Pathways to Stronger Futures in Haiti: the role of graduation programming in promoting early childhood development

RESEARCH REPORT

Keetie Roelen, Sung Kyu Kim, Inka Barnett and Devanshi Chanchani

March 2019

Executive summary

It is widely understood that poverty undermines early childhood development (ECD). In turn, poor ECD reinforces the intergenerational transmission of poverty. Economic strengthening through comprehensive social protection may offer a 'double boon': it can improve child wellbeing in the short-term and reduce poverty in the long-run. This report presents findings from a mixed-methods study that investigated how so-called graduation programmes can affect outcomes for young children, particularly seeking insights into pathways, dynamics and contextual factors that underpin positive or negative linkages. It does so in a context of widespread poverty, low levels of child wellbeing and limited availability of services in rural Haiti.

The study focuses on the *Chemen Lavi Miyò* (CLM) programme, which is implemented by local organisation Fonkoze in the Central Plateau in Haiti. In line with the 'graduation approach', the programme provides a sequenced package of support that include cash stipends, asset transfers, access to savings and credit, training and tailored coaching. The programme focuses on women in extremely poor households who are able to work. It aims to support sustainable moves out of poverty.

The Nurturing Care framework forms the foundation for our investigation into the relationship between the programme and ECD. The Nurturing Care framework was developed in response to the urgency for improving outcomes for young children across the globe. Nurturing care constitutes a safe and enabling environment that allows for young children to develop and thrive. The framework identifies five domains of nurturing care, namely (i) health, (ii) nutrition, (iii) security and safety, (iv) responsive caregiving and (v) early learning.

Findings from our research show that the CLM programme helps to support ECD, mostly in the areas of health, nutrition and security. The programme contributes to improved food intake, sanitation practices and housing conditions, thereby supporting fewer occurrences of illness and lower risk of harm and injury. The programme plays a modest role in terms of responsive caregiving and early learning. Caregivers learn about the importance of communicating with babies and report talking and singing to them as well as soothing them when distressed. Nevertheless, early learning and responsive caregiving are generally limited, particularly when children start moving around and talking. Corporal punishment is common as is exposure to other types of violence.

Access to more economic resources, both provided directly by the CLM programme and generated through women's economic activities, is crucial for positive change. The availability of cash, access to community savings and lendings groups or being able to sell assets allows caregivers to provide for their children's basic needs. It also affords caregivers with sense of purpose and hope, which has positive effects on their own wellbeing and their relationships with their children. Training, continuous messaging and tailored advice create awareness about nutrition, sanitation and caregiving practices. The combination of the income and training-related components allow for a synergy effect and the opportunity to put advice into practice, and the subsequent experience in those practices affords evidence of its effectiveness and confidence in implementation.

However, positive effects come at a cost. The programme reinforces women's struggle to combine work with child care, often being forced to choose between leaving their children at risk at lower quality care and foregoing economic opportunities. Economic activities often take place away from home, such as trading at markets and working on farms, and women are unable to bring their children along. High levels of distrust means that support networks are often relatively small and women may

not find another trusted adult to look after their children, in which case they opt to leave them alone or in the care of other – often young – siblings or elderly relatives. They do this with great concern for their children and their wellbeing.

A number of dynamics appear crucial to the linkages between the programme and ECD.

Firstly, the CLM programme emphasises women's capabilities and agency in developing their own economic activities and creating greater financial independence. This positively shifts women's views of their own role in their families and communities. Yet they remain to be seen as being primary responsible for the provision of childcare, thereby reinforcing the juggling act of paid work and care. The CLM programme plays into this understanding by emphasising its members' responsibilities across work and care and leaving the issue of who provides care unchallenged.

Secondly, high levels of distrust, often grounded in spiritual beliefs and concerns about putting children at risk, limit opportunities for children to be left in the care of others. Programme participants often rely on a circle of close relatives, extended family members or neighbours for child care. Balancing work and care becomes very difficult to juggle, and opportunities to integrate community childcare options within programmes like CLM are limited.

Thirdly, strong relationships are vital for success within the programme, and for positive impacts on children. Strong spousal relationships are associated with greater economic success, and with better outcomes for children in all aspects of nurturing care. Strong ties with family and community members help to juggle the multitude of tasks related to work and care. The relationship with case managers is also key, with positive relationships instilling a sense of confidence and self-worth that makes it easier to absorb messages and change practices that are vital for ECD.

Ultimately, caregivers' economic security needs to be accompanied with the availability of quality basic services such as schooling and health services. This combination is crucial for ensuring a positive and supportive environment for children. Basic service provision is greatly lacking in rural Haiti with hardly any ECD services available. This limits the potential for programmes such as CLM to achieve nurturing care, particularly in health and early learning. This need is reflected in caregivers' aspirations for their children: while they wish for their children to obtain good jobs, they hold limited hope that they – as caregivers – are able to secure this future for their children.

It follows that graduation programmes like CLM can do more to harness and expand their effect on ECD, but that real progress towards reductions in intergenerational reduction of poverty can only be made through systemic change.

Policy recommendations include greater focus on messaging in relation to early learning and responsive caregiving; greater involvement of male caregivers in training and coaching; acknowledging the gendered juggling act of work and care; challenging programme narratives about gendered roles and responsibilities in providing child care; discussing and trying community child care options; creating greater linkages to services where available; and – crucially – keeping pressure on government to provide basic services and infrastructures.

Acknowledgements

This research would not have been possible without the valuable contributions of many. This includes members of the research team, including Deepta Chopra, Reginal Jules, Carmen Leon-Himmelstine, Micah Sherer, Sophie Valeix, Steven Werlin and Dilmurad Yusopov; members of the fieldwork and transcription team, including Mirline Artus, Ludès Dorcely, Jocelyn Dumay, Marilien Jean-Baptiste, Reginal Jules, Keketie Léopold, Heguel Mesidor and Elvoit Miracle; translators, including Piera Spinella Barrile, Swans Germain Paul and Chantal Joachim; and participants in the research design and analysis workshops at IDS in Brighton in January 2018 and September 2018. We thank Fonkoze and their team for their collaboration and willingness to investigate this issue. Finally, we are grateful for the women and their family members in Haiti sharing their stories with us.

This research was funded by the British Academy Early Childhood Development programme, as part of the Global Challenges Research Fund.

List of Acronyms

BCC	Behaviour Change Communication
BRAC	Bangladesh Rural Advancement Committee
CLM	Chemen Lavi Miyò
ECD	Early Childhood Development
FGD	Focus Group Discussion
HCW	Health Care Worker
KII	Key Informant Interview
NGO	Non-Governmental Organisation
REC	Research Ethics Committee
VAC	Village Assistance Committee
VSLA	Village Savings and Loan Association
WHO	World Health Organization

Table of Contents

Executive summary 2
Acknowledgements 4
List of Acronyms 5
1. Introduction 8
1.1. Conceptual framework 8
1.1.1. ECD and Nurturing Care 9
1.1.2. Graduation programmes 9
1.1.3. Pathways and linkages 10
1.2. Poverty and childhood in Haiti 10
2. Methodology 11
2.1. Sample 12
2.2. Data collection and analysis 13
2.2.1. Qualitative data 13
2.2.2. Quantitative data 14
2.2.3. Analysis 14
2.3. Limitations 15
3. CLM programme and study context 15
3.1. CLM programme 16
3.1.1. Selection of members 16
3.1.2. Social and economic development 16
3.1.3. Evaluation and graduation 18
3.2. Study sites 18
4. Nurturing care 20
4.1. Health 20
4.2. Nutrition 23
4.3. Security and safety 26
4.4. Responsive caregiving 30
4.5. Early learning 32
5. Pathways of impact 35
5.1. Income effect 35
5.2. Training effect 38
5.3. Synergy effect 40
5.4. Work and care trade-off 42

6. Cross-cutting themes 44
6.1. Identity 44
6.2. Relationships 48
6.3. Trust 50
6.4. Basic services and infrastructure 51
6.5. Aspirations for the future 53
7. Conclusion 54
8. Programme recommendations 56
References 57
Appendix 60

1. Introduction

It is widely understood that poverty undermines early childhood development (ECD). In turn, poor ECD reinforces intergenerational transmission of poverty. Economic strengthening through comprehensive social protection may offer a 'double boon': it can improve ECD in the short-term and reduce poverty in the long-run. Economic strengthening may counteract risk factors in child development, such as undernutrition, maternal depression, poor caregiver-child relationships and violence (Engle et al. 2007; Walker et al. 2007, 2011). This in turn can break the intergenerational cycle of poverty and improve outcomes into the future.

A relatively new wave of programmes aiming to promote economic strengthening by offering a comprehensive package of support, including a combination of cash and asset transfers, access to savings and credit, and coaching and support, have spread across the globe in the past decade. Graduation programmes are now being implemented in more than 43 countries (Partnership for Economic Inclusion, 2018). These programmes are premised on the understanding that people living in extreme poverty require a big push to move them out of poverty in a sustainable manner, in order to 'graduate' from poverty (Devereux and Sabates-Wheeler 2015). They are therefore also referred to as 'graduation programmes'.

Rigorous evaluations of graduation programmes showcase positive impacts on consumption, assets and food security (Banerjee et al. 2015). However, evidence about the linkages between economic strengthening and child development is relatively thin and underlying mechanisms are poorly understood (Britto et al. 2013; Ellis and Chaffin 2015; Ssewamala et al. 2014). Yet securing children's development is crucial for poverty reduction to be intergenerational.

In light of the existing evidence gaps, the main question underpinning this study is:

> ***To what extent and how can economic strengthening through comprehensive social protection improve ECD at present and thereby break the intergenerational cycle of poverty*?**

We aimed to answer this question by focusing on the *Chemen Lavi Miyò* (CLM) programme in the Central Plateau region in Haiti. It is implemented by local organisation Fonkoze and targets women from extremely poor households, supporting them over a period of 18 months through a carefully tailored package of cash and asset transfers, skills development, coaching and service provision.

The objectives of this study are to: (i) obtain nuanced understandings of the pathways from economic strengthening to ECD, (ii) learn practical lessons about how comprehensive social protection can contribute to ECD, and (iii) inform policy and practice debates in Haiti and across the Global South on mutually reinforcing linkages between ECD and poverty reduction.

1.1. Conceptual framework

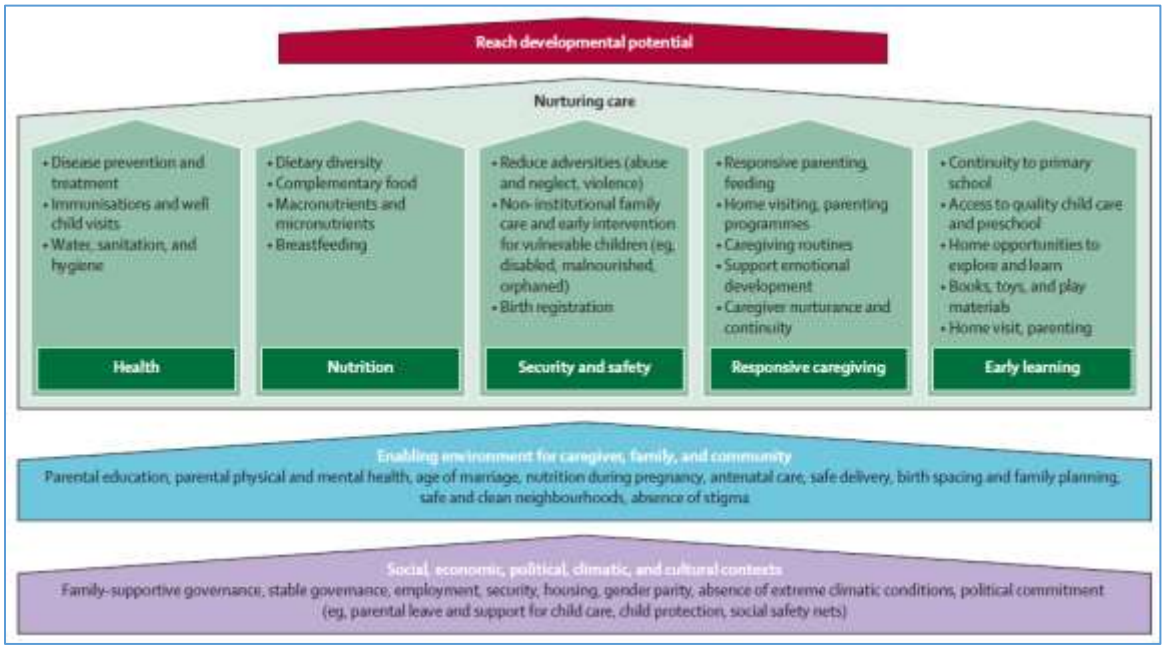
This research is grounded in understandings of ECD and the potential role of economic strengthening through comprehensive programming in promoting ECD. We use the relatively new Nurturing Care framework, which offers a holistic approach towards creating an enabling environment for children in support of their biological, cognitive and emotional development during infancy. Finally, we also build on work on graduation programming and child-sensitive social protection to frame linkages between programme participation and ECD.

1.1.1. ECD and Nurturing Care

Nurturing care has been defined as "a stable environment that is sensitive to children's health and nutritional needs, with protection from threats, opportunities for early learning, and interactions that are responsive, emotionally supportive, and developmentally stimulating" (Lancet, 2016). Nurturing care is about establishing the conditions that promote healthy development for young children and is therefore about children, their caregivers and the places where they interact (WHO, 2018). The framework identifies five domains of nurturing care, including (i) health, (ii) nutrition, (iii) security and safety, (iv) responsive caregiving and (v) early learning (Black, Walker et al. 2017).

As highlighted in Figure 1, positive outcomes in these domains need to be underpinned by supportive family and community environments. Conducive social and economic contexts are crucial for ensuring positive outcomes in early childhood development (ECD). Social protection services are considered to be part of the package of core interventions that can support children and their families throughout the life course in creating supportive and conducive environments (Richter, Daelmans et al. 2017), in part because of their direct impact on economic resources within the family (Engle, Fernald et al. 2011). Graduation programmes can be understood as a type of comprehensive social protection intervention.

Figure 1 Nurturing Care framework



Source: Black et al. 2017: 79

1.1.2. Graduation programmes

Graduation programmes have become an increasingly popular instrument in the development toolkit with interventions currently being implemented in more than 43 countries worldwide (Partnership for Economic Inclusion, 2018). Graduation programmes are based on the premise that extremely poor households require a big push in order to set in motion a positively reinforcing cycle of income generation and asset accumulation (Carter and Barrett 2007). Programmes therefore deliver a comprehensive mix of sequenced support, commonly including five components: (i) consumption support, (ii) asset transfers or seed capital, (iii) access to savings and credit, (iv) training and technical skills and (v) coaching and mentoring (Hashemi and Umaira, 2011; Partnership for Economic Inclusion, 2018). The programme's underlying rationale suggests that the combination of components and their mutually reinforcing synergies lead to positive and sustainable impacts on poverty.

Despite their fairly recent introduction, programmes have been applauded for their success in moving people out of extreme poverty (Devereux and Sabates-Wheeler 2015). A cross-country evaluation of six programmes showed positive impacts on many household-level outcomes, including consumption, asset holdings and food security (Banerjee, Duflo et al. 2015). However, effects on individual members and children remain mostly unexplored. A comprehensive literature review of the impact of graduation programmes, or economic strengthening programmes with at least three of the five components that are included in graduation programmes, shows that evidence is limited and experiences are mixed (Roelen et al. forthcoming).

1.1.3. Pathways and linkages

Based on previous research on cash transfers, social protection and graduation programmes, we identify four pathways through which graduation programmes may interact with childhood development, and contribute or undermine domains of nurturing care.

1) ***Income effect***: the availability of more cash can *directly* improve food security and dietary diversity, and access to health and education services (Bastagli, Hagen-Zanker et al. 2016, de Groot, Palermo et al. 2017) and *indirectly* improve child-caregiver relationships and improve caregiving practices through greater mental health and reduced poverty-induced stress (Roelen, Delap et al. 2017, Owusu-Addo, Renzaho et al. 2018);

2) ***Training effect***: intensive training and coaching by dedicated case managers can improve knowledge and may change caregiving practices (Barrientos, Byrne et al. 2014);

3) ***Synergy effect***: the combination of income-related support with provision of training and coaching lead to mutually reinforcing effects that can reinforce positive change and contribute to sustainability of impacts (Roelen and Devereux 2018);

4) ***Work and care trade-off***: an increase in economic activity for female caregivers can lead to a gendered increase in the combined burden of paid and unpaid work, thereby presenting a trade-off between economic gains and caregiving practices (Roelen 2015, Chopra and Zambelli 2017).

These pathways also arise from research in the specific area of nutrition. The first and fourth pathways are highlighted in research on linkages between women's engagement in agricultural work and nutritional outcomes (Rao, Gazdar et al. 2019). Higher incomes as well as more direct access to or lower costs of nutritious foods as afforded through agricultural work and economic empowerment contribute to nutritional improvements. However, additional demands on women's time and physical energy undermines their own health and nutrition as well as the ability to provide quality care for their children. Evidence is now also well-established that training matters; behaviour change communication (BCC) - i.e. advice and awareness about feeding practices – can improve nutritional outcomes for children (Fabrizio, van Liere et al. 2014). Finally, the power of the synergy effect emerged in relation to programmes that offer cash transfers and BCC, finding most significant impacts on nutrition when these components were combined (Ahmed, Hoddinott et al. 2016).

1.2. Poverty and childhood in Haiti

Haiti is the poorest country in the Americas and one of least developed countries in the world, ranking 163rd (out of 188) based on the 2016 Human Development Index (UNDP 2017). Poverty is widespread: in 2012, 60 percent of Haitians lived under the national poverty line of $2.42 per day (World Bank 2017), one in four Haitians experienced extreme poverty with less than $1.23 per day (ibid), and half of the population experienced multidimensional poverty (OPHI 2017).

Haiti has a young population. According to the Demographic and Health Survey 2016/7, over a third of the population are younger than 15 years old and 43 percent of the population is under 18 (IHE and ICF 2018). Deprivation among children is widespread, particularly in terms of nutrition, health and education. More than 20 percent of the children under five are stunted (IHE and ICF 2018), meaning that children suffer growth retardation as a result of long-term nutritional deprivation (WHO 2010). While the large majority of mothers breastfed their babies, the proportion of exclusive breastfeeding is low (IHE and ICF 2018). With respect to health, two-thirds of children aged 6-59 months were anaemic (USAID 2014). Haiti has one of the highest rates of infant mortality rates in the world, with a neonatal mortality rate of 25 per 1,000 births in 2011 (Cianelli, Mitchell et al. 2014). In 2012, nearly one in 12 children died before reaching the fifth year (IHE and ICF 2018). Primary school enrolment stands at 85 percent but quality of education is low and fees present high barriers to education for the poorest households (USAID 2017).

High poverty levels and poor outcomes for children interact with high levels of gender inequality. Haiti ranks 142nd based on the UN's Gender Inequality Index (UNDP 2017) with women being less likely to receive education or to be part of labour force. One in three women experience physical or sexual violence (USAID 2017). Only a small minority of women receive pre- or post-natal healthcare, in part because of lack of accessible and quality health services such as healthcare workers (HCWs), particularly in rural areas (Cianelli, Mitchell et al. 2014).

Traditionally, child care in Haiti can be best understood through the *lakou* system. *Lakou* is the traditional rural family structure in Haiti where a group of dwellings are occupied by a single family but also by extended families living under the authority of a family chief (Bastien 1985, cited in Lamaute-Brisson 2010). The *lakou* system has drastically reduced from its original form and extent, however. Extended family relations and networks remain crucial for young mothers for child care support when they are away from home working (Lamaute-Brisson 2010).

Mothers carry primary responsibility for looking after children. Fathers are less involved, but their inputs are not negligible (Schwartz 2000). A study on parental engagement in child care shows that fathers play with their children, check their homework, and take them to the health centre (Schwartz 2000, cited in Lamaute-Brisson 2010). It is also common for fathers in the rural areas to stay at home to look after children when mothers have to go to the markets for trading (Devin and Erickson 1996, Menon, Ruel et al. 2002). A study conducted in the Central Plateau in 2003 revealed that in most instances, however, work-away mothers would find female caregivers who are also relatives before resorting to their spouse or other male caretakers (Menon, Ruel et al. 2002). Moreover, large proportions of caregivers were younger than 15 or older than 50 years of age, indicating the significant role of older siblings and grandparents in provision of care (Menon, Ruel et al. 2002, cited in Lamaute-Brisson 2010). Child care is also often shared. According to the 2001 Household Living Condition Survey (IHSI 2005), a majority of the children under five living in rural areas (72 percent) were under the care and supervision of two or three caregivers (Lamaute-Brisson 2010).

2. Methodology

The study's methodology is based on an interdisciplinary and mixed-methods approach. It combines in-depth primary qualitative data with secondary monitoring and quantitative baseline survey data.

2.1. Sample

Data was collected in three sites where the W.K. Kellogg Foundation (WKKF) cohort of the CLM programme was implemented[1]. The selection of research sites within this region is guided by their degree of remoteness. Site 1 La Chappelle is deemed to be least remote, Site 2 Mache Kana to be moderately remote and Site 3 Mable to be very remote. A further description of the sites follows in section 3.2 below.

Data collection centred on 24 case studies of female CLM members, their children and wider family. In each site, eight case studies were selected on the basis of them having at least one child under the age of five and seeking a degree of heterogeneity across the sample in terms of age, spousal relationships and progress in the programme. At the time of data collection, women had been participating in the programme for approximately 10 months. The selection of case studies and invitation to participate in the research was undertaken by CLM programme staff. Table 1 provides an overview of the case studies, also indicating who else was interviewed as one of the children's main caregivers, and the code that is used in the text to denote this particular case study.

Table 1 Overview of case study respondents

site	pseudonym	age	other adult carer	age	# children in household	# children <5	code
La Chappelle	Darline	25	Spouse	25	5	3	LCCSCLM2-1
La Chappelle	Rachelle	24	Spouse	25	1	2	LCCSCLM2-2
La Chappelle	Judeline	28	Sister	35	5	2	LCCSCLM2-3
La Chappelle	Angeline	41	Spouse	50	4	4	LCCSCLM2-4
La Chappelle	Esther	36	Spouse	40	3	1	LCCSCLM5-1
La Chappelle	Vanessa	22	Spouse	40	3	1	LCCSCLM5-2
La Chappelle	Jessica	23	Brother	18	1	1	LCCSCLM5-3
La Chappelle	Madeline	23	Spouse	26	2	2	LCCSCLM5-4
Mache Kana	Marie	22	n/a	n/a	1	1	MBCSCLM2-1
Mache Kana	Gaelle	30	Spouse	69	3	1	MBCSCLM2-2
Mache Kana	Jenniflore	20	Spouse	24	3	1	MBCSCLM2-3
Mache Kana	Fabienne	27	Spouse	27	4	2	MBCSCLM2-4
Mache Kana	Nadia	26	Spouse	36	2	2	MBCSCLM5-1
Mache Kana	Kimberly	23	Spouse	29	1	2	MBCSCLM5-2
Mache Kana	Farah	25	Spouse	28	2	1	MBCSCLM5-3
Mache Kana	Manoucheca	42	Spouse	38	5	2	MBCSCLM5-4
Mable	Rose	24	n/a	n/a	0	1	MKCSCLM2-1
Mable	Medjine	38	Spouse	42	4	1	MKCSCLM2-2
Mable	Samantha	20	Mother	70	2	3	MKCSCLM2-3
Mable	Esterline	21	Spouse	33	2	2	MKCSCLM2-4
Mable	Nephtalie	31	Spouse	33	2	2	MKCSCLM5-1
Mable	Jesula	22	Spouse	28	2	1	MKCSCLM5-2
Mable	Fredeline	45	Spouse	45	5	1	MKCSCLM5-3
Mable	Guerlande	20	Spouse	22	2	2	MKCSCLM5-4

[1] This cohort includes 750 members and is funded by the W.K. Kellogg foundation.

In each site, additional data was collected through focus group discussions (FGDs) with CLM members and their family members, and community members, key informant interviews (KIIs) and group conversations with CLM case managers, and observations of interactions between CLM case managers and CLM members. These were complemented with cross-site interviews with CLM supervisors and management staff. Tables A1 and A2 in the Appendix provide an overview of all FGD and KII respondents, amounting to a total of 215 research respondents.

2.2. Data collection and analysis

The mixed methods approach underpinning this study includes primary qualitative data and secondary quantitative data.

2.2.1. Qualitative data

Primary qualitative data collection was grounded in participatory approaches and wide range of fieldwork activities was undertaken to elicit views, opinions and experiences across respondent groups. These include family mapping, daily activity clock, body map, programme component scoring and community mapping exercises at individual and group levels respectively. Table A3 in the Appendix outlines the various activities that were included. Research activities were co-constructed and developed during a multi-stakeholder research design workshop in January 2018. Fieldwork instruments were tested in February 2018 and data was collected in March and April 2018.

Picture 1 Fieldwork with body mapping and programme component scoring exercises (©K. Roelen)

All data was collected by a team of eight fieldworkers, who received extensive training prior to fieldwork and supervision and guidance during fieldwork in the first research site. The fieldwork team was led by a separate research and monitoring unit within Fonkoze. All activities were transcribed in separate documents Haitian Creole, and all transcripts were subsequently translated from Haitian Creole to English.

This research was approved by the Research Ethics Committee (REC) at the Institute of Development Studies. Key elements of ensuring adherence with principles for ethical research included ensuring that participants provided informed consent, ensuring that research participants felt at ease at their location of interview, handling data securely and anonymising data before starting data analysis.

2.2.2. Quantitative data

Two types of quantitative data were included, namely one-off survey data and continuous monitoring data.

This research took place in the middle of an ongoing quantitative evaluation of the WKKF cohort of the CLM programme. The two-year evaluation started in May 2017 and has an experimental design for estimating attributable impacts of the programme on child wellbeing and development. This timing allowed for the use of the baseline survey data to inform design and analysis. The baseline report and survey data offered contextual information (see Roelen and Müller, 2018[2]) and was used to support the analysis of individual case studies. The sample for the newly qualitative data is a sub-sample of the quantitative baseline data.

Data also included two waves of monitoring data, which was collected at baseline and after six months of participation in the programme. This provided insight into CLM members' family situation, and most crucially the number of children and their ages, the assets that they received and the progression that they made in the first phase of the programme. Based on indicators such as increase in assets and housing conditions, members are identified as either fast, slow or 'slow slow' climbers.

2.2.3. Analysis

This study combines thematic and case study analysis using all data available.

Thematic analysis was undertaken using a structured coding scheme. The scheme was developed during a research analysis workshop in September 2018 and grounded in conceptual frameworks and themes that emerged during fieldwork and first reading of transcripts. Top-nodes included components of the nurturing care framework (i.e. nutrition, health, safety and security, early learning and responsive caregiving), hypothesised pathways (e.g. income effect, training effect) as well as thematic categories such as paid work, unpaid work and aspirations for children. See Table A4 in the Appendix for the complete list of the coding framework. Coding was undertaken by three research officers using NVivo, working together to ensure consistency across.

Case study analysis focused on six out of 24 case studies. Additional data for these six case studies was collected in November 2018. Selection of case studies took place during the research analysis workshop, with workshop participants reading through transcripts for all 24 case studies and selecting two case studies per site based on criteria of heterogeneity (e.g. ensuring that the set of case studies

[2] More information about the baseline survey data, its sample and how it was collected can be found in the baseline report: https://fonkoze.org/assets/clm-baseline-study_ultra-poor-children_sept-2018.pdf

reflected experiences across age and progress in the programme) and detail of information. Each of the case studies centred on the women but also included interviews with another main caregiver and holding her children as central to the research. All available quantitative and qualitative data for each case study were combined, providing detailed insight into demographic characteristics, details of programme participation and areas of interest for this research.

2.3. Limitations

The most notable limitation of this study pertains to the lack of children's voices. This study did not directly include children and relies on caregivers' perceptions of children's wellbeing and the role of the programme. This inevitably leads to a partial picture at best and a biased story at worst. Information with respect to issues such as violence or caregiver-child relationships is particularly limited. This challenge has been partly counteracted by the use of a wide set of data collection activities, providing information on the basis of direct responses by caregivers but also observation and information from community members and programme staff. This allowed for a degree of triangulation and deepening of findings.

A related limitation refers to this study depending entirely on subjective data and caregivers' perceptions regarding childcare practices and changes in such practices as a result of the CLM programme or other events. While such data is powerful for gaining insight into how care for children is experienced, it may not provide accurate information about actual behaviour and behaviour change. Findings with respect to practices and outcomes, particularly in areas of nutrition and health, should therefore be interpreted with caution.

Another limitation includes the lack of a comparison group. While this study does not aim to directly attribute changes to the programme or draw comparisons to those not included in the programme, the lack of a comparison inevitably limits the ability to assess whether certain findings are exclusive to CLM members and their children or hold more widely. In this study we opted for depth of information as opposed to breadth across programme and non-programme populations. Comparative analysis and attribution of impacts is the focus of the quantitative impact evaluation study, which will be completed in the second half of 2019. This study will serve as crucial input in interpreting impact evaluation findings.

3. CLM programme and study context

The *Chemen Lavi Miyò* (CLM) programme is implemented by *Fondasyon Kolè Zepol*, or Fonkoze. Fonkoze is a non-profit organisation that is part of a family of organisations who share, as their mission, to provide financial and developmental services to empower Haitians –primarily women – to lift their families out of poverty. Since its founding in 1994, Fonkoze established branches across the country becoming Haiti's largest microfinance institution (Fonkoze 2019). Over the years, it found that even the smallest loans and financial services that Fonkoze could offer are beyond the reach for the ultra-poor (Fonkoze 2019). To bridge this gap, Fonkoze initiated CLM, which is a local adaptation of the Bangladesh Rural Advancement Committee's (BRAC) graduation programme. Participants in the CLM programme – so-called CLM members – go through an intensive 18-month process of building skills and assets to basic needs and achieving greater livelihood outcomes upon completion of the programme, and graduation.

3.1. CLM programme

The CLM programme targets women from extremely poor households with dependents but who are able to work, helping them onto a 'pathway to a better life'. It supports them over 18 months through a carefully tailored and sequenced package of cash and asset transfers, skills development, coaching and service provision. The programme follows three stages: (1) selection of members, (2) social and economic development, and (3) evaluation and graduation. We provide a summary of each stage of the programme (based on Werlin 2018).

3.1.1. Selection of members

Selection is an elaborate four-step process including social mapping, participatory wealth ranking, preliminary selection and final verification. Social mapping and participatory wealth ranking exercises aim to categorise a group of 50-100 households across five wealth categories; those in the bottom two categories are deemed potentially eligible for the programme. Case managers undertake preliminary selection by surveying the households identified as well as looking out for community members that may not have been mentioned (including individuals with disabilities). Main criteria for preliminary selection include (1) food security and hunger in the household, (2) housing conditions and ownership, (3) sources of income and possession of assets, and (4) family situation, including number of children and whether they attend school. A process of final verification involves a home-visit by programme management staff and an open-ended conversation with the potential member, seeking to understand her life and to determine whether she needs the supports that CLM offers.

Selected members are officially invited into the programme during a visit by the case manager. The case manager will introduce the programme and ask whether the members wish to participate. If they agree, they are then invited to the initial six-day training workshop. During this training, CLM staff lay out options in terms of income-generating activities that the programme can support such as livestock (goat, poultry and pig) rearing, commercial trading, and agriculture. New members learn about the benefits and costs of each enterprise, the inherent and potential risks involved, and the factors for consideration given their current circumstances. Members choose their preferred two activities after consultation with the case managers.

The official start of the programme is marked by a launch ceremony, which is both a celebration as well as a formal occasion as members sign a contract with the CLM programme. The contract stipulates that members will seek to protect the assets that they receive through the programme and show goodwill in working with CLM staff. They also receive a picture ID with which they can use it at the Partners in Health hospitals for free consultation and treatments.

3.1.2. Social and economic development

In the first few weeks after the launch ceremony, members receive their **asset transfer**. Depending on the selected business and livelihood activities, this transfer will consist of livestock such as poultry, goats and pigs or other materials.

During the first six months of the programme, members also receive a **weekly stipend** of 350 Gourdes (roughly USD 4). This stipend is paid by the case managers during each visit.

Women are encouraged to save money from their weekly stipend in the first six weeks of programme implementation, and from their earnings afterwards. All members are mobilised to save in a ***sól***, which is a traditional community savings group whereby members contribute regularly with one member receiving the whole pot at every contribution. In addition, groups also act as **Village Savings and Lendings Associations** (VSLA). VSLAs gather about 20 to 30 neighbours in one area, and each week, a

member can purchase one to five shares at a price per share determined by the group. The pooled amount of shares sold to members effectively become a loan fund, in which members can take out loans at an agreed interest rate. Members are also encouraged to create a savings account at the nearest Fonkoze office, but few make use of this opportunity.

Members receive weekly **home visits** by case managers. Case managers usually support 50 women, using motorbikes to get around. Case managers visit the members at home to observe their living conditions, discuss progress towards the business goals and discuss health and hygiene related messages. During each home visit, case managers will discuss two messages, which they rotate and then repeat again after a full rotation of six weeks. These messages include the following topics:

1) Clean water;
2) Family planning;
3) Considerations of childbearing at a young age;
4) Sexually transmitted diseases;
5) Pre- and post-natal care;
6) Sanitation and hygiene;
7) Cholera;
8) Parasitic infections of the gastrointestinal tract;
9) Vitamin A;
10) Vaccination;
11) Healthy diet and eating habits;
12) Early child development (mainly focused on the importance of talking with babies and infants).

The visit will be completed with a conversation about plans for the coming week and longer future. After 12 months, the case managers alternate home-visits with visits in small groups of neighbouring CLM members. Besides building social bonding and support network, the group visits also help prepare members to organise and run *sól* and VSLAs on their own once the programme terminates.

CLM members (and sometimes their spouses) participate in three-day **trainings** every three months. The content of these trainings is similar to the initial six-day training, but increasingly involves members in leading discussions. The objective is to build confidence by letting the women express their opinion and share their lessons with others in a positive and safe environment.

Members receive **material and other support** to improve housing and sanitation conditions. Members receive materials to improve their housing conditions and tailored support with construction of a pit latrine. The CLM programme provides a ceramic **water filter** and jug at the start of the programme and promotes other water treatment methods such as boiling and sunlight exposure.

Child **malnutrition** is common in rural areas, and the CLM staff are trained to recognise the signs of severe and acute forms of malnutrition. The team includes a licenced nurse, who screens all children under five for signs of malnutrition. Once detected, they refer the children to the nearest clinics for proper diagnosis and treatment with fortified therapeutic foods.

Finally, Fonkoze establishes **Village Assistance Committees** (VACs) to offer supervision and support in absence of case managers and to manage any tensions between beneficiaries and community members who are not part of the programme. Ideally VACS consists of two CLM members, one case manager, and eight community leaders or local officials. VACs meet once a month and deal with outstanding issues that require conflict mediation or general support.

3.1.3. Evaluation and graduation

The CLM programme collects four rounds of monitoring data on its members at six-month intervals. The survey instruments used for data collection differ in focus, particularly in the first three rounds, but collect information about assets, income generating activities, home repairs, and take up of advice by case managers. Members also hold a so-called 'pink book' in which the case managers keep record of cash stipends, assets, housing materials and other support received as well as home-visits, advice and follow-up provided by case managers. Since 2017, Fonkoze is also rolling out a digitised system that allows for improved data management and more real-time monitoring.

All CLM members graduate after 18 months of programme participation, which is marked by a celebratory graduation ceremony. Members receive a certificate of graduation, and often invite family members and friends to the ceremony.

Previous studies have demonstrated that the CLM programme leads to positive results for beneficiaries (Huda and Simanowitz, 2009; Pain et al, 2015). For example, 93 percent of beneficiaries having participated in the first pilot met the graduation criteria at the end of the 18-month programme period with 92 percent of beneficiaries operating at least two income generating activities. (Huda and Simanowitz, 2009). Whilst the intra-distributional allocation of increased income can be expected to benefit children at least proportionately, more evidence is needed. For example, severe malnutrition among children appeared to be eradicated among all beneficiary households participating in the first pilot of the CLM programme (Huda and Simanowitz, 2009).

3.2. Study sites

The study sites of La Chappelle, Mache Kana and Mable are all located in or adjacent to the Central Plateau in Haiti. The three sites represent different levels of remoteness, with La Chappelle being most accessible (close to a main road), Mache Kana being fairly accessible along a river bed, and Mable being a very remote mountainous area. It should be noted, however, that the degree of remoteness of CLM members within these sites can differ considerably as communities are spread out and the landscape can change dramatically at a short distance. Figure 2 situates the study sites within Haiti. They are all located in (relative) vicinity of Mirebalais, which is where the Fonkoze field office is located and from where the programme is implemented.

Figure 2 Map of Haiti – situating study sites (source: https://www.nationsonline.org/oneworld/map/haiti_map.htm)

Figure 3 presents a seasonal calendar that maps how agricultural activities, food availability and other elements of daily life change over the course of the year. The calendar is based on conversations with community groups in each of the sites, and offers a colour-coded overview of seasonal differences across sites with green, yellow and red representing good, moderate and bad situations respectively. There are strong overlaps between sites but also differences due to their distinct geographical locations. Any notable differences across sites are noted in the discussion below.

Figure 3 Seasonal calendar of study sites in and adjacent to Central Plateau

	January	February	March	April	May	June	July	August	September	October	November	December
Weather	Dry Period				Rain		Rain and Storms				Dry Period	
Agriculture	Prepare Soil/Planting		Planting		Weeding		Harvest/Planting			Harvest		
Work	Ample Work								Seasonal Migration			
Food	Average Food Availability		Limited Food Availability		Hunger		High Food Availability		Average Food Availability		High Food Availability	
Market Prices	Average Prices		High Prices				Average Prices		High Prices	Low Prices		
Health	Respiratory Disease		Cold/Respiratory Disease		Malnutrition/Anemia/ Cholera		Cholera		Flu and Fever		Flu and Fever	
Festivals/School	Catholic Festival			Protestant Festival		School Vacation					Church Festival	Voodoo Festival

Weather patterns are mostly similar across study sites, with limited rainfall from January to April and rain and storms roughly from June to October. Despite Haiti's tropical climate, temperatures drop considerably in the mountainous site of Mable in the period from October to December, especially at night.

Agricultural activities take place throughout the year, but the types of activities and crops that are cultivated differ by season. Preparation of land mostly takes place from January through to April, during which crops such as manioc, black beans, pigeon peas and corn are planted. Beans tend to be the first crop to be harvested, mostly taking place in July and followed by planting of a new crop in August. Harvest of beans takes place in July, with a new crop of beans being planted again in August. Corn is harvested in September and October, and pigeon peas are harvested in November and December. Fruit such as mangoes and breadfruit are mostly available from May to July, particularly in Mache Kana. Perennial crops include sugarcane and plantain. Millet used to be an important crop in the whole area but it is no longer being cultivated due to disease.

In terms of **food availability**, this means that food is in abundance from August to December, starts to get more restricted from March onwards and is very scarce in May and June prior to first harvests. Market prices are also highest in the lean period from April to June. This does not imply that the period from September to November is an easy one; the high supply of food means that prices are low and that it is a challenge to sell produce and earn an income.

Patterns of **work** activities are strongly associated with the cycle of agricultural activities; work on the fields is widely available from January to August but becomes scarce from September to November before picking up again in December. Seasonal migration to other communities or Dominican Republic in search of work is most prevalent from September to November. Other main economic activities such as charcoal production and petty commerce are undertaken throughout the year.

Occurrence of **disease** is highly associated with weather patterns and availability of food. The hungry period leads to anaemia, and cholera occurs mostly during the rainy season. In Mable, outbreaks of disease are most common in the period from September to December due to corn being the only staple available from September to October and the severe cold from October to December. The dry period was said to lead to colds and respiratory disease due to the dust.

4. Nurturing care

This section presents findings in relation to the five components of nurturing care, exploring current practices and linkages to the CLM programme. It should be noted that findings about programme effects are based on respondents' perceptions and experiences of change as opposed to measurable effects. Where possible, qualitative findings are complemented with quantitative data from the 2017 baseline survey.

4.1. Health

Following the Nurturing Care framework, we consider disease prevention and treatment, immunisation, and water, sanitation and hygiene, and the role of the programme in these.

Poor health is widespread among children of CLM members in the WKKF cohort. Findings from the baseline survey in 2017 indicated that half of all children of CLM members under 18 years of age had experienced either illness or injury in the past year. In the qualitative data, the occurrence of diarrhoea, stomach ache and fever were commonly mentioned. **Disease prevention and treatment**

especially for children's ailments are sought in both traditional and Western medicine. From the data, we can distinguish between four different types of treatment, namely (i) traditional remedies that caregivers apply themselves and knowledge of which is transferred goes back many generations, including herbal teas or balms, (ii) traditional doctors, who can offer herbal or traditional treatment beyond what caregivers are able to provide at home (*medsen fèy*, the literal translation is leaf doctor), (iii) *Vodoun* priests (*Bòkò, Ougan, Mambo*[3]), who provide treatments grounded in spiritual beliefs, and (iv) Western medical care, that is provided at health centres (commonly referred to as hospitals in the data) and healthcare workers. Church is also often referred to in relation to responses to illness, with caregivers resorting to prayer either at home or in church.

Types of treatment are often combined in trying to respond to a child's illness. Caregivers indicate that seeking medical care in health centres is the preferred or right response in case of diarrhoea or fever, but practically they often resort to traditional remedies, such as herbal teas, before seeking care in health centres. Many indicated to try traditional forms of medication first, such as herbal tea, and only to resort to care in health centres if those prove inadequate.

> *"If the child has a serious fever, I'll prepare an infusion from leaves for the child. If he doesn't improve, I'll bring him to the hospital to regain his health."* [MKCSSPOUSE5-1]

> *"I go to an herbalist doctor according to what they*[4] *has so that he can give them the appropriate remedy. If the herbalist doctor doesn't have a remedy for them, I take them to the doctor."* [LCSSPOUSE2-4]

A common treatment for diarrhoea consists of boiling tea made from leaves or herbs (see also Kirkpatrick and Cobb 1990). Respondents provided many examples: "*Langichat*, *bwa santi*, *malonnen* and *bon gazon*. All of them are good for diarrhoea." [LCSSSpouse2-4]. Plant-based forms of treatment also extend to fever and injuries: "You boil *asosi*, you squeeze bitter orange into it, you add Congo bean leaves, *papou* and the leaves of *kòmè mari*. It's good for stomach-aches." [LCSSpouse2-4]; "If they are injured, there is an herb called *geritout*, and if you don't sent them to the health centre, you rub them with *fèy koton* and the milk of Bellyache Bush, and then you put it on the wound and then you put *lè breziyèt* on it." [LCSSpouse2-4]; and "[If my child is injured and] the injury is not big, I will scratch ash plantain and salt to put on it." [MKCSCLM5-4]

The sequencing of treatment may also be the other way around, seeking care from health centres before resorting to traditional forms of treatment: *"Before bringing him to another person, I will bring him first to the hospital. If the disease can't be treated with Western medicine, I will bring him to see a Vodoun priest."* [MKCSCLM5-2]

Lack of money poses a real constraint to caregivers in seeking care from health centres and hospitals; many caregivers indicated that they were unable to bring their child to a health centre or hospital as a result of inadequate funds. This is echoed by findings from the baseline survey, with lack of money

[3] *Bòkò* (gender-neutral) is to be distinguished from *Ougan* (a male priest) or *Mambo* (a female priestess), with the latter usually offering darker methods (e.g. placing and countering curses) and the former providing more benign methods (e.g. offering herbal and spiritual healing treatments). However, often the terms are used interchangeably, especially by those who do not engage with *Vodoun*. We therefore report about *Vodoun* priests in general, and report the terms as they arose in conversations.

[4] In Haitian Creole, pronouns do not distinguish between genders. Unless the gender of the third person that was referred to was made explicit during the discussions and in the transcripts, we use the gender neutral pronoun 'they'.

being the reason for not seeking healthcare in nine of 10 children who were ill but whom did not receive health care.

The role of *Vodoun* was pervasive in discussions about illness, mostly in terms of treatment but also with respect to causes. Curses or evil spells are deemed to be a powerful factor in disease or other misfortune, as also reported elsewhere in reference to the 'evil eye' (Kirkpatrick and Cobb 1990).

> *"We don't let the children walk around by themselves because evil eyes can attack them; they can hurt them."* [MKFGCLM05]

> *"You own something and people hate you because of it and they hit you with a Vodoun powder called "Battery Strike". If he can't send the evil thing on you, he will send it on your children."* [MKCSSpouse5-1]

The extent to which caregivers engage with *Vodoun* priests in search for cures is mixed. *Vodoun* priests may be consulted to shed light on children's ailments. However, the practice was not held in esteem by all. Especially those with strong Christian faith indicated not to consult *Vodoun* priests. Religion plays an important role in CLM members' lives, and many caregivers highlighted the importance of their faith in dealing with illness.

> "[In case of a health problem] *I'll take them to the health centre. If it's not the kind of problem they can treat at the hospital, I'll bring them back home and I'll go to a Vodoun priest to light a candle and find out what is wrong with them."* [LCCSSpouse2-2]

> *"You go to the herbal doctor if it's not the kind of illness you can treat at the health centre. If you are a Protestant, you pray. If you are not a Protestant, you seek mystical treatment. […] No, I don't go to the bòkò to light candles or get a reading. They'll give you half lies and half truths."* [LCCSSpouse5-1]

Knowledge about **immunisation** and about its importance for preventing disease among children was widespread, and was discussed separately from response to illness: *"Vaccinations are important because they will prevent the baby from getting sick."* [LCCSCLM2-1]

The importance of **water, sanitation and hygiene** for children's health is widely acknowledged. The occurrence of diarrhoea, stomach ache and fever were often discussed in relation to poor water quality. Caregivers also mentioned the risk of cholera in relation to drinking unsafe water. However, baseline survey data shows that only a small minority of CLM members and their families – 8 percent – have access to safe drinking water.

We observe then, in keeping with findings across many rural communities (Nichter and Lock, 2003) that CLM members display pluralism in their health practices. In other words, they simultaneously or sequentially seek care from a range of traditional and modern providers of health services. While CLM members report receiving health advice and support from the programme, and these may be based on biomedical recommendations, cultural ideas continue to shape health seeking behaviour. It is expected that health ideas and practices reflect wider regional cultural patterns in Haiti and are thereby common to members of CLM programmes or those outside it.

We see from the quotations above however that CLM interventions have a direct influence on some underlying as well as proximate determinants of health. The programme was considered to contribute

to promotion of improved sanitation and living conditions, and thereby prevention of ill health of young children. It also allowed caregivers to access health services and supplementary feeding.

> *"Because of CLM, the children drink treated water, the children are not sick and they don't walk around dirty. CLM taught me how to keep them clean. The children don't get wet in the rain; they have a house to sleep in*." [LCCSCLM2-4]

> *"They got diarrhoea, and I boiled up a remedy and sent them to the health centre. They never got better. Thanks to CLM, they sent me to Mirebalais, they put them on peanut butter, now they are better."* [LCCSSpouse2-4]

The programme also allows its members to display agency in how they may use their money towards health promotion, disease prevention or treatment: "*He [the case manager] always said that I should buy a goat when it's my turn to receive the money from the savings scheme. But I had to take it and use it to go to the health centre with the child because they had a fever."* [LCCSCLM2-1]

4.2. Nutrition

We explore practices including breastfeeding and dietary diversity and common barriers to ensuring good nutrition practices, including food insecurity, poverty, maternal absence and poor maternal mental wellbeing.

When asked what young children need to stay healthy and develop well, the majority of mothers and caregivers had awareness of the health benefits of breastfeeding for infants and the importance of a varied and nutritious diet for small children. Breastfeeding was perceived as the most nourishing food for infants and could help to feed a child during times of food insecurity: ''*Breastfeeding will help the child being healthy, have memory."* [MBCSCLM2-3]

Nevertheless, there were some gaps in caregivers' knowledge and some doubts about the practicalities of following advice provided by health workers. For example, while all mothers agreed on the importance of breastfeeding, some were concerns that breastmilk alone might not be sufficient to satisfy the baby for the first six months. Therefore, additional complementary food (e.g. porridge) was often given during first months: *"I won't have the courage to spend the 6 months only breastfeeding the baby, because he will be hungry. I will give him plantain porridge".* [MKFGCLM2-2]

Many mothers worry that their own inadequate diets could negatively affect the quality of their breastmilk (e.g. "having milk like water" without sufficient nutrients). It could even make their children sick: "*Eating once a day is not good for the body because it can lead to getting sick. If you're breastfeeding a baby, the baby can get sick as well [if you eat only once a day]. He might have diarrhoea and pain in the belly."* [MKFGCLM2-2]

Data indicated that there is a gendered expectation that mothers are responsible for feeding children. In times of low food availability mothers often worked hard to find ways to protect their children from hunger. The difficulty of meeting this need weighs down heavily on women: *"[Mothers can get depressed] when they think about how they should live, if they don't have any money […] if the children complain that they are hungry and they haven't got any food to give them."* [LCCSCLM5-4]

Many mothers prioritised their children's needs over their own well-being in an attempt to minimise the impact of food insecurity. Common coping strategies included sending the children to neighbours, friends or relatives to eat or to ask for food; borrowing money or food; skipping meals themselves to ensure that their children had enough to eat.

Caregivers said that they got advice on how to feed their infants and young children from health workers, especially during antenatal care sessions, hospital delivery and routine growth monitoring (if available). Other trusted sources for child feeding information were relatives, neighbours and CLM case managers.

Nevertheless, many children are regularly exposed to some degree of **food insecurity** including not eating for an entire day, going to bed hungry, eating only small meals or only once a day, eating very monotonous diets with poor nutritional value (e.g. plain boiled rice or spaghetti only) and eating wild edible food plants (also called famine foods). Baseline survey data confirm that children eat few meals per day, experience hunger and lack dietary diversity. Figures in Table 2 show that more than half of all CLM members indicated that their children ate only one meal per day on the day prior to data collection, hunger is a common experience and that scores for dietary diversity indicate that children only eat foods from a low number of food groups.

Table 2 Nutrition indicators from 2017 baseline survey data for CLM members from WKKF cohort

Indicator	
% of CLM members with children eating one meal per day	59.9
# months during which the household experienced hunger in the past year	4.46
# months during which the household experienced hunger in the past month	10.87
Household Dietary Diversity Score index (out of 12)	3.95
Children's Dietary Diversity Score index (3-5 years) (out of 8)	2.91
Infant and Young Children Feeding Practice score (6-24 months) (out of 7)	1.84

The most commonly cited reason for uncertain or inadequate access to food was a **lack of financial resources**. It was cited by many as the main reason for poor diets and sub-optimal feeding practices (both with regards to dietary diversity and meal frequency) among young children.

> "*If you have money, you can eat properly every day. The reason you might not eat properly every day is lack of money."* [MKCSSPOUSE5-4]

> *"When I've got a bit of money, I make good food for her, but when I haven't, I don't. Food that gives children energy is: cornmeal with green vegetables, bread soup with leafy vegetables, bean juice, fresh fruit juice and plantains."* [LCCSCLM2-2]

Other reasons for food insecurity were seasonal variations in food availability (see also section 3.2) and time-consuming or difficult access to markets to purchase fresh foods: *"Problems with money prevent us [from eating well]. The people who sell don't live nearby. When you need to buy something, you have to walk 10 to 15 minutes to find what you need, or you have to wait for market day to go buy things."* [LCCSSPOUSE2-2]

In times of acute food insecurity and poverty, many mothers decided to undertaken work away from home to earn money (e.g. doing the laundry for other people, temporary farm work in the plantain fields, doing charcoal). **Maternal absence** often resulted in less frequent breastfeeding of infants and poorer feeding practices for young children. While mothers try to find reliable child care arrangements during their absence, this is not always possible.

> *"It [going out for work] means that the children aren't well looked after. They have a hard time. You leave home and you don't get back until at least 3pm. It means that the children don't always eat well […] because you leave them too often."* [LCFGCLM2-1]

> *"This [going to work] can result in the child living in the dirt because you might not have someone who can look after him. So, you give the child to a neighbour who doesn't take good care of him, […] the child can be malnourished because he didn't eat well with that person. You can leave the younger child (3-5 years old) with the older one, they can eat badly, he doesn't get washed because the older one might go play and leave the younger."* [MBFGCLM2-1]

Several lactating mothers explained that it was difficult for them to leave their infants to do work, go to the market or attend CLM training sessions. Usually the women returned to very hungry, crying babies who needed to be breastfeed immediately. While women acknowledged the importance of breastfeeding for the first 6 months, work commitments and other chores outside the house made it often impossible to follow the recommendations of exclusive breastfeeding (even if they wanted to). In case lactating mothers had to be absent for longer periods of time (and could not take the baby), infants had to be given formula (if women could afford to buy it), other milks or thin porridge.

> *"When the child is an infant, what is important is breast milk and formula when the mother is not there. If a baby doesn't breastfeed, they won't develop. When I go out, I leave the baby with someone else and I leave food for them (flour and plantain porridge)."* [LCCSCLM2-3]

As discussed above, however, there also appears to be a fairly widespread idea that exclusive breastfeeding will not offer the infant with adequate nutrients and therefore needs to be supplemented.

Some mothers also explained that their **poor mental well-being** caused by constant worries, stress and anxieties about poverty could be very disruptive and could affect their abilities to feed their infant and/or child: *"My worrying can make me forget to clean up the children or to make food for them."* LCCSCLM2-3

The CLM programme provides helpful support to improve food security. Most beneficiaries of the programme explained that they used at least some of the cash transfer to buy food for their children and thus relieve food insecurity in the short-term.

> *"Sometimes they [CLM programme] give us a little money which helps the children. You can use it to buy food. The children eat better nowadays because I didn't have any money, and when they gave me some [money], it came in very handy. The children eat to their fill. When we get the small handout, she [my wife] makes bean sauce and legim for the children."* [LCCSSPOUSE5-2]

However, this relief was usually only temporary. Food insecurity due to lack of financial resources was still perceived as a major barrier to following some of the child feeding advice given by CLM case workers: *"Yes, the CLM people come to give advice. They always come by to tell us what will make us healthy. They say that using milk and meat is good for us, but we don't always have the money [to buy those foods]."* [LCCSSPOUSE2-2]

4.3. Security and safety

We consider the aspect of security and safety in relation to caregiver perceptions about risks to children's safety and with respect to children's home environment. We also explore attitudes towards disciplining children.

Caregivers hold many concerns regarding children's **physical safety**. These exist across all spaces, including the community, school, church and their own home. Concerns pertain to risk of accidents, such as close to roads and cliffs, and to harm that may be inflicted upon children by others, either physically or spiritually.

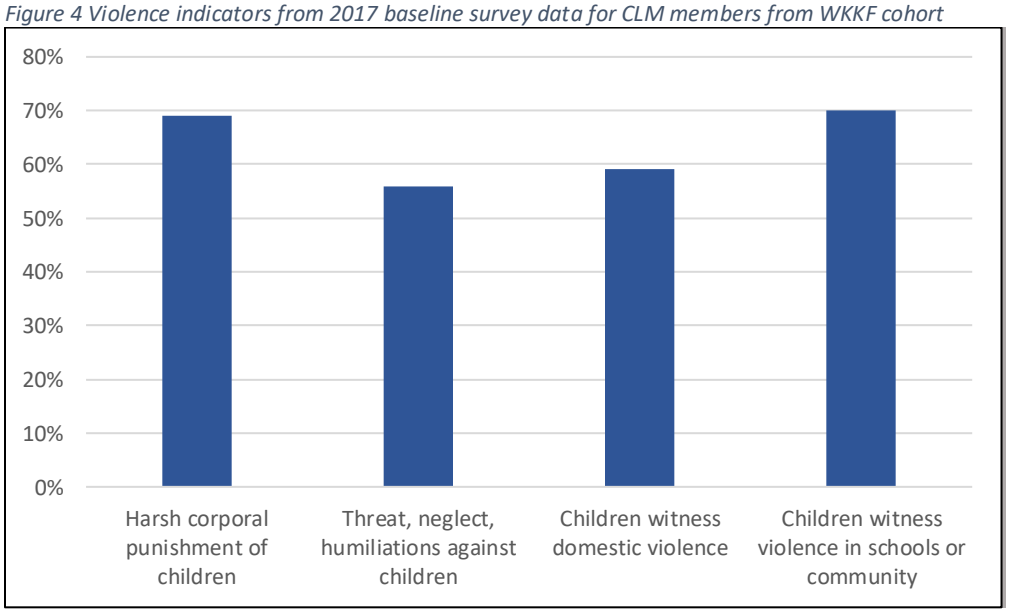
Roads and close to cliffs or river beds are areas in the community where children were considered not be safe, mostly because of the possibility of accidents: *"I don't leave her with others because I don't want them to hit her. […] "On the road, because when they are crossing the road, a motorcycle could hit them or other children could attack them."* [LCCSCLM5-1]

Caregivers also worried about physical violence directed at their children. Caregivers described that their children may be hit or bitten by other children on the way from school to home or when left alone at home, or that they may be beaten by other adults when out on the roads or being left in the care of others. Infants being left in the care of young siblings were also considered at risk as they would receive appropriate supervision. Becoming the victim of violence was also a concern for women themselves, particularly when travelling to the market or using public transport.

> *"There are areas where we feel afraid when we're passing by. Those areas are full of trees and underneath the sugarcane plantation because those areas don't have houses. Because we're not accompanied by men. We don't know whether there are robbers hiding there ready to assault us."* [MKFGCLM05]

The widespread experience of violence is corroborated by baseline survey data. Figure 4 shows that the majority of children is exposed to violence at home, at school and in the community, and are exposed to harsh corporal punishment, threat, neglect and humiliation.

Figure 4 Violence indicators from 2017 baseline survey data for CLM members from WKKF cohort



Concerns about physical hurt being inflicted upon children by others are closely related to spiritual beliefs as grounded in Haitian *Vodoun*. Risks of the 'evil eye' were widely mentioned or alluded to, with fears about children being cursed or becoming possessed being pervasive and widespread. Generally, caregivers were very suspicious of other community members and feared for how they might pose dangers to their children. Children were deemed at risk when alone but also in the company of their caregivers. Children are always to be carried in front of the mother to make sure that they are not at risk of the evil eye.

> *"In this area, children are not allowed to walk around alone. Even inside the church they're not safe. Sometimes, there are church people who are giving bad food to the children. They must always be watched so that other people won't attack them. They're not safe neither in school nor in the open-air market."* [MKFGCLM05]

Women themselves also feared being affected by evil spirits.

> "*In the street at night [they are not safe], because I don't want the sanpwèl to attack my children. When they find you they kill you, they take your spirit or if they can't take your spirit, they put a spell on you. […] I don't want to catch any evil winds, because then you can get diarrhea and fever."* [LCCSCLM2-3]

Being at home, however, may not necessarily ensure secure conditions for children. **Safe and stable home environments** are not always available to children, with many families experiencing shifts in their composition and children being separated from either one or both parents as a result. Women included in our study had children who were living with others, which could include direct or extended family members, friends or acquaintances or strangers[5]. Poverty and lack of financial resources to care for children prove an important reason for children to be separated from their mothers: *"I would like [my child] to go live with his aunt in Croix-des-Bouquets. So he's more informed, so he lives a good life, away from poverty."* [MKCSCLM5-2]

Unstable relationships and family tensions also contribute to family separation. The story of Rachelle from La Chappelle (see Box 1) shows how both poverty and unstable relations contributed to two of her children currently living with others. Children living with others clearly puts a strain on mothers' own wellbeing, and also raises concerns regarding the wellbeing of those children: *"My children who are not living with me make me sad. I always think about them, especially when I have finished preparing the meal. I wonder whether or not they have already eaten. For me to feel good, they would have to be here with me."* [LCCSCLM2-4]

[5] A widespread phenomenon in Haiti is 'Restavèk', which refers to children staying with other families. Children from poor families are often sent away in the hope of them receiving education and a better life but often end up as domestic servants. The practice is widely considered to be a form of bonded labour and modern-day slavery. Notwithstanding the importance of this issue, we did not explicitly explore it in our fieldwork.

Box 1 Case study of Rachelle – example of children living away from home

Rachelle is 25 years old and has three children. But only her three-year old daughter Sandra currently lives with her; her six-year old daughter Sabine and 6-month old son Dumay live with other people. When she was asked about why her children were not living with her, she explained:

"My daughter, who is 6 years old, is bigger. She's in Archaie with her father. When she was born, he didn't look after her. When she was 4, her father came to take her away with him because I didn't have the money to put her in school. I don't feel all that bad about the situation because I do go to see her. She's in school and she tells me that all is fine."

"As for the baby, who is 6 months old, when I met his father, he told me that he didn't have a wife or children. He asked me to have a child with him. We became a couple and he got me pregnant. Once I got pregnant, he left the house and, since then, I've not had any news of him. I was sick. I went to the hospital in Mirebalais. They told me to go there to have the baby. The baby was born, but the father never came to help support him. When I went to his mother's house to find out what was going on, I found out that he has a wife and that he's married. I asked him to give some support for the baby and he said he would. My father had been the one who used to help me out but then my father didn't have any more money.

I went to Archaie to stay at one of my brother's houses to see if he could help me. After 5 months, my brother sent me home. Then, when the baby was 6 months old, the father came to fetch him because he didn't want to support the child if he was with me. […] I never knew he was married. I feel bad because the baby isn't with me. I don't know if he is being looked after well. I would like to go to see him, but I don't have enough money yet. […] a cousin of mine told me that she saw the baby at the hospital with one of the father's sisters. It's a big problem for me. I don't know how my child is, how he's living, or whether he's eating properly."

[based transcripts for LCCSCLM2-2]

Corporal punishment also presents a risk to children at home. The use of beating as a way of disciplining children appears common practice in the research sites. Caregivers described that they may warn children first but then resort to using physical force for correcting their behaviour, including slapping them, letting children kneel for a long time or beating them with belts, branches or sticks.

> *"when a child misbehaves, you hit him so he doesn't do it anymore. If he continues you hit him again. […] You hit him on the feet with a small whip because if someone comes it's not nice if he sees that the child talks badly with you."* [MBFGCLM5-2]

The case of Fabienne, a 27-year old CLM member (see Box 2), illustrates that caregivers don't like hurting their children but that they deem it necessary to ensure that children will behave well.

Box 2 Case study of Fabienne – example of child discipline practices

How do you discipline your children?

Fabienne would first give a warning. Then she would use a belt to whip them. For instance, the younger 2.5 year-old boy, often picks fights with the older one, who is 6 years old. She disciplines the younger one a lot. They would listen to her while she is present, but when she is away such as for fetching water, they would fight and make a mess. She would discipline them in such a case. She also punishes them by making them sit on their knees [kneel]. Both methods (sitting on the knees and whipping) are effective, although the kneeling punishment is more effective than whipping.

Her husband would also discipline their children using a branch as a whip. Although he is around less, children fear more his punishment than hers.

After hitting them, how do you make up?

The older children would cry but they stop eventually, and everything is normal. They younger boy, however, would sometimes cry even more, then she would caress and hold and calm him down.

How do you feel about disciplining them by hitting?

Fabienne feels emotionally hurt too while she disciplines them, but she is obliged to raise them accordingly, so it is necessary.

[based on field notes for MKCSCLM2-4]

The CLM programme plays a modest role in improving safety and security for children by improving housing conditions and by providing advice about disciplining practices.

The provision of housing materials and follow-up with respect to building a house that can withstand the elements, is solidly built and be securely locked was considered to protect children against potential harm and injury: *"The children are not going to sleep in a house that's falling apart. They're safer."* [MKCSCLM5-4]

Experiences regarding corporal punishment are mixed. CLM members and their spouses indicated that they were told by case managers not to hit their children as this would have adverse effects on their relationships with their children. Case managers advised caregivers to talk to their children, but also suggested to replace beatings with letting children sit on their knees. Some case managers voiced the opinion that mothers slapping their child is important for encouraging good behaviour.

> Have you followed any of the advice that you got from the case managers and changed your behaviour? *"Yes, I follow the advice. It used to be that when the child cried, I would spank them. Now, I call them to me and talk to them, and if there is something they need, I give it to them. […] It was difficult, because out of habit, I was used to spanking them. Now I see I shouldn't do that anymore. It has been challenging, but I have changed."* [LCCSSPOUSE2-2]

Finally, given the programme's central focus on individual members and their families, there is no impact at community level in terms of making places more secure or offering safe places for children or their mothers. The programme may contribute to more harmonious spousal relationships, thereby offering more secure family conditions for children. In a few cases, case managers mediated between CLM members and their spouses, and contributed to less tension and acrimony and greater collaboration. This is illustrated by the case study of Madeline in Box 3.

Box 3 Case study of Madeline – example of programme improving relationships

Madeline is 23 years old and is a mother of three boys. She has been living with her current husband, Robenson, for over five years. Before joining CLM, the couple struggled. Robenson couldn't find work and didnt contribute to the family's needs. After encouragement from the CLM case manager, Madeline and Robenson talked together and made a decision to work together and improve their livelihoods. Coaching from the case manager helped to change Robenson's attitude. He used to be passive and uninterested in the CLM programme. The case manager encouraged him to take initiatives and work with a purpose. This fuelled Robenson's determination, and he now searches for work proactively. Today, Robenson works as a day labourer. During the peak season, he would be out working every day except Sunday. Although job opportunities are not reliable and intermittent, Robenson is not discouraged from the challenges that are beyond his control and carries on working one day at a time.

[based on transcripts for LCCSCLM5-4]

4.4. Responsive caregiving

In terms of responsive caregiving, we consider caregivers' responses to children's needs, and the extent to which caregivers are able to spend time with their children or leave in the care of others who are able to provide adequate care.

Practices in terms of **responding to children's needs** revolve primarily to breastfeeding and other forms of soothing when babies or young children are crying. Not letting babies cry unattended was voiced as part of what constitutes a good childhood and being a good mother. Feeding the child, soothing them through cuddles, singing or play and, if that doesn't help, taking them to the doctor or hospital was the commonly voiced sequence of actions to be taken in response children crying or being upset: *"When a baby is crying, you breastfeed it. I would feed it and bath it. If it's still crying, I would go to the doctor's with it, in case it is sick."* [LCCSCLM2-2]

The need to cuddle and play was clearly articulated by mothers and father alike, and both parents see it as their role to engage with their babies and young children in that way. Feeding the child was more commonly considered to be the mothers' responsibility, although men may be held responsible for providing money to buy such food. Taking the child to the doctor or hospital appeared a shared responsibility.

> "*You cuddle him, talk to him, ask him if he's thirsty. You don't get mad with him because he has a problem. If he needs a shower, you shower him. I need to cuddle my children because when I get old, I will be the baby needing attention. If I used to treat them badly, they'll treat me badly too."* [MCCSSPOUSE2-2]
>
> What about the father's main features and the father's activities with his child?
> *"The father has to buy groceries for the house, for his children, he has to work to take care of them. He has to play, caress them, talk to them to be loved by them."* [LCFGCLM5-1]

Both mothers and fathers raised concerns about the quality of responsive caregiving when leaving their children in the care of others. Others may not be so patient with their children and leave them crying or try less hard to respond to their needs.

When children grow older and are able to walk and speak, the role of soothing and play changes and focuses more on incentivising proper behaviour. Some spouses indicated that it is important not to become too lenient and to ensure that play and positive interactions are conditional on good behaviour: *"it's important to play with the child. But a child can't be rude. While you're playing with the child, you can't be too comfortable with him. While you're playing with him, he must be afraid of you so he can respect you."* [MKFGSPOUSE5-2]

Responses to behaviour that is deemed unacceptable or undesirable become more punitive as children grow older. As discussed above, corporal punishment is widespread. Respondents indicate that it will often go hand-in-hand with talking to the child and this may happen before or after the punishment. Punishments tend to become more severe as children grow older, with fewer warnings preceding the punishments and beatings being harder or more repetitive.

> *"[When a child is naughty, I] feed him and spank him, but only when I tell him to do something for me and he refuses. We talk to and cuddle kids who are 3 years old; we threaten him with small whips. When he's 5 years old, we spank him. […] You need to talk to him. You will tell him if he does something wrong, you will spank him. […] You need to spank him because the*

children understand things. After spanking him, you talk to him so he doesn't do it again." [MKFGCLM5-2]

The role of the CLM programme in promoting responsiveness to children's needs appears to be most prominent in relation to feeding and sanitation practices. CLM members and their spouses indicated that advice about how to care for children was very useful, but referred mostly to messages about nutrition, sanitation, water and health. In some cases, they made reference to seeing the case managers playing or singing with children. There was no explicit mention of the receipt of advice on the importance of affection for forming an emotional bond with children.

In terms of **provision of care**, CLM members prefer to be with their children – and young infants especially – as much as possible. As highlighted in the section on security and safety, concerns about children's safety are pervasive and leaving them at home without adequate supervision or in the care of others who are not fully trusted happens with great reluctance. Nevertheless, women's daily realities in which they have to juggle many tasks and do not always have the support available that allows for trusted supervision of their children means that women face having to leave their children alone, in the care of older (but still young) siblings or with others. Activities that require children to be left alone include fetching water, caring for animals, doing laundry[6], going to the market and going to the farm.

Figure 5 provides an overview of how CLM members in Mache Kana spend their time on a regular day. It shows that many activities that they undertake are difficult to combine with caring for children, particularly infants. In addition, to these regular activities, most women would also spend time to go to the market twice per week, wash laundry on Saturdays and spend time in church on Sundays. While children are generally brought along to church, children cannot accompany their mothers to the market and washing of laundry.

Figure 5 Overview of CLM members' daily activities in Mache Kana

<table>
<tr><th></th><th>MKCSCLM2-1</th><th>MKCSCLM2-2</th><th>MKCSCLM2-3</th><th>MKCSCLM2-4</th><th>MKCSCLM5-1</th><th>MKCSCLM5-2</th><th>MKCSCLM5-3</th><th>MKCSCLM5-4</th></tr>
<tr><td>5-6.</td><td></td><td rowspan="3">cooking for the children, sweeping, washing the dishes</td><td rowspan="3">I wash my face, tie the animals, feed the pigs.</td><td rowspan="3">I take a shower; I cook, sweep, wash the dishes; I send the children off to school</td><td rowspan="2">I brush my teeth, take a shower, wear different clothes</td><td rowspan="3">sweeping, feeding the animals, sweeping the goat shelter, cooking for the child</td><td></td><td></td></tr>
<tr><td>6-7.</td><td rowspan="3">chaining the animals, sweeping</td><td rowspan="3">brushing my teeth, taking a shower, sweeping, cleaning the house</td><td rowspan="3">sweeping, washing the dishes, making the bed, cooking food</td></tr>
<tr><td>7-8.</td><td>clean the house, wash dishes, cook</td></tr>
<tr><td>8-9.</td><td rowspan="2">cooking, washing the dishes</td><td rowspan="2">watering, chaining the animals</td><td>I sweep, wash the dishes, clean the house, cook</td><td rowspan="2">cook for the baby; irrigate the farm</td><td>I give the children a shower</td><td rowspan="3">taking care of the child</td><td rowspan="2">cooking food, feeding the pigs</td><td rowspan="2">cooking, washing the dishes,</td></tr>
<tr><td>9-10.</td><td rowspan="2">I go to the farm.</td><td rowspan="3">I go to wash clothes</td></tr>
<tr><td>10-11.</td><td rowspan="2">washing, taking shower</td><td rowspan="2">cooking for the children</td><td rowspan="3">cook, go fetch water</td><td rowspan="2">going to fetch water,</td></tr>
<tr><td>11-12.</td><td rowspan="2">go to fetch water and to wash</td></tr>
<tr><td>12-13.</td><td rowspan="2">I sit down and take a break</td><td rowspan="2">I move the animals to another spot, I take a break</td><td>I go to move the animals</td><td rowspan="3">I go to work at the sugarcane mill</td><td rowspan="3">moving the animals</td></tr>
<tr><td>13-14.</td><td rowspan="2">cooking</td></tr>
<tr><td>14-15.</td><td rowspan="2">look after the animals, get food for the animals</td><td rowspan="2">I go get the animals and fetch food for them</td><td rowspan="3">go fetch water, take a shower, sit down with the baby</td><td rowspan="2">I clean the house; I cook</td><td rowspan="2">cooking, washing the dishes</td></tr>
<tr><td>15-16.</td><td rowspan="2">taking a shower</td></tr>
<tr><td>16-17.</td><td rowspan="2">cooking</td><td rowspan="2">I sit down</td><td>I wash the dishes</td><td>sitting at home</td><td>giving children a shower</td><td>give the children a shower</td></tr>
<tr><td>17-18.</td><td rowspan="2">go fetch water</td><td>wash the dishes</td><td>playing with the children</td><td>picking up the animals</td><td rowspan="2">sitting down and talking with my husband</td><td rowspan="2">sitting to breastfeed the baby</td></tr>
<tr><td>18-19.</td><td rowspan="2">wash the dishes, I sit down</td><td rowspan="3">I make my bed and go to sleep</td><td>irrigate the plants, feed the animals</td><td rowspan="2">getting a shower, brushing</td><td rowspan="3">sleeping</td></tr>
<tr><td>19-20.</td><td>go take the animals</td><td>breastfeed the baby, give him a shower</td><td rowspan="2">sleeping</td><td rowspan="2">we're lying down</td></tr>
<tr><td>20-21.</td><td>sleeping</td><td>wash the baby and sleep</td><td>lying down, sleeping</td><td>sleeping</td></tr>
</table>

[6] Doing laundry for better-off families is a common economic activity for women in this part of Haiti. References to women going to wash clothes or doing laundry could therefore refer to both unpaid work and paid work.

When having to leave their children in the care of others, they would most commonly leave them with relatives who live in close by, such as the child's grandmother, father or aunt. Sometimes they are also left in the supervision of neighbours. Mothers as well as fathers prefer leaving their child alone or with siblings rather than with other adults whom they not fully trust, even when aware of the associated risks.

Leaving children in others' care, including those who are trusted, or on their own may compromise the quality of care. Women spoke about children not being fed properly, not being bathed, or getting dirty.

> *"It can happen that I leave the children with someone else, and they don't bathe them, so it is only after I return that I bathe them."* [LCCSCLM2-3]

> *"We leave them at home alone, and they can be hungry, they can get burned, the other children can hit them, when we leave early and we come back late they eat badly and they can get sick of malnutrition*. [MBFGCLM5-1]

For most CLM members, participation in the programme has meant that they are spending less time with their children and having to seek for childcare options. Taking part in day-long trainings and engagement with activities that are promoted through CLM, such as livestock rearing and trading, are difficult to combine with care for children, and mostly infants. Children are being left in the care of other trusted adults when possible or with siblings or on their own. This is not the case for everyone, however. In some cases, income-generating activities that are promoted through CLM allowed members to spend more time closer to their homes, for example by replacing work on the farm (which can be far away from the home) by rearing small livestock (which often takes place closer to home). This is discussed in greater detail in section 5.4.

4.5. Early learning

With respect to early learning, we assess CLM members' and other caregivers' perceptions, attitudes and practices towards early play, stimulation and interaction with their babies and infants and their engagement with ECD services.

CLM members, spouses and other caregivers articulated a clear understanding of the importance of **stimulation** of – such as talking and singing to – babies and infants, even in uterus. In response to questions about whether they sing or play with their children and whether this is important, caregivers indicated that it helps them to know their parents, to be comfortable and to learn and develop.

> "Do you think it is important to talk and sing to your child? Why? *"Yes, you can talk, sing, show him beautiful songs so he can be comfortable with you, so he understands you and doesn't have problems."* [MBCSCLM5-1]

> *"Yes, you start talking to him little by little, teach him to sing, his voice starts developing, he is not shy anymore."* [MBCSCLM5-2]

> "Do you think it is important to play with a baby (even before they talk themselves?) Why? *What's most important is to play with them, because if you don't, they won't know their mother and father. A woman doesn't make a baby by herself. A father doesn't make a baby by himself. Once the baby is born, they know the father when he speaks and will look at him. If another person talks, their eyes will remain closed, because the child will know what you show them."* [LCCSSPOUSE2-4]

The importance of play, stimulation and interaction was voiced by both female and male caregivers. In fact, male caregivers were often more elaborate in articulating the importance of singing or playing with their children. Data on understandings of what makes someone a good mother or father suggests that fathers may spend more time engaging with their children in play. Both CLM members and their spouses indicated that fathers' roles include the provision of income for securing food and other basic needs for children and to play, sing and cuddle with their children. Mothers' roles were focused on the immediate elements of care, including feeding, bathing and supervising children. The prominent role for male caregivers in early learning and stimulation is illustrated by the excerpt from a transcript of a focus group discussion with male caregivers in Box 4.

Box 4 Male caregiver perspectives of good motherhood and fatherhood

What are the main features of a mother of a child that lives well?

A participant says: The mother has to live in the cleanliness, she has to have a commercial activity, she can be a seamstress, she can be a school teacher.

The other participants agree.

What activities does a mother do with her child?

According to one participant, she wakes up in the morning, she cooks, she gives a bath to the child and she sends him to school, she talks with the child and she plays with him.

Another one says: the mother plays, she embraces him, she caresses his head, she cuddles him, if he cries she plays with him she puts him close to her and walks with him to calm him down. If he cries because he is hungry she gives him food.

What are a father's main features?

According to a participant, the father must have a profession as a bricklayer, a teacher, a driver

Everyone agrees.

What activities does a father do with his child?

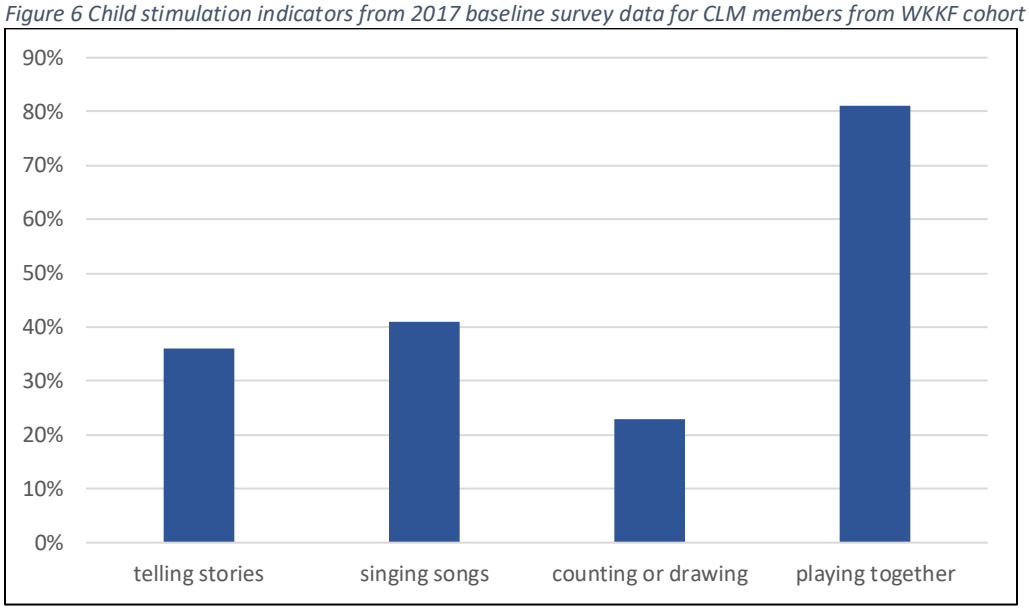
According to the participants, the father takes the child to school, he talks to him, he sings for him. It depends on how much he loves the child: if the child cries, he takes him and cradles him.

Another participant says: The father plays with the child because he loves him. If the child cries he consoles him, he can give him a candy.

[based on field notes for MBFGSPOUSE5-1]

Notwithstanding these positive attitudes, baseline survey data suggest that strides can still be made with respect to child stimulation. Figure 6 indicates that less than half of all CLM members told stories, sang songs or counted or drew with their children aged 3-5 in the three days prior to data collection. Many of them did report high levels of playing with children.

Figure 6 Child stimulation indicators from 2017 baseline survey data for CLM members from WKKF cohort



For children aged five and upwards, play was not always considered to be positive for children. Particularly play with other children and away from home was deemed undesirable as it takes time away from doing homework or helping out with chores around the house. It would also lead to children becoming dirty and might put them at risk of being harmed by other children or injured: *"I would like him to do his homework and study. I don't want him to play with other kids so he doesn't create trouble; so they don't hit him; he likes to play with other kids too much."* [MKCSCLM2-4]

Participation in the CLM programme appears to have contributed to more involvement in early learning practices for some children of CLM members. A few respondents indicated to have learned the importance of play and song for children and also how to do so: "*Since joining CLM, I learned to sing with the children and they learned how to play with other children (of CLM members)."* [LCCSCLM2-1]

This reflects the general learning among CLM members and other caregivers that young children are able to pick up on and learn from what happens around them and the actions of their caregivers. For example, spouses of CLM members learned that they should be careful about the language that they use and that their behaviour sets an example for their children:

> *"[I learned to] be careful of what you say in the presence of the children. Even if they don't know how to talk yet, they will hear what you say and they will repeat it tomorrow. […] How you raise them, how you treat them – that's the same way they will be and act when they grow up. If you use major obscenities, if you curse, they will do the same when they is older. Even if you are careful in how you raise the child, if they hears friends or other kids who are cursing, they will repeat it later on."* [LCFGSPOUSE2-2]

For children between three and five years old, caregivers are aware of the importance of early learning but lack of **ECD services** prevents them from providing children with opportunities at ECD or child care centres. None of the children included in our research were benefitting from early learning services.

> *"We have to go all the way to Mache Kana to bring the little children to school. There should be a school where the children can go. There should be a kindergarten to help the little children improve their speech."* [MKFGCLM05]

"What important services in the community are not available for children under 6? *I would like there to be a leisure centre for kids in the area so they can develop their children spirit."* [LCFGCLM05]

Education emerged as a recurring theme in conversations with caregivers in relation to aspirations for their children. When asked about what a good childhood looks like and about hopes for their children's future, going to school and studying were deemed to be of vital importance. This also ties in with the ability to send children to school as core expectations of being a good mother or father.

For children in middle childhood, the CLM programme contributes to primary school enrolment, with CLM members indicating that participation in the programme has allowed them to send their children to school. It should be noted that this certainly doesn't hold for all members; lack of funds and resources remains a barrier for many.

''When I wasn't in the programme yet, the child didn't go to school, he started school when I joined the program". [MBCSCLM5-1]

"With the CLM programme, I have been able to send Leica to school, so she's there instead of spending time with me. The CLM programme has taught me to save some money so I can buy things my daughter needs for school. I buy hair clips, knickers and shoes, so that I can send her to school, and I buy food to give to the children." [LCCSCLM2-2]

5. Pathways of impact

We explore the ways in which the CLM programme contributes to changes in outcomes for children, considering the effects that follow from conceptual considerations, namely income effect and training effect. We also assess the trade-off between work and care, and the emerging 'synergy' effect.

5.1. Income effect

Greater availability of income, assets and material resources facilitates nurturing care for young children. We consider the income effect in its broadest sense, also including the in-kind and material support that is provided, such as housing materials, livestock and water filters.

Figure 7 provides a comparative analysis of scoring of CLM programme components, presenting components with relatively high scores in dark colours and lower scores in lighter colours. CLM members were asked to rate programme components by listing them and distributing beans to those that are deemed most important. Findings show that income-related and material transfers were rated highly in terms of their direct benefits for children. The provision of livestock, housing materials, cash and support with savings and opening a bank account all received relatively high scores.

Figure 7 Overview of CLM programme ranking results based on FGDs with CLM members[7]

components	LCFGCLM2-2	LCFGCLM5-2	MBFGCLM2-2	MBFGCLM5-2	MKFGCLM2-1	MKFGCLM5-2
cash/ money	7	4	15	6	5	6
livestock/ animals	5	2	7	15	14	7
bank account/ access to savings	3		13		7	1
small retail business		2				
housing	14	1	16	9	3	2
latrine	3	4	0	6	2	9
water filter	10	8	22	9	6	
solar lamp			3	5		
food	2					
millet plants				6		
training	9	6	3	4	11	
learning how to write our names	8	9			2	
carnival for children		4				
Total # beans	61	40	79	60	50	25

The additional income generated through the programme supports caregivers to provide and care for their children. This refers to the direct provision of stipends but mostly pertains to the receipt of assets and the ability to earn money with these assets.

> *"When you sell an animal, you can buy a piece of land with it. You can sell one of the offspring in order to send the child to school, or to send the child to the health centre if they are ill."* [LCCSCLM2-1]

> *"CLM has helped me a lot with the children. They helped me to start a business. They gave me goats and pigs. When they reproduce, if the child has a problem, they can be used (in order to bring the child to the hospital). When CLM gives me money, I buy hens to raise for the children. I use it to buy groceries for the children."* [MKCSCLM5-1]

The income effect is also facilitated through the savings facilities that the programme provides. Many members and their spouses made reference to the importance of having the opportunity to save for their children, particularly when unexpected things happen such as illness.

> Why do you think that savings is the second most important thing for the children? *"Because the children might have a fever or get injured. You can use the money you saved to help the child*." [LCSSSPOUSE5-1]

> "*The AVEK [VSLA] program: it's money you save somewhere. If you have a problem and get sick, even if you had a hen, you might not be able to sell it on time. You're going to get the money from AVEK [VSLA] to solve the problem. It's money saved. […] The reason why AVEK [VSLA] is important for the children: you can borrow money from AVEK [VSLA] to prepare the child's future, to send him to school."* [MKCSSPOUSE5-2]

The provision of housing materials and messaging regarding the importance of constructing a new house, or reinforcement of the existing housing, contributes directly to improved living conditions for children. Similarly, the provision of the water filter allows children to drink clean water while the

[7] Each respondent was given 10 beans to distribute across programme components based on relative importance. Numbers in the columns reflect the count of beans allocated to respective components across group participants. Note that the total number of beans differ due to different numbers of participants per group, and because beans may not have been distributed accurately during the exercise.

construction of latrines prevents open defecation, all of which prevent illness and injury and improve health among children.

> *"When it rains and they [children] go into the weeds, they can slip and fall and this can disturb the children. When they poop on the ground, the microbes can enter the children's vagina and then the flies and the wind can take the microbes and bring them to the food. This is why children have major diseases such as fever, typhus and cholera. […]The toilet is important because the children go there often, the plants don't hurt them anymore, the thorns don't sting them anymore, when they need them, they have a place to go, you are not afraid for the children because you know they have a place to go, when it rains they can do their needs without problems. They have no problems when it rains."* [MKFGCLM5-2]

Greater access to economic and material resources also reflected positive on aspects of psychosocial wellbeing and strength of relationships, thereby offering an enabling environment for nurturing care. For instance, having a proper house and latrine affords CLM members and their children respect and a sense of dignity. Living in poor housing and having to use the bush for toileting was a shameful experience for both CLM members and their children, particularly as others would call them names.

> Why do you think that the house is the most important thing for the children? **"***Because when the children are in their own home, they feel more comfortable. People don't look at them in a bad light. […] When you don't have a house, they call you a chicken or a turkey."* [LCFGCLM2-2]
>
> **"***Many times when a child doesn't live in a good house, he walks with his head down in society, he doesn't feel comfortable."* [MBFGCM]

Women report that the income and material support contributes to greater self-esteem, reducing the amount of worrying that they do and offering a positive outlook on life and the future of themselves and their children.

> How do you think that women having low self-esteem and feeling depressed has an effect on young children? "*This makes the child suffer, you don't take care of the child."* [MBCSCLM5-2]

The availability of economic and material resources gives hope, and reduces the stress due not being able to secure children's basic needs.

> How does your participation in CLM affect your body and your emotions? **"**I sometimes feel that my body is sore, but my spirit is at peace because now I have hope." [LCCSCLM2-3]
>
> Has the CLM programme changed whether women get depressed and have a lack of self-esteem? If so, please explain how: "Yes. Perhaps she used to wonder what to do because she didn't have any animals, or a house, or how she could give the children something to eat. But CLM gives you a house, the woman has animals to take to graze, it gives funds to send the children to school, so she doesn't have to worry about those things anymore." [LCCSCLM2-2]

One case manager expressed these dynamics as follows: *"It changed people's mind sets, they no longer live as before, people are evolving, they are changing their status in society, they make other people see them in the society.*" [MBFGCM].

A greater sense of respect from community members was also voiced by CLM members themselves: *"CLM has made others see us as human beings."* [LCFGCLM5-2]

5.2. Training effect

Training and coaching prove crucial for enabling nurturing care, particularly in relation to health, sanitation and nutrition. The ranking of programme components in Figure 5 (above) shows that training was ranked to be of medium importance. CLM members indicated that they gained new knowledge related to practices ranging from family planning to breastfeeding and not letting children walk barefoot: "*Yes, they told me to have the child wash his hands when he comes from using the latrine, don't let him walk around barefoot. When they give me some money, I add it to my own money and I buy clothes for him and chickens for him".* [MKCSCLM5-2]

Caregivers displayed great knowledge of issues that are included in the CLM package of messages, such as vaccinations and family planning. CLM members and their spouses appreciated having learned about birth control, for example, and indicated that they wished that they knew about this previously so as to avoid more children when living in poverty and not having the means to support more children.

> *"For instance, they tell me don't have another child too quickly because I've already got one to cope with whose father doesn't take care of them. I have changed my behaviour, which is why I have taken birth control. I always say that if I had had this training before, I would have followed it and I wouldn't have got pregnant."* [LCCSCLM2-2]

Training and advice on savings and financial management was also deemed to be very important. Knowing how to save and take out a loan through VSLA and also how to earn money through livestock or other economic activities was often mentioned as a key outcome of trainings and interactions with case managers. In turn, this was considered crucial for ensuring good care for children.

> *"Yes, for example, if I have money and there's someone in the house who's always looking for money, I will give it to someone else to hold for me or I would buy an animal with it. Yes, as a result, I got into a savings program. This way, when I have money, I don't waste it. When I'm financially stuck, I have a way out."* [MKCSCLM5-2]

Generally, the messaging that was provided through the CLM programme is considered to be credible and relevant. CLM members consider all of what case managers say to be true, and to be in their best interest.

Nevertheless, CLM members' experiences regarding interactions with case managers are mixed. In roughly half of the cases, case managers appear to take a respectful, patient and constructive approach, and women and other caregivers spoke fondly of them. This mirrors voices of case managers and supervisors, who explained the importance of building a positive relationship and to gain trust of the women. In these positive cases, CLM members feel comfortable to ask for explanation in case they don't understand messages, and refer to the case managers as their friends: *"They are always very relaxed with me. They are a friend to me. They always joke with us. They sometimes play with my child and always gives us advice. They always talk politely to us."* [LCCSCLM2-2]

This is not always the case, however, with some case managers being less patient and getting angry when CLM members do not undertake tasks as agreed or are unable to perform tasks, such as writing their names. Some CLM members do not feel comfortable to ask for further explanation or support.

"They don't criticise us, but they don't have a good character, they get angry if we don't do some work they asked us to do […]. If I have a problem I don't know how to talk to them about it, I don't see them as a friend." [MBCSCLM2-3]

"When he visits me at home, he always takes his time to explain things to me clearly. But when he asks us to do something and we don't do it, he gets mad at us. I'm quite afraid of him. If I have a problem, I won't share it with him; I'm really scared of his attitude." [MKCSCLM5-1]

"*When he first came, he wasn't easy on us. When he had me write my name and I couldn't write it, he would yell at me. He would hit me with the pen on the back of my hand. I would get mad. Now, I know who he is. I don't hold any grudges against him. Now, I can write my name."* [MKCSCLM5-2]

As illustrated in the latter quote, relationships between members and case managers evolve over time, with mutual trust and respect being built during the implementation period. Supervisors indicated that it takes three to six months to build good relationships and for women to feel comfortable with case managers: *"In the beginning they don't believe [trust] the case manager but day after day the way we look after their family we ask the case manager to remember the name of their kids, […] so we make sure that the case manager see the evolvement."* [SUPERVISOR]

Respect of CLM members is part of case managers' and programme staff's contractual obligations and forms core to implementation and operation of the programme: "*The case managers know they are supposed to respect the members. Even if we have somebody like the cooks or someone who go to build the house we tell them and in their contract it says to respect the members."* [SUPERVISOR]

This does negate women's negative experiences, however. As data for this research was collected 10 months after members' start in the programme, responses therefore reflect experiences beyond the first stages of implementation. As such there appears to be a mismatch between the almost unanimously positive view of relationships between CLM members and case managers on behalf of programme staff and more mixed experiences by members themselves.

Yet pro-active and constructive engagements by case managers do appear to contribute to achieving positive change. This holds particularly in relation to more psychosocial issues, responsive caregiving and early learning for children. Cross-site analysis of case studies suggests that CLM members in La Chappelle mostly reported positive engagements with their case managers, and were also more forthcoming in terms of things that they had learned with respect to play and interaction with their children. The case study of Marceline and her spouse Robenson and their engagement with the case manager (Box 3 in section 4.3) provides an example of pro-active and positive interaction. Less positive experiences in interactions with case managers – such as those above – were reported more frequently in Mache Kana and Mable.

Messaging and advice is mostly directed at CLM members directly, with limited engagement of others. Depending on the extent to which spouses seek to engage, they may or may not be present during trainings or home visits. Few spouses indicated to know the case managers well, while most emphasised that they only see the case managers from a distance but never speak: *"I see them from afar, I never see their face to face, we never speak"* [MBCSSPOUSE5-1]. Across all 18 case studies for whom engagement with case managers was discussed, only two spouses indicated to have spoken with the case managers on multiple occasions.

Finally, it should be noted that case managers expressed frustration at their own situation and challenges in making ends meet. They indicated that they received low pay and that they are hardly able to provide for their own children. Case managers' own concerns about meeting their responsibilities as good parents and their ability to provide a good future for their children may undermine their motivation for their work, and particularly for dealing with complex or demanding cases: "*If we were to spend all our lives in the CLM programme, we would never be able to step up to our responsibilities because the little we are receiving is not worth much*". [LCFGCM]

This is not to say that case managers do not go to great lengths to try to help CLM members. Sometimes they use their own money to support women and their families: "*Because while encouraging them to send the child to school, you, as the project manager, have to help them. Because sometimes, you meet the member and he's telling you that they just sent the child back home from school because of tuition payment issues. If you have the money on you, you have to give it to the member."* (MKFGCM)

5.3. Synergy effect

The power of the programme appears to lie in the interaction and synergy between programme components. When asked about how the CLM programme has changed members' lives, respondents point towards the myriad of support that they received:

> *"CLM has brought changes to the community. It has helped people build houses and latrines. People have been given animals, and the programme has taught us how to manage the things we have. It has taught us how to write our names. It has given us a small amount of money to enable us to have a small sòl so we can send our children to school. They have given us training and shown us how we should take care of the children and how we should look after our homes".* [LCCSCLM2-2]

> Has the way in which you feed and care for your child changed since you became a CLM member? If so, how? ***"****Yes, because we are told at the trainings how to take care of them. The money they gave me helped buy materials to send the child to school. And I bought a chicken with the remainder of the money. If the child gets sick, I can sell the animal."* [MKCSCLM3-5]

> *"They are all important because they are all useful for us. I can sell one of the animal's babies and then I can pay for her school. The filter is good because it means my daughter drinks treated water. The training sessions and the advice they give me has meant that she doesn't go dirty any longer, she's clean. The house is helpful for her because she has a place to sleep."* [LCCSCLM5-3]

With respect to treating water, for example, the combination of teaching caregivers about the importance of drinking treated water in conjunction with the provision of water filters, showing how water filters are to be used and checking up on the use of water filters offered a synergetic effect, translating into firm statements about the use of treated water and its benefits: *"I drink treated water, it won't make me sick and I won't get diarrhoea or cholera. […] Because if you put water in the filter, it will purify it. When the children drink it, they won't get sick (diarrhoea)."* [LCCSCLM2-1]

Picture 2 Case manager discussing the use of the water filter with CLM member (©K Roelen)

This example also relates to the importance of experience in cementing positive change. The combination of economic, material and training support allows for creating new habits seeing the benefits of adopting new practices. Over the course of the programme, participants experience first-hand that drinking purified water reduces illness among their children, and that the practice of making this happen is feasible. Similar experiences were voiced with respect to a range of practices in relation to child care as well as income generation.

> "*He always gives us advice. Especially regarding how to take care of the children. Yes, the advice is good for us; we have taken it aboard now as a habit."* [LCFGCLM5-2]

> *"They gave me advice on how to take care of the livestock, I had goats, I tied them and take them in the afternoon, now I don't do that anymore. For negligence I sometime still do it but he [case manager] always comes to ask how they are. The advice make me go look after the livestock now. It was difficult because I wasn't used to do it. I forget, before it was difficult. Now it is not because I'm used to it. They gave me a lot of information and it's thanks to the trainings that I do these things now."* [MBCSCLM5-1]

Behaviour change may also result from regular supervision and check-up rather than intrinsic motivation. Various respondents indicated that they keep their children and home clean as case managers may visit by surprise. Supervisors indicated that avoidance of embarrassment when case managers make surprise visits plays into CLM members keeping up with advice. Such statements cast doubt over the sustainability of behaviour change and whether CLM members will maintain it after graduation: *"[I] used to be negligent in some ways, leaving the children dirty, but because [I] know [that I] might get a visit at any time, [I] keep them clean."* [LCFGCLM5-2]

It should also be noted that there are limitations to the extent to which the programme affects change. While positive change was widely reported, concerns about the inability to afford enough and adequate food, clothing and shoe wear, fees and supplies for schooling and health care remained widespread among CLM members. Despite positive change, lack of adequate nutrition, inability to go to school and poor sanitation were reported and observed as persistent problems for children of women participating in CLM (see also section 4).

"The members are often worried when they think about how they would like their children to be. One says she is worried because what she wants for her child can't be achieved because she doesn't have enough money. She doesn't ask for advice. […] However, the others are worried because they can't feed their children properly. They believe that their children should eat three times a day, but sometimes they can only feed them once a day. One of them says that sometimes she doesn't have anything and when she tries to borrow from others, they won't lend her anything. Another says she sometimes also worries because the child is sometimes barefoot and could get hurt, but she can't buy sandals for them." [LCFGCLM5-2]

5.4. Work and care trade-off

In line with existing evidence on the gendered juggling act of paid work and unpaid care (Chopra and Zambelli, 2018), we find that caregivers often struggle to combine their productive activities with the care for their children. This puts CLM members in a position of having to choose between two evils: leaving children at risk of low quality of care, or foregoing income-generating opportunities.

CLM members discussed how they often have to leave their infants with siblings, family members or neighbours as a result of undertaking activities that doesn't allow them to carry their children – and particularly infants – with them. In contrast to other contexts, mothers do not carry children on their backs out of concern that their children are affected by the 'evil eye'. Women generally only carry their children on their arm in front of them, meaning that it is very difficult to combine any type of chore or work activity with child care, especially for infants.

Women articulated the difficulties in combining chores and work with care, and the consequences for children of leaving them. They spoke of their children being dirty, not having received their bath or being unfed.

> Are there any times during the day when it is difficult to manage your own activities and those of the children at the same time? **"***Yes. When I go to fetch water. They stay in the yard by themselves. When their father is not there and I go to the marketplace, I don't know what they are going, I don't have any control over them and sometimes they are naughty. Once, I went to fetch a bit of water and I left them playing in the yard. One cut the other's finger, and I had to put aside what I was going to do in order to get them bandaged up in La Chappelle."* [LCCSCLM2-4]

> How do the consequences of paid work affect young children? Is there a difference between 0-2 year old children and 3-5? **"***This can result in the child living in the dirt because you might not have someone who can look after him. So you give the child to a neighbour who doesn't take good care of him, the 0-2 year old child can bit him. When you leave your child to someone, he can be malnourished because he didn't eat well with that person. You can leave the younger child (3-5 years old) with the older one, they can eat badly, he doesn't get washed because the older one might go play and leave the younger. The older one can take bad care of the younger, he mistreats him, he hits him."* [MBFGCLM2-1]

Sometimes this trade-off is directly related to the CLM programme, particularly in relation to the training that women undertook at the start of the programme. CLM members may spend less time with their children as a result or leave them without proper care. In instances when they can leave children with others, this may prevent the other person to undertake their paid work.

Since you started the CLM programme, do you spend more or less time with your children? **"***I spend less time with the baby. Sometimes I find she is soiled, because when I go to wash in the river, I leave her with the neighbour to watch over her for me*." [LCCSCLM2-2]

"*Sometimes my children go hungry when I go to the trainings*." [LCCSCLM2-1]

"*Sometimes I have to leave him in the care of other people so I can attend the [CLM] seminar. Sometimes, my mother can't go sell her stuff so she can stay with the baby for me when I go to the training."* [MKCSCLM2-1]

In a few cases, participation in CLM has led to more time being spent with children. In the case of Fabienne, for example, CLM has allowed her to substitute farming with rearing small livestock, which can be done closer to home and with more breaks.

Do you spend more or less time with your children after CLM? Why? **"***Yes, I spend more time; in the past, I used to spend my time on the farm; now I have animals to raise; I don't spend that kind of time anymore; The animals live close to me; they are being raised in my backyard; that's where I raise them. The children are always with me; I only leave them with grandma or their father when I go to attend the training."* [MKCSCLM2-4]

The extent to which CLM members consider the juggling act of combining paid work with unpaid work and care to pose a problem is mixed. A common response to questions about whether participation in the CLM programme and increased paid work poses a problem was that it indeed compromises the ability to care for children or that it hurts their bodies but that it is okay because of the larger economic benefits afforded by the programme.

"I spend less time with her because I have got work to do, like taking the goats to pasture, feeding the pigs, going to the training sessions. But I don't mind because they are helpful for me." [LCCSCLM5-3]

"When I went to take the livestock in the weeds, the rain wet me up and I got sick, I had a fever, I could fall down, get hurt, but I am happy because the livestock will be useful for me above all because I can sell them to send the children to school." [MBFGCLM5-1]

Nevertheless, we also find that challenges of the juggling act cannot always be downplayed and poses real constraints to women's abilities to make use of economic opportunities. If they don't have anyone else whom they may choose to forego such opportunities. This includes trade at the market or carrying any type of load, as this interferes with the ability to carry a child.

"There are certain activities I can't do because of the children, such as petty commerce, or carrying loads. Also - you can't find people to watch over them." [LCCSCLM2-4]

"I can't start a small business at any moment. You can't be selling things with the child." [MCCSCLM2-4]

Overall, women very clearly articulated the tension between the access to material resources in support of children's care that paid work affords and the risks of leaving their children with others or on their own. The extent to which they balance one against the other depends on their access to support networks with people that they trust (including their spouses) and the age of the child. For instance, during the first six months, babies are highly dependent on their mothers and cannot easily

be left with others. Gradually as the infant begins to wean and become more independent, mothers can more easily leave their child with other carers.

> *"When you're going to perform a paid job, you leave your child behind; or you leave him under someone else's care. He might suffer from malnutrition because he's not well taken care of. […] When you're not around, your child withers, he gets thin. His legs are thin because the father doesn't have the time to take care of the child. […] The paid jobs hurts [us], but when [we] get paid the money is useful. If the child was sick, they'd have money to bring the child to the hospital."* [MKFGCLM2-1]

> *"[I]f you have a 5 months or a 3 month-old baby, it is very important to have another family member, but if your kids are 5-6 years old they can take a shower by themselves, cook by themselves and they can also look after the little one. So they don't need another family member [to look after the baby], they need more money to feed them […] it depends [on] the age of your kids and how many family members you have with you."* [SUPERVISOR]

Similar to a study conducted in the Central Plateau in 2003, CLM members (and their spouses) tended to prefer female relatives to look after their children before resorting to husbands or non-related neighbours (Menon, Ruel et al. 2002). Grandmothers and aunts were often mentioned as first choice when it comes to care giving. A CLM member in La Chappelle puts it as follows: *"[a] grandmother is a second mother, she loves them because they are the son/daughter of her son/daughter, she is not bad with the child, they have the same blood."* [LCFGCLM5-1].

6. Cross-cutting themes

The effects of the CLM programme on ECD and child wellbeing are mitigated in various ways. We identify five themes that emerged from across our data, namely (i) identity, (ii) trust, (iii) relationships, (iv) basic services and infrastructure, and (v) aspirations for the future.

6.1. Identity

Identity, particularly in terms of gender, cuts across the way in which the CLM programme affects young children in important ways. Firstly, the programme introduces or strengthens a new identity for women as strong and independent individuals who are able to build lives for themselves. This dynamic presents the bedrock for the CLM programme and its objectives as greater economic activity by women reduces poverty and can lead to empowerment, both of which are to the benefit of children. Secondly, the programme reinforces traditional identities of women as primary caregivers, feeding into and building on women's roles as the main provider of care and unpaid work. While the immediate effect on children may be beneficial as the engagement with women offers the most direct route to improving nutrition, health and caregiving outcomes, the expectation that women are to combine both care activities, unpaid work and paid work is unsustainable and may ultimately lead to an erosion of quality of care for children. Thirdly, and relatedly, the programme does little to challenge identities of men as caregivers with very limited attempts to engage spouses or other men in messaging about health, nutrition and caregiving. This represents missed opportunities for the establishment of an enabling environment for nurturing care in the short-term and for creating more equal gender relations in the long-term.

We discuss each of these dynamics in turn below.

The CLM programme is premised on the belief that **women are powerful individuals with agency and resilience**, focusing on their economic and social empowerment. This premise rings through in both programme design and delivery. Explicit targeting of women as main beneficiaries, their engagement in economic activities and the establishment of VSLAs emphasise women's productive skills and economic agency. Importantly, the messaging that accompanies programme delivery reinforces the notion that women are powerful and resilient individuals. This is evidenced by the texts of the CLM songs that are sung at programme meetings and during trainings, such as the one in Box 5.

Box 5 Text of CLM song II

CLM song II

Nou p ap bay legen nan batay la. [We will not give up the fight]
Nou p ap fout sede pou asasen yo. [We will not give in to the assailants]
Nou p ap bay legen nan batay la. [We will not give up the fight]
Vitwa final la se pou fanm li ye. [The final victory will be ours, the women]

Nou pase mizè, se vre. [We have endured poverty, it's true]
Nou sibi lenjistis ase. [We suffered injustice]
Fòk nou pa bliye [It must not be forgotten,]
Fanm yo se wozo p ap kase o. [that women are reeds, they do not break]

The provision of comprehensive support allows women to put messaging about productivity and economic agency into practice, and to experience greater economic autonomy. The ability to save through VSLAs and knowledge of how to rear livestock were mentioned as important elements in this. Learning to write one's name – which happens early on in the programme – also proved powerful in improving women's sense of self-worth (see Box 6). As a result, CLM members feel greater autonomy and control over their lives. This in turn allows for them to provide better care to their children, and for intra-household relationships to improve.

Box 6 Effect of learning to write one's name

Why do you think that learning to write and training are the second most important things for you?
They answered by saying 'if our name is written somewhere, we'll know, because we can read and write our names now.' […] Another said: 'my mother couldn't write her name. She always used to have to use a thumbprint. I used to be ashamed about that. Now she can write her name thanks to CLM.

Why do you think that teaching the members to write their name is the most important thing for the children?
Some of the participants said that it has enabled them to send their children to school so they can learn how to write their names as well; it's nice when you go somewhere and the child can write their name.

[based on field notes for LCFGCLM5-2]

An element of programme implementation that runs counter to these messages is the gender composition of programme staff, and particularly of the case managers and supervisors that interact with CLM members directly. The large majority of staff is currently male.

In addition, while the programme clearly offers hope, aspiration and a sense of self-worth, these feelings are not accompanied by a sense of deservingness. CLM members are very grateful to the CLM programme and offer few suggestions for improvement as they deem the programme to be a gift

bestowed upon them from outside, with other deciding whether and what kind of support they are deserving of receiving: "*The programme has been good for me. I didn't have any future, but CLM has allowed me to live with hope. I don't know what should be done [to improve the programme]; they are the ones who should see what we deserve so they can give it to us."* [LCCSCLM2-4]

Greater emphasis on women's roles as economic agents is not matched with greater sharing of household work and care responsibilities. The belief that **mothers carry the primary responsibility for children's care** is held by both women and men. Female and male respondents voiced their opinion in no uncertain terms: "*When a mother has a child, she is responsible for providing them with everything*" [LCCSSpouse2-4]. The CLM programme does not explicitly state that women hold primary responsibility for the provision of care for their children. Yet, messaging on nutrition, health and caregiving tap into women's roles main providers of care. Moreover, beliefs held by programme staff reinforce existing beliefs about gender norms, particularly in terms of roles in caregiving.

The programme's lessons with respect to feeding practices, hygiene, sanitation and caregiving for unborn children are primarily directed at female CLM members. Men may be involved in discussions about these messages if they are around at the time of the case managers' visits, but their engagement is not actively pursued. As highlighted in section 5.2, spouses rarely engage with trainings or home visits. In addition, case managers emphasise that women are required to take good care of their children, reinforcing the notion that primary responsibility for child care lies with women*: "The advices we can give her, is that taking care of a child is not easy. If you can't take care of him, he is poor and then spends the rest of his life in misery."* [MBFGCM]

The notion that women are both powerful individuals with economic agency and that women are primarily responsible for children's care sets high expectations for CLM members that are virtually impossible to achieve. For instance, songs that are sung in relation to the CLM programme during the inception training, graduation ceremony and throughout the programmer period highlight women's strength and resilience, and their ability to rise above living in poverty and facing injustice. At the same time they also emphasise women's central role in the household, serving as the main pillar for the household (see Box 7). While the emphasis on women's strength and resilience certainly works empowering, the notion of women serving as the main foundation for the household also reinforces engrained gender roles.

Box 7 Text of CLM song III

CLM song III

Fanm se pa yon bale ki apiye nan yon kwen,
[The woman is not a broom that is leaning in a corner]
Fanm se pa yon rido pou w ap tchoule ban m pase,
[The woman is not a curtain to be dismissed and passed]
Fanm se pa yon kabann ki abiye san sòti,
[The woman is not a bed that is all dressed up and stays at home]
Fanm se poto mitan la vi a.
[The woman is the central pillar of household life]

Case managers' perceptions (see Box 8) of what makes a good mother or father also highlight the multitude of expectations, pointing at women' roles as successful entrepreneurs as well as housewives. In terms of their roles vis-à-vis men, they are expected to be successful but without overpowering their spouses.

Box 8 Case managers' perceptions of good motherhood and fatherhood

What would a mother of a child that has a good life be like?
CM #3: She would need to have an intellectual capacity, so the child could learn from her.
CM #6: The mother should know her rights and duties as a mother. She should have everything she needs.

What kind of activities would the child's mother do?
CM #4: She would need some business activity. It's good to spank the child too.
CM #6: The mother should be a housewife.

What would the child's father be like?
CM #6: The father must be strong, a person who won't let himself be dominated by women. He should have an activity so he can earn an income.
CM #1: The father needs to be responsible, because he needs to think about his family's future and not be someone who wants to party all the time.
CM #3: He ought to be knowledgeable and make money.

What kind of activities would the father do with the child?
CM #5: He needs to be a caring father, who is affectionate and who spends time with the child, and who gives them advice.
CM #3: He needs to be able to provide for his child's needs.

[based on transcripts for LCFGMCM]

Findings show that men play a vital role in providing for their children. As illustrated in Box 8, case managers consider good fathers to be main providers in terms of income and to be engaged with their children. Spouses and other male caregivers also talked about their responses to illness and feeding practices. At the same their responses also revealed that care for children was mostly considered a woman's responsibility.

> *"Yes, [the CLM managers] give advice. Keep the child healthy. Bring them to the health centre when they are sick. Always feed them, put clean clothes on them. The information is useful…The advice is often spot on, because there were times when she wasn't home and left the children with others. Some of the advice is not spot on, because sometimes the children's clothing is [still] dirty. Often, it is when they are going to get a visit that they clean up the children. Sometimes they are negligent. For the advice to be spot on, it is when they tell her something and she puts it into practice. When it is not spot on, that's when she doesn't apply it."* [LCCSSPOUSE2-2]

> *"The father takes the child and caresses him. If the baby continues to cry and is not hungry, it means he has a problem. I tell to my wife to take him to the hospital."* [MBCSSPOUSE2-2]

These expectations are not limited to men but are also prevalent among women. Women indicated that good fathers play and interact with their children in a more leisurely manner, and that they only get involved in providing care in terms of feeding, washing or dressing the child when the mother is absent.

The gendered division of roles also emerged in discussions about daily activities. Men spend most of their time in the fields, at the sugarcane mill or away from home, while women spend most of their time at the market, washing clothes, collecting firewood or doing chores in around the house. As

highlighted by one female respondent in response to whether her husband helps with activities around the house: "*No, because Haitian men don't help out with cleaning".* [LCCSCLM5-1]

Picture 3 Mother and father undertaking household chores and interacting with their children (© S. K. Kim)

Practices with respect to preparing and eating meals together also indicate that gender patterns are transferred to children. One spouse described how men and boys get served food at the table while girls help their mothers with the preparation of food and eat by the fire: *"Yes, there is a difference because the mother makes the food and she takes the boys food and serves him at the table. The girl is near the fire, helping her mother, and she serves herself [there]. They serve the boys at the table to teach them not to eat their food at the fireside."* [LCCSSPOUSE2-2]

The CLM programme does not attempt to challenge these norms regarding care responsibilities, and may even be seen to feed into them. Their explicit targeting of women for health messaging without seeking involvement of men means that women are singled out for improving wellbeing of their children. This reinforces the notion that nurturing care, particularly in terms of health and nutrition, is primarily a mother's responsibility.

6.2. Relationships

Three types of relationships prove crucial to programme success and for supporting child development, namely (i) supportive spousal relationships and family ties, (ii) positive community relationships and (iii) mutually respectful relationships with case managers.

Strong spousal relationships and family ties are vital for supporting CLM members in providing care for their children when they are engaging in paid or unpaid work activities. Experiences of women with trusted family and community members living close by show that the ability to leave children in the care of others is crucial for them: *"My husband's family, because when I am not here, they take care of the children for me. My family, because they help the children out in many ways. They give them things when they have them. The neighbours I go to church with, because they bathe the children and fix their hair for me."* [LCCSCLM2-1]

Unfortunately the experience of disruptive family and spousal relationships is a common one for CLM members. The story of Judeline, a 28-year old CLM member, illustrates the challenging relationships that many members have to navigate (see Box 9).

Box 9 Case study of Judeline – example of spousal relationships

Judeline is 28 years old and lives with her five children ranging from 2 months to 13 years old in age. She receives no support from the respective fathers of her children, following various conflict with them. Judeline explained:

"I have been living with my children since they were born. I have raised them in this area and this is where they have grown up. […] I used to argue with the father of the 3 first children. He would go out and come back and say that I had another husband. He left the house and never came back and since then I have never heard from him or seen him. I think he has died, because no one ever tells me they have seen him, and I have never seen any of his family members.

I had a man in the house; he was my boyfriend. He asked me to have a baby for him, but I had just given birth to a child and they weren't 3 months old yet. I didn't want to; so I used birth control without him knowing. When he found out, he got angry and left the house. Since then, he comes around once in a while, when he wants.

The father of the two [youngest] children fell ill, he went crazy. He was here, and his family came and took him away. He never came back, because the family said that it was because of me that he became ill. They said that he stepped into magical powder while working on one of his mother's plots of land.

Judeline's sister spoke about how the small support network is weighing down on Judeline: "she suffers because she doesn't have a husband who is living with her on a stable basis. Life is difficult for her because she doesn't have anyone to reach out to if she needs something."

[based on transcripts for LCCSCLM2-3 and LCCSSpouse2-3]

CLM programme staff highlighted that positive spousal relationships are vital to programme success. They referred to three categories of spouses: (i) cooperative spouses, (ii) disruptive spouses and (iii) disengaged spouses, and related these categories to members' progress in the programme:

> *"CLM [members] advance quickly when they have very good relationship with the husband, he is happy to talk with her, and sometimes the good relationship makes that women start to invest their money from 6 months onwards. The category of those who are slow climbers sometimes have husbands that don't work them; the case manager can go and give explanations but the husband doesn't want to work with them. Third category are slow climbers where the husband is not trustful and doesn't want to work or women who are not even there and who doesn't want to share the responsibility with them and don't care about the children. He doesn't even see his children at all."* [SUPERVISOR]

In some cases, CLM managers are able to improve relationships and foster spousal collaboration, such as in the case of Madeline (see Box 3 above) or to help manage a difficult situation and undertake damage control, such as in the case of Kimberley, a 23-year old CLM member from Mache Kana:

> *"My husband can be rude at times; he has a dirty mouth; he would say ugly things; we'd get into arguments, when they give me the money, he would take the money from me; when I ask him to give me the money back, he starts to insult me; he would even hit me. I reported that to Estiverne; he came and spoke to him. He finally returned 1000 gourdes out of the 360 Haitian dollars (1800 gourdes) that CLM gave to me and he had borrowed 360 Haitian dollars from me. Then I had to add the rest of the money in order to buy the goat. He took the money and he went and played some betting game with it. He would tell me that the CLM program*

won't be useful to him. After he returned the loan, he would claim that it was his money that bought the goat. I told him that he's lying and that it's CLM's money. It wasn't his." [MKCSCLM5-2]

The CLM programme has also helped some members to extricate themselves from disruptive and potentially harmful relationships, such as by allowing them to build a house for themselves to live in (see Box 10).

Box 10 Importance of housing for removing oneself from disruptive relationships

Why do you think the house is the most important thing for you?

Each of the participants gave a different answer.

The first one said: 'I had nowhere to live. I stayed at other people's houses. People used to swear at me. Now I have my own house. I can come in when I want and go out whenever I please.'

Another said: 'I was living with my mother. Some of my brothers used to hit my children because we don't have the same father. It was their father's house and he is not my Dad. After that, I went to live at my Godmother's house, but they kicked me out at 11 at night. Now, thanks to CLM, I have my own house and I won't have to put up with any more distress.'

Another one said: 'I was living at my father's house. He kept saying that he would knock down the house with me in it. I was very worried. When I joined CLM, he saw that I was getting corrugated metal, so he stopped saying those things.'

[based on field notes for LCFGCLM5-2]

Community relations were less frequently mentioned but did appear significant. Jealousy of community members and tensions were reported by some CLM members, sometimes making it harder for members to participate in economic activities on equal footing. For example, CLM members reported that other community members may not feel obliged to repay loans or pay for items purchased on credit as members are perceived to receive 'free money' through CLM [MBCSCLM2-3]. This puts a strain on the success of economic activities supported by CLM. CLM members also reported to feel ridiculed at times for practices that were uncommon, such as building shelter for their goats. Such tensions appear to lessen over time, particularly when the case managers help to explain the situation.

The latter example reinforces the notion that **case managers** play a crucial role in CLM, and that a positive relationship with members is foundational to this, as discussed in section 5.2.

6.3. Trust

Lack of trust in others, including family members, community members or strangers, emerged as a strong theme in discussions with children's caregivers. The lack of trust impedes the provision of nurturing care for children in two ways: Firstly it constrains social support networks, leaving many caregivers with a small circles of trusted individuals whom they feel that they can rely on for provision of care for their children in their absence. Secondly, and relatedly, it undermines the ability to make full use of the possibilities offered by CLM in conjunction with the provision of child care.

The lack of trust interacts with beliefs and practices surrounding *Vodoun* and the 'evil eye': *"There are some neighbours I don't trust, because not everyone acts the same way with children. That is why my*

husband doesn't want me to leave them with just anyone, because they are jealous of him because of land, and he doesn't want them to hurt the children." [LCCSCLM2-4]

As discussed in section 5.4, while members prefer to rely on female relatives to look after their young children, this may not always be possible. Furthermore, preferences also shift as infants and their children grow older. Children aged 5 and above are considered to be capable of looking after their younger siblings. CLM members do worry about the quality of care for all their children as a result of this arrangement but prefer this to asking adults whom they don't fully trust. Angeline from La Chappelle, for example, indicates that she leaves her one-year old daughter at home with her siblings, the oldest of whom is seven years old but that she worries about their wellbeing and returns as quickly as possible. She explains: *"When I go to the fields with others – when I sell a day's labour – that is when it is difficult for me. When that happens, I don't know what the children eat."* [LCCSCLM2-4]

Programme staff provided insights into sibling care, and the implications for infants and their siblings: *"it depends, if you have a 5 months or a 3 month-old baby, it is very important to have another family member, but if your kids are 5-6 years old they can take a shower by themselves, cook by themselves and they can also look after the little one. So they don't need another family member [to look after the baby], they need more money to feed them so it's… it depends on you know… the age of your kids and how many family members you have with you."* [SUPERVISOR]

Pervasive levels of distrust puts up barriers for interventions to support a nurturing environment. For example, the provision of child care at a communal level either through or supported by the programme would not work due to fears that others taking care of children may harm them or not have their best interests at heart: "*Only family members [can look after members' children] because, this is not like in other countries where they leave the baby in a day care centre, people won't do that here…because they think is not safe to leave the baby with someone else because you know they think that they are the one who are supposed to take care of the baby …"* [SUPERVISOR]

6.4. Basic services and infrastructure

Basic services such as health care and schooling, and infrastructure such as supply of clean drinking water were deemed vital by both CLM members, their family members and CLM staff for enabling healthy development of children. As discussed previously, the provision of public services is very low throughout the country. This also holds true for the research sites in Central Plateau, although cross-site differences exist.

In terms of **health**, CLM members – along with all community members – have access to community health agents. Community health agents play an important role in reducing the accessibility gap and cost of public and private health services. In areas where health agents live, they serve as a first point of contact for diagnosis, consultation and referral to health centres and hospitals. For instance, in La Chappelle, CLM members consulted with the health agent who lived nearby for various health concerns including fever, diarrhoea, cuts and bruises, and routine immunisation. Health agents can treat most of the minor injuries and prescribe generic medicine. They can also act swiftly in cases of emergency, and save lives. In one occasion, a CLM member recounts when her child was ill: *"I brought [my child] and [the health agent] told me to rush them to the hospital in Verettes because they had malaria."* [LCCSCLM5-1]

In places where health agents do not live in situ, then they make weekly rounds of visits to villages such is the case in Mache Kana. The frequency of such visits may be more sporadic in remote areas such as Mable. Overall, access to health services will differ considerably depending on where one lives.

The CLM programme offers quite strong linkages to health services. It has a staff nurse, who undertakes health checks and offers advice. CLM members also have access to healthcare in the hospital in Mirebalais that is run by Partners in Health free of charge. In cases of emergency, programme staff will try to get CLM members to the hospital, de facto serving as an ambulance service.

Such linkages do not exist for **education**. One of the supervisors explained: *"In our programme of course we help our members but because we also have a limited budget…we can't do everything for them. So even if we focus on education we can't provide them with assistance so their kids can go to school. We don't do that directly so we provide assets, we work on activities with our member so they can make money and they can send their kid to school and… because we know they don't have money to do that, you know, sometimes we sit with school directors and ask them not to send back their kids to their mom [if they don't have the money to pay] so that they can accept to receive the fees in different parts [instalments] instead of all together…*" [SUPERVISOR].

In referring to issues regarding school enrolment and attendance, these pertain to primary and secondary schooling. Early childhood education services are not available in the study sites.

In terms of **drinking water**, there are several sources of fresh water in the study sites with varying quality and difficulty in accessibility. In Mache Kana, for instance, there are several water springs and creeks and a river. People tend to use the river for bathing and laundry, and to use a spring for collecting drinking water. However, openings of water springs are not protected and when it rains, the overflow from the river contaminates the spring water, which makes it unsafe for consumption [MKCSCLM2-2]. The quality of water from the river is also questionable as "*animals might defecate in it, and it's next to a creek and [some people] might drop bad things in it."* [MKCSSPOUSE2-3].

In comparison, in La Chappelle, there are standpipes that provide clean water throughout the year. However, the number of standpipes are too low to cover the population adequately, and some CLM members living in this zone used spring water for drinking instead [LCFGCLM5-2].

For residents in Mable, which is the most remote of the three sites, water access is very limited. People collect rainwater. If this is insufficient, they rely on a pond. Once the pond dries up, then they go to the nearest water source or the river in the valley that could take at least 40 minutes to reach [MBFGCLM5-2]. The elevation and gradient of the route make the task nearly impossible without the help of a draught animal such as donkey, mule and horse. None of the CLM members owned draught animals so they often have to borrow them from other neighbours.

Picture 4 Water point in La Chappelle and washing in river in Mache Kana (© K. Roelen (left); © S.K. Kim (right))

The lack of availability of and access to basic services and infrastructure such as health care, schooling and early education and sources of clean drinking water presents a real barrier to improving early childhood development. One of the supervisors articulated this as follows:

> What are the biggest challenges for the CLM members to care after their children? *"[One] main problem with children is to go to the hospital when they are sick because sometimes when the child is sick that is going to create a problem. [Second] the water is not accessible. There are no schools of good quality and the children who are 10 are with children who are 4-5 years sold, and there is no formal economy and the market is far and there is no way to get there as they are in bad condition."* [SUPERVISOR]

The programme's limited set of linkages to services and infrastructure that are crucial for underpinning nurturing inevitably dampens the potential effect on ECD. One supervisor clearly articulated the need for such linkages but also pointed at the difficulties for a programme like CLM to do so given its short-term nature: So we know that it would be better if we could have that, you know? To pay fees, but you know because this is an 18 months programme, so if you do that in 18 months [afterwards] we think that they might leave their kids at home because they don't receive help anymore from us so we try to encourage them and to make them aware that this is a good thing, to send their children to school themselves" [SUPERVISOR].

6.5. Aspirations for the future

Aspirations for children's short-term future revolve around going to school, attending church and obeying their parents. This combination would ensure that children grow up to become good adults and that they do not cause problems in the community: "*He should go to school and attend church. He should grow fast without getting sick. He needs to go to church to have a good life. […] He needs to go to school because the school will allow him to progress and it will show him how to be a good citizen, how to speak […]. In the next five years, we'd like the children to be healthy, not sick, and they continue going to school."* [MKFGCLM5-1]

One of the core assumptions of raising a child in good manner and behaviour also has to do with preserving a long-term relationship with their children. A well-disciplined and principled child is unlikely to neglect in caring for the elderly parents and the society. A case manager from Mache Kana explained this point succinctly: "*I hope to remain on good terms with the child. I hope the child will*

progress and become well respected in the community, that he becomes a productive member of society." [MKFGCM]

Notwithstanding the programme's positive effects and members' gratitude for how it improves their own lives and the lives of their children, CLM members are also very aware of the programme's limitations in affecting sustainable change for their children into the future. The level of support is deemed too small and the context too challenging to allow for children to break the mould.

As parents, CLM members and their spouses expressed both hope and worry at the prospect of their children's future. Their main wish and concern was to be able to provide and meet the growing demands of the children. For example, one of the participants in the group discussion expressed that *"we'll look forward to the future so that I can provide for the child and so one day they can become someone worthy of respect, so that I can bring my child up".* [LCFGSPOUSE2-1]

Many parents saw children's futures away from farming and land. Parents aspired to their children pursuing jobs that would pay well and professions that would make good use of higher education. In the words of one CLM member: *"there is no need to go to school if they would only work on farming."* [LCCSCLM5-4]. Several CLM members were hoping for their children to travel and to settle outside of the country.

However, many of the CLM members and spouses expressed a sense of powerlessness at not being able to offer children the opportunities that they aspire to: *"[T]he most worrying thing is that you don't have any money. You say to yourself, look how I am living, and what will we do with the children who are on their way, how will we manage?"* [LCFGSPOUSE5-1]

Factors and risks beyond the control of individual families feed into these concerns. Political instability, job insecurity, natural disasters or sudden death from accident or illness and their consequences deeply worried some CLM members. Despite these bleak conditions, however, CLM members and their spouses were practical about their situation and saw the task at hand objectively: "I *don't have that ability. We are just doing our best*." [LCFGSPOUSE5-1]

7. Conclusion

Many children in Haiti face an unfavourable and challenging start to life. Poverty is common and deep, malnutrition is widespread and illness is an everyday reality. Many of them grow up in unstable family conditions and within limited networks of trustworthy relationships. This research aimed to gain an in-depth and contextualised understanding of the extent to which economic strengthening coupled with training and messaging regarding health, nutrition and sanitation practices through comprehensive social protection programming can support ECD and support stronger futures for children. In particular, it studied a programme based on the 'graduation approach' – the CLM programme – that is directed at women living in extreme poverty in rural Haiti, zooming in on their children below the age of five years old.

Findings suggest that 'graduation programmes' like the CLM programme can support ECD. In terms of the Nurturing Care framework, findings point to positive contributions in the areas of health, nutrition and safety and security. Children are reported to eat more and better foods, to be kept cleaner and safer, and to become ill less often. The programme has a more modest role in areas of and limited role in promoting responsive caregiving and early learning. Caregivers report to talk to their babies and infants, feed and sooth their babies when upset, and to sing and play with their children. Nevertheless,

stimulation of and positive engagement with children is limited with corporal punishment being common once children are able to talk and move around.

Positive changes are achieved through economic strengthening, provision of important materials such as housing materials and training and support by dedicated case managers that improves livelihoods and focuses on health, nutrition and sanitation practices. Synergies that are created by combining these components allow for gaining experience in practices and witnessing their positive effects on children. These positive effects of on early childhood development, albeit modest, are encouraging, particularly given the many structural barriers that programme participants and their families face. Such effects may be extended to the wider remit of nurturing care by expanding the set of health messages to include a greater focus on responsive caregiving and early learning.

However, the programme participation and the focus on women's economic activities also comes at a cost. The research clearly indicates that programme participants with young children are walking a tightrope, trying to fulfil a multitude of roles as primary caregivers, good wives, respected family and community members and productive farmers or traders. This inevitably undermines the quality of care for children, and particularly infants. Women are forced to choose between either engaging in income generation that may leave their children at risk of low-quality care, or looking after their children and losing out on earning much needed income. Programme participants may not voice their impossible balancing act as they feel grateful for the support that they receive through the programme and hold on to their identity as primary caregivers whilst at the same taking pride in entering a man's world of productive work. However, this does not negate the fact that the impossibility for women to juggle all their responsibilities undermines child development (and of course their own physical and mental wellbeing).

Other mediating (and related) factors for programme success and positive impacts on children are trust, strong relationships, and the availability of basic services and infrastructure. Concerns about putting children at risk, often grounded in spiritual beliefs, lead to high distrust of neighbours and community members, thereby limiting opportunities for provision of communal child care. Trust is crucial to social support networks that allow for a sharing of child care responsibilities and other tasks, both within extended families and communities. Strong relationships prove to be the backbone of programme success, and for positive impacts on children. Strong spousal relationships are associated with greater economic success, and with better outcomes for children in all aspects of nurturing care. The relationship with case managers is also key, with positive relationships instilling a sense of confidence and self-worth that makes it easier to absorb messages and change practices that are vital for ECD. Caregivers' economic security needs to be accompanied with the availability of quality basic services such as health care, early childhood education and clean water for securing an enabling environment for children.

Caregivers hold high hopes for their children's futures and at the same are concerned about the inability to provide their children with the chances to achieve such futures. Programme participation allows for taking the first steps to creating more favourable conditions for children's first stages in life. Changes to programme design and implementation may harness and expand the programme's positive effects on ECD. Ultimately, pathways to stronger futures for children in rural Haiti can only be secured by wider systemic change with greater availability of and access to basic services.

8. Programme recommendations

On the basis of research findings, we formulate the following recommendations for the CLM programme, and graduation programmes at large:

Firstly, **improving impacts on ECD and nurturing care** in areas of safety and security, responsive caregiving and early learning by:

- Including more messaging on responsive caregiving and early learning;
- Discussing and challenging the use of corporal punishment for disciplining children. Doing so may also require wider conversations about the pervasiveness of violence in children's and CLM members' lives;
- Involving spouses and other caregivers in messaging and discussions about all aspects of nurturing care;
- Working with 'nurturing care champions', ensuring that case managers and project staff lead by example. This entails the adoption of a respectful approach and appropriate attitude to early childhood development, in particular responsive caregiving and early learning.

Secondly, **recasting the (lack of) engagement with unpaid care** work that is undertaken by the women that the programme serves, including the care that is provided for their young children. This includes shifts in narratives that are introduced or reinforced through the programme and changes in livelihoods that are promoted through the programme. Ultimately, childhood development can only be achieved through graduation programming when it recognises, reduces and redistributes women's care responsibilities. This can be done through:

- Discussing the juggling act of work and care in programme trainings and during home visits to display recognition of the issue and start a conversation about potential solutions;
- Rethinking asset transfers and livelihoods option in light of the work and care juggling act, and exploring options for conducting economic activities closer to home. Viability of this option would depend on availability of local markets, amongst others. It should also be noted that this option does not challenge women's roles as primary caregivers;
- Actively seeking for and supporting solutions for child care by strengthening existing mechanisms or exploring and trying new, possibly member-led, initiatives. Trialling such initiatives during the launch and training may contribute to developing trust and confidence and to building a practice of child care that can gradually involve more people and extend the practice;
- Avoiding explicit and implicit messaging that women carry prime responsibility for provision of care for children, particularly in combination with economic activities;
- Actively challenging gender norms regarding responsibility for child care by discussing these in training and during home visits.

Finally, promoting childhood development for all children requires **access to affordable and quality basic services**. While provision of services is beyond the remit of graduation programmes, linkages can be strengthened by:

- Building more linkages and establishing closer collaboration with other organisations that offer vital services to infants and children, including early childhood education and health services;
- Discussing with and keeping pressure on government to provide basic services and infrastructure such as health care, schooling and clean drinking water.

References

Ahmed, A., J. Hoddinott, S. Roy, E. Sraboni, W. Quabili and A. Margolies (2016). Which Kinds of Social Safety Net Transfers Work Best for the Ultra Poor in Bangladesh? Operation and Impacts of the Transfer Modality Research Initiative. Dhaka: IFPRI and WFP.

Banerjee, A., E. Duflo, N. Goldberg, D. Karlan, R. Osei, W. Parienté, J. Shapiro, B. Thuysbaert and C. Udry (2015). A multifaceted program causes lasting progress for the very poor: Evidence from six countries. *Science* 348(6236).

Barrientos, A., J. Byrne, P. Peña and J. M. Villa (2014). Social transfers and child protection in the South. *Children and Youth Services Review* 47(2): 105-112.

Bastagli, F., J. Hagen-Zanker, L. Harman, V. Barca, G. Sturge, T. Schmidt and L. Pellerano (2016). Cash transfers: what does the evidence say? London: ODI.

Bastien, R. (1985). Le paysan haïtien et sa famille: vallée de Marbial, ACCT: Editions Karthala.

Black, M. M., S. P. Walker, L. C. H. Fernald, C. T. Andersen, A. M. DiGirolamo, C. Lu, D. C. McCoy, G. Fink, Y. R. Shawar, J. Shiffman, A. E. Devercelli, Q. T. Wodon, E. Vargas-Barón and S. Grantham-McGregor (2017). Early childhood development coming of age: science through the life course. *The Lancet* 389(10064): 77-90.

Carter, M. R. and C. B. Barrett (2007). Asset Thresholds and Social Protection: A 'Think-Piece'. *IDS Bulletin* 38(3): 34-38.

Chopra, D. and E. Zambelli (2017). No Time to Rest: Women's Lived Experiences of Balancing Paid Work and Unpaid Care Work. Brighton: Institute of Development Studies.

Cianelli, R., E. Mitchell, L. Albuja, C. Wilkinson, D. Anglade, M. Chery and N. Peragallo (2014). Maternal - Child Health Needs Assessment in Haiti. *International Journal of Applied Science and Technology* 4(5): 30-38.

de Groot, R., T. Palermo, S. Handa, L. P. Ragno and A. Peterman (2017). Cash Transfers and Child Nutrition: Pathways and Impacts. *Development Policy Review* 35(5): 621-643.

Devereux, S. and R. Sabates-Wheeler (2015). Graduating from Social Protection? Editorial Introduction. *IDS Bulletin* 46(2): 1-12.

Devin, R. B. and P. I. Erickson (1996). The influence of male care givers on child health in rural Haiti. *Social Science & Medicine* 43(4): 479-488.

Engle, P. L., L. C. H. Fernald, H. Alderman, J. Behrman, C. O'Gara, A. Yousafzai, M. C. de Mello, M. Hidrobo, N. Ulkuer, I. Ertem and S. Iltus (2011). Strategies for reducing inequalities and improving developmental outcomes for young children in low-income and middle-income countries. *The Lancet* 378(9799): 1339-1353.

Fabrizio, C. S., M. van Liere and G. Pelto (2014). Identifying determinants of effective complementary feeding behaviour change interventions in developing countries. *Maternal & Child Nutrition* 10(4): 575-592.

Fonkoze. (2019). "About Fonkoze." URL: https://www.fonkoze.org/about.html, last accessed 8 February 2019.

Fonkoze. (2019). "Chemen Lavi Miyò (CLM)." URL: https://www.fonkoze.org/clm.html, last accessed 8 February 2019.

Hashemi, S. M. and W. Umaira (2011). New pathways for the poorest: the graduation model from BRAC. CSP Research Report 10. Brighton: Centre for Social Protection/ Institute of Development Studies.

IHE and ICF (2018). Enquête Mortalité, Morbidité et Utilisation des Services en Haïti 2016-2017. Rockville, Maryland, USA, Institut Haïtien de l'Enfance (IHE) et ICF.

IHE and ICF (2018). Enquête Mortalité, Morbidité et Utilisation des Services en Haïti 2016-2017: Rapport de synthèse. Rockville, Maryland, USA, Institut Haïtien de l'Enfance (IHE) et ICF.

IHSI (2005). Enquête sur les Conditions de Vie des Ménages en Haïti (ECVH 2001). Volume II. Port-au-Prince: Institut Haïtien de Statistique et d'Informatique.

Kirkpatrick, S. M. and A. K. Cobb (1990). Health Beliefs Related to Diarrhea in Haitian Children: Building Transcultural Nursing Knowledge. *Journal of Transcultural Nursing* 1(2): 2-12.

Lamaute-Brisson, N. (2010). Economie des soins aux enfants en Haïti: prestataires, ménages et parenté. Santiago, Division de la promotion de l'égalité des sexes de la Commission économique pour l'Amérique latine et les Caraïbes (CEPALC), Nations Unies.

Menon, P., M. Ruel, M. Arimond and A. Ferrus (2002). Childcare, nutrition, and health in the Central Plateau of Haiti: The role of community, household, and caregiver resources. Report of the IFPRI-Cornell World Vision Baseline Survey, Haiti. IFPRI: Washington DC.

Nichter, M. and Lock, M. (2003). Introduction: From documenting medical pluralism to critical interpretations of globalized health knowledge, policies, and practices: *New horizons in medical anthropology* (1): 15-48.

Owusu-Addo, E., A. M. N. Renzaho and B. J. Smith (2018). The impact of cash transfers on social determinants of health and health inequalities in sub-Saharan Africa: a systematic review. *Health Policy and Planning* 33(5): 675-696.

Partnership for Economic Inclusion (2018). 2018 State of the Sector Synthesis Report. Washington DC: World Bank.

Rao, N., H. Gazdar, D. Chanchani and M. Ibrahim (2019). Women's agricultural work and nutrition in South Asia: From pathways to a cross-disciplinary, grounded analytical framework. *Food Policy* 82: 50-62.

Richter, L. M., B. Daelmans, J. Lombardi, J. Heymann, F. L. Boo, J. R. Behrman, C. Lu, J. E. Lucas, R. Perez-Escamilla, T. Dua, Z. A. Bhutta, K. Stenberg, P. Gertler and G. L. Darmstadt (2017). Investing in the foundation of sustainable development: pathways to scale up for early childhood development. *The Lancet* 389(10064): 103-118.

Roelen, K. (2015). The 'Twofold Investment Trap': Children and their Role in Sustainable Graduation. 46(2): 25-34.

Roelen, K., E. Delap, C. Jones and H. Karki Chettri (2017). Improving child wellbeing and care in Sub-Saharan Africa: The role of social protection. *Children and Youth Services Review* 73: 309-318.

Roelen, K. and C. Müller (2018). Fonkoze's CLM Ultra Poverty Programme: Understanding and improving child development and child wellbeing. Brighton: Centre for Social Protection, Institute of Development Studies. URL: https://fonkoze.org/assets/clm-baseline-study_ultra-poor-children_sept-2018.pdf

Roelen, K. and S. Devereux (2019). Money and the Message: The Role of Training and Coaching in Graduation Programming. The Journal of Development Studies 55(6): 1121-1139.

Roelen, K., Sherer, M. and C. Leon-Himmelstine (forthcoming). The role of economic strengthening in promoting early childhood development: the best of both worlds? An overview of impacts and experiences with graduation programmes. Journal of the British Academy. Forthcoming.

Schwartz, T. (2000). "Children are the Wealth of the Poor": High Fertility and the Organization of Labor in the Rural Economy of Jean Rabel, Haiti, University of Florida.

Werlin, S. (2018). Fonkoze's CLM Program: Its past, its present, and its future. Port-au-Prince: Fonkoze.

WHO (2010). Nutrition Landscape Information System (NLIS). Country Profile Indicators. Interpretation Guide. Geneva: World Health Organisation.

WHO (2011). Cholera Country Profile: Haiti. Global Task Force on Cholera Control. Geneva: World Health Organisation.

WHO (2018). Nurturing Care for Early Childhood Development. A framework for helping children survive and thrive to transform health and human potential. Geneva: World Health Organisation.

Appendix

Table A1 Overview of FGD respondents

type of group	site	# participants	sex	code
CLM members with children 0-5	La Chappelle	6	female	LCFGCLM05
CLM members with children 0-2	La Chappelle	8	female	LCFGCLM2-1
CLM members with children 0-2	La Chappelle	6	female	LCFGCLM2-2
CLM members with children 3-5	La Chappelle	8	female	LCFGCLM5-1
CLM members with children 3-5	La Chappelle	4	female	LCFGCLM5-2
Spouses of CLM members with children aged 0-2	La Chappelle	6	male	LCFGSPOUSE2-1
Spouses of CLM members with children aged 0-2	La Chappelle	4	male	LCFGSPOUSE2-2
Spouses of CLM members with children aged 3-5	La Chappelle	3	male	LCFGSPOUSE5-1
Spouses of CLM members with children aged 3-5	La Chappelle	3	male	LCFGSPOUSE5-2
Village Assistance Committee	La Chappelle	4	male	LCFGVAC
CLM members with children 0-5	Mache Kana	6	female	MKFGCLM05
CLM members with children 0-2	Mache Kana	4	female	MKFGCLM2-1
CLM members with children 0-2	Mache Kana	5	female	MKFGCLM2-2
CLM members with children 3-5	Mache Kana	4	female	MKFGCLM5-1
CLM members with children 3-5	Mache Kana	3	female	MKFGCLM5-2
Spouses of CLM members with children aged 0-2	Mache Kana	2	male	MKFGSPOUSE2-1
Spouses of CLM members with children aged 0-2	Mache Kana	2	male	MKFGSPOUSE2-2
Spouses of CLM members with children aged 3-5	Mache Kana	2	male	MKFGSPOUSE5-1
Spouses of CLM members with children aged 3-5	Mache Kana	2	male	MKFGSPOUSE5-2
Village Assistance Committee	Mache Kana	3	male	MKFGVAC
CLM members with children 0-5	Mable	6	female	MBFGCLM05
CLM members with children 0-2	Mable	4	female	MBFGCLM2-1
CLM members with children 0-2	Mable	5	female	MBFGCLM2-2
CLM members with children 3-5	Mable	4	female	MBFGCLM5-1
CLM members with children 3-5	Mable	3	female	MBFGCLM5-2
Spouses of CLM members with children aged 0-2	Mable	2	male	MBFGSPOUSE2-1
Spouses of CLM members with children aged 0-2	Mable	2	male	MBFGSPOUSE2-2
Spouses of CLM members with children aged 3-5	Mable	2	male	MBFGSPOUSE5-1
Spouses of CLM members with children aged 3-5	Mable	2	male	MBFGSPOUSE5-2
Village Assistance Committee	Mable	3	male	MBFGVAC

Table A2 Overview of KII respondents

type of respondent	site	# participants	sex	
director	Fonkoze office	1	male	SUPERVISOR
supervisor La Chappelle	Fonkoze office	2	male	SUPERVISOR
supervisor Mache Kana	Fonkoze office	1	male	SUPERVISOR
supervisor Mable	Fonkoze office	1	male	SUPERVISOR
case manager	La Chappelle	8	male	LCFGCM
case manager	Mache Kana	2	male	MKFGCM
case manager	Mable	2	male	MBFGCM

Table A3 Overview of fieldwork activities

Case Studies (CSs)	
CLM members (women with children aged 0-5)	- Family and social capital mapping - Daily activity clock - Aspirations exercise - Practices interview - Body map - CLM programme ranking - Home observation
Spouses of CLM members or other main caregivers of CLM members' children	- Family and social capital mapping - Daily activity clock - Aspirations exercise - Practices interview - CLM programme ranking
Focus Group Discussions (FGDs)	
CLM members with children aged 0-5 (who are NOT part of case studies)	- Community mapping - Seasonal calendar
CLM members with children aged 0-2 and 3-5	- Aspirations exercise - Practices interview - Body map - CLM ranking
Spouses of CLM members/ other main caregivers with children aged 0-2 and 3-5	- Aspirations exercise - Practices interview - Body map - CLM ranking
VAC members in core cluster	- Seasonal calendar - Aspirations exercise - CLM programme ranking
Key Informant Interviews (KIIs) and conversations	
Case managers	- Seasonal calendar - Aspirations exercise - Practices interview - CLM ranking - Observations of home visits
CLM supervisors	- Semi-structured interview
CLM programme manager	- Semi-structured interview

Table A4 Overview of coding framework

Top nodes	Sub-nodes	Top nodes	Sub-nodes	Top nodes	Sub-nodes	Top nodes	Sub-nodes	Top nodes	Sub-nodes
CLM Programme	access to health care	*Paid work*	location paid work child	*Community actors*	church leaders	*Wellbeing-CLM*	disability	*Nutrition*	breastfeeding
	asset transfer		location paid work CLM		CLM staff		illness		complementary feeding
	cash stipend		location paid work other adults		landlord		mental wellbeing		diet child
	clean drinking water		migration paid work		local authorities		physical wellbeing		diet household
	CLM latrine		time paid work child		local merchants	*Wellbeing-adult*	disability		diet in pregnancy
	coaching		time paid work CLM		neighbours		illness		food security
	government id		time paid work other adults		non CLM		mental wellbeing		healthy diet
	home repair		type paid work child		other CLM		physical wellbeing		healthy weight
	malnutrition screening		type paid work CLM		traditional faith	*Wellbeing-child*	disability		seasonality
	savings & credit		type paid work other adults		VAC members		illness		undernutrition
	training	*Paid work - effects*	effects of child	*Relationship dynamics*	advice		mental wellbeing	*Health*	health seeking bio-medical
	VAC		effects of other adults		conflict		physical wellbeing		health seeking traditional
Linkages - pathways	income effect		effects on children		fear	*Aspirations for children*	behaviour-asp		immunisation
	interaction effect		effects on CLM member herself		jealousy		development-asp		perceptions of health care
	material effect		effects on community dynamics		love-care		future of child-asp		routine contact
	training effect		effects on household dynamics		power over-even-under		health-asp	*Sanitation and water*	hygiene
Infrastructure and services	border		effects on household needs		support-cooperation		hygiene-asp		living environments
	church		effects on unpaid work		trust		nutrition-asp		latrine
	cockfighting ring	*Unpaid work*	location unpaid work child		violence		physical appearance-asp		seasonality water
	energy		location unpaid work CLM	*Household and members*	aunt-uncle		physical environment-asp		water usage
	health services		location unpaid work other adults		biological parent		play-asp	*Early learning*	material EL

	land		time unpaid work child		brother-sister-in-law		psychosocial environment-asp		perceptions EL
	local law and order		time unpaid work CLM		godparent		school-asp		practice EL
	markets		time unpaid work other adults		grandparent				preschool
	mill		type unpaid work child		nephew-niece-cousin			*Responsive caregiving*	care supervision
	schools		type unpaid work CLM		parent				caregiver continuity
	traditional medicine		type unpaid work other adults		sibling				caregiving routines
	transportation	*Unpaid work-effects*	effects of child		spouse				family size
	veterinary		effects of other adults						management misbehaviour
	water sources		effects on children						responsive caregiving others
			effects on CLM member herself						responsive infant feeding
			effects on household dynamics						responsive parenting
			effects on household needs					*Security and safety*	perceptions of child safety
			effects on paid work						perceptions of mother safety
			interactions of community dynamics						safety measures child
		Gender norms	norms child care						safety measures mother
			norms CLM						
			norms community interactions						
			norms household chores						
			norms livestock						
			norms paid work						