Right-Fit Evidence Unit

COMMUNITIES MAKE THE DIFFERENCE

COMPANY PARTNER/IRC/READ/IREX

EVALUATION REPORT

EXTERNAL VERSION

Prepared by Innovation for Poverty Action's Right-Fit Evidence Unit

Context

The Transforming Education in Cocoa Communities (TRECC) initiative aims at improving the living conditions of children and youth in Côte d'Ivoire by promoting quality education in cocoa-growing communities. Via its Grant Matching Mechanism round 2 (GMM2), 13 pilots-to-scale projects are being co-funded with 12 cocoa companies and implemented by 14 implementing organizations in the sectors of Early Childhood Development, Primary Education and Vocational Training.

The role of Innovations for Poverty Action (IPA) is to provide technical support to the companies and implementing agencies to design and implement sound monitoring systems to closely monitor and learn from these pilots. In parallel, IPA conducts its own independent and complementary data collection. IPA will use these two sources of information – the administrative data collected by the implementing organizations through their own M&E system and the independent data collection – to feed into an independent evaluation matrix to assess each pilot.

The final scale up report will therefore be based on the evaluation matrix that was agreed upon all partners.

IPA has used this data to make recommendations on the potential scale-up of the Company Partner /IRC/READ pilot to other relevant cocoa-growing communities. In addition, TRECC may consider whether certain pilots are feasible for future scale-up beyond such communities, for example to the regional or national level, though this has not been a central focus of this evaluation given the existing contractual arrangements of GMM2.

The report is divided into the following five sections:

1. Relevance;
2. Results (outputs and immediate outcomes);
3. Costs & Operations management;
4. Capacity to learn, improve and innovate; and
5. Sustainability.

For each section, we are describing the key findings based on quantitative and qualitative evidence.

Following the setup of the evaluation matrix, we are using a color system to provide an overall assessment against each of the 11 criteria: green means that the pilot is compliant with the criteria requirement for potential scale-up, red means that it is not, and orange means that it does partially comply and that eligibility for scale-up should be conditional on corrective measures to be taken in that area. As per the initial plan, our final overall recommendation is then decided as follows: pilots with green assessments on all 11 criteria receive an unconditional recommendation for eligibility for a scale-up proposal; pilots who have only green and orange criteria (no red), and among these a majority of green criteria, receive a conditional recommendation for scale-up – i.e. conditional on the various corrective measures being mentioned in the orange criteria. Pilots with any red criteria are not recommended for scale-up.

The Assessment signs used throughout the document are the following:

Acronyms:

IGA: Income Generating Activity

VSLA: Village Savings and Loans Associations

IPA: Innovations for Poverty Action

ICI: International Cocoa Initiative

READ: Rights Education And Development Centre

IREX: The International Research & Exchanges Board

FMD: Families Make the Difference

CMD: Communities Make the Difference

MICS : Multiple Indicator Cluster Surveys

M&E: Monitoring and Evaluation

SP: Skillful Parenting

TRECC: Transforming Education in Cocoa Communities

ECDI : Early Childhood Development Index

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Project summary

The International Rescue Committee (IRC) has partnered with Company Partner, READ and IREX through the TRECC initiative to test implementation and effectiveness of a pilot project to improve young children's care within target cocoa farming communities.

The pilot targeted 5 communities – X - in the Divo, Tiassalé, Taabo and Guitry departments of Côte d'Ivoire. The pilot objective is to develop a holistic, sustainable approach to ECD for members of cocoa farming communities though training and exposure to positive parenting approaches, while also promoting social mobilization and learning to create healthy communities and environments for the youngest members of society.

A parenting training was implemented in the 5 pilot communities. The trainings are based on the *Family Makes the Difference* (FMD) modules which have been developed by IRC. IRC staff will train the government local services who are in charge of delivering the FMD training to 200 beneficiary parents in total. Though the training of their parents, 800 children were to be affected by the program.

Combined with the FMD trainings, IRC set up community centers to provide access to services for community members in two selected communities. Using READ's approach, the community centers are aim to be entirely community-led, and to feature revenue-generating activities to support the centers' basic operating costs. The combination of both components will be called Communities Make the Difference (CMD).

Executive Summary

General assessment and recommendation:

The IRC/READ/IREX pilot was organized around two components, a parenting training delivered by social governmental workers and the construction of a community center that would support community development. The first component has shown encouraging results and IPA's independent evaluation identified positive changes around positive parenting practices and nutrition. The second component aiming at constructing community centers experienced very significant delays, as the 2 centers were not inaugurated at the end of the project. Low community engagement during the construction phase of the centers cast doubts on the sustainability of this approach. IPA therefore recommends reviewing the community center model in the light of the Ivorian context and invite stakeholders to identify clear pathways to maintain operation in centers.

Overall, the IRC/READ/IREX pilot has not earned a recommendation for scale-up as most criteria were rated orange. 5 of the eleven evaluation criteria were rated as green and 6 as orange. The pilot in its current form was not able to be successfully adapted and IPA recommends changing the design of the project along the key recommendations.

1. Relevance:

The IRC/READ/IREX two-pronged approach addresses an important need in cocoa communities. IPA's baseline survey reported that 49 percent of children are not developmentally on track, defined as the percentage of children aged 36 to 59 months who have a normal development on the 5 following domains – Literacy-numeracy, physical, social emotional and learning. Parents also reported a strong willingness to participate in parental skills training, despite 42 percent having participated in such training before.

Recommendation for scale-up:

- Align with priorities of donors: The program as implemented does not seem completely aligned with donor's objectives and it will be important to reach clarity on each partner's priorities for the future of the program before scale-up.

2. Results: Outputs and direct outcomes

Concerning the FMD component of the program, all outputs were achieved at expected quality. The project also experienced a very high attendance rate. In terms of direct outcomes, the project reached very encouraging results. Indeed, we observe an increase in knowledge around nutrition and hygiene. Concerning changes in practices, 20 percentage point more parents reported being engaged in four or more activities that promote learning in the past three days. This indicates that pre-school educators can be an effective channel to deliver the Family Makes a Difference program. Finally, beneficiaries also reported a high level of satisfaction related to the quality of the training and professionalism of facilitators.

Recommendations for scale-up:

- Community center construction: Due to the low engagement of communities in the center construction, the inauguration didn't happen before the end of the project, and as a result we do not have any data about the effectiveness of the program in terms of community participation or access to services, or the complementarities with the IRC program. For this reason, IPA cannot recommend the scale-up of this component of the program, as we cannot draw any conclusions about its effectiveness.
- Change in parental practices: Despite observing encouraging early changes in practices, the project didn't reach certain ambitious targets. Reaching such high targets (70 percent of parents engaged in four or more activities to promote learning in the past three days) would likely require longer/more intense training to deeply influence practices of most caregivers.

3. Costs and Operation management

IRC has provided strong and sustained monitoring on the program that translated into strong engagement of local facilitators and excellent participation rates. Due to the delays in implementation budget had to be reallocated but IRC tried to efficiently use the overall budget. The current proposal didn't really present a clear vision of the cost structure at scale as many components of the scale-up are still unclear.

Recommendations for scale-up:
- Scale-up proposal: The scale-up proposal suggests changing implementing partner through the course of the program. This will have a major influence on the cost structure and create another layer of uncertainty on the performance of the program. IPA therefore recommends partners to discuss each scenario separately to better plan future activities,
- Delays in implementation: As mentioned above, there were delays of around a year in the construction of community centers. These delays were communicated and approved by TRECC. Justification concerns conflict in one community and the lack of overall community engagement. To mitigate this, IRC increased the number of field visits to follow-up with communities. Despite these efforts, the significance of this delay is concerning from an operations management perspective.

4. Capacity to learn, improve and innovate

Overall, the project collected credible real time data on the progress of the pilot. IPA commend IRC on their willingness to test a variation of their pilot in testing training one parent versus both parents. In addition to this the strong M&E system implemented by IRC enabled the organization to draft a precise report on the main achievements of the pilot.

5. Sustainability

Community of practices are a good foundation to sustain behavioral changes on parental practices over time but only one community appeared to be engaged through this platform. Despite the limited use of community of practices, IPA recognizes the strong remaining knowledge within communities more than two months after the end of the program. The pilot managed to secure important government buy-in through the delivery of the Family Makes a difference program by social worker. Discussions around a possible Memorandum of Understanding with a Ministry could lead to potential scale-up opportunities, but (as far as we know) there is no source of funding identified yet.

Recommendations for scale-up:

- Low community engagement during the construction of the centers cast doubts on the sustainability of this approach. IPA therefore recommend reviewing the community center model in the light of the Ivorian context and invite stakeholders to identify clear pathways to maintain operation in centers.

Snapshot of specific assessment against each pre-defined evaluation criteria:

Evaluation Criteria	Assesment	Recommendations
1.Relevance		
1.1 Targets an important need in the community	✓	
1.2 Aligns with the priorities of the donors	✓	Re-discuss donors' objectives
2.Results: outputs and direct outcomes		
2.1 Delivers outputs at high quality	✓	Analyze community center component failure
2.2 Achieves direct outcomes	✓	Reduce ambition on key targets
2.3 Beneficiaries' feedback about the program is positive	✓	
3.Costs and operations management		
3.1 Costs are well managed/cost scale-up vision	✓	Better define the vision at scale and how the cost structure will be impacted by handover periods
3.2 Project management is successful	✓	Take stock of the current integration of both components and review operation management
4.Capacity to learn, improve and innovate		
4.1 Project collects credible monitoring data	✓	
4.2 Monitoring is used to learn and improve	✓	
5.Sustainability		
5.1 Provides sustained benefit to community	✓	Re-Asses the community model in the light of the Ivorian context
5.2 There are prospects of scale-up beyond GMM2	✓	

1. Relevance

The relevance section will include the following two criteria:

✓ 1.1 The program is targeting important needs in the community

✓ 1.2 The program is aligned with donor's priorities

1.1 Targets an important need in the community

Assessment: ✓

This project addresses specific important needs in targeted communities. Children experience delays in development in the pilot communities and parents have a low level of knowledge on parentings. Moreover, the large majority of parents expressed interest for parenting trainings as they sometimes feel helpless with their young child.

Overall, the project theory of change is in line with the key barriers identified by parents to educate their children.

Although those who receive the intervention were more likely to have already participated in other similar programs, they have a comparable level of need with the rest of the community in terms of development delay of their children and even knowledge on the best parenting practices.

Data

This section focusses on the relevance of the program in the community. The data analyzed in this section includes quantitative data collected by IPA, qualitative data collected by IRC as well as some information found in the needs assessment produced by IRC. All data discussed in this section were collected prior to the beginning of the intervention[1].

For the quantitative survey, we randomly selected 145 out of the initial list of 200 beneficiaries, including both women and men. In addition, IPA selected 78 non-beneficiaries. The objective of interviewing non-beneficiaries is to understand the characteristics of the beneficiaries relevant to non-beneficiaries in the community, including relative levels of need. IPA managed to interview 141 beneficiaries (97percent) and 69 non-beneficiaries (88.5percent). Concerning the qualitative approach , 7 focus groups discussions were conducted: 4 focus group discussions with 8 to 12 women selected randomly X; 2 focus group discussions with 9 men selected randomly in X.

Program eligibility criteria

The project proposal stated four eligibility criteria to participate in FMD sessions. After the needs assessment, a fifth criterion was added in two communities (see Table 1 below).

Approximately 5-10percent beneficiaries selected and invited to participate in the FMD sessions have not fulfilled all eligibility criteria. Table 1 summarizes the program eligibility criteria and the percentage of the 300 beneficiaries who fulfilled each criterion. IPA did not collect any data on criteria 4 (being a member of a family involved in cocoa-growing activities).

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[1] Baseline qualitative and quantitative data collections were conducted from July 28th to August 3rd, 2018.

Table 1: FMD eligibility criteria

Eligibility criteria	% beneficiaries who fulfilled the criteria	Source
Criteria 1 - Be a VLSA member	100%	Selection process[2]
Criteria 2 - Be the caregiver of a child between 0 and 5 years old	95%	Baseline data
Criteria 3 - Show interest and motivation in acquiring knowledge on ECD; psychological well-being; and the link between parenting practices and children's brain development	95%	Baseline data
Criteria 4 - Be member of a family involved in cocoa-growing activities.	N/A	No data
Criteria 5 (for X and X only) – Participate as a couple in the training	100%	Administrative data

After the needs assessment, the advisory committee decided to take two different FMD training approaches in the 5 communities. In 2 communities (X and X) both parents of a family will be trained, while in the other 3 communities only one parent per household will be trained, expecting a snowball effect. The idea of the partners was to test which is the most effective approach. This two-pronged approach will inform us on the mechanisms at play and the operational challenges but no robust conclusions could be drawn via our independent data collection due to the very reduced sample size. In this respect, we will use qualitative evidence to inform the decisions on the pro and cons of each approach

Criteria 1.1.1. Needs assessment report and IPA independent data collection shows evidence of the need being addressed

Criteria 1.1.1.a. Evidence of children experiencing developmental delays in the target communities.
Baseline data shows that children in the target communities experience developmental delays.

To measure early childhood development status in the 5 pilot communities, IPA administered the early childhood development module developed by UNICEF for the Multiple Indicator Cluster Surveys (MICS)[3] to mothers or primary caregivers of children under the age of 5 in the communities. We then compare our results with national data.

The early childhood development index (ECDI) measures four domains of development: literacy-numeracy, physical development, social-emotional development and learning. For each domain, children are identified as being developmentally on track if they can do several (or at least one) activities related to this domain. Items are based on benchmarks of an average normal child development in the same age range. The ECDI score is then calculated as the percentage of children who are developmentally on track in at least three of these four domains. The methodology used to construct the index and responses to the specific questions are in the annex A

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[2] Since beneficiaries were selected from the VSLA, we believe that 100 percent of beneficiaries are VSLA members

[3] Beginning with the fourth round of MICS (MICS4), the early childhood development indicators were consolidated into a single early childhood development module included in the questionnaire for children under 5 years of age.

We found that the proportion of children who are developmentally on track in the 5 communities is of 60.7 percent, which is very close to the national average for rural Cote d'Ivoire. Overall this index varies widely across countries, from 33 per cent in Chad to 97 per cent in Barbados. Across countries with available data, Cote d'Ivoire ranks in the bottom 15 countries.[4] Table 2 shows a comparison of the 5 pilot communities, with rural Cote d'Ivoire and national data.

Table 2: Early childhood development index

Children developmentally on track on	In pilot communities	Rural CI (MICS 2015)	National data (MICS 2015)
Literacy-numeracy	11.1%[5]	2.3%	7.4%
Physical	93.3%	94.3%	95.2%
Social-emotional	71.8%	71.1%	68.8%
Learning	82.9%	85.0%	87.2%
ECDI score	**60.7%**	**61%**	**62.8%**

Criteria 1.1.1.b. Low parenting skills and practices
Baseline data shows that the parenting skills and practices across the different pilot communities can be improved.

At baseline, about two thirds of respondents had incorrectly identified the right age to introduce solid food to babies. According to focus group participants, three major difficulties prevent exclusive breastfeeding until six months of age: the lack of breastmilk, the lack of time and mothers who decide not to breastfeed. According to the participants, different foods are introduced in child's diet before the age of six months and after the age of six months. Participants felt that for children under six months, in addition to breast milk, it was good to give food such as water, wheat flour, rice powder, biscuit porridge, corn powder, millet, milk, cocobaca, phosphatine, cerelac and quaker. Children over six months of age eat other complementary foods such as attiéké, rice, cassava with sauce, and so on. Basically, for the participants, the child at this age eats foods that an adult is used to consume.

In Cote d'Ivoire, the use of physical punishment is very widespread among parents and caregivers - 86.5percent of children have experienced violent discipline in the last month[6]. Supporting parents is critical to reduce harsh parenting, improve parenting practices, improve child development and increase early childhood health. On our sample, about one third of children was left unattended for more than an hour at least once during the past week and about one half of respondent applies only positive stress relief techniques. According to the focus group participants, when a 0 to 5 misbehave they use different types of methods including shouting, spanking, punishment, restrictions and verbal threats.

On a positive note, about 70-80percent of respondents in both groups has correctly identified key moments to wash hands. 20-25percent of parents disagree with the statement that physical punishment is needed to raise children properly.

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[4] Source https://data.unicef.org/topic/early-childhood-development/development-status/
[5] For this specific index, we believe that our sample was too small and mean scores artificially inflated.
[6] Source : MICS 2015

Criteria 1.1.1.c. Minority of beneficiaries have already participated in coaching or discussion on children's development

Interviews shows that about half of beneficiaries have already participated to discussions on children's development, but 95.percent would like to join additional training on the topic.

At baseline, about 42..9 percent of beneficiaries declared they have already participated in coaching activities or discussions on children's development. It is a high percentage, which is not representative of the overall population of Côte d'Ivoire. We believe beneficiaries were referring to early childhood development discussions that took place through the first Grant Matching Mechanism (GMM1) of TRECC. Indeed, some beneficiaries are participating to both programs.

However, the clear majority (95.5percent) would be interested in joining meetings and exchanges on parents' participation in the development and well-being of their children. Moreover, given their low scores, there is good reason to believe they still need more coaching.

Criteria 1.1.1.d Minority of beneficiaries have access to a community platform.

At baseline, a minority of beneficiaries declared having access to community platforms in their communities.

To improve children wellbeing, the pilot proposes an approach combining parenting trainings with community centers. The centers are aimed to support a culture of learning, focus on community development and generate enthusiasm for ECD, positive parenting, and education and opportunity for all.

During the baseline data collection, we asked respondents if they have access to places in their village where they can organize community activities or group sessions. 33percent of beneficiaries declared they have access.

Criteria 1.1.2. Beneficiaries' description of their needs, or the needs assessment, links to the theory of change of the pilot

Baseline qualitative data confirms that beneficiaries' description of their needs links to the theory of change of the pilot. According to information gathered through focus group discussions, parents are aware of most children's needs and of their role, but they face difficulties that prevent them from fulfilling those needs.

Discussions with parents show that the different components for nurturing care (figure 1) are known. A man in X listed the needs of young children: *"Small children 0 to 5 years old need their parent to grow up healthy, to be well nourished (breast milk), water, to be educated (show them good manners, give them advice, teach him to play), give them affection (pamper the child, show him love) and satisfy these needs."* (X, men)

That said, most parents acknowledge that they face difficulties to meet all their children's needs. Parents mentioned several difficulties: the lack of money, the lack of time, disagreement between parents, lack of information on child care, lack of electricity or the lack of day care.

During the baseline focus groups, wrong ideas on what is good for children's development were shared, illustrating the lack of knowledge on this topic in the pilot communities. For instance, for some parents, a child who cries after being breastfeed need to get solid food. For some others, at 6 months a child can eat as an adult. Moreover, parents declared feeling helpless to face some situations, which sometimes leads them to use violence. A participant in a focus group discussion in X said "*The problem is that I do not know how to behave with my child who does not listen." (Focus group of X, women).* They desire to discover new techniques to facilitate and improve the way they educate their children.

Social norms can impede the application of good parental practices. Indeed, in those communities, norms promote the use of harsh parenting practices to r properly raise children (without harsh parenting a child will become impolite) and discourage fathers to invest on children's rearing (it is the role of mothers).

Figure 1 : Components of nurturing care[7]

Finally, parents demonstrated interest in trainings and community platforms to help with their children's education. *"We lack education, we need a youth center to supervise children" (Focus group of X, women).* According to them, such platforms represent a support to the family unit to ensure the well-being of children. When IRC asked parents about their needs, a parent answered: *"A center for children from 0 to 3 years old from an education center to better educate children. To get parents to behave positively with their children, a specialized structure needs to be set up to train parents, and to share the knowledge gained with other members of the community who have not had access to this information."*

Criteria 1.1.3. If relevant, beneficiaries are those most in need of the pilot intervention

Beneficiaries are equally in need of additional training and support on parenting as the rest of their community. Even though beneficiaries are more likely to have participated to discussions on the topic, we found that their children experienced comparable developmental delays and more beneficiaries are interested in the trainings than non-beneficiaries.

Data gathered during baseline suggest that beneficiaries' children experience comparable developmental delays as the rest of their communities. Table 3 shows that there is no statistical difference in developmental delay of children from the beneficiary and non-beneficiary groups.

Table 3: Comparison of the child development index between beneficiaries' children and non-beneficiaries' children in the community

	Beneficiaries' children	Non-beneficiaries' children	Difference
Literacy-numeracy	13.4%	6.5%	-6.9%
Physical	93.2%	93.4%	0.2%
Social-emotional	70.7%	73.9%	3.1%
Learning	84.2%	80.4%	-3.8%

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[7] Source : https://nurturing-care.org/?page_id=1333

Child development index	**60.6%**	**60.8%**	**0.2%**

Statistically significant differences marked with asterisks: *p<0.1; **p<0.05; ***p<0.01

There is no difference in the access to community platforms between beneficiaries and non-beneficiaries, which is not surprising because they live in the same communities.

However, we found that there are about two times more beneficiaries that already participated to trainings on education. Again, we believe it is through the GMM1 program. But more beneficiaries are interested on (additional) trainings than non-beneficiaries who never attend trainings on education. Table 4 illustrates those differences.

Table 4: Access to trainings and community platforms

Outcomes	Beneficiaries	Non-beneficiaries	Difference
% of respondents with access to a place where activities such as reading centers, activity sessions, support groups are carried out	33.3%	27.9%	5.4%
% of respondents that have already participated in group discussions/group coaching on education of children and their needs	42.9%	18.8%	24.0%***
% of respondents interested in joining meetings and exchanges on parents' participation in the development and well-being of their children	95.5%	88.4%	8.7%***

Statistically significant differences marked with asterisks: *p<0.1; **p<0.05; ***p<0.01

1.2 Aligns with donors' priorities

> ### Assessment: ✓
>
> The intervention aligns with donor priorities, through its objective to protect children and promote early childhood development.
>
> However, at the end of the pilot, it is not clear for the donors that the resources centers as they were implemented are scalable.

Criteria 1.2.1 The pilot as implemented remains aligned with the objective of Company Partner
[Details removed]

Criteria 1.2.2 The pilot as implemented remains aligned with the objective of TRECC

[Details removed]

2. Results: output and direct outcomes

This section will include the following three criteria:

✔ Delivers outputs at high quality

✔ Achieves direct outcomes

✔ Beneficiaries' feedback about the program is positive

2.1 Delivers outputs at high quality

Assessment: ✔

Concerning the FMD trainings, all outputs were achieved with high quality during the pilot. Although it is a real success, it is important to note that the parents that participated to the training received a compensation of 1000FCFA which must explain part of the high rate of participation.

Concerning the READ centers, no output was achieved. There was a lot of delay in the construction of the centers. Centers were not equipped or inaugurated by the end of the project. Therefore, we can't really discuss in the report the overall success of this component. The engagement of the community was low on the construction.

Criteria 2.1.1 Key outputs from the proposal log-frame were achieved

In this section 2.1.1, the achievement on the pilot's key outputs are discussed using data collected by IPA or (if not available) data shared by the implementing partners.

✔ 5 communities directly impacted by FMD interventions

Before the beginning of the project, Company Partneridentified 5 communities to implement the FMD sessions: X, X, X, X and X. Though different visits in the pilot communities, we confirm that IRC conducted FMD sessions in all selected communities.

Table 5: key output 1

Indicator	Targeted	Achieved	Data source
Communities directly impacted by FMD interventions	5	5	Survey data collection and Spot check visits

✔ 16 state agents trained in FMD

Through a 4 days training on FMD – from July 23 to July 27 - IRC trained 10 pre-school educators (4 women and 6 men) and 5 representatives (4 women and a man). The pre-school educators trained are from Tiassale, N'Douci and Divo's centers for children protection[8] ; and Divo's complex for early childhood; the representatives from different ministry services[9]. One representative from Company Partnerand one representative from TRECC participated to the training.

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[8] Centre de protection de la petite enfance (CPPP)

[9] Service de Coordination des Structures Educatives de Base (SCSEB), du service du Développement Intégré du Jeune Enfant (DIJE), de la Direction de la Protection de l'Enfant (DPE), et de la Direction Régionale du Ministère de la Femme, de la Famille et de l'Enfant

Indicator	Targeted	Achieved	Data source
Representative of the ministry	6	5	IRC reports
CPP directors	2	0	IRC reports
Pre-school educators	10	10	IRC reports
All agents	16	15	IRC reports

✔ 500 children reached indirectly through parents who participate in the FMD program

IRC collected information on the parents who participated in the FMD program. In total, 200 persons that participated to the program declared having 735 children of which 228 aged 0-5 years.

Table 7: key output 3

Indicator	Targeted	Achieved	Data source
Children reached indirectly through parents who participate in the FMD program	500	735	Administrative data

The typical beneficiary has 4 children of which one is aged 0-5. There is a high variation in the number of children per beneficiaries. 42 beneficiaries have no children and 12 have more than 10.

X   2 community centers created (constructed, equipped and inaugurated)

Two community centers were built in X and X by the end of the program.

At the end of the pilot, in April 2019, IPA's senior M&E assistant visited the two relevant communities to observe the work progress of community centers. The construction had just ended, but the two centers were not equipped and inaugurated yet. The inauguration was scheduled for the first week of May, after the end of the pilot. The construction had about a year of delay. Reasons for the delay are discussed in the section 3.2.1.

Table 8: key output 4

Indicator	Targeted	Achieved	Data source
community centers created (constructed, equipped and inaugurated)	2	0	Spot check

20

✔ 2 community centers' committees established

IRC established and trained 2 steering committees to manage community centers. During the last spot check visit, IPA interviewed members of both committees.

Early in 2019, the Community Center Management Committees (CCMCs) of the X and X centers were set up. Each committee is composed of 11 individuals[10]. According to the plan, the committee should include two members of the FMD community of practice, one president, one representative of each section in the community center (children's section - youth section - women's section) . However, apart from the president, the other members of the committee did not know their role - or the objective of their role - when interviewed. As a result, despite being formally established, it is difficult to consider the committees as functional.

Table 9: key output 5

Indicator	Targeted	Achieved	Data source
Community centers committees established	2	2	Spot check visit

✔ 5 income-generating activities identified for each community center

At the end of the pilot, income-generating activities to support the centers were not clearly identified by the steering committee's members.

According to the final report, IRC has actively supported the committees of both communities to identify 5 income-generating activities. However, through interviews with members of the committees, we found that the members were not able to cite 5 different possible IGAs to support the centers. In X, the members of the committee reported they were exploring the possibility to develop an agricultural Income Generating activity .In X, the committee reported they have decided to put in place a community tax.

Recommendation for scale-up: Agricultural Income Generating activities can encompass a large array of activities with very different cashflows and exposure to idiosyncratic shocks. To build the sustainability of a community center, a specific diagnostic and mediation should be implemented so that community could jointly agree on the best approach that will minimize the risk of loss due to external factors and maximize the cashflow.

Table 10: key output 6

Indicator	Targeted	Achieved	Data source
Income-generating activities identified in each community center	5	~1	Spot check visit

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[10] Gender composition: X committee composed by 5 women out of 11 members, X committee: 8 women out of 11 members

X   At least 2 income-generating activities are tested in each target community to ensure sustainability of the community

At the end of the pilot, no income generating activities had been tested to support the centers. Steering committees had a vague idea of their role and possible IGA. This reflects the fact that the centers had not been formally inaugurated, and community members were likely waiting for the formal inauguration before really starting to build ownership around community centers. It also further indicates a lack of community engagement.

Table 11: key output 7

Indicator	Targeted	Achieved	Data source
Income-generating activities are tested in each target community	2	0	Spot check visit

✔   Indicators on community engagement for the center

In the evaluation matrix, we agreed on four indicators of success to capture the community engagement for the centers[11]. But we are not able to assess them because the implementation partner did not collect data on the number of members who participate to the different activities or the activities did not happen because the centers were not inaugurated yet.

Overall, IRC reported that the community engagement for the centers was lower than expected.

Community Engagement for Community Centers started with supporting communities in selecting Construction Monitoring Committees members. Then, through additional meetings, the IRC team increased community awareness around the need to be more engaged in the creation of the centers. In X, a committee was set up so that each community-based ethnic group members were available at the work site on a daily basis. In X, the Construction Monitoring Committee was responsible for mobilizing community members throughout the duration of the project. However, the final report explains that there was few or no engagement of the community in the creation of the community centers.

The READ's tested social mobilization methodology clearly didn't reach the expected results and a deeper diagnostic of the underlying reasons for this failure should be carried out by partners before moving to scale.

Recommendation for scale-up: Community engagement is a prerogative to the construction of a community center. Such an approach therefore requires ensuring representativeness, equity and establishing governance to avoid disillusionment. We highly recommend READ to take stock of the current progress and re-asses their methodology in the Ivoirian context. Indeed, strong prior NGO presence and high ethnic diversity might play against such a pure community model.

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[11] The four indicators with appropriate targets were:

1. 500 community members reached through community mobilization and outreach efforts;
2. 500 community members directly involved in the creation of community centers;
3. 500 community members engaged in the management and operations of community centers and;
4. # of persons that contribute money or in-kind donations for the establishment of the community centers.

Data shows an overall good participation rate and good diligence from FMD beneficiaries who received 1000FCFA per training session as a compensation for their time and the costs of transportation.

200 parents were selected and enrolled to participate to the FMD sessions in 5 pilot communities, 40 participants per community. Most participants were women, apart in X and X groups where men were also invited to the sessions. Table 12 shows the distribution of women and men per community.

Table 12: Distribution of FMD beneficiary per community

Community	Women	Men	Total
X	40	0	40
X	20	20	40
X	37	3	40
X	20	20	40
X	40	0	40
Total	157	43	200

Source: IRC's attendance data

The analysis of beneficiary participation uses administrative data shared by IRC at the end of the program. 93percent of the individuals present in the final administrative data match with the initial list of beneficiaries selected before the beginning of the program. Therefore, it seems that only 12 persons were replaced.

The training on FMD has 11 sessions, at the rate of one 2-hour session per week.

✔ 200 parents trained through FMD program

In the following section a person is consider as trained if he/she attended 70percent of the training representing at least 8 training sessions[12].
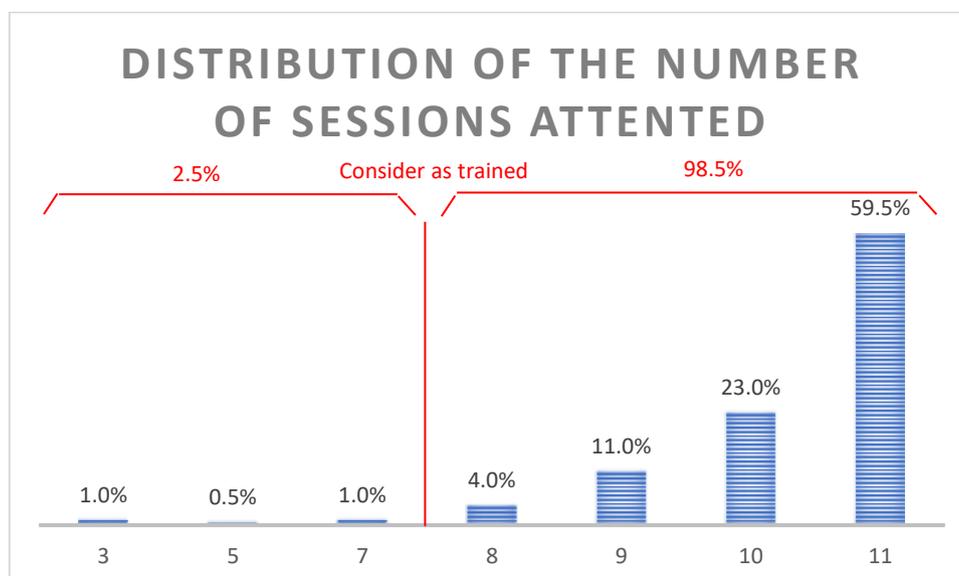
Figure 2: Distribution of the number of sessions attended

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[12] Although there was no definition in the matrix, we decided that a person is trained if she/he assisted to 70 percent of the training / 8 sessions to be consistent with other pilots.

195 persons – representing 98.5percent of beneficiaries - participated to at least 8 sessions of the training. Figure 3 illustrates the distribution on the number of sessions attended. About 60percent of the beneficiaries participated to all training sessions. The diligence of FMD beneficiaries on this training is good, with only 4 parents who left the training before the end.

It is important to note that the attendance rate is underestimated because IRC shared the attendance database before the last session took place in X and we consider missing values as no attendance for this session.

Table 13: Key output 8

Indicator	Targeted	Achieved	Data source
parents trained through FMD program	200	195	Attendance sheet

> 70 percent average participation rate in FMD training sessions

According to administrative data, the average participation rate per session per community is 93 percent. Overall it is a an excellent participation rate that exceeds expectations.

The average participation rate is slightly lower – although still higher than the average targeted - in X because we consider that no one participate to the last session. Figure 1 describes the average participation rate of the sessions per community.

Figure 3: Average participation rate of training sessions, per community
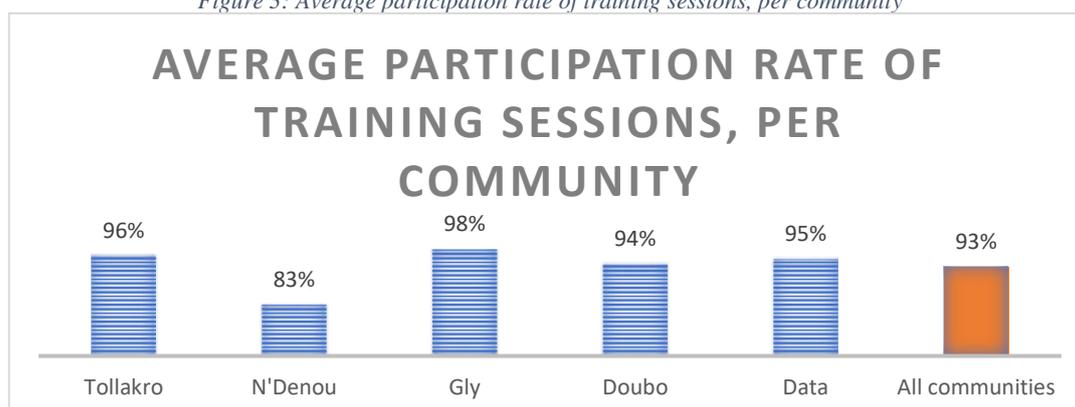
> **Recommendation for scale-up**: Financial incentives to ensure beneficiaries participation had a clear and significant impact on the overall attendance rate. However, questions on the sustainability of this approach should be raised during scale-up conversations.

2.1 Achieves direct outcomes

Assessment: ✓

Despite seeing limited improvements on knowledge around good parental practices, we observe that the program managed to change knowledge around key nutrition and hygiene indicators. Looking at reported practices of caregivers we observe very encouraging results with a significant increase in the percentage of parents engaged in activities that promote learning with their children: Concerning responsive care behavior, less parents are leaving their children alone and we observe encouraging results in the use of positive child discipline methods. Last, delays in the construction of the two community centers that were inaugurated after the end of the program didn't allow the pilot to reach the target indicators fixed in the matrix in terms of community engagement.

Criteria 2.2.1. Change in beneficiaries' knowledge, behavior and practices

Figure 4 Timeline with IRC and IPA's activities
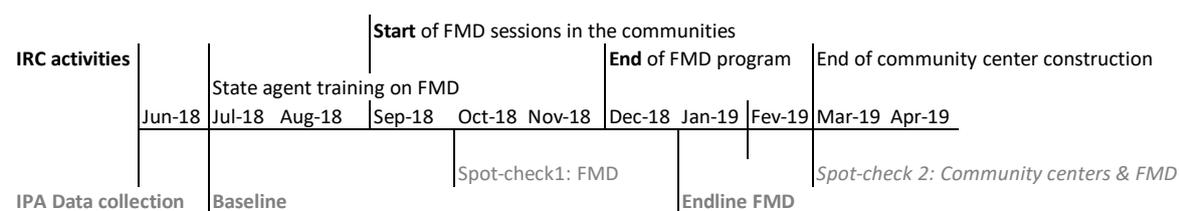
Methodology

IPA has carried out two waves of data collection. The first one was implemented before the beginning of the program (the baseline).

During the baseline, IPA collected data on beneficiaries and non-beneficiaries to assess the effectiveness of beneficiaries' targeting. The effective start of the program occurred two months after the baseline due to delays in beneficiaries' selection. The second wave of data collection is called the endline. This data collection occurred one week after the end of the program and aims at surveying the exact same people as during baseline. The following analysis will compare the results on program outcomes. Due to many reasons - travels, unavailability of the beneficiaries - the field team was unable to find the entire baseline population. IPA was successful in surveying 140 people from the baseline sample in the community at the endline (98 percent of the sample). Such a low level of attrition gives us high confidence that results are not driven by attrition bias.

For more details on how IPA conducted the data collection phase and the underlying power calculations please refer to the Annex A at the end of this document and our baseline report.

The table below presents interviewed households versus planned and completed rates by communities.

Table 14: Summary of endline interviews

Villages	Planned	Reached	Completed
X	29	27	93%
X	14	14	100%
X	28	28	100%
N'Demou	15	15	100%
X	27	27	100%
Total	113	111	98%

Baseline endline comparison was carried out on a sample of 107 respondents. 4 households did not match within both databases (baseline and endline) so they have been dropped for the rest of the analysis.

Changes in knowledge on good parental practices

Key Indicator:

- 70% of the parents improved knowledge on positive parental practices

The family is the primary environmental influence on children's development[13]. Any chronic domestic problem, especially of the mother or primary caregiver, such as intimate-partner violence or chronic illness, can have a deleterious effect on child development. Family members provide most stimuli for children, and families largely control children's contact with the wider environment (Clyde Hertzman, 2010).

As a result, and given the short implementation period, all stakeholders decided to focus part of the process evaluation on the parenting practices knowledge outcomes. IPA acknowledge that changes in knowledge do not always trigger changes in practices, as practices are deeply ingrained in complex socio-cultural structures. However, IPA still believes that looking at knowledge is relevant in this context as it lays the foundation of better-informed practices.

To assess respondents' knowledge about good parental practices, respondents were asked to recognize activities that promote child development and then name benefits of these activities. IPA chose to take a pilot-tailored approach to best monitor knowledge changes that are directly related to the curriculum of each pilot. On the four first questions[14], beneficiaries were asked to identify out of three pictures the picture showing the situation that promotes cognitive, speech, emotional and physical development of children. Then, the four following questions asked them to identify the benefit from a given activity that promotes child development, also shown as a picture. For details concerning the calculation of these outcomes refer to annex 3. A third indicator concerned the identification of positive child discipline methods. Parents were asked to report all the positive methods of child discipline they knew (enumerators categorized answers within the following items - Redirecting the child/ drawing attention to something else, suggesting an alternative activity, Explaining the rules and expectations, ignoring when the misbehavior is minor, Praising good behavior).

Looking at figure 5, we observe an increase in all reported scores, but no changes are statistically significant. This means that we can't rule out the possibility that those changes are due to sampling variance.

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[13]United Nations Children's Fund (UNICEF). *State of the world's children 2007: Women and children: The double dividend of gender equality*. New York, NY; United Nations Children's Fund (UNICEF); 2006.

[14] All questions were prompted randomly to avoid any bias in respondents automatically selecting the first available answer

Concerning the identification of positive child discipline methods (the first indicator in the figure below), using the same indicator as IPA, IRC seems to find better results in their final report, with 83 percent of parents able to cite four positive strategies compared with IPA's 15 percent. The reasons for this discrepancy are not clear to IPA. A possible explanation for at least part of the difference could come from the fact that IRC's questionnaire was delivered right after the training, while IPA's questionnaire was delivered a few weeks after the end of the training. This delay could result in a longer-term picture of the information retention.

On the second two indicators relating to parents' ability to identify benefits of activities that promote child development, and identifying child stimulation methods, we see that the baseline level of these indicators was already quite high, which could reflect the fact that many of the beneficiaries had previously been engaged through parenting programs, leaving little room for improvement on these metrics.

Figure 5: Changes in beneficiaries' knowledge scores
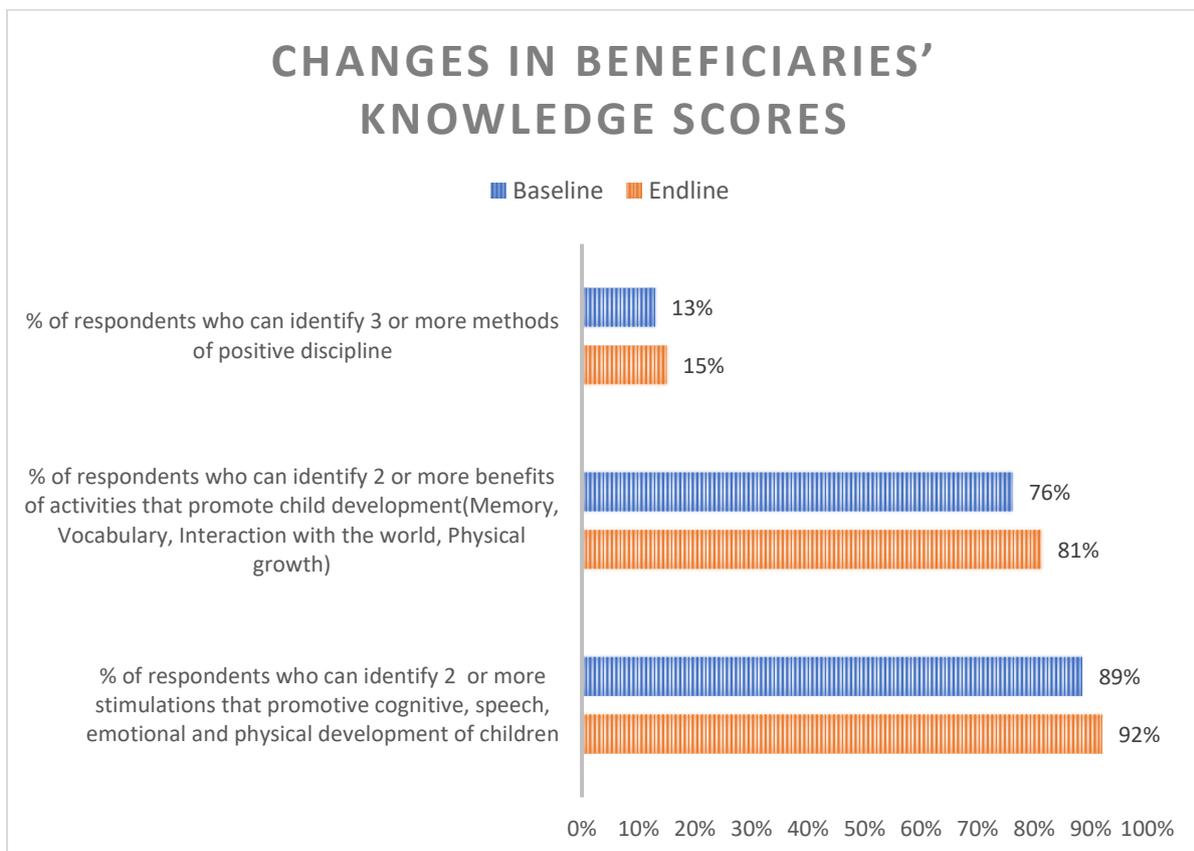
Statistically significant differences are marked with a star

Knowledge around good parental practices has in general shown more mixed results in our evaluation, potentially because of the lack of clarity on the definition of cognitive or emotional stimulation for beneficiaries, compared with the standard nutrition and hygiene indicators we used. To strengthen our analysis and give a more comprehensive picture of the changes the program could have triggered, we also collected standard indicators of self-reported parental practices and attitudes, below.

Change in knowledge on nutrition, hygiene and attitude towards violence

Key Indicator not in the matrix[15]:

   ✔ Improved knowledge on nutrition and hygiene

One of the key five components of the nurturing care approach is related to nutrition and hygiene[16]. In this respect, the FMD training included one module on nutrition, introducing the concept of exclusive breast feeding, age for introduction of complementary food and vitamin supplementation. Another module on hygiene and prevention of child diseases was addressing the concepts of vaccination, hand washing and bed nets.

To test knowledge over these two components two very standard indicators have been used[17]. For both indicators we observe an increase in knowledge as beneficiaries reported significantly more good answers. The sharpest increase in knowledge specifically concerns the percentage of respondents able to name the correct age to introduce solid food to toddlers.
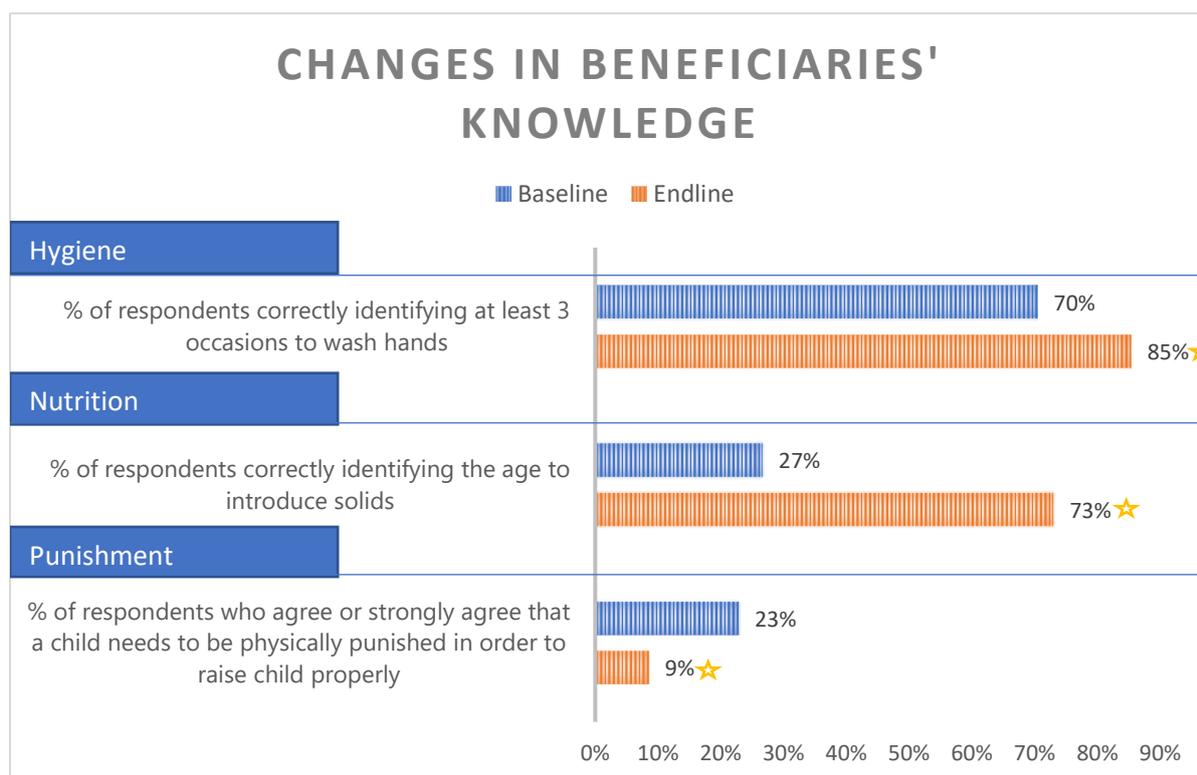
Statistically significant differences are marked with a star

Notably, we also observe a significant change in attitude towards the use of violence to educate children. In fact, parents reported much more disagreement related to the use of violence to raise a child.

Changes on good parental practices

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[15] While this indicator was not in the matrix, it was a core component of the program and a standard indicator agreed with TRECC to be included in all ECD pilots.

[16] Britto PR, Lye S, Proulx K, et al. Nurturing care: promoting early childhood development. Lancet 2016; published online Oct 4. http://dx.doi.org/10.1016/S0140-6736(16)31390-3

[17] Please refer to the MICS6 Indicator list for more details

Key Indicator:

- ✔ At least 70% of the caregiver's report having engaged in four or more activities to promote learning and school readiness in the past 3 days

The second part of the analysis focuses on reported practices indicators that are considered as direct outcomes of the program. By direct outcomes, we mean outcomes that have a high chance to be directly influenced by the program, observable without a counterfactual control group. Reported practices are collected using the standard MICS tools that will later ease comparison with other studies.

At this stage, IPA did not choose to use in-person observation tools for caregiver practices because of their high cost in terms of human and logistical resources. In fact, the WHO/UNICEF CCD M&E Manual[18] note that direct observations are mostly reserved for mostly for research studies for this reason.

Looking at table 15, we observe that our target indicator, "*% of children with whom an adult was engaged in four or more activities to promote learning in the past three days*" experienced a significative change. In fact, fully 20 percentage point more caregivers are now more involved in activities with their children, from a baseline of 27 percent. Despite this increase, the indicator's performance didn't reach the expected target fixed at 70 percent, which was somewhat unrealistic, but IPA has noted the strong performance on this target as part of our overall assessment. It is important to note that this indicator is not computed on the entire sample. As per standard practice, it targets caregivers with children from 2 to 5. Comparing this result with the MICS figures for the year 2016 in Ivory-Coast, we observe that results during baseline are relatively in line with the national average that reaches 28.7 percent. Having a closer look at the MICS results, we see that this percentage is about half as large for parents in rural areas. In this respect, this pilots' results appear to be very encouraging for the target population.

Table 15: Share of children with who an adult was engaged in four or more activities to promote learning in the past three days

Outcomes	N	Baseline	Endline	P-values	Sig
% of children with who an adult was engaged in four or more activities to promote learning in the past three days	75	27%	47%	0.006	***

Looking at the details of the changes in practice in figure 6, we observe that two key practices are driving the indicator upward. These are reading and telling stories.

Figure 6: Changes in beneficiaries' learning practices toward 2 to 5 years old children

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[18] The Framework for Monitoring and Evaluating the WHO/UNICEF Intervention on Care for Child Development, 2016

CHANGES IN CAREGIVERS' PRACTICES TOWARD 2 TO 5 YEARS OLD CHILDREN
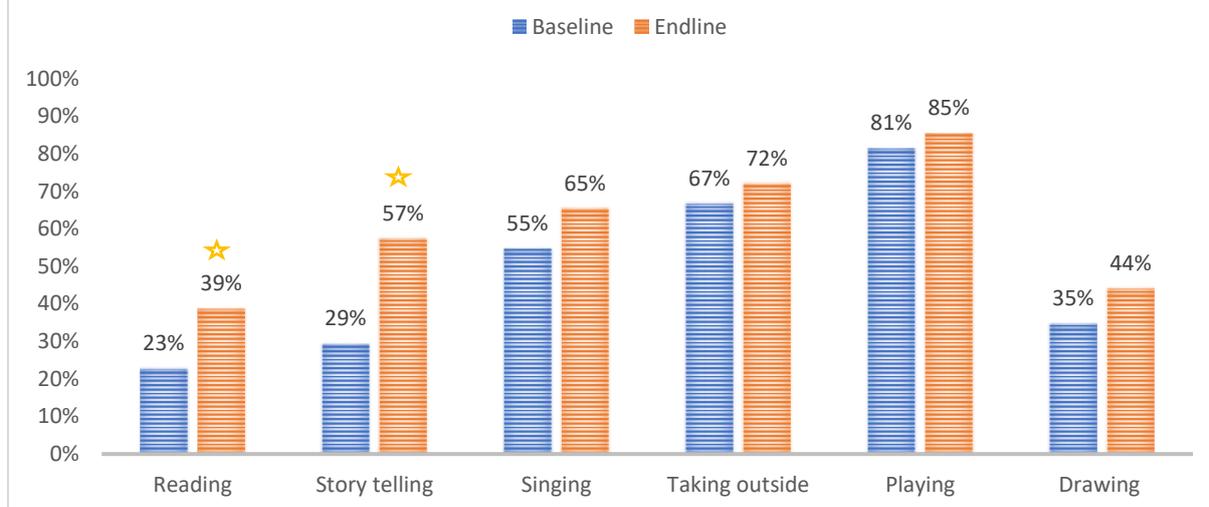
Statistically significant differences are marked with a star

Key Indicators not in the matrix:

- Responsive Caregiving and security and safety

Good parental practices include creating opportunities for early learning as displayed in the above indicators, but also other components such as child security and safety. In this sense, the percentage of parents that are leaving their children alone is one measure of the extent to which parents are safeguarding their children. Looking at this indicator displayed in the table 16 we observe that a significantly lower percentage of parents, from 32 percent to 18 percent, reported leaving their child alone or with a child under 10.

Finally, young children are also very vulnerable to harsh punishment that can cause uncontrollable fear and stress leading to emotional, mental and social maladjustment. Looking at the target indicator in table 16 we observe a small but statistically significant increase in the reported use of exclusively positive child discipline practices during the last 30 days.

Table 16: Other nurturing care indicators

Outcomes	Before		After		P-values	Sig
	N	Prop	N	Prop		
Responsive Caregiving						
% of respondents who left a child alone/with another child under the age of 10 for more than an hour at least once during the past week	69	32%	69	18%	0.029	**
Security and Safety						
% of respondents applying only positive methods of discipline	107	4%	105	6%	0.016	**

Figure 7 displays the reported negative and positive child discipline methods used by parents during the last 30 days. Despite observing only a 2 percentage point reduction in the aggregated indicator (from a low base of 6 percent), we observe a strong pattern of changes toward positive disciplinary practices and away from negative practices.

Figure 7: Changes in beneficiaries' attitude to rectify 1 to 5 years old children wrong behaviors

CHANGES IN BENEFICIARIES' ATTITUDE TO RECTIFY 1 TO 5 YEARS OLD CHILDREN WRONG BEHAVIOR

■ Baseline ■ Endline

Positive behavior

Praise his good behavior	88% / 96% ★
Explain him his behavior is wrong	73% / 86% ★
Create some rules with children	59% / 81% ★
Take away some privileges or hinder him to go out	42% / 53%
Give him something to do	30% / 39%

Negative behavior

Shout at him	44% / 63% ★
Beat him slightly with hands	32% / 41%
Shake him	25% / 41% ★
Hit his hands or legs	19% / 33% ★
Insult him	14% / 22%
Slap him or beat his head	3% / 9% ★
Beat him sligthly with something	5% / 5%
Beat him strongly	0% / 6% ★

Statistically significant differences are marked with a star

✔ Usage of community centers

Different key indicators were developed in the matrix to assess the implementation of community centers and the buy-in of the community. Due to the delay in the centers, all relevant indicators were not achieved.

The list of indicators displayed in the matrix are as follows:

– 30 % of the parents report actively participating in the community of practice;
– 30 % of the community members report trust in CMC members to lead the community center
– At least 2 income-generating activities are tested in each target community to ensure sustainability of the community center and community-led development efforts
– 50% of community members report accessing informal educational opportunities at community centers for themselves and their children;

2.3. Beneficiary feedback about the program is positive

Assessment: ✓

Most beneficiaries reported positive immediate outcomes and satisfaction with FMD training sessions. Focus groups revealed that beneficiaries appreciated the way FMD sessions took place and the professionalism of facilitators. These focus groups also revealed that beneficiaries are more aware about the importance of infant exclusive breastfeeding. In addition, they know now the negative effects of child labor on children's development and the importance to maintain good communication with children to manage their wrong behavior.

Criteria 2.3.1.a Beneficiaries provide positive feedback on the delivery of outputs

Through IPA's quantitative questionnaire we observe a large buy-in for the program from the beneficiaries' perspective. Respondents' opinion on delivery of the program can be grouped into 3 categories: (1) feedback on satisfaction with FMD sessions, (2) feedback on facilitators teaching, (3) feedback on training sessions location

Regarding feedback on satisfaction with FMD sessions (figure 8), 100 percent agreed that the sessions were clear and understandable. In addition to this, 98 percent beneficiaries declared that they enjoyed the sessions and 99 percent found the sessions useful.

Figure 8: Feedback on satisfaction with FMD sessions
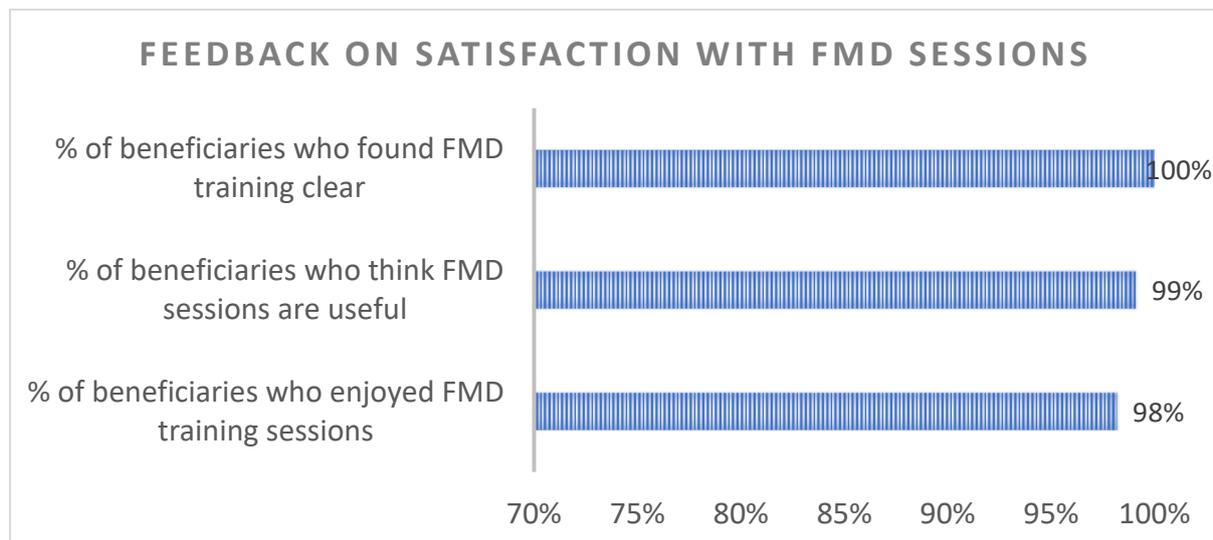
Feedback on facilitators teaching (Figure 9) shows that beneficiaries appreciated facilitators teaching, 99 percent found them enthusiastic and kind, 97 percent found them confidential and expressing well. In addition, 98 percent declared facilitators were listening to them.

Figure 9: Feedback on facilitators teaching

FEEDBACK ON FACILITATORS

% of respondents who reported that facilitator was enthusiastic	99%
% of respondents who reported that facilitator was kind	99%
% of respondents who reported that facilitator was listening peoples	98%
% of respondents who reported that facilitator expressed himself well	97%
% of respondents who reported that facilitator was confidential	97%

70% 75% 80% 85% 90% 95% 100%

The figure 10 summarizes respondents' feedback about training session location. 86 percent reported that sessions taken place in comfortable and spacious places and 95 percent agree that these places were safe.

Figure 10: Feedback on training session locations

FEEDBACK ON TRAINING SESSION LOCATION

% of respondents who reported that trainings were runned in safe places	95%
% of respondents who reported that trainings were runned in comfortable…	86%
% of respondents who reported that trainings were runned in spacious space	86%

70% 75% 80% 85% 90% 95% 100%
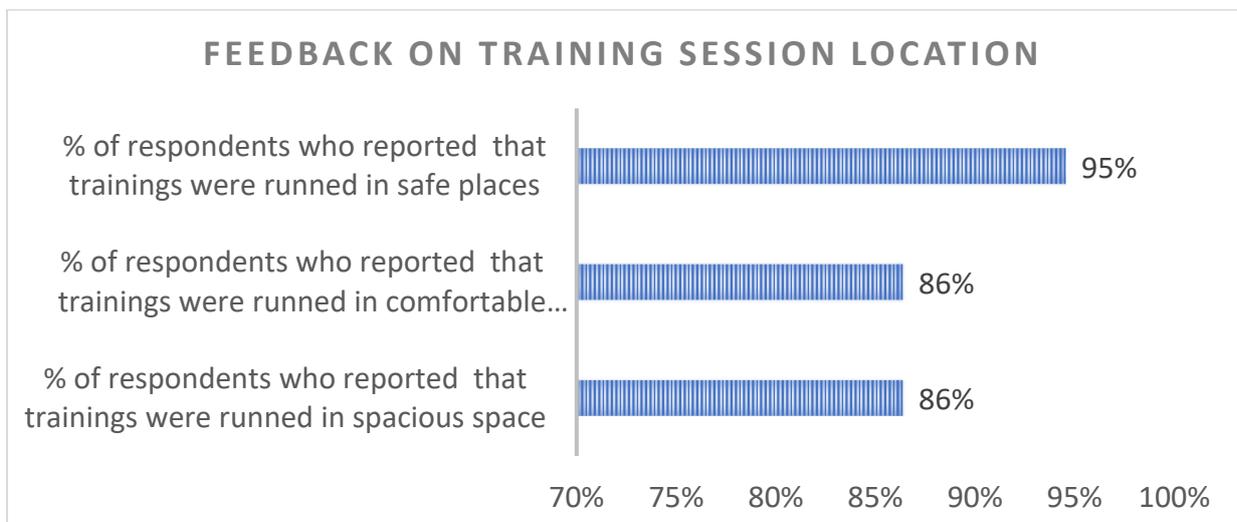
Criteria 2.3.1.b Beneficiaries provide positive feedback on the main immediate outcomes

99 percent of beneficiaries reported that FMD sessions has changed their daily life and 100 percent declared these changes to be positive. We assume that people have a positive feedback about the program if they can recommend it around them. 99 percent of respondents would recommend the program to friends and family.

To identify respondents' main immediate outcomes about the program, we asked beneficiaries to report the degree they think they would recommend it across the following choices: 0(Totally disagree), 1(Not agree), 2(Agree), 3(Totally agree), 4(Don't know). With "agree" or "totally agree" regarded as recommendation.

Figure 11: Feedback on main immediate outcomes

Criteria 2.3.1.c Interview with the beneficiaries shows that they are satisfied with the project

Overall, beneficiaries declared appreciating how the FMD sessions took place. They congratulated the professionalism of the facilitators: "*The facilitator was methodical and available. She listened and spoke calmly*". Also, they seemed to be satisfied with the content of the training. They find the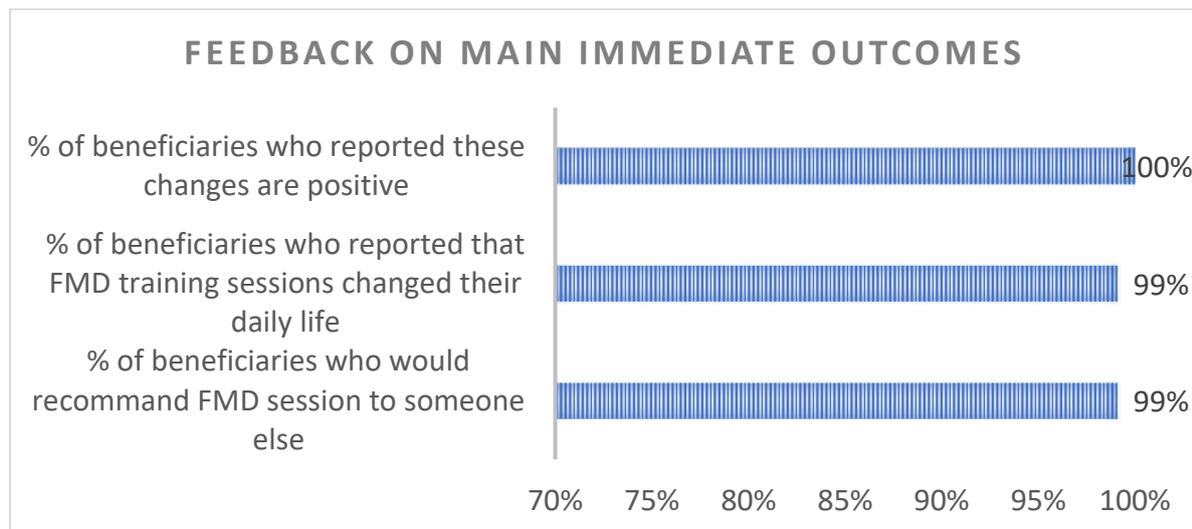 content useful and consider that it is adapted to their context: "*All modules were useful for us. Every module has its place in the family, that's what we live every day".* They report having particularly enjoyed modules on child care and communication which help them in their daily life. Modules were delivered in French and translated for some people in local language such as Baoule or Mossi.

Indeed, beneficiaries report that the pilot has changed positively their behavior towards their families and more particularly with their children. According to them, they can better take care of their children than they did in the past and their level of communication with their children and spouses has increased. Respondent reported that communication is now used instead of violence to settle issues that arise in their households. They report that they are more involved in their children's education since the beginning of the pilot. *"The project has brought me more in the education of my children, a new direction" "before I used to hit my children a lot, now thanks to the project, I do not do that anymore I stopped"; "It has helped me a lot, to hit a child today is not to educate him."* More details concerning the changes declared on the practices are described in section 2.3.2.

However, it seems necessary to take some of the beneficiaries' statement with caution as answer might be influenced by a social desirability bias.

2.3.2. How meaningful is the intervention to beneficiaries' lives?

Criteria 2.3.2 Beneficiaries report that the pilot was meaningful for them

Beneficiaries report that the pilot had a positive effect on the way they take care of their children. According to them, they communicate more with their children, have changed the way they discipline them, and have

gained more knowledge about nutrition appropriate for children. However, some reported that they encounter difficulties putting parenting skills developed during the training into practice.

Nutrition

Participants say they have learned about appropriate nutrition for young children. *"Regarding nutrition and complementary feeding of children, we learned that children between 0 to 6 months should only be given breast milk. From 6 months to 1 year, we can give him corn porridge, millet, cereals, pharmacy milk. More than a year, we give him rice, fish and what is available at home".* More specifically, most now agree on what is the adequate for exclusive breastfeeding: *"Before, when we saw a newborn, we gave him water to drink, but now because of the project we think we have to wait 6 months and that's what we do now".*

Responsive caregiving

Regarding behaviors to be adopted by parents to facilitate the development of children, many participants declared they communicate more with their children than in the past and use less violence against their children or with their spouses in the presence of their children. *"I do not hit the child anymore, I recommend it. I find things to tell him, so he does not do it again. Before the project, there were misunderstandings. It is thanks to the project that I know that I need to be a model for the child. Before the project, we did not get along, but it changed when the project came."*

Attitude towards child labor

Regarding child labor, participants seem to understand the impact child labor can have on children's development. They identify certain activities that may be particularly harmful to children's health: *"Children should not touch chemicals, it can make them sick. They must not use machetes because it can hurt them".* Also, most beneficiaries say they can put the knowledge acquired during training into practice. They explain that they no longer strike their children.

Barriers to change in practice

Beneficiaries report that they encounter difficulties that prevent them from putting into practice the knowledge they have learned during training sessions.

The lack of financial means is the first difficulty impeding the application of knowledge on some good parenting practices (that require additional costs):*"As a barrier to application of knowledge, there is a lack of money to take good care of our children and buy the food we were advised to buy during the project"* or *"As a barrier to knowledge translation, there is a lack of money to take good care of our children and buy the food we were advised to do during the project".*

Some parents seem to equate taking good care of a child only with access to financial resources. It is unarguable that access to financial resources is necessary to care for a child and contribute to his development. However, certain activities are not necessarily expensive or do not have a monetary value but can significantly contribute to children's development. Such activities include for example telling children a story, making sure they do their homework and wash their hands.

Also, beneficiaries report not having enough time to take care of their children. According to them, their field work takes so much time that it is sometimes impossible for them to spend time with their children: *"We go to the field very early, we cannot take good care of children due to a lack of time. Which means that we do not control them well".*

Social norms can also impede the application of good parenting practice. For instance, a few parents seem to believe that hitting their children remains the best methods to discipline them. *"Me, despite the project, I cannot control my anger towards my children, they are too stubborn I continue to hit them".*

3.Costs and operations management

The costs and operations section will include the following criteria:

- Costs are well managed

- Project management is successful

3.1 Costs are well managed

Assessment:

Although there were significant delays on the construction of the centers that generated additional costs, IRC tried to efficiently use the overall budget for the pilot.

Compared to other similar programs, the CMD approach is quite expensive and should have important impact on the readiness or nutrition of children to be cost effective.

The program proposed in the scale-up proposal is significantly different from the pilot. Moreover, the proposal and the budget attached do not include enough information for us to analyze economy of scale.

[Details removed]

3.2 Project management is successful

Assessment:

Significant delays occurred on the implementation of the community centers leading to major changes in the project implementation.

As for the FMD component programs went according to plan and trainings were delivered on time.

In the field, the cooperation between the different partners went well. However, the cooperation between the pilot partners and the other NGOs working on the Company partner initiative required additional coordination efforts from Company partner

[Details removed]

4. Capacity to learn, improve and innovate

This section will include the following criteria:

✓ Project collects credible monitoring data

✓ Monitoring is used to learn and improve

4.1 Project collects credible monitoring data

> ### Assessment: ✓
>
> Overall, the project collected credible real time data on the progress of the pilot. Spot-checks confirmed the quality of data collected.

Criteria 4.1.1 Routine monitoring data are collected and shared on time with stakeholders

During the pilot IRC collected data on attendance. During operational committees, updates on the pilot's progress - including attendance - and challenges were shared with all pilot partners. As described in the next section, we are confident IRC collected credible real time data. However, the database was not shared regularly with IPA as planned in the initial M&E plan. This was mostly due to the delays in consolidating the aggregated database and IPA's low level of enforcement.

Moreover, as part of their M&E plan, IRC had also planned to collect data on beneficiaries' knowledge on the FMD curriculum regularly. Those data were only shared at the end of the pilot.

Criteria 4.1.2 IPA's spot-check visits confirm the quality and accuracy of data

Through two spots check visits, IPA M&E assistant observed that the monitoring data collection process implemented during the pilot was efficient. Moreover, it confirmed that the information shared by IRC during the operational committees were accurate.

The objectives of the first spot check mission was to check how the M&E system was deployed in the field, observe FMD sessions in 4 communities and collect beneficiaries' feedback. The mission was conducted from October 10th to 15th 2018 in all target communities. During the FMD sessions observed, we observed that the trainers used the appropriate material (flipchart, marker, chart, attendance sheet, image support, facilitation manual). The M&E process observed allowed staff to collect accurate data. The attendance sheet includes all relevant information: date, modules developed, name of facilitator, name of village, names and signatures of beneficiary who attended to the session, and observations about the session. To ensure beneficiaries attended the entire session, they sign at the beginning and at the end. After the sessions, IRC M&E officers collect the attendance sheet of each facilitator and conduct the data entry on an excel file.

The main objectives of the second spot check were to discuss with the FMD beneficiaries 3 months after the end of the program; evaluate the organizational structure of community centers' steering committees and observe the completion of community centers' construction. It was conducted on March 27th, 28th and 31st, approximatively three months after the end of the FMD sessions. It took place in the two communities benefiting from community centers, namely X and X. Focus group discussions with the FMD beneficiaries suggested that the key lessons of the trainings were memorized and (sometimes) put into practice (stat s. Through discussions with the members of both steering committees, all members declared having been trained by IRC on the management of the centers. However, they are not clear with their responsibilities to operate the community center and do not have a clear idea of how such a center works. The IGAs to support the centers were not clearly identified yet.

Criteria 4.1.3 Monitoring data is actionable and aligned with program management

To assess the credibility of data collected we will use three key concepts:

- **Validity**: valid data accurately captures the core concept one is seeking to measure
- **Reliability**: implies that the same data collection procedure will produce the same data repeatedly
- **Unbiased**: data does not have systematic errors

The quality of the attendance data shared by IRC is good. Attendance was collected routinely by the facilitators using an efficient M&E process, as confirmed by the two spot-checks conducted by IPA. The final document shared was well constructed and clear.

We noticed 12 persons who were in the initial list of beneficiaries who do not appear anymore in the administrative data shared at the end of the program. We believe they were replaced before the beginning of the sessions. Because the share is relatively small, and the replacements were made before the beginning of the program, we don't consider it as a threat to the validity of our results.

We believe there is no measurement bias for those data. Therefore, we consider data on attendance is fully valid, accurate and unbiased.

Credible data criteria	Valid	Reliable	Unbiased
Attendance	✓	✓	✓

4.2 Monitoring is used to learn and improve

Assessment: ✓

Data were analyzed and used to learn and take corrective measures. IPA however advises IRC to strengthen their analysis on the couple VS lonely parent apporach.

As mentioned in the previous section, IRC shared updates regularly on project field activities during operational committee meetings. There were few changes that have been implemented during the pilot in response to monitoring.

As mentioned previously, the implementing partners decided to take two different FMD training approaches in the 5 communities: training both parents in 2 communities, but only one parent (expecting spillovers) in 3 communities. We did not see any pre-defined approach to learning about how these variations compared in advance, but we commend IRC for taking such a proactive approach to optimizing their pilot. .

As a response to the low engagement of the community, IRC increased its effort to mobilize support and increased their supervision on the construction of community centers.

Finally, IRC delivered their own final evaluation report based on their M&E system and a before after approach. Given the quality and clarity of the report it is clear that IRC has a very strong M&E team based in Abidjan able to provide a very detailed analysis on the changes related to the direct outcomes using standardized and field-tested measures,

5. Sustainability

This chapter will include the following criteria:

✅ Provides sustained benefit to community

✅ There are prospects of scale-up beyond GMM2

5.1. Provides sustained benefit to community

Assessment: ✅

Community of practices are a good foundation to sustain behavioral changes on parental practices over time but only one community appeared to be engaged through this plateform. Despite the limited use of community of practices, IPA recognizes the strong remaining knowledge within communities more than two months after the end of the program. Low engagement of the community during the construction and before the formal inauguration however casts serious doubts on the sustainability of the community centers.

Criteria 5.1.1. Indications that the community members are likely to continue with the practices or program activities

At the end of the program, IPA administered individual qualitative interviews with women, men and couples who benefited from the program. Through a spot check, IPA also visited the communities to evaluate beneficiaries' knowledge on the FMD and observe the advancement of community center 3 months after the end of the training sessions. This section discusses the perspectives of beneficiaries on the project's sustainability.

Enthusiasm of beneficiaries

Beneficiaries repeated their enthusiasm for the pilot during qualitative data collection and the spot check visits. Beneficiaries reported that the pilot had a positive effect on the way they take care of their children. According to them, they communicate more with their children, have changed the way they discipline them, and have gained more knowledge about nutrition appropriate for children. *"My husband was beating my children but because of the training he stopped. So, I want this to continue so that my husband's behavior does not change, that he stays sweet like that. It's better ".* Moreover, they find the training's content useful and consider that it is adapted to their needs. *"All the modules were useful for us. Every module has its place in the family, that's what we live every day."*

For all these reasons, beneficiaries wish for the expansion of the project. *"We would like the whole village to participate; that everyone sees that it is good what we have learned. It should not stop on us".*

However, it is important to note that beneficiaries received 1000 FCFA as compensation from IRC for their participation to training sessions. Under such circumstances, it is not clear whether the beneficiaries want to continue the training because they perceive the benefits of the program or whether this is motivated by the monetary compensation.

Prospects of maintaining practices over time

During the spot check, discussions with the beneficiaries showed that they continue to practice the concepts learned during the sessions. For example, on child labor, one participant reported: *"The training has allowed us to stop making our child lift heavy objects and we no longer hit them".* Also, the beneficiaries interviewed unanimously reported having adopted positive behaviors towards their children and that their parenting techniques improve gradually. Although it is encouraging, it is important to follow if those changes continue over time.

Communities of Practice

Communities of practice were established to facilitate understanding between members, the practice of skills gained and the dissemination of the program's key learnings. To form practice groups, FMD classes were divided into five-person discussion groups that meet at the home of one of their members once every two weeks. The establishment of communities of practice can contribute to the pilot's continuity because it encourages community members to take responsibility for the dissemination of the pilot's learning.

Beneficiaries from the community of X reported that they have continued those practices. *"As actions taken to ensure the continuity of the project, we review together with other people involved in the project and non-beneficiaries, we review between us, often with others next door. After the holidays, we had to do 3 reviews. We did 5".*

However, it doesn't seem that community of practice took place in the other communities.

Community centers

The READ portion of the pilot focused on engaging two communities to contribute toward and help construct two new community centres. It was expected that these centers will provide the communities access to resources that can uplift the entire community, give children spaces for engaging in learning behaviours, and give parents access to educational programs to further strengthen their parenting decisions and behaviours. However, the delays with implementation make us sceptical about the possibility of this without further investment.

The setup of community centers by IRC was intended to sustain the pilot after its end because community centers present the opportunity for beneficiaries and other members of the communities to have a dedicate place to exchange with other parents on ECD programs and to play with their children. However, it is not clear yet how communities will organize to support the centers and remunerate the persons in charge of running them.

Recommendation for scale-up: The implementation of READ centers has proven to be challenging in the Ivorian context. Building an autonomous community center without the support of private partners or governmental agencies might be a challenging path to scale. Before moving forward, READ should explore the pathways to better mobilize community and create a sustainable model. This could of course be achieved through a longer period of project roll-out, but specific support and backstopping should also be provided in the field.

5.2. There are prospects of scale-up beyond GMM2

Assessment: ✓

There are prospects of scale-up beyond company fundings, namely through the Ministry of the Family, Women and Children (MFFE) with which IRC is about to sign a Memorundum of Understanding. The current financing environnement is very supportive for programs such as FMD. One major caveat related to the submitted proposal is however the change in implementing partner through the course of the project. This startegy is of course interesting as it will built the capacity of local NGO's but does not really fit into the path to scale framework that suggests to test a program before going to scale.

Criteria 5.2.1 Evidence of government/partners buy-in

IRC has put a lot of energy to seek for institutional support from governmental counterparts. In this respect, IRC identified the Ministry of Women Family and Child (MFFE in French) as a possible key partner that is in charge of Community Action Centers for Children (CACEs). This government buy-in was translated by the preparation of an MoU signature between parties that would extend IRC engagement over more community.

IRC also worked on the the buy-in of the Ministry of Education working with the pre-school sub-directorate of the Ministry of National Education[19] ultimately aims to integrate elements of the IRC's parent capacity building program into CAFOP's[20] student training modules. The first activities should start with the Gagnoa CAFOP.

Recommendation for scale-up: Identifying governmental counterparts able to deliver an ECD training has proven to be challenging in Ivory Coast. In this respect these positive primary results from the pre-school educators should set the foundation for a larger and longer collaboration. This integration within the MFFE is also aligned with the path to scale approach that recommends thoroughly testing one specific program before replicating it at a larger scale.

Criteria 5.2.1 Enabling and financing environment

National environment is suitable for further scale up given the new investment of the World Bank on a Multi-sectoral Nutrition Plan (USD 60 million). The first Strategic Objective is the following: "Good nutritional practices and preventive measures are promoted". This objective aims to promote and support good nutritional practices and preventive measures with a focus on promoting key Essential Nutrition Actions (ENA +).

The Ministry of Education (MENETFP in French) has established a framework for addressing challenges in pre-primary education in the Education Sector Plan 2016-2025. By 2025, the MENETFP aims to increase enrolment in pre-primary from 10 percent to 16percent of children through a combination of developing pre-primary in existing primary schools, restructuring existing kindergartens, establishing community pre-

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[19] IRC has partnered with this Subdirectorate in the framework of different past projects
[20] Centres d'Animation et de Formation pédagogique, national training Institute for teachers of pre-primary and primary schools

schools, and private provision as indicated in table. In this context, the good performance of pre-school educators on this program could constitute a future opportunity in line with national strategic objectives.

Criteria 5.2.2 Organizational capacity to implement at scale

IRC is a big NGO with a national presence in Ivory Coast dating back to 1994. The organization developed several regional offices that facilitate the implementation of the different projects in the field through regular supervision visits. In addition to this, IRC benefits from a strong M&E culture with very well-trained staff able to analyze large survey data.

IRC is used to work on a large scale and received many significant grants from International Institutions and foundations. In 2017, Master Card Foundation and IRC signed a partnership of five year to train 10 000 young Ivorians

READ has for the moment proven to have limited ability to support the project implementation. This is mostly due to the remote nature of the support and to the language barriers that plays against a good contextualization of the project.

Recommendation for scale-up: Handing over the program to a local NGO or governmental counterparts is certainly a very interesting avenue forward. However, current evidence indicates that changing implementing partner can have a very significant impact on how the program is delivered and monitored. In this respect, IPA does not recommend going to scale without having tested the full implementation

Identifying governmental counterparts able to deliver an ECD training has proven to be challenging in Ivory Coast. In this respect these positive primary results from the pre-school educators should set the foundation for a larger and longer collaboration. This integration within the MFFE is also aligned with the path to scale approach that recommends thoroughly testing one specific program before replicating it at a larger scale.

The pilot and scaling plan included a number of strengths that should help to facilitate scaling and sustainability, including:

- Clearly articulated problem the initiative seeks to address;
- High participation rates in the Families Make the Difference sessions (97%) and positive feedback from both the participating parents and the facilitators of the program;
- Very strong rates of change reported from the FMD sessions; the final evaluation shows that 94% of parents use positive stress management strategies, compared to 57% in the baseline evaluation, as well as a very significant decrease (from 89% to 2%) in parents who believe in using physical punishment;
- Strong engagement with government actors throughout the pilot, including training officers from the Ministry of Woman, Family, and Children (MFFE) in the approach; ongoing collaboration between the IRC and the pre-school sub-directorate of the Ministry of National Education; and exploring a potential Memorandum of Understanding with the MMFE to support expanding implementation.
- Excellent to see plans in the scaling phase to include religious leaders from the beginning of activities in order to mitigate potential opposition.

Rather than highlight all the strengths of the proposal, we have focused below on a few key areas where additional consideration and thinking could be useful:

Lack of local buy in around community centers. The final pilot report underscored as a main challenge the lack of interest and engagement from the local communities in building and running the community centers. The report noted that in practice, it was difficult to secure community commitments to support the centers, despite the fact that the required contributions were quite small, and the IRC field team engaged in constant support for local mobilization. As a result of this lack of buy in, the final report noted that many project activities were delayed during the pilot phase, including the establishment and training of Management Committees, the establishment of income generating activities, the management of the centers, and holding the FMD sessions in the centers. The report further acknowledged that communities expressed a preference for other infrastructure, such as additional kindergarten classes or a health center, instead of a library. However, despite these significant challenges confronted with implementing the community centers, the draft scaling plan proposes moving on to an extension phase while maintaining the same integrated approach as was tested during the pilot phase. Adaptations to the approach of implementing these centers to mitigate these challenges do not appear to be incorporated into the scaling plan, but rather the proposed mitigation strategy is to target communities that already demonstrated an interest in setting up this type of center.

CUE has some concern over the plans to move forward with expanding the same model in the extension phase without adjustments, given these serious challenges identified. Research has demonstrated the critical importance of local community buy-in for a solution to effectively and sustainably scale, and without this demonstrated interest, scaling the integrated model as is may prove problematic. Further, only targeting communities where this buy in already exists may limit possibilities for additional expansion and progress towards the long-term scaling goals articulated. While the FMD training showed very strong positive results on parental behavior, it is not clear yet that the pilot has demonstrated sufficient evidence of the benefits of integrating the two models to move forward with expanding the integrated package. While appreciating the acknowledgment that the READ model typically needs 2-3 years to be operational and to achieve proper community engagement, it will be very important in this extension plan to give additional thought and consideration to strategies and adaptations that might be made to the integrated model in order to address and mitigate the challenge of low local buy-in, with an eye towards long term sustainability. CUE further

agrees with the recommendation from the pilot phase to assess the results of the first two READ centers before moving forward with plans for implementing an expanded version.

Additional challenges identified in the pilot not addressed in the scaling plan. Additional challenges and weaknesses identified in the pilot phase were not directly addressed in plans for the extension phase. For example, the final report mentioned the challenge of establishing income generating activities in communities with the community centers, due to the unavailability of land, lack of willingness to take joint action, low purchasing power, and the agriculture-dominated environment. However, the scaling plan did not discuss how learning from the pilot about this challenge would be incorporated into the next phase of work and used to inform adaptations in the extension phase. Similarly, the final report mentioned as one of the threats to the project the fact that "state entities involved in the project refused to support it." While this fact could pose an obstacle to plans for expansion, it was not discussed in the scaling plan. CUE would underscore the importance of taking into account these potential constraints and challenges seen in the pilot phase, as well as factors in the enabling environment that may further hinder scaling, when planning for the extension phase, and more directly build in ways to address or mitigate them.

Building government outreach and engagement into project activities in an ongoing manner. It was exciting to see one of the long-term goals for the extension phase being vertical scaling through the inclusion of parental education into the government's ECD interventions, as well as government inclusion of related costs into its annual budget. Further, it was excellent to see plans to share results from the midterm and end line evaluation with government and communities for their input and feedback built into proposed activities. However, beyond year one, there does not appear to be ongoing outreach and advocacy activities built into the project, such as the cultivation of national champions or ongoing government engagement. It would be useful to give additional consideration to what activities and actions might be required throughout the entire process to facilitate and enable this intended government take-up, especially given the fact that the state child protection structures already have very limited resources.

Additional consideration of changes in the early childhood development landscape and broader enabling environment might be useful. It was excellent to see that the scaling plan included considerations of unintended consequences of scaling, as well as potential cultural barriers and opponents. It may be beneficial to also include further discussion on the evolving political landscape and how it might constrain or enable scaling. Some of the current government programs and priorities were discussed on page 6 of the scaling plan, but it would be useful to further consider how these developments might present opportunities for further expansion, such as integration into new policies and frameworks.

Annnex 1: Early childhood development index

The 4 domains of the early childhood development index are defined as follows:

1. **Literacy-numeracy:** Children are identified as being developmentally on track if they can do at least two of the following: identify/name at least 10 letters of the alphabet; read at least 4 simple, popular words; and/or know the name and recognize the symbols of all numbers from 1 to 10.
2. **Physical:** If the child can pick up a small object with two fingers, like a stick or rock from the ground, and/or the mother/primary caregiver does not indicate that the child is sometimes too sick to play, then the child is regarded as being developmentally on track in the physical domain.
3. **Social-emotional:** The child is considered developmentally on track if two of the following are true: The child gets along well with other children; the child does not kick, bite or hit other children; and the child does not get distracted easily.
4. **Learning:** If the child follows simple directions on how to do something correctly and/or when given something to do, and is able to do it independently, then the child is considered to be developmentally on track in the learning domain.

Response categories for all questions included in the ECDI are: *yes, no* and *don't know.* The ECDI score is then calculated as the percentage of children aged 36 to 59 months who are developmentally on track in at least three of these four domains.

DEVELOPMENT OF CHILDREN FROM 3 TO 5 YEARS OLD IN PILOT COMMUNITIES

Learning

Children able to follow instructions	76%
Children able to complete a given task independently	66%

Social-emotional

Children who are easily distracted	55%
Children who bite others	36%
Children who get along with other children	93%

Physical

Children who were sometimes too sick to play	52%
Children able to grab a small object using two fingers	88%

Literacy-numeracy

Children who know names or symbol of digits from 1 to 10	16%
Children who can read 4 words	16%
Children who can cite 10 lettters of alphabet	13%

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Annex 2 Include the curriculum of FMD trainings

Nb	Module name	Content
1	Welcome to the program Families Make the Difference	Parents get to know each other and the facilitators. The program is presented, participants and facilitators set rules and discuss program expectations. Participants get to understand the fundamentals of positive parenting.
2	Take care of yourself to take care of your children	Parents learn to handle negative feelings, learn to calm down. Participants learn to take care of themselves
3	Positive interactions through play encourage healthy child development	Participants learn howyoung children's brains develop in young. Participants understand the importance of their role in helping a child learn in life. Participants are aware that different stages of childhood require different emotional, social and intellectual stimulation.
4	How to help your child learn positive behaviors	Parents will learn to provide appropriate supervision that reinforces the sense of security and positive behavior in the community. Parents will understand the importance of positive or negative attention. Parents will explore loving interactions through the daily routines of bathing, eating and chores.
5	Empathy and mutual respect among peoples promote peace and the development of happy children in good health	Participants will learn that positive parenting techniques such as rule-making and punishment are important for all children in their care. Participants will learn techniques to reinforce good behaviors and reduce bad ones. Participants will learn how to exercise discipline while preserving the dignity of all household members
6	Harmony and responsibilities in my home	Participants will learn that positive parenting techniques such as rule-making and punishment are important for all children in their care. Participants will learn techniques to reinforce good behaviors and reduce bad ones. Participants will learn how to exercise discipline while preserving the dignity of all household members
7	Essential family practices	Newborn Registration and care: Relating to Newborn care, Relating to the Management of Home-Based Illness Cases, Relating to the Recognition of Signs of Danger for children

8	Nutrition for child development	Relative to Breastfeeding Exclusively, Relative to complementary feeding, Relative to vitamin A supplementation and deworming of the child, Relative to the consumption of iodized salt in the household.
9	Prevention against childhood diseases	Relative to Breastfeeding Exclusively, Relative to complementary feeding, Relative to vitamin A supplementation and deworming of the child, Relative to the consumption of iodized salt in the household
10	Review and celebration: a commitment to positive parenting	Program participants will present the sessions and what they have learned to their families, village leaders and other members of the community. Participants to the program will receive a certificate of participation and make a commitment to positive parenting.

Annex 3: Assessment of both FMD and center component

IPA's assessment concerns the overall CMD two-pronged approach. To give better insights on how each component performed, Annex 3 displays a separate assessment for the FMD component and the community center component. It is important to note that each dimension was designed to assess the entire pilot. In this respect when not enough information was available for the center component the assessment is blank because not applicable.

Evaluation Criteria	Assesment FMD	Assesment Centers	Recommendations
1.Relevance			
1.1 Targets an important need in the community	✓	✓	
1.2 Aligns with the priorities of the donors	✓	✓	Re-discuss donors' objectives
2.Results: outputs and direct outcomes			
2.1 Delivers outputs at high quality	✓	✗	Analyze community center component failure
2.2 Achieves direct outcomes	✓	✗	Reduce ambition on key targets
2.3 Beneficiaries' feedback about the program is positive	✓	-	
3.Costs and operations management			
3.1 Costs are well managed/cost scale-up vision	✓	✓	Better define the vision at scale and how the cost structure will be impacted by handover periods
3.2 Project management is successful	✓	✓	Take stock of the current integration of both components and review operation management
4.Capacity to learn, improve and innovate			
4.1 Project collects credible monitoring data	✓	-	
4.2 Monitoring is used to learn and improve	✓	-	
5.Sustainability			
5.1 Provides sustained benefit to community	✓	✗	Re-Asses the community model in the light of the Ivorian context
5.2 There are prospects of scale-up beyond GMM2	✓	-	