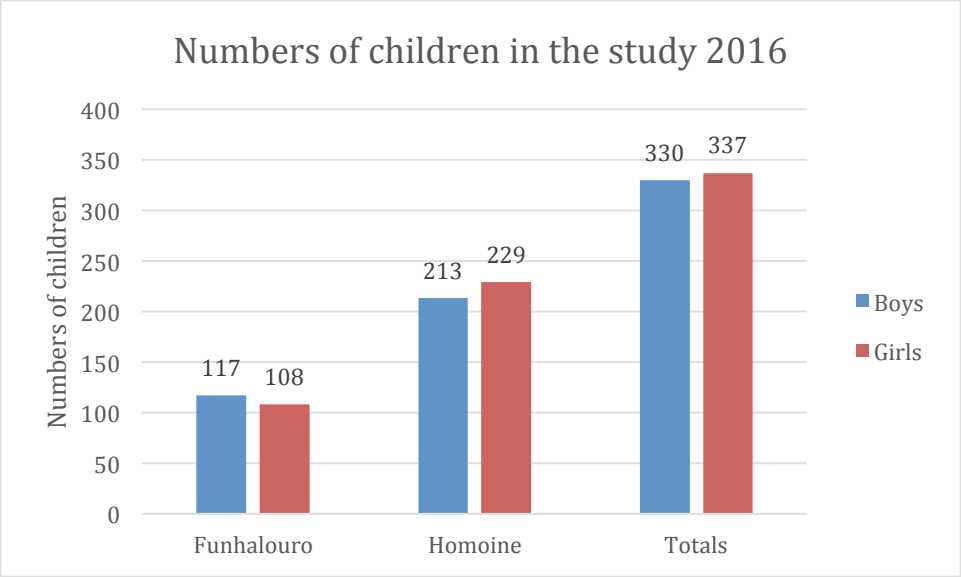
In addition, the Visual Guide developed for use by the Masungukate emphasized the relationship aspect of the Masungukate/dota's work through modeling friendship and listening in the illustrations. The effectiveness of the illustrations is discussed in detail on page 53 but what is important here is the fact that the modeling of behavior was another factor in encouraging a relationship between Masungukate/dota and caregiver.

Both the training and the Visual Guide have allowed relationships to develop between Masungukate/dota and caregivers and this in turn has allowed for trust to be built and emotional stress to be reduced as much as is possible in the context of life in these deep rural villages.

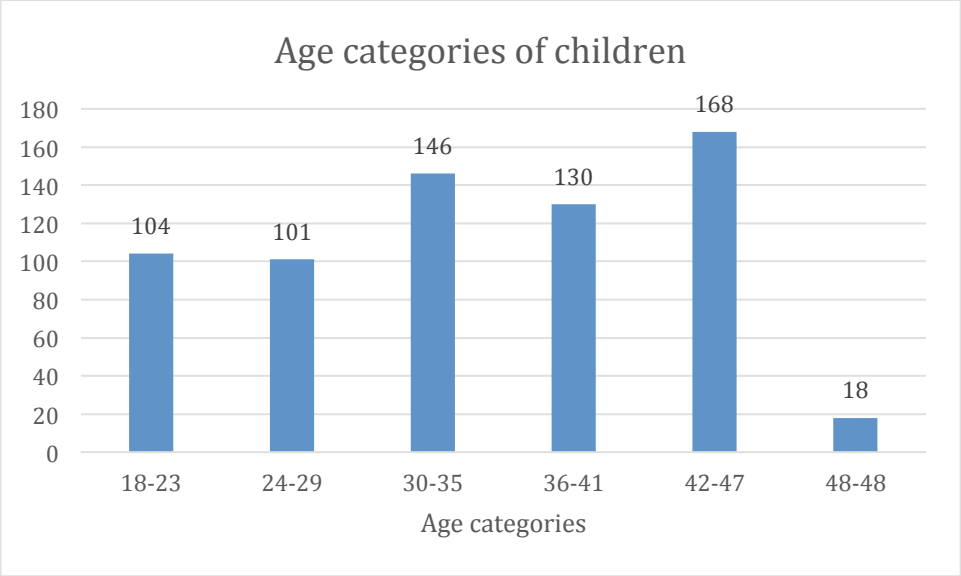
4.2 CHILD STATUS

The data from a total of 644 children was collected in 2014. In 2016 we collected data from 667 children (project and control). These are in the proportion of approximately one-third in Funhalouro and two-thirds in Homoine, according to the sampling strategy. The gender and locality breakdown for 2014 and 2016 was very similar. For readability we have put only 2016 data into the graph below.

[11] See Article titled Some reflections on training home visitors to give practical and emotional support November 2014 (published in HSRC newsletter 2014). Available from Glynis@clacherty.co.za



The sample was drawn from the 18 to 48 month range, with random selection of children in that range. The age category graph below shows numbers of children in each age group. As there are 31 months of children in the data set we have 5 columns showing 6-month periods, with one month left over at the end. Thus the last column shows just those children who are 48 months old. Proportionately, this would represent 108 children.

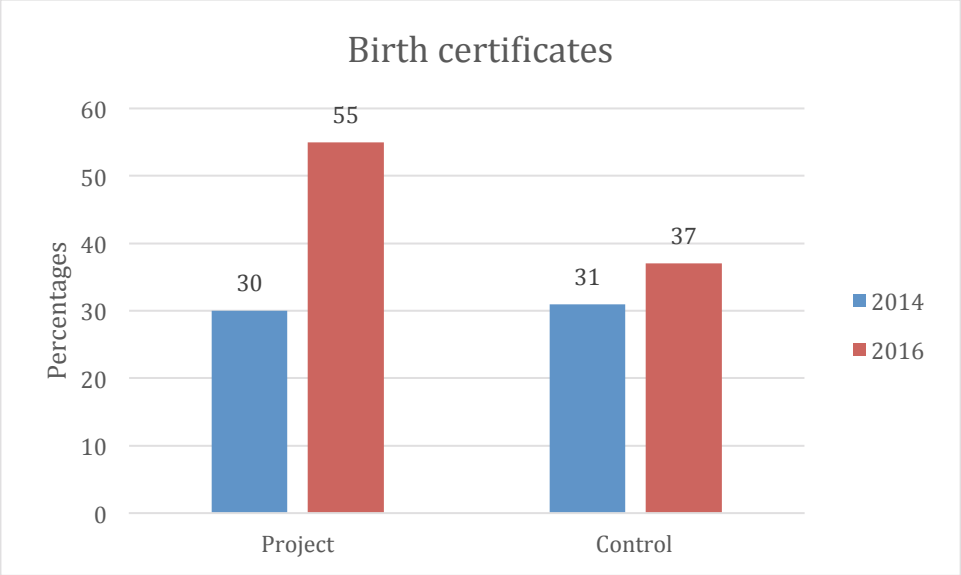


The graph above outlines the age categories of children who took part in the 2016 research. Children were aged from 18 months to 48 months. What the graph shows is that the majority of children in our sample were aged from 30 months to 47 months. This is important to keep in mind when looking at the results of the anthropometric data related to weight particularly (see Section 4.2.4).

4.2.1 Birth certificates

In 2014 the percentage of children with a birth certificate in both control and project groups was almost the same (30 and 31% respectively). In 2016, the percentages for

both groups rose, but by different amounts, resulting in an improvement of the project group over the control group (55% vs 37%). This is a statistically significant difference[12].



The graph illustrates how big an impact being part of the program had on the numbers of birth certificates.

The qualitative research gave us insight into this issue. Caregivers in the project groups reported in the 2016 focus groups that the Masungukate/dota had encouraged them to register their babies when they were born, which is probably one reason why the number of birth certificates has increased.

The qualitative research also gives us insight into an important contextual issue. One important barrier to registration is a cultural one – local cultural norms say that fathers are needed to name a child. The traditional naming process has to happen with the father present. This often means the family waits until the father is home (from working away), but by then the three-month period in which the registration is free has lapsed. Another reason for waiting for the father is that some civic bureaucrats will not register a child without the father being present. Once the father has arrived the child is often over three-months old and the cost of registration is more than the family can pay. Transport costs to the closest office add to the cost of the registration.

In the project areas Masungukate/dota, together with their CBO managers organized for the *Registo Civil* officers to come to the villages. They then assisted in negotiating with officials when fathers were not present. This could account for the increased number of birth certificates in the project group. This approach is in line with the philosophy behind the CARE ECD program, which assumes that parents want to do the right thing for their children but contextual barriers often stop them from doing this. In this case the Masungukate/dota and the CBOs sought to help parents overcome the contextual barriers.

[12] $\chi^2 = 6.2$ df = 1, $p < 0.01$

Summary of impact
The program had a major impact on the accessing of birth certificates. This was because Masungukate/dota (through the CBOs that managed them) were able to help reduce the contextual barriers of distance to the registration office and father's involvement.

Understanding implementation
Masungukate/dota have played a role in the education of caregivers about the importance of birth certificates and the need to register the child when it is born. But there is often a need for direct intervention beyond education. The important facilitating factor here was that the Masungukate/dota were supported by local CBOs who had the power to contact and 'contract' local district officials to help. This points to the need for community-based volunteers to be linked to support structures such as NGOs with connections to government officials beyond the village.

4.2.3 Under-5 health card

In the baseline research in 2014 89% of children (project and control combined) had under-5 health cards. This is high and shows the effectiveness of this health service intervention. There was no significant change in 2016 and no significant difference between project and control groups in 2016[13].

The qualitative research and reports from Masungukate/dota during implementation of the program showed us that though this indicator shows high numbers of children with an under-5 health card many caregivers do not take their children for regular growth monitoring and even struggle to get their child to the hospital or clinic when they are ill. Focus groups run with the Masungukate/dota suggest that one of the barriers to taking the children to the hospital is the long distance and the lack of money for transport. The quote from the Masungudota below shows how he overcame this barrier, building trust in the process.

> *At first the family did not trust me. They did not know why I was visiting. I saw the child needed the hospital but they did not listen to me. So one day I took the mother and the child to the hospital. I paid for the transport and then they did trust me. Now they know I am there to care for the children. Now they are changing many things. (Sungudota,* Chijinguiri*, Homoine)*

The quote below gives further insight as it shows the sense of powerlessness young mothers often feel in the face of child illness or contextual barriers such as distance, and how the simple intervention of a regular supportive visitor can make the difference.

> *Aaai the Masungukate are very important in our village because my child is now healthy because of the Masungukate. I love the Sungukate who visits me. I always want her to be visiting me. This son is so strong because of my Sungukate. She helped me a lot. When he was born he was very sick and I was using traditional medicine to give to him and he was not getting better. My*

[13] χ^2 = 0.5 df = 1, p > 0.48

Sungukate said I must take him to the hospital. I would say I am going to the hospital and get half way there and he was so sick that I would turn back again. But every day she came and said I must take the baby to the hospital. Then I took the baby and she helped me to give the medicine that the hospital gave me. Since I got the medicine the child feels better. She also brought me Moringa (a leaf from a local tree that is very nutritious) for the baby and showed me to put it in the porridge. She comes to visit only once a week now and she is always playing with my son to see that he is better. My son is healthy because of the Sungukate. (2015, Young woman, Project, Mavume Sede, Funhalouro).

The woman above describes how she gave her baby traditional medicine. Note that not all traditional medicines are a problem. The story of the Sungukate who is a traditional healer on page 35 illustrates how some traditional practices are helpful and can help caregivers and their children. But in the initial research conducted by the program team before the program was started in 2013 health providers reported seeing many babies who were ill because they had been given a particular traditional medicine as infants. This extract from Case Study 1 describes this particular tradition.

From birth until the age of 6 months, Dario received traditional medicine. The exact components of the medicine were unknown to Anna Jilda (his mother), but is typically a dried portion of root or plant ground into a powder and mixed into water, given to the child as a drink. The reason Dario was given this treatment was due to a local belief that claims that children are born with a certain beast inside of them when they are born. In the local language of Xitswa, this beast is known as inuocane. Traditional medicine is the only remedy, the only poison that will kill this beast and allow the child to live a long and healthy life. However, as often happens when this particular traditional medicine is taken, Dario became a very sick child. Instead of gaining weight, he lost it and grew very thin, as the little breastmilk that he took was unable to be absorbed by his weakened body. Dario's deteriorating health scared Anna Jilda sufficiently to induce her to stop giving her son the traditional medicine after only 6 months. (2015, extract from Case Study One, Project, Tsane, Funhalouro)

As well as giving traditional medicine to kill the *inuocane*, caregivers also used traditional medicine when a child was ill. One reason was because they could not get to the hospital as it was too far and they felt it was better to do something rather than nothing. It seems that mothers-in-law also often encouraged the use of traditional medicine over visits to the hospital when a child was ill.

If the child is sick I go to the traditional healer. If the child has malaria.
I don't go there. It is not helping. I go to the clinic. It is mostly the old people who go to the healer.
Researcher: So some of you go and others do not.
It is hard because our mothers-in-law say we must go to the healer. If the child dies then she will blame you because you did not go.
Sometimes when my son has malaria I go to the healer because I do not have money and the hospital is far. (2014, Young women, Project, Matimbe, Homoine)

Because of the initial research in 2013 and the findings from the baseline in 2014 Masungukate included messages about the problems associated with some traditional medicine when they visited. The topic was also discussed extensively during the training. Many caregivers identified this as a major change in their behavior in the 2015 research. Of course, this is reported behavior and we would need more research to find out if the practice had actually changed. We do, however, have qualitative data from Masungukate/dota suggesting that the inappropriate use of traditional medicine had in fact decreased. One of the most active and effective Masungukate in Funhalouro is a traditional healer. She was very clear about how she used what she knew to be good from her traditional knowledge and changed practices she knew to be harmful.

> *I do know about wild fruits and I encourage the mothers to grow them between the maize they plant … I do not give the babies traditional medicine and if I know I cannot help I always encourage the mothers to take the babies to the clinic. The people respect me so it is easy to share the knowledge I have from CARE. (Sungukate, Mavume Sede, Funhalouro)*

The extract from Case Study 1 below continues the story of Dario and illustrates how the ongoing support and sharing of knowledge by Masungukate/dota have helped to change behavior in relation to harmful traditional medicines.

> *When Sungukate Laura began to visit the family in 2014, after Dario had regained most of his health and Anna Jilda was now again pregnant, she taught the family about the dangers of some traditional medicine and how very likely it was that Dario's sickliness as an infant was the result of the treatment he was given. Because of this, the family's second child, Delsun, was not given the traditional medicine for inuocane and took only breastmilk until 6 months.*

The quote from the Sungudota below shows how knowledge about the problems of some traditional medicines has spread beyond those visited by Masungukate/dota. In fact what this quote illustrates is how visible change in some homes leads to a broader social change.

> *I am getting the other young women asking if I can come to visit their house and their babies. This is because they see my babies (he laughs). They are growing so fat because I tell the mothers to breastfeed - no traditional medicine. People can see in the village, my babies are getting fatter. (Sungudota, Homoine)*

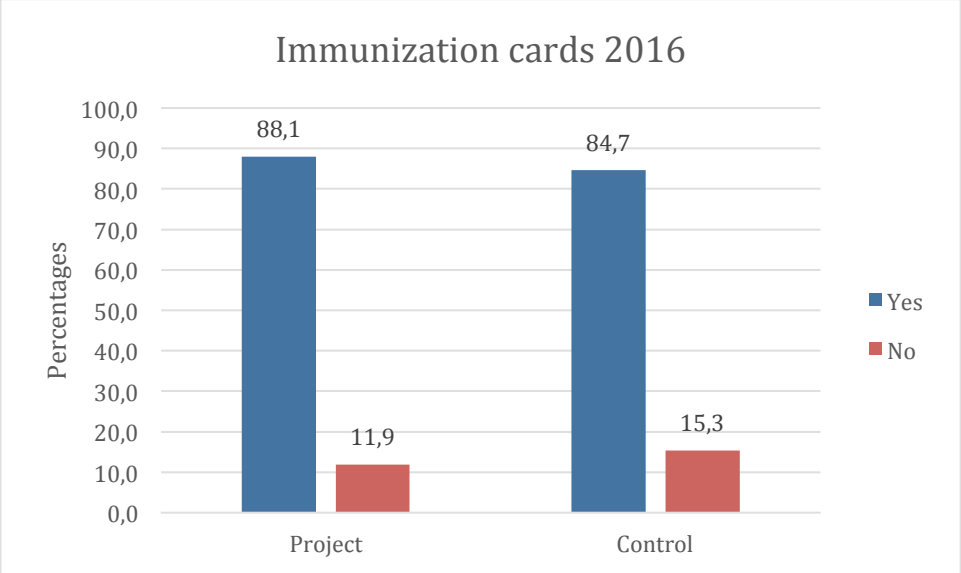
The extract below taken from Case Study Four is another illustration of how a Sungukate or dota can mediate the context for a parent. It tells the story of a mother constrained by her belief on traditional medicine, by her depression and deep poverty and by her fear of disapproval from health providers from taking her children to the hospital. The children's feet and hands were infected with sand fleas (*Tunga penetrans)*, called *matakenya* locally.

Day after day, excuses were made as to why Preciosa couldn't take the children to the hospital. At first she said that she believed the matakenya to be a genetic disorder and something untreatable. After all, every one of her children had them, so it must be something in the blood. Later, she tried treating the matakenya herself, using an insecticide on the black spots. Yet, this didn't seem to heal much of anything. Then, she explained that she didn't believe the condition to be that serious and that with time it would heal itself. Eventually, however, the truth came out, and Preciosa admitted that the real reason she was hesitant to go to the hospital was because she was ashamed. She was embarrassed that she had allowed the situation to become as severe as it had. She thought that maybe staff at the hospital would think that she wasn't a good mother, that if only she had taken better care of her children, this wouldn't have happened. She was ashamed because she herself had matakenya nesting in her feet and hands and didn't want anyone to know.

It is at this point that Sungukate Felizada José proves how valuable she is. She's patient with Preciosa. She's sympathetic. She insists that it wasn't the caregiver's fault. That is was a situation that she couldn't control. But now, she can take charge and control the situation. Now she can make sure that her children are taken care of. And so, Preciosa and her children visit the hospital with Sungukate Felizada right at their side. (extract Case Study Four)

4.2.3 Immunizations

Analysis shows that the project group had statistically significantly[14] more immunization cards than the control group in 2016 (88.1% vs 84.7%).



The qualitative research confirms the role that Masungukate/dota played in this positive result. Caregivers in the project group described how their Sungukate taught them about the importance of immunization and then reminded them (often every day) to take their children when the vaccination was due.

[14] χ^2 = 6.77 and 8.95, df = 1, $p < 0.01$

Sungukate Marta showed me the page in the book (Visual Guide) about vaccinations. She reminded me to take my baby. One week she came every day to see if I had taken the baby yet. One day I felt so sorry when she came again that I just took the baby that day (she laughs). (Older woman, 2015, Project Macuine, Funhalouro)

The regular ongoing visits by the Masungukate/dota were an important aspect of the program intervention as they motivated the caregivers to take action and apply the knowledge they learned in early visits, as this caregiver describes.

I started to cover the drinking water because she came to visit and I felt bad if she sees it uncovered. (She laughs). Mama Adelia did not check up or get angry, I just saw her coming and I went to check it was done before she came as she was always reminding me. (2015, Caregiver, Project, Ndambene, Homoine)

Summary of impact

Health card

Most children had health cards before the project intervention. What the qualitative research reveals is that many caregivers did not take the children to the clinic for regular growth monitoring and even struggled to take the children to hospital when they were sick. This research gives a clear idea of why caregivers don't take children to the hospital or clinic and also presents evidence that home visits encourage caregivers to access health services more readily.

Immunizations

The number of immunizations increased in the project areas over the two years. This suggests that there was effective knowledge transfer about the importance of immunization and also that Masungukate/dota helped caregivers overcome the barriers to accessing health services.

Understanding implementation

The qualitative research suggests that caregivers knew they should take their children to the hospital but the reality of walking long distances to catch local transport and the cost of the transport often got in the way. Knowledge about why a behavior is needed is important but also an awareness of the fact that the main barrier is a contextual one. The Masungukate/dota were able to help caregivers overcome this barrier, not through practical help (though this did sometimes happen) but through emotional support and encouragement. They were able to mediate the context so that caregivers could do the best that they could for their children.

4.2.4 Nutrition

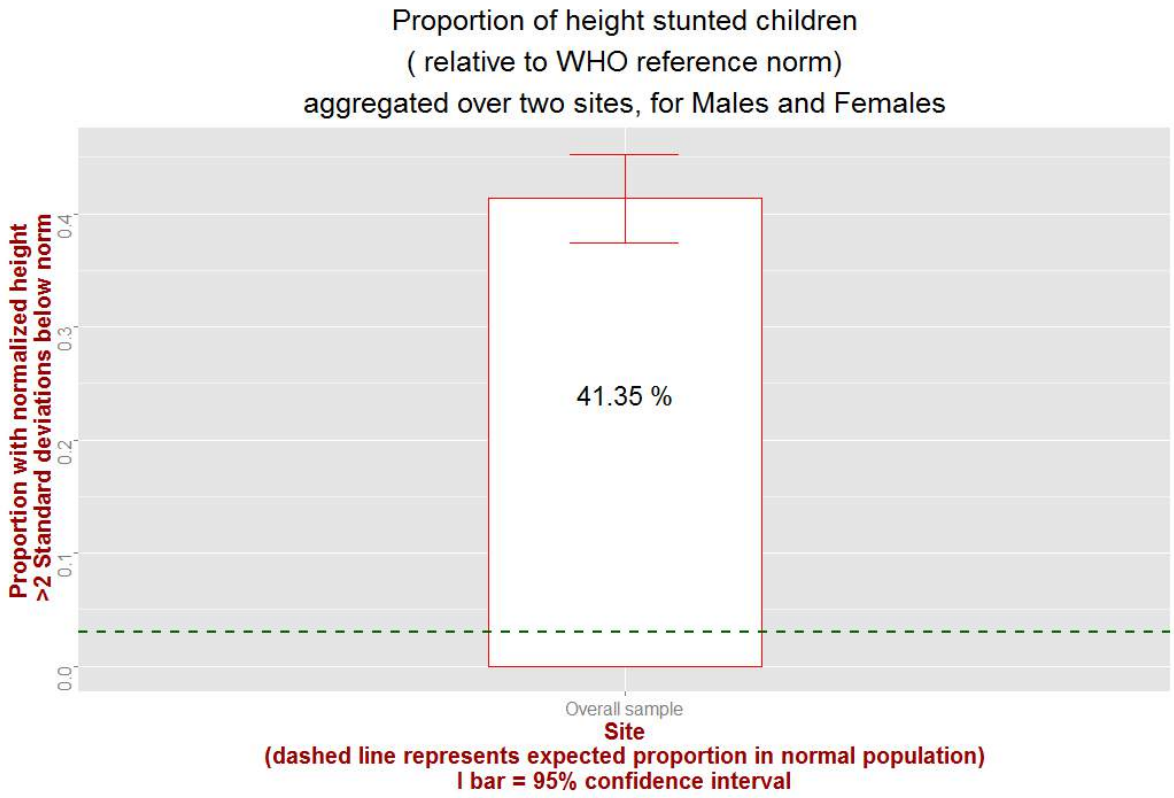
Two measures were used to assess nutritional status. One is dietary diversity and the other is a proxy for this, being weight and height data. This data was used to measure height stunting and underweight.

Height stunting

In 2014, 41.35% of children in the overall sample (project and control) were height stunted. In 2016 there was no statistically significant change. This is understandable

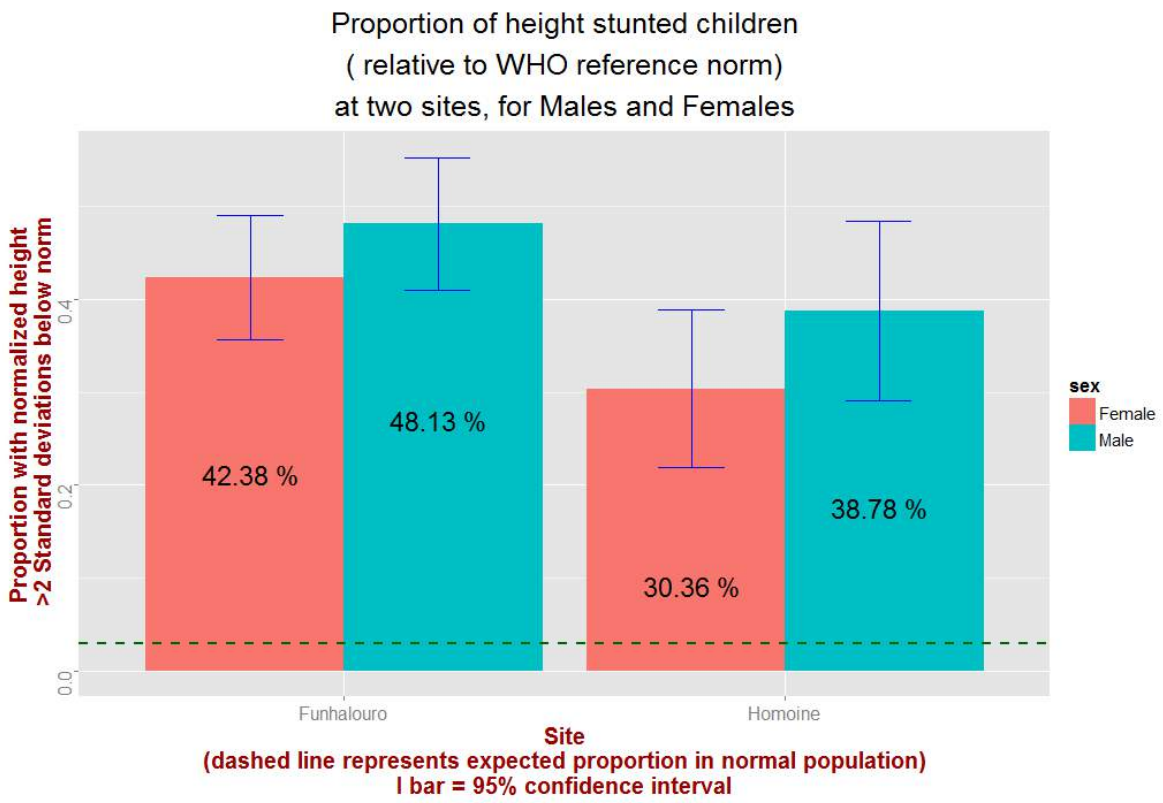
given the fact that once height stunting has taken place before two years research suggests[15] that it is difficult to impact on it (Beaton, 1993; Harahap, H, et al. 2000). It is worth looking at the data in a little more detail, though, because it does give an idea of the context in which the program was working and raises some important implementation issues.

The standard definition of height stunting is where the normalized scores obtained for the children in the sample are 2 standard deviations below the normalized scores provided by the WHO. The graph below describes the proportion of height-stunted children aggregated over both research sites in 2014 (there was no significant change in 2016).



Overall, 41.35% of children in our sample were height stunted in 2014. There was almost no difference in 2016 in either project or control groups.

[15] Kristjansson, E. Francis, D. and Welch, V. et al. (2016) in their review of the impact of nutritional supplementation make this point but also refer to research (Waber, DP, *et al.*, 1981) that suggests this has not been conclusively proven.

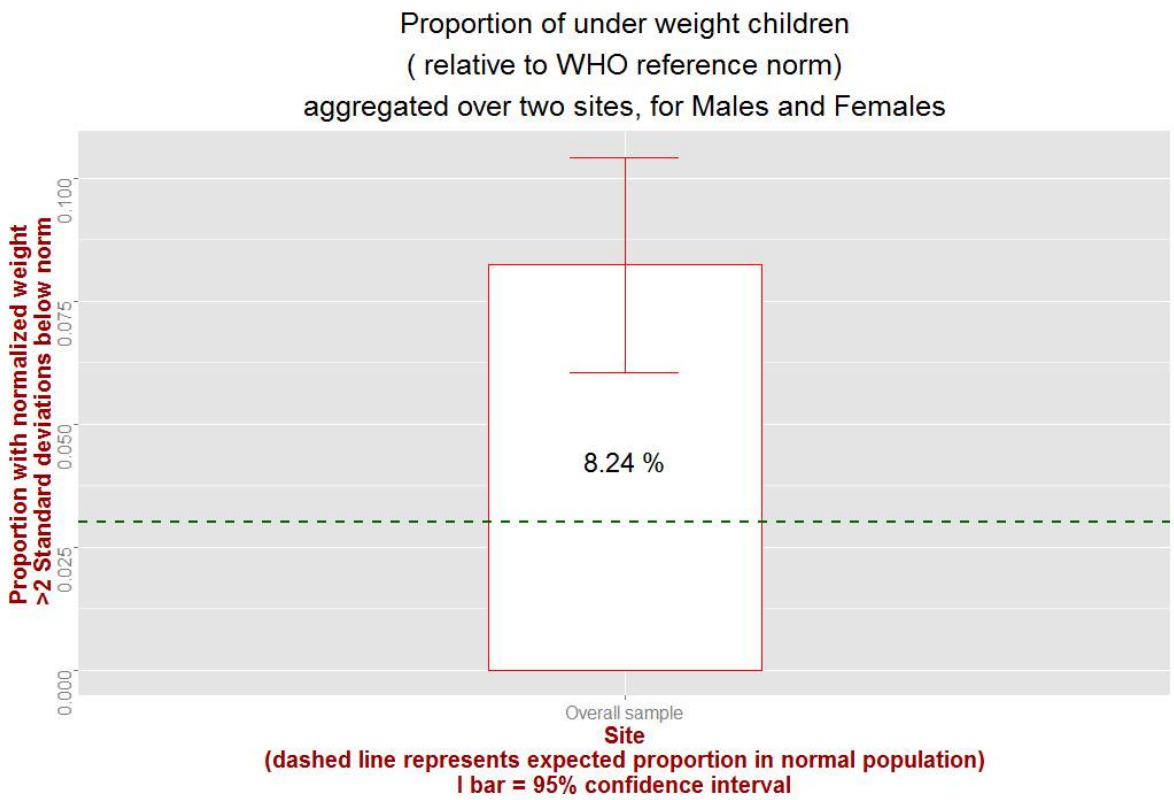


When breaking this down we found that of the 607 children included in this specific sample, the percentage of children at WHO normed rates of below height-for-age in Funhalouro was 42.38% (girls) and 48.13% (boys) and for Homoine 30.36% (girls) and 38.78% (boys). In both places the differences between boys and girls were not significant (Logistic regression analysis, B = 0.23, Z = 1.15, p > 0.25) but between the two places the difference (boy and girls aggregated) was significant (Logistic regression analysis, B= -0.52, Z = -2.11, p < 0.04). So, there are more children in Funhalouro that are height stunted than in Homoine.

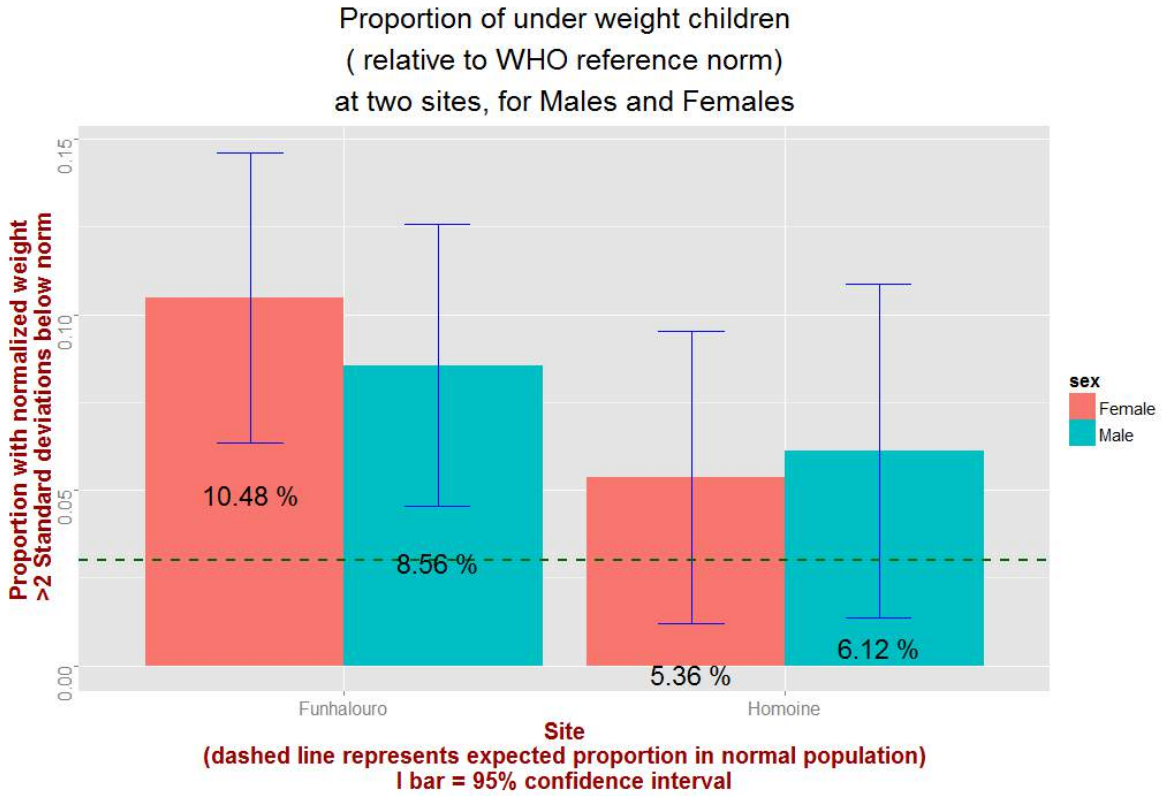
Underweight

In 2014 8.24% of children in the overall sample (project and control) were underweight. There was a small difference in 2016 with weights in the control group being slightly higher than the project group but only just so (F = 4.31, df = 1, 22, p = 0.05).

The standard definition of weight stunting is where the normalized scores obtained for the children in the sample are 2 standard deviations below the normalized scores provided by the WHO. The graph below shows the proportion of underweight children in 2014.



Overall, we found that 8.24% of children in our sample were underweight.



Of the 607 children included in the 2014 sample, the percentage of children at WHO normed rates of below weight-for-age in Funhalouro was 10.48% (girls) and 8.56%

(boys) and for Homoine 5.36% (girls) and 6.12% (boys). In both places the differences between boys and girls were not significant (Logistic regression analysis, B = -0.22, Z = -.65, p > 0.52) and between the two places the difference (boy and girls aggregated) was also not significant (Logistic regression analysis, B= -0.73 , Z = -1.53, p > 0.12)

The greater degree of stunting in children in Funhalouro is not surprising given its remoteness, consequent lack of access to commercial food sources, and harsher climate than Homoine. One can also note that height figures overall are significantly more reduced than weight figures; these children are more height stunted than they are underweight. Our figures (8.24% and 41.35% at 2 standard deviations below the norms for weight and height respectively) closely match WHO data for all of Mozambique (WHO Global database on child growth and malnutrition, July 2013) and for Inhambane Province, which has figures for 2011 of 7.1% and 36.8% (weight and height, respectively).

One of the reasons for the fact that the prevalence of underweight children has not changed in our project group could be explained by the fact that the focus of the nutrition component of the intervention was on infants who would not have been part of the sample in this research because the sample began at 18 months. Because of the slow start of the PROSAN intervention in the project areas the nutrition component of the ECD program was focused on exclusive breastfeeding and diverse complementary feeding after six months. This would have benefitted children who were born during the intervention period of two years from 2014 to 2016, meaning that the majority of them would not be in the sample for this research. If we had included 6 month olds in our sample we may have seen a difference in weight gain between project and control group (Hendricks, M[16] Pers. Comm.). The graph on page 31 shows that we had a very small sample of 18 month olds (104 in project and control). These children would have benefitted from the project but there are probably too few of them to have affected the data.

The qualitative research in 2014 suggested that exclusive breastfeeding until six months was not practiced by women in project or control groups. Women said they introduced solids (usually a watery porridge) at three, four or five months. In 2016 many more mothers knew about the importance of *exclusive* breastfeeding and had practiced it.

> *Researcher: When should a mother start to give her baby some food?*
> *Six months.*
> *Yes, six months.*
> *Researcher: Who told you that?*
> *The nurse at the hospital.*
> *Sungudota Samuel.*
> *(2016, Younger women, Project, Matimbe, Funhalouro)*

The impact of the drought on women's ability to introduce solids at 6 months (an important step for healthy growth) was affected by the drought. The comment below which is repeated from page 22 describes this.

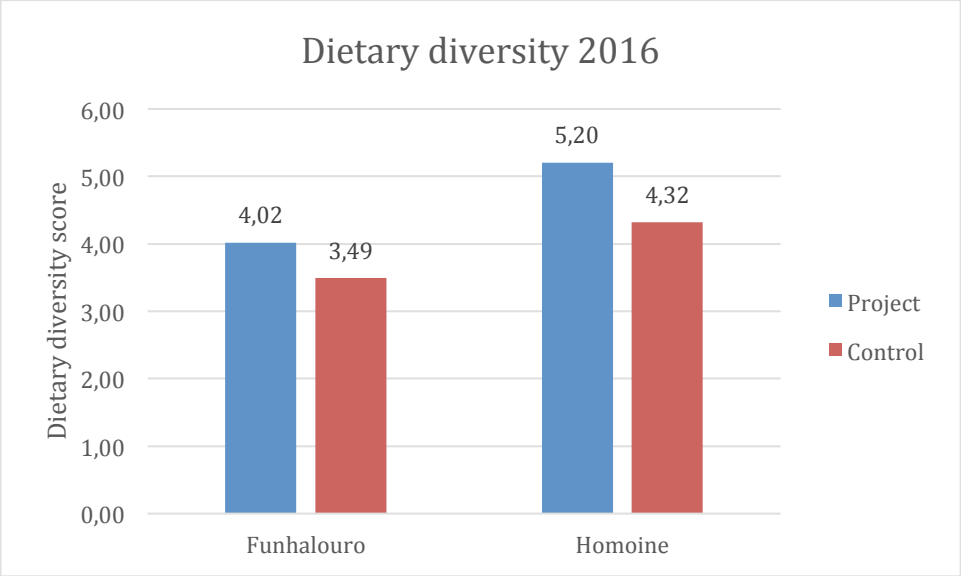
[16] Prof. Hendricks, Assoc Professor and District Pediatrician, School of Child and Adolescent Health UCT

The babies just keep on to breastfeed after 6 months because all we have is cacana and they do not want to eat it.
And they get diarrhea.
We have no porridge. (2016, Young women, Project, Mubalo, Homoine)

Dietary diversity

The second way of measuring good nutrition for development is to look at dietary diversity. The more diverse a child's diet, the more likely they are to be getting all their nutritional needs met. A measure of this was obtained using the Children's Dietary Diversity Score (CDDS), (Swindale and Bilinsky, 2006). It was used at an individual child level, not the household level. The tool assesses which of 12 different food groups the child has eaten in the last 24 hours.

Dietary diversity was statistically significantly higher for the intervention group than the control group in 2016[17]. The graph below illustrates this.



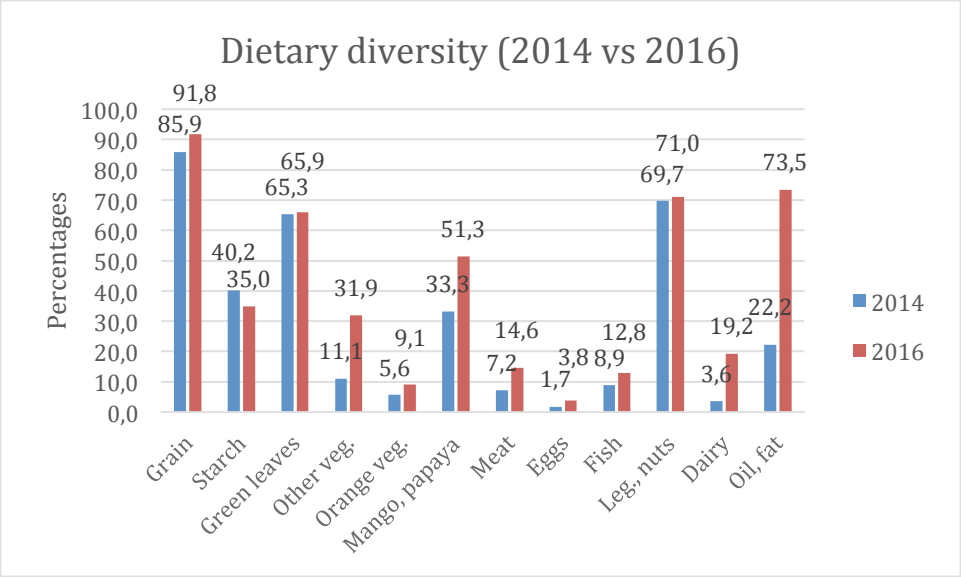
The table and graph below compare 2014 and 2016 data for Homoine and Funhalouro combined. From this we see that there was an increase in the percentage of children consuming most food groups. What is particularly important is the increased number of children eating orange vegetables and fruits and protein sources. Giving children these food types was a key message in the project's parenting education around nutrition.

Dietary diversity percentages for 2014 and 2016 in the project group

	Grain	Starch	Green leaves	Other veg.	Orange veg.	Mango, papaya	Meat	Eggs	Fish	Leg., nuts	Dairy	Oil, fat
2014	85.9	40.2	65.3	11.1	5.6	33.3	7.2	1.7	8.9	69.7	3.6	22.2
2016	91.8	35.0	65.9	31.9	9.1	51.3	14.6	3.8	12.8	71.0	19.2	73.5

Note the percentages in this table do not add up to 100%. This is because children eat more than one item in their diet. So if all children ate all items every cell would have 100% in it.

[17] Mean = 4.81 vs 4.02, F = 18.71, df = 1, 21, p < .01



This result is particularly impressive in the context of the present drought. The qualitative research again helps us understand what sources of food caregivers were accessing to make sure their children had a diverse diet. Initial research by CARE staff before the program began in 2013 suggested that mothers did not give their children mangoes or papaya – both foods that grow almost wild in Homoine and even in Funhalouro. The reason for this was a traditional one – older people taught that yellow fruits were seen as "bad for little children". Eggs were also available in some households but parents seldom gave young children eggs, they seemed to be reserved for men (Freedman, H. 2016). Masungukate/dota were trained to encourage caregivers to access easily obtainable foods for their children. This included wild fruits and leaves as well as mangoes and papaya and eggs.

> *My Sungukate taught me about Moringa and that I can give the young ones the 'yogurt' from the baobab. (2015, Caregiver, Ndambene, Homoine)*

Summary of impact

No impact on height and weight was evident in the sample of children involved in this research. This is partly explained by the sampling strategy. It would be useful to undertake further research with anthropometric data on the project group over the next year with a focus on children at 6 months, a year and 18 months. This should show some impact (Hendricks[18] Pers. Comm.).

Understanding implementation

Research (Beaton, 1993; Harahap, H, et al. 2000) tells us that there is a window period in which one can impact on underweight and stunting. This period is before a child turns 2. Given this it is good that the nutrition focus of the ECD program was on exclusive breastfeeding until 6 months and dietary diversity from six months.

[18] Prof. Hendricks, Assoc Professor and District Pediatrician, School of Child and Adolescent Health UCT

4.2.6 Developmental milestones appropriate for age

The Malawi Development Assessment Tool (Gladstone et al. 2010) developed in Malawi for monitoring and surveillance purposes in clinical settings was used to measure developmental milestones. We chose this particular tool because we thought it would relate better to the Mozambican context than many other tools from a developed world context. It should be noted that the use of MDAT in this context was not diagnostic and the analysis of results did not attempt to make comparisons with the normative data developed in Malawi. The scores were treated as mere numbers that could be compared across groups and over time, using appropriate statistical techniques.

The MDAT investigates child stages of development across four domains: gross motor coordination, fine motor coordination, language and social development. There were some differences in both project and control between 2014 and 2016 (i.e. all children seemed to improve their scores) but these were small. There were no significant differences between project and control in 2016 in any of the four domains.

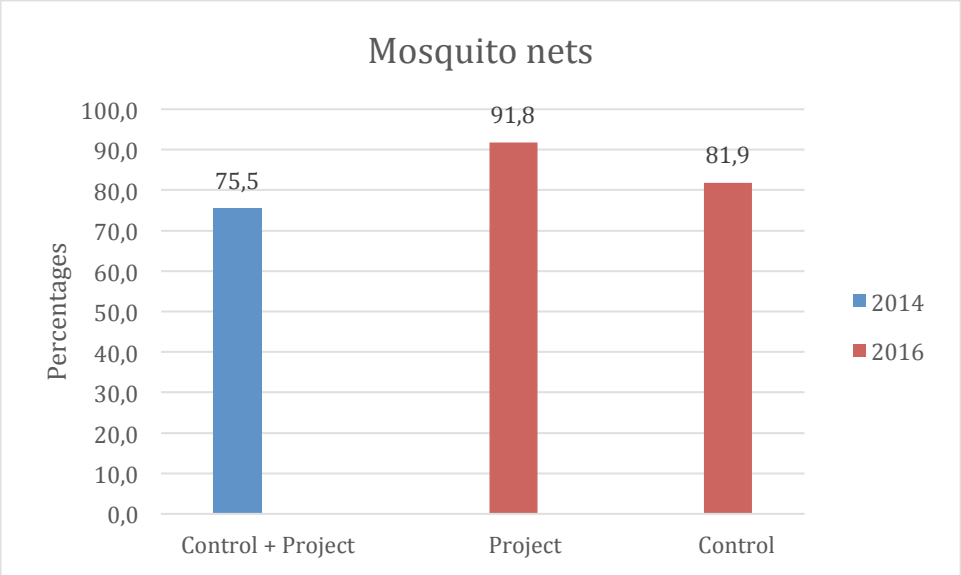
The results show increased stimulation activities by parents (see Section 4.3.2). Over time this should result in impacts on cognitive and language development indicators. Dawes, Biersteker and Hendricks (2012) highlight the fact that the best way to enhance cognitive and language development in under-fives is through group activities. The program has introduced playgroups run by Masungukate/dota into all villages in 2016. It is possible that this could have an impact on development indicators as children join these groups.

4.3 CAREGIVING ENVIRONMENT

4.3.1 Mosquito nets

In 2014 75.5% of caregivers reported that children slept under mosquito nets. In 2016 the reported use of mosquito nets went up in both project and control groups - 81.9% in the control group and 91.8% in the project group, respectively. The difference between project and control groups in 2016 was significant[19].

[19] $\chi^2 = 7.28$, df = 1, $p < 0.01$



It is clear that the CARE ECD program has made a difference in the use of nets. In the 2015 qualitative research on change of behavior caregivers described why they had changed their behavior. One common reason people referred to was hearing the correct knowledge for the first time. This was the reason most often given for now using mosquito nets.

> *We used to think that you could not get malaria in summer, only in winter so we didn't use the nets all the year. Then the Masungukate told us you can get malaria all year. Now I use the nets every, every day. (2015, Caregiver, Project, Mavume Sede, Funhalouro)*

These results suggest that simple information-giving can have a huge impact. The importance of a non-didactic and non-authoritarian style of information-giving was pointed out by caregivers.

> *My Sungukate is very friendly. She is so kind. She saw I was using a mosquito net for the chickens (as a coop). She asked me if I loved my chickens more that my children – we laughed at that together. But now I use the nets (for the children). (2015, Caregiver, Project, Maguba, Homoine)*

In the 2015 research many caregivers described how this relational and friendly approach made them want to please the Masungukate that visited them and this motivated them to change their behavior.

But what is also important is the link between use of mosquito nets and emotional stress. This quote is repeated from the discussion on emotional stress in 4.1.2.

> *I knew the mosquito net was needed for the baby but I was so heavy that I could not even do it. To pull it over the sleeping mat was too much, I just went to sleep - I did not even clean the dishes. (2015, Caregiver, Project, Macuine, Funhalouro)*

This link between depression and non-action is confirmed through the quantitative

data. We looked at inter-correlations of some of the predictors. There is a moderate correlation of -0.41 (this is a positive correlation – see footnote[20]) between emotional stress as measured by the SRQ20 and use of mosquito nets. This illustrates how being less emotionally stressed allows caregivers to take action for the wellbeing of children.

Summary of impact
An increase from 75.5% reported use of nets in 2014 to 98.8% in 2016 is a huge improvement. This seems to have resulted from a combination of correct information about malaria prevention, day-to-day encouragement and reduced emotional stress. It seems to that the wish to please the Masungukate because of the relationship that has been built was another motivating factor.

Understanding implementation
The implications for implementation are clear – caregivers need correct information if they are to make the right decisions for their children. This coupled with emotional support and a genuine relationship between the caregiver and the Masungukate encouraged caregivers to make small but significant changes such as using mosquito nets properly every night.

4.3.2 Stimulation and acceptance

The HOME inventory (Caldwell and Bradley, 1984) measures home-based indicators of child development such as caregiver stimulation of children through play. There was a significant difference between project and control in 2016 in relation to children's access to play materials[21]. The project group reported giving their children greater access to play materials (91% vs 85%), suggesting they understand the importance of play.

We explored interaction between caregivers and their children in the qualitative research by asking them to draw all the things they do in a day **with** their children. What emerged in the baseline research in 2014 was that almost all of the drawings showed that caregivers spent most of their time interacting with children around functional tasks.

> *I wake him up in the morning and wash his face and dress him. I tell him to sweep the yard.*
> *Researcher: How old is he?*
> *Five years. Then I tell him to play with his sister. Then I tell them to wash their hands so that they can sit and have lunch. (2014, Younger woman, Project* Nhaliseqque, *Funhalouro)*

In 2014 in control groups the response was much the same but in 2016 in the project groups caregivers talked about play.

> *I come home from the shamba (fields) and make lunch and then we play a*

[20] This correlation is negative as the higher the score in the SRQ20 the more emotionally stressed a caregiver is.
[21] $\chi^2 = 5.35$, df = 1, $p < 0.02$

little bit.
Researcher: What do you do?
I play with him on the rope swing that Sungukate Amelia made at my house. (2016, Older woman, Project, Matimbe, Homoine)

The caregivers often linked this discussion directly to education they had been given by Masungukate/dota.

My Sungudota told me it is one of the rights that children have to play. If you are always keeping children busy with work they will be angry. When they are seeing other children playing they will be angry. You must play with them and tell them stories. (2015, Caregiver, Project, Chijinguiri*, Homoine)*

Numerous caregivers also talked about how play was necessary for learning and development, something that no one mentioned in 2*014.*

Playing is helping them to learn. (2016, Younger woman, Project, Nhaliseqque, Funhalouro)

The next quote points to a key change in behavior as a result of the project – the increased involvement of men in the lives of children, particularly in the area of play and interaction.

I never used to talk to children, or play with them. Now I am playing. I play with my children – ball. I also play with the other children in the houses I visit and the children in the village. (Masungudota, Funhalouro)

Caregivers talking in the 2015 qualitative research reported how Masungukate/dota had sought to involve men in the lives of their children.

She (Sungukate) told even my husband that if the children come up to you, hold them and love them, it will be easy for them to come to you and you can tell them if they do something wrong if you love them. (2015, Caregiver, Project, Moguba, Homoine)

The Sungukate are talking to them and the men are also now talking to the children (at home). At first when the Sungukate came to visit us the husbands were not there and then when we told them (what the Sungukate said) they were not believing and disrespecting us. So the Sungukate came when the men were there and talked to them. Now they are believing and they even say, "You must do 'this and this' because the Sungukate said so" (she laughs). The men are respecting too now. (2015, Caregiver, Project, Macuine, Funhalouro)

Often the men had control over larger household decisions such as the building of a latrine or even spending money to get transport to the clinic so a child could be immunized. Masungukate/dota reported visiting at particular times so they could speak to the men in the household or waiting until the men came home at weekends or holidays to raise an issue with them.

The fact that men were working as Masungudota played an important role in the changing of men's attitudes. Here Sungudota Samuel from Mutuzi Village in Funhalouro tells how he slowly won over the men.

> *At first the men did not want me to visit their families, they completely ignored my presence in their homes. I was even accused by some men of using my position to approach their wives. On my visits I sometimes saw or heard about domestic violence such as beatings, insults and bad treatment of children and women. But I didn't give up. I just kept talking to the men in the homes I visited and in other social sites in the village – on the football field, in traditional games. I just kept telling men we need to care for women and children. Now slowly the men are interested. They are allowing me to visit their homes. One of the men I visit is my greatest success. He is Luis, husband of Florence with 3 children Fragnâncio (3 years), Paulino (2 years) and Cargito (3 months).*

We interviewed Luis who told us about how he had changed.

> *I had no knowledge about sharing activities with my wife, especially care for and play with the children – according to my education these tasks were exclusively for women and men should be concerned only in the maintenance of the house. After much resistance, one day I decided to participate in the session with my wife where the Sungudota Samuel spoke of the importance of parents in the child's life and how important family unity and showing love to children was. I realized it was important to share the activities with my wife and to give my time to play with the children. Today I feel happy because I have no fear to fetch water from the well, help in the kitchen, sweep the courtyard of the house, fetch firewood and bathe the children. At first I suffered discrimination from my friends. They said I had been stuck in the "bottle" or my wife had given me medicine she had received from the Sungudota. Nowadays, the whole village sees me as a normal and learned man and my companions are following my example, which makes the village an example of how men can share work with their wives.*

We also spoke to Florencia, his wife

> *I am very pleased with the changes. It was difficult for my husband to fetch water, go to farm, but today he helps me in almost every job I do. Today we have the time to discuss the challenges and successes of the house as well as what we can do to help our children grow better. I thank the Sungudota.*

When the project was initiated CARE staff did not anticipate men being elected as home visitors but it appears that they have become as effective as the Masungukate. Many of the Masungudota were active in their church and had worked as volunteer counselors so they had a role already as good advisors. What the CARE ECD program gave them was training on childcare so they could become a resource for children too. We spent some time in the qualitative research in 2015 exploring how they worked as home visitors in areas such as breastfeeding. Often a Masungudota took a Masungukate with him on a home visit but as this man explains they soon became accepted as experts on maternal and child care.

Researcher: How is it for you to talk to younger women about breastfeeding – are they shy of you?
I have no problems with this. From the training I know why it is important to breastfeed only so I can talk about it easily. The mothers know I have been trained. They see from the uniform that I am a Sungudota so they trust me. (2015, Masungudota, Ndambene, Homoine)

The story below describes how the older men, in particular, use their life experience to help with relationships between mothers and children.

"I have a long story of life. But I never learned that you can make a relationship with your children."

Papa Joaquim is a Sungudota in Moguba village in Homoine. He is the head of a household of eight made up of his wife, adult daughter and grandchildren.

The big change I can see in my family is seen by the example of my (adult) daughter. You can see that this daughter is pregnant and this pregnancy she got 'around', she has no husband. Before when she got pregnant she was trying to hide the pregnancy and she didn't show it because she knows that she will be beaten. A father will always beat to find out who is the owner of that pregnancy. Now I am a Sungudota and after having these lessons (training) I am more close to my daughter. I don't need to beat her and because we are now close she told me about this pregnancy. We talked and she told me who the father is and now we have a plan. In my family I was not close to all the members I was very hard on them. All my things I was solving using force. The training was teaching us to be a better person to be a role model. Now I am not using force any more in my house. I talk to my family members and since I was at the training I know many things that I did not know before because I was using force. I am trying to follow what the book is recommending. I learned from the book that I cannot beat for disciplining the children.

Before I was living with my son and the son was living with his wife in the house, here (he points to the house behind him). One time the son beat me and because of that he felt very shameful and he moved away. So my son had learned force from me and he beat me. You do not need to use force to solve your problems you must be more close to your sons. If I had a good relationship with my son he would be here now and look because of a bad relationship with my son and because of using force with my son look, he is gone (he sighs deeply).

I had never heard before that we must not beat, we can talk. There was no other way the only way we knew was to beat them, nobody had told us, this was the way we used to educate and discipline our children. I have a long story of life. But I never learned that you can make a relationship with your children.

I am seeing all of the houses I visit changing. Now I use my own experience and I show them what I feel when I see them beating their children because of what has happened in my life and in my family. I now tell people you should talk and not beat because it will help the relationship in your household.

Acceptance (positive discipline)

Acceptance is the term used in the HOME inventory to describe caregiver behavior related to discipline. We explored this in the qualitative research through a set of three scenarios where child "bad" behavior was related to their age or to an underlying reason. We wished to see if caregivers responded with positive discipline or at least explained the child's behavior. What emerged from each group is that in most cases the first response of caregivers is to *bonga bonga* which means to shout and in many cases to beat the child.

> *Researcher: Boaventura is 5 years old and Ernestina is 3 years. They were playing, and jumping in the house in the morning. Ernestina falls, knocks the table and breaks a dish. What you would do as Ernestina's mother!*
> *I would shout at them, find a stick, give them a hiding and tell them to play outside.*
> *Researcher: Anyone else!*
> *Nothing less than that, you can only do that, shout and tell them to stop playing inside the house. (2014, Older women, Project, Matimbe, Homoine)*

But in 2016 caregivers in the project group described that they no longer beat their children but now talked to them.

> *I know to talk to my children. My Sungudota taught me this. I am not beating and now the boys are happy to help me. We are friendly. Our relationship is much better. They talk to me as their grandmother. (2016, Older woman, Project, Matimbe, Homoine)*

This story illustrates (similarly to Sungudota Jordao's story) how the Masungukate had changed their own behavior in this regard and how the change they have seen has motivated them to share the need for positive discipline in the home.

"I never thought that I could change"

Sungukate Sauneta in Macuine, Funhalouro with her two younger children

I love to be a Sungukate. In most of the houses I always talk about the relationship between the caregiver and the children to show parents how to build a nice relationship so children are not scared of their parents. I always talk about this because in my neighborhood daily I was hearing children crying because they have been beaten by their parents and that was a worry for me since I learned at the training that we must teach caregivers to love their children. So I always talk about this first because I see children suffering.

This helped me because I was not loving my children. I was beating them also, before I became a Sungukate. I have three children, the youngest is two and a girl of seven and my boy is twelve. My children are very abongile (thankful) now I am a Sungukate (she laughs softly). They are very glad because I am not beating them anymore. My past with them was very shameful because I was constantly beating them. Now I am not beating them. Now I talk to them - I am not talking loud - I am having a nice conversation. We are friends now, (she laughs softly again). I changed because of the training.

It was a surprise. I never thought I could change. I went to the training and I thought I would not be different but I can see the change in my own life. I first learned the knowledge in the training that we should not beat the children. But I learned also from the book because I use the book to teach the caregivers. There is a page where there is a person with a child who has a stick and another picture of someone with a daughter showing love – it is that picture that I love. That picture did change me.

I live with just my children. My husband is in Joni (South Africa). He comes home in December or sometimes in the middle of the year. He does send money for food for the children so it is not too difficult but it is lonely. That is why I was beating and getting angry with the children. But I told him about loving the children and he also is happy because he sees that the children are

so happy now. We sit together as a family now and we talk, like the book (Visual Guide) says.

In the 2015 research into behavior change we explored what it was in the program that had promoted this change in behavior. Two key factors emerged. These are discussed in turn below.

- Personal stories and example
- Illustrations in the Visual Reference Guide

One of the main reasons people gave for the change in behavior towards their children was the personal examples they heard about and witnessed within the program. The personal narratives of change told in the Masungukate/dota training by CARE and local CBO staff had a huge impression on the Masungukate and Masungudota. The CARE and local CBO ECD program staff had all been through training in the pre-implementation phase of the program and this was where they had experienced their own epiphany about how they could change their relationships with their children. In the narrative below one of the CARE Community Managers tells her own story. It was this that she shared in the Masungukate/dota training.

"It is like for me a new day has come for my life and it is rising very, very well. I feel bright now."

Here I made three things from the clay to show how my life is changed, the first is the sun. It is rising. It is like for me a new day has come for my life and it is rising very, very well. I feel bright now. The second shows a bowl with a little food. This is how I was with my children before. I just came home and was angry and gave them just a little, no love. Now the third plate is full of many different fruits, this is how I love my children now my plate is full and we are enjoying the food together.

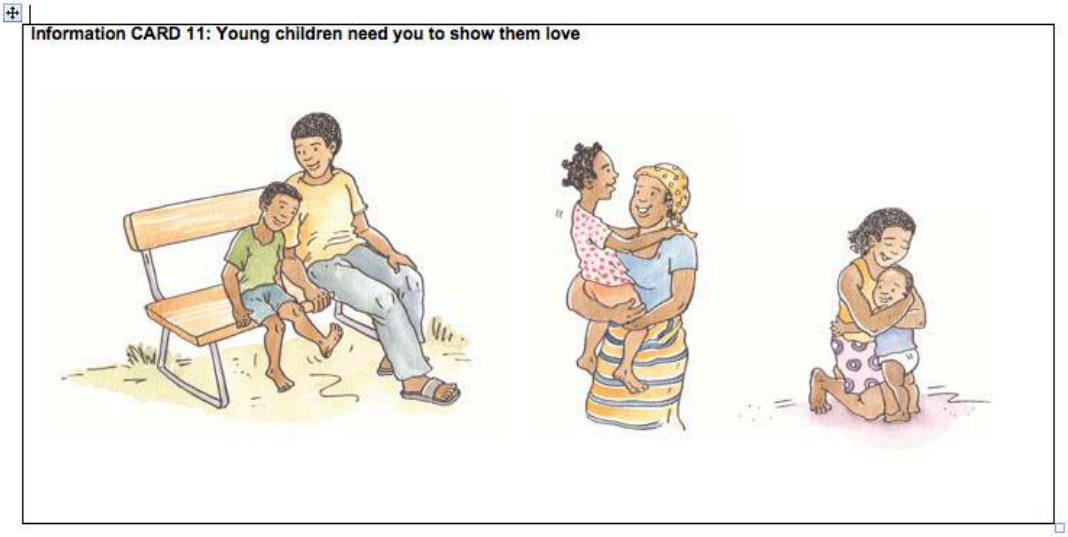
Before I became a Sungukate (the managers and facilitators also refer to themselves as Sungukate) when my children were seeing it is almost 5 o' clock they were starting to organize themselves, "Mum is coming back! If mama finds here that things are not well organized we will be beaten because mama don't like to find things not right". If they did someting wrong I was beating them. They were very afraid of me. Even if they were playing and they saw it was nearly time for mum to be home they were leaving everything they were doing and be standing quietly when I got home. They were so afraid.

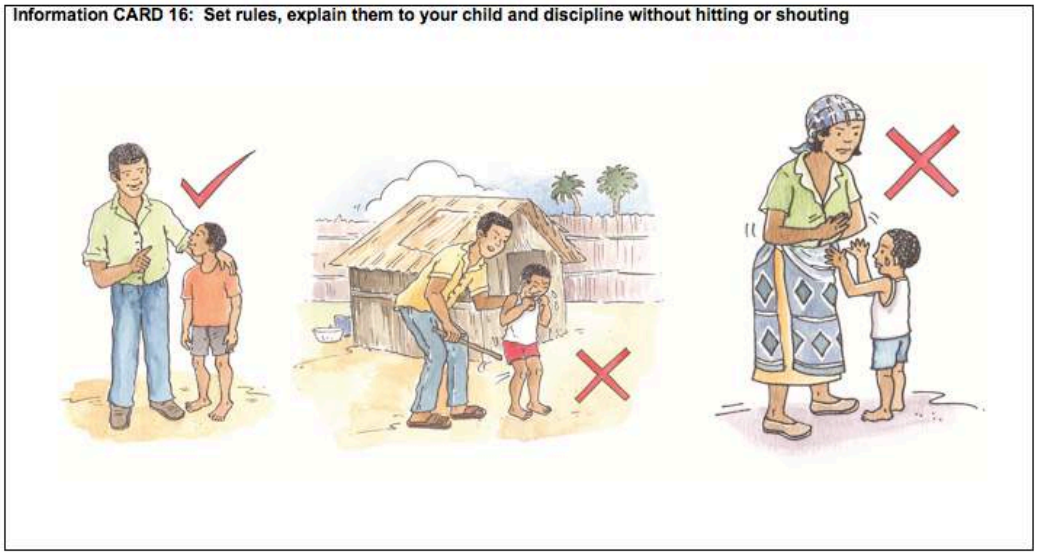
Now the children are seeing a difference and they even asked me, "What is going on now, you are more friendly, what is happening? You are more loving." Now the children and I are friends, we are having long conversations. I come home and they have made tea for me to drink, they are pleased to see me and we talk about the week. They are my friends.

Now I am in a different life, now I am not sad about the children, I am loving them. It is like for me a new day has come for my life and it is rising very, very well. I feel bright now. I feel I would like to go back and have birth for the first time because I wasted time. I only got this knowledge after I had my children. I would like to get this knowledge before I had my children because I would take care of my children in the sensitive period, that time that is very important for brain development now it is too late. But now I feel I am helping many other people. I don't care if it is Funhalouro were I work or Vilancoulos if I am finding caregivers not aware of these things in the children I stop there and give recommendations of what they must do. (CARE Community Manager)

The extent to which stories like the one above inspired is illustrated by Victoria's story on page 59 of this report. Note too how the Community Manager now takes the opportunity to reach all children and caregivers, not just those in the ECD Program. This was another common theme amongst the Masungukate/dota. They often talked about now playing with *all* children, looking out for *all* children in the village. During the field work we were walking with one of the Sungukate to visit one of the households. We passed a small boy whose feet were full of *matakenya* (*Tunga penetrans*, a parasitic arthropod from the sand that is common in the area – they need to be removed regularly and if a child is infested it is often a sign of neglect) the Sungukate bent down and spoke quietly to the boy, asking about his grandmother. She told us as he ran on that she would visit and see if she could help the old grandmother as she was obviously not coping with the small children in her care.

The second most common influence mentioned in the discussions was the illustrations in the Visual Reference Guide. These two pages were mentioned the most often.





Masungukate/dota and caregivers often took a copy of the Guide while we were talking and without hesitation found these two illustrations. Many of them knew the page numbers, repeating them as they looked for these illustrations.

The following quotes are typical of the answers we received when we explored with caregivers and Masungukate/dota why these particular illustrations had made an impact on them.

> *These people are like us. I think they are living here (in Funhalouro) (Sungukate, Funhalouro).*
>
> *I could see men talking to children and playing. I had never thought to do that. (Sungudota, Funhalouro)*
>
> *I love that drawing too much, that mother that is smiling at the child. (Caregiver, Funhalouro)*

I could see men talking to children and playing. I had never thought to do that. (Sungudota, Funhalouro)

The illustrations seem to have encouraged men and women to think about their own behavior and the fact that they could change it. It seems that the style of illustration is important. It was because they were realistic, attractive and carried some emotion in them that people related to them. Another key aspect of the illustrations was the fact that they modeled behavior.

Summary of impact

Stimulation

The quantitative research shows that the project had an impact on the presence of play materials in the home. The qualitative research confirms that caregivers in the project understand the importance of play for cognitive and social emotional development. One of the biggest impacts has been the growth in men's interaction with their children.

Acceptance

The qualitative research shows a marked growth in use of positive discipline strategies in the project group in 2016. This seems to have applied to men and women.

Understanding implementation

Giving information about why play was important for child development and why beating and shouting were harmful seems to be one reason for the change in behavior, but changing long-held norms needs more than information. Hearing personal stories of change and seeing changed relationships seems also to have played an important role. The role modeling in the illustrations in the Visual Guide also contributed to change. The direct engagement of men by Masungukate and the example of male home visitors (Sungudota) appears to be an important factor behind the increased involvement of men in the lives of their children.

4.3.6 Safe and hazard-free home environment

The hygiene section of the checklist covers topics such as whether children and adults wash their hands with soap and water before eating and after using the toilet, whether toilets and drinking water are suitably covered and so on. The safety section looks at storage of hazardous materials (medicines, inflammables), children playing near dangerous places or hazardous objects, child supervision, responses to accidents or emergencies, and so on.

The full hygiene and safety checklist is contained in the household questionnaire in Appendix 2. Research fieldworkers were instructed to observe first and if they were unable to find evidence for each question, only then to ask. Time was spent during the training on sensitive observation strategies and making sure that the rating of the indicators was consistent.

Scores from 0.00 to 1.00 are possible, where 1 shows a safe and hazard-free home environment. In 2014 overall (project and control) scores for Funhalouro and Homoine are 0.55 and 0.63, respectively. In 2016 the project group's score had

increased to 0.71, while the control group score remained almost constant at 0.65. The difference in 2016 was significant[22].

The qualitative research gives some understanding of how the Masungukate/dota impacted on health and safety, particularly in the area of latrines. In the 2015 research into behavior change one of the changes mentioned most often by caregivers was the fact that they now had a latrine at their home.

> *The big change for me is that I built a latrine. We did not have before. We used the bushes. Then Sungukate Linah said we needed and she helped me, the Masungukate came and helped me to dig the hole. (2015, Caregiver, Project, Moguba, Homoine)*

During this research Masungukate/dota described how they had first built latrines in their own homes after the training.

> *We have always gone to the toilet in the bush, our fathers did it, our grandfathers. There used to be space around the house, so we each had our own place. But now there are more people living here, it is different. I did not know that it can make children sick, that we need to wash our hands. I learned at the training. Now we know so we built a latrine, me and my wife, because I am a Masungudota and we need to be an example. (2015, Sungudota, Macuine, Funhalouro)*

One important implementation pattern was the fact that the Masungukate/dota worked together as a group to support each other in the building of latrines. In all of the project villages they formed teams to help dig latrines in their own homes and caregiver's homes. This was an important help especially to women or elder-headed households were the digging of a latrine was too difficult for the family.

Summary of impact
The impact of the project on health and safety in the households visited by Masungukate/dota has been significant, particularly in the area of latrine building but as the checklist shows this is not the only area of impact. Safe drinking water practices and accident awareness were also impacted.

Understanding implementation
The example set by Masungukate/dota in their own homes and the fact that they worked together to implement more difficult infrastructural changes such as digging a hole for a latrine seem to have been important implementation practices.

4.4 Reflecting on the role of the Masungukate/dota

One of the aims of the research was to "determine which program components contributed significantly to the impact". For this reason we have included a section here reflecting on the learning from the program about the role of the Masungukate/dota. Most of the data we draw on here was collected during the

[22] Mean = 0.71 vs 0.61, $F = 15.54$, $df = 1, 22$, $p < 0.01$

qualitative research into behavior change in 2015. During this research we spoke to 44 Masungukate/dota. We have also drawn on the focus group discussions (held in January 2016) around social accountability with a further 40 Masungukate/dota from different villages. Before looking at the results of this research it is important to remind ourselves that the Masungukate/dota worked entirely voluntarily.

The simple act of receiving a regular visit has had an impact on families. Caregivers talked about looking forward to the Masungukate/dota's visits. Masungukate/dota reported that the children too look forward to their visits.

> *At first they were scared of me. But then I played with them each time and now they run when they see me. Now they call after me in the village, "Sungukate, Sungukate".*
> *Yes, they do, "Papa papa" they call to me when I am walking to the forests to collect wood. They are not scared any more. The little ones see us as their friend. (2015, Sungukate and Sungudota, Marengo, Homoine)*

But it is not just a home visit that makes the difference. It is a visit from a particular kind of person. The individual interviews with the Masungukate and the Masungudota in 2015 explored their backgrounds, inner resources and motivations – what kind of people they were and what they brought personally to the work they did. Two clear themes emerged here. Firstly, some of the Masungukate and Masungudota are people of deep knowledge and experience and many had already served families in the community before they became part of the ECD program. Many had worked through their churches to help couples solve family problems, others were community leaders and a few were traditional healers. It is important to note here that the ECD program made existing resources available for the care of children. These wise elders are now knowledgeable about children and they are available to work not only for the church or in healing but also for the well-being of children in the village.

The second thing that emerged was that many of the Masungukate/dota were people who really wanted to make a contribution but did not have a vehicle for helping. Very often they too were depressed, with little sense of power and no outlet for their drive and intelligence. It seems that the ECD program has given them a sense of their own worth as a person, built their sense of power and given them a purpose in life and this is why they are so committed to their work as Masungukate/dota. This was a very strong theme in the clay figures that the Masungukate/dota made in the focus group discussions to illustrate the change that being involved in the program has made for them.

I was just a useless donkey before but now I am a boat. I am useful, I can help people to cross the river. (Sungukate, Homoine)

I was an empty pot but now I have a heart for children. (Sungdota, Homoine)

I am now a person, a person who listens to others. (Sungukate, Funhalouro)

What is significant here is the depth of inner change and commitment that the symbols represent. The story below also illustrates the depth of personal change and the growth in self-worth.

“I feel very good doing this job”

Victoria is the third wife in a very traditional household with thirteen children. She has two boys of her own and looks after her sister’s small daughter too.

I was an empty basket before. I had nothing to give. I had only Grade 2 and I did not know many things. I felt very important to be elected within many, many people. I think they saw something important in me - that made me feel good. The training was very important, very important for me. Very.

All the examples that Nalia and Olga were giving - that was touching me. All the examples of how they were disciplining their children before by beating was touching me because that was the way I am disciplining my kids, I could see that I had to change. Olga and Nalia told me that they changed and I saw that I can change too. I saw that I can also help other people to change. I feel very good doing this job.

A lot of things about the training were important for me. One of them I can mention, they taught us to go to the hospital. Look, one of my children was always sick and I didn’t know why he was always sick and so when I came

back from the training I was thinking about what I learned. So I took him to the hospital and they told me he had a problem in his blood. They gave him medicine. He is not having the same problem - he has been cured.

Aah, it (the training) was very important. I learnt about the hospital, about moringa. Everything I was struggling with I learned about. This little girl (she refers to the child on her lap) she gets Moringa now. Her mother is in Maputo. She stopped to breastfeed very early that is why she is small. I was struggling too much with the mother of this child, my sister. I was shouting too much for the mother of this child but now I am not doing that. I am a new person now. I can give information to help. I do not shout.

Before I wasn't good for my children. Before I was solving my problems speaking loud and beating them. I am not doing that anymore. That is one change. The children are much better now. They are good now. This older one he even if you send him now to go to market even though it is far he does not deny to go. They respect and hear what I am telling them. They know to greet people - it was not happening before. There is a good relationship between us now.

I like to do the home visits. I wake early to do my work at home so I can go to do my visits. Even my husband cares about my work. Sometimes we go to the far fields together and we stay there trying to find some cassava. When I go there he asks, "How will your caregivers do as you are here?" So I do see he cares about what I am doing.

Before I was feeling like an empty basket, now I am a full basket, I know many things and I can help people.

This photograph shows Papa Joao Cabindo who runs a playgroup in Matimbe in Homoine. He is 60 years old and attended school many years ago for only four years.

We visited Papa Joao in early 2016 as part of our research into the playgroup program. We observed his gentle way with the children and how he shows delight when they count correctly. He showed a clear understanding of number concepts and key language ideas and how to build incrementally on the children's knowledge.

> *I have learned that you need to go step-by-step with the little ones, I teach them to sing the song to name the parts of their body and we go slowly, slowly and now they are learning it! They love to play with the small cars I made, I have asked people in the village to bring back soda cans from the town so I can make some more.*

We observed how he manages the children in a gentle way when we set out to walk to the nearby playground and two children began wheeling the tin cars alongside us. He stopped them saying softly, "No, we can't bring those. Go and park them in the garage." They very happily wheeled them around and parked them carefully next to the door of his house. His description of why he thinks the playgroup is important gives some understanding of what his involvement in the program has given him as an older man.

> *I think that the group is very important for them because when they go to school they will know some few things and know how to sit with a group of children. It will not be so frightening for them. It is an important job we are doing. I am happy to be running the playgroup I always wanted to be a teacher but I had to leave school to work in the shamba (farm). I have made some small toys for the children. I made some cars from soda cans and also found some old car tires. The children play with these before we start the activities. I*

am sometimes running the group three times a week I love it so much. When I have things to do I run it once a week.

What Papa Joao and Victoria's stories give us is some understanding into why Masungukate/dota have stayed motivated and are still part of the program after two or more years. In their case the motivation comes from a feeling of personal fulfillment. The monitoring data shows that only 10% of Masungukate/dota have dropped out since their training in late 2013 and early 2014 and most of these drop outs have been caused by men and women needing to migrate to the city because of the drought and the need to earn money to buy food.

There were things other than personal fulfillment that the 2015 research showed up as motivating factors. One of the important ones is that the change in their own lives motivates the home visitors to encourage the parents they work with to make the change in their lives too, for an example of this look at Sungukate Sauneta's story on page 51.

Another motivating factor that emerged was the fact that the Masungukate/dota gained a certain amount of status in the village by being a Masungukate/dota. This status came from the fact that the community leadership was involved in the program, that the Masungukate/dota had been selected in a community meeting, that they had attended a formal training away from the village (this held status) and that they wore a uniform (T shirt and cap) that identified them as an expert in the care of young children. They were recognized as experts in child care and were often called on to give advice by traditional leaders as well as local clinic sisters and social welfare services to give advice.

Note too that the playgrounds built from local material by the Masungukate/dota with assistance from CARE added to the status of the home visitors and therefore also to the weight of what they had to say. The playgrounds seemed to serve as evidence that outsiders (CARE) took the program and the children in the village seriously; it became a symbol of the raised status of children and the role of the Masungukate/dota as advisors to be trusted.

Alongside the status motivation it seems that the regular support of the mentor/manager called ECD facilitators by the program was also important. These facilitators were employed by the local CBO that managed the program in the district. They met regularly with Masungukate/dota, holding once a month reflection meetings and accompanying Masungukate/dota on at least one home visit a month. They were also there to be called when a Sungukate could not solve a problem. This story illustrates how Masungukate accessed institutional resources with the help of the ECD Facilitator.

I asked Sungukate Alzira (the ECD Facilitator from the local CBO) to support me visiting a caregiver and her child. We discovered that the child was undernourished, not having appropriate weight for her age, did not play and her belly was large. (2015, Sungukate, Project, Mbanguine A, Funhalouro)

Sungukate Floriana informed me that a young child aged 3 living in Mbanguine A was undernourished and that she had referred the caregiver to

the Health Center in Funhalouro. The nurse who examined the child said she was indeed undernourished. The child needed the supplementary feeding program run by INAS[23]. But the mother and child did not have registration documents. I asked the community leader to apply for immediate supplementary feeding for the child while the registration documents were applied for. (ECD Community Facilitator, from AJEPROJ a local community organization in Funhalouro)

The 2015 research shows that a number of factors promoted the motivation of the Masungukate/dota over time. Alongside these factors the CARE staff point out that keeping the number of households visited to 6 or 7 is important as this is not an onerous task and allows time for Masungukate/dota to work on their farms and look after their own children.

This insight into the role of the Masungukate/dota is important as it helps us understand the implementation issue of sustainability. It seems that strong internal sustainability (i.e. people involved in the program have internal reasons for staying involved) is essential if a home visiting program based on the use of volunteers is to be sustained.

[23] Instituto Nacional De Accao Social – National Institute for Social Action

5. Case Studies

During 2015 and 2016 Mary Dawson conducted ethnographic research and wrote up five case studies to illustrate the impact of the Masungukate/dota on particular families. These were used as qualitative evidence in the analysis of findings.

Case Study One

Sungukate Laura José began to visit the Caesar family and caregiver Anna Jilda Alfreda at their home in the village of Tsane in 2014 with the implementation of CARE's Masungukate home-visiting program. Since that time, she has visited the family countless times and shared advice that has allowed Anna Jilda's two sons, Dario and Delsun, to not only develop properly, but thrive. However, that of Sungukate and caregiver is not the only relationship that Laura and Anna share. Laura José's son is married to Anna Jilda. Laura José is her mother-in-law.

In many cultures, the relationship between mothers-in-law and daughters-in-law can often be thought of as tense. However, both Laura and Anna say that their relationship is a good one, even prior to the start of the Masungukate program. Both women believe that their relationship has improved and deepened because of the program. Anna has come to rely on Sungukate Laura for emotional support and advice regarding her two young sons. Because of Laura's intervention, many changes have been made to the Caesar household.

Observing Dario as he obediently runs to his mother's side at the sound of her call, it is hard to imagine him as a rowdy and rebellious child. However, that is how Anna Jilda would describe his behavior prior to Sungukate Laura José's visits. "A young lion cub," she used to call him. As a way to discipline his unruly ways, Anna Jilda and her husband used corporal punishment, but saw hardly a change in their son's misbehaviors. Only after Sungukate Laura taught the young parents about appropriate forms of discipline and saw that these lessons were implemented in the household did Dario become more obedient and begin to listen to his parents when called. Nowadays, both he and his younger brother, though they love to run wild, always run back to their mother.

Dario and Delsun are like any other young children in that they love to play. However, the importance of play – and its implications in both social and physical development – were not known to Anna Jilda and her husband a few years ago. They certainly never played with Dario and never made sure that he had the company of other neighborhood children with which to interact. But now both parents play with their sons on a daily basis, after hearing from Sungukate Laura of the benefits of play and how familial bonds are strengthened by interacting and playing together. And although the boys love playing with mom and dad, their favorite thing to do will always be to go over to Sungukate Laura's house and play on the swing that she has built there. This is also a favorite activity for many of the children who live close-by and who also spend time playing at Laura's house, giving Dario and Delsun the opportunity to interact daily with other children their own ages.

In addition to teaching the family about appropriate forms of discipline and the importance of play, Sungukate Laura has taught them about important health and

hygiene practices, such as the necessity of washing hands after using the latrine, and why and how a mosquito net should be used. However, Laura has done much more for the family than that. In a way, she is responsible for the well-being and healthy development of Anna Jilda's youngest son, Delsun. In order to understand her part in this, however, a health history of Anna Jilda's oldest son, Dario, and the role that traditional medicine had on his health and development, must be given.

From birth until the age of 6 months, Dario received traditional medicine. The exact components of the medicine were unknown to Anna Jilda, but is typically a dried portion of root or plant ground into a powder and mixed into water, given to the child as a drink. The reason Dario was given this treatment was due to a local belief that claims that children are born with a certain beast inside of them when they are born. In the local language of Xitswa, this beast is known as *inuocane*. Traditional medicine is the only remedy, the only poison that will kill this beast and allow the child to live a long and healthy life. However, as often happens when this particular traditional medicine is taken, Dario became a very sick child. Instead of gaining weight, he lost it and grew very thin, as the little breastmilk that he took was unable to be absorbed by his weakened body[24]. Dario's deteriorating health scared Anna Jilda sufficiently to induce her to stop giving her son the traditional medicine after 6 months. When Sungukate Laura began to visit the family in 2014, after Dario had regained most of his health and Anna Jilda was now again pregnant, she taught the family about the dangers of some traditional medicine and how very likely it was that Dario's sickliness as an infant was the result of the treatment he was given. Because of this, the family's second child, Delsun, was not given traditional medicine for *incuoane* and took only breastmilk until 6 months. In this way, Delsun was and continues to be a healthy child and has developed at a more rapid rate than Dario before him.

Both Dario and Delsun are registered and have received all of their required immunizations. Caregiver Anna Jilda did admit, though, that the hospital is relatively far away from the house and that traveling there is consequently expensive. Because of this, and because Anna believes that she herself can sufficiently judge whether or not her children are developing normally, she stopped taking Dario to the hospital to be measured and weighed after just two years. And though she would have likely done the same for his brother, Delsun, due to Sungukate Laura's urging, she will continue to take her youngest son for regular check-ups at the clinic – despite the distance and subsequent effort that will have to be made to travel there. This is another important lesson that Sungukate Laura has taught the young mother – that of the importance of hospital visits and how necessary it is for Anna to not only take her children there for regular check-ups, but also if any health concern is made apparent.

One of the last things that Sungukate Laura will do for Dario (as he is now over 5 years old) will be to help him with the transition to school that will occur this next year. This will involve preparing him for the school year and helping with the registration process. According to both caregiver and Sungukate, Dario is ready for school. His language development is well on track, and socially he is also very

[24] Note that many traditional remedies are not harmful. Health providers interviewed prior to the start of the program identified this particular practice of giving medicine for *inuocane* as a cause of ongoing diarrhea that often led to babies failing to thrive.

advanced. But most importantly, he is healthy. And for this, he has Sungukate Laura José to thank.

Case Study Two

Caregiver Maria Aminos and her Sungukate, Eliza Fernando, are close friends. This is obvious as one observes the proximity with which they sit next to each other, the effortlessness with which they talk, and the ease with which Eliza can make Maria laugh. However, it wasn't always so.

Maria met the CARE Masungukate home-visiting program with some significant initial resistance. Her family was one of the first that Sungukate Eliza Fernando began visiting in late 2014, after she had been trained as a volunteer in the CARE program. However, it became very obvious to Eliza that unlike the other caregivers whom she was visiting, who were eager and open to the new program, Maria made no effort to participate. She refused to respond to Sungukate Eliza, some days refusing to speak even a word to her. As Eliza Fernando remembers it, some days she would visit the household and attempt to start a conversation with Maria, only to have the caregiver ignore her and walk away. Against all odds, though, the newly trained Sungukate continued to visit the household, week after week. When asked why, Eliza explains that she knew that Maria's only hesitation, her only reason for refusing to participate in the program, was because she wasn't aware of its importance. If Eliza could somehow convey to her its importance, how her participation could have a positive impact on the family, maybe she could change her mind. And eventually, it worked. According to Maria, after a few weeks of Sungukate Eliza's visits, she began to reflect on what the volunteer was saying and determined on her own that maybe this program was something her family needed. Eliza Fernando's intentions seemed good. It appeared that she sincerely wanted to do nothing else but help her family. And yes, Maria's admits with a smile, her determination in visiting the family every week and pure doggedness had a part in changing her mind, too. And so, Maria began responding and taking part in the visits, listening to what the Sungukate had to say and making more and more changes in the household.

Among these changes, Maria talks about appropriate forms of discipline and the importance of play – two things which she and her husband learned about from Sungukate Eliza. While neither parent made time to interact and play with the children prior to the start of the program, now they both do, and on a daily basis – oftentimes directly after a visit from Sungukate Eliza. Many children live near the family's compound, giving Amelia, Jamie, and Diferencio even more playmates. Maria draws our attention to a space behind the house where a swing was constructed at Sungukate Eliza's urging and to which now all of the neighborhood children flock and where her three spend much of their playtime.

Regarding other changes made to the household because of Eliza Fernando's visits, Maria points out a latrine that is visible from where we are sitting in front of the family's compound. Sungukate Eliza also taught the caregiver about the importance of good hygiene and cleanliness, and Maria gestures to the family's main living quarters where a thorough cleaning took place under Eliza's supervision. Sungukate Eliza also taught the family about the importance of the use of the mosquito net – something that caregiver Maria is very proud to point out that they use every day without fail. And for this reason, perhaps, her children have had no issues with illness

since the start of Eliza's home visits. Thanks also to lessons on exclusive breastfeeding and the importance of serving children hot foods (so as not to provoke stomach pains, Maria explains), any issue with regards to malnutrition or a lack of appetite in her children has been avoided, and they continue to mature and develop in a healthy manner.

In addition, with regards to health, all three of her children have received the required immunizations from the local hospital in Mavume, though only her two oldest are registered. Maria explained that that because the registry office was so far away from their home, transportation was expensive, and she had yet to raise the necessary funds that would support such a trip. When this came to the attention of Eliza Fernando during our visit, Maria's Sungukate immediately began talking to Fernando, Mavume's community facilitator who had accompanied us, regarding possible solutions to this problem. After some discussion, it was decided that a partners' group that supported registration made rounds through the different *povoados*, or villages, could be asked to make a visit to this household. And just like that, thanks to Sungukate Eliza Fernadando, Maria's problem is solved. With money as tight as it is in a household like Maria's, it's hard to say when the necessary money for a trip to the registry office would eventually have been raised. Weeks and even months could have passed before young Diferencio would have been registered. However, because Maria has her Sungukate looking out for her wellbeing and especially that of her children, she no longer has to worry.

Maria feels that she receives vital emotional support from Sungukate Eliza. According to the caregiver, her stress levels have decreased significantly since Eliza began visiting the family in 2014. As Maria tells it, the visits occupy her mind and allow her to think about other things, allowing her present worries to virtually disappear. The visits give her something to look forward to and provide an outlet to talk about any problems that the household is having. Maria knows that in Sungukate Eliza she has, and will always have, a willing listener who will always be there to support her. Looking back, Maria admits that it wasn't always so; that there was a time where she wasn't ready to trust Eliza and listen to what she had to say. But thanks to the stubborn determination of one dedicated Sungukate, caregiver Maria changed her mind. And as she fondly regards the healthy and happy children sitting by her side, she is so glad that she did.

Case Study Three

Caregiver Anna Leonardo Bizo lives with her husband and five children in the village of Mavume, located outside of the small town, Funhalouro. Her youngest, Clesio, has just turned one year old and is a healthy and happy child. For that, she has Sungudota Chavier Salamao Sitoe to thank. She says it was only due to his intervention that she was to have a safe pregnancy and Clesio to ultimately have a healthy birth. Despite the fact that she essentially denied the fact that she was pregnant with Celsio until she was already five months along.

Initially, Anna Leonardo believed that she was not indeed pregnant, despite the obvious signs stating the opposite, and had instead developed a strange illness. This belief was brought about by her neighbors who told her that she needed to visit Mavume's traditional healer or *curandeiro* in order to receive the proper treatment and traditional medicine. When she tried to convince them that maybe she was

actually pregnant, they refused to believe Anna, telling her that she was just telling stories. And although she never did visit the traditional healer, she continued to have doubts regarding the validity of the pregnancy, supported by an absence of illness that had accompanied her previous four pregnancies. This time around, the only illness she felt was a slight stomach pain. That, along with her hectic days as a full-time caregiver and mother of four children, were enough to keep her from putting off a visit to the hospital.

At five months, though, it became obvious to Sungudota Chavier that Anna was indeed pregnant and that it was time for him to intervene. At his serious urging, Anna Leonardo made the trip to the closest clinic and was sent almost immediately to the central hospital located in Funhalouro. There, at doctors' urgings, she spent the remaining time of her pregnancy and four months later gave birth to Clesio, without any complications for mother or child.

As we discuss this recent time in her life, Anna draws our attention to her second youngest child, a sweet and smiling girl named Stivia who turned five years old this year and will be entering school soon. Stivia is happy and healthy these days, but when Sunguldota Chavier first began visiting the family in 2014, she had just developed a strange illness and was very sick. Initially what started as a weak appetite led to the child refusing food completely. Soon after, Stivia developed a bloated belly, a familiar hallmark of acute malnutrition. At Sungudota Chavier's urging, Anna Leonardo took her youngest daughter to the hospital where Stivia remained for two months. There, doctors told her mother that the child was suffering from a "lack of blood" – something typically used to describe anemia. She was told that Stivia would have to take a certain medicine every day and that flare-ups of the disease were possible and very probable. Indeed, that has been the case, as approximately once every two months Stivia will suffer from stomach pains and edema. However, never has the illness returned to the severity with which it began and when the flare-ups occur, Sungudota Chavier makes sure that he is helps Anna Leonardo, offering support to both her and her daughter.

Anna Leonardo admits that her daughter had received traditional medicine (usually a root or dried plant ground into a powder and mixed with water) until the age of 2 years and 6 months. And in fact, all of her children received traditional medicine up until this age. The only child spared from the harmful practice was Clesio, the only reason being that Sungudota Chavier had by that time taught the family about the dangers of some traditional medicine and why exclusive breastfeeding was the healthiest and most beneficial option for a child under six months.

Sungudota Chavier goes above and beyond expectations in regard to his dedication and support to Anna Leonardo and her family. One may be surprised to learn that he visits the family every day, but Chavier says this is simply doing his job. According to the Sungudota, it's all about time management. Every Sungukate or Sungudota could visit their families each and every day if they only learned to manage their time efficiently. And when the ECD CARE program managers changed the structure of this program in its early days, making sure that a volunteer visited families only in their own povoado, or village, and very near their homes, daily visits became a viable reality.

One can see that these daily visits have made an impact on the closeness which bonds caregiver Anna Leonardo with her Sungudota. Anna feels that she receives very necessary emotional support from Chavier and is unbelievably grateful for all that he has done for her family and taught her. One of the most important things that he has taught her, she explains, is the fact that her own happiness is very important. That in order to take care of the children properly, she must be happy. And the care that Sungudota Chavier gives to her family, each and every day, she says, makes her very, very happy.

Case Study Four

Caregiver Preciosa Joãnquin and her seven children live in Ndambine village just a few kilometers outside of the small town of Homoine. They live in a compound with a tin roof and a sandy yard. The family's Sungukate, Felizada José, points out two small shaded enclosures in the backyard that she calls *barracas*. She explains that she helped ensure that the *barracas* were made safer by being spread apart and cleaned out. This was the second thing that she helped with when she first starting visiting the family last year when she was trained as a home volunteer as part of CARE's Masungukate home-visiting program. The first thing she did, though, required much more urgency and was much more important. When Sungukate Felizada first visited Preciosa and her children, she had to deal with the matakenya that had taken up residence.

matakenya, as the locals call them, are small fleas that burrow into toes and other areas around the feet and will often settle into the skin by laying sacks of eggs inside. *matakenya* are common in rural areas, especially in areas of low sanitary condition or where animals are kept. Preciosa and her family lived for a long time with pigs, there being such a lack of space in their compound that the children even sometimes slept with the animals. And along unfortunately common in areas such as Ndambine, *matakenya* is fortunately very easily treatable. The fleas and the sacks of eggs they lay inside the skin can be removed by a doctor if available, but in many cases they are simply taken care of by a local person handy with a knife. *Matakenya* are normally little cause for alarm, however when Sungukate Felizada José was first introduced to caregiver Preciosa and her family, she knew that this was no normal case.

Every child in the household had *matakenya*, and more than one flea. Sungukate Felizada remembers looking at the feet of the eldest son, Arnalyu, and seeing dozens of black spots, sacks of eggs, on each feet. Even more shocking was the fact that the *matakenya* had spread to the hands of the children – a development that is extremely rare when it comes to this sort of condition. Sungukate Felizada knew that something needed to be done for the family and soon. As she explained, *matakenya* is not only very painful, but can also lead to a development of anemia if left untreated. And so the Sungukate looked to her caregiver, Preciosa Joãnquin, for support and approval to take the family to the local hospital and seek treatment. However, to Felizada's surprise, the mother did not have the same sense of urgency.

Day after day, excuses were made as to why Preciosa couldn't take the children to the hospital. At first she said that she believed the *matakenya* to be a genetic disorder and something untreatable. After all, every one of her children had them, so it must be something in the blood. Later, she tried treating the *matakenya* herself,

using an insecticide on the black spots. Yet, this didn't seem to heal much of anything. Then, she explained that she didn't believe the condition to be that serious and that with time it would heal itself. Eventually, however, the truth came out, and Preciosa admitted that the real reason she was hesitant to go to the hospital was because she was ashamed. She was embarrassed that she had allowed the situation to become as severe as it had. She thought that maybe staff at the hospital would think that she wasn't a good mother, that if only she had taken better care of her children, this wouldn't have happened. She was ashamed because she herself had *matakenya* nesting in her feet and hands and didn't want anyone to know.

It is at this point that Sungukate Felizada José proves how valuable she is. She's patient with Preciosa. She's sympathetic. She insists that it wasn't the caregiver's fault. That is was a situation that she couldn't control. But now, she can take charge and control the situation. Now she can make sure that her children are taken care of. And so, Preciosa and her children visit the hospital with Sungukate Felizada right at their side. The *matakenya* are removed from their hands and feet, and they are given a medicine that must be taken every day for two months in order to complete the treatment. Sungukate Felizada takes the medicine home herself and keeps it in her own fridge. And every day for two months, she walks over to the family's house and ensures that each and every one of them takes the prescription.

You can still see the scars on the bottom of some of the children's feet. But the restless nights and the pain are gone. And as their feet and hands healed, the children have gone back to playing again. They play with Sungukate Felizada when she arrives at the house. They run around and show her their new, clean rooms that she helped them arrange in the house. They don't sleep with the pigs anymore. They don't even have the pigs anymore. The older children are able to tell me about the importance of the mosquito net they have and why they have to keep the house and themselves clean. Sungukate Felizada says that she likes working with such a big family. If she teaches the older kids about mosquito nets and malaria and hygiene and health, they'll teach the younger ones and continue teaching them as they learn new things.

Preciosa's husband and the father of her children, Alvera Justino, doesn't live in Ndambine. In fact, he doesn't even live in Homoine. He works and lives in South Africa. That isn't to say that he doesn't occasionally visit his family. And he sends them food when he can, usually every two or three months. However, Preciosa's husband isn't around to help her take care of the children. He isn't there to provide her with the emotional support that she needs. But Sungukate Felizada José is there. And will always be there for the family. Preciosa relies heavily on her sungukate, saying that if there is ever a problem, she knows that Sungukate Felizada will have a solution. And whether it is problems with *barracas* or *matakenya*, Sungukate Felizada always seems to know what to do.

Sungukate Felizada José doesn't believe that the *matakenya* will return, not with the changes that she has helped make in the household. But if they do return, she says she'll be there. And she'll visit the family every day for another two months if she has to.

Case Study Five

In Chijinguiri, a small village located just outside the town of Homoine, live caregiver Angelina Wetela and her three grandchildren. She took in Alezera, Belto, and Andre to live with her and her husband after her daughter, Gloria José, died from a long and drawn-out stomach disease.

Sungukate Isabel Josias has been visiting the family for only a few months. She was part of the newest recruitment of volunteers trained by CARE as part of their Masungukate home-visiting program. And although Sungukate Isabel has only been providing support to Angelina's family since December of last year, she has already done a great deal. She's overseen the purchase of a new mosquito net for the home and has taught the family of its importance. Under her supervision, a new latrine was built. Sungukate Isabel taught the family about the importance of hygiene and how to maintain a clean house. She draws one's eye to the spotless yard around the house and notes the absence of any trash.

Sungukate Isabel has a good relationship with this family, one of seven in Chijinguiri whom she visits regularly. Each of the homes she visits are located near her own, ensuring that she can easily keep in touch with them all on a regular basis. With caregiver Angelina's household, though, Sungukate Isabel has taken a special interest - more specifically, in the state of health of Angelina's youngest grandson, Belto.

Belto was the last to move into his grandparent's home. He was still living with his mother when she died. Because of her illness, she was unable to work or maintain her farmland or *machamba*. As a result, there was a severe lack of food in the household that quickened the deterioration of her state of health and also contributed to Belto's malnourishment. After his mother's death, her youngest son was taken in by his grandparents, but the damage had already been done. For months, Belto suffered from various illnesses related to malnutrition. He also contracted a severe case of malaria.

For the past month, Sungukate Isabel has been taking Belto regularly to the local clinic to receive treatment for both his malaria and malnutrition issues. His body has been weakened by both health problems and some weeks are better than others, but Sungukate Isabel never strays in her mission. She ensures that Belto receives proper nutrition at home and that he is eating with his two other siblings. If not for Sungukate Isabel's determination, Belto would not be improving at the rapid state that he is. Thanks to his Sungukate, Belto will be healthy once again in little time.

The children's father, Julião, lives nearby but rarely sees them. In fact, even before his wife's death he was hardly a presence in their lives. Legally, however, he is still the children's father and because of this he has in his possession their documents – documents that are necessary if his children are to transfer schools this year. This is a necessary change as they are still enrolled in the school located in the neighborhood where they lived with their mother. In order to continue with their primary studies, they need to enroll in Chijinguiri's local school. This also costs money, a small amount even for a budget-tight family, but one that their father is stubbornly unwilling to pay.

What Julião did not foresee, however, was the force and determination that is Sungukate Isabel Josias. She has been visiting him regularly, asking of him the documents that will allow his children to go to school, to learn and receive the education that they deserve. And her own stubbornness has won him over. He's given the paperwork over to Angelina and will not impede the process further. She has only been with the family a few months, but already Sungukate Isabel fights for them and their wellbeing as if they were her own.

Recently, Sungukate Isabel has taught caregiver Angelina and her grandchildren about the importance of play. She found a sturdy cord and tied it to a tree in an area behind the house. There, the children play and swing and laugh. Even little Belto grabs on to the cord now and then. He's still weak from the malaria and the malnutrition, but he's getting stronger every day. And Sungukate Isabel Josias will make sure that he continues to improve. And she'll make sure that the children are able to go the new school this year, the one that's closer to their grandparent's home. She's going to pay for the transfer. It's only a few meticais, she says. And just like that, Sungukate Isabel has given the family a new beginning.

6. Findings related to social accountability

6.1 Background

The term 'social accountability' refers to a process developed by CARE Malawi in 2002 that aimed to improve health services. It is generally referred to within CARE as the Community Scorecard (CSC). Since then, the CSC has become an internationally recognized participatory governance approach, spreading within CARE and beyond.

> The main goal of the Community Score Card is to positively influence the quality, efficiency and accountability with which services are provided at different levels. The core implementation strategy to achieve the goal is using dialogue in a participatory forum that engages both service users and service providers. (CARE Malawi, 2013 P 6.)

When the CARE Mozambique team conceptualized the ECD program in 2012 the aim was to make the CSC approach to social accountability a central part of the program. As the program model was developed, however, it became clear that the focus of the program would be volunteer home visitors and households with children under five and not service providers. The main goal of the ECD program was to pilot a volunteer home visiting program and not to influence the quality of the services that communities accessed. Because of this change of focus the CARE ECD program team decided to pilot an adapted form of the CSC in a few program villages. The Caregivers and Masungukate/dota used an adapted form of the scorecard approach to monitor their progress towards achieving the behaviors that would promote the wellbeing of children under five.

The process involved a series of meetings with Masungukate/dota and caregivers involved in the program. As with the CSC approach a first meeting was held where the participants made a social contract to work together on a set of indicators of success that they had identified together. Masungukate/dota and caregivers then met every four months over the next two years to rate their progress on each of these indicators.

Because many of the Masungukate/dota and caregivers were not literate CARE staff had to introduce the idea of a rating scale that used a familiar image. The metaphor of maize that grows well with water and good soil was used to teach people that children also need certain things to grow well. The caregivers and Masungukate agreed on what these things were and these became the indicators for measuring behavior change. This first meeting became known as *xivumelwade xa xifake* or the 'maize agreement'. Progress was measured on a five-point scale (0-4) superimposed on a large drawing of a maize plant.

The adapted CSC process was implemented in six pilot villages (Marengo, Macavane, Matimbe in Homoine and Bulangete, Mbone and Mutuzi in Funhalouro).

6.2 Research into adapted social accountability approach

One of the condition variables in the quantitative study was PROSAN + ECD + Social Accountability. This was done in order to discern whether the use of the CSC

approach made any difference to the impact of the project. Data was gathered from all six pilot villages.

Using 2016 data and comparing the social accountability condition with the PROSAN + ECD condition no statistically significant differences were found between any of the variables[25]. This suggests that the use of the CSC approach did not make a significant impact on the achievement of child wellbeing as measured by the indicators of impact described on page 8.

Qualitative research into implementation of the social accountability approach gives us further information. During January 2016 we ran twelve focus groups in the six villages. One focus group was held with caregivers and one with Masungukate/dota in each village. The focus group outline is reproduced in Appendix 3. The discussions in the groups were recorded and transcribed and were used to help us understand how participants understood the purpose of the meetings, the maize metaphor, the rating scale and the 'maize agreement' and the role the process had played in changing behavior.

Maize metaphor and idea of rating scale worked well
The metaphor of maize was an effective way of explaining the idea of a set of indicators to assess progress.

> *In this meeting we learned this maize is similar to our children. If we do not clear the ground and water the maize it will not grow up and we will get a bad crop. We do the same with our children. We must clean then and give them what we can so they can develop well. (2016, Caregivers, Project, Matimbe, Homoine*

Naming what needs to change
The first meeting made it very clear to the caregivers what the Masungukate were working on. In Macavane caregivers described how they had talked about what children need.

> *In the meeting we said we must take babies to hospital when they have fever and go to the hospital for vaccines.*
> *You need to play with them with a ball.*
> *You need to breastfeed your baby until 6 months.*
> *You must not beat children. We are not beating the children anymore.*
> *We learn in this meeting we need to care for pregnant women, we must help them, we must help husbands to help them. We learnt about family planning too.*
> *All these things we must do quatro (4) all the time. (2016, Caregivers, Project, Macavane, Homoine)*

This allowed caregivers and Masungukate/dota to be aware of what needed changing.

[25] $F = 1.51$, $df = 1, 13$, $p > 0.10$

CSC meetings provided a joint project focus
The caregivers and Masungukate described how they jointly owned the meetings held as part of the CSC process and therefore could work together on making the changes happen in their lives.

> *Researcher: Who owned this meeting?*
> *It belonged to the caregivers.*
> *To us.*
> *The meeting was for caregivers because we were talking about how we were doing with our children? (2016, Caregivers, Project, Macavane, Homoine)*

> *We were telling the mothers what we want them to be good at. So it helped us too. (2016, Sungukate, Project, Macavane, Homoine)*

Follow up meetings allowed for an ongoing process of identifying what needed to change.

> *We agreed to focus on birth registration in the last meeting.*
> *We are all at number 4 now. (2016, caregivers, Project, Bulangete, Funhalouro)*

Masungukate main motivator of change
What is clear though is that the meetings and rating scale were a useful teaching tool but the person of the Masungukate/dota were the main motivator for change.

> *In the first meeting I said 'Oh I am beating my children'. (she laughs)*
> *Researcher: So you were zero?*
> *Yes!! (she laughs)*
> *Researcher: Now? (she points to 4).*
> *What difference has it made?*
> *If you beat a child they don't respect you but now my children when I come form market they come up to me and they were not doing any mistake because they were afraid of me.*
> *Before they were afraid and now we are friends.*
> *Researcher: Was it this meeting that helped you to change or more than the meeting?*
> *Before CARE start to work here we were different – now all my children have birth registration – before they had none.*
> *Researcher: What made the change to happen was it this meeting?*
> *Masungukate day after day they came and they made the change.*
> *Researcher: Could you change if there was no Sungukate.*
> *No.*
> *We would not have knowledge without them.*
> *Researcher: When you see Sungukate/dota coming to your house what is inside your head.*
> *Eh!*
> *The child belongs to Sungukate – now I have to make the child clean I must organize myself, I must be ready!*
> *Researcher: Is that because she shouts "Wena! Wena!".*

Uh uh no Sungukate are very friendly. They come and sit and they never say anything uncomfortable. (2016, Caregivers, Project, Macavane, Homoine)

Rating scale becomes a tool to highlight change

It seems that in almost all the social accountability villages the Masungukate/dota and caregivers understood the maize metaphor and the idea of the rating scale. The idea of an agreement was understood in at least 4 of the 6 villages. Caregivers could list most of the indicators of progress they had agreed on and could also describe where their behavior had changed in elation to the rating scale.

[At the first meeting] we said that all mothers must use mosquito nets.
Researcher: So where were you before the Masungukate came to visit? (Pointing to the rating scale of 0-4 superimposed on a drawing of a maize plant.)
I was at 1 (she laughs).
I did not always use the nets – 3.
I was at 3.
Researcher: And now.
4 (quatro)!
We are always using the mosquito net?
Researcher: Really? Are you just saying that because I am here and you want to say the right thing?
(They laugh.)
No, we are all using.
I am 4 (quatro)!
My Sungukate says she is pleased I am now a 4 mother (quatro mama!)! (2016, Project, Mutuzi, Funhalouro)

This quote shows that they understood the idea of the rating scale and how it has worked for Masungukate and caregivers as a resource to mark progress of behavior change.

I learnt how to discipline child. If I beat my child I am zero and day after day I am evaluating myself and saying I am not beating my child. So I am growing every day from 0 to 4. (2016, Caregiver, Project, Macavane, Homoine)

The rating scale gave the caregivers and Masungukate/dota a language to talk about change.

The 'public' nature of the agreement

The first CSC (maize) meeting was important because it brought all the players in the program together in a semi-public forum. This meeting seems to have given the Masungukate credibility in the community. Caregivers and Masungukate reported that after the initial meeting they were made more welcome in the households they visited because caregivers understood the purpose of their visits after the meeting. This could suggest that it took a shorter period for them to win the trust of the families they visited.

Time consuming recording

CARE staff responsible for the implementation of the maize meetings and the recording of the indicators and rating scores after each meeting reported that the work on the scorecards generated by all of these meetings was time consuming. Given the results of the quantitative data (i.e. no obvious impact in any indicator) it may be sensible to not include the process in future programs. The qualitative research suggests that there is some value in the process, however. It may be possible to further adapt the social accountability checklist approach for future use in the ECD program. Scores could be kept in a looser narrative style by staff and the process of rating and soring progress could be used to monitor progress in a participatory way (with caregivers and Masungukate) and to develop strategic plans for future focus with the caregivers and Masungukate based on the rating of certain indicators.

7. Conclusions and recommendations

The aim of the impact evaluation was to assess whether the ECD program improves child development and nutritional outcomes and, if improvements do occur, which program components contributed significantly to that impact in the different environments.

7.1 Impact

The results presented above prove conclusively that impact has been made on caregiver status, child status (to some extent) and the caregiving environment – the pillars of ECD as identified by the Essential Package.

Home visits from Masungukate and Masungudota in the villages around Funhalouro and Homoine have given caregivers **information** they did not have before. More importantly, the evaluation shows that they have applied this information by changing their behavior. **Behavior changes** have been recorded in use of mosquito nets, home safety and hygiene, use of latrines, immunization, feeding children diverse foods, birth certificate access, taking children to the hospital when ill, stimulation of babies and children and in the reduction of beating and shouting to control children.

The Masungukate and Masungudota have become trusted friends who are able to help caregivers overcome contextual barriers such as lack of water sources and long distances to the hospital by providing encouragement and in many cases actual practical assistance. This support goes beyond **accessing services**; caregivers now have a regular visitor who cares about them and their children. The evaluation results show that this has had a significant impact by **reducing caregivers' emotional stress**. Caregiver stress is a major risk factor in early child development (Walker, 2011) and this evaluation shows how it can be reduced through a home visiting approach.

The caregiver education and practical support received from the Masungukate/dota have **increased dietary diversity**. Mothers and grandmothers now understand the importance of including foods with Vitamin A and protein in a young child's diet and they are applying this knowledge. This is a remarkable result given the present drought.

The results of the evaluation show the program has **impacted on relationships** between parents and children. Acceptance and affection have increased and parents report that they are no longer beating and shouting as they used to before the Masungukate and Masungudota began to visit. Parents (fathers and mothers) who have been part of the CARE ECD program talk about showing love to their children, thereby creating strong attachments, which we know are central to young child wellbeing (Richter and Naicker, 2013). This is a significant impact – it is known to be very difficult to change long-held social norms such as parenting behavior related to corporal punishment, or gender roles related to parenting (Regalado, Sareen, Inkelas, Wissow and Halton, 2004; Muñoz Boudot, Pettesch, Turk, Thumala, 2012)

No impact was recorded in **height and weight** gain but careful analysis and

discussion with a nutrition expert[26] of these findings suggests that we might have found change if we had included younger children (under 18 months) in our sample.

In the area of **learning and stimulation** the results of the evaluation show that parents now understand the importance of play as a tool for young children to learn. Men and women caregivers report that they now play with their children more often than they did before they became part of the program. The fact that men are becoming involved in care and interaction with children is a most significant impact. Though we did not identify an impact on cognitive and language development, given the two-year implementation period this is perhaps unsurprising. However, we hope that this will be recorded over time as parents continue to stimulate their children through play and storytelling and the children participate in the playgroup program.

It is important to note that any impacts of the CARE ECD program go beyond individual families. Entire communities have begun to change their behavior as Masungukate and Masungudota use their status within the community to encourage general care for young children.

The evaluation illustrates that these significant impacts can be made in remote rural areas where most parents are not literate. This is an important finding in the Mozambican context where pre-schools need to be complemented by home-based ECD because of the remoteness and poor access to resources of so many people.

7.2 Implementation

The ongoing qualitative research undertaken throughout the program implementation period provides useful information on which program components contributed significantly to the changes seen in project households. But before looking at this we would like to emphasize how important the pre-program implementation research done in 2013 was especially in the context of behavior change.

The use of what Wessels (2015) calls an "ethnographic phase" is slowly becoming an important practice, particularly in implementation programs that include community practices and processes. Bray and Dawes (2016) in a recent review of research on parenting point out that

> *Social scientists have long recognised the difficulties in initiating and sustaining effective behaviour change interventions. A current argument mounted by those working in the field of parenting support internationally is that such interventions need to be "culturally compelling", rather than merely culturally appropriate, if they are to engage people in ways that shift discourse and action (Panter-Brick et al., 2006; Wamoyi & Wight, 2014). The difference relates to the extent to which interventions "nestle within social and ecological landscapes" so that they are led by, rather than compatible with, existing social realities (Panter-Brick et al., 2006) … In practice, becoming culturally compelling means fitting into, or ideally emerging from, local understandings of the family, and of the social fabric through which support is given and received*

[26] Prof. Hendricks, Assoc Professor and District Paediatrician, School of Child and Adolescent Health UCT

more broadly, including leadership structures and administrative systems (p. 51).

The use of the data from the ethnographic phase carried out prior to the implementation of the CARE ECD program seems to have made the program "culturally compelling". The extent of the behavior change recorded in this impact study suggests that the program has been able to "'nestle within social and ecological landscapes' so that they are led by, rather than compatible with, existing social realities (Panter-Brick et al., 2006)".

Alongside the fact that the program was "culturally compelling" we would suggest that the findings of this impact research also suggest that the genuine relationship built over time between Masungukate/dota and caregiver was central to the impact. These two aspects stand out for us as evaluators as key areas of implementation for success. We discuss below some details within the two broad areas highlighted above and other implementation factors that played a role in impact.

Building trust and reducing emotional stress
The qualitative research shows us that the issue of trust is a complex one because there is a strong tradition of not talking outside the family about problems. But it is clear that many Masungukate/dota have managed to overcome this reticence through their caring actions and through their perseverance. Having **someone in the neighborhood that is seen as trustworthy** has made a contribution to reducing emotional stress. The **regular visits** by Masungukate/dota provide caregivers with ongoing emotional support. In some cases Masungukate/dota were able to solve specific problems that caused emotional stress, especially in the area of family relationships or in helping families access available services. But they could not easily address structural or contextual issues such as crop failure, lack of water or distances to the health facilities. Nevertheless, it is clear that they have **mediated these structural problems by 'standing with' the caregivers** while they coped with the problems – after all, they too also faced these issues. This support clearly meant a lot to caregivers and reduced their stress. Masungukate/dota have become wise and constant visitors, welcomed by the children too. They represented someone to play with, chat to, laugh with and break the hardship of stress, especially in the time of drought.

It is worth noting that the research that informed the original model suggested that visits should be made once a week if they were to impact on the emotional wellbeing of caregivers. The evaluation findings support this point as it seems that it is **the regular and frequent nature of the visits** that has the impact. It is important to point out that once a week is quite frequent in the life of a man or woman whose livelihood depends on their own labor. This means the Masungukate/dota should be allocated no more than 6 or 7 households to visit and these households must be close to their homes. If not, the burden of their role will become too much and motivation will dwindle.

Another important implementation issue relates to **the values that were promoted during the training of Masungukate/dota** and the way they see their role. The program staff worked hard to build an approach to parents that was not didactic and authoritarian. Masungukate/dota knew they had information to give to parents and

skills to teach but they also knew that their role was to be a friend. One of the songs made up by the Masungukate/dota at the training reinforces how they **saw their role as a collaborative one**.

> *We Masungukate don't come to change the rules of your home.*
> *We Masungukate come to exchange experiences.*
> *We will help each other to take care of our children.*

In addition, the Visual Guide developed for use by the Masungukate emphasized the relationship aspect of the Masungukate/dota's work through **modeling friendship and listening in the illustrations**. This modeling of behavior was a factor in encouraging a relationship between Masungukate/dota and caregiver as was the 'wanting to please' the Masungukate/dota phenomenon which was based on a genuine relationship between caregiver and Masungukate/dota.

Intervening to help caregivers access services
Masungukate/dota have played a role in the education of caregivers about the importance of birth certificates and the need to register the child when it is born. But **there is often a need for direct intervention beyond education**. The important facilitating factor here was that the Masungukate/dota were supported by local CBOs who had the power to contact and 'contract' local district officials to help. This points to the **need for community-based volunteers to be linked to support structures such as NGOs and CBOs** with connections to government officials beyond the village.

The qualitative research suggests that caregivers knew they should take their children to the hospital but the reality of walking long distances to catch local transport and the cost of the transport often got in the way. The research thus also shows that those involved in support of caregivers need to be aware that knowledge on its own is insufficient and that providing support to overcome contextual barriers is a critical counterpart. . The Masungukate/dota were able to help caregivers overcome this barrier, not through practical help (though this did sometimes happen) but through emotional support and encouragement. They were able **to mediate the context so that caregivers could do the best that they could for their children**.

Behavior change as a result of combined factors
The behavior change related to health, hygiene and safety resulted from a combination of correct information, day-to-day encouragement and reduced emotional stress. Firstly, caregivers need **correct information** if they are to make the right decisions for their children. The training the Masungukate/dota received gave them the correct information and then the Visual Guide made sure that the correct facts were passed on to caregivers. Simple factual information was obviously important in matters such as mosquito net use, the need for latrines, safe water practices and safety in the home, as well as dietary diversity. The **day-to-day encouragement** by Masungukate/dota to change behavior and the fact that their **regular visits and supporting care reduced depression** also played an important role.

The **example set by Masungukate/dota** in their own homes and the fact that they **worked together to implement more difficult infrastructural changes** such as

digging a hole for a latrine seem to have also been important implementation practices. It is important to recognize that these were spontaneous responses that grew from the internal motivation of the Masungukate/dota and the recognition and status that they enjoyed in their communities. Future implementation should not seek to 'make' this happen, but should provide an environment within which such responses are supported.

Encouraging stimulation through play and responsivity
Giving information about why play was important for child development and why beating and shouting were harmful seems to be one reason for the change in caregiver behavior. however, changing long-held norms needs more than information. **Hearing personal stories of change and seeing changed relationships in the families of Masungukate/dota** seems also to have played an important role. The **role-modeling in the illustrations** in the Visual Guide **and the personal nature of those illustrations** also contributed to change in this area.

Building on the existing resources and energy in the community
It is clear that the person of the Sungukate/dota is central to the success of the program. **Identifying existing support people** in the project villages and extending their expertise and reach to mothers and children has been successful. Being a Sungukate or Sungudota gives women and men with skill and energy an **opportunity to find self-fulfillment in service**. This is an internal motivation that could be fundamental in promoting sustainability.

Using CSC – the adapted approach to social accountability
It does not seem from the quantitative research that the use of the social accountability approach had any impact on the indicators of child development. However, the qualitative research suggests that it has some very **useful components that could be used as tools for motivation and self-monitoring** of volunteer home visitors and caregivers.

To summarize this section on implementation, each of the highlighted phrases in the section above are implementation factors that the research shows was central to the impact. If the ECD program is to be replicated in other areas these factors should be considered.

7.3 Recommendations
The evaluation team has the following recommendations for CARE Mozambique.

Research recommendations

- Further research should be carried out in the sample areas used in this study over at least the next two years as the program continues. The data that could be gathered will be an important resource that will allow CARE to assess further impact as the program progresses.

- Further research should be conducted around height and weight data from program and control sites if this is at all possible. It would be immensely useful to see if there had been any changes in anthropometric data from children aged 6 months to one year who had been part of the program.

- Some of the research tools employed in this study have been successful and should be retained for further research. In particular, the SRQ20 seems to have generated useful comparative data, as did the dietary diversity CDDS. The health and safety checklist also seems to have worked well.

- Qualitative research should accompany quantitative in future research for the following reasons:
    - The qualitative research has been immensely useful in the context of wanting to understand which aspects of the program brought about change.
    - The qualitative research has also provided added information on those aspects difficult to measure through quantitative means such as caregiver stress and trust.
    - The focus on cultural context in the qualitative research has provided important understandings for the program team e.g. knowing that traditionally fathers have a part in naming a child, understanding the role of traditional medicine, the traditional norm of keeping family problems within the home have all given essential knowledge to aid implementation.
    - The specific focus of the qualitative research on behavior change has provided useful understandings about implementation not only for this program but for parent education programs in general. For example we have begun to understand how certain factors such as relationships between caregivers and home visitors, consistency of visits, listening rather than telling, personal example and stories all play a role in bringing about behavior change

Program recommendations

- The ECD Program has had significant impact and therefore should continue to be supported by CARE in the present program areas.

- These aspects of the program need to be retained
    - Regular home visits at least once a week
    - Relationships between home visitor and caregiver should be encouraged
    - Training needs to encourage interaction beyond fact-giving
    - The program should be based on respect for parents and their wish to do the best for their children
    - The correct facts need to be given
    - An information or resource guide to support home visitors in giving information is an important support
    - The illustrations in this guide should model values and behavior
    - They should be empathetic and ‘speak’ to the emotional nature of parenting
    - Linking to services often needs to involve home visitors mediating the context either practically or emotionally
    - Volunteer home visitors need to adopt new behavior as an example in the community
    - Personal stories about behavior change should be a central part of training and program mentoring

    - Use should be made of existing good advisors who have energy and commitment and their reach should be extended to children's issues

- The present social accountability CSC approach should be adapted for use as a tool for motivation and self-monitoring of volunteer home visitors and caregivers. This tool should be for the use of local CBOs who manage the Masungukate/dota. This approach should be simplified to minimize the laborious record-keeping involved in the current version.

- CARE Mozambique should seek to extend the program into new areas but a *pilot* of this scale-up process should precede this. Given the fact that the International ECD sector is interested in how to scale up ECD interventions it would be important to seek out funds to replicate the program in other areas. Note that because of the relational and grass roots nature of the approach used this may not be able to happen using a conventional scale-up approach. This is why a pilot that focuses on how to stay true to the intimate scale of relational aspects of the program model is recommended. While this approach might seem a slow way of "going to scale", its power for positive change and the strong sustainability it represents is a rare and valuable commodity that is seldom achieved in large-scale development projects.

- It would be useful to understand the role that the fully implemented PROSAN program could play alongside the ECD program. Given the constraint of the drought this was not possible during the ECD program period. CARE should seek to test the fully implemented PROSAN intervention alongside the ECD intervention to assess the impact on child indicators of a livelihood program such as PROSAN.

Advocacy recommendations

- CARE Mozambique should embark on an advocacy program based on the results of this evaluation. The advocacy should focus on the fact that parent education and behavior change through home visiting by community volunteers is an achievable objective in Mozambique, even in remote rural areas. This advocacy should focus on national policy makers in ECD as well as on other service providers at provincial and district levels.

- The importance of an ethnographic phase prior to program implementation has been particularly influential in the impact of the CARE ECD program. This approach needs to be advocated for within CARE itself and beyond to other INGOs. The child protection sector is exploring the use of an ethnographic phase in their work on Community Based Child Protection Mechanisms (Wessells, 2009a) and CARE should seek to network with this process in advocacy around a similar use of pre-program research in ECD as well as other program areas.

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Appendix 1: Distributions and sample sizes

ECD + PROSAN

Town	Locality	Village	BASELINE Actual	ENDLINE Actual
Funhalouro	Manhica	Nhalisseque	22	23
		Nzongane	5	4
	Mavume	Pululo A	26	26
		Pululo B	19	20
	Mucine	Muchai 1	8	8
		Tsane	20	22
		25 Setembro	13	13
			113	**116**
Homoine	Chinchinguir	Chinchinguir	33	33
		Mubalo	23	27
	Inhamussua	Inhamussua	25	22
		Moguba	57	58
		Inhamangua	18	21
			156	**161**
			269	**277**

ECD + PROSAN + SA

Town	Locality	Village	BASELINE Actual	ENDLINE Actual
Funhalouro	Manhica	Bulangete	10	10
	Mavume	Mutuze	11	13
	Mucine	Mbone	11	12
			32	**35**
Homoine	Chinchinguir	Macavane	49	55
		Marengo	50	54
	Inhamussua	Matimbe	32	31
			131	**140**

			163	**175**

PROSAN only

Town	Locality	Village	BASELINE Actual	ENDLINE Actual
Funhalouro	Mucuine	Massalane	23	21
		Mazive	25	26
	Mavume	Gavico A	26	27
			74	**74**
Homoine	Nhaulane	Nhaulane	21	21
		Guija	24	24
	Pembe	Catina	57	60
		Quemanhane	36	36
			138	**141**
			212	**215**

Appendix 2: Household questionnaire

CARE ECD PROJECT
ENDLINE STUDY

CARE Code of household _____ Date of interview ____/____/____

Povoado name _____ Caregiver's names _____

Enumerator _____ Sungukate/dota name (not in control villages) _____

1. Check that you are talking to the primary caregiver that has been visited by the Sungukate/dota (not in control villages). The primary caregiver is the person who is mainly responsible for physically taking care of the children's needs (e.g. washing, dressing, feeding); not necessarily the breadwinner.) If the primary caregiver is not available, find out when they will be back and then move to the next house. If they are present, continue below.

2. Enumerator: Thank you for allowing me to talk to you. I would like to spend some time with you today, learning more about you, your children, and your household, what resources you have available and what challenges you might face. The interview should take no more than 2 hours of your time. lf there are any questions that you don't feel comfortable answering, just let us know and we will skip these. Do you have any questions?

How to find this house next time:

Do you agree to participate in this interview? Yes No

IF PARTICIPANT AGREES, PLEASE HAVE THEM SIGN OR MARK AN "X" BELOW:

_____ _____
PARTICIPANT WITNESS

If participant does not agree to participate, thank them for their time and end the inte

Cell phone number and name of caregiver interviewed or neighbour:

Firstly, are there children in this household between the ages of 18 and 48 months? (If not, then stop the interview, thank them and leave politely)

Selection of child to be done now by writing names on small pieces of paper and choosing one piece

Name of child being enumerated _____

Gender of child being enumerated _____

Date of birth of child being enumerated _____

Weight of child being enumerated _____kg

Height of child being enumerated _____cm

Here are some questions about the primary caregiver.

1.	Tick the box that best describes this primary caregiver:	☐ Mother ☐ Father ☐ Grandparent ☐ Extended family member ☐ Foster parent ☐ Older sibling ☐ Child-headed household ☐

		(i.e. no adult supervision) Other _____	
2.	What is the level of education of the primary caregiver? (E.g. Grade 4)		
Now I am going to ask you about the child aged between 18 and 48 months that we agreed we would talk about – this is the child we weighed and measured earlier.			
3.	Does the child have a birth record?		YES NO
	Does the child have an under-five card? May I see the card?		YES NO
	Consult under-five card if available: Has the children received all age-appropriate immunizations?		YES NO
	Consult under-five card if available: Does the child receive regular growth monitoring? (e.g. is weighed once per month?)		YES NO
	Does the child sleep regularly under a mosquito net?		YES NO
	Are play materials provided for the child (e.g. bowls, sticks, rocks, pots)		YES NO
4.	In the last 3 days did any household member over 15 years of age interact with the child in any of these ways?		For any YES answer below, also write down the name of the person who did this activity with the child.
	(a) Told stories		(a) YES NO
	(b) Sang songs		(b) YES NO
	(c)Took the child outside the home, compound or yard		(c) YES NO
	(d) Played with the child		(d) YES NO
	(e) Named, counted or drew things with the child		(e) YES NO
5.	THROUGH OBSERVATION ONLY: Does the primary caregiver caress, kiss or cuddle the children under 5 years during the visit?		YES NO

6. Now I would like to ask you about the types of foods that this same child ate yesterday during the day or night.

i. Any corn, bread, rice, or any other foods made from grains like millet, maize, rice, wheat	YES NO

[milho]? [add any other locally available grain]	
ii. Any white potatoes, white yams, cassava or any other foods made from roots or tubers? [mandioca]	YES NO
iii. Any dark, green, leafy vegetables such as cassava leaves, bean leaves, kale, spinach, pepper leaves, taro leaves, and amaranth leaves? [mocuna, canavalia, moringa]	YES NO
iv. Any other vegetables? [Write the names here]	YES NO
v. Any pumpkin, carrots, squash, or sweet potatoes that are yellow or orange inside? [batata doce e polpa alaranjada]	YES NO
vi. Any ripe mangoes, ripe papayas or [INSERT ANY OTHER LOCALLY AVAILABLE VITAMIN A-RICH FRUIT?	YES NO
vii. Any meat, for example, beef, pork, lamb, goat, rabbit wild game, chicken, duck, or other birds, liver, kidney, heart, or other organ meats?	YES NO
viii. Any eggs?	YES NO
ix. Any fresh or dried fish or shellfish?	YES NO
x. Any foods made from beans, peas, lentils, or nuts? [feijao buer, feijao nhemba, amendoim, gergelim]	YES NO
xi. Any cheese, yogurt, milk or other milk products?	YES NO
xii. Any foods made with or cooked in oil, fat, or butter?	YES NO

7. Sibling Study

Deleted in Endline -

8. Now I want to ask **you** some questions. You need to tell me what YOU think about these. You must choose from these answers in the boxes:

i. Most people in the community can be trusted.

strongly disagree	Disagree	agree	strongly agree

ii. I can rely on people in my community to help me if I can't provide my child with enough healthy food.

strongly disagree	disagree	agree	strongly agree

iii. I can rely on people in my community to help me deal with a violent or difficult family member.

strongly disagree	disagree	agree	strongly agree

iv. Most people in the community would take advantage of me if they got the chance.

strongly disagree	disagree	agree	strongly agree

9. How many adults do you know that you can trust to tell important things to? Write the number of those people in the box:

WHO SRQ 20
Read the following out loud to the caregiver. It is important that everyone taking the questionnaire follows the same instructions.

I have some questions for you about certain pains and problems that may have bothered YOU in the last 30 days. If you think the question applies to you and you had the described problem in the last 30 days, answer YES.

On the other hand, if the question does not apply to you and you did not have the problem in the last 30 days, answer NO.

Please answer these yourself - do not discuss them with anyone while you are answering.
If you are unsure about how to answer a question, please give the best answer you can.
We would like to reassure that the answers you are going to provide here are confidential.

1.	Do you often have headaches?	yes / no
2.	Is your appetite poor?	yes / no
3.	Do you sleep badly?	yes / no
4.	Are you easily frightened?	yes / no
5.	Do your hands shake?	yes / no
6.	Do you feel nervous, tense or worried?	yes / no
7.	Is your digestion poor?	yes / no
8.	Do you have trouble thinking clearly?	yes / no
9.	Do you feel unhappy?	yes / no
10.	Do you cry more than usual?	yes / no
11.	Do you find it difficult to enjoy your daily activities?	yes / no
12.	Do you find it difficult to make decisions?	yes / no
13.	Is your daily work suffering?	yes / no
14.	Are you unable to play a useful part in life?	yes / no
15.	Have you lost interest in things?	yes / no
16.	Do you feel that you are a worthless person?	yes / no
17.	Has the thought of ending your life been on your mind?	yes / no
18.	Do you feel tired all the time?	yes / no
19.	Do you have uncomfortable feelings in your stomach?	yes / no
20.	Are you easily tired?	yes / no

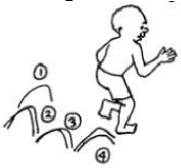
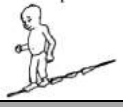
Hygiene and Safety Checklist

Fill this in by observing. Any gaps can be filled in by asking the main caregiver

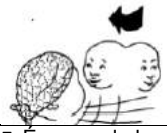
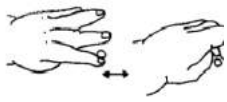
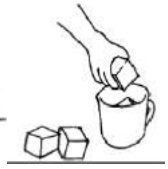
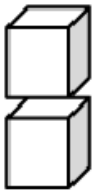
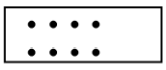
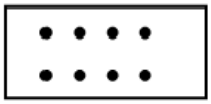
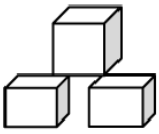
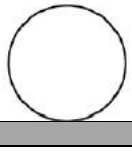
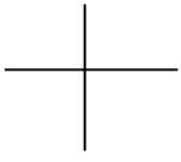
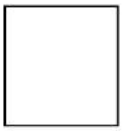
	1. Hygiene in the household (observe first, or ask the main caregiver)	**Yes**	**No**	**N/A**
A	Children always wash hands with soap and water before eating and after using the toilet.			
B	Adults always wash hands with soap and water after contact with faeces, and before handling food/ feeding children.			
C	Toilets/ buckets/ containers for human waste are covered.			
D	Water is collected in a clean container (if not on tap in household).			
E	Water is boiled before use (if not from a safe water source).			
F	Clean water is stored in covered containers.			
	2. Safety in the household (observe or ask the main caregiver)	**Yes**	**No**	**N/A**
A	All medicines, cleaning materials and poisons are kept out of the reach of children (e.g. insecticides, fertilisers, paraffin, bleach and other cleaning solutions, any medication).			
B	Children are not allowed to play in potentially dangerous areas (e.g. cooking areas, on or nearby a busy road, near a drain, near rubbish pits or toilets, or near electrical appliances or fires).			
C	Children are supervised by an older child not younger than 12 years or an adult at all times. (Supervision is defined as adults directly observing children as they play, and intervening where necessary to ensure safety).			
D	There are no potentially dangerous objects lying around the house where children are playing (e.g. Sharp objects, plastic bags, rusty materials, wire, buckets of water, matches, small object a child can suffocate on and machinery).			
	3. Safety in the household (observe or ask the main caregiver)	**Yes**	**No**	**N/A**
A	Children are kept away from boiling water, hot drinks, hot pots and pans, fires			
B	Injuries and emergencies are quickly and calmly assessed and immediate action is			
C	Children are kept away from paraffin lights			
D	Children are never left alone near water (baths, pools, dams or rivers).			
E	The caregiver does something/has a strategy to keep children safe from fire			
	TOTAL			
SCORE: (All the yes answers divided by all items scored)				

Now you must administer the MDAT on the child that you selected earlier AND after that, also the sibling of that child. There are two MDAT forms attached after this page.

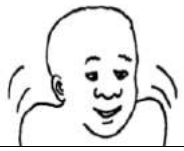
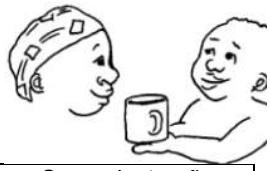
MDAT / MFAD
MFAD: MOTRICIDADE GERAL

1. Levanta o queixo do chão durante alguns segundos 	2. De bruços, consegue levantar a cabeça até 90 graus 	3. Segura a cabeça na vertical durante alguns segundos 	4. Faz força para se sentar sem balancear a cabeça para trás 	5. Levanta a cabeça, ombros e peito em posição debruçada 
6. Suporta o peso nas pernas 	7. Senta-se com ajuda 	8. Rebola de trás para a frente 	9. Senta-se sem ajuda durante um período de tempo mas não é capaz de o fazer sozinho durante um longo período de tempo. 	10. Senta-se bem sozinha 
11. Rasteja (de qualquer forma) 	12. Coloca-se na posição de pé / tenta levantar-se 	13. É capaz de ficar de pé se agarrada a objetos 	14. Caminha com o auxílio das duas mãos de outra pessoa 	15. Caminha com ajuda (usando a mão de alguém com se fosse conduzido ou uma peça de mobiliário) 
16. Caminha, mas cai por vezes 	17. Dobra-se e volta a levantar-se 	18. Caminha bem 	19. Corre, mas corrida básica - poderá cair algumas vezes 	20. Pontapeia uma bola numa direção / tenta pontapear uma bola 
21. Corre bem (com confiança), e consegue parar e recomeçar sem cair 	22. Ajoelha (como de forma respeitosa) e levanta-se sem usar as mãos 	23. Atira uma bola para dentro de um cesto (pelo menos uma vez em três tentativas) 	24. Corre, para e é capaz de chutar a bola alguns metros 	25. Salta do chão com os pés juntos 
26. Salta por cima de uma linha/fio no chão 	27. Fica de pé num pé só durante < 5 secs 	28. Caminha sobre os calcanhares 6 ou mais passos 	29. Salta sobre uma folha de papel (longitudinalmente) 	30. Caminha nas pontas dos pés 6 ou mais passos 
31. Pula num pé só sem apoio, quatro vezes seguidas 	32. Mantém-se de pé apoiada em um só pé - (5 segundos - 1 minuto) 	33. É capaz de atirar uma bola para o ar e agarrá-la com ambas as mãos 	34. Caminha sobre os calcanhares/pontas dos pés com um pé atrás do outro ao longo do fio demonstrando bom equilíbrio 	

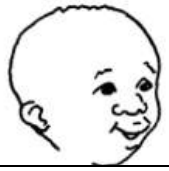
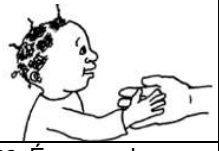
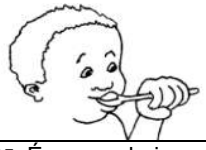
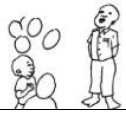
MFAD: MOTRICIDADE FINA & PERFORMANCE

1. Segue o rosto da mãe ou do tutor / objecto até à linha média 	2. Segue o objecto ou fixa e segue o rosto ou objecto brilhante com os olhos cerca de 180 graus 	3. Junta as mãos / tem consciência das mãos / coloca-as em frente aos olhos/boca 	4. Estende a mão para um objecto grande 	5. Quando segura objectos, tem a tendência de os colocar na boca 
6. Agarra um objecto grande 	7. É capaz de levantar do chão um objecto maior 	8. É capaz de ver um objecto pequeno 	9. Transfere objectos de uma mão para a outra 	10. Levanta objectos pequenos com quatro dedos em forma de ANCINHO 
11. Bate num objecto com outro de modo a imitar o examinador 	12. Encontra um objecto por baixo de tecido 	13. Com a mão em forma de pinça com o polegar e um dedo 	14. Coloca os blocos dentro e fora do copo em imitação 	15. Empurra um pequeno carro 
16. Coloca os blocos dentro da garrafa em imitação 	17. Despeja os blocos da garrafa propositadamente 	18. Rabisca num papel (rabisco direito) 	19. Rabisca num papel (rabisco circular) 	20. Torre de 2 blocos 
21. Coloca os pinos na placa em 2 minutos (< 2 min) 	22. Torre de 4 blocos 	23. Torre de 6 blocos 	24. Coloca os pinos na placa em até 30 segundos 	25. Desenrosca e enrosca novamente a tampa da garrafa 
26. É capaz de colocar 6 contas de cabelo num cordão de sapato (enfiá-las) 	27. Copia uma linha vertical (tal como desenhada pelo examinador) com carvão/giz no intervalo de 30 graus	28. Escolhe o pau mais longo por 3 vezes em 3 tentativas 	29. Levanta a caixa mais pesada 3 vezes em 3 tentativas 	30. É capaz de fazer uma ponte com blocos 
31. Faz uma boneca ou carro complexo a partir de barro 	32. Copia um círculo (precisa de ser completado) com giz or na areia com um pau 	33. Copia uma cruz com giz 	34. É capaz de desenhar um quadrado 	

MFAD: LINGUAGEM / AUDIÇÃO

1. Assusta-se ou salta/ responde a sons:	2. A vocalizar ou a fazer sons de forma alegre – não a chorar	3. Dá gargalhadas / ri 	4. Volta-se para a voz 	5. Usa monossílabos ou sons, por exemplo, Ma, Pa, Da, Ba
6. Responde ao seu nome, volta-se e olha para si 	7. Palreia palavras de 2/4 sílabas tais como dada, mama, mimi, tata, mas não especificamente para algo ou alguma pessoa	8. Entende quando está a ser avisada quanto a perigos, por exemplo, quando diz "não" a uma criança, esta pára ainda que por breves momentos 	9. Indica por gestos para dizer "Não". 	10. Segue instruções simples (1 etapa) 
11. Palavras incompreensíveis/tagarelar em frases - finge falar mas não faz faz qualquer sentido.	12. Diz 2 palavras, mas palavras para além de mama/dada:	13. Dizduas palavras juntas	14. Diz 6 palavras, mas palavras para além de mama/dada	15. Segue instruções com duas etapas
16. Identifica objectos no cesto (é capaz de lhe dar os objectos que nomeou) - pelo menos 5	17. Fala claramente em frases	18. Aponta para as partes do corpo: > 1 parte. 	19. Identifica e Diz os nomes dos 5 objectos no cesto	20. Sabe o seu nome próprio - e é capaz de o dizer
21. Sabe as acções dos objectos, por exemplo, "qual é que usas para varrer?"	22. Identifica objectos no cesto - pelo menos 10.	23. Identifica e Diz os nomes dos 10 objectos no cesto	24. É capaz de categorizar objectos	25. É capaz de seguir instruções com três etapas.
26. É capaz de lhe dizer a funcionalidade dos objectos.	27. É capaz de relembrar duas sílabas quando se repete à criança:	28. Sabe 2 de 3 questões relativas à compreensão de certos conceitos, por exemplo, O que fazes quando estás com fome?	29. Entende adjectivos tais como "mais rápido" ao responder "Qual é mais rápido: um carro ou uma bicicleta?"	30. É capaz de relembrar 4 sílabas quando se repete à criança:
31. É capaz de entender preposições e cumprir tarefas relacionadas com isto 	32. Compreende o conceito de opostos,	33. Sabe quantidades - até 3	34. Sabe quantidades - até 5	

MFAD: SOCIAL

1. Sorri, mas não para alguém em particular 	2. Sorri em resposta a uma pessoa 	3. Movimenta-se com a mãe ou prestador de cuidados 	4. Movimenta-se sozinho, brinca movimentando o corpo, esticando as pernas de forma alegre 	5. Reconhece ou acalma e sossega com prestadores de cuidados / familiares conhecidos:
6. Tira a mingau de uma colher, quando alimentado por um prestador de cuidados 	7. Ajuda a segurar no copo quando a mãe lhe dá de beber 	8. Indica que alguma forma que quer colo 	9. É capaz de segurar a colher com mingau mas não a leva bem à boca	10. Bebe correctamente de um copo sem derramar 
11. É capaz de indicar, apontando, que quer alguma coisa 	12. A criança é capaz de comer ao tirar de um prato nsima em pedaços feitos pela mãe	13. Estende as mãos para a mãe as lave 	14. É capaz de segurar a colher e comer a papa sozinho, mas derrama um pouco 	15. Indica de alguma forma que precisa de ir ao quarto de banho, por exemplo ao chorar, puxar as calças ou dizer algo:
16. Quer participar em jogos com canções	17. É capaz de cumprimentar tanto ao estender a mão como verbalmente 	18. Partilha coisas, incluindo comida com outros	19. Defeca ou urina autonomamente sem molhar as calças	20. É capaz de se alimentar sozinho com uma colher sem derramar 
21. É capaz de fazer os próprios pedaços de alimentos para colocar na boca	22. É capaz de se despir sozinho (despir apenas 1 item de roupa, tal como os calções) 	23. Quer ir visitar a casa de um amigo (mostra independência)	24. É capaz de ir ao quarto de banho sozinho em qualquer lugar 	25. É capaz de ingerir alimentos/ molhos com pedaços ou ossos:
26. É capaz de se vestir mas não completamente 	27. Lava bem as mãos sozinho antes / depois das refeições 	28. Sabe manter-se em silêncio em reuniões ou cerimónias importantes 	29. Executa tarefas domésticas ou ajuda o pai ou a mãe de uma forma útil	30. É capaz de se vestir totalmente sozinho 
31. Compreende o conceito de disciplina,	32. Jogar jogos à vez 	33. Sabe ser respeitoso para com os idosos	34. É capaz de ir ao quarto de banho/latrina sozinho 	

Appendix 3: Qualitative instruments

This appendix includes three different qualitative protocols

Impact study Focus group outline

Activity 1: Access to services (and social support networks)

1. Mapping. Draw their houses in the sand and show where do they go for advice about child rearing.

2. Ask them to put a flower or leaf on the map for where they have people they can go to talk to that they trust. Probe: social support

3. Show where the clinic is discuss how much they use the clinic for
Pregnancy Growth monitoring Illness Malaria

4. Show where they would go to register births – have they done this? Why? Why not?

Activity 2: Knowledge about food

Paper plates for different ages (pic of child of that age on the plate) and show with drawings what they give the children.

Talk about breastfeeding – for how long? Probe exclusive breastfeeding to 6 mths.

Activity 3: Caregiver emotional stress

1. Fill a basket with stones. It should be quite heavy. Place it in the middle of the discussion circle. Then ask one or two women to hold the basket. Say: "Sometimes in your life there are so many problems it is like a lot of stones come into your basket, making it very heavy."
2. Take the stones out of the basket. Tell the women: "These are the stones that some of us carry around. What can we call these stones?" They will begin to call out things like "no food", "feeling depressed", and so on. As they call out, write the labels on each stone and place it back into the basket.
3. Ask them: "Are those stones still there? Are you still carrying those worries? Is there anyone here who has been able to take some of the stones out of their basket?"
4. If they say some of the stones have been taken out, ask them: "Which stones were you able to take out? Who or what helped you to take them out?"
   Probe help with:
   i. Birth registration
   ii. Livelihood support
   iii. Health
   iv. Emotional problems e.g. family issues

Activity 4: Caregiving environment (play and language and stimulation)

What do you do with your child in a day?

1. Ask them to draw a timeline of their day on paper or in the sand to show whatthey do with children in their house who are under 5.
Probe: play, language, cognitive stimulation

Activity 5: Acceptance (positive discipline and responsiveness)
1. Talk about these situations
Francisco is 5 years old and his sister, Maria is 3. They were playing a jumping game in the kitchen area one morning when Maria fell over and knocked the table holding the drying plates. One of the plates broke. What would you do?

Paulina is 4 years old. On Sundays she goes with her mother to church. Her mother dressed her in clean clothes and told her to sit on the mat so as not to get dirty. She began to play with the chickens running after them and fell in the dust and dirtied her clean dress. What would you do?

It is January and Julia's husband Petros left yesterday to go back to his work in Johannesburg. The family has enjoyed a happy time while he has been home. Julia is sad and missing him already. Her twin boys of 4 are now fighting – they have been fighting all day - she just does not know what to do with them. What would you do?

Behaviour Change Research
Outline of focus group discussion and interviews
Workshop with Masungukate/dota August 2015

Activity 1: My job as a Masungukate/dota
Draw your house in the corner of the paper. Now draw all the houses you visit. Show me you walking to the houses:
Discuss:
What time of day do you visit?
How many times a week do you visit?
Tell me about the households you visit.
What is the best thing about being a Masungukate/dota?
What is the worst thing?
Mark the house that has changed the most since your visit. What changes have happened there? Why do you think they happened in that house and not at the others?
Mark the house that has changed the least. Why has there been so little change at this house?

Activity 2: The home visit
Look at the drawing of the Masungukate/dota making a home visit.
Discuss:
Why are we asking you to do this visiting?
What is happening during the visit to the caregivers?
What is the relationship between the Masungukate/dota and the mother?
What is the Masungukate/dota bringing to the mother?
Is the mother giving anything to the Masungukate/dota? (relationship, friendship)

Has the Masungukate/dota changed anything about how she interacts with the caregiver since she started visiting?
Has the Masungukate/dota changed anything about how she interacts with the children since she started visiting?
Draw a picture of a person and show their head (knowledge) and heart (emotional).
How much of what you do is for the head? For the heart? Show me with your hands – this much for head and this much for heart. Why not more for heart? Or why so much for heart?

Activity 3: Barriers to accessing services
Place caregiver figure on one side and then birth certificate and immunisation card and then medicine on other side
Tell me stories of how you have helped with referral to services?
What gets in the way?
Place small stones in between the caregiver and services
What are barriers to accessing services?
Can you as a Masungukate/dota overcome them?

Activity 4: Me before Masungukate/dota and after
Make two models with the clay. One must show "you before you became a Masungukate/dota" the second must show "you after you became a Masungukate/dota".
Discuss:
What personal changes have there been?
Have you changed your own parenting in any way? What?

Activity 5: Funhalouro – drought now (context) impact on their work
Discuss:
Do the caregivers need more heart now or more knowledge?
How does it affect what you do that you can't give practical help?

Interview with Masungukate/dota

Activity 1: My life story
Tell me more about you and your life. Explore the details of the small clay figures they made. Maybe do a drawn time line of their lives.
What in your life has helped you to be a good Masungukate/dota?
What in your personality has helped you to be a good Masungukate/dota?
What role has CARE played in making you a good Masungukate/dota – look at percentage of CARE and percentage of own self.
What stands in your way of being a better Masungukate/dota?

Activity 2: Your own behaviour change
Has anything changed in your house since you became a Masungukate/dota? Get details of what has changed.

Activity 3: Play
Show a child and caregiver figures
Why must the caregiver play with the baby?

Interview with caregiver

Activity 1: Who lives in my house?
Use the figures to make up the family.
Who lives in your house?
How long have you lived here?
Where did you live before?

Activity 2: Impact of Masungukate/dota visits
Two clay figures - me before Masungukate/dota visited and me after
Discuss/probe:
Social networks – a friend
Social capital – trust increased?
Emotional stress – reduced?

Activity 3: Change in behaviour in house
Has anything changed in your house since you the Masungukate/dota came to visit? Get details of what has changed.

Activity 4: Knowledge or emotional support
Draw a picture of a person and show their head (knowledge) and heart (emotional).
Is the Masungukate/dota giving you help here (head) or here (heart) which is she doing most? Show with hand scale.

Activity 3: Play
Show a child and caregiver figures
Why must the caregiver play with the baby?
Why must she sing to the baby? Talk to the baby?

Outline of research into "Maize Agreement" (Social Accountability approach - CSC)

Caregivers
Activity 1: Looking at what has changed since the Masungukate has been visiting me
Paper pieces and small drawings in a pile. Place them in circles.
Which changes were easy to make? Why?
Which were hard for you to make? Why?
What brought about each change? Why did you change?
Probe: The Masungukate herself, the knowledge you gained.
Are there still some things you would like to change?
Did you do anything else that made you think about what in your life needed to be changed? (Looking for reference to agreement)

Activity 2: The Maize Agreement meeting
I believe you have something called a "maize agreement" (Xivumelwane xa xifake). What is this thing? Why do you have it?

Do you remember the meeting when you made that agreement? Who was there? Who led?
Draw it for me on this large piece of paper.
What did you agree at this meeting?
This is a caregiver (use cut out figure) at the meeting. What is she feeling?
Do you remember other meetings that came after? (use paper to do quick drawings of these).
What happened at these meetings?
Do you remember the last meeting?
What did you agree should happen at your last meeting? Has it happened? Why/not?
Did the “maize agreement” help you to change anything?
Is the “maize agreement” a good thing? Why? Do the Masungukate like it? Why/not? Should we keep it?

Masungukate

Activity 1: Looking at what has changed in the lives of caregivers I work with since I have been visiting them

Paper pieces and small drawings in a pile. Place them in circles.
Which changes were easy for them to make? Why? Which were hard for them to make?
What brought about each change? Why did you change?
Probe: You, the knowledge they gained.
Are there still some things you would like them to change?
Did anything else make them think about what in their life needed to be changed? (Looking for reference to agreement)

Activity 2: What motivates you as a Masungukate?

Read this story
This is Maria Masungukate. She has lots of work to do every day in her fields as the rainy season is slow to come. She also has 4 children and an old mother. Some days she feels very tired. She is also a Masungukate. Most days she comes back from the fields, makes dinner and then sits to chat to her children. Then she has to get ready and do home visits.
How does she feel about this? Are you sure? (probe for motivation)
What motivates her to keep going?
Some of the caregivers are slow to change yet she still keeps going? Why?
Are there any meetings that help her to keep doing her work? (probe maize agreement)
People that motivate her?

Activity 3: The Maize Agreement meeting

I believe you have something called a “maize agreement” (Xivumelwane xa xifake). What is this thing? Why do you have it?
Do you remember the meeting when you made that agreement? Who was there? Who led the meeting?
Draw it for me on this large piece of paper.
What did you agree at this meeting?
This is a Masungukate (use cut out figure) at the meeting. What is she feeling?

Do you remember other meetings that came after? (use paper to do quick drawings of these).
What happened at these meetings? Do you remember the last meeting?
What did you agree should happen at your last meeting? Has it happened? Why/not?
Did the “maize agreement” help you to change anything?
Is the “maize agreement” a good thing? Why? Do the caregivers like it? Why/not? Should we keep it?