

The National Health Commission-UNICEF

**Formative evaluation of
the National Health Commission-UNICEF
Early Childhood Development Project of the Integrated Maternal and
Child Health and Development Programme (2017-2020)
Inception Report**

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Acronym

Acronym	Full name
CDC	Center for Disease Control and Prevention
COVID-19	Coronavirus disease of 2019
ECD	Early Childhood Development
MCH	Maternal and Child Health
MICS	Multiple Indicator Cluster Surveys
NCF	Nurturing Care Framework
NCWCH	National Centre for Women and Children's Health
NHC	National Health Commission
PI	Principle Investigator
PUHSC	Planning and Finance Department and Scientific Research Department
SDGs	Sustainable Development Goals
TOC	Theory of Change
TOR	Terms of Reference
UNEG	United Nations Evaluation Group
UNICEF	United Nations Children's Fund

1. Background

A growing body of evidence shows that early childhood is one of the most significant and influential phases of life - especially the first 1,000 days. It determines the basis for every child's future health, well-being, learning and earning potential, and sets the groundwork for young children's emotional security, and for developing competencies, resilience and adaptability. Intervening at this most critical stage of human development to provide to this group quality nurturing care is crucial to ensure a child's physical, cognitive, psychological and socio-emotional development. A poor start in life can lead to estimated losses of about a quarter of the average adult income per year, while countries may forfeit up to twice their current expenditures on health and education. A focus on early childhood development (ECD) brings clear benefits both to the individual and society, reducing health and economic problems that children can carry throughout their entire lives, and breaking the vicious cycle of intergenerational poverty, societal disparities and inequality of opportunities. The United Nations Convention on the Rights of the Child¹ explicitly spells out that child's health and well-being at the early age stage needs attention from all to ensure all children develop to their full potential, especially vulnerable and marginalized children.

Early childhood development (ECD) has received increasing attention from the international community. First, ECD related content is highlighted in the Sustainable Development Goals (SDGs), including targets on nutrition (SDG2.2), health (SDG3.2), education (SDG4.2), and protection (SDG16.2). Of these targets, SDG4.2 explicitly states that "By 2030, ensure that all girls and boys have access to quality early childhood development, care and preprimary education so that they are ready for primary education" ². Second, the UN's *Global Strategy for Women's, Children's and Adolescent's Health 2016-2030*³ envisions a world in which every woman, child and adolescent in every setting realizes their rights to physical and mental health and well-being, has social and economic opportunities, and is able to participate fully in shaping prosperous and sustainable societies. The Strategy spells out child's rights at the early age stage and conditions for child survival and development, mapping an integral framework and vision for early childhood development. Besides, *UNICEF's Programme Guidance for Early Childhood Development*⁴ also listed ECD as a key priority, stating that the goal for ECD is that all young children, especially the most vulnerable, from conception to age of school entry, achieve their developmental potential. On the one hand, all children should have equitable access to essential quality health, nutrition, protection and early learning services. On the other hand, parents and caregivers should be supported and engaged in nurturing care with their young children.

The Government of China paid high attention to the protection and promotion of children's rights and has achieved the Millennium Development Goal 4 of reducing the mortality rate among children under five by 2/3 between 1990 and 2015, eight years ahead of the schedule⁵, and the gap between urban and rural areas in child mortality rate is continuously narrowing⁶. With the decreasing child mortality rate and the improvement in children's living conditions, the Government's focus on child-related issues has transitioned from child survival to child development and wellbeing, especially ECD where there is much room for improvement. In recent years, the Government has gradually advanced the ECD agenda in China through overarching policy design, refinement of laws and regulations, and issuance of policies. For instance, in the recently concluded session of the Central Economic Working Conference⁷ in December 2018, ECD in poverty stricken rural areas was identified as one of the priority areas for economic development and poverty alleviation in China. The Central Government has committed to increasing investment in ECD, especially in disadvantaged areas.

Currently there are still many children in China not realizing their full development potential. China is home to 17 million children under five years old who are denied the opportunity to develop to their full potential due to a number of risk factors, such as child poverty, malnutrition, lack of psychosocial stimulation, and poor parenting practices, ranking second globally according to the 2016 Lancet ECD series⁸ (find additional facts under "Findings from project baseline survey" in section 2 on project description).

The Government has gradually advanced the ECD agenda in China through overarching policy design, refinement of laws and regulations, and issuance of policies. At the World Summit for Children in 1990, the heads of state and government of countries including China, signed the Convention on the Rights of the Child¹ and the World Declaration on the Survival, Protection and Development of Children¹², and pledged to pay close attention to children's health and development, in order to allow all children to achieve their full potential. According to the goals put forward by the conference and the national situation, in 1992, the State Council officially promulgated and implemented the China National Programme for Child Development for the 1990s¹³, China's first child-centered national action plan to promote child development. Since then, China has subsequently promulgated and implemented the National Programme for Child Development (2011-2020)¹⁴, the Healthy China 2030 Initiative¹⁵ etc. Prior to 2010, a majority of policy documents issued by the government focused on child survival. With the continuous decline of the child mortality rate in China, ECD has gradually gained the attention and become the focus of the government's agenda since 2010. Key government documents released since 2010 are presented in Table 1.

Table 1. Description of ECD in relevant government policy documents

Date	Document	Description
August 2011	National Programme for Child Development (2011-2020) ¹⁴	<p>Promote comprehensive ECD for children aged 0-3. Actively provide nurturing care guidance to parents of children aged 0-3. Actively establish affordable guiding institutes on integrated ECD services. Relying on kindergartens and communities, provide early care and education guidance for children aged 0-3 years and their families. Accelerate the training of professionals in early childhood education of children aged 0-3.</p> <p>Strengthen child health services and management. Promote the standardized establishment of children's medical and health departments, and provide services such as newborn care, growth and developmental monitoring, nutrition and feeding guidance, early comprehensive development, and assessment and counselling for psychological and behavioural development. Gradually expand the services on child health in the national basic public health service system.</p>
June 2012	The 12 th Five Year Plan for National Education Development ¹⁶	Strengthen scientific research on pre-primary education, and promote the integration of pre-primary and family education. Relying on kindergartens and the use of multiple channels, actively carry out affordable early childhood education and care for children aged 0-3.
December 2014	Child Development Plan in National Poverty Areas (2014-2020) ¹⁷	Relying on kindergartens and teaching support posts, provide early care and education guidance services for children aged 0-3 and their families.
October 2016	Healthy China 2030 Initiative ¹⁵	Implement the Healthy Children Plan, strengthen ECD, improve the establish of paediatric departments, increase the prevention and treatment of major childhood diseases, expand the screening of diseases of the newborn, and continue to carry out child nutrition and other projects in key areas.
February 2017	National Standards for Basic Public Health Services (Third Edition) ¹⁸	Standardization of health management services for children aged 0-6. The service content of each appointment includes asking about food intake and illnesses between this follow-up and the last follow-up, physical examination and evaluation of mental

Date	Document	Description
		and behavioral development, routine blood (or hemoglobin) test and vision screening, and provide health guidance on areas such as diet, growth and development, disease prevention, injury prevention and oral health.
April 2018	Healthy Children Action Plan (2018-2020) ¹⁹	Put forward ECD actions, strengthen the conceptualization of ECD, standardize ECD services and promote equitable access to ECD services.
April 2019	Guiding Opinions of the General Office of the State Council on Promoting the Child Care Services for Children aged 0-3 ²⁰	Establish and improve policies, regulations, standards, and service systems that promote the development of child care services, fully mobilize the enthusiasm of social forces, develop different types of child care services, gradually meet the public needs for child care services, and promote healthy growth of infants and young children, ensure families are harmonious and happy, and promote the sustainable economic and social development.
August 2019	The Pilot Work Plan for Early Childhood Development in Rural Areas ²¹	Explore the service model and content of ECD in rural areas of the country, popularize scientific ECD knowledge and skills in nurturing care, improve the health and development of children 0-3 years, and improve the quality of the population.
August 2019	Service Standards for Early Childhood Development in Rural Areas (Trial) ²²	Focusing on ECD of rural children is conducive to promoting the comprehensive development of children in poverty-stricken areas and eliminating the transmission of intergenerational poverty.

Based on the documents related to ECD outlined above, the following key points can be summarized:

China's child health and development service system continues to expand. The national basic public health service project has been implemented since 2009. The per capita subsidies for basic public health service packages have increased year by year, from RMB 15 per capita initially to RMB 74 per capita by 2020. Free basic health services are provided to children, including the creation of health record, health education, immunization, and health management system for children aged 0-6. The central government provides direct funding support, and local governments at all levels arrange additional subsidies to effectively ensure the healthy growth of children. The implementation of the national basic public health service project has laid a solid foundation for promoting equitable ECD services in China.

The ECD intervention in China has been strengthened. NHC issued the Healthy Children

Action Plan (2018-2020)¹⁹ in April 2018 to clearly propose the development of a multi-disciplinary cooperation mechanism in obstetrics, paediatrics (including neonatology), women's health care, and child health care that are in line with the characteristics of ECD services, and the establishment of speciality departments for ECD. The Plan also proposed to use comprehensive interventions in nutrition and psychology for pregnant women, management of children at risks, child growth and development, child nutrition, and child psychology, etc. to ensure children develop to their full potential and promote children's overall physical, psychological, cognitive, and social emotional development.

ECD services in China continued to be standardized. The Healthy Children Action Plan (2018-2020)¹⁹ issued by NHC further emphasized the need to strengthen the development of ECD demonstration sites, innovate service models, standardize institutional management, allow the demonstration sites to play a leading role in ECD promotion, promote and standardize ECD services, provide ECD technical training, and improve service capacity and technical skills of grassroots service providers. The ECD services within the health system have been further strengthened and standardized in recent years.

Equitable development of ECD services has been promoted. The early stage results of the ECD pilot project prompted NHC to issue the Service Standards for Rural Early Childhood Development (Trial)²² and the Pilot Work Plan on Rural Early Childhood Development²¹ in 2019, clearly emphasizing the need to further explore the model and content of ECD services for rural children, popularize scientific ECD knowledge and skills in child care, improve the health and development of children aged 0-3 years, and improve the quality of the population. Moreover, it emphasizes the need to further promote the comprehensive development of children in poverty-stricken areas and prevent intergenerational transmission of poverty. With the support of the national basic public health service project, the equitable development of ECD services will continue to be promoted.

At the same time, ECD services for children in China still face many challenges, especially for children under age 3. There is a shortage of government-led public ECD resources, especially in resource-limited settings. In poor rural areas, “how”, “who”, “at what frequency” and at “what cost” to implement programmes still remain elusive and challenging. In addition, the number of independently established ECD service institutions either through the education sector, the health sector or private enterprises are limited, and their quality still needs to be improved. In many of these settings, responsive caregiving, one of the most fundamental elements for optimal child development is not adequately addressed, and the

quality of services are far from standard. A vast number of families still find it hard to receive scientific and adequate guidance on children development in an easy and timely manner.

In response to the renewed global agenda on ECD, the Government of China's attention, and the unresolved problems and challenges to be addressed in ECD, the *Country Programme Document (2016-2020) of the Government of China and UNICEF*⁹ explicitly listed ECD as a prioritized area of cooperation in the programme cycle.

2. Project description

UNICEF China in collaboration with the National Health Commission (NHC) launched the ECD project in June 2017. The implementation period was set as four years (2017-2020)¹⁰.

The ECD project is being implemented in 781 villages of 61 selected townships in rural areas of 14 counties (districts) of five provinces (Hebei, Shanxi, Henan, Jiangxi and Guizhou) in Central and Western China. The total population of the project villages is about 746,200



Figure 1. Geographic distribution of ECD project

(20% of the total population in the pilot counties), with an estimated 30,000 children aged 0-3 years old to be covered, as well as around 1,000 ECD service providers.

The project aims to contribute to two outcomes: (1) A costed, feasible and scalable ECD model established for children under three years old to promote quality nurturing care practices and services; (2) ECD essential services and model embedded into existing government health systems for scale-up, in terms of HR, financing, supplies, and local incentives to prevent every child from compromised development and help them achieve their full potential.

Before the initiation of the ECD project, a baseline survey was conducted in three counties of the project provinces (find details in Table 3) to understand: (1) the early developmental status of children under three years old, (2) the knowledge, behaviors and service utilization of caregivers, (3) the service capacity of providers at county, township, and village levels, and

(4) the evidence for setting the project priorities and establish a baseline for the final project assessment.

Key issues identified in child growth and development in surveyed poor areas included: the prevalence of anaemia among children 6-59 months at 36.5%, the proportion of children under five with suspected development delay reaching 28%, and 27.8% of children identified to have social and emotional problems. In addition, the nurturing care practices were far from enough to secure the healthy development of children. For example:

- ✓ The micronutrient supplementation (Ying Yang Bao) only covered 24.5% of children aged 6-23 months. The rates of exclusive breastfeeding among children younger than 6 months was still low, at around one-fifth. In terms of complementary feeding, only 30% of children in project sites reached the minimum acceptable diet.
- ✓ Still, 23% of children under three did not receive any early stimulation and responsive care in the past three days. Father's participation in early learning was very limited, at 14.6%. Around 59% of children did not have at least three picture books and 20% of families did not have at least two toys. 75% of caregivers performed violent discipline in project villages, indicating appropriate counselling, support and guidance for the family was required.

Based on the findings from the baseline, the ECD project is working towards three outputs:

OUTPUT 1- Enhanced national, local and institutional capacity for evidence-based, quality ECD project design and implementation, especially for rural or remote areas, contributing to the development of national policies, strategies, and programmes on ECD.

OUTPUT 2- By 2020, 80% of pilot villages equipped with the applicable trained work forces to deliver quality ECD services to families and children via multiple delivery channels including clinics, care groups and home visits to enhance nurturing care covering health, nutrition, responsive caregiving, early learning and stimulation.

OUTPUT 3- Households, community leaders and ECD service providers engaged and mobilized, and the literacy, skills and behaviours of the most disadvantaged children under 3 years old and their caregivers improved to access and use ECD services with at least 70% of eligible children and caregivers reached by ECD services via multiple delivery channels by 2020.

Stakeholders of the project include: (1) Project primary beneficiaries: caregivers and children under three years old; (2) Project secondary beneficiaries: family members of children under three years old or pregnant women; community members; (3) Project tertiary beneficiaries: health providers and project managers (village, township, county, prefectural

and provincial levels), ECD workers at community level; (4) Project partners at national and local levels including NHC, National Centre for Women and Children's Health (NCWCH), the National Consultation Experts team, and the subnational health commissions.

To achieve the expected results, the NHC, as the leading agency in the national child health services, is responsible for overall guidance on national policies, overall project planning, organization, management and supervision, as well as investment in human resources, venues, funding support to the national basic public health services in which the project is embedded within, and future scale-up of the costed, feasible and scalable ECD model in China, particularly in resource-limited areas.

The NCWCH under the China Center of Disease Control and Prevention, the key national technical institute coordinating the National Consultation Experts team, is assigned by the NHC to implement the project, including the development of technical guidelines and toolkits on ECD to standardize the operation and service provision; introduction and implementation of project-developed materials through capacity building and technical support to the local implementation partners in order to improve the knowledge, attitudes and skills of ECD service providers; and strengthen project monitoring and funds management.

UNICEF, as an international organization particularly focusing on children in need, has extensive practical experiences in ECD. Aligned with UNICEF's global ECD-related policy and technical documents, the key role of UNICEF China is to support the NHC and other relevant national technical institutes on standards, guidelines, toolkits, training package development and testing in relation to ECD, carry out capacity building, and develop an effective monitoring, evaluation and quality assurance system to ensure the quality of ECD care. The project experiences and results not only contribute to strengthening ECD services and related policies, standards, regulations and the monitoring and evaluation system in China, but also provide added value to global lessons and approaches on ECD that other developing countries can learn from.

3. Progress of the inception report

The ECD project has commissioned an evaluation team composed of members from the School of Public Health of Peking University and Renmin University to conduct the formative evaluation of the project. Term of Reference (ToR) for this evaluation is attached as Annex 1 for ease of reference.

The objective of this inception report is to outline the framework and design of the formative evaluation to facilitate discussion between NHC, UNICEF, the reference group and

other stakeholders, and ensure mutual understanding of the evaluation team's methodology, workplan and timeline for conducting the evaluation. The inception report includes the following sections: background; project description; progress of the inception report; conceptual framework; draft theory of change; evaluation purpose, objectives and scope; deviations of evaluation questions from the Terms of Reference (TOR); evaluation criteria and questions; evaluation methodology; ethical considerations; time arrangement; and evaluation team.

The progress of the inception stage is as follows:

1. Project commencement: the evaluation team discussed the evaluation plan with relevant programme officers from UNICEF China and national level experts.
2. Desk review: this component was conducted to understand ECD related concepts and its progress globally, learn about the evaluation status of ECD projects in other countries and regions, review child health and child development strategies and related policies in China, and examine ECD related projects in China.
3. Determining the availability and sources of data for evaluation: the evaluation team communicated with UNICEF China and NCWCH of China CDC to understand the status of the monitoring data of the ECD project. Accordingly, the evaluation team determined what data can be obtained using the existing monitoring data and what can be obtained through field visits. Prioritized questions for the evaluation and whether they can be adequately answered were also identified. Subsequently, a data collection plan was developed.
4. Understanding the management and implementation of the ECD project: interviews with officials from the NHC were conducted to understand the main responsibilities and management mechanisms of it as the leading government agency in the project. Interviews with officials from the NCWCH of China CDC were conducted to understand its main responsibilities, project operation, supervision and guidance mechanisms as the leading national level technical agency. Interviews with national level experts were conducted to understand the development and training of relevant technical guidelines during the project implementation. These information improved the evaluation team's understanding of the overall operation and management of the ECD project and provided the basis for formulating interview outlines and the work plans for field visits.
5. Further consultation and drafting the evaluation inception report: the evaluation team carried out additional discussions with relevant UNICEF programme officers and stakeholders of the ECD project, revised the evaluation matrix and interview outlines (find details in Annex

2 and Annex 7.1), further clarified the specific definitions of key terms in the TOR (find details in Annex 4), and clarified the service content, delivery channels, service providers and service frequency of the ECD project. UNICEF accordingly provided a revised version of Annex 2 in the TOR (find details in Annex 5 of this inception report).

6. Inception report validation workshop: project officials from NHC and the NCWCH of the China CDC, and relevant UNICEF programme officers were invited to discuss about the scientific basis and the feasibility of the evaluation plan and evaluation tools, in order to provide support to the development of the field visit work plan and detailed implementation guidelines. After the workshop, the evaluation team revised the inception report accordingly.

The inception report reflects the evaluation framework and methodology to be adopted by the evaluation team and will be finalized after receiving feedback from the reference group.

4. Conceptual framework of ECD project design

The Nurturing Care Framework²³ identified the 5 components of nurturing care that helps the child achieve developmental potential: good health, adequate nutrition, responsive caregiving, opportunities for early learning, and safety and security. Nurturing children means keeping children safe, healthy and well nourished, attending and responding to their needs and interests, encouraging them to explore their environment and interact with caregivers and others. The Framework provides strategic directions for supporting the holistic development of children from pregnancy up to age 3. It aims to inspire multiple sectors – including health, nutrition, education, finance, water and sanitation, and social and child protection – to work in new ways to address the needs of the youngest children.

Young child's good health is the result of caregivers monitoring children's physical and emotional condition, giving affectionate and appropriate responses to children's daily needs, protecting young children from household and environmental dangers, having hygiene practices which minimize infections, using promotive and preventive health services, and seeking care and appropriate treatment for children's illnesses. Young child's adequate nutrition depends much on the mother's nutrition during pregnancy, breastfeeding after birth, complementary feeding, micronutrient supplements, growth monitoring, and health promotion. Responsive caregiving includes observing and responding to children's movements, sounds and gestures and verbal requests. Relevant services and interventions of responsive caregiving include skin-to-skin contact immediately after birth, kangaroo care for low-birthweight babies, responsive feeding, interventions that encourage play and communication activities of caregiver with the child, support for caregivers' mental health, involving fathers, extended family and other partners, etc. Opportunities for early learning

contain information, support and counselling about opportunities for early learning, including the use of common household objects and home-made toys, book sharing, good-quality day care for children, and pre-primary education, storytelling of elders with children, use local language in children’s daily care, etc. Security and safety include birth registration, provision of safe water and sanitation, good hygiene practices - at home, at work and in the community, prevention and reduction of indoor and outdoor air pollution, clean environments free of hazardous chemicals, safe family and play spaces, prevention of violence by intimate partners and in families, etc.

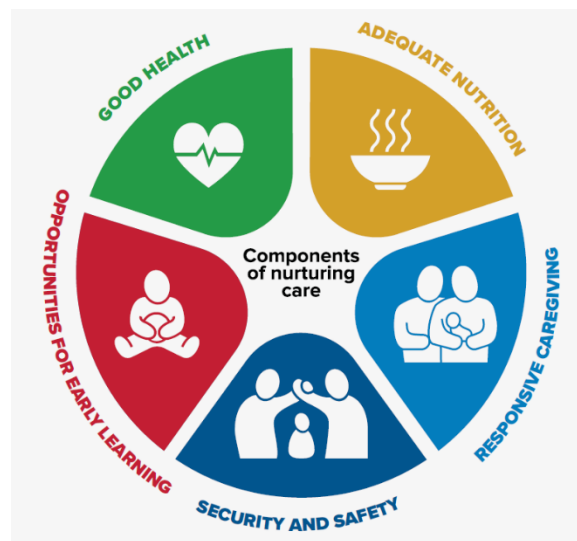


Figure 2. Five components of the Nurturing Care Framework

Following the global Nurturing Care Framework²³, the ECD project adopted a systematic approach to provide information and resources that is appropriate for the child’s age, developmental stages, and the family’s circumstances. The project aims at reducing or mitigating the damaging effects of risk factors and advance the healthy development of children aged 0-3 years old through parental guidance and support focused on improving responsive caregiving, early learning, and early detection of developmental delays or disabilities, as well as referral for additional support and interventions through the health system. In addition, the project supports overall strengthening of the health system including human resource capacity, project monitoring and coordination.

The Nurturing Care Framework defines three levels of support for meeting families’ and children’s needs depending on the challenges they face at different points: universal, targeted and indicated.

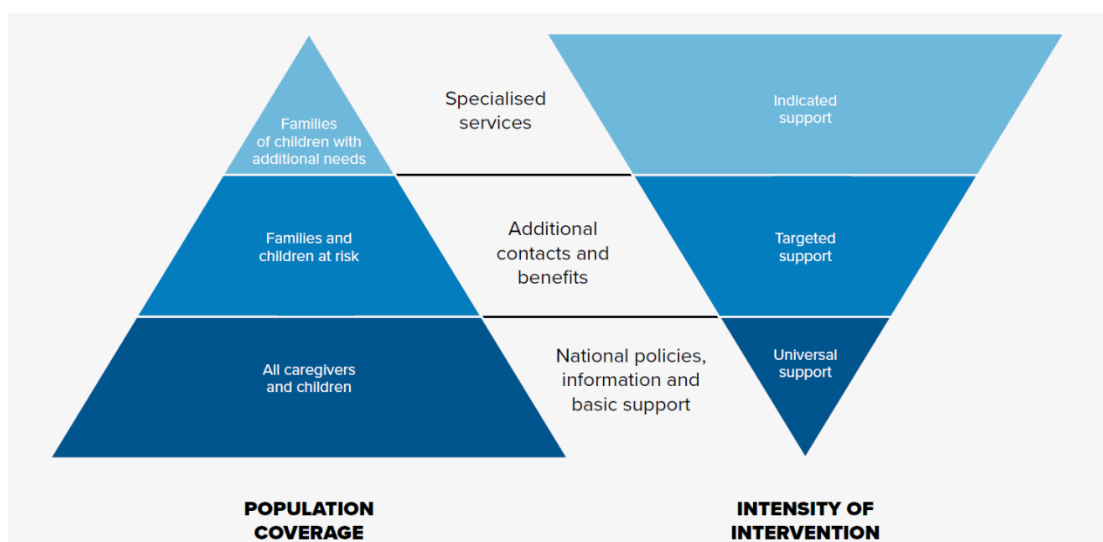


Figure3. Three levels of support

Universal support is for every child, through health promotion and primary prevention. Interventions are selected that benefit all children and ensure that developmental delays or problems are less likely. And when issues emerge, universal support identifies them early and refers caregivers and children to additional services.

Targeted support is designed for individuals who are at risk of developmental delays because of factors such as preterm, low birth weight, undernutrition, and other poverty of socio- economic related risks. Level II interventions aim to reduce the damaging effects of early life risk and strengthen caregiver and household capacity to address and cope with the additional needs of caregiving. Families and caregivers are provided additional services with home visits, and through contact with trained providers, either volunteers or paid workers.

Indicated support is designed for individual families or children who have additional needs. They include young children without caregivers, or with depressed mothers or violent homes, as well as children whose birthweight was very low, or who have disabilities, developmental difficulties or severe malnutrition. These children and families need extra services and assistance based on their identified needs.

The services at three levels work together, forming a seamless continuum of care. It should be noted that the current project mainly focuses on the first two levels.

5. Draft Theory of Change

According to draft Theory of Change (TOC) in the TOR, bottlenecks of ECD in China include: shortage of public ECD funding, lack of a standard service model, limited channels of existing ECD services and insufficient contact, quality of services far from standard, responsive

caregiving not adequately addressed, family not sufficiently supported due to lack of resources, scientific knowledge and methods.

At the national level, the NHC and UNICEF has implemented the Integrated Maternal and Child Health and Development Programme in the 2011-2015 cycle and has formed a relatively standardized and systemic integrated maternal and child health service model; From 2013 to 2016 the Integrated ECD Pilot Project for Poverty Areas was rolled out as a multisectoral collaboration endeavor, exploring an integrated ECD model that fits the situation of poverty areas. These pilot projects have provided precious experiences for the design of the ECD project in this programme cycle.

Based on the global Nurturing Care Framework, national progress on ECD, and bottlenecks identified above, the ECD project identified the following strategies (interventions and activities) to achieve three outputs and two outcomes (find details in section 2 on project description): advocate for government's increased awareness of the importance of ECD and investment; develop technical guidance, material and toolkits and carrying out training and capacity building; implement interventions through 3 delivery channels of village clinics, care groups, and home visits, targeting child health, nutrition, responsive care, early learning, and security. Project interventions are implemented at the multiple levels of country, subnational government, community, service institution, and family.

At the national level: first, advocate at all levels of governments for increased understanding of the importance of ECD among policy makers, and incentivize bigger investment in ECD and stronger policy commitment; second, facilitate the implementation of essential ECD interventions by formulating technical guidance or recommendations; third, organize national level expert team to provide technical support through technical training, supervision and guidance, etc.

At the subnational level: identify the local practical needs, formulate and implement measures promoting ECD interventions, including policies, services, protocols, and standards; establish and operationalize the government-led, multisectoral collaboration mechanism; explore and practice methods and channels for improving the utilization and quality of ECD services, and provide integrated ECD services that is standard, of good quality, people-oriented, and based on the full lifecycle approach; carry out regular monitoring and supervision, and improve service system and management mechanism.

At the community level: advocate for community leaders' support for ECD work through health promotion and social mobilization; improve the capacity of community workers in

providing ECD services through training and secondment to higher level facilities; carry out quality ECD services via multiple channels including village clinics, care group activities, and home visits.

At the service institution level: strengthen the institution's capacity in service delivery, supervision and management through training and further study.

At the family level: incentivize caregivers of children under three to proactively participate in ECD related activities; enhance the knowledge, skills, and behaviors of caregivers through health education, care group activities, etc.

The assumptions of the ECD project include:

- 1) The government continues to support ECD, and the local governments and communities are willing to support project implementation, building an enabling environment.
- 2) The relevant technical material/tools meet the needs of the target groups and could be adapted and applied in project areas.
- 3) Service providers, after trained, apply ECD related knowledge and skills in actual service provision.
- 4) Families and caregivers of children apply nurturing care knowledge learnt in child care.

This evaluation will validate the TOC. If necessary, the TOC will be reconstructed based on the evaluation findings to better illustrate how to apply and advocate for the ECD model in poverty areas under the current national/subnational situation and new social and policy changes.

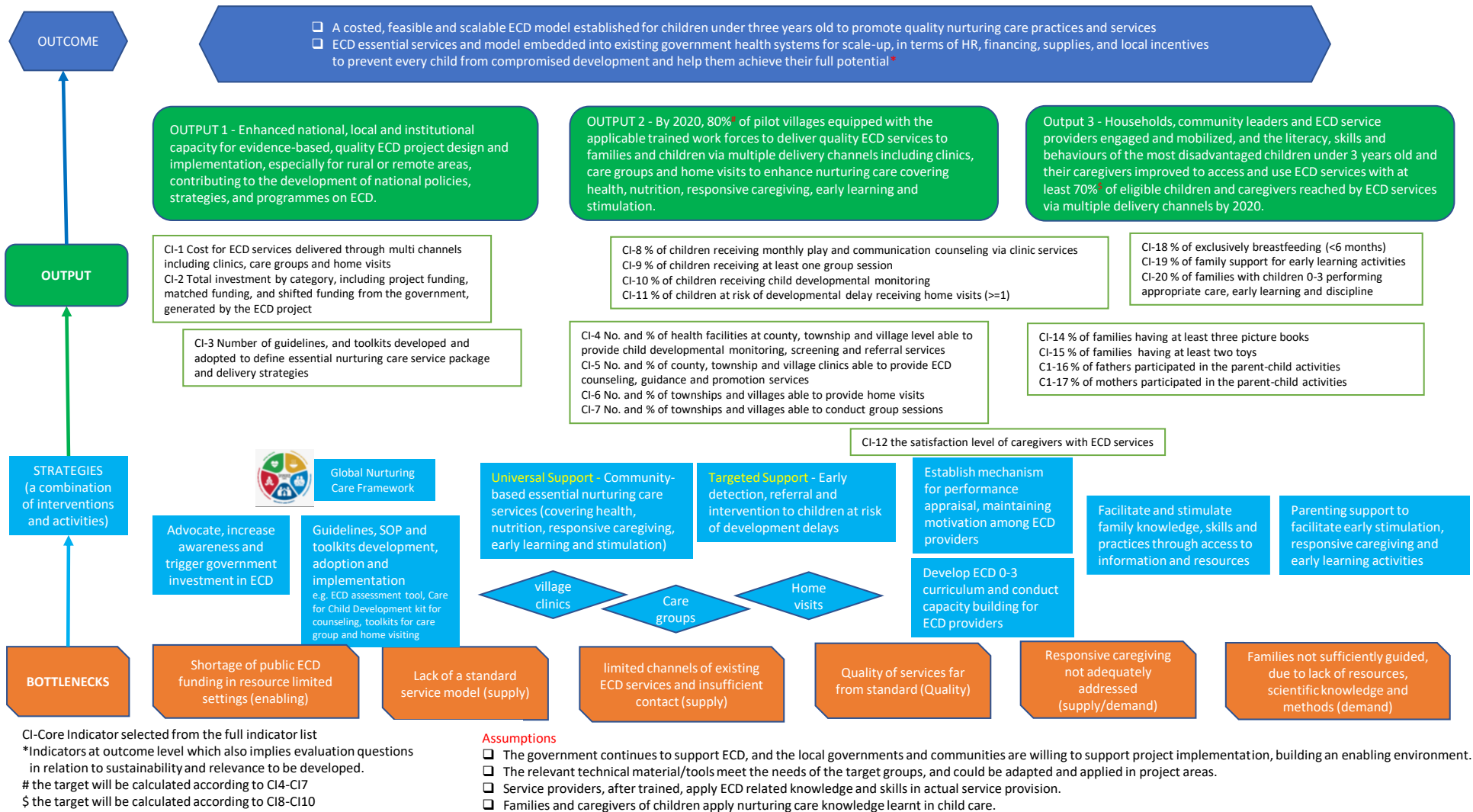


Figure 4. Draft Theory of Change

6. Evaluation purpose, objectives and scope

The year of 2020 is the concluding year of the ECD project (2017-2020). The formative evaluation will be used to verify whether the project targets have been achieved, demonstrate the project's outputs and effect, summarize and disseminate experiences and good practices, and identify challenges and bottlenecks, all of which will inform the next phase of the ECD project (2021-2025). At the same time, the year of 2020 is also the concluding year of the China National Program for Child Development (2011-2015) and the 13th Five Year Plan for Economic and Social Development, as well as the beginning year of the formulation of the next round of these two crucial national policy relevant to children. Against such background, the evaluation on the ECD project has the significant purpose of exploring how to integrate the ECD model into the National Basic Public Health Services System, and echoing the Government's reform and adjustment in the ECD area such as service assurance reinforcement, service content expansion, service provision standardization, etc.

6.1 Purpose and objectives

According to the TOR, the purpose of evaluation on the ECD project is to document results of the ECD project, explore the process of change among households and service providers to establish what works, what doesn't, and why.

The objective of the evaluation is to determine the relevance of the ECD project, its effectiveness in reaching its expected results and its potential to be sustainable. Specifically, the objectives are:

- ✓ Validate the Theory of Change and establish its alignment with current project interventions;
- ✓ Identify gaps in evidence and project delivery, and seek to outline the process of change that is underway in project areas;
- ✓ Identify policy and implementation challenges, emerging best practices and adaptations;
- ✓ Understand project progress and document results through answering evaluation questions mainly on relevance, effectiveness and sustainability;
- ✓ Costing analysis to understand key cost components for ECD package delivery.

The users of the evaluation include:

- ✓ Primary user: project partners at national and local levels, technical agencies and ECD services delivery institutions, project primary and tertiary beneficiaries, and UNICEF;
- ✓ Secondary user: other ministries and academic institutes working on ECD, project secondary beneficiaries;
- ✓ Other audiences: other UN agencies, NGOs, private institutions related to ECD.

All the stakeholders will be contacted for data collection and/or consultations (e.g. to validate the ToC as mentioned above). Key findings and recommendations of the evaluation will also be shared with them for verification and/or sharing as relevant.

The intended use of the evaluation is:

- ✓ Contribute to the development of a costed, feasible and scalable ECD model that can bring changes for children 0-3 years old in China, particularly in resource-limited areas, including rural poor areas;

- ✓ Determine the economic and policy environment for national scale-up based on the evaluation findings and policy recommendations on drivers and bottlenecks of the project;
- ✓ Deliver the evaluation findings and policy recommendations to decision makers of governments, and explore possible ways of integrating the ECD model into the National Basic Public Health Services System;
- ✓ Submit the evaluation findings and policy recommendations to NHC and UNICEF China to strengthen support to the Government of China on developing ECD policies, plans, and projects.

6.2 Scope

The time frame of the evaluation is from the launch of the ECD project (July 2017) to December 2020.

The analysis will cover 14 project counties in 5 provinces, spanning 5 administrative levels of country, province, county, township (town), and village. All project sites are in the rural area.

Considering the evaluation's stated objectives, feasibility as per given the resources and time as well as the implementation status of different project areas, five out of the 14 project counties are sampled for the quantitative survey and the costing analysis. For two project counties which have baseline, the same non-project counties selected at the baseline are used for comparison. For the rest three sampled project counties, the non-project townships within the respective project county serve as the comparison. Besides, the qualitative inquiry will be carried out in three out of the five counties selected. For details of selected counties and sampling selection of each stage within county, see 9.1 Selection of evaluation sites.

Based on TOR and the three outputs, the content of the evaluation spans from the levels of support, delivery channels, service recipients, service providers, service content, and service frequency (find details in Annex 5). What is worthy to note is that the global Nurturing Care Framework laid out the intervention and services for the five components including good health, adequate nutrition, responsive caregiving, opportunities for early learning, and safety and security. According to the project document, the evaluation will mainly cover the interventions related to health, nutrition, responsive caregiving, and some elements related to early learning and social security and safety. Specifically, the evaluation will cover child growth and developmental monitoring, infant and young child feeding counseling, ECD risks assessment/counseling, health promotion, parenting information sharing, parent-child interaction. It will not cover the infant health care, childhood disease management, maternal nutrition and health care, and psychosocial support for caregivers, as well as sanitation facilities, clean environment and other social protection and service interventions. In terms of the intervention intensity, the Nurturing Care Framework laid out three levels of support: universal support, targeted support and indicated support. This evaluation will only focus on the first two levels of support, i.e. universal support and the indicated support.

Limited by the evaluation terms of reference, available resource, and data (information) accessibility, impact was not covered as an evaluation criterion. The evaluation does not cover questions on cost-effectiveness.

7. Deviations of evaluation questions from the TOR

During rounds of communication with UNICEF at the inception stage, the evaluation questions got further clarified. The evaluation questions before and after the adjustment are as follows:

Table 2. Comparison of evaluation questions before and after adjustment

Original	Adjusted	Rationale for adjustment
Relevance		
1. How relevant is the project to national and sub-national government priorities?	1. How relevant is the UNICEF-supported Early Childhood Development (ECD) 0-3 project to national and sub-national government policy priorities?	Question adjusted to be clearer, exact, and focused.
	2.To what extent does the ECD project, conducted through the health system, in particular the Maternal and Child Health (MCH) system, accommodate the global recommendations of the Nurturing Care Framework (NCF)?	New question moved from the effectiveness part because it fits relevance criterion better.
2. How is the project design still valid compared with the current change of government policies? And how can UNICEF leverage resources in this changing context?		The part of “leverage resources” was deleted because it was considered not the focus of the question. The part of “How is the project design still valid compared with the current change of government policies?” was integrated into the third question in the relevance part. Question adjusted to be clearer, exact and focused.
3.To what extent are the project design, strategies and implementation still appropriate and valid to meet the needs of the different segments of the target groups in the settings where the project operates?	3.To what extent the ECD project design, strategies, and implementation were relevant onset and are still appropriate and valid to meet the needs of the different segments of the target groups in the project areas?	Question adjusted to fit relevance criterion better, emphasizing the differential needs of different target groups.
Effectiveness		
1. To what extent do the set of services implemented under this project through the health sector accommodate the recommended service package under the global ECD nurturing care framework?	Removed to relevance part.	The question examines the linkage between the project design with global ECD policies. It fits the relevance criterion better.
2. To what extent did the project design stratify the needs of different segments of the population?	Removed and combined with question 4 of relevance.	The question looks at different needs of targets groups and fit the relevance criterion better.
3. What are the variations in implementation and quality of the	2.What are the major differences in project implementation among the project areas, and to what extent	The original two questions (3 and 4) were combined.

Original	Adjusted	Rationale for adjustment
<p>interventions? What works, what doesn't, and why?</p> <p>4. Do the implementation strategies and use of different platforms (clinics, care groups and home visits) contribute to the equity of ECD covering especially disadvantaged groups (e.g., those in remote areas, experiencing cultural or language barriers, etc.)?</p>	<p>was equity reflected during project implementation?</p>	
<p>5. To what extent did the ECD project of the IMCHD programme achieve its intended objectives at output level?</p> <p>6. What were the major factors (barriers and bottlenecks) influencing the achievement or non-achievement of the results? To what extent have the barriers/bottlenecks been reduced?</p>	<p>1.To what extent did the ECD project achieve its intended objectives at the output level?</p>	<p>Original question 6 has been incorporated by question 5. The two questions were combined into one for clearance.</p>
<p>7. To what extent have UNICEF and its partners contributed to improving community, local and sub-national capacities on promoting and implementing ECD services?</p>	<p>Deleted</p>	<p>Original question 7 was considered no longer an essential question and was deleted.</p>
Sustainability		
<p>1. What components of the current model are likely to be sustainable and scalable? Can this ECD model be embedded into existing government health systems for scaling-up, in terms of HR, financing, supplies, and local incentives?</p> <p>2. What are the perceptions of scale and sustainability among key stakeholders (health care providers, care givers) and regarding the ECD package?</p>	<p>1. How is the sustainability considered and achieved via project design, implementation and exit strategy?</p>	<p>Original question 2 is incorporated into question 1 for clearance.</p>
<p>3. What are the key cost components that are essential for delivering ECD project at scale? What should the cost allocation be to ensure that all children are able to access ECD services? Are there other cost considerations for efficiency and effectiveness?</p>	<p>2. What are the cost considerations for scaling up the ECD project at different levels?</p>	<p>Original question 3 was adjusted to be clear and concise.</p>
<p>4. What policy, managerial and financial changes are needed to sustain and scale this package of services?</p>	<p>3. What policy, managerial and financial changes are needed to integrate the ECD project into the National Essential Public Health Services System?</p>	<p>Original question was adjusted to be clear, concise, and targeted. The adjusted question now focuses on the integration of the ECD model into the National Essential Public Health System.</p>

8. Evaluation criteria and questions

The evaluation will be guided by the UNICEF's revised Evaluation Policy (2018)²⁴, the Norms and Standards (2016)²⁵ of the United Nations Evaluation Group (UNEG), UN SWAP Evaluation Performance Indicator²⁶, the UNEG Guidance on Integrating Human Rights and Gender Equality in Evaluation (2014)²⁷, UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis (2015)²⁸, and UNICEF-Adapted UNEG Evaluation Report Standards (2017)²⁹.

Considering the evaluation objectives, priority, and usefulness, the evaluation will focus on three evaluation criteria of OECD-DAC: *relevance*, *effectiveness* and *sustainability*. Specific evaluation questions are presented below.

Relevance

- How relevant is the UNICEF-supported Early Childhood Development (ECD) 0-3 project to national and sub-national government policy priorities?
- To what extent does the ECD project, conducted through the health system, in particular the Maternal and Child Health (MCH) system, accommodate the global recommendations of the Nurturing Care Framework (NCF)?
- To what extent the ECD project design, strategies, and implementation were relevant onset and are still appropriate and valid to meet the needs of the different segments of the target groups in the project areas?

Effectiveness

- To what extent did the ECD project achieve its intended objectives at the output level?
- What are the major differences in project implementation among the project areas, and to what extent was equity reflected during project implementation?

Sustainability

- How is the sustainability considered and achieved via project design, implementation and exit strategy?
- What are the cost considerations for scaling up the ECD project at different levels?
- What policy, managerial and financial changes are needed to integrate the ECD project into the National Essential Public Health Services System?

For each evaluation question several sub-questions are designed, which is further linked to relevant indicators/areas of inquiry. Please find details in Annex 2 on evaluation matrix.

9. Evaluation methodology

The overall design of this formative evaluation will be theory-based and utilization-focused, using an applied mixed method approach including qualitative inquiry, quantitative survey and costing analysis. The data collection and analysis will consider gender sensitivity as much as possible. To be specific, the equal participation of male and female interviewees will be considered, and different perspectives of interviewees of different genders will be paid attention to. The interview outline of the

qualitative inquiry included gender-sensitive issues. Data collected will be analyzed through a gender lens.

9.1 Selection of evaluation sites

9.1.1 Site selection for the quantitative survey

The quantitative survey employs a mixture of non-probability sampling and the probability sampling. The sampling is of multiple stages. The purposive sampling is used at the first stage to select counties, and probability sampling is used for the subsequent stages within county.

9.1.1.1 Project county selection for the quantitative survey

The ECD project covers 14 counties of five provinces. Considering the overall time arrangement, limited budget and survey burden on local communities, and the need to capture differences across provinces, it is decided that one project county will be sampled from each province, or five project counties sampled in total.

Among the 14 counties, She County in Hebei Province, Wen County in Henan Province, and Yudu County in Jiangxi Province are the baseline counties from 2016. Due to the consideration of leveraging baseline data for comparison, these three project counties were tentatively selected.

The monitoring data of the ECD project show that all three counties selected above have relatively high warning sign screening rate among children under three (i.e. screening rate). Besides, She County in Hebei Province and Wen County in Henan Province also performed relatively well in the overall project implementation. It is decided that for the rest two provinces (Shanxi and Guizhou), counties that performed relatively poorly shall be chosen so that all counties selected will have a balanced distribution in the performance of ECD service provision. Therefore, Lin County in Shanxi Province and Songtao County in Guizhou Province are selected.

However, upon consultation with provincial Health Commission on the sampling plan, Yudu County of Jiangxi Province could not participate in the survey due to some special circumstances. The NHC suggested replacing Yudu County with Xingguo County, which has similar social and economic status and project implementation status of the ECD project. Therefore, the quantitative survey covers five project counties, namely: She County of Hebei Province, Wen County of Henan Province, Lin County of Shanxi Province, Xingguo County of Jiangxi Province, and Songtao County of Guizhou Province. Details could be found in Table 3.

9.1.1.2 Comparison group selection for the quantitative survey

In the two project counties of Hebei and Henan where the baseline was done, the same baseline comparison counties are kept, which are Zhouqu County in Handan City and Qinyang County in Jiaozuo City.

For the rest three counties where baseline data is not available (i.e. Lin County of Shanxi Province, Xingguo County of Jiangxi Province, and Songtao County of Guizhou Province), keeping comparability as much as possible, non-project townships within the project county would serve as the comparison groups. Details could be found in Table 3.

Table 3. Survey site selection

Project area	Project county	Baseline availability	Project implementation status	Screening rate (%)	Focused delivery channel	Qualitative inquiry county	Quantitative survey county	County as comparison group	Township as comparison group
East	Pingquan County		Poor	40.5	Village Clinics				
	She County	√	Good	97.9	ECD Care Group Activities	√	√	Quzhou County	
	Zanhuang County		Good	85.9	ECD Care Group Activities				
	Raoyang County		Poor	47.2	ECD Care Group Activities				
Central	Wen County	√	Good	97.0	ECD Care Group Activities /Village Clinics	√	√	Qinyang County	
	Song County		Good	83.0	ECD Care Group Activities /Home Visits				
	Lushan County		Good	85.0	Home Visits/ECD Care Group Activities				
	Fenxi County		Good	32.4	ECD Care Group Activities /Home Visits				
	Lin County		Poor	76.4	ECD Care Group Activities		√		√
	Yudu County	√	Poor	87.0	Home Visits				
	Xingguo County		Poor	66.7	Home Visits		√		√
	Hengfeng County		Good	89.3	ECD Care Group Activities				
West	Liping County		Good	85.3	Home Visits				
	Songtao County		Good	43.2	Home Visits/Village Clinics	√	√		√

9.1.2 Site selection for the qualitative inquiry

9.1.2.1 County selection for the qualitative inquiry

Three of the five project counties selected for the quantitative survey will be chosen for the qualitative inquiry, and the details are presented in Table 3. The selection of the counties has the following considerations: 1) the availability of baseline data to be used in data analysis and results interpretation. Two of the three counties selected have baseline data available (e.g. She County in Hebei Province and Wen County in Henan Province); 2) capacity for child health service provision, for which the overall project implementation status and the warning sign screening rate are used as indicators. Counties which had good service capacity (e.g. She County of Hebei Province and Wen County of Henan Province) are selected, allowing for summarization of project experiences and good practices. The counties with weak service capacity were also included (e.g. Songtao County in Guizhou Province) to identify bottlenecks and difficulties; 3) comprehensive consideration of the characteristics of the project counties in terms of delivery channels, geographic location, social and cultural environment, and ethnic composition. Three counties selected represent the eastern, central, and western region of China, spanning across mountainous, hilly, and plains areas with different delivery channels emphasized. Overall, the three counties selected represent different levels of development, demographic status, and ethnic characteristics.

9.1.2.2 Project village selection for the qualitative inquiry

The qualitative inquiry will be conducted at the five administrative levels: national, provincial, county, township(town), and village. Two townships (towns) will be selected in each county, and one village will be selected from each township (town). The qualitative inquiry therefore will be carried out in three project counties, six project townships (towns) and six project villages. Villages will be drawn from the list of villages already selected for the quantitative survey to ensure that the qualitative data can be triangulated and cross-validated with the quantitative survey results.

9.2 Survey subjects and sample size

9.2.1 Subject and sample size for the qualitative inquiry

The qualitative inquiry will consider all stakeholders and social groups (including eligible service recipients who did not participate in the project), especially children, parents/caregivers, community members, as well as decisionmakers at the central and local levels. At the same time, the evaluation will employ a human rights based approach, with considerations for ethics and gender equality. Both men and women are given equal opportunity to voice their opinions. The following qualitative methods will be used to collect information from relevant stakeholders and gather their views and opinions.

9.2.1.1 Desk review

Desk review will be conducted by collecting relevant documents, including policy documents, project annual summary reports, project progress reports and monitoring data. Specifically, it involves reviewing: 1) relevant documents of the ECD project; 2) the national policies, plans, programmes and reports relevant to the ECD project; 3) evaluation documents of similar projects implemented by UNICEF and other international organizations, and relevant global guidance documents; 4) baseline data and survey reports of the ECD project; and 5) monitoring data and reports of the ECD project.

9.2.1.2 Key informant interview

Semi-structured key informant interviews will be mainly conducted with government officials at the national, provincial, county and township level (including managers in charge), as well as programme officers of UNICEF, project managers, national level experts, and service providers, approximately including 26-37 interviewees. The basic information of the interviewees, including gender, will be reflected in the final list of interviewees.

Table 4. Key informant interview

Level	Project area/Institution	Role	Interview outline number	Number of interviewees	Total number of interviewees
National	Department of Maternal and Child Health and Department of Primary Health, NHC	Manager	7	2	9-13
	NCWCH of the China CDC	Manager		2-3	
	Experts in relevant areas	Manager		3-4	
	UNICEF	Manager		2-4	
	Other government sectors(education, poverty alleviation, finance, women’s federations, etc.) #	Manager		2-3	2-3
Provincial*	Hebei Provincial Health Commission	Manager	7	1	3
	Henan Provincial Health Commission	Manager		1	
	Guizhou Provincial Health Commission	Manager		1	
County*	She County of Handan City	Manager	6	1	6
		Service provider		1	
	Wen County of Jiaozuo City	Manager		1	
		Service provider		1	
	Songtao Miao Autonomous County of Tongren City	Manager		1	
		Service provider		1	
Township/ Village	3 counties cover 6 townships and 6 villages	Caregivers of children under three who did not receive or dropped out of the ECD project	2	6-12 (1-2 per township)	6-12

#Specific format of interviews for managers of other national level government sectors will depend on the situation. It is the best to have focus group discussions coordinated by the relevant department; if this is difficult, key informant interviews will be conducted with managers of different government sectors.

*Key informant interviews mainly involve managers in charge, such as deputy director in charge of provincial health commissions, deputy county mayors, and heads of the maternal and child health institutions.

9.2.1.3 Mini focus group discussion (2-3 participants)

The mini focus group discussion takes into consideration the characteristics of the Chinese

administrative system and the time limitation. It is a smaller focus group discussion targeting government officials, project managers, personnel in charge of service institutions, and community project personnel at the provincial, county, township (town) and village level. In-depth and detailed information will be collected, with around 18 mini focus group discussions planned.

Table 5. Mini focus group discussion (2-3 participants)

Level	Project area/Agency	Role	Interview outline number	Number of groups	Total number of groups
Provincial	Hebei Provincial Health Commission	Manager	7	1	3
	Henan Provincial Health Commission	Manager		1	
	Guizhou Provincial Health Commission	Manager		1	
County*	She County of Handan City	Manager	6	1	3
	Wen County of Jiaozuo City	Manager		1	
	Songtao Miao Autonomous County of Tongren City	Manager		1	
Township/ Village	3 counties cover 6 townships and 6 villages	Service provider/manager at the township level	4 or 5	6 (1 per township)	12
		Service provider/manager at the village level (organizers of home visits, ECD care group activities, etc.)	3	6 groups (1 per village)	

* Note: different from the key informant interview, managers at the provincial and county level mainly refer to the specific departments and personnel in charge of the ECD project, such as officials and project managers of the division of maternal and child health of provincial health commissions, and officials and project managers of the county health commissions in charge of maternal and child health.

9.2.1.4 Focus group discussion

Focus group discussions will mainly be organized for service providers (technical personnel) and service recipients to understand their views and opinions about the ECD project in a relatively broad and comprehensive manner, especially in terms of the effectiveness of the project. Approximately 15 focus group discussions are planned.

Table 6. Focus group discussion

Subject	Service type	Role	Interview outline number	Number of groups
Service provider	Service institutions at the county and township level	Service provider	4	3
Service recipient	—	Caregivers of children age 0-3 (mother if possible)	1	6

9.2.1.5 Observation

Non-participatory field observations of the facilities (e.g. village clinics, ECD centers/activity rooms) and the services delivered (e.g. ECD care group activities, home visits) will be conducted in the townships and villages selected for the qualitative inquiry. The observation will focus on: 1) universal support delivered through ECD care group activities (township/village level, 1 per township/village, 6 in total); 2) universal support delivered through village clinics (village level, 1 per village, 6 in total); 3) indicated support delivered through home visits, including services for preterm birth, low birthweight, anemia, malnutrition, and disability (village level, 1 per village, 6 in total).

9.2.2 Subjects and sample size for the quantitative survey

The quantitative survey will target children under three, service institutions, and service providers. Sample size needs to be separately calculated for children under three and service providers using the formula for two sample proportion comparison. Assuming the 1:1 allocation of sample size between the two comparison groups, the minimum sample size needed for each group in order to detect the indicated change is given as:

$$n = 2\bar{p}\bar{q}(Z_{\alpha/2} + Z_{\beta})^2 / (p_1 - p_0)^2, \quad \bar{p} = (p_1 + p_0) / 2, \quad \bar{q} = 1 - \bar{p}$$

In the formula P0 and P1 represents the proportions of the two groups for comparison, respectively.

Assume: $\alpha=0.05$ (two-sided), Power $(1-\beta) =0.8$.

9.2.2.1 Survey on caregivers of children under three

12 (CI8-CI20) of the key indicators listed in the TOR are about the nurturing care knowledge, practices and attitudes of caregivers. Data on these indicators will be collected through a household survey. After discussion, 8 indicators are selected and used for sample size calculation. The baseline values of these indicators are presented in column 2 of Table 7. The target increase rates (minimum detectable effect size), presented in column 3 of Table 7, come from the project document provided by the national level technical agency (the NCWCH of China CDC) for the ECD project. The minimum

sample size (sample 1) needed is calculated as 1428 for each group in order to have enough power to detect the indicated change for all 10 indicators, or a total of 2856 children.

Considering gender sensitivity, for indicators including CI10, CI16, and CI20, sample size is not big enough to detect difference between the project group and comparison group if limited to a single gender. This is one limitation of the evaluation.

Besides, sensitivity analysis on sample size calculation was done by adjusting the detectable effect size. Except for CI10, all indicators in the project’s document have the target increase rate set at 50%. Considering that the actual change might be smaller than what was expected, sample size was re-calculated by lowering the target increase rate to 20% and 30% to see if the original calculated sample size (sample 1) is appropriate. The calculation results are presented in column 5 and 6 of Table 7, respectively. Under 20% target increase rate, sample 1 is smaller than required for CI10, CI14, CI16, and CI20. Under 30%, sample 1 is smaller than required for CI16, but big enough for rest indicators. Considering the availability of funding, resources, and time, the originally calculated sample size (sample 1) is deemed as appropriate.

Table 7. Sample size calculation – children under three ^{*1}

Indicator	Baseline value ^{*2}	Target increase rate ^{*3}	Sample size	Sample size (target increase rate=20%)	Sample size (target increase rate=30%)
CI10: % of children receiving child developmental monitoring	25%	Increase by baseline’s 30%	1428:1428 (Sample 1)	3128:3128	1428:1428
CI14: % of families having at least three picture books	41%	Increase by baseline’s 50%	236:236	1443:1443	646:646
CI15: % of families having at least two toys	70%	Increase by baseline’s 50%	31:31	354:354	133:133
CI16: % of fathers participated in the parent-child activities	14.6%	Increase by baseline’s 50%	1098:1098	6204:6204	2858:2858
CI17: % of mothers participated in the parent-child activities	45%	Increase by baseline’s 50%	184:184	1211:1211	536:536
Minimum dietary diversity	63.9%	Increase by baseline’s 50%	53:53	499:499	206:206
CI19: % of families support for early learning activities	50%	Increase by baseline’s 50%	149:149	971:971	426:426
CI20: % families with children 0-3 performing appropriate care, early learning and discipline	25%	Increase by baseline’s 50%	538:538	3128:3128	1428:1428

*1: design effect=2; response rate=80%

*2: indicator values are estimated using baseline survey data from 2016.

*3: The target increase rates are based on the project document provided by the NCWCH of China CDC.

The sampling frame for the five project counties are all children under three in the ECD project townships. The sampling frame for the comparison groups are all children under three in non-ECD project townships for three project counties (Lin County, Xingguo County, and Sogntao County) and all children under three in two comparison counties (Zhouqu County and Qinyang County). For the quantitative survey, two stage probability sampling is used to select village and children in each county based on calculated sample size.

- ✓ Stage 1: 15 administrative villages are randomly selected using probability proportional to size (PPS) sampling method and the number of children under three is used as measurement of size. Administrative villages that did not participate in interventions of the ECD project are excluded from the sampling frame before the selection. Before sampling, if the number of children under three is less than 20 in an administrative village, the administrative village will be merged with the next one in order and used as one sampling unit.
- ✓ Stage 2: in each administrative village, 20 children under three are randomly selected from the roster of children under three.

Therefore, in total 1500 children under three would be selected ($15 \times 20 \times 5 = 1500$), respectively for the ECD project group and the comparison group, or a total of 3000 children, which is slightly bigger than the sample size needed and overpowers our study.

9.2.2.2 Survey on service institutions

All maternal and child health care centers in 7 selected counties, all hospitals in townships/towns where the sampled villages are located, and all clinics in sampled administrative/natural villages will fill the questionnaire on service institutions.

9.2.2.3 Survey on service providers

The average score of service providers on ECD knowledge is chosen as the key indicator to calculate the sample size of maternal and child health care service providers. Due to the lack of baseline value, we assumed that the service providers should have slightly higher knowledge level than caregivers, whose baseline average score is known as 50%. We therefore used 60% as an approximate baseline average score for service providers. Based on the project document's target of detecting baseline's 50% increase rate (or 90% at the end-line), we calculated the minimum sample size as 31 for each group. After considering the non-response and design effect, a total of at least 75 service providers are needed respectively for each group, or a total of 150 service providers.

ECD service providers at the county, township, and village level will fill the questionnaire and complete an ECD knowledge test. Detailed sample allocation plan is presented in the following table:

Table 8. Service providers to be selected in each county

Level	Subject	Quantity
County	ECD/child health service provider in maternal and child health institutions	2 per county
Township	ECD volunteers/child health service provider	1 per sample village's township

Level	Subject	Quantity
	Designated official for maternal and child health	1 per sample village's township
Administrative village	Village doctor	1 per sample village
	ECD volunteer/child health service provider	1 per sample village
	Designated official for maternal and child health	1 per sample village

Based on the estimated number of townships and villages visited at the baseline, the sampling plan presented above can meet the sample size requirement.

9.2.3 Subjects and sample size for service cost survey

Costing tools will be used to conduct key informant interviews with the ECD project's key personnel at the national, provincial and county level, as well as with UNICEF officers. At the same time, it aims to collect ECD project summary reports, funding expenditure records, detailed account records, and other relevant documents from respondents to understand and record the various project costs from different sources. The specific categories of respondents and the methods of the service cost survey are shown in Table 9.

Table 9. Survey respondents and methods

Method	Level	Respondent/ Materials	Number of interviewees
Key informant interview	National	Official from the Department of Women and Children, NHC	1
		Programme officers of UNICEF	1-2
		Officials from the National Center for Women and Children's Health, China CDC	2
Mini focus group discussion	Sub-national	Officials from the divisions of maternal and child health of county health bureaus, and maternal and child health institutions in intervention and comparison counties of five provinces	10 (1-2 participants per province x 5)
		ECD managers, village doctors and volunteers at 7 counties, townships and villages	20 (1-3 participants per county/township/village x 7)
Desk review		ECD project protocol, annual summary reports, funding expenditure records; Detailed account records in the project areas (county, township and village level), and at the provincial, national level, including China CDC	

9.3 Survey content and methodology

9.3.1 Qualitative inquiry

For the qualitative inquiry part, an evaluation matrix consisting evaluation questions, sub-questions, and areas of inquiry is developed around the three evaluation criteria in the TOR: relevance, effectiveness, and sustainability. Multiple qualitative data collection methods including key informant interview, mini-focus group discussion, focus group discussion, observation, and desk review are used to address each area of inquiry. Information collected from different angles and perspectives will be triangulated and cross-validated to understand the implementation status of the project.

9.3.2 Quantitative survey

In the quantitative survey, different data collection modalities including the face to face interview and self-administered questionnaire are used to understand how the project is implemented from different perspectives. Details are as follows:

- Questionnaire on the general situation of the surveyed areas: it mainly collects the socioeconomic and demographic information of the sampled administrative village as well as the town/township and county where the village is.
- Questionnaire on caregiver of children under three: a face to face interview will be conducted with the caregiver to understand her/his knowledge, skills and practices in nurturing care, the coverage of the ECD project, and the level of compliance and satisfaction with the ECD services. Children under three in the quantitative survey is defined as children not yet reaching three years old on the survey day. For instance, if the survey is conducted on March 10th, 2021, then any children born on or after March 10th, 2018 are counted as children under three. The first respondent should be the child's mother. If mother couldn't be found or interviewed, select an alternative caregiver such as father, grandmother, or grandfather who spent the most time taking care of the child. Electronic devices will be used to assist the survey.
- Questionnaires on service institutions: self-administered questionnaires will be used to understand the service accessibility, service provision, and human resources and equipment inputs of health institutions at the county, township, and village level. The county questionnaire will be filled by the county hospital/ maternal and child health care center. Township questionnaire will be filled by the township hospital. The village questionnaire will be filled by the village clinic. At each level relevant personnel in charge of the ECD project or who know the ECD project well should fill the questionnaire.
- Service provider questionnaires: self-administered questionnaires and ECD knowledge test will be given to the sampled service providers at the county/township/village level to understand their ECD service provision, the ECD knowledge level (assessed through designed questions), the level of acceptance/willingness towards interventions and activities recommended by the ECD project, and perception of the quality of the services delivered. Perception of service quality is measured by scoring the service content, delivery channels, etc.

9.3.3 Service cost survey

The cost survey will collect the data from 5 project counties and 5 comparison sites determined by qualitative survey and cover all the townships and villages within the administration areas. The data collection of the project counties will be completed by the evaluation team through filed visiting. The data collection of the comparison sites will be merged into the quantitative survey questionnaire and completed by counties with guidance provided by the evaluation team through online meeting. The data collected from the townships and villages which are not selected as sampling sites for the quantitative survey, will apply the same approach with the comparison sites.

As shown in Table 3, although the focused delivery channel varied across provinces and counties, the cost data will be collected on all three types of project activities (ECD care group activities, home visits, and village clinic developmental risk screening) from each county. At the same time, the activity records, accounting records, and equipment and material purchasing records of institutions at all levels will be requested and checked against the filling contents in questionnaire. After that, a costing analysis tool will be formed based on the actual survey results, so that subsequent cost analysis can be conducted.

For the project areas, it is necessary to confirm whether the project counties are carrying out early childhood development activities along with similar activities in the Essential Public Health Service Package project (e.g., nutrition package, child growth and development screening along with parenting care group activities at the same time, and newborn home visits and home visits at the same time); if so, it should estimate the proportion of time and personnel spent on early childhood development activities overall and measure the cost of the ECD project separately. In addition, the comparison areas may be influenced by the spill-over effects of the ECD project, which should be recorded.

The cost survey will be conducted through two phases. In the first phase, the total cost of the ECD project and the cost of the three different delivery channels (ECD care group activities, home visits, and developmental risk screening) will be measured through form filling, interview confirmation, and collection of secondary cost information. In the second phase, the cost analysis will be conducted, including cost measurement and marginal cost analysis for each category, and explore the incremental costs required to incorporate ECD service components into the national essential public health service package project.

In line with the TOR and the literature review, and based on the costing tools recommended by UNICEF (e.g. UNICEF Regional Modelling and Simulation Instrument) and World Bank (e.g. Brookings-World Bank Standardized ECD Costing Tool, or SECT), the survey considers the cost of the ECD project to include all inputs from the government, society and family units during the implementation of the ECD project (if there are inputs for essential public health, it also needs to be included in the calculation). Specifically, this would include funding inputs (UNICEF's project funds, national or local matching funds), human resource inputs (e.g. service personnel costs, public communication and training costs, supervision and technical support costs, management costs, etc.), equipment and material inputs (e.g. number of ECD centers/activity rooms, developmental monitoring and screening

tools, and recommended materials of the ECD project at the county, township and village level), and other relevant costs (e.g. transportation costs, time costs for getting interventions, etc.). All types of costs will be distinguished as to whether they are supported by UNICEF, matching funding at all levels or non-funding, and the content and amount of other non-funded support components of costs needs to be supplemented by interviews with personnel at county level (county contacts, village doctors, volunteers). By collecting statistics on each type of costs, the costs of the three different delivery channels of ECD for 1 year will then be measured. The cost components are as follows.

1)Funding inputs at all levels: UNICEF's project funds, national/local matching funds. Beside UNICEF's funds on the three different delivery channels of ECD, it is necessary to confirm the availability of funding support for other categories of costs (project training, project supervision and technical support, project management, and equipment and materials), and the corresponding amounts and percentages. The funding support among different regions also vary, so that it is necessary to confirm whether there is funding support and the corresponding amount and proportion for all regions.

2)Cost of project activities and services: The costs of three types of project activities are measured, including care group activities, home visits, developmental risk screening and counselling. The specific cost data collected includes the number of ECD project service providers, the number of children served, the length of activity, the cost of activity, and the cost of equipment and materials used, at the county, township, and village levels. The availability, the corresponding amounts and percentages will be confirmed for the services and equipments and materials used.

3)Training costs: The number of trainers for ECD training, the number of trainees, the length of training session, the honorarium for resources person, transportation costs, accommodation costs, training equipment and materials costs, and other costs. The cost for all different kinds of trainings arranged by national or provincial experts, and the county personnel seconded to the provincial or national institutions will be collected including the information of expert level/title/institution (UNICEF, national consultation expert team of CDC, provincial unit, etc.) and institution/personnel position of training recipients (township health center, maternal and child health center, etc.) and title (village doctor, kindergarten teacher, paediatrician, maternal and child health personnel, managers of early childhood development, etc.), and the level and type of the institutions conducting training. The corresponding amounts and percentages will be confirmed for the services and equipment and materials used.

4) Project supervision and technical support costs: The number of resources person involved in ECD project supervisors and technical support, the length of supervisor, the honorarium for resources person, transportation costs, accommodation costs, and other costs. The information of expert's level/title/institution (UNICEF, national consultation expert team of CDC, provincial unit, etc.) and institution/personnel position of supervision recipients (township health center, maternal and child health center, etc.) will be collected, including the corresponding funding, amounts and percentages for supervision and technical support.

5) Project management costs: The number of participants in meetings and discussions

conducted, the length of each meeting, the cost of meeting venues and equipment, the cost of materials for meetings, the honorarium for resources person, and other costs will be collected. This project management activities mainly include annual project meetings, annual work planning meetings, project model exploration and application discussions, project design discussions, project review meetings, etc. The relevant meeting costs are classified according to whether it is supported by UNICEF's funds, matched government funding at the national, provincial and county level, or not funded.

6) Project equipment and material costs: Cost categories include equipment and materials used in project activities, training, supervision or technical support, and management. Specifically, this includes the number of group activity centers or rooms, developmental monitoring and screening tools, and materials recommended for the project. The costs are classified according to whether it is supported by UNICEF's funds, matched government funding at the national, provincial and county level, or not funded, and the corresponding amount and percentage, as well as the content and amount of other non-funded support components and equipment and materials costs that are easily overlooked due to shared use (e.g., activity space, equipment depreciation, etc.).

9.4 Data analysis

9.4.1 Qualitative inquiry data analysis

On the basis of comprehensive and systematic collation and transcription of the interview data and observation data, the first-hand qualitative survey information will be analyzed by adopting the "grounded theory" analysis strategy which is based on the fact to form cognition, and through coding and establishing category relationship which will be helpful to form the overall logical framework.

Qualitative data will be carried out according to data processing, analysis standards and analysis methods. The whole qualitative survey will combine the baseline survey data and monitoring data of the project, and also combine the second-hand literature and first-hand observation data and interview data to form mutually related and mutually corroborated results through independently obtained information; meanwhile, through team discussions, more scientific, accurate and in-depth evaluation findings, conclusions and suggestions will be obtained.

9.4.2 Quantitative survey data analysis method

Data will be analyzed in STATA while considering the complex survey design characteristics.

- 1) The key indicators will be compared with the project target value to see if the goal has been reached.
- 2) For indicators with baseline data, the following model will be used to assess the effectiveness of project implementation. The model is:

$$\text{Outcome} = \beta_0 + \beta_1 \text{Time} + \beta_2 \text{Group} + \beta_3 \text{Time} \times \text{Group} + \text{Other Covariates} + \varepsilon$$

Time (1=end-line; 0=baseline) and Group (1=project group; 0=comparison group) are two dummy variables. Time×Group is an interaction term between the two dummies. The coefficients of the model can be interpreted as:

β_1 = time trend common to comparison and project group

β_2 = project group specific effect (average permanent differences between the project group and the comparison group)

β_3 = true effect of project

- 3) For indicators with no baseline data available, two sample mean test will be done to see if there is any difference between the project group and the comparison group.

9.4.3 Methods of cost analysis

The UNICEF-recommended costing tool (e.g. UNICEF Regional Modelling and Simulation Instrument) and the World Bank-recommended costing tool (e.g. Brookings-World Bank Standardized ECD Costing Tool, or SECT) will be used to analyse the key cost components of the ECD project counties and the comparison counties, conduct cost analysis and comparison, and provide cost reference standards for nationwide scale-up.

- 1) Cost accounting and marginal cost analysis: from a societal perspective, define the concept and type of cost, identify all related costs, determine the unit cost and quantity of each cost type, and measure the cost inputs of the project. The calculation of each cost composition is presented as follows:

Each cost type = unit cost × number of services

The total cost is calculated by adding up the various types of costs. Then, according to the types of ECD services, calculate the annual total cost of the three delivery channels (e.g. village clinics, home visits, care group activities) and the marginal cost of each additional ECD service provided using cost accounting and cost sharing methods as follows:

Marginal cost = (fixed cost + shared cost) / each additional time the ECD service is provided

Table 10. Indicators for cost analysis and marginal cost analysis

Indicator	Explanation
Cost indicator	
C1	The average cost per family for one-year of developmental risk screening and counselling, management of children at risk, etc (interventions at village clinics).
C2	The average cost per family for one-year of home visits
C3	The average cost per family for one-year of ECD care group activities
Marginal cost indicator	
MC1	The cost of each additional developmental risk screening and counselling, management of children at risk, etc.
MC2	The cost of each additional home visit
MC3	The cost of each additional ECD care group activity

- 2) Scenario analysis: because there are many cost indicators involved, the costs of the ECD delivery channels are listed separately for different regions in the analysis to compare the differences between project counties and comparison counties, and the differences within different project counties. During the cost accounting process, many variables may have a

certain range of values, which are considered uncertain factors. Scenario analysis is used to handle the uncertain factors to evaluate the reliability of the analysis results.

The main focus is on cost and marginal cost analysis, but short-term and long-term cost-effectiveness analysis can be implemented if necessary.

9.5 Evaluation risks, limitations and mitigations

This field data collection is broad in scope and involves institutions at different levels, communities and households, whose support and cooperation (especially the cooperation of the disadvantaged groups) are the pre-condition for the smooth implementation of the survey as planned. This is particularly important for the comparison group. If there is lack of strong coordination or unpredictable factors, the fieldwork is at risk of delay. Therefore, the support and coordination from NHC, UNICEF China, and NCWCH of China CDC is imperative.

Plan for formal field data collection needs to be approved by the NHC, and the time is uncertain due to COVID-19 pandemic control.

In addition, the COVID-19 pandemic may delay the progress of the field data collection. If there is an outbreak of COVID-19 in a certain place, with the consent of the NHC and UNICEF, the qualitative interviews would be conducted online as far as possible when necessary. For quantitative survey, if time permits, the original survey site would be changed, or to complete the survey after the outbreak is under control. Another alternative is to conduct the survey through local personnel trained on standardized procedures. If the field data collection cannot be completed by the end of June 2021, the evaluation team needs to coordinate with UNICEF to revise the timeline of evaluation report submission.

There are some limitations to the evaluation methodology. Firstly, due to the reasons mentioned earlier in the report, the first stage of the sampling does not employ probability sampling, therefore inference cannot be made about the 14 counties. Secondly, three counties out of the five counties selected lack baseline data, which limits the analysis. For counties which lack the baseline data, literature review is planned to allow other sources of information to complement the baseline key indicators, so that comparison can be made with the end-line results to better understand the impact of the implementation of the ECD project. Thirdly, since comparison groups were chosen from non-project townships for three project counties, we have learned from the preliminary communication that the training for service providers in some project counties covers the whole county. The contamination is a likely condition. The potential contamination of the intervention on the comparison group cannot be ruled out. There is the possibility of underestimating the effect of the ECD project. One possible approach would be to add a question to the village-level service provider questionnaire asking if the village-level service provider has received ECD program interventions. In the future, the analysis can be further stratified according to whether or not the service providers at the village level have received ECD program training, including stratified analysis of child caregivers according to whether or not the village service providers receive ECD program training, to understand the possible impact of the contamination. However, as ECD project intervention is a comprehensive intervention, for example, the parents of children in the control area may take their children to participate in the ECD project intervention activities in the project area irregularly, the causes of the contamination are

more diverse, and it is difficult to control it completely, which is certainly a limitation.

9.6 Quality control

Quality control is embedded throughout the entire process of the survey design, field survey, data analysis, and report writing. To ensure objectivity, authenticity, and accuracy, and to improve the quality of the data collected, quality control measures will include pre-test, training, discussion and communication, as well as strengthening of fieldwork supervision and data processing.

Survey design and pre-test. During the design of survey tools and the field manual, the evaluation team referenced international and domestic standardized survey questionnaire and tools, including UNICEF's Multiple Indicator Cluster Surveys (MICS). Before launching the official survey, a pre-test has been conducted in Song County, Henan Province to test all draft questionnaires and interview outlines. The pre-test enabled us understand the field procedures and identify the problems for improvements. After the pre-test, the survey instrument and tools got further improved.

It is yet to be determined whether to use paper-based questionnaire or PAD for the quantitative survey. Using PAD could bring benefits in the following aspects:

- The mandatory items could be set in the electronic questionnaire to reduce the missing values of key variables, improving the data quality.
- Logic checks could be included to reduce errors in answers.
- No need for data entry: the data collected through PAD could be directly uploaded to the online data platform, saving time and improving efficiency.

The selection and training of field interviewers. Eligible field interviewers and supervisors will be selected and trained using a standardized survey manual for the quantitative survey. Compared with the quantitative survey, the qualitative inquiry is very subjective and involves significant personal interactions, and thus necessitates certain level of expertise of the interviewers. The fieldwork of the qualitative inquiry will be carried out by personnel who participated in the evaluation design to ensure the qualitative data collect is of good quality.

Field data collection. Each quantitative survey team is composed of a field survey supervisor and 4-6 interviewers. The field survey supervisor is responsible for spot-checking the questionnaires filled out on the electronic survey equipment, correcting the issues identified in a timely manner, and ensuring the survey data is uploaded to the evaluation team at Peking University on the same day after the field survey. The assigned evaluation team member of Peking University will be responsible for checking the uploaded field data each day and communicating in a timely manner if problems are identified. The qualitative inquiry will strengthen supervision and review of data recorded in the field and the subsequent transcription process to ensure the completeness, objectivity and accuracy of the information. During the implementation of the field survey, attention should be given to strengthening the information sharing between the quantitative survey team and the qualitative survey team. During the implementation in the three project counties where the qualitative and quantitative surveys overlap, the quantitative survey team and the qualitative survey team will communicate in-person or online each day to summarize the progress of the data collection and discuss about experience and the challenges encountered.

Data analysis. When the evaluation team conducts data sorting, verification and analysis, the data processing procedures will be reviewed by at least two people to ensure correctness. In order to improve the reliability, accuracy and authenticity of the data, the evaluation will actively adopt the triangulation method to analyze data gathered through different methods and information sources, and focus on the validation and complementarity using various sources of literature analysis, qualitative data and quantitative data.

Report drafting. The evaluation team will conduct frequent discussions, exchanges and communication during the process of writing the evaluation report to ensure the development of a rigorous, objective, comprehensive and in-depth report. The inception report and the draft evaluation report will be reviewed by the reference group established by UNICEF China. At the same time, the draft evaluation report will be shared with the stakeholders involved in the evaluation through a validation workshop or in written correspondence to solicit their comments and suggestions. Accordingly, the evaluation team will discuss the comments and suggestions shared by all stakeholders, and revise and improve the report to ensure the quality. The evaluation report will be written in accordance with *UNICEF-Adapted UNEG Evaluation Report Standards (2017)*³⁰ and with reference to the UNICEF Geros to meet the requirements of the United Nations. Please find the evaluation report outline in Annex 6.

10. Ethical consideration

The evaluation will be carried out in accordance with the ethical standards and norms outlined in the *UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis (2015)*²⁸.

The evaluation team will submit all plans and informed consent forms to the Peking University Biomedical Ethics Committee, and the materials will be reviewed and approved by the committee.

All members of the evaluation team, as well as interviewers and supervisors will receive standardized ethical training before conducting field visits to ensure they have a clear understanding of the privacy protection, respect for human rights and dignity of the respondents, and know how to handle sensitive issues during the evaluation process.

During the field visits, informed consent forms will be shared with the respondents, so that they fully understand the purpose, significance and content of the evaluation, and provide written informed consent. The respondents can voluntarily choose to participate or withdraw at any time. Respondents will receive a small gift from the evaluation team after the survey is completed.

The data collected through field visits are encrypted and stored on the computer of the Department of Maternal and Child Health at the School of Public Health of Peking University. Only evaluation team members who know the password can access the data, and routine maintenance of the computer will be provided by a dedicated person. The individual records will be assigned an anonymous number to de-identify, ensuring that the evaluation team members who analyze the data will not have access to the individual's name and personal information, and the respondents'/subjects' privacy is protected.

11. Evaluation timeline

The inception report, survey tool preparation, ethical review and fieldwork preparation will be completed from December 2020 to March 2021; field data collection and data analysis will be completed from April to June 2021; draft, revision, improvement and finalization of the evaluation report will be completed between June and July 2021. Due to the influence of COVID-19 pandemic, the timeline for the fieldwork needs to be approved by the NHC, which has some uncertainties. Subject to approval by the NHC, it is estimated that it will take at least four months to complete the fieldwork, data analysis and report drafting.

Table 11. Timeline

Tasks \ Month	2020				2021								
	9	10	11	12	1	2	3	4	5	6	7	8	9
Complete the inception report	█	█	█	█	█	█	█						
Fieldwork preparation							█	█					
Ethical review							█	█					
Field data collection								█	█	█			
Data analysis									█	█	█		
Evaluation report drafting										█	█	█	
Evaluation report revision												█	█

12. Evaluation team

The evaluation team consists of two parts: a working team and an expert team. The team members have diverse research backgrounds, including maternal and child health, early childhood development, health economics, health policies, health statistics, and sociological surveys. The team includes male and female members, and their division of labor is shown in Table 12 below. The duty of expert team members is mainly to provide technical support and advice in the process of project design, data analysis, and report writing; working team members are mainly responsible for the field implementation.

The qualitative survey team consists of about 15 researchers and graduate students from Peking University and Renmin University of China. The quantitative survey team consists of researchers and graduate students from Peking University, Lanzhou University, Chongqing Medical University, and Capital Medical University. The total number of members in quantitative survey team is about 60. For this evaluation, Professor Wang Yan from School of Public Health, Peking University serves as the Principle Investigator of the project, and Professor Liu Shuang from Renmin University of China serves as the leader of the qualitative survey team. The project management office is established in School of Public Health, Peking University.

With the support of the National Health Commission, and the assistance of National Center for Women and Children's Health, China CDC and UNICEF, the entire evaluation team will organize and complete literature review, field visit and other work required for the implementation of the evaluation.

The team of Peking University is mainly responsible for the macro-management, organization and coordination, on-site supervision and quality control of the project, also the preparation of the quantitative survey implementation plans and work manuals, and completion of the respective part of the evaluation report; the team of Renmin University of China will be in charge of the preparation of qualitative survey implementation plans and work manuals, conducting field visit and completing the respective part of the evaluation report. At each stage of the evaluation process, the Peking University team will work with other university teams to establish an internal quality control process. Each output will be modified and improved based on thorough discussion and extensive consultation with the expert team.

Financial management personnel are set up for this evaluation, to inspect funds implementation and supervise the use of funds. Peking University Health Science Center has Planning and Finance Department and Scientific Research Department (PUHSC). The funds for scientific research projects should be approved, and the research projects and funds are under the unified management of PUHSC. The PUHSC sets up financial accounts for scientific research projects, to make sure funds are put in place and independently accounted. Peking University has formulated a series of financial policies, to ensure the use of scientific research funds in accordance with laws and regulations. These financial policies include science and technology development and technical cooperation projects and fund management, domestic travel expenses management, conference fee management, expert consultation fee management, personnel fee distribution and large-amount fund use, etc. The funds of this project will be used strictly in accordance of the relevant national regulations and the school's financial management policies. If national or school's financial management policies are updated, new ones will be followed.

Table 12. Members of the evaluation team and division of labor

	Members	Title	Affiliation	Roles and responsibilities in the evaluation
Work team	Wang Yan	Professor	Peking University	Principle Investigator (PI), mainly responsible for the coordination of personnel, application of ethical review, participating in the design of survey scheme and tools, participating in the discussion of data analysis, report writing, etc.
	Zhou Hong	Associate Professor	Peking University	Co-PI, assist PI, mainly responsible for quantitative survey, including survey design, survey tool design, preparation of materials for ethics application, investigator training, coordination of field, field implementation, data management, data analysis and report writing
	Liu Shuang	Professor	Renmin University of China	Qualitative survey team leader, lead and mainly responsible for qualitative survey scheme design, survey tool development, investigator training, field data collection, data analysis, report writing, etc
	He Hong	Professor	Renmin University of China	Assist qualitative survey team leader, participating in the design of qualitative survey scheme, survey tool development, taking the charge of the training of investigators, on-site data collection, data analysis, report writing, etc.
	Yang Li	Professor	Peking University	Co-PI, responsible for the cost analysis of quantitative survey, including survey design, survey tool design, investigator training, field implementation, cost data analysis and report writing
	Guo Yan	Professor	Peking University	Health policies expert; participating in the important discussions in data analysis and report writing. Providing advice on health policy issues
	Luo Shusheng	Lecturer	Peking University	Responsible for data collection and data management
	Liu Jue	Associate Professor	Peking University	Responsible for field implementation, database establishment and data analysis
	10 graduate students	Graduate Students	Peking University	Participating in literature review, field data collection, data analysis and part of report writing, and assigned personnel to take charge of financial management
	Li Zhilan	Professor	Lanzhou University	Responsible for part of field implementation and data entry
Expert team	Wang Huishan	Professor	National Center for Women and Children's Health, China CDC	Expert in early childhood development; participating in important discussion in project design, research tool development, data analysis, report writing etc. Providing consultation on ECD related questions
	Meng Qingyue	Professor	Peking University	Expert in health economics, providing consultation on cost analysis, including design, results analysis and policy recommendations
	An Lin	Professor	Peking University	Providing consultation on index determination related questions
	Liu Li	Associate Professor	Johns Hopkins University	Expert on international child survival and development; participating in the important discussions in data analysis and report writing
	Yu Shicheng	Professor	China CDC	Senior statistical expert; providing consultation on scheme design and data analysis
	Kang Xiaoping	Professor	Peking University	Statistical expert; providing consultation on scheme design and data analysis
	Wang Haijun	Professor	Peking University	Department head, providing personnel and other hardware support for the smooth implementation of the project

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14. Annex

Annex 1. Terms of Reference for the formative evaluation (see separate document)

Annex 2. Evaluation matrix

Annex 3: Indicators for quantitative survey

Annex 4. Definition of key terms

Annex 5. ECD intervention package

Annex 6: Outline for ECD evaluation report

Annex 7. Survey instruments (see separate document)

7.1. Interview outline

7.2. Quantitative survey questionnaire-project group

7.3, Quantitative survey questionnaire-comparison group

7.4. Costing questionnaire at the county, township and village level

Annex 1. Terms of Reference for the formative evaluation (see separate document)

Annex 2. Evaluation matrix

Evaluation questions	Sub-questions	Indicators/Areas of inquiry	Data source/collection method
(1)	(2)	(3)	(4)
Relevance¹			
R1. How relevant is the UNICEF-supported Early Childhood Development (ECD) 0-3 project² to national and sub-national government policy priorities?	R1.1 To what extent is the UNICEF-supported ECD project design aligned with national/sub-national government's child health policy priorities?	<ol style="list-style-type: none"> 1) Priorities and objectives of government policies on child health development that expected outcomes of the ECD project³ are aligned with; and the relative importance of ECD in these policies. 2) Government's prioritized work plan on health care (e.g. reduce maternal and child mortality, achieve NPA or Healthy China Action Plan (2019-2030), provide basic public health services) that the ECD project is aligned with, and the relative importance of ECD in the health care system. 3) Leadership support to the ECD project at all government levels, as demonstrated by national/sub-national directives from high-level management, allocation of human resources and matching funds, etc. 4) Association of UNICEF-supported ECD project with priorities of ECD related works conducted by other government sectors, such as the Leading Group on Poverty Alleviation, and National Development & Reform Commission. 	<ol style="list-style-type: none"> 1. Desk review <ul style="list-style-type: none"> • National child health development strategies and relevant policies; • Sub-national government (province/county level) child health development strategies and relevant policies; • Other national/sub-national government policies, strategies and reports related to ECD; • ECD project protocol, implementation reports, and other relevant materials. 2. Key informant interview <ul style="list-style-type: none"> • Officials from the Department of Maternal and Child Health and the Department of Primary Health under the National Health Commission (NHC); • Officials from the Division of Maternal and Child Health and the Division of Primary Health of provincial health commissions; • County governors in charge of health, directors of county health bureaus in charge of maternal and child health/primary health, directors of finance bureaus, development and reform commissions, education bureaus, women's federations, poverty alleviation offices, civil affairs bureaus and other

¹ Note: (a) Reasons/rationale, influencing factors, challenges/bottlenecks and opportunities, differences by geographic areas and sub-groups, as well as good practices and lessons learnt will be examined throughout as appropriate, although not explicitly mentioned in the question statements or under the areas for inquiry. (b) All lines of evidences will be cross validated by data sources, e.g. validation between primary or secondary sources, information collected at various levels, from different respondents. (c) Quantitative data on children aged 0-5 and their caregivers will be collected to supplement the responses to some of the sub-questions in phase two through an end-line survey and costing analysis, and not covered by this formative evaluation (phase one). (d) This formative evaluation seeks to answer relevant questions originally suggested by UNICEF in the TOR and modified with agreement by UNICEF at the inception stage.

² Hereafter referred to as ECD project.

³ A list of definition of key terms can be found in Annex 4 of this document for more information.

Evaluation questions	Sub-questions	Indicators/Areas of inquiry	Data source/collection method
			agencies at the county level related to the ECD project; <ul style="list-style-type: none"> • Heads and officials of Maternal and Child Health institutions at the county level; • Project officials from National Center for Women’s and Children’s Health (NCWCH) of the China Center of Disease Control and Prevention (China CDC), members of the national consultation experts team and relevant officials; • Managers and project officers of UNICEF China Office.
R2. To what extent does the ECD project, conducted through the health system, in particular the Maternal and Child Health (MCH) system, accommodate the global recommendations of the Nurturing Care Framework (NCF)?	R2.1 To what extent are the services and interventions (hereinafter referred to as ‘service content’, please refer to the revised Annex 2 of the TOR for service content details, now Annex 5 of this inception report) designed by the ECD project aligned with recommendations of the NCF?	1) Level of alignment of the ECD project design with the service content recommended by the NCF.	1. Desk review <ul style="list-style-type: none"> • Evidence of the latest international/domestic research related to best practices in ECD, including the NCF, published articles, published guidelines, evaluation reports and other relevant information; • ECD project’s design protocol, implementation documentation and other relevant materials; • Theory of Change for the ECD project.
	R2.2 What are the considerations in designing the delivery channels (i.e. village clinics, ECD care groups, home visits) in the ECD project? Does the project’s delivery channels fit China’s existing health system? How feasible are they in practice? What are the main challenges?	1) Consideration of applying universal support vs. targeted support, and alignment with the NCF. 2) Design rationality, compatibility with the existing health system, and feasibility and adaptation in implementation of the three delivery channels. 3) The similarities and differences between the services and interventions designed by ECD project and traditional child health care	2. Key informant interview <ul style="list-style-type: none"> • Officials from the Department of Maternal and Child Health, NHC; • Members of the national consultation experts team; • ECD project officials of NCWCH; • ECD project officers of UNICEF China Office; • Officials from the Division of Maternal and Child Health of provincial health commissions; • Officials of county health bureaus in charge of maternal and child health; • Officials of Maternal and Child Health institutions at the county level.

Evaluation questions	Sub-questions	Indicators/Areas of inquiry	Data source/collection method
<p>R3. To what extent the ECD project design, strategies, and implementation were relevant onset and are still appropriate and valid to meet the needs of the different segments of the target groups in the project areas?</p>	<p>R3.1 In the project areas, what are the service needs/expectations in terms of ECD of different target groups (government, service providers, children and their caregivers)? What are the changes of their service needs/expectations during project implementation?</p>	<p>Onset of the project vs. now, changes in:</p> <ol style="list-style-type: none"> 1) Changes in government strategies/plans/regulations and other enabling environment related to child health and ECD in China 2) Government’s awareness and capacity in ECD strategy development and project implementation. 3) Service providers’ perceptions on the needs/expectations in ECD and nurturing care of children, and those needs/expectations they hope to address through the ECD project. 4) Child caregivers’ needs/expectations in nurturing care services, and those needs/expectations they hope to address through participating in the ECD project. 	<p>1. Desk review</p> <ul style="list-style-type: none"> • Report on the status of ECD in project areas; • Report on ECD service delivery in project areas; • Project background information, baseline survey report and other related materials; • UNICEF related materials that justifies the launch of the ECD project, including the ECD project’s concept note, and expenditure record; • Relevant data of the project areas from previous surveys. <p>2. Key informant interview</p> <ul style="list-style-type: none"> • Officials from the Department of Maternal and Child Health, NHC; • Officials from the Division of Maternal and Child Health of provincial health commissions; • Members of the national consultation experts team; • Project officials from NCWCH; • Project officers of UNICEF China Office. <p>3. In-depth interview</p> <ul style="list-style-type: none"> • Officials of the Division of Maternal and Child Health of county health bureaus; • ECD project managers at the county level; • ECD project managers at the township level; • Administrative staff at the village/township level (such as head of township or head of village) in project areas; • Caregivers of disadvantaged children aged 0-5, either participants or non-participants in the project. <p>4. Focus group discussion</p> <ul style="list-style-type: none"> • ECD service providers of care group activities; • ECD service providers of universal support through village clinics; • ECD service providers of home visits; • Fathers of children aged 0-5;
	<p>R3.2 To what extent is the project design consistent with the actual service needs/expectations of the target groups in different project areas? How did different project areas adjust the project design to meet the changing needs/expectations of the target groups?</p>	<p>By specific target group:</p> <ol style="list-style-type: none"> 1) The extent that the project met the actual needs/expectations of different target groups. 2) Level of satisfaction of the design of ECD project service package and on-going adjustment to meet their changing needs. 	

Evaluation questions	Sub-questions	Indicators/Areas of inquiry	Data source/collection method
			<ul style="list-style-type: none"> • Mothers of children aged 0-5; • Other caregivers of children aged 0-5. <p>5. Field observation</p> <ul style="list-style-type: none"> • ECD care group activities; • Universal support through village clinics; • Targeted support through home visits.
Effectiveness			
E1. To what extent did the ECD project achieve its intended objectives at the output level?	E1.1 Did the ECD project enhance national and sub-national capacity in the development and implementation of ECD programmes and policies?	<ol style="list-style-type: none"> 1) Changes in government capacity in policy development, policy advocacy, financing, policy implementation, and monitoring and evaluation at all levels. 2) Status on policies/strategies/action plans highlighting ECD 0-3 developed by project provinces and counties; and ECD service content and service strategies highlighted in those documents. 3) Other positive influences of the ECD project on government's work on child health and ECD (management, standards and services, etc.). 4) Status of ECD technical guidelines/project documents adopted and applied by the project areas; and the suggestions for improvement. 	<p>1. Desk review of base-line report, periodical project reports, and monitoring data</p> <p>2. Key informant interview National level</p> <ul style="list-style-type: none"> • Officials from Division of Maternal and Child Health, NHC; • Project officials from NCWCH of the China CDC; • Project officers from UNICEF China Office; • Members of the national consultation experts team. <p>3. Mini focus group discussion Province level</p> <ul style="list-style-type: none"> • Provincial level officials in charge of maternal and child health; • Heads of the Division of Maternal and Child Health of provincial health commissions; • ECD project managers at the provincial level. <p>County level</p> <ul style="list-style-type: none"> • County governors in charge of health; • Heads of the Division of Maternal and Child Health of county health bureaus; • ECD project officials at the county level.
	E1.2 Were quality ECD services delivered to families and children by better trained work force through multiple delivery channels?	<p>Service availability</p> <ol style="list-style-type: none"> 1) The availability of ECD project services and its adaptations in practice, including: <ul style="list-style-type: none"> • CI4: Number and % of health facilities at county, township and village level able to provide child developmental monitoring, 	<p>1. Desk review of base-line report, periodical project reports, and monitoring data</p> <p>2. Mini focus group discussion</p> <ul style="list-style-type: none"> • Heads of the Division of Maternal and Child Health of county health bureaus;

Evaluation questions	Sub-questions	Indicators/Areas of inquiry	Data source/collection method
		<p>screening and referral services</p> <ul style="list-style-type: none"> • CI5: Number and % of county, township and village clinics able to provide ECD counseling, guidance and promotion services <p>2) The availability of child developmental risks screening and its adaptations in practice</p> <p>3) The availability of home visit and its adaptations in practice</p> <ul style="list-style-type: none"> • CI6: Number and % of townships and villages able to provide home visits <p>4) The availability of ECD care group and its adaptations in practice</p> <ul style="list-style-type: none"> • CI7: Number and % of townships and villages able to conduct group sessions • Number of sessions organized by ECD center/group session organizers in a defined time period <p>5) The availability of service provision for children at risk of development delays, and its adaptations in practice</p> <ul style="list-style-type: none"> • Number and % of health facilities at county level able to provide early interventions for children at risks • The timely detection, management, and service provision for children at risk of development delays. <p>Service quality</p> <p>6) The average score of county, township and village providers on ECD (questions to be defined)</p> <p>7) The acceptance of county, township and village service providers towards ECD</p>	<ul style="list-style-type: none"> • ECD project managers at the county level; • Managers of Maternal and Child Health institutions at the county level. <p>3. Focus group discussion</p> <p>County level</p> <ul style="list-style-type: none"> • Service providers of maternal and child health care institutions at the county level. <p>Township level</p> <ul style="list-style-type: none"> • Service providers of township health centers. <p>Village level</p> <ul style="list-style-type: none"> • Village doctors/village maternal and child health care workers; • Service providers of ECD care group activities; • ECD service providers conducting home visits. <p>4. Quantitative survey</p> <p>5. Project routine monitoring data</p>

Evaluation questions	Sub-questions	Indicators/Areas of inquiry	Data source/collection method
		<p>services proposed by the project</p> <p>8) The willingness of county, township and village service providers towards ECD services by the project</p> <p>9) The quality of county, township and village ECD project's service</p> <p>10) The extent of project training that matched the needs and contributed to improved knowledge, skills and behaviors of service providers</p> <p>11) The number of person-times attending training activities organized under the ECD project and the self-reporting feedback of the training effectiveness from the participants</p> <p>12) The service quality and the feedback mechanism of project supervision.</p> <p>13) Service providers' acceptance and willingness to implement the ECD project's service content and delivery channels.</p> <p>14) The level of satisfaction of service recipients regarding ECD project services</p> <ul style="list-style-type: none"> • CI12: The satisfaction level of caregivers with ECD services 	
	<p>E1.3 To what extent did ECD services reach eligible service recipients? Did it improve their literacy, skills and behaviors in ECD?</p>	<p>Service coverage and compliance</p> <p>1) A comparison of the number of recipients before and after the ECD project was launched</p> <ul style="list-style-type: none"> • CI8: % of children receiving monthly play and communication counseling via clinic services • CI9: % of children receiving at least one group session • CI10: % of children receiving child developmental monitoring 	<p>1. Desk review of base-line report, periodical project reports, and monitoring data</p> <p>2. Mini focus group discussion</p> <ul style="list-style-type: none"> • Heads of the Division of Maternal and Child Health of county health bureaus; • ECD project managers at the county level; • Managers of MCH institutions at the county level. <p>3. Focus group discussion</p> <ul style="list-style-type: none"> • ECD project managers of township health centers; • Service providers of township health centers; • Village doctors/village maternal and child health

Evaluation questions	Sub-questions	Indicators/Areas of inquiry	Data source/collection method
		<ul style="list-style-type: none"> • CI11: % of children at risk of developmental delays receiving home visits (> =1) • % of children taking YYB in line with national standard • Number of group sessions that children attended • % of children screened as positive using warning signs checklist • % of children at risk of delay referred under 1 years old <p>2) Coverage of target groups against eligibility criteria; gaps in coverage and rationale.</p> <p>3) The willingness and compliance of service recipients regarding project service content and delivery channels.</p> <p>4) The extent to which the project activities matched the needs of service recipients and contributed to improved knowledge, skills and behaviors of caregivers on providing nurturing care.</p> <ul style="list-style-type: none"> • % of caregivers knowing exclusive breastfeeding with children at a given age • % of caregivers knowing the age to begin complementary feeding • CI18: % of exclusive breastfeeding (< 6 months) • Minimum dietary diversity • CI14: % of families having at least three picture books • CI15: % of families having at least two toys • CI19: % of families support for early 	<p>care workers;</p> <ul style="list-style-type: none"> • Service providers of ECD care group activities; • ECD service providers conducting home visits. • Caregivers of children in project villages. <p>4. Quantitative survey</p> <p>5. Project routine monitoring data</p>

Evaluation questions	Sub-questions	Indicators/Areas of inquiry	Data source/collection method
		learning activities <ul style="list-style-type: none"> • CI20: % families with children 0-3 performing appropriate care, early learning and discipline • CI16: % of fathers participated in the parent-child activities • CI17: % of mothers participated in the parent-child activities 	
	E1.4 What are the key positive and negative factors that affect the achievement of the project outputs, and what approaches were used to overcome negative factors? What unexpected effects and changes did the project bring about?	<ol style="list-style-type: none"> 1) The main factors affecting the achievement of the ECD project outputs. 2) The innovative approaches and successful practices. 3) Unexpected effects and changes 4) Negative factors and approaches used to overcome negative factors 	1. Desk review of base-line report, periodical project reports, and monitoring data 2. Key informant interview with key personnel at the national and provincial level, as well as with UNICEF 3. Focus group discussion <ul style="list-style-type: none"> • Service providers of maternal and child health care institutions at the county level; • Service providers of township/ health centers; • Village doctors/village maternal and child health care workers; • Service providers of ECD care group activities; • ECD service providers conducting home visits. 4. Mini focus group discussion <ul style="list-style-type: none"> • Heads of the Division of Maternal and Child Health of county health bureaus; • ECD project managers at the county level. • Managers of MCH institutions at the county level.
	E1.5 To what extent the project's monitoring system is adequate and used?	<ol style="list-style-type: none"> 1) Completeness and appropriateness of the results framework 2) Functioning of monitoring tools 3) Quality of monitoring data 4) Usage of monitoring data in decision making 	
E2. What are the major differences in project implementation among the project areas, and to what extent was equity reflected during project implementation?	E2.1 What is the actual level of implementation in different project areas regarding the service content, delivery channels and technical materials/tools? Specifically, how has the project design been adapted to	<ol style="list-style-type: none"> 1) Differences in local characteristics among different project areas. 2) Difference in service accessibility <ul style="list-style-type: none"> • CI4: Number and % of health facilities at county, township and village level able to provide child developmental monitoring, 	1. Desk review of base-line report, periodical project reports, and monitoring data 2. Key informant interview with key personnel at the national and provincial level, as well as with UNICEF

Evaluation questions	Sub-questions	Indicators/Areas of inquiry	Data source/collection method
	<p>meet local needs (e.g. Who provides the services? What is the actual service content? What is the service frequency?)? What are the difficulties and challenges in service delivery? How were the difficulties addressed?</p>	<p>screening and referral services</p> <ul style="list-style-type: none"> • CI5: Number and % of county, township and village clinics able to provide ECD counseling, guidance and promotion services • CI6: Number and % of townships and villages able to provide home visits • Number and % of health facilities at county level able to provide early interventions for children at risks • CI7: Number and % of townships and villages able to conduct group sessions • Number of sessions organized by ECD center/group session organizers in a defined time period • Number of working days for group sessions <p>3) Differences in project design/implementation, local adaptations to suit specific local conditions and rationale.</p> <p>4) Diversified approaches to address various difficulties and challenges in different project areas.</p>	<p>3. Mini focus group discussion</p> <p>Province level</p> <ul style="list-style-type: none"> • Provincial level officials in charge of maternal and child health; • Officials from the Division of Maternal and Child Health of provincial health commissions; • ECD project managers at the province level. <p>County level</p> <ul style="list-style-type: none"> • Heads of the Division of Maternal and Child Health of county health bureaus; • ECD project officials at the county level. • Managers of Maternal and Child Health institutions at the county level. • Caregivers of children in project villages. <p>4. Quantitative survey</p> <p>5. Project routine monitoring data</p>
	<p>E2.2 To what extent does the project ensure the equitable participation of disadvantaged groups, such as children in remote and poverty areas, children with language or cultural barriers, children born preterm, children with malnutrition or anemia, children with disabilities, children left-behind?</p>	<p>1) Identified groups of disadvantaged children and their special needs.</p> <p>2) Coverage and compliance of services for disadvantaged groups (the indicators are same as E1.3 as above. The subgroup analysis of disadvantaged groups will be carried out during the analysis, however whether it is feasible or not depends on the sample size of the subgroup)</p> <p>3) Project efforts to ensure the equitable participation of all children who are eligible</p>	

Evaluation questions	Sub-questions	Indicators/Areas of inquiry	Data source/collection method
		(including disadvantaged children). 4) Extent to which the special needs of disadvantaged children are met or not met; suggestions for improvement.	
	E2.3 How does project design and/or its implementation reflect gender equality (including male participation) and human rights?	1) Project elements reflecting gender equality or promotion of gender equality. 2) Evidence of male participation and efforts to encourage it. 3) Evidence that legal rights of target groups are respected. 4) Possible burden or negative influence on stakeholders.	
Sustainability			
S1. How is the sustainability considered and achieved via project design, implementation and exit strategy?	S1.1 Are the project results likely to be sustainable?	1) Sustainability of the ECD project's service content and delivery channels under universal support and targeted support, respectively. 2) Construction of sustainable service system across county, township and village levels 3) Sustainability of gender and equity-related results. 4) Existence of project exit strategy and its adoption. 5) Examples of successful sustainability of the project.	1. Desk review of project design documents 2. Key informant interview with key personnel at the national and provincial level, as well as with UNICEF 3. Focus group discussion Service recipients <ul style="list-style-type: none"> • Caregivers of children in project areas; Service providers <ul style="list-style-type: none"> • Village doctors/village maternal and child health care workers; • Service providers of ECD care group activities; • ECD service providers conducting home visits; • Service providers at township health centers; • Service providers at county Maternal and Child Health institutions.
	S1.2 To what extent has the project built national and subnational ownership and capacity of stakeholders and institutions for systemic and sustainable change?	1) Sense of ownership expressed by relevant stakeholders. 2) Readiness in stakeholders' and institutional capacities for the scale-up. 3) Scalability and the scale-up strategies/plans made or considerations for incorporating the ECD project including the project's service content and delivery channels, and the reasons for challenges faced in the scale-up.	4. Mini focus group discussion <ul style="list-style-type: none"> • Managers of the township hospitals; • ECD project managers of township hospitals; • ECD project managers at the county level; • Managers of Maternal and Child Health institutions

Evaluation questions	Sub-questions	Indicators/Areas of inquiry	Data source/collection method
		4) Possibilities and reasons for continued investment in human resources, funding and equipment after the ECD project ends, and feasible incentive measures.	at the county level; <ul style="list-style-type: none"> • Heads of the Division of Maternal and Child Health of county health bureaus; • Officials from the Division of Maternal and Child Health of provincial health commissions; • ECD project managers at the province level.
S2. What are the cost considerations for scaling up the ECD project at different levels?		1) Current invested funding in the ECD project and its composition at all levels 2) Cost for various activities and services of the ECD project 3) ECD project training and Communication for Development cost 4) ECD project monitoring and technical support cost 5) ECD project management cost 6) ECD project design, equipment and materials cost 7) Stakeholders' views on the existing funding of the ECD project 8) Stakeholders' views on the existing costs of the ECD project	1. Desk review <ul style="list-style-type: none"> • Relevant ECD project inception report, annual reports, and funding utilization reports of UNICEF; • Relevant ECD project reimbursement reports of the CDC; • Relevant reimbursement reports of implementing partners in the ECD project areas (county, township and village level). 2. Key informant interview with key personnel at the national, provincial and county level, as well as with UNICEF <ul style="list-style-type: none"> • MCH and ECD project managers of the CDC; • Officials from the Division of Maternal and Child Health of provincial health commissions; • ECD project managers at the provincial level; • Heads of the Division of Maternal and Child Health of county health bureaus; • ECD project managers at the country level. 3. Mini focus group discussion <ul style="list-style-type: none"> • • Managers of MCH institutions at the county level; • Service providers of health institutions at the county level; • Service providers of township health centers; • Village doctor/village maternal and child health care workers; • Service providers of home visits; • Service providers of ECD care group activities.

Evaluation questions	Sub-questions	Indicators/Areas of inquiry	Data source/collection method
			Note: the implementation of project activities and the situation of funding support will be confirmed through interviews and focus group discussions. Moreover, the cost survey form will be explained, and support will be provided to complete the form where necessary.
S3. What policy, managerial and financial changes are needed to integrate the ECD project into the National Essential Public Health Services System?	S3.1 Among different levels of project managers and service providers, what are the perceptions about the extent to which the ECD project (including its service content, technical materials/tools, and delivery channels) could be integrated into the National Essential Public Health Services System?	<ol style="list-style-type: none"> 1) ECD project's service content that are relatively more mature and easier to be integrated into the National Essential Public Health Services System; the possible adaptations needed to be integrated and the corresponding reasons. 2) Gaps in resource allocation/administrative mechanism if the ECD project's service content were to be integrated into the National Essential Public Health Services System (including human resource, facilities and equipment, matching funds, coordination mechanism, and incentive mechanism). 3) Government's affordability of the aforementioned adjustments/gap-filling and suggestions. 	<ol style="list-style-type: none"> 1. Key informant interview <ul style="list-style-type: none"> • Officials from the Department of Maternal and Child Health, NHC; • Project officials from NCWCH of the China CDC; • Managers and project officers of UNICEF; • Project experts at the national level. 2. Mini focus group discussion <ul style="list-style-type: none"> • Officials from the Division of Maternal and Child Health of provincial health commissions; • ECD project managers at the province level; • Heads of the Division of Maternal and Child Health of county health bureaus; • ECD project managers at the county level; • Managers of MCH institutions at the county level. 3. Focus group discussion <ul style="list-style-type: none"> • Managers of township health centers; • ECD project managers of township health hospitals; • Service providers of township health centers; • Village doctors/village maternal and child health care workers.
	S3.2 What is the scalability of the ECD project nationwide and its scale-up strategies in the National Essential Public Health Services System? or any other ongoing programme?	<ol style="list-style-type: none"> 1) ECD project's scalability, the nationwide scale-up strategies, and the possible differences in priorities in the scale-up at different levels. 2) Possible key barriers and bottlenecks to scale-up the ECD project. 3) The opportune time to integrate the ECD project into the National Essential Public Health Services System in view of the 	<ol style="list-style-type: none"> 1. Key informant interview <ul style="list-style-type: none"> • Officials from the Department of Maternal and Child Health, NHC; • Project managers from NCWCH of the China CDC; • Project officers from UNICEF China Office; • Members of the national consultation experts team. 2. Mini focus group discussion <ul style="list-style-type: none"> • Officials from the Division of Maternal and Child

Evaluation questions	Sub-questions	Indicators/Areas of inquiry	Data source/collection method
		<p>existing service system and national/sub-national/community socio-economic conditions.</p> <p>4) Other feasible pathways and approaches to scale-up the ECD model nationwide, apart from being integrated into the National Essential Public Health Services System.</p>	<p>Health of provincial health commissions;</p> <ul style="list-style-type: none"> • ECD project managers at the province level; • Officials from the Division of Maternal and Child Health of county health bureaus; • ECD project managers at the county level; • Managers of Maternal and Child Health institutions at the county level.

Annex 3. Indicators for quantitative survey

OUTPUT	Indicators		Quantitative data collection methods	Baseline survey	Monitoring	Qualitative inquiry	Project counties	Comparison counties	
<p>OUTPUT 2- By 2020, 80% of pilot villages equipped with the applicable trained work forces to deliver quality ECD services to families and children via multiple delivery channels including clinics, care groups and home visits to enhance nurturing care covering health, nutrition, responsive caregiving, early learning and stimulation.</p>									
Input indicators	Human Resource	Number of person/times trained by the UNICEF-supported project at national, province, county, township and village level	Facility based survey		X		X		
		Number and % of local workers equipped with home visit skills	Facility based survey				X		
		Number and % of local workers equipped with child developmental monitoring skills	Facility based survey				X		
		Number and % of local workers equipped with parenting counselling skills to facilitate early stimulation, responsive caregiving and early leaning activities	Facility based survey				X		
		Number and % of local workers equipped with care group skills	Facility based survey				X		
	Facilities (supplies)	Number of ECD centers/activity rooms set up at county, township and village level supported by the project	Facility based survey		X			X	
		% of health facilities at county, township and village level having at least one type of ECD monitoring/screening tool available	Facility based survey					X	
% of health facilities at county, township and village level using materials recommended by the project for ECD counseling and guidance		Facility based survey					X		
Output indicators	Service availability	CI4: Number and % of health facilities at county, township and village level able to provide child developmental monitoring, screening and referral services	Facility based survey				X		
		CI5: Number and % of county, township and village clinics able to provide ECD counseling, guidance and promotion services	Facility based survey				X		

OUTPUT	Indicators		Quantitative data collection methods	Baseline survey	Monitoring	Qualitative inquiry	Project counties	Comparison counties
		CI6: Number and % of townships and villages able to provide home visits	Facility based survey				X	
		Number and % of health facilities at county level able to provide early interventions for children at risks	Facility based survey				X	
		CI7: Number and % of townships and villages able to conduct group sessions	Facility based survey				X	
		Number of sessions organized by ECD center/group session organizers in a defined time period	Facility based survey		X		X	
		Number of working days for group sessions	Facility based survey		X		X	
	Service quality	The average score of county, township and village providers on ECD (questions to be defined)	Facility based survey				X	X
		The acceptance of service providers towards ECD services proposed by the project	Facility based survey			X	X	
		The willingness of the service providers towards ECD services by the project	Facility based survey			X	X	
		The quality of service provision, including counseling, screening, group sessions and home visits	Onsite observation, facility based survey			X	X	
		CI12: The satisfaction level of caregivers with ECD services	Household survey			X	X	X
Output 3 - Households, community leaders and ECD service providers engaged and mobilized, and the literacy, skills and behaviours of the most disadvantaged children under 3 years old and their caregivers improved to access and use ECD services with at least 70% of eligible children and caregivers reached by ECD services via multiple delivery channels by 2020.								
Output indicators	Service coverage and compliance	CI8: % of children receiving monthly play and communication counseling via clinic services	Household survey				X	X
		% of children taking YYB in line with national standard	Household survey				X	X
		CI9: % of children receiving at least one group session	Household survey		X		X	X
		Number of group sessions that children attended	Household survey		X		X	X

OUTPUT	Indicators		Quantitative data collection methods	Baseline survey	Monitoring	Qualitative inquiry	Project counties	Comparison counties	
		CI10: % of children receiving child developmental monitoring	Household survey		X		X	X	
		% of children screened as positive using warning signs checklist	Household survey		X		X	X	
		% of children at risk of delay referred under 1 years old	Household survey		X		X	X	
		CI11: % of children at risk of developmental delays receiving home visits (>=1)	Household survey		X		X	X	
		Number of home visits children at risks received	Household survey		X		X	X	
	Nurturing care practice	CI18: % of exclusive breastfeeding (< 6 months)	Household survey	X				X	X
		Minimum dietary diversity	Household survey	X				X	X
		CI14: % of families having at least three picture books	Household survey	X				X	X
		CI15: % of families with two or more types of playthings	Household survey	X				X	X
		CI19: % of families support for early learning activities	Household survey	X				X	X
		CI20: % families with children 0-3 performing appropriate care, early learning and discipline	Household survey	X				X	X
		CI16: % of fathers participated in the parent-child activities	Household survey	X				X	X
	Nurturing care knowledge	CI17: % of mothers participated in the parent-child activities	Household survey	X				X	X
		% of caregivers knowing exclusive breastfeeding with children at a given age	Household survey					X	X
		% of caregivers knowing time for complementary feeding	Household survey					X	X
Demographic data		Number of project villages	Facility based survey	X			X		
	Total population in the county	Facility based survey	X				X	X	
	Total population in project sites	Facility based survey	X				X	X	
	Number of pregnant women in project sites	Facility based survey	X				X		
	Number of children under 3 in project sites	Facility based survey	X				X		
	Under 5 Child Mortality Rate in the county	Facility based survey	X				X		

OUTPUT	Indicators	Quantitative data collection methods	Baseline survey	Monitoring	Qualitative inquiry	Project counties	Comparison counties
	Education: illiterate rate	Facility based survey	X			X	
	Proportion of ethnic minorities	Facility based survey	X			X	
	Population living on less than US \$1.9/ day	Household survey	X			X	
	Population living on less than US \$3.2/day	Household survey	X			X	

Annex 4. Definition of key terms

This list contains definition of key terms, which is being updated and may be further enriched.

Key term	Definition
Project design	Project design includes service content, service frequency, delivery channels and specific modalities, and technical materials/tools used in the project.
Expected outcomes	Expected outcomes refers to the establishment of an ECD model in rural poverty areas of China and embed it into the existing government health system to prevent any child from compromised development and help them achieve their full potential.
Levels of support	Levels of support include universal support and targeted support, according to the definition in Nurturing Care Framework
Service content	Please refer to column 5 of Annex 5 for details.
Service frequency	Please refer to column 7 of Annex 5 for details.
Delivery channels	Delivery channels include village clinics, ECD care groups, and home visits.
Technical material/tools used in the project	Please refer to column 6 of Annex 5 for details.
ECD service package	ECD service package refers to service content, service frequency, technical materials/tools used in the project, and its delivery channels.
ECD model	ECD model refers to ECD service package, the enabling environment for the implementation of the ECD service package, and the specific modalities during the implementation of the ECD service package.
Target groups	The target groups include service recipients (children under 3 years old and their caregivers), service providers (at county, township, and village levels), and government (leaders and government officials in the health sector and other relevant sectors at all levels in the project areas).
Service recipients	Service recipients refer to children under 3 years old and their caregivers. Please refer to column 3 of Annex 5 for details.
Service providers	Service providers refer to service providers at the county, township, and village level. Please refer to column 4 of Annex 5 for details.
Government	Government refers to leaders and government officials in the health sector and other relevant sectors at all levels in relation to the ECD project.
Specific modalities	Implementation strategies for the ECD service package, such as how to select service providers, how to promote for ECD service package, how to attract family participation, how to maintain or improve family compliance, what incentive mechanisms are in place, and how to ensure service quality.
Disadvantaged children	Disadvantaged children include those in remote and poverty areas, children with language or cultural barriers, children born preterm, children with malnutrition or anemia, children with disabilities, and children left-behind. For the purposes of this evaluation, it also covers children from disadvantaged families, such as having a caregiver with mental illness or severe illness.

Annex 5. ECD intervention package

Levels of support (1)	Delivery channels (2)	Service recipients (3)	Service providers (4)	Service content (5)	Technical material/tools used in the project (6)	Service frequency (7)
Universal support	Village clinics	Children under 3 years old and their caregivers	Township child health care workers and village health care workers	<ol style="list-style-type: none"> 1. Growth monitoring 2. Developmental risks screening 3. Developmental delays screening with Warning Signs Checklist 4. Infant and young child feeding (IYCF) counseling 5. Play and communication counseling 6. Child safety and hand hygiene information sharing 7. Referral of children with suspected growth and developmental delays 	<ul style="list-style-type: none"> • WHO growth monitoring charts • Warning Signs Checklist • ECD counseling and guidance booklet based on the WHO-UNICEF Care for Child Development (CCD) and the IYCF counseling guideline • WHO-UNICEF CCD toolkit including CCD toys and materials 	Services delivered through village clinics rely on the national basic public health services. Accordingly, services for children should be provided on the 14 th and 28 th day, and then at the 3 rd , 6 th , 8 th , 12 th , 18 th , 24 th , 30 th and 36 th month after birth
Universal support	ECD care groups ⁴	Children under 3 years old and their caregivers	County MCH care workers, township child health care workers, village health care workers, and ECD care group facilitators (include but not limited to volunteers and parenting counselors)	<ol style="list-style-type: none"> 1. Conduct activities at the township, or village level 2. Main topics covered: parent-child secure attachment, sensitivity and responsiveness, communication, play, IYCF, injury prevention, book sharing 3. Each ECD care group session contains three components: a) Health education; b) Parenting information sharing; c) parent-child interaction activities 	<ul style="list-style-type: none"> • Care group manual • Care group health education flip charts 	Once every month
Targeted support	Home visits	Children under 3 years old at risk of developmental delays and their caregivers, including children born preterm, as well as children with low birth weight, anaemia, undernutrition, or other developmental delays)	Township child health care workers and village health care workers	<ol style="list-style-type: none"> 1. Topics covered: developmental monitoring, developmental risks counseling, IYCF counseling, play and communication counseling 2. Mobilize caregivers and children to participate in the ECD care group activities 3. Mobilize children with suspected growth and developmental delays to higher level institutions for support and intervention 	<ul style="list-style-type: none"> • Home visits service manual • IYCF counseling cards • Play and communication counseling cards • Developmental risks counseling cards • Warning Signs Checklist 	At least once every 1 or 2 month(s) for at least half of the year

⁴ ECD care group activities may be organized at the township or village level, depending on local arrangements.

Annex 6. Outline for the ECD evaluation report

Outline for the ECD Evaluation Report

Cover (project name, evaluation time period, sites, name, organization and entrusting party of evaluators)

Contents (Appendix)

Executive summary (project overview, evaluation purpose and objectives, report audience, evaluation methodology, key conclusions on findings, reflections and key recommendations)

1. Introduction
 - a) Country background
 - b) ECD project
2. Evaluation purpose, objectives, and scope
 - a) Purpose and specific objectives of evaluation
 - b) Evaluation scope
 - c) Evaluation criteria
3. Evaluation methods (methodology)
 - a) Data collection methods (information sources, sampling methods, interview and observation methods, etc.)
 - b) Data analysis strategies and applications
 - c) Quality control of data collection and analysis
 - d) Ethical issues (human rights, gender, privacy protection and anonymity, etc.)
 - e) Limitation of methods and its possible impacts
4. Main findings
 - a) Relevance
 - b) Effectiveness
 - c) Sustainability
5. Conclusions and Lessons Learned
 - a) Conclusions
 - b) Good practices and lessons learned
6. Recommendations
 - a) Suggestions on integrating the project into the national basic public health service system
 - b) Suggestions on the design of the next phase of the project
 - c) Issues that need attention in the future

Annex 7. Survey instruments (see separate document)

- 7.1. Interview outline
- 7.2. Quantitative survey questionnaire-project group
- 7.3. Quantitative survey questionnaire-comparison group
- 7.4. Costing questionnaire at the county, township and village level