EVALUATION REPORT

RAISING AWARENESS AND INNOVATIVE STRATEGIES FOR EARLY CHILDHOOD DEVELOPMENT (RAISE) PROJECT

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10 MARCH 2022

Save the Children

PHOTO CREDITS

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RAISE EVALUATION | 10 March 2022

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Stephen Van Houten
March 2022.

ACRONYMS

BL	Baseline
CC	Commune Council
CCWC	Commune Committee for Women and Children
CNCC	Cambodian National Council for Children
CO	Country Office
CREDI	Caregiver Reported Early Development Instruments
CSO	Civil Society Organization
DiD	Difference-in-Difference
DOE	District Office of Education
DWCCC	District Women and Children Consultative Committee
ECD	Early Childhood Development
ECE	Early Childhood Education
EL	Endline
CWD	Children With Disabilities
FGD	Focus Group Discussion
IECD	Integrated Early Childhood Development
KAP	Knowledge, Attitudes, and Practices
KII	Key Informant Interview
M&E	Monitoring and Evaluation
MEAL	Monitoring, Evaluation, Accountability and Learning
MoEYS	Ministry of Education, Youth and Sport
MoH	Ministry of Health
MoI	Ministry of Interior
MoSVY	Ministry of Social Affairs, Veterans and Youth Rehabilitation
MoWA	Ministry of Women's Affairs
MSC	Most Significant Change
NC	Nurturing Care
NC-ECCD	National Committee on ECCD
NCF	Nurturing Care Framework
OECD-DAC	Organisation for Economic Co-operation and Development's Development Assistance Committee
POE	Provincial Office of Education
PWCCC	Provincial Women and Children Consultative Committee
P-ESWG	Provincial Education Support Working Group
QLE	Quality Learning Environment
RAISE	Raising Awareness and Innovative Strategies for Early Childhood Development
RGoC	Royal Government of Cambodia
SBCC	Social and Behaviour Change Communications

SC	Save the Children Cambodia
SCI	Save the Children International
SCHC	Save the Children Hong Kong
SES	Socioeconomic Status
SIP	School Improvement Plan
ToR	Terms of Reference
ToT	Training of Trainers
VC	Village Chief
VHSG	Village Health Support Group
VC	Village Chief
VSG	Village Security Guard
WASH	Water, Sanitation and Hygiene
WCCC	Women and Children's Consultative Council

EXECUTIVE SUMMARY

INTRODUCTION

This evaluation assessed the Raising Awareness and Innovative Strategies for ECD (RAISE) project, implemented by Save the Children Cambodia and funded by Save the Children Hong Kong. The project piloted innovative strategies to increase awareness and positive behaviours around holistic and integrated Early Childhood Development (ECD) in Cambodia.

As stated in the Terms of Reference (ToR), the final evaluation was conducted to establish the endline for the project's key indicators and constitute the basis to measure the project performance. The impact of the project on and determinants of child development outcomes were examined in the survey. Moreover, the objective of this final evaluation was to examine how the project intervention including the design, strategies, and activities were relevant, efficient, effective, impactful, and sustainable. The evaluation covered the entire project period (1 January 2020 to 30 March 2022). The consultancy was conducted between December 2021 and March 2022.

QUANTITATIVE FINDINGS

The summary of the quantitative survey findings is outlined below in two main areas (1) changes in endline vs baseline scores for target and non-target groups, and (2) impact.

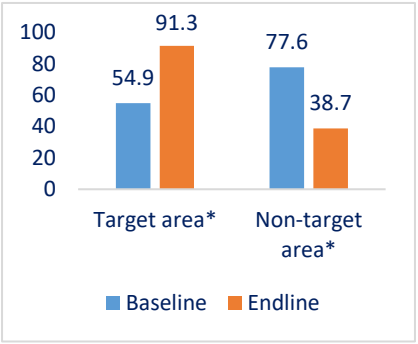
CHANGES IN ENDLINE VS BASELINE SCORES FOR TARGET AND NON-TARGET GROUPS

CAREGIVER'S AWARENESS OF POSITIVE PRACTICES IN INTEGRATED ECD

Good health and nutrition (3 practices)

HIGHLIGHTS

- **36.4%** ↑ There was a significant 36.4% increase in the number of caregivers who are aware of at least three good health practices, in the target group.
- **38.9%** ↓ There was a significant decrease of 38.9% for this indicator in the non-target group.
- **52.6%** ↑ At endline, results for this indicator were 52.6% higher in the target vs non-target group.



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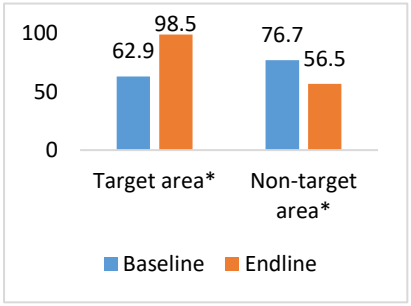
Early learning and responsive care (3 practices)

- **35.6%** ↑ There was a significant 35.6% increase in the number of caregivers who are aware of at least three early learning and responsive care practices, in the target group.
- **20.2%** ↓ There was a significant decrease of 20.2% for this indicator in the non-target group.
- **40%** ↑ At endline, results for this indicator were 40% higher in the target vs non-target group.



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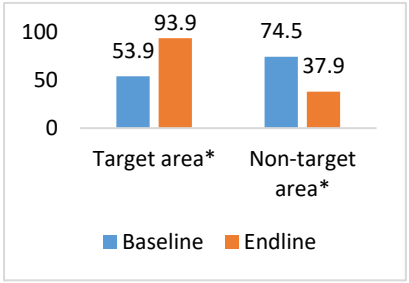
Safety and security (3 practices)

- **40%** ↑ There was a significant 40% increase in the number of caregivers who are aware of at least three safety and security practices, in the target group.
- **36.6%** ↓ There was a significant decrease of 36.6% for this indicator in the non-target group.
- **56%** ↑ At endline, results for this indicator were 56% higher in the target vs non-target group.



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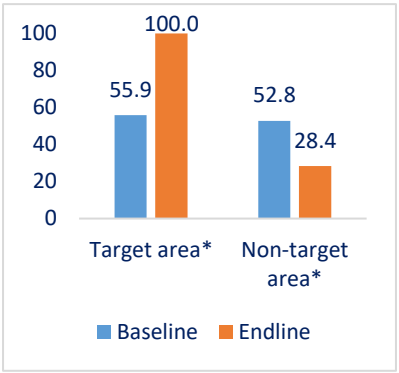
COMMUNITY ACTORS' CAPACITY TO PROVIDE LEADERSHIP & ADVICE ON INTEGRATED ECD TO CAREGIVERS

Awareness and understanding of positive practices towards integrated ECD

HIGHLIGHTS

- **44.1%** ↑ There was a significant 44.1% increase in the number of community actors who have awareness and understanding of positive practices towards integrated ECD, in the target group.
- **38.9%** ↓ There was a significant decrease of 38.9% for this indicator in the non-target group.
- **52.6%** ↑ At endline, results for this indicator were 52.6% higher in the target vs non-target group.



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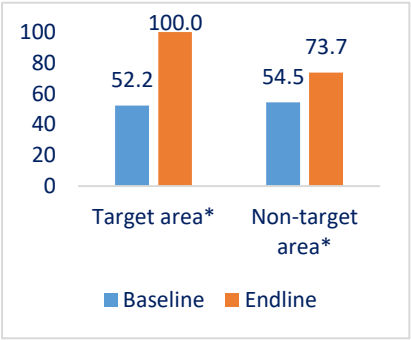
Community actors providing advice on integrated ECD to caregivers on at least 3 of the 13 indicators from outcomes 1,2 &3

- **47.8%** ↑ There was a significant 47.8% increase in the number of community actors who provided integrated ECD advice to caregivers, in the target group.
- **19.2%** ↓ There was a significant decrease of 19.2% for this indicator in the non-target group.
- **26.3%** ↑ At endline, results for this indicator were 26.3% higher in the target vs non-target group.



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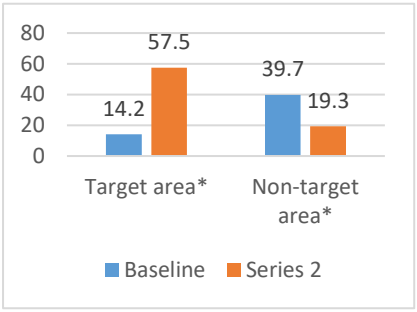
CAREGIVERS' KNOWLEDGE, ATTITUDES, AND PRACTICES ON INTEGRATED ECD

Caregivers' knowledge of integrated ECD

HIGHLIGHTS

- **43.3% ↑** There was a significant 43.3% increase in caregivers' knowledge of integrated ECD, in the target group.
- **20.4% ↓** There was a significant decrease of 20.4% for this indicator in the non-target group.
- **38.2% ↑** At endline, results for this indicator were 38.2% higher in the target vs non-target group.



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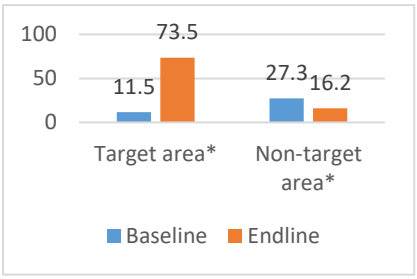
Caregivers' attitudes of integrated ECD

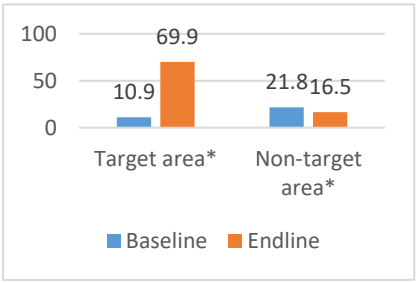
- **62% ↑** There was a significant 62% increase in caregivers' attitudes of integrated ECD, in the target group.
- **11.1% ↓** There was a significant decrease of 11.1% for this indicator in the non-target group.
- **57.3% ↑** At endline, results for this indicator were 57.3% higher in the target vs non-target group.



*p<0.05

Caregivers' practices of integrated ECD

- **58.7% ↑** There was a significant 58.7% increase in caregivers' practices of integrated ECD, in the target group.
- **5.3% ↓** There was a significant decrease of 5.3% for this indicator in the non-target group.
- **38.2% ↑** At endline, results for this indicator were 38.2% higher in the target vs non-target group.



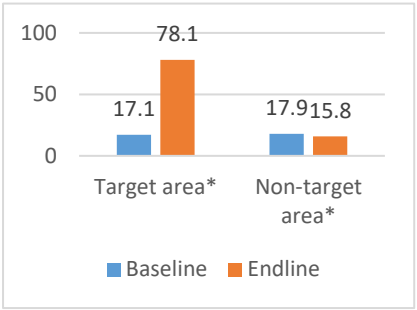
*p<0.05

COMMUNITY ACTORS' KNOWLEDGE, ATTITUDES, AND PRACTICES ON INTEGRATED ECD

Community actors' knowledge of integrated ECD

HIGHLIGHTS

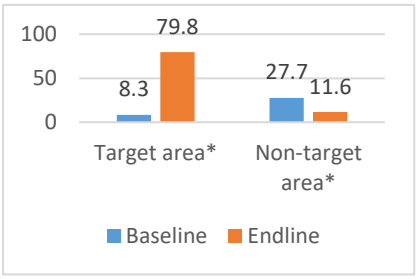
- **61% ↑** There was a significant 61% increase in community actors' knowledge of integrated ECD in the target group.
- **2.1% ↓** There was a significant decrease of 2.1% for this indicator in the non-target group.
- **62.3% ↑** At endline, results for this indicator were 62.3% higher in the target vs non-target group.



*p<0.05

Community actors' attitudes of integrated ECD

- **71.5% ↑** There was a significant 71.5% increase in community actors' attitudes of integrated ECD, in the target group.
- **16.1% ↓** There was a significant decrease of 16.1% for this indicator in the non-target group.
- **68% ↑** At endline, results for this indicator were 68% higher in the target vs non-target group.



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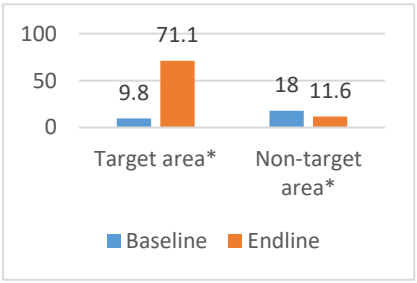
Community actors' practices of integrated ECD

- **61.3% ↑** There was a significant 61.3% increase in community actors' practices of integrated ECD, in the target group.
- **6.4% ↓** There was a significant decrease of 6.4% for this indictor in the non-target group.
- **59.5% ↑** At endline, results for this indicator were 59.5% higher in the target vs non-target group.



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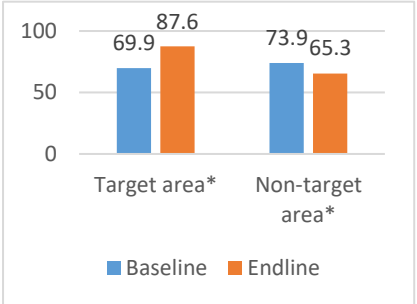
MALE ENGAGEMENT & REPORTED VIOLENCE

Male engagement in ECD activities

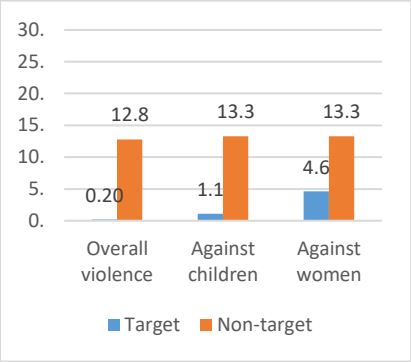
HIGHLIGHTS

- **17.7% ↑** There was a significant 17.7% increase in male engagement in ECD activities, in the target group.
- **8.6% ↓** There was a significant decrease of 8.6% for this indicator in the non-target group.
- **22.3% ↑** At endline, results for this indicator were 22.3% higher in the target vs non-target group.



Reported overall male violence (physical and emotional) against children and women[1]

- **12.6% ↑** Measured only at endline, reported overall male violence was 12.6% higher in non-target vs. target groups.
- **12.2% ↑** Reported male violence against children as 12.2% higher in non-target vs. target groups.
- **8.7% ↑** Reported violence against women was 8.7% higher in non-target vs. target groups.



GRANDMOTHERS' ENGAGEMENT IN INTEGRATED ECD

Comparison of caregivers' awareness of integrated ECD

- **8.9 points ↓** For awareness of good health and nutrition, grandmothers scored significantly less points (58.1) than the average of the other caregivers (67).
- **4.7 points ↓** For awareness of early learning and responsive care, grandmothers scored significantly less points (69.6) than the average of the other caregivers (74.2).
- **5.1 points ↓** For awareness of safety and security, grandmothers scored significantly less points (59.6) than the average of the other caregivers (64.7).

Awareness	Mother	Father	Grandmother	Other
Good health and nutrition	68.6	65.7	58.1	66.7
Early learning and responsive care	75.4	75.7	69.6	71.7
Safety and security	67.8	62.9	59.6	63.3

Comparison of caregivers' integrated ECD knowledge, attitudes, and practices

HIGHLIGHTS

- **2.5 points ↓** For knowledge, grandmothers scored significantly less points (27.0) than the average of the other caregivers (30.5).
- **5.6 points ↓** For attitudes, grandmothers scored significantly less points (24.0) than the average of the other caregivers (31.6).
- **7.8 points ↓** For practices, grandmothers scored significantly less points (22.7) than the average of the other caregivers (30.5).

Knowledge, attitudes, practices	Mother	Father	Grandmother	Other
Knowledge	35.5	34.3	27.0	21.7
Attitudes	36.2	33.3	24.0	25.4
Practices	36.9	26.7	22.7	27.9

[1] There was no baseline data available for this analysis; there is only the target vs non-target group comparison available.

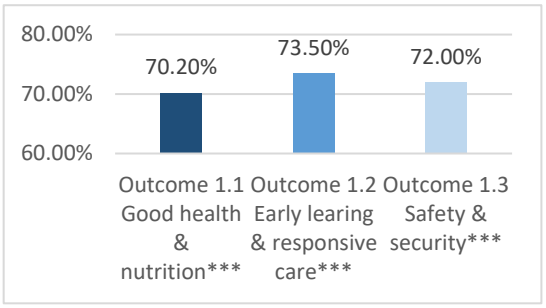
PROJECT IMPACT

After controlling for various variables, further analysis provided information of actual project impact.

CAREGIVERS' AWARENESS OF INTEGRATED ECD

HIGHLIGHTS

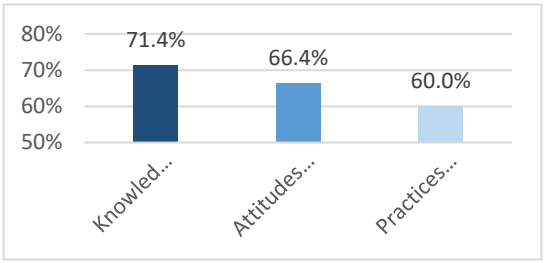
- **70.2%** ↑ The project increased caregiver's awareness of good health and nutrition by 70.2%.
- **73.5%** ↑ The project increased caregivers' awareness of early learning and responsive care by 73.5%.
- **72.0%** ↑ The project increased caregivers' awareness of safety and security by 72.0%.



* p<0.1; ** p<0.05; *** p<0.01

CAREGIVERS' KNOWLEDGE, ATTITUDES, AND PRACTICES OF INTEGRATED ECD

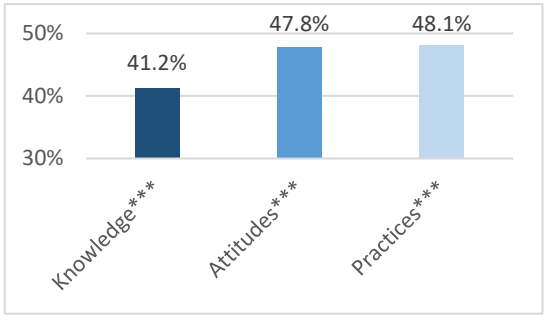
- **71.4%** ↑ The project increased caregivers' knowledge by 71.4%.
- **66.4%** ↑ The project increased caregivers' attitudes by 66.4%.
- **60%** ↑ The project increased caregivers' practices by 60%.



* p<0.1; ** p<0.05; *** p<0.01

COMMUNITY ACTORS' KNOWLEDGE, ATTITUDES, AND PRACTICES OF INTEGRATED ECD

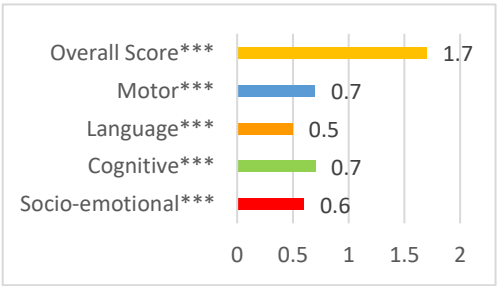
- **41.2%** ↑ The project increased community actors' knowledge by 41.2%.
- **47.8%** ↑ The project increased community actors' attitudes 47.8%, and practices by 48.1% (Annex 3).
- **48.1%** ↑ The project increased community actors' practices by 48.1%.



* p<0.1; ** p<0.05; *** p<0.01

CHILD DEVELOPMENT OUTCOMES (CREDI SCORES)

- The project significantly increased the CREDI scores as follows: socio-emotional (0.6), cognitive (0.7), language (0.5), motor (0.7), and overall CREDI score (1.7).



* *p*<0.1; ** *p*<0.05; *** *p*<0.01

QUALITATIVE FINDINGS

RELEVANCE

The RAISE project was clearly relevant for its direct and indirect beneficiaries, targeting identified gaps in knowledge, attitudes and practices related to holistic and integrated ECD at a community level. COVID-19-related adaptations in the project (such as the provision of sewing training and handwashing stations) were also relevant to the rapidly shifting context. RAISE was highly relevant to Save the Children's CO strategic goals, and to its work as a leader within the ECCD field in Cambodia. The project aligned with SCI's Building Brains Common Approach, which in turn aligns with international frameworks and commitments, such as the Nurturing Care Framework and the Sustainable Development Goals. The focus of RAISE also aligns with national and sub-national government commitments to ECCD.

EFFECTIVENESS

Despite the many challenges associated with project planning, implementation, and monitoring within the context of COVID-19, the project met or exceeded all its targets, aside from one that is on track to be reached before the project's end date. The training and IEC materials were effective in reaching target audiences and were well-received within communities. Teachers, health centre staff and VHSGs were seen as the most effective trainers, with strong facilitation skills for delivering lessons. To meet COVID-19 safety requirements, the size of training groups was reduced to small groups and one-on-one training. Some stakeholders preferred small groups, while others preferred one-on-one training. The engagement of men after working hours was an important factor enabling the inclusion of male caregivers. Stakeholders noted that some grandmothers were not able to keep up as easily with lessons, and that the pace may have been too quick for them, particularly for grandmothers (and others) with low levels of literacy. ICT capacity/digital literacy, connectivity and access was a challenge for some participants and trainers. The project's successes were driven in part by the team's adaptability and flexibility; the integrated approach to programming that drew on a wide range of stakeholders and key local actors; strong collaboration and communication within the team; and strong relationships and buy-in from government stakeholders and local authorities. Key challenges included the impacts of COVID-19 on programming, and the complexity of building an understanding of stakeholder roles, responsibilities, and coordination towards an integrated ECCD response.

EFFICIENCY

The RAISE project was implemented efficiently. The team acquired appropriate resources with due regard for cost, implemented activities as simply as possible, attempted to keep overheads as low as possible, achieved deliverables on time and budget, and addressed duplication and conflicts. The project budget was USD 772,882, and the project achieved a burn rate of 85% by 31 December 2022. The project had clear plans for further expenditure in the final three months of the project. The shift in modalities of project delivery (e.g., more online training and follow-up) meant that the project was able to maintain outputs and quality at a lower expenditure rate. However, additional time and resources were associated with one-on-one and small group training as opposed to larger group training. The team undertook a cost allocation analysis for the project, showing an overall cost of USD 210 per caregiver (inclusive of provincial project management expenses, country office expenses and other costs). Importantly, the cost associated with caregiver capacity development only (using a model of 12 caregiver sessions supported by necessary home visits and community awareness raising activities) is USD 44 per caregiver. This model is based on an assumption that ECD educators and facilitators at the community level are already equipped with the necessary skills and knowledge to facilitate caregiver sessions and organize community awareness activities. In terms of capacity, while navigating implementation in the context of COVID-19 placed some additional demands on staff, the team was well-capacitated to effectively implement and monitor the project, with strong collaboration and support from management and SCI HQ. The CO submitted a narrative report to SCHK every six months, with quarterly monitoring calls. Stakeholders

noted with appreciation the strong and clear communication between the CO and SCHK.

IMPACT

Despite its relatively short timeframe, the evaluation found substantial quantitative and qualitative impacts, including impact on children's development. Stakeholders spoke clearly about the impacts of RAISE at the community level, and this data was strongly triangulated through the input of a wide range of stakeholders such as POE and DOE officials, teachers and principals, VHSGs, local authorities, health centre staff and caregivers. Caregivers, particularly mothers and fathers, reported a range of improvements in their ECD knowledge, behaviours, and practices, as well as in their own well-being and relationships. Some grandmothers reported changes in their ECD knowledge, attitudes, and practices as well. Fathers reported increased engagement in domestic chores, and increased involvement with their children, among other changes. Importantly, there were numerous reports from different stakeholders regarding a reduction in alcohol consumption by fathers, and a reduction of violence and arguments within the household. Many stakeholders also argued that children were better cared for, cleaner, and healthier. While there are some indications that these changes are linked to the project, there may be other contributing factors to increased male engagement in the home, and reports of decreased alcohol consumption including COVID-19-related restrictions on gatherings. Similarly, improved hygiene practices for children may be linked to COVID-19 messaging and prevention practices. Incidence of violence was not measured at baseline, making comparison difficult. Trainers and local authorities also reported impacts on their own ECD knowledge, attitudes, and practices. Two unintended impacts were documented, namely, the qualitative reports of reduced domestic violence against women and children and the strengthened capacity of various stakeholders, for example, the PWCC, POE, and DOE in ECD, child protection, M&E, report writing, guideline development, photography, and video production.

SUSTAINABILITY

This evaluation found the project's sustainability goals to be clear and realistic in terms of the objectives and scope. It is important to note that this is a pilot project that looked more at what worked in terms of the ECD model and platform to build the associated evidence base rather than establishing sustainability. Moreover, extensive evidence of sustainability is not expected after just over two years of project implementation. Despite the scope and limitations to sustainability, this evaluation found emerging evidence of sustainability. At the local level, there is clear evidence of increased buy-in, commitment, and ownership at the local level. There are strong examples of Commune Council engagement, most notably, in their commitment to providing a budget for ECD. The project also contributed to building the ECD capacity of stakeholders at the local as well as the DOE and POE levels. There is solid evidence that this project resulted in significant knowledge sharing which has contributed to project sustainability. Crucially, knowledge sharing has gone beyond the target communities to non-target communities. In terms of scalability, it was reported that it is difficult to scale the project with limited resources, especially in low-density population regions. Overall, there are important and interesting opportunities to plan for, monitor, and assess sustainability in the forthcoming GRAND project.

CONCLUSIONS

SUMMARY

Save the Children Cambodia, with Save the Children Hong Kong's support, implemented the Raising Awareness and Innovative Strategies for ECD (RAISE) project over 27 months (1 January 2020 to 31 March 2022. The project's overall objective is to create an enabling, stimulating, and nurturing environment that gives children a better start to life. The three outcomes are (1) caregivers, including fathers and grandparents, showed improved awareness of integrated ECD for the 0-3 age group, (2) formal and informal community actors, especially female actors, have improved their capacity to provide leadership and advice on integrated ECD, and (3) evidence of appropriate communications channels is generated and used to inform the social and behaviour change communication (SBCC) interventions. The project was implemented in 43 villages in the Kampong Siem district of Kampong Cham province.

This evaluation found that the pilot project utilised innovative strategies to increase awareness and positive behaviours around holistic and integrated ECD in the target groups. The project was relevant, effective, and efficient. Notably, this project produced a cost allocation analysis that showed an overall cost per caregiver per year of USD 210 (inclusive of provincial project management expenses, country office expenses and other costs). Importantly, the cost associated with caregiver capacity development only (using a model of 12 caregiver sessions supported by necessary home visits and community awareness raising activities) is USD 44 per caregiver. This information and the individual contributions to this cost can now be communicated to the government for replication and scale-up considerations. It can also be used as comparative data for future ECD-related and other project planning, implementation, monitoring and evaluation.

In terms of project impact, the evaluation showed strong results across all three outcomes. For Outcome 1, the evaluation showed that overall, the project produced, tested, and disseminated appropriate and effective SBCC materials (less so for grandmothers, people with low literacy, and people with certain disabilities) and increased community exposure to relevant SBCC messaging. Specifically, the project increased caregivers' awareness (understanding) of good health and nutrition by 70.2%, early learning and responsive care by 73.5%, and safety and security by 72.0%. The project's impact (after controlling for extraneous variables) on caregivers showed a significant increase in ECD-related knowledge (71.4%), attitudes (66.4%), and practices (60%).

For Outcome 2, the evaluation showed that the project successfully trained formal community actors on integrated ECD and created informal delivery platforms (new and underutilised community delivery platforms, for example, pagodas, shops, and salons) to improve the enabling environment for holistic care for young children. Specifically, the project resulted in an increase of 47.8% of community actors who provided advice to caregivers for at least three of the indicators. The community actors' awareness and understanding increased by 44.1%. Overall, the project's impact (after controlling for extraneous variables) on community actors showed a significant increase in knowledge (41.2%), attitudes (47.8%), and practices (48.1%).

Generally, most respondents (trainers and trainees) noted a preference for small or medium group trainings, as opposed to large group trainings. Echoing mid-term evaluation results, teachers, health centre staff and VHSGs were cited by participants as generally the most effective trainers, as they were seen as credible with strong technical skills for delivering and facilitating lessons. Training undertaken in pairs, by a local authority with a teacher, health centre staff or VHSG was perceived to be effective for training,- and building the capacity of local authorities for future training. Trainers, participants, and other stakeholders particularly highlighted the importance and usefulness of the training on male engagement in ECD and training on caregivers' well-being.

For Outcome 3, there is strong evidence that appropriate communications channels have been developed and used to inform the SBCC interventions. The project monitoring reports show that the project learnings have been well documented and disseminated. Given that the project ends on 30 March, there were still some remaining dissemination activities (e.g., dissemination workshop to the national government) to be completed at the time of this evaluation.

For male engagement in ECD, the findings showed that the project increased male engagement in ECD by 17.6%.[2] Furthermore, overall violence (physical and emotional), as measured by the survey, was 0.2% for the target group and 1.8% for the non-target group, although there was no baseline data for comparison. The qualitative data provided substantial anecdotal support of the project having led to reduced rates of alcohol consumption amongst men, and reduced rates of overall violence in terms of violence against children, women, and between parents/caregivers. There may be other contributing factors to these findings, outside of the RAISE project.

The project also compared the role and effectiveness of caregivers, including grandmothers, in relation to project-related outcomes. The study showed that grandmothers had lower awareness in comparison to mothers, fathers, and other caregivers in all three areas of (1) good health and nutrition (score of 58.1 versus 68.6, 65.7, and 66.7 respectively), (2) early learning and responsive care (69.6 versus 75.4, 75.7, and 71.7), and (3) safety and security (59.6 versus 67.8, 62.9, and 63.3). The evaluation found that mothers in the target areas were less likely to leave their 0-2 year old children with other people, including grandmothers, because the mothers were more likely to care for them.[3] This raises questions about the relevance of targeting grandmothers only in ECD interventions in this such settings. This may be different for other districts or provinces, particularly in areas of high mobility, such as labour migration, but this would require further exploration and analysis.

For the child development outcomes, as measured by the Caregiver Reported Early Development Instruments (CREDI) tool, the study found that the project significantly increased ($p<0.01$) the socio-emotional, cognitive, language, motor, and overall CREDI scores by 0.6, 0.7, 0.5, 0.7, and 1.7, respectively. The results showed that caregiver's knowledge, attitudes, and practices are positively associated with all four domains of child development outcomes.

In terms of sustainability, it is important to note that this is a pilot project that looked more at what worked in terms of the ECD model and platform to build the associated evidence base rather than establishing sustainability. Moreover, extensive evidence of sustainability is not expected after just over two years of project implementation. Despite the scope and limitations to sustainability, this evaluation found emerging evidence of sustainability at the local level, as there is clear evidence of increased buy-in, commitment, and ownership at the local level. There are strong examples of Commune Council engagement, most notably, in their commitment to providing a budget for ECD. The project also contributed to building the ECD capacity of stakeholders at the local as well as DOE and POE levels. There is solid evidence that this project resulted in significant knowledge sharing which has contributed to project sustainability. Crucially, knowledge sharing has gone beyond the target communities to non-target communities. In terms of scalability, it was reported that it is difficult to scale the project with limited resources, especially in low density population regions. Overall, there are important and interesting opportunities to plan for, monitor, and assess sustainability in the forthcoming GRAND project.

RAISE is a relevant, innovative, and impactful project that will be useful in informing SC's ECD work as well as contributing to strengthening the national response to ECD. Save the Children is well-placed to

[2] For example, talk and read books to fetus; reading letters to the child and teach the child by using photos, drawing and playing games; bring wife to have prenatal care; use happy faces and actions to play with the child; tell the child about animals, plants, things to the child; help wife with washing clothes; and help wife with cooking.

[3] Mothers reported that they were more likely to leave their children 2 years old and older with grandmothers and other caregivers.

further develop the project's innovative strategies, disseminate learnings, and support the government and partner's work in this area.

RECOMMENDATIONS

Training

1. Extend community coverage. Where resources allow, consider extending coverage within communities; e.g., expanding training to include other interested community members outside the targeted groups of caregivers of children in the 0-3 year age range. For example, it may be useful to include newly married couples or those who are expecting children, aunts and uncles, older siblings, or mothers of slightly older children, who may have more children in future. While this was a frequent recommendation from a range of stakeholders in fieldwork, the efficacy and impact of such extended coverage would require investigation and analysis.

2. Expand sharing of training videos. Consider solutions for the sharing/screening of training videos in groups, where trainers only have a small screen phone (e.g., tablets that could be shared by various trainers or there could be projectors and a cloth to create a small cinema).

3. Expand online outreach. Consider expanding outreach through online platforms and social media popularly used with beneficiaries (beneficiaries suggested they particularly enjoyed videos and comedies). However, there is also a need to cater project activities for different levels of digital literacy and access.

4. Strengthen caregiver session approaches and delivery. Consider slower-paced training and enhancing targeted pedagogical approaches and delivery in caregiver sessions for older learners, including grandmothers (where relevant), and for caregivers who may have low levels of literacy.

5. Further engage male caregivers. Continue engaging male caregivers in ECD activities following the success of this project in this area. Future similar interventions could engage male caregivers during evening hours to enhance their attendance and participation.

6. Strengthen refresher training. Consider periodic follow-up with trainers to assess knowledge and training capacity and to assess the need for refresher trainings. Particular attention and support may be needed for older trainers, or those with less facilitation and training experience.

SBCC materials

7. Enhance the use of smart TVs. Ensure careful positioning of smart TVs (e.g., ensure they are not competing with meeting spaces, or situated where the sound will disrupt other business). Ensure that key stakeholders are adequately trained to operate smart TVs.

Impacts

8. Further assess the intervention impact on domestic violence and alcohol consumption. Further test the hypothesis (based on anecdotal evidence and endline data showing lower overall physical and emotional violence within the target group than non-target group) that domestic violence has decreased as a result of the project interventions, and if so, what aspects of the project contribute to this decrease. For example, variables could include whether one or both partners participate in caregiver sessions; how many of the father's peer group participate in the caregiver sessions; exposure to SBCC messaging; whether reduced alcohol consumption is a factor in reduced levels of violence; and whether reduced alcohol consumption is directly related to the project intervention or COVID-19 related restrictions on violence.

9. Develop violence reduction outcomes. If there is a clear correlation between the project interventions and reduced levels of violence, then violence reduction outcomes and indicators could be integrated into future similar project planning, implementation, and monitoring. In future related projects, SC should also ensure that there is adequate expertise on the team (e.g., social workers, GBV expertise) or collaboration with other organizations with such expertise, to effectively address the connections between alcohol abuse and household violence in programming.

10. Integrate referral system. Consider the integration of a clear referral system within programming to respond to cases of alcohol abuse and violence, along with the integration of resources to ensure the successful referral of cares.

National Level

11. Highlight the key role of Commune Councils in implementing integrated ECD.

    Document and communicate project findings regarding the engagement and pivotal role of Commune Councils as the core, functional body within communities for planning, implementation, and operation of an integrated, multisectoral local level approach to ECD, with support from other stakeholders (e.g., health centre and education actors).

12. Advocate for a stronger coordination mechanism.

    Drawing on project learnings, advocate for a stronger coordination mechanism for national and sub-national government actors to coordinate towards the delivery of integrated ECD initiatives.

Sustainability and MEAL

13. Monitor Commune Council budgets. Continue to monitor target Commune Council budgets in terms of their ECD commitments to build a better longitudinal understanding of financial commitment and sustainability at the community level.

14. Understand the differences between women and men's knowledge-sharing behaviour. Explore potential differences in knowledge-sharing behaviour between men and women trained through the project (for example, in fieldwork, respondents argued that fathers, other than male team leaders, were less likely to share information than mothers or grandmothers).

15. Conduct a Scalability Review. Conduct a Scalability Review based on the findings of this evaluation. Unfortunately, there was not enough data available for this evaluation to draw any definite conclusions regarding scalability. In future projects, it will be important to collect, evaluate, and disseminate practical lessons learned about applying positive lessons and overcoming common challenges to scale-up. Future projects should aim to test identified strategies that can enhance the roles of internal actors, including local community actors, local authorities, and the government.

Funder & SC Team

16. Respond to the finding of the relatively lower awareness of grandmothers in comparison to other caregivers. This finding raises important design questions, challenges, and possible adaptations in the upcoming GRAND project where it is planned to directly engage grandmothers in ECD activities.

BACKGROUND

PROJECT OVERVIEW

Name of Award	Raising Awareness and Innovative Strategies for ECD (RAISE)		
Member/Donor	Save the Children Hong Kong (SCHK) Unrestricted Funds		
Country Office	Cambodia	**SOF Number**	34400155
Award Start Date	01 January 2020	**Award End Date**	31 March 2022
Award Duration	27 months	**Award Location**	43 villages in Kampong Siem district of Kampong Cham province, Cambodia
Budget	**Total Award Amount in USD** 772,882	**Reporting period Total Spent in USD** 658,000	**Expenditure to date/Total Budget** Burn rate: 85% (2 Feb 2022**)**
Target Groups and Locations	Direct beneficiaries: **3,320** - **1,040 children** aged 0 – 3 - **2,080** caregivers - **200** community actors (school principals, pre-school teachers, health centre staff, village health support group, commune committees for women and children, commune council members, village chiefs, clergymen, Buddhist monks, and village-based shop owners) at commune and village level Indirect beneficiaries: **33,200** - **2,000** children - **31,200** adults living in the 43 target villages **Location:** 5 communes (Koh Tanem, Kian Chrey, Ampil, Ousvay and Krolar) of Kampong Siem district, in Kampong Cham province, Cambodia.		
Thematic Areas	Early Childhood Care and Development		
Country Office Contact	Ms. Elizabeth Pearce, Country Director elizabeth.pearce@savethechildren.org		
Member Office Contact	Ms. Junli Zhai, Program Manager, Save the Children Hong Kong junli.zhai@savethechildren.org		
Summary of Award	The RAISE project pilots innovative strategies to increase awareness and positive behaviours around holistic and integrated Early Childhood Development (ECD) in Cambodia. RAISE combines ground-breaking research with innovation and direct home-based interventions by engaging formal and informal community actors playing vital roles as agents of behaviour change in integrated ECD. The RAISE project		

	will strategically contribute towards SCI's global common approach 'Building Brains', addressing caregivers' abilities to provide quality nurturing care to children aged 0 – 3 years. Through the project, Save the Children is trying to address fundamental barriers, for instance limited knowledge of good ECCD practices among caregivers and community actors or lack of male engagement in childcare, to integrated early childhood development for children aged 0 – 3; pilot innovative communication strategies (including: digital based tracking tools, an online application for caregivers, user journey case studies, among others); produce and launch informative social behaviour change (SBC) materials (posters, audio and video); document and disseminate key learnings on fundamental aspects of positive early childhood development including how better to support male and grandparent caregivers in engaging with their children's development; test the efficacy of both traditional and new or under-utilized community delivery platforms as a method of awareness raising; develop digital materials for the Koan Chlaat app funded under the ARO Innovation Fund; provide capacity building, especially for female caregivers, in leadership and advice on integrated ECD within their communes, and support caregivers to create an enabling, stimulating and nurturing environment that gives children their best start in life. The RAISE project implements a series of mutually reinforcing direct and indirect interventions targeting caregivers for children aged 0 - 3 years, as well as key community actors. Direct interventions focus on field test messaging, home visits, community caregiver meetings, male caregiver support groups, community events and regular follow up with caregivers. This will be complemented by a suite of community awareness-raising and behaviour change campaigns, leveraging new and under-utilized community delivery platforms (such as pagodas, shops, salons, noodle sellers) as well as formal service providers. Through this combination of intensive community-level support and mass communications, the project will develop a model for initial awareness-raising of nurturing care in Year 1, building the foundation for longer-term changes in knowledge, attitudes, and behaviours in Year 2.

Screenshot of the project video "Behaviour Change of Mothers in Childcare."

Source: https://alchetron.com/Kampong-Cham-Province

The project goal and outcomes of these frameworks are presented below.[4]

Overall Objective: **To create an enabling, stimulating, and nurturing environment that gives children a better start to life**	
Outcome 1: Caregivers, including fathers and grandparents, showed improved awareness of integrated ECD for the 0-3 age group.	
Output 1.1	SBCC materials produced, tests and disseminated
Output 1.2	Increased exposure to relevant SBCC messaging
Outcome 2: Formal and informal community actors, especially female actors, have improved their capacity to provide leadership and advice on integrated ECD.	
Output 2.1	Formal community actors trained on integrated ECD
Output 2.2	Informal delivery platforms create an improved enabling environment for holistic care for young children
Outcome 3: Evidence of appropriate communications channels is generated and used to inform the social and behaviour change communication (SBCC) interventions.	
Output 3.1	Project learnings are documented
Output 3.2	Project learnings are disseminated

[4] SC, RAISE, Terms of Reference, Raising Awareness and Innovative Strategies for ECD (RAISE), 2001

EVALUATION PURPOSE AND OBJECTIVES

As stated in the ToR, the final evaluation was conducted to establish the endline for the project´s key indicators and constitute the basis to measure the project performance.[5] The impact of the project on and determinants of child development outcomes were examined in the survey. Specifically, the key objectives included:

1. Measure the changes in knowledge, attitude, and practices of caregivers regarding responsive care and stimulation to their children 0-3 years old including relevant components of nurturing care framework in line with the indicators identified in the M&E framework;
2. Measure changes in child development outcomes using CREDI tool and identify how caregivers' KAP associated with child development outcomes;
3. Measure changes in community understanding of practices towards integrated ECD;
4. Identify the effectiveness of the intervention by comparing the differences in key indicators and child development outcomes between different intervention platforms, SBCC strategies, and target and non-target communes.

Moreover, the objective of this final evaluation was to examine how the project intervention including the design, strategies, and activities were relevant, efficient, effective, impactful, and sustainable.

CONSULTANCY SCOPE

The evaluation covered the entire project period (1 Jan 2020 to 30 March 2022). The consultancy was conducted between December 2021 and March 2022.

Project participants, RAISE

[5] SC, RAISE, Terms of Reference, Raising Awareness and Innovative Strategies for ECD (RAISE), 2001

APPROACH AND METHODOLOGY

EVALUATION APPROACH

The evaluation was conducted by a mixed international and national team consisting of Dr Stephen Van Houten (International Consultant and Team Lead), Dr Sarah Pugh (International Consultant), Mr Cheb Hoeurn (National Quantitative Consultant), and Ms Mouyleng Khan (National Qualitative Consultant). The evaluation was independent and was carried out following Save the Children's evaluation guidelines,[6] as well as best practices in the international evaluation field (for example, the United Nations Evaluation Group's (UNEG) Norms and Standards for Evaluation).[7] Specifically, this evaluation utilised the OECD-DAC Evaluation Criteria to guide the evaluation planning, data collection and reporting.[8] These evaluation criteria are as follows:

Table 1. OECD-DAC Evaluation Criteria

1	**RELEVANCE**	The extent to which the intervention objectives and design respond to beneficiaries', global, country, and partner/institution needs, policies, and priorities, and continue to do so if circumstances change.
2	**EFFECTIVENESS**	The extent to which the intervention achieved, or is expected to achieve, its objectives, and its results, including any differential results across groups.
3	**EFFICIENCY**	The extent to which the intervention delivers, or is likely to deliver, results in an economic and timely way.
4	**IMPACT**	The extent to which the intervention has generated or is expected to generate significant positive or negative, intended or unintended, higher-level effects.
5	**SUSTAINABILITY**	The extent to which the net benefits of the intervention continue or are likely to continue.

Taken together, these criteria provide management and key stakeholders with the critical information needed to understand the project's successes and challenges and determine what should be done next.

Interview with a teacher, Dec 2021

[6] SCI, Evaluation Handbook, https://resourcecentre.savethechildren.net/node/5459/pdf/5459.pdf
[7] UNEG (2017), Norms and Standards for Evaluation. http://www.unevaluation.org/document/detail/1914
[8] OECD, DAC Criteria for Evaluating Development Assistance, http://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm

METHODOLOGY

Following this approach, mixed methods with participatory processes were used in the data collection and writing of this report, which included:

DATA COLLECTION

Quantitative data on child development outcomes using Caregiver Reported Early Development Instruments (CREDI) tool and KAP surveys with caregivers and community actors using structured questionnaires was conducted by the SCI MEAL team in collaboration with technical officials from the MoEYS, PoE, and DoE. Pre-school teachers from target areas collected data from the non-target areas under the supervision of the national consultant reporting to the Team Leader and the MEAL team. Pre-school teachers from non-target areas carried out data collection from target areas. This helped to control bias in data collection.

A list of caregivers and community actors from the target group was used as a sampling frame from which respondents could be selected for the interviews. For the non-target group, caregivers with children aged 0-3 years old and community actors were identified by local authorities and defined as the sample population for this study. Sample size and sampling strategies from the baseline were replicated at the endline (Table 2).

Table 2. Number of respondents by targeted group

Target	Commune	Community actors	Caregivers
Kampong Siem (Target)	Kaoh Tontuem	13	35
	Kien Chrey	19	57
	Ampil	28	130
	Ou Svay	19	81
	Krala	34	133
Sub-total		113	436
Target	**Commune**	**Community actors**	**Caregivers**
Prey Chhor (Non-target)	Boeng Nay	31	147
	Mien	28	157
	Sour Saen	19	39
	Sra Gnae	19	38
	Tong Rong	15	45
Sub-total		112	426

The quantitative component employed repeated cross-sectional data. The sample size and sampling procedure primarily followed the baseline study. In this endline survey, there were three groups of respondents including caregivers (Outcome 1), community actors (Outcome 2), and local authorities listed in National ECCD Policy including Provincial-member of WCCC, District-member of WCCC and Commune-member of CCWC (Outcome 3). Both caregivers and community actors were interviewed by enumerators while local authorities were invited to complete the online questionnaire. Three sets of questionnaires were developed for each type of respondent. In addition, the CREDI tool for children aged 0 to 3 years, which is used to measure child development outcomes, was used to interview caregivers. The project team coordinated the data collection.

For the endline survey, both data from baseline and endline was employed. To assess the impact of the project, a quasi-experimental method, especially difference-in-difference (DiD), was employed to analyse repeated cross-sectional data. However, it is important to note that not all analyses needed both baseline and endline data because some questions and objectives were just added such as comparing across intervention strategies (education, health, and community group) and participation mode (both parents vs only mother). The quantitative methodology is outlined below (Table 3).

Table 3. Research coordination framework

Objectives	Key indictors	Statistical analysis
Measure the changes in knowledge, attitude, and practices of caregivers regarding responsive care and stimulation to their children 0-3 years old including relevant components of nurturing care framework in line with the indicators identified in the M&E framework	Knowledge, Attitude, and Practice Outcome 1.1: Good health and nutrition Outcome 1.2: Early learning and responsive care: Outcome 1.3 Safety and security: These variables defined in baseline	PCA was used to compute index for knowledge, attitude, and practice. Cross-tabulation, t-test, and chi-square tests were used to analyse the comparison of these key indicators. These key indicators will be cross-tabulated with program intervention, gender, age, and type of caregivers (such as grandmother, parents, or other relatives). Repeated cross-sectional data was employed.
Measure changes in child development outcomes using CREDI tool and Identify how caregivers' KAP associated with child development outcomes	Child development outcomes are socio-emotional, cognitive, language, motor, and overall. Computation method of child development outcomes is needed to ensure consistency with computation in baseline.	Central tendency and compared means such as t-test and ANOVA were employed. Compared means were used for grouping variables including program intervention, gender, age, and type of caregivers (such as grandmother, parents, or other relatives).[9] Multiple regression analysis was used to analyse the repeated cross-sectional data from both baseline and endline.
Measure changes in community understanding of practices towards integrated ECD;	Knowledge, attitude, and practice were defined from baseline **Outcome 2.1** from baseline **<u>New indicators</u>** **Outcome 2.2**: based on the question from bassline on providing advice (3 out of 16) **Outcome 3.1**: See or hear IEC materials (all vs one) **Outcome 3.2**: Preference on	PCA was used to compute index for knowledge, attitude, and practice. Cross-tabulation, t-test and chi-square were used to analyse the comparison of these key indicators. These key indicators were cross-tabulated with program intervention, gender, age, and type of community actors. For outcome 3.1 and 3.2, only data from endline from targeted group was used. The targeted respondents were local authorities listed in

[9] Comparisons were not made against the global reference group to see if children were doing worse, better or the same.

	IEC materials (average score of 5 Likert scale)	National ECCD Policy including Provincial-member of WCCC, District-member of WCCC and Commune-member of CCWC.
Identify the effectiveness of the intervention by comparing the differences in key indicators and child development outcomes between different intervention platforms, SBCC strategies, and target and non-target communes	Outcome listed in logframe (3 for caregiver and 2 for community actor) and overall child deployment outcome Intervention platforms (education, health, and community group) SBCC strategies (seeing all IEC materials vs Non)	DiD was used to measure the impact of the program intervention on key indicators for caregivers, community, and child development outcomes. Repeated cross-sectional data was employed. For the effectiveness of intervention platforms (education, health, and community group) and SBCC strategies (seeing all IEC materials vs Non), cross-tabulation was employed using only endline data among targeted group. Additional analyses were also done with male engagement. This was done by doing cross-tabulation of these indicators by mode of participations (both parents vs only mother). This analysis used only data from endline among targeted group.

Qualitative data was collected through key informant interviews (KIIs) and focus group discussions (FGDs) with relevant project stakeholders. This data was supplemented with questionnaires, the collection of change stories, site visits and observations, and photographic evidence. Fieldwork was conducted in two rounds, on 14-16 December and 20-24 December 2021.

The stakeholder list was developed in collaboration with the relevant SC project and MEAL staff. Purposive sampling was used to select participants for the KIIs and FGDs. The selection of participants was made to allow for the overall evaluation of the project and comparative analysis between the different intervention platforms to deliver caregiver sessions (preschool teachers, health centre staff, village authority, and community volunteer), and target and non-target areas. Key informants included, amongst others:

1. SCHK program focal point
2. Save the Children CO project staff
3. Provincial Office of Education
4. District Office of Education
5. PWCCC stakeholders
6. Health Centre Staff
7. Commune Chief
8. Village Chief
9. Community Volunteers
10. Female caregivers (under 50 years old vs. older than 50 years old)
11. Male caregivers (under 50 years old vs. older than 50 years old)
12. Villagers in the target and non-target villages (male and female)

EVALUATION QUESTIONS

The evaluation questions followed the OECD-DAC evaluation criteria (Annex 4).

DATA QUALITY CONTROL AND ANALYSIS PLAN

The team leader managed the data quality control and analysis plan. All data was analysed by the relevant

team member, after which the team leader and international consultant verified the data. Various international humanitarian and development tools were utilised to collect, triangulate, and validate the data. These included, for example, using Collaborative Advantage; Program Logic; Maximising Accountability and Learning Opportunities; and Quality of Evidence. This evaluation ensured data quality through the application of the BOND Evidence Principles (Voice and Inclusion, Appropriate, Triangulation, Contribution, and Transparency) [10] and ALNAP's Quality of Evidence Criteria (Accuracy, Representativeness, Relevance, Generalisability, Attribution, and Clarity around contexts and methods).[11]

In the interviews, *descriptive*, *normative*, and *impact* questions were used to ensure that past, present, and future conditions were described, with cause-and-effect relationships explored.

MANAGEMENT ARRANGEMENT, QUALITY ASSURANCE PROCESS, AND ETHICS

The lead consultant communicated throughout the consultancy with SCI Cambodia's Head of Evidence and Learning, with close coordination with other relevant staff.

All interviews, FGDs and other discussions were conducted in accordance with best ethical practice in research, particularly with respect to ensuring participants' safety, anonymity, the protection of data, and risk mitigation. The evaluators have read and complied with Save the *Children's Child Protection Policy*, following the principles of Awareness, Prevention, Reporting and Responding.[12] The evaluation team ensured, in collaboration with SC Cambodia, that data collection methods were age and gender appropriate; that a referral mechanism was in place in case any child safeguarding, or protection issues arise; and that informed verbal consent was obtained ahead of all key informant interviews and FGDs. The evaluators explained that participation was voluntary and that participants could withdraw at any time from the discussion. The purpose of the evaluation and any potential risks of participating were explained ahead of stakeholder interviews. SCI staff were responsible for entry into the communities. The consultants were responsible for obtaining informed consent at the beginning of the KIIs and FGDs. The evaluation also followed COVID-19 safety protocols to protect the safety of SC staff, the evaluation team, and participants.

In summary, the evaluation adhered to the principles of:

- Safeguarding
- Sensitivity to child rights, gender, inclusion, and cultural contexts.
- Openness
- Confidentiality and data protection
- Public access
- Broad participation
- Reliability and independence.

Handwashing, Prek Youn Village, Kien Chrey

SUMMARY OF DATA

This endline evaluation collected data from a total of 1,212 (F 982, M 230) respondents (Table 4). There were 1,084 (89%) respondents for the quantitative survey and 128 (11%) respondents for the qualitative

[10] BOND, Evidence Principles, https://www.bond.org.uk/resources/evidence-principles
[11] ALNAP (2017), Strengthening the quality of evidence in humanitarian evaluations. www.alnap.org/system/files/content/resource/files/main/alnap-eha-method-note-5-2017.pdf
[12] Save the Children (2003), Child Protection Policy. https://resourcecentre.savethechildren.net/node/2690/pdf/2690.pdf

data (Table 4).

Table 4. Summary of data

QUANTITATIVE	QUALITATIVE		
Survey	**KIIs**	**FGDs**	**Site Visits**
# Baseline 1,087	# Interviews 20	# FGDs 28	# Communes 7
# Endline 1,084	# Persons 20	# Persons 108	# Schools 7
F 911 (84%), M 173 (16%)	F 71 (56%), M 57 (44%)		
1,084 (89%)	**128 (11%)**		
Total Respondents 1,212			
Females 982 (81%), Males 230 (19%)			

LIMITATIONS

This evaluation was planned and conducted during the global COVID-19 pandemic. As such, travel and border restrictions meant that international travel was not possible within the evaluation timeframe. The international consultants thus worked closely with the national consultancy team members to coordinate the fieldwork and sharing of data, guided by the principle of Do No Harm.

Notable analytic limitations were identified in relation to regression for caregiver's KAP and child development outcomes in this project. In the beginning multilevel regression was proposed as the method for assessing community actors' and caregivers' KAP and child development outcomes. However, because many formal and non-formal community actors had been interviewed in each commune, the research team realised that it may not be practical to merge every single community actor with caregiver data. Hence only the relationship between caregiver's KAP and child development outcome was analysed. It was also important to note that caregiver's KAP were separately included in the regression due to potential collinearity, where knowledge correlated to attitude and attitude correlated to practice.

100% of community actors in targeted areas in the endline survey had awareness and understanding of positive practices towards integrated ECD and provided advice to caregiver at least three indicators. This suggested that we could not employ difference-in-difference to assess the impact of the program on these two outcomes. Hence, we changed dependent variables from yes/no to number of indicators. Basically, we want to assess the program impact of number of indicators that community actors were aware of and provided advice to caregivers.

FGD with mothers, Dec 2021

FINDINGS

RELEVANCE

Beneficiaries. The RAISE initiative demonstrates clear relevance to the needs of its intended beneficiaries. These include 3,320 direct beneficiaries (children, caregivers, and community stakeholders such as school principals, pre-school teachers, health centre staff, Commune Committees for Women and Children (CCWC), Commune Council members, village chiefs, clergymen, Buddhist monks and village-based shop owners) and an estimated 33,200 indirect beneficiaries, including other children and adults living the 43 targeted villages. The project was designed to respond to some of the fundamental barriers to good ECCD practices within communities, including limited knowledge of such practices among caregivers (including grandparents), and lack of male engagement in childcare. Such barriers have been documented previously by SC, for example, in its 2018 research study, "Good Soil, Good Fruit"[13] and in other project work.

In this evaluation fieldwork, beneficiaries within communities confirmed the relevance of RAISE, sharing that previously, there had been limited knowledge regarding how important it was to respond not only to the physical needs of children in the 0-3 age group but also to their educational and emotional needs. The project was built on an approach of learning and testing evidence around what social and behaviour change approaches and tools worked well within communities, to ensure that its approach was relevant and effective.

Project beneficiaries were clearly willing to participate in RAISE, although the COVID-19 pandemic caused some challenges in the retention of trainers and required adjustments to the project's original plans to align with new regulations and safety requirements. This will be discussed in more detail under "Effectiveness." In fieldwork, the evaluation team also heard evidence of interest in participating in the project from caregivers of children outside the project's targeted age group of 0-3 (for example, mothers of children in the 4-5 age group).

The project is also relevant for its explicit holistic focus on children ages 0-3 years through an integrated ECD lens, as opposed to a more prevalent focus on early childhood education (ECE) only, or school readiness. While ECE and school readiness programming are much needed and important in Cambodia, it is essential that the development needs of Cambodia's youngest children are also effectively addressed.

The project's adaptations to COVID-19 were also relevant for beneficiaries. For example, in fieldwork, local authorities expressed a high level of appreciation for SC for its assistance in supporting COVID-19 safety measures in the targeted villages. The relevance of this work is highlighted in comments from some

[13] SC Cambodia (2018), Good Soil, Good Fruit.

Local Authority respondents, who shared that while SC provided some of the handwashing stations in villages, the Local Authorities expanded the number of these stations using Commune Council funds they allocated for this purpose. Another COVID-19 adaptation was the project's support for 14 women in the target communities who lost their jobs during the pandemic. While not part of the original project design, RAISE worked with Local Authorities through a clear set of screening criteria and home visits to select the women to be provided with sewing machines and related skills training. The selected women used these sewing machines to earn an income through producing masks and through other sewing and tailoring work within their communities. The relevance of this support to the overall objective and outcomes of the RAISE project is somewhat indirect, though there is some evidence that the sewing projects did offer a much-needed source of income for these women and their families, contributing to their overall health and well-being.

Organisational Relevance. The RAISE initiative is clearly aligned with and relevant to the strategic goals of Save the Children Cambodia in its Country Strategic Plan 2019-2021, particularly goal #1 (Build evidence for effective integrated programming for children aged 0-3 and drive government investment towards holistic Early Childhood Care and Development). Given its long-time presence and leadership in the ECD policy and programming in Cambodia, Save the Children in Cambodia is strongly positioned to undertake work in this thematic area. This is evidenced, for example, in SC's role as chair of the National ECCD civil society network, and its ongoing active engagement with the SUN Civil Society Alliance, a child protection consortium of over 40 civil society organizations (CSOs).

Save the Children Cambodia's Six Strategic Goals

1. Build evidence for effective integrated programming for children aged 0-3 and drive government investment towards holistic Early Childhood Care and Development.
2. Primary schools and preschools in the most and deprived areas are increasingly inclusive and support quality learning for all children.
3. Ensure children are better protected by families and communities against violence, neglect, and exploitation, through improved systems, policies, and service delivery.
4. Expand multisector approaches to reduce stunting and other forms of malnutrition in children under five and improve health and nutrition outcomes during adolescence.
5. Encourage children and youth, including the most deprived, meaningfully participate in decision-making that affects their rights and improves accountability of government.
6. Ensure the most deprived and marginalized children have more equal access to child-sensitive services and skills that will transform their future opportunities for the better.

In the two years leading up to the RAISE initiative, SC in Cambodia had already been actively developing a body of research, evidence and innovative activities focused on a holistic approach to ECD, for example, having been selected at the CO level in 2018 and 2019 to be part of the Early Learning Centenary Commitments pooled funding to undertake and disseminate innovative research on pathways for integrated holistic care for children aged 0-3, using the Nurturing Care Framework as a foundation. The CO has also used the RAISE project as an opportunity to further develop the mobile app "Koan Chlaat," designed in 2019 by the Country Office in Cambodia to provide caregivers with easily accessible information on the provision of age-appropriate nurturing care.

RAISE also provided an opportunity to test and develop ECD communications and awareness raising materials and channels, building on a Social and Behaviour Change Communications (SBCC) strategy developed in September 2019, as well as key learnings from previous ECD projects (such as the World Bank-funded Floating Villages project). The project also drew on a preliminary gender mapping exercise undertaken by SC and iDE between July and September 2019, which helped develop SC's understanding of the gender dynamics that shape and inform how caregivers respond to their young children, aged 0-3, in terms of responsive care, early learning, communication, safety and security, and nutrition from the postnatal period until the child is less dependent on the caregiver (around 1.5 years old).[14] In these ways, the RAISE project both builds on and feeds into SC's broader commitments and thematic expertise in ECD.

[14] SC & iDE (2019), ECCD Formative Research and Early Ideas, cited in SC RAISE Narrative Proposal, p.5.

This learning and its application also serve to enhance the project's relevance to beneficiaries, providing evidence to support the continued innovation of culturally and contextually relevant interventions.

The RAISE project is also closely aligned with SCI's 'Building Brains' Common Approach, which addresses caregivers' abilities to provide quality nurturing care to children aged 0-3 years, focusing on three core components including interactive play, early communication, and responsive care.[15] The approach "emphasizes the importance of listening, responding to young children's individual needs and supporting stimulating and caring interactions between the caregiver and the child."[16]

National and Sub-national Priorities. In Cambodia, commitment and investment for integrated and multisectoral ECD-related programming have been growing in recent years, both within the government and through initiatives from other development actors. While some stakeholders are exploring community-level interventions, others (such as the World Bank) are working towards the delivery of systems-strengthening support to integrated ECD and nutrition programming for the youngest children at both national and sub-national levels, in partnership with the Royal Government of Cambodia (RGC). For example, the World Bank's USD 53 million "Cambodia Nutrition Project 2019-2023" is being implemented in partnership with the Ministry of Health and the National Committee for Subnational Democratic Development, focusing on scaling up ECD for children in the 0-3 age group.[17]

The governments of the United States of America, Australia and Germany have planned or already invested in the promotion of integrated nurturing care in Cambodia as well. For example, in partnership with international and national NGOs, these governments are working on improving ECD access in formal institutions (such as preschools), or health and nutrition programs to reduce malnutrition and stunting. Within this landscape, the focus of the RAISE project on piloting and assessing social behaviour change strategies at a community home-based level has helped to address a gap not yet addressed in Cambodia in full, towards the goal of integrated ECD.

The promotion of integrated ECD for the 0-3 age group is closely aligned with the goals and commitments of the RGC, for example, through its ratification of the Convention on the Rights of the Child on October 15, 1992. The government has made many important strides towards improving children's health, education, and well-being, with children explicitly included in a wide range of policies, government strategies, and national action plans. In 2010, the National Policy on Early Childhood Care and Development, as prepared by the Ministry of Education, Youth and Sport (MoEYS) was endorsed by a council of ministers as an inter-ministerial ECCD policy. The policy's vision is that "All Cambodian children, from conception to age under six, especially disadvantaged, vulnerable and poor children, shall be provided with care and development services, in line with the Constitution of the Kingdom of Cambodia."[18] The key approaches of the policy include (1) ensuring the provision of early childhood care and development services from conception to under 6 years of age 6, (2) ensuring that children have access to holistic early childhood care and development services, and (3) ensuring that all concerned ministries, public institutions and civil societies work together for early childhood care and development.[19] The policy outlines the roles of eleven different ministries, with a leading role by MoEYS, as well as the role of parents, families, development partners and civil society, in improving access to and quality of ECCD for Cambodian children.

The country's National Strategic Development Plan (NSDP) 2014-2018 recognized the centrality of effective ECCD to realizing its educational aspirations, citing ECCD expansion as "the foundation for

[15] SCI (Updated June 2020), A Catalogue of Common Approaches: Delivering our Best Work for Children. https://www.savethechildren.org/content/dam/usa/reports/ed-cp/common-approaches-catalogue-2020-ch1455299.pdf
[16] Ibid.
[17] World Bank, Cambodia Nutrition Project. https://projects.worldbank.org/en/projects-operations/project-detail/P162675
[18] Government of the Kingdom of Cambodia, Nation Religion King, National Policy on Early Childhood Care and Development, 2010
[19] Ibid., pp. 4-5.

providing the next generation of healthy, skilled and knowledgeable citizens able to contribute to the social and economic development" and calling for building and expanding access to quality home-based, community and pre-school education.[20] In response to the NSDP, the MoEYS developed the Education Strategic Plan (ESP) 2014-2018, which focused on two key issues: the achievement of universal access to high quality basic education and; the promotion of equity in educational opportunities to increase income and employment.[21] The ESP identified three main policy objectives within the sub-sector of Early Childhood Education (ECE), including (1) Increased enrolment of children from 0 to 6 years old, especially for poor, ethnic minorities, and children with disabilities with priority to community pre-school and home-based care services, (2) Improved quality of ECE, care, nutrition and increased health care services, and (3) Ensure result-based management system fully functioning to support ECCD. Within these ECCD commitments, however, there has been more a concerted focus on ECE, as opposed to integrated and holistic ECD for the youngest Cambodians in the 0-3 age range.

"The head of PWCCC has strongly supported this project because achieving shared goals is really important to us. The project strongly complements the work of PWCCC, especially on children's matters. Therefore, PWCCC is supportive and appreciates the project team for their effort in implementing this project despite the disruption due to COVID-19. […] This project has shaped and changed the mindset and behaviours of people in our community." H.E. OnHeng Leakhena, Head of PWCCC in Kampong Cham

RAISE also aligns with priorities at sub-national levels. For example, the head of the Provincial Women's and Children's Consultative Committee (PWCCC) shared that they strongly supported RAISE and encouraged CWCCs to take an active role in the project, as it contributed to the achievement of shared goals and aligned with the focus of MoEYS on ECE. Stakeholders from PWCCC noted that the project was very relevant to their work with women, children, youth, and marginalized people, and particularly noted the importance of the project's focus on positive parenting, non-violence, and education. Officers from the Early Childhood Education office at the DOE also suggested that the project was "highly relevant" to the work of DOE, given the focus of the Ministry of Education on ECCD, noting the alignment with the national level policy on ECCD.

Participant family, RAISE

[20] Government of the Kingdom of Cambodia, Nation Religion King, National Strategic Development Plan 2014-2018, p.177.
[21] Government of the Kingdom of Cambodia, Nation Religion King, Education Strategic Plan 2014-2018, https://www.moeys.gov.kh/en/policies-and-strategies/559.html

International Initiatives, Frameworks and Policies. The RAISE project is also clearly aligned with, and relevant to, international frameworks and policies related to ECD. For example, SCI's 'Building Brains Common Approach aligns with the Nurturing Care for Early Childhood Development framework.'[22] The Nurturing Care framework was developed by the World Health Organization (WHO), UNICEF and the World Bank Group, in collaboration with the Partnership for Maternal, Newborn, and Child Health, the Early Childhood Development Action Network, and other partners. The framework "builds upon state-of-the-art evidence of how child development unfolds and of the effective policies and interventions that can improve early childhood development," and was developed to ensure "attainment of the Sustainable Development Goals and survive, thrive and transform goals of the Global Strategy on Women's, Children's and Adolescents' Health."[23]

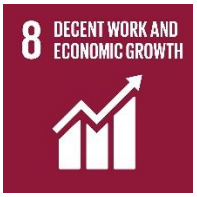
The objectives of the RAISE project are clearly in alignment with the objectives of the Global Strategy on Women's, Children's and Adolescents' Health: 2016-2030, which are "to end preventable mortality and enable women, children and adolescents to enjoy good health while playing a full role in contributing to transformative change and sustainable development."[24] These frameworks and strategies all align clearly with some of the specific goals and targets of the Sustainable Development Goals (SDGs). Non-exhaustively, these include, for example:

- Target 2.1 "By 2030, end hunger and ensure access by all people, in particular the poor and people in vulnerable situations, including infants, to safe, nutritious and sufficient food all year round."
- Target 2.2 "By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons."

Ensure healthy lives and promote well-being for all at all ages

- Target 4.2 "By 2030, ensure that all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education."

However, given the centrality of ECD for child development, health, and well-being, improved ECD outcomes for children are also likely to ultimately contribute towards a wide range of other SDGs, e.g.:



[22] WHO, UNICEF, & World Bank Group (2018), Nurturing Care for Early Childhood Development: A Framework for Helping Children Survive and Thrive to transform Health and Human Potential. https://nurturing-care.org/about/what-is-the-nurturing-care-framework/

[23] Ibid.

[24] UNICEF (2015), Every Woman Every Child, The Global Strategy on Women's, Children's and Adolescents' Health, 2016-2030, p.9. https://data.unicef.org/resources/global-strategy-womens-childrens-adolescents-health/

EFFECTIVENESS

This section is comprised of project (1) log frame achievements, (2) project exposure (survey), (3) intervention platforms, (4) drivers, and (5) challenges.

LOG FRAME ACHIEVEMENTS

The log frame analysis of the updated log frame (as of 3 February 2022) shows the project progress against the targets for the outputs. This analysis uses a range of +/- 5 points for 100%, that is, 95-105% is considered as an indication of "Achieved" and highlighted in green. The colour key below describes the categories of progress.

Achieved	Overachieved	Underachieved

OUTPUTS		OUTPUTS INDICATORS	BASELINE	TARGET	RESULTS	ACHIEVEMENT
1.1	**SBCC materials produced, tested & disseminated**	# of materials produced (Avoidance of gender stereotyping in behavior change communication materials)	0	15	38	**253%**
		# Communication strategy developed & tailored to different audiences (father, mothers, grandparents, disability, gender) guide project work to improve ECD awareness of caregivers and actors	0	1	1	**100%**
1.2	**Increased exposure to relevant SBCC messaging**	# of caregivers exposed to SBCC key message	0	1,200	1,754	**146%**
		# caregiver received at least 9 sessions out of 12 sessions	0	1,000	1,434	**143%**
		# of community events held	0	5	6	**120%**
		# households participated in small income generation activities in responding to COVID 19	0	5	14	**280%**
		# of male caregiver groups established	0	10	32	**320%**
2.1	**Formal community actors trained on integrated ECD**	# of formal community actors trained on integrated ECD	0	116	188	**162%**
		# mentoring/coaching visits to community actors by project staff	0	258	388	**150%**
2.2	**Informal delivery platforms create an improved enabling environment for integrated ECD for young children**	# of informal community actors trained on integrated ECD	0	86	320	**372%**
		# of new/innovative platforms installed with materials on integrated ECD	0	86	258	**300%**
3.1	**Project learnings are documented at community level**	# gender-sensitive KAP study of caregivers, formal community actors and informal community actors conducted	0	3	4	**133%**
		# of user journey case studies of caregivers' experience developed	0	6	6	**100%**

3.2	**Project learnings are disseminated at national level**	# of learning documents disseminated to subnational authorities as well community stakeholders (such as schools, commune council, etc.)	0	4	6	**150%**
		# of learning events organized	0	2	1[25]	**50%**

This log frame analysis shows strong achievement for the results against the targets for the outputs. There is notable overachievement in the log frame. Generally speaking, overachievement does not necessarily indicate a successful project because there might be negative contributing factors, such as inadequate planning, deliberately setting a low target to ensure the achievement of results, poor monitoring systems, and the double counting of beneficiaries. However, this evaluation showed that none of these factors are relevant to this project and, instead, the project overachievement was indicative of adaptive management and learning. The factors that contributed towards this overachievement are:

- The COVID-19 restrictions meant that it was easier to learn at home through the 25 project videos and caregivers had more time to join the sessions. There were also triangulated reports of increased interest and resulting uptake of the project activities (Outputs 1.1 and 1.2).
- During COVID-19, formal community actors were still able to access community members whose movement was otherwise restricted and create more informal platforms (like the point above). There were also reports of high interest and uptake (Outputs 2.1 and 2.2).
- The successful and extensive sharing of the project material. At the end of Year 1, three materials (Baby book, Bath towel, & Male engagement poster) were disseminated to the subnational authority and community stakeholders (school, health center, & commune councils). In addition, the WCCC shared these three materials to their network, the Department of Information, and KCM TV in Kampong Cham province. In Year 2, the three materials (Caregiver booklets, Male booklets, and Caregiver self-assessment) were disseminated to subnational authorities and community stakeholders (school, health center, and commune councils). The WCCC shared these materials with, for example, P-ESWG Kampong Cham, as well as sharing the additional three documents (Formal & Informal actor capacity, Caregiver meeting, & group meeting) at the national level with, for example, the Ministry of Education, Ministry of Interior, and Ministry of Health (Output 3.2).
- For the videos, 3-4 were planned but due to COVID-19 the team adapted to the context and ensured the intervention continuity. The team produced 25 videos to cover all 12 lessons with the same agreed budget. These were produced by project staff with support from the PoE, DoE, and teachers.
- Regarding the number of caregivers who received at least 9 out of the 12 sessions, the team planned for 1000 but achieved 1,434. This was due to additional commitments of the local authorities to support the project staff to reach more people with the same budget.
- Regarding the number of male caregiver groups that were established, the team planned for 10 but reached 32. This was because the local authorities were more interested and helped the project team to prepare the work plan, organize group meetings, and inform men to participate in the meetings.

Finally, from the data analysis, the hypothesis was formed that the online format of the project meant that more activities could be achieved with less funding. This issue is highlighted further below under Efficiency.

One additional and important point regarding project achievements is that due to COVID-19 restrictions, the baseline was only able to be completed in early 2021 (published in April 2021). This means that the quantitative results present changes as measured only over the second year of the project. The team

[25] One more will be completed in March 2022.

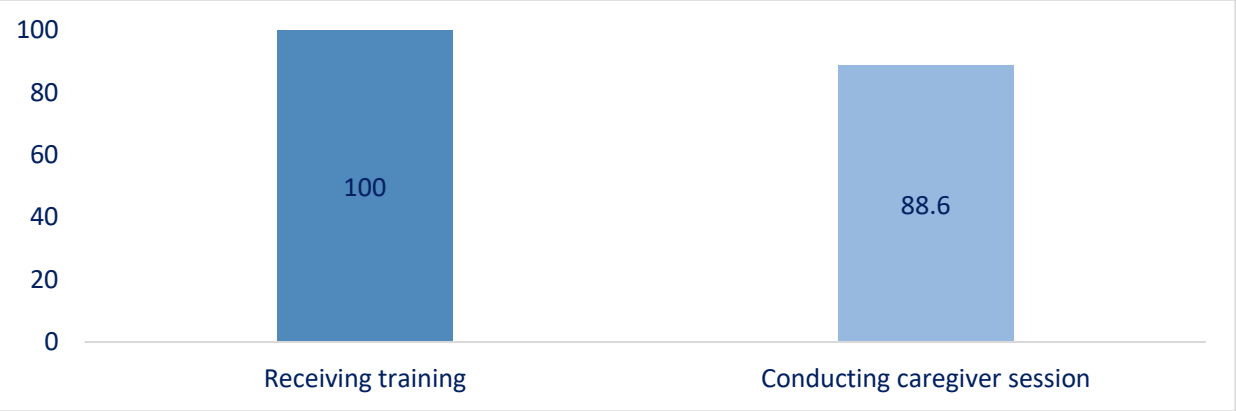
noted that it was very unusual to conduct a baseline at this point of the project, followed quite quickly by the mid-term review. However, the strong results demonstrated through the quantitative baseline and endline surveys are particularly striking given the relatively short duration between baseline and endline. It is worth noting that some of the baseline data may have been different had it been collected earlier in the project, and there is potential that the changes captured in the endline data may have been even greater if compared against data from a baseline conducted at the project outset.

PROJECT EXPOSURE (SURVEY)

This section presents the findings related to the project exposure of community actors, caregivers, and local authorities.

Community actors' exposure to the project. All community actors in the targeted area in endline survey received project training and 88.6% of them were actively involved in the project by conducting caregiver sessions or providing training to caregivers (Figure 1).

Figure 1. Percentage of community actors exposed to project



The percentage of community actors exposed to specific IEC materials and their rating (Likert Scale: 1=very unsatisfied to 5=very satisfied) are outlined below (Table 5). The data shows high exposure to all the IEC materials [82.5-100%] with the lowest exposure to Toy [51.8%]. Community actors rated all the IEC materials highly [4.8-4.9%].

Table 5. Percentage of community exposure to IEC materials and their rating

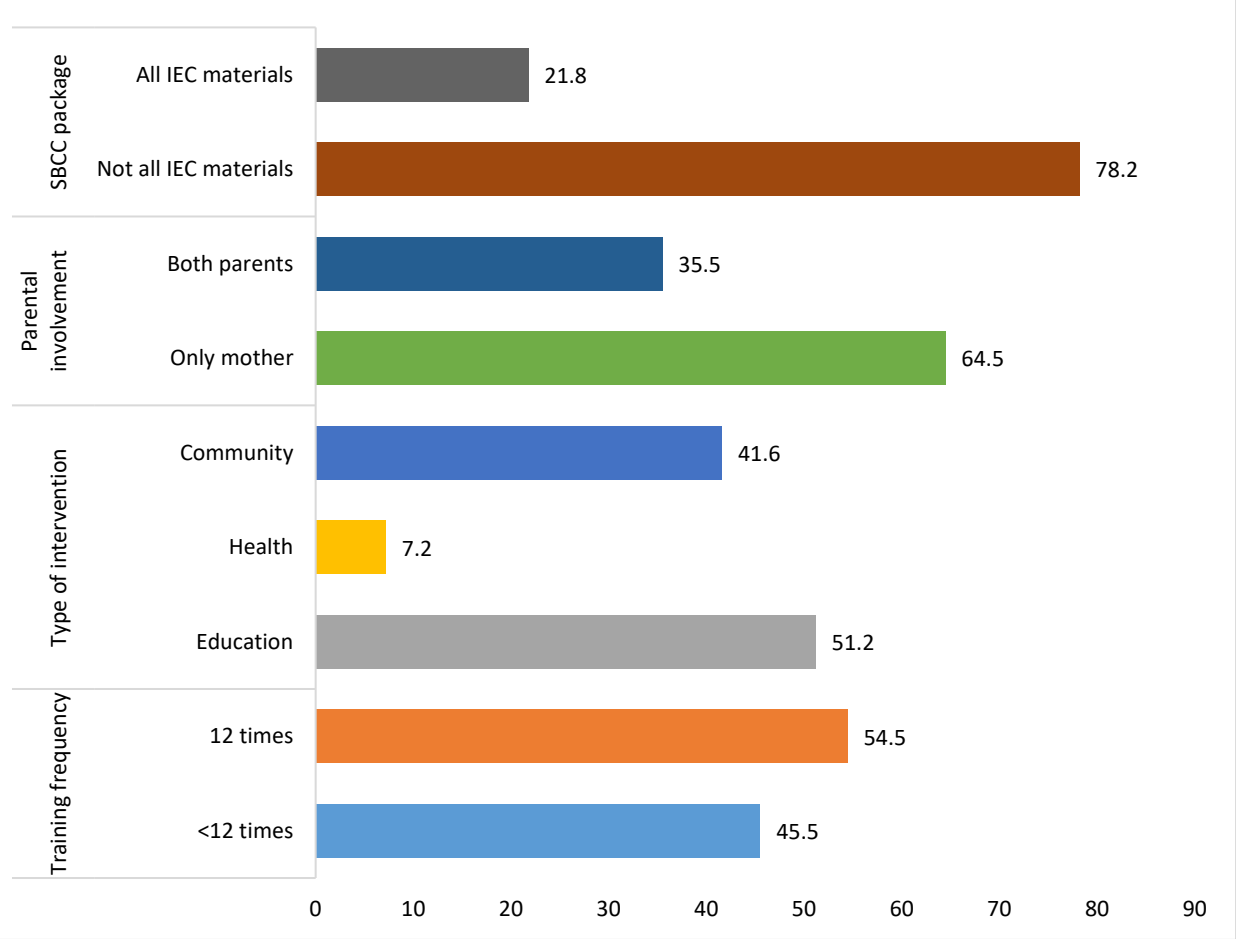
IEC materials	Proportion	Rating score (1 to 5)
Story book	82.5	4.9
Billboard	86.0	4.9
Poster	95.6	4.9
Towel	95.6	4.9
Toy	51.8	4.8
TV attached at commune hall or health center	98.3	4.9
Audio	100.0	4.9
Videos	100.0	4.9
Mobile broadcasting	99.1	4.9
T-shirts	100.0	4.9

Caregivers' session during COVID-19, Saya Village, Ampil Commune

Caregivers' session, Prek Youn Village, Kien Chrey Commune

Caregivers' exposure to the project. The data shows that 100% of the caregivers were exposed to the IEC materials, 21.8% exposed to all IEC materials and 78.2% to some IEC materials (Figure 2). In terms of parental involvement, 35.5% of both parents and 64.5% of only mothers were exposed to the project. Exposure to specific types of interventions was 51.2% education, 41.6% community, and 7.2% health. For training frequency, 54.5% of the caregivers attended 12 times and 45.5% attended less than 12 times.

Figure 2. Percentage of caregivers in the targeted areas exposed to project



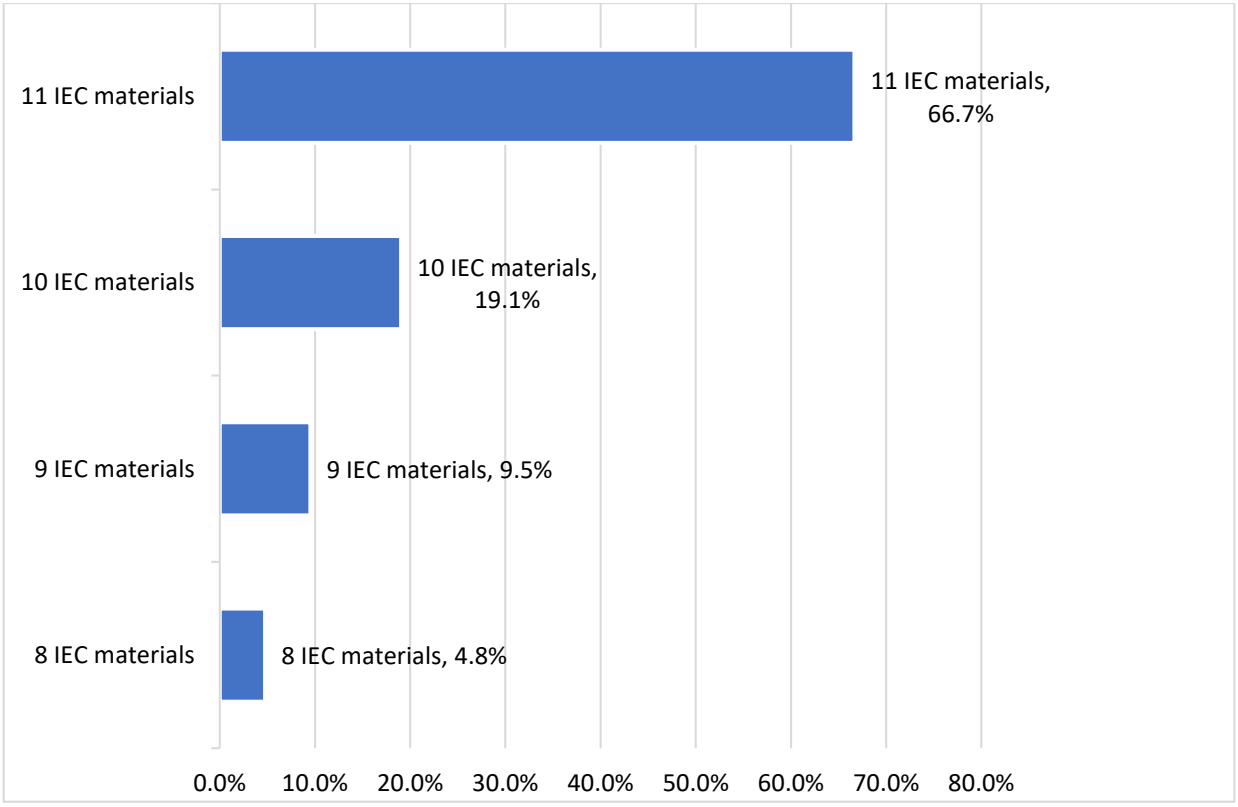
The data assessing the percentage of caregivers exposed to specific IEC materials and their rating shows high exposure for most IEC materials [86.1 (Billboard)-98.0% (booklets)] (Table 6). The IEC materials that had the least exposure are T-shirts (69.7%), TV (58.6%), and Toy (46.4%). Caregivers gave high ratings of the IEC materials [range of 4.4 (TV) to 4.8 (Towel)].

Table 6. Percentage of caregivers' exposure to IEC materials and their rating

IEC materials	Proportion	Rating score (1 to 5)
Booklets	98.0%	4.7
Story book	91.7%	4.7
Billboard	86.1%	4.5
Poster	95.6%	4.6
Towel	96.5%	4.8
Toy	46.4%	4.5
TV attached at commune hall or health center	58.6%	4.4
Audio	91.1%	4.6
Videos	87.8%	4.7
Mobile broadcasting	90.2%	4.6
T-shirts	69.7%	4.6

Local authorities' exposure to the project. The data shows that 100% of the targeted local authorities (21 including the provincial members of WCCC, district-members of WCCC, commune members of CCWC, and commune councils) were exposed to the IEC materials (Figure 3). Of this, 66.7% of the local authorities were exposed to all 11 IEC materials, 19.1% to 10, 9.5% to 9, and 4.8% to 8 IEC materials.

Figure 3. Percentage of local authorities exposed to IEC materials



The data assessing the percentage of local authorities exposed to specific IEC materials and their rating shows 100% exposure to seven materials (Story book, Towel, Toy, Audio, Videos, Mobile broadcasting, and T-shirts) (Table 7). Exposure to Poster was 95.2%, TV 85.7%, and Billboard 81%. Local authorities reported high satisfaction with IEC materials with the highest rating for Story book (85.7%) and Videos

(81%), and the lowest rating for TV (50%).

Table 7. Percentage of local authorities exposed to IEC materials and their rating

IEC materials	Proportion	Rating score (1=very unsatisfied to 5=very satisfied)	
		Satisfied	Very satisfied
Story book	100.0	14.3	85.7
Billboard	81.0	29.4	70.6
Poster	95.2	30.0	70.0
Towel	100.0	23.8	76.2
Toy	100.0	23.8	76.2
TV attached at commune hall or health center	85.7	50.0	50.0
Audio	100.0	23.8	76.2
Videos	100.0	19.1	81.0
Mobile broadcasting	100.0	22.2	77.8
T-shirts	100.0	33.3	66.7

INTERVENTION PLATFORMS

The following section presents the qualitative findings regarding the effectiveness of the training and IEC materials. Before these findings, it is important to note that the RAISE project was the first project implemented by SC Cambodia completely under COVID-19 restrictions. Thus, it can serve as an important baseline and comparison for other projects.

EFFECTIVENESS OF TRAINING

Overall, evaluation stakeholders and project participants spoke highly of the lessons and training provided through RAISE. This section presents qualitative findings regarding these lessons and training, including thematic findings on (1) the capacity of trainers; (2) training modalities; (3) engaging men; (4) engaging grandmothers; and (5) ICT challenges.

Capacity of trainers. Respondents spoke positively about the capacity of the trainers, noting that training was generally fun, engaging, and interesting. In particular, participants enjoyed videos and interactive games. DOE stakeholders in one project district shared that the facilitators were experienced, and able to explain concepts clearly in an engaging atmosphere, noting that most participants were now well-trained and could effectively deliver the training to target beneficiaries in the community. The in-depth focus on ECD was appreciated by some stakeholders, who noted that this allowed participants to really delve into ECD issues and learn extensively. Health centre staff highlighted that training undertaken in pairs (e.g., either a local authority and VHSG; a teacher and a local authority; or a health centre staff member and a local authority) were particularly effective, as each trainer brought specific perspectives and strengths to the training. VHSGs noted that this kind of pairing was very useful for local authorities, who could observe and learn from a lead trainer, building their knowledge and confidence for future training. Echoing mid-term evaluation results, teachers, health centre staff and VHSGs were cited by participants as generally the most effective trainers, as they were seen as credible with strong technical skills for delivering and facilitating lessons. At the same time, some stakeholders suggested that there were other trainers such as some village chiefs who had not yet developed enough skills to facilitate the training effectively.

Training of community actors, RAISE

Stakeholders shared that the qualifications and behaviour of trainers were crucial to the success of the project, arguing that if trainers were well-respected in the community, participants would not pay attention to their guidance. Others highlighted that some of the older trainers seemed to have more difficulty in absorbing the lessons, forgetting some points when delivering lessons to participants. COVID-19 also impacted the training of trainers. For example, in the second year of the project, some of the originally trained trainers left the project due to concerns related to the pandemic, and the project was required to select and newly train replacements for the second year. Some stakeholders argued that because of COVID-19, the quality of the training in the second year was not as strong as during the first round of training. However, they also shared that many of the earlier trainers continued to support the newer trainers.

Training modality. At different points of the project, training was provided to participants in several ways, from one-on-one training, small group training and large group training. The delivery modality of training was affected by COVID-19 school closures and face-to-face gathering restrictions within the target communities. During these periods, the project was able to utilise online platforms (e.g., Zoom, Facebook [now Meta], Microsoft Teams and Telegram) to coordinate and communicate with local authorities, and to conduct training. However, this created delivery challenges for the project, particularly with regards to low levels of digital literacy amongst some stakeholders. The project was able to work with local government officials to identify safe ways to continue providing sessions to caregivers by conducting 30-minute sessions in smaller groups, facilitated by formal community actors and with a maximum of two participants from each village. During these sessions, the project drew on videos of educational games from the 12 sessions, the caregivers' booklets, male engagement booklets and Nurturing Care Framework posters.

The school principal showing how the volunteers and trainers use technology (Facebook Messenger) to share videos, keep in touch, and share information to relevant stakeholders, Chakrei Primary School, Ou Svay Commune, Dec 2021

An overall challenge highlighted by numerous respondents, including the project team, was that some participants could not join regularly

and often took turns with other family members to attend caregiver sessions. The project attempted to respond to this challenge by trying to ensure that any family members who participated in the training shared the information or knowledge gained with the main caregiver. Facilitators would ask caregivers to share a photo of them sharing their knowledge and skills with other members of the family, through posting their photos in their caregiver Facebook group. The facilitator also followed up in the next session and conducted home visits to support those who missed the sessions.

In the fieldwork, stakeholders expressed different opinions regarding the effectiveness of training groups of different sizes, with some strongly preferring one-on-one or small group training, and others strongly preferring medium group sizes. However, none of the stakeholders argued that larger groups were most effective. Stakeholders from DOE in Kampong Siem, for example, expressed that they had observed one-on-one training to be more effective, allowing participants to fully focus on a kind of "special tutoring" class. Some teachers and principals and VHSGs also argued that while one-on-one training was time-consuming, participants could fully focus, and it was easy to conduct such training during COVID-19. However, other stakeholders highlighted the labour-intensity of one-on-one training, questioning how sustainable such training would be over time. Some health centre staff expressed that the one-on-one training was actually the most challenging, time-consuming and "risky," noting it could be awkward to be alone with a participant, particularly when the participant does not ask questions. Another challenge was that participants might not be available at the scheduled time, meaning multiple visits would be required to reach the individual.

> *"We would make an appointment in advance, but sometimes, the participants are not home at the agreed time. They ask to change to a different time. In some cases, we are not allowed to enter their house, so we had to stand outside of the fence to provide training. It is very difficult and awkward. I occasionally feel very demotivated."* Health Centre staff member, Kampong Siem district

These health centre staff members suggested that small group training was most effective, providing an opportunity for participants to learn collaboratively and assist each other with lessons. They also noted that the children of participants in small groups could play together during training.

> *"Small group training is the most effective. Participants can discuss with each other during the training and help each other to review the lessons. Their kids can play together when the mothers are in the training. The facilitation is also more convenient compared to big group training."* Health Centre staff member, Kampong Siem district

Stakeholders from PWCCC, along with school principals and teachers, argued that large group training was less effective because some participants would be absent, and the participants would change frequently. For example, sometimes a mother would join the training, while other times the grandmother would join in her place. Teachers and school principals noted that while big training can reach many people at once, it can also be "a bit chaotic" when participants bring their children with them.

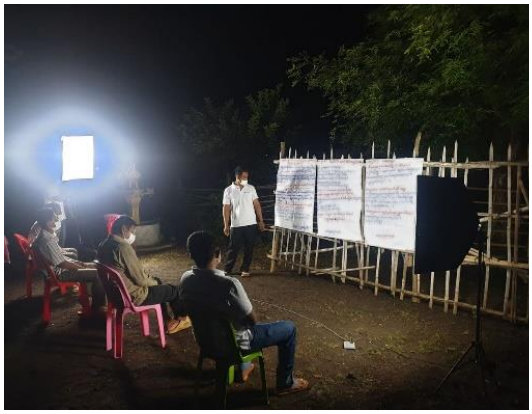
Along with different opinions regarding group size, stakeholders also had different opinions regarding which specific lessons were most interesting and applicable. However, trainers, participants and other stakeholders particularly highlighted the importance and usefulness of the training on male engagement in ECD and training on caregivers' well-being. Participants shared, for example, that learning breath work and meditation techniques to reduce stress was important and useful for them (although some new facilitators found this session somewhat difficult to deliver).[26] PWCCC stakeholders highlighted that the techniques related to anger management were particularly useful, to help parents more effectively respond to their children without the use of violence.

[26] This is an interesting finding as SC staff has noted that this has been challenging elsewhere.

Engaging men. The project's specific engagement with and targeting of men was highlighted by many different stakeholders as a key driver of project success. As noted above, many stakeholders highlighted the importance of the specific lessons within the project on male engagement within the family, noting that it helped mothers, other caregivers, and fathers to better understand the importance of male engagement in child-raising and family support, and that it helped to shift mindsets. Some noted the effectiveness of the project's approach of engaging men as trainers, arguing that in becoming trainers or team leaders, men would start changing their own behaviour in order to be a role model to others. Community members shared that when other men in the community saw the changes in the trainer, they began to take more interest and have more trust in project activities, which increased their own engagement. Teachers and principals highlighted the importance of having both men and women participating in the training, arguing that this meant impact could be seen more quickly.

> *"After joining the training, I have been promoted to be the male team leader. Now, I am responsible for providing training to other men in the village. I volunteer to teach four more men outside of the target groups. It is my contribution. I do not get any incentive to teach the four men."* Team leader, Fathers group, Ampil Commune

The flexibility of training hours was identified as a key driver of training effectiveness, particularly the project's flexibility in meeting and training men after work hours (and other caregivers on weekends). While originally planned for Monday to Friday, training for men was instead conducted in the evenings and payday, with the recognition that men often worked far from home and did not necessarily have weekend availability either. One fathers' group participant in Krala Commune, Kampong Siem district, shared "In our village, we have Mr. Hong as a team leader. He would come to our house to provide training in the evening, after working hours. We gather in a small group. We trust him to provide training to us." Project staff also highlighted the strategic importance of the project team's efforts to engage hard-to-reach men, including those men who were known to be heavy drinkers, or to be abusive. The team noted that this engagement was associated with particular challenges, given that these men often came from within poor households, had schedules that were difficult to keep track of, and often had low levels of education.



Male meeting during COVID-19, Andoungpor Village, Kralar Commune

Male engagement meeting, Prey Chakkrey village, Ousvay Commune

Engaging Grandmothers. Stakeholders identified some challenges in engaging grandmothers in the project. Stakeholders from POE, as well as principals and teachers, shared that in their experience, older caregivers often had difficulty keeping up in the training to the same level as others. They found that the pace of the sessions might be too fast for elderly participants, who may benefit from more time to absorb the contents and practice what they are learning, and even more focused teaching and training strategies. DOE stakeholders also suggested that within the training, more attention should be paid to all participants who are older, less experienced or have lower levels of literacy.

ICT Challenges. One of the most cited challenges to training, amongst staff and stakeholders, was related to ICT skills, accessibility, and connectivity issues. Stakeholders from POE as well as health centre staff highlighted that while some trainers were able to use their mobile phones to play videos during training, their screens were too small to be effective. They also noted that in other locations, where internet connectivity was very slow, videos were unable to be used in the training, and that not all caregivers had access to smartphones themselves. Further, the ICT skills of some trainers and participants were still limited. Some trainers shared that they were not sure whether the videos they shared via telegram or Messenger were watched by participants.

IEC MATERIALS

In qualitative fieldwork, stakeholders were asked about their perceptions of the various IEC materials distributed or used by the project. The following section summarizes key input from stakeholders.

Televisions. There were mixed responses from stakeholders regarding the efficacy of televisions. One of the key factors impacting the efficacy of the televisions was the placement of the set. For example, some community members suggested that they worked better when they were positioned at eye level, and where people were sitting. The effectiveness of TVs also appeared to be related to the commitment of the health centre staff and local authorities, where TVs were situated. Some community members suggested they were more likely to pay attention to the TVs at a health centre while they were waiting for an appointment or vaccination, whereas in the Commune Council halls, most people went in and out quickly for a specific reason and may not pay attention to a TV. Others suggested that even in health centres, their focus was not on the TV but on the health issue that brought them to the centre. Health centre staff shared that they played the videos every day at the health centres, and that they were often watched by pregnant women and mothers while they waited.

Some stakeholders highlighted that in noisy contexts, or contexts in which the space where the TV was positioned was also used as a meeting space (especially Commune Council halls), TVs might be on but were muted because the background noise was unwanted. Some observed that different stakeholders had different technical capacities for operating the "smart" TVs. Principals, teachers and VHSGs observed that at Commune Council halls, videos were often only played when there were many people around, but that sometimes commune council members were too busy and forgot to play the videos. They also noted that the smart TVs were also sometimes used for other purposes, such as showing the morning news, or sharing COVID-19 information, or joining online meetings as a group. Mothers shared that they were more likely to see the TVs at the health centre, as they seldom went to the Commune Council hall.

TV broadcasting at Ampil commune hall

TV broadcasting, Health Centre

RAISE books. All stakeholders cited their appreciation for the project books. POE stakeholders felt that the handbooks for participants were of good quality, and that they were durable and easy to carry

around. POE respondents shared that the books had good quality pictures and that they contained useful, easy to follow content. Project staff also noted that both trainers and participants found the books useful and easy to use, and that they were loved by the participants. Teachers and principals shared that the second version of the book (which was shorter and summarized) was better in terms of its design and easier to use and keep for reviewing lessons. Health centre staff and VHSGs agreed that the books were very beneficial, well-sized, easy to use, durable, and rich in content with a good design.

Child book illustration

Khmer to English translation:

Educational Message for Caregivers

Notice: This document is intended for caregivers who have children aged 0-3 years old. This document is for caregivers to read and apply the knowledge and practice with children in their daily life.

Caregivers also spoke highly of the books noting they were of good quality and were very durable. They shared that although their children play with it, it is not easily torn, and they appreciated that it contained many pictures and was easy to understand without reading. Caregivers noted that when they forget the lessons, they are able to review them.

Self-evaluation checklists. Self-evaluation checklists were also spoken of highly by various stakeholders. Health centre staff, VHSGs and mothers all noted that these checklists were helpful reminders for caregivers of what they have learned, and what their own practices are. Mothers shared that this was very helpful and provided a good opportunity for them to check their daily practices with their children.

> *"Whenever the trainers ask me to tick the checklist, I see my result and feel so guilty toward my child. Therefore, whenever I think of the checklist, I can control myself, and try to treat my child better." Mother, Koh Totuem commune, Kampong Siem district.*

Loudspeakers/Tuk-tuks. This strategy was considered by some stakeholders (such as VHSGs) to be one of the most effective approaches, with information shared in key community locations (e.g., marketplace, near the pagoda, local coffee shops, commune halls, etc) through loudspeakers on tuk-tuks. Project staff highlighted that this was a successful strategy that was suitable for the context of COVID-19. Local authorities were also supportive of this approach and provided the team with tips regarding how to most effectively organize the schedule and which strategic locations to include. VHSGs noted that tuk-tuks would often stop at one place where many people would pass through, to allow them to look at the posters and listen to the messages. Sometimes, local authorities would accompany the tuk-tuk.

Videos & Audio. Videos and audio materials also received positive feedback in the qualitative fieldwork, although challenges remain, as noted above, in terms of connectivity, access to devices, and digital literacy. POE stakeholders shared that the videos were useful with good sound, good quality and a suitable pace that was easy to follow. Health centre staff appreciated that the videos were easy to share via telegram to other caregivers who had access to smartphones, and they can watch whenever they want at home or anywhere. However, as noted above, they also shared that it was difficult for trainers with only smartphones to share videos due to the small screen size. Caregivers shared that they sometimes watched the videos with their children, too, and that they enjoyed the audio soap operas

during the training.

Video, Child Development, RAISE, Episode

Posters. There were some mixed responses from stakeholders regarding the effectiveness of posters. Overall, stakeholders, including caregivers, shared that they had seen the posters, which were both visible and attractive, in health centres, or at strategic junctions in the roads, or at the Commune Council hall or other places in the villages. Some health centre staff suggested that the small posters at handwashing stations were largely ignored by older community members, and VHSGs commented that some of the big posters at the Commune halls, while attractive, were not always durable and could be easily torn with strong wind. Caregivers shared that they also received posters from SC.

Male engagement poster, Trapaingkos Village, Ousvay Commune

Towels. The towels were appreciated by mothers, in particular, who noted they were very colourful and practical and could be used both for daily use and to play games with children. Health centre staff agreed that towels were much-loved by participants as a gift but believed that they were less effective in terms of messaging than some of the other materials.

Towel with RAISE messaging

DRIVERS

Following the above specific exploration of training and IEC material effectiveness, this section now turns to a broader discussion of drivers of effectiveness at the project level. The evaluation found that the main drivers of effectiveness are (1) the project's adaptability and flexibility, (2) the use of an integrated programming approach, engaging multiple stakeholders, and (3) SC's strong relationships with government authorities and local stakeholders.

Screenshot of the project video "Behaviour Change of Mothers in Childcare."

Adaptability and flexibility. The RAISE project was delivered almost entirely within the difficult context of the COVID-19 pandemic, even while the project planning had been completed before the onset of the pandemic. The ability of the SC team to so adeptly adapt its activities and deliver its programming within the context of this pandemic was identified in this evaluation as one of the key drivers of the project's effectiveness. This represents a major achievement of the team. As some stakeholders shared, many projects during COVID-19 were severely disrupted and often unable to conduct the planned activities. However, the Cambodia CO was able to redesign some of the project activities or their delivery modality. Examples include holding training online, reducing in-person training group sizes, and introducing new activities such as the installation of handwashing stations and the provision of sewing machines and training to 14 women who had lost their livelihoods' source due to the pandemic. As one stakeholder noted, "Those activities were not aligned with the original design but were a very quick adaptation to COVID-19. […] and the CO was able to deliver what they promised in terms of training. That is already quite impressive, in a challenging situation." Another stakeholder shared that team was particularly adaptive in terms of seeing issues on the ground, and being able to respond, noting, "It was really interesting that the team was so adaptive. We talk a lot about adaptive management, but this came really organically for them."

Stakeholders from DOE also noted with appreciation the flexibility and adaptability of the project, highlighting that even with the disruptions from COVID-19, the team still found different ways to provide the training and deliver messages, including adapting training group size, using technology such as voice messages, sharing messaging through loudspeakers on tuk-tuks, sharing videos online, and hosting meetings on online platforms. DOE stakeholders also appreciated that some administrative processes were simplified during COVID-19, including physical signatures on some documents, to reduce the risk of infection through in-person contact.

Some of the factors that likely contributed to the project's adaptability include:

1) A strong knowledge within the team of the local context and needs
2) The ability of the team to conceptualize and plan alternative interventions and approaches realistically and quickly
3) A bottom-up and results-oriented approach to project implementation, which allows project staff within communities the authority and flexibility to adapt quickly to the local context and emerging needs
4) The support of SC management and funding partners to adjust project approaches to respond to changing circumstances
5) Strong communication mechanisms between the CO and the funding partner
6) The project team's good relationships with government, local authorities, and stakeholders, who also supported the shifts and helped enable continued access
7) The buy-in and commitment of government, local authorities and stakeholders to the aims and activities of the project
8) A certain level of ICT capacity and connectivity amongst key stakeholders, which made alternative forms of communications and training possible.

"Stakeholders are very supportive of the project activities. They are committed and willing to go the extra mile to implement the project. E.g., Commune Councils contribute resources, financial and human resources, to expand the number of handwashing stations. They also provide free training to some families, more than what the project covers. POE, DOE and PWCCC are encouraging and supportive in M&E activities, a lot." SC RAISE project staff

One example of the project's COVID-19 related adaptations is the setting up of handwashing stations in the target communities, with educational messages for young children and adults. While the project supported some handwashing stations, Commune Councils in the targeted communities such as Koh Tatem, Kian Chrey, Ampil, Ousvay and Krolar also allocated budgets to set up handwashing stations. A food seller in Ampil Commune, Kampong Siem district, shared, "When the handwashing station was installed, there were not many people using it at first. After a week, people started using it. Sometimes, they thought the water tank is drinking water. As a seller, I often remind my customers to wash their hands first."

"When there is a handwashing station, my customers, especially young children, will wash their hands before coming in, especially during COVID-19. We have to protect ourselves. Also, I refill the water regularly, and add some soap as well." Seller, Trapang Chrey village, Krala Comm., Kampong Siem dist.

Another example of the project's adaptations was the provision of training and sewing machines to 14 women within the target communities who had lost their jobs due to COVID-19. Looking for ways to bridge a COVID-19 response with small income generation activities, the team, in consultation with the communities, considered supporting either a soap-making initiative or a sewing initiative with a focus on mask-making. When initial internal enquiries found that soap-making chemicals were expensive and difficult to procure, the team settled on the sewing project. SC purchased some of the masks that were produced, to provide to schools and workshop participants. One stakeholder shared that the adaptation was an important way of demonstrating SC's willingness to assist community members in a time of great need, during the pandemic. The evaluation found some evidence of impact from this sewing initiative (see Impact), but there was limited monitoring information available beyond the output level. With all adaptations, ensuring adequate monitoring and evaluation is essential to enable a robust assessment of the effectiveness, efficiency, impact, and sustainability of the adaptation.

Beyond COVID-19-related adaptations, the project also demonstrated its flexibility in its willingness to alter planned training schedules from weekdays to evenings and weekends, in order to be responsive to the needs and schedules of beneficiaries.

Demonstration with children, Cheungkork Village, Ampil Commune

Integrated programming involving multiple stakeholders. One of the core strengths of the RAISE project was its innovative design, which represented the CO's first time piloting a strategy of integrated care for the 0-3 year age group. While the CO has been working on ECE for many years, this project represented the first attempt to focus on SBCC through both formal (e.g., government, local authorities, health centres, schools) and non-formal platforms (pagodas, tuk-tuk drivers, shopkeepers). The project's approach of targeting both male and female caregivers as key stakeholders is also an important driver of effectiveness. Stakeholders were clear that within the project, the different groups and individuals each brought different perspectives, strengths, and value to the project. To illustrate, DOE stakeholders shared that engaging and maximizing the strengths of the different relevant stakeholders at the grassroots level was one of the key achievements of the project. They noted that local authorities were well positioned to facilitate local people joining the training, knowing the location and situation of each household, and having strong relationships with local people. On the other hand, they highlighted, teachers, school principals and health centre staff have strong facilitation skills to provide training in a simple and accessible way and were well-respected in communities. "As a result," one DOE stakeholder noted, "most participants pay attention during the training."

Strong team collaboration. The team highlighted that strong mechanisms for collaboration and the sharing of experiences, challenges, and good practices were an important factor of project achievements. Formal monthly meetings and weekly online interactions enabled the team to share their experiences of how to address various emerging circumstances, and to share the challenges they experienced. The team shared that they "learnt a lot through trials and errors." Strong communication and knowledge-sharing within the team were of particular importance in the context of a pilot project being implemented against the backdrop of the COVID-19 pandemic.

Strong relationships with government authorities and local stakeholders. Related to the above strength, another driver of effectiveness was the SC team's ability to build strong relationships with government authorities, at national, provincial, district and local authority levels. At the national level, for example, the team hosted learning workshops and discussions with the Ministry of Health, Ministry of Interior and Ministry of Education, Youth and Sport to share initial good practices and progress from the RAISE project. Particularly at the sub-national levels, strong relationships contributed to the project's ability to continue programming even in the height of COVID-19 restrictions, as authorities allowed for continued in-person training through different modalities (e.g., individual household training). One project staff member

shared, "[…] the local authorities expressed their full support for the implementation of the project, which contributed to the team's ability to deliver."

CHALLENGES

Two main overarching challenges were identified in this evaluation, including (1) the impact of the COVID-19 pandemic on programming, and (2) understanding stakeholder roles, responsibilities, and coordination towards an integrated ECCD approach.

COVID-19. The onset of the global COVID-19 pandemic presented significant challenges for the implementation of RAISE. Some of the core challenges included restrictions on gatherings and travel, along with the need to follow new safety protocols within all programming. Both the implementation of planned activities, as well as monitoring and evaluation of those activities, were impacted by these restrictions. Staff also shared that the travel restrictions limited travel for in-person follow-up support to trainers, as had been planned. As noted above, the project adapted in numerous important ways to the new and unexpected context, with some new activities added and other planned activities unable to proceed (for example, large community events) or taking place in formats that were different than initially planned (e.g., one-on-one or small group training versus larger group training). Staff also shared that the adjustments required by COVID-19 meant that project implementation was, at times, more time-consuming than it would have otherwise been. For example, training took longer to complete on a one-on-one or small group basis than they would have in larger-sized groups. COVID-19 also impacted budgeting, as discussed below under Efficiency.

Understanding stakeholder roles, responsibilities, and coordination towards an integrated ECD approach. One of the challenges faced by the RAISE project was that, as a pilot focused on an integrated approach to ECD, the team had to develop and build its own understanding of the different roles and responsibilities of so many different stakeholders. Roles and responsibilities within an integrated approach to ECD are shared even at the national level amongst a diversity of Ministries, such as the Ministry of Social Affairs, Ministry of Women's Affairs, Ministry of Interior, Ministry of Health, Ministry of Education, and others. At sub-national levels, a wide range of stakeholders and authorities are also necessarily involved in an integrated ECD approach. SC staff highlighted that while there were numerous existing policies within different government sectors relating to ECCD for the 0-3 age group, actually working on the translation of those policies into practice through the implementation of an integrated ECD project at the local level was something new. Aside from resource and capacity challenges, the lack of coordination mechanisms at national as well as sub-national levels meant that the flow of guidance and national budgets down to the community level was disjointed, presenting a challenge for the team. However, through the project, the SC team was able to build a stronger understanding of these various roles and responsibilities, which also represents a significant project achievement that can usefully serve as a platform for future related work, and which can be shared with other stakeholders towards more effective integrated ECD programming in future.

Caregiver session, Ampilkrom Village, Ampil Commune

EFFICIENCY

This section discusses the project budget, cost allocation analysis, reporting, and capacity.

BUDGET

The total budget was USD 772,882 with the actual expenditure (as of end of Dec 2021) of USD 658,000 (Table 8). The burn rate is 85%.

Table 8. RAISE budget

RAISE Budget vs Actual (US Dollars) (as of 2 Feb 2022)					
Code	**Description**	**Total Budget Jan 2020 - Mar 2022 USD**	**Actual Expenditure Jan 2020 - Dec 2021 USD**	**Remaining Jan-Mar 2022 USD**	**Burn Rate %**
OUTPUT 1.1	SBCC materials produced, tested, and disseminated	28,510	28,601	(91)	100%
OUTPUT 1.2	Increased exposure to relevant SBCC messaging	92,264	103,260	(10,995)	112%
OUTPUT 2.1	Formal community actors trained on holistic ECD	37,247	37,650	(403)	101%
OUTPUT 2.2	Informal delivery platforms create an improved enabling environment for holistic care for young children	12,944	13,946	(1,002)	108%
OUTPUT 3.1	Project learnings are documented	102,415	79,390	23,025	78%
OUTPUT 3.2	Project learnings are disseminated	31,293	12,213	19,080	39%
0007	Project staff - project staff	214,345	181,208	33,137	85%
0008	Supporting staff - supporting staff direct hours	83,848	85,013	(1,164)	101%
EQUIPMENT	Equipment and supplies	5,152	5,080	72	99%
MEAL	MEAL	29,221	16,500	12,722	56%
ADMIN	Admin and support costs	135,644	95,141	40,503	70%
	Total	**772,882**	**658,000**	**114,882**	**85%**

The 85% burn rate should be understood in terms of the fact that the project ends on 31 March 2022. Moreover, line items where there are still unspent funds reflect the remaining and ongoing activities until the end of the project. For example, (1) OUTPUT 3.1: Project learnings are documented (78%), (2) OUTPUT 3.2: Project learnings are disseminated (39%), (3) MEAL (56%), and (4) ADMIN: Admin and support costs (70%). The project team confirmed (8 Feb 2022) that the full amount will be spent by the end of the project in the four above started areas.

The project team also noted that with the shift to online training and follow up (with less associated costs, for example, decreased travel and per diems), the project was able to maintain the outputs and quality at a lower expenditure rate. The team stated that this remote modality allowed them to be more cost effective. It follows that if the burn rate is seen as a proxy for project management, this might have

created the false impression of lowered outputs.

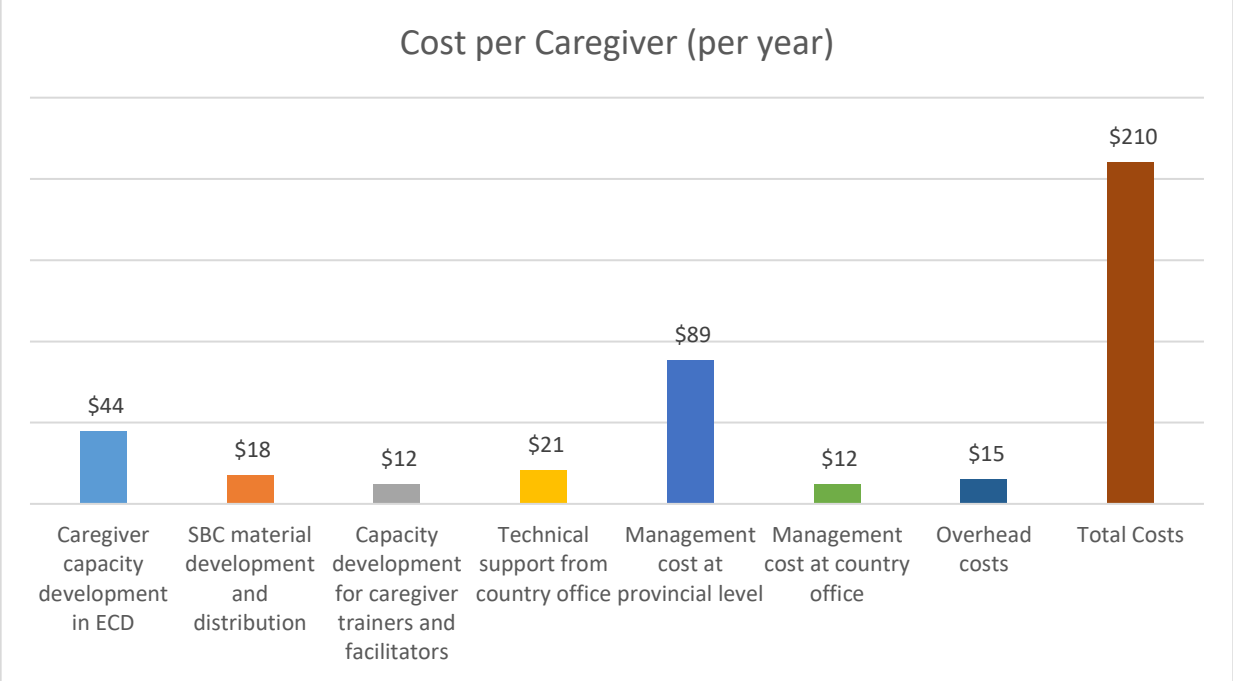
As mentioned above under the discussion of Achievements (Effectiveness), the online project delivery modality could have allowed for increased activities with less budget. It would be interesting to test this hypothesis because it would have important implications for project efficiency, impact, and sustainability moving forward.

DOE respondents noted one area where there was increased expenditure, that is, travel. The COVID-19 restrictions resulted in DoE staff not being allowed to travel to communities. Subsequently, more human resources were required to deliver one-on-one training which was more costly and time-consuming for the trainers as they had to travel from one household to another.

COST ALLOCATION ANALYSIS

The SC team conducted a cost allocation analysis for the RAISE project, in order to estimate the unit cost (cost per caregiver) of the intervention. The cost allocation analysis showed an overall cost per caregiver (per year) of USD 210 (Figure 4).[27]

Figure 4. Cost per caregiver (per year)



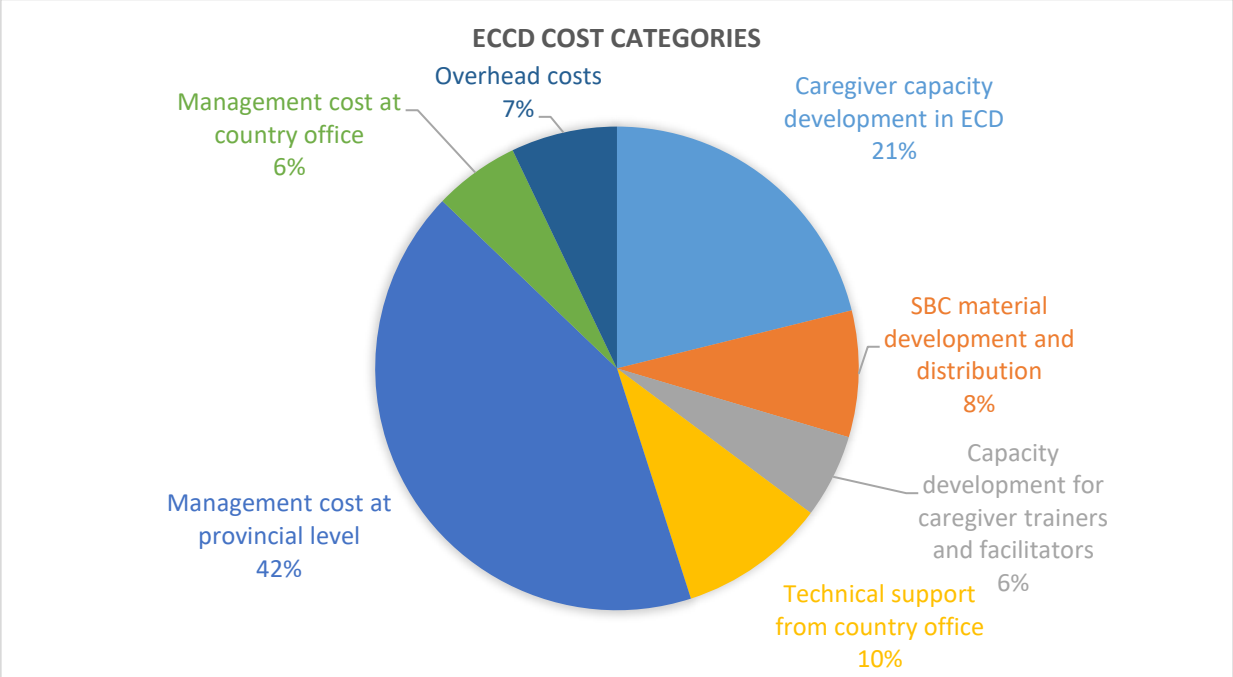
The higher costs in the breakdown above are associated with project management expenses at the provincial level (USD 89 (42%)per caregiver, which includes staff salary, benefits, transportation, etc) (Figure 5). In addition, the costs of technical support from the SC CO (e.g., Technical Experts from the Phnom Penh office) are approximately USD 21 (10%) per caregiver.

Importantly, the cost associated with caregiver capacity development only (using a model of 12 caregiver sessions supported by necessary home visits and community awareness raising activities) is USD 44 per caregiver. This model is based on an assumption that ECD educators and facilitators at the community level are already equipped with the necessary skills and knowledge to facilitate caregiver sessions and organize community awareness activities. If the costs of SBCC material distribution (USD 18) are added, then costs of ECD education would increase to USD 62 per caregiver. Costs to train community actors to

[27] DEA, Cost Analysis, Jan-Dec 2021

be ECD trainers and facilitators only would be USD 12 per caregiver (this excludes other costs).

Figure 5. ECCD cost categories and percentages



REPORTING

The CO submitted a narrative report every six months to SCHK, with a monitoring call every quarter. During this meeting, key indicator tracking results were available, to enable a discussion of achievements against targets during each quarter. Stakeholders within the CO as well as the funding partner noted with appreciation the clear and strong communication between them. The funding partner noted that the team's communication of and response to project challenges was noteworthy.

CAPACITY

While the adaptations and flexibility required to meet the challenges of the COVID-19 pandemic placed additional demands on staff, the project team indicated that the team was sufficient in numbers and capacity to effectively implement the project. While project planning took place before the COVID-19 pandemic, the implementation took place during the pandemic, meaning the team was required to adjust to higher levels of administrative demands, and new safety protocols to protect staff as well as project participants. Team members highlighted with appreciation the support they received from each other, local authorities, and SCI HQ staff. Save the Children's bottom-up and results-oriented approach allowed staff working at the community level to be flexible in their approach to implementation, and to respond to emerging needs and adjust to the local context as required.

The project team also highlighted the importance of having well-trained staff members with experience in ECD, child rights, and community engagement. The team noted that there were strong systems and supports in place for M&E, from the HQ level to the field level, with project teams having been trained on data tracking, M&E, and the development of formative/summative assessment tools for M&E purposes. The project team was able to form internal local level M&E teams including, for example, local authorities, and POE and PWCCC representatives. In terms of community level stakeholders, the project team noted that Commune Councils have some capacity gaps in relation to advocacy skills, budgetary skills to help ensure the sustainability of activities, and ICT skills (for example, utilising new technologies, or conducting online meetings).

IMPACT

Impact is divided into quantitative and qualitative data.

QUANTITATIVE

The quantitative findings are organised under the headings of:

1. Caregiver awareness of integrated ECD (Outcome 1)
2. Capacity of community actors to provide leadership and advice on integrated ECD to caregivers (Outcome 2)
3. Caregiver's knowledge, attitude, and practice on integrated ECD
4. Community actor's knowledge, attitude, and practice of integrated ECD
5. Male engagement in early childhood care
6. Grandmothers as caregivers and project-related outcomes
7. Child development outcomes

CAREGIVER AWARENESS OF INTEGRATED ECD

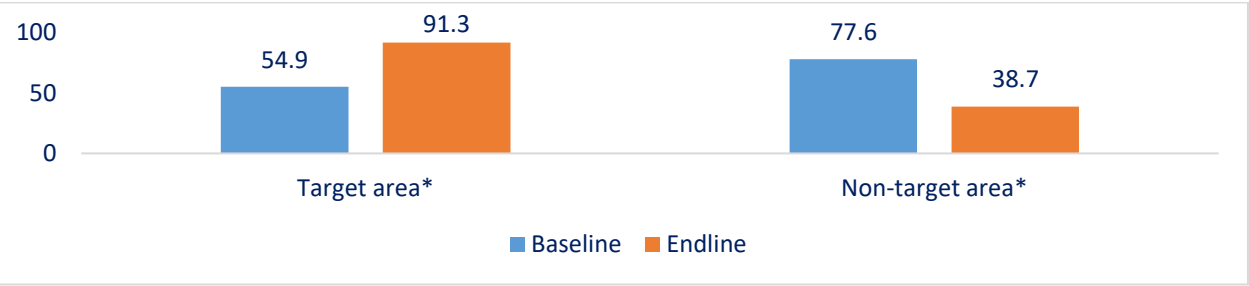
Awareness of good health and nutrition. Awareness of good health and nutrition refers to Outcome 1.1 in the log frame (see Box below).

5 Positive Practices in Good Health and Nutrition, where caregivers practice:

- Washing their hands at critical times (e.g., before preparing food, after using the toilet, after changing diapers, or after cleaning up their child after their child had used the toilet).
- Supporting their child in washing their hands at critical times (e.g., before eating, after using the toilet, duration of handwashing and the use of soap).
- Providing healthy snacks to their child of over 6 months old (healthy snacks were defined based on the government's definition).
- Taking their sick child to health centres.
- Drinking clean water or giving clean water to their child.

The project resulted in a significant increase of 36.4% in the percentage of caregivers who are aware of at least three positive practices in good health (54.9% baseline [BL] to 91.3% endline [EL]) (Figure 6). It is also important to note that there was a decrease of 38.9% of awareness in the non-target group (77.6% BL to 38.7% EL).[28] This means that at EL, the target group was 52.6% higher than the non-target group.

Figure 6. Percentage of caregivers aware of at least 3 positive practices in good health and nutrition



*p<0.05

[28] This is a notable finding that the survey attributed to the widespread negative effects of COVID-19 on learning. This point holds true for the subsequent findings below that show a decrease in the non-target groups.

Caregivers' awareness of at least 3 positive practices on good health and nutrition were not statistically significant in relation to gender, age, and ID Poor (p-value>0.05). Only socio-economic status was statistically significant at 5% in the non-targeted group (see Annex 3).

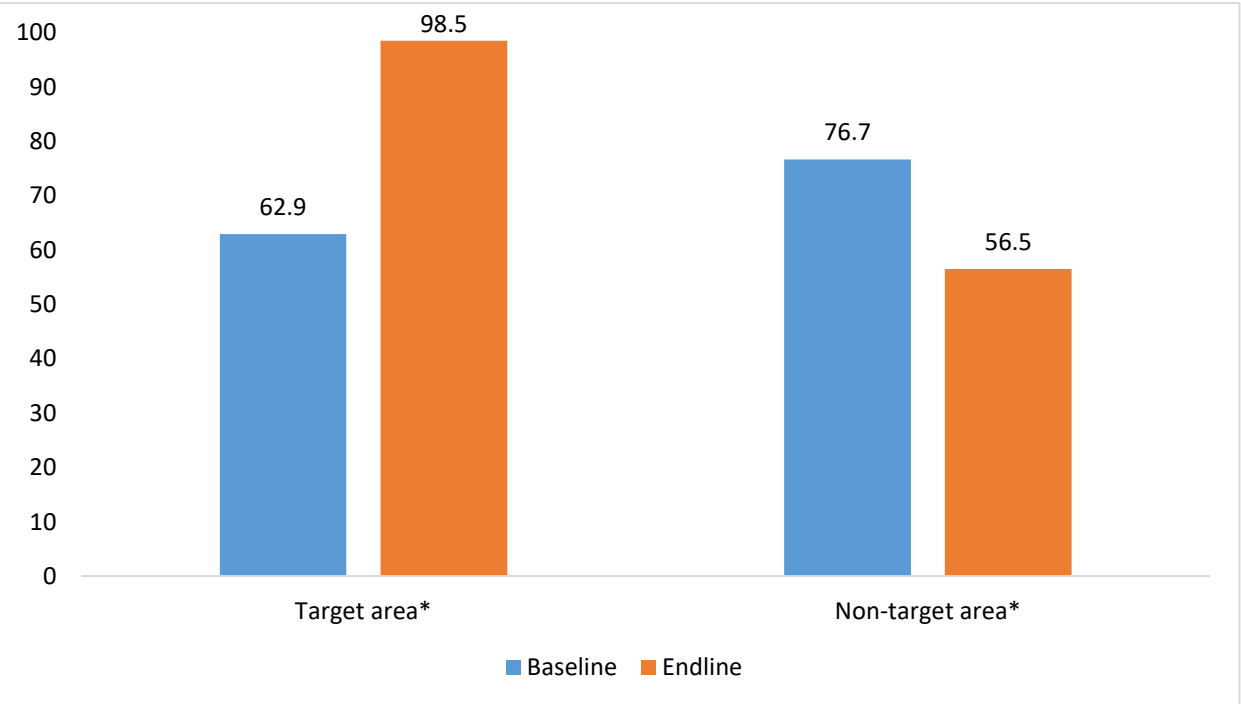
Awareness of early learning and responsive care. Awareness of early learning and responsive care refers to Outcome 1.2 in the log frame (see Box below).

Early Learning and Responsive Care

1. Taking turns to engage their child in responding and talking to help in their development (e.g., Serve & Return).
2. Washing their hands at critical times (e.g., before preparing food, after using the toilet, after changing diapers, or after cleaning up their child after their child had used the toilet).
3. Supporting their child in washing their hands at critical times (e.g., before eating, after using the toilet, duration of handwashing and the use of soap).
4. Providing healthy snacks to their child of over 6 months old (healthy snacks were defined based on the government's definition).
5. Taking their sick child to health centres.
6. Drinking clean water or giving clean water to their child.

This study found that the project resulted in a significant 35.6% increase (62.9 BL, 98.5% EL) in caregivers' awareness of at least 3 positive early learning and responsive care practices (Figure 7). There was a decrease of 20.2% in the non-target group. This means that at EL, the target group was 40% higher than the non-target group.

Figure 7. Percentage of caregivers aware of at least 3 positive early learning and responsive care practices



*p<0.05

The disaggregated data for caregivers' awareness were not statistically significant in relation to gender, age, and ID Poor. It was found that respondents' awareness in the non-targeted sites were significant for

socio-economic status (see Annex 3).

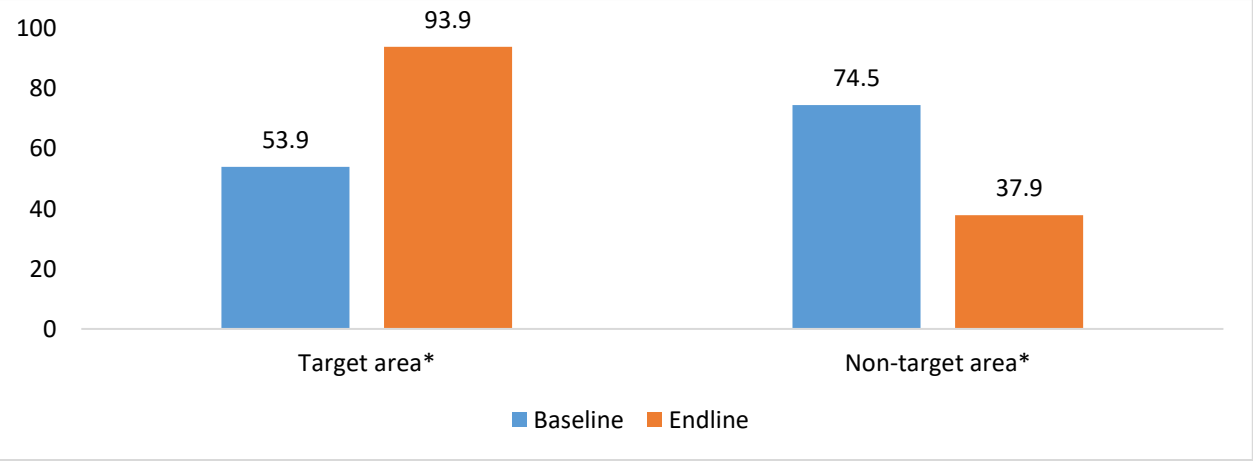
Awareness of safety and security. This refers to Outcome 1.3 in the log frame (see Box below).

Awareness and Safety and Security

1. Using a soothing voice with their child.
2. Hugging or patting their child when they were upset.
3. Using different ways to calm down their child when they were upset (e.g., check the child's diaper, check if the child was hungry or tired, distract the child with play).
4. Using different ways to distract children when they displayed unwanted behaviour (e.g., removing the stimuli from the child, removing the child from the stimuli, extinction, time-outs, positive reinforcement).
5. Calming down and thinking first to make the right decision.

The project resulted in a significant increase of 40% in the percentage of caregivers who are aware of at least three positive practices in safety and security (53.9% baseline [BL] to 93.9% endline [EL]) (Figure 8). There was a decrease of 36.6% of awareness in the non-target group (74.5% BL to 37.9% EL). This means that at EL, the target group was 56% higher than the non-target group.

Figure 8. Percentage of caregivers aware of at least 3 positive practices in safety & security



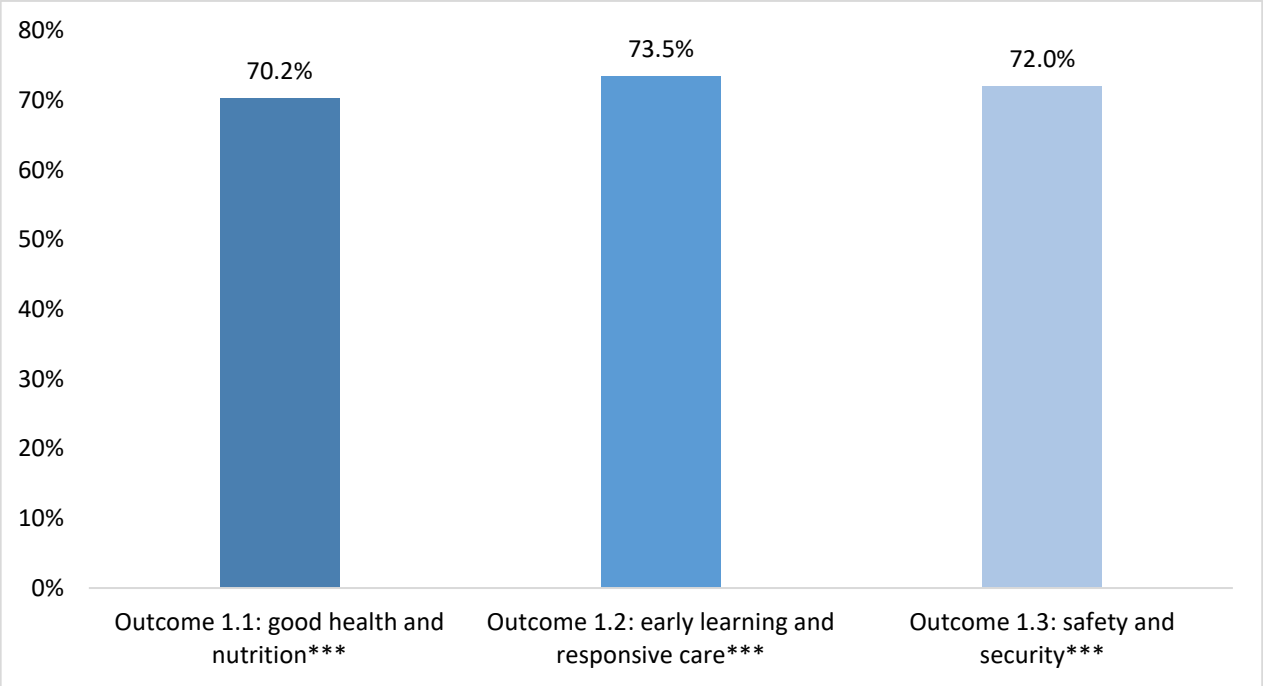
*p<0.05

Caregiver reading with children, Trapaing Char Village, Krala Commune

Disaggregating the awareness of safety and security, findings showed that such awareness was not statistically significant by gender, age and IDPoor. Like the earlier results, respondents with high SES had a higher awareness of safety and security than medium and low SES in both BL and EL in the non-target, but not in the targeted site.

Project impact of outcome 1 of caregivers. A regression analysis was conducted on the impact of the project on the three outcomes of caregivers' awareness (Annex 3). After controlling for variables, the analysis found that the project increased caregivers' awareness of good health and nutrition by 70.2%, early learning and responsive care by 73.5%, and safety and security by 72.0% (Figure 9).

Figure 9. Project impact on caregivers' awareness



* $p<0.1$; ** $p<0.05$; *** $p<0.01$

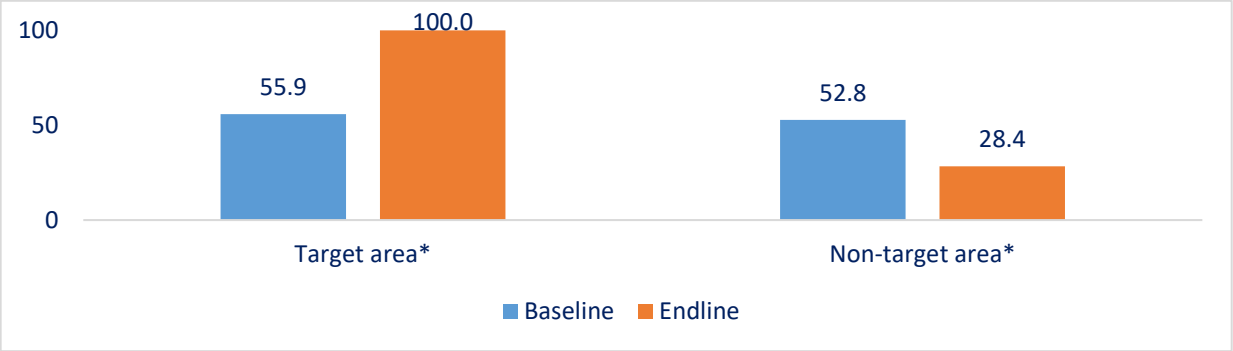
The study found that the awareness of good health and nutrition, early learning and responsive care, and safety and security were not statistically significant by intervention strategies, number of SBCC packages, or training frequency (p-value<0.05) (Annex 3).

COMMUNITY ACTORS' CAPACITY TO PROVIDE LEADERSHIP AND ADVICE ON INTEGRATED ECD TO CAREGIVERS

Community actors consist of both formal actors (e.g., commune councils, CCWCs, teachers and school directors, health centre staff, and village leaders) as well as information actors (e.g., religious representatives, village sellers, and others such as villagers and volunteers). The two outcomes for community actors include (1) awareness and understanding of positive practices towards integrated ECD, and (2) providing advice on integrated ECD to caregivers.

Awareness and understanding of positive practices towards integrated ECD. Outcome 2.1 was defined as community actors being at least aware of three positive practices in the three topics of good health and nutrition, early learning and responsive care, and safety and security. The study showed that the project resulted in a significant increase of awareness and understanding of 44.1% (55.9% BL to 100% EL) (Figure 10). The non-target group's awareness and understanding decreased by 24.4% (52.8% BL to 28.4% EL). At EL, the target group's awareness and understanding were 71.6% higher than the non-target group.

Figure 10. Percentage of community actors who had awareness & understanding of positive practices towards integrated ECD

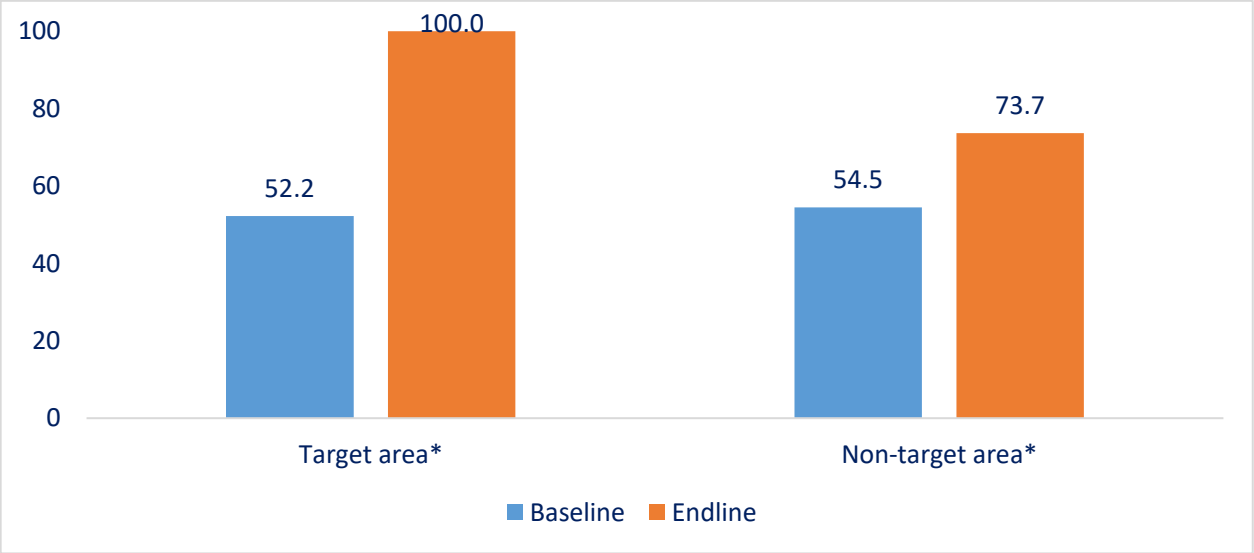


*p<0.05

Generally, the awareness and understanding of positive practices were not significant when considered in relation to gender, age group, or target group (Annex 3). It was only significant in relation to the type of actors in the baseline in the targeted areas.

Providing advice on integrated ECD to caregivers. Outcome 2.2 is defined as the proportion of community actors who provide advice to caregivers on at least three out of 16 indicators listed in outcome 1.1 (good health and nutrition), 1.2 (early learning and responsive care), and 1.3 (safety and security) above. Because the baseline data only included 13 indicators, the endline analysed at least three out of the 13 indicators in order to make a meaningful comparison. The project increased by 47.8% of community actors who provided advice to caregivers for at least three of the indicators (52.2% BL to 100% EL) (Figure 11). There was an increase of 19.2% in the non-target group (54.5% BL to 73.7% EL). At EL, the target group was 26.3% higher than the non-target group.

Figure 11. Percentage of community actors who provided advice to caregivers for at least 3 of 13 indicators



*p<0.05

In assessing the proportion of community actors who provided advice on specific indicators, the study found that, based on the 13 indicators, the advice increased from 9.9 (BL) to 12.7 (EL) (Table 9). From the non-target group, there was a decrease in advice from 10.5 (BL) to 7.0 (EL). Against the 16 indicators, the target group provided 15.7 versus the 9.7 of the non-target group.

Table 9. Advice against 13 indicators

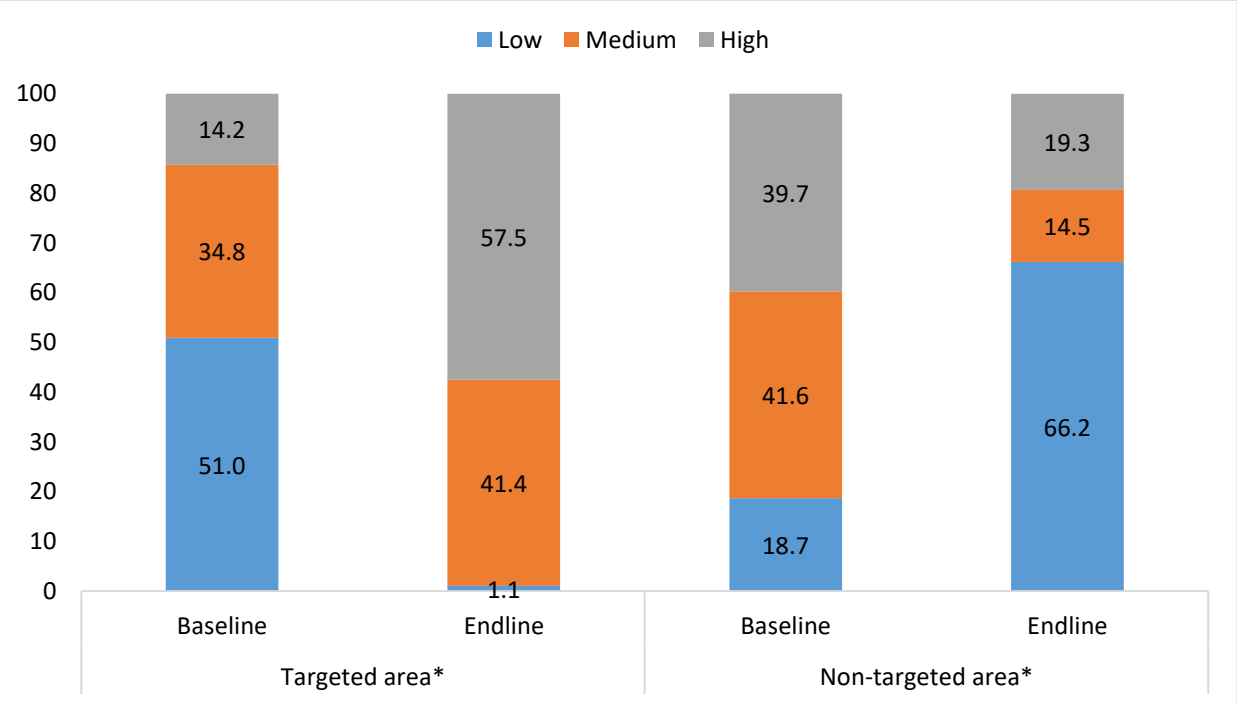
Area	Number of indicators	Baseline	Endline	p-value
Target	Number of advice (out of 13)	9.9	12.7	0.000
	Number of advice (out of 16)	n/a	15.7	
Non-target	Number of advice (out of 13)	10.5	7.0	0.000
	Number of advice (out of 16)	n/a	9.7	

Project impact on outcome 2.1 and 2.2. The project impact was assessed according to the number of indicators that community actors were aware of and provided advice to caregivers. The results showed that the project could increase the (1) awareness of community actors by 4.5 indicators, and (2) the advice that community actors provided to caregivers by 5.0 indicators.[29]

CAREGIVERS' KNOWLEDGE, ATTITUDES, AND PRACTICES ON INTEGRATED ECD

Knowledge of caregivers on integrated ECD. There was a significant increase of 43.3% in caregivers' knowledge on integrated ECD (14.2 BL to 57.5% EL at the high level) (Figure 12). The non-target group scores decreased by 20.4% (39.7% BL to 19.3% EL). At EL, the target group was 38.2% higher than the non-target group.

Figure 12. Caregivers' knowledge of integrated ECD

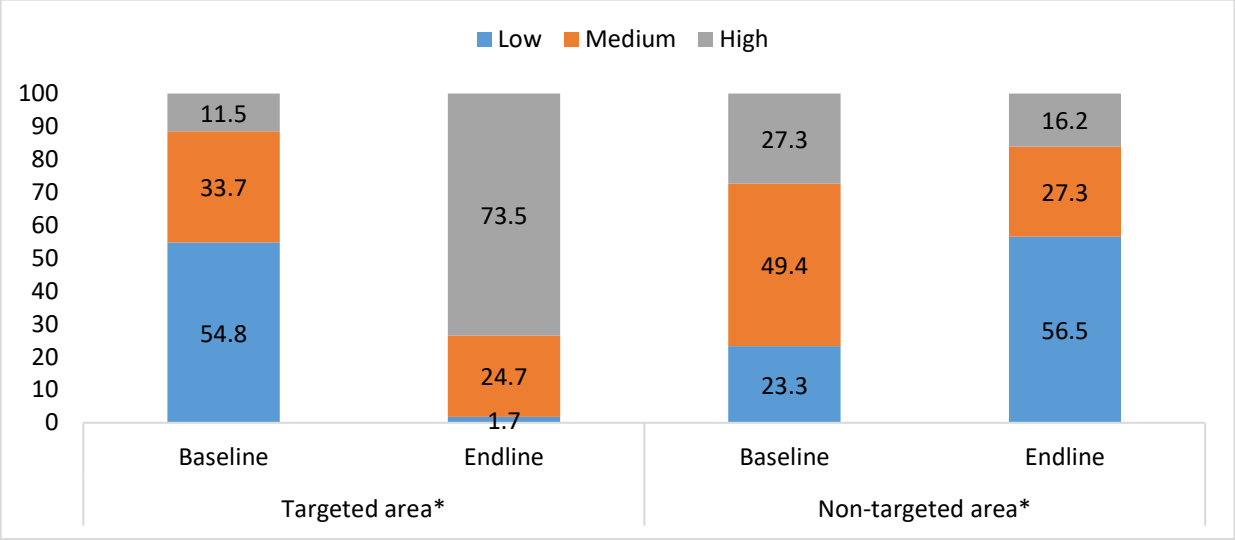


*p<0.05

Attitudes of caregiver on integrated ECD. The project resulted in a 62% increase in caregivers' attitudes to integrated ECD (11.5% BL to 73.5% EL at the high level) (Figure 13). The non-target group's scores decreased by 11.1% (27.3% BL to 16.2% EL). At EL, the target group's score was 57.3% higher than the non-target group.

[29] During the analysis, it was noted that 100% of the community actors in the target in the endline survey had awareness and understanding of positive practices towards integrated ECD and provided advice to caregiver at least three indicators. This suggested that a difference-in-difference analysis could not be employed to assess the impact of the program on these two outcomes. Hence, the dependent variables were changed from yes/no to number of indicators. Basically, the team assessed the program impact by the number of indicators which community actors were aware of and provided advice to caregivers.

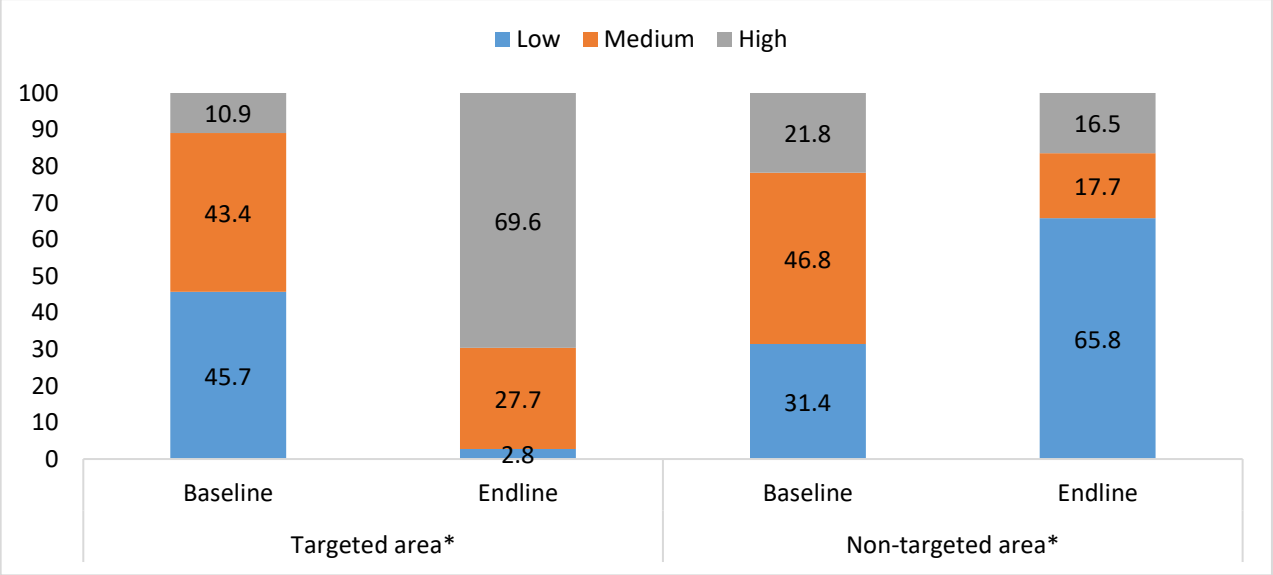
Figure 13. Caregivers' attitudes to integrated ECD



*p<0.05

Caregivers' practices of integrated ECD. The project resulted in an increase of 58.7% in caregivers' practices of integrated ECD (10.9% BL to 69.6% EL at the high level) (Figure 14). The non-target group showed a decrease 5.3% (21.8% BL to 16.5% EL). At EL, the target group was 53.1% higher than the non-target group.

Figure 14. Caregivers' practices of integrated ECD



*p<0.05

Project impact on caregiver's KAP. The project increased the caregivers' knowledge by 71.4%, attitudes by 66.4%, and practices by 60% (Annex 3).

Further disaggregation of this impact showed that (1) after controlling various confounders, knowledge did not differ by the type of intervention, SBCC packages, and training frequency, (2) attitudes and practices also were not significantly affected by the type of intervention and SBCC packages, but they were significantly affected by training frequency, and (3) caregivers who attended 12 training sessions have higher scores on attitudes and practices than caregivers who attended less than 12 training sessions. This is useful information but, unfortunately, we are not able to say by how much higher the scores were if they attended all 12 sessions. Ascertaining this information would in future programming.

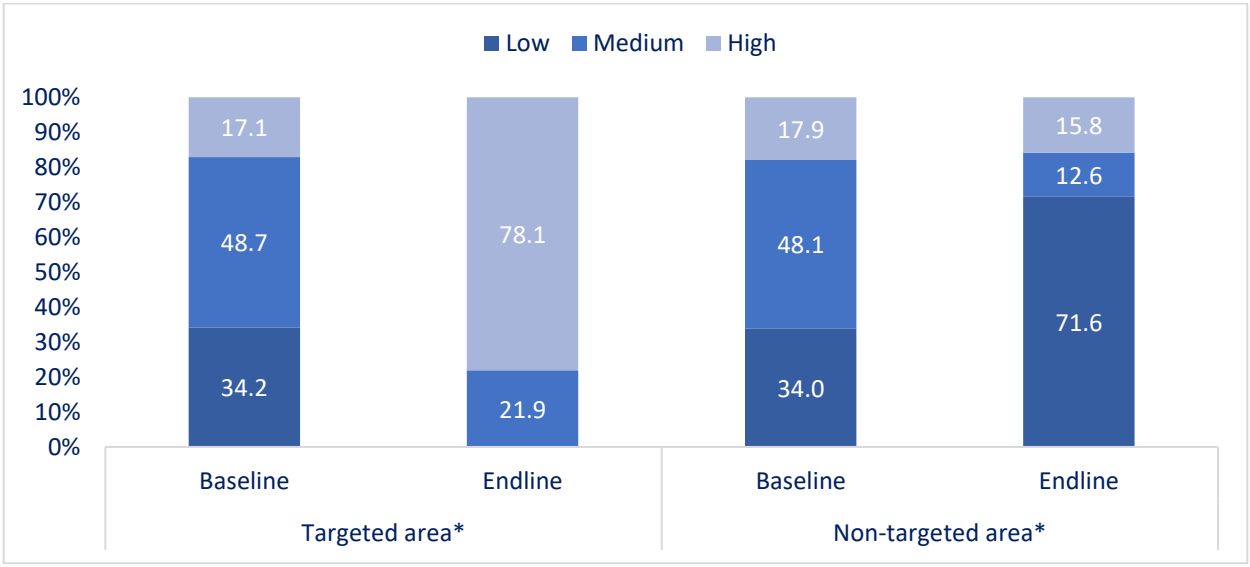
Male engagement, Outhnong Village, Ousvay Commune

COMMUNITY ACTORS' KNOWLEDGE, ATTITUDE, AND PRACTICE OF INTEGRATED ECD

In addition to community actors' awareness of integrated ECD, their knowledge, attitude, and practice of integrated ECD were also analysed.

Knowledge of community actors on integrated ECD. The project resulted in an increase of 61% (17.1% BL to 78.1% EL at the high level) in the knowledge of community actors on integrated ECD (Figure 15). For the non-target group, there was decrease of 2.1% (17.9% BL to 15.8 EL). At EL, the target group was 62.3% higher than the non-target group.

Figure 15. Knowledge of community actors on integrated ECD



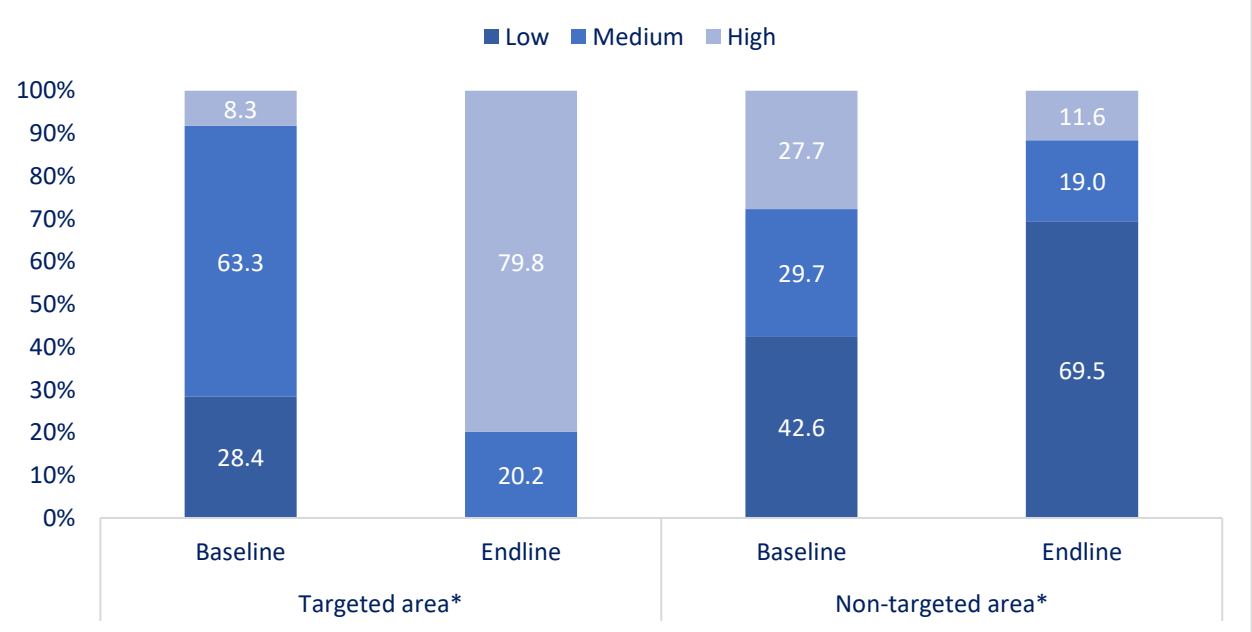
*p<0.05

Generally, the knowledge of the community actors did not differ by gender, age, or type of community in both areas, except by the type of community actors in the baseline in non-target area (Annex 3).

Sharing handwashing steps at Salabun, Romeas Village, Ampil Commune

Attitudes of community actors on integrated EC. The study found that the project improved the attitudes of community actors to integrated ECD by 71.5% (8.3% BL to 79.8% at the high level) (Figure 16). The non-target group's scores decreased by 16.1% (27.7% BL to 11.6% EL). At EL, the target group was 68% higher than the non-target group.

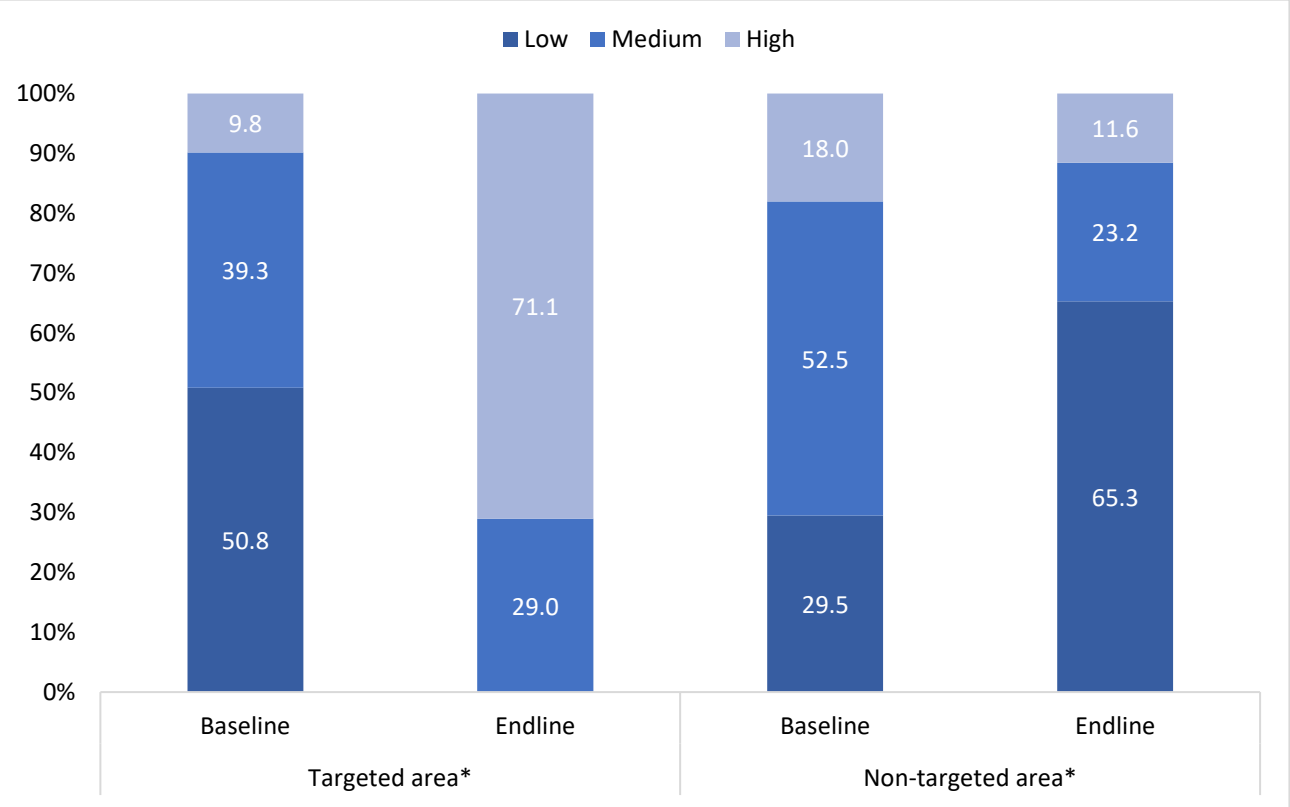
Figure 16. Attitudes of community actors on integrated ECD



*p<0.05

Practices of community actors on integrated ECD. The project resulted in a 61.3% increase in the practices of community actors in integrated ECD (9.8% BL to 71.1% EL at the high level) (Figure 17). There was a 6.4% decrease in the target group (18.0% BL to 11.6% EL). At EL, the target group was 59.5% higher than the non-target group.

Figure 17. Practices of community actors in integrated ECD



*p<0.05

Project impact on community actors' KAP. The project increased community actors' knowledge by 41.2%, attitudes by 47.8%, and practices by 48.1% (Annex 3).

MALE ENGAGEMENT IN EARLY CHILDHOOD CARE

Male engagement. The study showed that the project increased male engagement in ECD activities by 17.6% (69.9% BL to 87.6% EL). This engagement was measured across the following activities:

- Talk and read books to the fetus
- Reading letters to the child and teach the child by using photos, drawing, and playing games
- Bring wife to have prenatal care
- Use happy faces and actions to play with the child
- Tell the child about animals, plants, things
- Help wife with washing clothes
- Help wife with cooking

There was a significant decrease of 8.6% in the male engagement in the non-target group. At EL, the male engagement in ECD activities was 22.3% higher in the target vs non-target group.

Violence. While there was no baseline data, the study compared violence between the target and non-target groups. The overall violence (physical and emotional) was 0.2% for the target group and 12.8% for the non-target group. That is, the project resulted in a 12.6% difference in the reported overall violence between target vs non-target groups in community actors' attitudes of integrated ECD. For the reported violence against children, there was a 12.2% difference for the target (higher) vs non-target groups (lower). For the reported violence against women, there was an 8.7% difference for the target (higher)

vs non-target (lower) groups.[30]

GRANDMOTHER AS A CAREGIVER AND PROJECT-RELATED OUTCOMES

Caregivers' awareness by the role of the caregiver. In all three areas of (1) good health and nutrition, (2) early learning and responsive care, and (3) safety and security, grandmothers had lower awareness in comparison to mothers, fathers, and other caregivers (Table 10). That is, for awareness of good health and nutrition, grandmothers scored significantly less points (58.1) than the average of the other caregivers (67). For awareness of early learning and responsive care, grandmothers scored significantly less points (69.6) than the average of the other caregivers (74.2). For awareness of safety and security, grandmothers scored significantly less points (59.6) than the average of the other caregivers (64.7).

Table 10. Caregivers' awareness by the role of the caregiver

Awareness	Mother	Father	Grandmother	Other	p-vale
Good health and nutrition	68.6	65.7	58.1	66.7	0.005
Early learning and responsive care	75.4	75.7	69.6	71.7	0.167
Safety and security	67.8	62.9	59.6	63.3	0.038

Knowledge, attitudes, and practices by the role of the caregivers. The study found that grandmothers had lower knowledge, attitude, and practices on integrated early childcare and development than other caregivers. For knowledge, grandmothers scored significantly less points (27.0) than the average of the other caregivers (30.5). For attitudes, grandmothers scored significantly less points (24.0) than the average of the other caregivers (31.6). For practices, grandmothers scored significantly less points (22.7) than the average of the other caregivers (30.5).

The issue of grandmothers is explored further in the sections below on child outcomes and qualitative impact.

CHILD DEVELOPMENT OUTCOMES

The final section explores child development outcomes using the CREDI tools.[31] Child development outcomes here include social-emotional, cognitive, language, motor, and the overall CREDI scores.[32]

[30] It should be noted here that these figures are low compared to other similar studies. In this survey, the majority of the respondents were the mothers of the children. Based the meeting with the project team, two specific questions of violence were asked (1) Did the father or male family members commit physical violence against the mother or children in the past 3 months? yes/no, and (2) Did the father or male family members commit emotional violence (blaming, cursing, threatening, scolding, neglect) on the mother or children in the past 3 months? yes/no. During the analysis, survey consultant presented the preliminary findings to the project team. The team requested the presentation of both kinds of violence as the overall violence. Thus, the figure is the proportion of households whose mother and/or children experienced both types of violence in the last three months. This data is thus limited and is indicative at best and it would require further analysis with robust baseline and comparative data.

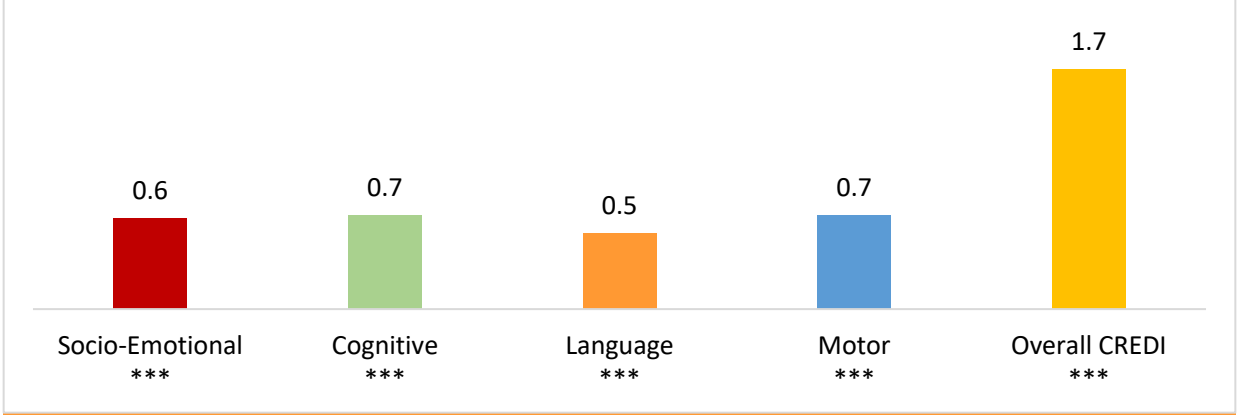
[31] The Caregiver Reported Early Development Instruments (CREDI) were designed to serve as a population-level measure of early childhood development (ECD) for children from birth to age three. As the name suggests, the CREDI exclusively relies on caregiver reports, and thus primarily focuses on milestones and behaviours that are easy for caregivers to understand, observe, and describe. See https://credi.gse.harvard.edu/ and https://resourcecentre.savethechildren.net/pdf/10322_credi-user-guide-14-april-2017.pdf/

[32] It is important to note the following two points regarding CREDI. One, it is not possible to directly compare raw scores across domains. The four domains in CREDI have different age-specific means and standard deviations, which means that a score of 57 in the motor domain and a score of 55 in the Cognitive domain does not necessarily mean that the child is more developed in the motor domain than in the cognitive domain. Two, this overall score will be highly correlated with all four domains but is computed based on a model combining all items and cannot be directly computed from the domain-specific scores.

Figure 18. CREDI domains

The analysis found that the project significantly increased the socio-emotional (0.6), cognitive (0.7), language (0.5), motor (0.7), and overall CREDI (1.7) scores (Figure 19). This is an important finding, demonstrating that the project resulted in a percentage increase of scores by 3% (socio-emotional), 3.5% (cognitive), 2.5% (language), 3.5% (motor), and 8.5% (overall CREDI score).

Figure 19. Project impact on child development outcomes



* $p<0.1$; ** $p<0.05$; *** $p<0.01$

The child development outcomes did not differ by gender, ID-Poor, and socio-economic status. Age was a significant difference, with older children having higher child development outcomes than younger children.

The cross-tabulation of child development outcomes by caregivers' KAP showed that in the target areas child development outcomes were positively associated with caregiver practices but not knowledge and attitudes (at the 5% significance level). In the non-target areas, the child development outcomes were associated with caregivers' knowledge, attitudes, and practices. The regression analysis of the relationship between caregivers' KAP and overall CREDI scores showed that caregivers' knowledge, attitudes, and practices did contribute significantly to the overall CREDI scores. Furthermore, these results showed that caregivers' knowledge, attitudes, and practices were positively associated with all four domains of the child development outcomes.

Child development outcomes did not differ according to the type of intervention or training frequency. Finally, regarding the type of intervention, this study found that children whose mothers were trained by the education and community groups had lower outcomes than children whose mothers were trained by the health group. That is, the overall CREDI score of children whose mother were trained by the education

and community groups were 0.84 and 0.72 respectively lower than children whose mothers were trained the by health group.

A mother reading to her children, Boeung Bobos Village, Kienchrey Commune

QUALITATIVE

In support of the quantitative findings, the qualitative data showed that the project has resulted in significant shifts in knowledge, attitudes, and behaviours amongst stakeholders. This section is comprised of (1) examples of change (amongst different stakeholder groups) and (2) unanticipated impacts. This section also contains 2 illustrative case studies and key learnings from the mothers' and fathers' groups.

EXAMPLES OF CHANGE

Caregivers. In the qualitative research, stakeholders spoke clearly about the impacts of RAISE at the community level. Importantly, this data was strongly triangulated through the input of a wide range of stakeholders, including POE and DOE officials, teachers and principals, VHSGs and local authority stakeholders, health centre staff, and caregivers themselves. The key changes identified amongst project participants included (1) behavioural changes among caregivers, by becoming more loving, supporting and understanding and using less violence verbal and physical with children, (2) caregivers having more organized, cleaner and child-friendly home environments, (3) improvements in parental interaction and engagement with children through creative game-playing, (4) enhanced knowledge among caregivers regarding nutrition (including limiting the consumption of "junk food"), (5) improved personal hygiene amongst children, and (6) a reduction in stress among caregivers due to improvements in their children's well-being and their own mental health.

> *"Before, if the children cried, parents would give them money to buy junk foods. Now they tell their children not to buy the junk foods."* Local Authority official, Kampong Siem district

By contrast, in a non-intervention community, stakeholders shared that the approaches they used in

caring for children in the 0-3 age range were largely based on meeting their children's physical needs as opposed to their educational or emotional needs. The importance and benefits of more holistic care for children within this age group were not well understood. As one stakeholder put it, "It is new. We have never heard about this before."

Mothers. The qualitative research found strong indications of impact specifically amongst mothers who had participated in RAISE, with clear accounts of mothers adapting their own parenting approach to incorporate learnings from the project. The fieldwork found that there was significant interest and appreciation from mothers regarding the project, including interest in being part of the project from mothers whose children were outside the targeted age range of 0-3 years. Mothers who had taken part in the project shared that following their involvement in RAISE, they spent more time and effort with their children, even if they were busy with other things. They spoke about different tools and approaches they had learned for engaging their very young children.

FGD, Mother's Group, Dec 2022

> *"My child always copies what I do. For example, when I make [a] strange sound, she follows me. My child often asks me to read books with pictures. My child can talk a lot and very is very smart."* Mother group participant, Trapang Kak village, Ou Svay Commune

School principals and teachers observed that mothers who had participated in RAISE were "calmer," and that they provided better, more nutritious foods to their children, while VHSG stakeholders shared that mothers were now more knowledgeable around children's hygiene, and that they had learned different ways to communicate with and calm children. Stakeholders also shared that mothers were better equipped to parent with less reliance on verbal or physical violence.

> *"I highly praise [the] RAISE Project because it has changed the behaviour of mothers in my community. In the past, it is common to see caregivers curse or hit their children. Now, they have changed. Their choice of words is more pleasant to the ears. They are knowledgeable and can take care of their children better."* CWCC, Kampong Siem district

Stakeholders also spoke about mothers sharing and modelling their new parenting and caregiving knowledge and practices amongst other mothers and caregivers.

> *"There was a case where a mother always verbally abused her children by shouting and cursing and neglecting the children. When the project first started, she did not want to join the training. Later, she realized her mistakes in her parenting practice. She experienced a transformation. She started modelling good practice and encouraged other mothers to come and join the training."* PWCCC Deputy Head, Kampong Cham province

Fathers. During the qualitative fieldwork, various impacts of the project's work in engaging fathers were identified and triangulated through input from a range of stakeholders. These impacts included (1) an increased level of involvement in domestic chores such as washing dishes and clothes; (2) increased time spent with family and increased engagement with children such as playing with them, and taking them for walks or drives; (3) increased engagement of men in the health care of their wives and children (for

example, taking their wife to the health centre, or taking their children for COVID-19 vaccinations); and (4) a reduction in violence and alcohol consumption. Regarding the latter point, it must also be noted that a reduction in alcohol consumption may also be a factor of COVID-19 public health restrictions on gatherings. Nonetheless, it was raised by multiple stakeholders, including fathers, within the qualitative research as a perceived impact of RAISE. It is also important to note that COVID-19 restrictions may also have contributed to fathers spending increased time at home, including time spent with their children.

Male group, Trapangp'ros village, Krala Commune

"There was a case in Trapang Chrey Village. Both husband and wife would always have arguments after they had a baby because the husband was not supportive or did not help with house chores. He would spend time playing football instead. After both joined the training, the husband better understood his wife struggles, so he started to help around the house. The family has fewer arguments now." VHSG of Trapang Chrey Village, Krala Commune

Representatives from POE and DOE spoke about the particular interest of community members in the training on male engagement in ECD, and the impacts of this particular lesson, noting that fathers who had participated in this training were now more likely to be involved in household chores and child-raising, without feeling ashamed or embarrassed. One participating father shared, "The most surprising lesson is talking to the fetus. Before joining the training, we never knew that we should talk to the fetus. It is amusing and fascinating!" Stakeholders from VSHG also observed that men were more engaged in household chores, and that couples seemed to be more supportive and understanding of each other.

"[The lesson about male engagement in ECD] is the most impactful lesson because it motivates men to involve [themselves] more in household chores and child-raising. In the past, men heavily rely on their wives or grandmothers to take care of young children. However, the lesson shows that both mother and father must [be] involved in taking care of young children. Now, more men are not ashamed to do housework or to help their wives." POE Stakeholder, Early Childhood Education office.

In focus groups, fathers who had participated in RAISE reported that their communication with their wives had improved, that they had reduced their levels of alcohol consumption, and that their perceptions of gender roles had shifted. They reported that husbands and wives were now more supportive of each other, that their families were happier, and that they were now closer to their children.

> *"For me, I used to be quite abusive and short-tempered. For example, when my wife went to the market and take a long time, I would get mad, and have [an] argument with her. When she was sick, I did not care. Now, whenever I am about to lose my temper, I remember the lesson and tell myself that argument is useless. I also take care of my family better, taking my wife or children to hospital when they are unwell."* Member of fathers' group, Khel Chey village, Ou Svay Commune

Fathers provided a range of clear examples of how they were now applying what they learned through their participation in the RAISE project. These included activities such as taking children for walks while their wives cooked dinner, washing baby clothes, buying fruit for their children, playing word guessing games with their babies, teaching children about body parts, heating water for their children's baths, and using the training materials/books provided by the project to read with their children.

> *"My baby likes it when I make animal sounds and play with them. Sometimes, I use the training materials (books and posters) and read them to my baby. The books have pictures and are colourful, so my baby loves them."* Member of a fathers' group, Ampil Commune

Handwashing, Prek Youn Village, Kien Chrey Commune

CASE STORY 1

Promoting male leadership and engagement: Making a difference at the individual, household, and community level

Mr. Heang Limsrun, 38, resides in Trapangp'ros village, Krala Commune, Kompong Siem district, Kampong Cham Province. He is married with three children, ages 17, 8 and 17 months. Mr. Limsrun and his wife own a small grocery store. After being involved in the RAISE project, Mr. Limsrun's enthusiasm and effectiveness as a leader of a fathers' group has contributed to his recent appointment to join the local authority as an official member of the village.

Mr. Limsrun washing clothes for his family

Mr. Limsrun first heard of the RAISE project when his wife was recruited to join one of the project's "mothers' groups" in 2020. During that time, he was not really interested in the work of the project. However, after seeing the books and materials that his wife received through the training, he became curious and began asking his wife questions about the purpose of the training, which then sparked his interest.

Mr. Limsrun was invited to join the training, along with his wife. Later, when the village chief organized a "fathers' group" in his community, Mr. Limsrun joined this group too. After attending the training for a while, the village chief and the trainer noticed his intelligence and ability. They asked him to become a team leader of a fathers' group in July 2021. Mr. Limsrun had already developed his own understanding of the significance of the project and its impact, and so when he was asked to become a team leader, he agreed without hesitation. The team leader's role is to provide training and sharing to other fathers in the group. He was trained by the trainer and village chief on the seven modules for the fathers' group. Because of his diligence, his ability improved significantly in a short period of time. As a result, he was able to independently provide training to other fathers in the village on behalf of the village chief. Since then, he has been providing training to the target group regularly.

"The SCI trainer and village chief provided the training to me for approximately a month when I was recruited to become a team leader," Mr. Limsrun shared. "Since then, I have continued to provide training to other fathers in my village. Each week, we have at least two sessions with the fathers' group. If the other male volunteer is busy, I go to provide training alone or with a village chief."

After he and his wife joined the training, there have been significant improvements in his family. His family is happier. Both husband and wife have noticed positive changes in each other, and their behaviour within the family. Family members have become closer, and more cooperative, understanding, and loving. Mr. Limsrun's children are communicating better and spend more time with their father. The children now rely more than before on their father to teach them, and they feel delighted. Community members in the village have also noticed this shift and have expressed their admiration and respect for him. They see him being more involved with his family and sharing his experiences with other villagers. Community members have noticed that when men are helpful and supportive in the family, their economic situation, as well as family well-being, improves because there is less conflict in the family. Mr. Limsrun shared his thoughts about the importance of male engagement in the family, noting that:

"All lessons are important, but I found the lesson related to male engagement in house chores the most fascinating and relatable. I think it is the most crucial for each family. Before I joined the project, I did not understand much about my role and how I can help my wife with house chores. I rarely spent time doing tasks. I would get irritated when my wife prepared food late. I used to enjoy drinking as well and had conflict often in the family. After joining the training, I start changing my behaviour. I realized that both I and my wife are busy making a living. Therefore, I should help her to take care of my kids, cook, wash clothes, and teach my kids. Now, I know how to communicate with my family, and learn how to teach my sons at night time. […] The lesson emphasizes that male support in household chores is crucial for family growth and happiness. I have witnessed the improvement in my family after I started following the lessons."

The impact of the project does not stop at the individual or even the family level. Within three months after receiving training, Mr. Limsrun has successfully trained 24 men in his village with some support from another male volunteer and/or a village chief. His involvement in the project was not smooth sailing. When he first provided training to other males in the village, they did not pay much attention to him. They were not welcoming and showed their hesitation and discontentment to join the training. Faced with many challenges, Mr. Limsrun got discouraged and almost gave up his role. However, the trainer from SC and the village chief continued to motivate and support him. With the support, consistent effort, and commitment, Mr. Limsrun started to positively influence other men. The participants also came to observe his actual practice at home and saw that Mr. Limsrun actually "walked-the-talk." Seeing the impact, other males slowly adjusted their mindset and accepted that the lessons provided are effective and practical. Now, they have more trust in the RAISE project. They practice what they have learnt from the training.

Mr. Limsrun providing training to other male groups in the village

"Every task always comes with challenges. However, we have to keep going and find different ways to solve it. With strong commitment and effort, we can make more impact," commented an SC staff member involved in implementing RAISE.

The village chief and trainer from SC have developed trust in Mr. Limsrun's ability and commitment. This ability and commitment have contributed to Mr. Limsrun's recent appointment as an official member of the village as part of the local authority. The commune council will provide a monthly incentive for Mr. Limsrun for his role as an official member of the village. Mr. Limsrun has also expressed an interest in becoming a member of the commune council when he gains more experience. With support from the local authority, he wants to continue sharing his knowledge with others.

"I have seen that roughly 70% of the participants are changing, especially doing household chores. Some men who have attended the training regularly show a 360-degree change. […] Most participants are interested in the lesson on male engagement in household chores," said Mr. Limsrun.

Grandmothers. Stakeholders spoke less about the impacts of the project specifically for grandmothers than they did of its impact for mothers and fathers. Nonetheless, some grandmothers who received training through RAISE expressed that they were will willing to change their own behaviours around child-

care for the 0-3 year age group, after learning new approaches from the project. For example, they spoke about providing afternoon snacks and healthy foods, and being more engaged in playing and talking to small children. One grandmother expressed, "Doing these things helps children be smarter and healthier." In fieldwork, some grandmothers reported feeling guilty about not previously having this knowledge and not having raised their children in this way. Some VHSGs suggested that they found that grandmothers who participated in RAISE were more knowledgeable and cared more about children's hygiene, and that they had learned different approaches to communicating with small children and calming them down when needed, without threatening, scaring, or using violence. During fieldwork, an evaluation team member observed a discussion between several grandmothers about why they also needed to adapt their caregiving behaviour, based on new knowledge from the project. While it was difficult for some to verbally recall lessons from the training, they were nonetheless able to demonstrate the learnings, when prompted with hypothetical situations.

Children. Stakeholders from DOE, POE, the SC project team, local authorities, health centres, as well as principals, teachers, and caregivers (including mothers and fathers) all reported a perceived improvement in the health and well-being of children. Stakeholders also pointed to improved hygiene practices among children. Mothers shared that their children were sick less often while health centre staff also noticed a decrease in the numbers of children presenting with flu, colds, and diarrhoea. It is important to note that such improvements in hygiene and health may also be attributable in part to behavioural changes connected to the COVID-19 pandemic, such as improved and more frequent handwashing practices, as well as to decreased levels of contact with others during the pandemic, particularly during school closures. However, during RAISE, as part of the project's COVID-19 related adaptations, the SC team provided significant support for local COVID-19 responses, including the provision of handwashing stations (which local authorities expanded with their own funding), and during fieldwork, the evaluation team found evidence of even very young children utilising these stations for handwashing.

4-year-old using a handwashing station

Illustration of handwashing, evaluation fieldwork, Dec 2022

Another commonly cited impact was the observation from stakeholders that young children now had better access to nutritious foods, given their parents' improved understanding of their children's nutritional needs. Others, including health centre and VHSG stakeholders, believed that children were benefiting from spending more time with their parents and having more educational toys to play with at home, helping them become "braver" and "smart." Further reports noted the impact on children's well-being within the home, especially in homes that were previously characterised by alcohol abuse and violence (verbal and physical).

Screenshot of the project video "Behaviour Change of Mothers in Childcare."

Trainers. The qualitative research also suggests that the RAISE project was impactful for the trainers themselves, in terms of their knowledge and practices regarding ECD for children 0-3 years of age. Stakeholders (e.g., VHSGs, PWCCC, CCWCs and others) noted that some of the lessons were new to the trainers, who were then able to practice new skills and approaches with their own children as well. One stakeholder commented that trainers were now more knowledgeable, sharing information with other villagers and applying what they have learned within their own families.

> *"I admit that although I have worked as a teacher, my knowledge of parenting skills is still limited. It doesn't mean I can do better than others, but I am committed to learning new practices. This project can change the habit and mindset of parents in the new generation."*
> PWCCC stakeholder, Kampong Cham

RAISE project staff also noted that some trainers are applying what they learn with their own families and that they share these practices or information with others who are not in the project. One staff member said, "They see the importance of promoting early childhood education and show a willingness to expand this project and a willingness to support the project in the future."

Commune Council. Another important qualitative impact of RAISE has been the successful mobilization of the engagement and support of Commune Councils in ECCD for the 0-3 age group. One RAISE staff member shared, "I see the ownership of the CCWC and the CC. It is very demanding to continue this project and they expressed themselves that they wanted to engage in the design and implementation as a co-lead, which is a very positive sign." Staff also highlighted the importance of the integration of some ECCD activities into CIP budgets, and the mobilization of approximately USD 10,000 within the target communities (including the funding of some of the handwashing stations within communities). This is discussed further under Sustainability, below.

SC staff and CC members themselves shared how CC members are also using and applying the training within their own families.

"For me, I used to be short-tempered and hit my children too. When my children have their own child, they repeat what I did to them. They used to curse and use violence on my grandchildren. However, after I [became] involved in this project, I started providing guidance to my children on the lessons. Now, I notice we do not use violence anymore. My grandchildren enjoy spending time with me and [are] not scared of me as before." Commune Chief, Kampong Siem district

Representatives from POE also commented on the improved relationships between participants and local authorities, which they believed had resulted from the project. Stakeholders cited an increased level of trust and communication between participants and stakeholders such as VHSGs and village Chiefs, leading to a greater openness to sharing concerns and a willingness to ask for assistance.

COVID-19 Adaptations. As noted under Effectiveness above, one of the project's COVID-19 related adaptations was the provision of sewing machines and training to 14 selected women within the target communities who had lost their jobs during the pandemic. While not all these women could be included within the evaluation fieldwork, there is some evidence of impact over the course of the project, with women reporting being able to earn money, pay off debts, and even begin to save money from their sewing. This included not just sewing to fill mask orders, but also through the provision of sewing services locally. RAISE project staff also shared that the contributions from the women's sewing income have contributed to improved social and economic well-being at the family level. However, there is limited impact tracking within the project documents, likely in part due to the adaptive nature of this project component, which was not envisioned during project planning. Case Story 2, below, provides an in-depth discussion of one woman's experience, following her selection to participate in the sewing intervention.

Below are some of the key learnings from the mothers and fathers' groups that were collected during the fieldwork.

Key "Takeaway" Learnings: Mothers' Groups

- Caregivers should spend more time interacting and playing with children.
- Teach children from a very young age.
- Caregivers should not shout or hit children because they are small and innocent.
- Caregivers should provide healthy snacks to children and not junk food.
- There should be no violence against children.
- Men should engage in child-raising and help around the house.
- Caregivers should be careful with children's safety (electricity, water, falling, etc.).

Key "Takeaway" Learnings: Fathers' Groups

- Men should help around the house because housework is tiring for women.
- When men are involved in child-raising, the children will be healthier and happier.
- Men should take their wives to the health centre during pregnancy and talk to the fetus.
- Men should play with young children and teach them about their surrounding environment, such as animals, trees, vehicles, etc.
- Children should eat only healthy snacks such as fruit or Khmer traditional rice cakes.
- Parents should not shout at children or use violence against children.
- Parents should be patient with children because they are innocent.
- Parents should be a role model for children.

CASE STORY 2

Project COVID-19 Adaptation: Linking Livelihoods, Education and Family Well-Being

Mrs. Theung Sarom, aged 29, is a mother of three children, with a fourth child currently on the way. The first three children are ages 8, 6 and 2. Her husband, Mr. Mon Rithy, works as a construction worker and a farmer. The family lives in Bangborbos Village, Kean Chrey Commune, Kampong Siem district, Kampong Cham Province. Following their marriage, Mrs. Sarom helped her husband with farming and mostly stayed at home to take care of their children. After delivering their second child, Mrs. Sarom's health became unstable. She fainted often in crowded or closed spaces. As a result, she could not go to work, and her husband was the sole breadwinner.

Mrs. Sarom is teaching her little boy to say "thank you"

In 2020, when their third child was about 5 months, Mrs. Sarom joined the RAISE Project with Save the Children as part of a 'mother group.' The village chief asked her to join the training with other mothers with a child aged 0-3 years. In March 2021, the COVID-19 pandemic spread to her village, and there was a lockdown in the area. To support the mothers who were struggling financially during the lockdown, SC specifically selected 14 mothers who had joined the project since 2020. Save the Children provided them with a sewing machine together with a two-day training on how to use the machine. Mrs. Sarom was chosen by the village chief and SC team.

"I was over the moon," explained Mrs. Sarom. "I did not expect to be chosen because there were many mothers. At first, I was hesitant and anxious. I had never learnt how to use the sewing machine before. With encouragement and support from the village chief, SC staff and my husband, I could learn how to use the machine. My husband attended the two-day training with me because he was worried, I might faint during the training. After the training, my husband continued to teach me at home. An SC project officer visited me many times and taught me more."

A few months after the training, SC was able to connect her with a large order for face masks. Using the new machine, Mrs. Sarom was able to complete roughly 2,000 pieces within the deadline, earning almost 1,000 USD. She used the income to pay off her family debt and buy some farming materials. She also used the money to buy learning materials for her children.

"In the past, my husband used to get irritated easily because I only stayed home," recalled Mrs. Sarom. "He rarely helped me with house chores. I was blamed that I did not help to earn income for the family. Since I started using the sewing machine to make a living, my family condition has improved. I can help my husband to earn additional income. Our relationship has also improved. After I joined the 'mother group,' my husband also joined the 'father group.' Now, he understands his role better. He would take me to the hospital for a health check and help around the house too. His way of speaking to children is softer and more loving. I feel appreciated and confident."

Mrs. Sarom also believes that after joining the training with SC, her own health has improved, as she has learned about healthy eating and nutrition. Such changes have also been observed by the SC team implementing RAISE. One SC project officer shared that:

"Compared to the first time Mrs. Sarom joined our project, she is now healthier and more competent. When she joined the two-day training, she could not even hold a ruler properly. […] When we accepted the order of face masks, Mrs. Sarom worked very hard, and she kept improving her skills. We are delighted to see her family condition improve."

Today, Mrs. Sarom continues to earn income by mending clothes, making hairbands, and through other minor tailoring and sewing transactions. She also plans to learn more skills following the birth of her baby.

Mrs. Sarom is mending clothes at home

"Nowadays, I am pregnant, so my husband asks me to stay at home for a while," said Mrs. Sarom. "I can stay home with my children and earn some money by mending clothes. The income is not much, but it is sufficient to pay for daily expenses such as utility bills and for buying snacks and food for my children. I can keep the income from my husband for saving."

UNANTICIPATED IMPACTS

This evaluation found some unintended impacts related to reports of a (1) reduction of domestic violence, and (2) capacity building.

Reduction in Domestic Violence. While the issue of domestic violence was not a focus in the project design, the team (during project implementation and monitoring) and various respondents (during the evaluation) reported anecdotal examples of reduced domestic violence against women and children as a result of the project. Because the focus was on engaging men and the project was implemented in communities where domestic violence is prevalent, the curriculum did include input on domestic violence. As one staff respondent notes, "This was an interesting yet risky approach – we wanted to learn from this." In so doing, the SC team also wanted to acknowledge and begin responding to the issue of domestic violence. Some of the examples are provided below.

- There were reports of less violence in the Ou Svay Kien Chrey, and Ampil Communes because of male and female participation in the project training (FGD, POE, Dec 2021).
- There were reports of less violence, more helpful men, and happier families with particular reference to the usefulness of the training on male engagement in ECCD and its resulting changes in knowledge, attitudes, and behaviours (FGD, DOE, Dec 2021).
- The VHSGs stated that there were fewer violence cases reported to the commune hall (FGDs, VHSGs, Dec 2021). For example, a local authority in Ampil Commune said, "Since Save the Children implemented this project, we have observed that domestic violence cases reported to the commune hall have decreased. More men are supportive and help with household chores." The VHSGs also stated that there had been less filing of divorce and alcohol consumption. As mentioned above, the

causality is less clear because these reported changes could also be linked to COVID-19 and the restrictions in social gatherings, etc.

- The SC project staff also reported that there had been less cases of domestic violence (KIIs and FGSs, SC Staff, Dec 2021 & Jan 2022). The project staff reported that they had observed changes in both men and women's behaviour related to violence against children. For example, a staff member reported, "Most caregivers used to use bad words with their children and hit their children when they are stubborn. Now, they use a softer approach."

Capacity Building. There were reports of increased capacity from stakeholders, for example, the PWCCC, POE, and DOE.

- *PWCCC.* The PWCCC reported strengthened capacity in report writing, guideline development, and M&E. They also stated that the 12 lessons on ECD were useful. Furthermore, they requested additional capacity development in the areas of video production, counselling, and negotiation skills.
- *POE.* POE described the usefulness of the ECD training and the resulting strengthening of their technical capacity in this area. They requested more support and input related to photography skills, video editing, and case study write-ups.
- *DOE.* DOE highlighted their new skills in the areas of training facilitation, developing guideline documents, photography, and child protection (e.g., taken during photographs and conducting interviews).

Father and daughter, RAISE project, Dec 2021

SUSTAINABILITY

Narrative Proposal. In the Narrative Proposal, it is stated that the RAISE project will "support advocacy and share learning with leaders at all levels to foster stimulating, nurturing and enabling environments for change." [33] Furthermore, the project aimed to build on the research findings that indicated changes in behaviour are more likely to be achieved if supported by the relevant group or community authority and by people respected by audience members. [34] This research highlighted emerging examples of behaviour change, including, more effective verbal and non-verbal communication, improved reading and storytelling, and practising positive parenting techniques with children.

Interview with the local authority, Dec 2021

The Narrative Proposal outlined specific sustainability strategies at the local and national levels. At the local level, these strategies involved, for example, identifying female and male champions for holistic and nurturing care at the local level. The project sought to empower communities, including male and grandparent caregivers, by increasing the awareness of high-quality service delivery targeting the 0-3 age group. The project aimed to build on its budget advocacy and social accountability work to engage local authorities at the commune level to identify and finance gaps in service delivery for the 0-3 age group. This work also focused on engaging female community actors to provide advice to local authorities regarding increased integrated ECD budgets at the commune level. Finally, the project aimed to train formal and informal community actors on integrated ECD and how to effectively communicate this using IEC materials (including posters) based on the communication strategy. These community actors would deliver activities to disseminate their learnings with their communities and lobby commune councils to invest in integrated ECD.

At the national level, these strategies involved, for example, the documentation and dissemination of project learnings at the national level to catalyse communities and their leaders to identify priorities, develop plans of action, and mobilize resources to carry out their plans. The proposal aimed to support and stimulate national level decision makers to operationalize integrated and multi-sectoral activities. The project also sought to support the National Committee on ECCD (NC-ECCD) to actively coordinate across ministries to address issues affecting children aged 0-3 and achieve the goals laid out in the National Action Plan on ECCD 2019-2023. The project aimed to conduct a national-level roundtable with key ministries and CSO stakeholders to discuss relevant social behaviour change findings and disseminate learning briefs on SBC strategies for integrated ECD. Finally, the project aimed to work with civil society networks and the Budget Working Group (a CSO networking platform led by NGO forums) to build shared understanding, consensus, and momentum behind the delivery of holistic nurturing care for the youngest children.

This evaluation found these sustainability goals to be clear and realistic in terms of the project objectives and scope (discussed below).

Project Scope and Limitations to Sustainability. In assessing sustainability, it is important to note that this

[33] SC (2019), RAISE, Narrative proposal
[34] SC & iDE (2019), ECCD Formative Research and Early Ideas

is a pilot project that is more about testing the model and platform as well as the SBBC materials. That is, the project aimed more at seeing what worked and building the associated evidence base rather than establishing sustainability. Moreover, extensive evidence of sustainability is not expected after just over two years of project implementation.

Emerging Evidence. Despite the scope and limitations to sustainability, this evaluation found emerging evidence of sustainability that can be considered for the upcoming GRAND project. This evidence is outlined below to highlight both the project's achievements regarding sustainability and relevant issues to take forward in the next related project.

Local Level. At this level, there are clear indications of increased buy-in, commitment, and ownership. During the fieldwork, local various local stakeholders (e.g., school staff, parents/caregivers, village members, and leadership) expressed their excitement about and commitment to the project. As outlined above under Relevance, Effectiveness, and Impact, community, and government stakeholders described how this project had resulted in increased ECD knowledge and application in communities. Staff commented on the fact that much time and work went into getting local commitment but that "it was worth it."

> *"Working through the system is challenging in terms of speed or how much we can push but relationships at the local level are good, and we have created interest and passion around the 0-3 age group."* SC Staff

Importantly, there were strong examples of Commune Council engagement, most notably, in their commitment to providing a budget for ECD. There is evidence of the empowerment and improved capacity of the Commune Councils to plan, implement, and run their own caregiver activities. They have also funded many of the handwashing stations and supported the caregiver activities. Commune Councils have integrated a plan into their CIP and managed to mobilize approximately USD 10,000 within the target communes. This empowerment of local community leaders and the Commune Councils is a significant change that needs to be further documented and shared at the national level. A respondent noted, "The national authorities are currently looking for any experienced communes who had successfully managed ECCD activities. From this project, we now have good evidence that communes are the functional body in the community for providing ECCD services."

While it is too early to comment on the success of securing local budgets as the Commune Councils have just only submitted their plans, this is an important first step in strengthening sustainability. A staff member noted, "Some Commune Councils have already shared their budget, which is a good sign, but we are not sure yet about next year. We need to look at this issue in a more systematic way."

Overall, respondents highlighted the increased ownership at the CWCC and Commune Council and that "they have expressed the need to be more involved in the design and implementations and being co-leads." Respondents also noted the increased number of local ECD focal persons from between 1-2 to 7-12 persons based on the project data tracking as well as the monthly work plans that are already in place at the commune level for ECD, led by the Commune Councils.

Finally, one of the important project learnings (as noted above under Effectiveness and Impact) is that of clearly understanding the important role of the Commune Council as the main body in charge of the planning, implementation, and management of the day-to-day ECD activities, supported by the school/education system (technical support) and health centres (care, nutrition, and health support). A respondent summarised, "It is now clear to us that the government would need to use the Commune Council to be the core stakeholder in charge of the management of operations of ECD while the other two sectors provide technical support. They would all work together collaboratively."

Knowledge Sharing. As highlighted under Effectiveness and Impact, there is solid evidence that this project resulted in significant knowledge sharing which has contributed to project sustainability. Crucially, knowledge sharing has gone beyond the target communities. For example, school directors and teachers stated that they are sharing ECD videos online with other relatives and caregivers, as well as sharing their experiences with other trainers.

> *"I have relatives who have small children, but they live far away from me. I shared the SC videos with them. My relatives found the videos very useful, and they asked if there are more videos on ECD."* Teacher, Kien Chrey Commune

DOE respondents also emphasized knowledge sharing in non-target areas. For example, the WCCC at the district level shared the project good practices with the DOE and other participants during the monthly meetings. There were also various examples of the project lessons being shared with relatives and friends in other provinces.

> *"There was a case when a mother joined the training with our project. After that, she started sharing the lessons (sharing videos via Messenger) with her relatives who also have young children. These relatives live in other provinces."* DOE respondent, Kampong Siem

As part of PWCCC's work, the project lessons learned and good practices were shared with non-target areas during field visits. However, respondents did note that this non-target sharing has not been as detailed and in-depth as the target communities. Respondents also stressed that the non-target communities do not have the capacity and resources to respond in the same way as the target communities.

During the fieldwork, it was stated that men were less likely to share information with others in comparison to, for example, mothers and grandmothers. It was noted that male team leaders seemed to play a more significant role in knowledge sharing. This is an observation that requires further investigation and consideration for the next GRAND project.

Capacity Building. While not the focus of this project, this evaluation found that the project also contributed to building the ECD capacity of stakeholders at the local, DOE, and POE levels (as highlighted above under Unintended Impact).

Project participants, RAISE

Replication. Strengthened sustainability is also evident in the examples of project replication in non-target areas. For example, each month, PWCCC hosted a meeting with the line departments to share information regarding RAISE activities. Thus, the CCWCs from each commune were exposed to and able to learn from the project implementation in the target communes.

Cost Allocation. The fact that the team has identified the importance of assessing the project's cost allocation is an important innovation, which has important implications for understanding project effectiveness, efficiency, impact, and sustainability (particularly scalability discussed below). Cost allocation has not been assessed in previous ECD or other education projects. The results, as discussed above, can now be used to inform conversations with the government and other stakeholders regarding the feasibility of similar ECD interventions, and could feed into a more robust cost-benefit analysis, if needed.

Scalability. It was difficult to gather much information on project scalability and the pathways for scale. Respondents expressed strong views about the need for increased project scalability. A government respondent stated, "We ask Save the Children to scale the project to the whole province because ECD is significant. We want to see all the children grow up well. They are the future resources of our country. The project has changed the mindset of people […]." Government and staff respondents highlighted the challenges of covering more areas in low density regions. This challenge is particularly relevant in Cambodia where increased coverage means significantly longer implementation hours and resources. That is, it is difficult to scale the project with limited resources, especially in low density population regions and ensure that extended districts needs are covered in the planning, implementation, and monitoring of the forthcoming GRAND project. In terms of project scalability, the emerging evidence is that the pilot project can (1) be integrated into existing services or platforms, (2) be implemented with public funds, and (3) be evaluated.

Participating Family, RAISE

National Level. While it was not the goal of this project to directly strengthen government sustainability, the project did increase ECD focus and engagement with the government. There is clearly much more to do in this area. Staff, DOE and POE respondents noted that there are still significant gaps for children in the 0-3 year age group and that despite these urgent needs, ECD is not a priority at the national level. Moving forward, there are interesting opportunities for SC in terms of ongoing ECD advocacy and reviewing the team strategy to bolster evidence.

Next steps. SC, with the support of SCHC, will be implementing the forthcoming GRAND project. While it is a separate project from RAISE, GRAND will be taking forward and adapting the learning from RAISE.

CONCLUSIONS

SUMMARY

Save the Children Cambodia, with Save the Children Hong Kong's support, implemented the Raising Awareness and Innovative Strategies for ECD (RAISE) project over 27 months (1 January 2020 to 31 March 2022. The project's overall objective is to create an enabling, stimulating, and nurturing environment that gives children a better start to life. The three outcomes are (1) caregivers, including fathers and grandparents, showed improved awareness of integrated ECD for the 0-3 age group, (2) formal and informal community actors, especially female actors, have improved their capacity to provide leadership and advice on integrated ECD, and (3) evidence of appropriate communications channels is generated and used to inform the social and behaviour change communication (SBCC) interventions. The project was implemented in 43 villages in the Kampong Siem district of Kampong Cham province.

This evaluation found that the pilot project utilised innovative strategies to increase awareness and positive behaviours around holistic and integrated ECD in the target groups. The project was relevant, effective, and efficient. Notably, this project produced a cost allocation analysis that showed an overall cost per caregiver per year of USD 210 (inclusive of provincial project management expenses, country office expenses and other costs). Importantly, the cost associated with caregiver capacity development only (using a model of 12 caregiver sessions supported by necessary home visits and community awareness raising activities) is USD 44 per caregiver. This information and the individual contributions to this cost can now be communicated to the government for replication and scale-up considerations. It can also be used as comparative data for future ECD-related and other project planning, implementation, monitoring and evaluation.

In terms of project impact, the evaluation showed strong results across all three outcomes. For Outcome 1, the evaluation showed that overall, the project produced, tested, and disseminated appropriate and effective SBCC materials (less so for grandmothers, people with low literacy, and people with certain disabilities) and increased community exposure to relevant SBCC messaging. Specifically, the project increased caregivers' awareness (understanding) of good health and nutrition by 70.2%, early learning and responsive care by 73.5%, and safety and security by 72.0%. The project's impact (after controlling for extraneous variables) on caregivers showed a significant increase in ECD-related knowledge (71.4%), attitudes (66.4%), and practices (60%).

For Outcome 2, the evaluation showed that the project successfully trained formal community actors on integrated ECD and created informal delivery platforms (new and underutilised community delivery platforms, for example, pagodas, shops, and salons) to improve the enabling environment for holistic care for young children. Specifically, the project resulted in an increase of 47.8% of community actors who provided advice to caregivers for at least three of the indicators. The community actors' awareness and understanding increased by 44.1%. Overall, the project's impact (after controlling for extraneous variables) on community actors showed a significant increase in knowledge (41.2%), attitudes (47.8%), and practices (48.1%).

Generally, most respondents (trainers and trainees) noted a preference for small or medium group trainings, as opposed to large group trainings. Echoing mid-term evaluation results, teachers, health centre staff and VHSGs were cited by participants as generally the most effective trainers, as they were seen as credible with strong technical skills for delivering and facilitating lessons. Training undertaken in pairs, by a local authority with a teacher, health centre staff or VHSG was perceived to be effective for training,- and building the capacity of local authorities for future training. Trainers, participants, and other stakeholders particularly highlighted the importance and usefulness of the training on male engagement in ECD and training on caregivers' well-being.

For Outcome 3, there is strong evidence that appropriate communications channels have been developed and used to inform the SBCC interventions. The project monitoring reports show that the project learnings have been well documented and disseminated. Given that the project ends on 30 March, there were still some remaining dissemination activities (e.g., dissemination workshop to the national government) to be completed at the time of this evaluation.

For male engagement in ECD, the findings showed that the project increased male engagement in ECD by 17.6%.[35] Furthermore, overall violence (physical and emotional), as measured by the survey, was 0.2% for the target group and 1.8% for the non-target group, although there was no baseline data for comparison. The qualitative data provided substantial anecdotal support of the project having led to reduced rates of alcohol consumption amongst men, and reduced rates of overall violence in terms of violence against children, women, and between parents/caregivers. There may be other contributing factors to these findings, outside of the RAISE project.

The project also compared the role and effectiveness of caregivers, including grandmothers, in relation to project-related outcomes. The study showed that grandmothers had lower awareness in comparison to mothers, fathers, and other caregivers in all three areas of (1) good health and nutrition (score of 58.1 versus 68.6, 65.7, and 66.7 respectively), (2) early learning and responsive care (69.6 versus 75.4, 75.7, and 71.7), and (3) safety and security (59.6 versus 67.8, 62.9, and 63.3). The evaluation found that mothers in the target areas were less likely to leave their 0-2 year old children with other people, including grandmothers, because the mothers were more likely to care for them.[36] This raises questions about the relevance of targeting grandmothers only in ECD interventions in this such settings. This may be different for other districts or provinces, particularly in areas of high mobility, such as labour migration, but this would require further exploration and analysis.

For the child development outcomes, as measured by the Caregiver Reported Early Development Instruments (CREDI) tool, the study found that the project significantly increased ($p<0.01$) the socio-emotional, cognitive, language, motor, and overall CREDI scores by 0.6, 0.7, 0.5, 0.7, and 1.7, respectively. The results showed that caregiver's knowledge, attitudes, and practices are positively associated with all four domains of child development outcomes.

In terms of sustainability, it is important to note that this is a pilot project that looked more at what worked in terms of the ECD model and platform to build the associated evidence base rather than establishing sustainability. Moreover, extensive evidence of sustainability is not expected after just over two years of project implementation. Despite the scope and limitations to sustainability, this evaluation found emerging evidence of sustainability at the local level, as there is clear evidence of increased buy-in, commitment, and ownership at the local level. There are strong examples of Commune Council engagement, most notably, in their commitment to providing a budget for ECD. The project also contributed to building the ECD capacity of stakeholders at the local as well as DOE and POE levels. There is solid evidence that this project resulted in significant knowledge sharing which has contributed to project sustainability. Crucially, knowledge sharing has gone beyond the target communities to non-target communities. In terms of scalability, it was reported that it is difficult to scale the project with limited resources, especially in low density population regions. Overall, there are important and interesting opportunities to plan for, monitor, and assess sustainability in the forthcoming GRAND project.

RAISE is a relevant, innovative, and impactful project that will be useful in informing SC's ECD work as well as contributing to strengthening the national response to ECD. Save the Children is well-placed to

[35] For example, talk and read books to fetus; reading letters to the child and teach the child by using photos, drawing and playing games; bring wife to have prenatal care; use happy faces and actions to play with the child; tell the child about animals, plants, things to the child; help wife with washing clothes; and help wife with cooking.

[36] Mothers reported that they were more likely to leave their children 2 years old and older with grandmothers and other caregivers.

further develop the project's innovative strategies, disseminate learnings, and support the government and partner's work in this area.

LESSONS LEARNED

1. The innovative project approach was successful in strengthening integrated ECD. The pilot project's innovative strategies did result in increased awareness and positive behaviours around holistic and integrated ECD. These strategies involved engaging formal and informal community actors as key agents of behaviour change in integrated ECD.

2. RAISE improved ECD knowledge, attitudes, and behaviours for caregivers. Knowledge, attitudes, and practices of caregivers on ECD were significantly improved during the interventions despite the COVID-19 pandemic.

3. RAISE holds unique organisational lessons. RAISE was the first SC Cambodia project implemented fully under COVID-19 and thus there are important lessons about planning, implementing, and monitoring under COVID-19 restrictions. While it was outside of the scope of this evaluation to do a comparative analysis with other SC projects, this project could be used as a baseline to highlight strengths and challenges when compared to other similar projects.

4. Targeted interventions for male stakeholders resulted in positive behaviour change. This project contributed to the reported changes in male knowledge, attitudes, and behaviour, for example, the reported increase in child-related engagement activities and household chores, and anecdotal reports of the reduction in gambling, alcohol abuse, and violence. The flexibility of the project in providing training for men outside of working hours was a key element of the success in reaching men. While challenging, staff also highlighted the strategic importance of engaging hard-to-reach men, including those men who were known to be heavy drinkers or to be abusive.

5. The participation of fathers in the caregiver sessions contributed to changes in behaviour at the household level for some participants, including increased engagement with children and enhanced contributions to household chores. Anecdotally, participation in the sessions may also have contributed to reduced levels of verbal and physical violence within households, although this was not an intended outcome of the project.

6. Commune Councils play a vital role in integrated, multisectoral ECD implementation. One of the questions in the original project design related to gaining a better understanding of which platforms at the community level supported the implementation of integrated, multisectoral ECD. During the project monitoring, and confirmed by this evaluation, it became clear that the Commune Council is the key institution at the local level to facilitate integrated ECD planning, implementation, and management, with the technical support and collaboration of the school/education system and health centres.

7. The complex coordination of ECD needs to be streamlined. Following from the above lesson, currently, ECD activities are part of a complex multisectoral approach at national and sub-national levels, with each sector having its own goals and specific indicators. This approach creates significant coordination challenges. This project demonstrated the practicality of identifying which components best support community-level implementation of an integrated ECD approach. This project showed that it is important to consider the local context and structures, and to adapt existing resources to existing capacity in the local communities to improve ECD outcomes for 0-3 year olds.

8. The relatively low project impact of grandmothers. This evaluation found that the change in knowledge, attitudes, and behaviours of grandmothers was relatively low in comparison to that

of mothers and fathers. Moreover, grandmothers did not have any significant effects on the child development outcomes. Importantly, this study found that in the local context, mothers seldom left their 0-2 year old children with other people, including grandmothers. This finding raises important design questions, challenges, and possible adaptations in the upcoming GRAND project where it is planned to directly engage grandmothers in ECD activities.

9. Cost allocation analysis shows the cost per caregiver per year and allows for further discussion with national authorities regarding possible replication and scale-up. The cost per caregiver per year was calculated at USD 210. The largest components of this are USD 89 (42%) for the management costs at the provincial level and USD 44 (21%) for caregiver ECD capacity development. These findings could be used for advocating, planning, implementing, and monitoring future ECD initiatives.

10. The flexibility and adaptability of the project teams, management, and SCHK as the funding partner was central to enabling the project to continue during the COVID-19 pandemic and to meet or exceed its targets. Without this flexibility and adaptability (for example, in the shift to one-on-one training, the recruitment and training of more formal actors as trainers in the second year of the project, and the shifts to online platforms where possible), it is likely that the project would have failed to meet all its targets and that its impact would have been substantially reduced.

11. ICT capacity, skills and access among stakeholders were key contributors to the project's ability to adapt during COVID-19 at both sub-national government and community levels. Without the ability to coordinate online and to reach stakeholders through online platforms, the project's capacity to adapt as well as it did to the circumstances of COVID-19 would have been compromised. However, reaching stakeholders and beneficiaries without ICT access and skills (low digital literacy) require different, multi-layered approaches to ensure they are not left behind. The project team noted the lack of ICT skills was particularly challenging for elderly participants, and that time, patience and age-appropriate approaches were important when engaging older participants.

Screenshot of the project video "Behaviour Change of Mothers in Childcare."

RECOMMENDATIONS

Training

1. Extend community coverage. Where resources allow, consider extending coverage within communities; e.g., expanding training to include other interested community members outside the targeted groups of caregivers of children in the 0-3 year age range. For example, it may be useful to include newly married couples or those who are expecting children, aunts and uncles, older siblings, or mothers of slightly older children, who may have more children in future. While this was a frequent recommendation from a range of stakeholders in fieldwork, the efficacy and impact of such extended coverage would require investigation and analysis.

2. Expand sharing of training videos. Consider solutions for the sharing/screening of training videos in groups, where trainers only have a small screen phone (e.g., tablets that could be shared by various trainers or there could be projectors and a cloth to create a small cinema).

3. Expand online outreach. Consider expanding outreach through online platforms and social media popularly used with beneficiaries (beneficiaries suggested they particularly enjoyed videos and comedies). However, there is also a need to cater project activities for different levels of digital literacy and access.

4. Strengthen caregiver session approaches and delivery. Consider slower-paced training and enhancing targeted pedagogical approaches and delivery in caregiver sessions for older learners, including grandmothers (where relevant), and for caregivers who may have low levels of literacy.

5. Further engage male caregivers. Continue engaging male caregivers in ECD activities following the success of this project in this area. Future similar interventions could engage male caregivers during evening hours to enhance their attendance and participation.

6. Strengthen refresher training. Consider periodic follow-up with trainers to assess knowledge and training capacity and to assess the need for refresher trainings. Particular attention and support may be needed for older trainers, or those with less facilitation and training experience.

SBCC materials

7. Enhance the use of smart TVs. Ensure careful positioning of smart TVs (e.g., ensure they are not competing with meeting spaces, or situated where the sound will disrupt other business). Ensure that key stakeholders are adequately trained to operate smart TVs.

Impacts

8. Further assess the intervention impact on domestic violence and alcohol consumption. Further test the hypothesis (based on anecdotal evidence and endline data showing lower overall physical and emotional violence within the target group than non-target group) that domestic violence has decreased as a result of the project interventions, and if so, what aspects of the project contribute to this decrease. For example, variables could include whether one or both partners participate in caregiver sessions; how many of the father's peer group participate in the caregiver sessions; exposure to SBCC messaging; whether reduced alcohol consumption is a factor in reduced levels of violence; and whether reduced alcohol consumption is directly related to the project intervention or COVID-19 related restrictions on violence.

9. Develop violence reduction outcomes. If there is a clear correlation between the project interventions and reduced levels of violence, then violence reduction outcomes and indicators could be integrated into future similar project planning, implementation, and monitoring. In

future related projects, SC should also ensure that there is adequate expertise on the team (e.g., social workers, GBV expertise) or collaboration with other organizations with such expertise, to effectively address the connections between alcohol abuse and household violence in programming.

10. Integrate referral system. Consider the integration of a clear referral system within programming to respond to cases of alcohol abuse and violence, along with the integration of resources to ensure the successful referral of cares.

National Level

11. Highlight the key role of Commune Councils in implementing integrated ECD.

    Document and communicate project findings regarding the engagement and pivotal role of Commune Councils as the core, functional body within communities for planning, implementation, and operation of an integrated, multisectoral local level approach to ECD, with support from other stakeholders (e.g., health centre and education actors).

12. Advocate for a stronger coordination mechanism.

    Drawing on project learnings, advocate for a stronger coordination mechanism for national and sub-national government actors to coordinate towards the delivery of integrated ECD initiatives.

Sustainability and MEAL

13. Monitor Commune Council budgets. Continue to monitor target Commune Council budgets in terms of their ECD commitments to build a better longitudinal understanding of financial commitment and sustainability at the community level.

14. Understand the differences between women and men's knowledge-sharing behaviour. Explore potential differences in knowledge-sharing behaviour between men and women trained through the project (for example, in fieldwork, respondents argued that fathers, other than male team leaders, were less likely to share information than mothers or grandmothers).

15. Conduct a Scalability Review. Conduct a Scalability Review based on the findings of this evaluation. Unfortunately, there was not enough data available for this evaluation to draw any definite conclusions regarding scalability. In future projects, it will be important to collect, evaluate, and disseminate practical lessons learned about applying positive lessons and overcoming common challenges to scale-up. Future projects should aim to test identified strategies that can enhance the roles of internal actors, including local community actors, local authorities, and the government.

Funder & SC Team

16. Respond to the finding of the relatively lower awareness of grandmothers in comparison to other caregivers. This finding raises important design questions, challenges, and possible adaptations in the upcoming GRAND project where it is planned to directly engage grandmothers in ECD activities.

ANNEXES

Annex 1: Stakeholder List

No.	Person interviewed	#	F	M	Position	Venue	Date	Method
Fieldwork: Phase 1								
1	SCI project team	6	3	3	SCI project manager, SCI project teams	SCI Kampong Cham Office	14 Dec 2021	FGD
2	H.E. OnHeng Leakhena H.E. Chean Lengtean	2	2	0	Head of PWCCC in Kampong Cham Deputy head of PWCCC in Kampong Cham	Provincial Dep. Of Women's Affairs	14 Dec	FGD
3	PoE Officers	3	3	0	Deputy head and officers, Dep. Childhood Education	Dep. of Childhood Education office in Kampong Cham	14 Dec	FGD
4	DoE Officers	3	2	1	Early Childhood Education, Kampong Siem district	DoE office, Kampong Siem district	14 Dec	FGD
5	Father's Group	4	0	4	Fathers (children 0-3 yrs.)	Ampil Commune, Kampong Siem Dist.	14 Dec	FGD
6	Local authority	4	2	2	Commune chief, members of Comm. Council, CWCC	Krala Comm., Kampong Siem Dist.	15 Dec	FGD
7	Hout Sothun & Soth Vanna	2	1	1	Head of health centre Nurse	Health Centre, Krala Comm.	15 Dec	FGD
8	Ol Meng Eang	1	0	1	Primary school teacher	Kouch Mengly Toul Beng Primary school	15 Dec	KII
9	Soun Sophanith	1	1	0	VHSG	Trapang Chrey village, Krala Comm.	15 Dec	KII
10	Chheng Lay	1	1	0	Seller in the community	Trapang Chrey vill.	15 Dec	KII
11	Mother's Group	4	4	0	Mothers (children 0-3 yrs.)	Trapang Ja village, Krala Commune	15 Dec	FGD
12	Father's Group	6	0	6	Fathers (children 0-3 yrs.)	Ondoung Por village, Krala Commune	15 Dec	FGD
13	Say Rady	1	1	0	Deputy principal, Krala PS	Krala Primary school	16 Dec	KII
14	Local authority	4	2	2	Comm. Council members, Clergymen, CCWC	Ampil Comm. Hall, Kampong Siem Dist.	16 Dec	FGD
15	Cheng Chorvin	1	1	0	Nurse, Ampil Commune	Health Centre	16 Dec	KII
16	Hoeun Dany	1	1	0	VHSG	Romeas Village, Ampil Commune	16 Dec	KII
17	Mother's Group	6	6	0	Mothers (children 0-3 yrs.)	Krala vill., Ampil Comm.	16 Dec	FGD
18	Villagers	3	1	2	2 sellers, 1 Buddhist monk	Pagoda, Ampil vill. & Comm.	16 Dec	FGD
Fieldwork: Phase 2: Non-target areas								
19	Koy Chanthy	1	0	1	DOE Head, Prey Chor Dist.	DoE office	20 Dec	KII
20	Local authority	4	1	3	Village chief, Comm. chief, CCWC, CC members	Mean Commune Hall, Prey Chor Dist.	20 Dec	FGD
21	Yarn Kim Eourn	1	0	1	Head Health Centre	Health Centre of Mean Commune	20 Dec	KII
22	Ous Sokleap Huon Chanrath	2	2	0	Primary school teachers	Namken Primary school, Mean Comm.	20 Dec	FGD
23	Villagers	7	4	3	Villagers (construction workers, housewives, sellers, & grandmothers)	Ou Ta Nov village, Mean Commune	21 Dec	FGD
24	Local authority	5	1	4	Commune chief, commune council member, CCWC	Tongrong Commune Hall, Prey Chor Dist.	21 Dec	FGD
25	Meas Sun Heng	1	1	0	VHSG	Doung Village,	21 Dec	FGD

						Tongrong Commune		
26	E Sokha	1	0	1	Deputy Head,Tongrong HC, Tongrong Commune	Remote Interview	21 Dec	KII
27	Lak Limkry	1	0	1	School principal of Hun Sen Monireangsey PS	Tongrong Commune, Prey Chor district	21 Dec	KII
28	Villagers	4	3	1	Grandmother, seller, and housewives	Doung Village, Tongrong Commune	21 Dec	FGD
Fieldwork phase 2: Targeted areas								
29	Chim Sok Kai	1	0	1	School Principal, Chakrei PS	Chakrei PS, Ou Svay Commune	22 Dec	KII
30	Hang Chenda	1	1	0	Nurse of Ou Svay HC	Ou Svay H. Centre	22 Dec	KII
31	Local Authority	3	0	3	Commune chief, village chief, and CC member	Ou Svay Comm. Hall, Kampong Siem distr.	22 Dec	FGD
32	Chorn Kimhouy	1	1	0	VHSG	Ou Svay Commune, Kampong Siem distr.	22 Dec	KII
33	Villager	1	1	0	Sellers	Ou Svay Commune, Kampong Siem distr.	22 Dec	KII
34	Mother's Group	2	2	0	Mothers (children 0-3 yrs.)	Trapang Kak village, Ou Svay Commune	22 Dec 2021	FGD
35	Father'S Group	5	0	5	Fathers (children 0-3 yrs.)	Khel Jeay village, Ou Svay Commune	22 Dec	FGD
36	Sek Chantha	1	1	0	Teacher of Koh Prak PS	Koh Prak PS, Koh Tontuem Commune	23 Dec	KII
37	Mother's Group	4	4	0	Mothers (children 0-3 yrs.)	Koh Tontuem Comm., Kampong Siem district	23 Dec	FGD
38	Local authority	5	2	3	Commune chief, CCWC, CC members	Koh Tontuem Comm. Kampong Siem distr.	23 Dec	FGD
39	Villagers	4	4	0	Seller, grandmothers, housewife	Koh Tontuem Comm., Kampong Siem distr.	23 Dec	FGD
40	Mr. HEANG Limsrun (Case story)	1	0	1	Leader of male group	Trapangp'ros village, Krala Comm., Kampong Siem distr.	23 Dec	KII
41	Mother's Group	4	4	0	Mothers (children 0-3 yrs.)	Bangborbos village, Kien Chrey Comm.	23 Dec	FGD
42	Local authority	6	2	4	Commune chief, CCWC, CC members	Kien Chrey Comm., Kompong Siem distr.	24 Dec	FGD
43	Try Mouysim	1	1	0	Teacher of Kien Chrey PS	Kien Chrey PS, Kien Chrey Commune	24 Dec	KII
44	Kea Lina	1	1	0	Nurse, Kien Chrey, Health Centre	Health Centre, Kien Chrey Commune	24 De	KII
45	Dam Kimsrorn	1	1	0	VHSG	Enthinel village, Kien Chrey Commune	24 Dec	KII
46	Villagers	2	2	0	Seller &housewife	Enthinel village, Kien Chrey Commune	24 Dec	FGD
47	Junli Zhai	1	1	0	International Program Manager	Remote	18 Jan 2022	KII
48	Gloria Donate Sana Mot Sarang Out	3	1	2	Director of Strategy, Program Development and Impact, SC Program Director, SC Senior Education Manager, SC	Remote	18 Jan	FGD
		128	71	57				

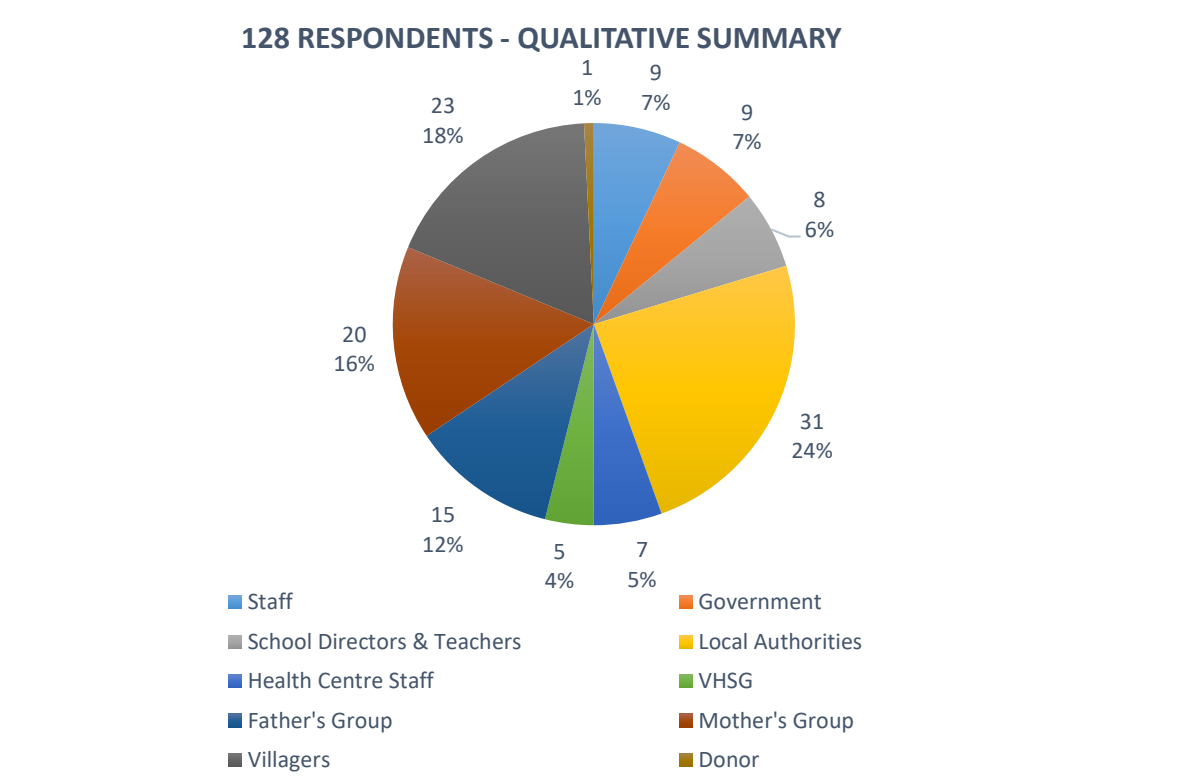
Data Summary

QUANTITATIVE	QUALITATIVE		
Survey	**KIIs**	**FGDs**	**Site Visits**
# Baseline 1,087	# Interviews 20	# FGDs 28	# Communes 7
# Endline 1,084	# Persons 20	# Persons 108	# Schools 7
F 911 (84%), M 173 (16%)	F 71 (56%), M 57 (44%)		
1,084 (89%)	**128 (11%)**		
Total Respondents 1,212			
Females 982 (81%), Males 230 (19%)			

Quantitative Data Summary. Total sample = 1,084 (F 911, M 173)

Caregivers				Community actors			
District	**Baseline**	**Endline**	**Total**	**Distict**	**Baseline**	**Endline**	**Total**
Kampong Siem	436	461	897	Kampong Siem(target)	113	114	227
Prey Chhor	426	414	840	Prey Chhor(non-target	112	95	207
Total	**862**	**875**	**1,737**	**Total**	**225**	**209**	**234**

Qualitative Data Summary. Total sample = 128 (F 71, M 57)



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Annex 3: Summary of Data

Quantitative

Table 1. Estimated sample sizes to detect difference in proportions between baseline and endline Descriptive statistics of the sample

No.	Indicator	Diff./ Target	α	1 – β	Est. Max. N per Round	Refusal rate (5%)	Attrition rate (10%)
1	% of caregivers who were aware of at least 3 positive practices in Good Health and Nutrition.	10% point	0.0500	0.8000	388	15	39
2	% of caregivers who were aware of at least 3 positive practices in Early Learning and Responsive Care.	10% point	0.0500	0.8000	388	15	39
3	% of caregivers who were aware of at least 3 positive practices in Safety & Security.	10% point	0.0500	0.8000	388	15	39
4	% of community actors who have improved awareness and understanding of positive practices in integrated ECD.	20% point	0.0500	0.8000	97	5	10
5	% of community actors who self-report an increase in providing advice on integrated ECD to caregivers.	20% point	0.0500	0.8000	97	5	10
6	% of audience who recalled hearing or seeing a specific product, practice, or service related to holistic care for the 0 to 3 age group.	80%	0.0500	0.8000	82	5	8
7	% of audience with a favourable (or unfavourable) attitude toward the product, practice, or service related to holistic care for the 0 to 3 age group.	70%	0.0500	0.8000	93	5	9

Diff.= difference in proportions between baseline and endline; Target: target proportion at endline. 1 – β: power; Alternative hypothesis (Ha): p2! = p1 using Pearson's chi-squared test; α: alpha, significance level.

Table 2. Characteristics of community actors

Characteristics	All sample	Kampong Siem (target)	Prey Chhor (Non-target)	p-value
Formal community actor	71.2%	73.6%	68.6%	0.254
Male	54.6%	47.1%	62.8%	0.001
Age	49.7	47.9	51.6	0.013
Education	9.0	9.3	8.6	0.089
Spoken Khmer at home	100%	100%	100%	n/a
ID Poor	1.9%	1.8%	2.0%	0.022
Smartphone	77.4%	81.4%	72.9%	0.035
Social Media	77.1%	81.0%	72.9%	0.047
Near main road	47.5%	46.9%	48.1%	0.810
Access clean water	35.4%	52.2%	17.0%	0.000
Access electricity	78.7%	76.5%	81.1%	0.252

Urban area	14.4%	13.7%	15.0%	0.693
N	434	327	207	

Table 3. Characteristics of surveyed caregivers

Characteristics	All sample		Kampong Siem (target)		Prey Chhor (Non-target)		p-value
	N	Value	N	Value	N	Value	
Male caregivers (%)	1,735	6.5%	896	5.1%	839	8.0%	0.016
Age (years)	1,737	35.9	897	35.4	840	36.4	0.127
Education (years)	1,728	6.5	894	7.0	834	6.0	0.000
Highest education (years)	1,708	8.5	887	9.2	821	7.8	0.000
Relationship with the child (%)							
Mother	1,735	73.0%	895	79.3%	840	66.2%	0.000
Father	1,735	4.0%	895	2.6%	840	5.6%	
Grand mother	1,735	19.5%	895	15.1%	840	24.3%	
Other	1,735	3.5%	895	3.0%	840	3.9%	
Marital status (%)							
Divorced/separated	1,730	1.8%	897	1.9%	833	1.8%	0.188
Live separate	1,730	10.1%	897	9.4%	833	10.9%	
Live together	1,730	84.3%	897	85.8%	833	82.7%	
Others	1,730	3.7%	897	2.9%	833	4.6%	
Language spoken at home (Khmer %)	1,733	99.9%	897	99.9%	836	99.9%	0.367
ID Poor (%)	1,730	15.2%	892	15.0%	838	15.4%	0.830
Near main road (%)	1,737	37.7%	897	40.0%	840	35.1%	0.035
Urban area (%)	1,733	37.7%	895	46.5%	838	28.3%	0.000
Smart phone (%)	1,728	61.8%	894	64.4%	834	59.0%	0.020
Social media (%)	1,725	61.7%	893	64.4%	832	58.8%	0.017
Socio-economic status							
Low	1,696	33.4%	877	26.8%	819	40.4%	
Medium	1,696	33.3%	877	29.5%	819	37.4%	
High	1,696	33.3%	877	43.7%	819	22.2%	0.000

Table 4. Proportion of caregivers who were aware of at least 3 positive practices in good health and nutrition by key classification

Classification		Target area		Non-target area	
		Baseline	Endline	Baseline	Endline
Gender	Female	53.9	91.2	78.3	37.3
	Male	69.2	95.0	69.6	50.0
	p-value	0.127	0.55	0.328	0.102
Age	< 30 years	58.2	95.6	79.8	41.1
	30-50 years	56.7	89.3	78.7	34.6
	>50 years	42.0	87.9	69.6	41.2
	p-value	0.061	0.054	0.207	0.408
ID Poor	Non-Poor	55.3	92.0	78.0	39.4
	Poor	50.0	87.8	74.6	34.8
	p-value	0.457	0.245	0.560	0.470
Socio-economic status	Low	48.5	86.7	66.3	27.5
	Medium	60.9	92.0	84.0	38.3
	High	55.9	92.9	90.1	57.8
	p-value	0.124	0.184	0.000	0.000

Table 5. Proportion of caregivers who were aware of at least 3 positive practices in early learning and responsive care by gender, age group, IDPoor, target group, and socio-economic status

Classification		Target area		Non-target area	
		Baseline	Endline	Baseline	Endline
Gender	Female	62.7	98.4	76.8	54.9
	Male	65.4	100.0	78.3	70.5
	p-value	0.78	0.57	0.867	0.049
Age	< 30 years	59.0	98.8	77.7	56.3
	30-50 years	63.9	98.8	76.7	54.1
	>50 years	69.1	96.6	73.9	60.8
	p-value	0.323	0.438	0.819	0.572
ID Poor	Non-Poor	64.2	98.7	77.7	56.8
	Poor	53.3	97.3	71.2	55.1
	p-value	0.106	0.363	0.273	0.790
Socio-economic status	Low	63.5	98.0	68.5	43.6
	Medium	62.1	98.4	84.0	60.0
	High	62.1	98.7	79.1	71.1
	p-value	0.962	0.865	0.005	0.000

Table 6. Proportion of caregivers who were aware of at least 3 positive practices in safety and security by gender, age group, IDPoor, target group, and socio-economic status

Classification		Target area		Non-target area	
		Baseline	Endline	Baseline	Endline
Gender	Female	54.6	93.7	74.1	35.4
	Male	42.3	100.0	81.8	59.1
	p-value	0.224	0.245	0.417	0.002
Age	< 30 years	52.8	94.4	73.7	35.4
	30-50 years	56.2	93.8	79.4	37.7
	>50 years	50.0	93.1	63.8	42.3
	p-value	0.624	0.937	0.038	0.551
ID Poor	Non-Poor	54.1	94.6	76.8	38.3
	Poor	55.9	90.5	61.7	36.2
	p-value	0.790	0.183	0.013	0.751
Socio-economic status	Low	56.6	90.8	60.8	28.9
	Medium	51.2	96.0	83.2	39.4
	High	55.2	94.1	85.7	50.0
	p-value	0.649	0.270	0.000	0.004

Table 7. Caregiver's awareness on early childhood care by project exposure

Project exposure		Outcome1.1: good health and nutrition	Outcome1.2: early learning and responsive care	Outcome1.3: safety and security
Intervention strategy	Education	91.1	98.7	95.3
	Health	87.9	100.0	90.9

	Community	92.2	97.9	92.7
	p-value	0.714	0.601	0.397
SBCC packages	Not all IEC materials	90.3	98.6	93.3
	All IEC materials	95.0	98.0	96.0
	p-value	0.136	0.661	0.321
Training frequency	<12 times	89.0	98.1	93.3
	12 times	93.2	98.8	94.4
	p-value	0.112	0.534	0.624

Table 8. Caregiver's awareness on early childhood care by project exposure

Program exposure		Outcome1.1: good health and nutrition	Outcome1.2: early learning and responsive care	Outcome1.3: safety and security
Intervention strategy	Education	91.1	98.7	95.3
	Health	87.9	100.0	90.9
	Community	92.2	97.9	92.7
	p-value	0.714	0.601	0.397
SBCC packages	Not all IEC materials	90.3	98.6	93.3
	All IEC materials	95.0	98.0	96.0
	p-value	0.136	0.661	0.321
Training frequency	<12 times	89.0	98.1	93.3
	12 times	93.2	98.8	94.4
	p-value	0.112	0.534	0.624

Table 9. Proportion of community actors who awareness and understanding of positive practices towards integrated ECD by classification

Classification		Target area		Non-target area	
		Baseline	Endline	Baseline	Endline
Gender	Female	52.6	100.0	42.1	34.2
	Male	59.3	100.0	58.8	24.6
	p-value	0.482	n/a	0.098	0.307
Age	< 41 years	53.9	100.0	53.9	36.0
	41-60 years	55.6	100.0	58.3	29.4
	>60 years	59.3	100.0	44.8	22.2
	p-value	0.908	n/a	0.515	0.496
Community actors	Informal	42.5	100.0	45.2	28.6
	Formal	63.4	100.0	56.0	28.4
	p-value	0.033	n/a	0.309	0.983

Table 10. Caregivers' awareness on specific indicators of early childhood care

Outcomes/indicators	Target area			Non-target area		
	Baseline	Endline	p-value	Baseline	Endline	p-value
Outcome 1.1: good health and nutrition						
1) Washing their hands at critical times	67.3%	97.6 %	0.000	92.6%	65.9 %	0.000
2) Supporting their child in washing their hands at critical times	61.7%	93.1 %	0.000	86.4%	54.3 %	0.000
3)Providing healthy snacks to their child of over 6 months old	54.9%	79.0 %	0.000	60.5%	34.5 %	0.000
4) Taking their sick child to health centres.	54.2%	62.7 %	0.010	71.2%	42.3 %	0.000
5)Drinking clean water or giving clean water to their child.	46.3%	56.0 %	0.004	61.2%	39.9 %	0.000
Outcome 1.2: early learning and responsive care						
1) Taking turns to engage their child in responding and talking to help in their development	96.3%	99.6 %	0.001	98.6%	89.9 %	0.000
2)Reading, signing, or telling stories to their child every day.	47.9%	98.0 %	0.000	61.3%	48.1 %	0.000
3)Telling their child the names of objects, plants, animals, and people that were around them.	32.9%	95.9 %	0.000	51.9%	37.0 %	0.000
4) Engaging everyone in the household with early learning and responsive care practices with their child.	47.0%	89.8 %	0.000	64.2%	50.2 %	0.000
5) Building trust and attachment to the child through interaction	67.7%	97.8 %	0.000	83.3%	63.8 %	0.000
6) Helping their child feel calm, safe, and relaxed, by responding to their child's needs	41.2%	83.1 %	0.000	64.9%	32.4 %	0.000
Outcome 1.3: Safety and security						
1) Taking turns to engage their child in responding and talking to help in their development	96.3%	99.6 %	0.001	98.6%	89.9 %	0.000
1) Using a soothing voice with their child.	86.6%	99.1 %	0.000	94.8%	80.9 %	0.000
2) Hugging or patting their child when they were upset.	63.9%	82.6 %	0.000	80.4%	46.4 %	0.000
3) Using different ways to calm down their child when they were upset	33.6%	44.7 %	0.001	50.7%	28.5 %	0.000
4) Using different ways to distract child when they displayed unwanted behaviour	47.9%	91.8 %	0.000	55.2%	46.1 %	0.009
5) Calming down and thinking first to make the right decision.	44.4%	76.4 %	0.000	54.7%	38.9 %	0.000

Table 11. Proportion of community actor who provided advice to caregiver at least three indicators by key classification

Classification		Target area		Non-target area	
		Baseline	Endline	Baseline	Endline
Gender	Female	56.9	100.0	43.6	68.4
	Male	47.3	100.0	60.3	77.2
	p-value	0.306	n/a	0.091	0.342
Age	< 41 years	50.0	100.0	35.7	60.0
	41-60 years	57.8	100.0	60.0	79.4
	>60 years	46.4	100.0	61.3	77.8
	p-value	0.603	na	0.076	0.192
Community actors	Informal	52.5	100.0	40.5	53.6
	Formal	52.1	100.0	61.3	82.1
	p-value	0.964	n/a	0.038	0.004

Table 12. Project Impact on community actor's outcome

Variables	Awareness (# of indicators out 16)	Providing counselling (# of indicators out 13)
Age (years)	-0.010	-0.008
	(0.014)	(0.016)
Male (Male=1, Female=0)	0.157	0.553
	(0.336)	(0.404)
Education (years)	-0.035	-0.011
	(0.042)	(0.044)
Smartphone (Yes=1, No=0)	1.094	-0.499
	(0.419)***	(0.462)
ID Poor (Poor=1, Non-poor=0)	0.691	-0.613
	(0.935)	(1.284)
Near main road (Yes=1, No=0)	0.052	0.224
	(0.273)	(0.309)
Access to clean water (Yes=1, No=0)	1.500	1.449
	(0.349)***	(0.401)***
Access to electricity (Yes=1, No=0)	0.766	0.239
	(0.458)*	(0.513)
Urban area (Yes=1, No=0)	0.971	0.544
	(0.415)**	(0.478)
Community actor (Formal=1, Non-formal=0)	0.964	1.979
	(0.365)***	(0.417)***
Project impact (DiD)	4.520	5.009
	(0.664)***	(0.702)***
Intervention (Target=1, Non-target=0)	0.257	-0.212
	(0.458)	(0.499)
Endline (Endline=1, Baseline=0)	-3.062	-3.514
	(0.552)***	(0.581)***
R^2	0.43	0.47
N	409	324

Standard errors are in the parathesis. * $p<0.1$; ** $p<0.05$; *** $p<0.01$

Table 13. Knowledge of community actors in integrated ECD by key variables

Classification		Baseline			Endline		
		Low	Medium	High	Low	Medium	High
Kampong Siem (target)							
Gender	Female	33.3	49.1	17.5	0.0	16.1	83.9
	Male	35.2	48.2	16.7	0.0	28.9	71.2
	p-value	0.977			0.102		
Age	< 41 years	38.46	53.85	7.69	0.0	13.2	86.8
	41-60 years	24.4	44.4	31.1	0.0	21.7	78.3
	>60 years	44.4	48.2	7.4	0.0	33.3	66.7
	p-value	0.023			0.136		
Community actors	Informal	42.5	45.0	12.5	0.0	15.0	85.0
	Formal	29.6	50.7	19.7	0.0	23.4	76.6
	p-value	0.333			0.409		
Prey Chhor (non-target)							
Gender	Female	39.5	44.7	15.8	68.4	13.2	18.4
	Male	30.9	50.0	19.1	73.7	12.3	14.0
	p-value	0.663			0.827		
Age	< 41 years	42.3	50.0	7.7	68.0	20.0	12.0
	41-60 years	31.3	41.7	27.1	67.7	11.8	20.6
	>60 years	31.0	58.6	10.3	77.8	8.3	13.9
	p-value	0.159			0.603		
Community actors	Informal	61.3	29.0	9.7	75.0	7.1	17.9
	Formal	22.7	56.0	21.3	70.2	14.9	14.9
	p-value	0.001			0.571		

Table 14. Attitudes of community actors on integrated ECD by key variables

Classification		Baseline			Endline		
		Low	Medium	High	Low	Medium	High
Kampong Siem (target)							
Gender	Female	26.8	62.5	10.7	0.0	8.1	91.9
	Male	30.2	64.2	5.7	0.0	34.6	65.4
	p-value	0.617			0.000		
Age	< 41 years	25.64	69.23	5.13	0.0	5.3	94.7
	41-60 years	27.9	58.1	14.0	0.0	19.6	80.4
	>60 years	33.3	63.0	3.7	0.0	40.0	60.0
	p-value	0.468			0.002		
Community actors	Informal	35.9	56.4	7.7	0.0	10.0	90.0
	Formal	24.3	67.1	8.6	0.0	22.3	77.7
	p-value	0.435			0.212		
Prey Chhor (non-target)							
Gender	Female	55.6	19.4	25.0	65.8	23.7	10.5
	Male	35.4	35.4	29.2	71.9	15.8	12.3
	p-value	0.114			0.627		
Age	< 41 years	50.0	25.0	25.0	68.0	28.0	4.0
	41-60 years	32.6	37.0	30.4	61.8	17.7	20.6
	>60 years	50.0	25.0	25.0	77.8	13.9	8.3

	p-value	0.53			0.184		
Community actors	Informal	63.3	30.0	6.7	71.4	17.9	10.7
	Formal	33.8	29.6	36.6	68.7	19.4	11.9
	p-value	0.004			0.964		

Table 15. Practice of community actors in integrated ECD by key variables

Classification		Baseline			Endline		
		Low	Medium	High	Low	Medium	High
Kampong Siem (target)							
Gender	Female	57.1	34.3	8.6	0.0	14.5	85.5
	Male	42.3	46.2	11.5	0.0	46.2	53.9
	p-value	0.519			0.000		
Age	< 41 years	63.64	36.36	0	0.0	10.5	89.5
	41-60 years	38.5	42.3	19.2	0.0	28.3	71.7
	>60 years	53.9	38.5	7.7	0.0	53.3	46.7
	p-value	0.186			0.001		
Community actors	Informal	73.9	26.1	0.0	0.0	15.0	85.0
	Formal	36.8	47.4	15.8	0.0	31.9	68.1
	p-value	0.010			0.130		
Prey Chhor (non-target)							
Gender	Female	47.1	35.3	17.7	71.1	21.1	7.9
	Male	22.7	59.1	18.2	61.4	24.6	14.0
	p-value	0.151			0.552		
Age	< 41 years	40.0	50.0	10.0	84.0	12.0	4.0
	41-60 years	20.0	53.3	26.7	55.9	23.5	20.6
	>60 years	36.8	57.9	5.3	61.1	30.6	8.3
	p-value	0.264			0.090		
Community actors	Informal	60.0	40.0	0.0	75.0	10.7	14.3
	Formal	19.6	56.5	23.9	61.2	28.4	10.5
	p-value	0.005			0.175		

Table 16. Project impact on knowledge, attitude, and practice (marginal effect)

Classification	Knowledge	Attitude	Practice
Low	-51.5%***	-59.9%***	-58.4%***
Medium	10.3%***	12.1%***	10.4%**
High	41.2%***	47.8%***	48.1%***

* $p<0.1$; ** $p<0.05$; *** $p<0.01$

Table 17. Caregiver's knowledge, attitude, and practice by key variables

Classification		Target						Non-target					
		Baseline			Endline			Baseline			Endline		
Knowledge		**Low**	**Medium**	**High**	**Low**	**Medium**	**High**	**Low**	**Mediu**	**High**	**Low**	**Medium**	**High**
Gender	Female	50.9	35.2	13.9	0.9	40.4	58.7	18.5	41.8	39.8	68.4	15.1	16.5
	Male	53.9	30.8	15.4	5.0	65.0	30.0	18.2	40.9	40.9	47.7	9.1	43.2
	p-value	0.898			0.014				0.994			0.000	
Age	<30 years	50.6	36.7	12.7	0.0	34.4	65.6	19.1	44.5	36.4	67.7	12.7	19.6
	30-50 years	49.2	34.0	16.8	1.7	44.4	53.9	19.1	37.1	43.8	68.6	15.1	16.4
	>50 years	56.7	32.8	10.5	1.7	48.3	50.0	16.4	46.3	37.3	59.8	16.5	23.7
	p-value	0.617			0.068				0.538			0.531	
ID Poor	Non-Poor	50.3	35.1	14.6	0.8	40.6	58.7	18.4	41.1	40.5	67.3	13.3	19.4
	Poor	52.7	34.6	12.7	2.7	46.0	51.4	20.7	43.1	36.2	60.9	20.3	18.8
	p-value		0.913			0.208			0.812			0.319	
Socio-economic status	Low	51.9	34.8	13.3	2.0	45.9	52.0	30.7	42.6	26.7	73.2	14.8	12.1
	Medium	52.9	30.9	16.3	2.4	44.0	53.6	8.4	49.6	42.0	65.7	13.1	21.1
	High	48.3	37.9	13.8	0.0	38.2	61.8	12.1	30.8	57.1	55.6	16.7	27.8
	p-value		0.791			0.083			0.000			0.029	
Attitude		**Low**	**Medium**	**High**	**Low**	**Medium**	**High**	**Low**	**Mediu**	**High**	**Low**	**Medium**	**High**
Gender	Female	55.3	33.5	11.2	1.6	25.4	73.0	23.3	49.2	27.5	58.9	27.6	13.5
	Male	47.8	34.8	17.4	5.0	10.0	85.0	25.0	50.0	25.0	36.4	25.0	38.6
	p-value		0.617			0.174			0.965			0.000	
Age	<30 years	52.0	36.2	11.8	1.9	16.9	81.3	21.8	56.4	21.8	58.9	26.6	14.6
	30-50 years	54.1	32.7	13.3	2.1	24.7	73.3	22.2	44.9	32.9	58.5	27.0	14.5
	>50 years	62.9	31.4	5.7	0.0	46.6	53.5	30.2	42.9	27.0	49.5	28.9	21.7
	p-value		0.392			0.000			0.087			0.467	
ID Poor	Non-Poor	52.4	35.2	12.4	1.8	21.7	76.5	22.7	47.7	29.7	56.8	27.0	16.2
	Poor	68.3	25.0	6.7	1.4	40.5	58.1	28.3	58.5	13.2	55.1	29.0	15.9
	p-value		0.066			0.003			0.044			0.942	
Socio-economic status	Low	62.6	26.0	11.5	1.0	35.7	63.3	31.7	56.3	12.0	65.8	22.8	11.4
	Medium	50.0	39.1	10.9	4.0	25.6	70.4	22.0	44.7	33.3	54.9	28.0	17.1

	High	48.2	38.3	13.5	0.8	19.8	79.4	10.6	41.2	48.2	44.4	33.3	22.2
	p-value		0.108			0.005			0.000			0.024	
Practice		**Low**	**Medium**	**High**	**Low**	**Medium**	**High**	**Low**	**Mediu**	**High**	**Low**	**Medium**	**High**
Gender	Female	45.9	43.8	10.3	2.4	27.2	70.4	32.1	46.8	21.2	68.5	17.0	14.5
	Male	44.4	38.9	16.7	10.5	36.8	52.6	22.2	44.4	33.3	44.1	23.5	32.4
	p-value	0.686			0.056				0.429			0.009	
Age	<30 years	49.6	42.0	8.4	2.0	23.0	75.0	35.3	45.1	19.6	64.1	17.5	18.5
	30-50 years	44.0	42.6	13.5	3.5	29.4	67.1	26.4	45.0	28.7	67.5	19.5	13.0
	>50 years	41.2	49.0	9.8	1.8	32.7	65.5	34.0	56.0	10.0	65.5	15.5	19.1
	p-value	0.601			0.435				0.264			0.728	
ID Poor	Non-Poor	42.0	46.4	11.6	3.0	26.3	70.7	29.3	48.3	22.4	66.2	17.5	16.3
	Poor	68.2	25.0	6.8	1.5	34.8	63.8	43.8	37.5	18.8	64.2	18.9	17.0
	p-value		0.005			0.298			0.138			0.959	
Socio-economic status	Low	61.4	30.7	8.0	1.1	37.5	61.4	45.9	45.1	9.0	74.5	12.3	13.2
	Medium	47.5	38.6	13.9	5.3	27.2	67.5	24.0	52.9	23.1	63.0	18.1	18.8
	High	33.0	55.7	11.3	2.2	24.1	73.7	18.1	41.7	40.3	57.6	25.8	16.7
	p-value		0.001			0.053			0.000			0.115	

Table 18. Project impact on caregiver's KAP

Classification	Knowledge	Attitudes	Practices
Low	-71.9%***	-75.3%***	-66.2%***
Medium	0.5%	8.9%***	6.2%***
High	71.4%***	66.4%***	60.0%***

* $p<0.1$; ** $p<0.05$; *** $p<0.01$

Table 19. Caregiver's KAP by the type of exposure

Exposure	Knowledge			Attitude			Practice		
	Low	Medium	High	Low	Medium	High	Low	Medium	High
Type of intervention									
Education	1.7	37.9	60.4	1.7	26.4	71.9	1.3	26.6	72.1
Health	0.0	36.4	63.6	6.1	21.2	72.7	6.3	28.1	65.6
Community	0.5	46.1	53.4	0.5	23.0	76.4	4.0	28.2	67.8
p-vale	0.312			0.153			0.34		
SBCC packages									
Not all materials	1.4	41.2	57.4	1.7	26.7	71.6	1.2	28.0	70.8
All IEC materials	0.0	41.0	59.0	1.0	17.0	82.0	8.3	25.0	66.7
p-vale	0.489			0.111			0.001		
Training frequency									
<12 times	1.9	45.5	52.6	1.9	31.1	67.0	3.1	35.9	61.0
12 times	0.4	37.6	62.0	1.2	19.2	79.6	2.5	20.3	77.2
p-vale	0.054			0.009			0.001		

Table 20. Male engagement in early childcare and development

Activities	Target area			Non-target area		
	Baseline	Endline	p-vale	Baseline	Endline	p-vale
Talk and read books to fetus	48.3%	65.7%	0.000	52.9%	52.9%	0.990
Reading letters to the child and teach the child by using photos, drawing, and playing games	44.4%	79.6%	0.000	46.0%	41.1%	0.154
Bring wife to have prenatal care	90.1%	96.3%	0.000	92.9%	89.1%	0.060
Use happy faces and actions to play with the child	80.9%	97.4%	0.000	86.7%	75.6%	0.000
Tell the child about animals, plants, things to the child	60.9%	91.5%	0.000	74.5%	58.5%	0.000
Help wife with washing clothes	86.4%	94.4%	0.000	85.0%	75.8%	0.001
Help wife with cooking	78.2%	88.5%	0.000	79.5%	63.8%	0.000
Male engagement	69.9%	87.6%	0.000	73.9%	65.3%	0.000
Physical violence on children and mother committed by male	-	1.1%	-	-	13.3%	-
Emotional violence on children and mother committed by male (blaming, cursing, threatening, scolding, neglect)	-	4.6%	-	-	13.3%	-
Overall violence (both physical and emotional violence)	n/a	0.2%	n/a	n/a	12.8%	n/a

Table 21. Male engagement in early childcare and development by the type of exposure

Project exposure		Male engagement	Overall violence
Parental involvement	Only mother	85.6%	0.3%
	Both parents	91.2%	0.0%
	p-vale	0.001	0.459
SBCC packages	Not all IEC materials	87.5%	0.3%
	All IEC materials	88.1%	0.0%
	p-vale	0.720	0.598

Table 22. Knowledge attitude and practice by the role of the caregivers

KAP		Mother	Father	Grandmother	Other	p-vale
Knowledge	Low	31.8	38.6	38.5	28.3	0.004
	Medium	32.6	27.1	34.6	50.0	
	High	35.5	34.3	27.0	21.7	
Attitude	Low	31.9	34.8	37.7	35.6	0.004
	Medium	31.9	31.9	38.3	39.0	
	High	36.2	33.3	24.0	25.4	
Practice	Low	31.1	35.0	42.1	27.9	0.000
	Medium	32.0	38.3	35.2	44.2	
	High	36.9	26.7	22.7	27.9	

Table 23. Child-development outcome by the role of the caregivers

Role of caregivers	Socio-Emotional	Cognitive	Language	Motor	Overall CREDI
Mother	47.9	47.8	48.4	47.6	47.2
Father	48.5	48.4	49.0	48.2	47.6
Grandmother	48.5	48.4	48.8	48.2	47.8
Other	48.7	48.5	49.1	48.5	47.9

p-vale		0.000		0.001		0.004		0.001		0.024	

Table 24. Child Development outcomes by key variables

KAP	Level	Baseline					Endline				
		Socio-Emotional	Cognitive	Language	Motor	Overall CREDI	Socio-Emotional	Cognitive	Language	Motor	Overall CREDI
Kampong Siem (Target)											
Gender of the child	Male	48.2	48.1	48.7	47.9	48.2	49.4	49.3	49.7	49.2	48.7
	Female	48.0	48.0	48.5	47.8	48.1	49.0	48.9	49.3	48.8	48.0
	p-vale	0.505	0.444	0.487	0.682	0.529	0.058	0.043	0.113	0.097	0.062
Age of child	<13 months	45.4	45.7	46.4	44.9	45.6	46.6	47.0	47.3	46.3	44.3
	13-24 months	49.0	48.9	49.0	48.7	48.9	49.9	49.8	49.9	49.8	49.4
	>24 months	51.1	50.4	51.3	51.0	51.0	51.7	51.0	51.9	51.6	52.2
	p-vale	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
ID Poor	Non-poor	48.2	48.1	48.6	47.9	48.2	49.3	49.2	49.6	49.1	48.5
	Poor	47.6	47.5	48.2	47.3	47.6	48.7	48.7	49.0	48.5	47.6
	p-vale	0.111	0.062	0.171	0.106	0.103	0.097	0.097	0.062	0.078	0.099
Socio-economic status	Low	47.7	47.7	48.3	47.4	47.8	48.7	48.7	49.0	48.5	47.5
	Medium	48.4	48.2	48.8	48.1	48.4	48.9	48.8	49.2	48.8	47.8
	High	48.2	48.1	48.6	47.9	48.2	49.6	49.4	49.8	49.4	48.9
	p-vale	0.127	0.095	0.241	0.195	0.154	0.007	0.010	0.003	0.009	0.005
Prey Chhor (Non-target)											
Gender of the child	Male	47.5	47.5	48.2	47.1	47.6	47.5	47.5	48.1	47.1	45.5
	Female	47.5	47.4	48.1	47.1	47.5	47.1	47.2	47.8	46.8	45.0
	p-vale	0.939	0.865	0.590	0.842	0.815	0.193	0.204	0.247	0.289	0.272
Age of child	<13 months	44.7	45.1	46.1	44.3	45.1	44.8	45.2	46.1	44.4	41.3
	13-24 months	48.8	48.6	48.7	48.0	48.5	48.8	48.6	48.8	48.3	47.4
	>24 months	51.0	50.3	51.2	51.1	50.9	50.8	50.2	51.1	50.9	51.0
	p-vale	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
ID Poor	Non-poor	47.4	47.4	48.1	47.0	47.5	47.4	47.4	48.0	47.0	45.3
	Poor	48.1	47.9	48.5	47.7	48.1	47.1	47.1	47.7	46.8	44.9
	p-vale	0.107	0.103	0.152	0.104	0.111	0.432	0.391	0.301	0.531	0.524
Socio-economic status	Low	47.4	47.4	48.1	47.1	47.5	47.2	47.2	47.8	46.8	45.0
	Medium	47.5	47.4	48.1	47.0	47.5	47.1	47.2	47.8	46.9	45.0
	High	47.9	47.7	48.4	47.4	47.8	47.9	47.8	48.4	47.5	46.0
	p-vale	0.519	0.469	0.624	0.644	0.564	0.097	0.127	0.060	0.207	0.163

Table 25. Child Development Outcomes by knowledge, attitude, and practice in the target and non-target

KAP	Level	Baseline					Endline				
		Socio-Emotional	Cognitive	Language	Motor	Overall CREDI	Socio-Emotional	Cognitive	Language	Motor	Overall CREDI
Kampong Siem (Target)											
Knowledge	Low	48.1	47.9	48.5	47.7	48.0	50.2	49.7	50.2	49.9	49.9
	Medium	48.0	48.0	48.4	47.7	48.0	49.0	49.0	49.4	48.9	48.1
	High	48.5	48.5	49.1	48.5	48.6	49.3	49.2	49.6	49.1	48.5
	p-vale	0.475	0.290	0.168	0.147	0.251	0.368	0.457	0.557	0.547	0.466
Attitude	Low	48.0	47.9	48.5	47.6	48.0	46.7	46.8	48.0	46.7	44.6
	Medium	48.3	48.1	48.6	47.9	48.2	49.3	49.2	49.6	49.1	48.6
	High	48.8	48.7	49.3	48.7	48.9	49.2	49.1	49.5	49.0	48.3
	p-vale	0.149	0.080	0.091	0.076	0.095	0.057	0.035	0.260	0.107	0.074
Practice	Low	47.7	47.5	48.1	47.2	47.6	48.0	47.8	48.3	47.8	46.4
	Medium	48.8	48.7	49.2	48.6	48.8	48.9	48.9	49.2	48.8	48.0
	High	48.9	48.8	49.3	48.7	48.9	49.6	49.5	49.8	49.4	49.0
	p-vale	0.000	0.000	0.000	0.000	0.000	0.003	0.001	0.005	0.010	0.006
Prey Chhor (Non-target)											
Knowledge	Low	47.5	47.5	48.1	47.1	47.6	47.1	47.1	47.8	46.7	44.9
	Medium	47.1	47.0	47.8	46.6	47.1	47.3	47.2	47.7	46.7	45.0
	High	48.0	47.9	48.5	47.7	48.0	48.3	48.2	48.9	48.2	46.9
	p-vale	0.018	0.008	0.023	0.014	0.014	0.008	0.003	0.001	0.001	0.003
Attitude	Low	47.5	47.5	48.1	47.2	47.6	47.0	47.1	47.7	46.7	44.8
	Medium	47.4	47.3	47.9	46.9	47.4	47.5	47.4	48.0	47.1	45.5
	High	48.4	48.2	48.9	48.0	48.4	48.1	48.1	48.6	47.9	46.5
	p-vale	0.014	0.007	0.005	0.009	0.008	0.030	0.018	0.018	0.019	0.026
Practice	Low	47.1	47.0	47.8	46.7	47.1	47.9	47.8	48.2	47.5	46.1
	Medium	47.8	47.6	48.2	47.2	47.7	49.0	48.8	49.2	48.7	47.9
	High	48.8	48.7	49.2	48.4	48.8	48.7	48.6	49.1	48.7	47.6
	p-vale	0.002	0.000	0.001	0.002	0.001	0.002	0.000	0.001	0.000	0.001

Table 26. Relationship between KAP and Overall CREDI score

Variables	Model 1	Model 2	Model 3
Female child (Female=1, Male=0)	-0.218	-0.241	-0.170
	(0.085)**	(0.087)***	(0.085)**
Age of child (years)	0.323	0.323	0.301
	(0.005)***	(0.005)***	(0.005)***
Male caregiver (Male=1, Female=0)	-0.117	-0.155	-0.254
	(0.218)	(0.229)	(0.209)
Age of caregiver (years)	0.004	0.004	-0.003
	(0.006)	(0.006)	(0.006)
Education (years)	0.017	0.016	0.010
	(0.015)	(0.015)	(0.015)
Relationship with the child (Ref: Mother)			
Father	-0.341	-0.232	-0.101
	(0.294)	(0.301)	(0.250)
Grandmother	0.072	0.076	0.120
	(0.181)	(0.184)	(0.179)
Other	-0.284	-0.258	-0.121
	(0.259)	(0.272)	(0.263)
Highest education (years)	-0.000	-0.002	-0.011
	(0.013)	(0.014)	(0.012)
ID Poor (Poor=1, Non-poor=0)	-0.183	-0.132	-0.179
	(0.133)	(0.136)	(0.132)
Socio-economic status (Ref: Low)			
Medium	-0.141	-0.107	-0.158
	(0.115)	(0.118)	(0.116)
High	0.038	0.051	-0.018
	(0.127)	(0.131)	(0.130)
Smartphone (Yes=1, No=0)	0.031	0.010	0.094
	(0.099)	(0.101)	(0.098)
Near main road (Yes=1, No=0)	-0.036	-0.014	-0.092
	(0.094)	(0.095)	(0.096)
Near health facility (Yes=1, No=0)	0.442	0.450	0.339
	(0.123)***	(0.125)***	(0.124)***
Near school (Yes=1, No=0)	0.008	-0.024	0.062
	(0.131)	(0.134)	(0.119)
Near pagoda (Yes=1, No=0)	0.181	0.168	0.194
	(0.129)	(0.132)	(0.115)*
Near market (Yes=1, No=0)	-0.032	0.002	-0.014
	(0.141)	(0.145)	(0.135)
Urban area (Yes=1, No=0)	-0.063	0.003	-0.128
	(0.129)	(0.133)	(0.127)
Target (Target=1, Non-target=0)	1.012	0.970	0.633
	(0.091)***	(0.092)***	(0.088)***
Endline (Endline=1, Baseline=0)	-1.215	-1.288	-0.872
	(0.090)***	(0.092)***	(0.090)***
Knowledge (index)	0.143	-	-
	(0.018)***	-	-
Attitude (index)	-	0.201	-
	-	(0.028)***	-
Practice (index)	-	-	0.196
	-	-	(0.018)***
R^2	0.81	0.80	0.79
N	1,548	1,526	1,250

Robust standard errors are in the parenthesis. * $p<0.1$; ** $p<0.05$; *** $p<0.01$

Annex 4: Qualitative Evaluation Questions

Key questions are outlined below for the following evaluation criteria.[37]

RELEVANCE
1. What is the project's relevance to the beneficiaries, partners, organisation, donor and international frameworks and policies? 2. Were we doing the right thing? Does the intervention respond to clearly identified needs and priorities of the project participants? Was the intervention appropriately adapted to the local context and target population? 3. How was learning and evidence used throughout the project cycle to adapt and ensure the project remained relevant? 4. How important is the relevance or significance of the intervention regarding local and national requirements and priorities? 5. Were the activities and outputs of the project consistent with the intended impacts and effects?
ACCPTABILITY AND APPROPRIATENESS
1. Was the intervention strategies and activities acceptable to the local community and stakeholders at the national and sub-national levels? Did they be willing to participate and engage? 2. Was the intervention approach appropriate to the local and national context in Cambodia especially the during COVID-19 pandemic? 3. What were the barriers and facilitators to beneficiaries participating in the intervention activities?
EQUITY & EQUALITY
1. Did the intervention have an impact on inequality or marginalization? 2. Was there evidence that the intervention reduces inequality and marginalization for specific groups? 3. What mechanisms or factors contributed to this result?
EFFECTIVENESS
1. To what extent were the knowledge, attitude, and practices of caregivers regarding responsive care and stimulation to their children 0-3 years old changed between baseline and endline and intervention and comparison groups? 2. Were caregivers' KAP associated with child development outcomes? 3. Measure changes in community understanding of practices towards integrated ECD. 4. What were the most effective intervention platforms for ECD? 5. Did the project achieve its intended results as spelled out in the Log frame? 6. Are there any differences in the results achieved by different groups? 7. Were there any unintended results?
EFFICIENCY
1. Were objectives achieved on time? 2. Were activities cost-efficient? (What was the cost of delivering outputs? How were cost drivers managed?) 3. Was the project implemented in the most efficient way compared to alternatives? 4. What are the associated costs for the intervention of ECCD at the commune level? 5. What were direct, indirect, and total costs of the intervention at the ground?

[37] Please note that these questions will be refined in the coming weeks to specifically respond to the project goal and activities.

6. How much did it cost for the implementation of caregiver session and cost per caregiver? Are these cost affordable by stakeholders at the national and local levels for the implementation of ECCD activities at the ground?
7. What could be the most efficient way for SCI to implement ECCD activities for children aged 0-3 years?

IMPACT

1. To what extent could the project improve child development outcomes based on CREDI scores including the attribution of changes?
2. Were there any differences in the results achieved by different groups?
3. Did the intervention strategies contribute to reaching higher level objectives at the impact level? Why/ why not?
4. What was the impact of the project in proportion to the overall situation of the target group or those effected?
5. What were the intended or unintended effects of the project, either positive or negative, direct or indirect?

SUSTAINABILITY

1. Are the positive effects or impacts sustainable?
2. To what extent are benefits of the intervention continue or are likely to continue?
3. How is the sustainability or permanence of the intervention and its effects to be assessed?

Replicability and Scalability

4. To what extent could be intervention strategies be replicated in other areas?
5. How could the intervention strategies be scaled up? And how much would it cost?

Additional Questions

- Did stakeholders find some of the SBCC materials to be more effective than others? Why or why not? (These included baby books, home posters, posters in handwashing stations, load speaker with tuk-tuks, bath towel, TV at health centre, big poster, and TV at commune hall)

- How effective were the videos that were developed? Why were they effective or not effective? Suggestions for making them more useful.

Save the Children

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