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Formative evaluation of the Integrated Early Childhood Development (IECD) approach 2016 2018

Volume I: Main evaluation report

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Formative evaluation of the Integrated Early Childhood Development (IECD) approach (2016 2018)

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The United Nations Children's Fund (UNICEF) in Cambodia produces and publishes evaluation reports to fulfil a corporate commitment to transparency. These reports are designed to stimulate the free exchange of ideas among those interested in the study topic and to assure those supporting UNICEF's work that it rigorously examines its strategies, results and overall effectiveness.

The Formative evaluation of the Integrated Early Childhood Development (IECD) approach (2016 2018) was prepared by Anaïs Loizillon, Chea Kosal, Seng Bunly, and Rowan Hamill McMahon. The evaluation was commissioned by UNICEF Cambodia on behalf of the Ministry of Education, Youth and Sport. It was managed by a team led by Erica Mattellone (Evaluation Specialist, UNICEF Cambodia) with support provided by UNICEF Cambodia colleagues, namely: Etienne Poirot (Chief of Child Survival and Development, Integrated Early Childhood Development), Dr. Rathmony Hong (Health Specialist), Katheryn Bennett (Chief of Education), Sophea Nhonh (Education Specialist), Davy Cheann (Early Childhood Development Officer), Santepheap Heng (WASH Specialist), Chivith Rottanak (Child Protection Specialist), Sovannary Keo (Social Policy Specialist), Savy Bou (Communication for Development Officer), Saky Lim (Monitoring and Evaluation Officer), Elizabeth Fisher (Research and Evaluation Associate) and Miguel Pugliese Garcia (Evaluation Intern).

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Executive summary

In 2014, the Royal Government of Cambodia's National Committee for Early Childhood Care and Development (NC-ECCD) published a five-year National Action Plan on Early Childhood Care and Development (NAP-ECCD) 2014–2018. In line with an established body of evidence on the benefits of holistic and integrated ECCD services, the NAP-ECCD set out the introduction of new legal, implementation, monitoring and capacity development mechanisms for integrating and coordinating ECCD services across sectors. In support of the NAP-ECCD, the Royal Government of Cambodia–United Nations Children's Fund (UNICEF) CP Action Plan 2016–2018 incorporated a strengthened focus on improving intersectoral integration and coordination through a programme focused on Integrated Early Childhood Development (IECD).

This sought to support the NC-ECCD's implementation of the NAP-ECCD (2014–2018) by working on building capacity of government ministries, officials and service providers in target provinces and districts to plan, budget and deliver adequate and equitable IECD services. The CP aimed to overcome the causes of fragmentation, poor quality and unaffordable basic social services for disadvantaged families.

Upon completion of the CP 2016–2018, UNICEF commissioned a formative evaluation of the IECD approach in Cambodia. The evaluation commenced in January 2019 following the procurement of evaluation services from Oxford Policy Management (OPM).

This evaluation report presents findings, conclusions, lessons learned and tentative recommendations. Recommendations will be developed further with the Government of Cambodia and UNICEF stakeholders through a validation workshop in Phnom Penh on 12 September 2019, after which the recommendations will be revised. The final evaluation report will be completed by the end of September 2019.

The IECD approach in Cambodia

Coordinating or integrating services among various government entities responsible for different aspects of early childhood is considered one of the best guarantees that young children receive quality, holistic services (CCGECCD, 2016; UNESCO, 2006). The concept of integration of social services targeting children and pregnant women presupposes that significant barriers and bottlenecks are created through a single-sector approach to service delivery. These hindrances are creating obstacles and slowing down outcomes related to the well-being and full development of children.

Through its support to implementation of the NAP-ECCD, the new IECD subprogramme of the UNICEF CP aimed to ensure that children under the age of five and pregnant women gained improved and more equitable use of early childhood survival, care and development interventions and practices (particularly in target districts). With a budget of US$25.3 million over three

years, the IECD subprogramme adopted a 'whole district' approach in geographic areas with the lowest child development indicators: the north-eastern provinces of Mondulkiri, Ratanakiri, Kratie, Stung Treng and Preah Vihear, as well as poor urban areas of Phnom Penh. The objectives of the IECD programme were organized around Outcome 1 of the CP:

> "By 2018, infants, children 0 to 5 years old and pregnant women in target provinces have improved and more equitable use of integrated early childhood survival, care and development interventions and practices, including in emergencies."

Evaluation purpose, objectives and scope

Purpose: The evaluation is intended to promote accountability and, as a primarily formative evaluation, is focused on documenting learnings and providing recommendations to inform the design and delivery of the successor CP (2019–2023).

Objectives: The primary objectives are to:

1. Validate and reconstruct the Theory of Change (TOC) of the IECD approach.
2. Provide an assessment of Outcome 1 of the 2016–2018 CP and achievement of outputs.
3. Understand gaps and bottlenecks in providing IECD support and services to the north-eastern provinces and to the urban poor in Phnom Penh.
4. Document and make recommendations on lessons learned, good practices and innovations.

Scope: The scope of the evaluation covers the evolution of the IECD programme and its approach from 2016 to 2018 in the six target provinces (of which primary research was conducted in three). Namely, in Mondulkiri, Ratanakiri, Kratie, Stung Treng and Preah Vihear, as well as in urban poor communities of Phnom Penh. In agreement with the Reference Group, the evaluation did not consider impact or cost effectiveness and included cost efficiency only at a high level of analysis.

Neither UNICEF activities nor implementation of the NAP-ECCD outside of the six IECD target provinces were included in the evaluation's scope. The evaluation did not include primary quantitative data collection in its scope. The primary research was entirely qualitative, and given a limited volume of villages covered, is intended as illustrative: it cannot be considered representative of all experiences of IECD across all implementation areas.

Evaluation methodology

Framework: The evaluation was designed to answer a set of 12 questions structured around the Organisation for Economic Cooperation and Development–Development Assistance Committee (OECD–DAC) criteria of relevance, effectiveness, efficiency and sustainability. Impact was not included, as per the Terms of Reference (TOR), due to the evaluation's formative purpose. The evaluation also includes cross-cutting themes as a criterion, with particular focus on equity, gender equality and human rights considerations. The 12 questions were agreed between the Evaluation Team and the Reference Group.

Evaluation questions

Relevance

1. How appropriate is the programme approach to meet the needs of disadvantaged pregnant women, carers and children in the north-eastern provinces and among the urban poor in Phnom Penh?
2. Is the design of the approach conducive to realizing the outcomes and outputs as defined in the CPD 2016–2018?
3. How well-aligned is the approach with the National Action Plan (NAP) on ECCD 2014–2018 in particular?
4. How has the IECD approach affected policy change at the national level?

Effectiveness

1. What were the major achievements and challenges under the IECD programme and why? How did these vary between IECD programme areas?
2. How did the IECD approach improve the effectiveness of activities under the six IECD programme outputs?

Efficiency

1. How could the efficiency of the integrated approach, including human resourcing, be improved?

Cross-cutting

1. How well does the IECD approach incorporate and encourage equity and gender dimensions in its interventions, especially for those most disadvantaged?
2. To what extent are age, gender ethnicity, disability and other disaggregated data collected and monitored?

Sustainability

1. How well will the current approach sustain positive outcomes without financial and technical support from UNICEF or other development partners?
2. What are the key enabling factors to consider in scaling up the IECD approach in other districts and provinces?
3. What are the gaps and bottlenecks to creating lasting systems and resources and to scale up the approach in other districts and provinces?
4. What were the major factors that influenced the achievement or non-achievement of sustainability of the programme between 2016 and 2018? Are there any other factors emerging that the programme should consider?

Methods: In addition to a desk review of secondary sources, including UNICEF programme and government documentation, the evaluation collected primary data through three qualitative methods: individual key informant interviews (KIIs); focus group discussions (FGDs); and case studies. Given time and resource constraints on the evaluation, it was decided that the geographic scope of primary data collection should be limited to five districts across Kratie, Ratanakiri and Phnom Penh. The sample of respondents contained 146 stakeholders (107 female; 39 male), from whom data were collected through 76 KII respondents, 52 FGD participants and 14 individual case studies.

Sampling: Given time and resource constraints, primary data collection was limited to three out of six target provinces/municipalities: Kratie and Ratanakiri and urban poor communities in the municipality of Phnom Penh. These were selected as the provinces both with greatest concentration of IECD activities (and included the six districts of the longitudinal data collection) but also primarily given logistical constraints for the evaluation team to travel to the provinces further from Phnom Penh. At district level, 2 districts each were covered in Kratie and Ratanakiri, thereby covering 5 of the 6 target districts in those areas or 5 out of 10 overall. Random selection was used to eliminate one of the three districts in Ratanakiri. This selection maintained the expected overall representation of urban and rural communes, as well as remote regions. Within each of the five districts, a simple random selection was made of a single commune among those where UNICEF had provided technical or financial support in the areas of water, sanitation and hygiene (WASH), nutrition, health or Early Childhood Education (ECE). Among each of the 5 communes, 2 villages were selected randomly among all villages in that commune, totalling 10 villages in the overall evaluation sample. The sample balance among districts included three urban areas and two rural or remote areas (one in each province).

The evaluation used purposive sampling, selecting individuals based on their characteristics relevant to the study, to balance the selection of interlocutors based on their age, gender, location and economic status to ensure wide representation of all sectors of society. Targeting of participants in FGDs and case studies was to be based on suggestions received from the village chiefs and village health volunteers. The sample was not intended to be statistically representative of all experiences in the targeted areas, given its small size and the qualitative nature of the primary data collection. Nonetheless, the use of a simple random selection process for the selection of villages was intended to reduce any risk of bias in the selection of individuals while maintaining a diverse target group.

Limitations: The chief limitations to the evaluation are the scale of primary data collection and the attribution of responses to the IECD approach. The IECD approach is not consistently defined, and the evaluation found that at provincial, district, commune and village levels awareness of the IECD programme and its approach among officials was low, which clouds attribution of responses given to the IECD programme. Because of the volume of administrative levels and sectors operating in the IECD target areas, the sample of stakeholders

interviewed is broad but limited in depth. This renders evidence illustrative rather than authoritative, and despite repeated attempts, a number of key respondents were not available for interview or could not be identified. The Evaluation Team did not have the access expected to quantitative data from the longitudinal survey. To the greatest extent possible, these limitations were mitigated by triangulating responses from a diverse range of respondents and from secondary sources.

Key findings

The evaluation drew the following key findings in response to the 12 evaluation questions.

Relevance

1. The approach is highly relevant to the needs of the groups targeted, although needs around service access in remote locations and time poverty need further attention.
2. The approach was well-designed towards achieving the stated outputs, but design of outputs was not conducive to increasing the integration of services as intended.
3. The design of the approach partially targeted equity, and failed to target resilience to emergencies.
4. The IECD approach was adequately developed to support the operationalization of the NAP-ECCD 2014–2018.
5. The IECD approach created an enabling environment for developing cross-sectoral strategies and has strengthened the technical capacity of line ministries, but cross-sectoral implementation is still challenging.

Effectiveness

1. The IECD approach has contributed to the achievement of the programme's six output objectives, but it missed opportunities for effectiveness around strengthening and integration of planning and coordination of services.
2. The capacity of sub-national administrators regarding the IECD programme has been strengthened by UNICEF-supported training and advocacy, but cross-sectoral collaboration is patchy.
3. The IECD programme appears to have helped build the foundations for the integration of local service delivery through training of education, health and rural development front-line workers. Yet, there is limited evidence in terms of formal intersectoral work at the service delivery level.
4. The IECD programme and its approach (in the provision of discrete activities) are filling much-needed gaps to build the foundations for an integrated approach across the relevant sectors for the improvement and more equitable use of integrated ECCD interventions and practices.
5. IECD-related activities, such as training of front-line workers, contributed to increasing parental knowledge and behaviour regarding the holistic developmental needs of their children.
6. The IECD approach appears to be slowly improving services regarding some vulnerable groups.
7. Ethnic minorities and remote villages are the most difficult populations to reach and are often neglected in terms of outreach and service delivery because of cost and resource restrictions.

Efficiency

1. At the operational and strategic levels, there is little to no evidence of systematic intersectoral coordination of activities and it is likely that opportunities to achieve efficiencies are missed.
2. At the activity level, the IECD approach has demonstrated some examples of efficient cross-sectoral collaboration.
3. Strategic opportunities to capture and demonstrate efficiencies were not exploited.

Cross-cutting

1. By targeting pregnant women and primary caregivers who tend to be female in most households, the IECD programme and approach largely omits fathers.
2. The most disadvantaged groups remain difficult to reach with the IECD approach.
3. Tools and disaggregated data collection specifically designed to identify and measure disadvantaged groups do not currently exist.
4. Some limited evidence of intersectoral monitoring and evaluation (M&E) was noted at the provincial level during the 2016–2018 period.
5. Data convergence does not occur within an administrative level or across sectors, making the monitoring of the target population of the IECD approach inherently difficult.

Sustainability

1. Most of the effective interventions (advocacy, capacity development and M&E) have received significant financial and technical support from UNICEF and other development partners.
2. The IECD approach's delivery of holistic ECCD information and training benefit from existing cross-sectoral infrastructures, but their capacity can also be a limiting factor.
3. Accountability for results in reaching NAP-ECCD outcomes is weak or not clearly delineated at the sub-national level.
4. The capacity development of rights holders is focused on training, with little follow-up or sufficient empowerment.
5. Participation in parental education training faces a number of barriers, including access and interest.
6. UNICEF funding enabled sub-national government activities focusing on pregnant women and children aged zero to five, which would not have occurred otherwise.
7. The IECD programme and its training activities rely heavily on the presence of non-governmental partners, which are frequently limited in scope and inequitable in coverage.

Conclusions

Relevance: The IECD approach was highly relevant in terms of both the serious and urgent needs of the target groups and alignment to the NAP-ECCD. The programme's generation of evidence and advocacy further heightened the relevance of the approach by raising the profile of IECD issues on the national policy agenda. At the sub-national level, there is substantial variation in commitment to IECD at the senior administrative level. The programme was well-designed to achieve its outputs but insufficiently oriented towards maximizing cross-sectoral integration. With the new NAP 2019–2023, there is a real opportunity to build and capitalize on growing support for IECD approaches.

Effectiveness: Overall, the IECD programme and approach have had a positive effect; through the advocacy and technical support provided by UNICEF and its partners, the well-being of pregnant women and children under age five has improved to some degree. Most notably, the IECD programme has advanced the discourse around ECCD and created an understanding around the need for integrated service delivery. Rights holders and front-line workers have developed a keener sense on the rights and needs of their children, and they are using and requesting public services that they have ignored in the past.

The capacity for cross-sectoral integration is still weak in the implementation of the approach and the organization of activities, with section and line ministry silos reducing the scale of effectiveness. Given the selection of target districts, the IECD approach has improved equity in reaching out to needy and vulnerable populations but has been less effective for the most difficult-to-reach groups.

Efficiency: The IECD approach has generated small examples of more efficient outreach and dissemination of information, which could be used to demonstrate the value of integrated approaches for increasing efficiency. However, workplans, budgets and monitoring were conducted largely within sector silos, and this obstructed systematic realization of efficiencies. Institutionally, government intersectoral coordination was stronger over the programme duration in Ratanakiri than in Kratie. Focused M&E of cost efficiency and cost effectiveness was not conducted. The approach would likely benefit from a more deliberate attitude towards efficiency by articulating efficiency as both an objective and a strategy towards improving ECCD outcomes.

Cross-cutting themes: By definition, the IECD approach targets vulnerable populations in the most disadvantaged areas of the Kingdom of Cambodia. The improvements in maternal and child outcomes among vulnerable populations is not recorded by the IECD approach as disaggregated data are not available, except for longitudinal data. The IECD programme has not sufficiently addressed the needs of the most vulnerable groups because of the diverse challenges in reaching these groups, nor has it been able to include fathers in a meaningful manner. These groups require additional or specific programmatic elements to be included successfully.

Sustainability: The IECD programme required significant investment from UNICEF in terms of financial and human resources, which were bolstered by the partnerships established with local and international non-governmental organizations (NGOs) as well as other development partners. The existence of cross-sectoral mechanisms, such as the Women and Children's Consultative Committees (WCCCs), provided a solid foundation for the inclusion of the IECD approach in government policies. Accountability was often lacking in key coordinating and implementing bodies. A critical missing aspect in the design of the IECD approach is the role and responsibilities of communities, which could have important implications for the sustainability of the IECD approach in the targeted areas as well as in other provinces. A sustainable scale-up of the IECD approach across the country should also be required to consider proper monitoring of inputs and outputs. Understanding a programme's strengths and weaknesses can provide learnings for expanding efforts in other environments. Yet, evidence-based policymaking in low-resource countries has financial and technical implications for the national expansion of IECD.

Lessons learned

The experience of the IECD programme 2016–2018 has generated some lessons with relevance to the design and implementation of other efforts towards the integration of ECCD services, both in Cambodia and elsewhere.

- Evidence and advocacy have played a key part in identifying the need and generating the consensus for reform for improved ECCD services.
- The IECD programme targeted pregnant women and children aged zero to five in vulnerable districts; nevertheless, focused, innovative strategies and disaggregated monitoring are required to ensure that IECD benefits are accessible and extended to the hardest-to-reach.
- Village-based actors have played a key role in the provision of more holistic ECCD information and in strengthening service referral, and are likely to represent a key outreach resource in hard-to-reach areas and other parts of Cambodia.
- Communities have much potential to improve the status of pregnant women and children aged zero to five, but this has not been sufficiently leveraged.
- Strengthening governance and accountability is essential to maximize the benefits from integration.
- Accountability for and ownership of IECD at all levels is fundamental.
- Implementation of strategies in (at least) planning, budgeting and monitoring is needed to break down silos.
- Efficiency is an important IECD objective, and quantifiable efficiency is a powerful advocacy tool that is easy to overlook.

Recommendations

National and sub-national strategic level

1. **Strengthen and reinforce national and sub-national capacities to implement the NAP-ECCD and IECD approach.** The NC-ECCD within the framework of the new NAP-ECCD should clearly state the roles and responsibilities of the different line

ministries and their decentralized bodies with regards to ECCD and to establish cross-sectoral linkages in a regular, reliable, effective and detailed framework. The members of the national NC-ECCD working group need to be high-level technical staff that are clearly assigned by each ministry so that all members can participate regularly (quarterly at minimum) and meaningfully in the meetings. The NAP-ECCD needs to define clearer roles and responsibilities for the PWCCCs/DWCCCs/CWCCCs to provide effective implementation and monitoring at the sub-national level and to reduce the fragmentation of service delivery.

2. **Each main line ministry of the NC-ECCD must establish clear roles and responsibilities for ECCD leadership and implementation at each sub-national level, with the aim of strengthening cross-sectoral effectiveness.** To support national-level objectives, mid-level mechanisms (provincial level) need to have clear roles and responsibilities to manage the implementation of ECCD priorities at lower administrative levels as established in the NAP-ECCD. Line ministries through the NAP-ECCD should receive adequate budget support to remove environmental bottlenecks that sub-national departments face in reaching vulnerable populations, e.g. transportation limits, seasonal migrants, etc.
3. **Establish an effective M&E framework to monitor the IECD approach which supports national standards and which ensures integrated delivery of services.** The M&E framework of the new NAP-ECCD needs to assess the status and progress on targeted outcomes for pregnant women and children. Indicators should go beyond measuring outcomes and also monitor the impact of integrated and cross-sectoral service delivery, while ensuring a sufficient level of data disaggregation to cover specific target populations and vulnerable communities. UNICEF technical support should ensure adequate training at the sub-national level on PWCCC monitoring capacity, sub-national convergence of quality data, and regular reporting mechanisms for the WCCCs from commune to provincial levels.
4. **Design and develop a national communication strategy to support awareness of ECCD.** UNICEF should develop a national communication strategy with the NC-ECCD to reinforce messages around holistic ECCD for children, parents, caregivers and future parents. The strategy needs to be adapted to target diverse populations (e.g. fathers, linguo-ethnic groups). The NAP-ECCD needs to be disseminated at both the national and sub-national levels and train all implementing stakeholders down to the provincial level (PWCCCs). UNICEF and partners should support the development of a national ECCD network of implementing stakeholders.

IECD service delivery and programmatic level

5. **Develop a holistic approach to counselling and service delivery by front-line workers** who are working with pregnant women and children aged zero to five. UNICEF can support the development of training, guidelines and guidebooks for implementing cross-sectoral activities across the various sub-national levels. Cross-sectoral links at the village and

commune levels should be further strengthened through an established framework on the delivery of coordinated services by each line ministry.

6. **Design and focus specific outreach programmes targeting the most vulnerable populations at greatest risk of poor development.** Cross-sectoral programming in low-resource areas requires a systematic approach that is better adapted to identifying and providing intensive services to the most vulnerable populations and excluded groups. Sub-national departments of NC-ECCD line ministries need to identify and target the most vulnerable families by enabling local authorities and service providers. UNICEF and government should work to formalize links between ECCD and social protection mechanisms to provide support to the most vulnerable families and encourage use of available protective social services.
7. **Strengthen community education and participation in ECCD.** Community-based programming enables more flexibility and adaptability in social service delivery to meet the specific needs of each village and commune. UNICEF and partners should continue to support MOI with regular resources (e.g. training, capacity-building and technical support) to build local decision-making capacity of councils. UNICEF should encourage opportunities for inclusive participation of civil society advocates and representatives of vulnerable families as observatory or standing members in DWCCCs and CWCCCs.

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List of abbreviations

ARNEC	Asia–Pacific Regional Network for Early Childhood
ASEAN	Association of Southeast Asian Nations
CLTS	Community-Led Total Sanitation
CP	Country Programme
CPD	Country Programme Document
CPS	Community Pre-School
CWCCC	Commune Women and Children's Consultative Committee
DOE	District Office of Education
DWCCC	District Women and Children's Consultative Committee
ECCD	Early Childhood Care and Development
ECCE	Early Childhood Care and Education
ECD	Early Childhood Development
ECE	Early Childhood Education
ESP	Education Strategic Plan
FGD	Focus Group Discussion
HWTS	Household Water Treatment and Safe Storage
IDPoor	Identification of Poor Households
IECD	Integrated Early Childhood Development
KII	Key Informant Interview
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MEF	Ministry of Economy and Finance
MIS	Management Information System
MOEYS	Ministry of Education, Youth and Sports
MOH	Ministry of Health
MOI	Ministry of Interior
MOWA	Ministry of Women's Affairs
MRD	Ministry of Rural Development
NAP	National Action Plan
NAP-ECCD	National Action Plan on Early Childhood Care and Development

NC-ECCD	National Committee for Early Childhood Care and Development
NGO	Non-Governmental Organization
NP-ECCD	National Policy on Early Childhood Care and Development
NSDP	National Strategic Development Plan
OECD–DAC	Organisation for Economic Cooperation and Development – Development Assistance Committee
OPM	Oxford Policy Management
PDRD	Provincial Department of Rural Development
POE	Provincial Office of Education
PWCCC	Provincial Women and Children's Consultative Committee
RAM	Results Assessment Module
RS	Rectangular Strategy
RWP	Rolling Workplan
RWSSH	Rural Water Supply, Sanitation and Hygiene
SAM	Nutrition-Specific Services
SDG	Sustainable Development Goal
SEL	Social Emotional Learning
TCC	Technical Coordinating Committee
TOC	Theory of Change
TOR	Terms of Reference
TWG-H	Technical Working Group for Health
TWG-RWSSH	Technical Working Group on Rural Water Supply and Sanitation
UNDP	United Nations Development Programme
UNEG	United Nations Evaluation Group
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WCCC	Women and Children's Consultative Committee

1 Introduction

In 2014, the Royal Government of Cambodia's NC-ECCD published a five-year NAP-ECCD 2014–2018. In line with an established body of evidence on the benefits of holistic and integrated ECCD services, the NAP-ECCD set out the introduction of new legal, implementation, monitoring and capacity development mechanisms for integrating and coordinating ECCD services across sectors.

In support of the NAP-ECCD and building on the findings of the midterm review of the previous CP (2011–2015), the Royal Government of Cambodia–UNICEF CP Action Plan 2016–2018 introduced a strengthened focus on improving intersectoral integration and coordination. This sought to support the NC-ECCD's implementation of the NAP-ECCD (2014–2018). By working on building capacity of government ministries, officials and service providers in target provinces and districts to plan, budget and deliver adequate and equitable IECD services, the CP aimed to overcome the causes of fragmentation, poor quality and unaffordable basic social services for disadvantaged families.

Through its support to implementation of the NAP-ECCD, the new IECD subprogramme of the CP aimed to ensure that children aged zero to five and pregnant women gained improved and more equitable use of early childhood survival, care and development interventions and practices, particularly in target districts.[1] With a budget of US$25.3 million over three years, the IECD subprogramme adopted a 'whole district' approach in geographic areas with the lowest early child development and socioeconomic indicators than national averages: the north-eastern provinces of Mondulkiri, Ratanakiri, Kratie, Stung Treng and Preah Vihear, and the poor urban areas of the capital, Phnom Penh.

At the culmination of the CP 2016–2018, UNICEF commissioned a formative evaluation of the IECD programme and approach in Cambodia. The evaluation is intended to document learnings and provide recommendations to inform the delivery and evolution of the successor CP (2019–2023). The evaluation will feed into UNICEF's midyear and annual programme reviews, as well as the midterm review of the CP. The evaluation was not intended to assess impact.

The evaluation commenced in January 2019 following the procurement of evaluation services from OPM. The scope of the evaluation covers all areas of IECD implementation but, because of resource constraints, primary data collection was

1 *The Cambodia CP Action Plan identifies the IECD programme and its approach as targeting "infants, children 0 to 5 years old and pregnant women" (Royal Government of Cambodia and UNICEF, 2015, p. 11). The NAP-ECCD's vision includes children from conception to under the age of six. The official years of ECE participation in Cambodia are ages three to five. The 2016–2018 and the 2019–2023 Country Programme Documents (CPD) identify the target population as children under the age of five. These inconsistencies in the upper age limit are noteworthy for coordinated and integrated policy action.*

limited to small samples in five districts of Kratie, Ratanakiri and Phnom Penh.[2] Data collection consisted of a desk review of programme and government documentation and a set of 76 KIIs, 10 FGDs and 14 case studies with rights holders and duty bearers at all administrative levels.

The chief limitations to the evaluation are the scale of primary data collection and the attribution of responses to the object of the evaluation. The IECD programme and approach are not consistently defined, and the evaluation found that, at provincial, district, commune and village levels, awareness of the IECD programme and its approach among officials was low, which clouds attribution of responses given to the IECD programme. Furthermore, the set of stakeholders is broad, given the number of administrative levels and sectors operating in the IECD target areas, but limited in depth. The size of the sample renders evidence illustrative rather than authoritative and, despite repeated attempts, a number of key respondents were not available for interview or could not be identified.

This evaluation report presents findings, conclusions, lessons learned and recommendations. Initial findings were presented and discussed with the Reference Group at a workshop in Phnom Penh in July 2019. The full findings and recommendations were developed further with Government of Cambodia and UNICEF stakeholders during a full-day validation workshop in Phnom Penh held on 12 September 2019, after which the findings were amended and recommendations were revised.

2 *Approximately half of the budget originally specified for the evaluation in the CP Action Plan was available.*

2 Context

Social, economic and political context

Cambodia's growth rate of 7.6 per cent between 1994 and 2015 was the sixth highest in the world, and in 2015 the country achieved lower-middle-income status (World Bank, 2019). Over the past five years, Cambodia has consistently been among the two fastest growing economies in the Association of Southeast Asian Nations (ASEAN) region (ADB, 2018), with high growth rates forecast to continue over the medium term. In 2019, growth is forecast to rise from 6.9 per cent to 7 per cent (World Bank, 2018b). Cambodia's economic development has contributed substantially to bringing millions of poor Cambodians out of extreme poverty. The World Bank has reported a reduction in extreme poverty from 47.8 per cent in 2007 to 13.5 per cent in 2014 (World Bank, 2018).[3] However, millions of Cambodians remain close to the poverty line.

Despite broad-based poverty reductions and the World Bank's reclassification of Cambodia as a lower middle-income country, the vast majority of families who escaped poverty did so by a small margin. According to the Oxford Poverty and Human Development Initiative's Global Multidimensional Poverty Index, which examines a combination of indicators on health, education and quality of living, 34.9 per cent per cent of Cambodians were poor in 2018. The United Nations Development Programme (UNDP)'s Human Development Index is a summary measure for assessing long-term progress in three basic dimensions of human development: a long and healthy life, access to knowledge and a decent standard of living. Between 1990 and 2017, Cambodia's Human Development Index has improved by almost 60 per cent. Over this period, life expectancy increased by 15.7 years and mean years of schooling by 2.1 years. Overall, however, Cambodia scores worse than the Lao People's Democratic Republic and Myanmar in a comparison of human development indicators, scoring worst in quality of health and quality of education, and joint worst in standard of living (UNDP, 2018).

There are substantial variations in poverty in Cambodia along urban–rural and regional lines. Cambodia's population is highly rural (84 per cent), and much of Cambodia's recent poverty reduction occurred among this majority rural population. Nevertheless, rural areas generally remain much poorer than urban areas. Just 1.2 per cent of the urban population is in severe poverty, compared to 14.1 per cent of the rural population (Oxford Poverty and Human Development Initiative and OPM, 2018). Severe poverty varies from just 0.5 per cent of the population in Phnom Penh and 4.8 per cent in Svay Rieng to 30.1 per cent in Kratie and Mondulkiri and Ratanakiri regions.

3 *Differences in estimates arise from the construction and setting of the poverty line (see ADB 2014 for further discussion).*

Human development has risen on the public policy agenda. While previous development strategies focused heavily on infrastructure, the Rectangular Strategy (RS) for growth, employment, equity and efficiency phase III (RS III) and National Strategic Development Plan (NSDP), both 2014–2018, placed much greater emphasis on human development. RS III identified human capital as a central element of Cambodia's future competitive advantage, while the 2011 National Social Protection Strategy for the Poor and Vulnerable and 2014 National Food Security and Nutrition Strategy both adopted multisectoral approaches in targeting poverty reduction (ADB, 2014).

Overview of the situation of infants, children aged zero to five and pregnant women in Cambodia[4]

In 2015, nearly 1.8 million children were under the age of five and 4.3 million women were of reproductive age; both groups represented nearly 40 per cent of the total Cambodian population (United Nations DESA, 2019).[5] The status of this large population group improved across a range of measures, but serious issues persist, particularly in the country's poorest and most remote areas. During the 1990s and 2000s in particular, Cambodia made significant progress towards the Millennium Development Goal (MDG) targets related to early childhood development (ECD), most notably by achieving all targets related to maternal mortality and under-5 survival (UNICEF, 2018).[6] Strengthening public health systems was an important factor in achieving these results. Cambodia invested in transport infrastructure, construction of health care facilities throughout the country and increased the quantity of trained midwives across formal and less formal maternity and extended delivery rooms (Mallick et al., 2018; WHO et al., 2015). A larger percentage of babies were delivered in health centres under the supervision of trained midwives (UNICEF, 2016a).

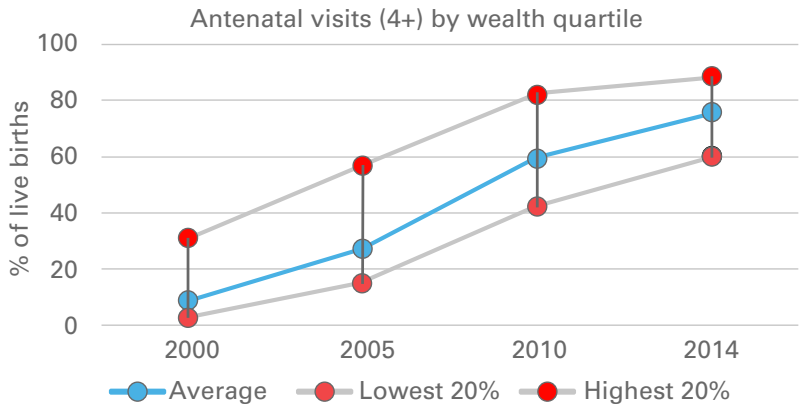
Cambodia was one of the nine countries worldwide to meet MDG Target 5A to reduce maternal mortality ratios by at least three-quarters between 1990 and 2015 (WHO et al., 2015). Between 1990 and 2015, the maternal mortality ratio reduced from 1,020 in every 100,000 live births to 161 in every 100,000 live births, an 84 per cent reduction (WHO, 2016). Cambodia demonstrated strong progress in improving equity in accessing maternal and newborn health. Of poor women, 60 per cent with a recent pregnancy made four or more antenatal care visits to health centres in 2015, compared to 3 per cent in 2000 (see Figure 1).

4 *The evaluation period is for 2016–2018. As far as possible, data reflect this period unless otherwise indicated.*

5 *Reproductive age is taken to be the range from 15 to 49 years old. The total population was 15.5 million in 2015.*

6 *The term ECD refers to the specific human developmental period which occurs pre-birth to the age of eight and defines the foundation of a child's future opportunities. During this period, the young child's brain architecture develops and is sensitive to positive stimulations – as well as adverse conditions – present in its environment. Responsive family and caregiving environments are critical elements to promote the child's development, and can be particularly beneficial to protect the children from the negative developmental impact of toxic stress (i.e. linked to conditions of poverty, natural disasters, conflict). A holistic approach to ECD considers the main development domains, which include cognitive, language, physical (gross and fine motor skills) and socioemotional development (Britto, 2017).*

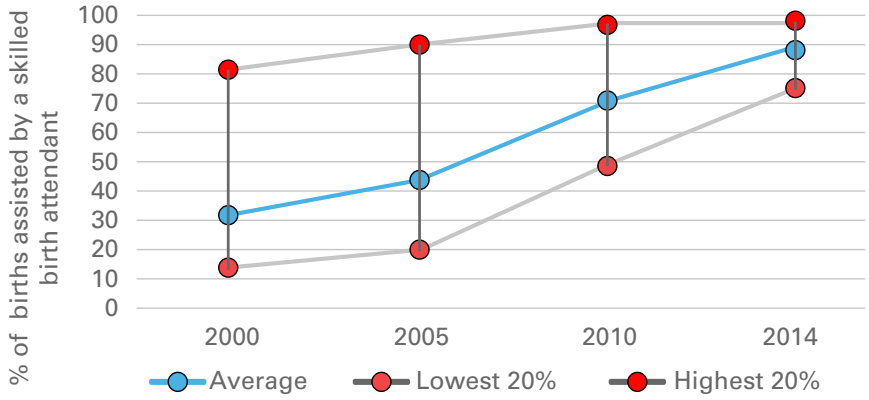
Figure 1: Improving antenatal care in Cambodia, 2000–2014



Source: *Mallick et al. (2018).*

Women who receive antenatal care are more likely to deliver with skilled birth attendants (Mallick et al., 2018). During this same period, the rate of skilled birth attendants assisting in delivery nearly tripled, from 32 per cent to 89 per cent of all births, with substantial improvements for women from the lowest wealth quintile (see Figure 2). The wealth gap between such medically accompanied births fell from 67 to 23 percentage points, indicating greater universality in proper health care during birth.

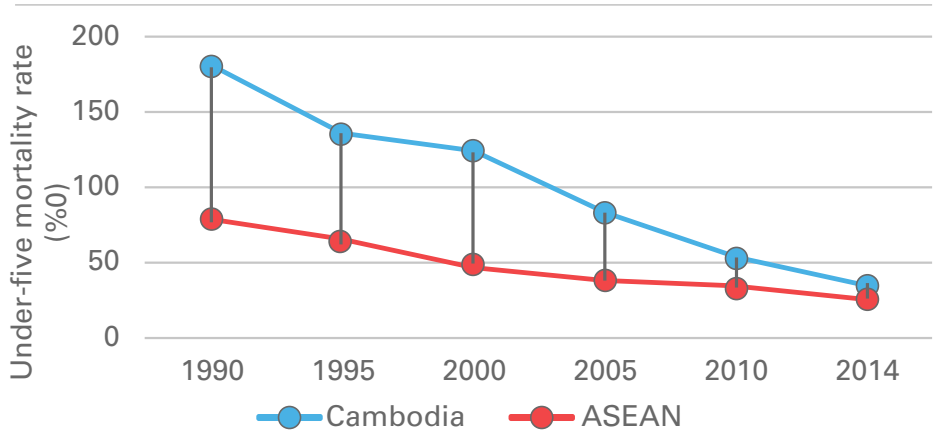
Figure 2: Improving delivery care in Cambodia, 2000–2014



Source: *Mallick et al. (2018).*

Among ASEAN countries, Cambodia's rapid decrease in under-five mortality rates since 1990 has been significant and enabled the country nearly to reach the ASEAN average in 2015 (see Figure 3). Under-five mortality rates in Cambodia dropped more than fivefold from 181 per 1,000 live births in 1990 to 35 per 1,000 in 2015 (Mallick et al., 2018).

Figure 3: Under-five mortality rates in Cambodia and ASEAN countries, 1900–2015



Source: *ASEAN Secretariat (2017); National Institute of Statistics et al. (2015).*

Despite these advances, maternal and child malnutrition – and undernutrition in particular – remain key human development challenges for Cambodia. Undernutrition stands out as the major contributing factor to Cambodia's high levels of stunting (32 per cent), wasting (10 per cent) and being underweight (24 per cent) among all children under the age of five years (National Institute of Statistics et al., 2015). Malnutrition also causes about 4,500 child deaths per year, or approximately one-third of all child deaths (Moench-Pfanner et al., 2016). The quality and quantity of the diet – as measured by the minimum acceptable diet – is insufficient for more than 60 per cent of children aged 6 to 24 months and 80 per cent of children aged 6 to 8 months. Maternal malnutrition (which can contribute to poor foetal development, low birth weight and higher stunting in children) is also prevalent in Cambodia among women of reproductive age (World Bank, 2019). In the north-eastern provinces, nearly one-quarter (23 per cent) of pregnant women were underweight, which makes their pregnancies at risk.

Birth registration is a fundamental human right protected by the 1989 United Nations Convention on the Rights of the Child. Having a civil registration – a proof of existence – opens the door for children to exercise their right to access social services, including health, child protection, sanitation, civil participation and education. The long-term implications of remaining unregistered as an adult further deepens gaps in equity. Significant efforts by the Cambodian government and technical and financial partners to incite communes to register births showed positive results. By 2014, 73 per cent of all births in Cambodia were registered by the time the child reached the age of five in a nearly equitable fashion between boys (73.7 per cent) and girls (72.9 per cent). Inequity in birth registration rates, however, is localized, notably among children from poor households living in rural areas or in the north-eastern provinces. In Ratanakiri and Kratie, only 40 per cent and 45 per cent of children, respectively, have had their births registered. Poor children are 1.5 times less likely to have a birth certificate than children from the wealthiest

households (National Institute of Statistics et al., 2015).

Access to ECE is increasing but remains low by the standards of lower-middle-income countries, with only 40 per cent of children aged three to five accessing ECE in 2018/19 (MOEYS, 2019). Coverage is particularly poor for younger children: only 18.5 per cent of three-year-olds accessed any form of education in 2018/19, well below the 31 per cent target established in the Education Strategic Plan 2014–2018 (ESP). For children aged four and five, however, incremental improvements in access to education have nearly reached national ESP targets, standing at 40 per cent (39.4 per cent actual) and 68 per cent (63.1 per cent actual) respectively. With 72 per cent of five-year-olds enrolled in ECE, the province of Ratanakiri reached the national target (set at 70 per cent). Kratie province and the Phnom Penh municipality were below the target, with 48 per cent and 59 per cent respectively accessing some form of ECE. Despite progress in the ECCD policy context in Cambodia (see the following section), the educational opportunities for young children have been slow to improve at numerous levels, as highlighted in the National Review of Education in 2015 (see Box 1).

Income and geographical disparities in Cambodia result in far worse childhood development opportunities for children living in poor and rural households. The national under-five mortality rate conceals significant disparities based on wealth and location. Children under the age of five are less likely to survive in rural areas and north-eastern provinces than in urban areas like Phnom Penh. Children born in poor households are four times more likely to die by the age of five than if they were born into a rich household (see Table 1).

Box 1: Status of ECE, Cambodia Education for All 2015 National Review

1. ECE services do not yet cover the entire country. This leads to low participation from children, especially children in remote areas, indigenous children, children from poor families and children with disabilities.
2. Expansion of ECCD programmes has not yet been regarded as an investment priority, even though it is the foundation for ensuring children enrol in subsequent educational grades.
3. A private sector service is only available for children from rich families in urban areas.
4. There is limited ability to include preschool education for five-year-old children in primary schools.
5. The ability to provide training on early childhood care, nutrition education and using health services has not yet been considered a priority.
6. Cooperation between relevant institutions has not yet been effective enough to expand the sector.

***Source**: Royal Government of Cambodia (2014).*

Table 1: Under-five mortality rates by wealth and location, 2014

Under-five mortality rates (‰)						
Wealth quintile		Geography		Municipality/province		
Lowest 20 per cent	**Highest 20 per cent**	**Rural**	**Urban**	**Phnom Penh**	**Kratie**	**Ratanakiri**
76	19	52	18	23	80	80

ource: *National Institute of Statistics et al. (2015).*

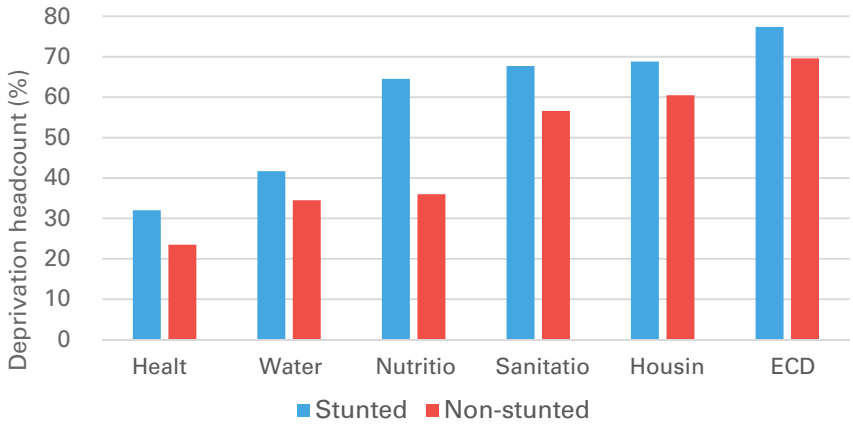
Similarly, Cambodian children in poor and rural households are more vulnerable to undernutrition and poor health. Wealth and geographic disparities in nutrition compound marginalization for children from poor households: children from the poorest families are four times less likely to receive a minimum acceptable diet than children from the wealthiest families, and children living in rural areas are two times less likely to do so than those living in urban areas. Stunting is three times more likely to occur among children living in poor households than their wealthier counterparts. Most unvaccinated children are from the poorest wealth quintile, and poor pregnant women are less likely to complete the full package of maternal care (National Institute of Statistics et al., 2015).

Inadequate access to clean water and proper sanitation facilities creates significant challenges to the development of young children's health in poor and rural areas. Almost 40 per cent of Cambodians living in rural areas do not have access to improved drinking water sources in the dry season and about 69 per cent do not have access to an improved toilet. About 50 per cent of people living in rural areas practise open defecation, which is a risk factor for exposing children to disease (National Institute of Statistics et al., 2015).

Indeed, deprivation in Cambodia is often multidimensional for children under the age of five and widespread. A study measuring children access to essential goods and services (including health, nutrition, water, sanitation, housing and education) found that 57 per cent of children in this age group are multidimensionally poor, meaning that they face on average 3.9 deprivations out of the total six dimensions. Nutrition, child development and housing deprivations are the most frequent among children, with 18 per cent deprived in those three areas (UNICEF, 2018c). Stunted children are significantly more deprived across all six dimensions compared to non-stunted children (see Figure 4). Specifically, attending ECE or preschool programmes, having improved toilets and not being underweight are associated with lower stunting rates.

Other groups of children are more likely to face inequitable access to services and face poorer developmental opportunities. Children with disabilities and children from ethnic minorities are particularly vulnerable to being excluded from health services,

Figure 4: Share of children under the age of five living in deprivation by area (dimension) and by stunting status, 2014



Notes: *Deprivation headcount percentage is the share of children under the age of five who are considered deprived (poor) in those sectoral areas (also known as 'dimensions' by authors of the study, based on the Cambodia 2014 Demographic and Health Survey).*

Sources: *Karpati et al. (2018, n.d.); UNICEF (2018c).*

schools and other social services.[7] The 2009 Cambodia Socioeconomic Survey found that 72 per cent of indigenous children and 88 per cent of Cham children under the age of five were not enrolled in preschool, compared to 68 per cent of Khmer children (Ministry of Education, Youth and Sport (MOEYS) et al., 2017). Girls have slightly lower access to ECE with 27.6 per cent of girls attending pre-primary in 2012, compared to 30.6 per cent of boys. While the overall trend of attendance has oscillated at each of the past three data points (2004, 2008 and 2012), girls have consistently had slightly lower attendance than boys (MOEYS et al., 2017). Internal and international migration of working parents for income generation disrupts family coherence and puts children at risk of improper or insufficient care in the hands of older relatives or non-family members (Hamilton et al., 2018).

Addressing this requires nutrition strategies that work across underlying causes at the household and social levels (World Bank, 2019). Interventions that are sensitive to and address the multidimensional aspects of malnutrition will have the highest impact (ASEAN et al., 2016, Karpati et al., 2018; World Bank, 2019). The causes also vary by context: for example, in urban areas, housing plays a larger role, while sanitation has greater significance in rural areas. Additional barriers include the quality of public health services, including poor access to WASH in health care facilities and the frequent unavailability of some essential medicines, vaccines and supplies, which continue to depend to a significant extent on development assistance. The lack of regulation of private health services and weak enforcement of standards, as well as limited certification and verification

7 *The Education Law of 2007 stipulates that every citizen has the right to access quality education for at least nine years free of charge in public schools, with additional provisions on the educational rights of children from ethnic minorities and children with disabilities.*

procedures for health practitioners, has also contributed to the poor quality of health services in the country (Royal Government of Cambodia and UNICEF, 2015).

Several programmes have been implemented with the intention of improving the well-being of children and their families in the north-eastern provinces of Cambodia and poor urban areas of Phnom Penh. Among these, access to education for vulnerable populations has increased through programmes targeting children with disabilities (i.e. inclusive education), children from ethnolinguistic minority groups (e.g. multilingual education) and children in under-served areas (e.g. development of community preschools). Other programmes, such as the Joint Programme for Children, Food Security and Nutrition in Cambodia, have aimed to improve health, sanitation and hygiene conditions for children and for pregnant and lactating mothers (Noij, 2013).

Legislative, policy and institutional context of ECCD in Cambodia

The Government of Cambodia's commitment to the early childhood period developed rapidly during the 2000s, with increased attention to the role of ECE as a foundation for general education (Royal Government of Cambodia, 2014). The emerging importance of ECE in national education strategies was highlighted in a number of key education planning documents, including the Education for All NAP 2003–2015, the ESP (2014–2018) and the NP-ECCD. The 2010 endorsement of the NP-ECCD marked a decade of advocacy and national efforts to raise the concerns around the rights of children 'from conception to aged under six'. As one of the few countries in the region that has established a multisectoral policy to promote holistic child development, this National Policy commits government actors working with pregnant women and children to cooperate around issues related to ECCD. It also urges for equity in the holistic development of children regarding their physical, cognitive, mental and emotional development. The design of this National Policy was informed by a range of lessons learned on national policy integration of ECCD outside Cambodia (described further under the Conceptual framework).

In 2013, the government created an NC-ECCD by Royal Decree as a strengthening mechanism for implementing the Law on Education and the NP-ECCD. The General Secretariat is based at MOEYS, following its central role under the terms of the NP-ECCD. The urgency to address the situation for many Cambodian children is emphasized throughout the decree. The line ministries members of the NC-ECCD (11 initially, 13 currently) have the responsibility of coordination at the sub-national level on ECCD issues, and point to the WCCC at the provincial (PWCCC) and district (DWCCC) level and the Commune WCCC (CWCCC) as the main sub-national partners.[8]

To enable successful implementation of the nine strategic areas of the NP-ECCD, the government identified a need for a realistic and feasible NAP-ECCD. The NAP-ECCD

8 *The original 11 line ministries are: MOEYS; the Ministry of Health (MOH); the Ministry of the Interior (MOI); the Ministry of Women's Affairs (MOWA); the Ministry of Information, Ministry of Social Affairs, Veterans and Youth Rehabilitation; the Ministry of Rural Development; the Ministry of Economy and Finance (MEF); the Ministry of Planning; the Ministry of Agriculture, Forestry and Fisheries; and the Ministry of Environment.*

(2014–2018) was formulated through a broad consultation with relevant ministries, agencies and development partners to ensure that these stakeholders could fulfil their respective roles and responsibilities. The NAP-ECCD was aligned with Cambodia's strategy for realization of the Cambodian MDGs, the NSDP (2014–2018), ESP (2014–2018) and other sector strategy plans. The NAP-ECCD was developed to create linkages between policies and strategies with financial resources. Specifically, the five-year NAP-ECCD was expected to provide the implementation mechanisms for integrated and coordinated services across relevant sectors. Priorities within the NAP-ECCD included the formulation of a legal framework and mechanisms, improvement of M&E mechanisms, capacity development, expansion of health education and care services to women and young children, especially early provision of basic education to young children with special focus on at-risk, vulnerable and poor young children. Motivation and capacity development for relevant officials at all administrative levels for the implementation of these activities were also incorporated.

Box 2: The second NAP-ECCD (2019–2023)

During 2019, while the present evaluation was in progress, the NC-ECCD finalized the new NAP-ECCD (2019–2023) following a participatory consultation process with ministries, agencies, development partners (including UNICEF) and NGOs at national and sub-national levels. The new plan responds to several challenges in the implementation of the first NAP-ECCD, most notably the need for national and sub-national dissemination, the assignment of clear roles and responsibilities, clear resource allocation and greater capacity-building of implementing stakeholders.

The second NAP-ECCD re-affirms the challenge of integrating ECCD service delivery across the country by emphasizing interministerial collaboration at national and sub-national levels. Several notable developments include the following.

- The new NAP-ECCD more clearly describes how the NAP is expected to be aligned to other ministries' strategic plans, the NSDP and the SGDs.
- The NAP-ECCD expects line ministries to develop budget plans linked to policy priorities, which include ECCD activities at the national and sub-national levels.
- Section 4 (Activation Plan Matrix and Estimated Cost) clearly gives ministries responsibilities for implementing the action plan.
- The new NAP-ECCD establishes new, clear reporting lines and supporting lines in Section 6.1 (Implementing and Monitoring Mechanisms), using a visual representation of reporting flows from one body to another.
- Section 6.2 (Role and Responsibilities) provides general level details for what is expected of provincial line departments, but also specifies planning, implementing and reporting responsibilities for 13 TCCs in the line ministries.

3 Object of the evaluation

Conceptual framework

The conceptual framework for the IECD approach is based on two interacting and concordant developments occurring at the national and international levels (UNICEF, 2016c).

International: In 2015, the international community reaffirmed the importance of the early childhood period as a foundation for lifelong development and in need of specific protection, as pronounced by the Sustainable Development Goals (SDGs). Throughout the SDGs, targets on malnutrition (SDGs 2.1 and 2.2), maternal and child mortality (SDGs 3.1 and 3.2), early learning (SDG 4.2), water and sanitation (SDGs 6.1 and 6.2) and protection from violence (SDG 16.2) outline an agenda for ECD. The inclusion of the early learning goal marks the efforts of international advocacy to promote investments for an integrated approach to ECD beyond a single-sector approach: "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." One of the two proposed indicators for SDG 4.2 relates to the holistic dimension of ECD in terms of its broad domains (physical, cognitive, language and psychosocial development).[9]

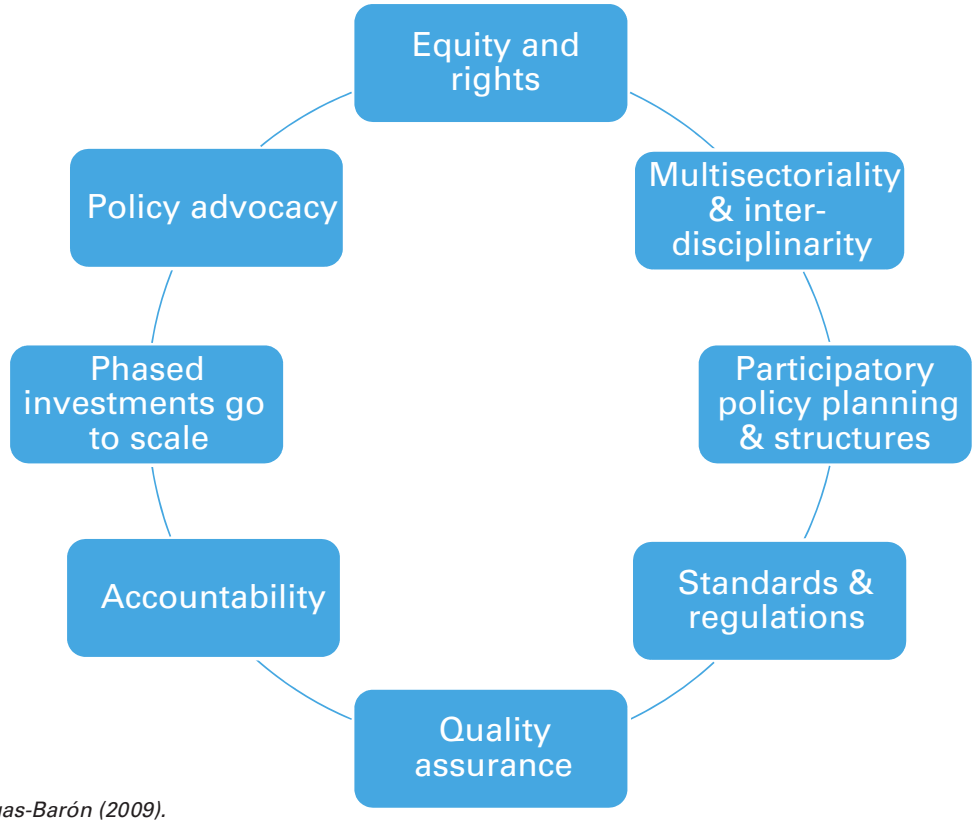
The Nurturing Care Framework (see Figure 5) provides the set of factors which enable early childhood well-being in a holistic approach regarding health, nutrition, security and safety, responsive caregiving and opportunities for early learning. Although the framework provides strategic directions for governments, communities and families to support children's development from pregnancy up to the age of three, it also recognizes that the health, child protection and education sectors need to work together to achieve better results that are long-lasting for children's developmental needs into adolescence (WHO et al., 2018).

The benefits of strengthening governance systems for national policy coordination

Figure 5: The Nurturing Care Framework

9 *Indicator 4.2.1: Proportion of children under five years of age who are developmentally on track in health, learning and psychosocial well-being, by sex.*

Figure 6: Essential elements for national integrated early childhood policies



Sources: *Vargas-Barón (2009).*

have been the subject of numerous international reviews.[10] As observed in health service delivery, complex webs of service delivery operators and various administrative levels "require good governance to enable their scaling up in an equitable, efficient, and effective manner" (Britto et al., 2014). Moreover, early childhood interventions can be affordably integrated into existing health and nutrition interventions and provide a holistic approach to support parents and their young children (Britto, 2017).

Coordinating or integrating services between various government entities responsible for different aspects of early childhood is considered as one of the best guarantees that young children will receive quality, holistic services (CCGECCD, 2016; UNESCO, 2006). The framework around the integration of social services targeting children and pregnant women presupposes that significant barriers and bottlenecks are created through a single-sector approach to service delivery. These hindrances create obstacles and slow down outcomes related to the well-being and full development of children. Several enabling factors have emerged from international experiences (see Box 4). The importance of national policy coherence around early childhood is paramount for accelerating results in health, nutrition and education.

The efficiency and financial cases to invest in children's early years are also strong. Evidence of positive economic returns for

10 *See, for example, Neuman and Devercelli (2013); Sayre et al. (2015); Vargas-Barón (2013, 2015); and Wagner (2013).*

Box 3: Key definitions: 'early childhood', 'integration' and 'holistic approach'

Throughout this report, references are made to the holistic development of the child, integration of ECCD services and holistic service provision. For clarity, each is distinguished below.

This report uses the term **Early Childhood Care and Development (ECCD)** to refer to all aspects related to the care and development of children aged zero to five in Cambodia. ECCD services and programmes can take place in the home or the community and are provided through organized arrangements that target children directly or indirectly (i.e. targeting parents and other primary caregivers to improve their care and education practices). This term indicates a holistic vision of young children's care, development and learning. Other similar terminologies used by multi-state organizations are 'ECD', 'Early Childhood Education and Care' and 'ECD and Education (ECCE)'. ECE refers to a subset of activities which have education and learning as principal components of the programme.

The term **holistic development** of children during the early childhood period refers to development of all the multiple interacting domains, the development of which is highly influenced by environment and social interactions with others. These domains are usually categorized as social, emotional, language, cognitive and physical (gross and fine motor) needs to build a solid and broad foundation for lifelong learning and well-being. A **holistic approach to ECCD** service delivery refers to the combination of programmes or services that take into consideration all of the needs related to holistic child development. It is possible for ECCD service provision to be 'holistic' (insofar as all relevant services are provided), but not integrated.

Integrated service provision is an organized framework for public service delivery that comprehensively ensures all the developmental needs of a child are met in a holistic fashion. Within the context of this IECD evaluation, integrated service provision can include sectors responsible for health, nutrition, WASH, child protection, centre-based ECE, home-based care, parental support or learning, and community development components (UNICEF, 2016c). It is possible for a system of ECCD service provision to be 'holistic' (insofar as all services are provided), but not integrated. Service integration presupposes that sectors are working together with other relevant sectors to jointly plan, budget, coordinate, implement and monitor activities.

> *"The proposed IECD programme will therefore contribute to national efforts to demonstrate the effectiveness of providing an integrated package of health, nutrition, WASH, childcare and stimulation, and early learning to support the optimal physical, social and cognitive development of disadvantaged children in selected provinces in Cambodia"* (Draft Strategy IECD Notes, 2015).

Box 4: Enabling factors and bottlenecks for integrated ECCD

Across the world, examples abound of successful integrated ECCD policies that have approached service delivery and governance with a systemic and integrated approach (Sayre et al., 2015). Other equally enabling factors include substantial public investment, appropriate training of front-line workers, strong data M&E systems and a participatory approach to policy development (OECD, 2006).

While the architecture of integrated ECCD systems can differ significantly depending on national contexts, several enabling factors and bottlenecks highlighted in other countries are notable in terms of observations and lessons learned (Britto et al., 2014; OECD, 2006):

- A lead ministry is needed to oversee, coordinate and monitor all activities related to ECCE.
- Local governance structures are key levers for facilitating intersectoral implementation of integrated services, but policy frameworks need to be harmonized at all decentralized levels.
- Although horizontal coordination of services can be observed at the national and local levels, cross-sectoral collaboration appears weakest at the middle administrative levels (provincial), where technical capacity might be a concern.
- Including the community and parents in ECCD governance and programming monitoring increases investments in social services and strengthens collaboration across service providers and the workforce.
- Institutional strengthening in integrated ECD theory and practice at all government levels and training front-line workers.
- Decentralization can widen equity gaps across different provinces or districts within a country.

general ECCD interventions or specific ones (such as adding nutrition interventions to existing services) have been observed in low and middle-income countries (Engle et al., 2011, 2013; Hoddinott et al., 2008; Maluccio et al., 2009; McGovern and Canning, 2015). Preparing inclusive programmes and policies – such as multilingual preschool education – can improve sociocognitive and socioemotional development outcomes (Nicoladis et al., 2016; Nicoladis and Genesee, 1996). Involving fathers in early stimulation and parenting programmes is likely to improve early child development (Jeong et al., 2016).

National: At the national level, the government's concerns around the status of children aged under five and pregnant women in Cambodia led to the emerging policy mechanisms around the integration of ECCD policies and activities, such as the NP-ECCD and the NAP-ECCD (see Section 2). UNICEF's support for the Government of Cambodia's multisectoral efforts around ECCD is outlined in the Royal Government

of Cambodia–UNICEF National CPD 2016–2018 and focuses on "strengthening systems and capacities of duty bearers" (Royal Government of Cambodia and UNICEF, 2015).

The IECD programme and approach in Cambodia

Given the existing challenges in enabling children in Cambodia to reach their full potential in life, UNICEF pioneered the IECD programme and approach under the CP 2016–2018 to support and complement the multisectoral government-led initiative as spelled out by the NAP-ECCD. The IECD programme and approach intends to ensure that public initiatives targeting better outcomes for children aged zero to five and their carers (i.e. mothers, fathers, grandparents or other primary caregivers) provide "integrated and coordinated services together with relevant sectors" (NC-ECCD, 2014). Over the three years, UNICEF allocated a budget of US$25.3 million to this component of the CP.

The object of the evaluation is the IECD approach in Cambodia. However, a comprehensive review of documentation did not find a consistent definition for the IECD approach. Moreover, the IECD programme, approach and areas were used in programme documentation with some degree of interchangeability. Indeed, the TOR for the evaluation state that "This evaluation will be focusing around UNICEF Cambodia's CP 2016–2018 Outcome 1."

In the understanding of the Evaluation Team, the IECD programme is the set of UNICEF-funded activities structured around six outputs and grouped under Outcome 1 of the CP 2016–2018 (see Box 6).

The IECD approach is the set of strategies employed by the programme to reinforce the importance and value of integrated aspect of health, nutrition, WASH, child protection and education service delivery to pregnant women and children aged zero to five. However, in practice, the Evaluation Team was unable to identify any consistent definition of the approach. The application of these strategies in the design of programme activities was also inconsistent, or at least not always evident.

The IECD subprogramme of the CP ('Outcome 1') was structured into a clear set of six outputs, which formed the basis of UNICEF's monitoring and reporting on IECD. The outputs generally corresponded to and were housed in individual UNICEF sections (e.g. Outputs 1.3 and 1.4 in Child Survival and Development (CSD), 1.6 in Education, etc). For some outputs, the key results and activities mapped precisely to the IECD programme outputs. For example, the key results specified in the CSD Rolling Workplan (RWP) reflected Outputs 1.3 and 1.4 of the IECD programme verbatim and consequently all sub-activities clearly pertained to the objectives of the IECD subprogramme. On the other hand, the outputs or key results used in the WASH and Education RWPs did not correspond directly to the respective IECD programme outputs, and many activities in the RWP appeared to reflect only sectoral objectives with no obvious relation to integrated approaches.

Objectives

The IECD subprogramme of the CP 2016–2018 aimed to overcome the barriers causing fragmentation, poor quality and

Box 6: Outcome 1 of the CP 2016–2018 and its six outputs

By 2018, infants, children between the ages of zero and five and pregnant women in target provinces have improved and more equitable use of integrated early childhood survival, care and development interventions and practices, including in emergencies.

1.1. By 2018, strengthened capacities of administrators in six target provinces in analysing, planning, coordinating, implementing and monitoring actions that promote IECD.

1.2. By 2018, strengthened capacities of communities, caregivers and families to practise timely and appropriate birth registration, complementary feeding, hygiene, positive parenting and health seeking behaviour for children under the age of five, especially in six target provinces.

1.3. By 2018, increased capacities of service providers to promote access to nutrition-specific services (SAM) at all levels in an enabling environment, particularly in six target provinces.

1.4. By 2018, increased capacities of service providers to promote access by more newborns, children and women to quality primary health services, focusing on neonatal and maternal health, and immunization, especially in six target provinces.

1.5. By 2018, strengthened commitment and capacity of government to provide more children and their families, particularly in the six target provinces, with increased access to quality WASH facilities and services.

1.6. By 2018, strengthened commitment and capacity of government to provide more children under five with increased access to inclusive quality ECE, particularly among children with disabilities, indigenous minority children, and those living in the six target provinces.

Source: *(Royal Government of Cambodia and UNICEF, 2015).*

unaffordable basic social services for disadvantaged families. Through its support to implementation of the NAP-ECCD, the IECD subprogramme aimed to ensure that children under the age of five and pregnant women gained improved and more equitable use of early childhood survival, care and development interventions and practices, particularly in target districts. The CP Action Plan framed these objectives under Outcome 1, and six outputs (see Box 6).

Strategies and activities

As is highlighted in Box 5, there is no consistent definition of the IECD approach or its strategies, nor any comprehensive aggregation of all IECD activities. However, organized along the six thematic areas (outputs), the Evaluation Team has identified some of the key IECD output targets and activities clearly associated with these in Table 3. Here, at Table 2, the report collects the different references to IECD strategies made in programme documentation.

Table 2: IECD strategies

Source	Strategies described
Strategy Note IECD: Child Survival and Development	The proposed IECD programme in Cambodia will demonstrate the benefits of an integrated approach through: • Reduction in transactional costs;. • A focus on the most disadvantaged children. • An optimal use of scarce resources.
	Strategies used to address existing inequities are intended to focus on removal of demand-, supply- and environment-related barriers causing fragmentation, inadequate, poor quality and unaffordable basic social services for disadvantaged and excluded children and communities. These include: • Building capacity of government ministries to better plan, budget and deliver adequate and equitable ECCD services. • Strengthening advocacy for increased political commitment to increase funding and implement IECD programmes. • Advocacy for greater community participation in monitoring accountability and quality in service delivery. • Communication and education for caregivers that promote key practices for full potential child development.
TOC concept schematic IECD	Strategic interventions: • Focus on availability and access for women and children. • Availability and access for facilities. • Improve behaviour and care practice. • Building an enabling policy environment. • Capacity-building [of service providers and local government]. • Partnerships [with ministries, NGOs and the private sector]. • Budgets (advocacy and technical support, to ensure increases in budget dedicated to essential services).
CP Action Plan 2016–2018	The programme will support the operationalization of the Government's NAP-ECCD 2014–2018 by demonstrating the physical, social and cognitive development benefits, along with cost effectiveness, of providing an integrated approach to health, nutrition, WASH, child protection, care and stimulation.
	UNICEF will prioritize technical and financial support to the selected districts, where monitoring systems will be developed in the targeted communities to generate evidence of the impact of investment in the integrated approach on behaviours, practices and outcomes for children.

Geographic focus

The IECD approach was developed and implemented to be tested in five north-eastern provinces (Mondulkiri, Ratanakiri, Kratie, Stung Treng and Preah Vihear) and in urban poor communities of Phnom Penh between 2016 and 2018, as a precursor to possible national expansion. These areas were selected as *"the regions in the country with the lowest child development indicators as compared to the rest of the country"* (see Evaluation TOR at Annex A).

Table 3: UNICEF Cambodia IECD thematic areas, output targets and activities

Thematic area	Key output targets	Associated activities
Supporting local administrations to deliver critical services for ECCD	• Six provinces begin annual reporting on sub-national ECCD coordination and implementation to the National ECCD Committee. • National ECCD Committee begins reporting annually on the National ECCD Action Plan implementation progress. • In 65 targeted communes, the proportion of 3–5-year-old children attending commune-funded preschool services increases from 5 per cent to 30 per cent. • In 65 targeted communes, the percentage of children under the age of five who are registered increases to 80 per cent.	• Training administrators in use of new guidance on district service project preparations, aiming to increase prioritization of social services delivery in District Investment Plans. • Training commune administrators and village chiefs in social service mapping. • Training commune administrators and village chiefs in using the Village Record Book. • Training CWCCC members in 'Promoting Social Services with Equity'.
Engaging with communities to promote positive caregiver practices	• Number of targeted communes with communication and parenting education initiatives that promote resilience, care, survival, protection and development of infants and children increases from 7 to 55. • Number of villages in target districts that are triggered with Community-Led Total Sanitation (CLTS) and reached through household water treatment and safe storage (HWTS) education session rises from 0 to 155. • Of 26 targeted health facilities, the percentage with infant and young child feeding counselling services rises from 23 to 62 per cent.	• Communication or parenting education initiatives promoting targeted caregiver practices. • Development for National Committee for Sub-National Democratic Development of a cross-cutting Communication Plan for Inclusive Civic Engagements, Social Services and Accountabilities in the context of the decentralization and deconcentration reform. • Education sessions in villages promoting water treatment and safe storage. • Training Provincial Department of Rural Development (PDRD) members in each target IECD province on CLTS, hygiene promotion and HWTS.

Thematic area	Key output targets	Associated activities
Providing adequate nutrition	• Of 26 targeted health facilities, the percentage providing SAM increases from 23 to 62 per cent. • Three new policies in nutrition adopted and implemented for SAM, micronutrient powder, fortification and budgeting.	• Longitudinal survey conducted in IECD target areas to collect in-depth data on health and nutritional status of children and mothers. • Financial and technical support to MOH for mass screening for malnutrition. • Support to the Ministry of Planning to collect and assess samples of salt for iodization. • Support to NGOs on community messaging through the mobile library and mHealth system.
Ensuring health services for every child	• Percentage of health centres in selected IECD districts conducting at least 80 per cent of planned outreach rises from 40 per cent to 90 per cent. • Percentage of health centres in selected IECD districts with <5 per cent out of stock of essential medicines/ commodities rises from 45 per cent to 90 per cent. • 90 per cent of health facilities in selected IECD districts with at least two midwives trained in antenatal care, delivery, postnatal care and early essential newborn care. • 90 per cent of Operational Districts with at least two cold chain/EPI officers trained on newly developed standard operation procedure. • Percentage of health facilities in selected IECD districts with stock-out of finger prick HIV test kit rises reduces from 40 per cent to less than five per cent.	• Longitudinal survey. • Support to development of provincial newborn action plan for Kratie, Ratanakiri and Phnom Penh. • Support in development and dissemination of effective vaccine management improvement plan. • Training and development of incentives for midwives and doctor outreach services, including on essential antenatal and postnatal care. • Assistance to strengthen service delivery monitoring mechanism.

Thematic area	Key output targets	Associated activities
Boosting access to clean water and sanitation	• Six provincial Rural Water Supply, Sanitation and Hygiene (RWSSH) working groups meeting. • 30 per cent of preschools in target areas begin implementing minimum WASH package. • Percentage of households in target rural areas with access to improved water supply increases from 72.5 per cent to 74.5 per cent. • 90 per cent of health care facilities in the target areas implement minimum WASH standards, including waste management.	• Support towards rural WASH sector coordination at the national and sub-national level. • Support to WASH improvements in community preschools. • Partnership with NGOs on improved drinking water supply through extension of piped water systems and water bottling kiosks, particularly in arsenic risk areas. • Technical support to National Guidelines on WASH in health care facilities. • Supporting roll-out of the national WASH in schools minimum requirement guidelines
Setting the foundation for lifelong learning	• Approved plan for decentralized preschool teacher training for state preschools and community preschools in place. • Percentage of preschools in districts implementing the inclusive ECE Approach in six targeted districts for I-ECD and all target districts for Inclusive ECE rises from two to 33 per cent in state preschools and from 13 per cent to 32 per cent in community preschools. • Percentage increase in the number of children enrolled in multilingual preschools in the five target districts and more broadly in the five north-eastern Provinces rises from 11.4 per cent to 20 per cent per year.	• ECD Scales research with Hong Kong University. • Support to Cambodia's hosting the Asia–Pacific Regional Network for Early Childhood (ARNEC) conference in March 2017. • Training on inclusive education for teachers in IECD target districts. • Partnership with SIPAR to support nutrition awareness among preschool teachers. Distribution of 170 ECD kits to state and community preschool. • Training on social emotional learning (SEL).

Source: *UNICEF(2016a).*

Theory of Change

Prior to the development of UNICEF's CP 2016–2018, at least two potential Theories of Change (TOC) were developed for the IECD approach in 2015.[11] In addition, each UNICEF section developed its own TOC, and an integrated TOC was developed in 2016 for the integration of WASH and nutrition for pregnant and lactating women and children under the age of two. However, the evaluation's review of UNICEF programme documentation 2016–2018, as well as interviews with UNICEF personnel, suggest that there was no single, clear TOC commonly agreed and understood for the IECD approach. Indeed, there is no indication that the two TOCs developed in 2015 were incorporated in any meaningful way into the CP 2016–2018: they are not clearly reflected in the programme's objectives or results framework and there is no evidence that either of these formed part of regular strategic review. This is discussed further under Findings.

The CP 2016–2018 documentation refers to the IECD approach in the CP's Outcome 1: *"By 2018, infants, children 0 to 5 years old and pregnant women in target provinces have improved and more equitable use of integrated early childhood survival, care and development interventions and practices, including in emergencies."* This was reflected in the TOR for this evaluation, which was framed around achievement of the objectives described under that output.

In the absence of a clearly documented and/or commonly agreed TOC for the approach, the Evaluation Team reconstructed a TOC for the approach to reflect the logic latent in its design, which is represented in Figure 7.

The main outcome in this TOC is centred on the well-being of Cambodian children: "Enabling every child 0 to 5 years old to thrive and achieve their full potential in Cambodia." The contribution of the IECD approach towards achieving this is framed as Outcome 1 from the CPD 2014–2018, which highlights the equity dimension of providing services to the most vulnerable populations.

In theory, through a set of strategies (which are described further below), the IECD approach promotes programmatic and sectoral integration across the five main areas representing the UNICEF programme organization: health, nutrition, WASH, education and child protection. The IECD approach hypothesizes that, if UNICEF provides adequate support for the integrated implementation of several targeted ECCD actions, the positive impact of these actions will be enhanced. Several sectors may address the multidimensional aspect of ECCD simultaneously, and the effect of the interventions will be accelerated. The convergence (as needed) of health, nutrition, WASH, ECE and protection interventions can enhance the different objectives of sectors.

Through diverse government and UNICEF IECD programme activities (supported by M&E, advocacy and communication), the expected initial outputs for IECD include a combination of service delivery and policy objectives:

- Improved capability of ECCD service providers.
- Improved capability of carers and communities.

11 *See Schematic Representation of a TOC for the IECD and Strategy Note on the IECD.*

- Improved ECCD awareness of carers and communities.
- Strengthened government commitment.
- Improved sub-national planning, coordination and management of services.

Achievement of these outputs would contribute to realization of higher-level outputs related to increased demand and delivery of quality ECCD services. Greater capacity at all levels – including parental education and service delivery capacity-building – will generate greater prioritization of efforts for young children and pregnant mothers. Parents will want government to deliver more and better ECCD services only if they are deemed to be valuable for their children. If there is greater capacity, motivation and demand for integrated ECCD services (and assuming the government has a basic level of capacity and interest to provide those services), then the quality and availability of the integrated ECCD services and practices will increase. If better services are available, assuming parents have an interest in improving outcomes for their children and believe that using services will improve these outcomes, this will hypothetically stimulate further demand for ECCD services at the local level, creating a positive feedback loop. The strategies and activities deployed under the programme are described in Table 2 and Table 3 respectively.

The TOC includes several assumptions that are beyond the means of this evaluation to test but which need to be considered as potential enabling or limiting factors. Of particular significance is the need for individual and organizational change within UNICEF and the Government of Cambodia for the successful implementation of these underlying integrated strategies. For example, individual change requires agents (i.e. front-line workers) to act on their new-found knowledge on the linkages of the various developmental ECCD domains to improve the delivery of integrated services and improve resulting outcomes for rights holders. The capacities of front-line workers can be strengthened in promoting change across and beyond sectoral obligations for a household in a targeted district. The evaluation does not have the scope to gather systematic information on the validity of these assumptions, but will obtain impressionistic data from primary data collection and look for examples of secondary data that might support a conclusion on the validity of assumptions.

Organizational change requires shifts in programming, practice and guidelines, as well as cultural shifts in understanding objectives that might be reached by other means of implementation. The evaluation questions do not ask about organizational change explicitly but, given that this is a critical link in any causal pathway between UNICEF's activities and desirable outcomes in terms of better integrated service delivery, the Evaluation Team will look for evidence – such as new documentation or procedures – of organizational change. Making links across organizations is another facet of this approach as stated by the underlying strategies, as intersectoral coordination and cooperation needs to occur effectively to reach the expected outcome. For example, under the broad definition of ECE, parental support programmes, crèches, childcare, preschools and other types of early learning programmes can become an integral part of nutrition, health, protection and

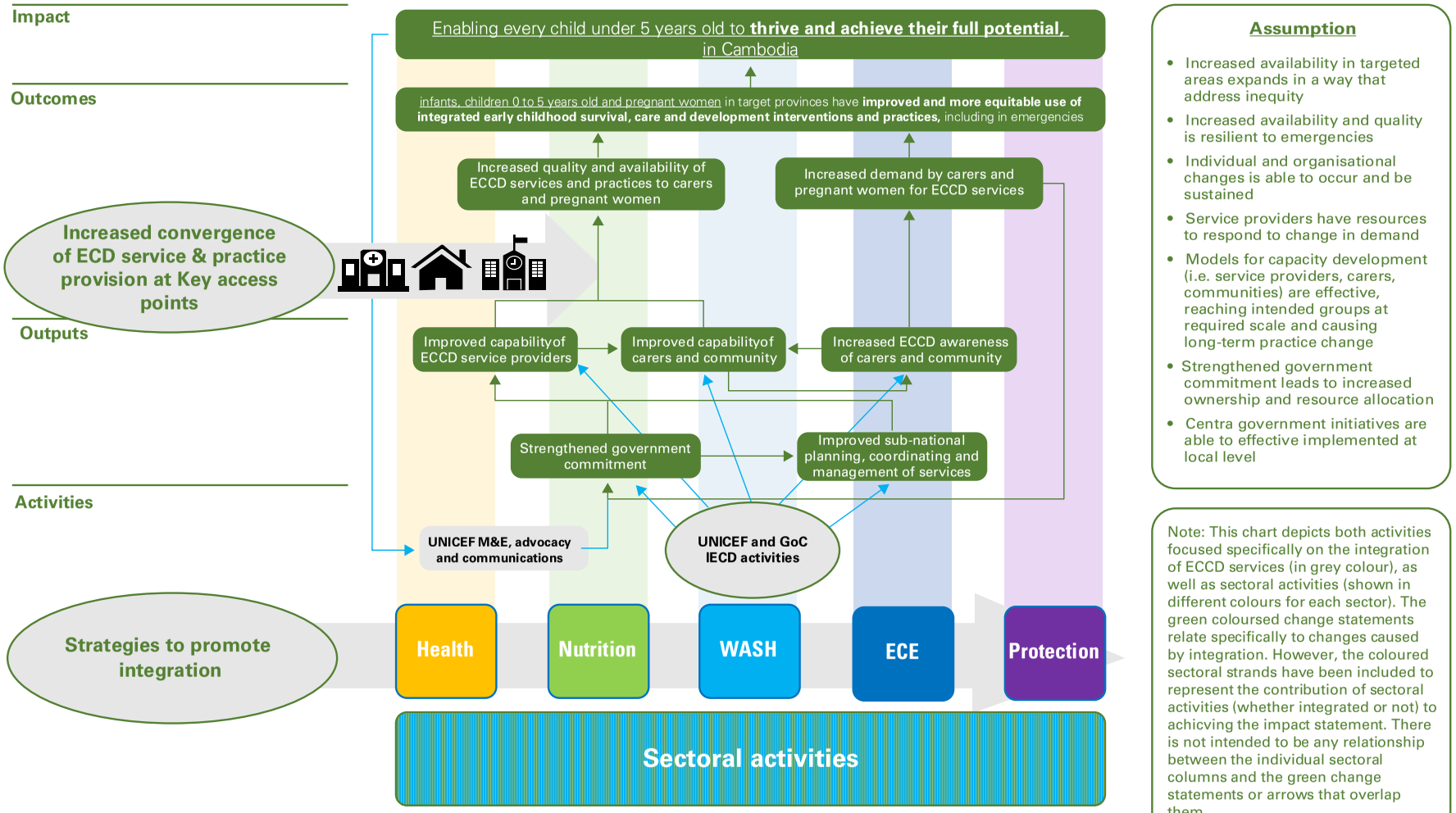
WASH interventions, or create integrated curricula. Increased accountability and a strengthened commitment underscore the need to provide vulnerable children under the age of five with more access to supportive integrated services, where needed.

Other assumptions relate to the quality of training provided (models for capacity development), the prioritization of vulnerable populations to increase equity, and the reality of decentralization. Validating all these assumptions is beyond the scope of the evaluation, but we will look for impressionistic and secondary data that confirm their validity where possible.

The risks associated with this TOC include the inadequate allocation of resources, the low capacity in decision-making structures at sub-national levels (especially within communes and villages), the lack of development prioritization for ECCD interventions and the difficulty in providing equitable service delivery to the difficult-to-reach or otherwise vulnerable populations.

This reconstructed TOC was included in the Inception Report, which received extensive feedback from the Reference Group, and presented to stakeholders at the initial findings workshop in July and final validation workshop in September. This TOC is evidently schematic and presented at a cross-sectoral level. Elaboration of a comprehensive TOC detailing all sectoral inputs would be an extensive exercise, which UNICEF should consider conducting in reviewing the next CP.

Figure 7: Reconstructed IECD approach TOC



Sources: *Vargas-Barón (2009).*

Key stakeholders

Table 4: Roles and responsibilities of key stakeholders

	Key stakeholders	Role and responsibilities
Primary rights holders*	• Children and pregnant women, especially those in the target districts (north-eastern provinces and Phnom Penh).	• Requesting services. • Receiving services.
Main duty bearers (national)	• UNICEF Cambodia. • MOEYS. • MOH; MRD. • MOWA. • MOI.	• Provide strategic direction for IECD policy development and implementation. • Organize six-monthly meetings to review IECD implementation progress and provide recommendations or decision for corrective actions. • Support the implementation, monitoring and reporting at line ministries and provincial level. • Advocate for more commitments and resources from the national and sub-national level and the public for NAP implementation. • Keep all key stakeholders informed about the progress and lessons learned from IECD. • Facilitate problem solving during the implementation of IECD. • Provide technical and capacity-building support to provincial departments. • Cooperate with WCCC at provincial (PWCCC) and municipal, district (DWCCC) and khan levels and CWCCC/Sangkat Committee for Women and Children. • Mobilize resources for supporting the undertaking the IECD approach. • Joint monitor and evaluate the implementation of IECD approach. • Produce the annual progress reports for the IECD.

	Key stakeholders	Role and responsibilities
Main duty bearers (provincial)	• UNICEF provincial team based in north-eastern provinces. • PWCCC. • Provincial Technical Working Group for WASH.	• Overall: support the implementation of IECD within the provinces. • Be the focal point in communicating with the provincial and deputy governor to update them and report on the status of implementation of IECD in the provinces. • Facilitate and promote effective collaboration between the provincial, district and commune administrations, as well as development partners, for effective IECD implementation. • Call for quarterly coordination meetings and annual review meetings on the implementation of IECD approach. • Provide technical support and capacity to DWCCC and CWCCC to include ECCD activities in their annual plans. • Disseminate all legal documents and guidelines of IECD to WCCCs. • Review the reports from WCCCs and provide feedback.
Duty bearers (district)	• DWCCC.	• Manage oversight of the IECD in the districts. • Convene the coordination meeting to review and provide necessary support for IECD implementation. • Provide capacity-building to local service providers. • Monitor the implementation of IECD approach and provide feedback to local implementers. • Support WCCCs to include activities of IECD in Commune Investment Plan and technical support to allocate commune fund and financial report. • Assist WCCCs to review and report the progress of IECD services delivery.

	Key stakeholders	Role and responsibilities
Duty bearers (commune and village)	Main duty bearers and implementers at commune and village level: • WCCC. • Preschool teachers. • Health centre officials. • Village health volunteers. • Core parents. • Village chiefs.	• Identify families and children, pregnant woman and coordinate with local authorities and NGOs to provide necessary and appropriate services at community level. • Map families and children that are at risk and provide appropriate referral to social services. • Plan and allocate commune funds to support IECD in annual Commune Investment Plan. • Support and collaborate with line departments and NGOs to support caregivers and deliver IECD services at commune level.
Implementing partners	Other duty bearers include other agencies and international and national NGOs working in the fields of health, nutrition, WASH and community development and empowerment.	• Provide technical and financial support for the development, implementation and documentation of IECD implementations. • Share knowledge, experiences and findings from research on IECD locally and internationally.

**No data was available specific to the population of primary rights holders targeted by the programme.*

Other key partners in IECD included: Agence Française de Développement; Belgian Technical Cooperation; the Department of Foreign Affairs and Trade, Australia; the European Union; the Swedish International Development Cooperation Agency; the United Nations Population Fund; the United States Agency for International Development; the World Food Programme; the World Bank; and WHO (UNICEF, 2016a).

4 Evaluation purpose, objectives and scope

4.1 Purpose

As noted in the TOR, this evaluation will promote accountability and enhance evidence-based learning and documentation. As a formative evaluation, it is intended to document learnings and provide recommendations to inform the delivery and evolution of the successor CP (2019–2023). In particular, the evaluation will feed into UNICEF's midyear and annual CP reviews, as well as the midterm review of the CP. To a lesser degree, it will also include summative elements, which will examine the 2016–2018 progress towards outputs and outcomes. The criteria of examining the impact was not part of the TOR and would be unsuitable given the brevity of the evaluation exercise and the lack of counterfactuals.

The evaluation aims to provide an overall view on the IECD approach being used to improve upon it during implementation of the 2019–2023 CP, and to validate and potentially scale up support with government ministries, NGOs and private partners.

The primary audience of the evaluation are the UNICEF Cambodia sections involved in the IECD Task Force (including Nutrition, Health, WASH, Education and Community Development and Empowerment); the NC-ECCD, MOH, MOEYS, MRD; Scaling up Nutrition;[12] and the regional UNICEF ECD Adviser for East Asia and Pacific. The secondary users are Sida, the European Union, the Korea International Cooperation Agency, the Australian Department of Foreign Affairs and Trade, USAID, GiZ/KfW, UNFPA, WHO, FAO, WFP, the International Movement of the Red Cross and Red Crescent, the World Bank and GPE. Other key stakeholders include primary rights holders (pregnant women, children and their parents or other primary carers), implementing partners, UNICEF donors, international organizations, other UN agencies and UNICEF headquarters. The participation of stakeholders in the evaluation is described at Section 4.2.

UNICEF Cambodia sections involved in the IECD Task Force and the Government of Cambodia stand to gain from the evaluation through the identification of recommendations for the improvement of IECD activities; the identification of successes will allow all parties to communicate the value of their interventions to their constituencies. Managers and decision makers also stand to gain through the accountability that this evaluation will generate for those involved in implementation of the CP 2016–2018.

4.2 Objectives

The main objectives of the evaluation as per the TOR and confirmed during inception were to:

12 *Scaling Up Nutrition is a movement hosted by the United Nations Office for Project Services but it belongs to all those agencies, organizations, individuals, etc. that support it.*

1. Validate and, where necessary, reconstruct the TOC of the IECD approach.
2. Provide an assessment of Outcome 1 of the 2016–2018 programme and achievement of outputs.
3. Understand the gaps and bottlenecks in providing IECD support and services to the north-eastern provinces and to the urban poor in Phnom Penh.
4. Document and provide recommendations regarding lessons learned, good practices and innovations that can be applied to other provinces.

4.3 Scope

The evaluation scope included evaluation themes that were discussed with the Reference Group during the inception mission held in March 2019, namely to focus on the IECD's approach with reference to its scalability across the country. The prioritisation of the evaluation questions allowed a more in-depth understanding of IECD implementation. Relative to the OECD-DAC's guidelines, the evaluation of the IECD approach focused on (in order of diminishing priority) relevance, sustainability, cross-cutting themes, effectiveness, and efficiency. The evaluation questions, and the process for their agreement, are discussed further under Methodology, Evaluation Framework at Section 5.1. A focus on equity and gender equality was built into the scope and evaluation design by adding two evaluation questions under a dedicated cross-cutting themes criterion. The effectiveness section also includes a dedicated sub-section on findings related to equity. See further under the Evaluation Framework section.

The evaluation covers the evolution of the IECD approach from 2016 to 2018. The object of the evaluation (the IECD approach in north-eastern provinces of Cambodia), including thematic areas and interventions, is described at Sections 2.4–2.5.

Geographically, the evaluation considers all areas in which UNICEF supported the IECD approach: namely, in north-eastern provinces, considering implementation at central government level and at province, district, commune and village level in five north-eastern provinces: Mondulkiri, Ratanakiri, Kratie, Stung Treng and Preah Vihear, as well as in urban poor communities of Phnom Penh. While the evaluation considers the wider geographical area described above, to make optimal use of available time resources, data collection was conducted in a total of five districts of Phnom Penh, Kratie and Ratanakiri – the most accessible provinces from Phnom Penh. As a formative evaluation, UNICEF and the Reference Group agreed to focus resources on implementation areas and the evaluation has not included non-intervention sites. Neither UNICEF activities nor implementation of the NAP-ECCD outside of the six IECD target provinces were included in the evaluation's scope.

It was agreed that primary quantitative data would not be conducted due to budget limitations.[13] The primary research was therefore entirely qualitative, and given a limited volume of villages covered, is intended as illustrative: it cannot be

13 This was due to be mitigated by analysis of quantitative data collected by the longitudinal study, but it later transpired that the Evaluation Team could not be granted access to this

considered representative of all experiences of IECD across all implementation areas.

The populations included in data collection are described at Section 5.2.2.

With an emphasis on learning, and with limited resources and impact data available to the Evaluation Team, it was agreed that the evaluation would not assess impact and will therefore did not consider progress towards impact indicators. The evaluation did not conduct primary quantitative data collection. Following discussion with UNICEF, it was been agreed that the evaluation would not cover questions relating to cost effectiveness; cost efficiency is included at a high level of analysis, drawing largely on stakeholder perceptions. More detailed quantitative analysis in this aspect would have required more detailed budgetary and expenditure data than was available.

5 Evaluation methodology

5.1 Evaluation framework

The evaluation framework was developed using the reconstructed TOC in relation to the standard OECD–DAC criteria of relevance, effectiveness, efficiency and sustainability, but not impact, which was excluded in line with the TOR due to the evaluation's formative purpose. The evaluation also includes cross-cutting themes as a criterion, with particular focus on equity, gender equality and human rights considerations. These criteria were selected based on the TOR provided by UNICEF. The selection of these criteria reflect the priority needs of the Reference Group and the evaluation's other key users in identifying improvements to ongoing and future ECCD programming. The criteria are standard and readily understood. For full definitions, see the OECD–DAC website.

The main questions the evaluation answer seeks to answer are listed below with their sub-questions. These evaluation questions were agreed with the Reference Group and finalized during the inception phase, following a process of refining and prioritizing the larger set of questions included in the evaluation TOR. Important considerations during this refinement process included the feasibility of answering the initial set of questions given resource limitations and data availability and maximizing the relevance of evaluation questions to the evaluation's purpose and objectives. The rationale for changes to each of the original questions was explained in detail in the evaluation Inception Report. For each evaluation question, the required sources, data collection method and indicators were specified in an evaluation matrix (see Annex D).

Evaluation questions

Relevance

1. How appropriate is the programme approach to meet the needs of disadvantaged pregnant women, carers and children in the north-eastern provinces and among the urban poor in Phnom Penh?
2. Is the design of the approach conducive to realizing the outcomes and outputs as defined in the CPD 2016–2018?
3. How well-aligned is the approach with the NAP on ECCD 2014–2018 in particular?
4. How has the IECD approach affected policy change at the national level?

Effectiveness

1. What were the major achievements and challenges under the IECD programme and why? How did these vary between IECD programme areas?
2. How did the IECD approach improve the effectiveness of activities under the six IECD programme outputs?

Efficiency

1. How could the efficiency of the integrated approach, including human resourcing, be improved?

Cross-cutting

1. How well does the IECD approach incorporate and encourage equity and gender dimensions in its interventions, especially for those most disadvantaged?
2. To what extent are age, gender ethnicity, disability and other disaggregated data collected and monitored?

Sustainability

1. How well will the current approach sustain positive outcomes without financial and technical support from UNICEF or other development partners?
2. What are the key enabling factors to consider in scaling up the IECD approach in other districts and provinces?
3. What are the gaps and bottlenecks to creating lasting systems and resources and to scale up the approach in other districts and provinces?
4. What were the major factors which influenced the achievement or non-achievement of sustainability of the programme between 2016 and 2018? Are there any other factors that are emerging that the programme should consider?

5.2 Data collection

The section that follows describes the methods, sources, approach to sampling and analysis, and limitations to the data collection. It describes both the evaluation design and any deviations in the design occurring during the conduct of the evaluation.

5.2.1 Methods

The methodology was drafted and agreed with UNICEF Cambodia and the Reference Group to answer the evaluation questions, with the knowledge that they reflect the United Nations Evaluation Group (UNEG) standards, all within the resource limitations.

Secondary data: The Evaluation Team conducted a review of UNICEF Cambodia programme documentation and resources, (including the CPD, Action Plan, RWPs and Result Assessment Modules (RAMs)) and Royal Government of Cambodia policy and legislation documents, as well as policy documents. These documents are all included in the bibliography. The Evaluation Team returned to these documents throughout primary data collection, analysis and the formulation of findings and conclusions. It had been expected that original data from the longitudinal survey would be available to Evaluation Team but, due to sensitivities surrounding the ownership of the data, only publicly available reports based on the survey could be accessed.

As noted under the section on Key Stakeholders (at Table 4), no data was available to quantify the target population of right holders or, for example, to specify the number of people accessing integrated ECCD services.

Primary data: The evaluation collected primary data through three qualitative methods, namely individual KIIs, [14] FGDs and case studies. Each of these methods and their purpose is described in Table 5.

14 *Four interviews (three international and one in country) were collected through Skype (audio or video) sessions to mitigate the distance of the Evaluation Team.*

Table 5: Summary table of qualitative data collection methods by international, national and sub-national levels

Method (quantity)	Purpose	Process
KIIs (76)	• To obtain in-depth information from individual respondents. • To provide respondents with privacy and freedom to respond openly without the presence of other group or community members.	Semi-structured interviews conducted with key informants who are stakeholders, including rights holders and duty bearers involved in delivery in the provision or receipt of social services related to ECCD in Cambodia. Interviews are semi-structured, following an interview guide, which provides a structure for interviews and details questions to be asked and gives suggested prompts for the respondents to elaborate further on limited answers. Semi-structured interview guides allow for conversational flexibility but ensure overall consistency between interviewers and between interviews.
FGDs (10)	• To understand multiple viewpoints and capture differential experiences and perceptions. • To increase data collection coverage. • To allow for internal verification of information through the participation of multiple respondents. • To gauge degree of agreement and disagreement on key themes.	FGDs bring together a group of between six to eight participants targeted as likely and actual beneficiaries of social services (status identified during FGDs). An experienced moderator introduces themselves, the purpose and format of the FGD, and reiterates the rights of participants (including not to answer questions and to leave the FGD at any point). The semi-structured FGD questions follow the FGD tool developed for that respondent group (see the example in Annex E). The moderator facilitates group discussion, ensuring the opportunity to respond for all participants, and steering the discussion in the direction required to ensure the relevant evaluation questions are answered. FGDs are be recorded (with participants' consent) and a note taker records written notes, highlighting points of particular relevance and interest.

Method (quantity)	Purpose	Process
Case studies (14)	• To explore in-depth the trajectory of the impact of participating (or not participating) in the programme. • To contextualize the wider circumstances within which pregnant women, mothers and young children make use of improved services and practices for early childhood survival, care and development, as well as to explore the reasons why some cannot access and use these services. • To focus on the access or delivery of services to specific vulnerable populations groups	Following a similar format to KIIs, case studies are generated through interviews with specific rights holders, following an interview guide. Case studies are designed to allow for a greater detail of exploration of individual attitudes, experiences and effects resulting from the IECD approach, and investigate in-depth particular circumstances (e.g. ethnic minorities, malnutrition case, young mothers, fathers' participation). Interviews are then to be written up into narrative form as case studies.

Data collection tools (questionnaires) were developed to cover a variety of questions regarding service management and provision from the non-beneficiary perspective and service access and use from the beneficiary perspective. In addition, KIIs focused on general knowledge about ECD and the IECD programme and its approach. The design of questionnaires drew from the evaluation criteria, evaluation questions and the sub-questions set out in the Evaluation Matrix (see Annex D) and was based on the reconstructed TOC (see Figure 7) to examine intersectoral coordination as well as the convergence of ECD service and practice at key access points. For example, questionnaires directed to non-beneficiary respondents working in the health sector (at any administrative level) included questions on social service provision, advice or referrals in the areas of ECE, parental education, nutrition, sanitation and birth registration.

Questionnaires were adapted according to the types of respondent (beneficiary/ non-beneficiary, administrative level, sector) to ensure the questions were optimally targeted and the most relevant information is obtained. Questionnaires were designed so that many questions were similar or comparable across most respondents for analytical purposes. In all, 13 KII questionnaires, 2 FGDs questionnaires (carers of infants and of children) and 1 case study questionnaire were used in this evaluation. An example of the KII questionnaire for a health centre director is included in Annex E. Additional questionnaires can be provided by the authors of this evaluation.

Suitability of methods

This combination of methods was designed to gather data that was as far as possible rich, representative of the range of stakeholders' experiences and relevant to evaluation's purpose, objectives and scope, within the resources available to the evaluation. The 'Purpose' column ofTable 5 details the value of each method; for example, at the level of the target beneficiary population, the mix of methods and case studies allowed the evaluation to record the views of a diverse population sample (through FGDs), while also being able to probe into depth and target specific respondents and issues of particular relevance and interest (through case studies).

The methods were suited to the evaluation's purpose, objectives and scope. These placed strong emphasis on the documentation of lessons learned; the review of programme documentation and KIIs with key stakeholders were essential to achieve this. Likewise, to understand gaps and bottlenecks in provision of IECD support and services in the north-eastern provinces and urban poor in Phnom Penh it was necessary to conduct primary data collection with service providers and recipients. The analysis and reconstruction of the TOC was required to achieve the evaluation's Objective 1, and this also informed the response to Objective 2 (assessment of Outcome 1).

The desk review of UNICEF results documentation, in conjunction with an illustrative set of qualitative primary data, represented the best available means to meet Objective 2, given the resources available (which did not extend to a quantitative survey), the exclusion of impact from the scope and the unavailability of quantitative data from the longitudinal study. Similarly, resources and scope did not allow for an intensive review of UNICEF or government budget or expenditure data.

5.2.2 Sources and sampling

Given time and resource constraints on the evaluation, it was agreed between the Evaluation Team and Reference Group that the geographic scope of primary data collection should be limited to two provinces (Kratie and Ratanakiri) out of the 5 targeted, plus the urban poor communities in the municipality of Phnom Penh, and in 5 of the 6 districts there, representing half of the total 10.[15] These provinces were selected as the provinces both with greatest concentration of IECD activities but also primarily given logistical constraints for the Evaluation Team to travel to the provinces further from Phnom Penh. This selection maintained the expected overall representation of urban and rural communes, as well as remote regions.

Selection of districts

Within the selected provinces and municipality (Kratie, Ratanakiri and the urban poor communities of Phnom Penh), the Evaluation Team selected all but one of the six IECD target districts. One was eliminated using random selection, leaving a total of five districts of those targeted under the IECD programme and which

15 *According to information provided by UNICEF, these 10 were Ban Lung, Bar Kaev, Chetr Borei, Kratie, Ou Chum, Ou Reang, Phnum Proek, Puok, Russei Kaev and Sampov Lun.*

formed part of the longitudinal study.[16] In the province of Ratanakiri, two districts were selected out of the three target districts to maintain a balanced distribution between urban and rural areas.

Selection of communes and villages

The selection of communes and villages was consistent with the intended design. Within each of the five districts, a simple random selection was employed of a single commune among those where UNICEF had provided technical or financial support in the areas of WASH, nutrition, health or ECE. Among each of the 5 communes, 2 villages were selected randomly among all villages in that commune, totalling 10 villages in the overall evaluation sample (see Table 6). The sample balance among districts included three urban areas and two rural or remote areas (one in each province).

Table 6: Data collection sample

	District	Commune	Village
Kratie	01 Krong Kratie	01 Roka Kandal	01 Roka Kandal 1
			02 Roka Kandal 2
	02 Chitr Borie	02 Thmei	03 Svay Chrum
			04 Treab 105
Ratanakiri	03 Krong Ban Lung	03 Kachanh	05 Village 1
			06 Village 3
	04 Bar Karv	04 Lung Khung	07 Lung Khung
			08 Pa Or
Phnom Penh	05 Russei Kaev	05 Chrang Chamreh Ti Muoy	09 Village 1
			10 Village 3

Selection of respondents: design

The sample of rights holder respondents was designed to balance the interlocutors based on their age, gender, location and economic status to ensure wide representation of all sectors of society. The design used a form of non-probability sampling (purposive sampling), in which individuals are selected based on their characteristics which are relevant to the study (e.g. carers of young children, members of vulnerable groups). This approach was intended to ensure the evaluation could gather evidence on the experience of IECD programme in relation to a range of stakeholders, including minorities, who might have been missed through random sampling methods.

Targeting of participants in FGDs and case studies was to be based on suggestions received from the village chiefs and

16 *The IECD longitudinal study locations are as follows: Phnom Penh municipality (Russei Kaev); Kratie province (Chitr Borie and Krong Kratie); and Ratanakiri province (Ou Chum, Krong Ban Lung and Bar Kaev).*

village health volunteers. Criteria to guide their selection included: meeting the definition of the specified FGDs or case study (e.g. mothers of children of a certain age); diversity in ethnic origin, gender and disability; and having lived in the geographical target area for at least six months between 2016 and 2018. For each case study, two or three respondents would be identified and five or six participants for each FGD.

The sample was not intended to be statistically representative of all experiences in the targeted areas, given its small size and the qualitative nature of the primary data collection. Nonetheless, the use of a simple random selection process for the selection of villages was intended to reduce any risk of bias in the selection of individuals while maintaining a diverse target group.

The inclusion of individuals from ethnolinguistic minority groups among respondents was important, given that this targeted population might be more likely to not receive services. The sampling targeted 6 of the 10 target villages with a large ethnic minority population.

Primary data were also collected from a wide range of institutional stakeholders and other respondents (e.g. front-line workers and service providers). The selection of these individuals for KIIs was based on their relationship with the IECD, their administrative role and responsibilities in the targeted organisations and their geographic location, and their identification was assisted by UNICEF staff. The institutional stakeholders are organized per their administrative level (international, national, provincial, district, commune and village) and sector of operation (health, education, rural development/WASH).[17] During the inception mission, the relative importance of the various administrative bodies at the provincial and district levels regarding the IECD approach was highlighted and added to the initial set of expected KIIs. In addition, the representation of persons identified at the commune level was specified more precisely due to interviews and discussions with the Reference Group which occurred during the inception mission.

Selection of respondents: implementation

Table 8 shows the characteristics of the participants in the FGD and case studies conducted (a full comparison of FGDs and case studies conducted against those planned is detailed at Annex F). In total, 66 individual parents were interviewed across the three target areas. The geographic distribution was relatively balanced as expected, with about 12 to 14 rights holders from each district. The distribution between urban and rural rights holders was also nearly equal, as intended.

Regarding socioeconomic characteristics, five different ethnic groups (including Muslims) were identified among the population, representing more than 60 per cent of all rights holders interviewed. Of the respondents, one in six was considered poor (per Identification of Poor Households (IDPoor) card). Despite multiple attempts, the data collection team was unable to identify the expected representation from carers of children with disabilities or fathers.

17 *Of 146 respondents, 80 (55%) were duty bearers or otherwise institutional; 66 (45%) were primary rights holders.*

Table 7: Respondents by level and sex

Administrative level or remit	Male	Female	Total
International	67%	33%	3
National	89%	11%	9
Provincial	31%	69%	16
District	58%	42%	12
Commune	37%	63%	19
Village	11%	89%	87
Total	27%	73%	146

Table 8: Characteristics of participants of FGDs and case studies

Socioeconomic characteristic	FGDs	Case studies	TOTAL
Total rights holders interviewed	52	14	66
Geographic location			
Kratie	21	7	28
Ratanakiri	20	6	26
Phnom Penh	11	1	12
Rural	21	7	28
Urban	31	7	38
Socioeconomic characteristics			
Carers of children 0–24 months	25	9	34
Carers of children 3–5 years	27	5	32
Fathers	1	0	1
Mothers	49	12	61
Of which pregnant and young mothers (18 years and under)	7	3	10
Grandmothers	2	2	4
Ethnic Group 1 (Kouy)	8	0	8
Ethnic Group 2 (Phnong)	1	3	4
Ethnic Group 3 (Muslim)	11	1	12
Ethnic Group 4 (Kroeng)	5	1	6
Ethnic Group 5 (Tompoun)	10	2	12
Child with a disability	1	0	1
Other disadvantage (IDPoor)[18]	15	8	23

18 *Respondents had an IDPoor card issued by the Ministry of Planning. IDPoor categorizes households as Poor Category 1 (very poor), Poor Category 2 (poor) or Not Poor (no card issued).*

The research firm was unable to complete interviews with all the intended respondents due to challenges with respondent availability and identifying respondents who met the criteria. A second round of field investigation was undertaken to complete interviews with additional respondents, but, even with the support of village chiefs, village health volunteers and UNICEF, it was not possible to complete all intended interviews. A full comparison of the KIIs conducted against those planned is detailed in Annex H.

5.2.3 Analysis

The analysis of the primary data took place in two stages, as the primary data collection was completed and delivered in two main phases. BN Consult prepared transcripts from the interviews conducted in the FGDs, case studies and KIIs, which they translated into English for all data collection results. The Evaluation Team was responsible for the data analysis.

The first analysis consisted of an initial set of 19 transcripts which was conducted during the validation mission and completed an initial examination of a limited set of evaluation questions. The initial findings were presented to the Reference Group committee on 11 July 2019 and in the Initial Findings Report submitted to UNICEF. In agreement between UNICEF and the Chair of the Reference Group, the planned group exercises to test and validate findings were removed from the agenda in place of open discussion on IECD issues. This discussion identified issues requiring further investigation or emphasis, such as the need to interview MEF and as a result some further additional data collection was organized.

The second analysis took place with the full set of completed KIIs and is the source of the evaluation findings in the next section. In this second phase, the Evaluation Team obtained the same findings as with the initial 19 transcripts, further validating the consistency and quality of the analytical process.

The analytical process was similar in both phases. Nearly all the interview notes and written responses were coded into a qualitative data analysis software, NVivo 11, which facilitates the sorting and iterative analysis of information across primary qualitative data sources (KIIs, FGDs and case studies in our case).[19] The transcripts are read systematically by NVivo to identify the formatted documents. The coding structure was set up by the study lead that categorized findings by evaluation question, key actor, sub-framework questions or cross-cutting theme. This enabled an analysis, for example, across all respondents around a similar question such as the birth registration of a child. NVivo can examine how birth registration was discussed across all administrative levels, all types of rights holders and service providers. In addition to the sectoral analysis, additional themes explored included cross-sectoral activities, sub-national governance structures and intra-provincial trends, as well as themes identified in the change statements included in the reconstructed TOC (such as capability of service providers and community and carer awareness of ECCD). Keyword

19 *About a dozen transcripts were excluded from the analytical process in NVivo, but incorporated into the analysis by being read manually. Those transcripts were mostly for the national and provincial levels.*

searches across all transcripts also enabled the examination of a particular theme or issue. Cross-cutting themes of equity, gender and human rights are also included as themes.

The contents of these discrete NVivo analyses generated an output (word document), producing a secondary body of source material collated by the thematic code (e.g. birth registration). The Team Leader directed and produced the material to develop the key findings. The Evaluation Team met as a group to discuss these findings and to begin formulating the main findings and recommendations to go into the report. An internal draft of the report was reviewed within OPM, with a particular focus on the strength of evidence behind findings and the conclusions drawn.

The analytical process summarizes key findings and reviews the evidence to ensure that the findings are robust across multiple stakeholders and qualitative data sources. Initial findings are triangulated on the basis of responses from multiple stakeholders and multiple primary data sources, and findings are further refined until stabilized, that is until there are consistent or varying findings across the target areas. For example, observations from rights holders can be compared with those from service providers (e.g. health workers, preschool teachers, NGOs) and sub-national administrative authorities. Given space limitations, it has not been possible to include all evidence that underpins a given finding, but (unless otherwise stated) only findings based on multiple sources of evidence have been included. As noted elsewhere, the broad, varied range of different stakeholders involved in IECD, and limited means of the evaluation to collect primary data, limited the scale to which findings could be triangulated.

As much as possible, variances in findings that result from differences in gender, location (urban/rural), poverty, ethnicity, disability or other background characteristics are highlighted regarding the differential impact of the IECD approach. The disaggregation of the qualitative data enhances the evaluation by identifying those groups which have benefited (or not) from the IECD approach as well as bottlenecks for certain marginalized groups.

5.2.4 Increasing reliability and validity of data collection and analysis

The analysis of primary qualitative data maximizes the quality, validity and reliability of evidence used for each evaluation question. The Evaluation Team used the following approaches:

- Preparation, revision and validation of the primary data collection tools by the Reference Group.
- Prior testing and revision of primary data collection tools led by the Research Lead, with in-country supervision from the Project Manager, to ensure that the data collection tools are fit for purpose and generating quality and relevant data (the initial set of questionnaires were modified as a result).
- Thorough fieldworker training process, led by the Research Lead with in-country supervision from the Project Manager, to ensure a consistency of approach to data collection.

- Supervision of data collection by the Research Lead to ensure rapid identification and to address any issues that may undermine the consistency or quality of fieldwork and the data it generates.
- Triangulation of data by comparing data for consistency across different sources (e.g. rights holders, service providers, administrative levels) that speak to the same issue (or node, in our analysis framework), identifying outliers from other data points, considering any incentives that may undermine the validity of some data points and using the judgement of the Evaluation Team to disregard or report explicitly data points that appear inconsistent.
- Interaction with rights holders in two format types (FGDs and case studies).
- Validating findings from multiple stakeholders through two multi-stakeholder validation workshops: (i) at the end of fieldwork to minimize the risk of basing findings on biased data or of reflecting the views of only one particular group; (ii) more intensive validation of findings and recommendations at a final validation workshop with a wide range of stakeholders from the three provinces in which data were collected and from across a wide range of organizations and administrative levels.
- A well-documented audit trail of materials and processes so that other stakeholders can review the process by which findings were generated and conclusions reached.

5.2.5 Limitations and mitigations

Attribution of responses to IECD: As noted under Section 3, interviews during data collection revealed that awareness of the IECD approach was often low. Desk review and consultations during the inception phase suggested that the IECD approach would be well-recognized, so this language was used in questionnaires designed to ensure the attribution of responses to the object of the evaluation. With low awareness of the IECD approach by name or by description (as provided by the interviewer), there is potentially limited attribution of some responses to the approach. This was mitigated to an extent by the use of prompts which described the approach throughout the findings section; particularly on effectiveness, some findings come with a caveat to highlight this issue.

Although efforts were taken to ensure respondents were selected on the basis of characteristics of interest (as described under Sampling at Section 5.2.2), it is possible that (particularly given the use of village chiefs and village health volunteers) the respondents selected had greater access to services, interest in and/or knowledge of the issues under discussion than the average person in the target areas. If this is the case, responses would likely be more positive than a fully representative sample.

Limited depth of primary data samples: Across the different categories of respondents, most samples consisted only of one respondent per category per district (the category of mothers is the clear exception). This limits the ability of analysis to validate findings specific to a particular category. This has been partially mitigated

by triangulation against respondents in other categories.

Lack of quantitative data on outcomes: The decision not to include quantitative primary data collection in the evaluation design was based on the data availability from the longitudinal survey. During the inception phase, however, it became clear that the raw data would not be available to the Evaluation Team, but rather only publicly available research reports using that data. This was a considerable unmitigated limitation, particularly as regards the ability to triangulate findings on effectiveness. For example, if rights holders stated increased awareness of new-found knowledge and reported new related practices, the associated behaviour change could not be ascertained through unavailable quantitative data. This limit, however, was mitigated as much as possible by triangulating the qualitative data using the balance between rights holders and other respondents (e.g. front-line workers and service providers who validate the behaviour change).

Monitoring and results data: As is noted under findings, the results framework was not well-designed towards capturing progress towards the objective of increased integration of services. As a consequence, the programme was lacked data and other reporting that might provide evidence of progress towards this objective. Similarly, the findings note that monitoring and reporting was done along sectoral lines. This means that the programme lacked a clear statement of integrated ECD results. The evaluation could only mitigate this insofar as it could collect new primary data.

Non-availability/engagement of respondents: As noted under Section 5.2.2, because of unavailability, unwillingness to participate or (in the case of male primary carers and parents of disabled children) being unable to identify any suitable participants in the data collection areas, the research firm and Evaluation Team were unable to complete all planned data collection. In addition to reducing the overall size of the data set, this means that some important and likely unique perspectives were missed. Among rights holders, this particularly included fathers and parents of children with disabilities; among duty bearers, it included some key stakeholders at a national level, both in government as well as in UNICEF. To remedy this, additional data collection was conducted (both in the field and by Skype) which reduced the gap, but still some stakeholders (including significantly at MOH) remained unavailable or (in the case of male primary carers and parents of disabled children) could not be identified even with the support of village chief, village health volunteers and UNICEF. This has been mitigated only partially insofar as other respondents could offer indirect accounts of the experiences of the groups that were missed.

Some key stakeholders, particularly at MEF, were not identified by the Reference Group as relevant to the evaluation until after data collection had been conducted. Although the Evaluation Team were able to schedule an interview, the insight gained from this came too late to influence the shape of the rest of data collection. It has not been possible to mitigate the latter aspect of this limitation.

Limited evidence on efficiency: As is noted under the findings for efficiency, UNICEF has not systematically gathered evidence that can be used to make any quantitative analysis of efficiency. This was mitigated partially in the design of the evaluation framework, which oriented data collection on efficiency towards qualitative aspects particularly around coordination and outreach.

Quality of responses: Although the field team was comprised of experienced facilitators, they were sometimes unable to elicit extended responses in FGDs, despite multiple attempts to probe for more in-depth answers. In addition, the reporting of FGDs by the field team does not allow for attribution to individuals. For example, the number of parents answering questions cannot always be identified. Case studies, however, allowed for more detailed probing of rights holders.

5.3 Ethics

The evaluation was designed and implemented in accordance with the United Nations Evaluation Group's Norms and Standards for Evaluation (2016) and the UNEG Ethical Guidelines (2008), as well as UNICEF's Evaluation Policy (2018), the UNICEF Procedure For Ethical Standards In Research, Evaluation, Data Collection And Analysis (2015), the obligations of evaluators in the UNEG Guidance on Integrating Human Rights and Gender Equality in Evaluation (2014), the UNEG Code of Conduct for Evaluation in the UN System (2008) and the UN-SWAP Evaluation Performance Indicator (2018).

The compliance of the design, governance and process of the Evaluation with the five UNEG standards as set out in UNEG's Norms and Standards for Evaluation (2016) was described in the Inception Report. Children were not interviewed for this evaluation (some young children were present when parents and carers were interviewed).

Fieldwork

In conducting fieldwork, the Evaluation Team applied a set of ethical principles OPM has developed based on its own experience as well as on the UNICEF Procedure for Ethical Standards in Research, Evaluation, and Data Collection and Analysis (2015) and the Young Live research ethics guidelines, which draws from existing literature on the governance of social research.

- **Ensuring the safety of participants:** This meant that the environment in which research was conducted was physically safe; there were at least two facilitators present at all times.
- **Recognizing the participants are vulnerable:** This meant that the researchers were aware of local conditions and made sure that the exercise and interactions were carried out in a manner that was respectful to all respondents.
- **Ensuring that people understand what is happening at all times:** This was ensured through the use of local enumerators, so that research was conducted in the appropriate language and dialect through fieldworkers who were familiar with local customs and terminology.

- **Clarifying the purpose:** This involved setting and communicating clear parameters for the interviews to the respondents, which included clearly stating the purpose, the limits and what the follow-up would entail.
- **Informed consent:** Potential respondents were given enough information about the research. Researchers were trained to ensure that there was no explicit or implicit coercion so that potential respondents made an informed and free decision on their possible involvement in the fieldwork. Respondents were informed that they could choose not to respond to all or any questions at any time. The team obtained explicit oral consent from each respondent before carrying out any research activity.
- **Anonymity:** Given that research respondents could share considerable amounts of personal information with us, it was the Evaluation Team's responsibility to ensure that their confidentiality was maintained and personal information protected. This was operationalized by ensuring that all data sets were anonymized, in the sense that all names of people were removed before any data were shared publicly.

Furthermore, the evaluation sought and obtained prior approval to conduct primary data collection in health centres from Cambodia's National Ethics Committee for Health Research. The approval letter is contained at Annex F.

Safeguarding

Because data collection would bring Evaluation Team members and field researchers into direct contact with and/or near vulnerable people (at least young children, mothers, pregnant women, people with disabilities and sick patients at health centres), OPM put in place additional safeguarding measures. Specifically, OPM conducted background checks on all personnel in the Evaluation Team and conducted a two-hour training in safeguarding for all members of the field team. This training provided familiarization with safeguarding concepts, a detailed explanation of OPM's safeguarding policy and procedures, and reinforced the contractual obligation upon all OPM subcontractors to act upon and safeguarding concern. Training was conducted by the project manager in English and translated into Khmer.

6 Evaluation findings

6.1 Relevance

The section on relevance evaluates the extent to which the IECD approach is suited to priorities and policies of the Royal Government of Cambodia and the needs of pregnant women, carers and children under the age of five. Findings for these evaluation questions focus largely on the design and TOC of the approach, drawing particularly on UNICEF programme documentation, and not on implementation, which is covered under Effectiveness.

Box 8: Main findings – relevance

1. The approach is highly relevant to the needs of the groups targeted, although needs around service access in remote locations and time poverty need further attention.
2. The approach was well-designed towards achieving the stated outputs, but design of outputs was not conducive to increasing the integration of services, as intended
3. The design of the approach partially targeted equity, and failed to target resilience to emergencies.
4. The IECD approach was adequately developed to support the operationalization of the NAP-ECCD 2014–2018.
5. The IECD approach created an enabling environment for developing cross-sectoral strategies and have strengthened the technical capacity of line ministries, but cross-sectoral implementation is still challenging.

R1: How appropriate is the programme approach to meet the needs of disadvantaged women and children in the north-eastern provinces and among the urban poor in Phnom Penh?

Finding 1: The approach is highly relevant to the needs of the groups targeted, although needs around service access in remote locations and time poverty20 need further attention.

The baseline data obtained from the longitudinal survey conducted under the IECD programme has made important contributions to a growing body of evidence on the needs of vulnerable groups which strongly underscores the relevance of integrated ECCD services to rights holders in the targeted areas. In the first year of the programme, evidence from the longitudinal survey demonstrated that 80 per cent of

20 *"Time poverty can be understood as the fact that some individuals do not have enough time for rest and leisure after taking into account the time spent working, whether in the labor market, for domestic work, or for other activities such as fetching water and wood" (Wodon and Bardasi, 2006).*

children in the focus areas did not have the minimum acceptable diet; more than 20 per cent of pregnant women were considered at risk during their pregnancy; exclusive breastfeeding was an issue, particularly in Phnom Penh; there was a high prevalence of stunting in Kratie and Ratanakiri among children aged 0 to 11 months; and more than 50 per cent of the population surveyed was not receiving nutrition or WASH messages (UNICEF, 2016b). In 2017, the survey generated findings specific to cross-sectoral issues; most notably, 32 per cent to 41 per cent of wasting and more than 30 per cent of stunting was attributable to WASH and nutrition indicators (Laillou, 2018). Likewise, UNICEF studies on the microbiological quality of drinking water identified high levels of contamination in target districts (46 per cent with E. Coli and 77 per cent with Total Coliforms at point of collection). One study using the longitudinal data identified determinants of child undernutrition, including poverty, WASH factors (e.g. access to improved water supply) and child nutrition practices (Laillou et al., n.d.).

The need for improved action is underscored by this baseline evidence showing very low outcomes in key women and children development indicators in the targeted areas. The IECD programme and approach recognizes the importance of targeting multiple challenges across social sectors in an integrated fashion to promote positive impact on pregnant women and children's outcomes.[21] International evidence also supports the effectiveness of such a holistic developmental approach using integrated programmatic strategies (see Section 3). Basic social services in Cambodia before 2015 were still considered limited and fragmented, with limited coordination between national and sub-national administrations (UNICEF, 2015).

FGDs and case studies confirm the importance of ECD issues to rights holders, including increased emphasis on ECE.[22] When asked about concerns regarding their child's development, parents and grandparents express worries about children's health, nutrition, hygiene, sanitation, environmental cleanliness and physical safety (frequent references were made to fears of road traffic accidents and drowning). The most frequent concerns expressed by respondents were in regard to their children's diet ('bad food', 'fried food', 'not enough and of low quality', 'unhealthy food') and health (risks around diarrhoea, fevers and, in Kratie, mosquitos).

ECE is also cited by rights holders as a primary concern regarding their children's development and for learning and school preparedness. While the evaluation cannot always ascertain whether the ECD focus is newly developed as a result of the IECD programme, one UNICEF respondent observed that "there are fast changing attitudes on the parts of parents on the value of ECE. Parents recognize value of it." Indeed, this view was reflected in the responses of rights holders, who expressed concern in FGDs in all sampled provinces for their children's early learning before primary school entry or mentioned the value of the parenting sessions. For example:

21 *This assumption is made in the draft UNICEF Schematic Theory of Change IECD document.*

22 *Several questions sought to understand parental concerns about childhood development, namely 'What aspects do you find challenging with raising a child?', 'Do you know how to prepare children for learning and school?', 'Are there any areas of the child's development that worry you most?' and 'Are you concerned about your child's development?'.*

> "We are concerned about the cognitive development of our children. We are afraid that our children won't be good at studying when they grow up." (FGD, Phnom Penh)
>
> "We worry about our children's intelligence." (FGD, Kratie)
>
> "The materials … provided by the meeting are useful for children, making children smarter and more intelligent and people know how to speak with their children." (FGD, Kratie)

Parental prioritization of education cannot be assumed in any context, and least in contexts where the opportunity cost of sending children to school competes with more immediate economic needs in the family. Nevertheless, the parents interviewed for the evaluation clearly accorded great importance to education for their child's potential. This corresponds with a finding of the recent evaluation of the National Education Scholarship Programmes in Cambodia that *"Cambodian parents and students have high aspirations and expectations of the role of education in helping find better jobs"* (UNICEF, 2019).

Rights holders in the FGDs recognize the importance of birth certificates, as 91 per cent have obtained birth certificates for all their children.[23] The importance was expressed primarily in terms of enabling school enrolment and finding jobs, as well as for formalizing marriage. Basic parenting skills emerged as another common concern, especially among first-time parents with infants, one of whom reported not knowing how to respond to their crying baby.

The programme's intended beneficiaries are time-poor and often in the hardest-to-reach areas, which limits access to existing services. Time and travel were as frequently identified by beneficiary respondents as challenges as were economic poverty and the inability to afford basic resources (such as medicine and school equipment). These statements were confirmed by front-line service providers and other administrative respondents, who noted hindrances both in health services and ECE access, and were more commonly impacting ethnic minorities.

> "[Our] children have never attended a community preschool, a preschool or another form of early learning programme because school is so far from home and we lack transportation to bring our child to school." (FGD, Kratie, Kuoy indigenous)
>
> "It is difficult to travel on the road to the health centre." (FGD, Ratanikiri, Kroeung ethnicity)
>
> "We are worry for raising children because we don't have enough time to look after them. When the children get sick I don't have enough time to take them to go to the health centre or money for curing them." (FGD, Phnom Penh, Muslim)

These responses demonstrate that lack of time caused by domestic and economic responsibilities can be a clear constraint to accessing services for the programme's most vulnerable target beneficiaries, as are physical and financial considerations caused by lack of transportation or accessibility. This is likely to limit the relevance and

23 *The national average for birth registration of children under the age of five is 64 per cent (40 per cent in Ratanakiri, 45 per cent in Kratie and 89 per cent in Phnom Penh).*

effectiveness of activities targeted at static service providers like health posts and centres whose outreach is limited by these factors. Mobile health care personnel and support workers, such as village health volunteers, can fill the accessibility gap. The programme's support under Output 1.1 to training Commune Administrators and village chiefs in social service mapping was well-oriented to identifying location-based access constraints. The programme's efforts to promote outreach for hard-to-reach populations was also geared towards addressing these challenges. Further, in other contexts, the tendency for time poverty to disproportionately affect women has been well-established (Wodon and Blackden, 2006; Turner and Grieco, 2000). Given the centrality of working with women and mothers in ECD interventions, addressing this constraint is of particularly acute importance.

R2: Is the design of the approach conducive to realizing the outcomes and outputs as defined in the UNICEF CP 2016–2018?

Finding 2: The approach was well-designed towards achieving the stated outputs, but the design of outputs was not entirely conducive to increasing the integration of services, as intended.

The programme lacked a clear implementation framework, or a statement of common strategies to be imbedded in the design of all 'IECD' outputs, resulting in a loss of coherence around the programme and its approach. The evaluation has found this to manifest in the varying understandings and interpretations of the approach within UNICEF and in the limited awareness of the IECD programme or approach among senior stakeholders external to UNICEF, particularly at sub-national level. Within UNICEF, there was (based on KIIs) inconsistent interpretation of IECD and its approach. Activities reported in the consolidated IECD RAMs clearly happened within rather than between sections. UNICEF personnel rarely spoke in terms of collaboration between sections and sectors, and more frequently emphasized the 'whole district' aspect of the approach or integrated service delivery. During a majority of KIIs with external stakeholders, the IECD approach was not known by its name. In one province, one senior official had only in 2018 become aware of the NAP-ECCD. It was also revealing that, at the evaluation inception workshop and in several national KIIs, there was evidently no clearly understood single translation of IECD in Khmer language (in particular, the word 'integrated' appears to have been confused with 'inclusive').

The programme established a logical set of activities which generally could reasonably be expected to achieve outputs. As discussed under the TOC, the pathways towards achieving outputs and outcomes were well-defined for WASH and nutrition and the link between sub-activities and output targets in those sectors was clear. For other sections, the TOC – and specifically the link between section sub-activities and the objective of promoting integration of services – was less clear.

However, in terms of the outcome, overall the six outputs did not sufficiently target integrated service delivery. As described in the sub-section on the TOC, the review of documents and interviews with UNICEF suggests the CP lacked an explicit framework linking integrated cross-sectoral activities

to outcomes resulting from integration. Rather, the approach's outputs established six strands of work – broadly: provincial administration, child protection/parenting and community development, nutrition, health, WASH and ECE – of which the latter four had high potential to become siloed. As discussed further under Effectiveness, it appears that these silos did develop for some sectors. Nutrition and health were the sectors which most actively pursued integration, but even for nutrition and health the programme outputs were not explicit about cross-sectoral promotion of health and nutrition services and information. Another consequence of this is that the programme monitoring framework was not designed in an adequate way to capture data indicating progress from outputs to integration-related outcomes.

KIIs with UNICEF staff at provincial suggested that IECD was understood at the level of implementation as being about ensuring holistic, comprehensive ECCD services in the target area, rather than being about integration of sectoral activities. At this level, achieving an *"integrated working style with strong encouragement at senior management level"* was identified by one UNICEF respondent as the primary challenge, and site selection was identified by another as the primary grounds of cooperation between sections. A similar picture emerged at the national level, where one section lead noted that collaboration with other sectors generally occurred only at specific times around policy development, and that the section workplan was focused purely on their sector and activities through their counterpart ministry.

Cross-sectoral convergence was most formalized between WASH and nutrition. The TOC for integration of WASH and nutrition was well-documented in a dedicated document *Integrating and Converging Nutrition Interventions in Cambodia* in March 2016, which established a clear case for and delineated a series of five pathways towards increased integration of nutrition and WASH (see Annex C). This was well followed-up with an investigation on *30 Months of Implementation,* which detailed progress against the TOC for integrating WASH and nutrition (Laillou, 2018). Beyond coordination and planning, other examples of formalized integration included the development of guidelines on SAM and an information system used as part of the health system; support to health practitioners to implement practices on Vitamin A supplementation, de-worming and screening for SAM; and the development of a TV series with integrated health and nutrition messages.

The programme's monitoring framework was not conducive to identifying increased integration. In general but with some exceptions (detailed below), UNICEF's monitoring framework did not include indicators clearly related to integration of services or cross-sectoral collaboration. Of the six outputs under Outcome 1, the output most clearly aligned to increasing integration was Output 1.1: strengthened capacities of administrators in six target provinces in analysing, planning, coordinating, implementing and monitoring actions that promote IECD.

The monitoring framework did include indicators that explicitly included evidence of cross-sectoral or integrated services. The Evaluation Team identified the following

four, where at least one sector is involved in delivering information or services about another sector's mandate:

> "1.2.4. Percentage of targeted (26) health facilities with infant and young child feeding counselling services.
>
> 1.3.1 Percentage of health facilities providing nutrition-specific services.
>
> 1.5.2 Percentage of preschools in target areas implementing minimum WASH package.
>
> 1.5.4 Percentage of health care facilities in the target areas implementing minimum WASH standards."

But in general, the remaining indicators focused on (and reporting in turn then detailed) changes that could be achieved without integration across sectors. That is, they report on direct service provision by one sector. Evidence of cross-sectoral work is not monitored in those cases.

Finding 3: The design of the approach partially targeted equity and failed to target resilience to emergencies.

Viewed from a national perspective, the targeting of specific provinces and districts embeds an equity focus into the approach. As described under Section 2, Kratie and Ratanakiri provinces, as well as the selected districts of Phnom Penh, show extreme disparities along a range of socioeconomic and ECCD indicators. Review of UNICEF annual reporting suggests the regional focus on the most disadvantaged areas is the programme's primary means of addressing inequity.

The approach's six outputs did not consistently or explicitly target constraints to equity. Although the programme's outcome statement targets more equitable use of integrated services, examination of the outputs finds this is not sufficiently reflected at the output level. Except for Output 1.6 on ECE (which makes explicit the targeting of *"children with disabilities and indigenous minority children")*, no other output makes clear in its phrasing the targeting of more equitable use of services. This is reflected in the results framework and reporting. Under Outcome 1, UNICEF's annual RAM documents disaggregated results most commonly by location (specifying the province in which results were achieved), sporadically by gender and in almost no instances by ethnicity, disability or other dimensions of exclusion.

Numerous activities were designed with a focus on addressing inequity, but this was not mainstreamed throughout. Activities under the education section more clearly targeted equity issues, but this this was less clear in the design of other section activities. Under Output 1, training on the promotion of social service with equity and social service mapping for vulnerable household identification, for example, were highly relevant to this objective. However, few activities under the other outputs had a clear inherent or explicit equity focus, other than by way of the areas targeted. The exception is ECE, with activities focused on an inclusive approach (for children with disabilities) and multilingual education.

It is not clear that the design embedded strategies to **promote use of integrated services in emergencies.** While the programme's work on WASH incorporated support to emergency resilience (for example on modelling climate resilient water supply in drought areas), the review of programme documentation suggests

this was absent from work under the other outputs. Similarly, the results framework does not reflect the intended emergency aspect of Outcome 1. No indicators under the programme relate to emergencies, and consequently the work (on WASH) in this area is reported on only in narrative reporting. There is no evidence to suggest the design considered the emergency resilience of integrated service delivery and use.

R3: How well-aligned is the approach with the NAP 2014–2018 in particular and with relevant national government priorities?

Finding 4: The IECD approach was adequately developed to support the operationalization of the NAP-ECCD 2014–2018.

The national policy environment for ECD in Cambodia flourished during the 2000s and peaked in 2014 with the development of the first NAP-ECCD 2014–2018 (see Section 2). The NAP-ECCD aims *"to provide integrated and coordinated services"* across 11 relevant ministries. Yet, in its initial years, the implementation of the NAP-ECCD met some challenges in reaching expected target goals (MOEYS, 2016).

This evaluation found that the IECD was developed with strong alignment to the government's NAP-ECCD, with evidence from the secondary data review and from KIIs with the national ministries and UNICEF. The alignment of the IECD approach with the NAP-ECCD is detailed Annex I. at Table 10, which compares the two sets of objectives. In short, the six objectives of the NAP-ECCD are very much aligned to and match the UNICEF's IECD outcome and six outputs.

In terms of equity, the IECD objectives are also aligned by targeting vulnerable families, defined specifically in the outputs as "children with disabilities, indigenous minority children." The NAP-ECCD's vision is equitable in principle, emphasizing the need to be inclusive of *"all young children, from conception to less than six years of age, especially disadvantaged, vulnerable and poor children."* It also later states that it *"seeks to increase enrolment and enhance protection for children aged 0 to 6 years, especially children from poor families, indigenous minorities and children with disabilities and prioritize community-based preschool and home-based early childhood education program"* (emphasis added).

R4: How has the IECD approach impacted policy change at the national level?

Finding 5: The IECD approach created an enabling environment for developing cross-sectoral strategies and has strengthened the technical capacity of line ministries, but cross-sectoral implementation is still challenging.

Although it is impossible to directly relate the IECD programme's impact on national policy, UNICEF's technical support and advocacy efforts have clearly raised the importance of a holistic approach to ECCD among national line ministries for the well-being of pregnant women and children aged zero to five. This, in turn, has created a supportive policy environment for the development of cross-sectoral strategies.

One of UNICEF's most notable advocacy efforts during the IECD programme was enabling the Royal Kingdom of Cambodia to host the 2017 annual conference for one of the region's largest network organizations

advocating for early childhood. The 2017 ARNEC conference was a high-level showcase of research and policy successes and challenges across the Asia–Pacific region.[24] In light of the NAP-ECCD, MOEYS (with UNICEF support) invited ministers and high-level technical staff from line ministries from the NC-ECCD to the conference. This was highlighted by one ministry KII as "key to helping bring other ministry heads to see evidence [for cross-sectoral coordination, the broad spectrum of programmes to support holistic ECCD and ECD's importance for national development] at the conference."

UNICEF's advocacy efforts also focused on demonstrating to government officials the physical, social and cognitive development benefits for children – along with their cost effectiveness – of providing an integrated approach to health, nutrition, WASH, child protection, care and stimulation in a more integrated manner. UNICEF's mechanisms for achieving these efforts include meeting with high-level ministerial officials, supporting cross-sectoral policy initiatives and collaborating with the MOEYS in its management of the NC-ECCD. Several examples of concrete applications and outcomes by UNICEF include the following.

- UNICEF Cambodia worked with the National Committee for Democratic Development to establish guidance and tools for provincial committees that promote adequate ECCD interventions. This work laid the foundation for strengthened collaboration among health, education, nutrition, WASH and child protection sectors at local and national levels to promote evidence-based policy development (UNICEF, 2016b).
- UNICEF supported five MOWA and NGO delegates to participate in the Parenting Support Interventions for Violence Prevention in East Asia and the Pacific in Manila. Cambodia presented the Positive Parenting Strategic Plan and TOC, followed by review/feedback from international experts and representatives. One of the three action points included the integration of ECE, health, parenting and violence against children.
- In 2018, UNICEF supported a formative evaluation of a cross-sectoral cash transfer pilot project, in which poor women and children are given money for attending health and nutrition community learning workshops or get antenatal and postnatal care at local health centres (CARD–UNICEF).
- Increased focus on early childhood WASH was supported though the collection, analysis and dissemination of WASH data on children under five, with key findings shared at national forums, meetings with regulators and service providers, and sub-national forums (UNICEF, 2017a; 2017b).

UNICEF also provides direct technical support aligned with the Government's NAP-ECCD (2014–2018) to overcome barriers causing fragmentation, poor quality, inadequate and unaffordable basic social services for disadvantaged and excluded children and communities. Through its support to the NAP-ECCD, the IECD approach has enabled national ministries to identify procedural gaps and develop new policies and guidelines with UNICEF guidance and technical support.

24 *"The transformative power of Early Childhood Development: the importance of holistic interventions' in March 2017 in Siem Reap, in partnership with MOEYS and supported by UNICEF Cambodia and other partners.*

New guidelines and policies have been developed to support the national policy on ECCD as part of the IECD approach. For example, UNICEF helped MOI to develop the Guidebook on Community Preschool Management for Communes/Sangkats, the development of the new NAP-ECCD 2019–2023 (see Box 2) and the new guidelines on WASH minimum requirements in schools in 2016 (UNICEF, 2016b). These guidelines help advocate for increased investment by MRD in basic WASH facilities in schools, including operation and maintenance.

In addition, 10 sub-decrees, guidelines and *Prakas* had been drafted, developed, adopted or planned to be adopted by different line ministries as of 2019, all with technical support from UNICEF. Out of the 10 policies, 5 were adopted and 5 are on track for approval in the coming based on the statement from the new ECCD-NAP (2019–2023).

Box 9: UNICEF support to policy development

- Sub-Decree No. 245 ANKr.BK dated 29 December 2017 on Community Pre-School (CPS) Management.
- Guidelines No. 42 AYK.SSN 2017 on the operation of public primary schools and preschools for the school year 2017–2018.
- Guidelines No. 22 AYK.SSN on the structure, roles and duties of the Division of Special Education and Multilingual Education in the provincial office of education (POE), the district office of education (DOE) and public education institutions.
- Decision on the Implementation of the Community Preschool Management Guide for Communes.
- *Prakas* no. 91 on the introduction of minimum standards for CPS (January 2018).
- Draft *Prakas* on formality and procedures for evaluating CPS.
- Draft Interministerial Prakas and allowance rate for standardized CPS.
- Draft Interministerial Prakas on procedure for disbursing and liquidating monthly allowances for preschool teachers, funds for children and CPS operating and development funds.
- Draft *Prakas* on criteria to transform a CPS class as an annex of a public institution.
- Draft *Prakas* on mechanism, procedures and requirements for the recruitment of CPS teachers.

New intersectoral working groups have also been established to fill policy gaps as the result of the IECD programme. Most notably, a Sub-Technical Working Group for WASH and nutrition was created in 2016 to maintain and ensure effective coordination between networks. One ministry official noted: *"Yes, there is change [in how the IECD approach changed implementation practices]: for example, MOEYS request MOI to form a workgroup to support preschool, there is more system for collaboration between ministries."* This points both to the relevance of the IECD programme to fostering stronger interministerial coordination and to its effectiveness.

6.2 Effectiveness

Box 10: Main findings – effectiveness

1. The IECD approach has contributed to the achievement of outputs under five programme areas, but it missed opportunities for effectiveness through increased strengthening and integration of planning and coordination of services.
2. The capacity of sub-national administrators regarding the IECD programme has been strengthened by UNICEF-supported training and advocacy, but cross-sectoral collaboration is patchy.
3. The IECD programme appears to have helped build the foundations for the integration of local service delivery through training of education, health and rural development front-line workers. Yet, there is limited evidence in terms of formal intersectoral work at the service delivery level.
4. The IECD programme and its approach – in the provision of discrete activities – are filling much-needed gaps to build the foundations for an integrated approach across the relevant sectors for the improvement and more equitable use of integrated ECCD interventions and practices.
5. IECD-related activities, such as training of front-line workers, contributed to increasing parental knowledge and behaviour regarding the holistic developmental needs of their children.
6. The IECD approach appears to be slowly improving services regarding some vulnerable groups.
7. Ethnic minorities and remote villages are the most difficult populations to reach and are often neglected in terms of outreach and service delivery because of cost and resource restrictions.

E1: What were the major achievements and challenges under the IECD programme and why? How did these vary between IECD programme areas?

Finding 1: The IECD approach has contributed to the achievement of the programme's six output objectives, but it missed opportunities for effectiveness around strengthening and integration of planning and coordination of services.

Improvements for children and families were observed across the six IECD programme outputs, with a strong emphasis on health and education as shown in Table 9. A comprehensive list of all programmes and training sessions realized across the target areas cannot be presented here, but their diversity underscores the existing need to improve the well-being of pregnant women and children aged zero to five. The listed programmes and activities are all attributed to the IECD programme and approach, as most activities did not exist previous to 2016.

Although improvements are noted regarding the outputs, the question remains whether greater coordination and monitoring across sectoral mandates could enhance IECD effectiveness. For example, IECD activities targeting pregnant women and their newborns for the delivery of information on antenatal and postnatal health and early nutrition has improved the well-being of these populations. Information received from village health volunteers, Core Parents, health centre staff and village chiefs – all of whom received training under the IECD programme –reinforce the message for a healthy pregnancy and delivery.[25] Kratie and Ratanakiri provinces report a significant increase in the number of mothers receiving antenatal care and delivering their babies in health centres and hospitals, and officials in these provinces link this progress with UNICEF's support. According to the Kratie Provincial Health Department, Kratie has reported zero maternal deaths (pregnancy to 42 days post-partum) in the first half of 2019, partly as the result of the department's increased outreach activities.[26] Yet, these are clearly missed opportunities as messages about early learning and stimulation are not delivered to expecting or new parents.

25 These trends are in continuation of those observed between 2000 and 2014 (Mallick et al., 2018).

26 Usual reported rates are five deaths per year on average

Table 9: Examples of evidence in realizing IECD programme outputs

IECD programme outputs	Primary data evidence in the target provinces	Secondary data evidence in the target provinces#
1.1 By 2018, strengthened capacities of administrators in six target provinces in analysing, planning, coordinating, implementing and monitoring actions that promote IECD	• A HC respondent in Kratie mentioned that, since 2015, the Global Alliance for Vaccination and Immunization has been providing financial support for outreach activities to provide vaccination across vulnerable villages. A health centre in Phnom Penh notes that a UNICEF worker keeps track of children's weight, height measurement and vaccination. Health centres are able to geographically map the vulnerable areas and provide training accordingly. • In Kratie, the POE and Technical Working Group for RWSSH (TWG-RWSSH) worked together to train preschool teachers on WASH. • In Kratie and Ratanakiri, all five village chiefs received training and/or guidance from CWCCCs, UNICEF or NGOs on IECD issues related to pregnant women and children aged zero to five. They, in turn, shared this information with community members (e.g. parents, village health volunteers and Core Parents) to build awareness and improve care and access to services.	• Newly updated practical tool and guidance for commune/ Sangkat and WCCC to analyse, plan, implement and monitor inclusive social service delivery "Commune/Sangkat Social Service Implementation Manual" was approved by MOI in May 2018, and approved commune/Sangkat social service expenditure guideline by MEF is part of the Manual. The recent launch of the "Social Service Implementation Manual" is a joint commitment of MOI, MEF (especially the National Treasury), development partners and UNICEF to strengthen capacity of sub-national administrations, especially for Commune/ Sangkat Councils and CCWCs for increased social investment for vulnerable women and children, including children with disabilities.#

IECD programme outputs	Primary data evidence in the target provinces	Secondary data evidence in the target provinces#
1.2 By 2018, strengthened capacities of communities, caregivers and families to practise timely and appropriate birth registration, complementary feeding, hygiene, positive parenting and health seeking behaviour for children under the age of five, especially in six target provinces	• In Russey Kaev (Phnom Penh), approximately 100 per cent of all caregivers participated in parenting education, even if they live far away [DOE]. • 91 per cent of the rights holders interviewed have birth registration certificates. • Five formal preschool teachers reported that their responsibilities include providing advice on sanitation and health care to children, while simultaneously supporting the various teaching activities.	• More than 5,000 parents and caregivers from 145 villages in targeted districts received information at a community level on key practices and behaviours regarding birth registration, nutrition, hygiene, health, positive parenting and brain stimulation.# • The achievements recorded in timely birth registration and enrolling 3–5-year-olds in ECE are largely attributed to strengthened communication and parenting education initiatives that promote targeted caregiver practices. 100 per cent of 34 communes in 5 IECD targeted provinces have budgeted and implemented the parenting education session.*
1.3 By 2018, increased capacities of service providers to promote access to SAM at all levels in an enabling environment, particularly in six target provinces	• Village health volunteers are guided by health centres about how to measure the children and to provide nutrition cake to children who are malnourished [Kratie Village Health Volunteer 1].	• Intensive interventions implemented in targeted IECD districts of Kratie and close monitoring of households have resulted in significant reductions in the prevalence of wasting. However, additional efforts are needed to ensure that children are treated according to WHO/UNICEF standards. Recent analysis of 947 hospitals inpatient treatment of SAM cases showed that after three follow-up visits, only 30 per cent were above -2sd, 56 per cent were moderate acute malnutrition and 14 per cent were still SAM. New SAM and nutrition minimum package of activities guidelines, new web-based monitoring, the addition of ready to use therapeutic food in the essential drug list and new investment by the Ministry of Health for BP100 (US$167,000 in 2018) should address several bottlenecks in future.#

IECD programme outputs	Primary data evidence in the target provinces	Secondary data evidence in the target provinces#
1.4 By 2018, increased capacities of service providers to promote access by more newborns, children and women to quality primary health services, focusing on neonatal and maternal health and immunization, especially in six target provinces		• The proportion of deliveries attended by skilled trained personnel increased from 45.12 per cent (2016) to 52.35 per cent (2017) and to 61.64 per cent (3Q of 2018), right above the national average of 61.22 per cent (2018). # • More than 80 per cent of planned integrated outreach involving midwives implemented in hard-to-reach areas. At least two midwives from each health centre in the target areas received practical hands-on training to provide essential antenatal and postnatal care.#
1.5 By 2018, strengthened commitment and capacity of government to provide more children and their families, particularly in the six target provinces, with increased access to quality WASH facilities and services	• Village chiefs, education workers and rights holders in Kratie and Ratanakiri attended training sessions to promote better sanitation and clean water for their families and young children. • DWCCC state awareness of need to promote sanitation and hygiene.	• Sanitation for families with children under the age of five has been strengthened with over 3,345 ergonomic child potties procured by UNICEF supplied to families in 8 provinces, to support sanitation promotion activities. One hundred and seventy-three villages (60 villages in 6 target IECD convergence districts and 113 villages in other geographical areas) have also been reached with HWTS education sessions.# • In 2018, progress was made with the rural WASH management information system (MIS) led by MRD, which has the potential to support strengthened coordination and progress chasing. UNICEF has been a key stakeholder in providing technical support to the MIS. # • The training of four members of the PDRD in each target IECD province on CLTS, hygiene promotion and HWTS, supported by UNICEF is considered an achievement that will strengthen capacity which will enable future progress.^^

IECD programme outputs	Primary data evidence in the target provinces	Secondary data evidence in the target provinces#
1.6 By 2018, strengthened commitment and capacity of government to provide more children under five with increased access to inclusive quality ECE, particularly among children with disabilities, indigenous minority children and those living in the six target provinces	• CPS (Kratie) received monthly training from UNICEF and partner organizations related to education, health care, sanitation and clean water.	• Within the 6 ICED target districts, 163 preschool teachers (161 female) were introduced to SEL and pedagogy.

Note: *Primary data evidence is from the KIIs. For secondary data evidence, UNICEF has several documents which provide evidence on the activities to support the six IECD-related outcomes and are listed separately below.*

Sources: *^(UNICEF, 2016a); ^^(UNICEF, 2016b); *(UNICEF, 2017a); #(UNICEF, 2018a);*

Finding 2: The capacity of sub-national administrators regarding the IECD programme has been strengthened by UNICEF-supported training and advocacy, but cross-sectoral collaboration is patchy.

The IECD programme has focused its support to the Kingdom of Cambodia, primarily by building capacity at the sub-national level through increased training and advocacy support. As per Output 1.1 of the CP 2016–2018, the technical support and training provided by UNICEF and its partners has focused on analysis, planning, coordinating, implementing and monitoring cross-sectoral activities. The IECD programme has collectively trained individual administrators at the commune, district and provincial levels by approaching the WCCCs and education and health departments. For example, senior officials in Kratie reported that UNICEF was instrumental in supporting a May 2018 training to provincial-level authorities and provided awareness and information on the NAP-ECCD, previously unknown to them.

Yet, the operational and implementation capacities of cross-sectoral mechanisms vary across provinces, districts and communes. Evidence from the provincial level shows different activity levels of the WCCCs across target provinces. Senior officials in Kratie reported that there is difficulty in getting sufficient representation of PWCCC members to attend the monthly meeting, while, in Ratanakiri, the meeting seems to be conducted regularly on a monthly basis (meeting at least 11 of the 12 target times). Insufficient attendance can limit the ability to make decisions or have the necessary presence of responsible entities. Indeed, senior officials in Kratie reported that the PWCCC appears to have

limited decision-making capacity compared to the one in Ratanakiri and that there is insufficient leadership or support from the provincial governor.

There are good examples of cross-sectoral collaboration on specific issues at the national level, but there is little systematic intersectoral collaboration. All the national and sub-national cross-sectoral mechanisms (see Box 11) preceded the IECD programme, as they were established and functional before 2016. As such, the influence of the IECD programme would hypothetically appear on the governance, planning, financing or other aspects that would increase the effectiveness of such systems. Yet, evidence from senior officials at the national level shows these aspects still occur in silos by sector, with little interaction across main line ministries. Collaborative examples only exist around specific themes such as positive parenting education (MOWA and MOEYS), birth registration (MOI and MOEYS), community preschools (MOI and MOEYS), health screenings before preschool enrolment (MOH and MOEYS) and latrine and clean water provision for preschools (MRD and MOEYS). Yet, the main platform for cross-sectoral coordination regarding pregnant women and children – the NC-ECCD – is weak operationally: it meets too infrequently (two to three times a year, with other technical ministries), attending technical staff from ministries change frequently and the agenda is not fully validated by all line ministries.

Box 11: Cross-sectoral national and sub-national working groups and committees

Three cross-sectoral mechanisms have been part of the decentralized administrative landscape in Cambodia for many years and oversee areas which intersect with the IECD: TWG-RWSSH, the WCCCs and the Technical Working Group for Health (TWG-H).[27] These groups exist at the national and lower sub-administrative levels. Provincial-level entities promote planning and budgeting and serve as directing and monitoring mechanisms for the implementation arms which are seated at the district and/or commune levels. At each level, technical departments from each represented sector report on progress and challenges faced in their administrations. They can also address progress on issues raised in previous meetings. A WASH-related working group has also been established by MRD. None of these entities have specifically coordinated or pooled budgets to support the implementation of jointly made decisions.

The TWG-H incudes sub-national administrators (directors of Provincial Health Departments), development partners and civil society representation. Its monthly meetings are co-chaired by the Minister of Health (or a Secretary of State) and the WHO Country Representative.

27 *Given the diversity of the pre-existing intersectoral groups at the national and sub-national levels, the NAP-ECCD did not establish an additional monitoring mechanism.*

The TWG-RWSSH brings together national and sub-national entities and development partners to monitor progress through quarterly meetings. Decisions are made at the provincial level, following a provincial plan with national oversight and budgeting. This group was first established in 2007. The TWG-RWSSH is co-chaired by the Minister of MRD and a rotating development partner (since 2011 UNICEF) and its members include MEF, Ministry of Planning, MOH, MOEYS, MOWA, MOI and others. An NGO representative and development partners are also members of the Technical Working Group. At the sub-national level, the provincial Technical Working Group is led by the Deputy Provincial Governor.

The WCCCs exist at the decentralized PWCCC, DWCCC and CWCCC level and are under the mandate of MOWA, which also provides them with technical support. The role of committees is advisory and focuses on recommending, advocating and coordinating services targeted at women and children by bringing together members from line ministries. The WCCCs were established by decree (Prakas No. 4275 BrK of 30 December 2009) in 2009.

Sources: *ADB (2012); KIIs (2019); Liverani et al. (2018); MRD (2019).*

Finding 3: The IECD programme appears to have helped build the foundations for the integration of local service delivery through training of education, health and rural development line workers. Yet, there is limited evidence in terms of formal intersectoral work at the service delivery level.

UNICEF and partner training activities under the IECD programme have increased knowledge among service delivery personnel about the importance of integrated service delivery and a holistic approach to ECD. International evidence supports the importance of quality training for health, education and social welfare workers to improve the quality of ECCE in developing countries (Engle et al., 2011; Rao et al., 2014). In the training sessions conducted in the targeted provinces, service delivery personnel and community members use a cascade training model, whereby information is shared to provide training (even informally) to others in the community. For example, DOE respondents in Kratie, Phnom Penh and Ratanakiri received training from UNICEF and MOEYS on holistic children's development. DWCCC and school directors reported receiving training and sharing information with preschool teachers and Core Parents. Village health volunteers reported receiving training on early nutrition from health centres, which they then used to improve guidance to parents. Village chiefs in Kratie and Ratanakiri reported receiving training from CWCCCs, UNICEF or NGOs on IECD issues and shared this information with community members (e.g. parents, village health volunteers and Core Parents) to build awareness and improve care and access to services. A formal preschool staff member in Ratanakiri provided an example of the types of cross-sectoral cooperation:

I meet with PLAN organization and the health centre to check hygiene, weight, height, health control and malnutrition of children under five years old. I work with VSO and UNICEF about playing materials

and games for children. The school has requested a health centre for de-worming children once a quarter. I cooperate with SOS organization on nutrition and provide lunch to poor children who are scholarship students. [Ratanakiri, Formal Preschool]

However, attribution of changes specifically to the IECD programme is uneven across sectors, as the data collected were not always able to identify who organized training sessions. Information on holistic child development is being delivered to parents, as clearly observed in FGD and case studies, but the awareness to the IECD programme (i.e. training by UNICEF or partners) is not always indicated, especially in the health and rural development sectors (see section 5.2.5). Only one out of five village health volunteers identified the source of training or had heard of the IECD programme or approach (even when described without its name). Line workers in the education sector, however, nearly always attributed improving their capacity in different ways to the IECD programme, as in the following examples (in response to questions on identifying changes related to the IECD programme or approach):

UNICEF has supported technical, training, and transportation fee … and it has helped [children with] disabilities and vulnerable children. [DOE]

> "There have been changes in the classroom. Previously, we did not know about hygiene after having a cooperation the organization has trained us on hygiene. … I educate the children to clean the courtyard around the house and on the street. It helps make parents more aware of hygiene." [CPS]

> "[IECD approach] changed that now I encourage children of the village to get vaccinated and get weighed." [Core Parent]

> "I work with UNICEF partners on the training programme [whose topics included] health problems, hygiene for small children and pregnant women." [Village Health Volunteer]

Village health volunteers and Core Parents are recognized by all stakeholders as strong focal points for delivering important IECD information to vulnerable families in villages and remote areas. Village health volunteers (see Box 12) and Core Parents regularly provide parents with valuable information on the holistic development of children regarding health, nutrition, sanitation, child protection and child development. Health officials in Kratie and Phnom Penh reported that, as the result of health worker training and village health volunteer outreach, antenatal care is now commonplace, a greater number of children are screened for malnutrition, and health centre staff teach communities about sanitation and hygiene at home.

Generally, line workers in the education sector are more likely to share holistic information on ECD compared to those in the health sector. Education service providers (in both formal and community preschools) and volunteer Core Parents (parental educators) go beyond their usual education mandates to include information from other sectors and provide information on child nutrition, birth registration, hygiene and information on WASH to parents. Rights holders identified that Core Parents are more likely to speak about a child development in a holistic manner (see Box 3), while village health volunteers seem to focus less on broader child development issues (e.g. stimulation,

playing, communication with children, non-violence). Information provided by front-line health workers appears less comprehensive as the information focus is on health and nutrition. No rights holders in the FGDs in Phnom Penh and Kratie indicated receiving information on birth registration, parenting education, preschool enrolment or holistic child development when probed.[28] Rights holders with infants in Ratanakiri reported learning some child development stimulation from the health worker.

Box 12: Village health volunteers and the IECD programme

Village health volunteers are among the strategic actors implementing the IECD approach at the community level for the health sector. They have received training on the IECD approach and work with other community-based actors, such as village chiefs, core parents and health centre staff to provide improved health services. Parents have implemented the health and nutrition advice received, as one Health District worker noted:

> All communities have changed their health behaviour because there are many people who come to receive health services from health centres. The increase in the quantity of people coming to receive health services at the health centre is because the village health volunteer also has helped to disseminate information about the benefits of available health services at health centre.

Village health volunteers are community members, selected to work in each village or commune and depend on a health centre where they receive training and supervision. The scope of their work is broad, as outlined in a 2003 health system policy development and described in the KIIs (see Annex H).

Regarding the IECD target population, their responsibilities include community dissemination of hygiene, nutrition and health-related information specific to pregnant women and young children, distribution of micronutrients, promotion of deliveries in health centres, follow-ups on health centre visits and identifying children for malnutrition. Their ability to be effective across IECD target communities is restricted, however, as noted across the FGDs and case studies. Beneficiary respondents had limited or no interaction with village health volunteers in their home (only 3 respondents in the 24 FGD and case studies noted home-based visits). Rights holders noted that village visits by volunteer health workers ranged from once to 10 times a year. Village health volunteers perform their work on a volunteer non-paid basis, with very limited resources (e.g. for covering transportation costs). Village health volunteers also build their capacity with the support of international and local NGOs.

Despite the value added by these workers in the provision of health care knowledge and referrals, national policy statements and strategic documents have limited recognition of their capacity. These observations are substantiated in other studies on the contributions and challenges of village health volunteers in Cambodia (for example, see Ozano et al., 2018).

28 *The probe in FGDs was 'Did the health centre staff explain how to talk to the child, how to play with the child, how to respond to the child when he/she cries?'.*

Village chiefs and volunteer Core Parents are committed to providing integrated information on child development to communities. Both sets of informants say that their capacity has improved with IECD because they advise parents on all aspects related to holistic child development, such as when to go to health centres, promoting non-violent parental education, and encouraging birth registrations and daily hygiene practices for their families. According to Core Parents, parents are more sensitive to health and hygiene practices and Village chiefs have received requests for a preschool. Village chiefs and Core Parents in Kratie reported that their participation in intersectoral meetings (presumably CWCCCs) was a useful source of information that they could then share in public meetings in communes and villages. One meeting subject that was reported, for example, was about how to reduce discrimination against women and children with disabilities.

> "I provided useful information, such as development in children brain and increasing knowledge about children hygiene and health." [Core Parent]

> "Yes, I have advertised by motorbikes on the street to villager to get children to register for birth certificates." [Core Parent]

Yet, there are few examples of formal intersectoral work at the service delivery level as the result of the IECD. Formal links across all IECD sectors are not visible at the service delivery level, except to a limited extent in education and in selected target areas. The Ratanikiri Provincial Health Department – which receives support from UNICEF – provides a strong example in its collaborative work with preschools, as described in Box 13. Cross-sectoral links have not been consistently well-observed at the district and commune levels among service delivery personnel, and guidelines have not been established at these administrative levels.

Box 13: Provincial collaboration between Departments of Health and Education

> "We have meetings two or three times [a year] between the Health Department and Department of Education and we train their preschool teachers from the district with children below five years. The trainer is from the central Russian hospital in Phnom Penh. This is with UNICEF support.

DOH has one person responsible for preschool health. They are invited to talk and take information from DOE about preschools and call preschool teachers and invite them to training, with transport cost provided. For example, today they train in Bokeo in preschool and next week they can come to my place. We have a group on the Telegram app.

With the outreach of these activities we can identify unvaccinated populations."

[Provincial Health Department]

Evidence suggests that informal links for integrated work are in development on an ad hoc basis, but their effectiveness or attribution to the IECD programme or approach cannot be determined. For example, in Ratanakiri, a formal preschool teacher who has received training from UNICEF partners is working with the head of village to inform all households that children should attend preschool as of age five to increase participation of children from ethnic minorities, but data are not available to evaluate the effectiveness of this strategy.

E2: How did the IECD approach improve the effectiveness of activities under the six IECD programme outputs?

Finding 4: The IECD programme and its approach – in the provision of discrete activities – are filling much-needed gaps to build the foundations for an integrated approach across the relevant sectors for the improvement and more equitable use of integrated early childhood survival, care and development interventions and practices.

The IECD approach has strengthened the delivery of services for pregnant women and children aged zero to five through an extensive set of discrete activities supported by UNICEF and its partners. These include cross-sectoral training programmes, development of administrative guidebooks and development of teaching materials that go beyond the original remit of the service provided. UNICEF documents, including signed workplans, reviewed for this evaluation provide various examples of UNICEF support for improved effectiveness in service delivery conducted in IECD target areas and at the national level.

- Village health volunteers received training on nutrition and malnutrition identification and prevention.
- Health facility workers received training on child protection (based on the clinical handbook for children subjected to violence or sexual abuse).
- MOI developed a 'Community Preschool Management' guidebook to help communes align community preschools with MOEYS minimum standards.
- The Provincial Rural Development Department strengthened to support the longitudinal study in improving water quality in coordination with the commune development planning process.

In addition to these examples, which aimed to improve cross-sectoral service delivery mechanisms, the target areas have attempted to improve effectiveness through joint monitoring missions at the district and commune level, as initiated by PWCCCs. Joint monitoring visits can be "highly useful for converging services for children" at the local level (UNICEF official). For example, when conducted with department representatives from several sectors (e.g. rural development, health, education), joint monitoring missions can instigate targeted and coordinated action across the sectors.

Finding 5: IECD-related activities, such as training of front-line workers, contributed to increasing parental knowledge and behaviour regarding the holistic developmental needs of their children.

The IECD programme has been effective in disseminating information to parents about holistic child development. Nearly all education officials interviewed in Kratie, Phnom Penh and Ratanakiri credited the IECD programme or approach as vehicles

for increasing parental knowledge and appreciation for children's education, as well as changing parental behaviour. Specifically, more parents are enrolling children of pre-primary school age, citing the importance of education and attend meetings and training sessions. Preschool education was cited as a priority preoccupation for parents. Parents in the FGDs living in remote areas of Kratie and Ratanakiri named education as a significant concern for their children (after health). More than half of all KIIs from duty bearers in direct contact with parents in all target areas (e.g. CWCCCs, Core Parents, formal preschool staff, village chiefs) noted positive parental behaviour changes around health, hygiene, child stimulation, ECE and sanitation.

Box 14: Examples of effectiveness at community level

Primary data collection gathered some rich responses regarding the effectiveness of IECD at community level. Some examples are presented below as an illustration of effectiveness, as told by those delivering services at community level and the recipients of those services.

On dissemination of information to parents

> "Yes, the IECD changes [parental behaviours] because now people send their children come to study more." [Formal Preschool]
>
> "There are some changes [related to IECD] because people start to wash their hands and drink clean water. People understand about sanitation and [links to] their children's health care." [Formal Preschool]
>
> "Better than before because people understand about take care health, during pregnancy they know what type of food they should eat, feed to their children, take care their children, increase weight of the children and development of children." [Village Health Volunteer]
>
> "Yes, it [the IECD] has changed behaviour of people by awareness of hygiene, wash hands with soap before and after meals, and after using toilets, cooked water, understanding health problems, changing old habits, and when they were sick need to go to the doctor or health centre. When giving birth, people go to a health centre; they do not delivery by traditional birth attendance." [Village Chief]

On preschool education and parental education

> "Before training, children are more susceptible to diarrhoea, and communication with children was difficult [not smooth]." [Beneficiary]
>
> "There is some change because after attend at school children gain a lot of knowledge. They tell us that do not allow children to work too much because they have to study." [Beneficiary]

Parents enrolling children in preschool education and attending parenting classes have been rich sources of information for parents about the importance of holistic development for their children. Three-quarters (18 out of 24) of beneficiary respondents interviewed in the target areas attended parenting classes and reported receiving a variety of information on hygiene, healthy food habits that can help the children fight off diseases, care of children (such as proper dietary intakes), caution regarding child abuse and bullying, proper washing of children's clothes, knowing about their children's whereabouts when they play, and feeding 'enriched porridge'.

Equity focus on vulnerable families and children

Finding 6: The IECD programme appears to be slowly improving services regarding some vulnerable groups.

Across Cambodia, children with disabilities are among the most vulnerable groups regarding school attendance and completion, with 57 per cent having never attended school or having not completed primary school (MOEYS et al., 2017).[29] The IECD programme in Kratie, Phnom Penh and Ratanakiri included UNICEF teacher training sessions to help teachers identify children with disabilities within the community, encourage their participation in school and adapt appropriate inclusive education practices. District core teachers attended training sessions on inclusive education (e.g. in Kampong Thom and Prey Veng province) supported or funded by UNICEF. A community preschool teacher in Ratanakiri mentioned receiving training from an intersectoral group composed of UNICEF, education and health district offices and indicated that MOH had produced guidelines on children, disability and malnutrition provided by the Provincial Department of Health.[30] Yet, education officials in Kratie (both administrators and teachers) still found that population to be a challenge as teachers lacked sufficient knowledge in how to teach those children at the preschool level: *"Teachers lack knowledge and it is difficult in teaching especially for disability students [due to the] teacher's lack of technical knowledge of disability."* [31]

Yet, line ministries do not necessarily see pregnant women and children aged zero to five as their target population and therefore do not attribute specific programmes or prioritize policies to improve their well-being. This is the case for the MRD, which was interviewed, where infrastructure planning and development are prioritized based on poverty and lack of water supply, not by target population. Ultimately, the infrastructure development might coincide with the geographical distribution of pregnant women and children aged zero to five, but they are not the focus or monitored group. Other line ministries part of the NC-

29 *A lack of published data on children with disabilities in EMIS means they are not included in enrolment figures and are largely invisible in mainstream government plans and budgets.*

30 *The UNICEF supported the Ministry of Social Affairs, Veterans and Youth Rehabilitation to design new disability identification tools to identify children with disabilities without the need to rely on medical diagnoses (UNICEF, 2016a, 2017b).*

31 *Disabilities are identified without any specifications in the report, but slow learners are associated with discussions about disabilities.*

ECCD might face similar situations where their mandates are more generalized, but they were not part of the evaluation's interview process.

Finding 7: Ethnic minorities and remote villages are the most difficult populations to reach and are often neglected in terms of outreach and service delivery because of cost and resource restrictions.

Providing essential health, education and sanitation services is a major challenge in the remote areas of Kratie and Ratanakiri, especially where ethnic minority groups live. All service providers identified at the provincial level indicated that higher costs for accessing these areas (e.g. by boat or all-terrain vehicles) and resource limitations created bottlenecks in delivering improved infrastructure (e.g. access to clean water supplies, health centres, preschools). A senior-level health official estimated that one-third of the Kratie provincial population is not adequately covered by health services.

As expected, transportation issues are less of a concern in Phnom Penh's Russei Kaev district, where parents participate in parental support classes despite living far away. Informal advice is an important component of these community-based workers: Core Parents follow up with and provide advice to parents when they meet in the community outside the formal sessions.

The outreach and provision of ECD-related information to vulnerable populations face significant challenges. In Kratie and Ratanakiri, parents from ethnic groups and living in poverty were reported to be the least likely to attend parenting information sessions, send children to preschool or visit health centres due to participation in income-generating activities.[32] In one case in Ratanakiri, the community preschool found that ethnic minorities might feel discriminated against in the school relative to other children.

> "Less children come study. Early in the school year, students come to school a lot, but then teacher was busy harvesting cashew nuts. Then during the rainy season, the road is slippery and so less children come to school." [Formal Preschool]

6.3 Efficiency

Box 15: Main findings – efficiency

1. At the operational and strategic levels, there is little to no evidence of systematic intersectoral coordination of activities, and it is likely that opportunities to achieve efficiencies are missed.
2. At the activity level, the IECD approach has demonstrated some examples of efficient cross-sectoral collaboration.
3. Strategic opportunities to capture and demonstrate efficiencies were not exploited.

32 KIIs reported that, during certain seasons, parents moved the entire family to the farm, which is far from education and health services.

E1: How could the efficiency of the integrated approach be improved?

Finding 1: At the operational and strategic levels, there is little to no evidence of systematic intersectoral coordination of activities, and it is likely opportunities to achieve efficiencies are missed.

UNICEF respondents at the provincial and national levels commented that work planning (and monitoring) is conducted independently by the various sections. As one respondent summarized: *"Planning of strategy and activities is done separately."* Another UNICEF respondent noted *"[The IECD approach] will be effective depending on the people and motivation for coordination to work in same direction,"* and upon joining UNICEF was struck by how *"It was very sector-based in UNICEF and with development partners. To do integrated programming for children, it's important that everyone makes time for coordination."*

This is (at least in part) a product of planning, budgeting and reporting processes, which are highly sector-siloed. Each section develops its own annual RWP, which is then cascaded down to provincial leads. Provincial leads coordinate on issues such as site selection (for example, with the WASH or education teams leveraging the Community Development Team's understanding of local areas to identify preschools to work with), but there is no structured process by which opportunities for cross-sectoral planning and cooperation can occur. At national strategic level, document review and interviews suggest that UNICEF's Task Force for IECD established in 2016 has not met with any regularity *("The IECD working group, which pulls together people from different sections, is not really functional"),* which would mean further missed opportunities for efficient coordination.

Finding 2: At the activity level, the IECD programme and approach have demonstrated examples of efficiency in outreach and integrated service delivery.

Increased cross-sectoral collaboration provides opportunities to increase the outreach of ECCD services with more efficient use of inputs. Primary data collection identified various examples where the IECD approach has achieved this, particularly through health workers in the provision of support in nutrition and WASH. Several respondents at village level described the role of village health volunteers and health centres in terms of a range of services beyond health. For example, a focus group with mothers in Kratie spoke of the value of the holistic range of training support received from the village health volunteer, which touched on both health (avoiding viruses and malaria) and WASH (water purification, hand washing and sanitation). As another example, a preschool teacher noted how advice received from the health centre allowed him/her to better address diet issues for malnourished children.

Qualitative evidence gathered points towards signs of efficient coordination of referral networks. KIIs with village health volunteers and health centres showed signs (with some consistency) that referral networks are developing and may at least partially be attributed to efforts to promoted an integrated approach. For example, village health volunteers described their role in referring pregnant women to the

health centre (for example to collect iron tablets) and mothers to the health centre for nutrition issues and to the school director for de-worming pills. Such responses highlighted the role of health centres in addressing malnutrition, of preschools in tackling health issues and the support role village health volunteers have played on health, nutrition and WASH.

These responses also attested to the training provided to village health volunteers, to their coordination with education providers, and to coordination between service providers. Staff at health centres in the target areas spoke of a clear change during the period of the IECD programme's implementation with a new focus on nutrition. For example, in Kratie, health centre staff noted:

> "[the integrated approach] changes the health centre's style to be able to provide nutrition service. It encourages patients to seek health services at health centre and referral hospitals that have been previously neglected. It provides knowledge and skills in community-based training" and "Identification of [children and pregnant women] with malnutrition – and their referral to health centres – by health centre staff and village health volunteers has improved since 2017."

There is also evidence that points towards the formalization of coordination networks, such as among and between Core Parents and village health volunteers. A health centre worker in Ratanakiri described this:

> "There is a core parents' network to support and train people in the community and village. There is training with regard to nutrition to core parents, and village health volunteers of health centres to understand how to weigh and measure children and screen malnutrition.... They are working as a connecting network between upper and lower levels and between different sectors to support them to in an integrated system."

These examples all point to progress in more holistic provision of care for nutrition, health and (less commonly mentioned) WASH. They also speak to steps forward in strengthening local level referral and coordination.

However, a lack of efficiency in outreach is observed when several outreach workers overlap in the same village and commune. One FGD indicated that some families received information from different set of workers (e.g. village health volunteers and Core Parents) during parenting support sessions, but that these were not linked or followed-up in any convergent or coordinated fashion. Another FGD reported that messages were duplicated from outreach services and delivered infrequently. Furthermore, as identified in the KIIs of provincial and district line ministries, the valuable and effective outreach provided by Core Parents and village health volunteers (see Section 6.2) faces similar limits and challenges due to limited resources. Those identified included few regular opportunities for capacity development, difficulty in access and high transportation costs for remote outreach and inability to frequently visit needy families.

Finding 3: Strategic opportunities to capture and demonstrate efficiencies were not exploited.

In a context in which government social service funding limitations are frequently cited as a major constraint, integration of services offers clear benefits in terms of cost efficiency. UNICEF's adoption of an integrated approach created an opportunity to generate evidence on cost savings, but the evaluation finds little evidence that this information was gathered and none that it was utilized. Although the sectoral structure of UNICEF budgets (contained in RWPs) complicates tracking of the use of the overall IECD budget, there are some examples where a UNICEF section budget – namely WASH – highlighted cross-sectoral pooled funding on collaborative activities, such as on improved WASH in health facilities. However, it appears that no analysis was conducted on the changes to cost efficiency, cost effectiveness or overall value for money as a result of integrated activities.

6.4 Cross-cutting themes

Box 16: Main findings – cross-cutting

1. By targeting pregnant women and primary caregivers who tend to be female in most households, the IECD programme and approach largely omits fathers.
2. The most disadvantaged groups remain difficult to reach with the IECD approach.
3. Tools and disaggregated data collection specifically designed to identify and measure disadvantaged groups do not currently exist.
4. Some limited evidence of intersectoral M&E was noted at the provincial level during the 2016–2018 period.
5. Data convergence does not occur within an administrative level or across sectors, making the monitoring of the target population of the IECD approach inherently difficult.

X1: How well does the IECD approach incorporate and encourage equity and gender dimensions in its interventions, especially for those most disadvantaged?

Finding 1: By targeting pregnant women and primary caregivers who tend to be female in most households, the IECD programme and approach largely omits fathers.

While pregnant women and mothers are the target population for the IECD programme and approach, it is important to include fathers as an explicit target population from an equity and developmental perspective. Children benefit tremendously from the participation of their fathers in their lives and developmental stages, and fathers can benefit from the knowledge and information received through parenting programmes and other activities to support new parents (Britto et al., 2016; Britto, 2017; Sayre et al., 2015). Although it can be difficult to include fathers, programmes which actively target them, address their specific needs and provide them with a safe space to exchange ideas are more successful in increasing

paternal knowledge about ECD and increase gender equality in the household (Britto, 2012; Sayre et al., 2015). Collectively, through the inclusion of all members, a community can improve its standards and quality of life and increase its advocacy potential.

The absence of fathers in the IECD programme and approach is noted at several levels, and their current level of participation in child development appears minimal. Pregnant women and mothers noted that fathers do not always recognize and care for the pregnant woman and are too busy with work to take care of the children. Only two FGDs and case studies specifically mentioned fathers taking children to hospitals and health centres for preventative or curative health services.

A small group of service providers did mention fathers' participation in parenting classes provided in preschools as a general challenge, with more difficulty experience among indigenous groups in Ratanakiri. It would be useful to further understand if the outreach in parental education classes or among other service providers included fathers, but that was not possible to ascertain in the context of this evaluation (see Section5 on data collection and limitations). In a similar vein, the Evaluation Team faced substantial difficulties in identifying and including fathers who are caregivers in the evaluation process. Only 1 father was interviewed among the 66 caregivers for young children in the 5 districts.

Finding 2: The most disadvantaged groups remain difficult to reach with the IECD programme and approach.

The most vulnerable groups – such as children with disabilities, internal migrants, extremely poor households and remote ethnic groups – are more difficult to reach with the limited resources available for public service delivery. In both Kratie and Ratanakiri, the district health office reported having more difficulty in providing health information and access to pregnant women and children living more remote villages or specific vulnerable groups (e.g. Vietnamese migrants living on the river). Two case studies from minority groups living in remote areas of Kratie and Ratanakiri provinces noted that visits and parenting classes from health workers were infrequent (only two visits per year) and that access to health centres was far from the home when on the farm. While the IECD programme and approach provided ad hoc support with small microtransfers given to health districts and centres for transportation costs (e.g. five village health volunteers reported receiving transport money to reach remote communities), the lack of monitoring makes it difficult to assess the effectiveness of this outreach support.

X2: To what extent are age, gender, ethnicity, etc. disaggregated data collected and monitored?

Finding 3: Tools and disaggregated data collection specifically designed to identify and measure disadvantaged groups do not currently exist.

The Evaluation Team sought to capture the total number of beneficiaries accessing or demanding services through the IECD programme and approach using the secondary data. However, UNICEF and other documents reviewed for this evaluation did not capture this information in a clear

manner which would enable attribution or links with the TOC. For example, activities reported in the consolidated IECD RAMs identify shares of children attending community preschools, numbers of villages receiving initiatives under the six outputs, but this information cannot be consolidated to identify which beneficiaries accessed which services provided across the six outputs.

The lack of disaggregated data collection and the difficulty in identifying vulnerable groups is an important bottleneck in providing more effective and equitable targeted services within poor districts. Identifying vulnerable families is a challenge in many low-resource environments and, in these provinces, relies on the knowledge of village health volunteers and other involved community members (e.g. village chiefs). The longitudinal study, as this evaluation's primary data collection process, required their intervention to identify families with specific vulnerabilities. While community participation is critical for local accountability and flexibility, it also poses questions about the reliability and inclusivity of their identification of vulnerable populations, as well as their capacity to assess and identify specific vulnerabilities. For example, only visible disabilities can be identified by village health volunteers. Migrant families tend to also miss identification if not considered part of the commune.

Finding 4: Some limited evidence of intersectoral M&E was noted at the provincial level during the 2016–2018 period.

The IECD approach has enabled some small improvements in data collection activities, of which the most noteworthy are the implementation of the longitudinal data study and joint monitoring visits (see Box 17). The longitudinal study is unique in its M&E approach because it consists of focused and intensive data collection in the selected provinces. By following families for a three-year period and adjusting programmes to improve survival and development of young babies and children, much evidence can be generated on service delivery at the community level. For example, one study using the longitudinal data identified determinants of child undernutrition (stunting and wasting measures), which included poverty, WASH factors (e.g. access to improved water supply) and child nutrition practices (Karpati et al., n.d.; Laillou, 2018).[33] The longitudinal study also found a 8.4 percentage point reduction in severe acute malnutrition rates over 18 months of follow-up in the 6 target districts. The biggest decrease from 22 per cent to 8 per cent of wasting was observed in Kratie (UNICEF, 2018a).

Joint monitoring visits conducted by the provincial WCCC and the RWSSH and supported by the IECD approach have provided positive feedback. In Kratie and Ratanakiri, for example, members of the DWCCCs and CWCCCs indicated using joint monitoring visits and reports to monitor the impact of the IECD approach (KIIs, 2019). This provided a baseline approach to their observations, which could be reported back as evidence to discuss as a cross-sectoral group and used as evidence to

33 *Child nutrition practices were established based on WHO and UNICEF indicators for appropriate feeding for children by age group (6–8 months, 9–11 months, and 12–23 months).*

support programme or funding support at the provincial level. For example, a senior-level official in Ratanakiri identified a cross-sectoral Provincial Action Plan to address child marriage and teenage pregnancy as the direct result of joint monitoring visits in Ratanakiri communes, which were funded and coordinated by UNICEF.

The provision of cross-sectoral evidence instrumented by UNICEF was cited as an important advocacy tool to use with provincial authorities. The longitudinal data and UNICEF's advocacy work for integrated services were instrumental in providing evidence to decision-making entities at the provincial level about cross-sectoral factors in child malnutrition. In Ratanakiri, for example, this evidence helped influence the provincial administration to make additional funds available to address the relevant problems regarding pregnant women and child malnutrition and poor sanitation. Yet, resource requirements limit the study's sustainability in the long-term and alternative monitoring measures should be considered. As one UNICEF staff member noted:

Box 17: Sokapheap Knhom ('My Health') longitudinal study

Launched in 2016, the longitudinal study is part of a project to collect in-depth data over three years on health and nutritional status of children and mothers to better inform the government on progress that can be made with enhanced health monitoring. The target areas include selected districts in Phnom Penh municipality (Russei Kaev district), Kratie province (Chitr Borie and Krong Kratie districts) and Ratanakiri province (Ou Chum, Krong Ban Lung and Bar Kaev districts). The sample was established using a list of children under three years of age from midwives and village health volunteers covering all the villages. Subsequently, households with children under three years of age were randomly designated to the study, together with siblings. Pregnant women and mothers of children under three years of age were interviewed on their health, nutrition and water/sanitation access and receive services from UNICEF and local partners to improve the survival and development of children (e.g. nutrition bars for malnourished pregnant women and children).

By 2017, more than 5,000 households had been reached in the three target areas. The data collected for the longitudinal study include gender, weight, height and mid–upper arm circumference for all children, as well as information from mothers on demographic and household characteristics, WASH practices, health knowledge, participation in health campaigns and child feeding practices.

The project includes UNICEF, Institut de Recherche pour le Développement (French Research Institute for Development) and the Government of Cambodia's Department of Fisheries. UNICEF Cambodia has supported the implementation of the cross-sectoral longitudinal study to facilitate measurement of the impact of IECD approach in reducing child deprivations under the leadership of MOH.

Sources: *de Verneuil and Laillou (2017); Laillou et al. (n.d.); Morooka (2016); UNICEF (2017b).*

Evidence-based is very important to convince province and commune administration; it is a strong advocacy tool. So it is important for each of the sectors with which they work to bring up strong evidence.

Finding 5: Data convergence does not occur within an administrative level or across sectors, making the monitoring of the target population of the IECD approach inherently difficult.

Each implementing UNICEF section, line ministry and sub-national unit has its own mandate and monitoring outputs, so reporting across sectoral or programming lines is difficult. This is true for sub-national administrations, NGOs and UNICEF (as evidenced by the IECD consolidated RAM). IECD-related reporting within one sector can be complex, as evidenced by the limited capacity that line ministries had to be able to respond to the Evaluation Team's requests for specific data on ministerial work in the targeted provinces and across targeted beneficiaries. The UNICEF consolidated RAM measures IECD results across outputs that are inherently organized by UNICEF sectoral divisions.

Data often come from various sources and do not always cover IECD-related outputs. For example, commune databases can provide a socioeconomic analysis of village households but cannot cover questions related to WASH or child malnutrition. Data collection and monitoring within line ministries is also weak for IECD-related outputs. The health system, for example, struggles with its own fragmented surveillance infrastructure, which lacks integration across health data sources, does not include private sector surveillance and provides limited evidence for non-communicable diseases.[34] The implementation of the periodic Demographic and Health Survey data provides the strongest level of available evidence on maternal and child health concerns and trends (Liverani et al., 2018). Convergence of existing data sources requires a coordinated approach to data collection.

The consequence of inadequate data collection and disaggregation is that advocacy cannot be evidence-based or context-dependent. Several national-level KIIs (UNICEF CO staff, ministries) identified data as a significant bottleneck in improving IECD-related services. Understanding provincial circumstances require adapting different solutions and approaches. The longitudinal study and the UNICEF IECD activities (e.g. joint monitoring visits) helped provide these baseline observations. According to the national-level KIIs and UNICEF staff, qualitative and quantitative evidence provides a reliable basis for influencing decision makers yet suggests a critical limit in the nationwide implementation of IECD without a proper M&E system.

34 *More than two-thirds (67 per cent) of first treatments are handled in the private sector (i.e. private clinics, pharmacies) in Cambodia (Liverani et al., 2018).*

6.5 Sustainability

Box 18: Main findings – sustainability

1. Most of the effective interventions – advocacy, capacity development and M&E – have received significant financial and technical support from UNICEF and other development partners.
2. The IECD approach's delivery of holistic ECCD information and training benefit from existing cross-sectoral infrastructures, but their capacity can be a limiting factor as well.
3. Accountability for results in reaching NAP-ECCD outcomes is weak or not clearly delineated at the sub-national level.
4. The capacity development of beneficiaries is focused on training, with little follow-up or sufficient empowerment.
5. Participation in parental education training faces a number of barriers, including access and interest
6. UNICEF funding enabled sub-national government activities focusing on pregnant women and children aged zero to five, which would not have occurred otherwise.
7. The IECD programme and its training activities rely heavily on the presence of non-governmental partners, which are frequently limited in scope and inequitable in coverage.

S1: How well will the current approach sustain positive outcomes without financial and technical support from UNICEF or other development partners?

Finding 1. Most of the effective interventions – advocacy, capacity development and M&E – have received significant financial and technical support from UNICEF and other development partners.

As reported in Section 6.2, effective interventions included UNICEF advocacy with national partners, capacity development of line ministries and sub-national administrations and training of line workers. The first step of increasing understanding of integrated child development required activities with cost implications, such technical consultations for policy development, cross-sectoral training sessions on the benefits of IECD, sponsorship of international conferences (i.e. ARNEC) and direct financial support for joint monitoring missions. Some of these activities required significant levels of funding from UNICEF and other partners (UNICEF-MOEYS, 2018).[35] For example, Cambodia's WASH programme benefited from UNICEF funding to strengthen the government's commitment to the RWSSH

35 *For example, UNICEF helped to obtain SIDA funding for US$167,000 in 2018 which went above the planned budget for Key Result 2.2 in 2018 ("Analytical research is disseminated to ECCD National Committee in order to inform policy").*

service delivery of the national strategy for 2011–2025. This included printing the RWSSH NAPs, supporting the work of provincial RWSSH groups to conduct effective coordination, planning and information (e.g. by establishing a practice to share minutes) and to develop a focus on WASH for the first 1,000 days during media and communication strategies.

When financial resources are limited, however, the IECD approach is not likely to be sustained alone by government or other stakeholders (i.e. NGOs) in the short term. Evidence collected in the KIIs and corroborated by the RWPs indicate that UNICEF's financial support can be necessary to maintain intersectoral activities. For example, the quotations below show the financial limitations of the IECD approach: training for Core Parents did not continue because of a lack of funding and families in more remote areas do not receive outreach health services when transportation costs are not available for village health volunteers.

> "There is no participating from member of core parents because there are no activities, lack of money for training, and support to core parents." [DOE]

> "Yes, we know that they [the commune] will implement a plan [three-year development plan of commune]. If they have little money, they go to village two times per year; if they have more money, they go to the village four times per year." [Village Chief]

S2: What are the key enabling factors to consider in scaling up the IECD approach in other districts and provinces?

Finding 2: The IECD approach's delivery of holistic ECCD information and training benefit from existing cross-sectoral infrastructures, but their capacity can be a limiting factor as well.

Sub-national mechanisms provide possible platforms for cross-sectoral IECD work in all provinces, but their capacity is not regular in all targeted provinces. Their administrative capacity can be strengthened with greater autonomy in local context-based decision-making about beneficiary needs. Evidence in this evaluation highlights importance of sub-national ownership for the identification and resolution of policy priorities. Varying provincial needs around pregnant women, carers and children aged zero to five need to be considered to adequately address their needs and focus policy and activities.

The existing vertical integration of the WCCCs has several weaknesses depending on the province. These include the strength of political leadership to champion the needs of pregnant women and children aged zero to five, the involvement of political leadership at the village and commune level, and the availability of NGOs to support UNICEF's activities. Evidence points to political leadership to harness intersectoral coordination at the provincial level. Limited buy-in from key sub-national administrators in one province was identified as a challenging factor for promoting intersectoral activities around pregnant women, carers and children aged zero to five. The WCCCs have increased their capacity from the commune to the provincial levels through coordinated training sessions on the holistic development of children. Lessons and bottlenecks learned from these

training sessions can be identified from the trainees and trainers to be considered in other contexts.

The health sector provides a critical starting point for scaling up the IECD approach, given its reach to pregnant women and children aged zero to five. Yet, it needs to be cognizant of its existing challenges and limits. These include difficulties in reaching the most vulnerable families in remote zones, focusing more on nutrition, health and hygiene at the expense of child protection, holistic child development and sanitation and its dependence on volunteer Village Health Workers for sustained information delivery and monitoring of families. Through more targeted training, outreach workers or health centre staff would be able to implement context-driven approaches to non-centre-based models, such as home visiting services and community play-groups, which show positive developmental outcomes for children in vulnerable environments. In addition, links to social policies with an emphasis on poverty reduction and family support to empower pregnant women and families with children aged zero to five can help create a supportive environment to enable change around ECCD.

S3: What are the gaps and bottlenecks to creating lasting systems and resources and to scale up the approach in other districts and provinces?

Finding 3: Accountability for results in reaching NAP-ECCD outcomes is weak or not clearly delineated at the sub-national level.

Accountability around IECD outcomes is still diffuse across various ministries and sub-national administrators. Government leadership and political prioritization are essential for adapting and developing approaches that work in other provinces in an efficient and effective manner. Depending on volunteers to be strong advocates for the IECD approach among rights holders, for example, reduces accountability among the sub-national administrators. This evaluation observed that political prioritization at the provincial, district or commune level could improve the well-being of pregnant women and children aged zero to five, but this requires the support of well-functioning cross-sectoral WCCCs to reinforce the development of policies and programmes.

In the targeted areas, monitoring mechanisms are irregular or costly and rely mostly on joint monitoring visits or the longitudinal study. Ensuring the inclusion of a core set of ECCD indicators, which go beyond access and services received, could be more effective in holding stakeholders accountable for their activities. The cross-sectoral nature of service delivery is not currently included in the monitoring indicators (e.g. RAMs), which limit the ability to monitor the extent and impact of integrated service delivery.

Finding 4. The capacity development of rights holders is focused on training, with little follow-up or sufficient empowerment.

Evidence from the KIIs and FGDs reveal that the notion of holistic development of young children was weak across the rights holders and local service providers before the implementation of IECD activities. Yet, the implementation of capacity development around IECD knowledge of rights holders is fragmented, irregular and not sustained in most targeted areas.

UNICEF and partners conduct training to rights holders, but there is no mechanism to assess the quality of the interventions, continued participation or lessons learned by rights holders. Evidence from village chiefs and village health volunteers in different target areas suggested that some rights holders did not return after the first training session. For example, one village chief noted: *"Most of the people only attend the first time as during the second and third time, people are busy with their farming or labour so they do not come."* Information, for example, on the follow-up of trainers was not provided and evidence points to the unavailability of materials to support training in one instance.

Building sustainable parental engagement for IECD requires taking into consideration local context and building upon positive social norms and practices to engage the community. The promotion of home-based services and community-based groups are not identified in the IECD approach, despite international evidence that encourages and empowers parents to build an enriching home environment. All sectors involved in the delivery of public services in the IECD approach can guide parents on how to create a nurturing environment from pregnancy and beyond to support the holistic development of children, but most do not currently address the early cognitive and socioemotional domains. Furthermore, the capacity development of rights holders and front-line workers in low-resource environments requires innovative approaches to encourage sustainable change.

Finding 5. Participation in parental education training faces a number of barriers, including access and interest.

Bottlenecks to attending parental education training sessions mentioned by rights holders and service providers included distance, language barriers, work imperatives and little interest in childhood development. Distance is particularly problematic for access to education and health services when parents are in the field and live further from villages. Affordability or lack of preschools was a common answer given by rights holders (as verified by service providers) regarding the inability to send children to preschool.

> "My challenge is the parents of the student are busy and they did not come to the meeting. The parents of the student do not understand the benefits for their children when they come to school." [Community Preschool]

> "Parents aren't encouraging the children enough; the government should help encourage the parents to help their children." [Formal Preschool]

S4: What were the major factors which influenced the achievement or non-achievement of sustainability of the approach between 2016 and 2018? Are there any other factors that are emerging that the approach should consider?

Finding 5. UNICEF funding enabled sub-national government activities focusing on pregnant women and children aged zero to five, which would not have occurred otherwise.

Sectoral budgets are not sufficient to cover all interventions and benefited from UNICEF funding to improve cross-sectoral work. UNICEF staff reported on how malnutrition interventions benefited from supplemental

funds provided by UNICEF in Kratie and Ratanakiri. Joint monitoring visits, which are a strength of IECD implementation, are financed by UNICEF and would not occur otherwise, according to UNICEF staff and validated by PWCCC respondents. Currently, there is no budget for intersectoral IECD projects within government or in the NC-ECCD (KIIs). Two KIIs at the ministerial level indicated that the lack of cross-sectoral budget lines or implementing activities under the NAP-ECCD budget were limits to implementing cross-sectoral work.

Although decentralization has enabled provincial-level decision-making on budget allocations, a dedicated body is not accountable for affairs regarding the IECD target population groups. As such, if provincial priorities support the achievement of alternative priorities (e.g. infrastructure development was often mentioned in the KIIs), then existing budget allocations do not support activities benefiting pregnant women and children aged zero to five, despite the NAP-ECCD priorities.

> "The tendency to invest in infrastructure instead of public services is due to many reasons, but one is that perception in strengthening social public services should come from organizations and NGOs as partners and not from the government alone." [UNICEF staff]

> "All departments recognize the important of working together to address the problem of women and children and continue implementation especially at the sub-national level. … Top-level government members understand very well about early learning, as well as at the sub-national level, and that is why the commune must use their own funds to support preschools in their communities." [National KII]

UNICEF's advocacy work during the IECD period aimed to increase government commitment to social services for the target population at the sub-national level. This resulted in recent commitments to increase funding in the social services fund (authorized by MOI).[36] UNICEF provided further technical and financial support to prepare guidelines to assist communes in their planning and decision-making processes (e.g. on selection of social services receiving allocations). The national government's commitment for greater decentralization and local capacity-building includes providing clear guidelines on social service procurement for WCCCs and commune council members, who are the decision-making entities at the local administrative level.

Finding 6. The IECD programme and its training activities rely heavily on the presence of non-governmental partners, which are frequently limited in scope and inequitable in coverage.

As in most low-resource areas, the presence of local or international NGOs can provide significant financial, technical and operational support to governments in the delivery of social services. In all three target zones, NGOs were cited as providing training and delivering information to rights holders, village chiefs and service

36 MOI informed the Evaluation Team that the commune budget for social services would increase annually from US$15,000–US$30,000 per commune to US$70,000–US$100,000 per commune by 2020.

delivery personnel.[37] While partnerships with NGOs are a strength to bolster the IECD programme and its approach, they also create a weakness for the sustainability and replicability of the approach across the Kingdom of Cambodia. Not all target areas will have NGOs focused on pregnant women and children aged zero to five or the ability to train rights holders on the holistic approach to child development, and so on. Furthermore, it is reasonable to assume that the availability, quality and reliability of service delivery of NGOs will be different throughout the Kingdom of Cambodia.

The evaluation's TOC defines a main output as the increased quality of ECCD services (see Figure 7). The quality of training provided under the IECD programme and approach were often provided by NGOs. Quality can be considered as improved from the broad perspective that the design of service delivery was either incorporating more holistic elements of child development or more inclusive of cross-sectoral mandates. This evaluation, however, was not able to fully assess the quality of the services delivered. Questions regarding programme quality could include, for example, whether messages were delivered effectively or whether learning materials used were culturally relevant to the participants. Further examination could be important to scale programme designs across the country and to adapt to other environments.

37 This evaluation was not able to assess the quality of the partnerships.

7 Conclusions

Relevance

The IECD approach was highly relevant in terms of need. Its stated objectives sought to address the serious, urgent, well-evidenced needs of the groups it targeted, through an approach proven internationally to be well-aligned to addressing those needs. Further, key women and children development indicators are very low in in the targeted areas. Rights holders concerned also see the relevance of the services provided under the IECD programme, most notably to improve outcomes in health, nutrition, hygiene, sanitation, environmental cleanliness, physical safety, education and child protection.

The 2016–2018 IECD programme was highly relevant to national government policy, employing an approach that closely reflected that of the NAP-ECCD. UNICEF's technical support and advocacy efforts have clearly raised the importance of a holistic approach to ECCD which, in turn, has enabled a supportive policy environment for the NAP-ECCD. The relevance of the integrated approach to national policymakers has also been seen, not least through the participation of senior politicians and ministerial staff in Cambodia's hosting of the 2017 ARNEC conference but also in the development of the new NAP 2019–2023, which has been supported by UNICEF. However, at sub-national level, it is not clear that the same degree of buy-in to integrated ECCD approaches is reflected, with a clear difference among sub-national commitments to IECD at the senior provincial administrative level.

The IECD programme was not clearly structured around a common set of cross-sectoral strategies or outputs. Administrators external to UNICEF had limited awareness or recognition of the IECD existence. In terms of the programme's design, a review of programme activities, outputs and intended outcomes (i.e. the implicit TOC) finds that the programme was well-designed to achieve its outputs but insufficiently oriented towards maximizing cross-sectoral integration. Likewise, the design did not fully reflect the emphasis in the program outcome on equity and on resilience to emergencies. The selection of target areas was highly relevant to addressing inequity in essential ECCD service use, and while some relevant strategies were adopted for identifying the hard-to-reach and increasing outreach to them, strategies for addressing inequity were not sufficiently mainstreamed into the design across most activities.

Nevertheless, through its generation of evidence, advocacy and technical support, the IECD programme has undoubtedly contributed to the further advancement of ECCD issues on the policy agenda. With the new NAP 2019–2023, there is a real opportunity to build and capitalize on growing support for IECD approaches.

Effectiveness

Overall, the IECD programme and approach have contributed to the overall achievement of Outcome 1, with notable improvements observed across the six IECD programme outputs, especially in health and education outcomes.[38] The question remains whether greater coordination and monitoring across sectoral mandates could have been included in the programme design and whether it would have enhanced the programme's effectiveness. While there were good examples of cross-sectoral coordination, the collaboration is not systematic and the main national platform – the NC-ECCD – is still developing.

Through the advocacy and technical support provided by UNICEF and its partners, the well-being of pregnant women and children aged zero to five has improved. The most salient contribution of the IECD programme has been its ability to change the policy landscape from the national to the village level by focusing the discourse around ECCD and creating an understanding around the need for integrated service delivery. Rights holders and front-line workers have developed a keener sense on the rights and needs for their children. They are also using and requesting public services that they have ignored in the past or that are newly available.

The IECD approach has strengthened the delivery of services for pregnant women and children aged zero to five by increasing the holistic approach of front-line workers. UNICEF and its partners have supported an extensive set of discrete activities reinforcing the IECD approach, including training and materials. It is unclear what changes can be attributed to the IECD programme and approach at times, even though the set of activities are filling a much-needed gap in the service delivery landscape. The capacity for cross-sectoral integration is still weak in the implementation of the approach. Activities and related outputs are organized according to UNICEF sections and line ministries, thereby reducing the scope of effectiveness.

Given the selection of target districts, the IECD approach has improved equity in terms of reaching out to needy and vulnerable populations. The IECD programme and approach have been less effective, however, in reaching the most difficult-to-reach groups, including ethnic minorities, internal migrants, children with disabilities and families living in very remote areas. They remain neglected due to access and participation barriers and require additional, targeted efforts within the IECD programme.

Efficiency

The largely sector-compartmentalized nature of the programme's planning and delivery posed a fundamental barrier to achieving clear gains in efficiency. Both at the national (typified by the non-functioning IECD task force) and at the provincial level, workplans, budgets and monitoring were conducted largely within sector silos. Instances of positive coordination exist, but were not consistent. Institutionally,

38 *Outcome 1 is "By 2018, infants, children 0 to 5 years old and pregnant women in target provinces have improved and more equitable use of integrated early childhood survival, care and development interventions and practices, including in emergencies."*

government intersectoral coordination was stronger over the programme duration in Ratanakiri than in Kratie. This is closely related to the low priority and importance accorded to IECD by a small number of key stakeholders in Kratie. Some gains in coordination among service providers at the village, commune and district levels were suggested in Ratanakiri.

Efficiency is not sufficiently embedded as an objective or strategy towards improving ECCD outcomes. This is particularly pertinent in the context of highly constrained budgets for social service delivery. Cost efficiency and cost effectiveness analysis was not conducted, and therefore an opportunity has been missed to use efficiency evidence as an advocacy tool. The IECD approach has generated instances of increasing outreach through cross-sectoral collaboration; these instances provide opportunities to highlight cost savings and increased potential for scale that come with increased integration. However, the sector-compartmentalized budgeting used by UNICEF for the 2016–2018 programme limits its ability to monitor, document and communicate efficiencies to budget-holding government counterparts.

Cross-cutting themes

By definition, the IECD approach is targeting vulnerable populations in the most disadvantaged areas of the Kingdom of Cambodia. The improvements in maternal and child outcomes among the vulnerable populations is not recorded by the IECD approach, as disaggregated data are not available (except for the longitudinal data).

Furthermore, the IECD programme has not sufficiently addressed the needs of the most vulnerable groups because of the diverse challenges in reaching these groups, nor has it been able to include fathers in a meaningful manner. These groups require additional or specific programmatic elements to be included successfully.

Regarding data collection, the IECD programme – per its design – is not currently monitoring the integration of cross-sectoral programming. Outcomes and outputs monitored by UNICEF in the RAMs are not able to catch efficiencies of the policies and programmes implemented. A formal framework for identifying and monitoring integration success appears to be missing at the sub-national level and could provide a stronger direction for sub-national implementation of the IECD approach. The current organization of data collection across ministries should be considered in light of the on-going national improvement of management information systems.

Sustainability

The IECD programme and approach between 2016 and 2018 required a significant financial and human resources investment from UNICEF, which was bolstered by the partnerships established with local and international NGOs and other development partners. UNICEF's financial support was necessary to maintain intersectoral activities as sectoral budgets were not sufficient to cover all interventions and improve cross-sectoral work. The low level of accountability regarding the IECD target population groups across ministries and decentralized bodies also impacts their ability in prioritizing budget allocations for social benefits.

The existence of cross-sectoral mechanisms (the WCCCs and decentralized bodies from the provincial to the commune level) provided a solid foundation for the inclusion of the IECD approach among government policies. These bodies, however, were not considered accountable for intermediary or final output results, and their capacity was often limited by external considerations (e.g. leadership, governance, political priorities). Similarly, the NC-ECCD is not strongly accountable for its ability to implement the NAP-ECCD, as the responsibility for implementation is diffused among 13 line ministries without any formal prioritization. As such, when considering the continuation or expansion of the IECD programme and approach, the need for stronger accountability and decision-making mechanisms could improve the results of the IECD approach.

A critical missing aspect in the design of the IECD approach is the role and responsibilities of communities, which could have important implications for the sustainability of the IECD approach in the targeted areas and other provinces. Once the foundations for holistic child development are established through communication strategies targeting parents and communities, the demand for services which are rights holders' rights should increase. In practice, this could lead to better outcomes for pregnant women and children aged zero to five.

A sustainable scale-up of the IECD approach across the country should also be required to consider proper monitoring of inputs and outputs, as well as links with desired outcomes indicated in the NAP-ECCD. Understanding a programme's strengths and weaknesses can provide learnings for expanding efforts in other environments. Yet, evidence-based policymaking in low-resource countries has financial and technical implications for the national expansion of IECD. The organization and quality of data collection around IECD outcomes must be properly monitored and collected to be used as benchmarks for progress made over time.

8 Lessons learned

The experience of the IECD programme 2016–2018 has generated some lessons with relevance to the design and implementation of other efforts towards the integration of ECCD services, both in Cambodia and elsewhere.

Evidence and advocacy have played a key part in identifying the need and generating the consensus for reform for improved ECCD services. Specifically, the IECD programme has built the foundations for improved service delivery and increased demand for services by pregnant women and children aged zero to five across the target areas.

The IECD programme targeted pregnant women and children aged zero to five in vulnerable districts, but focused, innovative strategies and disaggregated monitoring are required to ensure that IECD benefits are accessible and extended to the hardest-to-reach. It cannot be assumed that operating effectively in the poorest or most vulnerable districts improves access to the most (often time-poor, remote) vulnerable populations. Where outreach is constrained by resources, cost-efficient integrated approaches are highly relevant but may require innovation or adaptation to local context. It is essential that targets (and workplans, budgeting and reporting) be disaggregated to highlight the varying achievements for the hardest-to-reach.

Village-based actors have played a key role in the provision of more holistic ECCD information and in strengthening service referral, and they are likely to represent a key outreach resource in hard-to-reach areas and other parts of Cambodia. Training to Core Parents, village health volunteers and village chiefs, who have largely proved to be willing agents, has yielded gains in increased awareness of holistic ECCD issues. Where time poverty, remote location and low birth registration acutely restrict access to commune or district-based services, targeted support to these agents offers potential as an efficient, effective outreach channel. IECD communication strategies to inform on the holistic developmental needs of young children have relied on parental education and training sessions, which have limits and challenges in reaching the most vulnerable parents. In a low-resource environment, the IECD approach has not considered low-cost innovative solutions for improving outreach and training, with an emphasis on empowering vulnerable households.

Communities have much potential to improve the status of pregnant women and children aged zero to five, but this has not been sufficiently leveraged. Community ownership and participation have been minimal in the design and delivery of services. Sustainability of the approach requires understanding the importance of the target population's basic needs to be able to then consider concerns around broader community development and human resource objectives. Links with social policy support for the most vulnerable families can create a more appealing and supportive environment for this to occur. Training can be limited in its sustainability without sufficient community empowerment or inclusion of all stakeholders, including fathers and vulnerable groups. Leveraging the outreach potential and quality of community

service providers and volunteers is key for increasing scale, and for reaching the most vulnerable populations.

Strengthening governance and accountability is essential to maximize the benefits from integration. While resource-intensive, the combination of the longitudinal survey and targeting a limited number of whole districts has permitted the generation of reliable evidence that has both informed and enabled the development of new, strengthened ECCD policy. Despite the increase in the quality and availability of ECCD services and practices targeting pregnant women and children aged zero to five, the operationalization of the IECD approach 2016–2018 at the sub-national level was inhibited by the absence of a clear framework for implementation. There is a need for a clear framework of expectations and objectives regarding service delivery implementation and greater guidance to sub-national authorities generally (e.g. with implementation guidelines and requirements to attend WCCC meetings). Implementation needs to be supported with clear, consistent direction to sub-national level from line ministries, as agreed in the NC-ECCD.

Accountability for and ownership of IECD at all levels is fundamental. Clear accountability by a body or institution for results regarding women and children does not exist. While the NC-ECCD could have that role, it is not fully operational in technical terms. The new NAP-ECCD is moving in the right direction, but implementation and accountability of the individual members will be important to monitor and support. At the sub-national level, accountability for integration is very weak for IECD. While the WCCCs provide the appropriate cross-sectoral membership, they are not always effective. WCCCs have the capacity to oversee, monitor and identify challenges in service delivery but do not have sufficient decision-making authority or fully active participation of line ministries. Under the 2016–2018 approach, the experience of Kratie province shows the obstructive impact a single uncommitted individual could have in the absence of a clear accountability framework. There is no clear accountability at the local level either. Village chiefs can act as the quality assurance of ECCD service delivery, but that is not sustainable in all cases.

Implementation of strategies in (at least) planning, budgeting and monitoring is needed to break down silos. Both UNICEF and line ministries operate in silos, inevitably creating bottlenecks and gaps in the integration of service delivery. This means, for example, that health workers are still not prioritizing parental education beyond health and nutrition. The organization of workplans (and budgets and monitoring) around sector-focused results targets, without explicit targets on integration, is a clear obstacle to improving ministerial accountability and incentives for integration. Monitoring needs to address integrated implementation, for example, monitoring the progress of joint efforts (e.g. joint monitoring missions, policy changes and service delivery changes).

Efficiency is an important IECD objective, and quantifiable efficiency is a powerful advocacy tool that is easy to overlook. The IECD programme did not report on efficiency; nowhere in UNICEF's planning or reporting was cost efficiency or cost effectiveness included. Sector-compartmentalized activity budgets are a surmountable obstacle to this; incorporating results targets on (both monetary and non-monetary) efficiency would promote a stronger strategic and operational focus on this integral aspect of IECD.

9 Recommendations

This section presents the recommendations of the evaluation. These were initially derived from the evaluation findings, conclusions, lessons learned and the professional judgement of the Evaluation Team. The broad outlines of these recommendations were presented at the validation workshop on 12 September to the Reference Group, national and sub-national administrators and other relevant stakeholders (see Annex K). The final, more detailed recommendations below are the result of group work at the September workshop to refine and contextualize the initial set of recommendations, to test their feasibility and to identify strategies and targets for their implementation.

The following levers for a cross-sectoral comprehensive approach to improving early childhood well-being are arranged in order of priority based on those discussions held at the September workshop and the Evaluation Team's assessment. Prioritization is based on the importance in terms of impact, feasibility and timeliness of actions considering the findings and conclusions of this evaluation. The allocation of responsibilities is based on the Evaluation Team's understanding of the stakeholder landscape and on the suggestions developed during the validation workshop.

National and sub-national strategic level

1. **Build and reinforce national capacities to strengthen the new 2019–2023 NAP-ECCD in terms of attribution of accountability to line ministries and development of cross-sectoral strategies to meet national objectives for pregnant women and children aged zero to five.**

Actors: UNICEF, NC-ECCD, line ministries.

The IECD approach has enabled better cross-sectoral implementation and communication at the commune, district and provincial levels, but a sustainable and accountable national commitment to ECCD requires a stronger national framework and an institution that has the overall responsibility for delivering national policy on ECCD.

- **The NC-ECCD within the framework of the new NAP-ECCD should clearly state the roles and responsibilities of the different line ministries and their decentralized bodies with regards to ECCD and to establish cross-sectoral linkages in a regular, reliable, effective and detailed framework.**[39] The NC-ECCD should be recognized – and be held accountable – as the sole national authority to drive improvement and set clear objectives to guide the work of partner ministries, development partners and other relevant institutions to meet national policy objectives regarding children aged zero to five and pregnant women.

39 *The draft NAP ECCD 2019–2023 shared with the Evaluation Team has a specific section (Section 6.2) on the roles and responsibilities of certain actors, but does not include line ministries and their sub-national bodies, nor does it include guidelines on how this should be established.*

- **The members of the national NC-ECCD working group need to be high-level technical staff that are clearly assigned by each ministry so that all members can participate regularly (quarterly at minimum) and meaningfully in the meetings.** They need to have the capacity to represent their ministries with consideration of decision-making capacity, monitoring activities and intermediate goal-setting.
- **The NAP-ECCD needs to define clearer roles and responsibilities for the PWCCCs/DWCCCs/CWCCCs to provide effective implementation and monitoring at the sub-national level and to reduce the fragmentation of service delivery.** Participation by high-level sub-national representatives of decentralized line ministry should be mandatory in the WCCCs.

2. **Each main line ministry of the NC-ECCD must establish clear roles and responsibilities for ECCD leadership and implementation at each sub-national level, with the aim of strengthening cross-sectoral effectiveness.**

Actors: UNICEF, NC-ECCD, MEF, line ministries and sub-national department heads.

- **To support national-level objectives, mid-level mechanisms (provincial level) need to have clear roles and responsibilities to manage the implementation of ECCD priorities at lower administrative levels as established in the NAP-ECCD.** For this, each decentralized authority needs to be held accountable for their provincial objectives, and can receive training and support by UNICEF and its partners to facilitate planning and monitoring activities to provide more equitable delivery of integrated services for children aged zero to five and pregnant women, including in emergencies.
- **Line ministries through the NAP-ECCD should receive adequate budget support to remove environmental bottlenecks that sub-national departments face in reaching vulnerable populations, e.g. transportation limits, seasonal migrants, etc.**

3. **Establish an effective M&E framework to monitor the IECD approach which supports national standards and which ensures integrated delivery of services.**

Actors: UNICEF, NC-ECCD, MEF, Ministry of Planning (National Institute of Statistics).

The capacity-building of national and sub-national-level actors to implement the NAP-ECCD needs to be accompanied with an effective M&E framework to assess status and progress for desired outcomes.

- The development of a strong M&E framework for the new NAP-ECCD and the IECD programme requires meeting international standards for reliable and regular data collection that can inform policy and planning. The M&E framework of the new NAP-ECCD needs to assess status and progress on specific targeted outcomes for pregnant women and children. Indicators should go beyond measuring outcomes and also monitor the impact of integrated and cross-sectoral service delivery, while ensuring a sufficient level of data disaggregation to cover specific target populations and vulnerable communities.

- Once a national M&E framework is established, **UNICEF technical support should ensure adequate training at the sub-national level:**
  - Reinforce the technical capacity of the PWCCCs for the identification of province-specific key monitoring outcomes for integrated service delivery for and usage by pregnant women and their young children.
  - Work towards the convergence of high-quality data at sub-national levels.
  - Build in regular reporting mechanisms for the WCCCs from commune to provincial levels.
- **Local monitoring innovations, such as joint (cross-sectoral) monitoring missions, can support M&E and can be enabled by the IECD approach.** Such practices should reinforce the technical capacity of sectoral representatives at the provincial and district levels.

4. Design and develop a national communication strategy to support awareness of ECCD.

Actors: UNICEF, NC-ECCD, PWCCCs.

- **UNICEF should develop a national communication strategy with the NC-ECCD to reinforce messages around holistic ECCD for children, parents, caregivers and future parents.** The strategy needs to account for variability and adapt to diverse populations (e.g. fathers, linguo-ethnic groups) and develop innovative dissemination strategies within vulnerable communities (e.g. text messaging, corporate sponsors). Ownership by the NC-ECCD and the Royal Government of Cambodia is required.
- **The NAP-ECCD needs to be disseminated at both the national and sub-national levels and train all implementing stakeholders down to the provincial level (PWCCCs) to ensure they understand:**
  - The essential cross-sectoral components of the holistic plan.
  - Their roles and responsibilities to support the sub-national level to implement the plan.
  - Accountability mechanisms and validation processes for implementation (including M&E mechanisms).
  - Their responsibility in sharing their training to others at the district and commune levels.
- **UNICEF and partners should support the development of a national ECCD network of implementing stakeholders to:**
  - Create access to innovative continuous training or other resources to discuss questions and network with their ECCD colleagues across the country.
  - Build national ECCD champions and case studies from which to provide quality examples of success in the integration of service delivery at the local level.
  - Reinforce the delivery of services with training of trainers, who can contextualize and disseminate lessons learned.

IECD service delivery and programmatic level

5. Develop a holistic approach to counselling and service delivery by front-line workers who are working with pregnant women and children aged zero to five.

Actors: UNICEF, sub-national department heads, DWCCCs, CWCCCs, village chiefs, front-line workers.

- **UNICEF can support the development of training, guidelines and guidebooks for implementing cross-sectoral activities across the various sub-national levels.** These can provide a more sustainable framework for innovative IECD-supported activities that have provided positive outcomes in the target areas.
- **Cross-sectoral links at the village and commune levels should be further strengthened through an established framework on the delivery of coordinated services by each line ministry.** This could include, for example, more regular and intensive cross-sectoral training programmes for direct service providers, monthly meetings of CWCCCs with representation of all relevant line ministries to establish priorities for pregnant women and children aged zero to five, and stronger leadership from local authorities. UNICEF and its partners can provide support to the government to provide these training sessions and to fill gaps identified in the current IECD approach (e.g. development of a national CPS curriculum and stronger parenting support components).

6. Design and focus specific outreach programmes targeting the most vulnerable populations at greatest risk of poor development.

Actors: UNICEF, sub-national department heads, PWCCCs.

- **Cross-sectoral programming in low-resource areas requires a systematic approach that is better adapted to identifying and providing intensive services to the most vulnerable populations and excluded groups.** UNICEF and its partners can provide technical and financial support to improve and adapt programming, such as:
  - Piloting and developing evidence-based strategies for multisectoral interventions that have provided synergies in similarly difficult contexts in other countries.
  - Assisting WCCCs to design and enable targeted programming for most at-risk populations.
  - Examining the adaptability of innovative activities and programmes in other countries for the delivery of non-centre-based care, such as home visiting services and community mother groups, to provide essential and sustained support to the IECD approach using alternative service delivery models.
- **Sub-national departments of NC-ECCD line ministries need to identify and target the most vulnerable families by enabling local authorities and service providers** (e.g. village chief, village health volunteers, core parents, preschool teachers, health centre staff).

UNICEF and its partners can help provide these human resources with a greater understanding of early ECCD risks and long-term consequences for development in joint training sessions, which can facilitate local cooperation and coordination. UNICEF can also provide technical support to help local authorities improve the monitoring and identification processes of context-based vulnerabilities, especially during emergencies and internal migration.

- **UNICEF and government should work to formalize links between ECCD and social protection mechanisms to provide support to the most vulnerable families and encourage use of available protective social services.** Poverty and time poverty are major bottlenecks for families to access IECD services in a timely manner and supportive social protection mechanisms for poor families are underutilised.
- **UNICEF should strengthen existing social accountability by empowering caregivers in their own homes, which can provide longer-lasting results with the support and guidance of community education and health workers.** Parents can provide more quality stimulation and interaction with their children by talking, reading and playing with them. Parents' ability to give care can be enhanced through home visits, guidance and support from health providers, as well as through group parental training. Moreover, there appears to be a need for UNICEF to develop core programming support to males (fathers and grandparents) who are not currently involved in many IECD activities.

7. Strengthen community education and participation in ECCD.

Actors: UNICEF, MOI, CWCCCs, village chiefs.

Community-based programming enables more flexibility and adaptability in social service delivery to meet the specific needs of each village and commune. The decentralization of the social service fund provides an example to enable communities to take greater responsibility in local social service provision.

- **UNICEF and partners should continue to support MOI with regular resources (e.g. training, capacity-building and technical support) to build local decision-making capacity of councils.** Monitoring the implementation of the new guidelines would provide information on follow-up training.
- UNICEF should encourage opportunities for inclusive participation of civil society advocates and representatives of vulnerable families as observatory or standing members in DWCCCs and CWCCCs. This evaluation showed that the target areas are diverse in their needs and bottlenecks, and that communities have powerful human resources to support families and young children. Families and communities play an essential, instrumental role in creating a lasting impact of ECCD activities.