Programme

" COUNTRY-LED FORMATIVE EVALUATION OF THE FIRST 1,000 DAYS PROGRAMME IN THAILAND "

INCEPTION REPORT

August 5, 2021

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ACRONYMS

ANC	Antenatal care
DAC	Development Assistance Committee
DOH	Department of Health, Ministry of Public Health
FGD	Focus Group Discussions
HDC	Health Data Center
HPH	Health Promoting Hospital
IDI	In-Depth Interviews
MOI	Ministry of Interior
MOPH	Ministry of Public Health
MSDHS	Ministry of Social Development and Human Security
OECD	Organisation for Economic Co-operation and Development
VHV	Village Health Volunteers
WCC	Well Child Clinic

1. INTRODUCTION

1.1 OVERVIEW

To promote accountability and learning as well as evidence-based decision-making, the Department of Health of the Royal Thai Government's Ministry of Public Health, with support from UNICEF Thailand Country Office, is commissioning a country-led formative evaluation of the "First 1,000 Days" programme (referred to henceforth as the First 1,000 Days programme), a 5-year programme implemented between 2018-2023. The programme goal of health promotion and disease prevention in order to achieve the desired outcome that "Children aged 0-2 years have full potential height, optimal weight, and age-appropriate development.

This evaluation programme will apply triangulation, a combination of quantitative and qualitative methods that can strengthen the validity of findings. Quantitative methods will be used to collect information on beneficiaries, and qualitative methods will be used to collect information on beneficiaries and duty bearers. The concurrent use of these two approaches will enable triangulation.

The MOPH will support operating costs for the quantitative component of the evaluation. The qualitative component will be supported using funds provided by UNICEF Thailand. The findings from the evaluation will provide an assessment of implementation progress to date, assess the relevance, coherence, effectiveness, efficiency, sustainability, inclusiveness, and impact of the programme, enable any important issues or gaps to be addressed, and contribute data to inform the next 5-year planning cycle of the Ministry of Public Health (MOPH).

This inception report provides details of the following: (a) Evaluation Framework research questions and matrix; 2) Evaluation methods, including place/area for data collection, sampling, and tools (questionnaires/guidelines); and 3) Work plan.

1.2 BACKGROUND AND DESCRIPTION OF OBJECT OF THE EVALUATION

Child growth and development is recognized as being a major global health issue, with an impact on global development, as reflected in the UN's Sustainable Development Goals (SDGs). Accordingly, access to adequate nutrition, elimination of malnutrition and reduction of stunting are reflected in SDG Goal 2, reduction of maternal and neo-natal mortality is a goal of SDG 3, and Early Childhood Development (ECD) is included in target 4.2 of SDG Goal 4: "By 2030, ensure that all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education." The World Health Assembly (WHA) set the following Global Nutrition Targets to be achieved by 2030:

- Stunting - 40% reduction in the number of children under-5 who are stunted
- Overweight - No increase in childhood overweight
- Anaemia - 50% reduction in anaemia in women of reproductive age
- Breastfeeding - Increase in the rate of exclusive breastfeeding during the first 6 months up to at least 50%
- Low birth weight - 30% reduction in low birth weight
- Wasting - Reduce and maintain childhood wasting to less than 5% by 2030

Under the Royal Thai Government's 20-year National Strategic Plan (2018-2038) and the Strategic Plan of the Ministry of Public Health's Department of Health, the following goals were established to be reached by 2022:

- 64% of children aged 0-5 years have full potential height and optimal weight
- Average height of children at 2 years will be 92 cm for boys and 91 cm for girls
- Average height of children at 5 years will be 113 cm for boys and 112 cm for girls
- 85 % of children aged 0-5 years have age-appropriate development

In general, Thailand has shown good progress in meeting the WHA goals, and has exceeded them in several areas. However, in regard to other indicators, further efforts are needed to meet targets. According to the Multiple Indicator Cluster Survey undertaken in 2018-19 (MIC 6) by the National Statistical Office (NSO), with support from the National Health Security Office (NHSO) and UNICEF Thailand Country Office, the rate of low birthweight was 9.5%, the rate of exclusive breast-feeding in infants aged 0-6 months was 14%, the rate of moderate to severe stunting in children less than 5 years was 13%, and 9% of children under 5 years were overweight. In regard to nutrition, the survey found that only 66.0% of children 6-23 months had an acceptable diet, and 84.6% of households used iodized salt. In regard to factors influencing learning, the MICS 6 survey found low rates in some key areas, such as the rate of involvement of fathers in provision of learning support to infants and availability of children's books.

In order to address these issues and respond more effectively to the goals of the National Strategic Plan and World Health Assembly, the First 1,000 Days Programme aims to contribute to the following specific Health and social goals:

1. Good child growth and optimal development
2. Increase intelligence levels
3. Reduce the problem of sickness due to communicable diseases
4. Reduce infant mortality due to mal/undernutrition
5. Reduce chronic non-communicable disease (NCD) in adulthood

In its approach to achieving the above goals, the First 1,000 Days programme differs in some important ways from the previous ANC and early childhood development (ECD) programme. In general, the approach has involved the promotion of a more holistic approach to maternal Health and child growth and development, with increased cooperation among relevant agencies, addressing specific nutritional and health issues, and increasing community involvement. In 2018, the programme covers three main areas of service provision: i) improvement of the quality of ANC/WCC according to the entitlement package; ii) raising the level of services; and iii) raising the level of community/local and network participation, for three target groups, comprising i) pregnant women; ii) infants 0-6 months; and iii) infants aged 6 months-2 years. In 2019 to 2020, the programme aims to enhance the ownership of the program at the local and community level Activities and expand the coverage of the programme from 1 to 2 sub-district in every provinces under the non-exclusion, full coverage, and high quality services. The current program included the following:

1.1 A gap analysis of diet/food consumption; dispensing of iron-folic iodine tablets/iron supplements; oral health care; promotion of physical activity/play, sleep, and development;

1.2 Development of the system and mechanism of health districts, provinces, and districts, to close the gap;

1.3 Promotion of participation of network partners, especially the community;

1.4 Support for the provision of milk and eggs to pregnant women, lactating women, and children;

1.5 Food demonstrations for pregnant women, lactating women, and children aged 6 months-2 years;

1.6 Practical training in food preparation for pregnant women, lactating women, and children aged 6 months-2 years, including brushing teeth (hands on);

1.7 Practical training for pregnant women to interpret nutrition assessment results and trends of weight gain;

1.8 Practical training for parents/carers in interpretation of nutritional status assessment and trends in height and weight gain in children;

1.9 Use of the Development Promotion and Surveillance Manual (DSPM) for monitoring child development by parents/carers;

1.10 Increased involvement of hospital nutritionists in provision of nutritional services, such as assessment of food consumption behaviour and nutritional advice.

In terms of geographical coverage, the programme target was for implementation in at least one *tambon* (sub-district) in at least 90 per cent of districts of every province by 2019, and at least two sub-districts for every district by 2020. Full details of the rationale, activities, and implementation strategy of the First 1,000 Days programme are presented in the manual "*Naew thang kan khap khluean mahasachan 1,000 wan raek khong chiwit*" published by the Department of Health.[1]

1.3 **PURPOSE, OBJECTIVES, AND SCOPE OF WORK**

The First 1,000 Days programme has now been implemented for 2 years, and it is considered timely to conduct a of review progress in implementation and the results achieved to date. The purpose of the evaluation is to assess the effectiveness of the First 1,000 Days programme, its coverage, the extent to which outputs correspond to targets that were set, identify any important gaps in the programme, and make recommendations for adjustments that will improve the programme. The evaluation will provide valuable information for a wide variety of stakeholders, including the Royal Thai Government and international agencies, such as UNICEF Thailand Country Office, but will be of particular benefit to the Senior Administrators in the Department of Health, the Women and Early Childhood Cluster of the Ministry of Public Health, and other concerned agencies such as the Ministry of Social Development and Human Security, local government administration and the Ministry of Interior**.**

The findings will enable the programme to be fine-tuned and any important issues or gaps to be addressed and contribute data to inform the next national planning cycle. Specifically, the evaluation has three main objectives:

1) To assess to the extent to which the First 1,000 Days Programme can contribute to optimal growth and development of children in Thailand;
2) To identify the main achievements of the First 1,000 Days Programme to date, the key challenges experienced and the key factors that have contributed to successful implementation;
3) To provide recommendations on how future programming may be improved, including approaches that could improve programme design, implementation, coordination, and monitoring.

[1] "*Naew thang kan khap khluean mahasachan 1,000 wan raek khong chiwit*", Department of Health, Ministry of Public Health 2018 (in Thai).

1.4 EVALUATION FRAMEWORK AND QUESTIONS

The key evaluation question to be answered by the evaluation is "To what extent has the programme contributed to optimal growth and development of children in Thailand?". In answering this question, specific aspects of programme implementation and results will be assessed using the Organisation for Economic Co-operation and Development's (OECD) Development Assistance Committee's (DAC) evaluation criteria, comprising relevance, coherence, effectiveness, efficiency, sustainability and impact.[2] In this evaluation, a further criterion of "inclusiveness" has also been added that includes the cross-cutting issues of equity, gender and human rights. Specific evaluation questions according to OECD/DAC criteria are as follows:

1) Relevance: The extent to which the intervention objectives and design respond to beneficiaries , global, country, and partner/institution needs, policies, and priorities, and continue to do so if circumstances change.
    - To what extent did the First 1,000 Days programme respond to and meet the identified needs of the target groups?
    - How effective was the programme design?
        - To what extent were programme results based on a theory of change (TOC) clearly outlining intervention logic and a results chain?
        - How appropriate was the programme approach and model of implementation in regard to achieving expected objectives and results?
2) Coherence: The compatibility of the intervention with other interventions in a country, sector or institution.
    - To what extent has the programme been compatible with other interventions, including policies, in Thailand that are related to the area of ANC/WCC and Early Childhood Development (ECD)?
        - To what extent was there cooperation between different agencies?
3) Effectiveness: The extent to which the intervention achieved, or is expected to achieve, its objectives, and its results, including any differential results across groups.
    - To what extent has the programme achieved its stated objectives? Specifically:
        - To what extent has the programme achieved its objectives in terms of planned geographical coverage and scope of activities?
        - To what extent has the programme improved the quality of ANC/WCC according to the entitlement package in regard to pregnant women (270 days), infants 0-6 months (180 days) and infants aged 6 months – 2 years (550 days)?
        - To what extent has the programme raised the level of services?
        - To what extent has the programme raised the level of community/local and network participation?
        - To what extent did pregnant women, parents, carers, staff understand the DSPM Manual for Monitoring Child Development, nutritional status

[2] http://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm

        assessment, child development standards and the First 1,000 Days Programme as a whole?
    - To what extent did the First 1,000 Days Programme result in additional burdens on workload, administration, facilities & equipment, and how were these accommodated?
  - What challenges to achievement of the programme's objectives have been encountered in the course of implementation and how have they been addressed?
  - What have been the main achievements of the programme to date, and what are the key factors that have contributed to successful implementation?
4) Inclusiveness: the degree to which the programme includes different population groups and ensures that they are treated fairly and equally.
  - How successfully has the programme included equity and gender equality, and reached the most vulnerable and marginalised people in the community (including elderly carers, women with disability, migrants and mobile populations, ethnic minority groups and stateless people)?
5) Efficiency: The extent to which the intervention delivers, or is likely to deliver, results in an economic and timely way.
  - To what extent was the programme implemented in the most cost-effective way possible, as compared to feasible alternatives?
    - How efficient were the management structures?
    - Was the programme budget appropriate in terms of intended outcomes?
    - Can programme outcomes be demonstrated through monitoring data and reporting?
  - Are there any aspects of the programme that could have been achieved more effectively by other more cost or time-effective means?
6) Sustainability: The extent to which the net benefits of the intervention continue, or are likely to continue.
  - What is the likelihood of the benefits being sustained after completion of the programme?
    - How likely is it that relationships and cooperation between stakeholders will be maintained after completion of the programme?
    - Is there local ownership of the programme and will staff be motivated to maintain services at the same level after completion of the programme
  - What sort of continued support is necessary in order to ensure that services are maintained at the same level after completion of the programme?
    - Will provision need to made for on-going training or capacity building of staff?
    - What other resources would be required in order to maintain services?
    - Should any changes be made in management or at the policy level to ensure services continue to meet the required standards of care?
7) Impact: The extent to which the intervention has generated or is expected to generate significant positive or negative, intended or unintended, higher-level effects.
  - To the extent that can be determined, what has been the impact to date of the First 1,000 Days programme, including positive and negative, primary and secondary, long-term effects produced, directly or indirectly intended or unintended?

Based on these specific evaluation questions, an Evaluation Matrix developed, including Sub-Questions, Measures/Indicators of progress, Data Collection Methods and Main Sources of Data/ Information (the Evaluation Matrix is attached as Annex I)

2. EVALUATION METHODS

Based on the innovative nature of the programme and its objectives, this section presents a possible approach and methods for evaluation. The breadth of the programme presents several methodological challenges for evaluation. These include the large number and widespread nature of the implementation sites, implementation at several different levels, involvement of several different agencies, and the wide range of expected outcomes, including biometric, individual behaviour and coordination outcomes. Also, it is expected that the evaluation will be both summative, providing information on the achievement of results to date in implementation sites, as well as formative, providing information that can be used to improve the programme.

For this reason, the project employs different methodological approaches, a mix of quantitative and qualitative methods. It also includes views of all key stakeholders, including both rights holders (parents/carers, particularly pregnant women and mothers) and duty bearers (for example, health staff, officials, and community network representatives).

Quantitative data will be obtained from mainly survey data obtained through the administration of questionnaires, either printed or online. In order to help gather additional information which is non-quantifiable or difficult to quantify, quantitative data will be complemented by qualitative data obtained from informants through in-depth interviews and focus group discussions. Guidelines will be developed during the inception phase for qualitative data collection. Qualitative data, which can also be gathered in non-clinical settings, will be used to validate quantitative data through triangulation, as well as explore in further depth any issues or inconsistences encountered in findings. Qualitative data will be drawn on to prepare a number of case studies of women and children involved in activities, illustrating key aspects of the programme.

Data will be obtained from two main groups of informants. The first comprises stakeholders (duty bearers) and the second beneficiaries (rights holders). Stakeholders will comprise officers at different levels from the MOPH, MSDHS, and MOI who have been involved with planning and implementation of the programme. They will include responsible staff from Health Regions, Health Promotion Centers (DOH), Provincial Health Offices, District Health Offices, Regional Hospitals/General Hospitals/Community Hospitals/Sub-district Health Promotion Hospitals.

Beneficiaries of the programme (rights bearers) comprise pregnant women, parents, carers and infants. With support of DOH, evaluation team will coordinate with focal persons at the provincial and district level in sampling of beneficiaries and selection of informants for interviews and focus group discussions.

2.1 SAMPLING STRATEGY

A multi-stage systematic random sampling method is adopted. There are three stages for the selection process, as briefly described below. The result of the selection is shown in **Table 1**. Finally, 8 Sub-districts are selected for data collection.

1) Thailand is traditionally divided into 4 regions: North, Central, Northeastern, and Southern Thailand. The simple random method has been applied to select 1 province from each region. Then the 4 provinces have been selected.
2) Then 2 districts from each province above are randomly.
3) Each district above, one Sub-district with the highest birth rate (data from Health Data Center (HDC), 2020) will be included in the study.

Table 1 Area for collecting data

Region	Province	Sub-district /district 1	Sub-district /district 2
North	Sukhothai	Krai Nai/Kong Krailat	Wang Luek/Si Samrong
Northeastern	Nongkhai	Ban Pho /Phon Phisai	Khok Khon / Tha Bo
Central	Chanthaburi	Wan Yao / Khlung	Thap Chang / Soi Dao
South	Krabi	Khlong Hin /Ao Luek	Khaotor / Plai Phraya

2.2 SOURCES OF DATA AND DATA COLLECTION METHODS

2.2.1 Sources of data

There are multiple sources of data to be collected. Documents review for programme management such as policy, the working committee in each level, and the related projects in the sub-district. A site visit and checklist will perform for the facility provided in the hospital. For participants, there are two main groups of informants. The first comprises stakeholders (duty bearers) and the second beneficiaries (rights holders). Total participants in each type of stakeholder is shown in Table 2.

Table 2 Type and number of participants

Type of target group	Target group	Number
Executive	**Ministry of Public Health** 1. Inspector of the Ministry of Public Health	4
	2. Supervisor of the Ministry of Public Health	4
	3. Director of Regional Health Promotion Center	4
	4. Director of Provincial Public Health office	4
	5. Director of District Public Health office	8
	6. Director of Hospital center/Provincial Hospital	4
	7. Director of District Hospital	8
	8. Director of District Hospital Health Promoting Hospital	8
Technical Officer Decentralize level	**Ministry of Public Health** 1. Public Health Technical Officer, Regional Health Promotion Center	4
	2. Public Health Technical Officer, Provincial Public Health Director	4
	3. Public Health Technical Officer, District Public Health	8
	Ministry of Interior Officer of Public Health and Environment Subdivision, Sub-district Administration Organization (SAO) / Sub-district Municipality	8

Type of target group	Target group	Number
	Ministry of Social Development and Human Security Technical Officer, Provincial Social Development and Human Security Office)	4
Service provides at ANC/WCC	**Ministry of Public Health** 1. ANC Health officer in Hospital center/Provincial	4
	2. ANC Health officer in District Hospital	8
	3. WCC Health officer in Hospital center/Provincial Hospital	4
	4. WCC Health officer in District Hospital	8
Beneficiaries	1. Pregnant women	40
	2. Postnatal women 0-11 months	64
	3. Parents/carers of children aged 0 - 6 months	240

2.2.2 Data collection methods

This evaluation will collect the data using both quantitative methods and qualitative methods as triangulation. For beneficiaries, quantitative methods using questionnaires for data collection in the first phase. Then in the second phase, after preliminary data analysis from questionnaires, qualitative methods using IDI and FGD will be applied. For duty bearers, only IDI will be applied for data collection. However, for VHV, after IDI in the first phase and preliminary data analysis, FGD will be applied in the second phase. The survey questionnaires, interview, and focus group discussion guidelines are included in ANNEX III.

2.2.2.1 Quantitative methods

The questionnaires will be used to collect data from beneficiaries, i.e., pregnant women, postnatal women 0-11 months, and parents/carers of children aged 0 - 6 months. The questionnaires were tested for validity by 3 experts and face to face piloting with people similar to the participants. Then revised questionnaires will be used in the evaluation for data collection by trained interviewers.

2.2.2.2 Qualitative methods (In-depth interviews and FGDs)

There are two groups for data collection by IDI, i.e., stakeholders (Duty bearers) and beneficiaries. FGDs will be conducted with beneficiaries and village health volunteers (VHVs).

1) In-depth Interviews (IDI) with stakeholders (Duty bearers)

IDI will be carried out with 88 key stakeholders (Duty bearers) at the national, provincial, and district levels, purposively selected as listed in **Table 2**. Each identified stakeholder will be contacted for the scheduling of interviews and discussions.

2) In-depth Interviews (IDI) with beneficiaries

After structured interviews with programme beneficiaries have been finished (in the quantitative phase), follow-up in-depth qualitative interviews will be conducted with a smaller number of beneficiaries. Participants will be purposively selected based on the criteria that they have reflected clearly crucial issues and essential aspects of the program, both negative and positive. A total of 12 pregnant women, 12 mothers of children aged 0 - 11 months, and 24 parents/carers of children aged 0 - 2 years of each province will participate in structured interviews. With the estimation from those participants, about 10-20% of each type of programme beneficiaries will be included. Therefore,

a total of 48 beneficiaries will be invited and participate in IDI at the Health promoting hospital (HPH). **(Table 3)**

Table 3 The number of programme beneficiaries for conducting in-depth Interviews.

Province	Pregnant women, (n)	Mothers of children aged 0 - 11 months (n)	Parents/carers of children aged 0 - 2 years (n)	Total
Sukhothai	3	3	6	12
Nongkhai	3	3	6	12
Chanthaburi	3	3	6	12
Krabi	3	3	6	12
TOTAL	**12**	**12**	**24**	**48**

3) Focus Group Discussions (FGD)

Village health volunteers (VHV) and beneficiaries are subjects for focus group discussions (FGD). Details are as follows:

a. The six village health volunteers (VHV) from each province will participate in FGD, which will take place at the Health Promoting Hospitals (HPH). Therefore, a total of 24 village health volunteers will participate in the research. The sample selection for VHV is by the criterion that they must have worked under the programme for at least 1 year. **(Table 4)**

b. The programme beneficiaries who participate in the focus group discussions (FGD) will be selected based on availability and willingness. The discussions will be at the Health Promoting Hospitals (HPH). The FGD will take place a few weeks after the finish of quantitative data collection and IDI. The number of FGD participants calculate as IDI, but participants need not be the same person as IDI participants. A total of 48 programme beneficiaries will participate in FGD. There will be 2 FGD groups in each province, i.e., pregnant and mothers of children aged 0 - 11 months will participate in one group, and the other group will comprise parents/carers of children aged 0-2 years. **(Table 4)**

Table 4 The number of programme beneficiaries and village health volunteers for conducting FGD.

Participants/Province	Sukhothai	Nongkhai	Chanthaburi	Krabi	Total
Duty bearers					
Village health volunteers	6	6	6	6	24
Programme beneficiaries					
Pregnant women and mothers of children aged 0 - 11 months	6	6	6	6	24
Parents/carers of children aged 0 - 2 years	6	6	6	6	24
TOTAL	**18**	**18**	**18**	**18**	**72**

2.2.3 Data analysis

Quantitative data analysis will be applied to analyze data from questionnaires from beneficiaries using descriptive statistics.

Qualitative data will be analysed using an iterative analytical process for thematic identification and triangulation based on multiple stakeholders' feedback.

Data on the same topic will be collected from multiple sources and by different methods to cross-validate data and capture different dimensions of the same process to reduce respondent bias. Where possible, direct quotes from beneficiaries and stakeholders will be selected to illustrate key findings. Moreover, having a participatory approach will ensure that several stakeholders will be contacted multiple times to ensure that data is triangulated throughout the evaluation.

2.2.4 Increasing reliability and validity of data collection and analysis

In order to increase the reliability and validity of the evaluation methods, the following methods will be used during the preparation of data collection tools, fieldwork, and data analysis:

- Having a variety of item types (multiple-choice, open-ended, quantitative and qualitative) in questionnaires, presenting and accounting for multiple response types, and ensuring objective answers;
- Triangulation of data by cross verification of main findings from two or more sources and through interaction with beneficiaries in two format types, survey interviews and focus group discussions;
- Validating findings from multiple stakeholders;
- Well-documented audit trail of materials and processes; and
- Making cross-references to quantitative aspects wherever possible.

Qualitative data obtained from this evaluation component will be fed into the evaluation report to complement quantitative data and address the key evaluation questions.

2.2.5 Ethical Considerations

The Ministry of Public Health Committee of Human Rights for Experiments Conducted with Human Subjects has approved the evaluation programme include the part that the MOPH supports operating cost budgeting for mainly quantitative methods and this research.

Before administration of questionnaires, the commencement of IDIs or FGDs, informants will be provided with an explanation about the purpose and the process of the study. The participants will be asked to sign the informed consent form to certify that they receive the information about the nature of the research and that they are willing to participate in the study. If any participant would like to discontinue his/her participation in the research project, he/she has the right to do so without any prejudice. Confidentiality will be maintained through not disclosing names or other identifying information regarding informants, coding, and safe storage of responses.

3. EVALUATION LIMITATIONS

Data collection will process under Covid-19 pandemics. Therefore, the limitations are aspects that can potentially make the evaluation work difficult are describe as outlined in Table 5 below. This table also summarizes information on the strategies that will use to overcome these limitations.

Table 5 Evaluation limitations and mitigation measures

LIMITATIONS	IMPACT (Minor/ Moderate Major)	METHODS EMPLOYED TO OVERCOME LIMITATIONS
Bias against under-represented groups in the selection of respondents as a result of convenience sampling due to travel restrictions	Moderate	• When appropriate, disaggregate data by individual characteristics (e.g., sex, age, income, disability, religion, ethnicity, and indigenous status), economic activity, and spatial dimensions (e.g., urban and rural). • Purposive selection of informants for IDIs and FGDs during the qualitative phase of data collection. • Collect and analyze both quantitative and qualitative methods as triangulation.
Inability to conduct on-site interview data collection due to lockdown measures	Moderate	• Use of remote data collection and analysis methods • Surveys via mobile phone, email, online tools. • Using Line application by video call as the first and then interview via Line. • Interview via phone call for a target group who cannot use Line or any application from the smartphone.
Inability to conduct on-site measuring child nutritional status and development data collection due to lockdown measures		• Use secondary data from the pink book • If on-site data collection is possible, the evaluation team will measure child nutritional status and development on-site.
Limited availability of field office staff and counterparts due to COVID-19 response	Moderate	• If the selected province faces a severe Covid-19 burden, if possible the evaluation team will select the nearby province instead. The Covid-19 situation of each province is an essential criterion for selection of provinces. • At the province level, sampling 2-3 districts and consult Provincial Public Health Office to recommend the district with low or zero Covid-19 patients. • Extend timing for data collection.
Some documents are only for internal use. This will limit the evaluation's ability to use the respective information and make reference to the source document.	Moderate	• Avoid using these sources to describe the contextual factors that directly impact the object of the evaluation.

LIMITATIONS	IMPACT (Minor/ Moderate Major)	METHODS EMPLOYED TO OVERCOME LIMITATIONS
Possible selection bias owing to reliance on local health authorities for recruitment of participants in Focus Group Discussions	Major	• Participants for FGD, particularly direct beneficiaries, are a challenge. In most cases, the district health authorities and facility managers recruited participants on their own. To avoid bias in beneficiary responses, the inclusion criteria will be applied, and participants will recruited by the evaluators.
Difficulty in conducting FGDs due to Covid-19 pandemic owing to risk of infection and concerns by the target groups, who might feel that it is unsafe to go and join the FGD.	Moderate	• In such cases, the evaluators will instead use in-depthinterview method for qualitative data collection with an increased number of respondents. • If on-site data collection is possible, the evaluation team will conduct FGD as planned, keeping sessions to 60–90 minutes and limiting each group's number to 4–5 participants.

4. WORK PLAN

The six months of the evaluation project, will comprise 3 phases, which are 1) inception, 2) data collection and initial analysis, and 3) analysis reporting and communication of results analysis. The detailed work plan is presented in Table 7, with additional details of deliverables in ANNEX II

Table 6 Work plan

	ACTIVITY	DELIVERABLE	WEEK	DAYS	TIMEFRAME		
					July 5-Aug 5	Aug 6-Sep 9	Sep 10-Oct 14
I	**INCEPTION**		**2 weeks**	**10**			
1.	Document review	Draft evaluation framework, sampling frame, instruments, and work plan	Weeks 1	3	■		
2.	Draft evaluation framework, sampling frame, preparation of instruments (questionnaires and guidelines for interviews and focus group discussions), and tentative work plan		Week 1	2	■		
3.	Share draft evaluation framework, sampling frame, instruments, and work plan with Steering Committee for review and comment	Feedback notes and comments on drafts	Week 2	1	■		
4.	Prepare Inception Report and submit to Steering Committee for review and feedback	Draft Inception Report	Week 2	2	■		
5.	Feedback to Evaluation Consultants on draft Inception Report	Draft Inception Report with comments	Week 2		■		
6.	Revise and submit revised Inception Report to Steering Committee	Final Inception Report	Week 2	2	■		
II	**DATA COLLECTION AND INITIAL ANALYSIS**		**8 weeks**	**40**			
7.	Pilot and refine data collection instruments and training of data collectors	Final versions of questionnaires and interview guidelines etc.	Weeks 3	5	■		
8.	Data collection:		Weeks 4-8	25	■	■	
9.	Preliminary analysis of findings and preparation of PowerPoint presentation for Validation Workshop	PowerPoint presentation	Week 9-10	9	■	■	
10.	Validation Workshop	PowerPoint presentation, meeting minutes	Week 10	1	■	■	

	ACTIVITY	DELIVERABLE	WEEK	DAYS	TIMEFRAME		
					July 5-Aug 5	Aug 6-Sep 9	Sep 10-Oct 14
III	**ANALYSIS, REPORTING, AND COMMUNICATION OF RESULTS**		**5 Weeks**	**25**			
11.	Data entry, cleaning, and analysis of findings		Weeks 9-12	8			
12.	Prepare a draft of the Evaluation Report and submit to Steering Committee for review and comment	Draft Evaluation Report	Weeks 12-13	7			
13.	Feedback from Steering Committee on Draft Evaluation Report	Report with comments	Week 13				
14.	Present draft Evaluation Results to stakeholders' Validation Meeting	Revised Draft Evaluation Report and PowerPoint presentation	Week 13	1			
15.	Revision of draft Evaluation Report based on feedback from stakeholders' validation meeting and submit to Steering Committee for approval	Final Evaluation Report	Week 14	5			
16.	Approval of Final Report, PowerPoint, by Steering Committee	Final Evaluation Report, PowerPoint	Week 15	1			
17.	Prepare 4-page briefing paper and submit to Steering Committee for review and approval	1 briefing paper in English and Thai	Week 15	3			
18.	Review and approval of Briefing Paper	briefing paper	Week 15				
			Total working days	**75**			

5. EVALUATION TEAM AND ORGANIZATION

The evaluation team is composed of 3 team members who work on the project. All of them are working in the Faculty of Public Health, Mahidol University. The main activities of each member are shown in Table 8, however,

Table 7 Evaluation team, organization, and activities

Name	Organization	Activities
Assoc.Prof.Dr. Jeeranun Klaewkla	Department of Nutrition,	Develop an effective evaluation plan, develop a management plan for the evaluation, devise data collection strategies to support the evaluation questions and design, pilot test the data collection instruments and procedures, collect data, analyze and interpret data, monitor the management plan.
Asst.Prof. Dr. Malinee Sompopcharoen	Department of Health Education and Behavioral Sciences	Devise data collection strategies to support the evaluation questions and design, collect data, analyze qualitative data and interpret data.
Asst.Prof. Dr. Vanvisa Sresumatchai	Department of Biostatistics	Devise data collection strategies to support the evaluation questions and design, collect data, analyze quantitative data and interpret data.

ANNEX I EVALUATION MATRIX

Evaluation criterion 1. Relevance				
Evaluation Question **To what extent did the First 1,000 Days program respond to and meet the identified needs of the target groups?**				
Sub-questions	Measure/Indicator of progress	Data Collection Methods	Main Sources of Data/ Information	Note
Were the objectives of the intervention relevant to identified needs of the target?	Evidence of different types of service/activities provided based on needs.	IDI Desk review	Duty bearers, beneficiaries Project documents(Plan, result)	
3.1.1 To what extent were program results based on a theory of change (TOC) clearly outlining intervention logic and a results chain?	relevant	Desk review IDI	Documents (plan, results) Stakeholders, DOH	
Evaluation criterion 2. Coherence				
Evaluation Question **To what extent has the program been compatible with other interventions, including policies, in Thailand that are related to the area of ANC/WCC and Early Childhood Development (ECD)?**				
Sub-questions	Measure/Indicator of progress	Data Collection Methods	Main Sources of Data/ Information	Note
What extent has the program been compatible with other interventions?	Evidence of policy that compatible with program	IDI Desk review	Duty bearers, project documents	
	Evidence of projects and activity that compatible with program	IDI Desk review FGD (VHV)	Health volunteer, ANC/WCC Health officer, Director of hospital, DOH VHV	
Has the project facilitated synergies with interventions and strategies promoted by other Ministry in Thailand				

Evaluation criterion 3. Effectiveness				
Evaluation Question **3.1 How effective was the program design?**				
Sub-questions	Measure/Indicator of progress	Data Collection Methods	Main Sources of Data/ Information	Note
3.1.1 To what extent were program results based on a theory of change (TOC) clearly outlining intervention logic and a results chain?	relevant	Desk review IDI	Documents (plan, results) Stakeholders, DOH	
3.1.2 How appropriate was the program approach and model of implementation in regard to achieving expected objectives and results?	-Level of satisfaction among beneficiaries -Desk review -Evidence of the program appropriateness	Questionnaire IDI	Beneficiaries Hospital director Stakeholder (duty bearers)	
	- Impression service (neg+positive)	FGD, IDI	Beneficiaries	

Evaluation Question 3 Effectiveness **3.2 To what extent has the program achieved its stated objectives? Specifically**:				
Sub-questions	Measure/Indicator of progress	Data Collection Methods	Main Sources of Data/ Information	Note
3.2.1 To what extent has the program achieved its objectives in terms of planned geographical coverage and scope of activities?	-% of beneficiaries participated -Types of activities provided	Questionnaires Recorded from the MOPH -Desk review	beneficiaries MOPH report	
3.2.2 To what extent has the program improved the quality of ANC/WCC according to the entitlement package in regard to pregnant women (270 days), infants 0-6 months (180 days) and infants aged 6 months – 2 years (550 days)?	-% of beneficiaries have appropriate knowledge -% of beneficiaries practice appropriately -Level of satisfaction on ANC/WCC attendance	Questionnaire IDI FGD IDI	Beneficiaries Stakeholde(director, policy)	

Evaluation Question 3 Effectiveness **3.2 To what extent has the program achieved its stated objectives? Specifically**:				
Sub-questions	Measure/Indicator of progress	Data Collection Methods	Main Sources of Data/ Information	Note
3.2.3 To what extent has the program raised the level of services?	-Evidence of better service of ANC/WCC - Type of training received for the program among ANC/WCC health officer	IDI	- Hospital Director -ANC/WCC health officer	
3.2.4 To what extent has the program raised the level of community/local and network participation	-Evidence of community participation -Number of network/partnership -Type of support from partnerships	IDI FGD	-Health volunteer -ANC/WCC health officer - Hospital Director Beneficiaries, VHV	

Evaluation Question 3 Effectiveness **3.3 How and to what extent were the innovative aspects of the First 1,000 Days accommodated by the existing programme?**				
Sub-questions	Measure/Indicator of progress	Data Collection Methods	Main Sources of Data/ Information	Note
3.3.1 To what extent did pregnant women, parents, carers, staff understand the DSPM Manual for Monitoring Child Development, nutritional status assessment, child development standards, and the First 1,000 Days Program as a whole?	- Level of knowledge of beneficiaries on DSPM - Practice of beneficiaries on DSPM -Level of satisfaction among beneficiaries on DSPM	Questionnaires	-Beneficiaries	
	- Evidence of practice of beneficiaries on DSPM, problem and solution among them	FGD IDIs	-Beneficiaries	
	- Level of knowledge on DSPM among officer -Level of satisfaction of officer on DSPM	IDI	-ANC/WCC health officer	
3.3.2 To what extent did the First 1,000 Days Program result in additional burdens on workload, administration, facilities & equipment, and how were these accommodated?	-Type of workload from the program among ANC/WCC health officer -Evidence of management of facility and instruments for the program	-IDI	-Hospital director -ANC/WCC health officer	
3.3.3 To what extent did staff have the capacity to implement the program, including reporting?	- Level of officer performance for conducting the program -Level of officer capacity on development report -Capacity needed	IDI	-Hospital director, staff	
3.3.4 To what extent was there cooperation between different agencies?	-Evidence of collaboration between different agencies for the program	IDI	Stakeholders (Duty bearers)	

Evaluation Question 3 Effectiveness **3.4 What challenges to achievement of the programme's objectives have been encountered in the course of implementation and how have they been addressed?**				
Sub-questions	Measure/Indicator of progress	Data Collection Methods	Main Sources of Data/ Information	Note
3.4.1 What challenges to the achievement of the program's objectives have been encountered in the course of implementation, and how have they been addressed?	-Type of challenge for achieving program objectives -Evidence of running under the challenges -Covid-19 impact	IDI Documents	Stakeholders (Duty bearers)	
3.4.2 What have been the program's main achievements to date, and what are the key factors that have contributed to successful implementation**?**	-Type of key achievement of program -Factors drive to program achievement in the future	IDI	Stakeholders (Duty bearers)	

Evaluation Question 4. Inclusiveness How successfully has the program included equity and gender equality, and reached the most vulnerable and marginalised people in the community (including elderly carers, women with disability, migrants and mobile populations, ethnic minority groups and stateless people)?				
Sub-questions	Measure/Indicator of progress	Data Collection Methods	Main Sources of Data/ Information	Note
What are the extent of vulnerable and marginalised people in the community receiving intervention?	-% of coverage among beneficiaries -language problem -disability (place, facility)	Document Questionnaire	MOPH report Beneficiaries	
Are the vulnerable and marginalised people in the community receive intervention same as others?	- Level of satisfaction among the poor and minority			
What are the support for disability and migrants to access ANC/WCC?	Facility supported	Site visit	Check list	
	- Evidence of satisfaction, equity	FGD IDI	-Beneficiaries	

Evaluation Question 5. Efficiency				
Sub-questions	Measure/Indicator of progress	Data Collection Methods	Main Sources of Data/ Information	Note
5.1 To what extent was the program implemented in the most cost-effective way possible, as compared to feasible alternatives?				
5.1.1 How efficient were the management structures?	-Evidence of effectiveness of management structure	IDI Desk reviews	-Hospital director -ANC/WCC Staff -Hospital document	
5.1.2 Was the program budget appropriate in terms of intended outcomes?	- Budget	IDI	Stakeholders (Duty bearers)	
5.1.3 Can program outcomes be demonstrated through monitoring data and reporting?	-% of the report on time -% of the correctness of the report -Monitoring system	IDI Desk review (clear,)	-Hospital director/policy - Datacenter officer of MOPH	
5.2 Are there any aspects of the program that could have been achieved more effectively by other more cost or time-effective means?	-The suggestion from the leader for improving program efficiency	IDI	Stakeholders (Duty bearers)	

Evaluation Question 6. Sustainability				
Sub-questions	Measure/Indicator of progress	Data Collection Methods	Main Sources of Data/ Information	Note
6.1 What is the likelihood of the benefits being sustained after completion of the program?				
6.1.1 How likely is it that relationships and cooperation between stakeholders will be maintained after completion of the program?	-Evidence of stakeholder collaboration will be continued after the program end	IDI	Stakeholders (Duty bearers)	
6.1.2 Is there local ownership of the program and will staff be motivated to maintain services at the same level after completion of the program?	-The level of program ownership among people in the community (annual Plan, document, policy, committee etc) -The level of motivation among health officer to maintain service quality after program end	IDI Desk review	local government organization, VHV -Hospital director -Staff	
	- Evidence of ownership among people in the community	FGD	-Beneficiaries) -VHV	
6.2 What sort of continued support is necessary in order to ensure that services are maintained at the same level after completion of the program?				
6.2.1 Will provision need to made for on-going training or capacity building of staff?	-Type of continue training needed of officer -Type of capacity building training need of officer	IDI	Stakeholders (Duty bearers:MOPH)	
6.2.2 What other resources would be required in order to maintain services?	-Type of resource needed to maintain service quality	IDI	- Stakeholders (Duty bearers:MOPH) -VHV	

6.2.3 Should any changes be made in management or at the policy level to ensure services continue to meet the required standards of care?	-Type of policy change for maintain service quality -Type of management change for maintain service quality	IDI	- Stakeholders (Duty bearers:MOPH) -VHV	

Evaluation Question 7. Impact

7. To the extent that can be determined, what has been the impact to date of the First 1,000 Days program, including positive and negative, primary and secondary, long-term effects produced, directly or indirectly intended or unintended?

Sub-questions	Measure/Indicator of progress	Data Collection Methods	Main Sources of Data/ Information	Note
Are there any unintended changes – positive or negative – in the lives of beneficiaries and in their environment? What were they? Were they directly or indirectly related to the programme or due to external factors?	- Evidence of positive/negative impact of program	IDI	- Stakeholders (Duty bearers)	
		Questionnaires IDI	-Beneficiaries	
Is there evidence of change – positive or negative? If so, what contributed to this change? If not, why not?		Questionnaires	-Beneficiaries	

ANNEX II DELIVERABLES

Table 8 Expected deliverables and timeframe

N	Expected deliverable:	Timeframe:
1.	**Inception Report** covers the following: (a) The refine evaluation questions, (b) confirm the scope, (c) elaborate on the approach and methodology, including sampling, detailed evaluation framework (evaluation matrix), and work plan, (d) present instruments to be used for surveys and collection of qualitative data and plans for data analysis. The Inception Report also presents outline the composition and role of the members of the evaluation team, coordination and management plans, resources (including a detailed budget), identify possible limitations and/or challenges to implementation of the evaluation, and measures to prevent or mitigate these, and outline any ethical considerations that may be foreseen and how these will be addressed. Detailed information such as survey questionnaires, interview and focus group discussion guidelines, and other tables or frameworks should be included as annexes.	August 5, 2021
2.	**PowerPoint Summary of Preliminary Evaluation Findings**. This report will present preliminary evaluation findings from data collection and draft recommendations that include key initial findings, identify any gaps in data collection.	September 9, 2021
3.	**Draft and Final Evaluation Reports** include an executive summary and excluding annexes, prepared according to the format and guidelines in the UNICEF-Adapted UNEG Evaluation Report Standards (2017) and GEROS tool And proofread by a native English speaker. The Executive Summary is both in Thai and English. The first draft of the final report will be submitted to the Evaluation Manager who works with the Steering Committee for comments and recommendations for revision. The Evaluation Manager will consolidate all comments and return the feedback to the Evaluation Consultant for use in the preparation of the final draft.	October 15, 2021
4.	**PowerPoint Presentation of Evaluation Findings.** The PowerPoint will be used in the presentation of the main findings and recommendations of the evaluation at a stakeholders' validation workshop. The Evaluation Consultant will use feedback from the key stakeholders' workshop to prepare the Final Evaluation Report.	October 15, 2021
5.	**Briefing paper.** Following approval of the Final Evaluation Report, the Consultant submit a briefing paper of 4-pages in length, in English and Thai, including key findings, lessons, and recommendations with infographics	October 15, 2021